

Low Reporting of Medicaid Diabetes Quality Measures: Room for Improvement?

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ABSTRACT

Background: The provision of high-quality healthcare is a priority for US health plans and the CMS. Health plans can implement quality initiatives to ensure appropriate healthcare for their beneficiaries and use quality measures in their various initiatives to assess quality of care and outcomes.

Methods: We reviewed publicly reported diabetes quality measures for Medicaid fee-for-service (FFS) programs in all 50 states and the District of Columbia. Our objective was to provide insights into the extent of diabetes quality measure reporting (ie, which diabetes quality measures are being reported and what percentage of states are using the diabetes Healthcare Effectiveness Data and Information Set [HEDIS] measures) and into the quality of care being provided (ie, achievement of established goals in diabetes care and state-level performance on diabetes quality measures).

Results: Overall, the number of Medicaid FFS programs reporting these data was low: 23 states reported data on at least 1 HEDIS measure. The most common measures reported were process measures (eg, retinal eye exams and HbA1c testing); outcomes measures such as the proportion of patients achieving goal were much less frequently available. Few states had historical data available, which limits the opportunity for retrospective analyses or quality benchmarking.

Conclusions: This research is important, as an understanding of the current landscape of quality measures for the Medicaid diabetes population is critical to designing and implementing initiatives aimed at improving the quality of care for individuals living with diabetes.

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The provision of high-quality healthcare is a priority for the United States, in large part as a result of the Affordable Care Act (ACA) and its focus on 3 goals to improve the experience of care, improve the health of populations, and reduce the per capita costs of healthcare. These triple aims also guide the National Quality Strategy that was established as part of the ACA, which describes the national priorities and strategic plan for quality improvement in healthcare.

This reformative health policy environment has spurred many organizations to call for methods to measure, track, and improve the provision of healthcare and engage in the nationwide conversation regarding the definition of “value.”

Medicaid is responsible for providing healthcare coverage to more than 72 million beneficiaries.¹ The population served by Medicaid will continue to expand under the ACA. The CMS has been a major forerunner in implementing quality healthcare measures and has implemented ongoing initiatives to ensure quality healthcare for both Medicare and Medicaid beneficiaries through accountability and public disclosure.

The ACA required the implementation of a core set of healthcare quality measures for adults participating in Medicaid. The initial set of measures was released in 2013.² Reporting by states is voluntary; however, many states now require Medicaid managed care plans to report quality measures using the Healthcare Effectiveness Data and Information Set (HEDIS) tool. Although Medicaid is shifting away from a traditional fee-for-service (FFS) model, a substantial number of complex beneficiaries remain within this structure (eg, those with multiple chronic conditions and high resource utilization) and account for a disproportionate amount of total Medicaid expenditures.³ As such, we sought to explore the availability and breadth of data from quality measurement programs that traditional FFS Medicaid plans and Medicaid managed care organizations (MCOs) have instituted for patients with diabetes.

METHODS

Diabetes-related quality data were obtained as of July 2015 through a Web-based search of publicly reported data, such

PRACTICAL IMPLICATIONS

- Quality measures are important for monitoring the quality of healthcare provided and the impact on patient outcomes.
- In our review of Medicaid fee-for-service programs in all 50 states and the District of Columbia, we found that overall reporting of diabetes quality measures is low.
- Importantly, measures of diabetes outcomes, such as proportion of patients achieving glycated hemoglobin (HbA1c) goal, were much less frequently available.
- These findings are important, as improvements in the provision of healthcare can be recognized only if (a) measures are consistent across stakeholders and organizations and (b) performance data on quality measures are shared regularly to identify shortcomings and trends.

Table 1. Publicly Available Sources for Diabetes-Related Quality Data

State	URL
Alabama	medicaid.alabama.gov/
Alaska	<p>Goals: dhss.alaska.gov/HIT/Documents/Alaska%20Medicaid%20EHR%20Incentive%20Provider%20Program%20Manual%20Stage%202014%20v1.0.pdf</p> <p>Healthy Alaskans data (state population, not specific to Medicaid): dhss.alaska.gov/dph/Chronic/Documents/Diabetes/2010-15_AkDiabetesCoalitionStrategicPlanning.pdf</p> <p>Prevalence of diabetes among Medicaid eligibles (page 6): dhss.alaska.gov/dph/Chronic/Documents/Diabetes/2014_AkDiabetesMedicaidClaimsAfterDSME.pdf</p> <p>MUE for Medicaid payment incentives: ak-ehealth.org/wp-content/uploads/aehn-meaningful-use-overview.pdf</p>
Arizona	azahcccs.gov/Resources/OversightOfHealthPlans/quality.html
Arkansas	medicaid.state.ar.us/
California	<p>dhcs.ca.gov/dataandstats/Pages/Medi-CalAdultQualityCareImprovement.aspx</p> <p>dhcs.ca.gov/services/Pages/DHCSQualityStrategy.aspx</p>
Colorado	<p>colorado.gov/pacific/hcpf/quality-and-health-improvement-reports</p> <p>Additional link: colorado.gov/pacific/sites/default/files/Medicaid%20Aggregate%20Report%202014.pdf</p>
Connecticut	ct.gov/dss/cwp/view.asp?a=2353&q=305218
Delaware	dhss.delaware.gov/dhss/dmma/
District of Columbia	DC Department of Health Care: dc-medicaid.com/dcwebportal/home
Florida	fdhc.state.fl.us/Medicaid/Policy_and_Quality/Quality/index.shtml
Georgia	dch.georgia.gov/medicaid-quality-reporting
Hawaii	med-quest.us/ManagedCare/qualitystrategy.html
Idaho	healthandwelfare.idaho.gov/Health/DiseasesConditions/DiabetesHomePage/tabid/175/Default.aspx
Illinois	illinois.gov/hfs/agency/Pages/Reports.aspx
Indiana	indianamedicaid.com/
Iowa	<p>2 measures (LDL-C & HbA1C) (2012): dhs.iowa.gov/sites/default/files/Public%20Reporting%20of%20Measures%20for%20adult%20measures%20(2)_0.pdf</p>
Kansas	kmap-state-ks.us/
Kentucky	chfs.ky.gov/dCBS/diq/
Louisiana	<p>dhh.louisiana.gov/index.cfm/page/1582/n/313</p> <p>Additional link: dhh.louisiana.gov/index.cfm/page/244</p>
Maine	maine.gov/dhhs/oms/
Maryland	health.maryland.gov/quality/Pages/home.aspx
Massachusetts	mass.gov/eohhs/gov/departments/masshealth/

(continued)

as state Medicaid and related websites (list of websites provided in **TABLE 1**). This research included a review of all 50 states' Medicaid FFS programs, the District of Columbia, and the largest Medicaid MCO in the 10 states with the highest Medicaid enrollment through May 2015: California, New York, Texas, Florida, Illinois, Ohio, Pennsylvania, Michigan, Georgia, and New Jersey. For purposes of this research, a Medicaid MCO was defined as a contracted entity that administers Medicaid benefits on behalf of a state. Because of the inconsistencies observed in the degree and time frames with which Medicaid FFS plans reported their diabetes-related quality data on public websites, the investigators reached out personally to a 10% sample of states to validate the completeness of data that were captured after the initial Web-based research was completed. Medical and quality program directors at 5 state Medicaid FFS programs (California, New York, Florida, Ohio, and Michigan) were contacted via phone and/or e-mail by the research team. For each state, a director of policy and quality, or similar role, was sought to provide confirmation on the data. These 5 states were chosen for the sample because they include the greatest number of covered lives under their FFS models.

Data Collection and Analysis

The extent of diabetes-related quality measures found included mostly HEDIS Comprehensive Diabetes Care indicators (both current and previous measures), such as:

- ♦ Hemoglobin A1C (HbA1c) testing^a
- ♦ HbA1c poor control (>9.0%)
- ♦ HbA1c poor control (<8.0%)
- ♦ HbA1c control (<7.0%)
- ♦ Eye exam (retinal)^a
- ♦ Medical attention for nephropathy^a

- ♦ Blood pressure (BP) control (<140/90 mmHg)
- ♦ BP control (<140/80 mmHg)
- ♦ Low-density lipoprotein cholesterol (LDL-C) screening^a
- ♦ LDL-C (<100 mg/dL)

^aDenotes a process measure.

Other non-HEDIS diabetes-related quality measures were also identified and documented when found. When provided, the percentage of Medicaid patients meeting each quality indicator in each program was captured. Quality data were analyzed by examining the states' individually published information for trends in Medicaid program reporting and performance while also noting those Medicaid plans that did not report any data.

RESULTS

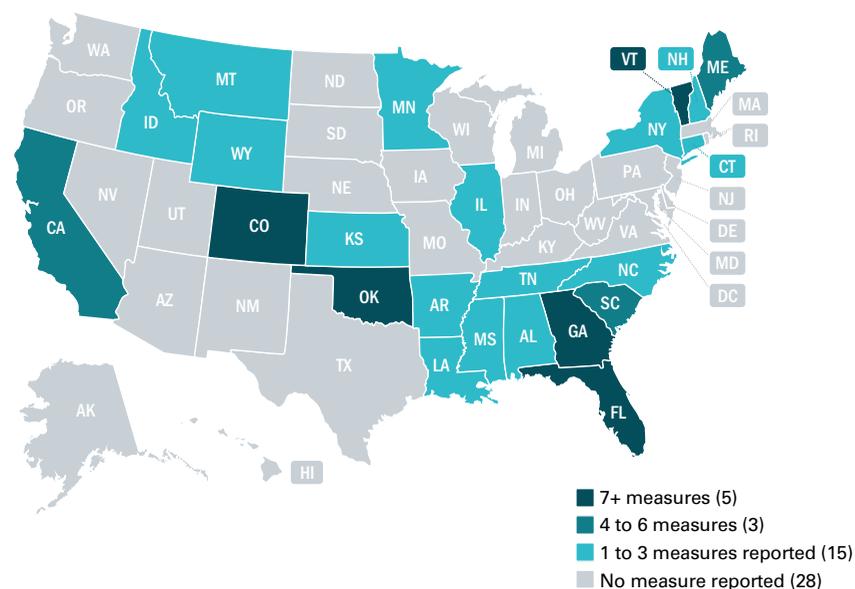
All 50 states and Washington, DC, reported using HEDIS as their quality reporting system for either Medicaid FFS or MCO patients. For FFS programs, publicly reported data on diabetes quality measures were poor, with only 23 states (45%) having published data on at least 1 HEDIS measure for their FFS Medicaid lives or total Medicaid lives (FIGURE 1). We also found that the data-reporting period (ie, the date of the data available on the websites) varied widely, from as early as 2002 through March 2015. Only 6 states reported data from the previous year (2014; Colorado, Illinois, Tennessee, Florida, Vermont, and Connecticut). Only Colorado, Florida, and Vermont reported 7 or more HEDIS diabetes quality measures. Other non-HEDIS diabetes measures identified included hospital admissions rate for short-term complications associated with diabetes, hospital admissions rate for long-term complications associated with diabetes, proportion of patients with microalbuminuria, proportion

Table 1 (Continued). Publicly Available Sources for Diabetes-Related Quality Data

State	URL
Michigan	michigan.gov/mdch/0,4612,7-132-2943_4860-39268--,00.html
Minnesota	mn.gov/dhs/
Mississippi	medicaid.ms.gov/
Missouri	Main Medicaid page: MO HealthNet: dss.mo.gov/fsd/msmed.htm
Montana	Diabetes Quality Improvement: dphhs.mt.gov/publichealth/Diabetes/QI.aspx
Nebraska	dhhs.ne.gov/publichealth/Pages/diabetes_index.aspx
Nevada	medicaid.nv.gov/
New Hampshire	Diabetes Health/New Hampshire Medicaid Quality Indicators: nhhealthyfamilies.com/members/medicaid/resources/quality-improvement.html
New Jersey	HEDIS & CAHPS information: state.nj.us/humanservices/dmahs/news/
New Mexico	New Mexico Takes on Diabetes: nmtod.com/aboutus1.html
New York	health.ny.gov/diseases/conditions/diabetes/ health.ny.gov/statistics/diseases/conditions/diabetes/ health.ny.gov/prevention/prevention_agenda/chronic_disease/diabetes.htm
North Carolina	dma.ncdhhs.gov/qualityhedis Additional link: classic.ncmedicaljournal.com/wp-content/uploads/NCMJ/Mar-Apr-09/DuBard.pdf
North Dakota	nd.gov/dhs/services/medicalserv/medicaid/
Ohio	medicaid.ohio.gov/MEDICAID101/QualityStrategyandMeasures.aspx
Oklahoma	okhca.org/
Oregon	oregon.gov/oha/metrics/Pages/index.aspx
Pennsylvania	dhs.state.pa.us/cs/groups/public/documents/communication/s_002193.pdf
Rhode Island	Main Rhode Island Department of Health and Human Services: healthrhode.ri.gov/HIXWebI3/DisplayRIServices
South Carolina	scdhhs.gov/site-page/medicaid
South Dakota	Outcome goals: dss.sd.gov/healthhome/outcomemeasures.aspx
Tennessee	tn.gov/tenncare/topic/eligible-professionals-clinical-quality-measures Additional Link: tn.gov/tenncare/topic/mco-quality-data
Texas	Main Medicaid home page: hhs.texas.gov/services/health/medicaid-chip-programs/star-medicicaid-managed-care-program
Utah	Utah Department of Health Medicaid: medicaid.utah.gov/
Vermont	Main Medicaid website/provider portal: vtmedicaid.com/ Blueprint for Health: blueprintforhealth.vermont.gov/sites/blueprint/files/BlueprintPDF/AnnualReports/Blueprint%20for%20Health%202012%20Annual%20Report%20%2002_14_13_FINAL.pdf Individual reports for geographic areas here, with comparison to state level data (displayed here): blueprintforhealth.vermont.gov/reports_and_analytics/hospital_service_area_profiles Vermont Chronic Care Initiative Annual Report: dvha.vermont.gov/for-providers/1vcci-annual-report-sfy-2013-4-21-14-final-revised-6-26-14.pdf
Virginia	dmas.virginia.gov/
Washington	hca.wa.gov/medicaid/Pages/index.aspx
West Virginia	Coventry Cares MCO: chcmemoicaid-westvirginia.coventryhealthcare.com/ Main Medicaid page: dhhr.wv.gov/bms/Pages/default.aspx
Wisconsin	dhs.wisconsin.gov/medicaid/index.htm
Wyoming	wyhealth.net/

CAHPS indicates Consumer Assessment of Healthcare Providers and Systems; HbA1c, glycated hemoglobin; HEDIS, Healthcare Effectiveness Data and Information Set; LDL-C, low-density lipoprotein cholesterol; MCO, managed care organization; MUE, medical use evaluation.

Figure 1. Extent of Reporting for Diabetes Quality Measures for State Medicaid FFS Programs (as of July 2015)



Measure	Number of FFS States Reporting (N = 23)*	Proportion of Patients Meeting Measure, Median (Range)
HbA1c testing measure	21 (91%)	73% (28%, 98%)
LDL-C screening measure	19 (83%)	63% (10%, 80%)
Eye exam (retinal) performed	12 (52%)	43% (11%, 61%)
LDL-C control (<100 mg/dL)	7 (30%)	31% (19%, 58%)
HbA1c control (<8.0%)	6 (26%)	39% (28%, 66%)
Medical attention for nephropathy	6 (26%)	70% (32%, 80%)
BP control (<140/90mm Hg)	6 (26%)	53% (40%, 78%)
HbA1c poor control (>9.0%)	5 (22%)	54% (19%, 68%)
BP control (<140/80mm Hg)	4 (17%)	35% (26%, 46%)
HbA1c control (<7.0%)	3 (13%)	31% (21%, 41%)

*A total of 12 states reported ≥1 measure for FFS programs only, 11 states reported data for FFS and MCO programs, 25 states reported data for MCO programs only, and 3 states had no data published. BP indicates blood pressure; FFS, fee-for-service; HbA1c, glycated hemoglobin; LDL-C, low-density lipoprotein cholesterol.

of patients receiving screening for microalbuminuria, proportion of patients classified as obese or overweight, receipt of influenza vaccine in adults aged 50 to 64 years, health literacy, tobacco use, and composite measure of HbA1c, low-density lipoprotein cholesterol (LDL-C), blood pressure, and tobacco use.

FFS Medicaid Programs

Of the 23 states with publicly reported data for the FFS programs, the most commonly reported process measure was “percentage of patients receiving HbA1c testing” (21 of 23 states), followed by the other screening measures:

LDL-C screening (19 of 23 states) and eye examination (12 of 23 states). The least frequently reported measures were those that require states to conduct medical record reviews or additional data analysis (eg, outcome measures such as percentage of patients achieving HbA1c <7%, proportion of patients achieving BP control, and proportion of patients achieving LDL-C <100 mg/dL).⁴ Moreover, few states had published consecutive data year over year that would enable examination of changes in reporting following Medicaid expansion as a result of the ACA, and only 5 states had historical FFS program quality data available (Colorado [2013], Illinois [2013], Kansas [2003-2008], North Carolina [2010], and Vermont [2012]). It is worth noting that the 5 states that had historical data generally reported more measures (ie, at least 3 measures: Colorado [9 measures], Illinois [3 measures], Kansas [4 measures], North Carolina [3 measures], and Vermont [10 measures]). As shown in Figure 1, the overall quality of diabetes care was low, although generalizations should be made with caution because of the small number of states with publicly reported data and the variance in the age of the reported data. In comparison, however, national benchmark data from the National Committee for Quality Assurance, the organization responsible for the development and maintenance of the HEDIS measures, shows that the proportion of members receiving

HbA1c testing was 94% in 2014; the percentage of members with poor control (HbA1c >9%) was 19%.⁵

Contrary to FFS programs, in the assessment of the 10 Medicaid MCOs, they all used the HEDIS core set of measures and had more recent data reporting time frames (all but 1 MCO reported data from 2013 or 2014). The most commonly reported measures were the process (screening) measures: HbA1c testing, eye examination, and LDL-C screening.

DISCUSSION

The degree and timing of reporting diabetes quality measures differed significantly among states, and historical data



were found to be scarce. There was sometimes a significant lag in the time from measurement to reporting of data (eg, 3 years from time of data measurement to report date in Wyoming, Louisiana, and Arizona). Overall, states did not consistently report quality measures on an annual or other regular interval. Moreover, a significant difference exists between Medicaid FFS program populations and MCO populations in terms of their available data. Despite many states' transitioning their Medicaid population from FFS plans to MCO plans that monitor performance via well-established HEDIS quality measures, the current state of reporting for Medicaid FFS programs remains inadequate. The issue of poor or low levels of public reporting of quality measures is an important one. One of the strategic goals and objectives of the US Department of Health and Human Services (HHS) plan for 2014 through 2018 is to strengthen and improve healthcare quality and patient safety.⁶ However, improvements can be recognized only if the measures are standardized across the various stakeholders and organizations and the performance data on quality measures are shared regularly. It is not known whether the states identified in this report were influenced by the ACA to report quality measures; although the ACA states that the HHS must publish and periodically update the Medicaid Adult Core Set, participation and reporting by Medicaid programs is voluntary. Although only 4 states had public reports that predated the availability of the Medicaid Adult Core Set (2012), it is not known whether the remaining 19 states that reported ≥ 1 measure began reporting because of this or whether the timing was coincidental.

There are ongoing initiatives that seek to enhance reporting within various Medicaid populations and more, such as the CMS Innovation Center's State Innovation Models (SIMs) and other state-level multipayer initiatives, which, perhaps, indicates that changes are on the horizon. In this assessment, 40 states were identified as either participating in SIMs or otherwise establishing larger statewide quality initiatives, with 22 of them tracking at least 1 diabetes-related measure. Because funding for these plans began in April 2013, these initiatives are still in their infancy, with only baseline outcomes data available for review at the time of publication. However, it is anticipated that the level of visibility for progress in diabetes care will continue

to increase as states continue to leverage the availability of these funding awards to test innovative health system management approaches.

CONCLUSION

With the continued expansion of Medicaid and the increasing number of eligible beneficiaries, continuous quality improvement and the impact on outcomes for patients will remain a top priority in the US healthcare system. The recognition of improvement, however, will begin only with the establishment of quality-driven benchmarks and consistent reporting within Medicaid programs. [ajpb](#)

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