



Quality Measures for Children's Health: A Place to Start

FORUM SESSION ANNOUNCEMENT

A DISCUSSION FEATURING:

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FRIDAY, APRIL 23, 2010

11:45AM–12:15PM—Lunch

12:15PM–2:00PM—Discussion

LOCATION

Reserve Officers Association
One Constitution Avenue, NE
Congressional Hall of Honor
Fifth Floor

*(Across from the Dirksen
Senate Office Building)*

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OVERVIEW

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), centered on expanding access to health insurance for low-income children, also incorporated provisions to measure and improve the quality of care delivered to those children. By focusing on children in Medicaid and CHIP—which together provide insurance coverage to nearly 40 million children—the law established a leadership role for federal and state governments in improving children's health quality. This meeting will review the CHIPRA quality provisions; the process whereby a core set of quality measures was proposed, evaluated, and recommended; and what this process revealed about the state of the art of quality measurement. It will also consider implementation challenges and the potential for states to become quality leaders.

SESSION

A dearth of quality measures designed for children has been lamented by pediatric professionals for years. Too often, the quality of care received by children has been a matter of anecdote and surmise. Where it could be studied, the news was not good: for example, landmark research by Rita Mangione-Smith and colleagues for RAND demonstrated that, on average, only 46.5 percent of children receive recommended care.¹ While its primary goal was coverage expansion, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) also addressed the quality gap, with provisions intended not only to improve quality of care, but to institute a process whereby quality measures can be systematically tested, evaluated, and upgraded over time.

Title IV of CHIPRA called for the Secretary of the Department of Health and Human Services (DHHS) to identify and publish for general comment an initial, recommended set of child health quality measures, further specifying that the core set be drawn from "existing quality of care measures for children that are in use under public and privately sponsored health care coverage arrangements, or that are part of reporting systems that measure both the presence and duration of health insurance coverage over time."² Measures in particular areas were stipulated, including duration of enrollment and coverage, preventive services, treatment and services for acute and chronic conditions, and availability of care in ambulatory and integrated systems.

The legislation also called for consultation with a broad range of clinicians, advocates, state programs, and other experts.

To carry out these directives, the Agency for Healthcare Quality and Research (AHRQ) and the Centers for Medicare & Medicaid Services (CMS) signed a Memorandum of Understanding in April 2009. This gave AHRQ the lead in identifying the initial core measure set and CMS the authority for implementation. AHRQ created a subcommittee to its National Advisory Council (NAC), the Subcommittee on Children's Healthcare Quality Measures for Medicaid and CHIP Programs, known as the SNAC.

The SNAC was charged with (i) providing guidance on criteria for identifying an initial core measurement set; (ii) providing guidance on a strategy for gathering additional measure information from state programs and others; and (iii) reviewing and applying criteria to measures currently in use by Medicaid and CHIP programs.³ The validity and feasibility of a set of 77 measures, drawn from the National Committee for Quality Assurance's (NCQA's) Healthcare Effectiveness Data and Information Set (HEDIS), state Medicaid programs, and other sources, were first evaluated by the group. Importance was subsequently added as a third domain. In determining importance, the SNAC considered such things as whether a measure were actionable by state Medicaid, CHIP, and managed care plans; whether the cost of the care and the extent of the quality problem related to the measure were substantial; and whether variation in performance on the measure could be documented.

After two voting meetings (and much work surrounding them), the SNAC recommended a set of 24 measures to the NAC in the fall of 2009. These include 13 measures of the quality of prevention and health promotion service, 5 measures of the quality of care for acute conditions, 4 measures of the quality of care for chronic conditions, and 1 measure each related to access and to family experience of care. (Each measure is expressed as a percentage indicating how often recommended care is delivered. See Table 1, next page, for examples.) No measures met the necessary criteria in the statutorily required categories of duration of coverage or care provided in integrated care settings. The SNAC agreed that measures needed to be developed in other areas, including specialty care, inpatient care, substance abuse services, mental health treatment, and health outcomes.

According to the SNAC, the set of 24 measures addresses care across multiple settings, multiple conditions, and multiple ages. However, the SNAC emphasized that the measures would need to

TABLE 1: Examples of Quality Measures

CATEGORY	MEASURE	NUMERATOR	DENOMINATOR
Prevention/ Health Promotion	Timeliness of prenatal care	Number of women in sample who had a prenatal visit in first trimester or within 42 days of enrollment	Sample of all deliveries in measurement year
	Chlamydia screening for women	At least one Chlamydia test during measurement year	Women ages 16 to 20 identified as sexually active
Management of Acute Conditions	Appropriate testing related to antibiotic dispensing for pharyngitis	A strep test was administered in the seven-day period surrounding the first episode	Children ages 2 to 18 who had an outpatient visit with a diagnosis of pharyngitis and were dispensed an antibiotic
Management of Chronic Conditions	Annual hemoglobin A1C testing	Number of patients in sample who have documentation of test date and result	Sample of patients ages 5 to 17 with diagnosis of diabetes

be reconfigured to be able to reflect children’s health care quality across all Medicaid and CHIP programs, consumers, and intermediaries such as health plans contracting with Medicaid. For example, HEDIS measures are designed to be reported by managed care plans and therefore may be difficult to use in CHIP or Medicaid plans with little or no managed care.

A period for public comment on the draft core measure set closed March 1, 2010. AHRQ and CMS are reviewing comments received with an eye to developing joint recommendations. By January 1, 2011, the Secretary must establish an ongoing program that will monitor and improve on the initial core measure set, publishing recommended changes and additions annually thereafter. The Secretary will award annual grants to states of up to \$20 million to develop and test pediatric quality measures. Along with providing technical assistance to states, CMS will implement quality demonstrations called for in CHIPRA, identify and share best practices, develop a standardized reporting format for states, and establish a program for developing a model electronic health record for children in Medicaid and CHIP.

CHIPRA requires states to submit an annual report to DHHS on child health quality; however, it does not mandate that they use the core measure set as their basis for reporting. Most states will receive enhanced administrative funding to support data collection and reporting.

KEY QUESTIONS

- Are there particular challenges with respect to measuring children's health care, compared with adults'? To what extent was children's health quality being measured before CHIPRA?
- What was the process the SNAC used to evaluate measures? Can it serve as a model for selecting core quality measures for other populations, for example Medicaid-eligible adults, as called for in the Patient Protection and Affordable Care Act? Would SNAC members recommend any modifications to the process?
- How will development proceed in areas where the SNAC found measures to be lacking?
- What are next steps for states? For CMS?
- How will data reported by states be collated, analyzed, and reported back to states? To providers?

SPEAKERS

Jeffrey Schiff, MD, medical director of Minnesota Health Care Programs and division director at the Minnesota Department of Human Services, was co-chair of the Agency for Healthcare Quality and Research's Subcommittee on Children's Healthcare Quality Measures for Medicaid and CHIP Programs (SNAC). **Mary McIntyre, MD**, medical director of the Office of Clinical Standards and Quality for the Alabama Medicaid Agency, also served on the SNAC. Drs. Schiff and McIntyre will talk about the SNAC's process and findings as well as state implementation of quality measurement and reporting. **Barbara Dailey**, director of the Division of Quality, Evaluation & Health Outcomes in the Centers for Medicare & Medicaid Services, will talk about CHIPRA's requirements and next steps at the federal level.

ENDNOTES

1. Rita Mangione-Smith *et al.*, "The Quality of Ambulatory Care Delivered to Children in the United States," *New England Journal of Medicine*, 357, no. 15 (October 11, 2007): pp. 1515–1523; available with subscription at <http://content.nejm.org/cgi/content/short/357/15/1515>.
2. Children's Health Insurance Program Reauthorization Act of 2009, P.L. 111-3, February 4, 2009; text available at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_public_laws&docid=f:publ003.111.pdf.
3. Agency for Healthcare Research and Quality, "National Advisory Council on Healthcare Research and Quality Subcommittee (SNAC)-recommended Initial Core Set," September 18, 2009; available at www.ahrq.gov/chip/coreset.htm.