

The Department of Health and Human Services
Children's Health Insurance Program Reauthorization Act
Annual Report on the
Quality of Care for Children in Medicaid and CHIP



Health and Human Services Secretary
Kathleen Sebelius

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“In a decent society, there are certain obligations that are not subject to tradeoffs or negotiation – health care for our children is one of those obligations.”

President Obama, upon signing CHIPRA

“We all have a stake in the health of our nation’s children. Exploring new technologies and initiatives will help ensure our kids get the high quality care they need and deserve.”

Kathleen Sebelius, upon release of ten CHIPRA Quality Demonstrations for \$100 million.

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Executive Summary

Medicaid and the Children's Health Insurance Program (CHIP) provide health coverage for nearly 40 million children who range in age from infants to early adulthood. Together, these programs have increased access to care for millions of children who otherwise may have gone without care. Federal and State efforts to monitor and improve the quality of care available to program enrollees have varied over the years. Much of the past focus has been on expanding coverage and improving the stability of coverage, both of which are key to quality of care. Recently enacted laws offer an unprecedented opportunity to build a strong base of coverage for children, to develop performance measures, and to engage in activities to improve the quality and outcomes of care for children enrolled in Medicaid and CHIP.

This report, required by section 1139A(c)(2) of the Social Security Act (the Act), as amended by 401(c) of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), summarizes State-specific and national information on the quality of health care furnished to children under titles XIX (Medicaid) and XXI (CHIP) of the Act. It also provides information on current State reporting of quality measures. The Centers for Medicare & Medicaid Services (CMS), of the Department of Health and Human Services (HHS), undertook several approaches to assess the quality of care that children enrolled in Medicaid and CHIP receive, including reviewing the external quality review technical reports for States with Medicaid managed care, analyzing data on four child quality measures reported to CMS in 2008, and summarizing findings from a report by the National Committee on Quality Assurance (NCQA) that assessed quality performance measures in 34 State Medicaid programs.

Key findings from this first annual children's health care quality report include:

Measurement and Reporting

- Varied approaches to assessing quality of care exist among States, including the development of State-specific quality metrics, demonstrating a need for standardized collection formats. The lack of uniformity results in great variation in data reliability.
- The infrastructure and processes established for external quality reviews under Medicaid managed care have led to quality improvements in specific health plans but have not yielded State-wide information. Moreover, these reviews do not include information on children in fee-for-service payment arrangements since that is beyond their scope of work.
- Many State officials recognize that current performance measures are inadequate and welcome the opportunity to create more meaningful and useful measures.

Quality and Access to Care

- Of the quality of care effectiveness measures reported by NCQA for children in Medicaid managed care plans in 34 States, 3 of the 7 children-focused measures (use of appropriate medication for asthma, appropriate treatment for upper respiratory infection; and childhood immunizations) had relatively high 2008 performance rates when compared to the rates for other measures in the NCQA report. The other 4 measures (lead screening, Chlamydia screening in 16-20 year olds, follow-up care for children prescribed medication for attention

deficit hyperactivity disorder, and appropriate testing for children with pharyngitis) had relatively low performance rates.

- Considerable evidence indicates that children enrolled in Medicaid/CHIP have much better access to primary care services than uninsured children and comparable access relative to privately insured children; however, access could be improved substantially for specialty care services (e.g., dental, mental health).
- Racial/ethnic minority children and children with special health care needs experience improved access to care once enrolled in Medicaid/CHIP. Despite these gains, disparities in access and quality of care remain.

This first annual Secretary's report, which includes data available to CMS at the time this report was prepared, demonstrates wide variation in the reliability and completeness of State data on the quality of care received by children enrolled in Medicaid/CHIP. In future years, we will have information systems that can better answer questions about the quality of care provided to children in specific States and nationwide. The CHIPRA, coupled with the American Recovery and Reinvestment Act (ARRA), and the Patient Protection and Affordable Care Act (Affordable Care Act) provide 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.

The HHS is actively building the infrastructure needed for assessing the quality of care children receive in Medicaid/CHIP. As a first step in this process, HHS released a core set of child health quality measures that States can use to monitor the care children receive. While reporting by States is voluntary, this represents a major step forward for developing an evidence-informed system for measuring the quality of care for children in Medicaid/CHIP. Under the Health Information Technology for Economic and Clinical Health (HITECH) Act, a part of ARRA, eligible health professionals and hospitals may qualify for Medicare or Medicaid incentive payments when they adopt and demonstrate meaningful use of electronic health records. This initiative holds great promise for both measuring and assuring better care for children as well as adults. Additionally, 10 State and multi-State collaborative quality demonstration grants ranging in size from \$7.8 million to \$11.3 million, were recently awarded. These grants will be used to develop a process to refine and evaluate the core quality measures, and help create a strategy for States to voluntarily collect and report data on the performance measures. HHS is committed to working closely with States, health care providers, and program enrollees to ensure a high quality system of care for children in Medicaid/CHIP, as well as for those with private insurance and other sources of coverage.

I. 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). As the largest payer of health services in the United States, CMS has and will continue to play a pivotal role in working with States in implementing quality measurement and improvement strategies.

Medicaid and CHIP provide health coverage for nearly 40 million children who range in age from infants to early adulthood. Medicaid also now pays for nearly half of all births 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 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/CHIP programs. They also have helped to foster a new culture and expectation for quality measurement and improvement activities in Medicaid/CHIP and more broadly for all Americans.

The objective of this report, which is required by 1139A((c)) of the Act, as amended by section 401(c) of CHIPRA, is to summarize State-specific information on the quality of health care furnished under titles XIX (Medicaid) and XXI (CHIP). The section 1139A(c)(1)(B) of the Act specifically requested information gathered from the external quality reviews of managed care organizations (MCOs)¹ and benchmark plans². The Secretary of HHS is required to make this information publicly available by September 30, 2010, and annually thereafter.

II. Current State and Federal Systems for Quality Measurement and Reporting

The last quarter-century has marked a turning point in the definition, perception, and attitude toward health care quality measurement and improvement activities among private and public purchasers of care. The releases of *To Err is Human: Building a Safer Health Care System* by the Institute of Medicine (IOM, 1999) and *Crossing the Quality Chasm: A New Health Care System for the 21st Century* (IOM, 2001) helped to chart a new course toward improving quality of care in the health system. The IOM defined quality in health care along a number of domains and dimensions, based on underlying principles that health care should be effective, safe, timely, patient-centered, efficient and equitable. Most recently, the IOM released a report by a Future Directions committee with additional suggestions for quality domains and recommendations to establish priority areas in health care quality and disparities.³

Measuring Quality of Care

Various approaches to measuring quality of care, including patient experiences with care have been proposed and used. In general, a quality measure is a mechanism to assign a quantity to quality of care by comparison to a criterion.⁴ There are 3 types of quality measures -- structure, process, and outcome -- that generally are used to assess the IOM quality domains described above. Structural measures examine relatively fixed aspects of health care delivery such as physical plant, existence of a computerized prescription order entry system) and human resources (e.g., nurse-patient staffing ratios; provider availability measures). Process measures assess specific clinical-patient encounters, such as use of appropriate antibiotics, which are expected to improve outcomes. Outcome measures, which comprise quality of life endpoints, as well as morbidity and mortality, are of particularly high interest to clinicians and patients. They also raise distinct technical challenges, as a substantial amount of the variance in some outcome measures may be attributable to patient and environmental factors in addition to the variance that may be readily modifiable by the health system.⁵

The CMS undertook several approaches to assess the status of quality measurement and reporting by States for this first Secretary's report on the Quality of Care for Children, including:

- Reviewing External Quality Review Technical Reports for all States required to report on quality of care for managed care delivery systems in Medicaid programs;
- Reviewing findings on four child quality measures reported to CMS in 2008;
- Conducting a search of the literature for studies and reports on the quality of care children in Medicaid/CHIP programs receive;
- Querying information from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) to assess data on the quality of care children in Medicaid/CHIP receive; and
- Summarizing findings from a National Committee on Quality Assurance (NCQA) report prepared under a CMS contract.

Federal Quality Standards and CMS' Organizational Activities

Federal law requires State Medicaid programs using MCOs or prepaid inpatient health plans (PIHPs) to have a quality strategy that is regularly assessed and includes standards for access to care, health plan structure and operations, and quality measurement and improvement (42 CFR Part §438 Subpart D). States also are required to have an external quality review of each contracted MCO and PIHP, which includes validation of performance measures and performance improvement projects.

Effective July 1, 2009, States contracting with MCOs for delivery of care under separate CHIP programs were required by section 403 CHIPRA (as codified at section 2103(f)(3) of the Act) to institute the same quality-assurance program for CHIP-contracting MCOs as required for Medicaid MCOs under section 1932(c) of the Act. In August and October of 2009, CMS released two State Health Official (SHO) letters to provide guidance on the application of the requirements for CHIP programs (SHO #09-008 and SHO #09-013).

To provide technical assistance to State Medicaid and CHIP programs on quality measurement and improvement, CMS established the Division of Quality, Evaluation and Health Outcomes in April of 2005. A number of initiatives and different types of guidance have been provided to States over the past 5 years on quality measurement and improvement. These include:

- Established a CMS Medicaid and CHIP Quality Web site (http://www.cms.gov/MedicaidCHIPQualPrac/03_evidencebasedcare.asp);
- Produced technical assistance documents (e.g., the Medicaid Technical Assistance Guide on Evaluating Section 1115 Demonstrations, Medicaid Tool Kit for Managed Care External Quality Review, the 2007 Medicaid Quality Measures Compendium);
- Provided technical assistance to States in developing their Medicaid quality strategies for managed care as well as quality improvement projects for home, community-based, and institutional services;
- Prepared a report highlighting model practices in State Medicaid core performance measure reporting;
- Provided feedback to States on their external quality review technical reports and their reporting of four quality measures using the CMS reporting tool, CHIP Annual Reporting Template System (CARTS);
- Conducted an assessment of nine State Medicaid quality programs in 2008 and 2009;
- Hosted a CMS National Town Hall Dental Forum in collaboration with the National Association of State Medicaid Directors and the American Dental Association;
- Hosted several national Medicaid and CHIP Quality webinars and teleconferences; and
- Established a Neonatal Outcomes Improvement Project based on evidence-based clinical intervention strategies.

Medicaid/CHIP face unique challenges in measuring and reporting on quality measures for a number of reasons, including the design of the program as a Federal/State partnership in which the partners share responsibility for funding but the State administers the programs, the varying resources of State Medicaid/CHIP programs to monitor quality, and concerns about the burden of quality measurement on providers.

The CMS Federal-State Data Systems for Quality Reporting

The CMS has several data sources that are used for management of the Medicaid and CHIP programs. Medicaid has two primary databases: the Medicaid Management Information System (MMIS) and Medicaid Statistical Information System (MSIS). MMIS is used by States and territories largely for processing provider claims. The Federal Government pays States an increased matching rate (90 percent for systems development, 75 percent for operations) for claims processing and information retrieval. MSIS is a CMS data source that includes nationwide Medicaid claims and compiles information submitted by States. The Balanced Budget Act of 1997 required States to submit all claims paid after January 1, 1999, in a standard format to MSIS. This database expanded CMS' capabilities for collecting data on enrollee characteristics, benefits, and expenditures. In addition, States provide CMS with quality information using CARTS and Form 416, the reporting tool for the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.

Even with these multiple information sources, current Medicaid and CHIP data are not sufficiently complete, accurate, or timely enough to meet objectives of evaluating program performance or the quality of care enrollees receive. There are many factors contributing to current limitations of CMS data sources including the complexity of the Medicaid program, variations in the data collected by each State, and the use of legacy data systems by many States.⁶

Reporting of quality data by State Medicaid/CHIP programs has evolved with the development of electronic information systems. In 2004, State CHIP programs were required to report annually on four, quality of care measures from the NCQA-developed Healthcare Effectiveness Data and Information Set (HEDIS®). They were encouraged, although not required, to report on the quality measures through the Web-based CARTS.

The CMS is committed to developing a uniform information and reporting system that will include accurate data for information management and monitoring quality improvement. States vary widely in their capability for quality reporting, with some States being highly sophisticated and others fairly basic. Major unresolved issues include choice of measures, appropriate level of reporting (e.g., institution, provider), and risk-adjustment (e.g., how best to compare patients with different health care needs). MSIS and MMIS are now under review by a CMS internal workgroup considering options for a combined system that would include Medicaid and CHIP payment and quality reporting needs. Such a system will facilitate better health outcomes for children and reduce health care costs associated with inefficiencies in the health care delivery system.

Private Sector Efforts Supporting Medicaid Quality Measurement and Improvement

In 2006, NCQA developed a Medicaid Managed Care Toolkit in collaboration with CMS. The toolkit is regularly updated via the NCQA Web page: <http://www.ncqa.org/tabid/134/Default.aspx>. It includes information to support public reporting of quality measures and summarizes Federal Regulations on quality measurement. States may elect to use the NCQA accreditation process for managed care organizations, which includes HEDIS® data collection and reporting (see Appendix A). As noted in the Toolkit, 75 percent of the NCQA accreditation standards address external quality review requirements under the Code of Federal Regulations for managed care. As of January 2009, 25 Medicaid programs recognize or require NCQA accreditation (see Appendix B). Of the 25 programs, nine (DC, IN, KY, MA, MI, NM, RI, TN, and VA) require NCQA accreditation by health plans participating in Medicaid.

Other nationally recognized organizations dedicated to improving quality of care in the United States have provided significant support to State efforts to evaluate and implement quality of care improvement initiatives for Medicaid and CHIP (see Appendix C). These organizations have established peer-to-peer and regional learning collaboratives on targeted clinical quality improvement initiatives, directed technical assistance to States on quality improvement methodologies, created opportunities to share lessons learned and promising practices in utilizing evidenced-based clinical improvement projects, and provided direct Medicaid leadership training that includes quality improvement technical support.

III. National and State-Specific Findings on Quality and Access in Medicaid and CHIP

Considerable research provides evidence that children enrolled in Medicaid/CHIP have better access to care than children who lack insurance coverage.^{7 8} Much less is known, however, about the extent to which the quality of care differs for children by coverage status. The most widely quoted national study, to date, on the quality of care provided to children irrespective of their coverage status found that, on average, children received roughly half (47 percent) of the indicated care for preventive services, chronic conditions, and acute conditions⁹. In this study, quality of care varied by type of service and by age groups, with the rate of adherence for indicated care being the lowest for preventive services.

This first annual Secretary's report includes data available to CMS at the time this report was prepared. It does not include all of the requested information specified in sections 1139A(c)(1)(A) and 1139A(c)(1)(B) of the Act. For example, the child health quality measures that CHIPRA requires be developed, which are to be included in these reports, were released for public comment in December 2009. Guidance for the voluntary reporting of these measures will not be issued until February 2011.¹⁰ Current studies and data reported to CARTS, however, provide some insight into the quality of care children in Medicaid/CHIP receive.

Studies of Health Care Quality and Access

In a review of the literature, CMS identified 19 studies that examined one or more indicators of children's access to care in Medicaid and/or CHIP since 2000. Of these studies, 15 included State-specific findings (see Appendix D). Both the State-specific and national studies provide evidence that children enrolled in CHIP programs have better access to preventive and primary care services after enrolling in CHIP. All but one of the studies documented a reduction in unmet need or delayed care by CHIP enrollees. Based on several State-specific and national studies, access to care for specialty services (e.g., dental and mental health), appears to be problematic.

Highlights from national studies are noted below:

- *Having a Medical Visit in the Past 2 Years.* 3 percent of children ages 2-17 covered by Medicaid and other public programs lacked a medical visit in the past 2 years, as compared with 2 percent of privately insured children (analysis of 2008 National Health Interview Survey).¹¹
- *Use of Preventive Services.* 41 percent of children ages 3-17 with family incomes below 250 percent of poverty had a preventive visit in the past year, with publicly covered children being more likely than privately covered, or uninsured, children to have had a preventive visit in the past year (analysis of 2001-2003 Medical Expenditure Panel Survey).¹²
- *Access to Specialty Services.* 28 percent of children in Medicaid/CHIP reported problems getting access to specialty services, as compared with 20 percent of privately insured children (analysis of 2003-2004 Medical Expenditure Panel Survey).¹³

- *Use of Dental Services.* 40 percent of publicly covered children ages 2-17 had a dental visit in the past year, as compared with 59 percent of privately covered children, and 28 percent of uninsured children (analysis of 2007 Medical Expenditure Panel Survey).¹⁴
- *Medical home.* Using the criteria in the 2007 National Survey of Child Health, 45.4 percent of publicly covered children met medical home criteria, compared to 66.5 percent of privately covered children.¹⁵

Several national and State-specific studies also provide information on the care obtained by children of different racial/ethnic groups or with special health care needs. Although studies indicate that children clearly experience improved access to care once enrolled in Medicaid/CHIP, disparities based on race, ethnicity, and special needs circumstances of children are issues of concern for access and quality of care. Findings from a review of the literature provide evidence that:

- Children with health coverage generally had better access to care than children without coverage; however, among children covered by Medicaid, African Americans were more likely than whites to lack a usual source of care (9 percent vs. 5 percent) and a medical visit in the past year (36 percent vs. 24 percent). Hispanic children in Medicaid were more likely than whites to lack a usual source of care (8 percent vs. 5 percent), but were similar in the percent that did not have a medical visit in the past year (26 percent vs. 24 percent). Similar disparities were observed among privately covered children (analysis of data from the 2003-2004 Medical Expenditure Panel Survey).¹⁶
- Children of minority race/ethnicity and children with special health care needs were less likely than their counterparts to experience consistent gains in access. The authors found gains in access before and after enrollment in CHIP, but substantial disparities remained in several studies (a review of studies of CHIP in 14 States).¹⁷
- Among Medicaid and CHIP enrollees, Asian and Pacific Islander children have the lowest reported patient-centeredness ratings of all racial/ethnic groups.¹⁸
- Patient safety among Medicaid and CHIP enrollees also varies by race and ethnicity. Accidental puncture and laceration during inpatient procedures is an area of concern for white children relative to black and Hispanic children. Across all payers, hospitalized white children are more likely to experience decubitus ulcers (i.e., pressure sores) than are Hispanic children.¹⁹
- With regard to children with special health care needs, there were significant declines in unmet need after enrolling in CHIP; yet, the rate of unmet needs remained 10 percentage points higher among children with special health care needs than other children (a 10-State SCHIP evaluation).²⁰

Quality Measurement Using HEDIS® Measures

In 2008, CMS contracted with NCQA to support Medicaid managed care quality improvement efforts. The project augmented NCQA's Quality Compass® database of health plan HEDIS®

information with additional compatible data from 9 States collected in 2006 through 2008. While not all measures are available for all States, the database for the project included data from 34 out of the 37 Medicaid programs that had managed care programs during those years.

Data on quality of care effectiveness measures examined for 2008 for the 34 State Medicaid programs with managed care revealed that 3 of the 7 children-focused HEDIS® measures had relatively high 2008 performance rates when compared to rates for other measures (for children and adults) in the NCQA report: use of appropriate medication for asthma by children ages 5-9 (89.7 percent); appropriate treatment for upper respiratory infection (85.0 percent); and childhood immunizations (72.5 percent). The other 4 children-focused measures had relatively lower performance rates: lead screening (61.3 percent); appropriate testing for children with pharyngitis (59.6 percent); Chlamydia screening in 16-20 year olds (49.1); and follow-up care for children prescribed medication for attention deficit hyperactivity disorder (36.4 percent).²¹

Of the HEDIS® measures available in 2008, NCQA designated 54 for reporting by Medicaid plans. According to a survey by the National Association of Children's Hospitals and Health Management Associates, most (90 percent) of Medicaid programs and all CHIP programs report on quality of care using some HEDIS® measures, although not always precisely following the HEDIS® technical specifications and data collection process required by NCQA.²² To assess and improve measurement using HEDIS® measures, NCQA convened a national advisory committee that met four times during the course of the project to establish criteria for State submission of information, guidance on project scope, and input to data collection and analysis. Advisory members were representative of Medicaid health plans, State Medicaid agencies, External Quality Review Organizations (EQROs), and industry quality experts.

Key findings from that assessment include:

- 36 out of 37 State Medicaid programs with managed care had health plans utilizing HEDIS® measures for quality improvement efforts.-- HEDIS® measures were most frequently collected on diabetes, asthma and pediatric care;
- States implement a variety of quality improvement (QI) initiatives to meet State-specific needs; however, the lack of comparable data limits comparisons across States;
- 6 of 14 States responding to a project survey indicated they made modifications to the HEDIS® specifications in collecting or calculating rates for a variety of reasons; and
- More than 170 health plans from 32 States submitted data to NCQA for 2006 to 2008, but 62 plans chose not to publicly report these data. For this project NCQA supplemented its HEDIS® data with additional data determined to be compatible for this project from 97 plans in 9 States.

Reporting of HEDIS® Quality Measures by CHIP and Medicaid Programs

Of the 51 CHIP programs reporting to CARTS, almost half (22) include data on children enrolled in Medicaid because the State operates a CHIP Medicaid expansion program or a combination Medicaid and CHIP program. Quality measures are similarly collected and reported for children in separate CHIP programs, Medicaid expansion programs, and combination Medicaid and CHIP programs.

The CMS has been working with States to improve the collection and reporting of data on 4 quality performance measures: well-child visits up to 15 months of life; well-child visits for the 3rd, 4th, 5th, and 6th year of life; use of appropriate medication for asthma; and access to primary care providers. About 30 States reported on all 4 measures in 2008; however, States vary in whether they use the validated HEDIS® technical specifications for the measures. As a result, data reported to CMS by States are not necessarily comparable and thus, are of limited usefulness for national comparisons.

Table 1 presents findings on the 4 quality performance measures for 2008 as reported by States using CARTS. The data indicate that while there is substantial variability in performance, States report that, on average:

- 89 percent of children from birth through 15 months of life had at least one well-child visit;
- 87 percent of children ages 5-17 had used the appropriate medication for asthma; however, while 7 States had average rates exceeding 95 percent (AL, AR, MI, MT, NY, NC and WY), 4 States had average rates of less than 70 percent (ME, ND, OR, SC); and
- 84 percent of adolescents ages 12-19 had at least one visit to a primary care provider.

The one measure for which there is substantial need for improvement nationally is the percent of children with at least one well-child visit in the 3rd, 4th, 5th, and 6th year of life. In these age groups, 59 percent of children, on average, had a well-child visit in a year, ranging from a low of 24 percent in North Carolina to a high of 86 percent in West Virginia. Many of the States in the West and South performed poorly on this indicator.

Table 1: Child Health Quality Measures Reported on CHIP & Medicaid Enrollees, 2008

| State | Well Child Visit: Percentage with at least one visit in first 15 months of life | Well Child Visit: Percentage with at least one visit in the third, fourth, fifth, and sixth years of life | Use of Appropriate Medications for Asthma: Percentage of Children ages 5-17 | Access to Care: Percentage of Children ages 12-19 with at least one visit to a primary care provider |
|--------------|--|--|--|---|
| AL | 94.7 | 43 | 95.7 | 89.6 |
| AK | 94 | 42 | N/R | N/R |
| AZ | 99.4 | 67.9 | 90.7 | 84.2 |
| AR | 96.7 | 43 | 95 | 83 |
| CA | 99.9 | 73 | 94 | 85.5 |
| CO | 89.4 | 55 | N/R | 89.9 |
| CT | 98.4 | 81.5 | N/R | 83.2 |
| DE | 99.8 | 79.3 | 92.4 | 87.4 |
| DC | 87.4 | 77.9 | 88.6 | 85.3 |
| FL | 72.5 | 53.2 | N/R | 91 |
| GA | N/R | 55.3 | 70.1 | 74.1 |
| HI | 96.7 | 60.9 | 87.7 | 86.5 |
| ID | N/R | 47.6 | N/R | 88.3 |
| IL | 86.5 | 59.9 | 90.4 | N/R |
| IN | 98.3 | 55 | 88 | 85 |
| IA | 70.6 | 54.9 | 83.3 | 94.3 |
| KS | N/R | 59.3 | N/R | N/R |
| KY | 99 | 72.9 | 96.9 | 90.4 |
| LA | 96.6 | 60.7 | 91.7 | 87.6 |
| ME | 97.4 | 64.1 | 66.7 | 87.6 |
| MD | 98.3 | 76.1 | 88.5 | 87.6 |
| MA | 98.9 | 84.5 | 93 | 94.7 |
| MI | 59.6 | 60 | 97.2 | 91.2 |
| MN | N/R | N/R | N/R | N/R |
| MS | N/R | 34.4 | 97 | 87.7 |
| MO | 96.2 | 53.7 | 89 | N/R |
| MT | 92 | 38.4 | 95.2 | 87.7 |
| NE | 61.9 | 58.3 | N/R | N/R |
| NV | N/R | 78.3 | N/R | 85.3 |
| NH | 99.7 | 79.8 | 91.1 | 96.2 |

| State | Well Child Visit: Percentage with at least one visit in first 15 months of life | Well Child Visit: Percentage with at least one visit in the third, fourth, fifth, and sixth years of life | Use of Appropriate Medications for Asthma: Percentage of Children ages 5-17 | Access to Care: Percentage of Children ages 12-19 with at least one visit to a primary |
|----------------|--|--|--|---|
| NJ | 97.8 | 74.4 | 90.4 | 85.5 |
| NM | 98.9 | 61.9 | 91.2 | 90.8 |
| NY | 99.2 | 80.5 | 95 | 93.3 |
| NC | N/R | 26 | 95 | 87.4 |
| ND | 54.5 | 14.4 | 39.5 | 85 |
| OH | 96.8 | 60.2 | 91.8 | 86 |
| OK | 96.8 | 57.1 | 87.8 | 80.1 |
| OR | 25 | 36.2 | 65.1 | 62.8 |
| PA | 98.5 | 69.2 | 94.7 | 88.6 |
| RI | N/R | N/R | 94.4 | 92.8 |
| SC | N/R | N/R | 33.8 | N/R |
| SD | 89.1 | 42.8 | 87 | 80.3 |
| TN | 61.5 | 36.4 | 84.7 | 50.8 |
| TX | N/R | N/R | N/R | 85.2 |
| UT | 97.2 | 47.8 | 92.1 | 86.7 |
| VT | 98.9 | 80.1 | N/R | N/R |
| VA | 94.1 | 61.5 | 93 | 79.7 |
| WA | 98.8 | 58.6 | N/R | 48.7 |
| WV | 94.1 | 85.9 | 89.8 | N/R |
| WI | 97.3 | 61.9 | 88.5 | N/R |
| WY | 44.4 | 34.3 | 97.8 | 51.3 |
| Average | 88.5 | 58.7 | 86.7 | 83.9 |
| Median | 96.7 | 59.9 | 91.1 | 86.7 |

N/R= Not reported; State did not report data in 2008

Note: Not all States used uniform HEDIS® Technical Specifications

SOURCE: CMS, CHIP Annual Report Template System (CARTS)

External Quality Reviews of Managed Care Organizations

Section 1139A(c) of the Act, as amended by section 401(c) of CHIPRA, specifically requires the Secretary of HHS to include in this annual report information States collect through external quality reviews of MCOs. All States that contract with MCOs and PIHPs for delivery of health care in Medicaid programs are required to have a system-wide quality program.

Within Medicaid and CHIP, there are 12 States (AK, AR, ID, LA, ME, MS, MT, NH, ND, OK, SD, and WY) that do not use MCOs or PIHPs to deliver services²³ and thus, have no Federal EQR reporting requirement. Such States generally offer care only through fee-for-service (FFS) or primary care case management (PCCM) delivery systems and quality review is solely the responsibility of the State. The net effect of these variations in delivery systems and reporting requirements is that there is not a single CMS national Medicaid or CHIP quality database that facilitates a national assessment of quality of care performance measures.

Appendix E displays a summary of selected information available to CMS through State managed care EQR reports. CMS abstracted data from annual external quality review reports to identify: 1) State-specified children's health care performance measures; 2) findings on children's health care quality issues and what follow-up is recommended; 3) performance improvement projects relating to children's health; 4) validation issues regarding the performance measures; and 5) use of health information technology in Medicaid programs. Health care quality measures for children most frequently assessed were access to preventive services (dental visits, well-child and adolescent well-child services including immunizations, and lead screening), and measures on appropriate treatments (pharyngitis, upper respiratory infections, medication for asthma). The CMS assessment revealed that States identify different health care priorities, and a number of States are engaged in quality improvement efforts at the State level.

The CHIPRA also requires the Secretary to report information on the external quality reviews of benchmark plans. Benchmark benefit plans give States flexibility in offering some Medicaid-eligible individuals a benefits package that is not necessarily comparable to the benefits available State-wide through Medicaid. The statute (section 1937 of the Social Security Act) identifies types of health benefit packages that qualify as Benchmark benefit packages. There are no separate reporting requirements for benchmark plans other than the EQR reporting process used for MCOs. Of the eight States with currently operating Medicaid benchmark plans (ID, KY, KS, NY, VA, WA, WI, and WV), only two States (WI and WV) include full service MCOs that trigger EQR reports. Since the EQR reports for these two States do not separately report information from benchmark plans, CMS only has data that combines information on the performance of benchmark plans and managed care plans.

The CMS' review of the EQR reports found limited information on the results of health care quality improvement (QI) projects specific to children. CMS requires States to report EQRO validation of performance improvement projects rather than report actual performance outcomes. The projects undertaken, however, reflect a variety of health care quality process and outcome areas. For example, California and the District of Columbia reported that they undertook QI projects focused on prevention or reduction of childhood obesity. Hawaii, Illinois, and New Jersey highlighted EPSDT specific improvement initiatives. Most State QI projects reflected

initiatives related to one or more of the performance measures identified as being collected by the EQRO review. Some States (AZ, DE, GA, MA, NE, NV, NJ, NM, OH, VA, and VT) voluntarily reported outcome information related to their improvement projects (e.g., actual rates of performance or whether project goals/objectives were met) in their EQRO report. This information is also summarized in Appendix E.

Patients' Experiences with Health Providers and Services

Obtaining assessments of patients' experiences of 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 section 1139A(a)(6)(A) of the Act, and fulfill the CHIPRA statutory requirement to provide CMS with information on children's experiences with care under Medicaid/CHIP. CAHPS® surveys include questions which ask the respondent to report on health plan 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.

The AHRQ maintains a database of CAHPS® health plan data, including data from the Child Medicaid survey. States voluntarily report Medicaid data to this database either annually or biannually. A total of 17 States submitted data in 2008 and 12 States submitted Medicaid data in 2009. In 2009, the CAHPS database included information on about 70,000 children in Medicaid from 107 health plans.²⁴ CMS is pursuing an intra-agency agreement with AHRQ through which AHRQ would provide technical assistance to States fielding the CAHPS® Medicaid Survey, collecting and entering the data into the database and producing reports. All EQROs use one or more of the CAHPS® instruments.

As an example of CAHPS® data, Table 2 summarizes information from one question, "How easy was it to get appointments with specialists for the child?" The optimal response is "always." The responses indicate that about a quarter of parents of children in Medicaid health plans report having difficulty obtaining specialty care. This finding was fairly consistent across the four regions of the country and for health maintenance organizations (HMOs) and point-of-service-(POS) plans, but there is not currently comparative data to assess whether this level of difficulty is the same or different from that faced by children in Medicaid fee-for-service systems.

Table 2. Proportion of Children in Medicaid/CHIP Whose Parents Reported Whether it is Easy to Get Appointments with Specialists, 2009

| Group | Population (n) | 'Never + Sometimes' | 'Usually' | 'Always' |
|------------------|-----------------------|----------------------------|------------------|-----------------|
| TOTAL | 15,834 | 24% | 26% | 50% |
| Midwest | 6,305 | 21% | 26% | 53% |
| Northeast | 2,642 | 25% | 27% | 48% |
| South | 4,603 | 27% | 23% | 49% |
| West | 2,284 | 25% | 28% | 47% |
| HMO/POS | 15,535 | 24% | 25% | 50% |

Source: CAHPS, Child Medicaid Questionnaire, 2009 AHRQ CAHPS® Health Plan Database

Note: The population “n” represents the number responding to this question.

IV. New Federal Laws Related to Quality Measurement in Medicaid and CHIP

Since 2009, significant opportunities have evolved for States and the Federal Government to engage in quality improvement activities for Medicaid/CHIP, as well as public and private health care systems. The signing into law of CHIPRA, ARRA, and the Affordable Care Act has created unprecedented opportunities to improve the quality of care. These laws renew the Federal commitment and provide new opportunities for States to improve the measurement and quality of care children receive not only in Medicaid/CHIP, but also through private insurance.

Children's Health Insurance Reauthorization Act (CHIPRA)

Section 1139A(a) of the Act, as amended by section 401(a) of CHIPRA establishes the foundation for building a comprehensive, high quality system of care for children by addressing key components essential to quality improvement strategies (see Appendix F for CHIPRA Title IV provisions). CMS is collaborating with States to establish the infrastructure for a quality measures program in which data are collected and reported in a standardized way for children enrolled in Medicaid/CHIP. Provisions of CHIPRA related to quality measurement and improvement include:

- Establishment of an initial core set of child quality performance measures for voluntary use by State programs (Section 1139A(a)(1));
- Creation of a pediatric quality measures program to test and refine the core quality measures and develop additional quality measures (Section 1139A(b)(1));
- Appropriation of \$100 million (over 5 fiscal years) for State demonstration projects that would test and evaluate approaches to assess the quality of care that children in Medicaid/CHIP receive (Section 1139A(d)(4));
- Development of a standardized reporting format for the voluntary core performance measures by February 2011 (Section 1139A(a)(4));
- Requirement for State CHIP programs to annually report on quality of care and consumer satisfaction measures included in the CAHPS® Medicaid survey starting in 2013 (Pub. L. 111-3, §402(b)(2));
- Requirement that CHIP managed care programs have an independent annual external quality review (HHS/CMS State Health Official Letter #09-008 CHIPRA#4);
- Creation and testing of a model pediatric EHR format (Section 1139A(f)(1); and
- Provision of technical assistance to States as they implement quality measures (Section 1139A(a)(7)).

Current Status: To assist in identifying the initial core set of child performance measures that could be used to monitor and improve children's health care services, AHRQ's National Advisory Council on Research and Quality established a Subcommittee on Children's Healthcare Quality Measures for Medicaid and CHIP (also referred to as the SNAC) in 2009. 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. The Subcommittee consisted of State Medicaid representatives, child health care quality experts, and family advocates. Based on guidance in the CHIPRA legislation and from CMS, and analyses of the evidence base, feasibility and importance of 121 nominated measures, the SNAC recommended the use of a small and balanced core set of quality measures.²⁵

In December 2009, the HHS Secretary posted for public comment in the *Federal Register* 24 of the SNAC recommended core set of children's health care quality measures for voluntary use by Medicaid/CHIP programs (see Appendix G).²⁶ The CAHPS® survey tool, which is required by CHIPRA to be collected starting in 2013, is included as one of the 24 core measures. Of the hundreds of public comments received regarding the initial core set of measures, principal concerns were about the burden of new quality reporting, current data collection and reporting system constraints, need for technical assistance, and the unique challenges for FFS and PCCM programs to collect and report on the measures. A number of States and stakeholders, however, also offered their support for the use of evidence-based quality measures for monitoring and improving the care received by Medicaid/CHIP enrollees.

While the initial core set covers a range of measures, gaps persist in several dimensions of pediatric quality measurement. For example, none of the measures as currently specified is able to be used across Medicaid and CHIP program types (e.g., MCO, FFS). Data on race, ethnicity, socioeconomic status, and special health care needs are not available by insurance source 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; integrated healthcare settings). The CHIPRA-required Pediatric Quality Measures Program is intended to fill these gaps. The program will issue cooperative agreement grant awards to an estimated 7 to 9 Centers of Excellence that will work with HHS to improve and enhance existing measures and develop new measures for priority topics. 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. A coordinating center will be identified to assist AHRQ and CMS with the goals of facilitating common approaches across the Centers of Excellence awardees, and identifying improved core measure sets as required by CHIPRA. AHRQ, in close collaboration with CMS, expects to make these grant and contract awards during the first quarter of fiscal year 2011. Additionally, only four of the initial core measures were electronically specified, (i.e., can be collected through an electronic health record (EHR)). Going forward, CMS and AHRQ will work with the rest of the Department to ensure that more measures are capable of being collected through an EHR.

In February 2010, CMS announced grants to 10 States and multi-State collaboratives to conduct demonstrations that address multiple aspects of quality improvement, including performance measurement, health information technology, and service delivery models (see Appendix H). A total of \$100 million was appropriated for these grants, with \$20 million to be awarded in each of 5 years for State and multi-State collaborations. Grant dollars are to be used for infrastructure development and related activities rather than for direct payment for services. Demonstration grants were awarded to: Colorado (with New Mexico), Florida (with Illinois), Maine (with Vermont), Maryland (with Georgia and Wyoming), Massachusetts, North Carolina, Oregon (with Alaska and West Virginia), Pennsylvania, South Carolina, and Utah (with Idaho). In total, 18 States will participate in these projects. Seven grantees will test the recommended set of child health quality measures, seven will implement health information technology (IT) strategies, and two plan to test the new pediatric electronic health record format being developed as required by CHIPRA. A national evaluation contractor will be selected by AHRQ, in partnership with CMS, and will work with the grantees to develop a consensus approach to determining the success of, and lessons learned, from the demonstrations.

The CHIPRA also requires the Secretary to provide technical assistance to States in using the initial core set of child health quality measures. CMS will provide tailored technical assistance on the measure specifications as well as the systems for reporting data on the quality measures. The technical assistance plan will address State barriers to collecting and reporting data on the performance measures using the developed specifications. Technical assistance under this effort will include: individual, onsite consultation; webinars and Web-based workshops; establishment of a CMS Quality Website Resource/Communications Exchange Center; regularly scheduled State technical assistance teleconferences; and an annual Medicaid/CHIP quality conference.

Through an intra-agency agreement with the CMS, AHRQ is developing the model pediatric EHR Format via a contract awarded in March 2010. This contract includes several component parts 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 IT vendor developers and other appropriate audiences. The model Format will be piloted in two of the 10 states (North Carolina and Pennsylvania) awarded CHIPRA quality demonstration grants.

American Recovery and Reinvestment Act (ARRA)

Much like CHIPRA, ARRA provisions also provide HHS with considerable new resources to promote and expand the use of health information technology (HIT) in the health care system. The related HIT provisions were located throughout ARRA and 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. Additionally, the law promotes efforts that lead to all Americans having an EHR by 2014 and defines the role of the HHS Office of the National Coordinator for HIT (ONC). 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/CHIP. Provisions of the law related to Medicaid/CHIP quality improvement include:

- Financial incentives to eligible health professionals and hospitals when they adopt, implement, upgrade, or meaningfully use certified EHR technology (July 28, 2010, Federal Register Notice CFR Parts 412, 413, 422 and 495 – Electronic Health Record Incentive Program, Final Rule);
- 100 percent Federal financial participation (FFP) match for State expenditures for incentives to providers who adopt, implement, upgrade, or meaningfully use a certified EHR (July 28, 2010, Federal Register Notice CFR Parts 412, 413, 422 and 495 – Electronic Health Record Incentive Program, Final Rule); and
- 90 percent FFP match for reasonable and approvable State expenditures related to administration of the incentive payments and to promote EHR adoption and health information exchange (HHS/CMS State Medicaid Director letter #10-016, August 17, 2010).

Current Status: Considerable efforts have been underway to develop policy and regulation in order to begin implementation of the EHR incentive program. The requirement for the EHR incentive payments includes the use of certified EHR technology for more efficient health care delivery processes – such as e-prescribing and clinical decision support tools – that ultimately

improve patient safety, quality of and access to care, and the collection of health information to assess and improve health outcomes. It is expected that between \$9 and \$27 billion may be expended on incentive payments over 10 years.

The CMS and ONC published two closely related final rules in July 2010. The first is the Medicare & Medicaid Electronic Health Record Incentive Payment Program, and the second is the Initial Set of Standards, Implementation Specifications, and Certification Criteria for EHR Technology. This much anticipated guidance will allow States, vendors, and providers to understand the program participation requirements in order to receive incentives for the adoption and meaningful use of certified EHR technology.

In order to receive administrative funding for this program, States are responsible for administering and overseeing the EHR incentives for Medicaid eligible providers. To demonstrate planning and implementation for the program, States must develop a roadmap, or a State Medicaid HIT Plan. As of August 2010, 49 of the 50 States, the District of Columbia, and 2 territories had submitted funding requests to begin this process. Thus far, \$78 million in Federal planning funds have been awarded to States. States and other partners also have funding opportunities through additional ARRA/HITECH grant initiatives available from the ONC and additional broadband expansion grants through various other Federal agencies authorized under ARRA. The ONC has established a nationwide network of Regional Extension Centers to assist certain primary care providers in adopting and meaningfully using EHRs. Under HITECH Act funds, CMS is procuring a national technical assistance contractor to assist States with successful implementation and oversight of the Medicaid EHR Incentive Program.

One example of gains that can be achieved through the coordination between Medicaid, ONC, and States, using electronic health records, can be found with the measurement of Body Mass Index (BMI), an indicator used in obesity prevention efforts. At present, this information is available only by medical chart abstraction for the vast majority of beneficiaries. However, height and weight measurement is required for demonstrating meaningful use under the EHR incentive programs. With these data available in EHRs, BMI documentation and actual BMI can be calculated and used to measure improvements in quality.

Patient Protection and Affordable Care Act (Affordable Care Act)

The Affordable Care Act expands sources of health insurance for millions of Americans and also includes health care delivery system reforms designed to improve the quality of care and lower costs. Among the provisions designed to substantially improve the quality of care provided to all Americans, the Affordable Care Act provides substantial new funding for developing a Medicaid adult quality measurement program to complement CHIPRA children's quality measurement program. CMS will need to leverage the knowledge gained through CHIPRA quality activities in order to ensure adult and child quality activities are aligned. The Affordable Care Act also includes provisions that both expand Federal-State partnerships in disease prevention and quality improvement in health care, and bolster the role of the private sector in promoting higher quality care for children and all Americans, including:

- Improved data collection for measuring, evaluating, and addressing health disparities in Medicaid and CHIP by race, ethnicity, primary language, and disability status (Section 4302);
- Development of performance measures and a Medicaid policy regarding payment for health care acquired conditions (Section 2702);
- Demonstration grants to States to test approaches that encourage healthier lifestyles among Medicaid enrollees with chronic health problems (Section 4108);
- Demonstration grants to establish value-based incentive payments to hospitals that meet performance standards (Section 2705);
- Incentive payments to States that eliminate Medicaid cost-sharing requirements for certain clinical preventive services (Section 4106);
- Provisions assuring preventive care for children and adults is a covered benefit in private insurance (Section 1001; Section 1302);and
- Assuring that Qualified Health Plans offered in Exchanges address quality, safety, wellness and disparities issues (Section 1311 (g) (h)).

Current Status: CMS, in July 2010, signed an intra-agency agreement with AHRQ to develop an initial core set of adult quality measures for adults in Medicaid using a process similar to that used in developing the child core quality measures. The measures will be published in the *Federal Register* for public comment by January 1, 2011. It is expected that grants will be provided to States and other entities to support measure development efforts, and to test the feasibility of State collection efforts. CMS will finalize a longer-term plan for annual quality reporting by State Medicaid/CHIP programs in consultation with the States. It is also expected that a number of the adult quality measures will be electronically specified and therefore calculated using an EHR. CMS plans to coordinate with HITECH planning efforts to assure that opportunities to demonstrate meaningful use of quality measures overlap as much as possible with the initial core set of adult quality measures. HHS is also in the process of soliciting comments on how to assure that State-based Exchanges promote quality and value, including in the definitions of performance measurement and what constitutes a Qualified Health Plan. Questions were published in the *Federal Register* for public comment in October 2010.

Coordination with Current Quality Reporting Initiatives and Partners

The CMS 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), and the Substance Abuse and Mental Health Services Administration (SAMHSA). CMS is working with HRSA on an oral health initiative and will continue solidifying collaborations related to children's quality of care. In particular, 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 BMI measurement research is important to CMS' CHIPRA quality measurement program, which includes documentation of BMI by a provider. Additionally, the CDC's Vaccine for Children's program, funded by CMS, provides free immunizations for low-income children.

The CMS' collaboration with AHRQ on the CHIPRA quality measures led to the creation of the CHIPRA HHS Federal Quality Group. This group is comprised of representatives of multiple divisions of HHS including: AHRQ, CDC, CMS, HRSA, ONC, 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 development of the core measurement set.

In developing a quality reporting format for States, CMS will consider existing and new national reporting efforts. Along with Medicare, several multi-program State agencies, such as the Pennsylvania Health Care Cost Containment Council (PHCCCC), have made detailed reports available at the facility and individual physician level. AHRQ produces an annual National Healthcare Quality Report (NHQR) and the National Healthcare Disparities Report (NHDR) that includes measures on the quality of children's care. In 2009 NHQR and NHDR reported on 32 children's health care quality measures, including measures on preventive care, care for chronic conditions such as diabetes and asthma, and avoidable hospitalizations. The memorandum of understanding between CMS and AHRQ signed in 2009 notes that the CHIPRA core measures will be included in forthcoming NHQRs and NHDRs.

The CMS has broadened support to States through liaison work with the AHRQ Medicaid Medical Directors Learning Network, the AHRQ "Technical Assistance for Health IT and HIE in Medicaid and CHIP" contract and several private sector national organizations focused on improving the quality of care. These include the NCQA, the National Improvement Partnership Network, the National Quality Forum, American Academy of Pediatrics, and the National Association of Children's Hospitals and Related Institutions. States will need continued flexibility in addressing the varying needs of their populations. Through collaborations with stakeholders and the resources of CHIPRA, ARRA, and Affordable Care Act, a stronger foundation exists for addressing current and emerging issues that impact the quality of care in Medicaid/CHIP. This is particularly important as CMS pursues improvement opportunities in focused areas such as in dental services and in other EPSDT services.

V. Summary and Conclusions

Since the CHIP program was created in 1997, States and the Federal Government have made substantial strides in expanding and improving health coverage for low-income children through Medicaid/CHIP. States and the Federal Government have now embarked on a new journey in measuring and improving the quality of care in Medicaid/CHIP.

A number of key findings emerged from this review of the quality of care furnished to children under Medicaid and CHIP. States, lacking a standardized format for collecting quality measures, have implemented various approaches to assessing quality, including developing State-specific quality metrics. Although all States collect some quality data; there is wide variance in the information and the processes used for quality reviews under managed care. Even less is known about the care provided in FFS payment arrangements.

The strategy for establishing a nationwide quality measurement and improvement system for Medicaid/CHIP consists of multiple components in which States play a key role throughout the process. The CHIPRA quality demonstration grants, which were awarded to 10 State and multi-State collaboratives, are one of the key mechanisms for learning about promising practices for measuring and reporting on quality of care. Other major components of the strategy include identifying an initial core set of quality performance measures for voluntary reporting to CMS, technical assistance to the States and health providers through a variety of mechanisms, and sizable investments in HIT, including funding for EHRs. Under the Medicaid EHR Incentive Program, States will be responsible for collecting certain quality measurement information related to meaningful use and reporting this information to CMS.

The CHIPRA, coupled with ARRA, and the Affordable Care Act offer an opportunity to develop a system of quality measurement and reporting that is linked to the development of interventions that can improve the quality and outcomes of care both in Medicaid/CHIP and throughout the health care system. While it will take several years to build the infrastructure for HHS and States to have a reliable process for collecting and reporting standardized quality metrics in Medicaid/CHIP, this process has begun with an intensity and recognition of the importance of these efforts. Efforts to encourage the adoption and use of health information technology are inextricably linked with plans to improve the quality of care in these programs. As more providers adopt EHRs, States will be able to collect and report on quality measures with greater efficiency and accuracy. States have the interest, and with the planned technical assistance efforts and the quality demonstration grants, will have greater ability to implement quality improvement initiatives in Medicaid/CHIP. Through collaborations with States and other stakeholders, HHS now has a stronger foundation for assuring that children, and ultimately all Medicaid/CHIP beneficiaries and all Americans, have access to high-quality care.

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