

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

Calendar Years 2011 through 2015



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# Executive Summary

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

## Key Findings

- In federal fiscal year (FFY) 2010, Illinois reported 13 core measures to CMS, with 17 reported in FFY2011, 20 reported in FFY2012, 25 reported in FFY2013, 21 reported in FFY2014, 22 reported in FFY2015, and 22 in FFY2016 (inclusive of CLABSI and CAHPS).
- HEDIS<sup>®</sup> 2016 percentiles were applied to CY2015 rates. In CY2015, three measures - Frequency of Ongoing Prenatal Care (>80% of expected visits), HPV Vaccine for Female Adolescents, and Well Child Visits in the First 15 Months of Life (6 or more visits) - achieved the 50<sup>th</sup> percentile or higher.
- When HEDIS<sup>®</sup> 2016 percentiles are available, performance on the remaining measures is below the 50<sup>th</sup> percentile. This shows substantial need for improvement to assure access to care and the quality of the content of care provided.

From CY2014 to CY2015, year to year performance improvement based on movement to a higher HEDIS<sup>®</sup> percentile was seen for BMI Assessment for Children and Adolescents, Adolescents, Children and Adolescents' Access to Primary Care Practitioners (ages 12 to 24 Months, 25 Months to 6 Years, 7 to 11 Years, and 12 to 19 Years), Timeliness of Prenatal Care, Well child Visits in 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup>, and 6<sup>th</sup> Years of Life, Adolescent Well Care Visits, Immunization Status for Adolescents, Chlamydia Screening in

Women, Percent of Eligibles who Received Dental Services, Medication Management for People with Asthma:>75% Days Covered, and Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication. While showing improvement, these measures remain below the 50<sup>th</sup> HEDIS<sup>®</sup> percentile showing lagging achievement and a need for sustained efforts to continue movement toward higher performance.

- A Key Findings section is included for each measure. Refer to that section for year to year comparisons describing whether increased or decreased performance is statistically significant.
- Measure programming deviations from some core measure specifications exist, but are minimized to the extent possible. These differences, as reported to CMS, are identified throughout this report.

# Background

## 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

## Child Core Set

The Agency for Healthcare Research and Quality (AHRQ) and CMS have shared responsibility for the core measures set mandated by CHIPRA, with AHRQ responsible for the development of the core measures 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 FFY2016 reporting, the Child Core Set includes 26 measures.

The technical specifications for the core measures set require that specific methods be used for the data collection and programming of each measure, including an administrative method using various administrative data sources, a hybrid method using data abstracted from medical records to supplement administrative data, and a survey method. In Illinois, the administrative method is used for

all core measures, with the exception of the Consumer Assessment of Healthcare Providers and Systems (CAHPS<sup>®</sup>) survey. The CAHPS<sup>®</sup> survey follows specifications established by the National Committee on Quality Assurance (NCQA).

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

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 voluntarily reported by states in the Medicaid and CHIP Program (MACPro) system. The annual report is available at:

<https://www.medicaid.gov/medicaid/quality-of-care/downloads/2015-child-sec-rept.pdf>

## Data Sources

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

# June 2016 Core Set of Health Care Quality Measures for Children in Medicaid and CHIP

NQF #	Steward	Measure Name
1959	NCQA	Human Papillomavirus Vaccine for Female Adolescents (HPV)
0024	NCQA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents: Body Mass Index Assessment for Children/Adolescents (WCC)
NA	NCQA	Children and Adolescent Access to Primary Care Practitioners (CAP)
0038	NCQA	Childhood Immunization Status (CIS)
1407	NCQA	Immunization Status for Adolescents (IMA)
1391	NCQA	Frequency of Ongoing Prenatal Care (FPC)
1517	NCQA	Timeliness of Prenatal Care (PPC)
1382	CDC	Live Births Weighing less than 2,500 Grams (LBW)
0471	CMQCC	Cesarean Rate for Nulliparous Singleton Vertex (PC02)
NA	AMA-PCPI	Behavioral Health Risk Assessment (for Pregnant Women) (BHRA)
1448	OHSU	Developmental Screening in the First Three Years of Life (DEV)
1392	NCQA	Well-Child Visits in the First 15 Months of Life (W15)
1516	NCQA	Well-Child Visits in the 3 <sup>rd</sup> , 4 <sup>th</sup> , 5 <sup>th</sup> , and 6 <sup>th</sup> Years of Life (W34)
NA	NCQA	Adolescent Well-Care Visit (AWC)
0033	NCQA	Chlamydia Screening in Women (CHL)
NA	CMS	Percentage of Eligibles that Received Preventive Dental Services (PDENT)
1799	NCQA	Medication Management for People with Asthma (MMA)
0576	NCQA	Follow-up After Hospitalization for Mental Illness (FUH)
0108	NCQA	Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (ADD)
0139	CDC	Pediatric Central-line Associated Blood Stream Infections—Neonatal Intensive Care Unit and Pediatric Intensive Care Unit (CLABSI)
NA	NCQA	Ambulatory Care – Emergency Department (ED) Visits (AMB)
2508	DQA (ADA)	Prevention: Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (SEAL)
NA	NCQA	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 5.0H Child and Chronic Conditions Supplement
1365	AMA-PCPI	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (SRA)
<b>Added to Child Core Set June 2016</b>		
NA	AHRQ	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)
1360	CDC	Audiological Evaluation No Later Than 3 Months of Age (AUD)
<b>Retired from Child Core Set June 2016</b>		
NA	NA	None

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

# Performance Measurement

HFS utilizes health care performance measurement for the following purposes.

## **Program Evaluation and Monitoring**

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

## **Quality Improvement**

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

## **Incentives**

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

## **Public Reporting**

HFS regularly reports on performance measures through a variety of public reports such as the CHIP Annual Report, federally-required reports, the Perinatal Report, and the Title V MCH Block Grant; access reports on HFS' [Reports Center web page](#). During CY2016, HFS developed a [Health Plan Comparison Tool](#) to provide information in a user friendly way to compare performance among the various health care plans.

## **Federal Participation/Compliance Reporting**

HFS reports annually to CMS on Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program services using form CMS-416. The annual report provides information on the number of children who received medical,

dental or blood lead level screens and the number referred for diagnostic or treatment services. This report determines the number of screens provided in accordance with the EPSDT periodicity schedule, and assesses whether children with health problems identified through the screens were treated for medical or dental issues.

## **Policy and Program Changes**

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

## **Meaningful Use**

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

# Data Housed in the Enterprise Data Warehouse

Data Source	Time Period	Data Shared	Data Description
<b>Current Data</b>			
HFS	1996-2017	Claims	Information about health care services, including patient information, service location, provider of service, procedure, diagnosis, CPT codes
HFS	1996-2017	Recipient File	Patient-level information including eligibility, demographics, recipient ID
HFS	1996-2017	Provider File	Provider information including provider ID, provider type, address, billing address
IDPH	1990-2017	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	1960-2017	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	1960-2017	Childhood Lead Screening	Information on lead screenings conducted by Local Health Departments and screening results for HFS children under age 7. Note: Currently only receive screenings, but will have results in the future.
IDPH	1970-2009	Vital Records	These are the legacy Vital Records prior to IDPH IVRS implementation. All data elements contained in the “certifiable” portion and all “Information for Medical and Health Use Only” portion of the Birth (1970-2009), Death (1970-2007).
IDPH	2008-2017	Expanded Illinois Vital Records System (IVRS)	Expanded tables that contain data from the IDPH IVRS. Birth: 2010-ongoing; Certified data through 2014 Death: 2008-ongoing; Certified data through 2015 Fetal Death: 1999-2012; Certified through 2013
IDPH	1970-2015	Out-of-State Vital Records	Out-of-state birth, death, and fetal death information for HFS enrollees
IDPH	1997-2017	Pre-Admission Screening	These data contain basic demographic data plus the determination of need (DON) score for patients admitted to a hospital.
IDPH	2009-2016	Hospital Discharges	Detailed data including up to 25 procedure diagnosis codes, limited to Illinois hospitals
IDHS Cornerstone	1992-2017	Family Case Management (FCM)	Enrollment and risk assessment information for pregnant women, infants and young children who are enrolled in FCM.
IDHS Cornerstone	1992-2017	Family Planning (FP)	Aggregate data on women served in FP program
IDHS Cornerstone	1992-2017	Healthy Start	Enrollment and risk assessment information for pregnant women, infants and young children who are enrolled in Healthy Start.
IDHS Cornerstone	1992-2017	Immunization	Immunization information for HFS participants from public health sector from Cornerstone.
IDHS Cornerstone	1992-2017	Better Birth Outcomes (BBO) (replaces Targeted Intensive Prenatal Case Management [TIPS])	Enrollment and risk assessment information for pregnant women, infants and young children who are enrolled in BBO.
IDHS Cornerstone	1992-2017	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	1992-2017	Early Intervention (EI)	Enrollment information for HFS participants 0-3.
DCFS	1996-2017	OBRA Medicaid Claims, skeletal data for client confirmation by HFS	Through the OBRA Waiver, Department of Children and Family Services (DCFS) sends claims for services to their Medicaid eligible wards. A skeletal file is also sent to HFS to confirm statuses and payment activity.
DSCC	2000-2013	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.
IDPH	2015-2017	Early Hearing Detection and Intervention	Screening and diagnostic results for HFS participants
<b>Under Construction</b>			
IDPH	1986-2013	Metabolic Genetic and Newborn Screening	Screening and diagnostic results for HFS participants; Sudden Infant Death Syndrome (SIDS) (basic information on child/mother for outreach/counseling purposes)
IDPH		Pregnancy Risk Assessment Monitoring System (PRAMS)	Aggregate data regarding population trends in activities and behaviors of pregnant women in Illinois.

# Technical Notes

## Data Limitations

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

Rates reported may be higher or lower than actual performance due to incomplete or untimely encounter data, coding, and claims adjudication issues. Between CY2014 and CY2015, Illinois Medicaid/CHIP experienced significant movement from fee for service to managed care. The number of Medicaid health plans grew from three to twelve and over one million recipients transitioned into managed care. Efforts to obtain encounter data are on-going and have improved data completeness.

The most current year of data in this report reflects HFS Enterprise Data Warehouse (EDW) data as of December 2016 and includes Title XIX (Medicaid), Title XXI (CHIP), and state-funded populations. Some measures in this report may be identified as provisional. This indicates the measure was in testing at the time of the report, or the measure was newly developed or revised and ad hoc reports were used.

## Data Quality

HFS implemented a number of initiatives to improve data quality, including contractual requirements for data reporting, reduced billing

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

## Differences from Child Core Set Measure Specifications

Any differences between the core specifications and the measure programming logic are identified in this report. When measures use HEDIS<sup>®</sup> specifications they align with the correct data year, unless otherwise noted (e.g., HEDIS<sup>®</sup> 2016 specifications applied to CY2015 data). The Child Core Set specifications are periodically updated and time and resource limitations may restrict the state's ability to update measures. Unless otherwise noted, the most recent version of the specifications is used (e.g., HEDIS<sup>®</sup> 2016 specifications for CY2015 data).

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

The Child Core Set specifications are available on the Medicaid CHIPRA Initial Core Set of

Children's Health Care Quality Measures web page.

## HEDIS<sup>®</sup> Percentiles

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

Throughout this report, the charts show the HEDIS<sup>®</sup> 2016 percentiles, when available, applied to CY2015 data and showing the percentile achieved. The dashboard applies the appropriate annual HEDIS<sup>®</sup> percentiles achieved for each calendar year of data. That is, HEDIS<sup>®</sup> 2014 percentiles are applied to CY2013 data, and so on.

## Measurement Years

A trend is reported, when possible. The measurement period for most measures is from calendar year (CY) 2011 to CY2015. Measure PDENT, Total Eligibles who Received Preventive Dental Services, is by federal fiscal year (FFY\*) as required by the federal CMS-416 report. Consistent with the specifications, Frequency of Ongoing Prenatal Care and Timeliness of Prenatal Care are reported from November 6 to November 5 of the measurement year.

\*FFY = October 1–September 30

Previous Child Core Set Data Books are available on HFS' [Reports Center](#) web page.



# Illinois' Child Core Set Performance CY2011-CY2015 Dashboard

Child Core Set Measure	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	<b>HEDIS® Percentiles:</b> <b>2012 for CY2011 Data</b> <b>2013 for CY2012 Data</b> <b>2014 for CY2013 Data</b> <b>2015 for CY2014 Data</b> <b>2016 for CY2015 Data</b> * Inverted - lower percentile denotes better performance	Child Core Set Measure	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015
HPV Vaccine for Female Adolescents	N/A	12.3	14.3	20.7	22.0			Well Child Visits in the First 15 Months of Life				
BMI Assessment for Children and Adolescents							0 Visits*	2.6	2.9	4.5	4.0	3.6
3 to 11 Years	0.8	1.3	2.0	3.7	7.4		1 Visit*	2.2	2.5	3.5	3.5	3.3
12 to 17 Years	0.8	1.3	2.2	3.9	7.8		2 Visits*	3.1	3.5	4.0	4.2	4.6
3 to 17 Years	0.8	1.3	2.1	3.8	7.6		3 Visits*	4.5	4.5	4.9	5.3	6.5
Children and Adolescents' Access to Primary Care Practitioners						90 <sup>th</sup> Percentile or greater	4 Visits*	6.4	6.3	6.1	6.9	8.9
12 to 24 Months	88.1	86.1	90.1	91.9	92.7		5 Visits*	9.2	8.7	8.4	9.0	12.9
25 Months to 6 Years	78.6	76.7	82.8	85.4	86.0	75 <sup>th</sup> Percentile	6 or More Visits	72.0	71.7	68.6	67.0	60.2
7 to 11 Years	80.1	80.1	84.9	87.7	89.0		Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life					
12 to 19 Years	79.5	79.3	85.5	88.1	89.8	50 <sup>th</sup> Percentile	3 Years	74.3	72.1	71.8	73.8	73.9
All Age Groups	80.5	79.7	85.2	87.8	89.0		4 Years	74.6	72.0	71.6	73.6	74.0
Childhood Immunization Status						25 <sup>th</sup> Percentile	5 Years	77.4	74.8	75.3	77.1	77.3
Combo 2	66.4	67.6	67.0	67.0	62.9		6 Years	57.7	56.1	57.2	58.4	59.4
Combo 3	61.2	63.1	62.8	62.7	58.6	10 <sup>th</sup> Percentile	Total	71.2	68.8	68.9	70.5	71.0
Combo 4	N/A	28.4	55.4	56.6	53.8		Adolescent Well Care Visits	41.8	42.0	47.7	45.3	47.4
Combo 5	N/A	49.5	51.7	52.2	48.3	Rate <10 <sup>th</sup> percentile	Chlamydia Screening in Women					
Combo 6	N/A	30.6	32.3	30.2	27.3		16-20 Years	45.6	43.8	43.1	44.4	45.9
Combo 7	N/A	23.7	46.8	48.0	45.2	N/A – Not Available	21-24 Years	55.7	52.8	53.5	54.4	56.3
Combo 8	N/A	16.1	30.2	28.6	26.1		Total	50.2	47.8	48.0	49.3	51.1
Combo 9	N/A	25.8	28.0	26.5	23.6		Percent of Eligibles Who Received Preventive Dental Services (FFY12-16)	50.5	52.1	51.5	44.5	42.4
Combo 10	N/A	14.0	26.5	25.2	22.7		Percent of Eligibles Who Received Dental Treatment Services (FFY12-14)	20.3	21.2	20.6	Retired	Retired
Immunization Status for Adolescents							Medication Management for People with Asthma: ≥50% Days Covered					
Meningococcal	43.1	49.8	55.3	60.7	67.5		5 – 11 Years	N/A	41.6	46.0	44.7	46.5
Tdap	47.6	54.9	68.0	80.1	84.6		12 – 18 Years	N/A	36.8	40.5	40.4	42.7
Combo (Meningococcal/Tdap)	35.9	43.3	50.9	57.9	64.7		19 – 20 Years	N/A	33.0	39.0	43.7	39.5
Frequency of Ongoing Prenatal Care							5 – 20 Years	N/A	39.7	43.8	43.0	44.8
<21% of expected visits*	10.9	4.8	5.6	5.2	4.8		Medication Management for People with Asthma: ≥75% Days Covered					
21 – 40% of expected visits*	6.5	4.0	4.2	4.3	4.0		5 – 11 Years	N/A	19.4	19.8	19.2	21.0
41 – 60% of expected visits*	10.6	4.5	4.7	4.9	4.7		12 – 18 Years	N/A	16.7	17.1	17.3	19.0
61 – 80% of expected visits*	21.1	6.0	6.1	6.5	6.6		19 – 20 Years	N/A	18.7	18.7	18.8	16.5
>80% of expected visits	51.0	80.7	79.4	78.9	79.7		5 – 20 Years	N/A	18.4	18.8	18.5	20.1
Timeliness of Prenatal Care	58.1	50.2	54.4	54.3	55.9		Follow-up After Hospitalization for Mental Illness					
Percentage of Live Births Weighing Less Than 2,500 Grams	8.7	8.5	9.0	8.6	9.0		7 Days	31.5	32.5	35.2	31.3	33.3
Cesarean Rate for Nulliparous Singleton Vertex	23.4	23.5	21.0	20.1	20.1		30 Days	51.2	55.2	56.6	50.2	52.5
Developmental Screening in the First 3 Years of Life							Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication					
1 Year	60.8	63.5	64.4	65.0	62.3		Initiation Phase	32.1	33.6	31.9	31.7	31.9
2 Years	49.7	53.5	54.4	57.5	58.0		Continuation & Maintenance Phase	39.3	38.3	38.3	38.6	39.3
3 Years	34.7	38.5	40.0	42.8	44.4							
Total	48.1	51.5	52.8	55.2	55.1							

\*Inverse rate - a lower rate indicates better performance.

# Illinois' Child Core Set Performance CY2011-CY2015 Dashboard

Child Core Set Measure	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	<b>HEDIS® Percentiles:</b> <b>2012 for CY2011 Data</b> <b>2013 for CY2012 Data</b> <b>2014 for CY2013 Data</b> <b>2015 for CY2014 Data</b> <b>2016 for CY2015 Data</b> * Inverted - lower percentile denotes better performance	Child Core Set Measure	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015
Ambulatory Care – Emergency Department Visits (Per 1,000 Member Months)- <b>HEDIS Age Group Not Limited CY2015</b>								Appropriate Testing for Children with Pharyngitis	46.8	49.7	Retired	
<1 Year*	95	95	87	88	86.1		Annual Percentage of Asthma Patients with One or More Asthma-related Emergency Room Visits	18.4	12.3	Retired		
1 – 9 Years*	51	49	49	50	50.1	90 <sup>th</sup> Percentile or greater	Annual Pediatric Hemoglobin (HbA1c) Testing	N/A	72.6	Retired		
10 – 19 Years*	32	31	34	34	35.1							
Total*	44	42	43	43	44.0	75 <sup>th</sup> Percentile						
Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk	N/A	N/A	N/A	25.6	21.6	50 <sup>th</sup> Percentile						
						25 <sup>th</sup> Percentile						
						10 <sup>th</sup> Percentile						
						Rate <10 <sup>th</sup> percentile						
						N/A – Not Available						

\*Inverse rate - a lower rate indicates better performance.

# 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 13<sup>th</sup> birthday. Continuous enrollment during the 12 months prior to the beneficiary's 13<sup>th</sup> birthday is required for inclusion in this measure.

**Notes on Measure Programming or Differences from Measure Specifications:**

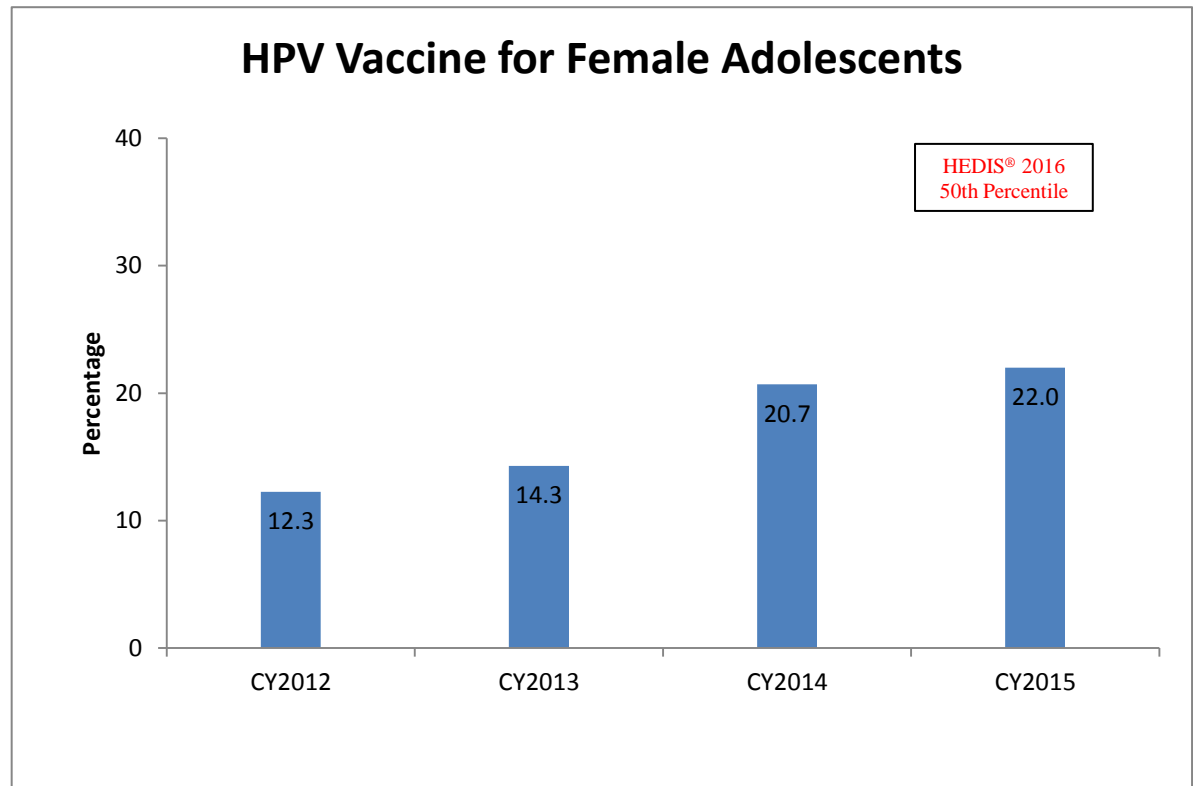
- The measure includes vaccinations identified using claims, the DPH state immunization registry and the DHS Cornerstone client information system.

**Eligible Population:**

Calendar Year	Numerator	Denominator
2012	4,719	38,447
2013	5,499	38,601
2014	7,479	36,067
2015	7,565	34,341

**Key Findings:**

- The increase from CY2012 to CY2015 is statistically significant (p<.05).
- The increase between CY2014 and CY2015 rates also is statistically significant (p<.05).
- While improving from the 25<sup>th</sup> percentile (HEDIS® 2015), performance on this measure is at the 50<sup>th</sup> percentile for HEDIS® 2016 showing there is improvement.



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

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

**Notes on Measure Programming or Differences from Measure Specifications:**

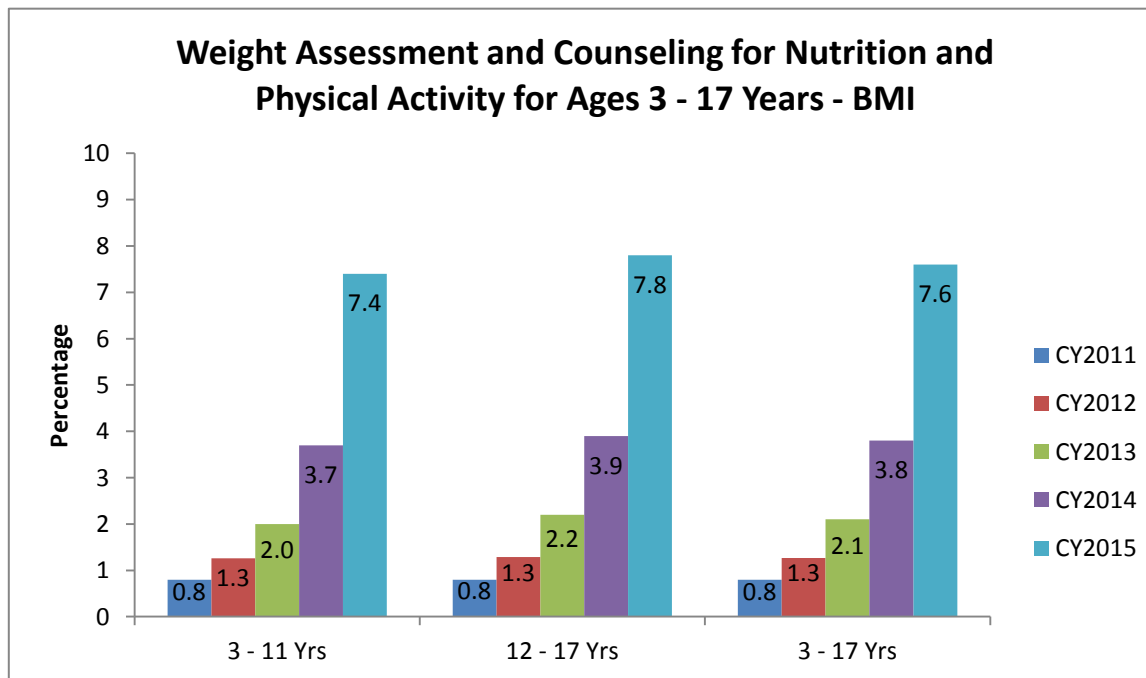
- CY2011-CY2012 rates were generated with HEDIS® 2012 specifications.

**Eligible Population:**

	CY2011		CY2012		CY2013		CY2014		CY2015	
	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator
<b>3-11 Yrs</b>	6,404	807,538	10,081	802,875	15,078	755,378	26,669	708,100	51,137	684,881
<b>12-17 Yrs</b>	3,574	440,009	5,718	444,237	9,383	427,092	15,989	406,354	31,735	402,977
<b>3-17 Yrs</b>	9,978	1,247,547	15,799	1,247,112	24,461	1,182,470	42,658	1,114,454	82,872	1,087,858

**Key Findings:**

- While rates increased from CY 2011 to CY2015, 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.



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

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

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

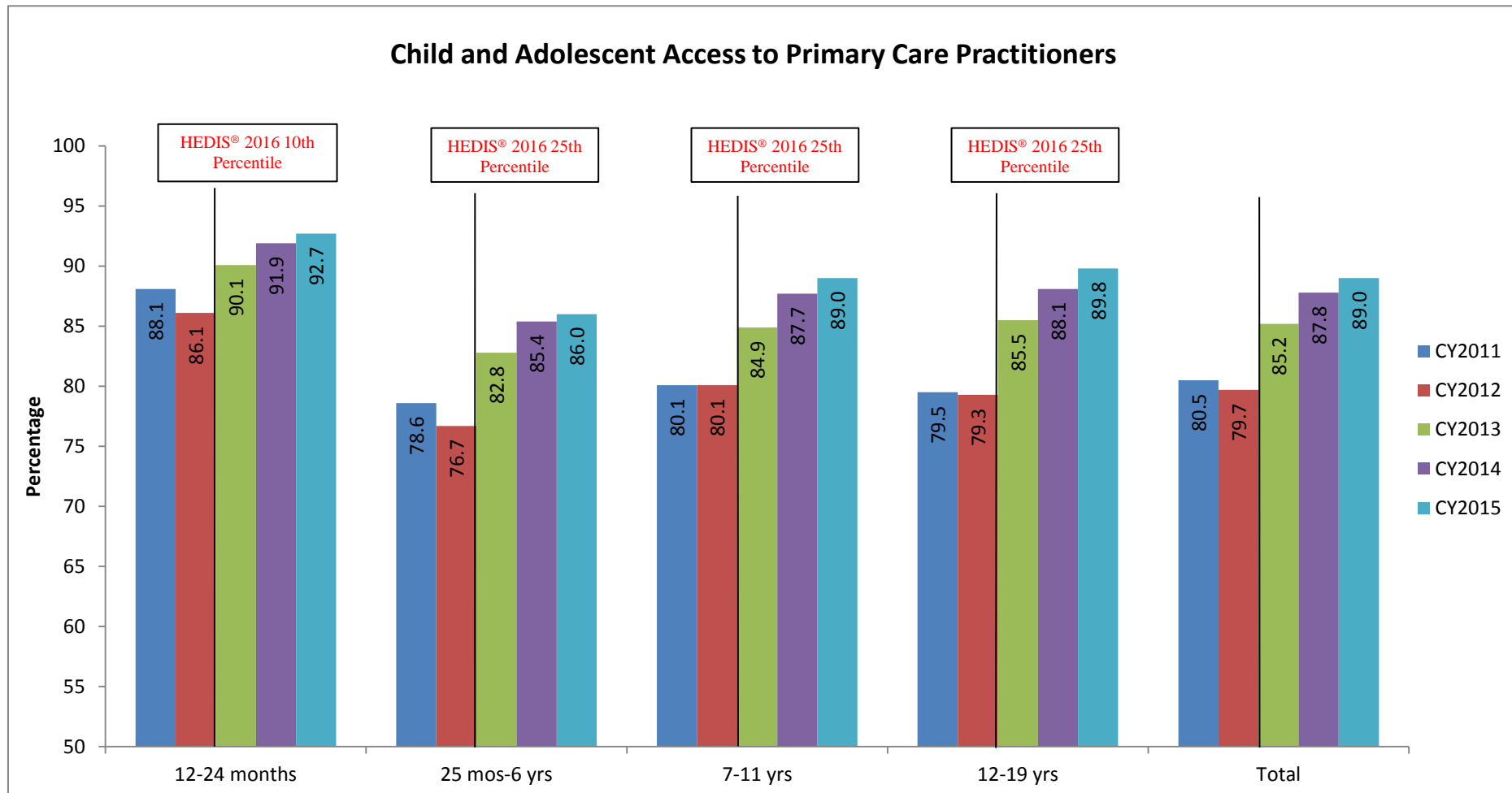
**Notes on Measure Programming or Differences from Measure Specifications:**

- The solid vertical line in the chart indicates that rates for CY2013 and after are not comparable to previous years due to measure re-programming. Previously, the definition of primary care provider (PCP) used a restrictive set of codes that too narrowly defined PCP and reduced our rates. Revised programming appropriately defines PCPs and is reflected in rates beginning with CY2013.

**Eligible Population:**

	CY2011		CY2012		CY2013		CY2014		CY2015	
	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator
<b>12–24 Mo</b>	161,039	182,796	149,614	173,719	145,044	161,051	140,997	153,380	137,362	148,082
<b>25 Mo–6 Yrs</b>	301,241	383,155	289,168	377,080	287,639	347,247	270,295	316,508	257,367	298,979
<b>7-11 Yrs</b>	317,382	396,017	321,700	401,695	327,951	386,303	321,435	366,296	315,465	354,238
<b>12-19 Yrs</b>	387,357	487,162	393,033	495,746	408,607	477,984	402,870	456,831	398,368	443,520
<b>Total</b>	1,167,019	1,449,130	1,153,515	1,448,240	1,169,241	1,327,585	1,135,597	1,293,015	1,108,562	1,244,819

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



#### Key Findings:

- From CY2013 to CY2015, there is a statistically significant ( $p < .05$ ) increase in performance for each age category and the total. The CY2013 to CY2015 trend shows higher rates achieved in each successive year.
- The CY2015 rates are at the HEDIS® 2015 10<sup>th</sup> percentile for ages 12-24 months. The 25<sup>th</sup> percentile was achieved for ages 25 months–6 years and 7-11 years, and 12-19 years. The performance in each age category shows room for improvement.

## Measure CIS: Childhood Immunization Status

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

**Notes on Measure Programming or Differences from Measure Specifications:**

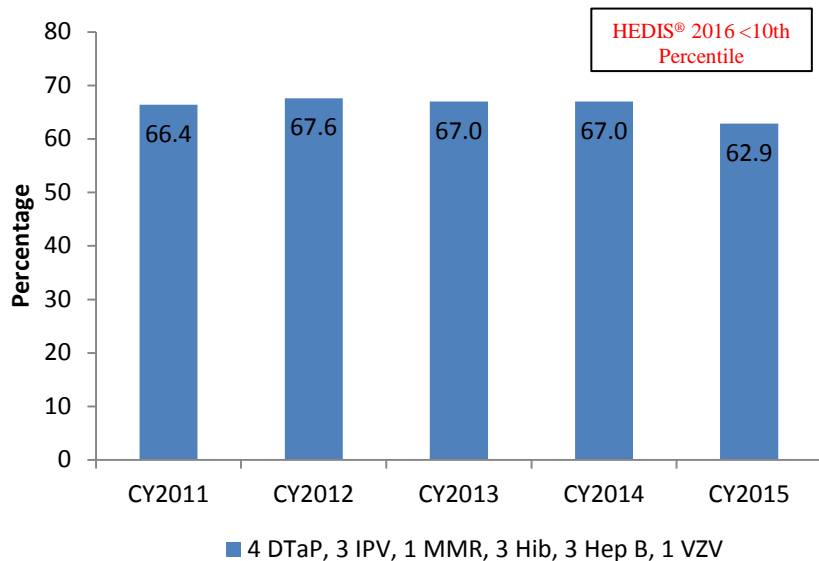
- CY2011 rates were generated with HEDIS® 2011 specifications.
- Combination vaccines 4 through 10 were first reported in CY2012.
- Individual vaccine rates are not included in this report.
- The measure includes vaccinations identified using claims, the DPH state immunization registry and the DHS Cornerstone client information system.
- Denominator exclusions were first applied for reporting CY2012 rates in FFY2013. These exclusions were not applied to the denominator in previous years.

**Eligible Population:**

	CY2011		CY2012		CY2013		CY2014		CY2015	
	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator
<b>Combo 2</b>	62,093	93,582	60,069	88,810	55,696	83,147	52,194	77,869	46,280	73,543
<b>Combo 3</b>	57,285	93,582	56,024	88,810	52,232	83,147	48,830	77,869	43,096	73,543
<b>Combo 4</b>			25,203	88,810	46,033	83,147	44,079	77,869	39,633	73,543
<b>Combo 5</b>			43,924	88,810	43,021	83,147	40,634	77,869	35,582	73,543
<b>Combo 6</b>			27,140	88,810	26,817	83,147	23,515	77,869	20,103	73,543
<b>Combo 7</b>			21,087	88,810	38,916	83,147	37,404	77,869	33,241	73,543
<b>Combo 8</b>			14,274	88,810	25,126	83,147	22,254	77,869	19,225	73,543
<b>Combo 9</b>			22,872	88,810	23,299	83,147	20,597	77,869	17,385	73,543
<b>Combo 10</b>			12,410	88,810	22,023	83,147	19,647	77,869	16,745	73,543

# Measure CIS: Childhood Immunization Status

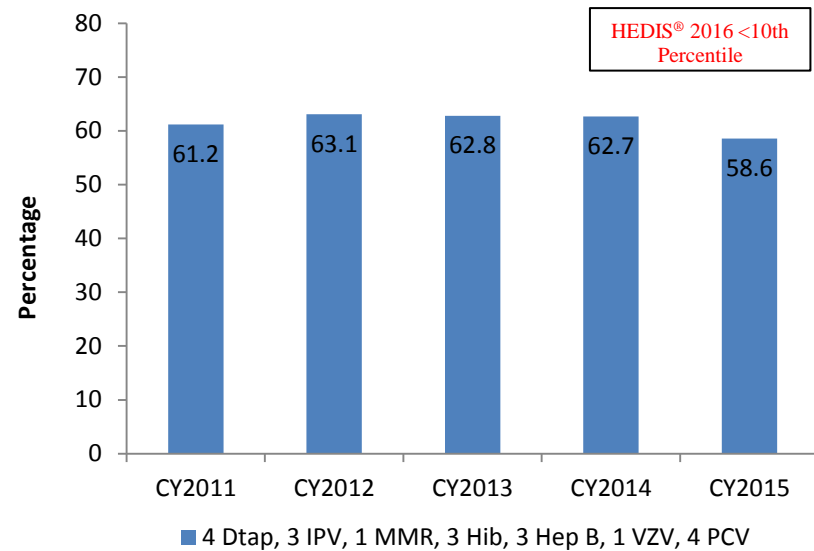
## Childhood Immunization Status - Combo 2



### Key Findings: Combo 2

- From CY2011 to CY2015, there was a decrease of 3.5 percentage points, a decrease of 5percent.
- The decrease from CY2011 is statistically significant ( $p < .05$ ).
- The decrease from CY2014 to CY2015 also is statistically significant ( $p < .05$ ).
- The decrease from CY2014 to CY2015 shows that room for improvement continues to be an issue.

## Childhood Immunization Status - Combo 3



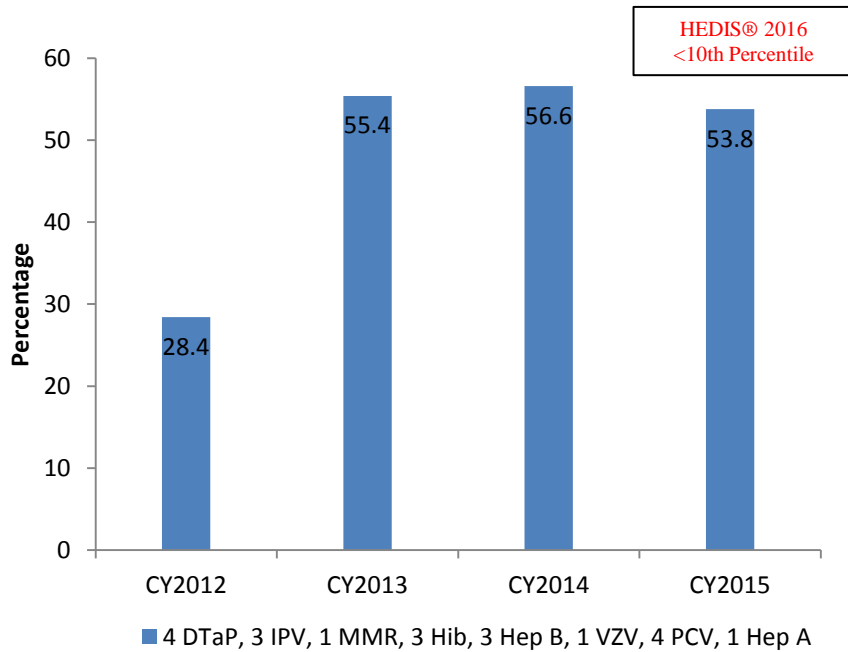
### Key Findings: Combo 3

- There was a decrease of 2.6 percentage points, a decrease of 4 percent, in Combo 3 from CY2011 to CY2015.
- The decrease from CY2011 to CY2015 is statistically significant ( $p < .05$ ).
- The decrease from CY2014 to CY2015 also is statistically significant ( $p < .05$ ).
- The decrease from CY2014 to CY2015 shows that room for improvement continues to be an issue.



# Measure CIS: Childhood Immunization Status

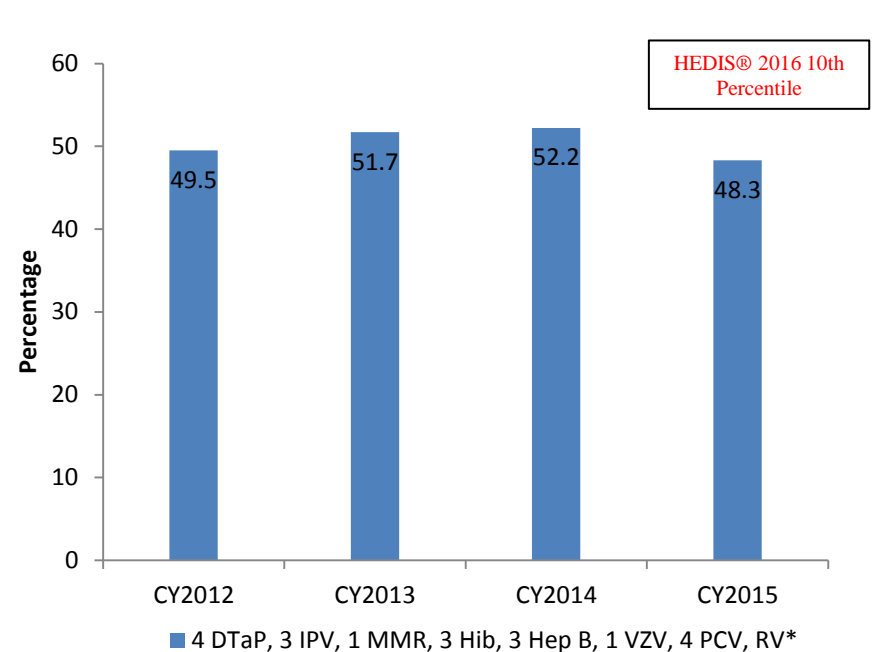
## Childhood Immunization Status - Combo 4



### Key Findings: Combo 4

- CY2013 and CY2014 show annual increases compared to the previous year. This is reversed in CY2015 with a 2.8 percentage point decrease, a decrease of 5 percent, compared to CY2014.
- The decrease from CY2014 to CY2015 is statistically significant ( $p < .05$ ).
- The decrease from CY2014 to CY2015 shows that room for improvement continues to be an issue.

## Childhood Immunization Status - Combo 5



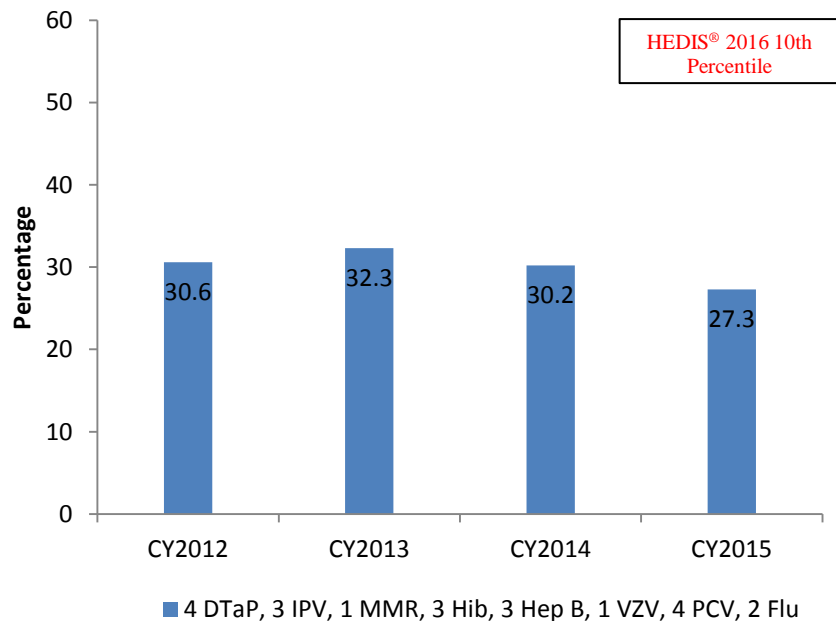
**Note:** \*RV= 2 doses of the 2-dose vaccine, or 1-dose of the 2-dose vaccine and 2 doses of the 3-dose vaccine, or 3-doses of the 3-dose vaccine

### Key Findings: Combo 5

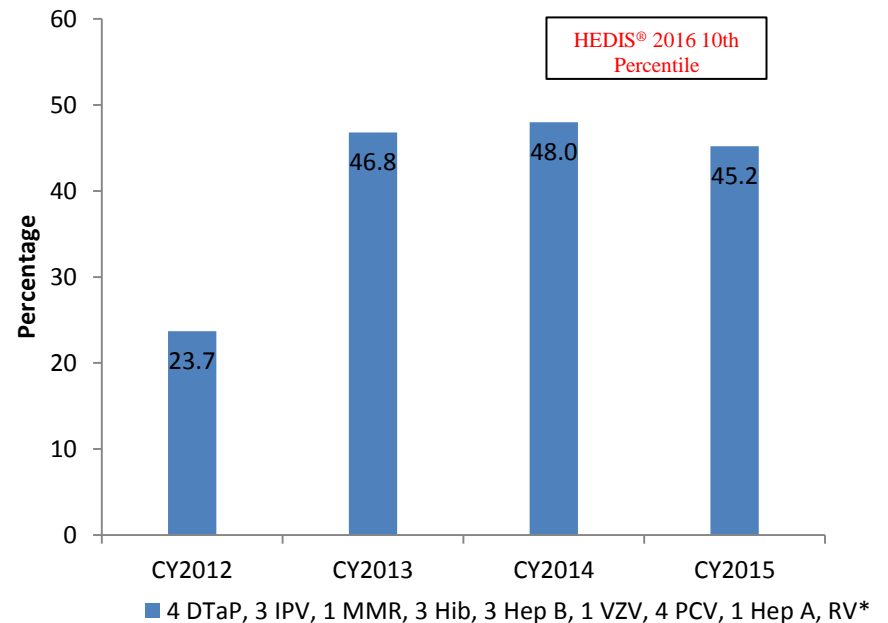
- CY2013 and CY2014 show annual increases compared to the previous year. This is reversed in CY2015 with a 3.9 percentage point decrease, a decrease of 7 percent, compared to CY2014.
- The decrease from CY2014 to CY2015 is statistically significant ( $p < .05$ ).
- The decrease from CY2014 to CY2015 shows that room for improvement continues to be an issue.

# Measure CIS: Childhood Immunization Status

## Childhood Immunization Status - Combo 6



## Childhood Immunization Status - Combo 7



### Key Findings: Combo 6

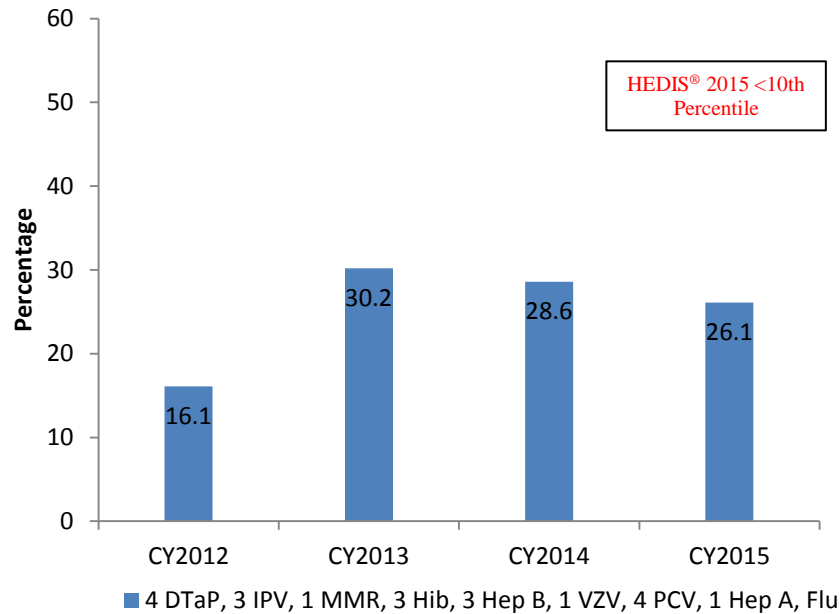
- The static low performance from CY2014 to CY2015 shows that room for improvement continues to be an issue.
- From CY2013 to CY2015 there is an annual decreasing trend.
- From CY2014 to CY2015 the decrease of 2.9 percentage points, or 10 percent, is statistically significant ( $p < .05$ ).

### Key Findings: Combo 7

- The static low performance from CY2014 to CY2015 shows that room for improvement continues to be an issue.
- CY2013 and CY2014 show annual increases compared to the previous year. This is reversed in CY2015 with a 2.8 percentage point decrease, a decrease of 6 percent, compared to CY2014.
- The decrease from CY2014 to CY2015 is statistically significant ( $p < .05$ ).

# Measure CIS: Childhood Immunization Status

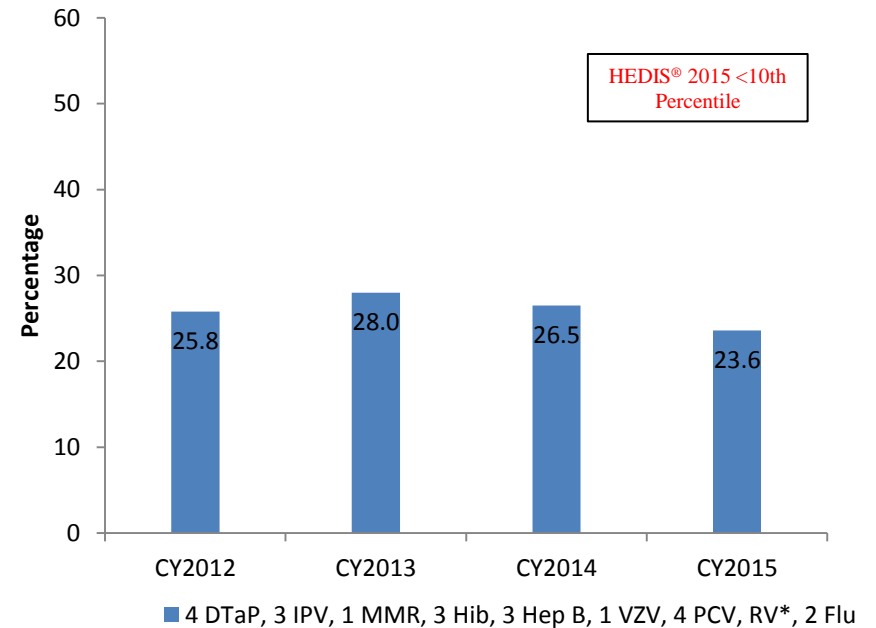
## Childhood Immunization Status - Combo 8



### Key Findings: Combo 8

- The decrease from CY2014 to CY2015 shows that room for improvement continues to be an issue.
- From CY2013 to CY2015 there is an annual decreasing trend.
- From CY2014 to CY2015 the decrease of 2.5 percentage points, or 9 percent, is statistically significant ( $p < .05$ ).

## Childhood Immunization Status - Combo 9

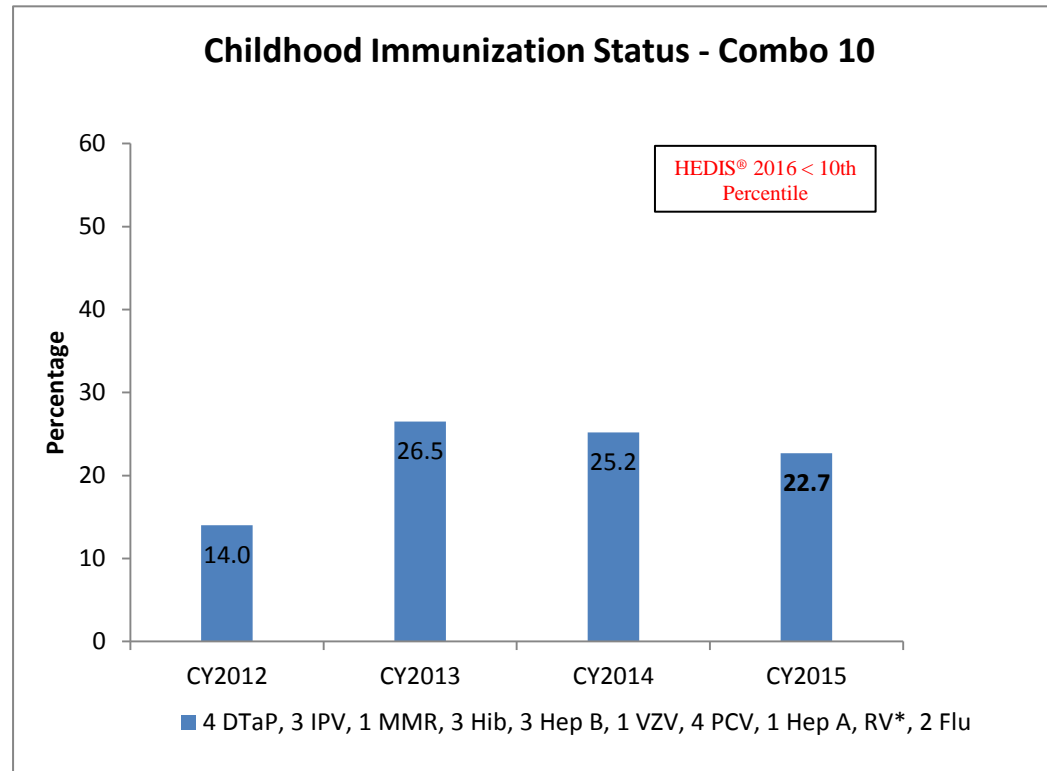


**Note:** \*RV= 2 doses of the 2-dose vaccine, or 1-dose of the 2-dose vaccine and 2 doses of the 3-dose vaccine, or 3-doses of the 3-dose vaccine

### Key Findings: Combo 9

- The decrease from CY2014 to CY2015 shows that room for improvement continues to be an issue.
- From CY2013 to CY2015 there is an annual decreasing trend.
- From CY2014 to CY2015 the decrease of 2.9 percentage points, or 11 percent, is statistically significant ( $p < .05$ ).

# 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 decrease from CY2014 to CY2015 shows that room for improvement continues to be an issue.
- From CY2013 to CY2015 there is an annual decreasing trend.
- From CY2014 to CY2015 the decrease of 2.5 percentage points, or 10 percent, is statistically significant ( $p < .05$ ).

# Measure IMA: Immunization Status for Adolescents

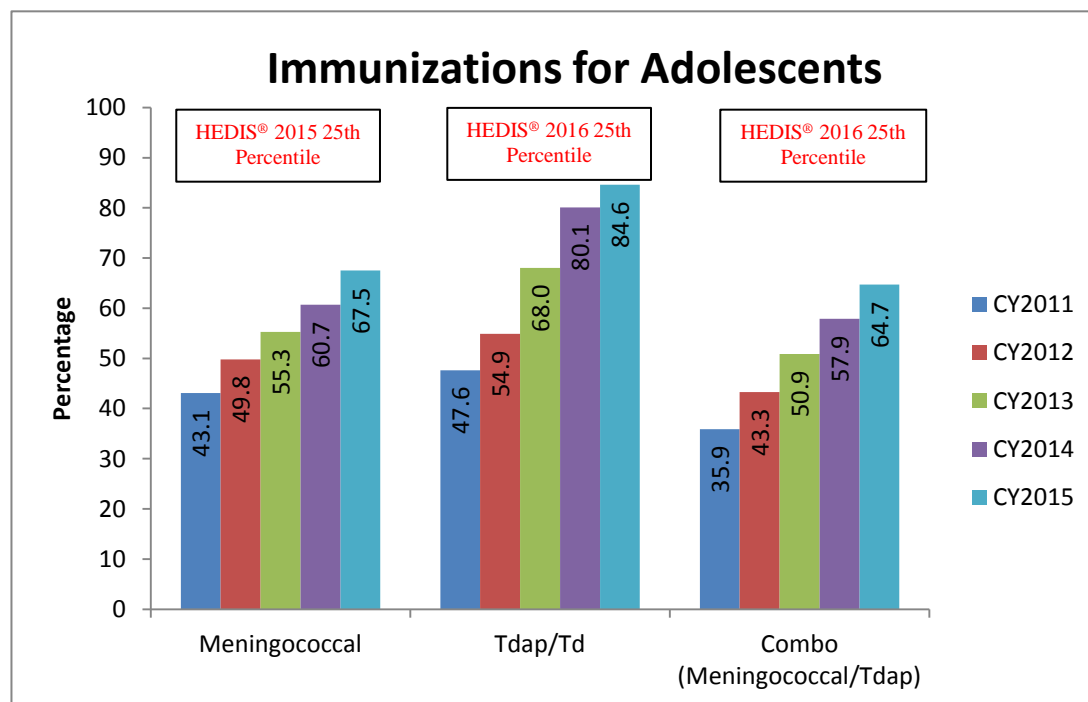
**Measure Description:** The percentage of adolescents who turned 13 years old during the measurement year and had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13<sup>th</sup> birthday.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

**Notes on Measure Programming or Differences from Measure Specifications:**

- CY2011-CY2012 rates were generated with HEDIS® 2012 specifications.
- The measure includes vaccinations identified using claims, the DPH state immunization registry and the DHS Cornerstone client information system.
- Denominator exclusions were first applied for reporting CY2012 rates in FFY2013. These exclusions were not applied to the denominator in previous years.

**Eligible Population:**

	CY2011		CY2012		CY2013		CY2014		CY2015	
	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator
<b>Meningococcal</b>	32,725	75,952	38,931	78,250	43,466	78,540	44,676	73,548	47,274	70,031
<b>Tdap/Td</b>	36,157	75,952	42,921	78,250	53,419	78,540	58,914	73,548	59,293	70,031
<b>Combo</b>	27,255	75,952	33,864	78,250	39,959	78,540	42,560	73,548	45,370	70,031



**Key Findings**

- There is a year to year increasing trend from CY2011 to CY2015.
- From CY2011 to CY2015, the Combo (Meningococcal and Tdap/Td) immunization rate for adolescents increased by 28.8 percentage points, an increase of 80 percent.
- There was an increase of 24.4 percentage points, or 57 percent, in the Meningococcal rate from CY2011 to CY2015.
- From CY2011 to CY2015 there was an increase of 37 percentage points, or 78 percent, in the Tdap/Td rate.
- For both vaccines and the Combo, the increases from CY2011 to CY2015 are statistically significant (p<.05).
- These increases in rates for each vaccine and combo are at the HEDIS® 2016 25<sup>th</sup> percentile presenting improvement from the 10<sup>th</sup> percentile the prior year.

## Measure FPC: Frequency of Ongoing Prenatal Care

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

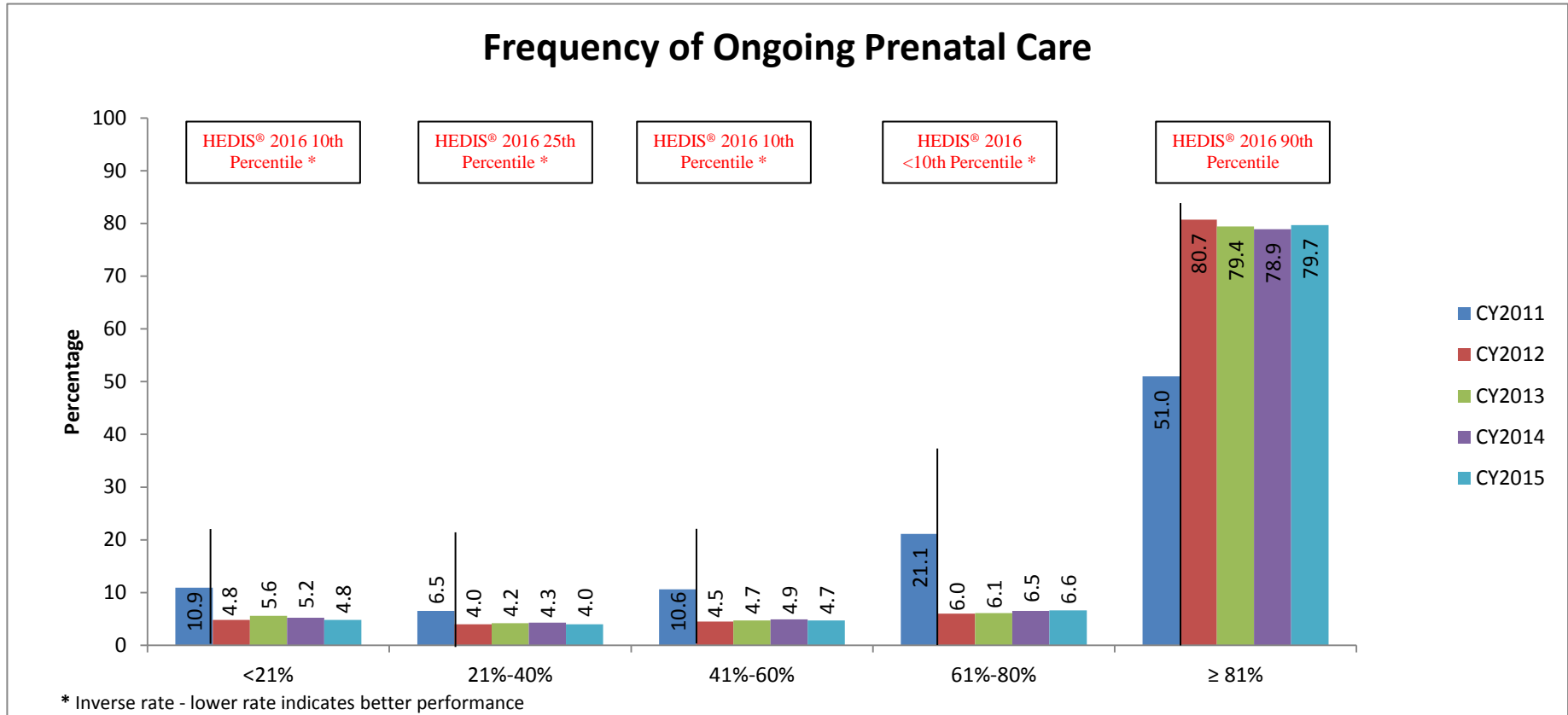
**Notes on Measure Programming or Differences from Measure Specifications:**

- Beginning with CY2013, a programming change results in a slightly lower denominator compared to earlier years.
- CY2011-CY2015 use uncertified Vital Records data.
- The solid vertical line in the chart indicates rates for CY2012 and after are not comparable to previous years because of the following measure programming updates:
  - CY2011 generated with HEDIS<sup>®</sup> 2007 specifications.
  - HFS used only Decision Rule 2 for CY2011. Beginning with CY2012 all four decision rules were used.

**Eligible Population:**

	CY2011		CY2012		CY2013		CY2014		CY2015	
	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator
<21%	8,677	79,996	3,863	79,948	4,372	78,275	3,902	74,812	3,553	74,044
21-40%	5,226	79,996	3,183	79,948	3,314	78,275	3,250	74,812	3,001	74,044
41-60%	8,437	79,996	3,620	79,948	3,663	78,275	3,724	74,812	3,493	74,044
61-80%	16,851	79,996	4,772	79,948	4,801	78,275	4,872	74,812	4,951	74,044
≥81%	40,805	79,996	64,510	79,948	62,125	78,275	59,064	74,812	59,046	74,044

# Measure FPC: Frequency of Ongoing Prenatal Care



### Key Findings:

- It is preferable to achieve the highest rate at the upper most visit frequency of  $\geq 81\%$  and the lowest rates at the lower visit frequencies. CY2012-CY2015 rates of prenatal care show that the majority of pregnant women are receiving 81% or more of the expected number of visits, which is considered adequate prenatal care.
- Comparing CY2012 and CY2015, there is a statistically significant ( $p < .05$ ) decrease in women receiving  $\geq 81\%$  of recommended visits. In each visit frequency category, there has been little change annually from CY2013 to CY2015; CY2016 performance is HEDIS® 2016 90<sup>th</sup> percentile.
- Compared to HEDIS® 2016 percentiles, among the lowest four visit frequency categories performance is at the below the 10<sup>th</sup> to the 25<sup>th</sup> percentile, which is an improvement as these categories are inverse rates, where a lower rate indicates better performance.

# Measure PPC: Timeliness of Prenatal Care

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

**Notes on Measure Programming or Differences from Measure Specifications:**

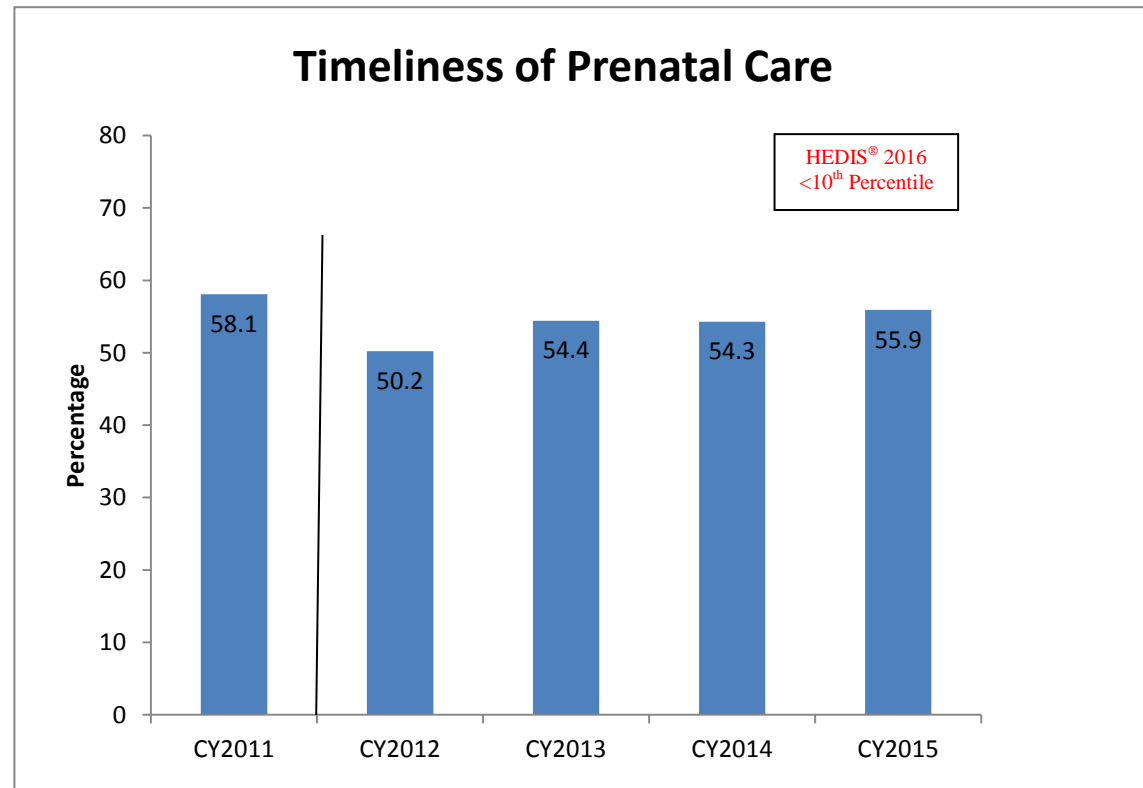
- From CY2012 to CY2013 a programming change results in a slightly lower denominator count in CY2013.
- CY2011-CY2015 use uncertified Vital Records data.
- The solid vertical line indicates that rates for CY2012 and after are not comparable to previous years because of the following measure programming updates:
  - CY2011 generated with HEDIS® 2007 specifications.
  - HFS used only Decision Rule 2 for CY2011. Beginning with CY2012 all four decision rules were used.

**Eligible Population:**

Calendar Year	Numerator	Denominator
2011	46,487	79,996
2012	39,728	79,141
2013	42,603	78,275
2014	40,639	74,812
2015	41,390	74,044

**Key Findings:**

- This measure shows that slightly more than one-half of pregnant women receive timely prenatal care.
- The increase from CY2012 to CY2015 is statistically significant ( $p < .05$ ).
- This measure is below the HEDIS® 2016 10<sup>th</sup> percentile for CY2015, and has been consistently below the 10<sup>th</sup> percentile since CY2011, showing need for improvement.





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

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

**Notes on Measure Programming or Differences from Measure Specifications:**

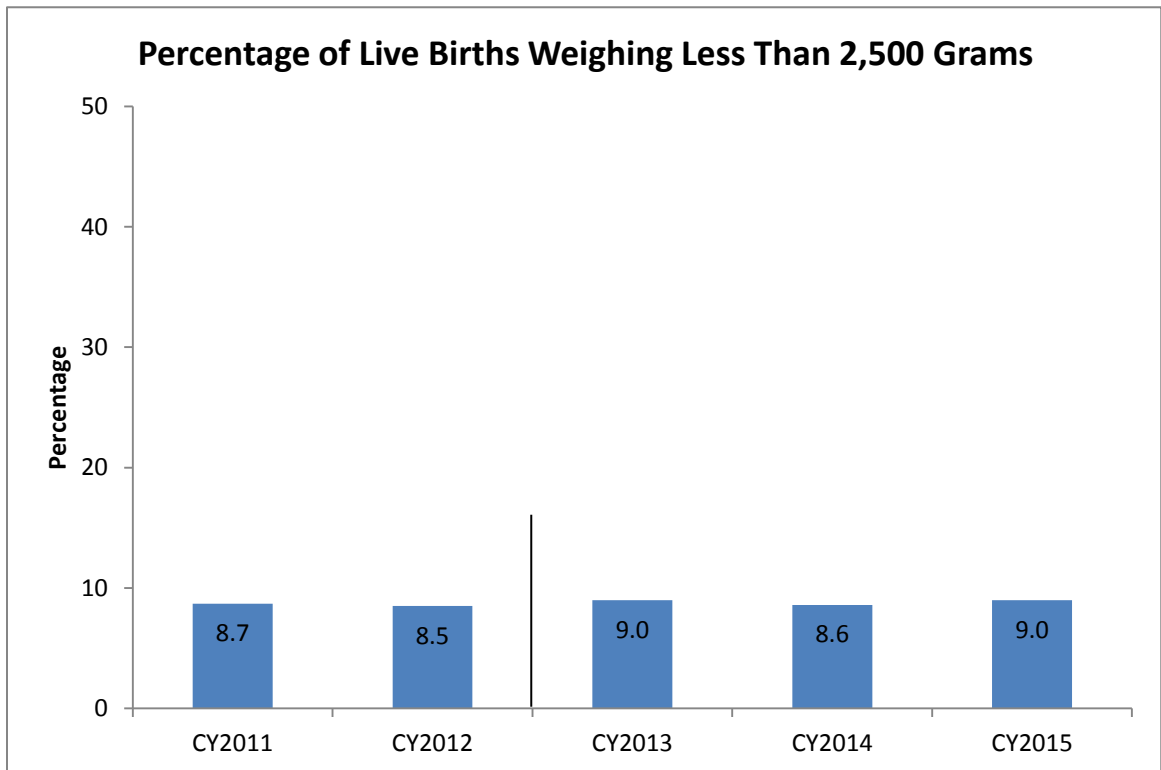
- CY2011-CY2015 rates use uncertified Vital Records and are, therefore, considered provisional.
- The solid vertical line indicates that rates for CY2013 and after are not comparable to previous years due to enhancements to the Moms/Babies Data Mart matching process.
- Rates are based on deliveries with >\$0 re-priced net liability amount.
- The June 2016 Child Core Set specifications were used to program this measure for CY2015.

**Eligible Population:**

Calendar Year	Numerator	Denominator
2011	5,558	63,560
2012	5,020	59,387
2013	6,101	67,808
2014	5,285	61,688
2015	6,351	70,139

**Key Findings:**

- There is no difference between CY2013 and CY2015 rates.
- The statistically significant decrease from CY2013 to CY2014 was reversed from CY2014 to CY2015 with a statistically significant ( $p < .05$ ) increase. Caution should be used, however, since the Vital Records data reported are not certified.



# Measure CSEC: Cesarean Rate for Nulliparous Singleton Vertex

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

**Notes on Measure Programming or Differences from Measure Specifications:**

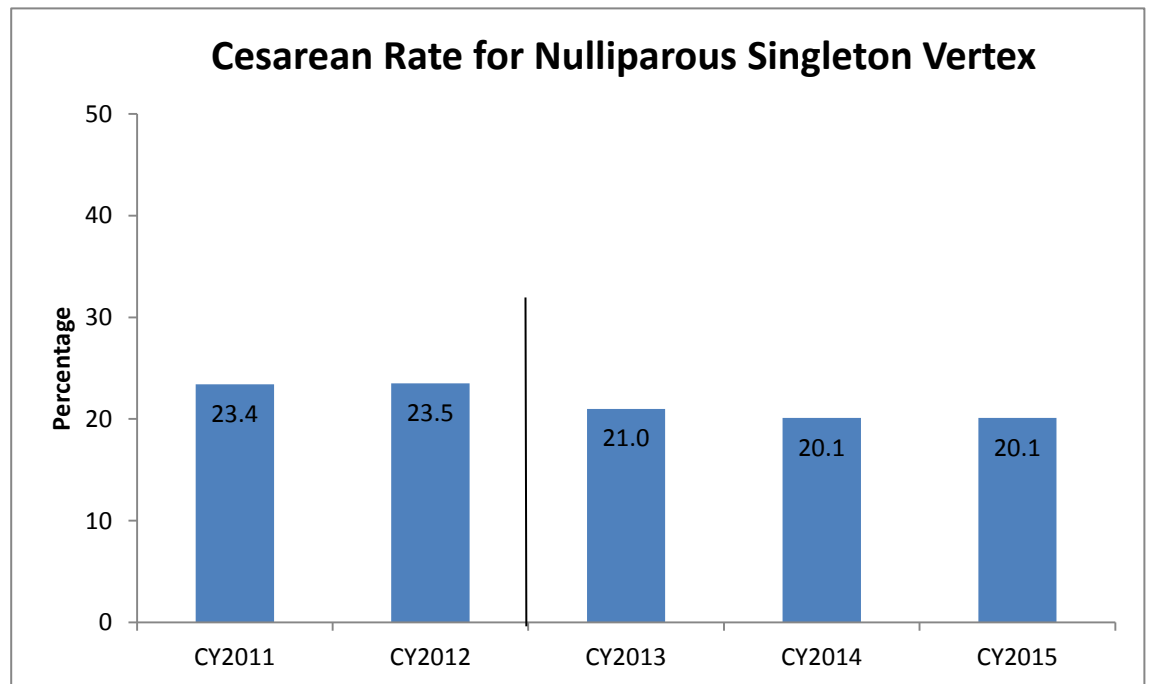
- The solid vertical line indicates that rates for CY2013 and after are not comparable to CY2011-CY2012 due to enhancements to the Moms/Babies Data Mart matching process. These enhancements identify more Mom/baby pairs and first births resulting in denominator and numerator increases compared to previous years.
- Due to report timing, the CY2011-CY2015 rates use uncertified Vital Records data and are, therefore, considered provisional.
- The June 2016 Child Core Set specifications were used to program this measure for CY2015.

**Eligible Population:**

Calendar Year	Numerator	Denominator
2011	3,357	14,335
2012	3,207	13,637
2013	4,528	21,612
2014	4,156	20,626
2015	4,022	19,991

**Key Findings:**

- The Vital Records data reported are not certified. So, the statistically significant (p<.05) -4 percent decrease from CY2013 to CY2015 should be viewed with caution.



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

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

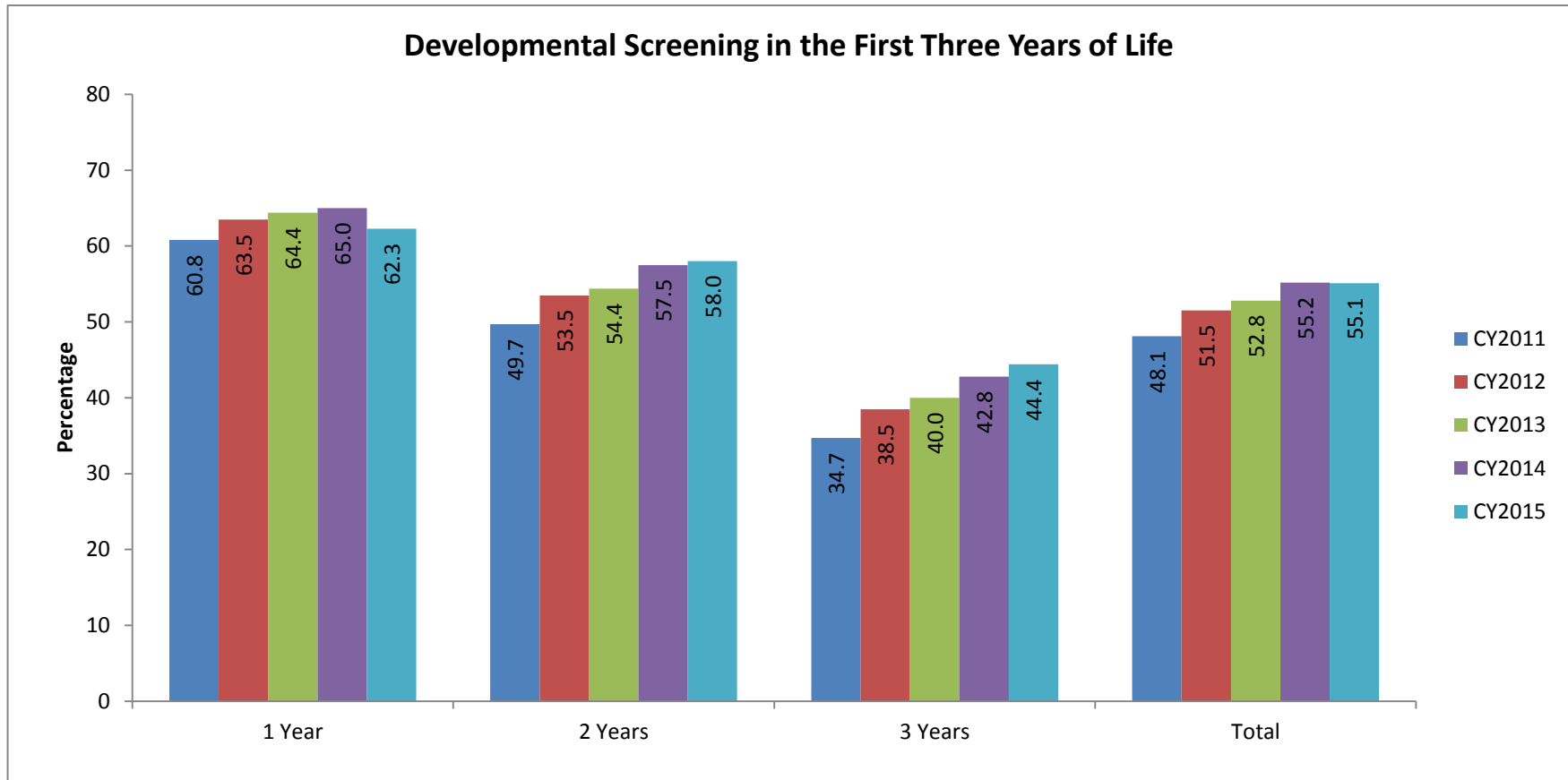
**Notes on Measure Programming or Differences from Measure Specifications:**

- The specifications define specific global screening tools that are to be counted for this measure. Screening tools allowed by HFS policy include global and domain-specific tools that differ from those included in the specifications. This measure deviates from the Child Core Set measure specifications by counting allowable screening tools as specified in HFS policy.
- The June 2016 Child Core Set specifications were used to program this measure for CY2015.

**Eligible Population:**

	CY2011		CY2012		CY2013		CY2014		CY2015	
	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator
<b>1 Yr</b>	55,294	90,878	55,913	88,073	55,324	85,893	53,789	82,763	51,245	82,306
<b>2 Yrs</b>	47,115	94,728	48,555	90,757	46,899	86,170	46,312	80,596	44,390	76,525
<b>3 Yrs</b>	33,819	97,511	36,423	94,666	35,391	88,374	34,662	80,914	33,949	76,540
<b>Total</b>	136,228	283,117	140,891	273,496	137,614	260,437	134,763	244,273	129,584	235,371

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



## Key Findings:

- From CY2011 to CY2014, each age category shows statistically significant increases ( $p < .05$ ) in screening rates.
- From CY2014 to CY2015 there is a statistically significant ( $p < .05$ ) decrease in developmental screening among those one year of age. This 2.7 percentage point decrease, a 4 percent reduction, is troubling since identification and intervention at an early age can ameliorate delay.
- From CY2011 to CY2014 among those screened by two years of age, the rate increased by 7.8 percentage points. From CY2014 to CY2015 the increase was 0.5 percentage points. This is of concern since early identification and intervention can ameliorate delay.
- Driven by a lower screening rate among one year olds, the CY2015 rate is slightly lower than the CY2014 rate. CY2015 marks the first year there has not been an increased rate of screening compared to the previous year.
- In each age category, the magnitude of increase is slowing with each successive year. This is especially true among 1 year olds where, for the first time, a decrease is seen from CY2014 to CY2015.
- HFS conducted quality improvement initiatives to promote objective developmental screening. The focused initiatives concluded in 2013. Sustaining these rates must be maintained through efforts of the medical home, care coordination and practicing evidence-based care.

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

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

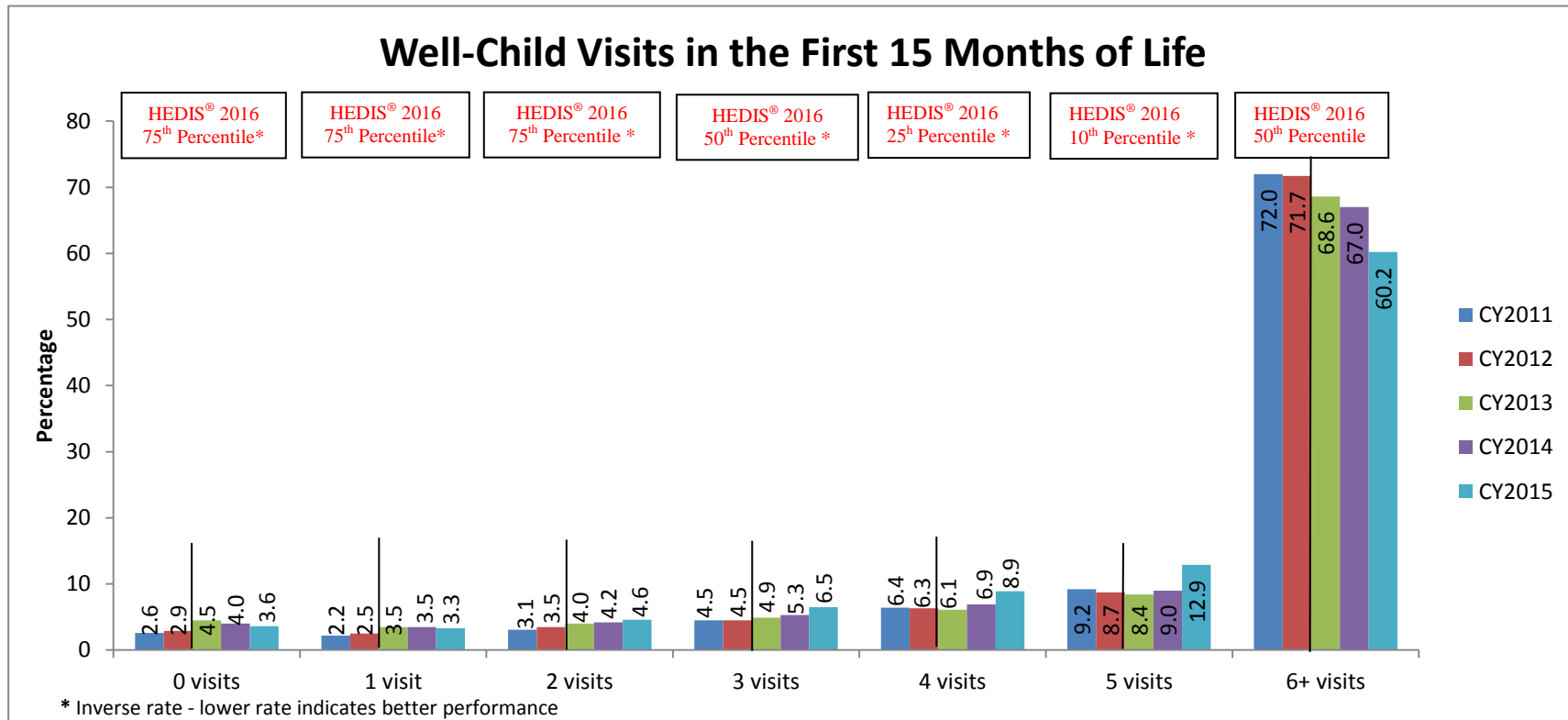
**Notes on Measure Programming or Differences from Measure Specifications:**

- The solid vertical line indicates that rates for CY2013 and after are not comparable to CY2011-CY2012. Before CY2013, PCP was not defined and the measure accepted all types. Measure programming was changed to assess by provider type code and specialty type to assure selection of only primary care providers.

**Eligible Population:**

	CY2011		CY2012		CY2013		CY2014		CY2015	
	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator
<b>0 Visits</b>	2,317	88,630	2,463	85,969	3,761	82,698	3,181	79,214	2,716	75,524
<b>1 Visit</b>	1,966	88,630	2,128	85,969	2,917	82,698	2,765	79,214	2,495	75,524
<b>2 Visits</b>	2,779	88,630	3,000	85,969	3,282	82,698	3,352	79,214	3,442	75,524
<b>3 Visits</b>	3,989	88,630	3,880	85,969	4,013	82,698	4,227	79,214	4,893	75,524
<b>4 Visits</b>	5,630	88,630	5,438	85,969	5,047	82,698	5,500	79,214	6,747	75,524
<b>5 Visits</b>	8,164	88,630	7,457	85,969	6,941	82,698	7,154	79,214	9,740	75,524
<b>6+</b>	63,785	88,630	61,603	85,969	56,737	82,698	53,035	79,214	45,491	75,524

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



#### Key Findings:

- For 0 to 5 visit categories lower rates indicate better performance. Rates at the HEDIS<sup>®</sup> 2016 75<sup>th</sup> percentile for 0 and 1 visit categories indicate poor performance for CY2015. This also is true for the CY2015 2 and 3 visit categories that are at the HEDIS<sup>®</sup> 2015 75<sup>th</sup> and 50<sup>th</sup> percentiles.
- During CY2015, the HEDIS<sup>®</sup> 2016 50<sup>th</sup> percentile was achieved for 6+ visit rate, a decline in performance for CY2014 rates.
- Receipt of 6 or more well care visits decreased from CY2013 to CY2015 by 8.4 percentage points, a 12 percent decrease, which is a statistically significant (p<.05) decline.
- In CY2013 and CY2014, just over two-thirds of children received 6 or more well care visits by 15 months of age. This decreases in CY2015 to just under two-thirds of children receiving 6 or more visits. This marks a three year trend of annual decreases.
- There is a statistically significant (p<.05) shift at the lower end points. Rates in the 0 visits and 1 visit categories decreased from CY2013 to CY2015. This decrease indicates better performance.
- From CY2013 to CY2015, there are statistically significant (p<.05) increases for 2, 3, 4, and 5 visits. This can be attributed to shifts up from 0 or 1 visits and a shift down from receiving 6 visits. The 5 visits category shows the largest increase (4.5 percentage points, or 54%) from CY2013 to CY2015 indicating that many children shifted downward from the 6 visits category.

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

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

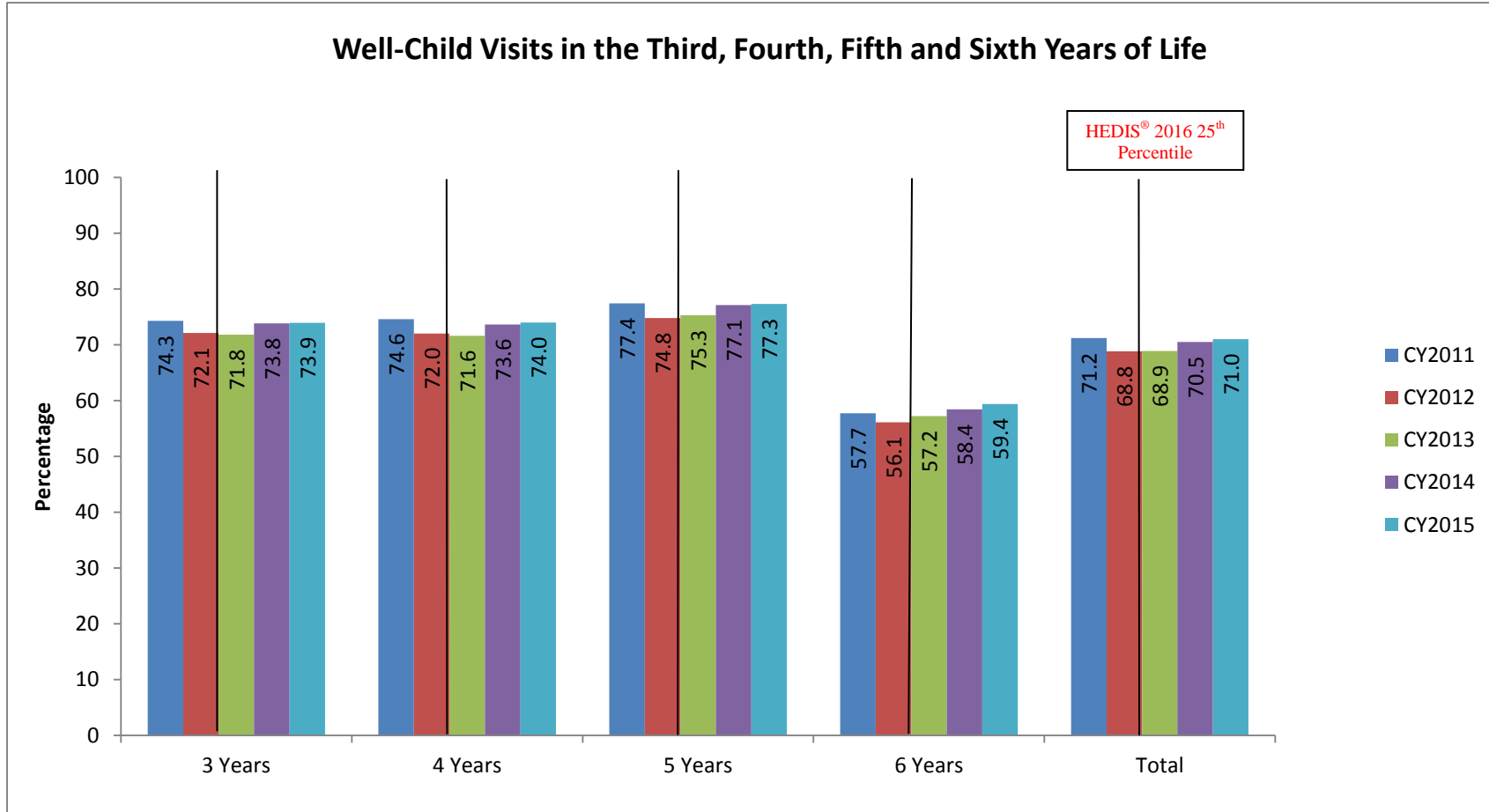
**Notes on Measure Programming or Differences from Measure Specifications:**

- The solid vertical line indicates that rates for CY2013 and after are not comparable to CY2011-CY2012. Before CY2013, PCP was not defined and the measure accepted all types. Measure programming was changed to assess by provider type code and specialty type to assure selection of only primary care providers.

**Eligible Population:**

	CY2011		CY2012		CY2013		CY2014		CY2015	
	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator
<b>3 Years</b>	72,008	96,883	66,312	91,953	59,267	82,549	55,540	75,220	53,937	72,909
<b>4 Years</b>	73,175	98,133	68,615	95,235	61,696	86,138	57,252	77,743	54,034	72,972
<b>5 Years</b>	74,372	96,070	71,799	96,039	66,937	88,890	62,212	80,655	58,270	75,379
<b>6 Years</b>	53,111	92,084	52,677	93,872	51,268	89,663	48,408	82,892	46,194	77,714
<b>Total</b>	272,666	383,170	259,403	377,099	239,168	347,240	223,412	316,510	212,435	298,974

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



## Key Findings:

- In CY2015, the total rate for children ages 3, 4, 5, and 6 years who received one or more well-child visits achieved the 25<sup>th</sup> percentile.
- CY2013-CY2015 totals for ages 3-6 years show over two-thirds received at least one preventive visit during the year.
- From CY2013 to CY2015 there were statistically significant ( $p < .05$ ) increases in each of the individual age categories and the total.
- From CY2014 to CY2015 rates increased in each age category and the total. However, these increases were not statistically significant or as large as those occurring between CY2013 and CY2014.
- The well-child visit rate for children in each age group does not meet the 50<sup>th</sup> percentile and presents opportunity for improvement. This need for improvement is especially true among those age 6 where just over half received a well-child visit.



# Measure AWC: Adolescent Well-Care Visits

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

**Notes on Measure Programming or Differences from Measure Specifications:**

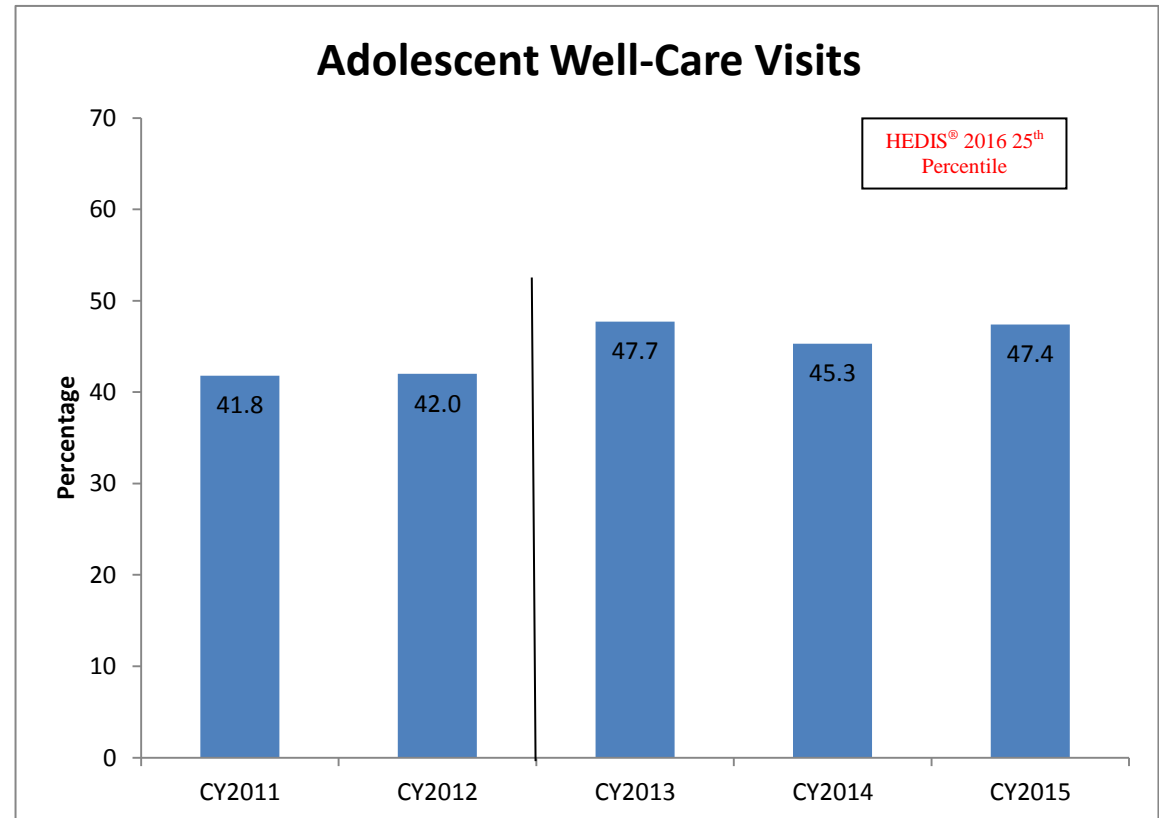
- The solid vertical line indicates that CY2013 rates are not comparable to CY2011-CY2012. Before CY2013, PCP was too narrowly defined using a restrictive set of codes thereby reducing rates. Programming was revised in CY2013 to appropriately define PCPs.

**Eligible Population:**

Calendar Year	Numerator	Denominator
2011	233,792	559,837
2012	235,694	561,494
2013	256,858	538,502
2014	244,171	539,135
2015	261,401	550,935

**Key Findings:**

- The CY2015 adolescent well-child visit rate achieved the HEDIS® 2016 25<sup>th</sup> percentile.
- The decrease of 0.3 percentage points, -1.0 percent, from CY2013 to CY2015 is statistically significant (p<.05).
- The increase of 2.1 percentage points, a 5 percent increase, is statistically significant (p<.05).
- Consistently, less than one-half of adolescents receive a comprehensive well care visit during the year. This presents an opportunity for improvement.



# Measure CHL: Chlamydia Screening in Women

**Measure Description:** The percentage of women ages 16 through 24 years of age who were identified as sexually active and who 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 and the total are reported here for comparison. Continuous enrollment during the measurement year is required for inclusion in this measure.

**Notes on Measure Programming or Differences from Measure Specifications:**

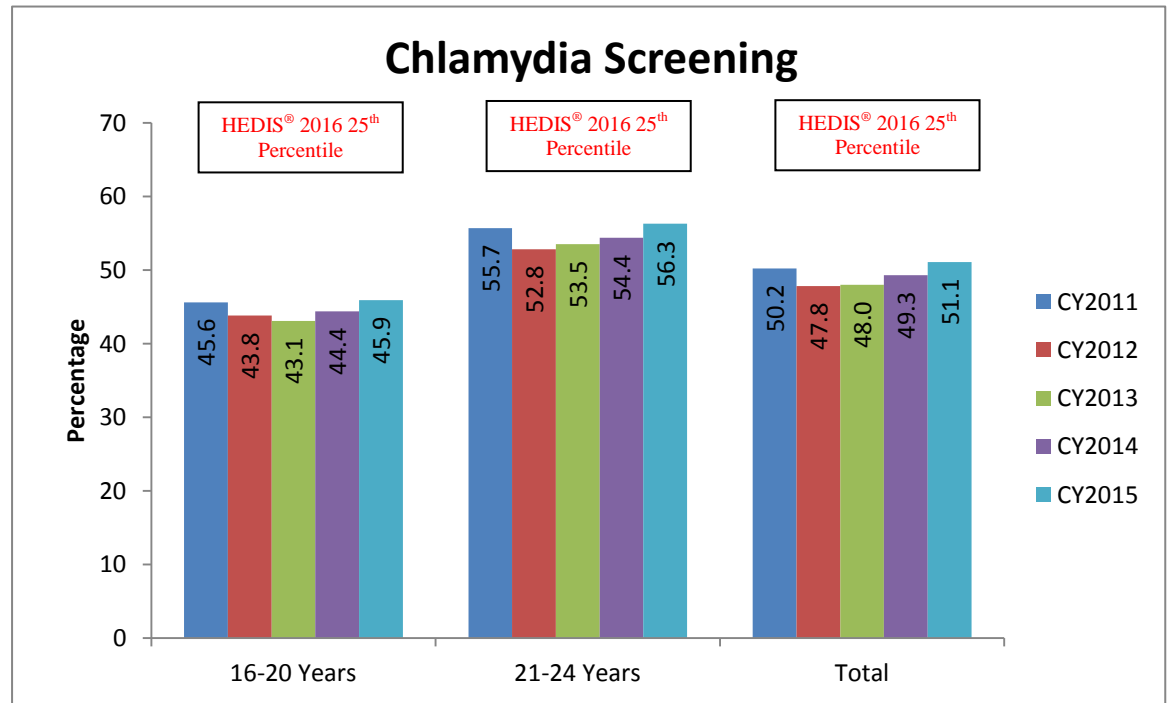
- None

**Eligible Population:**

	CY2011		CY2012		CY2013		CY2014		CY2015	
	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator
16-20 Years	25,264	55,466	22,434	51,780	19,895	46,184	21,332	48,045	22,407	48,796
21-24 Years	25,959	46,643	24,407	46,210	22,544	42,169	25,259	46,358	28,362	50,378
<b>Total</b>	<b>51,223</b>	<b>102,109</b>	<b>46,841</b>	<b>97,990</b>	<b>42,439</b>	<b>88,353</b>	<b>46,591</b>	<b>94,403</b>	<b>50,769</b>	<b>99,174</b>

**Key Findings:**

- Comparing CY2011 to CY2015 there are non-statistically significant increases in Chlamydia screening among those 16-20 and 21-24.
- The increase from CY2011 to CY2015 is statistically significant ( $p < .05$ ) for the total (ages 16-24).
- There is a statistically significant ( $p < .05$ ) increase in all categories from CY2013 to CY2014 and from CY2014 to CY2015.
- The Chlamydia screening rate is consistently lower from CY2011 to CY2015 among 16-20 year olds compared to those 21-24 years of age.
- The CY2015 screening rates in both age groups and the total cohort are at the HEDIS® 25<sup>th</sup> percentile. While this is an improvement over previous years where the 10<sup>th</sup> percentile was achieved, it is unchanged from CY2014, so there is opportunity for improvement.



# Measure PDENT: Percent of Eligibles Who Received Preventive Dental Services

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

**Notes on Measure Programming or Differences from Measure Specifications:**

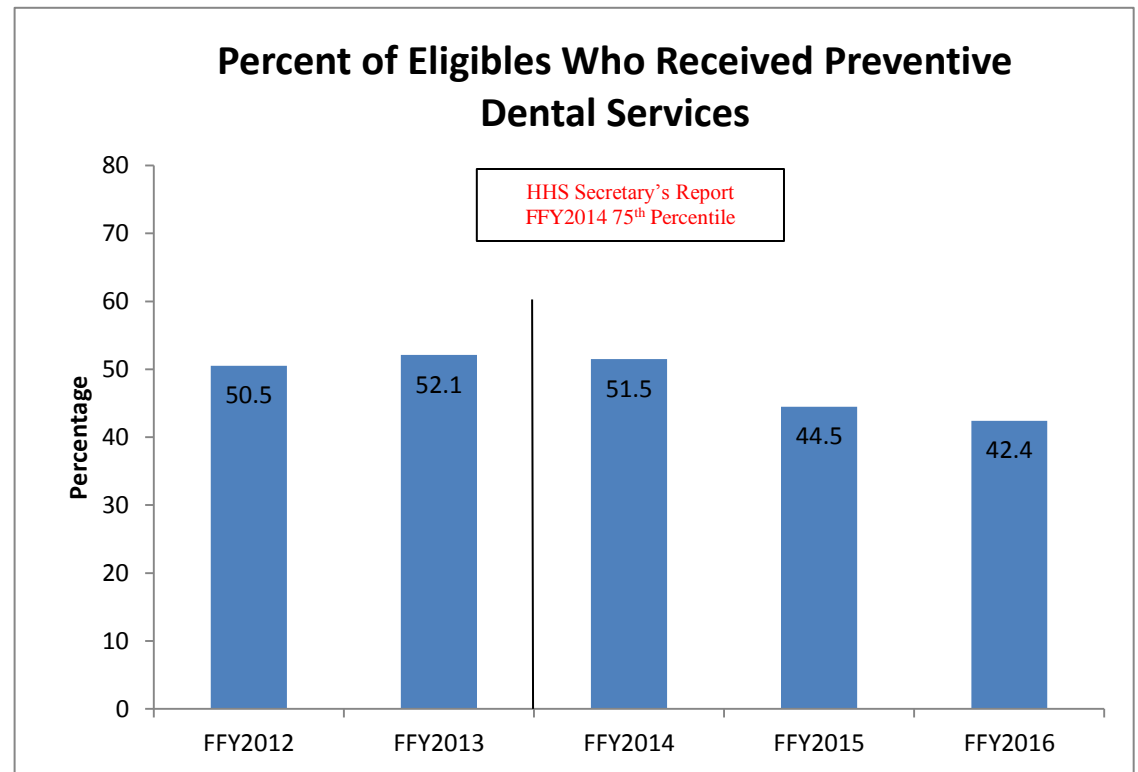
- The solid vertical line indicates that rates for FFY2014 and after are not comparable to FFY2012-FFY2013 rates. During November 2014, the FFY2014 reporting guidance was revised by CMS. Rates for FFY2014 and after are based on the revised guidance.
- The percentiles shown in the chart are from the HHS Secretary’s Annual Report on the Quality of Care for Children in Medicaid and CHIP for FFY2014 reflecting CY2013 data for most states.

**Eligible Population:**

Federal Fiscal Year	Numerator	Denominator
2012	798,269	1,581,522
2013	817,200	1,568,087
2014	796,490	1,547,301
2015	649,988	1,459,801
2016	602,486	1,417,866

**Key Findings:**

- FFY2015 data were updated in August 2016 allowing reporting of additional encounter data submitted after the April 1, 2016, due date to federal CMS. The FFY2016 data were run during March 2017 and do not have the same run-out period. This accounts for the lower rate compared to FFY2015.
- Based on HFS’ FFY2014 data, the FFY2014 HHS Secretary’s Report 75<sup>th</sup> percentile was achieved.



# Measure MMA: Medication Management for People with Asthma

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

**Notes on Measure Programming or Differences from Measure Specifications:**

- None

**Eligible Population:**

Days Covered	CY2012				CY2013				CY2014				CY2015			
	≥50		≥75		≥50		≥75		≥50		≥75		≥50		≥75	
	Num.	Den.	Num.	Den.	Num.	Den.	Num.	Den.	Num.	Den.	Num.	Den.	Num.	Den.	Num.	Den.
5-11 Yrs	7,620	18,320	3,560	18,320	6,795	14,787	2,933	14,787	5,906	13,202	2,547	13,202	5,822	12,511	2,629	12,511
12-18 Yrs	4,173	11,332	1,893	11,332	3,830	9,464	1,622	9,464	3,538	8,744	1,520	8,744	3,534	8,265	1,574	8,265
19-20 Yrs	147	445	83	445	121	310	58	310	232	530	100	530	229	579	96	579
5-20 Yrs	11,940	30,097	5,536	30,097	10,746	24,561	4,613	24,561	9,676	22,476	4,167	22,476	9,585	21,355	4,299	21,355

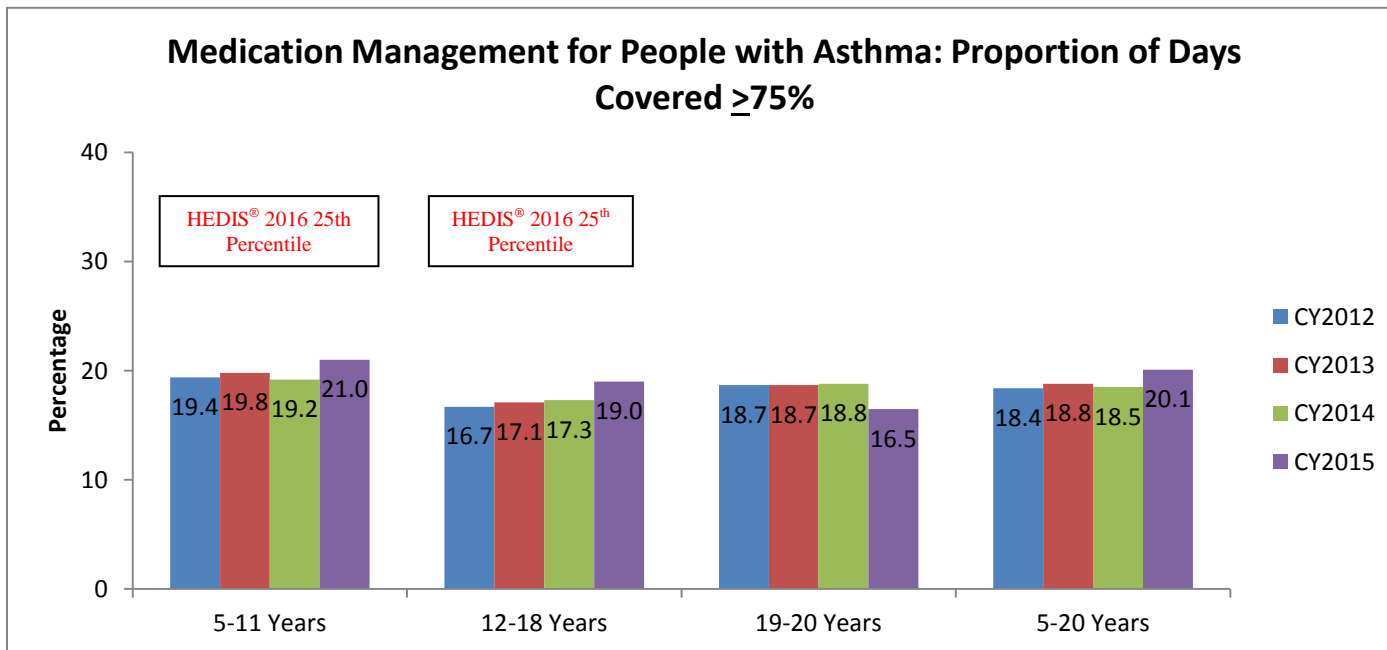
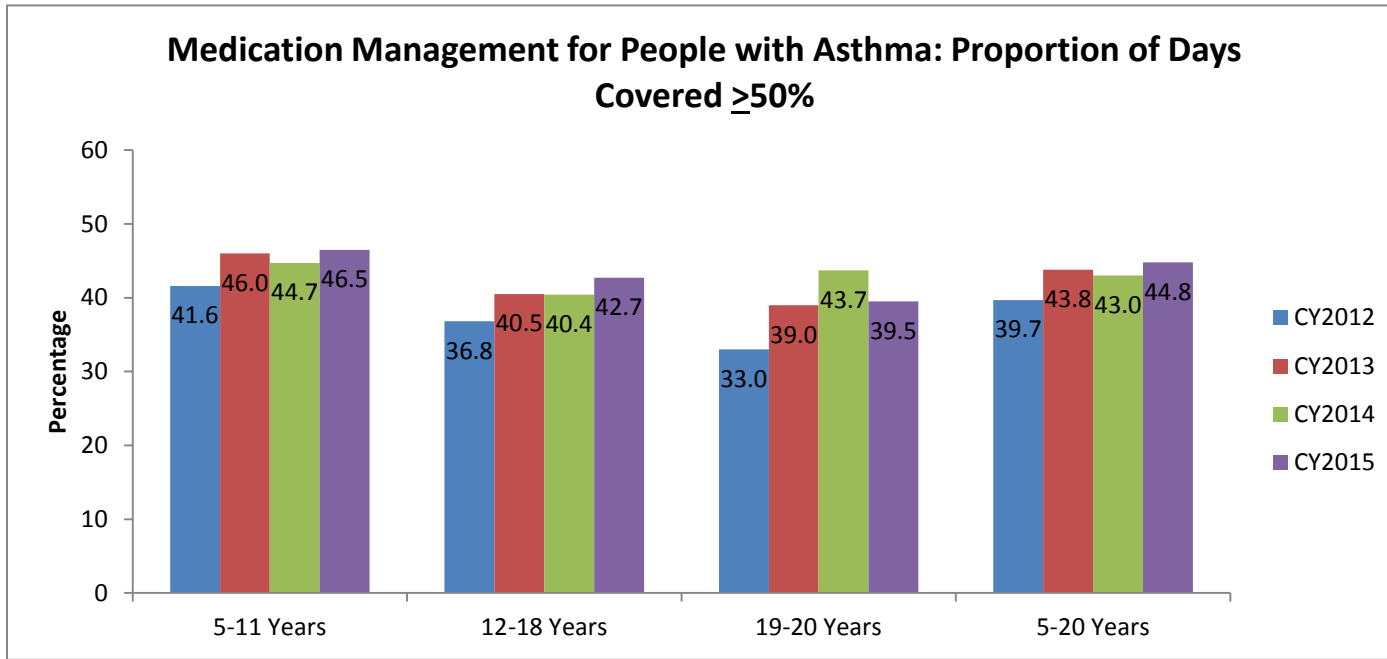
**Key Findings – Proportion of Days Covered ≥50%:**

- From CY2012 to CY2015, there were statistically significant (p<.05) increases in medication management in each age category and the total (ages 5-20).
- From CY2014 to CY2015, 19-20 years experienced a non-statistically significant decrease of 4.2 percentage points, a 10 percent decrease.
- For each age category and the total medication management is below 50 percent showing need for improvement.
- 2016 HEDIS percentiles are not available for this proportion of covered days.

**Key Findings – Proportion of Days Covered ≥75%:**

- Across each age category and the total approximately 20 percent remain on asthma medication for ≥75% of covered days, showing a need for improvement.
- During CY2015 the lowest rate is among 19-20 year olds. Previously, those 12-18 years showed the lowest annual rates. The lower rate in this age category compared to CY2014 is not statistically significant.
- From CY2012 to CY2015 there were statistically significant (p<.05) increased rates in the 5-11 and 12-18 age categories, and the total.
- Among those 5-11 and 12-18 years this measure is at the 25<sup>th</sup> percentile, showing some slight improvement from CY2014.

# Measure MMA: Medication Management for People with Asthma



# Measure FUH: Follow-Up after Hospitalization for Mental Illness

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

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

To be counted, the children must be continuously enrolled from the date of discharge through 30 days after discharge. The Child Core Set requires reporting children ages 6 through 20. This differs from HEDIS<sup>®</sup> specifications that include those ages 6 years of age and older

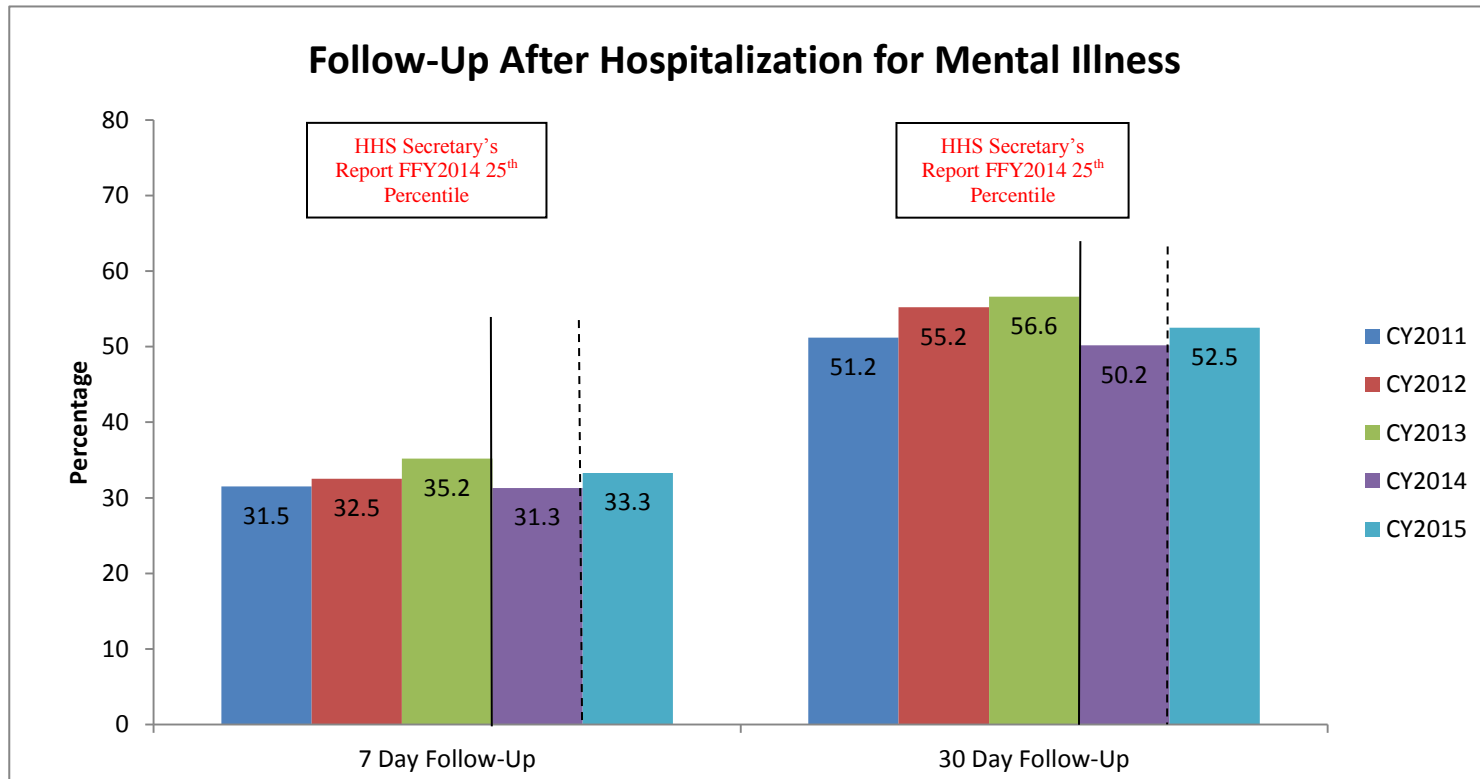
**Notes on Measure Programming or Differences from Measure Specifications:**

- The solid vertical line indicates that the CY2014 data are not comparable to previous years due to measure reprogramming. The denominator increased due to inclusion of rejected claims that were not previously used as per the specifications and changes to the exclusion logic. Additionally, HFS must convert HEDIS<sup>®</sup> Place of Service codes using a standard conversion to HFS Place of Service codes with specific exceptions for this measure to meet the intent of the specifications.
- The percentiles shown in the chart are from the HHS Secretary’s Annual Report on the Quality of Care for Children in Medicaid and CHIP for FFY2014 reflecting CY2013 data for most states.
- HFS may not identify all prescribing providers based on the HEDIS<sup>®</sup> practitioner type definition. We, therefore, believe follow-up visits may be undercounted.
- The dashed line indicates that the CY2015 data are not comparable to previous years. This is due to a denominator increase resulting from a revision to the use of the Non-acute value set (primarily associated with the conversion of Place of Service codes). Previously too many discharges were excluded from the denominator.

**Eligible Population:**

	CY2011		CY2012		CY2013		CY2014		CY2015	
	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator
<b>7 Day Follow-Up</b>	558	1,770	686	2,014	757	2,151	6,966	22,237	11,978	35,925
<b>30 Day Follow-Up</b>	906	1,770	1,166	2,014	1,218	2,151	11,182	22,237	18,877	35,925

# Measure FUH: Follow-Up after Hospitalization for Mental Illness



## Key Findings:

- Due to changes in the denominator exclusions, rates for CY2014 and CY2015 are not comparable.
- CY2015 data show one-third of those 6-20 years of age who were discharged from hospitalization for mental illness received follow-up within 7 days. Just over one-half received follow-up within 30 days.
- Using data reported by states for FFY2014 (CY2013 data for most states), the HHS Secretary's report 25<sup>th</sup> percentiles for CY2013 7 and 30 day follow-up were achieved. This shows need for improvement.
- HFS data for CY2015 shows a very slight improved performance.

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

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

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

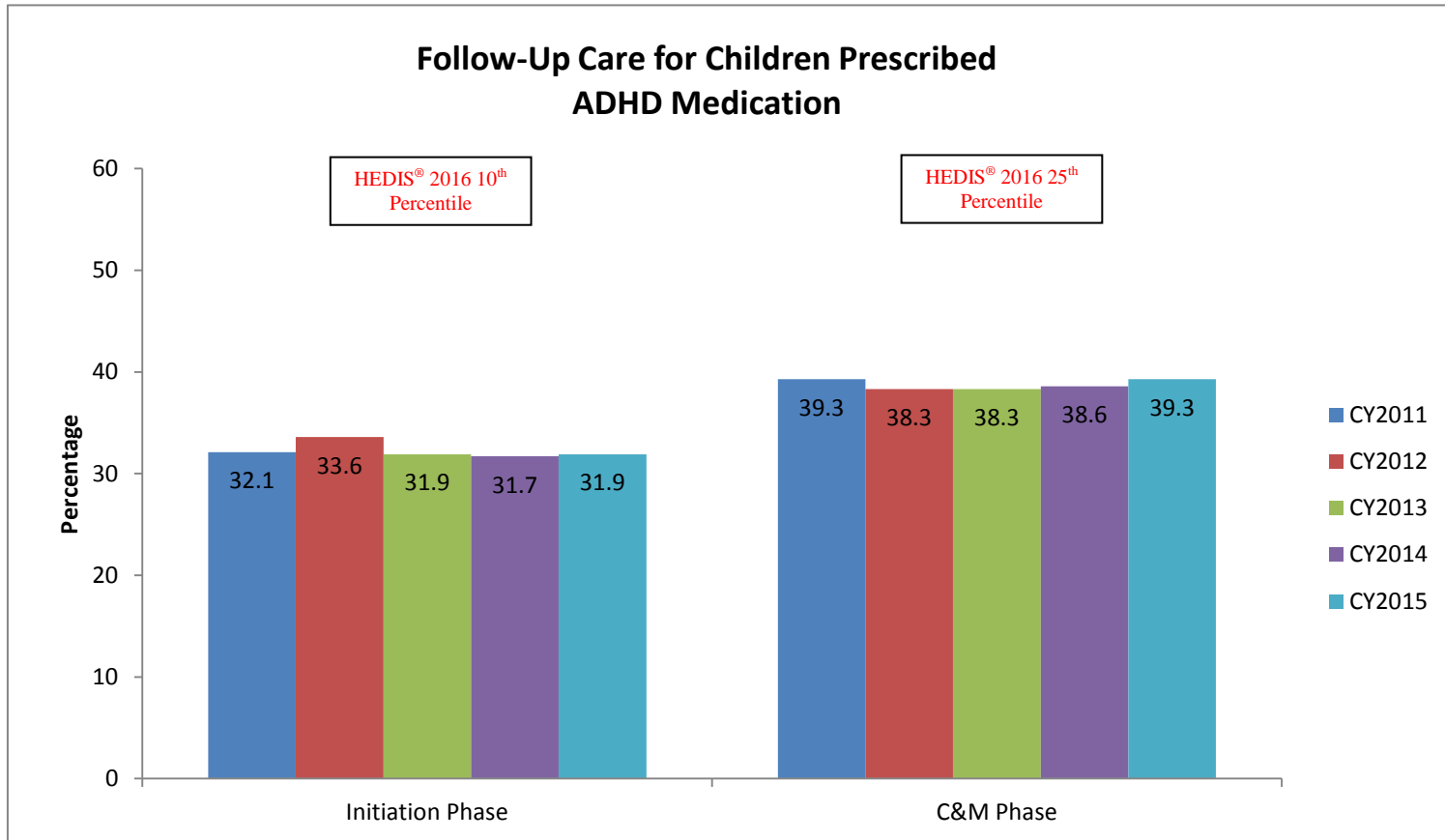
**Notes on Measure Programming or Differences from Measure Specifications:**

- CY2012 rates were generated with HEDIS<sup>®</sup> 2012 specifications.
- HFS must convert HEDIS<sup>®</sup> Place of Service codes using a standard conversion to HFS Place of Service codes with specific exceptions for this measure to meet the intent of the specifications.
- A considerable number of medication management follow-up visits are conducted in community mental health settings. Since these visits do not conform to the HEDIS<sup>®</sup> provider type definition of “prescribing provider”, follow-up visits conducted in these settings are not included in the measure possibly resulting in undercounting visits.

**Eligible Population:**

	CY2011		CY2012		CY2013		CY2014		CY 2015	
	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator
<b>Initiation Phase</b>	4,232	13,202	4,935	14,711	4,616	14,481	4,370	13,763	4,357	13,651
<b>C &amp; M Phase</b>	1,451	3,694	1,601	4,178	1,335	3,482	1,222	3,160	1,225	3,113





**Key Findings:**

- From CY2011 to CY2015 follow-up during the Initiation Phase remained relatively stable. The 0.2 percentage point decrease is not statistically significant.
- There is no difference between the CY2011 and CY2015 rates of follow-up during the C&M Phase. The rates achieved during the intervening years remained relatively stable.
- Improvement is needed since follow-up remained consistently at slightly less than one-third during the Initiation Phase and just over one-third in the C&M phase.
- Additionally, the Initiation and C&M phases remained at the 10<sup>th</sup> and 25<sup>th</sup> percentiles, respectively, indicating there is room for improvement during both phases.

# Measure AMB: Ambulatory Care – Emergency Department Visits

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

**Notes on Measure Programming or Differences from Measure Specifications:**

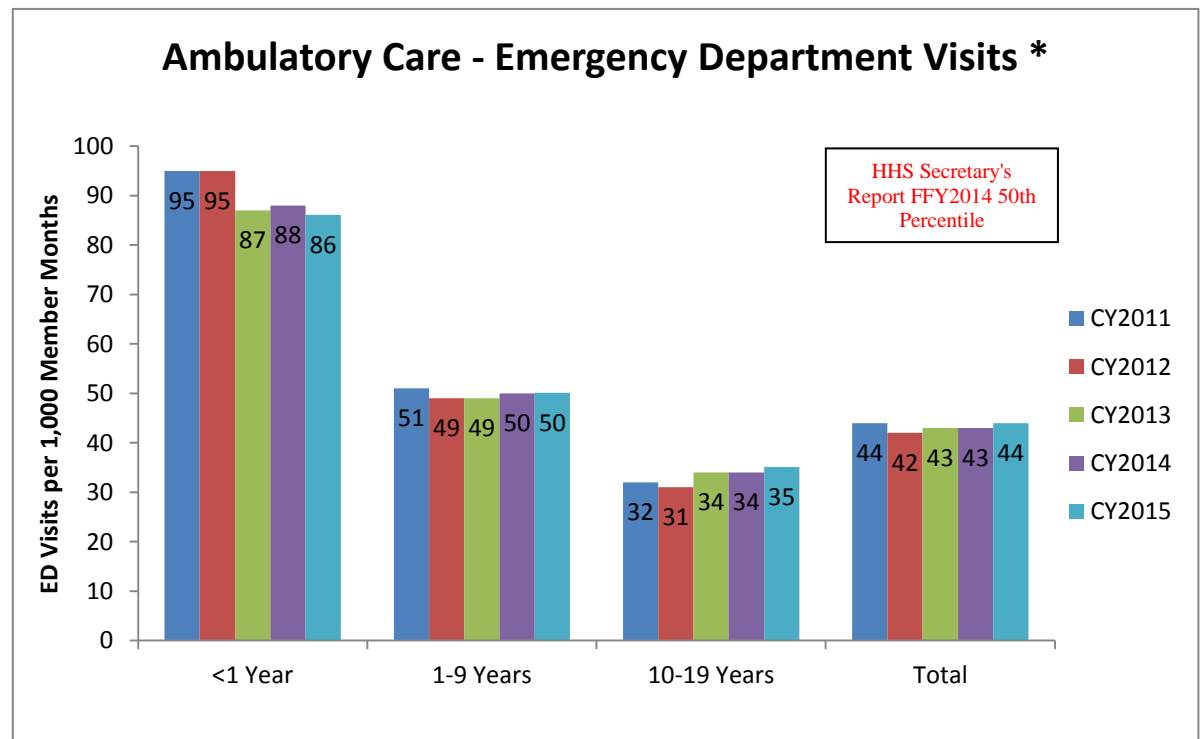
- None

**Eligible Population:**

	CY2011		CY2012		CY2013		CY2014		CY2015	
	Numerator (ED Visits)	Denominator (Member Months)	Numerator (ED Visits)	Denominator (Member Months)	Numerator (ED Visits)	Denominator (Member Months)	Numerator (ED Visits)	Denominator (Member Months)	Numerator (ED Visits)	Denominator (Member Months)
<1 Year	50,927	536,204	50,200	526,528	45,550	524,161	46,061	521,082	45,171	524,461
1-9 Years	470,100	9,177,349	448,907	9,098,690	492,038	9,958,474	481,180	9,559,182	458,959	9,154,233
10-19 Years	241,277	7,586,574	234,955	7,697,891	295,001	8,723,537	310,168	8,972,841	307,264	8,751,769
<b>Total</b>	<b>762,304</b>	<b>17,300,127</b>	<b>734,062</b>	<b>17,323,109</b>	<b>832,589</b>	<b>19,206,172</b>	<b>837,409</b>	<b>19,053,105</b>	<b>811,394</b>	<b>18,430,463</b>

**Key Findings:**

- From CY2011 to CY2014, there were statistically significant ( $p < .05$ ) decreases in ambulatory care emergency department visits in the <1 year and 1-9 years age categories. Since this is an inverse measure, these decreases indicate better performance. There is a decrease of 9 percent among those <1 year of age
- Among those 10-19 years, from CY2011 to CY2015 there was a statistically significant increase ( $p < .05$ ) of 9 percent. This increase indicates worse performance.
- HEDIS 2015 percentiles are not available for the age categories or total.
- Using data reported by states for FFY2014 (CY2013 data for most states), the HHS Secretary's report 50<sup>th</sup> percentile for CY2013 was achieved.



\* Inverse rate - lower rate indicates better performance

# Measure SEAL: Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk

**Measure Description:** The percentage of children ages 6 to 9 at elevated risk of dental caries (i.e., “moderate” or “high” risk) who received a sealant on a permanent first molar tooth within the measurement year. Children must be enrolled for at least a 180 day continuous enrollment during the calendar year measurement period. A three-year lookback period for applicable codes is permitted if data are available for that period.

**Notes on Measure Programming or Differences from Measure Specifications:**

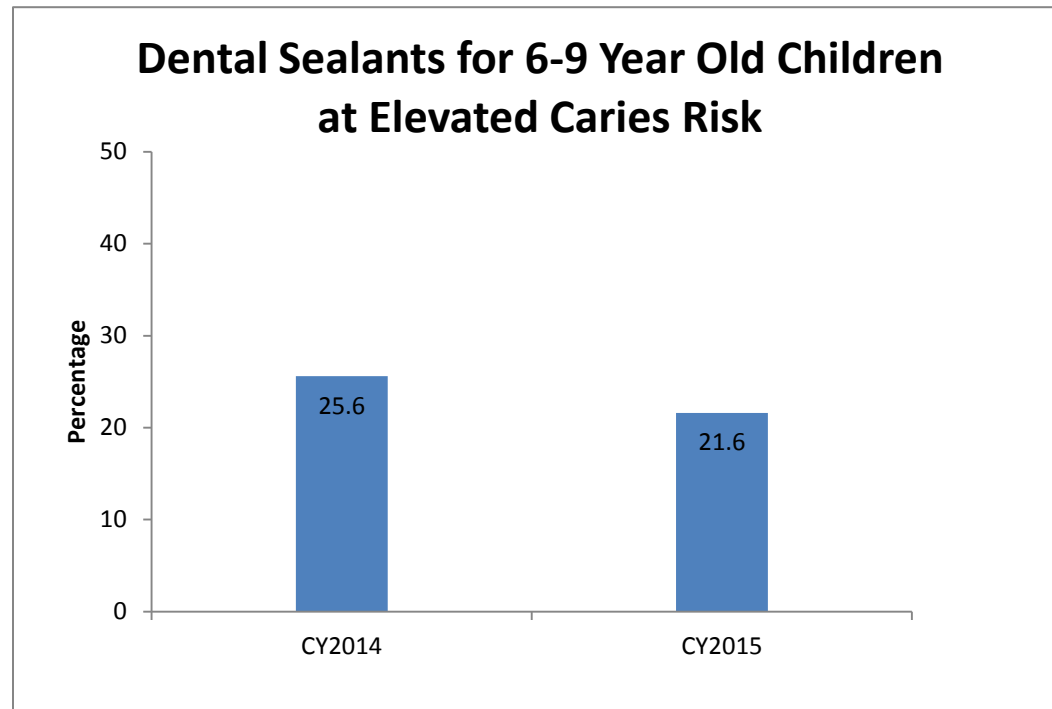
- This measure was newly added to the March 2015 Child Core Set for FFY2015 reporting to federal CMS.
- Data reported for CY2014 were updated. The denominator exclusion was revised resulting in increasing the denominator count.

**Eligible Population:**

CY	Numerator	Denominator
2014	46,050	179,799
2015	37,612	174,485

**Key Findings:**

- There is a statistically significant ( $p < .05$ ) decrease of 4 percentage points, or 16 percent, from CY2014 to CY2015.
- Approximately one in four children at elevated caries risk received dental sealants on permanent molars. This shows need for improvement.



## 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 (FCC) – Personal Doctor Who Knows Child, 3) Coordination of Care for CCC, 4) Access to Prescription Medicines, and 5) FCC – Getting Needed Information. The survey was implemented by a third party vendor in compliance with CAHPS® guidelines using a mixed methodology of mail and phone surveying to increase the overall response rate.

**Notes on Measure Programming or Differences from Measure Specifications:**

- 2016 are the most recent available data. The rates represent the CAHPS® results for the combined Illinois Title XIX (Medicaid) and Title XXI (CHIP) programs (i.e., statewide aggregate rates). The statewide aggregate rates were weighted based on the size of the total eligible population for each program (i.e., Title XIX and Title XXI) at the time the CAHPS® survey samples were drawn.
- A series of questions included in the CAHPS® 5.0H Child Medicaid Health Plan Survey with Children with Chronic Conditions (CCC) measurement set was used to identify children with chronic conditions (i.e., CCC screener questions). The survey responses for child members in both the general child sample and the CCC supplemental sample were analyzed to determine which child members had chronic conditions. Therefore, the general child population of children (i.e., general child sample) includes children with and without chronic conditions based on the responses to the survey questions. Based on parents'/caretakers' responses to the CCC screener questions, these completed surveys were used to calculate the child with chronic conditions (CCC) CAHPS® results presented in this report.
- The General Child CAHPS® results presented in this report are based on the completed surveys returned for the general child population.

**Eligible Population:**

2016	Initial Sample Size	Total Complete	Ineligible	Final Sample Size	Response Rate
Total Population	7,310	2,415	257	7,053	34.24%
Title XIX (Medicaid)	3,655	972	92	3,563	27.28%
Title XXI (CHIP)	3,655	1,443	165	3,490	41.34%

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

2016 General Child and Children with Chronic Conditions (CCC) CAHPS® 5.0H Result Summary Description	General Child	Child w/Chronic Condition(s)	General Child National Comparison	General Child Trend 2015 to 2016
<b>Global Ratings</b>				
Rating of Health Plan (% Responding 9 or 10 on scale of 0-10)	56.1%	50.7%	★	---
Rating of All Health Care (% Responding 9 or 10 on scale of 0-10)	61.9%	60.6%	★★★★★	---
Rating of Personal Doctor (% Responding 9 or 10 on scale of 0-10)	71.6%	70.5%	★★★★★	---
Rating of Specialist Seen Most Often (% Responding 9 or 10 on scale of 0-10)	62.7%	66.7%	★★	---
<b>Composite Measures</b>				
Getting Needed Care (% Responding “Usually” or “Always”)	81.1%	80.7%	★	---
Getting Care Quickly (% Responding “Usually” or “Always”)	87.4%	90.5%	★★	---
How Well Doctors Communicate (% Responding “Usually” or “Always”)	94.6%	90.5%	★★★★★	---
Customer Service (% Responding “Usually” or “Always”)	83.3%	80.8%	★	---
Shared Decision Making (% Responding “A lot” or “Yes”)	80.6%	83.1%		
<b>Children with Chronic Conditions (CCC) Composites and Items</b>				<b>CCC Trend 2015 to 2016</b>
Access to Specialized Services		68.3%		---
Family-Centered Care (FCC): Personal Doctor Who Knows Child		88.8%		---
Coordination of Care for Children with Chronic Conditions		77.5%		---
Access to Prescription Medicines		91.3%		---
FCC: Getting Needed Information		91.1%		---

Star assignments based on national percentiles:

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

90<sup>th</sup> or above ★★★★★ 75<sup>th</sup> to 89<sup>th</sup> ★★★★ 50<sup>th</sup> to 74<sup>th</sup> ★★★ 25<sup>th</sup> to 49<sup>th</sup> ★★ Below 25<sup>th</sup> ★

Trend analysis:

Statistically significantly higher ↑      Statistically significantly lower ↓      No statistically significant difference ---

## Child Core Set Measures Not Reported

Measure Abbreviation and Name	Reason For Not Reporting
CLABSI - Pediatric Central-line Associated Bloodstream Infections Neonatal Intensive Care Unit and Pediatric Intensive Care Unit	CMS obtains data directly from CDC; states not required to collect data or report to CMS
BHRA - Behavioral Health Risk Assessment	E-specified measure; HFS does not have the ability to report e-measures
SRA – Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	E-specified measure; HFS does not have the ability to report e-measures
APC – Use of Multiple Concurrent Antipsychotics in Children and Adolescents	Measure not programmed
AUD – Audiological Evaluation No Later than 3 Months of Age	Measure not programmed

# Summary

Illinois has made substantial progress on reporting the core set from 13 measures in FFY2010 (the baseline year), to 17 measures in FFY2011, 20 measures in FFY2012, 25 measures in FFY2013, 21 reported in FFY2014, 22 reported in FFY2015, and 22 in FFY2016 (inclusive of CLABSI and CAHPS). Illinois focused on the core measures and the measurement process leading to improvements in the data quality and the integrity of the programming logic of all HFS performance measures.

## Enterprise Data Warehouse

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

Importing data from other Illinois 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, security and access; and acceptable uses of data. The outcome, that far outweighs the challenges, includes a more robust data system with potential to improve quality measurement and care delivery.

## Administrative Methodology

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

- The administrative method results in a lower statewide rate due to incomplete or untimely encounter data. However, new contractual requirements are expected to improve the completeness and accuracy of encounter data over coming years.
- A limitation of using the administrative method is that it may underestimate rates due to lack of timely and complete data. Using the hybrid method, which includes medical record review, enhances the data by going to the source record to identify qualifying services.

- There are differences in how states report the Child Core Set measures. For example, differences exist in the methodology used (e.g., administrative, encounter, hybrid) and the population(s) included or excluded from the measures (e.g., Title XIX only, Title XXI only, MCO only, combined Title XIX and XXI). These differences affect comparability among states reporting on the Child Core Set. They also impact the HHS Secretary's report percentiles used as benchmarks for some measures included in this report.

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

## Delivery System Changes

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

# Summary

## Data Integrity/Efficiencies

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

- Beginning in April 2012, annual data audits are conducted by a certified External Quality Review Organization (EQRO) to improve the data quality and the fidelity of the program logic to the measure specifications. .
- Performance measurement is used within HFS for a variety of purposes. Previously, standardized performance measures were sometimes altered to suit those purposes. Performance measures now comply with nationally endorsed specifications, to the extent possible, with measures aligned across programs.
- A Quality of Care Measures Committee was formed to provide governance of the measurement process. The QoC includes representative from areas within HFS having responsibility for the performance measurement of various programs. The Committee meets regularly and has made a number of decisions to improve the efficiency

of the performance measurement process and the integrity of the data.

- HFS instituted programming that is table-driven and time-specific so that updates to measure coding schemes are more easily incorporated, less time consuming and anchored to the measurement period to which they apply.

## Barriers

While measurement and reporting efficiencies have been made, revisions to the core set measures and sweeping changes to measure specifications can consume a considerable amount of agency resources. HFS has adopted an annual schedule for identifying changes, programming, testing, reporting, and auditing to assure that reporting timeframes are met, as well as timeframes required for other measure uses, such as bonus payments.

## Performance Measurement

In programming the Child Core Set measures, a number of efficiencies were instituted to develop and maintain measures over time. Issues and questions about measures were identified and resolved through the Quality of Care Measures

Committee. Improvements include greater consistency, alignment, and better data quality. This results in more accurate performance measurement for Child Core Set reporting purposes and for measurement, generally.

Many of the aforementioned improvements were instituted through the efforts of the CHIPRA Quality Demonstration Grant. In February 2016 the CHIPRA grant period ended. However, Illinois will continue annual reporting on the Child Core Set measures. In future years, these measures will consist of those identified in the “core set” of measures included in HFS contracts. HFS’ work to improve performance measurement will be sustained through efforts of the Quality of Care Measures Committee and others involved in quality health measurement within HFS.

## For further information or questions, contact:

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