



MEDICAID AND CHIP STRATEGIES FOR IMPROVING CHILD HEALTH

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ABSTRACT: Medicaid and Children's Health Insurance Program (CHIP) leaders are assessing and improving the quality of care provided to children and adolescents, but many states are finding the resources available to them are inadequate for the job. This report identifies states' priorities for measuring and improving child and adolescent health outcomes and points to opportunities for foundation and government support of states' needs. States see a need for measures that focus on outcomes, not processes; measures that are standardized across programs and agencies serving children; and measures that indicate progress toward specific program goals. In addition, state officials want to be able to compare their state's performance against others in national data sets, using common metrics and methodologies. They would like additional strategies for tying their quality improvement efforts to reimbursement methodologies for health plans and individual providers, to encourage higher performance.

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EXECUTIVE SUMMARY

Medicaid and the Children's Health Insurance Program (CHIP) are at a turning point in their efforts to improve the health and well-being of children and adolescents. In each state, program officials are working with existing national measurement systems or state-developed tools to assess health care quality, and they have developed sufficient baseline data to show where improvements are needed. They are trying out new strategies, and take pride in their efforts to improve health outcomes for children and adolescents.

At the same time, states would like to do better. They believe their quality goals would be achieved more quickly if they had access to specialized technical assistance that allows them to learn from experts and from the experience of colleagues in other states. With states ready to push forward, new federal funding to support the advancement of child quality measurement and improvement would come at an opportune time.

This study is based on findings from a national survey of Medicaid and CHIP programs as well as focused discussions with selected program officials. Conducted by Health Management Associates, the survey and discussions addressed current approaches being used by states to improve quality of care and health outcomes for children and adolescents, the barriers states experience as they pursue quality improvement activities, and their assessment of what resources or strategies would lead to further improvements. Three compelling messages emerged:

1. The currently available set of measures is inadequate to fully address quality of care for children. States see a need for measures that focus on outcomes (as opposed to processes), measures that are standardized across health programs and across agencies serving children, and measures that would indicate progress in reaching their specific program goals.
2. State officials want to be able to compare their state's performance against others in national data sets, using common metrics and methodologies. Comparative data can be useful to states in prioritizing resources and managing provider and health plan contracts. Knowing the gap between current performance and best performance on valued measures can help mobilize quality improvement efforts.
3. State officials would like to enhance their quality improvement efforts by incorporating data on quality and performance into reimbursement methodologies for health plans and individual providers, to encourage and reward higher

performance. States would like to hear more about experiences of other states working with plans and providers in order to replicate or adapt best practices to their states.

The Centers for Medicare and Medicaid Services, the Agency for Healthcare Research and Quality, and other organizations have an opportunity to accelerate the pace of change. Medicaid and CHIP officials indicated that the strategies they would value most would include targeted technical assistance, improved opportunities to learn from each other and from experts in quality improvement, and participation in an active coaching process that includes expert guidance to the states and to their health plan partners.

MEDICAID AND CHIP STRATEGIES FOR IMPROVING CHILD HEALTH

INTRODUCTION

Medicaid and Children's Health Insurance Program (CHIP) leaders are increasingly involved in assessing and improving the quality of care provided to children and adolescents. Traditionally, Medicaid and CHIP programs have functioned as health insurers, with the primary goal of enabling access to care and with less emphasis on overseeing the actual content of the care provided. Over the past 15 years, however, state officials administering these programs have expanded their role to include oversight of the effectiveness of the care provided and creation of incentives for quality improvement.

Many states are finding the quality assessment and improvement resources currently available to them not fully adequate for their needs, primarily because current quality measures tend to focus on processes rather than outcomes. Many of the most frequently used measures are applicable to inpatient rather than ambulatory care, and many of these exclude children under age 18 from measurement specifications. With the majority of Medicaid and CHIP enrollees, especially children, being healthy and needing mostly primary and preventive care, current measurement resources do not align well with states' needs. In addition to problems with measures, many states have little experience in using performance measurement and lack adequate resources to launch effective quality improvement strategies.

In this context, The Commonwealth Fund asked Health Management Associates (HMA) to conduct a study to identify current state priorities for child and adolescent health outcomes and quality improvement and to identify opportunities for foundation and government support of states' needs. The study focused on activities led and coordinated by state Medicaid and CHIP programs that are designed to improve health care quality and outcomes for the children enrolled in these programs.

STUDY METHODOLOGY

This report is based on: 1) findings from a survey of Medicaid and CHIP directors in all 50 states and the District of Columbia; and 2) two focused discussions with selected state officials. The first discussion included Medicaid directors who serve on the executive committee of the National Association of State Medicaid Directors (NASMD) (see [Appendix 1](#) for a list these individuals). That discussion, which occurred in September

2008, was structured to inform the preparation of the survey on the issues of quality for children enrolled in Medicaid and CHIP. The second discussion occurred in a full-day meeting of the Project Advisory Group at the end of February 2009. The meeting was timed to occur while the survey was in the field and responses had been received from about half the states. The Project Advisory Group included 12 state officials: two Medicaid directors, three senior Medicaid staff with responsibility for managed care and quality issues, three Medicaid medical directors, three CHIP officials responsible for quality in stand-alone CHIP programs, and the executive director of NASMD ([Appendix 2](#)). Participants were asked to share promising state practices in improving child health outcomes, to identify additional ideas for technical support to achieve states' quality goals, and to assist in the interpretation of the early findings from surveys received at the time of the meeting.

The 50-question survey asked about current quality measurement and improvement policies, the adequacy of current quality measures to support state quality goals, needs for technical assistance, and the priority of quality relative to other Medicaid and CHIP concerns, such as budget uncertainties and access to care. Each question had multiple-choice responses, and each question offered the opportunity to provide additional information. (See [Appendix 3](#) for the survey instrument.)

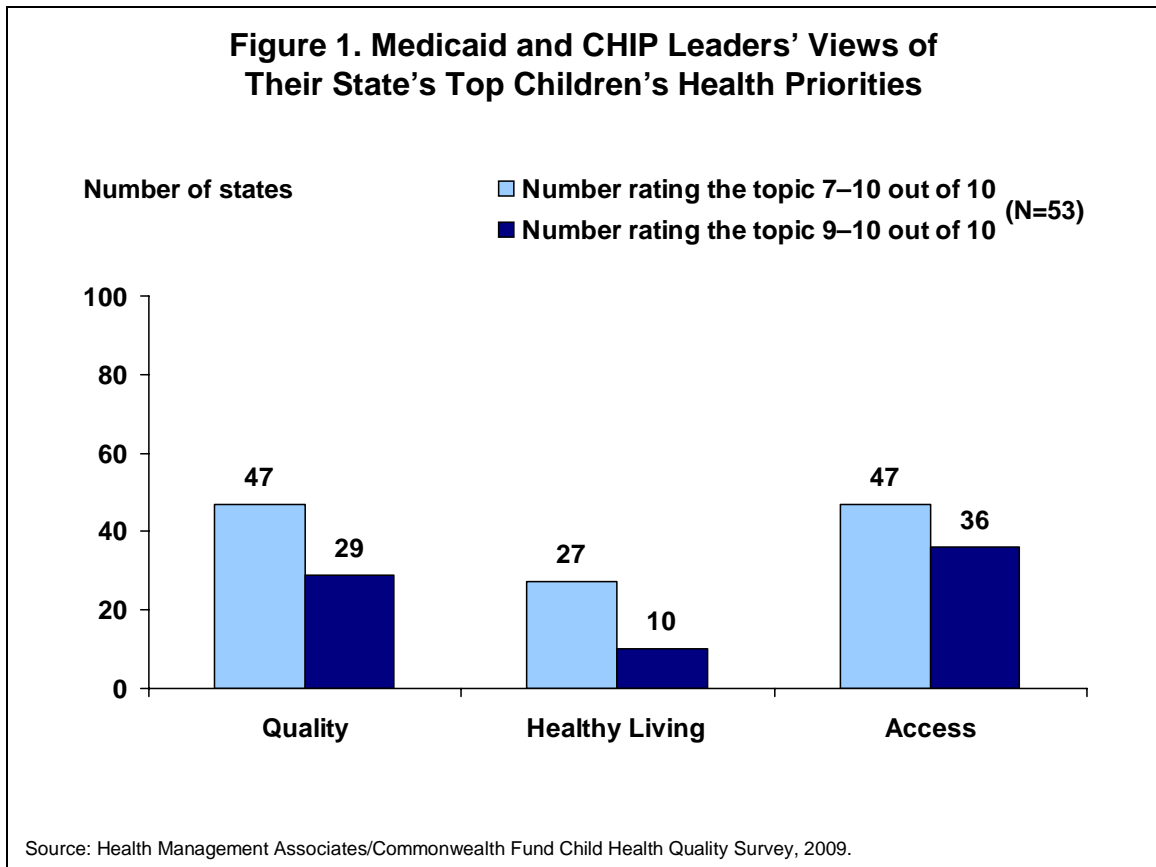
The survey period was February through March 2009, during which time the Children's Health Insurance Program Reauthorization Act (CHIPRA) passed Congress and was signed into law, providing new funding for CHIP and for child health quality improvement efforts. The survey included questions about the potential use of these anticipated funds.

A total of 54 completed surveys were received from 43 states and Washington, D.C., including responses from 43 Medicaid programs and 11 separate CHIP programs. Ten states responded with both a Medicaid survey and a CHIP survey.

FINDINGS

Quality is a very high priority for states at this time. State officials ranked quality of care nearly as high as access to care, which continues to receive much more attention in the media and among policymakers. Program directors rated the importance of access, quality, and health promotion in their states in 2009 on a scale of 1 to 10, with 10 being the highest priority (Figure 1). Child health quality was rated 7 or higher by 90 percent of responding Medicaid and CHIP leaders and 9 or 10 by almost 60 percent of state

Medicaid and CHIP officials. This makes quality of care a priority comparable to access to care, which was also rated 7 or higher by 90 percent of respondents and 9 or 10 by 70 percent. In contrast, just half of respondents rated school exercise, nutrition, and other health promotion activities for children as a high priority (7 or higher), and only 18 percent of respondents said that it was a very high priority (9 or 10).



Program leaders who participated in the project meetings confirmed the very serious commitment of state officials to quality improvement and better health outcomes for children. They noted that Medicaid and CHIP are the largest insurers of children in the state, and it is therefore up to them to take responsibility, as one official said, for “growing a healthier generation.” State officials communicated this sense of responsibility regardless of whether their Medicaid and CHIP programs were operated directly by the state on a fee-for-service basis or through contracts with health plans. They indicated they were enthusiastic to share what they were doing and to learn what strategies others have tried, so that they might improve their own programs.

Current Practices in Performance Measurement and Improvement

All states are engaged in measuring quality in some manner. However, they do not have a common approach to measurement or to how they use the information to leverage change and improvement. Nationally developed metrics required for health plan credentialing, such as the Healthcare Effectiveness Data and Information Set (HEDIS), developed by the National Committee for Quality Assurance (NCQA), are the most commonly collected and reported quality measures—probably because some states rely heavily on health plans to organize and deliver health care services for children. For CHIP, there is somewhat greater uniformity, since the Centers for Medicare and Medicaid Services (CMS) encourages states to use a group of HEDIS measures to report annually on their program.

Particularly in Medicaid (but also in CHIP), many states augment national measurement sets with complementary, state-developed measures that focus on state priorities, such as dental access. Often they deviate in some respect from the HEDIS specifications to accommodate specific state policies. States are concerned about the burden that data collection places on plans and providers and thus are often reluctant to impose additional requirements, such as NCQA accreditation. New measures that would assess quality more comprehensively, rather than through multiple individual measures, and that focus more on outcomes than processes would be well received.

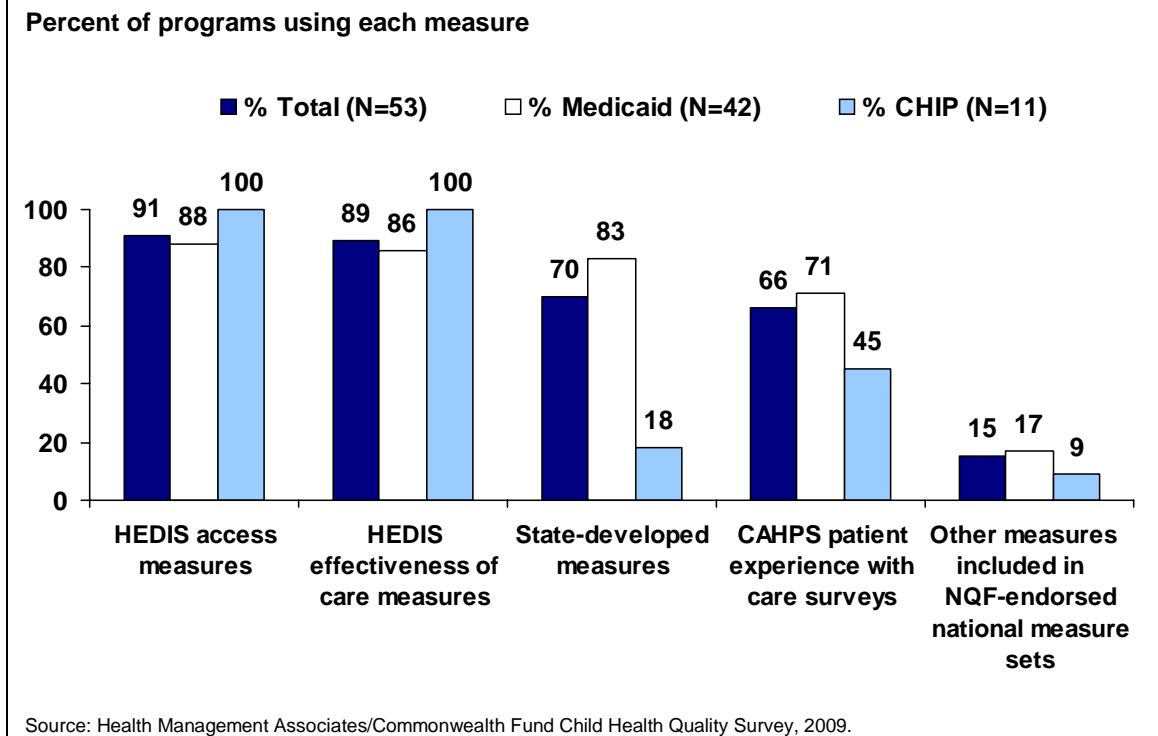
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States' approaches to quality improvement (as distinct from quality measurement) are more diverse. Public reporting was the sole quality improvement strategy used by half or more of the respondents to the survey. A number of state leaders reported that they lack the resources to implement performance bonuses or penalties, both because they lack a reliable, fair methodology and because the size of the incentive that could fit their budgets would not be adequate to change behavior.

Measurement

Children's coverage programs are nearly universal in their use of HEDIS measures to assess the quality of care for children. Of responding programs, almost 90 percent of Medicaid programs and all CHIP programs reported using both HEDIS access and effectiveness measures (Figure 2).

Figure 2. Performance Measures Currently in Use



Most Medicaid programs (83%), but only a few CHIP programs (18%), augment national measures with state measures. In discussions, program leaders reported their additional measures are designed to support state-specific quality initiatives or to fit better with a Medicaid primary care case management model of health services delivery. These additional state-developed measures are listed in Figure 3. Fifteen percent also use measures endorsed by the National Quality Forum, which are more clinically oriented, but which are not HEDIS measures. States are somewhat less likely to use Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient experience surveys, though more than two-thirds of Medicaid programs and 45 percent of CHIP programs reported they assess patient satisfaction with CAHPS surveys.

Figure 3. Other State-Developed Measures

- Early and Periodic Screening, Diagnosis and Treatment Rates, reported to the Centers for Medicare & Medicaid Services in the CMS–416 Report; or specific measures related to EPSDT such as developmental testing, lead screening, and immunization rates
- Modifications of standard HEDIS questions (e.g., well-child visits in the first 15 months; lead screening)
- Dental CAHPS Survey; other dental measures (e.g., access to dental care for children with special needs)
- Some AHRQ measures (e.g., taken from the National Quality Measures Clearinghouse)
- Process of care measures (e.g., use of beta agonists for asthma; diabetic care; vision)
- Youth Behavioral Risk Factor Surveillance Survey
- Increased health services utilization (general)
- Preventable hospitalizations (also known as ambulatory care–sensitive conditions)
- Post-hospital discharge follow-up care
- Mental health measures, e.g., attempted suicide rate or depression screening
- Member satisfaction survey developed and used by multipayer group
- Readmission rates
- Disease management reports
- Child Health Assessment and Monitoring Program (CHAMP) and Pregnancy Risk Assessment Monitoring (PRAMS)
- Adolescent preventive care measures (e.g., sexual activity, depression, tobacco, and substance abuse screening and counseling rates)
- Childhood obesity measures
- Birth outcomes
- Bright Futures

Source: Health Management Associates/Commonwealth Fund Child Health Quality Survey, 2009.

Medicaid and CHIP leaders are mixed in their beliefs about the adequacy of current measures for helping them achieve their goals (Figure 4). A quarter of Medicaid respondents and nearly half of CHIP respondents believe currently available measures are adequate for their work to improve care for children and adolescents. In discussions, some expressed the view that measures are a trigger or starting point for improvement work, but not the end-goal, so it is all right if they are imperfect. Others expressed that better, more credible measures would help them identify issues and gain support from providers and other stakeholders.

**Figure 4. Beliefs of State Officials
About the Adequacy of Current Measures**

	% Total (N=53)	% Medicaid (N=42)	% CHIP (N=11)
Currently available measures are adequate right now for Medicaid and/or CHIP	28	24	45
Currently available measures are not adequate right now for Medicaid and/or CHIP	26	31	9
Medicaid and CHIP could do a better job to improve care for children and adolescents if there were:			
Additional measures	75	79	64
Improvements in existing measures	74	76	64

Source: Health Management Associates/Commonwealth Fund Child Health Quality Survey, 2009.

The greater satisfaction with current systems seen among CHIP officials compared with Medicaid officials may be due to CHIP’s greater reliance on managed care plans. Managed care plans have to meet federal quality standards, which may lessen the burden on state officials. CHIP officials may be more willing to defer to the federal requirements. Medicaid is more likely to have a fee-for-service component or primary care case management—where the state is on its own with regard to quality oversight.

Several states reported that CAHPS in particular, but most measures generally, are not fully adequate to guide improvement efforts. Massachusetts, for instance, has moved away from satisfaction data collected at the plan level and toward practitioner-level data instead. Practitioner-level data, state officials find, are more “actionable” and better suited to benchmark against commercial plans that have also made the switch from CAHPS to a locally developed practitioner-level patient satisfaction survey. As an example, Massachusetts officials, rather than using the traditional CAHPS questions about whether doctors communicated well, use more specific questions, such as, “Were you counseled to quit smoking?”

New York indicated that the CAHPS survey provides them a broad overview of quality, but they have added their own questions to help them “peel the onion back.”

Several state officials expressed a desire for measures that link access, process, and outcomes. As one official noted, metrics should not just assess if a child with asthma got the right prescription, but whether or not the child had fewer trips to the emergency room as a result of that treatment decision.

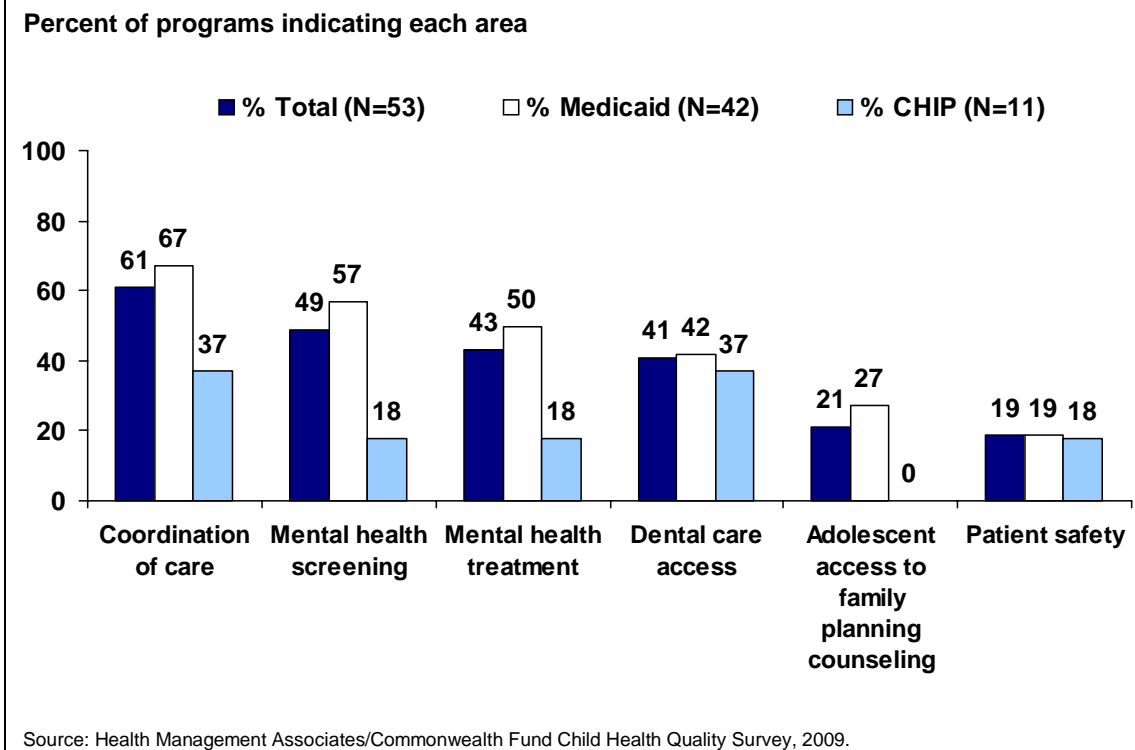
Metrics should not just assess if a child with asthma got the right prescription, but whether the child had fewer trips to the emergency room as a result of that treatment decision.

When pressed to identify measures that were regarded as most useful, meeting participants mentioned the HEDIS measures of immunization rates, well-child visits at 15 months of age, and adolescent well-care visits. In each case, participants felt these measures were useful flags of missed opportunities. Whether they agreed with the adequacy of current measures or not, about two-thirds (68%) thought they could do a better job of improving care for children and adolescents if there were additional measures or improvements in measures. When shown a list of topics for which better measures might be needed, respondents endorsed most as being valuable and prioritized care coordination, mental health screening and treatment, and dental access as the most important to their work (Figure 5).

Beyond the choices offered in the survey, states identified additional needed measures, such as:

- underuse of needed care;
- longitudinal measures that allow tracking from diagnosis and referral through treatment and health outcomes;
- measures relevant to special populations (e.g., measures of the impact of managed care on access and quality for SSI children);
- patient-centeredness of care;
- health literacy; and
- population health measures.

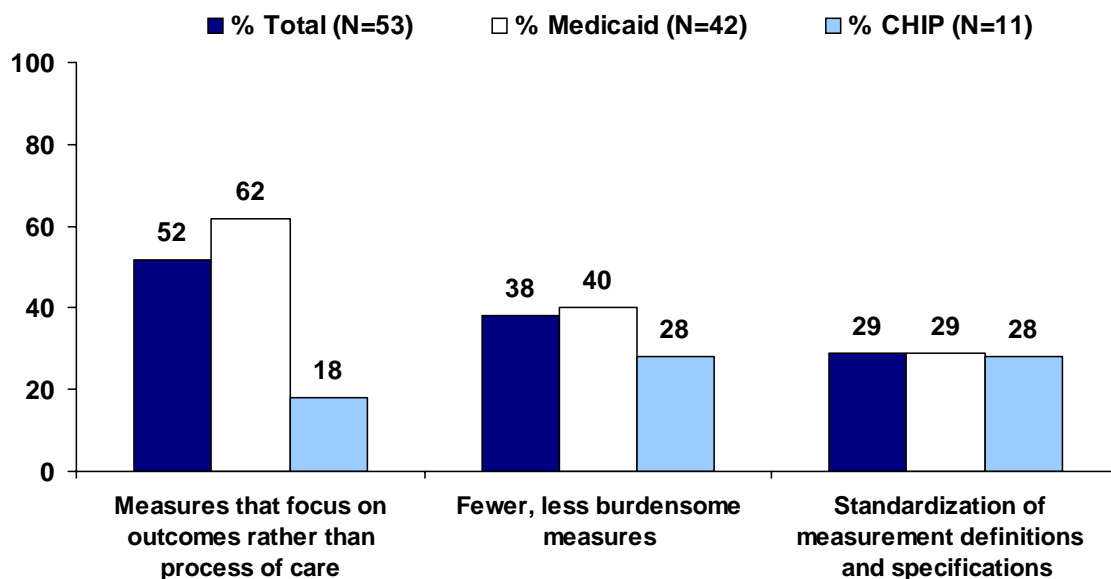
Figure 5. States Reporting an Interest in New Measures



Survey respondents agreed, too, on the need for several methodological improvements. Over one-half of the states indicated a need for new and better outcome measures, rather than process measures. Some state officials acknowledged their discomfort with process measures that put them in a dialogue with providers about the right way to treat patients. Mostly, they were not interested in that level of engagement, but would prefer to monitor outcomes. Almost 40 percent of all respondents also would prefer measures that placed less burden on providers to collect data. Nearly one-third wanted more standardization of measurement definitions and specification (Figure 6). In follow-up, several noted their wish to standardize Medicaid and CHIP measures to allow benchmarking and evaluation. Similarly, standardizing the manner in which children are counted on the HEDIS and Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program (CMS 416) reports to CMS would benefit states trying to compare access to preventive care for children.

Figure 6. Improved Measurement Strategies or Methodologies That States Report Would Be Beneficial

Percent of programs reporting each improvement



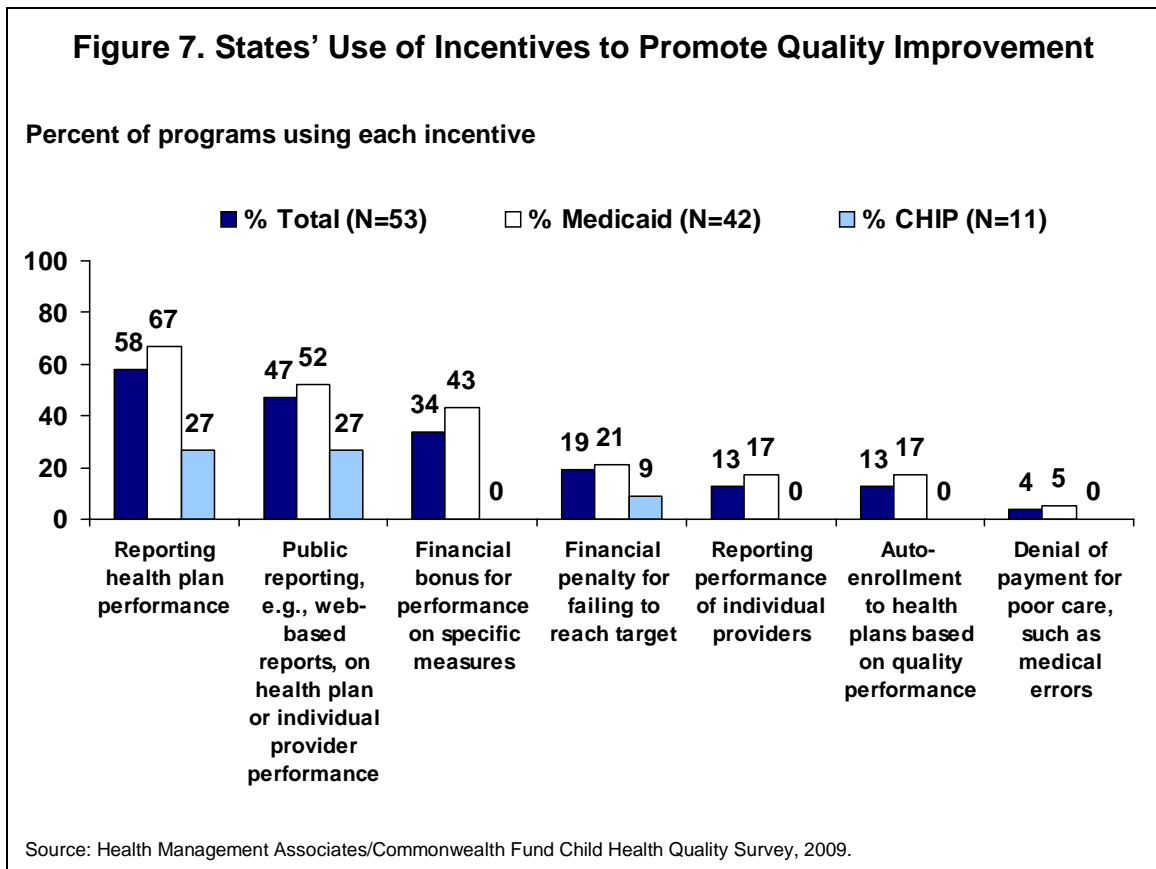
Source: Health Management Associates/Commonwealth Fund Child Health Quality Survey, 2009.

In addition to the three prompted categories, additional write-in responses illustrated how deeply state staff are delving into data collection efforts. They suggested quite specific improvements, such as:

- measures that are useful in a fee-for-service system and allow comparison between fee-for-service and managed care quality;
- standardized definitions of which populations are included in benchmark data, such as enrollees in Temporary Assistance for Needy Families (TANF), enrollees in Supplemental Security Income (SSI), and Medicare/Medicaid dual-eligibles;
- adaptations to measures to allow states to monitor quality for children not meeting the continuous enrollment criteria, who currently constitute a large share of enrollees;
- adaptations for states with unique program structures; and
- targeted measures that distinguish between general health status and health outcomes resulting from a specific treatment.

Performance Improvement

Medicaid and CHIP directors say that public reporting is one of their primary strategies for using health plan or provider performance data to improve quality of care. Supplying benchmarked data to plans or posting the data on a Web site for broader public use are the top two strategies employed by Medicaid or CHIP programs (Figure 7). States did not offer evidence that these strategies by themselves are having an impact on quality, though perhaps they contribute to the culture of transparency and quality improvement they seek to create in their states.



Some Medicaid programs, though none of the responding standalone CHIP programs, have embarked on paying bonuses for exceptional performance on state-selected quality measures. Eighteen of the 42 responding Medicaid programs (40%) currently award a bonus for exceeding specified quality benchmarks. For example, one state pays bonuses if 80 percent or more of participants receive the appropriate number of well-child visits. Another state adjusts premiums for past performance on preventable hospitalizations, inappropriate use of the emergency room, and inappropriate prescribing.

One state is engaged in a demonstration project that pays providers more based on their medical home score (calculated using the NCQA Patient-Centered Primary Care Medical Home instrument.)

Oklahoma Medicaid described its collaboration with the Department of Health to design an incentive based on delivery of the fourth DTaP (diphtheria, tetanus, and pertussis) vaccine. Oklahoma is just beginning to partner with the mental health and substance abuse agency to reward achievement of a state-defined substance-abuse measure. A third strategy in Oklahoma has been to tie graduate medical education payments to performance at the teaching hospitals. Though no money has yet been paid, the development of this policy was reported to have contributed to improved performance.

In this study, a number of states noted barriers to providing financial incentives. Barriers include inadequate data, no money or legislative authorization, and lack of a mechanism for taking back money if the “incentive” is actually a penalty for poor performance. Further, several state leaders said it was difficult to consider bonus payments without first addressing the adequacy of base provider payment rates, especially in instances in which reimbursement had been held to zero growth or was reduced in recent years.

Some states reward high-performing health plans with additional enrollees, through the formula for auto-enrollment of Medicaid beneficiaries who do not choose a specific health plan. For some states, this allocation of new enrollees is in addition to bonus payments awarded for performance; for other states, this is a primary incentive for rewarding plan performance. Seven of the 42 Medicaid respondents indicated that performance on specific quality measures is a factor in deciding whether or which providers or health plans are assigned children if the family does not select a provider. Two states reported that auto-enrollments stop altogether for plans not meeting standards. This can be a very powerful incentive for quality, the officials said, because auto-enrollment is often an important vehicle for plans to maintain or grow membership, given the continuous turnover that characterizes Medicaid enrollment.

Ten states use the stick rather than the carrot, by withholding a portion of payment if a plan fails to achieve a quality standard set in the contract. Two of the 42 responding Medicaid programs have instituted reimbursement policies that withhold payment in situations where there are serious avoidable medical errors.

Another, perhaps gentler policy option is to pay for participation in specific initiatives, where participation itself is regarded as contributing to higher performance. For example, one state with a primary care case management program described provider reimbursement add-ons that can be earned for participating in initiatives meant to improve quality, including a medical home initiative and a designated care coordination program administered by the state.

Accreditation

Some states leverage national accreditation as a tool for managing quality in their programs. Accreditation by a national organization reflects attainment of a certain level of performance and a commitment to continued improvement. One-fourth of Medicaid and one-fourth of standalone CHIP programs require health plans to be accredited by NCQA in order to be a participating plan. Six additional programs (including one CHIP program) reward plans that voluntarily undergo accreditation. For example, during the plan procurement process, one state gives additional points to plans that are accredited, as well as points for the duration of their accreditation status. Another state includes NCQA accreditation in the overall pay-for-performance calculation. However, other states acknowledged the cost to plans of accreditation and, instead of using accreditation, have relied upon their own quality assessment activities.

State Health Plan Monitoring

Pursuant to federal law, all states require their managed care partners to report on quality, cooperate with an external quality review organization hired by the state to audit quality at the health plans, and complete at least one performance improvement project.

Specific state quality standards vary quite a bit, which may reflect local needs and culture or uncertainty as to how much monitoring is necessary to achieve the program's goals. For example, one state requires a corrective action plan if the managed care organization is below the national average or if its score has dropped by at least 5 percent from the previous year. Another state sets the threshold for corrective action at an absolute level of 60 percent on three EPSDT measures. In some cases, state requirements are in addition to accreditation.

The extent of state staff involvement varies, too. Massachusetts, for example, takes a particularly active role in improving health plan quality. In addition to requiring data reporting, quality improvement plans, and regular monitoring, Massachusetts Medicaid staff convene quarterly quality management meetings with the medical director

of each plan on each improvement topic. Plans discuss best practices and process changes that would help them attain specific state goals for quality and performance. Virginia has a similar strategy for working closely with plans. Arizona has an internal advisory group that works closely with plans to identify improvement opportunities based on performance data in chosen areas. They start with a root cause analysis, bring in outside clinical experts, and jointly undertake an improvement initiative. In one state, each plan is scored based on two criteria: whether they are at, above, or below the standard, and if the trend is improving, stable, or getting worse. The intervention varies by where the plan falls on the two measures.

All programs do not have the capacity to work this closely with their plans. Committing to ongoing work with plans can be very labor-intensive. One state official commented on the breadth of this undertaking, noting that monitoring quality for health plans in their CHIP program took 20 staff people, whom he pulled from a variety of roles throughout the agency. It is not surprising, then, that some states rely almost exclusively on their external quality review organization to work with plans.

Impact of Quality Measurement and Improvement on State Policies and Practices

State program leaders were asked to identify any specific changes they have made to their programs based on the work they have been doing on quality. In other words, what difference had state quality improvement efforts made? What outcomes had resulted from the efforts to measure quality and improve performance? This was an open-ended question, and several themes emerged from state responses.

Nearly all state officials reported that their quality improvement efforts had resulted in beneficial changes. One of the most frequently mentioned results was improved reimbursement for priority services. Through measurement, many states identified the underuse of priority services, like medical and dental screening. When they approached their providers to address the deficiencies, providers raised concerns about inadequate payments. In several states, Medicaid underpayments over time had caused providers to leave the program or adopt practice styles that did not work well with screening and patient education needs.

For example, Virginia reported that as a result of low payments, access had suffered and it was impossible to measure quality. Over 80 percent of enrolled children were seen by only 100 dentists. The Medicaid program raised fees by 30 percent, which nearly doubled the number of dentists seeing children and increased utilization by

55 percent. Improvement on screening will now allow the state to measure improvement in dental outcomes. New York's experience was similar. Physician payments were the equivalent of a five-minute Medicare visit. Child Health Plus staff acknowledged they could not expect doctors to provide a good screening and treatment visit in five minutes. In addition to raising rates, New York added new reimbursement codes for diabetes and asthma education visits, which are intended to last 45 minutes.

Several other states noted rate improvements that grew out of quality measurement and improvement efforts. Through their quality work, states have raised payments for EPSDT screens, administration and scoring of a behavioral health screening tool, and interpreter services, for example. One state reported allowing developmental testing to be separately reimbursable on the same date of service as an EPSDT exam.

Another major category of changes reported by states involved making it simpler for providers to deliver priority services. Prior authorization requirements were a disincentive, particularly for psychological and neuropsychological testing and developmental screening services.

Some states changed the way they managed health plans—for example, requiring health plans to partner with the state and to be transparent to each other in how they measure and improve quality. Some states have monthly or quarterly meetings where data are shared and improvements are discussed and designed collaboratively.

Another outgrowth of quality measurement was to recognize that differences in CHIP and Medicaid requirements were burdensome and, in some cases, unnecessary. Some states have standardized benefits and their quality-of-care measures across the two programs.

Based on their experience, some states have structured their own performance improvement strategies. For example, some have discovered that the performance improvement projects can be too superficial to result in real changes in practice, so state staff have engaged with managed care organization staff to design more effective projects. They monitor them more closely, and some subsequently reward good outcomes. Failure to improve can result in new corrective action plans with state monitoring.

The focus on quality measurement has led some Medicaid and CHIP agencies to recognize that they need to work more closely with the state behavioral health agency.

One state reported that they made their health plans responsible for care coordination between physical and behavioral health providers, with defined minimum utilization management policies and procedures. Others are just beginning to establish standards for behavioral health benefits that differ from those applied to other specialty services.

Quality measurement has also helped states recognize that some patients have higher levels of needs and that delivering services to them may require more-targeted care management. Some health plans are now required to report on the evaluation and treatment plans for children with a wide range of special needs. In a few states, agency staff are implementing, or at least evaluating, the medical home model of care, which they believe may better achieve their quality goals.

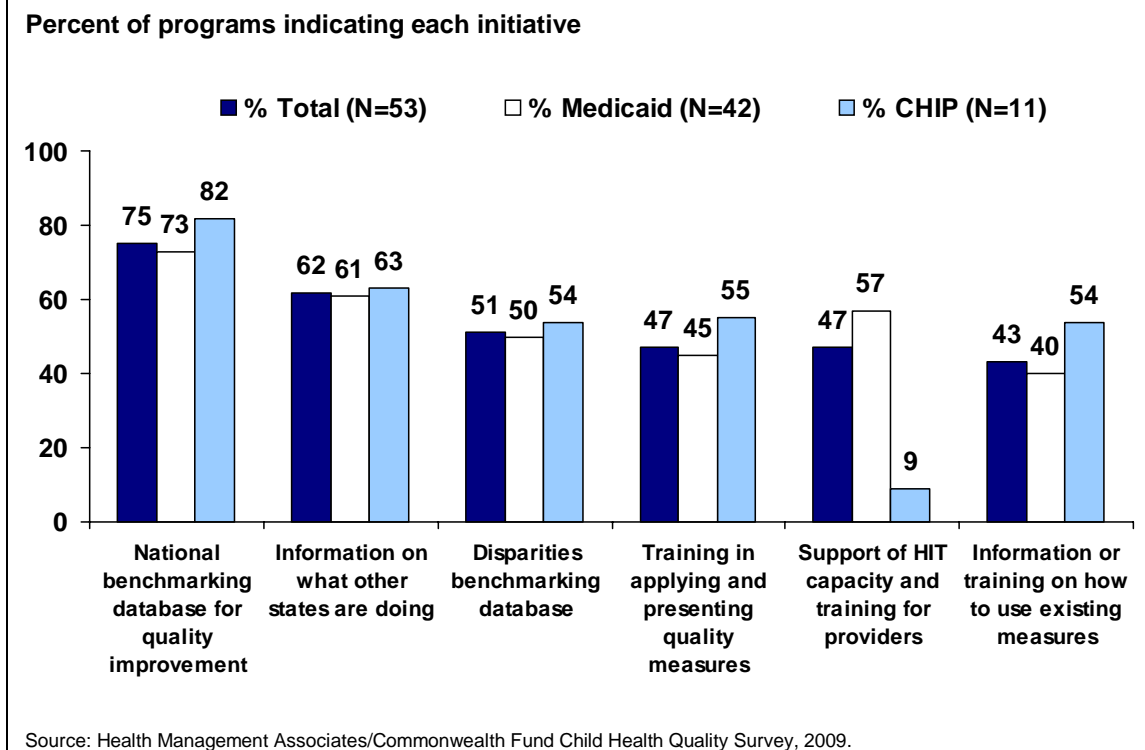
Strategies to Extend States' Reach on Quality

Anticipating forthcoming CHIP Reauthorization Legislation, the survey asked what priorities Medicaid and CHIP directors have for the proposed \$225 million, five-year quality initiative to be led by the U.S. Department of Health and Human Services.

The survey identified six types of technical assistance that might be offered. Of these, the highest priority identified by both Medicaid and CHIP directors would be a national database that would permit the calculation of benchmarks appropriate for quality improvement purposes (Figure 8). Eighty-two percent of CHIP directors and 73 percent of Medicaid directors agreed this would help their quality improvement efforts. In discussions with state officials, it was also pointed out that the data should provide holistic information about the patient, not just about their care. For example, a health risk assessment should be available. One Medicaid director noted that comparing one state's performance to that of other states would not be as helpful as comparing it to the best performance achieved nationally. A Commonwealth Fund "scorecard" comparing the child health care systems of all states¹ was used by officials from at least two states to support the need for new resources from the legislature; officials from another state, however, indicated that the controversy sparked by the performance gaps identified in the scorecard required state officials to spend time defending their performance in the legislature. In all cases, the state-specific data drew attention to states' comparative performance.

¹ K. Shea, K. Davis, and E. Schor, [*U.S. Variations in Child Health System Performance: A State Scorecard*](#) (New York: The Commonwealth Fund, May 2008).

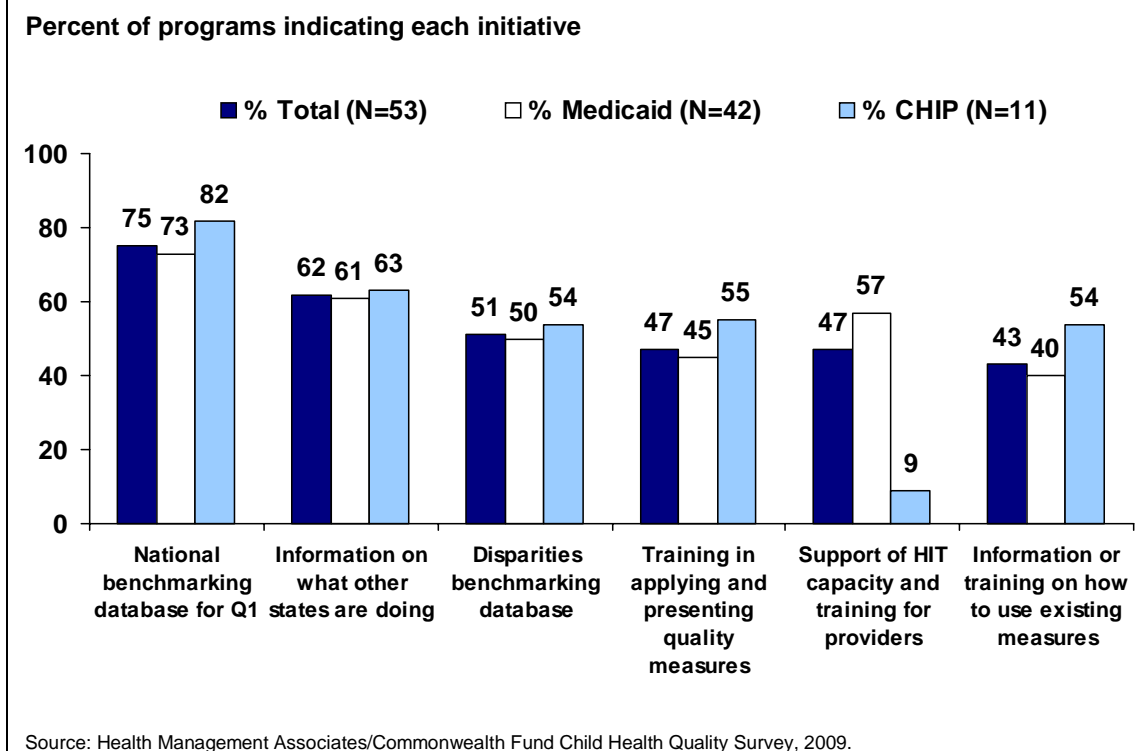
Figure 8. Programs' Priorities for Technical Assistance



A second highly valued form of technical assistance would be information about what other states are doing—and, to which we would add, how it is working. In write-in comments, one state specifically suggested a repository of performance measures, report cards, and other quality improvement tools used by states. One state mentioned the quality provisions of model contracts. Nearly two of three respondents thought sharing best practices would be valuable. Half agreed that a database that included information on disparities would be useful.

In the realm of hands-on training, states report they would like to have training in using data for quality, particularly how to specify measures, analyze data, and present results. Medicaid directors, much more so than CHIP directors, felt that direct support of health information technology capacity and training for clinics and hospitals would benefit their quality improvement efforts. In the discussion, states reported frustrations that provider data systems were inadequate to provide the type of health status information needed to monitor outcomes. They reported being unlikely to require much manual data collection, but expressed a desire for electronic data to fill this information

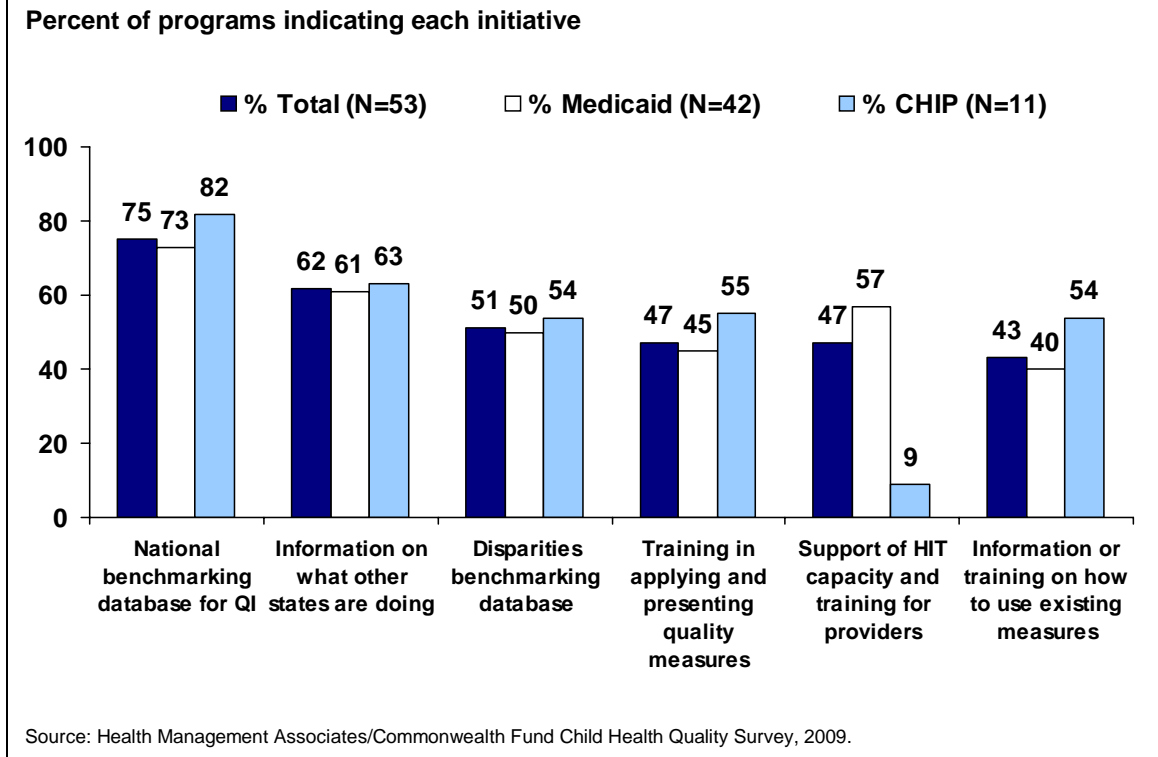
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need. In write-in comments, one state official suggested support for building the infrastructure to link the electronic medical record (EMR) directly to quality improvement initiatives. Another state official, though, raised concerns about the very high costs, adding that hardware and software are not enough; physician practices need training in using the EMR system so it produces useful information. The official doubted states had the capacity to provide such training.

On a related issue, states described how they typically had very small numbers of staff available to work on quality. Even some large states have only three or fewer staff working on quality, and those staff often are pulled into other work.

California pointed to the need for readily available data for all care, even when it is delivered and/or paid for by another agency. In some states, this is a significant issue. For example, one state's CHIP program does not have access to mental health data, because a state law prohibits such access.

When asked to think more broadly about supports that could lead to major expansions of their quality efforts, states asked for more help from each other and from outside experts.

In discussions and in write-in comments, state officials described the value that would come from the creation of a well-organized multistate network of Medicaid quality improvement staff. Officials indicated that they would especially value opportunities for face-to-face learning. They wanted small groups with lots of interaction, with a minimum of formal presentations. In addition to face-to-face meetings, they wanted ideas about and references to best practices to be shared on a Web site for states, plans, and providers. Participants were not interested in listservs, which they find lack the interactivity of meetings or the organization of a Web site. NASMD and the National Academy for State Health Policy (NASHP) were both mentioned as trusted sources for state policy information.

State officials also indicated quality improvement strategies they would like to pursue but have not been able to undertake because of limited knowledge or staff time. In order to overcome the resource barrier, one state suggested bringing providers and researchers together in an advisory capacity to design improvement projects, rather than relying on the plans to figure them out. Another state added that families should be part of the planning because they help the staff understand barriers to adherence to better health behaviors.

CONCLUSIONS

Medicaid and CHIP efforts to improve the well-being of children and adolescents are at a turning point. Universally, states have new knowledge from their measurement work to demonstrate that improvements in care are needed. As reflected in their survey responses, agency staff have developed a comfort and skill level in measurement and can identify needs for better measures quite extensively. In discussions, though, it was clear that states take pride not only in their ability to measure quality, but in their ability to improve health outcomes for kids. They intend to do much more in pursuit of quality improvement and would welcome and benefit from extensive support in that area.

Three compelling needs emerged:

- First, state officials believe the currently available set of measures is inadequate to fully address quality of care for children. States see a need for measures that focus on outcomes (as opposed to processes); measures that are standardized across health programs and across agencies serving children; and measures that would indicate progress toward accomplishment of their specific program goals.
- Second, state officials want to be able to compare their state's performance against others in national data sets using common metrics and methodologies. Comparative data can be useful to states in prioritizing resources and managing provider and health plan contracts. Knowing the gap between current performance and best performance on valued measures can help mobilize quality improvement efforts.
- Third, state officials would like to enhance their quality improvement efforts by incorporating data on quality and performance into reimbursement methodologies for health plans and individual providers, to encourage and reward higher performance across all providers. States would like to hear more about experiences of other states working with plans and providers in order to replicate or adapt best practices to their states.

The Centers for Medicare and Medicaid Services, the Agency for Healthcare Research and Quality, and other organizations have an opportunity to accelerate the pace of change. Medicaid and CHIP officials indicated that the strategies they would value most would include targeted technical assistance, improved opportunities to learn from each other and from experts in quality improvement, and participation in an active coaching process that includes expert guidance to the states and to their health plan partners.

**APPENDIX 1. MEDICAID DIRECTORS AND MEMBERS
OF THE EXECUTIVE COMMITTEE OF THE
NATIONAL ASSOCIATION OF STATE MEDICAID DIRECTORS
PARTICIPATING IN MEDICAID CHILD HEALTH ISSUES DISCUSSION,
SEPTEMBER 2008**

Carol Steckel, Alabama, *NASMD Chair*

Stan Rosenstein, California, *NASMD Vice-Chair*

David Parrella, Connecticut, *NASMD Past Chair*

Paul Reinhart, Michigan

Christine Bronson, Minnesota

Chuck Duarte, Nevada

Lynn Mitchell, M.D., M.P.H., Oklahoma

Michael Nardone, Pennsylvania

Darin Gordon, Tennessee

Joshua Slen, Vermont

Doug Porter, Washington

Ann Kohler, Executive Director, NASMD, Washington, D.C.

Project Advisor

Lee Partridge, National Partnership, Washington, D.C.

Project Staff

Vernon K. Smith, Ph.D., Principal, Health Management Associates

The Commonwealth Fund

Edward L. Schor, M.D., Vice President, The Commonwealth Fund

APPENDIX 2. PROJECT ADVISORY GROUP MEETING

Medicaid Directors/Staff

Lynn Mitchell, M.D., M.P.H., Medicaid Director, Oklahoma Health Care Authority

Patrick Finnerty, Director, Virginia Department of Medical Assistance Services

Patrick Roohan, Director, Bureau of Quality Management and Outcomes, New York
State Department of Health

Kim Elliott, Ph.D., Administrator, Clinical Quality Management, Division of Health Care
Management, Arizona Health Care Cost Containment System (AHCCCS)

Kate Aurelius, Assistant Director, Division of Health Care Management Managed Care
Contracting and Performance, Arizona AHCCCS

Ann Kohler, Executive Director, NASMD, Washington, D.C.

Medicaid Medical Directors

Mary Applegate, M.D., Medicaid Medical Director, Ohio Office of Health Plans

Mary McIntyre, M.D., Medical Director, Clinical Standards and Quality, Alabama
Medicaid Agency

Ann G. Lawthers, Sc.D., Director of Quality Improvement, Office of Clinical Affairs,
Massachusetts Office of Medicaid

CHIP Directors/Staff

Shelley Roulliard, Deputy Director for Benefits Quality and Monitoring, California
Healthy Families Program

Jennifer Kiser Lloyd, Chief External Affairs Officer, Florida Healthy Kids Corporation

Lowware Holliman, Director of Quality, Pennsylvania Insurance Department, Office of
CHIP and Adult Basic

Project Staff

Vernon K. Smith, Ph.D., Principal, Health Management Associates

Jennifer N. Edwards, Dr.P.H., Principal, Health Management Associates

The Commonwealth Fund

Edward L. Schor, M.D., Vice President, The Commonwealth Fund

APPENDIX 3. SURVEY

A Survey of Medicaid Directors or Medicaid Medical Directors on Quality Measures and Improvement Incentives in Medicaid and SCHIP

The purpose of this brief survey is to identify the tools and strategies states are using in Medicaid (including Medicaid Expansion SCHIP programs) to measure quality of care for children and adolescents, how you track and reward improvements in quality, and your ideas on how to improve the care provided.

This survey is being conducted by Health Management Associates for The Commonwealth Fund as part of a study of state efforts to improve quality of care for children in Medicaid and SCHIP. The study is also looking at the adequacy of current measures of performance for children and adolescents. The results from this survey are to be published in an Issue Brief in late spring 2009. We will send it to you as soon as it is available.

The survey has been designed to be as easy as possible for you to complete. For most questions, you can indicate your response by clicking a box, or with an X. For a few questions, you have the opportunity to write a sentence or two. If you are unable to complete a question, simply indicate with an "NA." We would like to receive your survey by March 2 even if it is not complete for every question.

We would like you to complete this survey from the perspective of the state Medicaid agency. A similar survey is being completed by stand-alone SCHIP programs. In some cases, the health plans that you contract with to serve Medicaid beneficiaries may be undertaking initiatives or policies to improve quality, perhaps as required by the Medicaid agency. You can indicate in the comment areas where that is the case, but the focus of this survey is on what the state Medicaid agency is doing.

State: _____

Contact person for the survey:

Name: _____

Phone: _____

Please email your completed survey by March 2 to Vernon Smith, Ph.D., at:
vsmith@healthmanagement.com

Or, you can FAX your response to: 517-482-0920 or mail to:
120 N. Washington Sq., Suite 705
Lansing, MI 48933

If you have any questions, please feel free to call Vern Smith at: 517-318-4819.

Thank you. We appreciate your taking the time to complete the survey.

**A Survey of Medicaid Programs
on Quality Measures and Improvement Incentives in Medicaid and SCHIP**

I. **Current policies.** Please indicate policies or strategies currently used in your Medicaid program to measure and improve quality of care for children and adolescents:

A. Performance measures used now (please check all categories that apply):

1. HEDIS[®] access measures (such as well child/well adolescent care visits)
2. HEDIS[®] effectiveness of care measures (such as immunization status or appropriate asthma treatment)
3. CAHPS[®] patient experience with care surveys (such as child CAHPS[®] or the Young Adult Health Care Survey (YACHS[®]))
4. Other measures included in NQF-endorsed national measure sets (such as neonatal mortality or patient safety in inpatient setting)
5. State-developed measures (such as EPSDT compliance)
6. Other performance measures (please describe briefly):

B. Incentives in place for providers or health plans designed to encourage quality care:

1. Financial Bonus for performance on specific measures
2. Financial Penalty for failing to reach target
3. Denial of payment for poor care, such as medical errors
4. Reporting health plan performance
5. Reporting performance of individual providers
6. Public reporting, e.g., web-based reports, on health plan or individual provider performance
7. Auto-enrollment to health plans based on quality performance
8. Other incentives or disincentives? (please describe briefly)

C. Quality requirements for health plans or providers that participate in Medicaid:

1. Accreditation of health plans, e.g., by NCQA, is required
2. Accreditation of health plans, e.g., by NCQA, is rewarded (please explain briefly how):

3. Specific performance measures and quality improvement activities are required (i.e., in the health plan contract or an enhanced PCCM agreement):

4. Other quality-based requirements (please describe briefly):

D. As a result of your experience with current policies, measures (e.g., findings related to health disparities or health issues for specific population groups), incentives and requirements identified in I.A., B., and C. above, please indicate if you have made (and if so briefly describe) any changes in:

1. Medicaid policies (e.g., benefits or reimbursement):

2. Operational procedures or protocols, or requirements:

3. Requirements for health plans or providers:

E. Please use this space for additional comments or descriptions of current measures, policies, or strategies:

II. ***Adequacy of measures available.*** National measure sets include only a limited number of performance measures specific to children and adolescents. What is your opinion of currently available measures (please check answers that apply):

- A. Currently available measures are adequate right now for Medicaid.
- B. Currently available measures are not adequate right now for Medicaid.
- C. Medicaid and SCHIP could do a better job to improve care for children and adolescents if there were:
 1. Additional measures. (please list any ideas below in III.)
 2. Improvements in existing measures. (please indicate below in IV.)

III. *If you checked “additional measures” above (II.C.1.), what measurement areas would be of particular importance to you in your state?*

- A. Mental health screening
 - B. Mental health treatment
 - C. Coordination of care
 - D. Patient safety
 - E. Adolescent access to family planning counseling
 - F. Dental care access
 - G. Please describe any other measures or offer comments:
-

IV. *If you checked “improved measures” above (II.C.2.), those improvements would include:*

- A. Better standardization of measurement definitions and specifications
 - B. Development of measures that focus on outcomes rather than process of care
 - C. Fewer measures that are burdensome for providers to collect, such as those requiring medical record reviews
 - D. Other suggested improvements (please describe) or offer comments:
-

V. **Technical assistance.** SCHIP reauthorization may include \$225 million for a new five-year HHS quality initiative, including support and technical assistance to state Medicaid and SCHIP agencies to improve quality of care. If such support becomes available, what would be most useful to you?

- A. Information or training on how to use existing measures
 - B. Information on what other states are doing
 - C. An accessible national database that would permit calculation of “benchmarks” appropriate for quality improvement purposes
 - D. A database that enabled benchmarking and identification of disparities in access and treatment
 - E. Access to training in appropriate use of measurement specifications and the analysis and public presentation of results
 - F. Direct support of HIT capacity and training to use this capacity for clinics and hospitals that serve low income patients and communities
 - G. Other technical assistance or support that would be helpful to you (please describe):
-

VI. **Priority of child health, health care, and quality.** In consideration of all the priorities across Medicaid:

A. How would you describe where the priority for child health care quality fits into the overall Medicaid picture in your state?

Very Low 1 2 3 4 5 6 7 8 9 10 Very High

Could you indicate a primary reason why you rated this priority as you did?

B. How would you describe the priority in your state for school exercise, food and nutrition and other strategies for healthier children?

Very Low 1 2 3 4 5 6 7 8 9 10 Very High

Could you indicate a primary reason why you rated this priority as you did?

C. How would you describe the priority to expand or assure access to health care services or coverage for children in your state:

Very Low 1 2 3 4 5 6 7 8 9 10 Very High

Could you indicate a primary reason why you rated this priority as you did?

D. How would you say current budget constraints in your state are impacting quality improvement efforts for children?

VII. **Role of stakeholders and the Medicaid Advisory Committee.** When considering a new Medicaid policy such as a new quality improvement initiative for children, how would you describe, in a few words, the role of the following stakeholders in your state policy-making process:

E. The Medicaid Advisory Committee: _____

F. Providers, such as the state Medical Association or state Chapter of the American Academy of Pediatrics: _____

G. Child Health Advocates: _____

H. Other stakeholders: _____

VIII. **State participation in initiatives of The Commonwealth Fund.** Please indicate if your state has participated in the following initiatives:

I. ABCD

J. Improvement Partnership

IX. *Do you have any further comments? Please let us know if you have any other comments on child health improvement strategies or approaches in your state.*

This concludes the survey.

Please email response to Vernon Smith, Ph.D. at: VSmith@healthmanagement.com

If you have any questions, please call Vern at: 517-318-4819.

Thank you.