

feasibility. MRMIB has organized its comments to indicate the measures MRMIB currently collects from its contracted HFP plans, the measures MRMIB may be able to collect if additional federal funding was provided, and the measures MRMIB would not be able to report.

MRMIB recommends that states report results for their Medicaid and CHIP programs separately. MRMIB has found, in general, plan performance is higher for the HFP population than for the Medicaid population enrolled in managed care plans in California, even though HFP and Medi-Cal contract with many of the same managed care plans. MRMIB would like to be able to evaluate the performance of the HFP compared to CHIP programs in other states. It would be helpful to know if there is a difference in performance between CHIP and Medicaid in other states as well and, if so, to identify the reasons why the performance varies based on the payor and to share best practices on how to bridge any performance gaps.

I. Measures Presently Collected by the California CHIP (Healthy Families Program)

Of the 24 proposed core measures, MRMIB currently collects 10 measures from HFP contracted health and dental plans. Those are:

- Childhood Immunization Status
- Immunizations for Adolescents
- Chlamydia Screening for Women
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the 3rd, 4th, 5th and 6th years of life
- Adolescent Well-Child Visits (12-21 years of age)
- Total Eligibles Receiving Preventive Dental Services
- Pharyngitis – Appropriate Testing
- Total EPSDT Eligibles who Received Dental Treatment Services
- Children and Adolescents' Access to Primary Care Practitioners (PCP), all ages

MRMIB recommends that these measures continue to be collected across all state Medicaid and CHIP programs and the results for Medicaid and CHP programs be reported separately.

MRMIB has specific comments on the following measures:

- **Total Eligibles Receiving Preventive Dental Services**

MRMIB supports having a measure regarding preventive dental care, but recommends that it not be tied to EPSDT. The Background Report accompanying the federal register notice stated that the denominator for this measure is the number of children eligible for EPSDT. The HFP is a separate program from California's Medicaid program and HFP does not provide or report EPSDT services. However, HFP covers preventive dental

services and requires the contracted dental plans to report on preventive services provided to enrolled children. The specification HFP uses is the percentage of children enrolled in dental managed care plans for at least 11 of the past 12 months who received any preventive dental service (D1000-D1999) in the measurement year. CMS should revise the specifications to accommodate separate CHIP programs that do not provide EPSDT services.

- **Total EPSDT Eligibles who Received Dental Treatment Services**

MRMIB supports having a measure to assess dental treatment services, but again recommends that it not be tied to EPSDT. As noted above, the HFP, as a separate CHIP, does not provide or report EPSDT services. MRMIB understands that tying the measure to EPSDT will allow states that do not use managed care plans to provide dental care will be able to report this measure. All children enrolled in HFP in California are enrolled in a dental managed care plan. MRMIB requires the contracted dental plans to report on dental treatment services provided to enrolled children. The specifications MRMIB uses is the percentage of members enrolled for at least 11 of the past 12 months who received any dental treatment, other than diagnostic or preventive services, in the measurement year. CMS should revise the specifications to accommodate separate CHIP programs that do not provide EPSDT services.

II. Measures MRMIB May Collect if CMS Provides Additional Funding

MRMIB may be able to collect and report 9 of the proposed core measures although the ability to do so would depend on the availability of additional federal funds to cover the increased costs associated with collecting these measures:

- Frequency of Ongoing Prenatal Care
- Timeliness of Prenatal Care
- Cesarean Rate for Low-Risk First Birth Women
- Weight Assessment for Children/Adolescents
- Screening using standardized screening tools for potential delays in social and emotional development.
- Otitis media with effusion
- Emergency Department (ED) utilization
- Annual number of asthma patients with >1 asthma related ER visits
- CAHPS Health Plan Survey 4.0, including supplements for Children with Chronic Conditions and Medicaid Plans

MRMIB has the following comments on these measures:

- **Frequency of Ongoing Prenatal Care; Timeliness of Prenatal Care; and Cesarean Rate for Low-Risk First Birth Women**

The Background Paper is inconsistent as to whether these measures are Medicaid only or are to be applied to both Medicaid and CHIP. For example, the Timeliness of Prenatal Care measure does not specify whether this is applied to a Medicaid-only population or to Medicaid and CHIP. The denominator for Frequency of Ongoing Prenatal Care is specific to Medicaid but the Cesarean Rate for Low-Risk First Birth Women is not. CMS should clarify whether these measures pertain to Medicaid only or Medicaid and CHIP, taking into consideration that some states operate stand-alone CHIP programs.

The HFP is a stand-alone CHIP, and although there are teens under age 19 in the program who become pregnant, the numbers are relatively small and may not be statistically significant for reporting. MRMIB would not require its plans to collect and report this data unless additional federal funding is provided.

- **Weight Assessment for Children/Adolescents**

The Background Report states this is the new NCQA measure that assesses the number of children ages 2-18 who had at least one outpatient visit with a PCP or OB/GYN during the measurement year whose medical record documents that a Body Mass Index (BMI) assessment was performed during a visit. This description of the measure does not include counseling, which is a component of the HEDIS specifications, so CMS should clarify whether this measure is the HEDIS measure and if so, restate the specifications to mirror the HEDIS specifications. For those plans and states that already collect and report the HEDIS specifications, the cost for reporting would be less than if they had to accommodate a different specification to report this measure for children. Without the counseling component, this measure is only a process measure. Since this measure requires a medical record review, MRMIB recommends that the indication that counseling was provided be included in the specification. If counseling was provided, it should be noted in the medical record.

While MRMIB agrees that assessing BMI in children is a good place to start, this alone is too low a standard. The measure should be expanded to include reporting on the actual BMI so this information could be tracked over time. MRMIB is concerned about the lack of standardization in how BMI is measured, such as kids being measured with their shoes or clothes on. This is important because counseling is triggered based on the BMI.

MRMIB would not be able to collect and report this measure which currently would require medical chart review, without additional federal financial support.

- **Screening using standardized screening tools for potential delays in social and emotional development**

MRMIB is pleased that the proposed core measure set includes a screening standard and believes this should remain in the final core set. However, MRMIB is concerned about the cost of the screening tools and how providers would be reimbursed for the time required to administer the tool. It could be quite costly both to purchase the tool and incentivize providers to use it. CMS should recommend several easy-to-administer tools such as those that could be completed by parents, as opposed to more complex tools like the Denver tool which is very labor intensive. The contracted health plans do not have the resources to collect the information or to provide incentives to providers to conduct the assessment without additional funding.

MRMIB would not be able to collect and report this measure without additional federal financial support.

- **Emergency Department (ED) Utilization**

The Background Report indicates the intent of this measure is to reduce unnecessary ED visits. MRMIB believes that a better measure would be to evaluate appropriate vs. inappropriate/avoidable use of the ED. The measure should be refined to separate by diagnosis ED use.

MRMIB recommends that the measure as currently constructed not be included in the final core set, but rather include an ED utilization measure to assess whether the ED visit was for a service that should or could have been provided in a less expensive and less intensive setting.

MRMIB would need additional federal financial support to cover plan costs to report this data.

- **Annual number of asthma patients (age 1 or older) with 1 or more asthma-related ER visits**

MRMIB agrees that a measure addressing the management of asthma in children is important to include in the core set. However, MRMIB believes that the more important issue related to asthma is whether the child is on a controller medication. Based on the specifications described in the Background Report, it appears that the denominator includes treatment with at least 2 beta adrenergic agents. MRMIB supports including an indication that a prescription for controller medication was filled.

MRMIB recommends that this measure be revised to include children over the age of 2 rather than age 1 or older because it is difficult to make a diagnosis of asthma in a child under the age of 2. The asthma measure used by the Joint Commission is for children over the age of 2.

MRMIB agrees that a measure related to asthma that can be reported administratively without medical chart review, should be included in the core set. However, MRMIB would need additional federal funding to report this data.

- **CAHPS Health Plan Survey 4.0, including supplements for Children with Chronic Conditions and Medicaid Plans**

MRMIB last conducted the CAHPS survey in 2007 and at that time included the supplement for Children with Chronic Conditions. Due to state funding limitations, MRMIB has not had the resources to conduct CAHPS since. MRMIB would need additional federal funding to be able to conduct the CAHPS in 2010.

III. Measures MRMIB Could Not Collect or Report

There are 5 proposed core measures that MRMIB could not report. These are:

- Pediatric catheter associated blood stream infection rates
- Follow-up care for children prescribed attention deficit/hyperactivity disorder (ADHD) medication
- Annual hemoglobin A1C testing
- Follow-up after hospitalization for mental illness
- Percent of live births weighing less than 2,500 grams

The HFP "carves out" from its contracted health plans, two types of services – services to treat children with Serious Emotional Disturbances (SED), and services to children with certain chronic conditions who are eligible for the California Children's Services (CCS) Program. CCS arranges and pays for specialized services to children with certain chronic conditions. These services are delivered outside of the HFP plans' provider networks. Plans identify children who may be eligible for services either through the county mental health departments (for services to treat SED) or county CCS programs and refer those children to the counties for assessments. If the county mental health department or CCS program determines a child eligible for one of these programs, the county then provides services for those conditions and the HFP plan continues to provide all other health services unrelated to the SED or CCS condition.

Due to the nature of the carve outs, under which plans do not provide most of the services to children with SED or with chronic conditions, MRMIB could not collect or report the following measures:

- **Pediatric catheter associated blood stream infection rates**

Under the CCS carve out, many, if not all, ICU and high risk infants would likely be referred to CCS. MRMIB would not be able to collect or report data on this measure. While this "never event" would be important to track, plans can not be held responsible for the rate of infections because accountability for ensuring these infections do not occur would be with hospitals, not with managed care plans.

While this measure is important to address from a public health perspective, the measure should not be included in the core set unless CMS obtains this data from hospitals directly. In California, such data may be available through the Office of Statewide Health Planning and Development (OSHPD), a department separate from both the CHIP and Medicaid programs.

- **Follow-up care for children prescribed attention deficit/hyperactivity disorder (ADHD) medication**

Many of the children enrolled in the HFP who have been diagnosed with ADHD are likely receiving services through county mental health departments and not through the HFP plans. This is because HFP "carves out" services for children who have SED to county mental health departments. County data is underreported and neither MRMIB nor the HFP plans have authority to hold county mental health departments accountable for services to treat children with SED or require counties to report this data.

While MRMIB agrees that follow-up care for children prescribed ADHD medication is important, this is not a measure that California could report for its CHIP population.

- **Annual hemoglobin A1C testing**

Diabetes is a CCS-eligible condition. Children diagnosed with diabetes are generally served through the CCS program and MRMIB does not have access to the CCS claims data. MRMIB does not have authority to hold the CCS program accountable for services to treat children CCS-eligible conditions or require counties to report this data.

However, if this measure remains in the core set, MRMIB recommends that the specifications for this measure include documentation of at least two determinations annually because testing only once per year is not an indicator of good management of diabetes. Also, in the event a child is tested more than once in a year, the specifications should indicate which value should be submitted (the best, worst or average).

- **Follow-up after hospitalization for mental illness**

MRMIB collected data for this measure in prior years, but found the measure not to be a good indicator of service utilization for HFP members because services to children with SED are carved out of health plan services and are provided primarily under county mental health departments. Most of the children who are hospitalized for mental illness typically fall under this category.

Because of the carve out, MRMIB was unable to collect and report data for these children. MRMIB currently requires plans to report the Mental Health Utilization HEDIS measure which includes inpatient, intensive outpatient and outpatient/ED mental health services provided by the plans. Plans provide services to treat mental health conditions that are not SED. This at least provides an idea of the volume of non-SED mental

health services provided by the plans, though it does not provide any indication of changes in outcomes as a result of services provided.

- **Percent of live births weighing less than 2,500 grams**

The Background Report indicates that this measure is derived from State-reported birth certificate data compiled in the National Vital Statistics System (NVSS). If that is the source of data, and CMS is not going to rely on plans or state CHIP or Medicaid programs to report this, then there should be no additional costs to the HFP. MRMIB has no opinion on whether this should be included in the final core set.

IV. Technical Assistance CMS Could Provide

The federal register notice seeks public comment on the nature of technical assistance and other resources required before State Medicaid and CHIP programs and health care providers can be expected to implement and report on these measures.

The primary resource MRMIB and other CHIP programs need is funding. In California, the state's dire financial situation has resulted in a Governor's budget proposal to reduce eligibility for HFP from 250 percent of the federal poverty level (FPL) to 200 percent FPL. If this proposal is adopted, more than 200,000 children in California will lose health coverage. Furthermore, HFP plans have not received a rate increase in several years and, actually have had their rates cut twice recently. Several plans are proposing service area reductions in the upcoming benefit year. Neither CMS nor MRMIB can expect plans to take on additional data collection and reporting obligations without increased federal funding.

Technical assistance CMS could provide would be to focus any new measure development on those which can be reported administratively. MRMIB is very concerned about the increased cost associated with requiring the contracted plans to report additional measures, particularly for those measures that will require chart reviews. Chart reviews are very expensive and labor intensive to complete. The HFP plans simply do not have the resources available to report new hybrid measures without a significant increase in federal financial support.

MRMIB recommends that, in developing new measures, CMS focus more on outcomes measures rather than process measures.

MRMIB recommends that there be a national database/warehouse where all states' data is collected and stored similar to the National CAHPS Benchmarking Database (NCBD) and NCQA's Quality Compass. The data warehouse should be accessible for states and programs to compare results as well as for research purposes.

CMS also could provide technical assistance on how states and Medicaid and CHIP programs can collect and report data by race/ethnicity/language in order to identify health disparities among sub-populations. MRMIB currently publicly reports

MRMIB Comments on Initial, Recommended Core Set of
Children's Healthcare Quality Measures

March 1, 2010

Page 9 of 10

HFP results by demographic variables including spoken language, ethnicity, income level and geographic region. Other states should do the same. CMS could convene a group of state Medicaid and CHIP programs to develop guidelines for states on how to identify health disparities within their enrolled populations.

In summary, MRMIB recommends the following remain in the core set of children's healthcare quality measures for voluntary use by Medicaid and CHIP programs:

- Childhood Immunization Status
- Immunizations for Adolescents
- Chlamydia Screening for Women
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the 3rd, 4th, 5th and 6th years of life
- Adolescent Well Child Visits (12 – 21 years of age)
- Total Eligibles Receiving Preventive Dental Services
- Appropriate Testing for Pharyngitis
- Total EPSDT Eligibles who Received Dental Treatment Services
- Children and Adolescents' Access to Primary Care Practitioners (PCP), all ages

MRMIB supports inclusion of the following in the final core set, with some suggested modifications, but, as noted above, would not be able to report these measures unless additional federal financial support was provided:

- Frequency of Ongoing Prenatal Care
- Timeliness of Prenatal Care
- Cesarean Rate for Low-Risk First Birth Women
- Weight Assessment for Children/Adolescents (if counseling is included in the specifications and a standard for measuring BMI is established)
- Screening using standardized screening tools for potential delays in social and emotional development (if easy-to-administer tools are recommended)
- Otitis media with effusion
- Emergency Department (ED) utilization (if changed to assess appropriate vs. inappropriate ED utilization)
- Annual number of asthma patients with >1 asthma related ER visits (if the age is changed to 2 or older and the specifications include indication that a prescription for controller medication was filled)
- CAHPS Health Plan Survey 4.0, including supplements for Children with Chronic Conditions and Medicaid Plans

MRMIB would not be able to report the following measures, primarily because responsibility for tracking or providing these services is done outside of the HFP managed care delivery system:

- Pediatric catheter associated blood stream infection rates

MRMIB Comments on Initial, Recommended Core Set of
Children's Healthcare Quality Measures

March 1, 2010

Page 10 of 10

- Follow-up care for children prescribed attention deficit/hyperactivity disorder (ADHD) medication
- Annual hemoglobin A1C testing
- Follow-up after hospitalization for mental illness

MRMIB has no opinion on whether the following measure should be included in the final core set:

- Percent of live births weighing less than 2,500 grams

Thank you for the opportunity to comment on the initial, recommended core set of children's healthcare quality measures.

Please direct any questions on these comments to:

Shelley Rouillard, Deputy Director
Benefits and Quality Monitoring Division
Managed Risk Medical Insurance Board
(916) 323-4130
srouillard@mrmib.ca.gov