

MILLIMAN REPORT

Evaluation of State Medicaid Scorecard Data

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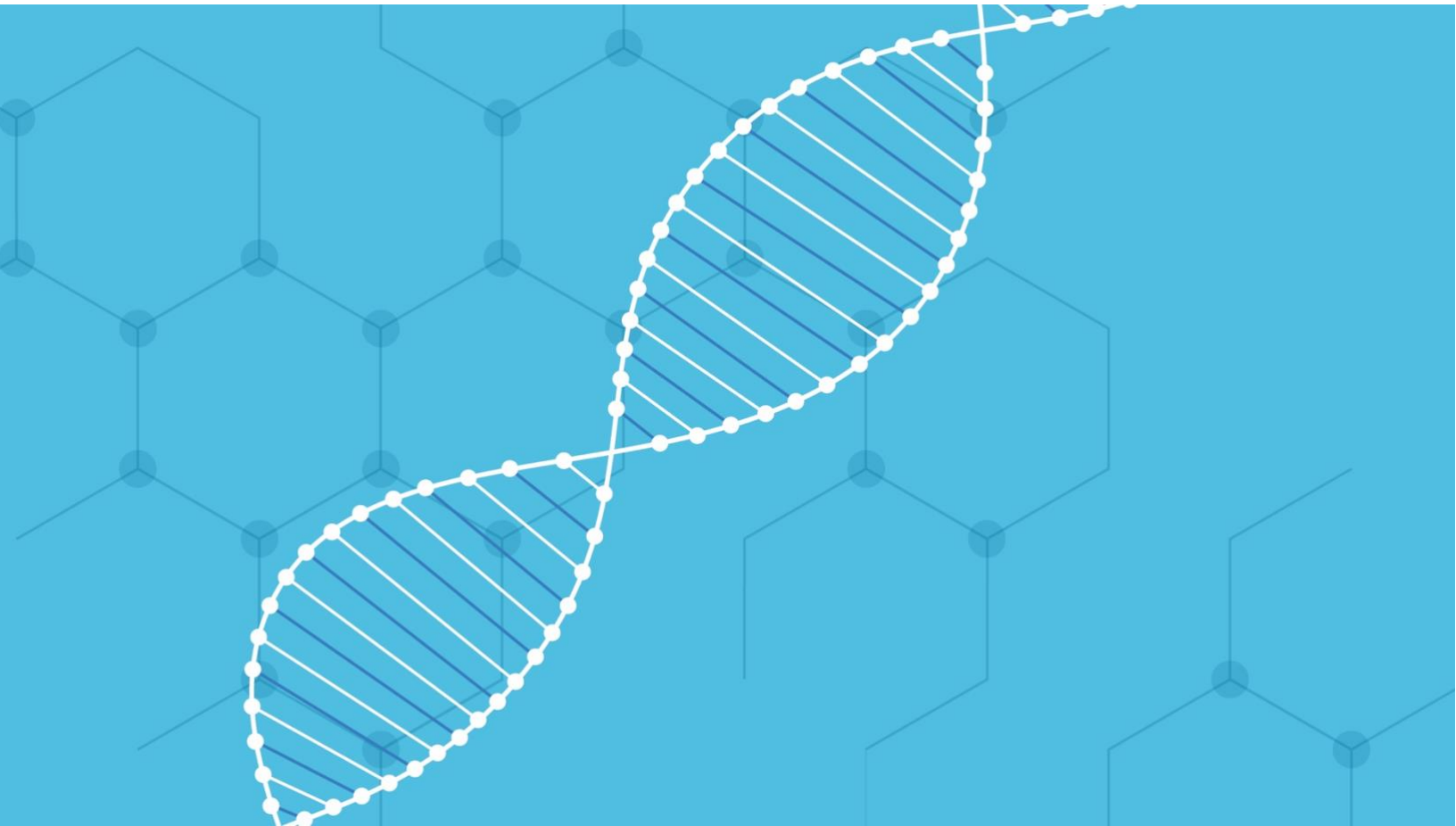




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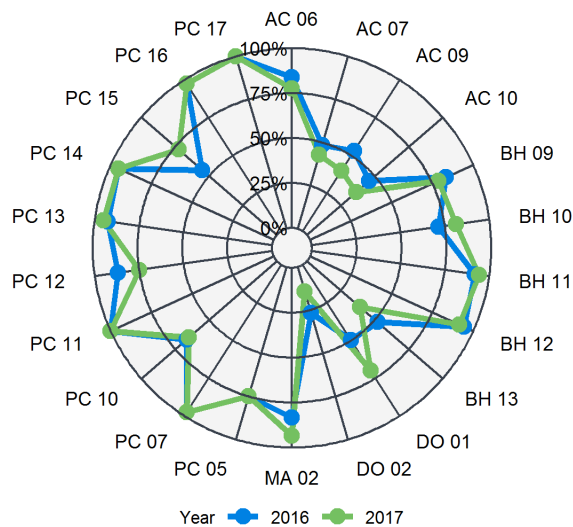
Executive Summary

This report provides an analysis of the recently announced Centers for Medicare and Medicaid Services (CMS) Medicaid and Children’s Health Insurance Program (CHIP) Scorecard. We primarily focus on the Scorecard’s State Health System Performance (SHSP) quality metrics, based on the Child and Adult Core Set data. As stated by the National Association of Medicaid Directors (NAMd), there are material differences in how states report these measures to CMS. However, in our analysis of the quality metric data, we have controlled for key differences in state-level reporting methodologies to provide meaningful comparisons. For states with available data, quality metrics have been summarized into a state profile report (provided in a separate document), illustrating how a state’s quality metrics measure relative to its applicable peers, controlling for variances in reporting methodologies and underlying populations for each quality measure.

State Profile Reports

Quality metrics for reporting states are summarized separately for Child and Adult Core Set measures in a “radar” chart. An example of a state chart is shown below.

FIGURE 1: NEW YORK CHILD CORE SET RADAR CHART



HOW TO INTERPRET THE RADAR CHARTS

- The state charts measure a rate on each axis (or “spoke”).
- Rates are only included when there are at least 10 states using the same population and reporting methodology, and the rates were reported for both 2016 and 2017.
- Rates are displayed on a percentile basis (compared to those states using the same population and reporting methodology for that rate).
- Points near the outside of the circle reflect better relative performance. For example, New York reported the most favorable rates for PC 11 and PC 17, so those points fall on the outer circle representing 100%.
- Rates are ordered by domain to facilitate the understanding of broad, domain-level trends.
- There are lines for both 2016 and 2017 to demonstrate changes over time.

There are cases when a state reports Medicaid and CHIP populations separately. In these instances, we calculate a weighted average of the rates, using the children’s enrollment report from CMS.¹ While New York’s Child Core Set has a significant number of comparable measures, other states with less complete reporting or fewer comparable

¹ The FY 2017 version is available at: <https://www.medicicaid.gov/chip/downloads/fy-2017-childrens-enrollment-report.pdf>.

measures will have significantly fewer measures illustrated in the radar chart. To the extent there are fewer than three comparable measures, a radar chart cannot be created.

These charts are intended to provide brief snapshots of each state's reporting. In addition to the radar charts, each state profile report includes more detailed metrics for each quality measure, such as the raw rate, equivalent percentile, number of comparable states, and select distribution statistics for the comparable rates. An example of a state table is shown in Figure 2. Even for states with relatively few comparable measures, the detailed Core Set metrics allow an assessment of improvement between 2016 and 2017 to be performed.

FIGURE 2: NEW YORK FFY 2017 CHILD CORE SET METRICS

ID	Reported?	Rate	Comparable?	# Comp.	Performance Percentile	Lowest Quartile	Median	Highest Quartile
AC 06 ^{1,4}	Y	39.1	Y	41	78%	39.3	42.3	51.1
AC 07	Y	0.261	Y	36	43%	0.243	0.269	0.321
AC 08 ³	N	NA	N	NA	NA	NA	NA	NA
AC 09	Y	0.267	Y	36	40%	0.248	0.280	0.323
AC 10	Y	0.264	Y	34	36%	0.249	0.272	0.319
BH 09	Y	0.592	Y	34	79%	0.413	0.494	0.556
BH 10	Y	0.675	Y	33	81%	0.552	0.618	0.662
BH 11	Y	0.852	Y	36	94%	0.603	0.686	0.800
BH 12	Y	0.716	Y	36	91%	0.392	0.469	0.646
BH 13 ¹	Y	0.031	Y	29	39%	0.017	0.025	0.035
DO 01	Y	0.244	Y	11	70%	0.140	0.207	0.245
DO 02	Y	0.403	Y	50	14%	0.447	0.482	0.521
MA 02 ¹	Y	0.074	Y	16	93%	0.083	0.088	0.104
MA 03	Y	0.665	Y	16	73%	0.542	0.659	0.677
MA 04	Y	0.888	Y	10	89%	0.771	0.831	0.881
PC 05	Y	0.650	Y	17	75%	0.499	0.555	0.650
PC 06 ³	N	NA	N	NA	NA	NA	NA	NA
PC 07	Y	0.730	Y	41	98%	0.448	0.492	0.567
PC 08	N	NA	N	NA	NA	NA	NA	NA
PC 09 ³	N	NA	N	NA	NA	NA	NA	NA
PC 10	Y	0.744	Y	21	65%	0.679	0.723	0.748
PC 11	Y	0.843	Y	19	100%	0.567	0.620	0.665
PC 12	Y	0.770	Y	21	75%	0.608	0.721	0.770
PC 13	Y	0.953	Y	42	95%	0.870	0.903	0.927
PC 14	Y	0.969	Y	42	95%	0.880	0.906	0.931
PC 15	Y	0.964	Y	41	73%	0.938	0.952	0.964
PC 16	Y	0.942	Y	42	98%	0.854	0.877	0.904
PC 17	Y	0.681	Y	22	100%	0.325	0.400	0.443
PC 18 ²	Y	0.776	Y	19	50%	0.684	0.776	0.839
PC 19 ²	Y	0.327	Y	19	89%	0.159	0.209	0.252

1. Lower rates are better for these measures.

2. These measures were added for 2017.

3. These measures were removed for 2017.

4. These measures are not expressed as percentages.

Note that, for select measures, a lower rate indicates a higher performance level. These measures are marked by a "1" in the appendices. For these measures, the "Lowest Quartile" reflects better performance relative to the Median and "Highest Quartile."

Key considerations when evaluating the information contained in the state reports include:

- **Assessing percentile changes.** The percentile changes from year to year do not necessarily indicate a state's performance rate for a quality metric has improved or declined between years. Changes in both the number of states with comparable measures as well as their corresponding performance rates will also change the percentile values. By reviewing values provided in the detailed appendices of these reports, a determination can be made regarding factors driving percentile changes from 2016 to 2017 for a given state.

- **Social determinants.** Low performance percentiles do not necessarily indicate the Medicaid program is operating poorly relative to other states. As the health policy community has gained a better understanding of how social determinants of health influence healthcare outcomes, such disparities between states should be recognized when evaluating results and opportunities for improvement.
- **Data reliance.** The performance measures made available by CMS are dependent upon the underlying data behind the measures. To the extent a state has difficulty in reporting a measure or incomplete data, it will influence the quality metric's performance rate. Data for this report was obtained through data.medicare.gov in November 2018. Values are displayed without modification.
- **Future reporting.** As CMS refines the Core Set measurements and states are able to provide more complete reporting, the usability of the Core Set data is likely to improve. Future performance assessments are likely to be impacted by these changes and may provide more robust benchmarking opportunities.

The remainder of this paper provides an overview of the CMS Scorecard and describes reporting methodologies employed by states in submitting the Child and Adult Core Set data to CMS. A description of each Child and Adult Core Set measure is provided in the appendix of this report and is also provided in each separately available state profile document.

Introducing the CMS Medicaid and CHIP Scorecard

On June 4, 2018, CMS announced the release of the first version of the Medicaid and CHIP Scorecard (Scorecard).² The development of the Scorecard was first announced by CMS Administrator Seema Verma during her remarks at the National Association of Medicaid Directors (NAMd) 2017 Fall Conference.³ The stated goals of the Scorecard include:⁴

- Tracking and displaying progress within the Medicaid program through meaningful data and improved transparency on an annual basis
- Facilitation of the development of best practices that lead to positive health outcomes

Overview of Scorecard sections

Two areas of the Scorecard focus on state and federal administrative accountability.⁵

- **State administrative accountability.** This portion of the Scorecard measures the timeliness of states' managed care rate certifications to CMS in relation to the start of the contract period, as well as the number of days it takes for a state to respond to questions from CMS regarding the managed care rates. Other measures focus on the approval periods for State Plan Amendments (SPAs) and waiver requests, renewals, and amendments. Additionally, CMS provides state level information regarding the portion of long-term services and supports (LTSS) expenditures attributable to home and community-based services (HCBS).
- **Federal administrative accountability.** Complementing the state administrative accountability measures, the federal administrative accountability measures focus on the length of time required by CMS to review and approve managed care rates. Other measures regarding SPAs and waiver requests overlap with the state administrative accountability section.

² CMS (June 4, 2018). CMS unveils scorecard to deliver new level of transparency within Medicaid and CHIP program. News release. Retrieved February 21, 2019, from <https://www.cms.gov/newsroom/press-releases/cms-unveils-scorecard-deliver-new-level-transparency-within-medicare-and-chip-program>.

³ CMS (November 7, 2017). Speech: Remarks by Administrator Seema Verma at National Association of Medicaid Directors (NAMd) 2017 Fall Conference. News release. Retrieved February 21, 2019, from <https://www.cms.gov/newsroom/fact-sheets/speech-remarks-administrator-seema-verma-national-association-medicare-directors-namd-2017-fall>.

⁴ CMS (June 4, 2018). CMS unveils scorecard, op cit.

⁵ Medicaid. Medicaid & CHIP Scorecard. Retrieved February 21, 2019, from <https://www.medicare.gov/state-overviews/scorecard/index.html>.

For these sections of the Scorecard, state-specific information is generally not provided. Rather, national median statistics or histograms are used to illustrate results. Metrics are provided for calendar year (CY) 2016 approvals, which were largely unaffected by updated Medicaid managed care regulations released during that year. It will be interesting to see the impact of these regulations on future years.

The final section of the Scorecard provides state-specific statistics on SHSP based on quality measures contained in the Child and Adult Core Sets.⁶

- **Child Core Set.** The Child Core Set was developed from the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), which required the U.S. Department of Health and Human Services (HHS) to develop a set of quality measures for Medicaid and CHIP programs based on voluntary reporting by states.⁷
- **Adult Core Set.** Section 1139B of the Patient Protection and Affordable Care Act (ACA) established the impetus for the Adult Core Set. The measures were first published by CMS in January 2012.⁸

To support states' efforts to report these measures, CMS established the Technical Assistance and Analytic Support (TA/AS) program.⁹ Annual updates are made to the Core Sets based on changes in clinical guidelines and discussion between state and federal officials, providers, health plans, and patient advocates.¹⁰

State Medicaid Directors concerns regarding SHSP measures

While CMS provides support to state Medicaid agencies to report the Core Set information, there are many nuances that may affect the state-specific score for a given measure. In a press release by NAMD reacting to the Scorecard, the organization stressed caution should be used in interpreting and using the Scorecard's SHSP measures due to the following factors:¹¹

- Reporting completeness (number of measures reported by a state)
- Methodology employed by a state to report a particular measure (claims-based or claims and medical record review)
- Variances in the populations underlying the reported measures (e.g., non-disabled vs. dual-eligible populations)

Assessing variances in reporting between states

To better understand the available data contained in the SHSP section of the Scorecard, we explored the issues identified by NAMD and the extent to which they may limit the ability for users to compare state Medicaid program performance. Our analysis focuses on the following assessments of the SHSP measures:

- Available measures and completeness of state reporting
- Variance in reporting methodology employed by states for individual measures
 - Correlation between reporting methodology and state ranking for certain measures
- Inconsistency in populations underlying reported measures between states

⁶ Core Set data is available from <https://data.medicaid.gov/>.

⁷ Medicaid. Children's Health Care Quality Measures. Retrieved February 21, 2019, from <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html>.

⁸ Medicaid. Adult Health Care Quality Measures. Retrieved February 21, 2019, from <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html>.

⁹ Medicaid/CHIP (February 2018). Fact Sheet: About the Technical Assistance and Analytic Support Program. Retrieved February 21, 2019, from <https://www.medicaid.gov/medicaid/quality-of-care/downloads/tafactsheet.pdf>.

¹⁰ CMS (November 14, 2017). 2018 Updates to the Child and Adult Core Health Care Quality Measurement Sets. CMCS Informational Bulletin. Retrieved February 21, 2019, from <https://www.medicaid.gov/federal-policy-guidance/downloads/cib111417.pdf>.

¹¹ NAMD (June 4, 2018). NAMD Statement on the CMS Scorecard. Retrieved February 21, 2019, from http://medicaiddirectors.org/wp-content/uploads/2018/06/Scorecard-1.0-NAMD-Statement_FINAL.pdf.

Available measures and completeness of reporting

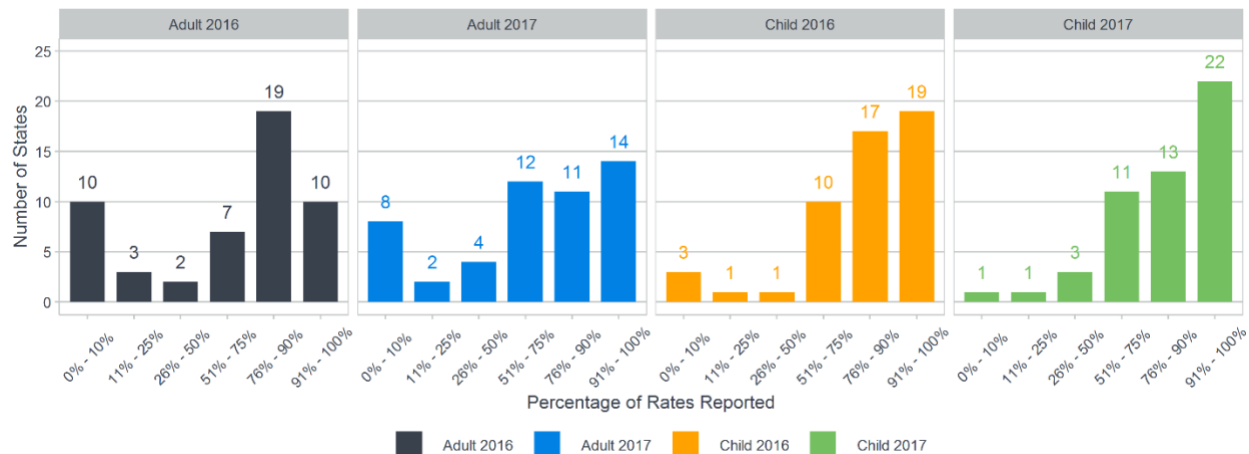
There are 48 unique metrics (rates) measured within the SHSP portion of the 2017 Scorecard based on the Child and Adult Core Sets. These metrics can be broken down into the two “Core Sets” as well as five different domains, as illustrated in Figure 3. Metrics may be added or removed to the Core Sets each year. A full list of the metrics included in the 2016 and 2017 Core Sets (including identification of annual changes) is provided in the appendices of this report.

FIGURE 3: NUMBER OF CHILD AND ADULT CORE SET MEASURES BY DOMAIN

Domain	2016			2017		
	Child	Adult	Total	Child	Adult	Total
Behavioral Health Care	5	8	13	5	8	13
Care of Acute and Chronic Conditions	5	5	10	4	8	12
Dental and Oral Health Services	2	0	2	2	0	2
Maternal and Perinatal Health	3	1	4	3	1	4
Primary Care Access and Preventive Care	13	4	17	13	4	17
All Domains	28	18	46	27	21	48

Figure 4 summarizes the number of states reporting various percentages of the Core Set measures in 2016 and 2017, separately for child and adult measures.

FIGURE 4: PERCENTAGE OF CHILD AND ADULT CORE SET MEASURES COMPLETED BY STATES



The following key observations can be made regarding the completeness of state reporting:

- Reporting for 2017 is slightly more complete than for 2016.
 - Twenty-two states reported more than 90% of measures in the 2017 Child Core Set relative to 19 states for the 2016 Child Core Set.
 - Fourteen states reported more than 90% of measures in the 2017 Adult Core Set relative to 10 states for the 2016 Adult Core Set.
 - Two states completed 25% or fewer of 2017 Child Core Set measures, versus four states for the 2016 Child Core Set measures.
 - Ten states completed 25% or fewer of 2017 Adult Core Set measures, versus 13 states for the 2016 Adult Core Set measures.

- Child reporting is more complete than adult
 - Thirty-five states reported more than 75% of measures in the 2017 Child Core Set relative to only 25 states for the 2017 Adult Core Set.
 - Only two states completed 25% or fewer of 2017 Child Core Set measures, versus 10 states for the 2017 Adult Core Set measures.
 - While the reporting of the 2017 Adult Core Set measures is less complete than the Child Core Set measures, 37 states still reported more than 50% of the measures.
 - Similar observations also apply for federal fiscal year (FFY) 2016.
- Factors driving low reporting of measures
 - In general, states with low Medicaid membership reported on fewer of the quality measures. For example, North Dakota and South Dakota are states with the lowest number of measures reported. Both of these states also have relatively low Medicaid membership.
 - The Child Core Set may be more complete due to CHIPRA preceding the ACA.

Variance in reporting methodology employed by states for individual measures

As indicated by NAMO, variances in reported measures may be influenced by the reporting methodology employed by the state. Core Set measures are calculated using four techniques:

- **Administrative.** The calculation of quality scores is completed using claims or encounter data. For states with risk-based managed care, incomplete encounter data may result in understated quality scores.¹² In addition to satisfying new Medicaid managed care regulations and facilitating capitation rate setting,¹³ complete encounter data will also likely increase quality measurements that use only administrative data.
- **Hybrid.** The hybrid method uses a combination of administrative data and a review of medical records to calculate a quality measure. A state may use the hybrid method due to administrative data that is incomplete or missing necessary information to calculate the measure. CMS indicates the hybrid method may yield more accurate rates than administrative data alone and cites a study showing that for 15 Healthcare Effectiveness Data and Information Set (HEDIS®) measures in commercial plans, hybrid measurements were 20 percentage points higher relative to using only administrative data. However, because the hybrid method requires a review of medical records, it may be too costly for states to implement.¹⁴
- **Administrative and hybrid.** Some states derive rates using both administrative and hybrid method data. This is due to variance in the reporting of quality measures by managed care organizations (MCOs), when a common means of reporting is not employed (administrative vs. hybrid).
- **Electronic health records.** Certain rates may be determined by using electronic health record (EHR) specifications. For 2017 Core Set measures, we observed Oregon reporting two adult measures based on EHR data.

¹² Medicaid/CHIP (October 2014). Technical Assistance Brief: Using the Hybrid Method to Calculate Measures From the Child and Adult Core Sets. Retrieved February 21, 2019, from <https://www.medicaid.gov/medicaid/quality-of-care/downloads/hybrid-brief.pdf>.

¹³ Cunningham, J., Lewis, M.T., & Houchens, P.R. (May 17, 2016). Encounter Data Standards: Implications for State Medicaid Agencies and Managed Care Entities From Final Medicaid Managed Care Rule. Milliman White Paper. Retrieved February 21, 2019, from <http://www.milliman.com/insight/2016/Encounter-data-standards-implications-for-state-medicaid-agencies-and-managed-care-entities-from-final-medicaid-managed-care-rule/>.

¹⁴ Medicaid/CHIP (October 2014), Technical Assistance Brief, op cit.

Figures 5 and 6 illustrate the number of states reporting each measure and the reporting methodology employed across states for the Child and Adult Core Sets, respectively. Measures are grouped by domain. Note that some measures contain duplicates due to some states reporting multiple populations with distinct methodologies. As an example, the state of Texas reports Adolescent Well-Care Visit: Ages 12-21 (PC 17) for the CHIP population and Medicaid population separately. The Medicaid-only population is reported with the Administrative and Hybrid methodologies whereas the CHIP-only population is reported solely with the Hybrid methodology. Because Texas reports two rates with two methodologies for this single measure, this creates two data points in the chart. Across all states in 2017, there are only seven instances of states reporting different methodologies for a given measure between Medicaid-only and CHIP-only.

FIGURE 5: REPORTING METHODOLOGIES BY DOMAIN: 2017 CHILD CORE SET

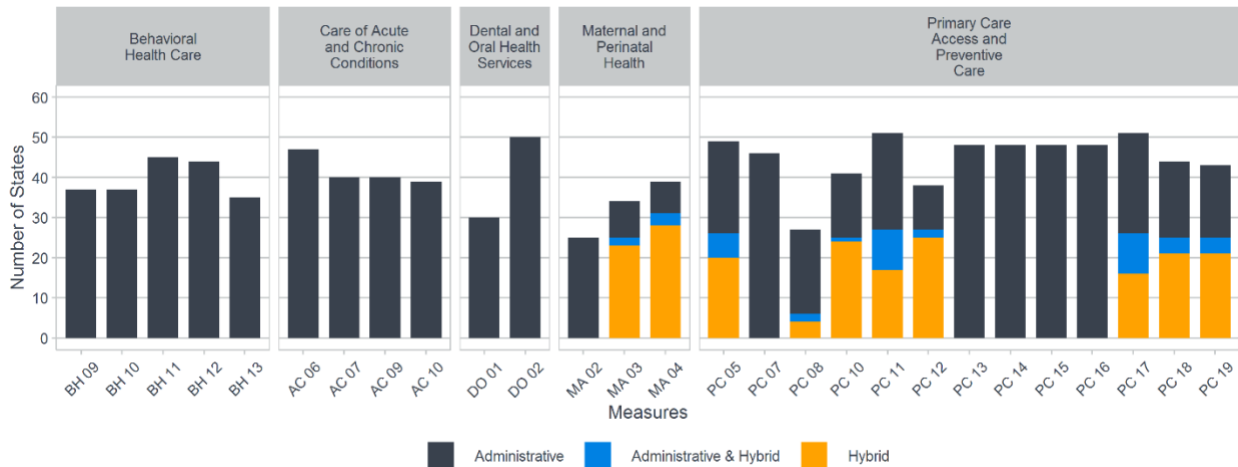
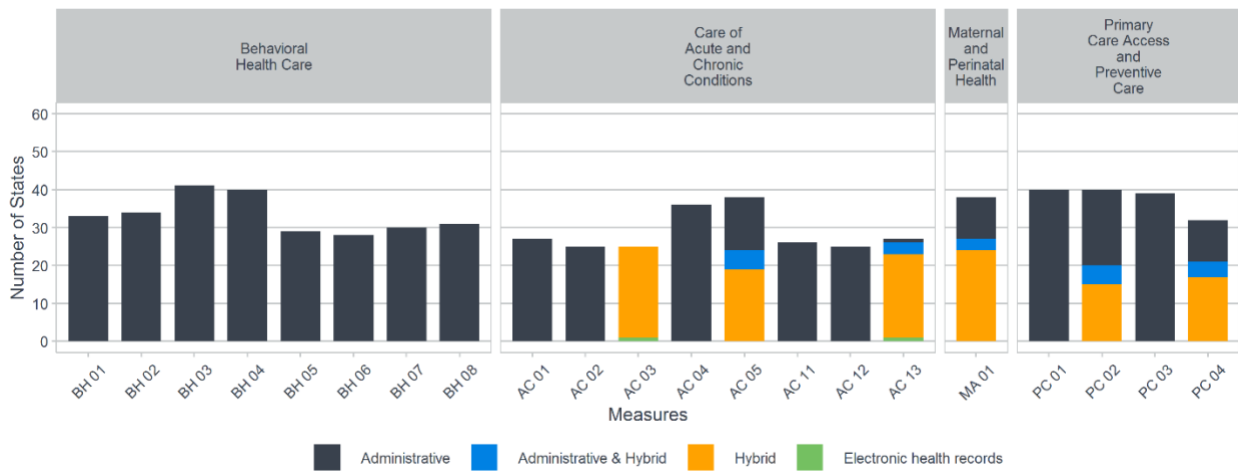


FIGURE 6: REPORTING METHODOLOGIES BY DOMAIN: 2017 ADULT CORE SET



The variance in reporting methodologies is confined to a minority of measures in both the Child and Adult Core Sets.

- **Child Core Set reporting methodologies.** For the Behavioral, Acute/Chronic, and Dental/Oral domains, reporting is entirely administrative. Within the Maternal/Perinatal and Primary/Preventive domains, a mix of reporting methodologies are employed. However, the Primary/Preventive domain has several measures that are reported entirely on an administrative basis. Within each domain except the Maternal/Perinatal, at least one measure is reported by nearly every state on an administrative basis.
- **Adult Core Set reporting methodologies.** The Behavioral Health domain is completely reported using the administrative methodology. The other domains incorporate a mixture of reporting methodologies. While overall reporting is less complete relative to the Child Core Set, there are still several measures across the domains, with approximately 35 states reporting on an administrative basis.

To illustrate how values for certain measures can be influenced by the reporting methodology, we selected two measures, one each from the Child and Adult Core Sets, with approximately an even split between states using the administrative versus hybrid methods as well as several states using a combination of methodologies. These examples clearly indicate that reporting methodology materially influences the reported measure’s value.

FIGURE 7: PERCENTAGE WITH 1 OR MORE WELL-CHILD VISITS WITH A PRIMARY CARE PRACTITIONER: AGES 3-6 (CHILD CORE SET) RATES BY REPORTING METHODOLOGY

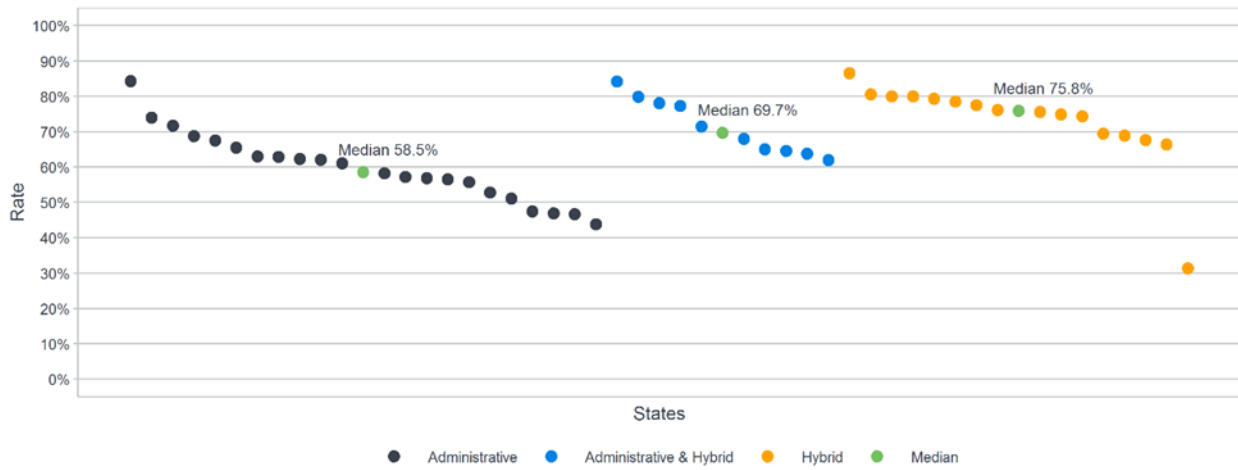
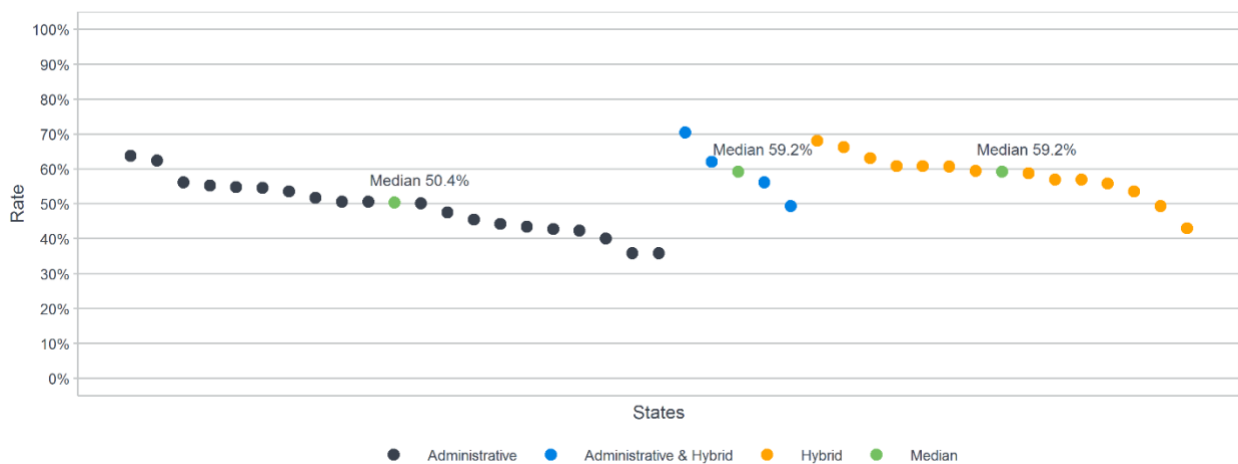


FIGURE 8: PERCENTAGE OF WOMEN SCREENED FOR CERVICAL CANCER: AGES 21-64 (ADULT CORE SET) RATES BY REPORTING METHODOLOGY



Variance in reported populations

There are variances in the underlying populations reported by each state. For the Child Core Set, states are reporting Medicaid-only, CHIP-only, or Medicaid and CHIP. For the Adult Core Set, states are reporting Medicaid and CHIP, Medicaid, Medicaid and Dual-Eligibles, or Medicaid, CHIP, and Dual-Eligibles. The differences in the reporting populations vary by state and by rate. The charts in Figures 9 and 10 show the number of populations reported for each rate within each domain and Core Set. It may be difficult to perform an accurate comparison between states reporting different populations for each rate. Note that, for the Adult Core Set, the populations for Medicaid and CHIP are included in Medicaid and the populations for Medicaid, CHIP, and Dual-Eligibles are included in Medicaid and Dual-Eligibles. Additionally, while not explicitly reported in the Core Set, states that expanded Medicaid under the ACA will likely have different mixes of adult beneficiaries relative to non-expansion states.

FIGURE 9: POPULATIONS BY DOMAIN: CHILD CORE SET

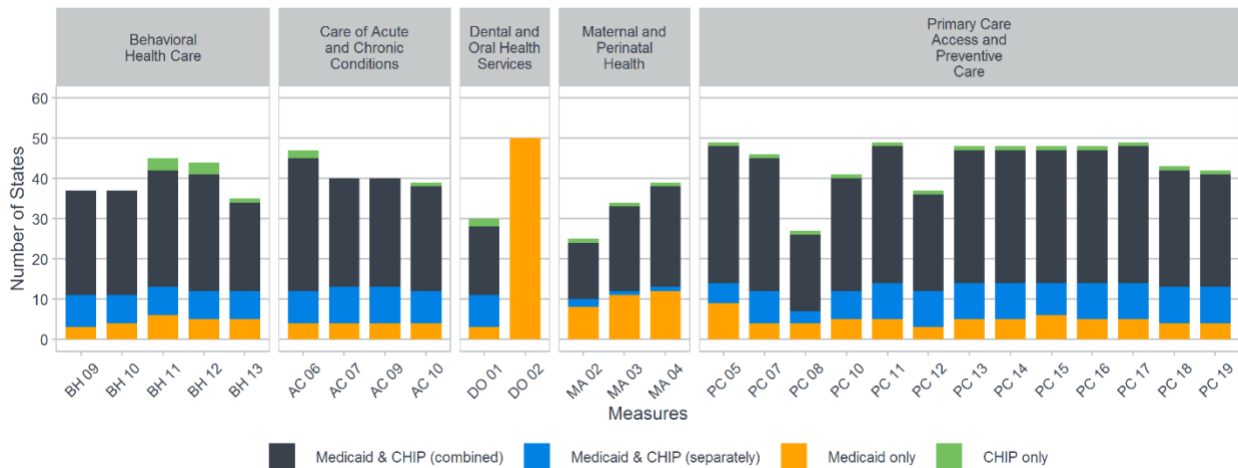
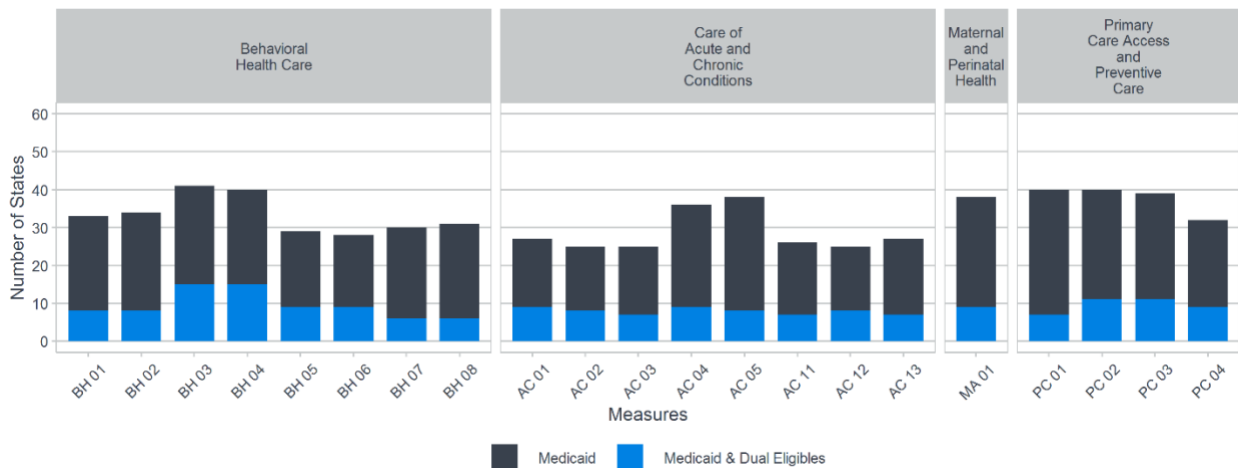


FIGURE 10: POPULATIONS BY DOMAIN: ADULT CORE SET



Appendix 1: Child Core Set Measures

ID	Definition
Care of Acute and Chronic Conditions	
AC 06 ^{1,4}	Emergency Department Visits per 1,000 Enrollee Months: Ages 0-19
AC 07	Percentage with Persistent Asthma who were Dispensed Appropriate Medication and Remained on Medication for at Least 75 Percent of Treatment Period: Ages 12-18
AC 08 ³	Percentage with Persistent Asthma who were Dispensed Appropriate Medication and Remained on Medication for at Least 75 Percent of Treatment Period: Ages 19-20
AC 09	Percentage with Persistent Asthma who were Dispensed Appropriate Medication and Remained on Medication for at Least 75 Percent of Treatment Period: Ages 5-11
AC 10	Percentage with Persistent Asthma who were Dispensed Appropriate Medication and Remained on Medication for at Least 75 Percent of Treatment Period: Ages 5-20
Behavioral Health Care	
BH 09	Percentage Newly Prescribed ADHD Medication with 1 Follow-Up Visit During the 30-Day Initiation Phase: Ages 6-12
BH 10	Percentage Newly Prescribed ADHD Medication with at Least 2 Follow-Up Visits During the 10-Month Continuation and Maintenance Phase: Ages 6-12
BH 11	Percentage of Hospitalizations for Mental Illness with a Follow-Up Visit Within 30 Days of Discharge: Ages 6-20
BH 12	Percentage of Hospitalizations for Mental Illness with a Follow-Up Visit Within 7 Days of Discharge: Ages 6-20
BH 13 ¹	Percentage on Two or More Concurrent Antipsychotic Medications: Ages 1-17
Dental and Oral Health Services	
DO 01	Percentage at Elevated Risk of Dental Caries (Moderate or High Risk) who Received a Sealant on a Permanent First Molar Tooth: Ages 6-9
DO 02	Percentage with at Least 1 Preventive Dental Service: Ages 1-20
Maternal and Perinatal Health	
MA 02 ¹	Percentage of Live Births that Weighed Less than 2,500 Grams
MA 03	Percentage of Women Delivering a Live Birth who had More Than 80 Percent of Expected Prenatal Visits
MA 04	Percentage of Women Delivering a Live Birth with a Prenatal Care Visit in the First Trimester or within 42 Days of Medicaid/CHIP Enrollment
Primary Care Access and Preventive Care	
PC 05	Percentage of Children who had 6 or More Well-Child Visits with a Primary Care Practitioner during the First 15 Months of Life
PC 06 ³	Percentage of Female Adolescents Receiving Three Human Papillomavirus Vaccine Doses by their 13th Birthday
PC 07	Percentage of Sexually Active Women Screened for Chlamydia: Ages 16-20
PC 08	Percentage Screened for Risk of Developmental, Behavioral, and Social Delays Using a Standardized Screening Tool: Ages 0-3
PC 09 ³	Percentage Up-to-Date on Immunizations (Combination 1) by their 13th Birthday
PC 10	Percentage Up-to-Date on Immunizations (Combination 3) by their Second Birthday
PC 11	Percentage who had 1 or More Well-Child Visits with a Primary Care Practitioner: Ages 3-6
PC 12	Percentage who had an Outpatient Visit with a Primary Care Practitioner or Obstetrical/Gynecological Practitioner who had Body Mass Index Percentile Documented in the Medical Record: Ages 3-17
PC 13	Percentage with a PCP Visit in the Past Two Years: Ages 12-19 Years
PC 14	Percentage with a PCP Visit in the Past Two Years: Ages 7-11 Years
PC 15	Percentage with a PCP Visit in the Past Year: Ages 12-24 Months
PC 16	Percentage with a PCP Visit in the Past Year: Ages 25 Months-6 Years
PC 17	Percentage with at Least 1 Well-Care Visit with a Primary Care Practitioner or an Obstetrical/Gynecological Practitioner: Ages 12-21
PC 18 ²	Percentage Receiving Meningococcal Conjugate and Tdap Vaccines (Combination 1) by their 13th Birthday
PC 19 ²	Percentage Receiving Three Doses of Human Papillomavirus (HPV) Vaccine by Their 13th Birthday

1. Lower rates are better for these measures.
2. These measures were added for 2017.
3. These measures were removed for 2017.
4. These measures are not expressed as percentages.

Appendix 2: Adult Core Set Measures

ID	Definition
Care of Acute and Chronic Conditions	
AC 01 ^{1,4}	Inpatient Hospital Admissions for Diabetes Short-Term Complications per 100,000 Enrollee Months: Ages 18-64
AC 02 ^{1,4}	Inpatient Hospital Admissions for Heart Failure per 100,000 Enrollee Months: Ages 18-64
AC 03	Percentage who had a Diagnosis of Hypertension and Whose Blood Pressure was Adequately Controlled (<140/90 mmHg) During the Measurement Year: Ages 18-64
AC 04	Percentage who Received at Least 180 Treatment Days of Ambulatory Medication Therapy and Annual Monitoring: Ages 18-64
AC 05	Percentage with Diabetes (Type 1 or Type 2) who had a Hemoglobin A1c (HbA1c) Test: Ages 18-64
AC 11 ^{1,2,4}	Inpatient Hospital Admissions for Asthma per 100,000 Enrollee-Months: Ages 18-39
AC 12 ^{1,2,4}	Inpatient Hospital Admissions for Chronic Obstructive Pulmonary Disease (COPD) or Asthma per 100,00 Enrollee Months: Ages 40-64
AC 13 ^{1,2}	Percentage with Diabetes (Type 1 or Type 2) who had Hemoglobin A1c in Poor Control (>9.0%): Ages 18-64
Behavioral Health Care	
BH 01	Percentage Diagnosed with Major Depression who were Treated with and Remained on Antidepressant Medication for 12 Weeks: Ages 18-64
BH 02	Percentage Diagnosed with Major Depression who were Treated with and Remained on Antidepressant Medication for 6 Months: Ages 18-64
BH 03	Percentage of Hospitalizations for Mental Illness with a Follow-Up Visit Within 30 Days of Discharge: Ages 21-64
BH 04	Percentage of Hospitalizations for Mental Illness with a Follow-Up Visit Within 7 Days of Discharge: Ages 21-64
BH 05	Percentage with a New Episode of Alcohol or Drug Dependence who Initiated and Engaged in Treatment: Ages 18-64
BH 06	Percentage with a New Episode of Alcohol or Drug Dependence who Initiated Treatment: Ages 18-64
BH 07	Percentage with Schizophrenia or Bipolar Disorder who were Dispensed an Antipsychotic Medication and had a Diabetes Screening Test: Ages 18-64
BH 08	Percentage with Schizophrenia who were Dispensed and Remained on Antipsychotic Medication for at Least 80 Percent of their Treatment Period: Ages 19-64
Maternal and Perinatal Health	
MA 01	Percentage of Women Delivering a Live Birth who had a Postpartum Care Visit on or Between 21 and 56 Days after Delivery
Primary Care Access and Preventive Care	
PC 01	Percentage of Sexually Active Women Screened for Chlamydia: Ages 21-24
PC 02	Percentage of Women Screened for Cervical Cancer: Ages 21-64
PC 03	Percentage of Women who had a Mammogram to Screen for Breast Cancer: Ages 50-64
PC 04	Percentage who had an Outpatient Visit with a BMI Documented in the Medical Record: Ages 18-64

1. Lower rates are better for these measures.
2. These measures were added for 2017.
3. These measures were removed for 2017.
4. These measures are not expressed as percentages.





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