



Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES



Robert Wood Johnson
Foundation

MARCH 2016

Measuring and Improving Health Care Quality for Children in Medicaid and CHIP: A Primer for Child Health Stakeholders

By Tricia Brooks

Support for this report was provided by a grant
from the Robert Wood Johnson Foundation

Author



Tricia Brooks, MBA
Associate Research Professor
Georgetown University Health Policy
Institute
Senior Fellow
Georgetown University Center for Children
and Families

The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center founded in 2005 with a mission to expand and improve health coverage for America's children and families.

As part of the University's McCourt School of Public Policy, Georgetown CCF provides research, develops strategies, and offers solutions to improve the health of America's children and families, particularly those with low and moderate incomes. In particular, CCF examines policy development and implementation efforts related to Medicaid, the Children's Health Insurance Program (CHIP) and the Affordable Care Act.

Table of Contents

<u>Introduction</u>	3
<u>The Role of Advocacy in Quality</u>	4
<u>A Brief History of Health Care Quality Efforts</u>	5
<u>The Basics of Health Care Quality</u> <u>Measurement and Improvement</u>	6
<u>Quality Measurement and Improvement</u> <u>in Medicaid</u>	8
<u>Health Care Quality Beyond Medicaid</u>	11
<u>Conclusion</u>	12
<u>Resources</u>	14

Introduction

Many Americans believe they receive the best health care in the world, but there is evidence to the contrary. Although the United States spends far more on health care than any other developed nation, our investment has not universally created a healthier population. We devote a third more of the nation's gross domestic product to health care than almost all European countries,¹ yet studies show that Americans receive recommended care only about half of the time.² While we do lead the world in health care research, medical education, and cancer treatment, we lag behind other countries in key measures of health outcomes such as life expectancy (26th place), infant mortality (31st place), and overweight and obese children (5th highest),³ as well as on dimensions of access, efficiency, and equity. These facts underscore the need for transforming the American health care system into a more efficient, effective, and patient-centered system.

The need to improve the value and effectiveness of health care is a system-wide problem, not one isolated to one source of coverage. However, as the nation's largest and fastest-growing health insurer, Medicaid has a key leadership role to play in this transformation, and is increasingly at the heart of efforts to remake and reform the health care delivery system.^{4,5}

A large body of evidence shows that, compared to low-income uninsured children, Medicaid has been highly successful in providing children with a usual source of care and regular well-child care while significantly reducing unmet or delayed needs for medical care, dental care, and prescription drugs due to costs.⁶ Nonetheless, quality improvement centers on the notion that systematic and continuous actions lead to measurable improvement in health care services and health status. To this end, health care quality improvement efforts in Medicaid and the Children's Health Insurance Program (CHIP) have accelerated significantly in the past several years largely due to the CHIP Reauthorization Act of 2009 (CHIPRA) and the Affordable Care Act of 2010 (ACA). In May 2015, the Centers for Medicaid and Medicare Services (CMS) also proposed a major modernization of federal rules regarding Medicaid managed care. If enacted, the regulations will have sweeping implications for state quality strategies that extend to all health care delivery

mechanisms, including fee-for-service. Provisions in the new rules call for transparency and for states to engage stakeholders in planning and implementation.

Given the acceleration in health care quality improvement and opportunities for stakeholder engagement, this brief is intended as a primer for child health policy and advocacy organizations that want to focus their efforts beyond coverage to ensure that every child enrolled in Medicaid and CHIP receives high quality health care. The goal is to help stakeholders better understand the current state of quality measurement and improvement, specifically as it pertains to children enrolled in Medicaid and CHIP. It covers a brief history of health care quality efforts, explains the basics of quality measurement and improvement, discusses the challenges in data collection and analysis, and describes how quality improvement initiatives work. Importantly, it discusses the key roles that child health policy and advocacy organizations can play in making sure that our public coverage programs for children deliver high quality health care that advances health outcomes and strives for continuous improvement.

Key Findings

- As the country's largest and fastest growing insurer, Medicaid has significant leverage in driving health care quality improvements that can lead to systemic change.
- When quality efforts largely focus on bending the cost curve, children may be overlooked because they are generally healthy and account for the lowest per-capita spending on health care.
- Improving the quality of health care will help eliminate health disparities and further boost the broader, long-term impacts of public coverage on children as evidenced by studies showing that Medicaid leads to better health, higher educational achievement, and greater economic success later in life.
- Child health policy and advocacy organizations have a meaningful role to play to ensure that improving children's health care is a public policy priority.

What role does Medicaid play in health care quality improvement?

With the expansion of Medicaid in nearly two-thirds of states beyond children, pregnant women, people with disabilities, and the poorest parents to low-income adults, Medicaid's growing enrollment of nearly 72 million people⁷ now exceeds that of Medicare by more than 40 percent. Given that average per capita costs in Medicaid are much lower than Medicare, overall spending in Medicaid has not yet reached that of Medicare. Nonetheless, Medicaid's \$475 billion expenditure represents significant leverage in the health care system.⁸ With Medicaid's expanded reach and increasing influence, it has the potential to lead the way for systemic change across the health care system as it assures high-quality care for its enrollees.

When it comes to children, the quality of health care in Medicaid and the Children's Health Insurance Program (CHIP) is especially important. Medicaid and CHIP pay for more than 45 percent of births and are the ticket

to health care for more than one-third of the nation's children, and nearly half of children under five years of age. Moreover, a majority of the nation's 4.4 million uninsured children are eligible but not enrolled in Medicaid and CHIP. As we continue to make strides in connecting uninsured children to coverage, even more children will rely on these key safety net programs to access the health care they need to grow up healthy and maximize their potential in life.

Although there is abundant evidence that a child's physical, cognitive, social, and emotional development is impacted by many factors – including where they live, learn, work and play – access to high quality health care is a core component of health. And the only way to know if children are receiving high quality health care is to measure it. Establishing measures, collecting and analyzing data, and tracking trends over time is essential to identifying opportunities for improvement and assessing whether quality improvement actions achieve their intended outcomes.

The Role of Advocacy in Quality

Why should child health care quality in Medicaid and CHIP be an advocacy priority?

While the sheer magnitude of the nation's public investment in Medicaid presents an economic and political imperative to ensure cost-effectiveness, value and health outcomes should be driving factors in actions to improve the quality of care in Medicaid and CHIP. Yet, much of the emphasis in quality improvement is on bending the cost curve by focusing on efforts to minimize costly medical errors, reduce waste, and implement effective coordination strategies targeted at the 5 percent of people who account for nearly half of all health care spending.⁹ Since children are generally healthy and the cost of covering them is low compared to other populations – children account for 50 percent of total Medicaid enrollment but only 21 percent of Medicaid spending¹⁰ – improving children's access and quality may not be a top priority for states or health plans. If the primary goal is to reduce costs, health care quality for children could be overlooked.

It is important to note, though, that cost is not the sole reason that children's health care quality measurement and improvement may not have been a priority. In the past, there has been a relative shortage of credible quality

measures and data for children.¹¹ Over the last few years, however, robust research on evidence-based care, better measurement tools, more quality improvement initiatives, and transparency in public reporting has emerged to move the needle forward.

Informed advocacy is essential to assuring that children are a top priority as Medicaid leads the way for systemic change across the health care system. Low-income children have much to gain from receiving high quality, developmentally appropriate health care services given that many early childhood developmental delays can be resolved or mitigated with early detection and intervention services. Advocates play a critical role in ensuring that all children, regardless of income or other demographics, get the health care they need to develop and thrive, and to address racial and ethnic disparities that impact low-income children disproportionately. Moreover, research has proven that Medicaid coverage not only improves health outcomes but also leads to educational and economic gains as children transition to adulthood and beyond.¹² Thus, investing in measuring and improving the quality of care children receive in Medicaid and CHIP means even bigger returns down the road.

In guidance to states on quality considerations for Medicaid and CHIP programs, CMS points out that stakeholder engagement is critical in designing and implementing a comprehensive quality strategy. From consumers, to providers, to patients, multi-stakeholder approaches are not only necessary but have proven to be a key to the success of quality improvement initiatives.¹³

What do child health policy experts and advocates bring to the table?

The child health policy and advocacy community has many assets that will contribute to efforts to improve the quality of health care in children’s public health coverage programs (see Table 1). Although quality measurement and improvement is highly complex and technical, child health stakeholders do not need to be experts in order to make a meaningful contribution to improving the quality of children’s health care in Medicaid and CHIP.

Table 1. What Child Health Policy Experts and Advocates Bring to the Table

Ability to give voice to the needs and wants of families with children, and to serve as a conduit for reaching, empowering, and mobilizing families.
Trust of families and credibility with decision-makers and their advisors, which enables advocates to educate and influence.
Experience working with multi-stakeholder groups and exceptional communication skills in telling “the story” effectively.
An understanding of the health care system and the importance of efforts to improve the quality of health care and health care outcomes and assure accountability in our public coverage programs
Skills in maneuvering the policy environment that drives change and sets priorities.

Where should child health policy experts and advocates start?

The best starting point is for child health policy experts and advocates to become better informed on federal requirements and the current status of health care quality measurement and improvement in Medicaid and CHIP. The quality section of Medicaid.gov offers a wealth of information on agency quality efforts, including links to numerous resources and reports. The next step is to assess where your state is on the quality front. This requires a multi-faceted environment scan, including researching the state’s current quality measurement and reporting, noting that the state is likely to have more information than is summarized in the annual quality reports published by CMS. Advocates should press their states to make all quality related information publicly available. Advocates should also prepare to take advantage of an emerging opportunity when proposed rules to modernize Medicaid managed care – the first in more than a decade – become final. As proposed, the rules have significant implications for health care quality, transparency, and stakeholder engagement.

Table 2. Steps for Child Health Policy Experts and Advocates

1	Become informed on federal requirements and activities.
2	Assess where your state is in quality measurement and improvement in Medicaid and CHIP.
3	Press for state to release all quality-related information.
4	Get ready to leverage the modernized Medicaid managed care regulations.

A Brief History of Health Care Quality Efforts

How have health care quality efforts evolved?

Improving the quality of health care dates back to the mid-1850s when Florence Nightingale, a public health pioneer, recognized the connection between hospital sanitation and deaths among wounded soldiers. Nonetheless, it would be another century before the concepts of modern quality improvement emerged in business and industry, eventually trickling down to the American health care system. In the late 1980s, corporate purchasers of health care began to look to quality improvement as a means to contain health care costs, leading to the creation of the

National Committee on Quality Assurance (NCQA) and the well known Health Effectiveness Data and Information Set or HEDIS™ measures that are prominently used in private insurance today.¹⁴ But at the time, doubts lingered about the effectiveness of various improvement initiatives, prompting Congress to commission the Institutes of Medicine (IOM) to study and report on health care quality.

The resulting IOM reports focused the country’s attention on the critical need for quality improvement in health care.¹⁵ Looking beyond the obvious need to reduce

medical errors and correct overuse, underuse, and misuse of services, the study called for a redesign of the health care system to be based on the best scientific and clinical information, to be patient-centered, and to coordinate care across different facets of the health care system. In the ensuing decade-and-a-half, health care organizations, providers, payers, government agencies, nonprofits, and consumer groups have accelerated quality efforts but progress has been slow. In the past, a relative shortage of credible quality measures and data for children hindered progress.¹⁶ More robust research on evidence-based care, better measurement tools, more quality improvement initiatives, and transparency in public reporting, have been needed and are now emerging as a result of landmark legislative actions.

Three major federal initiatives in recent years have accelerated quality efforts, starting with the Children's

Health Insurance Program Reauthorization (CHIPRA) in 2009. CHIPRA launched a number of child-health quality activities including introducing the Core Set of Health Care Quality Measures for Children in Medicaid and CHIP. On the heels of CHIPRA, the American Recovery and Reinvestment Act (ARRA) set up a framework and road map for universal adoption of health information technology, including electronic health records and health information exchanges, which are critical to better coordination of care.¹⁷ These laws were followed by the Affordable Care Act of 2010 (ACA), which called for a comprehensive national approach to health care quality. The ACA's provisions led to the creation of a National Quality Strategy and its triple aim – “better care, healthier people, smarter spending” – as well as a companion set of adult core measures and significant quality measurement and improvement activity at the federal level.

The Basics of Health Care Quality Measurement and Improvement

How is quality health care defined?

The Institutes of Medicine describes quality as health care services that are effective, efficient, equitable, safe, timely, and patient-centered. From the perspective of the Agency for Health Research and Quality (AHRQ), quality health care is doing the right thing for the right patient, at the right time, in the right way to achieve the best possible results. Neither of these definitions directly incorporates cost as a factor in determining if health care can be characterized as high quality, although efficient care implies the reduction of waste and ineffective spending. Importantly, many factors affect the quality of care including identifying the most effective care through clinical research; delivering evidence-based care; having access to medical records; coordinating care across different aspects of the health care delivery system; and engaging the patient and family to achieve the best outcomes and highest level of satisfaction.

Why measure quality?

A mantra within quality improvement is “what gets measured gets improved.”¹⁸ Measuring quality is the critical first step to assuring access to services, improving the quality of services, enhancing the patient's experience, and reducing unnecessary costs or waste in health

care delivery. Importantly, as Medicaid increasingly turns to private managed care as the primary delivery system, measuring quality is a critical check on plan performance in providing required services and benefits. Collecting and reporting data is not enough; data must be analyzed, compared, and trended over time to identify opportunities for improvement, to measure progress on quality improvement (QI) initiatives, and to meet specific performance targets.

What is quality measurement?

Quality measures are tools that assess or quantify organizational structure and/or systems, health care processes, health outcomes and patient perceptions that are integral to providing high-quality health care.¹⁹ Measuring health care quality is in itself a science, which is rapidly evolving with improvements in data collection and lessons learned. Effective quality measures are deeply steeped in evidence-based results that, through clinical research, link a specific structure, process, or outcome with improved health or patient experience. Creating rigorous measures is highly technical, but as noted previously, advocates do not have to be experts in quality measurement to make a meaningful contribution to improving children's health care.

Table 3. Types of Quality Measures

Type	Description	Example
Structural	Evaluates the infrastructure of the health care setting, including facilities, personnel, and policies related to care delivery.	Does the practice consistently follow a periodicity schedule of well-child visits such as Bright Future Guidelines, which is recommended by the American Academy of Pediatrics?
Process	Determines if services are consistent with care guidelines.	Are children diagnosed with asthma receiving controller medications?
Outcome	Looks at whether services result in a change in health or behavior.	Has the number of asthma-related visits to the emergency department been reduced?
Patient Experience	Provides feedback from the patient on their experience with care.	Does the doctor explain things in an easily understood way?

The various factors that impact health quality – evidenced-based care, access to medical records, care coordination, patient engagement, etc. – cannot be fully incorporated into an individual quality measure. Thus, quality measures fall in four categories (see Table 3) with each assessing a key component of care along the continuum of health care delivery. A composite of measures is required to get a robust picture of quality and identify opportunities for improvement. This may also require a combination of quantifiable and qualitative data.

How are measures developed?

Developing measures is perhaps the most complex aspect of quality measurement and improvement, and certainly not something that child health policy experts or advocates need to understand in depth. What is helpful to know is that there is a significant focus on developing ‘evidence-based’ quality measures that rely on rigorous clinical research to identify a structure, process, or outcome that leads to improved health or patient satisfaction. Determining which measures to develop can also be based on a combination of available evidence and expert opinion, particularly when it relates to emerging innovations in health care. When a possible measure is identified, it is common to bring together a broad cross-sector of groups – from researchers, government agencies and advocacy organizations to industry interests and professional associations – to assess the body of evidence on a particular treatment or protocol that shows promising results. Once the group agrees to pursue a measure, they work together to reach consensus on the best measurement approach, develop the specifications for the measure, and test the measure.

After quality measures are developed and successfully tested, they may get a “seal of approval” by being

endorsed by professional or consumer groups. This process also involves the convening of cross-sector stakeholders who rigorously assess potential quality measures and endorse those that meet strict standards. Such efforts are generally convened by a government agency (such as the AHRQ) or a nonprofit (such as the National Quality Forum (NQF) or National Committee on Quality Assurance (NCQA)).

How is data collected?

Once the complex process of developing and testing a measure is complete, the next step is to collect the data needed to assess the measure. Data – both quantitative and qualitative – are the foundation of quality improvement. *Quantitative* data deals with numbers and data that can be measured. This type of information is easy to analyze statistically and is familiar to health care professionals; for example, calculating the percentages of children who receive an appropriate developmental screening. *Qualitative* deals with descriptions and can be observed but not measured. It is often used to provide context for needed improvements; for example, does a provider communicate in a way that a parent understands. In a nutshell, quantitative data defines while qualitative data describes.

Quantitative data come from a variety of sources with the predominant source being administrative, including both eligibility/enrollment data and claims/encounter level data. A more costly source of data comes from medical chart reviews, although this is likely to become more accessible with greater use of electronic medical records. National and state-level disease and other health-related registries, such as a state-based immunization registry, provide other public health information. Qualitative data is also available through enrollee, patient or provider

surveys, such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS), as well as focus groups or secret shopper activities. Additionally, population-based studies, such as the National Survey on Children's Health (NSCH) or Behavioral Risk Factor Surveillance System (BRFSS), can provide insight into physical and mental health status, access to quality health care, as well as information on the child's family, neighborhood, and social context.

What is the process for improving the quality of care?

Improving quality is directly linked to an organization's service delivery approach or underlying system of care. The IOM notes that to improve quality, an organization's current system needs to change to achieve a different level of performance. In this respect, an organization's current system is defined as *how things are done now*, whereas health care *performance* is defined by an organization's efficiency and outcome of care, and level of patient satisfaction.²⁰

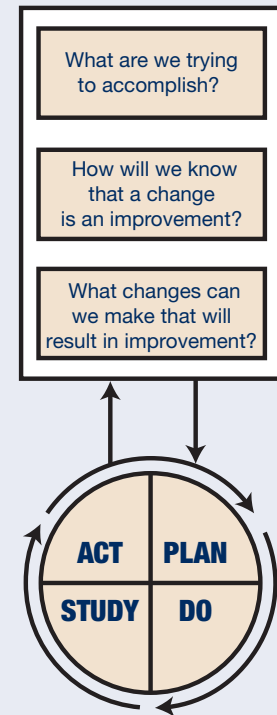
CMS guidance to states describes five key components as integral to a state's quality improvement vision and strategy: 1) goals, 2) interventions, 3) metrics, 4) targets, and 5) transparency and feedback. CMS notes that stakeholder perspectives and values should be incorporated into the process from the initial conception of a quality improvement model, as well as reflected in the programmatic goals and measurement approaches. This guidance sets the stage for new federal requirements for stakeholder engagement in the development of a comprehensive statewide quality strategy that has been proposed in the modernization of federal Medicaid managed care regulations.²¹

Using quality measurement data, organizations are able to identify strengths and pinpoint opportunities for improvement. To do so, data can be compared over time to a baseline or to other entities that are applying the measure to a similar population. For example, a state may compare a measure such as adherence to well-child care standards across various managed care plans that cover children in Medicaid. When measures show opportunity for improvement in one plan compared to others, the state should require the low-performing plan to take corrective

Figure 1. Steps in the PDSA Cycle

The Plan-Do-Study-Act (PDSA) cycle is part of the Institute for Healthcare Improvement Model for Improvement, "a simple yet powerful tool for accelerating quality improvement."

- Step 1: Plan—Plan the test or observation, including how to collect data.
- Step 2: Do—Try out the test on a small scale
- Step 3: Study—Set aside time to analyze the data and study the results
- Step 4: Act—Refine the change, based on what was learned from the test



Source: Institute for Healthcare Improvement, accessed at: <http://www.ihl.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx>.

action to improve the outcome and facilitate the sharing of best practices in use in other plans. These activities are known as performance improvement projects (PIPs) or quality improvement projects (QIPs).

Best practices in quality improvement often start with testing different strategies on a small scale to determine if they achieve the intended results before changes are introduced across a practice or system. This is widely known as the Plan-Do-Study-Act process (see Figure 1).²² Strategies that show promising results can be spread to confirm overall effectiveness, and ultimately may become standardized care guidelines that can be adopted on a wide scale basis. Importantly, quality measurement and improvement must be a continuous activity that reflects emerging science, clinical evidence, and innovations in health care delivery.

Quality Measurement and Improvement in Medicaid

Prior to CHIPRA, state officials felt that quality assessment and improvement resources did not adequately meet their needs. Many states had collected and reported health quality measures – mostly based on existing NCQA HEDIS measures. Most efforts focused on process measures rather than outcomes. For example, a state might measure whether children diagnosed with asthma were prescribed controller medications, but the state did not measure asthma-related emergency department visits. Although many states primarily relied on HEDIS measures, there was no standardization of measures adopted across programs and agencies. This thwarted the ability of states to take advantage of a comprehensive national comparison to further their own quality goals. Without the ability to compare quality measures across states, it was difficult to identify and share best practices in delivering high quality care.²³

What are Medicaid and CHIP programs required to do in measuring and improving quality?

The current regulatory framework relating to health care quality in Medicaid dates back to the Balanced Budget Act of 1997, which requires state Medicaid agencies – but only those contracting with Medicaid managed care plans – to develop a state quality assessment and improvement strategy.²⁴ It also requires CMS to develop protocols for an independent, external review of quality, and the timeliness of and access to care and services provided to Medicaid enrollees by different types of managed care organizations.²⁵ However, in what could be a game changer, CMS proposed a major modernization of the managed care regulations in May 2015.²⁶ If finalized, the rule will have significant implications for states' quality strategies, which are discussed in more detail below.

What is External Quality Review?

States must contract with an external entity to validate performance measures and performance improvement programs required of managed care entities. Validation means the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and follow standards for data collection and analysis. If the EQR entity is a certified independent organization (EQRO) that meets federal standards,²⁷ the federal government will pick up 75 percent of qualified EQR costs. Otherwise, the cost is shared equally with the state.

The EQR process must include review of and reporting on three mandatory activities as described in Table 4. However, states may also adopt one or more of five optional EQR activities to boost their review and oversight of the quality of health care delivered by managed care plans. The additional activities offer an opportunity for states to further advance quality measurement and improvement. Stakeholders may want to encourage their states to maximize the EQR process, such as using the EQRO to validate encounter-level data or calculating state-specific performance measures to ensure consistency in how the measure is calculated and reported.

How useful is EQR reporting?

Federal flexibility allows states to choose different measures and PIPs. Even when similar measures or PIPs are adopted, data collection and analysis methods may vary, including the rigor and depth of analyses employed by different EQROs. Differing interpretations of plan performance, as well as the organization and level of detail required in the reports may differ significantly.²⁸ As managed care organizations come and go, it is difficult to form a solid picture of overall system performance. The lack of standardization results in EQR reporting that may not be comparable from year to year, or across states. Moreover, although EQR technical reports must be submitted to CMS and provided upon request to the public, state officials may not act to address program deficiencies identified in the reports. It should be noted, however, that comprehensiveness of the ERQ reporting

Table 4. External Quality Review in Medicaid Managed Care

Mandatory EQR Activities
Evaluation of quality, timeliness, and access to care
Assessment of each plan's strengths and weaknesses and recommendations for quality improvement areas
Appraisal of how well each plan responded to previous quality improvement recommendations
Optional EQR Activities
Validation of encounter-level (claims) data
Administration or validation of consumer or provider quality of care surveys
Calculation of state-specific performance measures
Review of additional performance improvement projects
Focused, one-time studies

has improved in recent years, thanks in part to extensive technical assistance to the states from CMS.

In assessing the usefulness of the EQR process, it is important to reflect on the potential shortcomings of HEDIS and other quality measures as a result of enrollment churn. Quality measures tend to limit measurement to individuals with a full year of continuous enrollment, whereas the typical Medicaid beneficiary is enrolled for only nine months out of the year.²⁹ This means that a portion of the Medicaid population is invisible to evaluation. It also speaks to the need for enrollment and retention policies that support continuous coverage and for the reporting of enrollment and renewal performance indicators³⁰ that provide critical data for program administrators and policymakers to make informed decisions about how to improve their programs.

How does CHIPRA impact quality measurement and improvement?

CHIPRA set in motion a wide-ranging set of initiatives to advance pediatric health care quality measurement and improvement. The law required CMS to develop the Child Core Set of Health Care Quality Measures, which are described in more detail below. The agency is also charged with providing technical assistance to states, improving the mechanisms through which states report data, and publishing a report on the quality of health care for children enrolled in Medicaid and CHIP.

CHIPRA created the Pediatric Quality Measures Program, which funds seven centers of excellence intended to improve and strengthen the initial core set of measures and to increase the portfolio of evidence-based, consensus pediatric quality measures available to both public and private payers.³¹ The law also funded child health quality demonstration projects to evaluate promising ideas and identify strategies that can drive improvement, including experimenting with and evaluating different quality measures.³²

What is the Child Core Set of Health Care Quality Measures?

CHIPRA requires CMS to create and maintain a set of standardized, evidence-based measures, which states *voluntarily report*. To create the first Child Core Set, CMS partnered with ARHQ to create a cross-sector subcommittee to identify an initial set of 25 measures, which was trimmed to 24 after state review and public comment. The core set must be reviewed and updated annually and, over time, several measures have been retired

and new ones have been created. Most recently, HHS worked the NQF's Measures Application Partnership (MAP) to review the Child Core Set and to identify ways to improve it. The 2016 Child Core Set includes 26 measures categorized in seven areas (Table 5).³³ For a full list of the Child Core Set, see the Appendix.

Notably, the Child Core Set comes from different data sources, although two-thirds are based on NCQA's HEDIS measures. The majority of core set measures are developed from administrative data (eligibility/enrollment and encounter-level/claims data), although a hybrid approach may be used to aggregate medical record data with administrative data, particularly when administrative data is incomplete or of poor quality. The intent of CHIPRA was for the measures to be taken together and used to estimate the overall national quality of health care for children including children with special needs, and to compare pediatric health across states and populations.³⁴

How do states report the Child Core Set?

States currently calculate most measures directly although CMS pulls a few measures from the Center for Disease Control and Prevention's National Healthcare Safety Network or state annual reporting of Early, Periodic Screening, Diagnostic, and Treatment Services. Data are currently reported through the CHIP Annual Reporting Template System (CARTS) but will eventually be submitted through the Medicaid Statistical Information System (MSIS), which is undergoing its own transformation (T-MSIS) to improve statistical reporting and retrieval. Since states are also required to submit administrative and encounter-level data, a longer-term objective is for CMS to calculate the measures on behalf of states. This will help ensure consistency in data analysis and calculation of the measure.

Table 5. 2016 Child Core Set of Health Care Quality Measures

Measure Category	Number of Measures
Access to Care	1
Preventive Care	8
Maternal and Perinatal Health	7
Behavioral Health	4
Care of Acute and Chronic Conditions	3
Oral Health	2
Experience of Care	1

What's the status of voluntary reporting on the Child Core Set?

For calendar year 2014, two states reported all measures, while eight states reported all but one measure (21 of 22). Eighty percent of states (41) reported at least half of measures (11) in 2014. And although not all states report measures for both Medicaid and CHIP, the statistic has improved over time with 44 states reporting measures for both programs, up from 41 states in 2013.³⁵ In terms of the actual data reported by states, CMS only releases state-level data and ranks state performance based on four quartiles if at least 25 states report a specific measure. For the most part the number of measures reported and the quality of the reporting by states has improved over time. However, there is nothing to stop states from taking a backward step given that reporting is voluntary, as eight states did in reporting fewer measures in 2014 compared to 2013.

What's included in the CMS Report on Children's Health Care Quality?

The Secretary of HHS is tasked with reporting health care quality and improvement for children's enrollment in Medicaid and CHIP at least every three years, although the agency has published an annual report since 2011. In addition to reporting state level data on the Child Core Set, the publication must review and report on states' External Quality Reviews of Medicaid managed care plans. The most recent report provides EQR abstracts of priority areas, which currently include childhood obesity, dental care, prenatal and postpartum care, and adolescent-well care.

As yet, the publication has not covered the full scope of reporting set out in CHIPRA. In particular, duration

and stability of coverage and data on racial, ethnic and socioeconomic disparities have not been addressed in the five annual reports. Additionally, CMS only publishes state level data if at least 25 states report a specific measure. Achieving the full vision of CHIPRA in regard to child health care quality is hindered by the lack of a mandatory reporting requirement for states and resources needed to develop a more functional data repository.

What does EPSDT reporting tell us about quality in Medicaid?

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services. The Form CMS-416 is used by CMS to collect basic information on state Medicaid and CHIP programs to assess the effectiveness of EPSDT. In recent years, CMS has worked with stakeholders to identify how EPSDT can be improved, including how to advance the quality of data reporting.³⁶

Still, EPSDT reporting does not provide a complete picture of the quality of the health services that children receive. For example, it does not adequately reflect the share of children who are receiving age-appropriate development screenings. Furthermore, there are differences in EPSDT reporting and HEDIS measures, which are used for nearly two-thirds of the Child Core Set. For instance, HEDIS measures lead screening before the age of 2. EPSDT requires lead screening at ages 12 and 24 months.

Health Care Quality Beyond Medicaid

What about health care disparities?

The ACA included a number of provisions designed to improve the health of racial and ethnic minorities and other underserved or vulnerable populations. These include establishing data collection standards for race, ethnicity, sex, primary language, and disability status; creating individual offices of minority health in a number of HHS centers and agencies; and developing an action plan to reduce racial and ethnic health disparities. The

action plan complements the National Stakeholder Strategy for Achieving Health Equity, an existing effort which encompasses a comprehensive, community-driven approach to reduce health disparities in the U.S. and achieve health equity through collaboration. However, it remains unclear how the requirement to collect data that can be disaggregated intersects with quality measurement and reporting in Medicaid and CHIP.

What are the barriers to improving health care quality?

The challenges in quality measurement, reporting and improvement are numerous, starting with competing perspectives of payers, providers, government agencies, researchers, consumer advocates, and patients.³⁷ Additionally, the IT infrastructure and electronic health records (EHRs), including child-specific EHRs, across the health care spectrum need further development and standardization of data to facilitate collection and reporting. The lack of alignment of quality measurement and improvement activities results in different payers requiring providers to report different measures to different entities, making it even more difficult to get a clear picture of health care quality.³⁸ And while a number of payers are experimenting with performance-based incentives, it is essential that such inducements lead to improved health outcomes and greater patient satisfaction and not be focused on reducing costs by making it difficult to access needed care. Finally, improving health care quality will necessitate that patients be educated and engaged in managing both their health and health care.

Can ‘All Payers’ claims databases help with quality improvement?

States have another tool that can help implement a comprehensive quality strategy – all payers claims databases (APCD). Pioneered in Maine in 2003, and in use or development in 30 states as of the end of 2013, APCDs are large-scale databases that systematically collect medical claims, pharmacy claims, dental claims, and eligibility and provider files from private and public payers.³⁹ As more states implement APCDs, these systems may fill critical information gaps to drive quality improvements and promote transparency needed to support payment reform initiatives. In particular, APCDs facilitate a robust comparison of quality across all payers and plans to better assess opportunities for improvement and where to look for best practices. However, this effort suffered a recent blow when the Supreme Court ruled that federal law precludes states from requiring self-funded plans, which are common among large employers, to submit their health care claims. Although it is too early to determine the full impact of the ruling, it is clear that all payers claims databases will be incomplete and not as valuable as they could be.⁴⁰

How will the proposed Medicaid managed care rulemaking impact quality measurement and improvement activities?

The rules, if enacted as proposed, will require states to develop and sustain a comprehensive statewide quality strategy that extends beyond managed care and encompasses all delivery models, including fee-for-service. It fosters transparency in public reporting and calls for robust public engagement. It also requires that all incentive payments in managed care be tied to specific activities, targets, performance measures, and quality-based outcomes. States may already be using quality assurance and improvement performance as a factor for default auto-assignment in a managed care plan when Medicaid enrollees do not make an active choice. While the proposed rules recognize that quality-related factors in auto-assignment give states leverage and flexibility to prioritize quality, measuring quality and improvement performance underpins the state’s ability to do so.

Additionally, the proposed rule aligns certain quality requirements with those in place for Medicare and the health insurance marketplaces, such as developing a star rating system for managed care plans. Under the rule, access to information about quality will play an increasing role in plan selection allowing consumers to make informed choices. Importantly, the rule sets the stage for standardizing at least some subset of reporting requirements across states by giving CMS the authority to specify performance measures and topics for performance improvement projects.

Conclusion

A close look at the quality section of the Medicaid.gov website illustrates that significant progress has been made over the past five plus years in developing the Child and Adult Core Sets and through targeted quality initiatives in Medicaid and CHIP. However, participation by states remains voluntary and the effort lacks alignment with state requirements for external quality reviews of managed care plans. Nonetheless, with increased national attention focused on improving quality and the potential of new Medicaid managed care regulations to strengthen state quality activities, there are ample opportunities and momentum going forward.

CMS is by far the largest single payer of health care in the country and changing the way it pays for health care services by promoting value and quality could help bring the rest of the health care sector along. Significant work has already been devoted to advancing quality improvement in Medicare. And Medicaid's coverage of individuals across a broader range of enrollees expands the scope of quality work to assure equity across the generations. But unlike Medicare, Medicaid is a federal-state partnership. As such, stakeholders will need to be vigilant in ensuring that quality is a priority at the state level, and that improving health outcomes is the overarching goal.

CMS invests hundreds of millions of dollars in health care for low-income and vulnerable populations; thus, measuring quality is critical in assessing value and assuring accountability in our public coverage programs. However, advocates will need to make the case for why state officials and policymakers should prioritize children's health quality. If quality efforts are focused on reducing costs, we will miss out on opportunities to improve children's health in ways that would have longer term paybacks in better health, enhanced performance in school, higher productivity as future workers, and lower long-term health care costs.

Ultimately, maximizing the health and well-being of our nation means looking beyond the quality of health care services and addressing the social determinants of health – economic stability, education, home, community, and environment. Research emphasizes the significance of taking a life-course perspective but policy-making timelines are rarely measured over such long periods of time. It is clear that action beyond health care and cross-sector partnerships will be critical to implementing policy that addresses the social determinants of health. Even as we continue to refine how we measure and improve health care quality in our current system, it is important to pursue the expanded leadership role Medicaid can play in approaching health more broadly.

Acknowledgement

The author wishes to thank Wayne Turner of the National Health Law Program in Washington D.C. and Mike Odeh of Children Now in California for their thoughtful review and feedback on this brief.

Resources

Medicaid.Gov: Quality of Care Website and Resources
<http://medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/quality-of-care.html>

“The Triple Aim: Care, Health, and Cost,” Health Affairs
<http://content.healthaffairs.org/content/27/3/759.long>

“National Strategy for Quality Improvement in Health Care,” Department of Health and Human Services
<http://www.ahrq.gov/workingforquality/nqs/nqs2011annlrpt.pdf>

Agency for Health Care Research and Quality, “Child Health Care Quality Toolbox”
<http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/chttoolbx/index.html>

Medicaid.Gov: Quality of Care Health Disparities Website and Resources
<https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/quality-of-care-health-disparities.html>

National Evaluation of the CHIPRA Quality Demonstration Grant Program Website, Agency for Health Research and Quality
<http://www.ahrq.gov/policymakers/chipra/demoeval/index.html>

CHIPRA Pediatric Quality Measures Program Website, Agency for Health Research and Quality
<http://www.ahrq.gov/policymakers/chipra/pqmpback.html>

“EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents,” Centers for Medicaid and CHIP Services in collaboration with the National Health Law Program
https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/EPSDT_Coverage_Guide.pdf

“Data Resource Center for Child and Adolescent Health,” A Project of the Child and Adolescent Health Measurement Initiative
http://www.commonwealthfund.org/-/media/files/publications/chartbook/2004/apr/quality-of-care-for-children-and-adolescents--a-chartbook/leatherman_pedchartbook_700-pdf.pdf

“Quality of Health Care for Children and Adolescents: A Chartbook,” The Commonwealth Fund
http://www.commonwealthfund.org/-/media/files/publications/chartbook/2004/apr/quality-of-care-for-children-and-adolescents--a-chartbook/leatherman_pedchartbook_700-pdf.pdf

“The Essential Guide to Health Care Quality,” National Committee on Quality Assurance
https://www.ncqa.org/Portals/0/Publications/Resource%20Library/NCQA_Primer_web.pdf

“Measuring Health Care Quality Tutorial,” Kaiser Family Foundation
<http://kff.org/interactive/measuring-health-care-quality-tutorial/>

“Quality and Accountability: An Introduction for Advocates,” National Health Law Program
<http://www.healthlaw.org/publications/search-publications/health-advocate-july-2013#.VpKuWZMrIn0>

“External Quality Review: An Overview,” National Health Law Program
<http://www.healthlaw.org/publications/search-publications/EQR-Overview06162014pdf#.VpKu35MrLOQ>

“A Guide to Oversight, Transparency, and Accountability in Medicaid Managed Care,” National Health Law Program
<http://www.healthlaw.org/publications/browse-all-publications/managed-care-toolkit-march-2015#.Vr32cpMrLOR>

“Measuring Health Care Quality: An Overview of Quality Measures,” Families USA
http://familiesusa.org/sites/default/files/product_documents/HSI%20Quality%20Measurement_Brief_final_web.pdf

Endnotes

- 1 OECD, "Focus on Health Spending," Organization for Economic Cooperation and Development, July 2015. At 16.4% of the Gross Domestic Product (GDP), health care spending in the U.S. is a third higher compared to the second highest country (Netherlands), and most European countries, where expenditures hover between 10 and 11 percent. Accessed online August 29, 2015, at <http://kff.org/statedata/http://www.oecd.org/health/health-systems/Focus-Health-Spending-2015.pdf>.
- 2 E. McGlynn, et. al., "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine*, v. 348, no. 26, June 26, 2003, p. 2635-2645, accessed online on March 5, 2016, at http://www.rand.org/pubs/external_publications/EP20030617.html.
- 3 OECD, "Health at a Glance, 2013: OECD Indicators," Organization for Economic Cooperation and Development. Accessed online August 29, 2015, at <http://www.oecd.org/health/health-systems/Focus-Health-Spending-2015.pdf>.
- 4 M. Sparer, "Medicaid at 50: Remarkable Growth Fueled by Unexpected Politics," July 2015, *Health Affairs*, 34, no. 7 (2015): 1084-1091. <http://content.healthaffairs.org/content/34/7/1084.abstract>.
- 5 R. Cunningham, "Once A Welfare Add-On, Medicaid Takes Charge in Reinventing Care," July 2015, *Health Affairs*, 34, no. 7 (2015): 1080-1083. <http://content.healthaffairs.org/content/34/7/1080.abstract>.
- 6 J. Paradise and R. Garfield, "What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care, Setting the Record Straight on the Evidence," Kaiser Family Foundation, August 2013, accessed online on February 11, 2016, at <http://kff.org/report-section/what-is-medicaids-impact-on-access-to-care-health-outcomes-and-quality-of-care-setting-the-record-straight-on-the-evidence-issue-brief/>.
- 7 "Medicaid & CHIP: October 2015 Monthly Applications, Eligibility Determinations and Enrollment Report," December 30, 2015, Center for Medicaid and CHIP Services, accessed online on January 10, 2016, at <https://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/october-2015-enrollment-report.pdf>.
- 8 State Health Facts, Kaiser Family Foundation, accessed online on February 2016, at <http://kff.org/statedata/>.
- 9 J. Schoenman, "Understanding U.S. Health Care Spending," National Institute for Health Care Management, July 2011. <http://www.nihcm.org/images/stories/NIHCM-CostBrief-Email.pdf>.
- 10 Based on an analysis of December 2013 Medicaid and CHIP enrollment and spending data found on Kaiser Family Foundation State Health Facts at <http://kff.org/state-category/medicaid-chip/>.
- 11 V. Smith, J. Edwards, E. Reagan, D. Roberts, "Medicaid and CHIP Strategies for Improving Child Health," Commonwealth Fund, July 2009, accessed online on February 12, 2016, at <http://www.commonwealthfund.org/publications/fund-reports/2009/jul/medicaid-and-chip-strategies-for-improving-child-health>.
- 12 A. Chester and J. Alker, "Medicaid Provides an Excellent Long-Term Return on Investment," Say Ahhh! A Child Health Policy Blog, Georgetown University Center for Children and Families, July 2015, accessed online January 9, 2015, at <http://ccf.georgetown.edu/all/medicaid-provides-excellent-long-term-return-investment/>.
- 13 State Health Official Letter, "Quality Considerations for Medicaid and CHIP Programs," Centers for Medicaid and CHIP Services, CMS, November 2013. Accessed online on March 5, 2016, at <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-007.pdf>.
- 14 The National Committee on Quality Assurance (NCQA) pioneered quality work in accrediting health plans and developing the Health Effectiveness Data and Information (HEDIS) that are widely used to measure quality in private health insurance plans.
- 15 "To Err is Human: Building a Safer Health Care System" (1999) and "Crossing the Quality Chasm: A New Health System for the 21st Century" (2001).
- 16 *Op cit. 11.*
- 17 G. Fairbrother and L. Simpson, "Measuring and Reporting Quality of Health Care for Children: CHIRPA and Beyond," *Academic Pediatrics*, May-June 2011, accessed online on March 5, 2016, at <http://www.ncbi.nlm.nih.gov/pubmed/21570020>.
- 18 This quote is attributed to several leaders in the field of quality improvement, including Peter Drucker.
- 19 More information can be found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/index.html?redirect=/QualityMeasures/03_ElectronicSpecifications.asp.
- 20 This description of quality improvement is attributed to the Health Resources and Services Administration Quality Improvement Methodology website accessed online on February 10, 2016, at <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/index.html>.
- 21 *Op. cit. 13.*
- 22 The Plan-Do-Study-Act (PDSA) cycle is a model endorsed by the Institute for Healthcare Improvement, a simple yet powerful tool for accelerating quality improvement. For more information see <https://innovations.ahrq.gov/qualitytools/plan-do-study-act-pdsa-cycle>.
- 23 *Op. Cit. 11.*
- 24 §42 CFR 438 Subpart E.
- 25 More information on EQR protocols can be found at <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/quality-of-care-external-quality-review.html>.
- 26 S. Rosenbaum, "Game Changer: CMS' Proposed Medicaid Managed Care Regulation," *Health Affairs Blog*, June 10, 2015. <http://healthaffairs.org/blog/2015/06/10/game-changer-cms-proposed-medicicaid-managed-care-regulation/>.
- 27 §42 CFR 438.354.
- 28 E.M. Howell, A. Palmer, and F. Adams, "Medicaid and CHIP Risk-Based Managed Care in 20 States: Experiences Over the Past Decade and Lessons for the Future," July 2012, the Urban Institute. <http://www.urban.org/research/publication/medicaid-and-chip-risk-based-managed-care-20-states>.
- 29 L. Ku, E. Steinmetz and T. Bysshe, "Continuity in Medicaid Coverage in an Era of Transition," Association for Community Affiliated Plans, November 2015, accessed online on February 12, 2016, at https://www.statereforum.org/sites/default/files/gw_continuityinanaerofttransition_11-01-15.pdf.
- 30 CMS requires that Medicaid and CHIP agencies produce a set of performance indicators for Medicaid and CHIP. As yet, the agency is posting only a small subset of the measures in monthly Medicaid and CHIP Application, Eligibility Determination, and Enrollment Data, accessed online at <https://www.medicaid.gov/medicaid-chip-program-information/program-information/medicaid-and-chip-enrollment-data/medicaid-and-chip-application-eligibility-determination-and-enrollment-data.html>. The full list of performance indicators can be found at <https://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/list-of-indicators-and-subindicators.pdf>.
- 31 More information on the Pediatric Quality Measures Program can be found at <http://www.ahrq.gov/policymakers/chipra/pqmpback.html#COE>.
- 32 More information on the CHIPRA Child Health Quality Demonstration Grants can be found at <http://www.ahrq.gov/policymakers/chipra/demoeval/index.html>.
- 33 Measures Applications Partnership, "Strengthening the Core Set of Healthcare Quality Measures for Children Enrollment in Medicaid, 2015," National Quality Forum, August 2015. Accessed online on January 10, 2016, at http://www.qualityforum.org/Publications/2015/08/Strengthening_the_Core_Set_of_Healthcare_Quality_Measures_for_Children_Enrolled_in_Medicaid_2015.aspx.
- 34 Public Law 111-3—February 4, 2009.

- ³⁵ “2015 Annual Report on the Quality of Care for Children in Medicaid and CHIP,” The Department of Health and Human Services, February 2016, accessed online February 29, 2016, at <http://ccf.georgetown.edu/all/getting-magi-right-exceptions-counts-household-medicaid-chip/>.
- ³⁶ The National Health Law Program (NHeLP) has a number of helpful resources on EPSDT, see <http://www.healthlaw.org/issues/child-and-adolescent-health/epsdt>.
- ³⁷ E.A. McGlynn, “Six Challenges in Measuring the Quality of Health Care,” *Health Affairs*, 16, no. 3 May-June 1997.
- ³⁸ Recent progress was made in an effort to address the lack of alignment of quality measures among different payers. On February 16, 2016, CMS and major commercial health plans, in collaboration with physician groups and other stakeholders, announced the alignment and simplification of seven core sets of clinical quality measures. For more information, see <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures.html>.
- ³⁹ J. Porter et al, “The Basics of All-Payer Claims Databases: A Primer for States,” Robert Wood Johnson Foundation, January 2014. Accessed online on February 12, 2016, at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf409988.
- ⁴⁰ C. Ornstein, “Supreme Court Strikes at States’ Efforts on Health Care Transparency,” National Public Radio, March 2, 2016. Accessed online on March 5, 2016, at <http://www.npr.org/sections/health-shots/2016/03/02/468756393/supreme-court-strikes-at-states-efforts-on-health-care-transparency>.

Appendix

2014 Core Set of Children’s Health Care Quality Measures for Medicaid and CHIP

Abbreviation	NQF #	Measure Steward	Measure Name
ADD	0108	NCQA	Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication
AMB	NA	NCQA	Ambulatory Care - Emergency Department (ED) Visits
AWC	NA	NCQA	Adolescent Well-Care Visit
BHRA	NA	AMA-PCPI	Behavioral Health Risk Assessment (for Pregnant Women)
CAP	NA	NCQA	Child and Adolescents’ Access to Primary Care Practitioners
CHL	0033	NCQA	Chlamydia Screening in Women
CIS	0038	NCQA	Childhood Immunization Status
CLABSI	0139	CDC	Pediatric Central-line Associated Bloodstream Infections—Neonatal Intensive Care Unit and Pediatric Intensive Care Unit
CPC	NA	NCQA	Consumer Assessment of Healthcare Providers and Systems® CAHPS 5.0H (Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items)
CSEC	0471	CMQCC	Cesarean Rate for Nulliparous Singleton Vertex
DEV	1448	OHSU	Developmental Screening in the First Three Years of Life
FPC	1391	NCQA	Frequency of Ongoing Prenatal Care
FUH	0576	NCQA	Follow-up After Hospitalization for Mental Illness
HPV	1959	NCQA	Human Papillomavirus (HPV) Vaccine for Female Adolescents
IMA	1407	NCQA	Immunization Status for Adolescents
LBW	1382	CDC	Live Births Weighing Less than 2,500 Grams
MMA	1799	NCQA	Medication Management for People with Asthma
PDENT	NA	CMS	Percentage of Eligibles That Received Preventive Dental Services
PPC	1517	NCQA	Timeliness of Prenatal Care
TDENT	NA	CMS	Percentage of Eligibles That Received Dental Treatment Services
WCC	0024	NCQA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents
W15	1392	NCQA	Well-Child Visits in the First 15 Months of Life
W34	1516	NCQA	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life

AMA-PCPI: American Medical Association-Physician Consortium for Performance Improvement; CMQCC: California Maternal Quality Care Collaborative; CDC: Centers for Disease Control and Prevention; CMS: Centers for Medicare & Medicaid Services; NA: Measure is not NQF endorsed; NCQA: National Committee for Quality Assurance; NQF: National Quality Forum; OHSU: Oregon Health and Science University.



Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

Georgetown University Health Policy Institute
3300 Whitehaven Street, N.W., Suite 5000
Washington, DC 20007
Telephone (202) 687-0880
ccf.georgetown.edu