



REAUTHORIZING SCHIP: OPPORTUNITIES FOR PROMOTING EFFECTIVE HEALTH COVERAGE AND HIGH-QUALITY CARE FOR CHILDREN AND ADOLESCENTS

Lisa Simpson, Gerry Fairbrother, Stephaine Hale, and Charles Homer

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ABSTRACT: Over the last decade, the State Children’s Health Insurance Program (SCHIP) has expanded access to health coverage for millions of children, improved the quality and effectiveness of care, and expanded the knowledge and tools needed to measure and further improve quality. SCHIP reauthorization presents an opportunity to build on these gains. Indeed, significant provisions to enhance a focus on quality are included in both the House and Senate versions of the SCHIP reauthorization bills passed in July 2007. This report presents a framework for promoting effective health coverage and achieving high quality in SCHIP and Medicaid through the following strategies: 1) ensuring access to care through eligibility, enrollment, and retention policies, 2) providing a robust benefit package, 3) strengthening provider capacity, 4) measuring performance 5) improving quality, 6) providing incentives for quality, and 7) promoting the use of health information technology.

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CONTENTS

About the Authors	iv
Acknowledgments	v
Executive Summary	vi
Introduction	1
Why Focus on Quality in SCHIP and Medicaid?.....	1
Public Insurance Covers Millions of U.S. Children and Shapes the Private Health Care Market.....	1
Quality Improvement Field Has Advanced Since SCHIP’s Creation	2
High-Quality Children’s Care Can Improve Adult Health Outcomes	5
High-Quality Health Care Contributes to Broader Societal Goals	5
Framework for Promoting Effective Coverage and Quality in SCHIP and Medicaid.....	6
SCHIP and Medicaid Program Performance Goals.....	8
SCHIP and Medicaid Health Care System Performance Goals	13
SCHIP and Medicaid Health Care Services Quality Goals.....	16
Conclusion	24
Notes.....	25

ABOUT THE AUTHORS

Lisa Simpson, M.B., B.Ch., M.P.H., F.A.A.P., is professor and director of the Child Policy Research Center at Cincinnati Children's Hospital Medical Center and the University of Cincinnati, Department of Pediatrics. The Center provides evidence-based information to inform policy and program decisions at the local, state, and national levels, with an emphasis on strategies to improve the quality of health care, the effectiveness of public programs, and child well-being. Dr. Simpson, a board-certified pediatrician, is the National Director for Child Health Policy at the National Initiative for Children's Healthcare Quality and serves as an elected member on the board of directors of AcademyHealth and the Ambulatory Pediatric Association. She has led studies of the quality and safety of care for children and adolescents, focusing especially on the role of policies in advancing quality. She was formerly the Deputy Director of the Agency for Healthcare Research and Quality and the Maternal and Child Health Director in Hawaii. Dr. Simpson earned her undergraduate and medical degrees at Trinity College (Dublin) and a master of public health degree at the University of Hawaii.

Gerry Fairbrother, Ph.D., is a professor of pediatrics at the University of Cincinnati and holds a joint appointment in health policy and clinical effectiveness and epidemiology and biostatistics at Cincinnati Children's Hospital Medical Center. Dr. Fairbrother has led investigations into child health insurance enrollment patterns, barriers, and costs, the impact of Medicaid managed care on children's preventive health screening, and the effect of financial incentives on physician behavior. She has served as a consultant to the Institute of Medicine on projects dealing with immunization financing and the consequences of uninsurance and has worked with the Centers for Disease Control and Prevention to help states monitor immunization rates for children in Medicaid. Dr. Fairbrother holds a Ph.D. from Johns Hopkins University and is a Fellow of the New York Academy of Medicine and a Fellow of the Ambulatory Pediatric Association.

Stephaine Hale, M.D., M.P.H., F.A.A.P., is a neonatologist with the Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center and an instructor in Pediatrics at Harvard Medical School, Department of Pediatrics. Her research interests focus on disparities as they relate to neonatal outcomes and mortality in the U.S., as well as quality improvement within the neonatal intensive care unit, with an emphasis on those centers serving vulnerable populations. Dr. Hale has been the recipient of several honors and awards, including the Commonwealth Fund Fellowship in Minority Health Policy at the Harvard School of Public Health and the Presidential Scholars Award at Harvard University. Dr. Hale received her bachelor of science degree from Vanderbilt University,

her medical degree from Cornell University Medical College, and a master of public health degree from the Harvard School of Public Health.

Charles J. Homer, M.D., M.P.H., is president and CEO of the National Initiative for Children's Healthcare Quality, an action oriented organization headquartered in Cambridge, Mass., exclusively dedicated to improving the quality of health care for children. He is an associate professor in the Department of Society, Human Development and Health at the Harvard University School of Public Health and an associate clinical professor of pediatrics at Harvard Medical School. He was a member of the third U.S. Preventive Services Task Force from 2000 to 2002 and served as chair of the American Academy of Pediatrics Steering Committee on Quality Improvement and Management from 2001 to 2004. He obtained his bachelor's degree from Yale University, his medical degree from the University of Pennsylvania, and a master's degree in public health from the University of North Carolina at Chapel Hill.

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EXECUTIVE SUMMARY

The deadline for reauthorization of the State Children’s Health Insurance Program (SCHIP) on September 30, 2007, is fast approaching. This has generated intense discussion of SCHIP’s impact over the past 10 years and the extent to which it has met its original legislative intent. The successes of SCHIP are well documented. Over the last decade, there has been expanded access to health coverage for millions of children, improvements in the quality and effectiveness of the services delivered, and substantial growth in the knowledge, tools, and strategies available to measure and further improve quality.

SCHIP reauthorization presents an opportunity to build on these gains—to transform the “good” coverage and quality of care provided by SCHIP into “great” coverage and quality. In fact, both the House and Senate versions of the SCHIP reauthorization bill contain important, though somewhat different, provisions for improving the quality of the programs, the coverage and benefits they provide, and the care to which they would enable access. At the same time, the reauthorization process is opening the door for reforms in the Medicaid program, as well as the possibility for both Medicaid and SCHIP to work together seamlessly to advance the quality of children’s health care.

As large health care purchasers, the SCHIP and Medicaid programs play a powerful role in shaping the quality of coverage and care provided through public programs. SCHIP and Medicaid have dramatically expanded enrollees’ access to and use of care, and reduced delays in receiving care, unmet needs, and health care disparities. Because early intervention services can correct problems and help ensure better long-term health, educational, and social outcomes, ensuring high-quality health care for children can also improve adults’ outcomes.

In this report, we present a framework for promoting effective health coverage and achieving high quality in SCHIP and Medicaid through the following strategies: 1) ensuring access to care through eligibility, enrollment, and retention policies; 2) providing a robust benefit package; 3) strengthening provider capacity; 4) improving system performance; 5) measuring performance; 6) improving quality; 7) providing incentives for quality; and 8) promoting the use of health information technology.

Ensuring Access to Care Through Eligibility, Enrollment, and Retention Policies

SCHIP and Medicaid eligibility requirements, such as income eligibility thresholds, are determined by each state and vary considerably among states. Policies that govern enrollment and retention, also established by states, strongly influence program participation. Numerous studies have shown that eligible children who are enrolled in SCHIP/Medicaid and insured without interruption in coverage are more likely than children who experience gaps in coverage to have a usual source of care, well-child visits, and preventive care, and consequently have fewer unmet medical and medication needs and experience fewer delays in care.

To ensure access to stable coverage, we suggest that:

- The degree to which states achieve stable coverage among all eligible children should be monitored and reported.
- States should examine the impact of instability in coverage on children's access to and quality of care, as well as the impact of various program policies on rates of coverage renewal among eligible children.
- The SCHIP reauthorization could provide incentives to states to enhance outreach activities and achieve stable enrollment.
- Demonstration programs testing innovative strategies to simplify renewal processes and increase retention could be supported through additional federal investments.

Providing a Robust Benefit Package

The right benefits are essential for children to receive appropriate, effective, and high-quality care. The scope of benefits covered in SCHIP should ensure access to comprehensive and appropriate services that promote the development of optimal physical and mental health as well as social functioning into adulthood.

To ensure that children receive the right benefits, we suggest:

- In describing the standards for coverage, SCHIP could focus on preventive and developmental services as a preferred design for state benchmark plans. This standard could be aligned with the American Academy of Pediatrics policy on benefits.
- Future SCHIP reporting requirements should monitor states' provision of preventive and developmental services.

- The development, dissemination, and use of knowledge, tools, and best practices to improve benefit design and implementation, case management, and community-based services should be supported by additional federal resources.

Strengthening Provider Capacity

A high-quality SCHIP or Medicaid program should ensure that there are sufficient pediatric providers to deliver services. Many office-based private physicians will not accept large numbers of SCHIP or Medicaid patients because Medicaid/SCHIP programs frequently reimburse at lower rates than in the private sector. As a result, care of children enrolled in SCHIP or Medicaid is concentrated among safety net providers, and there are widespread problems in terms of access to dental care, mental health services, and specialty services.

To strengthen providers' capacity to deliver high-quality care in SCHIP and Medicaid, we suggest:

- State strategies to enhance provider capacity, such as improved reimbursement, incentives to practice in underserved areas, and medical school loan forgiveness, should be identified and disseminated.
- It is also essential to monitor providers' capacity to serve Medicaid/SCHIP-eligible children as program expansions occur and more children are enrolled.

Improving System Performance

The Commonwealth Fund Commission on a High Performance Health System recently defined the key characteristics of a high performance health system: accountability, transparency, capacity to improve, efficiency, integration, and partnerships. To achieve a high performance health system for children and youth, there need to be adjustments to the federal-state partnership through which SCHIP and Medicaid are managed. In particular, improved federal oversight and coordination among federal and state governments are needed. This could be achieved by linking advisory entities at the national and state levels and including families' perspectives in the advisory process.

To improve system performance, we suggest:

- The creation of a commission focused on children and youth to advise Congress on strategies to achieve high-performing SCHIP and Medicaid programs, just as the Medicare Payment Advisory Commission advises Congress on issues affecting the Medicare program.

- At the state level, the creation of child health and development councils could be encouraged by federal policy and charged with: fostering collaboration across diverse state programs serving children and youth; applying the national vision in their own state; identifying state-specific quality measures; and coordinating quality measurement activities across SCHIP/Medicaid programs.

Measuring Performance

Performance measurement is an essential step to improve the quality of care for children and youth. Yet, no single quality measure is consistently available from all 50 SCHIP programs, and not all states use Healthcare Effectiveness Data and Information Set (HEDIS) methodology consistently making comparisons across states difficult.

To measure the performance of SCHIP and Medicaid programs, we suggest:

- A core measure set should be developed through a public/private process (rather than legislatively specified) to enable consistent reporting across states.
- Investments in development, testing, refinement, and adaptation of new quality measures, as well as data collection and reporting systems, are needed.
- Provisions to report and compare performance across states, and to benchmark state performance against national averages, should be made to facilitate the identification of best practices and cross-state learning. Performance data could also be assigned to the Agency for Healthcare Research and Quality (AHRQ) for analysis and inclusion in the National Healthcare Quality Report and National Healthcare Disparities Report.
- Federal incentives for reporting should be created, similar to those in Medicare.
- It is also important to establish and fund learning networks, implementation resources, and a clearinghouse for states to identify tools and models for measuring health care quality.

Improving Quality

Our ability to improve the quality of care for children and youth has grown tremendously in the last five years. The quality improvement recommendations set forth here build on efforts already under way at the Centers for Medicare and Medicaid Services (CMS), such as the emphasis on value-driven health care.

To improve the quality of care in SCHIP and Medicaid, we suggest:

- Efforts currently under way through CMS and AHRQ to support Medicaid medical directors could be expanded to other senior Medicaid staff, leading to the formation of a child health improvement corps.
- The establishment of one or more National Resource Center, such as AHRQ's National Resource Center for Health Information Technology, could accelerate learning, innovation, and dissemination of effective improvement approaches among states.
- It will be important for CMS to provide proactive guidance to states on the parameters and approaches for using matching funds under SCHIP/Medicaid for the development of state-based, public-private improvement partnerships, such as the successful program in Vermont.
- Engaging patients and families in all stages of the process to maintain a family-centered approach to care is important. CMS could coordinate with the Maternal and Child Health Bureau to expand support for state-based Family-to-Family Health Information Centers to train and support families interested in improving the quality of the health system.

Providing Incentives

Providing incentives to states to improve the quality of care delivered through SCHIP/Medicaid can help spread exemplary practices and innovations. Incentives have included enhanced federal matching rates for specific actions, financial rewards for demonstrated high performance, and demonstration funds to support innovation or diffusion of exemplary practices. Pay-for-performance (P4P) programs are also being promoted as a strategy to improve quality. Although the potential effects of P4P programs on children's health have not been well studied, a recent survey found that, in five years, nearly 85 percent of state Medicaid programs plan to have such programs.

To provide incentives for states to improve their SCHIP and Medicaid programs, we suggest:

- The creation of a national demonstration program, with CMS leadership, involving at least five states, consistent metrics, and a robust evaluation of the effects of various incentives on the quality of children's health care. Such a program could have a profound impact on the utilization and adoption of incentives across states.

Promoting the Use of Health Information Technology

Electronic health records, personal health records, personal digital assistants, health information exchange, computerized order entry systems, e-prescribing, and disease-specific or population registries are key tools for improving the quality and efficiency of care. Use of such health information technologies (HIT) has been shown to eliminate health disparities for children in some settings. SCHIP and Medicaid could play a significant role in the promotion and adoption of HIT in the care of children and youth.

To promote use of HIT in SCHIP and Medicaid, we suggest:

- Congress could complement private-sector efforts by funding demonstrations on the role of clinical HIT in improving care for children, especially chronically ill children.
- States could sponsor the development of Medicaid-specific electronic health records or opt to share clinically relevant information from claims data about Medicaid patients at the point of care.

With the SCHIP reauthorization deadline nearing, there is a prime opportunity to build on the successes of SCHIP and Medicaid in providing access to effective coverage to children and youth. It is also time to capitalize on investments in research and health systems innovation in order to improve the quality of care provided not only to publicly insured children, but to all children in the United States.

REAUTHORIZING SCHIP: OPPORTUNITIES FOR PROMOTING EFFECTIVE HEALTH COVERAGE AND HIGH-QUALITY CARE FOR CHILDREN AND ADOLESCENTS

INTRODUCTION

The primary focus of child health policy is to improve access to effective coverage for children and youth through expansion, and better implementation, of public insurance programs. This year, the need to reauthorize the State Children's Health Insurance Program (SCHIP) no later than September 30, 2007, is generating intense discussion on the impact SCHIP has had on children's health coverage and access to care, and the extent to which SCHIP succeeded in meeting its original legislative intent. This report examines federal and state policies that could improve the effectiveness of the coverage available to children through SCHIP and Medicaid and increase states' accountability for the quality of health services they finance. The inclusion of significant provisions related to quality in both the House and Senate versions of the SCHIP reauthorization bill makes such an examination ever more urgent. Given the close link between Medicaid and SCHIP coverage, the findings and recommendations are applicable to both programs.¹

Numerous recent publications have summarized the evidence on the impact of the SCHIP program.² The successes include: enrolling the target population and reducing the rate of uninsured children; increasing access to and use of care; giving parents peace of mind about their children's health care; and reducing racial/ethnic disparities in health care coverage. Less is known about the program's effect on health care quality and health outcomes, though what has been reported is positive. For example, one study showed that children who were uninsured and gained coverage through SCHIP had fewer asthma-related attacks after gaining coverage.³ Another study found that improved access to care resulted in better reported physical, emotional, social, and school functioning among SCHIP children.⁴ There is limited information on such dimensions of program impact because of the variable ways in which states have implemented the existing performance reporting requirements.

WHY FOCUS ON QUALITY IN SCHIP AND MEDICAID?

Public Insurance Covers Millions of U.S. Children and Shapes the Private Health Care Market

More than a quarter of all children in the United States were insured through public programs, primarily Medicaid, in 2002. Together, Medicaid and SCHIP programs finance care for an estimated 30 million children.⁵ This is equivalent to nearly one of three of America's nearly 73 million children ages 0 to 17 and up to 40 percent of all children under age six in many states. In addition, children covered under these two programs have

much higher rates of special health care needs than their privately insured counterparts and rely disproportionately on the health care system. As dominant payers for children's health services, SCHIP and Medicaid play powerful roles in shaping the private health care market as well as private health care organizations such as children's hospitals.⁶ The majority of children's health care is provided in private offices, clinics, and hospitals that accept both public and private payers.⁷ Strategies to improve quality for publicly insured children have been shown to also improve the quality of care for privately insured children.⁸ Thus, these programs have a responsibility to finance care that is of the greatest value and highest possible quality.

Quality Improvement Field Has Advanced Since SCHIP's Creation

The field of quality measurement and improvement has matured significantly since 1997, when SCHIP was created. Modest investments in research, innovation, and improvement models in child health care have produced numerous quality measures and effective improvement strategies. This progress, together with the documented success of SCHIP to date, create an opportunity to move the program from "good" to "great."

Help Me Grow

Approach: Developmental surveillance is an ongoing process in which child health care providers obtain children's developmental history through interviews and screening, observe their development, and elicit parents' concerns. Many providers report that they lack the training to perform developmental surveillance well; many also say that, when they do detect problems, they lack the time or resources needed to refer children to appropriate intervention services.

Developed by pediatrician Paul Dworkin, M.D., of the Connecticut Children's Medical Center, the Help Me Grow program trains child health care providers to perform developmental surveillance and use a centralized referral and case management system. Providers refer children in need of services via a telephone hotline, and care coordinators connect children and families with support agencies, programs, and community services.

Impacts: Research has shown that the use of the Help Me Grow model dramatically increases identification of developmental and behavioral concerns and leads to timely follow-up services.

Results include:

- increased identification of developmental delays, parental depression, and other concerns;
- increased use of Part C (early intervention) services; and
- improvement in child health and development reported in pediatric visits.

In addition to Connecticut, a number of regions, including counties in California and Iowa and the states of Hawaii, North Carolina, and Ohio, are adopting or considering this model.

For more information: See the Help Me Grow manual, available at:

http://www.commonwealthfund.org/innovations/innovations_show.htm?doc_id=405593.

Many opportunities exist to improve the quality of health care for children and adolescents, as found in a 2004 report that synthesized more than 200 studies.⁹ There is particular room for improvement in well-child services, which can have a significant impact on children's healthy development by identifying and addressing health conditions early. In North Carolina, Utah, and Vermont, primary care practices are partnering with Medicaid and health plans to improve preventive and developmental services for children and adolescents.¹⁰ Numerous programs targeted at children's early development have demonstrated impressive gains in service quality, and some improvement in outcomes, by ensuring the provision of comprehensive preventive and developmental services.¹¹ Similarly, innovative programs within many states are improving care for chronically ill children and achieving better outcomes at lower costs.¹²

Healthy Steps for Young Children

Approach: Applying lessons drawn from new evidence and analysis about child behavior and development in medical practices is often challenging. There has not been a standardized approach to provide clinicians and parents with current information about the first three years of life. Healthy Steps for Young Children is a national initiative aimed at enhancing the quality of preventive health care for infants and toddlers. Established with Commonwealth Fund support, the program emphasizes a close relationship between health care professionals and parents in addressing the physical, emotional, and intellectual development of children from birth to age 3.

Impacts: Research has found that Healthy Steps:

- increases parental use of positive health practices, such as ensuring infants sleep on their backs, receive all vaccinations, and have injury prevention tools in their homes;
- improves interactions of parents with their toddlers, using positive disciplinary practices and paying attention to children's behavioral clues; and
- reduces toddler television viewing and improves child expressive vocabulary.

For more information: Visit the Healthy Steps Web site at www.healthysteps.org. Healthy Steps resources are available on the Fund Web site, http://www.commonwealthfund.org/general/general_show.htm?doc_id=246567.

At the same time, many gaps remain in the quality measures available, the reach of improvement efforts, and the relatively small investment in pediatric quality, compared with investments in adult care. This is not surprising, given the stark contrast between the quality investments and infrastructure in the federal Medicare program compared with state-operated Medicaid and SCHIP programs. Over the last decade, Medicare has enhanced its focus, infrastructure, and leadership to improve the quality of care for Medicare beneficiaries. Not only have such activities directly affected the care of individuals, they have also moved the provider, health plan, and purchaser community toward higher-quality care.

There are significant differences between Medicare coverage and children's coverage under Medicaid and SCHIP. Still, there are lessons to be learned from quality improvement efforts in Medicare that are relevant to these programs.

Assuring Better Child Health and Development (ABCD)

Approach: Supported by The Commonwealth Fund and administered by the National Academy for State Health Policy, the Assuring Better Child Health and Development (ABCD) Program is designed to assist states in improving the delivery of early child development services for low-income children and their families. The model promotes collaboration among Medicaid agencies, pediatric providers, the Maternal and Child Health Bureau, and Early Intervention services to develop strategies to increase developmental screening of young children and promote children's health mental development. The current ABCD Screening Academy is working with 19 state Medicaid programs to extend the lessons and innovations developed by eight states from 2000–2007.

Impacts: The states involved in ABCD have achieved many successes, including:
—increased identification of developmental delays and more timely follow-up services;
—earlier detection of autism and reduced time between identification and initiation of services;
—identification of signs of maternal depression and services to address this risk factor to children's development; and
—increased provision of anticipatory guidance to parents and greater response to parental concerns.

For more information: See the NASHP Web site,
http://www.nashp.org/catdisp_page.cfm?LID=2A78988D-5310-11D6-BCF000A0CC558925.

In particular, over the last decade Medicare has increased its use of evidence in benefit design, resulting in many more effective treatments being made available to beneficiaries. CMS has used its authority and resources to influence quality measurement in adult health care. For example, CMS has catalyzed hospital reporting of adult quality measures through its participation in the Hospital Quality Alliance (HQA) and sponsored the development of a survey instrument on the experiences of adult hospital patients. More recently, CMS is using its new authority under the Medicare Modernization Act to provide incentives for hospital reporting on quality of care provided to Medicare patients and, most recently, for physician reporting of quality measures. The scope of work of Medicare's Quality Improvement Organizations has moved over time toward more rigorous quality improvement interventions and documentation of health outcomes through comparative performance benchmarking across states. In addition, CMS has developed partnerships in the private sector through its collaboration with Premier, Inc., to implement the nation's largest pay-for-performance hospital initiative using consensus measures. Finally, CMS has promoted adoption of health information technology in physician offices, emphasizing a key means of improving the quality and efficiency of care.

In the absence of comparable federal leadership in SCHIP and Medicaid, a number of states have moved ahead in these areas of quality improvement. Yet, the lack of systematic federal support for these efforts has limited their potential impact and their spread to other states.

High-Quality Children’s Care Can Improve Adult Health Outcomes

A growing body of research is documenting the links between early health and life experiences and adult health outcomes.¹³ Together, childhood environmental exposures, health-related behaviors, risk states, and conditions can track into adulthood, resulting in substantial morbidity and mortality.¹⁴ This evidence base provides a framework for understanding how children’s health and experiences are related to the development of health conditions, morbidity, and mortality among adults.¹⁵ While adult health is the end result of complex environmental interactions and exposures over the lifespan, childhood is a critical period during which these interactions can have profound effects on future health.

High-Quality Health Care Contributes to Broader Societal Goals

The lifelong consequences of childhood health and development have impacts beyond the health care sector. In an era of global competition, state and national policymakers are concerned about children’s ability to enter school ready to learn and leave school ready to work.¹⁶ For children to enter school prepared to learn, they must possess a number of critical attributes: good health; physical and emotional development; social competence; curiosity and enthusiasm about learning; communication skills; and appropriate cognition. When children are delayed in one domain, typically they are delayed in multiple domains. This relationship between a child’s health and development and his or her ability to enter school ready to learn has important implications for health insurance coverage and benefit packages, and for the quality of care in both public and private health plans (see box, below).

First, health coverage needs to encompass the whole child, reaching beyond traditional medical services to include services that address needs stemming from environmental and social factors.¹⁷ This includes providing anticipatory guidance to parents, building effective partnerships with families, and strengthening protective factors in the child’s environment.¹⁸ Second, children’s health care needs to emphasize preventive and developmental services that focus on optimizing health and development through childhood and adolescence. Thus, the content of the benefits as well as access to those benefits and services are essential to ensure that children receive what they need for healthy development. This is distinct from adult health care, which emphasizes treatment of existing conditions. Children’s health care needs and goals are different from those of adults. Thus, children’s insurance benefit packages need be designed according to a child health model. This model encompasses technology-dependent care (such as neonatal intensive care) as well as comprehensive developmental services.

Characteristics of Adolescent Health Care that Promote School Readiness

1. Youth have the capacity to access the health care system. This capacity involves three broad components:
 - A comprehensive system exists, with necessary specialty care and care coordination;
 - Financing for this system is adequate; and
 - Youth have the skills to negotiate this system.
2. Preventable problems will be prevented.
3. For youth with chronic conditions, these conditions are managed and transition to adult care is ensured.

FRAMEWORK FOR PROMOTING EFFECTIVE COVERAGE AND QUALITY IN SCHIP AND MEDICAID

Discussions of the quality of care generally focus on the quality of the services themselves, and the degree to which these services are safe, effective, patient-centered, timely, efficient, and equitable.¹⁹ However, within the context of SCHIP and Medicaid, it also is appropriate to consider how the features of the SCHIP and Medicaid programs themselves help to shape the delivery system within which quality of care is attained. The framework for quality in SCHIP and Medicaid pictured in Figure 1 shows the path by which SCHIP and Medicaid policies can lead to improved child health outcomes. The performance of SCHIP and Medicaid can and should be judged by characteristics of the programs themselves, characteristics of the health care system they help to shape, and the quality of the services for which they pay.

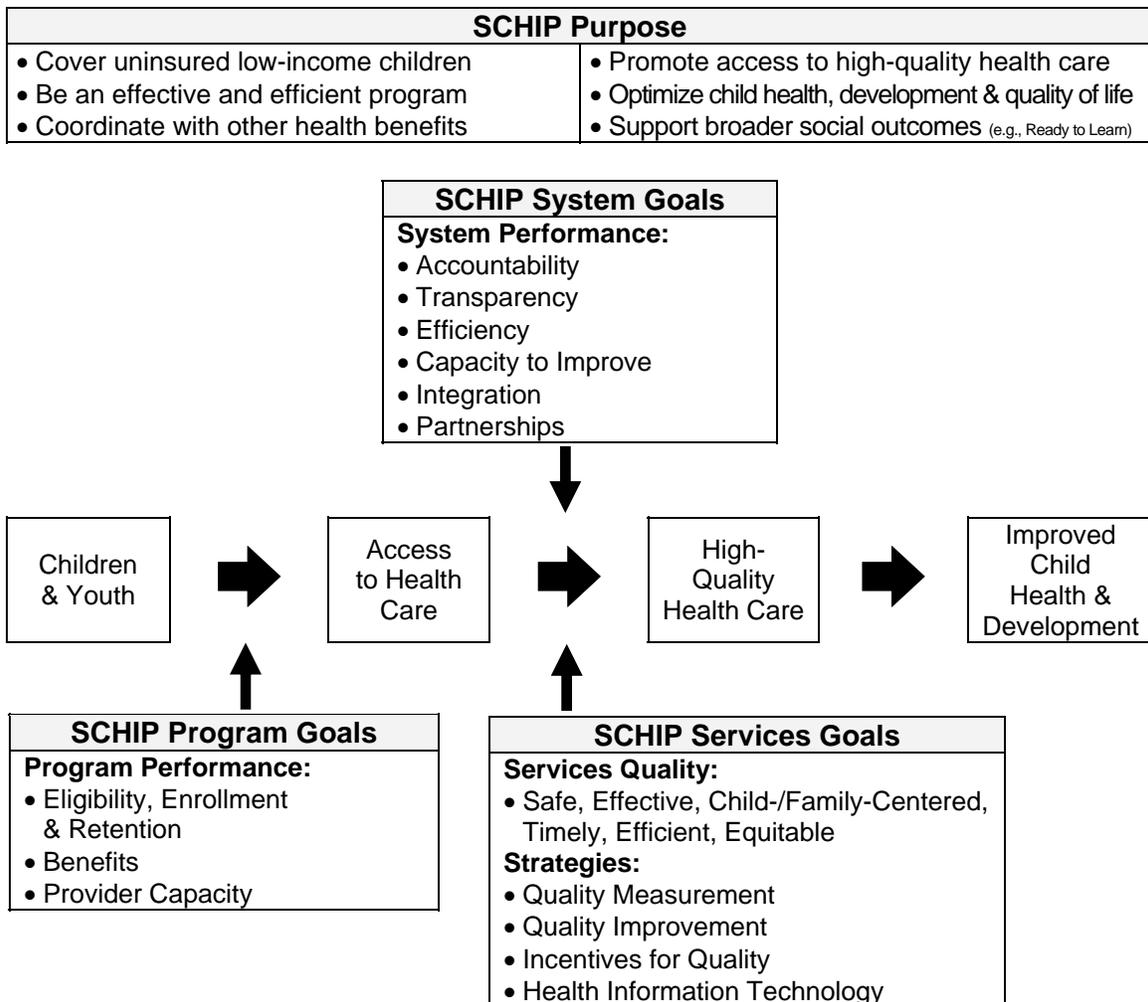
The framework presents strategies for promoting effective coverage and health care quality. It includes recommendations for the improving the performance of the SCHIP and Medicaid programs themselves, of the SCHIP and Medicaid health care system, and of the services provided under these programs:

- *SCHIP and Medicaid program performance.* SCHIP and Medicaid provisions related to eligibility, enrollment, and retention can help to bring coverage to large numbers of children and youth, and importantly, enable eligible children to stay insured. The benefit packages should ensure access to appropriate services and a stable provider network, including both primary and specialty care providers, so that covered benefits are actually delivered. Together, these features determine whether children have a medical home that provides continuous primary and preventive health services, as well as health services for illnesses and injuries.

- *SCHIP and Medicaid system performance.* In recent years, the characteristics of a high-performing health care system have been refined to include accountability, transparency, efficiency, and a capacity to improve.²⁰ For children and families in SCHIP and Medicaid, two additional features are critical: the integration of services across type, setting, and time and the partnerships between funders, systems, families, and providers.²¹
- *SCHIP and Medicaid services quality.* Ultimately, the result of SCHIP and Medicaid high performance at the program and system levels is the provision of health care to children and youth that is safe, effective, child- and family-centered, timely, efficient, and equitable, and that results in improved child health and development.

Figure 1. The Role of SCHIP and Medicaid in Improving Child Health Outcomes

SCHIP/Medicaid Improves Child Health Outcomes



SCHIP and Medicaid Program Performance Goals

- *Eligibility, Enrollment, and Retention*
- *Benefits*
- *Provider Capacity*

Providing access to effective health care through SCHIP and Medicaid begins with the statutory and regulatory components of the SCHIP and Medicaid programs that influence eligibility, enrollment, and retention. These components influence the number of children reached and the stability of their coverage, which, in turn, influences access to care.

Numerous studies have shown that children who have a stable source of insurance are more likely to have a usual source of care, well-child visits, and preventive care and consequently have fewer unmet medical and medication needs and experience fewer delays in care.²² The benefit package ensures that children have access to comprehensive and appropriate services, while provider capacity determines availability of these services. These components of program performance are crucial elements of quality, even though they are not usually thought of as such, and the building blocks of improved health and development of children.

Ensuring Access to Care Through Eligibility, Enrollment, and Retention Policies

Eligibility. Eligibility requirements, such as income eligibility thresholds, are determined by states and vary considerably among states. As of July 2006, most states (34) covered children in families earning income up to 200 percent of the federal poverty level (FPL) (annual income of \$33,200 for a family of three) through either Medicaid or SCHIP, while 16 states covered children in families earning between 201 percent and 300 percent of FPL (300 percent of FPL is equivalent to an annual income up to \$49,800).²³ More recently, several states have expanded coverage to reach children (and sometimes adults) at substantially higher income levels. Massachusetts and California have implemented or are proposing far-reaching plans for universal coverage for both children and adults. Illinois and Pennsylvania are implementing dramatic expansions of Medicaid and SCHIP to reach all or most of the remaining uninsured children. At least 10 other states are considering sizeable expansions.²⁴

Enrollment. Setting income eligibility thresholds at sufficiently generous levels is only the first step in reaching children. Policies that govern enrollment and retention, which are also the province of the states, strongly affect program participation. Some state policies, such as mounting aggressive outreach efforts, encourage enrollment, while state policies involving cost-sharing may deter enrollment.²⁵ As of 2006, 35 states had imposed

premiums or enrollment fees, most in the neighborhood of \$20 to \$50 per month.²⁶ After SCHIP enactment in 1997, many states mounted aggressive outreach and enrollment campaigns. Enrollment grew steadily and, by 2006, SCHIP annual enrollment was 6.6 million children. Moreover, the outreach conducted for SCHIP had spillover effects for Medicaid. As a result of SCHIP outreach, millions more children were enrolled in Medicaid.²⁷ Between 1997 and 2005, the enrollment increase in SCHIP and Medicaid contributed to a reduction in the rate of uninsured children in low-income families (with household income up to 200 percent of FPL), from 22.3 percent to 14.9 percent.²⁸

Retention. If the expansions are to be successful, they not only need to reach uninsured children, they also need to improve retention of current enrollees. Retention of eligible children has been a vexing problem for both SCHIP and Medicaid, but it is crucial for quality care. Lack of stable coverage, even if there are only short spells without insurance, adversely affects families' access to and use of services and leads to delays in care and unmet needs.²⁹ Continuously insured children are less likely to use high-cost emergency medical services and to be hospitalized for such conditions as asthma.³⁰

Further, moving on and off of Medicaid or SCHIP increases administrative costs and makes it more difficult to monitor and manage care.³¹ Loss of coverage often occurs at the point of renewal, when families need to prove their children's continued eligibility for the program according to requirements set by individual states. One study of retention of SCHIP children in four states showed that approximately half the children left the rolls at each renewal period.³² Children move off and on the program for a variety of reasons: some move into Medicaid, some into employer-sponsored coverage, and some become uninsured. Many children remain eligible and subsequently regain coverage. Another study, this one involving Medicaid children in five states, showed that half of the children who lost coverage returned to the program after only two to four months, and that most returned sometime in the course of a year. At least one state has implemented a "passive renewal" system for SCHIP, whereby return of a postcard stating that income and other criteria have not changed, combined with continued payment of premiums, are all that are needed to renew coverage.

➤ ***SCHIP, Medicaid, and Stable Coverage: Recommendations***

The degree to which states achieve stable coverage among all eligible children should be monitored and reported. The impact of various program policies on rates of renewal of coverage for eligible children, as well as the impact of insurance instability on access to and quality of care, should be examined. The federal government could provide incentives to states to achieve stable enrollment, giving states the ability to choose the best

strategies to achieve that goal. For example, states could adopt annual eligibility re-determinations and provide passive or automatic renewal if circumstances remained unchanged. Enhanced outreach activities at the state level could be supported by incentives. Finally, research on the impact of coverage instability on quality of care, as well as demonstration programs and strategies to simplify renewal and increase retention, could be supported through additional federal investments.

Program Performance: Benefits³³

The requirements for child health coverage differ from adult benefit design.³⁴ The right child health benefits are essential for ensuring appropriate, high-quality, and effective care. Covered services should promote the development of optimal physical and mental health and social functioning into adulthood. Several benefits guaranteed to Medicaid children through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program are optional under SCHIP, provided at state discretion. Commercial insurance benefit design has become the standard in SCHIP, in effect applying an adult standard to children and hence removing key features essential to addressing the unique health needs of children. One example of this relates to rehabilitative services. Most commercial coverage provides such benefits only until beneficiaries regain the functioning that they had lost because of an injury or illness. Children may have not reached full functioning, before a particular illness or injury, so that habilitative (not rehabilitative) services are needed to support the development of that functioning in the first place. SCHIP does emphasize preventive care; there are no required copayments for these services. In addition, a 2005 survey comparing standalone SCHIP programs and Medicaid expansions found fewer differences among SCHIP and Medicaid benefit packages than expected.³⁵

Examples of Comprehensive Preventive and Developmental Child Health Benefits

Currently covered by EPSDT

- Developmental screening: A medical home provides the opportunity to identify child health and developmental needs, linking them with needed resources, including early intervention services.
- Oral health: Poor oral health and untreated dental problems are significant problems for many children, especially low-income children.
- Vision screening: Up to half of low-income children have undetected vision problems at the time they enter school.
- Attention Deficit Hyperactivity Disorder, autism, and other child health conditions: such conditions can be most effectively addressed when they are identified early. Currently, there are substantial time gaps between initial detection, screening and diagnosis, and treatment.

Coverage for these services not explicitly specified in EPSDT

- Nutrition and exercise: Childhood obesity is one of the greatest threats to the health and well-being of children and adolescents. EPSDT covers nutritional and physical activity counseling and nutritional services but few states reimburse for such services.
- Parental depression: Parents' mental health affects their children's health and well-being. As part of their work, pediatric practitioners can screen for parental—especially maternal—depression and promote timely treatment.
- Language and literacy: Pediatric practitioners can promote early language development and literacy through well-child visits and the provision of free books to low-income families.

Source: Child and Family Policy Center, *Improving Children's Healthy Development Through SCHIP Reauthorization: Synopsis and Considerations from an Expert Panel Meeting*. Dec. 2006.

➤ *SCHIP and Benefit Design: Recommendations*

Several strategies exist to ensure children's access to the full range of needed benefits under SCHIP. First, the SCHIP statute could specify legislative intent for subsequent regulations to include a description of a preventive and developmental standard of coverage. This standard could be the preferred design for state benchmark plans or coverage systems and could be aligned with the American Academy of Pediatrics policy on benefits.³⁶ States' provision of these services could be monitored through a performance metric under future SCHIP reporting requirements. Consistency in reporting the benefits provided across states would significantly improve our understanding of the programs' impacts. Federal officials should encourage and support states in their efforts to strengthen preventive services for children prior to school entry and could provide incentives for states to monitor the provision of preventive and developmental services. Additionally, enhanced reimbursement for best practices for wraparound services, case management, and community-based services could be considered, especially since there is considerable variation in what is included within definitions of wraparound services.

In addition, federal funding could provide incentives for state demonstration and evaluation programs to examine innovative models of benefit design to meet the needs of the whole child, as well as flexibility on budget neutrality. These demonstrations and evaluations should be coupled with federal leadership, technical assistance, and incentives to states to incorporate evidence-based policies and programs that improve children's healthy development. In addition, federal investments in research on effective preventive and developmental health practices should be assigned higher priority within various federal agencies, including the Agency for Healthcare Research and Quality (AHRQ), Maternal and Child Health Bureau, and the National Institutes for Health.

Finally, the development, dissemination, and use of knowledge, tools, and best practices to improve benefit design and implementation, including wraparound services, case management, and community-based services, should be supported by additional federal resources.

Program Performance: Provider Capacity

In addition to stable insurance and a robust benefit package, there need to be sufficient providers to deliver primary care, as well as dental and mental health services and pediatric specialty care. The combination of low reimbursement rates, paperwork requirements, and the increased number of capitated patients deters many private, office-based physicians from accepting Medicaid and SCHIP children as patients.³⁷

Recently, physician groups in a few states (including Oklahoma and Illinois) have successfully sued their states for failing to provide "equal access" to care for Medicaid enrollees, comparable to that received by other children.³⁸ However, despite success in challenging low reimbursement rates in a few states, reimbursement rates in most states remain substantially lower than the market rate.³⁹ As a result, many office-based physicians do not accept children with Medicaid or SCHIP coverage, or accept only a few. As of 2004, 36 percent of physicians either were not accepting new Medicaid patients or had no Medicaid patients to begin with. Thus, children with Medicaid or SCHIP coverage are often concentrated among relatively few safety-net providers, such as those in community health centers, public clinics, hospitals, or large group practices.⁴⁰ Nationwide, just one-fifth of physicians provide half of all care for Medicaid patients.⁴¹ Access to dental care, mental health services, and specialty services is even more restricted than access to primary care.⁴²

With expansions bringing more and more children into public coverage, it will be important to ensure that there are sufficient numbers of physicians, dentists, mental health workers, pediatric specialists, and other providers to care for them. Medicaid and SCHIP provider reimbursements, which have historically been low, may need to be adjusted as

expansions occur, and administrative burdens may need to be modified to ensure adequate provider capacity.

➤ *SCHIP, Medicaid, and Provider Capacity: Recommendations*

Measures for monitoring provider capacity, including primary care providers, dentists, mental health providers, and pediatric specialists, are needed. State-level strategies to enhance provider capacity, including improved reimbursement, incentives to practice in underserved areas, and medical school loan forgiveness, should be identified and encouraged.

SCHIP and Medicaid Health Care System Performance Goals

- *Accountability*
- *Transparency*
- *Efficiency*
- *Capacity to Improve*
- *Integration*
- *Partnerships*

Health insurance should provide children with access to a health care delivery system that is structured to optimize the quality of care. Recently, The Commonwealth Fund Commission on a High Performance Health System defined the key characteristics of high performance.⁴³ Halfon, Bergman, and others have defined the features of a high-performing child health system that incorporates the dimensions of system performance especially relevant to children as they grow and develop.⁴⁴ Together, these reports provide a framework for defining the system of health care that SCHIP and Medicaid should support.

Health System Performance: Accountability

In a high-performing child health system, each stakeholder is accountable to others. Taxpayer-funded programs should be accountable to the public, while SCHIP and Medicaid programs should be accountable to the federal government and the states, as well as to their enrollees. Accountability is largely achieved by soliciting feedback from consumers, reporting progress and outcomes, and providing information about health system performance.

Transparency

A high-performing child health system embraces transparency, recognizing its role in promoting system improvement and innovation. Transparency is related to accountability in that results are made public so that all stakeholders understand the effectiveness of the programs they support and/or participate in.

Capacity to Improve

A high-performing child health system should have the capacity to reach and sustain excellence. To be successful there must be significant investment in research into the determinants of child health and development; substantially increased information on the comparative effectiveness of treatment choices; strategies to improve delivery processes to maximize quality, safety, and efficiency, including the use of health information technology; and ways to expedite the identification, adoption, and dissemination of best practices.

Efficiency

A high-performing child health system should provide efficient, high-value care that achieves the best health outcomes and benefits possible for children, families, and society. States support this goal by: ensuring efficient enrollment and retention of children in SCHIP and Medicaid; designing benefit packages that support high-value clinical services; promoting identification, treatment, and coordinated management of conditions that affect children's healthy development; and encouraging the development and deployment of health information systems.

Integration

A high-performing child health system integrates health services across all aspects of care, including health promotion and disease prevention as well as acute and chronic care services. Halfon et al. propose that integration in children's health care is both horizontal, encompassing the physical, behavioral, and oral health needs of children, and vertical, including services in the medical sector as well as those delivered in settings where children live, learn, and play, such as Women, Infants and Children clinics, schools, early interventions programs, state Title V agencies, public health services, and other community-based settings. A longitudinal care system organized around developmentally sensitive services and anticipatory guidance enables continuity of care through developmental transitions.⁴⁵

Partnerships

A high-performing child health system requires partnerships among the various stakeholders involved in health care financing and delivery. The concept of partnership is fundamental to SCHIP and Medicaid, as both of these programs are dependent on an effective relationship between federal and state policymakers and public administrators. Given that private providers deliver most of the care to SCHIP and Medicaid children, partnerships between the public and private sectors—combining market forces and public policy—are essential. Parents, too, must be key partners to ensure that programs meet the needs of children and families.

➤ *SCHIP and Medicaid System Performance Goals: Recommendations*

To achieve a high-performing system of care for children and youth, there need to be substantial adjustments to the federal–state partnership through which SCHIP and Medicaid are managed. In particular, there needs to be increased oversight, coordination, public input, and accountability to Congress.

One strategy for achieving improved oversight and coordination is to establish advisory entities at the national and state levels. A new national advisory entity for SCHIP and Medicaid could be created, similar to the Medicare Payment Advisory Commission (MedPAC). MedPAC advises the U.S. Congress on issues affecting the Medicare program under a broad statutory mandate that addresses the adequacy of the provider network, the quality of the services received, and other issues affecting Medicare.⁴⁶ So, too, should there be a commission focused specifically on children to advise Congress on strategies to achieve high-performing SCHIP and Medicaid programs. Such an advisory commission should have broad representation and include families, providers, plans, states, and child health experts in areas including coverage, benefits, access, and quality of care.

Similarly, at the state level, child health and development quality councils could be required or encouraged by federal policy and charged with fostering collaboration across diverse state programs serving children, applying the national vision in their own state, identifying state-specific measures, and facilitating quality measurement activities across programs. Participants of such a commission must actively engage families as full partners along with leadership from Medicaid, SCHIP, the Department of Health, insurers, employers, the American Academy of Pediatrics, American Academy of Family Physicians, Children’s Hospitals, Medical Schools, Title V, and External Quality Review Organizations.

SCHIP and Medicaid Health Care Services Quality Goals

Services Quality

- *Safe, Effective, Child- and Family-Centered, Timely, Efficient, Equitable*

Strategies

- *Quality Measurement*
- *Quality Improvement*
- *Incentives for Quality*
- *Health Information Technology*

Ultimately, SCHIP and Medicaid should lead to the receipt by children and youth of high-quality services that meet their health and developmental needs. As defined by the Institute of Medicine, quality of care is care that is safe, effective, timely, child- and family-centered, efficient, and equitable.⁴⁷ Four strategies in particular are relevant for consideration during the SCHIP reauthorization: quality measurement; quality improvement; incentives for performance; and health information technology.⁴⁸

*Quality Measurement*⁴⁹

Quality measurement is a necessary step toward improving the quality of care for children.⁵⁰ States already have numerous data and quality reporting goals, requirements, and mandates under both the SCHIP and Medicaid programs, yet no common measure is consistently available from all 50 SCHIP programs.⁵¹ Collection, analysis, and reporting of data on program and system performance, as well as the quality of services, can be expensive and labor-intensive. Many states use quality measures that are inconsistent from year to year across Medicaid and SCHIP, among different state agencies, and with the private sector. There are opportunities to integrate measurement efforts and gain economies of scale and strategic impact. Measurement in Medicaid and SCHIP focuses primarily on children's access to pediatric preventive and primary care and little on the quality of care. Only eight states report on pediatric inpatient care quality. Further, not all states use Healthcare Effectiveness Data and Information Set (HEDIS) methodology, making data comparisons difficult. State Medicaid agencies recognize the need to improve preventive care and care for children with special health care needs, and many are participating in statewide or national collaboratives to improve measures for these areas of care.⁵² States that measure the quality of care and offer performance incentives at the provider level will need to address the problem that, in many providers' patients panels, there are small numbers of Medicaid enrollees in a given category (e.g., asthmatics, children in well-child care ages 3 to 6).

Given states' substantial investments in quality reporting, coupled with the failure of these voluntary efforts to promote consistent reporting across states, a new quality measurement strategy for Medicaid and SCHIP is warranted.

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

Quality data available from administrative data

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

Quality data requiring parent report or chart audit

- Percent of children receiving a standardized developmental screen at 18 months
- Percent of children 2–6 years with a regular source of care
- Proportion of children with a chronic health problem who have a current management plan
- Percent of two-year-old children up to date on immunizations
- Percent of 4-year-olds with a documented vision screen
- Percent of parents whose informational needs were met by their child's health care provider
- Percent of parents asked whether they had concerns about their child's learning, development, or behavior
- Percent of children (2–18 years) for whom a BMI was computed at most recent well-child care visit

Source: Edward L. Schor, M.D., Vice President, Child Development and Preventive Care Program, The Commonwealth Fund.

➤ ***SCHIP, Medicaid, and Quality Measurement: Recommendations***

Currently, the SCHIP statute calls for state reporting on a number of dimensions measuring health insurance provision. These reports are currently submitted to CMS using a standard template; however, this template does not require consistency in the specifications of the actual measures, making comparisons nearly impossible. Consistent state reporting on a core set of quality measures for SCHIP and Medicaid programs across all states is needed. To achieve this, there are several considerations.

What to report? First, the measure set should not be specified in legislation but should be developed through a public–private process that convenes all key stakeholders.⁵³ This has become the model in consensus development for measures of adult care, as evidenced by the recent activities of the National Quality Forum, the Ambulatory Quality Alliance, and the Hospital Quality Alliance. There will need to be substantial state input. Legislative intent could guide this effort by specifying the domains of care and performance to be addressed by the core measures. Since children’s health care is complex, one measure set will not be able to cover all sectors and domains of care at once. Instead, there could be a core measure set, with certain measures cycled across several years. Measures should come from multiple sources, including standardized parent/youth surveys to ensure that the actual care experiences of SCHIP and Medicaid enrollees are included in state reporting.⁵⁴ Finally, many of the common conditions for which children receive health care, and many settings of care, still lack validated measures. Thus, investments in the development, testing, refinement, and adaptation of new quality measures and their data collection infrastructure and reporting systems are needed.

How to report? There are options for enhancing the existing quality reporting requirements in the SCHIP and Medicaid programs. As of spring 2006, 26 of 47 states responding to a survey reported performance results for health plans or providers.⁵⁵ Performance comparisons across states and benchmarking of state performance against national averages would enable the identification of exemplary programs and best practices. For this, data need to be aggregated to an overall state level for each measure and publicly reported. For example, all states could report data to CMS, including data required for fiscal and regulatory oversight and those used to measure performance. The performance data could be assigned to AHRQ for analysis and reporting back to the state sponsors, public reporting on a Web site, and inclusion in the National Healthcare Quality Report and National Healthcare Disparities Report.⁵⁶ Specific authorities and funding for this type of system would be needed. CMS could be encouraged to work with AHRQ, the Health Resources and Services Administration, and the Centers for Disease Control and Prevention on their numerous state measurement efforts relevant to children.⁵⁷

How to create incentives for reporting? State resistance to changes in reporting requirements is to be expected, particularly if no additional support, such as technical assistance and enhanced federal matching funds, is offered. Reporting requirements for SCHIP and Medicaid could be structured in a number of ways. An across-the-board requirement could be written into legislation, as in the 1999 Balanced Budget Act, but this is unlikely to be successful. It is more practical to focus on incentives instead of mandates for reporting, as the Medicare program has done. This is particularly important, given that quality measurement for pediatric inpatient care is not as well developed as it is

for adult inpatient care, and that the establishment of meaningful quality measurement across state programs is much more difficult than under a single-payer system such as Medicare. Congress could emulate the incentive approach in the Medicare Modernization Act of 2003 that requires Medicare providers to report on 10 standard quality measures in order to receive their annual payment update. Following this approach, states could have their level of federal financial participation in SCHIP or Medicaid linked to reporting. In addition, incentives for using best practice models of measurement and reporting could be made available through expansion of the administrative cap in SCHIP or enhanced match in Medicaid (at either the 75% or 90% matching rate), contingent on the reporting of measures in the manner prescribed by CMS.

How to improve reporting? Achieving a relevant, efficient, and continually updated quality measurement infrastructure for states will require substantial efforts and learning across states. Federal resources to support learning networks, implementation resources, and clearinghouses for states would accelerate progress in this area. In addition, investments will need to be made to developing new measures for domains of children's health care for which there are not well-developed and validated metrics.

*Quality Improvement*⁵⁸

Our ability to improve the quality of care for children and youth has grown tremendously in the last five years.⁵⁹ Some SCHIP and Medicaid programs require their contracted managed care plans to have an internal quality improvement program in place that meets certain standards.⁶⁰ In addition, most programs also require contracted plans to take some specific action to assess and improve quality. Although some states have made great progress in adopting initiatives to improve quality, these could be spread more widely and more states could adopt such efforts. In a letter to Medicaid directors, CMS recently outlined an opportunity for states to participate in the agency's national Value-Driven Health Care efforts and a new Medicaid Quality Improvement Program goal. In the letter, CMS recognizes that a number of states are already engaged in quality improvement efforts and offers to partner with them by launching an initiative to demonstrate quality in a targeted number of states in the short term, while developing a National Medicaid Quality Framework in the longer term.⁶¹ There are three additional actions that CMS could undertake that could make a dramatic difference in how well the health care system meets the needs of children and youth.

SCHIP, Medicaid, and the applications of methods and tools of improvement. Improving care entails the use of specific tools and techniques, including facilitation skills, measurement tools, and improvement methods. State agencies have explored multiple strategies to build and apply these capabilities, but most have not achieved a durable infrastructure for

improvement and rely heavily on time-limited or project-specific support for improvement activities. Several states have formed public-private stakeholder groups to review and recommend policy changes that can support quality improvement. Some states, such as Illinois, Minnesota, and North Carolina, have adopted and implemented recommendations to improve the quality of preventive and developmental services for young children.⁶² Minnesota and Wisconsin have undertaken similar efforts to improve care for children with special health care needs. California, North Carolina, and, most recently, a CMS-led initiative involving several states are focusing on neonatal intensive care. Finally, efforts have begun to move from single-focus improvement efforts to sustained regional organizations, working in partnership with the private sector, to improve children's health care over time.⁶³ Partnerships that bring together Medicaid with state institutions, plans, and provider associations are not easy to establish and maintain. Yet, when established, such partnerships are invariably helpful in sustaining the efforts of frontline providers.

Leadership. The Institute of Medicine (IOM) has made clear that health professional training must be reoriented toward five core competencies: quality improvement, use of informatics, the practice of evidence-based care, interdisciplinary approaches, and patient-centered care. Workforce development is needed to support leaders for children's health care quality improvement efforts and partnerships. Current efforts by CMS and AHRQ to support Medicaid medical directors could be expanded to other senior Medicaid staff, leading to the formation of a child health improvement corps. As stated above, establishing and supporting a federal child health care quality commission could lend greater visibility to these issues, both within the federal government and across the states.

Engagement of patients and families in all stages of the process. Family-centered care is a hallmark of care for children, particularly children with special health care needs. At a national level, CMS has actively supported the development of state-based Family-to-Family Health Information Centers. These programs could be expanded in scope to train and support families interested in improving the quality of health systems. Consumer health surveys focused on pediatric care could be more routinely used within Medicaid and SCHIP to provide information on the content and quality of children's health services. The Medicaid Advisory Councils in each state should include at least one family representative of a statewide parent organization.

➤ ***SCHIP, Medicaid, and Quality Improvement: Recommendations***

There is an urgent need to enhance states' capacity to improve the quality of children's health care. A number of actions by CMS as well as investments at the federal level could make a significant difference. First, CMS could provide proactive guidance to

states on the parameters and approaches for using matching funds under Medicaid for the development of state-based, public-private improvement partnerships, such as those established in Vermont and Utah and described above. For standalone SCHIP programs, federal support could come through expansion of the administrative cap and/or preferential federal financial participation for states that invest in improvement. Finally, the establishment of one or more National Resource Center would provide ways to share resources, approaches, and best practices among states. Such centers could focus on priorities identified in partnership with states; collect, synthesize, and disseminate information on innovation; design and test additional innovations; and serve as a hub for information, tools, and resources.

*Incentives for Performance*⁶⁴

Providing incentives to states to change quality provisions within their child health coverage can promote exemplary practices and innovations. Incentives in Medicaid/SCHIP programs have included enhanced federal matching rates for particular actions, financial rewards for demonstrated high performance, and demonstration funds to support innovation or diffuse exemplary practices. Other, non-monetary incentives include public reporting, recognition programs, and auto-assignment of SCHIP or Medicaid enrollees to a high-performing managed care plan to build its market share.

Pay-for-performance programs are one way to improve quality, control costs, and provide value for dollars spent.⁶⁵ In general, PFP programs have used at least four types of performance requirements: pay for participation, pay for process, pay for improvement, and pay for outcomes. A recent survey found that, as of July 1, 2006, more than half of all state Medicaid programs were operating one or more pay-for-performance programs, and that in five years nearly 85 percent of state Medicaid programs plan to have such programs.⁶⁶ Further impetus for this approach comes from Secretary Leavitt's initiative to promote value-driven health care. The four cornerstones of this initiative are health information standards, quality standards, price standards, and incentives. To date, 12 states have signed the statement of support for this initiative and "commit to support the following actions and will encourage the health insurance plans, third-party administrators, providers, and others with which we contract to take consistent actions to achieve these goals."⁶⁷

Evidence on the effectiveness and impact of pay-for-performance (P4P) programs is only now beginning to emerge, and is conflicting at best. Most published evaluations have not focused specifically on care for children, let alone publicly insured children.⁶⁸ In addition, incentive programs for hospital care for Medicaid-enrolled children pose special challenges, given that regional pediatric inpatient centers often serve children under multiple

state Medicaid programs and Medicaid reimbursement for hospital care in most states is substantially below cost.⁶⁹ Despite the lack of evidence, pay-for-performance is now emerging in Medicaid programs, including in Michigan and New York, at the health plan level, individual provider level, and even at the beneficiary level.⁷⁰ Past efforts have focused on incentives to health plans; however, there is growing interest in physician incentives. States are learning, however, that developing physician-level incentives is not easy. Experience has shown that, particularly where the state of practice is developing, incentives rather than regulatory mandates often are more successful in diffusing effective practices.

➤ *SCHIP, Medicaid, and Pay-for-Performance: Recommendations*

Given the limited evidence on the impacts—both beneficial and unintended—of P4P programs in children’s health care, the most important roles for SCHIP and Medicaid are to promote and fund demonstrations to test various incentives and approaches. A national demonstration with CMS leadership, involvement of at least five states, consistent metrics, and a robust evaluation (overseen by AHRQ) would be the preferred approach. The costs of demonstration programs could be supported under the SCHIP administrative cap or by making P4P costs eligible as a benefit-related cost rather than an administrative cost. In particular, states may want to pursue P4P programs for promoting excellence in developmental services, improving behavioral health care, addressing racial/ethnic health disparities, and engaging consumers. P4P efforts could also be conceived as federal incentives to improve state performance. Federal authority for state P4P programs could be expanded by establishing an optional supplement, or “add-on,” to state federal financial participation linked to a state’s success at promoting quality within Medicaid and SCHIP. Regardless of the type of P4P effort, funds are needed to conduct real-time evaluations of these programs to support rapid learning.

Health Information Technology

Health information technology (HIT) is a key tool for improving the quality and efficiency of care. HIT includes electronic health records, personal health records, use of personal digital assistants, health information exchange, computerized order entry systems, e-prescribing, and disease-specific or population-based registries.⁷¹ There is substantial policy interest in supporting the adoption of HIT by the public and private sectors. For example, in 2004, the combined state and federal investments in HIT in Medicaid reached \$2.7 billion for state Medicaid Management Information Systems (MMIS).⁷² Some states have used these funds for innovative applications that support quality, such as immunization registries, beneficiary portals, and e-prescribing capacities.⁷³

However, child health and public programs serving children have been ignored, or specifically excluded. Much of the attention has been on high-cost populations (e.g., the elderly and those with special health care needs) and chronic or high-cost medical conditions. Little attention has been given to health care related to children's development. For example, President Bush's August 22, 2006, Executive Order calling for federal health care programs to promote quality and efficient delivery of health care through the use of HIT systems that meet recognized interoperability standards specifically excluded SCHIP and Medicaid.⁷⁴ Whether and how HIT initiatives could improve the quality of care for children, particularly low-income children, remains unclear. There are many reasons to be concerned that child health care providers and public programs serving children have not been very involved in the use of HIT. First, because of the upfront costs, children's health care providers have been slow to adopt HIT, averaging 21 percent in a national sample and 13.7 percent in a state-based sample in the same year who *personally and routinely used an electronic health record*.⁷⁵ Second, child health care raises unique issues for development of interoperable HIT systems, such as the need for age-specific norms for lab values, growth charting, and weight-based dosing functionality for electronic prescribing.⁷⁶ Third, children's heavy reliance on publicly funded systems of care often precludes their access to providers with these technologies. To date, there has been little focus on the role of Medicaid in promoting clinical HIT.⁷⁷

Recently, pediatric organizations, the Maternal and Child Health Bureau, and AHRQ, among others, have led efforts to examine in the particular needs for HIT in children's health care.⁷⁸ These efforts have largely focused on the immunizations, newborn screenings, and pediatric standards to be included in electronic health records, and the exchange of health information through state-based regional health information organizations. One promising example is the proactive design of decision-support systems for the implementation of the new Bright Futures guidelines on well-child care, which will be released by the AAP later this year.⁷⁹

► ***SCHIP, Medicaid, and Health Information Technology: Recommendations***

SCHIP and Medicaid could play a much stronger role in promoting the diffusion and adoption of child health information systems. Through the SCHIP reauthorization, Congress could complement private sector efforts by funding demonstrations on the role of clinical HIT in improving care for children, especially chronically ill children. In addition, Congress could clarify that CMS' authority to provide enhanced matching funds within Medicaid for HIT investments (90/10 for development and 75/25 for maintenance) applies to a full range of HIT approaches, including electronic health records, personal health records, health information exchange, and patient registries.

At the state level, successful experiences with patient registries and improved Medicaid Management Information Systems could be replicated and expanded to most or all states. Existing payment rules could be modified to make clinical HIT investments an allowable cost in capital investment for certain providers, enabling providers to receive enhanced payments in proportion to their Medicaid patient mix.⁸⁰ States could sponsor the development of Medicaid-specific electronic health records, an approach that Tennessee has adopted in partnership with the state's Blue Cross Blue Shield plan.⁸¹ In addition, states could share clinically relevant information from claims data for Medicaid patients at the point of care.⁸² Additionally, financial preference for state funding for HIT could be given to rural, low-income providers and other providers who serve vulnerable populations. Finally, states could use managed care contracts to require further efforts to encourage the use of clinical HIT. CMS could support all of these state efforts by providing explicit guidance about allowable and preferred strategies.

CONCLUSION

This is a time of great opportunity to build on the success of SCHIP in providing health insurance to millions of low-income, uninsured children. It is also a time to capitalize on the investments in research and health system innovation in both the public and private sectors to support dramatic improvements in the quality of care provided to children insured through public programs. The SCHIP reauthorization can focus attention on quality in children's health coverage under SCHIP and Medicaid and expand the federal leadership role and resources to support states in develop high-performing, accountable public health care programs for children. If it does so, its impact will be to improve care for all of the nation's children and youth.

NOTES

¹ This report draws heavily on the work of two meetings held in 2006 on this topic. The first, hosted by the National Initiative for Children's Healthcare Quality (NICHQ) in partnership with the Child and Adolescent Health Measurement Initiative (CAHMI) and Family Voices, was held in August 2006. The second was hosted by the Child and Family Policy Center in December 2006. In addition, suggestions on the content of this report were provided by a number of key informants as part of its drafting.

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