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The Role of States in Improving Health and Health Care for Young Children

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ABSTRACT: States are uniquely positioned to make significant improvements in the quality of health and heath care for young children, due to their roles as administrators of Medicaid and the State Children's Health Insurance Program, as well as mental health, public health, and education programs. Quality improvement initiatives are often hampered, however, by lack of coordination among programs within a state, by the lack of adequate data and information technology, and the tendency of state officials to focus on short-term policy projects. Even in the face of these burdens and other difficult fiscal and administrative challenges, state officials are optimistic that improvements are possible. Potential solutions that state officials consider promising include developing specific child health quality measures, measuring and monitoring performance, making information on quality performance easily available, rewarding superior performance, and using performance measures in purchasing and program decisions.

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INTRODUCTION

The health of American children has improved over recent generations: infant mortality has declined, and the development of vaccines for polio and chicken pox has contributed to reductions of serious disabilities. Yet there is strong evidence that the quality of children's health care is inadequate. Research has found that up to three-quarters of children do not receive recommended health care to prevent disease, reduce disease complications, and achieve optimal health and development.[1] Children often receive inappropriate care, such as antibiotics for the common cold and unnecessary hospital admissions. Poor children and minority children are more likely to receive inferior care, and the level of care varies substantially across geographic regions in ways that appear to be unrelated to health needs.[2]

The incidence of some illnesses among children is rising to a disturbing extent. Asthma rates have more than doubled since 1980, and the incidence of cancer is on the rise, increasing by 26 percent between 1975 and 1998. About

1 million preschoolers have been exposed to lead to such an extent that they may suffer from brain damage, learning disabilities, and other problems.[3] About 37 percent of children on Medicaid are at risk for social or emotional delay, but only 60 percent of those identified are referred for follow-up care.[4]

Developmental assessments are especially important for children from birth to age 3, yet several studies have documented that all too often young children are not assessed or diagnosed until they reach school.[5] Even when assessments are done, a recent study found that about one-third cannot adequately identify early signs of disease and learning disabilities.[6] Failing to maximize the health of children is costly. One study estimates that in 2002, environmentally related pediatric disease alone accounted for 2.8 percent of health care costs, or almost $55 billion.[7]

Clearly, state policymakers must address these issues to improve the quality of health care for children. State resources, however, have been severely stretched during the recent economic downturn, forcing cutbacks in virtually every state program. From 2001 through 2004, every state initiated actions to slow the rate of growth in Medicaid spending.[8] In this fiscal environment, states cannot afford to waste resources by paying for poor-quality care, or for care that is ineffective or unnecessary.

Despite fiscal challenges, states are in key positions to affect children's health care, as they bear primary responsibility for critical programs and services. Medicaid is the largest of these programs, with coverage of children one of its primary responsibilities. In 2004, Medicaid provided health coverage for more than 27 million children,[9] or more than one of four of all children in the United States. In addition, the State Children's Health Insurance Program (SCHIP) covered nearly 6 million children of families of limited income.[10] States also administer mental heath, public health, and education programs that significantly affect health and health care for young children. State maternal and child health (Title V) programs address mental and physical health for 27 million women and children.[11] School readiness programs have a significant health component, and mental health programs for children are critically important for individuals and families needing these services. In addition, states are significant purchasers of health care due to the coverage they provide for state workers and their dependent children. Altogether, states administer health programs that serve about 100 million Americans—about half of whom are children.[12]

State governments, which license qualified providers, set standards, and enforce laws and regulations, have unique opportunities to directly affect quality of care for children. As purchasers, states can also powerfully influence quality by defining expectations and incentives for improvement and by rewarding performance that meets these expectations. The federal government clearly has an impact on quality, as well. It sets the rules under which states administer programs that are financed with federal funds. However, while the federal government plays a critical role, it generally is the states that administer and make key decisions about these programs. The Institute of Medicine, in assessing government roles in Medicaid, found that: "[T]he federal government has a very small role in quality enhancement. Federal regulatory requirements are minimal, and the states, which administer the program, have a great deal of latitude in carrying out quality oversight responsibilities."[13] Without question, states today are in the best position—among all American entities and organizations—to influence young children's health and health care.

STATE ROLES: OPTIONS, OPPORTUNITIES, AND STRATEGIES

Even in the face of significant challenges and obstacles, state officials are optimistic that improvements in quality of care can be achieved. Programs for children generally enjoy broad support among public policymakers, both in the legislative and executive branches. This may make it easier to build consensus around specific quality improvement strategies. In exploring potential solutions, state policymakers and officials should consider the key strategies described below.

Promote a Common Vision for Improving Quality

State officials have the opportunity to encourage quality improvement across all programs by reinforcing the idea that quality is a priority. To help promote a common agenda, state officials can look to national organizations. Conferences can help build consensus about the importance of improving quality. Organizations such as the National Governors Association and the National Conference of State Legislatures, among others, can provide a forum for sharing successful approaches and lessons learned. National initiatives, such as the Maternal and Child Health Bureau of the Health Resources and Services Administration,[14] can help build interest and momentum and can support the efforts of state policymakers working toward the same goals.

The Commonwealth Fund's Assuring Better Child Health and Development (ABCD) program exemplifies an initiative that has helped to foster a common vision. The program, which works to improve the delivery and financing of child development services for young children in low-income families, included four states (North Carolina, Utah, Vermont, and Washington) in its first phase and an additional five states (California, Illinois, Iowa, Minnesota, and Utah) with co-funding from the Michael Reese Trust in its second phase, which began in 2004. Projects like ABCD can serve as catalysts for bringing together state policymakers across program and organizational lines to agree on key issues and strategies.[15]

Encourage Small Changes in the Right Direction

Quality improvements can take many years to accomplish. In the interim, state programs should also take on shorter-term goals, like improving data systems, adopting reimbursement systems to reward higher quality, or incorporating measures of quality developed by national standard-setting organizations into Medicaid, SCHIP, or state employee health plan contracts.

States can be laboratories for innovation and progress. Demonstration projects can build expertise, develop capacity, foster new ideas, facilitate coalition and partnership relationships, demonstrate the impact of new approaches, and provide models for others. Several states have pioneered unique initiatives. In Minnesota, for example, the Department of Human Services partnered with the University of Minnesota to explore access to care and patient satisfaction among Hmong and Somali immigrants to help the Medicaid agency adapt its policies and make improvements.

Define Indicators of Quality and Performance That Can Be Measured

Measuring performance is key to quality improvement, but states generally do not have expertise in the development and use of quality measures. States may need technical assistance in this area, and should take advantage of work other states are already doing to help ensure uniform measurements. There are two significant efforts that can assist them in this endeavor. The National Academy for State Health Policy, under a contract from the Centers for Medicare and Medicaid Services (CMS), conducted a Performance Measurement Partnership Project that produced seven measures for Medicaid and SCHIP programs, including key measures for children like rates of well-child care visits and children's access to primary care.[16] In addition, the American Public Human Services Association conducted a project, with Commonwealth Fund support, to analyze Health Plan Employer Data and Information Set (HEDIS) data for Medicaid managed care plans. This project evaluated the quality and delivery of health care in such plans and developed national benchmarks with which to gauge performance and draw comparisons with commercial plans.[17] The project subsequently continued with support from CMS.

Develop Reimbursement Methodologies That Encourage Quality Performance

State reimbursement systems, such as those in Medicaid and SCHIP, can be designed to improve quality through incentive-based, pay-for-performance mechanisms that reward quality. There are several ongoing examples of these kinds of

statewide initiatives. For example, several states involved in the ABCD consortium provide models of how the Medicaid reimbursement policies can be used to foster high quality of care. In addition, Rhode Island has become a leader in developing policies that encourage quality improvement in Medicaid, SCHIP, and other public health programs.[18] Washington increased the payment rate for pediatric providers who use a new Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) charting tool for children enrolled in foster care. Vermont added a new case management billing code to increase reimbursement for providers who agreed to participate in a pilot that involved intensive home visits and the use of a unified care plan. North Carolina made primary pediatric offices eligible for special payments for care coordination services.[19]

States can also look to form partnerships with private sector organizations, like business groups, that are already pursuing quality improvements. By creating a united front, purchasers are more likely to be successful and providers are less likely to be resistant, particularly if they can be assured that they will not face duplicative, inconsistent, or conflicting demands. A joint effort is also likely to be less costly because of the economies of scale. In Massachusetts, for instance, the state Medicaid agency partnered with major employers to develop a common set of performance measures for contracts with managed care plans.

Make Information About Quality Performance Available to the Public

Making information transparent and available can help improve performance because providers, consumers, and policymakers can use the data when making decisions. In Arizona, the legislature requires all HMOs participating in Medicaid to publicly report childhood immunization rates. The New York State Health Department annually reports measures of performance for all commercial and Medicaid HMOs in the state and makes the results easily accessible on a Web site. The Arkansas Medicaid agency contracts with the Quality Improvement Organization to use HEDIS measures to evaluate performance of the program, and then reports these data to the public and the legislature. Michigan produces a pamphlet for Medicaid beneficiaries that shows performance on specific quality measures, and also makes the information available on its Web site. Most recently, the National Committee for Quality Assurance prepared a comprehensive report with measures on effectiveness, availability, access, and use of services for the Pennsylvania SCHIP program.[20]

Steer Business to Providers Based on Quality Performance

State programs have the opportunity to purchase health care based on quality measures. Because managed care plans depend on new members to maintain enrollment levels, they are motivated to focus on quality measures that feed Medicaid enrollment, including HEDIS or EPSDT measures that relate to children. In Michigan, for example, competitive procurement for Medicaid managed care plans in 2004 was based primarily on quality measures, including HEDIS and Consumer Assessment of Health Plans (CAHPS) indicators. This created a priority among health plans to improve performance for the next procurement cycle.

Educate Parents

When empowered with good information, parents can make informed choices and are in the best position to improve quality of health care for their own children. Parents with good information are better prepared to ask pertinent questions and be informed advocates. States can help to provide parents with such information, through printed materials or through telephone nurse hotlines, and can encourage them to take greater personal responsibility for ensuring quality health care. These approaches can result in appropriate self-treatment of minor medical issues, fewer unnecessary visits to the doctor or hospital emergency room, and improved adherence to medical recommendations.[21]

Make the Business Case for Quality

The absence of a business case for improving health care quality is widely acknowledged to be a significant obstacle to investment in quality improvement initiatives. In health care, the business case must go beyond the strict definition of a financial return on investment (ROI), as clear, positive ROI evidence in health care tends to be the exception, rather than the rule.[22] Demonstrating a business case for children's care may be even more difficult, requiring a less fragmented system of financing and delivery and a newly defined approach to providing excellent, family-centered care.[23]

It is typically difficult to demonstrate short-term savings, but there are successes. In North Carolina, for example, the economic benefit of enhanced case management services in the ACCESS II/III program was so great that the North Carolina legislature mandated expansion of the program during a time the state budget was experiencing serious financial shortfalls.[24] The program, operated by community providers, furnishes care to Medicaid beneficiaries and other low-income individuals.

Involve the Community

State officials see the value of involving partners—community organizations such as the YWCA, the March of Dimes, and faith-based groups—at the local level. Such groups would participate not because of a valid business case, but for moral or ethical reasons. Tapping these organizations also provides the opportunity to develop a coordinated local referral system and financing base. In these situations, states may enhance the prospects for success by tying a quality improvement effort to other popular objectives, like school readiness.

STATES FACE SIGNIFICANT CHALLENGES

States face considerable, but not insurmountable, challenges in improving health care quality. The following challenges illustrate the issues that states must overcome to achieve improvements in quality.

Challenges in the Health Care Delivery System

Improving health care quality may require changes to the culture, traditions, and practice patterns of the health care delivery system. Accomplishing such change will not be easy, especially when the current system can include incentives that encourage poor quality or inappropriate care, like use of emergency rooms to provide non-urgent care. State officials must play a role in changing these incentives with the powerful tools and assets they have at their disposal, including using reimbursement incentives, publishing and distributing performance results on key quality measures, using performance measures in purchasing decisions, and enforcing compliance with quality performance requirements.

Challenges in Financing

In recent years, all state programs have faced significant cutbacks and retrenchment due to budget constraints. Even modest state budget cuts are magnified when states must forgo federal matching funds to achieve savings in the state general fund budget. In addition, it is difficult for states to invest in quality improvements—particularly typically expensive information technology tools—in an environment of fiscal distress and budget shortfalls. While certain quality improvement initiatives do reduce costs, available studies often do not satisfy budget officials who demand evidence of fiscal impact to justify funding decisions. Some positive fiscal impacts have been identified in recent studies,[25] but additional documentation would go a long way in assisting state decision-makers.

Challenge of "Silo" Organizations, Programs, and Funding

States maintain purchasing leverage, not only because of the size of Medicaid and SCHIP programs, but also because they procure coverage for state employees and others, through education, public health, and mental health programs. In total, these programs represent a large share of the total market—in terms of dollars spent, individuals served, and participating providers. However, states have trouble taking advantage of this combined market strength because of the compartmentalized or "siloed" nature of state organizations and program funding

sources. There is no obvious mechanism for coordinating activities that influence health care for children, making it difficult to align resources—both dollars and people—across agencies and programs.

Because restructuring existing systems would be extremely onerous, states must seek to improve quality within the current organizational and funding systems. This may involve developing statewide standards and policies that could apply across diverse populations. Due to federal restrictions against blending funding across various programs and agencies, the state systems are fragmented—by Medicaid, SCHIP, education, mental health, and public health programs—with separate financing sources and multiple delivery systems. This kind of system makes tackling problems and coordination difficult, turf battles inevitable, and agreeing on strategies almost impossible. To address this fragmentation, some states have created a cabinet position focused on children. This idea can be easily replicated by other states, if it proves successful.

Challenge of Leadership

Transforming programs or policies usually requires a champion—a leader with the visibility, influence, and commitment to advocate for change and inspire others to follow. A champion might come from within state government (e.g., governor, key legislator, senior state official) or from outside it. Leaders must see the value and payoff of improving health care quality for young children and be able to communicate a way to turn that vision into action.

Challenge of a Short-Term State Policy Focus

State officials tend to think in terms of what can be achieved within a legislative session or budget year, instead of the longer term. As a result, policymaking often focuses on what can be achieved in the immediate future. Few resources are dedicated to thinking ahead. In many states, planning departments were casualties of the budget cuts of the 1990s. Adding to the challenge, many states have suffered from a talent drain, which has left fewer individuals who can contribute a long-range perspective.

Challenge of Inadequate Data and Information Systems

Historically, states have not been early adopters of information technology systems. As a result, data are often lacking or expensive to retrieve, such as medical treatment history that can be captured only through a medical record audit. Quality improvement requires a benchmark for performance and data to document progress. Inadequate information technology systems and data reporting hinder state efforts to focus on quality improvement efforts. For example, states have had difficulty reporting the number of children receiving comprehensive well-child EPSDT screens using fee-for-service data, although encounter data from Medicaid health plans have improved in recent years. States often have a mixture of data from fee-for-service and managed care plans; without adequate information technology systems, it is hard to measure quality, make the case for improvement, or enforce standards.

Challenge of Inadequate Measures of Quality for Children

While the science of quality improvement is no longer in its infancy, quality measures are often not fully developed or integrated into program operations. The National Quality Forum report on child health measures noted a "paucity of child-relevant measures in widespread use," and concluded that "performance measures applicable to children are markedly underrepresented in the universe of national voluntary consensus standards."[26]

This has been an especially pressing issue in mental health programs, particularly for infants and toddlers. The available measures are less well developed for infants and young children, but progress is being made in improving outcome measures for these populations.[27]

State health programs also are burdened with necessary rules and requirements designed to ensure that tax dollars are spent appropriately. These protective measures are reflected in complex eligibility requirements, benefit restrictions, payment rules and administrative procedures. Complexity

may be a necessary evil, but it inevitably is an impediment to adding quality measures.

Even when good measures of quality are developed, they are not always adopted readily by state programs, health plans, and private sector purchasers. It often takes time and resources for measures to be incorporated into state and health plan reporting and performance systems.

CONCLUSION

Despite significant challenges in funding, administration, data and leadership, states can take steps to improve quality of health care for young children. The priority should be to develop performance measures for key elements of state programs, generate the best data possible on those measures, share the results broadly, and use the data to reward good performance. Furthermore, working with key policymakers and officials will be of central importance, in order to encourage these leaders to become champions of the cause. State officials are more likely to realize improvements when they work across departmental lines collaboratively, with a focus on the health of the child rather than any individual program.

According to the Institute of Medicine, "government must assume a stronger leadership role to address quality concerns."[28] States are in a unique position to improve the quality of health and health care for young children, but they must work in a coordinated way to set standards, adopt measures, develop data, recognize improvements, reward performance, and make procurement decisions. The objective will not be easily achieved, yet few efforts states might undertake would have a greater impact on the well-being of children.

Notes

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13 Ibid.

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[25] Bailit, *Beyond Bankable Dollars*, 2004.

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About This Study

To address the roles state policymakers can play in improving the health care of young children, a group of senior state officials convened in June 2004, with support from The Commonwealth Fund. The participants were selected to include representatives of all key programs administered by states that are involved with child health care. The group included senior administrators of Medicaid, SCHIP, mental health, public health and education; a state legislator, a governor's health policy advisor and a state budget director. Also participating were former state health and human services officials now focusing on issues relating to child health and quality. These current and former state officials were asked to identify specific strategies that states might use to improve health and health care for young children. Participants included: Nancy Atkins, Commissioner, Bureau for Medical Services, West Virginia Department of Health and Human Resources; Garnet Coleman, State Representative, Texas; Barbara C. Edwards, Deputy Director, Ohio Health Plans, Ohio Department of Jobs and Family Services; Neva Kaye, Program Director and Co-Interim Executive Director, National Academy for State Health Policy, Portland, Maine; Deborah Bradley Kilstein, Director of Program Development, Center for Health Care Strategies, Princeton, N.J.; Wayne Roberts, State Budget Director/Senior Fiscal Advisor, Office of the Governor, State of Texas; Ree Sailors, Executive Health Policy Advisor, Washington State Governor's Office; Mary E. Smith, Strategic Planning, Evaluation and Service System Analysis, Division of Mental Health, Illinois Department of Human Services; Patricia Stromberg, Executive Director, Children's Health Insurance Program, Pennsylvania Department of Insurance; Peter Sybinsky, CEO, Association of Maternal and Child Health Programs, Washington, D.C.; Kim Townley, Director, Kentucky Kids Now Program, Division of Early Childhood Development, Kentucky Department of Education; Vernon K. Smith (Facilitator), Principal, Health Management Associates, Lansing, Mich.; Melinda Abrams, Senior Program Officer, The Commonwealth Fund; Ed Schor, Assistant Vice President, The Commonwealth Fund.

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