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On behalf of the Illinois Department of Healthcare and Family Services (HFS), we are pleased to announce the release of the 2012 Children's Health Insurance Program Reauthorization Act (CHIPRA) Data Book. The CHIPRA Data Book was developed through the CHIPRA Quality Demonstration Grant and reports on the CHIPRA core measure set of children's quality measures. This document represents the first major publication of its kind authored by the newly-created Bureau of Quality Management at HFS.

In February 2010, the Centers for Medicare & Medicaid Services (CMS) awarded grants to ten states for a five year period. Illinois, in partnership with Florida, was awarded one of ten federal grants. These grants are funded by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). The CHIPRA Quality Demonstration Grant is currently in year four of the five-year grant period and focuses on strengthening the quality of children's health care through measuring and reporting the core set of child health measures, improving quality through health information technology and exchange, improving and enhancing medical homes, and improving birth outcomes.

HFS has reported on various quality measures for several years, but the CHIPRA Data Book is the first time HFS has publicly reported on a comprehensive set of quality measures over time. As you will see in the CHIPRA Data Book, HFS has seen improvement in some areas, and has opportunities for improvement in others.

The CHIPRA Data Book also will serve as a template for future reporting. We are interested in your input, as we intend to report on the CHIPRA core set annually hereafter, and on a growing array of quality measures in the future.

Sincerely,

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Illinois' CHIPRA Quality Demonstration Grant

Pediatric Performance Measurement

Based on Administrative Data
Calendar Years 2009, 2010, and 2011

ILLINOIS CHIPRA Quality Demonstration Project
Improving Child Health and Medical Homes for Illinois AllKids

ILLINOIS DEPARTMENT OF Healthcare and Family Services

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Executive Summary

CHIPRA Quality Demonstration Grant: 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).

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. The data use a three-year trend period and reflect HEDIS® benchmarks and percentiles, where applicable.

Key findings:

- In 2010, Illinois reported on 13 core measures to CMS, with 17 reported in 2011 and 20 reported in 2012. Of those 20 reported measures in 2012, 14 showed improvement.
- Although Illinois has a history of performance measure reporting, compliance with the core measure specifications required a significant amount of time and resources for planning, programming, obtaining technical assistance, and reporting. Illinois made the decision to report all core measures using administrative data rather than incur additional expenses related to medical record reviews required for reporting with the hybrid method.
- Many details and data use issues had to be addressed with other State agencies for those measures that use registry and Vital Records data.
- Contracting issues and CMS guidance delayed reporting of the CAHPS® measure and the reporting of some CHIPRA measures at the provider level.
- The CHIPRA grant has allowed the Illinois Department of Healthcare and Family Services (HFS) to improve the quality of data used in performance measurement and adopt reporting efficiencies which will help to ease the burden of ongoing measure update and maintenance.
- Compliance with the core measure specifications has been challenging. Deviations from some of the core measure specifications continue to exist, but have been minimized to the extent possible. Deviations are identified throughout this report.
- State policies, priorities, legislation, procurements, and resource limitations also have impacted Illinois' ability to fully implement the CHIPRA core measures.

Background

Background

CHIPRA Legislation:
CHIPRA, Public Law 111-3, was signed into law on February 4, 2009. CHIPRA reauthorizes CHIP and extends CHIP funding through federal fiscal year (FFY) 2013. CHIPRA also 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. In January 2013, CMS retired one measure from the core set - 16 Otitis Media with Effusion. In addition, states are not required to report on measure 19 Pediatric Central Line Associated Blood Stream Infections, as CMS is collaborating directly with the U.S. Centers for Disease Control and Prevention (CDC) to obtain data for each state.

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, which is not reported in this document.

Illinois reports on the CHIPRA core 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.

Each year, the US 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 administrative data from many sources. Refer to page 9 of this document for a detailed description of the data housed in the EDW.

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

#	NQF #	Measure Steward	Measure Name
1	1517	NCQA	Prenatal and Postpartum Care: Timeliness of Prenatal Care
2	1391	NCQA	Frequency of Ongoing Prenatal Care
3	1382	CDC	Percentage of Live Births Weighing less than 2,500 Grams
4	0471	California Maternal Quality Care Collaborative	Cesarean Rate for Nulliparous Singleton Vertex
5	0038	NCQA	Childhood Immunization Status
6	1407	NCQA	Immunizations for Adolescents
7	0024	NCQA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents
8	1448	CAHMI and NCQA	Developmental Screening in the First Three Years of Life
9	0033	NCQA	Chlamydia Screening in Women
10	1392	NCQA	Well-Child Visits in the First 15 Months of Life
11	1516	NCQA	Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life
12	N/A	NCQA	Adolescent Well-Care Visits
13	N/A	CMS	Total Eligibles Who Received Preventive Dental Services (ages 1-20)
14	N/A	NCQA	Child and Adolescent Access to Primary Care Practitioners
15	0002	NCQA	Appropriate Testing for Children With Pharyngitis
16	0657	AMA-PCPI	Otitis Media with Effusion (OME) – Avoidance of Inappropriate Use of Systemic Antimicrobials in Children (ages 2-12)
17	N/A	CMS	Total Eligibles Who Received Dental Treatment Services (ages 1-20)
18	N/A	NCQA	Ambulatory Care: Emergency Department Visits
19	0139	CDC	Pediatric Central-line Associated Bloodstream Infections-Neonatal Intensive Care Unit and Pediatric Intensive Care Unit
20	1381	Alabama Medicaid	Annual Percentage of Asthma Patients with One or More Asthma-related Emergency Room Visits (ages 2-20)
21	0108	NCQA	Annual Percentage of Asthma Patients Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication
22	0060	NCQA	Annual Pediatric Hemoglobin A1C Testing
23	0576	NCQA	Follow-up After Hospitalization for Mental Illness
24	N/A	NCQA	CAHPS® 4.0H (child version including Medicaid and children with chronic conditions supplemental items)

AMA-PCPI: American Medical Association-Physician Consortium for Performance Improvement; CAHMI: Child and Adolescent Health Measurement Initiative; CDC: Centers for Disease Control and Prevention; CMS: Centers for Medicare and Medicaid Services; N/A: Measure is not NQF endorsed; NCQA: National Committee for Quality Assurance; NQF: National Quality Forum

Performance Measurement

HFS currently 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, demonstrate the success of programs and initiatives, and allows HFS to target efforts and resources where needed to improve health care delivery.

Quality Improvement: Quality improvement initiatives (QIIs) 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.

Public Reporting: HFS regularly reports on performance measures. Performance measures are included in a variety of public reports, including the HFS Annual Report, federally-required reports the Perinatal Report, and the Title V MCH Block Grant Report. Reports are publicly accessible on the HFS Web Site.

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 CHIPRA core measure set is 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 CHIPRA 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	1996-2013	Claims	Information about health care services , including patient information, service location, provider of service, procedure, diagnosis, CPT codes
HFS	1996-2013	Recipient File	Patient-level information including eligibility, demographics, recipient ID
HFS	1996-2013	Provider File	Provider information including provider ID, provider type, address, billing address
IDPH	1990-2013	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	1960-2013	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	1960-2013	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 soon.
IDPH	1970-2013*	Vital Records	All data elements contained in the "certifiable" portion and all "Information for Medical and Health Use Only" portion of the Birth, Death, and Fetal Death file. *Certified vital records are available from 1970-2010; vital records for 2011-2013 are not certified.
IDPH	2008-2012	Expanded Vital Records System	Expanded tables to contain new data from the new IDPH IVRS
IDPH	1970-2012	Out-of-State Vital Records	Out-of-state birth, death, and fetal death information for HFS enrollees
IDPH	1997-2013	Pre-Admission Screening	These data contain basic demographic data plus the DON score for patients admitted to a hospital.
IDPH	2009-2011	Hospital Discharges	Detailed data including up to 25 procedure diagnosis codes; limited to Illinois hospitals
IDHS Cornerstone	1992-2013	Family Case Management (FCM)	Enrollment information for pregnant women, infants and young children who are enrolled in FCM and identification of those who are not.
IDHS Cornerstone	1992-2013	Family Planning	Aggregate data on women served in FP program
IDHS Cornerstone	1992-2013	Healthy Start	Enrollment information for pregnant women, infants and young children who are enrolled in FCM and identification of those who are not.
IDHS Cornerstone	1992-2013	Immunization	Immunization information for HFS participants from PH sector from Cornerstone.
IDHS Cornerstone	1992-2013	Targeted Intensive Prenatal Case Management (TIPS)	Enrollment and risk assessment information for pregnant women, infants and young children who are enrolled in FCM and identification of those who are not.
IDHS Cornerstone	1992-2013	Supplemental Nutrition Program for Women, Infants and Children (WIC)	Enrollment information for pregnant women, infants and young children who are enrolled in FCM and identification of those who are not.
IDHS Cornerstone	1992-2013	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	1996-2013	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	1986-2012	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.

Core Measures

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 lower than what are actually occurring due to incomplete and/or inaccurate encounter data, coding, and claims adjudication issues. This report reflects HFS Enterprise Data Warehouse (EDW) data as of June 2013 and includes the Title XIX, Title XXI, and state-funded populations. Three measures in this report are identified as provisional. These measures are currently in testing and ad hoc reports were used.

Data Quality
HFS has implemented a number of initiatives aimed at improving data quality, including contractual requirements for data reporting, reduced billing timeframe requirements, and quality improvement initiatives.

Deviations from CHIPRA Core Measure Specifications
Any deviations between the CHIPRA core specifications and the specifications used for this report are identified. The CHIPRA core specifications are periodically updated and resource limitations restrict the State's ability to update measures. The versions of the specifications used for the measures are identified for each measure reported.

The CHIPRA Core 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
The measures reported include the HEDIS® percentile, when applicable. The percentiles reflected in the "Dashboard" are the HEDIS® percentiles achieved. The percentile(s) reflected for each HEDIS® 50th percentile, which depicts whether the state's performance on a particular measure is in the top or bottom 50th percentile.

Measurement Years

A three-year trend is reported, when possible.

The measurement years for most measures are by calendar year (CY) for 2009, 2010, and 2011. The measurement years for measure 13, Total Eligibles who Received Preventive Dental Services, and 17, Total Eligibles who Received Dental Treatment Services, are by federal fiscal year (FFY*) for 2010, 2011, and 2012 as required by the federal CMS-416 report.

*FFY – October 1 – September 30

IL CHIPRA Quality Demonstration Grant - Core Performance Measures CY2009-CY2011 Dashboard

CHIPRA Core Measure	CY2009	CY2010	CY2011
Timeliness of Prenatal Care	54.1	55.6	58.1
Frequency of Ongoing Prenatal Care			
<21% of expected visits	11.4	11.1	10.9
21 – 40% of expected visits	6.7	6.5	6.5
41 – 60% of expected visits	11.2	10.7	10.6
61 – 80% of expected visits	21.9	21.3	21.1
>81% of expected visits	48.9	50.3	51.0
Percent of Live Births Weighing <2,500g	8.9	8.6	8.7
Cesarean Rate for Nulliparous Singleton Vertex	N/A	N/A	N/A
Childhood Immunization Status			
DTaP	N/A	N/A	N/A
OPV/IPV	N/A	N/A	N/A
MMR	N/A	N/A	N/A
HiB	N/A	N/A	N/A
HepB	N/A	N/A	N/A
Chicken Pox	N/A	N/A	N/A
Pneumococcal	N/A	N/A	N/A
HepA	N/A	N/A	N/A
Rotavirus	N/A	N/A	N/A
Influenza	N/A	N/A	N/A
Combo 2	65.0	64.2	66.4
Combo 3	59.1	59.2	61.2
Combo 4	N/A	N/A	N/A
Combo 5	N/A	N/A	N/A
Combo 6	N/A	N/A	N/A
Combo 7	N/A	N/A	N/A
Combo 8	N/A	N/A	N/A
Combo 9	N/A	N/A	N/A
Combo 10	N/A	N/A	N/A
Immunizations for Adolescents			
Meningococcal	23.9	34.0	43.1
Tdap	30.6	39.5	47.6
Combo	18.1	27.0	35.9
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents: BMI Assessment for Children/Adolescents			
3 to 11 Years	0.4	0.6	0.8
12 to 17 Years	0.4	0.6	0.8
3 to 17 Years	0.4	0.6	0.8
Developmental Screening in the First 3 Yrs of Life			
1 Year	43.7	52.6	60.8
2 Years	32.2	41.0	49.7
3 Years	19.5	27.0	34.7
Total	31.9	40.0	48.1

Based on 2009-2011 Data and 2012 HEDIS® Benchmarks

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

75th percentile or greater

50th percentile or greater

25th percentile or greater

10th percentile or greater

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

N/A – Not Available

CHIPRA Core Measure	CY2009	CY2010	CY2011
Chlamydia Screening in Women			
16-20 Years	44.7	46.9	45.6
21-24 Years	52.5	55.2	55.7
16-24 Years	48.3	50.7	50.2
Well-Child Visits in the First 15 Months of Life			
0 Visits	3.2	2.6	2.6
1 Visit	2.7	2.4	2.2
2 Visits	3.7	3.2	3.1
3 Visits	5.0	4.6	4.5
4 Visits	7.1	6.7	6.4
5 Visits	10.3	9.8	9.2
6 or More Visits	68.1	70.8	72.0
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life			
3 Years	74.1	74.2	74.3
4 Years	74.7	74.7	74.6
5 Years	79.0	77.9	77.4
6 Years	58.2	58.1	57.7
3-6 Years	71.7	71.4	71.2
Adolescent Well-Care Visits	40.7	41.5	41.8
Total Eligibles Who Received Preventative Dental Care (Based on FFY 2010, 2011, 2012)	50.3	52.1	53.2
Children and Adolescents' Access to Primary Care Practitioners			
12 to 24 Months	87.8	87.8	88.1
25 Months to 6 Years	79.5	78.6	78.6
7 to 11 Years	80.3	81.1	80.1
12 to 19 Years	78.2	80.0	79.5
All Age Groups	80.5	81.0	80.5
Appropriate Testing for Children with Pharyngitis	41.7	43.3	46.8
Total Eligibles Who Dental Treatment Services (Based on FFY 2010, 2011, 2012)	21.3	21.6	22.5
Ambulatory Care: Emergency Department Visits Per 1,000 Member Months			
<1 Year	102	94	95
1-9 Years	57	50	51
10-19 Years	36	32	32
Total	50	44	44
Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Room Visits (ages 2-20)	17.5	17.8	18.4
Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication			
Initiation Phase	24.6	31.7	32.1
Continuation and Maintenance (C&M) Phase	26.1	36.1	39.3
Follow-Up After Hospitalization for Mental Illness			
7 Day Follow-Up	27.6	32.0	31.5
30 Day Follow-Up	46.3	51.8	51.2

Measure 1 - 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.

Deviations from CHIPRA Specifications:

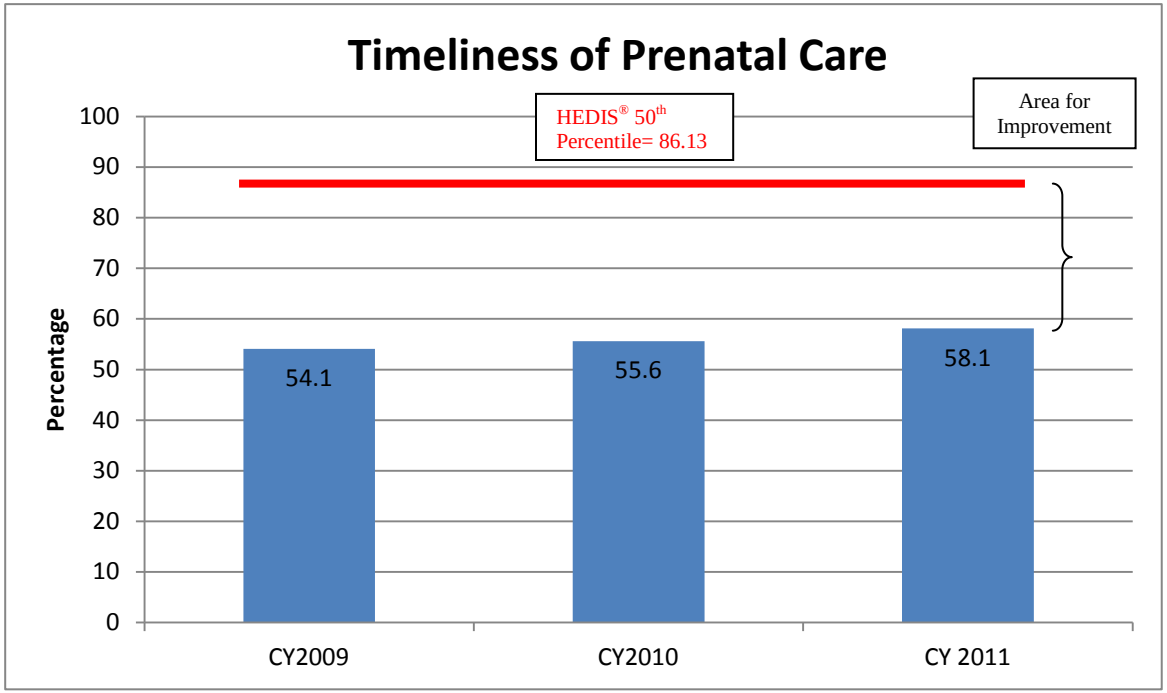
- All calendar years generated with HEDIS® 2007 specifications.
- HFS is currently using only Decision Rule 2.
- HFS does not use LOINC codes.

Eligible Population:

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

Key Findings:

- Timeliness of prenatal care visits increased by 4 percentage points from CY2009 to CY2011, a percent change increase of 7.4.
- This measure shows small steady increases from CY2009 to CY2011, but since only a slim majority of Medicaid-eligible women are receiving timely prenatal and postpartum care, it presents an opportunity for improvement.



Measure 2 – 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."

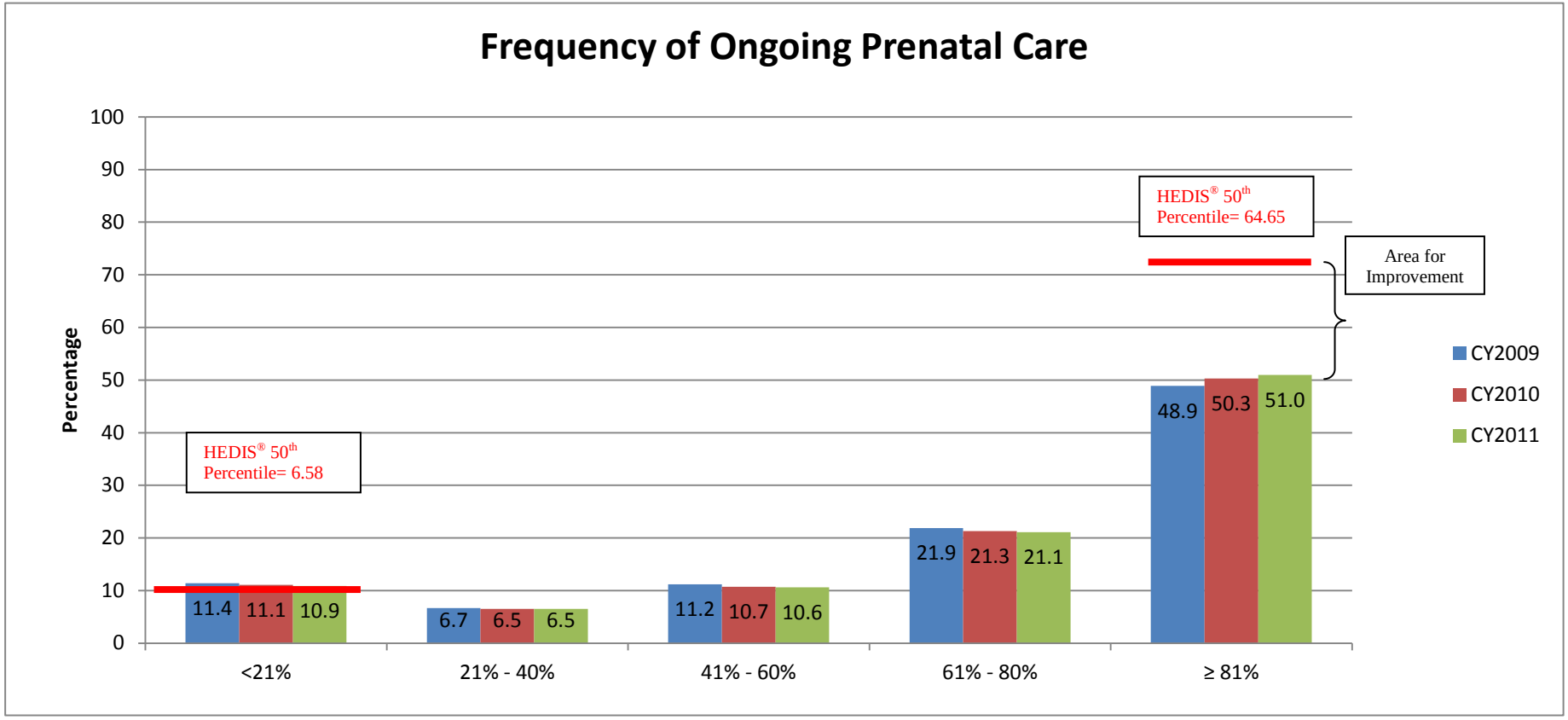
Deviations from CHIPRA Specifications:

- All calendar years generated with HEDIS® 2007 specifications.
- HFS is currently using only Decision Rule 2.
- HFS does not use LOINC codes.

Eligible Population:

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

Measure 2 – Frequency of Ongoing Prenatal Care



Key Findings:

- The percentage of women receiving <21%, 21%-40%, 41%-60% and 61%-80% of the expected number of prenatal visits showed small improvements from CY2009 to CY2011.
- The <21% rate is at the 75th percentile, which is 10.71, in CY2009 - CY2011. This is an inverted measure with a lower percentile indicative of better performance. There is opportunity for improvement on this measure.
- From CY2009 to CY2011, the percent of women who received ≥81 percent of expected visits increased by 2.1 percentage points, a percent change increase of 4.3.
- Although this measure shows improvement, only a slight majority of Medicaid-eligible women are receiving 81% or more of the expected number of prenatal visits, presenting opportunity for improvement.

Measure 3 – Percentage of 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.

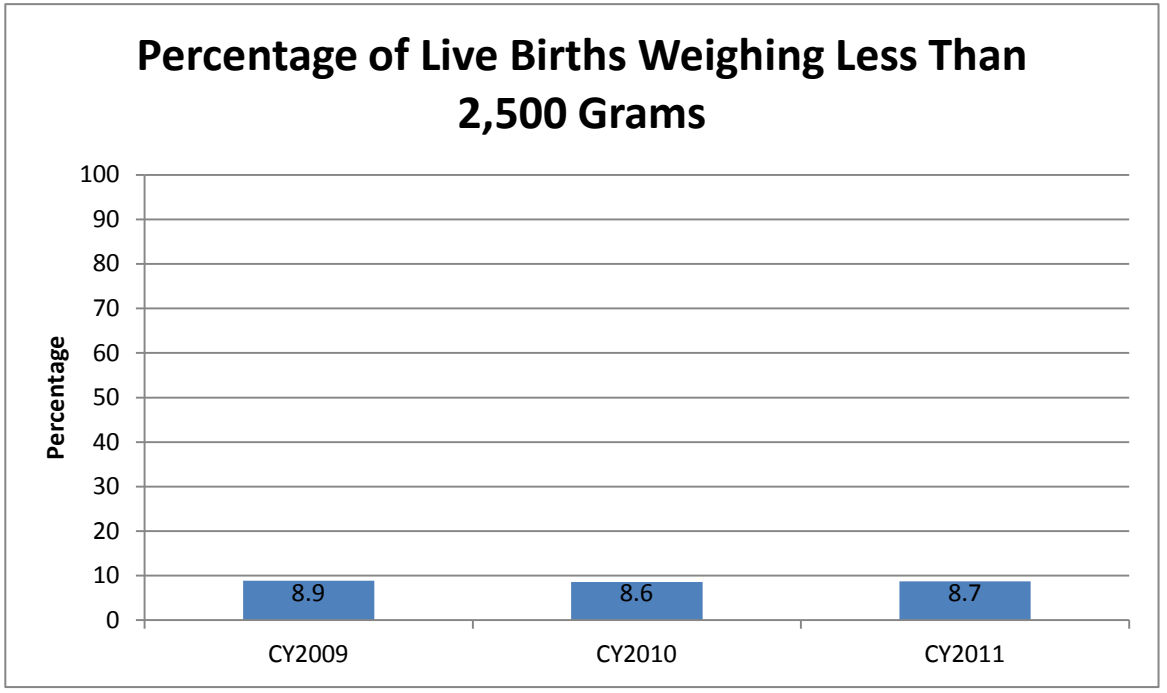
Relevance of Measure: The lower the birth weight of an infant, the greater chance of neonatal death or risk factors early and/or later in life. The rate can be decreased with preventive care, earlier interventions, and more education and intervention during pregnancy to address risk factors that contribute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

Deviations from CHIPRA Specifications: None

Eligible Population:

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

NOTE:
- Data are provisional since programming is newly revised and quality testing conducted by HFS was not fully complete prior to the release of this report.
- The CY2010 and CY2011 Illinois Vital Records birth file data are not yet certified by the Illinois Department of Public Health (IDPH).



Key Findings:
- The percentage of HFS covered low birth weight births remained statistically unchanged from CY2009 to CY2010.

Measure 5 – 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

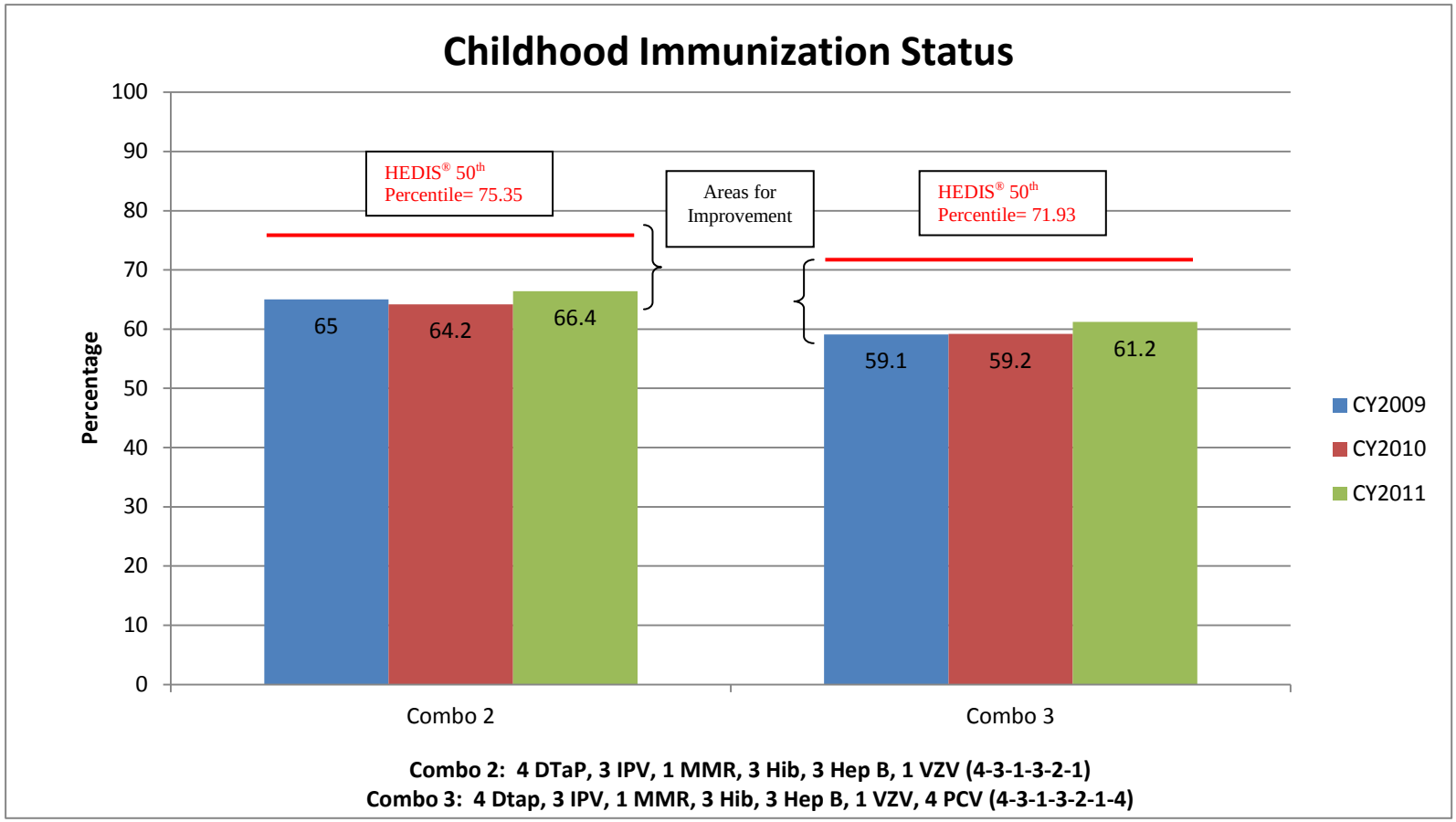
Deviations from CHIPRA Specifications:

- CY2009, 2010 and 2011 were generated with HEDIS® 2011 specifications.
- Individual vaccines and Combos 4-10 are not reported, pending completion of programming. Illinois reports on Combo 2 and Combo 3:
  - **Combo 2:** 4 DTaP, 3 IPV, 1 MMR, 3 Hib, 3 Hep B, 1 VZV, (4-3-1-3-3-1)
  - **Combo 3:** 4 DTaP, 3 IPV, 1 MMR, 3 Hib, 3 Hep B, 1 VZV, 4 PCV (4-3-1-3-3-1-4)
- HFS accepts 2 Hep B since the first vaccine is given to newborns in the hospital and is billed on the mother's claim.
- Using state Cornerstone immunization codes in addition to CPT and ICD-9 codes.

Eligible Population:

	CY2009		CY2010		CY2011	
	Numerator	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**
Combo 2	61,240	94,265	61,257	95,383	62,093	93,582
Combo 3	55,688	94,265	56,508	95,383	57,285	93,582

Measure 5 – Childhood Immunization Status



Key Findings:

Combo 2

- There was an increase of 1.4 percentage points, a percent change increase of 2.2, in Combo 2 from CY2009 to CY2011.

Combo 3

- There was an increase of 2.1 percentage points, a percent change increase of 3.6, in Combo 3 from CY2009 to CY2011.

Combo 2 and 3

- From CY2009 to CY2010 the slight rate changes for Combo 2 and 3 could be attributable to the change in Hib requirement from 2 to 3.
- Although there are slight increases in both the Combo 2 and Combo 3 rates over the reporting period, there is opportunity for improvement.

Measure 6 – Immunizations 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.

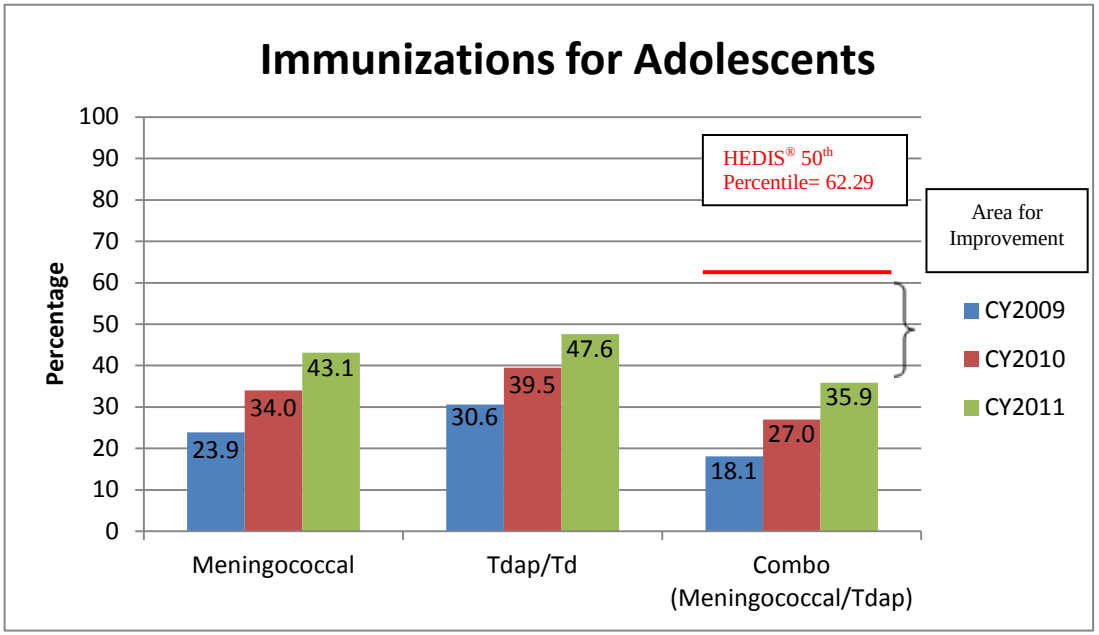
Relevance of Measure: Vaccinations are available to protect children from serious diseases that can result in illness, disability and death. Vaccinations are not only important for protecting individual children from disease, but also to protect communities and future generations as well. Vaccinations 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

Deviations from CHIPRA Specifications:

- CY2009, 2010 and 2011 were generated with HEDIS® 2012 specifications.
- Using state immunization registry data in addition to claims data.

Eligible Population:

	CY2009		CY2010		CY2011	
	Numerator	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**
Meningococcal	15,623	65,273	23,823	70,102	32,725	75,952
Tdap/Td	19,976	65,273	27,701	70,102	36,157	75,952
Combo	11,781	65,273	18,955	70,102	27,255	75,952



Key Findings:

- From CY2009 to CY2011, the combined Meningococcal and Tdap/Td immunization percentage rate for adolescents increased by 17.8 percentage points, a percent change of 98.3.
- There was an increase of 19.2 percentage points, a percent change increase of 80.3, in the Meningococcal rate from CY2009 to CY2011.
- From CY2009 to CY2011 there was an increase of 17 percentage points, a percent change increase of 55.6, in Tdap/Td.
- These are significant increases in light of the increased eligible population from CY2009 to CY2011 of 10,679 adolescents from (65,273 to 75,952, respectively), but the rate continues to be well below the 50th percentile, presenting opportunity for improvement.

Measure 7 – 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.

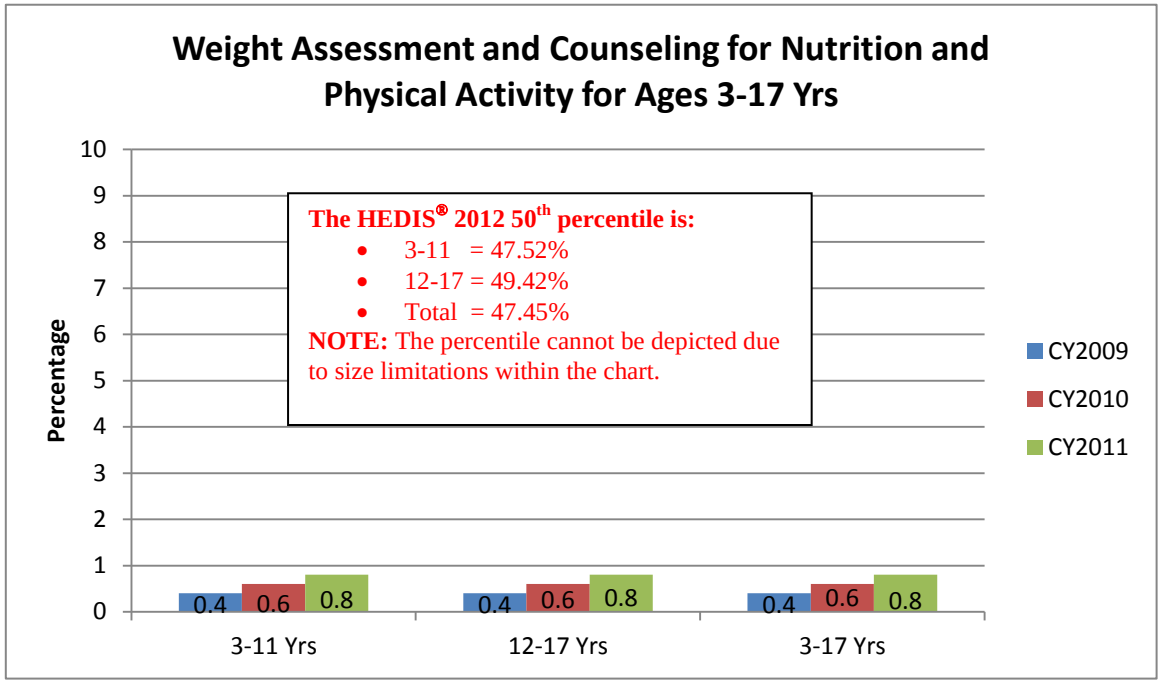
Relevance of Measure: The CDC and the AAP recommend the use of BMI to screen for overweight and obesity in children and teens aged 2 through 19 years. According to the CDC, in 2007-2008, 10.4% of 2-5 year olds, 19.6% of 6-11 year olds and 18.1% of 12-19 year olds were obese, defined as exceeding the 85th percentile for their age group. Once an overweight BMI has been 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.

Deviations from CHIPRA Specifications:

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

Eligible Population:

	CY2009		CY2010		CY2011	
	Numerator	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**
3-11 yrs	3,180	723,144	4,739	773,513	6,404	807,538
12-17 yrs	1,679	393,771	2,491	419,734	3,574	440,009
3-17 yrs	4,859	1,116,915	7,230	1,193,247	9,978	1,247,547



Key Findings:

- HFS has recently undertaken a quality improvement initiative on BMI which is expected to result in future improvement in this measure.
- **Note**: 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 data do not capture whether it is performed.

Measure 8 – 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. The use of objective developmental screening tests identifies developmental delays at a rate of almost three times the rate identified by surveillance.

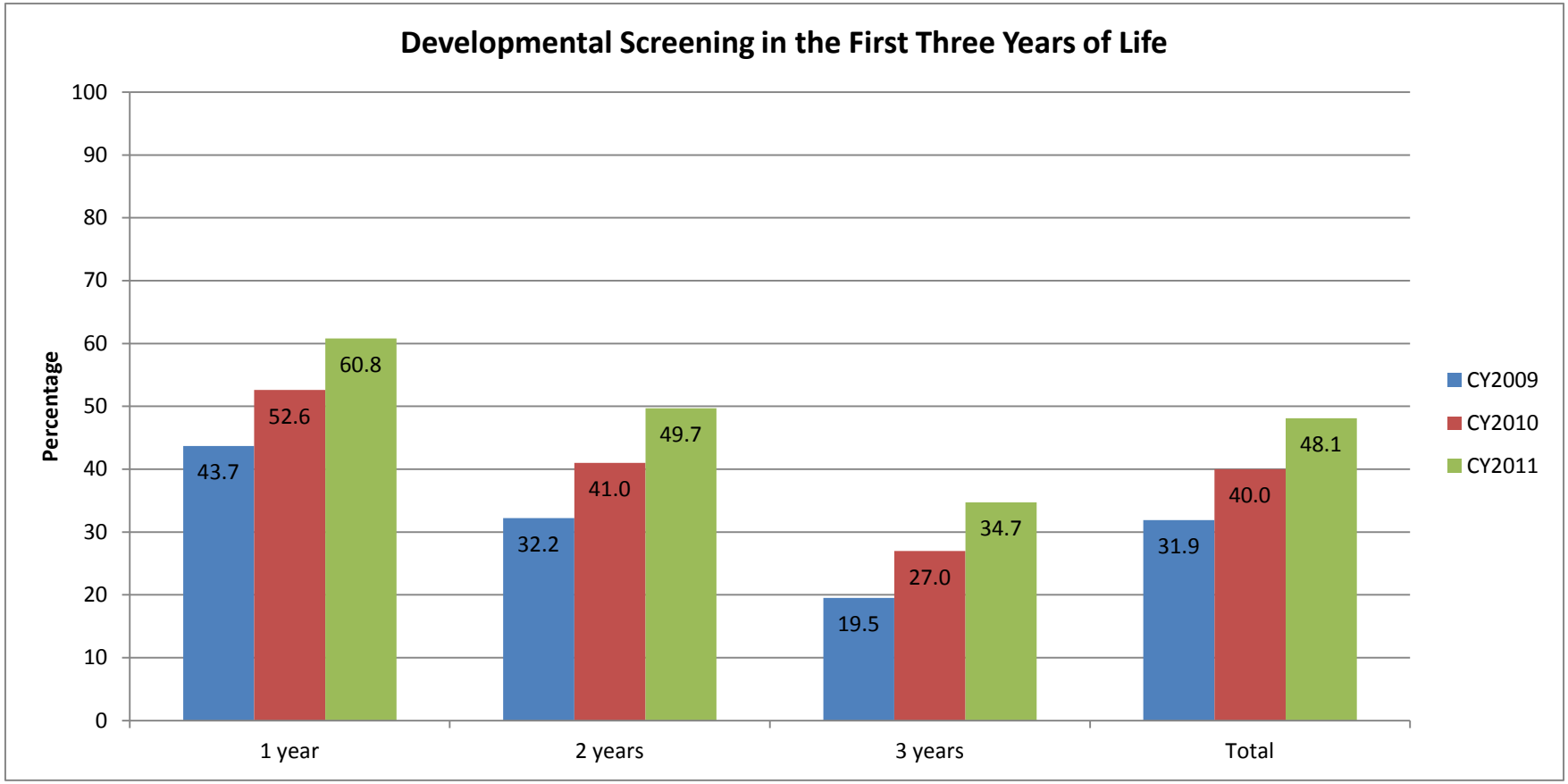
Deviations from CHIPRA Specifications:

- The specifications state domain-specific objective developmental screening tools should not be used in this measure. However, HFS policy allows domain-specific tools under CPT 96110. Administrative data do not allow for the distinction between general or domain-specific screening tools for CPT 96110, so domain-specific tools are counted.
- The specifications state specific screening tools that are to be counted for this measure. Screening tools allowed by HFS policy differ from those included in the specifications. This measure counts allowable screening tools as specified in HFS policy.
- HFS has not conducted a validity assessment of the claims data compared to the medical record, as the measure steward recommends in the November 2012 CHIPRA core measure specifications changes "summary of updates" document.

Eligible Population:

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

Measure 8 – Developmental Screening in the First Three Years of Life



Key Findings:

- Each age category showed substantial increases in the screening rate from CY2009 to CY2011.
- Among those screened by 1 year of age, the rate increased by 17.1 percentage points, a percent change increase of 39.1; among 2 year olds, the rate increased by 17.5 percentage points, a percent change increase of 54.3; and among those 3 years of age, the rate increased by 15.2 percentage points, a percent change increase was of 77.9.
- The screening rate is highest for children during the first year of age and steadily decreases each year thereafter.
- HFS currently has a quality improvement initiative underway for objective developmental screening, which may account for some of the improvement and which may produce future ongoing improvement in this measure.

Measure 9 – Chlamydia Screening in Women

Measure Description: The percentage of women ages 16 to 20 who were identified as sexually active and had at least one test for Chlamydia during the measurement year. Continuous enrollment during the measurement year is required for inclusion in this measure.

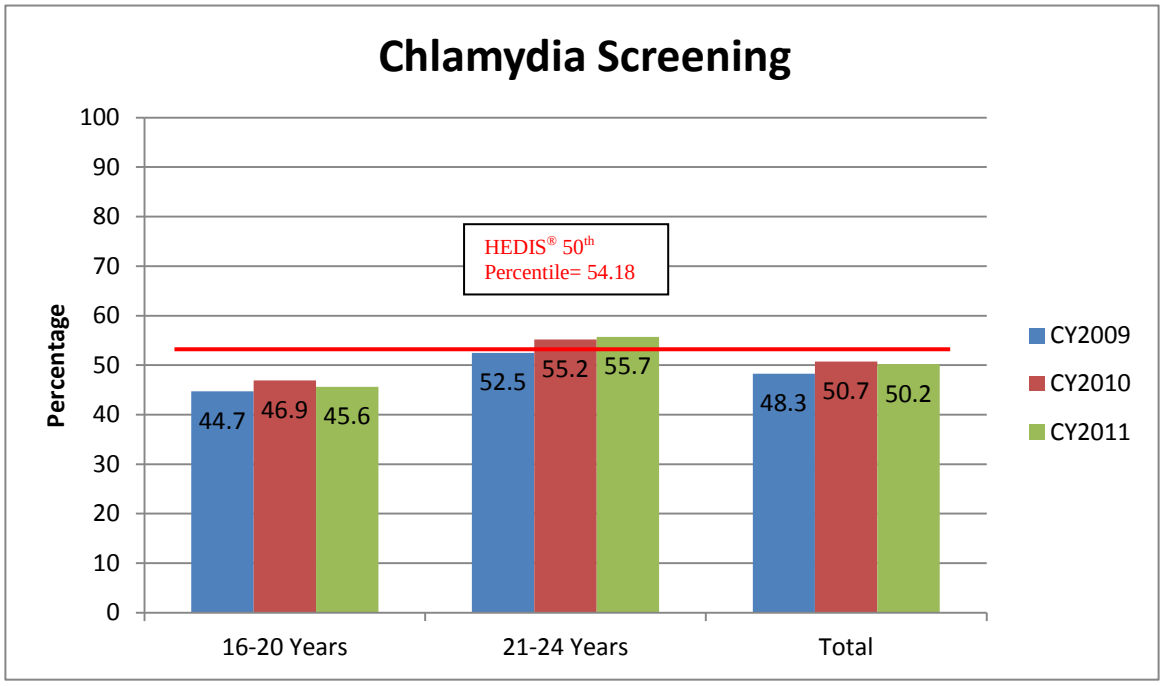
Relevance of Measure: According to the CDC, Chlamydia is the most frequently reported sexually transmitted disease in the United States. In 2010, 1.3 million cases were reported to CDC. Under-reporting is substantial because most people with Chlamydia are not aware of their infections and do not seek 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, the CDC recommends annual screenings for all sexually active women age 25 years and younger and for older women with risk factors for Chlamydia. All pregnant women should have a screening test for Chlamydia.

Deviations from CHIPRA Specifications:

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

Eligible Population:

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



Key Findings:

- Both age groups show a slight increase from CY2009 to CY2011.
- The overall rate for CY2009 to CY2011 increased by 1.9 percentage points, a percent change increase of 3.9.
- The 16-20 year olds and the overall rates are below the 50th percentile, presenting opportunity for improvement.

Measure 10 – 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 (PCP) 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.

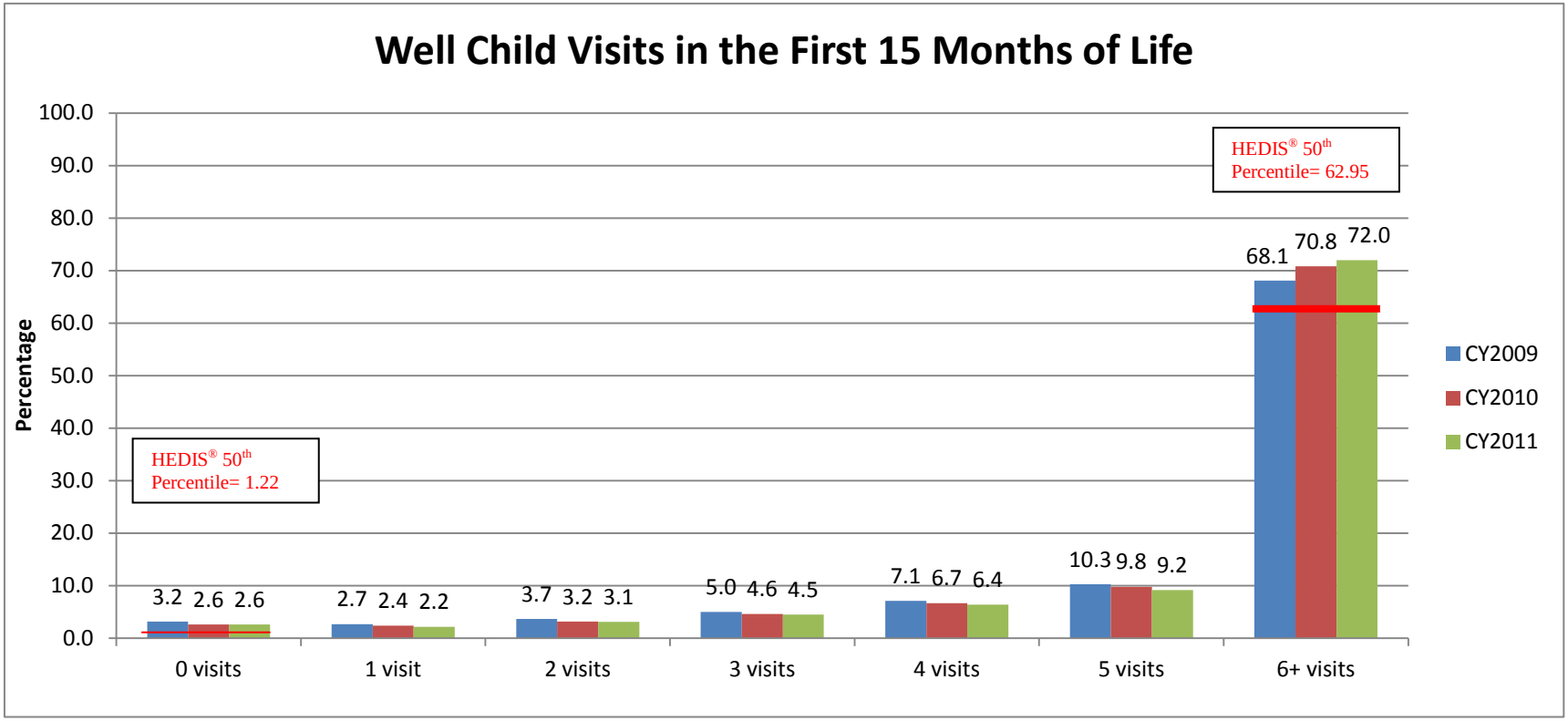
Relevance of Measure: Regular well child visits provide an opportunity for parent education, childhood immunizations, age-appropriate risk assessment, identification and treatment of health problems, and to monitor the growth and development of children to assure they are progressing satisfactorily, 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.

Deviations from CHIPRA Specifications: None

Eligible Population:

	CY2009		CY2010		CY2011	
	Numerator	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**
0 Visits	3,011	94,398	2,413	91,137	2,317	88,630
1 Visit	2,508	94,398	2,145	91,137	1,966	88,630
2 Visits	3,462	94,398	2,893	91,137	2,779	88,630
3 Visits	4,758	94,398	4,179	91,137	3,989	88,630
4 Visits	6,676	94,398	6,093	91,137	5,630	88,630
5 Visits	9,677	94,398	8,888	91,137	8,164	88,630
6+ Visits	64,306	94,398	64,526	91,137	63,785	88,630

Measure 10 – Well Child Visits in the First 15 Months of Life



Key Findings:

- All rates for fewer than 6 visits decreased slightly. These are inverted measures, with lower rates indicative of better performance.
- From CY2009 to CY2011, there was an increase of 3.9 percentage points, a percent change increase of 5.7, in children 15 months of age who received six or more well child visits.
- From CY2009 to CY2011, those children receiving 0 Well Child Visits exceeded the 50th percentile of 1.22 and 75th percentile of 2.43, presenting an opportunity for improvement.
- In CY2010 and CY2011, those children receiving 6+ Well Child Visits surpassed the 75th percentile, which is 70.70, placing Illinois Medicaid population in the top quarter nationally.

Measure 11 – 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.

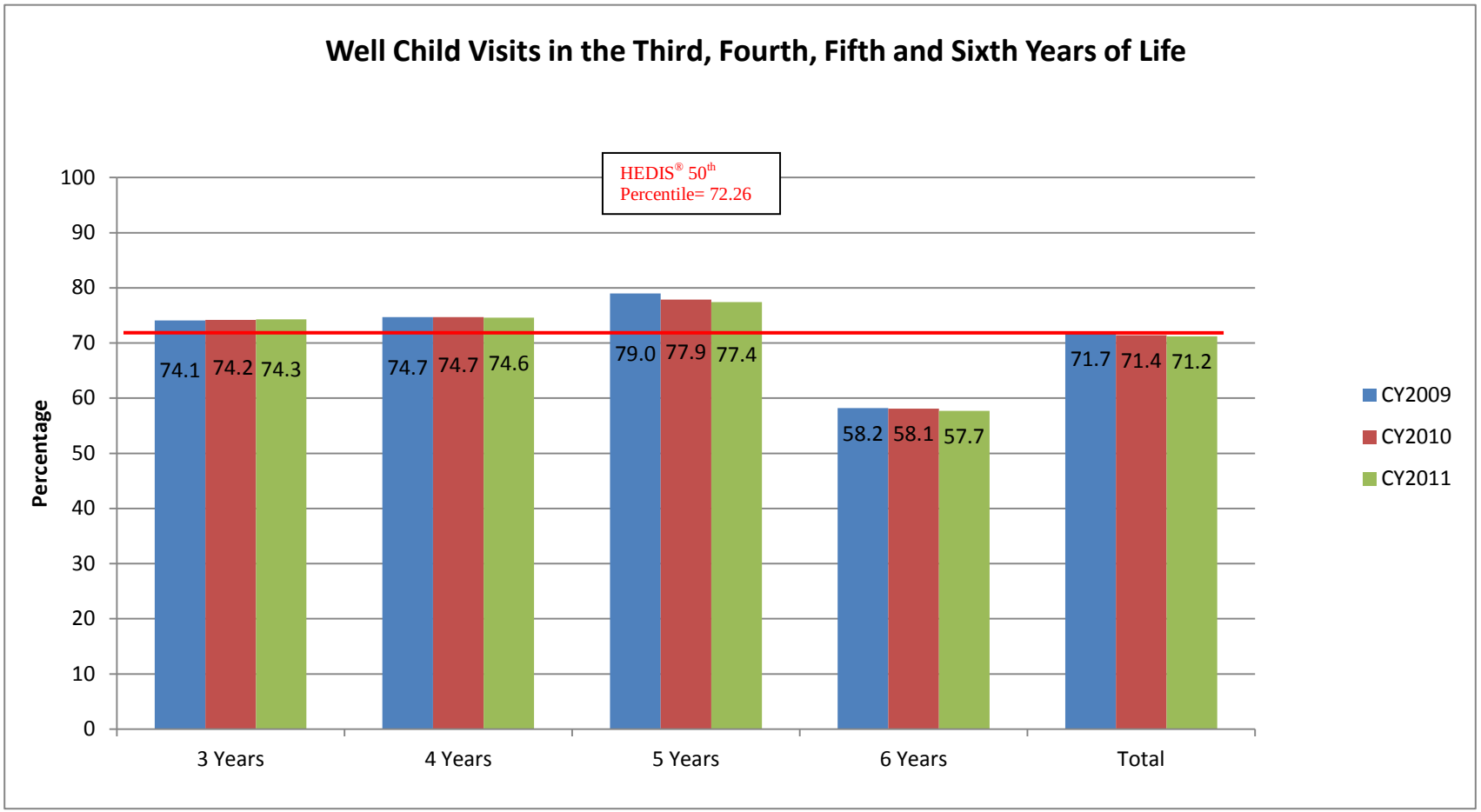
Relevance of Measure: Regular well child visits provide an opportunity for parent education, childhood immunizations, age-appropriate risk assessment, identification and treatment of health problems, and to monitor the growth and development of children to assure they are progressing satisfactorily, 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.

Deviations from CHIPRA Specifications: None

Eligible Population:

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

Measure 11 – Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life



Key Findings:

- From CY2009 to CY2011, the rate for all children ages 3, 4, 5, and 6 years who received one or more well-child visits remained consistent as the total number of children (denominator) increased.
- From CY2009 to CY2011, the individual rates for children 3, 4, and 5 years of age surpassed the 50th percentile.
- The well-child visit rate for children age 6 is well below the 50th percentile, presenting opportunity for improvement.

Measure 12 – 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.

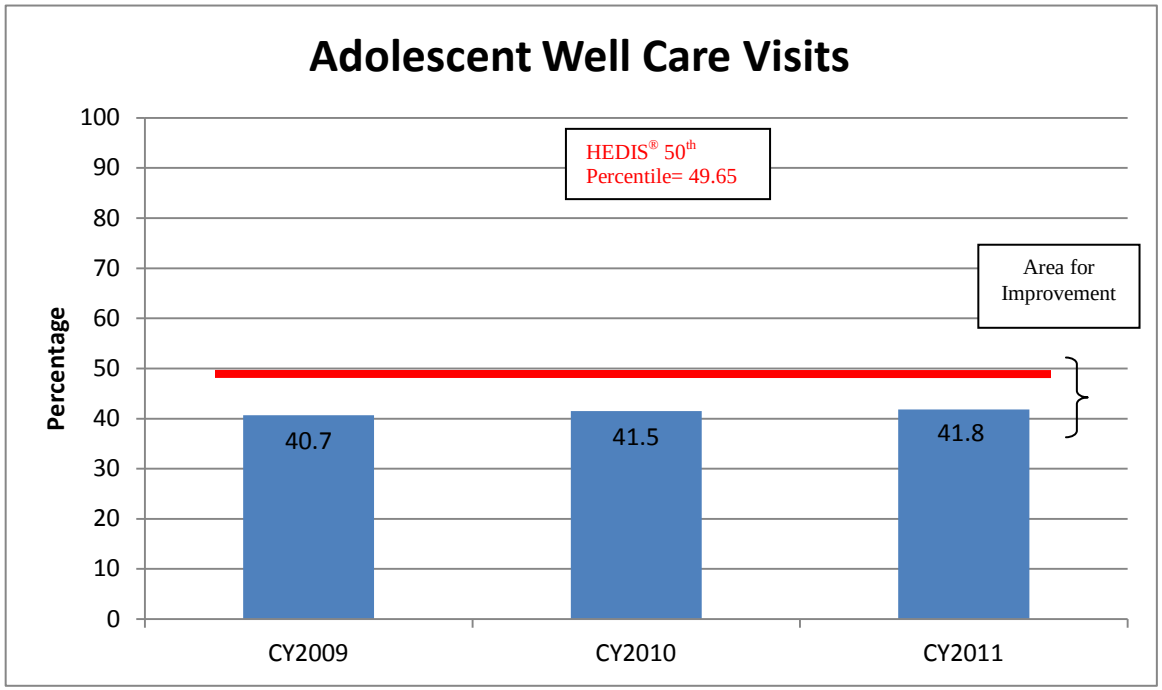
Deviations from CHIPRA Specifications: None

Eligible Population:

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

Key Findings:

- From CY2009 to CY2011, there was an increase of 1.1 percentage points, a percent change increase of 2.7, in adolescents receiving a well-care visit.
- In terms of numbers of children served, from CY2009 to CY2011 there was a substantial increase in the total number who received a well care visit (203,375 and 233,792, respectively). This is an increase of 30,417 children who were served.
- The rate showed small improvement, even though the eligible population increased significantly by 59,941 from CY2009 to CY2011 (499,896 to 559,837, respectively).
- The adolescent well-child visit rate is well below the 50th percentile, presenting opportunity for improvement.



Measure 13 – Total Eligibles Who Received Preventive Dental Services (ages 1 to 20)

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, 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.

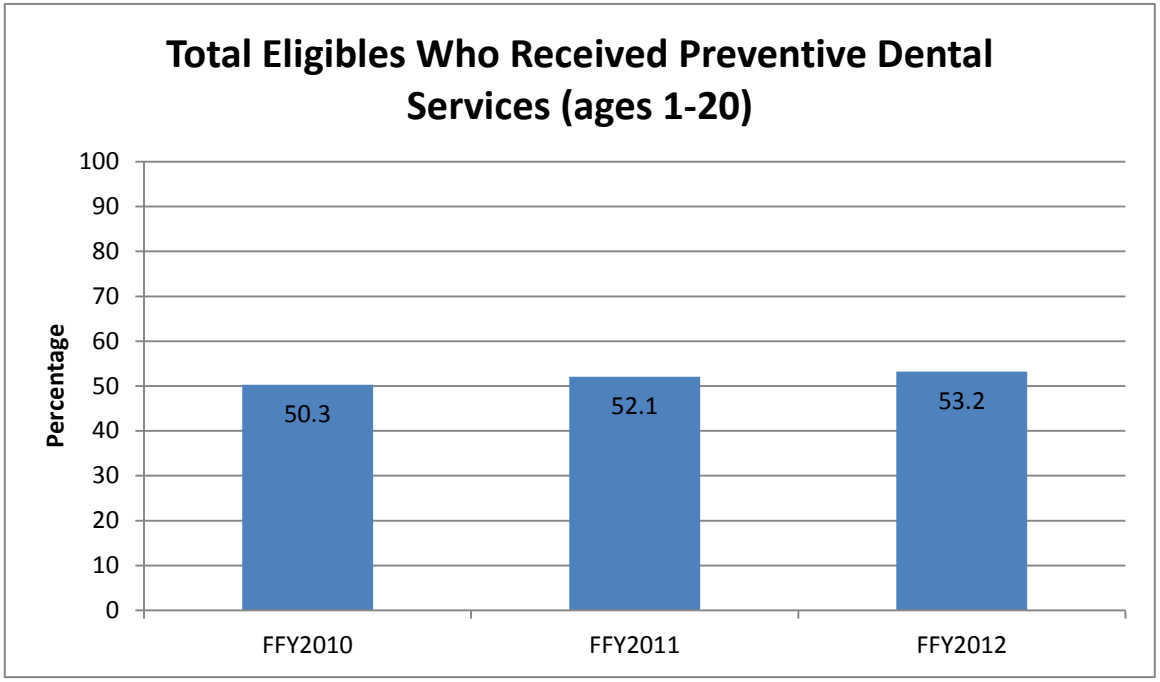
Deviations from CHIPRA Specifications: None

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

Key Findings:

- The rate of children who received preventive dental services increased by 2.9 percentage points, a percent change increase of 5.8, from FFY2010 to FFY2012.



Measure 14 – Child and Adolescent Access to Primary Care Practitioners

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.

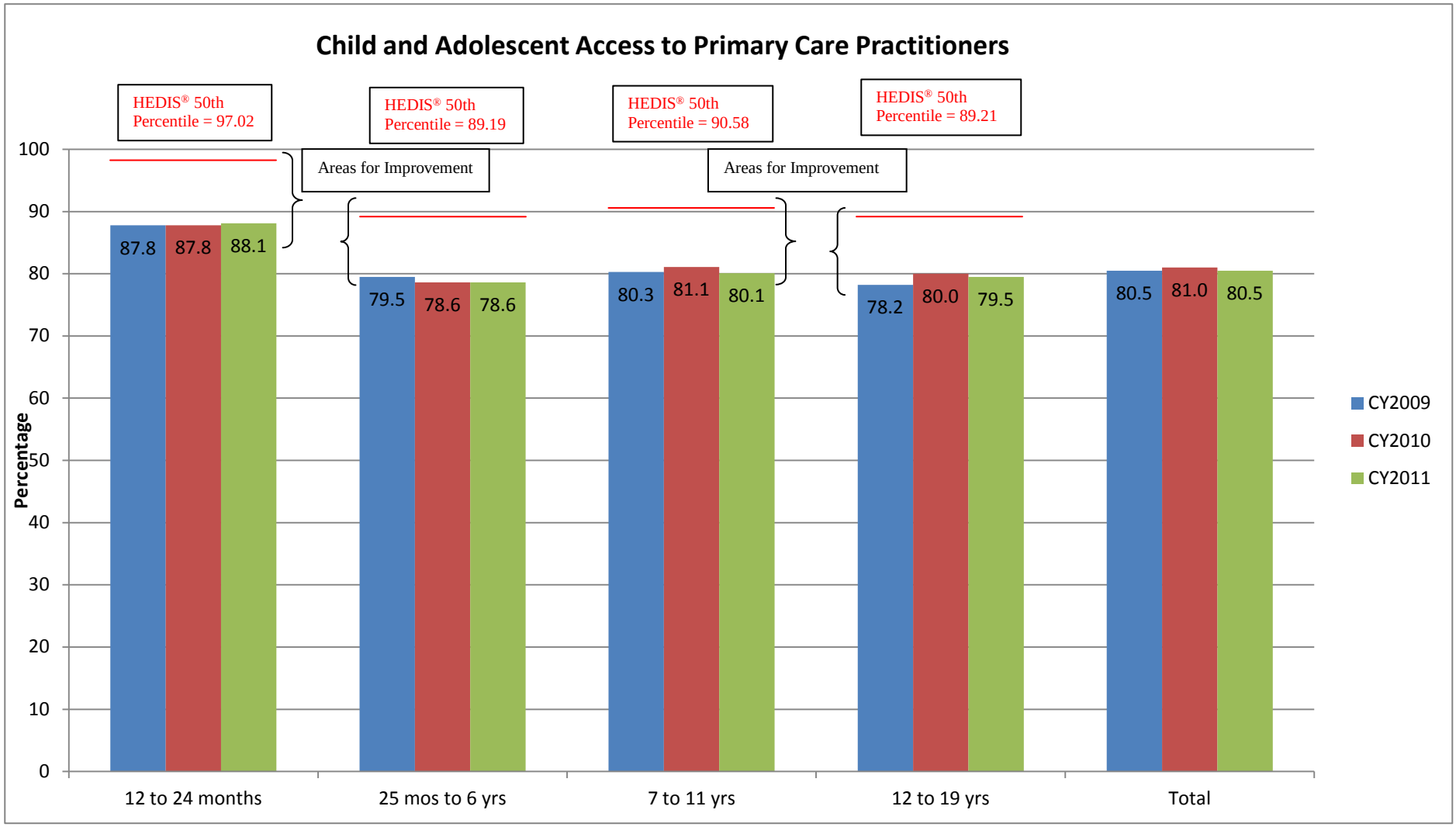
Relevance of Measure: The health of children is related to their access to regular health care services. Receiving regular preventive care, including physical exams, immunizations, medical intervention, observation and screening and counseling leads to improved outcomes.

Deviations from CHIPRA Specifications: None

Eligible Population:

	CY2009		CY2010		CY2011	
	Numerator	**Denominator**	**Numerator**	**Denominator**	**Numerator**	**Denominator**
12–24 mo	165,665	188,716	165,749	188,749	161,039	182,796
25 mo–6 yrs	275,155	346,005	290,255	369,356	301,241	383,155
7 -11 yrs	273,376	340,509	299,398	369,388	317,382	396,017
12-19 yrs	326,265	417,309	363,375	454,143	387,357	487,162
Total	1,040,461	1,292,539	1,118,777	1,381,636	1,167,019	1,449,130

Measure 14 – Child and Adolescent Access to Primary Care Practitioners



Key Findings:

- The rates remained stable for each age category, although from CY2009 to CY2011, there was a substantial increase of 156,591 in the total number of eligible children and adolescents (from 1,292,539 to 1,449,130).
- Each age category is consistently below the 50th percentile by approximately 10 percent, showing room for improvement.

Measure 15 – Appropriate Testing for Children with Pharyngitis

Measure Description: The percentage of children ages 2 to 18 who 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 enrollment 30 days prior to the Episode Date through 3 days after the Episode Date. (inclusive)

Relevance of Measure: According to the CDC, only 15% of all pharyngitis cases are due to Group A Streptococcus. Often times, 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.

Deviations from CHIPRA Specifications:

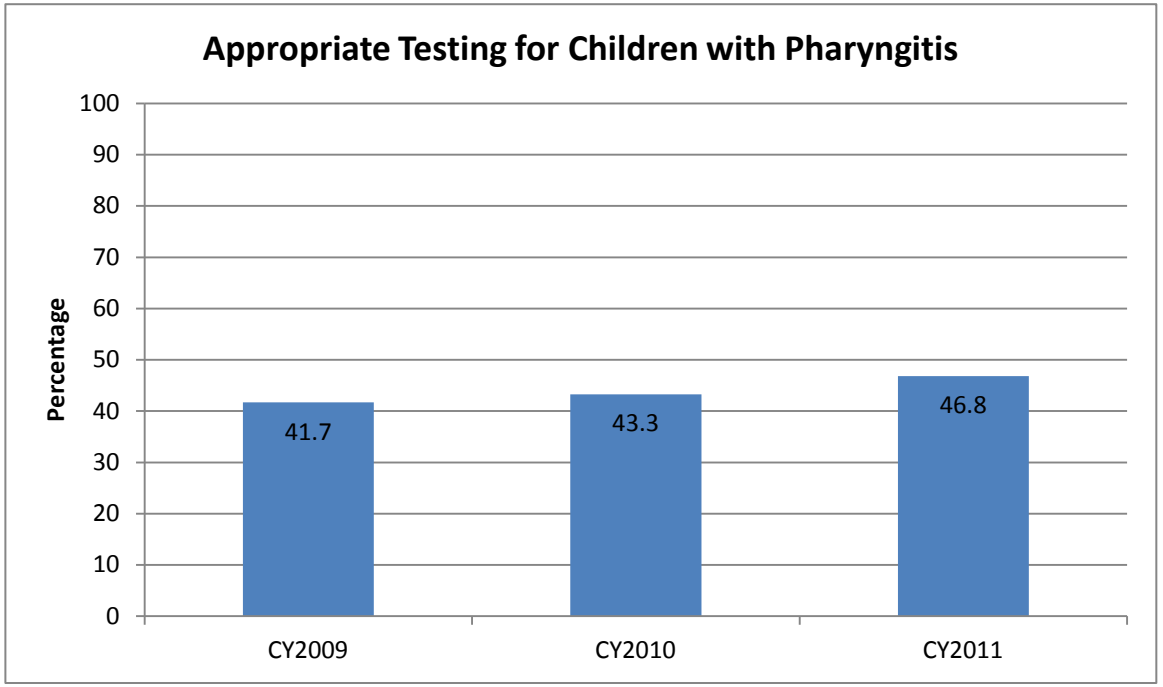
- CY2009, 2010, and 2011 were generated with HEDIS® 2012 specifications.
- Illinois does not use LOINC codes to identify a Group A Streptococcus test. However, the CPT codes being used are capturing the data needed.

Eligible Population:

Calendar Year	Numerator	Denominator
2009	40,640	97,459
2010	119,250	275,565
2011	143,679	306,777

Key Findings:

- From CY2009 to CY2011, there was an increase of 5.1 percentage points, a percent change increase of 12.2, in the children diagnosed with pharyngitis who were dispensed an antibiotic and received a group A streptococcus (strep) test.



Measure 17 – Total Eligibles Who Received Dental Treatment Services (ages 1 to 20)

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, 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.

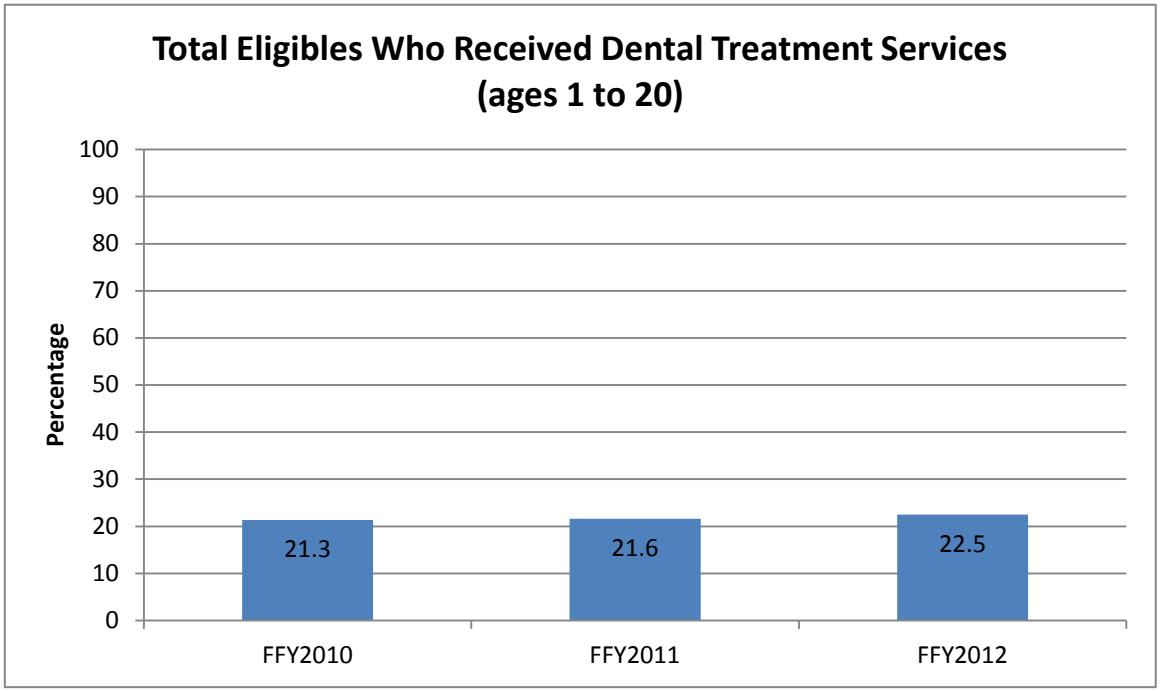
Deviations from CHIPRA Specifications: None

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

Key Findings:

- The rate of children who received dental treatment services increased by 1.2 percentage points, a percent change increase of 5.6, from FFY2010 to FFY2012.



Measure 18 – Ambulatory Care – Emergency Department Visits

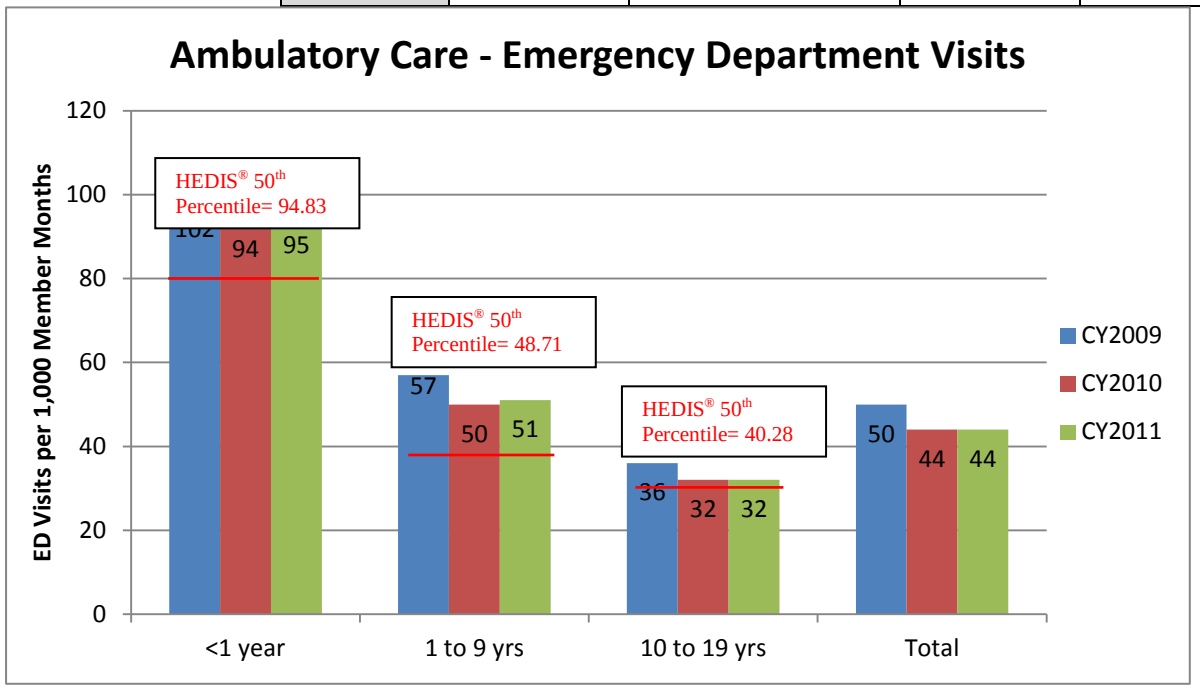
Measure Description: The rate of emergency department (ED) visits per 1,000 member months among children up to age 19. A lower rate for this measure is indicative of better performance. No continuous enrollment for this measure.

Measure Relevance: According to the CDC, people with Medicaid benefits are more likely to visit the emergency department in a 12-month period compared to those who have private insurance or are uninsured. Visits are often times triaged as non-urgent and are used in place of regular ambulatory care with a PCP.

Deviations from CHIPRA Specifications: None

Eligible Population:

	CY2009		CY2010		CY2011	
	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
1-9 Years	498,992	8,743,567	448,312	9,042,887	470,100	9,177,349
10-19 Years	248,419	6,879,454	234,522	7,298,683	241,277	7,586,574
Total	805,554	16,195,198	735,095	16,895,563	762,304	17,300,127



Key Findings:

- From CY2009 to CY2011, there was a decrease of 6 visits per 1,000 member months, a percent change decrease of 12.0, in ambulatory care emergency department visits.
- For those 10 to 19 years, the 50th percentile has been exceeded. For those <1 year and 1 to 9 years, the rates are slightly above the 50th percentile. There is room for improvement across all age categories.
- From CY2009 to CY2011 there is a decrease in actual visits and rates/per 1,000 member months for emergency department visits.

Measure 20 – Annual Percentage of Asthma Patients with One or More Asthma-related Emergency Room Visits (ages 2 to 20)

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.

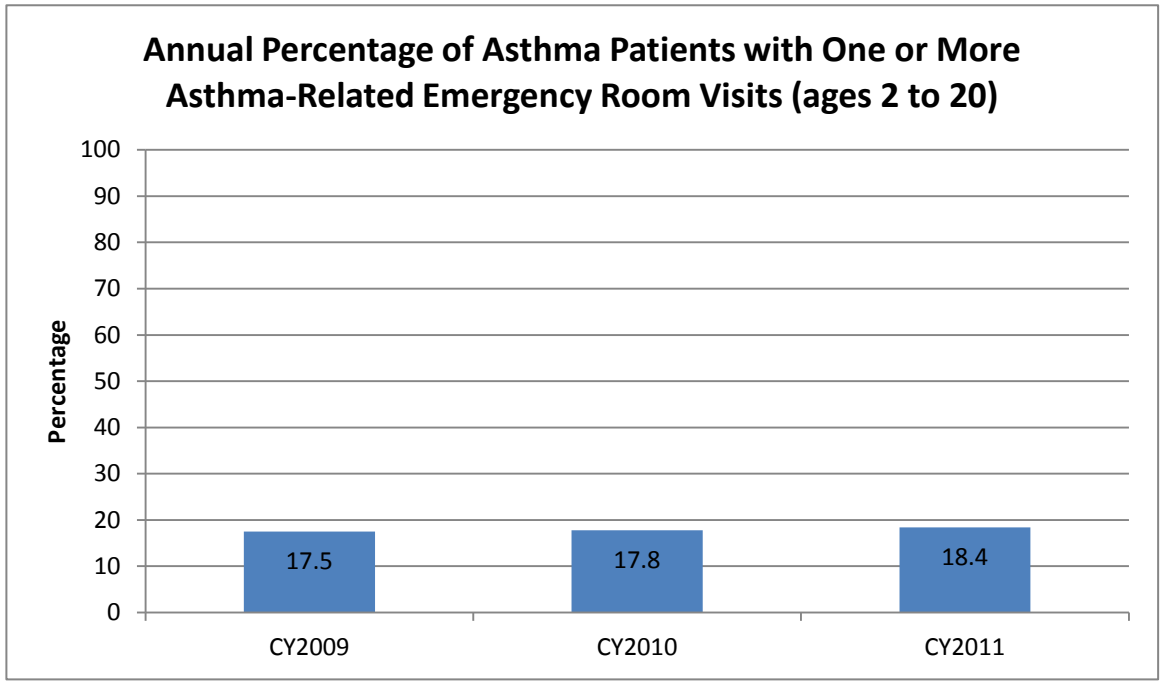
Deviations from CHIPRA Specifications: None

Eligible Population:

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

Key Findings:

- From CY2009 to CY2011 there was an increase of 0.9 percentage points, a percent change increase of 5.1, presenting opportunity for improvement.
- **Note:** Data are provisional since quality testing conducted by HFS is not fully complete.



Measure 21: 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 who 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 as of the Index Prescription Start Date (IPSD) with an ambulatory prescription dispensed for ADHD medication 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.

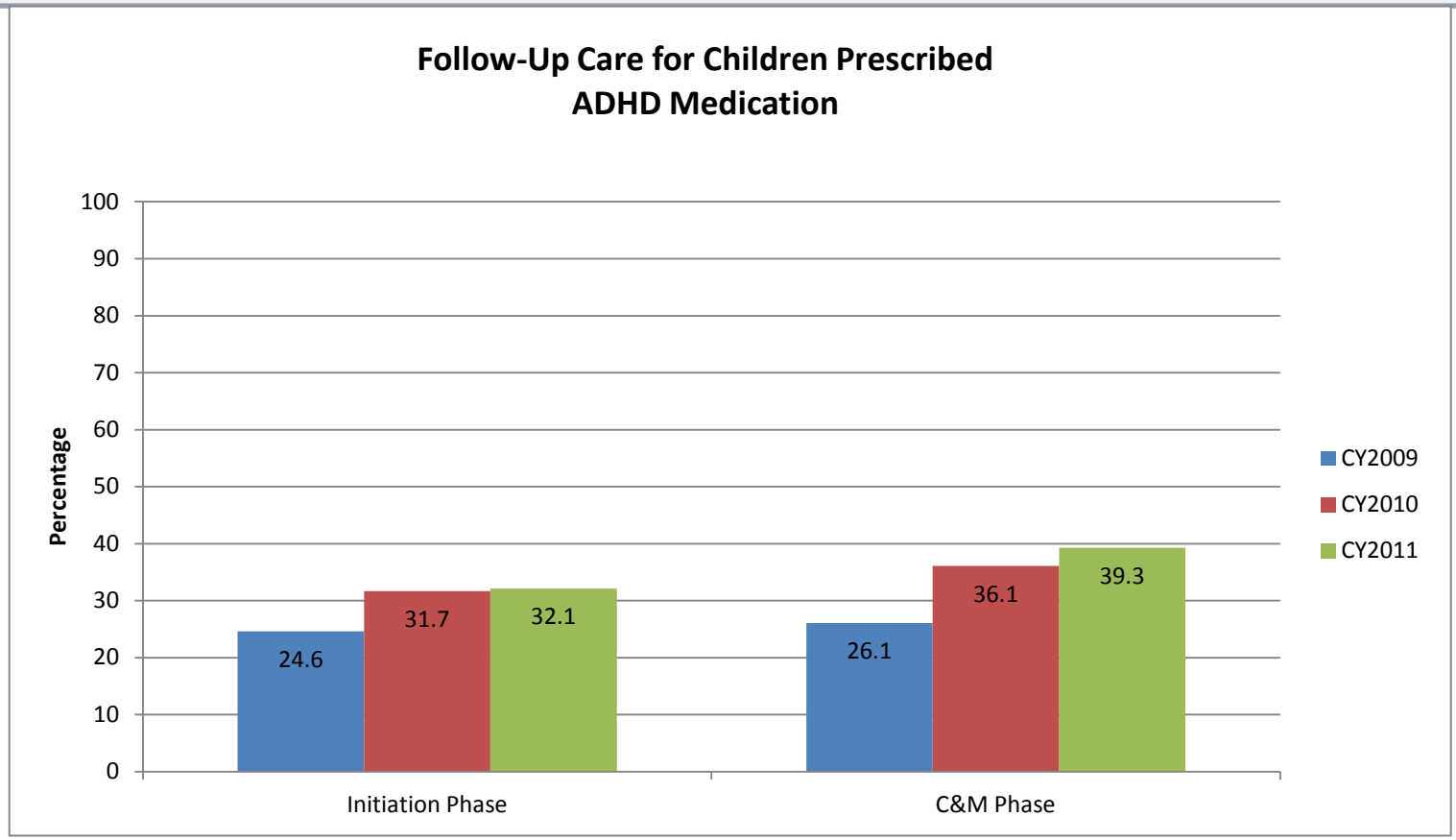
Deviations from CHIPRA Specifications:

- CY2009, 2010 and 2011 were generated with HEDIS® 2012 specifications.
- HFS believes that a large 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", HFS believes that follow-up visits are undercounted.

Eligible Population:

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

Measure 21: Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication



Key Findings:

- From CY2009 to CY2011 there was an increase of 7.5 percentage points, a percent change increase of 30.5, in follow-up during the Initiation Phase.
- From CY2009 to CY2011 there was an increase of 13.2 percentage points, a percent change increase of 50.6, in follow-up during the C&M Phase.

Measure 23 – 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 make sure follow-up occurs to assess effectiveness of medication and make appropriate adjustments.

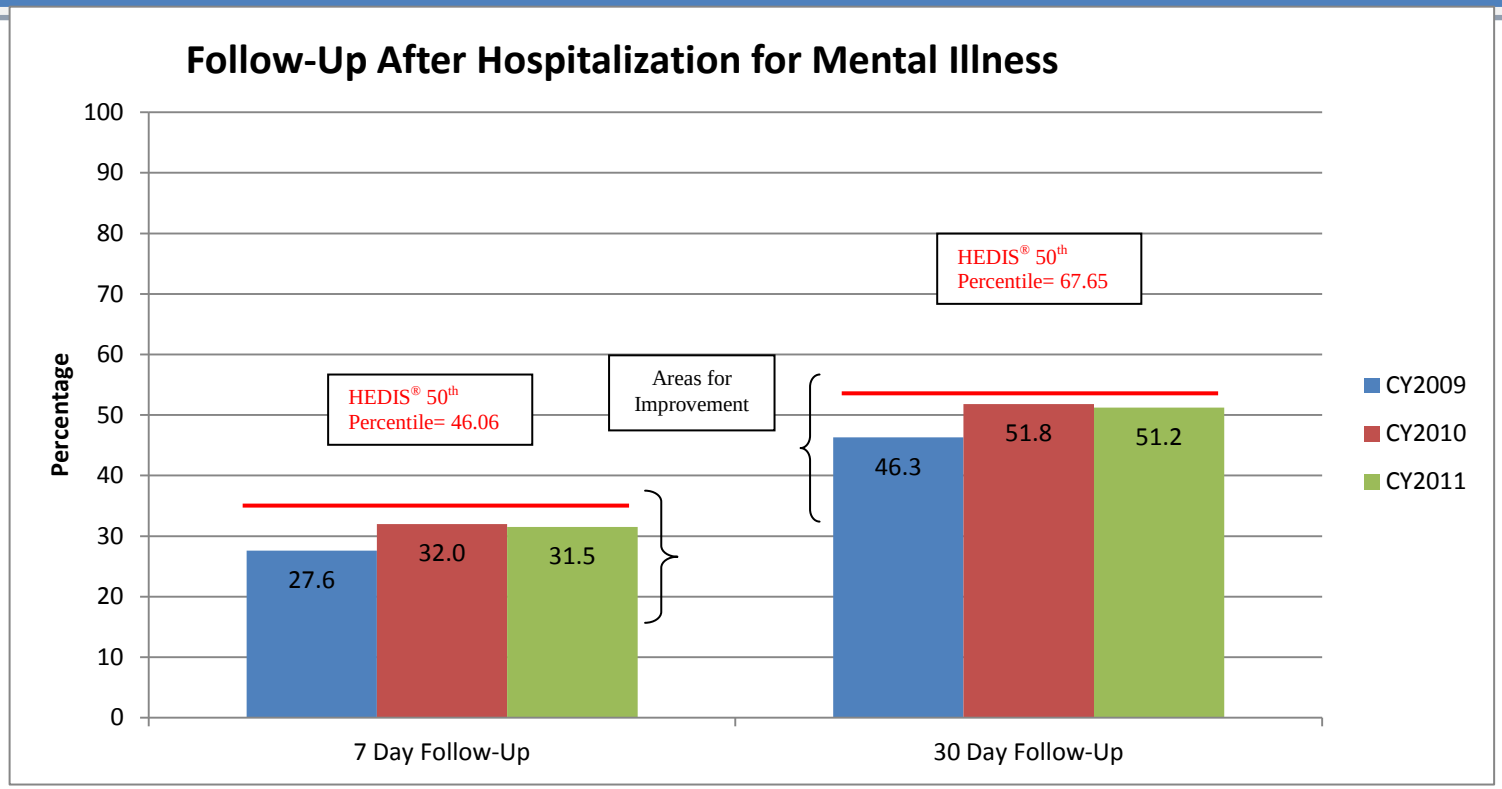
Deviations from CHIPRA Specifications:

- CY2009, 2010 and 2011 were generated with HEDIS® 2012 specifications.
- HFS is unable to identify all prescribing providers using the methodology required in the specifications; therefore, follow-up visits are undercounted.

Eligible Population:

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

Measure 23 – Follow-Up After Hospitalization for Mental Illness



Key Findings:

- From CY2009 to CY2011 there was an increase of 3.9 percentage points, a percent change increase of 14.1, in the 7 day follow-up.
- From CY2009 to CY2011 there was an increase of 4.9 percentage points, a percent change increase of 10.6, in the 30 day follow-up.
- The 7 and 30 day follow-up rates are below the 50th percentile, showing opportunity for improvement.
- **Note**: Data are provisional since quality testing conducted by HFS was not fully complete prior to the release of this report.

CHIPRA Core Measures Not Currently Reported

Measure #	Measure Name	Reason For Not Reporting
4	Cesarean Rate for Nulliparous Singleton Vertex	Measure under development
16	Otitis Media with Effusion (OME) – Avoidance of Inappropriate Use of Systemic Antimicrobials in Children (ages 2 to 12)	CMS retired this measure
19	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
22	Annual Pediatric Hemoglobin A1C	Measure under development
24	CAHPS® 4.0H (child version including Medicaid and children with chronic conditions supplemental items)	Pending procurement of an NCQA-Certified CAHPS® vendor and contract issuance

Project Summary

Project Summary

The CHIPRA Quality Demonstration Grant has provided Illinois with the opportunity to focus on improving quality of children's health care by testing and implementing the core set of 24 pediatric performance measures. Illinois has made significant improvement on reporting the core measures from the baseline year, from 10 measures in 2010 to 17 measures in 2011 and 20 measures in 2012. Many decisions and challenges arose during testing and reporting on the core measure set, some of which are yet to be resolved. 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, voluntary managed 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.

- Rather than using an aggregation methodology to include MCO hybrid rates, a straight administrative methodology is used. This 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 CHIPRA core measure specifications and the specifications used for reporting herein continue to exist, they have been minimized to the extent possible, and differences will continue to be eliminated in future reporting.

Contractual Issues

A number of contractual issues impacted HFS' ability to move forward with CHIPRA core measure reporting.

- Under the current Primary Care Case Management (PCCM) contract, HFS has responsibility for computing performance measures for PCCM participants and provides the PCCM Administrator with detailed data and measurement rates for quality improvement purposes. The PCCM Administrator disseminates these data to individual providers using Illinois Health Connect's Quality Tools. HFS intends to compute the CHIPRA core measures for PCCM participants as well. However, due to the pending re-procurement of the PCCM contract, all of the CHIPRA core measures have not yet been incorporated into the PCCM's Quality Tools for reporting at the individual provider level.
- Based on CMS guidance, HFS is currently involved in procuring the services of an NCQA-Certified CAHPS® vendor to conduct the CAHPS® survey for Medicaid and CHIP children, regardless of delivery system.

Project Summary

Data Integrity/Efficiencies

The CHIPRA Quality Demonstration Grant has allowed Illinois to make a number of changes that improve the efficiency of the performance measurement process and improve the integrity of the data.

- Although Illinois had previously conducted data audits by a certified External Quality Review Organization, data audits 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. Since CHIPRA requires compliance with the measure specifications, this resulted in a need for "parallel measures", or the same measure being computed using two different sets of specifications, resulting in inefficiency, duplication of effort, and resource consumption. Performance measures will now comply with nationally endorsed specifications, to the extent possible, with measures aligned across programs, eliminating the need for most parallel measures and improving efficiency
- The EDW supports performance measurement with its data repository and programming staff/resources. Specific reporting requirements for CHIPRA identified a number of changes needed in the areas of data collection, report formats, standardization of certain processes, and programming efficiencies. To address these issues, a Quality of Care Measures Committee was formed to include all areas within HFS with responsibility for performance measurement for various programs. The Committee 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. Even with these improvements, Illinois has not been able to report all the CHIPRA measures and continues to have deviations from the technical specifications. 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. Prior to being awarded a CHIPRA Quality Demonstration Grant, HFS had been reporting on a number of the measures included in the core set. In order to assure compliance with the core measure specifications, HFS looked closely at each existing measure, which brought a number of issues to light. These issues have been 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 CHIPRA grant year, Illinois will continue programming additional CHIPRA measures. The next year is likely to provide additional opportunities for improvement in performance measurement. In addition, decisions will be made on further dissemination of the CHIPRA measures and strategies for quality improvement. Input from providers and advocates will be sought and incorporated into performance measurement reporting.

For further information or questions, contact:

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