

December 22, 2009

Denise Dougherty, Ph.D.  
Senior Advisor, Child Health and Quality Improvement  
Agency for Healthcare Research and Quality  
540 Gaither Rd  
Rockville, MD 20850



email: [CHIPRAqualitymeasures@ahrq.hhs.gov](mailto:CHIPRAqualitymeasures@ahrq.hhs.gov)

Dear Dr. Dougherty:

On behalf of Medicaid Health Plans of America (MHPA) I am submitting comments on the initial core set of measures recommended by the National Advisory Council for Healthcare Research and Quality, Subcommittee on Quality Measures (SNAC), authorized by the Children's Health Insurance Program Reauthorization Act (CHIPRA).

#### About MHPA

MHPA is a national nonprofit organization and the leading trade association solely focused on representing Medicaid health plans. MHPA member plans range from large multi-state plans to small community-based plans. The mission of MHPA is to develop and advance public policy that improves access and delivery of quality health care to Medicaid members and improves efficiency of services.

#### Medicaid and CHIP is largely delivered and measured through managed care

As of 2008, 36 states and the District of Columbia have contracted with Medicaid managed care plans to provide benefits to over 21 million enrollees, and over 72% of CHIP enrollees receive benefits through managed care. Medicaid managed care plans have existing state and federal requirements to report performance measures. In addition, a majority of MHPA member organizations are accredited by the National Committee for Quality Assurance and report HEDIS performance measures. As health plan data will represent a significant portion of information states are likely to report to CMS, Medicaid managed care plans are uniquely positioned to comment on issues affecting states' reporting capabilities and the effectiveness of measuring clinical performance on impacting health care quality for children.

#### Overall Comments

MHPA supports efforts to improve state quality reporting and increase accountability and comparability of performance for Medicaid and CHIP programs. We strongly recommend that the initial core set only include well specified, standardized, and tested measures that are currently in use by Medicaid/CHIP programs as is consistent with the CHIPRA legislation. This may initially be a small set, however it would facilitate a step forward in increasing state reporting, produce comparable performance information, and limit increased resource burdens.

We also recommend that states reporting measures be required to report on their full Medicaid and CHIP populations, including managed care and fee-for-service. States should also be required to adhere to measure specifications.

### Measure Validity and Comparability

MHPA is concerned that the proposed initial core set is not consistent with the spirit and intent of the CHIPRA legislation. Sec 1139A (a)(2) of CHIPRA calls for the identification of a core set of measures for voluntary reporting that are *in use* under public and privately sponsored health care coverage arrangements. Further, Sec 1132A (a)(8) defines the core set as “a group of *valid, reliable, and evidence-based* quality measures.”

The CHIPRA legislation recognized that the performance measurement field has made great strides in the past decade, largely due to the work of NCQA, which pioneered the concept of standardized health plan performance measure reporting through HEDIS. NCQA has shown that measures must be crafted with detailed specifications including numerators, denominators, population exclusions, and enrollment criteria. Other elements are also essential: cognitive testing, a reporting time period, definitions, and applied testing in the setting / population in which the measures are to be used. NCQA has a detailed process for the ongoing reevaluation of measure scientific soundness, relevance and reporting feasibility.

MHPA has grave concerns that many of the measures recommended by the SNAC are not currently in use, or specified or validated for use by Medicaid and CHIP. Some measures completely lack any type of specifications. MHPA believes that these measures will severely limit state participation in the program due to an increased burden on states and plans and will prevent the Secretary from being able “to perform comparative analyses of pediatric health care quality” that the CHIPRA legislation calls for.

*We recommend that the measures included in the initial core set should be only those with detailed specifications and rigorous testing, such as HEDIS measures as specified by NCQA or measures produced by states using auditable, standard measures specifications.*

*We also recommend that the measures have a clearly defined process for measure maintenance to ensure that they are continuously valid. This would be consistent with the use and validity provisions of CHIPRA. It would be a disservice to the field of health care quality to promulgate measures that do not reflect the most current evidence or standards of care (such as the PHP-5 measure, which is not up to date on immunization requirements).*

*To further ensure comparability, CMS should develop standard reporting "buckets" or bands for various populations so that states and plans can be compared for the care provided to the specific populations eligible for Medicaid/CHIP in that state. A standard risk adjuster program could be applied in the reporting methodology. Reporting of the measures should include information on what percentage of the eligible population is included in the measure.*

*MHPA recommends that the non-specified measures and measures not currently in use by Medicaid or CHIP programs included in the recommended initial core set be tabled for analysis as part of the Pediatric Quality Measures Program. While the creation of an initial core set of measures calls for identifying measures already in use, CHIPRA calls for the identification of*

gaps in existing pediatric quality measures through the Pediatric Quality Measures Program (Sec 1139A (b)(3)). We believe this is a more appropriate place to identify future measure development priorities.

### Measurement Burden

We note our concern that allowing the states to selectively report measures, and possibly selectively report on different segments of Medicaid or CHIP, could distort the validity of the reporting program. We are concerned that states may choose to report only managed care data, which could place a new and undue administrative burden on health plans that already have several performance reporting requirements. Performance measurement activities are reflected as an administrative cost in health plan rates. New measures, especially those requiring medical record review, will increase data collection and QI costs which will be passed on to shrinking state budgets.

*An initial core set that only includes specified and validated measures currently in use will help prevent the imposition of additional resource burdens on states and health plans.* Health plans, especially those who have commercial and Medicare business, have made global investments in HEDIS and many state Medicaid programs turn to HEDIS to meet federal performance measurement requirements.

MHPA recognizes the importance of CAHPS in assessing the experience of health plan enrollees. CMS should consider recommending that CAHPS be administered at the state level to capture both health plan and fee-for-service enrollees. *Health plans should not be asked to administer or support both plan-level CAHPS and support physician level measurement through Clinician and Group CAHPS.*

### Voluntary Reporting Requirements

MHPA is aware of the serious resource limitations currently experienced by the states. Given the voluntary nature of the reporting requirement, it is likely that most states will report a subset of the measures. *MHPA recommends that CMS identify a small subset of priority measures for reporting* based on the measure validity recommendations made above. This will ensure that more states report each measure and help CMS to move forward with its goal of having comparable information across states. CMS should choose the highest priority measures, articulating transparent priorities based either on prevalence, cost, or impact of a condition of interest.

*We recommend that CMS develop its own reporting capability* using MSIS data augmented with other data sources as needed to represent all states and all programs (including CHIP). This will allow CMS to produce measure reports and will assure that measures specifications are used consistently across states. It will also reduce the reporting burden on states, which is likely to increase state participation. If CMS is not the data aggregator, alternatively CMS should provide software and a reporting platform to states to promote standardization.

### Additional Research

MHPA supports the view of the SNAC that there are important areas of pediatric care for which there is insufficient evidence and research. We support pediatric quality measure development and research efforts underway by the Commonwealth Fund and the Center for Health Care Strategies, and the need for additional research. *We do not believe CMS should adopt measures in the Initial Core Set nor the Pediatric Quality Measurement Program that are not supported by solid evidence, even if the topic is an important one.*

We fully support development of methods to evaluate the impact of enrollment continuity or lack thereof, and ways to assess care for individuals who move between Medicaid, CHIP, commercial insurance and uninsured status. There is currently little capability at the state level to trend enrollment or to identify the coverage status of dis-enrolled children. Enrollment continuity is a critical and "rate limiting" factor in assessing state performance; without continuity children drop out of the denominator and never get counted in any of the measures.

MHPA also supports research and measure development work to address the issue of carved out pharmacy and behavioral health services. It is very challenging for plans (or states) to report on many aspects of care quality with limited capability to access timely data on pharmacy and behavioral health services use.

Finally, MHPA encourages CMS and AHRQ to be creative in developing measures at the plan and provider level that build in rewards or "credit" for performance improvement. This is in contrast to current programs that reward plans and providers for meeting thresholds or benchmarks. This could have the perverse incentive or unintended consequence of discouraging providers to care for high risk populations or difficult patients. We should move towards a system that identifies performance benchmarks but also creates incentives for improvement. This will help to reduce disparities, encourage providers to take on challenging populations and drive measurable improvements.

We appreciate your consideration of these comments. While these comments directly address the initial core set of pediatric measures, they are relevant to the full Medicaid program as the Patient Protection and Affordable Care Act currently being considered in the Senate creates a similar program for the identification and development of adult quality measures in Medicaid.

For more information about MHPA or the perspective of Medicaid health plans, please contact me at [TJohnson@mhpa.org](mailto:TJohnson@mhpa.org) or (202) 857-5725, or contact Liza Greenberg, RN, MPH, MHPA Senior Consultant for performance measurement, at [Lgreenberg@mhpa.org](mailto:Lgreenberg@mhpa.org).

Sincerely,



Thomas L. Johnson  
President and CEO