September 27, 2016

The Honorable Orrin Hatch
Finance Committee
United States Senate
Washington, DC 20510

The Honorable Fred Upton
Energy and Commerce Committee
United States House of Representatives
Washington, DC 20515

The Honorable Ron Wyden
Finance Committee
United States Senate
Washington, DC 20510

The Honorable Frank Pallone
Energy and Commerce Committee
United States House of Representatives
Washington, DC 20515

Dear Chairmen Hatch and Upton and Ranking Members Wyden and Pallone:

Our organizations deeply appreciate your long-standing leadership on children's and pregnant women's health issues. Over the past decade, the programs established through your bipartisan efforts have led to unprecedented levels of health care coverage for children. In particular, the Children's Health Insurance Program (CHIP), through its improvements in both the CHIP Reauthorization Act of 2009 (CHIPRA) and its continuation in the Medicare and CHIP Reauthorization Act (MACRA) of 2015, has given millions of children better access to a medical home, a usual source of care and services tailored to their needs. The undersigned organizations respectfully submit these suggestions to build on these programs and strengthen the nation's only significant federal investment in pediatric and maternal health care quality.

CHIPRA's Title IV created the Pediatric Quality Measures Program (PQMP) and a number of important related initiatives to advance the quality of care for children and pregnant women. Since CHIPRA's enactment, many of our joint goals have been achieved: more than half the states report on the majority of the Child Core Set measures, PQMP's Centers of Excellence have produced a number of needed pediatric-specific measures, the Secretary of HHS has promulgated a yearly report on the status of pediatric health care quality in the United States, and a higher match rate has been established for information system upgrades.

Nevertheless, children and pregnant women continue to face challenges in achieving optimal health, so it is imperative that our quality measurement programs keep evolving to address them. For example, one in five US children lives in poverty. This is of deep concern, not only because poverty jeopardizes the ability of families to meet essential needs, but also because poverty creates stress, makes adverse experiences more likely, and can marginalize or exclude children from healthy growth trajectories and readiness to learn before entering kindergarten. The research on social determinants of health, resiliency, adverse childhood experiences, and toxic stress all make clear that healthy child development is dependent upon safety, stability, security, and nurturing in the child's home environment. Currently, the measurement of poverty and social determinants and their impacts is severely lacking. This is important because in order to make progress we need to know where we are now and how well programs are doing to address these critical issues.

In addition, the US health system and its pediatric components are undergoing a challenging period of change. Pediatricians, other providers, and child and family advocates are concerned that without a renewed federal commitment to the pediatric health care quality improvement enterprise, children's care may be overlooked, even though children are the first population mandated for special consideration in the National Quality Strategy's enacting statute.[1]

Children are not little adults. Children need quality initiatives specific to their unique needs and quality measures that can accurately assess their outcomes. The PQMP program plays a leading role in pediatric and perinatal measurement science, which includes developing, testing, refining and implementing quality measures; spreading measure use broadly; and maintaining and re-evaluating measures over a multi-year period. These measures need to draw upon the knowledge base on effective preventive, primary, and developmental child health services and respond to poverty and other social, as well as bio-medical, determinants of health.

The Child Core Set, established under CHIPRA, leads the way as the first and only national set of pediatric-specific measures, but additional work remains to be done. For example, the Child Core Set does not yet address some of the key drivers of child health outcomes and health care spending, such as children with medical complexity or social and environmental determinants. Moreover, only one of the measures assesses inpatient care and no measures specifically address care for children with complex conditions (chronic or acute). It is critical to evaluate the Child Core Set systematically and regularly for any outstanding gaps drawing from evidence-based and expert consensus engaged in meaningful child health improvement initiatives, e.g., the National Quality Forum's Child Medicaid and the CHIP Measure Applications Partnership committee. The investment in pediatric- and perinatal-specific measurement science requires continual support through PQMP similar to the support provided to measurement science efforts for seniors through Medicare (e.g., through CMS' *Measure and Instrument Development and Support $800M* indefinite-delivery/indefinite-quantity contract)[2].

On a related note, Medicare regulations have an enormous influence on our nation's entire healthcare landscape and eventually impact many more patients than the populations who receive care directly through the program. We appreciate the steps that have been taken through the implementation of new payment structures under MACRA to acknowledge that Medicare regulations will eventually impact pediatric and maternal populations. Medicare quality measurement systems, however, are not appropriate and cannot be accurately applied to measuring the quality of the care rendered to children and pregnant women. Measurement systems designed explicitly for senior adults cannot be accurately applied to the types of care delivered to children or pregnant women. It is imperative that efforts undertaken to improve the care delivered to all patient populations are done explicitly with children and pregnant women in mind, and not simply by applying the existing systems designed for adults.

Additional efforts must also be made to improve and align reporting on the Child Core Set. While major strides have been made to encourage state reporting, there is more work to do. The Child Core Set should set a standard for all payers, not just Medicaid and CHIP. Currently, more than

[1] See US Public Health Service Act §399HH(a)(2)(B)(i).
[2]WEB ACCESSED 8/3/2016: http://www.govconwire.com/2013/11/cms-picks-18-contractors-for-800m-care-evaluation-idiq/

half the states report on half the Child Core Set's measures as they apply to their Medicaid and CHIP populations. However, children receiving coverage through TRICARE, qualified health plans, and other private payers—as well as Medicaid and CHIP children in nearly half the states—are not captured by the full Child Core Set. To achieve a more comprehensive understanding of quality for all children and reduce the reporting burden on plans and providers, the Child Core Set should be extended to all payers of child health care. This would replace the patchwork of misaligned and sometimes inappropriate measures. Moreover, to accelerate alignment, providers and payers should be encouraged to participate through financial support.

Finally, Congress should advance efforts not only to measure pediatric and maternal health care quality, but to improve it. A sophisticated quality measurement enterprise can lead to improved health outcomes and smarter spending, but first must leverage standardized data and appropriate metrics for the target populations.

To address these priorities and realities, our organizations recommend the following actions:

1) Extend and expand the authority and funding provided under 42 USC 13206-9i.
2) Strengthen and extend funding for pediatric measurement science as follows:
    a. Establish a publicly-reported, periodic review of pediatric measures available for use at the state, hospital, practice and plan level, including a rigorous, systematic gap analysis of available measures that drives further measure development as appropriate for inclusion in the Child Core Set and for additional public or private applications.
    b. Extend funding in sufficient amount and duration to support a new round of competitive grants for pediatric Centers of Excellence, which are responsible for foundational research, measure development, testing, and implementation, and at least three years of stewardship of each measure to ensure measures remain valid and are included or retired as appropriate in the Child Core Set and other sets.
3) Promote improved alignment among public and private pediatric measure sets to reduce the reporting burden and create national consistency in measuring the quality of pediatric health care as follows:
    a. Expand and evaluate efforts to spread the use of valid pediatric measures developed through the PQMP across different health care delivery and coverage systems, including both public and private payers.
    b. Provide support for improved data collection and sharing between health systems, including CHIP, Medicaid, and other health insurance.
    c. Modify the electronic health records incentive program to include CHIP in case mix calculations that allow for incentive payments under the HITECH Act.
4) Support and encourage state reporting on the Child Core Set as follows:
    a. In consultation with the states and relevant medical provider organizations, ideally within one year of CHIP's extension, require states to report on all Child Core Set measures, and provide enhanced federal funding and technical assistance to states to achieve this goal.
    b. Direct states to work with measure experts, such as developers and stewards as appropriate to maximize utilization of each measure.

    c. Ensure that this renewed focus also includes attention to the impact that social determinants of health have on early childhood learning and the care needs of children and families.
5) Ensure that quality measurement leads to quality improvement for all children:
    a. Establish a state incentive payment program for states that demonstrate marked improvement on Child Core Set measures, to ensure that quality measurement leads to quality improvement.
    b. Provide funding to renew state demonstration projects that promote public-private partnerships to implement innovations in pediatric quality improvement nationwide.
    c. Emphasize that pediatrics be examined, in systems reform funding, with a different lens regarding the need for fast and significant returns on investment (ROIs). Children are not the drivers of overall health costs today, but it is critical to improve their health trajectories to reduce the prevalence of chronic conditions that will drive health costs in the future. Pediatric innovations need to be developed that will assess their long-term health and related benefits in achieving the triple aim. Financing systems need to be designed to support primary, preventive, and developmental services for children that are based upon those long-term impacts.

Your leadership has achieved remarkable results for children and pregnant women and we look forward to working with you to build upon these successes. We appreciate your willingness to consider our recommendations and look forward to working with you to continue these important efforts to improve their health. If you have questions regarding our vision for pediatric quality improvement, please contact Caitlin Van Sant at cvansant@aap.org.

Sincerely,

AIDS Alliance for Women, Infants, Children, Youth & Families
America's Essential Hospitals
American Academy of Ophthalmology
American Academy of Pediatrics
American Association of Child & Adolescent Psychiatry
American Association for Pediatric Ophthalmology and Strabismus
American Congress of Obstetricians and Gynecologists
American Society of Echocardiography
Association of Asian Pacific Community Health Organizations
Association of Community Affiliated Plans
Child and Family Policy Center
Children's Defense Fund
Children's Hospital Alliance of Tennessee
Children's Hospital Association
Children's Partnership
Family Voices
Green and Healthy Homes Initiative
Learning Collaborative on Health Equity and Young Children
March of Dimes

Mental Health America
National Alliance to Advance Adolescent Health
National Association of Pediatric Nurse Practitioners
National Health Care for the Homeless
Nemours Children's Health System
NETWORK Lobby for Catholic Social Justice
ZERO TO THREE