Perinatal Care in Medicaid and CHIP

February 2016

Centers for Medicare & Medicaid Services

Medicaid/CHIP

Health Care Quality Measures

ABOUT THIS SERIES OF REPORTS

This report is part of a series of domain-specific reports about the quality of health care delivered to children and adults enrolled in Medicaid and the Children's Health Insurance Program (CHIP). The five domain-specific reports include: (1) primary care access and preventive care, (2) perinatal health, (3) care of acute and chronic conditions, (4) behavioral health care, and (5) dental and oral health services.

The Secretary of the Department of Health and Human Services (HHS) is required to measure and report annually on the quality of health care delivered to children and adults in Medicaid and CHIP. To standardize the measurement of health care quality for these children and adults, the Secretary of HHS established a set of health care quality measures (referred to as the Child Core Set and the Adult Core Set, respectively). The Centers for Medicare & Medicaid Services (CMS), the HHS agency responsible for promoting quality health care for children and adults enrolled in Medicaid and CHIP, works collaboratively with states to strengthen systems for voluntarily collecting and reporting the Child and Adult Core Set measures, and using the measures to drive quality improvement.

Another vehicle for driving quality improvement is the annual External Quality Review (EQR) of care furnished to children and adults in managed care. States that contract with managed care organizations are required to submit an EQR technical report on the strategies used to improve the quality of care for children and adults in Medicaid and CHIP.

The 2015 Secretary's Reports on the quality of care for children and adults present information on the status of quality measurement and reporting efforts using the 2014 Child and Adult Core Sets and summarize information on managed care quality reported in the EQR technical reports. This report on perinatal care in Medicaid and CHIP supplements information presented in the 2015 Secretary's Reports. For additional information, please refer to the 2015 Secretary's Reports at the following links:

- 2015 Annual Report on the Quality of Care for Children in Medicaid and CHIP: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-child-sec-rept.pdf.
- 2015 Annual Report on the Quality of Care for Adults in Medicaid: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-adult-sec-rept.pdf.
- 2015 Domain-Specific Reports: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-SR-domain-specific-reports.zip.

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Introduction

In 2010, Medicaid financed nearly half of all births in the United States, ranging from a low of 24 percent of all births in Hawaii to a high of 69 percent of births in Louisiana.[1] As the largest payer for maternity care in the United States, Medicaid has an important role to play in improving perinatal health outcomes. Despite improvements in access to coverage and care, the rate of births reported as preterm or low birth weight among women enrolled in Medicaid is higher than the rate for those who are privately insured.[2]

This report provides state-specific findings on perinatal care in Medicaid and CHIP. It includes state-specific performance data on 5 of the 10 perinatal care measures in the Child and Adult Core Sets. For a measure to be publicly reported, data must be provided to CMS by at least 25 states and meet internal standards for quality. This is the first year of public reporting of data on the Adult Core Set measures. This report also summarizes information on managed care quality monitoring and improvement efforts related to prenatal and postpartum care that were reported in states' External Quality Review (EQR) technical reports.

Efforts to Improve Perinatal Care in Medicaid and CHIP

In July 2014, CMS launched a Maternal and Infant Health Initiative to drive improvements in the care provided during the postpartum and interconceptional periods to substantially improve the short- and long-term health outcomes of Medicaid/CHIP enrollees.[3] CMS's Initiative builds on strategies identified by the Expert Panel on Improving Maternal and Infant Outcomes in Medicaid and CHIP, which was convened 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. The Initiative is part of a comprehensive effort to develop and implement evidence-based policies and programs in Medicaid and CHIP.[4]

CMS collaborates closely with other federal agencies, states, providers, and other partners to improve maternal and infant care and outcomes. Recent activities include the following:

- Strong Start for Mothers and Newborns is led by the CMS Innovation Center and includes two main strategies: (1) testing ways across all payers to reduce early elective deliveries that lack medical indication; and (2) testing and evaluating models of enhanced prenatal care for Medicaid/CHIP enrollees to reduce preterm births and decrease the cost of medical care during pregnancy, delivery, and the first year of life.

[1] Markus, A.R., E. Andres, K.D. West, N. Garro, and C. Pellegrini. "Medicaid Covered Births, 2008 through 2010, in the Context of the Implementation of Health Reform." Women's Health Issues, vol. 23, no. 5, pp. e273–e280.

[2] Barradas D.T., et al. "Hospital Utilization and Costs among Preterm Infants by Payer: Nationwide Inpatient Sample, 2009." Unpublished manuscript 2014.

[3] http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-07-18-2014.pdf. The goals of the initiative are to: (1) increase by 10 percentage points the rate of postpartum visits among pregnant women in Medicaid and CHIP in at least 20 states over a 3-year period, and (2) increase by 15 percentage points the use of effective methods of contraception in Medicaid and CHIP in at least 20 states over a 3-year period.

[4] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Maternal-and-Infant-Health-Care-Quality.html.

- CMS partnered with the Centers for Disease Control and Prevention (CDC) to develop state capacity in data linkage and use of state Vital Records, Medicaid claims, and Title V data, an important mechanism for monitoring key maternal and infant health indicators, particularly collection of relevant Medicaid quality measures.
- CMS, in collaboration with CDC and the Office of Population Affairs, is supporting states in collecting and using a contraception utilization measure.
- CMS launched a three-year pilot project to work in collaboration with four state Medicaid agencies (California, Louisiana, Ohio, and Oklahoma) to customize interactive mobile text messages to provide expecting and new mothers with targeted information and local resources to improve performance on CMS core quality measures.
- In partnership with the Agency for Healthcare Research and Quality and the Health Resources and Service Administration, CMS supported state Medicaid Medical Directors efforts to track trends in elective deliveries, understand the impact of elective deliveries on birth outcomes, review the cost of such deliveries to Medicaid, and assist states in developing policies and programmatic changes.
- CMS convened an Action Learning Series with 11 states to develop strategies to increase the rate of postpartum care visits among women covered by Medicaid and CHIP and improve the content of these visits.
- CMS collaborates with the Health Resources and Services Administration (HRSA) and CDC to reduce infant mortality through HRSA's Collaborative Improvement and Innovation Network (CoIIN) which provides a platform for states to engage in collaborative learning, apply quality improvement methods, and spread policy and program innovation to accelerate improvement in birth outcomes.

State-Specific Findings on Perinatal Care

State performance related to perinatal care covered by Medicaid and CHIP is evaluated through the following measures in the 2014 Child (CH) and Adult (AD) Core Sets:

- Timeliness of Prenatal Care (PPC-CH)
- Frequency of Ongoing Prenatal Care (FPC-CH)
- Postpartum Care Rate (PPC-AD)
- Live Births Weighing Less than 2,500 Grams (LBW-CH)
- Central Line-Associated Blood Stream Infections in Neonatal Intensive Care Units (CLABSI-CH)[1]

This section presents an overview of state performance on these measures based on reporting for FFY 2014. Appendix A presents snapshots of state-specific performance on the measures. See Appendix B for state-specific data on the measures.

[1] The CLABSI measure was obtained from the Centers for Disease Control and Prevention's (CDC's) National Healthcare Safety Network (NHSN) beginning in FFY 2012.

The health of a child is affected by a mother's health and the care she receives during pregnancy, as well as the care of the mother and child after birth. For FFY 2014:

- The vast majority of pregnant women had a prenatal care visit in the first trimester or within 42 days of enrolling in Medicaid/CHIP (the median rate among 34 states was 81 percent).
- Two-thirds of women received at least 80 percent of the expected number of prenatal visits during their pregnancy (based on when they enrolled in Medicaid/CHIP and when they delivered) (the median rate among 27 states was 66 percent).
- Among the 34 states reporting for FFY 2014, a median of 58 percent of women covered by Medicaid/CHIP had a postpartum visit between 21 and 56 days after delivery.[2] This is the first year that the postpartum care visit measure is publicly reported.

The median rate of first-trimester prenatal care remained high at 83–84 percent between FFY 2012 and FFY 2014, for the 27 states reporting the measure for all three years. The median rate of ongoing prenatal care increased by more than 8 percentage points (from 59 percent in FFY 2012 to 67 percent in FFY 2014), among the 22 states reporting this measure for the past three years.

Two of the perinatal care measures have potential implications for the long-term health and health care costs of infants: low birth weight (LBW) and CLABSIs. For both measures, lower rates are better. For FFY2014,

- The median percentage of live births paid for by Medicaid or CHIP weighing less than 2,500 grams (5 pounds, 8 ounces) was 9 percent (29 states reporting).[3] The number of states reporting the low birth weight measure has nearly doubled since FFY 2012, increasing from 15 to 29 states. This is the first year that the low birth weight measure is publicly reported.
- Among the 41 states with state-level rates for CLABSIs in neonatal intensive care units (NICUs), 33 had a significant decrease in CLABSI infections in calendar year (CY) 2013 since the 2006–2008 baseline period, and 8 had no change in infections since the baseline period. No states had a significant increase in infections.[4]

[2] The rate of postpartum care among Medicaid/CHIP enrollees may be understated for two reasons: (1) visits may occur before 21 or after 56 days post-delivery; and (2) postpartum visits may be bundled in a global payment for maternity care and not billed separately.

[3] The U.S. rate for 2013 was 8 percent, ranging from 7 percent for non-Hispanic white and Hispanic infants to 13 percent for non-Hispanic black infants. More information on the characteristics of U.S. births is available at http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_01.pdf.

[4] This measure is obtained from data reported by hospitals to the CDC's NHSN. It includes all neonatal CLABSI incidents not just those for infants covered by Medicaid/CHIP. The statistic reported indicates whether the rate of infections increased, decreased, or did not change significantly relative to the baseline U.S. experience (calculated using data for 2006–2008). For further information on the methods used to assess state performance, see http://www.cdc.gov/HAI/pdfs/progress-report/hai-progress-report.pdf.

Monitoring and Improving Managed Care Quality

By 2016, an estimated 75 percent of Medicaid enrollees will obtain their care through managed care plans.[5] Regardless of the enrollment rate, states using a managed care delivery system must comply with certain federal requirements, including standards to assess and monitor the quality of care provided by contracted managed care plans. This section summarizes state activities related to monitoring and improving perinatal care in managed care.[6]

Of the 41 states[7] that contracted with managed care organizations (MCOs) or prepaid inpatient health plans (PIHPs) during the 2014–2015 reporting cycle, 38 states submitted EQR technical reports to CMS.[8] These states contracted with 15 different External Quality Review Organizations (EQROs) to conduct the annual EQR, and five EQROs conducted reviews for multiple states during the 2014–2015 reporting cycle.[9]

CMS conducted detailed abstractions of EQR technical reporting on performance measures and performance improvement projects (PIPs) related to perinatal care. Sixteen states reported a combined total of 62 improvement projects targeting prenatal or postpartum care during the current reporting cycle, of which 5 mandated the topic (District of Columbia, Florida, Georgia, Illinois, and New Hampshire). Fifteen states completed PIPs on this topic during the 2013–2014 reporting cycle, and 11 states conducted PIPs in both reporting cycles. While the interventions of each PIP varied, common improvement aims focused on timeliness and frequency of prenatal and/or postpartum care, low birth weight, and postpartum depression screening.

Analysis of the PIPs indicates that states are using a diverse set of interventions to improve the quality of perinatal care (see Appendix C).[10] This report highlights an example of a state improvement project related to improving perinatal care. Criteria for selecting states to highlight

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[5] Avalere Analysis: Medicaid Managed Care Expected to Grow by 13.5 Million (2015) http://avalere.com/expertise/managed-care/insights/avalere-analysis-medicaid-managed-care-enrollment-set-to-grow-by-13.5-milli.

[6] 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.

[7] For purposes of EQR technical reports, the term "states" includes the 50 states, the District of Columbia, and the territories.

[8] Of the 41 states that contracted with MCOs or PIHPs, three (Indiana, Puerto Rico, and Texas) did not submit an EQR technical report before April 30, 2015 for inclusion in this analysis, and one (Delaware) submitted readiness reviews only. North Dakota's managed care program was limited to the Children's Health Insurance Program (CHIP) population during the 2014–2015 reporting cycle. Alabama, Alaska, Arkansas, Connecticut, Guam, Idaho, Maine, Montana, Oklahoma, South Dakota, the Virgin Islands, and Wyoming do not have MCOs or PIHPs that enroll children covered by Medicaid or CHIP. While Vermont is required to conduct an EQR under the terms of its Section 1115 demonstration, its managed care entity is neither an MCO nor a PIHP and therefore is excluded from this analysis.

[9] For a list of EQROs with current state Medicaid contracts in 2014, see EQR Table CH-1 at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Child-Findings-from-EQR-Technical-Reports-2014-2015.zip.

[10] Information on "Findings from EQR Technical Reports, 2014–2015," including the detailed PIP abstractions related to prenatal and postpartum care, is available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Child-Findings-from-EQR-Technical-Reports-2014-2015.zip.

in the domain-specific reports included whether the EQR technical report contained some information on interventions and outcomes, and an interest in ensuring geographic diversity of the states profiled.

Illinois' quality strategy identified improving birth outcomes as one of its health care priorities. The state required its three MCOs to implement a collaborative improvement project focused on prenatal and postpartum care (the state has mandated PIPs on this topic since the 2011–2012 reporting cycle). The primary aim of the PIP was to improve performance on the timeliness of prenatal and postpartum care Healthcare Effectiveness Data and Information Set (HEDIS®) measures.[11] A secondary purpose of the PIP was to improve the rate of depression screening and appropriate depression treatment for women during the prenatal and/or postpartum period. All three MCOs identified member outreach as an area for improvement. To address this, two MCOs implemented reviews of Medicaid claims/encounter data to identify pregnant women and manage their care. Another MCO conducted hospital discharge follow-up calls to assist women with scheduling a postpartum visit and arrange transportation.

The MCOs in Illinois also implemented incentive programs to increase prenatal and postpartum visits, such as gift cards, coupons for a free baby photo, and a rewards program (stroller, portable play yard, or diapers) for members who had the recommended prenatal and postpartum visits. Two MCOs implemented provider-level interventions including a provider incentive program that paid providers for notifying the MCO of pregnant members, and a provider education program involving one-on-one meetings with providers to discuss their performance on study indicators, provide them with lists of members who had not received recommended visits, guidance on billing codes, and education on the importance of screening members for depression. Overall, 60 percent of the 45 reported study indicators across all three MCOs showed improvement compared to the 2013–2014 reporting cycle, and 93 percent of the indicators showed sustained improvement compared to the baseline period.

[11] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

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APPENDIX A

SNAPSHOTS OF STATE-SPECIFIC PERFORMANCE

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TIMELINESS OF PRENATAL CARE (PPC-CH)

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

- 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.[1]

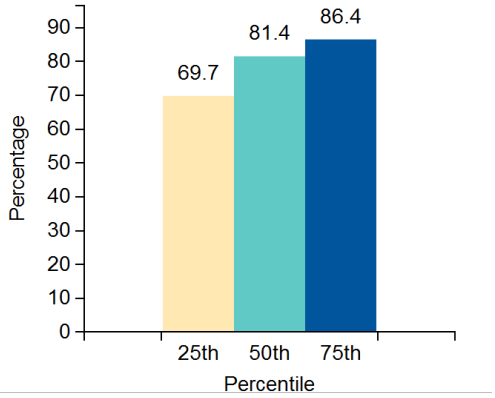
Overview of State Reporting

- The number of states reporting the Timeliness of Prenatal Care measure increased from 31 states for FFY 2012 to 33 states for FFY 2013 and 36 states for FFY 2014.[2]
- Of the 36 states reporting the measure for FFY 2014, 29 reported the measure for Medicaid and CHIP, 7 reported the measure for Medicaid only, and none reported the measure for CHIP only.

State Performance

- Among the 34 states using Child Core Set specifications to report the measure for FFY 2014, the median rate was 81 percent, with a 17-point spread between the 25th and 75th percentiles (Exhibit PPC-CH.1).[3]
- Performance on this measure ranged from 22 to 96 percent among states, with considerable geographic variation across states (Exhibit PPC-CH.3, next page).

Exhibit PPC-CH.1. Percentage of Pregnant Women with a Prenatal Care Visit in the First Trimester or within 42 Days of Medicaid/CHIP Enrollment, FFY 2014 (n = 34 states)



Source: Mathematica analysis of 2014 CARTS reports as of May 8, 2015.

Note: When a state reported separate rates for its Medicaid and CHIP populations, the rates were calculated using the rate for the larger measure-eligible population.

Trends

- Among the 27 states reporting the measure using the Child Core Set specifications for all three years, the median rate increased by 1 percentage point from 83.4 percent for FFY 2012 to 84.2 percent for FFY 2014 (Exhibit PPC-CH.2, next page).
- The 25th percentile increased by about 3 points from FFY 2012 to FFY 2014, while the 75th percentile decreased by about 2 points.

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

[2] The term "states" includes the 50 states and the District of Columbia.

[3] One state reported the measure using Child Core Set specifications, but reported a denominator of less than 30. As a result, the rate was not included in public reporting. An additional state did not use Child Core Set specifications to calculate the measure.

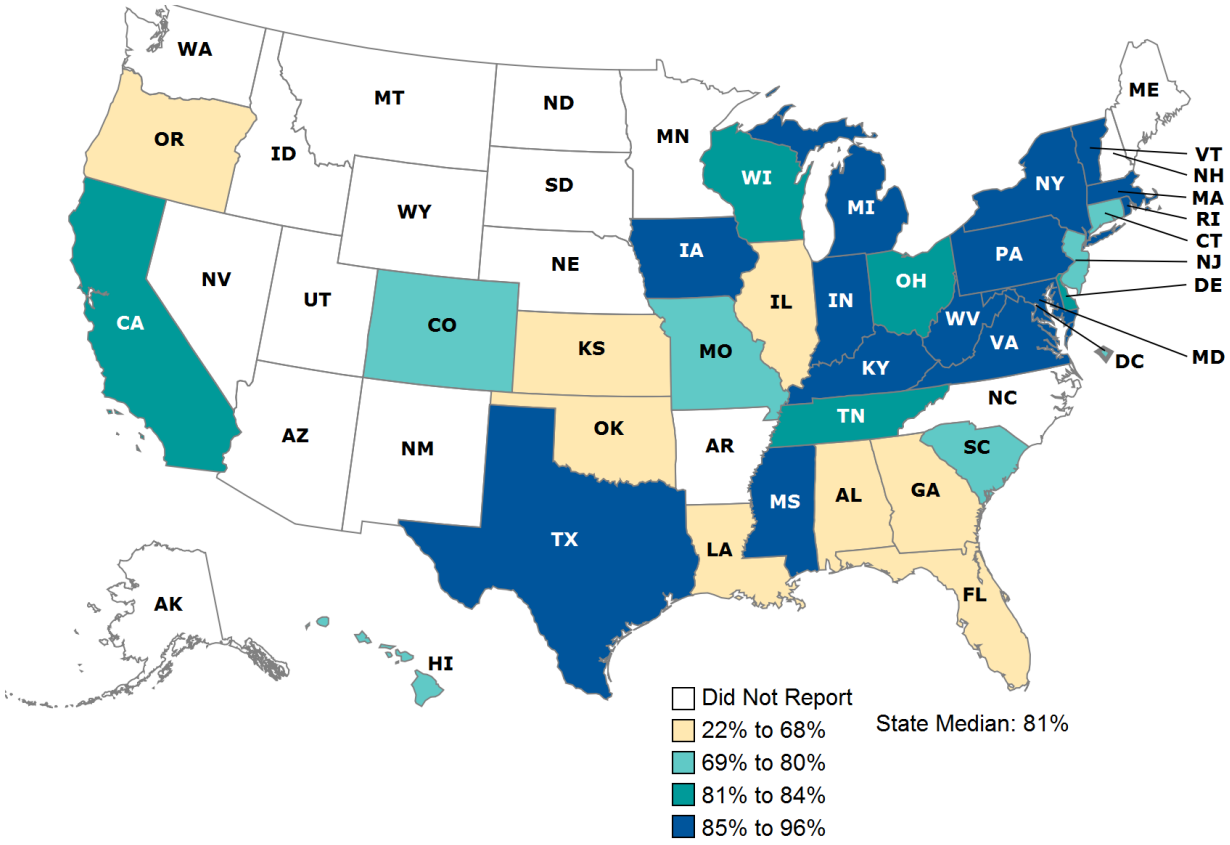
Exhibit PPC-CH.2. Trends in the Percentage of Pregnant Women with a Prenatal Care Visit in the First Trimester or within 42 Days of Medicaid/CHIP Enrollment, FFY 2012–2014 (n = 27 states)

Rate	FFY 2012	FFY 2013	FFY 2014
Mean	79.1	79.5	79.4
Median	83.4	83.2	84.2
25th Percentile	71.7	71.8	74.4
75th Percentile	88.7	87.8	86.4

Source: Mathematica analysis of FFY 2012, 2013, and 2014 Child CARTS reports as of May 8, 2015.

Notes: This table includes 27 states that reported the measure using Child Core Set specifications for all three years. When a state reported separate rates for its Medicaid and CHIP populations, the mean and median rates were calculated using the rate for the larger measure-eligible population.

Exhibit PPC-CH.3. 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 2014 (n = 34 states)



Source: Mathematica analysis of FFY 2014 Child CARTS reports as of May 8, 2015.

Notes: When a state reported separate rates for its Medicaid and CHIP populations, the rate for the larger measure-eligible population was used.

To view state-specific data for this measure, please see Table PPC-CH at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/performance-on-the-child-core-set-measures-ffy-2014.zip.

FREQUENCY OF ONGOING PRENATAL CARE (FPC-CH)
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. In this report, state performance is measured on the basis of the extent to which women had more than 80 percent of the expected prenatal care visits.

Measure Description

- 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
  - ≥ 81 percent of expected visits[1]

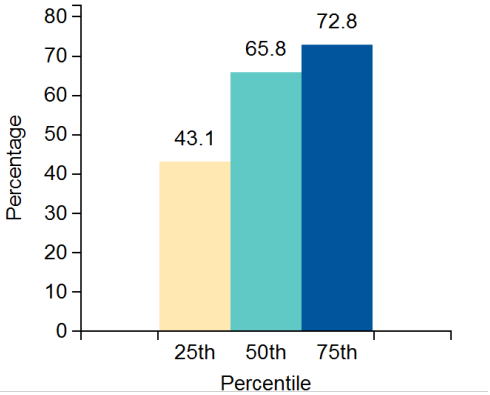
Overview of State Reporting

- The number of states reporting the Frequency of Ongoing Prenatal Care measure increased from 25 states for FFY 2012 to 27 states for FFY 2013 and 28 states for FFY 2014.[2]
- Of the 28 states reporting the measure for FFY 2014, 23 reported the measure for Medicaid and CHIP, 5 reported the measure for Medicaid only, and none reported the measure for CHIP only.

State Performance

- Among the 27 states using Child Core Set specifications to report the measure for FFY 2014, the median rate was 66 percent, with a 30-point spread between the 25th and 75th percentiles (Exhibit FPC-CH.1).[3]
- Performance on this measure ranged from 1 to 85 percent among states, with considerable geographic variation across states (Exhibit FPC-CH.3, next page).

Exhibit FPC-CH.1. Percentage of Pregnant Women Receiving More Than 80 Percent of the Expected Number of Prenatal Care Visits, FFY 2014 (n = 27 states)



Source: Mathematica analysis of 2014 CARTS reports as of May 8, 2015.

Note: When a state reported separate rates for its Medicaid and CHIP populations, the rates were calculated using the rate for the larger measure-eligible population.

Trends

- Among the 22 states reporting the ≥ 81 percent rate for this measure using the Child Core Set specifications for all three years, the median rate increased by 8 percentage points from FFY 2012 to FFY 2014 (Exhibit FPC-CH.2, next page).
- The 25th and 75th percentiles increased by about 1 point from FFY 2012 to FFY 2014.

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

[2] The term "states" includes the 50 states and the District of Columbia.

[3] One state did not use the Child Core Set specifications to calculate the measure.

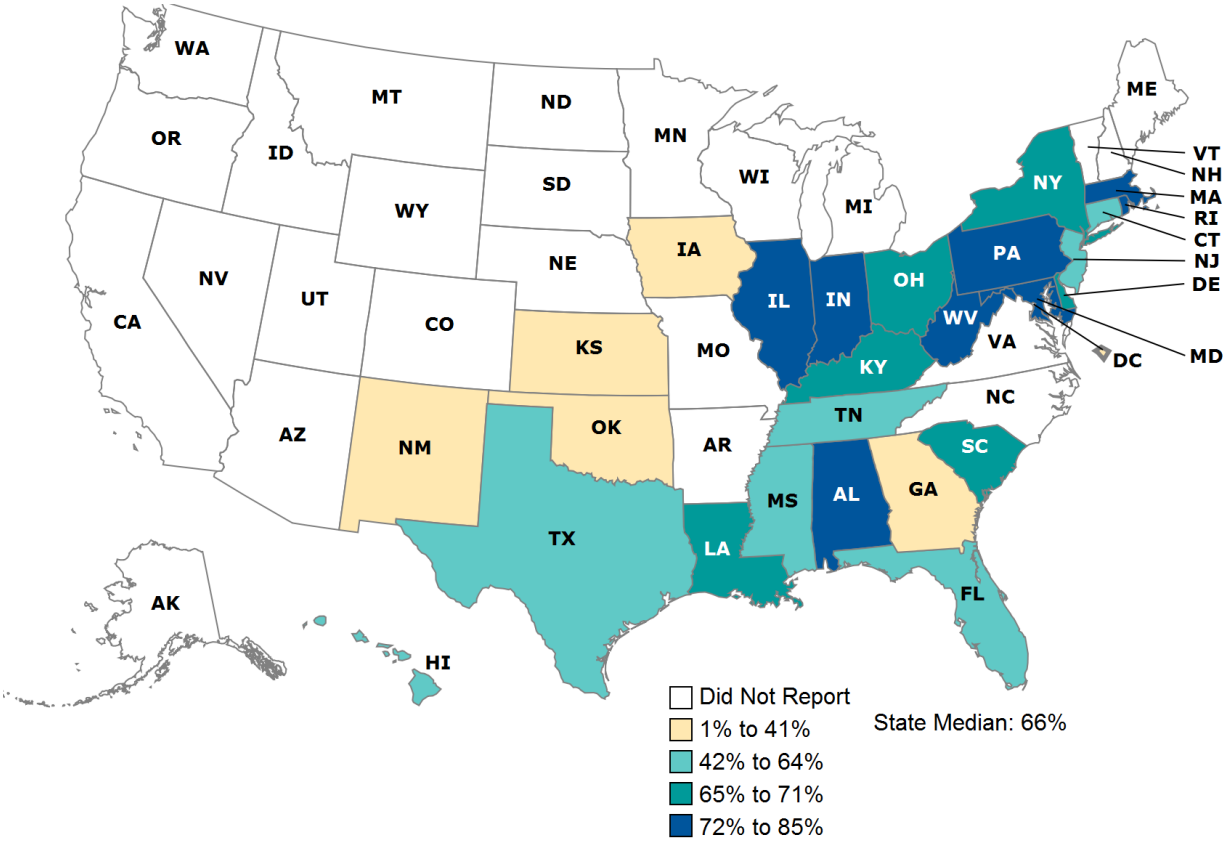
Exhibit FPC-CH.2. Trends in the Percentage of Pregnant Women Receiving More Than 80 Percent of the Expected Number of Prenatal Care Visits, FFY 2012–2014 (n = 22 states)

Rate	FFY 2012	FFY 2013	FFY 2014
Mean	59.9	59.3	60.4
Median	58.9	64.8	67.0
25th Percentile	50.9	49.2	52.0
75th Percentile	72.9	71.6	73.7

Source: Mathematica analysis of FFY 2012, 2013, and 2014 Child CARTS reports as of May 8, 2015.

Notes: This table includes 22 states that reported the measure using Child Core Set specifications for all three years. When a state reported separate rates for its Medicaid and CHIP populations, the mean and median rates were calculated using the rate for the larger measure-eligible population.

Exhibit FPC-CH.3. Geographic Variation in the Percentage of Pregnant Women Receiving More Than 80 Percent of the Expected Number of Prenatal Care Visits, FFY 2014 (n = 27 states)



Source: Mathematica analysis of FFY 2014 Child CARTS reports as of May 8, 2015.

Notes: When a state reported separate rates for its Medicaid and CHIP populations, the rate for the larger measure-eligible population was used.

To view state-specific data for this measure, please see Table FPC-CH at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/performance-on-the-child-core-set-measures-ffy-2014.zip.

POSTPARTUM CARE RATE (PPC-AD)

Measure Steward: National Committee for Quality Assurance (NCQA)

Postpartum visits provide an opportunity to assess women's physical recovery from pregnancy and childbirth, and to address chronic health conditions (such as diabetes or hypertension), mental health status (including postpartum depression), and family planning (including contraception and inter-conception counseling). They also provide an opportunity for counseling on nutrition and breastfeeding and other preventive health issues. CMS's Maternal and Infant Health Initiative aims to increase by 10 percentage points the rate of postpartum visits among women in Medicaid and CHIP in at least 20 states over a 3-year period. This measure indicates how often Medicaid enrollees receive timely postpartum care (that is, between 21 and 56 days after delivery).

Measure Description

- Percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year that had a postpartum visit on or between 21 and 56 days after delivery.[1]

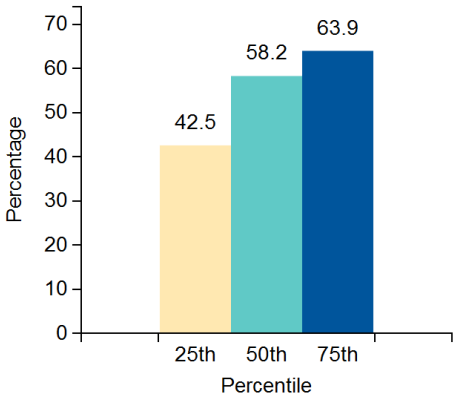
Overview of State Reporting

- The number of states reporting the Postpartum Care Rate measure increased from 29 states for FFY 2013 to 34 states for FFY 2014.[2]
- Of the 34 states reporting the measure for FFY 2014, 15 reported the measure for Medicaid only; 11 reported the measure for Medicaid and CHIP; 3 reported the measure for Medicaid and Medicare-Medicaid Dual Eligibles; and 5 reported the measure for Medicaid, CHIP, and Medicare-Medicaid Dual Eligibles.

State Performance

- Among the 34 states using Adult Core Set specifications to report the measure for FFY 2014, the median rate was 58 percent, with a 21-point spread between the 25th and 75th percentiles (Exhibit PPC-AD.1).
- Performance on this measure ranged from 20 to 90 percent among states, with considerable geographic variation across states (Exhibit PPC-AD.2, next page).

Exhibit PPC-AD.1. Percentage of Women Delivering a Live Birth with a Postpartum Care Visit on or Between 21 and 56 Days after Delivery, FFY 2014 (n = 34 states)



Source: Mathematica analysis of 2014 CARTS reports as of May 8, 2015.

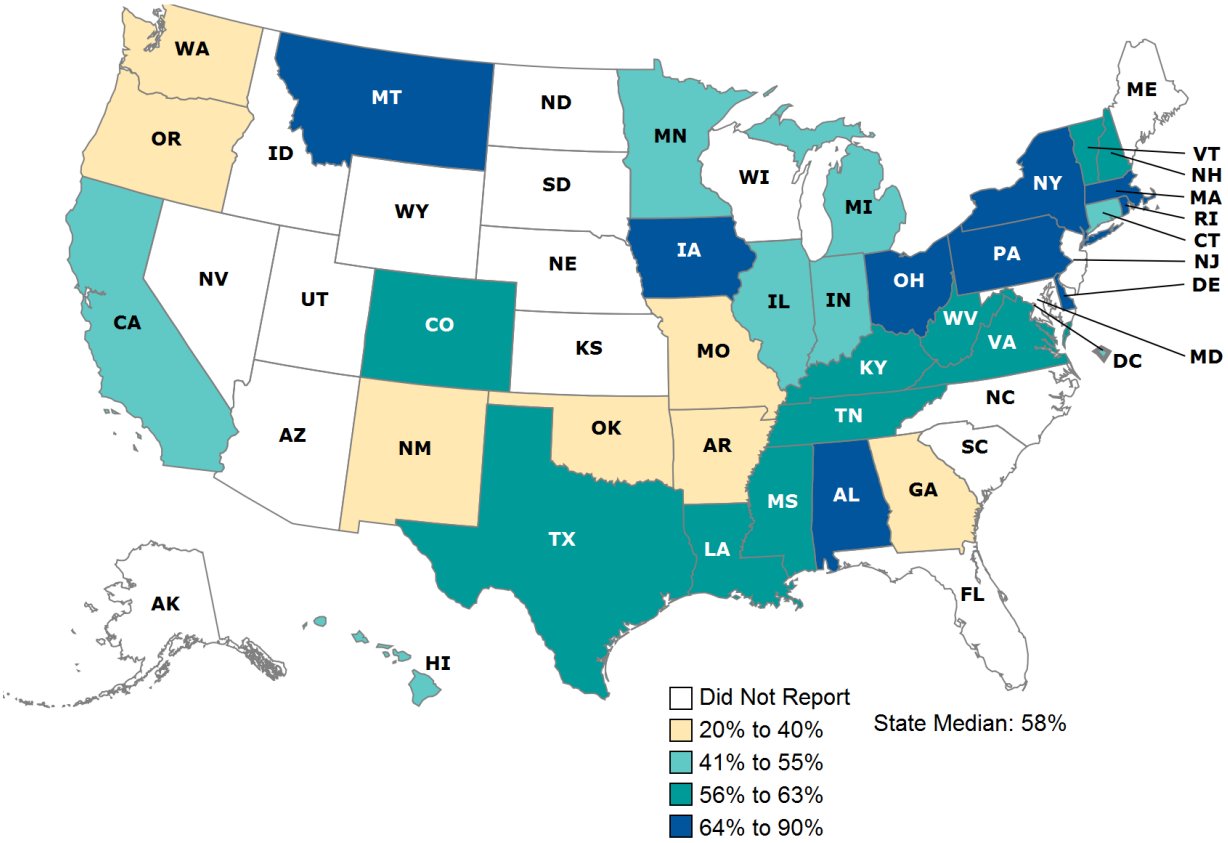
Trends

- Trends are not available for this measure. This is the first year of public reporting of the Adult Core Set measures.

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

[2] The term "states" includes the 50 states and the District of Columbia.

Exhibit PPC-AD.2. Geographic Variation in the Percentage of Women Delivering a Live Birth with a Postpartum Care Visit on or Between 21 and 56 Days after Delivery, FFY 2014 (n = 34 states)



Source: Mathematica analysis of FFY 2014 Adult CARTS reports as of May 8, 2015.

Note: To view state-specific data for this measure, please see Table PPC-AD at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/performance-on-the-adult-core-set-measures-ffy-2014.zip.

LIVE BIRTHS WEIGHING LESS THAN 2,500 GRAMS (LBW-CH)
Measure Steward: Centers for Disease Control and Prevention (CDC)

An infant's birth weight is a common measure of infant and maternal health and well-being. Infants weighing less than 2,500 grams at birth may experience serious and costly health problems and developmental delays. Pregnant women are at higher risk of giving birth to a low birth weight baby if they have chronic health conditions such as high blood pressure or diabetes, do not gain enough weight during pregnancy, experience high-levels of stress, or participate in high-risk behaviors such as drinking alcohol, smoking cigarettes, or using drugs. According to the CDC, eight percent of live births nationwide in 2013 were at low birth weight. The rate is even higher for minorities, with 13.1 percent of black infants being born at low birth weight in 2013. This measure provides an estimate of the percentage low birth weight live births paid for by Medicaid or CHIP.

Measure Description

- Percentage of live births that weighed less than 2,500 grams during the reporting period.[1]

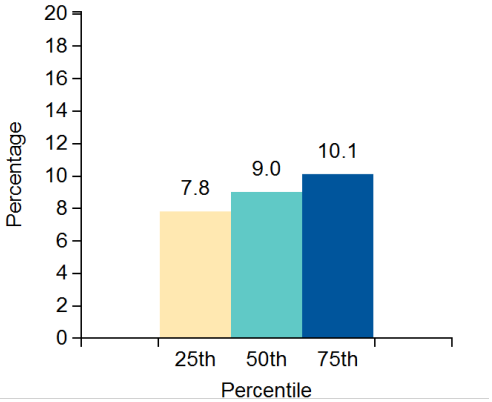
Overview of State Reporting

- The number of states reporting the Low Birth Weight measure increased from 15 states for FFY 2012 to 21 states for FFY 2013 and 29 states for FFY 2014.[2]
- Of the 29 states reporting the measure for FFY 2014, 20 reported the measure for Medicaid and CHIP, 9 reported the measure for Medicaid only, and none reported the measure for CHIP only.

State Performance

- Among the 29 states reporting the measure for FFY 2014, the median rate was 9 percent, with a 2-point spread between the 25th and 75th percentiles (Exhibit LBW-CH.1). Lower rates are better on this measure.
- Performance on this measure ranged from 5 to 13 percent among states, with considerable geographic variation across states (Exhibit LBW-CH.2, next page).

Exhibit LBW-CH.1. Percentage of Live Births Weighing Less than 2,500 Grams, FFY 2014 (n = 29 states) (Lower rates are better)



Source: Mathematica analysis of 2014 CARTS reports as of May 8, 2015.

Note: When a state reported separate rates for its Medicaid and CHIP populations, the rates were calculated using the rate for the larger measure-eligible population.

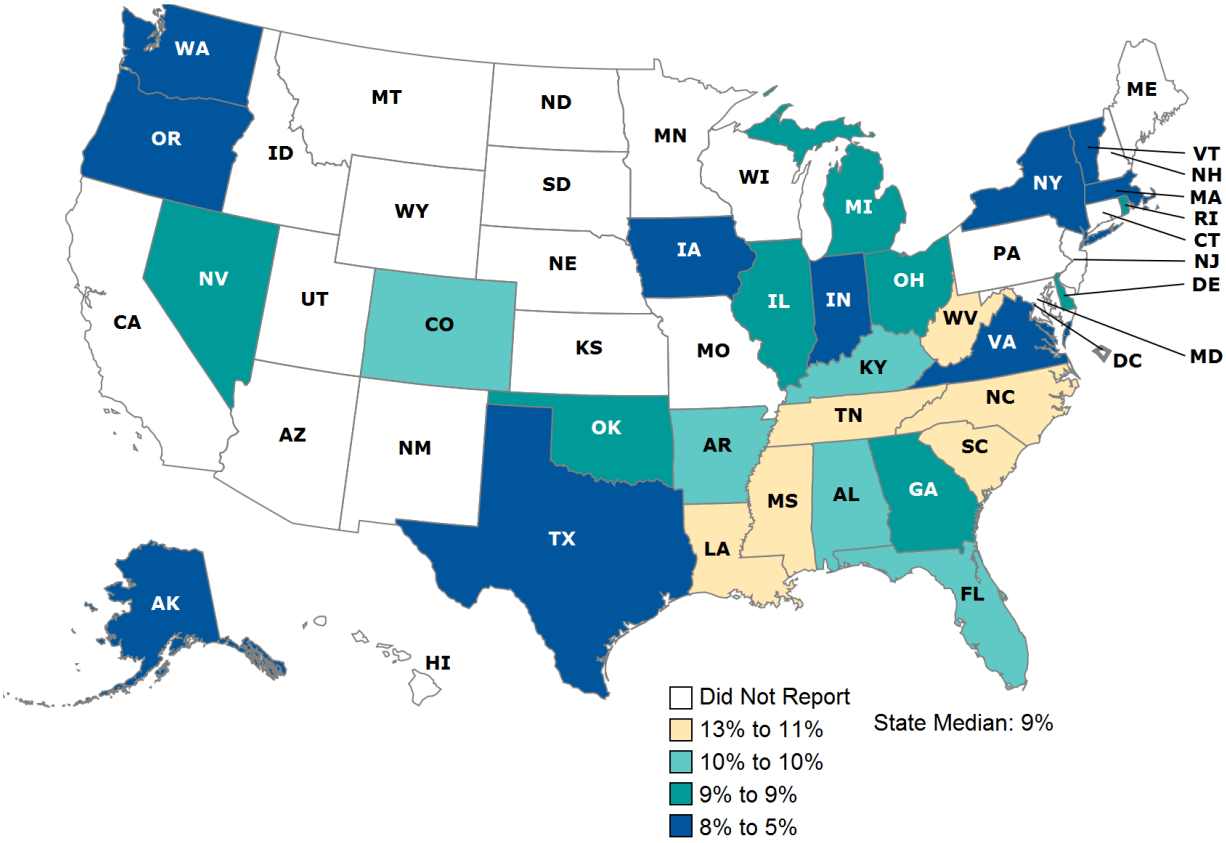
Trends

- Trends are not available for this measure. Trends are shown for measures reported by at least 20 states for all three years (FFY 2012 to FFY 2014); 14 states reported this measure for all three years.

[1] This measure is calculated using the administrative method (claims/encounter data).

[2] The term "states" includes the 50 states and the District of Columbia.

Exhibit LBW-CH.2. Geographic Variation in the Percentage of Live Births Weighing Less than 2,500 Grams, FFY 2014 (n = 29 states)



Source: Mathematica analysis of FFY 2014 Child CARTS reports as of May 8, 2015.

Notes: When a state reported separate rates for its Medicaid and CHIP populations, the rate for the larger measure-eligible population was used.

To view state-specific data for this measure, please see Table LBW-CH at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/performance-on-the-child-core-set-measures-ffy-2014.zip.

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

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.

Measure Description

- The rate of CLABSIs in NICUs.[1]
- 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 U.S. experience (calculated using data for 2006–2008). The SIR is evaluated based on the 95 percent confidence interval and the baseline population SIR of 1.
- The CLABSI measure is obtained from data reported by hospitals to the CDC's National Healthcare Safety Network. The measure includes all neonatal CLABSI events not just those for infants covered by Medicaid/CHIP.

Overview of State Reporting

- The number of states for which CDC calculated standardized infection ratios (SIRs) increased from 40 states for CY 2011 to 41 states for CY 2012 and CY 2013.[2] CDC does not calculate rates for states had fewer than five facilities reporting.

State Performance

- Of the 41 states with rates for 2013, 33 had a significant decrease in infections since the baseline period and 8 had no change in infections since the baseline period (Exhibit CLABSI-CH.1). No states had a significant increase in infections.
- Among the 41 states with CLABSI rates for 2013, the SIRs ranged from 0.175 to 0.954 (Exhibit CLABSI-CH.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.[3]

Progress

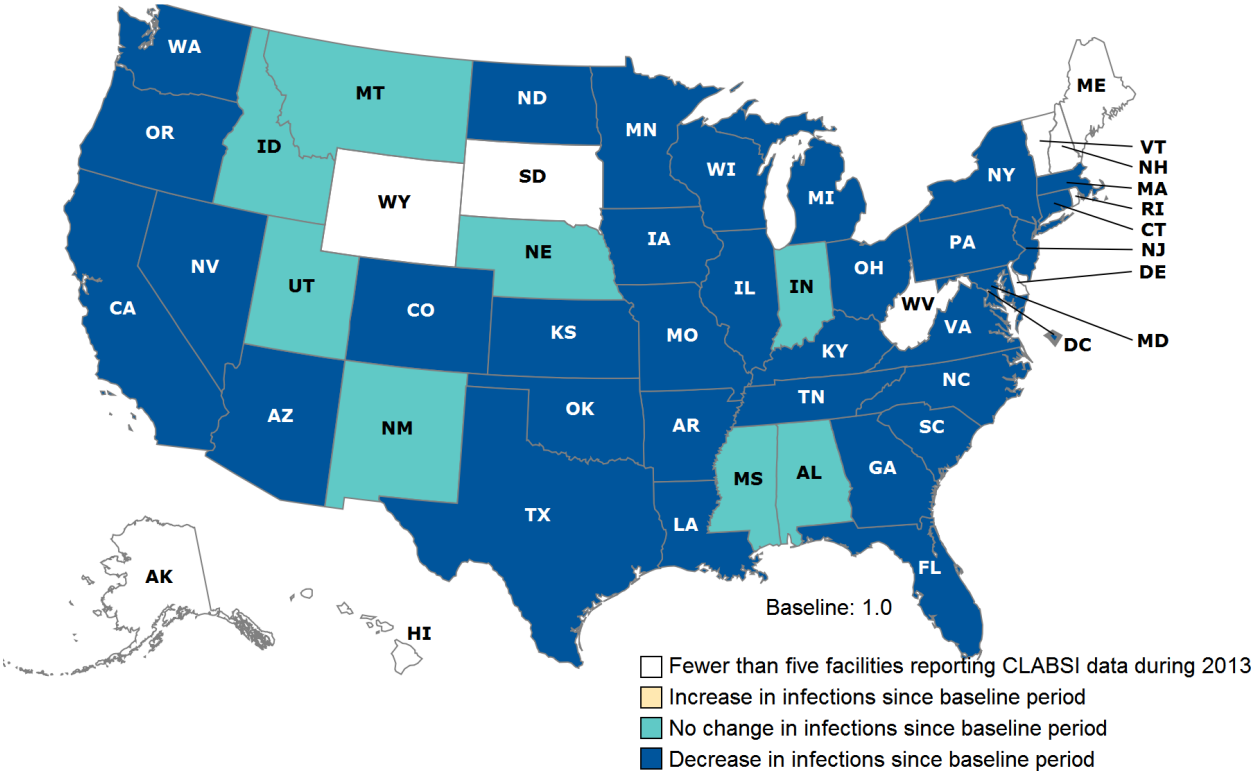
- The national goal for CLABSIs in all ICUs (including non-neonatal ICUs) is 0.51 by the end of 2013 and this goal was achieved within NICUs where the SIR was 0.499 in the 41 states in 2013.
- Additionally, the Secretary's Goal for reducing CLABSIs by 50 percent by the end of 2013 was met. However, there is still room for improvement, especially for states that did not have a decrease in infections since the baseline period.

[1] The Child Core Set measure also includes the rate of CLABSIs in pediatric intensive care units (PICUs). At this time, data on CLABSI incidents occurring in PICUs are not available.

[2] The term "states" includes the 50 states and the District of Columbia.

[3] The percentage change is determined by calculating 1 minus the SIR; for example, an SIR of 0.299 signifies a 70.1 percent reduction from the baseline period, while an SIR of 1.150 indicates a 15.0 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. For further information on the methods used to assess state performance, see the CDC 2013 National and State Healthcare-Associated Infections Standardized Infection Ratio Report, available at http://www.cdc.gov/HAI/pdfs/progress-report/hai-progress-report.pdf.

Exhibit CLABSI-CH.1. Geographic Variation in State Performance on Central Line-Associated Blood Stream Infections (CLABSIs) in Neonatal Intensive Care Units (NICUs), 2013 (n = 41 states)



Source: Centers for Disease Control and Prevention, 2013 National and State Healthcare-Associated Infections Standardized Infection Ratio Report, Table 3d, available at http://www.cdc.gov/hai/excel/hai-progress-report/HAI-Progress-Tables.xlsx.

Notes: To view state-specific data for this measure, please see Table CLABSI-CH at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/performance-on-the-child-core-set-measures-ffy-2014.zip.

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

Exhibit CLABSI-CH.2. State Performance on Central Line-Associated Blood Stream Infections (CLABSIs) in Neonatal Intensive Care Units (NICUs): Standardized Infection Ratios, 2013

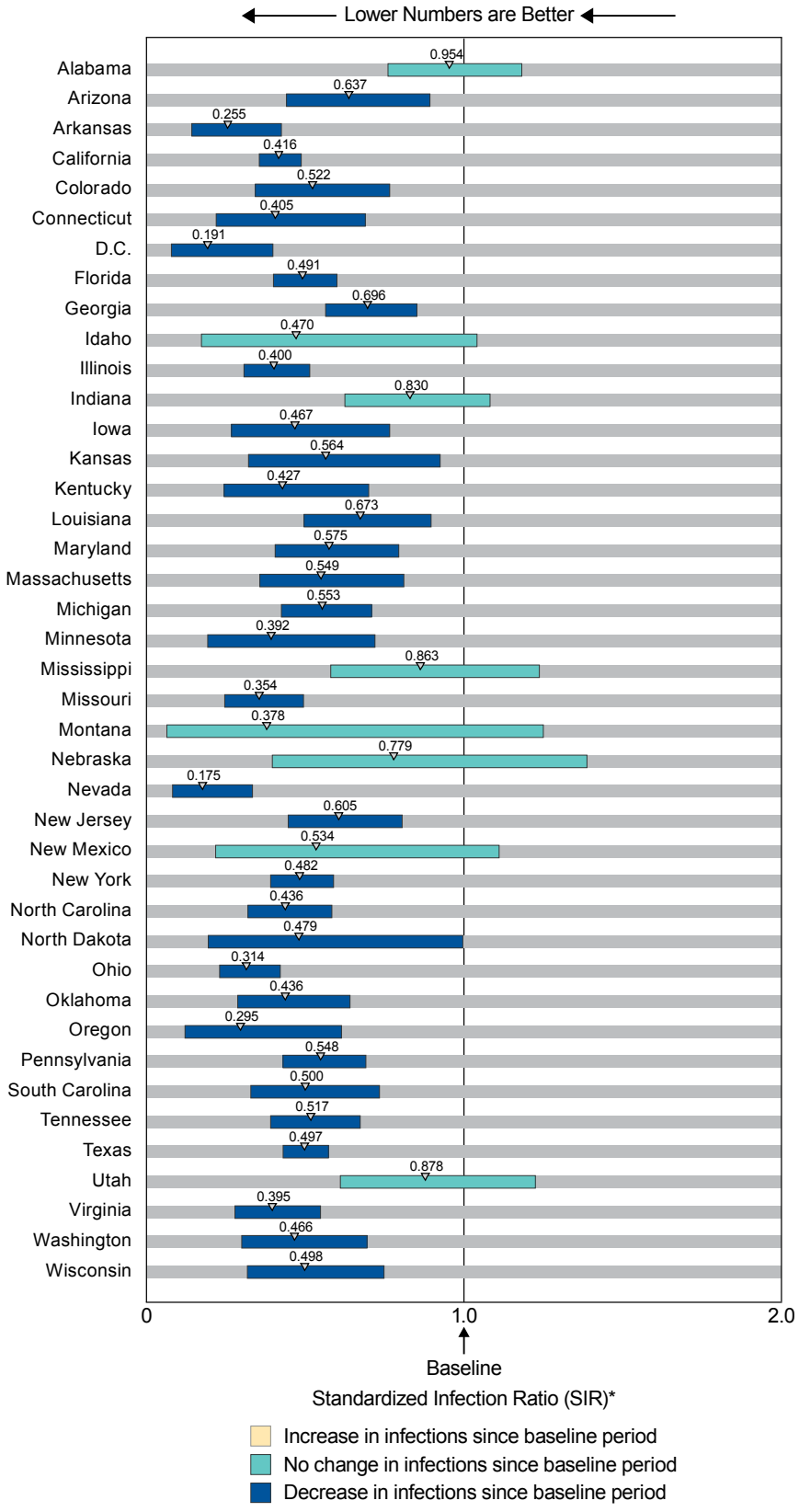


Exhibit CLABSI-CH.2 (continued)

Source: Centers for Disease Control and Prevention, 2013 National and State Healthcare-Associated Infections Standardized Infection Ratio Report, Table 3d, available at http://www.cdc.gov/hai/excel/hai-progress-report/HAI-Progress-Tables.xlsx.

Notes: This figure includes data for 41 states. Data are displayed if at least 5 facilities reported CLABSI data during the reporting period; 10 states (AK, DE, HI, ME, NH, 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 confidence interval contains 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 entire confidence interval 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 entire confidence interval 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. The percentage change is determined by calculating 1 minus the SIR; for example, an SIR of 0.299 signifies a 70.1 percent reduction from the baseline period, while an SIR of 1.150 indicates a 15.0 percent increase. More information is available at http://www.cdc.gov/hai/surveillance/QA_stateSummary.html and the confidence intervals are available at http://www.cdc.gov/hai/progress-report/index.html.

APPENDIX B

MEASURE-SPECIFIC TABLES OF STATE PERFORMANCE

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Table PPC-CH. Percentage of Pregnant Women with a Prenatal Care Visit in the First Trimester or within 42 Days of Medicaid/CHIP Enrollment, as Submitted by States for the FFY 2014 Child Core Set Report (n = 35 states)

State	Population	Methodology	Denominator	Rate
State Mean				77.1
State Median				81.4
Alabama	Medicaid only	Hybrid	29,113	58.1
Alabama	CHIP only	Administrative	162	71.0
California	Medicaid & CHIP	Hybrid	81,988	81.3
Colorado	Medicaid & CHIP	Hybrid	1,554	74.4
Connecticut	Medicaid & CHIP	Hybrid	411	80.3
Delaware	Medicaid & CHIP	Administrative	847	84.3
Dist. of Col.	Medicaid & CHIP	Hybrid	1,156	79.8
Florida	Medicaid & CHIP	Administrative & Hybrid	NR	63.3
Georgia	Medicaid & CHIP	Hybrid	410	46.8
Hawaii	Medicaid & CHIP	Hybrid	6,689	69.7
Illinois	Medicaid & CHIP	Administrative	77,927	54.4
Indiana	Medicaid & CHIP	Hybrid	1,167	90.9
Iowa	Medicaid only	Administrative	14,532	95.7
Kansas	Medicaid & CHIP	Hybrid	8,771	56.0
Kentucky	Medicaid & CHIP	Administrative	20,789	86.0
Louisiana	Medicaid & CHIP	Administrative	38,583	60.8
Maryland	Medicaid & CHIP	Hybrid	2,326	85.8
Massachusetts	Medicaid & CHIP	Hybrid	17,117	91.2
Michigan	Medicaid only	Hybrid	4,936	88.9
Mississippi	Medicaid only	Hybrid	841	88.3
Missouri	Medicaid & CHIP	Hybrid	3,761	80.2
New Jersey	Medicaid & CHIP	Administrative & Hybrid	21,975	79.4
New Mexico	Medicaid & CHIP	Hybrid	9	#
New York	Medicaid only	Hybrid	6,752	87.8
Ohio	Medicaid & CHIP	Administrative & Hybrid	51,475	84.2
Oklahoma	Medicaid & CHIP	Administrative	28,202	22.1
Oregon	Medicaid & CHIP	Administrative	5,598	67.3
Pennsylvania	Medicaid only	Hybrid	39,506	86.4
Rhode Island	Medicaid & CHIP	Hybrid	689	94.0
South Carolina	Medicaid & CHIP	Administrative	26,925	75.9
Tennessee	Medicaid only	Hybrid	2,668	80.7
Tennessee	CHIP only	Hybrid	398	73.6
Texas	Medicaid only	Hybrid	135,938	85.6
Vermont	Medicaid & CHIP	Hybrid	411	86.4
Virginia	Medicaid & CHIP	Administrative	NR	86.4
West Virginia	Medicaid only	Hybrid	9,036	86.3
Wisconsin	Medicaid & CHIP	Hybrid	4,931	81.5

Source: Mathematica analysis of FFY 2014 Child CARTS reports as of May 8, 2015.

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

Table PPC-CH (continued)

Means are calculated as the unweighted average of all state rates. When a state reported separate rates for its Medicaid and CHIP populations, the mean and median rates were calculated using the rate for the larger measure-eligible population.

Unless otherwise specified, states reporting this measure used Child Core Set specifications, based on HEDIS 2014 specifications. The following states used HEDIS 2013 specifications: DE, IA, KY, MA, NM, NY, and RI. The following state used HEDIS 2012 specifications: OR. This table excludes WA, which reported the measure but did not use Child Core Set specifications to calculate the measure.

Unless otherwise specified, the measurement period for this measure was 11/2012 to 11/2013. CA, CO, CT, DE, FL, GA, HI, IN, KS, KY, LA, MI, MO, MS, NJ, NM, OH, SC, TN, TX, VT, WI, and WV reported data for CY 2013; MA reported data for CY 2012; NY reported data for 11/2011 to 11/2012; and OR reported data for 9/2013 to 2/2014.

The Child Core Set specifications include guidance for calculating this measure using the administrative method or the hybrid method. The hybrid method uses a combination of administrative and medical records data to identify services included in the numerator or to determine exclusions from the denominator based on diagnoses or other criteria. Unless otherwise specified, administrative data sources are the state's MMIS and/or data submitted by managed care plans; medical record data sources are paper and/or electronic health records.

Denominators are assumed to be the measure-eligible population for states using the administrative method; states using the hybrid method often reported the sample size for the medical chart review rather than the measure-eligible population. Some states reported exclusions from the denominator, as noted in the state-specific comments below.

= Rate not reported because denominator is less than 30.

CHIP = Children's Health Insurance Program; CY = Calendar Year; EPSDT = Early and Periodic Screening, Diagnostic, and Treatment; EQRO = External Quality Review Organization; FFS = Fee for Service; FFY = Federal Fiscal Year; HEDIS = Healthcare Effectiveness Data and Information Set; HMO = Health Maintenance Organization; LOINC = Logical Observation Identifiers Names and Codes; MCO = Managed Care Organization; MMIS = Medicaid Management Information System; NR = Not Reported; PCCM = Primary Care Case Management; PCP = Primary Care Practitioner/Provider.

State-Specific Comments:

AL: Medicaid administrative data sources are the maternity contractor reporting system and MMIS.

AL: CHIP rate was calculated using CHIP claims data matched with state vital records. Markers of prenatal visits are not available in claims data. The month of gestation that prenatal care began was self-reported in birth certificate data. Data for the timeliness of prenatal visits are not comprehensive in claims data. The measurement specifications closely followed HEDIS.

CO: Rates include enrollees who had FFS, pre-paid inpatient health plans, and managed care during the year (9 Medicaid and CHIP Health Plan Plus [CHP+] MCOs). FFS enrollees represent approximately 70 percent of the Medicaid population. Denominator represents the sum of the sample sizes reported by the health plans. Rates were calculated by the state's EQRO.

DE: Rate includes enrollees who had managed care. Administrative data sources are vital records and claims.

DC: Rate excludes FFS enrollees. The district changed health plans during 2013, which caused beneficiaries who would normally be included to be excluded because of continuous enrollment rules.

FL: Medicaid rate was derived using administrative and hybrid methods and CHIP rate was derived using the administrative method only. Medicaid administrative data sources are claims data and live births data from the Florida State Health Online Tracking System.

GA: Rate includes enrollees who had FFS and/or managed care during the year. The majority of members who are pregnant are enrolled in managed care. The managed care hybrid rate for this measure was 82 percent. GA had poor medical record retrieval rates for the combined population (managed care and FFS) that resulted in the low hybrid rate for this population. The state plans to work with its contractors to improve retrieval rates.

IL: Rate includes rejected claims but excludes pending claims because they are adjudicated in sufficient time to not impact measurement. Rate also excludes bundled claims because they do not have the date specificity. Rate does not include LOINC codes. Administrative data sources are MMIS and vital records. Measure was audited by the state's EQRO during fall of 2014.

IN: Rate includes enrollees who had managed care (3 MCOs). Denominator represents the sum of the sample sizes reported by the MCOs.

IA: Rate includes paid claims only.

Table PPC-CH (continued)

KS: Rate includes enrollees who had managed care (3 MCOs). Denominator excludes 335 children and 15 adolescents who were covered on a FFS basis, representing two deliveries during the reporting period. Denominator represents the measure-eligible population across the MCOs.

KY: Rate includes managed care population only, representing approximately 93 percent of the population (4 MCOs). Rates exclude 38,573 FFS enrollees, representing 7.2 percent of the population.

MD: Rate includes enrollees who had managed care (6 MCOs). One MCO did not report this measure because enrollees did not meet continuous enrollment requirements.

MA: Rate includes all MassHealth members enrolled in MassHealth managed care (PCC Plan or a contracted MCO).

MS: Medicaid rate includes enrollees in coordinated care organizations (CCOs) (2 CCOs). CCO enrollees include all Medicaid-enrolled children ages 0 to 1 and pregnant enrollees ages 8 to 19. Special needs populations also have the option of enrolling in CCOs and those who were enrolled in these plans are included. Denominator represents the sum of the sample sizes reported by the CCOs.

MO: Administrative data sources are vital records, claims, and audited supplemental data. Denominator represents the sum of the sample sizes reported by the MCOs.

NJ: Rate includes enrollees who had managed care (4 MCOs). Three MCOs reported using the hybrid method and one MCO reported using the administrative method. Denominator represents measure-eligible population across the MCOs.

NM: Rate includes enrollees who had managed care (1 MCO). Managed care plan changes during the measurement period limited the size of the population eligible for this measure.

NY: Administrative data sources are individual health plan billing and HEDIS repository data systems. Denominator represents the sum of the sample sizes reported by the health plans. The measure-eligible population was 91,958. Data are the same as those reported in FFY 2013 CARTS report.

OH: Rate includes enrollees who had FFS and/or managed care during the year. MCOs calculated rates using the hybrid method; FFS rate was calculated using the administrative method.

OK: Rates may be underestimated because the majority of OK providers use global codes for prenatal visits.

OR: Because many MCOs in Oregon began providing coverage in August 2012, the state includes deliveries from September 2013 through February 2014 to have a representative sample for each MCO.

PA: Medicaid rate includes enrollees who had managed care (8 MCOs). The denominator represents the size of the measure-eligible population across the MCOs. Data were submitted by MCOs and compiled by the state's EQRO.

RI: Rate includes enrollees who had managed care.

SC: Rate does not include LOINC codes.

TX: Rate includes enrollees who had FFS and/or managed care during the year. Denominator represents the total measure-eligible population across the managed care and FFS population.

VA: Rate includes enrollees with managed care (6 MCOs), representing 95 percent of the population. Rate is pulled from NCQA's Quality Compass.

WV: Administrative data sources are MMIS, vital records, and claims data for medical services.

WI: Administrative data sources are administrative and chart data submitted by HMOs and audited by their HEDIS auditor.

Table FPC-CH. Percentage of Deliveries Receiving the Expected Number of Prenatal Care Visits, as Submitted by States for the FFY 2014 Child Core Set Report (n = 27 states)

State	Population	Methodology	Denominator	Rate				
				<21%	21–40%	41–60%	61–80%	≥81%
State Mean				12.8	7.4	8.2	13.0	56.6
State Median				8.5	4.3	7.1	13.2	65.8
Alabama	Medicaid only	Hybrid	29,113	1.0	2.2	4.8	13.2	73.7
Alabama	CHIP only	Administrative	162	3.1	3.1	8.6	21.0	64.2
Connecticut	Medicaid & CHIP	Hybrid	411	15.8	11.7	8.5	15.1	48.9
Delaware	Medicaid & CHIP	Administrative	847	7.9	3.4	6.3	11.1	71.3
Dist. of Col.	Medicaid & CHIP	Hybrid	1,156	11.0	9.3	16.9	22.8	40.1
Florida	Medicaid & CHIP	Administrative & Hybrid	23,842	9.3	5.6	11.3	26.1	52.0
Georgia	Medicaid & CHIP	Hybrid	409	48.7	15.7	7.3	5.9	22.5
Hawaii	Medicaid & CHIP	Hybrid	6,689	15.0	13.3	11.8	16.9	43.1
Illinois	Medicaid & CHIP	Administrative	77,927	5.6	4.2	4.7	6.1	79.4
Indiana	Medicaid & CHIP	Hybrid	1,127	2.9	1.2	4.2	10.3	84.9
Iowa	Medicaid only	Administrative	14,532	11.4	23.3	19.5	13.3	28.3
Kansas	Medicaid & CHIP	Hybrid	8771	49.6	15.5	7.2	6.7	21.0
Kentucky	Medicaid & CHIP	Administrative	20,791	7.1	4.3	6.4	16.1	66.2
Louisiana	Medicaid & CHIP	Administrative & Hybrid	NR	8.5	4.3	7.0	14.8	65.8
Maryland	Medicaid & CHIP	Hybrid	2,305	5.9	3.5	5.5	12.5	72.6
Massachusetts	Medicaid & CHIP	Hybrid	17,117	2.6	2.5	5.5	12.9	76.4
Mississippi	Medicaid only	Administrative	7,247	11.6	4.1	6.6	14.8	62.9
New Jersey	Medicaid & CHIP	Hybrid	21,979	10.4	5.1	8.9	16.5	59.1
New Mexico	Medicaid & CHIP	Hybrid	6,168	37.8	24.2	12.7	9.1	16.3
New York	Medicaid only	Hybrid	6,752	6.5	3.9	7.1	14.6	67.9
Ohio	Medicaid & CHIP	Administrative & Hybrid	51,475	6.2	4.3	8.7	13.4	67.5
Oklahoma	Medicaid & CHIP	Administrative	28,202	25.3	9.2	2.5	1.2	1.4
Pennsylvania	Medicaid only	Hybrid	39,506	4.2	4.1	6.8	12.2	72.8
Rhode Island	Medicaid & CHIP	Hybrid	689	1.2	2.6	5.3	12.9	77.9
South Carolina	Medicaid & CHIP	Administrative	26,925	13.3	3.9	6.0	10.3	66.5
Tennessee	Medicaid only	Hybrid	NR	7.1	6.1	9.3	14.4	63.1
Tennessee	CHIP only	Hybrid	411	15.1	2.9	8.0	14.4	59.6
Texas	Medicaid only	Administrative	140,987	14.6	6.1	9.3	18.0	52.0
Texas	CHIP only	Administrative	161	26.7	9.9	10.1	24.2	28.6
West Virginia	Medicaid only	Hybrid	9,036	5.0	5.9	10.4	10.4	75.5

Table FPC-CH (continued)

Source: Mathematica analysis of FFY 2014 Child CARTS reports as of May 8, 2015.

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

Means are calculated as the unweighted average of all state rates. When a state reported separate rates for its Medicaid and CHIP populations, the mean and median rates were calculated using the rate for the larger measure-eligible population.

Unless otherwise specified, states reporting this measure used Child Core Set specifications, based on HEDIS 2014 specifications. The following states used HEDIS 2013 specifications: DE, IA, KY, MA, NM, NY, RI, and TN. This table excludes WA, which reported the measure but did not use Child Core Set specifications to calculate the measure.

Unless otherwise specified, the measurement period for this measure was 11/2012 to 11/2013. CT, DE, FL, GA, HI, IN, KS, KY, LA, MS, NJ, NM, OH, SC, TN, and TX reported data for CY 2013; MA and TN reported data for CY 2012; NY reported data for 11/2011 to 11/2012; and WV reported data for 1/2012 to 12/2013.

The Child Core Set specifications include guidance for calculating this measure using the administrative method or the hybrid method. The hybrid method uses a combination of administrative and medical records data to identify services included in the numerator or to determine exclusions from the denominator based on diagnoses or other criteria. Unless otherwise specified, administrative data sources are the state's MMIS and/or data submitted by managed care plans; medical record data sources are paper and/or electronic health records.

Denominators are assumed to be the measure-eligible population for states using the administrative method; states using the hybrid method often reported the sample size for the medical chart review rather than the measure-eligible population. Some states reported exclusions from the denominator, as noted in the state-specific comments below.

CHIP = Children's Health Insurance Program; CY = Calendar Year; EPSDT = Early and Periodic Screening, Diagnostic, and Treatment; EQRO = External Quality Review Organization; FFS = Fee for Service; FFY = Federal Fiscal Year; HEDIS = Healthcare Effectiveness Data and Information Set; HMO = Health Maintenance Organization; LOINC = Logical Observation Identifiers Names and Codes; MCO = Managed Care Organization; MMIS = Medicaid Management Information System; NR = Not Reported; PCCM = Primary Care Case Management; PCP = Primary Care Practitioner/Provider.

State-Specific Comments:

AL: Medicaid administrative data sources are the maternity contractor reporting system and MMIS.

AL: CHIP rates were calculated using CHIP claims data matched with state vital records. Dates of prenatal visits are not available in claims data. The number of prenatal visits was self-reported in birth certificate data. Data for the frequency of prenatal visits are not comprehensive in claims data. The measurement specifications closely followed HEDIS.

DE: Rates include enrollees who had managed care.

DC: Rates exclude FFS enrollees. The district changed health plans during 2013, which caused beneficiaries who would normally be included to be excluded because of continuous enrollment rules.

FL: Medicaid rates were derived using administrative and hybrid methods and CHIP rate were derived using the administrative method only. Denominators exclude Title XXI Children's Medical Services Network. Denominator for the 81 percent or greater rate is not reported because the rate was reported separately and the denominator is not available.

GA: Rates include enrollees who had FFS and/or managed care during the year. The majority of members who are pregnant are enrolled in managed care. The hybrid rates reported by the managed care plans for this measure ranged from 53 to 63 percent of women with at least 81 percent of prenatal visits. GA had poor medical record retrieval rates for the combined population (managed care and FFS) that resulted in the low hybrid rate for this population. The state plans to work with its EQRO to improve retrieval rates.

IL: Rates include rejected claims but exclude pending claims because they are adjudicated in sufficient time to not impact measurement. Rates also exclude bundled claims because they do not have the date specificity. Rates do not include LOINC codes. Administrative data sources are MMIS and vital records. Measure was audited by the state's EQRO during fall of 2014.

IN: Rates include enrollees who had managed care (3 MCOs).

IA: Rates include paid claims only.

KS: Rates include enrollees who had managed care (3 MCOs). Denominators exclude 335 children and 15 adolescents who were covered on a fee-for-service basis, representing two deliveries during the reporting period. Denominators represent the measure-eligible population across the MCOs.

Table FPC-CH (continued)

KY: Rates include managed care population only, representing approximately 93 percent of the population (4 MCOs). Rates exclude 38,573 FFS enrollees, representing 7.2 percent of the population.

LA: Rates include enrollees who had managed care (5 health plans). Two of the plans reported using the hybrid method and three plans reported using the administrative method.

MA: Rates include all MassHealth members enrolled in MassHealth managed care (PCC Plan or a contracted MCO).

MS: Medicaid rates include enrollees in one of the state's two coordinated care organizations (CCOs). The other CCO did not report this measure for FFY2014. CCO enrollees include all Medicaid-enrolled children ages 0 to 1 and pregnant enrollees ages 8 to 19. Special needs populations also have the option of enrolling in CCOs and those who were enrolled in these plans are included.

NJ: Rates include enrollees who had managed care (4 MCOs). Denominators represent measure-eligible population across the MCOs.

NM: Rates include enrollees who had managed care (3 MCOs). Managed care plan changes during the measurement period affected the population eligible for this measure.

NY: Administrative data sources are health plan billing and HEDIS repository data systems. Denominator represents the sum of the sample sizes reported by the health plans. The measure-eligible population was 91,958. Data are the same as those reported in FFY 2013 CARTS report.

OH: Rates include enrollees who had FFS and/or managed care during the year. MCOs calculated rates using the hybrid method; FFS rate was calculated using the administrative method.

OK: Rates may be underestimated because the majority of OK providers use global codes for prenatal visits.

PA: Medicaid rates include enrollees who had managed care (8 MCOs). The denominators represent the size of the measure-eligible population across the MCOs. Data were submitted by MCOs and compiled by the state's EQRO.

RI: Rates include enrollees who had managed care.

SC: Rates do not include LOINC codes.

WV: Medicaid administrative data sources are MMIS, vital records, and claims data for medical services.

Table PPC-AD. Percentage of Women Delivering a Live Birth with a Postpartum Care Visit on or Between 21 and 56 Days after Delivery, as Submitted by States for the FFY 2014 Adult Core Set Report (n = 34 states)

State	Population	Methodology	Denominator	Rate
State Mean				54.4
State Median				58.2
Alabama	Medicaid	Administrative	23,046	90.0
Arkansas	Medicaid	Administrative	23,210	20.2
California	Medicaid	Administrative	208,428	48.7
Colorado	Medicaid & CHIP; Dual Eligibles	Hybrid	1,554	58.0
Connecticut	Medicaid & CHIP	Administrative	12,821	42.5
Delaware	Medicaid	Administrative	932	66.1
Dist. of Col.	Medicaid; Dual Eligibles	Hybrid	1,156	43.9
Georgia	Medicaid	Hybrid	409	37.4
Hawaii	Medicaid & CHIP; Dual Eligibles	Hybrid	6,689	53.1
Illinois	Medicaid & CHIP	Administrative	77,933	54.2
Indiana	Medicaid	Administrative	36,594	54.1
Iowa	Medicaid	Administrative	7,211	76.0
Kentucky	Medicaid; Dual Eligibles	Hybrid	1,688	57.9
Louisiana	Medicaid & CHIP	Hybrid	411	58.4
Massachusetts	Medicaid	Hybrid	18,000	69.8
Michigan	Medicaid & CHIP	Administrative	41,519	43.5
Minnesota	Medicaid & CHIP	Administrative	21,995	42.0
Mississippi	Medicaid	Hybrid	841	61.9
Missouri	Medicaid & CHIP	Administrative	29,249	39.7
Montana	Medicaid	Administrative	4,084	78.7
New Hampshire	Medicaid	Hybrid	453	63.4
New Mexico	Medicaid & CHIP	Administrative	9,396	29.5
New York	Medicaid	Hybrid	6,752	69.9
Ohio	Medicaid & CHIP	Administrative	81,230	66.4
Oklahoma	Medicaid & CHIP; Dual Eligibles	Administrative	28,202	21.7
Oregon	Medicaid & CHIP; Dual Eligibles	Administrative	13,385	33.4
Pennsylvania	Medicaid	Hybrid	39,506	63.9
Rhode Island	Medicaid & CHIP	Hybrid	689	70.7
Tennessee	Medicaid; Dual Eligibles	Hybrid	2,668	58.8
Texas	Medicaid	Hybrid	132,749	58.6
Vermont	Medicaid & CHIP, Dual Eligibles	Hybrid	411	60.6
Virginia	Medicaid & CHIP	Administrative & Hybrid	NR	63.0
Washington	Medicaid & CHIP	Administrative	27,457	30.7
West Virginia	Medicaid	Hybrid	8,385	62.7

Source: Mathematica analysis of FFY 2014 Adult CARTS reports as of May 8, 2015.

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

Means are calculated as the unweighted average of all state rates.

Unless otherwise specified, states reporting this measure used Adult Core Set specifications, based on HEDIS 2014 specifications. The following states used HEDIS 2013 specifications: AR, DE, KY, and NY. The following states used HEDIS 2012 specifications: CA and OR.

Table PPC-AD (continued)

Unless otherwise specified, the measurement period for this measure was 11/2012 to 11/2013. CT, DE, HI, IN, KY, LA, MI, MN, MS, NM, OH, OR, TN, TX, and WA reported data for CY 2013; CO reported data for CY 2014; DC reported data for 1/2013 to 11/2013; IA and MT reported data for 11/2012 to 12/2013; NY reported data for 11/2011 to 11/2012; AR reported data for 7/2012 to 6/2013; RI reported data for 11/2012 to 1/2014; and NH reported data for 12/2012 to 11/2013.

The Adult Core Set specifications include guidance for calculating this measure using the administrative method or the hybrid method. The hybrid method uses a combination of administrative and medical records data to identify services included in the numerator or to determine exclusions from the denominator based on diagnoses or other criteria. Unless otherwise specified, administrative data sources are the state's MMIS and/or data submitted by managed care plans; medical record data sources are paper and/or electronic health records.

Denominators are assumed to be the measure-eligible population for states using the administrative method; states using the hybrid method often reported the sample size for the medical chart review rather than the measure-eligible population. Some states reported exclusions from the denominator, as noted in the state-specific comments below.

CCO = Coordinated Care Organization; CHIP = Children's Health Insurance Program; CY = Calendar Year; EHR = Electronic Health Record; EQRO = External Quality Review Organization; FFS = Fee for Service; FFY = Federal Fiscal Year; HEDIS = Healthcare Effectiveness Data and Information Set; HMO = Health Maintenance Organization; LOINC = Logical Observation Identifiers Names and Codes; MCO = Managed Care Organization; MMIS = Medicaid Management Information System; NR = Not reported; PCCM = Primary Care Case Management; PCP = Primary Care Practitioner/Provider.

State-Specific Comments:

AL: Rate includes enrollees who had FFS and PCCM during the year. FFS enrollees represent 89 percent of the population and PCCM enrollees represent 11 percent of the population. Administrative data sources are state MMIS and Realtime Medical Electronic Data Exchange data provided by maternity contractors.

AR: Rate includes the PCCM population only, representing about 77 percent of the state's Medicaid population. Rate excludes enrollees who receive only limited Medicaid benefits (such as enrollees in the family planning waiver), enrollees receiving non-Medicaid developmental disability services, enrollees participating in a spend-down program, and enrollees who are in nursing or ICF/IID facilities.

CA: Rate includes enrollees who had FFS and managed care during the year (26 MCOs), as well as enrollees in the state's family planning program. Rate is provisional.

CO: Rate includes enrollees who had FFS, PCCM, and managed care during the year. FFS enrollees represent 91 percent of the population, PCCM enrollees represent 6 percent of the population, and MCO enrollees represent 3 percent of the population (2 Medicaid MCOs and 1 CHIP MCO). The weighted average was calculated by combining results from three Medicaid plans (FFS, DHMC and RMHP) and one CHP+ plan (SMCN).

CT: Rate includes FFS population only, and excludes Medicare-Medicaid Dual Eligibles.

DE: Rate includes managed care population only (2 MCOs).

DC: Rate includes managed care population only (4 MCOs). Rate excludes FFS enrollees. Because the District changed health plans during the year, otherwise eligible enrollees were excluded due to the continuous enrollment criteria.

GA: Rate includes enrollees who had FFS and managed care during the year. Most pregnant women are enrolled in managed care. The managed care hybrid rate for this measure was 62 percent. GA had a poor medical record retrieval rate for the combined population (managed care and FFS), which resulted in a low hybrid rate for the combined population. GA plans to work with its contractors to improve the retrieval rates.

HI: Rate includes managed care population only, representing more than 99 percent of the population (5 MCOs). Denominator includes Medicare-Medicaid Dual Eligible population only when the recipient had the same health plan for both Medicare and Medicaid coverage.

IL: Rate excludes bundled service claims because they do not have sufficient specificity. Rate includes paid and rejected claims, but excludes pending claims because they are adjudicated in sufficient time to not impact measurement. Rate includes enrollees who had FFS, PCCM, MCO/PIHP, and ICM coverage during the year.

IN: State did not implement HEDIS Decision Rule Parts A and B because the following data elements were not available: internal organization code for LMP or EDD with an obstetrical history and internal organization code for LMP or EDD with risk assessment and counseling/education. Rate includes enrollees who had managed care and FFS during the year, and excludes Medicare-Medicaid Dual Eligibles. FFS enrollees represent 45 percent of the population and MCO enrollees represent 55 percent of the population (4 MCOs).

Table PPC-AD (continued)

IA: Rate includes enrollees who had FFS, PCCM, and managed care during the year. FFS enrollees represent 32 percent of the population, PCCM enrollees represent 53 percent of the population, and MCO enrollees represent 15 percent of the population (1 MCO).

KY: Rate includes managed care population only, representing 90 percent of the population (4 MCOs).

LA: Rate includes enrollees who had FFS, PCCM, and managed care during the year (3 MCOs). Rate excludes Medicare-Medicaid Dual Eligibles.

MA: Rate includes enrollees who had PCCM and managed care during the year. PCCM enrollees represent 33 percent of the population and MCO enrollees represent 67 percent of the population (5 MCOs). The denominator represents the size of the measure-eligible population across the 5 MCOs and PCCM.

MI: Rate includes enrollees who had FFS and managed care during the year. FFS enrollees represent 4 percent of the population and MCO enrollees represent 96 percent of the population (13 MCOs). Rate excludes enrollees with other insurance (commercial or Medicare) or who participate in spenddown. Administrative data source is the State of Michigan Data Warehouse which contains MMIS data as well as vital birth records.

MN: Rate includes enrollees who had FFS and managed care during the year. FFS enrollees represent 19 percent of the population and MCO enrollees represent 81 percent of the population (8 MCOs).

MS: Rate includes managed care population only, representing 25 percent of the population (2 CCOs).

MO: Medicare-Medicaid Dual Eligibles are excluded by a process of excluding any time period that a participant had Medicare coverage when calculating the continuous eligibility. "Spenddown" participants with unmet spenddown that resulted in multiple gaps or one gap longer than 45 days are excluded from the continuous eligibles. For measures that required two years or more of continuous enrollment, MO followed the HEDIS guideline that allows a gap in each year. Further, the grouping was determined by their service in the latter year 2013. The eligibility segments and managed care and Medicare enrollment segments for CY 2013 were pulled in May 2014. Rate includes enrollees who had FFS, managed care, or both during the year. FFS enrollees represent 36 percent of the population, MCO enrollees represent 57 percent of the population (3 MCOs), and enrollees with both FFS and MCO represent 7 percent of the population.

MT: Rate includes enrollees who had FFS coverage, which includes members enrolled in PCCM.

NH: Rate includes FFS population only, representing almost all Medicaid enrollees. Rate excludes Medicare-Medicaid Dual Eligibles.

NM: Live delivery and newborn codes were used to identify the population. Rate includes paid claims only and excludes full third party liability. Rate includes enrollees who had FFS, managed care, or both during the year. FFS enrollees represent 18 percent of the population, MCO enrollees represent 29 percent of the population (4 MCOs), and enrollees with both FFS and MCO represent 53 percent of the population. Rate includes only individuals eligible for full Medicaid benefits.

NY: Rate includes managed care population only (20 MCOs).

OH: State identified postpartum visit claims up to 90 days after delivery. The earliest postpartum visit provider was used in place of the delivering provider if the rendering provider was a PCP or OB/GYN. If the provider type of the postpartum visit was a laboratory and the referring provider was a PCP or OB/GYN, then the referring provider was used. LOINC codes were not used because the data were not available. Rate includes managed care population only (7 MCOs). Ohio excluded the following groups from the measure: (1) individuals enrolled in home- and community-based waivers, (2) individuals receiving care in long-term care or intermediate care institutions, (3) Medicare-Medicaid Dual Eligibles, (4) individuals on spend-down, and (5) individuals diagnosed with cancer, cystic fibrosis, or hemophilia enrolled in the Ohio Department of Health/Bureau for Children with Medical Handicaps program. The estimated number of eligibles excluded from the measure is 570,000 (the number of members age 18 and older who were not enrolled in managed care in December 2013).

OK: Rate was calculated without global codes. Rates may be underestimated because the majority of OK providers use global codes for prenatal visits. Rate includes enrollees who had PCCM and FFS during the year. FFS enrollees represent 47 percent of the population and PCCM enrollees represent 53 percent of the population.

OR: Rate includes enrollees who had FFS and managed care during the year. FFS enrollees represent 10 percent of the population and CCO enrollees represent 90 percent of the population (15 CCOs).

PA: Rate includes managed care population only (8 MCOs). Data were submitted by managed care plans and compiled by EQRO. The numerator and denominator represent the eligible population for this measure.

RI: Rate includes managed care population only (2 MCOs). FFS/PCCM enrollees were excluded. Reported rate is based on a representative sample from each MCO. Approximately 85 percent of Rhode Island's Medicaid population is in managed care and approximately 15 percent is in FFS/PCCM.

Table PPC-AD (continued)

TN: Rate includes the managed care population (7 MCOs), representing 100 percent of the adult Medicaid population. In FFY 2014, Medicare-Medicaid Dual Eligibles from 3 of the 7 MCOs were included in the rate.

TX: Rate includes the STAR managed care population only (18 MCOs). Rate excludes FFS and PCCM enrollees as well as Medicare-Medicaid Dual Eligibles. The denominator includes a measure-eligible population of 132,749.

VT: Rate includes FFS population only. Rate includes Vermont's Medicaid expansion population.

VA: Rate is pulled from NCQA's Quality Compass. Rate includes managed care population only (7 MCOs). Rate excludes FFS enrollees, representing 60 percent of the adult Medicaid population.

WA: Washington identified clients using the live delivery and newborn codes and looked at the distribution of clients by age and gender. The state found infants identified in the live delivery set and mothers identified in the newborn set. Washington combined clients identified in both sets and selected for mothers using the restriction that gender must be female and age greater than or equal to 12. Since there can be multiple delivery dates for a client, Washington selected the earliest date as the delivery date and began checking for a second delivery 283.4 days after the initial delivery date. Rate includes paid claims only and excludes full third party liability. Rate includes enrollees who had FFS, managed care, or both during the year. FFS enrollees represent 7 percent of the population, MCO enrollees represent 16 percent of the population (5 MCOs), and enrollees with both FFS and MCO represent 76 percent of the population. Rate excludes enrollees with partial benefits. Washington managed care plans changed in July 2012, which may affect performance rates during this period.

WV: Rate includes managed care population only, representing 45 percent of the total population (3 MCOs).

Table LBW-CH. Percentage of Live Births Weighing Less than 2,500 Grams, as Submitted by States for the FFY 2014 Child Core Set Report (n = 29 states) [Lower rates are better]

State	Population	Methodology	Denominator	Rate
State Mean				9.0
State Median				9.0
Alabama	Medicaid only	Administrative	31,289	10.2
Alabama	CHIP only	Administrative	195	8.7
Alaska	Medicaid only	Administrative	5,582	7.5
Arkansas	Medicaid & CHIP	Administrative	20,884	9.6
Colorado	Medicaid only	Administrative	23,433	9.6
Delaware	Medicaid & CHIP	Administrative	1,892	8.7
Florida	Medicaid & CHIP	Administrative	82,043	9.7
Georgia	Medicaid & CHIP	Administrative	73,384	9.2
Illinois	Medicaid & CHIP	Administrative	71,388	8.7
Indiana	Medicaid & CHIP	Administrative	31,240	6.4
Iowa	Medicaid only	Administrative	15,212	6.9
Kentucky	Medicaid only	Administrative	24,812	10.0
Louisiana	Medicaid & CHIP	Administrative	43,818	12.6
Massachusetts	Medicaid & CHIP	Administrative	19,485	8.2
Michigan	Medicaid only	Administrative	67,003	8.5
Mississippi	Medicaid only	Administrative	26,439	12.6
Nevada	Medicaid & CHIP	Administrative	16,891	9.3
New York	Medicaid & CHIP	Administrative	120,226	8.0
North Carolina	Medicaid only	Administrative	55,219	10.6
Ohio	Medicaid & CHIP	Administrative	45,818	9.3
Oklahoma	Medicaid & CHIP	Administrative	29,064	9.0
Oregon	Medicaid & CHIP	Administrative	19,586	6.9
Rhode Island	Medicaid & CHIP	Administrative	5,220	8.6
South Carolina	Medicaid & CHIP	Administrative	29,488	11.0
Tennessee	Medicaid only	Administrative	52,900	10.8
Tennessee	CHIP only	Administrative	9,725	0.7
Texas	Medicaid only	Administrative	210,643	5.4
Vermont	Medicaid & CHIP	Administrative	2,760	8.0
Virginia	Medicaid & CHIP	Administrative	NR	8.1
Washington	Medicaid & CHIP	Administrative	28,289	7.0
West Virginia	Medicaid only	Administrative	10,282	11.0

Source: Mathematica analysis of FFY 2014 Child CARTS reports as of May 8, 2015.

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

Means are calculated as the unweighted average of all state rates. When a state reported separate rates for its Medicaid and CHIP populations, the mean and median rates were calculated using the rate for the larger measure-eligible population.

Unless otherwise specified, states reporting this measure used Child Core Set specifications, based on CDC 2014 specifications.

Unless otherwise specified, the measurement period for this measure was CY 2013. IL, MS, NY, RI, and VT reported data for CY 2012; MA reported data for CY 2010; AR reported data for FFY 2013; NV reported data for FFY 2014; CO reported data for 7/2012 to 6/2013; and NC reported data for 4/2013 to 3/2014.

The Child Core Set specifications include guidance for calculating this measure using state vital records. States may link vital records data to administrative data to determine payer source.

Table LBW-CH (continued)

Denominators are assumed to be the measure-eligible population for states using the administrative method. Some states reported exclusions from the denominator, as noted in the state-specific comments below.

CHIP = Children's Health Insurance Program; CY = Calendar Year; EPSDT = Early and Periodic Screening, Diagnostic, and Treatment; EQRO = External Quality Review Organization; FFS = Fee for Service; FFY = Federal Fiscal Year; HEDIS = Healthcare Effectiveness Data and Information Set; HMO = Health Maintenance Organization; LOINC = Logical Observation Identifiers Names and Codes; MCO = Managed Care Organization; MMIS = Medicaid Management Information System; NR = Not Reported; PCCM = Primary Care Case Management; PCP = Primary Care Practitioner/Provider.

State-Specific Comments:

AL: Medicaid administrative data sources are the maternity contractor reporting system and MMIS.

AL: CHIP administrative data source is state vital records matched with CHIP claims data. The measurement specifications closely followed CDC.

AK: Administrative data source is state vital records matched with Medicaid administrative claims data.

CO: Rate includes the Medicaid FFS population only, representing approximately 70 percent of the Medicaid population. Administrative data sources are vital records and MMIS; MMIS data were used to verify Medicaid eligibility.

DE: Rate includes enrollees who had managed care.

FL: Denominator excludes Title XXI Children's Medical Services Network. State did not link registry data with administrative data to determine whether births were paid by Medicaid, because the registry data includes a data field to identify if the birth was covered by Medicaid. Administrative data source is Department of Health Registry data.

GA: Rate based on AHRQ PQI #9 specifications from May 2013. Administrative data source is MMIS. Rate includes enrollees who had FFS and/or managed care during the year.

IL: Administrative data sources are vital records and claims data from MMIS. Rate calculated using uncertified vital records data after a one-year "run-out" period had elapsed. State reported data for CY2012 due to concerns about the stability of uncertified data. Data reflect births with a match between baby's vital record and mother's Medicaid eligibility and claims data. Measure was audited by the state's EQRO during fall of 2014.

IN: Administrative data source is data retrieved from the state data warehouse on December 1, 2014.

IA: Rate includes paid claims only.

KY: Rate excludes Kentucky resident births at out-of-state hospitals not using the 2003 revision of the Certificate of Live Birth, and 1,088 Kentucky resident births for whom the payment source was unknown on the live birth certificate. Denominator represents the sum of resident live births with Medicaid as payment source. 2013 data are preliminary and rate may change.

LA: Medicaid-financed deliveries are defined as deliveries with evidence of paid Medicaid claims for the mother or child during the month of delivery.

MA: Rate includes all MassHealth enrollees.

MI: Rate is provisional.

MS: Administrative data source is state vital records linked to MMIS data. Rate is provisional.

NV: Rate was calculated using state internal reporting systems.

NY: Rate is calculated using continuous enrollment of 10 or more months.

NC: Administrative data sources are vital records and claims data. Rate includes paid claims only. Rate is provisional.

OH: Administrative data sources are vital records, claims, encounter data, and enrollment files. Rate includes managed care population only, representing approximately 84 percent of the total Medicaid population.

OR: Rate is provisional.

RI: Rate calculated using birth file data. Rate represents the number of RIte Care Low Birth Weight Births divided by the total number of RIte Care Births.

SC: Rate includes women of child-bearing age (ages 15 to 44) enrolled in Medicaid or CHIP.

TN: CHIP rate calculated using administrative data.

TX: Rate calculated using AHRQ PQI low birth weight measure specifications. Rate includes enrollees who had FFS and/or managed care during the year.

VA: Administrative data sources are vital records and Medicaid and CHIP enrollment data.

WA: Administrative data source is state vital records linked to Medicaid claims and eligibility data.

Table CLABSI-CH. Pediatric Central Line-Associated Blood Stream Infections (CLABSIs)—Neonatal Intensive Care Units (NICUs): Number of Infections and Standardized Infection Ratio (SIR), by State, 2013 (n = 41 states)
[Lower rates are better]

State	Number of Infections Reported (A)	Predicted Number of Infections (B)	Standardized Infection Ratio (SIR) (A/B)	Evaluation of State Performance[a]
All U.S.[b]	1,648	3,299.309	0.499	
Alabama	79	82.789	0.954	No change in infections since baseline period
Arkansas	13	51.022	0.255	Decrease in infections since baseline period
Arizona	31	48.673	0.637	Decrease in infections since baseline period
California	155	372.202	0.416	Decrease in infections since baseline period
Colorado	24	45.943	0.522	Decrease in infections since baseline period
Connecticut	12	29.663	0.405	Decrease in infections since baseline period
Dist. of Col.	6	31.442	0.191	Decrease in infections since baseline period
Florida	94	191.302	0.491	Decrease in infections since baseline period
Georgia	90	129.350	0.696	Decrease in infections since baseline period
Iowa	14	29.956	0.467	Decrease in infections since baseline period
Idaho	5	10.637	0.470	No change in infections since baseline period
Illinois	57	142.506	0.400	Decrease in infections since baseline period
Indiana	51	61.454	0.830	No change in infections since baseline period
Kansas	14	24.803	0.564	Decrease in infections since baseline period
Kentucky	14	32.749	0.427	Decrease in infections since baseline period
Louisiana	44	65.354	0.673	Decrease in infections since baseline period
Massachusetts	23	41.921	0.549	Decrease in infections since baseline period
Maryland	34	59.180	0.575	Decrease in infections since baseline period
Michigan	59	106.616	0.553	Decrease in infections since baseline period
Minnesota	9	22.960	0.392	Decrease in infections since baseline period
Missouri	32	90.372	0.354	Decrease in infections since baseline period
Mississippi	27	31.288	0.863	No change in infections since baseline period
Montana	2	5.288	0.378	No change in infections since baseline period
North Carolina	42	96.326	0.436	Decrease in infections since baseline period
North Dakota	6	12.527	0.479	Decrease in infections since baseline period
Nebraska	10	12.834	0.779	No change in infections since baseline period
New Jersey	44	72.674	0.605	Decrease in infections since baseline period
New Mexico	6	11.230	0.534	No change in infections since baseline period
Nevada	8	45.590	0.175	Decrease in infections since baseline period
New York	91	188.854	0.482	Decrease in infections since baseline period
Ohio	42	133.850	0.314	Decrease in infections since baseline period
Oklahoma	24	54.985	0.436	Decrease in infections since baseline period
Oregon	6	20.312	0.295	Decrease in infections since baseline period
Pennsylvania	68	124.088	0.548	Decrease in infections since baseline period
South Carolina	24	47.953	0.500	Decrease in infections since baseline period

Table CLABSI-CH (continued)

State	Number of Infections Reported (A)	Predicted Number of Infections (B)	Standardized Infection Ratio (SIR) (A/B)	Evaluation of State Performance[a]
Tennessee	52	100.676	0.517	Decrease in infections since baseline period
Texas	182	366.258	0.497	Decrease in infections since baseline period
Utah	32	36.447	0.878	No change in infections since baseline period
Virginia	33	83.513	0.395	Decrease in infections since baseline period
Washington	22	47.232	0.466	Decrease in infections since baseline period
Wisconsin	21	42.177	0.498	Decrease in infections since baseline period

Source: Centers for Disease Control and Prevention, 2013 National and State Healthcare-Associated Infections Standardized Infection Ratio Report, Table 3d, available at http://www.cdc.gov/hai/excel/hai-progress-report/HAI-Progress-Tables.xlsx.

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

Data are displayed for a state if at least 5 facilities reported CLABSI data during the reporting period; 10 states (AK, DE, HI, ME, NH, RI, SD, VT, WV, and WY) had fewer than five facilities report.

Data are included from all NICU locations, including Level II/III and Level III nurseries. Umbilical line- and central line-associated bloodstream infections are both considered CLABSIs. The CMS Child Core Set measure also includes the rate of CLABSIs in pediatric intensive care units (PICUs). At this time, data on CLABSI events occurring in PICUs are not available.

[a] 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 confidence interval contains 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 confidence interval contains only values 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 confidence interval contains only values 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 and the confidence intervals are available at http://www.cdc.gov/hai/progress-report/index.html.

[b] The U.S. rate includes hospitals in Puerto Rico.

APPENDIX C

PROGRESS ON PERINATAL HEALTH PERFORMANCE IMPROVEMENT PROJECTS (PIPS), AS REPORTED IN EXTERNAL QUALITY REVIEW (EQR) TECHNICAL REPORTS, 2014–2015 REPORTING CYCLE

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Table C.1. Progress on Perinatal Health Performance Improvement Projects (PIPs), as Reported in External Quality Review (EQR) Technical Reports, 2014–2015 Reporting Cycle

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQR Validation Rating[a]	EQR Discussion and Recommendations
California: Anthem	PIP aims to improve timeliness of prenatal and postpartum care. The PIP was in the planning and implementation phase, and the EQR technical report does not include any data on performance.	None reported	Met	None reported
California: CalOptima	PIP aims to improve the prenatal visit rates for pregnant members. The PIP was in the planning and implementation phase, and the EQR technical report does not include any data on performance.	None reported	Met	None reported
California: Community Health Group Partnership Plan	PIP aims to improve the rate of postpartum visits for women between 21 and 56 days after delivery. The PIP was in the planning and implementation phase, and the EQR technical report does not include any data on performance.	Member outreach/education: call new mothers to remind them of postpartum visits; send post-delivery congratulatory and educational letter for each live birth; provide members with a $25 incentive gift card for completing postpartum visit during required time frame. Provider outreach/education: contact providers who bill for global delivery charges to obtain specific dates of postpartum visits. System change: help members who have delivered schedule their postpartum visits and provide taxi transportation to and from the visits; contract with home care vendor who can provide nurse practitioners to conduct postpartum visits; offer an in-home visit; obtain the member's hospital face sheet to compare the most current demographic data with data in the member profile and update if necessary.	Met	None reported
California: Contra Costa Health Plan	PIP aims to improve perinatal access and care. The PIP was in the planning and implementation phase, and the EQR technical report does not include any data on performance.	Member outreach/education: develop a system to call new mothers to ensure appointments are scheduled and remind them of their appointments. Provider outreach/education: work with the MCO's largest provider network to improve provision of contraception. System change: work with outside hospital to set up a process to schedule appropriately timed postpartum appointments before discharge; work with Contra Costa Regional Medical Center to develop a system that ensures providers will address the requirements of a postpartum visit.	Met	None reported

Table C.1 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQR Validation Rating[a]	EQR Discussion and Recommendations
California: Health Net Community Solutions	PIP aims to improve postpartum care among Medi-Cal women, including seniors and people with disabilities. The PIP was in the planning and implementation phase, and the EQR technical report does not include any data on performance.	None reported	Met	None reported
California: Health Plan of San Mateo	PIP demonstrated a decrease in performance on the percentage of members who had a prenatal care visit in the first trimester or within 42 days of enrollment (85.3 percent at baseline versus 84.2 percent at second remeasurement).	Member outreach/education: conducted outbound calls to eligible members. Provider outreach/education: reached out to providers who could benefit from the pay-for-performance (P4P) program. System change: maintained and catalogued records and forms from the P4P program to use as leads during the Healthcare Effectiveness Data and Information Set (HEDIS) process; redesigned reminder forms; researched ways to conduct outreach to members younger than age 21; reestablished community partnerships.	Met	Recommendations: The MCO should develop systemwide interventions strictly based on the root cause analysis of the problem this PIP is addressing and likely to induce permanent change. The MCO should conduct a new causal/barrier analysis and assess whether it needs to discontinue or modify existing interventions, or identify new interventions to better address the priority barriers.
California: Partnership Health Plan of California	PIP aims to improve the timeliness of prenatal and postpartum care. The PIP was in the planning and implementation phase, and the EQR technical report does not include any data on performance.	None reported	Met	None reported
District of Columbia (collaborative): AmeriHealth District of Columbia	PIP aims to improve performance on miscarriage or fetal loss; neonates weighing <2,500 grams; neonates with a gestational age <37 weeks; pregnancies for which the outcome is unknown; lack of maternal HIV testing; and death of an infant ages 0 to 365 days. The PIP was in the planning and implementation phase, and the EQR technical report does not include any data on performance.	Member outreach: identify pregnant members and reach out to them and supply them with a cell phone and 250 free minutes per month, along with unlimited text messaging and calls to the MCO; help members schedule prenatal appointments and will call and send text reminders; created Bright Start Baby Shower as a way for expectant mothers to receive vital prenatal information in a celebratory environment. Provider outreach: send notifications (in provider newsletters and fax blasts) regarding the mandatory submission of the obstetrician (OB) Authorization Form; may conduct review to identify noncompliant providers in order to provide targeted follow-up. System change: pilot a well-baby and postpartum visit coordination initiative due to members not keeping appointments; work with pilot offices to schedule postpartum visits on the same day as the baby's one-month well-child visit; categorize members into either a high-risk or low-risk intervention group; begin a maternity management program to help at-risk pregnant women have a healthy, full-term pregnancy.	Met (for sub-measures 1–6)	None reported

Table C.1 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQR Validation Rating[a]	EQR Discussion and Recommendations
District of Columbia (collaborative): Health Services for Children with Special Needs	PIP aims to improve performance on miscarriage or fetal loss; neonates weighing <2,500 grams; neonates with a gestational age <37 weeks; pregnancies for which the outcome is unknown; lack of maternal HIV testing; and death of an infant ages 0 to 365 days. The PIP was in the planning and implementation phase, and the EQR technical report does not include any data on performance.	Member outreach: contact by telephone or face to face; provide baby shower with Sudden Infant Death Syndrome (SIDS) training for pregnant members. Provider outreach: send mailing to the OB provider community to reintroduce the OB Assessment and Psychosocial Form; explain perinatal collaborative and the importance of identifying and treating HIV-positive pregnant women. System change: OB multidisciplinary team conducts clinical rounds on all pregnancy cases and prioritizes and triages member care management intensity based on the clinical case reviews; schedule, remind, and accompany members to their prenatal appointments; arrange transportation; follow up after appointments; provide health education regarding sexually transmitted infections and HIV; monitor baby's development/growth and provide education regarding breastfeeding; develop electronic tools to monitor perinatal care metrics and improve the timeliness of capturing data, including the OB Assessment and Psychosocial Form; conduct medical record reviews on pregnant members to obtain HIV status and perinatal visit information to gather complete and accurate information; revise the OB program description; conduct biweekly teleconference calls with Teen Alliance for Prepared Parenting (TAPP) to review previous referrals for updates and care coordination for new referrals; report weekly lab results to OB care management and the HEDIS manager to help identify pregnancies early and obtain HIV test results.	Met (for sub-measures 1–6)	None reported
District of Columbia (collaborative): MedStar Family Choice	PIP aims to improve performance on miscarriage or fetal loss; neonates weighing <2,500 grams; neonates with a gestational age <37 weeks; pregnancies for which the outcome is unknown; lack of maternal HIV testing; and death of an infant ages 0 to 365 days. The PIP was in the planning and implementation phase, and the EQR technical report does not include any data on performance.	Member outreach: refer pregnant teens/youth to the Washington Hospital Center TAPP program, which provides obstetric and gynecologic services, prenatal and parenting education, family planning/contraceptive services, individual and group counseling, and workshops in communication, conflict resolution, and other life management skills; refer pregnant members to the Department of Health Safe Cribs program, which offers services and education designed to reduce infant mortality, sudden unexplained infant deaths (SUIDs), and suffocation; provide pack and plays to the pregnant women. Provider outreach: use OB Authorization Form to collect information on new pregnancies and allow for timely pregnancy notification and risk assessment; send letter to providers summarizing the form and emphasizing the value of its completion for the perinatal collaborative; distribute biannual provider newsletters, including tips/advice for practitioners regarding member prenatal care and recommendations on communicating with members with diverse cultural backgrounds; schedule appointments with high-volume clinics to provide an educational session and explain the importance and value of completing the OB Authorization Form; contact and work with high-volume clinics that prove to be difficult to work with when scheduling member prenatal care appointments; intervene on behalf of the outreach department and work with these clinics.	Met (for sub-measures 1–6)	None reported

Table C.1 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQR Validation Rating[a]	EQR Discussion and Recommendations
District of Columbia (collaborative): Trusted Health Plan	PIP aims to improve performance on miscarriage or fetal loss; neonates weighing <2,500 grams; neonates with a gestational age <37 weeks; pregnancies for which the outcome is unknown; lack of maternal HIV testing; and death of an infant ages 0 to 365 days. The PIP was in the planning and implementation phase, and the EQR technical report does not include any data on performance.	Member outreach: develop an OB case management program: Healthy Beginnings. Education and outreach at the MCO's Outreach and Wellness Center in the District; OB case manager/care manager is stationed at the center and provides face-to-face contact and engagement with members; distribute educational materials, including information regarding the importance of prenatal care, awareness of bodily changes, and nutrition demands of pregnancy; partner with several organizations/programs to provide services at the Outreach and Wellness Center; work with the customer service, utilization review, and outreach departments to identify alternate member contact methods for hard-to-reach members, including door-to-door contact, participation in utilization management rounds/ monitoring daily census, and a regional information system. Provider outreach: visit provider practices to educate providers on the collaborative, available educational programs, appropriate use and timely submission of the OB Authorization Form, HIV screening requirements, and reporting birth weight in grams versus pounds. System change: send monthly queries using the lab vendor's data link to review HIV screenings for known pregnant members; subcontract with an agency that will monitor high-risk pregnancies, provide 48-hour assessments for neonatal intensive care unit (NICU) discharges, and help set up the home after NICU discharge; implement assessment tool to monitor milestones during an infant's first year of life; make referrals to special needs case management, care coordination, and home visitations/assessments as needed.	Met (for sub-measures 1–6)	None reported

Table C.1 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQR Validation Rating[a]	EQR Discussion and Recommendations
Florida: AMERIGROUP Community Care Better Health Children's Medical Services Coventry Health Care of Florida First Coast Advantage Humana Family Integral Quality Care Molina Healthcare Preferred Medical Plan Prestige Health Choice Simply Healthcare Plans South Florida Community Care Network Sunshine State Health Plan UnitedHealthcare Staywell Health	PIP aims to improve performance on the percentage of women who had a live birth who received a prenatal care visit as an enrollee in the first trimester or within 42 days of enrollment, and the percentage of children 15 months of age during the measurement period who received six or more well-child visits with a primary care provider (PCP). The PIP was in the planning and implementation phase, and the EQR technical report does not include any data on performance.	None reported	Met: 10 MCOs[b] Partially met: 4 MCOs Not met: 1 MCO	None reported
Georgia: Amerigroup	PIP demonstrated improvement in performance on the percentage of deliveries of live births by members that were followed by a postpartum visit on or between 21 and 56 days after delivery (59.5 percent at baseline versus 60.8 percent at first remeasurement).	Member outreach/education: made telephone calls and sent text message to schedule postpartum care visits; implemented member incentive program for completion of postpartum visit. Provider outreach/education: implemented nurse consultant visits for low-performing providers to share best practices and facilitate improvement of postpartum visit rate. System change: began pilot incentive program for OB provider schedulers to ensure completion of postpartum visits among eligible members.	Not met	In response to the lack of statistically significant improvement in the study indicator rate and intervention evaluation results, the MCO documented planned intervention-specific revisions for the following measurement period. The revisions include contracting with a new vendor to complete telephone outreach to members due for a postpartum visit, seeking enhanced member contact information through an outside vendor, and incorporating the appointment scheduling rates into the performance reviews of member outreach associates.

Table C.1 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQR Validation Rating[a]	EQR Discussion and Recommendations
Georgia: Peach State Health Plan	PIP demonstrated a statistically significant decline in performance on the percentage of deliveries of live births by members that were followed by a postpartum visit on or between 21 and 56 days after delivery (71.6 percent at baseline versus 61.8 percent at first remeasurement).	Member outreach/education: implemented the Healthy Start Program, in which clinical staff meet with members after they give birth but before they leave the hospital, to provide education on postpartum care and help schedule the postpartum visit. Provider outreach/education: began a collaborative partnership with the Obstetrics Society to increase provider awareness about the importance of completing postpartum visits between 21 and 56 days after delivery. System change: implemented a bonus program for providers who accurately code postpartum visits within the specified time frame using appropriate ICD-9 codes.	Not met	Given the statistically significant decline in the study indicator rate, the EQRO would have expected to see documentation of new or revised interventions to address the lack of improvement. The MCO reported that its team conducted a drill-down analysis in response to results of the first remeasurement; however, the PIP documentation did not include planned revisions to the improvement strategies.
Georgia: WellCare of Georgia, Inc.	PIP demonstrated an improvement in performance on the percentage of deliveries of live births by members that were followed by a postpartum visit on or between 21 and 56 days after delivery (62.5 percent at baseline versus 63.2 percent at first remeasurement).	Member outreach/education: implemented reminder calls for scheduled postpartum appointments; provided members an incentive for completing a timely visit, and the MCO offered a "maternity rewards program" where the members could select a stroller or play yard after completing of a timely postpartum visit; facilitated member outreach by OB social workers. Community outreach/education: Community relations department hosted postpartum events to promote importance of timely postpartum visits. Provider outreach/education: received assistance from the Obstetrics and Gynecology Society to provide education to specialist. System change: contracted with a vendor to conduct comprehensive outreach to members during and after pregnancy; issued a "Welcome Home Report" for each member recently discharged after delivery to plan transitional interventions; provided OB short-term case management.	Not met	The MCO provided insufficient information about the interventions implemented. The MCO reported only the calendar year for the intervention implementation dates, and it was unclear whether interventions were implemented for only part of the identified measurement period. The MCO failed to describe evaluation methods or results for the PIP interventions.
Illinois (collaborative): Family Health Network	The primary aim of the PIP is to improve the timeliness of prenatal care and postpartum care. A secondary aim is to improve the percentage of women who are screened for depression during the prenatal and/or postpartum period. Sixteen indictors (both HEDIS and state-specific) were used to measure the PIP's progress. Of the 13 reported PIP outcomes, 5 indicators declined, with 2 demonstrating a statistically significant decline, and 8 improved, with 1 demonstrating a statistically significant increase. There was sustained improvement over six indicators.	Member outreach/education: started text4baby program, where mothers receive information pertinent to the gestational age and to age of the baby up to 1 year. Provider outreach/education: sent provider incentive program designed to pay providers $25 for notifying the MCO of female members diagnosed as pregnant. System change: implemented routine reviews of emergency room claims to identify women diagnosed as being pregnant, and these women were referred to the prenatal case manager.	Met	Recommendations: The MCO should conduct causal/barrier and drill-down analyses more frequently than annually and incorporate quality improvement science, such as Plan-Do-Study-Act cycles, into its improvement strategies and action plans. The MCO should target interventions at high-priority barriers, rather than trying to address every identified priority with limited resources.

Table C.1 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQR Validation Rating[a]	EQR Discussion and Recommendations
Illinois (collaborative): Harmony Health Plan of Illinois	The primary aim of the PIP is to improve the timeliness of prenatal care and postpartum care. A secondary aim is to improve the percentage of women who are screened for depression during the prenatal and/or postpartum period. Sixteen indictors (both HEDIS and state-specific) were used to measure the PIP's progress. Of the 16 reported PIP outcomes, 1 indicator declined, and 14 improved, with 1 demonstrating a statistically significant increase. There was sustained improvement over 12 indicators.	Member outreach/education: made hospital discharge follow-up telephone calls to members to help schedule postpartum transportation and arrange transportation; continued Harmony Hugs, a program providing all members with a packet that includes a booklet containing articles about prenatal care, postpartum care, and depression screening. Provider outreach/education: executive staff members conducted one-on-one education with Independent Physician Associations about physician report cards, member noncompliant lists, how to use correct billing codes, the importance of submitting encounters, the importance of screening members for depression, and how to document these screenings in the medical record. System change: member services staff updated member contact information each time contact was made with the member.	Met	Recommendations: The MCO should conduct causal/barrier and drill-down analyses more frequently than annually and incorporate quality improvement science, such as Plan-Do-Study-Act cycles, into its improvement strategies and action plans. The MCO should target interventions at high-priority barriers, rather than trying to address every identified priority with limited resources.
Illinois (collaborative): Meridian Health Plan	The primary aim of the PIP is to improve the timeliness of prenatal care and postpartum care. A secondary aim is to improve the percentage of women who are screened for depression during the prenatal and/or postpartum period. Sixteen indictors (both HEDIS and state-specific) were used to measure the PIP progress. Of the 16 reported PIP outcomes, 5 indicators declined, with 2 demonstrating a statistically significant decline, and 5 improved, with 4 demonstrating a statistically significant increase. There was sustained improvement over seven indicators.	Member outreach/education: conducted outreach to members based on weekly reporting of claims; sent educational materials and incentive programs to meet member needs, including Spanish versions of all existing information; held raffles to promote timely prenatal and postpartum care. System change: automated the encounter data file provided by the state to capture the maximum amount of pregnant members for outreach and coordination of care services; reported weekly on prenatal claims based on HEDIS specifications; hired a behavioral health professional and licensed clinical professional to conduct high-risk prenatal and depression screening; established the Maternity Care Coordination program, through which postpartum members will be contacted by a representative and provided coordinated care through their perinatal period.	Met	Recommendations: The MCO should conduct causal/barrier and drill-down analyses more frequently than annually and incorporate quality improvement science, such as Plan-Do-Study-Act cycles, into its improvement strategies and action plans. The MCO should target interventions at high-priority barriers, rather than trying to address every identified priority with limited resources.

Table C.1 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQR Validation Rating[a]	EQR Discussion and Recommendations
Louisiana: UnitedHealthcare Community Plan of Louisiana	PIP aims to improve performance on the percentage of live singleton births with gestational age >= 37 weeks and <39 weeks that were nonmedically indicated; the percentage of live singleton births with gestational age >= 37 weeks and <39 weeks that were nonmedically indicated delivered by C-section; and the percentage of live singleton births with gestational age >= 37 weeks and <39 weeks that were nonmedically indicated resulting in an NICU admission. The PIP was in the planning and implementation phase, and the EQR technical report does not include any data on performance.	Member outreach/education: ensure Health First Steps scripting for member outreach; develop and implement scripting for providers on the benefits of full-term deliveries; send articles about the benefits of full-term deliveries in member newsletters; disseminate materials to PCPs to share with members identified as pregnant. Provider outreach/education: send articles about the benefits of full-term deliveries in provider newsletters. Community outreach/education: identify resources and education materials on the benefits of full-term deliveries and distribute them to school-based health centers; create a proposal for billboard/bus shelter advertising about the benefits of full-term deliveries. System change: engage with the Nurse Family Partnership and Healthy Start; identify other potential partners; identify facilities that are outliers with respect to gestational age at delivery and facilitate the development and implementation of improvement plans; demonstrate birth outcomes of members who see providers participating with Centering Pregnancy sites in Louisiana and use information to promote best practices learned from state pilot.	No validation findings that indicate that the credibility of the PIP results is at risk	The MCO has strong project rationale. Performance measures are relevant to study aim and were developed specifically for this project. Barrier analysis was conducted and interventions were developed based on findings. Recommendations: As the project progresses, the MCO might consider a hospital system as a possible partner, perhaps a hospital identified as an outlier.
Massachusetts: Health New England (HNE)	PIP demonstrated a nonstatistically significant improvement in performance on the Timeliness of Prenatal Care measure (88.2 percent in 2011 versus 93.7 percent in 2013). PIP demonstrated a nonstatistically significant improvement in performance on the Postpartum Care measure (73.9 percent in 2011 versus 76.0 percent in 2013).	Member outreach: implemented Maternity Management Program (MMP), a core set of educational materials and services to all pregnant HNE members that identifies and manages all potentially high-risk pregnancies as early as possible; mailed introductory letter/flyers, including information on car seats, choosing a provider, exercise, healthy weight, postpartum depression, and other issues if identified (HIV, travel, supplements, etc.); held Community Baby Shower and Education Day; made bilingual outreach calls to members identified as pregnant to explain the MMP; made postpartum outreach call two weeks after delivery. Provider outreach: held OB case discussions during grand rounds; posted article on HNE Talk (provider communication tool) to remind providers of MMP. System change: sent practice site reports, which are monthly and quarterly data reporting packages from the MCO healthcare economics department; conducted monthly consultative data review sessions with practice site leadership teams; updated the MCO “Be Healthy” website, including the section “For expecting mothers: MCO ‘BEE’ Healthy Babies Program.”	Varies by sub-measure; mostly met	Recommendations: Develop a process to measure the impact of the baby shower intervention—specifically, whether it generates a return on investment of staff time and plan resources. The EQRO recognizes that this is a community outreach effort, but if the MCO uses this as an intervention, there should be an effort to measure impact. The MCO should harness information from interactions of the bilingual medical services coordinator to determine whether there are any trends that would require new interventions or adjustments to current interventions. Determine what percentage of identified pregnant women the bilingual medical services coordinator reaches and how the remaining members should be reached. Explore ways to increase early identification of pregnant members. Implement a follow-up call to provider or member to ascertain whether the member received the postpartum visit; provide assistance with scheduling as needed.

Table C.1 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQR Validation Rating[a]	EQR Discussion and Recommendations
Massachusetts: Neighborhood Health Plan (NHP)	PIP demonstrated a nonstatistically significant decrease in performance on the Postpartum Care measure (66.3 percent in CY2010 versus 65.8 percent in CY2013).	Member outreach: sent a postpartum toolkit containing health and wellness resources to new mothers; conducted outreach to mother after childbirth to remind her of the importance of the postpartum visit and to facilitate an appointment if necessary; revised scripts for postpartum follow-up calls, with more emphasis placed on making and keeping the postpartum visit; published article in the member newsletter on the importance of the postpartum visit; sent postpartum checkup reminder cards and letters to members; posted information about postpartum care on website; implemented Early Intervention Partnership program to deliver care and resources to members throughout the postpartum period, including coordination of a postpartum assessment; designed and distributed a postpartum flyer in the Latina community; conducted radio interview on La Mega (Spanish radio station) with perinatal care manager (in Spanish) discussing the importance of prenatal, postpartum, and well-child visits. Provider outreach: sent risk scores to providers; conducted outreach to OB/GYN providers to obtain dates of postpartum visits; communicated with hospital postpartum discharge planners about the importance of discussing the postpartum visit with mothers before discharge; sent message about the importance of postpartum care placed on new provider telephone line; published article in the provider newsletter on the importance of postpartum care/follow-up visit. System change: conducted case management (telephonic outreach) for members identified with a risk score of 2.3 or higher; for members with risk scores below 2.3, mailed invitation/postpartum welcome letter with information on MCO's prenatal care management program ("For You Two") and collateral prenatal materials about text4baby, car seats, baby basics, and childbirth education via the "For You Two" prenatal booklet; implemented special referral queue to the perinatal team for immediate referral to the perinatal care manager upon identification from the health needs assessment that a member is pregnant; added clinical support coordinator to the staff to increase the timeliness of postpartum telephone calls; revised the postpartum toolkit.	Varies by sub-measure; mostly met	The MCO did not identify a specific intervention for ensuring access to services, which has been identified as a barrier. NHP should review access issues and standards for obstetrical care and report to oversight committees to ensure this important issue is addressed and that there is follow-up. Ensure committee minutes reflect the discussion. Recommendations from 2013 that should be reconsidered: Use information technology to help mothers with reminders, support resources, and educational information. These can be tweeter, daily reminders, or mobile applications that help inform members on diet, importance of keeping provider appointments, and tips for a healthy pregnancy. Recommendations: Continue outreach to members; look to nontraditional avenues to engage members beyond mass mailings and telephone calls. Use opportunities NHP has from interactions with members and providers or focus groups on how to do this. It may vary by geographic region, as well as demographic and cultural differences. Review Krames' literacy levels and assess whether materials are up-to-date. Use information technology applications to enhance communications with providers and members. Continue midcourse assessments to determine effectiveness of interventions. Develop a formal process for knowledge sharing to standardize education of providers and establish consistent performance expectations. Use lessons learned/best practices at Great Lawrence Health Center and share information with other health centers.

Table C.1 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQR Validation Rating[a]	EQR Discussion and Recommendations
Massachusetts: Tufts Health Plan–Network Health	PIP demonstrated a nonstatistically significant improvement in performance on the Timeliness of Prenatal Care measure (88.4 percent in CY2011 versus 92.7 percent in CY2013). PIP demonstrated a nonstatistically significant decrease in performance on the Postpartum Care measure (79.5 percent in CY2011 versus 75.6 percent in CY2013).	Member outreach: made telephone calls and sent mail upon identification of members who were pregnant; conducted outreach to members at 32 weeks of pregnancy and members self-identified as pregnant during enrollment with MassHealth; added monetary incentive for member completion of the prenatal registration form; mailed members a congratulations packet of information and instructions on how to sign up for text4baby; increased member "touches" in prenatal and postpartum stages partnering with the Visiting Nurse Association (VNA); enhanced VNA prenatal visits at 32 weeks and updated high-risk pregnancy risk category; created new women's health publications (one for women, one for teens)—information on importance of choosing OB provider is included in these. System change: piloted a study for provider incentive program; expanded time with OB high-risk case manager.	Varies by sub-measure; mostly met	Recommendations: Continue with plans under development with the new medical director to start a Doula program, and a Centering Pregnancy program.
Michigan (collaborative): Blue Cross Complete of Michigan	PIP aims to improve performance on the percentage of enrollees in Wayne County who receive timely postpartum care. The PIP was in the planning and implementation phase, and the EQR technical report does not include any data on performance. The PIP was in the planning and implementation phase, and the EQR technical report includes online baseline performance rates.	None reported	Met	The MCO appropriately selected a study topic both driven by data and that demonstrated an area for improvement. The study question set the framework for the PIP, and the study population and study indicators were completely and accurately defined. The MCO collected baseline data using a systematic data collection process that can be used to collect remeasurement data consistently. The MCO had not progressed to the point of developing and implementing interventions.
Michigan (collaborative): Molina Healthcare of Michigan	PIP aims to improve performance on the percentage of enrollees in Wayne County who receive timely prenatal and postpartum care. The PIP was in the planning and implementation phase, and the EQR technical report includes online baseline performance rates.	None reported	Met	The MCO appropriately selected a study topic both driven by data and that demonstrated an area for improvement. The study question set the framework for the PIP, and the study population and study indicators were completely and accurately defined. The MCO collected baseline data using a systematic data collection process that can be used to collect remeasurement data consistently. The MCO had not progressed to the point of developing and implementing interventions.

Table C.1 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQR Validation Rating[a]	EQR Discussion and Recommendations
Michigan (collaborative): Total Health Care	PIP aims to improve performance on the percentage of enrollees in Wayne County who receive timely prenatal and postpartum care. The PIP was in the planning and implementation phase, and the EQR technical report includes online baseline performance rates.	None reported	Met	The MCO appropriately selected a study topic both driven by data and that demonstrated an area for improvement. The study question set the framework for the PIP, and the study population and study indicators were completely and accurately defined. The MCO collected baseline data using a systematic data collection process that can be used to collect remeasurement data consistently. The MCO had not progressed to the point of developing and implementing interventions.
Missouri: Home State Health Plan	PIP demonstrated a positive impact in the percentage of pregnant members with delivery authorization or notification of pregnancy forms within eight months before delivery. The EQR technical report did not include performance rates.	Member outreach/education: provided outreach by telephone and in person to pregnant members. Provide outreach/education: provided outreach by telephone and in person to providers; provided provider education. System change: implemented CentAccount incentive program; created the “Healthy Moms and Babies” report; performed quarterly review of any MCO member who has a pregnancy claim and no notification of pregnancy form.	Met	The PIP significantly improved member outcomes. The MCO identified an issue and resolved it using the PIP process. Barriers were addressed, and the MCO understands the need to continue to monitor success and to implement actions necessary to maintain its current levels of achievement. Recommendations: The MCO should request technical assistance, as needed, in PIP development. The MCO should ensure that improvement are focused on enhancing member services. The MCO should continue involvement with the Statewide PIP planning group.
New Hampshire: NH Healthy Families	PIP aims to improve performance on timeliness of prenatal care. The PIP is in the design and implementation phase, and the EQR technical report does not include any data on performance.	None reported	Not reported	None reported
New Hampshire: Well Sense	PIP aims to improve performance on timeliness of prenatal care. The PIP is in the design and implementation phase, and the EQR technical report does not include any data on performance.	None reported	Not reported	None reported
New Jersey: Amerigroup	PIP aims to increase the rate of dental visits in pregnant enrollees. The EQR technical report did not include performance rates.	None reported	Not reported	None reported

Table C.1 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQR Validation Rating[a]	EQR Discussion and Recommendations
New Jersey: Healthfirst Health Plan of New Jersey	PIP aims to improve the timeliness of prenatal and postpartum care. The EQR technical report did not include performance rates.	None reported	Not reported	None reported
New Jersey: Horizon New Jersey Health	PIP aims to improve prenatal and birth outcomes. The EQR technical report did not include performance rates.	None reported	Not reported	None reported
New Jersey: UnitedHealthcare Community Plan	PIP aims to improve prenatal and birth outcomes. The EQR technical report did not include performance rates.	None reported	Not reported	None reported
New Mexico: Lovelace Community Health Plan	PIP demonstrated a decrease in performance on the frequency of prenatal visits to improve birth outcomes (83.6 percent at baseline versus 68.3 percent at second remeasurement).	Member outreach/education: located and identified pregnant women through the Baby Love program. System change: offered free car seats for completion of visits; provided a nurse advice line; streamlined the referral process; implemented the Community Health Worker program.	Moderate compliance	Recommendation: The MCO should research, implement, and evaluate evidence-drive best practices to improve quality indicators.
New Mexico: Molina HealthCare	PIP demonstrated an improvement in performance on the percentage of women who delivered a live birth who had a postpartum visit on or between 21 and 56 days after delivery (32.0 percent at baseline versus 70.7 percent at first remeasurement).	Member outreach/education: followed up with new mothers to make sure they are receiving proper care; used the Motherhood Matters program and the Rewards for Health Choices Incentive program to reach out to women who need prenatal and postpartum care; sent reminder cards and/or texts to new mothers about their appointments. Community outreach/education: partnered with St. Joseph Community Health Collaboration to promote prenatal, postpartum, well-child, dental care, and other health issues for at-risk families in Bernalillo County. System change: offered incentives to providers for adequate coding for initial diagnosis of pregnancy, initial and subsequent prenatal visits, and postpartum care.	Partially met	None reported
Oregon: All Care	PIP aims to increase the percentage of referrals to community substance abuse treatment programs for expectant mothers. The PIP was not reviewed by the EQRO.	None reported	Not reported	None reported
Oregon: CareOregon	PIP aims to improve access and quality of care for maternal and perinatal care. The PIP was not reviewed by the EQRO.	None reported	Not reported	None reported
Oregon: Columbia Pacific	PIP aims to improve performance on perinatal and maternity care and improve timeliness of prenatal care. The PIP was not reviewed by the EQRO.	None reported	Not reported	None reported

Table C.1 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQR Validation Rating[a]	EQR Discussion and Recommendations
Oregon: East Oregon CCO	PIP aims to improve performance on maternal and child outcomes. The PIP was not reviewed by the EQRO.	None reported	Not reported	None reported
Oregon: Jackson Care Connect	PIP aims to improve performance on timeliness of prenatal care and behavioral health screening. The PIP was not reviewed by the EQRO.	None reported	Not reported	None reported
Oregon: Columbia George	PIP aims to improve performance on post-partum care. The PIP was not reviewed by the EQRO.	None reported	Not reported	None reported
Oregon: Primary Health Josephine County	PIP aims to design and implement a local maternal medical home. The PIP was not reviewed by the EQRO.	None reported	Not reported	None reported
Oregon: Umpqua Health Alliance	PIP aims to improve performance on identification of addiction issues in pregnancy. The PIP was not reviewed by the EQRO.	None reported	Not reported	None reported
Oregon: Willamette Valley Community Health	PIP aims to improve performance on perinatal and maternity care. The PIP was not reviewed by the EQRO.	None reported	Not reported	None reported
Oregon: Yamhill Community Care Organization	PIP aims to improve performance on the timeliness of prenatal care and behavioral health screening. The PIP was not reviewed by the EQRO.	None reported	Not reported	None reported
Tennessee: Amerigroup	PIP aims to improve access to prenatal and postpartum care. The EQR technical report did not include performance rates.	None reported	Met	None reported
Wisconsin: Children's Community Health Plan	PIP demonstrated an increase in performance on postpartum rates. The EQR technical report did not include performance rates.	Member outreach/education: initiated mailing of a photo album with interconception information to members who attended their postpartum visit; resumed the use of a $10 gift care incentive. System change: maintained the Healthy Mom Health Baby program, a case management approach for high-risk women.	Not reported	None reported

Table C.1 (continued)

Source: EQR technical reports submitted to CMS for the 2014–2015 reporting cycle, as of April 30, 2015. Analysis includes PIPs targeting children or pregnant women from the submitted EQR technical reports.

Notes: During the 2014–2015 reporting cycle, the following states and territories did not contract with any MCOs or PIHPs: AL, AK, AR, CT, GU, ME, MT, OK, SD, VI, and WY. ND only had CHIP managed care. ID recently implemented an MCO for its dual eligible population; it has not yet produced an EQR report. In addition, IN, PR, and TX did not submit an EQR technical report before April 30, 2015 for inclusion in this analysis. While VT is required to conduct an EQR under the terms of its section 1115 demonstration, its managed care entity is neither an MCO nor PIHP and therefore is excluded from this analysis. EQR technical reports for DE and NY did not include any information about PIPs.

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.

Table 3 in the 2015 Annual Report on the Quality of Care for Children in Medicaid and CHIP indicates that Iowa has two prenatal and postpartum care PIPs. These PIPs do not have interventions related to prenatal and postpartum care and were therefore not included here.

[a] EQR validation rating is the overall validation rating assigned to the PIP in the EQR technical report. EQROs used different rating systems in the validation process. EQRO discussion and recommendations are summarized from the EQR technical report's discussion of the validation results for each PIP, including strengths, limitations, and recommendations for improvement.

[b] The following MCOs had a validation rating of "Met": AMERIGROUP Community Care; Better Health; First Coast Advantage; Integral Quality Care; Preferred Medical Plan; Prestige Health Choice; Simply Healthcare Plans; Sunshine State Health Plan; UnitedHealthcare; and Staywell Health. The following MCOs had a validation rating of "Partially met": Children's Medical Services; Coventry Health Care of Florida; Humana Family; and Molina Healthcare (Florida). The following MCO had a validation rating of "Not met": South Florida Community Care Network.