



Finding and Analyzing Medicaid Quality Measures

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The 2016 update of the Medicaid managed care regulations provide states great flexibility to design their own quality evaluation for Medicaid managed care programs. As part of their quality strategy, states may decide which performance measures managed care plans will collect and report. They also designate External Quality Review (EQR) activities for managed care plans and select EQR Organizations (EQROs) to perform them. Some states use performance measurement and EQR extensively to encourage plan improvement and compliance with Medicaid regulations. Others do far less.

But even in the states with bare-bones quality reporting, the currently available public data often receives little scrutiny. Part of this is due to poor transparency, and part stems from the difficulty of interpreting performance measure results.

This brief provides tools to find major sources of state and plan-level data, to learn how to evaluate and compare results, and to use that data to improve data transparency and to push your state to hold plans accountable to their mission: to manage care effectively and efficiently.

This brief is part of a broader series intended to help advocates find and use Medicaid managed care oversight and quality data to bolster their advocacy. Other papers in the series include:

- [Medicaid External Quality Review: An Updated Overview](#) (Nov. 2021)
- Addressing Health Equity in Medicaid Managed Care Quality Oversight (forthcoming)
- State quality fact sheets
- Medicaid Managed Care: Using Sanctions to Improve Accountability (forthcoming)

Data Variability across States

The federal government's decision to allow considerable flexibility in state managed care oversight also means that states report Medicaid quality data differently. Poor standardization makes it very hard to compare quality across states, providers, or managed care entities (MCEs). Ideally, such comparisons allow states and plans to identify and share effective policies and, when readily accessible to the public, to promote plan accountability. Comparable performance metrics can help individuals decide which plans best fit their needs. They also provide baseline data for advocates and state officials to evaluate care quality across plans

and over time. Comparisons will never be completely apples-to-apples due to differences in covered benefits and in the covered populations' risk characteristics across plans and states. But, nonetheless, these reasons point to why the federal government has repeatedly emphasized the importance of improving standardization in quality reporting.

One way to improve standardization and comparability would be to strengthen federal requirements. CMS has the statutory authority to mandate reporting on specific measures, but has not exercised this authority in the past.¹ Instead, CMS has issued recommended core sets of measures for children and adults since 2010 and 2012, respectively, and encouraged states to take them up, with some success.

National reports have demonstrated gradual improvements and expansion of core measure reporting. In 2019, every state reported data from least one of the 26 children's core measures, while 49 states reported at least 13 measures.² Two child core measures were reported by every state: the percentage of children who received preventive dental services and live births weighing under 2500 grams. Thirteen other core measures were reported by at least 41 states.³ One measure was reported by only two states, and another by just eight.⁴ On the adult side, 46 states reported at least one measure and 40 states reported at least 16 of the 33 adult core measures.⁵ Delaware reported all but one core measure, and New York reported all, though some by alternative specifications. Thirty-six states reported more adult measures in 2019 than in 2018.

In 2016, it appeared that change was afoot and that CMS would mandate collection and reporting of some federal measures. The 2016 revisions laid out a process for CMS to create a federal Medicaid Quality Rating System, intended as a next step in promoting comparability, improving consumer informed choice, and increasing managed care accountability. CMS previously indicated it would put a draft QRS out for comment by 2018. However, a 2018 proposed rule weakened the federal QRS by making it easier for states to run their own alternative system, which would likely undermine standardization. These changes were finalized in November 2020, but the Medicaid QRS remains under development.

While CMS has slow-footed requiring measures, Congress has stepped in to hasten standardized federal reporting. In 2018, Congress mandated that states begin to report to CMS on the child core measure set by FY2024.⁶ Later, it added that states must report all behavioral health measures in the adult core set by that same year.⁷ There are eleven such measures in the current set.⁸ CMS has yet to issue any guidance on how this transition to mandatory reporting measures will be implemented, including whether all core measures will be included, if and how the mandatory reporting will be phased in, and what degree of technical deviations from standardized reporting may be permitted.⁹ These details will be critical to make it easier for states to comply with the new reporting requirements.

Where Can Advocates Find Core Measure Results?

Managed care plans have to report quality data to states and CMS regularly, and posted are available in numerous places. Below are some of the common locations to check for data.

The required EQR annual technical reports are key resources to find year-over-year results at the plan level for measures each state requires plans to report. Our updated [overview](#) of the EQR process includes a chart where you can find each state's latest report as well as other links to state quality resources. Several states report HEDIS results directly on their websites.

CMS posts state and national level aggregated results from core measure reporting every year, though often with a substantial time lag. The most recent reporting covers FY 2019 data.¹⁰ Chart packs for children and adult core sets describe each measure, detail which measures each state reports, and include national averages for each core measure. CMS also publishes annual performance tables that provide state-by-state results for each measure, including notes that describe differences in data reporting or population covered. Sorting through the reports can be challenging because each measure is in a separate document with an abbreviated title. CMS also has a tool for users to create their own charts and tables based on the data.¹¹ The full dataset is available for free download for additional analysis.

Another CMS venture intended to promote cross-state quality comparisons is the Medicaid and CHIP Scorecard.¹² This tool includes cross-state comparison charts for nine child and ten adult core measures and two measures derived from nursing facilities data.¹³ It also includes administrative accountability tools for state and federal governments. One can find performance data on average time to review waivers and state plan amendments, timeliness of state submissions of base capitation certification rates, and CMS review times for submitted capitation rates, among others. While the scorecard shows some promise as an access point for comparative performance, the current data represents only a small fraction of all the reported quality metrics. There are, for example, no currently reported measures of health system performance related to home and community-based services (HCBS), aside from a process measure tracking states' use of three common HCBS experience-of-care surveys.¹⁴

CMS has also posted state-specific core-set performance data for 2019. While this data only represents a single year of data, it does include measures not listed in the Medicaid and CHIP Scorecard.¹⁵

HEDIS® and Performance Measurement

The predominant set of performance measures in managed care today is the Healthcare Effectiveness Data and Information Set (HEDIS®), published by the National Committee for Quality Assurance (NCQA), a private non-profit organization. Medicare, Medicaid, and many commercial ventures use HEDIS measures as part of their quality assessment programs. Currently, there are over 90 HEDIS measures related to six health care domains, including effectiveness of care, access/availability of care, experience of care, and use of services.¹⁶ Measures address: (1) asthma medication use; (2) breast and cervical cancer screening; (3) childhood and adolescent immunization status; (4) various aspects of diabetes care; and (6) antidepressant medication management.¹⁷

HEDIS measures often form the baseline for quality assessment of Medicaid managed care plans. They provide a useful snapshot of plan performance, particularly in the area of acute medical care, and allow some comparison between plans and against national standards, including commercial insurance. Some states or plans may vary data collection methods or

choose different measures from other entities, complicating direct comparisons. In addition, HEDIS measures historically focused on clinical care, which can be limiting. Many of the long term services and supports that people with disabilities and older adults need are not clinical services, or even medical in nature, thus have fallen outside the scope of traditional quality measurement. Thus, HEDIS results can be a useful tool, but use of HEDIS alone does not satisfy all Medicaid quality requirements or address all types of services and subpopulations.

To ensure that measures give plans some time to actually manage an enrollee's care, many HEDIS measures include only Medicaid beneficiaries with a full year of continuous eligibility in their denominators.¹⁸ This makes some policy sense, but it also can miss a large fraction of enrollees who churn in and out of the program. The typical Medicaid beneficiary is enrolled for less than ten months per year, while the typical adult remains covered for less than nine months.¹⁹ This dynamic renders a large share of the Medicaid population invisible for many common quality metrics.

Finally, much of NCQA's HEDIS performance measure data, member satisfaction surveys and technical measure specifications are only available for purchase from NCQA, often at prohibitive sums. For example, access to a single user license for NCQA's "Quality Compass" data tool starts at nearly \$3,500.²⁰ NCQA does publish annual health plan ratings based on selected HEDIS results and accreditation status that are available free of charge. Due to disruptions from the COVID-19 pandemic, NCQA cancelled the 2020-21 plan year ratings.²¹

Table 1. Common Quality Resources

Source	Description	Level	Pluses and Minuses
EQR Annual Technical Reports	Annual release of measure validation by an external quality review organization. Must be posted on state Medicaid website. State-by-state links available via NHeLP's EQR chart .	Plan, and sometimes state	<ul style="list-style-type: none"> • Allows year over year comparison • Reporting format varies substantially from state to state • Often broader than HEDIS or core measures alone, including long term care measures in states with managed long term supports and services (LTSS) • Often has data lag (12 - 24 months)
CMS Findings from EQR Technical Reports	CMS Tables summarize state EQR Activities. Table 3 shows the core measures each state reports. Table 4 shows how states compare performance measures, e.g. by sub-groups or against national averages.	State	<ul style="list-style-type: none"> • Shows differences in reporting style across states and helps identify best practices • Does not include actual performance results
CMS State Medicaid Quality Profiles	Includes links for adult and child core measure data from FY2019 for each state.	State	<ul style="list-style-type: none"> • Includes some measures not in the CMS Medicaid Scorecard • Includes national median and quartiles for clearer comparisons • Only one year – no trend analysis

Source	Description	Level	Pluses and Minuses
CMS Core Measure Annual Report for Children and Adults	Annual chart packs (Children and adults) describe each measure, which measures each state reports and national averages for each core measure. Annual performance tables (Children and adults) provide state core measure results, including notes on differences in their Medicaid populations.	State and National	<ul style="list-style-type: none"> • Allows for year over year comparison • Data lags. As of September 2020, current report details FY 2018 data • Allows rough comparison across states and from state to a national median • Full dataset available for download for customized analysis
CMS Medicaid and CHIP Scorecard	State Performance tab includes graphs for 19 child and adult core measures, as well as several measures from other data sets, such as nursing facilities.	State and National	<ul style="list-style-type: none"> • Currently reporting FY 2018 data • Does not allow year-over-year comparison • Includes a few nursing facilities measures, but no other long term care measures • Does not include all core measures
HEDIS Health Plan Ratings	This publicly available resource from NCQA scores plans on consumer satisfaction, prevention, and treatment.	Plan	<ul style="list-style-type: none"> • Searchable by state and by Medicaid line • Measure results translated into scores • Year-over-year available, but hard to compare • Full access to HEDIS data allows year over year comparison (up to 3 yrs), but user must pay for access.
State Report Cards	Some states post HEDIS or core measure data on their websites. Links available in Appendix A.	State and Plan	<ul style="list-style-type: none"> • Often allows for year over year comparison • Limited to states that choose to post
CMS-Form 416 Data for Early & Periodic Screening, Diagnostic and Treatment (EPSDT)	CMS's annual report provides tables with enrollment details and performance on recommended screenings performed for Medicaid and CHIP enrolled youth.	State and National	<ul style="list-style-type: none"> • Allows for year over year comparison • Data sometimes paints different picture than HEDIS reports (see, e.g., lead screening) • Most recent data posted for FY 2019 • Format makes direct comparisons across states difficult.

What Does Core Measure Data Tell Us?

Finding core measure results is, of course, just a first step. Figuring out what it means and what to do with the data is another. This section points out some basic questions and approaches to interpreting core measure data that might help inform and target advocacy strategies.

1. What types of measures are commonly used?

Determining whether a given result is “good” or “bad” requires a basic understanding of the types of data that health care quality measures provides.

Most analyses divide quality measures into three broad types: structural, process, and outcome (see chart below.) Measuring health outcomes has become something of a holy grail in performance measurement circles, since outcomes represent the ultimate goal of any health care intervention.

Types of Measures

Structural measures evaluate health system capacity, often at the plan or state level. This could include the fraction of people with disabilities receiving care in the community, or how many individuals delay needed care due to cost.

Process measures track whether needed steps of health care delivery occur at the provider level. For example, plans can measure how many patients received a telephone follow-up after a hospital discharge, the share of children who received appropriate screenings for lead exposure, or the percentage of enrollees who receive interpretive services when they need it. These measures test adherence policies and standards of practice, but not necessarily whether people are getting better due to quality care. Process measures often derive from administrative data and so can be relatively quick and inexpensive to generate.

Outcome measures track the effect of a health care intervention on a patient health status or quality of life. Examples include tracking how many enrollees have blood sugar under control, what proportion of individuals get re-admitted to a hospital within 30 days of discharge, or the share of patients who have controlled their high blood pressure with medication. Outcomes may be influenced by factors beyond the quality of health care delivered, so outcome measures alone may not tell the whole picture about care quality. Planners considering which types of measure to use typically weigh the ease of data reporting, the scientific evidence showing its validity and reliability, and whether the reported result points toward specific action steps for improvement. Measures of both types may apply at different levels (provider, plan, program, state, etc.), and so may point to different kinds of potential action steps.

However, in some cases a health plan or provider has limited control over the many factors that may shape an individual's health outcomes. A process measure may more accurately measure the scope of what a plan or provider can do. Structure or process measures may also serve as more easily trackable proxies for effective health outcomes.

2. Whose performance is being measured, and what can they do about it?

Another key starting point for measure analysis is to identify clearly the scale of analysis. A good core set should balance measures that evaluate providers directly along with aggregate measures that measure performance at the more systemic level of health plans or state-wide performance.

In an ideal world, every measure would apply at the provider level and allow for aggregation to analyze plan and state-level performance. This would help distinguish between problems that lie with individual provider policies and problems that may related to broader issues, like a state under-resourcing a particular service, or a health care disparity that stems from systemic discrimination. Unfortunately, states are not always willing or able to require this level of detail in their performance measurement budget.

One good example of this challenge comes from The National Core Indicators (NCI) survey. This instrument, which was adopted as a core measure for the 2020 adult core measure set, measures experience of care for people with intellectual and developmental disabilities. NCI provides detailed information about the quality of services, access to community, and ability of individuals to control their daily lives and achieve their goals. However, collecting the survey data is relatively costly, and so many states limit the number of individuals included in the sample to roughly 400 people. This small sample size only allows for meaningful results at the state level, which can make it harder to develop specific interventions to improve outcomes.

As a result, poor results on the NCI may not clearly show if the problems stem from issues with a group of low-quality providers, an underperforming health plan that has skewed results, or a broader issue at the state level. For example, the state may not pay providers enough for service delivery more generally, resulting in poorer quality care. Having a NCI larger sample would make it easier to distinguish between these different problems and develop more appropriate targeted solutions.

3. Is it your state's problem, or everyone's problem?

Some measures suggest poor performance nationwide. CMS's data on adult core measures shows that some measures have exceedingly poor results across states. For example, follow-up after emergency department visits for alcohol or other drug abuse occurred in only a small fraction of cases in the median reporting state (14 percent for 7-day follow-up, and 22 percent for 30-day follow-up.)²² Follow-up for ED visits due to mental illness is better, but still occurs only about half the time in the median state after 30 days.²³ Similarly, most states are not good at making sure adults with major depression receive and remain active with antidepressant prescriptions. Only half of such adults remain on medication during the acute phase (<12 weeks) and only 34 percent stay on medications through 6 months as

recommended.²⁴ Cervical cancer screening for women 21 to 64 also shows uniformly poor results, with just over half screened in both the top and bottom quartiles of reporting states and no year over year improvement.²⁵ Similarly, just under half of young enrollees received preventive dental services in 2019, with no state reporting more than 67% success.²⁶

Few if any states score high on these measures, suggesting broad systemic challenges or perhaps low prioritization. The important thing to realize is that your state may be shooting par for a given measure even as the absolute performance on a metric remains quite low.

Conversely, average performance on some measures is high across the board. For these measures your state may perform poorly relative to other states while also achieving reasonably high absolute results for a given measure. For example, the 2018 core measure on Children and Adolescents' Access to Primary Care, which measured whether Medicaid-enrolled youth had at least one primary care visit over the course of the year, had a state median average of over 90 percent for all ages and over 95% for 1-2 year olds, with little variation between top and bottom quartile.²⁷ This measure was retired as a core measure in 2020 partly due to the universally high results limiting the ability to act to improve the measure.²⁸ Advocates should consider both a state's relative and absolute performance on a measure in reading the data. High performance nationwide could suggest that a measure may set too low a bar for states.

Some core measures show large differences between states, inviting further investigation. Some core measures reveal striking discrepancies between better performing and flagging states. For example, admission rates for older adults with COPD or asthma are over seven times higher in Alabama (226.2/100,000 beneficiary months) than in Washington (31.2/100,000) or Oregon (29.7/100,000).²⁹ Admission rates for heart failure in Texas (65/100,000) and Alabama (77.1/100,000) far exceed those in Vermont (5.0/100,000) and Wyoming (8.4).³⁰ Similarly, just over three in ten women in Wyoming's Medicaid program have a post-partum care visit from three to eight weeks of delivery (30.8%), a rate that pales in comparison to Rhode Island (71.7%) and Maryland (75.3%) for the same measure.³¹

Interpreting direct state-to-state or plan-to-plan comparisons requires caution. The demographics of covered populations across state Medicaid programs and managed care plans can vary substantially. States sometimes also use slightly different reporting methodologies that can dramatically affect comparative results. In the above example related to post-partum care, Oklahoma's rate is reported at a nation-worst 22.9%, but the chart notes point out that this is due to state-specific billing practices, and that accounting for those billing practices raises the state's rate to 70%.³² Such differences can lead to variations in outcomes that do not necessarily reflect the quality of care provided. Moreover, some states or plans may cover populations that are sicker to begin with or face more barriers to accessing care. However, that reality should never be used to end an analysis by simply blaming socioeconomic risk or methodology.

Rather, large discrepancies like those cited above should be launching points for inquiries into which states might serve as models, and which states deserve more advocacy scrutiny.³³ Even where demographics complicates cross-state comparisons, year-over-year data can

provide useful insights into how well states and plans are addressing weak points in their managed care systems over time, as well as how states are prioritizing resource distribution.

4. How does health equity factor in measure results?

One of the fundamental priorities in CMS's national quality strategy is to reduce health disparities. Unfortunately, reporting Medicaid core measures to show disparities among key subpopulations, like race/ethnicity, remains the exception rather than the rule.

But understanding the effect disparities can have on measure performance is central to developing effective interventions. If poor outcomes are concentrated in a particular subgroup of the general population, the overall results may mask the poor outcomes in that specific group.

For example, take this hypothetical. Of a general population of 100 enrollees with diabetes, one fourth are Black or Latinx, while 75% are non-Latinx white or other. The measure tracks how many enrollees maintain blood sugar at normal levels. Say 85% of the enrollees show positive results – a reasonably good result. However, closer analysis shows that among the 25 enrollees who are Black or Latinx, only 15 show blood sugar under control (60%), while among the other 75 enrollees, only 5 have uncontrolled blood sugar (93.3%). If the data were not disaggregated by race/ethnicity in this hypothetical, the urgent need for specific interventions targeted at Black and Latinx enrollees would be completely missed.

While the numbers here are hypothetical to make a point, the reality is that many core measures show substantial and sustained disparities when that analysis has been conducted. But few states disaggregate more than a handful of measures by key demographic features, and fewer still do it annually. It is hard to know if plan or provider performance is really effective without prioritizing disaggregated data reporting.

The Agency for Healthcare Research and Quality (AHRQ) has published a National Healthcare Quality and Disparities Report annually since 2003. This report documents health disparities at the national level for hundreds of measures. It effectively shows trends over time, though the overarching message is that many disparities are persistent or even worsening over time, even as overall performance results may be slowly improving.³⁴ Unfortunately, national level data can help track some of the worst issues and reset priorities, but it is not fine-grained enough to identify actionable solutions that can work at the state, plan, or provider levels. State- and provider-specific disparities data is far more difficult to come by.

The COVID-19 epidemic, which has had profoundly disparate impact on communities of color and lower-income individuals, has shone a spotlight on this major shortcoming of quality data reporting. The long-lasting effects of the epidemic will likely worsen health inequities and advocates should push their states and Congress much harder to require the disaggregation of quality data by key demographic features, including age, race/ethnicity, gender, sexual orientation, primary language, and disability. For more on this issue, see the other paper in this series: *Addressing Health Equity in Medicaid Managed Care Quality Oversight* (forthcoming).

5. What is not being measured?

Perhaps as important as looking at the available results is considering what has not been measured at all. The federal Medicaid and CHIP scorecard, for example, includes no measures that apply specifically to the quality of Medicaid home and community-based services, despite the fact that Medicaid HCBS comprise a substantial fraction of annual Medicaid spending.

CMS only added the first HCBS-related adult core measure, the NCI, for the 2021 reporting year. There are relatively few widely-implemented HCBS measures and tools available, though a number of organizations have been working to develop new approaches. CMS itself has been working to develop a recommended set of core measures for HCBS. The first iteration was released in fall of 2020. More detail on available HCBS measures is available in the brief, [Medicaid External Quality Review: An Updated Overview](#).

Pushing States to Set a Higher Bar

While CMS has reported annually on state performance on core measures, individual states use different mechanisms to post their own state-specific results. Some of these approaches provide far more specificity than can be found in CMS's core data. Specifically, data on provider or health plan performance can only be found at the state-level or in the annual External Quality Review Technical Reports that states much submit to CMS and post on their website.

All states with comprehensive managed care program include HEDIS and other performance measures in their EQR annual reports. Some, like Louisiana and Texas, have created separate websites that allow users to explore and sort results by plan.³⁵ Still others create scorecards or report cards that include performance measurement data statewide or by county.³⁶

Some states make extensive use of the EQR enhanced match to fund oversight activities of their managed care programs. Minnesota's annual EQR report details specific strengths and weaknesses for each MCO and includes responses from each MCO on steps taken to address weaknesses over the prior two years.³⁷ The state also posts reports about MCO grievances and complaints on its main quality page. Texas contracts with an EQRO to perform many activities, including extensive encounter data validation, compliance reviews, MCO report cards, member satisfaction surveys and telephone interviews, and "secret shopper" studies. The same EQRO also facilitates the state's use of the National Core Indicators – Aging and Disabilities survey.

Texas posts aggregate and individual MCO performance profiles, along with performance trajectories, on its state website.³⁸ Appendix A includes links to Medicaid quality data from the 41 states that have Medicaid managed care programs.

On any state-specific comparative platform, state advocates should at least push for:

1. Longitudinal data that allows users to compare performance year-over-year;

2. Some benchmark, such as national averages or state-specific targets, to allow broader comparison of health plan or provider performance
3. Explanatory footnotes that describe any adjustments states have made for relative risk or other factors that might make straight comparisons across plans problematic.

Conclusion

Already available performance measurement data provides a trove of information advocates can use to push states to improve access to care for low-income individuals and families. This data is far from perfect, but remains often underutilized as an oversight and advocacy tool.

While interpreting the numbers requires some context and caution, state-specific data is readily available that cries out for immediate action to address abysmal results. Yet it remains hidden in plain sight buried in charts and links on state and federal Medicaid websites. Advocates should engage this data and use it to push for better access to care at all levels.

Still more work needs to be done to improve reporting of provider and plan-level data on health inequities to make it easier to target interventions to reduce health disparities, which have likely been worsened due to the COVID-19 pandemic.

Appendix A. Quality Measure and Related Data on State Medicaid Websites

State	Links to State Quality Data
Alabama	Quality strategy (2020) and quality measure performance data ³⁹ Special quality initiatives ⁴⁰
Alaska	Medicaid annual report (2019) ⁴¹
Arizona	Arizona health plan report card ⁴² Medicaid plan quality and performance improvement ⁴³
Arkansas	HEDIS reporting (through 2013 only) ⁴⁴ Medicaid Quality initiative ⁴⁵
California	Quality measure reporting ⁴⁶ Quality dashboards (state level for pediatric , dental, mental health, managed care) ⁴⁷
Colorado	Quality related reports ⁴⁸
Connecticut	HEDIS reporting ⁴⁹
Delaware	Quality reports ⁵⁰ 2019 Delaware Health Equity Guide ⁵¹
District of Columbia	Quality Strategy (2020) and MCO report card ⁵²
Florida	Quality homepage ⁵³ Medicaid managed care report card (by county) ⁵⁴ Performance measures data 2015-2018 (includes 2017 LTC measures) ⁵⁵
Georgia	Medicaid quality reporting ⁵⁶
Hawaii	EQR reports with HEDIS results ⁵⁷
Idaho	Some measures available in annual performance reports ⁵⁸
Illinois	Webpage for § 1115 waiver Illinois Integrated Care Program (scroll down for link to EQR report) ⁵⁹
Indiana	CHIP & Medicaid reports as well as quality strategy ⁶⁰ HEDIS results ⁶¹
Iowa	HEDIS and other performance reports ⁶²
Kansas	Kancare quality data ⁶³ Kancare quality dashboard (2018) ⁶⁴
Kentucky	FY2019 quality measure trend report (CMS report) ⁶⁵
Louisiana	Quality reporting and accountability resources ⁶⁶ Quality Initiatives tab ⁶⁷ 2019 Quality Companion Guide for Healthy LA managed care (an MCO “How to”) ⁶⁸ Grievance, appeals and other quality measures by plan ⁶⁹
Maine	Accountable Communities quality metrics ⁷⁰
Maryland	Managed Care quality assurance resource page with 2020 Consumer MCO Report Cards ⁷¹
Massachusetts	1115 annual reports (through 2018) ⁷² Office of Inspector General report on MassHealth (2019) ⁷³
Michigan	Quality Strategy and other oversight reports ⁷⁴ Medicaid health equity reports ⁷⁵

State	Links to State Quality Data
Minnesota	Quality data site (includes reports on grievances and appeals, controlling interest reports) ⁷⁶
Mississippi	Quality measure results page (including measures tied to payment withholds) ⁷⁷
Missouri	Managed care EQR and performance measures ⁷⁸
Montana	Medicaid expansion legislative reports ⁷⁹
Nebraska	Medicaid EQR reports ⁸⁰
Nevada	Medicaid EQR reports and behavioral health data ⁸¹
New Hampshire	Quality strategy (2020) and other resources ⁸²
New Jersey	EQR, managed care performance reports , and NCI-AD survey results ⁸³
New Mexico	HEDIS reports ⁸⁴ EQR reports ⁸⁵
New York	Recent health plan comparison quality data and outdated EQRs ⁸⁶ Individual plans 2017 EQR reports ⁸⁷ Health disparities reports from 2015-2017 (also under “Quality Review Reports” tab) ⁸⁸
North Carolina	Performance dashboards (including HEDIS) ⁸⁹
North Dakota	EQR reports (scroll to bottom) ⁹⁰
Ohio	HEDIS reporting and other quality measurement resources ⁹¹ Managed care dashboard ⁹² 2019 quality report card for MCOs ⁹³
Oklahoma	Quality strategy and other quality reports (click on studies and evaluations for quality data) ⁹⁴
Oregon	Transformation Center page with reports and quality data ⁹⁵ Oregon has a health equity measurement committee and an Office for Equity & Inclusion . ⁹⁶ Published data on performance measures disaggregated by race, a 2017 report on how OR Coordinated Care Organizations can promote health equity. ⁹⁷ See also: Using a Health Equity Lens in the Transformation and Quality Strategy (TQS) . ⁹⁸
Pennsylvania	Quality resources (scroll down for EQR reports and HEDIS data) ⁹⁹
Rhode Island	EQR reports and Long Term Care Finance and Performance Report ¹⁰⁰
South Carolina	EQR reports ¹⁰¹ MCO report cards (through NCQA) ¹⁰²
South Dakota	Medicaid and long term care reports ¹⁰³
Tennessee	HEDIS reports and most recent EQR ¹⁰⁴ TennCare Enrollee Survey ¹⁰⁵ TennCare § 1115 annual report (2019) ¹⁰⁶
Texas	Centralized page for quality reporting , including Community integration data from NCI-AD ¹⁰⁷ Detailed database of HEDIS® results by plan and program ¹⁰⁸
Utah	EQR and other reports ¹⁰⁹ 2020 EQR report ¹¹⁰ is posted in a different location, under the resources tab ¹¹¹

State	Links to State Quality Data
Vermont	Performance measure results ¹¹² EQR reports ¹¹³
Virginia	EQR and compliance reports and performance incentive awards for Medallion 4.0 ¹¹⁴
Washington	EQR reports and HEDIS reports ¹¹⁵
West Virginia	Managed care reports including EQR reports ¹¹⁶
Wisconsin	Family Care EQR reports ¹¹⁷ Family Care LTSS reports and evaluations ¹¹⁸ NEMT data reports ¹¹⁹
Wyoming	Medicaid 2018 Health Outcomes Report ¹²⁰ (Click on “publications” button from Medicaid home page ¹²¹)

ENDNOTES

¹ 42 U.S.C. § 1396u-2(c)(1)(B). *See also*, 42 C.F.R. § 438.330(a)(2).

² CMS, Fact Sheet: Quality of Care for Children and Adults in Medicaid and CHIP: Overview of Findings from the 2019 Child and Adult Core Sets, 1 (Sept. 2020), <https://www.medicaid.gov/medicaid/quality-of-care/downloads/ffy-2019-core-set-reporting.pdf>.

³ CMS, *Quality of Care for Children in Medicaid and CHIP: Findings from the 2018 Child Core Set Chart Pack*, 8 (Oct. 2020), <https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2020-child-chart-pack.pdf>.

⁴ The least reported measure was audiological diagnosis no later than 3 months of age. Screening for depression in adolescents was reported in eight states. *Id.*

⁵ CMS, Fact Sheet: Quality of Care for Children and Adults in Medicaid and CHIP: Overview of Findings from the 2018 Child and Adult Core Sets, 1 (Oct. 2020), <https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2020-adult-chart-pack.pdf>. The five states that did not report any core adult measures in 2019 were Alaska, Idaho, Maine, Montana, and North Dakota. CMS, *Quality of Care for Adults in Medicaid: Finding from the 2019 Adult Core Set Chart Pack*, 94 (Oct. 2020), <https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2020-adult-chart-pack.pdf>.

⁶ Bipartisan Budget Act of 2018, Pub. L. 115-123, § 50102, 132 Stat. 175 (2018) [Amending 42 U.S.C. § 1320b-9a to mandate that states report annually on the child core measure set]

⁷ Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act, Pub. L. 115-271, § 5001, 132 Stat. 3961 (2018) [requiring states to report annually on all adult behavioral health core measures by 2024].

⁸ MACPAC, *Chapter 2: State Readiness to Report Mandatory Core Set Measures*, 68 (Mar. 2020), <https://www.macpac.gov/wp-content/uploads/2020/03/State-Readiness-to-Report-Mandatory-Core-Set-Measures.pdf>.

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