APPENDICES

The Department of Health and Human Services
Children's Health Insurance Program Reauthorization Act
Annual Report on the Quality of Care for Children in Medicaid and CHIP

Appendix A: NCQA and URAC Medicaid Accreditation

NCQA

In 2006, NCQA developed a Medicaid Managed Care Toolkit in collaboration with the Centers for Medicare & Medicaid Services, and provides regular updates via their Webpage: http://www.ncqa.org/tabid/134/Default.aspx. The tool kit includes information to support public reporting and summarizes the Federal regulations regarding quality assessment and managed care. In lieu of some of the required external quality review, States may elect to use the NCQA accreditation process, which includes HEDIS® data collection and reporting. As noted in the toolkit, 75% of the NCQA accreditation standards address External Quality Review requirements under the Code of Federal Regulations for managed care. As of January 2009, 25 Medicaid programs recognize or require NCQA accreditation (see Appendix B). Of the 25 programs, eight States (Kentucky, Indiana, Massachusetts, Missouri, New Mexico, Rhode Island, Tennessee, and Virginia) and the District of Columbia require NCQA accreditation by health plans participating in Medicaid.

URAC

URAC (formerly known as the Utilization Review Accreditation Commission) also provides health plan accreditation reference information, although not explicitly for Medicaid. Recently updated, URAC's health plan accreditation standards include key quality benchmarks for network management, provider credentialing, utilization management, quality management and improvement and consumer protection. More information is available at:

http://www.urac.org/programs/prog_accred_HPlan_po.aspx

URAC does provide explicitly for Medicaid Managed Care programs a reference guide on Medicaid Managed Care External Quality Review. URAC is a private national accrediting organization approved by the Centers for Medicare & Medicaid Services pursuant to 42 CFR §422.158 (See 71 Fed. Reg. 30422, May 26, 2006). Several States, including Florida, Georgia, Hawaii, Indiana, Michigan, Minnesota, South Carolina, Virginia, and Wisconsin currently recognize one or more URAC accreditation programs in their Medicaid statutes, regulations, or contracts.

Information on that is available at:
http://www.urac.org/policyMakers/resources/GuidetoMedicaidManagedCElQReview.aspx

Appendix B: States Recognizing NCQA and Other Medicaid Accreditation

- **Arizona:** The Arizona Health Care Cost Containment System recognizes providers credentialed by NCQA Accredited health plans as meeting state credentialing requirements (AHCCCS Medical Policy Manual, Chapter 900; http://www.azahcccs.gov/regulations/OSPPolicy/).

- **California:** NCQA Accreditation is deemed for meeting state credentialing requirements. Non-accredited plans contracting with NCQA certified physician organizations are also deemed compliant with state requirements (MMCD Policy Letter 02-03).

- ***District of Columbia:** DC's Medical Assistance Administration requires contracted managed care plans to hold NCQA Accreditation.

- **Florida:** Accreditation is required for health plans serving the commercial market and health plans contracted with the Medicaid and state employee benefit programs (State Regulation 59A-12.0071). Accreditation is also required for credentialing verification organizations (State Law: 456.047). NCQA is an approved accrediting organization. Rules for approved accrediting organizations can be found under 59A-12.0072.)

- **Georgia:** Medicaid managed care plans are required to obtain private accreditation by 2009 (Georgia Department of Community Health).

- **Hawaii:** Accreditation is required for all health plans (State Law: 432E-11).

- ***Indiana:** Managed care organizations and managed behavioral health organizations in the Medicaid program must be NCQA Accredited by January 1, 2011 (SB 42).

- **Iowa:** The Human Services Department accepts NCQA Accreditation for the State's accreditation requirement for Medicaid managed care plans (State Regulation: 441-88.2).

- ***Kentucky:** Kentucky's Cabinet for Health and Family Services requires managed care plans to be NCQA Accredited as a condition of doing business.

- **Maryland:** Health plans may submit accreditation reports to demonstrate compliance with state requirements (State Law: 19-705.1).

- **Massachusetts:** MassHealth plans can use evidence of NCQA accreditation to demonstrate compliance with several components of the EQRO review. Plans must obtain NCQA accreditation within 2 years of their contract start date. July 1, 2010, MCO Contract.

- **Michigan:** Accreditations required for Medicaid managed care plans per state contract requirements.

- **Minnesota:** Minnesota Department of Human Services recognizes many NCQA accreditation standards under CFR 438.360. Specific standards categories that are recognized are under quality improvement, utilization management, credentialing and member rights and responsibilities.

- ***Missouri:** Missouri's request for proposals for Medicaid managed care requires that plans obtain NCQA health plan accreditation within 2 years of the effective date of the contract. (REQ NO.: NR 886 25759006134 - http://oa.mo.gov/bids/b3z09135.htm).

- ***New Mexico:** NCQA accreditation is required for Medicaid managed care plans (State Regulation: 8.305.8.11).

- **Oregon:** NCQA and other recognized private accrediting organizations standards have been deemed equivalent to quality improvement requirements for Medicaid managed care (State Regulation: OAR 410-141-0200).

- **Pennsylvania:** NCQA accreditation reports are used as part of the state's routing monitoring of Medicaid manages care plans (Pennsylvania Department of Public Welfare).

- ***Rhode Island:** NCQA accreditation is required for Medicaid manages care plans. See - (Monitoring Quality and Access in RIte Care http://www.ritecare.ri.gov/documents/reports_publications/PGP%20report%202008%2010-08.pdf).

- **South Carolina:** Accreditation is required for Medicaid manages care plans. South Carolina Department of Health and Human Services.

- **Texas:** The Texas Department of Insurance mandates the use of NCQA's credentialing standards by all health care plans in the state. Plans must follow the most current version of NCQA's credentialing requirements from year to year.

- ***Tennessee:** All plans contracting with TennCare (Medicaid) must be NCQA Accredited.

- **Utah:** NCQA Accreditation meets some of Utah's contractual requirements for Medicaid plans (Utah Department of Health).

- ***Virginia:** Medicaid managed care plans are required to maintain NCQA Accreditation.

- **Washington:** Washington State Department of Social and Health Services, Health and Recovery Services Administration recognizes NCQA accreditation for meeting state quality improvement requirements for plans serving Medicaid and SCHIP.

- **Wisconsin:** Wisconsin Medicaid HMP Accreditation Incentive allows health plans to submit evidence of accreditation in lieu of providing documentation for performance improvement projects and undergoing onsite external quality reviews

*NCQA Accreditation was required at the time this report was prepared

---

Source: 2009 NCQA Medicaid Managed Care Toolkit

Appendix C: Public-Private Partnerships to Improve Quality Measurement

Several nationally recognized organizations dedicated to improving quality of care in the United States have provided significant support toward State efforts to evaluate and implement quality of care improvement initiatives for Medicaid and CHIP. This section highlights examples that are meant to represent those efforts, but are not considered exhaustive of all efforts being implemented nationally.

The National Improvement Partnership Network **(**NIPN) has information available at: www.improvementpartnerships.org. As noted at this Website, this initiative is known as an "Improvement Partnership" and reported to be a durable, regional collaboration of public and private partners in a state/region that uses measurement-based efforts and a systems approach to improve the quality of children's health care. Improvement Partnerships bring together key players from across the health care system that can effect desired changes. This coordination supports quality improvement in the clinical settings where care takes place and promotes policy changes at the regulatory or state levels to sustain these improvements in care. It has been said that "all improvement is local." Experiences with Improvement Partnerships suggest that while this is true, it is also true that local improvements benefit enormously from coordination and support on a state or regional basis. A number of Improvement Partnerships are based within medical school pediatric departments or children's hospitals.

The list of participants includes, but is not be limited to:

- American Academy of Pediatrics Chapters: Arizona, Minnesota, Oregon, West Virginia
- State Medicaid programs such as Connecticut, Michigan, DC
- Department of Health: Maine, New York, Ohio, Washington
- University: New Mexico, Oklahoma, Utah, Vermont
- Children's Hospital: District of Columbia (with Medicaid)

Of particular note, two CHIPRA Quality Demonstration grantees - Maine (along with its partner State, Vermont) and Utah - have committed to collaborate with the NIPN as a means of sharing information developed through the Medicaid demonstrations with other grantees and other States. Formed in 1999, the Vermont Child Health Improvement Program (VCHIP) was the first improvement partnership (IP) in the nation and has the mission to optimize the health of Vermont's children by initiating and supporting measurement-based efforts to enhance private and public child health practice. In 2005, VCHIP received support from The Commonwealth Fund to provide leadership and technical assistance to States to establishing their own IPs to address child health care quality. In July 2009, at the request of participating States, VCHIP established the NIPN. Through sharing and mentorship between and across IP States, a variety of effective child health care quality improvement initiatives are being developed, disseminated, and evaluated. As the founder of NIPN, Vermont is now connected to a nationwide network of over 15 States that have worked extensively to improve the quality of children's health care practice and infrastructure.

Through Maine's demonstration, Vermont intends to take the lead role in continuing to develop the NIPN and further refine the model in order to facilitate sharing, learning, the provision of technical assistance, and the dissemination of promising practices related to areas of focus for the

demonstration (e.g., CHIPRA core quality measures, health information technology, and delivery system models). To achieve these ends, Maine and Vermont intend to develop an online IP resource center that will provide a mechanism to share insights on accomplishments and success stories, provide specific job descriptions and training curricula, share reports and mechanisms for communicating successes to state stakeholders, share data and results, provide a forum for discussion of common issues facing states in improving access and quality, share tools and techniques for data collection, analysis and reporting, and link to any child health resources developed through national CHIPRA and other technical assistance efforts.

The Utah Pediatric Partnership to Improve Healthcare Quality (UPIQ) is a member of the NIPN and plans to use technical assistance provided by the network's leaders to enhance the UPIQ infrastructure, conduct quality improvement projects, and support the activities of the national network. Established in 2003, UPIQ includes the University of Utah Department of Pediatrics, Utah Medicaid, the Utah Department of Health, the Utah Chapters of the American Academy of Pediatrics and American Academy of Family Physicians, *HealthInsight*, Intermountain Healthcare's Primary Care Clinical Programs, Utah Voices for Children, Molina Healthcare of Utah (which offers a CHIP program), University of Utah Health Care (which offers a Medicaid managed care plan), and the Pediatric Education Services program at the Primary Children's Medical Center (PCMC) in Salt Lake City. UPIQ's aim is to improve the health and healthcare of Utah's children by supporting primary care practices in implementing evidence-based and measurement-guided quality improvement strategies. UPIQ has involved 120 pediatric clinicians, from 60% of the state's 97 pediatric practices, 3 Medicine-Pediatrics physicians, and 47 family medicine clinicians in at least one (some in as many as 5) of 14 quality improvement projects. These have focused on topics such as asthma, ADHD, immunization delivery, screening for developmental and social-emotional problems, oral health risks, and obesity, and implementation of Medical Home concepts related to children and youth with special healthcare needs.

The Commonwealth Fund: Consistent with changes CMS has observed in how States address quality initiatives over the past 2 years, the Commonwealth State Profiles Web pages reflect a shift in focus from pay-for-performance to new State initiatives on value-based purchasing, quality reporting and measurement, patient safety, medical homes, and health information technology.

The Commonwealth provides State-specific profiles for innovative approaches to improve care at: http://mobile.commonwealthfund.org/Innovations/State-Profiles/View-All.aspx?topic=Health+Care+Quality&page=1

Additionally, the Commonwealth Fund provides information on state innovations via a Newsletter - *Commonwealth States in Action Briefs.* Recent updates include information on the CHIPRA quality demonstrations:
http://www.commonwealthfund.org/Publications/Newsletters/States-in-Action.aspx

The Center for Health Care Strategies (CHCS) is dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. CHCS works with

state and Federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs.

Between 2006 and 2008, CHCS and the Robert Wood Johnson Foundation Regional Quality Improvement Initiative worked to improve chronic care throughout a region or state, with key stakeholders in the health care marketplace coordinating strategies at the purchaser, health plan, provider, and consumer level. The goal of the Initiative is to achieve improvement in health care quality when health care system alignments occur. RQI was funded by the Robert Wood Johnson Foundation, which is also testing regional coalitions though its ***Aligning Forces for Quality*** initiative. Information on that initiative is available at http://www.rwjf.org/qualityequality/af4q/index.jsp.

RQI created regional systems-level changes through multiple coordinated strategies:

1) *Cross-Payer Data Aggregation and Reporting of Performance Measures:* Developing common measures to assess quality of care and aggregating and sharing data with providers that reflect performance across multiple purchasers and insurers.
2) *Quality Improvement Infrastructure:* Helping providers improve their care delivery by using quality improvement tools, such as evidence-based guidelines, health information technology, and chronic care innovations.
3) *Consumer Engagement:* Engaging and educating consumers in self-management techniques and informed decision-making.
4) *Realigning Resources and Creating Financial Incentives:* Aligning provider payment and performance outcomes to support higher quality and more efficient care.

More information on this initiative is available at http://www.chcs.org/info-url_nocat3961/info-url_nocat_show.htm?doc_id=377021

Fact Sheets for fifteen individual State Snapshots in 2009 on the *Aligning Forces for Quality* Communities is available at: http://www.chcs.org/publications3960/publications_show.htm?doc_id=1013824

Additional information by the Robert Wood Johnson Foundation also highlights 17 States - including Boston and central Indiana at: http://www.rwjf.org/qualityequality/af4q/about.jsp

The Robert Wood Johnson Foundation has launched a program to build the Leadership capacity of Medicaid Directors. The *Medicaid Leadership Institute* is a national initiative of the Robert Wood Johnson Foundation, but is run by the Center for Health Care Strategies. The Institute provides a unique opportunity for Medicaid directors to develop and enhance the skills and expertise to enhance their State programs as well as maximize Medicaid's contributions to transform the nation's health care system. Table 1 highlights the Medicaid directors competitively selected for the inaugural class of 2009-2010 and the second class of 2010-2011.

Table 1-Robert Wood Johnson Foundation Medicaid Director Leadership Institute Fellows

2009-2010	2010-2011
Toby Douglas, California	Thomas Betlach, Arizona
Carolyn Ingram, New Mexico	Theresa Eagleson, Illinois

MaryAnne Lindeblad, Washington	Donna Frescatore, New York
Lynn Mitchell, Oklahoma	Darin Gordon, Tennessee*
Carol Steckel, Alabama	Judy Mohr Peterson, Oregon
Sandeep Wadhwa, Colorado	Michael Nardone, Pennsylvania

* Chairs the CMS Quality Technical Assistance Group that provides ongoing support and information to support State Medicaid and CHIP quality program efforts.

These directors participate in a 12-month leadership development curriculum covering three tracks:

1. Understanding how broad macroeconomic and political issues can affect, and be affected by, State Medicaid programs;
2. Increasing expertise in the technical and operational aspects of Medicaid with a specific focus on building analytic and strategic capacity to improve the quality and cost effectiveness of health care; and
3. Developing leadership and organizational management skills necessary to manage complex Medicaid programs.

National Initiative for Children's Healthcare Quality: Founded in 1999, the National Initiative for Children's Healthcare Quality (NICHQ) is an action-oriented organization dedicated to achieving a world in which all children receive the healthcare they need. Led by experienced pediatric healthcare professionals, NICHQ's mission is to improve children's health by improving the systems responsible for the delivery of children's healthcare. Information on various initiatives underway at NICHQ can be found at www.nichq.org.

One initiative includes *The National Initiative for Children's Healthcare Quality to Advance* One initiative includes *The N Pediatric Quality Improvement in Partnership with the New York State Department of Health*. Announced in April of 2009, this quality improvement effort focuses on school-based health centers, and neonatal and asthma outcomes. As part of the school base health center contract, NICHQ works with New York State to further enhance clinical quality based in the State's school based health centers.

Additionally, the New York State Department of Health, along with CMS, in partnership with NICHQ, continues efforts on a neonatal outcomes improvement project designed to build State infrastructure in supporting neonatal quality improvement initiatives. Specifically this project will (1) improve newborn and maternal outcomes; (2) reduce health care costs, and (3) establish capabilities within the State for ongoing quality improvement/transformation. Clinical teams will focus on ten interventions beginning with maternal high risk medical and behavioral conditions, through NICU care, and ultimately hospital discharge and infant follow-up care. Based on scientific evidence and expert consensus, the focus will be on reducing morbidity and mortality associated with premature birth. New York State is the second State to join NICHQ in this critically important effort, following Ohio, NICHQ's first State partner. NICHQ is in the process of working with CMS to add additional States.

Appendix D: Children's Access to Care in CHIP, State-Specific Data

Table 3. Changes in Children's Access to Care Within SCHIP, by State

State	Study	Usual Source of Care	Provider Visits[a]	Preventive Care	Specialty Care	Reduction of Emergency Department Use	Reduction of Unmet Need or Delayed Care
Alabama	Mulvihill et al. (2000)*	+					+
California	Stevens (2006)	+	0				+
	Kenney et al. (2005)	+	0	0	0	0	+
	MRMIB (2004)*	+					+
Colorado	Kempe et al. (2005)	0	Mixed[b]	+	0	0	+[c]
	Kenney et al. (2005)	+	+	0	0	0	+
	Eisert and Gabow (2002)		+	+	0	0	
Florida	Kenney et al. (2005)	+	0	0	0	+	+
	Nogle and Shenkman (2004)*	+					+[d]
	Shenkman et al. (2000)	+		+			+
Illinois	Kenney et al. (2005)	0	0	0	0	0	+
Iowa	Damiano and Tyler (2005)	0	Mixed[e]			0	+
	Damiano et al. (2003)	+					+
Kansas	Fox et al. (2003)	+	+	+		+	+
Louisiana	Kenney et al. (2005)	+	+	+	0	+	+
Missouri	Kenney et al. (2005)	0	0	0	0	0	+
New Hampshire	RKM (2004)*	+		+			+
New Jersey	Kenney et al. (2005)	+	0	0	0	+	+
New York	Kenney et al. (2005)	0	0	0	0	0	+
	Szilagyi et al. (2004)	+	+	+	0	0	+
North Carolina	Kenney et al. (2005)	+	+	0	+	0	+
	Slifkin et al. (2002)	+		0		0	+
Texas	Kenney et al. (2005)	+	0	0	0	+	+
	Shenkman (2003)*	+					+
10-state estimate[f]	Kenney et al. (2005)	+	0	0	0	+	+

Note: Except where noted, the (+) symbol indicates that the study reported that SCHIP had a statistically significant positive effect on the access measure; the (–) symbol represents a statistically significant negative effect; (0) indicates no effect. Shading indicates the access measure was not evaluated in the study.

* Indicates statistical significance testing not performed.

[a]Provider visits defined as the average number of provider visits for Eisert and Gabow (2002), Damiano and Tyler (2005), Fox et al. (2003), and Szilagyi et al. (2000). Provider visits defined as the percent of enrollees with *any* provider visits in the past year for all other studies.

[b]The percent of children with any routine care significantly increased; however, the average number of routine visits did not change.

[c]Delays in care were measured among those who sought care when sick or injured and those who sought routine care.

[d]Delays in care were reduced in all categories measured, including preventive care, minor illness, and surgical care.

[e]The distribution of the average number of provider visits changed significantly, with fewer children having one visit or less and fewer children having more than 10 visits, but more children having between 2 and 9 visits per year.

[f]Aggregate findings from California, Colorado, Florida, Illinois, Louisiana, Missouri, New Jersey, New York, North Carolina, and Texas.

Source: Schulman, Shanna & Rosenbach, Margo. (2007) "SCHIP at 10: A Synthesis of the Evidence on Access to Care in SCHIP – Final Report." Mathematica Policy Research, Inc.

Appendix E: Findings from EQRO Validation Studies

States	State Specified Performance Measures	Findings and Follow-up	Performance Improvement Projects Reported	Validation Issues	Status of Health Information Technology Assessment
AL	1) % of Low Birth Weight Infants 2) % of Very Low Birth Weight Infants (VLBWI) 3) % of VLBWI born at Facilities with a NICU	NONE	This is a PIHP for pregnant women. While it has PMs and PIPS for obstetrics, it has no pediatric ones.	NONE	NONE
AK	Not required				
AZ	1) Adolescent Well Care Visits 2) Annual Dental Visits Among Children 3) Children's Access to PCP 4) Well Child Visits- First 15 Mos. 5) Well Child Visits- 3-6 Yrs.	36.3% 57.5% 76.7% 58.6% 61.3%	Timely Submission of Immunization Info. to the State (Increased from 86.4% to 89.3% in 1 year)	NONE	State used Transformation Grant to begin implementation of statewide Medicaid EHR
AR	Not required				

Appendix E: Findings from EQRO Validation Studies

States	State Specified Performance Measures	Findings and Follow-up	Performance Improvement Projects Reported	Validation Issues	Status of Health Information Technology Assessment
CA	1) Well Child Visits- First 15 Mos. 2) Well Child Visits- 3-6 Yrs. 3) Adolescent Well Care Visits 4) Appropriate treatment for Children with URIs 5) Childhood Immunization Status (Combo 3)	2009 HEDIS results: weighted average for CA Medicaid managed care: 56.5% 76.9% 43.1% 84.8% 74.9% Note: Many plans score higher than the program average for these measures, some at or above CA's High Performance Level, (national 90th percentile). See 2009 HEDIS results on the DHCS Website at http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/HEDIS_Reports/HEDIS2009.pdf	Preventing Adolescent Obesity Health plans currently are conducting children's health PIPs. See Appendix A of QIP quarterly status report at http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/EQRO_QIPs/CA%202009-10%20QIP%20Qtr%2010-1%20to%2012-31-09%20Report.pdf Current statewide collborative improvement project, Reducing Avoidable ER Visits by Members One Year of Age & Above>including parents, to seek care from PCPs for non-emergency conditions.	The State is advised to implement a new validation procedure for PIPs, the present system is inadequate. In 2009, CA Dept of Health Care Services implemented a more rigorous validation procedure for PIPs which is fully compliant with Federal requirements. This is documented in the *Quality Improvement Assessment Guide for Medi-Cal Managed Care Plans* (May 2009) on the DHCS Website at http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/EQRO_QIPs/CA%202008-9%20QIA%20Guide.pdf.	The *Medi-Cal Managed Care Quality Strategy* (Dec 2009) includes a section on health information technology on pg. 21 See the DHCS Website at http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/Studies_Quality_Strategy/2009_Quality_Strategy_12-14-09.pdf.

Appendix E: Findings from EQRO Validation Studies

States	State Specified Performance Measures	Findings and Follow-up	Performance Improvement Projects Reported	Validation Issues	Status of Health Information Technology Assessment
CO	1)Childhood Immunization Status-DTaP 2)Childhood Immunization Status-IPV 3)Childhood Immunization Status-MMR 4)Childhood Immunization Status-HiB 5)Childhood Immunization Status-Hep B 6)Childhood Immunization Status-VZV 7)Childhood Immunization Status-Pneum conjugate 8)Childhood Immunization Status-Combo 2 9)Childhood	MCO-85.6% PIHP-88.1% MCO-94.9% PIHP-95.0% MCO-93.2% PIHP-94.7% MCO-94.4% PIHP-93.7% MCO-95.4% PIHP-94.4% MCO-93.2% PIHP-91.5% MCO-88.1% PIHP-85.0% MCO-85.2% PIHP-81.5% MCO-84.2% PIHP-75.9% MCO-1.9% PIHP-1.4% MCO-63.1% PIHP-30.6% MCO-56.9% PIHP-59.5%	1)Childhood Immunizations 2) Therapy with children and adolescents 3)Screening for bipolar disorder 4)Assure least restrictive level of care for children and	NONE	NONE

Appendix E: Findings from EQRO Validation Studies

States	State Specified Performance Measures	Findings and Follow-up	Performance Improvement Projects Reported	Validation Issues	Status of Health Information Technology Assessment
CO *(cont'd)*	13) Adolescent well-care visits	MCO- 31.9%, PIHP- 40.8%			
	14) Follow-up care for children prescribed ADHD medication-Initiation	MCO – 16.2 %, PIHP-NR			

Appendix E: Findings from EQRO Validation Studies

States	State Specified Performance Measures	Findings and Follow-up	Performance Improvement Projects Reported	Validation Issues	Status of Health Information Technology Assessment
CT	Community Health Network of CT [**CHN**] – Children's Access to Preventive Care Anthem Blue Care Family Plan [**BCFP]** – "EPSDT	**CHN** – The Children's Access PM was found to be fully compliant with one minor issue concerning coding, The age category for CAPC1 should be 25 - 72 (months) but the code submitted is 12 – 24 (months). **BCFP** – The EPSDT PM was found to fully compliant and all 2007 recommendations were addressed. **Note:** Both health plans became a prepaid inpatient health plan (PIHP) as of January 1, 2008.	**CHN** - "Adolescent Access to Primary Care" **BCFP** – "Improving Adolescent Access to Preventive Services"	**CHN** – Measured for two situations – 91.4% member s age 12 – 19 had a visit with a primary care practitioner in 2008 and 41.5 % members age 15 – 19 had at least one comprehensive well care visit with either a PCP or OB/GYN practitioner. The confidence in both measures was considered high while the confidence in success/sustainability of improvement efforts was considered moderate (only minor deviations from standard protocol). Compliance with specifications was partially met. **Note:** The projects were designed to apply CT DSS-developed specifications as well as some 2008 Health Effectiveness Data and Information Set (HEDIS) specifications.	**CHN –** It was recommended that CHN complete their management information system (MIS) projects in process and update the policies and procedures to address system software changes and provide CHN the capability to trend issues. CHN was also recommended to complete the cross training of the staff member(s) who will back-up for SAS programming. **BCFP** – No recommendations made.

Appendix E: Findings from EQRO Validation Studies

States	State Specified Performance Measures	Findings and Follow-up	Performance Improvement Projects Reported	Validation Issues	Status of Health Information Technology Assessment
CT *(cont'd)*				**BCFP**- 58.9% of members age 12 – 21 had a preventive health care visit in 2008; up from 53.7% in 2007 and the baseline in 2003 was 46.6%. Confidence in the reported results as high, confidence in the success/ sustainability of improvement efforts was high and compliance with specifications was met.	
DE	NONE relating to children	NONE	1.) Low Birth Weight (6.96%) 2.) Very Low Birth Weight (0.76%) 3.) Lead Screening in Children (74.93%)	NONE	NONE
DC	1) Timeliness of Prenatal Care 2) Timeliness of Postpartum Care 3) Childhood Immunization 4) Well Child Visits- First 15 Mos. 5) Well Child Visits- 3-6 Yrs. 73.72% 6) Adolescent Well Visits	58.27% 44.96% Combo #2 (67.4%) 42.34% 73.72% 44.53%	1.) Reducing Pediatric Obesity 2.) Prenatal Care	NONE	NONE

Appendix E: Findings from EQRO Validation Studies

States	State Specified Performance Measures	Findings and Follow-up	Performance Improvement Projects Reported	Validation Issues	Status of Health Information Technology Assessment
FL	Tests all HEDIS® measures	MCOs should address any "points of clarification" for scores that have been met but could be enhanced further.	1) Well Child Birth to 15 Months of Life, 6 or more visits - collaborative 2) Childhood Immunizations 3) Lead Screening in Children 4) Child Health Check Up: 2-20 years 5) Improving the Management of Pediatric Asthma 6) Prenatal Care 7) Improving the rate of Child and Adolescent Dental Care 8) Improve the rate of HbA1c among Children and Adolescents with Diabetes	1) PMs substantially validated. 2) PIPs: Initial submission year, validated through Activity IV.	NONE

Appendix E: Findings from EQRO Validation Studies

States	State Specified Performance Measures	Findings and Follow-up	Performance Improvement Projects Reported	Validation Issues	Status of Health Information Technology Assessment
GA	1) Use of Appropriate Medications for People With Asthma 2) Well-Child Visits in the First15 Months of Life—Six or more Visits 3) Lead Screening in Children 4) Childhood Immunization Status—Combination 2	91.09% 62.25%, 51.58, 57.42%c (three MCOs- no weighted average given) 68.21% 57.18% 65.94% (three MCOs- no weighted average given) 29.84% , 62.77%, 75.91% (three MCOs- no weighted average given)	1) Improving Childhood Lead Rates 2) Well Child Visits 3) Childhood Immunization	NONE	1. Actively involved in designing an information system to enhance reporting and data analysis of performance. 2. Collaborating with HIT to design a Website to communicate information to providers, consumers, and other constituents.
HI	Childhood Immunization Rates	One MCO has major room for improvement (all rates below HEDIS 25th percentile). One MCO can be a best practice model (all rates exceed HEDIS 90th percentile).The third MCO is slightly below average. All immunization rates fell below HEDIS 50th percentile.	1.) Assessment of BMI Using EPSDT Form 2.) Children and Adolescent's Access to Primary Care 3.) Access to care	Childhood immunization rates for a fourth MCO were not available due to a small denominator.	NONE
ID	Not required				

Appendix E: Findings from EQRO Validation Studies

States	State Specified Performance Measures	Findings and Follow-up	Performance Improvement Projects Reported	Validation Issues	Status of Health Information Technology Assessment
IL	1) Childhood Immunization Status	Combo 2- 61.7% Combo 3- 48.1%	EPSDT Screening (validation report shows 13 of 13 elements met for 2 MCOs)	NONE	NONE
	2) Well Child Visits in first 15 Months no visits Six visits	 9.6% 25.5%			
	3) Well Child Visits 3-6 years	63.2%			
	4) 4)Adolescent Well-Care Visits	34.8%			
	5) Lead Screening	68.3%			
	6) Appropriate Treatment for children with URI	90.8%			
	7) Children's access to PCPs-12-24 months	80.7%			
	8) Children's access to PCPs-(25 months-six years)	65.6%			
	9) Children's access to PCPs (7-11 years)	59.1%			
	10) Adolescent access to PCPs	57.2%			
	11) Appropriate medication for asthma-(5-9)	85.8%			
	12) Appropriate medication for asthma (10-17)	84%			

Appendix E: Findings from EQRO Validation Studies

States	State Specified Performance Measures	Findings and Follow-up	Performance Improvement Projects Reported	Validation Issues	Status of Health Information Technology Assessment
IN	NONE (State has some data on children elsewhere but not in the EQR)	NONE	None relating to children	NONE	NONE
IA	(IA has managed care-MH only) No child related PMs	NONE	No child related PIPS	NONE	NONE

Appendix E: Findings from EQRO Validation Studies

States	State Specified Performance Measures	Findings and Follow-up	Performance Improvement Projects Reported	Validation Issues	Status of Health Information Technology Assessment
KS	1) Well Child Visits in 1st 15 Months 2) Well Child Visits: (Ages 3, 4, 5, 6) 3) Use of Medication for Asthma (Ages 5-17 years) 4) Child Access to Primary Care (25mos-6yrs) 5) Overall Average of Childhood Immunization	46.14% 68.99% 5-9yrs - 94.09% 10-17yrs – 88.14% 25mos-6yrs - 87.56% Combo 2 – 80.66% Combo 3 – 75.43% Other finding: Investigate the reasons why the rate of access to PCPs for children is less in 2009 compared to 2008	<u>CMFHP</u> Improving Customer Service Rates (based on Medicaid Child CAHPS rates; initiated fall 2008) Lead Screening Rates (2009 – measuring for sustained improvement) <u>UniCare</u> Adolescent Well Care Visits (2009 – measuring for sustained improvement) Provider Satisfaction – increasing knowledge of transportation and translation services. (PIP initiated in 2009)	NONE	NONE

Appendix E: Findings from EQRO Validation Studies

States	State Specified Performance Measures	Findings and Follow-up	Performance Improvement Projects Reported	Validation Issues	Status of Health Information Technology Assessment
KY	1. % of children and adolescents who saw a PCP and received and assessment/counseling for physical activity 2. % of children and adolescents who saw a PCP and received a nutritional assessment /counseling referral 3. % of children and adolescents whose medical records contain weight and height 4. % of children and adolescents found to have appropriate weight to height 5. % of children who received an anemia screening between 8-13 mos. of age 6. % of children 8-13 mos. Who met the parameters of anemia 6a. % of children identified with anemia who received counseling or treatment/referral 7. Lead screening in children before 2 yrs	42.18% 67.40% 80.10% 66.54% 70.59% 13.58% 61.36% 77.70%	1) EPSDT Screening	Measure denominators for the child and adolescent measures are drawn from the HEDIS® measures for Childhood and Adolescent Immunization. Therefore, only children aged 2 years and aged 13 years are included, and the majority of the child members (children ages 3 to 12 years and 14 to 20 years) are excluded. Additionally, a flaw in the original specification was found, in that based CDC criteria, it is not appropriate to calculate a BMI for a child under 2 years of age. This required that these children (less than 2 years of age) be removed from the BMI numerator component, and they will be excluded from the denominator as well for the 2009 HEDIS® BMI/Physical Activity/Nutritional Counseling. measure for children.	NONE

Appendix E: Findings from EQRO Validation Studies

States	State Specified Performance Measures	Findings and Follow-up	Performance Improvement Projects Reported	Validation Issues	Status of Health Information Technology Assessment
KY *(cont'd)*				Note that these flaws in the specifications did not impact the validity of the rates calculated, and ultimately reported. The main impact was the lack of ability to generalize the findings to the overall child/adolescent member population.	
LA	Not required				
ME	Not required				

Appendix E: Findings from EQRO Validation Studies

States	State Specified Performance Measures	Findings and Follow-up	Performance Improvement Projects Reported	Validation Issues	Status of Health Information Technology Assessment
MD	1) Childhood Immunization Status 2) Well Child Visits 1st 15 Months – 0 visits 3) Well Child Visits: Ages 3- 6 yrs 4) Adolescent Well Care Visits 5) Appropriate Testing for Children w/ Pharyngitis 6) Treatment for Children with URI 7) Children and Adolescents' Access to PCP 8) Appropriate medication for asthma-5-9 9) Appropriate medication for asthma- 10-17 10) Access to primary care-12-24 months 11) Access to Primary Care-25 months to 6 years 12) Access to Primary Care-7-11 13) Access to Primary Care- 12-19 years	Combo 2- 81.9% Combo 3- 78.7% 1.8% 76.8% 54.7% 71.4% 85.5% 95% 91.8 86.9 95% 90.4 91.4% 87.7%	None relating to children	NONE	NONE

Appendix E: Findings from EQRO Validation Studies

States	State Specified Performance Measures	Findings and Follow-up	Performance Improvement Projects Reported	Validation Issues	Status of Health Information Technology Assessment
MA	1) Appropriate Treatment for Children with URI 2) Childhood Immunization Status 3) Well-Child Visits in the First 15 Months of Life 4) Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life 5) Adolescent Well-Care Visits 6) Children and Adolescents' Access to Primary Care Physicians 7) Use of Appropriate Medications for People with Asthma 8) Follow-up After Hospitalization for mental illness (age 6 years and older)	90.6% Combo 2-81.2% Combo 3- 76.8% 6+ Visits: 81.1% 84.5% 61.1% 6a) Ages 12 to 24 Months: 97.3% 6b) Ages 25 Months to 6 Years: 93.5% 6c) Ages 7 to 11 Years: 97% 6d) Ages 12 to 19 Years: 94.7% 7a) Ages 5 to 9 Years: 94.4% 7b) Ages 10 to 17 Years: 90.8% 8a) 7 – Day: 55.9% 8b) 30 Day: 75.8%	Increasing Well Child Visits Three of the four plans that engaged in the well-child visit project provided evidence of improvement for the well-child project; however, such improvement was not statistically significant across all the well-child measures.	The EQRO confirmed the methods and techniques for calculating performance measures for five plans. The EQRO was able to confirm the appropriate methods and implementation for three of the four plans conducting the well-child PIP. The fourth plan had a opportunities to improve indicator definitions, analysis plans and the examination of barriers to implementation.	MCOs continued their strong processes related to their respective information technology infrastructures and documented data warehouses. Three MCOs have recently completed or are in the process of upgrading to new core systems—a demonstration of MCOs' commitment to continued investment in integrity of data and updated technology

Appendix E: Findings from EQRO Validation Studies

States	State Specified Performance Measures	Findings and Follow-up	Performance Improvement Projects Reported	Validation Issues	Status of Health Information Technology Assessment
MI	1) Childhood Immunization Status 2) Lead Screening 3) Well Child Visits 1st 15 Months 4) Adolescent Well Care Visits 5) Appropriate Treatment for Children w/ URI 6) Appropriate Testing for Children w/ Pharyngitis 7) Use of Appropriate Medication for People w/ Asthma 8) Children's Access to PCP- 24 mos to 6 yrs 9) Adolescent Access to PCP- 12 to 19 yrs	Combo 2- 81.8% Combo 3- 74.7% 76.3% 98.7% 54.3% 81.2% 48% 5-9 yrs- 90.4% 10-17 yrs- 86% 86.8% 84.6%	NONE	NONE	NONE

Appendix E: Findings from EQRO Validation Studies

States	State Specified Performance Measures	Findings and Follow-up	Performance Improvement Projects Reported	Validation Issues	Status of Health Information Technology Assessment
MN	1) Adolescent Well Visits 2) Childhood Immunization 3) Child Access to PCP- 24 mos to 6 yrs 4) Adolescent Access to PCP- 12 to 19 yrs 5) Well Child Visits 1st 15 Months- 6+ Visits 6) Well Child Visit- 3 to 6 yrs	36.3% Combo 2- 65.4% Combo 3- 61.7% 92.8% 91.9% 50.1% 65.4%	1) Improving rates of HPV immunization- ages 11-12 2) Improving Asthma Management and Treatment in HealthPartners' PMAP Population – Ages 5 – 17 3) Improving Self-Management of Asthma in Child Members – Ages 3 – 21 4) Interventions to Improve Blood Lead Screening at 24 Months Lead Screening – Age 24 Months	Administrative data was used to evaluate the PMs, therefore the actual rates for MCOs maybe higher than in the summarized report	NONE
MS	Not required				

Appendix E: Findings from EQRO Validation Studies

States	State Specified Performance Measures	Findings and Follow-up	Performance Improvement Projects Reported	Validation Issues	Status of Health Information Technology Assessment
MO	1) Adolescent Well-Care- 2) Annual Dental Visit-	38.59% 34.71% Other Findings: - Overall compliance with regs-90.8% - Opportunity to improve in coordination of care	1) Improving Adolescent well Care 2) Improving Annual Dental Visit 3) Improving Well Child Visits 4) Improving Lead Screening	1) PM- substantially valid 2) PIPs only moderate confidence, sampling and data collection errors. Insufficient data to trend	NONE
MT	Not required				
NE	1) Childhood Immunization Status (3) 2) Well Child Visits (6 or more) 3) Well Child visits (3-6) 4) Adolescent Well Care- 5) Access to PCP (12-19)-	66.1% 64.88% 59.75% 52.07% 91.22% Other Findings: - Consider Adolescent Immunization PIP - Weaknesses in QI-no evidence of root cause analyses	1) Well Child 15 mos.- met 2) Childhood Immunizations (2)- met	Generally valid, but some samples are too small for 95% confidence	1) Good Administrative HIT systems, but little EHR progress 2) No evidence of effective collection of encounter data

Appendix E: Findings from EQRO Validation Studies

States	State Specified Performance Measures	Findings and Follow-up	Performance Improvement Projects Reported	Validation Issues	Status of Health Information Technology Assessment
NV	1) Childhood Immunization Status (3) 2) Access to PCP (12-19) 3) Well Child (3-6) 4) Adolescent well Care 5) Annual Dental Visit 6) 6) Lead Screening	59.6% - 77.2% 62% 37.2% 55.0% 21.9% Other Findings: Overall compliance-99%, grievance and complaint process needs improvement	1) Improving Immunization Rates under 2 Yrs.-met 2) Lead Screening in Children-met	New MCO Amerigroup has insufficient data. Other MCO (HPN) data is valid with exception of HIFA pregnant population where sample size is too small	Successful e-prescribing project and good benchmarking process with NCQA data.
NH	Not required				
NJ	1) Childhood Immunization Status (2) 2) Well Child Visit 15 mos. (6 visits or more)- 3) Well-Child Visit (3-6) 4) Adolescent Well Care 5) Access to PCP (12-19) 6) Lead screening	74.62% 66.76% 77.99% 59.25% 83% 80%	1) Annual Dental Visit-met 2) Age appropriate EPSDT visits-met	NONE- except one MCO used inadequate sample size.	NONE

Appendix E: Findings from EQRO Validation Studies

States	State Specified Performance Measures	Findings and Follow-up	Performance Improvement Projects Reported	Validation Issues	Status of Health Information Technology Assessment
NM	PMs validated, but numbers not provided- 1) Childhood Immunization Status (2) 2) Annual Dental Visits 3) Well Child Visits-15 mos. 4) Well-Child Visits (3-6) 5) Use of appropriate meds in children with asthma 6) Children's Access to PCP (12-19)	Compliance review-all MCOs in full compliance	1) Childhood Immunization Status-met 2) Annual Dental Visit-met	1) PM Validation-5 of 6 measures valid 2) PIP Validation- valid	Because all of NM's contracted Medicaid physical health MCOs are accredited by NCQA, validation of all PMs occurs through annual HEDIS® audits, with EQR oversight of the process rather than the actual data.

Appendix E: Findings from EQRO Validation Studies

States	State Specified Performance Measures	Findings and Follow-up	Performance Improvement Projects Reported	Validation Issues	Status of Health Information Technology Assessment
NY	1) Annual Dental Visit 2) Access to PCP 12-24 months 3) Access to PCP 25-months to six years 4) Access to PCP 7-11 years 5) Access to PCP 12-19 years 6) Follow-up for ADHD Medication- Initiation 7) Follow-up for ADHD Medication-Continuation 8) Use of appropriate asthma medication 5-17 9) Appropriate Testing for Pharyngitis 10) Appropriate treatment for URI 11) Weight Assessment 3-17 12) Weight Counseling for nutrition 13) Weight Counseling for Physical Activity	48% 95% 94% 90% 90% 54% 61% 92% 81% 89% 43% 57% 43% Other findings: Compliant in 10 of 14 categories. Opportunities for Improvement: more root cause analysis, more concurrent review, improve MH access, improve accuracy of provider directory, shorten delays in authorization process	All plans were compliant with conducting Performance Improvement Projects; plans participated in a learning collaborative to improve ADHD diagnosis and follow-up. Other plan topics included adolescent care, depression, lead, women's health and satisfaction.	NONE	NONE

Appendix E: Findings from EQRO Validation Studies

States	State Specified Performance Measures	Findings and Follow-up	Performance Improvement Projects Reported	Validation Issues	Status of Health Information Technology Assessment
NC	NONE (NC has only 1 PIHP that does MH/SA and MRDD only)	No separate child measures	NONE	NONE	Adequate HIT for business purposes, but not able to track and trend quality data.
ND	Not required				
OH	1) Childhood Immunization Status - Combo #2 2) Childhood Immunization Status – Combo #3 3) 2) Adolescent Immunization	67.8% 57.9% 47.2% Overall Finding: No major issues	1) Identifying Children with special health needs- met 2) Well Child Visits -15 mos.- met 3) Annual Dental Visit-met 4) Blood Lead Testing- met	NONE	NONE
OK	Not required				

Appendix E: Findings from EQRO Validation Studies

States	State Specified Performance Measures	Findings and Follow-up	Performance Improvement Projects Reported	Validation Issues	Status of Health Information Technology Assessment
OR	1) Childhood Immunization Status 2) Asthma Care for Children Ages 4-8 years and 9-16 years 1) ED Visits with primary diagnosis of Asthma for Children with Asthma 2) Follow up Outpatient Visit within 30 days after an ED Visit for Asthma 3) Children with Persistent Asthma who had at least one Controller Medicine Dispensing 4) Children with Persistent Asthma who had more than 6 Rescue Medicine Dispensing 5) Children with Persistent Asthma who had more than 6 Rescue Medicine Canisters	Summary findings - No data reported for measure, only that the process was valid Other findings: 1) Substantial compliance with CMS regulations by all MCOs 2) Need to train MCOs on use of Oregon priority list 3) Many MCOs need new policies on second opinions, seclusion and restraint, subcontracting, and advance directives	1) Follow up Outpatient Visit within 30 days after an ED Visit for Asthma 2) Asthma Medication Ratio for Members with Persistent Asthma	NONE (for pediatric issues)	New MMIS System has programming issues that have delayed claims processing. Encounter data is incomplete.

Appendix E: Findings from EQRO Validation Studies

States	State Specified Performance Measures	Findings and Follow-up	Performance Improvement Projects Reported	Validation Issues	Status of Health Information Technology Assessment
PA	1) Access to PCP (12-19) 2) Well-Child 15 mos.- 3) Childhood Immunization Status (3) 4) Adolescent Well Care 5) Annual BMI (2-20) 6) Lead Screening 7) Annual Dental Visits	86% 93% 74% 58% 65% 72% 42% Other findings: -Need to improve prenatal visits received- help with reminders, transportation and surveys - Reduce unnecessary ER Visits- Add off –hour clinics	1) Increasing Dental Utilization for children 2) Coordination between mental health and physical health care	NONE	NONE

Appendix E: Findings from EQRO Validation Studies

States	State Specified Performance Measures	Findings and Follow-up	Performance Improvement Projects Reported	Validation Issues	Status of Health Information Technology Assessment
PR	1) Childhood Immunizations 2) Appropriate Treatment for Children with Asthma- (5-17) 3) Annual Dental Visit 4) Well Child 15 mos.- 0 visit 1 visit 2 visits 3 visits 4 visits 5 visits 6 visits 5) Follow-up on children on ADHD medication 6) Well Child visit 3-6 7) Children Access to PCP 12-24 months 25 months-6 years 7-11 years 12-19 years	64.5% 52.2% 50.5% 65.6% 24.3% 10.5% 5.4% 2.9% 1.6% 2.2% 29.2%% 24.4 % 69.9% 59.5% 65.3 % 57.1% Other finding: - Need for improved handling of grievances and better documentation	NONE	1) some sampling error in PIPs, but high confidence in PMs	NONE

Appendix E: Findings from EQRO Validation Studies

States	State Specified Performance Measures	Findings and Follow-up	Performance Improvement Projects Reported	Validation Issues	Status of Health Information Technology Assessment
RI	1) Childhood Immunizations 2 2) Lead Screening 3) Children's access to PCPs-(12-19) 4) Follow-up care for children on ADHD meds 5) Well Child Visit -15 mos. 6) Well Child Visit (3-6) 7) Adolescent well care 8) Children's access to PCPs 12-24 months 9) Children's access to PCPs 25 months-six years 10) Children's access to PCPs (7-11)	79% 87% 91% 46% 82% 78% 57% 99% 92% 95% Other finding: Some credentialing issues on verification of Board Certification, but overall performance very good	1) Asthma Management 2) Childhood Immunization	NONE	With regard to the status of health information technology assessment, each of the Health Plan-specific EQRs addresses how the Health Plans use information systems in conducting their HEDIS® measures. Each of the Plans also uses GeoAccess for monitoring purposes. To give additional examples, the Health Plan-specific EQR reports provide details about how the Plans use technology, such as TeleVox® to outreach to their members, and data systems for care management functions. All of the RIte Care Health Plans work collaboratively with the RI Department of Health's KIDSNET Immunization Registry, so that the Plans can outreach to the families of 18-month olds who appear to be under-immunized. There is also an annual data exchange from KIDSNET to each MCO, as each Health Plan collects data each Spring for its Childhood Immunization Status (CIS) HEDIS® measurement.

Appendix E: Findings from EQRO Validation Studies

States	State Specified Performance Measures	Findings and Follow-up	Performance Improvement Projects Reported	Validation Issues	Status of Health Information Technology Assessment
SC	NONE (for children)	Need to develop documentation policy.	NONE (for children)	NONE	NONE
SD	Not required				
TN	1) Childhood Immunization Status (3) 2) Appropriate testing of children with pharyngitis 3) Appropriate treatment for children with URI 4) Use of appropriate meds for children with asthma 5) Children's access to PCP (12-19) 6) Lead Screening 7) Well Child (3-6) 8) Adolescent Well Care	72.6% 69.52% 75.06% 94.29% 80.95% 59.76% 60.79% 35.77%	NONE	NONE	NONE

Appendix E: Findings from EQRO Validation Studies

States	State Specified Performance Measures	Findings and Follow-up	Performance Improvement Projects Reported	Validation Issues	Status of Health Information Technology Assessment
TX	1) Well-Child 15 mos. 2) Well-Child 3-6 3) Adolescent Well Care 4) Children's Access to PCP 5) Pediatric inpatient stays for gastroenteritis- 6) Appropriate Testing for Children with Pharyngitis	48% 71% 51% 93% 146/100,000 population 46% Other Finding: Excessive pediatric hospitalizations for asthma , gastroenteritis, and urinary infections apparently due to poor doctor to parent communication	1) Well-Child 15 mos. is 5% below national average- do PIP 2) Appropriate care for children with Pharyngitis is 12% below national average –do PIP	NONE	NONE

Appendix E: Findings from EQRO Validation Studies

States	State Specified Performance Measures	Findings and Follow-up	Performance Improvement Projects Reported	Validation Issues	Status of Health Information Technology Assessment
UT	1) Childhood Immunizations- 2) Well-Child 3-6 3) Well-Care 12-21 4) Pharyngitis appropriate care in children (2-18) 5) Appropriate use of asthma meds-children-(10-17)	75.7% 65.1% 46.3% 82.8% 85.2%	1) Coordinating care between mental health and physical health providers-shows improvement The care coordination PIP was the only PIP which required EQRO validation and which was in the EQR; however, each Medicaid health plan is required to conduct more than one PIP. UT requires a range of clinical and non-clinical PIPs, appropriate for the size of the plan, which they report to UDOH annually.	NONE	UDOH requires each health plan to submit only data that has been audited by an NCQA certified auditor. The audit includes the IS systems assessment and in the EQR reports it States that report is available on request.

Appendix E: Findings from EQRO Validation Studies

States	State Specified Performance Measures	Findings and Follow-up	Performance Improvement Projects Reported	Validation Issues	Status of Health Information Technology Assessment
VT	1) Well-Child15 mos. 2) Well-Child 3-6 yrs. 3) Annual Dental Visits 4) Children's Access to PCP- (12-21) 5) Adolescent Well Care 6) Lead-Screening	39.4% 74.08% 65.2% 92.31% 47.02% 87.53%	1) Early Identification of children's health needs- met goal	1) State uncertain that the Well-Child 15 months measure is valid	MMIS audits showed 100% accuracy
VA	1) Childhood Immunization Status (3)- 2) Well-Child 15 mos. 3) Well-Child 3-6 yrs. 4) Adolescent well care 5) Lead Screening- 6) Appropriate use asthma meds-children	69% 59.6% 69.4% 42.1% 51.9% 92.2% Other Finding: - Do root Cause Analysis where not meeting HEDIS® Medicaid national average	1) Childhood Immunization Status- shows improvement 2) Well-Child 15 mos.-shows improvement	NONE	NONE

Appendix E: Findings from EQRO Validation Studies

States	State Specified Performance Measures	Findings and Follow-up	Performance Improvement Projects Reported	Validation Issues	Status of Health Information Technology Assessment
WA	1) Adolescent Well-Care 2) Childhood Immunization Status (HEDIS Combo 2) 3) WC Visits-15 mos. (6 or more visits) 4) WC Visits 3-6	State Average: 37.23% State Average: 71.37% State Average: 57.05% State Average: 59.91% Other Finding: State needs to integrate separate Mental Health and Physical Health Quality strategies	Contract Requirement: Required performance improvement project for childhood immunizations if performance <75% for Combo 2. Required performance improvement project if any well-child care sub-measure <60%.	NONE	NONE

Appendix E: Findings from EQRO Validation Studies

States	State Specified Performance Measures	Findings and Follow-up	Performance Improvement Projects Reported	Validation Issues	Status of Health Information Technology Assessment
WV	1) Childhood Immunization Status- 2) Access to PCP- (12-19) 3) WC Visits-15 mos. 4) WC Visits 3-6 5) Adolescent Well-Care	68% 70.9% 70.6% 67.6% 45% Other Finding: No root-cause analysis in PIPs	1) Childhood Immunization 2) Well-Child Care 3) Adolescent Immunizations	NONE	Multiple HIT Transformation Grants

Appendix E: Findings from EQRO Validation Studies

States	State Specified Performance Measures	Findings and Follow-up	Performance Improvement Projects Reported	Validation Issues	Status of Health Information Technology Assessment
WI	1) Childhood immunization status 2) Lead screening in one year olds 3) Lead screening in 2 year olds 4) Appropriate testing for children with pharyngitis 5) Appropriate treatment for children with upper respiratory infection 6) Appropriate medication for children with asthma 7) Follow-up care children prescribed ADHD medication 8) Seven and thirty day follow-up after hospitalization for mental illness 9) Annual monitoring for patients on persistent medications 10) Annual dental visits 11) Mental health utilization 12) Tobacco cessation 13) Identification of Alcohol and Other Drug Abuse Services	No measures data reported Specific EQRO review comments included: - No MCO record of languages spoken by patient -No encryption of email - Required Federal restraint practices not followed - Plan of correction	1) Immunizations by age 2 2) BLL screening 1 and 2 yr. olds 3) Post-natal Care 4) EPSDT 5) Beneficiary engagement in mental health services to prevent readmission 6) Healthy birth outcomes 7) Tobacco cessation 8) Crisis plan 9) Diabetic testing HbA1c and LDL 10) Diabetes eye care 11) Emergency room utilization	NONE	Quality Dashboard on Website

Appendix E: Findings from EQRO Validation Studies

States	State Specified Performance Measures	Findings and Follow-up	Performance Improvement Projects Reported	Validation Issues	Status of Health Information Technology Assessment
WY	Not required				

Appendix E: Findings from EQRO Validation Studies

Appendix F:
TITLE IV—STRENGTHENING QUALITY OF CARE AND HEALTH OUTCOMES

SEC. 401. CHILD HEALTH QUALITY IMPROVEMENT ACTIVITIES FOR CHILDREN ENROLLED IN MEDICAID OR CHIP.

(a) DEVELOPMENT OF CHILD HEALTH QUALITY MEASURES FOR CHILDREN ENROLLED IN MEDICAID OR CHIP.—Title XI (42 U.S.C. 1301 et seq.) is amended by inserting after section 1139 the following new section: SEC. 1139A. CHILD HEALTH QUALITY MEASURES.

(a) DEVELOPMENT OF AN INITIAL CORE SET OF HEALTH CARE QUALITY MEASURES FOR CHILDREN ENROLLED IN MEDICAID OR CHIP.

(1) IN GENERAL.—Not later than January 1, 2010, the Secretary shall identify and publish for general comment an initial, recommended core set of child health quality measures for use by State programs administered under titles XIX and XXI, health insurance issuers and managed care entities that enter into contracts with such programs, and providers of items and services under such programs.

(2) IDENTIFICATION OF INITIAL CORE MEASURES.—In consultation with the individuals and entities described in subsection (b)(3), the Secretary shall identify existing quality of care measures for children that are in use under public and privately sponsored health care coverage arrangements, or that are part of reporting systems that measure both the presence and duration of health insurance coverage over time.

(3) RECOMMENDATIONS AND DISSEMINATION.—Based on such existing and identified measures, the Secretary shall publish an initial core set of child health quality measures that includes (but is not limited to) the following:

(A) The duration of children's health insurance coverage over a 12-month time period.

(B) The availability and effectiveness of a full range of—

(i) preventive services, treatments, and services for acute conditions, including services to promote healthy birth, prevent and treat premature birth, and detect the presence or risk of physical or mental conditions that could adversely affect growth and development; and

(ii) treatments to correct or ameliorate the effects of physical and mental conditions, including chronic conditions, in infants, young children, school-age children, and adolescents.

(C) The availability of care in a range of ambulatory and inpatient health care settings in which such care is furnished.

(D) The types of measures that, taken together, can be used to estimate the overall national quality of health care for children, including children with special needs, and to perform comparative analyses of pediatric health Publication.

(4) ENCOURAGE VOLUNTARY AND STANDARDIZED REPORTING.—Not later than 2 years after the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2009, the Secretary, in consultation with States, shall develop

a standardized format for reporting information and procedures and approaches that encourage States to use the initial core measurement set to voluntarily report information regarding the quality of pediatric health care under titles XIX and XXI.

(5) ADOPTION OF BEST PRACTICES IN IMPLEMENTING QUALITY PROGRAMS.— The Secretary shall disseminate information to States regarding best practices among States with respect to measuring and reporting on the quality of health care for children, and shall facilitate the adoption of such best practices. In developing best practices approaches, the Secretary shall give particular attention to State measurement techniques that ensure the timeliness and accuracy of provider reporting, encourage provider reporting compliance, encourage successful quality improvement strategies, and improve efficiency in data collection using health information technology.

(6) REPORTS TO CONGRESS.—Not later than January 1, 2011, and every 3 years thereafter, the Secretary shall report to Congress on—

(A) the status of the Secretary's efforts to improve—

(i) quality related to the duration and stability of health insurance coverage for children under titles XIX and XXI;

(ii) the quality of children's health care under such titles, including preventive health services, health care for acute conditions, chronic health care, and health services to ameliorate the effects of physical and mental conditions and to aid in growth and development of infants, young children, school-age children, and adolescents with special health care needs; and

(iii) the quality of children's health care under such titles across the domains of quality, including clinical quality, health care safety, family experience with health care, health care in the most integrated setting, and elimination of racial, ethnic, and socioeconomic disparities in health and health care;

(B) the status of voluntary reporting by States under titles XIX and XXI, utilizing the initial core quality measurement set; and

(C) any recommendations for legislative changes needed to improve the quality of care provided to children under titles XIX and XXI, including recommendations for quality reporting by States.

(7) TECHNICAL ASSISTANCE. The Secretary shall provide technical assistance to States to assist them in adopting and utilizing core child health quality measures in administering the State plans under titles XIX and XXI.

(8) DEFINITION OF CORE SET. In this section, the term 'core set' means a group of valid, reliable, and evidence-based quality measures that, taken together—

(A) provide information regarding the quality of health coverage and health care for children;

(B) address the needs of children throughout the developmental age span; and

(C) allow purchasers, families, and health care providers to understand the quality of care in relation to the preventive needs of children, treatments aimed at managing and resolving acute conditions, and diagnostic and treatment services whose purpose is to correct or ameliorate physical, mental, or developmental conditions that could, if untreated or poorly treated, become chronic.

Appendix E: Findings from EQRO Validation Studies

(b) ADVANCING AND IMPROVING PEDIATRIC QUALITY MEASURES.—

(1) ESTABLISHMENT OF PEDIATRIC QUALITY MEASURES PROGRAM.— Not later than January 1, 2011, the Secretary shall establish a pediatric quality measures program to—

(A) improve and strengthen the initial core child health care quality measures established by the Secretary under subsection (a);

(B) expand on existing pediatric quality measures used by public and private health care purchasers and advance the development of such new and emerging quality measures; and

(C) increase the portfolio of evidence-based, consensus pediatric quality measures available to public and private purchasers of children's health care services, providers, and consumers.

(2) EVIDENCE-BASED MEASURES.—The measures developed under the pediatric quality measures program shall, at a minimum, be—

(A) evidence-based and, where appropriate, risk adjusted;

(B) designed to identify and eliminate racial and ethnic disparities in child health and the provision of health care;

(C) designed to ensure that the data required for such measures is collected and reported in a standard format that permits comparison of quality and data at a State, plan, and provider level;

(D) periodically updated; and

(E) responsive to the child health needs, services, and domains of health care quality described in clauses

(3) PROCESS FOR PEDIATRIC QUALITY MEASURES PROGRAM.— In identifying gaps in existing pediatric quality measures and establishing priorities for development and advancement of such measures, the Secretary shall consult with—

(A) States;

(B) pediatricians, children's hospitals, and other primary and specialized pediatric health care professionals (including members of the allied health professions) who specialize in the care and treatment of children, particularly children with special physical, mental, and developmental health care needs;

(C) dental professionals, including pediatric dental professionals;

(D) health care providers that furnish primary health care to children and families who live in urban and rural medically underserved communities or who are members of distinct population sub-groups at heightened risk for poor health outcomes;

(E) national organizations representing children, including children with disabilities and children with chronic conditions;

(F) national organizations representing consumers and purchasers of children's health care;

(G) national organizations and individuals with expertise in pediatric health quality measurement; and

(H) voluntary consensus standards setting organizations and other organizations involved in the advancement of evidence-based measures of health care.

(4) DEVELOPING, VALIDATING, AND TESTING A PORTFOLIO OF PEDIATRIC QUALITY MEASURES.— As part of the program to advance pediatric quality measures, the Secretary shall—

(A) award grants and contracts for the development, testing, and validation of new, emerging, and innovative evidence-based measures for children's health care services across the domains of quality described in clauses (i), (ii), and (iii) of subsection (a)(6)(A); and

(B) award grants and contracts for—

(i) the development of consensus on evidence based measures for children's health care services;

(ii) the dissemination of such measures to public and private purchasers of health care for children; and

(iii) the updating of such measures as necessary.

(5) REVISING, STRENGTHENING, AND IMPROVING INITIAL CORE MEASURES.— Beginning no later than January 1, 2013, and annually thereafter, the Secretary shall publish recommended changes to the core measures described in subsection (a) that shall reflect the testing, validation, and consensus process for the development of pediatric quality measures described in subsection paragraphs (1) through (4).

(6) DEFINITION OF PEDIATRIC QUALITY MEASURE. — In this subsection, the term 'pediatric quality measure' means a measurement of clinical care that is capable of being examined through the collection and analysis of relevant information, that is developed in order to assess 1 or more aspects of pediatric health care quality in various institutional and ambulatory health care settings, including the structure of the clinical care system, the process of care, the outcome of care, or patient experiences in care.

(7) CONSTRUCTION.—Nothing in this section shall be construed as supporting the restriction of coverage, under title XIX or XXI or otherwise, to only those services that are evidence- based.

(c) ANNUAL STATE REPORTS REGARDING STATE-SPECIFIC QUALITY OF CARE MEASURES APPLIED UNDER MEDICAID OR CHIP.—

(1) ANNUAL STATE REPORTS.—Each State with a State plan approved under title XIX or a State child health plan approved under title XXI shall annually report to the Secretary on the—

(A) State-specific child health quality measures applied by the States under such plans, including measures described in subparagraphs (A) and (B) of subsection (a)(6); and

(B) State-specific information on the quality of health care furnished to children under such plans, including information collected through external quality reviews of managed care organizations under section 1932 of the Social Security Act (42 U.S.C. 1396u–4) and benchmark plans under sections 1937 and 2103 of such Act (42 U.S.C. 1396u–7, 1397cc).

(2) PUBLICATION.—Not later than September 30, 2010, and annually thereafter, the Secretary shall collect, analyze, and make publicly available the information reported by States under paragraph (1).

(d) DEMONSTRATION PROJECTS FOR IMPROVING THE QUALITY OF CHILDREN'S HEALTH CARE AND THE USE OF HEALTH INFORMATION TECHNOLOGY.—

(1) IN GENERAL. During the period of fiscal years 2009 through 2013, the Secretary shall award not more than 10 grants to States and child health providers to conduct demonstration projects to evaluate promising ideas for improving the quality of children's health care provided under title XIX or XXI, including projects to—

(A) experiment with, and evaluate the use of, new measures of the quality of children's health care under such titles (including testing the validity and suitability for reporting of such measures);

(B) promote the use of health information technology in care delivery for children under such titles;

(C) evaluate provider-based models which improve the delivery of children's health care services under such titles, including care management for children with chronic conditions and the use of evidence-based approaches to improve the effectiveness, safety, and efficiency of health care services for children; or

(D) demonstrate the impact of the model electronic health record format for children developed and disseminated under subsection (f) on improving pediatric health,including the effects of chronic childhood health conditions, and pediatric health care quality as well as reducing health care costs.

(2) REQUIREMENTS.—In awarding grants under this subsection, the Secretary shall ensure that—

(A) only 1 demonstration project funded under a grant awarded under this subsection shall be conducted in a State; and

(B) demonstration projects funded under grants awarded under this subsection shall be conducted evenly between States with large urban areas and States with large rural areas.

(3) AUTHORITY FOR MULTISTATE PROJECTS.—A demonstration project conducted with a grant awarded under this subsection may be conducted on a multistate basis, as needed.

(4) FUNDING.—$20,000,000 of the amount appropriated under subsection (i) for a fiscal year shall be used to carry out this subsection.

(e) CHILDHOOD OBESITY DEMONSTRATION PROJECT.

(1) AUTHORITY TO CONDUCT DEMONSTRATION.—The Secretary, in consultation with the Administrator of the Centers for Medicare & Medicaid Services, shall conduct a demonstration project to develop a comprehensive and systematic model for reducing childhood obesity by awarding grants to eligible entities to carry out such project. Such model shall—

(A) identify, through self-assessment, behavioral risk factors for obesity among children;

(B) identify, through self-assessment, needed clinical preventive and screening benefits among those children identified as target individuals on the basis of such risk factors;

(C) provide ongoing support to such target individuals and their families to reduce risk factors and promote the appropriate use of preventive and screening benefits; and

(D) be designed to improve health outcomes, satisfaction, quality of life, and appropriate use of items and services for which medical assistance is available under title XIX or child health assistance is available under title XXI among such target individuals.

(2) ELIGIBILITY ENTITIES.—For purposes of this subsection, an eligible entity is any of the following:

(A) A city, county, or Indian tribe.

(B) A local or tribal educational agency.

(C) An accredited university, college, or community college.

(D) A federally-qualified health center.

(E) A local health department.

(F) A health care provider.

(G) A community-based organization.

(H) Any other entity determined appropriate by the Secretary, including a consortia or partnership of entities described in any of subparagraphs (A) through (G).

(3) USE OF FUNDS.—An eligible entity awarded a grant under this subsection shall use the funds made available under the grant to—

(A) carry out community-based activities related to reducing childhood obesity, including by—

(i) forming partnerships with entities, including schools and other facilities providing recreational services, to establish programs for after school and weekend community activities that are designed to reduce childhood obesity;

(ii) forming partnerships with daycare facilities to establish programs that promote healthy eating behaviors and physical activity; and

(iii) developing and evaluating community educational activities targeting good nutrition and promoting healthy eating behaviors;

(B) carry out age-appropriate school-based activities that are designed to reduce childhood obesity, including by—

(i) developing and testing educational curricula and intervention programs designed to promote healthy eating behaviors and habits in youth, which may include—

(I) after hours physical activity programs; and

(II) science-based interventions with multiple components to prevent eating disorders including nutritional content, understanding and responding to hunger and satiety, positive body image development, positive self-esteem development, and learning life skills (such as stress management, communication skills, problem solving and decision making skills), as well as consideration of cultural and developmental issues, and the role of family, school, and community;

(ii) providing education and training to educational professionals regarding how to promote a healthy lifestyle and a healthy school environment for children;
(iii) planning and implementing a healthy lifestyle curriculum or program with an emphasis on healthy eating behaviors and physical activity; and
(iv) planning and implementing healthy lifestyle classes or programs for parents or guardians, with an emphasis on healthy eating behaviors and physical activity for children; (C) carry out educational, counseling, promotional, and training activities through the local health care delivery systems including by—
(i) promoting healthy eating behaviors and physical activity services to treat or prevent eating disorders, being overweight, and obesity;
(ii) providing patient education and counseling to increase physical activity and promote healthy eating behaviors;
(iii) training health professionals on how to identify and treat obese and overweight individuals which may include nutrition and physical activity counseling; and
(iv) providing community education by a health professional on good nutrition and physical activity to develop a better understanding of the relationship between diet, physical activity, and eating disorders, obesity, or being overweight; and

(D) provide, through qualified health professionals, training and supervision for community health workers to—
(i) educate families regarding the relationship between nutrition, eating habits, physical activity, and obesity;
(ii) educate families about effective strategies to improve nutrition, establish healthy eating patterns, and establish appropriate levels of physical activity; and
(iii) educate and guide parents regarding the ability to model and communicate positive health behaviors.

(4) PRIORITY.—In awarding grants under paragraph (1), the Secretary shall give priority to awarding grants to eligible entities—
(A) that demonstrate that they have previously applied successfully for funds to carry out activities that seek to promote individual and community health and to prevent the incidence of chronic disease and that can cite published and peer-reviewed research demonstrating that the activities that the entities propose to carry out with funds made available under the grant are effective;
(B) that will carry out programs or activities that seek to accomplish a goal or goals set by the State in the Healthy People 2010 plan of the State;
(C) that provide non-Federal contributions, either in cash or in-kind, to the costs of funding activities under the grants;
(D) that develop comprehensive plans that include a strategy for extending program activities developed under grants in the years following the fiscal years for which they receive grants under this subsection;
(E) located in communities that are medically underserved, as determined by the Secretary;

(F) located in areas in which the average poverty rate is at least 150 percent or higher of the average poverty rate in the State involved, as determined by the Secretary; and

(G) that submit plans that exhibit multisectoral, cooperative conduct that includes the involvement of a broad range of stakeholders, including—

(i) community-based organizations;
(ii) local governments;
(iii) local educational agencies;
(iv) the private sector;
(v) State or local departments of health;
(vi) accredited colleges, universities, and community colleges;
(vii) health care providers;
(viii) State and local departments of transportation and city planning; and
(ix) other entities determined appropriate by the Secretary.

(5) PROGRAM DESIGN.—

(A) INITIAL DESIGN.—Not later than 1 year after the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2009, the Secretary shall design the demonstration project. The demonstration should draw upon promising, innovative models and incentives to reduce behavioral risk factors. The Administrator of the Centers for Medicare & Medicaid Services shall consult with the Director of the Centers for Disease Control and Prevention, the Director of the Office of Minority Health, the heads of other agencies in the Department of Health and Human Services, and such professional organizations, as the Secretary determines to be appropriate, on the design, conduct, and evaluation of the demonstration.

(B) NUMBER AND PROJECT AREAS.—Not later than 2 years after the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2009, the Secretary shall award 1 grant that is specifically designed to determine whether programs similar to programs to be conducted by other grantees under this subsection should be implemented with respect to the general population of children who are eligible for child health assistance under State child health plans under title XXI in order to reduce the incidence of childhood obesity among such population.

(6) REPORT TO CONGRESS.—Not later than 3 years after the date the Secretary implements the demonstration project under this subsection, the Secretary shall submit to Congress a report that describes the project, evaluates the effectiveness and cost effectiveness of the project, evaluates the beneficiary satisfaction under the project, and includes any such other information as the Secretary determines to be appropriate.

(7) DEFINITIONS.—In this subsection:

(A) FEDERALLY-QUALIFIED HEALTH CENTER.—The term 'federally-qualified health center' has the meaning given that term in section 1905(l)(2)(B).

(B) INDIAN TRIBE.—The term 'Indian tribe' has the meaning given that term in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

(C) SELF-ASSESSMENT.—The term 'self-assessment' means a form that—

(i) includes questions regarding—

(I) behavioral risk factors;
(II) needed preventive and screening services; and
(III) target individuals' preferences for receiving follow-up information;

(ii) is assessed using such computer generated assessment programs; and
(iii) allows for the provision of such ongoing support to the individual as the Secretary determines appropriate.

(D) ONGOING SUPPORT.—The term 'ongoing support' means—
(i) to provide any target individual with information, feedback, health coaching, and recommendations regarding—
(I) the results of a self-assessment given to the individual;
(II) behavior modification based on the self assessment; and
(III) any need for clinical preventive and screening services or treatment including medical nutrition therapy;
(ii) to provide any target individual with referrals to community resources and programs available to assist the target individual in reducing health risks; and
(iii) to provide the information described in clause (i) to a health care provider, if designated by the target individual to receive such information.

(8) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection, $25,000,000 for the period of fiscal years 2009 through 2013.

(f) DEVELOPMENT OF MODEL ELECTRONIC HEALTH RECORD FORMAT FOR CHILDREN ENROLLED IN MEDICAID OR CHIP.

(1) IN GENERAL.—Not later than January 1, 2010, the Secretary shall establish a program to encourage the development and dissemination of a model electronic health record format for children enrolled in the State plan under title XIX or the State child health plan under title XXI that is—
(A) subject to State laws, accessible to parents, caregivers, and other consumers for the sole purpose of demonstrating compliance with school or leisure activity requirements, such as appropriate immunizations or physicals;
(B) designed to allow interoperable exchanges that conform with Federal and State privacy and security requirements;
(C) structured in a manner that permits parents and caregivers to view and understand the extent to which the care their children receive is clinically appropriate and of high quality; and
(D) capable of being incorporated into, and otherwise compatible with, other standards developed for electronic health records.

(2) FUNDING.—$5,000,000 of the amount appropriated under subsection (i) for a fiscal year shall be used to carry out this subsection.

(g) STUDY OF PEDIATRIC HEALTH AND HEALTH CARE QUALITY MEASURES.

(1) IN GENERAL.—Not later than July 1, 2010, the Institute of Medicine shall study and report to Congress on the extent and quality of efforts to measure child health status and the quality of health care for children across the age span and in relation to

preventive care, treatments for acute conditions, and treatments aimed at ameliorating or correcting physical, mental, and developmental conditions in children. In conducting such study and preparing such report, the Institute of Medicine shall—

(A) consider all of the major national population-based reporting systems sponsored by the Federal Government that are currently in place, including reporting requirements under Federal grant programs and national population surveys and estimates conducted directly by the Federal Government;

(B) identify the information regarding child health and health care quality that each system is designed to capture and generate, the study and reporting periods covered by each system, and the extent to which the information so generated is made widely available through publication;

(C) identify gaps in knowledge related to children's health status, health disparities among subgroups of children, the effects of social conditions on children's health status and use and effectiveness of health care, and the relationship between child health status and family income, family stability and preservation, and children's school readiness and educational achievement and attainment; and

(D) make recommendations regarding improving and strengthening the timeliness, quality, and public transparency and accessibility of information about child health and health care quality.

(2) FUNDING.—Up to $1,000,000 of the amount appropriated under subsection (i) for a fiscal year shall be used to carry out this subsection.

(h) RULE OF CONSTRUCTION.
Notwithstanding any other provision in this section, no evidence based quality measure developed, published, or used as a basis of measurement or reporting under this section may be used to establish an irrebuttable presumption regarding either the medical necessity of care or the maximum permissible coverage for any individual child who is eligible for and receiving medical assistance under title XIX or child health assistance under title XXI.

(i) APPROPRIATION.
Out of any funds in the Treasury not otherwise appropriated, there is appropriated for each of fiscal years 2009 through 2013, $45,000,000 for the purpose of carrying out this section (other than subsection (e)). Funds appropriated under this subsection shall remain available until expended.

(b) INCREASED MATCHING RATE FOR COLLECTING AND REPORTING ON CHILD HEALTH MEASURES.—Section 1903(a)(3)(A) (42 U.S.C. 1396b(a)(3)(A)), is amended—

(1) by striking ''and'' at the end of clause (i); and

(2) by adding at the end the following new clause:

(iii) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b)) of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to such developments or modifications of systems of the type described in clause (i) as are necessary for the efficient collection and reporting on child health measures; and''.

Appendix E: Findings from EQRO Validation Studies

SEC. 402. IMPROVED AVAILABILITY OF PUBLIC INFORMATION REGARDING ENROLLMENT OF CHILDREN IN CHIP AND MEDICAID.

(a) INCLUSION OF PROCESS AND ACCESS MEASURES IN ANNUAL STATE REPORTS.—Section 2108 (42 U.S.C. 1397hh) is amended—

(1) in subsection (a), in the matter preceding paragraph (1), by striking ‘‘The State’’ and inserting ‘‘Subject to subsection (e), the State’’; and

(2) by adding at the end the following new subsection:

(e) INFORMATION REQUIRED FOR INCLUSION IN STATE ANNUAL REPORT.— The State shall include the following information in the annual report required under subsection (a):

(1) Eligibility criteria, enrollment, and retention data (including data with respect to continuity of coverage or duration of benefits).

(2) Data regarding the extent to which the State uses process measures with respect to determining the eligibility of children under the State child health plan, including measures such as 12-month continuous eligibility, self-declaration of income for applications or renewals, or presumptive eligibility.

(3) Data regarding denials of eligibility and redeterminations of eligibility.

(4) Data regarding access to primary and specialty services, access to networks of care, and care coordination provided under the State child health plan, using quality care and consumer satisfaction measures included in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

(5) If the State provides child health assistance in the form of premium assistance for the purchase of coverage under a group health plan, data regarding the provision of such assistance, including the extent to which employer-sponsored health insurance coverage is available for children eligible for child health assistance under the State child health plan, the range of the monthly amount of such assistance provided on behalf of a child or family, the number of children or families provided such assistance on a monthly basis, the income of the children or families provided such assistance, the benefits and cost sharing protection provided under the State child health plan to supplement the coverage purchased with such premium assistance, the effective strategies the State engages in to reduce any administrative barriers to the provision of such assistance, and, the effects, if any, of the provision of such assistance on preventing the coverage provided under the State child health plan from substituting for coverage provided under employer-sponsored health insurance offered in the State.

(6) To the extent applicable, a description of any State activities that are designed to reduce the number of uncovered children in the State, including through a State health insurance connector program or support for innovative private health coverage initiatives.

(b) STANDARDIZED REPORTING FORMAT.—

(1) IN GENERAL.— Not later than 1 year after the date of enactment of this Act, the Secretary shall specify a standardized format for States to use for reporting the

information required under section 2108(e) of the Social Security Act, as added by subsection (a)(2).

(2) TRANSITION PERIOD FOR STATES.—Each State that is required to submit a report under subsection (a) of section 2108 of the Social Security Act that includes the information required under subsection (e) of such section may use up to 3 reporting periods to transition to the reporting of such information in accordance with the standardized format specified by the Secretary under paragraph (1).

(c) ADDITIONAL FUNDING FOR THE SECRETARY TO IMPROVE TIMELINESS OF DATA REPORTING AND ANALYSIS FOR PURPOSES OF DETERMINING ENROLLMENT INCREASES UNDER MEDICAID AND CHIP.—

(1) APPROPRIATION.—There is appropriated, out of any money in the Treasury not otherwise appropriated, $5,000,000 to the Secretary for fiscal year 2009 for the purpose of improving the timeliness of the data reported and analyzed from the Medicaid Statistical Information System (MSIS) for purposes of providing more timely data on enrollment and eligibility of children under Medicaid and CHIP and to provide guidance to States with respect to any new reporting requirements related to such improvements. Amounts appropriated under this paragraph shall remain available until expended.

(2) REQUIREMENTS.—The improvements made by the Secretary under paragraph (1) shall be designed and implemented (including with respect to any necessary guidance for States to report such information in a complete and expeditious manner) so that, beginning no later than October 1, 2009, data regarding the enrollment of low-income children (as defined in section 2110(c)(4) of the Social Security Act (42 U.S.C. 1397jj(c)(4)) of a State enrolled in the State plan under Medicaid or the State child health plan under CHIP with respect to a fiscal year shall be collected and analyzed by the Secretary within 6 months of submission.

(d) GAO STUDY AND REPORT ON ACCESS TO PRIMARY AND SPECIALITY SERVICES.

(1) IN GENERAL. The Comptroller General of the United States shall conduct a study of children's access to primary and specialty services under Medicaid and CHIP, including—

(A) the extent to which providers are willing to treat children eligible for such programs;

(B) information on such children's access to networks of care;

(C) geographic availability of primary and specialty services under such programs;

(D) the extent to which care coordination is provided for children's care under Medicaid and CHIP; and

(E) as appropriate, information on the degree of availability of services for children under such programs.

(2) REPORT. Not later than 2 years after the date of enactment of this Act, the Comptroller General shall submit a report to the Committee on Finance of the Senate and the Committee on Energy and Commerce of the House of Representatives on the study conducted under paragraph (1) that includes recommendations for such Federal and State legislative and administrative changes as the Comptroller General determines are

necessary to address any barriers to access to children's care under Medicaid and CHIP that may exist.

SEC. 403. APPLICATION OF CERTAIN MANAGED CARE QUALITY SAFEGUARDS TO CHIP.

(a) IN GENERAL. Section 2103(f) of Social Security Act (42 U.S.C. 1397bb(f)) is amended by adding at the end the following new paragraph: (3) COMPLIANCE WITH MANAGED CARE REQUIREMENTS.— The State child health plan shall provide for the application of subsections (a)(4), (a)(5), (b), (c), (d), and (e) of section 1932 (relating to requirements for managed care) to coverage, State agencies, enrollment brokers, managed care entities, and managed care organizations under this title in the same manner as such subsections apply to coverage and such entities and organizations under title XIX.

(b) EFFECTIVE DATE. The amendment made by subsection (a) shall apply to contract years for health plans beginning on or after July 1, 2009.

Appendix E: Findings from EQRO Validation Studies

Appendix G: Initial Core Set of Children's Quality Measures for Voluntary Reporting

	Measure	Measure Steward	Description
1	Timeliness of Prenatal Care	NCQA/HEDIS	Percent of deliveries that received a prenatal care visit in the first trimester or within 42 days of enrollment
2	Annual Pediatric hemoglobin A1C testing	NCQA/HEDIS	Percentage of pediatric patients with diabetes with a HBA1c test in a 12-month measurement period
3	Frequency of Ongoing Prenatal Care	NCQA/HEDIS	Percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that received the following number of visits: < 21 percent of expected visits 21 percent – 40 percent of expected visits 41 percent – 60 percent of expected visits 61 percent – 80 percent of expected visits ≥ 81 percent of expected visits
4	Childhood Immunization Status	NCQA/HEDIS	Percentage of patients who turned 2 years old during the measurement year who had four DTaP/DT, three IPV, one MMR, three H influenza type B, three hepatitis B and one chicken pox vaccine (VZV) by the time period specified and by the child's second birthday
5	Immunizations for Adolescents	NCQA/HEDIS	Percentage of patients who turned 13 years old during the measurement year who had a second dose of MMR and three hepatitis B vaccinations, and one varicella vaccination by their thirteenth birthday
6	Well Child Visits in the First 15 Months of Life	NCQA/HEDIS	Percentage of members who received zero, one, two, three, four, five, and six or more well child visits with a primary care practitioner during their first 15 months of life
7	Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	NCQA/HEDIS	Percentage of members age 3 to 6 years old who received one or more well-child visits with a primary care practitioner during the measurement year.
8	Adolescent Well-Care Visits	NCQA/HEDIS	Percentage of members age 12 through 21 years who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.
9	BMI Assessment for Children/Adolescents	NCQA/HEDIS	Percentage children, 2 through 18 years of age, whose weight is classified based on BMI percentile for age and gender
10	Chlamydia Screening	NCQA/HEDIS	Percentage of women 16- 20 who were identified as sexually active who had at least one test for Chlamydia during the measurement year

Appendix E: Findings from EQRO Validation Studies

	Measure	Measure Steward	Description
11	Total Eligibles who Received Preventive Dental Services	EPSDT	Total Eligibles who Received Preventive Dental Services
12	Total Eligibles who Received Dental Treatment Services	EPSDT	Total Eligibles who Received Dental Treatment Services
13	Follow-Up Care for Children Prescribed ADHD Medication	NCQA/HEDIS	Percentage of children newly prescribed attention ADHD medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed
14	Appropriate Testing for Children with Pharyngitis	NCQA/HEDIS	Percentage of patients who were diagnosed with pharyngitis, prescribed an antibiotic and who received a group A streptococcus test for the episode
15	Child and Adolescent Access to Primary Care	NCQA/HEDIS	Percentage of enrollees who had a visit with a primary care practitioner
16	CAHPS® 4.0 (children with chronic conditions)	NCQA/HEDIS	Family of surveys of experiences of care, an aspect of patient-centeredness. Parents or other responsible adults report about experiences of care during visits in which they accompany their children
17	Otitis media with effusion – avoidance of inappropriate use of systemic antimicrobials – ages 2-12	AMA/PCPI	Percent of patients aged 2 months through 12 years with a diagnosis of OME who were not prescribed systemic antimicrobials
18	Emergency department utilization – average number of emergency room visits per member per reporting period (Admin)	Maine	The number of visits per member per year as a function of all child and adolescent members enrolled and eligible during the measurement year
19	Pediatric central-line associated blood stream infections – NICU and PICU (medical records collected by hospital infection control staff)	CDC	Central line-associated blood stream infections (CLABSI) identified during periods selected for surveillance as a function of the number of central line catheter days selected for surveillance in pediatric and neonatal intensive care units
20	Annual number of asthma patients (>= 1 yo) with > 1 asthma-related emergency room visits (Admin)	Alabama	Asthma emergency department utilization for all children >1 year of age diagnosed with asthma or treatment with at least two short-acting beta adrenergic agents during the measurement year with more than one asthma-related ER visit

Appendix E: Findings from EQRO Validation Studies

	Measure	Measure Steward	Description
21	Percent of live births weighing less than 2,500 grams	HRSA	The measure assesses the number of resident live births less than 2,500 grams as a percent of the number of resident live births in the State reporting period
22	Cesarean rate for nulliparous singleton vertex	CQMAIH	Percent of women who had a cesarean section (C-section) among women with first live singleton births (also known as nulliparous term singleton vertex [NTSV] births) at 37 weeks of gestation or later
23	Screening using standardized screening tools for potential delays in social and emotional development	ABCD Project	Assesses the extent to which children at various ages from 0-36 months were screened for social and emotional development with a standardized, documented tool or set of tools
24	Follow-up after hospitalization for mental illness	ABCD Project	Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, in intensive outpatient encounter or partial hospitalization with a mental health practitioner.

Appendix E: Findings from EQRO Validation Studies

Appendix H: CHIPRA Quality Demonstration Projects

Colorado, in partnership with **New Mexico**, was awarded $1,722,161 for the first year of the 5-year grant that will total $7,784,030. Colorado and New Mexico will form an Inter-Alliance of School-Based Health Centers (SBHCs) to integrate school-based health care into a medical home approach to improve the health care of underserved school-aged children and adolescents. Colorado and New Mexico also plan to utilize SBHCs to improve the delivery of care within the school setting and to improve screening, preventive services, and management of chronic conditions. The goal will also be to educate adolescents to encourage more involvement in their own health care, and follow-up with primary care providers. The demonstration will also focus on the integration of mental health with primary care.

Florida, in partnership with the State of **Illinois** was awarded $880,371 for the first year of the 5-year grant that will total $11,277,361. The two States will test collection and reporting of recommended and selected supplemental measures of children's health quality, using existing data sources and improved data sharing. The two States will also work to ensure that ongoing statewide health information exchange and health information technology efforts support the achievement of child health quality objectives. Additionally, funds from this grant will be used to enhance the development of provider-based systems of care that incorporate practice redesign and strong referral and coordination networks, particularly for children with special health care needs. Florida and Illinois will also work to support collaborative quality improvement projects to improve birth outcomes across the two States.

Maine, in partnership with the State of **Vermont** was awarded $2,030,721 for the first year of a 5-year grant that will total $11,277,362. The State of Maine plans to test, develop and expand the use of evidence-based child performance measures. In addition, Maine and Vermont will be able to expand their information technology systems in order to improve the exchange of child health data and expedite the provision of services to children in foster care. The two States will also test and evaluate a pediatric medical home model that will test the impact of changes in payment reform, implementation of consensus practice guidelines, and provider education on child health outcomes. In particular, Vermont will build upon its leadership role as convener of the National Improvement Partnership Network to increase the number of participating States, particularly States that are not part of this grant program.

The State of **Maryland**, in partnership with **Georgia and Wyoming**, was awarded $2,401,467 for the first year of a 5-year grant totaling $10,993,171. The three States are committed to improving the health and social outcomes for children with serious behavioral health needs. The grant will be used to implement and/or expand a Care Management Entity (CME) provider model to improve the quality and better control the cost of care for children with serious behavioral health challenges who are enrolled in Medicaid or the Children's Health Insurance Program. The CME will incorporate wrap-around services, peer supports, and intensive care coordination. The participating States will utilize the CME model to improve access to appropriate services, and employ health information technology to support clinical decision making. The model will also be designed to reduce unnecessary use of costly services, improve clinical and functional outcomes for children and youth with serious behavioral health needs, and involve youth and their families in care decisions.

Appendix E: Findings from EQRO Validation Studies

Massachusetts was awarded $1,496,542 for the first year of the 5-year grant that will total $8,777,542. The State will work with the University of Massachusetts Medical School, the Children's Hospital of Boston, the Massachusetts Health Quality Partners, and the National Initiative for Children's Healthcare Quality to apply and evaluate recommended measures of children's health care quality and to make comparative quality performance information available to providers, families, and policymakers. Massachusetts will also use learning collaboratives and practice coaches to support the process of transforming pediatric practices into medical homes that provide family and child-oriented care, measure and improve that care, and enhance outcomes, particularly for children with targeted conditions (Attention Deficit and Hyperactivity Disorder, asthma, and childhood obesity).

North Carolina was awarded $2,210,712 for the first year of the 5-year grant that will total $9,277,361. The State agency will be working with the State's Academy of Family Physicians, the State Pediatric Society, and Community Care of North Carolina to build on a strong public-private partnership that has documented successes in quality improvement, efficiency and cost-effectiveness of care for more than 12 years. Funds from this grant will be used to implement and evaluate the use of recommended quality measures. Additionally, this initiative will strengthen the medical home model for children with special health care needs by testing and evaluating three provider-led community-based models. These models will be used to identify, treat, and coordinate care for children with special health care needs, particularly children with developmental, behavioral, and/or mental health disorders. North Carolina has also agreed to be one of two States implementing a model electronic health record format for children.

Oregon, in partnership with **Alaska and West Virginia**, was awarded $2,231,890 for the first year of a 5-year grant that will total $11,277,361. The demonstration will test the combined impact of patient-centered care delivery models and health information technology in improving the quality of children's health care. The three States will work together to develop and validate quality measures, improve infrastructure for electronic or personal health records utilizing health information exchanges, and implement and evaluate medical home and care coordination models. Oregon, Alaska and West Virginia share the demographic quality of having a large proportion of their populations residing in rural areas that are disproportionately low-income.

Pennsylvania was awarded a grant, with several medical centers and hospitals within the State to assist with execution of this demonstration. The State will receive $1,934,754 for the first year of the 5-year grant that will total $9,777,361. Pennsylvania will test and report on recommended pediatric quality measures and promote the use of health information technology in health care delivery to maximize the early identification of children with developmental delay, behavioral health issues, and complex medical conditions. This will facilitate coordination of care with the primary care practitioner medical home, medical specialists, and child-serving social service agencies. A pre-clinic visit assessment is expected to enhance communication between providers and patients, and an electronic tracking system will link children with special needs to appropriate services. Pennsylvania has also agreed to be one of two States implementing a model electronic health record format for children.

South Carolina was awarded $2,214,263 for the first year of the 5-year grant that will total $9,277,361. South Carolina plans to build a quality improvement infrastructure that enhances the ability of the State's pediatric primary care practices to establish medical homes that

effectively coordinate and integrate physical and mental health services. Health information technology will be used to gather, aggregate, and report on outcomes data to support the provision of evidence-based care and allow peer-to-peer comparisons. South Carolina will automate data collection of, and feedback on, recommended child health quality indicators in 15 pilot practices. These practices will participate in learning collaboratives to disseminate knowledge, develop plans, assess success of implementation and adjust plans of action.

Utah, in partnership with **Idaho**, was awarded $2,877,134 for the first year of the 5-year grant that will total $10,277,360. Utah and Idaho will develop a regional quality system guided by the medical home model to enable and assure ongoing improvement in the healthcare of children enrolled in Medicaid and CHIP programs. The project will focus on improving health outcomes for children and youth with special health care needs through the use electronic health records, health information exchanges, and other health information technology tools. The States plan to pilot a new administrative service using Medical Home Coordinators embedded in primary and sub-specialty care practices to support ongoing improvements in care, coordination of care, and support for children with chronic and complex conditions and their families. Utah and Idaho also plan to use learning collaboratives, practice coaches, and parent partners to train primary and sub-specialty child health practices in medical home concepts. The ultimate outcome will be improved health care for children in the two States, robust integration of health information technology into child health practices, and a regional quality system and valuable quality improvement tools and resources that can be shared with other States and regions.