

The Department of Health and Human Services

2013 Annual Report on the

Quality of Care for Children in Medicaid and CHIP



Health and Human Services Secretary

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GLOSSARY

AAP	American Academy of Pediatrics
ABCD	Assuring Better Child Health and Development
ACA	Affordable Care Act
ACSC	Ambulatory Care Sensitive Condition
ADD	Follow-Up Care for Children Prescribed ADHD Medication
ADHD	Attention-Deficit/Hyperactivity Disorder
AHRQ	Agency for Healthcare Research and Quality
AWC	Adolescent Well-Care Visits
Behav	Behavioral
BHC	Behavioral Health Concepts
BHO	Behavioral Health Organization
BMI	Body Mass Index
CAP	Child and Adolescent Access to Primary Care Practitioners
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CARTS	CHIP Annual Reporting Template System
CCC	Supplemental Items for Children with Chronic Conditions
CDC	Centers for Disease Control and Prevention
CG	Clinician & Group Survey
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009
CHL	Chlamydia Screening
CIS	Childhood Immunization Status
CLABSI	Central Line-Associated Blood Stream Infection
CMCS	Center for Medicaid and CHIP Services
CMS	Centers for Medicare & Medicaid Services
COE	Center of Excellence
CPT	Current Procedural Terminology
CWP	Appropriate Testing for Children with Pharyngitis

CY	Calendar Year
C&M	Continuation and Maintenance
DTaP	Diphtheria, Tetanus, and Acellular Pertussis Vaccine
ED	Emergency Department
EHR	Electronic Health Record
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
ER	Emergency Room
FFS	Fee-for-Service
FFY	Federal Fiscal Year
FPC	Frequency of Ongoing Prenatal Care
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FUH	Follow-Up After Hospitalization for Mental Illness
HbA1c	Hemoglobin A1c
HCE	Health Care Excel
HCPCS	Healthcare Common Procedure Coding System
HEDIS	Healthcare Effectiveness Data and Information Set
HepA	Hepatitis A
HepB	Hepatitis B
HFS	Healthy First Steps
HHS	U.S. Department of Health and Human Services
HiB	Haemophilus Influenza Type B
HIO	Health Insuring Organization
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
HPV	Human Papillomavirus
HSAG	Health Services Advisory Group

ICD	International Classification of Diseases
ICHP	Institute for Child Health Policy
IMA	Adolescent Immunization Status
IPV	Inactivated Polio Virus Vaccine
LOINC	Logical Observation Identifiers Names and Codes
MACBIS	Medicaid and CHIP Business Information Solutions
MCO	Managed Care Organization
MMIS	Medicaid Management Information System
MMR	Measles, Mumps, and Rubella
NA	Not Applicable
NCQA	National Committee for Quality Assurance
NHSN	National Healthcare Safety Network
NICU	Neonatal Intensive Care Unit
NR	Not Reported
NTSV	Nulliparous Term Singleton Vertex
OB	Obstetrician
OB/GYN	Obstetrical/Gynecological Provider
OME	Otitis Media with Effusion
ONC	Office of the National Coordinator for Health Information Technology
PCCM	Primary Care Case Management
PCMH	Patient-Centered Medical Home
PCP	Primary Care Practitioner/Provider
PCV	Pneumococcal Conjugate Vaccine
PDENT	Preventive Dental Services
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PPC	Timeliness of Prenatal Care
PQMP	Pediatric Quality Measures Program
RHCC	Rural Health Care Center

RSV	Respiratory Syncytial Virus
RV	Rotavirus
SCI	State Coverage Insurance
SEDS	Statistical Enrollment Data System
SFY	State Fiscal Year
SIPP	Statewide Inpatient Psychiatric Program
SIR	Standardized Infection Ratio
SQL	Structured Query Language
SSIS	SQL Server Integration Services
STI	Sexually Transmitted Infection
TA/AS	Technical Assistance and Analytic Support
Td	Tetanus and Diphtheria Vaccine
Tdap	Tetanus, Diphtheria, and Pertussis Vaccine
TDENT	Dental Treatment Services
URI	Upper Respiratory Infection
VNA	Visiting Nurse Association
WCC	Body Mass Index Assessment for Children and Adolescents
W15	Well-Child Visits in the First 15 Months of Life
W34	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

EXECUTIVE SUMMARY

Together, Medicaid and the Children’s Health Insurance Program (CHIP) served more than 44 million children in federal fiscal year (FFY) 2012, representing more than half the beneficiaries currently enrolled in these programs and more than 1 in 3 children in the United States.^{1,2} Medicaid and CHIP play a key role in ensuring that low-income children get health care coverage and 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(a) of the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA), summarizes state-specific information on the quality of health care furnished to children covered by Medicaid and CHIP.

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 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’s 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.³

Over the past three years, CMS and states have continued to break new ground with standardized reporting on CMS’s core set of children’s health care quality measures (referred to as the Child Core Set).⁴ The 2013 Secretary’s Report presents information on key activities CMS undertook to provide an update on the quality of care children receive in Medicaid/CHIP, including reviewing findings on the Child Core Set and summarizing information on managed care quality measurement and improvement efforts reported in the External Quality Review (EQR) technical reports. Below are key findings from these information sources.

Measurement and Voluntary Reporting Using the Child Core Set

- Over the past year, CMS has made substantial efforts to streamline reporting of Child Core Set data, reduce the burden on states, and improve consistency of the data. For FFY 2012, data on the Child Core Set measures were obtained through three sources: (1) the CMS CHIP Annual Reporting Template System (CARTS), (2) Form CMS-416, and (3) the Centers for Disease Control and Prevention’s (CDC’s) National Healthcare Safety Network (NHSN). One Initial Child Core Set measure that had proven challenging for

¹For additional information, see Table I.16 in “2012 CMS Statistics,” available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ResearchGenInfo/CMSStatistics.html>.

²<http://kff.org/other/state-indicator/children-0-18/>.

³<http://www.ahrq.gov/workingforquality/nqs/nqs2012annlrpt.pdf>.

⁴The 2010, 2011, and 2012 Secretary’s Reports are available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html>.

states to collect in previous years was not collected for FFY 2012, and will be retired in FFY 2013.⁵

- All states reported two or more of the Child Core Set measures for FFY 2012 (Exhibit 1).⁶ The median number of measures reported by states for FFY 2012 was 14, up from 12 in FFY 2011. Altogether, 35 states reported at least 11 of the 22 core measures to CMS in FFY 2012.⁷ Two states, Florida and Tennessee, reported 22 of the core measures for FFY 2012.
- The increase in the number of measures reported by states for FFY 2012 has allowed CMS, for the first time, to conduct deeper analysis on 16 Child Core Set measures reported by 25 or more states.⁸ Detailed findings for these measures (including percentiles, trends, and geographic variation) are featured in the Appendix.
- The completeness of Child Core Set data reported by states improved for FFY 2012. For example, 38 states now include both Medicaid and CHIP populations in one or more measures, up from 34 states for FFY 2011.
- The most frequently reported measures in the Child Core Set assess children's access to primary care, well-child visits, and dental services (Exhibit 2).

State Performance on the Child Core Set

1. Primary Care Access and Preventive Care

- In FFY 2012, as in FFY 2011, states continued to have high performance rates on the children's primary care access measure. The vast majority of children, across all states, had at least one visit to a primary care practitioner (PCP) during the reporting period, with the median rate ranging from a high of 97 percent among children ages 12 to 24 months to 88 to 91 percent for the other age groups (Exhibit 3).
- As in FFY 2011, the proportion of children with a well-child visit varied by age group, but remained below the recommended guidelines (Exhibit 3).⁹
- The content of a well-child visit can be indicated by several Child Core Set measures (Exhibit 3):

⁵ Otitis Media with Effusion (OME) – Avoidance of Inappropriate Systemic Antimicrobials in Children (ages 2-12) was retired in 2013. For more information, see the 2013 Children's Core Set of Health Care Quality Measures state health official letter available at <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-002.pdf>.

⁶ The term "states" includes the 50 states and the District of Columbia.

⁷ The base of 22 measures excludes two core measures: (1) the central line-associated blood stream infections (CLABSI) measure, which was obtained from the CDC's NHSN beginning in FFY 2012; and (2) the otitis media with effusion (OME) measure, which was not collected for FFY 2012 and was retired in 2013 because it draws on CPT-II codes not commonly used by Medicaid/CHIP agencies.

⁸ Although 17 measures were reported by at least 25 states for FFY 2012, the ambulatory care: emergency department visits measure is not profiled in the Appendix due to data quality issues.

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

- The median childhood immunization rate for children turning age 2 was 68 percent, while the adolescent immunization rate among 13-year-olds was 52 percent.
- The median Chlamydia screening rate among sexually active girls between the ages of 16 and 20 was 60 percent.
- The median rate of body mass index (BMI) percentile documentation in the medical record was 39 percent for children ages 3 to 17.

2. Perinatal Health

- The health of a child is affected by a mother's health and the care she receives during pregnancy. In FFY 2012, data on two of the maternity care measures in the Child Core Set indicate (Exhibit 3):
 - The large majority of pregnant women (a median of 83 percent) had a prenatal care visit in the first trimester or within 42 days of enrollment in Medicaid/CHIP.
 - Slightly more than half of women (a median of 59 percent) received the expected number of visits during their pregnancy (based on when they enrolled in Medicaid/CHIP and when they delivered).

3. Management of Acute and Chronic Conditions

- The extent to which children are receiving safe, timely, and effective treatment can be indicated by several Child Core Set measures (Exhibit 3):
 - Two-thirds (a median of 69 percent) of children diagnosed with pharyngitis and dispensed an antibiotic received the recommended strep test.
 - A median of 41 percent of children prescribed medication for attention-deficit/hyperactivity disorder (ADHD) had a follow-up visit during the first 30 days (known as the initiation phase), and of the children with a visit during the initiation phase, a median of 53 percent had two visits during the next nine months (known as the continuation and maintenance phase).
 - The median rate of a 30-day follow-up visit after hospitalization for mental illness was 68 percent.
 - Among the 40 states with state-level rates for central line-associated blood stream infections (CLABSIs) in neonatal intensive care units (NICUs), 28 had a significant decrease in CLABSIs since the 2006–2008 baseline period, and 12 had no change in infections since the baseline period. No state had a significant increase in infections.

4. Dental and Oral Health Services

- Children’s access to dental services in FFY 2011 was similar to patterns observed in previous years (Exhibit 3).¹⁰
- A median of 44 percent of children ages 1 to 20 received at least one preventive dental service (such as dental cleanings or application of dental sealants) paid for by Medicaid in FFY 2011.
- A median of 24 percent of children ages 1 to 20 received at least one dental treatment service paid for by Medicaid in FFY 2011.

Managed Care External Quality Review Findings

1. External Quality Review Technical Reports

- Of the 41 states¹¹ that currently contract with managed care plans to deliver services to Medicaid and CHIP enrollees, 33 submitted EQR technical reports to CMS for the 2012–2013 reporting cycle. The most frequently reported children’s performance measures in the EQR reports are similar to those in the Child Core Set (Exhibit 4).
- The 33 EQR technical reports varied considerably in their organization, level of detail, and focus of the discussion on quality, access, and timeliness of care. This variation is a byproduct of differences in states’ interpretation of regulatory language. For example, although the regulations require states to annually validate performance measures and performance improvement projects (PIPs), they do not require states to include details related to outcomes or interventions. Therefore, some states choose to include this information, while others do not.

2. Performance Improvement Projects

- Through their managed care entities, states are engaged in various types of improvement projects specific to children. Among the 28 states that submitted EQR technical reports over the last three reporting cycles, the most frequently reported PIP topics focused on immunizations and well-child care (Exhibit 5).
- PIP topics, target populations, and interventions and activities were generally specific to each managed care organization (MCO) or prepaid inpatient health plan (PIHP) in a state, but 18 states mandated PIP topics or required MCOs or PIHPs to engage in collaborative PIPs on priority health care topics.¹² For example, Georgia, Missouri,

¹⁰ States are to submit the CMS-416 report to CMS by April 1 of each year. At the time of this writing, CMS had not received enough FFY 2012 data from states to make meaningful comparisons, so this report includes data submitted by states on the FFY 2011 CMS-416. The Child Core Set measures for dental services include children enrolled in Medicaid and CHIP Medicaid expansion programs that are eligible for the EPSDT benefit. Children enrolled in separate CHIP programs are not included in this measure.

¹¹ For purposes of EQR, the term “states” includes the 50 states, the District of Columbia, and the territories.

¹² States mandating PIP topics for MCOs or PIHPs include Arizona, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Maryland, Michigan, Minnesota, Missouri, Nevada, New Jersey, Pennsylvania, Rhode Island, South Carolina, Virginia, and Washington.

and New Jersey required all MCOs to implement PIPs to improve dental care for children, and Arizona required MCOs to implement PIPs to improve asthma care.

- As in the previous reporting cycle, CMS conducted detailed abstractions of External Quality Review Organization (EQRO) reporting on PIPs in four CMS priority health topic areas: (1) childhood obesity, (2) dental care, (3) prenatal and postpartum care, and (4) adolescent well care. Overall, the analyses of PIP design and implementation provided in the current EQR technical reports were more comprehensive than were found during the 2011–2012 reporting cycle. Analysis of the PIPs indicates that states are using a diverse set of interventions to improve quality of care.

CMS/HHS Efforts to Improve the Quality of Care for Children in Medicaid and CHIP

This report shows the progress made by CMS and states to systematically measure and report on the quality of care children receive in Medicaid/CHIP. Although 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.

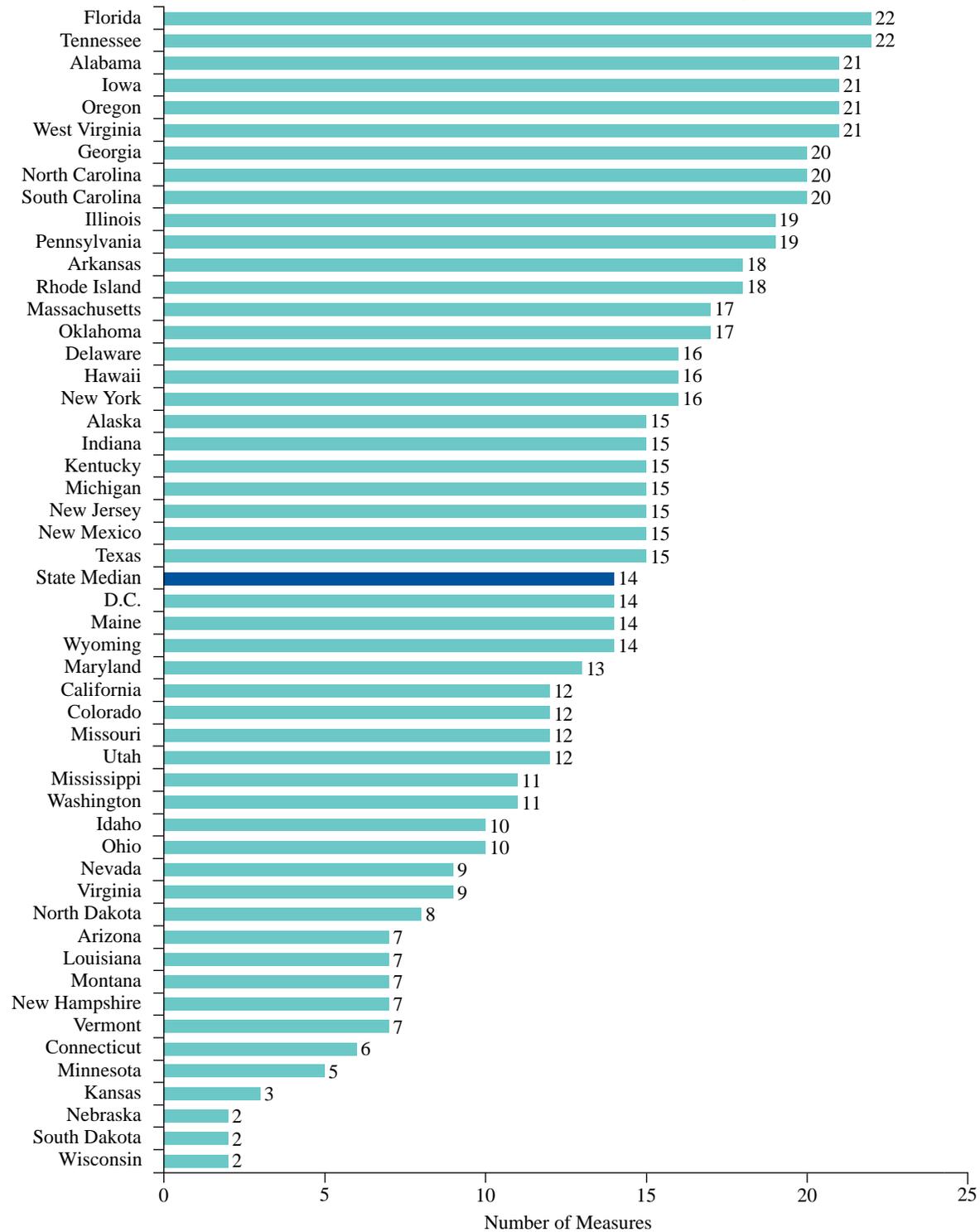
CMS and the states have built a solid foundation for improving the quality of care provided to Medicaid and CHIP enrollees through efforts such as: the Medicaid and CHIP Quality Measures Technical Assistance and Analytic Support (TA/AS) Program, the Oral Health Initiative, the Perinatal Health Initiative, the 10 CHIPRA quality demonstration grantees across 18 states, technical assistance efforts to standardize and strengthen managed care quality monitoring and improvement activities in Medicaid and CHIP, and CMS’s Technical Advisory Groups (workgroups that focus on policy areas such as quality, oral health, mental health, managed care, and coverage).^{13,14}

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 will strengthen existing partnerships and build new ones between CMS, states, health care providers, and program enrollees on quality measurement as well as quality improvement. The quality improvement efforts recently launched by CMS are helping to set the stage for the next generation of efforts designed to improve children’s health care and health outcomes and to help transform Medicaid/CHIP into a high quality system of coverage and care.

¹³ 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).

¹⁴ For more information about these efforts, please see <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care.html>.

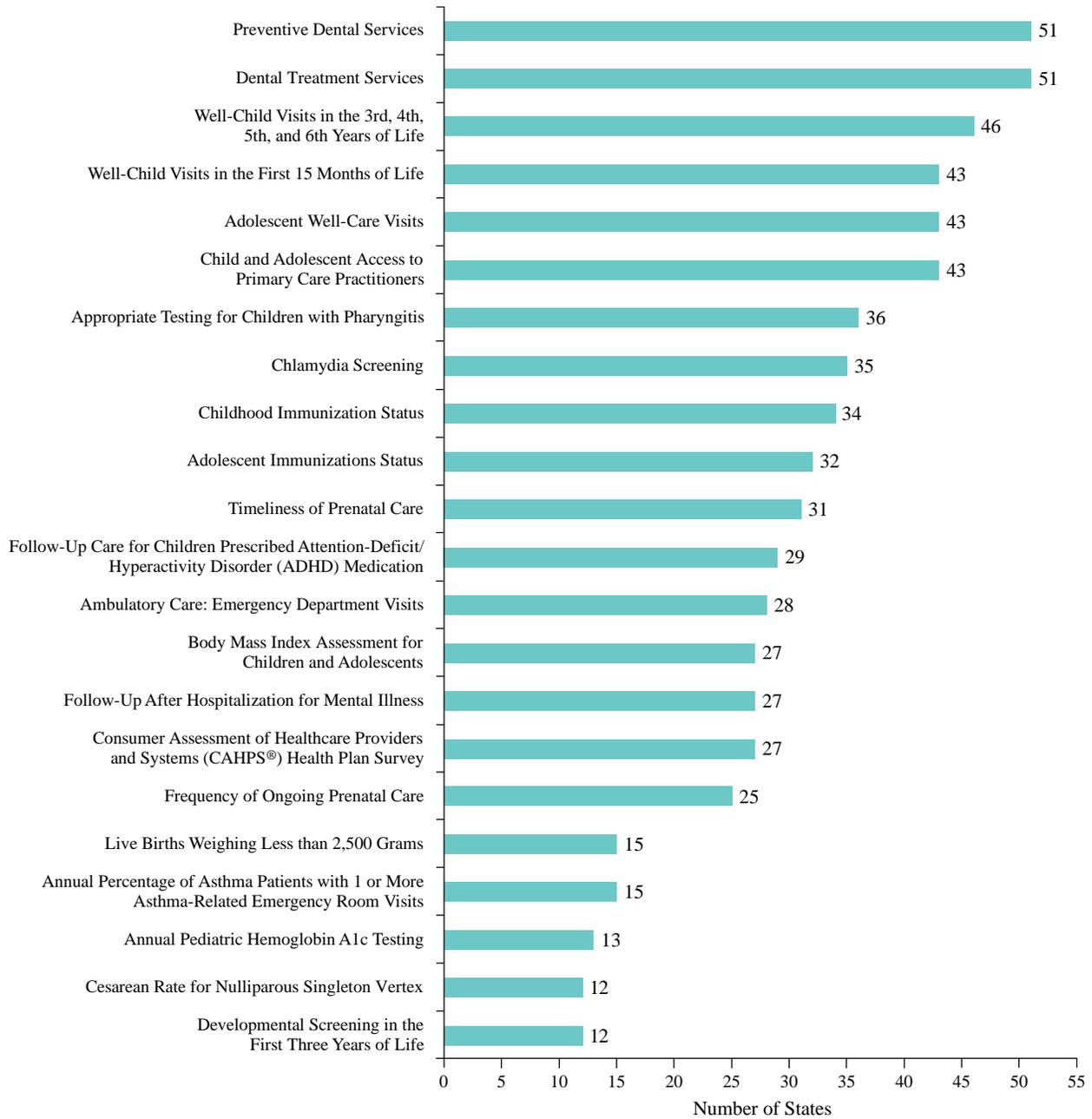
Exhibit 1. Number of Medicaid/CHIP Children’s Health Care Quality Measures Reported by States, FFY 2012



Source: Based on Mathematica analysis of FFY 2012 CARTS reports.

Notes: This figure is based on state reporting of 22 core set measures for FFY 2012. Beginning in FFY 2012, data for the CLABSI measure were obtained from the National Healthcare Safety Network. The OME measure was not collected for FFY 2012 and was retired in 2013. The term “states” includes the 50 states and the District of Columbia.

Exhibit 2. Number of States Reporting the Core Set of Medicaid/CHIP Children’s Health Care Quality Measures, FFY 2012



Source: Based on Mathematica analysis of FFY 2012 CARTS reports.

Notes: Beginning in FFY 2012, to minimize state burden, the two dental measures were calculated using data reported by states on Form CMS-416. Beginning in FFY 2012, data for the CLABSI measure were obtained from the National Healthcare Safety Network. The OME measure was not collected for FFY 2012 and was retired in 2013. The term “states” includes the 50 states and the District of Columbia.

Exhibit 3. Performance Rates on Frequently Reported Medicaid/CHIP Children’s Health Care Quality Measures, FFY 2012

Measure Description	Measure	Number of States Reporting Using Core Set Specifications	Performance Metrics			
			Mean	Median	25th Percentile	75th Percentile
Preventive Dental Services: 1 – 20 Years	Percentage with a Preventive Dental Service	51	43.0	44.0	39.3	48.3
Dental Treatment Services: 1 – 20 Years	Percentage with a Dental Treatment Service	51	23.7	23.8	19.6	25.8
Access to Primary Care: 12 – 24 Months	Percentage with a PCP Visit in the Past Year	43	95.6	96.8	94.9	98.0
Access to Primary Care: 25 Months – 6 Years	Percentage with a PCP Visit in the Past Year	43	87.7	88.1	85.2	91.2
Access to Primary Care: 7 – 11 Years	Percentage with a PCP Visit in the Past Two Years	43	88.5	91.0	86.5	93.1
Access to Primary Care: 12 – 19 Years	Percentage with a PCP Visit in the Past Two Years	43	87.4	89.2	85.8	91.5
Well-Child Visits: First 15 Months	Percentage with Six or More Visits	43	59.5	62.1	55.3	67.3
Well-Child Visits: 3 – 6 Years	Percentage with One or More Visits	46	65.9	67.7	60.9	74.9
Well-Care Visits: 12 – 21 Years	Percentage with One or More Visits	43	44.4	41.7	38.0	53.5
Childhood Immunization Status: 2 Years	Percentage Up to Date on Immunizations (Combination 3) ^a	33	64.2	67.9	61.0	76.4
Adolescent Immunization Status: 13 Years	Percentage Up to Date on Immunizations (Combination 1) ^b	30	57.6	59.9	48.8	71.1
Chlamydia Screening: 16 – 20 Years	Percentage of Sexually Active Women Screened	35	48.0	49.5	42.2	57.8
Body Mass Index Assessment: 3 – 17 Years	Percentage with a BMI Percentile Documented	27	31.8	38.9	1.6	51.9
Timeliness of Prenatal Care	Percentage with a Prenatal Visit in the First Trimester (or within 42 Days of Medicaid/CHIP Enrollment)	31	78.1	83.4	72.2	87.8
Frequency of Ongoing Prenatal Care	Percentage with More than 80 Percent of Expected Prenatal Visits	25	55.6	58.7	50.9	70.2
Appropriate Testing for Children with Pharyngitis: 2 – 18 Years	Percentage Who Were Dispensed an Antibiotic and Received a Strep Test	36	64.5	69.1	55.4	75.8
Follow-Up After Hospitalization for Mental Illness: 6 – 20 Years	Percentage of Discharges with a Follow-Up Visit within 7 Days	27	50.0	53.4	40.3	60.2
Follow-Up After Hospitalization for Mental Illness: 6 – 20 Years	Percentage of Discharges with a Follow-Up Visit within 30 Days	27	66.9	68.4	61.1	79.9
Follow-Up Care for Children Prescribed ADHD Medication: 6 – 12 Years	Percentage with a Follow-Up Visit during the Initiation Phase	29	42.1	41.1	37.1	50.0
Follow-Up Care for Children Prescribed ADHD Medication: 6 – 12 Years	Percentage with Two Follow-Up Visits during the Continuation and Maintenance Phase	28	52.9	53.4	46.4	61.1

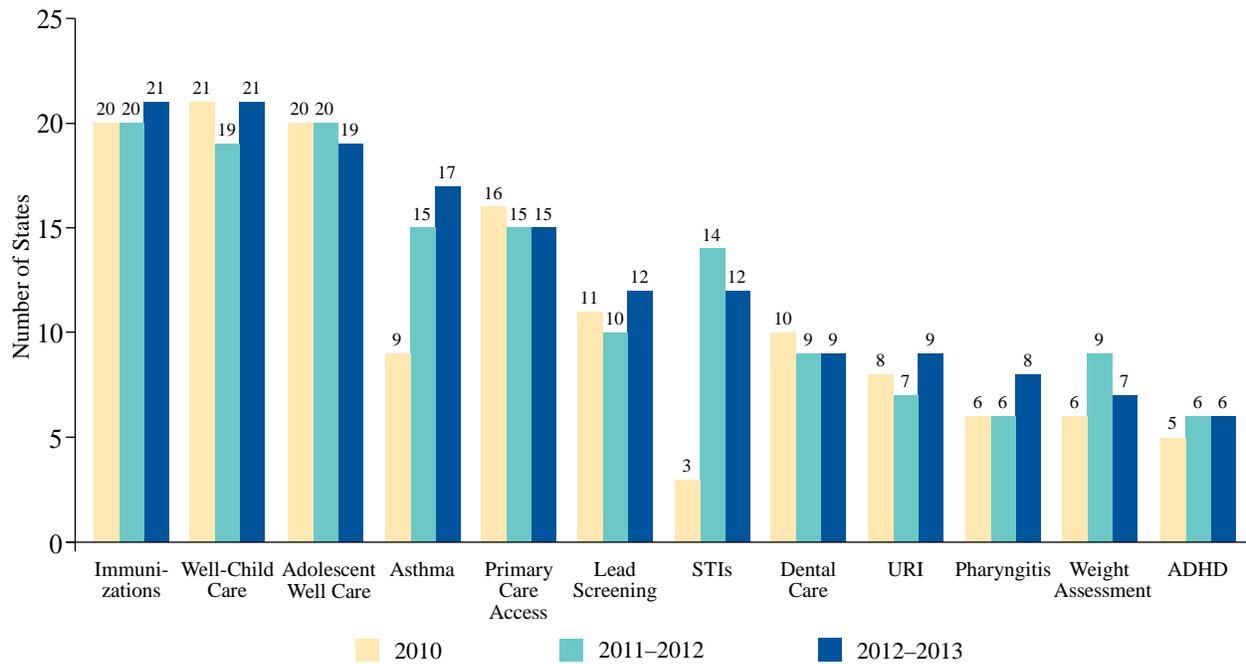
Source: Based on Mathematica analysis of FFY 2012 CARTS reports.

Notes: This table includes data for states that used core set specifications to report the measures. This table excludes states that used other specifications and states that did not report the measures for FFY 2012. If a state reported separate rates for its Medicaid and CHIP populations, the rate for the program with the larger measure-eligible population was used. The ambulatory care: emergency department visits measure was excluded from this table due to data quality issues. The central line-associated blood stream infections (CLABSI) measure was excluded from this table because the measure uses a summary statistic different from those in this table.

^aCombination 3 includes four doses of diphtheria, tetanus, and acellular pertussis (DTaP); three doses of polio (IPV); one dose of measles, mumps, and rubella (MMR); two doses of H influenza type B (HiB); three doses of hepatitis B (HepB), one dose of chicken pox (VZV); and four doses of pneumococcal conjugate (PCV) vaccine.

^bCombination 1 includes one dose of meningococcal vaccine and one tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine or one tetanus and diphtheria toxoids (Td) vaccine.

Exhibit 4. Comparison of Performance Measures Evaluating Children’s Health Care Quality That Were Reported in External Quality Review (EQR) Technical Reports for the 2010, 2011–2012, and 2012–2013 Reporting Cycles for 26 States, by General Topic



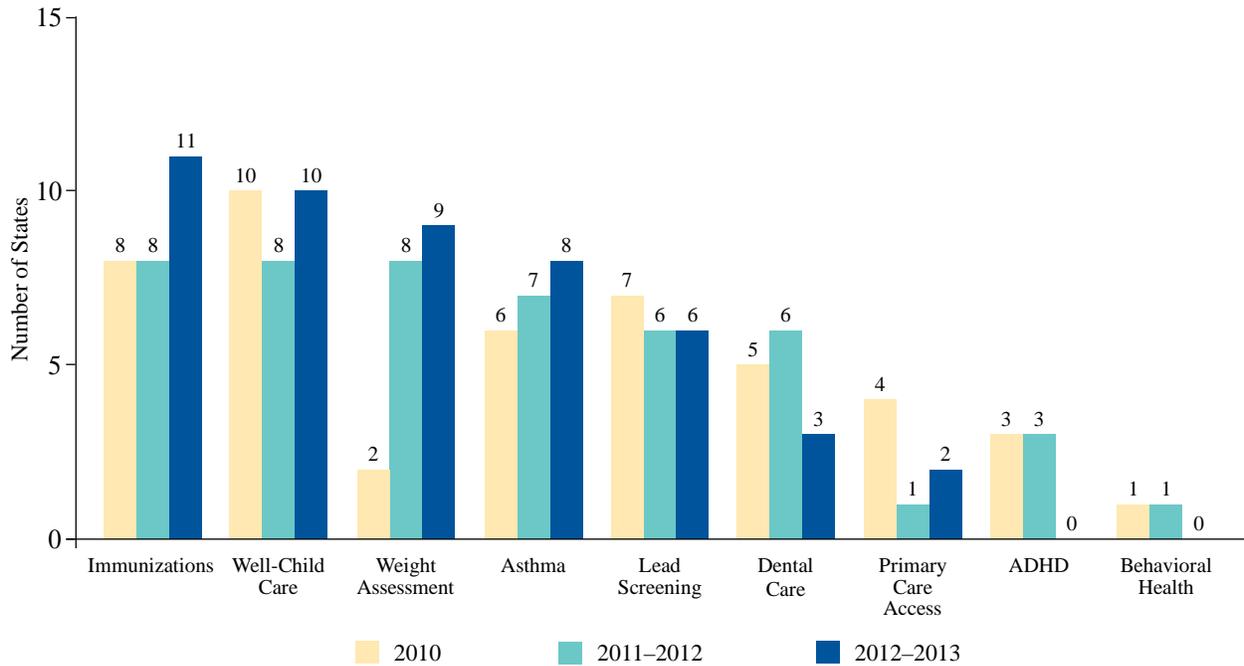
Sources: Performance measures for 2010 EQR technical reports obtained from the 2011 Secretary’s Report. Performance measures in the EQR technical reports for the 2011–2012 and 2012–2013 reporting cycles from Mathematica analysis of 2011–2012 and 2012–2013 EQR technical reports.

Notes: Data are from managed care EQR technical reports. States include AZ, CA, DE, FL, GA, HI, IL, IN, MD, MA, MI, MN, MO, NE, NV, NJ, NM, NY, PA, RI, TN, UT, VT, VA, WA, and WV. SC and WI submitted EQR technical reports in the 2010, 2011–2012, and 2012–2013 reporting cycles, but one or more of these reports did not list performance measures, so the states were excluded from this 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 5. Comparison of Performance Improvement Projects (PIPs) Targeting Children That Were Reported in External Quality Review (EQR) Technical Reports for the 2010, 2011–2012, and 2012–2013 Reporting Cycles for 28 States, Selected Topics



Sources: PIPs for the 2010 EQR technical reports obtained from the 2011 Secretary's Report. PIPs in the EQR technical reports for the 2011–2012 and 2012–2013 reporting cycles from Mathematica analysis of 2011–2012 and 2012–2013 EQR technical reports.

Notes: Data are from managed care EQR technical reports. States include AZ, CA, DE, FL, GA, HI, IL, IN, MD, MA, MI, MN, MO, NE, NV, NJ, NM, NY, PA, RI, SC, TN, UT, VT, VA, WA, WV, and WI.

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 EQR technical report for each state that specifically targeted children or pregnant women.

ADHD = attention-deficit/hyperactivity disorder.

I. INTRODUCTION

With the adoption of a core set of children's health care quality measures (Child Core Set) in 2010, the Centers for Medicare & Medicaid Services (CMS) has a new set of tools to promote high quality care in Medicaid and the Children's Health Insurance Program (CHIP). As documented in the 2012 Secretary's Report on the Quality of Care for Children in Medicaid and CHIP,¹⁵ CMS and states have made considerable progress in building a solid foundation for quality measurement and improvement. Working collaboratively with its many partners including states, health care providers, and program enrollees, CMS is now engaged in a number of efforts to use this information to drive improvements in care.

Together, Medicaid and CHIP served more than 44 million children in federal fiscal year (FFY) 2012, representing more than half the beneficiaries currently enrolled in these programs and more than 1 in 3 children in the United States.^{16,17} Enrollment increased nearly 2 percent between FFY 2011 and FFY 2012, and it is anticipated that the number of children covered by Medicaid and CHIP will continue to increase due to (1) extensive outreach efforts related to implementing the Affordable Care Act (ACA) of 2010, and (2) parents learning about the available coverage options when they seek coverage. It is important to continue to build a strong foundation for quality measurement and improvement as these key sources of coverage continue to grow.

The majority (64 percent) of children covered by Medicaid and CHIP obtain care from managed care arrangements (Table 1), although the range of services and the population groups included in these plans vary across states. For example, some states provide behavioral health and dental services through their managed care plans and others provide these services using fee-for-service arrangements. Because of the varying arrangements, a diverse set of quality measurement and improvement efforts are under way across payment and service delivery settings.

The objective of this report, as required by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA),¹⁸ is to summarize state-specific information on the quality of health care furnished to children under Titles XIX (Medicaid) and XXI (CHIP). Section 1139A(c)(1)(B) of the Act specifically requests information gathered from the external quality reviews (EQRs) of managed care organizations (MCOs)¹⁹ and benchmark plans.²⁰ The Secretary of the Department of Health and Human Services (HHS) is required to make this information publicly available annually. This year's report provides a snapshot of states' performance on the Child Core Set measures for which at least 25 states provided information to CMS.

¹⁵ <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2012-Ann-Sec-Rept.pdf>.

¹⁶ For additional information, see Table I.16 in "2012 CMS Statistics," available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ResearchGenInfo/CMSStatistics.html>.

¹⁷ <http://kff.org/other/state-indicator/children-0-18/>.

¹⁸ Section 1139A(c)(2) of the Social Security Act, as amended by Section 401(c) of CHIPRA.

¹⁹ Established under the authority of Section 1932 of the Social Security Act.

²⁰ Established under the authority of Sections 1937 and 2103 of the Social Security Act.

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II. STATE-SPECIFIC FINDINGS ON QUALITY AND ACCESS IN MEDICAID AND CHIP

A. Quality Measurement Using the Core Set of Children's Health Care Quality Measures

For the past three years, CMS and its partner states have continued to break new ground with standardized reporting on CMS's core set of children's health care quality measures (Child Core Set).²¹ The 2010 Secretary's Report signaled the first time CMS released state-specific information from voluntary reporting on the Child Core Set, an important milestone in CMS's efforts to uniformly measure and report on the quality of care obtained by children covered by Medicaid/CHIP. Over the next two years, states continued to improve the quality and completeness of the data they collected and reported for the Child Core Set measures.

For FFY 2012, CMS set the following internal goals for quality measurement and improvement:

- Increase the number of states reporting on the core measures
- Maintain or increase the number of measures reported by each state
- Improve the completeness of the data reported (that is, report on both Medicaid and CHIP enrollees)
- Streamline data collection and reporting processes, to the extent possible
- Assess states' managed care performance improvement projects (PIPs) related to the core measures
- Support states to drive improvements in health care quality at the local level using data from the Child Core Set

CMS continues to work with states, through its Quality Measures Technical Assistance and Analytic Support (TA/AS) Program, to improve the completeness and accuracy of the data reported, and to support states' efforts to build internal capacity to conduct quality improvement projects. Over the past year, CMS's TA/AS program provided support to states in understanding the technical aspects of collecting and reporting the Child Core Set measures through technical assistance webinars on calculating state-level rates, collecting the Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) survey data, and reporting the developmental delays screening core set measure.²²

Section 1139A(b)(5) of the Social Security Act provides that, beginning January 1, 2013, and annually thereafter, the Secretary shall publish recommended changes to the Initial Child Core Set. Part of the process of collecting, reporting, and using the Child Core Set measures is to establish a way to periodically identify new measures for possible inclusion in the Child Core

²¹ For a list of the Child Core Set measures, please see Table 1 at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Overview-of-the-Child-Core-Set-Measures-FFY-2012.zip>.

²² These resources are available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html>.

Set. This process serves several purposes: (1) build upon the original measure set by addressing gap areas, (2) improve upon existing Initial Child Core Set measures, and (3) better align with national quality measurement activities. The intended result is a Child Core Set that is more robust and better able to support states' and CMS's quality measurement needs. CMS issued a January 2013 state health official letter outlining updates to the Initial Child Core Set and the multi-stakeholder process used to inform the decision-making process.²³ Three measures were added as a result of this process and one of the Initial Child Core Set measures was retired due to reporting challenges cited by state Medicaid and CHIP agencies.²⁴ States choosing to voluntarily report these new measures can submit data to CMS during the FFY 2013 reporting cycle.

Related to ensuring that measures are relevant to current approaches to health care delivery and reflect updates to clinical guidelines and feedback from states is devoting the resources necessary to continue developing the pediatric measurement field. Through a partnership with the Agency for Healthcare Research and Quality (AHRQ), CMS has spent the past three years working with the seven Centers of Excellence (COEs) that comprise the AHRQ-CMS Pediatric Quality Measures Program (PQMP).²⁵ CMS funded grants to these centers, administered by AHRQ, of \$60 million over four years. Additionally, CMS continues to work with the Office of the National Coordinator for Health Information Technology (ONC) to develop pediatric measures in areas that support the gaps in the Child Core Set and that can be collected through an electronic health record (EHR).

As with the measures themselves, the data systems and sources used to collect information and monitor progress are also subject to periodic adjustments. Learning from the experiences of the past three years of reporting, CMS has made additional refinements to the CMS CARTS reporting system, the vehicle states use to report the children's quality measures to CMS. In FFY 2012, CMS decided to abstract data from other sources on behalf of the states for three Child Core Set measures: (1) preventive dental services, (2) dental treatment services, and (3) neonatal central line-associated blood stream infection (CLABSI) rates. Because the two dental measures parallel the reporting on lines 12b and 12c of Form CMS-416, CMS has begun calculating these measures on behalf of states using data from that report. Also, as hospitals already report data for the CLABSI measure to the Centers for Disease Control and Prevention's (CDC's) National Healthcare Safety Network (NHSN), CMS now collaborates with the CDC to obtain state-level data for Child Core Set reporting.

CMS has also continued to make progress toward a modernized and streamlined Medicaid and CHIP data infrastructure known as the Medicaid and CHIP Business Information Solutions (MACBIS) initiative. In the future, information collected as part of MACBIS will serve as the

²³ The 2013 Children's Core Set of Health Care Quality Measures state health official letter is available at <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-002.pdf>.

²⁴ The three measures added to the Child Core Set in 2013 are: Medication Management for People with Asthma, Human Papilloma Virus (HPV) Vaccination for Female Adolescents, and Behavioral Health Risk Assessment (for pregnant women). One measure was retired: Otitis Media with Effusion (OME)—Avoidance of Inappropriate Systemic Antimicrobials in Children (ages 2–12).

²⁵ Additional information on the PQMP is available at <http://www.ahrq.gov/policymakers/chipra/pqmpback.html>.

primary data source for the Center for Medicaid and CHIP Services' (CMCS's) quality reporting and performance measurement capacities for Medicaid and CHIP. CMS expects that these efforts will (1) help ensure that information is more accurate, complete, and uniform; (2) reduce burden on our state partners; and (3) have the potential to strengthen quality reporting for children, reduce health care costs associated with inefficiencies in the health care delivery system, and ultimately facilitate better health outcomes for children.

CMS undertook the following activities to assess the status of quality measurement, reporting, and improvement efforts by states for the 2013 Secretary's Report:

- Reviewing and analyzing findings on the Child Core Set measures reported to CMS by states for FFY 2012, including detailed analyses of 16 measures reported by at least 25 states (see the Appendix for profiles on these measures)
- Analyzing data submitted by states on the CMS-416
- Reviewing and analyzing neonatal CLABSI data submitted to CDC's NHSN
- Abstracting and summarizing information on the quality measures and PIPs reported in the EQR technical reports from states that contract with managed care plans to deliver services to Medicaid and CHIP enrollees

B. Changes in State Reporting of the Child Core Set for FFY 2012

One of CMS's quality measurement-related goals is to work with states to improve the completeness of data reported (that is, to include both Medicaid and CHIP enrollees). CMS continues to encourage states to report data on the Child Core Set that include both Medicaid and CHIP populations. The number of states reporting at least one measure for both Medicaid and CHIP enrollees has increased consistently over the past three years, from 23 states in FFY 2010 to 34 states in FFY 2011 and 38 states in FFY 2012 (Table 2).

The third year of voluntary reporting also saw an overall increase in the number of states reporting child core measures and the number of measures reported by each state. In FFY 2012, the number of states reporting on the Child Core Set was 51, up from 49 in FFY 2011 and 43 in FFY 2010 (Figure 1). This steady increase in the number of states reporting from FFY 2010 to FFY 2011 can be attributed to various factors, including increased familiarity with the measures by states and technical assistance support provided by CMS. In addition, the increase in reporting in FFY 2012 is due in part to CMS's streamlining of state reporting of the Child Core Set measures.^{26,27} Altogether, 35 states reported at least 11 of the 22 core measures to CMS in FFY

²⁶ Beginning in FFY 2012, to minimize state burden, the two dental measures were calculated using data reported by states on Form CMS-416. Beginning in FFY 2012, data for the CLABSI measure were obtained from the National Healthcare Safety Network. The measure, otitis media with effusion, was not collected for FFY 2012 and was retired in 2013.

²⁷ For information on the number of states reporting each measure as well as the reasons for not reporting, see Table 7 at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Overview-of-the-Child-Core-Set-Measures-FFY-2012.zip>.

2012 (Figure 2).²⁸ Two states, Florida and Tennessee, reported 22 of the core measures for FFY 2012.

The median number of measures reported by each state also continued to increase gradually over the past three years, moving from 7 in FFY 2010 to 12 in FFY 2011 and 14 in FFY 2012. While three measures were reported by fewer states for FFY 2012 than for FFY 2011,²⁹ and three other measures were reported by the same number of states over the same period,³⁰ all other measures saw increases in reporting for FFY 2012 (Figure 1). The measures with the largest increases in reporting from FFY 2011 to FFY 2012 were:

- Body Mass Index (BMI) Assessment for Children and Adolescents (increased from 18 to 27 states reporting)
- Frequency of Ongoing Prenatal Care (increased from 18 to 25 states reporting)
- Appropriate Testing for Children with Pharyngitis (increased from 28 to 36 states reporting)

The increase in the number of measures reported by states allowed CMS to conduct deeper analysis on 16 Child Core Set measures reported by 25 or more states for FFY 2012.³¹ State performance on these measures (including percentiles, trends, and geographic variation) is profiled in the Appendix.³²

C. Summary of Key Findings

This section summarizes CMS's analysis of state performance on 16 frequently reported measures for FFY 2012 (Table 3).³³ The most frequently reported measures reflect a continuum of quality measures within the maternal and child health population, including overall access to

²⁸ The base of 22 measures excludes the CLABSI measure, for which data were obtained from the CDC's NHSN beginning in FFY 2012, and the OME measure, which was not collected for FFY 2012 and was retired in 2013 because it draws on CPT-II codes not commonly used by Medicaid/CHIP agencies.

²⁹ Well-Child Visits in the First 15 Months of Life; Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life; and Child and Adolescent Access to Primary Care Practitioners.

³⁰ Adolescent Well-Care Visits; Preventive Dental Services; and Dental Treatment Services.

³¹ Although 17 measures were reported by at least 25 states for FFY 2012, the Ambulatory Care: Emergency Department visits measure is not profiled in the Appendix due to data quality issues.

³² These 16 measures were profiled because they were consistently reported by at least 25 states for FFY 2012 using core set specifications. Trends were calculated for 6 of the 16 measures for which at least 20 states reported data for FFY 2010–2012 using core set specifications.

³³ For a comparison of state Medicaid/CHIP and commercial medians for key measures, see Table 6 at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Overview-of-the-Child-Core-Set-Measures-FFY-2012.zip>.

primary care and use of well-child care, timeliness and frequency of prenatal care, management of acute and chronic conditions, and use of dental and oral health services (Figure 3).³⁴

1. Primary Care Access and Preventive Care

States continued to have high performance rates on the children's primary care access measure, as reflected by the state median among the 43 states reporting the measure for FFY 2012. As shown in Table 3, the state median of the percentage with a visit to a primary care practitioner (PCP) was highest for children ages 12 to 24 months (97 percent had at least one PCP visit in the past year), and lowest for children ages 25 months to 6 years (88 percent). Among older children, most had a PCP visit in the past two years (the state median was 91 percent for children ages 7 to 11 and 89 percent for children ages 12 to 19).

Despite high rates of overall PCP access, fewer children received well-child care according to the periodicity schedule recommended by the American Academy of Pediatrics and Bright Futures.³⁵ For example, nine well-child visits are recommended during the first 15 months of life. As shown in Table 3, about two-thirds of infants received six or more visits (the state median was 62 percent).

Adolescents ages 12 to 21 had the lowest well-care visit rate of all age groups. The state median for the adolescent well visit rate was 42 percent in FFY 2012. Table 3 also shows that the median adolescent immunization rate was 60 percent; 50 percent of sexually active women ages 16 to 20 were screened for Chlamydia; and BMI percentile documentation in the medical record was 39 percent for children in FFY 2012.

2. Perinatal Health

State reporting on two of the maternity care measures in the Child Core Set doubled over the past three years, from 15 to 31 states for the timeliness measure, and from 12 to 25 states for the frequency of ongoing prenatal care measure (Figure 1). The state median for timely prenatal care (care in first trimester or within 42 days of enrollment) was 83 percent (Table 3). About 6 in 10 women received the expected number of visits (based on when they enrolled in Medicaid/CHIP and when they delivered).

³⁴ In previous Secretary's Reports, data from the Consumer Assessment of Healthcare Providers and System (CAHPS[®]) survey were included to provide important information on consumer experiences with care, a dimension of quality of care. Although states are asked to report in CMS's CARTS system whether they collected the CAHPS survey data, CMS does not accept raw data from states into the system, but rather analyzes data voluntarily submitted by states to AHRQ's National CAHPS Benchmarking Database for this report. Due to contractual issues, the Benchmarking Database was unavailable at the time of this writing, and data collected for 2012 were similarly inaccessible. CMS aims to include data from the CAHPS survey in the 2014 Secretary's Report.

³⁵ American Academy of Pediatrics. "Recommendations for Preventive Pediatric Health Care." Practice Management Online at <http://brightfutures.aap.org/pdfs/AAP%20Bright%20Futures%20Periodicity%20Sched%20101107.pdf>.

3. Management of Acute and Chronic Conditions

The growth in state reporting of the Child Core Set is also facilitating an increased understanding by CMS about the clinical quality of care provided to children in Medicaid and CHIP. Four measures of the management of acute and chronic conditions available for analysis in FFY 2012 indicate:

- About two-thirds (a state median of 69 percent) of children diagnosed with pharyngitis and receiving an antibiotic had a strep test (Table 3).
- Among children prescribed ADHD medication, the state median for a follow-up visit during the first 30 days (known as the initiation phase) was 41 percent, and of the children with a visit during the initiation phase, 53 percent had a visit during the next nine months (known as the continuation and maintenance phase; Table 3).
- Among the 40 states with state-level rates for central line-associated blood stream infections (CLABSIs) in neonatal intensive care units (NICUs), 28 had a significant decrease in CLABSI infections since the 2006–2008 baseline period, and 12 had no change in infections since the baseline period.³⁶ No states had a significant increase in infections. The Standardized Infection Ratio (SIR) in NICUs was 0.65 in 2011, compared with a national goal of 0.51 by the end of 2013.³⁷ These data suggest there is room for improvement for states to reach the national goal of reducing CLABSIs by 50 percent by the end of 2013.³⁸

4. Dental and Oral Health Services

All children enrolled in Medicaid and CHIP have coverage for dental and oral health services. Children’s access to oral health care continues to be a primary focus of improvement efforts in Medicaid and CHIP. Among children ages 1 to 20 enrolled in Medicaid and CHIP Medicaid Expansion programs (those eligible for Early and Periodic Screening, Diagnostic, and Treatment [EPSDT]), 44 percent received a preventive dental service in FFY 2011 and 24 percent received

³⁶ See Table CLABSI at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2012.zip>.

³⁷ The SIR is the summary measure used to track CLABSIs over time. It compares the number of infections reported in a given year to the number that would be predicted based on national, historical baseline data that adjust for the type of facility and patient population. The SIR indicates whether the rate of infections increased, decreased, or did not change significantly relative to the baseline (calculated using data for 2006–2008). The SIR is evaluated based on the 95 percent confidence interval, standardized to a baseline of 1. This measure is obtained from data reported by hospitals to the CDC NHSN. It includes all neonatal CLABSI incidents not just those for infants covered by Medicaid/CHIP. For further information on the methods used to assess state performance, see the 2011 National and State Healthcare-Associated Infections Standardized Infection Ratio Report, available at http://www.cdc.gov/hai/pdfs/SIR/SIR-Report_02_07_2013.pdf.

³⁸ More information about CDC's NHSN Healthcare-associated Infections Summary Data Reports is available at http://www.cdc.gov/hai/surveillance/QA_stateSummary.html.

a dental treatment service (Table 3).³⁹ These rates are similar to those reported by states in FFY 2010. In 11 states, however, at least half of children received a preventive dental service in FFY 2011 (Alabama, Colorado, Connecticut, District of Columbia, Maryland, Massachusetts, New Hampshire, South Carolina, Texas, Vermont, and Washington).

³⁹ The two core set dental measures are obtained from data reported by states in the CMS-416 reports. States are to submit the CMS-416 report to CMS by April 1 of each year. At the time of this writing, CMS had not received enough FFY 2012 data from states to make meaningful comparisons, so this report includes FFY 2011 data.

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III. MONITORING AND IMPROVING CARE FOR CHILDREN ENROLLED IN MANAGED CARE

In FFY 2012, 64 percent of publicly insured children obtained their care through managed care plans (Table 1). The rate of managed care enrollment varied widely across state Medicaid and CHIP programs, ranging from 17 percent of children in Iowa to 95 percent of children in both Maryland and Michigan. Regardless of the rate of managed care enrollment, states implementing a managed care delivery system must comply with certain federal requirements, including standards related to assessing and monitoring the quality of care provided by contracted managed care plans. This chapter summarizes CMS's and states' activities related to monitoring and improving care for children enrolled in managed care.

A. Overview

The Balanced Budget Act of 1997 created system-wide quality standards for states opting to use managed care for the delivery of health care in Medicaid or CHIP.⁴⁰ Federal regulations implemented in 2003 require states to perform an annual EQR for each contracted MCO, prepaid inpatient health plan (PIHP), and health insuring organization (HIO).^{41,42} These annual EQRs analyze and evaluate information on quality, timeliness, and access to the health care services that an MCO or PIHP, and their contractors, furnish to Medicaid beneficiaries. Section 1139A(c) of the Social Security Act, as amended by Section 401 of CHIPRA, requires the HHS Secretary to include in this annual report the information that states collect through EQRs of MCOs and PIHPs participating in Medicaid or CHIP.⁴³

Federal managed care regulations 42 CFR 438.300 et seq. lay out the parameters for conducting an EQR, including state responsibilities, qualifications of an external quality review organization (EQRO), federal financial participation, and state deliverable requirements. Per the regulations, the state, its agent (not an MCO or PIHP), or an EQRO may perform eight EQR-related activities. The following three of these activities are mandatory:

⁴⁰ Codified at Section 1932(c) of the Social Security Act.

⁴¹ See 42 CFR 438.2 for full definitions of a PIHP and HIO.

⁴² The external quality review requirement applies to Medicaid programs and CHIP Medicaid expansion programs. For separate CHIP programs, the external quality review requirement became law with the enactment of CHIPRA. Specifically, Section 403 of CHIPRA requires all states that operate a CHIP managed care program to comply with the requirements of Section 1932 of the Social Security Act.

⁴³ Section 1139A(c) of the Social Security Act also requires the reporting of state-specific information on the quality of health care furnished to children in benchmark plans under Sections 1937 and 2103 of the Act. There are currently no separate state reporting requirements for benchmark plans other than the EQR reporting process required for states contracting with MCOs and PIHPs. In other words, state EQR technical reports must include information related to benchmark plans that deliver care through MCOs or PIHPs; however, because this information is reported in the aggregate, which is allowable under EQR requirements, detailed data are not available for benchmark plans.

1. Validation of performance measures⁴⁴
2. Validation of PIPs
3. A review, at least every 3 years, to determine the managed care plan's compliance with state standards for access to care, structure and operations, and quality measurement and improvement

The state may choose to perform up to five additional, optional EQR-related activities.⁴⁵ A statutorily required set of CMS EQR Protocols provide instruction to states and EQROs on the standards for conducting the eight EQR-related activities.⁴⁶ In October 2012, CMS revised the EQR Protocols for the purpose of standardizing and strengthening managed care quality monitoring and improvement activities in Medicaid and CHIP.

In accordance with regulations, the EQRO must produce an annual technical report for the state that assesses the quality, timeliness, and access to care provided by each managed care plan. This report must also include an assessment of each MCO's or PIHP's strengths and weaknesses with respect to quality and set forth recommendations for improving the quality of health care provided by each managed care entity. Per regulations, the EQR technical report is a public document, available upon request to all interested parties. Annually, CMS reviews each state's EQR technical report for evaluation and follow-up.

B. External Quality Review Technical Reports Submitted to CMS for the 2012–2013 Reporting Cycle

Of the 41 states⁴⁷ that contracted with MCOs or PIHPs during the 2012–2013 reporting cycle, 33 submitted EQR technical reports to CMS.⁴⁸ These states contracted with 16 different EQROs to conduct the annual EQR, and 4 EQROs conducted reviews for multiple states in 2012–2013.⁴⁹

⁴⁴ In accordance with 42 CFR 438.240, states that use Medicaid managed care must require each MCO and PIHP to annually measure and report to the state its performance using standard measures specified by the state or MCO. States are then required to validate any performance measures reported by the MCO or PIHP during the preceding 12 months. 42 CFR 438.320 defines validation as the review of 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.

⁴⁵ Refer to 42 CFR 438.358 for a comprehensive list of EQR-related activities.

⁴⁶ The CMS EQR Protocols are available under "Technical Assistance Documents" at <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>.

⁴⁷ For purposes of EQR, the term "states" includes the 50 states, the District of Columbia, and the territories.

⁴⁸ Alabama, Alaska, Arkansas, Connecticut, Guam, Idaho, Maine, Montana, New Hampshire, Oklahoma, South Dakota, the Virgin Islands, and Wyoming do not have MCOs or PIHPs that enroll children covered by Medicaid or CHIP. Mississippi and North Dakota were not required to submit EQR technical reports for the 2012–2013 reporting cycle. Kentucky, Louisiana, North Carolina, Ohio, Puerto Rico, and Texas did not submit EQR technical reports before May 13, 2013, for inclusion in this analysis.

⁴⁹ For a list of EQROs with current state Medicaid contracts in 2013, see Table EQR 1 at <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Findings-from-EQR-Technical-Reports-2012-2013-.zip>.

The 2012–2013 EQR technical reports revealed that managed care entities engage in a variety of different quality measurement and improvement efforts, based on the states’ priorities and other factors, such as clinical areas in need of improvement.

The 33 EQR technical reports varied considerably in their organization, level of detail, and focus of the discussion on quality, access, and timeliness of care. This variation is a byproduct of a difference in state interpretation of regulatory language. For example, although the regulations require states to annually validate performance measures and PIPs, they do not specifically require them to include details about outcomes or interventions. Therefore, some states choose to include this information in the final EQR technical report, while others do not.

To improve the content of the EQR technical reports, CMS included language in the updated CMS EQR Protocols encouraging states to include outcomes and interventions information. CMS also recently began providing feedback to states that submit EQR technical reports. This feedback aims to assist states in producing EQR technical reports that include more meaningful information about the quality of care each managed care plan provides to Medicaid/CHIP enrollees. Additionally, because the regulations only require states to produce EQR technical reports annually, the updated CMS EQR Protocols encourage states to submit the EQR technical report to CMS and the public by April 30 of each year.

C. Reporting of Performance Measures in 2012–2013 External Quality Review Technical Reports

Of the 33 EQR technical reports submitted for the 2012–2013 reporting cycle, every state except one identified the performance measures reported by MCOs and PIHPs. The most frequently reported performance measures focused on childhood immunization rates, well-child visits, adolescent well-care visits, and prenatal care, and are similar to those included in the Child Core Set (Figure 4). In the 2012–2013 reporting cycle:

- Thirty of the 33 EQR technical reports included the performance rates achieved by each MCO or PIHP for all performance measures evaluating children or pregnant women. Some states listed each measure and the performance rate achieved by the MCO or PIHP, while other states also included context for the performance rates achieved by the MCO or PIHP and suggestions for improving future performance.
- Nine states reported performance rates for subpopulations within their state. Colorado, Michigan, Minnesota, New Mexico, Rhode Island, Kansas, Nevada, and New York separately reported performance for different Medicaid populations, including children and families. Florida and New York included performance rates for different geographic regions within the state.
- Twenty-six states compared performance in the 2012–2013 reporting cycle to performance in previous years; 23 states compared performance by MCOs and PIHPs to national Healthcare Effectiveness and Information Data Set (HEDIS[®]) Medicaid rates; and 20 states included statewide managed care performance rates.

D. Description of Performance Improvement Projects in 2012–2013

Thirty of the 33 EQR technical reports submitted for the 2012–2013 reporting cycle included PIPs specific to children or pregnant women. Among these states, the number of PIPs for children or pregnant women varied (Table 4). For example, while most states conducted 10 or fewer PIPs during the reporting cycle, Florida had 37 PIPs aimed at improving well-child care visit rates and 23 PIPs focused on improving the quality of mental health care for children or pregnant women.

PIP topics, target populations, and interventions and activities were generally specific to each MCO or PIHP in a state, but 18 states mandated PIP topics or required MCOs or PIHPs to engage in collaborative PIPs on priority health care topics.⁵⁰ For example, Georgia, Missouri, and New Jersey required all MCOs to implement PIPs to improve dental care for children; Pennsylvania required all five PIHPs to implement PIPs on promoting healthy weight through screening, physical activity, and nutrition counseling; and Arizona required MCOs to implement PIPs to improve asthma care.

As in previous years, many states had PIPs to improve prenatal and postpartum care. In the 2012–2013 reporting cycle, states also frequently reported PIPs on improving well-care visits for children and adolescents, childhood immunization rates, asthma, weight assessment, and BMI counseling. All 33 EQR technical reports indicated that the EQR validated PIPs as required by the managed care regulations.

There were some shifts in PIP topics over the last three reporting cycles among the 28 states that submitted reports for all three years (Figure 5). The number of states conducting weight assessment/BMI PIPs increased and the number of dental care PIPs decreased. Some PIP topics were undertaken by similar numbers of states in all three reporting cycles, but the states conducting the PIPs shifted. For example, of the states reporting PIPs on weight assessment/BMI in 2011–2012 and 2012–2013, only five completed PIPs on this topic during both reporting cycles. No states reported behavioral health or ADHD PIPs during the 2012–2013 reporting cycle. Changes in PIP topics may reflect changing health care priorities in these states or that progress was achieved in improving care. Since EQR technical reports are not required to include outcomes data on PIPs from previous years, CMS’s ability to assess performance improvements realized from these projects is limited.

E. Focused Review of Performance Improvement Projects

Although states may contract with their EQRO to provide detailed interventions and outcomes data related to PIPs, the current regulations do not explicitly require states to submit this information to CMS. Education and outreach for members, providers, and communities are common interventions across the profiled health topics, but interventions vary significantly

⁵⁰ States that mandated PIP topics for MCOs or PIHPs include Arizona, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Maryland, Michigan, Minnesota, Missouri, Nevada, New Jersey, Pennsylvania, Rhode Island, South Carolina, Virginia, and Washington.

across topic areas and MCOs. Over the next year, CMS plans to continue to share best practices and innovations to encourage further quality improvement in these areas and others.

Overall, the analyses of PIP design and implementation provided in the current EQR technical reports were more comprehensive than those provided in the 2011–2012 reporting cycle; however, descriptions of PIPs frequently lacked key details. Discussions of the EQRO findings on the performance, progress, and limitations of each PIP differed greatly across reports. These factors have limited CMS’s ability to provide comprehensive outcomes information on the efficacy of states’ quality improvement efforts for children enrolled in managed care.

This section presents findings from detailed abstractions of EQRO reporting on PIPs in four CMS priority health topic areas: (1) childhood obesity, (2) dental care, (3) prenatal and postpartum care, and (4) adolescent well care.⁵¹ An example of a state PIP, including interventions and outcomes (where available), is provided for each priority topic area.

1. Childhood Obesity

Eleven states reported childhood obesity-related PIPs for one or more health plans during this reporting cycle (Table 5). Nine states focused on this topic during the previous reporting cycle, and five states reported PIPs on this topic across both cycles. Reported PIPs mainly focused on improving BMI percentile documentation, nutrition counseling, and physical activity counseling. Only two states (Georgia and West Virginia) reported baseline and post-intervention performance rates.

For example, Michigan was one of four states to mandate PIPs aimed at reducing childhood obesity. PIPs resulted in improved performance across MCOs. Interventions in Michigan included community outreach and education such as grants to elementary schools to implement programs to promote healthy eating and exercise habits, and sponsorship/partnership of community wellness events. Care delivery changes included a county partnership to provide reimbursement for dietician visits, nutritional counseling programs, and revised policies and procedures for services related to childhood weight management. Interventions for providers included training in conducting exercise programs, office visits, profile reports to identify members with special needs, and initiatives to align clinical practices with evidence-based practices. Member-focused interventions included education, incentives, reminder calls and letters, and educational newsletters.

2. Dental Care

During this reporting cycle, managed care plans in three states conducted mandatory PIPs focused on improving performance on the annual dental visit rate (Table 6). All states currently reporting dental PIPs also reported PIPs on this topic during the 2011–2012 cycle.

⁵¹ Additional information on “Findings from EQR Technical Reports, 2012-2013” is available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Findings-from-EQR-Technical-Reports-2012-2013-.zip>.

In Georgia, for example, the PIPs resulted in a statistically significant improvement over the baseline rate for the annual dental visit measure for children ages 2 to 21 for all MCOs. Interventions in Georgia included community outreach and education through dental events, providing dental services to members via a mobile van, and dental presentations at local Head Start locations. Provider-focused interventions included a pay-for-performance program for high-volume practices that improved quality scores, missed opportunity reports, handbooks, and annual dental rate report cards to providers. Member-focused interventions included outreach and education such as telephone calls to remind members of their dental benefits and to offer assistance in finding a dentist, missed appointment reminders, and educational newsletters.

3. Prenatal/Postpartum Care

PIPs targeting prenatal or postpartum care were conducted in 13 states during this reporting cycle (Table 7). Sixteen states completed PIPs on this topic during the previous reporting cycle, and 10 states conducted PIPs in both reporting cycles.

For example, Illinois mandated PIPs on prenatal/postpartum care during this reporting cycle. Three MCOs collected performance data on the perinatal HEDIS[®] measures along with rates of depression screening and treatment. Although the results across measures and MCOs were mixed, the EQRO reported strong performance in the design and implementation phases for these PIPs. Interventions also varied by MCO and included care delivery changes such as referral of high-risk cases to additional services. Outreach and education interventions for members included health-related text messaging (for prenatal health, mental health, and health education) and family case management services, and provider interventions included immunization incentives and educational materials.

4. Adolescent Well Care

During this reporting cycle, six states reported PIPs aimed at improving rates of adolescent well-care visits (Table 8). Three of these states reported PIPs on this topic during both the 2011–2012 and 2012–2013 reporting cycles. At the time the EQR technical reports were drafted, the PIPs in four states (Maryland, Oregon, Virginia, and West Virginia) were in the first year of implementation and able to report only baseline data. Two of the six states (Hawaii and Maryland) provided details on their interventions.

For example, Maryland required all MCOs to conduct PIPs on adolescent well care. The MCOs incorporated multiple interventions for both members and providers. Interventions related to care delivery included the use of school-based clinics and Saturday appointments. Member-focused interventions included outreach and education such as health fairs at pediatric offices for members without well-care visits, focused outreach calls and other reminders to members, and incentives for completing visits. Provider interventions included reports on members without well-child visits and incentives to schedule well-child visits. Systems-focused interventions included hiring additional staff, such as provider relations liaisons and outreach representatives.

IV. SUMMARY AND CONCLUSION

The 2013 Secretary's Report on the Quality of Care for Children in Medicaid and CHIP documents the substantial progress made by HHS and states in building a solid foundation for national, cross-state quality measurement and improvement in Medicaid/CHIP. All states reported two or more of the Child Core Set measures for FFY 2012, and both the number of states reporting and the number of measures reported by states reflect progress over last year. Although some variation remains in the populations included, 38 states now include both Medicaid and CHIP populations in one or more measures, up from 34 states for FFY 2011. Additionally, CMS's detailed review of performance improvement projects summarized in the EQR technical reports from the 2012–2013 reporting cycle identified the many state-initiated efforts under way to improve the quality of care for children enrolled in managed care.

This report provides evidence that, across all states, Medicaid and CHIP provide an important source of access to primary care and other services for children. It also highlights opportunities to improve care for children, including their use of preventive dental services and adolescent care, and the need to improve the content of the clinical care provided (as measured by immunization rates, Chlamydia screening rates, and appropriate testing for pharyngitis).

To help states further improve the completeness and consistency of their reporting and their performance, CMS has undertaken several efforts including: (1) continuing the Quality Measures Technical Assistance and Analytic Support Program, (2) providing better oversight and monitoring of data submitted on Form CMS-416, and (3) better aligning quality measurement and reporting efforts across Medicaid/CHIP-related activities. With access to data on a comprehensive set of performance measures and efforts under way to improve the stability of coverage for children in Medicaid/CHIP, HHS now has a greater capacity to work toward its goal of achieving a high quality system of coverage and care for all children enrolled in Medicaid/CHIP.

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Table 1. Number and Percentage of Children Enrolled in Medicaid or CHIP by State and Service Delivery Type, FFY 2012

State (CHIP Program Type)	Total Medicaid/CHIP Enrollment	Managed Care (Number)	Managed Care (Percentage)	Fee-for-Service (Number)	Fee-for-Service (Percentage)	Primary Care Case Management (Number)	Primary Care Case Management (Percentage)
U.S. Total	44,453,639	28,317,604	64	9,958,975	22	6,177,060	14
Alabama (S) ^a	979,066	48,284	5	112,972	12	817,810	84
Alaska (M)	98,425	0	0	98,425	100	0	0
Arizona (S)	967,179	874,311	90	92,868	10	0	0
Arkansas (C)	521,520	0	0	521,520	100	0	0
California (C)	6,324,764	4,834,393	76	1,490,371	24	0	0
Colorado (S)	611,051	169,135	28	430,030	70	11,886	2
Connecticut (S)	333,231	6,720	2	326,511	98	0	0
Delaware (C)	102,394	95,327	93	4,957	5	2,110	2
D.C. (M)	99,777	89,574	90	10,203	10	0	0
Florida (C)	2,470,453	1,471,027	60	326,885	13	672,541	27
Georgia (S)	1,422,184	1,219,526	86	202,658	14	0	0
Hawaii (M)	183,884	163,899	89	19,985	11	0	0
Idaho (C)	254,809	0	0	0	0	254,809	100
Illinois (C)	2,657,779	157,528	6	955,179	36	1,545,072	58
Indiana (C)	853,624	753,246	88	100,354	12	24	0
Iowa (C)	395,317	66,938	17	116,166	29	212,213	54
Kansas (S)	294,176	227,201	77	56,669	19	10,306	4
Kentucky (C)	568,450	413,924	73	151,631	27	2,895	1
Louisiana (C)	823,298	336,547	41	103,927	13	382,824	46
Maine (C)	212,931	0	0	80,428	38	132,503	62
Maryland (M)	606,931	589,257	97	17,674	3	0	0
Massachusetts (C)	652,310	302,323	46	163,919	25	186,068	29
Michigan (C)	1,286,270	1,232,144	96	54,126	4	0	0
Minnesota (C)	503,961	376,374	75	127,587	25	0	0
Mississippi (S)	550,703	117,948	21	432,755	79	0	0
Missouri (C)	657,378	394,400	60	262,978	40	0	0
Montana (C)	106,781	0	0	28,596	27	78,185	73
Nebraska (C)	223,269	175,446	79	47,823	21	0	0
Nevada (C)	276,783	207,117	75	69,666	25	0	0
New Hampshire (M)	105,954	0	0	105,954	100	0	0

Table 1 (continued)

State (CHIP Program Type)	Total Medicaid/CHIP Enrollment	Managed Care (Number)	Managed Care (Percentage)	Fee-for-Service (Number)	Fee-for-Service (Percentage)	Primary Care Case Management (Number)	Primary Care Case Management (Percentage)
New Jersey (C)	860,796	808,311	94	52,485	6	0	0
New Mexico (M)	390,698	316,575	81	74,123	19	0	0
New York (C)	2,757,215	2,435,988	88	321,227	12	0	0
North Carolina (C)	1,411,865	0	0	266,401	19	1,145,464	81
North Dakota (C)	64,324	0	0	17,853	28	46,471	72
Ohio (M)	1,685,004	1,330,642	79	354,362	21	0	0
Oklahoma (C)	674,079	570,628	85	103,451	15	0	0
Oregon (S)	521,785	136,410	26	383,320	73	2,055	0
Pennsylvania (S)	1,582,616	1,270,318	80	97,002	6	215,296	14
Rhode Island (C)	137,898	128,413	93	9,485	7	0	0
South Carolina (M)	626,901	330,993	53	180,287	29	115,621	18
South Dakota (C)	64,815	0	0	15,613	24	49,202	76
Tennessee (C)	862,817	787,332	91	75,485	9	0	0
Texas (S)	4,518,670	3,670,344	81	777,303	17	71,023	2
Utah (S)	347,369	65,983	19	140,616	40	140,770	41
Vermont (S)	80,499	0	0	14,215	18	66,284	82
Virginia (C)	827,092	679,929	82	142,325	17	4,838	1
Washington (S)	815,683	650,183	80	159,960	20	5,540	1
West Virginia (S)	298,479	208,357	70	84,872	28	5,250	2
Wisconsin (C)	712,817	595,894	84	116,923	16	0	0
Wyoming (S)	67,565	8,715	13	58,850	87	0	0

Source: CMS analysis of CHIP Statistical Enrollment Data System (SEDS) as of June 13, 2013.

Notes: Managed care is defined in this context as a system in which the state contracts with health maintenance organizations (HMOs) or health insuring organizations (HIOs) to provide a comprehensive set of services on a prepaid capitated risk basis. Enrollees choose a plan and a primary care provider (PCP) who will be responsible for managing their care. A child is counted in the managed care category if managed care was the last system in which he or she was covered for basic services during the quarter.

CHIP program type is denoted as follows: S = Separate CHIP program; M = CHIP Medicaid Expansion program; C = Combination CHIP program.

^a Data for Alabama Medicaid are for FFY 2011 due to technical issues with FFY 2012 data at the time of publication of this table.

Table 2. Overview of State Reporting of the Core Set of Medicaid/CHIP Children’s Health Care Quality Measures, FFY 2012

	Number of Measures Reported	State Reported at Least One Measure for Both Medicaid and CHIP Populations	Timeliness of Prenatal Care	Frequency of Ongoing Prenatal Care	Live Births Weighing Less than 2,500 Grams	Cesarean Rate for Nulliparous Singleton Vertex	Childhood Immunization Status	Adolescent Immunization Status	Body Mass Index Assessment for Children and Adolescents	Developmental Screening in the First Three Years of Life	Chlamydia Screening	Well-Child Visits in the First 15 Months of Life	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Adolescent Well-Care Visits	Preventive Dental Services	Child and Adolescent Access to PCPs	Appropriate Testing for Children with Pharyngitis	Dental Treatment Services	Ambulatory Care: Emergency Department Visits	Asthma Patients with 1 or More Asthma-Related Emergency Room Visits	Follow-Up Care for Children Prescribed ADHD Medication	Annual Pediatric Hemoglobin A1c Testing	Follow-Up After Hospitalization for Mental Illness	CAHPS Health Plan Survey	
Total	14 (Median)	38	31	25	15	12	34	32	27	12	35	43	46	43	51	43	36	51	28	15	29	13	27	27	
Alabama	21	-	X	X	X	X	X	X	-	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Alaska	15	X	-	-	X	X	-	-	-	X	X	X	X	X	X	X	X	X	X	X	X	-	X	-	
Arizona	7	-	-	-	-	-	X	X	-	-	-	-	X	X	X	X	X	X	-	-	-	-	-	-	
Arkansas	18	X	X	X	X	X	X	X	X	-	X	X	X	X	X	X	X	X	X	-	X	-	X	-	
California	12	X	X	-	-	-	X	X	X	-	X	X	X	X	X	X	X	X	-	-	-	-	-	-	
Colorado	12	X	X	-	-	-	X	X	X	-	X	X	X	X	X	X	-	X	X	-	-	-	-	-	
Connecticut	6	X	-	-	-	-	-	-	-	X	X	-	-	-	X	X	-	X	-	-	X	-	-	-	
Delaware	16	X	X	X	-	-	X	X	X	-	X	X	X	X	X	X	X	X	-	-	X	-	X	X	
D.C.	14	X	X	X	-	-	X	X	X	-	X	X	X	X	X	X	X	X	-	-	-	-	X	-	
Florida	22	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Georgia	20	X	X	X	X	X	X	X	X	-	X	X	X	X	X	X	X	X	X	X	X	X	X	-	
Hawaii	16	X	X	X	-	-	X	X	X	-	X	X	X	X	X	X	X	X	X	X	X	-	X	-	
Idaho	10	X	-	-	-	-	-	-	-	-	X	X	X	X	X	X	X	X	X	X	-	-	-	-	
Illinois	19	X	X	X	X	-	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	-	X	-	
Indiana	15	X	X	X	-	-	X	X	-	-	X	X	X	X	X	X	X	X	-	-	X	-	X	X	
Iowa	21	X	X	X	X	X	X	X	X	-	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Kansas	3	X	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	X	-	-	-	-	-	X	
Kentucky	15	X	X	X	-	-	X	X	X	-	X	X	X	X	X	X	X	X	X	X	-	-	-	-	X
Louisiana	7	X	-	-	-	-	-	-	-	-	-	X	X	X	X	X	X	X	-	-	-	-	-	X	
Maine	14	X	-	-	-	-	-	-	-	-	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Maryland	13	X	X	X	-	-	X	X	-	-	X	X	X	X	X	X	X	X	-	-	-	-	-	-	X
Massachusetts	17	X	X	X	-	-	X	X	X	-	X	X	X	X	X	X	X	X	X	-	X	X	X	X	X
Michigan	15	-	X	-	-	-	X	X	X	-	X	X	X	X	X	X	X	X	X	-	X	-	-	X	
Minnesota	5	X	-	-	-	-	-	-	-	-	-	X	X	-	X	X	-	X	-	-	-	-	-	-	
Mississippi	11	-	-	-	-	-	-	-	-	-	X	-	X	X	X	X	X	X	X	-	X	-	X	X	
Missouri	12	X	X	-	-	-	X	X	-	-	X	X	X	X	X	-	-	X	X	-	-	-	X	X	
Montana	7	-	-	-	-	-	-	-	-	-	-	X	X	-	X	X	X	X	X	-	-	-	-	-	
Nebraska	2	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	X	-	-	-	-	-	-	
Nevada	9	-	-	-	-	-	X	-	-	-	-	X	X	X	X	X	-	X	-	-	-	-	X	X	
New Hampshire	7	X	-	-	-	-	-	-	-	-	-	X	X	-	X	X	X	X	-	-	-	-	X	-	

Table 2 (continued)

	Number of Measures Reported	State Reported at Least One Measure for Both Medicaid and CHIP Populations	Timeliness of Prenatal Care	Frequency of Ongoing Prenatal Care	Live Births Weighing Less than 2,500 Grams	Cesarean Rate for Nulliparous Singleton Vertex	Childhood Immunization Status	Adolescent Immunization Status	Body Mass Index Assessment for Children and Adolescents	Developmental Screening in the First Three Years of Life	Chlamydia Screening	Well-Child Visits in the First 15 Months of Life	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Adolescent Well-Care Visits	Preventive Dental Services	Child and Adolescent Access to PCPs	Appropriate Testing for Children with Pharyngitis	Dental Treatment Services	Ambulatory Care: Emergency Department Visits	Asthma Patients with 1 or More Asthma-Related Emergency Room Visits	Follow-Up Care for Children Prescribed ADHD Medication	Annual Pediatric Hemoglobin A1c Testing	Follow-Up After Hospitalization for Mental Illness	CAHPS Health Plan Survey	
New Jersey	15	X	X	X	-	-	X	X	X	-	X	X	X	X	X	-	X	X	-	-	X	-	X	X	
New Mexico	15	X	X	X	-	-	X	X	X	-	X	X	X	X	X	X	X	X	-	-	X	-	-	X	
New York	16	X	X	X	-	-	X	X	X	-	X	X	X	X	X	X	X	X	X	-	X	-	-	X	
North Carolina	20	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	-	
North Dakota	8	-	-	-	-	-	-	X	-	-	-	-	X	X	X	X	X	X	-	-	-	-	X	-	
Ohio	10	X	X	X	-	-	-	-	-	-	-	X	X	X	X	X	-	X	-	-	X	-	-	X	
Oklahoma	17	X	-	-	-	-	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	-	X
Oregon	21	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	-
Pennsylvania	19	X	X	X	X	X	X	X	X	-	X	X	X	X	X	X	X	X	X	X	X	-	-	X	
Rhode Island	18	X	X	X	X	-	X	X	X	-	X	X	X	X	X	X	X	X	X	-	X	-	-	X	
South Carolina	20	X	X	X	-	-	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
South Dakota	2	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	X	X	-	-	-	-	-	-	
Tennessee	22	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Texas	15	-	X	X	-	-	-	-	X	-	X	X	X	X	X	X	X	X	X	-	X	-	-	X	
Utah	12	-	-	-	-	-	X	X	X	-	-	X	X	X	X	X	X	X	-	-	X	-	-	X	
Vermont	7	X	-	-	X	-	-	-	-	-	-	X	X	X	X	X	-	X	-	-	-	-	-	-	
Virginia	9	X	X	-	X	-	X	-	-	-	-	X	X	X	X	-	-	X	-	-	-	-	-	X	
Washington	11	X	X	X	X	X	X	-	-	-	-	X	X	X	X	-	-	X	X	-	-	-	-	-	
West Virginia	21	X	X	X	-	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Wisconsin	2	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	X	-	-	-	-	-	-	
Wyoming	14	-	-	-	-	-	X	X	X	X	X	X	X	X	X	X	X	X	X	-	-	X	-	-	

Source: Based on Mathematica analysis of FFY 2012 CARTS reports.

Note: This table excludes the OME and CLABSI measures. The OME measure was not collected for FFY 2012 and was retired in 2013. Beginning in FFY 2012, data for the CLABSI measure were obtained from CDC's National Healthcare Safety Network.

Table 3. Performance Rates on Frequently Reported Medicaid/CHIP Children’s Health Care Quality Measures, FFY 2012

Measure Description	Measure	Number of States Reporting Using Core Set Specifications	Mean	Median	25th Percentile	75th Percentile
Preventive Dental Services: 1 – 20 Years	Percentage with a Preventive Dental Service	51	43.0	44.0	39.3	48.3
Dental Treatment Services: 1 – 20 Years	Percentage with a Dental Treatment Service	51	23.7	23.8	19.6	25.8
Access to Primary Care: 12 – 24 Months	Percentage with a PCP Visit in the Past Year	43	95.6	96.8	94.9	98.0
Access to Primary Care: 25 Months – 6 Years	Percentage with a PCP Visit in the Past Year	43	87.7	88.1	85.2	91.2
Access to Primary Care: 7 – 11 Years	Percentage with a PCP Visit in the Past Two Years	43	88.5	91.0	86.5	93.1
Access to Primary Care: 12 – 19 Years	Percentage with a PCP Visit in the Past Two Years	43	87.4	89.2	85.8	91.5
Well-Child Visits: First 15 Months	Percentage with 6 or More Visits	43	59.5	62.1	55.3	67.3
Well-Child Visits: 3 – 6 Years	Percentage with 1 or More Visits	46	65.9	67.7	60.9	74.9
Well-Care Visits: 12 – 21 Years	Percentage with 1 or More Visits	43	44.4	41.7	38.0	53.5
Childhood Immunization Status: 2 Years	Percentage Up to Date on Immunizations (Combination 3) ^a	33	64.2	67.9	61.0	76.4
Adolescent Immunization Status: 13 Years	Percentage Up to Date on Immunizations (Combination 1) ^b	30	57.6	59.9	48.8	71.1
Chlamydia Screening: 16 – 20 Years	Percentage of Sexually Active Women Screened	35	48.0	49.5	42.2	57.8
Body Mass Index Assessment: 3 – 17 Years	Percentage with a BMI Percentile Documented	27	31.8	38.9	1.6	51.9
Timeliness of Prenatal Care	Percentage with a Prenatal Visit in the First Trimester (or within 42 Days of Medicaid/CHIP Enrollment)	31	78.1	83.4	72.2	87.8
Frequency of Ongoing Prenatal Care	Percentage with More than 80 Percent of Expected Prenatal Visits	25	55.6	58.7	50.9	70.2
Appropriate Testing for Children with Pharyngitis: 2 – 18 Years	Percentage Who Were Dispensed an Antibiotic and Received a Strep Test	36	64.5	69.1	55.4	75.8
Follow-Up After Hospitalization for Mental Illness: 6 – 20 Years	Percentage of Discharges with a Follow-Up Visit within 7 Days	27	50.0	53.4	40.3	60.2
Follow-Up After Hospitalization for Mental Illness: 6 – 20 Years	Percentage of Discharges with a Follow-Up Visit within 30 Days	27	66.9	68.4	61.1	79.9
Follow-Up Care for Children Prescribed ADHD Medication: 6 – 12 Years	Percentage with a Follow-Up Visit During the Initiation Phase	29	42.1	41.1	37.1	50.0
Follow-Up Care for Children Prescribed ADHD Medication: 6 – 12 Years	Percentage with Two Follow-Up Visits During the Continuation and Maintenance Phase	28	52.9	53.4	46.4	61.1

Source: Based on Mathematica analysis of FFY 2012 CARTS reports.

Notes: This table includes data for states that used core set specifications to report the measures. This table excludes states that used other specifications and states that did not report the measures for FFY 2012. If a state reported separate rates for its Medicaid and CHIP populations, the rate for the program with the larger measure-eligible population was used. The ambulatory care: emergency department visits measure was excluded from this table due to data quality issues. The central line-associated blood stream infections (CLABSIs) measure was excluded from this table because the measure uses a summary statistic different from those in this table.

^aCombination 3 includes four doses of diphtheria, tetanus, and acellular pertussis (DTaP); three doses of polio (IPV); one dose of measles, mumps, and rubella (MMR); two doses of H influenza type B (HiB); three doses of hepatitis B (HepB), one dose of chicken pox (VZV); and four doses of pneumococcal conjugate (PCV).

^bCombination 1 includes one dose of meningococcal vaccine and one tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine or one tetanus and diphtheria toxoids (Td) vaccine.

Table 4. Performance Improvement Projects (PIPs) Targeting Children or Pregnant Women Included in External Quality Review (EQR) Technical Reports, 2012–2013 Reporting Cycle, by Topic Area

State	Number of PIPs for Children or Pregnant Women	Years of Data	PIPS Validated by EQRO ^a	ADHD	Asthma	Behav. Health	Childhood Immunization	Dental Care	Lead Screening	Mental Health	Prenatal Care	Primary Care Access	Weight/BMI	Well-Child Care	Adolescent Well Care	Other ^b
Total PIPs (33 States)	300	.	.	0	28	4	25	13	26	27	28	4	40	52	16	37
Total States (33 States)	30	.	.	0	9	2	12	3	6	3	13	2	11	8	6	11
Arizona	7	FFY 2010	All	-	7*	-	-	-	-	-	-	-	-	-	-	-
California ^c	8	SFY 2011	All	-	1	-	-	-	-	-	2	-	2	-	-	3
Colorado	6	FY 2011–12	All	-	2	-	-	-	-	1	-	-	2	1	-	-
Delaware	4	Varies by PIP	All	-	1	-	-	-	1	-	2*	-	-	-	-	-
D.C.	3	CY 2011	All	-	-	-	-	-	-	-	3*	-	-	-	-	-
Florida	73	Varies by PIP	All	-	-	-	-	-	3	23*	-	3	7	37*	-	-
Georgia	15	Varies by PIP	All	-	-	-	3*	3*	3*	-	-	-	3*	3*	-	-
Hawaii	4	Varies by PIP	All	-	-	-	2	-	-	-	-	1*	-	-	1*	-
Illinois	6	SFY 2010–2011	All	-	-	-	-	-	-	-	3*	-	-	-	-	3*
Indiana	0	NA	NA	-	-	-	-	-	-	-	-	-	-	-	-	-
Iowa	1	2009–2011	All	-	-	1	-	-	-	-	-	-	-	-	-	-
Kansas	5	Varies by PIP	All	-	-	-	-	-	-	-	1	-	-	1	-	3
Maryland	7	CY 2011	All	-	-	-	-	-	-	-	-	-	-	-	7*	-
Massachusetts	3	CY 2010	All	-	-	-	-	-	-	-	3	-	-	-	-	-
Michigan	14	CY 2011	All	-	-	-	-	-	-	-	-	-	14*	-	-	-
Minnesota	8	2011	All	-	-	-	-	-	-	-	-	-	-	-	-	8*
Missouri	11	CY 2011	All ^d	-	2	-	2	6*	-	-	-	-	-	-	-	1
Nebraska	5	2011	All	-	-	-	1	-	-	-	1	-	2	1	-	-
Nevada	4	FY 2011–2012	All	-	-	-	2*	-	2*	-	-	-	-	-	-	-
New Jersey	16	CY 2011	All	-	-	-	-	4*	4*	-	4*	-	2*	1*	1*	-
New Mexico	6	FY 2011	All	-	2	-	1	-	-	-	2	-	-	-	-	1
New York	7	Varies by PIP	All	-	5	-	1	-	-	-	1	-	-	-	-	-
Oregon	14	Varies by PIP	Some ^e	-	-	3	1	-	-	-	-	-	1	-	1	8
Pennsylvania	5	2011	All	-	-	-	-	-	-	-	-	-	5*	-	-	-
Rhode Island	4	2010–2011	All	-	-	-	1	-	-	-	1*	-	-	-	-	2*
South Carolina	17	2011	Some	-	7*	-	1	-	-	-	4	-	-	1	-	4
Tennessee	4	Varies by PIP	All	-	-	-	-	-	-	-	-	-	1	-	-	3
Utah	0	NA	NA	-	-	-	-	-	-	-	-	-	-	-	-	-
Vermont	0	NA	NA	-	-	-	-	-	-	-	-	-	-	-	-	-
Virginia	5	2011	All	-	-	-	-	-	-	-	-	-	-	-	5*	-
Washington	15	2011	All	-	-	-	5*	-	-	3	-	-	-	7*	-	-
West Virginia	4	CY 2011	All	-	1	-	-	-	-	-	-	-	1	-	1	1
Wisconsin	19	2010	All	-	-	-	5	-	13	-	1	-	-	-	-	-

Table 4 continued

Source: EQR technical reports submitted to CMS for the 2012–2013 reporting cycle as of May 13, 2013.

Notes: AL, AK, AR, CT, GU, ID, ME, MT, NH, OK, SD, VI, and WY do not have MCOs or PIHPs that enroll children covered by Medicaid or CHIP. MS and ND were not required to submit EQR technical reports for the 2012–2013 reporting cycle. KY, LA, NC, OH, PR, and TX did not submit EQR technical reports before May 13, 2013, for inclusion in this 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.

Analysis includes PIPs for children or pregnant women that were listed in the EQR technical report for each state.

Information about the EQR process is available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>.

^a Use of the term “validation” differed across EQR technical reports. In this analysis, “validation” indicates that the EQRO 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 (SC, TN); appropriate treatment for children with upper respiratory infections (CA); assuring better child health and development (OR); Chlamydia screening (CA, KS); Consumer Assessment of Healthcare Providers and Systems (CAHPS) quality improvement activity for children (SC); Early and Periodic Screening, Diagnostic and Treatment participation (IL, SC); health risk assessments for children (RI); human papillomavirus (MN); improving diabetes care for children (KS); reducing non-emergent Emergency Department use among children (MO, WV); preventive health screenings for children ages 3 to 6 (SC); use of synagis in improving health and reducing hospitalizations in RSV vulnerable infants and children (NM).

^c Information for this analysis was extracted from the Medi-Cal Managed Care Program Technical Report: July 1, 2010–June 30, 2011. Additional CA quality reports are available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsRpts.aspx>.

^d EQR was unable to fully validate PIPs for one MCO that refused to participate in the on-site review.

^e EQR did not validate the Assuring Better Child Health and Development (ABCD) program PIPs because a separate EQRO (the Oregon Pediatric Improvement Partnership) held the contract for PIP development and validation.

* PIP topic was mandated by state.

ADHD = attention-deficit/hyperactivity disorder; Behav. = behavioral; BMI = body mass index; CY = calendar year; EQRO = external quality review organization; FFY = federal fiscal year
NA = not applicable, EQR technical report did not include any PIPs for children or pregnant women; NR = not reported; RSV = respiratory syncytial virus; SFY = state fiscal year; STI = sexually transmitted infection.

Table 5. Childhood Obesity Performance Improvement Projects (PIPs) Included in External Quality Review (EQR) Technical Reports, 2012–2013 Reporting Cycle

State	Number of MCOs Participating	Performance Measure(s) and/or Aims	Comments	Results
California*	2	Varied by MCO; BMI percentile documentation, nutrition counseling, physical activity counseling	No intervention information	Improvement across MCOs, some statistically significant
Colorado	2	Varied by MCO; BMI percentile documentation, nutrition counseling, physical activity counseling	No intervention information	First year of PIP no outcomes reported
Florida	7	Reduce obesity; no measures identified	No intervention information; did not fully meet validation rating	None reported
Georgia	3 (All)	BMI percentile documentation, nutrition counseling, physical activity counseling	Detailed intervention information	Mixed results; varied by MCO
Michigan*	14	Varied by MCO; BMI percentile documentation, nutrition counseling, physical activity counseling	Some intervention information	Improvement across MCOs, some statistically significant; decline on one measure for two MCOs
Nebraska*	2 (All)	BMI percentile documentation, nutrition counseling, physical activity counseling	Detailed intervention information	None reported
New Jersey	2	Varied by MCO; BMI percentile documentation	No intervention information	None reported
Oregon*	1	BMI percentile documentation	Some intervention information	None reported
Pennsylvania	5	Varied by MCO; BMI percentile documentation, nutrition counseling, physical activity counseling, provider education	PIP not fully implemented; some intervention information	None reported
Tennessee	1	BMI percentile documentation, nutrition counseling, physical activity counseling	No intervention information	None reported
West Virginia*	1	BMI percentile documentation, nutrition counseling, physical activity counseling	Detailed intervention information	Mixed results; very small changes

Source: EQR technical reports submitted to CMS for the 2012–2013 reporting cycle as of May 13, 2013.

Notes: Analysis includes PIPs that were listed in the EQR technical report for each state.

* State reported a PIP on this topic during both 2011–2012 and 2012–2013 reporting cycles.

Additional details can be found in the EQR technical report tables at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Findings-from-EQR-Technical-Reports-2012-2013-.zip>.

Table 6. Dental Care Performance Improvement Projects (PIPs) Included in External Quality Review (EQR) Technical Reports, 2012–2013 Reporting Cycle

State	Number of MCOs Participating	Performance Measure(s) and/or Aims	Comments	Results
Georgia*	3 (All)	Annual dental visit	Detailed intervention information	Improvement, not all statistically significant
Missouri*	6 (All)	Annual dental visit	Detailed intervention information	Varied by MCO
New Jersey*	4 (All)	Varied by MCO; Improve oral health, annual dental visit	No intervention information	None reported

Source: EQR technical reports submitted to CMS for the 2012–2013 reporting cycle as of May 13, 2013.

Notes: Analysis includes PIPs that were listed in the EQR technical report for each state.

* State reported a PIP on this topic during both 2011–2012 and 2012–2013 reporting cycles.

Additional details can be found in the EQR technical report tables at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Findings-from-EQR-Technical-Reports-2012-2013-.zip>.

Table 7. Prenatal/Postpartum Care Performance Improvement Projects (PIPs) Included in External Quality Review (EQR) Technical Reports, 2012–2013 Reporting Cycle

State	Number of MCOs Participating	Performance Measure(s) and/or Aims	Comments	Results
California*	2	Varied by MCO; depression screening, postpartum care	Some intervention information	Some improvement
Delaware*	2	Varied by MCO; NICU ^a admission rate, prenatal care, low birth weight rate, postpartum care, preterm delivery rate	Detailed intervention information	Results varied by measure; low to moderate confidence in results
District of Columbia*	3 (All)	Reduce adverse prenatal outcomes ^b	Some intervention information	Varied by MCO
Illinois*	3 (All)	Prenatal care (timeliness and frequency), postpartum care, multiple depression measures	Some intervention information	Results varied by measure
Kansas	1	Prenatal care, postpartum care	Detailed intervention information	Results varied by measure
Massachusetts	3	Varied by MCO; prenatal care (timeliness and frequency), low birth weight rate, postpartum care	Detailed intervention information	First year of PIP no outcomes reported
Nebraska*	1	Prenatal care (timeliness and frequency), postpartum care	Detailed intervention information	Performance declined
New Jersey*	4 (All)	Varied by MCO; prenatal care, birth outcomes, smoking cessation; no measures identified	No intervention information	None reported
New Mexico*	2	Varied by MCO; prenatal care (frequency), postpartum care	Some intervention information	Varied by MCO
New York*	1	Reduce readmissions for pregnant women; no measures identified	Detailed intervention information	First year of PIP for this MCO; no outcomes reported
Rhode Island*	1	Prenatal care (timeliness and frequency), postpartum care	Detailed intervention information	Results varied by measure
South Carolina*	4	Varied by MCO; prenatal care, postpartum care, and improve birth outcomes; no measures identified	No intervention information	None reported; first year of PIP for one MCO
Wisconsin	1	Improve birth outcomes; no measures identified	No intervention information	No improvement

Source: EQR technical reports submitted to CMS for the 2012–2013 reporting cycle as of May 13, 2013.

Notes: Analysis includes PIPs that were listed in the EQR technical report for each state.

* State reported a PIP on this topic during both 2011–2012 and 2012–2013 reporting cycles.

Additional details can be found in the EQR technical report tables at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Findings-from-EQR-Technical-Reports-2012-2013-.zip>.

^a NICU = neonatal intensive care unit.

^b Adverse prenatal outcomes are defined as newborns with birth weight less than 2,500 grams, newborns of 32 weeks or less gestational age, pregnant women not tested for HIV before giving birth, pregnancies ending in miscarriage or fetal loss (early or late), and deaths of infants in the first year of life.

Table 8. Adolescent Well-Care Performance Improvement Projects (PIPs) Included in External Quality Review (EQR) Technical Reports, 2012–2013 Reporting Cycle

State	Number of MCOs Participating	Performance Measure(s) and/or Aims	Comments	Results
Hawaii*	1	Primary care visit rate	Detailed intervention information	No significant improvement
Maryland	7 (All)	Well-care visit rate	Detailed intervention information	First year implementation; no reported results
New Jersey*	1	Well-care visit rate	No intervention information	None reported
Oregon*	1	Well-care visit rate	Some intervention information	First year implementation with revised age range; no reported results
Virginia	5	Well-care visit rate	No intervention information	First year implementation; no reported results
West Virginia	1	Well-care visit rate	Baseline proposal; no intervention information	First year implementation; no reported results

Source: EQR technical reports submitted to CMS for the 2012–2013 reporting cycle as of May 13, 2013.

Notes: Analysis includes PIPs that were listed in the EQR technical report for each state.

* State reported a PIP on this topic during both 2011–2012 and 2012–2013 reporting cycles.

Additional details can be found in the EQR technical report tables at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Findings-from-EQR-Technical-Reports-2012-2013-.zip>.

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FIGURES

Figure 1 Changes in the Number of States Reporting the Medicaid/CHIP Children’s Health Care Quality Measures, FFY 2010–2012 35

Figure 2 Number of Medicaid/CHIP Children’s Health Care Quality Measures Reported by States, FFY 2012 36

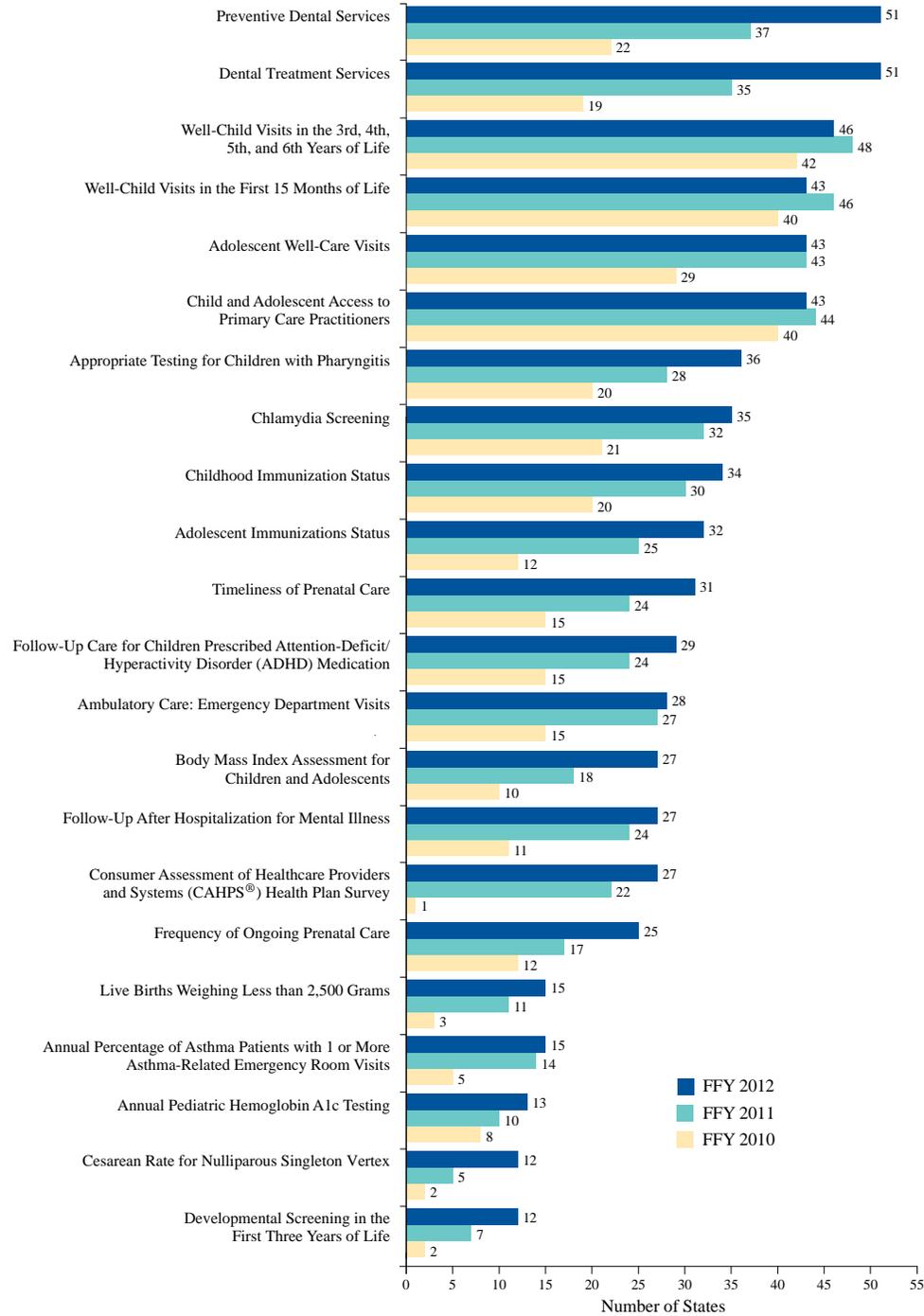
Figure 3 Number of States Reporting the Core Set of Medicaid/CHIP Children’s Health Care Quality Measures, FFY 2012 37

Figure 4 Comparison of Performance Measures Evaluating Children's Health Care Quality That Were Reported in External Quality Review (EQR) Technical Reports for the 2010, 2011–2012, and 2012–2013 Reporting Cycles for 26 States, by General Topic 38

Figure 5 Comparison of Performance Improvement Projects (PIPs) Targeting Children That Were Reported in External Quality Review (EQR) Technical Reports for the 2010, 2011–2012, and 2012–2013 Reporting Cycles for 28 States, Selected Topics 39

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Figure 1. Changes in the Number of States Reporting the Medicaid/CHIP Children’s Health Care Quality Measures, FFY 2010–2012



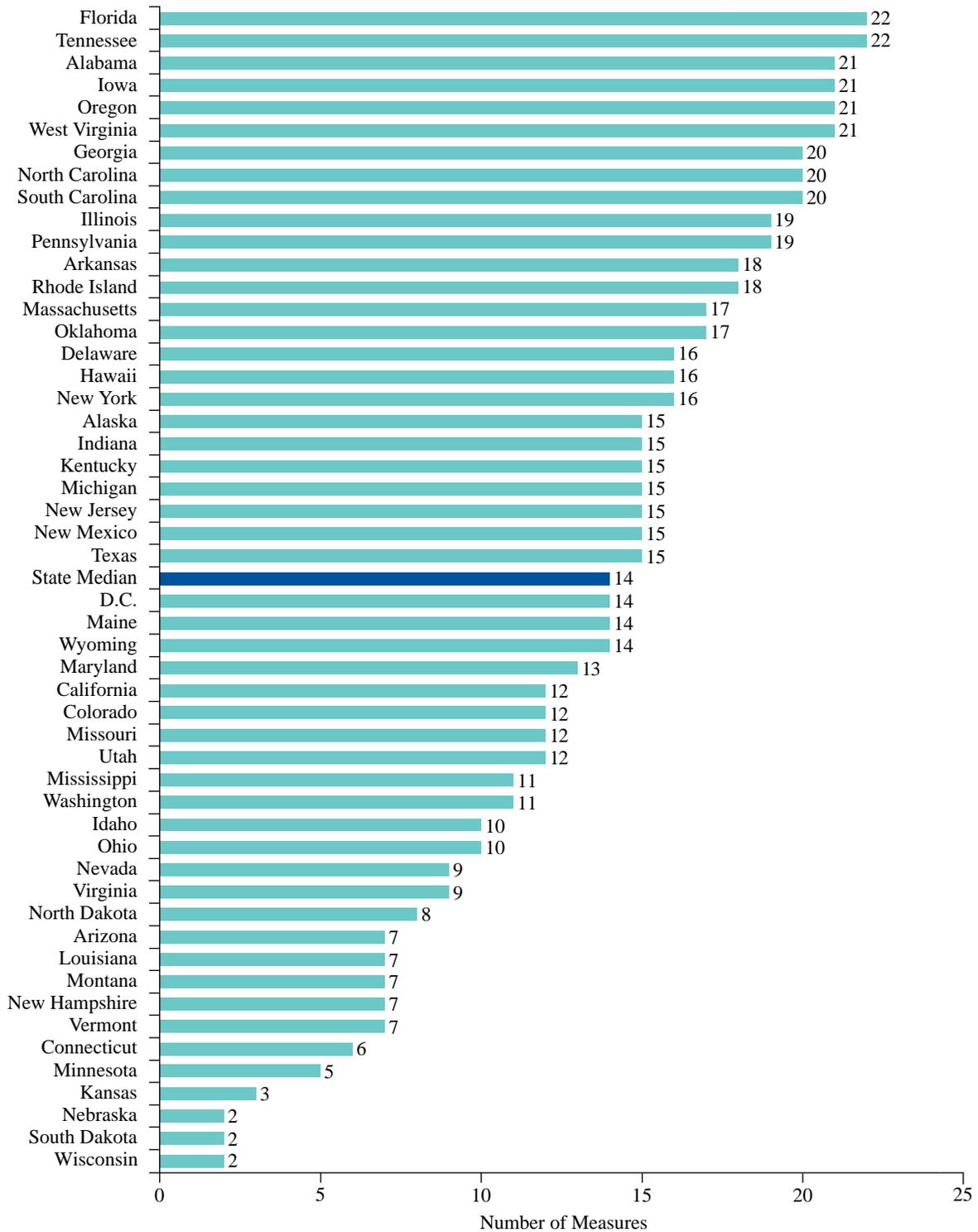
Source: Based on Mathematica analysis of FFY 2010–2012 CARTS reports.

Notes: The term “states” includes the 50 states and the District of Columbia.

The FFY 2010 and 2011 counts for the two dental measures reflect the number of states reporting the dental measures in CARTS, whereas the FFY 2012 count reflects the number of states reporting data on Form CMS-416. In FFY 2012, to minimize state burden, CMS began calculating the two dental measures on behalf of states using data reported on Form CMS-416.

Beginning in FFY 2012, data for the CLABSI measure were obtained from the CDC National Healthcare Safety Network. The OME measure was not collected for FFY 2012 and was retired in 2013.

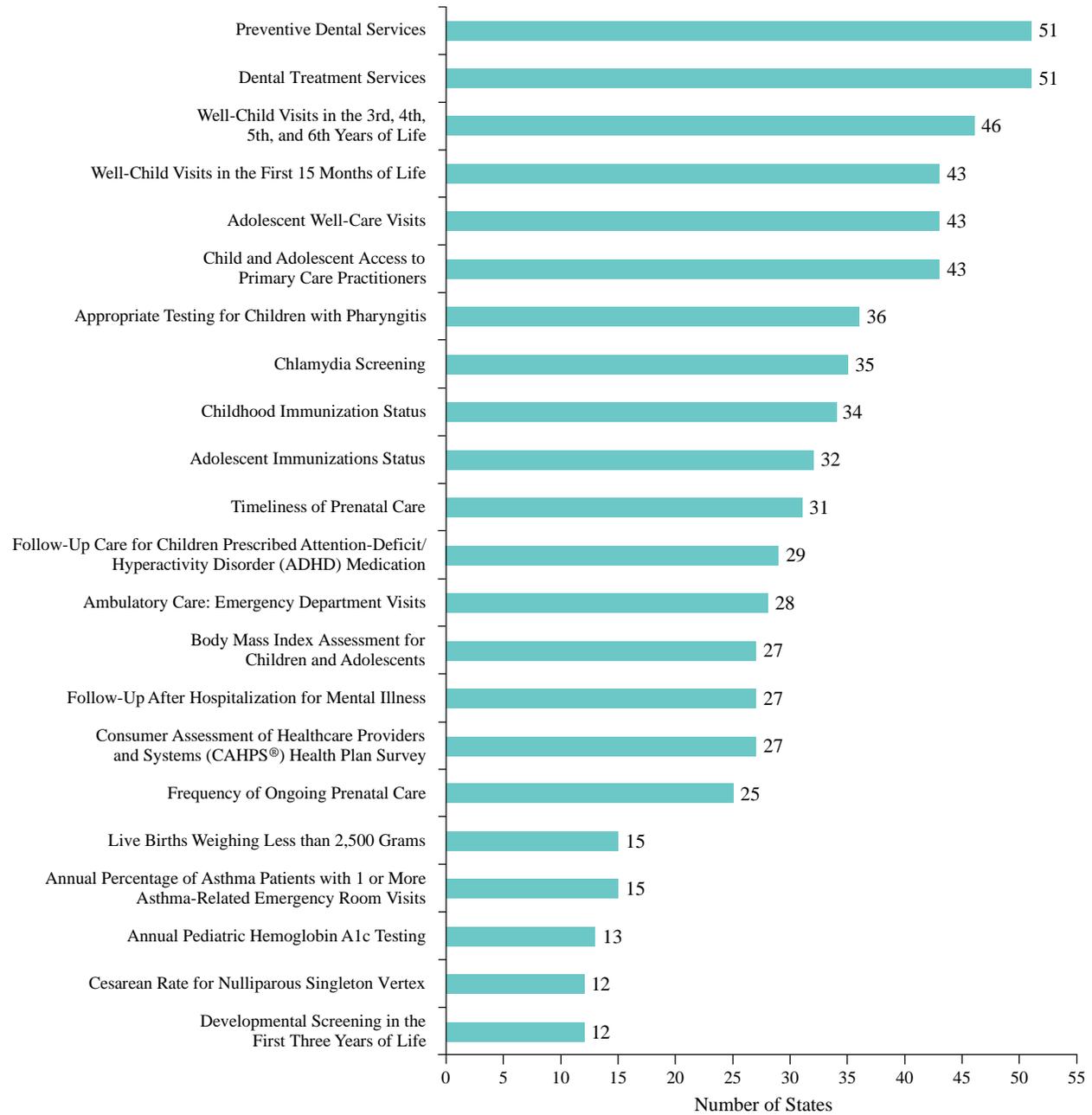
Figure 2. Number of Medicaid/CHIP Children’s Health Care Quality Measures Reported by States, FFY 2012



Source: Based on Mathematica analysis of FFY 2012 CARTS reports.

Notes: This figure is based on state reporting of 22 Core Set measures for FFY 2012. Beginning in FFY 2012, data for the CLABSI measure were obtained from the CDC National Healthcare Safety Network. The OME measure was not collected for FFY 2012 and was retired in 2013. The term “states” includes the 50 states and the District of Columbia.

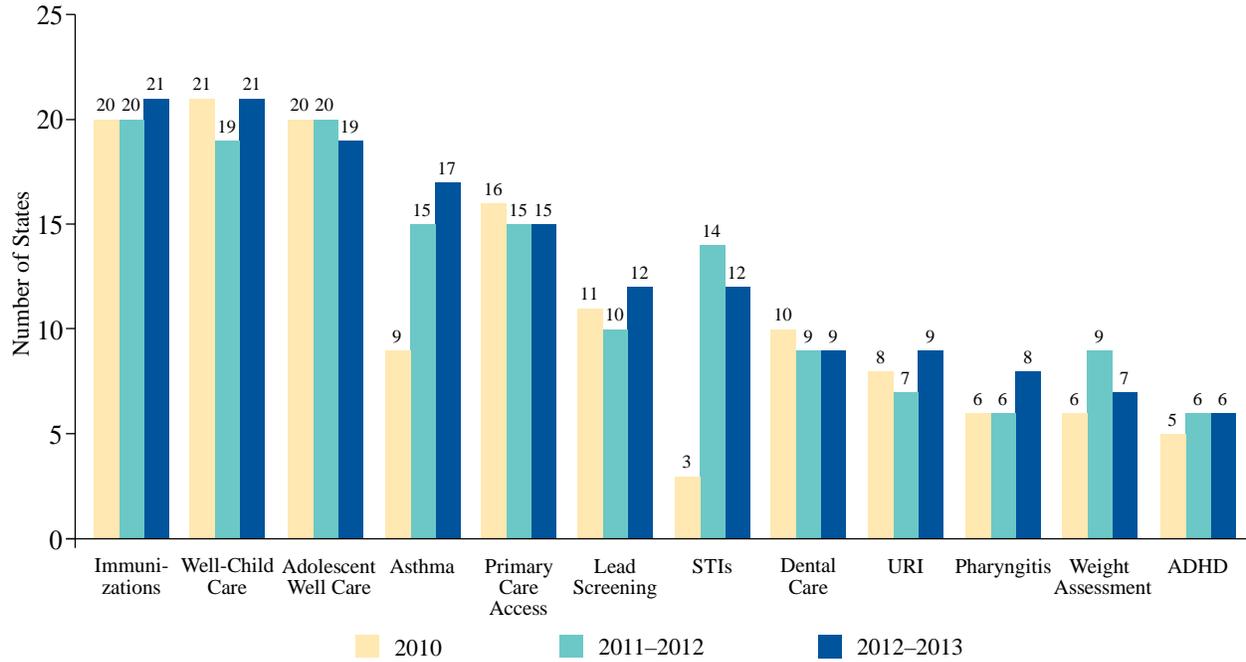
Figure 3. Number of States Reporting the Core Set of Medicaid/CHIP Children’s Health Care Quality Measures, FFY 2012



Source: Based on Mathematica analysis of FFY 2012 CARTS reports.

Notes: Beginning in FFY 2012, to minimize state burden, the two dental measures were calculated using data reported by states on Form CMS-416. Beginning in FFY 2012, data for the CLABSI measure were obtained from the CDC National Healthcare Safety Network. The OME measure was not collected for FFY 2012 and was retired in 2013. The term “states” includes the 50 states and the District of Columbia.

Figure 4. Comparison of Performance Measures Evaluating Children’s Health Care Quality That Were Reported in External Quality Review (EQR) Technical Reports for the 2010, 2011–2012, and 2012–2013 Reporting Cycles for 26 States, by General Topic



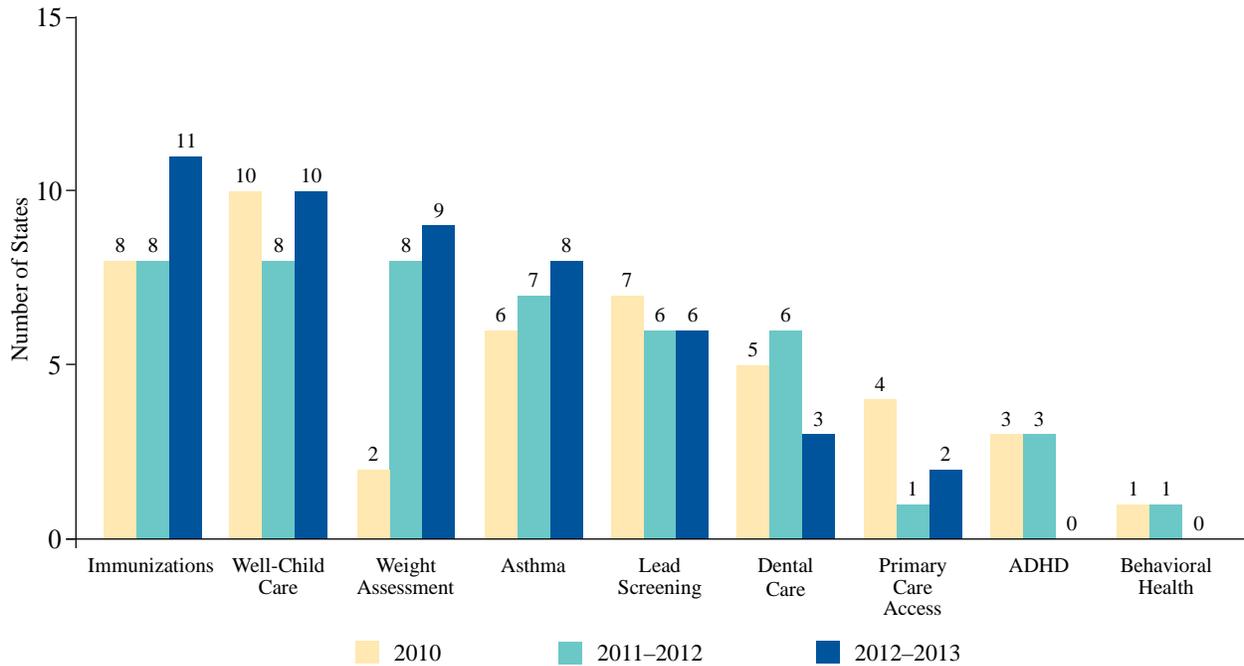
Sources: Performance measures for 2010 EQR technical reports obtained from 2011 Secretary’s Report. Performance measures in the EQR technical reports for the 2011–2012 and 2012–2013 reporting cycles from Mathematica analysis of 2011–2012 and 2012–2013 EQR technical reports.

Notes: Data are from managed care EQR technical reports. States include AZ, CA, DE, FL, GA, HI, IL, IN, MD, MA, MI, MN, MO, NE, NV, NJ, NM, NY, PA, RI, TN, UT, VT, VA, WA, and WV. SC and WI submitted EQR technical reports in the 2010, 2011–2012, and 2012–2013 reporting cycles, but one or more of these reports did not list performance measures, so the states were excluded from this 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.

Figure 5. Comparison of Performance Improvement Projects (PIPs) Targeting Children That Were Reported in External Quality Review (EQR) Technical Reports for the 2010, 2011–2012, and 2012–2013 Reporting Cycles for 28 States, Selected Topics



Sources: PIPs for the 2010 EQR technical reports obtained from the 2011 Secretary's Report. PIPs in the EQR technical reports for the 2011–2012 and 2012–2013 reporting cycles from Mathematica analysis of 2011–2012 and 2012–2013 EQR technical reports.

Notes: Data are from managed care EQR technical reports. States include AZ, CA, DE, FL, GA, HI, IL, IN, MD, MA, MI, MN, MO, NE, NV, NJ, NM, NY, PA, RI, SC, TN, UT, VT, VA, WA, WV, and WI.

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 EQR technical report for each state that specifically targeted children or pregnant women.

ADHD = attention-deficit/hyperactivity disorder.

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APPENDIX
MEASURE SNAPSHOTS

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PRIMARY CARE ACCESS AND PREVENTIVE CARE

Access to regular primary care and services that help prevent infectious and chronic disease are important to helping people live longer, healthier lives and improving the health of the population. Medicaid and CHIP help millions of children gain access to wellness visits and other preventive health care services. Preventive services include immunizations, screenings for common chronic and infectious diseases, clinical and behavioral interventions to manage chronic disease and reduce associated risks, and counseling to support healthy living and self-management of chronic disease.

In 2013, CMS launched several new activities to support state efforts to expand access to and improve the quality of preventive health care in Medicaid and CHIP. For example:

- The Promoting Prevention in Medicaid and CHIP technical assistance webinar series, held in spring 2013, featured presentations on the activities of several state Medicaid programs and their collaborations with federal prevention initiatives, managed care organizations, public health departments, and other stakeholders to improve access to preventive care.
- The Medicaid Prevention Learning Network will be launched in fall 2013 and aims to help states increase access to and use of preventive services and improve reporting and performance on CMS's prevention-related quality measures. The Learning Network will provide enhanced technical assistance to states and facilitate exchange of information about promising practices of high impact, effective preventive care delivery.
- New content on Medicaid.gov provides summaries and links to information on prevention-related coverage policy, prevention provisions in the Affordable Care Act that affect Medicaid and CHIP, and opportunities for additional technical assistance.

The eight Child Core Set measures included in this section are those for which information is available from at least 25 states for the FFY 2012 reporting year.¹ These measures are useful in assessing the adequacy of children's and adolescents' access to essential primary and preventive care, and provide insights into the current status of health care quality provided to publicly insured children and areas for improvement. The measures are as follows:

1. Child and Adolescent Access to Primary Care Practitioners
2. Well-Child Visits in the First 15 Months of Life
3. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
4. Adolescent Well-Care Visits
5. Childhood Immunization Status
6. Adolescent Immunization Status
7. Chlamydia Screening
8. Body Mass Index Assessment for Children and Adolescents

¹ Another measure, Ambulatory Care – Emergency Department Visits – is not included in the Appendix due to data quality issues.

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CHILD AND ADOLESCENT ACCESS TO PRIMARY CARE PRACTITIONERS (CAP)
 Measure Steward: National Committee for Quality Assurance (NCQA)

Access to primary care practitioners (PCPs) is essential for all children. Whether children have a comprehensive well-care visit or see a PCP when they are sick, all primary care visits offer the opportunity for routine care, such as determining whether children are up to date immunizations, measuring height and weight, gathering vital signs, offering age-appropriate counseling, and generally assessing their well-being. A basic measure of access to PCPs is whether children ages 1 to 6 had a visit in the past year and children ages 7 to 19 had a visit in the past two years.

Measure Description

- This measure shows the percentage of children and adolescents ages 12 months to 19 years that had a visit with a PCP. Rates are reported for four age groups: children ages 12 to 24 months and 25 months to 6 years that had a PCP visit during the measurement year and children ages 7 to 11 and 12 to 19 that had a PCP visit during the current or prior measurement year.²

- Performance on this measure ranged from 79 to 100 percent for children ages 12 to 24 months and from 75 to 96 percent for children ages 25 months to 6 years. The range across states was wider for the older age groups, ranging from 62 to 97 percent for ages 7 to 11 and from 61 to 97 percent for ages 12 to 19 (Exhibits CAP.3 through CAP.6).

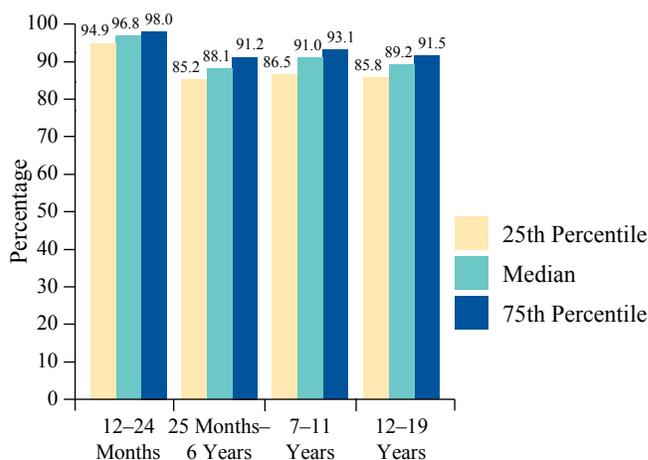
Overview of State Reporting

- The number of states reporting the Children and Adolescent Access to PCPs measure increased from 40 states for FFY 2010 to 44 states for FFY 2011 and decreased to 43 states for FFY 2012.³
- Of the 43 states reporting the measure for FFY 2012, 29 states reported the measure for both their Medicaid and CHIP populations, 11 reported the measure for their CHIP population only, and 3 reported the measure for their Medicaid population only.
- In FFY 2012, all 43 states reported the measure using Core Set specifications.

State Performance

- The median rate among the 43 states reporting the measure for FFY 2012 was highest for the 12-24 month age group, with a median of 97 percent and a 3-point spread between the 25th and 75th percentiles (Exhibit CAP.1). Median rates for other age groups were slightly lower, but still quite high: 88 percent for ages 25 months to 6 years (6-point spread); 91 percent for ages 7 to 11 (7-point spread); and 89 percent for ages 12 to 19 (6-point spread).

Exhibit CAP.1. Percentage of Children and Adolescents with a PCP Visit in the Past Year (12 to 24 Months and 25 Months to 6 Years) or Past Two Years (7 to 11 Years and 12 to 19 Years), FFY 2012 (n = 43 states)



Source: Mathematica analysis of FFY 2012 CARTS reports.

² This measure is calculated using the administrative method (claims/encounter data) or the hybrid method (claims/encounter data combined with medical record review).

³ The term “states” includes the 50 states and District of Columbia.

Trends

- Among the 35 states reporting the measure using Core Set specifications for all three years, the median rates did not change substantially between FFY 2010 and 2012 (Exhibit CAP.2). Across all three years, the rates were highest for the 12-to-24-month age group, exceeding 95 percent each year.

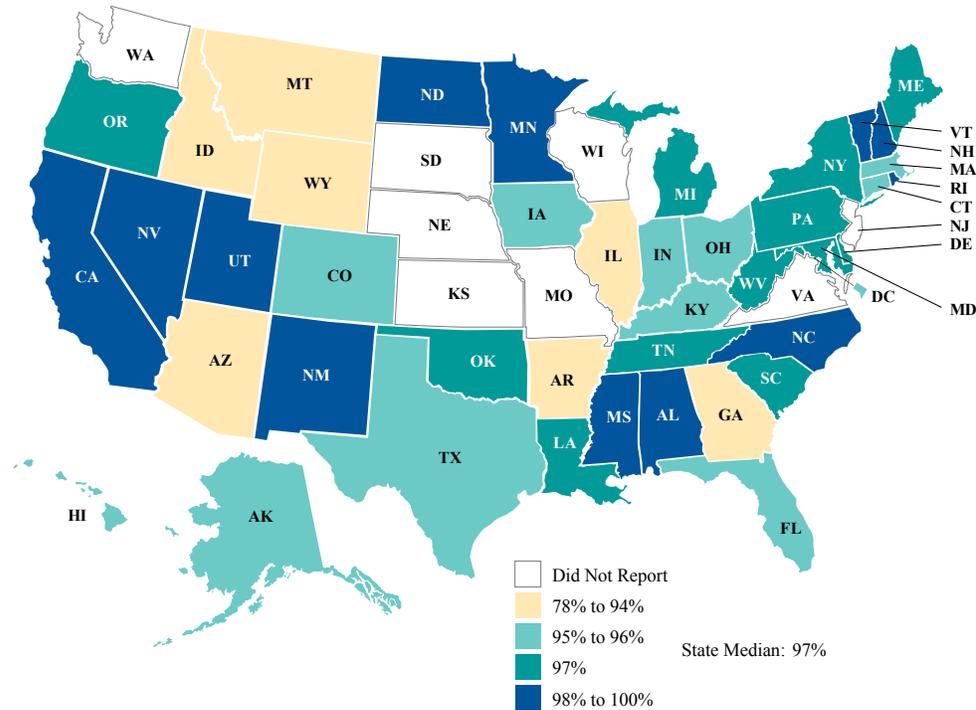
Exhibit CAP.2. Trends in the Percentage of Children and Adolescents with a PCP Visit in the Past Year (12 to 24 Months and 25 Months to 6 Years) or Past Two Years (7 to 11 Years and 12 to 19 Years), FFY 2010–2012 (n = 35 states)

Rate	FFY 2010	FFY 2011	FFY 2012
12 to 24 Months^a			
Mean	95.7	96.4	95.7
Median	96.5	97.1	97.0
25th Percentile	95.6	95.8	95.3
75th Percentile	98.0	98.2	98.2
25 Months to 6 Years			
Mean	88.2	88.4	88.0
Median	90.1	89.3	88.5
25th Percentile	85.9	85.5	85.8
75th Percentile	92.4	91.6	91.8
7 to 11 Years			
Mean	89.9	89.3	88.8
Median	91.5	90.8	91.2
25th Percentile	87.5	87.7	86.5
75th Percentile	93.4	93.0	93.1
12 to 19 Years			
Mean	88.5	88.2	87.8
Median	88.9	89.3	89.7
25th Percentile	86.4	85.6	85.8
75th Percentile	91.6	92.1	91.6

Source: Mathematica analysis of FFY 2010, 2011, and 2012 CARTS reports.

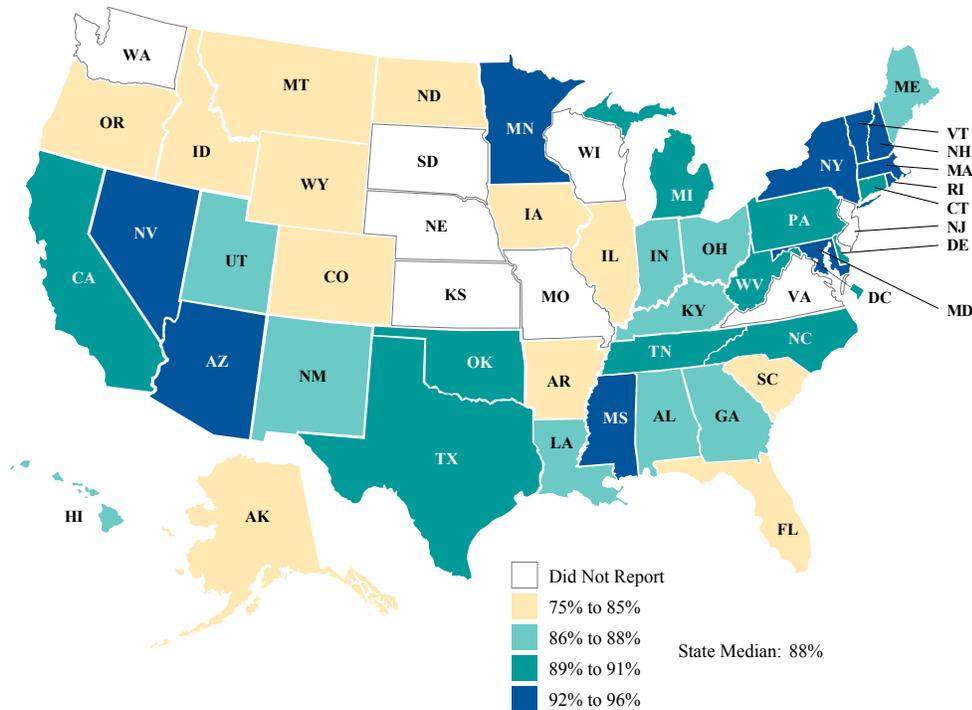
^aTwo states did not report a rate for the 12-to-24-month age group for all three years (n = 33).

Exhibit CAP.3. Geographic Variation in the Percentage of Children Ages 12 to 24 Months with a PCP Visit in the Past Year, FFY 2012 (n = 43 states)



Source: Mathematica analysis of FFY 2012 CARTS reports.

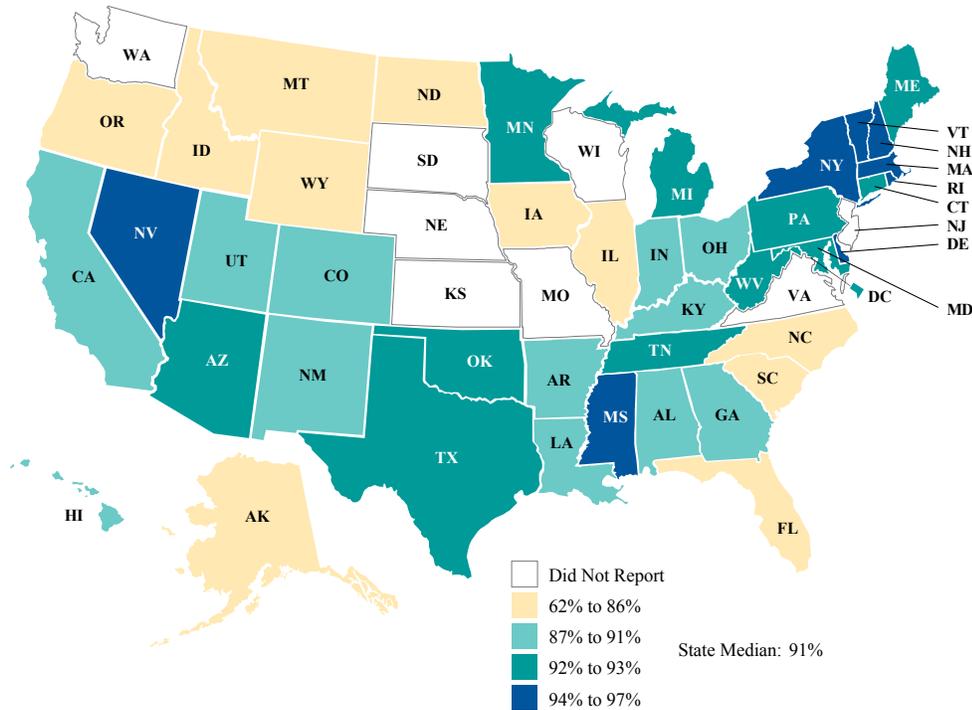
Exhibit CAP.4. Geographic Variation in the Percentage of Children Ages 25 Months to 6 Years with a PCP Visit in the Past Year, FFY 2012 (n = 43 states)



Source: Mathematica analysis of FFY 2012 CARTS reports.

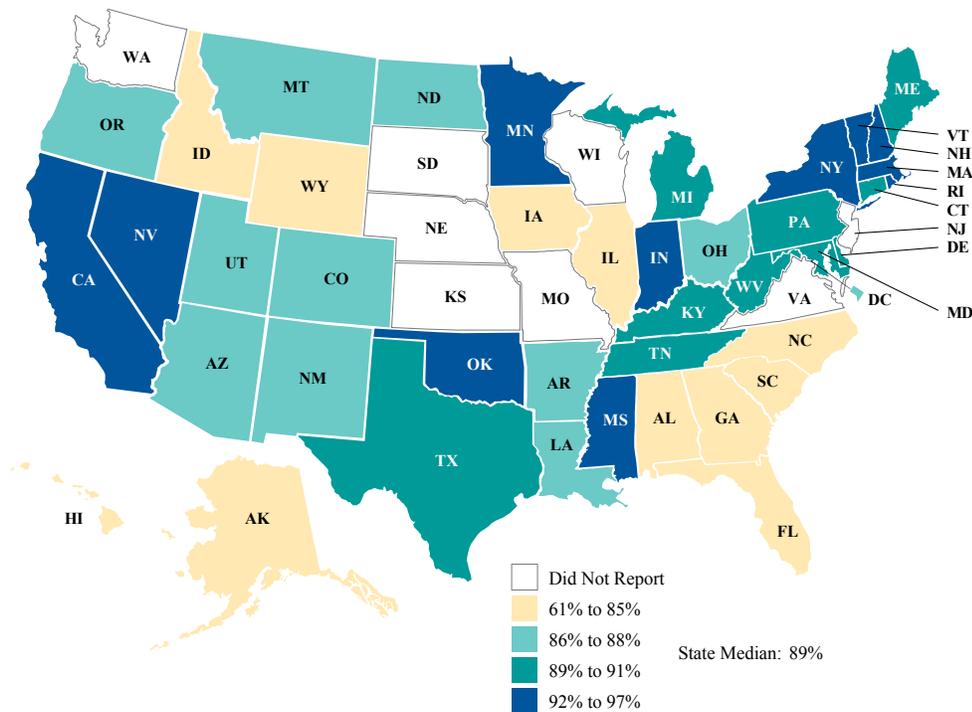
To view state-specific data for this measure, please see Table CAP at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2012.zip>.

Exhibit CAP.5. Geographic Variation in the Percentage of Children Ages 7 to 11 with a PCP Visit in the Past Two Years, FFY 2012 (n = 43 states)



Source: Mathematica analysis of FFY 2012 CARTS reports.

Exhibit CAP.6. Geographic Variation in the Percentage of Adolescents Ages 12 to 19 with a PCP Visit in the Past Two Years, FFY 2012 (n = 43 states)



Source: Mathematica analysis of FFY 2012 CARTS reports.

To view state-specific data for this measure, please see Table CAP at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2012.zip>.

WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE (W15)
Measure Steward: National Committee for Quality Assurance (NCQA)

The American Academy of Pediatrics and Bright Futures recommend nine well-care visits by the time children turn 15 months of age, including a newborn evaluation and evaluations at 3 to 5 days after birth, by 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, and 15 months. Preventive care during infancy includes a health history, physical examination, immunizations, vision and hearing screening, developmental/behavioral assessment, and an oral health risk assessment. In addition, parenting education on a wide range of topics (including breastfeeding and nutrition) is a key component of providing support to new parents. The Core Set measure assesses the percentage of children receiving six or more visits by 15 months.

Measure Description

- This measure shows the percentage of children that turned 15 months old during the measurement year and had zero, one, two, three, four, five, or six or more well-child visits with a primary care practitioner during their first 15 months of life.⁴

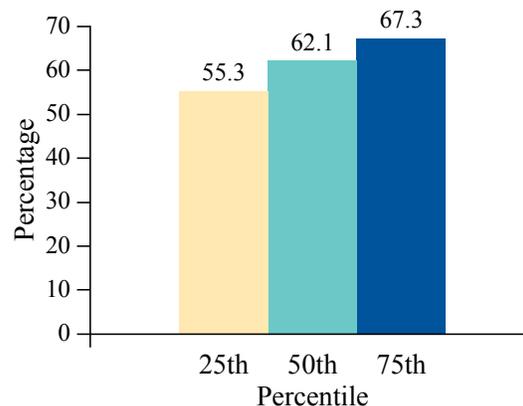
Overview of State Reporting

- The number of states reporting the Well-Child Visits in the First 15 Months of Life measure increased from 40 states for FFY 2010 to 46 states for FFY 2011, then decreased to 43 states for FFY 2012.⁵
- Of the 43 states reporting the measure for FFY 2012, 32 states reported the measure for both their Medicaid and CHIP populations, 8 states reported the measure for their CHIP population only, and 3 states reported the measure for their Medicaid population only.
- In FFY 2012, all 43 states reported the measure using Core Set specifications.

State Performance

- The median rate among the 43 states reporting the measure for FFY 2012 was 62 percent, with a 12-point spread between the 25th and 75th percentiles (Exhibit W15.1).
- Performance on this measure ranged from 23 percent to 88 percent among states, with considerable geographic variation across states (Exhibit W15.3, next page).

Exhibit W15.1. Percentage of Children Receiving 6 or More Well-Child Visits in the First 15 Months of Life, FFY 2012 (n = 43 states)



Source: Mathematica analysis of FFY 2012 CARTS reports.

Trends

- Among the 33 states reporting the measure using Core Set specifications for all three years, the median rate with 6 or more visits in the first 15 months of life increased by 6.5 percentage points from FFY 2010 to FFY 2012 (Exhibit W15.2).

Exhibit W15.2. Trends in the Percentage of Children Receiving 6 or More Well-Child Visits in the First 15 Months of Life, FFY 2010–2012 (n = 33 states)

Rate	FFY 2010	FFY 2011	FFY 2012
Mean	52.9	59.4	62.3
Median	55.4	60.5	61.9
25th Percentile	50.9	56.6	55.9
75th Percentile	64.6	69.2	68.8

Source: Mathematica analysis of FFY 2010, 2011, and 2012 CARTS reports.

⁴ This measure is calculated using the administrative method (claims/encounter data) or the hybrid method (claims/encounter data combined with medical record review).

⁵ The term “states” includes the 50 states and District of Columbia.

WELL-CHILD VISITS IN THE THIRD, FOURTH, FIFTH, AND SIXTH YEARS OF LIFE (W34)
Measure Steward: National Committee for Quality Assurance (NCQA)

The American Academy of Pediatrics and Bright Futures recommend a comprehensive annual preventive visit at ages 3, 4, 5, and 6. These visits should include a health history, physical examination, immunizations, vision and hearing screening, developmental/behavioral assessment, and an oral health assessment (at ages 3 and 6). In addition, these visits should include age-appropriate anticipatory guidance on a wide range of topics to engage parents in promoting their child’s healthy development. Referrals for follow-up care may occur if physical, social, or emotional issues are detected. A key aim of preventive care during this period is to facilitate a child’s school readiness and address any issues that would interfere with their school attendance and learning.

Measure Description

- This measure shows the percentage of children ages 3 to 6 that had one or more well-child visits with a primary care practitioner during the measurement year.⁶

Overview of State Reporting

- The number of states reporting the Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life measure increased from 42 states for FFY 2010 to 48 states for FFY 2011 and then decreased to 46 states for FFY 2012.⁷
- Of the 46 states reporting the measure for FFY 2012, 34 reported the measure for both their Medicaid and CHIP populations, 10 reported the measure for their CHIP population only, and 2 reported the measure for their Medicaid population only.
- In FFY 2012, all 46 states reported the measure using Core Set specifications.

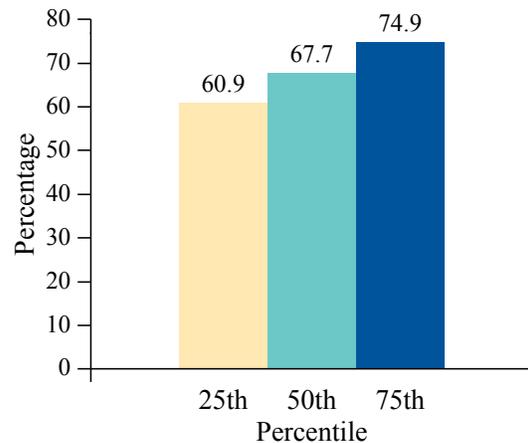
State Performance

- The median rate among the 46 states reporting the measure for FFY 2012 was 68 percent, with a 14-point spread between the 25th and 75th percentiles (Exhibit W34.1).
- Performance on this measure ranged from 40 percent to 85 percent among states, with considerable geographic variation across states (Exhibit W34.3, next page).

⁶ This measure is calculated using the administrative method (claims/encounter data) or the hybrid method (claims/encounter data combined with medical record review).

⁷ The term “states” includes the 50 states and District of Columbia.

Exhibit W34.1. Percentage of Children Receiving At Least One Well-Child Visit in the Third, Fourth, Fifth, and Sixth Years of Life, FFY 2012 (n = 46 states)



Source: Mathematica analysis of FFY 2012 CARTS reports.

Trends

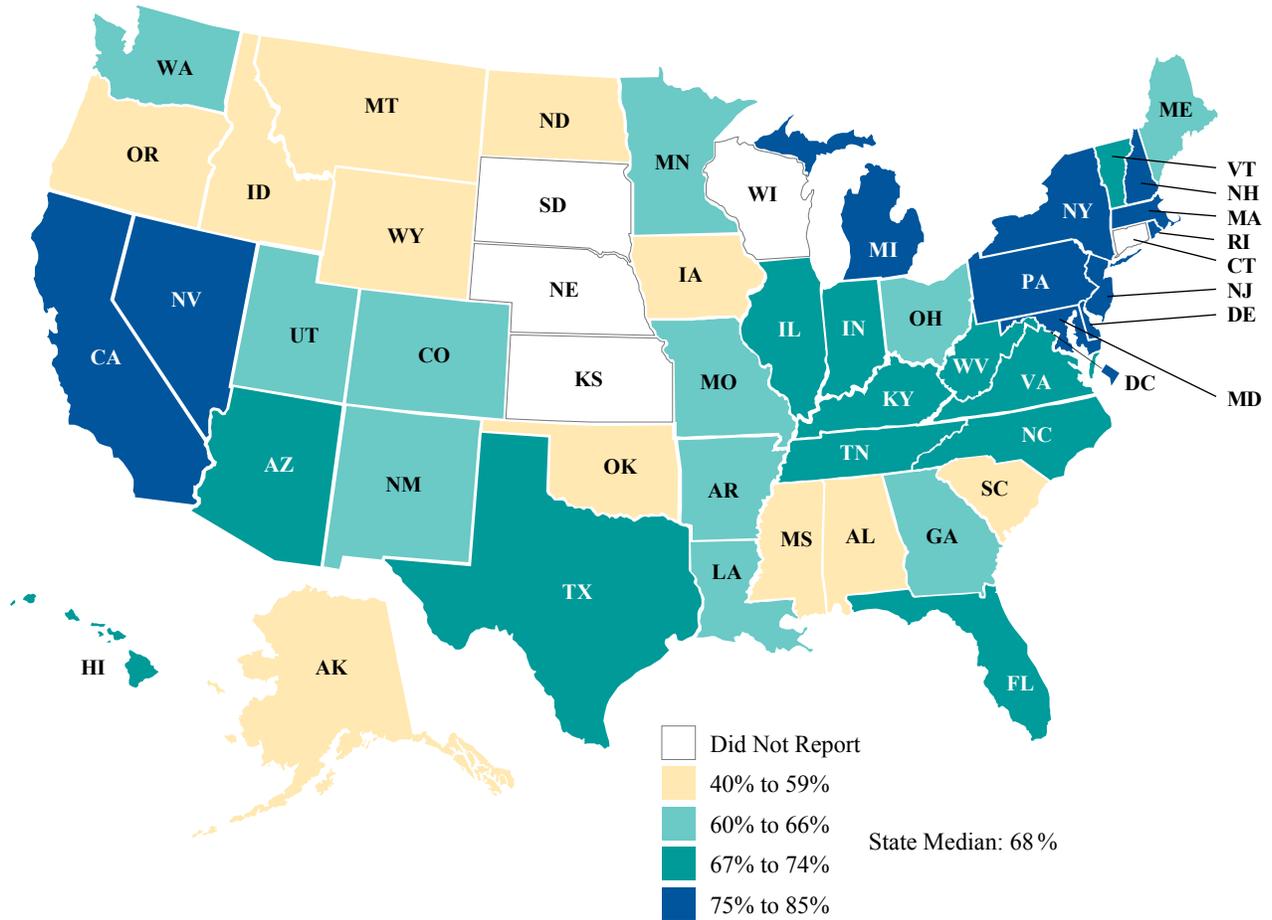
- Among the 37 states reporting the measure using Core Set specifications for all three years, the median rate increased by 3 percentage points from FFY 2010 to FFY 2012 (Exhibit W34.2).

Exhibit W34.2. Trends in the Percentage of Children Receiving At Least One Well-Child Visit in the Third, Fourth, Fifth, and Sixth Years of Life, FFY 2010–2012 (n = 37 states)

Rate	FFY 2010	FFY 2011	FFY 2012
Mean	63.8	66.6	66.9
Median	64.9	69.6	67.7
25th Percentile	58.9	61.5	62.2
75th Percentile	74.1	74.9	75.1

Source: Mathematica analysis of FFY 2010, 2011, and 2012 CARTS reports.

Exhibit W34.3. Geographic Variation in Percentage of Children Receiving At Least One Well-Child Visit in the Third, Fourth, Fifth, and Sixth Years of Life, FFY 2012 (n = 46 states)



Source: Mathematica analysis of FFY 2012 CARTS reports.

To view state-specific data for this measure, please see Table W34 at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2012.zip>.

ADOLESCENT WELL-CARE VISITS (AWC)
Measure Steward: National Committee for Quality Assurance (NCQA)

The American Academy of Pediatrics and Bright Futures recommend annual well-care visits during adolescence to promote healthy behaviors, prevent risky ones, and detect conditions that can interfere with a teen’s physical, social, and emotional development. Comprehensive well care includes a physical exam, immunizations, screening, developmental assessment, an oral health risk assessment, and referral for specialized care if necessary. Anticipatory guidance is tailored by age but, in general, covers such topics as physical growth and development, social and academic competence, emotional well-being, risk reduction, and violence and injury prevention. Additional Core Set measures reflect the clinical quality of these visits, including adolescent immunization status, Chlamydia screening among sexually active women, and assessment of body mass index.

Measure Description

- This measure shows the percentage of adolescents ages 12 to 21 that had at least one comprehensive well-care visit with a primary care practitioner or an obstetrical/gynecological practitioner during the measurement year.⁸

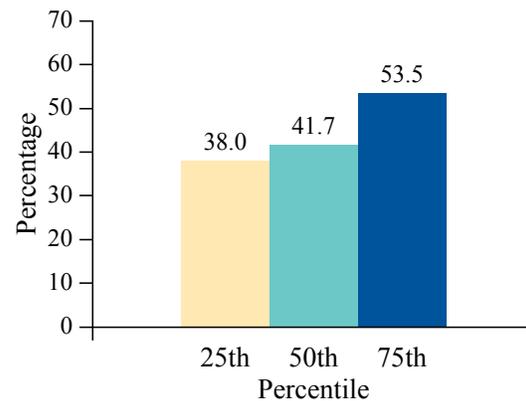
Overview of State Reporting

- The number of states reporting the Adolescent Well-Care Visits measure increased from 29 states for FFY 2010 to 43 states for FFY 2011 and remained at 43 states for FFY 2012.⁹
- Of the 43 states reporting the measure for FFY 2012, 32 states reported the measure for both their Medicaid and CHIP populations, 8 reported the measure for their CHIP population only, and 3 reported the measure for their Medicaid population only.
- In FFY 2012, all 43 states reported the measure using Core Set specifications.

State Performance

- The median rate among the 43 states reporting the measure for FFY 2012 was 42 percent, with a 16-point spread between the 25th and 75th percentiles (Exhibit AWC.1).
- Performance on this measure ranged from 24 percent to 67 percent among states, with considerable geographic variation across states (Exhibit AWC.3, next page).

Exhibit AWC.1. Percentage of Adolescents with a Well-Care Visit, FFY 2012 (n = 43 states)



Source: Mathematica analysis of FFY 2012 CARTS reports.

Trends

- Among the 27 states reporting the measure using Core Set specifications for all three years, the median rate remained at 46 between FFY 2010 and FFY 2012 (Exhibit AWC.2).

Exhibit AWC.2. Trends in the Percentage of Adolescents Ages 12 to 21 Receiving At Least One Well-Care Visit, FFY 2010–2012 (n = 27 states)

Rate	FFY 2010	FFY 2011	FFY 2012
Mean	46.1	45.9	46.8
Median	46.3	46.3	46.0
25th Percentile	37.3	37.5	39.6
75th Percentile	56.1	56.4	57.6

Source: Mathematica analysis of FFY 2010, 2011, and 2012 CARTS reports.

⁸ This measure is calculated using the administrative method (claims/encounter data) or the hybrid method (claims/encounter data combined with medical record review).

⁹ The term “states” includes the 50 states and District of Columbia.

CHILDHOOD IMMUNIZATION STATUS (CIS)
Measure Steward: National Committee for Quality Assurance (NCQA)

A key indicator of the continuity of primary care is whether children are up to date on their immunizations by age 2. The Centers for Disease Control and Prevention recommends the following immunizations by age 2: four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); two H influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines. The Childhood Immunization Status measure includes 10 rates for the individual vaccines and 9 combination rates. The most common combination rate reported by states is “Combination 3,” which includes all of the vaccines except HepA, RV, and flu. State performance is measured on the basis of the Combination 3 rate.

Measure Description

- This measure shows the percentage of children that turned 2 years old during the measurement year and had specific vaccines and combinations of vaccines by their second birthday. This measure is reported as 10 separate immunization rates and 9 combination rates. State performance is measured on the basis of Combination 3, as noted above.¹⁰

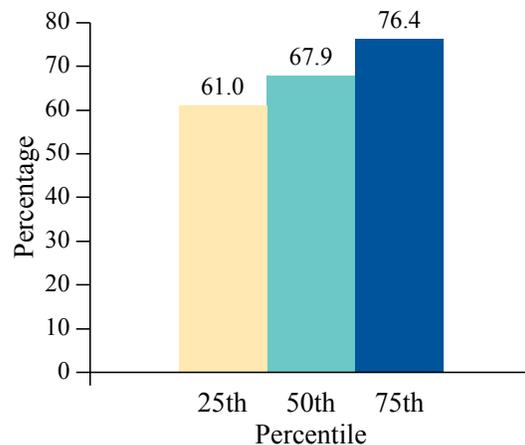
Overview of State Reporting

- The number of states reporting the Childhood Immunization Status measure increased from 20 states for FFY 2010 to 30 states for FFY 2011 to 34 states for FFY 2012.¹¹
- Of the 34 states reporting the measure for FFY 2012, 28 states reported the measure for both their Medicaid and CHIP populations, 5 reported the measure for their CHIP population only, and 1 reported the measure for their Medicaid population only.
- In FFY 2012, 33 states reported the measure using Core Set specifications (although 2 of these states did not report the Combination 3 rate for FFY 2012). One state used another specification.

State Performance

- The median Combination 3 rate among the 31 states using Core Set specifications to report the measure for FFY 2012 was 68 percent, with a 15-point spread between the 25th and 75th percentiles (Exhibit CIS.2, next page).
- Performance on this measure ranged from 4 percent to 92 percent among states, with considerable geographic variation across states (Exhibit CIS.2, next page).

Exhibit CIS.1. Percentage of Children Up to Date on Recommended Immunizations by their Second Birthday, FFY 2012 (n = 31 states)



Source: Mathematica analysis of FFY 2012 CARTS reports.

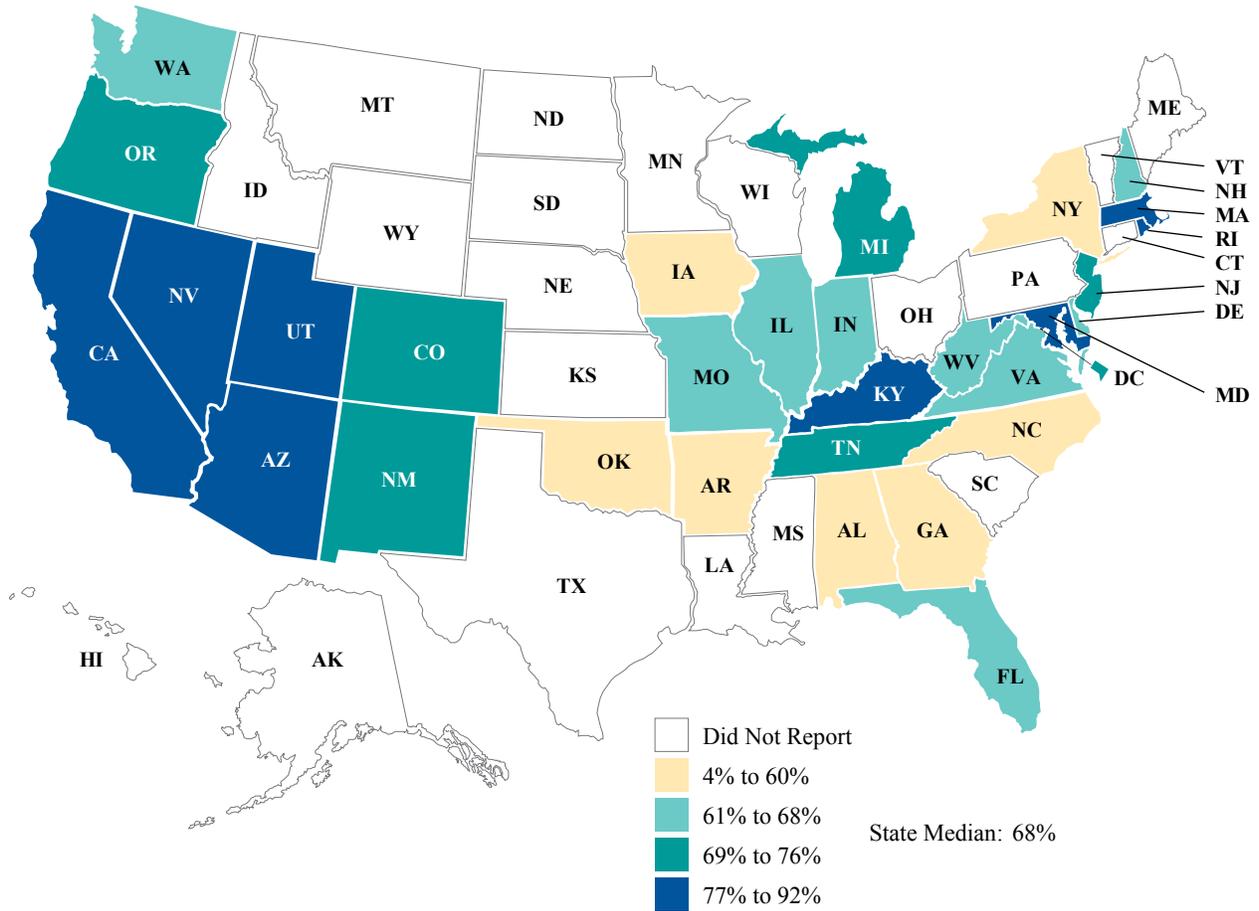
Trends

- Trends are not available for this measure. Trends are shown for measures reported by at least 20 states for all three years (FFY 2010 to FFY 2012); 17 states reported this measure for all three years.

¹⁰ This measure is calculated using the administrative method (claims/encounter or registry data) or the hybrid method (claims/encounter data combined with medical record review).

¹¹ The term “states” includes the 50 states and District of Columbia.

Exhibit CIS.2. Geographic Variation in the Percentage of Children Up to Date on Recommended Immunizations by their Second Birthday, FFY 2012 (n = 31 states)



Source: Mathematica analysis of FFY 2012 CARTS reports.

To view state-specific data for this measure, please see Table CIS at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2012.zip>.

ADOLESCENT IMMUNIZATION STATUS (IMA)
Measure Steward: National Committee for Quality Assurance (NCQA)

Recommended well care for adolescents includes reviewing their immunization history to ensure they are up to date on their vaccines. Between their 11th and 13th birthdays, adolescents should receive one dose of meningococcal vaccine and one tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine or one tetanus and diphtheria toxoids (Td) vaccine. Adolescents should also receive the 3-dose human papillomavirus (HPV) series, although the HPV vaccine is not captured in this quality measure. The Adolescent Immunization Status measure includes two rates for the individual vaccines and one combination rate. State performance is measured on the basis of the combination rate. An indicator of high-quality preventive care for adolescents is being up to date on these vaccines by their 13th birthday.

Measure Description

- This measure shows the percentage of adolescents that turned 13 years old during the measurement year and had one meningococcal and one Tdap or Td vaccine by their 13th birthday. This measure is reported as two separate immunization rates and one combination rate. State performance is measured on the basis of the combination rate.¹²

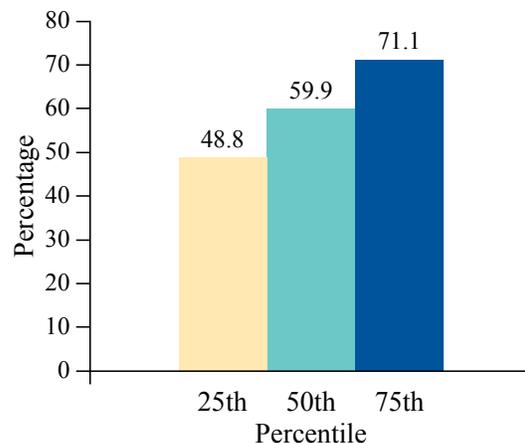
Overview of State Reporting

- The number of states reporting the Adolescent Immunization Status measure increased from 12 states for FFY 2010 to 25 states for FFY 2011 and 32 states for FFY 2012.¹³
- Of the 32 states reporting the measure for FFY 2012, 26 states reported the measure for both their Medicaid and CHIP populations, 4 reported the measure for their CHIP population only, and 2 reported the measure for their Medicaid population only.
- In FFY 2012, 30 states reported the measure using Core Set specifications (although one of these states did not report the combination rate for FFY 2012). One state used another specification.

State Performance

- The median combination rate among the 30 states using Core Set specifications to report the measure for FFY 2012 was 60 percent, with a 22-point spread between the 25th and 75th percentiles (Exhibit IMA.1).
- Performance on this measure ranged from 15 percent to 86 percent among states, with considerable geographic variation across states (Exhibit IMA.2, next page).

Exhibit IMA.1. Percentage of Adolescents Up to Date on Recommended Immunizations by their 13th Birthday, FFY 2012 (n = 30 states)



Source: Mathematica analysis of FFY 2012 CARTS reports.

Trends

- Trends are not available for this measure. Trends are shown for measures reported by at least 20 states for all three years (FFY 2010 to FFY 2012); 10 states reported this measure for all three years.

¹² This measure is calculated using the administrative method (claims/encounter or registry data) or the hybrid method (claims/encounter data combined with medical record review).

¹³ The term “states” includes the 50 states and District of Columbia.

CHLAMYDIA SCREENING (CHL)
Measure Steward: National Committee for Quality Assurance (NCQA)

Recommended well care for adolescents includes annual screening for Chlamydia for women who are sexually active. Chlamydia is the most commonly reported sexually transmitted infection and easy to cure when it is detected. However, most people have no symptoms and are not aware they are infected. Left untreated, Chlamydia can affect a woman’s ability to have children. This measure is an indicator of the clinical quality of care for adolescents.

Measure Description

- This measure shows the percentage of women ages 16 to 20 that were identified as sexually active and had at least one Chlamydia test during the measurement year.¹⁴

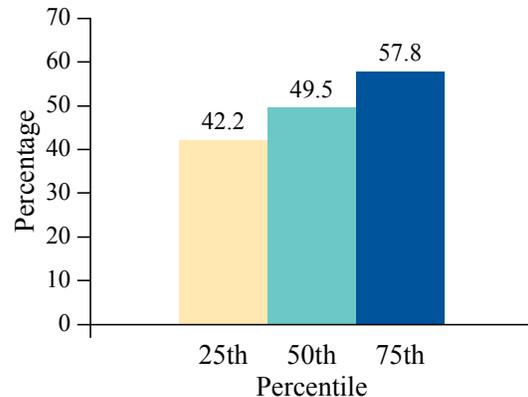
Overview of State Reporting

- The number of states reporting the Chlamydia Screening measure increased from 21 states for FFY 2010 to 32 states for FFY 2011 and 35 states for FFY 2012.¹⁵
- Of the 35 states reporting the measure for FFY 2012, 25 states reported the measure for both their Medicaid and CHIP populations, 5 reported the measure for their CHIP population only, and 5 reported the measure for their Medicaid population only.
- In FFY 2012, all 35 states reported the measure using Core Set specifications.

State Performance

- The median rate among the 35 states reporting the measure for FFY 2012 was 50 percent, with a 16-point spread between the 25th and 75th percentiles (Exhibit CHL.1).
- Performance on this measure ranged from 5 percent to 69 percent among states, with considerable geographic variation across states (Exhibit CHL.3, next page).

Exhibit CHL.1. Percentage of Sexually Active Women Ages 16 to 20 Receiving At Least One Test for Chlamydia, FFY 2012 (n = 35 states)



Source: Mathematica analysis of FFY 2012 CARTS reports.

Trends

- Among the 20 states reporting the measure using Core Set specifications for all three years, the median rate increased by 5 percentage points from FFY 2010 to FFY 2012 (Exhibit CHL.2).

Exhibit CHL.2. Trends in the Percentage of Sexually Active Women Ages 16 to 20 Receiving At Least One Test for Chlamydia, FFY 2010–2012 (n = 20 states)

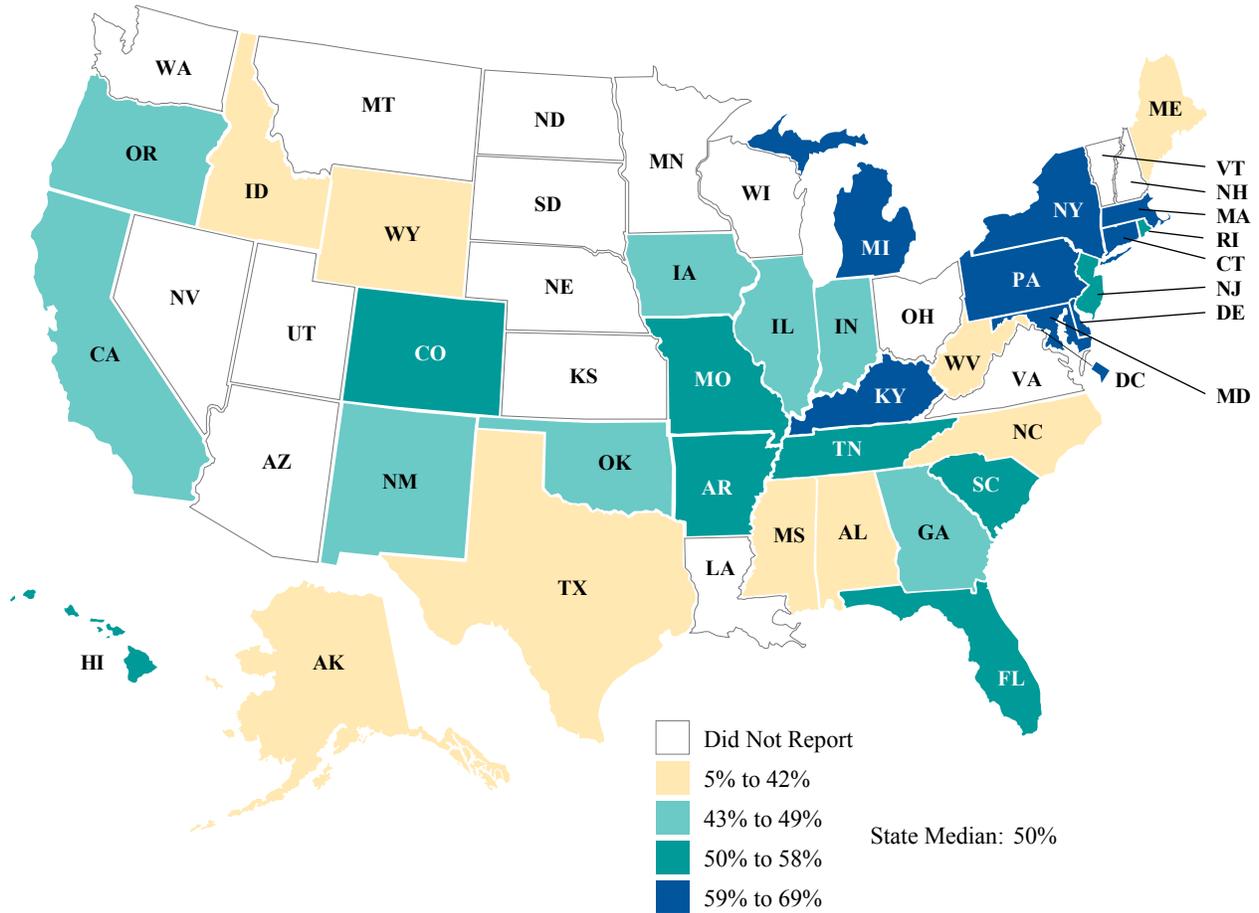
Rate	FFY 2010	FFY 2011	FFY 2012
Mean	41.7	46.1	46.7
Median	44.0	48.4	49.4
25th Percentile	25.1	39.6	39.0
75th Percentile	58.7	59.0	57.2

Source: Mathematica analysis of FFY 2010, 2011, and 2012 CARTS reports.

¹⁴ This measure is calculated using the administrative method (claims/encounter data).

¹⁵ The term “states” includes the 50 states and District of Columbia.

Exhibit CHL.3. Geographic Variation in the Percentage of Sexually Active Women Ages 16 to 20 Receiving At Least One Test for Chlamydia, FFY 2012 (n = 35 states)



Source: Mathematica analysis of FFY 2012 CARTS reports.

To view state-specific data for this measure, please see Table CHL at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2012.zip>.

BODY MASS INDEX ASSESSMENT FOR CHILDREN AND ADOLESCENTS (WCC)
Measure Steward: National Committee for Quality Assurance (NCQA)

Overweight and obesity in childhood pose serious short- and long-term health risks, including higher incidence of chronic diseases (such as high blood pressure, high cholesterol, diabetes, and asthma) and a higher risk of social and emotional problems (such as low self-esteem). Overweight and obesity are frequently assessed based on the child's body mass index (BMI). BMI is calculated based on a child's height and weight, adjusting for age and gender. Primary care practitioners can play an important role in detecting and addressing overweight and obesity among children by assessing their BMI. This measure indicates the frequency with which the BMI percentile is recorded in the medical record.

Measure Description

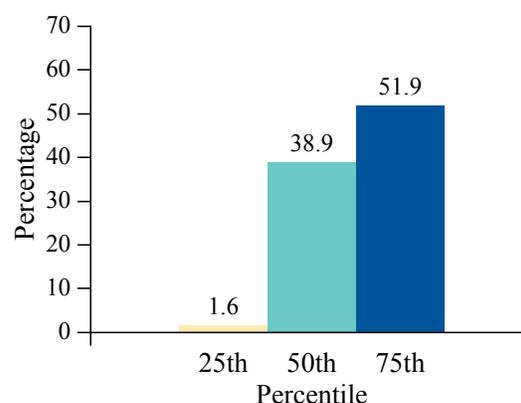
- This measure shows the percentage of children ages 3 to 17 that had an outpatient visit with a primary care practitioner or obstetrical/gynecological provider and whose weight is classified based on BMI percentile for age and gender.¹⁶

- The 15 states using the hybrid method had a median of 45 percent, whereas the 12 states using the administrative method had a median of 2 percent. Assessment of the BMI percentile is more likely to be noted in medical records than in claims/encounter data.

Overview of State Reporting

- The number of states reporting the BMI Assessment for Children and Adolescents measure increased from 10 states for FFY 2010 to 18 states for FFY 2011 and 27 states for FFY 2012.¹⁷
- Of the 27 states reporting the measure for FFY 2012, 21 states reported the measure for both their Medicaid and CHIP populations, 3 reported the measure for their CHIP population only, and 3 reported the measure for their Medicaid population only.
- All 27 states reported the measure using Core Set specifications for FFY 2012.

Exhibit WCC.1. Percentage of Children Whose Weight is Classified Based on BMI Percentile, FFY 2012 (n = 27 states)



Source: Mathematica analysis of FFY 2012 CARTS reports.

State Performance

- The median rate among the 27 states reporting the measure for FFY 2012 was 39 percent, with a 50-point spread between the 25th and 75th percentiles (Exhibit WCC.1).
- Performance on this measure ranged from 0.1 percent to 89 percent, with considerable geographic variation across states (Exhibit WCC.2, next page).

Trends

- Trends are not available for this measure. Trends are shown for measures reported by at least 20 states for all three years (FFY 2010 to FFY 2012); 10 states reported this measure for all three years.

¹⁶ This measure is calculated using the administrative method (claims/encounter data) or the hybrid method (claims/encounter data combined with medical record review).

¹⁷ The term "states" includes the 50 states and District of Columbia.

PERINATAL HEALTH

Two out of every three women enrolled in Medicaid are in their reproductive years (ages 19 to 44) and Medicaid currently finances about 45 percent of all births in the United States. CMS has a major role to play in improving maternity care and birth outcomes, and measuring how care is delivered to pregnant and postpartum women. Despite improvements in access to coverage and care, the rate of preterm births among low-income women enrolled in Medicaid is higher than the rate for all other women (11.9 percent vs. 8.7 percent).¹⁸

CMS launched two national initiatives in 2012 to help improve perinatal outcomes among Medicaid/CHIP and other payers. One initiative, Strong Start for Mothers and Newborns, which is led by the CMS Innovation Center, includes two primary strategies: (1) testing ways to encourage best practices for reducing the number of early elective deliveries that lack medical indication, across all payer types; and (2) a grant initiative to test and evaluate four models of enhanced prenatal care for reducing preterm births and decreasing the anticipated total cost of medical care during pregnancy, delivery, and the first year of life among women and infants covered by Medicaid/CHIP. In February 2013, CMS awarded grants to 27 recipients to support the testing of enhanced prenatal care through three approaches: (1) group or centering visits, (2) at birth centers, and (3) at maternity care homes.¹⁹ Projects are located in 32 states, the District of Columbia, and Puerto Rico, and will serve more than 80,000 women enrolled in Medicaid or CHIP over a three-year period.

The second initiative, the Expert Panel on Improving Maternal and Infant Outcomes in Medicaid and CHIP (Expert Panel), was launched in June 2012 to explore policy and reimbursement opportunities for Medicaid programs to provide better care, improve birth outcomes, and reduce health care costs for mothers and infants. In August 2013, the Expert Panel presented strategies for CMS leadership to consider as it develops implementation plans to improve birth outcomes. The strategies were selected based on potential impact, available resources, and partnership opportunities.

To support its maternity-focused efforts, CMS identified a core set of eight Medicaid/CHIP maternity measures for voluntary reporting by states. This core set, which consists of five of CMS's Child Core measures and three of the Adult Core Set measures, will be used by CMS to measure progress toward improvement and evaluate efforts.²⁰

The two Child Core Set measures included in this section are those for which information is available from at least 25 states for the FFY 2012 reporting year. The measures are as follows:

1. Timeliness of Prenatal Care
2. Frequency of Ongoing Prenatal Care

These measures, along with the measure assessing children's receipt of well-child visits in the first 15 months of life (discussed in the previous section), are three of the five Child Core Set measures that are part of CMS's Maternity Core Set.

¹⁸ CDC, PRAMS 2008. Infants born preterm (that is, at less than 37 weeks of gestation) are at higher risk of developmental problems and health problems than infants born at full term. Substantial medical and societal costs are also associated with preterm births.

¹⁹ The fourth model, home visiting implemented by the Health Resources and Services Administration (HRSA), will be evaluated along with the other three enhanced models of care.

²⁰ The CMS Medicaid/CHIP Maternity Core Set is available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2013-Core-Set-of-Maternity-Measures.pdf>.

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TIMELINESS OF PRENATAL CARE (PPC)
 Measure Steward: National Committee for Quality Assurance (NCQA)

Initiation of prenatal care during the first trimester of pregnancy facilitates a comprehensive assessment of a woman’s health history, pregnancy risk, and health knowledge. Early screening and referrals for specialized care can prevent pregnancy complications resulting from pre-existing health conditions (such as diabetes and high blood pressure) or promote access to recommended care (such as immunizations and oral health services). Moreover, health education and counseling related to having a healthy pregnancy can encourage healthy behaviors (such as healthy eating and weight gain) and reduce risky behaviors (such as tobacco, alcohol and other drug use). This measure indicates how often Medicaid/CHIP enrollees receive timely prenatal care (that is, in the first trimester or within 42 days of Medicaid/CHIP enrollment).

Measure Description

- This measure shows the percentage of deliveries of live births that received a prenatal care visit in the first trimester or within 42 days of Medicaid/CHIP enrollment.²¹

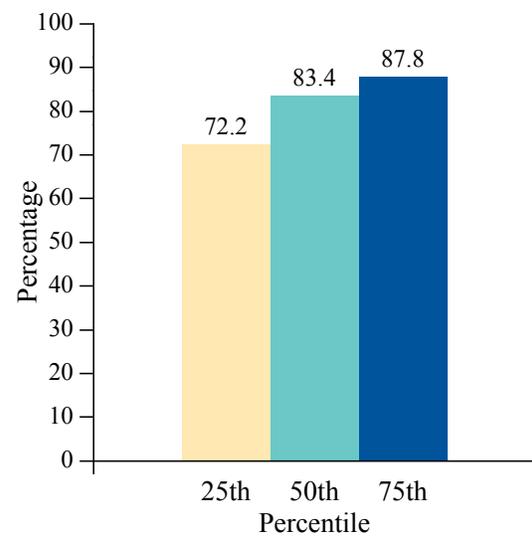
Overview of State Reporting

- The number of states reporting the Timeliness of Prenatal Care measure increased from 15 states for FFY 2010 to 24 states for FFY 2011 and 31 states for FFY 2012.²²
- Of the 31 states reporting the measure for FFY 2012, 20 states reported the measure for both their Medicaid and CHIP populations, 9 reported the measure for their Medicaid population only, and 2 reported the measure for their CHIP population only.
- In FFY 2012, 31 states reported the measure using Core Set specifications.

State Performance

- The median rate among the 31 states reporting the measure for FFY 2012 was 83 percent, with a 16-point spread between the 25th and 75th percentiles (Exhibit PPC.1).
- Performance on this measure ranged from 30 percent to 92 percent among states, with considerable geographic variation across states (Exhibit PPC.2, next page).

Exhibit PPC.1. Percentage of Pregnant Women with a Prenatal Care Visit in the First Trimester or within 42 Days of Medicaid/CHIP Enrollment, FFY 2012 (n = 31 states)



Source: Mathematica analysis of FFY 2012 CARTS reports.

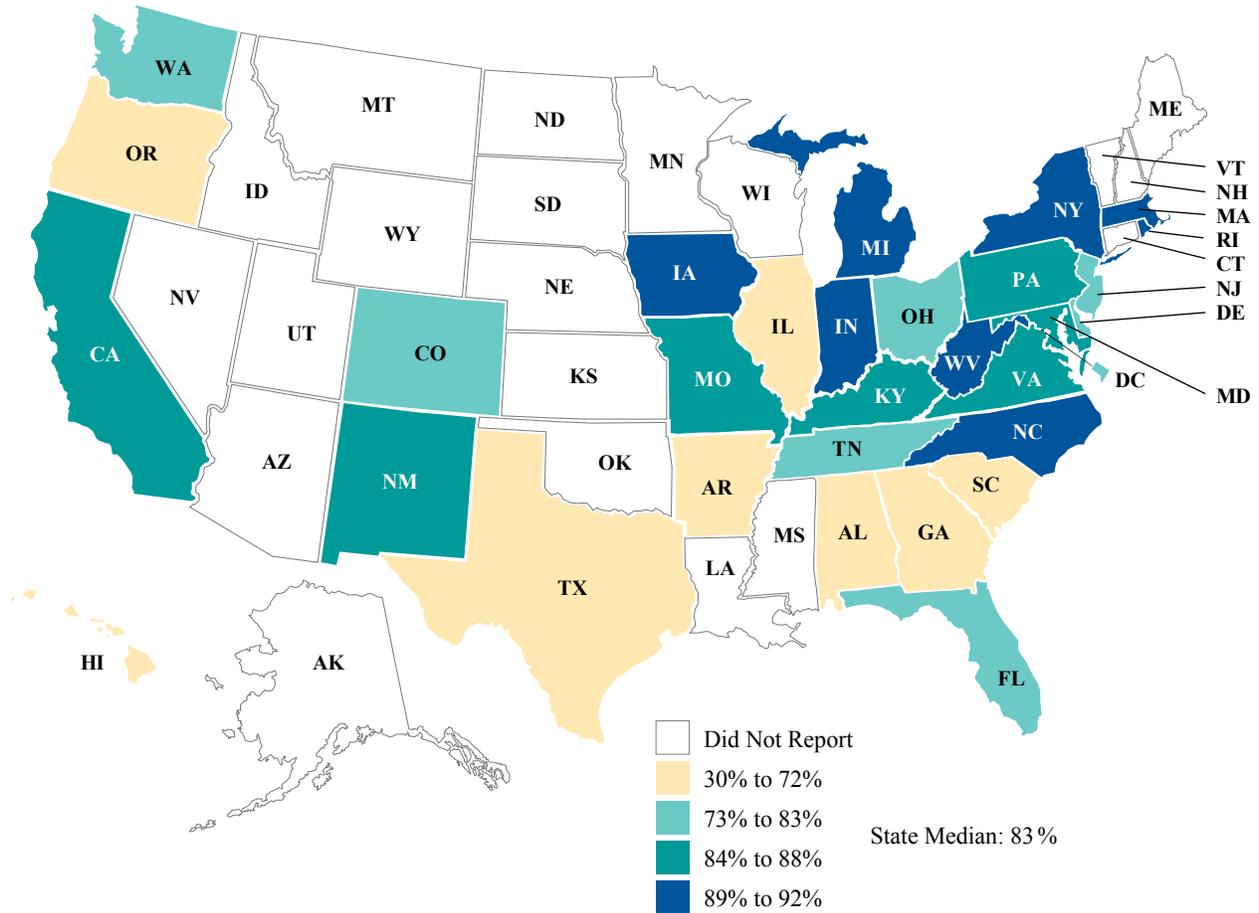
Trends

- Trends are not available for this measure. Trends are shown for measures reported by at least 20 states for all three years (FFY 2010 to FFY 2012); 13 states reported this measure for all three years.

²¹ This measure is calculated using the administrative method (claims/encounter data) or the hybrid method (claims/encounter data combined with medical record review).

²² The term “states” includes the 50 states and District of Columbia.

Exhibit PPC.2. Geographic Variation in the Percentage of Pregnant Women with a Prenatal Care Visit in the First Trimester or within 42 Days of Medicaid/CHIP Enrollment, FFY 2012 (n = 31 states)



Source: Mathematica analysis of FFY 2012 CARTS reports.

To view state-specific data for this measure, please see Table PPC at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2012.zip>.

FREQUENCY OF ONGOING PRENATAL CARE (FPC)
Measure Steward: National Committee for Quality Assurance (NCQA)

Ongoing prenatal care enables prenatal care providers to make periodic assessments of a woman’s pregnancy risk and health status, perform recommended screenings and laboratory tests, and provide timely referrals for specialized care. Through regular, ongoing prenatal care, women can develop trusted relationships with their prenatal care providers, facilitating meaningful opportunities for health education and counseling targeted to a woman’s circumstances and stage of pregnancy. Regular prenatal care enables providers to promote positive maternal and infant health outcomes by addressing a wide range of women’s health, social, and emotional issues. The Core Set measure focuses on the extent to which women had more than 80 percent of the expected prenatal care visits.

Measure Description

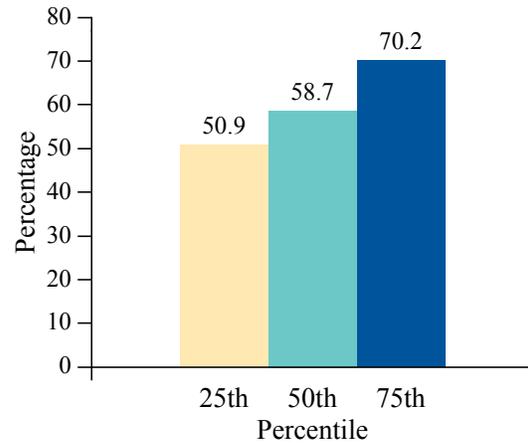
- This measure shows the percentage of deliveries that received the following number of expected prenatal visits:
 - < 21 percent of expected visits
 - 21 percent – 40 percent of expected visits
 - 41 percent – 60 percent of expected visits
 - 61 percent – 80 percent of expected visits
 - > 80 percent of expected visits.²³

- Performance on this measure ranged from 2 percent to 79 percent among states, with considerable geographic variation across states (Exhibit FPC.2, next page).

Overview of State Reporting

- The number of states reporting the Frequency of Ongoing Prenatal Care measure increased from 12 states for FFY 2010 to 17 states for FFY 2011 and 25 states for FFY 2012.²⁴
- Of the 25 states reporting the measure for FFY 2012, 17 states reported the measure for both their Medicaid and CHIP populations, 6 reported the measure for their Medicaid population only, and 2 reported the measure for their CHIP population only.
- In FFY 2012, 25 states reported the measure using Core Set specifications.

Exhibit FPC.1. Percentage of Pregnant Women Receiving More Than 80 Percent of the Expected Number of Prenatal Care Visits, FFY 2012 (n = 25 states)



Source: Mathematica analysis of FFY 2012 CARTS reports.

State Performance

- The median rate among the 25 states reporting the measure for FFY 2012 was 59 percent, with a 19-point spread between the 25th and 75th percentiles (Exhibit FPC.1).

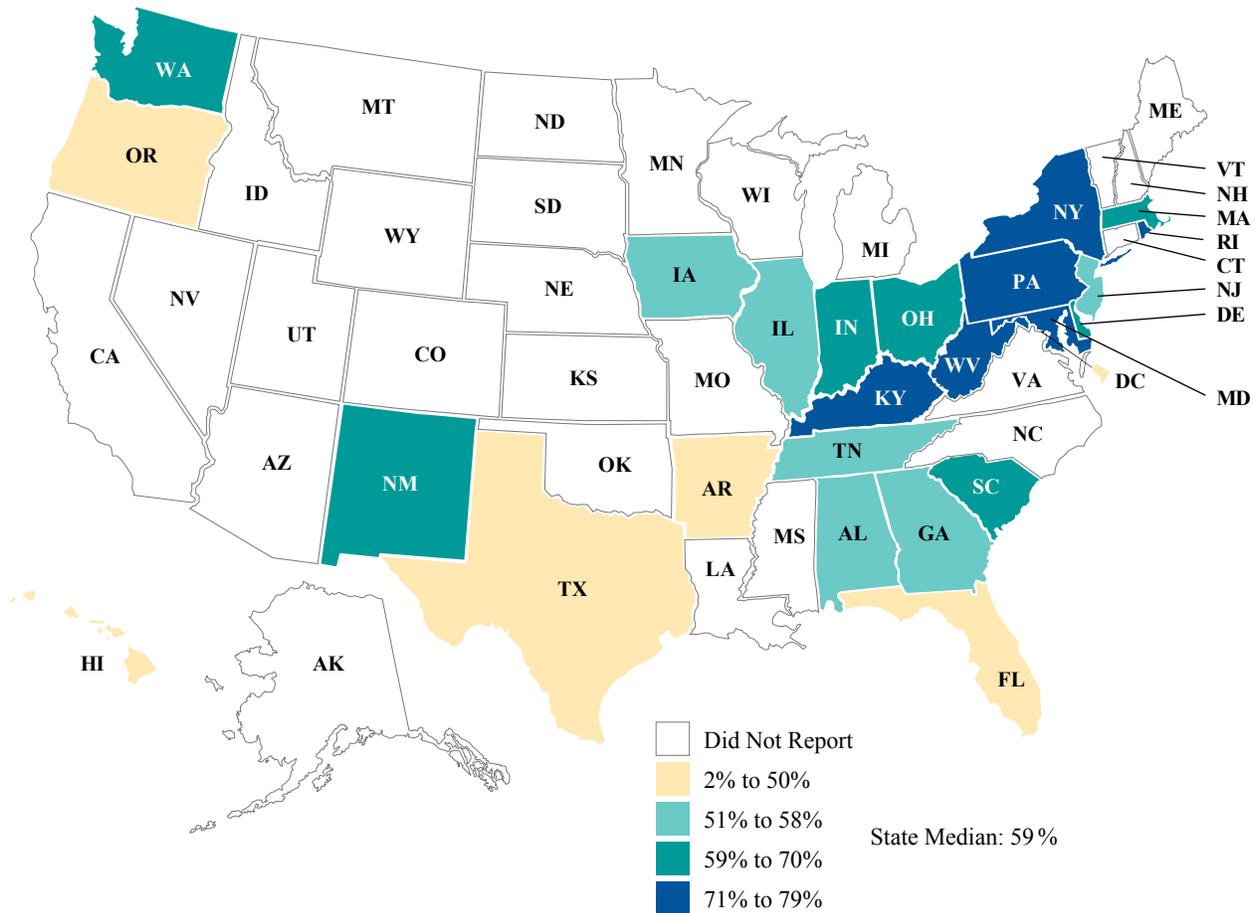
Trends

- Trends are not available for this measure. Trends are shown for measures reported by at least 20 states for all three years (FFY 2010 to FFY 2012); 10 states reported the measure for all three years.

²³ This measure is calculated using the administrative method (claims/encounter data) or the hybrid method (claims/encounter data combined with medical record review).

²⁴ The term “states” includes the 50 states and District of Columbia.

Exhibit FPC.2. Geographic Variation in the Percentage of Pregnant Women Receiving More Than 80 Percent of the Expected Number of Prenatal Care Visits, FFY 2012 (n = 25 states)



Source: Mathematica analysis of FFY 2012 CARTS reports.

To view state-specific data for this measure, please see Table FPC at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2012.zip>.

MANAGEMENT OF ACUTE AND CHRONIC CONDITIONS

The extent to which children receive safe, timely, and effective care is a key indicator of the quality of care provided in Medicaid and CHIP. Children covered by Medicaid have higher rates of physical, developmental, and intellectual health problems than privately insured children. Therefore, ensuring early detection and effective treatment will reduce the need for more costly care later and improve children's chances of leading healthy, productive lives.

Through Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, children and adolescents under age 21 are entitled to receive treatment for Medicaid-covered services listed in Section 1905(a) of the Social Security Act if that treatment or service is necessary to "correct or ameliorate" a physical or mental condition.²⁵ Children enrolled in CHIP Medicaid expansion programs are also entitled to this benefit.

CMS has efforts under way to improve children's access to and use of medically necessary care. For example:

- The CHIPRA-funded, multistate Quality Demonstration Grants include efforts to evaluate provider-based models of care, use of electronic health record systems, and integration of physical and behavioral health services.²⁶
- A Health Home provision, authorized by Section 2703 of the Affordable Care Act, gives states two years of an enhanced match to improve care coordination for children and adults with multiple chronic conditions (such as asthma, obesity, and substance use disorder).
- Two recently released informational bulletins provide guidance on (1) coverage of behavioral health services for children with mental health and substance abuse problems, and (2) promotion of trauma-informed services for children.²⁷

To support these efforts, CMS has identified several Child Core Set measures to track performance on getting children the "right care in the right setting at the right time." The four Child Core Set measures included in this section are those for which information is available from at least 25 states for the FFY 2012 reporting year:

1. Appropriate Testing for Children with Pharyngitis
2. Follow-Up After Hospitalization for Mental Illness
3. Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication
4. Pediatric Central Line-Associated Blood Stream Infections in Neonatal Intensive Care Units

²⁵ Section 1905(a)(r)(5).

²⁶ See <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/CHIPRA-Quality-Demonstration-Grants-Summary.html>.

²⁷ See <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf> and <http://medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf>.

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APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS (CWP)
 Measure Steward: National Committee for Quality Assurance (NCQA)

Appropriate administration of a strep test for pharyngitis (sore throat) among children dispensed an antibiotic is an indicator of clinical quality in the delivery of primary care for children. A strep test is required to assess whether a sore throat is caused by a viral rather than a bacterial infection. Antibiotics should be prescribed only for sore throats caused by bacterial infections, and most sore throats in children are caused by viruses. Concerns about overuse of antibiotics and development of antibiotic resistance have led to increased emphasis on conducting a strep test before an antibiotic is prescribed. Therefore, this measure assesses whether providers performed a strep test among children diagnosed with a sore throat and dispensed an antibiotic.

Measure Description

- This measure shows the percentage of children ages 2 to 18 that were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode.²⁸

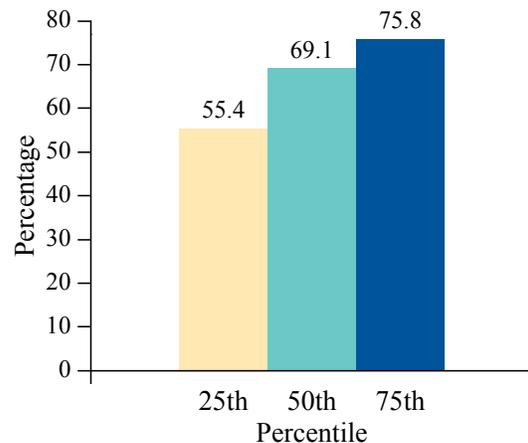
Overview of State Reporting

- The number of states reporting the Appropriate Testing for Children with Pharyngitis measure increased from 20 states for FFY 2010 to 28 states for FFY 2011 and 36 states for FFY 2012.²⁹
- Of the 36 states reporting the measure for FFY 2012, 24 states reported the measure for both their Medicaid and CHIP populations, 9 reported the measure for their CHIP population only, and 3 reported the measure for their Medicaid population only.
- In FFY 2012, all 36 states reported the measure using Core Set specifications.

State Performance

- The median rate among the 36 states reporting the measure for FFY 2012 was 69 percent, with a 20-point spread between the 25th and 75th percentiles (Exhibit CWP.1).
- Performance on this measure ranged from 17 percent to 91 percent among states, with considerable geographic variation across states (Exhibit CWP.3, next page).

Exhibit CWP.1. Percentage of Children Diagnosed with Pharyngitis, Dispensed an Antibiotic, and Received a Group A Streptococcus Test, FFY 2012 (n = 36 states)



Source: Mathematica analysis of FFY 2012 CARTS reports.

Trends

- Among the 20 states reporting the measure using Core Set specifications for all three years, the median rate for Medicaid/CHIP programs increased by 5 percentage points from FFY 2010 to FFY 2012 (Exhibit CWP.2).

Exhibit CWP.2. Trends in the Percentage of Children Diagnosed with Pharyngitis, Dispensed an Antibiotic, and Received a Group A Streptococcus Test, FFY 2010–2012 (n = 20 states)

Rate	FFY 2010	FFY 2011	FFY 2012
Mean	62.7	62.9	66.9
Median	65.6	65.3	70.8
25th Percentile	55.5	55.8	58.8
75th Percentile	72.8	72.8	78.0

Source: Mathematica analysis of FFY 2010, 2011, and 2012 CARTS reports.

²⁸ This measure is calculated using the administrative method (claims/encounter data).

²⁹ The term “states” includes the 50 states and District of Columbia.

FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS (FUH)
Measure Steward: National Committee for Quality Assurance (NCQA)

After a child receives inpatient treatment for mental illness, follow-up outpatient mental health treatment is necessary to manage medications, continue therapy, facilitate transitions to home and school, and generally prevent readmissions due to the lack of continuous care. The first visit with an outpatient mental health provider should take place within 30 days of discharge and ideally, within 7 days of discharge. This measure is an indicator of the coordination of care across settings (inpatient and outpatient) for children with behavioral health conditions.

Measure Description

- This measure shows the percentage of discharges for children ages 6 to 20 hospitalized for treatment of selected mental health disorders who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge and within 30 days of discharge.³⁰

Overview of State Reporting

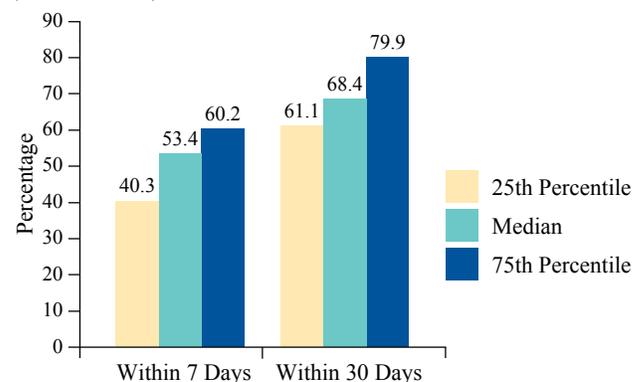
- The number of states reporting the Follow-Up After Hospitalization for Mental Illness measure increased from 11 states for FFY 2010 to 24 states for FFY 2011 and 27 states for FFY 2012.³¹
- Of the 27 states reporting the measure for FFY 2012, 21 states reported the measure for both their Medicaid and CHIP populations, 5 reported the measure for their CHIP population only, and 1 reported the measure for their Medicaid population only.
- In FFY 2012, 27 states reported the measure using Core Set specifications.

State Performance

- The median rate among the 27 states reporting the measure for FFY 2012 was 68 percent for a follow-up visit within 30 days of discharge (with a 19-point spread between the 25th and 75th percentiles). The median rate for a follow-up visit within 7 days of discharge was 53 percent (with a 20-point spread) (Exhibit FUH.1).

- Performance on the 7-day follow-up visit measure ranged from 7 percent to 80 percent among state and from 16 percent to 94 percent for the 7-day follow-up visit measure, with considerable geographic variation across states (Exhibits FUH.2 and FUH.3, next page).
- Although the Child Core Set measure is specified to include discharges for children ages 6 to 20, 9 of the 27 states reporting this measure for FFY 2012 noted that their rates are not limited to children and include individuals over age 20.³²

Exhibit FUH.1. Percentage of Discharges for Mental Illness for Children Ages 6 to 20 Receiving a Follow-Up Visit within 7 and 30 Days of Discharge, FFY 2012 (n = 27 states)



Source: Mathematica analysis of FFY 2012 CARTS reports.

Trends

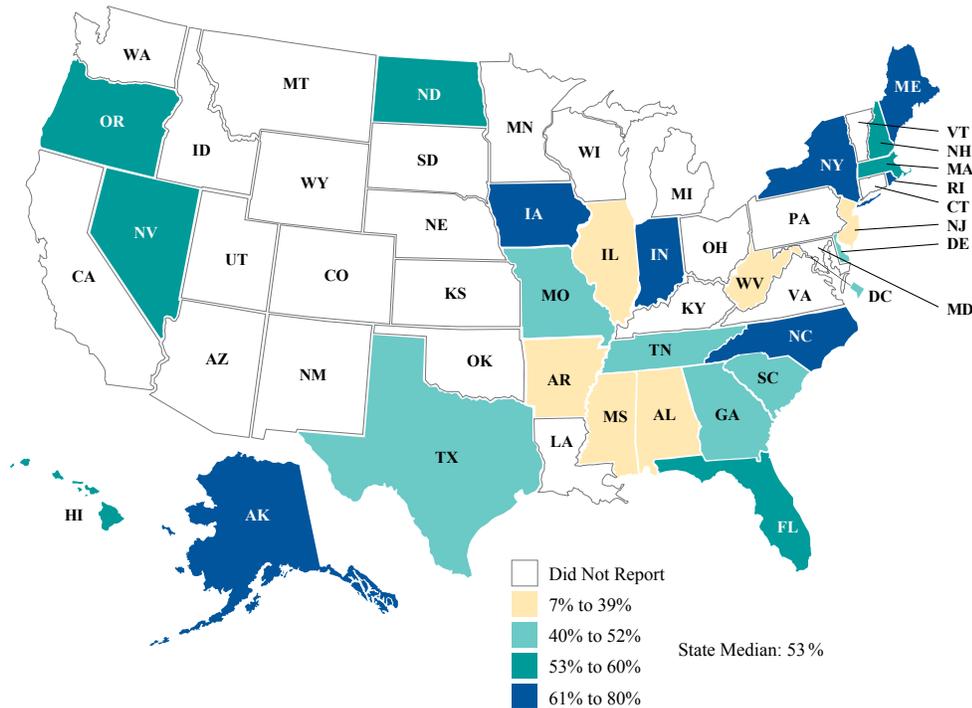
- Trends are not available for this measure. Trends are shown for measures reported by at least 20 states for all three years (FFY 2010 to FFY 2012); 7 states reported this measure for all three years.

³⁰ This measure is calculated using the administrative method (claims/encounter data).

³¹ The term “states” includes the 50 states and District of Columbia.

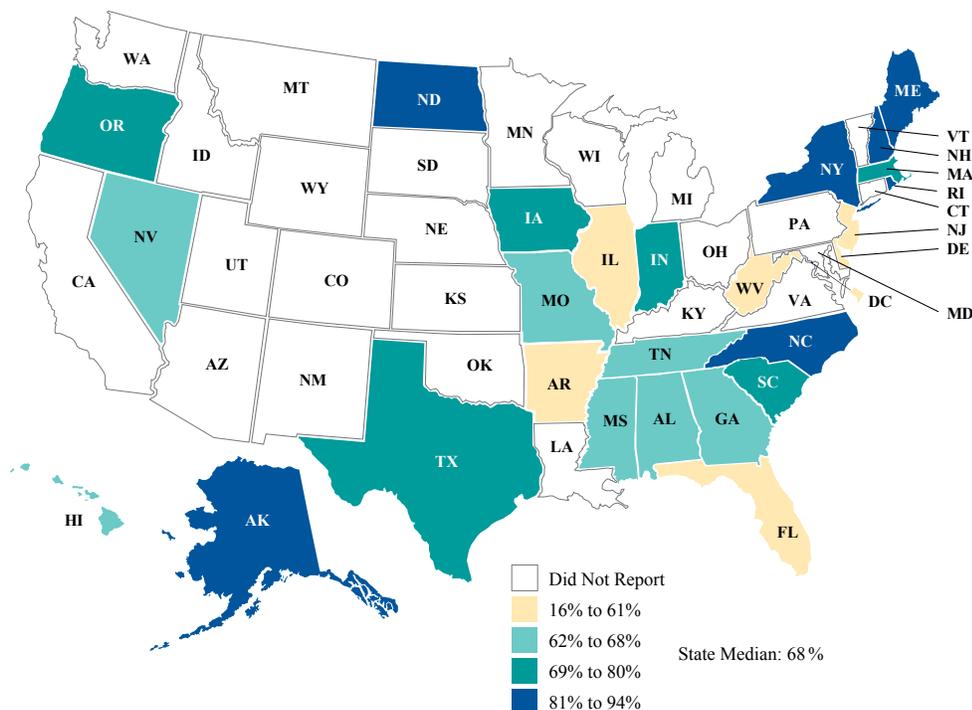
³² The HEDIS measure, on which the Core Set measure is based, includes individuals 6 years of age and over and does not disaggregate this measure for children ages 6 to 20.

Exhibit FUH.2. Geographic Variation in the Percentage of Discharges for Mental Illness for Children Ages 6 to 20 Receiving a Follow-Up Visit within 7 Days of Discharge, FFY 2012 (n = 27 states)



Source: Mathematica analysis of FFY 2012 CARTS reports.

Exhibit FUH.3. Geographic Variation in the Percentage of Discharges for Mental Illness for Children Ages 6 to 20 Receiving a Follow-Up Visit within 30 Days of Discharge, FFY 2012 (n = 27 states)



Source: Mathematica analysis of FFY 2012 CARTS reports.

To view state-specific data for this measure, please see Table FUH at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2012.zip>.

FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ATTENTION-DEFICIT/HYPERACTIVITY DISORDER MEDICATION (ADD)

Measure Steward: National Committee for Quality Assurance (NCQA)

Attention-deficit/hyperactivity disorder (ADHD) is a common chronic condition among school-age children, associated with academic, behavior, and relationship problems, and often treated with medication to improve children’s functioning. Among those newly prescribed an ADHD medication, clinical guidelines recommend a follow-up visit within the first 30 days (the Initiation Phase) for medication management. Among those remaining on ADHD medication, two additional visits are recommended during the 9-month Continuation and Maintenance (C&M) Phase for ongoing medication management and assessment of the child’s functioning. This measure shows the clinical quality and continuity of care for children with a chronic condition.

Measure Description

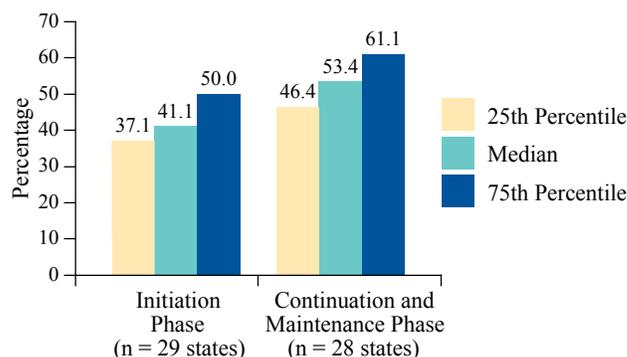
- This measure shows the percentage of children newly prescribed ADHD medication that had at least three follow-up visits within a 10-month period, one of which was within 30 days from the time the first ADHD medication was dispensed. Two rates are reported: one for the Initiation Phase and one for the C&M Phase.³³

- Performance on this measure ranged from 18 percent to 66 percent among states for the Initiation Phase and from 5 percent to 100 percent for the C&M Phase, with considerable geographic variation across states (Exhibit ADD.2, next page).

Overview of State Reporting

- The number of states reporting the Follow-Up Care for Children Prescribed ADHD Medication measure increased from 15 states for FFY 2010 to 24 states for FFY 2011 and 29 states for FFY 2012.³⁴
- Of the 29 states reporting the measure for FFY 2012, 23 states reported the measure for both their Medicaid and CHIP populations, 4 reported the measure for their CHIP population only, and 2 reported the measure for their Medicaid population only.
- In FFY 2012, all 29 states reported the measure using Core Set specifications (although one of these states did not report a rate for the C&M Phase).

Exhibit ADD.1. Percentage of Children Prescribed Medication for ADHD that Received At Least One Visit during the 30-Day Initiation Phase and At Least Two Visits during the 9-Month Continuation and Maintenance Phase, FFY 2012



Source: Mathematica analysis of FFY 2012 CARTS reports.

State Performance

- The median rate among the states reporting the measure for FFY 2012 was 41 percent for the Initiation Phase (29 states) and 53 percent for the C&M Phase (28 states), with a 13- and 15-point spread between the 25th and 75th percentiles (Exhibit ADD.1).³⁵

Trends

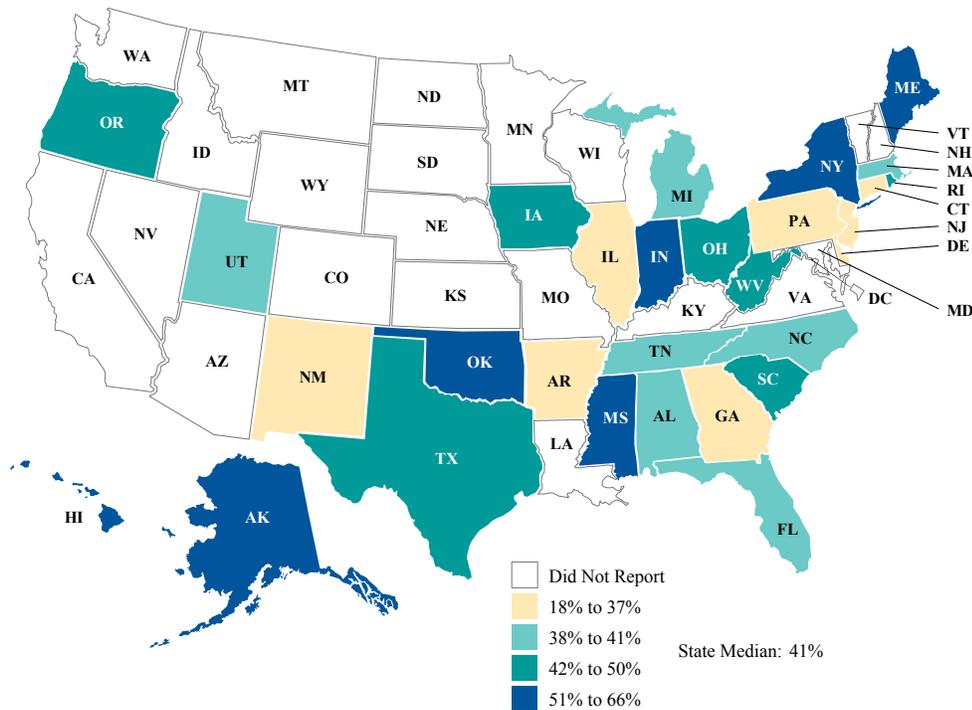
- Trends are not available for this measure. Trends are shown for measures reported by at least 20 states for all three years (FFY 2010 to FFY 2012); 15 states reported this measure for all three years.

³³ This measure is calculated using the administrative method (claims/encounter data).

³⁴ The term “states” includes the 50 states and District of Columbia.

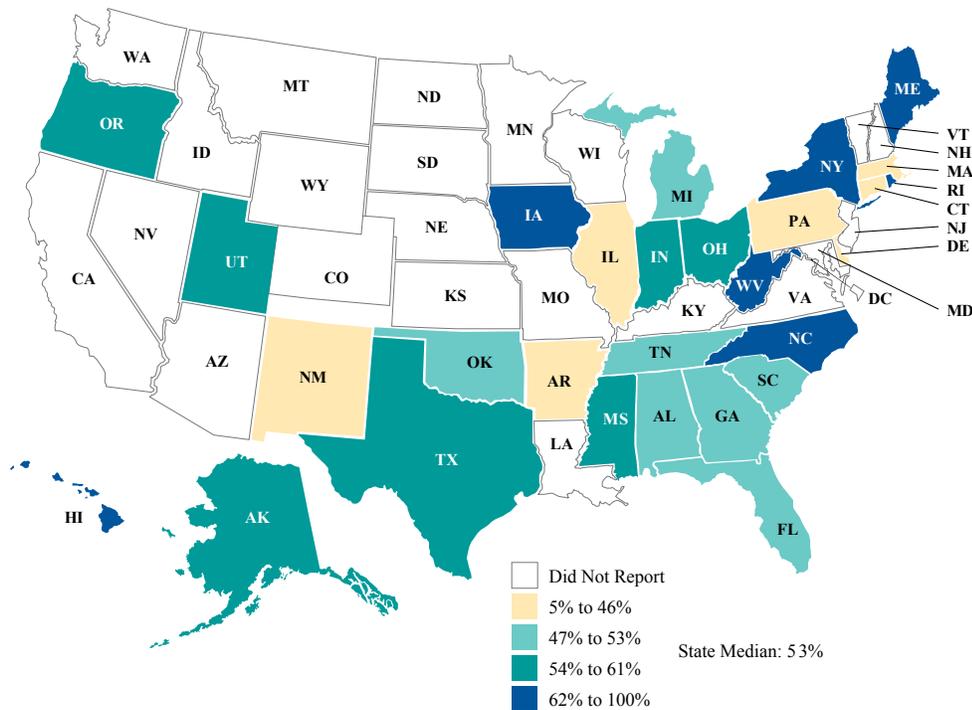
³⁵ The rate for the C&M Phase is based on those children who had at least one visit in the 30-day Initiation Phase.

Exhibit ADD.2. Geographic Variation in the Percentage of Children Prescribed Medication for ADHD that Received At Least One Visit during the 30-Day Initiation Phase, FFY 2012



Source: Mathematica analysis of FFY 2012 CARTS reports.

Exhibit ADD.3. Geographic Variation in the Percentage of Children Prescribed Medication for ADHD that Received At Least Two Visits during the 9-Month Continuation and Maintenance Phase, FFY 2012



Source: Mathematica analysis of FFY 2012 CARTS reports.

To view state-specific data for this measure, please see Table ADD at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2012.zip>.

CENTRAL LINE-ASSOCIATED BLOOD STREAM INFECTIONS IN NEONATAL INTENSIVE CARE UNITS (CLABSI)

Measure Steward: Centers for Disease Control and Prevention (CDC)

Central Line-Associated Blood Stream Infections (CLABSIs) are a significant cause of mortality and morbidity in hospital neonatal intensive care units (NICUs). Improper insertion of central lines (an intravascular catheter that terminates at or close to the heart or in one of the great vessels) can cause life-threatening infections. Premature infants in NICUs are particularly susceptible to infection because of their immature immune systems. Neonatal CLABSIs are preventable through changes in the safety culture in NICUs, including the use of proper insertion techniques and maintenance protocols. Efforts to prevent CLABSIs are effective in reducing infections, saving lives, and reducing health care costs. This measure is an indicator of state performance in reducing CLABSIs in NICUs.

Measure Description

- This measure shows the rate of CLABSIs in NICUs. The Child Core Set measure also includes the rate of CLABSIs in pediatric intensive care units (PICUs). At this time, data on CLABSIs occurring in PICUs are not available.
- The Standardized Infection Ratio (SIR) is the summary measure used to track CLABSIs over time. The SIR compares the number of infections reported in a facility or state to the baseline U.S. experience, adjusting for several risk factors that have been found to be associated with differences in infection rates.
- The SIR indicates whether the rate of infections increased, decreased, or did not change significantly relative to the baseline (calculated using data for 2006–2008). The SIR is evaluated based on the 95 percent confidence interval and the baseline population SIR of 1.
- This measure is obtained from data reported by hospitals to the CDC National Healthcare Safety Network. The measure includes all neonatal CLABSI events not just those for infants covered by Medicaid/CHIP.

Overview of State Reporting

- In 2011, CDC calculated state-level CLABSI rates for 40 states.³⁶ CDC does not calculate rates for states that had fewer than five facilities reporting (Exhibit CLABSI.1, next page).

State Performance

- Of the 40 states, 28 had a significant decrease in infections since the baseline period and 12 had no change in infections since the baseline period (Exhibit CLABSI.1). No states had a significant increase in infections.
- Among the 40 states with CLABSI rates for 2011, the SIRs ranged from 0.233 to 1.307 (Exhibit CLABSI.2). An SIR less than 1 means that fewer infections occurred relative to what would have been predicted given the baseline data. An SIR greater than 1 means that more infections occurred relative to what would have been predicted given the baseline data. An SIR equal to 1 means that the number of infections is no different than the baseline period. The percentage change is determined by calculating 1 minus the SIR; for example, an SIR of 0.233 signifies a 76.7 percent reduction from the baseline period, while an SIR of 1.307 indicates a 30.7 percent increase. Whether an increase or decrease is significant is determined by evaluating the SIR based on the 95 confidence interval and the baseline population SIR of 1.³⁷

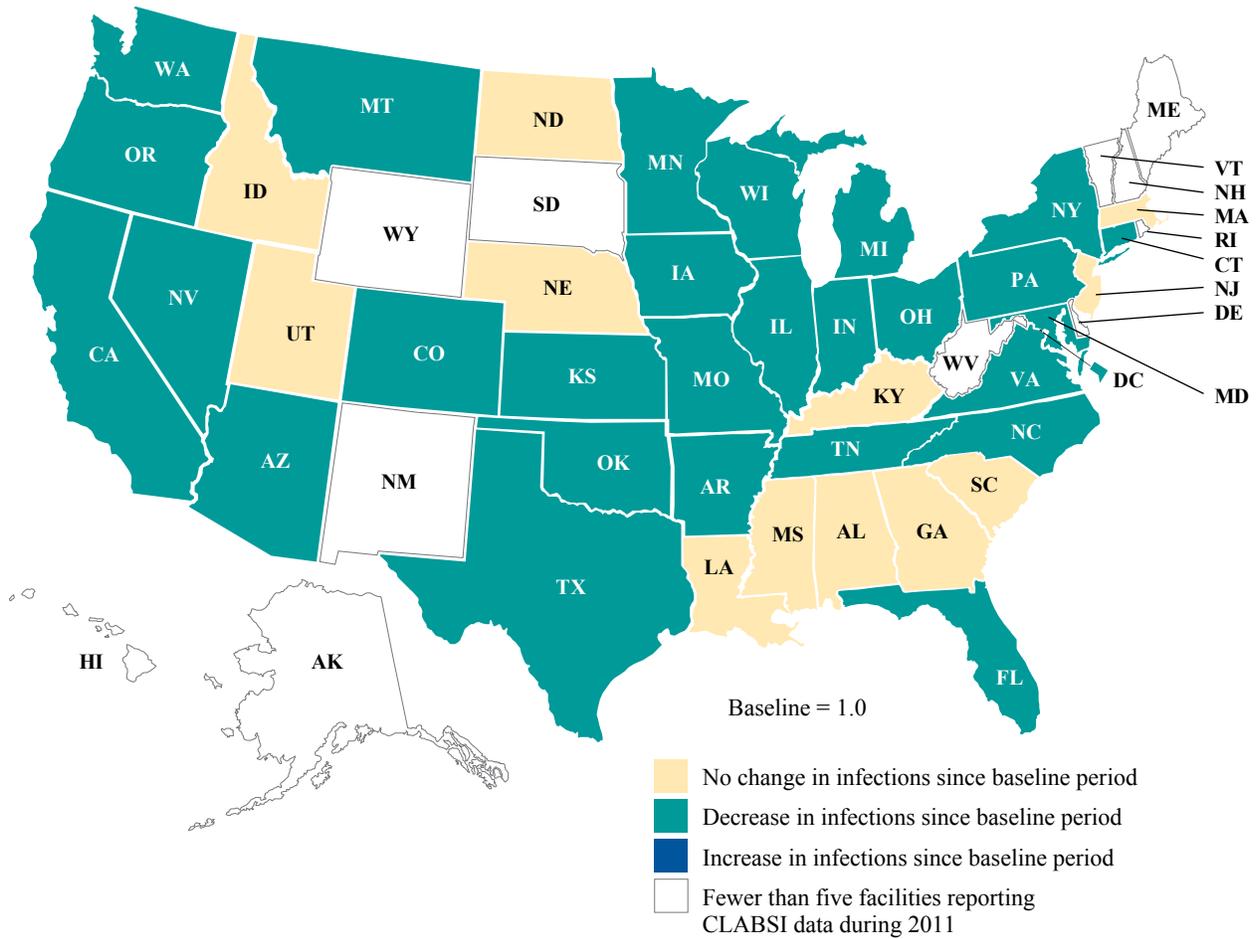
Progress

- The national goal for CLABSIs in all ICUs (including non-neonatal ICUs) is 0.51 by the end of 2013. The CLABSI rate in NICUs was 0.65 in the 40 states in 2011.
- Although no states reported an increase in CLABSIs in NICUs since the baseline period, there is room for improvement for states to meet the Secretary's Goal for reducing CLABSIs by 50 percent by the end of 2013.

³⁶ The term "states" includes the 50 states and District of Columbia.

³⁷ For further information on the methods used to assess state performance, see the CDC 2011 National and State Healthcare-Associated Infections Standardized Infection Ratio Report, available at http://www.cdc.gov/hai/pdfs/SIR/SIR-Report_02_07_2013.pdf.

Exhibit CLABSI.1. Geographic Variation in State Performance on Central Line-Associated Blood Stream Infections in Neonatal Intensive Care Units, 2011



Source: Centers for Disease Control and Prevention, 2011 National and State Healthcare-Associated Infections Standardized Infection Ratio Report, Table 3d, available at http://www.cdc.gov/hai/pdfs/SIR/SIR-Report_02_07_2013.pdf.

To view state-specific data for this measure, please see Table CLABSI at <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FY-2012.zip>.

To view a CMS-convened workgroup report on state reporting of the CLABSI measure, please see <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/CLABSI-Workgroup-Report.pdf>.

Exhibit CLABSI.2 (continued)

Source: Centers for Disease Control and Prevention, 2011 National and State Healthcare-Associated Infections Standardized Infection Ratio Report, Table 3d, available at http://www.cdc.gov/hai/pdfs/SIR/SIR-Report_02_07_2013.pdf.

Notes: This figure includes data for 40 states. Data are displayed if at least 5 facilities reported CLABSI data during the reporting period; 11 states (AK, DE, HI, ME, NH, NM, RI, SD, VT, WV, and WY) had fewer than 5 facilities reporting. The term “states” includes the 50 states and the District of Columbia.

Data are included from all NICU locations, including Level II/III and Level III nurseries. For this report, umbilical-line and central line-associated bloodstream infections are both considered CLABSIs.

*The Standardized Infection Ratio (SIR) compares the actual number of healthcare-associated infections (HAIs) in a facility or state with the baseline U.S. experience, adjusting for several risk factors that have been found to be most associated with differences in infection rates. Evaluation is determined using the 95 percent confidence interval around the SIR. If the SIR is 1, the number of infections reported is the same as the number of infections predicted given the baseline data, indicating there has been no change in infections since the baseline period. If the SIR is less than 1, the number of infections reported is less than the number of infections predicted given the baseline data, indicating that infections have been prevented since the baseline period. If the SIR is greater than 1, the number of infections reported is greater than the number of infections predicted given the baseline data, indicating that infections have increased since the baseline period. More information is available at: http://www.cdc.gov/hai/surveillance/QA_stateSummary.html.

DENTAL AND ORAL HEALTH SERVICES

States' efforts over the past decade have resulted in improved access to dental care for children covered by Medicaid and CHIP. Between 2007 and 2011, almost half of all states achieved at least a 10 percentage point increase in the proportion of enrolled children who received a preventive dental service during the reporting year.³⁸ Despite considerable progress in pediatric oral health care in recent years, tooth decay remains the most common chronic disease among children. As such, children's oral health continues to be a primary focus of improvement efforts in both Medicaid and CHIP, through which all enrolled children have dental coverage.

Over the past several years, CMS has worked with federal and state partners, the dental and medical provider communities, and other stakeholders to continue to improve children's access to dental care. Launched in April 2010, CMS's Oral Health Initiative has two goals: (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.

In April 2013, CMS set state-specific baselines and FFY 2015 goals for children's use of preventive dental services, based on data reported by states on the FFY 2011 Form CMS-416.³⁹ CMS invited Medicaid agencies to develop Oral Health Action Plans as a roadmap to achieving these goals.

CMS offers technical assistance to states to develop and implement their Oral Health Action Plans. It also hosts a quarterly series of webinars entitled *The CMS Learning Lab: Improving Oral Health Through Access*.⁴⁰ In September 2013, CMS released a strategy guide highlighting effective approaches for state Medicaid programs. It also released oral health education materials available for order at no cost.⁴¹

Important components of these efforts are the data used to set baselines and monitor progress. To improve the completeness and accuracy of data, CMS initiated a quality improvement process for FFY 2010 Form CMS-416 data, from which the data originate. Data are checked against a series of audit criteria intended to identify possible reporting and arithmetic errors. This audit has been made a permanent part of the data-submission process.

State performance related to children's access to dental care is evaluated through two measures in the Child Core Set.⁴² The measures are as follows:

1. Preventive Dental Services
2. Dental Treatment Services

To streamline reporting and reduce burden on states, in FFY 2012, CMS began calculating these measures on behalf of states using data from the CMS-416. The two dental measures were reported by at least 25 states for the FFY 2012 reporting year and are included in this section.

³⁸ See <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-04-18-13.pdf>.

³⁹ Ibid.

⁴⁰ See *CMS Learning Lab*, available at <http://www.medicicaid.gov/Medicicaid-CHIP-Program-Information/By-Topics/Benefits/Dental-Care.html>.

⁴¹ These materials are available at <http://www.insurekidsnow.gov/professionals/dental/index.html>.

⁴² The two Child Core Set dental measures parallel reporting on lines 12b and 12c of the Form CMS-416.

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PREVENTIVE DENTAL SERVICES (PDENT)
Measure Steward: Centers for Medicare & Medicaid Services

Tooth decay, or dental caries, is the most common chronic disease of children. It is a growing problem: among children ages 2 to 5, the prevalence of early childhood caries increased 15 percent between 1988–1994 and 1999–2004. Low-income children suffer disproportionately from tooth decay: in 1999–2004, 32 percent of children in households with incomes above 200 percent of the federal poverty level (FPL) had tooth decay, compared with 54 percent of children in households with incomes below 100 percent of FPL. The disease is almost entirely preventable through a combination of good oral health habits at home, a healthy diet, and early and regular use of preventive dental services. This measure assesses the extent to which children are receiving preventive dental services.

Measure Description

- This measure shows the percentage of children ages 1 to 20, eligible for Medicaid or CHIP Medicaid Expansion programs (that is, eligible for the EPSDT benefit), enrolled for at least 90 continuous days, who received preventive dental services.⁴³
- The EPSDT benefit provides comprehensive and preventive health care services, including dental services, for children under age 21 who are enrolled in Medicaid.⁴⁴

Overview of State Reporting

- The number of states reporting the Preventive Dental Services measure in CARTS increased from 22 states for FFY 2010 to 37 for FFY 2011.⁴⁵ In FFY 2010 and 2011, states reported data on this measure in two ways: through CARTS and Form CMS-416 (the annual EPSDT report). The number of states reporting may vary depending on the data source used for public reporting.⁴⁶
- To reduce state reporting burden and have a single information source, in FFY 2012, CMS formally began calculating this measure on behalf of states based on data submitted as part of the CMS-416. It should be noted, however, that performance data from the CMS-416 have been presented for

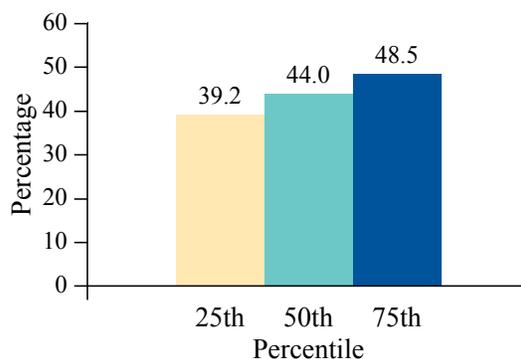
this measure since the 2011 Secretary’s Report.

- For the FFY 2012 Core Measures reporting cycle, all 51 states submitted data for this measure on the FFY 2011 CMS-416.⁴⁷

State Performance

- The median rate among the 51 states reporting the measure for the FFY 2012 Core Measures reporting cycle was 44 percent, with a 9-point spread between the 25th and 75th percentiles (Exhibit PDENT.1).
- Performance on this measure ranged from 14 percent to 58 percent among states, with considerable geographic variation across states (Exhibit PDENT.3, next page).

Exhibit PDENT.1. Percentage of Children Receiving Preventive Dental Services, FFY 2012 Core Measures Reporting Cycle (n = 51 states)



Source: Mathematica analysis of FFY 2011 CMS-416 reports.

⁴³ This measure is calculated using the administrative method (claims/encounter data).

⁴⁴ <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html>.

⁴⁵ The term “states” includes the 50 states and District of Columbia.

⁴⁶ The 2011 and 2012 Secretary’s Reports reflect the number of states reporting the dental measures in CARTS, whereas the performance data for this Report are drawn from the CMS-416 and represent all 51 states. CMS formally began calculating this measure on behalf of states using CMS-416 data for the FFY 2012 Core Measures reporting cycle.

⁴⁷ States are to submit the CMS-416 report to CMS by April 1st of each year. At the time of this writing, CMS had not received enough FFY 2012 data from states to make meaningful comparisons. As such, this Report includes data submitted by states on the FFY 2011 CMS-416.

Trends

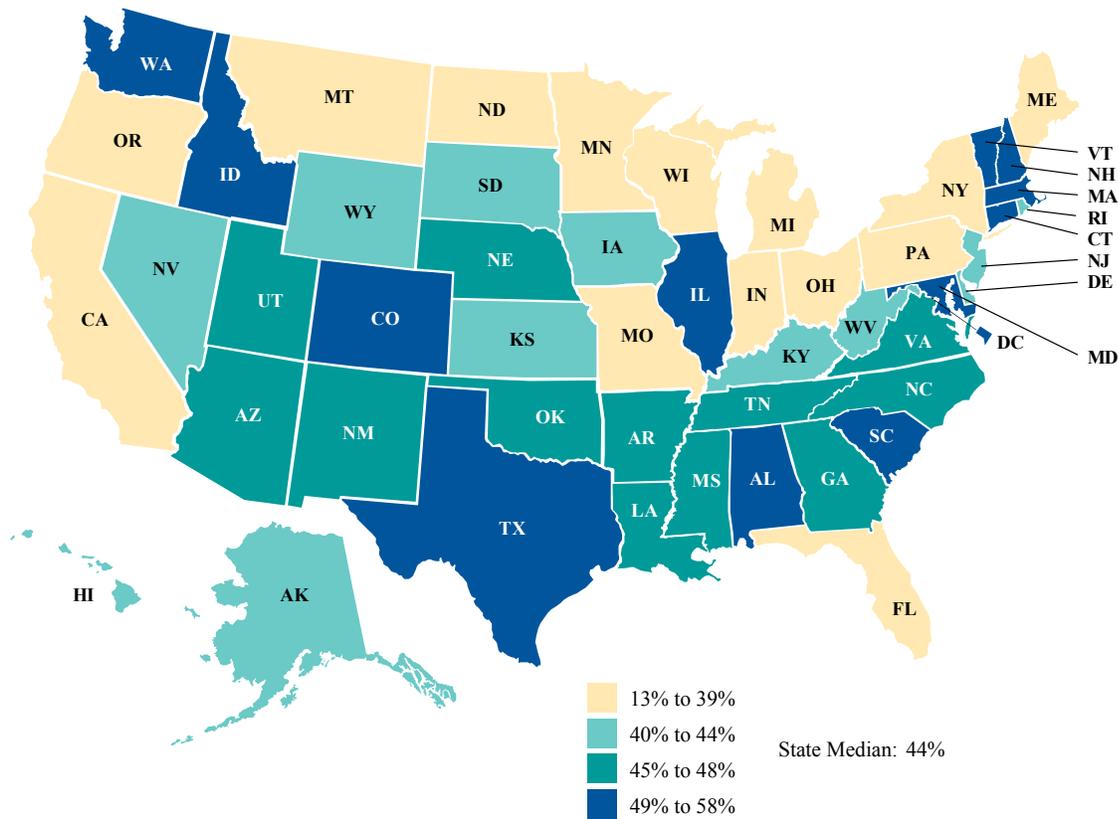
- Among the 51 states reporting data for this measure on the CMS-416 for two years using the new reporting definition,⁴⁸ the median rate increased by less than 1 percentage point between the FFY 2011 and FFY 2012 reporting cycles (Exhibit PDENT.2).

Exhibit PDENT.2. Trends in the Percentage of Children Receiving Preventive Dental Services, FFY 2011–2012 Core Measures Reporting Cycles (n = 51 states)

Rate	FFY 2011	FFY 2012
U.S. Total	40.8	41.5
Median	43.2	44.0
25th Percentile	38.2	39.2
75th Percentile	46.8	48.5

Source: Mathematica analysis of FFY 2010 and 2011 CMS-416 reports.

Exhibit PDENT.3. Geographic Variation in the Percentage of Children Receiving Preventive Dental Services, FFY 2012 Core Measures Reporting Cycle (n = 51 states)



Source: Mathematica analysis of FFY 2011 CMS-416 reports.

To view state-specific data for this measure, please see Table PDENT at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2012.zip>.

⁴⁸ Starting with the FFY 2010 CMS-416, the population of children for whom the receipt of dental services was to be reported shifted from all children, regardless of length of enrollment, to children covered by Medicaid for at least 90 continuous days.

DENTAL TREATMENT SERVICES (TDENT)
Measure Steward: Centers for Medicare & Medicaid Services

Tooth decay, or dental caries, is the most common chronic disease of children. If left untreated, tooth decay can negatively affect a child’s physical and social development and school performance. The prevalence of untreated tooth decay among children ages 2 to 5 increased 7 percent between 1988–1994 and 1999–2004. Among children ages 2 to 11, untreated tooth decay disproportionately affects low-income children: in 1999–2004, 33 percent of children in households with incomes below 100 percent of the federal poverty level (FPL) had untreated tooth decay, compared with 28 percent of children between 100 and 200 percent of FPL and 15 percent of those above 200 percent of FPL. This measure assesses the extent to which children are receiving dental treatment services.

Measure Description

- This measure shows the percentage of children ages 1 to 20 eligible for Medicaid or CHIP Medicaid Expansion programs (that is, individuals eligible for the EPSDT benefit), enrolled for at least 90 continuous days, who received dental treatment services.⁴⁹
- The EPSDT benefit provides comprehensive and preventive health care services, including dental services, for children under age 21 who are enrolled in Medicaid.⁵⁰

Overview of State Reporting

- The number of states reporting the Dental Treatment Services measure in CARTS increased from 19 states for FFY 2010 to 35 for FFY 2011.⁵¹ In FFY 2010 and 2011, states reported data on this measure in two ways: through CARTS and Form CMS-416 (the annual EPSDT report). The number of states reporting may vary depending on the data source used for public reporting.⁵²
- To reduce state reporting burden and have a single information source, in FFY 2012, CMS formally began calculating this measure on behalf of states based on data

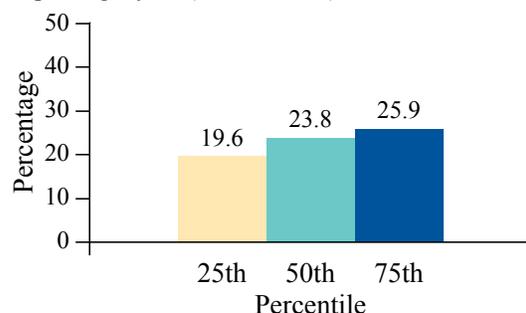
submitted as part of the CMS-416. It should be noted, however, that performance data from the CMS-416 have been presented for this measure since the 2011 Secretary’s Report.

- For the FFY 2012 Core Measures reporting cycle, all 51 states submitted data for this measure on the FFY 2011 CMS-416.⁵³

State Performance

- The median rate among the 51 states reporting the measure for the FFY 2012 Core Measures reporting cycle was 24 percent, with a 6-point spread between the 25th and 75th percentiles (Exhibit TDENT.1).
- Performance on this measure ranged from 8 percent to 51 percent among states, with considerable geographic variation across states (Exhibit TDENT.3, next page).

Exhibit TDENT.1. Percentage of Children Receiving Dental Treatment Services, FFY 2012 Core Measures Reporting Cycle (n = 51 states)



Source: Mathematica analysis of FFY 2011 CMS-416 reports.

⁴⁹ This measure is calculated using the administrative method (claims/encounter data).

⁵⁰ <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html>.

⁵¹ The term “states” includes the 50 states and District of Columbia.

⁵² The 2011 and 2012 Secretary’s Reports reflect the number of states reporting the dental measures in CARTS, whereas the performance data for this Report are drawn from the CMS-416 and represent all 51 states. CMS formally began calculating this measure on behalf of states using CMS-416 data for the FFY 2012 Core Measures reporting cycle.

⁵³ States are to submit the CMS-416 report to CMS by April 1st of each year. At the time of this writing, CMS had not received enough FFY 2012 data from states to make meaningful comparisons. As such, this Report includes data submitted by states on the FFY 2011 CMS-416.

Trends

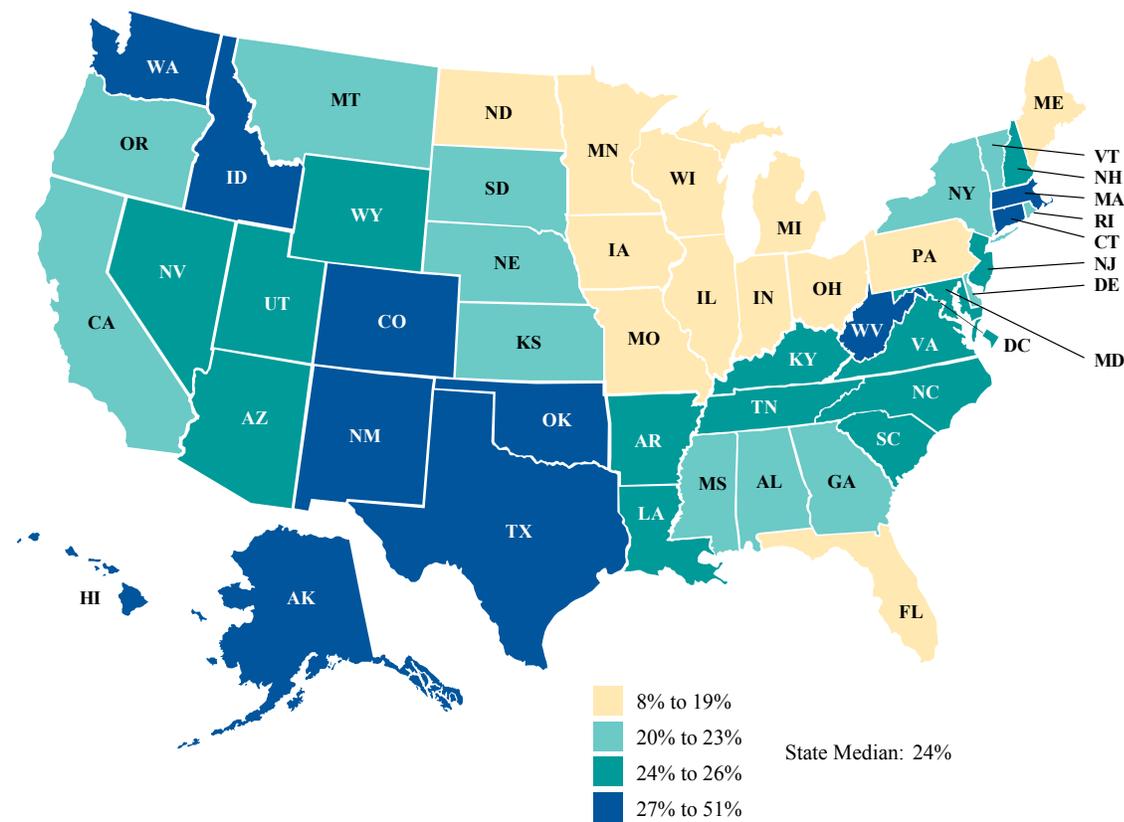
- Among the 51 states reporting data for this measure on the CMS-416 for two years using the new reporting definition,⁵⁴ the median rate increased by less than 1 percentage point between the FFY 2011 and FFY 2012 reporting cycles (Exhibit TDENT.2).

Exhibit TDENT.2. Trends in the Percentage of Children Receiving Dental Treatment Services, FFY 2011–2012 Core Measures Reporting Cycles (n = 51 states)

Rate	FFY 2011	FFY 2012
U.S. Total	23.0	23.1
Median	23.5	23.8
25th Percentile	20.2	19.6
75th Percentile	25.8	25.9

Source: Mathematica analysis of FFY 2010 and 2011 CMS-416 reports.

Exhibit TDENT.3. Geographic Variation in the Percentage of Children Receiving Dental Treatment Services, FFY 2012 Core Measures Reporting Cycle (n = 51 states)



Source: Mathematica analysis of FFY 2011 CMS-416 reports.

To view state-specific data for this measure, please see Table TDENT at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2012.zip>.

⁵⁴ Starting with the FFY 2010 CMS-416, the population of children for whom the receipt of dental services was to be reported shifted from all children, regardless of length of enrollment, to children covered by Medicaid for at least 90 continuous days.