CHIPRA Core Set of Children's Health Care Quality Measures for Medicaid and CHIP: Illinois' Performance

Calendar Years 2010 through 2014

ILLINOIS DEPARTMENT OF Healthcare and Family Services

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Executive Summary

Public Law 111-3, the Children's Health Insurance Program Reauthorization Act (CHIPRA), was signed into law on February 4, 2009. CHIPRA reauthorizes Title XXI of the Social Security Act, the Children's Health Insurance Program (CHIP), previously known as the State Children's Health Insurance Program (SCHIP). CHIP provides affordable health care coverage to children with family incomes that exceed Medicaid standards. In Illinois, the CHIP population includes children up to 185% of the federal poverty level (FPL). Effective January 1, 2014, under the Affordable Care Act (ACA) Illinois extended coverage to adults who previously did not qualify for medical benefits. This includes adults 19 through 64 with income ≤138% FPL. The measures in this report are among children and do not include adults (21 years and older).

CHIPRA Quality Demonstration Grant

The CHIPRA legislation included direction to the Centers for Medicare and Medicaid Services (CMS) to establish a demonstration grant program for states, with a focus on improving the quality of children's health care. Illinois, as the partner state, in collaboration with the State of Florida, as the lead state, was awarded one of ten grants in 2010. The grant requires Illinois to test and report to CMS on a core set of pediatric quality measures over the six-year grant period, inclusive of a one year extension. The measures are reported annually to CMS. This report presents results for the measures that Illinois reported. Most measures include a five year trend period and reflect HEDIS® 2015 percentiles, where applicable.

Key Findings

- In federal fiscal year (FFY) 2010, Illinois reported 13 core measures to CMS, with 17 reported in FFY2011, 20 reported in FFY2012, 25 reported in FFY2013, 21 reported in FFY2014, and 22 in FFY2015.
- HEDIS® 2015 percentiles were applied to CY2014 rates. In CY2014, two measures - Frequency of Ongoing Prenatal Care (>80% of expected visits) and Well Child Visits in the First 15 Months of Life (6 or more visits) - achieved the 50th percentile or higher.
- When HEDIS® percentiles are available performance on the remaining measures is below the 50th percentile. This shows substantial need for improvement to assure access to care and the quality of the content of care provided.
- From CY2013 to CY2014, year to year performance improvement based on movement to a higher HEDIS® percentile was seen for HPV Vaccine for Female Adolescents, Children and Adolescents' Access to Primary Care Practitioners (ages 12 to 24 Months, 25 Months to 6 Years and 12 to 19 Years), Immunization Status for Adolescents, and Chlamydia Screening in Women. While showing improvement, these measures remain below the 50th HEDIS® percentile showing lagging achievement and a need for sustained efforts to continue movement toward higher performance.
- A Key Findings section is included for each measure. Refer to that section for year to year comparisons describing whether increased or decreased performance is statistically significant.
- Measure programming deviations from some core measure specifications exist, but are minimized to the extent possible. These differences, as reported to CMS, are identified throughout this report.

Background

Background

CHIPRA Legislation
CHIPRA, Public Law 111-3, was signed into law on February 4, 2009. CHIPRA includes provisions to expand coverage to uninsured children and improve the quality of children's health care, including:

- Simplification of the enrollment and renewal process
- Performance bonuses for enrollment simplification and increased enrollment
- Mandated dental coverage
- Development of a core set of health care quality measures for children covered by Medicaid and CHIP

The Core Measure Set
The Agency for Healthcare Research and Quality (AHRQ) and CMS have shared responsibility for the core measure set mandated by CHIPRA, with AHRQ responsible for the development of the core measure set and CMS responsible for implementation. AHRQ and CMS convened the National Advisory Committee Subcommittee on Children's Healthcare Quality Measures for Medicaid and CHIP Programs (SNAC) to:

- create the initial core measurement set,
- review measures currently in use for their possible inclusion,
- nominate additional measures to consider, and
- select measures to improve and enhance the core set.

The SNAC process for the initial core set involved combining measures and eliminating overlapping measures, resulting in 65 measures which were categorized and scored. After voting on the measures, 24 measures were recommended for the initial core set. AHRQ contracts with seven academic centers of excellence to improve and enhance the Child Core Set measures. Since inception of the CHIPRA Child Core Set measures (referred to throughout this document as the Child Core Set), CMS has retired and added measures. For FFY2015 reporting, the Child Core Set includes 24 measures.

The technical specifications for the core measure set require that specific methods be used for the data collection and programming of each measure, including an administrative method using various administrative data sources, a hybrid method using data abstracted from medical records to supplement administrative data, and a survey method. In Illinois, the administrative method is used for all core measures, with the exception of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey. The CAHPS® survey follows specifications established by the National Committee on Quality Assurance (NCQA).

Illinois reports on the Child Core Set measures annually to CMS. The rates reported to CMS include the combined Title XIX (Medicaid) and Title XXI (CHIP) populations. The rates reported to CMS differ from the rates reported in this document since this document also includes the population of children who are state-funded (neither Title XIX nor Title XXI).

Each year, the U.S. Department of Health and Human Services publishes the Annual Report on the Quality of Care for Children in Medicaid and CHIP, which is compiled from the information reported by states in the CHIP Annual Report Template System (CARTS). The annual report is available at: http://www.Medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care.html

Data Sources
HFS maintains an Enterprise Data Warehouse (EDW) that contains data from many sources. This document includes a detailed description of the data housed in the EDW.

March 2015 Core Set of Health Care Quality Measures for Children in Medicaid and CHIP

NQF #	Measure Steward	Measure Name
1959	NCQA	Human Papillomavirus Vaccine for Female Adolescents
0024	NCQA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents: Body Mass Index Assessment for Children/Adolescents
NA	NCQA	Children and Adolescent Access to Primary Care Practitioners
0038	NCQA	Childhood Immunization Status
1407	NCQA	Immunization Status for Adolescents
1391	NCQA	Frequency of Ongoing Prenatal Care
1517	NCQA	Timeliness of Prenatal Care
1382	CDC	Live Births Weighing less than 2,500 Grams
0471	CMQCC	Cesarean Rate for Nulliparous Singleton Vertex
NA	AMA-PCPI	Behavioral Health Risk Assessment (for Pregnant Women)
1448	OHSU	Developmental Screening in the First Three Years of Life
1392	NCQA	Well-Child Visits in the First 15 Months of Life
1516	NCQA	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
NA	NCQA	Adolescent Well-Care Visit
0033	NCQA	Chlamydia Screening in Women
NA	CMS	Percentage of Eligibles that Received Preventive Dental Services
1799	NCQA	Medication Management for People with Asthma
0576	NCQA	Follow-up After Hospitalization for Mental Illness
0108	NCQA	Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication
0139	CDC	Pediatric Central-line Associated Blood Stream Infections—Neonatal Intensive Care Unit and Pediatric Intensive Care Unit
NA	NCQA	Ambulatory Care – Emergency Department (ED) Visits
NA	NCQA	Consumer Assessment of Healthcare Providers and Systems® (CAHPS) 5.0H (Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items)
Added to Child Core Set March 2015		
2508	DQA (ADA)	Prevention: Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (SEAL)
1365	AMA-PCPI	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (SRA)
Retired from Child Core Set March 2015		
NA	CMS	Percentage of Eligibles that Received Dental Treatment Services (TDENT)

Child Core Measure as of March 2015. AMA-PCPI: American Medical Association-Physician Consortium for Performance Improvement; CMQCC: California Maternal Quality Care Collaborative; CDC: Centers for Disease Control and Prevention; CMS: Centers for Medicare & Medicaid Services; DQA (ADA) – Dental Quality Alliance (American Dental Association); NA: Measure is not NQF endorsed; NCQA: National Committee for Quality Assurance; NQF: National Quality Forum; OHSU: Oregon Health and Science University.

Performance Measurement

HFS utilizes health care performance measurement for the following purposes.

Program Evaluation and Monitoring
Measuring performance over time allows HFS to monitor the status of particular health care indicators. This process can identify problems or barriers and areas for needed improvement. This information helps focus HFS' quality initiatives and resources to improve health care delivery. It also can demonstrate the success of programs and initiatives so that they can be sustained and expanded over time.

Quality Improvement
Quality improvement initiatives (QII) are selected based on 1) information obtained from ongoing program evaluation and monitoring that identifies problems, barriers or areas for improvement, 2) HFS' goals for improving health care outcomes, 3) compliance with care guidelines or federal requirements, and 4) research/literature on best practices. Quality improvement can take many forms, including policy changes, reimbursement/incentives, and provider education on evidence-based health care. More structured QIIs also can be used to address priority issues and may involve provider education and technical assistance, provider feedback, identification of lessons learned and best practices, and monitoring over time to assess performance improvement.

Incentives
HFS rewards primary care providers enrolled in the Primary Care Case Management Program (PCCM) for high performance through bonus payments. Bonus payments are made to providers who meet or exceed performance thresholds on particular performance measures. HFS has seen improvement in performance for those measures on which bonus payments are made. Bonus payments also are included in managed/coordinated care organization contracts to drive improvement.

Public Reporting
HFS regularly reports on performance measures through a variety of public reports such as the CHIP Annual Report, federally-required reports, the Perinatal Report, and the Title V MCH Block Grant; access reports on HFS' Reports Center web page. During CY2016, HFS will develop new report formats to provide information in a user friendly way to compare performance among the various plans providing health care services.

Federal Participation/Compliance Reporting
HFS reports annually to CMS on Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program services using form CMS-416. The annual report provides information on the number of children who received medical, dental or blood lead level screens and the number referred for diagnostic or treatment services. This report determines the number of screens provided in accordance with the EPSDT periodicity schedule, and assesses whether children with health problems identified through the screens were treated for medical or dental issues.

Policy and Program Changes
Information obtained from performance measurement is used by HFS to inform policy decisions and make program changes, allowing HFS to focus resources on efforts that result in improved health outcomes and cost effectiveness.

Meaningful Use
Pursuant to the Health Information Technology for Economic and Clinical Health (HITECH) Act, a provision of the American Recovery and Reinvestment Act of 2009 (ARRA), HFS is partnering with Federal CMS to demonstrate that electronic health records (EHRs) are being adopted and used in meaningful ways. The federal government has identified specific criteria to be measured to demonstrate meaningful use of EHRs by HFS' enrolled providers. Several of the core measures also are aligned with meaningful use measures.

Data Housed in the Enterprise Data Warehouse

Data Source	Time Period	Data Shared	Data Description
Current Data			
HFS	1996-2016	Claims	Information about health care services, including patient information, service location, provider of service, procedure, diagnosis, CPT codes
HFS	1996-2016	Recipient File	Patient-level information including eligibility, demographics, recipient ID
HFS	1996-2016	Provider File	Provider information including provider ID, provider type, address, billing address
IDPH	1990-2016	Adverse Pregnancy Outcomes Reporting System (APORS)	Information on infants born with birth defects or other abnormal conditions as contained in the infant discharge record.
IDPH	1960-2016	Childhood Immunizations	Immunizations administered in Local Health Departments and through the Cook County Department of Public Health, immunization information from the Global and Illinois Comprehensive Automated Immunization Registry Exchange (ICARE) registries, and immunization information from IDHS Cornerstone. Information includes clinic, medical information (BMI, lead screening, TB test, basic insurance information, basic school district information, patient immunization information – date, vaccine)
IDPH	1960-2016	Childhood Lead Screening	Information on lead screenings conducted by Local Health Departments and screening results for HFS children under age 7. Note: Currently only receive screenings, but will have results in the future.
IDPH	1970-2009	Vital Records	These are the legacy Vital Records prior to IDPH IVRS implementation. All data elements contained in the "certifiable" portion and all "Information for Medical and Health Use Only" portion of the Birth (1970-2009), Death (1970-2007).
IDPH	2008-2016	Expanded Illinois Vital Records System (IVRS)	Expanded tables that contain data from the IDPH IVRS. Birth: 2010-ongoing; Certified data through 2013 Death: 2008-ongoing; Certified data through 2014 Fetal Death: 1999-2012; Certified through 2013
IDPH	1970-2015	Out-of-State Vital Records	Out-of-state birth, death, and fetal death information for HFS enrollees
IDPH	1997-2016	Pre-Admission Screening	These data contain basic demographic data plus the determination of need (DON) score for patients admitted to a hospital.
IDPH	2009-2015	Hospital Discharges	Detailed data including up to 25 procedure diagnosis codes, limited to Illinois hospitals
IDHS Cornerstone	1992-2016	Family Case Management (FCM)	Enrollment and risk assessment information for pregnant women, infants and young children who are enrolled in FCM.
IDHS Cornerstone	1992-2016	Family Planning (FP)	Aggregate data on women served in FP program
IDHS Cornerstone	1992-2016	Healthy Start	Enrollment and risk assessment information for pregnant women, infants and young children who are enrolled in Healthy Start.
IDHS Cornerstone	1992-2016	Immunization	Immunization information for HFS participants from public health sector from Cornerstone.
IDHS Cornerstone	1992-2016	Better Birth Outcomes (BBO) (replaces Targeted Intensive Prenatal Case Management [TIPS])	Enrollment and risk assessment information for pregnant women, infants and young children who are enrolled in BBO.
IDHS Cornerstone	1992-2016	Supplemental Nutrition Program for Women, Infants and Children (WIC)	Enrollment and risk assessment information for pregnant women, infants and young children who are enrolled in WIC.
IDHS Cornerstone	1992-2016	Early Intervention (EI)	Enrollment information for HFS participants 0-3. **In Process** - Information from the EI Referral Form and the EI Referral Follow-up Form, including program eligibility and services, and specified information from the Individualized Family Services Plan.
DCFS	1996-2016	OBRA Medicaid Claims, skeletal data for client confirmation by HFS	Through the OBRA Waiver, Department of Children and Family Services (DCFS) sends claims for services to their Medicaid eligible wards. A skeletal file is also sent to HFS to confirm statuses and payment activity.
DSCC	2000-2012	Claim information, procedure and diagnosis information, basic demographic information	General claim information regarding children who have had a need for specialized care for which the University of Illinois Division of Specialized Care for Children (UIC-DSCC) provided services.
Under Construction			
IDPH		Early Hearing Detection and Intervention	Screening and diagnostic results for HFS participants
IDPH	1986-2013	Metabolic Genetic and Newborn Screening	Screening and diagnostic results for HFS participants; Sudden Infant Death Syndrome (SIDS) (basic information on child/mother for outreach/counseling purposes)
IDPH		Pregnancy Risk Assessment Monitoring System (PRAMS)	Aggregate data regarding population trends in activities and behaviors of pregnant women in Illinois.

Child Core Set

Technical Notes

Data Limitations
The measures reported herein are computed on the administrative methodology using administrative claims, Vital Records, and registry data. The hybrid methodology, employing sampling and medical record reviews, was not used to calculate rates.

Rates reported may be higher or lower than actual performance due to incomplete or untimely encounter data, coding, and claims adjudication issues. Performance decreases for CY2014 could be the result of under reporting encounter data by managed care plans. Between CY2014 and CY2015, Illinois Medicaid/CHIP experienced significant movement from fee for service to managed care. The number of Medicaid health plans grew from three to twelve and over one million recipients transitioned into managed care.

The most current year of data in this report reflects HFS Enterprise Data Warehouse (EDW) data as of December 2015 and includes Title XIX (Medicaid), Title XXI (CHIP), and state-funded populations. Some measures in this report may be identified as provisional. This indicates the measure was in testing at the time of the report, or the measure was newly developed or revised and ad hoc reports were used.

Data Quality
HFS implemented a number of initiatives to improve data quality, including contractual requirements for data reporting, reduced billing timeframe requirements, and quality improvement initiatives. Performance measure validation of the core set measures is conducted annually by a National Committee for Quality Assurance (NCQA**)** certified vendor. NCQA licenses organizations and certifies selected employees or contractors of licensed organizations to conduct audits using NCQA's standardized audit methodology.

Differences from Child Core Set Measure Specifications
Any differences between the core specifications and the measure programming logic are identified in this report. When measures use HEDIS® specifications they align with the correct data year, unless otherwise noted (e.g., HEDIS® 2015 specifications applied to CY2014 data). The Child Core Set specifications are periodically updated and time and resource limitations may restrict the state's ability to update measures. Unless otherwise noted, the most recent version of the specifications is used (e.g., HEDIS® 2015 specifications for CY2014 data).

Specifications describe the claim types to use in measure reporting. Affecting some measures, HFS uses rejected claims, but does not use pending claims since adjudication occurs in sufficient time to not impact measurement. Measure descriptions used in this report are from the Child Core Set.

The Child Core Set specifications are available on the Medicaid CHIPRA Initial Core Set of Children's Health Care Quality Measures web page.

HEDIS® Percentiles
A percentile is a measure showing the percentage performing at or below a certain level. At the 50th percentile, 50 percent of those measured are performing better and 50 percent performing worse than the performance level attained.

Throughout this report, the charts show the HEDIS® 2015 percentiles, when available, applied to CY2014 data and showing the percentile achieved. The dashboard applies the appropriate annual HEDIS® percentiles achieved for each calendar year of data. That is, HEDIS® 2014 percentiles are applied to CY2013 data, and so on.

Measurement Years
A trend is reported, when possible. The measurement period for most measures is from calendar year (CY) 2010 to CY2014. Measure PDENT, Total Eligibles who Received Preventive Dental Services, is by federal fiscal year (FFY*) as required by the federal CMS-416 report. Consistent with the specifications, Frequency of Ongoing Prenatal Care and Timeliness of Prenatal Care are reported from November 6 to November 5 of the measurement year.

*FFY = October 1–September 30

Previous Child Core Set Data Books are available on HFS' Reports Center web page.

Illinois' Child Core Set Measures Performance CY2010-CY2014 Dashboard

Child Core Set Measure	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014
HPV Vaccine for Female Adolescents	N/A	N/A	12.3	14.3	20.7
BMI Assessment for Children and Adolescents					
3 to 11 Years	0.6	0.8	1.3	2.0	3.7
12 to 17 Years	0.6	0.8	1.3	2.2	3.9
3 to 17 Years	0.6	0.8	1.3	2.1	3.8
Children and Adolescents' Access to Primary Care Practitioners					
12 to 24 Months	87.8	88.1	86.1	90.1	91.9
25 Months to 6 Years	78.6	78.6	76.7	82.8	85.4
7 to 11 Years	81.1	80.1	80.1	84.9	87.7
12 to 19 Years	80.0	79.5	79.3	85.5	88.1
All Age Groups	81.0	80.5	79.7	85.2	87.8
Childhood Immunization Status					
Combo 2	64.2	66.4	67.6	67.0	67.0
Combo 3	59.2	61.2	63.1	62.8	62.7
Combo 4	N/A	N/A	28.4	55.4	56.6
Combo 5	N/A	N/A	49.5	51.7	52.2
Combo 6	N/A	N/A	30.6	32.3	30.2
Combo 7	N/A	N/A	23.7	46.8	48.0
Combo 8	N/A	N/A	16.1	30.2	28.6
Combo 9	N/A	N/A	25.8	28.0	26.5
Combo 10	N/A	N/A	14.0	26.5	25.2
Immunization Status for Adolescents					
Meningococcal	34.0	43.1	49.8	55.3	60.7
Tdap	39.5	47.6	54.9	68.0	80.1
Combo (Meningococcal/Tdap)	27.0	35.9	43.3	50.9	57.9
Frequency of Ongoing Prenatal Care					
<21% of expected visits*	11.1	10.9	4.8	5.6	5.2
21 – 40% of expected visits*	6.5	6.5	4.0	4.2	4.3
41 – 60% of expected visits*	10.7	10.6	4.5	4.7	4.9
61 – 80% of expected visits*	21.3	21.1	6.0	6.1	6.5
>80% of expected visits	50.3	51.0	80.7	79.4	78.9
Timeliness of Prenatal Care	55.6	58.1	50.2	54.4	54.3
Percentage of Live Births Weighing Less Than 2,500 Grams	8.6	8.7	8.5	9.0	8.6
Cesarean Rate for Nulliparous Singleton Vertex	22.7	23.4	23.5	21.0	20.1
Developmental Screening in the First 3 Years of Life					
1 Year	52.6	60.8	63.5	64.4	65.0
2 Years	41.0	49.7	53.5	54.4	57.5
3 Years	27.0	34.7	38.5	40.0	42.8
Total	40.0	48.1	51.5	52.8	55.2

HEDIS® Percentiles:
2012 for CY2011 Data
2013 for CY2012 Data
2014 for CY2013 Data
2015 for CY2014 Data
* Inverted - lower percentile denotes better performance

90th Percentile or greater

75th Percentile

50th Percentile

25th Percentile

10th Percentile

Rate <10th percentile

N/A – Not Available

Child Core Set Measure	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014
Well Child Visits in the First 15 Months of Life					
0 Visits*	2.6	2.6	2.9	4.5	4.0
1 Visit*	2.4	2.2	2.5	3.5	3.5
2 Visits*	3.2	3.1	3.5	4.0	4.2
3 Visits*	4.6	4.5	4.5	4.9	5.3
4 Visits*	6.7	6.4	6.3	6.1	6.9
5 Visits*	9.8	9.2	8.7	8.4	9.0
6 or More Visits	70.8	72.0	71.7	68.6	67.0
Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life					
3 Years	74.2	74.3	72.1	71.8	73.8
4 Years	74.7	74.6	72.0	71.6	73.6
5 Years	77.9	77.4	74.8	75.3	77.1
6 Years	58.1	57.7	56.1	57.2	58.4
Total	71.4	71.2	68.8	68.9	70.5
Adolescent Well Care Visits	41.5	41.8	42.0	47.7	45.3
Chlamydia Screening in Women					
16-20 Years	46.9	45.6	43.8	43.1	44.4
21-24 Years	55.2	55.7	52.8	53.5	54.4
Total	50.7	50.2	47.8	48.0	49.3
Percent of Eligibles Who Received Preventive Dental Services (FFY)	48.8	50.5	52.1	51.5	44.5
Percent of Eligibles Who Received Dental Treatment Services (FFY)	19.2	20.3	21.2	20.6	Retired
Medication Management for People with Asthma: ≥50% Days Covered					
5 – 11 Years	N/A	N/A	41.6	46.0	44.7
12 – 18 Years	N/A	N/A	36.8	40.5	40.4
19 – 20 Years	N/A	N/A	33.0	39.0	43.7
5 – 20 Years	N/A	N/A	39.7	43.8	43.0
Medication Management for People with Asthma: ≥75% Days Covered					
5 – 11 Years	N/A	N/A	19.4	19.8	19.2
12 – 18 Years	N/A	N/A	16.7	17.1	17.3
19 – 20 Years	N/A	N/A	18.7	18.7	18.8
5 – 20 Years	N/A	N/A	18.4	18.8	18.5
Follow-up After Hospitalization for Mental Illness					
7 Days	32.0	31.5	32.5	35.2	31.3
30 Days	51.8	51.2	55.2	56.6	50.2
Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication					
Initiation Phase	31.7	32.1	33.6	31.9	31.7
Continuation & Maintenance Phase	36.1	39.3	38.3	38.3	38.6

Illinois' Child Core Set Measures Performance CY2010-CY2014 Dashboard

Child Core Set Measure	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014
Ambulatory Care – Emergency Department Visits (Per 1,000 Member Months)					
<1 Year*	94	95	95	87	88
1 – 9 Years*	50	51	49	49	50
10 – 19 Years*	32	32	31	34	34
Total*	44	44	42	43	43
Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (Chart not provided)	N/A	N/A	N/A	N/A	33.6

HEDIS® Percentiles:
2012 for CY2011 Data
2013 for CY2012 Data
2014 for CY2013 Data
2015 for CY2014 Data
* Inverted - lower percentile denotes better performance

90th Percentile or greater

75th Percentile

50th Percentile

25th Percentile

10th Percentile

Rate <10th percentile

N/A – Not Available

Child Core Set Measure	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014
Appropriate Testing for Children with Pharyngitis	43.3	46.8	49.7	Retired	
Annual Percentage of Asthma Patients with One or More Asthma-related Emergency Room Visits	17.8	18.4	12.3	Retired	
Annual Pediatric Hemoglobin (HbA1c) Testing	N/A	N/A	72.6	Retired	

Measure HPV: Human Papillomavirus (HPV) Vaccine for Female Adolescents

Measure Description: Percentage of female adolescents turning 13 years of age during the measurement year who had three doses of the Human Papillomavirus (HPV) vaccine by their 13th birthday. Continuous enrollment during the 12 months prior to the beneficiary's 13th birthday is required for inclusion in this measure.

Notes on Measure Programming or Differences from Measure Specifications:

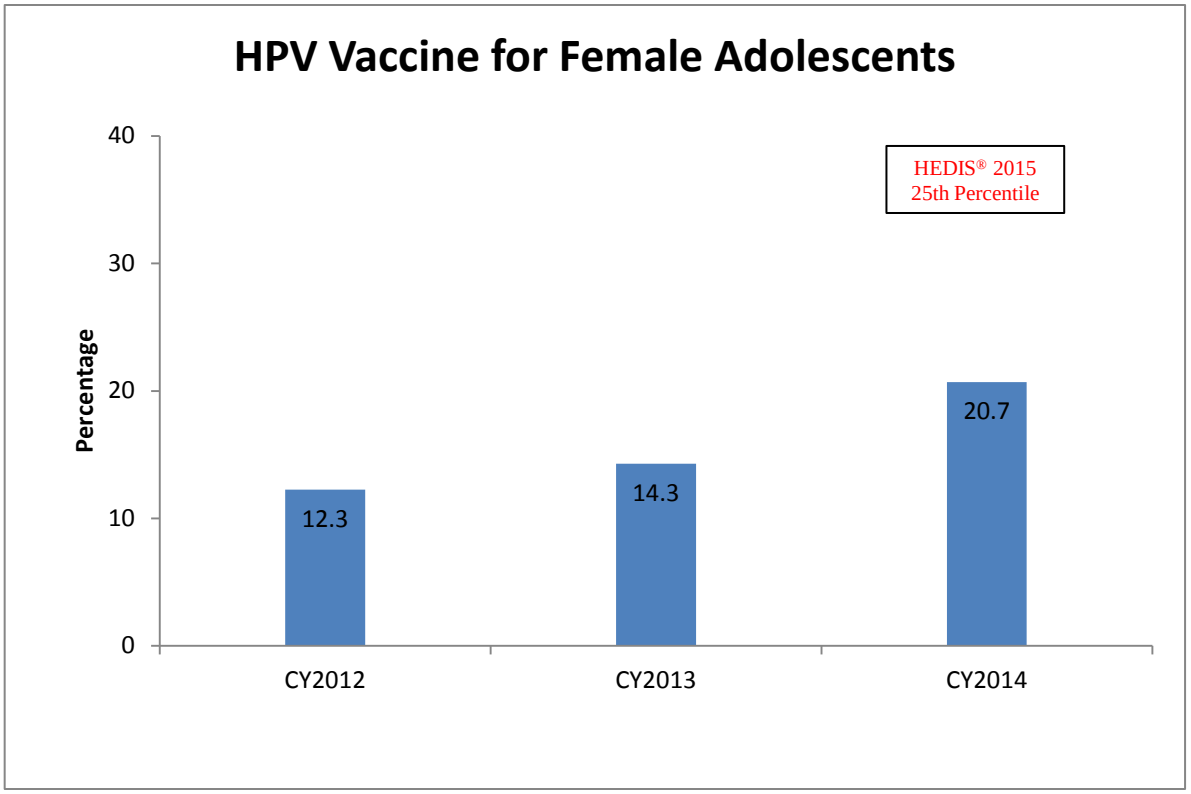
- With the shift to a predominately managed care healthcare delivery system, the CY2014 rate may be affected by incomplete encounter data.

Eligible Population:

Calendar Year	Numerator	Denominator
2012	4,719	38,447
2013	5,499	38,601
2014	7,479	36,067

Key Findings:

- The increase from CY2012 to CY2014 is statistically significant ($p<.05$).
- While improving from the 10th percentile (HEDIS® 2014), performance on this measure is at the HEDIS® 2015 25th percentile showing there is a need for improvement.



Measure WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents: BMI Assessment for Children/Adolescents

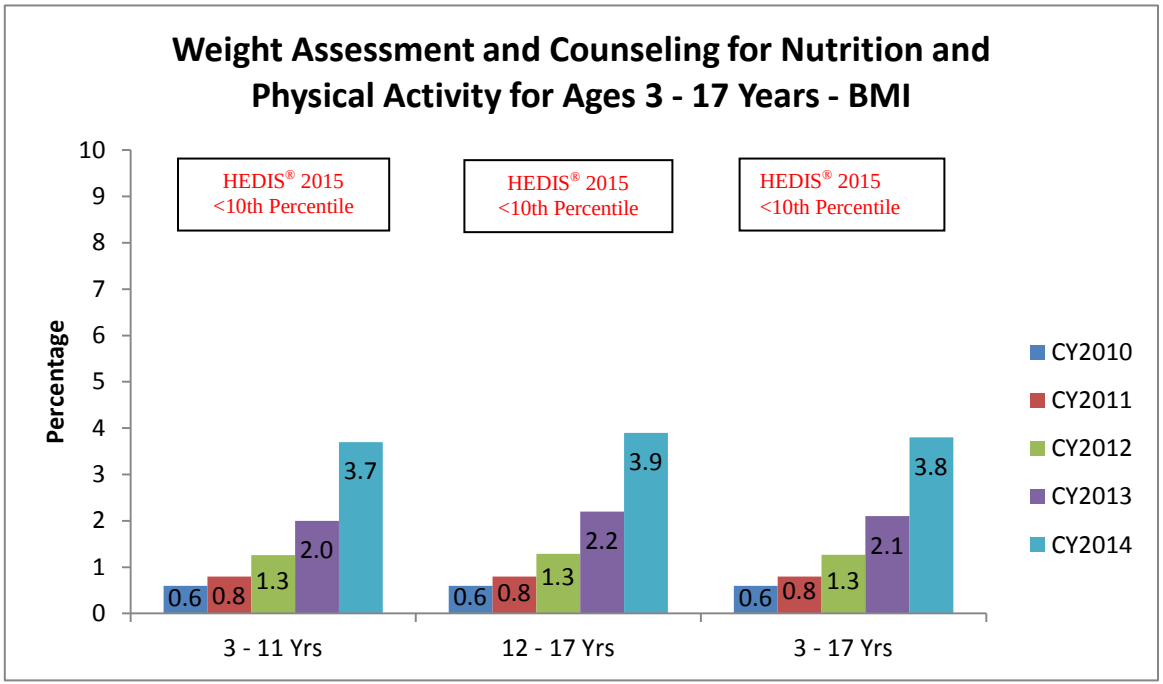
Measure Description: The percentage of children ages 3-17 who had an outpatient visit with a PCP or obstetric/gynecologic (OB/GYN) practitioner and whose weight is classified based on body mass index (BMI) percentile for age and gender. Because BMI norms for youth vary with age and gender, the measure evaluates whether BMI percentile is assessed rather than an absolute BMI value. Continuous enrollment during the measurement year is required for inclusion in this measure.

Notes on Measure Programming or Differences from Measure Specifications:

- CY2010-CY2012 rates were generated with HEDIS® 2012 specifications.
- With the shift to a predominately managed care healthcare delivery system, the CY2014 rates may be affected by incomplete encounter data.

Eligible Population:

	CY2010		CY2011		CY2012		CY2013		CY2014	
	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator
3-11 Yrs	4,739	773,513	6,404	807,538	10,081	802,875	15,078	755,378	26,669	708,100
12-17 Yrs	2,491	419,734	3,574	440,009	5,718	444,237	9,383	427,092	15,989	406,354
3-17 Yrs	7,230	1,193,247	9,978	1,247,547	15,799	1,247,112	24,461	1,182,470	42,658	1,114,454



Key Findings:

- HFS in collaboration with the Illinois Chapter, American Academy of Pediatrics (ICAAP) with funding from the Otho S.A. Sprague Memorial Institute is conducting a quality improvement initiative on BMI which is expected to result in future improvement in this measure.
- HFS believes the actual rate of BMI assessment is much higher, but reporting of BMI is low since there is no separate reimbursement for BMI assessment and claims are not submitted when assessment is performed. To address this, HFS published a provider notice (Oct. 2013) advising providers to report BMI assessment in claims and clarifying when weight management follow-up visits can be billed.

Measure CAP: Child and Adolescent Access to Primary Care Practitioners (PCP)

Measure Description: The percentage of children ages 12 months through 19 years who had a visit with a PCP, including four separate age groupings or categories:

- Children ages 12 through 24 months and 25 months through 6 years who had a visit with a PCP during the measurement year.
- Children ages 7 through 11 years and adolescents 12 through 19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year.

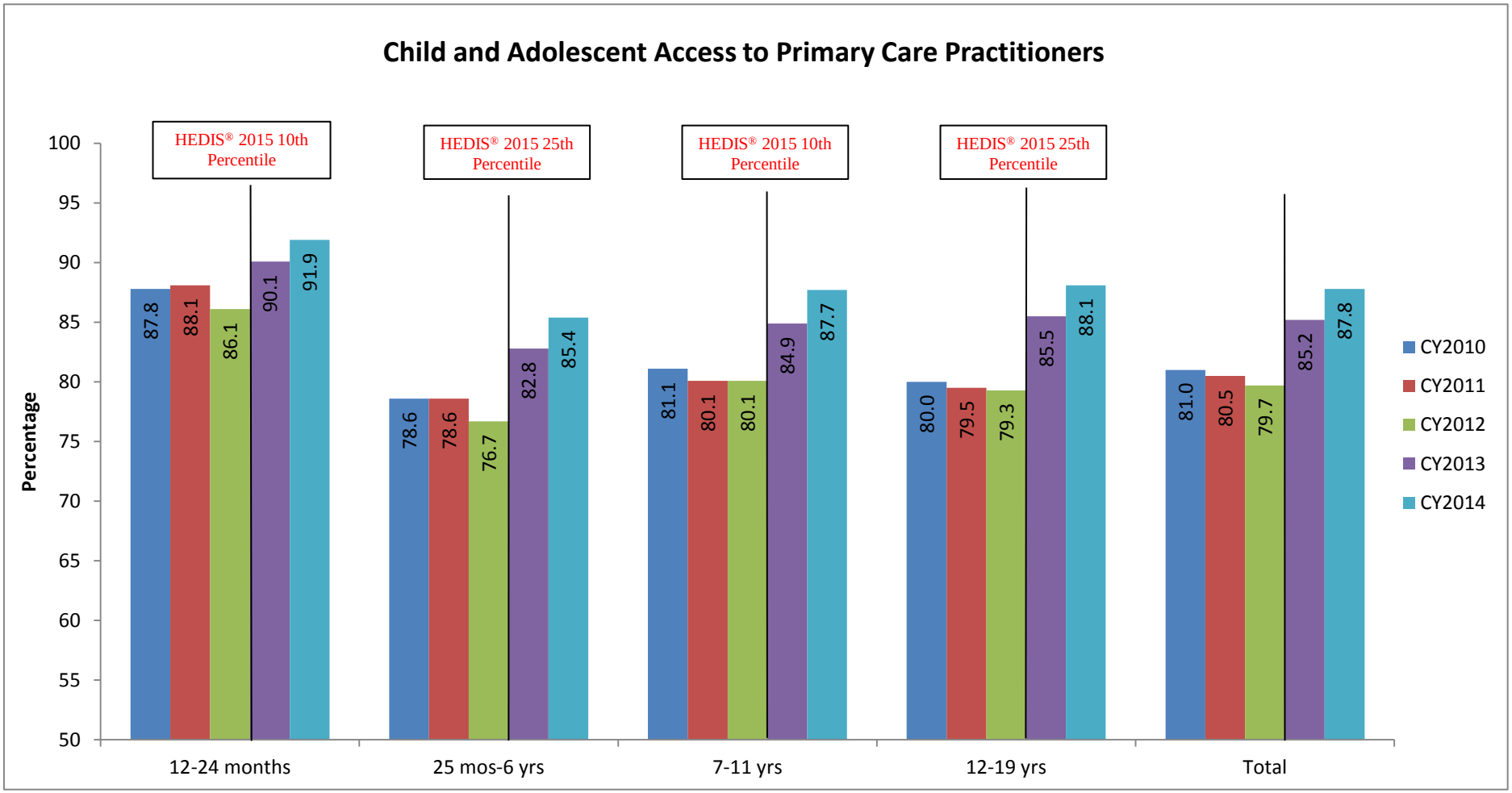
Notes on Measure Programming or Differences from Measure Specifications:

- CY2010 rates were generated with HEDIS® 2012 specifications.
- The solid vertical line in the chart indicates that rates for CY2013 and after are not comparable to previous years due to measure re-programming. Previously, the definition of primary care provider (PCP) used a restrictive set of codes that too narrowly defined PCP and reduced our rates. Revised programming appropriately defines PCPs and is reflected in rates beginning with CY2013.
- With the shift to a predominately managed care healthcare delivery system, the CY2014 rates may be affected by incomplete encounter data.

Eligible Population:

	CY2010		CY2011		CY2012		CY2013		CY2014	
	Numerator	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**
12–24 Mo	165,749	188,749	161,039	182,796	149,614	173,719	145,044	161,051	140,997	153,380
25 Mo–6 Yrs	290,255	369,356	301,241	383,155	289,168	377,080	287,639	347,247	270,295	316,508
7-11 Yrs	299,398	369,388	317,382	396,017	321,700	401,695	327,951	386,303	321,435	366,296
12-19 Yrs	363,375	454,143	387,357	487,162	393,033	495,746	408,607	477,984	402,870	456,831
Total	1,118,777	1,381,636	1,167,019	1,449,130	1,153,515	1,448,240	1,169,241	1,327,585	1,135,597	1,293,015

Measure CAP: Child and Adolescent Access to Primary Care Practitioners (PCP)



Key Findings:

- Compared to earlier years, the CY2013 performance increase in each age category is likely due primarily to measure re-programming to comply with the definition of PCP.
- From CY2013 to CY2014, there is a statistically significant ($p<.05$) increase in performance for each age category and the total.
- The CY2014 rates are at the HEDIS® 2015 10th percentile for ages 12-24 months and 7-11 years. The 25th percentile was achieved for ages 25 months–6 years and 12-19 years. The performance in each age category shows room for improvement.

Measure CIS: Childhood Immunization Status

Measure Description: The percentage of children who turned age 2 during the measurement year and had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates. To be counted, children must have reached their second birthday by the end of the measurement year and be continuously enrolled for 12 months prior to the child's second birthday.

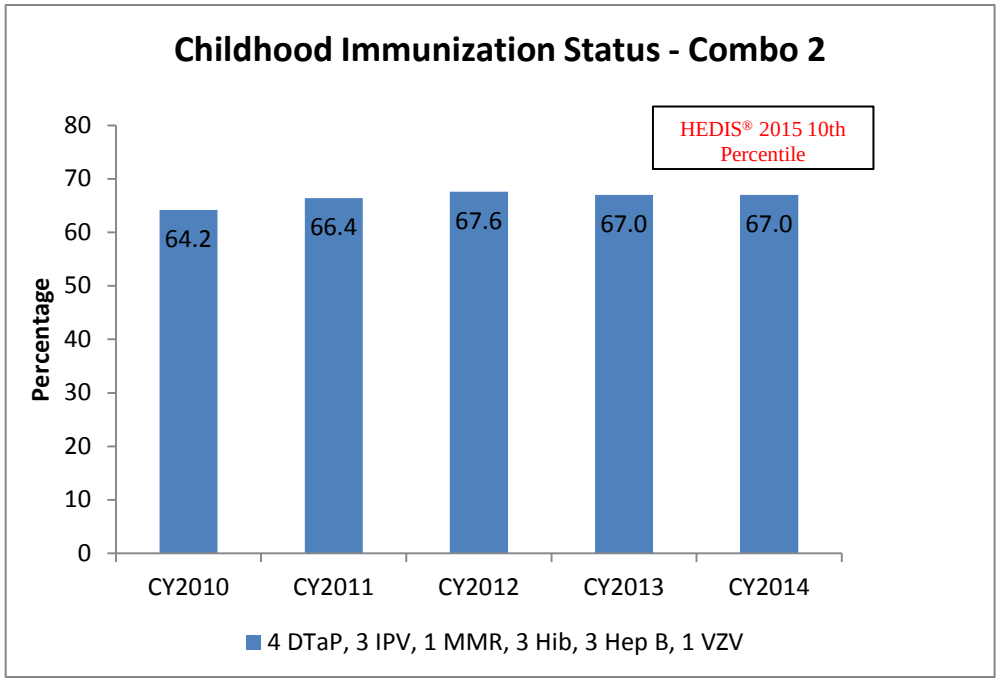
Notes on Measure Programming or Differences from Measure Specifications:

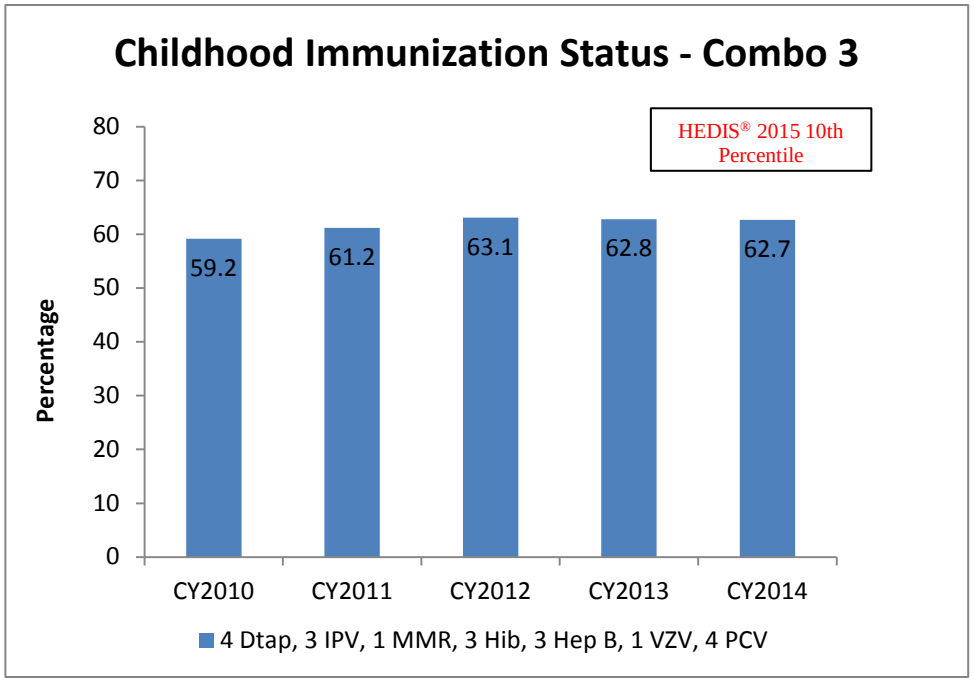
- CY2010-CY2011 rates were generated with HEDIS® 2011 specifications.
- Combination vaccines 4 through 10 were first reported in CY2012.
- Individual vaccine rates are not included in this report.
- The measure includes vaccinations identified using claims, the state immunization registry and the DHS Cornerstone client information system.
- Denominator exclusions were first applied for reporting CY2012 rates in FFY2013. These exclusions were not applied to the denominator in previous years.
- With the shift to a predominately managed care healthcare delivery system, the CY2014 rates may be affected by incomplete encounter data.

Eligible Population:

	CY2010		CY2011		CY2012		CY2013		CY2014	
	Numerator	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**
Combo 2	61,257	95,383	62,093	93,582	60,069	88,810	55,696	83,147	52,194	77,869
Combo 3	56,508	95,383	57,285	93,582	56,024	88,810	52,232	83,147	48,830	77,869
Combo 4					25,203	88,810	46,033	83,147	44,079	77,869
Combo 5					43,924	88,810	43,021	83,147	40,634	77,869
Combo 6					27,140	88,810	26,817	83,147	23,515	77,869
Combo 7					21,087	88,810	38,916	83,147	37,404	77,869
Combo 8					14,274	88,810	25,126	83,147	22,254	77,869
Combo 9					22,872	88,810	23,299	83,147	20,597	77,869
Combo 10					12,410	88,810	22,023	83,147	19,647	77,869

Measure CIS: Childhood Immunization Status





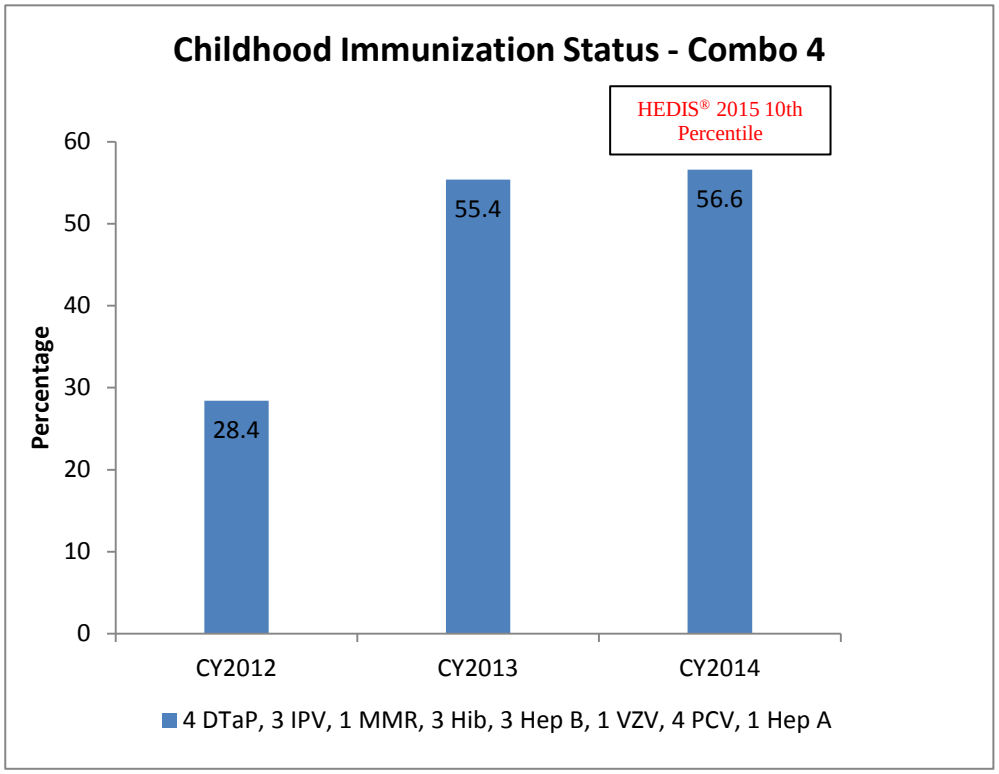
Key Findings: Combo 2

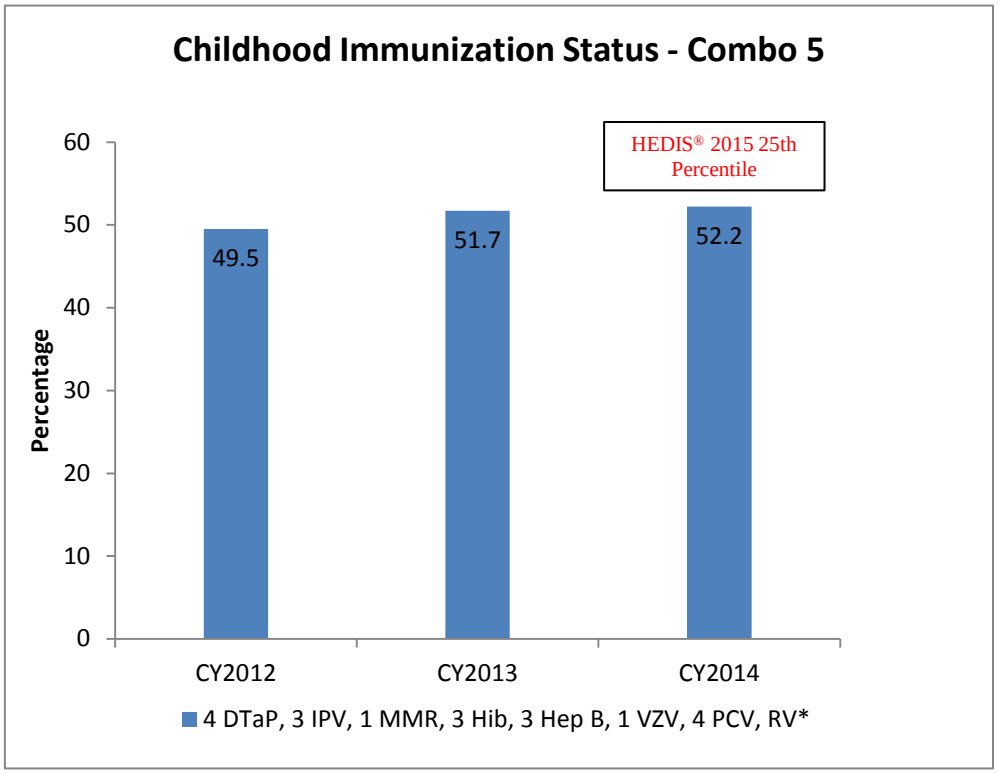
- From CY2010 to CY2014, there was an increase of 2.8 percentage points, an increase of 4.4 percent.
- While the increase from CY2010 to CY2014 is statistically significant ($p<.05$), there is a significant decline ($p<.05$) from CY2012 to CY2014.
- The HEDIS® 2015 10th percentile was achieved for CY2014 showing room for improvement.

Key Findings: Combo 3

- There was an increase of 3.5 percentage points, an increase of 5.9 percent, in Combo 3 from CY2010 to CY2014.
- The increase from CY2010 to CY2014 is statistically significant ($p<.05$). The decrease from CY2012 to CY2014 is not statistically significant.
- The HEDIS® 2014 10th percentile was achieved for CY2014 showing room for improvement.

Measure CIS: Childhood Immunization Status





Key Findings: Combo 4

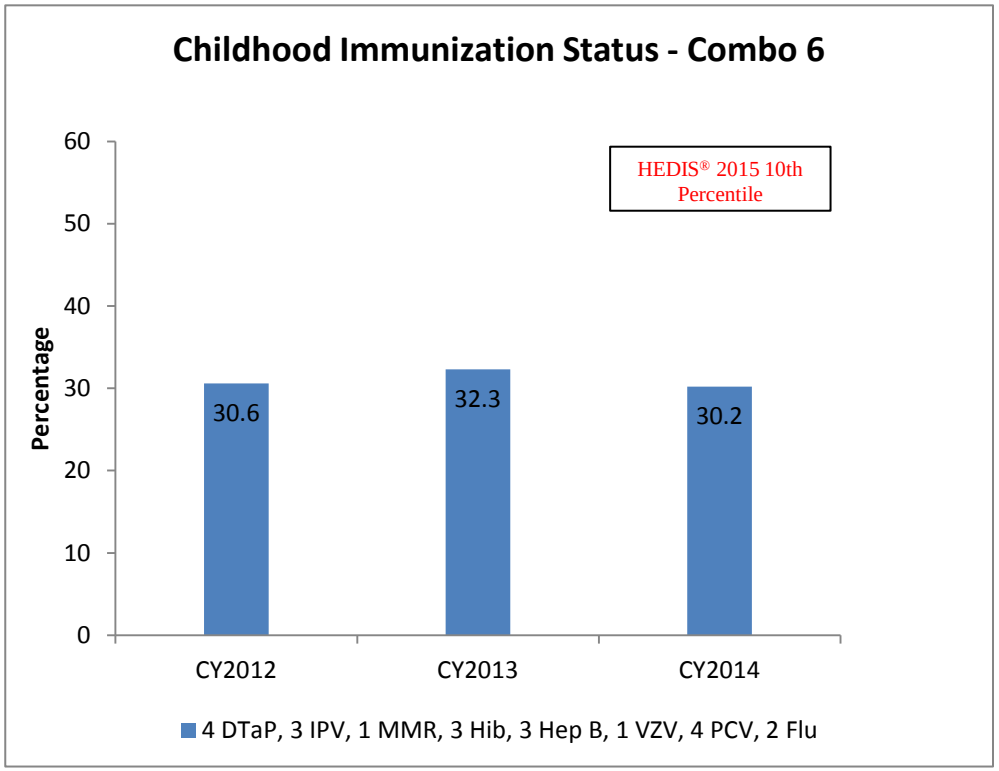
- The HEDIS® 2015 10th percentile was achieved for CY2014 showing room for improvement.
- Individual vaccine rates show that Hep A increases are likely the cause for the statistically significant ($p<.05$) increase from CY2012 to CY2013 and CY2012 to CY2014.

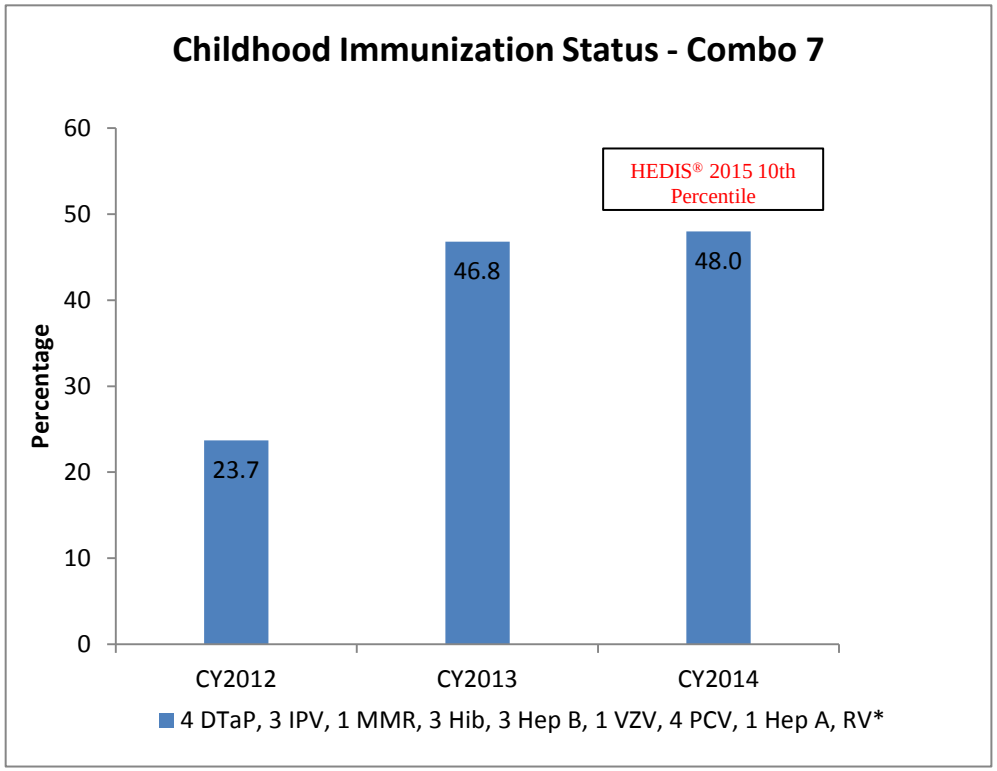
Note: *RV= 2 doses of the 2-dose vaccine, or 1-dose of the 2-dose vaccine and 2 doses of the 3-dose vaccine, or 3-doses of the 3-dose vaccine

Key Findings: Combo 5

- The HEDIS® 2015 25th percentile was achieved for CY2014 showing room for improvement.
- The 2.7 percentage point increase from CY2012 to CY2014 is statistically significant ($p<.05$).

Measure CIS: Childhood Immunization Status





Key Findings: Combo 6

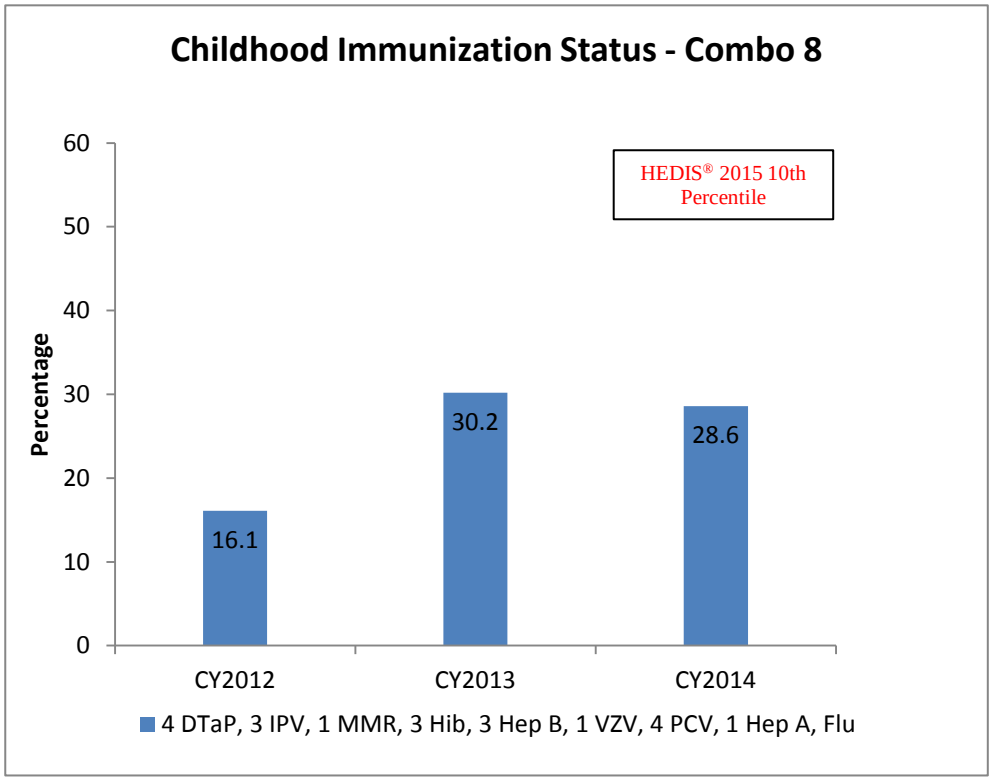
- The HEDIS® 2015 10th percentile was achieved for CY2014 showing need for improvement.
- The decrease from CY2012 to CY2013 is not statistically significant. However, the 2.1 percentage point decrease from CY2013 to CY2014 is statistically significant ($p<.05$).
- Low rates of Influenza vaccine administration (37.2%, 39.2% and 37.4%, respectively) relative to other vaccines may contribute to this low Combo immunization rate.

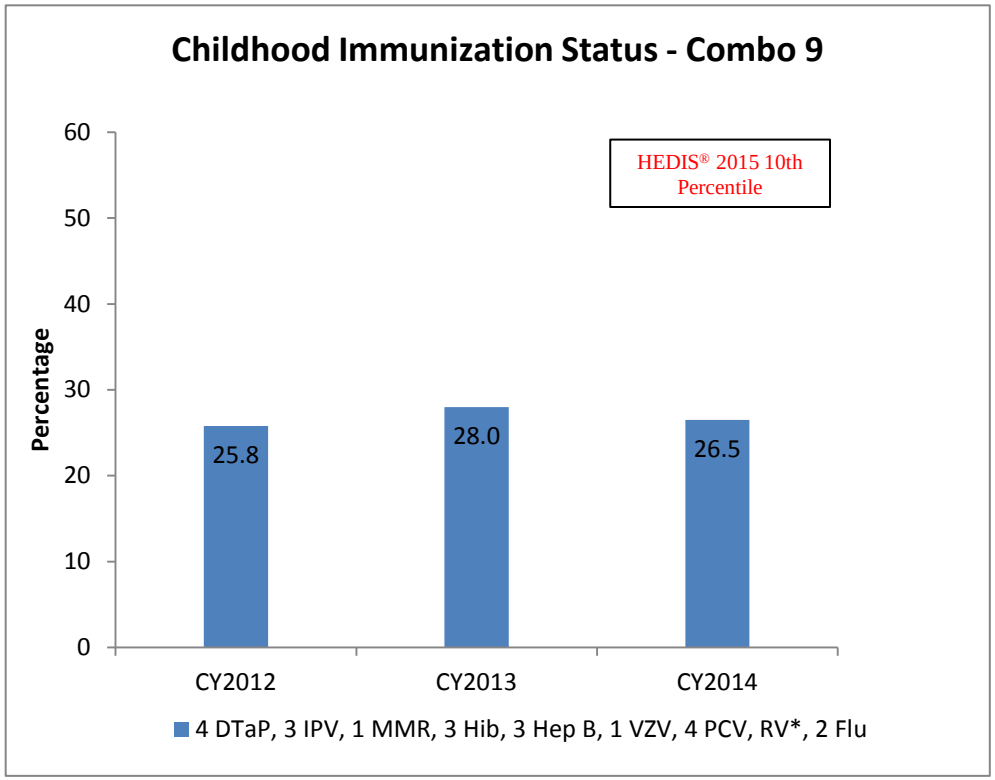
Note: *RV= 2 doses of the 2-dose vaccine, or 1-dose of the 2-dose vaccine and 2 doses of the 3-dose vaccine, or 3-doses of the 3-dose vaccine

Key Findings: Combo 7

- The HEDIS® 2015 10th percentile was achieved for CY2014 showing need for improvement.
- Individual vaccine rates show that Hep A increases are likely the cause for the statistically significant ($p<.05$) increases from CY2012 to CY2013 and CY2012 to CY2014.
- From CY2013 to CY2014 there also was a statistically significant increase ($p<.05$).

Measure CIS: Childhood Immunization Status





Key Findings: Combo 8

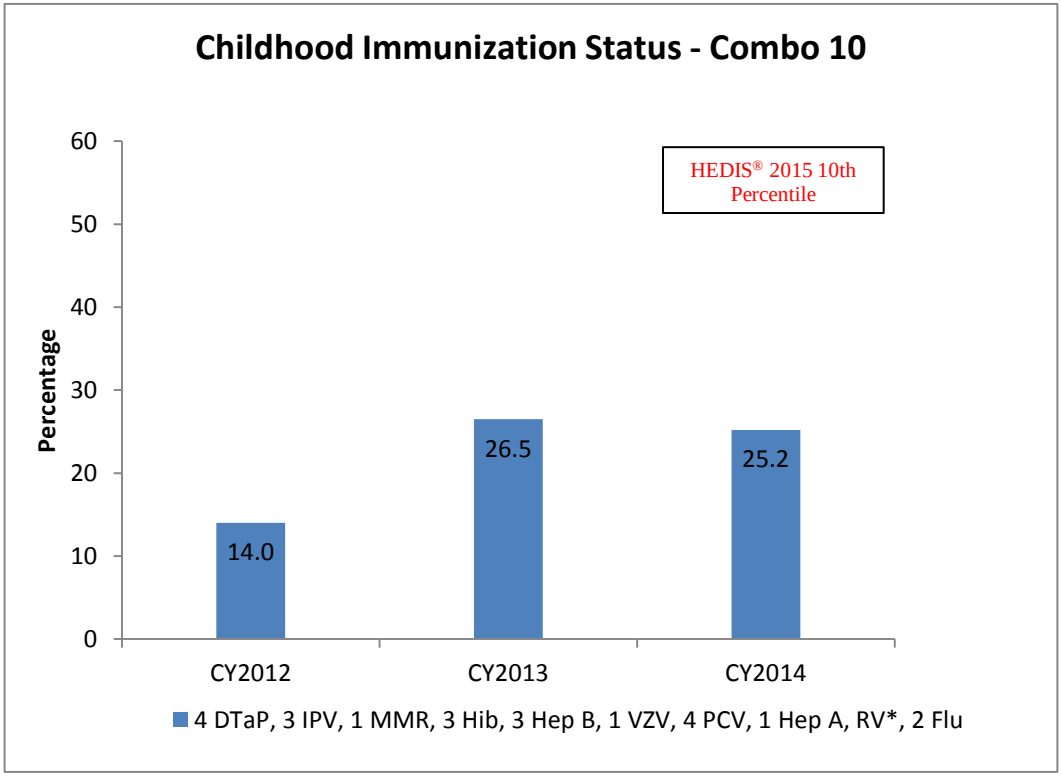
- The HEDIS® 2015 10th percentile was achieved for CY2014 showing need for improvement.
- Individual vaccine rates show that Hep A increases are likely the cause for the statistically significant ($p<.05$) increases from CY2012 to CY2013 and CY2012 to CY2014.
- The decrease of 1.6 percentage points, or -5.3 percent, from CY2013 to CY2014 is statistically significant ($p<.05$).

Note: *RV= 2 doses of the 2-dose vaccine, or 1-dose of the 2-dose vaccine and 2 doses of the 3-dose vaccine, or 3-doses of the 3-dose vaccine

Key Findings: Combo 9

- The HEDIS® 2015 10th percentile was achieved for CY2014 showing need for improvement. This is a decrease from the 25th percentile achieved in CY2013.
- The increases from CY2012 to CY2013 and CY2012 to CY2014 are statistically significant ($p<.05$).
- The decrease of 1.5 percentage points, or -5.4 percent, from CY2013 to CY2014 is statistically significant ($p<.05$).
- Low rates of Influenza vaccine administration (37.2%, 39.2% and 37.4%, respectively) relative to other vaccines may contribute to this low Combo immunization rate.

Measure CIS: Childhood Immunization Status



Note: *RV= 2 doses of the 2-dose vaccine, or 1-dose of the 2-dose vaccine and 2 doses of the 3-dose vaccine, or 3-doses of the 3-dose vaccine

Key Findings: Combo 10

- The HEDIS® 2015 10th percentile was achieved for CY2014 showing need for improvement. This is a decrease from the 25th percentile achieved in CY2013.
- The increases from CY2012 to CY2013 and CY2012 to CY2014 are statistically significant ($p<.05$). Individual vaccine rates show that Hep A increases are likely the cause for the statistically significant ($p<.05$) increases from CY2012 to CY2013 and to CY2014.
- The decrease of 1.3 percentage points, or -4.9 percent, from CY2013 to CY2014 is statistically significant ($p<.05$).

Measure IMA: Immunization Status for Adolescents

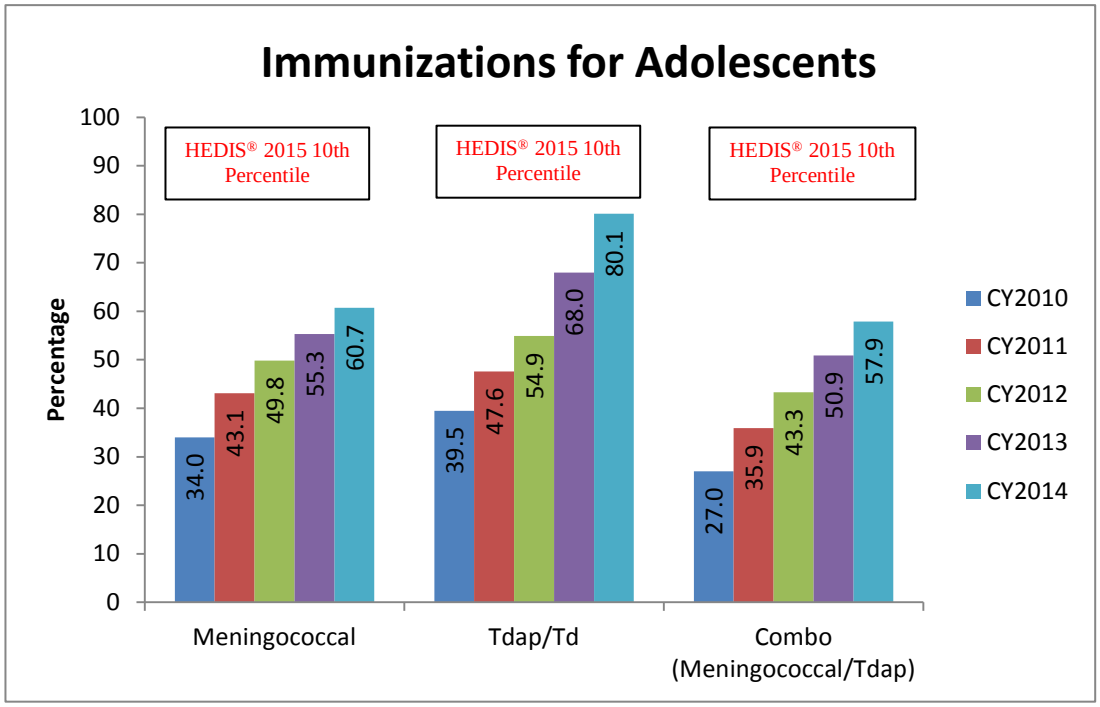
Measure Description: The percentage of adolescents who turned 13 years old during the measurement year and had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday. The measure calculates a rate for each vaccine and one combination rate. Continuous enrollment is 12 months prior to the child's 13th birthday.

Notes on Measure Programming or Differences from Measure Specifications:

- CY2010-CY2012 rates were generated with HEDIS® 2012 specifications.
- The measure includes vaccinations identified using claims, the state immunization registry and the DHS Cornerstone client information system.
- Denominator exclusions were first applied for reporting CY2012 rates in FFY2013. These exclusions were not applied to the denominator in previous years.
- With the shift to a predominately managed care healthcare delivery system, the CY2014 rates may be affected by incomplete encounter data.

Eligible Population:

	CY2010		CY2011		CY2012		CY2013		CY2014	
	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator
Meningococcal	23,823	70,102	32,725	75,952	38,931	78,250	43,466	78,540	44,676	73,548
Tdap/Td	27,701	70,102	36,157	75,952	42,921	78,250	53,419	78,540	58,914	73,548
Combo	18,955	70,102	27,255	75,952	33,864	78,250	39,959	78,540	42,560	73,548



Key Findings

- From CY2010 to CY2014, the Combo (Meningococcal and Tdap/Td) immunization rate for adolescents increased by 30.9 percentage points, an increase of 114.4 percent.
- There was an increase of 26.7 percentage points, or 78.5 percent, in the Meningococcal rate from CY2010 to CY2014.
- From CY2010 to CY2014 there was an increase of 40.6 percentage points, or 102.8 percent, in the Tdap/Td rate.
- For both vaccines and the Combo, the increases from CY2010 to CY2014 are statistically significant ($p<.05$).
- Regardless of these increases, rates for each vaccine and combo are at the HEDIS® 2015 10th percentile presenting opportunity for improvement.

Measure FPC: Frequency of Ongoing Prenatal Care

Measure Description: The percentage of women with deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that received <21 percent, 21-40 percent, 41-60 percent, 61-80 percent, or ≥81 percent of expected prenatal visits. To be counted, enrolled women must be continuously enrolled 43 days prior to delivery through 56 days after delivery. A lower percentage of visits in categories <81% and a higher percentage of visits ≥81% for this measure indicates better performance.

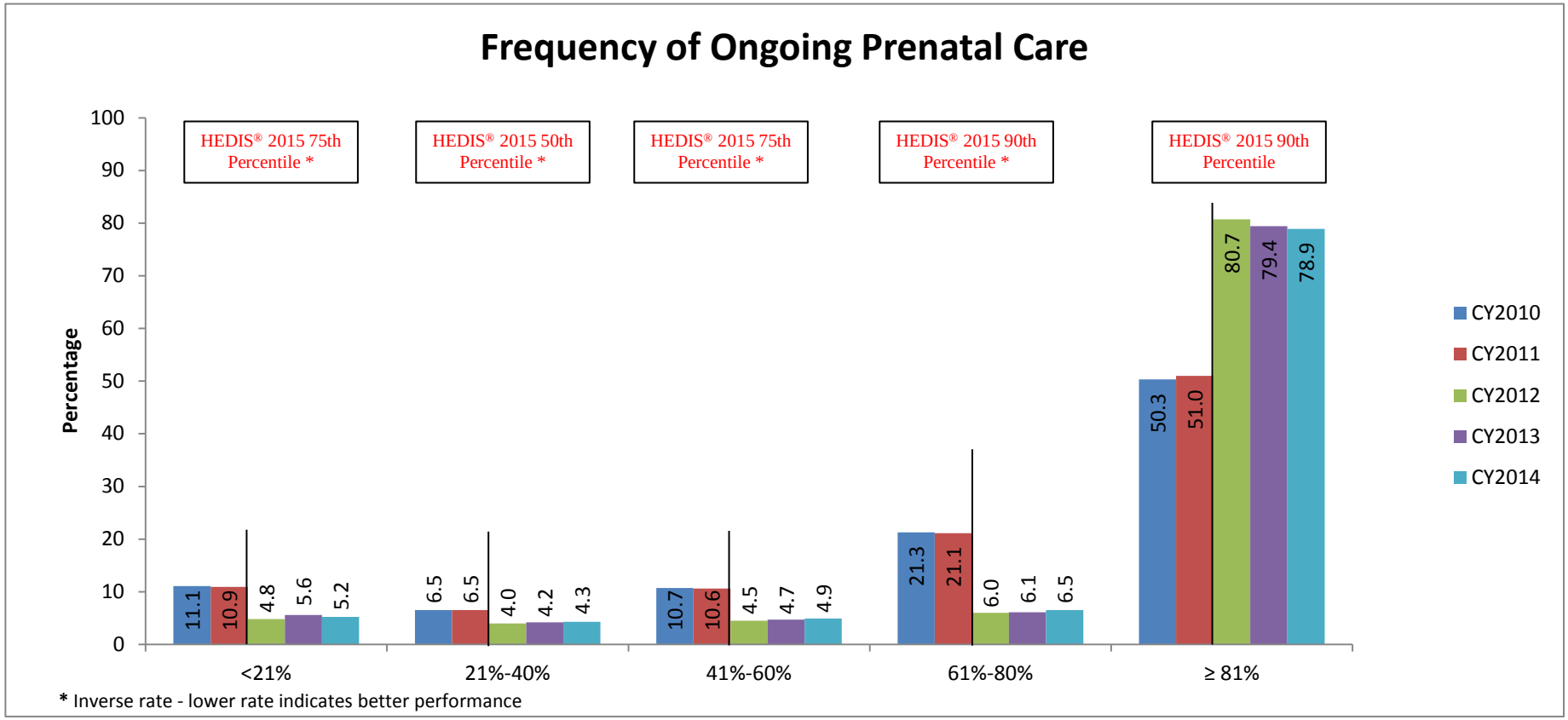
Notes on Measure Programming or Differences from Measure Specifications:

- Beginning with CY2013, a programming change results in a slightly lower denominator compared to earlier years.
- CY2010-CY2014 use uncertified Vital Records data.
- The solid vertical line in the chart indicates rates for CY2012 and after are not comparable to previous years because of the following measure programming updates:
  - CY2010-CY2011 generated with HEDIS® 2007 specifications.
  - HFS used only Decision Rule 2 for CY2010-CY2011. Beginning with CY2012 all four decision rules are used.
- With the shift to a predominately managed care healthcare delivery system, the CY2014 rates may be affected by incomplete encounter data.

Eligible Population:

	CY2010		CY2011		CY2012		CY2013		CY2014	
	Numerator	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**
<21%	9,134	82,636	8,677	79,996	3,863	79,948	4,372	78,275	3,902	74,812
21-40%	5,408	82,636	5,226	79,996	3,183	79,948	3,314	78,275	3,250	74,812
41-60%	8,879	82,636	8,437	79,996	3,620	79,948	3,663	78,275	3,724	74,812
61-80%	17,614	82,636	16,851	79,996	4,772	79,948	4,801	78,275	4,872	74,812
≥81%	41,601	82,636	40,805	79,996	64,510	79,948	62,125	78,275	59,064	74,812

Measure FPC: Frequency of Ongoing Prenatal Care



Key Findings:

- It is preferable to achieve the highest rate at the upper most visit frequency of ≥81% and the lowest rates at the lower visit frequencies. CY2012-CY2014 rates for frequency of prenatal care show that the majority of pregnant women are receiving 81% or more of the expected number of prenatal visits, which is considered adequate prenatal care.
- Comparing CY2012 and CY2013 to CY2014, there are statistically significant declines in women receiving ≥81% of recommended visits. While CY2014 decreased performance could be attributed to incomplete MCO encounter data, the consistent decreasing trend is of concern.
- Compared to HEDIS® 2015 percentiles, among the lowest three visit frequency categories performance is at the 50th to the 75th percentile. However, there is still opportunity to shift visits to higher frequency categories.

Measure PPC: Timeliness of Prenatal Care

Measure Description: The percentage of women with deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year who received a prenatal care visit in the first trimester or within 42 days of enrollment in Medicaid/CHIP.

Notes on Measure Programming or Differences from Measure Specifications:

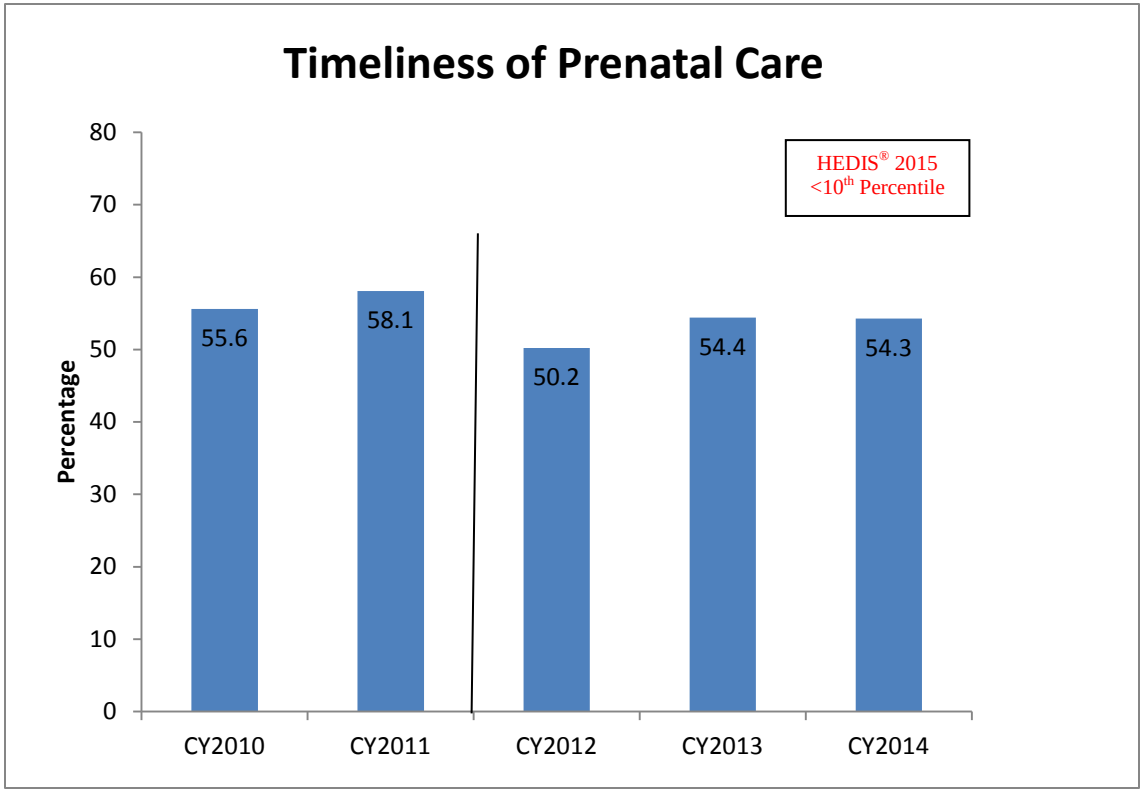
- From CY2012 to CY2013 a programming change results in a slightly lower denominator count in CY2013.
- CY2010-CY2014 use uncertified Vital Records data.
- The solid vertical line indicates that rates for CY2012 and after are not comparable to previous years because of the following measure programming updates:
  - CY2010-CY2011 generated with HEDIS® 2007 specifications.
  - HFS used only Decision Rule 2 for CY2010-CY2011. Beginning with CY2012 all four decision rules are used.
- With the shift to a predominately managed care healthcare delivery system, the CY2014 rate may be affected by incomplete encounter data.

Eligible Population:

Calendar Year	Numerator	Denominator
2010	45,979	82,636
2011	46,487	79,996
2012	39,728	79,141
2013	42,603	78,275
2014	40,639	74,812

Key Findings:

- This measure shows that slightly more than one-half of pregnant women receive timely prenatal care.
- The increase from CY2012 to CY2014 is statistically significant ($p<.05$).
- This measure is below the HEDIS® 2015 10th percentile for CY2014, and has been consistently below the 10th percentile since CY2011, showing need for improvement.



Measure LBW: Live Births Weighing Less Than 2,500 Grams

Measure Description: The measure assesses the number of resident live births less than 2,500 grams as a percentage of the number of resident live births in the State. The denominator includes the number of Medicaid and CHIP resident live births in the State during the measurement period regardless of the length of enrollment for women with these births. A lower percentage on this measure indicates better performance.

Notes on Measure Programming or Differences from Measure Specifications:

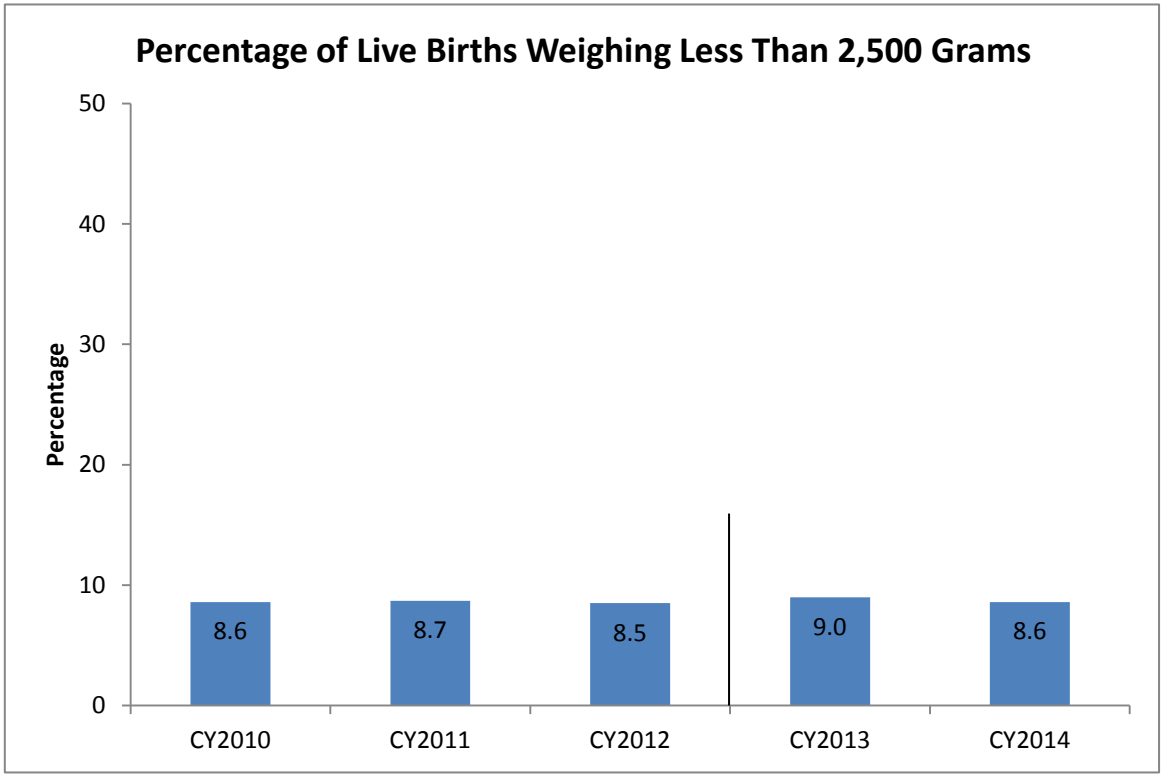
- CY2010-CY2014 rates use uncertified Vital Records and are, therefore, considered provisional.
- The solid vertical line indicates that rates for CY2013 and after are not comparable to previous years due to enhancements to the Moms/Babies Data Mart matching process.
- Rates are based on deliveries with >$0 re-priced net liability amount.
- The March 2015 Child Core Set specifications were used to program this measure for CY2014.
- With the shift to a predominately managed care healthcare delivery system, the CY2014 rate may be affected by incomplete encounter data.

Eligible Population:

Calendar Year	Numerator	Denominator
2010	5,722	66,446
2011	5,558	63,560
2012	5,020	59,387
2013	6,101	67,808
2014	5,285	61,688

Key Findings:

- The Vital Records data reported are provisional. So, the statistically significant (p<.05) -4.4 percent decrease from CY2013 to CY2014 should be viewed with caution.



Measure CSEC: Cesarean Rate for Nulliparous Singleton Vertex

Measure Description: The percentage of women that had a Cesarean section among women with first live singleton births (also known as nulliparous term singleton vertex [NTSV] births) at 37 weeks of gestation or later. This measure identifies the portion of Cesarean births that has the most variation among practitioners, hospitals, regions, and states and focuses attention on the proportion of Cesarean births affected by elective medical practices such as induction and early labor admission. Furthermore, management of the first labor directly impacts the remainder of the woman's reproductive life especially given the current high rate of repeat Cesarean births.

Notes on Measure Programming or Differences from Measure Specifications:

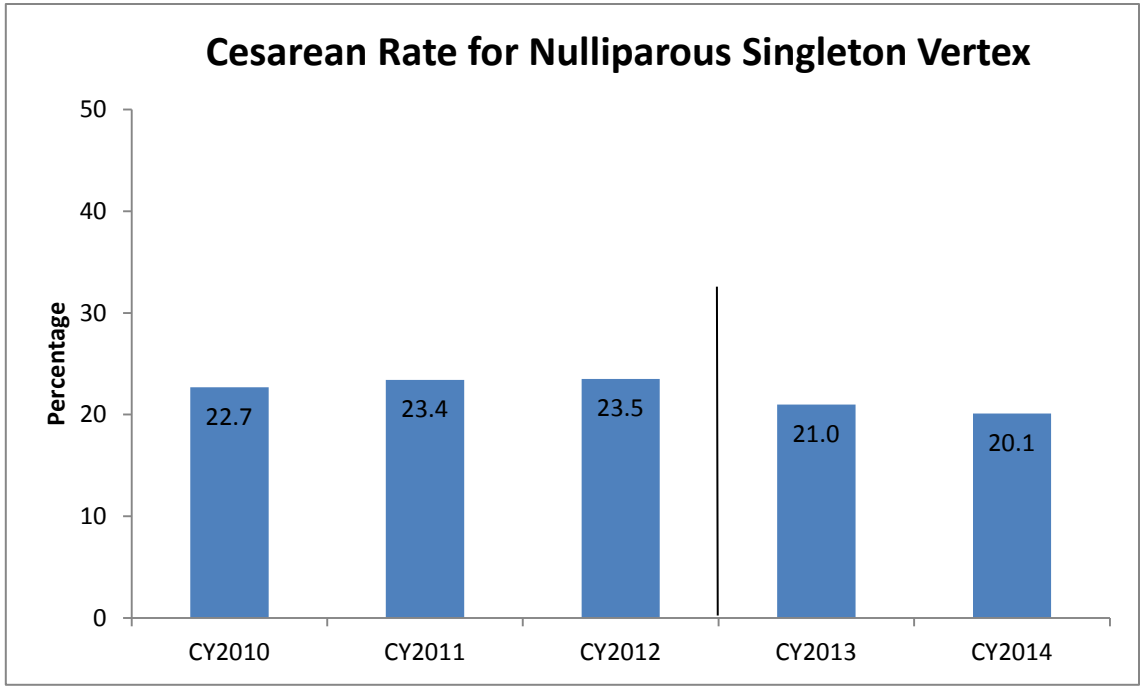
- The solid vertical line indicates that rates for CY2013 and after are not comparable to CY2010-CY2012 due to enhancements to the Moms/Babies Data Mart matching process. These enhancements identify more Mom/baby pairs and first births resulting in denominator and numerator increases compared to previous years.
- The CY2010-CY2014 rates use uncertified Vital Records data and are, therefore, considered provisional.
- The March 2015 Child Core Set specifications were used to program this measure for CY2014.
- With the shift to a predominately managed care healthcare delivery system, the CY2014 rate may be affected by incomplete encounter data.

Eligible Population:

Calendar Year	Numerator	Denominator
2010	3,553	15,638
2011	3,357	14,335
2012	3,207	13,637
2013	4,528	21,612
2014	4,156	20,626

Key Findings:

- The Vital Records data reported are provisional. So, the statistically significant ($p<.05$) -4.3 percent decrease from CY2013 to CY2014 should be viewed with caution.



Measure DEV: Developmental Screening in the First Three Years of Life

Measure Description: The percentage of children who are screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthday. To be counted, children must have reached their first, second or third birthday by the end of the measurement year (calendar year) and be continuously enrolled during the measurement year.

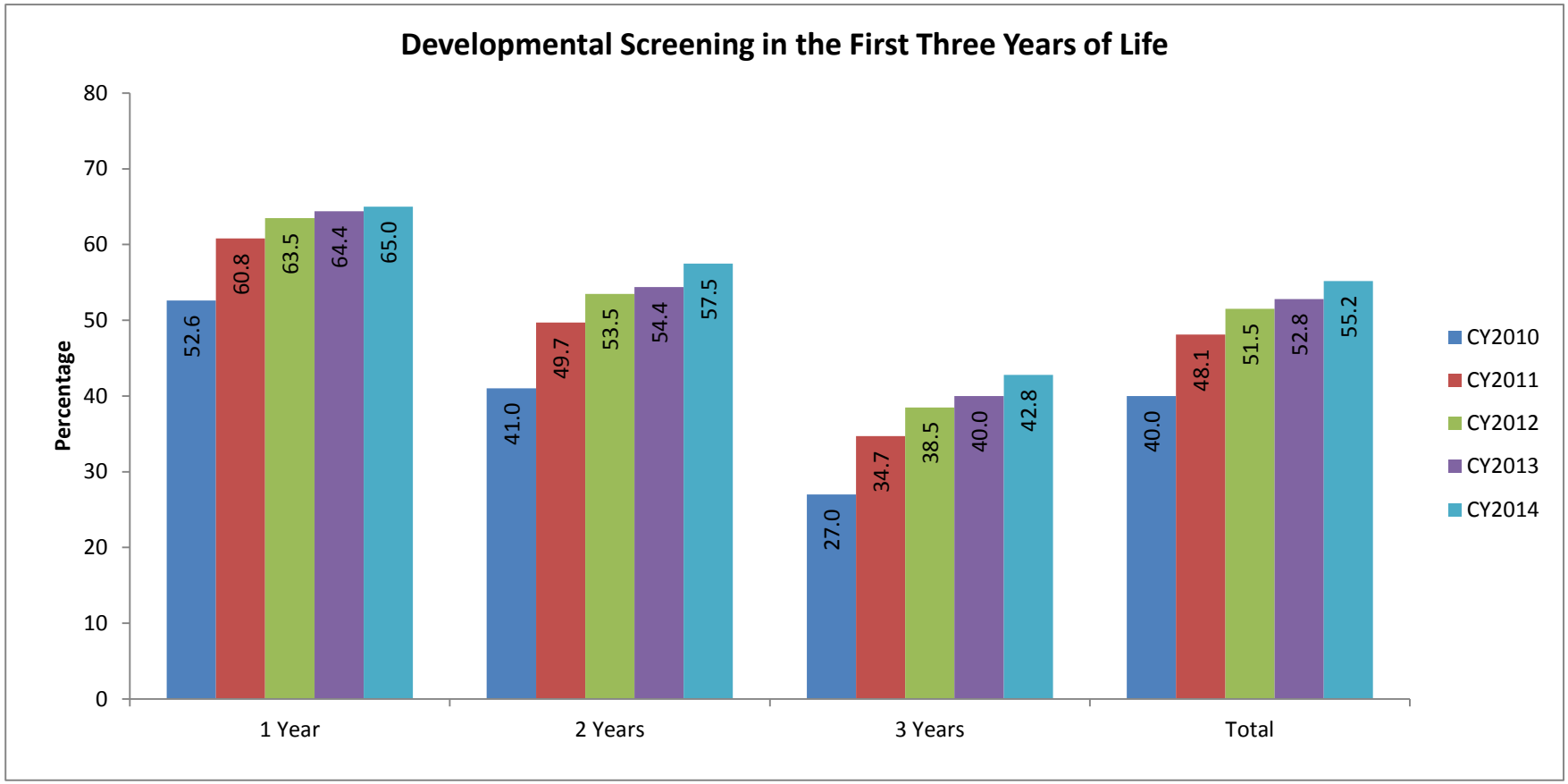
Notes on Measure Programming or Differences from Measure Specifications:

- The specifications define specific global screening tools that are to be counted for this measure. Screening tools allowed by HFS policy include global and domain-specific tools that differ from those included in the specifications. This measure counts allowable screening tools as specified in HFS policy.
- The March 2015 Child Core Set specifications were used to program this measure for CY2014.
- With the shift to a predominately managed care healthcare delivery system, the CY2014 rates may be affected by incomplete encounter data.

Eligible Population:

	CY2010		CY2011		CY2012		CY2013		CY2014	
	Numerator	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**
1 Yr	49,345	93,808	55,294	90,878	55,913	88,073	55,324	85,893	53,789	82,763
2 Yrs	39,387	95,978	47,115	94,728	48,555	90,757	46,899	86,170	46,312	80,596
3 Yrs	26,492	97,965	33,819	97,511	36,423	94,666	35,391	88,374	34,662	80,914
Total	115,224	287,751	136,228	283,117	140,891	273,496	137,614	260,437	134,763	244,273

Measure DEV: Developmental Screening in the First Three Years of Life



Key Findings:

- Each age category shows statistically significant increases ($p<.05$) in screening rates from CY2010 to CY2014.
- From CY2010 to CY2014 among those screened by 1 year of age, the rate increased by 12.4 percentage points, an increase of 23.6 percent; among 2 year olds, the rate increased by 16.5 percentage points, or 40.2 percent; and among those 3 years of age, the rate increased by 15.8 percentage points, an increase of 58.5 percent.
- Among the total population of 1 to 3 year olds, the screening rate from CY2010 to CY2014 increased by 15.2 percentage points, an increase of 38.0 percent.
- The screening rate is highest for children during the first year of age and lower for 2 and 3 year olds.
- While increases from the end-point years are great, the magnitude of increase is slowing with each successive year. This is especially true among those one year of age.
- HFS conducted quality improvement initiatives to promote objective developmental screening. The focused initiatives concluded in 2013. Sustaining these rates must be maintained through efforts of the medical home, care coordination and practicing evidence-based care.

Measure W15: Well-Child Visits in the First 15 Months of Life

Measure Description: The percentage of children who turned 15 months old during the measurement year and had 0, 1, 2, 3, 4, 5, or 6 or more well-child visits with a primary care provider during their first 15 months of life. To be counted, children must have turned 15 months old during the measurement year (calendar year) and must have been continuously enrolled from 31 days to 15 months of age.

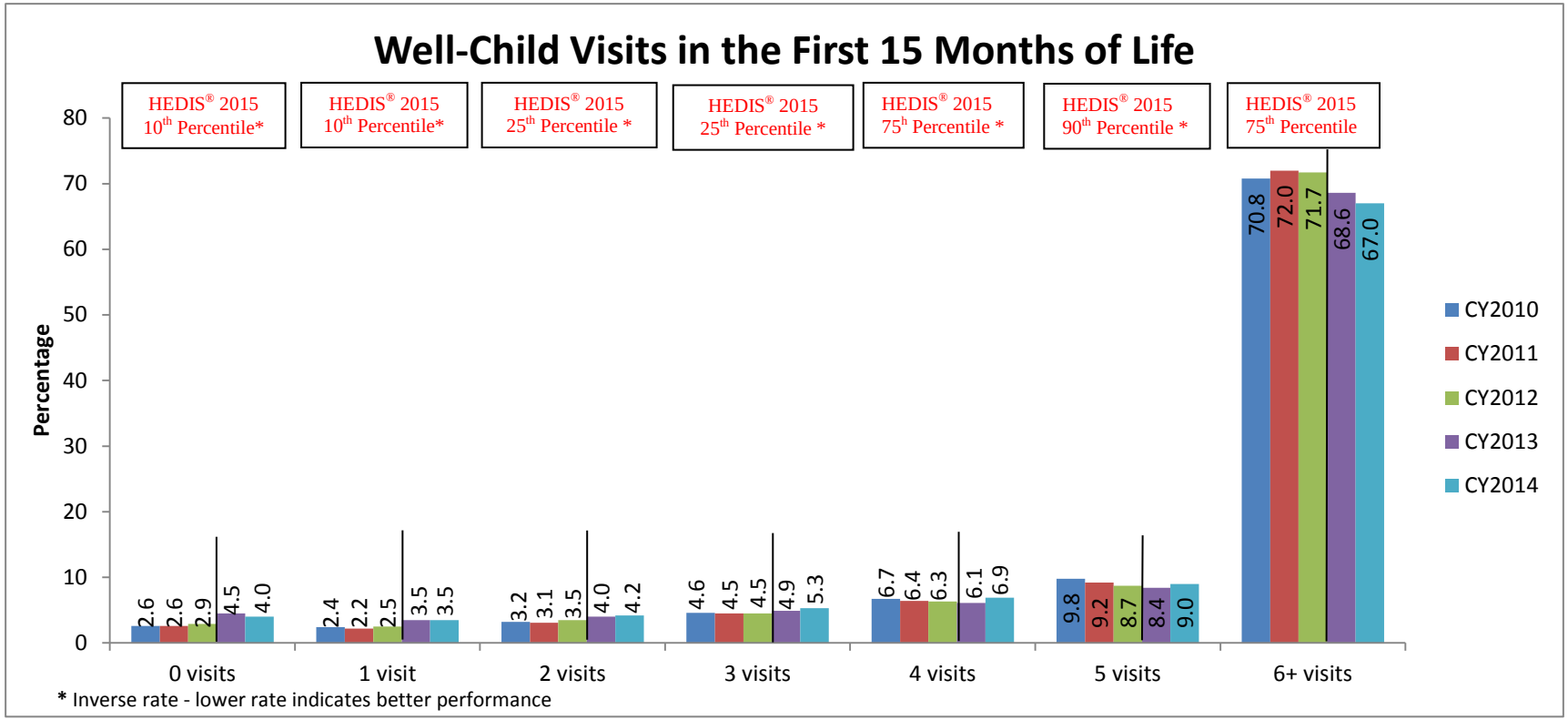
Notes on Measure Programming or Differences from Measure Specifications:

- CY2010 rates were generated with HEDIS® 2012 specifications.
- The solid vertical line indicates that rates for CY2013and after are not comparable to CY2010-CY2012. Before CY2013, PCP was not defined and the measure accepted all types. Measure programming was changed to assess by provider type code and specialty type to assure selection of only primary care providers.
- With the shift to a predominately managed care healthcare delivery system, the CY2014 rates may be affected by incomplete encounter data.

Eligible Population:

	CY2010		CY2011		CY2012		CY2013		CY2014	
	Numerator	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**
0 Visits	2,413	91,137	2,317	88,630	2,463	85,969	3,761	82,698	3,181	79,214
1 Visit	2,145	91,137	1,966	88,630	2,128	85,969	2,917	82,698	2,765	79,214
2 Visits	2,893	91,137	2,779	88,630	3,000	85,969	3,282	82,698	3,352	79,214
3 Visits	4,179	91,137	3,989	88,630	3,880	85,969	4,013	82,698	4,227	79,214
4 Visits	6,093	91,137	5,630	88,630	5,438	85,969	5,047	82,698	5,500	79,214
5 Visits	8,888	91,137	8,164	88,630	7,457	85,969	6,941	82,698	7,154	79,214
6+ Visits	64,526	91,137	63,785	88,630	61,603	85,969	56,737	82,698	53,035	79,214

Measure W15: Well-Child Visits in the First 15 Months of Life



Key Findings:

- For 0 to 5 visit categories lower rates indicate better performance. Rates at the HEDIS® 2015 10th percentile for 0 and 1 visit categories indicate poor performance for CY2014. This also is true for the CY2014 2 and 3 visit categories that are at the HEDIS® 2015 25th percentile.
- During CY2014, the HEDIS® 2015 75th percentile was achieved for 6+ visit rate.
- In CY2013 and CY2014, just over two-thirds of children received 6 or more well care visits by 15 months of age. Receipt of 6 or more well care visits decreased from CY2013 to CY2014 by 1.6 percentage points which is a statistically significant ($p<.05$) decline.
- Performance on this measure shows need for improvement.

Measure W34: Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

Measure Description: The percentage of children ages 3 through 6 who had one or more well-child visits with a PCP during the measurement year. To be counted, children must have reached their third, fourth, fifth or sixth birthday by the end of the measurement year and must have been continuously enrolled during the measurement year.

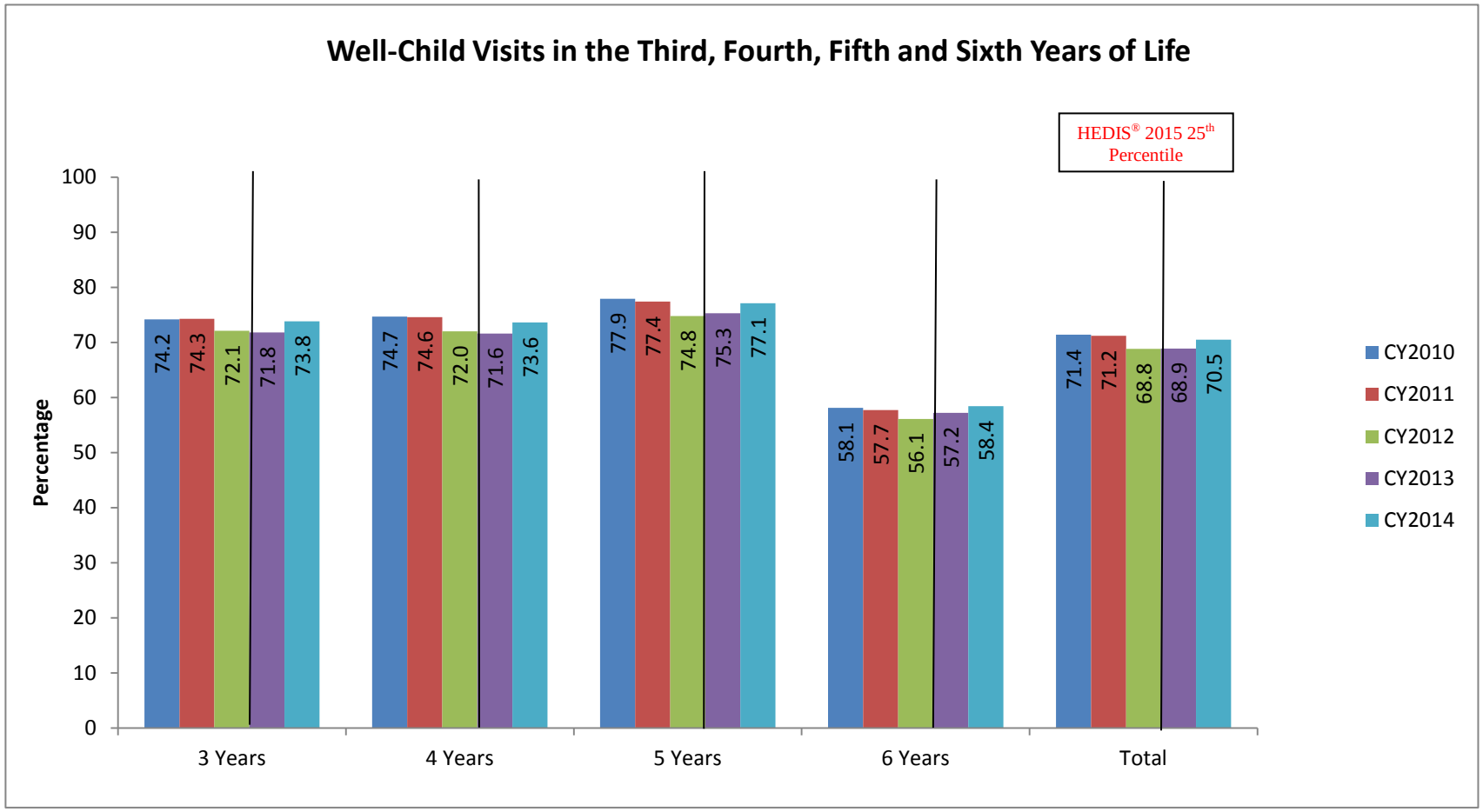
Notes on Measure Programming or Differences from Measure Specifications:

- CY2010 rates were generated with HEDIS® 2012 specifications.
- The solid vertical line indicates that rates for CY2013 and after are not comparable to CY2010-CY2012. Before CY2013, PCP was not defined and the measure accepted all types. Measure programming was changed to assess by provider type code and specialty type to assure selection of only primary care providers.
- With the shift to a predominately managed care healthcare delivery system, the CY2014 rates may be affected by incomplete encounter data.

Eligible Population:

	CY2010		CY2011		CY2012		CY2013		CY2014	
	Numerator	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**
3 Years	71,953	96,950	72,008	96,883	66,312	91,953	59,267	82,549	55,540	75,220
4 Years	70,666	94,610	73,175	98,133	68,615	95,235	61,696	86,138	57,252	77,743
5 Years	70,460	90,435	74,372	96,070	71,799	96,039	66,937	88,890	62,212	80,655
6 Years	50,775	87,382	53,111	92,084	52,677	93,872	51,268	89,663	48,408	82,892
Total	263,854	369,377	272,666	383,170	259,403	377,099	239,168	347,240	223,412	316,510

Measure W34: Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life



Key Findings:

- In CY2014, the total rate for children ages 3, 4, 5, and 6 years who received one or more well-child visits achieved the 25th percentile.
- The CY2014 total for ages 3-6 years shows over two-thirds received at least one preventive visit during the year.
- From CY2013 to CY2014 there was a statistically significant ($p<.05$) increase in each of the individual age categories and the total. However, the well-child visit rate for children in each age group does not meet the 50th percentile and presents opportunity for improvement. This need for improvement is especially true among those age 6 where just over half received a well-child visit.

Measure AWC: Adolescent Well-Care Visits

Measure Description: The percentage of enrolled adolescents ages 12 through 20 who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement year. To be counted, adolescents must have reached their 13th, 14th, 15th, 16th, 17th, 18th, 19th, or 20th birthday by the end of the measurement year and must have been continuously enrolled during the measurement year.

Notes on Measure Programming or Differences from Measure Specifications:

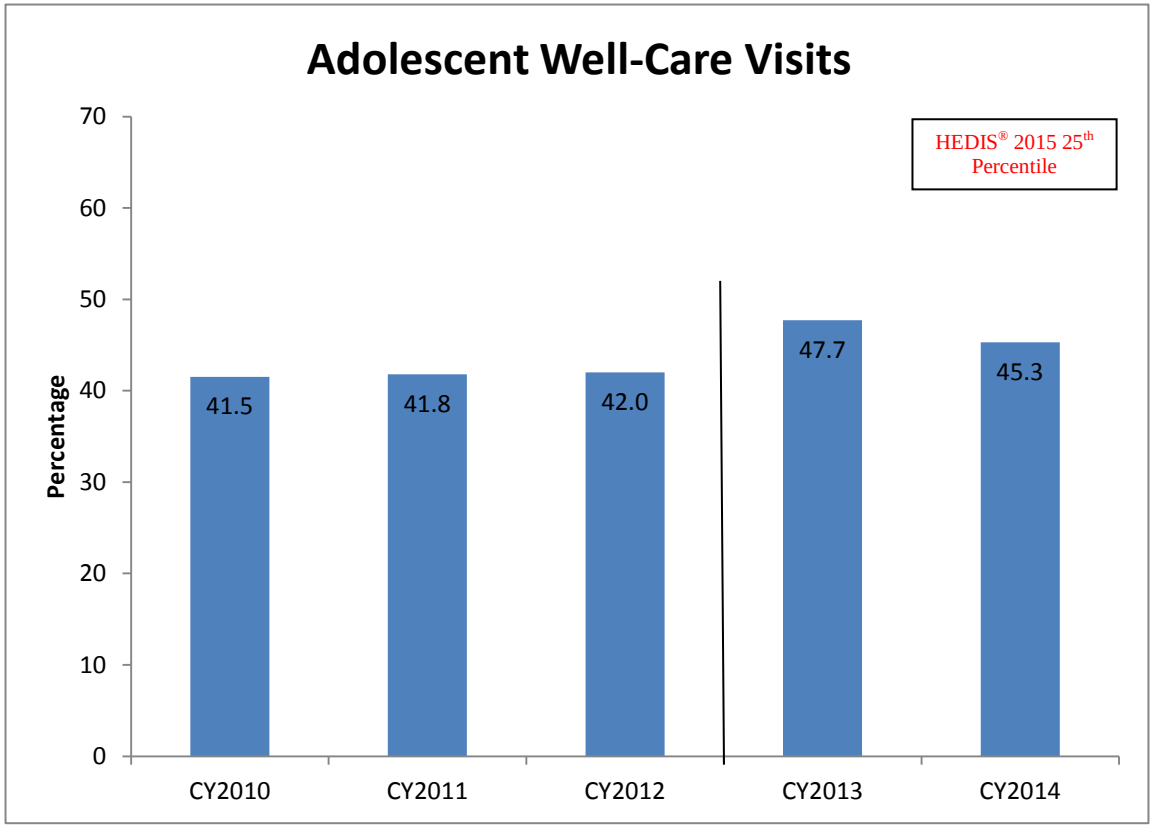
- The solid vertical line indicates that CY2013 rates are not comparable to CY2010-CY2012. Before CY2013, PCP was too narrowly defined using a restrictive set of codes thereby reducing rates. Programming was revised in CY2013 to appropriately define PCPs.
- With the shift to a predominately managed care healthcare delivery system, the CY2014 rate may be affected by incomplete encounter data.

Eligible Population:

Calendar Year	Numerator	Denominator
2010	222,762	537,320
2011	233,792	559,837
2012	235,694	561,494
2013	256,858	538,502
2014	244,171	539,135

Key Findings:

- The CY2014 adolescent well-child visit rate achieved the HEDIS® 2015 25th percentile.
- The decrease of 2.4 percentage points, -5.0 percent, from CY2013 to CY2014 is statistically significant ($p<.05$). This may be the result of underreporting CY2014 encounter data by managed care plans.
- Consistently, less than one-half of adolescents receive a comprehensive well care visit during the year. This presents an opportunity for improvement.



Measure CHL: Chlamydia Screening in Women

Measure Description: The percentage of women ages 16 through 24 years of age who were identified as sexually active and had at least one test for Chlamydia during the measurement year. The Child Core Measure Set requires reporting of only the age group from 16-20. Both age groups are reported here for comparison. Continuous enrollment during the measurement year is required for inclusion in this measure.

Notes on Measure Programming or Differences from Measure Specifications:

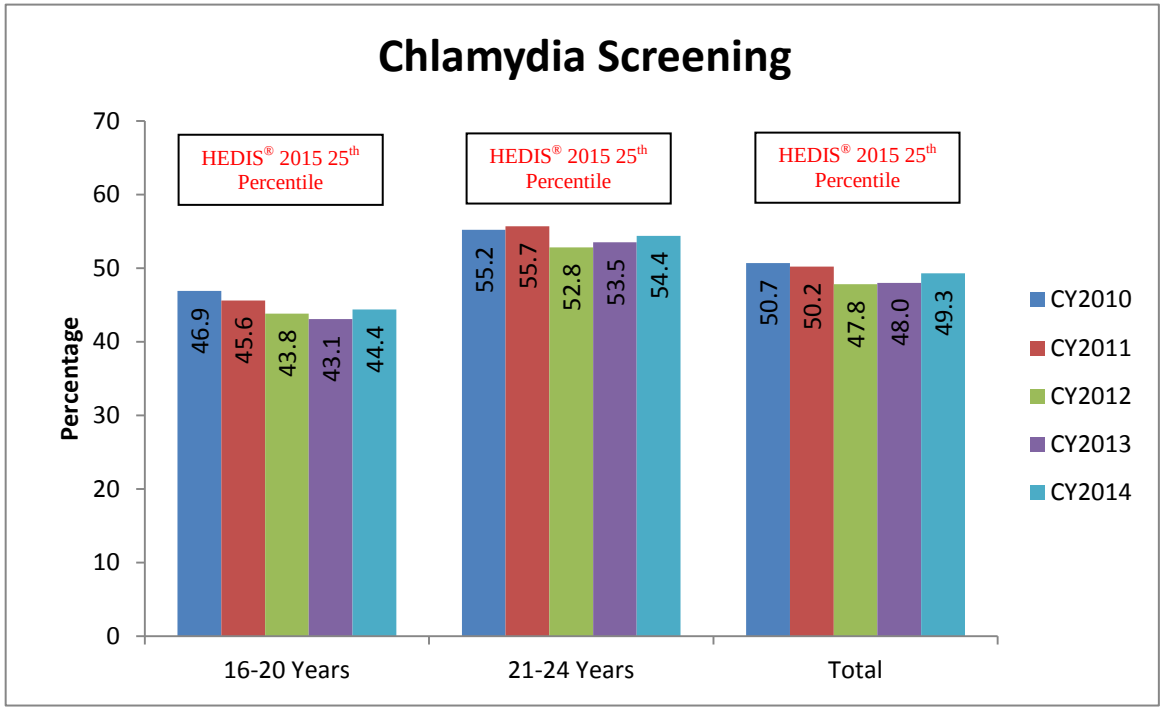
- CY2010 rates were generated with HEDIS® 2009 specifications and CY2012 with HEDIS® 2012 specifications.
- With the shift to a predominately managed care healthcare delivery system, the CY2014 rates may be affected by incomplete encounter data.

Eligible Population:

	CY2010		CY2011		CY2012		CY2013		CY2014	
	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator
16-20 Years	26,339	56,171	25,264	55,466	22,434	51,780	19,895	46,184	21,332	48,045
21-24 Years	25,696	46,562	25,959	46,643	24,407	46,210	22,544	42,169	25,259	46,358
Total	52,035	102,733	51,223	102,109	46,841	97,990	42,439	88,353	46,591	94,403

Key Findings:

- Comparing CY2010 to CY2014 there is a statistically significant decrease ($p<.05$) in Chlamydia screening among those 16-20, 21-24 and total (ages 16-24).
- There is a statistically significant ($p<.05$) increase in all categories from CY2013 to CY2014.
- The Chlamydia screening rate is consistently lower from CY2010 to CY2014 among 16-20 year olds compared to those 21-24 years of age.
- The CY2014 screening rates in both age groups and the total cohort are at the HEDIS® 25th percentile. While this is an improvement over previous years where the 10th percentile was achieved, there is opportunity for improvement.



Measure PDENT: Percent of Eligibles Who Received Preventive Dental Services

Measure Description: The percentage of individuals ages 1 through 20 who are enrolled in Medicaid or CHIP Medicaid Expansion programs, are eligible for Early Periodic Screening, Diagnosis and Treatment (EPSDT) services, and who received preventive dental services. To be counted for this measure, children ages 1 through 20 must be continuously enrolled for at least 90 days during the measurement year.

Notes on Measure Programming or Differences from Measure Specifications:

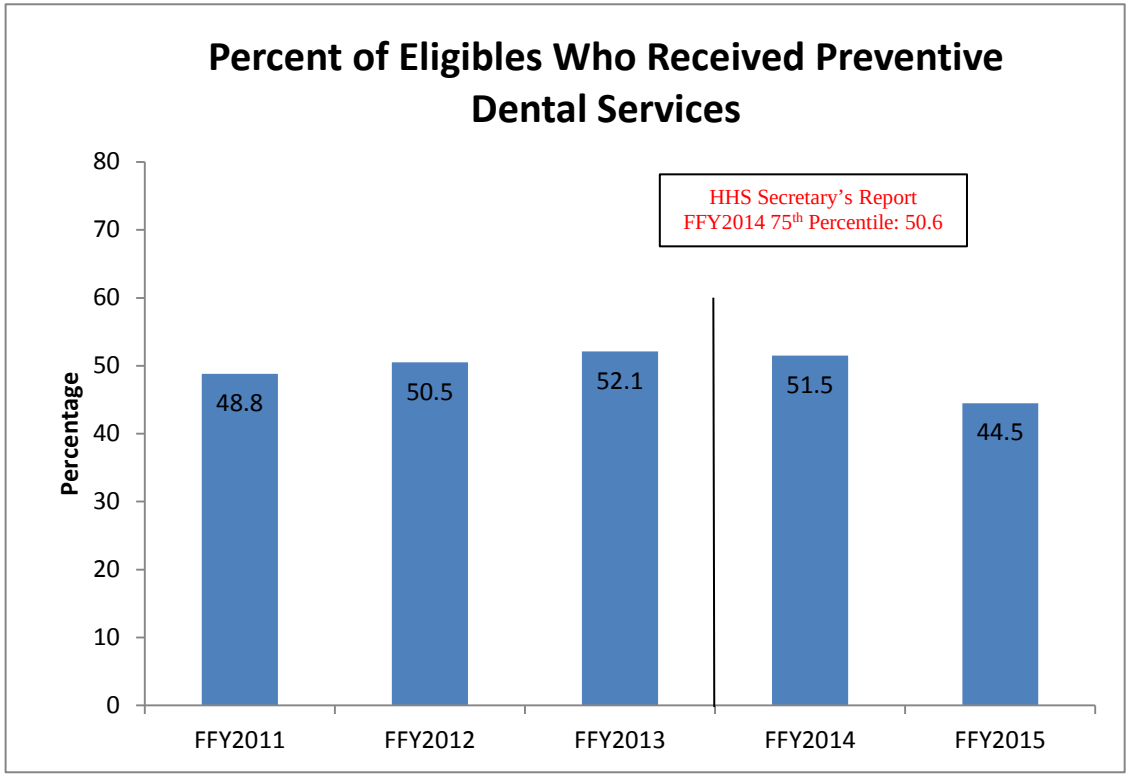
- The solid vertical line indicates that rates for FFY2014 and after are not comparable to FFY2011-FFY2013 rates. During November 2014, the FFY2014 reporting guidance was revised by CMS. Rates for FFY2014 and after are based on the revised guidance.
- The percentile shown in the chart is from the HHS Secretary's Annual Report on the Quality of Care for Children in Medicaid and CHIP for FFY2014 reflecting CY2013 data for most states.
- With the shift to a predominately managed care healthcare delivery system, rates beginning with FFY2014 may be affected by incomplete encounter data.

Eligible Population:

Federal Fiscal Year	Numerator	Denominator
2011	759,190	1,554,421
2012	798,269	1,581,522
2013	817,200	1,568,087
2014	796,490	1,547,301
2015	649,988	1,459,801

Key Findings:

- Performance decreases for FFY2015 are the result of underreported dental encounter data by managed care plans. Between FFY2014 and FFY2015, Illinois Medicaid/CHIP experienced significant movement from fee for service to managed care. The number of Medicaid health plans grew from three to twelve and over 1 million recipients transitioned into managed care.
- Based on HFS' FFY2014 data, the FFY2014 HHS Secretary's Report 75th percentile was achieved.



Measure MMA: Medication Management for People with Asthma

Measure Description: The percentage of children ages 5 through 20 that were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported: 1) Percentage of children who remained on an asthma controller medication for at least 50 percent of their treatment period, and 2) Percentage of children who remained on an asthma controller medication for at least 75 percent of their treatment period. The treatment period is defined as the period of time beginning on the Index Prescription Start Date (IPSD) through the last day of the measurement year.

Notes on Measure Programming or Differences from Measure Specifications:

- With the shift to a predominately managed care healthcare delivery system, the CY2014 rates may be affected by incomplete encounter data.

Eligible Population:

	CY2012				CY2013				CY2014			
	Proportion of Days Covered ≥50		Proportion of Days Covered ≥75		Proportion of Days Covered ≥50		Proportion of Days Covered ≥75		Proportion of Days Covered ≥50		Proportion of Days Covered ≥75	
	Num.	Den.	Num.	Den.	Num.	Den.	Num.	Den.	Num.	Den.	Num.	Den.
5-11 Years	7,620	18,320	3,560	18,320	6,795	14,787	2,933	14,787	5,906	13,202	2,547	13,202
12-18 Years	4,173	11,332	1,893	11,332	3,830	9,464	1,622	9,464	3,538	8,744	1,520	8,744
19-20 Years	147	445	83	445	121	310	58	310	232	530	100	530
5-20 Years	11,940	30,097	5,536	30,097	10,746	24,561	4,613	24,561	9,676	22,476	4,167	22,476

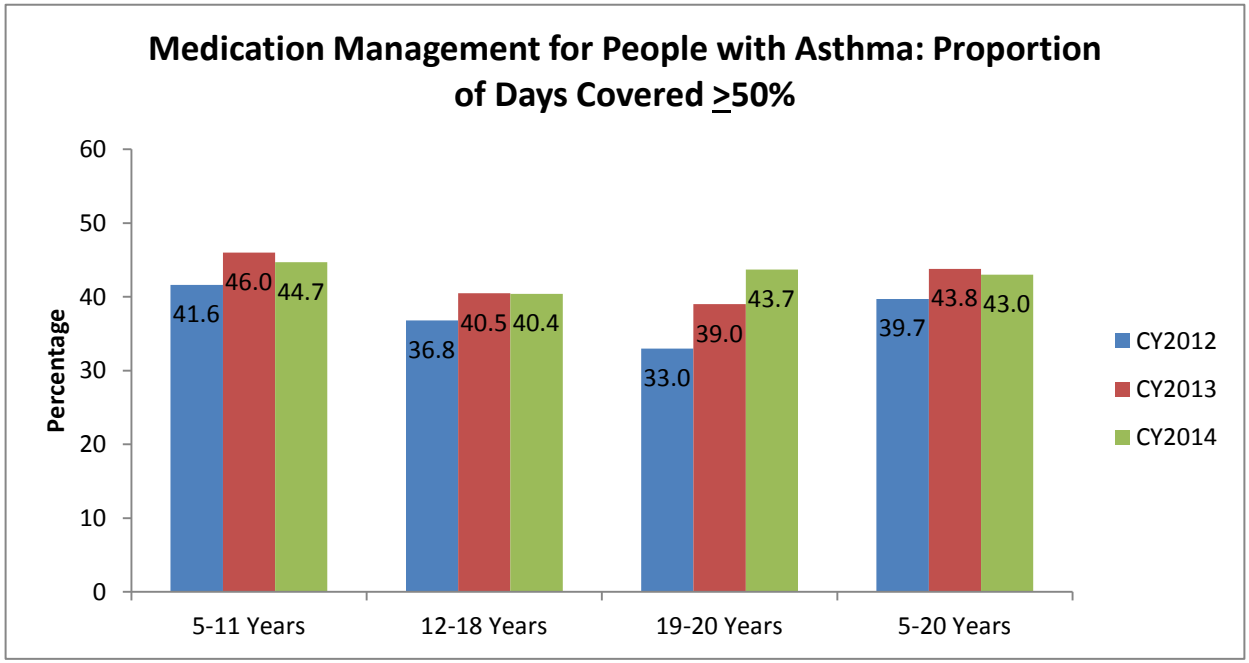
Key Findings – Proportion of Days Covered ≥50%:

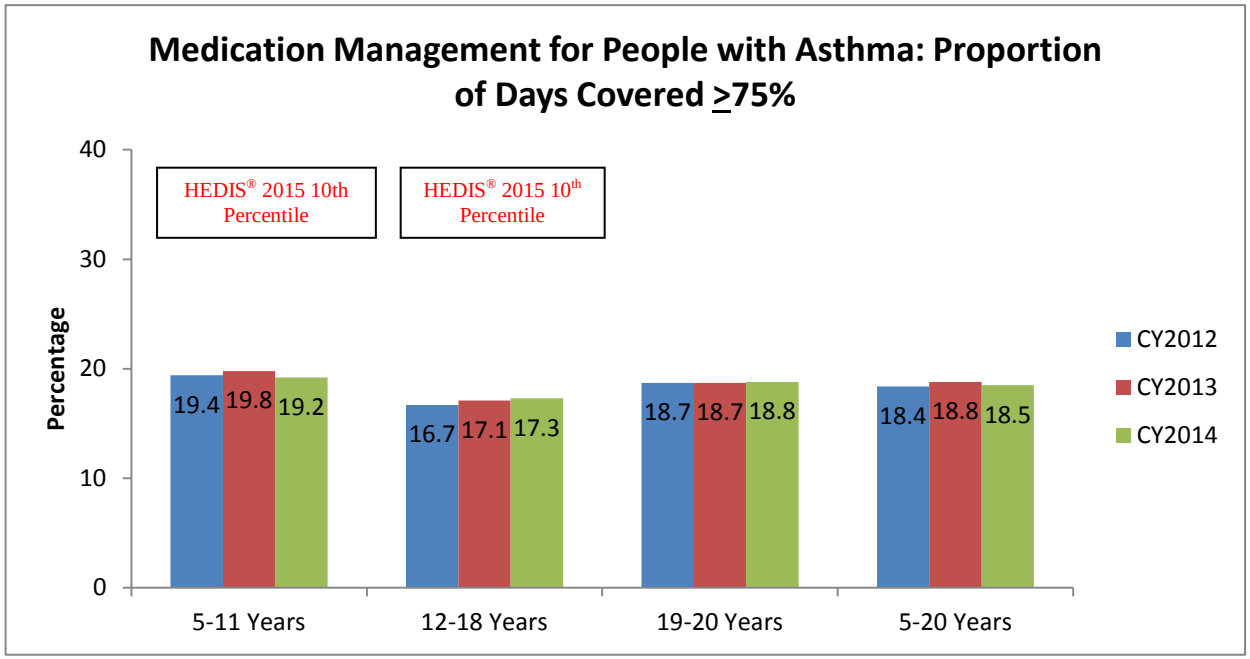
- From CY2012 to CY2014, there were statistically significant ($p<.05$) increases in medication management in each age category and the total (ages 5-20).
- From CY2013 to CY2014, those 5-11 years experienced a statistically significant ($p<.05$) decrease in performance while those 12-18 and 19-20 years, and the total (ages 5-20) experienced non-statistically significant changes.
- 2015 HEDIS percentiles are not available for this proportion of covered days.

Key Findings – Proportion of Days Covered ≥75%:

- Across each age category fewer than 20 percent remain on asthma medication for ≥75% of covered days, showing a need for improvement.
- From CY2012 to CY2014 there were no significant changes in rates within any age category.
- Among those 5-11 and12-18 years this measure is at the 10th percentile, showing need for improvement.

Measure MMA: Medication Management for People with Asthma





Measure FUH: Follow-Up after Hospitalization for Mental Illness

Measure Description: The percentage of discharges for children ages 6 through 20 who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. Two rates are reported:

- The percentage of discharges for which children received follow-up within 7 days of discharge.
- The percentage of discharges for which children received follow-up within 30 days of discharge.

To be counted, the children must be continuously enrolled from the date of discharge through 30 days after discharge.

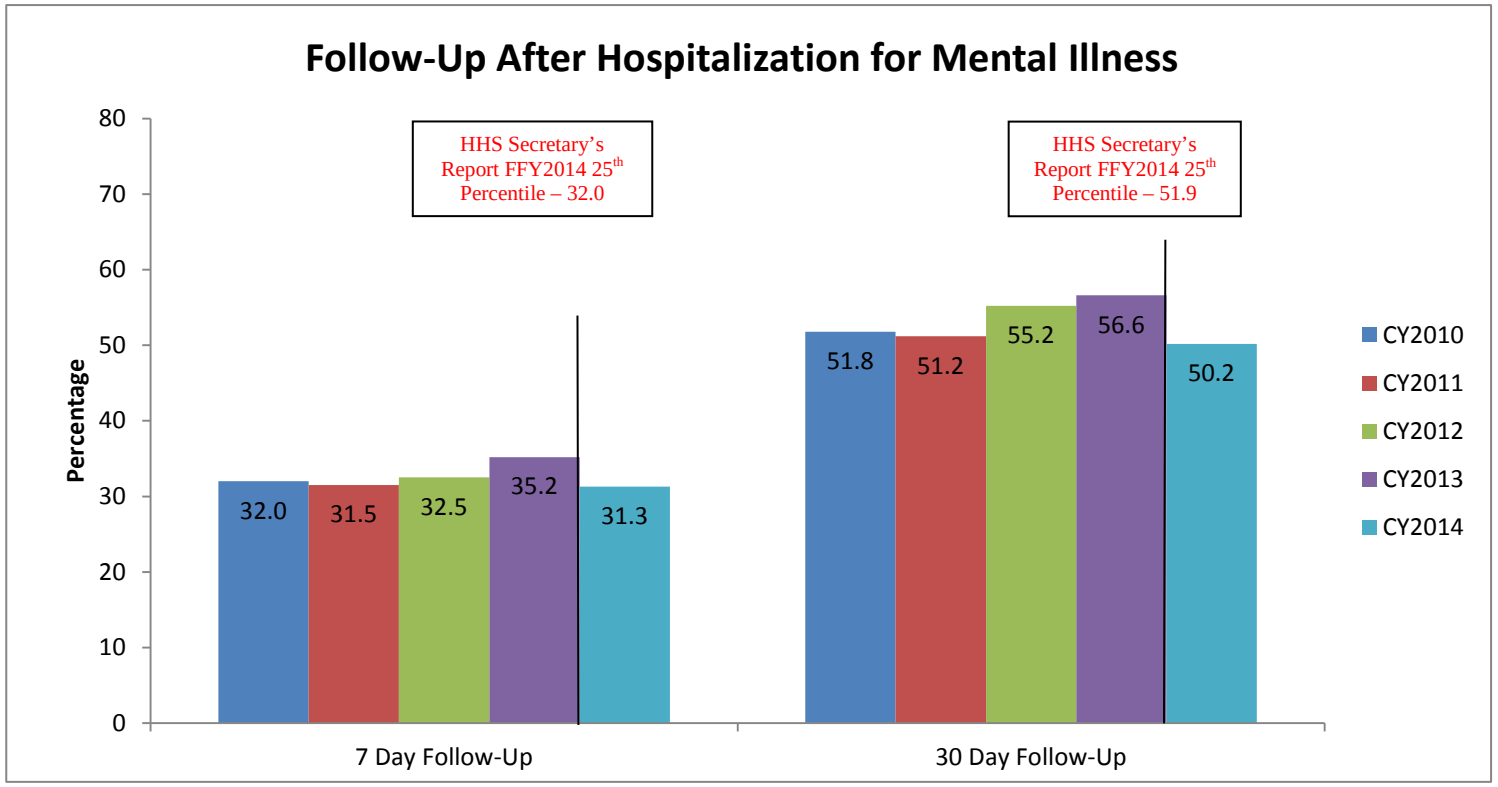
Notes on Measure Programming or Differences from Measure Specifications:

- CY2010 rates were generated with HEDIS® 2012 specifications.
- The solid vertical line indicates that the CY2014 data are not comparable to previous years due to measure reprogramming. The denominator increased due to inclusion of rejected claims that were not previously used as per the specifications and changes to the exclusion logic. Additionally, HFS must convert HEDIS® Place of Service codes using a standard conversion to HFS Place of Service codes with specific exceptions for this measure to meet the intent of the specifications.
- While calculated using HEDIS® specifications that include ages ≥6, this measure is reported per the Child Core Set requirements and includes children ages 6 through 20. The percentiles shown in the chart are from the HHS Secretary's Annual Report on the Quality of Care for Children in Medicaid and CHIP for FFY2014 reflecting CY2013 data for most states.
- HFS is unable to identify all prescribing providers using the methodology required in the specifications; therefore, we believe follow-up visits are undercounted.
- With the shift to a predominately managed care healthcare delivery system, the CY2014 rates may be affected by incomplete encounter data.

Eligible Population:

	CY2010		CY2011		CY2012		CY2013		CY2014	
	Numerator	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**
7 Day Follow-Up	621	1,942	558	1,770	686	2,014	757	2,151	6,966	22,237
30 Day Follow-Up	1,006	1,942	906	1,770	1,166	2,014	1,218	2,151	11,182	22,237

Measure FUH: Follow-Up after Hospitalization for Mental Illness



Key Findings:

- Using data reported by states for FFY2014 (CY2013 data for most states), the HHS Secretary's report 25th percentiles for CY2013 7 and 30 day follow-up were achieved. This shows need for improvement.

Measure ADD: Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication

Measure Description: The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication that had at least three follow-up care visits within a 10-month period, one of which was within 30 days from the time the first ADHD medication was dispensed. Two rates are reported.

- *Initiation Phase:* The percentage of children 6 through 12 years old as of the Index Prescription Start Date (IPSD) with an ambulatory prescription dispensed for ADHD medication and who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase. To be counted, the children must be continuously enrolled in Medicaid/CHIP for 120 days (4 months) prior to the IPSD through 30 days (1 month) after the IPSD.
- *Continuation and Maintenance (C&M) Phase:* The percentage of children 6 through 12 years old as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended. To be counted, the children must be continuously enrolled in Medicaid or CHIP for 120 days (4 months) prior to the IPSD through 30 days (1 month) after the IPSD.

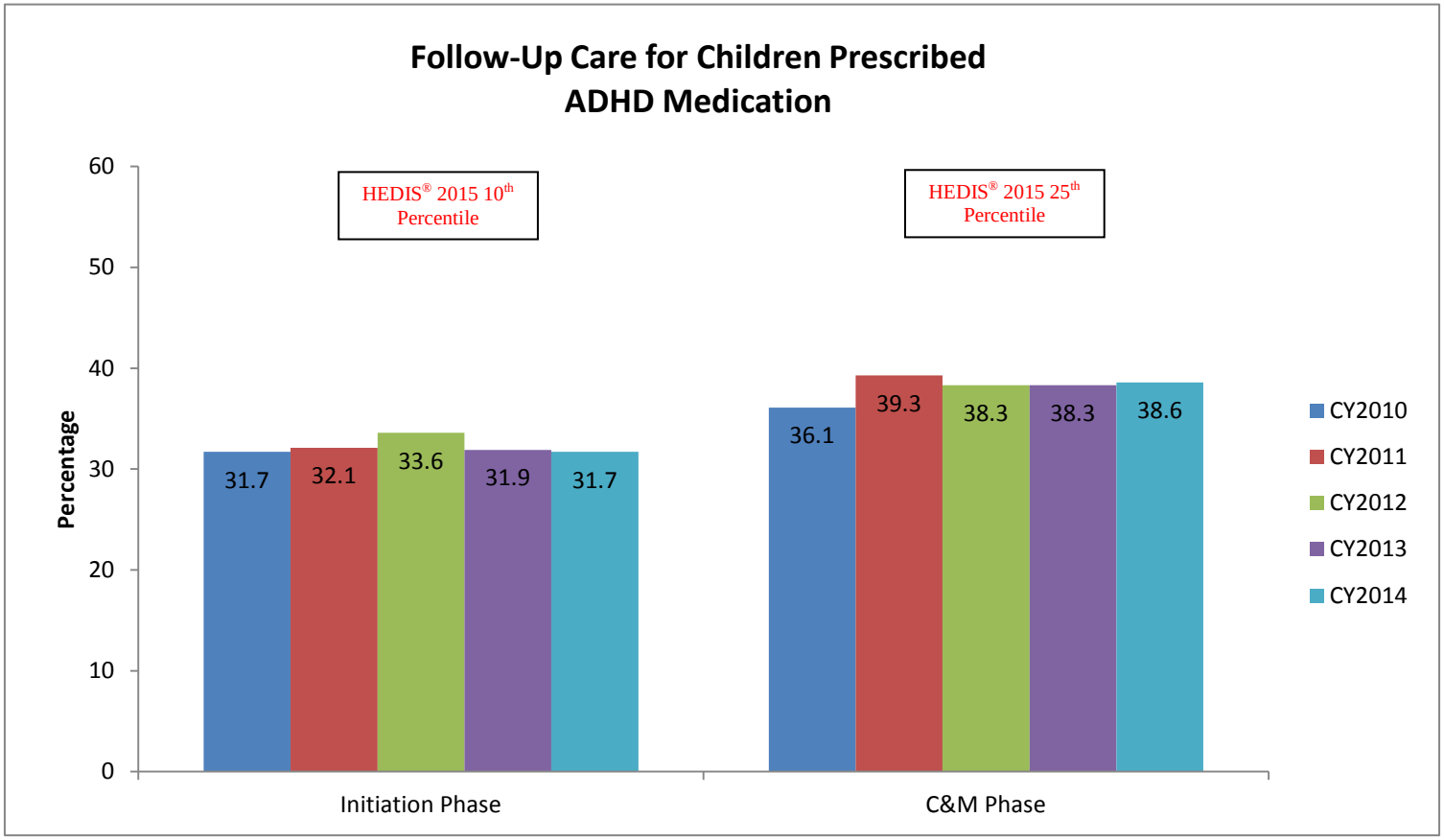
Notes on Measure Programming or Differences from Measure Specifications:

- CY2010-CY2012 rates were generated with HEDIS® 2012 specifications.
- HFS must convert HEDIS® Place of Service codes using a standard conversion to HFS Place of Service codes with specific exceptions for this measure to meet the intent of the specifications.
- A considerable number of medication management follow-up visits are conducted in community mental health settings. Since these visits do not conform to HEDIS® guidelines defining "prescribing provider", follow-up visits conducted in these settings are not included in the measure resulting in undercounting visits.
- With the shift to a predominately managed care healthcare delivery system, the CY2014 rates may be affected by incomplete encounter data.

Eligible Population:

	CY2010		CY2011		CY2012		CY2013		CY 2014	
	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator
Initiation Phase	3,936	12,401	4,232	13,202	4,935	14,711	4,616	14,481	4,370	13,763
C & M Phase	654	1,811	1,451	3,694	1,601	4,178	1,335	3,482	1,222	3,160

Measure ADD: Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication



Key Findings:

- From CY2010 to CY2014 follow-up during the Initiation Phase has remained relatively stable.
- From CY2010 to CY2014 there was a non-statistically significant increase of 2.5 percentage points, or 6.9 percent, in follow-up during the C&M Phase.
- Improvement is needed since follow-up occurred for slightly less than one-third during the Initiation Phase and just over one-third in the C&M phase.
- Additionally, the Initiation and C&M phases are at the 10th and 25th percentiles, respectively, indicating there is room for improvement during both phases.

Measure AMB: Ambulatory Care – Emergency Department Visits

Measure Description: The rate of emergency department (ED) visits per 1,000 member months among children through age 19. A lower rate indicates better performance.

Notes on Measure Programming or Differences from Measure Specifications:

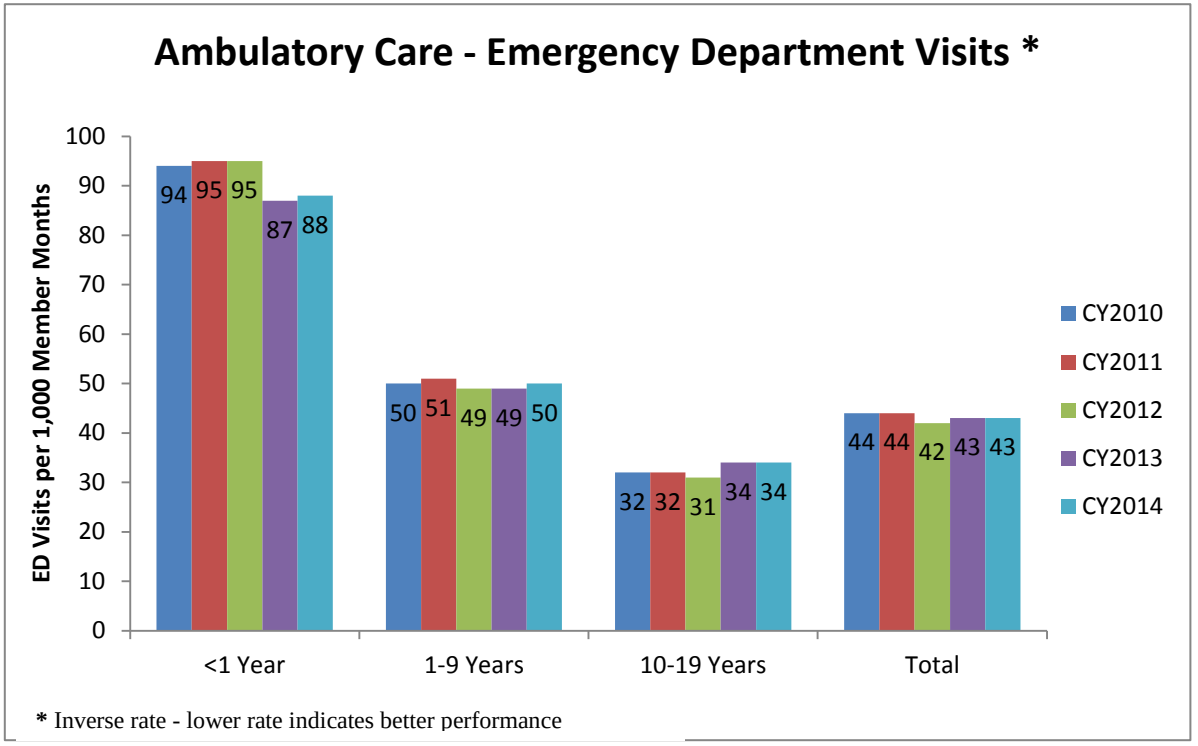
- With the shift to a predominately managed care healthcare delivery system, the CY2014 rates may be affected by incomplete encounter data.

Eligible Population:

	CY2010		CY2011		CY2012		CY2013		CY2014	
	Numerator (ED Visits)	Denominator (Member Months)	Numerator (ED Visits)	Denominator (Member Months)	Numerator (ED Visits)	Denominator (Member Months)	Numerator (ED Visits)	Denominator (Member Months)	Numerator (ED Visits)	Denominator (Member Months)
<1 Year	52,261	553,993	50,927	536,204	50,200	526,528	45,550	524,161	46,061	521,082
1-9 Years	448,312	9,042,887	470,100	9,177,349	448,907	9,098,690	492,038	9,958,474	481,180	9,559,182
10-19 Years	234,522	7,298,683	241,277	7,586,574	234,955	7,697,891	295,001	8,723,537	310,168	8,972,841
Total	735,095	16,895,563	762,304	17,300,127	734,062	17,323,109	832,589	19,206,172	837,409	19,053,105

Key Findings:

- From CY2010 to CY2014, there were statistically significant ($p<.05$) decreases in ambulatory care emergency department visits within the <1 year age category and the total.
- However, among those 10-19 years from CY2010 to CY2014 there was a statistically significant increase ($p<.05$).
- HEDIS 2015 percentiles are not available for the age categories or total.
- There is room for improvement in each age category. Among those 1-9 and 10-19 years the rates have been stable or increased over the last two years.



***** Inverse rate - lower rate indicates better performance

Measure CPC: Consumer Assessment of Healthcare Providers and Systems® (CAHPS) 5.0H

Measure Description: This is a survey-based measure of the general child population and, as a sub-set of that population, children with chronic conditions. The measure assesses parents' experiences with their child's health care. Four global rating questions of overall satisfaction are provided: 1) Rating of All Health Care, 2) Rating of Personal Doctor, 3) Rating of Specialist Seen Most Often, and 4) Rating of Health Plan. Five composite scores summarize key response areas: 1) Customer Satisfaction, 2) Getting Care Quickly, 3) Getting Needed Care, 4) How Well Doctors Communicate, and 5) Shared Decision Making. Additional questions are asked of children who are identified using general survey responses as children with chronic conditions. Among children with chronic conditions (CCC) additional CCC composites assess: 1) Access to Specialized Services, 2) Family Centered Care – Personal Doctor Who Knows Child, and 3) Coordination of Care for CCC. The survey was implemented by a third party vendor in compliance with CAHPS® guidelines using a mixed methodology of mail and phone surveying to increase the overall response rate.

Notes on Measure Programming or Differences from Measure Specifications:

- 2015 is the most recent available data. The rates represent the CAHPS® results for the combined Illinois Title XIX (Medicaid) and Title XXI (CHIP) programs (i.e., statewide aggregate rates). The statewide aggregate rates were weighted based on the size of the total eligible population for each program (i.e., Title XIX and Title XXI) at the time the CAHPS® survey samples were drawn.
- A series of questions included in the CAHPS® 5.0H Child Medicaid Health Plan Survey with Children with Chronic Conditions (CCC) measurement set was used to identify children with chronic conditions (i.e., CCC screener questions). The survey responses for child members in both the general child sample and the CCC supplemental sample were analyzed to determine which child members had chronic conditions. Therefore, the general child population of children (i.e., general child sample) includes children with and without chronic conditions based on the responses to the survey questions. Based on parents'/caretakers' responses to the CCC screener questions, these completed surveys were used to calculate the child with chronic conditions (CCC) CAHPS® results presented in this report.
- The General Child CAHPS® results presented in this report are based on the completed surveys returned for the general child population.

Eligible Population:

2015	Sample Size	Total Complete	Complete by Phone	Complete by Mail	Ineligible	Final Sample Size	Response Rate
Total Population	7,310	2,601	985	1,616	99	7,211	36.07%
Title XIX (Medicaid)	3,655	970	424	546	29	3,626	26.75%
Title XXI (CHIP)	3,655	1,631	561	1,070	70	3,585	45.50%

Measure CPC: Consumer Assessment of Healthcare Providers and Systems® (CAHPS) 5.0H

2015 General Child and Children with Chronic Conditions (CCC) CAHPS® Result Summary Description	General Child	Child w/Chronic Condition(s)	General Child National Comparison	General Child Trend 2013 to 2015
Global Ratings				
Rating of Health Plan (% Responding 9 or 10 on scale of 0-10)	55.3%	51.2%	★	---
Rating of All Health Care (% Responding 9 or 10 on scale of 0-10)	62.4%	59.2%	★★★	---
Rating of Personal Doctor (% Responding 9 or 10 on scale of 0-10)	73.0%	74.4%	★★★★	---
Rating of Specialist Seen Most Often (% Responding 9 or 10 on scale of 0-10)	70.9%	69.2%	★★★★	---
Composite Measures				
Getting Needed Care (% Responding "Usually" or "Always")	81.1%	83.0%	★	⬆
Getting Care Quickly (% Responding "Usually" or "Always")	85.3%	89.5%	★	⬇
How Well Doctors Communicate (% Responding "Usually" or "Always")	92.0%	92.9%	★★	---
Customer Service (% Responding "Usually" or "Always")	86.4%	85.7%	★	---
Shared Decision Making (% Responding "A lot" or "Yes")	76.9%	80.9%		
Children with Chronic Conditions (CCC) Composites and Items				**CCC Trend 2013 to 2015**
Access to Specialized Services		67.9%		---
Family-Centered Care (FCC): Personal Doctor Who Knows Child		87.0%		---
Coordination of Care for Children with Chronic Conditions		79.9%		⬆
Access to Prescription Medicines		89.0%		⬆
FCC: Getting Needed Information		88.6%		---

Star assignments based on national percentiles:
Star ratings are based on a three point mean scores calculated by Health Services Advisory Group, Inc. (HSAG) using an NCQA-approved scoring methodology. The results were then compared to published NCQA HEDIS® Benchmarks and Thresholds for Accreditation three point meant scores. NCQA data are not available for Shared Decision Making or for Children with Chronic Conditions questions.

90th or above ★★★★★ 75th to 89th ★★★★ 50th to 74th ★★★ 25th to 49th ★★ Below 25th ★

Trend analysis:
Statistically significantly higher ⬆ Statistically significantly lower ⬇ No statistically significant difference ---

Child Core Set Measures Not Reported

Measure Abbreviation and Name	Reason For Not Reporting
CLABSI - Pediatric Central-line Associated Bloodstream Infections Neonatal Intensive Care Unit and Pediatric Intensive Care Unit	CMS obtains data directly from CDC; states not required to collect data or report to CMS
BHRA - Behavioral Health Risk Assessment	E-specified measure; HFS does not have the ability to report e-measures
SRA – Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	E-specified measure; HFS does not have the ability to report e-measures

Summary

Summary

Illinois has made substantial progress on reporting the core set from 13 measures in FFY2010 (the baseline year), to 17 measures in FFY2011, 20 measures in FFY2012, 25 measures in FFY2013, 21 reported in FFY2014 and 22 in FFY2015. Illinois focused on the core measures and the measurement process leading to improvements in the integrity of the data and programming of all HFS performance measures.

Enterprise Data Warehouse

Illinois' Enterprise Data Warehouse (EDW) is the foundation of performance measurement. The EDW is a repository that includes administrative claims data for Medicaid and CHIP participants in all delivery systems (fee-for-service, managed/coordinated care, and primary care case management), as well as data imported from other state agencies, including Vital Records data, and immunization registries. With the change in HFS' healthcare delivery system from fee-for-service to predominately managed care (see Delivery System Changes), the agency is focused on improving receipt of timely and complete encounter data.

Importing data from other state agencies comes with its own set of challenges and opportunities. Challenges include establishing needed authority by executing and maintaining cross-agency data sharing agreements, having needed resources in each agency to operationalize the data exchange, and working through complex issues, including data ownership, data access, and acceptable uses of data. The outcome, that far outweighs the challenges, includes a more robust data system with potential to improve quality measurement and care delivery.

Administrative Methodology

Illinois' decision to use the administrative method is based on the availability of data housed in the EDW. However, state budget constraints also contributed to this decision, since the hybrid method is expensive and the HFS budget has been under significant pressure.

- The administrative method results in a lower statewide rate due to incomplete or untimely encounter data. However, new contractual requirements are expected to improve the completeness and accuracy of encounter data over coming years.
- A limitation of using the administrative method is that it may underestimate rates due to lack of timely and complete data. Using the hybrid method, which includes medical record review, enhances the data by going to the source record to identify qualifying services.
- Differences in how states report the Child Core Set, such as, the methodology used (e.g., administrative, encounter, hybrid) and the population(s) included or excluded from the measures (e.g., Title XIX only, Title XXI only, MCO only, combined Title XIX and XXI), affect comparability among states reporting on the Child Core Set

While differences between the Child Core Set measure specifications and the specifications used for reporting herein continue to exist, they have been minimized to the extent possible.

Delivery System Changes

By January 2015, Illinois transitioned from a primarily fee-for-service delivery system to a managed/coordinated care system. Quality measures are essential to assessing performance within the delivery system and identifying areas in need of quality improvement. To assure consistency, Illinois developed its own "core set" of measures to be included in all contracts, which includes a number of the Child Core Set measures.

Summary

Data Integrity/Efficiencies
A number of changes were made to improve the efficiency of the performance measurement process and improve the integrity of the data.

- Beginning in April 2012, data audits are conducted annually by a certified External Quality Review Organization to improve upon the integrity of data and programming used for performance measurement.
- Performance measurement is used for a variety of purposes, and previously standardized performance measures were sometimes altered to suit those purposes. Performance measures now comply with nationally endorsed specifications, to the extent possible, with measures aligned across programs.
- A Quality of Care Measures Committee was formed to include all areas within HFS with responsibility for performance measurement for various programs. The Committee meets regularly and has made a number of decisions to improve the efficiency of the performance measurement process and the integrity of the data.
- HFS instituted programming that is table-driven and time-specific so that updates to measure coding schemes are more easily incorporated, less time consuming and anchored to the measurement period to which they apply.

Barriers
Revisions to the specifications consume a considerable amount of resources. Illinois has adopted an annual schedule for identifying changes, programming, testing, reporting, and auditing to assure that reporting timeframes are met, as well as timeframes required for other measure uses, such as bonus payments.

Performance Measurement
In programming the Child Core Set measures, a number of efficiencies were instituted to develop and maintain measures over time. Issues and questions about measures were identified and resolved through the Quality of Care Measures Committee. Improvements include greater consistency, alignment, and better data quality, resulting in more accurate performance measurement, not only for Child Core Set reporting purposes, but for measurement generally.

Many of the aforementioned improvements were instituted through the efforts of the CHIPRA Quality Demonstration Grant. In February 2016 the CHIPRA grant period ended. However, Illinois will continue annual reporting on the Child Core Set measures. HFS' work to improve performance measurement will be sustained through efforts of the Quality of Care Measures Committee and others involved in quality health measurement within HFS.

For further information or questions, contact:
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