



2009 Children's Health Insurance Program (CHIP) Reauthorization Includes Historic Expansion of Quality Measurement

SUMMARY OF QUALITY MEASUREMENT PROVISIONS

On February 4, 2009, President Obama signed the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), ensuring continued and potential expansion of health coverage for 11 million children through September 30, 2013. The continuation of the program is itself major news, but the act also included some very significant provisions to improve quality that will help advance the agenda for performance-based health reform. For the first time, states will be required to report annually to the Secretary of the Department of Health and Human Services (HHS) on the quality of health care that children are receiving in *both* Medicaid and CHIP. A limited quality reporting requirement has existed in the CHIP statute from the beginning, but there has never been a similar requirement for state Medicaid programs, and the CHIP efforts had received little federal encouragement and support. The importance of measuring quality of care provided to children is a priority among many advocates, given that on average, children are provided the appropriate level of care less than 50 percent of the time.¹

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These new quality provisions are the result of many years of work, particularly by consumer advocates and provider organizations concerned about the dearth of information available regarding the quality of care available to children. With this legislation, HHS will now:

- Require state reporting of quality information about Medicaid and CHIP to HHS annually;
- Designate an initial core set of quality measures and fund the development of a broader, more comprehensive set;
- Publish the data that states report;
- Provide technical assistance to states to assist them in adopting and utilizing the measures; and
- Establish a permanent pediatric quality measures program.

The Act also funds up to 10 grants to state and child health providers for demonstration projects to test new measures and models, including use of more health information technology, that show promise of improving pediatric health care quality. A more detailed description of these important provisions follows.

These quality reporting provisions are major expansions but they also underscore how little actionable information is available regarding the quality of care provided to children. The critical gaps in performance reporting related to pediatric care include:

- Few meaningful measures (e.g. ones that look at outcomes and functional status) at the individual clinician and hospital levels;

¹ Mangione-Smith, R., et al., "The Quality of Ambulatory Care Delivered to Children in the United States," *The New England Journal of Medicine*, Vol. 26, No. 5, September 2007, pp 644-649.

- Children's health care performance measures based on information that combines public and private sectors (and where data is not combined, measures should be aligned); and
- The need for effective vehicles to publicly report performance information

The resources made available under the new law will be very helpful in addressing these gaps.

The voices of consumers, labor and employers will be important during the implementation phase to ensure that:

- The measures that make up the core measure set and the pediatric quality measures expansion set include reporting of patient experience data using CAHPS, as well as outcome measures;
- The measures include maternity care measurement, given that Medicaid and CHIP pay for nearly half of the births in the United States and the quality of maternity care can impact the health of the newborn;
- The electronic health records (EHRs) that are called for in funded demonstration projects include data on gender, ethnicity/race, and language in order to facilitate collection of the data necessary to address disparities in care, as well as patient safety; and
- The standardized format for reporting the core measures and other quality information is developed in a way that is patient-centered and consumer-friendly.

CHIPRA PROVISIONS FOR DEVELOPING A CORE AND EXPANDED MEASURE SET

The Act requires HHS, by January 1, 2010, to identify and make available for public comment an initial set of core child health quality measures recommended for use by states for both Medicaid and CHIP. The core measure set must *at least* include:

- An enrollee's duration of coverage over a 12 month period;
- The availability and effectiveness of preventive services, services for acute and chronic conditions, and behavioral health services;
- Availability of ambulatory and inpatient care; and
- Other measures that can be used to gauge overall quality of health care for children as well as to identify disparities in care.

The inclusion of specific reference to disparities is the result of many years of advocacy and reflects the expansion of measurement to assure health care is indeed equitable.

By January 1, 2011, HHS must establish a pediatric quality measures¹ program to improve and expand upon the core set as well as fund the development and testing of new measures. That work must be done in consultation with purchasers, consumers, providers, and measurement specialists. Annual updates to the core set will be mandated beginning in 2013. It is likely that the core set will initially only be used at the state and health plan levels;

While there is no express discussion of individual physician or hospital measurement in the CHIPRA legislation, there is hope that between the update process itself and the stakeholders who participate in it, there will be avenues to address this gap. What may be more fruitful initially, however, is for advocates to focus on ensuring that states consistently collect the same data in order to build a nationwide dataset that has depth and integrity.

The new state and health plan measurement efforts build on CMS initiating voluntary requests to states in 2002 to include in their annual CHIP reports information on the state's use of certain measures from the National Committee for Quality Assurance (NCQA) Health Plan Employer Data and Information set (HEDIS). These four measures include:

² Note that the term "pediatric quality measure" is very broad: "A measurement of clinical care that is capable of being examined through the collection and analysis of relevant information, that is developed in order to assess one or more aspects of pediatric health care quality in various institutional and ambulatory health care settings, including the structure of the clinical care system, the process of care, the outcome of care, or patient experiences in care."

- Child and adolescent access to primary care practitioners (reported in four age groups)
- Number of well-child visits in the first 15 months of life (reported in seven parts, from percentage having zero visits up to percentage having six visits or more)
- Annual well-child visits for ages 3 through 6
- Use of appropriate medications for children with persistent asthma (reported in three age groups)

States were not required to use the measures, and could deviate from the NCQA specifications. Over time, an increasing number of states have started using these four measures in a comparable manner, with 34 states reporting on one of the measures (treatment of children with asthma) by 2005³. Most of the data comes to the states from the health plans with whom they contract, but some states (e.g., Arkansas and Oklahoma) use the measures in a solely fee-for-service environment, in effect evaluating the state's performance as if it were itself the health plan.

The core measure set is expected to build on the states' experience with these four measures and expand the set to include additional mandated measures of coverage duration and availability of care. It must also facilitate the identification of racial, ethnic, and socioeconomic disparities in child health and health care. A number of states also regularly seek patient experience of care data in their CHIP and/or Medicaid programs. Since the core measure set includes reference to patient experience measures there is the potential to expand standardized patient experience reporting. What additional measures, and at what level – e.g. health plan, physician, hospital – will be included in the core and expansion sets, are areas where the input of advocates in the consumer, labor and purchaser communities will be critical. Without quality measurement at the physician and hospital levels, CHIP and Medicaid members will not have the tools they need to make informed health care choices. In addition, without this information, providers will not have the information they need to improve and states and health plans will not have the information they need to reform payments to foster quality improvement.

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Beginning on July 1, 2009, CHIP will be required to adhere to the same managed care beneficiary protections as applies to Medicaid. Some of these protections relate to quality assurance standards, which include the provision of enrollment notices, instructional materials, and comparative information on services available and the quality and location of such services. Others relate to beneficiary rights, including the right of a beneficiary to terminate enrollment without cause within the first 90 days or at least every 12 months thereafter, and the provision of information on benefits not covered and where such benefits may be available.

CHIPRA PROVISIONS FOR PERFORMANCE REPORTING

The reauthorization bill includes a number of provisions related to internal and public reporting:

- Beginning not later than September 30, 2010 HHS shall collect, analyze and make publicly available the Medicaid and CHIP quality information that states report to the Department.
- By 2011, HHS must develop a standardized format for reporting the recommended core measures and other quality information.
- HHS will be required to provide technical assistance to states to assist them in their quality measurement work, including sharing strategies for collecting information from providers in a timely manner, assuring data accuracy, and improving efficiency of data collection through use of health information technology.
- HHS efforts to improve quality under Medicaid and CHIP, including the status of states' voluntary use of the core measurement set, must be documented in a report presented from HHS to Congress every three years, beginning on January 1, 2011.

³ L. Partridge, Review of Access and Quality of Care in SCHIP Using Standardized National Performance Measures, National Health Policy Forum, George Washington University, April 4, 2007, www.nhpf.org.

While there is strong concern about relying on “voluntary” reporting by the states, establishing a core set of measures – as well as the federal technical support for adopting them – are important first steps that advocates can build upon for consistent nationwide reporting in the future.

CHIPRA FUNDING FOR QUALITY MEASUREMENT AND IMPROVEMENT

The bill appropriates a total of \$45 million in *each* of the next five years (2009-2013) for the quality activities. Unspent funds can be rolled over into the next fiscal year. Some of the funding is tied to specific activities, such as:

- \$20 million for grants to states and/or child health providers for the purpose of testing and evaluating promising measures and/or ideas for improving children’s health care (the number of grants is capped at 10 total over the five years);
- \$5 million allocated to HHS to encourage development and dissemination of a model electronic health records for children in CHIP or Medicaid; and
- \$1 million for an Institute of Medicine study of pediatric health and health care quality measures, the study to be completed by summer of 2010.

These programs provide an opportunity for advocates to push for programs and projects that address outcomes, move measurement to the clinician and hospital settings and that leverage initiatives that are in place in the private sector, particularly in the area of EHRs.

NEXT STEPS

As this brief describes, there are many opportunities for advocates to build on the CHIPRA provisions to assure that quality measurement fosters higher quality care. See Table 1 below for dates to keep in mind.

TABLE 1: SCHEDULE OF CHIPRA ACTIVITY

Date	Action
1/1/2010	HHS must identify and put out for public comment the initial set of core child health quality measures HHS must establish a model electronic health record for children.
9/30/2010	HHS must collect, analyze and make publicly available the information reported to it by the states
1/1/2011	HHS must develop pediatric quality measure program to expand on the initial core measurement set and consult with a wide group of interested parties.
2/4/2011	HHS must develop a standardized format for state reporting of quality data to HHS
1/1/2013	HHS must publish recommended changes to core measure set in 2013, and annually thereafter

As Notices of Proposed Rule Making, public comment periods, and other opportunities for involvement arise, the Consumer-Purchaser Disclosure Project will notify its constituents.