



**National Committee for Quality Assurance Comments on the Initial Core Set
of Children's Healthcare Quality Measures for Voluntary Use by Medicaid
and CHIP Programs**

CMS Proposed Rule CMS-2474-NC

February 2010

The National Committee for Quality Assurance (NCQA) strongly supports the work of the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare & Medicaid Services (CMS) to improve the value and quality of care provided to Medicaid and CHIP enrollees. Publicly reported performance results should be based on recognized, standardized, evidence-based measures that are audited. Reporting performance will provide states, health plans and providers with the information they need to improve quality of care for many of this nation's children.

The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 provides an unprecedented opportunity to use measurement to stimulate quality improvement. NCQA applauds AHRQ and CMS, as well as the Subcommittee of AHRQ's National Advisory Council (SNAC), for their outstanding work on the measures recommended for the initial core set of children's healthcare quality for voluntary reporting by Medicaid and CHIP programs. NCQA is also pleased to see the alignment of CHIPRA implementation with health information technology implementation through The American Recovery and Reinvestment Act of 2009 and other federal quality improvement initiatives.

Thank you very much for your consideration of our comments. We would be pleased to offer any clarification of our comments, or to provide other support to CMS and AHRQ as they move forward to implement the measurement reporting program. Please do not hesitate to contact me or Sarah Thomas, Vice President of Policy and Communications at (202) 955-1705 or thomas@ncqa.org if there are any questions.

Sincerely,

A handwritten signature in black ink that reads 'Margaret E. O'Kane'. The signature is written in a cursive style with a large, looped 'M' and 'K'.

Margaret E. O'Kane
President



NCQA Comments and Recommendations

HEDIS and Current Medicaid Reporting

NCQA commends CMS and AHRQ on the initial CHIPRA core set, specifically the inclusion of the 13 HEDIS measures and the CAHPS® 4.0 survey for Children with Chronic Conditions. We believe the HEDIS measures are valid and useful and many Medicaid plans already report them. In 2009, Medicaid HEDIS data was collected for 10.7 million beneficiaries, more than half of Medicaid enrollees in the US. NCQA has been collecting performance measurement data from Medicaid managed care organizations since 1997. Over 30 states currently use HEDIS for quality measurement in Medicaid managed care. HEDIS reporting to NCQA by Medicaid managed care organizations is encouraged through 25 states' recognition of NCQA Managed Care Organization (MCO) Accreditation. Accredited plans are required to submit data on HEDIS measures which make up almost a third of the accreditation score. In 2009, accredited health plans significantly outperformed non-accredited health plans on many of the measures submitted.

NCQA general comments on proposed core set:

NCQA recommends that CMS minimize burden on reporting entities, particularly those without measurement experience, by limiting the number of clinically important and scientifically based measures at first, and increase the number of measures over time. Such a phased-in approach would help those that do not have experience in quality measurement and reporting. We also recommend a phased approach for the type of entities that report, starting with those that are more experienced. (Later in this document, we provide specific comments on each measure proposed for the core set.)

NCQA suggests that the foundation set of measures be the following:

- 1) Well-Child Visits in the First 15 Months of Life,
- 2) Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life,
- 3) Childhood Immunization Status,
- 4) Adolescent Immunization Status,
- 5) Frequency of Ongoing Prenatal Care, and
- 6) NCQA HEDIS dental visit measure (though the EPSDT dental measures are currently in the proposed core set, NCQA believes that the HEDIS dental measure should be considered to replace the EPSDT measures.)

Other measures should be published as “supplemental” measures to be tested in state demonstration projects. These supplemental measures will be familiar to entities that already measure quality and be feasible to calculate using current data systems. Some of these supplemental measures might not become part of the core set if the demonstrations or other pediatric quality programs show that the measures are not feasible or meaningful or if better measures are identified.



Medicaid/CHIP managed care organizations should be the first entities to report the CHIPRA core measure set. Primary Care Case Management (PCCM) and FFS programs should be added later as these programs will need different specifications of the measures and more assistance in reporting. The later version of the measures set should also rely on patient experience data and, when appropriate, should be aligned with Meaningful Use measures. Furthermore, while claims based data will continue to be appropriate, future measures should begin to utilize electronic clinical data sources and electronic reporting capabilities.

NCQA also recommends that CMS be clear about the reporting level (e.g. State, plan, physician groups, individual physicians) and align measures to this level. The desired reporting level(s) will drive which measures are appropriate and feasible to implement. CMS should consider both the availability of data and the sample size available for each measure.

We suggest the following measure criteria should be considered when creating the final list of core measures for 2010; these criteria are consistent with the NCQA and National Quality Forum (NQF) criteria and also take into account issues that arise with child health measures:

- *Relevance.* Measures should
 - provide meaningful data on child health and development and address important health issues that affect outcomes to children
 - be currently widely used.
 - be clinically and economically understandable and significant to decision-makers
 - provide actionable data to providers, plans, states, and national players.
 - allow for comparisons among states
 - show variations across entities and allow for substantial room for improvement on performance
- *Scientific Soundness.* Measures should
 - be developed from evidence-based guidelines or evidence-informed consensus documenting the links between the clinical processes and outcomes addressed
 - be endorsed by the National Quality Forum when possible
 - be reproducible, valid, and accurate. The accuracy, reproducibility and validity of the measure should not be affected by use of different data sources.
- *Feasibility.* Measures should
 - have clear and precise specifications for data sources and methods for data collection and reporting. Data sources supporting each measure should be available to reporting entities.
 - be logistically and financially feasible
 - not be susceptible to manipulation or “gaming.”



NCQA comments on the Statements in the Public Comment Announcement on CMS and AHRO's next steps:

1. Establishing methodologies to create measure specifications that are applicable to all Medicaid and CHIP enrollees, and suitable for identifying disparities in quality by race, ethnicity, socioeconomic status, and special health care needs status, as required by CHIPRA.

Based on years of experience developing and implementing performance measures, NCQA fully supports standardized measure specifications, approved methods of data collection, and audited results which are then publicly reported.

NCQA recommends requiring the reporting of race and ethnicity using the Office of Management and Budget (OMB) categories, as recommended by the Institute of Medicine. If more detailed information on race or ethnicity is needed, the state should have a consistent process to aggregate these responses into the OMB categories. We also recommend that CMS require states to follow a standardized mechanism for reconciling conflicting data about an individual; for example more authoritative data sources should be chosen over other sources when there are conflicts.

States should use consistent categories and methods for collecting data on race/ethnicity, language and SES, starting with enrollment into Medicaid or CHIP. The state, health plans and providers that serve Medicaid/CHIP beneficiaries should collaborate on collecting and sharing these data using consistent methods. When data obtained directly from the beneficiary are not available, the data should be estimated using one of the validated methods in widespread use. We recommend that language or English language proficiency be included among the characteristics for which disparities must be identified.

Although ideally measure specifications would be applicable to all Medicaid and CHIP enrollees, we have found that some measures are not appropriate for all Medicaid/CHIP enrollees. The methodology for application of measure specifications to the CSHCN population should take into account the appropriateness of each measure for the population

2. Providing technical assistance to States to help implement the initial, recommended core measure set.

Based on our long history of assisting health plans and physicians, NCQA strongly supports the provision of technical assistance to states and managed care organizations. Such assistance will be very important in successful implementation of the core set, especially to those unfamiliar with performance measure reporting. Areas of technical assistance include: collecting data based on specifications, applying specifications to state specific codes, auditing and



verifying data, analysis of findings, and identifying and performing subsequent improvement efforts in response to findings.

3. Using a public process for the pediatric quality measures grants and contracts program to build on priorities identified during the 2009 identification of the initial, recommended core set. Priority topics already identified include quality measures for: mental health and substance abuse services for children, other specialty services, inpatient care, duration of enrollment and coverage, medical home and other integrated health care delivery mechanisms, and availability of services.

NCQA supports the continuing expansion of the CHIPRA core set through grants and contracts.

Other priority topics for which AHRQ and CMS could drive measure development are: screening and assessment for behavioral, developmental, mental and social issues; medical home; care coordination for children; patient and family engagement; and psychotropic medication use in children. Other topics could include: breastfeeding counseling, newborn screenings, maternal depression screening, sudden infant death syndrome counseling, and environmental tobacco screening. Topics with measures specific to adolescents are blood pressure screening and risky behavior screening. NCQA is developing and testing measures in many of these areas, and we would be happy to meet with you to discuss our work on these to date.

4. Considering ways to align State reporting requirements across CHIPRA provisions, with Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) via CMS 416 reporting, and with annual reporting requirements for CHIP.

AHRQ and CMS should use the measure opportunities presented in CHIPRA and ARRA to enhance the EPSDT requirements. NCQA has found wide support for composite measures focusing on receipt of age-appropriate preventive services, which aligns with the American Academy of Pediatrics recommendations for care, as well as the 416 form. NCQA recently tested measures of comprehensive well care for children, where the composite measure included indicators for immunizations, screenings, developmental and behavioral risks, appropriate follow-up care, and care coordination. This composite measure set would be valuable in evaluating EPSDT care.

5. Coordinating quality measurement efforts with payment reform strategies, health information technology and electronic health record initiatives, and working with States to identify the best formats for sharing Medicaid and CHIP quality measurement data, including when and how state reports should be made publicly available.

NCQA supports coordinating quality measurement with payment reform strategies. Rigorous tested and evidence –informed quality measures will be needed to assure purchasers and patients that attempts to pay for quality actually result in better health outcomes. We know from our



experience working with providers that the current fee-for-service payment methodology works against improvement in quality and efficiency.

6. Continuing to work with States and national stakeholders to develop national intervention strategies for improving health care quality and outcomes for children (for example, Medicaid Transformation Grants and the CHIPRA Quality Demonstration Grants).

NCQA has learned that states seek direction from CMS to improve data collection for comparisons among states. While some states may welcome direction from CMS and will appreciate the benefits of standardized reporting, others may resist changing their current measure initiatives, CMS may need to be more directive and prescriptive about standardization in order to achieve ability to benchmark.

Demonstration projects are vital to understanding the feasibility of Health information exchange (HIE) and data sharing arrangements in order to best support measurement. Lessons learned from the demonstrations may be used to reward strategies that support quality measurement across populations and delivery systems. Specific state requirements (such as EPSDT reporting, EQRO requirements; data validation requirements) may need to be reviewed and changed to facilitate the state efforts.

7. Continuing development and implementation of the Federal-State National Quality Framework in alignment with CHIPRA initiatives for improving the quality of care for children.

NCQA supports the Framework and alignment with CHIPRA initiatives.

8. Due to the concurrent CHIPRA and American Recovery and Reinvestment Act (ARRA) HIT implementation activities, CMS will align the two programs and strive to create efficiencies for States and pediatric providers, where applicable, by prioritizing consistency in measure selection for pediatric providers.

NCQA strongly supports the alignment of the ARRA HIT and CHIPRA implementation activities and commends the Departments for its proposals that do so. CMS should consider requiring new measures developed in pediatric quality programs to have EHR specifications and testing. As you know, ARRA requirements for eligible providers are being phased in over time, so the number and capability of providers able to report should increase in 2011-2015. It may take longer for information to become available across settings through health information exchange. CMS should take into account this timeline in laying out a strategy for measure definition and reporting.



Measure comments in detail:

HEDIS measures

Below is a chart of the HEDIS measures recommended for the initial core set. The measure name, description and data source are provided, as well as information on plan reporting rates in 2008. We provide information on the number of reporting Medicaid plans, the number of states that are represented in the reporting, and the percent of plans that reported a valid rate. The valid rate, calculated by NCQA, is the percent of plans with reported results that are audited and attested to as specified by NCQA. Valid rates are affected by sample size which reflects plan enrollment and benefit coverage or carve-outs and sometimes by the difficulty of collecting data required for the measure. Many more HEDIS measure results would be valid if the measurement level is changed from the plan to the state, as the sample size would increase.

As we noted in the beginning of our comments, we recommend that HEDIS measures be phased in over time; the table below shows our recommendations for what measures be included by phase. Phase 1 measures are not only already reported, but they also have a high reporting rate and high valid rate by many Medicaid/CHIP plans and thus proven as feasible.

The HEDIS measures suggested for the later phased-in set would most likely need assistance as they either rely on data supplemented by medical record review, currently have low reporting rates, or have a low percentage of valid rates.¹ However, for some of the HEDIS measures, the impact of small sample size on valid rates would be lessened if the measures were specified for state-level reporting.

First phase of measures			
HEDIS Measure	Measure description	Data Source	Number (%) of plans reporting
Well-Child Visits in the First 15 Months of Life	<i>Percentage of members who had the appropriate number of well-child visits with a Primary Care Practitioner</i>	Administrative and medical record	156 Medicaid plans (88% with a valid rate) in 2008 which represents 32 states.
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	<i>Percentage of members who had the appropriate number of well-child visits with a Primary Care Practitioner</i>	Administrative and medical record	160 Medicaid plans (90% with a valid rate) in 2008 which represents 32 states.
Adolescent Well-Care Visits (age 12-21 years)	<i>Percentage of enrolled members 12-21 years who had at least one Comprehensive well-care visit with a Primary Care Practitioner or OB/GYN practitioner during the year</i>	Administrative and medical record	161 Medicaid plans (90% with a valid rate) in 2008 representing 32 states.

¹ Valid rates are calculated by NCQA and show that the results were audited and attested to. The share of plans with valid rates can be affected by sample size and benefit coverage or carve-outs.

First phase of measures			
HEDIS Measure	Measure description	Data Source	Number (%) of plans reporting
Adolescent immunization	<i>Percentage of members who had appropriate immunizations</i>	Administrative and medical record	The most recent data NCQA has is from field testing the measure in 2008. The measure was tested with one Medicaid plan (615,866 enrolled members) and one Commercial plan (enrollment was 262,397 members). As a hybrid measure, the Medicaid plan reported that 26.4% of patients received either Tdap or Td vaccine and 9.7% of patients received either MCV4 or MPSV4 vaccine. The commercial plan reported 59.8% and 27.9% respectively. This measure will be reported as a first year measure in 2010. ²
Childhood Immunization Status	<i>Percentage of members who had appropriate immunizations based on the CDC schedule</i>	Administrative and medical record	163 Medicaid plans (92% with a valid rate) in 2008 representing 32 states.
Frequency of ongoing prenatal care	<i>Percentage of Medicaid deliveries that received the correct number of expected prenatal visits</i>	Administrative and medical record	94 Medicaid plans (52% with a valid rate) in 2008 which represents 28 states.
NCQA suggests that the Annual Dental Visit HEDIS measure be considered	<i>Percentage of members 2-21 years who had at least one dental visit during the year (applies if dental care is a covered benefit in the organization's Medicaid contract.)</i>	Administrative data	56 Medicaid plans (31% with a valid rate) in 2008 representing 16 states. The HEDIS <i>Annual Dental Visit</i> measure will allow for comparability across reporting entities.

Measures for a later phase			
HEDIS Measure Name	Specification	Data Source	Information on measure
Appropriate Testing for Children With Pharyngitis	<i>Percentage of children 2-18 years, who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus test</i>	Administrative only	108 Medicaid plans (61% with a valid rate) in 2008 representing 28 states.
Child and Adolescents'	<i>The percentage of members 12 months – 19 years of age who</i>	Administrative only	Was reported by an average ³ of 124 Medicaid plans (with a valid

² As a first year measure that plans submit for the first time, data are evaluated with the important understanding that rates may be low. Moreover, in the first year, health plans may choose not to report a measure without penalty. Consistently, NCQA sees the number of submissions as well as the rates improve once the measure is required for public reporting and health plans become familiar with the measure.

Measures for a later phase			
HEDIS Measure Name	Specification	Data Source	Information on measure
Access to Primary Care Practitioners	<i>had a visit with a primary care practitioner</i>		rate ranging from 67% to 73%) in 2008 representing an average of 31 states.
Chlamydia Screening in Women	<i>Percentage of women 16-24 years who were identified as sexually active and who had at least one test for Chlamydia during the year</i>	Administrative only	129 Medicaid plans (72% with a valid rate) in 2008 representing 30 states.
Follow up after Hospitalization for Mental Illness	<i>The percentage of discharges for members 6 years and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner</i>	Administrative only	55 Medicaid plans (31% with a valid rate) in 2008 representing 17 states.
Follow up Care for Children Prescribed ADHD Medication (Continuation and Maintenance Phase)	<i><u>Continuation and Maintenance Phase:</u> Percentage of members 6-12 years with an ambulatory prescription dispensed for ADHD medication who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended</i>	Administrative only	73 Medicaid plans (41% with a valid rate) in 2008 representing 24 states.
BMI documentation 2-18 year olds	<i>Percentage children, 2 through 18 years of age, whose weight is classified based on BMI percentile for age and gender</i>	Administrative and medical record	NCQA has recently become the owner of the NICHQ BMI measure which is proposed for the core set. NCQA does not have reporting data on the NICHQ BMI documentation 2-18 year olds measure however, the NICHQ measure is similar to the BMI rate within the HEDIS <i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)</i> . The HEDIS WCC measure was a first year measure ⁴ in 2009 and so

³ An average of all four age groups is reported in this document

⁴ As a first year measure that plans submit for the first time, data are evaluated with the important understanding that rates may be low. Moreover, in the first year, health plans may choose not to report a measure without penalty. Consistently, NCQA sees the number of submissions as well as the rates improve once the measure is required for public reporting and health plans become familiar with the measure.



Measures for a later phase			
HEDIS Measure Name	Specification	Data Source	Information on measure
			we have more robust performance data to share. In 2009, 88 plans, representing 54% of Medicaid plans that reported HEDIS, reported documentation of BMI percentile, as well as counseling for nutrition and physical activity. 44% of commercial plans submitted this same data in 2009. The national mean for all reporting plans was the following: BMI percentile (21.29), counseling for nutrition (35.53) and physical activity (26.46).
Timeliness of prenatal care rate (rate within the Prenatal and Postpartum Care measure)	<i>(a rate within the Prenatal and Postpartum Care measure) Percentage of deliveries that received a prenatal care visit in the first trimester or within 42 days of enrollment and the percentage of deliveries that had a postpartum visit</i>	Administrative and medical record	158 Medicaid plans (89% with a valid rate) in 2008 which represents 32 states.
CAHPS® 4.0 (children with chronic conditions)	<i>Parent's or guardian's overall rating of their child's doctor (survey)</i>	Survey	28 Medicaid plans in 2008 representing 7 states.

With respect to non-HEDIS measures, NCQA suggests the following points to consider.

- All measures should have a measure steward that agrees to provide measure specifications and to be responsible for updating the measures. Measure stewards need to be funded to carry out their responsibilities.
- All measures should be tested to determine feasibility.
- All measures should be evaluated on how actionable the measure is, on the impact on child health outcomes, and on the comparability of data.
- For all measures, the need for risk adjustment should be considered.

NON-HEDIS MEASURES IN CHIPRA CORE SET	NCQA's comment
Annual hemoglobin A1C testing	There must be a dedicated measure steward who agrees to publicizing measure specifications and to the responsibility of updating the measures; NCQA is unaware of who the current measure steward is and what the specifications are. NCQA has an Annual hemoglobin A1C testing HEDIS measure which is proposed for the ARRA Meaningful Use Pediatric Measure Set and is currently being specified for electronic reporting. If or when this measure



NON-HEDIS MEASURES IN CHIPRA CORE SET	NCQA's comment
	topic is selected for the CHIPRA core set, NCQA suggests the HEDIS measure is chosen to further align programs.
Emergency Department Utilization	There must be a dedicated measure steward who agrees to publicizing measure specifications and to the responsibility of updating the measures; NCQA is unaware of who the current measure steward is and what the specifications are.
Otitis Media with Effusion	NCQA has received feedback from multiple stakeholders that this measure cannot be operationalized from administrative claims data and that the impact is not strong enough to warrant national reporting. ⁵ Additionally, otitis media with effusion is not a significant health outcome issue for children and does not have a high cost to plans or states.
Percent of live births weighing less than 2,500 grams	The need for risk adjustment should be considered
Rates of screening using standardized screening tools for potential delays in social and emotional development	There must be a dedicated measure steward who agrees to publicizing measure specifications and to the responsibility of updating the measures; NCQA was unable to identify the current measure specifications.
Cesarean rate for low-risk first birth women*	This measure may not be feasible by many plans today as it requires information not included on claims. NCQA is working on a measure with AMA-PCPI to assess the possibility of creating a health plan feasible measure.
Pediatric catheter associated blood stream infection rates (PICU and NICU)	There must be a dedicated measure steward who agrees to publicizing measure specifications and to the responsibility of updating the measures; NCQA was unable to identify the current measure steward or measure specifications.
Total EPSDT eligibles receiving preventive dental services	CMS and AHRQ should consider how actionable the measure is, the impact on child health outcomes, and the comparability of data across states.
Total EPSDT eligibles who received dental treatment services	CMS and AHRQ should consider how actionable the measure is, the impact on child health outcomes, and the comparability of data across states.
Annual number of asthma patients with > 1 asthma related ER visits	There must be a dedicated measure steward who agrees to publicizing measure specifications and to the responsibility of updating the measures; NCQA was unable to identify the current measure steward or measure specifications.

⁵ S. H. Scholle, S. L. Sampsel, N. E. P. Davis, and E. L. Schor, [Quality of Child Health Care: Expanding the Scope and Flexibility of Measurement Approaches](#), The Commonwealth Fund, May 2009