

## SECTION I. BASIC MEASURE INFORMATION

### I.A. Measure Name

***Reporting of Supplemental CAHPS Data Regarding Availability of Treatment or Counseling Services for Children on Medicaid***

### I.B. Measure Citation Information

Clark SJ, Riebschleger MP, Nelson SA, Young KA, Shoulders EN, Duong S, Dombkowski KJ. Reporting of Supplemental CAHPS Data Regarding Availability of Treatment or Counseling Services for Children on Medicaid. National Quality Measures Clearinghouse (NQMC). Rockville (MD): Agency for Healthcare Research and Quality (AHRQ). Published July 20, 2015.

### I.C. Measure Description

This Q-METRIC measure requires states to collect and report CAHPS data regarding whether parents easily get treatment or counseling for their Medicaid-enrolled children when the child has an emotional, developmental, or behavioral problem.

This measure uses data on parent perceptions of the availability of treatment or counseling for Medicaid-enrolled children experiencing emotional, developmental, or behavioral problems. The data are collected via an individual question from the Consumer Assessment of Healthcare Providers and Systems (CAHPS), specifically the Item Set for Children with Chronic Conditions (CCC) supplement to the CAHPS Health Plan Survey – Child Medicaid Survey. This is not in the core CAHPS survey; rather, it is part of an array of supplemental questions that can be included by those administering CAHPS.

CAHPS is a program of the US Agency for Healthcare Research and Quality (AHRQ). The core survey and any additional questions chosen by the state are mailed to parents of children younger than 18 years of age enrolled in the program, followed by reminders to non-responders by either mail or telephone. As mandated by the Children’s Health Insurance Program Reauthorization Act (CHIPRA), the federal government currently requires that states administer the core CAHPS survey to their Children’s Health Insurance Program (CHIP) populations (Chapter XXI) and report to the Centers for Medicare & Medicaid Services (CMS) that CAHPS was conducted. The government leaves administration of CAHPS to the Medicaid-only population (Chapter XIX) as optional. In neither case is there any requirement or suggestion to include the Item Set for CCC or the individual question about how easily parents can access treatment or counseling for their children. Moreover, CHIPRA does not currently require states to report the results for each question; currently, very few states do so.

Emotional, developmental, and behavioral problems can represent a broad spectrum of conditions and situations. The CAHPS measure is correspondingly broad and does not define “emotional, developmental, or behavioral problems.” As such, it does not set limits with respect to diagnosis, severity, or duration of the child’s problem; rather, it relies entirely on parents’ perspectives of what

the terms “emotional, developmental and behavioral problems” may represent. Furthermore, treatment and counseling can be provided in a number of settings and formats. Settings may include primary care offices, medical specialist offices, schools, community agencies, and mental health practices. It may be provided by doctors, psychologists, social workers, school nurses, or many other roles, and done individually, in groups, or in other formats. Throughout this measure description, we will continue to use the CAHPS terminology of “treatment or counseling” to emphasize the broad scope of problems and service options parents may consider when they respond to these CAHPS questions.

Questions regarding availability of treatment or counseling care have been included in multiple versions of CAHPS, though the wording has changed slightly with each version. States are encouraged, but not required to use CAHPS version 5.0.; at present, many continue to use version 4.0. While the Item Set for CCC supplement has only been released through version 4.0, states may include any questions in their surveys, whether from earlier supplements or from questions crafted by the states themselves. Specifically, this measure requires states that sample their Medicaid populations to include the optional supplement question and report the percentage of parents who responded **Usually** or **Always** to the treatment or counseling availability question from version 4.0 of the Item Set for CCC in their CAHPS Health Plan Survey – Child Medicaid Survey or its equivalent question in future versions of the CCC Item Set. The treatment or counseling availability question is written as follows in the CAHPS CCC Item Set currently offered:

*Version 4.0: In the last 6 months, how often was it easy to get this treatment or counseling for your child?*

The question is asked of parents who answer **Yes** to the CAHPS screener question immediately preceding it. This screener question asks parents, “In the last 6 months, did you get or try to get treatment or counseling for your child for an emotional, developmental, or behavioral problem?” (Note, here and elsewhere in this documentation, the word “parent” is inclusive of all caregivers that CAHPS allows to respond on behalf of a child, including biological parents, legal guardians, or other family members [CMS, 2012]). A high percentage of parents responding **Usually** or **Always** to the availability question reflects parents’ ability to access treatment or counseling services in a timely manner for children perceived to be in need of that care. A parent’s inability or difficulty in obtaining treatment or counseling services for a child may lead to further distress or negative emotional outcomes for the child.

This Q-METRIC measure assesses the degree of reporting for this parent-reported rating of the availability of care. This information, particularly if reporting includes data for each health plan or other consumer options, may lead to improved choices for health care consumers while allowing Medicaid programs to assess the adequacy of their provider options for treatment or counseling and/or their efforts around care coordination.

#### **I.D. Measure Owner**

The Quality Measurement, Evaluation, Testing, Review, and Implementation Consortium (Q-METRIC)

## I.E. National Quality Forum (NQF) ID (if applicable)

Not applicable

## I.F. Measure Hierarchy

Please use this section to note if the measure is part of a measure hierarchy or is part of a measure group or composite measure. The following definitions are used by AHRQ's National Quality Measures Clearinghouse and are available at

<http://www.qualitymeasures.ahrq.gov/about/hierarchy.aspx>:

- I.F.1.** Please identify the name of the **collection** of measures to which the measure belongs (if applicable). A Collection is the highest possible level of the measure hierarchy. A Collection may contain one or more Sets, Subsets, Composites, and/or Individual Measures.

This measure is part of the Q-METRIC Availability of Specialty Services Measures collection.

- I.F.2.** Please identify the name of the measure **set** to which the measure belongs (if applicable). A Set is the second level of the hierarchy. A Set may include one or more Subsets, Composites, and/or Individual Measures.

Not applicable

- I.F.3.** Please identify the name of the **subset** to which the measure belongs (if applicable). A Subset is the third level of the hierarchy. A Subset may include one or more Composites and/or Individual Measures.

Not applicable

- I.F.4.** Please identify the name of the **composite** measure to which the measure belongs (if applicable). A Composite is a measure with a score that is an aggregate of scores from other measures. A Composite may include one or more other Composites and/or Individual Measures. Composites may comprise component measures that can or cannot be used on their own.

Not applicable

## I.G. Numerator Statement

A numerator of one (1) demonstrates that a particular state collects the treatment or counseling availability question from the CAHPS Item Set for Children with Chronic Conditions and publicly reports the results of the individual question among their Medicaid-only (Chapter XIX) population. A numerator of zero (0) demonstrates that the state does not publicly report those results.

## I.H. Numerator Exclusions (as appropriate)

None

### I.I. Denominator Statement

The denominator is the individual state required to report the CAHPS Health Plan Survey – Child Medicaid version, and therefore will always be one (1).

### I.J. Denominator Exclusions (as appropriate)

None

### I.K. Data Sources

Check all the data sources for which the measure is specified and tested.

Data Source	
1. Administrative Data (e.g., claims data)	
2. Paper Medical Record	
3. Survey – Health care professional report	
4. Survey – Parent/caregiver report	X
5. Survey – Child report	
6. Electronic Medical Record	
7. Other (If other, please list all other data sources in the field below.)	X

Reporting of this CAHPS measure by a state program may take any form that clearly conveys the results of this question; it may be reported alone, or as one component of a broader array of parent-reported availability and access measures that include this specific treatment or counseling availability question.

### **References for Section I**

Centers for Medicare & Medicaid Services, Children’s Health Care Quality Measures Core Set Technical Assistance and Analytic Support Program. Technical Assistance Brief: Guidance for Conducting the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H Child Survey, Medicaid.gov. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/CAHPSBrief.pdf>. December, 2012. Accessed July 7, 2014.

## SECTION II. DETAILED MEASURE SPECIFICATIONS

Provide sufficient detail to describe how a measure would be calculated from the recommended data sources, either by uploading a separate document or by providing a link to a URL in the field below. Examples of detailed measure specifications can be found in the CHIPRA Initial Core Set Technical Specifications Manual 2011 published by the Centers for Medicare & Medicaid Services.<sup>1</sup> Although submission of formal programming code or algorithms that demonstrate how a measure would be calculated from a query of an appropriate electronic data source are not requested at this time, the availability of these resources may be a factor in determining whether a measure can be recommended for use.

This measure requires states to collect and report specific CAHPS results regarding whether parents of Medicaid-enrolled children get treatment or counseling services for their children when their children experience emotional, developmental, or behavioral problems. This measure also requires states to report the results of this question individually, rather than as part of a composite measure. This measure uses data on treatment or counseling availability for Medicaid-enrolled children collected via CAHPS, specifically a question from the optional Item Set for CCC supplement to the CAHPS Health Plan Survey. Please see the CAHPS measure specification provided as a separate document in Appendix 1. The question reads as follows:

*Item Set Version 4.0: In the last 6 months, how often was it easy to get this treatment or counseling for your child?*

This question is asked of parents who answered affirmatively that they obtained or tried to obtain treatment or counseling for their child for an emotional, developmental, or behavioral problem in the previous 6 months.

While the general Medicaid definition of children includes all individuals younger than 21 years of age, the CAHPS Health Plan Survey – Child Medicaid Survey is only administered to parents with children younger than 18 years of age. Individuals aged from 18-20 years are included in the Adult Medicaid Survey. As such, the data reported may not be directly comparable with other Medicaid data on children. However, the survey instructions are the same between states and over time, and thus may provide an opportunity for a baseline comparison if states choose to use it in this manner.

This measure allows states to follow all relevant CMS and CAHPS guidelines (CMS, 2012). The number of states that collect Medicaid-only data is not publicly available, but states have rapidly expanded aggregate CAHPS data reporting on Medicaid/CHIP populations, from only one state in 2010 to 27 states in 2012, including the District of Columbia (HHS, 2013; See Figure1, page 35 and Table 2, pages 23-24). Specific CAHPS survey data may also be voluntarily provided to AHRQ's National CAHPS Benchmarking Database.

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<sup>1</sup> Initial Core Set of Children's Health Care Quality Measures: Technical Specifications and Resource Manual for Federal Fiscal Year 2011 Reporting. Available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/InitialCoreSetResourceManual.pdf> and <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html>.

Reporting of this CAHPS measure by a state program may take any form that clearly conveys the results of this question; it may be reported alone, or as part of a broader array of parent-reported availability and access measures that includes this specific treatment or counseling availability question. Some states have already reported the results of this question publicly in their CAHPS reports, with New York as a notable example. New York reported the results of the question exactly according to this measure's specification, providing the proportion of respondents who answered **Usually** or **Always** to the treatment or counseling availability question, and further provided the proportions for the state overall and other plan types. (See example from the New York state report excerpted in Appendix 2).

### **References for Section II**

- Centers for Medicare & Medicaid Services, Children's Health Care Quality Measures Core Set Technical Assistance and Analytic Support Program. Fact Sheet: Collecting and Reporting the CAHPS® Survey as Required Under the Children's Health Insurance Program Reauthorization Act (CHIPRA), Medicaid.gov. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/CAHPSFactSheet.pdf>. December, 2012. Accessed July 7, 2014.
- The Department of Health and Human Services, 2013 Annual Report on the Quality of Care for Children in Medicaid and CHIP, Medicaid.gov. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2013-Ann-Sec-Rept.pdf>. September, 2013. Accessed July 7, 2014.

## SECTION III. IMPORTANCE OF THE MEASURE

In the following sections, provide brief descriptions of how the measure meets one or more of the following criteria for measure importance (general importance, importance to Medicaid and/or CHIP, complements or enhances an existing measure). Include references related to specific points made in your narrative (not a free-form listing of citations).

### III.A. Evidence for General Importance of the Measure

Provide evidence for all applicable aspects of general importance, including but not limited to the following:

- Addresses a known or suspected quality gap or disparity in quality (e.g., addresses a socioeconomic disparity, a racial/ethnic disparity, a disparity for Children with Special Health Care Needs (CSHCN) and/or a disparity for limited English proficiency (LEP) populations.
- Potential for quality improvement (i.e., there are effective approaches to reducing the quality gap or disparity in quality).
- Prevalence of condition among children under age 21 and/or among pregnant women.
- Severity of condition and burden of condition on children, family, and society (unrelated to cost).
- Fiscal burden of measure focus (e.g., clinical condition) on patients, families, public and private payers, or society more generally, currently and over the life span of the child.
- Association of measure topic with children's future health—for example, a measure addressing childhood obesity may have implications for the subsequent development of cardiovascular diseases.
- The extent to which the measure is applicable to changes across developmental stages (e.g., infancy, early childhood, middle childhood, adolescence, young adulthood).

#### Availability and EPSDT (The CAHPS Measure)

Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit provides the foundation for comprehensive and preventive health care services for all Medicaid-enrolled children under age 21. Health screenings are mandated by the EPSDT guidelines, under which states are required to arrange (directly or through referral) for corrective treatment as indicated by the

screenings, which include screening for developmental and behavioral concerns. Further, states must report to CMS the number of children referred for corrective treatment (Medicaid.gov, 2014). The CAHPS measure assesses if parents are able to secure this care, regardless of whether the need derives from EPSDT screening or any other impetus.

### **The Value of Reporting Results on Availability of Care (the Q-METRIC Measure)**

This Q-METRIC measure requires states to report CAHPS data regarding whether parents of Medicaid-enrolled children get treatment or counseling for their children when needed. The value of a parent-reported measure is that it offers a comprehensive view of both the need for care and the receipt of services across settings. Contrary to specialty care, treatment and counseling can occur in a multitude of settings; therefore, medical record reviews are unlikely to capture services provided through schools or community agencies. Utilization measures will be incomplete if they do not capture behavioral/mental health services provided under both medical benefits and behavioral/mental health carve-outs, and would not include services provided but not billed. Furthermore, neither of these methods will capture unmet need. Thus, parents' views may be the most accurate indicator on the availability of treatment and counseling services.

Reporting about parental views on the availability of care is presumed to foster improvement through two mechanisms (Werner et al., 2005). First, by ensuring a consistent mechanism to generate data on treatment or counseling availability, Medicaid programs can track their progress toward improving parental perceptions of availability of behavioral/mental health services for their beneficiaries. Second, if such information is reported in a forum accessible to the public, patients (parents) have additional information on which to compare health plans (when available), and all stakeholders have a mechanism to compare availability across states and to track progress over time (Werner et al., 2005).

Public reporting in the health care setting is defined as data, publicly available or available to a broad audience free of charge or at a nominal cost, about a health care structure, process, or outcome at any provider level (individual clinician, group, or organizations [e.g., hospitals, nursing facilities]) or at the health plan level (Totten et al., 2012). Public reporting is seen as a possible way to bridge the gap between current and improved levels of quality in the practice of health care (AHRQ, 2011).

Both consumer-driven and provider-driven changes can improve the quality of care after the initiation of public reporting (Werner et al., 2010). Likewise, a study of the effect that voluntary information disclosure had on quality of care in health maintenance markets showed a significant and positive effect on quality (Jung, 2010). Disclosing data collected as part of the Health Plan Employer Data and Information Set (HEDIS) led to a ~7% improvement in quality scores, though improvement was not universal across all quality measures (Jung, 2010).

Public reporting has also been noted to have the potential for unintended and negative consequences (Werner et al., 2005). These largely derive from the scenario in which physicians or providers screen their patients to avoid negative outcomes in their reported performance scores. As this measure relies on aggregate and anonymous reporting, it is not expected that these unintended negative consequences will occur.



## Performance Gaps

Research shows a variety of issues related to the availability of behavioral/mental health treatment and counseling for Medicaid enrolled children:

- Physicians report varying degrees of success in their ability to refer Medicaid- and CHIP-enrolled patients *versus* privately insured patients to specialists. Mental health care (such as psychology and psychiatry) is one of “the most frequently cited specialties for children” by physicians when asked with which specialties they experienced the most difficulty when referring children (US GAO, 2011).
- Parents may have different expectations regarding their roles in setting up specialist appointments for a child (Stille et al., 2007; Clark et al., 2014). It is possible this type of relationship extends to treatment and counseling appointments when parents are referred or directed by other authority figures.
- Many states and regions have variable geographic distribution and shortages of specialists. In particular, developmental behavioral pediatrics typically requires larger populations of children to attract a physician (Mayer, 2006).

Research shows that consumers are beginning to seek out health care quality data. A report by the Kaiser Family Foundation noted that the number of consumers seeking such information increased from 27% in 2000 to 35% in 2004; moreover, 14% of consumers reported using quality information to choose health plans (KFF, 2004). However, the extent of public reporting varies by state.

### III.B. Evidence for Importance of the Measure to Medicaid and/or CHIP

Comment on any specific features of this measure important to Medicaid and/or CHIP that are in addition to the evidence of importance described above, including the following:

- The extent to which the measure is understood to be sensitive to changes in Medicaid or CHIP (e.g., policy changes, quality improvement strategies).
- Relevance to the Early and Periodic Screening, Diagnostic and Treatment benefit in Medicaid (EPSDT).<sup>2</sup>
- Any other specific relevance to Medicaid/CHIP (please specify).

#### Availability and Medicaid/CHIP

According to CMS, approximately 43 million children are currently covered by Medicaid/CHIP programs (Medicaid.gov, n.d.). Recent research estimates one in six US children experience developmental disorders of one kind or another (Boyle et al., 2011). Other research estimates that nearly half of all children will experience an emotional or behavioral disorder (separate from developmental disorders) at some point in their life (Merikangas et al., 2010). Combined, this evidence suggests that a significant proportion of children at some point will be in a situation to

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<sup>2</sup> The EPSDT is a comprehensive set of benefits available to children and youth under age 21 who are enrolled in Medicaid. For more information, see <http://www.healthlaw.org/images/stories/epsdt/3-ESDPT08.pdf>.

require treatment or counseling services and that the overall number of Medicaid-enrolled children needing these services could be substantial. CAHPS survey data are focused on capturing the parent's success in obtaining this care. The Q-METRIC measure is focused on ensuring that states collect and report this data in a systematic manner, demonstrating whether states and programs make this information publicly available to allow tracking over time.

### **III.C. Relationship to Other Measures (if any)**

Describe, if known, how this measure complements or improves on an existing measure in this topic area for the child or adult population, or if it is intended to fill a specific gap in an existing measure category or topic. For example, the proposed measure may enhance an existing measure in the initial core set, it may lower the age range for an existing adult-focused measure, or it may fill a gap in measurement (e.g., for asthma care quality, inpatient care measures).

To our knowledge, there are currently no quality measures of parent-reported availability of treatment or counseling services for children.

HEDIS has a related quality measure titled "Follow-Up After Hospitalization for Mental Illness (FUH)" (National Committee for Quality Assurance, 2009). The HEDIS measure tracks the percentage of patients who receive follow-up care with a mental health practitioner after being discharged from a hospital stay that was for the purposes of treating any of a number of selected mental health disorders. The measure tracks this percentage for two periods of time: within 7 days of discharge and within 30 days of discharge, specifically among patients 6 years of age and older.

The current CAHPS measure differs from the HEDIS measure in a number of ways:

1. Given the nature of the CAHPS question that allows for parents to determine whether the child has a need, this CAHPS measure will reach a much larger population that deals with a significantly greater number of problems that children may encounter, compared with the limited diagnoses allowed by HEDIS.
2. Similarly, the CAHPS measure also is more expansive because it tracks attempts to obtain treatment or counseling at any time, rather than solely following mental health-related hospitalizations. These hospitalizations are likely to represent much more severe conditions and situations with much greater urgency than the CAHPS measure.
3. HEDIS tracks the percentage of discharged patients regardless of their interest or intent in obtaining follow-up care, while the CAHPS measure focuses on the patients (via their parents) who actively seek care.
4. HEDIS includes all adults and excludes children under age 6, so the CAHPS measure will have a noticeably different population as it includes all children under age 18.

### **References for Section III**

- Agency for Healthcare Research and Quality. Public Reporting as a Quality Improvement Strategy: A systematic review of the multiple pathways public reporting may influence quality of health care. [http://effectivehealthcare.ahrq.gov/ehc/products/343/763/CQG-Public-Reporting\\_Protocol\\_20110817.pdf](http://effectivehealthcare.ahrq.gov/ehc/products/343/763/CQG-Public-Reporting_Protocol_20110817.pdf). August 17, 2011. Accessed July 9, 2014.
- Boyle CA, Boulet S, Schieve LA, et al. Trends in the prevalence of developmental disabilities in US children, 1997–2008. *Pediatrics* 2011; 127(6): 1034-1042.
- Clark SJ, Kauffman AD, Singer DC, Gebremariam A, Davis MM. Seeing specialists: Roles of parents and providers unclear. C.S. Mott Children’s Hospital National Poll on Children’s Health, University of Michigan. Vol 20, Issue 2, January 2014. Available at: <http://mottnpch.org/reports-surveys/seeing-specialists-roles-parents-providers-unclear>.
- Jung K. The impact of information disclosure on quality of care in HMO markets. *Int J Qual Health Care* 2010; 22(6):461-468.
- Kaiser Family Foundation. Five years after IOM report on medical errors, nearly half of all consumers worry about the safety of their health care, kff.org. <http://kff.org/other/poll-finding/five-years-after-iom-report-on-medical/>. November 15, 2004. Accessed July 9, 2014.
- Mayer, ML. Are we there yet? Distance to care and relative supply among pediatric medical subspecialties. *Pediatrics* 2006; 118(6): 2313-2321.
- Medicaid.gov. Children. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Population/Children/Children.html>. No date. Accessed July 8, 2014.
- Medicaid.gov. Early and Periodic Screening, Diagnosis and Treatment. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html>. Updated June 17, 2014. Accessed July 9, 2014.
- Merikangas KR, He JP, Brody D, et al. Prevalence and treatment of mental disorders among US children in the 2001-2004 NHANES. *Pediatrics* 2010; 125(1): 75-81.
- National Committee for Quality Assurance. Follow-Up after Hospitalization for Mental Illness (FUH). <http://www.ncqa.org/portals/o/Follow-Up%20After%20Hospitalization%20for%20Mental%20Illness.pdf>. Updated 2009; Accessed August 6, 2014.
- Stille, CJ, Primack, WA, McLaughlin, TJ, Wasserman, RC. Parents as information intermediaries between primary care and specialty physicians. *Pediatrics* 2007; 120(6): 1238-1246.
- Totten AM, Wagner J, Tiwari A, O’Haire C, Griffin J, Walker M. Public reporting as a quality improvement strategy. Closing the quality gap: Revisiting the state of the science. Evidence Report No. 208. (Prepared by the Oregon Evidence-Based Practice Center under Contract No. 290-2007-10057-I.) AHRQ Publication No. 12-E011-EF. Rockville, MD: Agency for Healthcare Research and Quality. July 2012. [www.effectivehealthcare.ahrq.gov/reports/final.cfm](http://www.effectivehealthcare.ahrq.gov/reports/final.cfm).

United States Government Accountability Office. MEDICAID and CHIP: Most physicians serve covered children but have difficulty referring them for specialty care. GAO.gov. <http://www.gao.gov/assets/330/320559.pdf>. June, 2011. Accessed July 9, 2014.

Werner RM, Asch DA. The unintended consequences of publicly reporting quality information. *JAMA* 2005; 293(10): 1239-1244.

Werner R, Stuart E, Polsky D. Public reporting drove quality gains at nursing homes. *Health Aff* 2010; 29(9): 1706-1713.

## SECTION IV. MEASURE CATEGORIES

CHIPRA legislation<sup>3</sup> requires that measures in the initial and improved core set, taken together, cover all settings, services, and topics of health care relevant to children. Moreover, the legislation requires the core set to address the needs of children across all ages,<sup>4</sup> including services to promote healthy birth. Regardless of the eventual use of the measure, we are interested in knowing all settings, services, measure topics, and populations that this measure addresses. These categories are not exclusive of one another, so please indicate "Yes" to all that apply.

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<sup>3</sup> Children's Health Insurance Program Reauthorization Act of 2009. Public Law No. 111-3, 123 Stat. 8 (2009). Available at: [http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111\\_cong\\_public\\_laws&docid=f:publ003.111](http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_public_laws&docid=f:publ003.111).

<sup>4</sup> Under Section 214 of CHIPRA, States may elect to cover the following groups under Medicaid only or under both Medicaid and CHIP: pregnant women and children up to age 19 for CHIP or up to age 21 for Medicaid.

	Does the measure address this category [Yes/No drop-down]	
a. Care Setting – ambulatory	Yes	
b. Care Setting – inpatient	No	
c. Care Setting – other—please specify	No	[Add the following choices: home, school, other community and public health settings, long-term care, other---drop-down or radio buttons]
d. Service – preventive health	No	
e. Service – care for acute conditions	Yes	
f. Service - care for children with special health care needs/chronic conditions	Yes	
g. Service – health promotion and services to promote healthy birth	No	
h. Service-other (please specify)	No	
i. Measure Topic -duration of enrollment	No	
j. Measure Topic – clinical quality	No	
k. Measure Topic – patient safety	No	
l. Measure Topic – family experience with care	Yes	
m. Measure Topic – care in the most integrated setting	No	
n. Measure Topic – other (please specify)		n/a
o. Population – pregnant women		n/a
p. Population – neonates (28 days after birth) (specify age range) [o on new form]	Yes	Birth – 28 days
q. Population – infants (29 days to 1 year) (specify age range)[ p on new form]	Yes	All ages in this range
r. Population – pre-school age children (1 year through 5 years) (specify age range)	Yes	All ages in this range
s. Population – school-age children (6 years through 10 years) (specify age range)	Yes	All ages in this range
t. Population – adolescents (11 years through 20 years) (specify age range)	Yes	Adolescents 11 through 17 years, i.e., younger than 18 years

## SECTION V. EVIDENCE OR OTHER JUSTIFICATION FOR THE FOCUS OF THE MEASURE

The evidence base for the focus of the measures will be made explicit and transparent as part of the public release of CHIPRA deliberations; thus, it is critical for submitters to specify the scientific evidence or other basis for the focus of the measure in the following sections.

### V.A. Research Evidence

Research evidence should include a description of the evidence base for valid relationship(s) among the structure, process, and/or outcome of health care that is the focus of the measure. For example, evidence exists for the relationship between immunizing a child (process of care) and improved outcomes for the child and the public. If sufficient evidence existed for the use of immunization registries in practice or at the State level and the provision of immunizations to children and adolescents, such evidence would support the focus of a measure on immunization registries (a structural measure). Describe the nature of the evidence, including study design, and provide relevant citations for statements made. Evidence may include rigorous systematic reviews of research literature and high-quality research studies.

Mental health disorders and emotional/behavioral issues often develop early in life. Autism spectrum disorder is commonly diagnosed very early in life and demonstrates the importance of early treatment. In a review of autism treatment literature, Rogers and Vismara noted that improvements in children's "language, communication, and IQ, and reduction in severity of autism symptoms indicate that the core symptoms of autism appear malleable in early childhood" (Rogers and Vismara, 2008). Focusing on disorders found in the Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> Edition (DSM-IV), Kessler, et al. found that the 50<sup>th</sup> percentile for the selected age of onset for a variety of these disorders was only 14 years of age. In other words, half of those diagnosed with a range of conditions including anxiety disorders, mood disorders, impulse-control disorders, and substance use disorders had received their diagnosis by age 14. A further 25% received their diagnosis by age 24 (Kessler et al., 2005).

However, there can be significant variation in obtaining treatment and services for mental health care, as well; this variation may extend to care for other emotional, developmental, and behavioral problems. In 2012, Ellis et al. found that mental health care provision varied nearly three-fold by regional network within the state of Washington. The authors concluded that this variation appeared to be due to factors such as "funding, the networks' geographic size, and availability of providers" in addition to Access to Care standards (Ellis et al., 2012).

This Q-METRIC availability measure focuses on reporting the results of the CAHPS measure regarding parents' ability to make an appointment for treatment or counseling services. The table below summarizes several key sources of evidence for this measure, using the US Preventive Services Task Force (USPSTF) rankings. (Criteria are denoted in the table.)

**Table 1: Evidence Supporting the Importance of Availability of Care for Children Needing Treatment or Counseling Services**

Type of evidence	Key findings	Level of evidence (USPSTF ranking*)	Citation(s)
<b>Clinical Guideline</b>	The EPSDT benefit for Medicaid-enrolled children provides that if the screening exam warrants it, any necessary referral must be made without delay. Further, states are required to provide any additional health care services that are coverable under the Federal Medicaid program and found to be medically necessary...regardless of whether the service is covered in a state's Medicaid plan.	III	Early and Periodic Screening, Diagnosis and Treatment. Medicaid.gov. <a href="http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html">http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html</a> . Updated June 17, 2014. Accessed July 9, 2014.
<b>Descriptive Study</b>	The 50 <sup>th</sup> percentile for age of onset for a variety of DSM-IV conditions is 14 years of age, and the 75 <sup>th</sup> percentile for age of onset is 24 years of age.	III	Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. <i>Arch Gen Psychiatry</i> 2005; 62:593-602.
<b>Descriptive Study</b>	Provision of mental health care services varies greatly for Medicaid-eligible children within the state of Washington.	III	Ellis WR, Huebner C, Vander Stoep A, Williams MA. Washington state exhibits wide regional variation in proportion of Medicaid-eligible children who get needed mental health care. <i>Health Aff</i> 2012; 31(5): 990-999.
<b>Descriptive Study</b>	More than three times as many physicians have reported difficulty in referring children in Medicaid and CHIP to specialty care compared with privately insured children <i>regardless of physician type and geographic location</i> .	III	United States Government Accountability Office (GAO). MEDICAID and CHIP: Most physicians serve covered children but have difficulty referring them for specialty care, GAO.gov. <a href="http://www.gao.gov/assets/330/320559.pdf">http://www.gao.gov/assets/330/320559.pdf</a> . June, 2011. Accessed July 9, 2014.

*Note: USPSTF criteria for assessing evidence at the individual study level are as follows: I) Properly powered and conducted randomized controlled trial (RCT); well-conducted systematic review or meta-analysis of homogeneous RCTs. II) Well-designed cohort or case-control analytic study. III) Opinions of respected authorities, based on clinical experience; descriptive studies or case reports; reports of expert committees.*



**V.B. Clinical or Other Rationale Supporting the Focus of the Measure (optional)**

Provide documentation of the clinical or other rationale for the focus of this measure, including citations as appropriate and available.

Not applicable

**References for Section V**

Rogers SJ, Vismara LA. Evidence-based comprehensive treatments for early autism. *J Clin Child Adolesc Psychol* 2008; 37(1): 8-38.

## SECTION VI.

### SCIENTIFIC SOUNDNESS OF THE MEASURE

Explain the methods used to determine the scientific soundness of the measure itself. Include results of all tests of validity and reliability, including description(s) of the study sample(s) and methods used to arrive at the results. Note how characteristics of other data systems, data sources, or eligible populations may affect reliability and validity.

#### VI.A. Reliability

Reliability of the measure is the extent to which the measure results are reproducible when conditions remain the same. The method for establishing the reliability of a measure will depend on the type of measure, data source, and other factors. Explain your rationale for selecting the methods you have chosen, show how you used the methods chosen, and provide information on the results (e.g., the Kappa statistic). Provide appropriate citations to justify methods.

##### Data and Methods

This measure has two aspects of reliability to consider: reliability of reporting the specific availability measure and reliability of the data collected.

The first aspect, reliability of reporting the specific availability measure, has not been assessed. Reliability of reporting is expected to be high, as common threats to reliability identified by the National Quality Forum (specifically “ambiguous measure specifications” and “small case volume or sample size”) are not expected to be concerns (NQF, 2011).

The second aspect is the reliability of the underlying CAHPS data. This measure is based on parents’ responses to the CAHPS survey. CAHPS surveys have been extensively tested for reliability and have been consistently found to have high reliability ( $>0.70$ ) (Dyer et al., 2012; Scholle et al., 2012). There may be some concern over using a single-item question to assess the concept of availability. However, West found that reliability of single-item measures is relatively unaffected compared with multiple-item measures of the same concept (West et al., 2012). Hays hypothesized that this may be due to the narrowness of the concept being measured, which would be consistent with the current measure’s conceptual focus (Hays et al., 2012). As a consequence, we anticipate a high degree of reliability for this measure.

#### VI.B. Validity

Validity of the measure is the extent to which the measure meaningfully represents the concept being evaluated. The method for establishing the validity of a measure will depend on the type of measure, data source, and other factors. Explain your rationale for selecting the methods you have chosen, show how you used the methods chosen, and provide information on the results (e.g.,  $R^2$  for concurrent validity). Provide appropriate citations to justify methods.

## **Validity of CAHPS Questions**

CAHPS is a well-established tool for obtaining patient reports of their health care experience and is accepted by a variety of stakeholder groups. The measurement question was only asked of parents who responded **Yes** when asked if they got or tried to get treatment or counseling for their child for an emotional, developmental, or behavioral problem in the previous 6 months. CAHPS tests their surveys for reliability and validity, and notes that the survey results “will be reliable and valid if (the survey) specifications are followed” (AHRQ, n.d.). Medicaid programs are likely to contract with approved CAHPS vendors who agree to adhere to CAHPS specifications, and thus their CAHPS results would be expected to maintain their validity.

## **Face Validity**

The validity of this measure was determined from face validity, the degree to which the measure construct characterizes the concept being assessed. The face validity of the relevant CAHPS question was reviewed by a panel convened by Q-METRIC. The Q-METRIC expert panel included nationally recognized experts representing pediatrics, family medicine, psychiatry, dentistry, and two parent representatives. In addition, validity was considered by experts in state Medicaid program operations, health plan quality measurement, health informatics, and health care quality measurement. In total, the Q-METRIC Availability of Specialty Services panel included 13 experts, providing a comprehensive perspective on the availability of specialty services and the measurement of quality metrics for states and health plans.

The Q-METRIC expert panel concluded that this measure has a high degree of face validity through a detailed review of concepts and metrics considered to be essential to the ability of parents to obtain appointments for children referred to treatment and counseling. Concepts and draft measures were rated by this group for their relative importance. The measure was rated as follows: parent-reported-availability of specialty appointments received a score of 6.7 on a scale of 1-9, with 9 representing the highest possible ranking.

The Q-METRIC expert panel had additional discussion about the data that would be reported out for this measure. Prior to deciding to use the CAHPS measure, this discussion included such topics as whether appointments should refer to urgent or non-urgent appointments, and whether the measure should be stratified by age due to the typical practice that mental health practitioners often do not see patients under age 3 or 4.

## **References for Section VI.A**

Agency for Healthcare Research and Quality (AHRQ). Established Child Health Care Quality Measures: CAHPS®: Consumer Assessment of Health Plans <http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/chttoolbox/downloads/CAHPS.doc>. Accessed July 24, 2014

Dyer N, Sorra JS, Smith SA, Cleary P, Hays R. Psychometric properties of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Clinician and Group Adult Visit Survey. *Medical Care* 2012; 50(Suppl): S28-S34.

Hays RD, Reise S, Calderon JL. How much is lost in using single items? *J Gen Internal Med* 2012; 27(11): 1402-1403.

National Quality Forum. Guidance for Measure Testing and Evaluating Scientific Acceptability of Measure Properties.  
<http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=59116>. January, 2011. Accessed July 7, 2014.

Scholle SH, Vuong O, Ding L, et al. Development of and field test results for the CAHPS PCMH Survey. *Medical Care* 2012; 50(11): S2-S10.

West CP, Dyrbye LN, Satele DV, Sloan JA, Shanafelt TD. Concurrent validity of single-item measures of emotional exhaustion and depersonalization in burnout assessment. *J Gen Internal Med* 2012; 27(11): 1445-1452.

## **SECTION VII. IDENTIFICATION OF DISPARITIES**

CHIPRA requires that quality measures be able to identify disparities by race, ethnicity, socioeconomic status, and special health care needs. Thus, we strongly encourage nominators to have tested measures in diverse populations. Such testing provides evidence for assessing measure's performance for disparities identification. In the sections below, describe the results of efforts to demonstrate the capacity of this measure to produce results that can be stratified by the characteristics noted and retain the scientific soundness (reliability and validity) within and across the relevant subgroups.

### **VII.A. Race/Ethnicity**

This measure does not address any disparities related to race or ethnicity. However, states have two options to analyze data based on race/ethnicity:

1. The core component of the CAHPS Health Plan Survey – Child Medicaid Survey includes questions about the child's race and ethnicity. As such, bivariate analyses of the specialist availability data by race/ethnicity can be conducted. The challenges of doing so may include requirements for a minimum number of respondents in each group to obtain reliable estimates; previous estimates indicate that a minimum of 100 people are needed (Martino et al., 2013). Further challenges may include missing data, as well as a lack of a uniform standard for racial and ethnic categories.
2. It is highly likely that Medicaid programs have internal data sources (e.g., demographic information in enrollment files) to support sampling by race/ethnicity for the CAHPS survey; in this approach, the vendor can use the sample files to calculate result by race/ethnicity. However, not all states have sufficient racial diversity to support this approach.

### **VII.B. Special Health Care Needs**

This measure does not address disparities related to special health care needs. However, information related to this issue is potentially available in the CAHPS survey if states choose to analyze them.

The core component of the CAHPS Health Plan Survey – Child Medicaid Survey does not include questions asking about children's special health care needs, though the Item Set for CCC supplement does. Consequently, states currently have the ability to report on disparities in health care specialist availability by special health care needs through this optional supplement to the survey. The proposed measure does not require states to collect and report that data beyond the specific treatment or counseling question; however, given the expectation that children with special health care needs may require a greater level of treatment or counseling services, conducting a targeted CAHPS survey for this population to assess availability of specialty care is encouraged.

### **VII.C. Socioeconomic Status**

This measure does not address any disparities related to socioeconomic status (SES). Furthermore, neither the core component nor the supplement to the CAHPS Health Plan Survey – Child Medicaid Survey include direct questions about the child’s socioeconomic status. By definition, all Medicaid-enrolled children meet their program’s income eligibility requirements, so a certain comparability of SES is inherent to the population. The core component only asks the indirect question of the highest educational level achieved by the parent.

It may be possible for states to compare treatment and counseling availability to different SES groups by comparing the results of this CAHPS measure with comparable questions from the CAHPS Child Commercial Survey administered to different plans. However, the measure questions are not identical across these two surveys; the primary distinction between them is the time frame parents are asked to consider – 6 months for parents of Medicaid beneficiaries compared with 12 months for parents of children enrolled in commercial plans. Even if optional questions are edited to be consistent with the others, this difference should not prevent comparisons between the surveys, as long as the difference in time frame is acknowledged.

### **VII.D. Rurality/Urbanicity**

This measure does not address any disparities related to rural or urban residential status. Furthermore, neither the core component nor the CCC Item Set include questions about the parent’s (or the child’s) place of residence. It is highly likely that Medicaid programs have internal data sources (e.g., demographic information in enrollment files) to support sampling by rural/urban status for the CAHPS survey; in this approach, the vendor can use the sample files to calculate result by rural/urban status. However, not all states have sufficient numbers of enrollees in rural areas to support this approach.

### **VII.E. Limited English Proficiency (LEP) Populations**

This measure does not address any disparities related to LEP populations. However, information related to this issue may potentially be available in the CAHPS survey itself if states so choose to analyze them.

CAHPS offers alternate language surveys of the Child Medicaid Survey in Spanish. Primary Spanish speakers are a majority in the US among populations that speak a primary language other than English in the home, with 37.5 million people greater than 5 years of age falling into this category. The remaining groups combined account for 23 million people over age 5 years, and no other individual language is represented by more than 2.8 million people (Chinese). Therefore, the only LEP population about whom CAHPS may be able to provide data directly would be Spanish speakers, provided states offer the alternate language version (Ryan, 2013).

Identifying other LEP populations would only be accessible through the CAHPS questions asking whether the parent had been helped with the survey and if so, how they were helped (version 5.0:

questions 40-41). The latter question offers a response option that the survey was translated into the parent's language, but offers no further indication of what the parent's primary language is.

**References for Section VII**

Martino SC, Weinick RM, Kanouse DE, et al. Reporting CAHPS and HEDIS data by race/ethnicity for Medicare beneficiaries. *Health Serv Res* 2013; 48(2): 417-434.

Ryan C. Language use in the United States: 2011. Census.gov.

<http://www.census.gov/prod/2013pubs/acs-22.pdf>. August 2013. Accessed July 7, 2014.

## SECTION VIII. FEASIBILITY

Feasibility is the extent to which the data required for the measure are readily available, retrievable without undue burden, and can be implemented for performance measurement.<sup>5</sup> Using the following sections, explain the methods used to determine the feasibility of implementing the measure.

### VIII.A. Data Availability

#### VIII.A.1. What is the availability of data in existing data systems? How readily are the data available?

For states that already collect CAHPS data for their Medicaid program and routinely include the Item Set for CCC or at least include the two required questions, this measure draws upon readily available survey data. It does not require any additional data collection by those states; rather, it only requires states to report the results from one CAHPS measure that they already collect. For states that collect the core set of CAHPS data but do not include the Item Set for CCC supplement, the infrastructure for conducting the survey and analyzing the data would be in place, and the survey administration would need to include the necessary questions every year. For states that collect CAHPS data on a combined Medicaid/CHIP population to meet CHIPRA requirements, but do not sample the Medicaid population separately, the infrastructure for conducting the survey and analyzing the data may already be in place. States that currently do not collect CAHPS data may not have readily available data or infrastructure to collect the data.

Some states have already reported the results of this question publicly in their CAHPS reports, with New York as a notable example. New York reported the results of the question exactly according to this measure's specification, providing the proportion of respondents who answered **Usually or Always** to the treatment or counseling availability question, and further provided the proportions for the state overall and other plan types. (See Appendix 2, pages 20 & 81).

#### VIII.A.2. If data are not available in existing data systems or would be better collected from future data systems, what is the potential for modifying current data systems or creating new data systems to enhance the feasibility of the measure and facilitate implementation?

CAHPS data collection and reporting are already required of states for CHIP programs. For those states that already sample the Medicaid population and include the CCC Item Set, the measure may only require minimal modifications of existing data systems, as necessary, to analyze this question individually and to report it publicly rather than only to CMS. States that do not sample the Medicaid population separately but sample the CHIP population should be able to use the same infrastructure

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<sup>5</sup> The definition is adapted from: Centers for Medicare & Medicaid Services Quality Measurement and Health Assessment Group glossary, as part of the Measures Management System Measure Development Overview. Available at: [http://www.cms.gov/MMS/19\\_MeasuresManagementSystemBlueprint.asp#TopOfPage](http://www.cms.gov/MMS/19_MeasuresManagementSystemBlueprint.asp#TopOfPage). Accessed February 6, 2012.



and emulate the process. States that do not collect the CAHPS supplement for either population would need to include the CCC supplement or necessary questions on treatment and counseling to the surveys. States that do not collect CAHPS data for either population would need to build the infrastructure for data collection, analysis, and reporting, or contract with an approved CAHPS vendor for data collection.

For Medicaid programs that currently do not conduct CAHPS, structural guidance is available through AHRQ, allowing programs to work with an approved CAHPS vendor to conduct their own. States may also consider adding the two CAHPS questions to other survey instruments that they may use and reporting the results from those. There is no prohibition on doing so and could provide an alternate means of collecting and reporting this data that is less burdensome to those states.

## **VIII.B. Lessons from Use of the Measure**

**VIII.B.1.** Describe the extent to which the measure has been used or is in use, including the types of settings in which it has been used, and purposes for which it has been used.

Not applicable

**VIII.B.2.** If the measure has been used or is in use, what methods, if any, have already been used to collect data for this measure?

Not applicable

**VIII.B.3.** What lessons are available from the current or prior use of the measure?

Not applicable

## SECTION IX. LEVELS OF AGGREGATION

CHIPRA states that data used in quality measures must be collected and reported in a standard format that permits comparison (at minimum) at State, health plan, and provider levels. Use the following table to provide information about this measure's use for reporting at the levels of aggregation in the table.

For the purpose of this section, please refer to the definitions for provider, practice site, medical group, and network in Section XVI. Glossary of Terms.

If there is no information about whether the measure could be meaningfully reported at a specific level of aggregation, please write "Not available" in the text field before progressing to the next section. Table IX-1 shows the questions (in columns) about the measure's use at different levels of aggregation for quality reporting (in rows) included in the CHIPRA PQMP Candidate Measure Submission Form (CPCF).

Table IX-1. Questions about the measure’s use at different levels of aggregation for quality reporting

Level of aggregation (Unit) for reporting on the quality of care for children covered by Medicaid/CHIP <sup>†</sup>	<b>Intended use:</b> Is measure intended to support meaningful comparisons at this level? (Yes/No)	<b>Data Sources:</b> Are data sources available to support reporting at this level?	<b>Sample Size:</b> What is the typical sample size available for each unit at this level? What proportion of units at this level of aggregation can achieve an acceptable minimum sample size?	<b>In Use:</b> Have measure results been reported at this level previously?	<b>Reliability &amp; Validity:</b> Is there published evidence about the reliability and validity of the measure when reported at this level of aggregation?	<b>Unintended consequences:</b> What are the potential unintended consequences of reporting at this level of aggregation?
State level*: Can compare States	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Yes.	CAHPS recommends that vendors sample 1650 respondents for every survey conducted).	No.	No.	None identified.
Other geographic level: Can compare other geographic regions (e.g., MSA, HRR)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Yes.	CAHPS recommends that vendors sample 1650 respondents for every survey conducted. Subpopulation sizes will vary by state and population, though to be reliable, they should meet the minimum recommended amount per population. Per Martino et al., the minimum size for reliably comparing racial and ethnic groups is 100 respondents.	No.	No.	None identified.
Medicaid or CHIP Payment model: Can compare payment models (e.g., managed care, primary care case management, FFS, and other models)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Yes.	CAHPS recommends that vendors sample 1650 respondents for every survey conducted. Subpopulation sizes will vary by state and population, though to be reliable, they should meet the minimum recommended amount per population. Per Martino et al., the minimum size for reliably comparing racial and ethnic groups is 100 respondents).	No.	No.	None identified.
Health plan*: Can compare quality of care among health plans.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Yes.	CAHPS recommends that vendors sample 1650 respondents for every survey conducted. Subpopulation sizes will vary by state and population, though to be reliable, they should meet the minimum recommended amount per population. Per Martino et al., the minimum size for reliably comparing racial and ethnic groups is 100 respondents.	No.	No.	None identified.

<b>Level of aggregation (Unit) for reporting on the quality of care for children covered by Medicaid/CHIP<sup>†</sup></b>	<b>Intended use: Is measure intended to support meaningful comparisons at this level? (Yes/No)</b>	<b>Data Sources: Are data sources available to support reporting at this level?</b>	<b>Sample Size: What is the typical sample size available for each unit at this level? What proportion of units at this level of aggregation can achieve an acceptable minimum sample size?</b>	<b>In Use: Have measure results been reported at this level previously?</b>	<b>Reliability &amp; Validity: Is there published evidence about the reliability and validity of the measure when reported at this level of aggregation?</b>	<b>Unintended consequences: What are the potential unintended consequences of reporting at this level of aggregation?</b>
<b>Provider-level*</b> Individual practitioner: Can compare individual health care professionals	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	No	Not applicable	No	No	Not applicable
Hospital: Can compare hospitals that serve SCD patients.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	No.	Not applicable	No	No	Not applicable
Practice, group, or facility:** Can compare: (i) practice sites; (ii) medical or other professional groups; or (iii) integrated or other delivery networks	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	No	Not applicable	No	No	Not applicable

<sup>†</sup> There could be other levels of reporting that could be of interest to Medicaid agencies such as markets and referral regions.

\* Required in CHIPRA legislation.

\*\* There is no implication that measures that are applicable at one level are automatically applicable at all three of the levels listed in this row.

### **References for Section IX**

Martino SC, Weinick RM, Kanouse DE, et al. Reporting CAHPS and HEDIS data by race/ethnicity for Medicare beneficiaries. *Health Serv Res* 2013; 48(2): 417-434.

## SECTION X. UNDERSTANDABILITY

CHIPRA states that the core set should allow purchasers, families, and health care providers to understand the quality of care for children. Please describe the usefulness of this measure toward achieving this goal. Describe efforts to assess the understandability of this measure (e.g., focus group testing with stakeholders).

This measure provides states, Medicaid programs, parents, and other stakeholders with a way to assess the availability of treatment or counseling services for children. Low rates of parents' ability to obtain an appointment when needed are easily understood to be unacceptable. The simplicity of the measure allows providers and purchasers to assess how well the system accommodates parents when they attempt to obtain treatment or counseling services for their child.

The primary information needed for this measure comes from data acquired from the library of CAHPS supplemental items. The two questions required for this measure are part of the Item Set for CCC supplement to the CAHPS survey, which has been assessed for comprehension. However, the understandability of different reporting formats of the measure has not been.

## SECTION XI. HEALTH INFORMATION TECHNOLOGY

Please respond to the following questions in terms of any health information technology (health IT) that has been or could be incorporated into the calculation of the measure.

### XI.A. Health IT Enhancement

Please describe how health IT may enhance the use of this measure.

As CAHPS is administered via a private and confidential mailed survey, health IT will not be directly applicable to the use of this measure; any attempts to use personal medical records after the survey is conducted would violate the promise that CAHPS requires to be made to respondents:

***Your Privacy is Protected.** All information that would let someone identify you or your family will be kept private. {VENDOR NAME} will not share your personal information with anyone without your OK. Your responses to this survey are also completely **confidential**. You may notice a number on the cover of the survey. This number is used **only** to let us know if you returned your survey so we don't have to send you reminders (CAHPS, 2012).*

However, health IT may play a key role prior to survey administration. State databases used for Medicaid enrollment and administration (e.g., claims processing) can be used to generate targeted samples of smaller sized populations that may not reach a sufficiently high number of respondents to accurately analyze without oversampling (e.g., rural residents, children with a chronic condition, oversampling to ensure adequate samples by race/ethnicity, etc.). In that situation, an indicator for group status is included with the sampling file, allowing the CAHPS vendor to report results by group (e.g., rural vs. urban, children with vs. without chronic conditions).

### XI.B. Health IT Testing

Has the measure been tested as part of an electronic health record (EHR) or other health IT system?

No

### XI.C. Health IT Workflow

Please describe how the information needed to calculate the measure may be captured as part of routine clinical or administrative workflow.

Not applicable

#### **XI.D. Health IT Standards**

Are the data elements in this measure supported explicitly by the Office of the National Coordinator for Health IT Standards and Certification criteria (see:

[http://healthit.hhs.gov/portal/server.pt/community/healthit\\_hhs\\_gov\\_standards\\_ifr/1195](http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov_standards_ifr/1195))?

Not applicable

#### **XI.E. Health IT Calculation**

Please assess the likelihood that missing or ambiguous information will lead to calculation errors.

Not applicable

#### **XI.F. Health IT Other Functions**

If the measure is implemented in an EHR or other health IT system, how might implementation of other health IT functions (e.g., computerized decision support systems in an EHR) enhance performance on the measure?

Not applicable

#### **References for Section XI**

CAHPS. CAHPS® Health Plan Surveys – Version: Child Medicaid Survey 5.0.

[https://cahps.ahrq.gov/surveys-guidance/surveys5.0-docs/2155a\\_engchildmed\\_50.pdf](https://cahps.ahrq.gov/surveys-guidance/surveys5.0-docs/2155a_engchildmed_50.pdf). Updated April 30, 2012. Accessed July 24, 2014.

## SECTION XII. LIMITATIONS OF THE MEASURE

Describe any limitations of the measure related to the attributes included in this CPCF (i.e., availability of measure specifications, importance of the measure, evidence for the focus of the measure, scientific soundness of the measure, identification of disparities, feasibility, levels of aggregation, understandability, health information technology).

This measure requires states to report the percentage of parents who responded **Usually** or **Always** to the relevant treatment or counseling availability question from the optional Item Set for CCC supplement to the CAHPS Health Plan Survey – Child Medicaid Survey. The question is asked of parents who answer **Yes** to the CAHPS screener question on treatment or counseling services. It asks whether parents were successful in making an appointment for treatment or counseling related to their child’s emotional, developmental, or behavioral problem. This reflects the ease of timely access to treatment or counseling for children on Medicaid when they are in need of it.

However, this measure does have limitations:

1. Because of the self-report nature of the survey and the lack of any question regarding specifically why the parent sought care for their child’s emotional, developmental, or behavioral problem, the measure does not necessarily reflect who needed care, in terms of the severity of the problem or how urgent the parent perceives the need for treatment or counseling to be.
2. Comparisons between states and over time will not be perfect, as the screener question (and measure question) may vary over time, including changes that alter the population being discussed.

Despite these limitations, CAHPS is an established and long-lasting tool that can provide a better proxy of this measure nationwide than other available tools, and can easily be incorporated into this measure without significant burden on those asked to implement it.



## SECTION XIII. SUMMARY STATEMENT

Provide a summary rationale for why the measure should be selected for use, taking into account a balance among desirable attributes and limitations of the measure. Highlight specific advantages this measure has over alternative measures on the same topic that were considered or over existing measures. If there is any information about this measure that is important for the review process but has not been addressed above, include it here.

This measure uses data on parent perceptions of the availability of treatment or counseling for Medicaid-enrolled children experiencing emotional, developmental, or behavioral problems. The data are collected via an individual question from CAHPS, specifically the Item Set for Children with Chronic Conditions (CCC) supplement to the CAHPS Health Plan Survey – Child Medicaid Survey. The government leaves administration of CAHPS to the Medicaid-only population (Chapter XIX) as being optional, and there is no requirement to include the Item Set for CCC. Moreover, CHIPRA does not currently require states to report the results for each question; currently very few states do so.

Specifically, this measure requires states that sample their Medicaid populations to include the optional supplement question and report the percentage of parents who responded **Usually** or **Always** to the treatment or counseling availability question from version 4.0 of the Item Set for CCC or its equivalent question in future versions. A high percentage of parents responding **Usually** or **Always** reflects their ability to access services in a timely manner for children in need. A parent's difficulty in obtaining care for a child may lead to further distress or negative emotional outcomes.

The value of a parent-reported measure is that it offers a comprehensive view of the need for care and the receipt of services across settings. Unlike specialty care, treatment and counseling can occur in a multitude of settings; medical record reviews are unlikely to capture services provided through schools or community agencies. Parent views may be the most accurate indicator on the availability of treatment and counseling services. Further, while mental health disorders and emotional/behavioral issues often develop early in life, there can be significant variation in obtaining treatment. This measure focuses on reporting the results of parents' ability to make an appointment.

Reliability for the measure has not been assessed, but is expected to be high; CAHPS sample sizes and specifications are known to be sufficient and appropriate. This measure provides states, Medicaid programs, parents, and other stakeholders a way to assess the availability of treatment or counseling services for children. Low rates are easily understood to be unacceptable. The simplicity of the measure allows providers and purchasers to assess how well the system accommodates parents when they attempt to obtain care for their child.

Despite some minor limitations related to self-reporting and a potential lack of comparability between states, CAHPS is an established tool that can provide a good proxy of this measure nationwide. As CAHPS is confidential, health IT may be of use only prior to survey administration. State databases used for Medicaid enrollment and administration may provide targeted samples of smaller sized populations unlikely to reach a sufficiently high number of respondents to accurately analyze without oversampling.

## SECTION XIV. IDENTIFYING INFORMATION FOR THE MEASURE SUBMITTER

Complete information about the person submitting the material, including the following:

- a. Gary L. Freed, MD, MPH
- b. Percy and Mary Murphy Professor of Pediatrics, School of Medicine; Professor of Health Management and Policy, School of Public Health
- c. University of Michigan
- d. 300 North Ingalls, Room 6E08, Ann Arbor, MI 48109
- e. 734-615-0616
- f. [gfreed@med.umich.edu](mailto:gfreed@med.umich.edu)
- g. Signed written statement guaranteeing that all aspects of the measure will be publicly available, as defined in the Public Disclosure Requirements.

### Public Disclosure Requirements

Each submission must include a written statement agreeing that, should U.S. Department of Health and Human Services accept the measure for the 2014 and/or 2015 Improved Core Measure Sets, full measure specifications for the accepted measure will be subject to public disclosure (e.g., on the Agency for Healthcare Research and Quality [AHRQ] and/or Centers for Medicare & Medicaid Services [CMS] websites), except that potential measure users will not be permitted to use the measure for commercial use. In addition, AHRQ expects that measures and full measure specifications will be made reasonably available to all interested parties. "Full measure specifications" is defined as all information that any potential measure implementer will need to use and analyze the measure, including use and analysis within an electronic health record or other health information technology. As used herein, "commercial use" refers to any sale, license or distribution of a measure for commercial gain, or incorporation of a measure into any product or service that is sold, licensed or distributed for commercial gain, even if there is no actual charge for inclusion of the measure. This statement must be signed by an individual authorized to act for any holder of copyright on each submitted measure or instrument. The authority of the signatory to provide such authorization should be described in the letter (Section XIV: Identifying Information for the Measure Submitter).

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