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The State of Children's Health Care Quality in Medicaid and CHIP: State Strategies to Promote Reporting and Performance

Introduction

The Core Set of Children's Health Care Quality Measures (Child Core Set) provides a national- and state-level snapshot of the quality of care provided to children in Medicaid and the Children's Health Insurance Program (CHIP). It also can be used as a tool for driving improvements in quality by identifying best practices and lessons learned for sharing across states.

To promote the use of the Child Core Set measures for quality improvement, in May 2015 the Centers for Medicare & Medicaid Services (CMS) released an analytic brief, *The State of Children's Health Care Quality in Medicaid and CHIP: Who Are the Higher-Performing States?*. The brief highlighted state performance on the 15 Child Core Set measures reported by at least 25 states for FFY 2013.[1] Six states were identified as "higher-performing" overall because they reported at least 10 of the 15 measures, reported data for at least Medicaid enrollees, and had rates in the top quartile for at least half (n = 8) of these measures: Connecticut, Maryland, Massachusetts, Michigan, New York, and Rhode Island. Five of the six states (Maryland, Massachusetts, Michigan, New York, and Rhode Island) used a capitated managed care delivery system, while one state (Connecticut) used a self-insured managed fee-for-service arrangement to cover all children enrolled in Medicaid and CHIP.

To identify the strategies that contributed to quality measure reporting and performance in the six higher-performing states, interviews were conducted with state officials (including Medicaid directors, managed care contracting staff, and quality improvement staff). This analytic brief highlights key themes and lessons learned from the interviews, to facilitate ongoing improvements in the quality of care obtained by children in Medicaid and CHIP.

Overview of State Strategies

State officials in the six states shared examples of strategies they used to promote quality measure reporting and higher performance among their health plans.[2] As shown in Table 1, all six states included quality measure reporting requirements in their contracts with managed care organizations (MCOs; five states) or administrative services organization (ASO; one state), requiring reporting of selected Child Core Set measures by MCOs, which aligned MCO contracts with voluntary reporting of the Child Core Set. All six states were engaged in public reporting of quality measures. Five of the six states rewarded health plans for high performance, either through financial incentives or auto-enrollment of new members who had not selected a health plan by a designated date. Finally, five of the six states required that health plans be accredited by an external entity, such as the National Committee for Quality Assurance (NCQA) or the Utilization Review Accreditation Commission (URAC). The remainder of this brief describes state strategies and lessons learned by these states about measuring and achieving high performance in their Medicaid and CHIP programs.

[1] More information on the analysis of higher-performing states, including the methodology and results, is available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/child-core-set-hps-brief.pdf.

[2] For the purpose of this brief, we use the term "health plans" to refer to the managed care organizations and administrative service organization that contract with the Medicaid programs in the six states.

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Table 1. Overview of Strategies Used by Higher-Performing States to Promote Quality Measure Reporting and Performance

State	Strategies to Promote Quality Measure Reporting		Public Reporting of Quality Measures	Incentives Tied to Performance		Accreditation Requirement
	Health Plan/ Provider Reporting Requirements	Contractual Requirements and Technical Assistance		Health Plan/ Provider Financial Incentives	Auto-Enrollment of Members	
Connecticut	X	X	X	X	n.a.[a]	X
Maryland	X	X	X	X	--	X
Massachusetts	X	X	X	--	--	X
Michigan	X	X	X	X	X	X
New York	X	X	X	X	X	--[b]
Rhode Island	X	X	X	X	--	X

Source: Interviews with higher-performing states conducted by Mathematica Policy Research conducted in October 2015.

[a] Auto enrollment is not applicable in Connecticut; the state contracts with one administrative services organization (ASO) to provide medical services, and contracts with three other ASOs to provide behavioral health, dental, and non-emergency medical transportation services.

[b] Accreditation is not required, but some health plans choose to be accredited.

State Approaches to Promote Quality Measure Reporting and Performance

Interviews with state officials in the six higher-performing states revealed that no one strategy alone was key to driving higher performance, but rather the strategies were used in combination and included a mix of contractual requirements (such as accreditation or reporting requirements) and collaborative efforts (such as monthly meetings with health plans or provider trainings). Although the strategies used by the six states shared many similarities, each state adapted the approach to its individual state context and historical experience. In this section, we provide examples of how the states used these strategies to promote reporting and performance. Table 2 describes state-specific approaches related to each of the strategies.

Contractual requirements and technical assistance for health plan quality measurement and improvement. Each of the six states required their health plans to report on HEDIS® measures—many of which overlap with the Child Core Set measures—and, in some cases, also required reporting of state-specific indicators or metrics. They also required auditing or validation of quality measures, typically through contracts with their External Quality Review Organization (EQRO). To promote accurate and complete reporting, several states performed direct outreach to health plans and providers around improving reporting and service delivery. Other states connected health plans to existing technical assistance resources or obtained assistance from NCQA on reporting HEDIS measures. In some cases, states and health plans also worked with providers to ensure appropriate provision of care and proper billing and documentation of services to promote accurate reporting. For example, Connecticut's ASO offered providers a variety of resources around billing, screening, and reporting on services, including online webinars, reference guides, trainings, and other materials; in addition, the state issued periodic policy bulletins to providers on relevant issues, such as coding for developmental screenings. As another example, Massachusetts encouraged higher performance among health plans through contractual requirements to develop improvement projects within such domains as access, timeliness, and quality. In 2012, Massachusetts' health plans conducted performance improvement projects related to (1) prenatal and postpartum care and (2) aftercare for reducing readmission rates following inpatient substance abuse treatment.

> *"Looking at the data and identifying areas where there might be some billing issues and working with providers to correct that, that's an ongoing challenge...you constantly have to be looking at your data and testing it so you can make sure that what you're reporting is accurate."*
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> *– Connecticut*

Public reporting on health plan performance. All of the states use public reporting as a mechanism to provide information to consumers and promote improvement among health plans. The states advocated transparency to health plans, providers, and consumers, and full disclosure of ranking methodology and incentive structures. For example, both Maryland and Michigan produce a report card for consumers to use when selecting a health plan; the report card compares performance among the state's health plans using a methodology based on a subset of the performance measures that the plans are contractually obligated to report. Similarly, Connecticut is developing a public dashboard that includes aggregate data demonstrating performance over time, while other states, including Massachusetts and Michigan, produce periodic reports that measure performance for each health plan. These report cards, dashboards, and reports use a variety of methods to compare health plan performance, including comparisons against state or national benchmarks (for example, the 75th percentile among all plans reporting a measure), thresholds based on state averages, or rank ordering all plans in the state based on reported rates. Maryland uses state benchmarks to compare performance among its health plans because its average rates are consistently higher than national benchmarks; state respondents noted that comparing health plans to state-determined benchmarks more effectively incentivizes higher performance among its plans. In addition to public reporting on health plan performance, some states also consider performance at the provider level; while none of the states publically releases provider rates, Connecticut tries to encourage continuous quality improvement among its providers by providing annual feedback reports on how they are doing compared to their peers.

> *"We have used the data to support the work with the MCOs and quality management with the PCC [Primary Care Clinician] plan in supporting providers to deliver better care."*
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> *– Massachusetts*

Incentives tied to health plan performance. Among the higher-performing states, value-based purchasing and other programs that tie a health plan's performance to incentives or withholdings were viewed as important drivers of overall state performance. Five of the six states currently use financial incentives based on quality measure rates to reward higher-performing plans with financial bonuses and, in some cases, penalize lower-performing plans with financial withholds. For example, Maryland's value-based purchasing initiative, which included 10 measures in 2013, used the average of its health plans' performance to set incentive thresholds. Maryland calculates a neutral zone around a target based on the state average; health plans with rates higher than the upper range of the neutral zone received incentives, while those with rates lower than the bottom range had funding withheld. Connecticut may withhold a portion of the ASO's per-member-per-month payment based on its performance. In addition, through its person-centered medical home program, fee-for-service providers may be rewarded for higher performance. Michigan and New York indicated that they use auto-enrollment of members as a strategy to promote performance on quality metrics; within these states, members who have not selected a health plan by a designated date are automatically enrolled in higher-performing plans. While this arrangement is intended to reward health plans by increasing membership, some states acknowledged that financial incentives are preferred by its health plans, rather than assignment of additional members who may be less engaged in their health care.

> *"We put some money…to reward [plans] for incremental improvements or improvements over a certain amount versus all-or nothing…it just has a mindset to it that says we want you to get better…and if you get better by so many points, we'll give you some part of the award."*
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> *– Rhode Island*

Accreditation requirements for health plans. Five of the six higher-performing states require their health plans to undergo accreditation through organizations such as NCQA and URAC. Rhode Island considers NQCA accreditation a critical tool for providing the oversight and measure auditing that is beyond the capacity of the state's infrastructure and resources. Michigan and Connecticut indicated that accreditation helps maintain high standards and supports the development of effective data systems. Maryland recently began requiring health plans to become NCQA-accredited and staff suggested the accreditation process provides an incentive for health plans to bolster reporting processes and perform well on HEDIS measures.

Other strategies to promote health plan compliance with reporting and performance goals. The six states described a variety of strategies they use to help health plans comply with reporting and performance goals. Some states emphasized the importance of working closely with health plans that have not met quality goals to avoid the need for corrective action plans. For example, according to New York's health plan contracts, the health plans may be asked to leave the system after three consecutive years of poor performance relative to their peers. However, in most cases, the state will work closely with health plans approaching the "three strikes" mark to create a remedial plan for quality improvement before terminating a contract becomes necessary. Similarly, Rhode Island has monthly meetings with its health plans as part of its monitoring and oversight process, and addresses reporting and performance issues during the meetings.

Table 2. Description of Strategies Used by Higher-Performing State to Promote Quality Measure Reporting and Performance

State	Strategies to Promote Quality Measure Reporting	Public Reporting of Quality Measures	Incentives Tied to Performance	Accreditation and Other Contractual Arrangements
Connecticut	CT's ASO offers online webinars, reference guides, trainings, and other materials to support providers in billing, screening, and reporting. CT also issues policy bulletins to providers on relevant issues.	CT created a public dashboard that includes aggregate performance data for HEDIS and other measures. CT also compares performance within practice settings and provides non-public comparisons to providers.	A portion of the per-member-per-month payment for CT's ASO may be withheld based on the ASO's performance. CT also has a patient-centered medical home program that rewards fee-for-service providers for their performance and improvement on certain measures.	The ASO is accredited by URAC.
Maryland	MD contracts with vendors to validate measures and samples, audit information systems, and administer the CAHPS survey. MD uses EPSDT nurses consultants to recruit, train, certify, and support EPSDT providers, including chart review and compliance with EPSDT requirements.	MD's EQRO produces a consumer report card for performance based on the measures in its value-based purchasing initiative and CAHPS survey results, which every person who becomes eligible for Medicaid receives before selecting a health plan.	MD uses a value-based purchasing initiative that included 10 measures in 2013 including 4 from the Child Core Set; thresholds are determined based on performance across all MCOs.	MD recently began requiring MCOs to become NCQA-accredited.
Massachusetts	MA offers training to providers around billing for services. MA is working with the Department of Public Health data systems to increase reporting of non-HEDIS measures in the Child Core Set.	MA produces an annual managed care report that compares measure rates by MCOs to national Medicaid benchmarks (75th percentile).	MA does not offer financial incentives to MCOs to improve quality, but MCOs have contractual requirements to meet quality standards and develop improvement projects within certain domains.	MA requires NCQA accreditation for its MCOs.
Michigan	MI is developing the infrastructure to report on non-HEDIS measures; strategies include using the state's vital records data system, a shared data warehouse, and collaboration with the Population Health and Community Services Administration in the Michigan Department of Health and Human Services. MI is also building infrastructure to address disparities by stratifying measures.	MI publishes an annual HEDIS Statewide Aggregate Report (available in print and online), an annual Health Equity Report (available online), and a consumer guide for Medicaid enrollees containing health plan ratings. In addition, MI publishes a quarterly performance monitoring report that is shared with its applicable MCOs.	MI awards performance bonuses based on national Medicaid percentiles. For example, the state awards two points for health plans with rates at or above the 75th percentile, and 4 points for rates at or above the 90th percentile for approximately 10 Child Core Set measures. MI uses an algorithm to auto-assign the (approximately) 25 percent of the Medicaid-eligible population that does not choose a health plan. The algorithm includes criteria such as network adequacy, CAHPS scores, and HEDIS rates, including rates for some Child Core Set measures.	MI meets with health plans frequently to discuss progress and work on quality initiatives. MCOs must submit corrective action plans for any measures that do not meet the Michigan Medicaid Quality Strategy standards.

State	Strategies to Promote Quality Measure Reporting	Public Reporting of Quality Measures	Incentives Tied to Performance	Accreditation and Other Contractual Arrangements
New York	While NY previously held one-on-one meetings with its MCOs around reporting, it now focuses on providing support through an annual webinar and ongoing technical assistance.	NY publishes an annual report that compares health plan performance to state averages and national benchmarks, as well as five-star consumer guides assessing measures across domains.	NY offers incentive payments to MCOs based on peer rank order and provides documentation to MCOs explaining the methodology to promote transparency and fairness. MCOs that meet quality thresholds are auto-assigned members that do not choose a health plan.	NY uses strict standards to motivate improvement. For example, the state may ask a health plan to leave the network or enter remedial status if performance standards are not met for three years in a row. However, NY also works with health plans to understand and help address their challenges.
Rhode Island	RI engages in intensive monitoring and oversight with its two MCOs, including monthly meetings on a variety of topics.	RI publishes an aggregate EQRO report (combining information across MCOs) and is working on a new public report addressing quality for all populations.	RI has a long history of pay-for-performance and rewards health plans for incremental improvements rather than using an "all-or-nothing" rewards system. The state awards the full payment for performance at the 90th percentile and a partial payment for performance at the 75th percentile of the benchmark.	RI requires accreditation to establish an external standard for its health plans. RI sets high contractual expectations around quality based on external benchmarks, and uses accountability and collaboration with MCOs to drive high performance.

Source: Interviews with states conducted by Mathematica Policy Research conducted in October 2015.

ASO = Administrative Services Organization; CAHPS = Consumer Assessment of Healthcare Providers and Systems; EPSDT = Early and Period Screening, Diagnostic and Treatment; EQRO = External Quality Review Organization; HEDIS = Health Effectiveness Data and Information Set; MCO = Managed Care Organization; NCQA = National Committee for Quality Assurance; PCCM = Primary Care Case Management; URAC = Utilization Review Accreditation Commission.

Lessons Learned from State Experiences with Child Core Set Reporting

The six states shared several lessons from their experiences with quality measurement and improvement that provide additional context for Child Core Set reporting. These lessons highlight the connection between Child Core Set reporting and overall Medicaid/CHIP monitoring and oversight.

It takes time to build a reporting infrastructure, a culture of quality improvement, and a partnership with health plans. Most of these states have two decades of experience working with health plans, and were early adopters of value-based purchasing. They noted that their years of Medicaid managed care experience contributed to an infrastructure that facilitates performance measurement and a culture that emphasizes continuous quality improvement.

> *"Continuous quality improvement over a lot of years, a stable program, a stable MCO base…all those things, the fact that the program's been in effect since 1997, that we've had the EPSDT program since 1982…"*
>
> *– Maryland*

Rhode Island's performance goal program (PGP) was established in 1998 to measure and reward performance. Because many of the PGP measures overlap with the Child Core Set measures, Rhode Island had a "head start" with Child Core Set reporting. The state attributes its designation as a "higher-performing state" in part to its active use of quality measures for the purposes of public reporting and quality improvement.

New York has had a statewide Medicaid managed care program since 1997. Respondents from New York believe that public reporting has been essential in promoting quality measurement and improvement among health plans. The state ensures health plans understand how their data will be used, and engages health plans around quality improvement to share best practices and address challenges. Massachusetts indicated that the CHIPRA Quality Demonstration Grant helped to establish the

> *"The biggest lesson…is making the reporting matter… we learned early on that asking people to report data and not doing anything with it that is visible to the people reporting is a recipe for people to not care about it."*
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> *– New York*

infrastructure and collaboration necessary for Child Core Set reporting. The state's grant objectives included testing the Child Core Set measures using multiple data sources and building stakeholder coalitions. The state believes that the grant helped them to understand the complexities of reporting, particularly for the non-HEDIS measures, and to understand the challenges that providers face as a result of reporting requirements.

Build linkages with other state agencies and vendors to expand capacity for quality measurement in Medicaid and CHIP. All states acknowledged that measure reporting is resource-intensive, especially Child Core Set measures that rely on sources other than claims/encounter data, or where claims/encounter data may be incomplete (such as immunizations or prenatal care). Several states indicated that they have begun to develop agreements with their public health agencies to use vital records, immunization registry, or EPSDT chart reviews for calculating Child Core Set measures. In addition, states may rely on EQROs or other vendors to collect or validate quality measure data. For example, Maryland contracts with vendors to validate measures and samples, audit information systems, and administer the CAHPS survey. Maryland's EQRO also produces a consumer report card on health plan performance, which Medicaid enrollees receive before selecting a health plan. Massachusetts and Michigan are collaborating with their health department to build capacity for reporting of non-HEDIS measures in the Child Core Set.

Engage other stakeholders to further Medicaid/CHIP quality initiatives. All states emphasized the importance of collaboration with other stakeholders in quality measurement and improvement. They noted that other stakeholders help leverage limited Medicaid/CHIP agency resources and broaden the reach of Medicaid/CHIP quality initiatives. For example, in Maryland, frontline public health staff (such as visiting nurses) interact with providers and members on a regular basis to encourage compliance with and documentation of recommended care (such as well-child visits). Rhode Island highlighted the role of strong advocacy groups in the state to disseminate quality measure data and encourage health plan improvement.

> *"We definitely do things [using] a multi-stakeholder approach, recognizing that there are always lots of people that need to be at the table…the local health departments are actively engaged many times with our stakeholders and they see where they fit and play a role in promoting the initiatives that we have as a state…"*
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> *– Michigan*

Remaining Challenges and Opportunities

The six higher-performing states have made great strides in reporting the Child Core Set since reporting began in 2010; however, they acknowledged three issues they are currently addressing to improve the completeness and usefulness of the Child Core Set measures to drive quality improvement.

Reporting non-HEDIS measures in the Child Core Set. Although the states that require NCQA accreditation have health plans that routinely report on HEDIS measures as a condition for accreditation, the states do not have the capacity to report many of the non-HEDIS measures. Reporting of non-HEDIS measures by health plans often is not required contractually by the states, and state Medicaid agencies may not have access to data for these measures if they require medical chart reviews, electronic health records, vital records, or survey data. Several of the states commented that they are addressing these challenges. For example, Massachusetts and New York have included reporting requirements for non-HEDIS measures in their contracts with health plans, while Michigan has improved its non-HEDIS reporting infrastructure by including vital records data in its data warehouse.

Including all Medicaid/CHIP populations in the measures. States acknowledged both the challenge and importance of reporting on all children covered by Medicaid and CHIP, including difficult-to reach-populations. States explained, however, that because some populations, including children living in institutional settings or in foster care, may frequently transition in and out of coverage, these populations generally do not meet the continuous enrollment criteria for many measures. Despite these limitations, some states are actively trying to improve their ability to report on difficult-to-reach populations. For example, New York is in the process of transitioning some institutionalized populations into its managed

care program, which will allow the state to report on more publicly insured children in future years. Similarly, Michigan is working on its infrastructure to include fee-for service Medicaid populations and to integrate quality measure data for children enrolled in CHIP.

Stratifying quality measures by demographic and geographic characteristics. As states seek to drive improvement in performance, many recognize the value of stratifying measures by demographic and geographic characteristics to identify disparities and target improvement activities to specific populations. For example, Michigan and New York, both large states with diverse regions, discussed efforts to stratify reporting in an attempt to highlight and reduce regional, racial, and geographic disparities in the state. In addition, CMS now allows and encourages states to report Child Core Set measures stratified by race, ethnicity, sex, primary language, disability status, and geography.

Moving Forward

Interviews with state officials from the six states highlighted the successes and challenges they encountered in reporting the Child Core Set measures for FFY 2013. The promising approaches and lessons learned that these states shared may be useful to other states to enhance their reporting and use of the Child Core Set measures to improve the quality of care obtained by children in Medicaid/CHIP. Moving forward, CMS plans to conduct a similar analysis of state data reported for FFY 2015, and looks forward to continuing to work with states to improve quality measure reporting and performance in future years.

For Further Information

Additional information about state reporting of the Child Core Set measures for FFY 2013 is available in the 2014 Annual Report on the Quality of Care for Children in Medicaid and CHIP (http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2014-child-sec-rept.pdf). To obtain technical assistance with collecting, reporting, and using the Medicaid/CHIP core set measures, contact **MACQualityTA@cms.hhs.gov**.