

Center for Medicaid, CHIP and Survey & Certification

SHO# 11-001
CHIPRA# 20

February 14, 2011

Re: CHIPRA Quality Measures

Dear State Health Official:

Part of creating an effective and efficient health system is the ability to measure access to services; the quality of the services provided; and most importantly, the individual's experiences with those services. Most States already collect and report health care quality measures and have done so for years. However, differences in States' resources, data collection systems and capabilities, measures used, and quality improvement priorities limit comprehensive national comparisons on the quality of children's health care across a set of standardized, evidence-based measures.

This letter provides guidance to States regarding implementation of provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (Pub. L. 111-3), enacted on February 4, 2009. CHIPRA includes a broad range of provisions to improve the quality of health care provided to children. Specifically, section 401 of CHIPRA adds section 1139A to the Social Security Act (the Act) to develop, improve, and promote child health care quality measures. Section 1139A(a) requires the Secretary of the Department of Health and Human Services to identify an initial core set of recommended pediatric quality measures for voluntary use by State Medicaid and Children's Health Insurance Program (CHIP) programs. Section 1139A(b) requires the Secretary to create a Pediatric Quality Measures Program (PQMP) and regularly update the child health care quality measures established in section 1139A(a). This letter also provides guidance about section 402 of CHIPRA, which is designed to improve the availability of public information regarding the enrollment of children in CHIP and Medicaid.

The Centers for Medicare & Medicaid Services (CMS), in collaboration with States, health care providers, health care quality experts, and families, seeks to improve care for children enrolled in Medicaid and CHIP, as well as improve how this care is measured. While reporting on the initial core set of children's quality measures is voluntary for States, the core measures set represents a major step toward developing a quality-driven, evidence-based, national system for measuring the quality of children's health care. This guidance highlights five components that will help build the foundation of this national quality measurement system, including additional information on the initial core set of children's quality measures previously published by the Secretary.

Components of CHIPRA's Child Health Care Quality Performance Measures System

I. Establishment of an initial core set of child health care quality performance measures for voluntary use by State programs

Section 1139A(a)(1) of the Act requires the Secretary to identify and publish children's health care quality measures. In 2009, under delegated authority of the Secretary, CMS began collaborating with the Agency for Healthcare Research and Quality (AHRQ) to identify a set of child-focused health care quality measures. In order to include a wide range of national expertise in identifying measurement priority areas and the initial core set of measures, AHRQ established a Subcommittee of its National Advisory Council (SNAC) on Quality Measures for Children's Healthcare in Medicaid and CHIP Programs. The SNAC evaluated which measures were best suited for the core set based on their validity, feasibility of use by Medicaid and CHIP programs, and importance to improving health outcomes for children. Specific details on the process and criteria used to identify the initial core set can be found at: <http://www.ahrq.gov/chipra/>. The SNAC recommended an initial core set of 25 measures which represents a wide spectrum of facets related to the quality of health care for children as required by CHIPRA. When used with other measures States already collect, the core set is intended to provide a broader window with which to view, assess, and improve the quality of health care children receive.

In September 2009, CMS held a listening session to provide State Medicaid and CHIP programs the opportunity to comment on the draft initial core set of quality measures recommended by the SNAC. Additionally, a Federal Quality Work Group comprised of representatives from various Federal agencies reviewed the measures. After CMS and AHRQ reviewed the feedback provided by States, the Federal Quality Work Group and the SNAC, the Secretary released a set of 24 measures for public comment on December 29, 2009 through a *Federal Register* notice. States, providers, and health plans will likely have some degree of familiarity with over half (15) of the initial core set measures, as they are National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) measures. The list of measures is provided in Enclosure A.

CMS encourages States to collect measures from the initial core set, in addition to their existing State-specific measures. The more States that collect and report the initial core set of measures, the greater the potential for States and others to benefit from this information. CMS is developing data information systems to standardize reporting and make access to quality data more available to States for comparison purposes. By having access to these data, States will have the opportunity to integrate quality data in designing and implementing their quality improvement initiatives.

II. Reporting the initial core set of measures to CMS

CMS recognizes that State Medicaid and CHIP programs are enhancing information systems to address opportunities and requirements under CHIPRA, the Health Information Technology for Economic and Clinical Health Act (HITECH) enacted as part of the American Recovery and Reinvestment Act of 2009, and the Affordable Care Act. CMS is also conducting similar enhancements to meet the data exchange needs of evolving State systems. While these system transitions are in development, CMS has designated the CHIP Annual Reporting Template System (CARTS), a web-based data submission tool currently used by Title XXI Programs, as the vehicle which all States choosing to report the initial core measures (or a subset thereof)

should use. Since most CHIP programs are experienced users of CARTS, CMS has provided them with updated instructions for annual reporting. State Medicaid programs will receive access to the CARTS system through a designated entry screen for voluntary reporting on the child health care quality measures.

As required by CHIPRA, CMS released guidance, reporting procedures, and technical specifications for the initial core set of measures on February 3, 2011. The CHIPRA Initial Core Set Technical Specification Manual can be found at:

<http://www.cms.gov/MedicaidCHIPQualPrac/Downloads/CHIPRACoreSetTechManual.pdf>

III. Requirement for State CHIP Programs to annually report on the quality of health care and consumer satisfaction measures included in the CAHPS Medicaid survey

The ability to measure patient experience is critical to understanding how to improve the quality of health care children receive. As required by CHIPRA section 402(a)(2), which amends reporting requirements in section 2108 of the Act, Title XXI programs are required to report results from AHRQ's Consumer Assessment of Healthcare Providers and Systems (CAHPS) Child Medicaid Survey. Currently, States voluntarily report Medicaid data to the CAHPS database either annually or biannually. According to AHRQ's National CAHPS Benchmarking Database, a total of 17 States submitted data in 2008 and 12 States submitted Medicaid data in 2009. In 2009, the CAHPS database included information on about 70,000 children. States that currently report CAHPS through AHRQ can continue to do so. Other States have the option to submit results of their CAHPS data to AHRQ or to CMS through CARTS.

CHIPRA section 402 specifically addresses reporting requirements for CHIP programs for collecting data on AHRQ's CAHPS and provides up to three reporting periods for States that need time to make operational and infrastructure changes (e.g., implement legislative changes, update data collection processes, modify contracts with health plans). With CARTS as the reporting vehicle, we are deeming that the three transition periods outlined in CHIPRA become the CARTS reporting periods: December 31, 2010; December 31, 2011; and December 31, 2012. We expect States to vary in how long they will need to implement collection and reporting efforts related to the core measures with all Title XXI programs submitting measurement data to CARTS by December 31, 2013. CMS is currently undergoing a review of its multiple reporting systems. As this effort evolves CMS may identify other reporting vehicles for the quality measures.

The CAHPS Medicaid survey is also part of the 24 initial core set of children's health care quality measures. Title XIX programs can choose to voluntarily report the CAHPS survey.

IV. Creation of a Pediatric Quality Measures Program to enhance the initial core set of measures and to develop additional health care quality measures

While the initial core set of measures covers a range of quality areas, it does not comprehensively reflect all the dimensions of children's health care. As required by section 1139A(b)(1) of the Act, the Secretary will create a Pediatric Quality Measures Program (PQMP) that will: (1) test and refine the initial core set of measures to make them more broadly applicable to Medicaid, CHIP, and other programs; and (2) develop additional quality measures that address dimensions of care where standardized measures do not currently exist.

Through the PQMP, AHRQ will issue grant awards to Centers of Excellence that will work to improve and enhance the initial core children's measures and to develop new health care quality measures meaningful to State Medicaid and CHIP programs, and applicable to all payer systems. The Centers of Excellence approach will create a cohort of entities with expertise in health care quality measurement specific to the needs of children and their health care delivery system. By April 2011, AHRQ will identify a CHIPRA Coordinating and Technical Assistance Center to facilitate common approaches, provide technical assistance, and ensure coordination of efforts across the Centers of Excellence. The Coordinating Center will also assist in creating a transparent process to recommend improved core measures to the Secretary. In December 2010, AHRQ released a *Federal Register* notice soliciting public comments on priority areas for measurement development and asking the public to identify additional priorities as needed. As required by CHIPRA, the Secretary will then incorporate these improved measures into the children's health care quality measures core set by January 1, 2013, and annually thereafter. Additional information on the Pediatric Quality Measures Program, the Centers of Excellence, and the CHIPRA Coordinating and Technical Assistance Center can be found at: <http://www.ahrq.gov/chipra/#Core2>

V. Technical assistance to States implementing the initial core set of measures

In public comments received in response to the December 2009, *Federal Register* notice, States' concerns about the initial core measures ranged from the burden of new quality reporting, current data collection and reporting systems constraints, challenges for partial-risk programs to report measures, to the need for technical assistance. Section 1139A(a)(7) of the Act requires CMS to provide technical assistance to States for voluntary reporting on the initial core set. CMS is committed to supporting State efforts, and will be establishing a specific plan for technical assistance to include webinars, learning networks, sharing of promising practices and lessons learned, and an annual CMS State Medicaid and CHIP quality conference.

The national technical assistance program will support States in understanding how to collect, report, and analyze the core measures to target improvements in the quality of health care for children. The overarching goals for providing technical assistance and analytic support are to increase the number of States consistently collecting and uniformly reporting the voluntary initial core measures set, and to help States understand how to use these data to improve the quality of health care for children. As part of the technical assistance and analytic support program, CMS will gain an understanding of States' abilities in reporting on the initial core measures. Subsequently, technical assistance will be largely tailored to States' needs, and will be available through a variety of vehicles, including annual CMS State Medicaid and CHIP Quality Conferences starting in 2011, and continuing through 2015.

CMS will provide technical assistance to States on all of the core measures through a variety of methods (e.g., webinars, one-on-one technical assistance, etc.). However, based on public comments received from States, national health care quality experts, and other stakeholders in response to the *Federal Register* notice of December 29, 2009, CMS will focus initial outreach and technical assistance efforts on 12 of the 24 measures. CMS selected this subset of measures for targeted technical assistance because they reflect existing and evolving State reporting efforts, including the alignment of children's health care quality measure collection opportunities under CHIPRA and the Electronic Health Record (EHR) Incentive Program. In subsequent years, CMS will offer technical assistance to States on the additional core measures.

Table 1. Children’s Quality Measures Targeted for Technical Assistance in Year One

Prevention and Health Promotion

| Measure | Measure Steward¹ | Used in other CMS Measurement Activities |
|--|------------------------------------|---|
| Childhood immunization status | NCQA/HEDIS | Meaningful Use |
| Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents | NCQA/HEDIS | Meaningful Use |
| Chlamydia screening | NCQA/HEDIS | Meaningful Use |
| Well-child visits in the first 15 months of life | NCQA/HEDIS | Current CHIP reporting element |
| Well-child visits in the 3 rd , 4 th , 5 th , and 6 th years of life | NCQA/HEDIS | Current CHIP reporting element |
| Total eligible children who received preventive dental services | CMS | CMS Form 416 |

Management of Acute Conditions

| Measure | Measure Steward | Used in other CMS Measurement Activities |
|--|--|---|
| Appropriate testing for children with Pharyngitis | NCQA/HEDIS | Meaningful Use |
| Total eligible children who received dental treatment services | CMS | CMS Form 416 |
| Pediatric central-line associated blood stream infections – Neonatal Intensive Care Unit and Pediatric Intensive Care Unit | Centers for Disease Control and Prevention | Reporting activity related to health care acquired conditions |

Management of Chronic Conditions

| Measure | Measure Steward | Used in other CMS Measurement Activities |
|--|------------------------|---|
| Annual number of asthma patients ages 2 through 20 years old with 1 or more asthma-related emergency room visits | Alabama Medicaid | |
| Annual pediatric hemoglobin A1C testing | NCQA | |

¹ A measurement steward is responsible for updating or retiring measures as the technical specifications are changed, new clinical evidence emerges, or the measure’s performance changes.

Availability of Care

| Measure | Measure Steward ¹ | Used in other CMS Measurement Activities |
|--|------------------------------|--|
| Children and adolescent access to primary care practitioners | NCQA/HEDIS | Current CHIP reporting element |

As illustrated in the table, 10 of the 12 measures selected for the initial phase of technical assistance align with current CMS measurement activities. Four of the initial core set of child health measures are identified as meeting the meaningful use criteria for quality measures under the EHR Incentive Program. Likewise, three core set measures are among the four measures previously reported by Title XXI programs (CHIP, Medicaid Expansions, and Combination CHIP and Medicaid). We believe this list balances the benefits of quality measurement data collection and reporting with efforts to minimize the reporting burden on States who want to participate in multiple measurement-related initiatives.

Conclusion

CHIPRA establishes a process for States to participate in a national effort for assuring optimal health care quality, including the identification of a core set of health care quality measures for children. The initial core set of children’s measures, along with the Pediatric Quality Measures Program and the creation of a national technical assistance program, are the first steps taken, after much consultation with States, in making quality measurement a priority for Medicaid and CHIP. These efforts will promote a new focus and commitment to ensure our nation’s children receive the quality of care they deserve. If you have questions or suggestions related to these initiatives, please contact our Chief Quality Officer, Marsha Lillie-Blanton at Marsha.Lillie-Blanton@cms.hhs.gov.

Sincerely,

/s/

Cindy Mann
Director

Enclosures:

- A) CHIPRA Initial Core Measures
- B) Timeline of Quality Reporting Activities

¹ A measurement steward is responsible for updating or retiring measures as the technical specifications are changed, new clinical evidence emerges, or the measure’s performance changes.

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
Division of Medicaid and Children's Health

Andrew Allison
President
National Association of Medicaid Directors

Alan R. Weil, J.D., M.P.P.
Executive Director
National Academy for State Health Policy

Matt Salo
Director of Health Legislation
National Governors Association

Rick Fenton
Acting Director
Health Services Division
American Public Human Services Association

Christine Evans, M.P.H.
Director, Government Relations
Association of State and Territorial Health Officials

Debra Miller
Director for Health Policy
Council of State Governments

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Enclosure A: Initial Core Set of Children’s Quality Measures for Voluntary Reporting

Prevention and Health Promotion

| Measure | Measure Steward | Description |
|---|---|--|
| Frequency of Ongoing Prenatal Care | NCQA/HEDIS | Percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that received the following number of visits: < 21 percent of expected visits 21 percent – 40 percent of expected visits 41 percent – 60 percent of expected visits 61 percent – 80 percent of expected visits ≥ 81 percent of expected visits |
| Prenatal and Postpartum Care: Timeliness of Prenatal Care | NCQA/HEDIS | The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year that received a prenatal care visit in the first trimester or within 42 days of enrollment in the organization. |
| Percent of live births weighing less than 2,500 grams | Centers for Disease Control and Prevention | The measure assesses the number of resident live births less than 2,500 grams as a percentage of the number of resident live births in the State reporting period. |
| Cesarean rate for nulliparous singleton vertex | California Maternal Quality Care Collaborative | Percentage of women who had a cesarean section among women with first live singleton births [also known as nulliparous term singleton vertex (NTSV) births] at 37 weeks of gestation or later. |
| Childhood Immunization Status | NC National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) QA/HEDIS | Percentage of patients who turned 2 years old during the measurement year who had four DTaP/DT, three IPV, one MMR, three H influenza type B, three hepatitis B, one chicken pox vaccine (VZV), four pneumococcal conjugate (PCV), two hepatitis (HepA), two or three rotavirus (RV); and two influenza vaccines by the child's second birthday. The measure calculates a rate for each vaccine and nine separate combination rates. |

Prevention and Health Promotion

| Measure | Measure Steward | Description |
|--|---|--|
| Immunizations for Adolescents | NCQA/HEDIS | Percentage of patients who turned 13 years old during the measurement year who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and a cellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their thirteenth birthday; a second dose of MMR and three hepatitis B vaccinations; and one varicella vaccination by their thirteenth birthday. The measure calculates a rate for each vaccine and one combination rate. |
| Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents | NCQA/HEDIS | Percentage of children, 3 through 17 years of age, whose weight is classified based on body mass index percentile for age and gender. |
| Developmental Screening in the First Three Years of Life | Child and Adolescent Health Measurement Initiative and NCQA | Assesses the extent to which children at various ages from 0-36 months were screened for social and emotional development with a standardized, documented tool or set of tools. |
| Chlamydia Screening | NCQA/HEDIS | Percentage of women 16 through 20 who were identified as sexually active who had at least one test for Chlamydia during the measurement year. |
| Well-Child Visits in the First 15 Months of Life | NCQA/HEDIS | Percentage of members who received zero, one, two, three, four, five, and six or more well-child visits with a primary care practitioner during their first 15 months of life. |
| Well-Child Visits in the 3 rd , 4 th , 5 th , and 6 th Years of Life | NCQA/HEDIS | Percentage of members ages 3 through 6 years old who received one or more well-child visits with a primary care practitioner during the measurement year. |
| Adolescent Well-Care Visit | NCQA/HEDIS | Percentage of members ages 12 through 21 years who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year. |
| Total Eligibles Who Received Preventive Dental Services | CMS | Total eligible children 1 through 20 years of age who received preventive dental services. |

Management of Acute Conditions

| Measure | Measure Steward | Description |
|--|---|--|
| Appropriate Testing for Children with Pharyngitis | NCQA/HEDIS | Percentage of patients who were diagnosed with Pharyngitis, dispensed an antibiotic, and who received a group A streptococcus test for the episode. |
| Otitis media with effusion (OME) – avoidance of inappropriate use of systemic antimicrobials in children – ages 2 through 12 | American Medical Association /PCPI ¹ | Percentage of patients ages 2 months through 12 years with a diagnosis of OME who were not prescribed systemic antimicrobials. |
| Total Eligibles who Received Dental Treatment Services | CMS | Total eligible children 1 through 20 years of age who received dental treatment services. |
| Ambulatory Care: Emergency Department Visits | NCQA/HEDIS | The number of visits per member per year as a function of all child and adolescent members enrolled and eligible during the measurement year. |
| Pediatric central-line associated blood stream infections – Neonatal Intensive Care Unit and Pediatric Intensive Care Unit | Centers for Disease Control and Prevention | Rate of central line-associated blood stream infections (CLABSI) identified during periods selected for surveillance as a function of the number of central line catheter days selected for surveillance in pediatric and neonatal intensive care units. |

Management of Chronic Conditions

| Measure | Measure Steward | Description |
|--|------------------|--|
| Annual number of asthma patients ages 2 through 20 years old with 1 or more asthma-related emergency room visits | Alabama Medicaid | Asthma emergency department utilization for for patients ages 2 through 20 years old diagnosed with asthma or treatment with at least 2 short-acting beta adrenergic agents during the measurement year who also had one or more asthma-related emergency room visits. |

¹ Physician Consortium for Performance Improvement

Management of Chronic Conditions

| Measure | Measure Steward | Description |
|---|-----------------|---|
| Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication | NCQA/HEDIS | Percentage of children ages 6 through 12 years of age with newly prescribed ADHD medication who had at least 3 follow-up care visits within a 10-month period, one of which was within 30 days from the time the first ADHD medication was dispensed. |
| Follow-up after hospitalization for mental illness | NCQA/HEDIS | Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. |
| Annual Pediatric hemoglobin A1C testing | NCQA | Percentage of pediatric patients with diabetes who had a hemoglobin A1c test in a 12-month measurement period. |

Family Experiences of Care

| Measure | Measure Steward | Description |
|---|-----------------|---|
| CAHPS® 4.0 (child version including Medicaid and Children with chronic conditions supplemental items) | NCQA/HEDIS | Survey on an individual’s experiences with health care. |

Availability

| Measure | Measure Steward | Description |
|---|-----------------|--|
| Child and Adolescent Access to Primary Care Practitioners | NCQA/HEDIS | <p>Percentage of enrollees 12 months through 19 years of age who had a visit with a primary care practitioner (PCP). Four separate percentages are reported:</p> <ul style="list-style-type: none"> • Children 12 months through 24 months and 25 months through 6 years who had a visit with a PCP during the measurement year. • Children 7 through 11 years and adolescents 12 through 19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year. |

Enclosure B: Timeline of CMS/CMCS CHIPRA Quality Measurement & Improvement Activities

2010

- 09/30/2010** Issue Secretary's 1st Annual Report on the Quality of Care for Children in Medicaid & CHIP (with State-specific quality data)
- 12/31/2010** States can submit voluntary core quality measures to CMS using the CHIP Annual Report Template (CARTS) with updated instructions.

2011

- 02/03/2011** Issue written guidance (CMS Informational Bulletin) for voluntary reporting of CHIPRA core quality performance measures and reporting data through CARTS
- Summer 2011** Annual Quality Conference
- 09/30/2011** Issue Secretary's 2nd Annual Report on the Quality of Care for Children in Medicaid & CHIP (with State-specific quality data)
- 12/31/2011** Deadline for States to submit data on voluntary core quality measures [(including Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey)]

2012

- 09/30/2012** Issue Secretary's 3rd Annual Report on the Quality of Care for Children in Medicaid & CHIP (with State-specific quality data)
- Summer 2012** Annual Quality Conference
- 12/31/2012** Deadline for States to submit data on voluntary core quality measures (including CAHPS)

2013

- 01/01/2013** States begin data collection for required reporting of CAHPS
- 01/01/2013** Publication of recommended changes to initial core quality measure set and new measures
- Summer 2013** Annual Quality Conference
- 09/30/2013** Issue Secretary's 4th Annual Report on the Quality of Care for Children in Medicaid & CHIP (with State-specific quality data)
- 12/31/2013** States begin required reporting of CAHPS survey along with voluntary core quality performance measures