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State challenges to child health quality measure reporting and recommendations for improvement

Ankoor Y. Shah [a,*], Karen LLanos [b], Denise Dougherty [c], Stephen Cha [b], Patrick H. Conway [b]

[a] Children's National Health System, Washington, DC, USA
[b] Centers for Medicare and Medicaid Services, Baltimore, MD, USA
[c] Agency for Healthcare Research and Quality, Rockville, MD, USA

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ABSTRACT

Objective: The Children's Health Insurance Program (CHIP) was re-authorized in 2009, ushering in an unprecedented focus on children's health care quality one of which includes identifying a core set of performance measures for voluntary reporting by states' Medicaid/CHIP programs. However, there is a wide variation in the quantity and quality of measures states chose to report to the Center's for Medicare & Medicaid Services (CMS). The objective of this study is to assess reporting barriers and to identify potential opportunities for improvement.
Methods: From 2013 to 2014 a questionnaire developed in coordination with CMS and the Agency for Healthcare Research and Quality (AHRQ) was sent to state Medicaid and CHIP officials to assess barriers to child health quality reporting for Federal Fiscal Year 2012. States were categorized as high, medium, or low reporting for comparative analysis.
Results: Twenty-five of the 50 states and the District of Columbia agreed to participate in the study and completed the questionnaire. States placed a high priority on children's health care quality reporting (4.2 of 5 point Likert Scale, SD 0.99) and 96% plan to use measurement results to further improve their quality initiatives. However, low reporting states believed they had inadequate staffing and that data collection and extraction was too time-consuming than high reporting states.
Conclusion: Based on state responses, possible solutions to improve reporting includes funding and staff support, refining the technical assistance provided, and creating venues for state-to-state interaction. Realistic and tangible improvements are within reach and opportunities for CMS and states to collaborate to improve child health care quality.

1. Introduction

In 1997, the Children's Health Insurance Program (CHIP) was enacted in order to help states insure children above the Medicaid threshold but unable to afford private health insurance.[1] A year before the Patient Protection and Affordable Care Act was enacted in 2010, the Children's Health Insurance Program Re-authorization Act (CHIPRA) was signed into law.[2] The 2009 re-authorizing legislation also marked an unprecedented focus on children's health care quality measurement and improvement.

An example of this is Title IV of the law which called for the identification of an initial core set of quality measures in children's health care (Child Core Set) for voluntary use by state Medicaid and CHIP programs. The Centers for Medicare & Medicaid Services (CMS) identified the initial Child Core Set in collaboration with the Agency for Healthcare Research and Quality (AHRQ) and a multi-stakeholder panel of experts representing a wide range of children's health care quality areas domains including measurement.[3,4]

The initial Child Core Set included a total of 24 measures across a range of children's health and health care areas.[4] These measures represent the health care dimensions of population/community health; clinical care; care coordination; efficiency and cost reduction; safety; and person and caregiver centered experience. Many individual health plans use the Healthcare Effectiveness Data and Information Set (HEDIS) developed by the National Committee for Quality Assurance (NCQA) to measure healthcare quality in adults and children.[5] Multiple Child Core Set measures are the same as HEDIS measures that health plans already collect.

Abbreviations: AHRQ, Agency for Healthcare Research and Quality; CHIP, Children's Health Insurance Program; CHIPRA, Children's Health Insurance Program Reauthorization Act of 2009; CMS, Centers for Medicare & Medicaid Services; FFS, Fee-for-Service; HEDIS, Healthcare Effectiveness Data and Information Set; MCO, Managed Care Organizations; TA/AS, Technical Assistance and Analytical Support Team

* Correspondence to: Children's National Health System, 111 Michigan Ave, NW. W3.5 –700A, Washington, DC 20010, USA.
E-mail address: Anshah@cnmc.org (A.Y. Shah).

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However, even though the measures are the same, the method to collect the measure is slightly different due to the intrinsic goals of HEDIS versus the Child Core Set. HEDIS measures are aimed at the health plan level, whereas the Child Core Set are state based measures. Therefore, the Child Core Set has to extrapolate the HEDIS technical methods in order to incorporate Fee-for-Service and Capitation enrollees as well as Managed Care enrollees.

This study focuses on the 2012 Child Core Set Measures that states voluntarily reported.[6] States have support for quality measurement and reporting is through a CMS established Technical Assistance and Analytic Support team (TA/AS team), which individually works with states to trouble shoot problems with reporting and using data.[7]

As of 2012, CMS estimates that more than 44 million children are covered by Medicaid and CHIP, which makes measuring, monitoring and improving health care quality a priority.[8] Annually, as required by CHIPRA, CMS publishes a report on the quality of care of children in Medicaid and CHIP, which includes state-level quality information focused principally on data reported to CMS by state Mediciad/CHIP programs using the Child Core Set.[8] Reporting on the Child Core Set by states is completely voluntary. Since federal fiscal year (FFY) 2010, there has been an overall trend for more states to report and to report on more measures. In FFY 2010, 43 states (including the District of Columbia) reported a median of 7 measures, which increased to 49 states and a median of 12 measures in FFY 2011.[9] By FFY 2012, all states reported at least two measures with the median increased to 14 measures.[10]

Despite a positive trend for reporting, the number of Child Core Set measures reported on by each state and submitted to CMS varies. For example in FFY 2012, Tennessee reported on all 22 measures, whereas Wisconsin only reported on two measures.[10] This still creates an incomplete understanding of the quality of healthcare delivered to children enrolled in Medicaid and CHIP. Informed and targeted quality improvement initiatives are thus difficult to pursue. Measurement itself will not improve quality, but the first steps of the Child Core Set is to start the process of reporting and then to have completeness of reporting. It is only after that data can be used to improve quality and measure that improvement.

When the Child Core Set was initially launched, the AHRQ created a subcommittee national advisory council to annually review, adjust, add, or remove measures. This committee was comprised of staff from AHRQ and CMS as well as experts in Medicaid and CHIP. However, now the Child Core Set has joined the National Quality Forum's Measure Application Partnership which is in charge of reviewing other federal quality measures in Medicare and the correlated Adult Core Set in Medicaid. The current process of developing measures is structured and transparent with state input, including a public comment process and an independent panel. Each year new measures are added or removed, thus always aiming to make the measures the most applicable and useful as possible.[11]

We know that prior to the passage of CHIPRA, state Medicaid and CHIP directors placed a high priority (90%) in child health quality measures.[12] At that time states' biggest challenges included having standardized measures and technical assistance. Because CHIPRA introduced a standardization to the measures, a review process, and technical specifications about how to collect the measures, as well as the development of the TA/AS team; we do not know how or if CHIPRA has changed these views.

The goals of this study are to: analyze the Child Core Set reporting between high, medium, and low reporting states; identify systematically what barriers exist for states to report on the Child Core Set measures by surveying State Mediciad/CHIP program officials, and to identify potential opportunities to improve the quantity and quality of voluntary reporting across the states.

2. Methods

This study focuses on the 22 of the 24 2012 Child Core Set Measures [Table 1], which are categorized as Population/Community Health, Clinical Care, Care Coordination, Efficiency and Cost Reduction, Safety, and Person and Caregiver Centered Experience. These categories are determined through the National Quality Forum's Measure Application Partnership process. A questionnaire was developed through coordination with the Centers for Medicare & Medicaid (CMS), Agency for Healthcare Research and Quality (AHRQ), and CMS's TA/AS team for the Child Core Set measures, Mathematica Policy Research. Inc. The survey was administered by an independent researcher that is not affiliated with the Child Core Set nor any of the federal agencies involved with the Child Core Set. In order to promote honesty of responses, no specific response is matched to a specific state. The goal of the questionnaire was to assess difficulty of reporting, determine barriers to reporting, and elicit possible solutions to help improve reporting. The questionnaire consisted of items scored using Likert scales, dichotomous yes/no response opportunities, and open-ended questions. Two open ended response questions were asked: (1) What barriers does your state currently face with Child Core Set reporting; and (2) Are there any

Table 1
2012 Child Core Set quality measures, by category[a].

Population/Community health
- Annual pediatric hemoglobin A1c testing
- Body mass index assessment for children and adolescents

Clinical care
- Child and adolescent access to primary care practitioners
- Childhood immunization status
- Adolescent immunization status
- Frequency of ongoing prenatal care
- Timeliness of prenatal care
- Live births weighing less than 2500 g
- Cesarean rate for nulliparous singleton vertex
- Developmental screening in the first three years of life
- Well-child visits in the first 15 months of life
- Well-child visits in the 3rd, 4th, 5th, and 6th, years of life
- Adolescent well-care visits
- Chlamydia screening
- Preventative dental services
- Dental treatment services
- Appropriate testing for children with pharyngitis
- Otitis Media with Effusion (OME) – avoidance of inappropriate systemic antimicrobials in children (ages 2–12)[b]

Care coordination
- Follow-up after hospitalization for mental illness
- Follow-up care for children prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) medication

Efficiency and cost reduction
- Ambulatory care: emergency department visits
- Annual percentage of asthma patients with 1 or more asthma-related emergency room visits

Safety
- Pediatric central line associated-blood stream infections[b]

Person and caregiver centered experience
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) health plan survey

[a] Adapted from Fig. 3 of 2013 Annual Report on the Quality of Care for Children in Medicaid and CHIP.

[b] Quality Measures not voluntarily reported on by states in FFY 2012 due to measures being retired early or technical barriers.

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