Report to Congress

HHS Secretary’s Efforts to Improve Children’s Health Care Quality in Medicaid and CHIP

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EXECUTIVE SUMMARY

Ensuring access to continuous health care coverage is the foundation for creating a comprehensive health care system that is focused on improving health care quality. Through comprehensive health coverage, families can secure preventive, primary, and acute health care services for their children. Without stable health care coverage, children rotate in and out of the health care system making it impossible to measure the quality of care provided or to significantly improve the quality of that care. As the largest single payer of health care for children, Medicaid and Children's Health Insurance Program (CHIP) programs have an important role to play in assuring that the care provided to children is stable, continuous, and quality-focused. Recent legislation, such as the Children's Health Insurance Program Reauthorization Act (CHIPRA) and the Affordable Care Act, support the Secretary of Health and Human Services' (HHS)[1] efforts to target improvement across multiple dimensions of children's health care. Implementation of these laws offers Medicaid and CHIP programs unique opportunities to better measure, monitor, and improve health care quality by increasing access to continuous health care coverage for children. Within HHS, the Centers for Medicare & Medicaid Services (CMS) is taking a leading role in implementing child health care quality improvements in Medicaid and CHIP. These efforts are aligned with CMS' overarching approach to improve health care by improving the experience of people's care, improving public health, and lowering the per capita cost of care.

CHIPRA requires the Secretary to report to Congress on: (1) the status of HHS' efforts to improve the quality of health care furnished to children under titles XIX (Medicaid) and XXI (CHIP); (2) the status of voluntary reporting by States using the initial core quality measure set; and (3) any recommendations for legislative changes needed to improve the quality of care provided to children under Medicaid and CHIP. Section 401 of CHIPRA adds section 1139A(a)(6) of the Social Security Act (the Act) which requires HHS to issue a Report to Congress every three years beginning January 1, 2011. This is the first of the required Reports to Congress and comes as HHS has identified an initial core set of children's quality measures; has awarded 10 Grants across 18 States to implement quality improvement strategies; is moving toward voluntary State reporting of quality measures, and is developing new quality measures through the Pediatric Quality Measures Program (PQMP) and the CHIPRA Centers of Excellence.

Highlights from this report include:

HHS' Efforts to Improve the Quality of Care Provided in Medicaid and CHIP

- As part of HHS' quality measures program, the Secretary released an initial core set of 24 CHIPRA measures for voluntary reporting by States. Over the next few months, the Pediatric Quality Measures Program, established by CHIPRA, and Centers of Excellence will test, refine, and develop new measures for children's health care.

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[1] References to "the Secretary" are to the Secretary of HHS.

- Ten CHIPRA Quality Demonstration Grants, authorized by section 401 of CHIPRA, were awarded to a total of 18 States to test quality improvement strategies and collect the CHIPRA core measures.
- A range of quality improvement strategies targeting quality measurement, infant/child development, oral health, and obesity are underway that address preventive and clinical care across multiple dimensions of children's health care.
- $100 million in Federal initiatives was provided through CHIPRA to increase outreach, enhance enrollment tools, measure retention, and provide guidance to States about policies that affect children's access to health services.
- Performance bonuses and outreach grants were provided to States to improve retention of Medicaid and CHIP coverage for children.

Status of Voluntary Reporting by States Using the CHIPRA Initial Core Set of Quality Measures

- CMS is collaborating with States to establish an infrastructure to implement standardized measurement processes to assess the quality of care provided to children in Medicaid and CHIP.
- States that choose to voluntarily report the 24 CHIPRA core measures can do so beginning in December 2010.
- To facilitate States' reporting of the core measures, CMS will provide States with technical assistance and analytic support to report and use these measures to drive quality improvement.
- Though it is difficult to gauge how many States intend to report all or some of the measures in the initial collection year, 10 of the 18 States participating in the CHIPRA Quality Demonstrations have plans to implement quality measure data collection and reporting processes for at least some of the core measures. As States become more comfortable with the measures and reporting mechanisms, the number of States collecting and reporting these measures will increase.

In an effort to improve transparency, engage its public partners, and leverage the knowledge of health care policy experts from throughout the country, HHS obtained input for this report by requesting public comment to assist in identifying additional opportunities to improve the quality of care provided to children in Medicaid and CHIP. The public comments and stakeholder interviews addressed topics such as access to quality care, quality measurement and monitoring, quality of coverage related to its duration and stability, financing and payment strategies, and research opportunities. Suggestions to improve the implementation of CHIPRA identified through public comments included: creating a single application for use across programs to streamline enrollment and renewal into Medicaid and CHIP; requiring all States to provide mental health services as part of their CHIP benefits package; and funding provider-level incentives to support patient and family-centered care.

Improving the quality of health care children receive is an important and ongoing effort, and HHS' initiatives are steadily making progress. Through the authorities provided by CHIPRA, the American Recovery and Reinvestment Act, and the Affordable Care Act, HHS is furthering quality improvement in children's health care by implementing the CHIPRA Pediatric Quality Measures Program, implementing an initial core set of children's quality measures, developing an infrastructure to support the voluntary reporting of the core quality measures by States, and awarding 10 Demonstration Grants. In the months ahead, HHS will have access to quality data from the core measures and will begin development of new quality measures through the PQMP and the CHIPRA Centers of Excellence. Additionally, HHS already has in place, and is continuing to implement, a variety of quality-related efforts targeting infant/child development, oral health, and obesity. The public comments and stakeholder feedback reflected in this report offer an invaluable "on the ground" perspective that the Secretary will use to improve the efforts HHS makes, in partnership with States, to measure and improve the quality of care provided to children in Medicaid and CHIP, including the implementation of the quality measures program. Future reports will address HHS' efforts to improve children's health care quality in the areas of chronic care management, physical/behavioral integration; reducing disparities in health care, and will expand upon the CHIPRA quality measures program as States begin to report on the core quality measures.

INTRODUCTION

Since 2005, the Centers for Medicare & Medicaid Services (CMS) of the Department of Health and Human Services (HHS) has greatly enhanced its capacity to support State efforts to improve the quality of health care in Medicaid and the Children's Health Insurance Program (CHIP). Medicaid and CHIP provide health coverage for nearly 32[2] million children ranging in age from infants to early adulthood. Medicaid also now pays for four in ten births[3] in the United States, making these programs a major source of coverage for children and their families.

In 2009, President Barack Obama signed the Children's Health Insurance Program Reauthorization Act (CHIPRA), the American Recovery and Reinvestment Act (ARRA), and a year later, the Patient Protection and Affordable Care Act (Affordable Care Act). These laws provide CMS new authorities to work with States to improve the quality of health care for children by establishing national data collection and quality improvement strategies in Medicaid and CHIP programs.

Section 1139A of the Social Security Act (the Act), as added by section 401 of CHIPRA, includes broad provisions to improve the quality of care provided to children. Section 1139A(a)(6) requires the Secretary to report to Congress no later than January 1, 2011 about:

> (A) the status of the Secretary's efforts to improve—
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> > (i) quality related to the duration and stability of health insurance coverage for children under titles XIX (Medicaid) and XXI (CHIP);

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[2] U.S. Dept of Health and Human Services, 2009 CMS Statistics. Table I.16; CMS Pub. No.03497 August, 2009.

[3] Kaiser Commission on Medicaid and the Uninsured. *Medicaid Primer: Key Information on Our Nation's Health Coverage Program for Low-Income People,* June 2010.

(ii) the quality of children’s health care under such titles, including preventive health services, health care for acute conditions, chronic health care, and health services to ameliorate the effects of physical and mental conditions and to aid in growth and development of infants, young children, school-age children, and adolescents with special health care needs; and
(iii) the quality of children’s health care under such titles across the domains of quality, including clinical quality, health care safety, family experience with health care, health care in the most integrated setting, and elimination of racial, ethnic, and socioeconomic disparities in health and health care;

(B) the status of voluntary reporting by States under titles XIX and XXI, utilizing the initial core quality measurement set; and

(C) any recommendations for legislative changes needed to improve the quality of care provided to children under titles XIX and XXI, including recommendations for quality reporting by States.

CHIPRA supports the transformation of children’s health care in the United States by providing a dual emphasis on quality of care and child health care coverage. Specifically, the legislation establishes mechanisms to accomplish the following:

- Develop standardized quality measures and encourage reporting of quality measures;
- Promote Health Information Technology (HIT), including the testing of an Electronic Health Record (EHR) format for children;
- Test provider-level quality improvement strategies through the CHIPRA quality demonstration grants;
- Provide sufficient Federal funding and technical assistance to improve child health care coverage;
- Boost health insurance participation rates generally and specifically among the lowest-income, Medicaid-eligible children; and
- Realign incentives to focus on quality and child health outcomes.

This report, prepared to meet the Congressional requirement that the Secretary of Health and Human Services (HHS)[4] provide information on the status of the Secretary’s efforts to improve the quality of care provided to children eligible for Medicaid and CHIP, is organized by the following sections:

- HHS’ efforts to improve the quality of care as well as the duration and stability of the health care coverage provided to children enrolled in Medicaid and CHIP;
- Status of voluntary reporting by States utilizing the initial core quality measurement set;
- Summary of findings from public comment and stakeholder interviews; and

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[4] References to “the Secretary” are to the Secretary of HHS.

- Secretary's recommendations for improving the quality of care for children in Medicaid and CHIP.

CHIPRA, coupled with the ARRA and the Affordable Care Act, provides HHS and States new authorities and resources to build on current efforts and establish the foundation for a comprehensive, high-quality system of health care services for children and adults.

I. HHS' EFFORTS TO IMPROVE THE QUALITY OF CARE, DURATION, AND STABILITY OF CHILDREN'S HEALTH CARE COVERAGE IN MEDICAID AND CHIP

In recent years there has been a marked change in the way both private and public purchasers of health care in the United States view quality measurement and improvement activities. Publication of two Institute of Medicine (IOM) reports, *To Err is Human: Building a Safer Health Care System in* 1999,[5] and *Crossing the Quality Chasm: A New Health Care System for the 21st Century* in 2001,[6] helped chart a new course toward improving quality of health care. The IOM defined quality along a number of domains and dimensions, based on the principle that health care should be effective, safe, timely, patient-centered, efficient and equitable. A recent IOM report by the Committee on Future Directions provides additional suggestions for quality domains and recommendations to establish priority areas in health care quality and disparities.[7]

In September 2010, HHS released the first annual *Secretary's Report on the Quality of Care for Children in Medicaid and CHIP*.[8] The report, which is required by 1139A(c) of the Act, as added by section 401 of CHIPRA, summarized State-specific information on the quality of health care furnished under titles XIX (Medicaid) and XXI (CHIP). The report also provided information on current State reporting of quality measures. The Secretary of HHS will publically release this report on an annual basis.

Through CHIPRA's broad provisions for improving quality, HHS has solidified its ongoing commitment to improve health care for children. This section of the report highlights a sampling of the numerous strategies HHS has undertaken through CHIPRA or as part of the Affordable Care

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[5] L.T. Kohn, J.M. Corrigan, and M.S. Donaldson, eds., *To Err Is Human: Building a Safer Health System* (Washington: National Academy Press, 1999.

[6] Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the Twenty-first Century* (Washington: National Academy Press, 2001).

[7] Cheryl Ulmer, Michelle Bruno, and Sheila Burke; *Future Directions for the National Healthcare Quality and Disparities Reports*. Committee on Future Directions for the National Healthcare Quality and Disparities Reports Board on Health Care Services, Institute of Medicine of the National Academies the National Academies Press, Washington, D.C. www.nap.edu

[8] The HHS Secretary's Annual Report on the Quality of Care for Children in Medicaid and CHIP: http://www.cms.gov/MedicaidCHIPQualPrac/02_Spotlight.asp#TopOfPage

Act's quality provisions to improve the quality of care that children in publicly-financed health care programs receive and to promote retention of coverage among eligible children. Through these efforts, HHS is creating new opportunities for States to measure and improve the quality of care for children as well as increasing its understanding and knowledge of children's health care through research and demonstration grants.

HIGHLIGHTS OF HHS' EFFORTS TO IMPROVE THE QUALITY OF CARE FOR CHILDREN IN MEDICAID AND CHIP

Multiple HHS agencies are undertaking and implementing a variety of initiatives and grant programs focused on improving the quality of care for children in Medicaid and CHIP across various dimensions of children's health care including but not limited to: child development, preventive care, and the coordination of physical and mental health conditions. In Section II of this report, family experience with health care is addressed as part of the CHIPRA voluntary core measures set. As the agency within HHS responsible for supporting States' implementation of Medicaid and CHIP programs, CMS plays a key role in improving the quality of care provided to children enrolled in these programs. CMS' overarching approach to improving health care through the simultaneous pursuit of three goals: improving the experience of care; improving the health of populations; and reducing per capita costs of health care (without any harm whatsoever to individuals, families, or communities) is reflected in the range of activities it is currently pursing to improve how the quality and continuity of children's health care is measured, monitored, and improved.

HHS' CHIPRA quality improvement efforts for children in Medicaid and CHIP have created the foundation for a quality strategy that focuses on measurement, monitoring, and improving quality for children in Medicaid and CHIP, while building off and leveraging other HHS quality-improvement efforts. As directed by CHIPRA, CMS' quality strategy is rooted in the establishment of an initial core set of quality measures that can be used to measure quality of care for children; implementation of Demonstration grants to test innovative approaches to quality improvement, measurement, and use of health information technology; creation of a Pediatric Quality Measures Program to test and refine the initial core set of measures to make them more broadly applicable to Medicaid and CHIP programs; and the development of additional quality measures that address dimensions of care where standardized measures do not currently exist.

Creating opportunities for children in Medicaid and CHIP to have stable health care coverage is critical to HHS' ability to measure and impact the health care provided. In December 2009, the Secretary released an initial core set of child health quality measures that States can use to assess the care children receive. While reporting on these measures is voluntary for States, the core measures set represents a major step toward developing a quality-driven, evidence-based, national system for measuring children's quality of care.

Establishment of an Initial Core Set of Child Quality Performance Measures for Voluntary Use by State Programs

To assist in identifying the initial core set of child performance measures for voluntary use by States, the Agency for Healthcare Research and Quality (AHRQ), on behalf of CMS, enlisted its National Advisory Council on Healthcare Research and Quality to establish a Subcommittee on Children's Healthcare Quality Measures for Medicaid and CHIP (also referred to as the SNAC). The SNAC, consisting of representatives of key stakeholder groups and experts in children's health care and quality measurement, convened in public sessions in July and September 2009. Based on guidance in the CHIPRA legislation and the SNAC's analyses of the evidence base underlying the validity, feasibility, and importance of 121 nominated measures, the SNAC recommended a set of children's quality measures.

In December 2009, the Secretary posted for public comment in the *Federal Register* a core set of 24 SNAC-recommended children's health care quality measures. The core set includes a range of children's quality measures encompassing both physical and mental health, including chronic conditions, such as asthma, attention deficit hyperactivity disorder, and diabetes. The CAHPS® (Consumer Assessment of Healthcare Providers and Systems) survey tool, which Title XXI programs are required to collect starting 2013, is also included as one of the 24 core measures. Appendix D lists the CHIPRA core measures as well as a description of each measure. Additional information on the process used by the SNAC to identify the initial core set can be found at: http://www.ahrq.gov/chipra/corebackgrnd.htm

States are encouraged to collect measures from the initial core set, in addition to their existing State-specific measures. However, the more States that collect and report the initial core set of measures, the greater the potential for States and others to benefit from this information. CMS is developing data information systems to standardize reporting and make access to quality data more available to States for comparison purposes. By having access to these data, States will have the opportunity to integrate quality data in designing and implementing their quality improvement initiatives. The CHIPRA core measures serve as a starting point for States to report on a standardized set of measures that can be used to assess the quality of health care for children in Medicaid and CHIP.

Pediatric Quality Measures Program and Centers of Excellence

As required by section 1139A(b) of the Act, the Secretary will create, by January 1, 2011, a Pediatric Quality Measures Program (PQMP) that will: (1) test and refine the initial core set of measures to make them more broadly applicable to Medicaid, CHIP, and other programs; and (2) develop additional quality measures that address dimensions of care where standardized measures do not currently exist.

Through the PQMP, AHRQ will issue grant awards to Centers of Excellence that will work to improve and enhance the initial core child health measures and to develop new quality measures meaningful to State Medicaid and CHIP programs, and applicable to all payer systems. The Centers of Excellence approach will create a cohort of entities with expertise in health care quality measurement specific to the needs of children and their health care delivery system. By April 2011, AHRQ will identify a CHIPRA Coordinating and Technical Assistance Center to facilitate common approaches, provide technical assistance, and ensure coordination of efforts across the Centers of Excellence. The Coordinating Center will also assist in creating a transparent process to recommend improved core measures to the Secretary. In December 2010, AHRQ released a Federal Register Notice soliciting public comments on priority areas for measurement development and asking the public to identify additional priorities as needed. As required by CHIPRA, the Secretary will then incorporate these improved measures into the quality measures core set by January 1, 2013, and annually thereafter.

While the initial core set covers a range of dimensions of pediatric quality measurement, measurement gaps exist. For example, none of the measures as currently specified can be used across health care financing models (e.g., full-risk managed care, fee-for-service). Data on race, ethnicity, socioeconomic status, and special health care needs are not currently available for any of the measures included in the core set. The SNAC was unable to identify valid and feasible measures for some of the CHIPRA measure topics (e.g., duration of enrollment and coverage over 12 months; availability of services; integrated health care settings); even if available, some otherwise valid and feasible measures were not being reported regularly across States. The goal of the CHIPRA-required Pediatric Quality Measures Program is to fill these gaps.

CHIPRA Quality Demonstration Grants

In February 2010, CMS awarded 10 grants[9] across 18 States to conduct demonstrations targeting quality improvement across multiple aspects of health care. The purpose of these grants is to evaluate promising ideas for improving the quality of children's health care under Medicaid or CHIP, including projects such as promoting the use of health information technology for the delivery of care for children covered by Medicaid/CHIP and evaluating provider-based models which improve the delivery of children's health care services.

A total of $20 million in first-year CHIPRA Quality Demonstration Grant funds were awarded to: Colorado, Florida, Maine, Maryland, Massachusetts, North Carolina, Oregon, Pennsylvania, South Carolina, and Utah. These projects will be conducted over a five-year period, with grant awards totaling $100 million. Ten of the 18 participating States will test the CHIPRA initial core quality measures. More detailed descriptions of the Grantee projects can be found in Appendix C.

National Evaluation of the CHIPRA Quality Demonstration Grants

In August 2010, HHS awarded a five-year contract to Mathematica Policy Research and its research partners, the Urban Institute and the Cincinnati Children's Hospital Child Policy Research Center, to assess the implementation and outcomes of the CHIPRA Quality Demonstration grants. Through this national evaluation, HHS seeks to understand how to replicate successful programs to improve

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[9] As required by section 1139A(d) of the Social Security Act, which was added by CHIPRA section 401(a).

children's health care quality, enhance families' access to information, and promote consumer choice. The research team will work with grantees to gather qualitative and quantitative information on the implementation and outcomes of States' efforts to use recommended measures of children's care quality, promote health information technology for delivery of care, test new provider-based levels of service delivery, demonstrate the impact of a model electronic medical health record, and/or test other state-designed approaches to quality improvement in Medicaid and CHIP.[10]

Coordination of Physical and Behavioral Health

Three of the CHIPRA Demonstration grantees are testing interventions that focus on integrating physical and behavioral health services for children:

- Maryland, in collaboration with Georgia and Wyoming, is seeking to improve the clinical, functional, and social outcomes of children with serious behavioral health needs through a contractor-supported care management entity provider model that will use specialized services, intensive care coordination, and peer support interventions.
- Pennsylvania is using quality measures and pre-assessment questionnaires to promote use of HIT and maximize early identification of children with developmental delays, behavioral issues, and complex medical conditions.
- South Carolina is using a medical home model to effectively coordinate care and integrate behavioral health into primary care and Early and Periodic Screening, Diagnostic, and Treatment Benefit (EPSDT) screenings in 18 diverse pilot practices.

Developing and Testing a Pediatric Electronic Health Record Template

Through an intra-agency agreement with the CMS, AHRQ is developing the model pediatric EHR format via a contract awarded in March 2010. This work includes several components including developing prototypes of some of the core functions needed for children's care that can be incorporated into existing EHRs and disseminating the model format and prototypes to information technology vendor developers and other appropriate audiences. The model format will be piloted in North Carolina and Pennsylvania as part of their CHIPRA Quality Demonstration grants.

HHS Initiatives Targeting Priority Areas for Children in Medicaid and CHIP

Other HHS priority areas targeting the quality of health care for children in Medicaid and CHIP include the growth and development of children, oral health, and childhood obesity. As HHS implements these and other quality-focused initiatives, future Reports will address children's health care in the areas of health care safety, health care in the most integrated settings, and elimination of racial, ethnic, and socioeconomic disparities in health and health care.

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[10] Mathematica Policy Research, Inc., *Mathematica to Evaluate Demonstration Program to Improve the Quality of Care in CHIP and Medicaid.* Media Advisory, September 2010. Accessed from: http://www.mathematica-mpr.com/newsroom/releases/2010/CHIPRA_9_10.asp

Growth and Development of Children

With Medicaid financing approximately 40 percent of all births in the United States,[11] HHS has targeted efforts aimed at improving the quality of and the services provided for prenatal, infant, and child growth and development.

Early and Periodic Screening, Diagnostic, and Treatment Benefit (EPSDT)

The EPSDT benefit is a key mechanism Medicaid uses to provide comprehensive and preventive child health care services for individuals under the age of 21. The benefit entitles Medicaid-eligible individuals to all medically necessary coverable services to ensure that their health and developmental needs are met. EPSDT services are provided in all States and are designed to improve the health of low-income children by financing appropriate and necessary pediatric services. As one in three U.S. children under age six is eligible for Medicaid, EPSDT offers a particularly important way to ensure that young children receive appropriate clinical, oral and mental health as well as developmental services. It also has great promise for meeting the unique needs of adolescents.

In December 2010, CMS convened a National EPSDT Improvement Workgroup that included State representatives, children's health providers, consumer representatives, and other experts in the areas of maternal and child health, Medicaid, and data analysis. The members of the group will help CMS identify the most critical areas for improvement of EPSDT. The group, which will meet periodically over the next year and a half, will also discuss steps that the Federal government might undertake in partnership with States and others to both increase the number of children accessing services and improve the quality of the data reporting that enables a better understanding how effective HHS is putting EPSDT to work for children.

Neonatal Outcomes Improvement Project (NOIP)

HHS has the unique opportunity to impact an entire population by reducing infant morbidity, mortality, and cost. Since 2005, prematurity has been the greatest contributor to the U.S. infant mortality rate of 6.8 deaths per 1,000 live births.[12] To address the problem of premature births, CMS convened, in 2005, a group of nationally-recognized experts in quality improvement, pediatrics, neonatology and obstetrics, as well as State Medicaid medical directors, to develop a project to promote the use of evidence-based clinical practices to improve care of high-risk newborns through a Neonatal Outcomes Improvement Project (NOIP). In 2007 and 2008, CMS awarded Medicaid Transformation Grants to several States that adopted innovative methods to improve their Medicaid programs. Arkansas, North Carolina, and Ohio are using their grants specifically for NOIP intervention implementation, while New York is providing its own funding.

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[11] Kaiser Commission on Medicaid and the Uninsured. *Medicaid Primer: Key Information on Our Nation's Health Coverage Program for Low-Income People,* June 2010.

[12] The Kaiser Family Foundation, *statehealthfacts*.org. Data Source: Infant Mortality Rate (Deaths per 1,000 Live Births), Linked Files, 2004-2006. Matthews, TJ, M.S., et. al., Infant Mortality Statistics from the 2006 Period Linked Birth/Infant Death Data Set. Division of Vital Statistics. National Vital Statistics Report, Vol 58, No. 17, April 30, 2010, accessed December 8, 2010.

Initial findings indicate that Ohio has successfully demonstrated establishing a collaborative focused on the elimination of late pre-term births (36-38 weeks) and reduction of Neonatal Intensive Care Unit (NICU)-associated bloodstream infection in 24 NICUs. Over a period of two years, outcomes measures show a reduction of 8,256 pre-term births; 3,300 fewer C-sections; elimination of 200 NICU admissions; prevented 16 infant deaths, and 64 fewer infections.

North Carolina and its collaborative partners have implemented two NOIP interventions: elimination of late pre-term births and reduction of NICU bloodstream infections in 14 NICUs. Thirty-seven hospital teams worked together to achieve a forty-three percent decrease in the rate of elective deliveries less than 39 weeks between October 2009 and June 2010. North Carolina and its partners set another goal of reducing catheter-related blood stream infections by seventy-five percent in participating Newborn Critical Care Centers by decreasing the number of line days and by standardizing catheter insertion and line maintenance.

Arkansas and its collaborative partners are implementing the NOIP intervention for elimination of late pre-term births through the Telemedicine Outreach Utilization Collaborative Healthcare program, which provides additional telemedicine equipment from eight Arkansas hospital nurseries and labor and deliveries to University of Arkansas Medical System (UAMS) and Arkansas Children's Hospital's Neonatal NICUs and UAMS' Labor and Delivery Unit. The program integrates neonatal best practices into services delivered at outlying hospitals to increase effectiveness and efficiency of care.

Through the NOIP, CMS has found that building a Medicaid stakeholder collaborative is one of the most effective ways of leveraging care innovations, capturing efficiencies in care delivery, and improving health outcomes. In 2010, CMS began to expand access to the NOIP collaborative to all States by offering education about public/private collaboratives and opportunities for networking with other States. Additionally, CMS began holding quarterly NOIP conference calls in June 2010 to spread best practices and lessons learned through this project.

Oral Health

Improving access to preventive and oral health care services for children is a high priority for HHS. Through the CMS Oral Health Strategy and the broader 2010 Oral Health Initiative, HHS supports a wide range of oral health activities to improve Medicaid and CHIP enrollees' oral health care and access to oral health services.

CMS Oral Health Strategy

All children enrolled in Medicaid and CHIP have coverage for dental services; however, ensuring access to these services remains a concern. CMS has been working in coordination with State and Federal partners, as well as the dental provider community, children's advocates, and others, to improve access to pediatric dental care. CHIPRA made dental services a mandatory benefit for States that have separate CHIP programs and requires that States post their dental provider information and benefit packages along with a listing of all participating Medicaid and CHIP dental providers on the Insure Kids Now website.[13] To further maintain and accelerate access to oral health services, CMS announced new oral health goals for children enrolled in Medicaid and CHIP at the April 2010 National Oral Health Conference.

CMS recently convened two workshops with State officials to discuss the goals. Building on this input, in 2011, CMS will issue a State Health Official letter formally launching the initiative and announcing the goal to increase the rate of low-income children and adolescents enrolled in Medicaid or CHIP who received any preventive dental services by 10 percentage points over a five year period. A second goal of increasing the rate of low-income children and adolescents ages six - nine enrolled in Medicaid or CHIP who receive a dental sealant on a permanent molar tooth by 10 percentage points over five years, will be phased in over the next two years. Progress toward these goals will be measured nationally and on a State-specific basis. CMS is developing an oral health strategy that will support and advance the achievement of these goals.

CMS: Review of Innovative State Medicaid Dental Programs, HHS Oral Health Initiative 2010
Children's access to dental services varies by State, and some States have been particularly adept in identifying ways to overcome the barriers they face in improving access to oral health services. As part of a 2010 HHS Oral Health Initiative that emphasizes access to oral health care and the effective delivery of services to the underserved, CMS reviewed the innovative practices of eight States that had undertaken initiatives to improve access to oral health services. Based on the information gathered, CMS developed a report based on the reviews which describes the challenges States face in improving oral health as well as innovations States are implementing to address these challenges. Of the challenges facing States, enrolling sufficient dental providers and creating a dental home are among the top. Other barriers States encounter include attracting dental specialists to participate in Medicaid, providing access to dental services in rural areas, and engaging a larger number of dentists to treat children with special health care needs.

The report also highlights the innovations found in those States, including the importance of partnerships and collaborations among State partners and stakeholder in addressing access to dental services; simplifying administrative processes; educating families; targeting young children; increased reimbursement; educating families; collaboration with dental schools and loan repayment programs; and dental home initiatives. CMS will release this report by spring 2011.

Childhood Obesity
Childhood obesity has more than tripled in the U.S. over the past 40 years, with 17% of children between the ages of two and nine estimated to be obese in 2007-2008. There is also a high prevalence of obesity among children covered by the Medicaid and CHIP programs. As such, these programs have major roles to play in positively affecting the trajectory of childhood obesity in America. CHIPRA authorized and the Affordable Care Act provided funding for $25 million in

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[13] Insure Kids Now is a website that provides information about Medicaid and CHIP programs. Accessed from: http://www.insurekidsnow.gov

grants to select communities for health care providers to work with schools, community programs, recreation centers, and other groups to build seamless community-clinical systems to reduce and prevent obesity among children.[14] In early 2011, HHS will release a Funding Opportunity Announcement for these obesity demonstration grants. The Centers for Disease Control and Prevention is leading these demonstrations, and CMS will participate in a steering committee that will assist with the program.

In addition, CMS, as required by the Affordable Care Act, will issue guidance to Medicaid and CHIP programs on coverage of obesity-related services to encourage States to implement the U.S. Preventive Services Task Force recommendations on prevention and treatment of obesity. The guidance, which will be issued in early 2011, will reinforce that the EPSDT benefit covers a full range of services necessary to prevent and treat obesity in children, and will encourage States to remind all providers that well-child examinations should be comprehensive and include diet and exercise advice. CMS will also encourage States to include specific information on the standards of practice related to obesity prevention and treatment in their provider manuals. Examples include: the importance of calculating body mass index regularly; the content of nutritional assessments; the importance of an appropriate recording of a patient's physical activity; and information regarding nutritional and behavioral health therapy.

Quality Improvement through Research

Across HHS, agencies are implementing projects to test and identify the best clinical practices and quality improvement strategies for children. The information derived from these projects can be used to inform HHS' knowledge and clinical evidence base. AHRQ, the lead Federal agency on quality research, is conducting several studies related to health quality for children enrolled in Medicaid and CHIP and underserved populations, including a study on the link between primary health care quality and emergency department utilization for children; a study of how changes in families' health insurance affects children's health care; and a study of the factors associated with quality of care delivered to children in U.S. emergency departments. AHRQ is also collaborating with CMS on a variety of CHIPRA activities designed to better assess the quality of care for children in Medicaid and CHIP.

Also focused on researching children's health care quality is the Institute of Medicine (IOM). Working in collaboration with CMS, the IOM is required by section 1139A(g) of the Act, as added by section 401 of CHIPRA, to research and report to Congress on the extent and quality of efforts to measure child health status and the quality of health care for children relative to preventive care, treatment for acute conditions, and treatments focused on better coordinating physical, mental, and

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[14] U.S. Department of Health and Human Services, Senate HELP Subcommittee on Children and Families, Statement for hearing "The State of the American Child: The Impact of Federal Policies on Children" by David Hansell, Principal Deputy Assistant Secretary Administration for Children and Families, July 29, 2010. Accessed from: http://www.hhs.gov/asl/testify/2010/07/t20100729b.html

developmental conditions in children. IOM will be releasing its *Study of Pediatric Health and Health Care Quality Measures* in 2011.

CMS also collaborates with and leverages the ongoing work of other HHS agencies focused on improving the quality of child health, including the Health Resources and Services Administration (HRSA), the Centers for Disease Control and Prevention (CDC), the Administration for Children and Families (ACF), and the Substance Abuse and Mental Health Services Administration (SAMHSA). HRSA's Maternal and Child Health Bureau, with its similar quality goals and priorities for improving children's health, will be a key partner for CMS. The CDC has been, and will continue to be, a quality partner for CMS on children's health care issues such as obesity prevention and immunization efforts. The CDC's "Vaccine for Children" program, funded by CMS, for example, provides free immunizations for low-income children, and the CDC also conducts translational research to investigate approaches to improving the delivery of vaccines to children CMS' collaboration with AHRQ on the CHIPRA quality measures led to the creation of the CHIPRA HHS Federal Quality Group which is comprised of representatives of multiple divisions of HHS including: AHRQ, CDC, CMS, HRSA, Office of the National Coordinator, Office of the Assistant Secretary for Planning and Evaluation, and SAMHSA. Serving in an advisory capacity, the HHS Federal Quality Group provides feedback to CMS related to the quality provisions of CHIPRA, including the identification of the initial core set of measures.

Additional HHS Efforts to Improve the Quality of Care for Children Through Recent Legislation

The Affordable Care Act calls on the Secretary of HHS to establish a national quality strategy for both children and adults, develop an accompanying comprehensive strategic plan to implement the strategy, and to identify priorities to improve the delivery of health care services, beneficiary health outcomes, and population health. Using the legislative criteria for establishing national priorities, the National Health Care Quality Strategy will identify priorities for both children and adults in each of the following areas:

- <u>Better Care</u>: Person-centered care that works for patients and providers. Better care should expressly address the quality, safety, access, and reliability of how care is delivered and how patients rate their experience in receiving such care;
- <u>Affordable Care:</u> Care that reins in unsustainable costs for families, government, and the private sector to make it more affordable; and
- <u>Healthy People/Healthy Communities:</u> The promotion of health and wellness at all levels.

On September 9, 2010, HHS released a Federal Register Notice for public comment on the National Health Care Quality Strategy. The initial Health Care Quality Strategy and Plan are due to Congress by January 1, 2011. The creation of a National Quality Strategy further solidifies the Secretary's broad-sweeping efforts to make health care quality a priority for HHS.

In addition to its current efforts, HHS is planning additional ways to improve the quality of care for children through provisions of the Affordable Care Act such as:

- Section 2703: *State Option to Provide Health Homes for Enrollees with Chronic Conditions:* Provides enhanced Federal funding to States implementing or expanding a health home initiative for individuals with chronic conditions. The health home service delivery model will provide a cost-effective, longitudinal "home" to facilitate access to an inter-disciplinary array of medical care, behavioral health care, and community-based social services and supports for both children and adults with chronic conditions.

- Section 2706: *Pediatric Accountable Care Organization Demonstration Project:* Creates pediatric accountable care organizations that are eligible for incentive payments if they meet certain quality and cost savings targets.

- Section 2951: *Maternal, Infant, and Early Childhood Home Visiting Program:* Provides grants to States to identify and provide effective evidence-based childhood home visiting programs to families in at-risk communities.

- Section 4101: *School-Based Health Centers:* Provides grants to support the establishment and operation of school-based health centers serving communities with high numbers of uninsured or underinsured children, or children enrolled in public insurance programs, as well as children and communities that have experienced barriers to health and mental health care services.

- Section 4107: *Coverage of Comprehensive Tobacco Cessation for Pregnant Women:* Beginning October 2010, Medicaid is required to cover comprehensive tobacco cessation services for pregnant women, and removes cost sharing for such services.

- Section 4302: *Understanding Health Disparities: Data Collection and Analysis*: In an effort to reduce health disparities, the Secretary must establish data collection standards for five demographic categories – race, ethnicity, sex, primary language, and disability status – and CMS must collect and report this data for all Medicaid and CHIP enrollees in conjunction with existing quality reporting requirements and programs.

American Recovery and Reinvestment Act (ARRA)

Much like CHIPRA, ARRA provisions also provide HHS with considerable new resources to promote and expand the meaningful use of HIT in the health care system. The related HIT provisions located throughout ARRA are collectively referred to as the Health Information Technology for Economic and Clinical Health (HITECH) Act. The law provides incentives to encourage the adoption and "meaningful use" of EHRs for exchanging information across the health care system. While this new law impacts all Americans, it also is key to HHS' efforts to better measure, monitor and assure the quality of care provided to children in Medicaid and CHIP.

While this section of the report provides a sampling of HHS' quality initiatives focused on the health care of children in Medicaid and CHIP, these efforts serve to illustrate the range of opportunities and levers HHS has to improve the quality health care for children.

IMPROVING THE DURATION AND STABILITY OF HEALTH CARE COVERAGE FOR CHILDREN ENROLLED IN MEDICAID AND CHIP

The quality of health care a child receives and the ability to provide that child with stable health care coverage are closely interlinked. Measuring the quality of care that a child enrolled in Medicaid and CHIP receives becomes nearly impossible when he/she rotates in and out of health care. A health care system that supports continuous health care coverage for children creates opportunities to better measure, analyze, and ultimately improve the quality of the care provided to that child.

A top priority of this Administration is "to achieve the long-sought goal of ensuring that uninsured children are enrolled [in Medicaid and CHIP] and *that they stay enrolled for as long as they are eligible* (emphasis added)."[15] Focusing on enrollment, HHS has designated increasing health insurance coverage for children through CHIP as a High Priority Performance Goal.[16] Specifically, HHS hopes to improve the availability and accessibility of health insurance coverage by increasing enrollment of eligible children in CHIP by nine percent over the 2008 baseline and in Medicaid by 11 percent over the 2008 baseline by the end of 2011. Progress toward this goal will be measured from State-reported quarterly and annual CHIP enrollment data through the Statistical Enrollment Data System (SEDS).[17]

The Administration also recognizes that reducing the number of uninsured children depends as much upon efforts to retain eligible children in Medicaid and CHIP as it does on taking the steps necessary to see that they get enrolled. Various studies have identified the Medicaid and CHIP renewal process as a risk point at which children (and other beneficiaries) are in danger of losing health coverage even though they continue to qualify for it.[18] Some children lose coverage because they are no

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[15] Kathleen Sebelius, "Rising to the Challenge: Tools for Enrolling Eligible children in Health Coverage," *Health Affairs*, October 2010.

[16] High Priority Performance Goals: http://goals.performance.gov/node/12?goalId=38&agencyId=75.

[17] SEDS reports the number of children under age 19, who are enrolled in separate CHIP programs and Medicaid expansion CHIP programs.

[18] L. Summer and C. Mann, "Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences and Remedies," Georgetown University Health Policy Institute, June 2006; D. Mancuso, et al., "Understanding the Children's Medical Caseload Decline," Washington State Department of Social and Health Services Research and data Analysis Division, August 2005; L. Duchon, et al., "Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk," The Commonwealth Fund, 2001; M. Birnbaum and D. Holahan, "Renewing Coverage in NY's Child Health Plus B Program: Retention Rates and Enrollee Experiences," United Hospital Fund, 2003.

longer eligible due to an increase in family income, a change in family composition, or because they "age out" on their 19th birthday. However, many children lose coverage for procedural reasons, typically when their families have not returned State-required forms or submitted documentation that may be required or premium payments have not been received on time. Loss of coverage for procedural reasons causes "churning" of coverage -- the phenomenon that occurs when children who are disenrolled from Medicaid or CHIP are re-enrolled within a short period of time. Churning indicates that children are losing coverage even though they meet the eligibility requirements.

Why is Stable Health Coverage a High Priority?

Assuring that children have access to health care services, stable health coverage provides continuous opportunities for physicians and other caregivers to impact the quality of children's health care and facilitates measuring health care outcomes. Children with unstable coverage are similar to children with no coverage at all in the benefits they receive from health care.[19] Additionally, providing stable health coverage to children has both health and fiscal advantages. Comprehensive health care coverage is the gateway through which families can secure necessary preventive, primary, and acute health care services for their children. Research shows that even short periods without coverage can cause individuals to forgo needed care, which can be detrimental, especially for children with chronic conditions and special health care needs.[20] Uninterrupted coverage can reduce avoidable hospitalizations by 25 percent and improve care.[21, 22, 23]

Keeping eligible children enrolled in Medicaid and CHIP also saves States' administrative costs. Policies that lengthen the enrollment period and reduce paperwork requirements lower the costs associated with administering the renewal process. Less effort on the part of eligibility workers is needed to monitor the completion of the renewal process and fewer children need to be re-enrolled who have lost coverage even though they remain eligible. In addition, focusing on retention protects State and Federal investments in outreach.

States Have the Flexibility to Reduce Administrative Barriers to Retention

In accordance with Federal law, States have considerable discretion to establish simplified enrollment and renewal procedures in both Medicaid and CHIP, and many States have done so. Simplification strategies lead to improved duration and stability of coverage. Reducing the number

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[19] G. Fairbrother and J. Schuchter, "Stability and Churning in Medi-Cal and Healthy Families," The California Endowment, March 2008.

[20] L. Ku and D. Cohen Ross, "Staying Covered: The Importance of Retaining Health Insurance for Low-Income Families," Center on Budget and Policy Priorities, December 2002; P. Silberman, et. al., "The North Carolina Health Choice Enrollment Freeze of 2001: Health Risks and financial Hardships, for Working Families, Cecil B. Sheps Center for Health Services Research, University of North Carolina for the Kaiser Commission on Medicaid and the Uninsured, January 2003.

[21] L. Ku, "New Research Shows Simplifying Medicaid Can Reduce Children's Hospitalizations," Center on Budget and Policy Priorities, June 2007.

[22] L. Simpson and G. Fairbrother, "Health Policy Influences Quality of Care in Pediatrics," Pediatric Clinics of North America - August 2009 (Vol. 56, Issue 4, Pages 1009-1021, DOI: 10.1016/j.pcl.2009.05.014).

[23] G. Fairbrother, G. Madhavan, J. Watring , A. Goudie, K. Jones, L. Ranbom, et. al., Policy Brief: Monitoring Enrollment and Retention of Children in Ohio Medicaid Programs; Volume2, Issue 3: The Child Policy Research Center at Cincinnati Children's Hospital Medical Center/University of Cincinnati; 2010.

of times each year a family must renew a child's coverage and streamlining the renewal process increase the likelihood that an eligible child will retain coverage. State premium payment policies also may promote or adversely affect the duration and stability of health care coverage.

- While families are required to renew their child's coverage at least once every 12 months, there is no requirement to do so more frequently. Moreover, the Balanced Budget Act of 1997 gave States the option to provide children 12 months of continuous eligibility, meaning they can guarantee eligible children a full year of coverage, regardless of changes in family income or other circumstances. Currently, 47 States (including the District of Columbia) allow children to renew their Medicaid or CHIP coverage once a year (although they still must report changes in the interim); 22 of those States guarantee 12 months of continuous eligibility.[24]

- Reducing paperwork requirements at renewal can significantly cut the red tape associated with retaining coverage. While an initial application requires the signature of a parent or caretaker, no signature is required for renewal, making it possible to renew by phone or on-line.[25] States are required to employ an *ex parte* review at the point of Medicaid renewal, meaning to the extent possible, they must use the data they have available to renew a child's coverage without asking for additional information from the family. In both Medicaid and CHIP, States can use electronic data-matching procedures to obtain information from various government databases (other public benefit programs, State wage reporting systems, etc.) to substantiate that a child remains eligible for coverage.

- A growing number of States are utilizing these and other options to promote retention and they report significant improvements. Most notably, over the course of the last decade, Louisiana has implemented a mix of simplification strategies that has reduced the rate of case closures for procedural reasons from 22 percent in 2001 to less than 1 percent in 2010.[26] The State was able to take these steps without jeopardizing program integrity, as shown by its low error rate -- 1.54 percent.[27] Many States are using the Louisiana experience as a model for establishing more streamlined renewal procedures.

- Premium payment policies may impose both administrative and financial barriers to renewing health coverage. Children may lose health coverage if parents are unable to afford a premium payment even though they remain eligible for coverage, a situation families are more likely to

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[24] D. Cohen Ross, et al., "A Foundation for Health Reform: Findings from a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP for Children and Parents During 2009, Kaiser Commission on Medicaid and the Uninsured, December 2009.

[25] "Continuing the Progress: Enrolling and Retaining Low-Income Children and Families in Health Care Coverage," Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, August 2001.

[26] V. C. Grant, "Transforming State Government Services through Process Improvement: A Case Study of Louisiana," IBM Center for the Business of Government, March 2010.

[27] News Release, "Louisiana Medicaid Recognized as a National Best Practice for Administrative Efficiency," LA Department of Health and Hospitals, November 20, 2009.

face during tough economic times. A drop in family income may warrant a reduction or elimination of a CHIP premium obligation, but families may not realize this and may not attempt to renew a child's coverage if they cannot afford the premium payment. Even when income does not fluctuate, families sometimes have trouble making premium payments on time. In 12 States, missing a payment may cause a child to be barred from coverage for a period of time (known as a "lock-out" period) that can range from 30 days to six months.[28] Premium payment policies that give a variety of options for they ways families can pay their premiums and provide them information up-front about circumstances under which they can get premiums reduced or waived are factors in promoting uninterrupted coverage.

How Does CHIPRA Help to Support Improved Retention?

CHIPRA provides States tools and incentives to reach out and enroll eligible children in Medicaid and CHIP. These provisions can also be used to improve the renewal process. The CHIPRA Express Lane Eligibility provision provides a new way for States to streamline the renewal process. Under this option, States can use findings from another program [e.g., Supplemental Nutrition Assistance Program; the National School Lunch Program; Women, Infant and Children's program (WIC); etc], regardless of methodology, to facilitate the eligibility determination in Medicaid and CHIP. Six States have approved State Plan Amendments to implement Express Lane Eligibility during initial enrollment and renewal.

Two key CHIPRA provisions provide incentives for States to implement retention strategies:

- <u>Performance Bonuses</u>: One focus of the CHIPRA legislation is to encourage States to boost enrollment for the lowest income children. Under the law, States can earn a performance bonus by increasing the enrollment of children in Medicaid according to specified targets. In order to qualify for a bonus payment, States must show that they have adopted at least five of eight program features known to simplify the enrollment and renewal process. Of the eight program features, several pertain to the renewal and enrollment processes, such as no face-to-face interview, use of same enrollment and renewal forms in Medicaid and CHIP, and Express Lane Eligibility. Two program features are related exclusively to the renewal process: 12-month continuous eligibility and administrative/automatic renewal.

  In 2009, the first year these bonuses were available, 10 States received $75 million in performance bonus payments. All of these States are implementing program features related to streamlining the renewal process. HHS is still processing the 2010 performance bonus requests, but many of the States that have applied have implemented at least one program feature that will simplify the renewal process.

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[28] D. Cohen Ross, et al., "A Foundation for Health Reform: Findings from a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP for Children and Parents During 2009, Kaiser Commission on Medicaid and the Uninsured, December 2009.

- <u>Outreach and Enrollment Grants:</u> CHIPRA provides $90 million in funding for outreach grants to States, nonprofit organizations, and providers that can be used to facilitate enrollment and renewal for children. The first round of $40 million was awarded in September 2009 to 68 grantees across the country. Another approximately $10 million was awarded to 41 American Indian/Alaska Native grantees. Many of these grantees are focusing their attention on improving the retention of coverage. A solicitation for the second round of $40 million is being prepared and will specifically encourage States and other stakeholders to work on improving retention.

- <u>National Enrollment Campaign</u>: CHIPRA also provides $10 million for a National Enrollment Campaign. Outreach materials, training, and technical assistance focus on strategies that can help improve retention of health coverage.

HHS' Efforts to Better Understand Retention Issues through Data Collection

Data can help HHS, States, and others better understand why health care coverage fluctuates in the first place and to evaluate how interventions may or may not promote the continuity of coverage. To ensure that reliable data is reported on a routine basis, CHIPRA requires States to include specific data in the CHIP annual reports, including:

- Eligibility criteria;
- Enrollment and retention data (including data with respect to continuity of coverage or duration of benefits);
- Data regarding the extent to which the State uses process measures to determine the eligibility of children under the State child health plan, including measures such as 12- month continuous eligibility, self-declaration of income for applications or renewals, or presumptive eligibility; and
- Data regarding denials of eligibility and redeterminations of eligibility.

To meet these requirements, CMS reviewed the template used by States to submit their annual reports, the CHIP Annual Reporting Template System (CARTS). CARTS already includes most of the data CHIPRA requires on eligibility criteria, enrollment data, and the actions States have taken to simplify enrolment and retention (i.e., use of 12-month continuous eligibility, self-declaration of income, presumptive eligibility, etc.). CMS modified CARTS so that States could submit additional data about the reasons why children were denied eligibility at application and redetermination along with information about retention and duration of coverage. States are required by CHIPRA to report on these new data requirements starting in 2013. The improved availability of data measuring retention and understanding the reasons for eligibility denial at the time of application and redetermination will provide HHS, States and the public with essential information on the extent, and reasons why, eligible children are denied or lose coverage.

The ability to provide children with quality health care and the importance of continuous health care coverage becomes even more critical when implementing a national quality measurement strategy.

Most measures, which assess care over the course of a 12-month period, exclude those enrollees without continuous coverage. Unless children can have continuous health coverage, there is little opportunity to measure the quality of care received by children who churn on and off Medicaid within that 12-month period. Through HHS and State efforts to promote continuous enrollment, the ability to measure (and subsequently improve) the quality of health care for a larger number of children enrolled in Medicaid and CHIP also grows.

II. STATUS OF VOLUNTARY REPORTING BY STATES UNDER TITLES XIX AND XXI, UTILIZING THE INITIAL CORE QUALITY MEASUREMENT SET

Part of creating an effective and efficient health system for children is the ability to measure access to services; the quality of the services provided; and perhaps most importantly, the individual's experiences with those services. States can use quality measures to help understand: (1) what kind of care (if any) is being provided; and (2) what can be done to improve the quality of that care. Section 401 of CHIPRA, which adds section 1139A of the Act, outlines the key components of a foundation for building a comprehensive, high quality system of care for children and includes: establishing of an initial core set of child quality performance measures for voluntary use by State programs; developing of a standardized reporting format for the voluntary core performance measures; requiring[29] CHIP programs to annually report on quality of care and consumer satisfaction measures included in the CAHPS® Medicaid survey; and providing technical assistance to States as they implement quality measures.

This section of the report provides an overview on the status of voluntary reporting by States on the initial core set of children's quality measures as well as describes HHS efforts to support States in reporting and using the measures to drive quality improvement for children in Medicaid and CHIP.

Voluntary Reporting of CHIPRA Core Measures: Year One Expectations

Most States already collect a variety of quality measures, and have done so for years. Differences in States' resources, data collection systems and capabilities, types of measures used, and quality improvement priorities, however, limit comprehensive national comparisons of children's health care quality across a set of standardized, evidence-based measures.

Since the release of the CHIPRA initial core set of voluntary measures in 2009, States have been encouraged to collect measures from the initial core set. At this time, it is difficult to assess the status of reporting on the CHIPRA core set because this is the first year when States will be able to

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[29] As revised by Public Law 111-3, section 2108(e) of the Act, only Title XXI programs are required to report results from AHRQ's Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Child Medicaid Survey. The Secretary designated the CAHPS® survey as one of the 24 CHIPRA core measures.

submit data on the quality measures to CMS. States who choose to submit Fiscal year 2010 data measures will do so through CARTS by December 31, 2010.

It is expected that the 22 CHIP Programs that already report data to CARTS will continue to do so on the three quality performance measures that are also CHIPRA core measures (well-child visits up to 15 months of life; well-child visits for the 3rd, 4th, 5th, and 6th year of life; and access to primary care providers). As noted in the Secretary's Annual Report on the *Quality of Care for Children in Medicaid and CHIP,* CMS has been working with CHIP programs to improve the collection and reporting of data on these quality performance measures.

CMS expects States to vary in the amount of time needed to implement collection and reporting efforts related to the core measures. However, at least 10 of the 18 States participating across the CHIPRA Quality Demonstrations have initial plans to implement quality measure data collection and reporting processes related to the core measures set. The number of States collecting and reporting the core measures will increase over the next several years as States become more comfortable with the measures and CMS' reporting mechanisms.

Development of a Standardized Reporting Format for the Voluntary Core Measures

CMS recognizes that State Medicaid and CHIP programs are enhancing information systems to address opportunities and requirements under CHIPRA, HITECH enacted as part of the American Reinvestment and Recovery Act of 2009, and the Affordable Care Act. CMS is also conducting similar enhancements to meet the data exchange needs of evolving State systems. While those system transitions are in development, CMS has designated the CARTS data submission tool currently used by Title XXI Programs, as the vehicle all States choosing to report the initial core measures (or a subset thereof) should use. Since most CHIP programs are experienced users of CARTS, CMS will provide them with updated instructions for annual reporting. State Medicaid programs will receive access to the CARTS system through a designated entry screen for voluntary reporting on the CHIPRA initial core set of quality measures. As required by CHIPRA, CMS will release guidance, reporting procedures, and technical specifications for the initial core set of measures by February 4, 2011.

CHIP Program Reporting on the Quality of Care and Patient/Family Experience

Measuring patients' experience with care is critical to evaluating the degree to which State Medicaid programs achieve CHIPRA goals. Surveys developed by the CAHPS® program (Consumer Assessment of Healthcare Providers and Systems, funded by AHRQ) were designed to measure patient experiences. Since 1995, CAHPS® has developed and rigorously tested surveys that measure patient experience in a wide variety of care delivery settings and facilities, such as health plans, hospitals, nursing homes, doctors' offices, and many others. The recently updated CAHPS® Child Medicaid Survey Version 4.0, which includes questions concerning care for children with chronic conditions, will be used to implement CHIPRA section 402(a)(2), which adds reporting requirements in section 2108 of the Act and requires Title XXI programs to report results from the CAHPS® tool.

As one of the 24 voluntary CHIPRA initial core set measures, Title XIX programs can also choose to collect and report the CAHPS® survey. CAHPS® surveys include questions which ask the respondent about his/her experience with care received, including dimensions such as: provider communication (e.g., how well she/he explained diagnoses, treatment options and other issues); whether the patient is treated with courtesy and respect; and access to care in every-day or urgent situations. In future reports, HHS will be able to include specific data on patient/family satisfaction with health care for children enrolled in CHIP programs.

Technical Assistance to States Reporting Voluntary Core Measures

To encourage and support additional States to report on the CHIPRA initial core measures, CMS will provide States with technical assistance, including webinars, learning networks, sharing of promising practices and lessons learned on the core measures. On December 9, 2010, CMS held a webinar to teach States how to use the CARTS tool to submit the voluntary core measures. The overarching goals for providing technical assistance and analytic support are to increase the number of States consistently collecting and uniformly reporting the voluntary initial core measures set and to help States understand how to use these data to improve the quality of care for children.

In public comments received in response to the December 2009 Federal Register Notice, States' concerns about the initial core measures ranged from the burden of new quality reporting, current data collection and reporting systems constraints, challenges for partial-risk programs to report measures, to the need for technical assistance. CMS will focus initial outreach and technical assistance efforts on 11 of the 24 measures. Those eleven measures are listed in the table on the following page.

Table 1. Children's Quality Measures Targeted for Technical Assistance in Year One

Measure	**Measure Steward**[30]	**Used in other CMS Measurement Activities**
Prevention and Health Promotion		
Childhood Immunization Status	NCQA[31]/HEDIS[32]	Meaningful Use
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents	NCQA/HEDIS	Meaningful Use
Chlamydia Screening	NCQA/HEDIS	Meaningful Use
Well-Child Visits in the First 15 Months of Life	NCQA/HEDIS	Current CHIP reporting element
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	NCQA/HEDIS	Current CHIP reporting element
Total Eligibles who Received Preventive Dental Services	CMS	CMS Form 416
Management of Acute Conditions		
Appropriate Testing for Children with Pharyngitis	NCQA/HEDIS	Meaningful Use
Total Eligibles who Received Dental Treatment Services	CMS	CMS Form 416
Management of Chronic Conditions		
Annual Number of Asthma Patients Ages 2 Through 20 Years Old with 1 or More Asthma-Related Emergency Room Visits	Alabama Medicaid	
Annual Pediatric Hemoglobin A1C Testing	NCQA	
Availability of Care		
Children and Adolescent Access to Primary Care Practitioners	NCQA/HEDIS	Current CHIP reporting element

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[30] A measurement steward is responsible for updating or retiring measures as the technical specifications are changed, new clinical evidence emerges, or the measure's performance changes.
[31] National Committee for Quality Assurance (NCQA)
[32] Healthcare Effectiveness Data and Information Set (HEDIS)

Recognizing the importance and benefits of coordinating existing and evolving State reporting efforts, including the alignment of quality measure collection opportunities under CHIPRA and the EHR Incentive Program, nine of the 11 measures selected for the initial phase of technical assistance align with current CMS measurement activities. Four of the initial core set of child health measures are identified as meeting the meaningful use criteria for quality measures under the EHR Incentive Program. Likewise, three other core set measures are three of the four previously reported quality measures by Title XXI programs (CHIP, CHIP Expansions, and Combination CHIP and Medicaid). CMS believes this list balances the benefits of quality measurement data collection and reporting with efforts to minimize the reporting burden on States who want to participate in multiple measurement-related initiatives.

III. FEEDBACK FROM PUBLIC COMMENTS AND STAKEHOLDER INTERVIEWS

In an effort to improve transparency, engage its public partners, and leverage the knowledge of health care policy experts, HHS obtained public input to assist in identifying opportunities to improve the quality of care provided to children in Medicaid and CHIP. This section of the report presents findings from more than 57 unique public commenters to a Federal Notice and from in-depth interviews with 20 health care quality experts regarding opportunities to improve the quality of health care for children. The Notice was published on July 30, 2010, and the comment period closed on August 15, 2010. The stakeholder interviews were held between August 23, 2010 and September 15, 2010. A complete description of the methodology used to conduct this research is found in Appendix B. The findings from both the public comments and the stakeholder interviews offer an invaluable "on the ground" perspective that HHS will use to better understand how it can improve the manner in which the CHIPRA quality provisions are interpreted, implemented, and ultimately used to by its State partners to improve the care provided to children in Medicaid and CHIP.

Feedback received from the public and stakeholders was summarized and organized into five broad topics:

1. access to quality health care;
2. quality measurement and monitoring;
3. health care coverage and duration of that coverage;
4. financing and payment strategies; and
5. research

The list of individuals and groups, along with their comments, will be posted on the CMS website www.cms.gov under the Medicaid and CHIP Quality Practices webpage.

Access to Quality Health Care

Much of the feedback provided related to improving access to and the quality of health care for children. Many comments related to EPSDT services, including ensuring access to services in all States; requiring States to provide mental health services not just mental health parity and improving physical-behavioral health care coordination. Feedback also included the need to strengthen and expand access to oral health services by providing higher reimbursements to Medicaid/CHIP dental providers (e.g., 90 percent of the Federal financial participate rate); and requiring children to have a dental examination within 30 days of enrolling in Medicaid and CHIP. Recommendations also focused on improving the overall quality of health care by reducing the variability of the services provided between State Medicaid and CHIP programs, particularly for children living in rural or impoverished communities, and those with special health care needs. Other suggestions focused on improving access to care for children with special health care needs by providing States who provide disease and chronic care management with a Federal match as well as prioritizing at-risk children for access to early intervention services and developmental therapies. Comments about improving prenatal and newborn health care ranged from providing preventive and restorative oral health care to mothers of infants and newborns as pregnancy-related services; encouraging breastfeeding and awareness of lactation services in Medicaid and CHIP through training, and education; and providing optional coverage for nurse home visitation services for high-risk perinatal care to assure appropriate quality of care for newborns. Commenters also noted the need to strengthen collaboration and align initiatives, where possible, with WIC and other public health programs that provide nutritional and social supports to infants and children.

Quality Measurement and Monitoring

The public comments and stakeholder interviews indicate strong support for child health quality measurement, and generally characterize the quality measurement components in CHIPRA as a tremendous opportunity to standardize quality. At the same time, however, comments addressed a range of issues including ways to improve measurement and reporting of children’s quality measures such as measurement gaps, and issues related to the process of collecting and reporting CHIPRA quality data.

While there was no clear consensus, some commenters wanted to require States to collect, report, and monitor the CHIPRA core measures rather than allow for voluntary reporting. In an effort to support States, one commenter suggested that HHS provide financial incentives to offset States’ costs associated with collecting and reporting on these measures. Providing States with these types of incentives, the commenter suggested, could potentially increase the number of States reporting and subsequently increase HHS’ ability to better assess the quality of care provided to children.

Some commenters disagreed about the extent to which new measures are necessary and the burden these new measures could bring to States, health plans, and providers. For example, several commenters expressed concern about the large number of core measures, with some suggesting that HHS ask States to implement a smaller subset of measures and then phase in more measures.

Another commenter noted that in order to minimize burden of collecting the core measures, HHS consider including measures that reflect the type of data States are already collecting. An additional suggestion to minimize the burden associated with collecting the core measures was to pay for States' measures to be audited. There was also a wide mix of comments about the need for HHS to expand measurement domains such as safety, effectiveness, continuity, and patient centeredness. Among the measurement gaps identified were complex measures such as language, cultural competencies, and diversity in family participation, and measures that address care coordination, transition to adult care, children with special health care needs, vision screenings, developmental delays, oral health, mental health screenings and services, and continuity of coverage. One commenter suggested that HHS offset States' costs associated with reporting on eligibility, enrollment, and retention data (including data with respect to continuity of coverage or duration of benefits). Other commenters noted that HHS should actively monitor States' accuracy in both the application approval/denial process and the renewal/re-determination processes.

A few commenters also suggested that technology improvement efforts were needed to facilitate information sharing within the health care system and across providers. Commenters recommended the development of HIT monitoring systems and disease registries to improve care coordination for children with special health care needs and to support communication across the health care system.

It is important to note that many of the recommendations made through public comments and stakeholder interviews echo some of the same issues (e.g., measurement gap areas, opportunities for refining the core measures, etc.) identified by the Subcommittee to AHRQ's National Advisory Council on Children's Healthcare Quality Measures for Medicaid and CHIP. The Subcommittee, which was convened by AHRQ in partnership with CMS, consisted of representatives of key stakeholder groups and experts in children's health care and quality measurement, recommended to HHS the CHIPRA initial core set of children's measures.

Health Care Coverage and Duration

CHIPRA provides financial support, guidance, and incentives for States to enhance eligibility and to streamline enrollment and renewal processes. The public feedback suggested strategies to ensure eligible children are enrolled, have continuous coverage, and receive high quality of care. Some comments noted that certain CHIPRA components, such as the bonus program and strategies for improving enrollment and retention, are helpful, but could be expanded and strengthened.

Streamlining and simplifying the enrollment and renewal processes were among the stakeholder and the public's chief concerns. One suggestion was to create a single application that families could use across Medicaid and CHIP programs. To reduce gaps in coverage and limit churning, several groups and individuals suggested automatic processes to help ensure the stability of coverage. A specific comment was to automatically enroll all children in Medicaid and CHIP until it has been determined that a child has minimal essential coverage from an alternate source. Another suggestion was to establish a 12-month enrollment period for all States, separate from the bonus payment program, to emphasize continuity of care for children. Emphasizing the importance of having all family members enrolled under the same plan, it was recommended that HHS create State-level premium-assistance programs to facilitate continuous coverage in private plans so that family members did not have to receive care from different plans. Other suggestions focused specifically on coverage and duration for special populations, including omitting the five-year delay for coverage of all legal immigrant children and pregnant women, and suspending, rather than terminating coverage for children who enter the juvenile corrections system.

Financing and Payment Strategies

Public feedback regarding payment and financing strategies focused on a wide range of financing and payment issues, including incentives, and using additional funding sources. Many commenters expressed that CHIP is a national investment in children's health and that it is in the Nation's interest to assure that every child is born healthy and raised in a healthy environment. Consequently, commenters noted concern about what will happen in September 2013[33] (when CHIP will need to be reauthorized again) and recommended that program funding continue beyond the current five-year timeline.

Several commenters stated the need to move from a volume-based payment system to a quality-based payment system with higher payments for improved outcomes and a program of reimbursements tied to performance. In light of an increasing number of new enrollees, suggestions focused on strengthening the provider workforce by increasing reimbursement rates to assure adequate payment to primary-care and dental providers, exploring the use of incentives to States for the use of non-physician personnel, and assuring the actuarial soundness of the Medicaid and CHIP programs.

The vast majority of comments related to financing provided recommendations for either incentive payments or reimbursement for sustaining or increasing services for children in Medicaid and CHIP. Comments suggested that HHS provide incentives or enhanced payments for preventive care, screenings, treatment of certain chronic illnesses, reporting CHIPRA quality measures, and the use of HIT. There were also recommendations to HHS to improve care coordination, with some suggesting the use of incentives to better coordinate care, and one commenter recommending that the current restriction on payment for more than one service on a given day be eliminated, when appropriate. Incentives were also suggested as a way to encourage consistent provider reporting of EPSDT requirements. A number of comments discussed financial support for implementing the medical home model, while others noted that consideration should be given to funding provider-level incentives to support patients and family-centered care. Recommendations regarding providing reimbursements to improve the quality of care for children focused mainly on behavioral health and included reimbursing providers to screen for and treat prenatal problems that interfere with a child's mental health and/or developmental functioning; families that want to attend family-based residential programs for the treatment of substance use but cannot due to financial constraints; families that use mental health services or therapeutic interventions; and primary care providers for conducting oral

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[33] Although CHIPRA reauthorization is through 2013, the Affordable Care Act extends authorization and funding of the Program through 2015.

health preventive services such as oral health risk assessments and applying fluoride varnish. A related recommendation was that HHS consider therapeutic foster care as a new medical assistance category and fund it appropriately.

Research

HHS is conducting research and using demonstration grants to test various approaches to quality improvement for children in Medicaid and CHIP. Public comments and stakeholder interviews addressed the need for additional research. To identify "best financial practices," a commenter suggested funding CHIP-focused pilot demonstration models to examine different reimbursement methodologies and evaluate the results, similar to the Medicaid payment infrastructure studies previously completed. Several commenters suggested research to improve the health care quality for children with special health care needs, such as demonstration programs for the treatment of Autism, research that identifies the barriers and obstacles that restrict access to home-based and community programs, and studies that examine "best practices" for the financing and delivery of therapeutic foster care.

Additionally, as CHIPRA encourages the implementation of meaningful use of health information technology for the care of children in Medicaid and CHIP, comments suggested that HHS consider pursuing research in several areas of Medicaid and CHIP payment strategies that would fulfill Stage One Meaningful Use Objectives of the Medicaid EHR Payment Program. This part of the program is focused on: reducing health disparities; engaging patients and families in their health care; improving care coordination; ensuring adequate privacy and security protections for personal health information; and improving population and public health.

IV. RECOMMENDATIONS

The public comments and stakeholder interviews provided valuable input about the potential of Medicaid and CHIP programs to further improve the quality of care of enrollees, and will be used to inform the process for implementing CHIPRA at both the HHS and State level. Feedback demonstrated that while there is strong support for many of the existing efforts to improve the quality of health care for children in Medicaid and CHIP, there remain significant, tangible opportunities to strengthen the implementation of certain aspects of these programs. It is also important to note that several of the recommendations identified through stakeholder interviews and public comments are either being implemented (e.g., streamlining and simplifying the enrollment process) or are part of planned demonstration grant efforts to aid in their consideration for broader use (e.g., financial incentives targeting enrollees at-risk for chronic disease). Given the recent new authorities given to CMS by CHIPRA, ARRA, and the Affordable Care Act, HHS does not have recommendations for legislative changes at this time, but will work on the implementation of these new statutes to identify opportunities to strengthen the quality of care provided to children to help achieve the goals that commenters identified.

HHS is committed to continuing to improve the quality of care provided to children in Medicaid and CHIP through the current initiatives as outlined in this report. It also plans to strengthen access and quality of care in areas in which efforts are nascent, including integrating health care across settings, eliminating disparities in care on the basis of race, ethnicity, primary language, education, geographic, and health conditions. HHS efforts in these areas will be described in greater detail in future reports.

V. CONCLUSION

The quality of health care a child receives and the ability to provide that child with stable health care coverage are closely interlinked. Measuring the quality of care that a child enrolled in Medicaid and CHIP receives becomes nearly impossible when he/she goes in and out of the health care system. Through HHS' dual emphasis on improving the quality of care for children and health care coverage, it is making notable strides towards creating a health care system that supports continuous health care coverage for children while simultaneously creating opportunities to better measure, analyze, and ultimately improve the quality of the care provided to that child.

Through the authorities provided by CHIPRA, the American Recovery and Reinvestment Act, and the Affordable Care Act, HHS, in partnership with States, is furthering the development of a comprehensive health care system focused on measuring, monitoring and improving the quality of care for children. The CHIPRA quality strategy signals the beginning of national effort to better understand the quality of care provided to children in Medicaid and CHIP through the implementation of an initial core set of children's quality measures, development an infrastructure to support the voluntary reporting of the core quality measures by States, and awarding of 10 Demonstration Grants. In the months ahead, HHS will have access to quality data from the core measures and will begin development of new quality measures through the Pediatric Quality Measures Program (PQMP) and the CHIPRA Centers of Excellence. Additionally, HHS already has in place, and is continuing to implement, a variety of broader quality-related efforts focused on improving children's health care across a variety of dimensions including infant/child development, obesity, and oral health.

The public comments and stakeholder feedback reflected in this report offer an invaluable "on the ground" perspective that the Secretary will use to improve the efforts HHS makes in partnership with States to measure and improve the quality of care provided to children in Medicaid and CHIP, including the implementation of the quality measures program. Future reports will address HHS efforts to improve children's health care quality in the areas of chronic care management, physical/behavioral integration; and reducing disparities in care.

The efforts outlined in this report seek to improve the quality of children's health care through the simultaneous pursuit of three goals: improving the experience of care for children and families by measuring their satisfaction with the care provided; improving overall health for children through targeted quality improvement strategies across multiple dimensions of children's health care; and reducing per capita costs of health care are reflected by reducing gaps in health care coverage and creating opportunities for continuous access to care. Through various efforts to promote continuous enrollment, the ability to measure (and subsequently improve) the quality of health care for children enrolled in Medicaid and CHIP also grows.

REPORT TO CONGRESS

HHS SECRETARY’S EFFORTS TO IMPROVE CHILDREN’S HEALTH CARE QUALITY IN MEDICAID AND CHIP

APPENDICES

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APPENDIX A
BIBLIOGRAPHY

Key words used in web search:
CHIPRA, children's health care quality initiatives, children's health care, and CHIPRA health quality initiatives.

Websites Searched in addition those listed in the environmental scan:

Agency for Healthcare Research and Quality — http://www.ahrq.gov/
Centers for Disease Control and Prevention — http://www.cdc.gov/
Centers for Medicare & Medicaid Services — http://www.cms.gov/
The Commonwealth Fund — http://www.commonwealthfund.org/
The George Washington University School of Public Health and Health Services, Department of Health Policy — http://www.gwumc.edu/sphhs/departments/healthpolicy/index.html
Georgetown University Center for Children and Families — http://ccf.georgetown.edu/
Georgetown University Health Policy Institute — http://ihcrp.georgetown.edu/
Health Resources and Services Administration— http://www.hrsa.gov/
The Henry J. Kaiser Family Foundation — http://www.kff.org/
Institute of Medicine — http://www.iom.edu/
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National Academy for State Health Policy — http://www.nashp.org/
National Committee for Quality Assurance — http://www.ncqa.org/
National Quality Forum — http://www.qualityforum.org/
Piper Report — http://www.piperreport.com
Substance Abuse and Mental Health Services Administration— http://www.samhsa.gov/
United States Department of Health and Human Services— http://www.hhs.gov/
Urban Institute — http://www.urban.org/

Additional Documents

Letter from National Academy for State Health Policy to the Agency for Healthcare Research and Quality, dated March 1, 2010. RE: the CHIPRA quality measures and the CHIP Director Workgroup; Public Comment, CHIPRA Core Measures, CMS-2474-NC.

APPENDIX B
METHODOLOGY

CMS contracted with Provider Resources, Incorporated (PRI) to conduct research, stakeholder intervews, and other activities related to the preparation of this report. Four different foci of inquiry were used to derive the information in this report:

1) An environmental scan of State and Federal efforts to address duration and stability of health insurance coverage;
2) An environmental scan of a sampling of Federal initiatives and reports that address quality of care in Medicaid and CHIP; preventive services, acute and chronic conditions, and health services to ameliorate effects of physical and mental conditions for children (infants, young children, school-age children, and adolescents); and cross domains of quality (effectiveness, efficiency, equity, patient-centeredness, safety, and timeliness);
3) An in-depth review of public comments received from CMS' Federal Register publication dated July 30, 2010; and
4) Primary interviews with key stakeholder organizations representing the critical Key Focus Areas (KFAs):
    a) Clinical Quality Improvement,
    b) Medicaid/CHIP Policy and Operations, and
    c) Health Quality Analytics.

The following paragraphs describe in further detail each of these focuses of inquiry.

Environmental Scan of Duration and Stability

The purpose of this environmental scan was to identify Federal and State efforts to improve quality of care by addressing duration and stability of health insurance in Medicaid and CHIP. An online literature review was conducted between August 4 and August 12, 2010, using the PubMed database, along with the websites of CMS, Kaiser Family Foundation, Commonwealth Fund, Robert Wood Johnson Foundation (RWJF), and the Urban Institute.[1] The scan used only papers and official reports published since 2000 and identified through the following search keywords: "duration," "stability," "Medicaid," "retention," "churn," and "disenrollment" paired with "Medicaid," "child health," or "CHIP." CMS received a report of the scan results.

Federal Quality Initiative Scans

The purpose of this environmental scan was to identify documents and review websites to answer the following primary research question: "What activities has the Secretary implemented to improve quality of care for children enrolled in Medicaid and CHIP?" All of the identified Federal initiatives and projects in this environmental scan were charged with improving children's health care quality or measuring children's health care quality. The quality initiative scan was conducted between August

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[1] PubMed Database: accessed from: http://www.ncbi.nlm.nih.gov/pubmed.

4 and August 17, 2010, using the HHS website and related links.[2] CMS received a report of the scan results.

Review of Public Comments

This inquiry involved all public comments received on CMS' notice published in the Federal Register on July 30, 2010. These comments were retrieved from the Federal Docket Management System (FDMS) and organized using specialized software. Through consultations with CMS, an outline of initial comment categories was developed to correspond with the sections of the notice. Each comment was parsed and assigned to an unlimited number of categories using a drag and drop feature in the software. The comments were then reviewed to eliminate duplicates from the same commenter, move erroneously categorized comments to the correct category, and reorganize categories and subcategories as needed. A final report was produced that summarized all of the comments received.

Stakeholder Interviews

Stakeholder interviews were conducted to solicit salient input from diverse stakeholder groups about quality improvement-based projects, feedback, and recommendations for programmatic or legislative changes to improve the quality of care provided under Medicaid/CHIP coverage and improve health outcomes of children covered by Medicaid/CHIP. The pool of stakeholders included representatives of all three Key Focus Areas (KFAs). Project leads specific to each KFA drafted interview guides for use with their respective KFA. The team reviewed, edited, and submitted the interview guide to CMS for approval prior to sending them to stakeholder representatives. The interview topics were generalized and made brief to allow for the natural progression of a conversation without limiting stakeholders to a prescriptive agenda.

All interviews were conducted between August 30 and September 8, 2010, by telephone and recorded using WebEx.™ Individual stakeholder comments and recommendations were reviewed and categorized based on topical area and policy objectives. For analysis and development of the narrative summary, all stakeholder comments and recommendations were categorized by key topical areas and sorted so that all comments and recommendations addressing like categories and policy areas were collected together for individual project team analysis.

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[2] U.S. Department of Health and Human Services website: http://www.hhs.gov.

APPENDIX C
SUMMARY OF CHIPRA QUALITY DEMONSTRATION GRANTS

CHIPRA Quality Demonstration Grants[3]

Section 401(d) of CHIPRA awards grants to no more than 10 States "to evaluate promising ideas for improving the quality of children's health care" under Medicaid or CHIP, including projects to:

1) Experiment with, and evaluate the use of new measures for quality of Medicaid/CHIP children's health care;
2) Promote the use of Health Information Technology (HIT) for the delivery of care for children covered by Medicaid/CHIP;
3) Evaluate provider-based models which improve the delivery of Medicaid/CHIP children's health care services; or
4) Demonstrate the impact of the model Electronic Health Record (EHR) format for children (developed and disseminated under section 401(f) on improving pediatric health, and pediatric health care quality, as well as reducing health care costs.

On February 22, 2010, CMS awarded $20 million in first-year CHIPRA Quality Demonstration Grants to 10 States: Colorado, Florida, Maine, Maryland, Massachusetts, North Carolina, Oregon, Pennsylvania, South Carolina, and Utah. These projects will be conducted over a five-year period, with cumulative grant awards totaling $100 million. Including both single-State projects and multi-State collaborations, 18 States will participate in these projects. Grantees are addressing all four areas of focus specified in the legislation, as well as other related topics.

Colorado

Colorado, in partnership with New Mexico, will form an Interstate Alliance of School-Based Health Centers (SBHCs) to integrate school-based health care into a medical home approach to improve the care of underserved school-aged children and adolescents. The States plan to utilize the SBHCs to improve the delivery of care within the school setting and to improve screening, preventive services, and management of chronic conditions. In additions, the goal will be to educate adolescents to encourage more involvement in their own health care and follow-up by school-based health centers with primary care physicians. This demonstration project will also focus on the integration of mental health with primary care for chronic care populations.

Florida

Florida, in partnership with Illinois, will test the collection and reporting of CHIPRA-recommended core measures as well as other supplemental measures determined by the States. These two States will work to ensure the on-going Statewide health information exchange and health information

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[3] InsureKidsNow.gov, CHIPRA Quality Demonstration Grants-Summary, February 22, 2010. Accessed from: http://insurekidsnow.gov/professionals/CHIPRA/grants_summary.html.

technology efforts to support the achievement of the States' and Federal child health quality objectives and to enhance the development of provider-based systems of care that incorporate practice redesign and strong referral and coordination networks, particularly for children with special health care needs. The two States will also develop collaborative quality improvement projects to improve birth outcomes.

Maine

Maine will test, develop, and expand the use of evidence-based children performance measures (i.e. the initial core set of child health measures). In partnership with Vermont, they will expand their information technology systems to improve the exchange of child health data and expedite the provision of service to children in foster care. The two States will also adapt and strengthen a pediatric medical home model and test the impact of these changes on payment reform, implementation of consensus practice guidelines, and provider education on child health outcomes. Vermont will build upon its leadership role as convener to increase the number of States participating in the National Improvement Partnership Network (NIPN) (an organization of States that utilizes information sharing and mentorship to promote the development, dissemination, and evaluation of child health care quality improvement initiatives).

Maryland

Maryland, in partnership with Georgia and Wyoming, will focus on improving the health and social outcomes for children with serious behavioral health needs. They will implement and expand a Care Management Entity (CME) provider model to improve the quality of care and control the cost associated with children with serious behavioral health needs enrolled in Medicaid/ CHIP. The CME model will incorporate wrap-around services, peer supports, and intensive care coordination. The States will utilize the CME model to improve access to appropriate care services and use health information technology to support clinical decision-making. The grantees will also use the CME model as a way to reduce the unnecessary use of services, improve clinical and functional outcomes for youth with serious behavioral needs, and involve children and their families in health care-related decisions.

Massachusetts

Massachusetts will work with the University of Massachusetts Medical School, the Children's Hospital of Boston, Massachusetts Quality Health Partners, and the National Initiative for Children's Healthcare Quality (NICHQ) to apply and evaluate recommended measures of children's health care quality and to make comparative quality performance information available to providers, families, and policymakers. The State will also use learning collaboratives and practice coaches to support the process of transforming pediatric practices into medical homes that provide family and child-oriented care, measure and improve that care, and enhance outcomes particularly for children with Attention Deficit and Hyperactivity Disorder (ADHD), asthma, and childhood obesity.

North Carolina

The North Carolina State agency will work with the State's Academy of Family Physicians, the State Pediatric Society, and Community Health of North Carolina to build upon a public-private partnership that has documented success in quality improvement, efficiency, and cost-effectiveness of care for more than 12 years. They will implement and evaluate the use of recommended quality measures and strengthen the medical home for children with special health care needs by testing and evaluating three provider-led community-based models. These models will be used to identify, treat, and coordinate care for children with special health care needs, particularly children with developmental, behavioral, and/or mental health disorders. North Carolina is also one of the two Grantee States implementing an EHR format for children.

Oregon

Oregon, in partnership with Alaska and West Virginia, will test the patient- centered care delivery models and health information technology to improve the quality of children's health care. Together they will develop and validate quality measures, improve their infrastructures for EHRs utilizing health information exchanges, and implement and evaluate medical home and care coordination models. All three States have a large proportion of their population residing in disproportionately low-income rural areas.

Pennsylvania

Pennsylvania will partner with several medical centers and hospitals in the State to test and report the CHIPRA recommended pediatric quality measures as well as promote the use of health information technology to maximize the early identification of children with developmental delays, behavioral health needs, and special health care needs. The Quality Demonstration is designed to facilitate the coordination of care among the primary care medical home, specialists, and child-serving social service agencies. Use of an assessment/survey instrument prior to the clinic visit to identify potential conditions needing special attention is expected to enhance communication between providers and patients, and an electronic tracking system will link children with special needs to appropriate services. Pennsylvania will also be implementing a model EHR format for children.

South Carolina

South Carolina will build a quality improvement infrastructure to enable pediatric primary care practices to establish medical homes that effectively coordinate physical and mental health services. The State will use health information technology to gather, aggregate, and report on outcome data to support the provision of evidence-based care and allow providers to initiate quality improvement efforts based on peer-to-peer comparisons. The State will automate data collection of, and provide feedback on, the CHIPRA quality measures in 15 pilot practices. These practices will participate in learning collaboratives to disseminate knowledge, develop and adjust action plans, and assess the success of implementation.

Utah

Utah, in partnership with Idaho, will develop a regional quality system guided by the medical home model to enable and assure on-going improvement in the care of children enrolled in Medicaid and CHIP. The project will focus on improving health outcomes for children with special health needs through the use of EHRs, Health Information Exchanges (HIEs), and other HIT tools. The States will pilot a new administrative service using medical home Coordinators embedded in primary and sub-specialty care practices to support on-going improvement in care, coordination of care and support for children with chronic and complex conditions and their families. The States will use learning collaborative, practice coaches, and parent partners to train primary and sub-specialty child health practices in home concepts.

Mathematica Policy Research will evaluate these demonstration projects to determine their effectiveness in improving the quality of health care provided to enrolled children and to assess if, and how the programs increased transparency and consumer choice.

APPENDIX D
INITIAL CORE SET OF CHILDREN'S QUALITY MEASURES FOR VOLUNTARY REPORTING

Prevention and Health Promotion

Measure	Measure Steward[4]	Description
Frequency of Ongoing Prenatal Care	NCQA[5]/HEDIS[6]	Percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that received the following number of visits: < 21 percent of expected visits 21 percent – 40 percent of expected visits 41 percent – 60 percent of expected visits 61 percent – 80 percent of expected visits ≥ 81 percent of expected visits
Prenatal and Postpartum Care: Timeliness of Prenatal Care	NCQA/HEDIS	The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year that received a prenatal care visit in the first trimester or within 42 days of enrollment in the organization.
Percent of live births weighing less than 2,500 grams	Centers for Disease Control and Prevention	The measure assesses the number of resident live births less than 2,500 grams as a percentage of the number of resident live births in the State reporting period.
Cesarean rate for nulliparous singleton vertex	California Maternal Quality Care Collaborative	Percentage of women who had a cesarean section among women with first live singleton births [also known as nulliparous term singleton vertex (NTSV) births] at 37 weeks of gestation or later.
Childhood Immunization Status	NCQA/HEDIS	Percentage of patients who turned 2 years old during the measurement year who had four DTaP/DT, three IPV, one MMR, three H influenza type B, three hepatitis B, one chicken pox vaccine (VZV), four pneumococcal conjugate (PCV), two hepatitis (HepA), two or three rotavirus (RV); and two influenza vaccines by the child's second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.

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[4] A measurement steward is responsible for updating or retiring measures as the technical specifications are changed, new clinical evidence emerges, or the measure's performance changes.

[5] National Committee for Quality Assurance (NCQA)

[6] Healthcare Effectiveness Data and Information Set (HEDIS)

Prevention and Health Promotion

Measure	Measure Steward	Description
Immunizations for Adolescents	NCQA/HEDIS	Percentage of patients who turned 13 years old during the measurement year who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and a cellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their thirteenth birthday; a second dose of MMR and three hepatitis B vaccinations; and one varicella vaccination by their thirteenth birthday. The measure calculates a rate for each vaccine and one combination rate.
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents	NCQA/HEDIS	Percentage of children, 3 through 17 years of age, whose weight is classified based on body mass index percentile for age and gender.
Developmental Screening in the First Three Years of Life	Child and Adolescent Health Measurement Initiative and NCQA	Assesses the extent to which children at various ages from 0-36 months were screened for social and emotional development with a standardized, documented tool or set of tools.
Chlamydia Screening	NCQA/HEDIS	Percentage of women 16 through 20 who were identified as sexually active who had at least one test for Chlamydia during the measurement year.
Well-Child Visits in the First 15 Months of Life	NCQA/HEDIS	Percentage of members who received zero, one, two, three, four, five, and six or more well-child visits with a primary care practitioner during their first 15 months of life.
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	NCQA/HEDIS	Percentage of members ages 3 through 6 years old who received one or more well-child visits with a primary care practitioner during the measurement year.
Adolescent Well-Care Visit	NCQA/HEDIS	Percentage of members ages 12 through 21 years who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.
Total Eligibles who Received Preventive Dental Services	CMS	Total eligible children 1 through 20 years of age who received preventive dental services.

Management of Acute Conditions

Measure	Measure Steward	Description
Appropriate Testing for Children with Pharyngitis	NCQA/HEDIS	Percentage of patients who were diagnosed with Pharyngitis, dispensed an antibiotic, and who received a group A streptococcus test for the episode.
Otitis media with effusion (OME) – avoidance of inappropriate use of systemic antimicrobials in children – ages 2 through 12	American Medical Association/PCPI[7]	Percentage of patients ages 2 months through 12 years with a diagnosis of OME who were not prescribed systemic antimicrobials.
Total Eligibles who Received Dental Treatment Services	CMS	Total eligible children 1 through 20 years of age who received dental treatment services.
Ambulatory Care: Emergency Department Visits	NCQA/HEDIS	The number of visits per member per year as a function of all child and adolescent members enrolled and eligible during the measurement year.
Pediatric central-line associated blood stream infections – Neonatal Intensive Care Unit and Pediatric Intensive Care Unit	Centers for Disease Control and Prevention	Rate of central line-associated blood stream infections (CLABSI) identified during periods selected for surveillance as a function of the number of central line catheter days selected for surveillance in pediatric and neonatal intensive care units.

Management of Chronic Conditions

Measure	Measure Steward	Description
Annual number of asthma patients ages 2 through 20 years old with 1 or more asthma-related emergency room visits	Alabama Medicaid	Asthma emergency department utilization for for patients ages 2 through 20 years old diagnosed with asthma or treatment with at least 2 short-acting beta adrenergic agents during the measurement year who also had one or more asthma-related emergency room visits.

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[7] Physician Consortium for Performance Improvement

Management of Chronic Conditions

Measure	Measure Steward	Description
Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication	NCQA/HEDIS	Percentage of children ages 6 through 12 years of age with newly prescribed ADHD medication who had at least 3 follow-up care visits within a 10-month period, one of which was within 30 days from the time the first ADHD medication was dispensed.
Follow-up After Hospitalization for Mental Illness	NCQA/HEDIS	Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner.
Annual Pediatric Hemoglobin A1C testing	NCQA	Percentage of pediatric patients with diabetes who had a hemoglobin A1c test in a 12-month measurement period.

Family Experiences of Care

Measure	Measure Steward	Description
CAHPS® 4.0 (child version including Medicaid and Children with chronic conditions supplemental items)	NCQA/HEDIS	Survey on an individual's experiences with health care.

Availability

Measure	Measure Steward	Description
Child and Adolescent Access to Primary Care Practitioners	NCQA/HEDIS	Percentage of enrollees 12 months through 19 years of age who had a visit with a primary care practitioner (PCP). Four separate percentages are reported: • Children 12 months through 24 months and 25 months through 6 years who had a visit with a PCP during the measurement year. • Children 7 through 11 years and adolescents 12 through 19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year.