

State Medicaid and Children's Health Insurance Program's Perspective on CHIPRA Core Measures

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IMPROVING THE QUALITY of health care for children is a goal shared by many partners who serve the children of our country and certainly is a priority for Medicaid and the Children's Health Insurance Program (CHIP) in every state. There are few tools to measure quality of care, especially for children, and mechanisms to compare the quality of children's health care services across states, programs, delivery systems, etc, are lacking. The inclusion of a section on the quality of children's health care in the Children's Health Insurance Program Reauthorization Act (CHIPRA)¹ has caused excitement among those working on health care improvement and the measurement of quality and improvement. This is a step in the right direction in moving the vision for improved health care quality and improved health status for all children closer to becoming a reality.

The CHIPRA initial core set of quality measures is the beginning of a discussion to determine which children's quality measures states will be reporting on in the future for Medicaid and CHIP enrollees. This, along with other activities outlined in CHIPRA, will provide further input and opportunities to refine how states measure children's health care quality. The work of the Subcommittee on Quality Measures for Children's Healthcare in Medicaid and CHIP, following the criteria set out in legislation and narrowing down an extensive list of measures, is a starting point. It is important to stress that these are the initial measures and that a mechanism for ongoing review of the measures and an evaluation of whether the measures continue to be relevant for Medicaid and CHIP will be necessary. Technology changes as do medical priorities, and we must recognize that what may be relevant to measure in 2010 may not be so relevant in 2 to 3 years.

It is essential that the core measures be flexible enough to accommodate the uniqueness of each state's Medicaid and CHIP programs. Although the measures seem to be applicable in each state, until the first round of measurement is collected and reported, it is hard to tell how the differences in state operations may impact the outcomes. Benefits, eligibility, and program design (fee for service

vs managed care) can vary by state. For state comparisons to be useful and informative, it is essential that these program differences be clearly articulated. This provides a rationale for incorporating ongoing evaluations, not just of the results and outcomes generated by the voluntary reports but evaluations of the measures themselves and what can be gleaned from measurements that seemed to be a good idea on paper but whose outcomes did not provide any useful results.

With so much activity underway, it is easy to become excited as the core set of children's quality measures acts as a catalyst for a broad discussion on the quality of children's health care. At the same time, this set presents many challenges to states. States will be faced with an increase in program administration costs at a time when new funding for states is very limited. Although Congress had the foresight to include an enrollment performance bonus process for states with increased CHIP and Medicaid enrollment, there is no similar mechanism available to states for improving the quality of children's health care. Second, there is the potential for duplicate reporting by states on the same areas, at a time when everyone (health plans, governments, providers, etc) is trying to reduce administrative costs.

The introduction of the CHIPRA core measure set comes at a time when states are looking for assistance in the identification of measures to meet a number of requirements related to health care quality improvement created by the flurry of activity resulting from the passage of additional federal legislation, the American Recovery and Reinvestment Act (ARRA).² The need for collaboration at the federal level on the use of the CHIPRA core measure set when and wherever feasible will aid in its adoption by states. At a time when states are struggling with budget shortfalls resulting in budget cuts and reduced manpower, introducing multiple measure sets from different agencies will ensure that adoption is hindered and uptake is limited. Although the CHIPRA core measure set addresses the need for consistency that many states have asked for, the failure of federal collaboration on its use in health care

measurement activities related to other legislation (ARRA, health care reform, etc) will result in the limited usefulness of this set of measures. In addition, states should pursue the usefulness of these measures within other activities related to health care quality, such as shared savings or pay for performance and provider and patient incentive programs. The impact of the use of these measures should be assessed on care decisions through collaboration with providers and other stakeholders, followed by a discussion and consideration of how the changes in care might impact policy changes surrounding coverage decisions and payment structure.

Although not perfect, the CHIPRA core measure set should enhance the ability of all states to develop cohesive, quality measurement programs through the provision of actionable information that has the potential to improve health care outcomes. Being strictly voluntary, the CHIPRA core measure set should be considered just the beginning. We will need to revisit and refine it to ensure that a final set of measures is developed and utilized, taking into consideration differing program and delivery system designs so that data are collected and reported that will allow for accurate comparisons of quality between

states. The hope is that states will use this as an opportunity to test these measures so that maximum quality improvement can be achieved and result in attainment of the ultimate goal of improved health care outcomes for all children.

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