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RECOMMENDATIONS FOR CMS RESPONSIBILITY, AUTHORITY, AND RESOURCES ON MEDICAID QUALITY AND PERFORMANCE MEASUREMENT FOR CHILDREN

Presented to the Medicaid Commission

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The National Association of Children's Hospitals (N.A.C.H.) represents more than 130 institutions across the country. They are dedicated to providing clinical care, training, research, and public health advocacy to address children's unique health care needs, and they have extensive experience in serving children assisted by Medicaid. On average, children's hospitals devote more than 50 percent of their patient care to children assisted by Medicaid. N.A.C.H. is pleased to have the opportunity to present recommendations to the Medicaid Commission.

__Summary__ Because neither the private health care marketplace nor private philanthropy focuses in a significant way on the quality of health care provided to children, it is imperative that as the nation's biggest payers of children's health care, Medicaid and the State Children's Health Insurance Program (SCHIP) – through the federal Centers for Medicare and Medicaid Services (CMS) – play a major role. CMS must provide leadership in the development and demonstration of consistent, reliable quality and performance measures for children, particularly their inpatient care.

However, most state Medicaid programs lack either the financial resources or sufficient pediatric population, or both, to develop appropriate pediatric

inpatient measures. Despite the fact that more than half of all Medicaid recipients are

children and Medicaid and SCHIP provides health care coverage for about one-third of all children in the country, CMS lacks the federal responsibility, authority, and resources to play more than a role of facilitator of state initiatives.

CMS uses its authority and resources as administrator of Medicare to play a powerful role in influencing quality and performance measurement of adult health care. But the federal agency plays no comparable role in Medicaid and SCHIP for children. The absence of CMS leadership is a setback not only for children who are assisted by Medicaid and SCHIP but for all children, since these programs have such a disproportionately large impact on the financing of health care for children and, therefore, the financing of the nation's pediatric health care infrastructure.

If, as a nation, quality and performance measurement of children's health care is not to fall farther and farther behind measurement of adult health care quality, CMS must have the responsibility, authority, and resources to lead. N.A.C.H. urges the Medicaid Commission to include in its final report of recommendations to Congress enactment of legislation that would give CMS the ability to:

- invest in the identification and distribution of consistent, national measures of quality and performance measurement for children's health care, particularly inpatient care;

- invest in consensus-based processing of pediatric measures through organizations such as the National Quality Forum (NQF) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO);

- invest in the development of a pediatric equivalent of the "Hospital Consumer Assessment Health Plan Survey" (HCAHPS), which was developed by the Agency for Healthcare Research and Quality (AHRQ) with CMS for application to adult hospital care but not pediatric hospital care;

- invest in state-specific and multistate demonstrations of quality and performance measurement for primary and preventive care, outpatient hospital care, and inpatient hospital care focused on children's unique health care needs;

- invest in the demonstration of tools necessary for the transformation of pediatric hospital care, such as development and implementation of health

care information technology and disease or care management focused on children; and

- report to Congress annually on the progress it is making in the development and use of pediatric quality and performance measures.

The Pediatric Market Medicaid plays an unexpectedly large role in the financing of pediatric health care because children's health care lacks sufficient demographic or economic clout to command the focus of the competitive private health care marketplace on children's unique health care needs.

Demographically, children are a minority in the United States, accounting for only about 25 percent of the total population. Economically, children are an even smaller minority. Because they are statistically much healthier than adults, children consume little health care compared to adults. Children account for less than
11 percent of all personal health care spending, and 95 percent of all children account for only about six percent of all personal health care spending.

Because children are such a small part of the competitive health care marketplace, they rely on public policy to ensure the market meets their unique needs. The best illustration of this market reality in recent years is the set of decisions by successive administrations and Congresses to enact bipartisan market incentives and regulatory requirements to ensure that pharmaceutical manufacturers appropriately test the safety and effectiveness of new products for children. In the absence of such incentives and regulation, only about 20 percent of all pharmaceutical products had been tested and labeled for pediatric use.

As the health care marketplace moves increasingly to rely on quality and performance measurement, not just price, to determine the allocation of health care goods and services, it is essential we ensure the development of appropriate pediatric measures, because children's and adult health care are so different. The lack of such development could result in either the application of inappropriate adult measures to pediatric health care or the exclusion of pediatric health care from measurement, neither of which is in the best, long-term interests of children's health and health care.

Market and Philanthropic Failure to Invest in Pediatric Measures For the same reasons the health care marketplace lacks demographic and economic incentives to focus sufficiently on children's health care needs overall, the

competitive market lacks the incentives to focus on the need for appropriate pediatric measures.

Recently, N.A.C.H. sought to assess both private insurance and private philanthropy's investment in pediatric quality and performance measurement by examining the contribution of private health plans identified by the Leapfrog Group's Compendium and the contribution of the nation's 15 leading foundations that support quality-related initiatives.

Of 30 private health insurance plans' quality and pay for performance programs identified by Leapfrog, it was possible to obtain information on 18 (60 percent) of them. Of these plans:

- 22 percent used no measures applicable to the pediatric population.
- 61 percent used only publicly available measures, which have little applicability to pediatric care – particularly pediatric inpatient care – beyond maternity and newborn care.
- Only 17 percent developed pediatric specific inpatient measures, working in conjunction with individual children's hospitals.

Of the 15 major foundations that supported quality and performance related initiatives between 2001 and 2005 (the most recent years for which data are publicly available):

- The foundations provided nearly $70 million in investment in work related to the measurement and improvement of health care quality overall.
- However, together, they devoted less than $11 million, or only about 14 percent, to pediatric health care quality, with only three foundations providing the bulk of that support.
- In the last two years, one of the three major foundation supporters of pediatric quality measurement and improvement withdrew from the field, reducing total foundation support by about 40 percent, or to less than $6 million.

CMS' Inability to Invest in Pediatric Measures In recent years, CMS facilitated states' adoption and use of quality and performance measures in Medicaid and

SCHIP, particularly measures for pediatric primary and preventive care. However, this work has resulted in little state development in pediatric inpatient measures.

According to an unpublished national survey of state Medicaid and SCHIP programs conducted by Health Management Associates with N.A.C.H. sponsorship, responses from 36 states in spring 2006 produced the following results:

- All but one responding state were involved in performance measurement and quality improvement activities in pediatric primary and outpatient care.

- Only 42 percent of responding states were involved in the collection of any hospital inpatient performance data, mainly limited to admissions data or lengths of stay for maternity and newborn care.

- Only five states had hospital inpatient measures for patient safety, serious reportable errors or infrastructure included in the quality monitoring of their Medicaid programs.

- Only two Medicaid programs had recently established initiatives to improve hospital inpatient care that includes pediatric inpatient performance measures.

- Only one Medicaid program had a hospital pay for performance initiative in place, begun recently as a pilot.

Most states are actively involved in quality and performance measurement, but the emphasis is largely on preventive and primary care, with little focus on pediatric inpatient care. Four themes emerged in responding states' identification of barriers to advancing quality of care improvement in Medicaid and SCHIP:

- limited financial and staff resources, including a lack of staff expertise;

- limitations of existing performance measurement tools and information technology as well as an unmet need for more standards of care or practice guidelines;

- inadequate access to care, particularly specialty care, in rural areas; and

- concerns about providing care to special populations (e.g., homeless. immigrants, particular ethnic groups) and patients' responsibility for their own care.

These limitations – especially when applied to pediatric inpatient care – reflect:

- a lack of nationally consistent, publicly available and consensus-based pediatric measures;

- a lack of state financial resources to invest in the development of such measures, particularly after years of state Medicaid spending reductions;

- a lack of pediatric population of sufficient size in most states to develop valid and reliable measures of quality for pediatric inpatient care, and

- the challenges of applying measures to pediatric inpatient care, which is often highly regionalized and encompasses the care of pediatric populations of multiple states in one facility.

States need CMS to play a leadership role in the development, testing, demonstration, and assessment of pediatric inpatient measures under Medicaid and

SCHIP. The absence of such leadership is striking when compared to the leadership CMS plays in Medicare:

- CMS is a major investor in the development of consensus-based measures of adult health care through support of the work of NQF, Quality Improvement Organizations (QIOs) and others. CMS plays virtually no comparable role for pediatric measures.

- CMS is a major catalyst for hospital reporting on quality measures through its participation in the Hospital Quality Alliance (HQA) and its use of authority to withhold Medicare inpatient reimbursement market-basket updates if hospitals do not report on agreed upon measures. CMS provides no comparable leadership for hospital reporting under Medicaid or SCHIP for children.

- CMS is a major catalyst for hospital performance against agreed upon measures through its collaboration with Premier, Inc., on the nation's largest pay for performance hospital initiative. None of the measures used in the Premier demonstration is appropriate to children's hospital care, and CMS provides no comparable leadership for hospital performance on pediatric inpatient care.

- CMS invested in the development of a hospital equivalent of the CAHPS experience with care instrument, but it excludes pediatric inpatient care;

CMS has not made a comparable investment in an experience with care instrument for children's inpatient care.

Recommendations The absence of CMS leadership on pediatric quality and performance measurement is a consequence, according to agency staff, of a lack of legislative authority and financial resources to focus on Medicaid or SCHIP, comparable to the legislative authority and resources the agency has to promote quality and performance measurement for adults through Medicare.

Therefore, it is imperative that the Medicaid Commission, as part of its comprehensive recommendations for long-term Medicaid reform, speak specifically to the responsibility, authority, and resources Congress should enact for CMS in order for the agency to be able to:

- invest in the identification and distribution of consistent, national measures of quality and performance measurement for children's health care, particularly inpatient care;

- invest in consensus-based processing of pediatric measures through organizations such as the National Quality Form (NQF) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO);

- invest in the development of a pediatric equivalent of the "Hospital Consumer Assessment Health Plan Survey" developed by the Agency for Healthcare Research and Quality (AHRQ) with CMS for application to adult hospital care but not pediatric hospital care;

- invest in state specific and multistate demonstrations of quality and performance measurement for primary and preventive care, outpatient hospital care, and inpatient hospital care focused on children's unique health care needs;

- invest in the demonstration of tools necessary for the transformation of pediatric hospital care, such as development and implementation of health care information technology and disease or care management focused on children; and

- report to Congress annually on the progress it is making in the development and use of pediatric quality and performance measures.

It is often not understood that Medicaid and SCHIP are so influential in children's health care that decisions affecting these programs have tremendous ripple effects through all health care for children; these programs are the financial foundation of pediatric health care.

If, as parents, grandparents and stewards of the next generation, we do not ensure that CMS has the responsibility, authority, and investment capability to lead in quality and performance measurement for children, all children – and generations to come – will suffer for it.