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Issue Brief

Improving Child Health Care Through Federal Policy: An Emerging Opportunity

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ABSTRACT: Policymakers considering the 2009 reauthorization of the State Children's Health Insurance Program (SCHIP) have an opportunity to strengthen federal provisions to promote primary, preventive, and developmental child health care. Several pieces of legislation introduced in 2007 focused on aspects of child health quality, but none placed a specific emphasis on primary care. This issue brief describes three legislative proposals and additional quality provisions related specifically to primary care to consider for incorporation into federal law. These provisions include: 1) establishing a core set of primary child health service outcomes for tracking within Medicaid and SCHIP; 2) creating a structure within the Centers for Medicare and Medicaid Services that focuses on strengthening primary, preventive, and developmental child health services; 3) supporting additional research on child health quality and outcomes in primary care; and 4) providing incentives to states to promote evidence-based practices in children's primary health care.

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INTRODUCTION

Many states, often with the leadership of child advocacy organizations in broad-based child health coalitions, have taken strides in developing systems that provide all children with health care coverage. These efforts have built on both the Medicaid program and the State Children's Health Insurance Program (SCHIP) to create affordable options for parents seeking secure health coverage for their children.

While many states' efforts have included developing insurance coverage products and strategies for children not enrolled in Medicaid or SCHIP, those programs are still the foundation for covering otherwise uninsured children. In August 2007, Medicaid and SCHIP together have provided health coverage for approximately 30 percent of all children in the country and approximately 40 percent of all children under age 6.

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The programs provide coverage for a large percentage of children with special health care needs. Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, for example, is specifically designed to meet health needs from a child health perspective and serves a particularly important role for children with chronic health problems whose families could falter, if not collapse, without its comprehensive approach.

In 2005, Voices for America's Children, a national, nonpartisan, nonprofit organization representing 60 multi-issue child advocacy organizations in 47 states, established a Child Health Advisory Committee to work with national policy and advocacy organizations to strengthen and expand SCHIP. Voices established its goals for covering all children not only by making basic family coverage affordable, but also by providing children with necessary developmental health services. While efforts failed to reauthorize and expand SCHIP in 2007, they did lay much of the groundwork for federal action to expand child health coverage in 2009 when a new administration begins.

Congress has not yet introduced bills that speak directly to strengthening the quality of primary, preventive, and developmental health services, particularly through well-child care. This issue brief outlines elements that would move toward this end, and which Voices for America's Children believes should be considered for incorporation into federal child health care legislation.

The Voices program continues to press for the development of federal policies that both expand child health coverage and promote quality in that coverage, particularly around primary and preventive health services. While EPSDT calls for providing comprehensive preventive and developmental primary care, actual results from the program are unclear but show that it often falls short of providing that care. This problem may have occurred from failure of the federal program to hold states accountable for achieving access and quality benchmarks, and from failure of state programs to be explicit in their expectations of managed care organizations and health care providers. States also fall short when monitoring the quality of care they purchase and holding providers accountable.

Congress has begun to formulate policies that address child health quality issues. While not enacted into law, several provisions within the reauthorization of SCHIP move in this direction, especially regarding hospital-based and chronic illness care. Other bills have been introduced that could become vehicles for improving and ensuring the quality of child health services. Voices for America's Children promotes federal actions that would:

- establish and apply a core set of primary care child health service outcomes for tracking within Medicaid and SCHIP; create a structure within the Centers for Medicare and Medicaid Services that focuses its attention on strengthening primary and preventive child health services;
- support additional research on child health quality and outcomes in primary care; and
- provide incentives to states to promote evidence-based practices in children's primary health care.

2007 FEDERAL LEGISLATIVE CHILD HEALTH PROPOSALS

HR976: Children's Health Insurance Reauthorization Act of 2007. While securing substantial bipartisan support, Congress fell several votes short in overriding the presidential veto of this act. The primary points of controversy were the degree to which coverage should be extended to children in higher-income families, how states should address coverage of immigrant children, and how states that currently cover adults should transition their programs away from that coverage.

Receiving little public attention, largely because no controversy was raised over its provisions, HR976 included a set of provisions related to:

a. developing an initial core set of child health quality measures for children enrolled in Medicaid or SCHIP;
b. advancing and improving these measures by establishing a pediatric quality measures program;

c. requiring annual state reports regarding state-specific quality measures;

d. supporting demonstration projects to improve the quality of children's health care and the use of health information technology; and

e. establishing a specific childhood obesity demonstration project.

Under paragraph d, $20 million annually was committed within the reauthorization legislation for up to 10 grants to states and child health projects over a four-year period to conduct demonstration projects to:

- experiment with and evaluate the use of new measures of quality of children's health care;
- promote the use of health information technology in care delivery;
- evaluate provider-based models that improve the delivery of children's health services (including care management for children with chronic conditions and the use of evidence-based approaches to improve the effectiveness, safety, and efficacy of child health services); or
- demonstrate the impact of a model electronic health record format for children.

While paragraph d allows for use of demonstration funds to develop or diffuse models of child health service delivery, the primary emphasis of the demonstrations appears to be on the development and expanded use of quality measures and health information technology in state Medicaid and SCHIP programs.

S1226: Children's Health Care Quality Act. Also in 2007, Senators Bayh, Hatch, Lincoln, Bingaman, Coleman, and Salazar introduced this act. The legislation establishes a pediatric quality and performance measurement program within the Centers for Medicare and Medicaid Services, with funding of $10 million annually over the next four years for this purpose. While the measurement program speaks generally to pediatric quality measures, the remaining parts of the legislation focus primarily on hospital-based or chronic care, not on primary health care services.

The legislation also provides $10 million for each of the next four years that includes demonstrations in four categories of projects focusing on children served by Medicaid or SCHIP.

- Health Information Technology Systems. This demonstration includes projects for developing these systems, implementing model systems, and evaluating their impact on the quality, safety, and costs of care.
- Disease Management. This demonstration includes projects for provider-based disease management for children with chronic conditions, demonstrating their effectiveness, reducing adverse health outcomes, and preventing avoidable hospitalizations.
- Evidence-Based Quality Improvements. This demonstration includes projects for implementing evidence-based approaches to improving the delivery of hospital care for children across hospital services.
- Quality and Performance Measures for Providers of Children's Health Care Services. This demonstration includes projects to pilot-test evidence-based pediatric quality and performance measures for inpatient hospital services, physician services, or services of other health professionals.

Within 12 months of the enactment of this legislation, the comptroller general is required to submit a report to Congress with recommendations for the design and implementation of a demonstration project that evaluates the suitability of existing quality and performance measures for children's inpatient hospital services and provides a basis for payment rewards.

While the general development of pediatric quality and performance measures is not limited to hospital services or chronic care disease management, the general thrust of the legislation is on improving the quality of secondary and tertiary, rather than primary, pediatric care.

S2376: Medical Home Act. Senators Durbin and Burr introduced this third piece of legislation in 2007 to establish a demonstration project for providing patient-centered medical homes to up to one million beneficiaries under Medicaid or SCHIP. A medical home is a practice-based structure that facilitates the delivery of comprehensive care and promotes strong relationships between patients and their primary-care, physician-led team. The project is to be conducted in eight states over a three-year period. States will be required to establish a steering committee and a medical management committee to guide development and implementation of the project and to provide additional payments ($2.50 per month per beneficiary) to primary care providers. The findings within the legislation cite the importance of patient-centered medical homes in better managing chronic diseases and maintaining basic preventive care, and reducing racial and ethnic health disparities, duplicative health services, and inappropriate emergency room use.

The legislation does not contain any explicit reference to well-child care or to providing medical homes for preventive and developmental child health services. Thus, states could place most of their emphasis on targeted beneficiaries, particularly adults under Medicaid who have chronic health conditions and are high-cost users of services.

Formulating Policy to Improve the Quality of Children's Primary, Preventive, and Developmental Care

Each of the proposed bills addresses issues of quality within the health care system: creating new quality measurements in SCHIP and Medicaid; establishing new quality measures in children's hospital-based care; and managing patient care (adult Medicaid patients) through the use of the medical home concept. All involve increased use of or the creation of information technology, and all intend to increase the quality of patient services as well as the measurement of care outcomes. In addition, all would utilize a demonstration project to test and study quality issues.

While these three legislative proposals all address aspects of children's health care, none focus explicit federal attention on the opportunities and needs to improve primary pediatric practice or to strengthen well-child care to ensure that it addresses children's healthy development.

Additional provisions, which could be incorporated into any SCHIP reauthorization legislation developed in 2009 or as freestanding legislation, could enhance primary, preventive, and developmental care. The following four provisions would complement those in HR976, S1226, and S2376 regarding health quality and are particularly appropriate for inclusion within SCHIP reauthorization.

1. *Establish and apply a core set of primary care child health service outcomes for tracking within Medicaid and SCHIP*. Health experts generally agree that quality measurement is an essential step in developing a high-performance health care system. Currently, however, measurement in Medicaid and SCHIP focuses primarily on children's access to care and little on the actual content or quality of that care.

The Healthcare Effectiveness Data and Information Set (HEDIS) contains a limited number of measures related to primary child health services (well-child visits, lead screening, immunizations, and access to primary care physicians), as well as several treatment measures (follow-up services for Attention Deficit Hyperactivity Disorder, testing for children with pharyngitis, and treatment for children with upper respiratory infections). This limited list can be contrasted with a much broader set of recommended options for assessing the quality of children's ambulatory health care shown in the table on the next page.

Federal leadership could provide important guidance and direction to states in developing quality measures for primary and preventive child health services and could minimize duplication of effort in the development of measures and measurement methodology.

2. *Create a structure within the Centers for Medicare and Medicaid Services that focuses attention on strengthening primary and preventive child health services*. While children represent almost

Recommended Options for Assessing the Quality of Children's Ambulatory Health Care

Quality data available from administrative data:

- Percentage of 2-year-old children referred to Individuals with Disabilities Education Act Part C program
- Percentage of children 12–23 months screened for lead poisoning
- Proportion of children with diagnosis of asthma on inhaled steroid medication
- Percentage of newborn infants with a well-child visit in the first week of life
- Percentage of recently hospitalized children receiving a follow-up appointment within two weeks of discharge
- Percentage of children with a diagnosed mental illness who have received mental health services or are on psychiatric medication
- Total average well-child visits in the first 15 months of life
- Percentage of children ages 2–6 who received a well-child visit during the past year
- Percentage of children by age groups (3–15) who received corrective lenses

Quality data currently requiring parent report or chart audit:

- Percentage of children receiving a standardized developmental screen at 9, 18, and 24 or 30 months of age
- Percentage of children ages 2–6 with a regular source of care
- Proportion of children with a chronic health problem who have a current management plan
- Percentage of 4-year-olds with a documented vision screen
- Percentage of parents whose informational needs were met by their child's health care provider
- Percentage of parents asked whether they had concerns with their child's learning, development, or behavior
- Percentage of children (2–18) for whom a body mass index was computed at the most recent well-child care visit

Source: E. L. Schor (unpublished), as cited in L. Simpson, G. Fairbrother, S. Hale, and C. Homer, *Reauthorizing SCHIP: Opportunities for Promoting Effective Health Coverage and High-Quality Care for Children and Adolescents* (New York: The Commonwealth Fund, Aug. 2007).

half of all people served under the federal Medicaid program, they constitute less than 20 percent of all program costs. Much of the emphasis of the Centers for Medicare and Medicaid Services has been on cost containment, which naturally has led to a focus on the most costly users of health care services: the elderly and people with disabilities.

Improving the trajectory of children's health and development, however, can reduce future expenditures for disease and chronic care management. High-quality primary, preventive, and developmental services for children are key to the long-term containment of health care needs and their resulting demands on the health system.

Reducing future health care and other social expenditures requires attending to and adequately financing children's primary health services within Medicaid and SCHIP—in particular, those that reduce the risk for illness and injury and promote healthy development. A Children's Healthy Development Commission within the Centers for Medicare and Medicaid Services could help to bring this focus to light. Specifically, it could review Medicaid and SCHIP policies and regulations affecting the provision of primary, preventive, and developmental health services and promote the identification, development, and use of evidence-based practices to improve children's healthy development. This mission could involve addressing the following components of a comprehensive medical service for children:

- Medicaid and SCHIP payment policies that support primary and preventive health services

- Medicaid and SCHIP policies that promote effective referrals to and use of other, nonmedical, federal and state programs and services
- exemplary pediatric practices to improve children's healthy development and ways Medicaid and SCHIP can support their adoption and promotion by states
- coverage for screening and treatment services for family members whose own physical and mental health or social circumstances are likely to adversely impact children's healthy development
- specific practices that can address cultural, language, and racial issues that reduce health care disparities in the provision of primary and preventive care
- needed research and demonstration programs to expand the knowledge base of effective primary pediatric practices and quality in child health services

Such a commission could help the Centers for Medicare and Medicaid Services provide greater clarity in its guidance, based on evidence of effective practice, on the following: appropriate uses and reimbursement for targeted case management and care coordination services; use of rehabilitation services under EPSDT; and use and reimbursement for allied health services provided through referrals from primary care providers. Such a commission also would be especially useful in ensuring that some of the Centers for Medicare and Medicaid Services activities focus explicitly on primary care and preventive services—services that apply to meeting children's needs for healthy development, rather than disease management or chronic care services for adults.

3. *Support additional research on child health quality and outcomes in primary care*. One of the commission's responsibilities would be to identify research needed to expand the knowledge base on effective primary pediatric practices and quality in child health services. Again, the lion's share of research funding, both federal and private, has been devoted to disease management and not to health care practices intended to prevent illness and promote good health. Most attention has focused on the last, rather than the first, years of life.

Primary child health care is an evolving field with many opportunities to improve quality, efficiency, and effectiveness. Many promising practices in primary care pediatrics deserve to be more extensively studied. The federal guidance for preventive child health care, Bright Futures, recently has been revised and offers a strong foundation, based on existing research and practice, for providing comprehensive preventive and primary health care services for infants, children, adolescents, and their families.

Bright Futures also notes the need for further research on child health services, to develop both effective interventions that prevent, detect, and address as early as possible specific child conditions that compromise health, and secondly, to apply effective practices within pediatric settings. Further, research that focuses on prevention and seeks population-based impacts likely will require different and more research than that typically used in clinical trials. Emphasis should be placed on finding and appropriating funding and leadership at the federal level for such research.

4. *Provide incentives to states to promote evidence-based practices in children's primary health care*. Each policy recommendation cited in the previous section proposes demonstration projects, projects that expand quality measurement, quality oversight, quality incentives, and research on the quality of primary and preventive child health care services. Demonstrations have a recognized value in spreading the diffusion of new practices to a larger share of practitioners within the system. Demonstrations also can help address critical

questions related to the adoption of previously isolated, exemplary practices as the standard of care in communities.

Even if all three pieces of federal legislation discussed earlier became law, the focus of their demonstrations would not necessarily contribute much to improving the quality of primary and preventive child health care. Specific federal incentives, through demonstrations and payment reform, could substantially advance the availability and quality of primary, preventive, and developmental child health care. Awarding grants to states to conduct demonstration projects on primary care could be directed to the following types of activities:

- expanding the use of evidence-based programs and practices under Medicaid and SCHIP such as Help Me Grow, Healthy Steps, Reach Out and Read, and state actions under the Assuring Better Child Health and Development (ABCD) Commonwealth Fund initiative
- establishing effective care coordination elements within Medicaid and SCHIP to ensure appropriate and successful referrals and follow-up for developmental services and to address social determinants of health
- developing and promoting evidence-based practices to identify, enroll, and provide appropriate services to children at particular risk for poor child development outcomes, with a particular emphasis on reducing racial and ethnic disparities and providing culturally competent care
- refining and adapting screening tools and protocols for routine use in well-child visits to detect developmental and social, as well as physical, issues impacting children's healthy development
- identifying and addressing parental issues, such as mental illness, substance abuse, and family violence that impact children's healthy development within the context of Medicaid and SCHIP programs

Taken together, these strategies—developing primary child care quality measures, creating a commission within CMS focused upon strengthening primary child health care under Medicaid and SCHIP; supporting additional primary and preventive care research; and providing incentives to states to strengthen their own child health systems—can lead to improved child health quality and better child health and development outcomes. Ultimately, such investments are likely to lead to improved adult health status and reduced demand for and costs of acute and chronic health care services, especially later in life.

CONCLUSION

Federal leadership can spur state actions to build stronger primary and preventive child health services and ensure quality and accountability. While state Medicaid and SCHIP programs vary substantially, most states can benefit from federal leadership to define and promote primary and preventive health services, particularly within Medicaid and SCHIP, and would respond to opportunities to build on evidence-based programs to strengthen their systems.

The American Academy of Pediatrics has established sound guidelines for primary care and well-child visits, and Bright Futures contains many of the tools and resources for incorporating these into practice. The challenge is to support adoption of these best practices so they become routinely available to all children.

This goal cannot be achieved without concerted and intentional efforts to incorporate them into Medicaid and SCHIP, without the attendant regulations, policies, and reimbursement systems that support them. The four federal actions discussed here, in addition to those developed in proposed federal legislation, should be part of the deliberations that go into developing health policy legislation in 2009, with SCHIP reauthorization representing a logical place for this action.

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