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U.S DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Healthcare Research and Quality

Priority Setting for the Children's Health Insurance Program Reauthorization Act (CHIPRA) Pediatric Quality Measures Program

AGENCY: Agency for Healthcare Research and Quality, HHS.

ACTION: Request for public comments.

SUMMARY: Section 401(a) of the Children's Health Insurance Program Reauthorization Act of 2009 (Pub. L. 111-3) amended title Xl of the Social Security Act by inserting after section 1139 the new section 1139A, "Child Health Quality Measures.": Subsection 1139A(b), "Advancing and Improving Pediatric Quality Measures," directs the Secretary to establish a pediatric quality measures program to: improve and strengthen the initial core child health care quality measures established by the Secretary under section 1139A(a); expand on existing pediatric quality measures used by public and private health care purchasers and advance the development of new quality measures; and increase the portfolio of evidence-based, consensus pediatric quality measures available to public and private purchasers of children's healthcare services, providers, and consumers. Section 1139A(b)(3) requires the Secretary to consult with a broad range of stakeholders to set these priorities. To meet the requirement for extensive stakeholder consultation, we are seeking general public comment on these draft priorities, and asking the public to identify additional priorities as needed.

DATES: Comments on this notice must be received by JANUARY 14, 2010. The public comment period will close on January 14, 2010 at 5 p.m. EST. Any comments received after the close of the comment period will not be considered.

ADDRESSES: You may submit comments by any of the following methods:

1. Electronic Mail - CHIPRAqualitymeasures@AHRQ.hhs.gov.

2. Mail - Agency for Healthcare Research and Quality, Attention: Office of Extramural Research, Education, and Priority Populations-Public Comment, CHIPRA PQMP Priorities, 540 Gaither Rd., Rockville, MD 20850.

Comments cannot be sent by facsimile transmission, because of staff and resource limitations. Please note that all submissions may be posted without change to http://www.AHRQ.gov/chipra, including any personal information provided.

FOR FURTHER INFORMATION CONTACT:

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For information regarding this Notice, please contact:

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SUPPLEMENTARY INFORMATION:

On February 4, 2009, the Congress enacted the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (Pub. L. 111-3)., Section 401(a) of the legislation amended title XI of the Social Security Act (the Act) to establish section 1139A (42 U.S.C. 1320b-9a). Subsection 1139A(b)(E) requires the Secretary to consult with a wide spectrum of national stakeholders to identify gaps in existing pediatric quality measures and establish priorities for development and advancement of such measures. The Secretary delegated CHIPRA implementation to the Centers for Medicare & Medicaid Services (CMS). A "Memorandum of Understanding "was entered into with the Agency for Healthcare Research and Quality (AHRQ), by which AHRQ would conduct several activities in Title IV. These included the identification of an initial, recommended core set of children's healthcare quality measures for voluntary use by Medicaid and CHIP programs and establishment of the Pediatric Quality Measures Program (PQMP), both in collaboration with CMS.

Pediatric Quality Measures Program (PQMP). The PQMP was required to be established by January 1, 2011, and authorized to award grants and contracts. The PQMP will consist of 7-9 cooperative agreement awards to successful applicants to HS11-001 (http://grants.nih.gov/grants/guide/rfa-files/RFA-HS-11-001.html), and a contract award to a CHIPRA Coordinating and Technical Assistance Center (http://www.ahrg.gov/chipra/#CTAC), both supervised by AHRQ and CMS. As required by CHIPRA, successful applicants will work on priorities for measurement methods and topics set by HHS and informed by the input of multiple stakeholders.

Multi-stakeholder consultation. Section 1139A(b)(3) requires a consultation process for establishing priorities for the pediatric quality measures program that requires consultation with multiple stakeholders, as follows:

"...the Secretary shall consult with

"(A) States;

(B) pediatricians, children's hospitals, and other primary and specialized pediatric health care professionals (including members of the allied health professions) who specialize in the care and treatment of children, particularly children with special physical, mental and developmental health care needs;

(C) dental professionals, including pediatric dental professionals;

(D) health care providers that furnish primary health care to children and families who live in urban and rural medically underserved communities or who are members of distinct population sub-groups at heightened risk for poor health outcomes;

(E) national organizations representing children, including children with disabilities and children with chronic conditions;

(F) national organizations representing consumers and purchasers of children's health care;

(G) national organizations and individuals with expertise in pediatric health quality measurement; and

(H) voluntary consensus standards setting organizations and other organizations involved in the advancement of evidence-based measures of health care."

Measure topics: Section 1139A(b)(2)(E) requires that the improved core measure sets include (but not necessarily be limited to) the following topics and types of healthcare quality measures:

"(A) The duration of children's health insurance coverage over a 12-month time period.

"(B) The availability and effectiveness of a full range of--

"(i) preventive services, treatments, and services for acute conditions, including services to promote healthy birth, prevent and treat premature birth, and detect the presence or risk of physical or mental conditions that could adversely affect growth and development; and

"(ii) treatments to correct or ameliorate the effects of physical and mental conditions, including chronic conditions, in infants, young children, school-age children, and adolescents.

"(C) The availability of care in a range of ambulatory and inpatient health care settings in which such care is furnished.

"(D) The types of measures that, taken together, can be used to estimate the overall national quality of health care for children, including children with special needs, and to perform comparative analyses of pediatric health care quality and racial, ethnic, and socioeconomic disparities in child health and health care for children.

CHIPRA Section 1139A (b)(2)) requires that the measures developed under the pediatric quality measures program shall, at a minimum, be:

"(A) evidence-based and, where appropriate, risk adjusted;

"(B) designed to identify and eliminate racial and ethnic disparities in child health and the provision of health care;

"(C) designed to ensure that the data required for such measures is collected and reported in a standard format that permits comparison of quality and data at a State, plan, and provider level;

"(D) periodically updated; and

"(E) responsive to the child health needs, services, and domains of health care quality described in clauses (i), (ii), and (iii) of subsection (a)(6)(A).

Definition of healthcare quality measure. For purposes of this notice, a healthcare quality measure is defined as a mechanism that enables a user to quantify the quality of a selected aspect of care by comparing it to a criterion (adapted from http://www.qualitymeasures.AHRQ.gov/resources/measure use.aspx).

Definition of healthcare quality. An Institute of Medicine Committee on a Future Vision for the National Healthcare Quality and Disparities Reports has recently updated the IOM recommended framework for assessing and improving quality so that 6 components of quality care are identified (safety, timeliness, effectiveness, patient/family-centeredness, access, efficiency), as well as 2 crosscutting dimensions (equity and value), three types of care (preventive care, acute treatment, and chronic condition management), and two additional elements (care coordination, health systems infrastructure capabilities). (http://iom.edu/Reports/2010/Future-Directions-for-the-National-Healthcare-Quality-and-Disparities-Reports.aspx). We adopt this framework for purposes of this public notice.

Prior work to identify priorities for the POMP. The first phase of CHIPRA required a process for developing recommendations for an initial core set of quality measures for voluntary use by Medicaid and CHIP programs. As discussed in the Federal Register Notice and background paper that accompanied the public posting of the initial, recommended core set (http://www.ahrq.gov/chip/chipraact.htm#Core), not all CHIPRA criteria were able to be met for the initial core set. Public comments on the initial, recommended core set, and an expert meeting on measure criteria for the CHIPRA PQMP (http://www.AHRQ.gov/chipra/#Expert) provided additional insights into potential priorities for the PQMP. The combination of these efforts and events led to the identification of the following potential priorities for measure enhancement and development of new measures:

1. Development or enhancement of methods to:

a. Standardize measures across all payers, programs, and providers, public and private, as appropriate, to ensure that comparisons are valid.

b. Assess disparities in quality by race, ethnicity, socioeconomic status, geographic region and residence, and special health care needs, for example by developing new measurement methods or enhancing existing measurement methods.

c. Adjust for risk by enrollment duration

d. Stratify or adjust for risk by depth and breadth of coverage

e. Stratify or adjust for risk by medical conditions, including severity and acuity

f. Capitalize on current and coming investments in health information technology (e.g., patient and procedure registries, electronic health records, health information exchanges, interoperability), including meaningful use criteria under the American Recovery and Reinvestment Act (ARRA).

g. Increase State programs' and CMS's ability to rely on non-Medicaid and CHIP data sources through improvement in public health sector measurement (e.g., birth certificate data; immunization surveys).

h. Come to consensus on the meaning and application of "evidence-based" in the context of healthcare quality measurement for children.

i. Incorporate patient and family perspectives into measurement to increase understandability

2. Development or enhancement of measures in key topic areas:

a. Most integrated healthcare settings

b. Availability of services

c. Duration of enrollment as a standalone measure

d. Measures of the content (quality) of care now typically measured as broad utilization categories (e.g., prenatal, postpartum, newborn care (including breastfeeding support), well-child and adolescent well-care visits, screening services, and follow-up visits for chronic conditions and related medications).

e. Specific care settings and conditions:

i. Perinatal care (e.g., family planning clinics, obstetric and gynecological care, birth centers).

ii. Quality of mental/behavioral health and substance abuse services, including prevention and treatment services, across all settings.

iii. Quality of care in settings beyond traditional medical care settings (e.g., for screening, diagnostic services and therapies)

iv. Inpatient settings (including specialty inpatient settings)

v. Specialty care for child conditions and diseases.

vi. Care transitions for patients transitioning within and across health care settings.

vii. Additional measures related to family experiences of care (e.g., child or adolescent self-reports; perinatal experiences of care; inpatient experiences)

viii. Health outcome measures (e.g., measures of patient and population health or other outcomes of healthcare).\2\

ix. Structural measures (e.g., measures of system design features that are causally linked to improved healthcare processes and outcomes).

Those submitting comments are encouraged to include a summary of evidence for the readiness of a topic for quality measurement and the importance of a topic or method. Additional background information may be attached. Commenters may wish to address these issues using the following questions. Commenters may also wish to include in their comments a summary score based on a scale of 1-5, where 1 is a high score, 3 is a medium score, and 5 is a low score.

Validity/Underlying Scientific Soundness: To what extent is there a demonstrated causal relationship between the element of quality to be measured (as a structure, process, or health outcome of healthcare delivery) and another element of the healthcare delivery system (e.g., structure and process; process and outcome). Commenters may wish to use as a guide to assessing underlying scientific soundness the method and criteria used by the AHRQ National Advisory Council Subcommittee on Children's Healthcare Quality Measures for Medicaid and CHIP, where appropriate (http://www.AHRQ.gov/chipra/corebackground/corebacktab.htm#note5).

Importance: Importance has several dimensions:

- To what extent is the topic important to children's health outcomes, family functioning, or societal functioning, including but not necessarily limited to high monetary costs of poor quality healthcare to children, families, or society?

- To what extent is the topic important to reducing disparities in the quality of care for particular racial and ethnic groups of children, socioeconomic groups, geographically underserved groups, and children with special healthcare needs?

- To what extent is the topic important as a sentinel measure that could have spillover effects to the rest of the children's healthcare delivery system?

- To what extent is the proposed methodology important for addressing current shortcoming of healthcare quality measurement?

We strongly encourage comments to be as succinct as possible (250 words or less per topic, with additional supporting data allowed).

3. Collection of Information Requirements

This voluntary request does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 35).

4. Regulatory Impact Analysis

As this notice does not meet the significance criteria of Executive Order 12866, it was not reviewed by the Office of Management and Budget.

Dated: NOV 24 2010

Carolyn M. Clancy, M.D.
AHRQ Director

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