Using Quality Measures to Improve Patient Care and Outcomes for Medicaid Beneficiaries
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• The Medicaid and CHIP Scorecard initiative is to promote data transparency as well as state and federal accountability in the Medicaid and CHIP Program.

• The majority of the measures in the Scorecard are drawn from the CMS Medicaid and Child Core Sets which are currently voluntary for states and territories to collect.

• The Scorecard includes measures voluntarily reported by states, as well as federally reported measures in 3 areas:
  • 1) state health system performance;
  • 2) state administrative accountability; and
  • 3) federal administrative accountability
Adult and Child Medicaid and CHIP Quality Core Set Measures

The Core Sets are measures of health care quality and access that, taken together, provide a meaningful indication of how well the Medicaid and CHIP programs are meeting the needs of the beneficiaries enrolled in these programs.

The Adult Core Set includes several measures focused on behavioral health. These along with similarly focused measures from the Child Core Set have been identified as a Behavioral Health Core Set.

State data derived from the core measures are part of CMS’s annual Child and Adult Core Set measure reporting, which includes publication of chart packs and datasets that highlight publicly reportable measures.

CMS and states continue to improve health care reporting. This year information on 20 frequently reported child measures and 19 frequently reported adult measures are available!

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<tr>
<th>Child Core Set Measure</th>
<th>Adult Core Set Measures</th>
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<td>45 states reporting at least half (13) of the measures</td>
<td>43 states voluntarily reported data and 32 states reported at least half (15) of the measures</td>
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Mandatory Measurement

- Reporting on the Child Core Set and the behavioral health measures on the Adult Core Set become mandatory in 2024 due to the Bipartisan Budget Act and the SUPPORT for Patients and Communities Act, respectively.

- The move from voluntary to mandatory reporting will allow the Medicaid and CHIP programs to take the next step forward in the evolution of their quality measures program, to gain a more comprehensive and consistent picture of how well we’re serving our beneficiaries.

- The diligent effort we have undertaken together with states over the past 10 years of voluntary reporting lays the groundwork for our future success.
Technical Assistance and Analytic Support Program

CMS is committed to supporting states’ efforts to measure and improve the quality of health care for children and adults enrolled in Medicaid and the Children’s Health Insurance Program (CHIP). CMS established the Technical Assistance and Analytic Support Program to support states in collecting, reporting, and using measures for four Core Sets of Medicaid/CHIP quality measures: Adult, Child, Maternal and Infant Health, and Health Homes.

TA for the Medicaid/CHIP quality measures is driven by states’ needs and covers a wide range of topics, such as:

- Interpreting technical specifications for the Core Set measures, including applications across delivery systems, data sources, and data collection approaches.
- Assessing data quality to improve completeness and accuracy of state reporting of the Core Set measures.
- Designing and implementing quality improvement initiatives focused on the Core Set measures.
We are actively working with states to assess and improve the quality of T-MSIS data submissions to provide high-quality data supporting improved monitoring and oversight of the Medicaid and CHIP programs.

We will continue working with states as they address the 12 Top Priority Items for data quality, as discussed in the August 10, 2018 State Health Official Letter, and will preview data quality information reflecting states progress on these 12 priority areas in the coming weeks.
We are in the early stages of development of the Medicaid and CHIP QRS, which will aim to increase transparency regarding Medicaid and CHIP managed care plan performance, increase consumer and stakeholder engagement, and enable beneficiaries to consider quality when choosing a managed care plan.

The QRS will align where appropriate with other CMS managed care plan quality rating systems, such as the QHP QRS and the Medicare Advantage 5-star rating system, and will also provide important measurement plan level data to help support the Medicaid and CHIP Scorecard.

We look forward to continuing to work closely with states and other stakeholders as we continue QRS policy development and testing leading to a QRS proposed notice for public comment in the Federal Register.
CMS continues to evaluate our approach to understanding access to care across Medicaid delivery system. November 16, 2017, we issued a State Medicaid Director Letter on complying with the Medicaid Access to Care regulations. And earlier this year, we issued a notice of proposed rulemaking that would alleviate state burden by adding thresholds to the access rules for states with high managed care and certain payment changes.

- The Medicaid Scorecard includes a number of important access indicators, such as the percent of children receiving well-child visits and immunizations and the ability of individuals to get care quickly.
- In line with the Scorecard initiative, we are interested in developing and adopting meaningful access measures that could apply consistently regardless of the service delivery approach used by the state. Our ultimate goal is to better measure, monitor and ensure Medicaid access across state programs and delivery systems.
In March, 2014, CMS provided information on modifications to the 1915(c) waiver Quality Improvement Strategy (QIS). The Bulletin focused on the following areas:

- Systemic oversight
- Four areas related to actions to be taken by a state as part of the Health and Welfare assurance:
  - Demonstrate that it identifies and seeks to prevent instances of abuse, neglect, exploitation, and unexplained death.
  - Demonstrate that an incident management system is in place.
  - Ensure adherence to policies and procedures for the use or prohibition of restrictive interventions.
  - Establish and monitor providers against overall health care standards.
We have heard from some states that the lack of standardized HCBS quality measures and inconsistent HCBS requirements can make it difficult for them to effectively oversee and monitor their programs and can increase their administrative burden. To address these challenges, we have drafted a proposed HCBS quality strategy to better organize and align our work within CMS and with our federal partners.

- This strategy will help us to identify and address gaps related to HCBS quality, better ensure the safety and well-being of people receiving HCBS, and support states, managed care organizations, and providers with innovative activities to improve the quality and value of HCBS.

- The quality strategy builds off of some of our recent accomplishments related to HCBS quality. For instance, we received NQF endorsement of 19 measures derived from the HCBS CAHPS experience of care survey, which was developed and tested in partnership with states through the Testing Experience and Functional Tools demonstration.

- We have also completed development of eight measures for use by states with MLTSS programs. Four of these measures and have been adopted by NCQA for HEDIS 2019 and two others are under consideration for endorsement by NQF. The technical specifications for all eight measures are posted on Medicaid.gov and we encourage states to begin incorporating them into their quality strategies for their MLTSS programs.