# Systematic Evidence-Based Quality Measurement Life-Cycle Approach to Measure Retirement in CHIPRA

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## Abstract

***Objective:*** In 2009, Centers for Medicare and Medicaid Services (CMS) publicly released an initial child core set (CCS) of health care quality measures for voluntary reporting by state Medicaid and Children's Health Insurance Program (CHIP) programs. CMS is responsible for implementing the reporting program and for updating the CCS annually. We assessed selected CCS measures for potential retirement.

***Methods:*** We identified a 23-member external advisory group to provide relevant expertise. We worked with the group to identify 4 major criteria with multiple subcomponents for assessing the measures. We provided information corresponding to each criterion and subcriterion, using a variety of sources such as the 2009 Medicaid Analytic eXtract (MAX), state-level Medicaid and CHIP data submitted to the CMS, and summaries of published literature on clinical and quality improvement effectiveness related to the CCS topics. Using this information, the group: 1) used a modified Delphi process to score the measures in 2 anonymous scoring rounds (on a scale of 1 to 9 in each round); 2) voted on whether each measure should be retired; and 3) provided narrative explanations of their choices (which formed the basis of our qualitative findings). Recommendations were reviewed by CMS before promulgation to state programs.

***Results:*** The Subcommittee of the National Advisory Council on Healthcare Research and Quality (SNAC) recommended that the 4 major criteria be importance, scientific acceptability, feasibility, and usability. The SNAC recommended 3 measures for retirement: access to primary care; testing for strep before recommending antibiotics for pharyngitis; and annual HbA1c testing of children with diabetes. Explanations for suggesting retirement of the measures included: views that the well-visit measures were a better measure of access than the primary care measure; a likely ceiling effect (pharyngitis); and the paucity of clinical evidence and low prevalence (both for HbA1c). CMS recommended that state Medicaid and CHIP programs retire 2 of the recommended measures from the CCS, but retained the access to primary care measure.

***Conclusions:*** Periodic reassessment of the value of health care quality measures can reduce reporting burden and allow measure users to focus on measures with higher likelihood of leading to improvements in quality of care and child health outcomes.

**Keywords:** AHRQ; CHIPRA; CMS; quality measures

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In an environment with increasing quality measurement demands,[1] attention to the life cycle of quality measures is essential.[2] A life-cycle approach to quality measurement may involve the periodic examination of measures to determine whether or not they continue to be important, valid, and feasible for use.[3] Unthinking continued use of quality measures—the alternative to a life-cycle approach—creates unwarranted burdens on reporting entities and can limit opportunities for more valuable measures to enter the marketplace and drive improvements in quality, equity, and child health.[4] Here we report on an effort to reexamine selected health care quality measures from a child core set (CCS) voluntarily reported on by a number of state Medicaid and Children's Health Insurance Program (CHIP) programs over the 3 federal fiscal years (FFY) from 2010 through 2012.

## Background

As described fully by Mangione-Smith et al,[5] under the auspices of the 2009 Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), an expert panel (the 2009 Subcommittee of the National Advisory Council on Healthcare Research and Quality [2009 SNAC]) established and used 3 principal criteria (importance, validity, and feasibility) and a series of Delphi processes and voting to recommend an initial CCS relevant to all child age

groups and all settings in which children received health care services. The measures were for potential future voluntary use by Medicaid and CHIP programs. By the FFY 2012 reporting period, at least 1 of the 24 measures was being reported to the Centers for Medicare and Medicaid Services (CMS) for all states and the District of Columbia; in turn, as required by CHIPRA, the secretary of the US Department of Health and Human Services released this information in a September 2013 report.[6] In early 2013, as part of the continuing partnership between the Agency for Healthcare Research and Quality (AHRQ) and CMS, CMS asked for AHRQ's assistance in exploring whether some of the CCS measures should be retired from the CCS set so that CMS could reflect the changes in its annual update due January 2014. By early 2013, there were several reasons to consider retiring 1 or more quality measures from the CCS. These included: lessons to be learned from 3 years of state and CMS experience with the CCS[6]; the possibility of updated science to inform consideration of the measures' validity and reliability; and an emerging imperative for alignment with other public and private policies on the updating of quality measure sets.[3,7,8]

Retirement of measures has become a theme nationally as the number of quality indicators, many of them overlapping, has grown. The National Committee for Quality Assurance (NCQA) and the National Quality Forum (NQF) both reevaluate measures every 3 years, with measure retirement or removal as a possible outcome of the reviews.[8,9] Review of measures for potential retirement is a component of the CMS blueprint.[7] Beyond key national entities, some health care professional societies recognize the importance of considering retirement or removal of measures as part the quality-measure life cycle.[10] However, in comparison with the level of detailed criteria related to measure endorsement, guidance for the retirement or removal of measures from measure sets is still somewhat broad. For example, NCQA notes that it may retire measures when it is "clear… that a measure no longer adds value commensurate with the cost of data collection and reporting."[3] NQF recommendations are based on a measure approaching being "topped out" or current development of "superior" measures.[7]

## METHODS

### OVERVIEW

The authors and a group of experts (called the 2013 SNAC for Subcommittee on Children's Healthcare Quality Measures of the AHRQ National Advisory Council on Healthcare Research and Quality[11]) undertook the reexamination of 20 CMS-selected CCS measures. As shown in the Figure, the steps for considering CCS measures for potential retirement included: 1) selection by CMS of a subset of the initial CCS measures for consideration for potential retirement; 2) appointment of the 2013 SNAC); 3) a collaborative effort across AHRQ, CMS, and the 2013 SNAC to identify relevant criteria; 4) identification, consideration, and use of relevant information sources by which to assess adherence to the agreed-upon criteria; 5) the 2013 SNAC's application of agreed-upon criteria and criteria-relevant information to the selected measures in 2 rounds of a Modified Delphi approach[5] scoring and voting on each measure; 6) transmittal of the SNAC guidance to CMS; and 7) CMS consideration and transmittal of its recommendations in its January 2014 update. In addition, members of the SNAC provided comments explaining their scoring and voting decisions. These comments formed the basis of our qualitative findings.

### MEASURE SELECTION

Of the 26 CCS measures as of January 2013, CMS selected 20 for consideration for possible retirement. As shown in Table 1, the measures selected included 4 related to perinatal care, 9 related to clinical preventive services for children and adolescents, 3 related to management of acute conditions, and 4 related to management of chronic conditions. Of the CCS measures not considered, 2 dental measures were excluded because data came from states' Early and Periodic Screening Diagnosis and Treatment reports[12]; the Child Medicaid CAHPS was excluded because it can be used to fulfil a CHIPRA requirement for state CHIP programs[13]; a measure related to antibiotic overuse in otitis media with effusion was removed from the CCS in January 2013 because data proved too challenging to collect[14]; and 3 measures had just been added to the CCS in January 2013.[15]

### SELECTION OF THE 2013 SNAC

The 2013 SNAC members were selected by AHRQ and CMS from 2 overlapping pools of experts and stakeholders: subject matter experts and Medicaid/CHIP experts (primarily officials working for Medicaid or CHIP). All 2013 SNAC members[16] signed a form certifying they had no conflict of interest that would affect their assessments of the 20 CCS measures, and agreed to participate actively in the entire process.

### SELECTION OF CRITERIA

We based our initial suggestions to the 2013 SNAC for measure retirement criteria primarily on the 3 criteria used in 2009[5] and the desirable measure attributes codified in the CHIPRA Pediatric Quality Measures Program Candidate Measure Submission Form.[17,18] The desirable measure attributes were informed by criteria used by NQF but were modified in order to emphasize the CHIPRA foci on children, public insurance, and the existence of racial and ethnic and other socioeconomic and special needs disparities. The retirement criteria we proposed to the 2013 SNAC also took into account emerging guidance on recommending measures for retirement.[3,7,8]

AHRQ initially proposed 5 criteria to the SNAC initially: importance, measure reliability and validity, measurement performance, whether a better measure was available, and feasibility. In response, the 2013 SNAC expressed a strong preference for the following: 1) reducing the number of major criteria; 2) relabeling the measure reliability and validity criterion as scientific

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