



AMERICA'S ESSENTIAL HOSPITALS

December 21, 2015

Mr. Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Ave., SW
Washington, DC 20201

**Ref: CMS-2328-NC: Medicaid Program; Request for Information (RFI) –
Data Metrics and Alternative Process for Access to Care in the Medicaid
Program**

Dear Mr. Slavitt:

Thank you for the opportunity to submit comments on this Centers for Medicare & Medicaid Services (CMS) request for information (RFI) on core measures and metrics of beneficiary access to care in Medicaid and thresholds and goals for improving program access. America's Essential Hospitals supports CMS' work to identify measures and metrics that appropriately assess Medicaid beneficiaries' access to care.

America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to high-quality care for all, including the most vulnerable. Filling a vital role in their communities, our roughly 275 member hospitals provide a disproportionate share of the nation's uncompensated care and devote about half of their inpatient and outpatient care to Medicaid and uninsured patients. Through their integrated health systems, members of America's Essential Hospitals offer primary care through quaternary care, including trauma care, outpatient care in ambulatory clinics, public health services, mental health and substance abuse services, and wraparound services vital to vulnerable patients.

Essential hospitals play a unique and critical role in the Medicaid delivery system. Given our largely low-income, vulnerable patient populations, we are distinctly positioned to make a real and lasting impact on the lives and well-being of the most disadvantaged among us. We have the expertise, passion,

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and commitment to apply and adapt proven models of care to the benefit of our patients, and to pioneer new models to meet their specialized needs.

In its RFI, CMS solicits feedback to inform potential development of standards to assess beneficiary access to covered services under Medicaid. As CMS moves forward with developing thresholds and goals to inform and improve access in the program, we ask the agency to consider the following comments.

1. CMS should consider access measures that are relevant for the full range of services critical to the Medicaid population.

As CMS develops standards to assess beneficiary access to covered services, the agency should look at measures that are relevant for all services—*especially* hospital services. Measures should demonstrate an appropriate range of available preventative, primary care, and specialty services; and a sufficient number, mix, and geographic distribution of providers to meet the needs of all Medicaid patients in a service area. Without adequate access, enrollees would not receive primary and specialty care vital to positive health outcomes.

Measures also should focus on issues particularly relevant to the Medicaid population. In state reviews, CMS should include relevant measures that identify patients' ability to receive social support, such as language services, other culturally competent care, transportation services, and access to after-hours care. These types of services are especially important to Medicaid beneficiaries. Reviewing these factors will help protect essential providers from rate changes that hinder their ability to provide the full range of care to vulnerable patients.

2. CMS should identify a set of uniform measures for states to collect.

In addition to developing measurement standards that capture meaningful access to covered services, CMS should identify a set of uniform measures for which states must collect data. This will enable CMS to compare data across states and develop a better understanding of measures that particularly impact access. CMS could still provide flexibility to states to satisfy the access monitoring review requirements using other measures, but the burden would be on the state to demonstrate the strength of its alternative measures.

In its role as first co-chair of The Partnership for Medicaid, America's Essential Hospitals has encouraged the adoption of uniform measures and access to care summary indicators. The Partnership has developed a quality reporting framework and process aimed at improving health care quality and reducing costs in Medicaid. The Partnership for Medicaid is a nonpartisan, national coalition of 23 organizations representing hospitals, physicians and other health care providers, safety net health plans, counties, and labor. The

coalition's goal is to preserve and improve Medicaid. As outlined in further detail in the attached proposal, the Partnership urges adoption of a four-step process for comprehensive state reporting and accountability, to include these components:

- federal reporting infrastructure
- a succinct common reporting set
- federal incentives to report
- mandatory reporting by all states

America's Essential Hospitals urges CMS to consider key aspects of this proposal as it works to develop a system that establishes a baseline for identifying access gaps and institutes a standardized measurement method.

3. CMS should ensure any measures used for comparisons of payment include the cost of services.

For comparing payment rates, CMS should consider measures that assess whether the payment rates cover providers' average costs. CMS should also clarify that cost should be calculated as the agency has defined it—i.e., through a Medicare cost reporting methodology, consistent with standards for other parts of the Medicaid program. This will help to ensure that the definition of cost is not manipulated to create the appearance of sufficient payment rates.

4. CMS should apply any measures used to determine adequacy of fee-for-service (FFS) payment rates to managed care payment rates.

CMS seeks comment on comparisons or measures that would inform managed care rate adequacy. Inclusion of such comparisons or measures is critically important, as more than 70 percent of Medicaid enrollees are in some form of managed care,¹ and states are increasingly looking to Medicaid managed care as a way to limit costs. Managed care capitation rates must support plan payments to providers sufficient to ensure access at least equivalent to that available to the general population. Too often, current Medicaid managed care rates result in less access to services for beneficiaries.

As states continue to increase use of managed care for their Medicaid populations, it is vital that plans are paid rates that are sufficient to provide not just access to these services, but equal access, as the statute requires. As such, CMS should ensure states accurately account for the costs associated with providing care to guarantee that payment rates are actuarially sound and preserve access to providers. The development of actuarially sound rates

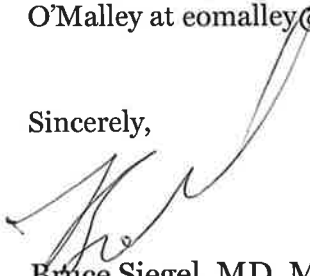
¹ Kaiser Family Foundation. State Health Facts: Total Medicaid Managed Care Enrollment, 2013. <http://kff.org/medicaid/state-indicator/total-medicaid-mc-enrollment/>. Accessed November 2015.

should include, as part of the base data, the assumption of provider payment rates that meet the (a)(30)(A) standard.

* * * * *

America's Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Director of Policy Erin O'Malley at eomalley@essentialhospitals.org or 202-585-0127.

Sincerely,

A handwritten signature in black ink, appearing to read 'Bruce Siegel', is written over a light gray horizontal line.

Bruce Siegel, MD, MPH
President and CEO

THE NEXT STEP: IMPROVING HEALTH CARE QUALITY AND REDUCING COST IN THE MEDICAID PROGRAM

MARCH 2014

Executive Summary

AS THE HEALTH CARE SYSTEM EVOLVES, policymakers have focused on quality measurement and improvement initiatives to find common-ground solutions to deliver better quality care, access to providers, and, ultimately, lower costs. While the Medicare program has benefited from federal initiatives for comprehensive measurement and improvement, such efforts for the Medicaid program largely have focused on the state level.

But the Medicaid program is a vital component of the U.S. health care system, providing care and critical services to more than 60 million patients. To ensure that the Medicaid program continues to evolve and improve, the Partnership for Medicaid supports the development of a comprehensive, standardized quality measurement and reporting program to promote improvement in the quality of care for our nation's most vulnerable populations.

The Partnership for Medicaid recommends the development of a uniform, state-level reporting mechanism for the Medicaid program. This mechanism will build on existing quality measurement and

improvement processes and provisions in federal law, expanding them to all states and all delivery system modalities. As an important next step in advancing the National Quality Strategy for the Medicaid program, this reporting mechanism would establish a baseline for the quality of provided care, identify quality gaps in the Medicaid program, and institute a standardized method to

measure quality and promote quality improvement.

In recognition of overburdened state Medicaid agencies, the Partnership proposes federal funding to assist in the implementation of the reporting system and the collection of metrics from plans and providers. These entities would report to their respective

states according to an established set of measures, which would evolve with time and stakeholder input. In addition, the Centers for Medicare & Medicaid Services (CMS) would develop a standardized reporting infrastructure to allow states to report their data to CMS. Information gleaned from comprehensive mandatory reporting would be available to Congress, stakeholders, and the public, providing policymakers with the information needed to make evidence-based decisions about improvements to the Medicaid program.

The Medicaid program must be efficient and effective, and must provide value to its beneficiaries and to those who fund it. Without a comprehensive measurement and reporting system, we cannot know whether this is the case, nor can we determine where improvements may be needed.

As with all health care programs, Medicaid must be efficient and effective, and must provide value to its beneficiaries and to those who fund it. Without a comprehensive measurement and reporting system, we cannot know whether this is the case, nor determine where improvements may be needed. This proposal represents an important step toward that goal.

I. Background and Statement of Need

Established nearly 50 years ago, Medicaid is a unique state/federal partnership that annually provides health care and other critical services to more than 60 million vulnerable people. Several populations with very different health care needs and utilization patterns are served through the Medicaid program. These populations include pregnant women, children, older adults (aged 65 and over), people with disabilities, and, particularly in those states that are expanding Medicaid, adults under 65 years of age. Despite the challenge of providing health care to a diverse and often difficult-to-reach population, Medicaid has lower per-capita costs than most private insurance and lower overhead costs than Medicare.¹ The quality and costs of care provided through Medicaid must be well understood to ensure the value of this program to beneficiaries and to society.

The federated model... allows for state experimentation, but also creates challenges in measuring and assuring high-quality and affordable care for all Medicaid beneficiaries.

¹ Park, E., and Broaddus, M. *Correcting Five Myths About Medicaid*. Center on Budget and Policy Priorities. <http://www.cbpp.org/cms/index.cfm?fa=view&id=4023>. Accessed 24 September 2013.

Medicaid as a Learning Laboratory

The Medicaid program is perhaps the country's greatest experiment in federalism. Medicaid's unique federal nature means that "the Medicaid program" is a misnomer. In fact, the 50 states, the District of Columbia, and five U.S. territories run 56 different Medicaid programs.² With respect to services provided and populations covered, all states comply with the minimal requirements established by the federal government. Above the minimum, each state determines eligibility levels for the populations it covers, selects additional covered services, and decides how services will be financed and delivered (e.g., through fee-for-service or managed care).

Medicaid's diffuse structure has opportunities and challenges. Each Medicaid program is different, and overall program structure provides significant opportunity for state-level and even regional innovation, making Medicaid one of the great laboratories in health care. ***The variation in Medicaid programs, however, means that it is difficult to compare programs across states.*** Each state has a different mix of eligible populations in different types of delivery systems. Further, many services provided to Medicaid beneficiaries – such as mental health services – may be funded and/or delivered at the local level (e.g., Community Mental Health Centers). Challenges in integrating federal, state, and local data, in addition to a lack of consistent measurement, make it difficult to measure the relative benefit of Medicaid coverage across the country.

² Hereafter, we use "states" to refer to Medicaid programs, although these programs also exist in the District of Columbia and five U.S. territories.

Ensuring Better Health Care, Healthy People and Communities, and Lower Costs

In 2011, the Department of Health and Human Services (HHS) adopted the National Strategy for Quality Improvement in Health Care (National Quality Strategy) to create national goals and priorities to guide local, state, and national efforts to improve the quality of health care in the United States. The three-part aim of the National Quality Strategy is to achieve healthier people and communities, better health care, and affordable care through six priorities: making care safer, ensuring person- and family-centered care, promoting effective communication and coordination of care, promoting the most effective prevention and treatment for the leading causes of mortality, working with communities to promote wide use of best practices to enable healthy living, and making high-quality care more affordable.

Much of the federal quality improvement activity historically has occurred in the Medicare program. While providers serving the Medicaid program participate in various quality measurement activities (see Appendix for a summary of the kinds of current quality improvement activities), improvement efforts in the Medicaid program largely focus on state-level requirements.

Medicaid managed care—one delivery system area with significant quality measurement requirements—provides services to approximately half of Medicaid enrollees through comprehensive, risk-based managed care plans.³ Pursuant to federal

requirements, states require managed care organizations with which they contract to report standard Healthcare Effectiveness Data and Information Set (HEDIS®) performance measures and to meet requirements for access. But these reporting and access measures, as well as the populations enrolled in managed care, vary by state. These differences limit the validity of cross-state quality comparisons.

The federated model of Medicaid and the Children's Health Insurance Program (CHIP) allows for state experimentation, but also creates challenges in measuring and assuring high-quality and affordable care for all Medicaid beneficiaries. Congress recognized that the unique needs of the Medicaid population were not fully met by existing Medicare, or Medicaid managed care, quality improvement measures. As a result, federal law established the new Medicaid Quality Measurement Program to develop core quality measures for adult health care under Medicaid (Section 1139B of the Social Security Act). This section mirrors aspects of the federal investment in Medicaid and CHIP quality improvement contained in the CHIP Reauthorization Act (CHIPRA, Section 1139A of the Social Security Act).⁴

The development of core quality measures for adult health care under Medicaid and the CHIPRA quality provisions are important first steps. But measurement and reporting requirements vary across states and are voluntary. Additionally, existing measures do not adequately address all of the domains of quality; all sub-populations of Medicaid

³ Approximately 71 percent of Medicaid enrollees receive some type of service through a managed care arrangement, which CMS defines to include comprehensive, risk-based managed care as well as

primary care case management and limited-benefit plans.

⁴ New funding for the quality improvement activities authorized under CHIPRA expired September 30, 2013.

beneficiaries (e.g., children, pregnant women, and frail elderly); or all settings in which these beneficiaries receive care. These measurement gaps and variation in reporting also inhibit the ability of Medicaid stakeholders to nationally examine quality of care, access to care, beneficiary health, and patient satisfaction across populations.

Federal policymakers are rightly interested in investigating opportunities to improve Medicaid to ensure that it provides access to cost-effective, high-quality health care.^{5,6} With the Medicaid expansion that took effect in January 2014, the Partnership for Medicaid seeks to work with policymakers to find innovative solutions to measure and, as necessary, improve the quality of the care provided to beneficiaries. With limited information about the quality and benefit of Medicaid coverage and services, changes to the Medicaid program have often focused on cost-shifting to states and providers rather than on improving care and value. This cost-shift can have significant negative impacts on beneficiary access to care and other unintended consequences.

The Partnership for Medicaid believes that a health care system built on a strong foundation and supported by quality measurement and improvement initiatives is critical to achieve common-ground solutions that lead to better quality, better access, and

lower costs. Efforts to improve the quality of care currently are gaining tremendous momentum and broad support from the private and public sectors.^{7,8} Plans and providers serving Medicaid beneficiaries, including safety net providers, lead these efforts. Transforming the U.S. health system to be more efficient and effective is critical in these times of constrained resources. Quality improvement is central to achieving this goal and is predicated on quality measurement.

The Partnership for Medicaid supports the development of a comprehensive quality measurement and reporting program for Medicaid to create a consistent, standardized method of reporting, measuring, and promoting improvement in the quality of care for our nation's most vulnerable people. Patients and beneficiaries deserve access to the highest-quality coverage available; and there is always room for improvement within any program, including Medicaid. The Partnership believes that the development of a comprehensive Medicaid quality reporting program that measures and ultimately advances Medicaid in the following three key areas will accelerate its improvement:

⁵ One of the overall charges of the Medicaid and CHIP Payment and Access Commission (MACPAC) is the responsibility to conduct analyses of many Medicaid-related issues, including quality of and access to care. Several reports available at www.macpac.gov address aspects of these issues.

⁶ See investigations into how to modernize the program, such as the May 2013 "Making Medicaid Work" blueprint released in 2013 by House Energy and Commerce Committee Chairman Fred Upton (R-MI) and Senate Finance Committee Ranking Member Orrin Hatch (R-UT).

⁷ The Department of Health and Human Services. CMS 2012 Annual Report on the Quality of Care for Children in Medicaid and CHIP. Medicaid. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2012-Ann-Sec-Rept.pdf>. Accessed 21 November 2013.

⁸ MACPAC. June 2013 Report to the Congress on Medicaid and CHIP. Google Docs. <https://docs.google.com/viewer?a=v&pid=sites&srcid=bWFjcGFjLmdvdnxtYWwYWN8Z3g6NWE3MTM2NWU4NjhhdVYmYQ>. Accessed 21 November 2013.

1) Quality of care for Medicaid

beneficiaries: Clinical standards and the appropriate delivery of health care services are important to achieve effective, high-quality health care and better health. For Medicaid beneficiaries in particular, delivery of the right services, in the right setting, at the right time can generate significant savings over time to states, the federal government, and taxpayers—in addition to providing high-quality health care.

2) Access to care for Medicaid

beneficiaries: Low-income and minority populations are significantly more likely to report barriers to accessing needed health care services. Patients with public insurance are more likely than their privately insured counterparts to delay and even forego necessary medical and dental care and use of prescription medicines due to challenges including cost, language, transportation, and availability of providers. These access barriers negatively influence personal and societal health while driving up costs and the unnecessary utilization of emergency services. Access measures are critical components of a robust platform for improving health care quality, improving health, and decreasing costs.

3) Patient experience among Medicaid

beneficiaries: The way patients interact with their providers, and their unique experiences in receiving care, can impact patient compliance, adherence and effectiveness of treatment regimens, and resource utilization. In fact, studies find that patient-centered approaches to care improve health status. Measures of patient experience with care are a critical aspect of quality and cut across measures specific to health conditions.

II. Detailed Recommendations

The Partnership for Medicaid recommends the development of a uniform, state-level reporting mechanism for the Medicaid and CHIP⁹ programs that builds on existing measures and the provisions in federal law associated with quality measurement and improvement. As an important next step in advancing the National Quality Strategy for the Medicaid program, this reporting mechanism would be used to establish a baseline understanding of the quality of care provided, identify quality gaps within the Medicaid program, and institute a standardized method to measure quality and promote quality improvement.

Principles for Measurement and Reporting

1) Comprehensiveness: Federal quality measurement and reporting programs should provide a full picture of quality for all Medicaid beneficiaries, including:

- all subpopulations (pregnant women, children, older adults, people with disabilities, and newly insured adults in Medicaid expansion programs);
- all settings of care (outpatient, inpatient, subacute, etc.);
- all delivery systems (managed care, fee for service, accountable care organizations, and primary care case management);
- and all dimensions of quality (safety, timeliness, effectiveness, efficiency, equity, and patient centeredness).

This proposal seeks to build a framework for such a comprehensive program. The Partnership recognizes it will take time to develop a robust reporting program.

⁹ Hereafter, the use of term “Medicaid” can be understood to include CHIP where applicable.

2) Appropriate Adjustment in Comparing

Results: Medicaid beneficiaries are frequently complex patients who are often not only low-income but also medically underserved. Measures included in a federal quality measurement and reporting program, to the extent possible, need to be appropriately risk adjusted to take the Medicaid patient populations into account. Furthermore, social determinants of health often play a significant role in the health status of Medicaid patients, especially as compared to other, non-Medicaid-eligible individuals. Performance measures must factor in the multitude of barriers and obstacles arising from such social determinants of health that may impact both the baseline and expected improvement for such individuals. Appropriate risk adjustment for severity of illness and social factors is especially important when comparing results across populations such as Medicaid and non-Medicaid individuals.

3) Appropriate Balance of Measurement

and Costs/Burden: The costs of measurement and reporting to providers and states should be coupled with improvements in health and health care.

4) Stakeholder Input: Measure sets should be developed and maintained in a way that includes stakeholder input. The NQF Measures Application Partnership, development of the National Committee for Quality Assurance HEDIS®, and Partnership for Patients are possible models for such a process.

5) Data Use: Information collected for measure reporting must continue to meet all Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy requirements. Measure reporting must be

accompanied by timely feedback reports to providers and plans to inform their practices and activities. To ensure provider willingness to report quality data, any data collected from individual providers should be protected from legal discovery, as is currently the practice for data reported to Medicare Quality Improvement Organizations.

We recognize that the implementation of a comprehensive reporting strategy will require federal support at all levels. This support includes:

- Federal funding for further development of applicable measures for all Medicaid beneficiaries, recognizing the wide variation in health care needs of the various subpopulations served by the Medicaid program
- Federal incentives to states to report on applicable measures and develop the necessary infrastructure to do so
- Federal financial support to Medicaid providers and plans to support necessary collection and reporting of measures to state Medicaid agencies, as well as the underlying infrastructure needed for reporting
- The development of a federal reporting infrastructure
- Technical assistance to states and providers to aide in standardized reports

Four-Step Process to Comprehensive State Reporting and Accountability:

Establishment of the Succinct Common Reporting Set (Target Date: Federal Fiscal Year 2015): The Reporting Set should be reported at the state level, allowing for assessment of overall program activity as well as activity by delivery service modality (e.g., managed care, fee-for-service,

accountable care organizations, and primary care case management) using a standardized format to be developed by CMS.

- Measures should be phased in, beginning with a limited number of measures to guarantee that reporting is manageable for providers, plans, and states. Over time, the number of measures will increase to ensure that the reporting set is comprehensive. The common reporting sets of measures are not intended to supersede or reduce the level of current reporting.
- To the extent possible, measures should be appropriately risk-adjusted to take into account severity of illness and social determinants of health that may account for different baselines for different populations and sub-populations (e.g., education level, language barriers, food security, income/poverty level, etc.).
- Data should be stratified to reflect reporting for fee-for-service providers and managed care; diverse Medicaid populations (i.e., children, pregnant women, adults, blind, and disabled); state eligibility levels; and duration of enrollment. To minimize reporting burdens, when possible, measures should be drawn from those that have already been established, such as measures endorsed by the National Quality Forum (NQF), and use currently available data to the extent possible. It is essential that the common reporting set evolve over time to address gaps in measurement.
- To the extent possible, and recognizing the varying subpopulations that different health care programs address, Medicaid quality measures should be harmonized with those of other programs.
- Development of the common reporting sets should entail broad stakeholder input.

Development of Federal Reporting

Infrastructure (Target Date: Federal Fiscal Year 2015): Coinciding with the development of an initial Reporting Set, CMS should complete development of a standardized reporting infrastructure. This mechanism should provide a standard method for states to report to CMS; an infrastructure to collect, house, and analyze data; and the ability of the public to compare results.

Federal Incentives to Report (Target Date: Federal Fiscal Year 2016): No later than one year after the development of an initial Reporting Set, states would begin to receive financial incentives through the Medicaid program for reporting on applicable measures. These incentives would take into account the cost of implementing a comprehensive measurement system at the state, plan, and provider level. Measure reporting must be accompanied by timely feedback reports to providers to inform their practice.

Mandatory Reporting by All States (Target Date: Federal Fiscal Year 2017): No sooner than one year after the introduction of financial incentives for reporting, CMS should require all states to report on all applicable measures.

Information gleaned from comprehensive mandatory reporting would be available for Congress to make informed, evidence-based decisions about how to provide financial and programmatic incentives to states to improve their Medicaid program based on quality, patient experience, and access to care.

III. Areas for Additional Consideration

Healthier Individuals and Communities— Social Determinants of Health:

The Partnership for Medicaid recognizes that the health of an individual does not depend on medicine and health care alone. Many factors from outside the walls of a medical facility—and outside the scope of access to traditional health care services—affect an individual's health, such as housing, poverty, education, nutrition, and even the urban environment. In fact, much of life expectancy and health status can be attributed to social determinants of health: 40 percent to social and economic factors, 30 percent to health behaviors, and 10 percent to the physical environment, leaving just 20 percent to clinical care.¹⁰ Although this proposal focuses on health care quality, comprehensive approaches to achieve the aims of the National Quality Strategy will be needed to address population health.

Health Care Quality Is a Person-Centric Issue:

This proposal is designed to assist all stakeholders in understanding and improving the quality of care provided to Medicaid beneficiaries. But the Medicaid program operates within, and is significantly influenced by, the health care system at large. Moreover, many beneficiaries are often disenrolled and reenrolled into the program due to changes in income or bureaucratic issues. This situation leads to churning between Medicaid and other coverage

options. To capture the quality of care provided to populations across payers, it will be vital to work toward standardized processes to measure quality and system-wide improvements. With the goal of assisting all individuals to receive high-quality health care, the members of the Partnership for Medicaid stand ready to participate in such an effort.

Program Improvement Can Be Achieved Through a Variety of Mechanisms:

Quality measurement is not an end unto itself. Rather, quality is measured so that program managers, policymakers, and stakeholders can identify areas where services are delivered effectively and efficiently, as well as areas for improvement. This information can also be used in ways beyond payment reform, such as the highlighting of best practices and the scaling up of these best practices for larger audiences. The members of the Partnership for Medicaid expect that such changes will occur as a result of the actions proposed here and look forward to working with other stakeholders on these efforts.

¹⁰ Booske, B., Athens, J., Kindig, D., Park, H., and Remington, P. Different perspectives for assigning weights to determinants of health. County Health Rankings Working Paper. <http://www.countyhealthrankings.org/sites/default/files/differentPerspectivesForAssigningWeightsToDeterminantsOfHealth.pdf>. Accessed 21 November 2013.

APPENDIX: Existing Quality Activities Conducted by Medicaid Providers and Plans

While Medicaid lacks a standardized federal reporting strategy, safety net providers have done substantial improvement. But these efforts have been largely uncoordinated and vary among providers, health plans, and within Medicaid.

The following efforts, listed by provider type or program, provide a foundation for a coordinated, national

Provider Type	Medicaid Population Served	Existing Federal Medicaid Quality Measurement Reporting Requirements	Existing State or Private-Payer Quality Measurement Reporting Requirements	Opp
Acute Care Hospitals	More than 3,400 acute care hospitals nationwide serve Medicaid patients in varying numbers, including hospitals that serve a safety net role by caring for a disproportionate share of Medicaid beneficiaries.	Few federal-level reporting requirements for Medicaid: <ul style="list-style-type: none"> • No federal payments to states for provider-preventable conditions, most of which apply to hospitals. • Voluntary state reporting to CMS on CMS Core Set quality measures for Medicaid-eligible adults; hospital reporting to the state is mandatory. 	<ul style="list-style-type: none"> • Hospitals must report CMS Core Set quality measures to the state. • In a handful of states, hospitals participating in Medicaid delivery system transformation waivers also have to report quality-related measurement data to the state and to CMS. 	<ul style="list-style-type: none"> • While quality Medica to repo many c Medica manda measu • Incre reporti only M
Community Mental Health Centers (CMHCs)	CMHCs and other related organizations serve over 8 million low-income children and adults with serious mental health and addiction disorders.	No Medicaid-focused federal reporting requirements.	<ul style="list-style-type: none"> • Some CMHCs participate in Medicaid Managed Care and report quality measures to the MCO as part of the MCO's broader quality reporting requirements. 	Multipl improv <ul style="list-style-type: none"> • NCQ/ Practic • The S Health (SAMH Service for Inte • Natio Health.

Provider Type	Medicaid Population Served	Existing Federal Medicaid Quality Measurement Reporting Requirements	Existing State or Private-Payer Quality Measurement Reporting Requirements	Opp
Dental Providers	There is little available information about dental care for adult Medicaid beneficiaries, as it is not a provided benefit in most states. Dental benefits are required for children in Medicaid and CHIP; a 2008 CMS study found that 38 percent of eligible children received a dental visit that year.	No federal reporting requirements, but quality measures for pediatric oral health care have been developed.	<ul style="list-style-type: none"> • Dental Quality Alliance (DQA) has developed and endorsed a set of pediatric oral health measures. The measures apply across public and private programs; align with current CMS oral health strategy; and were tested for feasibility, validity, reliability, and usability based on the CHIPRA measure criteria and that of the National Quality Forum. • AHRQ has developed an adult dental survey for CAHPS that focuses on patient satisfaction. 	<ul style="list-style-type: none"> • At thi quality but the perform
Family Health Providers	Family health providers serve diverse groups of Medicaid-eligible individuals, including disabled and low-income non-disabled adults, children, the elderly, and pregnant women. On average, 15% of family physician's patients are Medicaid recipients; in non-metropolitan areas, that number jumps to 19%.	<p>Few federal reporting requirements:</p> <ul style="list-style-type: none"> • Initial Core Set of Adult Health Care Quality Measures for Medicaid-Eligible Adults: state reporting to CMS is voluntary and, to the extent adopted, may result in state-specific mandatory provider reporting. • CHIPRA Quality of Care and Performance Measurement Initial Core Set of Children's Health Care Quality Measures: state reporting to CMS is 	<ul style="list-style-type: none"> • The American Board of Family Medicine requires certified Family Physicians to complete Maintenance of Certification courses in a variety of areas, including Performance in Practice Modules, which are web-based, quality improvement modules in different health areas. Through these modules, quality indicators for individual physician practice are assessed and the physician completes a quality 	<ul style="list-style-type: none"> • Trem the Pat and Ac practic many s and pil care m while l each pa their h • Sixty Acader membe patient

Provider Type	Medicaid Population Served	Existing Federal Medicaid Quality Measurement Reporting Requirements	Existing State or Private-Payer Quality Measurement Reporting Requirements	Opp
		<p>voluntary and, to the extent adopted, may result in state-specific mandatory provider reporting.</p> <ul style="list-style-type: none"> Clinical Quality Measure (CQM) reporting associated with the EHR Meaningful Use Incentive Program. 	<p>improvement plan for their practice by using their own performance data indicators.</p> <ul style="list-style-type: none"> Providers who contract with Medicaid MCOs report quality measures to the MCO as part of the MCO's broader quality reporting requirements. 	<p>numbe implem Afford as the Parity provid fee-for setting service meet c</p>
Federally Qualified Health Centers (FQHCs)	FQHCs serve 1 in 7 Medicaid beneficiaries nationwide. Of the over 22 million patients health centers serve, 40% (approximately 8.8 million) are covered by Medicaid/CHIP.	<p>Comprehensive federal-level reporting requirements related to health center operations, not Medicaid specific:</p> <ul style="list-style-type: none"> Federally funded FQHCs are required to report clinical quality performance measures annually through the Uniform Data System (UDS). Health centers currently report clinical outcome data to HRSA on 15 measures. UDS is maintained by HRSA, and measures reflect HRSA priorities; many measures are similar to measures from NQF, NCQA, etc. Health centers receiving Medicaid EHR Incentive Payments also report Meaningful Use (MU) Clinical Quality Measures (CQMs) associated with the CMS Medicaid EHR Incentive Program. 	<ul style="list-style-type: none"> 80% of FQHCs participate in Patient-Centered Medical Home (PCMH) transformation initiatives, including the CMS Advanced Primary Care Demonstration, the Safety Net Medical Home Initiative sponsored by Commonwealth Fund, and PCMH recognition and accreditation and report requisite quality measures. Most FQHCs have experience reporting clinical measures and quality metrics to private payers and within state-based initiatives, but very little data is available. 	<ul style="list-style-type: none"> Lack quality PCMH, metric: Data financi signific infrast resource among Medica to inter data. Addit docum which perform and pa

Provider Type	Medicaid Population Served	Existing Federal Medicaid Quality Measurement Reporting Requirements	Existing State or Private-Payer Quality Measurement Reporting Requirements
Long-Term Services and Supports (LTSS)	<p>Medicaid is the primary payer for long-term services and supports (LTSS). These services are delivered in both institutional and home and community-based settings and cover services such as nursing center and home health care, as well as a variety of others at the state's option or through waivers. These services and supports are available to people who lack the capacity for self-care due to a physical, cognitive, or mental disability or condition, which can result in the need for hands-on assistance or supervision over an extended period of time.</p>	<p>In LTSS and Medicaid, there are both provider-based and population-based quality measures. Federal requirements include:</p> <ul style="list-style-type: none"> • CMS computes and publicly reports quality measures from data Medicare- and Medicaid-certified nursing centers routinely collect. • CMS requires Medicare-certified home health agencies to collect and transmit performance data for all adult patients whose care is reimbursed by Medicare and Medicaid with the exception of patients only receiving pre- or postnatal services. • Medicaid-financed Home and Community-Based Services (HCBS) quality measures are included in Section 1915(c) waivers and implemented on a state-by-state and program-by-program basis. • Under the duals demonstrations, contracts with managed care plans focus primarily on population based quality measures, including HEDIS, rather than provider based quality measures. CMS requires MCOs in the demonstrations, and thus the LTSS providers with whom they contract, to meet reporting requirements applicable to Medicare Special Needs Plans (SNPs) in addition to state requirements and reporting on LTSS. The National Quality Forum Measurement Advisory Panel has developed measures relevant to the demonstrations. 	<ul style="list-style-type: none"> • A number of states have public reporting programs for certain provider types (e.g., nursing centers, home health) that are not tied to payment, and generally focus on structure or process quality measures. • Among states that collect quality measures for nursing centers that are tied to payment, they tend to focus on staffing, survey outcomes, patient satisfaction, and clinical quality measures.

Provider Type	Medicaid Population Served	Existing Federal Medicaid Quality Measurement Reporting Requirements	Existing State or Private-Payer Quality Measurement Reporting Requirements
Medicaid Managed Care Organizations	Capitated Medicaid MCOs serve 29.1 million Medicaid enrollees—more than half of the 57 million individuals enrolled in the Medicaid program in 2011.	<p>Significant federal-level reporting requirements:</p> <ul style="list-style-type: none"> • Federal law requires various quality monitoring and improvement processes for capitated Medicaid managed care. • Quality assurance and improvement strategy must include standards such as continuity and access as well as procedures to monitor quality and appropriateness of care. • Enhanced federal funding is available for external quality review organizations that conduct independent reviews of MCO activities. 	<p>States set reporting requirements, often using nationally established quality measures, including:</p> <ul style="list-style-type: none"> • Healthcare Effectiveness Data and Information Set (HEDIS) measures, which assesses effectiveness, access and availability, and experience of care, as well as utilization and relative resource use. • Consumer Assessment of Health Providers and Systems (CAHPS) measures, which assess patient experience and satisfaction. • Some states require MCOs to be accredited by NCQA. • Some states publish a health plan report card.
Obstetric and Women's Health Providers	Medicaid provides services to 22.4 million women, covers 45 percent of births, and is the largest financer of publicly funded family planning services.	<p>Few federal reporting requirements:</p> <ul style="list-style-type: none"> • CHIPRA and the Affordable Care Act (ACA) established an initial core set of children's and adult health care quality measures for voluntary state reporting to CMS, which include measures for obstetric, gynecologic, and primary care. To the extent that states adopt measure reporting, may result in state-specific mandatory provider reporting. 	<ul style="list-style-type: none"> • Providers who contract with Medicaid MCOs report quality measures to the MCO as part of the MCO's broader quality reporting requirements.

Provider Type	Medicaid Population Served	Existing Federal Medicaid Quality Measurement Reporting Requirements	Existing State or Private-Payer Quality Measurement Reporting Requirements
Pediatric Providers	<ul style="list-style-type: none"> • More than one-third of all children in the United States—and two-thirds of children with medical complexities—are covered by Medicaid. • On average, 30 percent of a pediatrician's patients are covered by Medicaid. • Pediatricians provide two-thirds of all office visits for children on Medicaid, often in multidisciplinary teams. • Although they account for less than 5 percent of hospitals, children's hospitals provide 47 percent of the hospital care required by children covered by Medicaid. 	<p>Few federal reporting requirements:</p> <ul style="list-style-type: none"> • The Children's Health Insurance Program Reauthorization Act (CHIPRA) established a core set of children's health care quality measures: state reporting to CMS is voluntary and, to the extent adopted, may result in state-specific mandatory provider reporting. • CHIPRA also disseminated best practices in measurement and reporting, established the Pediatric Quality Measures Program, authorized demonstration projects, and created the children's EHR format. • One of the 24 measures of the initial core set focuses on children's hospital care quality; remaining measures focus on prevention and primary care. 	<ul style="list-style-type: none"> • The American Board of Pediatrics (ABP) Maintenance of Certification requires pediatricians to participate in a range of ABP-approved quality improvement projects to assess and improve the quality of pediatric care. • For nurse practitioners, the Quality and Safety Education for Nurses (QSEN) program offers an opportunity to ensure that evidence-based practice and quality improvement expertise is part of pediatric nurse practitioner programs and continuing education requirements. • Children's hospitals that are accredited by the Joint Commission report on ORYX measures. Additionally, as with acute care hospitals, reporting and non-payment for potentially preventable conditions in the Medicaid program apply to children's hospitals, and children's hospitals and eligible providers report on clinical quality measures for EHR meaningful use.

Acronyms and Definitions

ACA: Affordable Care Act

AHRQ: Agency for Healthcare Research and Quality

CAHPS: Consumer Assessment of Healthcare Providers and Systems, a comprehensive and evolving family of surveys that ask consumers and patients to evaluate the interpersonal aspects of health care

CHIP: Children's Health Insurance Program, a program that provides health coverage to children in families with incomes too high to qualify for Medicaid but who can't afford private coverage

CHIPRA: Children's Health Insurance Program Reauthorization Act, which among other things established the initial core measure set of children's health care quality measures

CIHS: Center for Integrated Health Solutions, a joint initiative of the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA)

CMHC: Community Mental Health Center

CMS: Centers for Medicare & Medicaid Services

CQM: Clinical Quality Measure, a set of measures of which reporting is required for meaningful use for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs

DQA: Dental Quality Alliance

EHR: Electronic Health Record

FFS: Fee for Service

FQHC: Federally Qualified Health Center

HCBS: Home and Community-Based Services

HEDIS: Healthcare Effectiveness Data and Information Set, a set of performance and quality measures developed and maintained by the National Committee for Quality Assurance (NCQA)

Hospital Compare: A consumer-oriented website maintained by CMS that provides information on how well hospitals provide recommended care to their patients

HRSA: Health Resources and Services Administration

Initial Core Set Quality Measures: A set of quality measures for voluntary use in Medicaid and CHIP programs developed and maintained by CMS and AHRQ; the pediatric set was established by CHIPRA while the adult set was established by the Affordable Care Act

LTSS: Long-Term Services and Supports, which includes both institutional care and home and community based services

MCO: Managed Care Organization

MU: Meaningful Use, the set of standards defined by the CMS Incentive Programs that governs the use of electronic health records and allows eligible providers and hospitals to earn incentive payments by meeting specific criteria

NCQA: National Committee for Quality Assurance

NQF: National Quality Forum

ORYX: The Joint Commission's national hospital quality measures which are publicly reported

PCCM: Primary Care Case Management

PCMH: Patient Centered Medical Home

SAMHSA: Substance Abuse and Mental Health Services Administration

SNP: Special Needs Plan, a type of Medicare Advantage Plan for individuals with specific diseases or characteristics

UDS: The Uniform Data System, a core set of information appropriate for reviewing the operation and performance of health centers

About the Partnership for Medicaid

The Partnership for Medicaid is a nonpartisan, nationwide coalition made up of 23 organizations representing doctors, health care providers, safety net health plans, counties and labor. The goal of the coalition is to preserve and improve the Medicaid program.

While this proposal represents the collective views of the Partnership as a coalition, it has not been officially endorsed by each constituent Partnership organization.

The Partnership for Medicaid

AFL-CIO
America's Essential Hospitals
American Academy of Family Physicians
American Academy of Pediatrics
American Congress of Obstetricians and Gynecologists
American Dental Association
American Dental Education Association
American Health Care Association
Association for Community Affiliated Plans
Association of Clinicians for the Underserved
Catholic Health Association of the United States
Children's Hospital Association
Easter Seals
The Jewish Federations of North America
Medicaid Health Plans of America
National Association of Community Health Centers
National Association of Counties
National Association of Pediatric Nurse Practitioners
National Association of Rural Health Clinics
National Council for Behavioral Health
National Health Care for the Homeless Council
National Hispanic Medical Association
National Rural Health Association