

Report to Congress

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



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GLOSSARY

ACF	Administration for Children and Families
ADHD	Attention-Deficit/Hyperactivity Disorder
Affordable Care Act	Patient Protection and Affordable Care Act of 2010
AHCA	Agency for Health Care Administration
AHRQ	Agency for Healthcare Research and Quality
AMA	American Medical Association
ARRA	American Recovery and Reinvestment Act
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CCNC	Community Care of North Carolina
CDC	Centers for Disease Control and Prevention
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
CHIP	Children’s Health Insurance Program
CHIPRA	Children’s Health Insurance Program Reauthorization Act
CLABSI	Central Line-Associated Blood Stream Infection
CoIIN	Collaborative Improvement and Innovation Network
CMCS	Center for Medicaid and CHIP Services
CME	Care Management Entity
CMS	Centers for Medicare & Medicaid Services
COE	Center of Excellence
CPC	Comprehensive Primary Care
CUSP	Comprehensive Unit-based Safety Program
EHDI	Early Hearing Detection and Intervention
EHR	Electronic Health Record
ELE	Express Lane Eligibility
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment

FFY	Federal Fiscal Year
HCAC	Health Care-Acquired Condition
HEDIS	Healthcare Effectiveness Data and Information Set
HEN	Hospital Engagement Network
HHS	U.S. Department of Health and Human Services
HITECH	Health Information Technology for Economic and Clinical Health Act
HPV	Human Papillomavirus
HRSA	Health Resources and Services Administration
IHOC	Improving Health Outcomes for Children
Innovation Center	Center for Medicare & Medicaid Innovation
Learning Network	Medicaid Prevention Learning Network
MACBIS	Medicaid and CHIP Business Information Solutions
MHPAEA	Mental Health Parity and Addiction Equity Act
MSIS	Medicaid Statistical Information System
National Quality Strategy	National Quality Strategy for Quality Improvement in Health Care
NCQA	National Committee for Quality Assurance
NHSN	National Healthcare Safety Network
NICU	Neonatal Intensive Care Unit
NIPN	National Improvement Partnership Network
NOIP	National Outcomes Improvement Project
NTSV	Nulliparous Term Singleton Vertex
OB/GYN	Obstetrical/Gynecological Practitioner
OME	Otitis Media with Effusion
ONC	Office of the National Coordinator for Health Information Technology
OPPC	Other Provider-Preventable Condition
PCP	Primary Care Practitioner

PCPCH	Patient Centered Primary Care Home
PCPI	Physician Consortium for Performance Improvement
PfP	Partnership for Patients
PPC	Provider-Preventable Condition
PQMP	Pediatric Quality Measures Program
QI	Quality Improvement
SAHM	Society for Adolescent Health and Medicine
SAMHSA	Substance Abuse and Mental Health Services Administration
SBHC	School-Based Health Center
SNAP	Supplemental Nutrition Assistance Program
SPA	State Plan Amendment
TA/AS	Technical Assistance and Analytic Support
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children
YEHS!	Youth Engagement with Health Services

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EXECUTIVE SUMMARY

In federal fiscal year (FFY) 2012, Medicaid and the Children’s Health Insurance Program (CHIP) covered more than 44 million children,¹ representing about one-third of all children in the United States and more than half of all low-income children.² Medicaid is also the largest provider of prenatal and delivery services for pregnant women, covering nearly half (48 percent) of all births in the United States.³ The substantial reach of the Medicaid/CHIP programs underscores the importance of ongoing efforts to improve the quality of care for children in these programs.

The U.S. Department of Health and Human Services (HHS) is working closely with states, health care providers, and program enrollees to build high quality systems of care for children in Medicaid/CHIP. This report, required by Section 1139A(a)(6) of the Social Security Act, as amended by Section 401 of the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA), summarizes the ongoing efforts of HHS to improve the quality of care for children enrolled in Medicaid/CHIP. Since the first Report to Congress on Children’s Health Care Quality in Medicaid and CHIP was submitted in 2010,⁴ HHS and its federal, state, and private partners have made significant progress on initiatives related to improving stability of coverage and improving the quality of care for infants and children (including voluntary reporting of the children’s core set of health care quality measures).

With standardized measurement and reporting tools now in place, HHS is working closely with its state partners to more thoroughly measure the care obtained by children covered by Medicaid/CHIP and to use the measures to assess and improve the quality of care provided to children in their states. Over the past three years, HHS has implemented a wide range of children’s health care quality initiatives.

Highlights from this report include:

1. HHS’s Efforts to Improve the Quality of Care for Children

- Health care coverage and enrollment for children in Medicaid and CHIP have improved, with Medicaid/CHIP reaching a higher proportion of eligible children. HHS has conducted a national outreach campaign, issued a Secretarial challenge, and awarded more than \$140 million in outreach grants to increase enrollment.

¹ U.S. Department of Health and Human Services. “2013 Annual Secretary’s Report on the Quality of Care for Children in Medicaid and CHIP.” September 2013, Table 1. Available at: <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2013-Ann-Sec-Rept.pdf>.

² The Kaiser Commission on Medicaid and the Uninsured. “Medicaid: A Primer.” March 2013. Available at: <http://kaiserfamilyfoundation.files.wordpress.com/2010/06/7334-05.pdf>.

³ Markus, A.R., E. Andres, K.D. West, N. Garro, and C. Pellegrini. “Medicaid Covered Births, 2008 through 2010, in the Context of the Implementation of Health Reform.” *Women’s Health Issues*, vol. 23, no. 5, pp. e273–e280.

⁴ “Report to Congress on Children’s Health Care Quality in Medicaid and CHIP.” December 2010. Note: this report is due every three years. Available at: http://www.medicicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/RTC_ChildHealthImprovement.pdf.

Further, evidence suggests that CHIPRA bonus payments have provided an impetus for some states to improve their outreach, enrollment simplification, and retention efforts.

- Multiple quality improvement efforts are well underway that cut across all domains of children’s health care, with special attention to maternal and infant health, oral health, and prevention.
- Strong public-private partnerships, as demonstrated by the American Academy of Pediatrics and Childbirth Connections, have accelerated quality improvement initiatives.

2. Status of Voluntary Reporting by States

- State reporting of the Child Core Set is more complete than in FFY 2010, the first year of voluntary reporting. All states reported two or more of the Child Core Set measures for FFY 2012.⁵ The median number of measures reported by states for FFY 2012 was 14, up from 12 in FFY 2011. Altogether, 35 states reported at least 11 of the 22 core measures to the Centers for Medicare & Medicaid Services (CMS) in FFY 2012.⁶ The most frequently reported measures in the Child Core Set assess children’s access to primary care, well-child visits, and dental services.
- CMS is partnering with states to improve the completeness and accuracy of the data to monitor state performance.
- Although much of the technical assistance to states to improve performance has been made available to all states, CMS has tailored several efforts (such as quality improvement training series) to states with lower performance or with specific areas of interest.

The quality improvement efforts recently launched by CMS are helping to set the stage for the next generation of efforts designed to improve children’s health care and health outcomes to continue to transform Medicaid/CHIP into a high quality system of coverage and care. In the FFY 2015 President’s Budget, HHS proposed two changes relevant to Medicaid and CHIP quality: a one-year extension of the Performance Bonus Fund and permanently extending Express Lane Eligibility (ELE) for children beyond the end of FFY 2014.⁷

⁵ The term “states” includes the 50 states and the District of Columbia.

⁶ The base of 22 measures excludes two core measures: (1) the central line-associated blood stream infections (CLABSI) measure, which was obtained from the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) beginning in FFY 2012; and (2) the otitis media with effusion (OME) measure, which was not collected for FFY 2012 and was retired in 2013 because it draws on CPT-II codes not commonly used by Medicaid/CHIP agencies.

⁷ U.S. Department of Health and Human Services. “Fiscal Year 2015 Budget-in-Brief.” Available at: <http://www.hhs.gov/budget/fy2015/fy-2015-budget-in-brief.pdf>.

I. INTRODUCTION

Medicaid and the Children’s Health Insurance Program (CHIP) covered more than 44 million children in federal fiscal year (FFY) 2012,⁸ about one-third of all children in the United States and more than half of all low-income children.⁹ From 2008–2010, Medicaid was the largest provider of prenatal and delivery services for pregnant women, covering nearly half (48 percent) of all births in the United States.¹⁰ In recent years, Medicaid participation rates have increased as a result of outreach, enrollment simplification, and retention efforts, with 87 percent of eligible children enrolled in 2011.¹¹ The substantial reach of the Medicaid/CHIP programs underscores the importance of ongoing efforts to improve the quality of care for children.

The National Strategy for Quality Improvement in Health Care (National Quality Strategy), was established in 2011 as a national blueprint to align new and existing quality improvement efforts around three goals—better care; healthy people/healthy communities; and affordable care—and to measure progress toward achieving these goals.^{12,13} Many initiatives are underway to promote continued improvement of children’s health care quality under Medicaid/CHIP, as part of broader efforts to transform health care and create a higher-performing system. These include enhanced oversight and quality improvement efforts of managed care systems, quality measurement systems and value-based purchasing that promote high quality care over high volume, and electronic health records and other health information technology to improve care coordination and adherence to recommended care.

Many of these initiatives have been made possible by the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA),¹⁴ which provided funding and incentives to states to identify, enroll, and retain eligible children in Medicaid/CHIP, and supported various Medicaid/CHIP quality improvement efforts, including the development of a core set of children’s health care quality measures, ongoing improvements to the core set and development of new quality measures, and establishment of a quality demonstration program. (See Exhibit 1

⁸ U.S. Department of Health and Human Services. “2013 Annual Secretary’s Report on the Quality of Care for Children in Medicaid and CHIP.” September 2013, Table 1. Available at: <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2013-Ann-Sec-Rept.pdf>.

⁹ The Kaiser Commission on Medicaid and the Uninsured. “Medicaid: A Primer.” March 2013. Available at: <http://kaiserfamilyfoundation.files.wordpress.com/2010/06/7334-05.pdf>.

¹⁰ Markus A.R., E. Andres, K.D. West, N. Garro, and C. Pellegrini. “Medicaid Covered Births, 2008 through 2010, in the Context of the Implementation of Health Reform.” *Women’s Health Issues*, vol. 23, no. 5, pp. e273–e280.

¹¹ Kenney, G., N. Anderson, and V. Lynch. “Medicaid/CHIP Participation Rates Among Children: An Update.” September 2013. Available at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf407769.

¹² The National Quality Strategy. “Guiding Principles.” Available at: <http://www.ahrq.gov/workingforquality/nqs/principles.htm>.

¹³ U.S. Department of Health and Human Services. “2013 Annual Progress Report to Congress: National Strategy for Quality Improvement in Health Care.” July 2013. Available at: <http://www.ahrq.gov/workingforquality/nqs/nqs2013annlrpt.htm>.

¹⁴ “CHIP Reauthorization Act of 2009.” Available at: <http://www.gpo.gov/fdsys/pkg/PLAW-111publ3/html/PLAW-111publ3.htm>.

for a list of the Child Core Set measures and Appendix A for a description of the CHIPRA quality demonstration projects.)

The Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH), enacted under the American Recovery and Reinvestment Act (ARRA), provided incentives for the adoption of electronic health records and investment in health care technology infrastructure among providers nationwide;¹⁵ and the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) is supporting testing of various innovations, such as value-based purchasing, primary care transformation, and efforts to speed the adoption of best practices among health care providers.¹⁶

Section 1139A(a)(6) of the Social Security Act, as amended by Section 401 of CHIPRA, directs the Secretary of HHS to report to Congress every three years on:

- (A) The status of the Secretary's efforts to improve:
 - (i) Quality related to the duration and stability of health insurance coverage for children under Titles XIX and XXI;
 - (ii) The quality of children's health care under these 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 these 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.

Since the first Report to Congress on Children's Health Care Quality in Medicaid and CHIP was submitted in 2010, HHS and state partners have made significant progress on initiatives related to improving stability of coverage and improving the quality of care for infants and children (including voluntary reporting of the children's core set of health care quality measures).¹⁷

¹⁵ "American Recovery and Reinvestment Act of 2009." Available at: http://www.healthit.gov/sites/default/files/hitech_act_excerpt_from_arra.pdf.

¹⁶ For more information on CMS Center for Medicare & Medicaid Innovation Models, see <http://innovation.cms.gov/initiatives/index.html#views=models>.

¹⁷ "Report to Congress on Children's Health Care Quality in Medicaid and CHIP." December 2010. Note: this report is due every three years. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/RTC_ChildHealthImprovement.pdf.

II. HHS EFFORTS TO IMPROVE QUALITY OF CARE FOR CHILDREN

A. Efforts to Improve the Duration and Stability of Health Insurance Coverage for Children

Medicaid and CHIP provide health insurance coverage to more than one in three children in the United States. Nevertheless, more than four million children remain eligible but uninsured, and many children lose coverage at renewal despite continued eligibility. 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. Over the past three years, HHS has continued its focus on streamlining Medicaid/CHIP enrollment and retention procedures and enhancing outreach efforts. This section describes selected HHS efforts to raise awareness of Medicaid/CHIP coverage, simplify enrollment, and facilitate retention.

1. Efforts to Enhance Outreach

Over the past four years, CHIPRA and the Affordable Care Act authorized \$140 million to support national, state, and local outreach and enrollment efforts, including a national campaign; grants to Indian tribes and providers that serve tribes; and grants to states, community-based organizations, schools, health care provider groups, and others.¹⁸ In 2009, the HHS Secretary announced a new enrollment challenge called “Connecting Kids to Coverage,” to encourage public and private partners to enroll five million eligible but uninsured children in Medicaid/CHIP. The “Insure Kids Now” website is one of the vehicles used to support the outreach and enrollment campaign, a public–private partnership established to reach eligible but uninsured children, enroll them in Medicaid/CHIP, and maintain their coverage as long as they are eligible.

In July 2013, the most recent grant cycle, HHS awarded 41 grants in 22 states totaling \$32 million. These grants had five general aims:¹⁹

1. Engaging schools in outreach, enrollment, and retention activities
2. Bridging health coverage disparities by reaching out to subgroups of children with below-average health coverage rates
3. Designing and implementing targeted enrollment strategies to streamline health coverage enrollment for individuals participating in Supplemental Nutrition Assistance Program (SNAP); Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); or other public benefit programs

¹⁸ For more information, see the Insure Kids Now website at <http://www.insurekidsnow.gov/professionals/outreach/grantees/>.

¹⁹ Centers for Medicare & Medicaid Services. “Connecting Kids to Coverage Outreach and Enrollment Grants.” Available at: <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2013-Fact-Sheets-Items/2013-07-02.html>.

4. Developing application assistance resources to provide high quality, reliable Medicaid/CHIP enrollment and renewal services in local communities
5. Conducting training programs to equip communities to help families understand the new application and enrollment system and to deliver effective assistance to families with children eligible for Medicaid and CHIP

With the implementation of the Affordable Care Act, coordination between Medicaid/CHIP and the Marketplaces (both state-based exchanges and the federally facilitated marketplace) will be essential to minimize confusion and coverage disruptions among families with children currently enrolled in Medicaid/CHIP and ensure that newly eligible family members obtain coverage. HHS will continue to work with states and their partners to support efforts to extend health coverage to those who are uninsured and to maintain coverage among those who already have it.

2. Efforts to Streamline Enrollment and Retention Procedures

CHIPRA established a Performance Bonus Program for states that implemented at least five of eight enrollment simplifications and achieved Medicaid enrollment increases.^{20,21} Program simplification included:

- Continuous eligibility
- Elimination/liberalization of asset and resource requirements
- Use of same forms in both Medicaid and CHIP for application and renewal
- Administrative renewals
- Presumptive eligibility
- Express lane eligibility
- Premium assistance subsidies

In FFY 2009, 10 states received bonuses for implementing at least five of these practices and achieving Medicaid enrollment targets. More states followed, with 16 states receiving bonuses in FFY 2010, 25 states in FFY 2011, and 23 states in FFY 2012.²² Performance bonuses amounted to \$37 million in FFY 2009, and reached more than \$307 million in FFY 2013.²³

²⁰ “Health Policy Brief: Enrolling More Kids in Medicaid and CHIP.” Health Affairs, January 27, 2011. Available at: http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_39.pdf.

²¹ CMS State Health Official Letter: “CHIPRA Performance Bonus Payments.” December 16, 2009. Available at: <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/sho09015.pdf>.

²² Kaiser Family Foundation. “CHIPRA Performance Bonus Awards, FY 2009–FY 2012.” Available at: <http://kff.org/other/state-indicator/chipra-performance-bonuses/>.

²³ CMS and the Center for Medicaid and CHIP Services (CMCS). “CMCS Informational Bulletin: FY 2013 CHIPRA Performance Bonuses.” December 30, 2013. Available at: <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-30-2013.pdf>.

Evaluation results suggest that ELE, one of the eight enrollment simplifications, yields administrative savings for states as well as a more streamlined application process for families.²⁴ Through ELE, states can use eligibility findings from other public benefit programs, such as SNAP to determine eligibility for Medicaid and CHIP. Since 1997, states have had the option to guarantee a full year of coverage to children in their Medicaid and CHIP programs by providing 12 months of continuous eligibility, another of the eight simplifications. Under this option, children retain coverage for 12 months regardless of changes in most family circumstances, such as income or household size. For children and states, the option can mitigate the problems associated with “churning”, the enrollment and re-enrollment of eligible people when they lose coverage for procedural reasons or because of slight fluctuations in income. As of April 2014, 33 states have adopted 12-month continuous eligibility in their Medicaid or CHIP programs for children, compared to 30 states with such a program in January 2009.²⁵ In 2013, 23 states implemented the option in both Medicaid and CHIP programs, compared to 18 states in 2009 with a coordinated policy.²⁶

The Affordable Care Act also included multiple provisions designed to streamline the eligibility and enrollment process. CMS developed regulations, guidance, and multiple tools to assist states in the implementation of these provisions. Eligibility is determined based on modified adjusted gross income, simplifying the determination and bringing consistency to the way income is counted across the country. These new laws and policies are designed to create coordination and alignment across Medicaid, CHIP, and the Health Insurance Marketplace, so beneficiaries and families can have a more seamless experience enrolling in health coverage and less confusion about coverage options.

For example, the Affordable Care Act mandates states to use a single streamlined application to allow applicants to apply for coverage using one application and receive an eligibility determination for all insurance affordability programs, including Medicaid, CHIP, and coverage in a qualified health plan with advance premium tax credits, cost-sharing reductions, or both. Applications are accepted online, over the phone, via mail, and in person. The eligibility procedures used by states were also simplified by updating ways to verify eligibility, moving from paper-based verification to electronic verifications, and increasing reliance on self-attestation. Administrative efficiencies were also gained by changing the process used for renewing a person’s eligibility for the program, requiring states to rely on information known to the system, before requesting additional information from enrollees.

²⁴ Mathematica Policy Research. “CHIPRA Mandated Evaluation of Express Lane Eligibility: Final Findings.” December 2013. Available at: <http://aspe.hhs.gov/health/reports/2013/ELE/ELE%20Final%20Report%20to%20ASPE%2012%2011%2013.pdf>.

²⁵ Insure Kids Now. “Continuous Eligibility for Medicaid and CHIP Coverage.” Available at: <http://www.insurekidsnow.gov/professionals/eligibility/continuous.html>.

²⁶ Georgetown University Health Policy Institute, Center for Children and Families. “Program Design Snapshot: 12-Month Continuous Eligibility.” Available at: <http://ccf.georgetown.edu/wp-content/uploads/2012/03/CE-program-snapshot.pdf>.

In May 2013, CMS issued a State Health Official letter describing other strategies states can use to increase Medicaid/CHIP enrollment and promote more continuous enrollment once enrolled.²⁷ These strategies often require Medicaid systems enhancements. CMS is offering enhanced federal matching funds (at a 90 percent rate for development and a 75 percent rate for operations) for state Medicaid systems changes, as long as those systems meet applicable requirements.²⁸

These opportunities will help to ensure that eligible individuals obtain access to Medicaid coverage in a simple, streamlined manner and that, by aligning coverage policies for parents and children, coverage is better coordinated for families. Although some of these options apply to coverage for parents rather than children, evidence suggests that a parent's health insurance status is strongly associated with a child's health insurance coverage.²⁹ Research shows that, when coverage is extended to parents, more children enroll in Medicaid/CHIP; they stay covered longer; and they are more likely to access health care, including preventive care. Thus, when many parents gain coverage in 2014 as a result of the Affordable Care Act, children's access and coverage may improve as well.

3. Effects of HHS Outreach, Enrollment, and Retention Efforts on Children's Health Coverage

Although it is not possible to isolate the impact of specific efforts on the duration and stability of children's coverage, recent evidence suggests that these efforts, taken together, contributed to a significant increase in Medicaid/CHIP participation rates. Between 2008 and 2011, Medicaid/CHIP participation rates increased more than five percentage points (from 81.7 percent to 87.2 percent) and the number of eligible-but-uninsured children fell by nearly 1 million (from 4.9 million to 4.0 million). In 2011, nineteen states (Alabama, Arkansas, Connecticut, Delaware, Illinois, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Mexico, New York, Rhode Island, Tennessee, Vermont, West Virginia, and Wisconsin) and the District of Columbia had participation rates of 90 percent or higher. In contrast, in 2008 four states and the District of Columbia had rates at or above 90 percent and fifteen states had rates below 80 percent.³⁰

²⁷ CMS State Health Official Letter: "Facilitating Medicaid and CHIP Enrollment and Renewal in 2014." May 17, 2013. Available at: <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-003.pdf>.

²⁸ "Affordable Care Act: State Resources FAQ." April 25, 2013. Available at: <http://www.medicaid.gov/state-resource-center/FAQ-medicaid-and-chip-affordable-care-act-implementation/downloads/Affordable-Care-Act-FAQ-enhanced-funding-for-medicaid.pdf>.

²⁹ U.S. Government Accountability Office. "Medicaid and CHIP: Given the Association Between Parent and Child Insurance Status, New Expansions May Benefit Families." GAO-11-264, February 2011. Available at: <http://www.gao.gov/products/GAO-11-264>.

³⁰ Kenney, G., N. Anderson, and V. Lynch. "Medicaid/CHIP Participation Rates Among Children: An Update." September 2013. Available at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf407769.

Despite significant progress, additional efforts are required to continue to reduce the number of children who are eligible but uninsured. Nationally, four million eligible children have yet to be covered. About half of all eligible-but-uninsured children live in six states: Texas, California, Florida, Georgia, New York, and Arizona. In response, HHS targeted half of the Connecting Kids to Coverage Outreach and Enrollment grants awarded in July 2013 to organizations in these six states.

B. Efforts to Improve Health Care Quality

1. The Quality Roadmap

In 2013, HHS and its partner states continued to build on and advance efforts to improve the quality of health care for children in Medicaid/CHIP. Over the past two years, CMS has used the HHS National Strategy for Quality Improvement in Health Care (National Quality Strategy) as the roadmap for improving the delivery of health care services, patient health outcomes, and population health. The National Quality Strategy aims to align new and existing health care improvement efforts around three goals (better care, healthy people/healthy communities, and affordable care) and to measure progress toward achieving these goals. As Medicaid covers about 44 million children in the United States, it is critical that the quality improvement efforts of the Medicaid program align with and reflect the priorities of the nation as a whole. CMS has a responsibility to implement the six goals of the National Quality Strategy:

1. Make care safer by reducing harm caused in the delivery of care
2. Ensure that each person and family are engaged as partners in their care
3. Promote effective communication and coordination of care
4. Promote effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease
5. Work with communities to promote wide use of best practices to enable healthy living
6. Make quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models

The following sections of this report provide a broad overview of these activities.

2. Preventive Health Care

HHS is leading a number of efforts to improve the health and well-being of children and adults through primary and secondary prevention initiatives. These efforts include both programmatic efforts and population-based efforts. Within the Medicaid program, CMS offered a technical assistance webinar series entitled Promoting Prevention in Medicaid and CHIP in spring 2013. This series featured presentations on the activities of several state Medicaid programs and their collaborations with federal prevention initiatives, managed care organizations, public health

departments, and other stakeholders to improve access to preventive care.³¹ Additionally, CMS launched the Medicaid Prevention Learning Network (Learning Network) in late fall 2013, to help states increase access to and use of preventive services and improve reporting and performance on CMS's prevention-related quality measures. The Learning Network will also provide enhanced technical assistance to states and facilitate exchange of information about promising practices of high-impact, effective preventive care delivery. CMS is also partnering with the Centers for Disease Control and Prevention (CDC) on efforts related to the Vaccines for Children Program, which provides vaccines at no cost to parents of children under age 19 who are enrolled in Medicaid, uninsured, underinsured, or American Indian/Alaskan Native.³²

Several HHS initiatives focus on promoting healthy communities. The National Prevention Strategy provides evidence-based recommendations to increase the health of Americans in seven major areas: (1) tobacco use, (2) drug and alcohol use, (3) healthy eating, (4) active living, (5) injury and violence prevention, (6) reproductive and sexual health, and (7) mental and emotional well-being.³³ Other wide-scale prevention initiatives address specific health issues and health disparities. These include (1) the President's Teen Pregnancy Prevention Initiative, in which the CDC has partnered with the federal office of the Assistant Secretary for Health to fund community-wide initiatives to reduce rates of teen pregnancy and births, with a focus on reaching African American and Latino young adults;³⁴ and (2) the Surgeon General's Call to Action to Support Breastfeeding, which identifies 20 key actions that can be taken by the health care sector, employers, child care providers, and others to increase rates of breastfeeding.³⁵ In addition, the 2012 Report of the Surgeon General on Preventing Tobacco Use Among Youth and Young Adults presents updated evidence on the epidemiology and health consequences of tobacco use among youth, along with evidence-based interventions to address tobacco use among this population.³⁶ More information on HHS's efforts to improve preventive health care for children in Medicaid and CHIP is available in a 2014 Report to Congress on Preventive Services and Obesity-related Services.³⁷

³¹ For more information on the CMS webinar series Promoting Prevention in Medicaid and CHIP, see <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prevention.html>.

³² For more information on the Vaccines for Children Program, see <http://www.cdc.gov/vaccines/programs/vfc/index.html>.

³³ U.S. Department of Health and Human Services. "National Prevention Strategy." Available at: <http://www.surgeongeneral.gov/initiatives/prevention/strategy/index.html>.

³⁴ For more information, see "Teen Pregnancy Prevention 2010–2015. Integrating Services, Programs, and Strategies through Communitywide Initiatives: The President's Teen Pregnancy Prevention Initiative." Available at: <http://www.cdc.gov/TeenPregnancy/PreventTeenPreg.htm>.

³⁵ For more information, see "The Surgeon General's Call to Action to Support Breastfeeding." Available at: <http://www.surgeongeneral.gov/library/calls/breastfeeding/index.html>.

³⁶ For more information, see "Preventing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General." Available at: <http://www.surgeongeneral.gov/library/reports/preventing-youth-tobacco-use/exec-summary.pdf>.

³⁷ The Report to Congress is available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/RTC-Preventive-Obesity-Related-Services2014.pdf>

3. Obesity-Related Initiatives

Nearly 18 percent of children and adolescents are obese, and many more are overweight.³⁸ Because obese children are at increased risk for adverse health outcomes, the obesity epidemic presents an urgent public health challenge.³⁹ Medicaid and CHIP play an integral role in anti-obesity efforts by providing access to screenings and interventions to prevent and reduce obesity, and promoting healthy eating and physical activity.

Section 4004(i) of the Affordable Care Act requires HHS to provide guidance to states and health care providers regarding preventive and obesity related-services, such as screening and counseling, available to Medicaid and CHIP enrollees. States are also required to design public awareness campaigns to educate Medicaid beneficiaries about the availability and coverage of these services. To help meet these requirements, in 2013 CMS hosted a webinar series on Promoting Prevention in Medicaid and CHIP, which included information about successful obesity interventions developed by state Medicaid managed care plans. CMS has also posted information and resources related to obesity on the Medicaid.gov website, and provided individualized technical assistance to states as needed.⁴⁰ More information on HHS's Medicaid and CHIP-specific activities related to obesity can be found in the 2014 Report to Congress on Preventive Services and Obesity-related Services.⁴¹

4. Efforts to Improve Maternal and Infant Health

Nearly two out of every three women enrolled in Medicaid are of childbearing age (19 to 44 years) and Medicaid currently finances about 48 percent of all births in the United States.⁴² States, CMS, federal partners, and other stakeholders and experts are engaged in numerous activities to improve the health of mothers and newborns. At the heart of these efforts is an ongoing emphasis on measuring and reporting the quality of maternal and infant health care. CMS's work in this area began several years ago through the Neonatal Outcomes Improvement Project (NOIP) and was further solidified in June 2011 when CMS and the Center for Medicare & Medicaid Innovation (Innovation Center) hosted a Perinatal Symposium to convene thought leaders to discuss opportunities for CMS to improve perinatal care outcomes. The following are examples of the activities underway at HHS to improve maternal and child health:

- **Strong Start for Mothers and Newborns.** Led by the Innovation Center, the Strong Start for Mothers and Newborns Initiative includes two primary strategies: (1)

³⁸ For more information, see “CDC Childhood Obesity Facts.” Available at: <http://www.cdc.gov/healthyouth/obesity/facts.htm>.

³⁹ For more information, see “Basics About Childhood Obesity.” Available at: <http://www.cdc.gov/obesity/childhood/basics.html>.

⁴⁰ For more information, see “Reducing Obesity.” Available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Reducing-Obesity.html>.

⁴¹ The Report to Congress is available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/RTC-Preventive-Obesity-Related-Services2014.pdf>

⁴² Markus A.R., E. Andres, K.D. West, N. Garro, and C. Pellegrini. “Medicaid Covered Births, 2008 through 2010, in the Context of the Implementation of Health Reform.” *Women’s Health Issues*, vol. 23, no. 5, pp. e273–e280.

testing ways to encourage best practices for reducing the number of early elective deliveries that lack medical indication across all payer types; and (2) a cooperative agreement program to test and evaluate four models of enhanced prenatal care across three settings to reduce preterm births and decrease the cost of medical care during pregnancy, delivery, and the first year of life. In February 2013, 27 recipients received awards to support the testing of enhanced prenatal care in three settings: (1) group or centering visits, (2) birth centers, and (3) maternity care homes.⁴³

- **Expert Panel on Improving Maternal and Infant Outcomes in Medicaid and CHIP.** CMS’s contractor, Provider Resources Incorporated, convened this expert panel quarterly between June 2012 and July 2013 to explore policy and reimbursement opportunities for Medicaid programs to provide better care, improve birth outcomes, and reduce the costs for mothers and infants. In August 2013, the expert panel presented strategies to CMS leadership for consideration as CMS develops implementation plans to improve birth outcomes based on potential impact, available resources, and partnership opportunities. These strategies included enhanced maternal care management, reproductive health, perinatal payment, data measurement, and reporting. Over the next several months, CMS will develop implementation plans for the policy opportunities identified.
- **Collaborative Improvement and Innovation Network (CoIIN).** The CoIIN is a public-private partnership comprised of HRSA, CMS, CDC, state leaders, and others focused on identifying and sharing innovations and evidence-based practices to improve maternal and infant health outcomes. CoIIN teams working in 13 southern states are currently seeking to reduce infant mortality by providing inter-conception care management services to women who had an adverse pregnancy outcome. They are also focused on improving data linkages across Medicaid agencies and departments of public health to facilitate sharing vital statistics information.

CMS has undertaken other efforts to improve infant health outcomes. In 2011, CMS provided guidance to states on coverage of comprehensive tobacco cessation services for pregnant women through Medicaid.⁴⁴ In 2012, CMS produced an issue brief on Medicaid Coverage of Lactation Services and collaborated with the Association of Women’s Health, Obstetric and Neonatal Nurses to disseminate the brief.⁴⁵ Currently, CMS has several efforts in place to reduce early elective delivery, including working with the Medicaid Medical Directors Learning Network to support quality improvement efforts focused on reducing early elective deliveries and enhancing

⁴³ The fourth model, home visiting, implemented by the Health Resources and Services Administration (HRSA), will also be evaluated along with the other three enhanced models of care.

⁴⁴ Section 4107 of the Patient Protection and Affordable Care Act (Affordable Care Act), P.L. 111-148, which amended Title XIX (Medicaid) of the Social Security Act (the Act) to provide for Medicaid coverage of comprehensive tobacco cessation services for pregnant women, including both counseling and pharmacotherapy, without cost sharing. Available at: <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd11-007.pdf>.

⁴⁵ Centers for Medicare & Medicaid Services. “Lactation Services Issue Brief.” 2012. Available at: http://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Lactation_Services_IssueBrief_01102012.pdf.

state data capacity using matched vital records and Medicaid eligibility/claims data. Additionally, CMS launched the following other maternal- and infant-related quality improvement and demonstration projects:

- Under the Adult Medicaid Quality grants, 10 states are implementing quality improvement projects related to maternal and infant health; of these, five states are implementing projects to reduce early elective deliveries, and all states are working to improve measures of maternal health, such as prenatal and postpartum care visits.⁴⁶
- Under the CHIPRA Quality Demonstration Grants, two states (Florida and Illinois) are working to reduce early elective deliveries to improve maternal and infant outcomes.⁴⁷
- In August of 2013, CMS launched a Quality Improvement (QI) Learning Series (QI 201), building on the successful QI 101 webinar series attended by nearly 500 people. The QI 201 Series involves 10 teams focused on developing and implementing specific maternal and infant health projects tailored to their own state needs. The QI 201 Series takes a deeper dive into the topics covered in the QI 101 Series, such as creating aims statements, identifying interventions and measures, and implementing tests of change designed to improve maternal and infant health care quality.

5. Oral Health

Tooth decay remains one of the most common preventable chronic childhood diseases and can cause pain, missed school days, infections, and even death.⁴⁸ Although considerable progress in pediatric oral health care has been achieved in recent years,⁴⁹ CMS continues to work with state partners and other stakeholder groups to increase the number of dental professionals participating in Medicaid and increase awareness of the need for dental care among beneficiaries. In April 2010, CMS launched the Oral Health Initiative to: (1) increase by 10 percentage points (from FFY 2011 to FFY 2015) the percentage of children ages 1 to 20 enrolled in Medicaid for at least 90 continuous days who received a preventive dental service; and (2) increase by 10 percentage points the percentage of children ages 6 to 9 enrolled in Medicaid for at least 90 continuous days

⁴⁶ For more information about the Medicaid Adult Quality Grants, see <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Adult-Medicaid-Quality-Grants.html>.

⁴⁷ In February 2010, CMS awarded CHIPRA Quality Demonstration Grants to 10 grantees (involving a total of 18 states across the 10 grantees). Descriptions of the grantees' projects are in Appendix A.

⁴⁸ Centers for Medicare & Medicaid Services. "Improving Access to and Utilization of Oral Health Services for Children in Medicaid and CHIP Programs: CMS Oral Health Strategy." April 11, 2011. Available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/CMS-Oral-Health-Strategy.pdf>.

⁴⁹ From 2007 to 2011, almost half (24) of all states achieved at least a 10 percentage point increase in the proportion of enrolled children who received a preventive dental service during the reporting year. For more information on the CMS Oral Health Initiative, see <http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-04-18-13.pdf>.

who received a sealant on a permanent molar.⁵⁰ CMS launched an educational campaign in September 2013 targeting oral health education for pregnant women.⁵¹ CMS, through its Health Care Innovation Awards, is funding a children’s oral health initiative focused on children enrolled in Medicaid and the Indian Health System in South Dakota. The goal of the initiative is to improve oral health care for American Indian mothers, their children, and American Indians with diabetes. By coordinating community-based oral care with other types of care or social services, the model is expected to reduce the high incidence of oral health problems in the area; improve patient access, monitoring, and overall health; and lower cost through prevention.⁵²

The ability to accurately measure dental services provided to children is critical to assessing progress toward these goals. To improve the completeness and accuracy of the data being used to set baselines and track progress, CMS developed a data quality improvement process for the annual Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) report, which includes information on dental services provided to children under age 21 enrolled in Medicaid. In addition, the Child Core Set includes two measures related to children’s access to dental care.⁵³ Beginning in FFY 2012, to minimize state burden, the two dental measures were calculated using data reported by all 50 states and the District of Columbia on Form CMS-416. As a result, CMS was able to profile all states’ performance on these oral health measures in the 2013 Annual Secretary’s Report on Children’s Health Care Quality in Medicaid and CHIP.⁵⁴

6. National EPSDT Improvement Workgroup

The EPSDT benefit is vital for Medicaid-enrolled children because it ensures coverage of a comprehensive range of preventive services and all medically necessary health care services prescribed by a physician to treat a condition diagnosed under this benefit, even if the services are not covered under a state’s Medicaid plan.⁵⁵ Recognizing the importance of this benefit, CMS convened a National EPSDT Improvement Workgroup from December 2010 through February 2013 to identify areas for improvement of EPSDT, including increasing the number of

⁵⁰ Centers for Medicare & Medicaid Services. “Improving Access to and Utilization of Oral Health Services for Children in Medicaid and CHIP Programs: CMS Oral Health Strategy.” April 11, 2011. Available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/CMS-Oral-Health-Strategy.pdf>.

⁵¹ For more information, see <http://www.insurekidsnow.gov/professionals/dental/index.html>.

⁵² CMS Health Care Innovation Awards: South Dakota. “Improving the care and oral health of American Indian mothers and young children and American Indian people with diabetes on South Dakota reservations.” Available at: <http://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/South-Dakota.html>.

⁵³ Two of the measures in the Child Core Set focus on oral health: total eligibles who received a preventive dental service (ages 1–20); and total eligibles who received a dental treatment service (ages 1–20). U.S. Department of Health and Human Services. “2013 Annual Secretary’s Report on the Quality of Care for Children in Medicaid and CHIP.” September 2013.

⁵⁴ U.S. Department of Health and Human Services. “2013 Annual Secretary’s Report on the Quality of Care for Children in Medicaid and CHIP.” September 2013. Available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2013-Ann-Sec-Rept.pdf>.

⁵⁵ Centers for Medicare & Medicaid Services. “Early and Periodic Screening, Diagnostic, and Treatment.” Available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html>.

children accessing services under EPSDT and improving quality of data reporting on EPSDT to better evaluate performance. Soon-to-be-released EPSDT strategy guides focus on improving care coordination, adolescent well-care visits, and oral health under EPSDT, as well as outreach and education to families.

7. CHIPRA Quality Demonstration Grants

In February 2010, CMS awarded 10 grants funding 18 states to improve health care quality and delivery systems for children enrolled in Medicaid/CHIP. The Quality Demonstration Grant Program aims to identify effective, replicable strategies for enhancing quality of care for children. Many states are using these funds to support the collection and reporting of the Core Set of Children's Health Care Quality Measures, in addition to various quality improvement projects. As described in Appendix A, the states are engaging in a wide array of quality improvement activities targeted to special populations, such as children with special health care needs, underserved children, and foster care children.

With funding from CMS, the Agency for Healthcare Research and Quality (AHRQ) is overseeing a national evaluation team comprised of Mathematica Policy Research, AcademyHealth, and the Urban Institute to evaluate the CHIPRA Quality Demonstration Program. The goals of the national evaluation are to determine the demonstration's effectiveness in improving the quality of health care provided to children in Medicaid and CHIP and to assess if and how the demonstration increases transparency and consumer choice. The team released five Evaluation Highlights in 2013 focusing on interim findings from the first three years of the Demonstration. The Highlights examined a diversity of topics including (1) how demonstration states are approaching practice-level quality measurement; (2) how selected grantee projects are measuring medical homeness; and (3) how demonstration states worked together to improve adolescent health. Other evaluation activities have included site visits to each of the demonstration states, provision of technical assistance to state-sponsored evaluation teams, and preparation for a survey of parents and child-serving physicians about their perceptions of quality initiatives. More information on the national evaluation is available on AHRQ's website.⁵⁶

8. Behavioral Health Initiatives

HHS supports various initiatives to promote behavioral health among children and adolescents, prevent youth substance abuse and violence, and prevent suicide. Over the past several years, CMS released the following Informational Bulletins and State Medicaid Director letters designed to inform and support state Medicaid and CHIP agencies to improve mental health and prevent substance use among youth:

⁵⁶ For more information on the evaluation of CMS's CHIPRA Quality Demonstrations, see <http://www.ahrq.gov/policymakers/chipra/demoeval/index.html>.

- Informational Bulletin: Collaborative Efforts and Technical Assistance Resources to Strengthen the Management of Psychotropic Medications for Vulnerable Populations⁵⁷
- State Medicaid Director’s Letter: Trauma Informed Care⁵⁸
- State Health Official Letter: Application of the Mental Health Parity and Addiction Equity Act (MHPAEA)⁵⁹
- Informational Bulletin: Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions⁶⁰
- Informational Bulletin: Prevention and Early Identification of Mental Health and Substance Use Conditions⁶¹

In addition to the activities noted above, CMS, through its Health Care Innovation Awards, is funding behavioral health initiatives for children in Medicaid/CHIP. CMS also partners with the Administration for Children and Families (ACF) and the Substance Abuse and Mental Health Services Administration (SAMHSA) to strengthen state systems of prescribing and monitoring psychotropic medication use among children in foster care.⁶² CMS activities include disseminating information and resources on the extent of the problem; promoting the use of the core set of children’s health care quality measures to monitor the quality of Medicaid behavioral health care; and convening directors of Medicaid, state child welfare, and mental health authorities to develop action plans for addressing this issue.⁶³

⁵⁷ CMS and the Center for Medicaid and CHIP Services (CMCS). “CMCS Informational Bulletin: Collaborative Efforts and Technical Assistance Resources to Strengthen the Management of Psychotropic Medications for Vulnerable Populations.” August 24, 2012. Available at: <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-08-24-12.pdf>.

⁵⁸ CMS State Director Letter. “Use of Trauma-Focused Screening, Functional Assessments and Evidence-Based Practices in Child-Serving Settings.” July 11, 2013. Available at: <http://medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf>.

⁵⁹ CMS State Health Official Letter. “Application of the Mental Health Parity and Addiction Equity Act to Medicaid MCOs, CHIP, and Alternative Benefit (Benchmark) Plans.” January 16, 2013. Available at: <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf>.

⁶⁰ CMS and the Center for Medicaid and CHIP Services. “CMCS Informational Bulletin: Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions.” May 7, 2013. Available at: <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf>.

⁶¹ CMS and the Center for Medicaid and CHIP Services. “CMCS Informational Bulletin: Prevention and Early Identification of Mental Health and Substance Use Conditions.” May 27, 2013. Available at: <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-03-27-2013.pdf>.

⁶² CMS State Director Letter. November 23, 2011. Available at: <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-11-23-11.pdf>.

⁶³ Medicaid Medical Directors Learning Network (MMDLN)/Rutgers CERTs, “Antipsychotic Medication Use in Medicaid Children and Adolescents: Report and Resource Guide From a 16-State Study.” Publication No. 1, June 2010. Available at: http://rci.rutgers.edu/~cseap/MMDLNAPKIDS/Antipsychotic_Use_in_Medicaid_Children_Report_and_Resource_Guide_Final.pdf.

In 2012 and 2013, SAMHSA awarded grants and cooperative agreements to cities, states, and tribal organizations across a variety of areas related to community mental health services for children with emotional disturbances, community-level interventions to promote child wellness, and effective treatment and support systems for youth with substance use and/or mental health disorders.^{64,65,66,67}

9. Health Homes for Children and Adults with Chronic Conditions

Section 2703 of the Affordable Care Act created an optional Medicaid State Plan benefit for states to establish health homes to coordinate care for child and adult Medicaid enrollees with chronic conditions.⁶⁸ The health home service delivery model is intended to integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to create a person-centered system of care that achieves improved outcomes for beneficiaries and improved value for state Medicaid programs. CMS is collaborating with federal partners, including SAMHSA and the HHS Assistant Secretary for Planning and Evaluation, to ensure an evidence-based approach and consistency in implementing this statutory provision.⁶⁹ As of June 2014, 15 states have at least one approved Health Home State Plan Amendment (SPA), and 12 others have submitted a SPA or a planning request to CMS.⁷⁰

The impact of the health homes provision will be monitored by CMS. A forthcoming 2014 Report to Congress will provide more detailed information about this program. Section 1945(f) of the Social Security Act requires states that implement health homes to track avoidable hospital readmissions, calculate cost savings that result from improved coordination of care and chronic disease management, and monitor the use of health information technology to improve service delivery and coordination across the care continuum. States are also expected to track emergency room visits and skilled nursing facility admissions for the evaluation.⁷¹

⁶⁴ “Planning Grants for Expansion of the Comprehensive Community Mental Health Services for Children and Their Families.” Available at: <http://www.samhsa.gov/grants/2013/sm-13-001.aspx>.

⁶⁵ “Press Release: Planning Grants for Expansion of the Comprehensive Community Mental Health Services for Children and Their Families.” July 15, 2013. Available at: <http://www.samhsa.gov/newsroom/advisories/1307150448.aspx>.

⁶⁶ “FY 2013 Cooperative Agreements for State Adolescent and Transitional Aged Youth Treatment Enhancement and Dissemination.” Available at: <http://www.samhsa.gov/grants/2013/ti-13-014.aspx>.

⁶⁷ “Safe Schools/Healthy Students State Planning, Local Education Agency, and Local Community Cooperative Agreements.” Available at: <http://www.samhsa.gov/grants/2013/sm-13-006.aspx>.

⁶⁸ For more information on health homes, see <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html>.

⁶⁹ CMS State Medicaid Director Letter. “Health Homes for Enrollees with Chronic Conditions.” November 16, 2010. Available at: <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf>.

⁷⁰ CMS. “State Health Home CMS Proposal Status (effective June 2014).” Available at: http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-MAP_v32.pdf.

⁷¹ CMS State Medicaid Director Letter. “Health Homes for Enrollees with Chronic Conditions.” November 16, 2010. Available at: <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf>.

10. The Pediatric Quality Measures Program

CHIPRA (Pub. L. 111-3) added Section 1139A(a) to the Social Security Act, which requires the development of a Pediatric Quality Measures Program (PQMP) to (1) improve and strengthen 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. The AHRQ-CMS PQMP, funded by CMS and managed by AHRQ, comprises seven CHIPRA Centers of Excellence (CoEs) and two CHIPRA quality demonstration project grantees (Illinois and Massachusetts) focused on developing measures that could be considered as improvements to the initial core set measures. Measures being developed under the PQMP by each CoE encompass topics related to duration of enrollment, availability of services, family experiences of care, identification of children with special health care needs, continuum of care, transitions and care coordination, hospital readmissions, person-reported outcomes, quality of care for children in the child welfare system, quality to cost, prevention and health promotion, and management of acute and chronic conditions.⁷² New research from some of the CoEs on readmission and mental health measures has been published in the *Journal of the American Medical Association and Pediatrics*.⁷³ CMS also is working with the Office of the National Coordinator for Health Information Technology (ONC) to develop new pediatric measures that can be collected through an electronic health record and to electronically specify measures from the initial core set.

C. Quality of Children's Health Care Across the Domains of Quality

HHS is undertaking multiple efforts to improve the quality of health care delivered to children enrolled in Medicaid and CHIP through various domains, including clinical quality, innovation, health care safety, family experience with health care, and elimination of health care disparities.⁷⁴

1. Clinical Quality

CMS's clinical quality strategy is pursued through six priorities: (1) making care safer; (2) strengthening person and family engagement; (3) promoting effective communication and coordination of care; (4) promoting effective prevention and treatment; (5) working with communities to provide best practices of healthy living; and (6) making care affordable. These aims and priorities are reflected in the range of activities CMS currently is pursuing to improve the quality of health care for children in Medicaid and CHIP.

As discussed in greater detail in Section 2, the National Quality Strategy relies on accurate, comprehensive measurement and monitoring of clinical quality, which CMS supplements through the implementation of the core set of children's health care quality measures (Exhibit 1).

⁷² "CHIPRA Measures by CHIPRA Categories." Rockville, MD: Agency for Healthcare Research and Quality, May 2012. Available at: <http://www.ahrq.gov/policymakers/chipra/pqmpmeasures.html>.

⁷³ Berry, Jay G., et al. "Pediatric Readmission Prevalence and Variability Across Hospitals Pediatric Readmissions and Hospital Variability." *JAMA*, vol. 309, no. 4, 2013, pp. 372–380.

⁷⁴ An additional domain, health care in the most integrated setting, is discussed throughout the report.

In partnership with other agencies, HHS is pursuing numerous initiatives to improve the clinical quality of care for mothers and children: CHIPRA Quality Demonstration Grants; the Neonatal Outcomes Improvement Project;⁷⁵ Strong Start for Mothers and Newborns;⁷⁶ the Maternal, Infant, and Early Childhood Home Visiting Program;⁷⁷ Early Hearing Detection and Intervention (EHDI) programs;⁷⁸ and a pilot project on delivery of educational messages through mobile health technology to pregnant and postpartum women. In addition, CMS launched the Oral Health Project in April 2010 with a focus on improving access to and utilization of preventive dental services for children.⁷⁹

Another national clinical quality improvement project, led by AHRQ and part of the HHS National Plan to Prevent Healthcare-Associated Infections and the Partnership for Patients, involved reducing neonatal central line-associated bloodstream infections (CLABSIs) in Neonatal Intensive Care Units (NICUs).⁸⁰ CLABSI is a significant contributor to morbidity and mortality for infants in NICUs because of these patients' immature immune systems.⁸¹ Beginning in August 2011, 100 NICUs in nine states implemented a Comprehensive Unit-based Safety Program (CUSP) and saw a reduction in their overall infection rates.^{82,83} As part of its Children's Core Set measures reporting, CMS is also tracking CLABSI data reported by

⁷⁵ For more information, see CMS Issue Brief, "Reducing Early Elective Deliveries in Medicaid and CHIP." Detailed descriptions of NOIP Grantee projects and outcomes are on pp. 3–4. Available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/EED-Brief.pdf>.

⁷⁶ For more information, see "Strong Start for Mothers and Newborns Initiative: General Information." Available at: <http://innovation.cms.gov/initiatives/strong-start>.

⁷⁷ For more information, see the CMS Fact Sheet, "Strong Start for Mothers and Newborns: Testing Approaches to Prenatal Care." February 15, 2013. Available at: <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2013-Fact-sheets-items/2013-02-15.html?DLPage=7&DLSort=0&DLSortDir=descending>.

⁷⁸ For more information, see "Improving Hearing Screening and Intervention Systems." Available at: http://www.nichq.org/our_projects/newborn_hearing.html.

⁷⁹ For more information, see "CMS Oral Health Strategy: Improving Access to and Utilization of Oral Health Services for Children in Medicaid and CHIP Programs." April 11, 2011. Available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/CMS-Oral-Health-Strategy.pdf>.

⁸⁰ "Intensive Care Units for Newborns in Nine States See Sharp Drop in Bloodstream Infections." Rockville, MD: Agency for Healthcare Research and Quality, January 2013. Available at: <http://www.ahrq.gov/news/newsroom/press-releases/2013/nclabsipr.html>.

⁸¹ "Eliminating CLABSI, A National Patient Safety Imperative: Neonatal CLABSI Prevention: A Progress Report on the National On the CUSP: Stop BSI Project, Neonatal CLABSI Prevention." Rockville, MD: Agency for Healthcare Research and Quality, January 2013. Available at: <http://www.ahrq.gov/professionals/quality-patient-safety/cusp/using-cusp-prevention/clabsi-neonatal/index.html>.

⁸² The nine states are: Colorado, Florida, Hawaii, Massachusetts, Michigan, New Jersey, North Carolina, South Carolina, and Wisconsin.

⁸³ "Intensive Care Units for Newborns in Nine States See Sharp Drop in Bloodstream Infections." Rockville, MD: Agency for Healthcare Research and Quality, January 2013. Available at: <http://www.ahrq.gov/news/newsroom/press-releases/2013/nclabsipr.html>.

hospitals to the CDC National Healthcare Safety Network. The measure includes all neonatal CLABSI events, not just those for infants covered by Medicaid/CHIP.⁸⁴

2. Innovations

The Innovation Center supports initiatives that test new models for delivering and paying for health care, with the ultimate goal of creating systems that offer high quality care at lower costs to Medicare, Medicaid, and CHIP beneficiaries.⁸⁵ Three of the current initiatives target Medicaid and/or CHIP populations with the potential to provide higher quality care to child beneficiaries. The Comprehensive Primary Care (CPC) initiative provides funding to states to offer additional reimbursements to Medicaid providers who provide comprehensive care management, with the goal of increasing the quality of primary care available to Medicaid beneficiaries.⁸⁶ Strong Start for Mothers and Newborns is testing methods to reduce early elective deliveries, and offering funding to providers, states, and others to test three prenatal care approaches to reduce preterm births for Medicaid beneficiaries.⁸⁷ The State Innovation Models initiative funds state efforts to design and test multi-payer payment and delivery models that will improve the quality of health care, particularly for Medicare, Medicaid, and CHIP beneficiaries.⁸⁸

3. Health Care Safety

CMS established the Partnership for Patients (PfP) in 2011. It is a different type of quality improvement intervention. It represents a full-court press, combining the efforts of multiple partners and federal and non-federal programs, in an aligned effort to improve patient safety by reducing Hospital Acquired Conditions by 40 percent and readmissions by 20 percent. The PfP partnership is a consortium of more than 3,700 participating hospitals distributed throughout all 50 states which has committed to improve care by participating with one of 26 hospital engagement networks (HENs). To facilitate this effort, the HENs have established the infrastructure to support these hospitals in improvement, measurement, engaging with patients and families, learning, reporting and generating results. The goals of the PfP initiative include reducing inpatient adverse events, such as adverse drug events, CLABSIs, catheter-associated urinary tract infections, and obstetric events such as early elective deliveries, as well as reducing readmissions through better care transitions and reducing obstetric adverse events.⁸⁹

⁸⁴ U.S. Department of Health and Human Services. Appendices to the “2013 Annual Secretary’s Report on the Quality of Care for Children in Medicaid and CHIP.” September 2013. Available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2013-Ann-Sec-Rept-App.pdf>.

⁸⁵ “CMS Health Care Innovation Awards.” Available at: <http://www.medicaid.gov/State-Innovations.html>.

⁸⁶ “Comprehensive Primary Care Initiative Fact Sheet.” August 22, 2012. Available at: <http://innovation.cms.gov/Files/fact-sheet/CPCI-Fact-Sheet.pdf>.

⁸⁷ “CMS State Innovations.” Available at: <http://www.medicaid.gov/State-Innovations.html>.

⁸⁸ “CMS State Innovation Models Initiative: General Information.” Available at: <http://innovation.cms.gov/initiatives/state-innovations/index.html>.

⁸⁹ “CMS Partnership for Patients: What the Partnership is About.” Available at: <http://partnershipforpatients.cms.gov/about-the-partnership/what-is-the-partnership-about/lpwhat-the-partnership-is-about.html>.

In June 2011, CMS published a final rule implementing Section 2702 of the Affordable Care Act, which prohibits federal Medicaid payments to states for care provided to treat health care-acquired conditions. The final rule required states to implement non-payment policies for a range of provider-preventable conditions (PPCs), which include health care-acquired conditions (HCACs) (applicable to any inpatient hospital settings in Medicaid), as well as other provider-preventable conditions (OPPCs) (applicable to any health care setting).⁹⁰ This policy is intended to provide an incentive for providers to apply best practices in order to prevent secondary conditions and prevent adverse outcomes.

4. Family Experience with Health Care

An important dimension of quality is the patient’s or family’s experience with care. Experience can be measured globally (such as overall satisfaction with the health plan or ability to get needed care), or in relation to a specific event or encounter (such as a medical visit, hospitalization, or nursing home stay). The most commonly used set of tools to measure experiences with health care are AHRQ’s Consumer Assessment of Healthcare Provider System (CAHPS) family of surveys.⁹¹ Two key HHS efforts to promote the understanding of patient and family experiences with health care are as follows:

1. Section 402(a)(2) of CHIPRA requires all Title XXI (CHIP) programs to provide “data regarding access to primary and specialty services, access to networks of care, and care coordination provided under the state child health plan” in their annual reports. Since the children’s CAHPS survey tool is part of the CMS Child Core Set, many states plan to use CAHPS surveys to fulfill the requirement.
2. One of the AHRQ-CMS Pediatric Centers of Excellence, The Boston Children’s Hospital, developed the Child Hospital Consumer Assessment of Healthcare Providers and Systems Survey (Child HCAHPS).⁹² Many of the survey items are taken from the original HCAHPS instrument and are being adapted for pediatric care, though several new domains have been proposed, including those covering the admission process, care coordination, family involvement, cultural competence, child-appropriateness, privacy, safety, and age-specific items (for example, for adolescents). The survey was completed in 2014.

5. Health Care Disparities

Health disparities have been defined as a “particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage.”⁹³ Disparities are documented

⁹⁰ “Medicaid Program; Payment Adjustments for PPCs Including HCACs; Final Rule,” 76 FR 108 (June 6, 2011), pp. 32816–32838. Available at: <http://www.gpo.gov/fdsys/pkg/FR-2011-06-06/pdf/2011-13819.pdf>.

⁹¹ For more information, see the Agency for Healthcare Research and Quality, Consumer Assessment of Healthcare Provider and Systems Survey (CAHPS) overview. Available at: <http://cahps.ahrq.gov/about.htm>.

⁹² For more information, see <http://www.childrenshospital.org/research-and-innovation/research-labs/center-of-excellence-for-pediatric-quality-measurement-cepqm/cepqm-measures/pediatric-hcahps>.

⁹³ Healthy People 2020. Available at: <http://www.healthypeople.gov/2020/about/DisparitiesAbout.aspx>.

in many conditions and in access to health care for adults and children. A number of HHS initiatives seek to eliminate racial, ethnic, and socioeconomic disparities in health and health care, and to ensure more accurate data collection across population subgroups.

The Affordable Care Act includes several provisions to address health and health care disparities, including provisions focused on workforce development, quality of care, prevention and health promotion, and data collection and analysis. One of the key provisions relates to improving data collection and analysis, which will enable a better understanding of the needs, gaps, and opportunities for quality improvement to eliminate health disparities. Section 4302(a) of the Affordable Care Act required HHS to develop data collection standards for five demographic categories—race, ethnicity, sex, primary language, and disability status—and requires that any federally conducted or supported health care or public health program, activity, or survey collect and report data on these categories to the extent practicable. The final data standards apply to the collection of data in HHS-sponsored population surveys where person-level data are collected either via self-report or from a respondent who serves as a knowledgeable household representative.⁹⁴ Section 4302(b) also required that the Secretary evaluate approaches for collecting and evaluating data on health care disparities in Medicaid/CHIP. This evaluation has already led CMS to make changes in the collection and analysis of Medicaid and CHIP data, including:

- Integrating many of the section 4302 data elements into the single, streamlined application that is used to determine eligibility in the new insurance marketplaces
- Updating the data dictionary for the Medicaid Statistical Information System (MSIS), CMS’s primary, claims-based data system, to include the section 4302 data elements
- Integrating the racial and ethnic categories from the section 4302 standards into CMS’s Statistical Enrollment Data System

Further complementing these activities is the HHS Disparities Action Plan, which builds upon the Affordable Care Act, and outlines goals and actions HHS will take to reduce health disparities among racial and ethnic minority groups.⁹⁵ CMS is the lead agency for a number of actions in the HHS Disparities Action Plan, and several of the overarching Secretarial priorities are specific to CMS, including an initiative focused on improving access to dental care for children in Medicaid and CHIP.

⁹⁴ U.S. Department of Health and Human Services, Office of Minority Health. “OMB Standards for Data on Race and Ethnicity.” Available at: <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=172>.

⁹⁵ “HHS Disparities Action Plan: A Nation Free of Disparities in Health Care.” Available at: http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.

III. STATUS OF VOLUNTARY REPORTING BY STATES

As discussed previously, CHIPRA directed the Secretary of HHS to (1) identify and publish an initial core set of children's health care quality measures for voluntary use by state programs administered under Medicaid (Title XIX) and CHIP (Title XXI);⁹⁶ (2) develop a standardized reporting vehicle for the core set of children's health care quality measures;⁹⁷ and (3) annually report state-specific information on the quality of children's health care in Medicaid/CHIP.⁹⁸ CHIPRA also called for the establishment of a national technical assistance program, the Medicaid/CHIP Technical Assistance and Analytic Support (TA/AS) Program, to support states in consistently collecting, reporting, and using the core set of children's health care quality measures.⁹⁹ This chapter summarizes the status of voluntary reporting by states and discusses progress over the past three years.

A. Core Set of Children's Health Care Quality Measures

For the past three years, states have continued to break new ground with standardized reporting on CMS's core set of children's health care quality measures (referred to as the Child Core Set). The 2010 Secretary's Report signaled the first time CMS released state-specific information from voluntary reporting on the Child Core Set, an important milestone in CMS's efforts to uniformly measure and report on the quality of care obtained by children covered by Medicaid/CHIP. Over the next two years, states continued to improve the quality and completeness of the data they collected and reported for the Child Core Set measures. CMS's FFY 2012 goals for quality measurement and improvement were to:

- Increase the number of states reporting on the core measures
- Maintain or increase the number of measures reported by each state
- Improve the completeness of the data reported (that is, report on both Medicaid and CHIP enrollees)
- Streamline data collection and reporting processes, to the extent possible

⁹⁶ For more information on the initial core set measures, see the February 2011 CMS State Health Official letter at <http://www.cms.gov/smdl/downloads/SHO11001.pdf>.

⁹⁷ CARTS is a web-based data submission tool, which serves as the standardized reporting vehicle for the Child Core Set. States are asked to submit and certify core set measure data in CARTS on an annual basis.

⁹⁸ The 2010–2013 Secretary's Reports are available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html>.

⁹⁹ The CMS TA/AS contract is led by Mathematica Policy Research and supported by subcontracts with the National Committee for Quality Assurance, the Center for Health Care Strategies, and the National Initiative for Children's Healthcare Quality. Through the TA/AS Program, CMS works with states to improve the completeness and accuracy of the data reported, and to support states' efforts to build internal capacity to conduct quality improvement projects. Resources are available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html>.

- Support states to drive improvements in health care quality at the local level using data from the Child Core Set

B. Measurement and Voluntary Reporting Using the Child Core Set

CMS continues to gain experience and insight in ways to facilitate state reporting of CMS’s Child Core Set of measures, including streamlining state reporting of the Child Core Set data and evaluating measures for retirement.¹⁰⁰ Additionally, CMS and states have made great strides in reporting since the 2010 Report to Congress,¹⁰¹ most notably:

- All states reported two or more of the Child Core Set measures for FFY 2012 (Exhibit 2). The median number of measures reported by states for FFY 2012 was 14, up from 7 in FFY 2010 and 12 in FFY 2011. Altogether, 35 states reported at least 11 of the 22 core measures to CMS for FFY 2012.¹⁰² Two states, Florida and Tennessee, reported 22 of the core measures for FFY 2012.
- CMS continues to encourage states to report data on the Child Core Set that include both Medicaid and CHIP populations. The completeness of Child Core Set data reported by states improved for FFY 2012. For example, 38 states now include both Medicaid and CHIP populations in one or more measures, up from 23 states for FFY 2010 and 34 states for FFY 2011.
- The most frequently reported measures in the Child Core Set assess children’s access to primary care, well-child visits, and dental services (Exhibit 3).

C. State Performance on the Child Core Set for FFY 2012

The increase in the number of measures reported by states for FFY 2012 has allowed CMS, for the first time, to conduct deeper analysis on 16 Child Core Set measures reported by 25 or more states. These measures reflect a continuum of quality measures within the maternal and child health population, including overall access to primary care and use of well-child care, timeliness and frequency of prenatal care, management of acute and chronic conditions, and use of dental and oral health services. Detailed findings for these measures (including percentiles, trends, and geographic variation) are featured in the Appendix to the 2013 Secretary’s Report.¹⁰³

¹⁰⁰ The 2010–2013 Secretary’s Reports are available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html>.

¹⁰¹ U.S. Department of Health and Human Services. “2011 Report to Congress on the Quality of Children’s Health Care in Medicaid and CHIP.” December 2010. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/RTC_ChildHealthImprovement.pdf.

¹⁰² The base of 22 measures excludes two core measures: (1) the central line-associated blood stream infections (CLABSI) measure, which was obtained from the CDC’s NHSN beginning in FFY 2012; and (2) the otitis media with effusion (OME) measure, which was not collected for FFY 2012 and was retired in 2013 because it draws on CPT-II codes not commonly used by Medicaid/CHIP agencies.

¹⁰³ U.S. Department of Health and Human Services. “2013 Annual Secretary’s Report on the Quality of Healthcare for Children in Medicaid and CHIP.” September 2013. Available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2013-Ann-Sec-Rept.pdf>.

D. Updates to the Core Set of Children’s Health Care Quality Measures

Section 1139A(b)(5) of the Social Security Act provides that, beginning January 1, 2013, and annually thereafter, the Secretary shall publish recommended changes to the Initial Child Core Set. CMS issued a January 2013 State Health Official letter outlining updates to the Initial Child Core Set and the multi-stakeholder process used to inform decision-making.¹⁰⁴ Three measures were added as a result of this process and one of the measures was retired due to reporting challenges cited by state Medicaid and CHIP agencies.¹⁰⁵ States choosing to voluntarily report these new measures can submit data to CMS during the FFY 2013 reporting cycle.

In order to ensure that measures reflect updates to clinical guidelines and current approaches to health care delivery, it is necessary to continue to evolve the pediatric measurement field. As noted in previous sections of this report, the AHRQ-CMS Pediatric Quality Measures Program is developing measures that will be considered for inclusion in future versions of the Child Core Set. Additionally, CMS continues to work with ONC to develop pediatric-focused measures that can be collected through an electronic health record. These measures are currently under development and, once completed, will be considered for inclusion in stage three of the Electronic Health Record Medicaid Incentive Program.

As with the measures themselves, the data systems and sources used to collect information and monitor progress are also subject to periodic adjustments. Learning from the experiences of the past three years of reporting, CMS has made additional refinements to the CMS CARTS reporting system, the vehicle states use to report the children’s quality measures to CMS. CMS has also continued to make progress toward a modernized and streamlined Medicaid and CHIP data infrastructure known as the Medicaid and CHIP Business Information Solutions (MACBIS) initiative. In the future, information collected as part of MACBIS will serve as the primary data source for CMS’s quality reporting and performance measurement capacities for Medicaid and CHIP. CMS expects that these efforts will (1) help ensure that the information is more accurate, complete, and uniform; (2) reduce burden on our state partners; and (3) have the potential to strengthen quality reporting for children, reduce health care costs associated with inefficiencies in the health care delivery system, and ultimately facilitate better health outcomes for children.

¹⁰⁴ CMS State Health Official Letter. “2013 Children’s Core Set of Health Care Quality Measures.” January 24, 2013. Available at: <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-002.pdf>.

¹⁰⁵ The three measures added to the Child Core Set in 2013 are: (1) Medication Management for People with Asthma, (2) Human Papilloma Virus (HPV) Vaccination for Female Adolescents, and (3) Behavioral Health Risk Assessment (for Pregnant Women). One measure was retired: Otitis Media with Effusion (OME) – Avoidance of Inappropriate Systemic Antimicrobials in Children (ages 2–12).

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IV. RECOMMENDATIONS

Over the past three years HHS has continued to identify and implement multifaceted ways to measure, monitor, and improve the quality of health care for children in Medicaid and CHIP. Using a variety of mechanisms, including efforts to expand eligibility to the Medicaid/CHIP program, standardized measurement, and quality-focused demonstration grants, tangible improvements to the quality of health care received by children are just beginning to emerge.

Section 1139A(a)(6) of the Social Security Act, as amended by section 401 of CHIPRA, directs the Secretary of HHS to include in the report to Congress 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. In the FFY 2015 President's Budget, HHS proposed two changes relevant to Medicaid and CHIP quality: one year extension of the Performance Bonus Fund and permanent extension of the ELE for children beyond the end of FFY 2014.¹⁰⁶ These two recommendations are intended to support state efforts to assure comprehensive, continuous coverage of children, while also encouraging reporting on quality of care.

¹⁰⁶ U.S. Department of Health and Human Services. "Fiscal Year 2015 Budget-in-Brief." Available at: <http://www.hhs.gov/budget/fy2015/fy-2015-budget-in-brief.pdf>.

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V. CONCLUSION

With standardized measurement and reporting tools now in place, HHS is working closely with its state partners to more thoroughly measure the care obtained by children covered by Medicaid/CHIP and use the measures to assess and improve the quality of care provided to children in their states. The efforts described in this report are a snapshot of the activities underway across HHS and state Medicaid and CHIP agencies designed to improve the quality of health care provided to children. HHS has implemented activities across a wide range of children's health care quality domains including:

- Health care coverage and enrollment for children in Medicaid and CHIP have improved, with Medicaid/CHIP reaching a higher proportion of eligible children. Further, evidence suggests that CHIPRA bonus payments have provided an impetus for some states to improve their outreach, enrollment simplification, and retention efforts.
- Multiple quality improvement efforts are well underway that cut across all domains of children's health care, with special attention to maternal and infant health, oral health, and prevention.
- State reporting of the Child Core Set is more complete than in FFY 2010, the first year of voluntary reporting of these measures. CMS is working with its state partners to improve the completeness and accuracy of the data to monitor state performance. In addition, the measures are being used to set priorities for child health quality improvement initiatives at both the national and state levels.
- Public-private partnerships support and have helped to accelerate quality improvement initiatives.

Moving forward, HHS will continue to strengthen existing partnerships and build new ones among states, HHS agencies (that is, CMS, HRSA, CDC, SAMHSA, and ACF), health care providers, and program enrollees to continue on the path toward nationally standardized quality measurement and expansion of quality improvement efforts. Among the varied efforts underway, CMS will be focusing on aligning managed care requirements in a way that supports states in the voluntary reporting of the Child and Medicaid Adult Core Set measures.

The quality improvement efforts recently launched by CMS are helping to set the stage for the next generation of efforts designed to improve children's health care and health outcomes to continue to transform Medicaid/CHIP into a high quality system of coverage and care.

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Exhibit 1. 2013 Core Set of Children’s Health Care Quality Measures for Medicaid and CHIP

Measure	Measure Steward	Description	Data Source
Human Papillomavirus (HPV) Vaccine for Female Adolescents	National Committee for Quality Assurance (NCQA)/Healthcare Effectiveness Data and Information Set (HEDIS)	Percentage of female adolescents that turned 13 years old during the measurement year and had three doses of the human papillomavirus (HPV) vaccine by their 13th birthday	Administrative or hybrid
Body Mass Index Assessment for Children and Adolescents	NCQA/HEDIS	Percentage of children ages 3 to 17 that had an outpatient visit with a primary care practitioner (PCP) or obstetrical/gynecological (OB/GYN) practitioner and whose weight is classified based on body mass index percentile for age and gender	Administrative or hybrid
Child and Adolescent Access to Primary Care Practitioners	NCQA/HEDIS	Percentage of children and adolescents ages 12 months to 19 years that had a visit with a primary care practitioner (PCP), including four separate percentages: Children ages 12 to 24 months and 25 months to 6 years that had a visit with a PCP during the measurement year Children ages 7 to 11 years and adolescents ages 12 to 19 years that had a visit with a PCP during the measurement year or the year prior to the measurement year	Administrative
Childhood Immunization Status	NCQA/HEDIS	Percentage of children that turned 2 years old during the measurement year and had specific vaccines by their second birthday	Administrative or hybrid
Immunization Status for Adolescents	NCQA/HEDIS	Percentage of adolescents that turned 13 years old during the measurement year and had specific vaccines by their 13th birthday	Administrative or hybrid
Frequency of Ongoing Prenatal Care	NCQA/HEDIS	Percentage of 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 expected prenatal 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	Administrative or hybrid
Timeliness of Prenatal Care	NCQA/HEDIS	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	Administrative or hybrid

Exhibit 1 (continued)

Measure	Measure Steward	Description	Data Source
Live Births Weighing Less Than 2,500 Grams	Centers for Disease Control and Prevention (CDC)	Percentage of live births that weighed less than 2,500 grams in the state during the reporting period	State vital records
Cesarean Rate for Nulliparous Singleton Vertex	California Maternal Quality Care Collaborative	Percentage of women that 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	State vital records alone or merged with discharge diagnosis data
Behavioral Health Risk Assessment (for Pregnant Women)	American Medical Association (AMA) – Physician Consortium for Performance Improvement (PCPI)	Percentage of women, regardless of age, that gave birth during a 12-month period seen at least once for prenatal care who received a behavioral health screening risk assessment that includes the following screenings at the first prenatal visit: depression, alcohol use, tobacco use, drug use, and intimate partner violence	Electronic health records
Developmental Screening in the First Three Years of Life	Oregon Health and Science University	Percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthday	Administrative or hybrid
Annual Pediatric Hemoglobin A1c Testing	NCQA	Percentage of children ages 5 to 17 with diabetes (type 1 and type 2) that had a Hemoglobin A1c (HbA1c) test during the measurement year	Administrative or hybrid
Well-Child Visits in the First 15 Months of Life	NCQA/HEDIS	Percentage of children that turned 15 months old during the measurement year and had zero, one, two, three, four, five, or six or more well-child visits with a primary care practitioner (PCP) during their first 15 months of life	Administrative or hybrid
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	NCQA/HEDIS	Percentage of children ages 3 to 6 that had one or more well-child visits with a primary care practitioner during the measurement year	Administrative or hybrid
Adolescent Well-Care Visits	NCQA/HEDIS	Percentage of adolescents ages 12 to 21 that had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetrical/gynecological (OB/GYN) practitioner during the measurement year	Administrative or hybrid
Chlamydia Screening	NCQA/HEDIS	Percentage of women ages 16 to 20 that were identified as sexually active and had at least one test for Chlamydia during the measurement year	Administrative
Preventive Dental Services	Centers for Medicare & Medicaid Services (CMS)	Percentage of individuals ages 1 to 20 eligible for Medicaid or CHIP Medicaid Expansion programs, are eligible for EPSDT services, and that received preventive dental services	Form CMS-416

Exhibit 1 (continued)

Measure	Measure Steward	Description	Data Source
Dental Treatment Services	CMS	Percentage of individuals ages 1 to 20 eligible for Medicaid or CHIP Medicaid Expansion programs, are eligible for EPSDT services, and that received dental treatment services	Form CMS-416
Medication Management for People with Asthma	NCQA/HEDIS	<p>Percentage of children ages 5 to 20 that were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period</p> <p>Two rates are reported:</p> <ul style="list-style-type: none"> • Percentage of children that remained on an asthma controller medication for at least 50 percent of their treatment period • Percentage of children that remained on an asthma controller medication for at least 75 percent of their treatment period. <p>This measure is reported using the following age ranges: 5 to 11 years; 12 to 18 years; 19 to 20 years; and total</p>	Administrative
Follow-Up After Hospitalization for Mental Illness	NCQA/HEDIS	Percentage of discharges for children ages 6 to 20 that were hospitalized for treatment of selected mental health disorders and had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge and within 30 days of discharge	Administrative
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication	NCQA/HEDIS	Percentage of children newly prescribed medication for attention-deficit/hyperactivity disorder (ADHD) that had at least three 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, including two rates: one for the initiation phase and one for the continuation and maintenance phase	Administrative
Pediatric Central Line-Associated Blood Stream Infections – Neonatal Intensive Care Unit and Pediatric Intensive Care Unit	CDC	Rate of central line-associated blood stream infections (CLABSI) in pediatric and neonatal intensive care units during periods selected for surveillance	National Healthcare Safety Network (NHSN)
Appropriate Testing for Children with Pharyngitis	NCQA/HEDIS	Percentage of children ages 2 to 18 that were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus test for the episode	Administrative
Annual Percentage of Asthma Patients 2 through 20 Years Old with One or More Asthma-Related Emergency Room Visits	Alabama Medicaid	Percentage of children ages 2 to 20 diagnosed with asthma during the measurement year with one or more asthma-related emergency room (ER) visits	Administrative

Exhibit 1 (continued)

Measure	Measure Steward	Description	Data Source
Ambulatory Care: Emergency Department Visits	NCQA/HEDIS	Rate of emergency department (ED) visits per 1,000 member months among children up to age 19	Administrative
Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey	NCQA/HEDIS	Survey on parents' experiences with their children's care	Survey

Source: Centers for Medicare & Medicaid Services. "Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set): Technical Specifications and Resource Manual for Federal Fiscal Year 2013 Reporting." May 2013. Available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-and-CHIP-Child-Core-Set-Manual.pdf>.

Notes: The measure steward is the organization responsible for maintaining a particular measure or measure set. Responsibilities of the measure steward include updating the codes that are tied to technical specifications and adjusting measures as the clinical evidence changes.

Beginning in FFY 2012, data for the CLABSI measure were obtained from the National Healthcare Safety Network and data for the two core set dental measures were obtained from the Form CMS-416. The OME measure was not collected for FFY 2012 and was retired in 2013.

Exhibit 2. Overview of State Reporting of the Core Set of Medicaid/CHIP Children's Health Care Quality Measures, FFY 2012

	Number of Measures Reported	State Reported at Least One Measure for Both Medicaid and CHIP Populations	Timeliness of Prenatal Care	Frequency of Ongoing Prenatal Care	Live Births Weighing Less than 2,500 Grams	Cesarean Rate for Nulliparous Singleton Vertex	Childhood Immunization Status	Adolescent Immunization Status	Body Mass Index Assessment for Children and Adolescents	Developmental Screening in the First Three Years of Life	Chlamydia Screening	Well-Child Visits in the First 15 Months of Life	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Adolescent Well-Care Visits	Preventive Dental Services	Child and Adolescent Access to PCPs	Appropriate Testing for Children with Pharyngitis	Dental Treatment Services	Ambulatory Care: Emergency Department Visits	Asthma Patients with 1 or More Asthma-Related Emergency Room Visits	Follow-Up Care for Children Prescribed ADHD Medication	Annual Pediatric Hemoglobin A1c Testing	Follow-Up After Hospitalization for Mental Illness	CAHPS Health Plan Survey	
Total	14 (Median)	38	31	25	15	12	34	32	27	12	35	43	46	43	51	43	36	51	28	15	29	13	27	27	
Alabama	21	-	X	X	X	X	X	X	-	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Alaska	15	X	-	-	X	X	-	-	-	X	X	X	X	X	X	X	X	X	X	X	X	-	X	-	
Arizona	7	-	-	-	-	-	X	X	-	-	-	-	X	X	X	X	X	X	-	-	-	-	-	-	
Arkansas	18	X	X	X	X	X	X	X	X	-	X	X	X	X	X	X	X	X	X	-	X	-	X	-	
California	12	X	X	-	-	-	X	X	X	-	X	X	X	X	X	X	X	X	-	-	-	-	-	-	
Colorado	12	X	X	-	-	-	X	X	X	-	X	X	X	X	X	X	-	X	X	-	-	-	-	-	
Connecticut	6	X	-	-	-	-	-	-	-	X	X	-	-	-	X	X	-	X	-	-	X	-	-	-	
Delaware	16	X	X	X	-	-	X	X	X	-	X	X	X	X	X	X	X	X	-	-	X	-	X	X	
D.C.	14	X	X	X	-	-	X	X	X	-	X	X	X	X	X	X	X	X	-	-	-	-	X	-	
Florida	22	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Georgia	20	X	X	X	X	X	X	X	X	-	X	X	X	X	X	X	X	X	X	X	X	X	X	-	
Hawaii	16	X	X	X	-	-	X	X	X	-	X	X	X	X	X	X	X	X	X	-	X	-	X	-	
Idaho	10	X	-	-	-	-	-	-	-	-	X	X	X	X	X	X	X	X	X	X	-	-	-	-	
Illinois	19	X	X	X	X	-	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	-	X	-	
Indiana	15	X	X	X	-	-	X	X	-	-	X	X	X	X	X	X	X	X	-	-	X	-	X	X	
Iowa	21	X	X	X	X	X	X	X	X	-	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Kansas	3	X	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	X	-	-	-	-	-	X	
Kentucky	15	X	X	X	-	-	X	X	X	-	X	X	X	X	X	X	X	X	X	-	-	-	-	X	
Louisiana	7	X	-	-	-	-	-	-	-	-	-	X	X	X	X	X	-	X	-	-	-	-	-	X	
Maine	14	X	-	-	-	-	-	-	-	-	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Maryland	13	X	X	X	-	-	X	X	-	-	X	X	X	X	X	X	X	X	-	-	-	-	-	X	
Massachusetts	17	X	X	X	-	-	X	X	X	-	X	X	X	X	X	X	X	X	-	-	X	X	X	X	
Michigan	15	-	X	-	-	-	X	X	X	-	X	X	X	X	X	X	X	X	X	-	X	-	-	X	
Minnesota	5	X	-	-	-	-	-	-	-	-	-	X	X	-	X	X	-	X	-	-	-	-	-	-	
Mississippi	11	-	-	-	-	-	-	-	-	-	X	-	X	X	X	X	X	X	X	-	X	-	X	X	

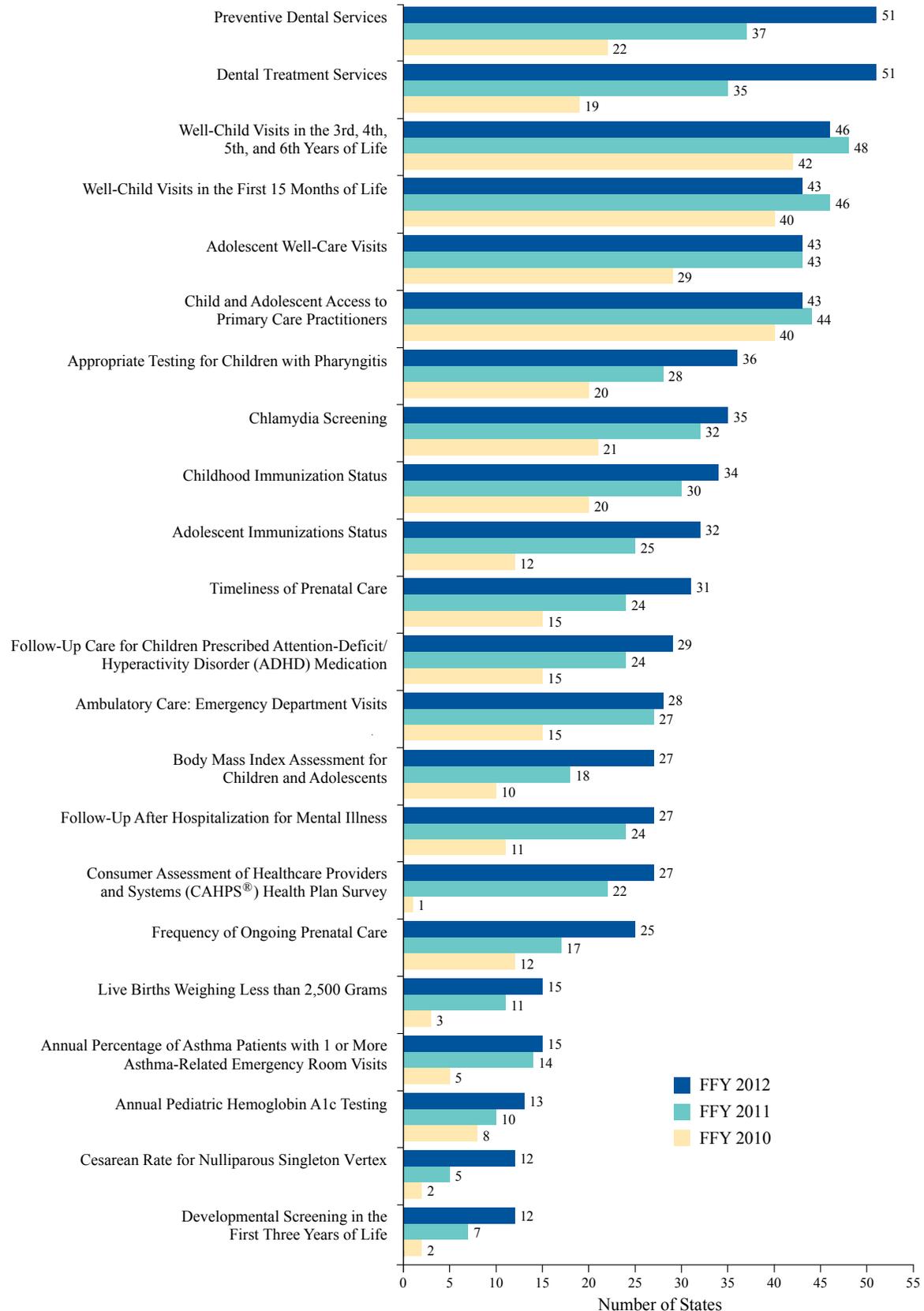
Exhibit 2 (continued)

	Number of Measures Reported	State Reported at Least One Measure for Both Medicaid and CHIP Populations	Timeliness of Prenatal Care	Frequency of Ongoing Prenatal Care	Live Births Weighing Less than 2,500 Grams	Cesarean Rate for Nulliparous Singleton Vertex	Childhood Immunization Status	Adolescent Immunization Status	Body Mass Index Assessment for Children and Adolescents	Developmental Screening in the First Three Years of Life	Chlamydia Screening	Well-Child Visits in the First 15 Months of Life	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Adolescent Well-Care Visits	Preventive Dental Services	Child and Adolescent Access to PCPs	Appropriate Testing for Children with Pharyngitis	Dental Treatment Services	Ambulatory Care: Emergency Department Visits	Asthma Patients with 1 or More Asthma-Related Emergency Room Visits	Follow-Up Care for Children Prescribed ADHD Medication	Annual Pediatric Hemoglobin A1c Testing	Follow-Up After Hospitalization for Mental Illness	CAHPS Health Plan Survey
Missouri	12	X	X	-	-	-	X	X	-	-	X	X	X	X	X	-	-	X	X	-	-	-	X	X
Montana	7	-	-	-	-	-	-	-	-	-	-	X	X	-	X	X	X	X	X	-	-	-	-	-
Nebraska	2	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	X	-	-	-	-	-	-
Nevada	9	-	-	-	-	-	-	-	-	-	-	X	X	X	X	X	X	X	-	-	-	-	-	X
New Hampshire	7	X	-	-	-	-	-	-	-	-	-	X	X	-	X	X	X	X	-	-	-	-	-	X
New Jersey	15	X	X	X	-	-	X	X	X	-	X	X	X	X	X	-	X	X	-	-	X	-	X	X
New Mexico	15	X	X	X	-	-	X	X	X	X	X	X	X	X	X	X	X	X	-	-	X	-	X	X
New York	16	X	X	X	-	-	X	X	X	-	X	X	X	X	X	X	X	X	X	-	X	-	X	-
North Carolina	20	X	X	-	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	-
North Dakota	8	-	-	-	-	-	-	X	-	-	-	-	X	X	X	X	X	X	-	-	-	-	X	-
Ohio	10	X	X	X	-	-	-	-	-	-	-	X	X	X	X	X	-	X	-	-	X	-	-	X
Oklahoma	17	X	-	-	-	-	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	-
Oregon	21	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	-
Pennsylvania	19	X	X	X	X	X	X	X	X	-	X	X	X	X	X	X	X	X	X	X	X	-	-	X
Rhode Island	18	X	X	X	X	-	X	X	X	-	X	X	X	X	X	X	X	X	X	-	X	-	X	X
South Carolina	20	X	X	X	-	-	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
South Dakota	2	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	X	-	-	-	-	-	-
Tennessee	22	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Texas	15	-	X	X	-	-	-	X	-	X	X	X	X	X	X	X	X	X	X	-	X	-	X	X
Utah	12	-	-	-	-	-	X	X	-	-	-	X	X	X	X	X	X	X	-	-	X	-	-	X
Vermont	7	X	-	-	X	-	-	-	-	-	-	X	X	X	X	X	-	X	-	-	-	-	-	-
Virginia	9	X	X	-	X	-	X	-	-	-	-	X	X	X	-	-	-	X	-	-	-	-	-	X
Washington	11	X	X	X	X	X	X	-	-	-	-	X	X	X	-	-	-	X	X	-	-	-	-	-
West Virginia	21	X	X	X	-	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Wisconsin	2	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	X	-	-	-	-	-	-
Wyoming	14	-	-	-	-	-	X	X	X	X	X	X	X	X	X	X	X	X	X	-	-	X	-	-

Source: Based on Mathematica analysis of FFY 2012 CARTS reports.

Notes: This table excludes the OME and CLABSI measures. The OME measure was not collected for FFY 2012 and was retired in 2013. Beginning in FFY 2012, data for the CLABSI measure were obtained from CDC's National Healthcare Safety Network.

Exhibit 3. Changes in the Number of States Reporting the Medicaid/CHIP Children’s Health Care Quality Measures, FFY 2010–2012



Source: Based on Mathematica analysis of FFY 2010–2012 CARTS reports.

Notes: The term “states” includes the 50 states and the District of Columbia.

The FFY 2010 and 2011 counts for the two dental measures reflect the number of states reporting the dental measures in CARTS, whereas the FFY 2012 count reflects the number of states reporting data on Form CMS-416. In FFY 2012, to minimize state burden, CMS began calculating the two dental measures on behalf of states using data reported on Form CMS-416.

Beginning in FFY 2012, data for the CLABSI measure were obtained from the CDC National Healthcare Safety Network. The OME measure was not collected for FFY 2012 and was retired in 2013.

APPENDIX A

OVERVIEW OF THE CHIPRA QUALITY DEMONSTRATION GRANTS

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The CHIPRA Quality Demonstration Program includes 10 lead grantees and 8 collaborating states that are implementing multi-dimensional projects in the following five areas to improve the quality of children's health care: (1) use of quality measures; (2) use of health information technology; (3) implementation of provider-based delivery models; (4) use of a model format for pediatric electronic health records (EHRs); and (5) implementation of other innovative approaches to improve quality. This appendix summarizes activities of the 18 Demonstration states.¹⁰⁷ The lead grantee is shown first (followed by collaborating states).

1. Colorado (New Mexico)

Colorado and New Mexico have developed an initiative focusing on improving adolescent health through school-based health centers (SBHCs). The SBHCs receive training in disease prevention and management; data collection; consultation, referral, and coordination of care; interacting with adolescents; and enabling them to direct their own health care as they mature. To monitor the quality of health in school-age adolescents, Colorado and New Mexico have developed the Youth Engagement with Health Services (YEHS!) survey. The YEHS! instrument was recently evaluated, and results presented at the Society for Adolescent Health and Medicine (SAHM) Annual Meeting in March 2013. Initial results indicate that the YEHS! is a feasible and reliable measure of youth engagement and the quality of care delivered at SBHCs.

2. Florida (Illinois)

Florida and Illinois are collaborating on efforts to improve maternal and infant health outcomes, with a common focus on reducing early elective deliveries using improvement science and evidence-based practices to improve quality. Florida has also been using the CHIPRA demonstration grant to support and expand its Pediatric Medical Home Demonstration Project, known as Change for Kids. In January 2013, Florida's Agency for Health Care Administration (AHCA) announced that 16 pediatric primary care practices serving more than 100,000 children across Florida graduated from AHCA's quality improvement initiative aimed at strengthening medical homes and fostering patient-centered health care. The program has demonstrated improvement in the percentage of medically complex children with an updated care plan at each visit and the number of children receiving screenings during their checkups to assess their needs for specialty follow-up care. In addition to reducing early elective deliveries, Illinois's maternal health project is focused on various quality initiatives surrounding maternal care, including development of a prenatal electronic data set to improve quality of labor and delivery care and reduce system duplication; a prenatal risk assessment tool; and maternity care coordination guidelines for care transitions.

¹⁰⁷ The website for the national evaluation of CMS's CHIPRA Quality Demonstration is available at <http://www.ahrq.gov/policymakers/chipra/demoeval/index.html>.

3. Maine (Vermont)

Maine and Vermont are investing in interventions to improve the health of all Medicaid- and CHIP-eligible children, with a particular focus on children in foster care, through information technology enhancement and the development of a pediatric medical home model. The University of Southern Maine surveyed pediatric and family practices about how they use data, clinical guidelines, and office systems to monitor and improve children's health care quality as part of the grant's "Improving Health Outcomes for Children" (IHOC) initiative. In 2014, a follow-up survey will be conducted to assess how quality improvement has changed in child-serving practices statewide over time in areas targeted for improvement by IHOC (for example, use of Bright Futures and state registries) and within subgroups, including practices participating in IHOC learning sessions. In addition, the CHIPRA grant funds the National Improvement Partnership Network (NIPN), a Vermont-led network of 27 states that have developed Improvement Partnerships to advance quality and transform health care for children and their families.

4. Maryland (Georgia and Wyoming)

These three states are implementing innovative care models to improve the quality of care for children with serious behavioral health challenges. Maryland is implementing a Care Management Entity (CME) model to improve crisis intervention services. Maryland convened a workgroup to design a comprehensive and statewide behavioral health crisis system for children and adolescents. The aims are to reduce inpatient psychiatric hospitalizations, reach children in the least restrictive setting, and reduce behavioral health care costs. The work group conducted an assessment and recommended a robust crisis system that involves a continuum of services, from hotlines to stabilization services. Within Maryland's landscape, the workgroup determined what core crisis components and services are required to increase rapid and competent community access to youth and families in crisis. In addition to implementing the CME model for high-utilizing children, Wyoming is integrating a total health record for health home and electronic health record functions into CME practices. Georgia's approach involves developing and implementing a statewide network of certified parent and youth Peer Support Specialists.

5. Massachusetts

Massachusetts is leveraging its CHIPRA demonstration grant to improve care, focusing on high-impact conditions such as attention deficit hyperactivity disorder, asthma, and childhood obesity, through expansion of a medical home model of care and practice-level quality reporting for children enrolled in Medicaid, CHIP, and commercial insurance plans. The state believes that this comprehensive reporting will provide practices with more complete information about their performance, which may help with planning quality improvement efforts. Massachusetts has addressed various challenges in its effort to implement comprehensive reporting, including identifying a patient-provider attribution methodology and minimizing administrative burden by collecting data from state-level systems.

6. North Carolina

North Carolina is expanding the patient-centered medical home model to improve the health of children with special health care needs, as well as developing a pediatric EHR model that is

applicable to all children. Most recently, the state has been testing and expanding quality measurement and improvement projects through its medical home network, Community Care of North Carolina (CCNC). Fourteen participating networks have received a half-time quality improvement specialist to provide quality measurement and feedback data to providers, identify quality improvement goals, and connect practices to resources and training.

7. Oregon (Alaska and West Virginia)

These three states are targeting low-income rural populations by testing the impact of patient-centered care models and health information technology on pediatric care quality. Oregon has created a Patient Centered Primary Care Home (PCPCH) recognition program to promote their development, and encourage populations covered by the Oregon Health Authority to receive care in this new model. Across the state, more than 170 clinics have been recognized as an official PCPCH model of care. Recognized primary care homes offer a team-based approach to care focused on care coordination and keeping people healthy. At its heart, this model of care fosters strong relationships with patients and their families to better treat the whole person. Primary care homes reduce costs and improve care by catching problems earlier and focusing on prevention, wellness, and community-based management of chronic conditions. Alaska's approach involves adapting the medical home model to the state's rural and frontier practices, while West Virginia is using a virtual learning collaborative approach to assist practices in implementing quality improvement processes.

8. Pennsylvania

Pennsylvania is using the CHIPRA demonstration grant to implement a pediatric EHR model and enhance health information technology-based care coordination efforts for children with developmental delay, behavioral issues, and complex medical conditions. The state established a pay-for-performance system that rewards pediatric practices in seven health systems for extracting and reporting eight of the Child Core Set quality measures from EHRs and either maintaining good performance or improving performance. Providers in Pennsylvania indicated they are initiating new quality improvement efforts as a result of CHIPRA practice-level reports. To increase well-child visits, for example, clinics are redesigning reminder letters and completing reminder calls earlier in the month when parents are more likely to have available cell phone minutes.

9. South Carolina

Through its CHIPRA Quality Demonstration Grant, South Carolina is implementing the medical home model for pediatric practices, and enhancing health care quality for children through provider quality data feedback loops. The state is hosting a learning collaborative for pediatric practices to improve their performance on the core set of children's health care quality measures. The state recently found that all 18 participating practices improved on some measures since baseline reporting began.

10. Utah (Idaho)

Utah and Idaho are supporting the development of medical home models in pediatric practices by embedding Medical Home Coordinators in primary care practices and conducting learning collaboratives to implement multiple quality improvement projects. These projects focus on improving collaboration among pediatric generalists and specialists; implementing care and self-care plans for children with chronic conditions; facilitating care transitions for children with special health care needs; and identifying ways to sustain overall quality improvement efforts.