



## **IMPLEMENTATION CHOICES FOR THE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009**

Lisa Simpson, Gerry Fairbrother, Joseph Touschner, and Jocelyn Guyer

September 2009

**ABSTRACT:** The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 has the potential to transform children's health care in the United States. The authors of this report analyze selected provisions of the legislation that involve outreach and enrollment, as well as child health quality and measurement. Using input from interviews with a range of stakeholders and a panel of experts, the report provides a set of recommendations for the federal government officials charged with implementing CHIPRA. Recommendations include: giving funding priority to states that will adopt or maintain key simplifications, providing clarity on the relationship between express-lane procedures (which allow states to use relevant findings from other public programs when determining children's enrollment eligibility) and error measurement, ensuring quality measures focus on priority health needs for children, and building quality measurement and improvement capabilities into electronic health information systems, among others.

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff. This and other Fund publications are available online at [www.commonwealthfund.org](http://www.commonwealthfund.org). To learn more about new publications when they become available, visit the Fund's Web site and [register to receive e-mail alerts](#). Commonwealth Fund pub. no. 1315.



## CONTENTS

About the Authors .....	iv
Acknowledgments.....	v
Executive Summary .....	vi
I. Introduction .....	1
II. Methods.....	2
III. Opportunities in CHIPRA .....	2
Considering the Context: States in 2009 and Beyond .....	4
IV. Overview: Key Features Strengthen Outreach, Enrollment, and Quality .....	5
V. Implementation Choices for CHIPRA Provisions.....	7
Outreach and Sustained Enrollment Provisions in CHIPRA.....	7
Title IV: Strengthening Quality of Care and Health Outcomes .....	15
How Health Reform Can Continue the Progress of CHIPRA .....	28
Notes .....	30
Appendix. Individuals Participating in Key Informant Interviews, One-Day Expert Meeting, or Those Providing Written Comments .....	33

## ABOUT THE AUTHORS

**Lisa Simpson, M.B., B.Ch., M.P.H., F.A.A.P.**, professor and director of the Child Policy Research Center at Cincinnati Children's Hospital Medical Center and the University of Cincinnati, Department of Pediatrics. The center provides evidence-based information to inform policy and program decisions at the local, state, and national levels, with an emphasis on strategies to improve the quality of health care, the effectiveness of public programs, and child well-being. Dr. Simpson, a board-certified pediatrician, is also a national policy advisor for the National Initiative for Children's Healthcare Quality and serves as an elected member on the board of directors of AcademyHealth and the Coalition for Health Services Research. She has served on two Institute of Medicine committees, the most recent of which focused on priorities for comparative effectiveness research. She has led studies of the quality and safety of care for children and adolescents, focusing especially on the role of policies in advancing quality. She was formerly the Deputy Director of the Agency for Healthcare Research and Quality and the Maternal and Child Health Director in Hawaii. Dr. Simpson earned her undergraduate and medical degrees at Trinity College (Dublin) and a master of public health degree at the University of Hawaii.

**Gerry Fairbrother, Ph.D.**, is a professor of pediatrics at the University of Cincinnati and holds a joint appointment in health policy and clinical effectiveness and epidemiology and biostatistics at Cincinnati Children's Hospital Medical Center. Dr. Fairbrother has led investigations into child health insurance enrollment patterns, barriers, and costs; the impact of Medicaid managed care on children's preventive health screening; and the effect of financial incentives on physician behavior. She has served as a consultant to the Institute of Medicine on projects dealing with immunization financing and the consequences of uninsurance and has worked with the Centers for Disease Control and Prevention to help states monitor immunization rates for children in Medicaid. Dr. Fairbrother holds a Ph.D. from Johns Hopkins University and is a Fellow of the New York Academy of Medicine and a Fellow of the Ambulatory Pediatric Association.

**Joseph Tuschner, M.P.P.**, is a state health policy analyst for the Center for Children and Families (CCF). In this capacity, he supports the efforts of state-level advocates to improve health care coverage policies for children and families. He also conducts research on Medicaid, CHIP, and related topics. Before joining CCF, Mr. Tuschner served as assistant director for state government affairs for the American Academy of

Physician Assistants. He also served as staff for members of the Ohio General Assembly from 2001–2003. He earned a master’s degree in public policy from the Humphrey Institute of the University of Minnesota.

**Jocelyn Guyer** is co-executive director at CCF and a senior researcher at the Georgetown University Health Policy Institute. At CCF, she has worked extensively on child and family health issues, including reauthorization of CHIP and the role of Medicaid in covering children and families. She joined CCF from the Kaiser Commission on Medicaid and the Uninsured, where she served most recently as an associate director. In the past, she has served as a senior health policy analyst on health and welfare policy at the Center on Budget and Policy Priorities. She has also served as legislative research assistant to former Senator Daniel Patrick Moynihan. She holds a master of public affairs in economics and public policy from Princeton University’s Woodrow Wilson School.

#### **ACKNOWLEDGMENTS**

The authors gratefully acknowledge the editorial assistance of Jessica McAuliffe, Pam Schoettker, and Wendy Groznik in preparing the manuscript.

---

*Editorial support was provided by Deborah Lorber.*

## EXECUTIVE SUMMARY

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) has the potential to support the transformation of children's health care in the United States. The legislation emphasizes both coverage and quality of care, and provides funding to enroll millions of children who would otherwise be uninsured. Specifically, the legislation establishes mechanisms to finance and improve coverage; to boost participation rates among the lowest-income, Medicaid-eligible children; to develop consistent quality-of-care measures and encourage reporting on these measures; to promote health information technology; and to realign incentives to focus on quality and outcomes.

Much of the legislation's transformative potential lies in the details of implementation, both in the rulemaking at the Centers for Medicare and Medicaid Services (CMS), which will define the boundaries within which states work, and in further implementation decisions in the state capitols. Nearly every aspect of the new law depends on current and upcoming federal and state decisions.

This report explores two key areas of the implementation process—outreach and enrollment and quality of care—and makes recommendations for each. This report was developed based on three sources: legislative and policy analysis conducted by the authors over the past six months, key informant interviews with stakeholders and experts conducted between March and June 2009, and a meeting held in Washington, D.C. in June 2009.

### **OUTREACH AND ENROLLMENT PROVISIONS IN CHIPRA**

#### **Outreach Grants**

CHIPRA includes a number of provisions to increase outreach funding and activities to enroll eligible but uninsured children in coverage, with an emphasis on those who are hardest to reach. The law allocates \$100 million to support Medicaid and CHIP outreach and enrollment activities. It provides guidelines on how the funding will be allocated, but gives the Secretary of Health and Human Services (HHS) broad discretion in implementation.

#### *Recommendation:*

- HHS could give priority to states that will adopt or maintain key simplifications.

### **Express Lane Eligibility**

Currently, many uninsured Medicaid- and CHIP-eligible children are enrolled in other public programs. The new law provides states with tools and flexibility for enrolling these children. In particular, it gives states the opportunity to use relevant findings from other public programs, like food stamps, school lunch, and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), when determining children's eligibility for CHIP and Medicaid at enrollment or renewal.

#### *Recommendations:*

- Provide clarity on the relationship between express-lane procedures and error measurements.
- Align guidance from federal agencies on data sharing.

### **Citizenship Documentation**

CHIPRA allows states to document citizenship by submitting names and Social Security numbers to the Social Security Administration for verification. Previously, citizenship for children, parents, and pregnant women was required to be documented in a highly prescriptive and paperwork-intensive manner, according to stipulations in the Deficit Reduction Act of 2005.

#### *Recommendations:*

- Monitor state adoption of new requirements.
- Convene all stakeholders to ensure timely adoption of Social Security number matching.
- Clarify the question of citizenship versus identity documentation.
- Update rules for states that do not adopt Social Security number matching.

### **Performance Bonus**

Performance bonuses are designed to encourage states to enroll eligible, uninsured children. States that increase enrollment of eligible children above a target level receive a federal payment for each extra child enrolled to help defray the added costs of successful efforts. States must also adopt at least five of eight specified measures for simplifying enrollment and retention to qualify for the bonus.

#### *Recommendations:*

- Provide rapid guidance on how qualifying simplifications will be counted.
- Ratchet up qualifying simplification efforts.
- Make appropriate, allowable adjustments to enrollment targets.

### **Payment Error Rate Measurement Rules**

CHIPRA requires that HHS adopt new rules for the measurement of payment errors and includes important clarifications for states. The new rules also provide an opportunity to modify the definition of errors to include those that result in eligible individuals being denied coverage—so-called “negative case errors.”

*Recommendation:*

- Take into account negative case errors.

### **CHIP Enrollment Reporting**

The law requires states to include data in their annual reports to help assess enrollment and retention efforts, including data on continuity of coverage, denials of eligibility at both the application and renewal stages, and children’s access to care. It also requires states to provide more timely Medicaid and CHIP enrollment data to the HHS Secretary and to include a description of state activities to reduce administrative barriers to enrollment and renewals in their CHIP state plans.

*Recommendations:*

- Convene stakeholders to determine how data should be collected to allow for meaningful comparisons across states and over time.
- Share data rapidly and publicly.
- Coordinate data collection with other CHIPRA provisions.

### **Medicaid and CHIP Payment and Access Commission (MACPAC)**

The law creates a commission to report to Congress on payment policies, access issues, and the relationship of Medicaid and CHIP to the rest of the health care system.

*Recommendations:*

- Take advantage of previous efforts to study Medicaid.
- Measure access across all populations.

## **STRENGTHENING QUALITY OF CARE AND HEALTH OUTCOMES**

### **Develop an Initial Core Set of Health Care Quality Measures**

By January 1, 2010, the Secretary of HHS will identify an initial recommended core set of child health quality measures for use by state programs. The measures include, but are not limited to, duration of children’s coverage over a 12-month period and a wide range of preventive services and treatments.



*Recommendations:*

- Extend the core set beyond the existing Healthcare Effectiveness Data and Information Set (HEDIS) measures for children, adolescents, and maternal care.
- Consider developing a CORE–PLUS set that identifies additional measures that address high-priority topics, but which some states may not be able to use immediately.
- Ensure that appropriate criteria are used in selecting the set.

### **A Pediatric Quality Measures Program**

By January 1, 2011, the Secretary must establish an ongoing program that advances and improves pediatric quality measures for all children. This program will expand upon and increase existing pediatric measures and will award grants for developing and testing pediatric quality measures.

*Recommendations:*

- Build measures for the future.
- Focus measure development funding on outcomes and composites.
- Design improved specifications for measures at all levels of accountability.

### **Provisions Related to Measure Use and Reporting**

By February 4, 2011, the Secretary of HHS will develop a standardized format for reporting information, procedures, and approaches that encourage states to use the initial core measurement set to voluntarily report information on quality of pediatric programs. The Secretary will also disseminate information to states on best practices for measuring and reporting on the quality of health care for children.

*Recommendations:*

- Ensure meaningful collaboration with states in the design and execution of each step of the reporting strategy.
- Make consistent quality reporting on the core set a goal for all states on all populations.
- The data that support the core measures should be made available nationally, not just aggregate data.
- Begin investing in a national and state infrastructure for ongoing, sustained quality improvement.

### **Demonstration Projects**

CHIPRA includes \$20 million annually for demonstration projects. HHS will provide grants to up to 10 states and child health providers to use and test child health quality measures and promote the use of health information technology for children. The law also includes a separate allocation of \$25 million for a childhood obesity demonstration project.

#### *Recommendations:*

- Demonstrations should focus on improving quality of care generally, as well as demonstrating specific aspects targeted in the legislation (e.g., health information technology, provider-based models).
- Most of the demonstrations should focus on all children in Medicaid and CHIP, not just those in selected sites or plans.
- Demonstrations could be designed to answer questions across the priorities identified in the legislative language.

### **Development of Model Electronic Health Record (EHR)**

CHIPRA includes \$5 million for the development of a model EHR that addresses children's unique needs.

#### *Recommendations:*

- Ensure that the health information technology-related activities of CHIPRA are coordinated with those of the Office of the National Coordinator, which has oversight for the implementation of the American Recovery and Reinvestment Act investments.
- Build quality measurement and improvement capabilities into health information systems, including the model EHR.

Beyond the opportunities offered by the provisions themselves, CHIPRA offers an opportunity to enhance federal capacity to assist states in designing, implementing, evaluating, and improving care for children. CHIPRA is an opportunity to recalibrate the partnership between states and HHS, particularly CMS, and to move from a culture of audit and penalty, driven by concerns of fraud and abuse, to one that seeks to provide assistance, guidance, and expertise to the states. This will require an investment in staff and resources within the agencies, which has existed for the Medicare program for decades. In addition, this investment needs to be coupled with a commitment by HHS to have a coordinated approach across all agencies.

# **IMPLEMENTATION CHOICES FOR THE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009**

## **I. INTRODUCTION**

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) has the potential to support the transformation of children's health care in the United States. The legislation emphasizes both coverage and quality of care and provides the funding to enroll millions of children who would otherwise be uninsured. The Congressional Budget Office projects that 4.1 million children will gain coverage as a result of the new law.<sup>1</sup> Specifically, the legislation establishes mechanisms to finance and improve coverage, to boost participation rates among the lowest-income Medicaid-eligible children, to develop consistent quality measures and encourage reporting on those measures, to enhance health information technology (HIT), and to realign incentives to focus on quality and outcomes.

The focus of action is shifting to state capitols, where policymakers across the country must decide how to take advantage of the opportunities afforded by this legislation. However, the Department of Health and Human Services (HHS) has several implementation decisions before them that could dramatically enhance the transformative potential of the legislation. By issuing guidance or rules, it will translate the legislation into options that states will implement. It will also need to make decisions regarding implementation of significant quality provisions and align the advances and incentives in CHIPRA with other relevant legislation, such as the American Recovery and Reinvestment Act (ARRA), which dramatically expands federal investments in health information technology and comparative effectiveness research. Much of the opportunity for the legislation to live up to its transformative potential lies in the details of implementation, both in the rulemaking at HHS, which will define the boundaries within which states work, and in further implementation decisions in the state capitols. Nearly every aspect of the new law depends on current and upcoming federal and state decisions.

This project was designed to inform the implementation process by providing a framework and range of implementation choices and options for CHIPRA legislation and examining the advantages and disadvantages of each. The paper focuses on two key areas: outreach and enrollment and quality and health information technology.

## II. METHODS

This report was developed based on three sources: legislative and policy analysis conducted by the authors over the past six months, key informant interviews with stakeholders and experts conducted between March and June 2009, and a meeting held in Washington, D.C. in June 2009. Participants are listed in the appendix. They were selected to represent the full range of stakeholders in child health care, state programs, and quality—namely state Medicaid and CHIP representatives, pediatric care experts, quality experts, pediatric health information technology experts, and families.

## III. OPPORTUNITIES IN CHIPRA

Many of the provisions of CHIPRA were informed by research on CHIP and Medicaid and an understanding of how best to enroll and retain eligible children. The inclusion of a well-developed set of authorities and requirements around quality of care and outcomes reflects the culmination of continued policy and advocacy in this area. CHIPRA also builds on a tradition of allowing states to innovate and test different approaches to achieve the goals of the program, namely enrolling all eligible children and developing new methods for delivering care and measuring outcomes. At the same time, CHIPRA also moves to limit the range of choices states can make by emphasizing priority areas (e.g., linking enrollment incentives to the use of strategies from a list and restricting the use of additional demonstration funds to certain topics and methods).

To ensure that CHIPRA achieves the full impact of its landmark provisions, actions at federal and state levels are needed: 1) building capacity at the national, state, and local levels for rapid learning across states, and 2) designing incentives that enable states to fully develop, sustain, and spread meaningful measurement, improvement, and accountability approaches. HHS could adopt the following principles to maximize the impact of CHIPRA.

**Enhancing federal and state capacity to design, implement, evaluate, and improve the delivery of quality care for children.** CHIPRA is an opportunity to recalibrate the partnership between states and HHS, in particular the Center for Medicare and Medicaid Services (CMS). While a “50-state-laboratory” approach has yielded some important improvements in some states, far too few have benefitted from their peers’ experience. Many continue to lack the capacity and expertise to accomplish their goals. Diffusion of innovations and translation of research into practice and policy have been limited. At the same time, a regulatory culture of audit and penalty, driven by concerns about fraud and abuse, has chilled many states’ desire for innovation.

CMS, the Agency for Healthcare Research and Quality (AHRQ), the Health Resources and Services Administration, and other agencies can build more national capacity to provide additional assistance, guidance, and expertise to states. This will require a significant investment in staff and resources—an investment that has existed for the Medicare program for decades. This investment must be coupled with a commitment by HHS for a coordinated approach across agencies. This report highlights areas where CMS can assist states in their quality efforts.

Outreach and quality efforts have been a high priority for many state leaders, and they are eager for additional specialized assistance from experts and learning from their peers. They are frequently limited, though, by the resources available to them to implement quality improvement approaches.<sup>2</sup> Collaboration is needed across states to accelerate improvements. Building on existing efforts, such as the AHRQ-sponsored Medicaid Medical Directors Learning Network, can bring states together to learn from each other in all their efforts.

**Commit to accountability, transparency, and reporting at both the state and national levels.** Reporting at many levels (provider, plan, program, state, and national) will be needed to move the system to higher quality. However, achieving national reporting will be key, as it provides comparative benchmarks and ensures the national accountability that CHIPRA seeks to create.

Having states measure and report quality, however, is unlikely to lead to care improvement if measurement investments are devoid of any concerted actions to support the use of the results. This legislation is an opportunity to expand the evidence base regarding which approaches result in improvements. Actions beyond those specifically called for in CHIPRA will be needed by states to build a sustainable quality improvement infrastructure for children.

**Recognize that service quality and outcomes are integrally linked to program performance overall.** Stable enrollment in the Medicaid and CHIP programs is an essential first step to ensuring that children have access to care and to maintaining a focus on quality. As the program is implemented federally and in each state, this link should remain central to implementation choices. Failure to recognize its importance could seriously undermine the success of outreach and quality efforts. In addition, actions to implement this legislation will occur in the context of many other activities states are currently pursuing to improve quality for all populations, not just children. CHIPRA-related efforts must leverage and coordinate with these other activities.

**Attention to disparities should apply across provisions.** As with adults, disparities in health status and health care are pervasive for children, with devastating and often lifelong consequences. Disparities exist based on race, ethnicity, primary language, special needs, and geography. Implementation of CHIPRA is an opportunity to develop an explicit disparity strategy that cuts across all the provisions discussed here to ensure efforts reach those most in need first. Focusing on disparities will influence the outreach and enrollment approaches chosen, the quality measures included in the core measure set, the priority given to new measures, and the way in which reporting is done.

**CHIPRA is important in improving child health and health care, but it did not go far enough.** This major legislative achievement is but a piece of the solution to the challenges that continue to limit our ability to deliver safe, high-quality care to all children in the United States. It falls short in the following ways: 1) it is a bill expanding an existing program and does not provide a guarantee of universal coverage for all children; and 2) it establishes a framework and resources primarily for quality measurement. Far more attention must be devoted to building national and state capacity to improve care. National health reform provides the opportunity to do both, as well as make other changes important to the health and well-being of children.

### **CONSIDERING THE CONTEXT: STATES IN 2009 AND BEYOND**

CHIPRA represents an enormous opportunity to insure new eligible children and enhance program quality. However, implementation of the provisions requires state match funding. Thus, the ability of states to fulfill the potential in CHIPRA depends, at least in part, on the condition of their budgets. While the elimination of CHIP (currently being considered in California) is an extreme example, most states are facing severe shortfalls. In addition to required state funding, successful implementation will depend on state readiness.

CHIPRA will be implemented at a time of highly constrained state budgets. Economic conditions continue to worsen in 2009 and strongly affect states' ability to implement CHIPRA. State budget shortfalls are occurring as public coverage rolls are rising; thus, more funds are needed to serve the eligible uninsured. The outlook for future fiscal years is also bleak, with the potential for rising unemployment and widespread program cutbacks.<sup>3</sup> These conditions will strongly influence the ability of the states to implement provisions that require additional funding. Indeed, as one expert commented, "fiscal issues are overwhelming all programmatic decisions."

States have considerable experience in measurement and appear to be ready to push forward in the directions indicated by CHIPRA. A recent national survey assessed

the status of quality measurement in the states and reported encouraging findings for adoption of quality provisions in CHIPRA.<sup>2</sup> It found that states were working with existing national measurement systems or state-developed tools to assess health care quality and have sufficient baseline data to show where improvements are needed. The survey also reported that states would like to do better and believe they could achieve their quality goals more quickly with specialized technical assistance that would allow them to learn from experts and the experiences of colleagues in other states.<sup>2</sup> Thus, the states appear to be ready to take advantage of the new provisions to make reporting more uniform, rigorous, and related to quality improvement. States, though, are at many different levels of sophistication and experience; this must be taken into account as CHIPRA is implemented.

CHIPRA implementation will follow on the successes of CHIP. CHIP was enacted in 1997. By 2007, it was providing coverage to approximately 6.6 million U.S. children over the course of the year.<sup>4</sup> A decade of research and evaluation studies have demonstrated that children covered through CHIP experience markedly improved access to and use of care, better communication with physicians, fewer unmet needs and financial burdens, and less parental worry about meeting health care needs.<sup>5-8</sup> CHIP has helped to shrink or eliminate racial disparities.<sup>9</sup> Research has also shown that CHIP's full potential for improving health and health care has yet to be reached—approximately two-thirds of uninsured children are eligible for Medicaid or CHIP.<sup>10</sup> Further, quality monitoring, though much enhanced, is not uniform and needs to be more rigorous and reflective of the full range of services that children need, particularly hospital-based services. Both the successes of the original CHIP program and the remaining gaps set the stage for implementation of CHIPRA.

#### **IV. OVERVIEW: KEY FEATURES STRENGTHEN OUTREACH, ENROLLMENT, AND QUALITY**

Reaching, enrolling, and retaining eligible children in Medicaid and CHIP are system and program goals closely related to quality. That is, enrollment and access must be in place before quality improvements can occur. A body of evidence supports the relationship between stability in coverage—which largely depend on the outreach and enrollment processes—and quality of care.<sup>11,12</sup> The table below shows the key features of the CHIPRA legislation.

---

## Outreach and Enrollment Provisions in CHIPRA

---

Outreach grants	CHIPRA includes a number of provisions increasing outreach funding and activities to enroll eligible but uninsured children, with emphasis on those who may be hardest to reach. The law allocates \$100 million to support Medicaid and CHIP outreach and enrollment activities. It provides guidelines on how the funding will be allocated, but gives the Secretary of HHS broad discretion in implementation.
Express lane eligibility	Currently, a high number of uninsured Medicaid- and CHIP-eligible children are enrolled in other public programs. The new law provides states with tools and flexibility for enrolling these children. In particular, it gives states the opportunity to use relevant findings from other public programs, like food stamps, school lunch, and WIC, when determining children's eligibility for CHIP and Medicaid at enrollment or renewal.
Citizenship documentation requirements	CHIPRA allows states to document citizenship by submitting names and Social Security numbers to the Social Security Administration for verification. Previously, citizenship for children, parents, and pregnant women needed to be documented in a highly prescriptive and paperwork-intensive manner, according to requirements in the Deficit Reduction Act of 2005.
Performance bonus	Performance bonuses are designed to encourage states to enroll eligible, uninsured children. States that increase enrollment of eligible children above a target level receive a federal payment for each extra child enrolled to help defray the added costs of successful efforts. States must also adopt at least five of eight specified measures for simplifying enrollment and retention as a precondition to qualify for the bonus.
CHIP enrollment reports	The law requires states to include data in their annual reports to help assess enrollment and retention efforts, including data on continuity of coverage, denials of eligibility at both the application and renewal stages, and children's access to care. It also requires states to provide more timely Medicaid and CHIP enrollment data to the Secretary of HHS and to include a description of state activities to reduce administrative barriers to enrollment and renewals in their CHIP state plans.
Medicaid and CHIP Payment and Access Commission	The law creates a commission to report to Congress on payment policies, access issues, and the relationship of Medicaid and CHIP to the rest of the health care system.

---



<b>Provisions Strengthening Quality of Care and Health Outcomes</b>	
Developing an initial core set of health care quality measures	By January 1, 2010, the Secretary of HHS will identify an initial recommended core set of child health care quality measures for use by state programs. The measures include, but are not limited to, duration of children's coverage over a 12-month period and a wide range of preventive services and treatments.
Establishing a pediatric quality measurement program	By January 1, 2011, the Secretary must establish an ongoing program that advances and improves pediatric quality measures for all children. This program will expand upon and increase existing pediatric measures and will award grants for developing and testing pediatric quality measures.
Measure use and reporting related requirements	By February 4, 2011, the Secretary of HHS will develop a standard format for reporting information, procedures, and approaches that encourage states to use the initial core measurement set to voluntarily report information on quality of pediatric programs. The Secretary will also disseminate information to states on best practices for measuring and reporting on the quality of health care for children.
Demonstration projects	CHIPRA includes \$20 million annually for demonstration projects. HHS will provide grants to up to 10 states and child health providers to use and test child health care quality measures and to promote the use of health information technology for children. The law also includes a separate allocation of \$25 million for a childhood obesity demonstration project.
Development of a model electronic health record	The law requires HHS by January 1, 2010, to establish a program to encourage the development of a model electronic health record format for children in Medicaid and CHIP.

## **V. IMPLEMENTATION CHOICES FOR CHIPRA PROVISIONS**

### **OUTREACH AND SUSTAINED ENROLLMENT PROVISIONS IN CHIPRA**

Through CHIPRA, Congress made clear that covering the lowest-income eligible children is a national goal. CHIPRA encourages states to reduce barriers to enrollment and provides resources to help them do so. Getting and keeping eligible children enrolled is a key component of a high-quality child health system and is critical to measuring quality consistently.<sup>13</sup> There are a number of areas in which strong CMS guidance would help states use the provisions of CHIPRA to maximize sustained enrollment of eligible children. This section will focus on seven elements of the law:

- Outreach grants
- Express lane eligibility
- Citizenship documentation requirements
- The performance bonus
- Payment Error Rate Measurement rules

- CHIP enrollment reports
- Medicaid and CHIP Payment and Access Commission

### **Outreach Grants**

CHIPRA authorizes \$100 million in outreach grants over the course of the reauthorization—\$80 million available to states, community-based organizations, and others; \$10 million for a national outreach campaign; and \$10 million for efforts aimed at enrolling Native American children. These funds are widely viewed as an important resource in the effort to enroll and keep more children in stable coverage.<sup>14</sup> HHS has significant discretion to decide how to distribute and use these funds and has published a request for applications for the first round of funding.

In making decisions about awarding grants, the long history of outreach efforts and interviews with key informants suggest three useful principles:

**Outreach efforts must include enrollment simplifications.** While outreach can signify media campaigns to inform people about their children’s eligibility for coverage, the experts interviewed for this report emphasized HHS should not invest undue resources in such campaigns. Instead, outreach should be viewed in the broadest sense—getting children covered. This most often means states must engage in the substantive work of simplifying their application and renewal procedures in CHIP and Medicaid.

**Emphasizing simplified renewal is critical.** Many experts highlighted the importance of efforts to keep children covered once they are enrolled. Strategies could include providing 12 months of guaranteed coverage or simplifying renewal forms and documentation procedures. A reduction in churning (that is, children going in and out of Medicaid and CHIP coverage) has the potential to create more stable coverage for children, boost participation rates, and prevent unnecessary administrative expenses created by having families repeatedly apply for coverage for their children.<sup>12</sup>

**Outreach needs can vary significantly by state and over time, often depending on states’ commitments.** The need for—and most appropriate use of outreach funds—can depend significantly on the policy and political choices made by states. For example, it is ideal to conduct aggressive efforts to educate families about the availability of coverage in states that have made strong commitments to simplifying their application and renewal processes. Some states, on the other hand, may not share a commitment to aggressive outreach efforts or may be unable to make such a commitment during the economic downturn. Some informants recommended sending outreach

grants to community-based organizations when states are not active partners, but others cautioned that community-based organizations would have limited effectiveness without cooperation from state officials.

HHS's request for applications reflects these themes, in large part. The grants will allow for a wide range of projects, are available to community-based organizations, integrate data collection, and reserve half of the funds for later years. There is an opportunity for the agency to emphasize enrollment and renewal simplifications through the outreach grants.

*Recommendation:*

- **HHS could give priority to states that will adopt or maintain key simplifications.** Outreach and enrollment grants are likely to be most successful in states with enrollment systems that are streamlined and poised to accept eligible children. In making grants, HHS should consider whether a state has adopted simplifications such as 12-month continuous coverage, use of simplified application and renewal forms, use of electronic verification of eligibility information (rather than imposing the burden directly on families), and others outlined in the “five of eight” criteria used in the performance bonus, which is discussed below.

### **Express Lane Eligibility**

Express lane eligibility is a promising tool for states to reduce the paperwork burden on families and eligibility workers while making eligibility determinations more efficient.<sup>15</sup> Many informants view the express lane as a tool that gives states significant flexibility to rethink, reshape, and dramatically improve and simplify how they conduct eligibility and renewal determinations. At the same time, informants have noted that states have some lingering concerns about whether they will be subject to fiscal consequences if they rely on express lane eligibility and it results in errors. Moreover, the concept's promise of greatly simplified eligibility determinations also means that states may give up some precision in enrollment. Specifically, states may end up with some children enrolled in Medicaid who otherwise would have signed up for a separate CHIP program or vice versa.

*Recommendations:*

- **Provide clarity on the relationship between express lane procedures and error measurements.** The most important strategy for encouraging states to adopt express lane procedures is to quickly provide clear guidance on its allowable uses. A major barrier for some states is the perception that it will

increase error rates. Error measurements through Medicaid Eligibility Quality Control and Payment Error Rate Measurement should appropriately privilege the state process. If the state process is followed, including any express lane procedures, errors should not count against the state.

- **Align guidance from federal agencies on data sharing.** Express lane eligibility practices will use data from a variety of federal programs, including Supplemental Nutrition Assistance Program (i.e., food stamps), school nutrition, and the tax system. The federal agencies that oversee these programs—the departments of agriculture, education, and the treasury—should provide guidance to their state counterparts to clarify that data sharing with state Medicaid and CHIP agencies is allowable and encouraged. The Inspectors General of these departments have a special role in assuring state officials that appropriate data sharing will not bring federal penalties.

### **Citizenship Documentation**

Because the Deficit Reduction Act's citizenship documentation requirement has markedly depressed enrollment, particularly among children who are citizens, the new rules and options under CHIPRA represent an important opportunity for reducing barriers.<sup>16</sup> CHIPRA's new options were highlighted by a number of informants as key to reducing unnecessary and costly paperwork requirements now imposed on families seeking Medicaid.<sup>17-19</sup> The new electronic option for states to document citizenship is widely viewed as preferable to the current, paperwork-intensive mandate, but many informants were concerned about whether HHS would work effectively with the Social Security Administration (SSA) to make it available to states by January 1, 2010, as called for in CHIPRA.<sup>20</sup> In addition, informants raised significant concerns about the new extension of the citizenship documentation requirement to separate CHIP programs, beginning January 1, 2010, especially if the new electronic verification options is not up and running by that date. Finally, some informants noted that the provisions in CHIPRA designed to improve the existing citizenship documentation requirement—even as the new SSA option is being developed—have not been highlighted by HHS, and many states seem unaware of them.

#### *Recommendations:*

- **Monitor state adoption of new requirements.** CMS could quickly take steps to ensure that states have complied with the provisions of CHIPRA designed to make it easier for families to comply with the existing citizenship documentation requirement. Strategies include providing reasonable opportunity to applicants to obtain and submit documents, ensuring that

infants born in U.S. hospitals are not required to provide proof of citizenship when they first renew coverage, and making certain that tribal documents are honored as satisfactory citizenship documentation.

- **Convene all stakeholders to ensure timely adoption of Social Security number matching.** CMS should move quickly to work with the SSA, states, and representatives of beneficiaries to ensure that the option to electronically verify citizenship is up and running smoothly by January 1, 2010. CMS reportedly has established a working group with the SSA, but it is not clear that it involves the state officials who will be responsible for using the new option or beneficiary representatives who can provide a family-based perspective on proposed changes.
- **Clarify the question of citizenship versus identity documentation.** Federal officials must address the issue of clarifying whether the option to match records with the SSA will serve as documentation of citizenship only, or of both citizenship and identity. Producing separate documents to establish identity for young children can be just as burdensome as citizenship documentation, so CMS should clarify that CHIPRA allows SSA matches to establish both and make this finding clear to states.
- **Update rules for states that do not adopt Social Security number matching.** It is possible that some states will not rely on the new electronic option. CMS should therefore consider updating the rules that govern the existing process for documenting citizenship status. These requirements, which, for example, require families to show originals of birth certificates and driver's licenses, are much more complex and strict than necessary to comply with the law. CMS could reissue these regulations and simplify the convoluted hierarchy of documents required to prove citizenship and stipulate that copies that appear authentic are acceptable because the requirement for original documentation is particularly problematic for families.

### **Performance Bonus**

CHIPRA allows for a Medicaid performance bonus for states that meet the conditions of successful enrollment and the adoption of multiple enrollment simplification procedures, with states required to adopt five out of eight specified simplifications. In effect, the performance bonus provides states with fiscal assistance if they succeed in markedly increasing their enrollment of eligible children in Medicaid. As such, it supports and

strengthens the potential effectiveness of all of the other provisions in CHIPRA aimed at reaching eligible children.

In discussing the bonus, informants noted that the statute gives HHS broad discretion to determine if a state has met the “five out of eight” criteria, which means it is currently difficult to assess the number of states that meet the basic preconditions for receiving bonus payments. Some also said that the enrollment gains states must meet are ambitious and may be out of range for many, even if they adopt five of the eight simplification measures.

*Recommendations:*

- **Provide rapid guidance on how qualifying simplifications will be counted.** To adopt the required simplifications and make their states eligible for bonus payments, state officials must know how CMS will determine state compliance. CMS should provide this information as soon as possible, because CHIPRA provides for performance bonuses each year, beginning in 2009.
- **Ratchet up qualifying simplification efforts.** In establishing compliance criteria, CMS may want to create an expectation that simplification efforts will become more robust over time, especially for some of the new or more complicated simplifications. For example, a state that adopts express lane eligibility and launches it on a pilot basis should perhaps be initially considered in compliance with this measure. But, in future years, the state could be expected to move beyond the pilot and to adopt it statewide to be deemed in compliance. While the requirements should be meaningful to ensure significant improvements, it is also unrealistic to expect states to implement new options at the optimal level immediately.
- **Make appropriate, allowable adjustments to enrollment targets.** To address the concern that many states believe they cannot meet the enrollment targets required for the bonus, CMS should make these targets more realistic, if possible. For example, the law may allow CMS to reduce a state’s enrollment target if the size of its child population is shrinking.

### **Payment Error Rate Measurement Rules**

Informants with strong state affiliations noted that state officials are acutely sensitive to the negative consequences—including the effect on public reputation—of reports that their programs have high error rates. In light of this, they highlighted the importance

of clear rules on errors and of providing states with the tools needed to minimize them. Moreover, since error rates can drive policy to a surprising extent, some informants encouraged CMS to consider including situations where eligible children are denied coverage, not just those where ineligible children secure coverage.<sup>21</sup> One informant said there are mixed messages to states, which have had a chilling effect. Another said, “[CMS] needs to decide what they want to do.... If they are going to be focused on outreach and simplification, then they have to provide some relief to states.”

*Recommendation:*

- **Take into account negative case errors.** CHIPRA requires that CMS publish a new final rule on payment error rate measurements by August 2009. The current Payment Error Rate Measurements focus on identifying when states err in enrolling ineligible children and inaccurately pay for services. The new rule could further encourage states to enroll and retain eligible children by explicitly measuring the extent to which states are improperly denying enrollment or renewal to eligible children. By not recognizing that these so-called negative case errors are as detrimental to progress as enrolling ineligible children, CMS and states forego a significant opportunity to ensure program success. Measuring negative case errors is the first step in working to minimize them.

### **CHIP Enrollment Reporting**

CHIPRA adds a number of elements to states’ required annual CHIP reports, reflecting Congress’s strong interest in tracking states’ progress in enrolling eligible children. States now are expected to report on eligibility criteria, enrollment, retention, use of simplification measures, access to care, care coordination, and, if a state provides premium assistance, information on its efforts to coordinate premium assistance with employer-based coverage.<sup>22</sup> Informants identified these requirements as a new, rich source of data to document program activities and inform opportunities for program improvements, as well as to create greater transparency in the effectiveness of states’ child health enrollment efforts.

*Recommendations:*

- **Convene stakeholders to determine how data should be collected to allow for meaningful comparisons across states and over time.** CMS will have significant discretion to identify the kinds of data that states must provide in these reports. Informants noted, for example, that states could be expected to provide information on the number of applications that they receive each

month, the share of such applications approved, the share disapproved for paperwork reasons, and other key measures of the state's application process. Similarly, states could be expected to provide information on renewal rates and continuity of coverage. States, though, are unlikely to be willing or able to comply with data requirements unless they have a chance to provide input in their development. CMS should lead a process that brings together federal and state officials as well as beneficiary advocates to develop workable data standards that allow for meaningful comparisons among states and over time.

- **Share data rapidly and publicly.** By combining information on eligibility criteria and simplification with enrollment and retention, these reports will allow states to assess the success of efforts in other states. States will be best able to take advantage of the knowledge generated by the experience of their peers if data are available quickly and if CMS compiles the data from the state-specific reports and makes it publicly available on its Web site.
- **Coordinate data collection with other CHIPRA provisions.** The standardized reporting format for enrollment data should mesh with the data required by other provisions of the bill. This includes the core quality measures, the data necessary to determine which states meet the Medicaid performance bonus, and the data collected to support evaluation of the effectiveness of the outreach grants.

### **Medicaid and CHIP Payment and Access Commission (MACPAC)**

CHIPRA establishes a 17-member commission to study payment policies, access issues, and the relationship of Medicaid and CHIP to the rest of the health care system. The Commission is charged with making two reports to Congress each year, beginning on March 1, 2010. While much of the Commission's activity will be determined by its legislative charge and its yet-to-be appointed members, lessons from the Medicare Payment Advisory Commission (MedPAC) informed two recommendations for MACPAC.

#### *Recommendations:*

- **Take advantage of previous efforts to study Medicaid.** MACPAC has an aggressive timeline for its first reports, so it will need to rely on existing data and analysis, which it should plan to build on. Specifically, the Medicaid Yellow Book, produced by Congressional agencies in 1988 and 1993 and by the Kaiser Commission on Medicaid and the Uninsured in 2002, could serve



as both an important source of information and a model for future reports. In addition, MedPAC's predecessor, the Physician Payment Review Commission, studied access to Medicaid and produced recommendations that should inform MACPAC's early efforts.

- **Measure access across all populations.** Access concerns exist not only in Medicaid and CHIP, but in Medicare and private health insurance. The same providers serve patients from all payers. MACPAC should ensure that its assessment of access is comprehensive and that its recommendations work in harmony with other health system initiatives. One possibility is to collaborate with MedPAC's physician surveys, so the two commissions can align their recommendations.

#### **TITLE IV: STRENGTHENING QUALITY OF CARE AND HEALTH OUTCOMES**

CHIPRA's Title IV is the result of years of drafting and input from many sectors and reflects the field's consensus around the importance of quality measures and consistent reporting, balanced by concerns about state flexibility. Importantly, it established that these provisions apply to both Medicaid and CHIP, making an important move toward a consistent strategy across the programs nationally and at the state level. However, the provisions focus disproportionately on measurement and less on improvement, which must be addressed for care to improve.<sup>23</sup>

Despite the scope of these provisions, significant strategic choices by HHS will be necessary to ensure that they support improved care and outcomes for children. In this report, the authors examine the aspects of the provisions where the greater number of implementation options exist, either at the federal or state levels.

In April 2009, CMS and AHRQ executed a memorandum of understanding that outlines which agency will take a lead role on various provisions. According to the agreement, AHRQ is leading the implementation of four provisions: the development of the initial core measure set, the establishment of a quality measures program, the development of a model electronic health record, and the Institute of Medicine study.

#### **Developing an Initial Core Set of Health Care Quality Measures**

The legislation specifies that an initial core set of health care quality measures be published by January 1, 2010. AHRQ has moved quickly to execute. It established a sub-committee of the AHRQ National Advisory Council to function as the public advisory

body and meet the extensive legislative requirements regarding the types of input needed in this process.

A critically important aspect of the legislative language of this section is that while the set of measures is labeled health care quality, it actually emphasizes measures of coverage and availability of services as much as, if not more than, measures of quality of care.

Informants' range of input and concerns varied. In general, state representatives expressed concerns about new measures being useful to states, as well as the additional costs and burden that the collection and reporting will entail at a time of strained budgets and with states' limited technical expertise or capabilities. At the same time, the 2009 survey of Medicaid and CHIP leaders found that most states (68%) thought that Medicaid and CHIP could "do a better job to improve care for children if there were [other] measures."<sup>2</sup> Pediatric experts and others interviewed as part of this project felt that the provisions fell short of what was needed, but were a good start. Several themes emerged from conversations with informants:

**States are already heavily engaged in quality measurement activities.** In 2009, almost 90 percent of Medicaid programs and 100 percent of CHIP programs report using HEDIS access and effectiveness measures related to child health.<sup>2</sup> In addition, 83 percent of Medicaid programs report augmenting national measures with state-specific measures in priority areas (e.g., dental care). In contrast, only 18 percent of CHIP programs report using additional state measures.

**Having comparable data across states is not enough.** All informants underscored the importance and value of having comparable data across states, Medicaid and CHIP populations, and programs types (i.e., fee-for-service, primary care case management, and managed care). However, concern was voiced repeatedly that the initial core set not simply represent "the lowest common denominator." HEDIS, or HEDIS-like measures, are used by most state programs today, but simply ensuring consistency across states would be viewed by some as "a worst-case scenario."

**Move rapidly to a broader set of state-relevant measures.** Several priority measurement domains were suggested for inclusion in the core set, such as perinatal measures, development and healthy behaviors, autism-related measures, oral health, obesity, behavioral and mental health, chronic illness, coordination of care, medical

home, and patient experiences of care. HHS should incorporate changes to the core measurement set regularly, rather than waiting for a report to Congress in 2013.

**Ensure that a focus on clinical quality is achieved.** Information relevant to the clinical services being delivered should be available to support improvement by providers.

**The set needs to work for today and build toward the future.** The enhanced measurement set should build for the future. It should consist of measures that add content and expand upon those currently in place, and also be flexible enough to accommodate new measures. Future measures could anticipate electronic health records and the ability to report on outcomes, as well as processes.

*Recommendations:*

- **The core set should go beyond the existing HEDIS measures.** HEDIS alone is inadequate to respond to the legislative intent of this section and the strong desire of the majority of stakeholders. Importantly, the core set must ensure a balance between programmatic measures of performance and clinical quality of care. In addition, stakeholders were emphatic in their call for specific attention to measures on perinatal care, measures of hospital care, and an explicit focus on information relevant to examine disparities across groups.

Whether all these dimensions can be addressed with the initial core set is not clear. However, it will be necessary to expand the core set as new measures are tested and developed. For example, measures currently under development by NCQA that not only measure whether a visit has occurred, but examine whether age-appropriate aspects of care have been delivered are candidates for addition.<sup>24</sup> As more measures become available, some measures may be rotated in and out of the core set.

- **Consider developing a CORE-PLUS set.** A CORE-PLUS set would provide guidance to states that have already moved beyond the current HEDIS measures and are ready to enter into more developmental areas. This may require a constrained set of final adaptation or testing for active use, but not full-blown new measure development. One possibility would be adding questions to the existing ambulatory Medicaid Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys to report on health behaviors, emotional and behavioral health, and developmental concerns.<sup>2</sup> This approach should

also be considered to include a more global assessment of outcomes, such as days missed from school or functional status.<sup>25</sup> Finally, another high priority domain is measures that address family issues that have a high impact on the child, such as maternal depression.

- **Ensure that appropriate criteria are used in selecting the set.** Specific criteria are needed to guide the development of the core set. The recently updated criteria published by the National Quality Forum could be an appropriate starting point for this effort.<sup>26</sup> However, additional criteria will be needed, such as relevance and actionability to states; importance to consumers, patients and families; and appropriateness to children and their unique needs.<sup>27</sup>

### **Establishing a Pediatric Quality Measures Program**

Section 1139A(b) calls for the establishment of a pediatric measures program by January 1, 2011, to improve and strengthen the core set, expand on current measures, and increase the portfolio of “evidence-based, consensus pediatric quality measures” available. It is important to note that this new program is charged with going beyond the Medicaid and CHIP programs and must specifically address the needs of public and private purchasers, providers, and consumers.

The fact that CMS and AHRQ have agreed to have AHRQ lead this provision recognizes the long-standing role that AHRQ has had in developing quality measures for both public and private purchasers. However, it is important to note that AHRQ has a legislative mandate to advance quality measures and that children are named as one of AHRQ’s priority populations in legislation. Thus, this newly funded CHIPRA program should not be seen as substituting for existing or future AHRQ investments—from the AHRQ appropriation—in these topics.

Recently, national quality groups have established numerous efforts to develop measure sets and new measures. Child-focused measures have been underrepresented in much of this work, a gap the CHIPRA provisions were designed to address.

**Clear priorities, within a well-accepted framework for new measures, are needed.** Many informants commented on the need for additional content in the core measurement set. They recognized that this will require additional measurement development and testing. Rather than a broadly framed program, several informants emphasized the need to establish clear priorities and direct measure development efforts. This is the direction that other quality measurement efforts are taking (e.g., the National

Priorities Partnership Program). In addition, using well-accepted frameworks, such as those developed by the Institute of Medicine, would ensure that measures across all the domains of quality (i.e., safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity) and at all levels (i.e., patient and community, clinical systems, organization, and environment/policy), are developed. A well-developed approach to planning new measure investments is essential to avoid special interests of some groups from determining the content of the new measures.

**New measures should reflect children’s unique needs.** The ways in which child health, health care, and quality measurement needs differ from adult needs have been well described. They are described as the “four Ds:”<sup>28</sup> children experience different diseases from adults (differential epidemiology); have their needs change over time as they grow and mature (developmental trajectory); rely on their parents and caregivers to access needed services (dependency); and are disproportionately low-income and racially and ethnically diverse and, thus, rely on a unique set of public and private providers (different systems). From a measurement perspective, this would prioritize such measures as care for children with special health care needs, limited English proficiency, health literacy, and obesity.

**Increase emphasis on outcomes and bundled measures.** Most of the recently developed measures in pediatric care are process measures.<sup>23,29</sup> Less attention has focused on the methodologic and feasibility issues surrounding the use of outcomes measures in a quality measurement context. Measures of functional status are critical, and these must include such elements as school readiness. NCQA has developed a measurement framework for improving the HEDIS set for children that includes a focus on content of the visit (protection of health, healthy development, and safe environment), to address broader outcomes, including school readiness, family productivity, and workforce readiness.<sup>24</sup>

Another trend in quality measurement is the development and use of bundled or composite measures. These measures cover various aspects of the same care process or condition, and credit is given only if all aspects of the care are provided.<sup>30</sup>

**Support multiple levels of accountability.** Some informants said that the new provisions suggest a move from health plans as the focus of accountability to Medicaid and CHIP as the primary focus. This change in focus would lead to state-level Medicaid- and CHIP-wide measures and to a different strategy for including children in the measurement system.

A number of informants spoke to the need for robust measures at the physician or hospital levels. These are the levels that provide actionable information, not the health plan level. As one informant stated, “The system needs to be designed to report at the individual physician level and then you can aggregate up.” Finally, maintaining a focus on national reports, particularly for clinical measures where comparisons by provider types are more actionable, is critical.

*Recommendations:*

- **Build measures for the future.** Implementers must envision a multiyear effort to develop measures that will extend beyond the time horizon of the current CHIPRA. The initial core set of measures will need to rely largely on HEDIS and what states are already doing. Two interrelated changes should be anticipated: in the future, data collection will rely more on downloads from EHRs, and, in turn, this change will improve the ability to move from process measures to outcomes and measures of health status.
- **Focus measure development funding on outcomes and composites.** There has been significant progress in measure development over the last decade.<sup>23,24,31,32</sup> There are several additional measures in widespread use that should be considered for testing for children. As AHRQ establishes the measures development program, it should further expand the content to include some missing groups or themes, such as measures for the prenatal/postnatal period, measures directed at hospitals, or measures that assess coordination of care.
- **Design improved specifications for measures at all levels of accountability.** Measure developers should be mindful of creating a family of measures that allow for assessing quality across both Medicaid and CHIP, not just at the contracted health plan level. In addition, focus accountability to a variety of subgroups, such as health plans, hospitals, or even primary care practitioners. Further, accountability provisions should include examining the performance of all children as well as the performance of subgroups separately, such as separate racial and ethnic groups or language groups to identify and reduce disparities in access and treatment.

### **Provisions Related to Measure Use and Reporting**

Several sections of Title IV create new responsibilities for HHS related to reporting on quality and the core measure set. The legislation directs the Secretary of HHS to

provide technical assistance to the states to foster standardized reporting. Areas of assistance include: 1) development of standardized reporting formats, 2) dissemination of information about best practices for measuring and reporting the quality of health care for children, and 3) assistance to states to help adopt and use the core child health measures.

In addition, CHIPRA requires that the Secretary of HHS report to Congress on both the stability of coverage and the quality of children's health care, based on state reports. These provisions offer an important opportunity to sharply enhance transparency in the program and give the states and federal government the information they need to understand where improvements are needed and how to make them. The importance of these provisions lies in enabling measurement of quality to be the first step in improving quality. Medicare has a long history of lessons learned through collecting data and working with providers to improve quality, but Medicaid and CHIP have not yet developed robust quality improvement capacity across all their populations. Currently, funds for quality improvement for Medicaid, even given the increase in CHIPRA, are dramatically outpaced by similar funds in Medicare.

**Partnership with states is critical.** While CMS already has in place numerous venues and mechanisms where discussions with states occur, structured, ongoing, and meaningful partnership will take added time and require commitment and significant investment of resources and staff from HHS to be successful. At a minimum, the partnership would include CMS, AHRQ, and the Surgeon General, who are charged with implementation of CHIPRA, and possibly the Centers for Disease Control and Prevention and the National Institutes of Health as well.

**Voluntary reporting may not yield a national picture.** Informants expressed concern that voluntary reporting may not be sufficient to meet the intent of the legislation and truly spur improvement efforts. They felt that incentives may be needed. Reporting currently is most complete for managed care plans, less so for primary care case management populations, and generally not done for fee-for-service. In addition, special populations like the aged, blind, and disabled are often left out of the reports. Informants believe that all populations should be included, with specific guidance given on how to handle different populations.

**Opportunity to use incentives in multiple ways.** CHIPRA sets the stage for behavior change by many stakeholders: HHS, including CMS and AHRQ; states (i.e., Medicaid and CHIP programs); health plans; hospitals and physicians; and parents and children. The existing "pay-for" strategies (e.g., pay for reporting, improvement, or

performance) are resulting in varying and often low levels of success or improvement.<sup>33,34</sup> In child health care even less is known about effective ways to structure such incentives.<sup>35</sup> However, there is a consensus that incentives will be critical to helping states implement these provisions. Incentives can be designed to foster certain state actions (e.g., use of the core set, reporting at multiple levels, etc.) or system and provider actions (e.g., states setting up pools to be used for pay-for-performance programs), as follows:

- *State incentives.* Most of the discussion focused on providing additional resources for developing the data collection infrastructure required for the core measure set. Suggested approaches included expanding the types of state data investments that are eligible for 90/10 match beyond eligibility systems, creating a pool of funds for states to use for a range of administrative costs related to reporting, or creating an additional pool of resources nationally for which states could compete.
- *Physician incentives.* The Physician Quality Reporting Initiative (PQRI) was created in 2006 and provides an incentive payment for eligible professionals who satisfactorily report data on quality measures for covered services to Medicare beneficiaries.<sup>36</sup> Incentives could be linked to participating in a CMS-approved registry, with reporting on the key measures for that disease or condition. If physicians are provided with feedback, information, and value on the care they provide, they will continue to report. This would be particularly useful in pediatrics around such issues as asthma or attention deficit hyperactivity disorder. One informant commented that “PQRI was all about payment, not improvement.”

**Level of accountability.** Some informants called for core measure data to be reported in a way that allows states to report on quality of care for Medicaid and CHIP children at the state level, as well as in local communities. They pointed out that improving quality often was a community-wide effort, and, thus, data needed to be available at the community level to encourage the community to act. Other informants raised the issue of reporting at the provider level, generally noting that some providers (generally private providers) may not have sufficient numbers of Medicaid and CHIP children to make reporting at this level valid. They also pointed out that, in many cases, Medicaid and CHIP data would need to be combined with data from other children to create provider-level estimates. Finally, it is critical to ensure that national reporting enables comparisons across hospitals and eventually other providers, as in Medicare.

**Data quality.** Currently, under HEDIS, states often use a hybrid measure involving both administrative data and chart review. Many state-level informants told



us that their hybrid measure data had been audited many times and was of high quality. However, the quality of claims data is often a problem. As most states have moved to managed care plans for their covered-child populations, these plans often send encounter data, not claims data, to the state and these serve as “shadow claims,” (i.e., health care encounter records not used for billing purposes) further compounding the problem. Because claims may play a stronger role in future reporting, efforts to ensure that data quality is high are important. Robust and accurate claims data are needed at various levels. Some informants urged working toward this end. Others noted that data supplied at high levels of aggregation from states will be of limited utility.

**Use of quality data for other purposes.** To date, data on the performance of child health systems at the state level have been limited to that available from vital statistics, national surveys, and hospitals.<sup>37</sup> As HHS moves ahead with the implementation of the provisions, it is critical that quality reporting on children is not relegated to just one annual report to the Secretary. The data could also be included in the AHRQ National Healthcare Quality and Healthcare Disparities Reports and made available to researchers.

**Measurement alone does not lead to improvement.** Quality efforts have too often failed when the only strategy was measurement. While measurement is a necessary first step, it is not enough. CHIPRA does not emphasize improvement, other than promoting the use of the core measures to support improvement and the demonstration authorities. Yet, it is clear that the legislative intent is to improve care, not just measure it. Indeed, the HHS Secretary is called upon to report “to Congress on efforts to improve ... the quality of children’s health care under such titles...,” as well as the status of voluntary reporting. Systematic, sustained improvement that yields measurable results takes work, time, and resources. There is currently little or no infrastructure for states to do this. However, several successful models exist that HHS can draw on and adapt to meet this mandate. Nonetheless, the funds appropriated under Title IV are not adequate for this purpose. Bills have been introduced in Congress to significantly expand the focus on quality improvement.

*Recommendations:*

- **Ensure meaningful collaboration with states in the design and execution of each step of the reporting strategy.** Achieving comparable reporting across all states that supports benchmarking and is meaningful, useful, and sustainable will require extensive participation by states. This does not

mean that state concerns or resistance should trump critical input from other stakeholders, such as health plans, physicians, and parents.

- **Make the goal consistent quality reporting on the core set by all 50 states on all populations.** CHIPRA does not mandate state reporting on the core set, however, anything less than full participation will be a disappointment and a distinct failure of the promise of the legislation. If HHS and states can agree on this as a goal, it will drive a set of actions to make it possible.
  - *Focus efforts on encouraging state reporting.* Incentives are needed to encourage all states to report and reduce the cost of entry. Several strategies are possible. For example, incentives could take the form of enhanced state match for the reporting function. CMS should consider using a 75/25 or 90/10 match to encourage efforts to report quality data. The latter may require a legislative change, however. In addition, reporting on all populations may also be more likely if incentives are provided. States may need to report using the same specifications as a managed care plan for children in fee-for-service Medicaid or for children in primary care case management programs, as was done in New York and other states.
  - *Ensure that sufficient resources are devoted nationally to achieving quality reporting.* At the same time that states will need help with their programs, the effort could be accelerated by investing in sufficient national resources to support states in the move to standardized reporting. These could include the development of data tools and resources to support the collection of the core set (e.g., templates, shell programs, etc.) and technical assistance, peer support across states, and other collaborative approaches. One possible model is to create a national program for supporting states, ongoing reporting, and use of the measures. As one stakeholder noted, “Using CHIPRA to maximize cross-state learning and uptake of promising strategies and tools seems critical and a very important use of funds.” Many states will be confronted with the decision of whether to build or buy the expertise and having national capacity would accelerate progress by many states.
  - *Take steps to encourage faithful adherence to technical specifications.* Even if states submit what they believe to be core measures, in the

early years some review and feedback likely will be needed to ensure comparability and consistency across states and populations. Some informants suggested that CMS staff should review reports and notify states if they are not in the standardized format. Informants stressed the importance of this detailed and time-consuming work in ensuring that reports were of sufficiently high quality to portray an accurate picture of quality. As noted previously, funds are needed for this activity.

- *CMS should make funds available to improve data quality.* The CHIPRA legislation provides \$5 million to CMS to improve the timeliness of data in the Medicaid Statistical Information System (MSIS) for monitoring enrollment and eligibility. No comparable earmark for helping states with the data requirements for reporting exists. However, CMS could use enhanced matching formulas to help states with data quality challenges.
- **The data that support the core measures should be made available nationally, not just aggregate data.** Reports from states aggregated at the state level, or even at the individual plan level, are of limited utility for policymakers or toward the goals of transparency or advancing knowledge. This recommendation would have Medicaid moving in the direction of Medicare, where data is reported by organization (e.g., hospitals, nursing homes). Data could be put into a national data structure, such as the Healthcare Cost and Utilization Project (HCUP) family of data sets, the CAHPS benchmarking database, or even CMS sites such as Nursing Home Compare, to create a “Child Health Compare,” where queries or specific prepackaged state reports could run. The information would be available broadly for state programs, researchers, and policymakers.
- **Begin investing in a national and state infrastructure for ongoing, sustained quality improvement.** To couple CHIPRA’s investment in quality measurement with real improvements in care delivery, states and providers will need targeted improvement assistance. CHIPRA calls on HHS to “disseminate information to states regarding best practices among states with respect to measuring and reporting on the quality of health care for children” and to pay particular attention to approaches that “encourage successful quality improvement strategies.”

## **Demonstration Projects**

The CHIPRA law authorizes two new types of demonstration projects. First, it calls for up to 10 grants to states and child health providers to conduct demonstration projects to evaluate promising ideas for improving the quality of children’s health care. The second is focused on childhood obesity.

Some informants believe that the 10 projects should demonstrate the way measurement is used to improve quality, in addition to demonstrating the more technical aspects of measurement and health IT use as specified in the legislation. There were different views of priorities for the demonstrations. Many informants expressed the view that the demonstrations needed to show measurement for all children, but some believed that demonstrations of selected new measures aimed at subsets of children were appropriate as well.

Informants who suggested focusing projects on subsets of children wanted to use the demonstrations to improve quality of care in areas of key concern and where care is more complex. For example, in cases of chronically ill children, weight control and diabetes, and any of several high-cost, high-prevalence diagnoses. These demonstrations would test a quality improvement program tied to process and outcome measures for the problem areas.

It was noted that there have been many demonstrations in Medicaid.<sup>23</sup> They have yielded much information but have generally been single-site demonstrations. Our informants believed that the time for single-site demonstrations (so-called “boutique” demonstrations by informants) has passed. They called, instead, for multistate studies on, for example, how to create and sustain a medical home for children in Medicaid and CHIP. In addition to multistate demonstrations, the theme of learning across demonstration sites and projects emerged—states can and want to learn from each other.

The legislation also calls for a demonstration project to develop a comprehensive and systematic model for reducing childhood obesity. The model would: 1) identify behavioral risk factors for obesity through self-assessment, 2) identify needed preventive and screening benefits, 3) provide ongoing support to target individuals and their families to reduce risk factors, and 4) be designed to improve health outcomes, satisfaction, quality of life, and appropriate use of items and services available for Medicaid and CHIP children.

*Recommendations:*

- CMS has a long history of sponsoring demonstration programs within Medicare and Medicaid. Many have fallen short of their potential to advance the field and develop and test new strategies. Demonstrations can have different themes and purposes but need to adhere to some common rules, as follows:
  - Demonstrations should focus on improving quality of care generally, as well as demonstrating the specific aspect to which they are targeted in the legislation (e.g., health IT, provider-based models).
  - Most of the demonstrations should focus on all children in Medicaid/CHIP, not just those in selected sites or plans. Most should demonstrate measurement and improvement for children in managed care, primary care case management, and fee-for-service.
  - Demonstrations could be designed to answer questions across the priorities identified in the legislative language, for example, comparing medical home or care coordination approaches alone or with a health IT component.

**Development of a Model Electronic Health Record (EHR)**

CHIPRA provides \$5 million for the development of a model that addresses children's unique needs. While the inclusion of this provision was important, the subsequent passage of the American Reinvestment and Recovery Act (ARRA), or stimulus bill, with its \$19 billion investment in promoting the adoption of EHRs by both hospitals and ambulatory providers, makes this CHIPRA provision critical. In addition to the funds provided as direct financial incentives to promote adoption, this legislation also establishes important health IT policy and standards committees and it earmarks \$2 billion for HHS to support adoption through grants, a national resource center, a network of regional resource centers, and an extension program. All of these have the potential to dramatically improve the use of EHRs by child health providers, if attention to children's needs is assured in HHS's implementation of these new funds.

In addition to the many unique functionalities that child health providers need (e.g., ability to chart growth and development, age-referenced laboratory values, links to public health and schools), several informants underscored the need to build quality measurement and improvement capabilities into health information systems. Priorities among these were registries, decision support, prescribing support, and reminder systems.

*Recommendation:*

- HHS should ensure that the health IT-related activities of CHIPRA are coordinated with those of the Office of the National Coordinator, which has oversight for the implementation of the ARRA investments.

## **HOW HEALTH REFORM CAN CONTINUE THE PROGRESS OF CHIPRA**

With various health reform proposals under discussion, there is enormous potential not only to expand coverage to millions of Americans, but also to transform the health care system as a whole. The CHIPRA legislation begins this transformation process for children. Regardless of the final architecture for reform or whether CHIP survives as a separate program, it is essential that the progress achieved with CHIPRA—particularly in recognizing the unique needs of children in the area of quality and health information technology—be maintained and serve as the starting point for larger health reform efforts.

The overall quality-monitoring strategy begun under CHIPRA should serve as a starting point for monitoring quality for children both in Medicaid and in any health insurance exchange. However, these provisions should be viewed as a starting point only. As shown in this brief, the CHIPRA legislation, while groundbreaking, does not go far enough. Its emphasis is on improving measurement rather than using measurement as a tool to improve quality. Quality improvement provisions in health reform go beyond CHIPRA to stress quality improvement outcomes. Several of the quality improvement efforts under CHIPRA should flow naturally into improvement efforts for children in the larger landscape envisioned by health reform. Among these are the following:

### **Make quality of care for children and youth part of the national priorities.**

Proposals have called for the establishment of a national quality strategy. It is essential, when developing this strategy, to include children as a priority group.

**Monitor quality for all children, regardless of program, and look at important subgroups.** The CHIPRA legislation supports looking at quality for populations as a whole, not just within a given program. The measurement provisions apply to both public programs—Medicaid and CHIP—and begins the process of including children with private coverage. The emphasis in health reform on bringing coverage to all or most of the population and de-emphasizing programmatic boundaries will bring with it a shift from quality improvement within distinct programs to quality improvement for all children in a given state. Likewise, efforts to monitor quality overall and by important subgroups (e.g., racial or ethnic groups), communities, and accountability units (e.g., providers) will set the stage for monitoring the effects of health reform.

**Establish data infrastructure for collection across programs.** The data system implemented under CHIPRA can serve as both a model and a core for a larger data infrastructure that covers programs in the health insurance exchange and other employer-sponsored programs.

**Invest in a robust national strategy for improvement of child health outcomes that builds on CHIPRA and lessons learned.** Federal and state officials have learned many lessons about making the process of signing up for and renewing coverage easy for families. Many of these were incorporated into CHIPRA. It will be important to take advantage of these lessons as health reform commences. At the same time, strategies for outreach and enrollment must adapt to the changed environment envisioned under health reform. In addition, significant new investments in training and supporting providers and systems for quality improvement will be critical.

## NOTES

- <sup>1</sup> Congressional Budget Office, “Projected Average Monthly New Enrollment of Otherwise Uninsured Children in Medicaid and CHIP for Fiscal Year 2013” (Washington, D.C.: CBO, Feb. 11, 2009).
- <sup>2</sup> V. Smith, J. Edwards, E. Reagan et al., *Medicaid and CHIP Strategies for Improving Child Health* (New York: The Commonwealth Fund, July 2009).
- <sup>3</sup> Kaiser Commission on Medicaid and the Uninsured, *Medicaid in a Crunch: A Mid-FY 2009 Update on State Medicaid Issues in a Recession* (Washington, D.C.: Kaiser Family Foundation, Jan. 2009).
- <sup>4</sup> Centers for Medicare and Medicaid Services, *FY 2006 Annual Enrollment Report* (Baltimore, Md.: CMS, 2007).
- <sup>5</sup> J. Wooldridge, G. Kenney, C. Trenholm et al., *Congressionally Mandated Evaluation of the State Children’s Health Insurance Program: Final Report to Congress* (Washington D.C.: U.S. Department of Health and Human Services, Oct. 2005).
- <sup>6</sup> G. Kenney, “The Impacts of the State Children’s Health Insurance Program on Children Who Enroll: Findings from Ten States,” *Health Services Research*, Aug. 2007 42(4):1520–43.
- <sup>7</sup> P. G. Szilagyi, A. W. Dick, J. W. Klein et al., “Improved Asthma Care After Enrollment in the State Children’s Health Insurance Program in New York,” *Pediatrics*, Feb. 2006 117(2):486–96.
- <sup>8</sup> J. R. Lave, C. R. Keane, C. J. Lin et al., “Impact of a Children’s Health Insurance Program on Newly Enrolled Children,” *Journal of the American Medical Association*, June 10, 1998 279(22):1820–25.
- <sup>9</sup> L. P. Shone, A. W. Dick, J. D. Klein et al., “Reduction in Racial and Ethnic Disparities After Enrollment in the State Children’s Health Insurance Program,” *Pediatrics*, June 2005 115(6):e697–e705.
- <sup>10</sup> G. Fairbrother, J. Schuchter, and L. Simpson, “What Do We Know About the Effect of Insurance Expansion for Children?” *Child Policy Research Center Policy Brief* (Cincinnati, Ohio: Cincinnati Children’s Hospital Medical Center, 2008).
- <sup>11</sup> L. M. Olson, S. F. Tang, and P. W. Newacheck, “Children in the United States with Discontinuous Health Insurance Coverage,” *New England Journal of Medicine*, July 28, 2005 353(4):382–91.
- <sup>12</sup> A. Cassidy, G. Fairbrother, and P. W. Newacheck, “The Impact of Insurance Instability on Children’s Access, Utilization, and Satisfaction with Health Care,” *Ambulatory Pediatrics*, Sep–Oct 2008 8(5):321–28.
- <sup>13</sup> D. Horner, *Program Design Snapshot: 12-Month Continuous Eligibility* (Washington, D.C.: Georgetown University Center for Children and Families, March 2009).
- <sup>14</sup> The outreach provisions can be found in §201–202 of “The Children’s Health Insurance Program Reauthorization Act of 2009,” Pub. L. 111–3, 123 Stat 8 (2009).



- <sup>15</sup> S. Dorn, *Express Lane Eligibility and Beyond: How Automated Enrollment Can Help Eligible Children Receive Medicaid and CHIP* (Washington D.C.: The Urban Institute, April 21, 2009).
- <sup>16</sup> V. Smith, B. C. Edwards, and J. Tolbert, *Current Issues in Medicaid: A Mid-FY 2008 Update Based on a Discussion with Medicaid Directors* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, Jan. 2008).
- <sup>17</sup> L. Summer, *Getting and Keeping Coverage: States' Experience with Citizenship Documentation Rules* (New York: The Commonwealth Fund, Jan. 2009).
- <sup>18</sup> D. Cohen Ross, *Medicaid Documentation Requirement Disproportionately Harms Non-Hispanics, New State Data Show: Rule Mostly Hurts U.S. Citizen Children, Not Undocumented Immigrants* (Washington, D.C.: Center on Budget and Policy Priorities, July 10, 2007).
- <sup>19</sup> K. Allen, S. Anthony, S. Barnidge et al., *Medicaid: States Reported that Citizenship Documentation Requirement Resulted in Enrollment Declines for Eligible Citizens and Posed Administrative Burdens* (Washington, D.C.: United States Government Accountability Office, June 2007).
- <sup>20</sup> L. Ku, D. Cohen Ross, and M. Broadduss, *Documenting Citizenship and Identity Using Data Matches: A Promising Strategy for State Medicaid Programs* (Washington, D.C.: Center for Budget and Policy Priorities, Sept. 1, 2006).
- <sup>21</sup> The PERM provisions can be found in §601 of “The Children’s Health Insurance Program Reauthorization Act of 2009,” Pub. L. 111–3, 123 Stat 8 (2009).
- <sup>22</sup> An act to amend title XXI of the Social Security Act to extend and improve the Children’s Health Insurance Program, and for other purposes.
- <sup>23</sup> D. Dougherty, and L. A. Simpson, “Measuring the Quality of Children’s Health Care: A Prerequisite to Action,” *Pediatrics*, Jan. 2004 113(1 Pt. 2):185–98.
- <sup>24</sup> S. H. Scholle, N. E. Sampsel, P. Davis, and E. L. Schor, *Quality of Child Health Care: Expanding the Scope and Flexibility of Measurement Approaches* (The Commonwealth Fund, May 2009).
- <sup>25</sup> C. Bethell, Data Resource Center for Child and Adolescent Health 2009; <http://www.childhealthdata.org/content/Default.aspx>, 2009.
- <sup>26</sup> National Quality Forum, *Measure Evaluation Criteria* (Washington, D.C.: NQF, Aug. 2008).
- <sup>27</sup> C. M. Lannon, E. S. Hodgson, and L. Simpson, *Policy Statement: Principles for the Development and Use of Quality Measures* (American Academy of Pediatrics, Feb. 2008).
- <sup>28</sup> C. B. Forrest, L. Simpson, and C. Clancy, “Child Health Services Research. Challenges and Opportunities,” *Journal of the American Medical Association*, June 11, 1997 277(22):7.
- <sup>29</sup> M. R. Miller, P. Gergen, M. Honour et al., “Burden of Illness for Children and Where We Stand in Measuring the Quality of This Health Care,” *Ambulatory Pediatrics*, Sept.–Oct. 2005 5(5):268–78.

- <sup>30</sup> T. Nolan and D. M. Berwick, “All-or-None Measurement Raises the Bar on Performance,” *Journal of the American Medical Association*, March 8, 2006 295(10):1168–70.
- <sup>31</sup> L. Partridge, “Review of Access and Quality of Care in SCHIP Using Standardized National Performance Measures,” *National Health Policy Forum*, April 4, 2007.
- <sup>32</sup> L. Simpson and S. Lawless, “Quality Measurement: Is the Glass Half Full Yet?,” *Ambulatory Pediatrics*, Sep–Oct 2005 5(5):279–80.
- <sup>33</sup> J. B. Christianson, S. Leatherman and K. Sutherland, “Lessons from Evaluations of Purchaser Pay-For-Performance Programs: A Review of the Evidence,” *Medical Care Research and Review*, Dec. 2008 65(6 Suppl.):5S–35S.
- <sup>34</sup> S. R. Grossbart, “What’s the Return? Assessing the Effect of “Pay-For-Performance” Initiatives on the Quality of Care Delivery,” *Medical Care Research and Review*, Feb. 2006 63(1 Suppl.):29S–48S.
- <sup>35</sup> G. L. Freed and R. L. Uren, “Pay-For-Performance: An Overview for Pediatrics,” *Journal of Pediatrics*, July 2006 149(1):120–24.
- <sup>36</sup> Physician Quality Reporting Initiative 2009; <http://www.cms.hhs.gov/pqri/>. Accessed July 1, 2009.
- <sup>37</sup> K. Shea, K. Davis, and E. Schor, *U.S. Variations in Child Health System Performance: A State Scorecard* (New York: The Commonwealth Fund, May 2008).

**APPENDIX. INDIVIDUALS PARTICIPATING IN  
KEY INFORMANT INTERVIEWS, ONE-DAY EXPERT MEETING,  
OR THOSE PROVIDING WRITTEN COMMENTS**

Mary Applegate, M.D., Ohio Medicaid Medical Director  
Judy Arnold, New York Child Health Insurance Program  
Bruce Bagley, M.D., American Academy of Family Physicians  
Tricia Brooks, Center for Children and Families, Georgetown University  
Charlie Bruner, Center For Families and Children, Iowa  
Helen Burstin, National Quality Forum  
Debbie Chang, M.P.P., Nemours  
Sarah DeLone, National Academy for State Health Policy  
Stan Dorn, J.D., Urban Institute  
Carolyn Carney Doebbeling, M.D., M.Sc., Indiana Medicaid  
Donna Cohen Ross, Center for Budget and Policy Priorities  
Jennifer Edwards, Health Management Association  
Donna Folkemer, National Conference of State Legislatures  
Foster Gesten, M.D., New York State Medicaid Medical Director  
Robert Hall, American Academy of Pediatrics  
Cathy Hess, National Academy for State Health Policy  
Nikki Highsmith, Center for Health Care Strategies  
Charlie Homer, National Initiative for Children's Hospitals  
Genevieve Kenney, Ph.D. Urban Institute  
Ann Langley, National Association of Children's Hospitals  
Michael Leu, M.D., pediatrician nominated by the American Academy of Pediatrics for interview  
Patricia MacTaggart, George Washington University  
Marlene Miller, M.D., National Association of Children's Hospitals and Related Institutions  
Meg Murray, Association of Community-Affiliated Plans  
Julia Paradise, Kaiser Commission on Medicaid and the Uninsured  
Lee Partridge, National Partnership for Women and Families  
Greg Pawlson, M.D., M.P.H., National Committee for Quality Assurance  
Nicole Ravenell, Southern Institute on Children and Families  
Sarah Scholle, Dr.P.H., National Committee for Quality Assurance  
Ed Schor, M.D., The Commonwealth Fund  
Ellen Schwallenstocker, Ph.D., National Association of Children's Hospitals and Related Institutions  
Vern Smith, Health Management Associates  
Chris Trenholm, Ph.D., Mathematica  
Alan Weil, National Academy for State Health Policy  
Marina Weiss, Ph.D., March of Dimes