

Summary Report

Background Report on 2013 Retirement of CHIPRA Measures from the Child Core Set

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Agency for Healthcare Research and Quality
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Abstract

Background: In 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA) (Public Law 111-3) directed the Secretary of the U.S. Department of Health and Human Services (HHS) to identify by January 1, 2010, an initial core set of health care quality measures for voluntary use by Medicaid and the Children's Health Insurance Program (CHIP) programs. In addition, CHIPRA directed the Secretary to establish a CHIPRA Pediatric Quality Measures Program (PQMP). The purposes of the PQMP go beyond use by Medicaid and CHIP programs; the PQMP is to improve and strengthen the initial core set of measures of health care quality established under CHIPRA; expand on existing pediatric quality measures used by public and private health care purchasers; and increase the portfolio of evidence-based consensus pediatric quality measures available to public and private purchasers of children's health care services, providers, and consumers. In 2012 the following measures were recommended by the Secretary to be added in the Child Core Set: human papillomavirus (HPV) vaccine for female adolescents, medication management for people with asthma, and behavioral health risk assessment (for pregnant women). One measure was recommended for retirement: otitis media with effusion—avoidance of inappropriate systemic antimicrobials in children (ages 2–12). In 2013, as part of the annual review specified by CHIPRA to maintain the Child Core Set, the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare & Medicaid Services (CMS) considered whether retirement of any measures from the initial core set was warranted in light of any new evidence on the measures' importance, scientific acceptability, feasibility, and usability. Twenty of the 24 measures in the initial core set were considered for retirement in 2013. Measures specific to dental care and consumer surveys were not considered for retirement. Measures considered for retirement included those related to prenatal care, well child visits, immunizations, asthma, emergency room use, preventive care screenings, access to care, diabetes, and mental health. **Methods:** In 2013, the task of the National Advisory Council on Healthcare Research and Quality 2013 Subcommittee on Quality Measures for Children's Healthcare for Medicaid and CHIP (SNAC) was to assess whether a measure was appropriate for retirement from the initial core set. AHRQ, CMS, the CHIPRA Coordinating and Technical Assistance Center (CCTAC; awarded to RTI International as part of the PQMP), and the SNAC worked collaboratively to define the categories of information and analyses needed to assess each measure on the selected criteria. With those definitions, AHRQ, CMS, and CCTAC developed a draft analytic report on each measure that included basic measure information and, where available, information on the following criteria: the importance of the measure (prevalence/incidence and cost/utilization related to the measure topic, as well as recent State and health plan performance on the measure), scientific acceptability (validity and reliability of the measure), feasibility (number of States reporting and data source), and usability (evidence of the ability to improve performance on the measure). In a process similar to that used in 2012, the SNAC used a modified Delphi approach and other scoring processes to assess measures and make retirement recommendations. CMS considered the SNAC recommendations and advised the Secretary of HHS on potential improvements to the initial core set. **Results:** From the 20 measures reviewed, AHRQ identified three as having a clear recommendation for retirement: children and adolescent access to primary care practitioners, appropriate testing for children with pharyngitis, and annual pediatric hemoglobin (HbA1c) testing. After careful consideration, CMS is recommending that the Secretary retire the following measures: appropriate testing for children with pharyngitis, annual pediatric hemoglobin (HbA1c) testing, and annual percentage of asthma patients who are 2–20 years old with one or more asthma-related emergency

department visits. The updates for the 2014 Child Core Set have been posted online by CMS in an Informational Bulletin dated December 19, 2013. **Conclusion:** The second year of a collaborative public-private process met the CHIPRA legislative deadline of January 1, 2014, to make recommendations to improve the Child Core Set. The retirement recommendations take into account the legislative requirements of CHIPRA, help the Child Core Set reflect the most current information available and the most current standards of practice, and continue to identify areas of need for quality improvement.

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Background

In 2013, the Agency for Healthcare Research and Quality (AHRQ), in close collaboration with the Centers for Medicare & Medicaid Services (CMS), implemented a process for considering potential retirement of CMS-selected measures in the initial Child Core Set (CCS) identified in 2009. The initial CCS was required by the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009.^{1,2} The initial CCS, consisting of 24 quality measures, was to be used voluntarily by State Medicaid and CHIP programs, who were encouraged to provide resulting data to CMS. In turn, CMS used the State-level data to develop CHIPRA-required reports to Congress.³ Besides reporting, State Medicaid and CHIP programs could use the data to target specific quality improvement efforts to reduce gaps in quality.

In addition to the 2009 identification of an initial CCS, CHIPRA required the Department of Health and Human Services (HHS) to post improvements to the CCS annually beginning in January 2013. The January 2013 improvements were informed by deliberations of a 2012 National Advisory Council on Healthcare Research and Quality Subcommittee on Quality Measures for Children's Healthcare (SNAC).^{4,5} The 2013 work was intended to contribute to improvements to be posted by January 2014.⁶

Methods

Overview

The process for considering retirement of CCS measures comprised a number of steps undertaken from May through October 2013. These included identification of measures to be considered for retirement, creation of a 2013 SNAC (see Appendix A for list of members), identification of criteria by which to assess measures for retirement, identification of information sources to be used to provide data relevant to the criteria, data searches and analysis, provision of the information to the 2013 SNAC, and two rounds of scoring measures against criteria and voting on retirement. This process is described in more detail here.

Measure Selection

CMS selected 20 quality measures from the initial CCS to be considered for potential retirement. A listing of these measures and their stewards is provided in Appendix B. Of the measures in the CCS as of January 2013 that were not included in the 20 to be considered for retirement, 3 had just been added,⁷ 1 had been retired in January 2013 because it proved impossible to collect (avoidance of systemic antibiotic use for otitis media with effusion), 1 was required under a separate provision of CHIPRA (Child Consumer Assessment of Healthcare Providers and Systems [CAHPS] 4.0 for Medicaid), and 2 were collected as part of mandatory reporting under Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) provisions (preventive and treatment dental services).

2013 SNAC Deliberations

First SNAC meeting. The first 2013 SNAC meeting was held June 5, 2013. During this meeting, AHRQ and CMS discussed with SNAC members (1) the methods that would be used to make recommendations, (2) a proposed set of criteria for assessing measures using a modified Delphi method, and (3) a proposed relative weighting of those criteria. In a subsequent exchange

of emails and postings to a password-protected Extranet site, SNAC members confirmed the final criteria and an analytic approach to be guided by AHRQ to provide information relevant to the criteria. Between the first and second SNAC meetings, AHRQ provided draft “measure reports” containing the agreed-to information for each measure.

Second SNAC meeting. A second SNAC meeting was held September 6, 2013. During this meeting, SNAC members were given an opportunity to provide feedback on the draft measure reports. In addition, the meeting discussion focused on initial views of the strengths and weaknesses of each measure. Each of these meetings was held as a video-enabled webinar. SNAC members also had the opportunity to communicate with AHRQ between meetings using a password-protected Extranet site. The draft analytic reports included basic measure information and, where available, information on the importance of the measure (prevalence/incidence and cost/utilization related to the measure topic, as well as recent State and health plan performance on the measure), scientific acceptability (validity and reliability^a of the measure), feasibility (number of States reporting, data source, and requests for technical assistance), and usability (evidence of the ability to improve performance on the measure).

During the period September 6–23, 2013, AHRQ, CMS, and RTI revised the draft analytic reports as needed. In addition, at the request of the SNAC, AHRQ developed a table of findings on a restricted number of key subcriteria. Data sources for the analytic reports varied by topic area because AHRQ, CMS, and the CHIPRA Coordinating and Technical Assistance Center (CCTAC) focused on readily available data from sources such as the National Survey of Children’s Health, the Healthcare Cost and Utilization Project, the Medical Expenditure Panel Survey, State Medicaid and CHIP program submissions to CMS, and data on the reliability of most Healthcare Effectiveness Data and Information Set (HEDIS) measures in the CCS (provided by the National Committee for Quality Assurance [NCQA] for use by the SNAC only). CCTAC analyzed the 2009 Medicaid Analytic eXtract (MAX) data to obtain prevalence/incidence and cost/utilization information. The aim for each report was to provide information specific to the Medicaid/CHIP population by race/ethnicity, socioeconomic status, and special health care need, wherever possible. Measure-specific definitions for prevalence/incidence and cost/utilization and the sources used are presented in Appendix C. An example of the final measure report template, including all possible content areas, is provided in Appendix D.

First round of SNAC scoring and voting. In each round, SNAC members were asked to provide a score between 1 and 9 for each measure for each of the major criteria—importance, scientific acceptability, feasibility, and usability—with 1 representing the lowest possible score (i.e., does not meet the criterion) and 9 representing the highest possible score (i.e., does meet the criterion). In addition to scoring each measure by using specific criteria, SNAC members were also to vote on whether or not to retire each measure. Finally, SNAC members were given the opportunity to provide additional comments to explain the rationale behind their scores and retirement votes. Upon receiving scores on each measure criterion, CCTAC calculated a total score as the average score for the four criteria, with each criterion weighted equally. A total score

^a Reliability data were provided only for National Committee for Quality Assurance (NCQA) measures. Validity information was not provided for 14 of the measures, and only limited validity information was provided for the remaining six measures.

was not calculated for SNAC members who did not score all four criteria. A higher median score is one indication of the group's assessment of whether the measure should be retained in the CCS rather than retired. Responses to the retirement question were not necessarily dependent on the numeric scores but were based on the overall judgment of the SNAC members after considering all the pertinent information provided for each measure.

Second round of SNAC scoring and voting. Before the second (final) round of scoring, SNAC members received a summary of the first scoring round (in which 15 SNAC members participated). The scoring summary included (1) the distribution of scores on each criterion, (2) the distribution of total scores for each measure, (3) the count of individuals who recommended retirement, and (4) the comments made on each criterion and on the measure overall. SNAC members also received updated measure reports that corrected any inaccuracies or misinterpretations in the draft reports and, where possible, incorporated SNAC suggestions and provided additional measure information. The second round of SNAC scoring was completed on October 28, 2013.

Results

Appendix E presents summary results from the two scoring rounds, ordered by the number of SNAC members voting for the measure's retirement in the final round (fewest votes to most votes). In summary, the 2013 SNAC identified three measures for retirement: Child and Adolescent Access to Primary Care Practitioners, Appropriate Testing for Children with Pharyngitis, and Annual Pediatric Hemoglobin (HbA1c) Testing. A summary of the comments for each measure, including measure-specific discussion, is provided in Appendix F.

Although the number of SNAC members who scored and voted changed between the two rounds, with 22 scoring and voting in Round 2, the median total score did not change substantially for any of the measures and was identical for seven of the measures in both rounds. The themes raised in the comments during the preliminary and final scoring rounds were similar.

Overall, SNAC members recommended retaining measures that reflected provision of preventive services for children in Medicaid/CHIP (immunizations, well-child visits) and a key outcome for births covered by Medicaid/CHIP (low birthweight). Other retained measures covered topics such as preventive care for women and adolescent girls, prenatal care, pediatric use of the emergency department, patient safety, and followup care for behavioral health and mental illness. Most SNAC members voted to retain measures they felt were significant to the Medicaid/CHIP population but recommended that they be replaced with better measures when possible. Examples of such measures include two measures of prenatal care (i.e., Timeliness of Prenatal Care and Frequency of Ongoing Prenatal Care), the body mass index (BMI) assessment for children/adolescents, and measures for which there were validity concerns (e.g., inadequate risk adjustment). As an example, a better BMI measure would indicate the actual BMI and an assessment of followup. A measure of BMI followup is in development by one of the CHIPRA Pediatric Quality Measures Program (PQMP) Centers of Excellence.⁸

Conclusions

As part of the life cycle of a quality measurement approach, a 2013 SNAC used information provided by AHRQ, CMS, and CCTAC to respond to CMS's need for recommendations for retirement of measures.

References

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- ¹ Agency for Healthcare Research and Quality. Background report on request for public comment on initial, recommended core set of children's healthcare quality measures for voluntary use by Medicaid and CHIP programs. <http://www.ahrq.gov/policymakers/chipra/overview/background/tables.html>.
 - ² U.S. Congress and U.S. President. Public Law 111-3, [Children's Health Insurance Program Reauthorization Act 2009](#). Accessed Dec. 31, 2013.
 - ³ Secretary of U.S. Department of Health and Human Services. 2013 annual report on the quality of care for children in Medicaid and CHIP. <http://medicaid.gov/Medicaid-CHIP-ProgramInformation/By-Topics/Quality-of-Care/Downloads/2013-Ann-Sec-Rept.pdf>.
 - ⁴ Centers for Medicare & Medicaid Services. 2013 children's core set of health care quality measures (SHO letter #13-002). <http://www.medicare.gov/Federal-Policy-Guidance/FederalPolicy-Guidance.html>.
 - ⁵ Agency for Healthcare Research and Quality. Recommendations to improve children's health care quality measures: Background report on the 2012 process. <http://www.ahrq.gov/policymakers/chipra/pubs/background-2012/index.html>.
 - ⁶ Centers for Medicare & Medicaid Services. CMCS Informational Bulletin: 2014 updates to the child and adult core health care quality measurement sets. <http://medicaid.gov/FederalPolicy-Guidance/Downloads/CIB-12-19-13.pdf>.
 - ⁷ Agency for Healthcare Research and Quality. Recommendations to improve children's health care quality measures. Background report on the 2012 process. <http://www.ahrq.gov/policymakers/chipra/pubs/background-2012/index.html>.
 - ⁸ Pediatric Quality Measures Program (PQMP) Centers of Excellence grant awards. Fact Sheet (AHRQ Publication No. 12-P006). Rockville, MD: Agency for Healthcare Research and Quality; March 2012.

Appendix A. Members of the 2013 AHRQ Subcommittee to the National Advisory Council on Children's Health Quality Measures (SNAC)

Name	Affiliation
Mary S. Applegate, MD, FAAP, FACP	Ohio Office of Medical Assistance
Louise Bannister, RN, JD	University of Massachusetts Medical School
Dennis J. Barbour, JD	The Boys Initiative
John Billimek, PhD	Health Policy Research Institute at the University of California, Irvine
Sharon Carte, MHS	West Virginia Children's Health Insurance Program
Tina Cheng, MD, MPH	Johns Hopkins Children's Center
Benard Dreyer, MD	New York University Department of Pediatrics
Elizabeth E. Drye, MD, SM	Yale School of Medicine
Rebekah Gee, MD, MPH	Louisiana Department of Health and Hospitals
Andrea Gelzer, MD, MS, FACP	AmeriHealth Caritas Family of Companies
Raj Kamal, MS, MBA	Wisconsin Department of Health Services
Heather Kaplan, MD, MSCE	Cincinnati Children's Hospital Medical Center
David Kelley, MD, MPA	Pennsylvania Department of Public Welfare's Office of Medical Assistance Programs
Deborah Kilstein, JD, MBA, BSN	Association of Community Affiliated Plans
Coleen Kivlahan, MD, MSPH	Association of American Medical Colleges
Elizabeth Ozer, PhD	University of California San Francisco School of Medicine
Wilson Pace, MD, FAAFP	University of Colorado School of Medicine
Patrick J. Roohan, MS	New York State Department of Health
Jill Rosenthal, MPH	National Academy for State Health Policy
Judith Shaw, EdD, MPH, RN	University of Vermont College of Medicine
Colleen Sonosky, JD	District of Columbia Department of Health Care Finance

Peter Szilagyi, MD, MPH	University of Rochester School of Medicine and Dentistry
Joseph Wiley, MD	The Herman and Walter Samuelson Children's Hospital at Sinai and The Alvin and Lois Lapidus Cancer Institute

Appendix B: Initial Core Set Measures Considered for Retirement by 2013 SNAC

Initial Core Set Measure	NQF#	Measure Steward
1. Timeliness of Prenatal Care	1517	National Committee for Quality Assurance
2. Frequency of Ongoing Prenatal Care	1391	National Committee for Quality Assurance
3. Percentage of Live Births Weighing Less than 2,500 Grams	1382	Centers for Disease Control
4. Cesarean Rate for Nulliparous Singleton Vertex	0471	California Maternal Quality Care Collaborative
5. Childhood Immunization Status	0038	National Committee for Quality Assurance
6. Immunizations for Adolescents	1407	National Committee for Quality Assurance
7. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents	0024	National Committee for Quality Assurance
8. Developmental Screening in the First Three Years of Life	1448	CAHMI and NCQA
9. Chlamydia Screening in Women	0033	National Committee for Quality Assurance
10. Well-Child Visits in the First 15 Months of Life	1392	National Committee for Quality Assurance
11. Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	1516	National Committee for Quality Assurance
12. Adolescent Well-Care Visit	NA	National Committee for Quality Assurance
13. Child and Adolescent Access to Primary Care Practitioners	NA	National Committee for Quality Assurance
14. Appropriate Testing for Children with Pharyngitis	0002	National Committee for Quality Assurance
15. Ambulatory Care: Emergency Department Visits	NA	National Committee for Quality Assurance
16. Pediatric Central-Line Associated Bloodstream Infection – Neonatal Intensive Care Unit and Pediatric Intensive Care Unit	0139	Centers for Disease Control
17. Annual Percentage of Asthma Patients with One or More Asthma-related Emergency Room Visits (ages 2-20)	1381	Alabama Medicaid
18. Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication	0108	National Committee for Quality Assurance
19. Annual Pediatric Hemoglobin A1C Testing	0060	National Committee for Quality Assurance

20. Follow-Up After Hospitalization for Mental Illness	0576	National Committee for Quality Assurance
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Appendix C: Definitions for Prevalence/Incidence and Cost/Utilization per Measure

Prevalence/Incidence (Source)	Health Care Cost/Utilization (Source)
1. Timeliness of Prenatal Care	
<ul style="list-style-type: none"> – Number of discharges for liveborns with Medicaid as payer (HCUPNet, 2011) – Number of discharges for liveborns with Medicaid as payer by race/ethnicity (MAX) – Number of discharges for liveborns for all payers (HCUPNet, 2011) – Medicaid percentage of all payer discharges for liveborns (HCUPNet, 2011) 	<ul style="list-style-type: none"> – Aggregate costs and mean costs per discharge for liveborns with Medicaid as payer (HCUPNet, 2011) – Aggregate costs and mean costs per discharge for liveborns with Medicaid as payer by race/ethnicity (MAX) – Aggregate costs and mean cost per discharge for liveborns all payers (HCUPNet, 2011) – Medicaid percentage of all payer costs for liveborns (HCUPNet, 2011)
2. Frequency of Ongoing Prenatal Care	
<ul style="list-style-type: none"> – Number of discharges for liveborns with Medicaid as payer (HCUPNet, 2011) – Number of discharges for liveborns with Medicaid as payer by race/ethnicity (MAX) – Number of discharges for liveborns for all payers (HCUPNet, 2011) – Medicaid percentage of all payer discharges for liveborns (HCUPNet, 2011) 	<ul style="list-style-type: none"> – Aggregate costs and mean costs per discharge for liveborns with Medicaid as payer (HCUPNet, 2011) – Aggregate costs and mean costs per discharge for liveborns with Medicaid as payer by race/ethnicity (MAX) – Aggregate costs and mean cost per discharge for liveborns all payers (HCUPNet, 2011) – Medicaid percentage of all payer costs for liveborns (HCUPNet, 2011)
3. Live Births Weighing Less Than 2,500 Grams	
<ul style="list-style-type: none"> – Number of discharges for premature birth and low birth weight with Medicaid as payer (HCUPNet, 2011) – Number of discharges for premature birth and low birth weight with Medicaid as payer by race/ethnicity (MAX) – Number of discharges for premature birth and low birth weight for all payers (HCUPNet, 2011) – Medicaid % of all payer discharges for premature birth and low birth weight (HCUPNet, 2011) 	<ul style="list-style-type: none"> – Aggregate costs and mean costs per discharge for hospitalizations for premature birth and low birth weight with Medicaid as payer (HCUPNet, 2011) – Aggregate costs and mean costs per discharge for hospitalizations for premature birth and low birth weight with Medicaid as payer by race/ethnicity (MAX) – Aggregate costs and mean cost per discharge for premature birth and low birthweight all payers (HCUPNet, 2011) – Medicaid percentage of all payer costs for premature birth and low birth weight (HCUPNet, 2011)
4. Cesarean Rate for Nulliparous Singleton Vertex	

<ul style="list-style-type: none"> – Number of discharges for cesarean deliveries with Medicaid as payer (HCUPNet, 2011) – Number of discharges for cesarean deliveries with Medicaid as payer by race/ethnicity (MAX) – Number of discharges for cesarean deliveries all payers (HCUPNet, 2011) – Medicaid percentage of all payer discharges for cesarean deliveries (HCUPNet, 2011) 	<ul style="list-style-type: none"> – Aggregate costs and mean costs per discharge for hospitalizations for cesarean deliveries with Medicaid as payer (HCUPNet, 2011) – Aggregate costs and mean costs per discharge for hospitalizations for cesarean deliveries with Medicaid as payer by race/ethnicity (MAX) – Aggregate costs and mean cost per discharge for cesarean deliveries all payers (HCUPNet, 2011) – Medicaid % of all payer costs for cesarean deliveries (HCUPNet, 2011)
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Appendix C: Definitions for Prevalence/Incidence and Cost/Utilization per Measure (continued)

Prevalence/Incidence (Source)	Health Care Cost/Utilization (Source)
5. Childhood Immunization Status	
<ul style="list-style-type: none"> – Number of Medicaid/CHIP-enrollees who turn 2 during the year (MAX) – Number of Medicaid/CHIP-enrollees who turn 2 during the year by race/ethnicity (MAX) 	<ul style="list-style-type: none"> – Existing literature
6. Adolescent Immunization Status	
<ul style="list-style-type: none"> – Number of Medicaid/CHIP-enrollees who turn 13 during the year (MAX) – Number of Medicaid/CHIP-enrollees who turn 13 during the year by race/ethnicity (MAX) 	<ul style="list-style-type: none"> – Existing literature
7. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents	

Appendix C: Definitions for Prevalence/Incidence and Cost/Utilization per Measure (continued)

<ul style="list-style-type: none"> - Number and percentage of children age 10-17 with public insurance who are obese (NSCH) - Number of Medicaid/CHIP enrollees age 3-17 (MAX) - Number of Medicaid/CHIP enrollees age 3-17 by race/ethnicity (MAX) - Number and percentage of children age 10-17 who are obese (NSCH) - Number and percentage of children age 10-17 who are obese by race/ethnicity (NSCH) - Number and percentage of children age 10-17 who are obese by income level (NSCH) - Number and percentage of children age 10-17 who are obese by special health care needs status (NSCH) - Medicaid as percentage of the total population (NSCH) 	<ul style="list-style-type: none"> - Existing literature
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Prevalence/Incidence (Source)	Health Care Cost/Utilization (Source)
8. Developmental Screening In the First Three Years of Life	
<ul style="list-style-type: none"> - Number and percentage of children age 2-17 with public insurance who have developmental delay (NSCH) - Number of Medicaid/CHIP enrollees ages 0-3 (MAX) - Number and percentage of children age 2-17 with developmental delay (NSCH) - Number and percentage of children age 2-17 with developmental delay by race/ethnicity (NSCH) - Number and percentage of children age 2-17 with developmental delay by income level (NSCH) - Number and percentage of children age 2-17 with developmental delay by special health care needs status (NSCH) - Medicaid as % of total population (NSCH) - Existing Literature 	<ul style="list-style-type: none"> - Existing literature
9. Chlamydia Screening – sexually active females ages 16-20	
<ul style="list-style-type: none"> - Number of female Medicaid/CHIP enrollees age 16-20 who are sexually active (MAX) - Existing Literature 	<ul style="list-style-type: none"> - Total Medicaid expenditures for claims with diagnosis code for pelvic inflammatory disease for females age 16-20 (MAX) - Total Medicaid expenditures for claims with diagnosis code for pelvic inflammatory disease for females age 16-20 by race/ethnicity (NSCH)

10. Well-Child Visits in the First 15 Months of Life	
<ul style="list-style-type: none"> – Number of Medicaid/CHIP enrollees age 0 – 15 months (MAX) – Number of Medicaid/CHIP enrollees age 0 – 15 months by race/ethnicity (MAX) 	<ul style="list-style-type: none"> – Number of well-child visits for children age 0-15 months (MAX) – Number of well-child visits for children age 0-15 months by race/ethnicity (MAX) – Total Medicaid expenditures for well-child visits for children age 0-15 months (MAX) – Total Medicaid expenditures for well-child visits for children age 0-15 month by race/ethnicity (MAX)
11. Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	
<ul style="list-style-type: none"> – Number of Medicaid/CHIP enrollees age 3 – 6 years (MAX) – Number of Medicaid/CHIP enrollees age 3 – 6 years by race/ethnicity (MAX) 	<ul style="list-style-type: none"> – Number of well-child visits for children age 3-6 (MAX) – Number of well-child visits for children age 3-6 by race/ethnicity (MAX) – Total Medicaid expenditures for well-child visits for children age 3 – 6 (MAX) – Total Medicaid expenditures for well-child visits for children age 3 – 6 by race/ethnicity (MAX)

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Appendix C: Definitions for Prevalence/Incidence and Cost/Utilization per Measure (continued)

Prevalence/Incidence (Source)	Health Care Cost/Utilization (Source)
12. Adolescent Well-Care Visit	
<ul style="list-style-type: none"> – Number of Medicaid/CHIP-enrollees age 12-17 years (MAX) – Number of Medicaid/CHIP-enrollees age 12-17 years by race/ethnicity (MAX) 	<ul style="list-style-type: none"> – Number of well-child visits for children age 12-17 (MAX) – Number of well-child visits for children age 12-17 by race/ethnicity (MAX) – Total Medicaid expenditures for well-child visits for children age 12-17 (MAX) – Total Medicaid expenditures for well-child visits for children age 12-17 by race/ethnicity (MAX)
13. Child and Adolescent Access to Primary Care Practitioners	
<ul style="list-style-type: none"> – Number of Medicaid/CHIP-enrollees (MAX) – Number of Medicaid/CHIP-enrollees by age (12-24 months, 25 months-6 years, 7-11 years, 12-19 years) (MAX) – Number of Medicaid/CHIP-enrollees by race/ethnicity (MAX) 	—
14. Appropriate Testing for Children with Pharyngitis	
<ul style="list-style-type: none"> – Percentage of children enrolled in Medicaid who sought treatment for sore throat (not pharyngitis specific), 2002-2004 (MEPS) – Percentage of total children who sought treatment for sore throat (not pharyngitis specific) (MEPS) – Percentage of total children who sought treatment for sore throat (not pharyngitis specific) by race/ethnicity (MEPS) 	<ul style="list-style-type: none"> – Medicaid expenditures for antibiotic prescriptions to treat pharyngitis for children age 2-18 (MAX) – Medicaid expenditures for antibiotic prescriptions to treat pharyngitis for children age 2-18 by race/ethnicity (MAX) – Medicaid expenditures for antibiotic prescriptions to treat pharyngitis for children age 2-18 as a percentage of total Medicaid expenditures for prescriptions for children age 2-18 (MAX) – Medicaid expenditures for antibiotic prescriptions to treat pharyngitis for children age 2-18 as a percentage of total Medicaid expenditures for prescriptions for children age 2-18 by race/ethnicity (MAX)
15. Ambulatory Care – Emergency Department (ED) Visits	

Appendix C: Definitions for Prevalence/Incidence and Cost/Utilization per Measure (continued)

<ul style="list-style-type: none"> – Number of Medicaid/CHIP enrollees age 0-19 with ED visits (MAX) – Number of Medicaid/CHIP enrollees age 0-19 with ED visits by age (<1, 1-9, 10-19) (MAX) – Number of Medicaid/CHIP enrollees age 0-19 with ED visits by race/ethnicity (MAX) – Number of ED visits among children age 0-19 (MAX) – Number of ED visits among children by age 0-19 age (<1, 1-9, 10-19) (MAX) – Number of ED visits among children age 0-19 by race/ethnicity (MAX) 	<ul style="list-style-type: none"> – Total expenditures for ED visits for children age 0-19 (MAX) – Total expenditures for ED visits for children age 0-19 by age (<1, 1-9, 10-19) (MAX) – Total expenditures for ED visits for children age 0-19 by race/ethnicity (MAX) – Mean expenditures per ED visit (MAX) – Mean expenditures per ED visit by age (<1, 1-9, 10-19) (MAX) – Mean expenditures per ED visit by race/ethnicity (MAX) – Mean expenditures for ED visits per child (MAX) – Mean expenditures for ED visits per child by age (<1, 1-9, 10-19) (MAX) – Mean expenditures for ED visits per child by race/ethnicity (MAX)
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Prevalence/Incidence (Source)	Health Care Cost/Utilization (Source)
16. Pediatric Central Line–Associated Blood Stream Infections – Neonatal Intensive Care Unit and Pediatric Intensive Care Unit	
<ul style="list-style-type: none"> – Number of admissions with NICU or PICU hospital stays (MAX) – Number of admissions with NICU or PICU hospital stays by race/ethnicity (MAX) – Admissions with NICU or PICU stay as percentage of total hospital admissions for children (MAX) – Admissions with NICU or PICU stay as percentage of total hospital admissions for children by race/ethnicity (MAX) 	<ul style="list-style-type: none"> – Total and mean Medicaid expenditures per discharge for admissions that include NICU or PICU stays (MAX) – Total and mean Medicaid expenditures per discharge for admissions that include NICU or PICU stays by race/ethnicity (MAX)
17. Annual Percentage of Asthma Patients 2 Through 20 Years Old with One or More Asthma-Related Emergency Room Visits	

Appendix C: Definitions for Prevalence/Incidence and Cost/Utilization per Measure (continued)

<ul style="list-style-type: none"> - Number and percentage of children age 0-17 with public insurance who have current asthma (NSCH) - Number and percentage of total children age 2-17 with current asthma (NSCH) - Number and percentage of total children age 2-17 with current asthma by race/ethnicity (NSCH) - Number and percentage of total children age 2-17 with current asthma by income level (NSCH) - Number and percentage of total children age 2-17 with current asthma by special health care needs status (NSCH) - Medicaid as a percentage of the total population (NSCH) 	<ul style="list-style-type: none"> - Number of child ED visits for asthma among children age 2-20 (MAX) - Number of child ED visits for asthma among children age 2-20 by race ethnicity (MAX) - Mean child Medicaid expenditures per ED visit for asthma among children age 2-20 (MAX) - Mean child Medicaid expenditures per ED visit for asthma among children age 2-20 by race/ethnicity (MAX) - Total Medicaid expenditures for ED visits with asthma diagnosis among children age 2-20 (MAX) - Total Medicaid expenditures for ED visits with asthma diagnosis among children age 2-20 by race/ethnicity (MAX) - Medicaid expenditures for ED visits for asthma for children age 2-20 as a percentage of total Medicaid expenditures for ED visits for children age 2-20 (MAX) - Asthma-related ED visits for children age 2-20 as a percentage of total ED visits for children age 2-20 (MAX)
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(continued)

Prevalence/Incidence (Source)	Health Care Cost/Utilization (Source)
18. Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication	

Appendix C: Definitions for Prevalence/Incidence and Cost/Utilization per Measure (continued)

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| <ul style="list-style-type: none">– Number and percentage of children age 2-17 with public insurance with ADD or ADHD (NSCH)– Number and percentage of children age 2-17 with public insurance with ADD/ADHD currently taking medication for this condition (NSCH)– Number and percentage of children age 2-17 with ADD or ADHD (NSCH)– Number and percentage of children age 2-17 with ADD or ADHD by race/ethnicity (NSCH)– Number and percentage of children age 2-17 with ADD or ADHD by income level (NSCH)– Number and percentage of children age 2-17 with ADD or ADHD by special health care needs status (NSCH)– Medicaid as a percentage of total population (NSCH)– Number and percentage of children age 2-17 with ADD/ADHD currently taking medication for this condition (NSCH)– Number and percentage of children age 2-17 with ADD/ADHD currently taking medication for this condition by race/ethnicity (NSCH)– Number and percentage of children age 2-17 with ADD/ADHD currently taking medication for this condition by income level (NSCH)– Number and percentage of children age 2-17 with ADD/ADHD currently taking medication for this condition by special health care needs status (NSCH)– Medicaid as % of total population (NSCH) | <ul style="list-style-type: none">– Total expenditures for prescriptions for ADHD medications among children age 6-12 (MAX)– Total expenditures for prescriptions for ADHD medications among children age 6-12 by race/ethnicity (MAX)– Expenditures for prescriptions for ADHD as percentage of total Medicaid expenditures for children age 6-12 (MAX)– Expenditures for prescriptions for ADHD as percentage of total Medicaid expenditures for children age 6-12 by race/ethnicity (MAX)– Expenditures for prescriptions for ADHD as percentage of Medicaid expenditures for prescriptions for children as 6-12 (MAX)– Expenditures for prescriptions for ADHD as percentage of Medicaid expenditures for prescriptions for children as 6-12 by race/ethnicity (MAX)– Expenditures for prescriptions for ADHD as percentage of total Medicaid expenditures for prescriptions (total population <65) (MAX)– Expenditures for prescriptions for ADHD as percentage of total Medicaid expenditures for prescriptions (total population <65) by race ethnicity (MAX)– Medicaid as percentage of total (all-payer) expenditures for treatment of ADHD (MEPS)– Medicaid as percentage of total (all-payer) ambulatory ADHD visit expenditures (MEPS)– Medicaid as % of total (all-payer) expenditures for prescription medications for ADHD (MEPS) |
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(continued)

Appendix C: Definitions for Prevalence/Incidence and Cost/Utilization per Measure (continued)

Prevalence/Incidence (Source)	Health Care Cost/Utilization (Source)
<i>19. Annual Pediatric Hemoglobin A1C Testing</i>	

Appendix C: Definitions for Prevalence/Incidence and Cost/Utilization per Measure (continued)

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| <ul style="list-style-type: none">– Number and percentage of children in public insurance age 0-17 with current diabetes (NSCH)– Number and percentage of children age 0-17 with current diabetes (NSCH)– Number and percentage of children age 0-17 with current diabetes by race/ethnicity (NSCH)– Number and percentage of children age 0-17 with current diabetes by income level (NSCH)– Number and percentage of children age 0-17 with current diabetes by special health care needs status (NSCH)– Medicaid as % of total population (NSCH) | <ul style="list-style-type: none">– Number of hospital admissions and ED visits with diagnosis code for diabetes among children ages 0-17 (MAX)– Number of hospital admissions and ED visits with diagnosis code for diabetes among children ages 0-17 by race/ethnicity (MAX)– Mean Medicaid expenditures per hospital admission/ED visit (MAX)– Mean Medicaid expenditures per hospital admission/ED visit by race/ethnicity (MAX)– Total Medicaid expenditures for hospital admissions and ED visits (MAX)– Total Medicaid expenditures for hospital admissions and ED visits by race/ethnicity (MAX)– Number of aggregate costs and mean cost per discharge for hospitalizations for diabetes with complications, and separately for diabetes without complications with Medicaid as payer (HCUPNet, 2011)– Number of ED visits with first-listed diagnosis code of diabetes with complications, and separately for first-listed diagnosis diabetes without complications for people enrolled in Medicaid, all ages. (HCUPNet, 2010)– Hospital admissions/ED visits with diagnosis code for diabetes as percentage of total Medicaid expenditures for hospital admissions and ED visits for children age 0-17 (MAX)– Medicaid costs for discharges for diabetes as % of total Medicaid costs for hospital discharges for children (HCUPNet, 2011)– Aggregate costs and mean cost per discharge for diabetes with complications, and separately for diabetes mellitus without complications all payers (HCUPNet, 2011)– Medicaid as percentage of total (all-payer) discharges and aggregate costs for diabetes with complications, and separately for diabetes without complications (HCUPNet, 2011)– Number of ED visits with first-listed diagnosis code of diabetes mellitus with complications, and separately for first-listed diagnosis code of diabetes mellitus without complications for children age 1-17, all payer (HCUPNet, 2010) |
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(continued
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Appendix C: Definitions for Prevalence/Incidence and Cost/Utilization per Measure (continued)

Prevalence/Incidence (Source)	Health Care Cost/Utilization (Source)
20. Follow-Up After Hospitalization for Mental Illness ages 6+	
<ul style="list-style-type: none"> – Number of Medicaid/CHIP enrollees age 6-20 with a hospital or other inpatient or residential admission for a mental health disorder (MAX) – Number of Medicaid/CHIP enrollees age 6-20 with a hospital or other inpatient or residential admission for a mental health disorder by race/ethnicity (MAX) – Existing Literature – Children age 6-20 with an admission for a mental health disorder as % of all Medicaid/CHIP enrollees age 6-20 (MAX) – Children age 6-20 with an admission for a mental health disorder as % of all Medicaid/CHIP enrollees age 6-20 by race/ethnicity (MAX) 	<ul style="list-style-type: none"> – Number of admissions for children age 6-20 for hospital admissions with a diagnosis code for a mental health disorder (MAX) – Number of admissions for children age 6-20 for hospital admissions with a diagnosis code for a mental health disorder by race/ethnicity (MAX) – Mean Medicaid expenditures per admission for children age 6-20 for hospital admissions with a diagnosis code for a mental health disorder (MAX) – Mean Medicaid expenditures per admission for children age 6-20 for hospital admissions with a diagnosis code for a mental health disorder by race/ethnicity (MAX) – Total Medicaid expenditures for children age 6-20 for hospital admissions with a diagnosis code for a mental health disorder (MAX) – Total Medicaid expenditures for children age 6-20 for hospital admissions with a diagnosis code for a mental health disorder by race/ethnicity (MAX) – Medicaid expenditures for children age 6-20 for hospital admissions with a diagnosis code for a mental health disorder as % of total Medicaid expenditures for children age 6-20 (MAX) – Medicaid expenditures for children age 6-20 for hospital admissions with a diagnosis code for a mental health disorder as % of total Medicaid expenditures for children age 6-20 by race/ethnicity (MAX)

Appendix D: Example Analytic Report Template for Measures Considered for Retirement

Basic Measure Information		
1	Measure #	09
2	NQF Measure #	0033
3	Measure Steward	NCQA/HEDIS (http://www.ncqa.org)
4	Brief Measure Name and Description	
4.a.	Measure Name	Chlamydia Screening in Women
4.b.	Measure Description (brief narrative)	The percentage of women ages 16 to 20 that were identified as sexually active and had at least one test for Chlamydia during the measurement year.
5	Numerator	At least one chlamydia test during the measurement year as documented through administrative data. A woman is counted as having had a test if she had a claim/encounter with a service date during the measurement year with one or more of the applicable codes.
6	Numerator Exclusions	Women who had a pregnancy test during the measurement year, followed within 7 days (inclusive) by either a prescription for isotretinoin (Accutane) or an x-ray. This exclusion does not apply to women who qualify for the denominator based on services other than the pregnancy test alone.
7	Denominator	The eligible population
8	Denominator Exclusions	No more than one gap in enrollment of up to 45 days during the measurement year.

Source for this table: Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set): Summary from Technical Specifications and Resource Manual for Federal Fiscal Year 2013 Reporting (<http://www.medicaid.gov/Medicaid-CHIP-ProgramInformation/By-Topics/Quality-of-Care/Downloads/Medicaid-and-CHIP-Child-Core-SetManual.pdf>)

Appendix D. Example Analytic Report Template for Measures Considered for Retirement (continued)

Section #	Information Category or Criterion	Data Sources Used	Data Pertaining to This Measure	This column is available for SNAC to add comments (e.g., rationale for preliminary score)
1.	IMPORTANCE			
1.a	Prevalence/Incidence for Focus of Measure			
1.a.i	Medicaid/CHIP prevalence/incidence for focus of measure	MAX 2009	CAVEAT: Counts exclude enrollees age 20 and under who are not eligible for full Medicaid benefits, who are dually eligible for Medicare, and for whom eligibility category was unknown. Number of sexually active women in Medicaid/CHIP, ages 16–20 Total: 2,167,125	—
1.a.i.1	Variation in prevalence/incidence within Medicaid/CHIP <i>Note to SNAC: Whether a difference is a disparity and what type and level of disparities/differences are important to consider in measure retirement are judgment calls best made by the SNAC. For informational purposes, the HHS National Healthcare Disparities report currently considers a difference a disparity if it is statistically significant and a 10% difference.</i>			
1.a.i.1.a	Variation by race and ethnicity	CAVEAT: Counts exclude enrollees age 20 and under who are not eligible for full Medicaid benefits, who are dually eligible for Medicare, and for whom eligibility category was unknown. Number of sexually active women in Medicaid/CHIP, ages 16–20: White, non-Hispanic 871,404 Black, non-Hispanic 559,505 Hispanic 536,864 Other, non-Hispanic 199,352		—
1.a.i.1.b	Variation by SES	Not available		—
1.a.i.1.c	Variation by special health care need	Not available		—
1.a.ii	Optional CONTEXTUAL DATA—Prevalence/Incidence for focus of measure for all U.S. children or on average for U.S. children <i>(Enter if data are readily available (e.g., from source used to estimate prevalence/incidence among Medicaid/CHIP children))</i>			

		Not available	—
1.a.iii	Optional CONTEXTUAL DATA—Variation in Prevalence/Incidence U.S. Children overall/on average (Enter if readily available (e.g., from source used to estimate prevalence/incidence among Medicaid/CHIP children))		

(continued)

Section #	Information Category or Criterion	Data Sources Used	Data Pertaining to This Measure	This column is available for SNAC to add comments (e.g., rationale for preliminary score)
1.a.iii.a	Variation by race and ethnicity		Not available	—
1.a.iii.b	Variation by SES		Not available	—
1.a.iii.c	Variation by special health care need		Not available	—
1.b	Health care utilization and costs related to the focus of the measure			
1.b.i.	Health care utilization specific to Medicaid/CHIP		Not available	—
1.b.i.1	Variation in Medicaid/CHIP-specific health care utilization			
1.b.i.1.a	Variation by race and ethnicity		Not available	—
1.b.i.1.b	Variation by SES		Not available	
1.b.i.1.c	Variation by special health care need		Not available	

1.b.ii	Health care costs specific to Medicaid/CHIP	MAX 2009	Total Payments, Women Ages 16–20 (FFS Claims Only): \$4,260,709	—
1.b.ii.1	Variation in Medicaid/CHIP-specific health care costs			
1.b.ii.1.a	Variation by race/ethnicity	MAX 2009	Payments, Sexually Active Women Ages 16–20 (FFS Claims Only): White, non-Hispanic \$1,467,201 Black, non-Hispanic \$1,801,925 Hispanic \$608,393 Other, non-Hispanic \$383,190	—
1.b.ii.1.b	Variation by SES	Not available		—

(continued)

Section #	Information Category or Criterion	Data Sources Used	Data Pertaining to This Measure	This column is available for SNAC to add comments (e.g., rationale for preliminary score)
1.b.ii.1.c	Variation by special health care need		Not available	—
1.b.iii	OPTIONAL INFORMATION FOR CONTEXT <i>(Enter only if readily available)</i>			
1.b.iii.1	Health care utilization overall		Not available	—
1.b.iii.2	Health care costs overall		Not available	—
1.c	Summary of evidence for focus of the measure <i>(NOTE TO SNAC: SNAC agreed with AHRQ's recommendation that only those measures with less than a B grade in 2009 would be subject to AHRQ staff's rapid literature review.)</i>			

		AHRQ ²	2009 Evidence Grade: B	—
1.d	Performance on the measure overall and variations <i>(NOTE TO SNAC: In interpreting this section, SNAC should attend to different numbers of States reporting in different years for this measure and different approaches to measurement among States as shown below in the Feasibility section.)</i>			
1.d.i	Average State Medicaid/CHIP performance on the measure (mean, median; and # of reporting States)			
1.d.i.1	FFY 2010	CMS, from CARTS	CAVEAT: Data is only for the 20 States that reported the measure using HEDIS specifications for all 3 years. Mean: 42% Median: 44% 20 States reporting	—
1.d.i.2	FFY 2011	CMS, from CARTS	CAVEAT: Data are only for the 20 States that reported the measure using HEDIS specifications for all 3 years Mean: 46% Median: 48% 20 States reporting	—

(continued)

Section #	Information Category or Criterion	Data Sources Used	Data Pertaining to This Measure	This column is available for SNAC to add comments (e.g., rationale for preliminary score)
1.d.i.3	FFY 2012	CMS, from CARTS	CAVEAT: Data are only for the 20 States that reported the measure using HEDIS specifications for all 3 years Mean: 47% Median: 49% 20 States reporting	—
1.d.ii	Cross-State Medicaid/CHIP variation in performance on the measure			

² AHRQ. Background Report on request for public comment on initial, recommended core set of Children's Healthcare Quality Measures for voluntary use by Medicaid and CHIP Programs. <http://www.ahrq.gov/policymakers/chipra/overview/background/tables.html>. Accessed January 7, 2014.

1.d.ii.1	FFY 2010	CMS, from CARTS	CAVEAT: Data are only for the 20 States that reported the measure using HEDIS specifications for all 3 years 25 th percentile: 25% 75 th percentile: 59% 20 States reporting	—
1.d.ii.2	FFY 2011	CMS, from CARTS	CAVEAT: Data are only for the 20 States that reported the measure using HEDIS specifications for all 3 years 25 th percentile: 40% 75 th percentile: 59% 20 States reporting	—
1.d.ii.3	FFY 2012	CMS, from CARTS	CAVEAT: Data is only for the 20 States that reported the measure using HEDIS specifications for all 3 years 25 th percentile: 39% 75 th percentile: 57% 20 States reporting	—
1.d.iii	Overall state Medicaid/CHIP performance on the measure—other data sources IF AVAILABLE (e.g., HEDIS/NCQA REPORTS)	NCQA, measurement year 2012	Medicaid HMOs: Average (10 th percentile, 90 th percentile) [Provided to SNAC members only]	—

(continued)

Section #	Information Category or Criterion	Data Sources Used	Data Pertaining to This Measure	This column is available for SNAC to add comments (e.g., rationale for preliminary score)
1.d.iii.1	OPTIONAL—Contextual information on performance (e.g., commercial performance data on measure from HEDIS/NCQA)	NCQA, measurement year 2012	Commercial HMOs: Average (10 th percentile, 90 th percentile) [Provided to SNAC members only] Commercial preferred provider organizations: Average (10 th percentile, 90 th percentile) [Provided to SNAC members only]	—

1.d.iv	Variation in State Medicaid/CHIP performance on the measure using other data sources IF AVAILABLE.		
1.d.iv.1	Variation by race and ethnicity	Not available	—
1.d.iv.2	Variation by SES	Not available	
1.d.iv.3	Variation by special health care needs	Not available	
OPTIONAL—AHRQ STAFF OBSERVATIONS THAT MAY BE OF INTEREST TO SNAC:			—

(continued)

Section #	Information Category or Criterion	Data Sources Used	Data Pertaining to This Measure	This column is available for SNAC to add comments (e.g., rationale for preliminary score)
SNAC preliminary member score for this measure on Importance Criterion (scale of 1–9 ²)			[Enter score here]	[Enter comments here]
2.	SCIENTIFIC ACCEPTABILITY			
2.a	Reliability	NCQA, measurement year 2012	[Provided to SNAC members only]	—
2.b	Validity	Not available		—
2.c	Medicaid/CHIP Program Deviation from technical specifications provided by CMS: Number (%) of reporting States with a deviation, by Federal fiscal year			

2.c.i	FFY 2010	CMS	Not available	—
2.c.ii	FFY 2011	CMS	Not available	—
2.c.iii	FFY 2012	CMS	0 (0%)	—
OPTIONAL – AHRQ STAFF OBSERVATIONS THAT MAY BE OF INTEREST TO SNAC:				—

(continued)

²

In the Modified Delphi approach that we are using, the scale of 1–9 is typically broken into three categories: a score of 1–3 is low, a score of 4–6 is considered medium, and a score of 7–9 is considered high. For more information about the use of Delphi scoring to select quality measures, see the following:

Schuster MA, Asch SM, McGlynn EA, et al. Development of a quality of care measurement system for children and adolescents. Methodological considerations and comparisons with a system for adult women. *Arch Pediatr Adolesc Med.* Nov 1997;151(11):1085-1092.

Mangione-Smith R, Schiff J, Dougherty D. Identifying children's health care quality measures for Medicaid and CHIP: An evidence-informed, publicly transparent expert process. *Acad Pediatr.* May-Jun 2011;11(3 Suppl):S11-21.

Jefferis L, Law M, Straus S, et al. Defining quality outcomes for complex-care patients transitioning across the continuum using a structured panel process. *BMJ Qual Saf.* Jul 12 2013;22:1014-1024.

Davies S, Romano P, Schmidt E, et al. Assessment of a novel hybrid Delphi and Nominal Groups technique to evaluate quality indicators. *Health Serv Res.* Dec 2011;46(6 pt 1):2005-2018.

Section #	Information Category or Criterion	Data Sources Used	Data Pertaining to This Measure		This column is available for SNAC to add comments (e.g., rationale for preliminary score)
	SNAC preliminary member score for this measure on Scientific Acceptability (scale of 1–9)		[Enter score here]	[Enter comments here]	

3.	FEASIBILITY			
3.a.i	Number (%) of States, including District of Columbia, reporting, by fiscal year <i>CAVEAT: If a State doesn't report, SNAC should not necessarily infer that there is a technical/feasibility problem with the measures. Some States may not wish to participate at all or have to be selective about resources.</i>			
3.a.i.1	FFY 2010	CMS, from CARTS	21 (42%)	—
3.a.i.2	FFY 2011	CMS, from CARTS	32 (63%)	—
3.a.i.3	FFY 2012	CMS, from CARTS	35 (70%)	—
3.a.ii	Number (%) of State Medicaid/CHIP programs reporting the measure at least once during the 3 fiscal years	CMS, from CARTS	37 (74%)	—
3.a.iii	Number (%) of State Medicaid/CHIP programs reporting the measure all 3 years	CMS, from CARTS	20 (40%)	—
3.a.iv	Number (% of reporting states) by program in 2012	CMS, from CARTS	35 (100%)	—
3.a.iv.1	Medicaid only	CMS, from CARTS	5 (14%)	—
3.a.iv.2	CHIP only	CMS, from CARTS	5 (14%)	—

(continued)

Section #	Information Category or Criterion	Data Sources Used	Data Pertaining to This Measure	This column is available for SNAC to add comments (e.g., rationale for preliminary score)
3.a.iv.3	Combined	CMS, from CARTS	25 (71%)	—
3.b	State Medicaid/CHIP program challenges experienced with data collection and/or reporting (State reported) in 2012			
3.b.i.	Data not available	CHIPRA TA Mailbox	8	—
3.b.ii	Population not covered		0	—
3.b.iii	Sample size too small		0	—
3.b.iv	Other		10	—
3.b.v	Not specified		0	—
3.c	State reporting challenges reflected in the TA requests submitted to the CHIPRA TA mailbox			
3.c.i	Number of TA requests re measure for period May 2011–May 2013 and number of States making requests	CMS	2	—
3.c.ii	TA topics for the measure	CMS	Calculation of denominator	—
3.d	Data source for the measure	FFY 2013 CMS Resource Manual and Technical Specifications	Administrative claims	—

3.e	Alignment with measures for other Federal programs (For each measure, report the name of the measure and the Federal program using the measure) CAVEAT: <i>The HHS measure inventory provides information on measures in other HHS programs that may include measures similar to one or more Child Core Set measures. In addition, the National Quality Measures Clearinghouse includes information about use for each measure it lists. Both databases are available at http://www.qualitymeasures.ahrq.gov/. We did not have the resources to do a comprehensive search of either database in time for the 2013 SNAC process.</i>			
3.e.i	Name of other measure(s)	CMS ³	Same	—

(continued)

Section #	Information Category or Criterion	Data Sources Used	Data Pertaining to This Measure	This column is available for SNAC to add comments (e.g., rationale for preliminary score)
3.e.ii	Federal program(s) using the measure	CMS	Adult Medicaid Core Set; CMS Electronic Health Record Incentive Program for Eligible Professionals; Physician Quality Reporting System; proposed in Value-Based Payment Modifier	—
OPTIONAL – AHRQ STAFF OBSERVATIONS THAT MAY BE OF INTEREST TO SNAC:				—
SNAC preliminary member score for this measure for Feasibility (scale of 1–9)			[Enter score here]	[Enter comments here]
4	USABILITY			

³ State Health Officials Letter #13-002. Children’s Core Set of Health Care Quality Measures. January 24, 2013. <http://www.medicaid.gov/Federal-PolicyGuidance/downloads/SHO-13-002.pdf>. Accessed September 20, 2013.

4.a	Action(s) Taken by States on measure topic		CAVEAT: It is important to note that what is listed on the grid of State activities is only the tip of the iceberg as to what is really happening out there. Because of resource constraints and, more importantly, our inability to survey all Medicaid and CHIP programs for examples of quality improvement strategies, AHRQ had to limit its search to only projects with documentation on the Web or elsewhere.	
4.a.i	State Medicaid/CHIP efforts		[Preliminary findings shared with SNAC only]	—
4.a.ii	Other State program initiatives (not Medicaid/CHIP)		Not available	—
4.b	Improvability (potential to improve)—summary of studies demonstrating that performance <i>can</i> be improved		[Preliminary findings shared with SNAC only]	—
OPTIONAL – AHRQ STAFF OBSERVATIONS THAT MAY BE OF INTEREST TO SNAC:				—

(continued)

Section #	Information Category or Criterion	Data Sources Used	Data Pertaining to This Measure		This column is available for SNAC to add comments (e.g., rationale for preliminary score)
SNAC preliminary member score for this measure for Usability (scale of 1–9)			[Enter score here]	[Enter comments here]	

SNAC member comments:

Observations, concerns, questions about the measures not covered by domains in the template

Taking all criteria into consideration, should measure be retired from the Child Core Set? (Circle YES or NO)

Yes

No

Note: “This column is available for SNAC to add comments (e.g., rationale for preliminary score)” was space offered to individual SNAC members as they worked through their recommendations.

Key: AHRQ = Agency for Healthcare Research and Quality; CARTS = CHIP Annual Reporting Template System; CHIP = Children’s Health Insurance Program; CHIPRA = Children’s Health Insurance Program Reauthorization Act of 2009; CMS = Centers for Medicare & Medicaid Services; FFS = fee for service; FFY = Federal fiscal year; HEDIS = Healthcare Effectiveness Data and Information Set; HHS = U.S. Department of Health and Human Services; MAX = Medicaid Analytic eXtract; NCQA = National Committee for Quality Assurance; NHIS = National Health Interview Survey; NSCH = National Survey of Children’s Health; SES = socioeconomic status; SNAC = National Advisory Council on Healthcare Research and Quality 2013 Subcommittee on Quality Measures for Children’s Healthcare for Medicaid and CHIP; TA = technical assistance.

Appendix E: SNAC Scoring Results and Retirement Recommendations, ordered by Retirement Votes in Final Round

Measure		Median Total Score Preliminary Round (N)	Median Total Score Final Round (N)	Retirement Votes Final Round	Status in CMS's 2014 Update to Child Core Set
5.	Childhood Immunization Status	8.25 (15)	8.25 (22)	0	No change
3.	Live Births Weighing Less Than 2,500 Grams	7.25 (15)	7.25 (22)	1	No change
6.	Immunization Status for Adolescents	8.25 (15)	8.13 (22)	1	No change
10.	Well-Child Visits in the First 15 Months of Life	7.75 (15)	7.88 (22)	1	No change
11.	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	7.75 (15)	7.88 (22)	1	No change
20.	Follow-up After Hospitalization for Mental Illness	6.75 (15)	6.75 (22)	1	No change
1.	Timeliness of Prenatal Care	6.75 (15)	6.88 (22)	2	No change
12.	Adolescent Well-Care Visits	7.75 (15)	7.63 (22)	3	No change
7.	Weight Assessment Counseling for Nutrition and Physical Activity for Children and Adolescents: Body Mass Index Assessment for Children/Adolescents	6.00 (15)	6.50 (22)	4	No change
8.	Developmental Screening in the First Three Years of Life	6.75 (15)	6.75 (22)	4	No change
2.	Frequency of Ongoing Prenatal Care	6.25 (15)	6.25 (22)	5	No change
4.	Cesarean Rate for Nulliparous Singleton Vertex	6.75 (15)	6.50 (22)	5	No change
9.	Chlamydia Screening in Women	6.75 (15)	6.50 (22)	5	No change

18.	Followup Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication	6.25 (14)	6.50 (21)	5	No change
17.	Annual Percentage of Asthma Patients with One or More AsthmaRelated Emergency Room [ER] Visits	6.75 (15)	6.50 (20)	6	Retired
15.	Ambulatory Care – Emergency Department [ED] Visits	6.25 (15)	6.25 (22)	7	No change
16.	Pediatric Central Line–Associated Blood Stream Infections	6.00 (15)	6.38 (21)	8	No change
13.	Children and Adolescent Access to Primary Care Practitioners	5.75 (14)	5.75 (21)	16	No change
19.	Annual Pediatric Hemoglobin (HbA1c) Testing	5.50 (15)	5.25 (22)	19	Retired
14.	Appropriate Testing for Children With Pharyngitis	5.00 (14)	4.75 (21)	20	Retired

Appendix F: Discussion or Rationale Related to Each Measure

Comment Summary

1. Timeliness of Prenatal Care

SNAC members regarded this measure as important, especially as a proxy for access to care and in combination with the measure of frequency of prenatal care. Although they also expressed interest in an improved measure including the content of the prenatal visit, they did not think this measure should be retired until an improved measure was available. One noted that the measure has room for improvement when compared to commercial rates. As with other HEDIS measures, this measure has high reliability scores, but little information on measure validity was provided. Many States reported on the measure, and overall the percentage of States able to report is increasing, so SNAC members rated this measure high on feasibility. Several SNAC members noted that although the evidence for improvability was lacking, they also credited the measure for driving improvement in managed care organizations.

2. Frequency of Ongoing Prenatal Care

SNAC members noted that although the measure is not well tied to outcomes, it affects a large proportion of Medicaid patients, and there is room for improvement. Similar to measure 1 (timeliness), this measure demonstrates high reliability, even if information on validity is lacking. Overall, although SNAC members would prefer an improved measure, the measure represents an important topic area and is important to retain in conjunction with measure 1.

3. Live Births Weighing Less Than 2,500 Grams

SNAC members enthusiastically endorsed the importance of this measure because it was one of the few measures of outcomes. With regard to scientific acceptability, there was some concern that the measure was not risk adjusted, but otherwise validity was rated as high. Because the measure can rely on links between Medicaid and vital statistics, there are some concerns regarding data collection difficulties; however, at least one SNAC member thought it was important to encourage those links. Another SNAC member noted that, with regard to improvability, even small improvements in this measure could have an important impact.

4. Cesarean Rate for Nulliparous Singleton Vertex

SNAC members acknowledged that this measure represents a high-cost issue that is aligned with Federal concerns, but they noted that there seems to be disagreement on reliability and validity. Some SNAC members have feasibility concerns relative to data collection because of the use of vital statistics, whereas others felt diagnosis coding would make this measure highly feasible. Other SNAC member concerns were what an appropriate C-section rate is, and the measure's failure to consider reasons for a C-section. The measure would be improved with risk adjustment. Some SNAC members believed that managed care contracts or payment reform could improve this measure or that it might be more applicable to obstetrics than pediatrics.

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Comment Summary

5. Childhood Immunization Status

SNAC members noted that this measure affects a large portion of the Medicaid population, has a large public health impact, can help address disparities, and still has room for improvement. Reliability is high, and some data suggest that validity is good as well. The measure specifications are well understood by Medicaid agencies, but concerns remain over coding and administrative burden. One member noted the measure's importance in monitoring public health access and creating feedback to drive improvement.

6. Immunization Status for Adolescents

SNAC members noted that this measure affects a large portion of the Medicaid population, has a large public health impact, can help address disparities, and still has room for improvement. Reliability is high and some data suggest that validity is good as well. The measure specifications are well understood by Medicaid agencies, but concerns remain over coding and administrative burden.

7. Weight Assessment Counseling for Nutrition and Physical Activity for Children and Adolescents: Body Mass Index Assessment for Children/Adolescents

SNAC members acknowledged that obesity has a high prevalence in the population covered by Medicaid and CHIP, it results in increased costs and chronic health conditions over time, there is room for improvement, and the measure addresses health care disparities. Some members noted that data collection may be burdensome unless an electronic health record is adopted, but they also noted that because this is a HEDIS measure, the specification should be well understood. Although this measure aligns with other federal initiatives, it does not address treatment of obesity or followup care related to the body mass index assessment. Some SNAC members suggested that coupling it with an intervention measure would be important, whereas others noted that the measure as it is as is key for intervention assessment and outcome-driven research.

8. Developmental Screening in the First Three Years of Life

SNAC members noted that many children in this age group are insured by Medicaid, there is room for improvement, and disparities are present. However, no reliability or validity data were available, and members expressed concern that the measure does not address several components of quality, such as the validity of screenings used or the use of followup based on screening results. Other concerns about feasibility centered on the inability to capture screening done in different venues, as well as the newness of this measure. SNAC members believe that the importance and potential for improvement is strong, but an improved measure should be considered.

9. Chlamydia Screening in Women

SNAC members expressed mixed sentiments about this measure. On one hand, some noted that many in this age group are insured by Medicaid or CHIP, and there may be room for improvement. The measure also received enthusiastic review by some SNAC members because it represents evidence-based care and is the only measure for gynecological care for this population. With regard to feasibility, SNAC members noted that as a HEDIS measure, its specifications are familiar to Medicaid programs, and administrative data can be collected easily. However, others questioned the measure's validity because of the difficulty in identifying sexually active teens. Additionally, one SNAC member questioned whether this could be a proxy for the quality of adolescent care, and others were uncertain as to the measure's improvability.

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Comment Summary

10. Well-Child Visits in the First 15 Months of Life

SNAC members agreed that this is an important measure of a key part of pediatric care: prevention. Well-child visits affect many insured by Medicaid, and the measure shows room for improvement, particularly when compared to the commercial population. SNAC members also noted that the measure has high reliability, but that little information on validity data was provided—yet, looking across all the well-care visit measures, one SNAC member stated that the link between these visits and child outcomes was the greatest. As a HEDIS measure, SNAC members believed that the specifications are familiar to Medicaid programs, and high levels of reporting indicate that the measure is feasible. Overall, SNAC members agreed that this measure is important for measuring access and monitoring and addressing disparities in care, but there is some concern that the content of such visits is not addressed in the measure.

11. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

SNAC members agreed that this is an important measure of a key part of pediatric care: prevention. One SNAC member suggested that all three well-care visit measures should be considered as linked and either kept in the set together or retired from the set together. Similar to the other well-child visit measures, this measure shows room for improvement, particularly when compared to the commercial population. SNAC members also noted that the measure has high reliability, but that little information on validity data was provided. With regard to validity, one SNAC member's perspective was that this measure may be less tightly linked to outcomes for first 15 months of life. With regard to feasibility, SNAC members also noted that this is a HEDIS measure and has high levels of reporting by States. Although this measure was considered to be important for measuring access and monitoring and addressing disparities in care, one common concern was that the measure does not address the content of such visits.

12. Adolescent Well-Care Visits

SNAC members agreed that this is an important measure, focused on prevention, that affects many insured by Medicaid and shows room for improvement, particularly when compared to the commercial population. SNAC members also noted that the measure has high reliability. However, several SNAC members questioned this measure's validity more than the validity of the other well-care visit measures, either because this population may get free or low-cost care from different sources, or because the evidence linking these visits to health outcomes was weak or not available. With regard to feasibility, SNAC members also noted that this is a HEDIS measure and that high levels of reporting indicate that the measure is feasible. Although this measure was considered to be important for measuring access and monitoring and addressing disparities in care, one common concern was that the measure does not address the content of such visits.

13. Children and Adolescent Access to Primary Care Practitioners

SNAC members varied in their assessment of the importance of this measure. Although the SNAC members noted this as an important concept, and access to care is an issue that affects a large number of children, common concerns cited by the SNAC members were that the performance is already high, and that measures of preventive visits are a better measure of access. It was noted several times that this is a measure of utilization, not quality. Although SNAC members noted the high reliability and feasibility of this measure, they questioned the measure's validity. In general, SNAC members seemed to agree that it is unclear whether this measure adds value beyond the other well-child-visit measures under consideration.

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Comment Summary

14. Appropriate Testing for Children with Pharyngitis

The members that attended the second SNAC meeting seemed to universally agree that this measure should be retired, and the comments on this measure supported that perspective. As one SNAC member put it, “Discussion suggests evidence for the clinical importance of this measure is obsolete.” For example, the measure does not target inappropriate antibiotic use and may increase unnecessary testing. While at least one SNAC member supported retaining this measure because it was the only measure of appropriateness of care, and other SNAC members noted that many States report this measure and it scores high on reliability, there were general concerns about its usefulness, as well as the true potential to improve on this measure. One SNAC member suggested that a better measure for reducing antibiotic use for viral infections is needed.

15. Ambulatory Care – Emergency Department [ED] Visits

SNAC members generally supported the importance of this measure because the cost of ED visits is high, but they also acknowledged that the measure may be difficult to interpret without the context of primary care measures. At least one SNAC member called for replacing this measure with an improved measure, if possible. Although ED use is an important topic, this measure does not differentiate appropriate and inappropriate ED use, and it is not risk adjusted. Relatively few States report on this measure, causing some SNAC members to question the feasibility of the measure as well. Several SNAC members noted that it is unclear whether there is room for improvement, and results may not be timely enough to be actionable.

16. Pediatric Central Line–Associated Blood Stream Infections

SNAC members gave mixed support for this measure. They generally acknowledged this measure’s importance because, although the number of affected individuals is small, these infections can be a huge cost for Medicaid, the event is an outcome that is completely avoidable. Also, at this time there is low performance on the basis of statewide Centers for Disease Control and Prevention data, which are currently used as a proxy for Medicaid/CHIP performance rather than data specific to Medicaid- or CHIP-covered children in the neonatal intensive care unit. However, SNAC members differed as to their assessment of the appropriateness of this measure in the Child Core Set. Some stated that, although this is an important measure of quality, as a hospital-level measure it may not be appropriate to report at the State Medicaid level. Others indicated that there would be potential for Medicaid/CHIP programs and hospitals to partner to address this quality issue.

17. Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Room [ER] Visits

SNAC members noted that many Medicaid and CHIP enrollees have asthma, and many asthma-related ER visits are costly and likely treatable in the primary care setting instead of the ER. Despite these indicators of the measure’s importance, SNAC members were concerned about the validity of the measure (the measure is not risk adjusted) and the feasibility of the measure because its steward has decided not to continue maintenance of the measure. Although some preference was expressed for this measure over the other ER measure (measure 15) because of its focus on a specific prevalent condition with demonstrated disparities in care, several SNAC members indicated that there may be better measures related to asthma care.

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Comment Summary

18. Followup Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication

SNAC members noted that a large percentage of Medicaid-insured children have a diagnosis of ADHD, and there appears to be room for improvement, arguing for this measure's importance. However, several SNAC members noted weaknesses in the measure's validity—namely, that the measure does not address coordination of care between different types of providers who are likely involved (e.g., the primary care physician, behavioral care specialist, prescriber), and that because followup visits by telephone are not being counted, this measure could have the unintended consequence of encouraging unnecessary office visits. SNAC members seemed to conclude that although an improved measure is preferred, the measure represents an important area of focus.

19. Annual Pediatric Hemoglobin (HbA1c) Testing

SNAC members generally expressed support for retiring this measure. They noted that this measure affects a small number of Medicaid-enrolled children, has a poor evidence grade, and may be approaching an improvement ceiling. Among other concerns with validity, at least one SNAC member noted that the measure does not distinguish between Type I and Type II diabetes, and it is unclear whether it is a good measure of care in pediatric patients. With regard to feasibility, SNAC members noted that few States report this measure.

20. Followup After Hospitalization for Mental Illness

SNAC members supported retention of this measure because it addresses the clinically important topic of behavioral health and demonstrates an opportunity for improvement. SNAC members noted that no reliability or validity data were provided. With regard to feasibility, SNAC members noted that an increasing number of States are reporting the measure. With regard to usability, other SNAC members noted that there seems to be some improvement in this measure over time. Although several SNAC members expressed preference for an improved measure, such as a measure of coordination between a primary care physician and behavioral health providers, there was general agreement that the measure represents an important area of focus.

Note: ADHD = attention deficit/hyperactivity disorder; CHIP = Children's Health Insurance Program; C-section = cesarean section; ED = emergency department; ER = emergency room; HEDIS = Healthcare Effectiveness Data and Information Set; SNAC = Agency for Healthcare Quality and Research Subcommittee to the National Advisory Council on Children's Health Quality Measures.