POLICY PAPER NO.3 • DECEMBER 2007

STRENGTHENING MEDICAID

# Moving Forward with Quality: State and Federal Approaches to Measure, Manage, and Improve Quality in the Medicaid Program

by Lisa Simpson, Gerry Fairbrother, & Joe Schuchter

## Overview

Medicaid provides health coverage to millions of low-income families, including more than 30 million children. Medicaid, together with the State Children's Health Insurance Program (SCHIP), provides many important benefits, including improved access to care, reduced racial and ethnic disparities, diminished family financial burdens, and improved quality of life.

The need for measuring and improving quality of care throughout the health care system is clear. Recent research shows that fewer than half of all children—and just over half of all adults—receive care in accordance with professional guidelines.[1] As a mainstay of health coverage in the United States and one of the nation's major health purchasers, Medicaid has an important role to play in moving health care quality efforts forward. Medicaid can improve quality for all of the populations it serves, but especially for children, since Medicaid covers one in every four children in the United States, including many children who have significant health care needs. This paper identifies four strategies that can be implemented either at the federal or state level to advance the quality of care in Medicaid. Some of the approaches described in this paper can apply to the entire population Medicaid insures, and some are specific to children.

According to the Institute of Medicine, for health care to be of high quality, it needs to be safe, effective, timely, patient-centered, equitable, and efficient (Table 1). Some state Medicaid programs already have longstanding quality initiatives in place, and all states are required by federal law to address performance measurement and quality in a variety of ways.[2] At the same time, many states are looking for ways to intensify quality measurement and improvement efforts. The federal government has recently encouraged states to increase their focus on managing quality as part of CMS' Value-Driven Health Care initiative.[3]

Table 1: Key Components of Quality Improvement and Sample Goals

| Component of Quality Care | Example of Quality Improvement Goal |
|---|---|
| Safe | Eliminating surgical site infections |
| Effective | Ensuring that individuals with asthma receive evidence-based care |
| Timely | Making sure that individuals with disabilities have adequate access to specialty care |
| Patient-centered | Increasing patients' positive experiences with care |
| Equitable | Ensuring that limited-English proficiency patients receive the same care as others |
| Efficient | Eliminating use of antibiotics to treat inappropriate conditions, such as the common cold |

Georgetown University Health Policy Institute
Center for Children and Families

As discussed below, for states to truly manage the care provided by Medicaid, it is essential that states maintain stable coverage for beneficiaries. It also is essential that they provide a Medicaid benefits package that meets beneficiaries' needs, especially for children and individuals with disabilities. Managing quality also means that Medicaid beneficiaries have access to care and that provider participation is adequate to ensure access. Finally, quality improvement efforts must reflect the complex health needs of the Medicaid population, where nearly four of every ten beneficiaries have one or more chronic conditions.

## Improving Enrollment and Retention

Many may not initially think of enrollment and retention of Medicaid eligible individuals as a dimension of quality, but studies have demonstrated that stable coverage plays a key role in promoting quality care. Lack of coverage, even for short spells, adversely impacts access to and use of services and leads to delays in care and unmet needs.[4] Instability in coverage also makes it more difficult for program administrators and health plans to monitor and manage care.[5] HEDIS (Health Plan Employer Data and Information Set) quality measures, for example, can only be properly applied to individuals who have been enrolled in care for a continuous period of time.[6]

Enrollment and retention of eligible individuals are therefore key components to an effective quality agenda. While considerable progress boosting participation rates among eligible individuals—particularly children—has been achieved in recent years, more can be done.[7] Nationally, approximately half (49 percent) of all uninsured children are eligible for Medicaid but not enrolled and another one-fifth (19 percent) of uninsured children are eligible for SCHIP but not enrolled.[8] Furthermore, more than one in four parents who are eligible for Medicaid or SCHIP are uninsured.[9] While a comprehensive review of specific strategies to promote enrollment and retention of eligible people is beyond the scope of this brief,[10] it is important to note that these issues can be tackled successfully.

For example, states have many tools to address the well-documented problem that a large share of children lose coverage when their Medicaid coverage comes up for renewal (even though they remain eligible), often to return to the program a few months later.[11] States can minimize these losses and disruptions in care for children and others by extending the length of renewal periods, adopting continuous eligibility periods for individuals under age 19, simplifying procedures (including verification requirements), and relying more on information already available to the agency when eligibility is being reviewed. At least one state—Louisiana—has succeeded in reducing children's coverage losses at renewal not related to ineligibility to below two percent.[12]

## Recommendations

*Recommendations to improve quality by improving **Medicaid enrollment and retention** include:*

ST★TE Include strategies to improve participation rates among eligible individuals in state quality improvement plans.

ST★TE Collect and regularly monitor data on enrollment and coverage stability across population groups (and, if relevant, across counties or other localities) to help identify best practices and pin point where improvement is needed.[13]

ST★TE Devote particular attention to addressing renewals of Medicaid, which represent a major "risk point" for loss of coverage among eligible individuals.

# Quality Measurement

## Measuring and Reporting on Performance Is the First Step

Measuring performance is the essential first step toward improving the quality of care for all populations, for we must measure the quality of the care that is being provided in order to manage it.[14] States already make a substantial investment in quality reporting and face many federal data and quality reporting goals and requirements.[15] Many states also participate in voluntary quality measurement processes. Forty of 47 states report that they collect data for one or more HEDIS measures.[16] The HEDIS (Health Plan Employer Data and Information) measurement system is a set of 25 indicators that span services for children, females, adults, people with chronic conditions, people with mental health conditions, and emergency care use which focus on effectiveness, access, satisfaction, and use of care primarily for managed care plans. In addition, 16 states submitted CAHPS (Consumer Assessment of Healthcare Providers and Systems) data for Medicaid in 2006 to the National CAHPS Benchmarking database, covering over 40,000 adults and 50,000 children.[17] These survey data measure patient satisfaction and consumers' views of the care experience.

However, current measures generally focus primarily on access to preventive and primary care. Although there is some emphasis on chronic illness, quality measures typically provide little information about the quality of care for acutely or chronically ill individuals. For example, only 17 of 47 states report that they currently collect quality data on hospital inpatient care. In some respects, this is surprising given that nationally 14 percent of all hospital discharges are charged to Medicaid. On the other hand, it is less surprising when one considers that national inpatient quality measures for the services for which Medicaid plays the biggest role, pediatric and maternity care, have not yet been developed.[18] States have made some progress in using HEDIS measures related to chronic care, focusing on asthma care for children and diabetic care for adults. While HEDIS is an important part of measuring quality, and some states have adapted HEDIS for use in primary care case management and fee-for-service environments, far less is known about the quality of care in these environments.

Finally, although states already make substantial investments in quality reporting, the data that is reported frequently suffers from a lack of consistency. This inconsistency occurs across programs (for example, across Medicaid and SCHIP), across state agencies, and between public programs and private insurance, making comparisons and consistent approaches to quality improvement difficult. At the national level, quality data varies significantly among states, making national efforts at understanding or measuring quality extremely challenging. A CMS effort launched in 2002 to promote voluntary reporting on seven measures for SCHIP resulted in no state yet reporting all seven.

At the national level, quality measurement efforts could be advanced by developing a core measure set nationally through a public–private process that convenes all key stakeholders, including substantial leadership on the part of states. This has become the model in consensus development for measures of care in Medicare, where over the last

**Performance Measurement Partnership Project:**
**HEDIS Measures Adopted By CMS for SCHIP Reporting**

1. Well-child visits in the first 15 months of life;
2. Well-child visits in the 3rd, 4th, 5th, and 6th years of life;
3. Use of appropriate medications for people with asthma;
4. Children's access to primary care practitioner;
5. Diabetes care (Hemoglobin A1c screening, ages 18-75);
6. Access to preventive care for adults; and
7. Timeliness of prenatal care.

five years providers, consumers, purchasers and experts have participated in formal consensus activities to help Medicare select measures. Since care for the many populations covered by Medicaid is complex, one measure set will not be able to cover all sectors and domains of care at once. Instead, there could be a core measure set for each population group (e.g., children, adults, disabled adults), with some measures cycled across several years. A number of the key bills to reauthorize SCHIP in 2007 included a requirement for HHS to develop and publish a core measure set for voluntary reporting on pediatric healthcare quality for children covered through both Medicaid and SCHIP.[19]

States could also increase the degree to which they report the quality data they gather to the public. As of spring 2006, only 26 of 47 states said that they publicly reported performance results for health plans or providers.[20] Some states are also now making some quality information available to beneficiaries. States could undertake some changes in reporting approaches and infrastructure on their own, or through voluntary collaborative efforts, but their abilities would be enhanced by federal support, such as technical assistance and/or enhanced federal matching funds. At the federal level, performance comparisons across states and benchmarking of state performance against national averages would enable the identification of exemplary programs and best practices.

## Recommendations

*Recommendations to **enhance measurement and use of measures of quality** in Medicaid programs include:*

FEDERAL — Develop a national set of core measures for children, adults, and disabled adults covered by Medicaid through a public/private consensus development process to enable consistent reporting across states. This process would ideally be led by CMS and undertaken in close collaboration with the states.

STATE — Engage individual states—or several states working collaboratively—to develop core measures on quality and to increase public reporting of quality measures.

FEDERAL — Take steps to report and compare performance across states, and to benchmark state performance against national averages in order to facilitate the identification of best practices and cross-state learning.

FEDERAL — Establish and fund learning networks, implementation resources, and a clearinghouse for states to identify tools and models for measuring health care quality.

STATE/FEDERAL — Any measurement set should include indicators relating to enrollment, retention, benefits, access (including provider availability), use, and outcomes.

## Quality Improvement

### Initiatives to Manage and Improve the Quality of Care

Moving beyond measuring the quality of care, Medicaid can contribute to a high performing health system by using the measures it collects to drive improvements in the quality of care that is delivered to the people Medicaid covers. The need for this is reinforced by findings that Medicaid managed care enrollees receive lower-quality care than that received by commercial (private) managed care enrollees.[21] Our ability to improve the quality of care has grown tre-

mendously in the last five years.[22] Research and demonstrations have identified how to work with medical practices to improve care, the role that health information technology can play in improving quality (e.g., by prompting providers on needed services such as immunizations), how to engage consumers in self management for chronic illnesses, and more.

State agencies have explored multiple strategies to make improvements. Medicaid and SCHIP programs in 35 states recently reported that they have over 100 quality improvement initiatives underway (Table 2). For example, initiatives in California, North Carolina, and, most recently, a CMS-led initiative in Ohio, focus on improving neonatal care. The Ohio initiative is engaging obstetrical and neonatal providers in various improvement methods, including benchmarking and a collaborative approach to address the causes of prematurity and to reduce morbidity among high-risk newborns. Quality improvement initiatives also are under discussion among federal policymakers. During the 2007 debate over the future of SCHIP, a number of leading bills included demonstrations to improve care for children on such topics as chronic illnesses, medical home, and obesity.[23]

Most states have not yet achieved a durable infrastructure for quality improvement, relying instead on time-limited or project-specific support for improvement activities. States could increase the visibility and importance of quality improvement efforts by creating state-based quality improvement advisory councils that engage a broad range of stakeholders. These councils could be charged with:

- fostering collaboration across diverse state programs serving Medicaid covered children, youth, individuals with disabilities, and adults;
- identifying state-specific quality measures;
- coordinating quality measurement activities across Medicaid, SCHIP, and other programs in the public and private sectors (e.g., Title V);
- identifying priorities for quality improvement; and
- monitoring the impact of quality improvement efforts and identifying best practices.

States could create these councils on their own but federal support, like making the costs associated with these councils eligible for enhanced federal matching funds, would encourage such efforts.

Some states have already moved beyond focusing solely on quality improvement in state-administered programs to creating initiatives that work in partnership with the private sector to improve children's health care more broadly.[24] These state-based "improvement partnerships" bring together state Medicaid programs, state universities, state professional associations, and providers to work together on targeted improvement projects. These organizations employ provider educational strategies, performance feedback, and improvement collaboratives where groups of providers work together to improve the care they deliver and learn from each other, as well as offering direct technical assistance to providers. Using this approach, Vermont, for example, has successfully improved preventive services for children, care for youth in foster care, and perinatal services.[25] For example, all practices participating in the preventive services initiative demonstrated improvement in one or more areas, such as conducting an environmental tobacco smoke–exposure risk assessment, lead screening, and counseling on sleep position to prevent SIDS.

Table 2: Examples of Recent Outpatient Care Quality Improvement Initiatives in Medicaid and SCHIP

| Quality Improvement Focus | States[1] | Number of Programs |
|---|---|---|
| High-risk maternity care, prenatal, perinatal care, improving birth outcomes | ID, IL, KA-S, MA, NJ, OK, PA, TN, TX, UT, VA | 11 |
| Well child visits, immunizations, general children's preventive health, pediatric developmental screening tools | AZ, CA-S, CA, IL, IN, LA, MI, MN, OK, PA-S, WA | 11 |
| Appropriate medications/care management for people with asthma (efforts mainly target children, some both children and adults) | AL-S, AR, KA-S, MA, NV, NJ, NY-S, SC, TN, UT | 10 |
| Care management for adults (and in some cases children) with diabetes | AZ, CA, MA, NV, OK, SC, TN, UT, VT | 9 |
| Other disease/care management, care coordination (unspecified) | GA, NH, ND, PA, TN, TX, VT | 7 |
| Blood lead screening | IN, ME, MI, MN, MO, NJ, PA-S | 7 |
| Weight management/obesity reduction initiatives (most target children/adolescents only) | AR, AZ, NM, PA, PA-S, TN | 6 |
| Initiatives targeting children with special health care needs | DC, KA-S, PA, PA-S, VA | 5 |
| Oral health/dental care, access for children | AL, AZ, NJ, OR, PA-S | 5 |
| Mental/behavioral health or substance abuse treatment, including ADHD | AL-S, ID, PA-S, SC, TN | 5 |
| EPSDT screening rates | AR, IL, TN, UT, WI | 5 |
| Adolescent health | CA-S, CA, NJ, OK | 4 |
| Emergency room utilization | MA, SC, TN | 3 |

[1] State abbreviations with a "-S" refer to separate SCHIP programs.
Source: Duchon L, Smith V. Quality Performance Measurement in Medicaid and SCHIP: Results of a 2006 National Survey of State Officials. Alexandria, VA: National Association of Children's Hospitals and Related Institutions; 2006. Reprinted with permission from the National Association of Children's Hospitals.

## Recommendations

*Recommendations to **improve** the quality of care in Medicaid include:*

STATE

Develop state-level quality improvement advisory councils to create a durable infrastructure for quality improvement in state programs, coordinate quality improvement efforts across programs, develop measures, initiate and monitor the impact of quality improvement efforts, and identify best practices.

STATE

Establish quality improvement partnerships with an array of health care providers, purchasers, and academic experts to conduct education efforts, provide performance feedback to providers, offer technical assistance, and offer opportunities for collaborative learning and quality improvement.

FEDERAL

Expand efforts currently under way through CMS and AHRQ to support Medicaid medical directors by adding other senior Medicaid staff, leading to the formation of a "corps" committed to quality improvement.

## Providing Incentives for Quality Care

Pay-for-performance (P4P) programs are also being employed as a strategy to improve health care quality.[26] Evidence on the effectiveness and impact of P4P programs is only now beginning to emerge, and is conflicting.[27] In some studies P4P programs led to improved rates of immunizations[28] and asthma care while in others no change was noted. In addition, one study showed that most of the added P4P payments went to already high performing plans, rather than those who improved. Even as evidence on the impact of these programs is emerging, P4P is now being used in Medicaid programs to provide incentives to health plans and other providers. One recent survey found that, in five years, nearly 85 percent of state Medicaid programs plan to have such P4P programs.[29] Some states are using non-monetary P4P incentives like public reporting, recognition programs, and auto-assignment of SCHIP or Medicaid enrollees to a high-performing managed care plan to build its market share. At the same time that innovation is needed in this area, it will be critical for states to evaluate the impact of these new P4P programs. Evaluations can help identify which P4P program characteristics (such as measures, type of incentive, level of incentive, etc.) are most effective, the circumstances under which these characteristics work, and the impact on beneficiaries. The studies should also examine potential unintended consequences (e.g., providers dropping enrollees who might contribute to poor quality scores) that need more attention. The key SCHIP reauthorization bills taken up by the Congress in 2007 included state demonstrations on incentive programs to improve quality.

## Recommendations

*Recommendations on the use of performance-based incentives in Medicaid and SCHIP:*

STATE

Work individually and in concert to test specific incentives that could be applied to different populations and regions to better understand the characteristics of effective incentive strategies and the impact they have on beneficiaries, providers, and quality of care.

STATE/FEDERAL

Conduct rigorous evaluations at the state and federal level to determine the impact on quality, outcomes, and costs, and to identify any unintended consequences of performance-based incentives.

## Conclusion

States are already engaged in quality measurement and improvement activities, and are ready to advance further as part of broader efforts to provide quality and value in the health care system. In addition to the approaches identified in this paper, effective use of health information technology, such as electronic health records or health information exchanges, can be an integral part of quality improvement efforts. Medicaid programs across the country have already committed resources to quality, and the tools and knowledge exist today to substantially improve care for Medicaid enrollees. Current efforts need to be retooled and expanded to realize Medicaid's potential to improve quality of care for Medicaid beneficiaries.

## FOR MORE INFORMATION

• Center for Health Care Strategies, www.chcs.org. The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving the quality and cost effectiveness of health care services for low-income populations and people with chronic illnesses and disabilities. We work directly with states and federal agencies, health plans, and providers to develop innovative programs that better serve people with complex and high-cost health care needs.

• Child and Adolescent Health Measurement Initiative www.cahmi.org, ensures that children, youth and families are at the center of quality measurement and improvement efforts in order to advance a high quality consumer-centered health care system. The CAHMI achieves this mission through the development, testing and strategic implementation nationally, state-wide and locally of valid health care quality and outcomes measures and the effective communication and dissemination of this research to inform and advance improvements in policy and practice.

• National Initiative for Children's Healthcare Quality www.nichq.org is an action-oriented organization dedicated solely to improving the quality of health care provided to children. Founded in 1999, NICHQ's mission is to eliminate the gap between what is and what can be in health care for all children. NICHQ has worked with many states to improve quality of care for children in such areas of medical home, epilepsy, newborn screening, asthma and perinatal services.

• National Academy for State Health Policy www.nashp.org is an independent academy of state health policymakers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice. NASHP has several relevant activities in the areas of quality, Medicaid and child health.

• The Commonwealth Fund www.cmwf.org is a private foundation that aims to promote a high performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults. It produces several resources useful to understanding and improving quality of care.

## ENDNOTES

1. R. Mangione-Smith, *et al.*, "The Quality of Ambulatory Care Delivered to Children in the United States," *New England Journal of Medicine*, 357: 1515-1523 (October 11, 2007); and E. McGlynn, *et al.*, "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine,* 348: 2635-2645 (June 26, 2003).

2. Some of these requirements are broad reporting requirements (such as state reporting to the federal government on services provided under EPSDT, although data quality issues have limited use of this information) and others are specific to some parts of the Medicaid program (for example, the Balanced Budget Act of 1997 imposed quality measurement and improvement requirements on states contracting with managed care organizations. States are required to have a) a quality strategy and routine assessment and audit of their state systems b) performance measures of plans and contracted providers c) performance improvement projects in plans and contracts and providers and d) a contract with external quality review organizations.).

3. Letter from Dennis Smith, Director of Medicaid and State Operations at the Centers for Medicare & Medicaid Services, to State Medicaid Directors (SMD #07-005), (April 25, 2007).

4. L. Olson, S. Tang, & P. Newacheck, "Children in the United States With Discontinuous Health Insurance Coverage," *New England Journal of Medicine*, 353: 382-91 (2005); and Kaiser Family Foundation, "The Uninsured: A Primer," (October 2007).

5. G. Fairbrother, *et al.*, "Churning in Medicaid Managed Care and Its Effect on Accountability," *Journal of Health Care for the Poor and Underserved,* 15:30-41, (February 2004); and G. Fairbrother, *et al.,* "Periods of Unmanaged Care in Medicaid Managed Care," *Journal of Health Care for the Poor and Underserved,* 16:444-452, (August 2005).

6. L. Summer & C. Mann, "Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies," The Commonwealth Fund (June 2006).

7. Participation in Medicaid among children in "poverty-related" categories increased from 60 percent in 1997 to 75 percent in 2002, according to an analysis of the National Survey of America's Families by Dr. Lisa Dubay.

8. Based on analysis of March 2005 Current Population Survey using July 2004 state eligibility rules by Dr. Lisa Dubay.

9. L. Dubay, J. Holahan, & A. Cook, "The Uninsured and the Affordability of Health Insurance Coverage," *Health Affairs*, web: w22-w30, (November 30, 2006).

10. Several publications have reviewed strategies for improving participation rates; see Southern Institute on Children and Families, "Promising Practices from the Nation's Single Largest Effort to Insure Eligible Children and Adults Through Public Health Coverage," Covering Kids & Families (April 2007); D. Horner & B. Morrow, "Opening Doorways to Health Care for Children," Kaiser Commission on Medicaid and the Uninsured (April 2006); and D. Cohen Ross, L. Cox, & C. Marks, "Resuming the Path to Health Coverage for Children and Parents," Kaiser Commission on Medicaid and the Uninsured (January 2007).

11. A. Dick, *et al.,* "Consequences of States' Policies for SCHIP Disenrollment," *Health Care Financing Review*, 23: 65-88, (Spring 2002); and G. Fairbrother, H. Emerson, & L. Partridge, "How Stable is Medicaid Coverage for Children?," *Health Affairs*, 26: 520-528 (2007).

12. Personal communication with J. Ruth Kennedy, Medicaid Deputy Director/LaChip Director, Louisiana Department of Health and Hospitals (November 28, 2007).

13. *Op. cit.* (6).

14. D. Dougherty & L. Simpson, "Measuring the Quality of Children's Health Care: A Prerequisite to Action," *Pediatrics.* 113: 185-198 (January 2004).

15. L. Partridge, "Review of Access and Quality of Care Using Standardized Nation Performance Measures," (Presentation to the National Health Policy Forum, Washington, D.C., April 4, 2007).

16. L. Duchon, & V. Smith, "Quality Performance Measurement in Medicaid and SCHIP: Results of a 2006 National Survey of State Officials," National Association of Children's Hospitals and Related Institution (2006).

17. Agency for Healthcare Research and Quality. "2006 CAHPS Health Plan Survey Chartbook," (2006).

18. *Op. cit.* (16); and Agency for Healthcare Research and Quality, HCUPNet analysis, available at http://hcupnet.ahrq.gov/ (accessed November 27, 2007).

19. See the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2007; H.R. 976, which was vetoed by President Bush on October 3, 2007, and H.R. 3963, which was presented to the President on November 30, 2007 and is not expected to be signed into law.

20. *Op. cit.* (16); and National Association of Health Data Organizations, "State Trends and Issues in Quality Reporting Initiatives," (Autumn 2005).

21. B. Landon, *et al.*, "Quality of Care in Medicaid Managed Care and Commercial Health Plans," *Journal of the American Medical Association*, 298: 1674-1681 (October 10, 2007); and J. Thompson, *et al.*, "Quality of Care for Children in Commercial and Medicaid Managed Care," *Journal of the American Medical Association*, 290: 1486-1493 (2003).

22. S. Leatherman, & D. McCarthy, "Quality of Care for Children and Adolescents: A Chartbook," The Commonwealth Fund (2004).

23. *Op. cit.* (19).

24. J. Shaw, *et al.*, "Statewide Quality Improvement Outreach Improves Preventive Services for Young Children," *Pediatrics*, 118:e1039-e14047 (October 2006).

25. *Op. cit.* (5), Fairbrother *et al.* (2005).

26. Letter from Dennis Smith, Director of Medicaid and State Operations at the Centers for Medicare & Medicaid Services, to State Health Officials (SHO #06-003), (April 6, 2006).

27. G. Freed, & R. Uren, "Pay-for-performance: An Overview for Pediatrics," *Journal of Pediatrics*, 149: 120-124 (July 2006).

28. G. Fairbrother, *et al.*, "Impact of Financial Incentives on Documented Immunization Rates in the Inner City: Results of a Randomized Controlled Trial," *Ambulatory Pediatrics*, 1: 206-212 (July-August 2001).

29. K. Kuhmerker, & T. Hartman, "Pay-for-Performance in State Medicaid Programs: A Survey of State Medicaid Directors and Programs," The Commonwealth Fund (2007).

## About the Authors

Lisa Simpson, M.B., B.Ch., M.P.H., F.A.A.P. is Professor and Director of the Child Policy Research Center at Cincinnati Children's Hospital Medical Center and the University of Cincinnati, Department of Pediatrics. The Center provides evidence based information to inform policy and program decisions at the local, state and national levels with an emphasis on strategies to improve the quality of health care, the effectiveness of public programs, and child well being. Dr. Simpson, a board-certified pediatrician, is the National Director for Child Health Policy at the National Initiative for Children's Healthcare Quality, an education and research organization dedicated solely to improving the quality of health care provided to children, and serves as an elected member on the board of directors of two national professional associations, AcademyHealth and the Ambulatory Pediatric Association. She has led studies of the quality and safety of care for children and adolescents and has focused especially on the role of policies in advancing quality. She was formerly the Deputy Director of the Agency for Healthcare Research and Quality, and the Maternal and Child Health Director in Hawaii. Dr. Simpson earned her undergraduate and medical degrees at Trinity College (Dublin) and a Masters in Public Health at the University of Hawaii.

Gerry Fairbrother, Ph.D., is a professor of pediatrics at the University of Cincinnati and holds a joint appointment in health policy and clinical effectiveness and epidemiology and biostatistics at Cincinnati Children's Hospital Medical Center. Dr. Fairbrother has led investigations into child health insurance enrollment patterns, barriers, and costs, the impact of Medicaid managed care on children's preventive health screening, and the effect of financial incentives on physician behavior. She has served as a consultant to the Institute of Medicine on projects dealing with immunization financing and the consequences of uninsurance and has worked with the Centers for Disease Control and Prevention to help states monitor immunization rates for children in Medicaid. Dr. Fairbrother holds a Ph.D. from Johns Hopkins University and is a Fellow of the New York Academy of Medicine and a Fellow of the Ambulatory Pediatric Association. She received he 2006 "Best Ohio Health Policy Award for Independent Scholar or Practitioner" from the Health Policy Institute of Ohio.

Joe Schuchter, MPH is an Epidemiologist with the Child Policy Research Center at Cincinnati Children's Hospital. His current work is focused on issues of health care access, specifically, health insurance coverage for children. He has also worked in public health, academic and non-government organizations performing research, surveillance, investigation, and monitoring and evaluation.

## About this Project

The Center for Children and Families (CCF) at the Georgetown University Health Policy Institute, working with health policy consultant Vikki Wachino, is initiating a project, **"Strengthening Medicaid"** designed to develop fresh ideas to strengthen the Medicaid program and to engage policymakers and stakeholders at the state and federal levels in discussion about how these ideas might be translated into policies. These approaches will focus on (1) promoting access to high-quality, cost effective care that meets beneficiaries' needs; (2) improving coverage options; and (3) assuring sustainable financing while ensuring that available resources are used in the most efficient way. These approaches, which will be presented through a series of short policy papers, will represent some of the best ideas from a number of experts in different areas, including some who will bring their expertise from outside of Medicaid to the Medicaid context. The policy papers are edited by Joan Alker, Deputy Executive Director of CCF and consultant Vikki Wachino.

To visit our project website, please go to http://ccf.georgetown.edu/strengtheningmedicaid/

Georgetown University Health Policy Institute
Center for Children and Families

GEORGETOWN UNIVERSITY HEALTH POLICY INSTITUTE
CENTER FOR CHILDREN AND FAMILIES

BOX 571444 ■ 3300 WHITEHAVEN STREET, N.W., SUITE 5000
WASHINGTON, DC 20057-1485
(202) 687-0880 ■ FAX (202) 687-3110
CCF.GEORGETOWN.EDU