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

Calendar Years 2009 through 2012

ILLINOIS CHIPRA Quality Demonstration Project
Improving Child Health and Medical Homes for Illinois ~~All~~Kids

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 by President Barack Obama 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).

CHIPRA Quality Demonstration Grant:
The CHIPRA legislation included direction to the Centers for Medicare and Medicaid (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 five-year grant period. The measures are reported annually to CMS. This report describes Illinois' experience in testing the core set of measures and presents results for the measures that Illinois calculated. Most measures include a four year trend period and reflect HEDIS® 2013 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, and 25 reported in FFY2013.
- HEDIS® 2013 percentiles were applied to 16 measures and a total of 48 distinct categories (e.g., age, immunization combination). In CY2012, three measures, Frequency of Ongoing Prenatal Care, Well Child Visits in the First 15 Months of Life, and Ambulatory Care – Emergency Department Visits, achieved the 50th percentile or higher.
- During CY2012, Frequency of Ongoing Prenatal Care achieved the HEDIS®2013 50th percentile for <21%, 21%-40% and 41%-60% of expected visits conducted; and the 90th percentile was achieved for 61%-80% and >81% of expected visits conducted. This shows that the majority of women receive adequate prenatal care.
- During CY2012, Well Child Visits in the First 15 Months of Life achieved the 50th percentile for the rate of 15 month olds receiving three visits during the year, the 75th percentile for the rates of four and six or more visits conducted in the year, and the 90th percentile for the five visit rate.
- The Ambulatory Care – Emergency Department visit rate per 1,000 member months achieved the 50th percentile for those <1 year of age and for those 1-9 years of age; and the 75th percentile for 10-19 year olds. Lower rates of emergency department utilization indicate better performance.
- 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.
- Through efforts of the CHIPRA grant, the Illinois Department of Healthcare and Family Services (HFS) has benefited from an improvement in the quality of data used in performance measurement. Moreover, measure programming efficiencies were achieved to ease the burden of ongoing measure update and maintenance.
- Compliance with the core measure specifications was initially challenging. Deviations from some of the core measure specifications continue to exist, but have been minimized to the extent possible. Deviations, 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 both have 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 FFY2013 reporting, the Child Core Set includes 26 measures.

The technical specifications for the core measure set require that specific methods be used for the collection and reporting 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 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 using the CHIP Annual Reporting Template System (CARTS). The rates reported in CARTS include the combined Title XIX (Medicaid) and Title XXI (CHIP) populations. The rates reported in CARTS 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 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 operates and 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.

May 2013 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
0060	NCQA	Annual Pediatric Hemoglobin A1C Testing
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 Preventative Dental Services
NA	CMS	Percentage of Eligibles that Received Dental Treatment 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
0002	NCQA	Appropriate Testing for Children with Pharyngitis
1381	Alabama Medicaid	Annual Percentage of Asthma Patients 2 through 20 Years Old with One or More Asthma-Related Emergency Room Visits
NA	NCQA	Ambulatory Care – Emergency Department (ED) Visits
NA	NCQA	Consumer Assessment of Healthcare Providers and Systems® (CHAPS) 5.0h (Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items)

Child Core Measure as of May 2013. 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; 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, areas for improvement, and demonstrate the success of programs and initiatives, and allows HFS to target efforts and resources to improve health care delivery.

Quality Improvement: Quality improvement initiatives (QII) are selected based on 1) information obtained from ongoing program evaluation and monitoring that identifies problems or barriers and/or areas for improvement, 2) HFS goals for improving health care outcomes, 3) compliance with care guidelines and/or federal requirements, and 4) research/literature. 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 involve provider education and technical assistance, provider feedback, identification of lessons learned and best practices, and monitoring over time to assess performance improvement.

Pay for Performance: HFS rewards primary care providers enrolled in the Primary Care Case Management Program (PCCM) for performance through bonus payments. Bonus payments are made to providers who meet or exceed performance thresholds on particular performance measures. HFS has seen tremendous 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. Reports are accessible on the HFS Reports web page.

Federal Participation/Compliance Reporting: HFS is required to report annually to the federal government on EPSDT services using the CMS-416 reporting format. The annual report provides basic 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 reporting process allows states to determine the number of screens provided in accordance with the EPSDT periodicity schedule, assess the percentage of children with health problems identified through the screens and those who were treated for medical or dental issues, and monitor provider participation and utilization patterns.

CHIPRA Child Health Quality Demonstration Grant Reporting: HFS, in partnership with the State of Florida, is one of ten grantees, involving eighteen states, testing a core set of children's health care quality measures. The measures are intended to demonstrate the quality of health care received by children enrolled in HFS' medical assistance programs (Medicaid and CHIP) and will be used by CMS to evaluate the quality of care nationally. The Child Core Set measures are reported annually to CMS.

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.

Future use of performance measurement includes:

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 substantially aligned with meaningful use measures.

Data Housed in the Enterprise Data Warehouse

Data Source	Time Period	Data Shared	Data Description
Current Data			
HFS	1996-2014	Claims	Information about health care services, including patient information, service location, provider of service, procedure, diagnosis, CPT codes
HFS	1996-2014	Recipient File	Patient-level information including eligibility, demographics, recipient ID
HFS	1996-2014	Provider File	Provider information including provider ID, provider type, address, billing address
IDPH	1990-2014	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	1960-2014	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	1960-2014	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	1970-2014*	Vital Records	All data elements contained in the "certifiable" portion and all "Information for Medical and Health Use Only" portion of the Birth (1970-2014), Death (1970-2010), and Fetal Death file (1999-2012). *Certified Vital Records are available from 1970-2010; Vital Records for 2011-2014 are not certified.
IDPH	2008-2014	Expanded Vital Records System	Expanded tables to contain new data from the new IDPH IVRS
IDPH	1970-2013	Out-of-State Vital Records	Out-of-state birth, death, and fetal death information for HFS enrollees
IDPH	1997-2014	Pre-Admission Screening	These data contain basic demographic data plus the DON score for patients admitted to a hospital.
IDPH	2009-2012	Hospital Discharges	Detailed data including up to 25 procedure diagnosis codes; limited to Illinois hospitals
IDHS Cornerstone	1992-2014	Family Case Management (FCM)	Enrollment and risk assessment information for pregnant women, infants and young children who are enrolled in FCM.
IDHS Cornerstone	1992-2014	Family Planning	Aggregate data on women served in FP program
IDHS Cornerstone	1992-2014	Healthy Start	Enrollment and risk assessment information for pregnant women, infants and young children who are enrolled in Healthy Start.
IDHS Cornerstone	1992-2014	Immunization	Immunization information for HFS participants from PH sector from Cornerstone.
IDHS Cornerstone	1992-2014	Better Birth Outcomes (replaces Targeted Intensive Prenatal Case Management [TIPS])	Enrollment and risk assessment information for pregnant women, infants and young children who are enrolled in Better Birth Outcomes.
IDHS Cornerstone	1992-2014	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	1992-2014	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	1996-2014	OBRA Medicaid Claims, skeletal data for client confirmation by HFS	Through the OBRA Waiver process 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; 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 based on the administrative methodology using administrative claims, Vital Records, and registry data. The hybrid methodology, employing medical record reviews, was not used to calculate measure rates.

Rates reported may be higher or lower than actual performance due to incomplete and/or untimely encounter data, coding, and claims adjudication issues. The most current year of data in this report reflects HFS Enterprise Data Warehouse (EDW) data as of December 2013 and includes the Title XIX (Medicaid), Title XXI (CHIP), and state-funded populations. Some measures in this report are 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 has implemented a number of initiatives to improve data quality, including contractual requirements for data reporting, reduced billing timeframe requirements, and quality improvement initiatives.

Deviations from Child Core Set Measure Specifications

Any deviations between the core specifications and the specifications used for this report are identified. The Child Core Set specifications are periodically updated and time and resource limitations may restrict the State's ability to update measures. The versions of the specifications used for the measures are identified for each measure reported.

Specifications detail 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.

The Child Core Set specifications are available at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html.

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.

The measures reported include the HEDIS® 2013 percentile, when applicable. The percentiles in the "Dashboard" are the HEDIS® percentiles achieved. The percentiles reflected in the charts depict whether the state's performance on a particular measure met the HEDIS® 50th percentile. When performance exceeds the 50th percentile the next higher percentile is shown as the "stretch" goal.

Measurement Years
A trend is reported, when possible. The measurement years for most measures are from calendar year (CY) 2009 to CY2012. The measurement years for measure PDENT, Total Eligibles who Received Preventive Dental Services, and TDENT, Total Eligibles who Received Dental Treatment Services, are 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

The 2012 CHIPRA Data Book is available at: http://www2.illinois.gov/hfs/SiteCollectionDocuments/2012CHIPRADatabook.pdf

Illinois' Child Core Set Measures Performance - CY2009-CY2012 Dashboard

Child Core Set Measure	CY2009	CY2010	CY2011	CY2012
HPV Vaccine for Female Adolescents	N/A	N/A	N/A	12.3
BMI Assessment for Children/Adolescents				
3 to 11 Years	0.4	0.6	0.8	1.3
12 to 17 Years	0.4	0.6	0.8	1.3
3 to 17 Years	0.4	0.6	0.8	1.3
Children and Adolescents' Access to Primary Care Practitioners				
12 to 24 Months	87.8	87.8	88.1	86.1
25 Months to 6 Years	79.5	78.6	78.6	76.7
7 to 11 Years	80.3	81.1	80.1	80.1
12 to 19 Years	78.2	80.0	79.5	79.3
All Age Groups	80.5	81.0	80.5	79.7
Childhood Immunization Status				
Combo 2	65.0	64.2	66.4	67.6
Combo 3	59.1	59.2	61.2	63.1
Combo 4	N/A	N/A	N/A	28.4
Combo 5	N/A	N/A	N/A	49.5
Combo 6	N/A	N/A	N/A	30.6
Combo 7	N/A	N/A	N/A	23.7
Combo 8	N/A	N/A	N/A	16.1
Combo 9	N/A	N/A	N/A	25.8
Combo 10	N/A	N/A	N/A	14.0
Immunization Status for Adolescents				
Meningococcal	23.9	34.0	43.1	49.8
Tdap	30.6	39.5	47.6	54.9
Combo (Meningococcal/Tdap)	18.1	27.0	35.9	43.3
Frequency of Ongoing Prenatal Care				
<21% of expected visits	11.4	11.1	10.9	4.8
21 – 40% of expected visits	6.7	6.5	6.5	4.0
41 – 60% of expected visits	11.2	10.7	10.6	4.5
61 – 80% of expected visits	21.9	21.3	21.1	6.0
>81% of expected visits	48.9	50.3	51.0	80.7
Timeliness of Prenatal Care	54.1	55.6	58.1	50.2
Percentage of Live Births Weighing Less Than 2,500 Grams	8.9	8.6	8.7	8.5
Cesarean Rate for Nulliparous Singleton Vertex	N/A	22.7	23.4	23.5
Developmental Screening in the First 3 Yrs of Life				
1 Year	43.7	52.6	60.8	63.5
2 Years	32.2	41.0	49.7	53.5
3 Years	19.5	27.0	34.7	38.5
Total	31.9	40.0	48.1	51.5

Based on CY2009-CY2012 Data and 2013 HEDIS® Percentiles

90th percentile or greater (or inverted measure, 10th percentile – lower score denotes better performance)

75th percentile

50th percentile

25th percentile

10th percentile

No percentile available for comparison or rate is not at least the 10th percentile

N/A – Not Available

Child Core Set Measure	CY2009	CY2010	CY2011	CY2012
Annual Pediatric Hemoglobin (HbA1c) Testing	N/A	N/A	N/A	72.6
Well Child Visits in the First 15 Months of Life				
0 Visits	3.2	2.6	2.6	2.9
1 Visit	2.7	2.4	2.2	2.5
2 Visits	3.7	3.2	3.1	3.5
3 Visits	5.0	4.6	4.5	4.5
4 Visits	7.1	6.7	6.4	6.3
5 Visits	10.3	9.8	9.2	8.7
6 or More Visits	68.1	70.8	72.0	71.7
Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life				
3 Years	74.1	74.2	74.3	72.1
4 Years	74.7	74.7	74.6	72.0
5 Years	79.0	77.9	77.4	74.8
6 Years	58.2	58.1	57.7	56.1
Total	71.7	71.4	71.2	68.8
Adolescent Well Care Visits	40.7	41.5	41.8	42.0
Chlamydia Screening in Women				
16-20 Years	44.7	46.9	45.6	43.8
21-24 Years	52.5	55.2	55.7	52.8
Total	48.3	50.7	50.2	47.8
Percent of Eligibles Who Received Preventive Dental Services (FFYs 2010-2013)	46.3	48.8	50.5	52.1
Percent of Eligibles Who Received Dental Treatment Services (FFYs 2010-2013)	18.3	19.2	20.3	21.2
Medication Management for People with Asthma: ≥50% Days Covered				
5 – 11 Years	N/A	N/A	N/A	41.6
12 – 18 Years	N/A	N/A	N/A	36.8
19 – 20 Years	N/A	N/A	N/A	33.0
5 – 20 Years	N/A	N/A	N/A	39.7
Medication Management for People with Asthma: ≥75% Days Covered				
5 – 11 Years	N/A	N/A	N/A	19.4
12 – 18 Years	N/A	N/A	N/A	16.7
19 – 20 Years	N/A	N/A	N/A	18.7
5 – 20 Years	N/A	N/A	N/A	18.4
Follow-up After Hospitalization for Mental Illness				
7 Days	27.6	32.0	31.5	32.5
30 Days	46.3	51.8	51.2	55.2
Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication				
Initiation Phase	24.6	31.7	32.1	33.6
Continuation & Maintenance Phase	26.1	36.1	39.3	38.3

Illinois' Child Core Set Measures Performance - CY2009-CY2012 Dashboard

Child Core Set Measure	CY2009	CY2010	CY2011	CY2012
Appropriate Testing for Children with Pharyngitis	41.7	43.3	46.8	49.7
Annual Percentage of Asthma Patients with One or More Asthma-related Emergency Room Visits	17.5	17.8	18.4	12.3
Ambulatory Care – Emergency Department Visits (Per 1,000 Member Months)				
<1 Year	102	94	95	95
1 – 9 Years	57	50	51	49
10 – 19 Years	36	32	32	31
Total	50	44	44	42

Based on CY2009-CY2012 Data and 2013 HEDIS® Percentiles

90th percentile or greater (or inverted measure, 10th percentile – lower score denotes better performance)

75th percentile

50th percentile

25th percentile

10th percentile

No percentile available for comparison or rate is not at least the 10th percentile

N/A – Not Available

Child Core Set Measure	CY2009	CY2010	CY2011	CY2012

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.

Relevance of Measure: The HPV vaccine is available to protect female adolescents from the common genital HPV virus. The vaccines are given in three shots over a six month period. HPV vaccinations are important to receive prior to sexual activity and being exposed to HPV. Most HPV types do not have symptoms associated with them and go away without treatment. However, some types of HPV can cause genital warts and cervical cancer. Every year, approximately 12,000 women are diagnosed with cervical cancer and about 1% of sexually active adults in the U.S. have visible genital warts at any given time. To find out more information on HPV vaccines for young women, visit the CDC website at http://www.cdc.gov/std/hpv/STDFact-HPV-vaccine-young-women.htm.

Notes on Measure Programming or Deviations from Measure Specifications:

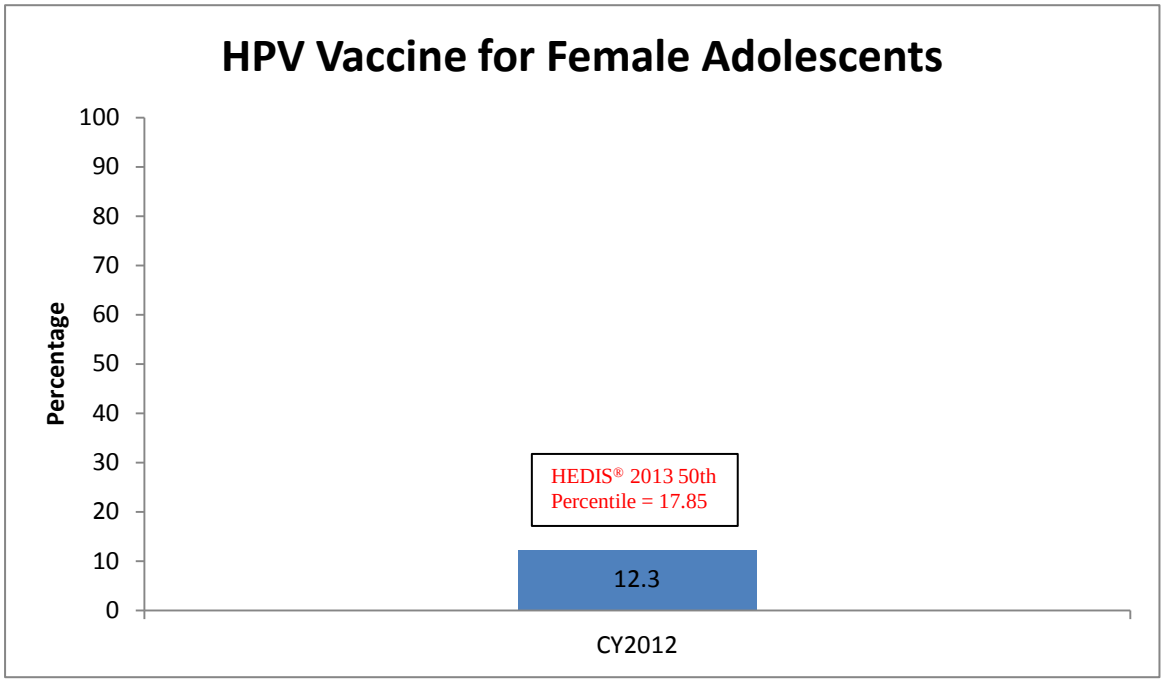
- This measure was added to the Child Core Set for reporting in FFY2013. Only one year of data is reported for CY2012.
- The CY2012 rates are provisional pending revised measure programming testing conducted by HFS.
- CY2012 rates based on HEDIS® 2013 specifications

Eligible Population:

Calendar Year	Numerator	Denominator
2012	4,719	38,447

Key Findings:

- While the HEDIS® 2013 50th percentile is provided in the chart as a mid-point of performance achievement, the 25th percentile (14.12) for this measure was not achieved. This shows there is an opportunity 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 to 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.

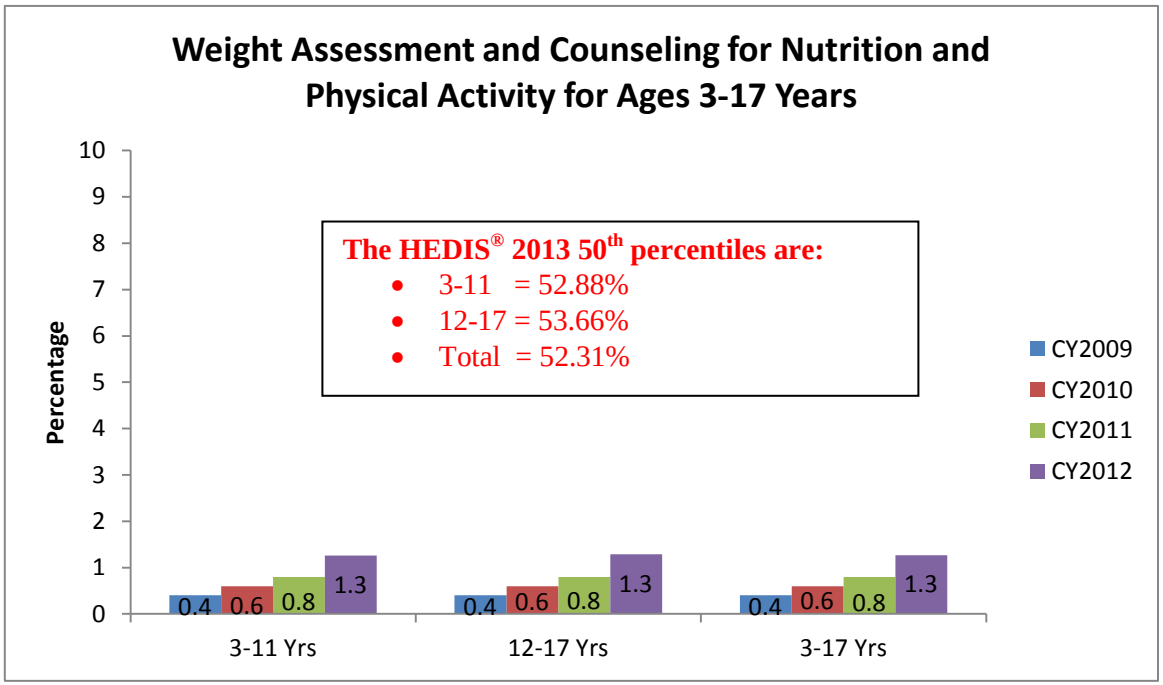
Relevance of Measure: The CDC and the AAP recommend the use of BMI to screen for overweight and obesity in children and teens aged 2 through 19 years. According to the CDC, in 2011-2012, 8.4% of 2-5 year olds were obese compared with 17.7% of 6-11 year olds and 20.5% of 12-19 year olds; obesity is defined as exceeding the 85th percentile for their age group. Among those ages 2-5 years the CDC reports a significant decline in obesity from 13.9 percent in 2003-2004 to 8.4 percent in 2011-2012. Once an overweight BMI is determined, the primary care provider can counsel the child or adolescent and their parents on nutrition, exercise, and lifestyle changes. Early detection of a high BMI can reduce health care risks for the child or adolescent.

Notes on Measure Programming or Deviations from Measure Specifications:

- CY2009 was generated with HEDIS® 2009 specifications, and CY2010- CY2012 use HEDIS® 2012 specifications.

Eligible Population:

	CY2009		CY2010		CY2011		CY2012	
	Numerator	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**
3-11 yrs	3,180	723,144	4,739	773,513	6,404	807,538	10,081	802,875
12-17 yrs	1,679	393,771	2,491	419,734	3,574	440,009	5,718	444,237
3-17 yrs	4,859	1,116,915	7,230	1,193,247	9,978	1,247,547	15,799	1,247,112



Key Findings:

- HFS recently undertook 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. Education sessions are planned. These activities are expected to increase the BMI rates in the future.

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

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

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

Relevance of Measure: The health of children is related to their access to regular health care services. Receiving regular preventive care, including physical exams, immunizations, medical intervention, observation and screening and counseling leads to improved outcomes.

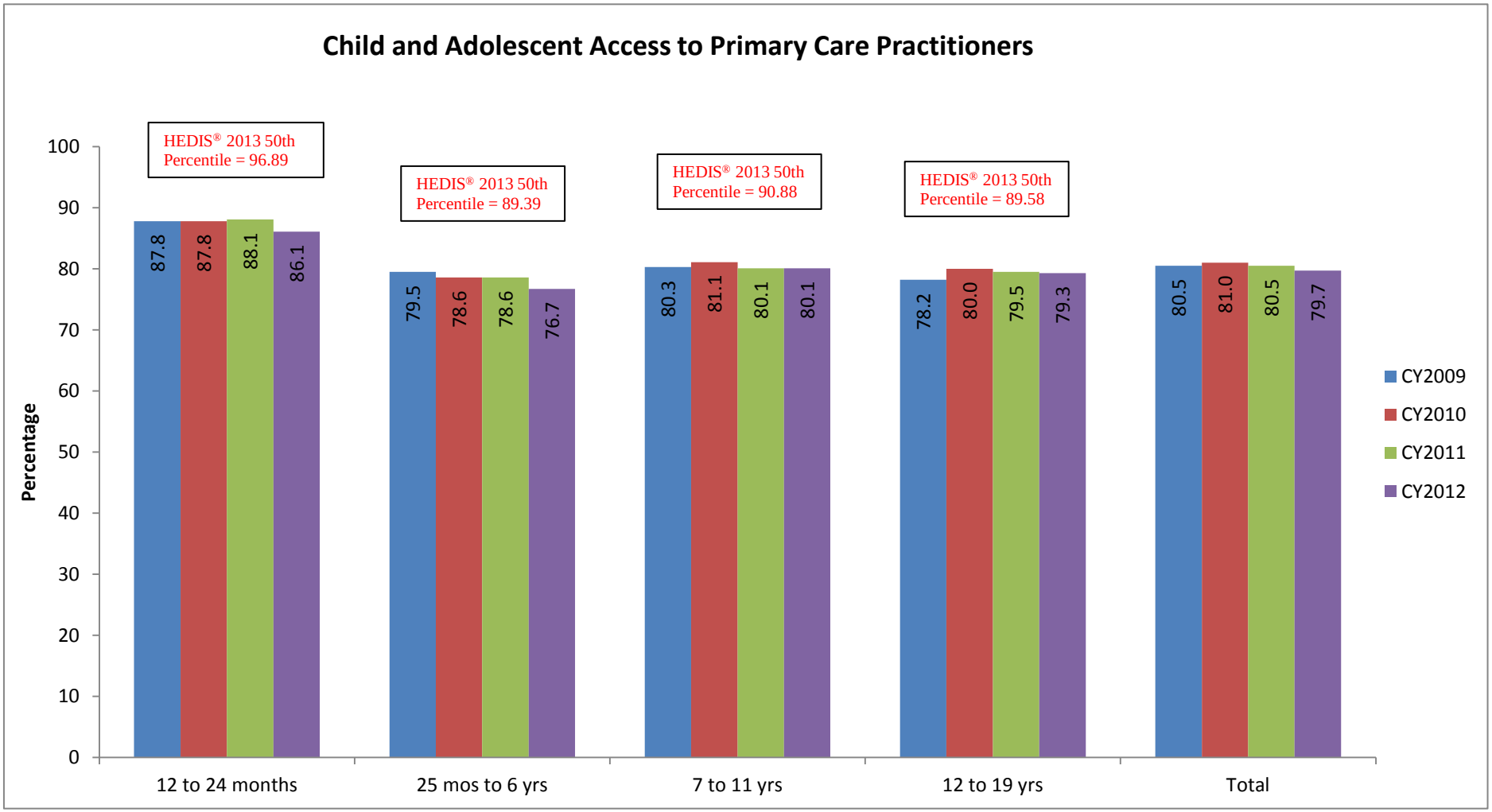
Notes on Measure Programming or Deviations from Measure Specifications:

- CY2012 data are based on HEDIS® 2013 specifications.

Eligible Population:

	CY2009		CY2010		CY2011		CY2012	
	Numerator	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**
12–24 mo	165,665	188,716	165,749	188,749	161,039	182,796	149,614	173,719
25 mo–6 yrs	275,155	346,005	290,255	369,356	301,241	383,155	289,168	377,080
7 -11 yrs	273,376	340,509	299,398	369,388	317,382	396,017	321,700	401,695
12-19 yrs	326,265	417,309	363,375	454,143	387,357	487,162	393,033	495,746
Total	1,040,461	1,292,539	1,118,777	1,381,636	1,167,019	1,449,130	1,153,515	1,448,240

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



Key Findings:

- The rates remained stable for each age category, although from CY2009 to CY2012, there was a substantial increase of 155,701 in the total number of eligible children and adolescents (from 1,292,539 to 1,448,240).
- Each age category is consistently below the 50th percentile by approximately 10 percent or more, showing 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); two 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.

Relevance of Measure: Vaccinations are available to protect children from serious diseases that can result in illness, disability and death. Vaccinations are not only important for protecting individual children from disease, but also to protect communities and future generations as well. Vaccinations should be administered in accordance with the Childhood Immunization Schedule as approved by the Advisory Committee on Immunization Practices of the U.S. Centers for Disease Control and Prevention (CDC), and the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP). The schedule is updated annually. The current version is available at: http://www.cdc.gov/vaccines/recs/schedules/default.htm

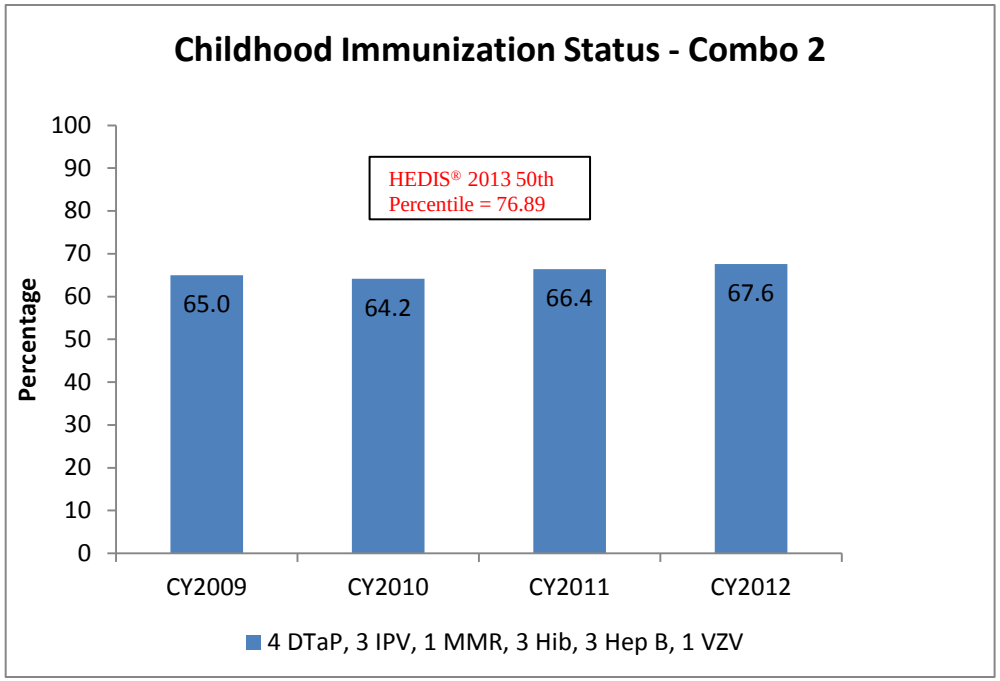
Notes on Measure Programming or Deviations from Measure Specifications:

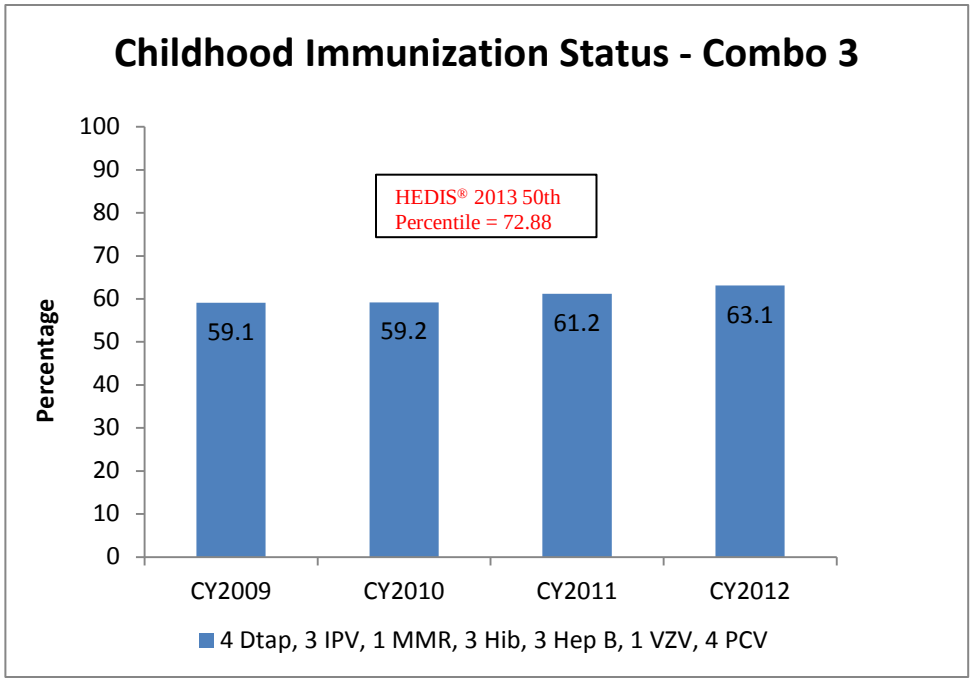
- CY2009 - CY2011 were generated with HEDIS® 2011 specifications and CY2012 were generated with HEDIS® 2013 specifications
- Combination vaccines 4 – 10 were first reported in CY2012.
- Individual vaccine rates are not reported.
- The measure includes vaccinations identified using state immunization registry systems in addition to administrative claims data.
- CY2012 rates are provisional pending revised measure programming testing conducted by HFS.
- Denominator exclusions were first applied for reporting CY2012 rates in FFY2013. These exclusions were not applied to the denominator in previous years.

Eligible Population:

	CY2009		CY2010		CY2011		CY2012	
	Numerator	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**
Combo 2	61,240	94,265	61,257	95,383	62,093	93,582	60,069	88,810
Combo 3	55,688	94,265	56,508	95,383	57,285	93,582	56,024	88,810
Combo 4							25,203	88,810
Combo 5							43,924	88,810
Combo 6							27,140	88,810
Combo 7							21,087	88,810
Combo 8							14,274	88,810
Combo 9							22,872	88,810
Combo 10							12,410	88,810

Measure CIS: Childhood Immunization Status





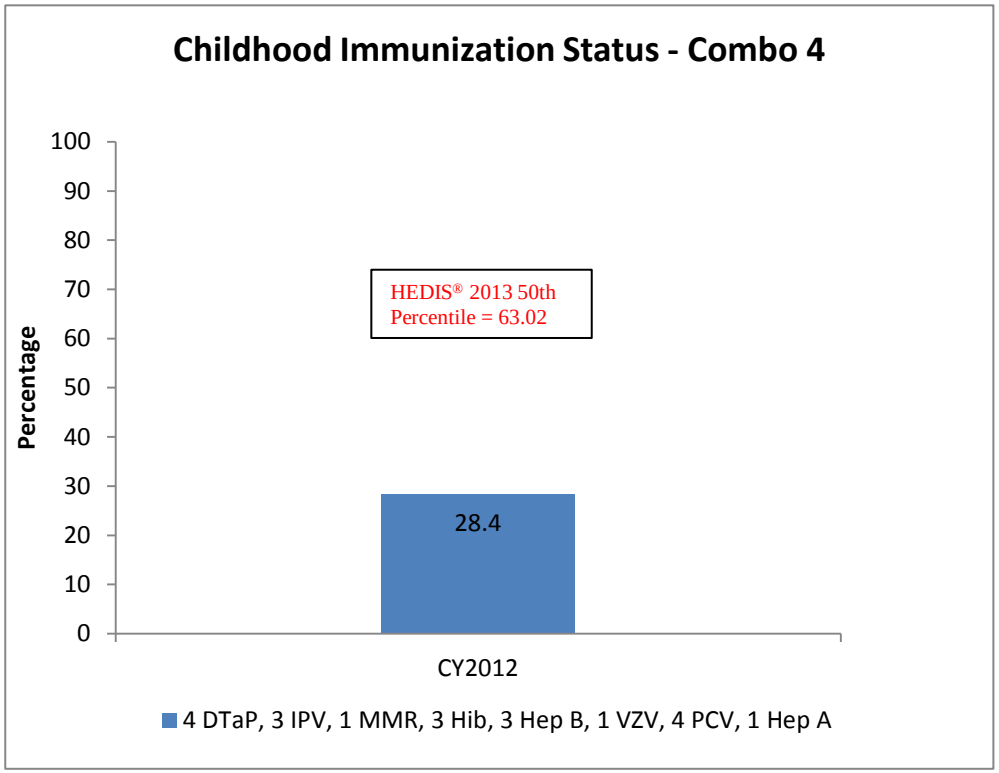
Key Findings: Combo 2

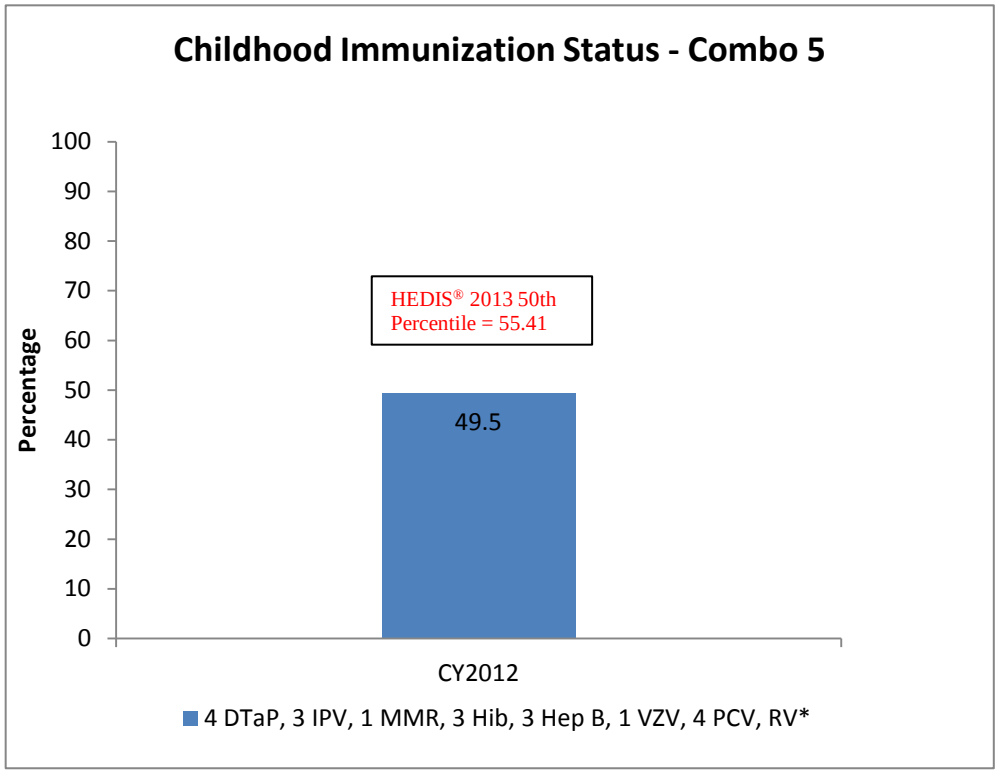
- There was an increase of 2.6 percentage points, an increase of 4.0 percent, in Combo 2 from CY2009 to CY2012.
- The HEDIS® 50th percentile is nearly 10 percentage points higher than the CY2012 rate showing room for improvement.
- This measure is below the HEDIS® 25th percentile (70.44%) showing need for improvement.

Key Findings: Combo 3

- There was an increase of 4.0 percentage points, an increase of 6.8 percent, in Combo 3 from CY2009 to CY2011.
- The HEDIS® 50th percentile is nearly 10 percentage points higher than the CY2012 rate showing room for improvement.
- This measure is below the HEDIS® 2013 25th percentile (66.08%) showing need for improvement.

Measure CIS: Childhood Immunization Status





Key Findings: Combo 4

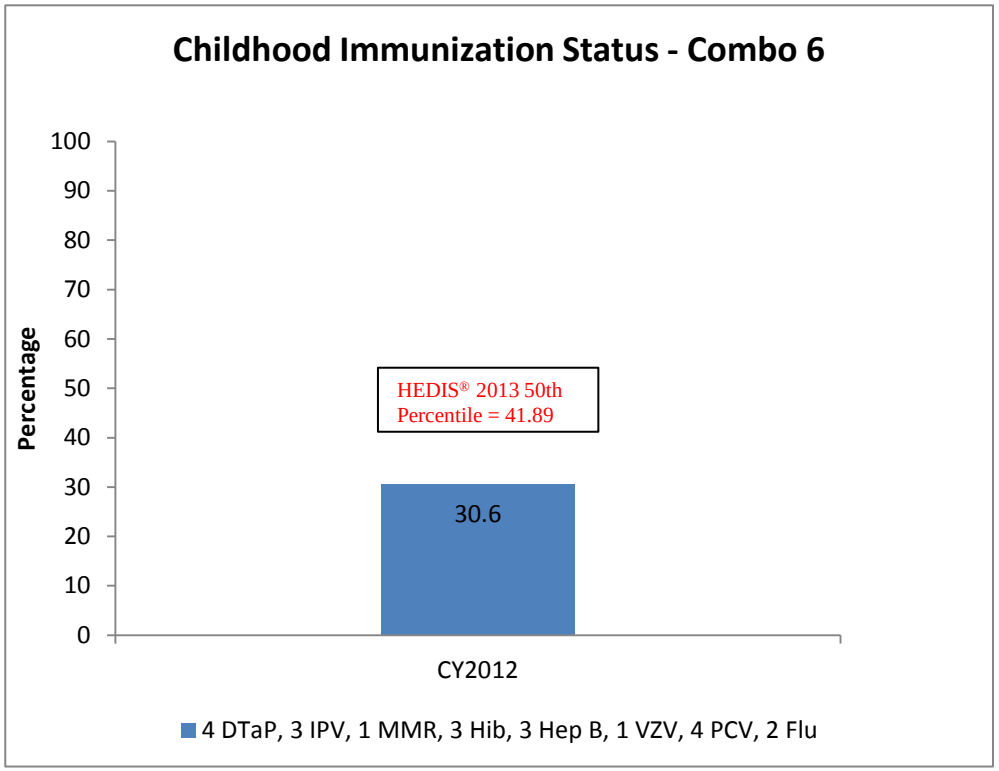
- The HEDIS® 2013 50th percentile is nearly 35 percentage points higher than the CY2012 rate showing considerable room for improvement.
- This measure is below the HEDIS® 2013 5th percentile (29.20%) showing significant need for improvement.
- Rates of Hep A administration (32.8%) may contribute to this lower combo immunization rate.

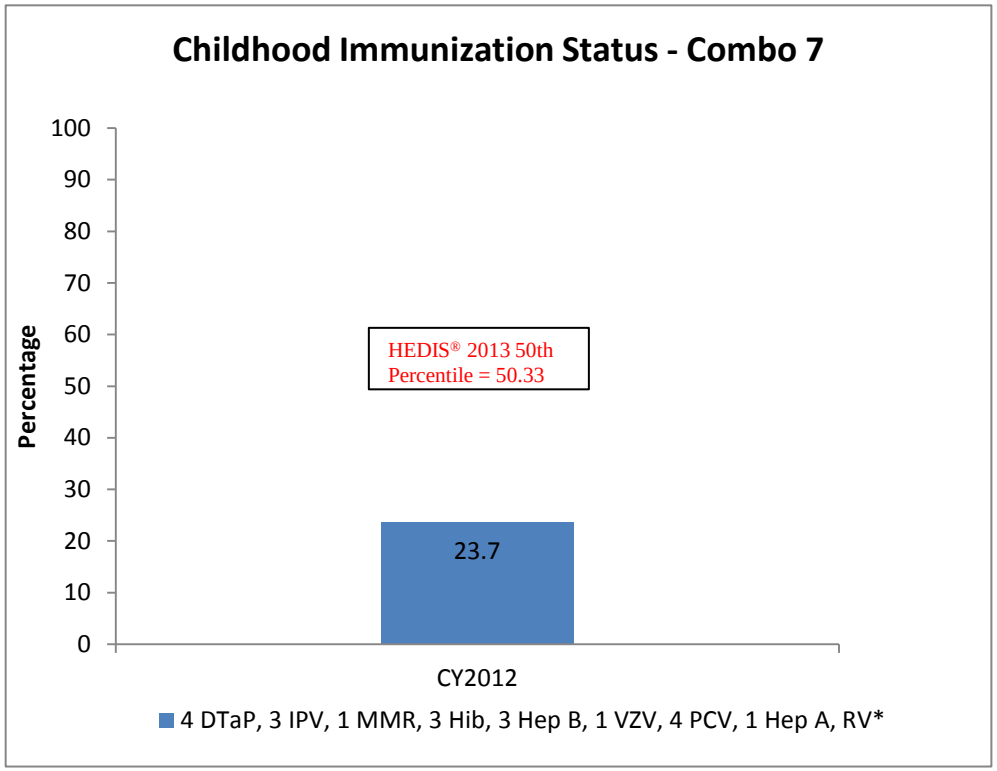
Note: *RV= 2 doses of the 2-dose vaccine, or 1-dose of the 2-dose vaccine and 2 doses of the 3-dose vaccine, or 3-doses of the 3-dose vaccine

Key Findings: Combo 5

- The HEDIS® 2013 50th percentile is approximately six percentage points higher than the CY2012 rate.
- Performance exceeded the HEDIS® 2013 25th percentile (48.91).

Measure CIS: Childhood Immunization Status





Key Findings: Combo 6

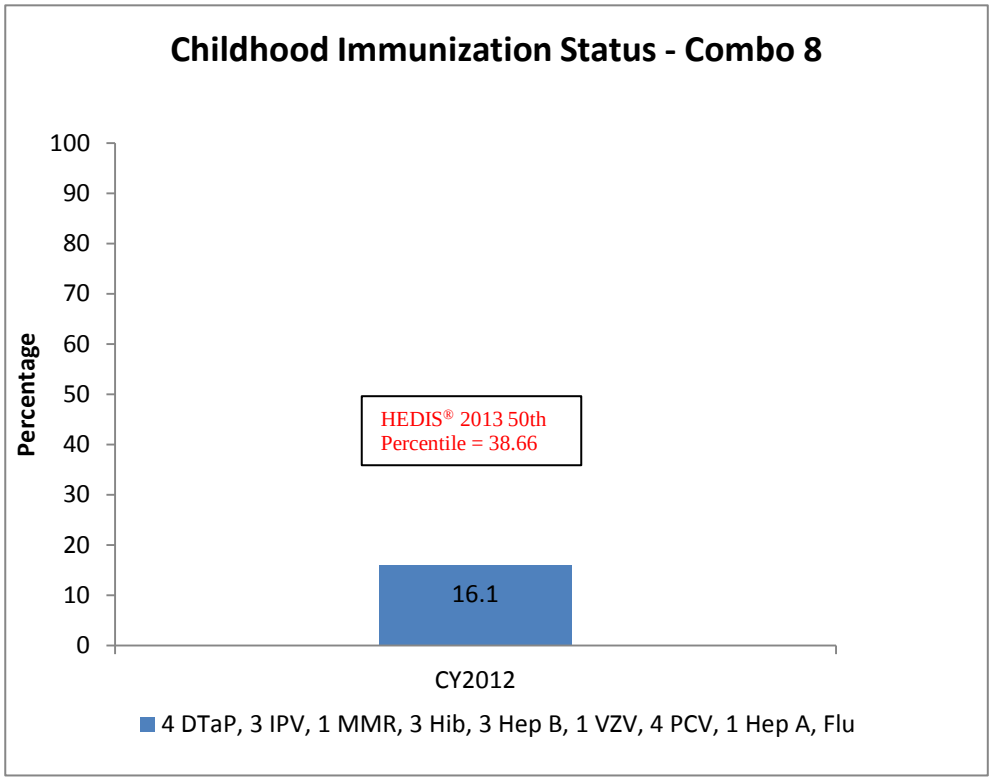
- The HEDIS® 2013 50th percentile is over 10 percentage points higher than the CY2012 rate.
- This measure is below the HEDIS® 2013 25th percentile (33.33%) showing need for improvement.
- Rates of Influenza vaccine administration (37.2%) may contribute to this lower combo immunization rate.

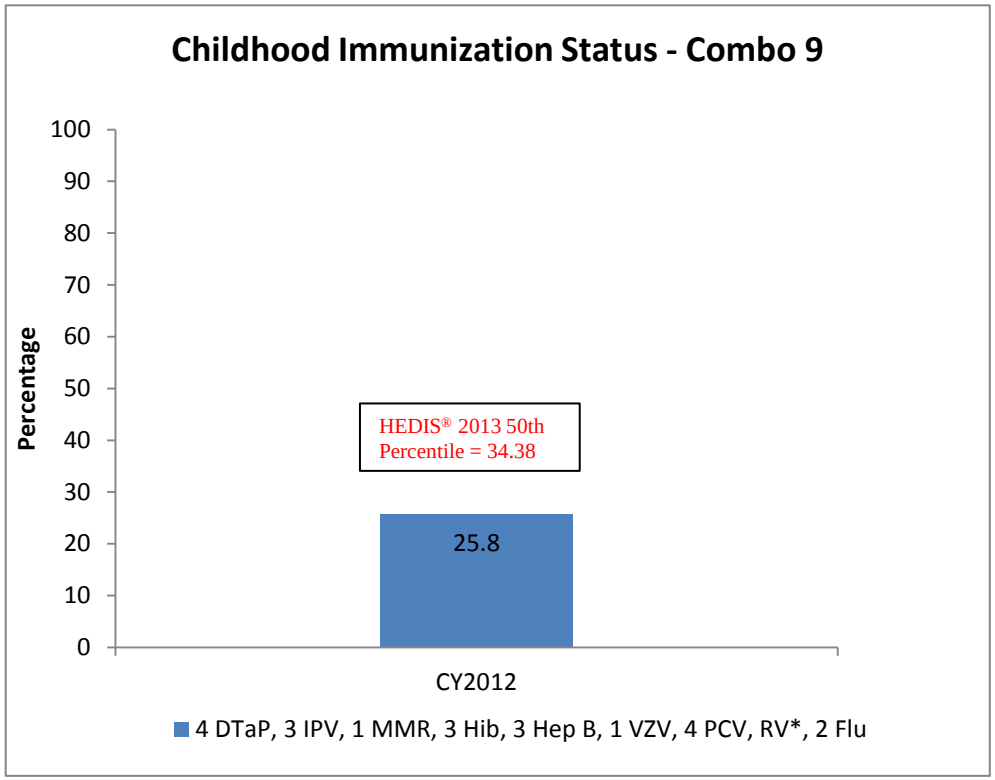
Note: *RV= 2 doses of the 2-dose vaccine, or 1-dose of the 2-dose vaccine and 2 doses of the 3-dose vaccine, or 3-doses of the 3-dose vaccine

Key Findings: Combo 7

- The HEDIS® 2013 50th percentile is over 25 percentage points higher than the CY2012 rate showing considerable room for improvement.
- This measure is below the HEDIS® 2013 10th percentile (27.04%) showing need for improvement.
- Rates of Hep A administration (32.8%) may contribute to this lower combo immunization rate.

Measure CIS: Childhood Immunization Status





Key Findings: Combo 8

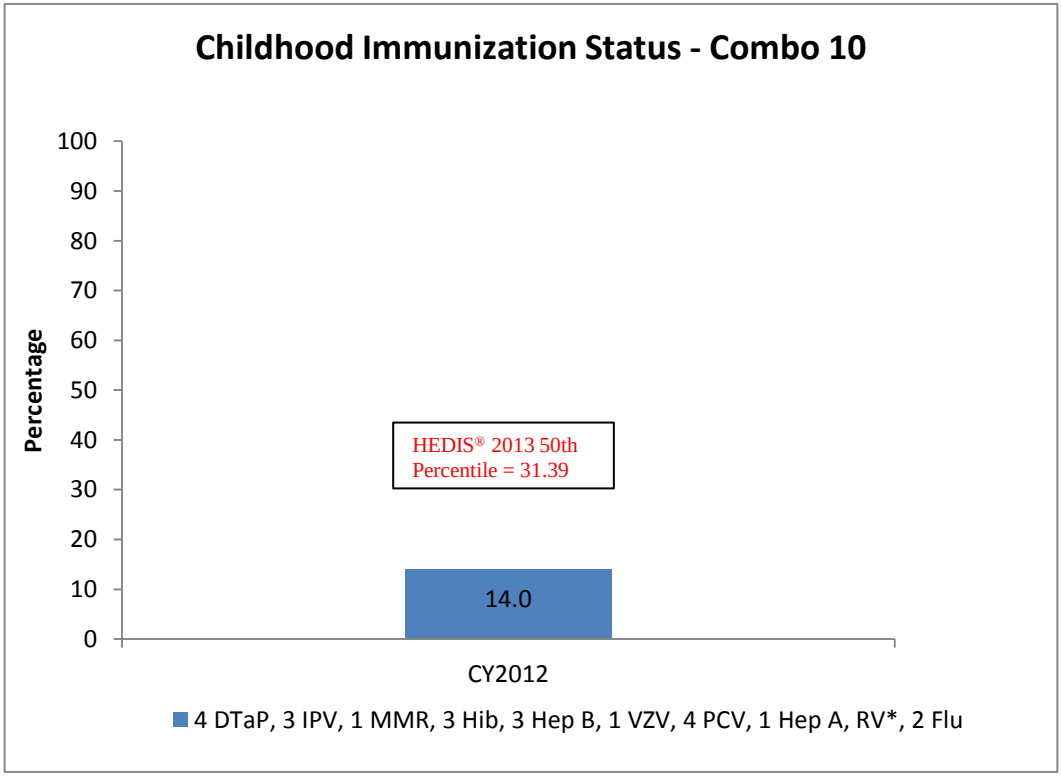
- The HEDIS® 2013 50th percentile is over two times higher than the CY2012 rate showing substantial need for improvement.
- This measure is below the HEDIS® 2013 10th percentile (19.91%) showing need for improvement.
- Rates of Influenza vaccine administration (37.2%) may contribute to this lower combo 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 9

- The HEDIS® 2013 50th percentile is over eight percentage points higher than the CY2012 rate.
- This measure is below the HEDIS® 2013 25th percentile (27.25%) showing need for improvement.
- Rates of Influenza vaccine administration (37.2%) may contribute to this lower 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® 2013 50th percentile is over two times higher than the CY2012 rate showing considerable need for improvement.
- This measure is below the HEDIS® 2013 10th percentile (16.06%) showing need for improvement.
- Rates of Hep A (32.8%) and Influenza vaccine administration (37.2%) may contribute to this lower combo immunization rate.

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.

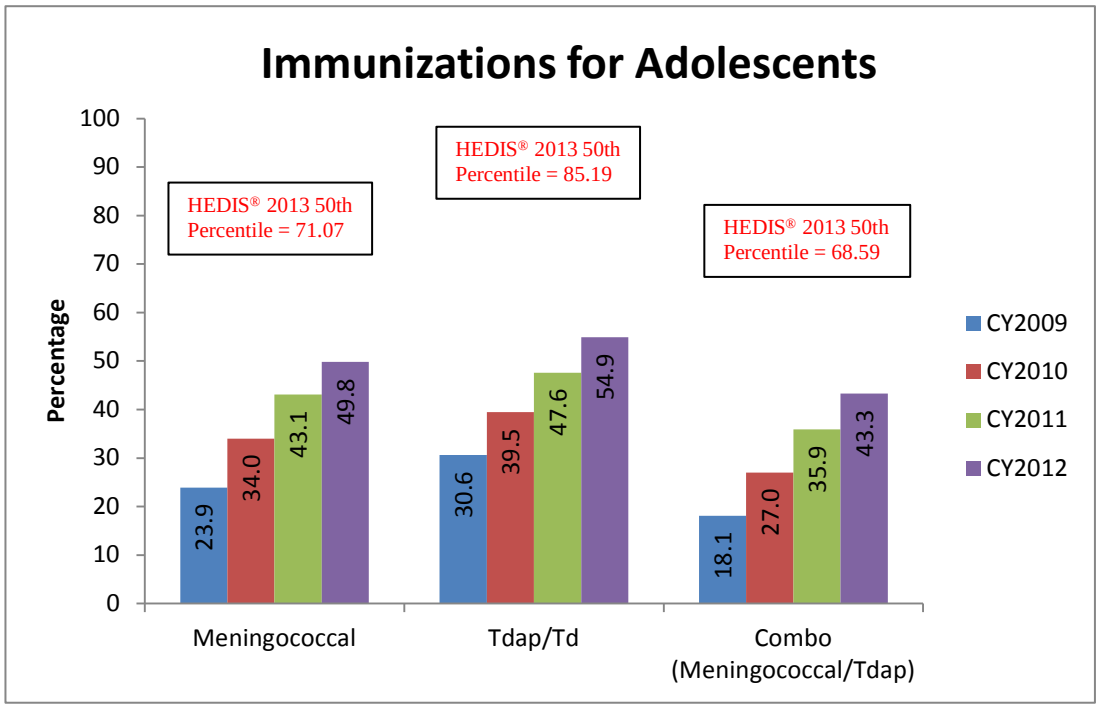
Relevance of Measure: Vaccinations are available to protect children from serious diseases that can result in illness, disability and death. Vaccinations are not only important for protecting individual children from disease, but also to protect communities and future generations as well. Vaccinations should be administered in accordance with the Childhood Immunization Schedule as approved by the Advisory Committee on Immunization Practices of the CDC, the AAP and the AAFP. The schedule is updated annually. The current version is available at: http://www.cdc.gov/vaccines/recs/schedules/default.htm

Notes on Measure Programming or Deviations from Measure Specifications:

- CY2009- CY2012were generated with HEDIS® 2012 specifications.
- The measure includes vaccinations identified using the state immunization registry in addition to administrative claims data.
- Denominator exclusions were first applied for reporting CY2012 rates in FFY2013. These exclusions were not applied to the denominator in previous years.

Eligible Population:

	CY2009		CY2010		CY2011		CY2012	
	Numerator	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**
Meningococcal	15,623	65,273	23,823	70,102	32,725	75,952	38,931	78,250
Tdap/Td	19,976	65,273	27,701	70,102	36,157	75,952	42,921	78,250
Combo	11,781	65,273	18,955	70,102	27,255	75,952	33,864	78,250



Key Findings

- The Combo (Meningococcal and Tdap/Td) immunization rate for adolescents increased by 25.2 percentage points, an increase of 139.2 percent.
- There was an increase of 25.9 percentage points, an increase of 108.4 percent, in the Meningococcal rate from CY2009 to CY2012.
- From CY2009 to CY2012 there was an increase of 24.3 percentage points, an increase of 79.4 percent, in the Tdap/Td rate.
- The CY2012 increased rates may be due to changes in the denominator exclusions that were not previously applied.
- Rates for each vaccine and combo are below the HEDIS® 2013 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 <21% and a higher percentage of ≥81% for this measure are indicative of better performance.

Relevance of Measure: Prenatal care, the health care received during pregnancy, helps to identify and treat many health problems early, and prevent others. Prenatal care also includes the woman caring for herself and her baby, by following her health care providers' advice about nutrition, exercise, and lifestyle. Early and ongoing prenatal care can reduce health care risks for the woman and her baby. According to the U.S. Department of Health and Human Services, Maternal and Child Health Bureau, "Babies born to mothers who received no prenatal care are three times more likely to be born at low birth weight, and five times more likely to die, than those whose mothers received prenatal care."

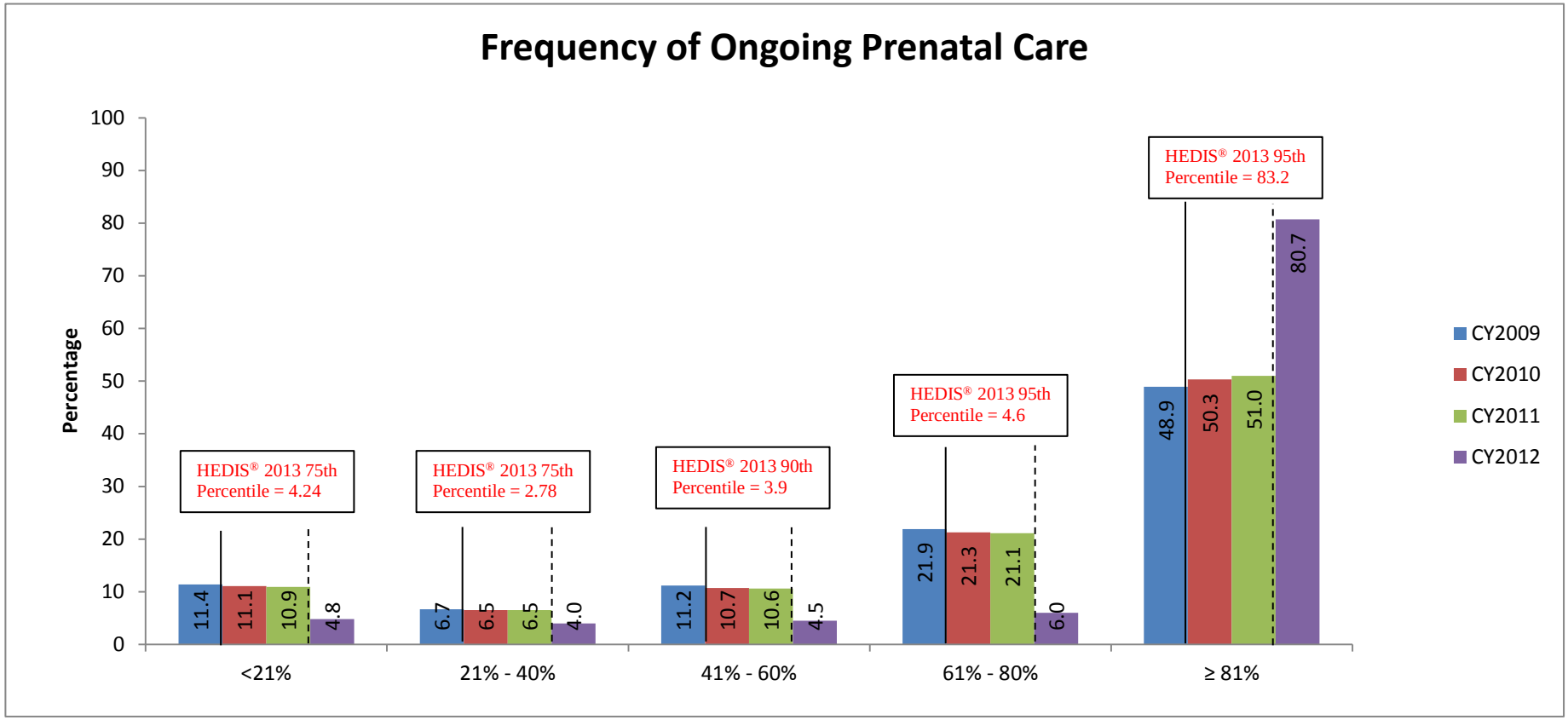
Notes on Measure Programming or Deviations from Measure Specifications:

- The CY2012 rates are provisional pending revised measure programming testing conducted by HFS.
- The solid vertical line indicates that CY2010-CY2012 rates use uncertified Vital Records data and are, therefore, not comparable to CY2009 rates that use certified Vital Records.
- The dashed line in the chart indicates that rates for CY2012 are not comparable to previous years because of the following measure programming updates:
  - CY2009-CY2011 generated with HEDIS® 2007 specifications and CY2012 generated with HEDIS® 2013 specifications
  - HFS used only Decision Rule 2 for CY2009 - CY2011. Beginning with CY2012, all four decision rules are used.

Eligible Population:

	CY2009		CY2010		CY2011		CY2012	
	Numerator	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**
<21%	9,692	85,429	9,134	82,636	8,677	79,996	3,863	79,948
21-40%	5,690	85,429	5,408	82,636	5,226	79,996	3,183	79,948
41-60%	9,596	85,429	8,879	82,636	8,437	79,996	3,620	79,948
61-80%	18,676	85,429	17,614	82,636	16,851	79,996	4,772	79,948
≥81%	41,775	85,429	41,601	82,636	40,805	79,996	64,510	79,948

Measure FPC: Frequency of Ongoing Prenatal Care



Key Findings:

- Due to re-programming bringing this measure into compliance with HEDIS® 2013 specifications, our rates substantially improved for CY2012. Although CY2012 rates are not comparable to previously reported years, previous years' rates were not accurately reflecting performance.
- CY2012 rates are at the 75th to 95th HEDIS® percentile showing high performance on this measure.
- The majority of pregnant women are receiving 81% or more of the expected number of prenatal visits, indicating they receive adequate prenatal care.

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.

Relevance of Measure: Prenatal care, the health care received during pregnancy, helps to identify and treat many health problems early, and prevent others. Prenatal care also includes the woman caring for herself and her baby, by following her health care provider's advice about nutrition, exercise, and lifestyle. Early and ongoing prenatal care can reduce health care risks for the woman and her baby. First trimester (and ongoing) care provides an opportunity to identify and address health issues and behaviors that may cause problems in fetal development and the mother's health that will lead to improved birth outcomes.

Notes on Measure Programming or Deviations from Measure Specifications:

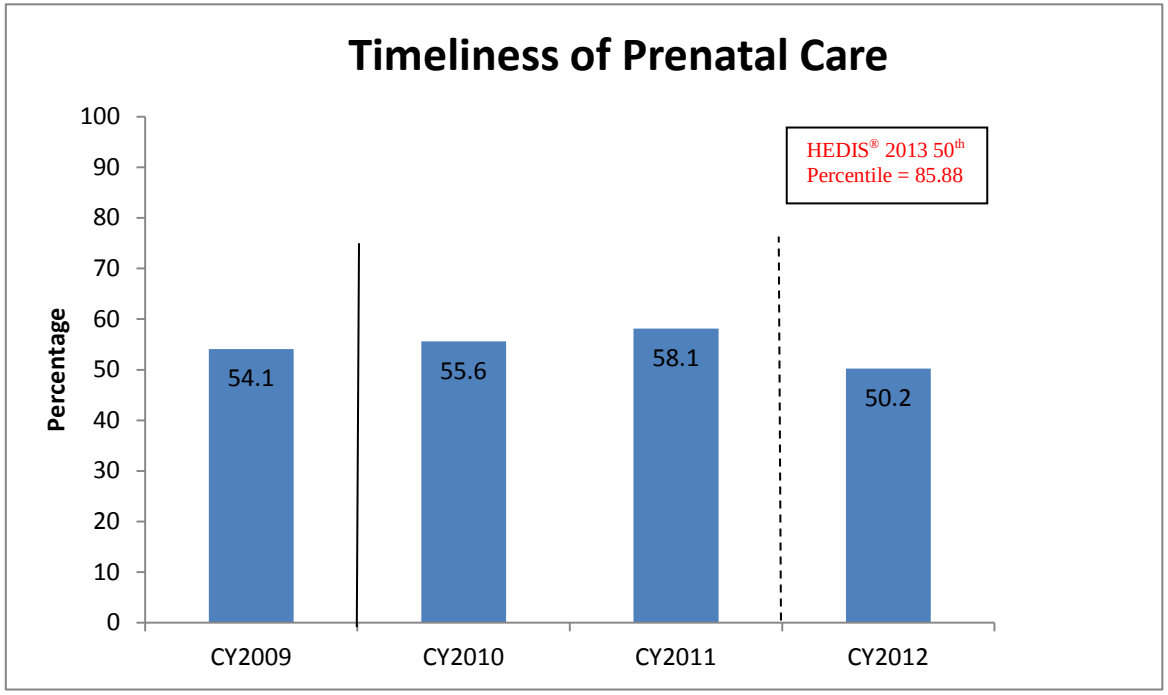
- The CY2012 rates are provisional pending revised measure programming testing conducted by HFS.
- The solid vertical line indicates that CY2010-CY2012 rates use uncertified Vital Records data and are, therefore, not comparable to CY2009 rates that use certified Vital Records.
- The dashed line in the chart indicates that rates for CY2012 are not comparable to previous years because of the following measure programming updates:
  - CY2009-CY2011 generated with HEDIS® 2007 specifications and CY2012 generated with HEDIS® 2013 specifications
  - HFS used only Decision Rule 2 for CY2009 - CY2011. Beginning with CY2012, all four decision rules are used.

Eligible Population:

Calendar Year	Numerator	Denominator
2009	46,242	85,429
2010	45,979	82,636
2011	46,487	79,996
2012	39,728	79,141

Key Findings:

- This measure shows that one-half of pregnant women (CY2012) receive timely prenatal care.
- This measure is below the HEDIS® 2013 5th percentile (66.38%) showing significant 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 is indicative of better performance.

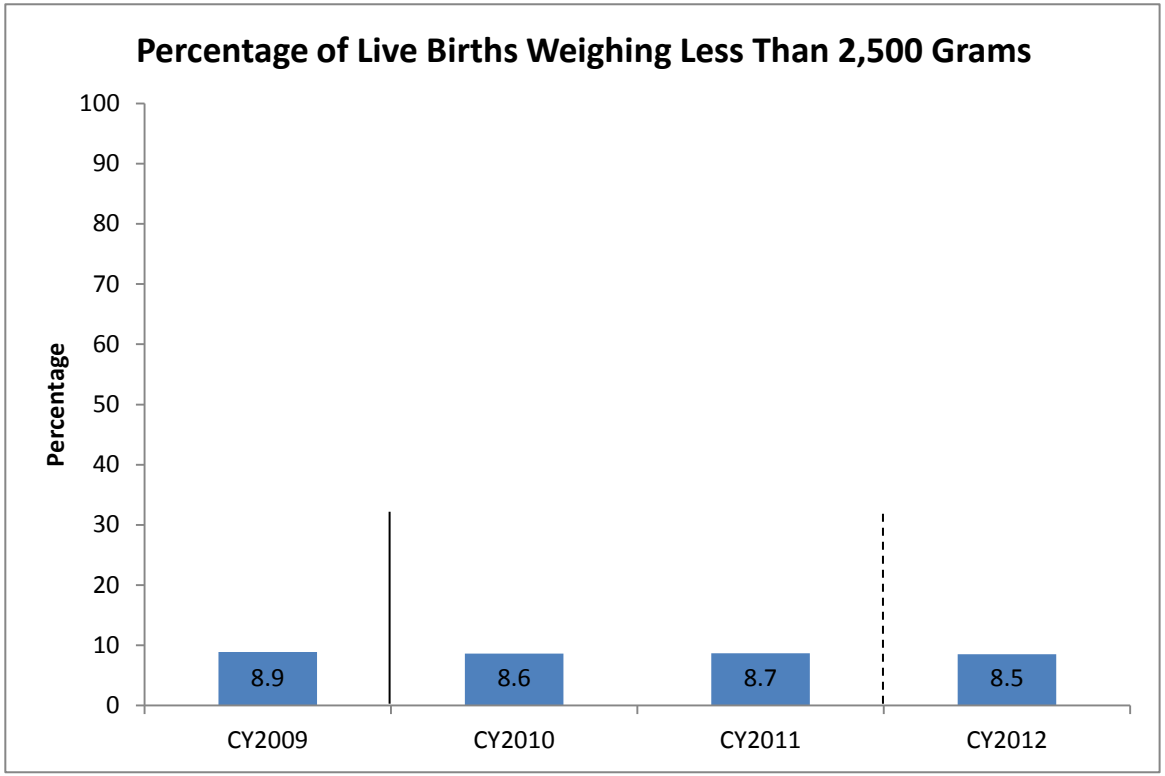
Relevance of Measure: The lower the birth weight of an infant, the greater chance of neonatal death or risk factors early and/or later in life. The rate can be decreased with preventive care, earlier interventions, and more education and intervention during pregnancy to address risk factors that contribute to low birth weight, including chronic conditions such as diabetes, asthma, behavioral issues, and substance abuse, which often result in a low birth weight baby.

Notes on Measure Programming or Deviations from Measure Specifications:

- The CY2012 rate is provisional pending revised measure programming testing conducted by HFS.
- The solid vertical line indicates that CY2010 - CY2012 rates use uncertified Vital Records data and are therefore not comparable to CY2009 rates that use certified Vital Records.
- CY2012 uses a revised process that enhances the Mom to baby match. The dashed line indicates that CY2012 data are not comparable to previous years due to this enhanced matching process.
- Rates are based on deliveries with >$0 re-priced net liability amount.
- The May 2013 Child Core Set specifications were used to program this measure.

Eligible Population:

Calendar Year	Numerator	Denominator
2009	5,591	62,834
2010	5,722	66,446
2011	5,558	63,560
2012	5,020	59,387



Key Findings:

- The percentage of HFS covered low birth weight births has remained stable.

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.

Relevance of Measure: As described in the Child Core Measure specifications, "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." Cesarean sections for non-medical reasons can cause problems for the Mother (e.g., surgical complications, longer hospital stay, longer recovery) and the baby (e.g., being born too early, breathing and other medical problems).

Notes on Measure Programming or Deviations from Measure Specifications:

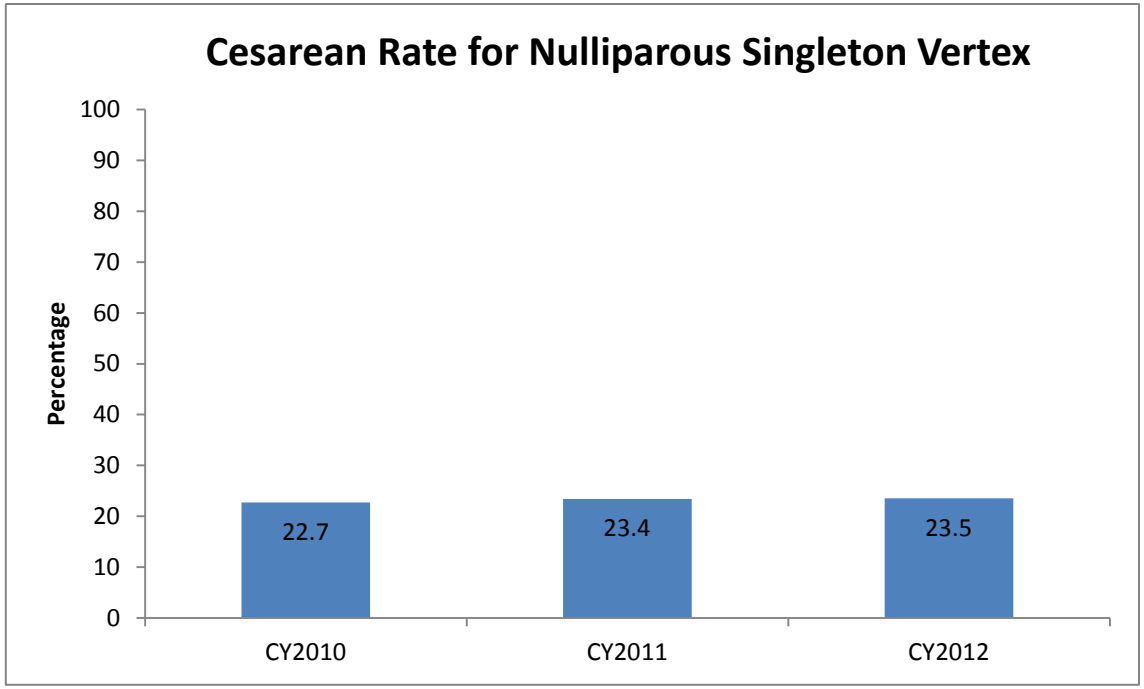
- The CY2012 rates are provisional pending revised measure programming testing conducted by HFS.
- The CY2010 - CY2012 rates use uncertified Vital Records data.
- The May 2013 Child Core Set specifications were used to program this measure.

Eligible Population:

Calendar Year	Numerator	Denominator
2010	3,553	15,638
2011	3,357	14,335
2012	3,207	13,637

Key Findings:

- The percentage of Cesarean sections among first birth women with no other complications increased by an increase of 3.5 percent from CY2010 to CY2012.
- The high rate of non-medically indicated early elective delivery (EED) is a state and national problem. A number of quality improvement initiatives are directed at reducing EED. This focus is expected to result in a reduced EED rate, including Cesarean sections.



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.

Relevance of Measure: Many children have developmental disorders that have not been identified. To address this issue, the AAP recommends that developmental surveillance, a skilled, but subjective method of assessing development, be incorporated at every well-child preventive care visit. Any concerns identified during surveillance or by parents should be addressed with an objective developmental screening test. In addition, objective screening tests are recommended to be administered regularly at the 9-, 18-, and 24- and 30-month visits, and more frequently as medically indicated. Objective developmental screening helps providers identify children with developmental and social-emotional delays earlier and make referrals to Early Intervention or other services, as appropriate, to help children overcome identified delays. Objective developmental screening tests identify developmental delays at a rate of almost three times the rate identified by surveillance alone.

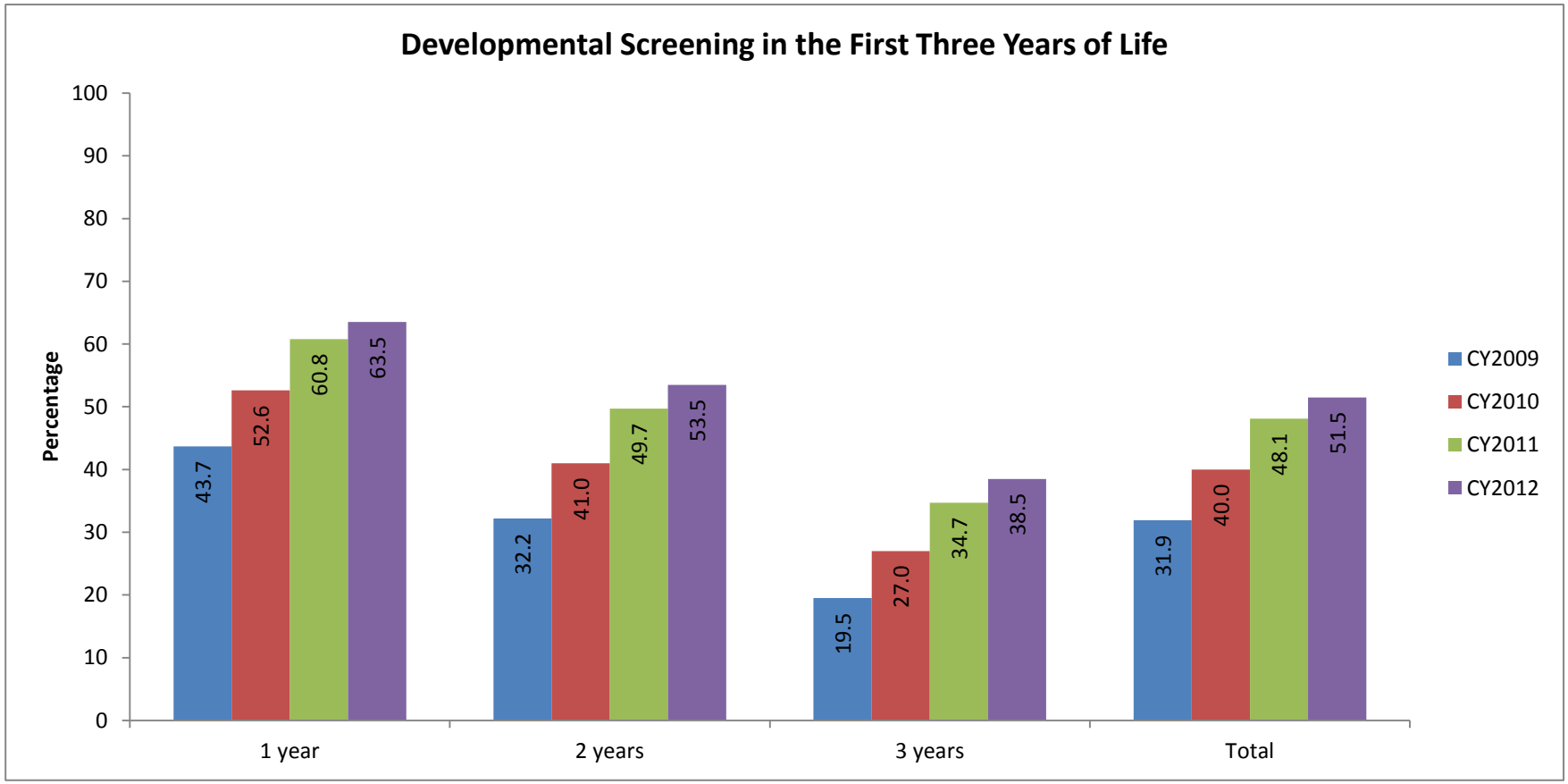
Notes on Measure Programming or Deviations from Measure Specifications:

- The specifications define specific global screening tools that are to be counted for this measure. Screening tools allowed by HFS policy include domain-specific tools that differ from those included in the specifications. This measure counts allowable screening tools as specified in HFS policy.
- The May 2013 Child Core Set specifications were used to program this measure.

Eligible Population:

	CY2009		CY2010		CY2011		CY2012	
	Numerator	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**
1 yr	40,973	93,822	49,345	93,808	55,294	90,878	55,913	88,073
2 yrs	30,714	95,460	39,387	95,978	47,115	94,728	48,555	90,757
3 yrs	18,079	92,489	26,492	97,965	33,819	97,511	36,423	94,666
Total	89,766	281,771	115,224	287,751	136,228	283,117	140,891	273,496

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



Key Findings:

- Each age category showed substantial increases in the screening rate from CY2009 to CY2012.
- From CY2009 to CY2012 among those screened by 1 year of age, the rate increased by 19.8 percentage points, an increase of 45.3 percent; among 2 year olds, the rate increased by 21.3 percentage points, an increase of 66.2 percent; and among those 3 years of age, the rate increased by 19.0 percentage points, an increase of 97.4 percent.
- Among the total population of 1 to 3 year olds, the screening rate from CY2009 to CY2012 increased by 19.6 percentage points, for an increase of 61.4 percent.
- The screening rate is highest for children during the first year of age and steadily decreases each year thereafter.
- 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 PA1C: Annual Pediatric Hemoglobin (HbA1c) Testing

Measure Description: The percentage of children ages 5 to 17 with diabetes (type 1 and type 2) that had a Hemoglobin A1c (HbA1c) test during the measurement year.

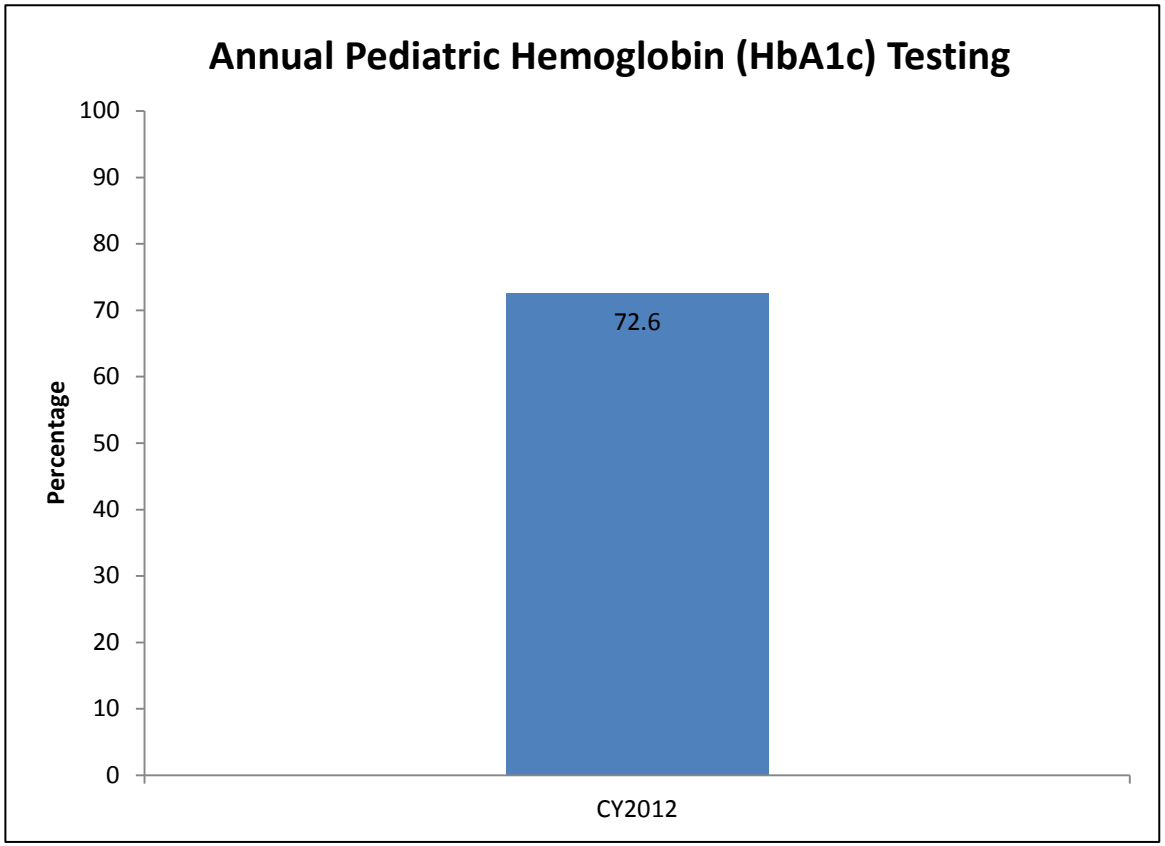
Relevance of Measure: Diabetes (insulin dependent) is one of the common diseases in children below the age of 20 years. The CDC reports that, generally, when diabetes is diagnosed during childhood it is likely to be type 1. But, type 2 diabetes (also known as adult-onset diabetes – insulin resistant) is being diagnosed more frequently in children and adolescents. High rates of obesity and low levels of physical activity among youth contribute to diabetes onset. Blood test screening for diabetes can identify the disease to assure that children who need appropriate treatment receive it.

Notes on Measure Programming or Deviations from Measure Specifications:

- This measure was newly reported in FFY2013. Only one year of data is reported for CY2012.
- The CY2012 rate is provisional pending revised measure programming testing conducted by HFS.
- The May 2013 Child Core Set specifications were used to program this measure.

Eligible Population

Calendar Year	Numerator	Denominator
2012	2,714	3,741



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.

Relevance of Measure: Regular well child visits provide an opportunity for parent education, childhood immunizations, age-appropriate risk assessment, identification and treatment of health problems, and to monitor the growth and development of children to assure they are progressing satisfactorily, and if not, to refer them to needed services. HFS' minimum guidelines require health screenings during the first 2 weeks after birth and at 1, 2, 4, 6, 9, 12 and 15 months.

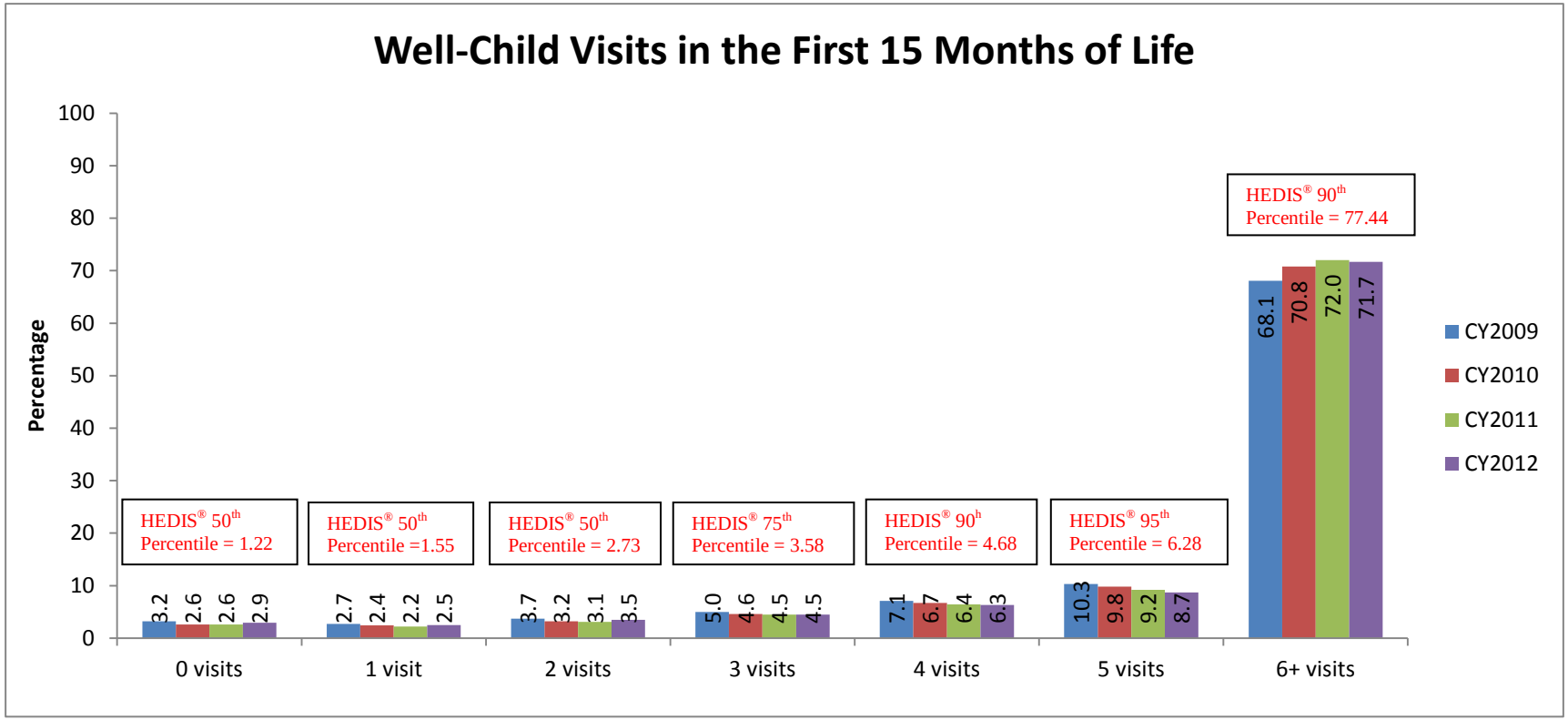
Notes on Measure Programming or Deviations from Measure Specifications:

- CY2009-CY2011 generated with HEDIS® 2012 specifications and CY2012 generated with HEDIS® 2013 specifications.

Eligible Population:

	CY2009		CY2010		CY2011		CY2012	
	Numerator	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**
0 Visits	3,011	94,398	2,413	91,137	2,317	88,630	2,463	85,969
1 Visit	2,508	94,398	2,145	91,137	1,966	88,630	2,128	85,969
2 Visits	3,462	94,398	2,893	91,137	2,779	88,630	3,000	85,969
3 Visits	4,758	94,398	4,179	91,137	3,989	88,630	3,880	85,969
4 Visits	6,676	94,398	6,093	91,137	5,630	88,630	5,438	85,969
5 Visits	9,677	94,398	8,888	91,137	8,164	88,630	7,457	85,969
6+ Visits	64,306	94,398	64,526	91,137	63,785	88,630	61,603	85,969

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



Key Findings:

- For 0 to 5 visits lower rates indicate better performance. For CY2012, the HEDIS® 2013 50th percentile was not achieved for 0 to 2 visits.
- The HEDIS® 2013 50th percentile was achieved for 3 visits, the 75th percentile was achieved for 4 visits and the 90th percentile was achieved for 5 visits.
- From CY2009 to CY2012, there was an increase of 3.6 percentage points, an increase of 5.3 percent, in children 15 months of age who received six or more well child visits.
- In CY2011 and CY2012, children receiving 6+ Well Child Visits surpassed the HEDIS® 2013 75th percentile (70.9).

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

Measure Description: The percentage of children ages 3 to 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.

Relevance of Measure: Regular well child visits provide an opportunity for parent education, childhood immunizations, age-appropriate risk assessment, identification and treatment of health problems, and to monitor the growth and development of children to assure they are progressing satisfactorily, and if not, to refer them to needed services. HFS' minimum guidelines for health screenings require screenings annually at 3, 4, 5, and 6 years of age.

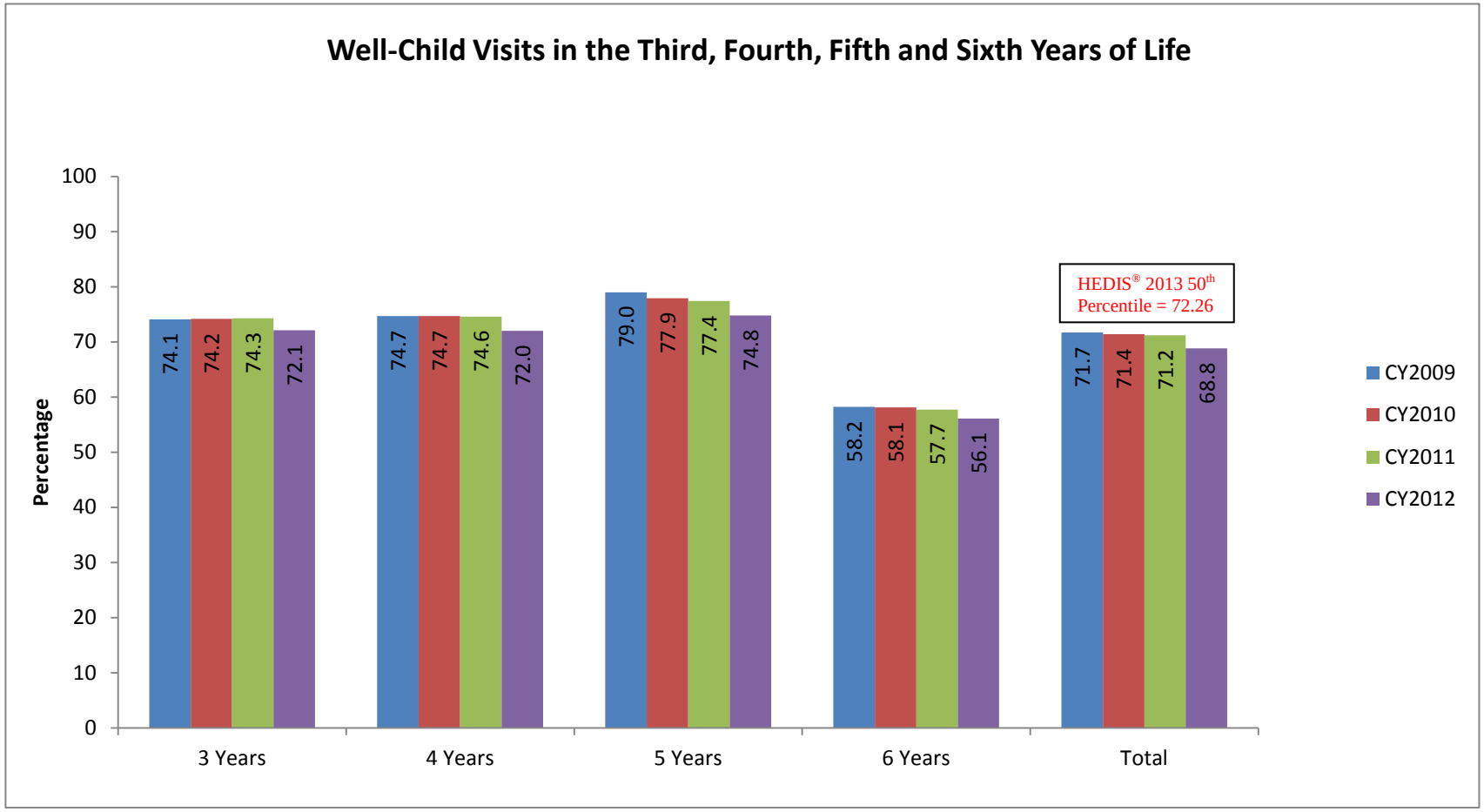
Notes on Measure Programming or Deviations from Measure Specifications:

- CY2009-CY2011 generated with HEDIS® 2012 specifications and CY2012 generated with HEDIS® 2013 specifications.

Eligible Population:

	CY2009		CY2010		CY2011		CY2012	
	Numerator	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**
3 Years	68,117	91,983	71,953	96,950	72,008	96,883	66,312	91,953
4 Years	65,505	87,670	70,666	94,610	73,175	98,133	68,615	95,235
5 Years	66,483	84,185	70,460	90,435	74,372	96,070	71,799	96,039
6 Years	47,868	82,181	50,775	87,382	53,111	92,084	52,677	93,872
Total	247,973	346,019	263,854	369,377	272,666	383,170	259,403	377,099

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



Key Findings:

- From CY2009 to CY2012, the total rate for children ages 3, 4, 5, and 6 years who received one or more well-child visits was above the 25th percentile (67.40), but did not achieve the HEDIS 2013 50th percentile.
- There was a decrease in the total visit rate of nearly three percentage points from CY2009 to CY2012, a decrease of 4.0 percent.
- In CY2012, the individual rates for children 3, 4, 5, and 6 years of age declined compared to previous years showing a need for improvement.
- From CY2009 to CY2012, the well-child visit rate for children age 6 is well below the visit rate for other ages, presenting opportunity for improvement.

Measure AWC: Adolescent Well-Care Visits

Measure Description: The percentage of enrolled adolescents ages 12 to 21 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, 20th, or 21st birthday by the end of the measurement year and must have been continuously enrolled during the measurement year.

Relevance of Measure: Regular well care visits provide an opportunity for education, immunizations, age-appropriate risk assessment, identification and treatment of health problems, and to monitor the growth and development of adolescents to assure they are progressing satisfactorily, and if not, to refer them to needed services. HFS' minimum guidelines for adolescent health screenings require screening every other year or more often if medically necessary.

Notes on Measure Programming or Deviations from Measure Specifications:

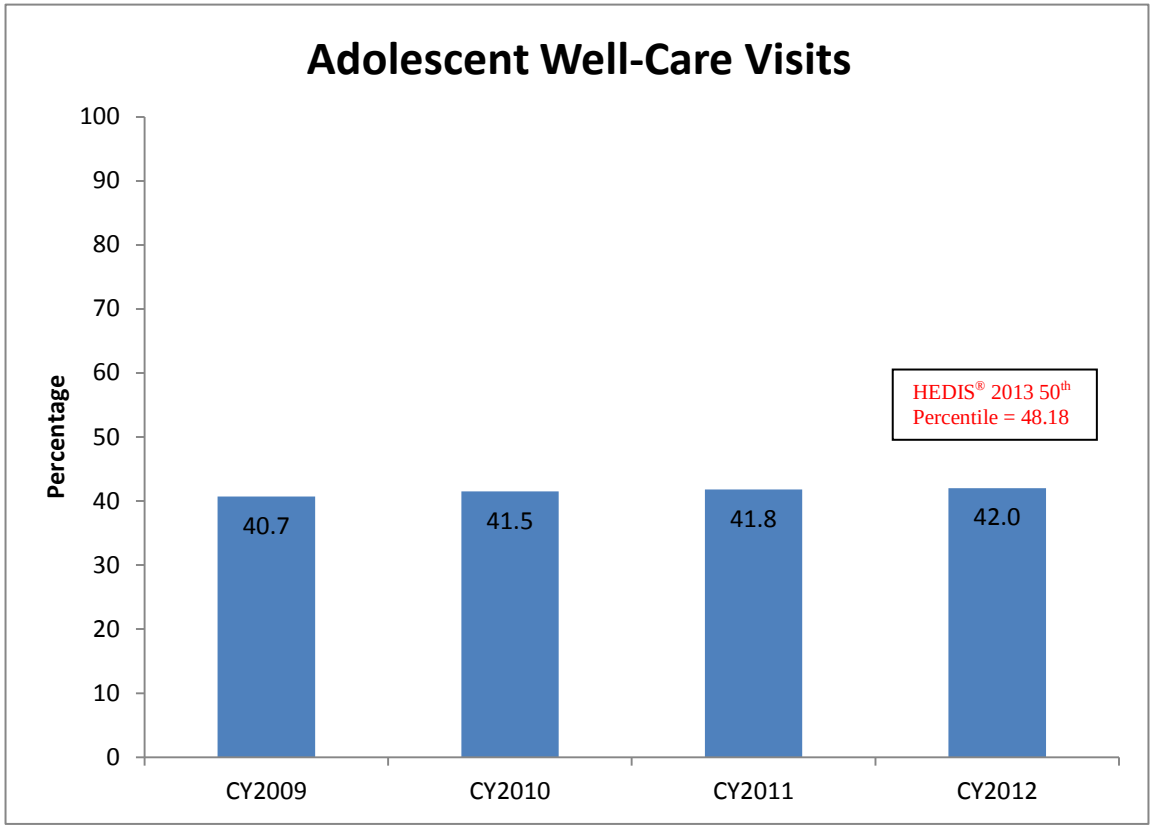
- CY2009-CY2010 generated with HEDIS® 2011, CY2011 generated using HEDIS® 2012 specifications and CY2012 generated with HEDIS® 2013 specifications.

Eligible Population:

Calendar Year	Numerator	Denominator
2009	203,375	499,896
2010	222,762	537,320
2011	233,792	559,837
2012	235,694	561,494

Key Findings:

- From CY2009 to CY2012, there was a nominal increase of 1.3 percentage points, an increase of 3.2 percent, in adolescents receiving a well-care visit.
- The adolescent well-child visit rate is above the 25th percentile (41.72), but below the HEDIS® 2013 50th percentile.
- Less than one-half of adolescents receiving visit during the year. This presents an opportunity for improvement.



Measure CHL: Chlamydia Screening in Women

Measure Description: The percentage of women ages 16 to 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.

Relevance of Measure: According to the CDC, Chlamydia is the most frequently reported sexually transmitted disease in the United States. In 2012, 1.4 million cases were reported to CDC with most occurring among 16-24 year olds. Under-reporting is substantial because most people with Chlamydia are not aware of their infections and do not seek testing. If untreated, serious reproductive and other health problems with both short-term and long-term consequences may occur. To help prevent the serious consequences of Chlamydia infection, the CDC recommends annual screenings for all sexually active women 24 years of age and younger, and for older women with risk factors for Chlamydia. All pregnant women should have a screening test for Chlamydia.

Notes on Measure Programming or Deviations from Measure Specifications:

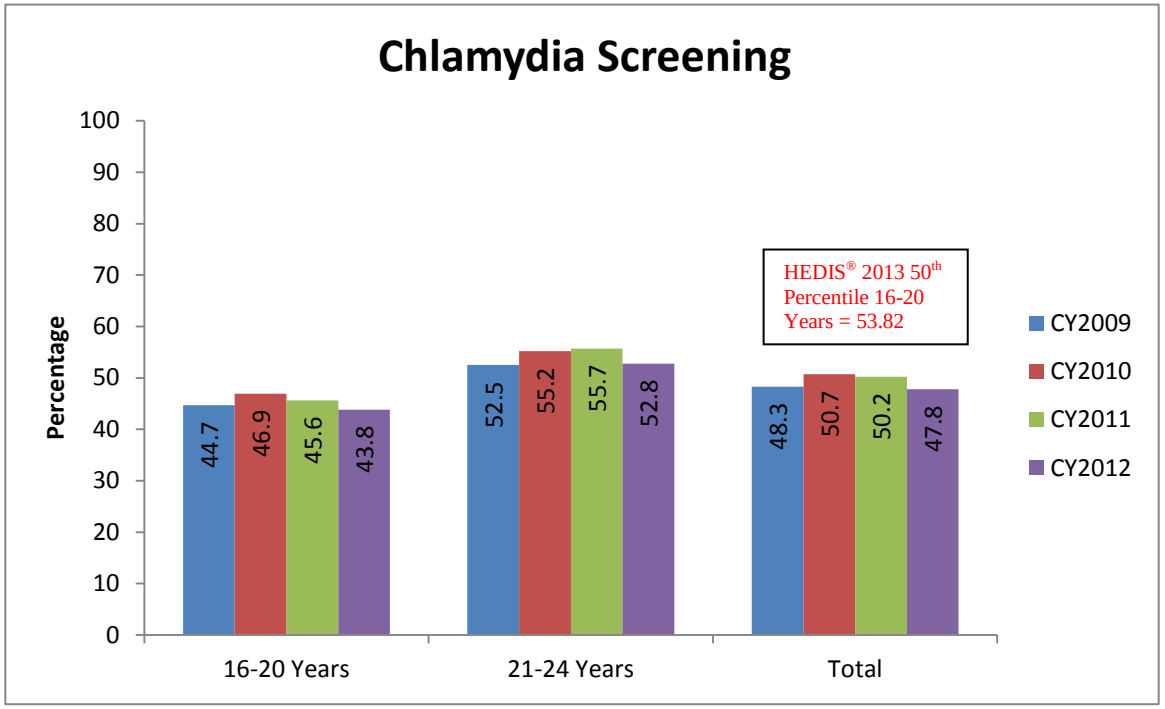
- CY2009 and CY2010 generated with HEDIS® 2009 specifications, CY2011 and CY2012 with HEDIS® 2012 specifications.

Eligible Population:

	CY2009		CY2010		CY2011		CY2012	
	Numerator	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**
16-20 Years	24,084	53,886	26,339	56,171	25,264	55,466	22,434	51,780
21-24 Years	23,724	45,190	25,696	46,562	25,959	46,643	24,407	46,210
Total	47,808	99,076	52,035	102,733	51,223	102,109	46,841	97,990

Key Findings:

- By CY2012, both age groups and the overall rate show slight decreases compared to CYs2009 to 2011.
- The Chlamydia screening rate is consistently lower from CY2009 to CY2012 among 16-20 year olds compared to those 21-24 years of age.
- The 16-20 year old rates are below the HEDIS® 50th percentile, and the 25th percentile (46.94), presenting opportunity for improvement.



Measure PDENT: Percent of Eligibles Who Received Preventive Dental Services

Measure Description: The percentage of individuals ages 1 to 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 age 1 to 20 must be continuously enrolled for at least 90 days during the measurement year.

Measure Relevance: EPSDT is a federal program specific to Medicaid (Title XIX) that requires states to provide health screening, vision, hearing, and dental services to children from birth through age 20 at intervals that meet reasonable standards of medical and dental practice. HFS requires that all preventive health services be provided in accordance with guidelines published by the American Dental Association, the American Academy of Pediatric Dentistry, CMS Oral Health Guidelines, Bright Futures, state law, and procedures and protocols established by HFS. The purposes of measuring participation in EPSDT services are to: 1) assure the availability and accessibility of required health resources, including oral health resources, and 2) help children use those services/resources.

Notes on Measure Programming or Deviations from Measure Specifications:

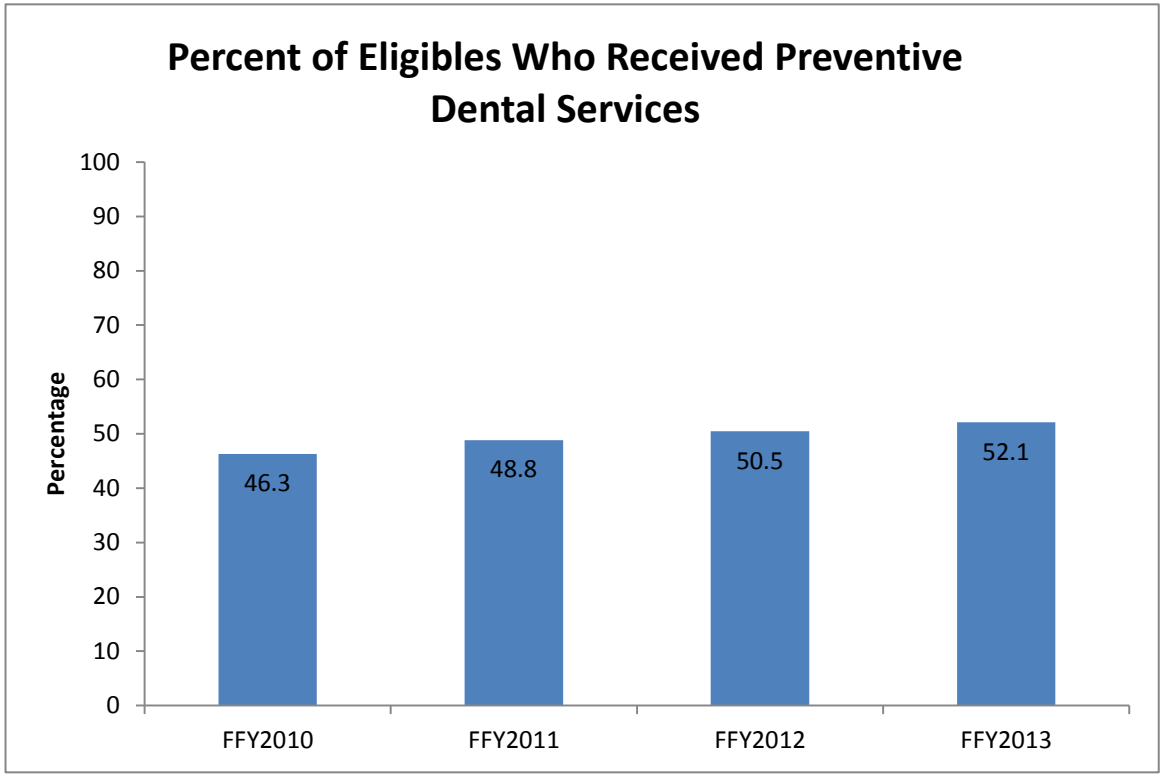
- The May 2013 Child Core Set specifications were used to program this measure.

Eligible Population:

Federal Fiscal Year	Numerator	Denominator
2010	697,930	1,507,472
2011	759,190	1,554,421
2012	798,269	1,581,522
2013	817,200	1,568,087

Key Findings:

- The rate of children who received preventive dental services increased by 5.8 percentage points, an increase of 12.5 percent, from FFY2010 to FFY2013.
- There are annual increases in preventive dental services between FFY2010 and FFY2013.
- Annually, approximately one of two children received preventive dental services indicating a need for improvement.



Measure TDENT: Percent of Eligibles Who Received Dental Treatment Services

Measure Description: The percentage of individuals ages 1 to 20 who are enrolled in Medicaid or CHIP Medicaid Expansion programs, are eligible for EPSDT services and who received a dental treatment services. To be counted for this measure, children age 1 to 20 must be continuously enrolled for at least 90 days during the measurement year.

Measure Relevance: EPSDT is a federal program specific to Medicaid (Title XIX) that requires states to provide health screening, vision, hearing, and dental services to children from birth through age 20 at intervals that meet reasonable standards of medical and dental practice. HFS requires that all preventive health services be provided in accordance with guidelines published by the American Dental Association, the American Academy of Pediatric Dentistry, CMS Oral Health Guidelines, Bright Futures, state law, and procedures and protocols established by HFS. The purpose of measuring participation in EPSDT services is to 1) assure the availability and accessibility of required health resources, including oral health resources, and 2) help children use those services/resources.

Notes on Measure Programming or Deviations from Measure Specifications:

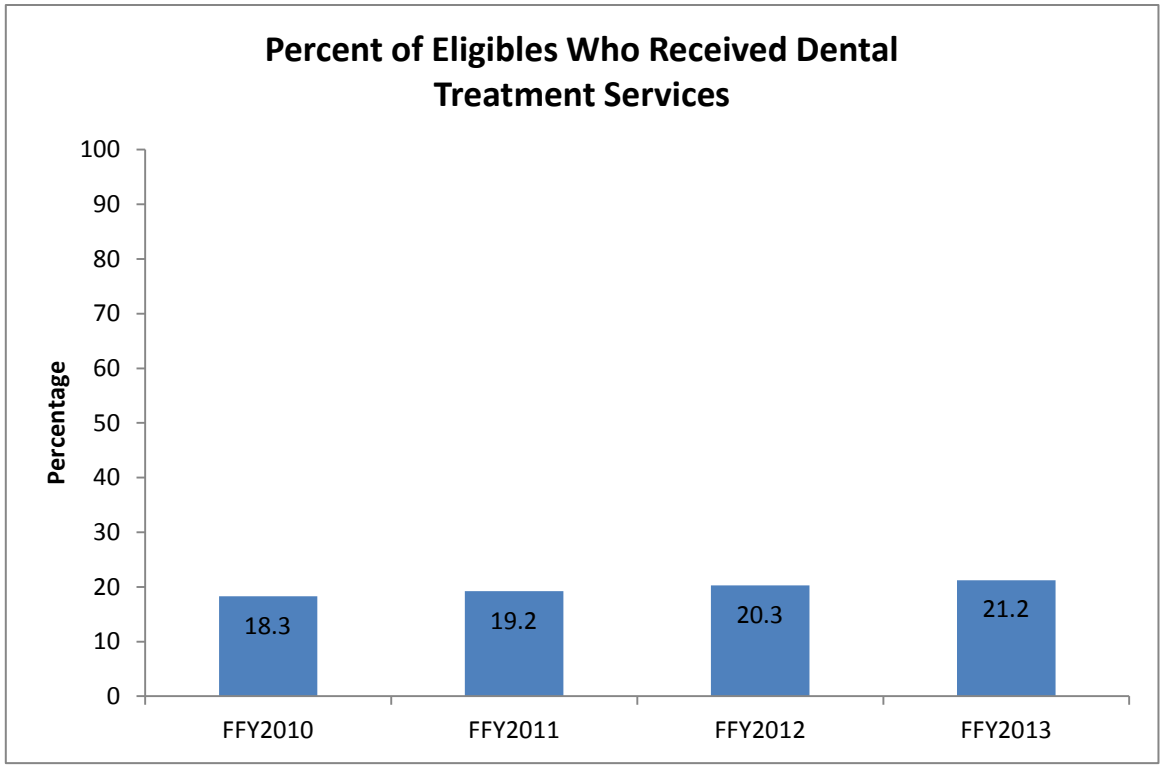
- The May 2013 Child Core Set specifications were used to program this measure.

Eligible Population:

Federal Fiscal Year	Numerator	Denominator
2010	275,626	1,507,472
2011	298,891	1,554,421
2012	320,818	1,581,522
2013	333,068	1,568,087

Key Findings:

- The rate of children who received dental treatment services increased by 2.9 percentage points from FFY2010 to FFY2013. This is an increase of 15.8 percent.
- There are annual increases in treatment dental services between FFY2010 and FFY2013.



Measure MMA: Medication Management for People with Asthma

Measure Description: The percentage of children ages 5 to 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.

Measure Relevance: Asthma is a chronic disease of the lungs that makes breathing difficult. Asthma attacks can vary from mild to life-threatening. Asthma cannot be cured but symptoms can be controlled with appropriate medication and patient education leading to better quality of life. Direct health care costs associated with asthma, including inpatient hospitalization, emergency room visits, and office visits can be significantly decreased with appropriate asthma management.

Notes on Measure Programming or Deviations from Measure Specifications:

- The CY2012 rates are provisional pending revised measure programming testing conducted by HFS.
- CY2012 generated with HEDIS® 2013 specifications.

Eligible Population:

	CY2012		CY2012	
	Proportion of Days Covered ≥50		Proportion of Days Covered ≥75	
	Numerator	Denominator	Numerator	Denominator
5 to 11 Years	7,620	18,320	3,560	18,320
12 to 18 Years	4,173	11,332	1,893	11,332
19 to 20 Years	147	445	83	445
5 to 20 Years	11,940	30,097	5,536	30,097

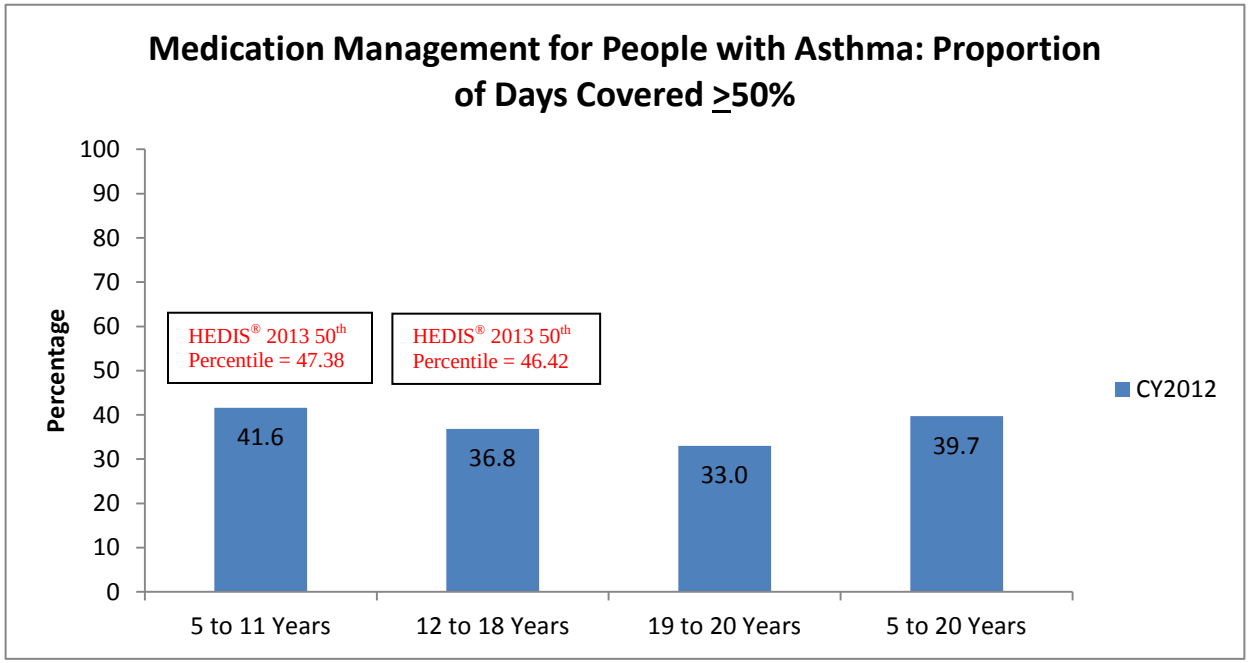
Key Findings – Proportion of Days Covered ≥50%:

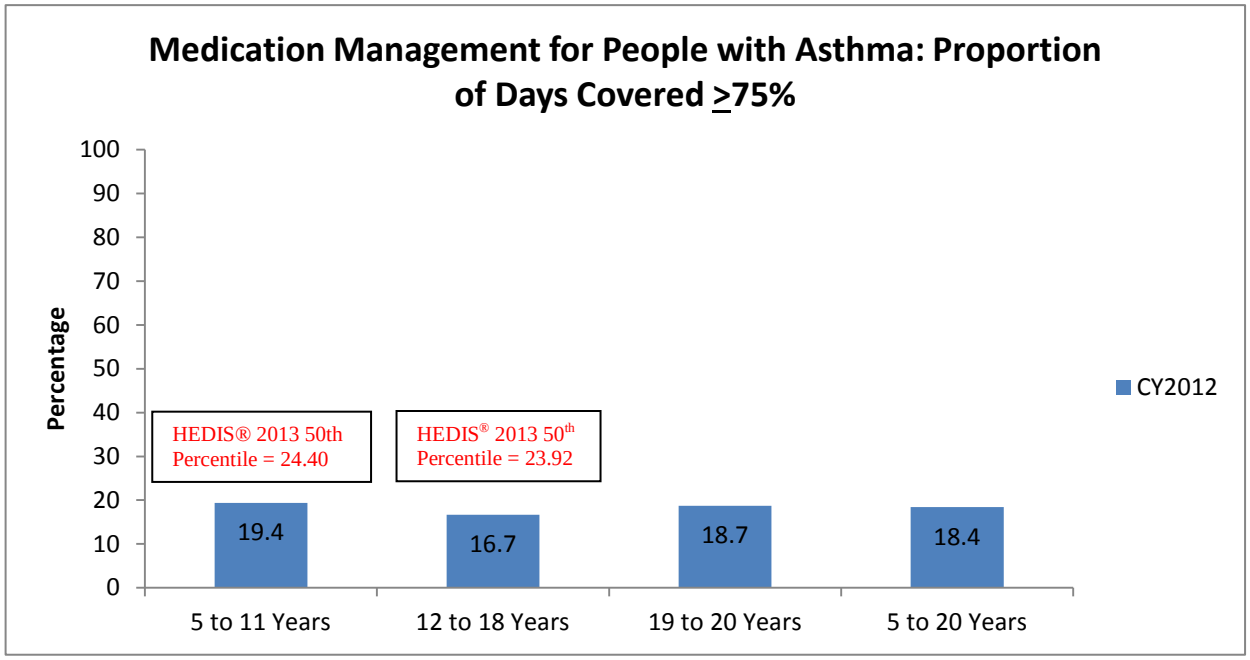
- Those 5-11 years are most likely to remain on asthma medication ≥50% of covered days while those 19-20 years are less likely to remain on medication.
- Among those 5-11 years the rate is nearly at the HEDIS® 2013 50th percentile. However, this shows room for improvement.
- Among those 12-18 years this measure did not achieve the 25th percentile (40.35%), showing room for improvement among this age group.

Key Findings – Proportion of Days Covered ≥75%:

- Across each age category fewer than 20 percent remain on asthma Medicaid for ≥75% of covered days showing a need for improvement.
- Among those 5-11 years the rate is nearly at the HEDIS® 2013 50th percentile. However, this shows room for improvement.
- Among those 12-18 years this measure did not achieve the 25th percentile (18.36%), showing room 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 to 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.

Relevance of Measure: After a child is seen in the hospital for a behavioral health issue, it is important to conduct follow-up to assess status and provide needed care to prevent recurrent hospitalization and improve quality of life.

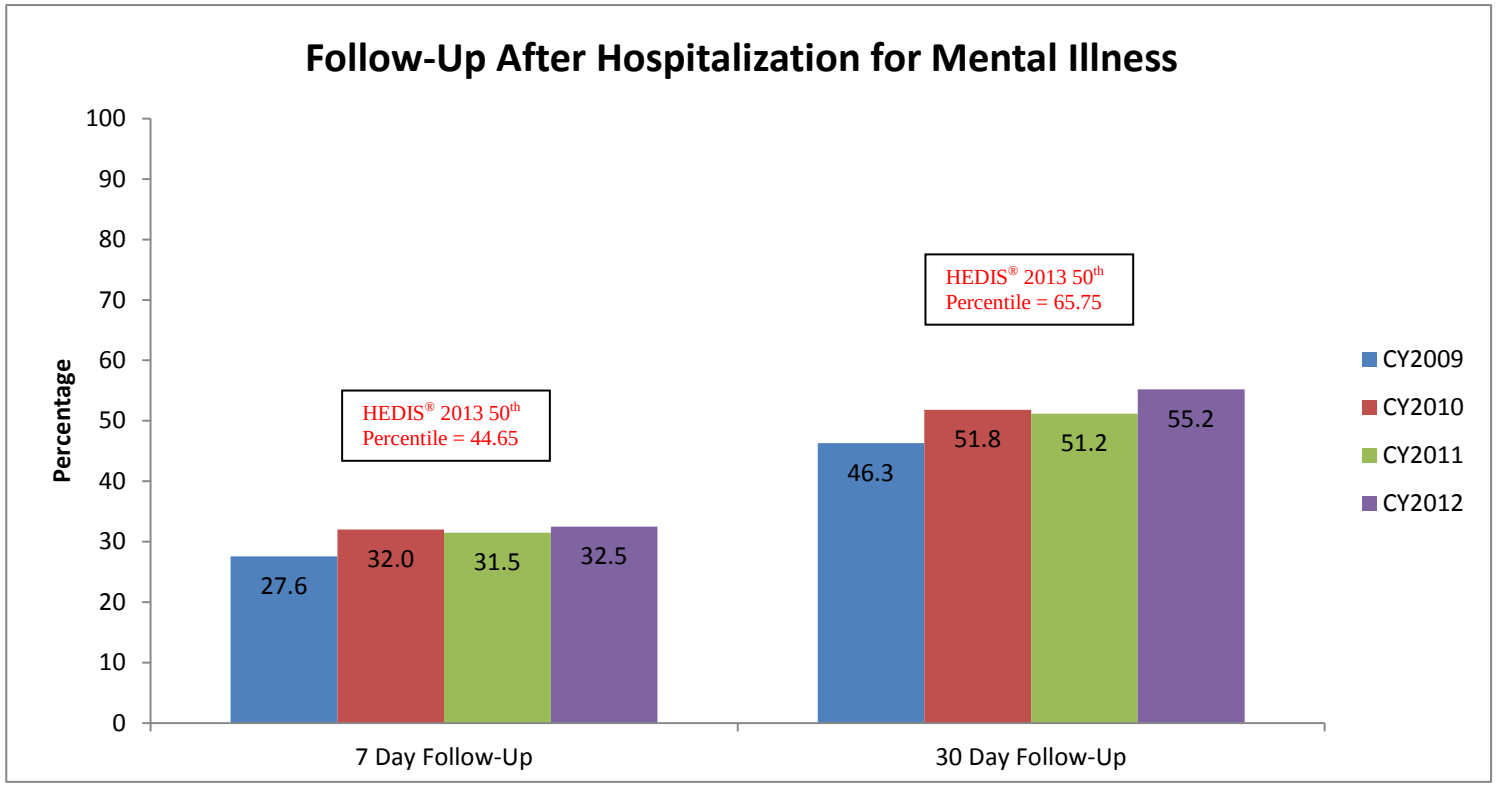
Notes on Measure Programming or Deviations from Measure Specifications:

- CY2009 - CY2011 were generated with HEDIS® 2012 specifications and CY2012 were generated with HEDIS® 2013 specifications
- HFS is unable to identify all prescribing providers using the methodology required in the specifications; therefore, we believe follow-up visits are undercounted.
- CY2012 rates are provisional pending revised measure programming testing conducted by HFS.

Eligible Population:

	CY2009		CY2010		CY2011		CY2012	
	Numerator	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**
7 Day Follow-Up	528	1,910	621	1,942	558	1,770	686	2,014
30 Day Follow-Up	885	1,910	1,006	1,942	906	1,770	1,166	2,014

Measure FUH: Follow-Up after Hospitalization for Mental Illness



Key Findings:

- From CY2009 to CY2012 there was an increase of 4.9 percentage points, an increase of 17.8 percent, in the 7 day follow-up.
- From CY2009 to CY2012 there was an increase of 8.9 percentage points, an increase of 19.2 percent, in the 30 day follow-up.
- The 7 and 30 day follow-up rates are below the HEDIS® 2013 50th percentile, and the 30 day follow-up is slightly below the 25th percentile (56.83%), showing opportunity 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 to 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 to 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/CHIP for 120 days (4 months) prior to the IPSD through 300 days (9 months) after the IPSD.

Relevance of Measure: ADHD is a chronic condition that affects millions of children. Children with ADHD can have a combination of problems, such as difficulty sustaining attention, hyperactivity and impulsive behavior. Early diagnosis and treatment can improve the outcome. ADHD cannot be cured, but symptoms can be controlled with appropriate medication and patient education, leading to better quality of life.

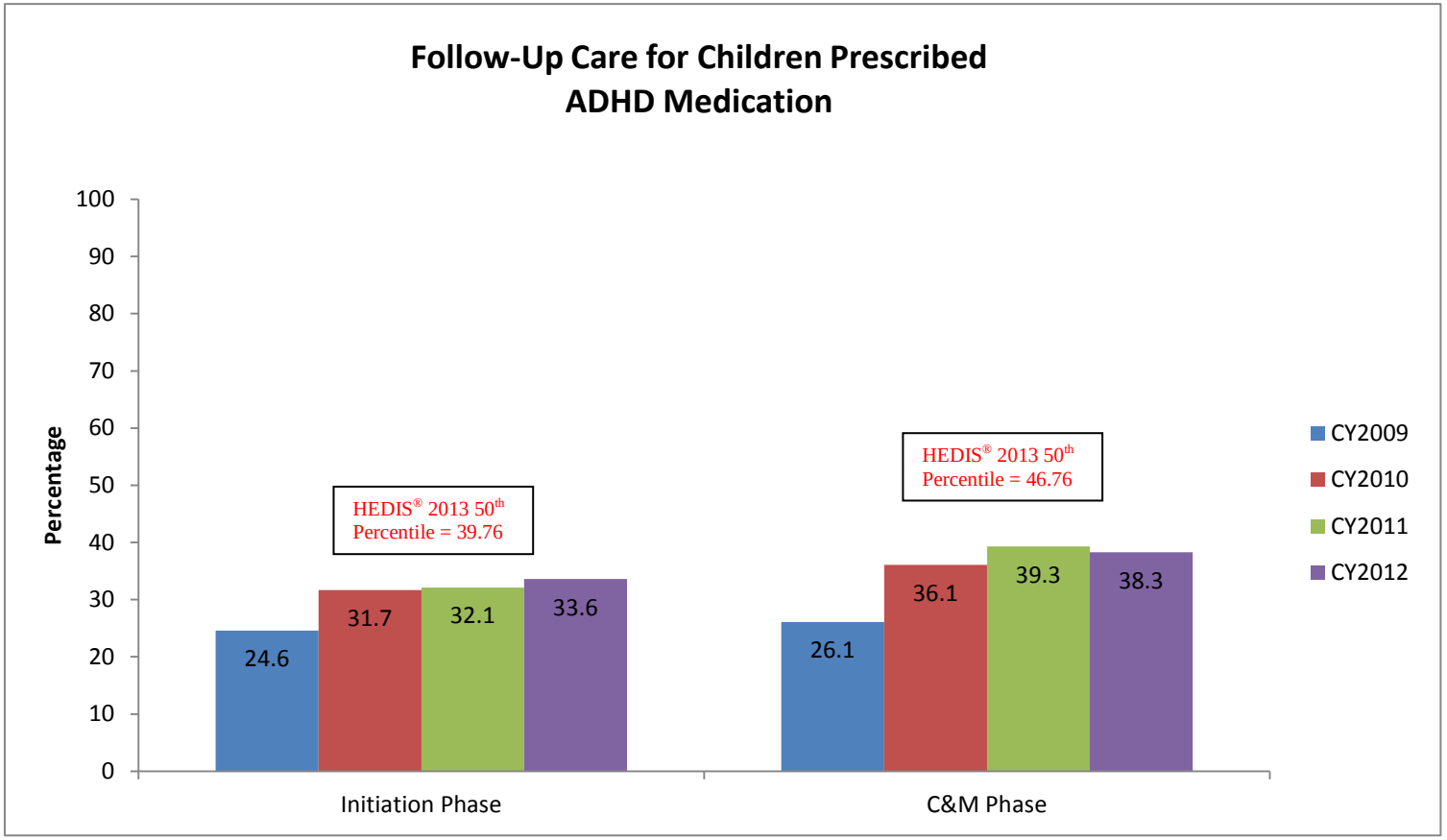
Notes on Measure Programming or Deviations from Measure Specifications:

- CY2009 - CY2012 were generated with HEDIS® 2012 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", these follow-up visits may be undercounted.

Eligible Population:

	CY2009		CY2010		CY2011		CY2012	
	Numerator	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**
Initiation Phase	2,815	11,453	3,936	12,401	4,232	13,202	4,935	14,711
C & M Phase	809	3,104	654	1,811	1,451	3,694	1,601	4,178

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



Key Findings:

- From CY2009 to CY2012 there was an increase of 9.0 percentage points, an increase of 36.6 percent, in follow-up during the Initiation Phase.
- From CY2009 to CY2012 there was an increase of 12.2 percentage points, an increase of 46.7 percent, in follow-up during the C&M Phase.
- While rates increased throughout the measurement period, performance is below the HEDIS® 2013 50th percentile indicating there is room for improvement during both the initial and continuation and maintenance phases.

Measure CWP: Appropriate Testing for Children with Pharyngitis

Measure Description: The percentage of children ages 2 to 18 years old that were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode. To be counted for this measure, children must have continuous enrollment 30 days prior to the Episode Date through three days after the Episode Date (inclusive).

Relevance of Measure: According to the CDC, only 15 percent of all pharyngitis cases are due to Group A Streptococcus. Often, antibiotics are given inappropriately because strep tests or throat cultures are not performed to identify pharyngitis. When these types of tests are performed, the appropriate antibiotic can be prescribed for the specific upper respiratory infection. Using antibiotics only when necessary will help reduce the development of antibiotic resistant organisms and strengthen the child's natural immunological defenses.

Notes on Measure Programming or Deviations from Measure Specifications:

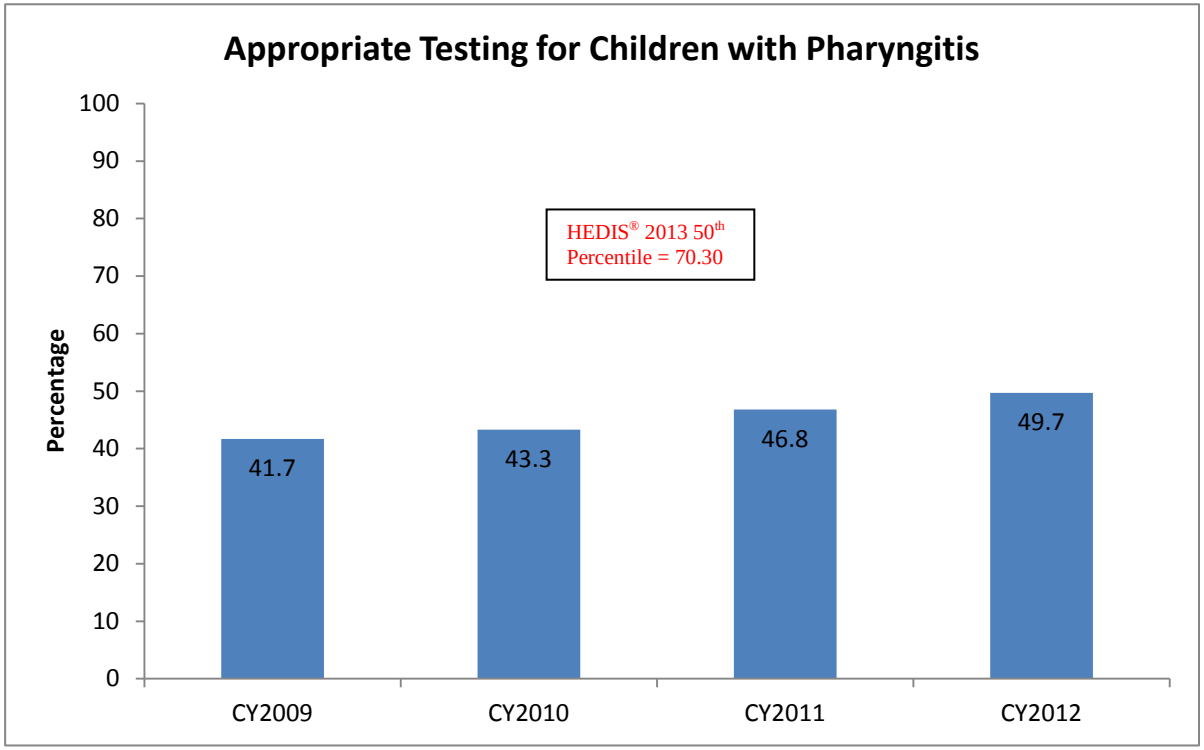
- CY2009 - CY2011 were generated with HEDIS® 2012 specifications and CY2012 generated with HEDIS® 2013 specifications. In this report, the numerator and denominator data for CY2010 and CY2011 are updated to correct an error that was included in the 2012 Data Book.

Eligible Population:

Calendar Year	Numerator	Denominator
2009	40,640	97,459
2010	39,750	91,855
2011	47,893	102,259
2012	44,749	90,034

Key Findings:

- From CY2009 to CY2012, there was an increase of 8 percentage points, an increase of 19.18 percent, in the children diagnosed with pharyngitis who were dispensed an antibiotic and received a group A streptococcus (strep) test.
- While the 50th HEDIS® 2013 percentile is provided in the chart, this measure did not achieve the 10th percentile (50.84) showing considerable room for improvement.



Measure ASMER: Annual Percentage of Asthma Patients with One or More Asthma-related Emergency Room Visits

Measure Description: The percentage of children ages 2 to 20 diagnosed with asthma during the measurement year with one or more asthma-related emergency room (ER) visits. To be counted, individuals must be ages 2 to 20 years and be continuously enrolled for 12 consecutive months during the measurement year. A lower percentage is indicative of better performance for this measure.

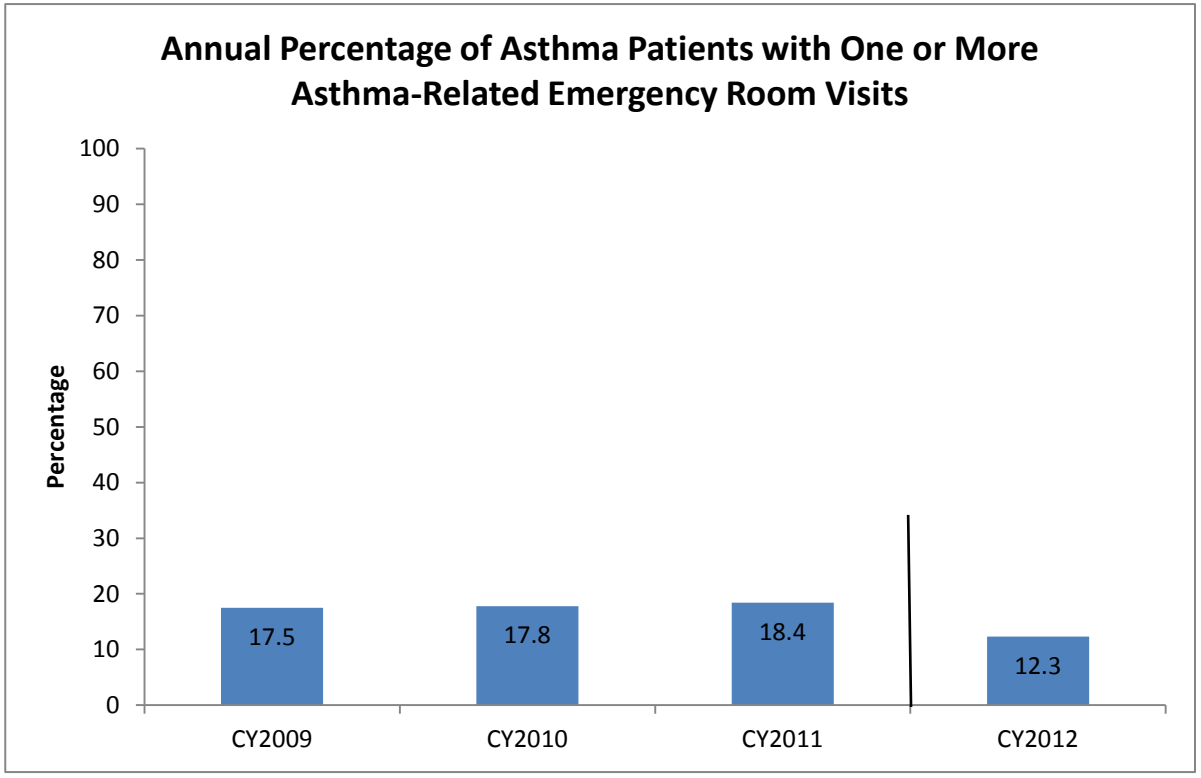
Relevance of Measure: Asthma is a chronic disease of the lungs that makes breathing difficult. Asthma attacks can vary from mild to life-threatening. Asthma cannot be cured but symptoms can be controlled with appropriate medication and patient education leading to better quality of life. Direct health care costs associated with asthma, including inpatient hospitalization, emergency room visits, and office visits can be significantly decreased with appropriate asthma management.

Notes on Measure Programming or Deviations from Measure Specifications:

- The CY2012 rate is not comparable to CY2009-CY2011 rates because the denominator includes both primary and secondary diagnosis of asthma, consistent with the specifications, whereas previous years included only those with a primary asthma diagnosis. The denominator now captures more asthma diagnoses lowering the rate reported for CY2012.
- The vertical line indicates that CY2012 data are not comparable to previously reported years due to denominator differences described above.
- The May 2013 Child Core Set specifications were used to program this measure.

Eligible Population:

Calendar Year	Numerator	Denominator
2009	13,759	78,839
2010	13,889	77,881
2011	14,578	79,251
2012	14,302	116,457



Measure AMB: Ambulatory Care – Emergency Department Visits

Measure Description: The rate of emergency department (ED) visits per 1,000 member months among children up to age 19. A lower rate for this measure is indicative of better performance. No continuous enrollment for this measure.

Measure Relevance: According to a CMS Informational Bulletin dated January 2014, research indicates that "Medicaid beneficiaries use the ED at an almost two-fold higher rate than the privately insured." The Bulletin notes that this may be because Medicaid beneficiaries are in poorer health and use the ED for "…urgent or more serious medical problems." States are encourage to reduce ED utilization by "…promoting continuous coverage for eligible individuals and improving access to appropriate care settings to better address the health needs of the population."

Notes on Measure Programming or Deviations from Measure Specifications:

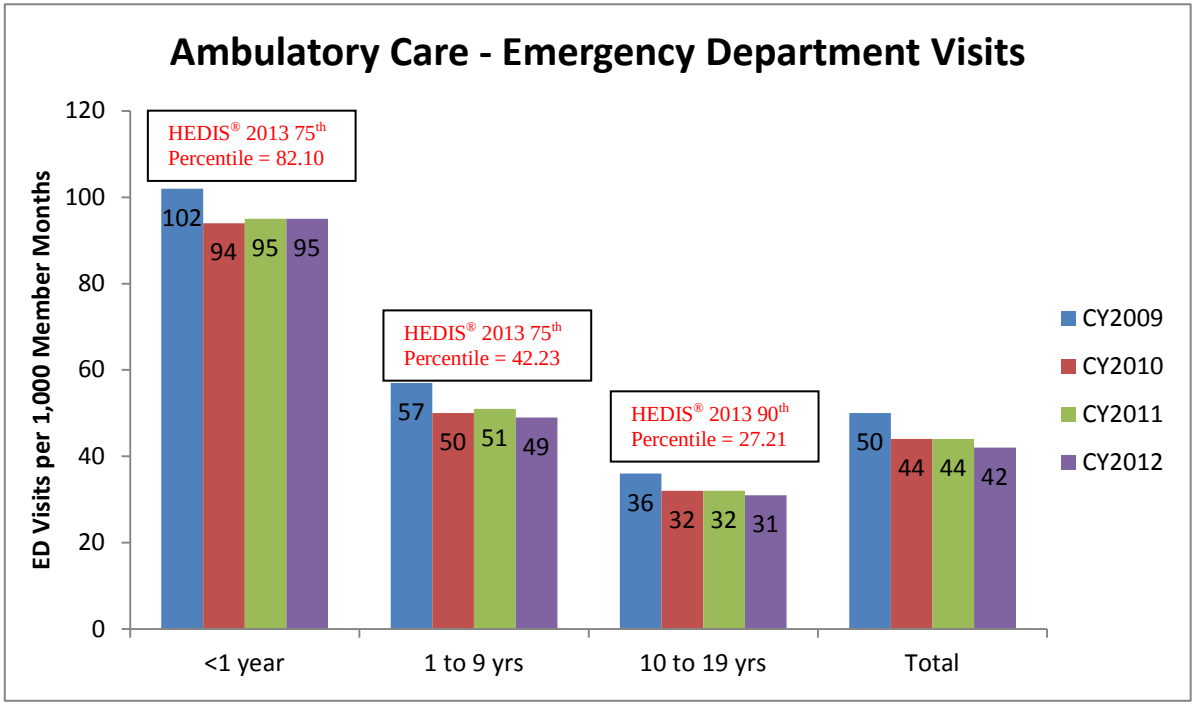
- CY2012 generated using HEDIS® 2013 specifications.

Eligible Population:

	CY2009		CY2010		CY2011		CY2012	
	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	58,143	572,177	52,261	553,993	50,927	536,204	50,200	526,528
1-9 Years	498,992	8,743,567	448,312	9,042,887	470,100	9,177,349	448,907	9,098,690
10-19 Years	248,419	6,879,454	234,522	7,298,683	241,277	7,586,574	234,955	7,697,891
Total	805,554	16,195,198	735,095	16,895,563	762,304	17,300,127	734,062	17,323,109

Key Findings:

- From CY2009 to CY2012, there was a decrease of eight visits per 1,000 member months, a decrease of 16.0 percent, in ambulatory care emergency department visits.
- For those <1 year and those 1 to 9 years, the HEDIS® 2013 50th percentile was exceeded. Among those 10 to 19 years, the 75th percentile was exceeded.
- While achievement on this measure is better than the 50th percentile, there is room for improvement across all age categories as the rates seem to have stabilized over the last three year period.



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.

Measure Relevance: Measures of the amount of services delivered do not reflect the experiences of the patients receiving that care. The CAHPS® survey assesses the health care experience based on the responses of patients receiving care to assure that high quality services are being delivered.

Notes on Measure Programming or Deviations from Measure Specifications:

- 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® 5.0 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:

	Sample Size	Total Complete	Complete by Phone	Complete by Mail	Ineligible	Final Sample Size	Response Rate
Total Population	7,071	2,552	794	1,758	188	6,883	37.08%
Title XIX (Medicaid)	3,655	1,393	443	950	84	3,571	39.01%
Title XXI (CHIP)	3,416	1,159	351	808	104	3,312	34.99%

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

2013 General Child and Children with Chronic Conditions (CCC) CAHPS Result Summary Description	General Child	Child w/Chronic Condition(s)
Global Ratings		
Rating of Health Plan (% Responding 9 or 10 on scale of 0 - 10)	56.9%	46.2%
Rating of All Health Care (% Responding 9 or 10 on scale of 0 - 10)	60.2%	54.6%
Rating of Personal Doctor (% Responding 9 or 10 on scale of 0 - 10)	75.3%	69.9%
Rating of Specialist Seen Most Often (% Responding 9 or 10 on scale of 0 - 10)	65.6%	66.4%
Composite Measures		
Getting Needed Care (% Responding "Usually" or "Always")	72.2%	78.0%
Getting Care Quickly (% Responding "Usually" or "Always")	92.8%	92.1%
How Well Doctors Communicate (% Responding "Usually" or "Always")	93.5%	95.0%
Customer Service (% Responding "Usually" or "Always")	86.0%	80.9%
Shared Decision Making (% Responding "A lot" or "Yes")	46.1%	56.4%
Children with Chronic Conditions (CCC) Composites and Items		
Access to Specialized Services		70.3%
Family-Centered Care (FCC): Personal Doctor Who Knows Child		88.8%
Coordination of Care for Children with Chronic Conditions		72.7%
Access to Prescription Medicines		78.1%
FCC: Getting Needed Information		91.4%

Child Core Set Measures Not Currently Reported

Measure Name	Reason For Not Reporting
Pediatric Central-line Associated Bloodstream Infections Neonatal Intensive Care Unit and Pediatric Intensive Care Unit	CMS to obtain data directly from CDC; states not required to collect data or report to CMS
Behavioral Health Risk Assessment	E-specified measure; HFS does not have the ability to report e-measures

Project Summary

Project Summary

The CHIPRA Quality Demonstration Grant provided an opportunity to focus on improving the quality of children's health care by testing and implementing the core set of pediatric performance measures. Illinois has made substantial progress on reporting the core measures from 10 measures in 2010 (the baseline year), to 17 measures in 2011, 20 measures in 2012, and 25 measures in 2013. The CHIPRA funding allowed Illinois to focus on the core measures and the measurement process, leading to improvements in the integrity of the data and the measurement process for all state 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/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.

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. Opportunities include a more robust data system with potential to improve quality measurement and care delivery.

Administrative Methodology

Illinois' decision to use the administrative method was made easier by 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 reporting method results in a lower statewide rate due to incomplete and inaccurate encounter data. However, new contractual requirements are expected to improve the completeness and accuracy of encounter data over coming years.

Deviations

While deviations 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

Illinois is currently involved in moving 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. Many different models of care are being tested across various populations. To assure consistency, Illinois developed its own "core set" of measures to be included in all contracts, which includes 14 of the Child Core Set measures.

Project Summary

Data Integrity/Efficiencies
Through the focus of the CHIPRA Quality Demonstration Grant on improving data quality, a number of changes were made to improve the efficiency of the performance measurement process and improve the integrity of the data.

- Although data audits had been conducted by a certified External Quality Review Organization, they were not conducted annually. Beginning with the data audit conducted in April 2012, data audits are being conducted annually to improve upon the integrity of data used for performance measurement.
- Performance measurement is used for a variety of purposes, and standardized performance measures were often altered to suit those purposes. Performance measures will 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.
- All HFS performance measurement has benefitted from the availability of the CMS Technical Assistance (TA) contractor for CHIPRA grantees. TA received is often transferable to other performance measures.

Barriers
Revisions to the specifications consume an enormous amount of resources. Illinois has adopted an annual schedule for identifying changes, programming, testing, reporting, and data auditing to assure that reporting timeframes are met, as well as timeframes required for other measure uses, such as bonus payments. Illinois has encouraged CMS to limit the number of changes to specifications and introduction of new measures to the extent possible.

Performance Measurement
The CHIPRA grant has been instrumental in improving performance measurement. In reporting on the Child Core Set measures, a number of inconsistencies were brought to light and resolved either through receipt of technical assistance from the CMS TA contractor or through research and discussion with the Quality of Care Measures Committee. Improvements include greater consistency, alignment, and better data quality, resulting in more accurate performance measurement, not only for CHIPRA purposes, but for measurement generally.

During the next state fiscal year the five-year CHIPRA grant period will end. However, Illinois will continue annual reporting on the Child Core Set measures. As noted throughout this document, Illinois continues to make progress in improving performance measurement. That work will continue through sustained 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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