



State Strategies for Medicaid Quality Improvement for Children and Youth with Special Health Care Needs

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Executive Summary

Addressing the unique needs of children and youth with special health care needs (CYSHCN) enrolled in Medicaid and assuring the quality of care they receive is a growing priority for state and national health policymakers. States have launched numerous initiatives to transform how they deliver and pay for care, and are utilizing health care quality measures to monitor and assess the quality of care provided to Medicaid beneficiaries. They are increasingly linking these quality measures to alternative payment models that reward providers for delivering high-quality and cost-effective care. While state Medicaid quality improvement initiatives have historically targeted adult beneficiaries, today federal and state interest in quality improvement for CYSHCN is gaining greater traction.

The National Academy for State Health Policy (NASHP), with support from the Lucile Packard Foundation for Children's Health, convened a national work group representing state Medicaid agencies, state Title V CYSHCN programs, families of CYSHCN, child health services researchers, pediatric providers, and federal agencies to assess the current state of Medicaid quality measurement and improvement for this population, and recommend key opportunities and strategies for state Medicaid agencies to strengthen these efforts.

There are numerous barriers to implementing Medicaid quality measurement activities for CYSHCN, which stem from or are compounded by the unique needs and heterogeneity of this population. However, NASHP identified 10 key strategies based upon a comprehensive literature review, interviews with leading states, and the recommendations of the national work group.

1. Engage families in the development and implementation of quality improvement strategies for CYSHCN.
2. Establish standardized criteria or mechanisms for identification of CYSHCN.
3. Conduct a baseline assessment to understand the needs of this population and set benchmarks.
4. Convene diverse stakeholders to support quality improvement activities.
5. Stratify existing quality measures for CYSHCN to evaluate the services they receive and their care experience.
6. Expand opportunities to integrate family-reported measures.
7. Coordinate with other state agencies serving CYSHCN in order to enhance quality measurement programs.
8. Use data to drive improvements in care for CYSHCN.
9. Build on other health reform initiatives to advance quality improvement for this population.
10. Plan for sustainability from the outset when developing quality measurement and improvement strategies.

This issue brief examines these strategies, in addition to the current landscape of children's health care quality measurement and the challenges inherent in developing Medicaid quality measurement and improvement strategies for CYSHCN. This issue brief also includes a table summarizing selected national measure sets and survey tools that are applicable to CYSHCN (Appendix A) and in-depth case studies on three states - Michigan, New York, and Texas - with leading efforts in quality measurement and improvement for this population (Appendix B).

Introduction

Addressing the unique needs of CYSHCN enrolled in Medicaid and assuring the quality of care they receive is a growing priority for state and national health policymakers. Health care reform is occurring across the United States and most states are implementing multiple initiatives to transform the way care is delivered and paid for, reduce health care costs, and ultimately improve health outcomes. Many of these reforms are designed to improve services and the quality of care for Medicaid beneficiaries with complex needs.¹ State reforms include:

- Development of alternative payment models;
- Integration of previously carved-out behavioral health services into Medicaid managed care;
- Creation of specialized managed care plans, particularly for children and adults with chronic and complex health care needs; and
- Design of new health care delivery models, such as pediatric accountable care organizations.

Quality improvement is a core component of these health reform initiatives.

As of June 2017, 47 states and Washington, DC, all use some form of managed care to provide services to all or some children and adults enrolled in Medicaid. This includes states that are implementing risk-based managed care organizations (MCOs), primary care case management (PCCM), and prepaid ambulatory health plan (PAHP) systems. Only Alaska, Connecticut, and Wyoming provide services to Medicaid beneficiaries exclusively through fee-for-service (FFS) health care delivery systems.^{2,3} Of these 47 states and Washington, DC, all enroll at least some populations of CYSHCN into Medicaid managed care either through mandatory or voluntary enrollment.⁴ Federal regulations require state Medicaid agencies to conduct external quality reviews of their MCOs to assess the quality, timeliness, and access to care provided to enrollees.⁵ As states expand their Medicaid managed care programs to serve more complex pediatric populations, they can leverage their managed care quality strategies to advance quality improvements for this population of children.

States, the federal government, and the private sector are increasingly interested in programs that include pay-for-performance and reward improvements based on specific quality metrics. Indeed, use of evidence-based quality measurement provides states with important opportunities to hold health plans accountable, address disparities, and ensure health care services are neither over- or under-utilized by those in need of care.⁶ Quality improvement activities have been predominantly targeted to adult beneficiaries, particularly those with complex needs who account for a disproportionate amount of health care spending. Currently, federal and state interest in quality improvement for CYSHCN is gaining greater traction.^{7,8}

Children and Youth with Special Health Care Needs in Medicaid

Over 20 percent of all US children ages birth to 18 years (over 14 million children) have a chronic and/or complex physical, developmental, behavioral, or emotional condition (e.g., asthma, diabetes, spina bifida) requiring health care services and supports beyond what children require normally.⁹ A smaller but increasing group of children have complex medical conditions that require the highest levels of services. There are an estimated 3 million children – about 4 percent of all children – with medical complexity in the United States.¹⁰

Medicaid, the Children's Health Insurance Program (CHIP), and other public insurance programs covered 44 percent of all CYSHCN in 2009-2010.¹¹ Among all children with medical complexity in the United States, approximately two-thirds are enrolled in Medicaid, with many eligible for Medicaid due to their disabilities or medical conditions.¹² Although children with medical complexity represented only 6 percent of all children enrolled in Medicaid in 2011, they accounted for 34 percent (\$1.6 billion) of all health care spending for children enrolled in Medicaid.¹³

This issue brief describes some of the leading Medicaid quality improvement models that states are using, identifies gaps in quality measurement and improvement approaches, and outlines strategies states can use to build and advance quality improvement initiatives targeted to CYSHCN. These strategies are based on a comprehensive literature review, interviews with leading state policymakers, and the recommendations of the national work group. (For the full list of work group members, see Appendix C).

The Current Landscape of Medicaid Quality Measurement of Children's Health

Until passage of the CHIP Reauthorization Act (CHIPRA) of 2009, no uniform system for assessing the quality of care for children across states existed for Medicaid and CHIP. In response to CHIPRA, the Secretary of Health and Human Services through the Centers for Medicare & Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ) released the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP¹⁴ (known as the Child Core Set) after an in-depth process involving input from experts in the field of quality measurement and other stakeholders.¹⁵ The Child Core Set measures are updated on an annual basis, and available for voluntary use by state Medicaid agencies and CHIP programs.

Prior to CHIPRA, most states relied on Healthcare Effectiveness and Data Information Set (HEDIS), a set of performance measures developed by the National Committee for Quality Assurance (NCQA), as the basis for any children's health care quality measurement activities.¹⁶ HEDIS measures continue to be a significant component of state quality strategies because they are typically derived from claims data, which are widely accessible to state Medicaid agencies.

Several other efforts are also underway to advance children's health quality measurement in public and private insurance coverage programs. CMS and AHRQ are leading the Pediatric Quality Measurement Program (PQMP), which was established under CHIPRA. The first phase of PQMP was designed to strengthen the Child Core Set, and develop, strengthen, and/or test new measures that public and private payors can use to improve children's health care quality. In 2016, PQMP entered its next phase with funding from Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). It is now focused on supporting efforts to test the feasibility and usability of new pediatric quality measures in real-world settings. One area of focus under PQMP is the development of measures specific to children with complex needs.¹⁷

Additionally, CMS, private and public health plans, purchasers, physicians and other provider organizations, and consumers have come together through the Core Quality Measures Collaborative (CQMC), led by America's Health Insurance Plans, to establish core sets of measures that are aligned across public and private payors. CQMC has released core measure sets in eight areas, the latest of which is the Pediatric Core Measures Set.¹⁸ The proposed Pediatric Core Measures Set consists of nine measures, seven of which are also included in the latest CMS Child Core Set.¹⁹

The Child Core Set, PQMP measures, and CQMC Pediatric Core Measures Set join other published measure sets and measurement tools that are being used to advance children's health care quality, including the HEDIS, Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, National Quality Forum-endorsed measures, and the Title V Maternal and Child Health Services Block

Grant National Performance Measures. Most of the measures are designed to assess the quality of care for general pediatric populations; however, some have the potential to support quality measurement for CYSHCN. (Appendix A includes a table summarizing selected national measure sets and survey tools relevant for CYSHCN.)

In spite of national and state recognition of the need to assess child health quality in Medicaid and CHIP, quality measurement for children continues to lag behind that for adults. State Medicaid agencies are strengthening their capacity for children's health care quality measurement and refining their approaches to quality improvement for children. However, they continue to face competing demands that limit their ability to implement and require measures for pediatric populations, and develop the infrastructure needed to collect and report on these measures. In many ways, these barriers are compounded when implementing quality measurement activities for CYSHCN.

The Role of Medicaid Quality Measurement in Improving Health Care Delivery Systems

Quality measurement is a critical component of all state Medicaid programs and a requirement for states with Medicaid managed care. States use Medicaid quality metrics to support population health, identify and address disparities in care, and hold health plans and providers accountable for care. Quality metrics also serve as the foundation of Medicaid's quality improvement strategies, including:

- Public reporting to increase health plan and provider transparency;
- Requiring health plans to implement performance improvement projects; and
- Auto-enrolling Medicaid members in higher performing health plans.

State Medicaid programs vary in the quality measures they require plans and providers to report on, and how they collect and analyze the data. They have some flexibility in designing and implementing quality improvement strategies. While there are some commonalities in the aspects of quality that states focus on, such as diabetes care and primary care access, states also develop or adapt measures to meet their specific priorities.²⁰ To promote a national system for measurement and quality improvement, CMS developed the Adult and Child Core Sets, which states can voluntarily report on for their Medicaid enrollees.

While a few states still rely exclusively on fee-for-service systems for their Medicaid program, managed care has become the dominant delivery system of state Medicaid programs across the country. As states implement and expand the reach of Medicaid managed care programs, external quality review organizations (EQROs) are playing a prominent role in states' quality improvement strategies. States with Medicaid managed care delivery systems are required to contract with an EQRO to conduct an annual review of the quality, timeliness, and access to services that a MCO provides to its enrollees. As part of this review, EQROs validate performance measures and ensure that MCOs comply with federal regulations. Based on their review, EQROs recommend how states can improve the quality of care provided by MCOs.²¹ EQROs are also required to validate performance improvement projects (PIPs), which MCOs must implement on an annual basis. PIPs are designed to target improvement on specific topics identified by the state, and allow MCOs to test new quality improvement strategies.²²

State Medicaid programs are also implementing other delivery models, such as patient-centered medical homes, accountable care organizations, and health homes. To evaluate the effectiveness of these delivery models on health care quality, outcomes and costs, states use Medicaid quality metrics. Additionally, states are linking quality measurement to payment reform efforts as they move away from FFS systems to value-based payments (VBP), which reward quality over volume. Value-based payments are designed to incentivize higher quality and more efficient care, while improving outcomes. Value-based payments are still burgeoning, and while these initiatives may impact children's health care, they currently primarily target adult populations. Value-based payment models that states are using fall along a continuum that can be categorized as follows:²³

- **FFS linked to quality and value:** These payment models use FFS systems, but provide enhanced payments to support investments that improve care delivery, incentivize providers to report quality data (pay-for-reporting), and/or reward providers for performing well on quality metrics (pay-for-performance).
- **Alternative payment models built on FFS:** Under these types of payment models, providers continue to receive FFS payments, but they have the opportunity to receive a portion of the savings generated if they meet cost or utilization targets, and in some models, they may incur losses if they do not meet the targets. Quality measures are used to ensure providers are providing appropriate care, and they are incentivized only to reduce ineffective, harmful, and unnecessary care.
- **Population-based payment models:** These payment models provide a set payment to a provider or provider group to either cover the treatment of specific conditions or to cover the care for a defined population. Quality measures are also used to ensure providers are not reducing necessary care as a means to lowering costs. Under some of these models, providers may also receive bonus payments based on their performance on a specific set of measures.

Challenges to Medicaid Quality Improvement

CYSHCN require targeted quality improvement approaches due to the complex nature of their conditions and the health care systems that they typically use. They can receive care from multiple providers and systems, and their care tends to be highly fragmented with little communication or coordination across providers, especially for children with the most complex needs.²⁴ Additionally, their conditions and care requirements can have significant and far-reaching consequences on their entire family, impacting their quality of life, ability to attend school or work, and financial stability.²⁵ Consequently, there are inherent challenges for state Medicaid agencies when designing and implementing quality improvement strategies for this population of children.

Lack of standardization in identification procedures can impede quality measurement efforts.

Identification of CYSHCN is a critical step in monitoring the quality of care, comparing performance across providers and health plans, and using data to drive quality improvement. In fact, identifying enrollees with special health care needs is a federal requirement for all state Medicaid managed care programs.²⁶ However, identifying this population of children can be challenging due to the heterogeneity of this group and the lack of standardized mechanisms used for identification efforts. State Medicaid programs and/or MCOs typically use claims data, diagnoses, or referrals to identify high-needs children, but these methods may not capture all CYSHCN who would benefit from targeted quality improvement efforts. Tools are available to support identification, such as the Pediatric Medical Complexity Algorithm,²⁷ however, few state Medicaid agencies have utilized these tools due to lack of awareness and capacity.

Some states have specialized programs within Medicaid for CYSHCN that have condition-specific eligibility requirements or rely on eligibility for other programs (such as Title V CYSHCN programs), both of which streamline the identification of this population of children. Based on a limited review of states' efforts in this area, it appears that these types of programs lend themselves more easily to Medicaid quality measurement activities because they establish a clearly defined target population. In other cases, the state may require its MCOs to identify CYSHCN as part of contractual requirements, but may not provide standardized criteria for MCOs to use when identifying this population of children.²⁸ In the absence of such criteria, MCOs may target different subgroups, thereby limiting a state's ability to compare health plan performance and hold MCOs accountable for specific quality metrics. The lack of standardized definitions or identification mechanisms at the national level also limits the ability to compare how CYSHCN are faring across states.

State Medicaid agencies have limited capacity and infrastructure for quality measurement.

State Medicaid agencies face numerous challenges regarding the infrastructure and capacity needed to implement quality measurement. These challenges are not unique to CYSHCN, but they represent fundamental components of any quality measurement strategy.

- **Measure and data limitations:** Medicaid programs are limited by the data and measures that are available to them. It can take several years to develop reliable and valid measures. Most Medicaid agencies rely on HEDIS measures to assess quality because these measures are validated and primarily drawn from claims data, one of the most widely accessible sources of Medicaid data.²⁹ However, HEDIS measures do not reflect all aspects of quality. The CAHPS surveys can be used to assess the experience of Medicaid beneficiaries with their health plan and providers.³⁰ Yet, CAHPS is costly to implement and may have low response rates, which can result in a sample size that is too small for accurate analysis.³¹ Furthermore, many state agencies and programs collect data and report on measures that may be duplicative of or useful to Medicaid programs. For example, CYSHCN may be served by the state Title V CYSHCN program, Part C

Early Intervention, and Supplemental Security Income program, each of which has its own data collection and reporting requirements. However, these state agencies' data systems often are not linked, and linking data systems has numerous policy, legal, and technical challenges, such as inconsistencies in how measures are defined or how each agency reports its data.

- **Resource challenges:** Measure reporting is resource-intensive both in terms of financial costs and personnel. States need systems that can receive, store, and analyze data. They also need staff with the expertise to select appropriate and validated measures, ensure the measures are being calculated appropriately, and analyze their data. In 2016, 31 state Medicaid agencies reported experiencing budgetary constraints, and 38 reported staffing challenges.³² These resource challenges limit states' ability to implement and collect new data, enhance the capacity of their analytic systems, and cultivate and maintain staff capacity for quality measurement and improvement.

Current opportunities for quality measurement have limitations.

Recent federal investments in children's health care quality measurement have accelerated the development and validation of a variety of measures that have potential to support quality measurement for CYSHCN. These measures can be grouped in several domains – primary and preventive care, acute and chronic condition-specific care, and other cross-cutting measures. However, the measures in each of these domains present challenges when applying them to CYSHCN.

- **Primary and preventive care measures (e.g., well-child visits, immunizations, developmental screenings, etc.):** These types of measures are already in use by most state Medicaid agencies and could be stratified by CYSHCN. However, they may not always be appropriate quality indicators for the entirety of this population. For example, children with the most complex conditions may not be able to receive immunizations due to their health conditions and therefore, measuring receipt of immunizations may not be relevant. These types of measures also do not address the unique care needs of this population of children, such as functional status and family burden.
- **Acute and chronic condition-specific measures (e.g., ADHD medication management, hospital admissions related to asthma, etc.):** There are numerous condition-specific measures that are validated and relevant to CYSHCN. However, these measures are only applicable to conditions with sufficient prevalence to produce stable data. Many children in this population have conditions that are much lower in prevalence than what is needed for accurate and reliable quality measurement. Additionally, these measures only examine one aspect of care related to that condition and not the child's care overall.
- **Other cross-cutting measures (e.g., care coordination, transition to adult care systems, etc.):** These types of measures are important to effectively meet the needs of CYSHCN and families and assess the overall quality of care. There are examples of validated and reliable measures in this domain, such as measures derived from the Family Experience with Care Coordination survey or Pediatric Integrated Care Survey (PICS).^{33, 34} However, these types of measures are not as accessible or readily available to state Medicaid agencies compared to the measures in the previously discussed domains. To collect these measures, states would likely need to implement additional data collection mechanisms because these measures are not typically captured in administrative data. They also have not been included in prominent measure sets such as HEDIS and the CMS Child Core Set, which would promote adoption at the state level.

The challenge underlying these approaches to quality measurement is the heterogeneity of CYSHCN. Applying measures across this entire population can mask the diversity of their diagnoses and health care needs, especially in the case of children with medical complexity. However, measures that tar-

get specific conditions may not be feasible due the low prevalence of any given condition. Thus, any quality measurement strategy may require separate measures for the broad population of CYSHCN, and others for children with medical complexity to ensure that their respective needs are being met.

Many existing measures do not measure quality as defined by families.

As noted above, a number of measures exist that state Medicaid agencies could apply to CYSHCN. Many of these measures, such as well-child visits, developmental screenings, and access to primary care providers, are structural or process measures. Structural and process measures are valuable to ensure the appropriate systems and evidence-based practices are in place, but they are not always indicative of outcomes, especially for CYSHCN and their families. Families report that current approaches to quality measurement often fail to convey the value of health care services and supports in a meaningful way, or they do not reflect what constitutes high-quality care from a family's perspective.³⁵ Families view quality in terms of their quality of life and experience with care. Such quality indicators include missed days of school or work, parental stress, and whether a family received the education and support needed to care for a child at home.³⁶ However, there are gaps in the quality measures that can be used to assess such aspects of care and outcomes that matter most to families. Some of these broader outcome measures, such as missed days of school, can also be difficult to attribute directly to the child's health care providers.

Developing and implementing quality improvement strategies takes time and cross-system collaboration.

There are a variety of incentive strategies – both financial and non-financial – that state Medicaid agencies could use, including public reporting on provider and health plan performance, technical assistance to support quality improvement activities, pay-for-reporting, and pay-for-performance.³⁷ The process for implementing effective quality improvement initiatives is lengthy and challenging no matter the target population or condition. For example, states typically engage diverse stakeholders, including providers, health plans, researchers, consumers, and multiple state agencies, through work groups and advisory councils to ensure the quality improvement activities reflect a range of perspectives. States need to obtain buy-in from health plans and providers to implement the quality improvement strategy, especially in cases where they will be held accountable for specific measures and outcomes, and ensure that health plans and providers are able to collect and report on specific measures in consistent ways. States also need to procure and maintain data analytic systems that can support the data collection and analysis underlying the quality improvement strategy. These challenges are more pronounced when targeting quality improvement for CYSHCN due to the complexity of the systems serving them and diversity of this population of children.

Value-based payment strategies are challenging to apply.

Using financial incentives to improve care for CYSHCN requires special considerations. Protections need to be in place to ensure that this population of children, especially those with medical complexity, do not experience additional inequities in care as a result of bias selection, as value-based payments may encourage plans and providers to select less complex clients. Additionally, improving quality of care for children with the most complex and highest needs will not necessarily translate into cost savings. High utilization of services and hospital admissions, and the associated costs, might be necessary for many children with severe, chronic, and complex needs. Promoting better care coordination and care management for this population may also lead to increased utilization and costs as additional unmet needs are identified.³⁸

Strategies for Using Medicaid Quality Measurement to Improve Care

Despite these challenges, there is significant potential to use Medicaid quality metrics to improve care for CYSHCN, and states have already begun. Many of the following strategies and opportunities are being used by state Medicaid agencies to support quality measurement for this population of children, and others were recommended by the national work group. For examples of how states are implementing these types of strategies, see the case studies on Michigan, New York, and Texas in Appendix B.

- 1. Engage families in the development and implementation of quality improvement strategies.** Family engagement is critical in all aspects of quality measurement and improvement for CYSHCN. Parents and caregivers are the foremost experts in their child's needs and the systems serving them. Their input and perspective can help ensure that quality measures:
 - Assess the care and outcomes that matter most to their children and families, and
 - Support meaningful improvements in their experience with care delivery systems.Additionally, quality measurement results should be accessible to and actionable for families, such as through public reporting or their inclusion in health plan and provider report cards.
- 2. Establish standardized criteria or mechanisms for identification of children.** Before any Medicaid program can monitor health needs, care quality, and changes in quality over time, they must first identify the populations of CYSHCN who will be targeted by the state's quality improvement strategy. Standardized criteria or tools could be established to support consistent identification. For example, some states have integrated questions into their Medicaid application to identify CYSHCN at the time of their enrollment. In other states where MCOs are required to identify this population of children, the MCOs typically use algorithms based on claims data, diagnoses, and referrals. This standardization will ensure that plan and provider performance can be accurately compared to one another, and that any quality improvement strategy supports its intended population. Identification tools can enable states or health plans to stratify the children by factors such as medical complexity, utilization, and risk based on social determinants of health, which will allow for additional data aggregates that they can use to target potential interventions.
- 3. Conduct a baseline assessment to understand the needs of the target population and set benchmarks.** To date, few states have Medicaid quality measurement strategies that specifically apply to CYSHCN. As a result, many states may not be aware of potential gaps or disparities in the quality of care rendered to this population. Conducting a baseline assessment can reveal how the current health system is performing, and assess the current health status of CYSHCN. This process allows state Medicaid agencies to establish benchmarks that they can use to assess and monitor the performance of health plans and providers. The benchmarks can also help states identify the aspects of care that they should target with quality improvement activities, and can serve as the basis for incentive strategies.
- 4. Convene diverse stakeholders to support quality improvement activities.** Engaging stakeholders early and often is critical to any Medicaid quality improvement initiative. Stakeholders should represent the range of systems and programs serving CYSHCN, including family representatives, primary care and specialty providers, health plans, researchers, advocates, and other state agencies. These stakeholders can provide crucial input into common principles and priorities that will guide the state's approach to quality improvement for this population. They also aid in the selection of relevant and meaningful quality measures. See "Lessons from Massachusetts" on page 9 for an example of how a state Medicaid agency engaged stakeholders in the development of quality measures. Additionally, as quality improvement strategies are developed and implemented, state Medicaid agencies need a curriculum on quality improvement education that can support the various stakeholders, particularly health plans and providers, in the collection and use of data.

Lessons from Massachusetts: Engaging Stakeholders in the Development of Quality Measures

MassHealth, Massachusetts' Medicaid program, is in the midst of transitioning to [accountable care organizations \(ACOs\)](#) as its payment model. The ACO Pilot Program is currently underway, and MassHealth plans to expand ACOs statewide in 2018. As part of the ACO development and implementation process, MassHealth has convened a multi-stakeholder work group, including payors, providers, researchers, advocates, and consumers, to advise on quality measures for ACOs. The work group developed a set of guiding principles at the outset of this work to ensure all members had a common understanding of what they should be looking for in the design of a quality measurement approach. While these principles are not specific to quality measurement for CYSHCN, they represent a statewide approach to supporting ongoing quality measures development that can be applied across all populations of Medicaid enrollees. Of note, the principles are intended to serve as a guide. Measures may not necessarily meet all the principles, especially when addressing additional needs of a specific population in the new service delivery model.

MassHealth's ACO Guiding Principles

The ACO quality measures should:

- Assess variation and opportunity for improvement (e.g., provider level variation, disparities).
- Have demonstrated reliability and validity, and consider population size and statistical validity.
- Be drawn, where possible, from nationally-accepted standards of measures that have with broad impact, and are aligned with other payors and CMS, where applicable, balanced by the unique needs of the MassHealth (Massachusetts Medicaid) program goals.
- Balance parsimony, feasibility of data collection, and administrative burden with the advancement of policy goals for integration of behavioral health, long-term services and supports, medical services and social services.
- Consider cross-cutting measures that can be applied across adult and pediatric populations or to multiple sub-populations (e.g., CYSHCN, elderly individuals, adults with chronic conditions, etc.)
- Monitor under/overutilization.

5. **Stratify existing quality measures.** State policymakers and health services researchers serving on the work group strongly recommended that existing quality measures be used to support quality improvement for CYSHCN, as opposed to devoting time and resources to developing new measures. Existing measures include condition-specific metrics, such as asthma medication management and follow-up care for children diagnosed with ADHD. In addition to these types of condition-specific measures, state Medicaid agencies may already be gathering general pediatric quality metrics that could be stratified by CYSHCN, such as well-child visits or access to primary care providers. While these measures do not reflect all aspects of care specific to this population of children, these types of structural and process measures represent a key starting point, helping to ensure that health systems have the capacity to care for this vulnerable population. The stratification of measures is not a simple process and has numerous technical hurdles. However, in focusing their efforts on using the measures that are currently available, states will be better able to align measures across programs and reduce provider reporting burden.
6. **Expand opportunities to integrate family-reported measures.** Stratifying current measures presents a promising strategy for quality measurement for CYSHCN – yet gaps in this measurement approach persist. One opportunity to address such gaps is to incorporate the use of family-reported measures as part of the quality improvement strategy. The family's perspective is critical to fully understanding the quality of care for CYSHCN. Families can provide feedback about their children's functional status, integration into communities, and continuity of care, which cannot be gleaned through other data sources. States may have existing mechanisms to collect and develop these types of family-reported measures. Such mechanisms may include incorporating additional questions into the CAHPS or other survey and focus groups conducted by the state.
7. **Coordinate with other state agencies to enhance quality measurement programs.** Given the numerous systems serving CYSHCN, there is an opportunity to coordinate quality measurement efforts across state agencies. For example, many state Title V CYSHCN programs assess cross-cutting measures (e.g., those served by medical homes, transition to adult health systems, etc.). State Medicaid agencies could coordinate and align with Title V CYSHCN programs to incorporate these types of cross-cutting measures into their measurement activities for CYSHCN who are enrolled in Medicaid.

8. Use data to drive improvements in care. Collecting data is necessary, but not sufficient, to improve care quality, patient experience, and health outcomes. Quality improvement strategies need to be in place to enable state Medicaid agencies to use the data to support or incentivize changes. There are numerous approaches to quality improvement that states have implemented that could be applied to CYSHCN. For example, states can:

- Make data publicly available so providers can compare their performance against their peers;
- Develop quality rating systems to inform plan and provider selection; and
- Provide enhanced payments based on specific quality measures, or establish a bonus pool that provides additional payments to high-performing plans/providers.

States serving CYSHCN through Medicaid managed care have the opportunity to incorporate specific reporting requirements or metrics into contracts with MCOs. These metrics could be factored into the external quality review and serve as the basis for quality improvement initiatives. Incorporating metrics into contracts can promote the development of PIPs that specifically target this population of children. States can also contractually require plans to conduct PIPs on specific topics related to CYSHCN.

9. Build on other health reform initiatives to advance quality improvement. State Medicaid agencies are currently engaged in a variety of health system transformation initiatives, including the federal Comprehensive Primary Care Plus (CPC+) initiative and Delivery System Reform Incentive Payment (DSRIP) program, and state-based initiatives, such as the development of accountable care organizations and the expansion of Medicaid managed care. These efforts strive to redesign how care is delivered and paid for in order to improve the quality and value of care. States can integrate quality improvement strategies for CYSHCN into these health reform efforts, which will allow them to build on the state's platform for transformation and align the quality improvement strategies for this population with its broader health reform goals. For an example of a health care reform initiative that can advance quality improvement for CYSHCN, see the text box, "Spotlight on Comprehensive Primary Care Plus (CPC+)" on page 10.

10. Plan for sustainability from the outset when developing quality measurement and improvement strategies. Designing and implementing quality improvement strategies for CYSHCN is a lengthy and iterative process, and it may take several years to establish a robust quality improvement system. To support sustainability, states can incorporate quality measurement at the beginning of initiatives and take an incremental approach to adoption by testing selected measures on a small scale before expanding statewide or holding providers and health plans accountable for them.

Building on State Health Reform: Spotlight on Comprehensive Primary Care Plus

[Comprehensive Primary Care Plus](#) (CPC+) is a multi-payor payment reform initiative developed by the Center for Medicare and Medicaid Innovation (CMMI) to strengthen primary care based on five key functions:

1. Access and continuity
2. Care management
3. Comprehensiveness and coordination
4. Patient and caregiver engagement
5. Planned care and population health

CPC+ is aligning public and private payors in the implementation of alternative payment models to provide the necessary financial support for practices as they transform how they deliver care.³⁹ CPC+ includes performance-based incentive payments based on practices' performance on measures of patient experience, clinical quality, and utilization.⁴⁰ With its strong emphasis on comprehensive primary care, including care coordination, and the payments to support these activities, CPC+ provides a key opportunity to improve the quality of care for CYSHCN as part of states' broader payment and delivery reform efforts.

Conclusion

States are increasingly interested in the potential role Medicaid quality measurement can play in improving care for CYSHCN and their families. Recent federal and private investments are supporting the development of children’s health care quality metrics that can be used to advance quality improvement for this population. Existing measures available to state Medicaid agencies have limitations, and state Medicaid agencies face challenges as they design quality improvement strategies that target the unique needs of this population of children, as this remains largely uncharted territory for states. In spite of these challenges, states can use strategies outlined in this issue brief to begin to leverage Medicaid quality metrics to drive improvements in care specifically for this population of children. As payment and delivery system reform efforts become better established in states, there are increasing opportunities for states to build on these efforts to advance quality improvement for CYSHCN.

Endnotes

1. CMCS Informational Bulletin. “Targeting Medicaid Super-Utilizers to Decrease Costs and Improve Quality,” Centers for Medicaid and CHIP Services, July 24, 2013, <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-07-24-2013.pdf>
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Appendix A: Selected Quality Measure Sets, Surveys, and Measure Concepts for Children and Youth with Special Health Care Needs

These tables provide an overview of current key national measure sets, survey tools, and measure concepts that can be used to monitor and assess care quality for children and youth with special health care needs (CYSHCN). Table 1 describes selected measure sets and surveys from which measures can be derived. Table 2 provides an overview of selected measure concepts by measure set/survey that could be applied to CYSHCN. These tables are non-exhaustive, and they are designed to capture the types of measures, surveys, and measure sets that are available to assess care for CYSHCN and states can consider when developing a quality improvement strategy for this population.

Table 1: Descriptions and Key Characteristics of Select Measure Sets and Surveys

Measure Sets and Surveys	Description	Target Populations	Data Source
Agency for Healthcare Research and Quality (AHRQ) Pediatric Quality Indicators	This measure set assesses the quality of pediatric health care provided in the hospital inpatient setting. The AHRQ Pediatric Quality Indicators assess problems that patients experience as a result of exposure to the health care system.	Infants and children	Hospital discharge data
CAHPS Survey: Children with Chronic Conditions	A supplemental question set that assesses the experiences of this population with health plans and health care services.	Children with chronic and complex needs	Survey data
Family Experience with Care Coordination (FECC)	This survey, developed by the AHRQ Center of Excellence on Quality of Care Measures for Children with Complex Needs, assesses care coordination for children with chronic and complex conditions.	Children with chronic and complex needs	Survey data
Healthcare Effectiveness Data and Information Set (HEDIS)	The National Committee for Quality Assurance (NCQA) developed this measure set to measure health plan performance. Medicaid health plans accredited by NCQA <u>must</u> report on 35 select measures annually.	All individuals	Administrative, hybrid, and survey data
Medicaid/CHIP Child Core Sets	This set of health care quality measures identified by the Centers for Medicare and Medicaid Services (CMS) is for <u>voluntary</u> use by state Medicaid and Children's Health Insurance Program (CHIP) programs.	Infants, children, and pregnant women/new mothers	Administrative, hybrid, and survey data
National Quality Forum (NQF) Endorsed Measures	NQF is a nonprofit membership organization that catalyzes improvements in health care through quality measurement. NQF-endorsed measures are a compendium of measures, drawn from a variety of existing measure sets and other sources, designed to enhance health care value and improve outcomes across private and public programs.	All individuals	Administrative, hybrid, and survey data
Pediatric Integrated Care Survey (PICS)	A validated survey that measures experiences of families with the integration of health care and related services for children with complex medical, behavioral, and developmental needs.	Children with complex medical, behavioral and developmental needs	Survey data
Pediatric Quality Measures Program	A program of CMS and AHRQ that is strengthening the Medicaid/CHIP Child Core Set and developing new pediatric measures.	Infants, children, and pregnant women/new mothers	Administrative and medical records data
Title V National Performance Measures (NPMs)	A set of measures developed by the Maternal and Child Health Bureau to assess the impact of state Title V programs. States are required to select and report on eight of the fifteen measures.	Infants, children, and pregnant women/new mothers	National data sources (e.g., National Survey of Children's Health)

Table 2: Selected Quality Measure Concepts for CYSHCN by Measure Set and Survey Tool

Measure Concepts	Measure Sets and Surveys								
	AHRQ Pediatric Quality Indicators	CAHPS: Children with Chronic Conditions	FECC	HEDIS	Medicaid/CHIP Child Core Set ¹	NQF-Endorsed Measures	PICS	PQMP ²	Title V National Performance Measures (NPMs)
Primary Care and Preventive Care									
Well-child visits (Birth – 6 years)				✓	✓	✓	✓		
Adolescent well-care visits				✓	✓		✓		
Weight assessment or nutrition and physical activity counseling				✓	✓	✓			
Immunizations for children/adolescents				✓	✓	✓			
Preventive dental care				✓	✓				
Lead screening				✓					
Developmental screening					✓	✓			
Access to primary care providers				✓	✓		✓		
Behavioral Health Care									
ADHD: Follow-up care				✓	✓	✓		✓	
Depression screenings for children/adolescents				✓	✓	✓			
Metabolic monitoring and use of antipsychotics for children/adolescents				✓	✓	✓		✓	
First-line psychosocial care for children on antipsychotics				✓	✓	✓		✓	
Follow-up after hospitalization for mental illness				✓	✓	✓		✓	

1. In addition to the Child Core Set, CMS also updates and publishes the Adult Core Set on an annual basis. The Adult Core Set includes several measures that may be applicable to youth with special health care needs (18 years old and older), but these measures are not reflected in the table.
 2. More than 80 measures have been developed or are under development through PQMP. This table only reflects the PQMP measures that have been developed and tested.

Measure Concepts	Measure Sets and Surveys								
	AHRQ Pediatric Quality Indicators	CAHPS: Children with Chronic Conditions	FECC	HEDIS	Medicaid/CHIP Child Core Set	NQF-Endorsed Measures	PICS	PQMP	Title V NPMs
Acute and Chronic Condition Care									
Emergency department visits					✓				
All-condition readmissions rate						✓		✓	
Prescription medications: Access and management		✓				✓			
Asthma medication management				✓	✓	✓			
Emergency department utilization or admissions among children with asthma	✓					✓		✓	
Diabetes complications admission rate	✓					✓			
Appropriate testing for children with pharyngitis				✓					
Appropriate treatment for children with upper respiratory infection						✓			
Timely testing and appropriate screening for children with sickle cell anemia						✓		✓	
Other Measures									
Access to medical home							✓		✓
Transition to adult health care services						✓	✓	✓	✓
Family-centered care		✓					✓		
Care coordination		✓	✓			✓	✓	✓	
Parental guidance and education		✓	✓				✓		
Patient/family experience with care		✓	✓	✓	✓ ³		✓	✓	

3. The Child Core Set includes the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 5.0H – Child Version including Medicaid and Children with Chronic Conditions Supplemental Items as a measure for patient and families’ experience of care. No state has yet reported on this measure.

Appendix B: Implementing Quality Measurement and Improvement for CYSHCN in Three States

Michigan: Children's Special Health Care Services Program

Michigan has been using managed care as the primary service delivery model for its Medicaid program since 1997, and today the majority of its Medicaid beneficiaries are enrolled in managed care organizations. This includes high-needs populations, such as adults and children with disabilities, foster care youth, and children enrolled in the state's Children's Special Health Care Services (CSHCS) program. Michigan has a robust quality improvement strategy for its managed care program that applies to all enrollees, including children and youth with special health care needs (CYSHCN). In addition to this broad quality improvement strategy through managed care, Michigan has developed a targeted approach for quality measurement for children enrolled in the CSHCS program, which is the focus of this case study.

Overview of Children's Special Health Care Services Program

Michigan's CSHCS program provides services and supports to CYSHCN throughout the state. CSHCS is part of Michigan's Title V CYSHCN program, which is administered by the Michigan Department of Health and Human Services (MDHHS). CSHCS serves children and youth up to the age of 21 who have chronic and complex physical conditions, as well as individuals 21 years old and older with cystic fibrosis and hemophilia. Eligibility for CSHCS is based on a diagnosis and the severity and chronicity of a child's condition. Children with developmental, behavioral, or intellectual conditions are not eligible for CSHCS. Because eligibility is driven by diagnoses and not income, CSHCS serves children enrolled in Medicaid, as well as the uninsured and privately-insured.¹

CSHCS assists its enrollees in accessing coordinated, family-centered, and community-based services, and helps cover the costs of specialty medical services related to the child's qualifying condition. In cases where the child is covered by Medicaid or private insurance, CSHCS serves as the payor of last resort per federal requirements under the federal Title V Maternal and Child Health Services Block Grant program. It also maintains the Children With Special Needs Fund to assist families in purchasing equipment and services, which may not be available through other funding sources, to support children's health, mobility, and quality of life.² Under CSHCS, local health departments in each county assist CYSHCN and their families in accessing community-based resources and provide care coordination.³ The local health departments are required to follow up with CSHCS enrollees at least once per year to ensure they are receiving the appropriate care and services and that their needs are being met. Additionally, CSHCS oversees the Family Center for CYSHCN (Family Center), a parent-directed network providing peer-to-peer support to families and assisting them in navigating the various systems serving their children.⁴

CSHCS and Medicaid

Approximately 70 percent of children enrolled in CSHCS are Medicaid beneficiaries. As of August 2017, 33,666 individuals were enrolled in CSHCS and 22,763 of them were also eligible for Medicaid. In FY 2013, Michigan transitioned children who were eligible for both CSHCS and Medicaid from fee-for-service (FFS) to managed care. The switch to managed care was designed to:

- Improve access to and better coordinate primary care for children enrolled in Medicaid and CSHCS;
- Provide case management and care coordination services;
- Increase access to mental health services and non-emergency transportation services; and
- Support enhanced quality monitoring.⁵

While some joint CSHCS-Medicaid enrollees remain in the FFS Medicaid program, the majority – 19,515 as of August 2017 – are enrolled in Medicaid Health Plans (MHPs), which is Michigan’s term for managed care organizations.⁶

Michigan’s MHPs help identify children who are eligible for CSHCS, conduct assessments to determine the care needs of enrollees, and provide targeted outreach and education to CSHCS enrollees. MHPs also are required to maintain provider networks that can serve CSHCS enrollees and establish agreements with the local health departments to coordinate care for the CSHCS enrollees. MHPs monitor and report their performance to MDHHS.⁷

Quality Measurement and Improvement Strategies

With the majority of Medicaid beneficiaries enrolled in managed care in Michigan, most of Michigan’s quality measurement activities are designed for its MHPs. All MHPs report on HEDIS measures selected by the state to assess and monitor the quality of care across all populations served, including CYSHCN. In 2016, the selected HEDIS measures covered the following eight domains: child and adolescent care, women – adult care, access to care, obesity, pregnancy care, living with illness, health plan diversity, and utilization.⁸

To measure the quality of care specifically for its CSHCS enrollees, Michigan Medicaid uses the Consumer Assessment of Healthcare Providers and Systems (CAHPS) 5.0 Child Medicaid Health Plan Survey with the Children with Chronic Conditions (CCC) measurement set. Michigan administers the survey to all CSHCS enrollees, including those enrolled in MHPs, Medicaid FFS, and non-Medicaid FFS, and compares results by insurance type.

The survey includes additional composite and individual measures that assess aspects of care, such as access to specialized services and prescription medicines, provider communication, and transportation. Michigan also developed and integrated several state-specific measures into the CAHPS survey to measure the experience of families with the Family Center and local health departments. The survey results are used to develop global ratings based on parent or caregiver ratings of five key areas: health plan, specialist seen most often, health care, children’s multi-disciplinary specialty (CMDs) clinics, and beneficiary help line.⁹

Michigan CSHCS and Medicaid use the CAHPS survey results to inform and guide quality improvement for its CSHCS enrollees in several ways.

- **Public reporting:** The results of the CAHPS survey are made public and the data are reported by MHPs, which allows health plans to see how they compare to one another and to promote improvement.
- **Programmatic oversight:** The results from the CAHPS surveys are reviewed in consultation with the CSHCS Advisory Committee, which has representatives from families of CYSHCN, pediatric hospitals, local health departments, and disease-specific advocacy organizations.¹⁰ The advisory committee uses the survey results to identify strengths and gaps in CSHCS and to determine if any programmatic changes are needed to improve the systems of care serving its enrollees.

Michigan also factors care quality for its CSHCS enrollees into its broader incentive strategies that are designed to drive improvements across all populations served by MHPs.

- **Auto-enrollment of new members:** MDHHS uses an algorithm to auto-enroll Medicaid members into MHPs if they have not selected an MHP by a designated date. The algorithm is designed to factor in a health plan's performance based on HEDIS and CAHPS surveys, including the CAHPS for CSHCS enrollees, when auto-enrolling individuals, with high-performing plans receiving more automatic assignments.
- **Incentive payments:** MDHHS has established a 1 percent capitation withhold from its payments to MHPs in order to create an incentive pool. The state defines benchmarks based on CAHPS, including the CAHPS for CSHCS enrollees, and HEDIS measures. If a plan meets or exceeds the benchmarks, they receive a share of the incentive pool. Michigan Medicaid also conducts focus studies to determine how well the MHPs are complying with the terms of their contract. Every other year, the focus studies examine the MHPs' compliance with CSHCS program requirements. The focus studies' findings are factored into apportioning the bonus payments available to MHPs from the incentive pool.

Additionally, MHPs are required to support population health management by using data analysis to address health disparities, improve community collaboration, and enhance care coordination and case management for targeted populations, including CSHCS enrollees. The state allows MHPs to define their own approach to population health management that utilizes data from a variety of sources, such as claims data, pharmacy data, and laboratory results, and incorporates measures for social determinants of health. MHPs are required to design targeted interventions for any subpopulation experiencing health disparities. MHPs must incorporate their population health management plan into their Quality Assessment and Performance Improvement (QAPI) program, which all MHPs are required to develop to assess and improve the quality of care provided to enrollees. MHPs submit semi-annual reports on the implementation of their population health management plans.¹¹

Collaboration between Michigan Title V and Medicaid to Improve Care for CYSHCN

In Michigan, CSHCS is housed within the state's Medicaid agency even though CSHCS is a distinct program and serves both Medicaid and non-Medicaid beneficiaries. Michigan Title V and Medicaid officials closely coordinate their program and policy activities to improve the systems serving CYSHCN throughout the state, which includes the use of shared measures and alignment of priorities. For example, Michigan Title V has selected the state performance measure, "percent of CYSHCN enrolled in CSHCS that receive timely medical care and treatment without difficulty," to assess the state's progress in reducing barriers, improving access, and increasing the availability of health services for CYSHCN, as part of the state's Title V Maternal and Child Health MCH Services Block Grant.¹² Michigan's Title V program uses data from the CAHPS survey of CSHCS enrollees as the basis for monitoring this state performance measure.

Another priority of the Michigan Title V program is increasing the "percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care," which is derived from the National Survey of Children with Special Health Care Needs (NS-CSHCN).¹³ Michigan Title V and Medicaid programs are developing a coordinated strategy to improve the state's performance on this measure, which involves educating and training both local health departments and MHPs in transition to adult care. This close collaboration has allowed for a comprehensive and streamlined approach to monitoring and improving the quality of care of CYSHCN.

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Appendix B: Implementing Quality Measurement and Improvement for CYSHCN in Three States

New York: Health Homes Serving Children

New York is in the midst of a substantial redesign of its health care payment and delivery systems under Medicaid. As part of this redesign, New York is implementing numerous, concurrent initiatives to improve health outcomes and the quality of care for its residents while containing costs. One initiative – Health Homes Serving Children (HHSC) – specifically addresses children with chronic and complex health and behavioral health care needs, and is the focus of this case study. However, other ongoing efforts in the state also impact children and youth with special health care needs, and provide important context for understanding the role of the HHSC program in New York’s evolving health care landscape.

New York’s Health System Transformation Landscape

In April 2014, the Centers for Medicare & Medicaid Services (CMS) approved the New York Medicaid Redesign Team’s (MRT) 1115 waiver amendment, which is designed to transform the state’s health care system, contain Medicaid’s cost, and ensure Medicaid enrollees have access to quality care. Through this waiver amendment, New York is able to reinvest \$8 billion in federal savings that will be generated by its comprehensive reforms. The centerpiece of the waiver amendment is the Delivery System Reform Incentive Payment (DSRIP) Program, which accounts for \$6.42 billion of the \$8 billion reinvestment dollars. Under DRSIP, New York aims to reduce avoidable hospital use by 25 percent through redesign of the state’s delivery system and promoting community-level collaboration among providers.¹ The state also is requiring its managed care plans to use value-based payment methodologies for at least 80 percent of its payments to providers by DRSIP’s fifth year of implementation in March 2020.²

As part of these broader health system transformation efforts, New York Medicaid has several initiatives to redesign health care systems for children. For example, the state will integrate children’s behavioral health services under Medicaid from a fee-for-service payment system into managed care effective July 2018. New York also will transition children from six of its Medicaid 1915(c) Home and Community Based Services (HCBS) waiver programs into managed care in July 2018, and its foster care population will be moved into managed care in January 2019.³ Each of these populations of children had previously been exempt from New York’s Medicaid managed care program. Children who are eligible for Home and Community Based Services will receive Health Home care management.

Overview of New York’s Health Homes Serving Children Program

In concert with its other health system transformation efforts, New York Medicaid launched the HHSC program in December 2016 to meet the needs of children with chronic and complex health and behavioral health needs. Health Homes is an optional state plan benefit under Section 2703 of the Affordable Care Act (ACA) that uses a care management model to support Medicaid enrollees with chronic and complex conditions. Six core services make up the cornerstone of the Health Home care management model:

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care
- Enrollee and family support
- Referrals to community and social supports
- Use of health information technology to link to services⁴

New York began its original Health Homes program in 2012 to serve adults. While children met the eligibility criteria for Health Homes, New York recognized that children and adults have unique care management needs and opted to create a tailored program just for children.⁵

Children enrolled in Medicaid are eligible for Health Home services if they have two or more chronic conditions, or one or more of the following qualifying conditions: HIV/AIDS, serious emotional disturbance (SED), or complex trauma.⁶ In addition to meeting one of these criteria, the intensive level of care management that Health Homes provide must be deemed appropriate for the needs of participating children. Examples of these needs include:

- The child is at-risk for an adverse event;
- The child has inadequate social/family/housing support, or serious disruptions in family relationships;
- The child does not adhere to treatments or has difficulty managing medications;
- The child has deficits in activities of daily living, learning or cognition issues; or
- The child has recently been released from incarceration, placement, detention, or psychiatric hospitalization.⁷

Enrollment in the HHSC program is voluntary – families must opt-in to be enrolled. Children in both Medicaid managed care and fee-for-service programs can participate in the HHSC program. However, the majority of eligible children are currently enrolled in managed care plans, and this will likely increase over time as New York transitions additional high-need populations, such as foster care youth, into managed care over the next several years.⁸

New York Medicaid’s Quality Measurement and Improvement Activities

Even before the implementation of the HHSC program, New York, in accordance with federal requirements,⁹ required all of its Medicaid managed care plans to report on quality measures across all populations of children, including those with special health care needs. These include broad measures such as well-child visits, adolescent care visits, childhood immunization status, children’s access to primary care providers, and experience of care, as measured by the CAHPS Health Plan Survey 5.0 – Child Version. New York Medicaid does not specifically stratify these measures by children with chronic and complex health and behavioral health needs. However, they require the use of several measures that would capture care quality for specific subgroups of children with chronic and complex health and behavioral health needs, such as asthma medication ratio, use of multiple concurrent antipsychotics in children and adolescents, and follow-up care for children prescribed ADHD medication.¹⁰ New York Medicaid anticipates these measurement requirements will change to accommodate the integration of behavioral health services and waiver programs, and will eventually include measures specifically targeted for children with the highest care needs.

While these managed care plan reporting requirements continue, New York is also developing quality measurement and improvement strategies tailored to children with chronic and complex health and behavioral health needs who are served by Health Homes.

New York’s Health Home Performance Management Program

New York has developed a comprehensive performance management program to improve health outcomes of Health Home members. Under this performance management program, all Health Homes, serving adults and children, are required to report on measures that were detailed in New York’s Health Home State Plan Amendment (SPA) and included in CMS’s Health Home Core Set of Quality Measures.

Health Homes serving children are also required to report on additional measures included in the HHSC application. Not all of the measures included in the SPA and CMS Health Home Core Set can be applied to children, therefore Health Homes serving children are exempt from reporting on those specific measures. New York is using these measures to track progress in achieving the long-term goals of the Health Homes program – increasing use of primary care providers and decreasing emergency department utilization and inpatient admissions/readmissions.¹¹ See Table 1 for the list of SPA measures on page 24.

New York also has developed a preliminary “Health Home Measures Subset,” which is a list of performance measures that are designed to support providers in moving toward the Health Home program’s long-term goals. The measures subset includes adult- and child-specific measures, as well as measures that can be applied to both children and adults. They reflect a mix of clinical and process measures, some of which are focused on members’ well-being and others (e.g., follow-up after emergency department visits, and all-cause readmission rates) are intended to assess the impact of care management activities. Health Homes have started reporting on several of these measures as of July 2017, and additional measures are being phased in over the next year. See Table 2 for the full list of subset measures on page 25.

In selecting these measures, New York used data that it was already collecting from providers and that are aligned with DSRIP measures to minimize provider reporting burden. New York anticipates that this list of measures will evolve over time as new data and measures become available, and the state hones its approach to quality improvement.¹² The state will review the quality measures recommended by the Children’s Health Subcommittee and Clinical Advisory Group to see if any should be included in Health Home measures subset. This group was convened to make recommendations to the state on an overall design for children’s value-based payment, including quality measures to be used as part of Medicaid value-based payments arrangements. Additionally, New York plans to expand the measures list to incorporate measures for individuals with intellectual and developmental disabilities (I/DD), who will be transitioned into Health Homes in 2018.

Another component of the performance management program is the Health Home re-designation process. Every three years, New York Medicaid will review each Health Home’s performance to determine whether they should continue to serve Health Home members. The determination is made based on the Health Home’s compliance with federal and state standards and requirements, including:

- Reporting requirements;
- Progress in reducing preventable hospitalizations and emergency room visits, and avoiding unnecessary care;
- Governance and operational integrity;
- Evidence of integration of care and improved outcomes for members; and
- Ability to participate in other state-based health reform activities, including behavioral health integration and DSRIP.¹³

Health Home Quality Management Program

In addition to reporting the measures described above to the state, all Health Homes must develop and maintain a Quality Management Program (QMP) that monitors, evaluates, and improves the quality of care for Health Home members. The QMP must define the Health Home’s approach to collecting and analyzing data that measure the following:

- Effectiveness of care coordination and chronic disease management on individual-level clinical outcomes (e.g., medical conditions, impact on health-related or general quality of life, resource utilization, etc.);
- Member satisfaction (e.g. timely appointments, easy access to information, good communication with care managers, etc.); and
- Quality of care outcomes at the population level (e.g., readmissions, etc.).

The Health Home measurement approach can build off the SPA Quality Measures and Health Homes measures subset and can include additional claims and encounters data, data from managed care plans, electronic health records, and care management software systems, among others. Health Homes must evaluate their QMP on an annual basis to measure progress towards their specified goals, identify areas for improvement, and determine changes for the QMP in the coming year. If any negative outcomes are identified through the review process, the Health Home must design and implement a Performance Improvement Plan (PIP) to determine the root cause of the issue and develop goals and a timeline for improvement.¹⁴

Health Homes and Value-based Payments

The current quality measurement activities are laying the groundwork for New York to eventually integrate Health Homes into the statewide transition to value-based payments, with the goal of holding Health Homes accountable for the quality of care and outcomes of their members. As New York solidifies its Health Home measurement approach, it is strengthening the ability of Health Home providers to provide and demonstrate value through the use of performance and outcome measures. As Health Home payments are folded into capitated managed care rates beginning in 2019, Health Homes will begin negotiating care management payments directly with managed care plans.

Bringing Health Homes into the managed care environment and focusing on quality measures for their target populations are two major steps required to prepare Health Homes to participate in and even lead to value-based payment arrangements within New York State Medicaid. New York officials continue to educate health plan administrators and providers about the transition to value-based payments. Having an understanding of how their activities contribute to the quality of care and outcomes of patients will position Health Homes well when entering these contract discussions. For the most complex and high-needs patients, the patient-centered care management approach Health Homes use aligns well with a transition towards value-based payment.

Cross-Agency Collaboration Among New York's Child-Serving Systems

New York has engaged a wide array of state partners in the design and implementation of its children's health system transformation initiatives, including the HHSC program. Representatives from the New York State Department of Health (DOH), Office of Mental Health (OMH), Office of Alcohol and Substance Abuse Services (OASAS), AIDS Institute (AI), Office for People with Development Disabilities (OPWDD), and Office of Children and Family Services (OCFS) are jointly leading the Children's Health and Behavioral Health Medicaid Redesign Team (MRT) Subcommittee, which is overseeing the implementation of the HHSC program and the child-serving systems being transitioned into Medicaid managed care. These agencies have collaborated in the development of standards and requirements for New York's managed care plans and Health Home programs, as well as the selection of quality measures to support these initiatives.

Additionally, the various state partners are working to align their programs, priorities, and strategies to provide a comprehensive, coordinated, seamless system of supports and services for children with chronic and complex health care needs. For example, New York’s Title V program has aligned its strategies under the Children with Special Health Care Needs domain of its 2017 Title V Maternal and Child Health Services Block Grant application with Medicaid’s HHSC program. Title V seeks to continue to provide subject matter expertise and support to the implementation of the HHSC program, particularly in improving care coordination and transition supports for its members. In light of the changing system for children with chronic and complex health care needs, the New York Title V program also plans to conduct a systematic analysis – including systems mapping – of the systems serving CYSHCN to identify gaps and barriers, and ensure that Title V’s activities are coordinating with and building on those provided by the HHSC program.¹⁵

Table 1: New York State Health Home State Plan Amendment Quality Measures

Goal 1: Reduce Utilization Associated with Avoidable (Preventable) Inpatient Stays	
<i>Clinical Outcomes Measures</i>	
Inpatient Utilization – General Hospital/Acute Care	
Goal 2: Reduce Utilization Associated with Avoidable (Preventable) Emergency Room Visits	
<i>Clinical Outcomes Measures</i>	
Ambulatory Care (Emergency Department Visits)	
Goal 3: Improve Outcomes for Persons with Mental Illness and/or Substance Use Disorders	
<i>Clinical Outcomes Measures</i>	<i>Quality of Care Measures</i>
Mental Health Utilization	Antidepressant Medication Management
Follow-up after Hospitalization for Mental Illness	Follow-up Care for Children Prescribed ADHD Medication
Follow-up after Hospitalization for Alcohol and Chemical Dependency Detoxification	Adherence to Antipsychotics for Individuals with Schizophrenia
	Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder
Goal 4: Improve Disease-Related Care for Chronic Conditions	
<i>Quality of Care Measures</i>	
Medication Management for People with Asthma	
Comprehensive Diabetes Care (HbA1c test and LDL-c test)	
Persistence of Beta-Blocker Treatment after Heart Attack	
Goal 5: Improve Preventive Care	
<i>Quality of Care Measures</i>	
Chlamydia Screening in Women	
Colorectal Cancer Screening	

Adapted from: “NYS Health Home SPA for Individuals with Chronic Behavioral and Medical Health Conditions,” New York State Department of Health, https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/docs/statewide_hh_quality_measures.pdf

Table 2: New York State Health Home Measure Subset

Applicable Population	Measure	Measure Steward
A/IDD	Adult Body Mass Index (BMI) Assessment	NCQA/HEDIS
A/IDD	Members Without Outreach (adults)	OQPS
C/IDD	Well-Child Visits in the 3 rd , 4 th , 5 th , & 6 th Year	NCQA/HEDIS
C/IDD	Adolescent Well-Care Visits	NCQA/HEDIS
C/IDD	Multiple Concurrent Antipsychotic Use in Children and Adolescents	NCQA/HEDIS
C/IDD	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA/HEDIS
C/IDD	Metabolic Monitoring for Children and Adolescents on Antipsychotics	NCQA/HEDIS
C/IDD	Members Without Outreach (children)	Salient
C/IDD	Time from Health Home Referral to Outreach/Enrollment	Salient
A/C/IDD	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence	NCQA/HEDIS
A/C/IDD	Follow-Up After Hospitalization for Mental Illness	NCQA/HEDIS
A/C/IDD	Follow-Up After Emergency Department Visit for Mental Illness (FUM)	NCQA/HEDIS
A/C/IDD	Viral Load Suppression	NYS Specific
A/C/IDD	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NCQA/HEDIS
A/C/IDD	Mental Health Utilization	NCQA/HEDIS
A/C/IDD	Medication management for people with asthma	NCQA/HEDIS
A/C/IDD	Plan All-Cause Readmission Rate	NCQA/HEDIS
A/C/IDD	Chronic Condition Hospital Admission Composite – Prevention Quality Indicator	AHRQ
A/C/IDD	At Risk – Lost to Follow-Up	OQPS
A/C/IDD	Inpatient Discharge Contact	OQPS
A/C/IDD	Response to Emergency Department	OQPS

A= Health Home Serving Adults

C=Health Home Serving Children

IDD = Health Home Serving Individuals with Intellectual/Developmental Disabilities

OQPS = Office of Quality and Patient Safety

Adapted from: "NYS Health Home Measure Subset," New York State Department of Health, https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/docs/measure_subset.pdf

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Appendix B: Implementing Quality Measurement and Improvement for CYSHCN in Three States

Texas STAR Kids

Overview of STAR Kids

In Texas, most Medicaid beneficiaries receive coverage through the state's Medicaid managed care programs. There are several managed care programs designed specifically to meet the unique health care needs of specific populations. The state's STAR program serves primarily children and pregnant women, STAR Health serves children in foster care, and STAR+PLUS serves adults with disabilities or people aged 65 or older. In November 2016, the state Medicaid agency – the Texas Health and Human Services Commission (HHSC) – launched STAR Kids, the managed care program serving children and youth with disabilities and complex conditions under the age of 21. STAR Kids integrates delivery of acute care, pharmacy, behavioral health, and long-term services and supports (LTSS) benefits, with the goal of promoting higher quality care, improving outcomes, and containing costs for this population.

Children and young adults who receive Supplemental Security Income (SSI) or who receive services through the state's Medically Dependent Children Program waiver are mandatorily enrolled in STAR Kids, which provides Medicaid-covered services including acute care services, LTSS, and service coordination. Children and young adults with disabilities who reside in long-term care institutions or receive services through 1915(c) waiver programs (e.g., Home and Community-Based Services, or Youth Empowerment Services) are also enrolled in STAR Kids, however, STAR Kids only provides acute care services and care coordination. Long-term services and supports are carved out and continue to be provided through the institution or waiver program.¹ As of June 2017, approximately 161,950 children and young adults were enrolled in STAR Kids.

Quality Measurement and Improvement Strategies

Texas has a multi-pronged approach to driving improvements through quality measurement for children and young adults enrolled in STAR Kids. The quality improvement strategies for STAR Kids are modeled after those that already exist in Texas's other Medicaid managed care programs. However, the STAR Kids measures are tailored to address the needs of the children it serves. The STAR Kids quality improvement strategies are being phased in over several years to give managed care organizations (MCOs) time to better understand the needs of this population and establish baselines that the state can use to assess MCOs' future performance.

Pre- and Post-Implementation Studies

The state Medicaid agency's external quality review organization (EQRO) is currently implementing pre- and post-implementation studies of the children and young adults enrolled in STAR Kids. The pre-implementation study, which EQRO conducted prior to the launch of STAR Kids, provides baseline measures evaluating utilization, access, and satisfaction. HHSC will use these baseline measures to monitor the STAR Kids program and identify aspects of care that should be targeted for improvement. In 2018, 18 months after the launch of STAR Kids, the EQRO will conduct the post-implementation study to assess the performance of STAR Kids during its first year of implementation and evaluate how MCOs compare. HHSC will use the results of the studies to determine which measures will be integrated into future quality improvement activities, and assess the impact of the STAR Kids programs on the quality of care provided to enrollees and their outcomes over time.

The pre- and post-implementation studies include both a survey of caregivers and an analysis of administrative measures for STAR Kids enrollees. The caregiver survey tool uses questions from the Consumer Assessment of Healthcare Providers and Systems Health Plan Survey for Children with Chronic Conditions and the National Survey of Children with Special Health Care Needs. The survey questions are centered on measuring caregiver experience and satisfaction with care their child has recently received, including aspects of shared-decision making, care coordination, person-centered care, and transition to adult care.

The EQRO also is using claims and encounter data to assess utilization, access, and effectiveness of care in the following four domains: primary and preventive care, care for respiratory conditions, behavioral health care, and potentially preventable events. The selected measures include those from the CMS Child Core Set, Healthcare Effectiveness Data and Information Set (HEDIS), the Agency for Healthcare Research and Quality (AHRQ) Pediatric Quality Indicators, and 3M measures of potentially preventable events (PPEs).²

Table 1. STAR Kids Pre-Implementation Administrative Measures

Measurement domain	Measure name (abbreviation)	Measure steward
Primary and preventive care	Developmental Screening in the First Three Years of Life (DEV) ^a	OHSU ^b
	Well-Child Visits in the First 15 Months of Life (W15) ^a	NCQA
	Well-Child Visits in the 3 rd , 4 th , 5 th , and 6 th Years of Life (W34) ^a	NCQA
	Adolescent Well-Care Visit (AWC) ^a	NCQA
Care for respiratory conditions	Appropriate Testing for Children with Pharyngitis (CWP)	NCQA
	Medication Management for People with Asthma (MMA) ^a	NCQA
Behavioral health care	Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (ADD) ^a	NCQA
	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC) ^a	NCQA
	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	NCQA
	Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) ^a	NCQA
	Follow-Up After Hospitalization for Mental Illness (FUH) ^a	NCQA
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	NCQA
	Potentially preventable events	PDI – Asthma (PDI 14)
	PDI – Diabetes Short-Term Complications (PDI 15)	AHRQ
	PDI – Gastroenteritis (PDI 16)	AHRQ
	PDI – Perforated Appendix (PDI 17)	AHRQ
	PDI – Urinary Tract Infection (PDI 18)	AHRQ
	Potentially Preventable Admissions (PPA)	3M
	Potentially Preventable Readmissions (PPR)	3M
	Potentially Preventable Emergency Department Visits (PPV)	3M

^a Measure is part of the 2017 CMS Core Measures Set for CHIPRA Reporting.

^b OHSU = Oregon Health and Science University

Source: Texas Medicaid Managed Care: STAR Kids Program Focus Study Pre-implementation Descriptive Report. May 2017.

Performance Improvement Projects

Additionally, STAR Kids MCOs began implementing targeted performance improvement projects (PIPs) for this population in 2017. All Medicaid MCOs are required by federal law to conduct PIPs, and the PIPs must be designed to drive improvements in both clinical and non-clinical areas. The state Medicaid agency, in coordination with the EQRO, identifies PIP topics based on an MCO's performance. For STAR Kids, many of the 2017 PIPs focused on implementing a screening and assessment instrument to identify the needs of the children and young adults enrolled in the program, and connecting them to additional services and supports based on those results. Data from the first year of STAR Kids implementation and results from the first year of PIPs will help guide the state's ongoing quality improvement activities.

PIPs also are integrated into each MCO's Quality Assessment and Performance Improvement (QAPI) Program, which the STAR Kids MCOs are required to develop on an annual basis. The QAPI plans are designed to improve clinical and nonclinical processes and outcomes for their STAR Kids population, and must include annual goals and objectives and mechanisms for oversight of quality activities. MCOs must also integrate behavioral health services into the QAPI program, and evaluate improvements in physical health outcomes resulting from behavioral health integration. Each year, MCOs develop a QAPI Program Annual Summary that they submit to EQRO for review.³

Future Quality Improvement Activities

While STAR Kids is in the early stages, HHSC plans to expand its quality improvement activities to include the following initiatives over the next several years. These quality improvement activities will be aligned with those currently in use in other managed care programs.

- **MCO report cards:** Beginning in 2019, the state Medicaid agency will release an annual report card for each of the STAR Kids MCOs. The report cards, which are already in place for the other managed care programs,⁴ will use a three-star rating system to grade each MCO's performance on a variety of HEDIS and care satisfaction survey measures. This quality initiative is designed to help STAR Kids enrollees and their families choose the health plan that would best fit their needs and provide them with high-quality care.
- **Performance indicator dashboards:** By 2018, HHSC will develop and implement a performance indicator dashboard to assess important aspects of MCO performance.⁵ Similar to dashboards for other programs such as STAR, STAR+PLUS, and CHIP, these dashboards will be shared publicly to hold MCOs accountable to certain measurable benchmarks. Additionally, incentives and disincentives may be attached to some of the dashboard measures in coming years.
- **Pay for quality (P4Q):** In the medical P4Q program, 3 percent of the MCOs capitation (payment) is at-risk. MCO performance is evaluated in three ways:
 - Performance against self (comparison of an MCO's performance to its prior year);
 - Performance against benchmarks (comparison of an MCO's performance against Texas and national peers); and
 - Bonus pool measures.

Utilizing performance against self and performance against benchmarks allows HHSC to reward high-performing plans while still incentivizing plans to improve regardless of their current level of performance. Plans can earn or lose money based on their performance against self and performance against benchmarks. Any money remaining after recoupments and distributions is placed in a bonus pool. MCOs can earn rewards if they meet a separate set of bonus pool measures, which allow HHSC to encourage improvement with no financial risk to the health plans.

Stakeholder Engagement

Stakeholder engagement has been incorporated into the various aspects of STAR Kids development and implementation. The STAR Kids Medicaid Managed Care Advisory Committee, which includes representation from health plans, advocacy organizations, families of children chronic and complex health care needs, and providers, provides advice and guidance on critical policies related to implementation of STAR Kids.⁶ Additionally, the Policy Council for Children and Families, comprised of family members of children with disabilities and other community organizations, has provided recommendations to HHSC to ensure that STAR Kids is advancing care for children with disabilities and that its incentive programs are tailored to the unique needs of this population.⁷

HHSC will continue to use input from key stakeholders, including family partners, as they phase in quality measurement activities. Stakeholders will advise on selection of quality measures and the design of the STAR Kids MCO report cards to ensure they capture the information families need to make informed plan selections. Family experience and satisfaction with care will also be a key component of all quality measurement activities under STAR Kids.

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