The Department of Health and Human Services

2014 Annual Report on the Quality of Care for Children in Medicaid and CHIP

Health and Human Services Secretary

Sylvia Mathews Burwell

November 2014

This page left blank for double-sided copying.

CONTENTS

This page left blank for double-sided copying.

TABLES

This page left blank for double-sided copying.

FIGURES

This page left blank for double-sided copying.

APPENDIX: STATE-SPECIFIC OUTCOMES

This page left blank for double-sided copying.

GLOSSARY

ADD	Follow-Up Care for Children Prescribed ADHD Medication
ADHD	Attention-Deficit/Hyperactivity Disorder
AHRQ	Agency for Healthcare Research and Quality
AWC	Adolescent Well-Care Visits
Behav.	Behavioral
BH	Behavioral Health
BMI	Body Mass Index
C&M	Continuation and Maintenance
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	Child and Adolescent Access to Primary Care Practitioners
CARTS	CHIP Annual Reporting Template System
CCME	Carolinas Center for Medical Excellence
CCO	Coordinated Care Organization
CDC	Centers for Disease Control and Prevention
CFR	Code of Federal Regulations
CHCS	Center for Health Care Strategies
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009
CHL	Chlamydia Screening in Women
CIS	Childhood Immunization Status
CLABSI	Central Line-Associated Blood Stream Infection
CMCS	Center for Medicaid and CHIP Services
CMS	Centers for Medicare & Medicaid Services
COE	Center of Excellence
CPT	Current Procedural Terminology
CWP	Appropriate Testing for Children with Pharyngitis
CY	Calendar Year
DOM	Mississippi Division of Medicaid
DTaP	Diphtheria, Tetanus, and Acellular Pertussis Vaccine
EHR	Electronic Health Record
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
ER	Emergency Room

FFY	Federal Fiscal Year
FPC	Frequency of Ongoing Prenatal Care
FPL	Federal Poverty Level
FUH	Follow-Up After Hospitalization for Mental Illness
HAI	Healthcare-Associated Infection
HEDIS	Healthcare Effectiveness Data and Information Set
HepA	Hepatitis A
HepB	Hepatitis B
HHS	U.S. Department of Health and Human Services
HiB	H Influenza Type B
HIO	Health Insuring Organization
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
HPV	Human Papillomavirus
ICU	Intensive Care Unit
IMA	Immunization Status for Adolescents
IPV	Inactivated Polio Vaccine
LTC	Long-term Care
MACBIS	Medicaid and CHIP Business Information Solutions
MCO	Managed Care Organization
MMR	Measles, Mumps, and Rubella
NA	Not Available
NCQA	National Committee for Quality Assurance
NHSN	National Healthcare Safety Network
NICU	Neonatal Intensive Care Unit
OME	Otitis Media with Effusion
ONC	Office of the National Coordinator for Health Information Technology
PCP	Primary Care Practitioner
PCV	Pneumococcal Conjugate Vaccine
PDENT	Preventive Dental Services
PH	Physical Health
PICU	Pediatric Intensive Care Unit
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PPC	Timeliness of Prenatal Care
PQMP	Pediatric Quality Measures Program
QI	Quality Improvement

RV	Rotavirus
SEDS	Statistical Enrollment Data System
SFY	State Fiscal Year
SIR	Standardized Infection Ratio
SMCO	Special Managed Care Organization
STI	Sexually Transmitted Infection
TA/AS	Technical Assistance and Analytic Support
Td	Tetanus and Diphtheria Vaccine
Tdap	Tetanus, Diphtheria, and Acellular Pertussis Vaccine
TDENT	Dental Treatment Services
The Act	Social Security Act
URI	Upper Respiratory Infection
VZV	Varicella Zoster Virus (Chicken Pox)
W15	Well-Child Visits in the First 15 Months of Life
W34	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
WCC	Body Mass Index Assessment for Children and Adolescents

This page left blank for double-sided copying.

EXECUTIVE SUMMARY

Together, Medicaid and the Children's Health Insurance Program (CHIP) served more than 45 million children in federal fiscal year (FFY) 2013, representing more than 1 in 3 children in the United States (see Table 1 of the report).[1] Medicaid and CHIP play a key role in ensuring that low-income children get health care coverage and access to a comprehensive set of benefits and other medically necessary services. This report, required by Section 1139A(c)(2) of the Social Security Act (the Act), as added by section 401(a) of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), summarizes state-specific information on the quality of health care furnished to children covered by Medicaid and CHIP.

The Department of Health and Human Services (HHS) is working closely with states, health care providers, and program enrollees to ensure a high quality system of care for children in Medicaid/CHIP. As the HHS agency responsible for ensuring effective health care coverage for Medicare, Medicaid, and CHIP beneficiaries, the Centers for Medicare & Medicaid Services (CMS) plays a key role in promoting quality health care for children in Medicaid/CHIP. CMS's quality agenda is closely aligned with that of the HHS National Quality Strategy's three aims of achieving better care, a healthier population and community, and more affordable care.[2]

Over the past four years, CMS and states have continued to break new ground with standardized reporting on CMS's core set of children's health care quality measures (referred to as the Child Core Set).[3] The 2014 Secretary's Report presents information on key activities CMS undertook to provide an update on the quality of care children receive in Medicaid/CHIP, including reviewing findings on the Child Core Set and summarizing information on managed care quality measurement and improvement efforts reported in the External Quality Review (EQR) technical reports.[4] Below are key findings from these information sources.

Measurement and Voluntary Reporting Using the Child Core Set

- CMS has made substantial efforts to streamline reporting of Child Core Set data, reduce the burden on states, and improve consistency of the data. For FFY 2013, data on the Child Core Set measures were obtained through three sources: (1) the CMS CHIP Annual Reporting Template System (CARTS) web-based data submission tool, (2) Form CMS-416, and (3) the Centers for Disease Control and Prevention's (CDC's) National Healthcare Safety Network (NHSN).

[1] http://kff.org/other/state-indicator/children-0-18/.

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

[3] Three measures were added to the Child Core Set in 2013: Medication Management for People with Asthma, Human Papillomavirus (HPV) Vaccination for Female Adolescents, and Behavioral Health Risk Assessment (for pregnant women). One measure was retired: Otitis Media with Effusion (OME)–Avoidance of Inappropriate Systemic Antimicrobials in Children (ages 2 to12). More information on the 2013 Child Core Set can be found in a January 2013 State Health Official letter, available at http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-002.pdf.

[4] Previous Secretary's Reports are available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html.

- All states voluntarily reported two or more of the Child Core Set measures for FFY 2013 (see Figure 1 of the report).[5] The median number of measures reported by states for FFY 2012 was 16, up from 12 for FFY 2011 and 14 for FFY 2012. Altogether, 33 states reported at least 13 of the 25 core measures to CMS for FFY 2013.[6] Two states, North Carolina and South Carolina, reported 25 core measures for FFY 2013.
- The completeness of Child Core Set data reported by states improved for FFY 2013. For example, 41 states now include both Medicaid and CHIP populations in one or more measures, up from 34 states for FFY 2011 and 38 states for FFY 2012.
- The measures most frequently reported by states assess children's access to primary care, percentage with well-child visits, and use of dental services (see Figure 2 of the report).
- Detailed analysis of data on the 16 Child Core Set measures reported by at least 25 states (including percentiles, trends, and geographic variation) are featured in the Appendix.[7]

State Performance on the Child Core Set

1. Primary Care Access and Preventive Care

- In FFY 2013, as in FFY 2012, states continued to have high performance rates on the children's primary care access measure. The vast majority of children, across all states, had at least one visit to a primary care practitioner (PCP) during the reporting period, with the median rate ranging from a high of 97 percent among children ages 12 to 24 months to 88 to 91 percent for the other age groups (see Table 3 of the report).
- As in FFY 2012, the proportion of children with a well-child visit varied by age group, but remained below the recommended guidelines (see Table 3 of the report).[8]
- The content of a well-child visit can be indicated by several Child Core Set measures (see Table 3 of the report):
    - The median childhood immunization rate for children turning age 2 was 67 percent, while the median adolescent immunization rate among 13-year-olds was 66 percent.
    - The median Chlamydia screening rate among sexually active women between the ages of 16 and 20 was 50 percent.
    - The median rate of body mass index (BMI) percentile documentation in the medical record was 37 percent for children ages 3 to 17.

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

[6] The base of 25 measures excludes the Central Line-Associated Blood Stream Infections (CLABSI) measure, which was obtained from the CDC's NHSN beginning in FFY 2012.

[7] Although 17 measures were reported by at least 25 states for FFY 2013, the Ambulatory Care: Emergency Department Visits measure is not profiled in the Appendix due to data quality issues that CMS is actively working to address in collaboration with states.

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

2. Perinatal Health

- The health of a child is affected by a mother's health and the care she receives during pregnancy. In FFY 2013, data on two of the maternity care measures in the Child Core Set indicate (see Table 3 of the report):
    - The vast majority of pregnant women (a median of 83 percent) had a prenatal care visit in the first trimester or within 42 days of enrollment in Medicaid/CHIP.
    - More than three-fifths of women (a median of 62 percent) received at least 80 percent of the expected number of visits during their pregnancy (based on when they enrolled in Medicaid/CHIP and when they delivered).

3. Management of Acute and Chronic Conditions

- The extent to which children are receiving safe, timely, and effective treatment can be indicated by several Child Core Set measures (see Table 3 of the report):
    - A median of 68 percent of children diagnosed with pharyngitis and dispensed an antibiotic received the recommended strep test.[9]
    - A median of 46 percent of children newly prescribed medication for attention-deficit/ hyperactivity disorder (ADHD) had a follow-up visit during the first 30 days (known as the Initiation Phase), and of the children with a visit during the Initiation Phase, a median of 50 percent had two visits during the next nine months (known as the Continuation and Maintenance [C&M] phase).
    - The median rate of a 30-day follow-up visit after hospitalization for mental illness was 63 percent, while the median rate of a follow-up visit within 7 days of discharge was 43 percent.
    - Among the 41 states with state-level rates for central line-associated blood stream infections (CLABSIs) in Neonatal Intensive Care Units (NICUs), 29 had a significant decrease in CLABSI infections in calendar year (CY) 2012 since the 2006–2008 baseline period, and 12 had no change in infections since the baseline period. No states had a significant increase in infections.[10]

[9] This is the last year of state reporting on the Appropriate Testing for Children with Pharyngitis measure. This measure is being retired from the 2014 Child Core Set.

[10] This measure is obtained from data reported by hospitals to the CDC NHSN. It includes all neonatal CLABSI incidents not just those for infants covered by Medicaid/CHIP. For further information on the methods used to assess state performance, see the CDC 2012 National and State Healthcare-Associated Infections Standardized Infection Ratio Report, available at http://www.cdc.gov/HAI/pdfs/progress-report/hai-progress-report.pdf.

4. Dental and Oral Health Services

- Children's access to dental services in FFY 2013 was similar to patterns observed in previous years (see Table 3 of the report):[11]
    - A median of 46 percent of children ages 1 to 20 received at least one preventive dental service (such as application of topical fluoride or dental sealants) in FFY 2013.
    - A median of 25 percent of children ages 1 to 20 received at least one dental treatment service (such as dental fillings) in FFY 2013.

Managed Care External Quality Review Findings

1. Overview: External Quality Review (EQR) Technical Reports

- Of the 42 states[12] that currently contract with managed care plans to deliver services to Medicaid and CHIP enrollees, 40 submitted EQR technical reports to CMS for the 2013–2014 reporting cycle. The most frequently reported children's performance measures in the EQR reports are similar to those in the Child Core Set (see Figure 4 of the report).
- The 40 EQR technical reports varied considerably in their organization, level of detail, and focus of the discussion on quality, access, and timeliness of care. This variation is a byproduct of differences in states' interpretation of regulatory language. For example, although the regulations require states to annually validate performance measures and performance improvement projects (PIPs), they do not require states to include details related to outcomes or interventions. Therefore, some states choose to include this information, while others do not.

2. Performance Improvement Projects

- Through their managed care entities, states are engaged in various types of improvement projects specific to children. Prenatal and postpartum care was the most common PIP topic among states for the 2013–2014 reporting cycle (15 states and 37 PIPs).
- Among the 27 states that submitted EQR technical reports over the last three reporting cycles, PIP topics demonstrated a notable shift. The number of states conducting PIPs focused on childhood immunizations, asthma, and lead screening decreased, while the number reporting a behavioral health PIP increased (see Figure 5 of the report). These shifts in topical focus may reflect changing health care priorities within the states or may indicate that the PIPs either achieved their intended health care improvements or consistently failed to show demonstrable improvements.
- PIP topics, target populations, and interventions and activities were generally specific to each managed care organization (MCO) or prepaid inpatient health plan (PIHP) in a state,

[11] The Child Core Set measures for dental services include children enrolled in Medicaid and CHIP Medicaid expansion programs that are eligible for the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. Children enrolled in separate CHIP programs are not included in this measure.

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

but 10 states mandated PIP topics or required MCOs or PIHPs to engage in collaborative PIPs on priority health care topics. For example, Georgia, Missouri, New Jersey, and Ohio required all MCOs to implement PIPs to improve dental care for children, and Georgia, Maryland, Ohio, and Virginia required MCOs to implement PIPs to improve adolescent well care.

- CMS conducted detailed abstractions of EQR technical reporting on PIPs in four CMS priority health topic areas: (1) childhood obesity, (2) dental care, (3) prenatal and postpartum care, and (4) adolescent well care. Overall, the level of detail presented in the EQR technical reports has become more comprehensive over the past few years. Analysis of the PIPs indicates that states are using a diverse set of interventions to improve quality of care.

Conclusion

This report shows the continued progress made by HHS and states in building a national, cross-state quality measurement and reporting system for children's health care in Medicaid and CHIP. The quality measurement initiatives underway at CMS and in the states are gaining momentum to accelerate improvements in children's health care and health outcomes and to help transform Medicaid/CHIP into a high quality system of coverage and care.

This page left blank for double-sided copying.

I. INTRODUCTION

With the adoption of a core set of children's health care quality measures (Child Core Set) in 2010, the Centers for Medicare & Medicaid Services (CMS) has a new set of tools to promote high quality care in Medicaid and the Children's Health Insurance Program (CHIP). As documented in the 2013 Secretary's Report on the Quality of Care for Children in Medicaid and CHIP,[13] CMS and states have made considerable progress in building a solid foundation for quality measurement and improvement. Working collaboratively with its many partners including states, health care providers, and program enrollees, CMS is now engaged in a number of efforts to use this information to drive improvements in care.

Together, Medicaid and CHIP served more than 45 million children in federal fiscal year (FFY) 2013 (Table 1), representing more than 1 in 3 children in the United States.[14] Enrollment increased nearly 3 percent between FFY 2012 and FFY 2013.[15] Medicaid and CHIP participation rates have increased as a result of outreach, enrollment simplification, and retention efforts, including regulations and program changes adopted as a result of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act). Reductions in the percentage of children without health insurance reflect these gains; the uninsured rate for children under age 18 decreased from 9.8 percent in 2010 to 7.3 percent in 2013.[16] Given that Medicaid and CHIP are key sources of coverage for children, it is important to continue to build a strong foundation for children's health care quality measurement and improvement.

The majority (66 percent) of children covered by Medicaid and CHIP obtain care from managed care arrangements (Table 1), although the range of services and the population groups included in these plans vary across states. For example, some states provide behavioral health and dental services through their managed care plans and others provide these services using fee-for-service arrangements. Because of the varying arrangements, a diverse set of quality measurement and improvement efforts are under way across payment and service delivery settings.

The objective of this report, as required by CHIPRA,[17] is to summarize state-specific information on the quality of health care furnished to children under Titles XIX (Medicaid) and XXI (CHIP). Section 1139A(c)(1)(B) of the Act specifically requests information gathered from the external quality reviews (EQRs) of managed care organizations (MCOs)[18] and benchmark plans.[19] The Secretary of the Department of Health and Human Services (HHS) is required to make this information publicly available annually. This year's report provides a snapshot of states' performance on 16 Child Core Set measures for which at least 25 states voluntarily provided information to CMS.

---

[13] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2013-Ann-Sec-Rept.pdf.

[14] http://kff.org/other/state-indicator/children-0-18/.

[15] http://www.medicaid.gov/CHIP/Downloads/FY-2013-Childrens-Ever-Enrolled-Report.pdf.

[16] U.S. Census Bureau. "Health Insurance Statistical Tables." Table HIB-3, available at: http://www.census.gov/hhes/www/hlthins/data/historical/HIB_tables.html and Table 2. Type of Health Insurance Coverage by Age 2013, available at: http://www.census.gov/hhes/www/hlthins/data/incpovhlth/2013/Table2.pdf.

[17] Section 1139A(c)(2) of the Social Security Act, as added by section 401(a) of CHIPRA.

[18] Established under the authority of Section 1932 of the Social Security Act.

[19] Established under the authority of Sections 1937 and 2103 of the Social Security Act.

This page left blank for double-sided copying.

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

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

For the past four years, CMS and its partner states have continued to break new ground with standardized reporting on CMS's core set of children's health care quality measures (Child Core Set).[20] For FFY 2013, CMS set the following internal goals for quality measurement and improvement:

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

CMS continues to work with states, through its Quality Measures Technical Assistance and Analytic Support (TA/AS) Program, to improve the completeness and accuracy of the data reported, and to support states' efforts to build internal capacity to conduct quality improvement (QI) projects using the Child Core Set measures.[21] These activities are strengthening the federal-state partnership in quality measurement and improvement in Medicaid and CHIP.

Section 1139A(b)(5) of the Social Security Act provides that, beginning January 1, 2013, and annually thereafter, the Secretary shall publish recommended changes to the Initial Child Core Set. Part of the process of collecting, reporting, and using the Child Core Set measures is to establish a way to periodically identify new measures for possible inclusion in the Child Core Set. This process serves several purposes: (1) build upon the original measure set by addressing gap areas, (2) improve upon existing Child Core Set measures, and (3) better align with national quality measurement activities. The intended result is a Child Core Set that is more robust and

[20] For a list of the Child Core Set measures, please see Supplemental Table 1 at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Overview-of-the-Child-Core-Set-Measures-FFY-2013.zip.

[21] The TA/AS Program is led by Mathematica Policy Research in collaboration with National Committee for Quality Assurance (NCQA) and Center for Health Care Strategies (CHCS). More information about the TA/AS Program is available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html.

better able to support states' and CMS's quality measurement needs.[22] CMS issued a January 2013 state health official letter outlining updates to the Initial Child Core Set and the multi-stakeholder process used to inform the decision-making process.[23] Three measures were added as a result of this process and one of the Initial Child Core Set measures was retired due to reporting challenges cited by state Medicaid and CHIP agencies.[24] Three additional measures were retired from the Child Core Set in 2014.[25]

In addition to ensuring that the measures are relevant to current health care delivery approaches, reflect updates to clinical guidelines, and incorporate feedback from states, CMS is devoting the resources necessary to continue developing the pediatric measurement field. Through a partnership with the Agency for Healthcare Research and Quality (AHRQ), CMS has spent the past four years working with the seven Centers of Excellence (COEs) that comprise the AHRQ-CMS Pediatric Quality Measures Program (PQMP).[26] CMS funded grants to these centers of $60 million over four years. Additionally, CMS continues to work with the Office of the National Coordinator for Health Information Technology (ONC) to develop pediatric measures in areas that address the gaps in the Child Core Set and that can be collected through an electronic health record (EHR).

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

---

[22] Background on the Initial Core Set can be found in a February 2011 State Health Official letter, available at http://www.cms.gov/smdl/downloads/SHO11001.pdf.

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

[24] The three measures added to the Child Core Set in 2013 are: Medication Management for People with Asthma, Human Papillomavirus (HPV) Vaccination for Female Adolescents, and Behavioral Health Risk Assessment (for pregnant women). One measure was retired: Otitis Media with Effusion (OME)–Avoidance of Inappropriate Systemic Antimicrobials in Children (ages 2 to12). Additional information on the 2013 Child Core Set can be found in a January 2013 State Health Official letter, available at http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-002.pdf.

[25] The three measures retired from the 2014 Child Core Set are: Annual Pediatric Hemoglobin A1C Testing, Appropriate Testing for Children with Pharyngitis, and Annual Percentage of Asthma Patients 2 Through 20 Years Old with One or More Asthma-Related Emergency Room Visits. Updates to the 2014 Child Core Set are described in a Center for Medicaid and CHIP Services (CMCS) Informational Bulletin, available at http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-19-13.pdf.

[26] Additional information on the PQMP is available at http://www.ahrq.gov/policymakers/chipra/pqmpback.html.

CMS also has continued to make progress toward a modernized and streamlined Medicaid and CHIP data infrastructure known as the Medicaid and CHIP Business Information Solutions (MACBIS) initiative. In the future, information collected as part of MACBIS will serve as the primary data source for the Center for Medicaid and CHIP Services' (CMCS's) quality reporting and performance measurement capacities for Medicaid and CHIP. CMS expects that these efforts will (1) help ensure that information is more accurate, complete, and uniform; (2) reduce burden on our state partners; and (3) have the potential to strengthen quality reporting for children, reduce health care costs associated with inefficiencies in the health care delivery system, and ultimately facilitate better health outcomes for children.

CMS undertook the following activities to assess the status of quality measurement, reporting, and improvement efforts by states for the 2014 Secretary's Report:

- Reviewed and analyzed findings on the Child Core Set measures reported to CMS by states for FFY 2013, including detailed analyses of 16 measures reported by at least 25 states (see the Appendix for state-specific outcomes on these measures)
- Conducting outreach to selected states about the accuracy and completeness of their Child Core Set data
- Analyzing dental services utilization data submitted by states on Form CMS-416
- Reviewing and analyzing neonatal CLABSI data submitted to CDC's NHSN
- Abstracting and summarizing information on the quality measures and PIPs reported in the EQR technical reports from states that contract with managed care plans to deliver services to Medicaid and CHIP enrollees (see Chapter III)

B. Changes in State Reporting of the Child Core Set for FFY 2013

Similar to last year, all 51 states reported at least two Child Core Set measures for FFY 2013 (Figure 1 and Table 2).[27] The number of states reporting has remained high in recent years as states became more familiar with the measures and from increased efforts by CMS to provide technical assistance and to streamline reporting.[28] Altogether, 33 states reported at least 13 of the 25 core measures to CMS for FFY 2013.[29] Two states—North Carolina and South Carolina—reported on all of the core measures for FFY 2013. Seven states reported on 24 of the 25 core measures for FFY 2013. States with the largest increases in the number of measures reported from FFY 2011 to FFY 2013 are Delaware (+23 measures), Oklahoma (+20 measures), Pennsylvania (+13 measures), North Carolina (+12 measures), and Massachusetts (+11

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

[28] For information on the number of states reporting each measure as well as the reasons for not reporting, see Supplemental Table 7 at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Overview-of-the-Child-Core-Set-Measures-FFY-2013.zip.

[29] The base of 25 measures excludes the CLABSI measure, for which data were obtained from the CDC's NHSN beginning in FFY 2012, and the OME measure, which was retired in 2013 because it draws on CPT-II codes not commonly used by Medicaid/CHIP agencies.

measures).[30] Eight states reported fewer measures for FFY 2013 than in the previous year, generally due to a lack of timely data available for FFY 2013.

One of CMS's quality measurement-related goals is to work with states to improve the completeness of data reported. CMS continues to encourage states to report data on the Child Core Set that include both Medicaid and CHIP populations. The number of states reporting at least one measure for both Medicaid and CHIP enrollees has increased consistently over the past four years, from 34 states for FFY 2011 to 38 states for FFY 2012 and 41 states for FFY 2013 (Table 2).[31]

The fourth year of voluntary reporting also saw an overall increase in the number of measures reported by each state. The median number of measures reported by each state has increased over the past three years, from 12 for FFY 2011 to 14 for FFY 2012 and 16 for FFY 2013. The most frequently reported measures for FFY 2013 were the two dental measures (49 states reporting), the well-child visit and access to PCP measures (43 to 47 states reporting), and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey measure (41 states reporting) (Figure 2).[32] The first year of reporting for the three new measures in the 2013 Child Core Set was encouraging, with 23 states reporting the HPV Vaccine for Female Adolescents and Medication Management for People with Asthma measures; 2 states reported the Behavioral Health Risk Assessment (for Pregnant Women) measure due to the requirement for EHRs to calculate the measure.

The majority of Child Core Set measures saw an increase in the number of states reporting data for FFY 2013 (Figure 3). The measures with the largest increases in reporting from FFY 2012 to FFY 2013 were:

- Developmental Screening in the First Three Years of Life (increased from 12 to 20 states reporting)
- Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Room Visits (increased from 15 to 22 states reporting)
- Live Births Weighing Less Than 2,500 Grams (increased from 15 to 21 states reporting)
- Cesarean Rate for Nulliparous Singleton Vertex (increased from 12 to 17 states reporting)

[30] For information on the change in the number of measures reported by each state, see Supplemental Table 3 at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Overview-of-the-Child-Core-Set-Measures-FFY-2013.zip.

[31] For information on state reporting of Child Core Set measures for both Medicaid and CHIP populations, please see Supplemental Figure 2 http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Overview-of-the-Child-Core-Set-Measures-FFY-2013.zip.

[32] Beginning in December 2013, CHIP programs are required by CHIPRA to collect and separately sample CAHPS survey data. A fact sheet with additional information on the CHIPRA CAHPS requirement is available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/CAHPSFactSheet.pdf.

The increase in the number of measures reported by states allowed CMS to conduct deeper analysis on 16 Child Core Set measures reported by 25 or more states for FFY 2013.[33] State performance on these measures (including percentiles, trends, and geographic variation) is profiled in the Appendix.[34] CMS will continue to work with states to increase the number of measures they report for FFY 2014 to expand the number of measures reported by at least 25 states.

C. Summary of Key Findings

This section summarizes CMS's analysis of state performance on 16 frequently reported measures for FFY 2013 (Table 3). The most frequently reported measures reflect a continuum of quality measures for children and pregnant women, including overall access to primary care and use of well-child care, timeliness and frequency of prenatal care, management of acute and chronic conditions, and use of dental and oral health services (Figure 3).

1. Primary Care Access and Preventive Care

States continued to have high performance rates on the children's primary care access measure, as reflected by the state median among the 45 states reporting the measure for FFY 2013. As shown in Table 3, the state median of the percentage of children with a visit to a primary care practitioner (PCP) was highest for children ages 12 to 24 months (97 percent had at least one PCP visit in the past year), and lowest for children ages 25 months to 6 years (88 percent had at least one PCP visit in the past year). Among older children, most had a PCP visit in the past two years (the state median was 91 percent for children ages 7 to 11 and 90 percent for children ages 12 to 19). Among the 40 states that reported the measure for the last three years, the median rates did not change substantially across all four age groups.

Despite high rates of overall PCP access, significant numbers of children received fewer well-child visits than what is recommended by the American Academy of Pediatrics and Bright Futures.[35] For example, nine well-child visits are recommended during the first 15 months of life. As shown in Table 3, about three out of five infants received six or more visits during the first 15 months of life for FFY 2013 (the state median was 63 percent). Two out of three children

[33] Although 18 measures were reported by at least 25 states for FFY 2013, the Ambulatory Care: Emergency Department and the CAHPS Health Plan Survey measures are not profiled in the Appendix. The Ambulatory Care measure is not profiled due to data quality issues. To view state-specific information on collection of the CAHPS Health Plan Survey, please see Table CAHPS at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2013.zip.

[34] These 16 measures were profiled because they were consistently reported by at least 25 states for FFY 2013 using core set specifications. Trends were calculated for 9 of the 17 measures for which at least 20 states reported data for FFY 2011–2013 using core set specifications. See Supplemental Table 4 for a comparison of performance rates for these measures, available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Overview-of-the-Child-Core-Set-Measures-FFY-2013.zip.

[35] Bright Futures/American Academy of Pediatrics. "Recommendations for Preventive Pediatric Health Care." Practice Management Online at http://www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity Schedule_FINAL.pdf.

who turned two years old received Combination 3 immunizations for FFY 2013 (the state median was 67 percent).[36]

Adolescents ages 12 to 21 had the lowest well-care visit rate of all age groups (Table 3). The state median for the adolescent well visit rate was 43 percent for FFY 2013. This compares to a state median of 67 percent of children ages 3 to 6 who received at least one well-child visit in the last year. For children ages 3 to 17 who saw a PCP, about one-third had their body mass index (BMI) percentiles documented in medical records (the state median was 37 percent). Table 3 also shows that the median adolescent immunization rate was 66 percent and that 50 percent of sexually active women ages 16 to 20 were screened for Chlamydia.

2. Perinatal Health

The number of states reporting on two of the maternity care measures in the Child Core Set has increased by 10 states since FFY 2011: from 23 to 33 states for the timeliness of prenatal care measure, and from 17 to 27 states for the frequency of ongoing prenatal care measure (Figure 3). The state median for timely prenatal care (percentage of deliveries of live births that receive a prenatal care visit in first trimester or within 42 days of Medicaid/CHIP enrollment) was 83 percent (Table 3). About 62 percent of women received more than 80 percent of the expected number of prenatal care visits (based on when they enrolled in Medicaid/CHIP and when they delivered) (Table 3).

3. Management of Acute and Chronic Conditions

The growth in state reporting of the Child Core Set now enables public reporting of measures of the clinical quality of care provided to children in Medicaid and CHIP. Four measures of the management of acute and chronic conditions were available for analysis for FFY 2013:

- About two-thirds (a state median of 68 percent) of children diagnosed with pharyngitis who received an antibiotic had a strep test (Table 3). Among the 26 states that have reported this measure for the past three years, the median rate increased by 6 percentage points from FFY 2011 to FFY 2013.[37]
- After a child receives inpatient treatment for a mental health disorder, follow-up with outpatient mental health providers is important to managing medications, continuing therapy, facilitating a child's transition to home and school, and preventing readmissions. Among children ages 6 to 20 who were hospitalized for treatment of selected mental health disorders, the state median percentage of children who had a follow-up visit within 7 days of discharge was 43 percent. The state median for follow-up within 30 days of discharge was 63 percent (Table 3).

[36] The Childhood Immunization Status measure includes 10 rates for the individual vaccines and 9 combination rates. The most common combination rate reported by states is "Combination 3," which includes all of the vaccines except Hepatitis A (HepA), Rotovirus (RV), and influenza (flu).

[37] This is the last year of state reporting on the Appropriate Testing for Children with Pharyngitis measure. This measure is being retired from the 2014 Child Core Set.

- Among children prescribed attention-deficit/hyperactivity disorder (ADHD) medication, the state median for a follow-up visit during the first 30 days (known as the Initiation Phase) was 46 percent. Among the children with a visit during the Initiation Phase, half had a visit during the next nine months (known as the Continuation and Maintenance [C&M] Phase; Table 3).
- Among the 41 states with state-level rates for CLABSIs in NICUs, 29 had a significant decrease in CLABSI infections in CY 2012 since the 2006–2008 baseline period, and 12 had no change in infections since the baseline period.[38] No states had a significant increase in infections. The Standardized Infection Ratio (SIR) in NICUs was 0.56 in CY 2012, compared with a national goal of 0.51 by the end of 2013.[39] These data show that for Medicaid and CHIP children states have yet to reach the national goal of reducing CLABSIs by 50 percent by the end of 2013.[40]

4. Dental and Oral Health Services

All children enrolled in Medicaid and CHIP have coverage for dental and oral health services. Children's access to oral health care continues to be a primary focus of improvement efforts in Medicaid and CHIP. Among children ages 1 to 20 enrolled in Medicaid and CHIP Medicaid Expansion programs (those eligible for Early and Periodic Screening, Diagnostic, and Treatment [EPSDT]), a median of 48 percent received a preventive dental service in FFY 2013 and a median of 23 percent received a dental treatment service (Table 3).[41] The rate for preventive dental services (PDENT) increased from the rate reported by states for FFY 2011 across the 49 states reporting in both years, while the rate for dental treatment services (TDENT) decreased slightly from the rate reported in FFY 2011 (45 percent in FFY 2011 versus 48 percent in FFY 2013 for PDENT and 24 percent in FFY 2011 versus 23 percent in FFY 2013 for TDENT).

[38] See Table CLABSI at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2013.zip.

[39] The SIR is the summary measure used to track CLABSIs over time. It compares the number of infections reported in a given year to the number that would be predicted based on national, historical baseline data that adjust for the type of facility and patient population. The SIR indicates whether the rate of infections increased, decreased, or did not change significantly relative to the baseline (calculated using data for 2006–2008). The SIR is evaluated based on the 95 percent confidence interval, standardized to a baseline of 1. This measure is obtained from data reported by hospitals to the CDC NHSN. It includes all neonatal CLABSI incidents not just those for infants covered by Medicaid/CHIP. For further information on the methods used to assess state performance, see the CDC 2012 National and State Healthcare-Associated Infections Standardized Infection Ratio Report, available at http://www.cdc.gov/HAI/pdfs/progress-report/hai-progress-report.pdf.

[40] More information about CDC's NHSN Healthcare-Associated Infections Summary Data Report is available at http://www.cdc.gov/hai/QA_stateSummary.html.

[41] The two core set dental measures are obtained from data reported by states in the Form CMS-416 reports. States are to submit the CMS-416 report to CMS by April 1 of each year.

This page left blank for double-sided copying.

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

In FFY 2013, 66 percent of publicly insured children obtained their care through managed care plans (Table 1). The rate of managed care enrollment in states utilizing a managed care delivery system varied widely across state Medicaid and CHIP programs, ranging from 4 percent of children in Oregon to 100 percent of children in several states. Regardless of the managed care 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 chapter summarizes state activities related to monitoring and improving care for children and pregnant women in managed care.

A. Overview

The Balanced Budget Act of 1997 created system-wide quality standards for states opting to use managed care for the delivery of health care in Medicaid or CHIP.[42] Federal regulations implemented in 2003 require states to perform an annual external quality review (EQR) for each contracted managed care organization (MCO), prepaid inpatient health plan (PIHP), and health insuring organization (HIO).[43,44] These annual EQRs analyze and evaluate information on the quality, timeliness, and access to the health care services that an MCO or PIHP, and their contractors, furnish to Medicaid beneficiaries. Section 1139A(c) of the Social Security Act requires the HHS Secretary to include in this annual report the information that states collect through EQRs of MCOs and PIHPs participating in Medicaid or CHIP.[45]

Federal managed care regulations at 42 CFR 438.310 et seq. describe the parameters for conducting an EQR, including state responsibilities, qualifications of an external quality review organization (EQRO), federal financial participation, and state deliverable requirements. Per regulation, the state, its agent (not an MCO or PIHP), or an EQRO must perform three EQR-related activities:

[42] Codified at Section 1932(c) of the Social Security Act.

[43] See 42 CFR 438.2 for full definitions of MCO, PIHP, and HIO. HIOs are treated as MCOs for purposes of this analysis.

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

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

1. Validation of performance measures[46]
2. Validation of performance improvement projects (PIPs)[47]
3. A review, at least every 3 years, to determine the managed care plan's compliance with state standards for access to care, structure and operations, and quality measurement and improvement

The state may choose to perform up to five additional EQR-related activities.[48] A statutorily required set of CMS EQR Protocols provide instruction to states and EQROs on the process for conducting each of the eight EQR-related activities.[49] The state must contract with a qualified EQRO to produce an annual technical report that uses information from the EQR-related activities to assess the quality, timeliness, and access to care provided by each MCO and PIHP. This EQR technical report must also include an assessment of strengths and weaknesses with respect to quality, access, and timeliness and set forth recommendations for improving the quality of health care services furnished by each MCO or PIHP. Per regulation, the EQR technical report is a public document, available upon request to all interested parties.[50] Annually, CMS reviews each state's EQR technical report(s) for evaluation and follow-up.

B. External Quality Review Technical Reports Submitted to CMS, 2013–2014 Reporting Cycle

Of the 42 states[51] that contracted with MCOs or PIHPs during the 2013–2014 reporting cycle, 40 states submitted EQR technical reports to CMS.[52] These states contracted with 17 different EQROs to conduct the annual EQR, and six EQROs conducted reviews for multiple states during

[46] In accordance with 42 CFR 438.240(c), managed care states must require each MCO and PIHP to annually measure and report to the state its performance using standard measures required by the state. States are then required to annually ensure that any performance measures reported by the MCO or PIHP during the preceding 12 months are validated. Validation is defined as the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.

[47] In accordance with 42 CFR 438.240(d), managed care states must require each MCO and PIHP to have an ongoing program of performance improvement projects that focus on clinical and nonclinical areas. States are then required to annually ensure that any MCO or PIHP performance improvement projects underway during the preceding 12 months are validated.

[48] Refer to 42 CFR 438.358 for a comprehensive list of EQR-related activities.

[49] In October 2012, CMS revised the EQR Protocols for the purpose of standardizing and strengthening managed care quality monitoring and improvement activities in Medicaid. The CMS EQR Protocols are available under "Technical Assistance Documents" at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

[50] The following provides a link to EQR technical reports submitted to CMS and currently posted on State Medicaid web sites: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/External-Quality-Review-Technical-Reports.html.

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

[52] 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. Utah and New Hampshire did not submit EQR technical reports by May 16, 2014 for inclusion in this analysis.

the 2013–2014 reporting cycle.[53] The majority of EQR technical reports focused on physical health services, but some included information on other types of managed care services, such as dental or behavioral health.

As in previous years, the 2013–2014 EQR technical reports provide insight into the strategies and efforts that states use to improve the quality of care for the population groups served. The 2014 Secretary's Report on the Quality of Care for Children profiles quality measurement and improvement efforts underway related to children and pregnant women enrolled in Medicaid and CHIP managed care entities. The EQR technical reports indicate that states and managed care entities engage in a variety of different quality measurement and improvement efforts based on factors such as the population groups enrolled, stakeholder and beneficiary feedback, and clinical areas in need of improvement.

The structure, level of detail, and focus on quality, access, and timeliness of care varied considerably depending on the EQR technical report. For example, some EQR technical reports did not explicitly discuss quality, access, and timeliness at all, while others provided substantial detail related to the performance measure and PIP validation process, PIP interventions, and performance outcomes. This lack of uniformity across reports is partly due to differences in state interpretation of regulatory language. While regulations require states to annually validate performance measures and PIPs, they do not specifically require the inclusion of details on outcomes or interventions in the EQR technical reports.

C. Performance Measures, 2013–2014 Reporting Cycle

In the 2013–2014 reporting cycle, the most frequently reported performance measures for children and pregnant women focused on well-child care (29 states), primary care access (27 states), childhood immunization rates (25 states), prenatal/postpartum care (25 states), mental health (25 states), and adolescent well-care (24 states) (Figure 4). The reported performance measures showed considerable overlap with both the CMS Child Core Set and the 2013 Healthcare Effectiveness Data and Information Set (HEDIS®) measures, though the use of these measure sets is not required by CMS.[54] Additionally:

- All states except two identified the types of performance measures reported by MCOs and PIHPs, and all but three identified the performance measures validated by the EQRO.

[53] For a list of EQROs with current state Medicaid contracts in 2014, see Table EQR 1 at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Child-Findings-from-EQR-Technical-Reports-2013-2014.zip.

[54] See Table EQR5 at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Child-Findings-from-EQR-Technical-Reports-2013-2014.zip.

- Thirty-four states included the performance rates achieved by each MCO or PIHP. Of these:
  - Seventeen states compared individual MCO and PIHP performance rates to statewide managed care averages, and nine included comparisons to state target rates (Table EQR4).[55]
  - Thirty-two states compared performance in the 2013–2014 reporting cycle to performance in previous years, and 22 states compared MCO and PIHP performance to national HEDIS® Medicaid rates (Table EQR4).
- Eleven states reported performance rates for specific subpopulations within the state. For example, Arizona, Colorado, Michigan, Minnesota, New York, and Texas separately report performance results for children enrolled in Medicaid vs. children enrolled in CHIP. Florida, Pennsylvania, and New York included performance rates for different geographic regions within the state (Table EQR4).

D. Performance Improvement Projects, 2013–2014 Reporting Cycle

Thirty-eight of the 40 states that submitted EQR technical reports for the 2013–2014 reporting cycle included at least one PIP that targeted children or pregnant women and 35 provided information on validation as required by regulation.[56] States mainly deferred to the MCO or PIHP to propose and implement topics and interventions; however, 10 states mandated a specific PIP topic or required participation in a collaborative project.[57]

The topical focus and number of PIPs varied considerably among the 38 states that included at least one PIP that targeted children or pregnant women (Table 4):

- Twenty states reported four or fewer PIPs targeting children or pregnant women, while Florida conducted 39 PIPs aimed at improving well-child care visit rates and 20 PIPs focused on improving the quality of mental health care for children or pregnant women[58]
- Consistent with previous years, prenatal and postpartum care was the most common PIP topic among states (15 states and 37 PIPs)
- Other recurrent PIP topics included weight/BMI assessment and counseling (11 states), childhood immunization rates (8 states), asthma (8 states), and well-child care (7 states)

Among the 27 states that submitted EQR technical reports during the current and previous two reporting cycles, PIP topics demonstrated a few notable shifts (Figure 5). The number of states

[55] See Table EQR4 at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Child-Findings-from-EQR-Technical-Reports-2013-2014.zip.

[56] Oregon's EQRO did not validate any PIPs for this reporting cycle because the state's Coordinated Care Organizations (CCOs) were in their first year of operation; the technical report instead provided information on the PIPs in development and outlined a protocol for validating PIPs in the next reporting cycle.

[57] States that mandated PIP topics for MCOs or PIHPs include DE, FL, GA, IL, MD, MO, NV, NJ, OH, and VA.

[58] Florida included validation scores for all PIPs within their EQR technical report; however, data was limited to validation scores alone on many of the PIPs, with no mention of outcomes or interventions.

conducting PIPs focused on childhood immunizations, asthma, and lead screening decreased from previous years. While no states reported a behavioral health PIP in the previous reporting cycle, six states focused on this topic in the 2013–2014 reporting cycle. These shifts in topical focus may reflect changing health care priorities within the states or may indicate that the PIPs either achieved their intended health care improvements or consistently failed to show demonstrable improvements.

Discussions of EQRO findings on the performance, progress, and limitations of each PIP differed greatly across reports, with descriptions of PIPs occasionally lacking key details. This lack of detailed intervention and outcomes information within the EQR technical reports has limited CMS's ability to conduct a comprehensive assessment on the efficacy of state quality improvement efforts for children and pregnant women enrolled in managed care. However, the level of detail presented in the EQR technical reports has become more comprehensive over the past few years, following intensive CMS outreach and technical assistance efforts to that effect.

E. Review of Performance Improvement Projects

The following section presents findings from detailed abstractions of EQRO reporting on PIPs in four CMS priority health topic areas: (1) childhood obesity, (2) dental care, (3) prenatal and postpartum care, and (4) adolescent well care.[59] An example of a state PIP is highlighted for each priority topic area. Criteria for selecting states to highlight included geographic diversity and the amount of information related to both interventions and outcomes in the EQR technical reports.

1. Childhood Obesity

Eleven states reported a combined total of 41 childhood obesity-related PIPs during this reporting cycle (Table 5). While the interventions of each PIP varied, common aims included improving BMI percentile documentation, nutrition counseling, and physical activity counseling.

California had three MCOs implement a PIP focused on increasing BMI percentile documentation, nutrition counseling, and physical activity counseling for children. Provider interventions included: (1) conducting provider education at annual childhood obesity summits; (2) distributing childhood obesity toolkits; (3) training medical assistants on BMI assessment; and (4) educating pediatric physician chiefs on the childhood obesity HEDIS® measure. System-level interventions included: modifications to the well-child forms used by providers to facilitate documentation of BMI assessment and counseling, and the addition of a new electronic medical record component that reminds providers to collect BMI data, calculates BMI percentile, and prompts providers to initiate counseling for nutrition and physical activity if the BMI value is of concern. These PIPs resulted in statistically significant improvements on improving BMI percentile documentation, nutrition counseling, and physical activity counseling for all four MCOs.

[59] Additional information on "Findings from EQR Technical Reports, 2013-2014" is available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Child-Findings-from-EQR-Technical-Reports-2013-2014.zip.

2. Dental Care

Six states reported a combined total of 16 PIPs aimed at improving performance on the HEDIS® annual dental visit rate measure (Table 6). Three of the six states (Georgia, Missouri, and New Jersey) mandated this topic.

New Jersey required all four of its MCOs to implement a PIP aimed at promoting dental care for children. Two of New Jersey's four MCOs achieved notable improvements in utilization of dental care through this PIP; one achieved a steady statistically significant increase over three years in the rate of annual dental visits for children ages 1–2 years, and the other increased the rate of dental visits for children ages 2–3 years by 27.9 percent. These PIPs used both member and provider interventions, including: (1) member education on good oral hygiene through letters, telephone calls, newsletters and websites; (2) a small monetary incentive for members who complete a dental visit; (3) the distribution of a pediatric dentist directory; (4) a fluoride varnish incentive program for primary care physicians (PCPs) who refer members to dentists, with an additional incentive once a dental visit is completed; (5) PCP education on guidelines and best practices; and (6) encouraging PCPs to apply fluoride varnish for children with early childhood caries through training and reimbursement for this service.

3. Prenatal/Postpartum Care

Fifteen states reported a combined total of 37 PIPs targeting prenatal or postpartum care during this reporting cycle (Table 7), with three states (Delaware, Illinois, and New Jersey) mandating the topic. Thirteen states completed PIPs on this topic during the previous reporting cycle, and 10 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.

Massachusetts had three MCOs implement PIPs focused on prenatal and/or postpartum care. Using HEDIS® measures, all three examined timeliness of postpartum care, two considered timeliness of prenatal care, and one looked at the frequency of ongoing prenatal care. Interventions varied, but included: (1) providing outreach calls and educational materials in both English and Spanish; (2) providing free breast pumps and prenatal classes; (3) conducting Visiting Nurse Association visits during the postpartum stage; (4) offering incentives to providers for completion of prenatal registration forms; and (5) increasing the focus on ethnic and cultural diversity needs. While two MCOs saw improvement in the timeliness of postpartum care measure and the third saw a decline, none of these changes were statistically significant. Both MCOs examining the timeliness of prenatal care measure demonstrated improvement, one of which was statistically significant. There was a statistically significant increase for the frequency of ongoing care measure, though the EQRO noted this might be due to a change in methodology between the baseline and remeasurement period.

4. Adolescent Well Care

Seven states reported a combined total of 27 PIPs aimed at improving rates of adolescent well-care (Table 8), three of which also reported PIPs on this topic during both the 2011–2012 and 2012–2013 reporting cycles. Three states (Georgia, Maryland, and Virginia) mandated the topic.

West Virginia had one MCO implement a PIP that aimed to increase the adolescent well-care visit rate by 5 percentage points each year, with an ultimate goal of reaching the National Committee for Quality Assurance (NCQA) Quality Compass 90th Percentile by the end of the project. Interventions included identifying and reaching out to adolescent members in need of an annual well-care visit through case managers, phone calls, and letters, and the development and mailing of monthly lists to providers that contained all members in need of an annual visit. In its first remeasurement year, the PIP fell slightly short of its goal, increasing the percentage of members 12–21 years of age with at least one comprehensive well-care visit from 42.13 percent to 46.58 percent. Although the EQRO identified barriers to improving performance on this indicator, such as the reluctance of many adolescents to seek well-care visits, it concluded that the PIP has well thought-out interventions that target the identified barriers and promising first-year results.

This page left blank for double-sided copying.

IV. SUMMARY AND CONCLUSION

This report documents the continued progress made by HHS and states in building a national, cross-state quality measurement and reporting system for children enrolled in Medicaid and CHIP, whether they obtain services through a fee-for-service or a managed care setting. The number of measures reported by states increased from a median of 12 measures for FFY 2011 to 16 measures for FFY 2013. In addition, the completeness of the data is improving, with more states reporting measures for both Medicaid and CHIP enrollees (increasing from 34 states for FFY 2011 to 41 states for FFY 2013). Additionally, CMS's detailed review of performance measures and improvement projects summarized in the EQR technical reports identified state-initiated efforts under way to monitor and improve the quality of care for children enrolled in managed care.

States continue to have high performance rates on the children's primary care access measure (i.e., percent with a visit to a PCP); however, this report highlights the need for improvement in areas such as the use of preventive services by young children and adolescents (e.g., well child visits for infants and for adolescents) and the coordination of care for children with mental or behavioral health needs (e.g., follow-up after hospitalization for mental illness or for children newly prescribed ADHD medication).

To help states further improve the completeness and consistency of reporting and performance, CMS is undertaking several efforts: (1) continuing the Quality Measures Technical Assistance and Analytic Support Program, (2) increasing the oversight of Form CMS-416 data reported by states, and (3) aligning quality measurement and improvement efforts across Medicaid/CHIP and other CMS initiatives. Together, CMS, states, and their quality partners are working toward the goal of achieving a high quality system of coverage and care for all children enrolled in Medicaid/CHIP.

This page left blank for double-sided copying.

TABLES

Table 1. Number and Percentage of Children Enrolled in Medicaid or CHIP by State and Service Delivery Type, FFY 2013

State	Total Medicaid/CHIP Enrollment	Managed Care (Number)	Managed Care (Percentage)	Fee-for-Service (Number)	Fee-for-Service (Percentage)	Primary Care Case Management (Number)	Primary Care Case Management (Percentage)
U.S. Total*	45,292,410	30,021,277	66	9,770,978	22	4,902,110	11
Alabama*	711,535	--	--	113,420	--	--	--
Alaska	103,492	0	0	103,492	100	0	0
Arizona	993,509	901,580	91	91,929	9	0	0
Arkansas	516,422	0	0	516,422	100	0	0
California	6,921,363	5,569,207	80	1,352,156	20	0	0
Colorado	537,340	122,664	23	388,494	72	26,182	5
Connecticut	344,413	0	0	344,413	100	0	0
Delaware	110,096	103,216	94	5,538	5	1,342	1
District of Columbia	100,769	92,041	91	8,728	9	0	0
Florida	2,592,739	1,573,288	61	351,963	14	667,488	26
Georgia	1,432,435	1,233,563	86	198,872	14	0	0
Hawaii	169,237	169,073	100	164	0	0	0
Idaho	257,006	0	0	0	0	257,006	100
Illinois	2,689,299	156,899	6	1,065,560	40	1,466,840	55
Indiana	854,219	751,479	88	102,734	12	6	0
Iowa	402,047	91,058	23	94,805	24	216,184	54
Kansas	313,190	313,144	100	46	0	0	0
Kentucky	569,355	530,782	93	38,573	7	0	0
Louisiana	820,697	335,255	41	85,030	10	400,412	49
Maine	204,840	0	0	67,154	33	137,686	67
Maryland	625,463	607,479	97	17,984	3	0	0
Massachusetts	693,570	318,150	46	177,096	26	198,324	29
Michigan	1,285,319	1,223,098	95	62,221	5	0	0
Minnesota	509,099	385,121	76	123,978	24	0	0
Mississippi	561,038	167,164	30	393,874	70	0	0
Missouri	652,183	392,570	60	259,613	40	0	0
Montana	128,108	0	0	44,693	35	83,415	65
Nebraska	220,821	199,414	90	21,407	10	0	0
Nevada	284,735	210,754	74	73,981	26	0	0
New Hampshire	105,012	0	0	105,012	100	0	0

Table 1 (continued)

State	Total Medicaid/CHIP Enrollment	Managed Care (Number)	Managed Care (Percentage)	Fee-for-Service (Number)	Fee-for-Service (Percentage)	Primary Care Case Management (Number)	Primary Care Case Management (Percentage)
New Jersey	868,959	818,772	94	50,187	6	0	0
New Mexico	389,658	316,305	81	73,353	19	0	0
New York	2,799,685	2,326,163	83	473,522	17	0	0
North Carolina	1,423,062	0	0	267,724	19	1,155,338	81
North Dakota	62,238	4,754	8	19,891	32	37,593	60
Ohio	1,769,993	1,365,278	77	404,715	23	0	0
Oklahoma	706,173	616,490	87	89,683	13	0	0
Oregon	529,782	21,538	4	508,162	96	82	0
Pennsylvania	1,576,935	1,454,066	92	119,456	8	3,413	0
Rhode Island	138,579	129,242	93	9,337	7	0	0
South Carolina	658,484	314,950	48	216,588	33	126,946	19
South Dakota	64,580	0	0	17,362	27	47,218	73
Tennessee	897,396	813,829	91	83,567	9	0	0
Texas	4,538,999	4,024,678	89	514,321	11	0	0
Utah	346,214	188,473	54	157,741	46	0	0
Vermont	79,905	0	0	13,937	17	65,968	83
Virginia	845,084	705,709	84	139,375	16	0	0
Washington	812,460	655,872	81	150,334	19	6,254	1
West Virginia	297,391	210,444	71	82,534	28	4,413	1
Wisconsin	710,023	598,900	84	111,123	16	0	0
Wyoming	67,459	8,815	13	58,644	87	0	0

Source: CMS analysis of Statistical Enrollment Data System (SEDS) as of July 24, 2014.

Notes: Data are reported by individual states and are representative of children ever-enrolled in Medicaid and CHIP as of July 24, 2014. States may subsequently revise their current and/or historical data.

Managed care is defined in this context as a system in which the state contracts with health maintenance organizations (HMOs) or health insuring organizations (HIOs) to provide a comprehensive set of services on a prepaid capitated risk basis. Enrollees choose a plan and a primary care provider, who will be responsible for managing their care.

A child is reported in the service delivery system in which he or she was last covered for basic services during the quarter.

*While the total for Alabama (711,535) reflects children enrolled in both Medicaid and CHIP, the state did not report Medicaid data by service delivery type. The 113,420 children reported under fee-for-service are children enrolled in CHIP only. As such, the U.S. total for total Medicaid/CHIP enrollment does not equal the sum of managed care, fee-for-service, and primary care case management.

Table 2. Overview of State Reporting of the Core Set of Medicaid/CHIP Children's Health Care Quality Measures, FFY 2013

	Number of Measures Reported	State Reported at Least One Measure for Both Medicaid and CHIP Populations	Timeliness of Prenatal Care	Frequency of Ongoing Prenatal Care	Live Births Weighing Less than 2,500 Grams	Cesarean Rate for Nulliparous Singleton Vertex	Childhood Immunization Status	Immunization Status for Adolescents	Body Mass Index Assessment for Children and Adolescents	Developmental Screening in the First Three Years of Life	Chlamydia Screening in Women	Well-Child Visits in the First 15 Months of Life	Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	Adolescent Well-Care Visits	Preventive Dental Services	Child and Adolescent Access to PCPs	Appropriate Testing for Children with Pharyngitis	Dental Treatment Services	Ambulatory Care: Emergency Department Visits	Asthma Patients with One or More Asthma-Related Emergency Room Visits	Follow-Up Care for Children Prescribed ADHD Medication	Annual Pediatric Hemoglobin A1c Testing	Follow-Up After Hospitalization for Mental Illness	CAHPS Health Plan Survey	Human Papillomavirus (HPV) Vaccine for Female Adolescents	Behavioral Health Risk Assessment (for Pregnant Women)	Medication Management for People with Asthma
U.S. Total	16 (Median)	41	33	27	21	17	34	31	25	20	37	44	47	43	49	45	36	49	32	22	31	19	28	41	23	2	23
Alabama	23	-	X	X	X	X	X	X	-	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	-	X
Alaska	16	X	-	-	X	X	-	-	-	X	X	X	X	X	X	X	X	X	X	X	X	-	X	X	-	-	-
Arizona	6	-	-	-	-	-	-	-	-	-	-	-	X	X	X	X	-	X	-	-	-	-	-	X	-	-	-
Arkansas	13	X	-	-	X	X	-	-	-	-	X	X	X	X	X	X	X	X	X	-	X	-	X	-	-	-	-
California	15	X	X	-	-	-	X	X	X	-	X	X	X	X	X	X	X	X	X	-	-	-	-	X	-	-	X
Colorado	15	X	X	-	-	-	X	X	X	-	X	X	X	X	X	X	X	X	X	-	X	-	-	X	-	-	-
Connecticut	22	X	X	X	-	-	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	-	X
Delaware	23	X	X	X	X	-	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	-	X
D.C.	18	X	X	X	-	-	X	X	X	-	X	X	X	X	X	X	X	X	-	-	X	-	X	X	X	-	X
Florida	22	X	X	X	X	X	X	X	X	X	X	X	X	X	-	X	X	-	X	X	X	X	X	X	X	-	X
Georgia	24	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	-	X
Hawaii	17	X	X	X	-	-	X	X	X	-	X	X	X	X	X	X	X	X	X	-	X	-	X	X	-	-	-
Idaho	13	X	-	-	-	-	-	-	-	-	X	X	X	X	X	X	X	X	X	X	-	-	-	X	X	-	X
Illinois	24	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	-	X
Indiana	23	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	-	-	X
Iowa	24	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	-	X
Kansas	7	X	X	-	-	-	-	-	-	-	-	X	X	-	X	X	-	X	-	-	-	-	-	X	-	-	-
Kentucky	19	X	X	X	-	-	X	X	X	-	X	X	X	X	X	X	X	X	X	-	X	-	X	X	X	-	X
Louisiana	7	X	-	-	-	-	-	-	-	-	-	X	X	X	X	X	-	X	-	-	-	-	-	X	-	-	-
Maine	15	X	-	-	-	-	-	-	-	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	-	-	-
Maryland	13	X	X	X	-	-	X	X	-	-	X	X	X	X	X	X	X	X	-	-	-	-	-	X	-	-	-
Massachusetts	22	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	-	-	-
Michigan	16	-	X	-	-	-	X	X	X	-	X	X	X	X	X	X	X	X	X	-	X	-	-	X	X	-	-
Minnesota	5	X	-	-	-	-	-	-	-	-	-	X	X	-	X	X	-	X	-	-	-	-	-	-	-	-	-
Mississippi	7	-	-	-	-	-	-	-	-	-	X	-	X	X	X	X	X	X	-	-	-	-	-	-	-	-	-
Missouri	10	X	X	-	-	-	X	X	-	-	X	X	X	X	-	-	-	-	X	-	-	-	X	X	-	-	-
Montana	8	X	-	-	-	-	-	-	-	-	-	X	X	-	X	X	X	X	X	-	-	-	-	X	-	-	-
Nebraska	2	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	X	-	-	-	-	-	-	-	-	-
Nevada	9	-	-	-	-	-	X	-	-	-	-	X	X	X	X	X	-	X	-	-	-	-	X	X	-	-	-
New Hampshire	3	X	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	X	-	-	-	-	-	X	-	-	-

Table 2 (continued)

	Number of Measures Reported	State Reported at Least One Measure for Both Medicaid and CHIP Populations	Timeliness of Prenatal Care	Frequency of Ongoing Prenatal Care	Live Births Weighing Less than 2,500 Grams	Cesarean Rate for Nulliparous Singleton Vertex	Childhood Immunization Status	Immunization Status for Adolescents	Body Mass Index Assessment for Children and Adolescents	Developmental Screening in the First Three Years of Life	Chlamydia Screening in Women	Well-Child Visits in the First 15 Months of Life	Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	Adolescent Well-Care Visits	Preventive Dental Services	Child and Adolescent Access to PCPs	Appropriate Testing for Children with Pharyngitis	Dental Treatment Services	Ambulatory Care: Emergency Department Visits	Asthma Patients with One or More Asthma-Related Emergency Room Visits	Follow-Up Care for Children Prescribed ADHD Medication	Annual Pediatric Hemoglobin A1c Testing	Follow-Up After Hospitalization for Mental Illness	CAHPS Health Plan Survey	Human Papillomavirus (HPV) Vaccine for Female Adolescents	Behavioral Health Risk Assessment (for Pregnant Women)	Medication Management for People with Asthma
New Jersey	15	X	X	X	-	-	X	X	X	-	X	X	X	X	X	X	X	X	-	-	X	-	X	-	-	-	-
New Mexico	17	X	X	X	-	-	X	X	X	-	X	X	X	X	X	X	X	X	X	-	X	-	-	X	X	-	-
New York	18	X	X	X	-	-	-	X	-	-	X	X	X	X	X	X	X	X	X	X	X	-	X	X	X	-	X
North Carolina	25	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
North Dakota	7	-	-	-	-	-	-	X	-	-	-	-	X	X	X	X	X	X	-	-	-	-	-	-	-	-	-
Ohio	10	X	X	X	-	-	-	-	-	-	-	X	X	X	X	X	-	X	-	-	X	-	-	X	-	-	-
Oklahoma	24	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	-	X
Oregon	24	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	-	X
Pennsylvania	24	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	-	X
Rhode Island	19	X	X	X	X	-	X	X	X	-	X	X	X	X	X	X	X	X	X	-	X	-	X	-	X	-	X
South Carolina	25	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
South Dakota	4	X	-	-	-	-	X	-	-	-	-	-	-	-	X	-	-	X	-	-	-	-	-	X	-	-	-
Tennessee	24	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	-	X
Texas	21	X	X	X	-	-	X	-	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	-	X
Utah	10	-	-	-	-	-	X	X	-	-	-	X	X	X	X	X	X	X	-	-	-	-	-	-	-	-	X
Vermont	11	X	-	-	X	-	-	-	-	-	X	X	X	X	X	X	X	X	-	-	X	-	-	X	-	-	-
Virginia	10	X	X	-	X	-	X	-	-	X	-	X	X	X	X	-	-	X	-	-	-	-	-	X	-	-	-
Washington	17	X	X	X	X	X	X	X	-	-	X	X	X	X	X	X	-	X	X	X	-	-	-	X	X	-	-
West Virginia	23	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	-	X	X	X	X	X	X	X	X	-	X
Wisconsin	2	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	X	-	-	-	-	-	-	-	-	-
Wyoming	8	-	-	-	-	-	X	-	-	-	X	X	X	-	X	X	-	X	-	-	-	X	-	-	-	-	-

Source: Based on Mathematica analysis of FFY 2013 Child CARTS reports and Form CMS-416 reports.

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

The 2013 Child Core Set includes 26 measures. Three measures were added to the 2013 Child Core Set: Human Papillomavirus (HPV) Vaccine for Female Adolescents, Medication Management for People with Asthma, and Behavioral Health Risk Assessment (for Pregnant Women). The Otitis Media with Effusion (OME) measure was retired from the Child Core Set in 2013.

Beginning in FFY 2012, to minimize state reporting burden, CMS began calculating the two dental measures on behalf of states using data reported on Form CMS-416.

This table excludes the Central Line-Associated Bloodstream Infection (CLABSI) measure. Beginning in FFY 2012, data for the CLABSI measure were obtained from the CDC National Healthcare Safety Network.

Table 3. Performance Rates on Frequently Reported Medicaid/CHIP Children's Health Care Quality Measures, FFY 2013

Measure Description	Measure	Number of States Reporting Using Child Core Set Specifications	Mean	Median	25th Percentile	75th Percentile
Preventive Dental Services: 1–20 Years	Percentage with a Preventive Dental Service	49	46.0	47.5	40.9	51.5
Dental Treatment Services: 1–20 Years	Percentage with a Dental Treatment Service	49	24.5	22.8	20.0	27.0
Access to Primary Care: 12 – 24 Months	Percentage with a PCP Visit in the Past Year	45	96.1	96.5	95.2	97.6
Access to Primary Care: 25 Months–6 Years	Percentage with a PCP Visit in the Past Year	45	87.6	88.3	85.2	91.4
Access to Primary Care: 7–11 Years	Percentage with a PCP Visit in the Past Two Years	45	88.4	91.3	86.8	93.4
Access to Primary Care: 12–19 Years	Percentage with a PCP Visit in the Past Two Years	45	87.5	89.6	86.3	91.4
Well-Child Visits: First 15 Months	Percentage with 6 or More Visits	44	60.4	62.8	56.2	67.2
Well-Child Visits: 3–6 Years	Percentage with 1 or More Visits	47	66.2	67.0	61.1	74.5
Well Care Visits: 12–21 Years	Percentage with 1 or More Visits	43	44.8	43.3	38.7	53.4
Childhood Immunization Status: 2 Years	Percentage Up-to-Date on Immunizations (Combination 3)[a]	30	64.3	67.1	59.7	75.5
Immunization Status for Adolescents: 13 Years	Percentage Up-to-Date on Immunizations (Combination 1)[b]	30	63.2	66.2	55.3	73.2
Chlamydia Screening: 16–20 Years	Percentage of Sexually Active Women Screened	37	49.0	49.6	42.2	58.4
Body Mass Index Assessment: 3–17 Years	Percentage with a BMI Percentile Documented	25	34.3	36.5	6.6	51.6
Timeliness of Prenatal Care	Percentage with a Prenatal Visit in the First Trimester (or within 42 Days of Medicaid/CHIP Enrollment)	33	76.7	83.1	68.6	87.2
Frequency of Ongoing Prenatal Care	Percentage with More than 80 Percent of Expected Prenatal Visits	27	56.2	62.2	43.1	71.6
Appropriate Testing for Children with Pharyngitis: 2–18 Years	Percentage who were Dispensed an Antibiotic and Received a Strep Test	36	67.8	68.4	57.9	77.1
Follow-Up After Hospitalization for Mental Illness: 6–20 Years	Percentage of Discharges with a Follow-Up Visit within 7 Days	27	46.6	42.8	33.7	62.0
Follow-Up After Hospitalization for Mental Illness: 6–20 Years	Percentage of Discharges with a Follow-Up Visit within 30 Days	27	65.1	63.0	55.2	77.2
Follow-Up Care for Children Prescribed ADHD Medication: 6–12 Years	Percentage with 1 Follow-Up Visit during the Initiation Phase	31	45.6	45.8	37.2	55.7
Follow-Up Care for Children Prescribed ADHD Medication: 6–12 Years	Percentage with at least 2 Follow-Up Visits during the Continuation and Maintenance Phase	30	54.0	50.4	45.2	63.9

Table 3 (continued)

Source: Based on Mathematica analysis of FFY 2013 Child CARTS reports and Form CMS-416 reports.

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

This table includes data for states that used Child Core Set specifications to report the measures and excludes states that used other specifications and states that did not report the measures for FFY 2013. In cases where a state reported separate rates for its Medicaid and CHIP populations, the rate for the program with the larger measure-eligible population was used. Measure-specific tables are available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2013.zip.

The Ambulatory Care: Emergency Department Visits measure was excluded from this table due to substantial variation from year to year. The Central Line-Associated Blood Stream Infections (CLABSI) and the CAHPS Health Plan Survey measures were excluded from this table because the measures use a summary statistic different from those in this table.

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

[b] Combination 1 includes one dose of meningococcal vaccine and one tetanus, diphtheria toxoids, and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) vaccine.

Table 4. Performance Improvement Projects (PIPs) Targeting Children or Pregnant Women Included in External Quality Review (EQR) Technical Reports, 2013–2014 Reporting Cycle, by Topic Area

State	Number of PIPs for Children/ Pregnant Women	Years of Data	PIPs Validated[a]	ADHD	Asthma	Behav. Health	Mental Health	Childhood Immunizations	Dental Care	EPSDT	ER Visits	Hospital Readmissions	Lead Screening	Prenatal and Post-partum Care	Weight/ BMI	Well-Child Care	Adolescent Well Care	Other[b]
Total PIPs	308	.	.	6	16	24	21	26	16	10	7	10	14	37	41	46	27	7
Total States	38	.	.	3	8	5	2	8	6	4	2	2	3	15	11	7	7	4
Arizona	9	PH: 2010–2011; BH: 2011–2012; LTC: CY 2011	All	-	-	-	-	-	-	-	-	9	-	-	-	-	-	-
California	7	2011–2012	All	-	1	-	-	-	-	-	-	-	-	3	3	-	-	-
Colorado	6	Varies by PIP	All	-	2	-	1	-	-	-	-	-	-	-	2	1	-	-
D.C.	4	2013	All	-	-	-	-	-	-	-	-	-	-	4	-	-	-	-
Delaware	2	Not Reported	Some	-	-	-	-	-	-	-	-	-	-	2*	-	-	-	-
Florida	75	2012–2013	Some	-	-	4	20	-	-	5	-	-	1	-	6	39*	-	-
Georgia[c]	21	SFY 2013	All	3*	-	-	-	3*	3*	-	3	-	-	-	3*	-	3*	3*
Hawaii	2	Varies by PIP	All[d]	-	-	-	-	-	-	-	-	-	-	-	2	-	-	-
Illinois	6	SFY 2011	All[d]	-	-	-	-	-	-	3*	-	-	-	3*	-	-	-	-
Indiana	3	Varies by PIP	Some	-	-	-	-	-	-	-	-	-	-	-	-	-	3	-
Iowa	2	Varies by PIP	Some	-	-	-	-	-	-	-	-	1	-	1	-	-	-	-
Kansas	2	Varies by entity	Some	-	-	-	-	-	-	-	-	-	-	1	-	1	-	-
Kentucky	4	CY 2012	All	-	-	1	-	-	1	-	-	-	-	1	-	-	-	1
Louisiana	1	Varies by PIP	All[d]	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-
Maryland	6	CY 2012	All	-	-	-	-	-	-	-	-	-	-	-	-	-	6*	-
Massachusetts	3	CY 2012	All[d]	-	-	-	-	-	-	-	-	-	-	3	-	-	-	-
Michigan	13	2012–2013	All	-	-	-	-	-	-	-	-	-	-	-	13	-	-	-
Minnesota	4	Not Reported	All	-	-	-	-	-	-	-	4	-	-	-	-	-	-	-
Mississippi[e]	2	2012	All	-	2	-	-	-	-	-	-	-	-	-	-	-	-	-
Missouri	4	2009–2012	All[d]	-	-	-	-	-	3*	-	-	-	-	1	-	-	-	-
Nebraska	3	Varied by PIP	All	-	-	-	-	-	-	-	-	-	-	1	2	-	-	-
Nevada	2	2012–2013	All	-	-	-	-	2*	-	-	-	-	-	-	-	-	-	-
New Jersey	16	CY 2012	All	-	-	-	-	-	4*	-	-	-	4*	4*	2	2	-	-
New Mexico	4	2012–2013	All[d]	-	2	-	-	-	-	-	-	-	-	1	-	-	-	1
New York[f]	3	2011–2012	All	-	3	-	-	-	-	-	-	-	-	-	-	-	-	-
North Carolina	1	2012	All	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-
North Dakota	3	2012	All[d]	-	-	-	-	1	1	-	-	-	-	-	-	1	-	-
Ohio	11	CY 2010	All[d]	-	-	-	-	-	4*	-	-	-	-	-	-	-	7*	-
Oregon[g]	12	NA	NA	-	-	-	-	-	-	1	-	-	-	10	-	1	-	-
Pennsylvania	6	CY 2012	Some	-	-	-	-	-	-	-	-	-	-	-	6	-	-	-
Puerto Rico	1	CY 2012–2013	All[d]	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-
Rhode Island[h]	0	2011–2012	All	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
South Carolina	5	Not Reported	All	-	4	-	-	1	-	-	-	-	-	-	-	-	-	-
Tennessee	19	CY 2012	All	2	-	11	-	-	-	1	-	-	-	1	1	-	1	2
Texas	8	FY 2011	All	-	-	-	-	8	-	-	-	-	-	-	-	-	-	-

Table 4 (continued)

State	Number of PIPs for Children/ Pregnant Women	Years of Data	PIPs Validated[a]	ADHD	Asthma	Behav. Health	Mental Health	Childhood Immunizations	Dental Care	EPSDT	ER Visits	Hospital Readmissions	Lead Screening	Prenatal and Post-partum Care	Weight/ BMI	Well-Child Care	Adolescent Well Care	Other[b]
Vermont[i]	0	2010–2011	All	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Virginia[j]	6	CY 2011–2012	All	-	-	-	-	-	-	-	-	-	-	-	-	-	6*	-
Washington	10	Varies by PIP	Some	1	1	7	-	-	-	-	-	-	-	-	-	1	-	-
West Virginia	3	2012	All[d]	-	-	-	-	1	-	-	-	-	-	-	1	-	1	-
Wisconsin	19	MCOs: CY 2011; SMCOs: CY 2012; LTC: FY 2012–2013	All	-	-	-	-	9	-	-	-	-	9	1	-	-	-	-

Source: EQR technical reports submitted to CMS for the 2013–2014 reporting cycle as of May 16, 2014.

Notes: During the 2013–2014 reporting cycle, the following states and territories did not contract with any MCOs or PIHPs: AL, AK, AR, CT, GU, ID, ME, MT, OK, VI, and WY. ND only had CHIP managed care. UT and NH did not submit an EQR technical report before May 16, 2014 for inclusion in this analysis.

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.

Analysis excludes entities that do not serve children or pregnant women, such as Medicare Advantage plans that cover dual eligibles.

* PIP topic was mandated by the state.

[a] In accordance with 42 CFR 438.320, 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. EQR discussion and recommendations are summarized from the EQR report's discussion of the validation results for each PIP, including strengths, limitations, and recommendations for improvement.

[b] PIPs for children on "Other" topics include children with pharyngitis (TN), children with pharyngitis and URIs (KY), ER visits (GA, MN), hospital readmissions (AZ, IA), member satisfaction (GA), and respiratory syncytial virus (NM).

[c] Georgia had mandated PIPs on ER visits and member satisfaction in which 3 MCOs participated and which are captured here in the "Other" category. In addition to the PIPs represented in this table, Georgia also conducted a PIP on provider satisfaction that targeted both adults and children, which is represented in the 2014 Annual Report on the Quality of Care for Adults in Medicaid.

[d] This state EQRO validated all of the PIPs mentioned in the technical report, it was unclear if any additional PIPs were conducted in the state but not validated or noted in the technical report.

[e] Focused studies were submitted as performance improvement projects (PIPs). Carolinas Center for Medical Excellence (CCME) was directed by the Mississippi Division of Medicaid (DOM) to review the projects as focused studies.

[f] NY conducted two asthma PIPs that included both children and adult populations. One of those PIPs is represented in this table and the other is accounted for in Table 4 of the 2014 Annual Report on the Quality of Care for Adults in Medicaid.

[g] Because this was the first full year of operation for Oregon's coordinated care organizations (CCOs), the 2013 report highlights results of the readiness reviews of the CCOs to evaluate their capacity to meet federal requirements.

[h] Rhode Island conducted two PIPs which included both children and adults: chlamydia screening in women ages 16–24, and Initial Health Screens for Special Populations. These PIPs are represented in Table 4 of the 2014 Annual Report on the Quality of Care for Adults in Medicaid; therefore, they are not represented here in order to avoid duplication.

[i] VT did not provide information on any PIPs targeted at children or pregnant women in their EQR technical reports.

[j] In addition to the PIPs indicated here for VA, the state's MCOs also conducted a PIP focused on follow-up after hospitalization for mental health for enrollees age six and older. This PIP is represented in Table 4 of the 2014 Annual Report on the Quality of Care for Adults in Medicaid; therefore, it is not represented here in order to avoid duplication.

ADHD = attention-deficit/hyperactivity disorder; Behav. = behavioral; BH = behavioral health; BMI = body mass index; CY = calendar year; EPSDT = early and periodic screening, diagnostic, and treatment; EQRO = external quality review organization; ER = emergency room; FY = fiscal year; LTC = long-term care; NA = not available; PH = physical health; SFY = state fiscal year; SMCO = special managed care organization (Wisconsin's MCOs serving children with special needs); URI = upper respiratory infection.

Table 5. Childhood Obesity Performance Improvement Projects (PIPs) Included in External Quality Review (EQR) Technical Reports, 2013–2014 Reporting Cycle

State	Number of MCOs/PIHPs Participating	Performance Measure(s) and/or Indicators	Intervention/Validation Ratings	Results
California*	3	BMI assessment, documentation of referrals for nutrition and physical activity counseling	Some intervention information; all entities met validation ratings	Statistically significant improvement across MCOs
Colorado*	2	Varied by MCO; BMI percentile documentation, nutrition counseling, physical activity counseling	Some intervention information; both entities met validation ratings	Statistically significant improvement for one MCO; no results reported for one MCO
Florida*	6	Childhood obesity in residential psychiatric treatment	No intervention information; did not meet validation rating	None reported
Georgia*	3	BMI percentile documentation, nutrition counseling, physical activity counseling	Some intervention information; all entities partially met validation ratings	Improvement on some measures for all MCOs; some statistically significant; decline on one measure for two MCOs
Hawaii	2	BMI percentile documentation	Some intervention information; validation ratings varied	Mixed results
Michigan*	13	Varied by MCO; BMI percentile documentation, nutrition counseling, physical activity counseling	Some intervention information; all entities met validation ratings	Mixed results; some statistically significant; decline on one measure for one MCO
Nebraska*	2	BMI percentile documentation, nutrition counseling, physical activity counseling	Detailed intervention information, validation ratings not reported	Mixed results; improvement on two measures, decline on one measure, statistical significance not reported
New Jersey*	2	Varied by MCO; BMI percentile documentation, nutrition counseling, physical activity counseling	Some intervention information, validation ratings not reported	No improvement for one entity, no results reported for one entity
Pennsylvania*	6	BMI percentile documentation, nutrition counseling, physical activity counseling, percentage of obese children enrolled in case management, percentage of primary care physicians receiving education on obesity coding	Detailed intervention information; all entities met or partially met validation ratings	None reported
Tennessee*	1	BMI assessment, nutrition counseling, physical activity counseling	No intervention information; met validation rating	None reported
West Virginia*	1	BMI percentile documentation, nutrition counseling, physical activity counseling	Detailed intervention information; validation rating not reported	Mixed results; improvement on two measures, decline on one measure, statistical significance not reported

Table 5 (continued)

Source: EQR technical reports submitted to CMS for the 2013–2014 reporting cycle as of May 16, 2014.

Notes: During the 2013–2014 reporting cycle, the following states and territories did not contract with any MCOs or PIHPs: AL, AK, AR, CT, GU, ID, ME, MT, OK, VI, and WY. ND only had CHIP managed care. UT and NH did not submit an EQR technical report before May 16, 2014 for inclusion in this analysis.

Analysis includes PIPs from the EQR technical reports that targeted children or pregnant women.

In addition to the PIPs represented here, eight states (CA, CO, FL, HI, MS, NJ, PR, and WA) conducted PIPs targeting weight or BMI among adults.

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.

*State reported a PIP on this topic during both 2012–2013 and 2013–2014 reporting cycles.

Table 6. Oral Health (Children) Performance Improvement Projects (PIPs) Included in External Quality Review (EQR) Technical Reports, 2013–2014 Reporting Cycle

State	Number of MCOs/PIHPs Participating	Performance Measure(s) and/or Indicators	Intervention/ Validation Ratings	Results
Georgia*	3	Annual dental visit rate for ages 2–3, annual dental visit rate for ages 2–21	Some intervention information; all entities partially met validation rating	Improvement on both measures for all entities; statistically significant improvement for two entities
Kentucky	1	Annual dental visit rate for children with special health care needs	Detailed intervention information; validation rating not reported	No improvement
Missouri*	3	Annual dental visit rate	Some intervention information; all entities met or partially met validation rating	Mixed results; no results reported for two entities, improvement varied by region for one entity
New Jersey*	4	Varied by entity; Annual dental visit rate for ages 1–2, annual dental visit rate for ages 2–3, annual dental visit rate for ages 6 months–7 years	Some intervention information; validation ratings not reported	Mixed results; improvement for one entity, decline for one entity, no results reported for two entities
North Dakota	1	Preventive dental services	Detailed intervention information; met validation rating	No improvement
Ohio	4	Annual dental visit rate for ages 2–20	No intervention information; validation ratings varied	Mixed results; improvement for three entities, no improvement for one entity

Source: EQR technical reports submitted to CMS for the 2013–2014 reporting cycle as of May 16, 2014.

Notes: During the 2013–2014 reporting cycle, the following states and territories did not contract with any MCOs or PIHPs: AL, AK, AR, CT, GU, ID, ME, MT, OK, VI, and WY. ND only had CHIP managed care. UT and NH did not submit an EQR technical report before May 16, 2014 for inclusion in this analysis.

Analysis includes PIPs from the EQR technical reports that targeted children or pregnant women.

In addition to the PIPs represented here, MN conducted a PIP targeting oral health among adults.

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.

*State reported a PIP on this topic during both 2012–2013 and 2013–2014 reporting cycles.

Table 7. Prenatal/Postpartum Health Performance Improvement Projects (PIPs) Included in External Quality Review (EQR) Technical Reports, 2013–2014 Reporting Cycle

State	Number of MCOs/PIHPs Participating	Performance Measure(s) and/or Indicators	Intervention/Validation Ratings	Results
California*	3	Varies by MCO; postpartum care, postpartum depression screening	Some intervention information; all MCOs met validation rating	Mixed results; improvement for 2 MCOs, performance varied by county for one MCO
Delaware*	2	Prenatal care, postpartum care	No intervention information; low to moderate confidence in results	Limited measureable improvement
District of Columbia*	4	Adverse perinatal outcomes**; prematurity; low birth weight; infant death; unknown birth outcomes	No intervention information; all MCOs met validation rating	First year of PIP; no outcomes reported
Illinois*	3	Timeliness of prenatal and postpartum care, depression screening	Detailed intervention information; met validation ratings	Mixed results; results vary by measure; all MCOs demonstrated improvement on some measures
Iowa	1	Timeliness of prenatal care, timeliness of postpartum care, prenatal and postpartum depression screening and follow-up	No intervention information; met validation rating	First year of PIP; no outcomes reported
Kansas*	1	Timeliness and frequency of prenatal and postpartum care	Detailed intervention information; validation rating not reported	Mixed results; improvement on one measure, decline on one measure
Kentucky*	1	Prenatal and postpartum depression screening and management	Detailed intervention information; validation rating not reported	None Reported
Massachusetts*	3	Varies by MCO; adverse perinatal outcomes, prenatal care, depression screening, postpartum care	Detailed intervention information; validation ratings varied	Mixed results; all three MCOs showed improvements; one MCO declined on one measure
Missouri	1	Rate of Notice of Pregnancy receipt	Detailed intervention information; met validation rating	First year of PIP; no outcomes reported
Nebraska*	1	Timeliness of prenatal and postpartum care, frequency of prenatal care	Detailed intervention information; met validation rating	Performance declined on all measures

Table 7 (continued)

State	Number of MCOs/PIHPs Participating	Performance Measure(s) and/or Indicators	Intervention/Validation Ratings	Results
New Jersey*	4	Varies by MCO; prenatal dental visits, timeliness of prenatal and postpartum care, low birth weight	Some intervention information; validation ratings not reported	Mixed results; improvement for two MCOs, no improvement for one MCO, no results reported for one MCO
New Mexico*	1	Adverse birth outcomes, prenatal care	Detailed intervention information; "moderate compliance" validation rating	Performance continues to decline since 2009 baseline
Oregon	10	Varied by MCO; Access and quality of care for prenatal and postpartum care, substance abuse screening for expectant mothers; no specific measures indicated	Some intervention information; PIPS not validated for 2013 EQR	First year of PIP; no outcomes reported
Tennessee	1	Prenatal and postpartum care access	No intervention information; met validation rating	None Reported
Wisconsin	1	Birth outcomes; no specific measures indicated	No intervention information; validation rating not reported	None Reported

Source: EQR technical reports submitted to CMS for the 2013–2014 reporting cycle as of May 16, 2014.

Notes: During the 2013–2014 reporting cycle, the following states and territories did not contract with any MCOs or PIHPs: AL, AK, AR, CT, GU, ID, ME, MT, OK, VI, and WY. ND only had CHIP managed care. UT and NH did not submit an EQR technical report before May 16, 2014 for inclusion in this analysis.

Analysis includes PIPs from the EQR technical reports that targeted children or pregnant women.

Because this was the first full year of operation for Oregon's coordinated care organizations (CCOs), the 2013 report highlights results of the readiness reviews of the CCOs to evaluate their capacity to meet federal requirements.

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.

*State reported a PIP on this topic during both 2012–2013 and 2013–2014 reporting cycles.

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

Table 8. Adolescent Health Performance Improvement Projects (PIPs) Included in External Quality Review (EQR) Technical Reports, 2013–2014 Reporting Cycle

State	Number of MCOs/PIHPs Participating	Performance Measure(s) and/or Indicators	Intervention/Validation Ratings	Results
Georgia	3	Well-care visit rate	Detailed intervention information; partially met validation ratings	Improvement for all entities; statistically significant improvement for two entities
Indiana	3	Varied by MCO; well-care visit rate, access to primary care	Detailed intervention information; partially met validation ratings	No statistically significant improvement; statistically significant decline for two entities
Maryland*	6	Well-care visit rate	Detailed intervention information; all entities met or partially met validation ratings	None reported
Ohio	7	Well-care visit rate	No intervention information; all entities met or partially met validation ratings	None reported; PIPs were in baseline measurement year
Tennessee	1	Adolescent screening rate	No intervention information; met validation rating	None reported
Virginia	6	Adolescent well-care visit rate	No intervention information; all entities met validation ratings	Mixed results; statistically significant improvement for one entity, no improvement for most entities, decline for a few entities
West Virginia*	1	Well-care visit rate	Detailed intervention information; validation rating not reported	Improvement, but statistical significance not reported

Source: EQR technical reports submitted to CMS for the 2013–2014 reporting cycle as of May 16, 2014.

Notes: During the 2013–2014 reporting cycle, the following states and territories did not contract with any MCOs or PIHPs: AL, AK, AR, CT, GU, ID, ME, MT, OK, VI, and WY. ND only had CHIP managed care. UT and NH did not submit an EQR technical report before May 16, 2014 for inclusion in this analysis.

Analysis includes PIPs from the EQR technical reports that targeted children or pregnant women.

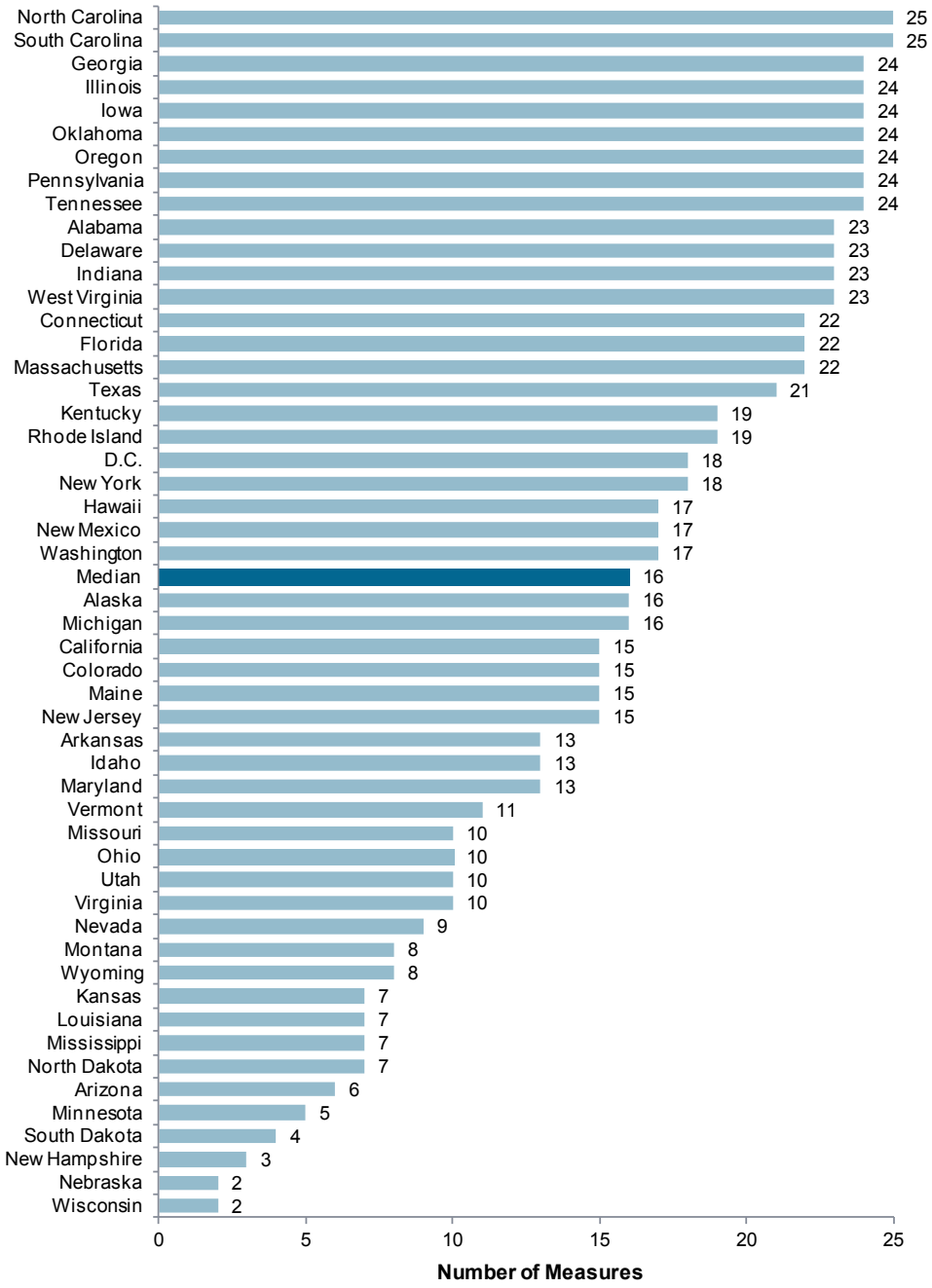
Information about the EQR process is available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

*State reported a PIP on this topic during both 2012–2013 and 2013–2014 reporting cycles.

This page left blank for double-sided copying.

FIGURES

Figure 1. Number of Medicaid/CHIP Children's Health Care Quality Measures Reported by States, FFY 2013



Source: Based on Mathematica analysis of FFY 2013 Child CARTS reports.

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

The 2013 Child Core Set includes 26 measures. Three measures were added to the 2013 Child Core Set: Human Papillomavirus (HPV) Vaccine for Female Adolescents, Medication Management for People with Asthma, and Behavioral Health Risk Assessment (for Pregnant Women). The Otitis Media with Effusion (OME) measure was retired from the Child Core Set in 2013.

Beginning in FFY 2012, to minimize state reporting burden, CMS began calculating the two dental measures on behalf of states using data reported on Form CMS-416.

This figure is based on state reporting of 25 Child Core Set measures for FFY 2013. This figure excludes the Central Line-Associated Bloodstream Infection (CLABSI) measure. Beginning in FFY 2012, data for the CLABSI measure were obtained from the CDC National Healthcare Safety Network.

Figure 2. Number of States Reporting the Core Set of Medicaid/CHIP Children's Health Care Quality Measures, FFY 2013

Source: Based on Mathematica analysis of FFY 2013 Child CARTS reports and Form CMS-416 reports.

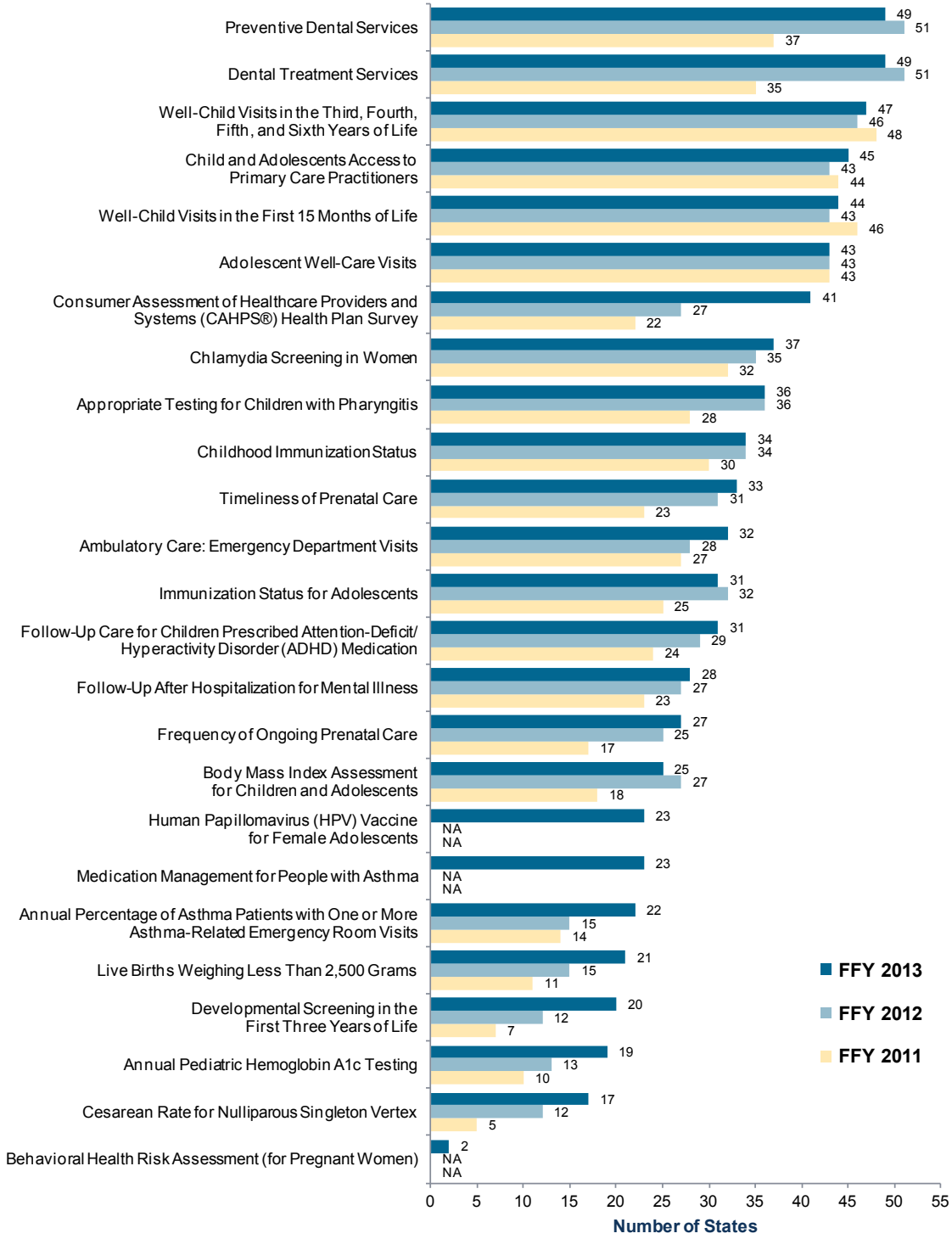
Notes: The term "states" includes the 50 states and the District of Columbia.

The 2013 Child Core Set includes 26 measures. Three measures were added to the 2013 Child Core Set: Human Papillomavirus (HPV) Vaccine for Female Adolescents, Medication Management for People with Asthma, and Behavioral Health Risk Assessment (for Pregnant Women). The Otitis Media with Effusion (OME) measure was retired from the Child Core Set in 2013.

Beginning in FFY 2012, to minimize state reporting burden, CMS began calculating the two dental measures on behalf of states using data reported on Form CMS-416.

This figure excludes the Central Line-Associated Bloodstream Infection (CLABSI) measure. Beginning in FFY 2012, data for the CLABSI measure were obtained from the CDC National Healthcare Safety Network.

Figure 3. Changes in the Number of States Reporting the Medicaid/CHIP Children's Health Care Quality Measures, FFY 2011–2013



Source: Based on Mathematica analysis of FFY 2011–2013 Child CARTS reports and FFY 2012–2013 Form CMS-416 reports.

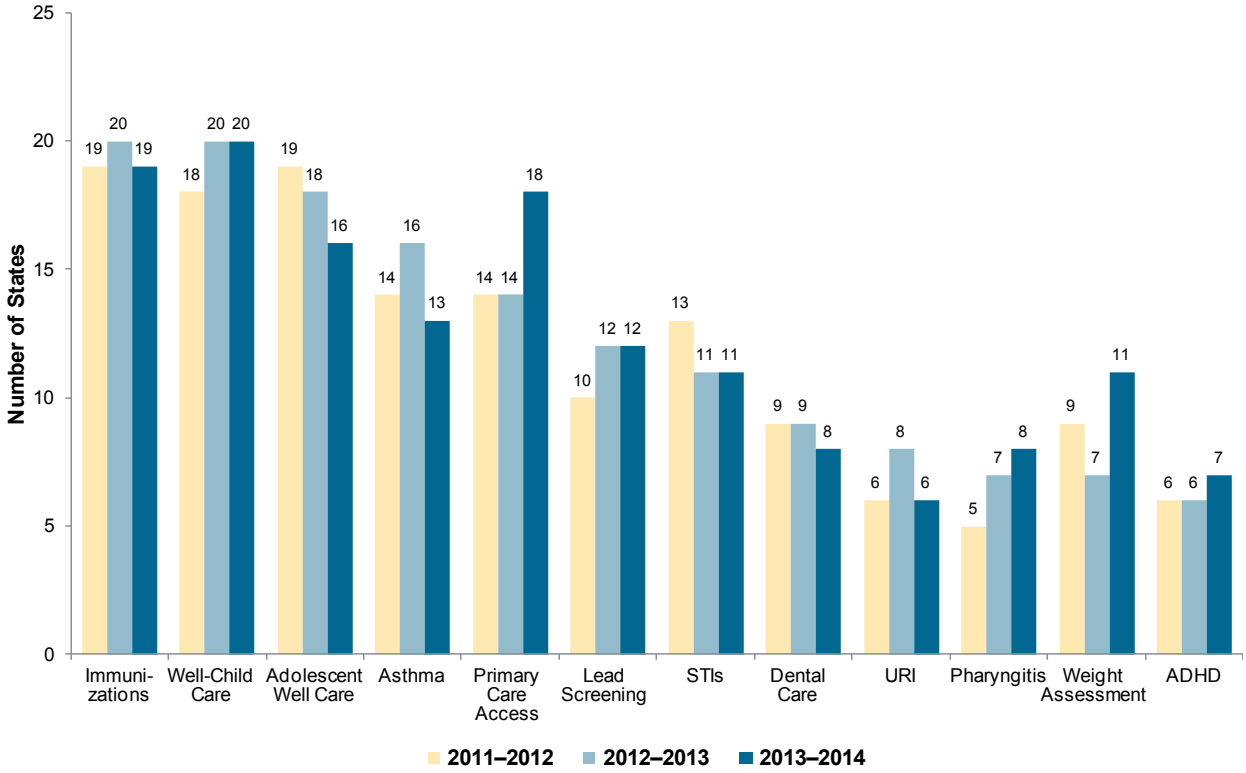
Notes: The term "states" includes the 50 states and the District of Columbia.

Beginning in FFY 2012, to minimize state reporting burden, CMS began calculating the two dental measures on behalf of states using data reported on Form CMS-416. In FFY 2011, states reported the two dental measures in CARTS.

This figure excludes the Central Line-Associated Bloodstream Infection (CLABSI) measure. Beginning in FFY 2012, data for the CLABSI measure were obtained from the CDC National Healthcare Safety Network.

NA = not available; measures were not collected for FFY 2011 and FFY 2012.

Figure 4. Comparison of Performance Measures Evaluating Children's Health Care Quality That Were Reported in External Quality Review (EQR) Technical Reports for the 2011–2012, 2012–2013, and 2013–2014 Reporting Cycles for 25 States, by General Topic



Source: Performance measures for 2011–2012 and 2012–2013 obtained from the 2013 Secretary's Report on the Quality of Care for Children in Medicaid and CHIP. Performance measures for 2013–2014 are from analysis of 2013–2014 EQR technical reports.

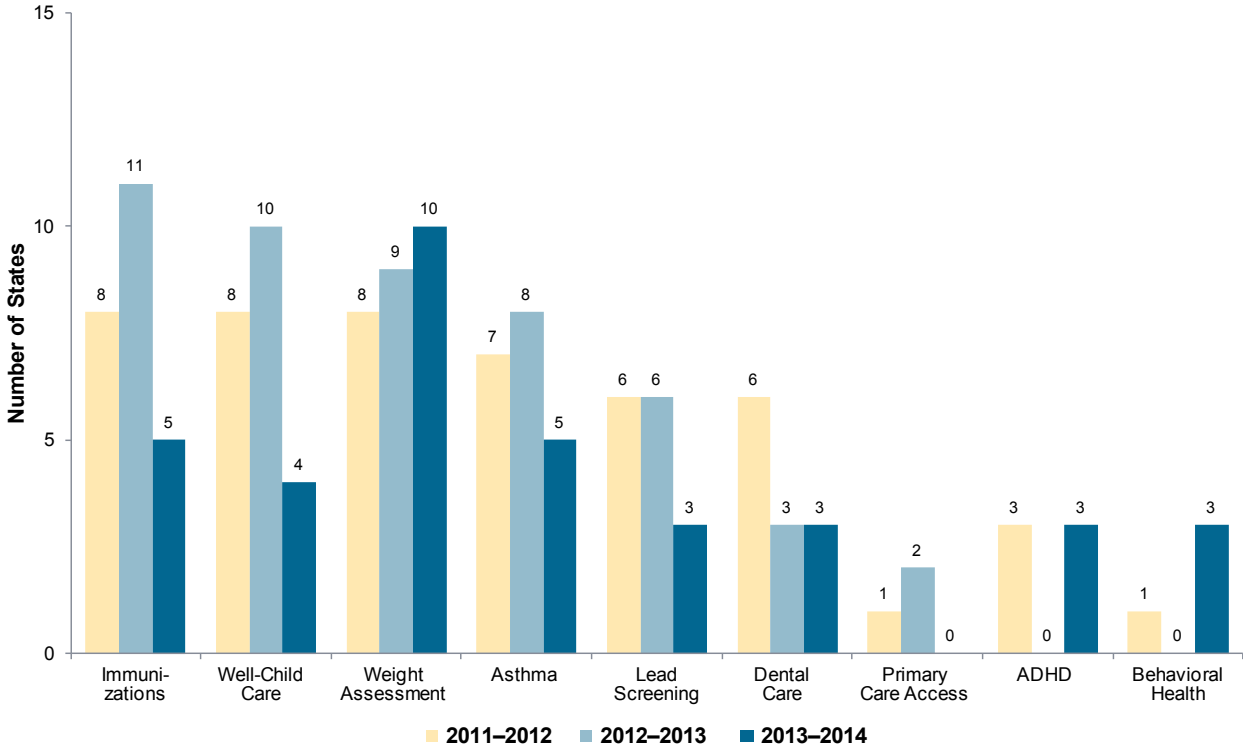
Notes: EQR technical reports submitted to CMS for the 2013-2014 reporting cycle as of May 16, 2014. States include: AZ, CA, DE, FL, GA, HI, IL, IN, MD, MA, MI, MN, MO, NE, NV, NJ, NM, NY, PA, RI, TN, VT, VA, WA, and WV. These are states that submitted reports in all three comparison years.

Analysis excludes entities that do not serve children or pregnant women, such as Medicare Advantage plans that cover dual eligibles.

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.

ADHD = attention-deficit/hyperactivity disorder; Pharyngitis = appropriate testing for children with pharyngitis; STI = sexually transmitted infection; URI = upper respiratory infection.

Figure 5. Comparison of Performance Improvement Projects (PIPs) Targeting Children That Were Reported in External Quality Review (EQR) Technical Reports for the 2011–2012, 2012–2013, and 2013–2014 Reporting Cycle for 27 States, Selected Topics



Source: PIPs for 2011–2012 and 2012–2013 obtained from the 2013 Secretary's Report on the Quality of Care for Children in Medicaid and CHIP. PIPs for 2013–2014 are from analysis of 2013–2014 EQR technical reports.

Notes: EQR technical reports submitted to CMS for the 2013–2014 reporting cycle as of May 16, 2014. States include AZ, CA, DE, FL, GA, HI, IL, IN, MD, MA, MI, MN, MO, NE, NV, NJ, NM, NY, PA, RI, SC, TN, VT, VA, WA, WV, and WI. These are the states that submitted reports in all three comparison years.

Analysis excludes entities that do not serve children or pregnant women, such as Medicare Advantage plans that cover dual eligibles.

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.

The number of states captured in this figure for weight assessment and behavioral health are slightly inconsistent with the number of states represented in Table 4 of the Report. Some of the PIPs in these topic areas are targeted to both children and adults and are represented in Table 4 of the 2014 Annual Report on the Quality of Care for Adults in Medicaid.

ADHD = attention-deficit/hyperactivity disorder.

APPENDIX

STATE-SPECIFIC OUTCOMES

This page left blank for double-sided copying.

PRIMARY CARE ACCESS AND PREVENTIVE CARE

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

Over the past two years, CMS launched several activities to support state efforts to expand access to and improve the quality of preventive health care in Medicaid and CHIP. For example:

- The Promoting Prevention in Medicaid and CHIP technical assistance webinar series, held in spring 2013, featured presentations on the activities of several state Medicaid programs and their collaborations with federal prevention initiatives, managed care organizations, public health departments, and other stakeholders to improve access to preventive care.
- The Medicaid Prevention Learning Network, launched in late 2013, aims to help states increase access to and use of preventive services and improve reporting and performance on CMS's prevention-related quality measures. The Learning Network provides enhanced technical assistance to states and facilitates exchange of information about effective preventive care delivery.
- The Birth to 5: Watch Me Thrive! Initiative is promoting universal developmental and behavioral screening for children enrolled in Medicaid/CHIP, and developing strategies to ensure that children and their families receive necessary early intervention and developmental support services.[1]
- CMS is also partnering with the Centers for Disease Control and Prevention (CDC) on efforts related to the Vaccines for Children Program, which provides vaccines at no cost for children under age 19 who are enrolled in Medicaid, uninsured, underinsured, or American Indian/Alaskan Native.[2]
- New content on Medicaid.gov provides summaries and links to information on prevention-related coverage policy, prevention provisions in the Affordable Care Act that affect Medicaid and CHIP, and opportunities for additional technical assistance.[3]

The eight Child Core Set measures included in this section are those for which information is available from at least 25 states for the FFY 2013 reporting year.[4] These measures are useful in assessing the adequacy of children's and adolescents' access to essential primary and preventive care, and provide insights into the current status of health care quality provided to publicly insured children and areas for improvement. The measures are as follows:

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

[1] http://www.acf.hhs.gov/programs/ecd/watch-me-thrive.

[2] http://www.cdc.gov/vaccines/programs/vfc/index.html.

[3] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prevention.html.

[4] The Ambulatory Care: Emergency Department Visits measure is not included in the Appendix due to data quality issues.

This page left blank for double-sided copying.

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

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

Measure Description

- The percentage of children and adolescents ages 12 months to 19 years who had a visit with a PCP. Rates are reported for four age groups: children ages 12 to 24 months and 25 months to 6 years who had a PCP visit during the measurement year and children ages 7 to 11 and 12 to 19 who had a PCP visit during the current or prior measurement year.[1]

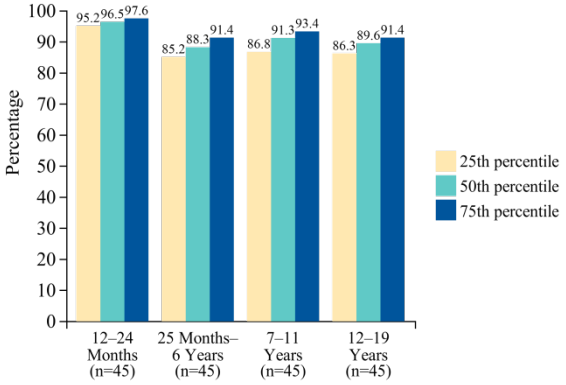
Overview of State Reporting

- The number of states reporting the Child and Adolescent Access to PCPs measure decreased from 44 states for FFY 2011 to 43 states for FFY 2012 and then increased to 45 states for FFY 2013.[2]
- Of the 45 states reporting the measure for FFY 2013, 35 reported the measure for Medicaid and CHIP, 2 reported the measure for Medicaid only, and 8 reported the measure for CHIP only.

State Performance

- Among the 45 states using Child Core Set specifications to report the measure for FFY 2013, the median rate was highest for the 12-to-24 month age group, with a median of 97 percent and a 2-point spread between the 25th and 75th percentiles (Exhibit CAP.1). Median rates for other age groups were slightly lower, but still quite high: 88 percent for ages 25 months to 6 years (6-point spread); 91 percent for ages 7 to 11 (7-point spread); and 90 percent for ages 12 to 19 (5-point spread).
- Performance on this measure ranged from 86 to 100 percent for children ages 12 to 24 months and from 73 to 95 percent for ages 25 months to 6 years. The range across states was wider for the older age groups, ranging from 36 to 98 percent for ages 7 to 11 and from 47 to 96 percent for ages 12 to 19 (Exhibits CAP.3–CAP.6, next page).

Exhibit CAP.1. Percentage of Children and Adolescents with a PCP Visit in the Past Year (12 to 24 Months and 25 Months to 6 Years) or Past Two Years (7 to 11 Years and 12 to 19 Years), FFY 2013 (n = 45 states)



Source: Mathematica analysis of 2013 CARTS reports as of August 4, 2014.

Trends

- Among the 40 states reporting the measure using Child Core Set specifications for all three years, the median rates did not change substantially between FFY 2011 and 2013 (Exhibit CAP.2, next page). Across all three years, the rates were highest for the 12-to-24 month age group, exceeding 95 percent each year.

[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.

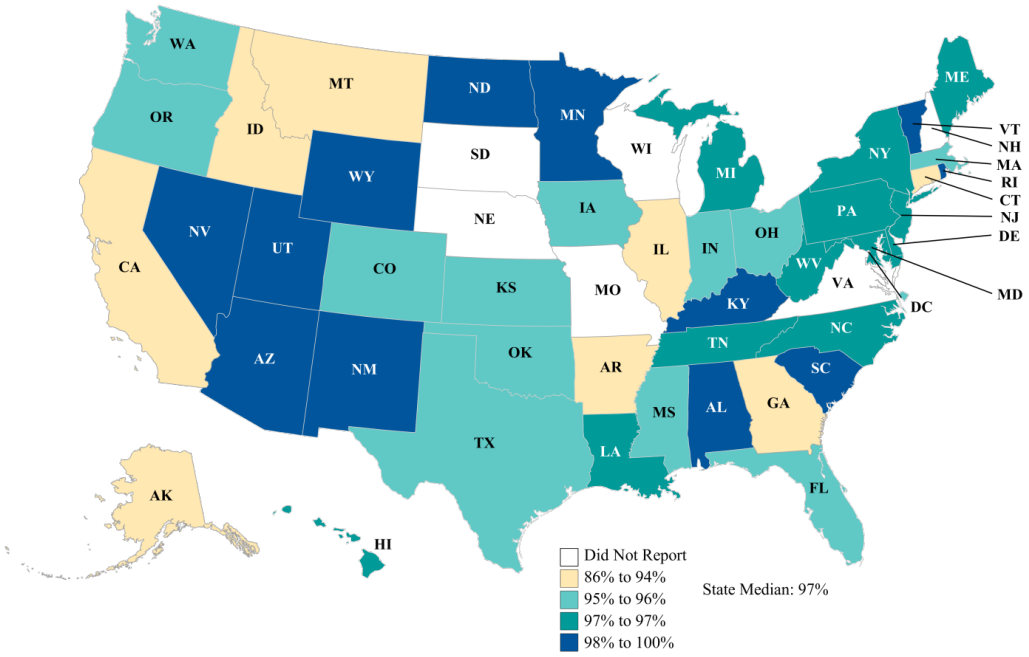
Exhibit CAP.2. Trends in the Percentage of Children and Adolescents with a PCP Visit in the Past Year (12 to 24 Months and 25 Months to 6 Years) or Past Two Years (7 to 11 Years and 12 to 19 Years), FFY 2011-2013 (n = 40 states)

Rate	FFY 2011	FFY 2012	FFY 2013
12 to 24 months			
Mean Rate	96.0	95.5	96.1
Median Rate	96.8	96.7	96.5
25th Percentile	95.6	94.8	95.1
75th Percentile	98.0	98.0	97.7
25 months to 6 years			
Mean Rate	87.7	87.3	87.3
Median Rate	88.0	87.9	87.8
25th Percentile	85.0	84.9	84.9
75th Percentile	91.6	90.9	91.4
7 to 11 years			
Mean Rate	88.5	88.0	87.8
Median Rate	90.2	90.3	90.8
25th Percentile	86.6	86.0	86.2
75th Percentile	92.9	92.8	93.2
12 to 19 years			
Mean Rate	87.2	86.9	87.0
Median Rate	88.8	89.0	89.0
25th Percentile	85.2	85.7	85.8
75th Percentile	91.7	91.4	91.2

Source: Mathematica analysis of FFY 2011, 2012, and 2013 Child CARTS reports as of August 4, 2014.

Note: This table includes 40 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.

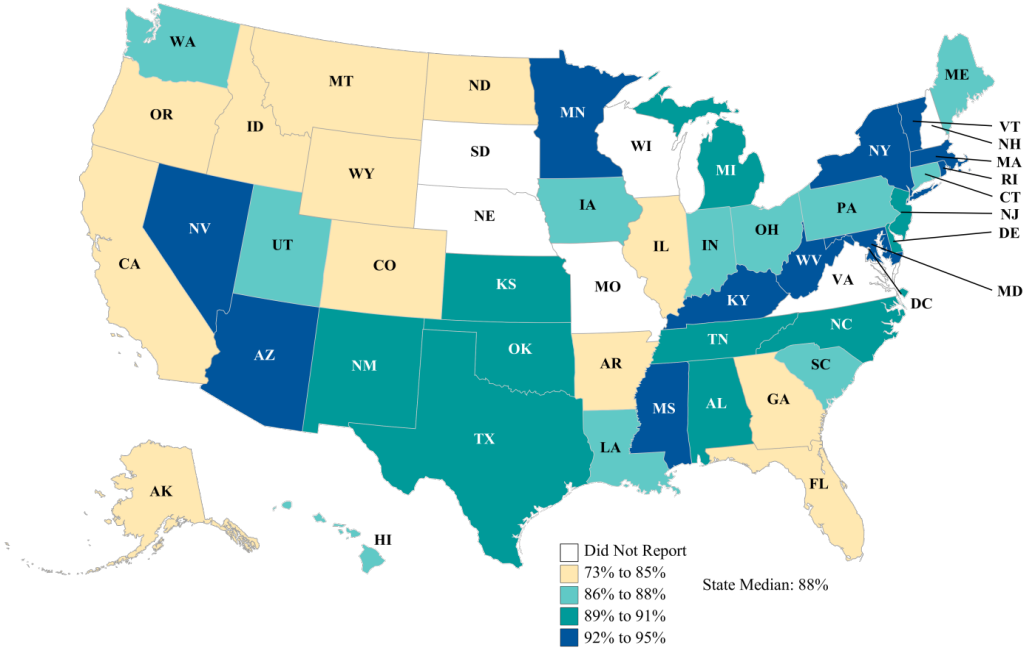
Exhibit CAP.3. Geographic Variation in the Percentage of Children and Adolescents with a PCP Visit in the Past Year (12 to 24 Months), FFY 2013 (n = 45 states)



Source: Mathematica analysis of FFY 2013 Child CARTS reports as of August 4, 2014.

To view state-specific data for this measure, please see Table CAP at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2013.zip.

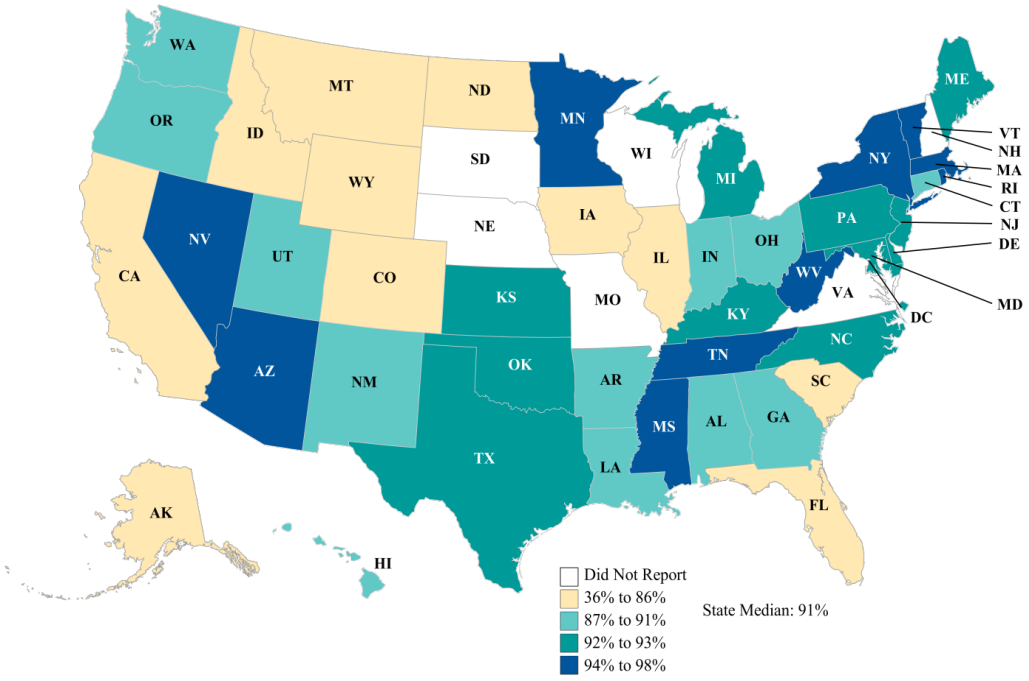
Exhibit CAP.4. Geographic Variation in the Percentage of Children and Adolescents with a PCP Visit in the Past Year (25 Months to 6 Years), FFY 2013 (n = 45 states)



Source: Mathematica analysis of FFY 2013 Child CARTS reports as of August 4, 2014.

To view state-specific data for this measure, please see Table CAP at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2013.zip.

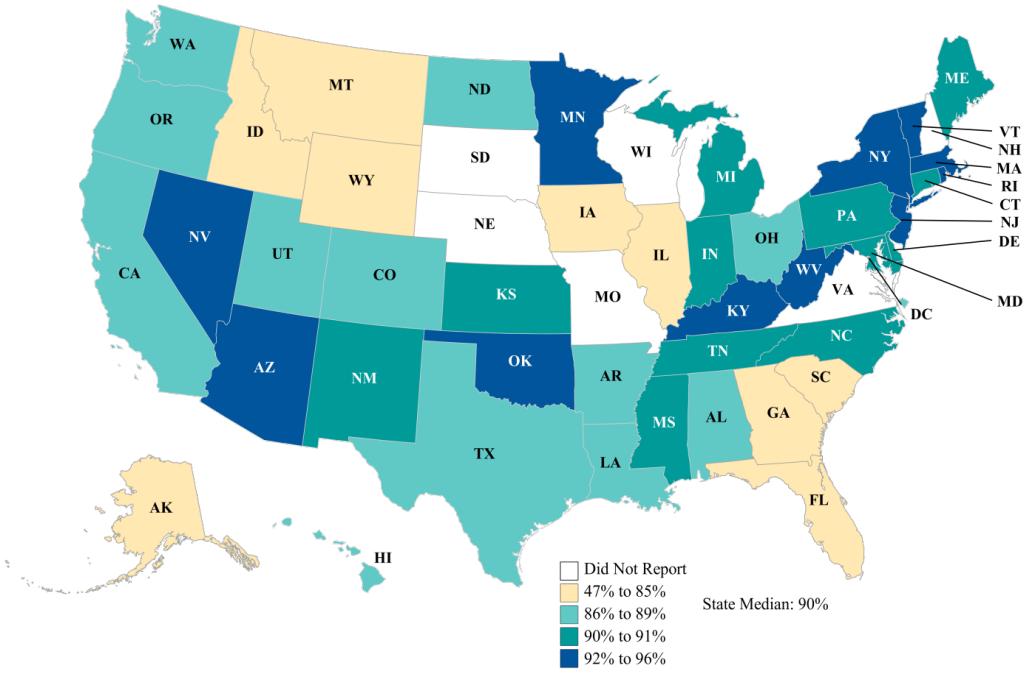
Exhibit CAP.5. Geographic Variation in the Percentage of Children and Adolescents with a PCP Visit in the Past Two Years (7 to 11 Years), FFY 2013 (n = 45 states)



Source: Mathematica analysis of FFY 2013 Child CARTS reports as of August 4, 2014.

To view state-specific data for this measure, please see Table CAP at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2013.zip.

Exhibit CAP.6. Geographic Variation in the Percentage of Children and Adolescents with a PCP Visit in the Past Two Years (12 to 19 Years), FFY 2013 (n = 45 states)



Source: Mathematica analysis of FFY 2013 Child CARTS reports as of August 4, 2014.

To view state-specific data for this measure, please see Table CAP at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2013.zip.

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

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

Measure Description

- The percentage of children who turned 15 months old during the measurement year and had zero, one, two, three, four, five, or six or more well-child visits with a primary care practitioner (PCP) during their first 15 months of life.[1]

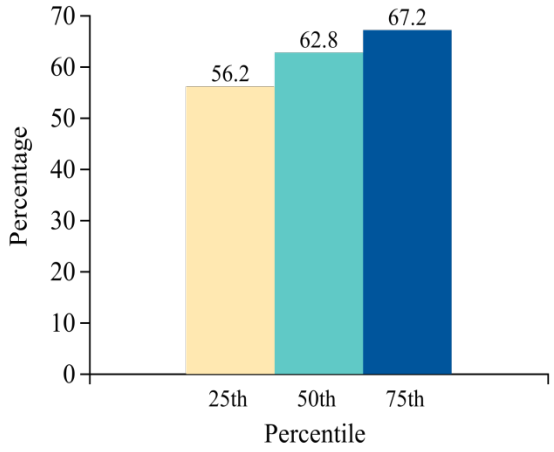
Overview of State Reporting

- The number of states reporting the Well-Child Visits in the First 15 Months of Life measure decreased from 46 states for FFY 2011 to 43 states for FFY 2012 and then increased to 44 states for FFY 2013.[2]
- Of the 44 states reporting the measure for FFY 2013, 35 reported the measure for Medicaid and CHIP, 3 reported the measure for Medicaid only, and 6 reported the measure for CHIP only.

State Performance

- Among the 44 states using Child Core Set specifications to report the measure for FFY 2013, the median rate was 63 percent, with an 11-point spread between the 25th and 75th percentiles (Exhibit W15.1).
- Performance on this measure ranged from 13 to 84 percent among states, with considerable geographic variation across states (Exhibit W15.3, next page).

Exhibit W15.1. Percentage of Children Receiving 6 or More Well-Child Visits in the First 15 Months of Life, FFY 2013 (n = 44 states)



Source: Mathematica analysis of FFY 2013 Child CARTS reports as of August 4, 2014.

Trends

- Among the 41 states reporting the measure using Child Core Set specifications for all three years, the median rate increased by 2 percentage points from FFY 2011 to FFY 2013 (Exhibit W15.2).

[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.

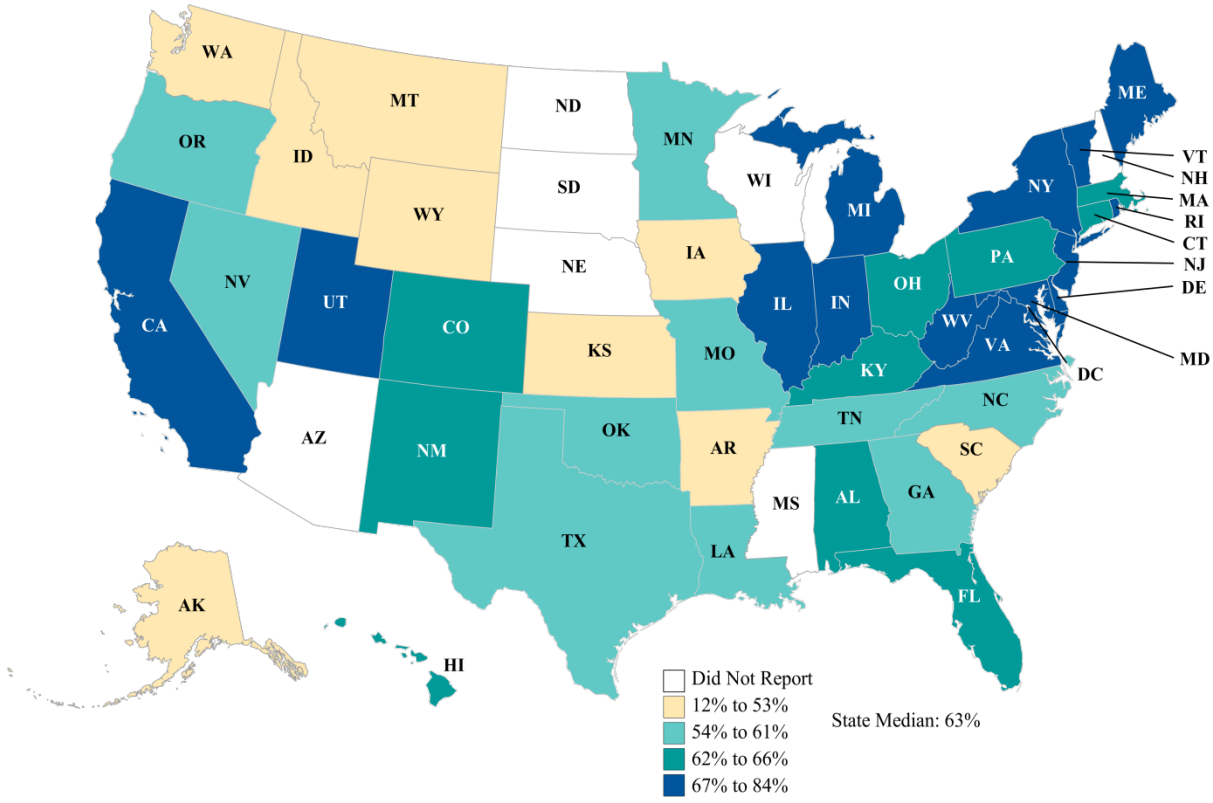
Exhibit W15.2. Trends in the Percentage of Children Receiving 6 or More Well-Child Visits in the First 15 Months of Life, FFY 2011–2013 (n = 41 states)

Rate	FFY 2011	FFY 2012	FFY 2013
Mean	56.9	59.8	60.3
Median	60.2	62.1	62.2
25th Percentile	52.0	55.3	56.4
75th Percentile	68.7	67.3	67.2

Source: Mathematica analysis of FFY 2011, 2012, and 2013 Child CARTS reports as of August 4, 2014.

Notes: This table includes 41 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 W15.3. Geographic Variation in the Percentage of Children Receiving 6 or More Well-Child Visits in the First 15 Months of Life, FFY 2013 (n = 44 states)



Source: Mathematica analysis of FFY 2011, 2012, and 2013 Child CARTS reports as of August 4, 2014.

To view state-specific data for this measure, please see Table W15 at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2013.zip.

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

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

Measure Description

- The percentage of children ages 3 to 6 who had one or more well-child visits with a primary care practitioner (PCP) during the measurement year.[1]

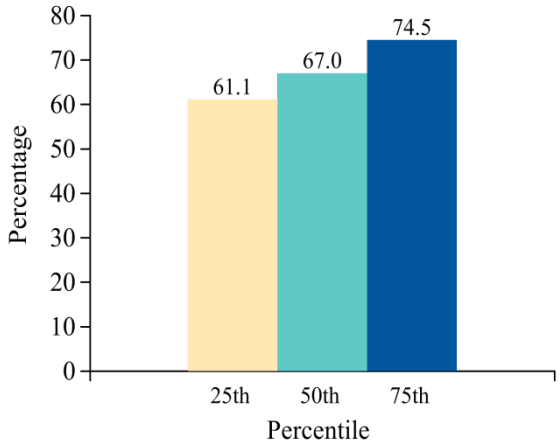
Overview of State Reporting

- The number of states reporting the Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life measure decreased from 48 states for FFY 2011 to 46 states for FFY 2012 and then increased to 47 states for FFY 2013.[2]
- Of the 47 states reporting the measure for FFY 2013, 37 reported the measure for Medicaid and CHIP, 2 reported the measure for Medicaid only, and 8 reported the measure for CHIP only.

State Performance

- Among the 47 states using Child Core Set specifications to report the measure for FFY 2013, the median rate was 67 percent, with a 13-point spread between the 25th and 75th percentiles (Exhibit W34.1).
- Performance on this measure ranged from 41 to 83 percent among states, with considerable geographic variation across states (Exhibit W34.3, next page).

Exhibit W34.1. Percentage of Children Receiving At Least One Well-Child Visit in the Third, Fourth, Fifth, and Sixth Years of Life, FFY 2013 (n = 47 states)



Source: Mathematica analysis of FFY 2013 Child CARTS reports as of August 4, 2014.

Trends

- Among the 44 states reporting the measure using Child Core Set specifications for all three years, the median rate decreased by 1 percentage point from FFY 2011 to FFY 2013 (Exhibit W34.2, next page).

[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.

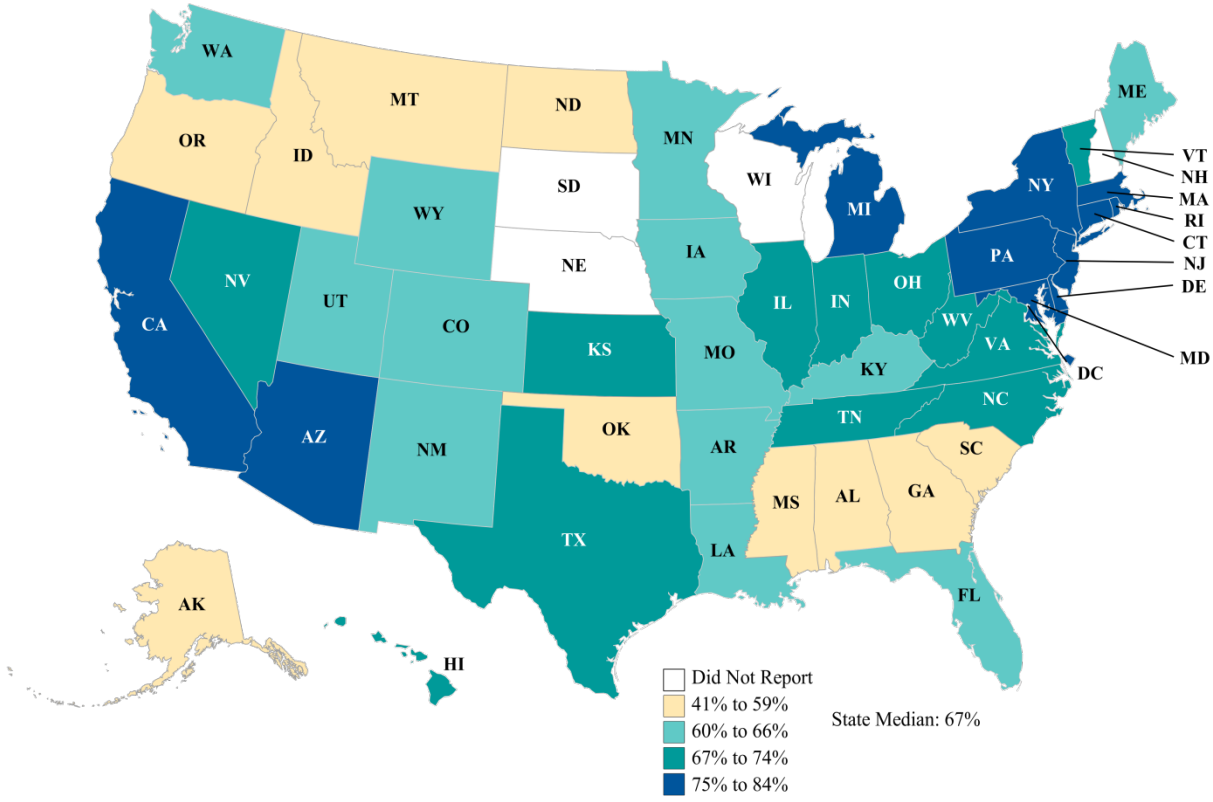
Exhibit W34.2. Trends in the Percentage of Children Receiving At Least One Well-Child Visit in the Third, Fourth, Fifth, and Sixth Years of Life, FFY 2011–2013 (n = 44 states)

Rate	FFY 2011	FFY 2012	FFY 2013
Mean	65.1	65.2	65.6
Median	67.1	66.3	65.9
25th Percentile	59.5	58.3	61.1
75th Percentile	74.9	74.1	73.4

Source: Mathematica analysis of FFY 2011, 2012, and 2013 Child CARTS reports as of August 4, 2014.

Note: Includes 44 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 W34.3. Geographic Variation in the Percentage of Children Receiving At Least One Well-Child Visit in the Third, Fourth, Fifth, and Sixth Years of Life, FFY 2013 (n = 47 states)



Source: Mathematica analysis of FFY 2013 Child CARTS reports as of August 4, 2014.

To view state-specific data for this measure, please see Table W34 at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2013.zip.

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

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

Measure Description

- The percentage of adolescents ages 12 to 21 who had at least one comprehensive well-care visit with a primary care practitioner or an obstetrical/gynecological practitioner during the measurement year.[1]

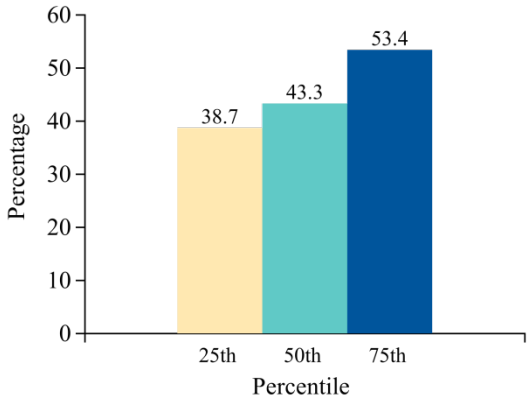
Overview of State Reporting

- The number of states reporting the Adolescent Well-Care Visits measure remained at 43 states for FFY 2011, FFY 2012, and FFY 2013.[2]
- Of the 43 states reporting the measure for FFY 2013, 34 reported the measure for Medicaid and CHIP, 2 reported the measure for Medicaid only, and 7 reported the measure for CHIP only.

State Performance

- Among the 43 states using Child Core Set specifications to report the measure for FFY 2013, the median rate was 43 percent, with a 15-point spread between the 25th and 75th percentiles (Exhibit AWC.1).
- Performance on this measure ranged from 26 to 67 percent among states, with considerable geographic variation across states (Exhibit AWC.3, next page).

Exhibit AWC.1. Percentage of Adolescents Ages 12 to 21 Receiving At Least One Well-Care Visit, FFY 2013 (n = 43 states)



Source: Mathematica analysis of FFY 2013 Child CARTS reports as of August 4, 2014.

Trends

- Among the 40 states reporting the measure using Child Core Set specifications for all three years, the median rate decreased by about 1 percentage point from FFY 2011 to FFY 2013 (Exhibit AWC.2).

[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.

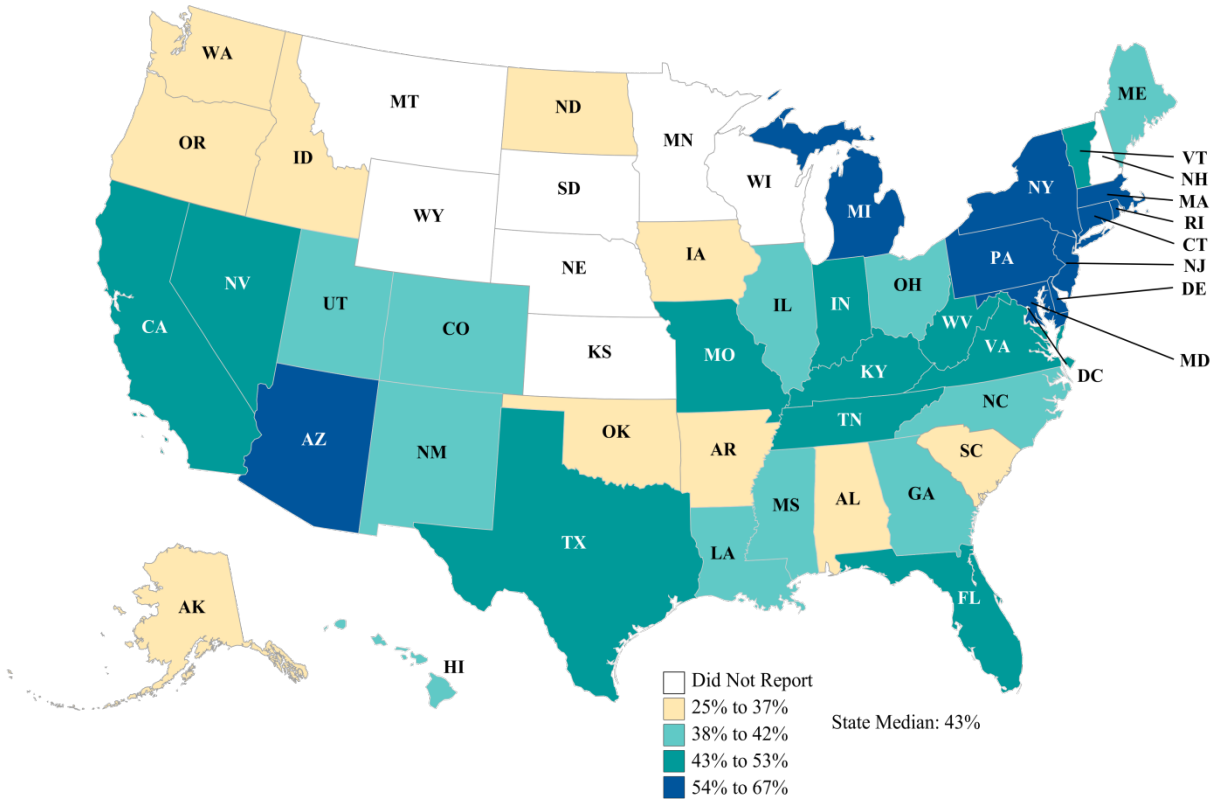
Exhibit AWC.2. Trends in the Percentage of Adolescents Ages 12 to 21 Receiving At Least One Well-Care Visit, FFY 2011–2013 (n = 40 states)

Rate	FFY 2011	FFY 2012	FFY 2013
Mean	43.5	44.2	44.4
Median	43.2	41.7	42.4
25th Percentile	34.0	36.2	37.1
75th Percentile	51.3	55.0	53.1

Source: Mathematica analysis of FFY 2011, 2012, and 2013 Child CARTS reports as of August 4, 2014.

Notes: This table includes 40 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 AWC.3. Geographic Variation in the Percentage of Adolescents Ages 12 to 21 Receiving At Least One Well-Care Visit, FFY 2013 (n = 43 states)



Source: Mathematica analysis of FFY 2013 Child CARTS reports as of August 4, 2014.

To view state-specific data for this measure, please see Table AWC at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2013.zip.

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

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

Measure Description

- The percentage of children who turned 2 years old during the measurement year and had specific vaccines and combinations of vaccines by their second birthday. This measure is reported as 10 separate immunization rates and 9 combination rates. State performance is measured on the basis of Combination 3, as noted above.[1]

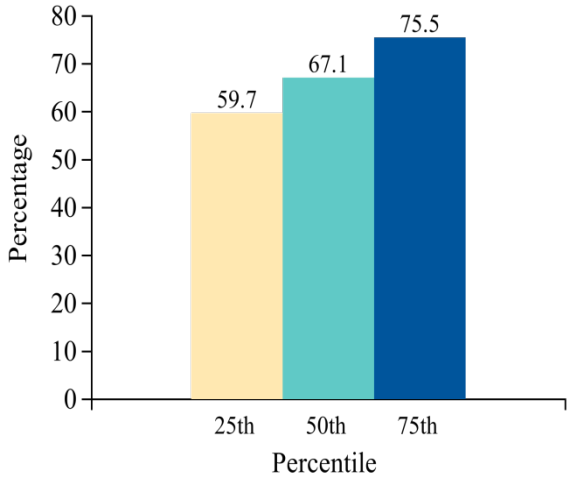
Overview of State Reporting

- The number of states reporting the Childhood Immunization Status measure increased from 30 states for FFY 2011 to 34 states for both FFY 2012 and FFY 2013.[2]
- Of the 34 states reporting the measure for FFY 2013, 26 reported the measure for Medicaid and CHIP, 3 reported the measure for Medicaid only, and 5 reported the measure for CHIP only.

State Performance

- Among the 30 states using Child Core Set specifications to report the measure for FFY 2013, the median Combination 3 rate was 67 percent, with a 16-point spread between the 25th and 75th percentiles (Exhibit CIS.1).[3]
- Performance on this measure ranged from 6 to 83 percent among states, with considerable geographic variation across states (Exhibit CIS.3, next page).

Exhibit CIS.1. Percentage of Children Up to Date on Recommended Immunizations (Combination 3) by their Second Birthday, FFY 2013 (n = 30 states)



Source: Mathematica analysis of FFY 2013 Child CARTS reports as of June 18, 2014.

Trends

- Among the 25 states reporting the measure using Child Core Set specifications for all three years, the median rate decreased by 4 percentage points from FFY 2011 to FFY 2013 (Exhibit CIS.2).

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

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

[3] Two states used Child Core Set specifications to calculate the measure but did not provide data for Combination 3 and two states did not use Child Core Set specifications to calculate the measure.

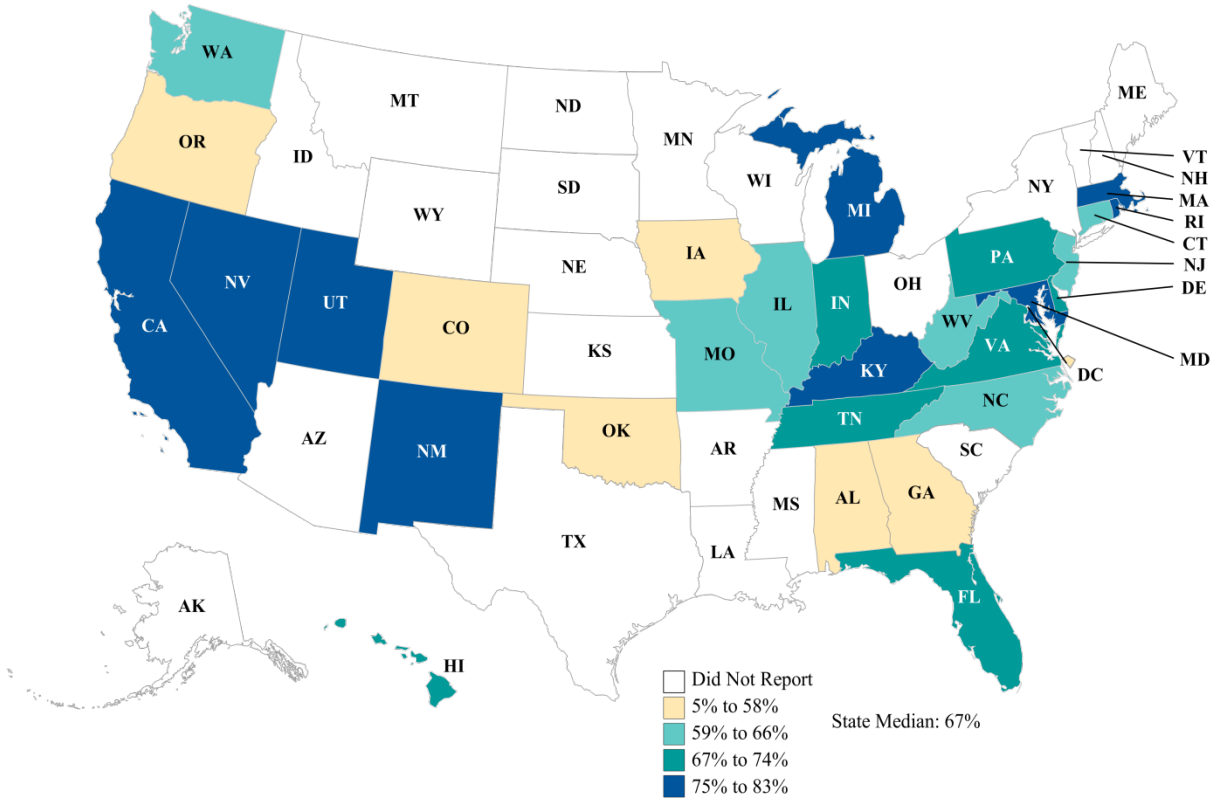
Exhibit CIS.2. Trends in the Percentage of Children Up to Date on Recommended Immunizations (Combination 3) by their Second Birthday, FFY 2011–2013 (n = 25 states)

Rate	FFY 2011	FFY 2012	FFY 2013
Mean	65.9	67.5	66.4
Median	71.0	72.0	67.2
25th Percentile	61.8	61.3	59.2
75th Percentile	77.4	77.6	76.6

Source: Mathematica analysis of FFY 2011, 2012, and 2013 Child CARTS reports as of August 4, 2014.

Notes: This table includes 25 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 CIS.3. Geographic Variation in the Percentage of Children Up to Date on Recommended Immunizations (Combination 3) by their Second Birthday, FFY 2013 (n = 30 states)



Source: Mathematica analysis of FFY 2013 Child CARTS reports as of August 4, 2014.

Note: This exhibit excludes two states (TX and WY) that used Child Core Set specifications to calculate the measure but did not provide data for Combination 3, and two states (SC and SD) that did not use Child Core Set specifications to calculate the measure.

To view state-specific data for this measure, please see Table CIS at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2013.zip.

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

Recommended well care for adolescents includes reviewing their immunization history to ensure they are up to date on their vaccines. Between their 11th and 13th birthdays, adolescents should receive one dose of meningococcal vaccine and one tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine or one tetanus and diphtheria toxoids (Td) vaccine. Adolescents should also receive the 3-dose human papillomavirus (HPV) series, although the HPV vaccine is captured in a separate Child Core Set measure. The Adolescent Immunization Status measure includes two rates for the individual vaccines and one combination rate. In this report, state performance is measured on the basis of the Combination 1 rate.

Measure Description

- The percentage of adolescents who turned 13 years old during the measurement year and had one meningococcal and one Tdap or Td vaccine by their 13th birthday. This measure is reported as two separate immunization rates and one combination rate. State performance is measured on the basis of the combination rate, as noted above.[1]

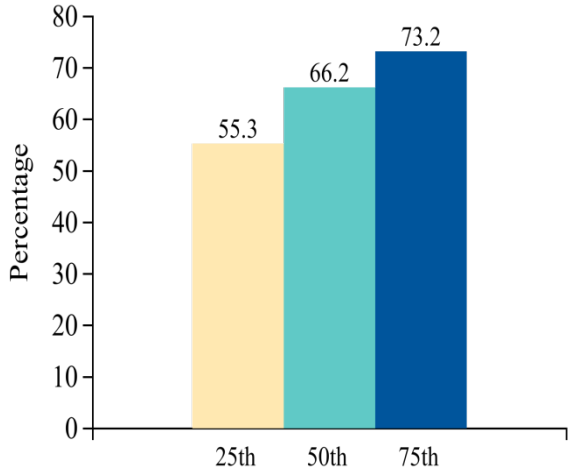
Overview of State Reporting

- The number of states reporting the Immunization Status for Adolescents measure increased from 25 states for FFY 2011 to 32 states for FFY 2012, and then decreased to 31 states for FFY 2013.[2]
- Of the 31 states reporting the measure for FFY 2013, 26 reported the measure for Medicaid and CHIP, 2 reported the measure for Medicaid only, and 3 reported the measure for CHIP only.

State Performance

- Among the 30 states using Child Core Set specifications to report the measure for FFY 2013, the median rate was 66 percent, with an 18-point spread between the 25th and 75th percentiles (Exhibit IMA.1).[3]
- Performance on this measure ranged from 20 percent to 89 percent among states, with considerable geographic variation across states (Exhibit IMA.2, next page).

Exhibit IMA.1. Percentage of Adolescents Up to Date on Recommended Immunizations (Combination 1) by their 13th Birthday, FFY 2013 (n = 30 states)



Source: Mathematica analysis of FFY 2013 Child CARTS reports as of August 4, 2014.

Trends

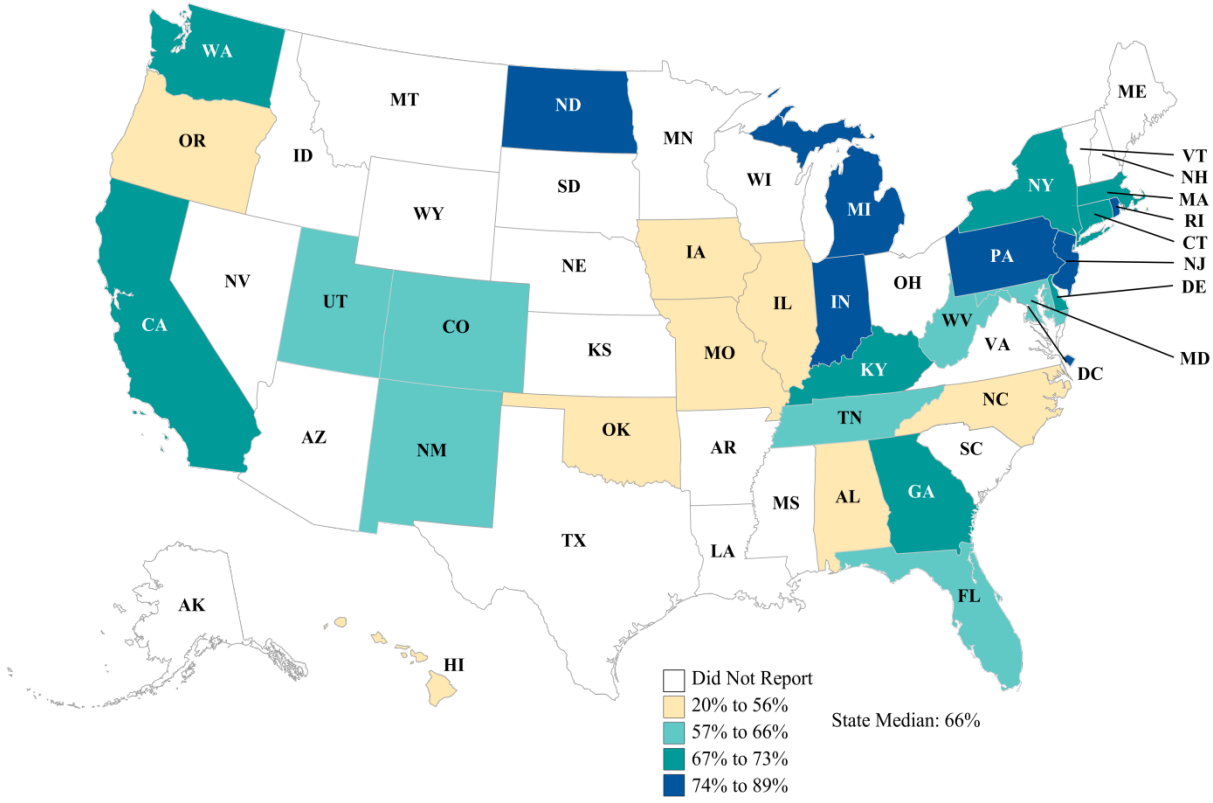
- Trends are not available for this measure. Trends are shown for measures reported by at least 20 states for all three years (FFY 2011 to FFY 2013); 18 states reported this measure for all three years.

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

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

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

Exhibit IMA.2. Geographic Variation in the Percentage of Adolescents Up to Date on Recommended Immunizations (Combination 1) by their 13th Birthday, FFY 2013 (n = 30 states)



Source: Mathematica analysis of FFY 2013 Child CARTS reports as of August 4, 2014.

Note: This exhibit excludes data for one state (SC) that reported this measure using another specification.

To view state-specific data for this measure, please see Table IMA at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2013.zip.

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

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

Measure Description

- The percentage of women ages 16 to 20 who were identified as sexually active and had at least one Chlamydia test during the measurement year.[1]

Overview of State Reporting

- The number of states reporting the Chlamydia Screening in Women measure increased from 32 states for FFY 2011 to 35 states for FFY 2012 and 37 states for FFY 2013.[2]
- Of the 37 states reporting the measure for FFY 2013, 29 reported the measure for Medicaid and CHIP, 4 reported the measure for Medicaid only, and 4 reported the measure for CHIP only.

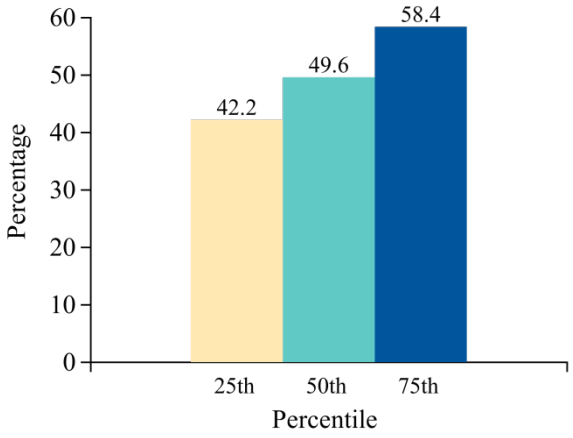
State Performance

- Among the 37 states using Child Core Set specifications to report the measure for FFY 2013, the median rate was 50 percent, with a 16-point spread between the 25th and 75th percentiles (Exhibit CHL.1).[3]
- Performance on this measure ranged from 7 to 78 percent among states, with considerable geographic variation across states (Exhibit CHL.3, next page).

Trends

- Among the 29 states reporting the measure using Child Core Set specifications for all three years, the median rate increased by 2 percentage points from FFY 2011 to FFY 2013 (Exhibit CHL.2).

Exhibit CHL.1. Percentage of Sexually Active Women Ages 16 to 20 Receiving At Least One Test for Chlamydia, FFY 2013 (n = 37 states)



Source: Mathematica analysis of FFY 2013 Child CARTS reports as of June 18, 2014.

Exhibit CHL.2. Trends in the Percentage of Sexually Active Women Ages 16 to 20 Receiving At Least One Test for Chlamydia, FFY 2011–2013 (n = 29 states)

Rate	FFY 2011	FFY 2012	FFY 2013
Mean	45.7	46.7	47.9
Median	47.7	48.9	49.6
25th Percentile	35.3	38.5	39.6
75th Percentile	57.4	56.3	57.7

Source: Mathematica analysis of FFY 2011, 2012, and 2013 Child CARTS reports as of June 18, 2014.

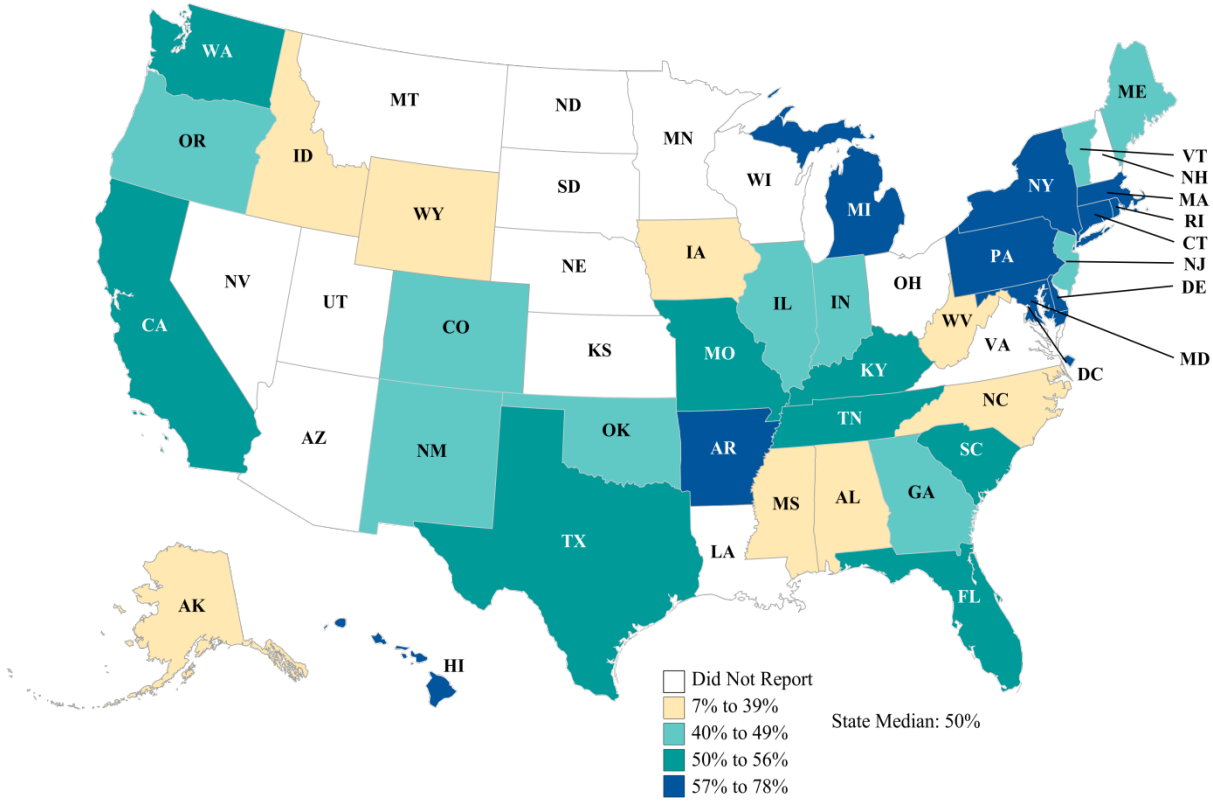
Notes: This table includes 29 states that reported the measure using Child Core Set specifications for all three years. When a state reported separate rates for its Medicaid and CHIP populations, the mean and median rates were calculated using the rate for the larger measure-eligible population.

[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.

[3] The Child Core Set rate is for women ages 16 to 20. The rate for women ages 21 to 24 is reported as part of the Medicaid Adult Core Set.

Exhibit CHL.3. Geographic Variation in the Percentage of Sexually Active Women Ages 16 to 20 Receiving At Least One Test for Chlamydia, FFY 2013 (n = 37 states)



Source: Mathematica analysis of FFY 2013 Child CARTS reports as of August 4, 2014.

To view state-specific data for this measure, please see Table CHL at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2013.zip.

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

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

Measure Description

- The percentage of children ages 3 to 17 who had an outpatient visit with a primary care practitioner or obstetrical/gynecological practitioner and whose weight is classified based on BMI percentile for age and gender.[1]

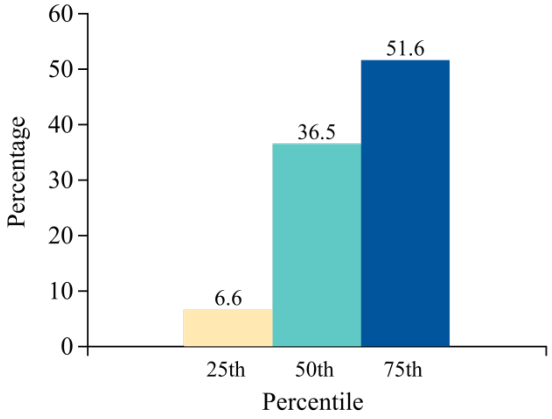
Overview of State Reporting

- The number of states reporting the BMI Assessment for Children and Adolescents measure increased from 18 states for FFY 2011 to 27 states for FFY 2012 and then decreased to 25 states for FFY 2013.[2]
- Of the 25 states reporting the measure for FFY 2013, 22 reported the measure for Medicaid and CHIP, 3 reported the measure for Medicaid only, and none reported the measure for CHIP only.

State Performance

- Among the 25 states using Child Core Set specifications to report the measure for FFY 2013, the median rate was 37 percent, with a 45-point spread between the 25th and 75th percentiles (Exhibit WCC.1).
- Performance on this measure ranged from 0.2 percent to 72 percent among states, with considerable geographic variation across states (Exhibit WCC.2, next page).
- The 15 states using the hybrid method had a median of 45 percent, whereas the 10 states using the administrative method had a median of 3 percent. Assessment of the BMI percentile is more likely to be noted in medical records than in claims/encounter data.

Exhibit WCC.1. Percentage of Children Whose Weight is Classified Based on BMI Percentile, FFY 2013 (n = 25 states)



Source: Mathematica analysis of FFY 2013 Child CARTS reports as of August 4, 2014.

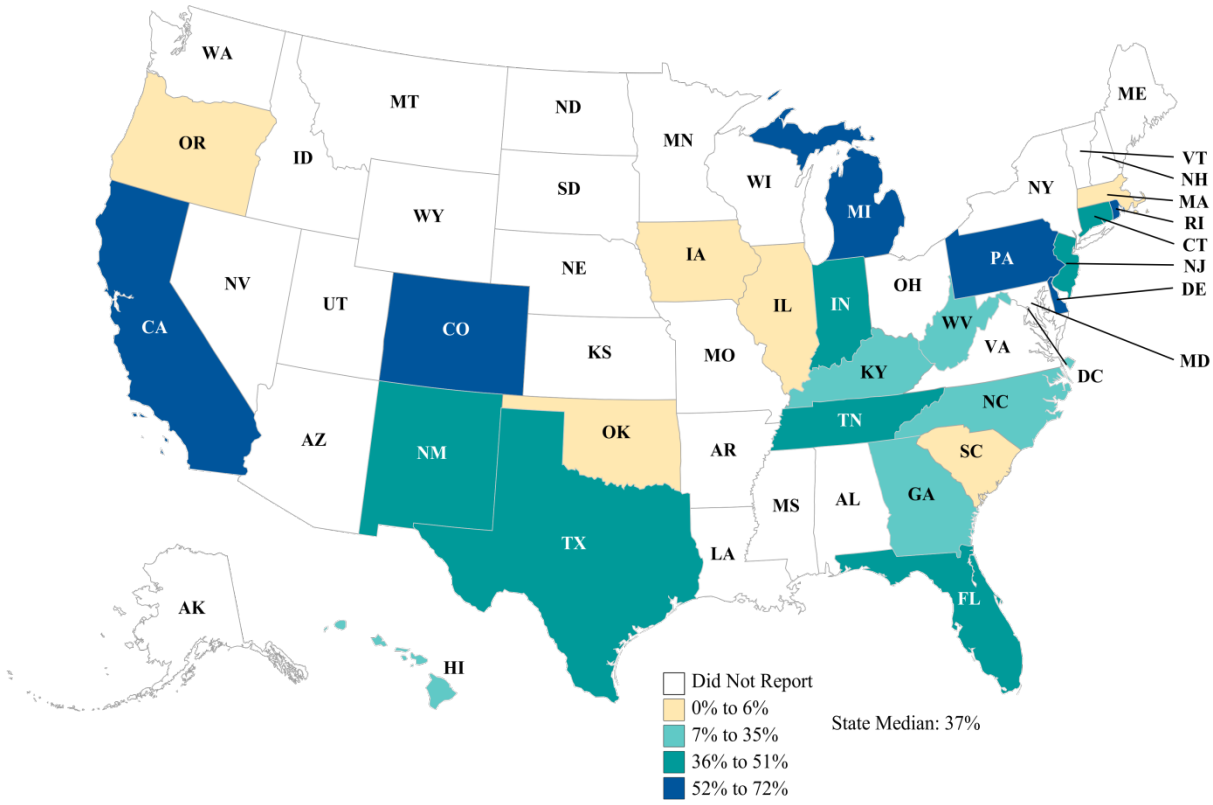
Trends

- Trends are not available for this measure. Trends are shown for measures reported by at least 20 states for all three years (FFY 2011 to FFY 2013); 9 states reported this measure for all three years.

[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 WCC.2. Geographic Variation in the Percentage of Children Whose Weight is Classified Based on BMI Percentile, FFY 2013 (n = 25 states)



Source: Mathematica analysis of FFY 2013 Child CARTS reports as of August 4, 2014.

To view state-specific data for this measure, please see Table WCC at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2013.zip.

Nearly two out of three adult women covered by Medicaid are ages 18 to 44 and are in their reproductive years.[1] Medicaid provides coverage for a range of services including family planning, preventive services such as pap smears and mammography, and pregnancy-related services. Medicaid financed nearly 48 percent of all births in the United States in 2010, ranging from a low of 24 percent of all births in Hawaii to a high of 69 percent of births in Louisiana.[2] As the largest payer for maternity care in the U.S., CMS 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 the privately insured (10.4 percent vs. 9.1 percent).[3]

In July 2014, CMS launched a new Maternal and Infant Health Initiative to drive improvements in the care provided to Medicaid/CHIP enrollees during the perinatal and interconceptional periods in order to substantially improve the short- and long-term health outcomes of Medicaid/CHIP enrollees.[4] CMS's Maternal and Infant Health Initiative is part of a comprehensive effort to develop and implement evidence-based policies and programs to improve perinatal health care and outcomes in Medicaid/CHIP.[5] The Initiative builds upon 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. Other key activities include:

- 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, a critical mechanism for monitoring key maternal and infant health indicators, particularly collection of relevant Medicaid quality measures.
- 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.
- CMS launched a three year pilot project with Text4baby to work in collaboration with four state Medicaid agencies (California, Louisiana, Ohio, and Oklahoma) to customize mobile messages to provide expecting and new mothers with targeted information and local resources to improve performance on CMS core quality measures. Text4baby is a mobile information service designed to promote maternal and child health through text messaging. Participants receive free educational text messages, timed to their due date or their baby's birth date, through pregnancy and up until the baby's first birthday.

To support its maternity-focused efforts, CMS identified a core set of nine Medicaid/CHIP maternity measures for voluntary reporting by states. This core set, which consists of six Child Core Set measures and three Medicaid Adult Core Set measures, is used by CMS to measure progress and evaluate efforts.[6] The two Child Core Set measures included in this section are those for which information is available from at least 25 states for the FFY 2013 reporting year. The measures are as follows:

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

These measures, along with the measure assessing children's receipt of well-child visits in the first 15 months of life (discussed in the previous section), are three of the six Child Core Set measures that are part of CMS's 2013 Maternity Core Set.

[1] Kaiser Family Foundation. "Medicaid's Role for Women Across the Lifespan: Current Issues and the Impact of the Affordable Care Act." Available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7213-04.pdf.

[2] 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.

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

[4] 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.

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

[6] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2013-Core-Set-of-Maternity-Measures.pdf.

This page left blank for double-sided copying.

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

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

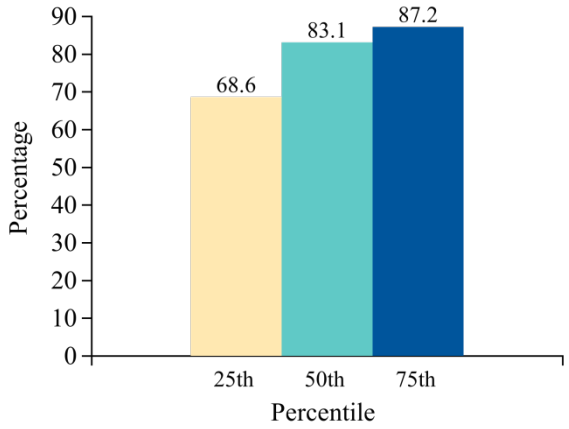
Overview of State Reporting

- The number of states reporting the Timeliness of Prenatal Care measure increased from 23 states for FFY 2011 to 31 states for FFY 2012 and 33 states FFY 2013.[2]
- Of the 33 states reporting the measure for FFY 2013, 23 reported the measure for Medicaid and CHIP, 8 reported the measure for Medicaid only, and 2 reported the measure for CHIP only.

State Performance

- Among the 33 states using Child Core Set specifications to report the measure for FFY 2013, the median rate was 83 percent, with a 19-point spread between the 25th and 75th percentiles (Exhibit PPC.1).
- Performance on this measure ranged from 22 to 95 percent among states, with considerable geographic variation across states (Exhibit PPC.3, next page).

Exhibit PPC.1. Percentage of Pregnant Women with a Prenatal Care Visit in the First Trimester or within 42 Days of Medicaid/CHIP Enrollment, FFY 2013 (n = 33 states)



Source: Mathematica analysis of FFY 2013 Child CARTS reports as of August 4, 2014.

Trends

- Among the 21 states reporting the measure using Child Core Set specifications for all three years, the median rate increased by nearly 1 percentage point from FFY 2011 to FFY 2013 (Exhibit PPC.2, next page).

[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.

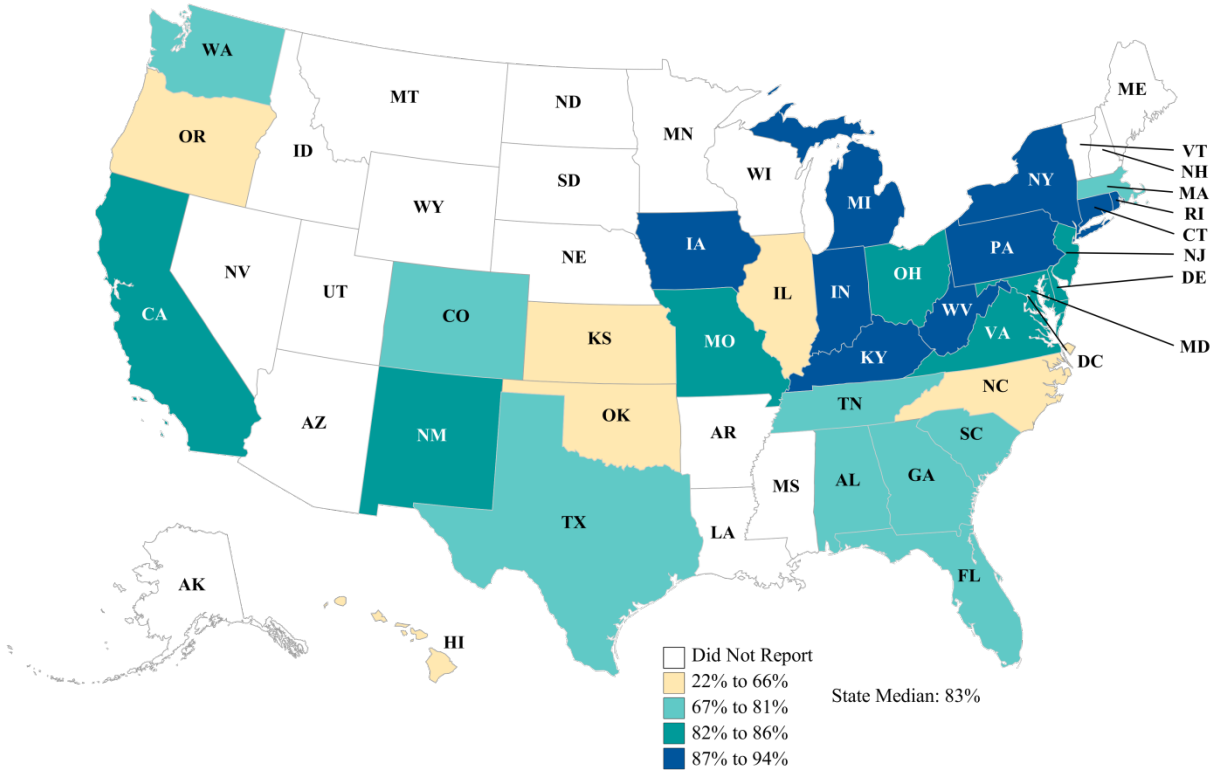
Exhibit PPC.2. Trends in the Percentage of Pregnant Women with a Prenatal Care Visit in the First Trimester or within 42 Days of Medicaid/CHIP Enrollment, FFY 2011–2013 (n = 21 states)

Rate	FFY 2011	FFY 2012	FFY 2013
Mean	78.1	79.0	79.3
Median	83.2	83.4	84.0
25th Percentile	67.9	72.2	72.9
75th Percentile	88.9	88.4	87.1

Source: Mathematica analysis of FFY 2011, 2012, and 2013 Child CARTS reports as of August 4, 2014.

Notes: This table includes 21 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.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 2013 (n = 33 states)



Source: Mathematica analysis of FFY 2013 Child CARTS reports as of August 4, 2014.

To view state-specific data for this measure, please see Table PPC at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2013.zip.

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

Ongoing prenatal care enables prenatal care providers to make periodic assessments of a woman's pregnancy risk and health status, perform recommended screenings and laboratory tests, and provide timely referrals for specialized care. Through regular, ongoing prenatal care, women can develop trusted relationships with their prenatal care providers, facilitating meaningful opportunities for health education and counseling targeted to a woman's circumstances and stage of pregnancy. Regular prenatal care enables providers to promote positive maternal and infant health outcomes by addressing a wide range of women's health, social, and emotional issues. 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 to 40 percent of expected visits
  - 41 to 60 percent of expected visits
  - 61 to 80 percent of expected visits
  - ≥ 81 percent of expected visits[1]

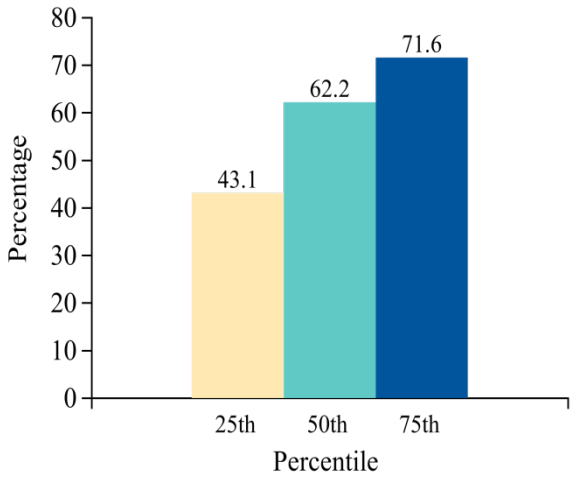
Overview of State Reporting

- The number of states reporting the Frequency of Ongoing Prenatal Care measure increased from 17 states for FFY 2011 to 25 states for FFY 2012 and 27 states for FFY 2013.[2]
- Of the 27 states reporting the measure for FFY 2013, 20 reported the measure for Medicaid and CHIP, 6 reported the measure for Medicaid only, and 1 reported the measure for CHIP only.

State Performance

- Among the 27 states using Child Core Set specifications to report the measure for FFY 2013, the median rate was 62 percent, with a 29-point spread between the 25th and 75th percentiles (Exhibit FPC.1).
- Performance on this measure ranged from 3 to 85 percent among states, with considerable geographic variation across states (Exhibit FPC.2, next page).

Exhibit FPC.1. Percentage of Pregnant Women Receiving More Than 80 Percent of the Expected Number of Prenatal Care Visits, FFY 2013 (n = 27 states)



Source: Mathematica analysis of 2013 CARTS reports as of August 4, 2014.

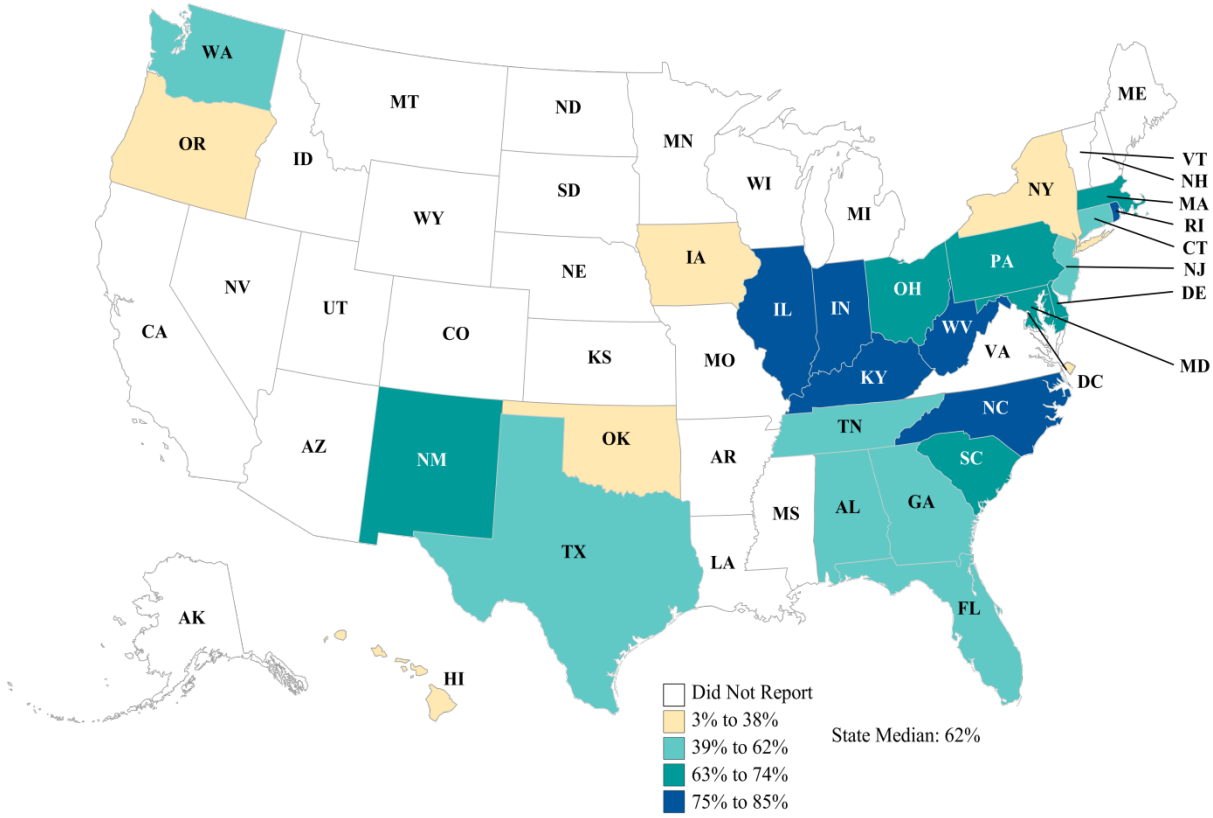
Trends

- Trends are not available for this measure. Trends are shown for measures reported by at least 20 states for all three years (FFY 2011 to FFY 2013); 16 states reported this measure for all three years.

[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 FPC.2. Geographic Variation in the Percentage of Pregnant Women Receiving More Than 80 Percent of the Expected Number of Prenatal Care Visits, FFY 2013 (n = 27 states)



Source: Mathematica analysis of FFY 2013 Child CARTS reports as of August 4, 2014.

To view state-specific data for this measure, please see Table FPC at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2013.zip.

MANAGEMENT OF ACUTE AND CHRONIC CONDITIONS

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

Through Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, children and adolescents under age 21 are entitled to receive treatment for Medicaid-covered services listed in Section 1905(a) of the Social Security Act if that treatment or service is necessary to "correct or ameliorate" a physical or mental condition.[1] Children enrolled in CHIP Medicaid expansion programs are also entitled to this benefit.

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

- The CHIPRA-funded, multistate Quality Demonstration Grants include efforts to evaluate provider-based models of care, use of electronic health record systems, and integration of physical and behavioral health services.[2]
- A Health Home provision, authorized by Section 2703 of the Affordable Care Act, gives states two years of an enhanced match to improve care coordination for children and adults with multiple chronic conditions (such as asthma, obesity, and substance use disorder).
- Two recently released informational bulletins provide guidance on (1) coverage of behavioral health services for children with mental health and substance abuse problems, and (2) promotion of trauma-informed services for children.[3]

In addition, CMS's Partnership for Patients aims to make care safer, in part by reducing preventable hospital-acquired infections, such as pediatric central line-associated blood stream infections (CLABSIs), one of the most deadly and preventable healthcare-associated infections. CMS also partners with CDC in tracking CLABSIs and making information available on the Hospital Compare website.

CMS has identified several Child Core Set measures to track performance on getting children the "right care in the right setting at the right time." The four Child Core Set measures included in this section are those for which information is available from at least 25 states for the FFY 2013 reporting year:

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

[1] Section 1905(a)(r)(5).

[2] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/CHIPRA-Quality-Demonstration-Grants-Summary.html.

[3] http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf and http://medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf.

This page left blank for double-sided copying.

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

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

Measure Description

- The percentage of children ages 2 to 18 who were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode.[1,2]

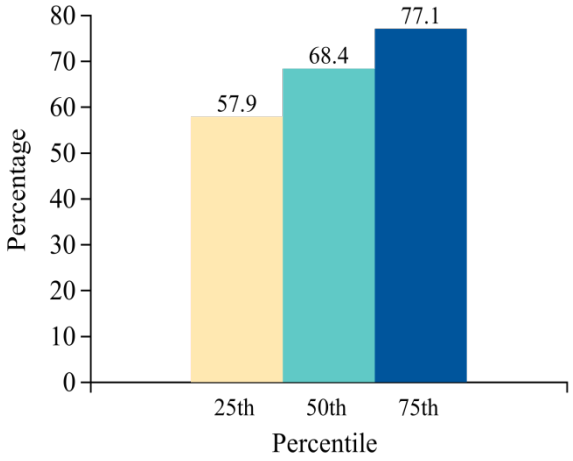
Overview of State Reporting

- The number of states reporting the Appropriate Testing for Children with Pharyngitis measure increased from 28 states for FFY 2011 to 36 states for FFY 2012 and FFY 2013.[3]
- Of the 36 states reporting the measure for FFY 2013, 28 reported the measure for Medicaid and CHIP, 2 reported the measure for Medicaid only, and 6 reported the measure for CHIP only.

State Performance

- Among the 36 states using Child Core Set specifications to report the measure for FFY 2013, the median rate was 68 percent, with a 19-point spread between the 25th and 75th percentiles (Exhibit CWP.1).
- Performance on this measure ranged from 49 to 87 percent among states, with considerable geographic variation across states (Exhibit CWP.3, next page).

Exhibit CWP.1. Percentage of Children Diagnosed with Pharyngitis, Dispensed an Antibiotic, and Received a Group A Streptococcus Test, FFY 2013 (n = 36 states)



Source: Mathematica analysis of FFY 2013 Child CARTS reports as of August 4, 2014.

Trends

- Among the 26 states reporting the measure using Child Core Set specifications for all three years, the median rate increased by 6 percentage points from FFY 2011 to FFY 2013 (Exhibit CWP.2).

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

[2] The measure denominator includes children with a diagnosis of pharyngitis who received an antibiotic. The numerator is the number of children who received a strep test for pharyngitis that were diagnosed with pharyngitis, and received an antibiotic.

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

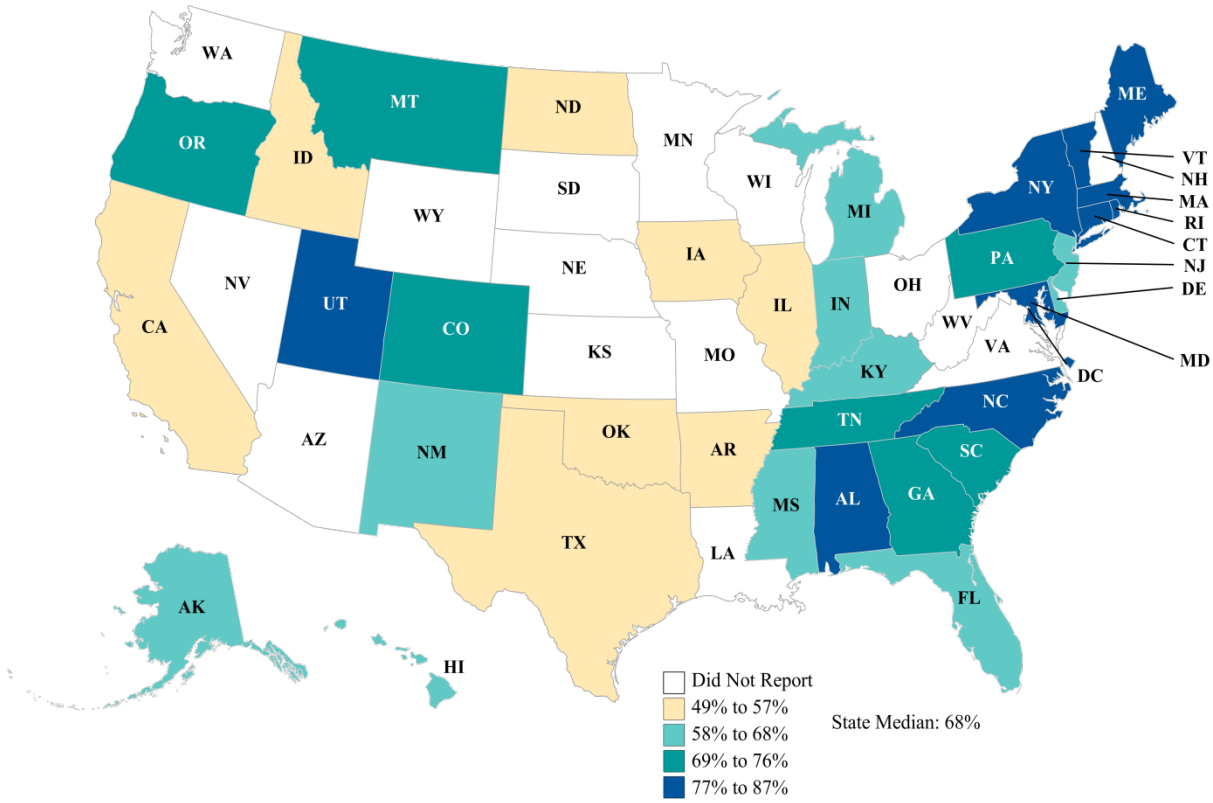
Exhibit CWP.2. Trends in the Percentage of Children Diagnosed with Pharyngitis, Dispensed an Antibiotic, and Received a Group A Streptococcus Test, FFY 2011–2013 (n = 26 states)

Rate	FFY 2011	FFY 2012	FFY 2013
Mean	61.7	65.5	67.4
Median	62.5	70.6	68.3
25th Percentile	50.3	57.8	57.8
75th Percentile	72.1	75.7	76.7

Source: Mathematica analysis of FFY 2011, 2012, and 2013 Child CARTS reports as of August 4, 2014.

Notes: This table includes 26 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 CWP.3. Geographic Variation in the Percentage of Children Diagnosed with Pharyngitis, Dispensed an Antibiotic, and Received a Group A Streptococcus Test, FFY 2013 (n = 36 states)



Source: Mathematica analysis of FFY 2013 Child CARTS reports as of August 4, 2014.

To view state-specific data for this measure, please see Table CWP at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2013.zip.

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

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

Measure Description

- The percentage of discharges for children ages 6 to 20 hospitalized for treatment of selected mental health disorders who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge and within 30 days of discharge.[1]

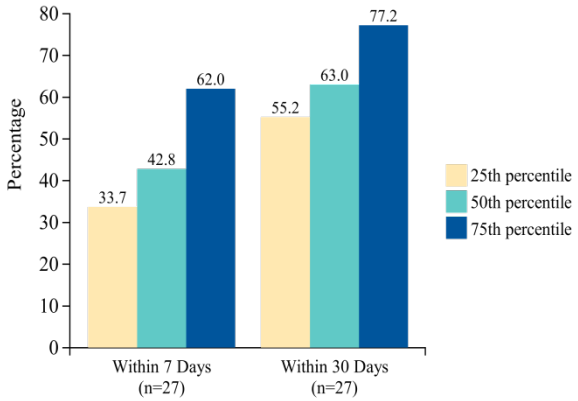
Overview of State Reporting

- The number of states reporting the Follow-Up After Hospitalization for Mental Illness measure increased from 23 states for FFY 2011 to 27 states for FFY 2012 and 28 states for FFY 2013.[2]
- Of the 28 states reporting the measure for FFY 2013, 25 reported the measure for Medicaid and CHIP, 1 reported the measure for Medicaid only, and 2 reported the measure for CHIP only.[3]

State Performance

- Among the 27 states using Child Core Set specifications to report the measure for FFY 2013, the median rate was 43 percent for a follow-up visit within 7 days of discharge (with a 28-point spread between the 25th and 75th percentiles). The median rate for a follow-up visit within 30 days of discharge was 63 percent (with a 22-point spread) (Exhibit FUH.1).[4]
- Performance on the 7-day follow-up visit rate ranged from 23 to 80 percent among states, while performance on the 30-day follow-up visit rate ranged from 44 to 92 percent, with considerable geographic variation among states for each rate (Exhibits FUH.2 and FUH.3, next page).

Exhibit FUH.1. Percentage of Discharges for Mental Illness for Children Ages 6 to 20 Receiving a Follow-Up Visit within 7 and 30 Days of Discharge, FFY 2013



Source: Mathematica analysis of FFY 2013 Child CARTS reports as of August 4, 2014.

Trends

- Trends are not available for this measure. Trends are shown for measures reported by at least 20 states for all three years (FFY 2011 to FFY 2013); 16 states reported this measure for all three years.

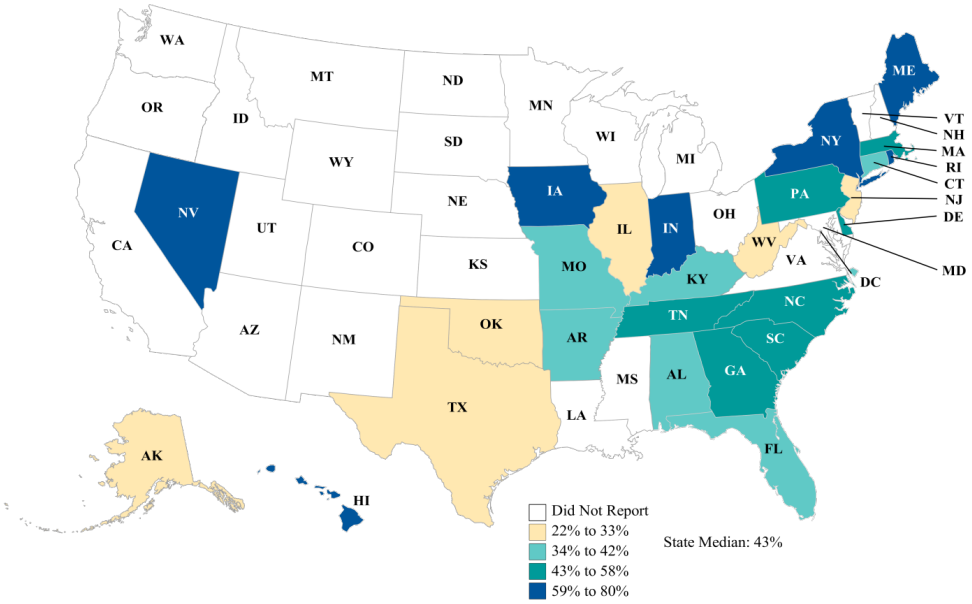
[1] This measure is calculated using the administrative method (claims/encounter data).

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

[3] Although the Child Core Set measure is specified to include discharges for children ages 6 to 20, 10 states noted that their FFY 2013 rates are not limited to children and include Medicaid/CHIP enrollees over age 20. The HEDIS specification, on which the Child Core Set measure is based, includes individuals age 6 and over and does not disaggregate this measure for children ages 6 to 20.

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

Exhibit FUH.2. Geographic Variation in the Percentage of Discharges for Mental Illness for Children Ages 6 to 20 Receiving a Follow-Up Visit within 7 Days of Discharge, FFY 2013 (n = 27 states)

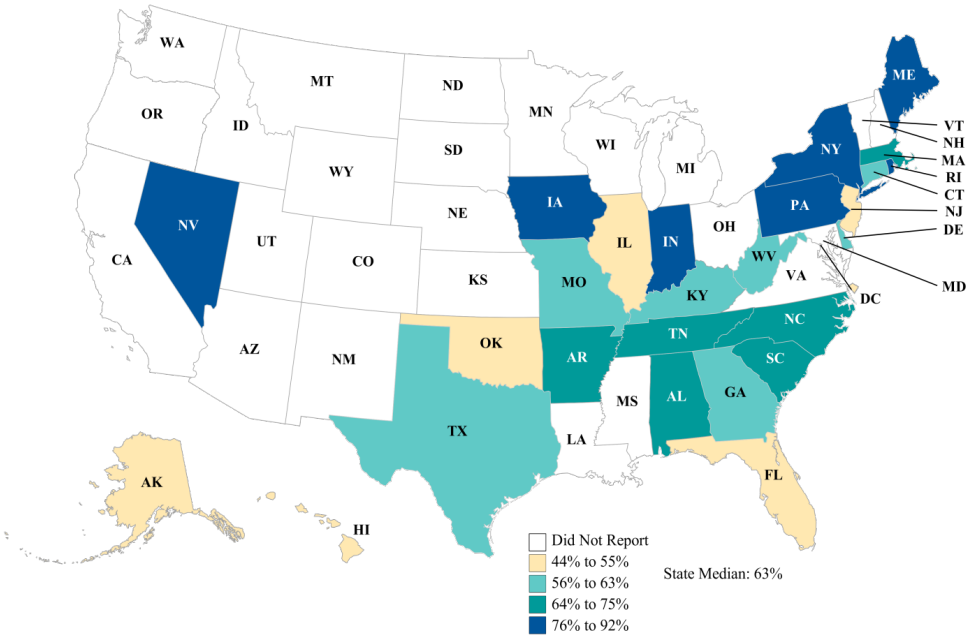


Source: Mathematica analysis of FFY 2013 Child CARTS reports as of August 4, 2014.

Note: This exhibit excludes data for one state (OR) that reported this measure using another specification.

To view state-specific data for this measure, please see Table FUH at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2013.zip.

Exhibit FUH.3. Geographic Variation in the Percentage of Discharges for Mental Illness for Children Ages 6 to 20 Receiving a Follow-Up Visit within 30 Days of Discharge, FFY 2013 (n = 27 states)



Source: Mathematica analysis of FFY 2013 Child CARTS reports as of August 4, 2014.

Note: This exhibit excludes one state (OR) that did not use Child Core Set specifications to calculate the measure.

To view state-specific data for this measure, please see Table FUH at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2013.zip.

FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ATTENTION-DEFICIT/HYPERACTIVITY DISORDER MEDICATION (ADD)
Measure Steward: National Committee for Quality Assurance (NCQA)

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

Measure Description

- The percentage of children ages 6 to 12 newly prescribed ADHD medication who had at least three follow-up visits within a 10-month period, one of which was within 30 days from the time the first ADHD medication was dispensed. Two rates are reported: one for the Initiation Phase and one for the C&M Phase.[1]

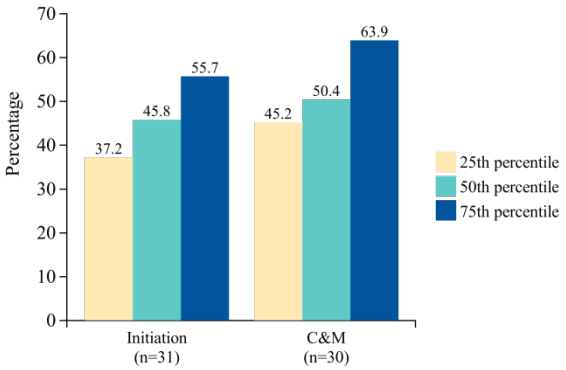
Overview of State Reporting

- The number of states reporting the Follow-Up Care for Children Prescribed ADHD Medication measure increased from 24 states for FFY 2011 to 29 states for FFY 2012 and 31 states for FFY 2013.[2]
- Of the 31 states reporting the measure for FFY 2013, 28 reported the measure for Medicaid and CHIP, 2 reported the measure for Medicaid only, and 1 reported the measure for CHIP only.

State Performance

- Among the states using Child Core Set specifications to report the measure for FFY 2013, the median rate was 46 percent for the Initiation Phase (31 states) and 51 percent for the C&M Phase (30 states), with a 19-point spread between the 25th and 75th percentiles for both rates (Exhibit ADD.1).[3]
- Performance on this measure ranged from 25 to 68 percent among states for the Initiation Phase and from 29 to 91 percent for the C&M Phase, with considerable geographic variation across states (Exhibits ADD.3 and ADD.4, next page).

Exhibit ADD.1. Percentage of Children Prescribed Medication for ADHD who Received At Least One Visit during the 30-Day Initiation Phase and At Least Two Visits during the 9-Month Continuation and Maintenance Phase, FFY 2013



Source: Mathematica analysis of FFY 2013 Child CARTS reports as of August 4, 2014.

Trends

- Among the states reporting the measure using Child Core Set specifications for all three years, the median rate did not change for the Initiation Phase and increased by 0.2 percentage points for the C&M Phase from FFY 2011 to FFY 2013 (Exhibit ADD.2, next page).

[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.

[3] The rate for the C&M Phase is based on those children who had at least one visit in the 30-day Initiation Phase. One state reported a rate for the Initiation Phase but did not report a rate for the C&M Phase.

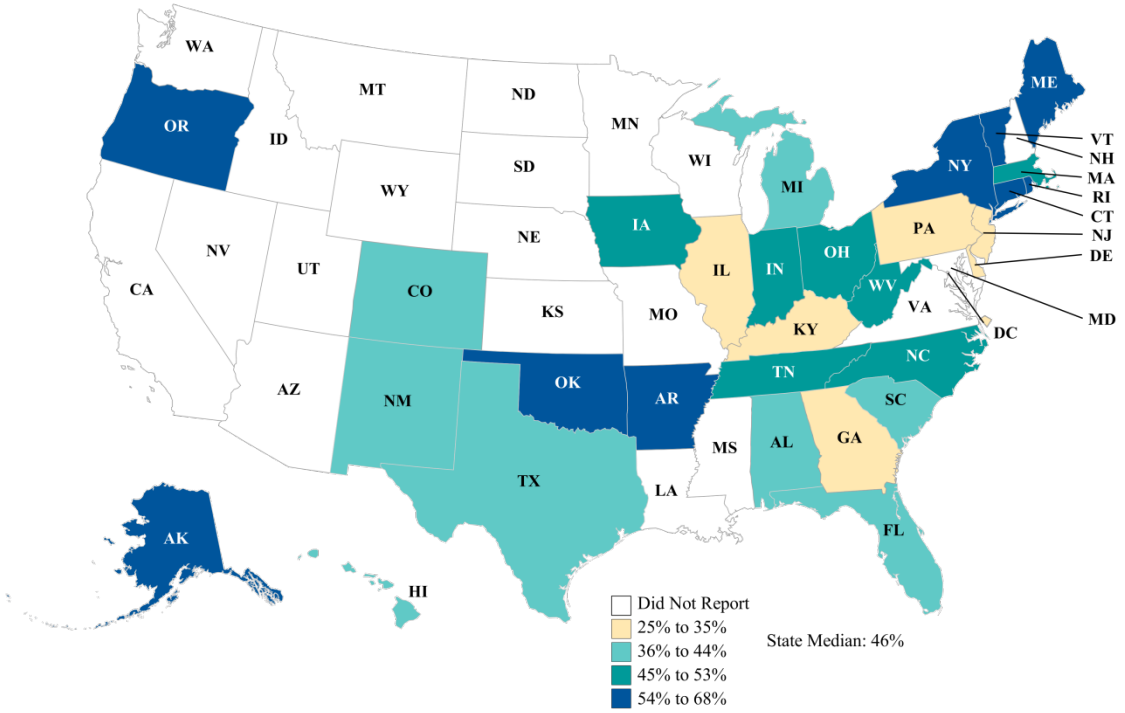
Exhibit ADD.2. Trends in the Percentage of Children Prescribed Medication for ADHD who Received At Least One Visit during the 30-Day Initiation Phase and At Least Two Visits during the 9-Month Continuation and Maintenance Phase, FFY 2011–2013

Rate	FFY 2011	FFY 2012	FFY 2013
Initiation Phase (n = 22 states)			
Mean Rate	47.6	42.8	47.3
Median Rate	46.5	41.2	46.4
25th Percentile	37.1	38.0	39.8
75th Percentile	54.3	50.4	56.2
C&M Phase (n = 21 states)			
Mean Rate	52.2	50.7	55.7
Median Rate	53.6	52.4	53.8
25th Percentile	44.1	45.7	47.5
75th Percentile	60.0	61.0	64.0

Source: Mathematica analysis of FFY 2011, 2012, and 2013 Child CARTS reports as of August 4, 2014.

Notes: This table includes 22 states (for the Initiation Phase) and 21 states (for the C&M Phase) 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.

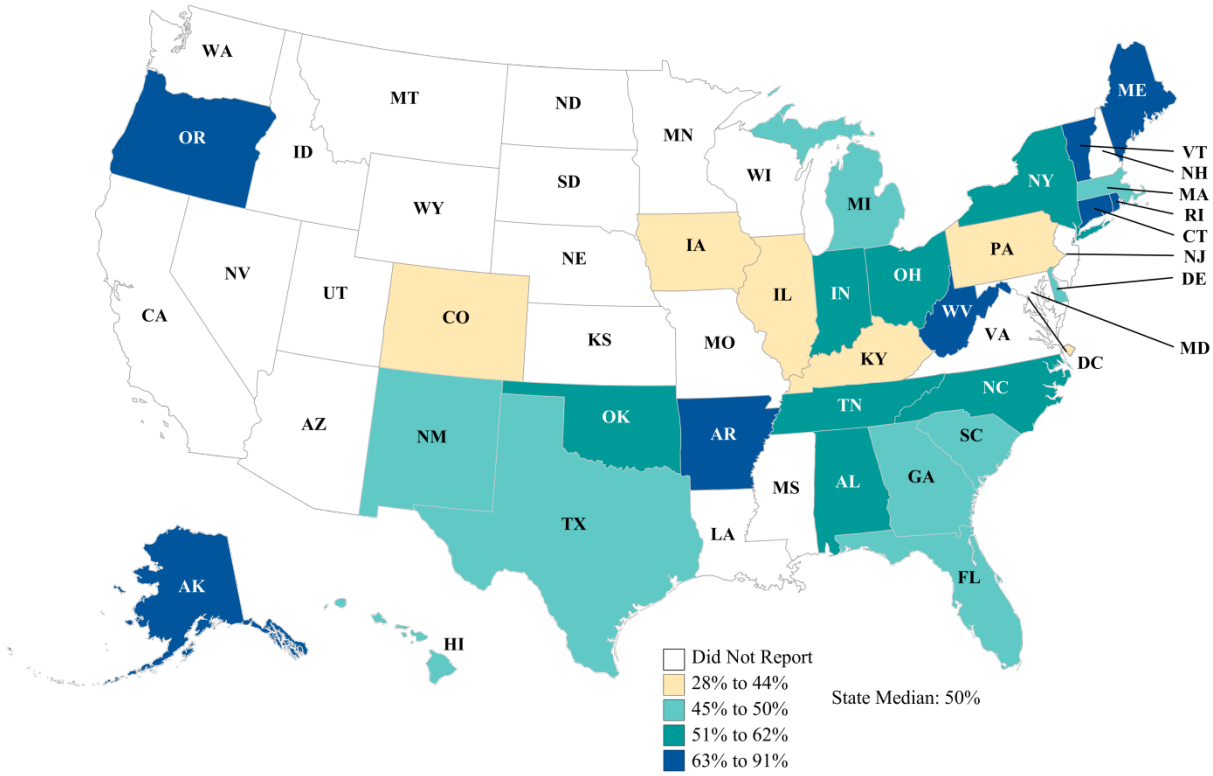
Exhibit ADD.3. Geographic Variation in the Percentage of Children Prescribed Medication for ADHD who Received At Least One Visit during the 30-Day Initiation Phase, FFY 2013 (n = 31 states)



Source: Mathematica analysis of FFY 2013 Child CARTS reports as of August 4, 2014.

To view state-specific data for this measure, please see Table ADD at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2013.zip.

Exhibit ADD.4. Geographic Variation in the Percentage of Children Prescribed Medication for ADHD who Received At Least Two Visits during the 9-Month Continuation and Maintenance Phase, FFY 2013 (n = 30 states)



Source: Mathematica analysis of FFY 2013 Child CARTS reports as of August 4, 2014.

Note: To view state-specific data for this measure, please see Table ADD at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2013.zip.

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

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

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

Measure Description

- The rate of CLABSIs in NICUs. The Child Core Set measure also includes the rate of CLABSIs in pediatric intensive care units (PICUs). At this time, data on CLABSI incidents occurring in PICUs are not available.
- The Standardized Infection Ratio (SIR) is the summary measure used to track CLABSIs over time. The SIR compares the number of infections reported in a facility or state to the baseline U.S. experience, adjusting for several risk factors that have been found to be associated with differences in infection rates.
- The SIR indicates whether the rate of infections increased, decreased, or did not change significantly relative to the baseline 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 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. [1] CDC does not calculate rates for states had fewer than five facilities reporting.

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

State Performance

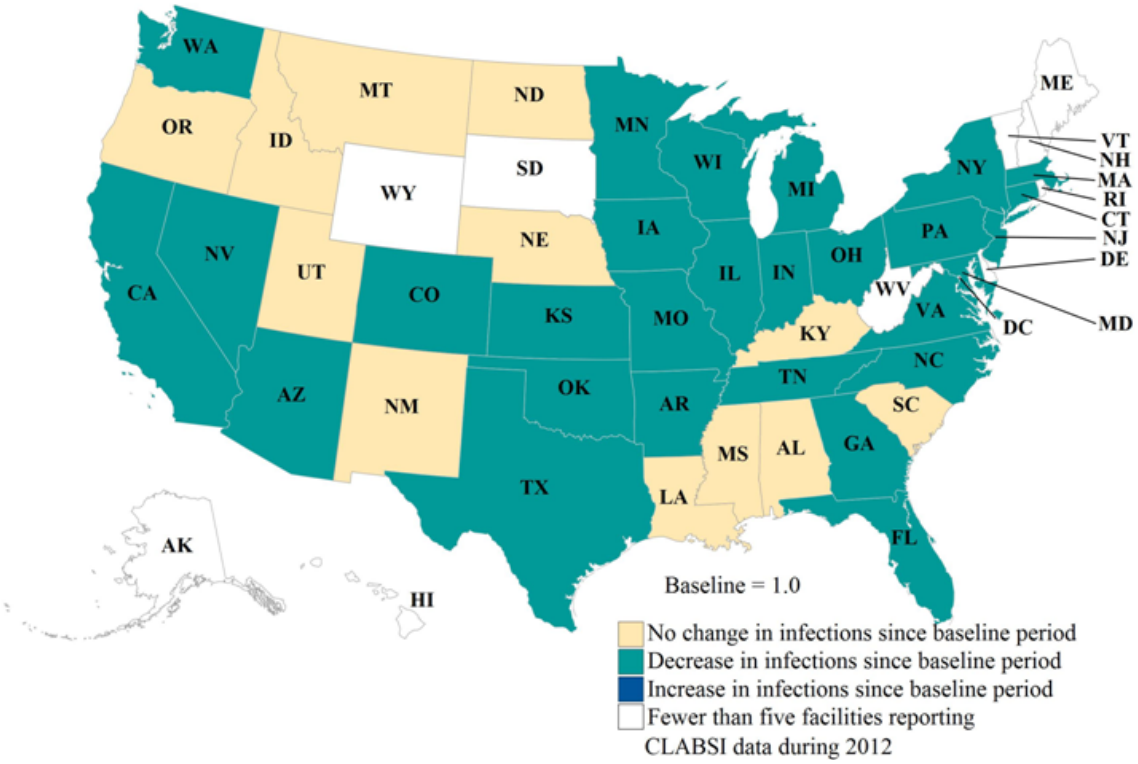
- Of the 41 states with rates for 2012, 29 had a significant decrease in infections since the baseline period and 12 had no change in infections since the baseline period (Exhibit CLABSI.1). No states had a significant increase in infections.
- Among the 41 states with CLABSI rates for 2012, the SIRs ranged from 0.299 to 1.150 (Exhibit CLABSI.2). An SIR less than 1 means that fewer infections occurred relative to what would have been predicted given the baseline data. An SIR greater than 1 means that more infections occurred relative to what would have been predicted given the baseline data. An SIR equal to 1 means that the number of infections is no different than the baseline period.[2]

Progress

- The national goal for CLABSIs in all ICUs (including non-neonatal ICUs) is 0.51 by the end of 2013. The CLABSI rate in NICUs was 0.56 in the 41 states in 2012.
- Although no states reported an increase in CLABSIs in NICUs since the baseline period, there is room for improvement for states to meet the Secretary's Goal for reducing CLABSIs by 50 percent by the end of 2013.

[2] 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 2012 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.1 Geographic Variation in State Performance on Central-Line Associated Blood Stream Infections (CLABSIs) in Neonatal Intensive Care Units (NICUs), 2012 (n = 41)



Source: Centers for Disease Control and Prevention, 2012 National and State Healthcare-Associated Infections Standardized Infection Ratio Report, Table 3d, available at http://www.cdc.gov/hai/excel/hai-progress-report/2012-HAI-Progress-Final-Tables.xlsx

To view state-specific data for this measure, please see Table CLABSI at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2013.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.2. State Performance on Central-Line Associated Blood Stream Infections (CLABSIs) in Neonatal Intensive Care Units (NICUs): Standardized Infection Ratios, 2012

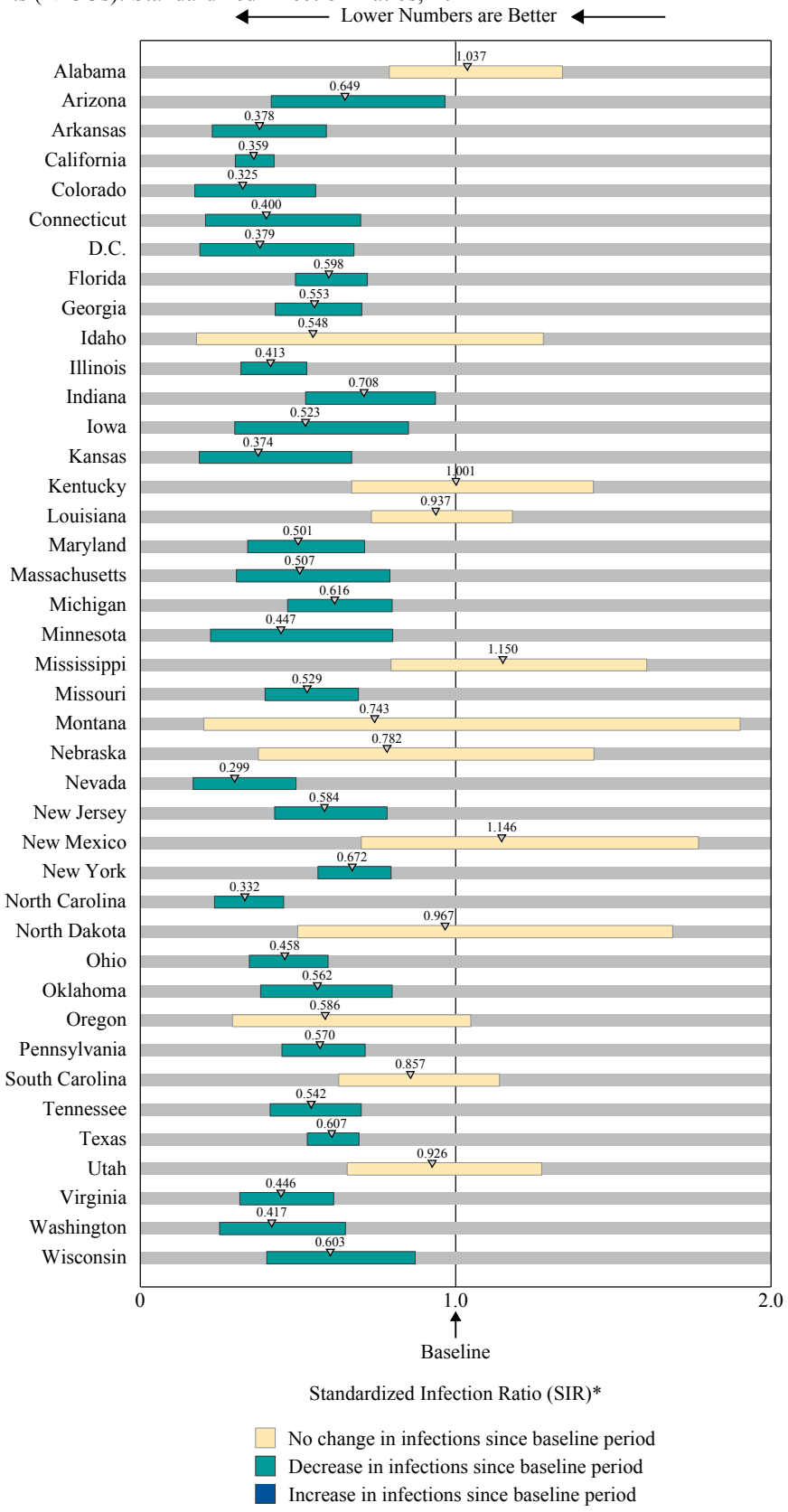


Exhibit CLABSI.2 (continued)

Source: Centers for Disease Control and Prevention, 2012 National and State Healthcare-Associated Infections Standardized Infection Ratio Report, Table 3d, available at http://www.cdc.gov/hai/excel/hai-progress-report/2012-HAI-Progress-Final-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 SIR is 1, the number of infections reported is the same as the number of infections predicted given the baseline data, indicating there has been no change in infections since the baseline period. If the SIR is less than 1, the number of infections reported is less than the number of infections predicted given the baseline data, indicating that infections have been prevented since the baseline period. If the SIR is greater than 1, the number of infections reported is greater than the number of infections predicted given the baseline data, indicating that infections have increased since the baseline period. 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. More information is available at: http://www.cdc.gov/hai/surveillance/QA_stateSummary.html.

This page left blank for double-sided copying.

DENTAL AND ORAL HEALTH SERVICES

States' efforts over the past decade have resulted in improved access to dental care for children covered by Medicaid and CHIP. Between FFY 2007 and FFY 2011, almost half of all states achieved at least a 10 percentage point increase in the proportion of enrolled children who received a preventive dental service during the reporting year.[1] Between FFY 2011 and FFY 2012, 15 states achieved at least an additional two percentage point improvement.[2] But despite considerable progress in pediatric oral health care in recent years, tooth decay remains one of the most common chronic diseases among children. As such, children's oral health continues to be a primary focus of improvement efforts in both Medicaid and CHIP, through which all enrolled children have dental coverage.

Over the past several years, CMS has worked with federal and state partners, the dental and medical provider communities, and other stakeholders to continue to improve children's access to dental care. Launched in April 2010, CMS's Oral Health Initiative has two goals: (1) increase by 10 percentage points the proportion of Medicaid and CHIP children ages 1 to 20 who receive a preventive dental service; and (2) increase by 10 percentage points the proportion of Medicaid and CHIP children ages 6 to 9 who receive a sealant on a permanent molar.

In April 2013, CMS set state-specific baselines, based on data reported by states on the FFY 2011 Form CMS-416, along with FFY 2015 goals for children's use of preventive dental services.[3] CMS invited Medicaid agencies to develop Oral Health Action Plans as a roadmap to achieving these goals. CMS offers technical assistance to states to develop and implement their Oral Health Action Plans. CMS also supports state planning through other efforts including:

- CMS hosts a quarterly series of webinars entitled *The CMS Learning Lab: Improving Oral Health Through Access*.[4]
- CMS provides oral health education materials available for order at no cost.[5]
- In September 2013, CMS released a strategy guide, *Keep Kids Smiling: Promoting Oral Health Through the Medicaid Benefit for Children and Adolescents*, which describes effective approaches for state Medicaid programs.[6]

State performance related to children's access to dental care is evaluated through two measures in the Child Core Set.[7] The measures are as follows:

1. Preventive Dental Services
2. Dental Treatment Services

To streamline reporting and reduce burden on states, in FFY 2012, CMS began calculating these measures on behalf of states using data from Form CMS-416. The two dental measures were reported by 49 states for FFY 2013 and are summarized in this section.

[1] See http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-04-18-13.pdf.

[2] See http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-07-10-2014.pdf .

[3] See http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/OHIBaselineGoals.pdf.

[4] Information on the *CMS Learning Lab* is available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Dental-Care.html.

[5] These materials are available at http://www.insurekidsnow.gov/professionals/dental/index.html.

[6] The strategy guide is available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Keep-Kids-Smiling.pdf.

[7] The two Child Core Set dental measures are calculated using data from lines 1b, 12b, and 12c of the Form CMS-416.

This page left blank for double-sided copying.

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

Tooth decay, or dental caries, is one of the most common chronic diseases of children. It is a growing problem: among children ages 2 to 5, the prevalence of early childhood caries increased 15 percent between 1988–1994 and 1999–2004.[1] Untreated tooth decay affects 19.5 percent of 2-to-5 year olds and 22.9 percent of 6-to-9 year olds.[2] The disease is almost entirely preventable through a combination of good oral health habits at home, a healthy diet, and early and regular use of preventive dental services.

Measure Description

- The percentage of individuals ages 1 to 20 who are enrolled in Medicaid or CHIP Medicaid Expansion programs for at least 90 continuous days, are eligible for EPSDT services, and who received at least one preventive dental service.[3]
- The EPSDT benefit provides comprehensive and preventive health care services, including dental services, for children under age 21 who are enrolled in Medicaid.[4]

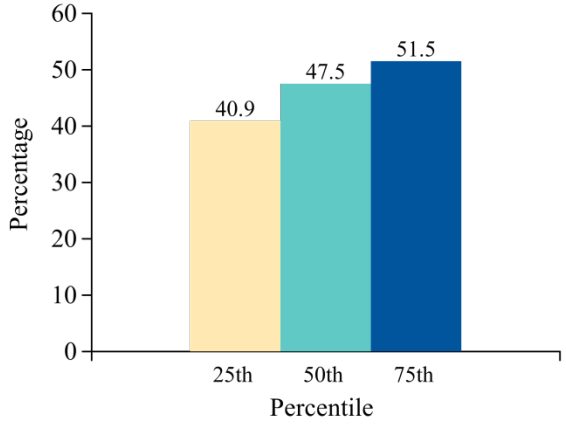
Overview of State Reporting

- The number of states reporting the Preventive Dental Services measure through Form CMS-416 decreased from 51 states for FFY 2011 and FFY 2012 to 49 states for FFY 2013 by the deadline for this report.[5]
- To reduce state reporting burden and have a single information source, in FFY 2012, CMS formally began calculating this measure on behalf of states based on data submitted as part of the Form CMS-416.[6]

State Performance

- Among the 49 states reporting the measure for FFY 2013, the median rate was 48 percent, with an 11-point spread between the 25th and 75th percentiles (Exhibit PDENT.1).
- Performance on this measure ranged from 21 to 60 percent among states, with considerable geographic variation across states (Exhibit PDENT.3, next page).

Exhibit PDENT.1. Preventive Dental Services, FFY 2013 (n = 49 states)



Source: Mathematica analysis of FFY 2013 Form CMS-416 reports as of August 4, 2014.

Trends

- Among the 49 states reporting data for this measure on the Form CMS-416 for all three years, the median rate increased by 3 percentage points from FFY 2011 to FFY 2013 (Exhibit PDENT.2).

Exhibit PDENT.2. Trends in the Preventive Dental Services Measure, FFY 2011–2013 (n = 49)

Rate	FFY 2011	FFY 2012	FFY 2013
Mean	43.8	44.8	46.0
Median	44.5	46.1	47.5
25th Percentile	39.7	40.0	40.9
75th Percentile	48.7	50.5	51.4

Source: Mathematica analysis of FFY 2011, 2012, and 2013 Form CMS-416 reports as of August 4, 2014.

[1] http://www.cdc.gov/nchs/data/series/sr_11/sr11_248.pdf.

[2] http://www.cdc.gov/features/dsuntreatedcavitieskids/.

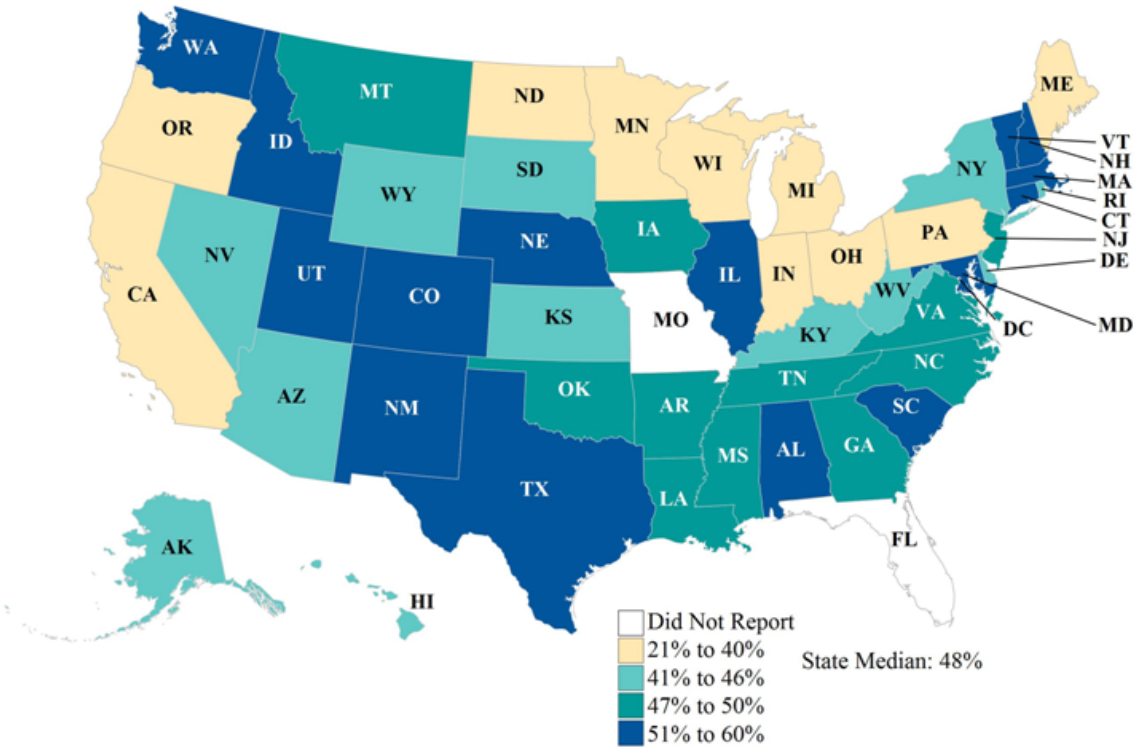
[3] This measure is calculated using the administrative method (claims/encounter data).

[4] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html.

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

[6] Performance data from Form CMS-416 have been presented for this measure since the 2011 Secretary's Repor

Exhibit PDENT.3. Geographic Variation in the Preventive Dental Services Measure, FFY 2013 (n = 49 states)



Source: Mathematica analysis of FFY 2013 CMS-416 reports as of August 4, 2014.

To view state-specific data for this measure, please see Table PDENT at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2013.zip.

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

Tooth decay, or dental caries (cavities), is one of the most common chronic diseases of children. If left untreated, tooth decay can negatively affect a child's physical and social development and school performance. The prevalence of untreated tooth decay among children ages 2 to 5 increased 7 percent between 1988–1994 and 1999–2004.[1] Over 19 percent of children ages 2–19 had untreated tooth decay in 2001–2004.[2] Children in families with incomes below 100 percent of the federal poverty level (FPL) had higher rates of untreated tooth decay than children from higher income families.

Measure Description

- The percentage of individuals ages 1 to 20 who are enrolled in Medicaid or CHIP Medicaid Expansion programs for at least 90 continuous days, are eligible for EPSDT services, and who received at least one dental treatment service.[3]
- The EPSDT benefit provides comprehensive and preventive health care services, including dental services, for children under age 21 who are enrolled in Medicaid.[4]

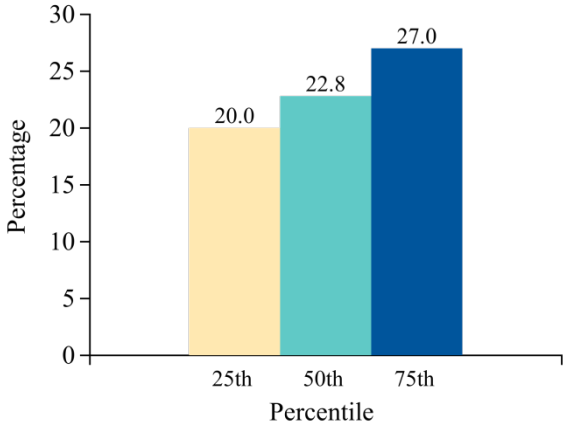
Overview of State Reporting

- The number of states reporting the Dental Treatment Services measure decreased from 51 states reporting for FFY 2011 and FFY 2012 to 49 states for FFY 2013 by the deadline for this report.[5]
- To reduce state reporting burden and have a single information source, in FFY 2012, CMS formally began calculating this measure on behalf of states based on data submitted as part of the Form CMS-416.[6]

State Performance

- Among the 49 states reporting the measure for FFY 2013, the median rate was 23 percent, with a 7-point spread between the 25th and 75th percentiles (Exhibit TDENT.1).
- Performance on this measure ranged from 9 to 54 percent among states, with considerable geographic variation across states (Exhibit TDENT.3, next page).

Exhibit TDENT.1. Dental Treatment Services, FFY 2013 (n = 49 states)



Source: Mathematica analysis of FFY 2013 Form CMS-416 reports as of August 4, 2014.

Trends

- Among the 49 states reporting data for this measure on the Form CMS-416 for all three years, the median rate decreased by 1 percentage point from FFY 2011 to FFY 2013 (Exhibit TDENT.2).

Exhibit TDENT.2. Trends in the Dental Treatment Services Measure, FFY 2011-2013 (n = 49)

Rate	FFY 2011	FFY 2012	FFY 2013
Mean	24.2	24.1	24.5
Median	23.9	23.1	22.8
25th Percentile	19.7	19.7	20.0
75th Percentile	26.1	26.0	26.9

Source: Mathematica analysis of FFY 2011, 2012, and 2013 Form CMS-416 reports as of August 4, 2014.

[1] http://www.cdc.gov/nchs/data/series/sr_11/sr11_248.pdf

[2] http://www.cdc.gov/features/dsuntreatedcavitieskids/

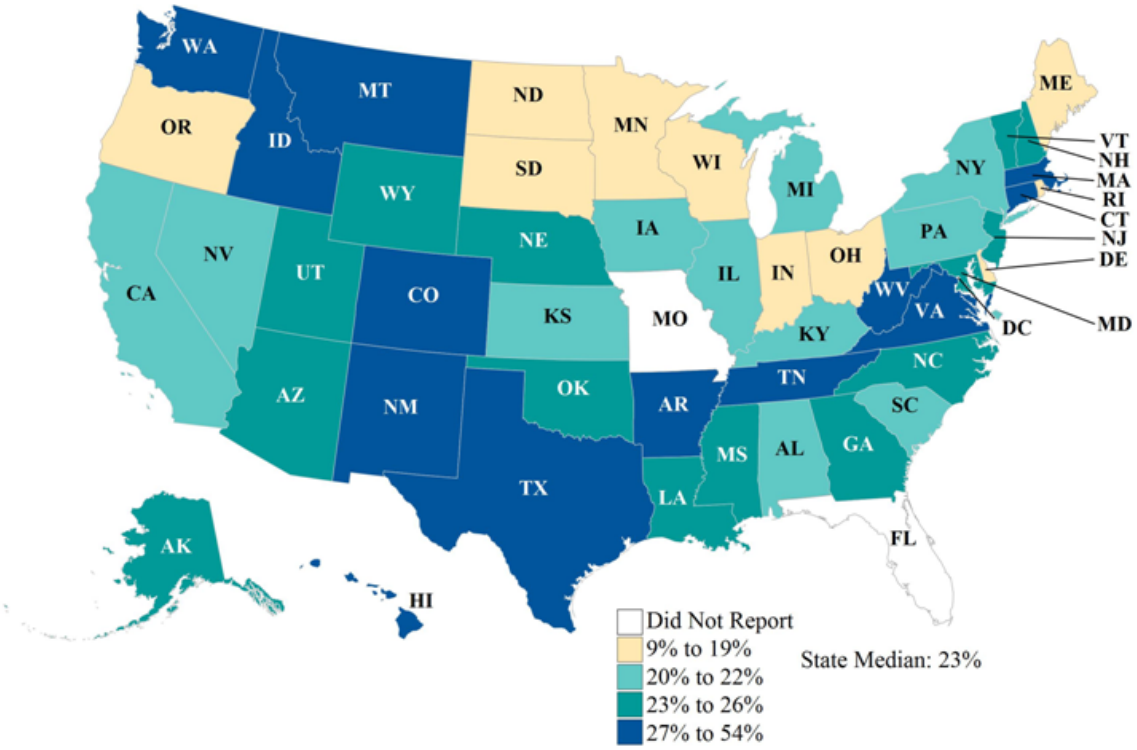
[3] This measure is calculated using the administrative method (claims/encounter data).

[4] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html.

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

[6] Performance data from Form CMS-416 have been presented for this measure since the 2011 Secretary's Report.

Exhibit TDENT.3. Geographic Variation in the Dental Treatment Services Measure, FFY 2013 (n = 49 states)



Source: Mathematica analysis of FFY 2013 CMS-416 reports as of August 4, 2014.

To view state-specific data for this measure, please see Table TDENT at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2013.zip.