

March 1, 2010

Dr. Carolyn Clancy
Administrator, Agency for Healthcare
Research and Quality
540 Gaither Road
Rockville, MD 20850

File Code: CMS-2474-NC

Re: Comments on Initial Core Set of Children's Healthcare Quality Measures for Voluntary Use by Medicaid and CHIP Programs

Dear Dr. Clancy:

The Consumer-Purchaser Disclosure Project, representing consumer, labor and purchaser interests, is pleased to have the opportunity to comment on the proposed core set of quality measures for use in Medicaid and Children's Health Insurance Program (CHIP). We commend AHRQ and CMS' continued commitment to the expansion of quality data collection and public reporting, and appreciate their efforts in fostering increased transparency and promoting the concept of using measurement to improve quality throughout our health care system. We believe that quality measurement is an essential component of transforming the health care system into one that delivers appropriate, high quality, efficient, equitable, and patient-centered care. Public accountability has been sorely lacking in Medicaid and CHIP. Our members are committed to using measurement to improve quality and ensure that all Americans have access to publicly reported health care performance information. We believe that all consumers – regardless of whether their care comes through the private or public sectors – should be able to select hospitals, physicians, and treatments based on nationally standardized measures for clinical quality, consumer experience, equity, and efficiency, and that by reporting on the quality of care, providers and health plans are held accountable for improving the care they deliver. On average, children are provided the appropriate level of care less than 50 percent of the time¹, a finding that truly underscores the necessity of measuring the quality of care that this population receives. By expanding the quality reporting program for Medicaid and CHIP, AHRQ is playing a pivotal role in fostering increased transparency, and promoting a market that recognizes quality. Our comments address: 1) suggestions for improving the voluntary core measure set; and 2) recommendations for driving nationwide use of the voluntary core measure set.

Core Measure Set

We are very pleased to see four prenatal/perinatal care measures included, given that a) Medicaid and CHIP pay for nearly half of the births in the United States; and b) the quality of maternity care can impact the health of the newborn and subsequent costs to the Medicaid and CHIP programs. We are also very pleased with the inclusion of the Child Version of CAHPS 4.0, including the "children with chronic conditions" supplement. Collecting this patient experience is critical to both improving quality of care delivered at the provider and health plan level, and to transforming the system into one that is patient-centered.

In general, we understand the importance of utilizing measures that many states may already be collecting, in order to make this new quality measure activity gain traction. However, we do note that with a few exceptions, most of the 24 core measures proposed in the proposed rule are process measures that are likely to have little resonance with consumers. Given that the CHIPRA legislation specifically outlined a goal of public reporting of

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.

performance information, it is crucial that measures meaningful to consumers – including those that focus on outcomes and functional status, as well as measures that report quality at the clinician and hospital levels – be added to the core set. While concentrating on HEDIS measures that states are familiar with is a pragmatic way to begin building the core set, we strongly urge CMS to look beyond process measures, and include measures that will demonstrate variation in outcomes to consumers, states, and providers. Further, without quality measurement and reporting at the physician and hospital levels, CHIP and Medicaid members will not have the tools they need to make informed health care choices and work with their doctor to chart the best course of care given their situation. 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. Our comments on specific measures include:

- States do not have experience with collecting measure 19, “*annual number of asthma patients (>= 1year old) with >= 1 asthma related ER visit.*” While it is a reasonable measure, states do not have experience with collecting it, unlike the HEDIS measure “*appropriate medications for children with persistent asthma*” which is one of the four CHIP measures that states were asked to voluntarily submit starting in 2002 and is already being collected by 20 states. We ask that you eliminate measure 19 and replace it with the HEDIS measure, or at the very least, add the HEDIS measure to the core set to provide a more comprehensive picture of how well chronic asthma is being managed.
- In addition to the child version of CAHPS, we urge you to accept the recommendation of the AHRQ special subcommittee on quality measurement in Medicaid and CHIP by including the Clinician and Group CAHPS survey in the core measure set. The C&G CAHPS survey will address the concerns raised above, regarding the lack of measures in the core set for raising accountability at the individual and group provider level, and ensuring that we use measures that are meaningful to consumers.

Beyond adding to the core measure set, we applaud both AHRQ and CMS for their commitment to working with the states to help them collect data under consistent specifications, which will be necessary in order to build a national dataset that has depth and integrity. The core measure set – if collected and reported by all 50 states – will succeed in creating a nationwide database; the concern is the “if.” Without a required data collection effort, the goals envisioned by the CHIPRA legislation will not be realized.

Driving Nationwide Use of the Core Measure Set

The proposed rule asked for suggestions on how to achieve the goal of all states reporting this information. To ensure that the core measures are collected, and subsequently that information will be available to drive decision-making, payment reforms, and quality improvement, respectively, there must be specific mechanisms in place to foster states’ participation in this reporting initiative. CMS needs to develop a standardized format for reporting the core measures and other quality information in a way that is patient-centered and consumer-friendly. We suggest inviting the states to participate and be partners in developing the design of this format, in order to get broader buy-in to the notion of bringing the quality measurement enterprise to the Medicaid and CHIP programs. In the absence of any financial incentive or penalty being placed on states for reporting data on these measures, we believe that meaningful involvement of all key stakeholders will help encourage states to “race to the top.”

On behalf of consumers and purchasers across the country, thank you for your efforts and your responsiveness to our comments. If you have any questions, please contact either of the Disclosure Project’s co-chairs, Peter V. Lee, Executive Director for National Health Policy of the Pacific Business Group on Health, or Debra L. Ness, President of the National Partnership for Women & Families.

Sincerely,



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Executive Director for
National Health Policy
Pacific Business Group on Health



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President
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