

Reporting of CAHPS Data Regarding Availability of Specialist Care for Children on Medicaid

Section 1. Basic Measure Information

1.A. Measure Name

Reporting of CAHPS Data Regarding Availability of Specialist Care for Children on Medicaid

1.B. Measure Number

0237

1.C. Measure Description

Please provide a non-technical description of the measure that conveys what it measures to a broad audience.

This measure requires States to report Consumer Assessment of Healthcare Providers and Systems (CAHPS) data regarding whether parents of Medicaid-enrolled children receive specialty care appointments for their children when needed. The measure uses data on parent perceptions of specialist availability for Medicaid-enrolled children collected via an individual question from the CAHPS, specifically CAHPS Health Plan Survey – Child Medicaid Survey. CAHPS is a program of the U.S. Agency for Healthcare Research and Quality (AHRQ). The survey is mailed to parents of children younger than 18 years of age enrolled in the Medicaid program, followed by reminders to non-responders by either mail or telephone. As mandated by the Children’s Health Insurance Program Reauthorization Act (CHIPRA) of 2009, the Federal Government requires that States administer CAHPS 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 being optional. CHIPRA does not currently require States to report the results for each question, and very few States do so.

Questions regarding availability of specialty care have been included in multiple versions of CAHPS, though the wording has changed slightly with each version. At this writing, States were encouraged but not required to use CAHPS version 5.0, but many continued to use version 4.0. Specifically, this measure requires States that sample their Medicaid populations to report the percentage of parents who responded “Usually” or “Always” to the specialist availability question from the CAHPS Health Plan Survey – Child Medicaid Survey or its equivalent question in future versions of the same CAHPS survey. The specialist availability question is written as follows in the CAHPS surveys in use in 2014:

- Version 5.0: In the last 6 months, how often did you get appointments for your child to see a specialist as soon as he or she needed?

- Version 4.0: In the last 6 months, how often was it easy to get appointments for your child with specialists?

The question is asked of parents who answer “Yes” to the CAHPS screener question regarding whether parents made specialist appointments for their children. (Note, here and elsewhere in this report, 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 this question reflects parents’ ability to access specialty medical services in a timely manner for children in need of specialty care. A parent’s inability or difficulty in obtaining timely appointments for specialist care for a child may lead to negative health outcomes for the child.

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

1.D. Measure Owner

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

1.E. National Quality Forum (NQF) ID (if applicable)

Not applicable.

1.F. Measure Hierarchy

Please note here 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:

- 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.

- 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.

- 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.

- 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.

1.G. Numerator Statement

A numerator of one (1) demonstrates that a particular State publicly reports the results of the individual question on specialist availability among their Medicaid-only (Chapter XIX) population. If the numerator is zero (0), the State does not publicly report the results.

1.H. Numerator Exclusions

None.

1.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).

1.J. Denominator Exclusions

None.

1.K. Data Sources

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

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 specialist availability question.

If other, please list all other data sources in the field below.

Not applicable.

Section 2: Detailed Measure Specifications

Provide sufficient detail to describe how a measure would be calculated from the recommended data sources, uploading a separate document (+ Upload attachment) or a link to a URL. 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. 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 report specific CAHPS results regarding whether parents of Medicaid-enrolled children get specialty care appointments for their children when needed. This measure uses data on specialist availability for Medicaid-enrolled children collected via CAHPS, specifically CAHPS Health Plan Survey – Child Medicaid Survey. Detailed technical specifications are provided (see the Supporting Documents). In the CAHPS Health Plan Survey – Child Medicaid Survey 5.0, the following question is asked of parents who answered affirmatively that they had made or tried to make a specialist appointment in the previous 6 months:

- In the last 6 months, how often did you get appointments for your child to see a specialist as soon as he or she needed?

While the general Medicaid definition of children includes all individuals under 21 years of age, the CAHPS Health Plan Survey – Child Medicaid Survey is only administered to parents with children under 18 years of age. Individuals 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 among States and over time, and thus may provide an opportunity for a baseline comparison if States choose to use it in this manner. In the event States wish to evaluate the 18-20 year old population, they will have that data available through the Adult Medicaid survey.

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). Specific CAHPS survey data may also be voluntarily provided to AHRQ's National CAHPS Benchmarking Database.

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 specialist availability question.

Some States have already reported the results of this question publicly in their CAHPS reports, including Indiana, New York, and Virginia (HealthNow, 2013; The Myers Group, 2009; WBA

Market Research, 2011). 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 specialist availability question, and they further provided the proportions for the State overall and for other plan types. Indiana and Virginia provided similar responses, but they also provided the respective percentages for both "Usually" and "Always" individually, as well.

It is important to note that the measure will not be satisfied if States include the results of this question as part of a weighted composite measure without also individually providing the percentage of people responding "Usually" or "Always." An example of insufficient reporting for this measure might include a composite measure that provides an averaged response to multiple CAHPS questions, such as the three core CAHPS questions that ask about availability of urgent care, primary care, and specialist care, if the State fails to also provide the individual results on specialist availability.

Section 3. 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).

3.A. Evidence for General Importance of the Measure

Provide evidence for all applicable aspects of general importance:

- **Addresses a known or suspected quality gap and/or disparity in quality (e.g., addresses a socioeconomic disparity, a racial/ethnic disparity, a disparity for Children with Special Health Care Needs (CSHCN), a disparity for limited English proficient (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, Diagnostic, and Treatment (EPSDT) benefit provides the foundation for comprehensive and preventive healthcare services for all Medicaid-enrolled children under age 21 years. 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. Further, States must report the number of children referred for corrective treatment to CMS (CMS, 2014). Specialty care referrals from EPSDT health screenings must be made available and provided promptly in order for parents to make timely appointments for their children. The CAHPS measure assesses whether parents are able to secure these appointments.

Value of Reporting Results on Availability of Specialist Care

This Q-METRIC measure requires States to report CAHPS data regarding whether parents of Medicaid-enrolled children get specialty care appointments for their children when needed. Reporting about parents’ views on the availability of specialty care is presumed to foster improvement through two mechanisms (Werner, Asch, 2005). First, by ensuring a consistent mechanism to generate data on specialist availability, Medicaid programs can track their progress toward improving availability for their beneficiaries. Second, if such information is reported in a forum accessible to the public, patients (parents) have additional information to help them compare health plans (when available), and stakeholders have a mechanism to compare availability across States and to track progress over time (Werner, Asch, 2005).

Public reporting in the healthcare setting is defined as data, publicly available or available to a broad audience free of charge or at a nominal cost, about a healthcare 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, Wagner, Tiwari, 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 healthcare (AHRQ, 2011).

Both consumer-driven and provider-driven changes can improve the quality of care after the initiation of public reporting (Werner, Stuart, Polsky, 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 percent 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, Asch, 2005). These largely derive from a scenario in which physicians or providers screen their patients to avoid those 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 specialist availability for Medicaid-enrolled children:

- Parents may have different expectations regarding their roles in setting up specialist appointments for a child (Clark, Kauffman, Singer, et al., 2014; Stille, Primack, McLaughlin, et al., 2007).
- Physicians report varying degrees of success in their ability to refer Medicaid- and CHIP-enrolled patients vs. privately insured patients (Government Accountability Office [GAO], 2011).
- Timely and sufficient communication between the general pediatrician and the specialist can affect the degree of success in providing optimal care (Stille, McLaughlin, Primack, et al., 2006).
- Many States and regions have variable geographic distribution and shortages of specialists (Mayer, 2006).

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

3.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).**
- **Any other specific relevance to Medicaid/CHIP (please specify).**

According to CMS, approximately 43 million children are currently covered by Medicaid/CHIP programs (CMS, 2019), suggesting that a significant proportion of these children at some point will be in a situation to require specialty care. A primary care provider for a Medicaid/CHIP-enrolled child may refer the child to a specialist when the child has specialized health problems or treatment needs. CAHPS survey data are focused on capturing the parent's success in obtaining the specialist appointment. The Q-METRIC measure is focused on demonstrating whether States and programs make this information publicly available.

3.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, currently there are no quality measures related to reporting of availability of specialty care for children.

Section 4. Measure Categories

CHIPRA legislation 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, 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.

Does the measure address this category?

- a. Care Setting – ambulatory: Yes.
- b. Care Setting – inpatient: No.
- c. Care Setting – other – please specify: No.
- d. Service – preventive health, including services to promote healthy birth: No.
- e. Service – care for acute conditions: Yes.
- f. Service – care for children with special health care needs/chronic conditions: Yes.
- g. Service – other (please specify): No.
- h. Measure Topic – duration of enrollment: No.
- i. Measure Topic – clinical quality: No.
- j. Measure Topic – patient safety: No.
- k. Measure Topic – family experience with care: Yes.
- l. Measure Topic – care in the most integrated setting: No.
- m. Measure Topic other (please specify): No.
- n. Population – pregnant women: No.
- o. Population – neonates (28 days after birth) (specify age range): Yes; birth-28 days.
- p. Population – infants (29 days to 1 year) (specify age range): Yes; ages 29 days-1 year.
- q. Population – pre-school age children (1 year through 5 years) (specify age range): Yes; ages 1-5 years.
- r. Population – school-aged children (6 years through 10 years) (specify age range): Yes; ages 6-10 years.
- s. Population – adolescents (11 years through 20 years) (specify age range): Yes; adolescents ages 11 through 17 years (i.e., younger than 18 years).

- t. **Population – other (specify age range):** No.
- u. **Other category (please specify):** Not applicable.

Section 5. 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.

5.A. Research Evidence

Research evidence should include a brief 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 or adolescent (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.

In April 2011, the GAO reported that the access of Medicaid- and CHIP-enrolled children to needed specialty care is an issue warranting closer monitoring. For children, parents and caregivers often serve as the main source of information about the child’s experience with healthcare. Gathering feedback from families can help improve the care these children receive and perhaps influence the course of their treatment. This Q-METRIC availability measure focuses on reporting the results of the CAHPS measure regarding parents’ ability to make an appointment for specialty care using data that are already collected by many States; measure reporting has not been previously required.

Table 1 (see Supporting Documents) summarizes several key sources of evidence for this measure, using the U.S. Preventive Services Task Force (USPSTF) rankings (criteria are denoted in the table).

5.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.

Section 6. 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.

6.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.

This measure has two aspects of reliability to consider: (1) reliability of reporting the specific availability measure and (2) 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 (NQF)—specifically “ambiguous measure specifications” and “small case volume or sample size”—are not expected to be concerns with this measure (NQF, 2013).

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 repeatedly tested for reliability and consistently found to have high reliability (>0.70) (Dyer, Sorra, Smith, et al., 2012; Scholle, Vuong, Ding, et al., 2012). There may be some concern over using a single-item question to assess the concept of availability. However, West and colleagues found that reliability of single-item measures is relatively unaffected compared with multiple-item measures of the same concept (West, Dyrbye, Satele, et al., 2012). Hays and colleagues 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, Reise, Calderon, 2012).

6.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., R2 for concurrent validity).

Validity of CAHPS Questions

CAHPS is a well-established tool for obtaining patient reports of their healthcare 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 had made a specialist appointment in the previous 6 months. CAHPS tests their surveys for reliability and validity and notes that the surveys “will be reliable and valid if (the survey) specifications are followed” (AHRQ, 2008). 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 also determined from face validity, the degree to which the measure construct characterizes the concept being assessed. The face validity of the CAHPS question on specialist availability 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, Title V (Children’s Special Health Care Services) program operations, health plan quality measurement, health informatics, and healthcare 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 specialty care and treatment. 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 to report specialist availability for new patients or for any patient seeking to make specialist appointments; whether appointments should refer to urgent or non-urgent appointments; and, finally, the role that prior authorizations may have for Medicaid patients and the difficulty this may pose for data collection.

Section 7. 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.

7.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, Weinick, Kanouse, et al., 2013). Further challenges may include missing data, as well as the 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 results by race/ethnicity. However, not all States have sufficient racial diversity to support this approach.

7.B. Special Health Care Needs

This measure does not address any disparities related to special healthcare needs. However, data related to this issue are potentially available in the CAHPS survey itself, if States so 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 healthcare needs, though the Item Set for Children with Chronic Conditions supplement does. States currently have the ability to report on disparities in healthcare specialist availability by special healthcare needs through the supplemental component of the survey. This measure does not require States to collect and report those data; however, given the expectation that children with special healthcare needs would require a greater level of specialist care, conducting a targeted CAHPS survey for this population to assess availability of specialty care is encouraged and has been conducted and reported by several States.

7.C. Socioeconomic Status

This measure does not address any disparities related to socioeconomic status. Furthermore, neither the core component nor the supplemental component of 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 similarity of socioeconomic status (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 specialist 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 timeframe parents are asked to consider – 6 months for Medicaid parents compared with 12 months for commercial parents. This difference should not prevent comparisons between the surveys, as long as the difference in timeframe is acknowledged.

7.D. Rurality/Urbanicity

This measure does not address any disparities related to rural or urban residential status. Furthermore, neither the core component nor the supplemental component of the CAHPS Health Plan Survey – Child Medicaid Survey include questions about the parent’s (or the child’s) place of residence. However, 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.

7.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 it.

CAHPS offers alternate language surveys of the Child Medicaid Survey in Spanish. Primary Spanish speakers are a majority in the United States 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 possible through the CAHPS questions asking whether the parent had been helped with the survey and, if so, how the parent was 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 it offers no further indication of what the parent’s primary language is.

Section 8. 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. Using the following sections, explain the methods used to determine the feasibility of implementing the measure.

8.A. Data Availability

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

As described, this measure draws upon readily available survey data for States that already collect CAHPS data for their Medicaid program. 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 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 the infrastructure to collect the data.

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, 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 and emulate the process. States that do not collect CAHPS data for either population would need to build the infrastructure for data collection, analysis, and reporting, or hire 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 surveys. 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 this could provide an alternate means of collecting and reporting the data that would be less burdensome to those States.

8.B. Lessons from Use of the Measure

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.

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.

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

Not applicable.

Section 9. 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 the 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.

Level of aggregation (Unit) for reporting on the quality of care for children covered by Medicaid/ CHIP†:

State level Can compare States*

Intended use: Is measure intended to support meaningful comparisons at this level? (Yes/No)

Yes.

Data Sources: Are data sources available to support reporting at this level?

Yes.

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?

CAHPS recommends that vendors sample 1,650 respondents for every survey conducted.

In Use: Have measure results been reported at this level previously?

No.

Reliability & Validity: Is there published evidence about the reliability and validity of the measure when reported at this level of aggregation?

No.

Unintended consequences: What are the potential unintended consequences of reporting at this level of aggregation?

None identified.

Other geographic level: Can compare other geographic regions (e.g., MSA, HRR)

Intended use: Is measure intended to support meaningful comparisons at this level? (Yes/No)

Yes.

Data Sources: Are data sources available to support reporting at this level?

Yes.

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?

CAHPS recommends that vendors sample 1,650 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 and colleagues, the minimum size for reliably comparing racial and ethnic groups is 100 respondents (Martino, et al., 2013).

In Use: Have measure results been reported at this level previously?

No.

Reliability & Validity: Is there published evidence about the reliability and validity of the measure when reported at this level of aggregation?

No.

Unintended consequences: What are the potential unintended consequences of reporting at this level of aggregation?

None identified.

Medicaid or CHIP Payment model: Can compare payment models (e.g., managed care, primary care case management, FFS, and other models)

Intended use: Is measure intended to support meaningful comparisons at this level? (Yes/No)

Yes.

Data Sources: Are data sources available to support reporting at this level?

Yes.

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?

CAHPS recommends that vendors sample 1,650 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 and colleagues, the minimum size for reliably comparing racial and ethnic groups is 100 respondents (Martino, et al., 2013).

In Use: Have measure results been reported at this level previously?

No.

Reliability & Validity: Is there published evidence about the reliability and validity of the measure when reported at this level of aggregation?

No.

Unintended consequences: What are the potential unintended consequences of reporting at this level of aggregation?

None identified.

Health plan*: Can compare quality of care among health plans.

Intended use: Is measure intended to support meaningful comparisons at this level?

(Yes/No)

Yes.

Data Sources: Are data sources available to support reporting at this level?

Yes.

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?

CAHPS recommends that vendors sample 1,650 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 and colleagues, the minimum size for reliably comparing racial and ethnic groups is 100 respondents (Martino, et al., 2013).

In Use: Have measure results been reported at this level previously?

No.

Reliability & Validity: Is there published evidence about the reliability and validity of the measure when reported at this level of aggregation?

No.

Unintended consequences: What are the potential unintended consequences of reporting at this level of aggregation?

None identified.

Provider Level

Individual practitioner: Can compare individual health care professionals

Intended use: Is measure intended to support meaningful comparisons at this level?
(Yes/No)

No.

Data Sources: Are data sources available to support reporting at this level?

No.

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?

Not applicable.

In Use: Have measure results been reported at this level previously?

No.

Reliability & Validity: Is there published evidence about the reliability and validity of the measure when reported at this level of aggregation?

No.

Unintended consequences: What are the potential unintended consequences of reporting at this level of aggregation?

Not applicable.

Provider Level

Hospital: Can compare hospitals

Intended use: Is measure intended to support meaningful comparisons at this level?
(Yes/No)

No.

Data Sources: Are data sources available to support reporting at this level?

No.

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?

Not applicable.

In Use: Have measure results been reported at this level previously?

No.

Reliability & Validity: Is there published evidence about the reliability and validity of the measure when reported at this level of aggregation?

No.

Unintended consequences: What are the potential unintended consequences of reporting at this level of aggregation?

Not applicable.

Provider Level

Practice, group, or facility:** Can compare: (i) practice sites; (ii) medical or other professional groups; or (iii) integrated or other delivery networks

Intended use: Is measure intended to support meaningful comparisons at this level? (Yes/No)

No.

Data Sources: Are data sources available to support reporting at this level?

No.

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?

Not applicable.

In Use: Have measure results been reported at this level previously?

No.

Reliability & Validity: Is there published evidence about the reliability and validity of the measure when reported at this level of aggregation?

No.

Unintended consequences: What are the potential unintended consequences of reporting at this level of aggregation?

Not applicable.

Section 10. 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 specialty care appointments 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 more than primary care for their child.

The basic information needed for this measure comes from CAHPS survey data, which has been assessed for comprehension. However, the understandability of different reporting formats of the measure has not been tested.

Section 11. 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 measure calculation.

11.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 (CMS, 2012).*

Health IT may, however, 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). 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).

11.B. Health IT Testing

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

No.

If so, in what health IT system was it tested and what were the results of testing?

Not applicable.

11.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.

11.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 (ONC) criteria (see healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__standards_ifr/1195)?

No; not applicable.

If yes, please describe.

Not applicable.

11.E. Health IT Calculation

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

Not applicable.

11.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 characteristics on the measure?

Not applicable.

Section 12. 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 specialist availability question from the CAHPS Health Plan Survey – Child Medicaid Survey. The question is asked of parents who answer “Yes” to the CAHPS screener question on specialist appointments. It asks whether parents successfully either made or tried to make an appointment with a specialist (depending on the version). This is conducted as a means to assess ease of timely access to specialty care for children on Medicaid when they are in need of it. However, this measure does have its limitations:

1. Because of the self-report nature of the survey, the measure does not necessarily reflect who needed care. “Needed” is not defined in the survey in any way and so could be interpreted by

the parent in a multitude of ways (e.g., referred by a primary care provider, determined by a parent due to perceived need or due to dissatisfaction with the provider, etc.).

2. Comparisons among 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, if only slightly. A specific example is the change in wording of the screener question from version 4.0 (“tried to make an appointment”) to version 5.0 (“made an appointment”). Version 5 fails to account for those parents who tried to make an appointment but were unable to – perhaps the primary population the question hopes to identify.

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 the measure without significant burden on those asked to implement it.

Section 13. 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 that this measure has over alternative measures on the same topic that were considered by the measure developer or specific advantages that this measure has 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 Q-METRIC measure requires States to report CAHPS data regarding whether parents of Medicaid-enrolled children get specialty care appointments for their children when needed. The measure uses data on parent perceptions of specialist availability for Medicaid-enrolled children collected via an individual question from the CAHPS Health Plan Survey – Child Medicaid Survey. The Federal Government currently requires that States administer CAHPS to their CHIP populations (Chapter XXI) and report to CMS that CAHPS was conducted. However, the Government leaves administration of CAHPS to the Medicaid-only population (Chapter XIX) as being optional. CHIPRA does not require States to report the results for each question, and very few States do so.

Specifically, this measure requires states that sample their Medicaid populations to report the percentage of parents who responded “Usually” or “Always” to the specialist availability question from the CAHPS Health Plan Survey – Child Medicaid Survey or its equivalent question in future versions of the same CAHPS survey. A high percentage of parents responding “Usually” or “Always” to this question reflects parents’ ability to access specialty medical services in a timely manner for children in need of specialty care. A parent’s inability or difficulty in obtaining timely appointments for specialist care for a child may lead to negative health outcomes for the child.

This Q-METRIC measure assesses the degree of reporting for this parent-reported rating of the availability of care. Accessible information, particularly if reporting includes data for each health plan or other consumer options, may lead to improved choices for healthcare consumers while

allowing Medicaid programs to assess the adequacy of their specialist-provider methods and/or their efforts around care coordination.

Reporting about parents' views on the availability of specialty care is presumed to foster improvement through two mechanisms (Werner, Asch, 2005). First, by ensuring a consistent mechanism to generate data on specialist availability, Medicaid programs can track their progress toward improving availability 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 stakeholders have a mechanism to compare availability across States and to track progress over time (Werner, Asch, 2005).

In April 2011, the GAO reported that the access of Medicaid- and CHIP-enrolled children to needed specialty care is an issue warranting closer monitoring. For children, parents and caregivers often serve as the main source of information about the child's experience with healthcare. Gathering feedback from families can help improve the care these children receive and perhaps influence the course of their treatment. Research shows a variety of issues related to specialist availability for Medicaid-enrolled children, including different expectations between parents and doctors, difficulties in referring Medicaid and CHIP patients compared with privately insured children, and others.

This measure provides States, Medicaid programs, parents, and other stakeholders with a way to assess the availability of specialty care appointments 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 more than preventive care for their child.

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Section 14: Identifying Information for the Measure Submitter

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The CHIPRA Pediatric Quality Measures Program (PQMP) Candidate Measure Submission Form (CPCF) was approved by the Office of Management and Budget (OMB) in accordance with the Paperwork Reduction Act.

The OMB Control Number is 0935-0205 and the Expiration Date is December 31, 2015.

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.

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