The Department of Health and Human Services

Executive Summary
2012 Annual Report on the
Quality of Care for Children in Medicaid and CHIP

Health and Human Services Secretary

Kathleen Sebelius

December 2012

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EXECUTIVE SUMMARY

Together, Medicaid and the Children's Health Insurance Program (CHIP) served more than 43.5 million children in federal fiscal year (FFY) 2011, representing about half of the beneficiaries currently enrolled in these programs. The number of children enrolled in Medicaid and CHIP grew by more than 1.5 million between FFY 2010 and FFY 2011. This increase in enrollment is evidence of the role Medicaid and CHIP play in ensuring that low-income children get the health care coverage they need, including access to a comprehensive set of benefits and other medically necessary services. This report, required by section 1139A(c)(2) of the Social Security Act (the Act), as amended by section 401(c) of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), summarizes state-specific and national information on the quality of health care furnished to children under Titles XIX (Medicaid) and XXI (CHIP) of the Act.

Under the Affordable Care Act of 2010, millions of uninsured Americans will gain access to coverage through Medicaid, CHIP, and the Affordable Insurance Exchanges. The Department of Health and Human Services (HHS) is working closely with states, health care providers, and program enrollees to ensure a high-quality system of care for children in Medicaid/CHIP, as well as for those with private insurance and other sources of coverage. As the HHS agency responsible for ensuring effective health care coverage for Medicare, Medicaid, and CHIP beneficiaries, the Centers for Medicare & Medicaid Services (CMS) plays a key role in promoting quality health care for children in Medicaid/CHIP. CMS' quality agenda is closely aligned with that of the HHS National Quality Strategy's three aims of achieving better care, a healthier population and community, and more affordable care.[1]

Since the release of the Secretary's annual Report on the Quality of Care for Children in Medicaid and CHIP in 2011, CMS has continued to work collaboratively with states and other stakeholders to strengthen systems for measuring and collecting data on access and quality, including developing capacity through ten CHIPRA quality demonstration grantees in 18 multi-state collaborations, and working with the CMS Technical Advisory Groups (workgroups that focus on policy areas such as quality, oral health, mental health, managed care, and coverage).

The 2012 Secretary's Report presents information on key activities CMS undertook to update information on the quality of care children receive in Medicaid/CHIP, including reviewing findings on the initial set of core children's health care quality measures reported to CMS by the states and summarizing information on the quality measures and performance improvement projects reported in the External Quality Review Organization (EQRO) technical reports provided to CMS by states. This report offers the first nationwide review of improvement projects initiated by state managed care plans,[2] and supported by the 75 percent Federal matching rate available to states contracting with EQROs. Key findings from these information sources include:

[1] http://www.ahrq.gov/workingforquality/nqs/nqs2012annlrpt.pdf.

[2] Either managed care organizations (MCOs) or Prepaid Inpatient Health Plans (PIHPs).

Measurement and Reporting

- Forty-eight states and the District of Columbia (D.C.) voluntarily reported one or more of the initial core set of children's health care quality measures for FFY 2011 for Medicaid and/or CHIP children (Exhibit 1). The median number of measures reported by states for FFY 2011 was 12, up from 7 for FFY 2010. Altogether, 27 states and D.C. reported at least half (12 of 24) of the children's quality measures. One state, Oregon, reported data on all 24 measures for FFY 2011.
- Completeness of reporting on the children's core measures improved for FFY 2011. The number of states reporting at least one measure for both Medicaid and CHIP enrollees increased from 23 states and D.C. for FFY 2010 to 33 states and D.C. for FFY 2011.
- The most frequently-reported measures assess children's use of preventive services, primary care, and dental services (Exhibit 2).
- Of the 41 states (including D.C. and Puerto Rico) that contract with managed care plans to deliver services to Medicaid and CHIP enrollees, 37 submitted EQRO technical reports to CMS for the 2011-2012 reporting cycle. The most frequently-reported children's performance measures in the EQRO reports are similar to those in the initial core set of children's health care quality measures[3] (Exhibit 3).

Quality and Access to Care

- In FFY 2011, as in FFY 2010, states had high performance rates on the children's primary care access measure: a visit to a primary care practitioner (PCP). Most children, across all states, had at least one primary care visit during the reporting period, with the median rate ranging from a high of 97 percent among children ages 12-24 months to 88-90 percent for the other age groups (Exhibit 4).
- The proportion of children with a well-child visit varied by age group, but generally was below the recommended guidelines.[4] A median of 61 percent of children had 6 or more well-child visits in the first 15 months of life. The rate was slightly higher for children ages 3-6, with a median of 67 percent having a well-child visit during the reporting period. Adolescents (ages 12-21 years) had a considerably lower median well-child visit rate (46 percent) than the other age groups (Exhibit 4).
- An indication of the effectiveness of a well-child visit can be reflected by four of the children's core measures reported by at least 25 states. The median childhood immunization rate for children turning age 2 was 71 percent, while the median adolescent immunization rate among 13 year olds was 52 percent. The Chlamydia screening rate among sexually active girls between the ages of 16 and 20 was 47 percent and the rate for appropriate testing for children with pharyngitis was 63 percent (Exhibit 4).

[3] The most frequently-reported children's performance measures were focused on immunization rates, well-child visits, adolescent well-care, and prenatal and perinatal care.

[4] The American Academy of Pediatrics and Bright Futures recommend 9 well-child visits in the first 15 months of life and annual well-child visits for children ages 3 and older.

- Children's access to dental services in FFY 2010 was similar to patterns observed in FFY 2009.[5] A median of 43 percent of children ages 1 to 20 received at least one preventive dental service (e.g., dental cleanings, application of dental sealants) paid for by Medicaid. The percentage of children receiving at least one preventive dental service ranged across states from a low of 7 percent to a high of 58 percent (Exhibit 5).
- Although children covered by Medicaid/CHIP and by commercial plans differ demographically and socio-economically, their access to care and quality of care was fairly comparable on five of eight measures tracked by the National Committee for Quality Assurance (NCQA) for private plans and also reported by at least 25 states: a PCP visit in the past year; well-child visit rates for adolescents 12-21 years; childhood immunization status, adolescent immunization status; and Chlamydia screening rate (Exhibit 6).

Consumer Experiences with Health Care

- Data from the Child Medicaid Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey from 25 states in 2010 provide information on consumer experiences with care, a dimension of quality of care. This survey indicates that:
  - Parents generally could get care for their child when needed for an illness or injury (state median of 76 percent responding "always"), but it was more difficult to get routine care (state median of 65 percent responding "always") or specialty care (state median of 47 percent responding "always") (Exhibit 7).
  - Most parents had a favorable assessment of their child's doctor's communication with the parent, but somewhat less favorable assessment of the doctor's interactions with the child (Exhibit 8).

Improving the Quality of Care

- CMS is engaged in a number of efforts to improve the quality of care available to children in Medicaid and CHIP. Two major efforts underway – one on perinatal health and the other on oral health – are national in scope and use the core health care quality measures to guide improvement efforts and evaluate outcomes.

[5] States are to submit the annual CMS-416 (EPSDT) report to CMS by April 1st of each year. At the time of this writing, CMS had not received enough data from states for FFY 2011 to make meaningful comparisons. As such, this Report includes data for FFY 2010.

- In 2012, CMS launched two initiatives to improve perinatal health outcomes: Strong Start for Mothers and Newborns (Strong Start)[6] and an Expert Panel for Improving Maternal and Infant Health Outcomes (Expert Panel).[7]
- CMS' Oral Health Initiative seeks to improve children's access to dental care, with an emphasis on early prevention. The initiative has two improvement goals,[8] and CMS is working with state partners and other stakeholder groups to achieve them.

- States, through their managed care plans, also are engaged in various performance improvement projects (PIPs) specific to children or pregnant women. The 268 PIPs, described in the EQRO technical reports, vary by state in number and focus and sometimes target only a subset of Medicaid/CHIP enrollees. For example, Florida had 14 PIPs focused on improving the quality of mental health care of institutionalized children, while Michigan and New York required all MCOs to implement PIPs to improve weight assessment and body mass index (BMI) counseling (Exhibit 9).
- Information on PIPs abstracted from the EQRO technical reports in four CMS priority areas – weight assessment and BMI counseling, dental care, prenatal care, and adolescent well-care – reveal the strengths and weaknesses of current approaches states and CMS use to improve care in MCOs. For example, while many of the PIPs commonly engaged in interventions that included member and provider outreach and education, the EQROs varied in the criteria they used to validate PIPs as well as the level of detail they included in technical reports about PIP progress and performance.

[6] Strong Start, under the leadership of the CMS Center for Medicare and Medicaid Innovation, has two primary strategies to improve maternal and infant health outcomes. First, a public-private partnership is testing ways to encourage best practices for reducing early elective deliveries prior to 39 weeks (across all payer types) that lack medical indication. Second, through a funding opportunity made available to states and providers, it is testing whether three models of enhanced prenatal care can reduce the rate of preterm births among women covered by Medicaid and/or CHIP at high risk for poor pregnancy outcomes.

[7] The Expert Panel, initiated by the CMS Center for Medicaid and CHIP Services, is identifying specific opportunities and strategies to provide better care, while reducing the cost of care for mothers and infants covered by Medicaid/CHIP. Co-chaired by the Ohio Medicaid Medical Director and the immediate past president of the American Congress of Obstetricians and Gynecologists (ACOG), the Expert Panel consists of Medicaid medical directors, clinical experts, representatives of health plans, and advocacy stakeholder groups.

[8] The two oral health goals are to: (1) increase the proportion of Medicaid and CHIP children ages 1 to 20 who receive a preventive dental service by 10 percentage points; and (2) increase the proportion of Medicaid and CHIP children ages 6 to 9 who receive a sealant on a permanent molar by 10 percentage points.

The objective of this report is to show the progress HHS and states have made to systematically measure and report on the quality of care children receive in Medicaid/CHIP. While the ultimate goal is to improve children's health by driving improvements in the quality of care, measuring the care children receive is a critically important step in that process. Through mechanisms such as the Center for Medicaid and CHIP Services Quality Measures Technical Assistance and Analytic Support (TA/AS) Program[9] and the Annual CMS Medicaid/CHIP Quality Conference,[10] HHS and the states have built a solid foundation for measuring and improving children's quality of health care.

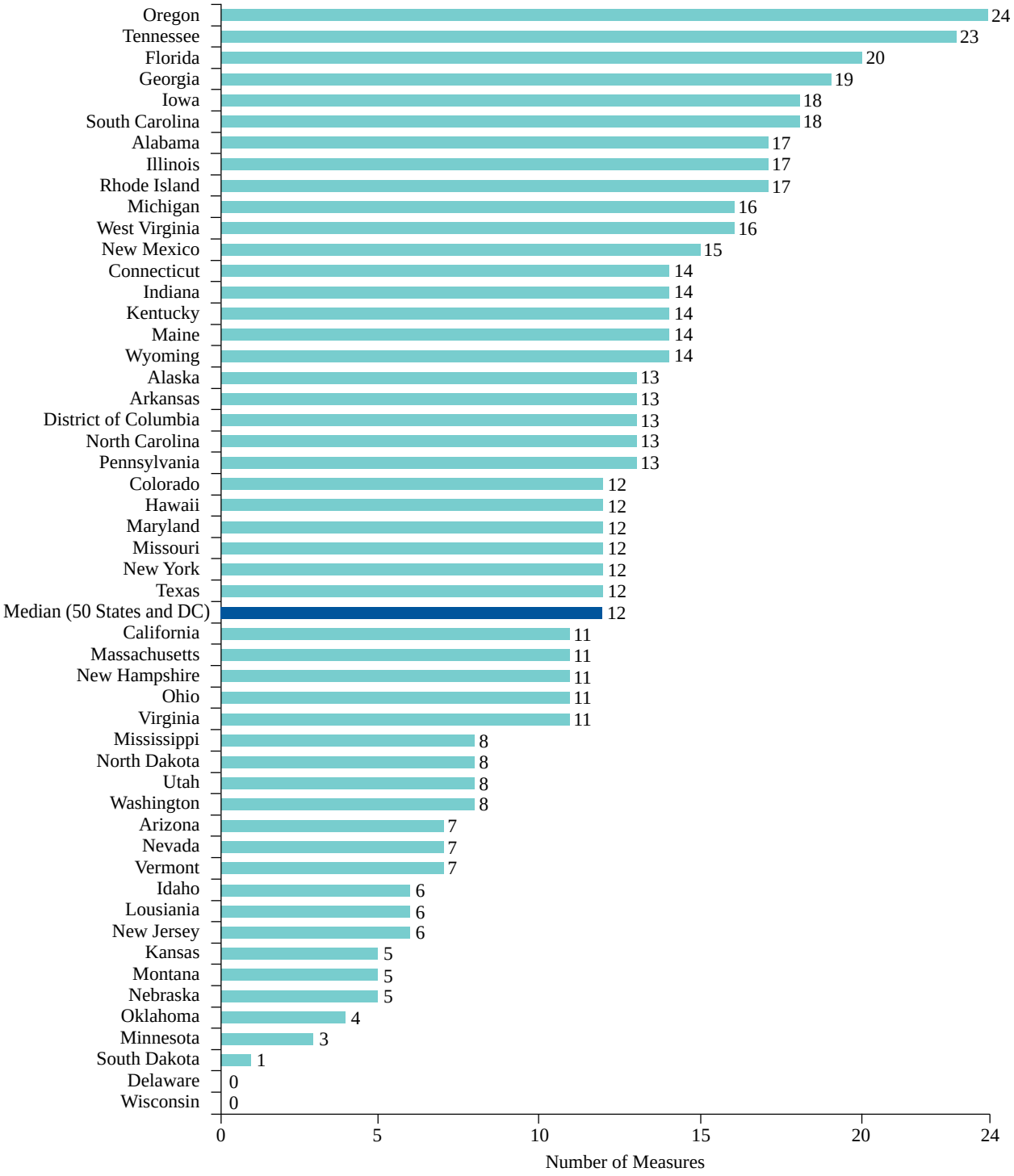
Evidence in this report suggests that access to care and quality of care were fairly comparable for children with public and private coverage for five of the eight measures tracked by NCQA and routinely reported by at least 25 states. Yet, this comparison is a cursory assessment of care given considerable evidence that low-income children have greater health care needs than children covered by commercial health plans. Nonetheless, the measurement and reporting tools now in place can guide HHS and states in the next phase of efforts to more thoroughly measure the care obtained by children covered by Medicaid/CHIP and use the measures to assess and improve the quality of care provided to children in their states.

Moving forward, HHS seeks to build a stronger and more effective partnership between CMS, states, health care providers, and program enrollees on quality measurement as well as quality improvement. The two major quality-improvement efforts recently launched by CMS are helping to set the stage for the next generation of efforts designed to improve health care and health outcomes of children, and to help transform Medicaid/CHIP into a high quality system of coverage and care.

[9] The TA/AS contract is led by Mathematica Policy Research and supported by subcontracts with the National Committee for Quality Assurance (NCQA), the Center for Health Care Strategies (CHCS), and the National Initiative for Children's Healthcare Quality (NICHQ). The TA/AS program supports state reporting of the initial core set measures by responding to individual state requests for TA with the initial core set measures, helping to plan and implement CMS's annual Medicaid/CHIP Quality Conferences, holding technical assistance webinars, and creating TA briefs and tool kits to provide states with information on specific topics.

[10] http://www.medicaid.gov/State-Resource-Center/Events-and-Announcements/Annual-Medicaid-CHIP-Quality-Conference.html

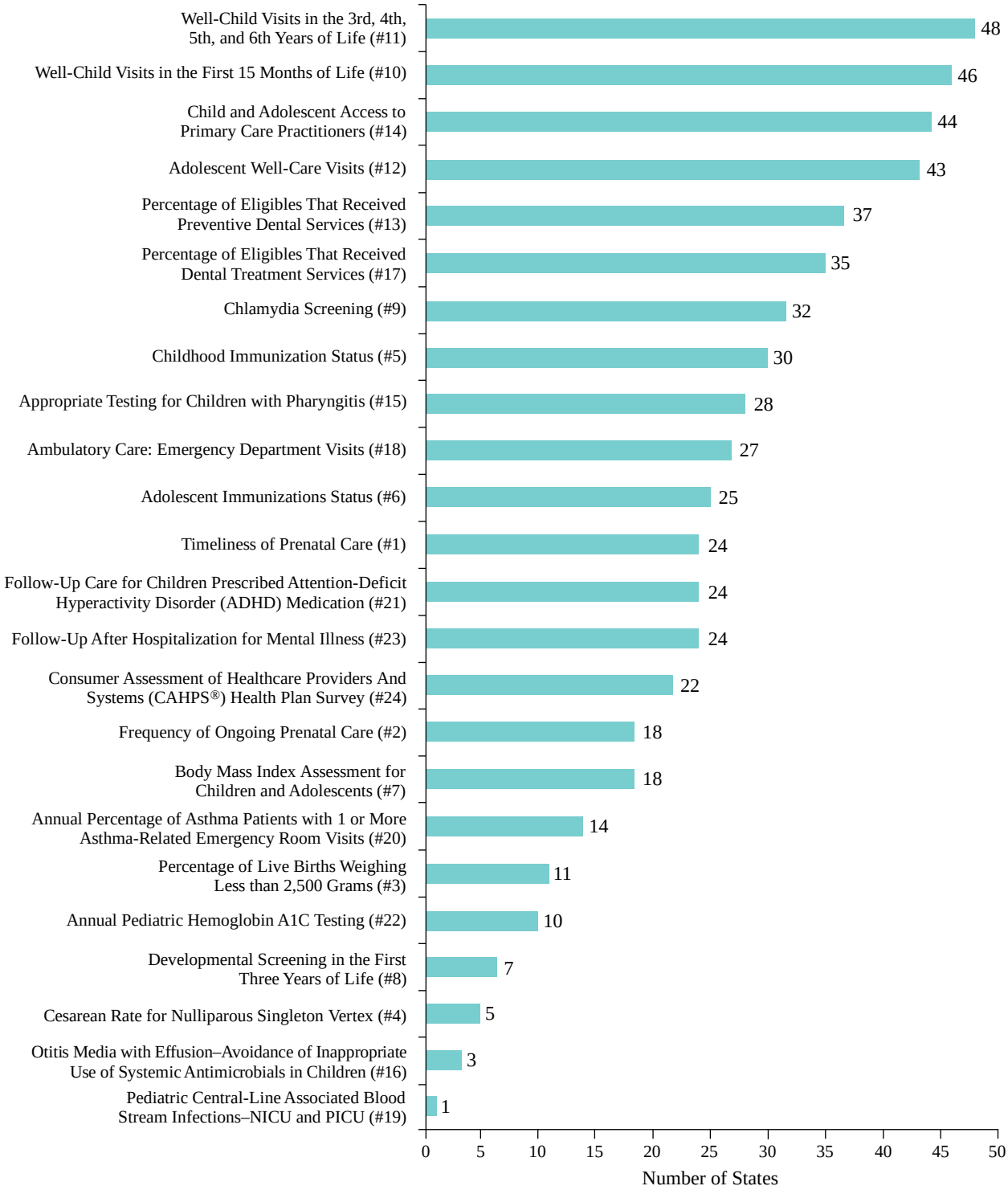
Exhibit 1. Number of Initial Core Set of Medicaid/CHIP Children's Health Care Quality Measures Reported in FFY 2011 CARTS Reports, by State



Source: Mathematica analysis of FFY 2011 CARTS reports as of June 20, 2012.

Notes: Wisconsin did not submit a CARTS report for FFY 2011. Delaware submitted an FFY 2011 CARTS report, but did not submit data on any of the initial core set of children's health care quality measures. For the eight states that submitted separate data for their Medicaid and CHIP programs (Colorado, Iowa, Kentucky, Michigan, New York, Pennsylvania, Tennessee, and West Virginia), the state was counted as reporting a measure if either report included data for that measure. The Medicaid/CHIP initial core set includes 24 measures.

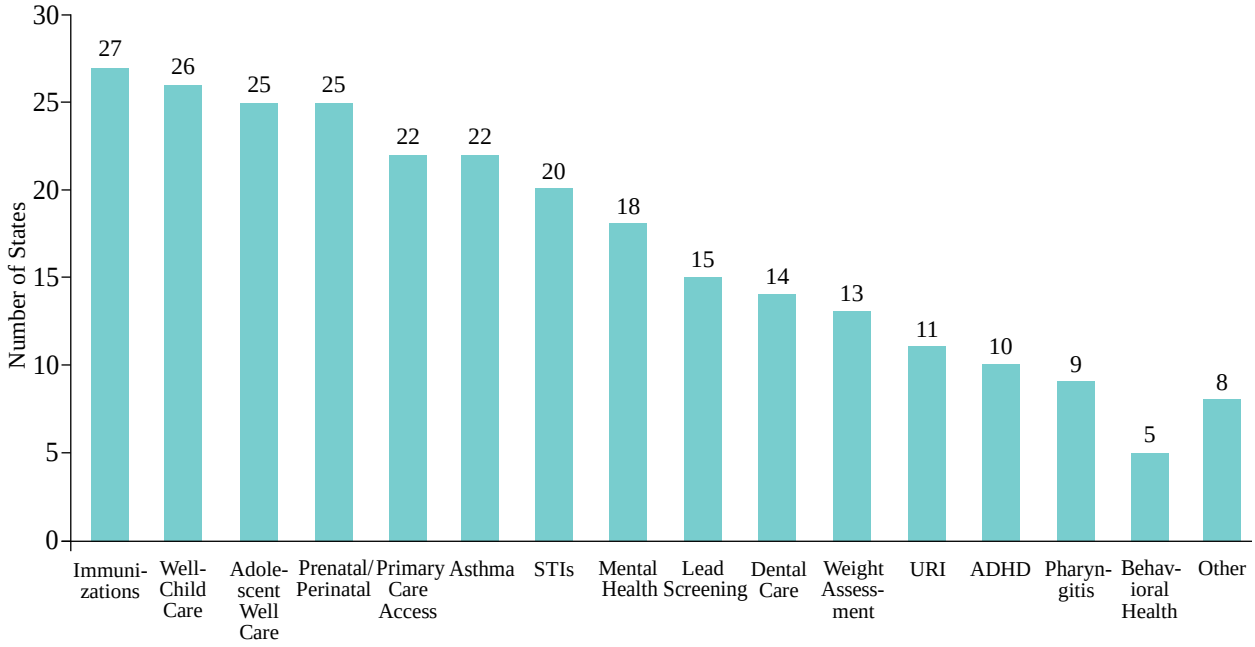
Exhibit 2. Number of States Reporting the Initial Core Set of Medicaid/CHIP Children's Health Care Quality Measures in FFY 2011 CARTS Reports



Source: Mathematica analysis of FFY 2011 CARTS reports as of June 20, 2012.

Notes: Numbers in parentheses identify the measure number in the children's initial core set. Wisconsin did not submit a CARTS report for FFY 2011. Delaware submitted an FFY 2011 CARTS report, but did not submit data on any of the initial core set of children's health care quality measures. For the eight states that submitted separate data for their Medicaid and CHIP programs (Colorado, Iowa, Kentucky, Michigan, New York, Pennsylvania, Tennessee, and West Virginia), the state was counted as reporting a measure if either report included data for that measure.

Exhibit 3. Performance Measures Evaluating Children or Pregnant Women Included in External Quality Review Organization (EQRO) Technical Reports for the 2011-2012 Reporting Cycle for 37 States, by General Topic



Source: EQRO technical reports submitted to CMS for the 2011-2012 reporting cycle as of July 31, 2012.

Notes: Alabama, Alaska, Arkansas, Connecticut, Idaho, Maine, Montana, New Hampshire, Oklahoma, South Dakota, and Wyoming do not have MCOs or PIHPs that enroll children covered by Medicaid or CHIP. Louisiana, Mississippi, and North Dakota have newly applicable managed care requirements and were not required to submit EQRO technical reports for 2011. North Carolina submitted an EQRO technical report, but managed care in the state was limited to behavioral health programs that did not enroll children, so the state is excluded from the analysis.

Analysis excludes plans that provide only limited services, such as primary care case management. Analysis also excludes plans that do not serve children or pregnant women, such as long-term care plans or Medicare Advantage plans that cover dual eligibles.

ADHD = Attention Deficit Hyperactivity Disorder; Pharyngitis = Appropriate Testing for Children with Pharyngitis; STI = Sexually Transmitted Infection; URI = Upper Respiratory Infection.

Exhibit 4. Performance Rates on Frequently Reported Medicaid/CHIP Children's Health Care Quality Measures in FFY 2011 CARTS Reports

Measure	Age Group	Number of States Reporting Using HEDIS Specifications	Mean	Median	25th Percentile	75th Percentile
Access to Primary Care						
Percent with a PCP Visit	12-24 Months	43	95.9	96.7	95.6	98.2
	25 Months - 6 Years	43	87.8	88.1	85.1	91.6
	7-11 Years	43	88.5	90.0	86.7	93.0
	12-19 Years	43	87.3	89.0	85.3	91.7
Well-Child Visits						
Percent with 6 or More Visits	First 15 Months	45[a]	57.9	60.8	54.8	69.3
Percent with 1 or More Visits	3-6 Years	47	65.0	66.9	59.6	74.9
Percent with 1 or More Visits	12-21 Years	43	45.2	45.7	35.4	56.4
Childhood Immunization Status						
Percent Up to Date on Immunizations (Combo 3)[b]	2 Years	28	65.0	70.7	62.1	76.6
Immunizations for Adolescents						
Percent Up to Date on Immunizations (Combo 1)[c]	13 Years	22	48.4	51.9	32.8	59.5
Chlamydia Screening						
Percent Screened	16-20 Years	32	46.0	47.1	36.8	57.0
Appropriate Testing for Children with Pharyngitis						
Percent Tested	2-18 Years	28	62.2	63.1	52.2	75.2

Source: Mathematica analysis of FFY 2011 CARTS Reports as of June 20, 2012.

Note: Exhibit 4 includes states that used HEDIS specifications to report these measures. Exhibit excludes states that used other specifications and states that did not report these measures in FFY 2011 CARTS Reports. In the cases where a state reported rates for both their Medicaid and CHIP populations, the highest rate of the two populations was used. See Appendix Tables E.2 – E.9 for details.

[a] South Dakota did not report the percent of children in the first 15 months of life with 6 or more well-child visits but reported rates for other numbers of well-child visits.

[b] Combination 3 includes DTaP, IPV, MMR, HiB, HepB, VZV, and PCV.

[c] Combination 1 includes Meningococcal and Tdap.

PCP = Primary Care Practitioner.

Exhibit 5. Percentage and Number of Eligible Children Age 1-20, Enrolled for at Least 90 Continuous Days, Who Received Preventive Dental Services and Dental Treatment Services in FFY 2010

State	Total Number of Children Receiving Dental Service: Preventive	Percent of Children Receiving Dental Service: Preventive	Total Number of Children Receiving Dental Service: Treatment	Percent of Children Receiving Dental Service: Treatment
Alabama	244,112	50	105,432	21
Alaska	33,016	41	21,780	27
Arizona	333,511	46	189,986	26
Arkansas	166,106	46	91,528	25
California	1,451,686	37	870,922	22
Colorado	167,886	47	95,085	27
Connecticut	155,039	54	77,445	27
Delaware	36,357	41	18,763	21
D.C.	32,435	39	18,060	22
Florida	266,213	15	146,327	8
Georgia	471,278	46	231,232	22
Hawaii	53,413	41	32,479	25
Idaho	10,887	7	7,279	5
Illinois	703,305	47	282,818	19
Indiana	201,713	29	102,865	15
Iowa	103,098	40	49,098	19
Kansas	36,774	18	15,169	7
Kentucky	205,633	43	118,592	25
Louisiana	318,133	43	183,682	25
Maine	49,654	38	23,758	18
Maryland	252,729	48	132,667	25
Massachusetts	256,381	50	152,793	30
Michigan	395,241	35	173,502	15
Minnesota	162,552	40	81,715	20
Mississippi	160,053	43	83,026	22
Missouri	183,283	30	99,882	17
Montana	23,779	35	14,829	22
Nebraska	66,420	46	31,780	22
Nevada	69,767	36	45,064	24
New Hampshire	48,020	56	22,390	26
New Jersey	244,920	40	149,067	24
New Mexico	153,855	45	165,572	49
New York	712,872	37	368,940	19
North Carolina	430,929	44	231,775	24
North Dakota	12,780	30	6,607	16
Ohio	484,502	44	225,042	20
Oklahoma	236,163	47	142,334	28
Oregon	105,438	36	58,916	20
Pennsylvania	400,804	37	220,480	20
Rhode Island	39,542	41	18,613	19
South Carolina	277,137	53	135,827	26
South Dakota	30,099	39	12,026	16

Exhibit 5 (continued)

State	Total Number of Children Receiving Dental Service: Preventive	Percent of Children Receiving Dental Service: Preventive	Total Number of Children Receiving Dental Service: Treatment	Percent of Children Receiving Dental Service: Treatment
Tennessee	340,073	45	186,995	24
Texas	1,591,256	55	1,037,158	36
Utah	81,512	48	40,871	24
Vermont	33,403	58	14,003	24
Virginia	265,212	46	148,238	26
Washington	357,672	51	225,107	32
West Virginia	84,670	44	96,313	50
Wisconsin	114,869	23	57,367	12
Wyoming	22,366	43	12,277	24
U.S. Total	12,678,548	43 (Median) 41 (Mean)	7,073,476	22 (Median) 23 (Mean)

Source: FFY 2010 CMS-416 reports, Line 1b, Line 12b, Line 12c.

Exhibit 6. Comparison of Median Rates for State Medicaid/CHIP Programs and Commercial Health Plans for Frequently Reported Children's Health Care Quality Measures, FFY 2011

Measure	Age Group	State Medicaid/CHIP Median	Health Plan Commercial Median
Access to Primary Care			
Percent with a PCP Visit	12-24 Months	96.7	98.2
	25 Months - 6 Years	88.1	91.8
	7-11 Years	90.0	92.4
	12-19 Years	89.0	89.6
Well-Child Visits			
Percent with 6 or More Visits	First 15 Months	60.8	78.1
Percent with 1 or More Visits	3-6 Years	66.9	73.1
Percent with 1 or More Visits	12-21 Years	45.7	41.8
Childhood Immunization Status			
Percent Up to Date on Immunizations (Combo 3)[a]	2 Years	70.7	75.8
Immunizations for Adolescents			
Percent Up to Date on Immunizations (Combo 1)[b]	13 Years	51.9	51.3
Chlamydia Screening			
Percent Screened	16-20 Years	47.1	39.6
Appropriate Testing for Children with Pharyngitis			
Percent Tested	2-18 Years	63.1	79.6

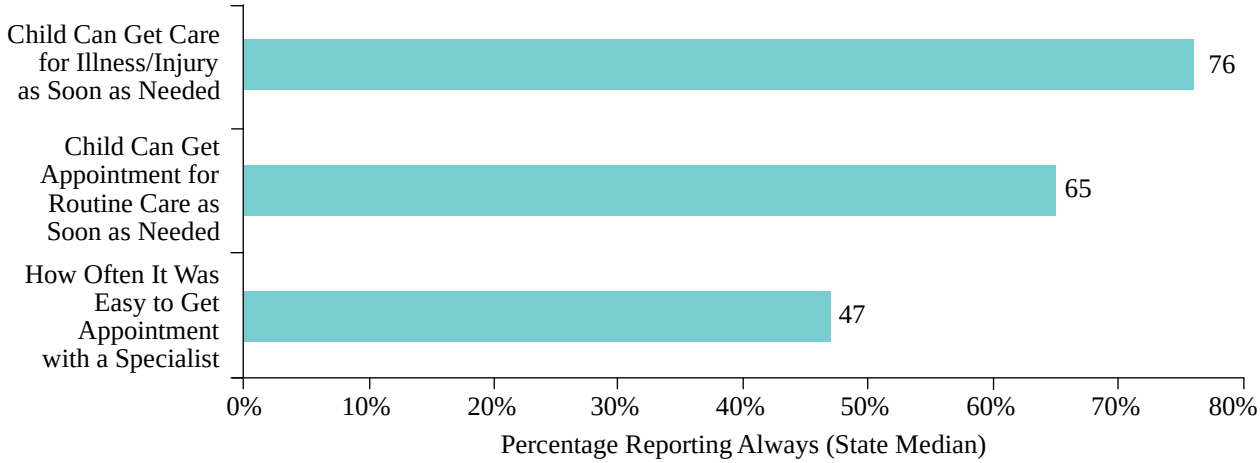
Sources: State Medicaid/CHIP medians from FFY 2011 CARTS reports; Commercial Health Plan medians from unpublished data provided by the National Committee for Quality Assurance (NCQA).

[a] Combination 3 includes DTaP, IPV, MMR, HiB, HepB, VZV, and PCV.

[b] Combination 1 includes Meningococcal and Tdap.

PCP = Primary Care Practitioner.

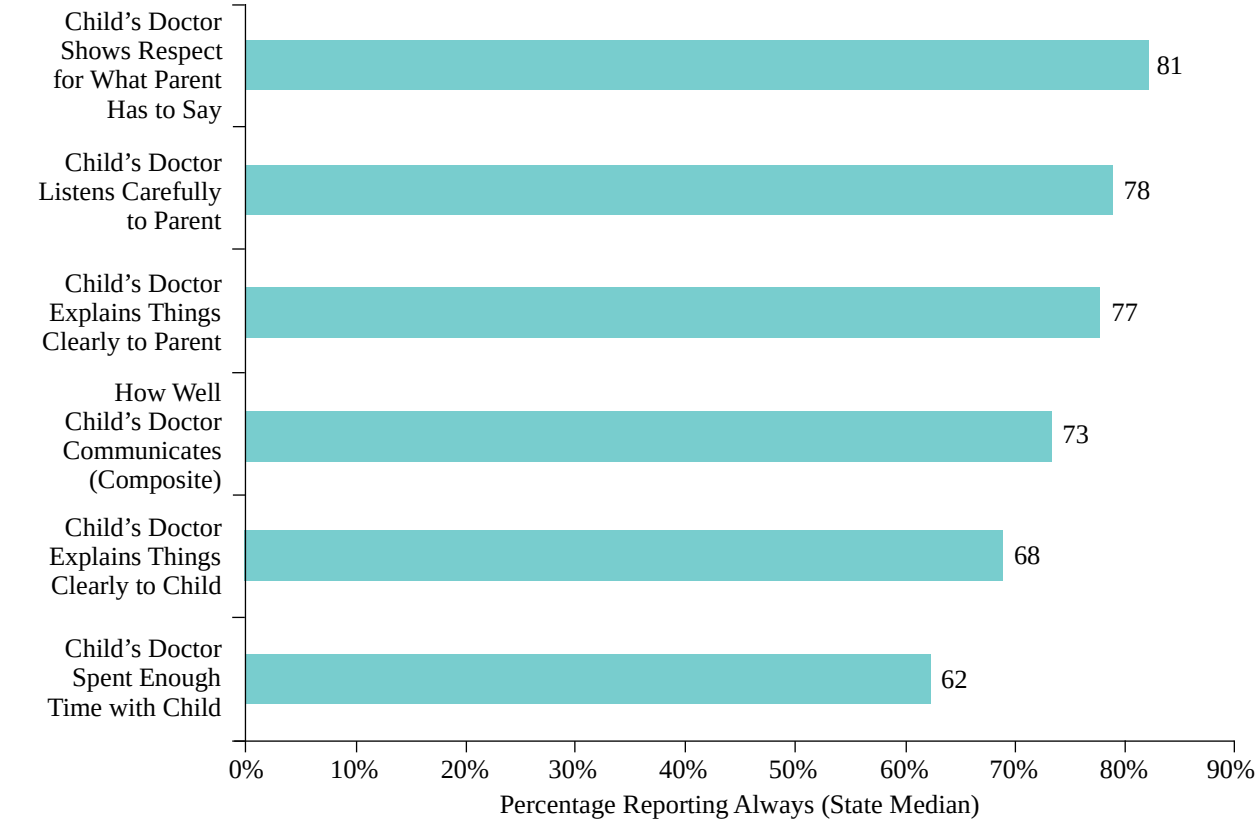
Exhibit 7. Parents' Assessment of the Ease of Getting Care for Their Child, 25 States, 2010



Source: Mathematica analysis of National CAHPS Benchmarking Database.

Note: Parents assessed the ease of getting care on a four-point scale (never, sometimes, usually, always). The percentages shown here are the median percentages reporting "always."

Exhibit 8. Parents' Assessment of How Well Their Child's Doctor Communicates, 25 States, 2010



Source: Mathematica analysis of National CAHPS Benchmarking Database.

Note: Parents assessed doctor's communication on a four-point scale (never, sometimes, usually, always). The percentages shown here are the median percentages reporting "always."

Exhibit 9. Performance Improvement Projects (PIPs) Targeting Children or Pregnant Women Included in External Quality Review Organization (EQRO) Technical Reports, 2011-2012 Reporting Cycle

State	Number of PIPs for Children or Pregnant Women	Years of Data	PIPs Validated by EQRO [a]	Number of PIPs by Topic Area											
				ADHD	Asthma	Behav Health	Childhood Immunization	Dental Care	Lead Screening	Mental Health	Prenatal Care	Primary Care Access	Weight / BMI	Well-Child Care	Other [b]
Total PIPs (37 States)	268			4	16	5	17	24	11	19	46	2	42	56	26
Total States (37 States)	30			4	7	1	9	7	6	4	16	1	9	11	9
Arizona	7	FFY 2006–2009	All		7*										
California	22	Jan–March 2012	All	1	1						12		5		3
Colorado	3	FFY 2010–2011	All							1				1	1
Delaware	4	Varies by PIP	All		1				1		2*				
D.C.	3	CY 2010	All								3*				
Florida	59	SFY 2011	All		2	5*		3	3	14*	2			30*	
Georgia	9	Varies by PIP	All				3*		3*					3*	
Hawaii	6	Varies by PIP	All									2	3	1	
Illinois	6	SFY 2009–2010	All								3*				3*
Indiana	3	CY 2010	All						1		1			1	
Iowa	0	CY 2009-2010	All												
Kansas	2	Varies by PIP	All												2
Kentucky	4	Varies by PIP	All					1			1		1		1
Maryland	0	NA	All												
Massachusetts	0	NA	NA												
Michigan	14	CY 2010	All										14*		
Minnesota	2	NR	All						1				1		
Missouri	11	CY 2010	All		2		1	6*			2				
Nebraska	5	CY 2010	All				1				1		2	1	
Nevada	4	CY 2011	All				2		2						
New Jersey	16	CY2009	All					6*			4*			6*	
New Mexico	5	FY 2010	All		1		1	1			2				
New York	17	2009-2010	All								3*		14*		
Ohio	12	SFY 2010	All					4						1	7*
Oregon	12	2011–2012	Some [c]				1			2			1	1	7*
Pennsylvania	6	CY 2008–2010	All					3			3				
Puerto Rico	1	NR	All	1											
Rhode Island	2	Varies by PIP	All	1							1				
South Carolina	4	NR	All								3				1
Tennessee	4	CY 2010	Some	1							3				

Exhibit 9 (continued)

State	Number of PIPs for Children or Pregnant Women	Years of Data	PIPs Validated by EQRO [a]	Number of PIPs by Topic Area											
				ADHD	Asthma	Behav Health	Childhood Immunization	Dental Care	Lead Screening	Mental Health	Prenatal Care	Primary Care Access	Weight / BMI	Well-Child Care	Other [b]
Texas	0	NA	NA												
Utah	0	2010	All												
Vermont	0	NA	NA												
Virginia	10	CY 2010	All				5*							5*	
Washington	10	Varies by PIP	All				2			2				6*	
West Virginia	5	CY 2010	All		2		1						1		1
Wisconsin [d]	0	NA	NA												

Source: EQRO technical reports submitted to CMS for the 2011-2012 reporting cycle as of July 31, 2012.

Notes: Alabama, Alaska, Arkansas, Connecticut, Idaho, Maine, Montana, New Hampshire, Oklahoma, South Dakota, and Wyoming do not have MCOs or PIHPs that enroll children covered by Medicaid or CHIP. Louisiana, Mississippi, and North Dakota have newly applicable managed care requirements and were not required to submit EQRO technical reports for the 2011-2012 reporting cycle. North Carolina submitted an EQRO technical report, but managed care in the state was limited to behavioral health programs that did not enroll children.

Analysis excludes plans that provide only limited services, such as primary care case management. Analysis also excludes plans that do not serve children or pregnant women, such as long-term care plans or Medicare Advantage plans that cover dual eligibles.

Analysis includes PIPs listed in the EQRO technical report for each state that specifically targeted children or pregnant women.

[a] Use of the term "validation" differed across EQRO technical reports. In Exhibit 9, validation indicates that the EQRO technical reported reviewing information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis. Some PIPs that were reviewed in the validation process did not meet all of the review criteria.

[b] PIPs for children on "Other" topics include appropriate treatment for children with pharyngitis (South Carolina); assuring better child health and development (Oregon); emergency room diversion (Colorado, West Virginia); EPSDT participation rates (Illinois, Kentucky, Ohio); improving customer service rates: children (Kansas); improving rates of cervical cancer screening (California); reduction of out-of-home placement (California); school attendance rates (California); sexually transmitted infections (Kansas).

[c] EQRO did not review or validate the Assuring Better Child Health and Development (ABCD) Program PIP because a separate EQRO (the Oregon Pediatric Improvement Partnership) held the contract for PIP development and validation.

[d] Managed care plans in Wisconsin operate PIPs, but PIP topics and descriptions were not included in the 2011 EQRO technical report.

*PIP topic was mandated by state; ADHD = Attention Deficit Hyperactivity Disorder; Behav = Behavioral; BMI = Body Mass Index; NA = Not Applicable, EQRO technical report did not include any PIPs for children or pregnant women; NR = Not Reported