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Findings from the CHIPRA Quality Demonstration Grant Program

September 17, 2015

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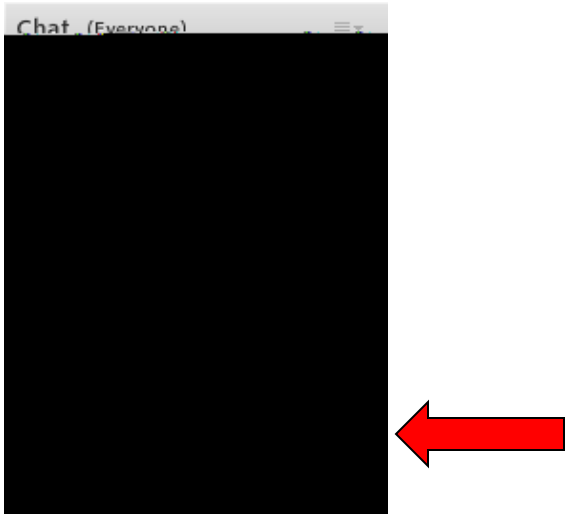

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Agenda

Welcome and Introduction

Core Set of Children's Health Care Quality Measures for Medicaid and CHIP: Lessons from the CHIPRA Quality Demonstration Grant Program

Anna Christensen, Ph.D., Senior Health Researcher, Mathematica Policy Research

SC Medicaid-USC Partnership: Implementing CHIPRA Core Measures in South Carolina

Kathy Mayfield Smith, MA, MBA, Associate Director, Medicaid Policy Research, USC Institute for Families in Society

Implementing Child Health Measures at the State and Practice-level: Lessons Learned through Maine's Improving Health Outcomes for Children CHIPRA Quality Demonstration Grant

Kimberley Fox, MPA, Senior Research Associate, Cutler Institute for Health and Social Policy, Muskie School of Public Service, University of Southern Maine

Elizabeth Hill, Centers for Medicare and Medicaid Services

Q+A and Discussion

Current SUPLN Members

California (UCSF, UCD, UCLA)

Connecticut

Delaware

Florida

Georgia

Iowa

Kentucky

Maine

Maryland

Massachusetts

Michigan (MSU, UM)

Minnesota

New Hampshire

New Jersey

Ohio

Pennsylvania

South Carolina

Wisconsin

Lessons from the CHIPRA Quality Demonstration Grant Program

Anna L. Christensen, Ph.D., Senior Health Researcher,
Mathematica Policy Research

Background on the CHIPRA Quality Demonstration Grants and the CMS Child Core Set

Evaluation Findings and Lessons Learned from the CHIPRA Quality Demonstration Grant Program

How are Demonstration States ?0on rø̄n Set

Congressionally mandated by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

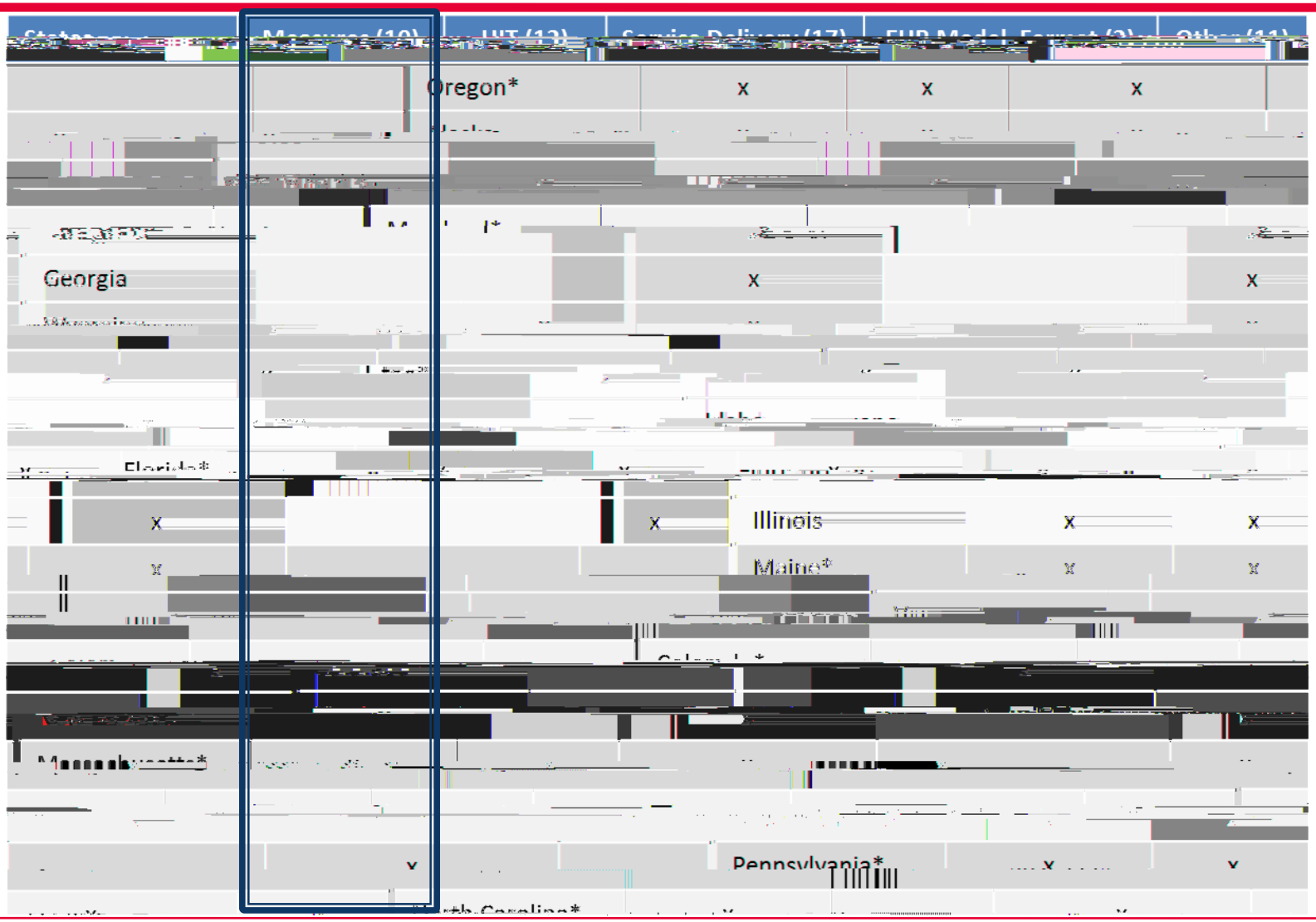
- $100 million program
- One of the largest federally funded efforts to focus on health care for children

Five-year grants awarded by CMS

- 10 grants, including multi-State partnerships (18 States total)
- February 2010–February 2015, with some extensions
- $9 to $11 million per grantee

National evaluation

- CMS funding, AHRQ oversight
- August 2010–September 2015
- Mathematica, Urban Institute, AcademyHealth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- **Set of measures for voluntary annual reporting by Medicaid and CHIP agencies (24 measures in 2015)**
- **Annual updates to measures based on review and public comment**
- **Measure areas**
  - **Access to care, preventive care, maternal and perinatal health, behavioral health, care of acute and chronic conditions, oral health, experience of care**
- **Fills a gap by providing a uniform set of state-level quality measures for children's care**

NQF #		

NQF #	Measure Steward	Measure Name
Maternal and Perinatal Health		
0139	CDC	Pediatric Central Line-Associated Bloodstream Infections Neonatal Intensive Care Unit and Pediatric Intensive Care Unit (CLABSI)
0471	TJC	PC-02: Cesarean Section (PC02)
1382	CDC	Live Births Weighing Less Than 2,500 Grams (LBW)
1391	NCQA	Frequency of Ongoing Prenatal Care (FPC)
1517	NCQA	Prenatal & Postpartum Care: Timeliness of Prenatal Care (PPC)
NA	AMA-PCPI	Behavioral Health Risk Assessment (for Pregnant Women) (BHRA)
Behavioral Health		
0108	NCQA	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)
0576	NCQA	Follow-Up After Hospitalization for Mental Illness (FUH)
1365	AMA-PCPI	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (SRA)

NQF #	Measure Steward	Measure Name
Care of Acute and Chronic Conditions		
0024	NCQA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents Body Mass Index Assessment for Children/Adolescents (WCC)
1799	NCQA	Medication Management for People with Asthma (MMA)
NA	NCQA	Ambulatory Care Emergency Department (ED) Visits (AMB)
Oral Health		
2508	DQA (ADA)	Prevention: Dental Sealants for 6 9 Year-Old Children at Elevated Caries Risk (SEAL)
NA	CMS	Percentage of Eligibles Who Received Preventive Dental Services (PDENT)
Experience of Care		
NA	NCQA	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H (Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items) (CPC)

Measures that states report to CMS should include data on entire population of children in Medicaid/CHIP in the state

Two-thirds are based on HEDIS health plan measures

Data sources

- **Primarily Medicaid/CHIP administrative data (enrollment and claims or managed care encounters)**
- **Some measures can use HEDIS hybrid methods (administrative data plus medical chart review)**
- **Some perinatal measures require vital records data**
- **States can link to other administrative data sources, including immunization registries**
- **One survey-based measure (CAHPS)**
- **Two EHR measures added in 2013 and 2015**

Technical specifications manual available online:
www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf

and CHIP (Child Core Set)

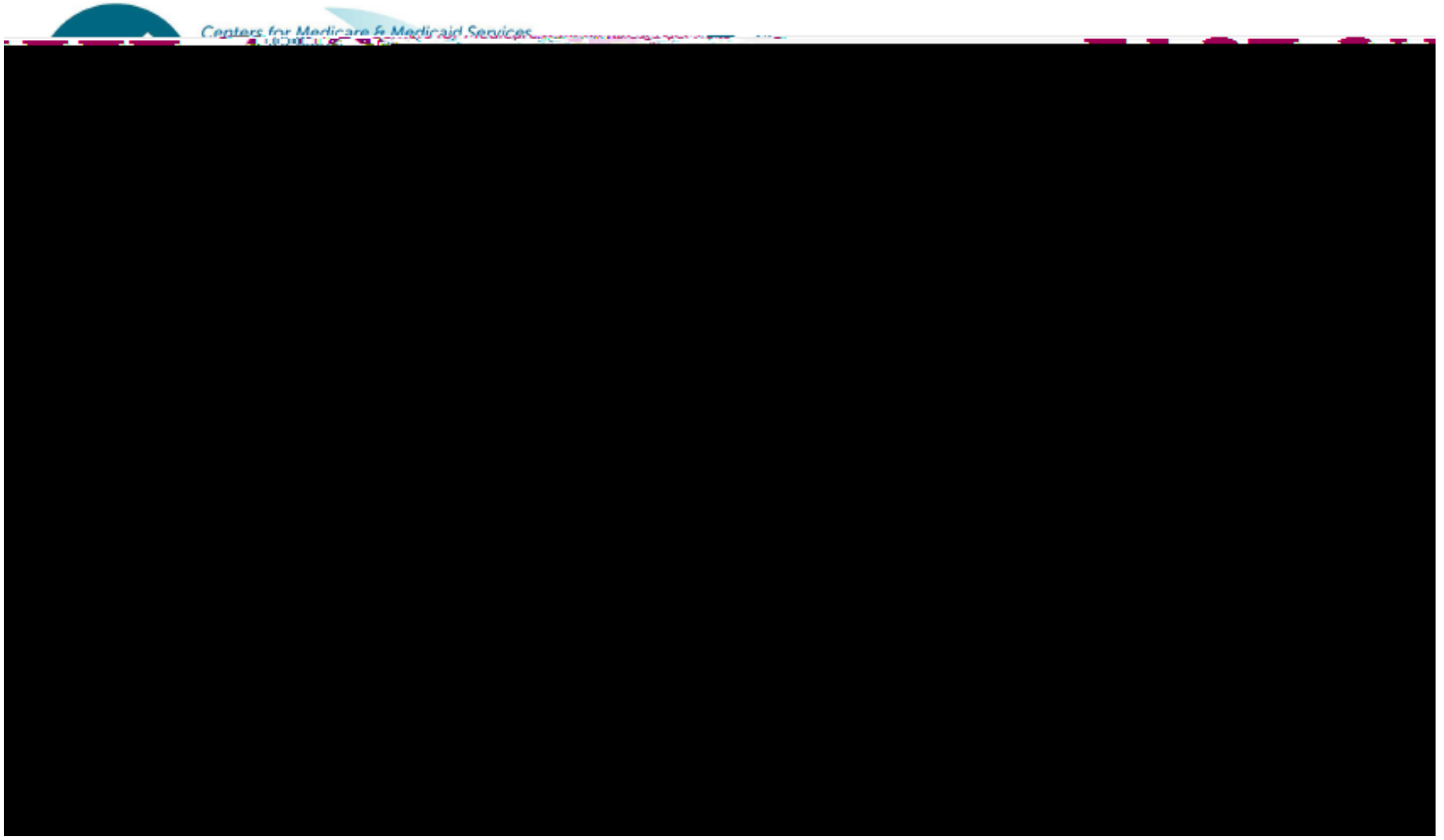
Technical Specifications and Resource Manual for
Federal Fiscal Year 2015 Reporting

Medicaid/CHIP Health Care Quality Measures Technical Assistance (TA) and Analytic Support Program

Established by CMS in 2011 as a capacity-building program

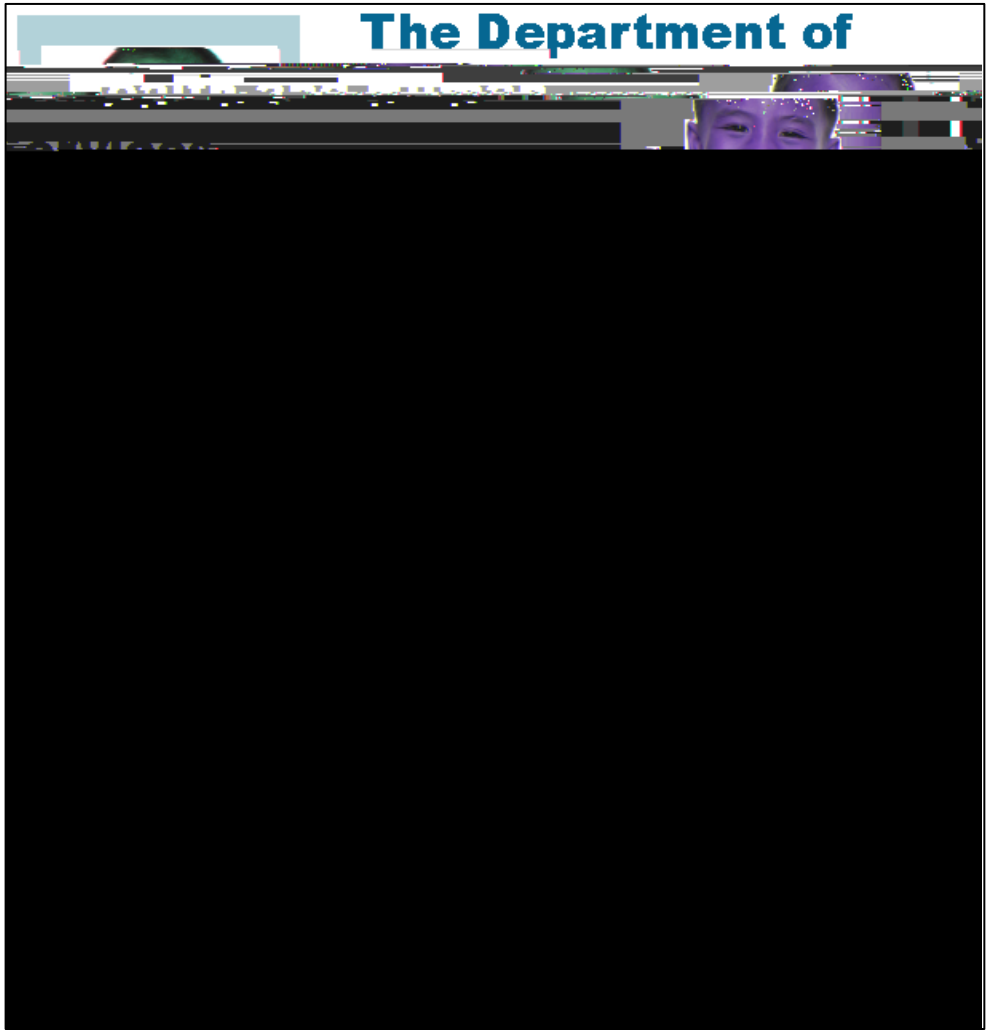
TA available to all states via:

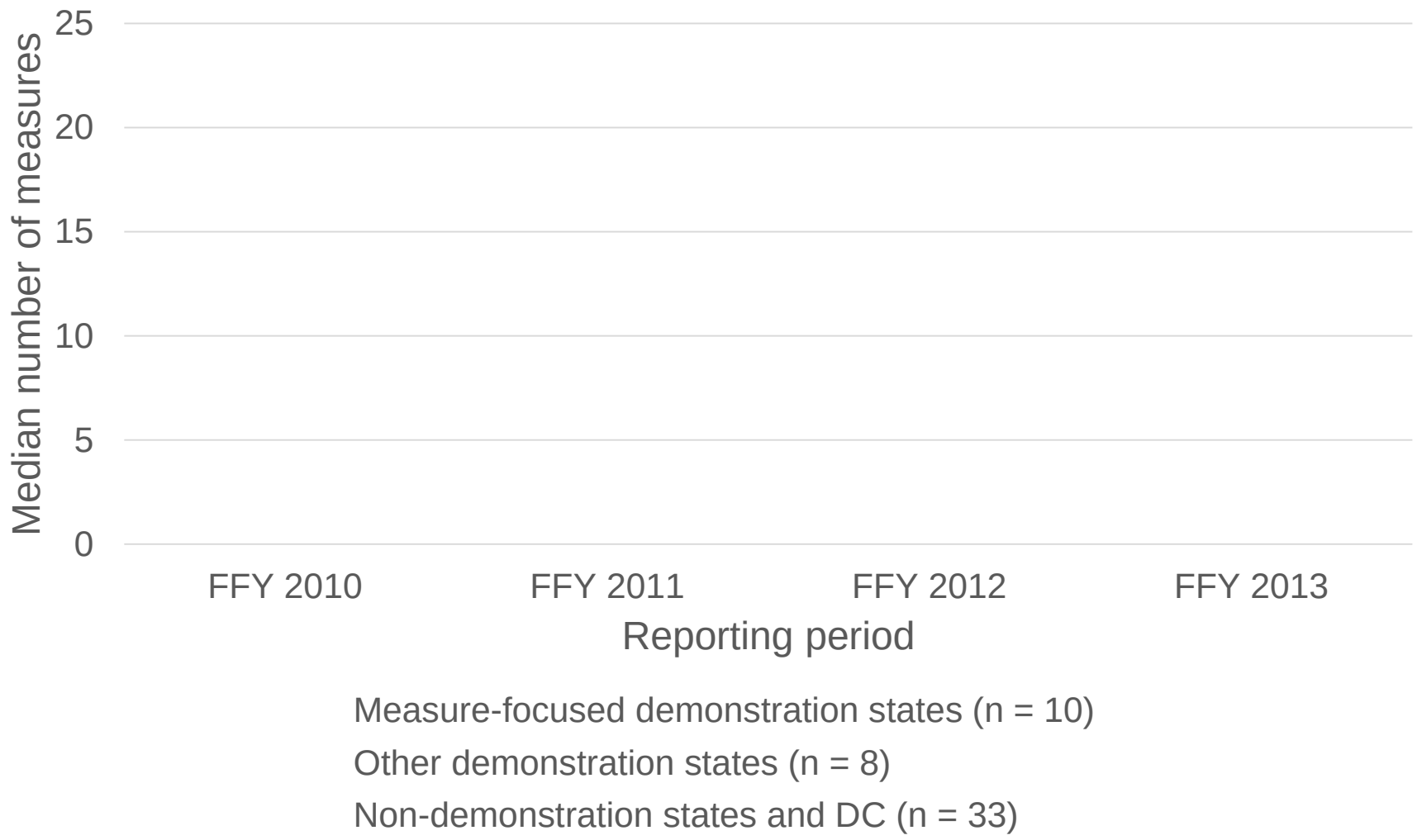
- Resource manuals
- Email helpdesk
- Webinars
- Issue briefs
- In-person quality conferences


Centers for Medicare & Medicaid Services

Child Core Set measures are publicly reported annually by HHS

www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2014-child-sec-rept.pdf




Median number of measures
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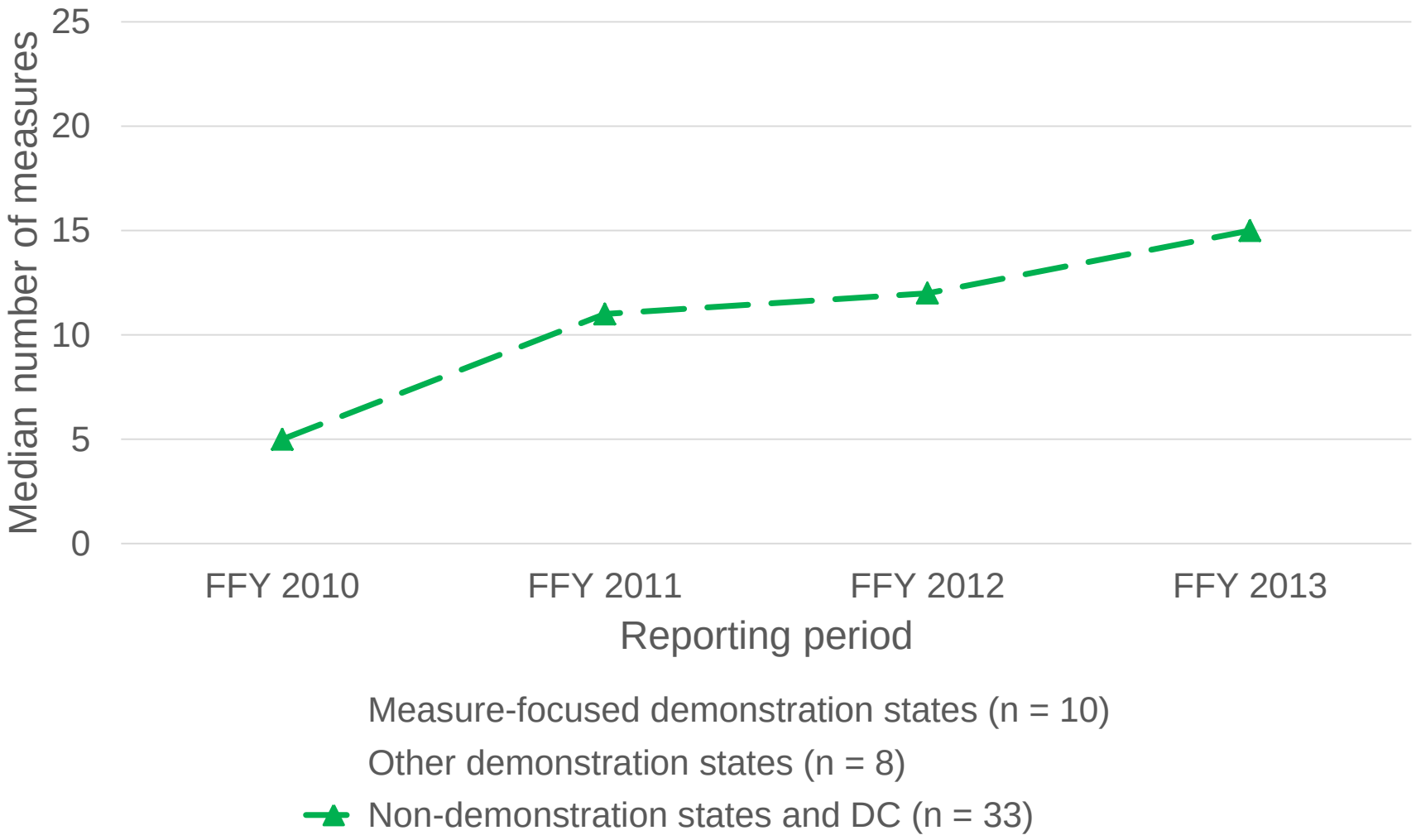
FFY 2010
FFY 2011
FFY 2012
FFY 2013
Reporting period
Measure-focused demonstration states (n = 10)
Other demonstration states (n = 8)
Non-demonstration states and DC (n = 33)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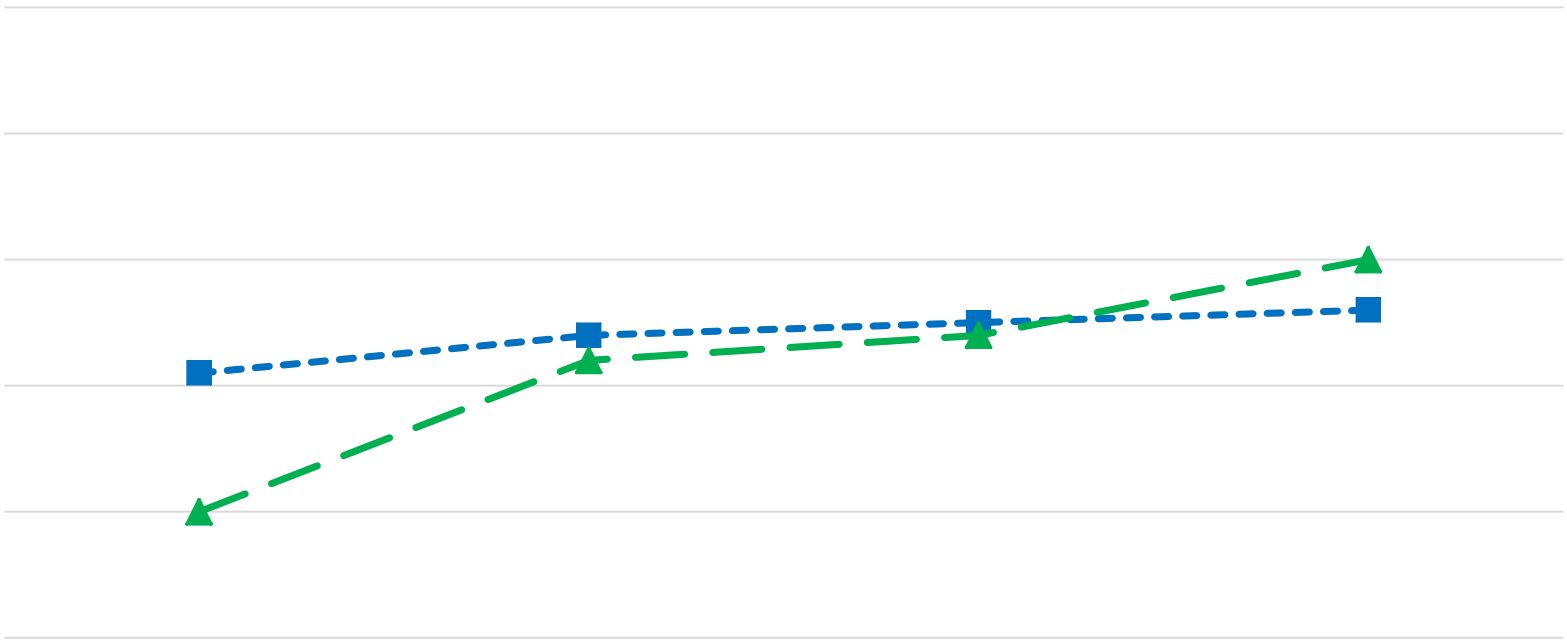
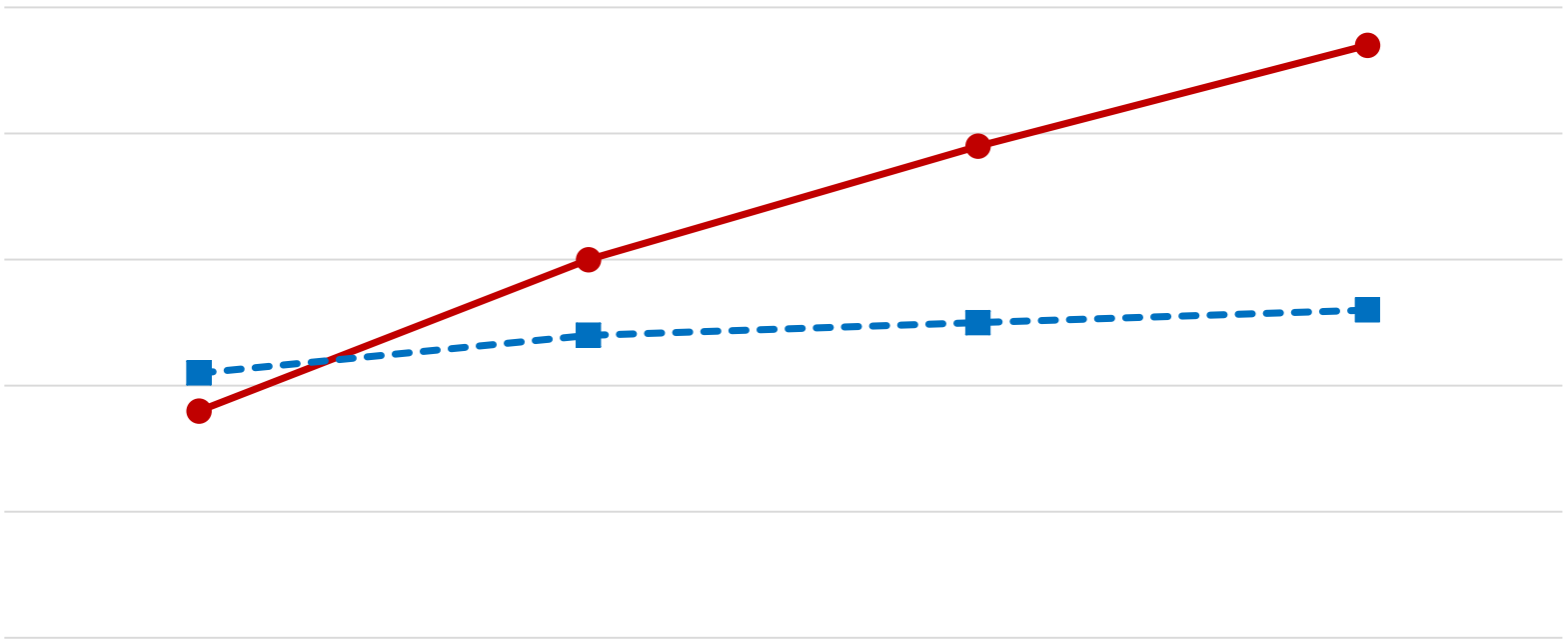




Combining data from different programs/sources

Medicaid FFS, Medicaid MCOs, CHIP (if separate CHIP agency)

Goals

- Document and be transparent about performance
- Allow comparisons across states, regions, and health plans
- Identify QI priorities and track improvement over time

CHIPRA state strategies

- Produce reports from existing data (Medicaid claims, immunization registries)
- Develop reports for different stakeholders: policymakers, health plans, providers, and the public

Goals

- Foster system-level reflection
- Set the stage for collective action
- Create a powerful incentive for providers to improve care

CHIPRA state strategies

- Formed multi-stakeholder quality improvement workgroups
- Encouraged consistent quality reporting standards across programs
- Required managed care organizations to meet quality benchmarks

Goals

- **Help providers interpret quality reports and track performance**
- **Help providers identify QI priorities and design QI activities**
- **Encourage behavior change and use of evidence-based practices among providers**

CHIPRA state strategies

- **Financial support**
  - Paid providers for reporting measures and demonstrating improvement
  - Changed reimbursement to support improvements
- **Technical support**
  - Hosted learning collaboratives
  - ProvidProvidProv0 1ptBT/F1 18 Tfr.BT/I 87vid

View evaluation highlights and other materials on the evaluation webpage:

www.ahrq.gov/policymakers/chipra/demoeval/index.html

SC Medicaid-USC Partnership: Implementing CHIPRA Core Measures in South Carolina

Presented by Kathy Mayfield Smith, MA, MBA

Associate Director, Medicaid Policy Research

USC Institute for Families in Society

September 17, 2015

State University Partnership
Continuous since 1996

Historical Context

SC Medicaid

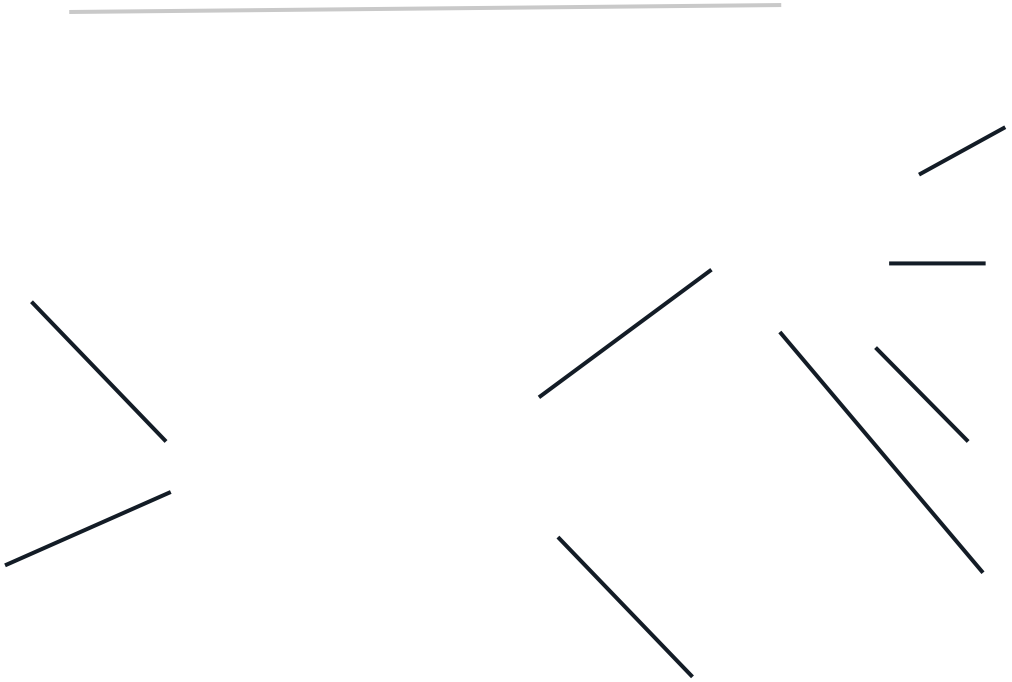
Covers about 22-25% of population, 52% of all births

Majority Managed Care (Capitated MCO model)

72,000 (2007) 700,000+ (2015) 60%

SCDHHS University of SC Partnership

- Data Analysis Program and Policy
- Technical Assistance & Evaluation Support
- Geo-spatial analysis
- Managed Care Quality Measure report card since 2007 (HEDIS and CAHPS)
- CARTS quality reporting



Leveraged Partnershipes

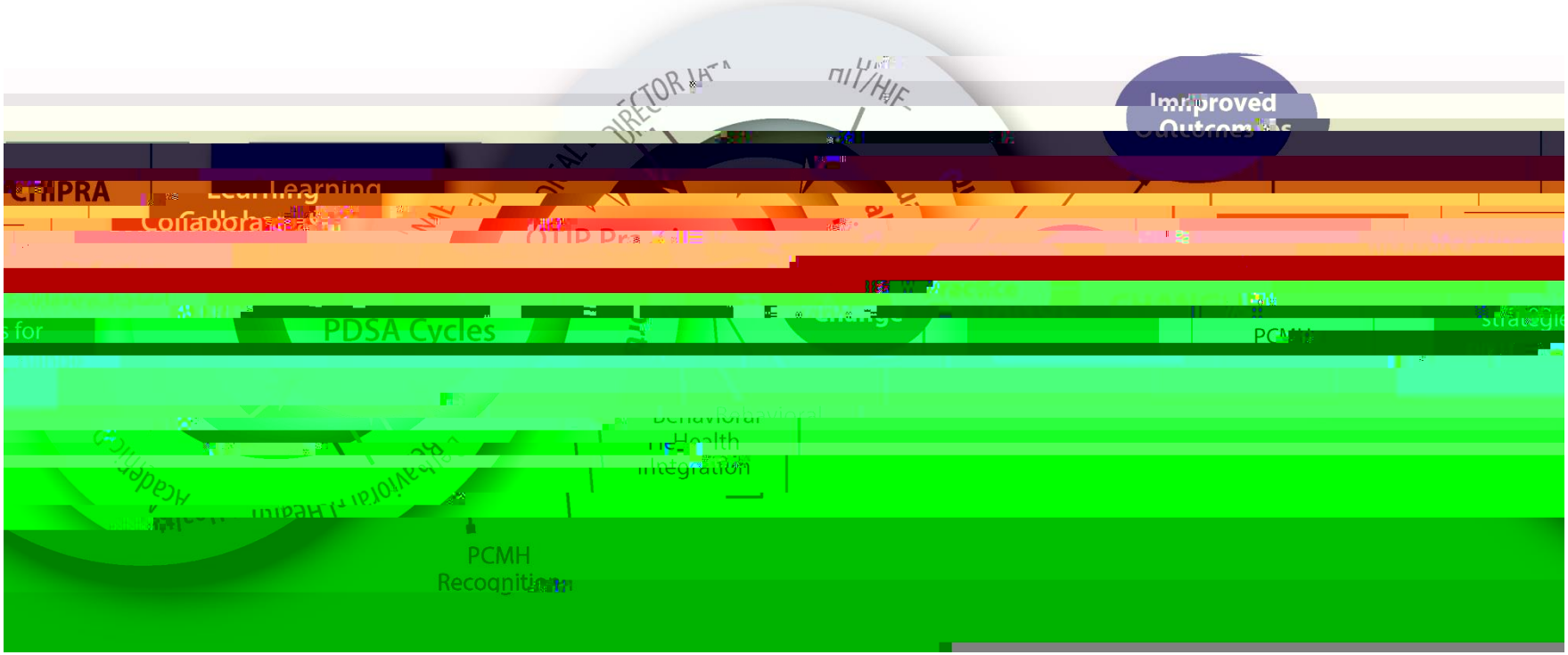
- Collaboration to conceptualize and write the grant
- Technical assistance and evaluation for state
- Collect - report on all CHIPRA Core measures (including CAHPS)
- Compare practices to matched comparison practices, total CHIPRA, Total MCO and Total State
- Support and participate in Learning Collaborative
- Technical assistance with practices

SCâs CHIPRA Demonstration -
Quality through Technology and Innovation in Pediatrics (QTIP)

Four integrated areas:

- **collecting and using a set of core child quality measures to improve healthcare outcomes;**
- enhancing HIT/HIE to facilitate quality improvement;
- developing provider-based model of integrated primary and behavioral health care; and
- transforming pediatric practices into patient-centered medical homes.

SCâs CHIPRA Demonstration -



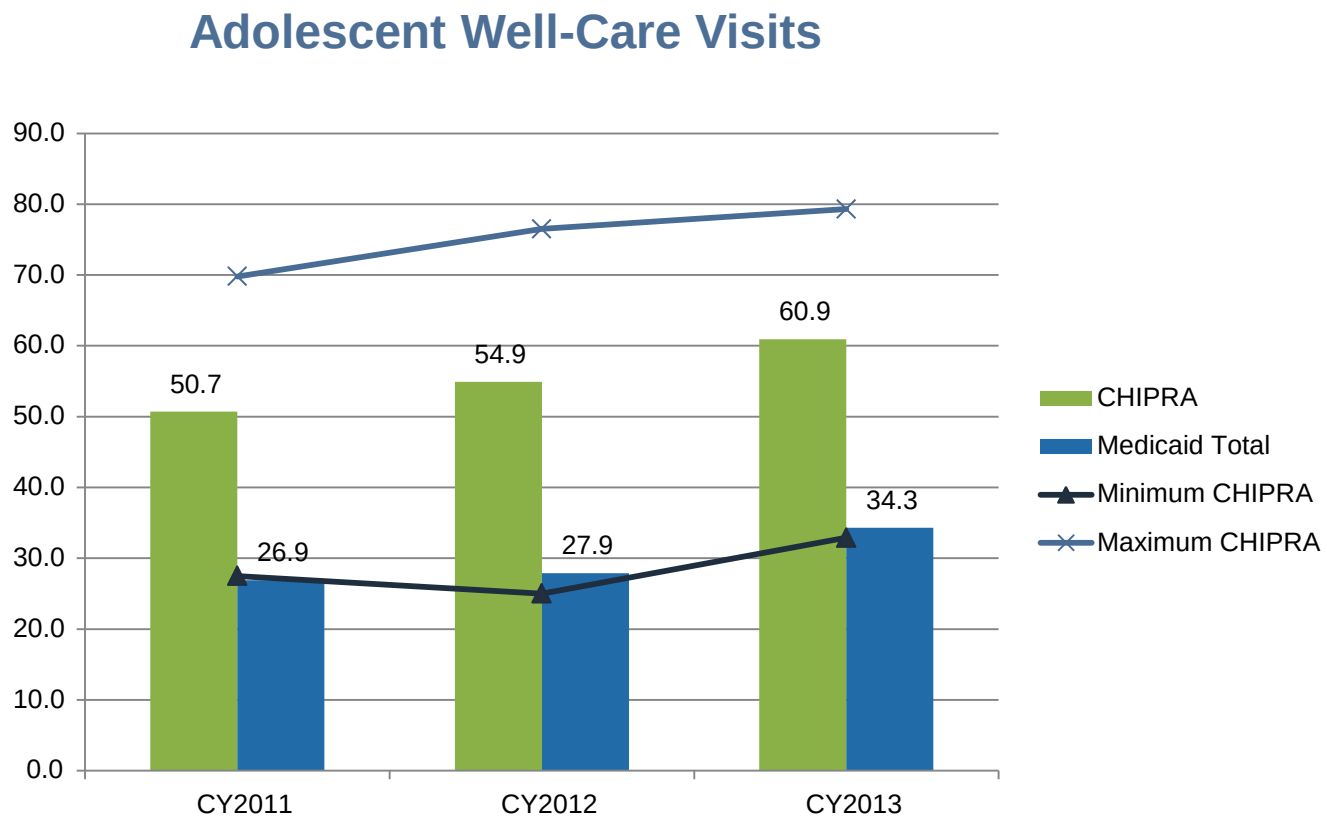
Quality Strategies

Quality improvement (QI) team formed at each practice

- Lead practitioner, typically a physician champion
- Other clinician, typically a lead nurse
- Administrative staff, typically the office manager
- All team members required to attend LCs to network, learn, and share experiences

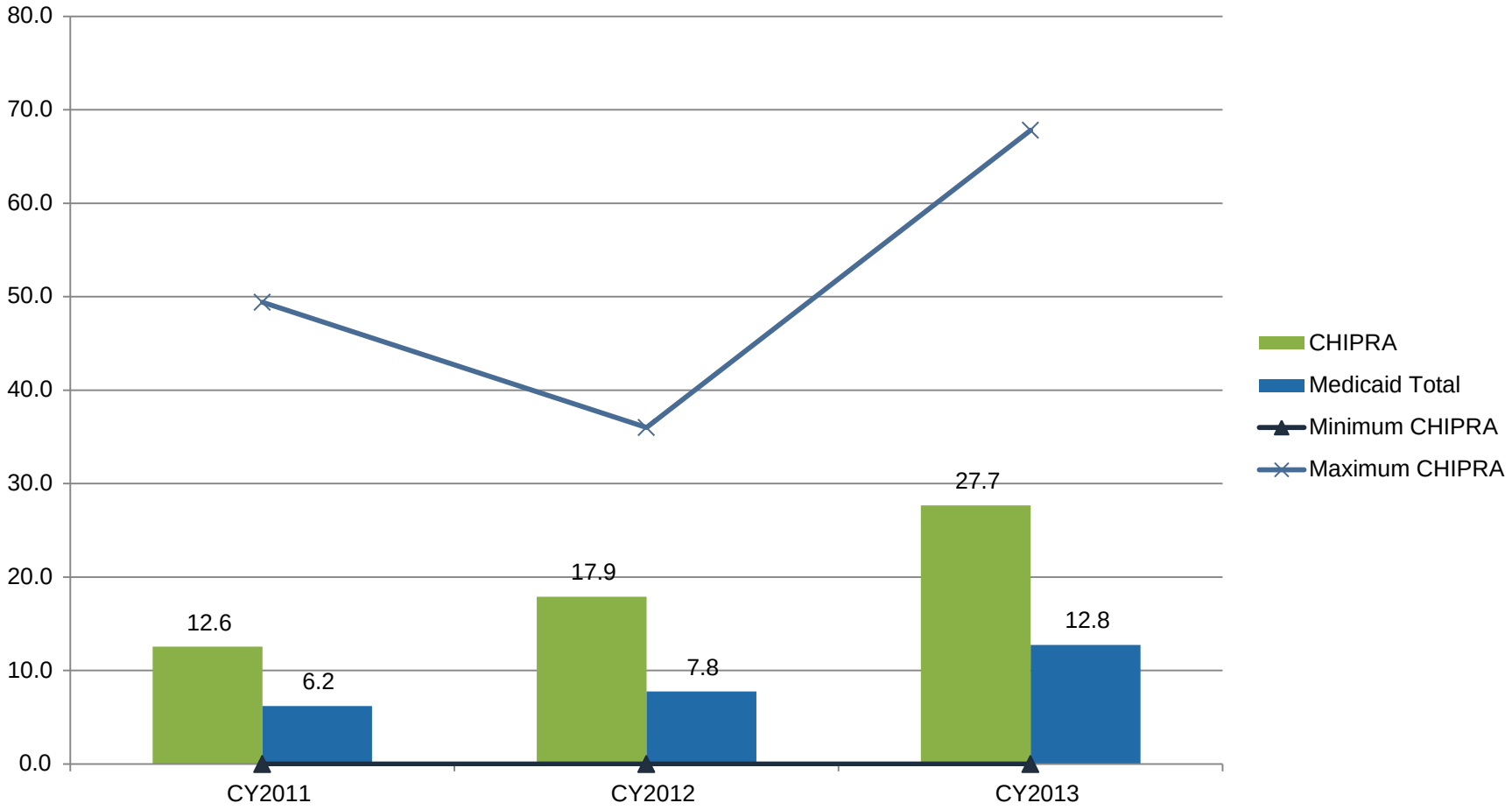
Core Measure Quality Strategies

Results - Selected Measures



Well-Child Visits-
Third, Fourth, Fifth and Sixth Years of Life

Developmental Screening - Screened by 12 months of age



Lessons Learned

Practice performance drives state performance

TA and QI tools needed for data-driven quality improvement

Continued QI effort critical to sustained high performance

QI Team critical to practice change and improved performance
- Workflow changes, staff empowerment
- Communication of changes to ensure follow-through

Barriers between physician/practice coding and MCO/State impact performance measures

Successes/Outcomes

Improved performance on quality measures

- Intervention practices showed statistically significant improvement over time on 11 measures (e.g., Dental visits, Developmental screening, all Well Care)
- Intervention practices showed statistically significant improvement over comparison on 4 measures (e.g., Weight assessment, Chlamydia screening, developmental screenings)

Demonstrated practice performance drives state performance on quality measures

Successes/Outcomes

Infusion of lessons learned into SCDHHS initiatives and policy changes

- Billing and coding changes to support quality measurement
- MCO incentives/withholds encourage TA with practices
- TA quality initiatives and contracts target quality at practice level
-

Get in Touch

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Sept 17, 2015

State University Partnership Network Webinar

Kimberley Fox
Cutler Institute for Health and Social Policy
Muskie School of Public Service, University of Southern Maine

Funding for this work is provided under grant CFDA 93.767 from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) authorized by Section 401(d) of the Child Health Insurance Program Reauthorization Act (CHIPRA)

UNIVERSITY OF SOUTHERN MAINE

Builds off longstanding cooperative agreement between Maine DHHS and University of Southern Maine, Muskie School of Public Service

- Technical assistance and data analytic support using longitudinal data warehouse
- Policy analyses, program development, grant writing support
- Program evaluation and monitoring for Maine's Medicaid program.

Unique grant requirement rewarding multi-State initiative allowed us to also partner with State of Vermont and University of Vermont.

- Pre-award
  - Data warehouse and measurement experience on which to demonstrate expertise, grant application preparation in partnership with Vermont.
- Post-award
  - Cross-state grant and program administration in Maine, TA and data analytic support for child health measurement implementation at statewide and practice-level, rapid cycle evaluation.
- Value of cross-state/university partnership

Collaborate with health systems, pediatric and family practice providers, associations, state programs and consumers to:

- Select and promote a set of child health quality measures.
  - Create Maine Child Health Improvement Partnership to identify priorities and advise on child health topics in Maine.
- Build a health information technology infrastructure to support the reporting and use of quality measurement information.
- Transform and standardize the delivery of healthcare services by promoting patient centered medical home principles in child-serving practices.
- Evaluate implementation and provide timely feedback to program and policymakers.

Broad stakeholder engagement to identify/prioritize child health measures and identify gaps in care needing statewide/practice improvement
Investigate and assess the quality of data sources and feasibility of measure calculation methods.
Collect and analyze data to inform planning, implementation, and monitoring.
Identify policy and payment opportunities and guide change required to support child health quality improvement and measurement efforts.
Evaluate measure implementation to inform planning and assess effectiveness and disseminate results

- Maine Patient Centered Medical Home Pilot and MaineCare Health Homes initiative.
- Pathways to Excellence

- Developed IHOC Master List of Pediatric Measures
- IHOC measures adopted/used by other statewide quality initiatives (e.g. PTE, MaineCare Health Homes, SIM, health systems internal QI)
- Expanded number of child health statewide measures on R s

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- Implemented data-driven QI learning collaborative (First STEPS)
  - 28 practices participated collectively serving 37,630 (@30%) MaineCare children
- Provided technical assistance to support state registry modifications and changes to health systems EHRs for generating practice-level IHOC child health measures (e.g. immunizations, oral health risk assessments).
- Guided MaineCare policy change and clarified billing payment to support QI and measurement (e.g. developmental screening and oral health)

First STEPS Phase I: Raising Immunization Rates & Building a Patient Centered Medical Home (Sept 2011-April 2012):

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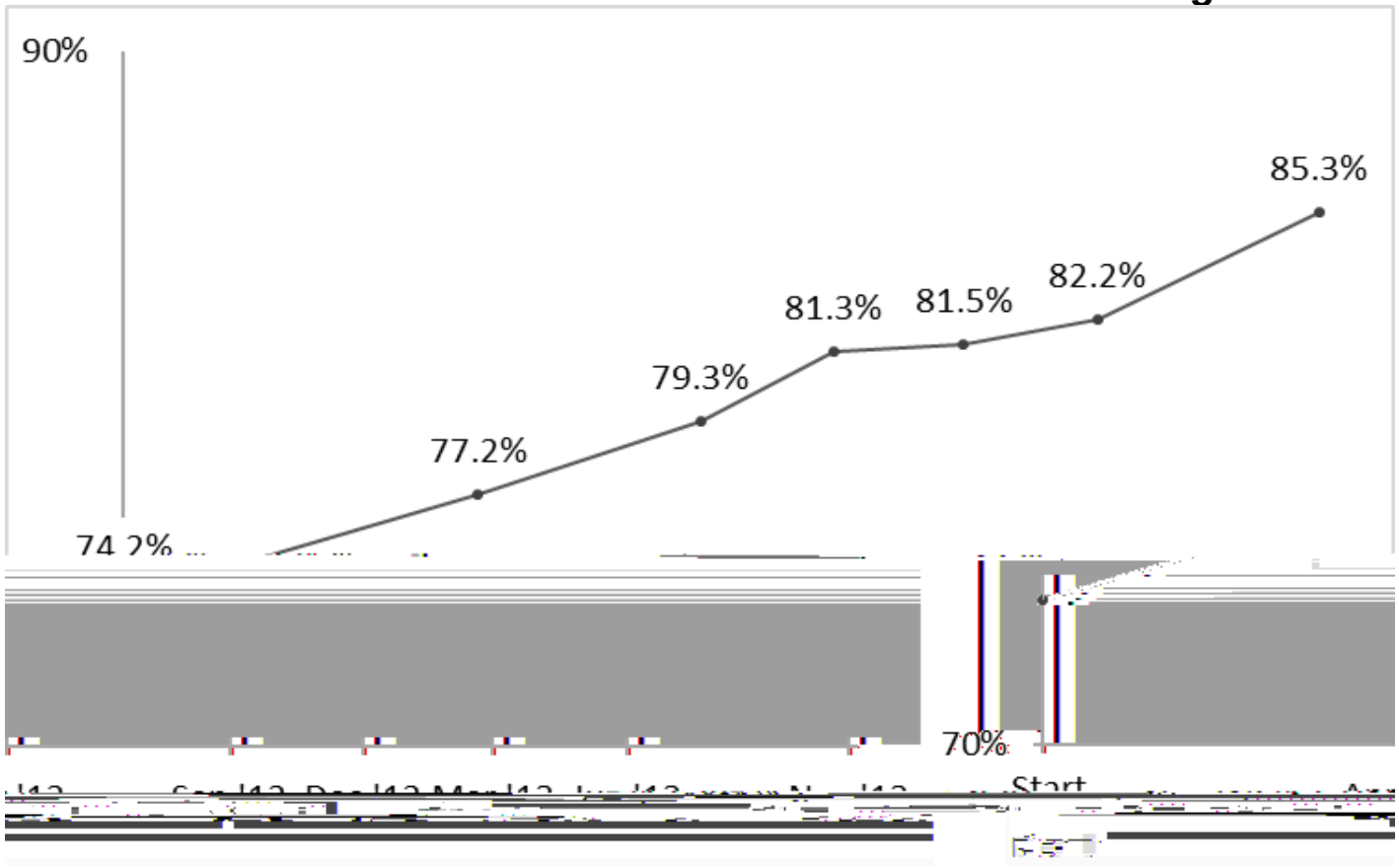
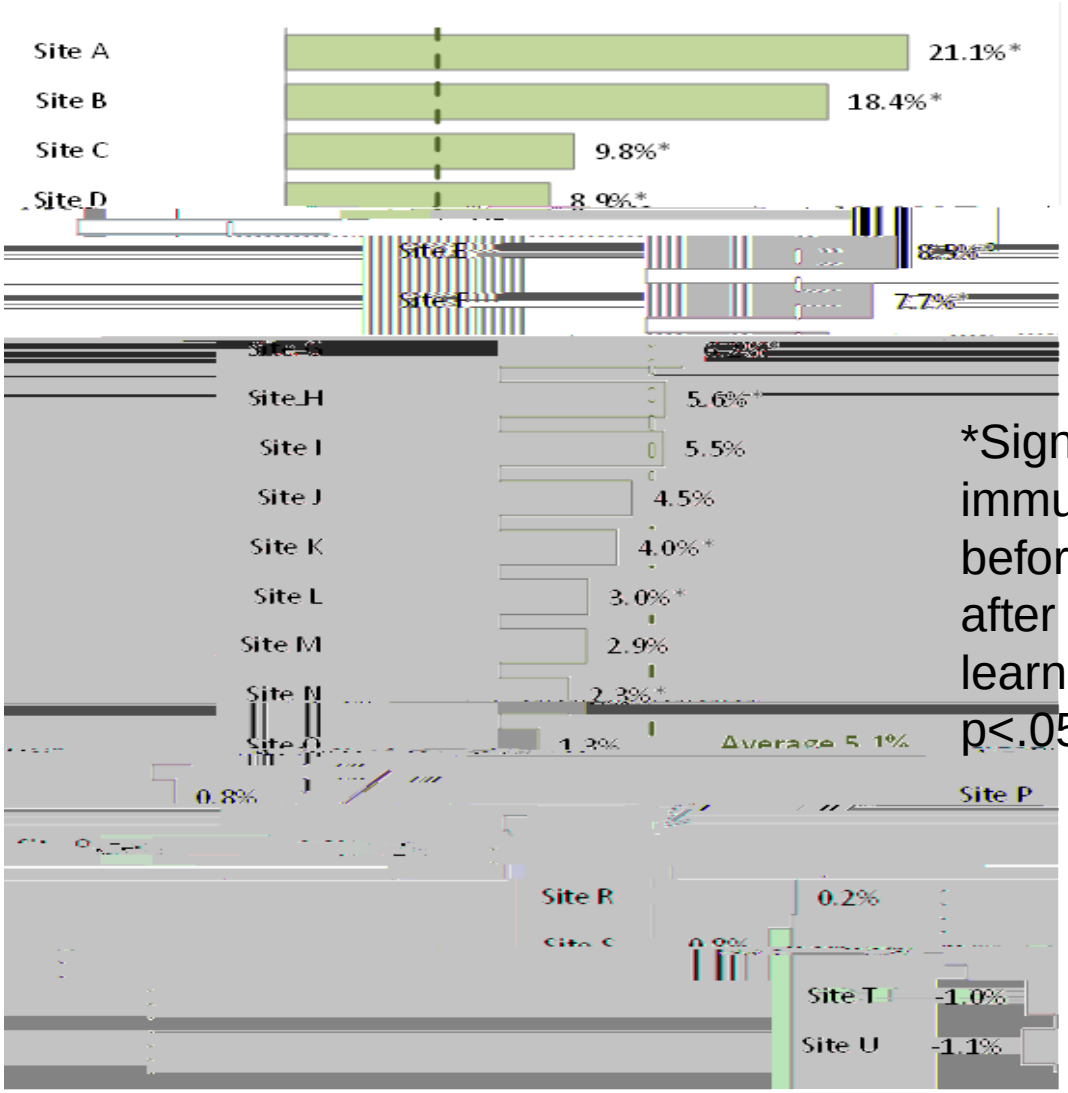
Immunization Rates in First STEPS Phase I Practices from Aug 2011 to Nov 2013



* Significant change in immunization rate before and one year after First STEPS Phase I learning sessions, $p<.05$.



*Significant change in immunization rate before and one year after First STEPS Phase I learning sessions, $p<.05$.

Existing registry reporting functions were based on ACIP guidelines (grace periods/age cut-offs) that meet Nat'l CDC

- Increased use of state registry/ accuracy of data reported.
- Monthly practice-level reports helpful in measuring progress toward quality improvement goals.
- Producing registry reports for pediatric practices not in First STEPS to submit rates for public reporting to Pathways to Excellence.
- Changes to registry underway so practices will be able to
  - Produce reports based on CHIPRA measures
  - Produce reports according to MaineCare eligibility status
  - Produce reports for comparison across affiliated locations.
- Other statewide immunization measures (NIS, ACIP) have improved significantly, which has been attributed to IHOC/First STEPS.

):

Monthly data reports based on chart review.

MaineCareœclaims.

Improve the rate of these screenings (according to Bright Futures guidelines) by 50% between May 2012 and December 2012.

Extremely (and unexpected) low statewide rates.

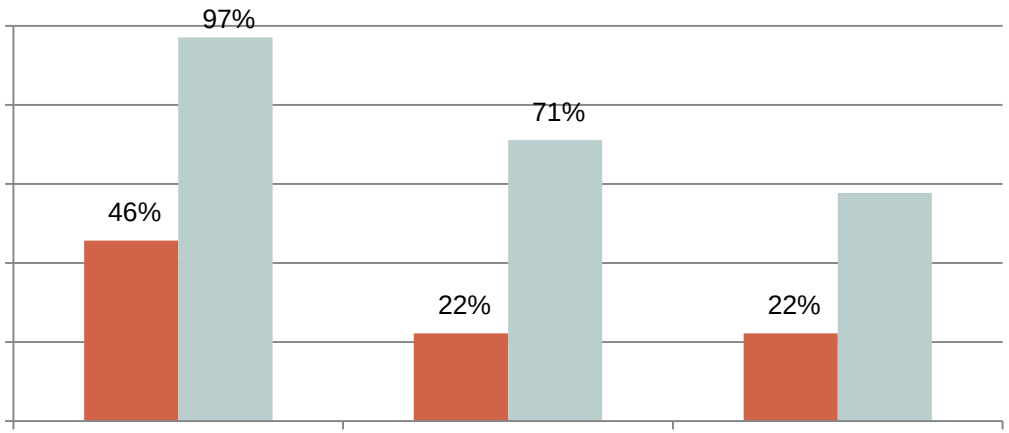
Difficulty identifying specific types of screenings using the 96110 billing code as specified in the measure.

MaineCare clarified and modified the billing method for developmental and autism-specific screenings (and autism testing) for use by primary care providers.

Clarified existing rate structure for related screenings and tests.

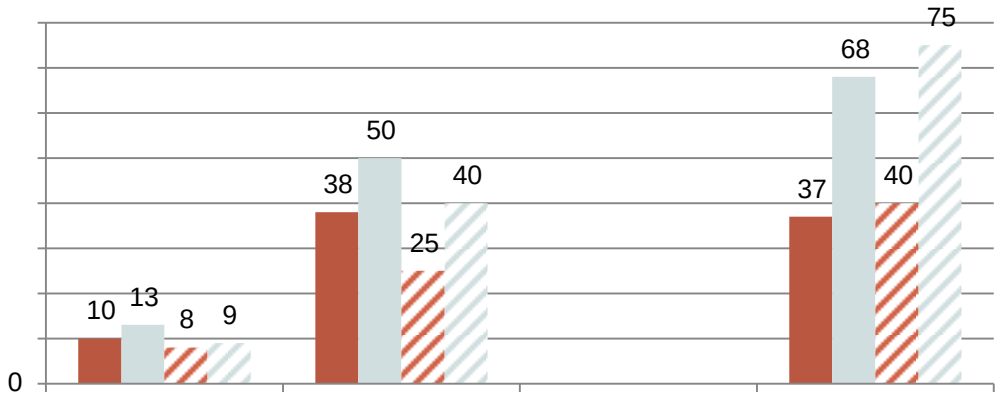
Added modifiers to existing billing codes to distinguish between global developmental & autism-specific screening, and follow-up autism testing.

96110 = global developmental screening
96110 HI = autism-specific screening
96111 HK = autism testing

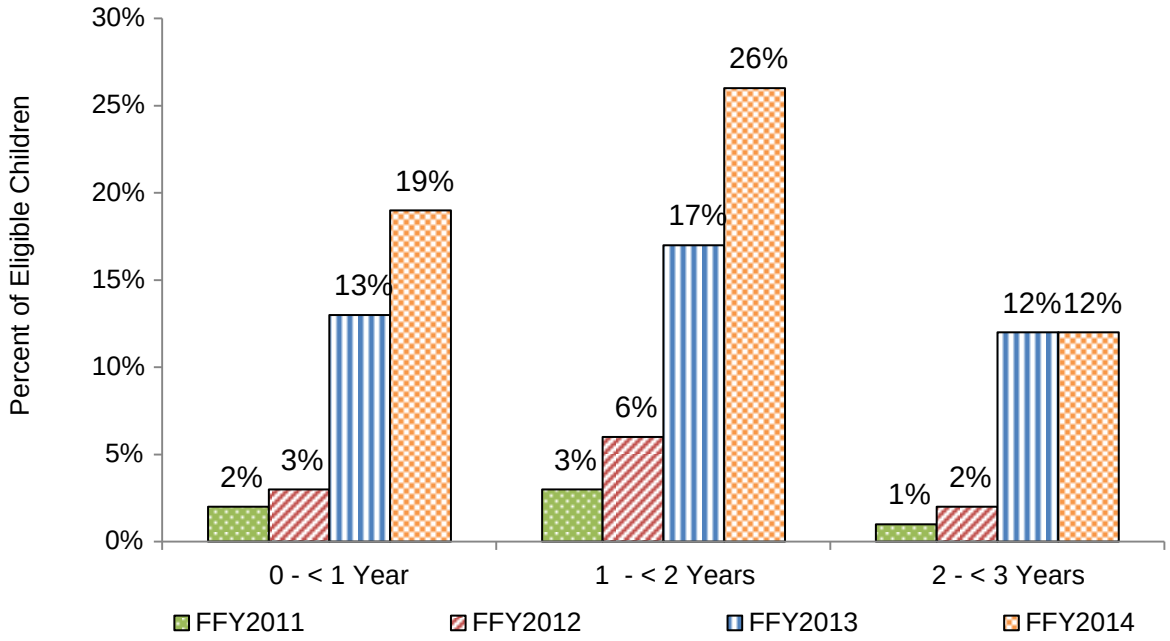


Source: Chart Review data from Phase II First STEPS practices as reported in: Improving Health Outcomes for Children (IHOC) First STEPS Phase II Initiative: Improving Developmental, Autism and Lead Screening for Children Final Evaluation Report, Muskie School of Public Service, University of Southern Maine, Aug 2013

Source: MaineCare Paid claims analyses. Improving Health Outcomes for Children (IHOC) First STEPS Phase II Initiative: Improving Developmental, Autism and Lead Screening for Children Final Evaluation Report, Muskie School of Public Service, University of Southern Maine, Aug 2013

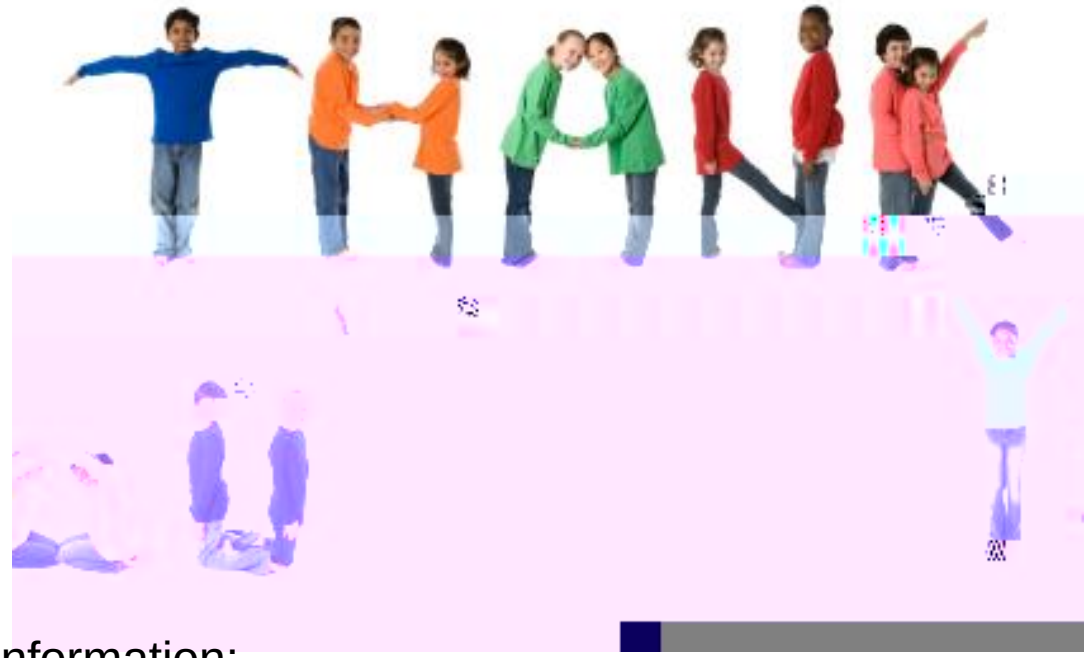


Source: MaineCare administrative claims data as reported in: Improving Health Outcomes for Children (IHOC) First STEPS Phase II Initiative: Improving Developmental, Autism and Lead Screening for Children Final Evaluation Report, Muskie School of Public Service, University of Southern Maine, Aug 2013



Source: MaineCare administrative paid claims data as reported in: IHOC Summary of Pediatric Quality Measures for Children Enrolled in MaineCare FFY 2011-2014, Muskie School of Public Service, University of Southern Maine, Sept 2015.

- Child health measures need to be actionable and available at the practice-level to improve performance.
- Data source matters. Measures cannot be operationalized without reliable methods for capturing, collecting, calculating, and reporting the data.
- Integrating data system improvements as part of child QI efforts helps increase visibility and accuracy of data and demonstrates how data can be 'meaningfully used' to sustain quality improvement over time.
- Aligning measures across state initiatives is key for provider-buy in and to sustain quality improvement work after grant funding.



For more information:
Please contact: Kimberley Fox, kfox@usm.maine.edu
Or visit the IHOC website:
http://www.maine.gov/dhhs/oms/provider/ihoc.shtml

Thank You!

Please fill out the evaluation questions on screen

Additional Questions? Contact:

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