The Department of Health and Human Services

Appendix

2012 Annual Report on the

Quality of Care for Children in Medicaid and CHIP

Health and Human Services Secretary

Kathleen Sebelius

December 2012

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APPENDIX

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APPENDIX TABLES

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APPENDIX A

CMCS EFFORTS TOWARD A HIGH PERFORMING MEDICAID/CHIP PROGRAM

IMPROVING CARE AND LOWERING COSTS

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Over the past two years, the Center for Medicaid and CHIP Services (CMCS) has embarked on an aggressive set of initiatives to provide better care, improve health and lower costs in Medicaid/CHIP. Below is a list of initiatives underway or soon to be launched.

Quality of Care Measurement, Reporting, Improvement

Children

- Identified and published in the Federal Register an initial core set of children's quality measures for Medicaid and CHIP[i]
- Established Pediatric Quality Measures Program that includes seven academic Centers of Excellence[ii]
- Awarded $100 million over 5 years in quality demonstration grants to 10 state and multi-state partnerships to evaluate promising practices for measuring and improving quality of care for children[iii]
- Identified a Technical Assistance and Analytic Support contractor to support states in efforts to uniformly collect, report and use quality measures in improving care
- Launched data-collection tool for states to voluntarily report on the initial core set of quality measures for children
- Issued 2011 Secretary's report that made public state-specific data on the children's core measures[iv]
- Organized Medicaid-CHIP Quality Conferences in 2011 and 2012, which were attended by state partners working on quality measurement and improvement efforts

Early and Periodic Screening, Diagnosis & Treatment (EPSDT) Benefit

- Launched EPSDT National Improvement Workgroup
    - Includes state representatives, children's health providers, consumer representatives, and other experts in the areas of maternal and child health, Medicaid, and data analysis
    - Helping CMS identify the most critical areas for improvement of EPSDT, and provide ideas on how CMS can work with states and other partners to increase awareness and access to services, and improve data reporting to improve the quality of care provided to children
- Conducted first mini audit of the EPSDT CMS416 data to improve accuracy and completeness of data
- Drafting a strategy guide to improve knowledge of EPSDT benefits and state responsibilities

Oversight of Managed Care External Quality Review Process

- Updated quality review protocols, which were published in Federal Register for public comment and approved by the Office of Management and Budget (OMB) for use through September 30, 2015[v]
- Developed new policies and procedures to improve CMS oversight of state quality strategy and EQR process
- Partnered with accrediting organizations (e.g., NCQA, URAC) to cross walk their accreditation standards that comply with MCO regulations under CFR Part 438
- Started providing technical assistance to states on managed care regulatory requirements and their External Quality Review Organizations (EQRO) annual technical reports

Population Health

- Issued NPRM that updates administrative fees paid to providers for the Vaccines for Children (VFC) Program
- Issued a letter to State Health Officials offering guidance on coverage of tobacco cessation services
- Issued a Report to Congress on Prevention and Obesity services[vi]
- Issued guidance on updated policy on lead screening services

Service Delivery Reform

- Issued regulations requiring state Medicaid programs to make a payment adjustment for healthcare acquired conditions, called provider preventable conditions in the rule[vii]
- Created an optional Medicaid State Plan (SPA) benefit for states to establish Health Homes to coordinate care for people with Medicaid who have 2 or more chronic conditions[viii]
    - States receive a 90 percent enhanced Federal match for health home services.
    - Thus far, the following states have approved Health Home SPAs: Missouri; Rhode Island; New York; Oregon; North Carolina; Iowa. Two states have submitted requests for approval of SPAs: Alabama, New York
- Issued Report to Congress on approaches for identifying, collecting, and evaluating data on health care disparities in Medicaid and CHIP[ix]

Population Group/Service Specific efforts

- Oral Health Initiative
  - Working with states to achieve two goals for improving oral health[x]
    - To increase by 10 percentage points the proportion of children enrolled in Medicaid or CHIP that receive a preventive dental service between 2011- 2015
    - To increase by 10 percentage points the proportion of children ages six to nine enrolled in Medicaid or CHIP that receive a dental sealant on a permanent molar tooth to be phased in
  - Launched a webinar series, the CMS Learning Lab: Improving Oral Health Through Access, a series of informational seminars for state Medicaid and CHIP agencies and other interested partners
  - Offering (since June 2012) one-on-one technical assistance to states in developing an Oral Health Action Plan to assist them in meeting their goal
- Improving Maternal and Child Health Outcomes
  - Implemented Neonatal Outcomes Improvement Project: 3 Pilot states – Arkansas, North Carolina, Ohio
  - Developed Perinatal Outcomes Symposium (CMCS & CMMI), June 2011: Where Are We? Where Can We Go?
    - Profiled interventions to improve perinatal outcomes
    - Identified key elements of agenda to advance perinatal health
  - Conducted Webinars
    - Patient Safety in Neonatal Intensive Care Unit - May 2011
    - Improving Birth Outcomes: Healthy Babies, Lower Costs - July 2011
  - Launched Expert Panel to Improve Maternal and Infant Health Outcomes
    - Chaired by Ohio Medicaid Medical Director and former President of ACOG
    - Two working groups:
      - Preconception/Post-Partum/Inter-conception Care
      - Pregnancy and Delivery Care
    - Expected Outcomes
      - Specific opportunities for improvement using Medicaid policy and payment levers
      - Evidence based Tools and Best Practices
      - Improving Performance Measurement and Reporting Systems
      - Coordination of Activities with other National Initiatives

- Working with Innovation Center Strong Start Initiative to reduce early elective deliveries and test three models of enhanced prenatal care through entering/group care; birthing centers; or medical homes[xi]

- Reducing long term care costs and improving access to long term care services and supports in the community

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[i] http://www.ahrq.gov/chipra/

[ii] http://www.ahrq.gov/chipra/pqmpfact.htm

[iii] http://www.insurekidsnow.gov/professionals/CHIPRA/grants_summary.html

[iv] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2011_StateReporttoCongress.pdf

[v] Agency Information Collection Activities; Submission for OMB Review; Comment Request, 77 Fed. Reg. 32119 (May 31, 2012), available at: http://www.gpo.gov/fdsys/pkg/FR-2012-05-31/pdf/2012-13206.pdf https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-R-305.html

[vi] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/RTC_PreventiveandObesityRelatedServices.pdf

[vii] Medicaid Program: Payment Adjustment for Provider-Preventable Conditions Including Health Care-Acquired Conditions, 76 Fed. Reg. 32816 (June 6, 2011) (amending 42 CFR Parts 434, 438, and 447).

[viii] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Health-Homes/Health-Homes.html. Health Homes were authorized by 2702 of the Affordable Care Act.

[ix] http://www.healthcare.gov/law/resources/reports/disparities09292011a.pdf

[x] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/CMS-Oral-Health-Strategy.pdf

[xi] http://innovations.cms.gov/initiatives/Strong-Start/

APPENDIX B

PUBLIC–PRIVATE PARTNERSHIPS TO IMPROVE QUALITY OF CARE IN MEDICAID/CHIP

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The 2010 and 2011 Secretary's reports highlighted a growing trend in collaborative quality improvement efforts to support states in improving care delivery and health outcomes for children. This section of the 2012 Secretary's Report highlights recent examples that represent collaborative efforts underway.

ANNUAL CMS MEDICAID/CHIP QUALITY CONFERENCE, JUNE 2012

The 2nd Annual CMS Medicaid/CHIP Quality Conference on Improving Care and Proving It was held in June 2012, to broaden support of state efforts in collecting and reporting quality measures and using that information to improve their programs. For more details, view the conference website at: http://www.medicaid.gov/State-Resource-Center/Events-and-Announcements/Annual-Medicaid-CHIP-Quality-Conference.html. Approximately 280 participants attended the conference. More than a third of the attendees were state Medicaid/CHIP agency representatives. In addition, representatives from the following organizations attended:

AcademyHealth

American Academy of Pediatric Dentistry

American Academy of Pediatrics

American Dental Association

Booz Allen Hamilton

Center for Health Care Strategies, Inc.

Children's Hospitals

Families USA

HSAG External Quality Review Organization

IPRO External Quality Review Organization

March of Dimes

Mathematica Policy Research

National Academy for State Health Policy

National Association of Medicaid Directors

National Committee for Quality Assurance

National Initiative for Children's Healthcare Quality

Provider Resources, Inc.

Rutgers University

TeenScreen

The National Alliance to Advance Adolescent Health

W.K. Kellogg Foundation

CONNECTING KIDS TO COVERAGE: 2ND NATIONAL CHILDREN'S HEALTH INSURANCE SUMMIT, NOVEMBER 2011

The Summit, held in Chicago on November 1-3, 2011, brought together Children's Health Insurance Program Reauthorization Act (CHIPRA) outreach grantees, state agencies, tribes, health care providers, nonprofit groups, researchers, advocates and others focused on reaching out, enrolling and retaining eligible children in Medicaid and CHIP. For two and a half days, nearly 400 attendees from all over the country participated in a wide range of substantive workshops and communications skill-building sessions designed to share effective strategies and innovative approaches to outreach and enrollment. For more details view the conference agenda at: http://www.medicaid.gov/State-Resource-Center/Downloads/Connecting-Kids-to-Coverage.pdf or visit http://insurekidsnow.gov/professionals/events/index.html> for additional materials and presentations.

4th ANNUAL CMS MULTI-STATE MEDICAID HITECH CONFERENCE, APRIL 2012

The conference served as an excellent opportunity for the Center for Medicaid and CHIP Services to meet with colleagues from state Medicaid agencies, federal partners and health information technology industry leaders to encourage exchange of programmatic information and share best practices related to the Medicaid Electronic Health Record Incentive Program, Health Information Technology, and Health Information Exchange (HIT/HIE). For more information, see www.medicaidhitechconference.com.

AHRQ-CMS CHIPRA PEDIATRIC QUALITY MEASURES PROGRAM

Now in its second year, the AHRQ-CMS CHIPRA Pediatric Quality Measures Program comprises:

- Seven CHIPRA Pediatric Healthcare Quality Measures Program Centers of Excellence supported with cooperative agreement grants with AHRQ, funded by CMS. For more information about these grants, see http://grants.nih.gov/grants/guide/rfa-files/RFA-HS-11-001.html. A fact sheet highlighting the comprehensive list of public and private partners is available at http://www.ahrq.gov/chipra/pqmpfact.htm;
- A CHIPRA Coordinating and Technical Assistance Center provides technical assistance and support to the Centers of Excellence [1] and
- Two state CHIPRA quality demonstration project grantees (Illinois, a partner to the Florida grantee, and Massachusetts) funded by CMS that are undertaking new quality measure development as part of their demonstration grants. For more

[1] For more information see https://www.fbo.gov/index?s=opportunity&mode=form&tab=core&id=c52c24d3cad2b34a74f6f26086b35f11&_cview=0.

information about these grantees, see
http://www.cms.gov/CHIPRA/15_StateDemo.asp#TopOfPage

NATIONAL CLINICALLY FOCUSED PARTNERSHIPS

CMS continues to explore national partnership efforts targeted to clinical areas pertinent to children in Medicaid and CHIP:

Partnership for Patients

Continuing efforts from 2011, the Partnership for Patients has been making progress in bringing on national partners to achieve two important goals:

- By the end of 2013, preventable hospital-acquired conditions would decrease by 40 percent compared to 2010.
- By the end of 2013, preventable complications during a transition from one care setting to another would be decreased so that all hospital readmissions would be reduced by 20 percent compared to 2010.
- As of July 2012, more than 7,500 partners (including many children's hospitals as well as physicians and nurses groups, consumer groups, and employers), have pledged their commitment to the Partnership for Patients. More information is available at: http://partnershippledge.healthcare.gov/.

Strong Start

The Strong Start initiative supports reducing the risk of significant complications and long-term health problems for both expectant mothers and newborns. Strong Start includes two strategies:

- Public-Private Partnership to Reduce Early Elective Deliveries:
  Building on the work of the Partnership for Patients, this initiative will test ways to encourage best practices and supports providers in reducing early electives deliveries prior to 39 weeks. CMS will team up with advocacy and professional organizations to increase current public awareness efforts and develop new ones. The March of Dimes and the American College of Obstetricians and Gynecologists are two examples of participating partners.
- Funding Opportunity for Testing New Approaches to Prenatal Care:
  CMS will make funding available for providers, states and other eligible applicants to test the effectiveness of three enhanced prenatal care approaches to reduce preterm births for women covered by Medicaid who are at risk for preterm births.

EPSDT National Improvement Workgroup

Since December 2010, the Centers for Medicare and Medicaid Services (CMS) has convened a National EPSDT Improvement Workgroup that includes state representatives, children's health providers, consumer representatives, and other experts in the areas of maternal and child health, Medicaid, and data analysis. The group helps CMS identify the most critical areas for

improvement of EPSDT, and provides ideas on how CMS can work with states and other partners to increase awareness and access to services, and improve data reporting to improve the quality of care provided to children.

CMS National Maternal and Infant Health Outcomes Expert Panel

Recognizing that between 40 and 50 percent of all births in the US annually are covered under Medicaid, CMS has leveraged the opportunity to partner with a wide range of well-known and respected experts in the maternity and infant healthcare field. Panelists come from the healthcare industry as well as from state agencies and private industry. The first meeting was held in Baltimore on June, 13, 2012 with a schedule to meet regularly through July 2013.

APPENDIX C

NCQA, URAC, AND AAAHC MEDICAID ACCREDITATION PROCEDURES

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States are authorized to use accreditation by private organizations in support of oversight of Medicaid managed care plans. During the accreditation process, plans undergo a detailed review to ensure they meet quality standards related to their operational and administrative systems. Currently, three organizations accredit managed care plans: National Committee for Quality Assurance (NCQA), URAC, and the Accreditation Association for Ambulatory Health Care (AAAHC).

NCQA maintains a Medicaid Managed Care Toolkit, which was developed in 2006 in collaboration with the Centers for Medicare & Medicaid Services. The toolkit, updated in 2012 and available at: http://www.ncqa.org/tabid/134/Default.aspx, includes information to support public reporting and provides a crosswalk of NCQA accreditation standards with the Federal quality standards under 42 CFR Part 438, subpart D. As noted in the toolkit, 75 percent of the NCQA accreditation standards satisfy regulatory requirements under 42 CFR Part 438, subpart D.

URAC is another private organization that provides managed care plan accreditation. URAC's managed care plan accreditation standards are usually updated every three years and include key quality benchmarks for network management, provider credentialing, utilization management, quality management and improvement and consumer protection. More information is available at: https://www.urac.org/accreditation/. URAC provides explicitly for Medicaid Managed Care programs a reference guide on Medicaid Managed Care External Quality Review. In 2012, seven states, including Florida, Georgia, Michigan, Minnesota, South Carolina, Virginia, and Wisconsin recognize URAC accreditation by means of statute, regulation, or contract. Two states, Florida and Michigan, currently have a total of 5 Medicaid managed care plans with URAC accreditation. Like NCQA, URAC also provides a crosswalk between the Federal regulations and URAC accreditation standards. According to the reference guide, the accreditation standards are comparable to 81 percent of the regulatory standards required under 42 CFR Part 438, subpart D. More information is available at: http://www.urac.org/policyMakers/resources/GuidetoMedicaidManagedCElQReview.aspx.

AAAHC also provides accreditation for managed care organizations (MCOs). Accredited MCOs can use their proof of AAAHC accreditation to partially meet the requirements for Medicaid MCOs set forth in 42 CFR, Part 438, subpart D. At least one state, Wisconsin, includes a Medicaid health plan with accreditation by this entity. More information on accreditation is available on the AAAHC website at https://www.aaahc.org/en/accreditation/Managed-Care-Organizations/.

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APPENDIX D

STATES RECOGNIZING NCQA AND URAC ACCREDITATION

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1. Arizona: The Arizona Health Care Cost Containment System recognizes providers credentialed by NCQA Accredited managed care plans as meeting state credentialing requirements (AHCCCS Medical Policy Manual, Chapter 900; http://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap900.pdf).
2. 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).
3. Delaware: The state recognizes NCQA Accreditation as meeting access to care, structure and operations, and quality and improvement standards (State Regulation: 14 De, 650).
4. *District of Columbia: DC's Department of Health Care Finance requires contracted managed care plans to hold NCQA Accreditation.
5. Florida: All managed care plans must be accredited by NCQA or another nationally recognized accrediting body (HB7107 – Passed 06/02/2011). As of July 2012, two state Medicaid managed care plans are accredited by URAC.
6. Georgia: Medicaid managed care plans are required to obtain private accreditation by 2009 (Georgia Department of Community Health).
7. Hawaii: Accreditation is required for all managed care plans (State Law: 432E-11).
8. *Indiana: Managed care organizations and managed behavioral health organizations in the Medicaid program must be NCQA Accredited by January 1, 2011 (IC 12-15-12).
9. Iowa: The Human Services Department accepts NCQA Accreditation for the state's accreditation requirement for Medicaid managed care plans (State Regulation: 441-88.2).
10. *Kansas: Per KanCare contracts and the State Quality Strategy, Medicaid contractors and subcontractor(s) are required to become accredited by NCQA as defined by the state.
11. *Kentucky: Kentucky's Cabinet for Health and Family Services requires managed care plans to be NCQA Accredited as a condition of doing business.
12. Louisiana: Accreditation is required for the full-risk Medicaid managed care plans per state contracting requirements (LAC 50:I.3501).
13. Maryland: Managed care plans may submit accreditation reports to demonstrate compliance with state requirements (State Law: 19-705.1).
14. *Massachusetts: MassHealth plans must be NCQA accredited within two years of the start of their (July 2012) contract. MCOs can use evidence of NCQA accreditation to show compliance with several components of the EQRO review.
15. Michigan: Per state contract requirements, Medicaid managed care plans must be accredited (Section 1.022-K). As of July 2012, three state Medicaid managed care plans are accredited by URAC.

16. 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.
17. *Missouri: Missouri's managed care plans are required to obtain managed care plan accreditation, at a level of "accredited" or better, from NCQA within twenty-four (24) months of the first day of the effective date of the contract. The managed care plans are required to maintain such accreditation thereafter and throughout the duration of the contract.
18. Nebraska: MCOs must have NCQA Accreditation or another national accreditation for the Medicaid managed care plan. MCOs must submit a copy of the accrediting body's letter indicating the most recent accreditation status at the time of initial contracting. Any changes or updates must be sent to DHHS within 30 days of receipt (State Regulation: 482 NAC 6-000).
19. New Hampshire: Managed care plans may delegate credentialing activities only if such delegated credentialing is maintained in accordance with the NCQA delegated credentialing requirements and any comparable requirements defined by DHHS.
20. *New Mexico: NCQA accreditation is required for Medicaid managed care plans (State Regulation: 8.305.8.11).
21. *Ohio: Managed care plans must hold and maintain, or must be actively seeking accreditation by NCQA. A managed care plan not currently NCQA accredited must submit a signed copy of the NCQA Survey Contract to ODJFS by July 1, 2012 and complete the accreditation process by June 30, 2013 (MCP Contract, Appendix C: MCP Responsibilities – 45).
22. Pennsylvania: NCQA accreditation reports are used as part of the state's routine monitoring of Medicaid managed care plans (Pennsylvania Department of Public Welfare).
23. *Rhode Island: Per state contracting requirements, Medicaid managed care plans must be accredited by NCQA (sec. 2.02 Licensure).
24. *South Carolina: Accreditation is required for Medicaid managed care plans. South Carolina Department of Health and Human Services.
25. Texas: The Texas Department of Insurance mandates the use of NCQA's credentialing standards by all managed care plans in the state. Plans must follow the most current version of NCQA's credentialing requirements from year to year.
26. *Tennessee: All plans contracting with TennCare (Medicaid) must be NCQA Accredited.
27. Utah: NCQA Accreditation meets some of Utah's contractual requirements for Medicaid plans (Utah Department of Health).
28. *Virginia: Medicaid managed care plans are required to maintain NCQA Accreditation.

29. Wisconsin: The Wisconsin Medicaid HMO Accreditation Incentive allows managed care 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: 2012 NCQA Medicaid Managed Care Toolkit.

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APPENDIX E

STATE-SPECIFIC TABLES FOR FREQUENTLY REPORTED CHILDREN'S HEALTH CARE QUALITY MEASURES

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Appendix Table E.1. Initial Core Set of Medicaid/CHIP Children's Health Care Quality Measures, as Reported by States in Their FFY 2011 CARTS Reports

	Number of Measures Reported by State[a]	Prenatal and Postpartum Care: Timeliness of Prenatal Care (#1)	Frequency of Ongoing Prenatal Care (#2)	Percentage of Live Births Weighing Less than 2,500 Grams (#3)	Cesarean Rate for Nulliparous Singleton Vertex (Low-Risk First Birth Women) (#4)	Childhood Immunization Status (#5)	Immunizations for Adolescents (#6)	Body Mass Index Assessment for Children and Adolescents (#7)	Developmental Screening in the First Three Years of Life (#8)	Chlamydia Screening (#9)	Well-Child Visits in the First 15 Months of Life (#10)	Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (#11)	Adolescent Well-Care Visits (#12)	Percentage of Eligibles who Received Preventive Dental Services (#13)	Child and Adolescent Access to Primary Care Practitioners (#14)	Appropriate Testing for Children with Pharyngitis (#15)	Otitis Media with Effusion – Avoidance of Inappropriate Use of Systemic Antimicrobials in Children – Ages 2-12 (#16)	Percentage of Eligibles who Received Dental Treatment Services (#17)	Ambulatory Care: Emergency Department Visits (#18)	Pediatric Central-Line Associated Blood Stream Infections – NICU and PICU (#19)	Annual Percentage of Asthma Patients (2-20 years old) with 1 or More Asthma-Related Emergency Room Visits (#20)	Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (#21)	Annual Pediatric Hemoglobin A1C Testing (#22)	Follow-Up After Hospitalization for Mental Illness (#23)	Consumer Assessment of Healthcare Providers And Systems (CAHPS®) Health Plan Survey (#24)
States Reporting		24	18	11	5	30	25	18	7	32	46	48	43	37	44	28	3	35	27	1	14	24	10	24	22
Alabama	17					X	X		X	X	X	X	X	X	X	X		X	X		X	X	X	X	X
Alaska	13			X						X	X	X	X	X	X	X		X	X		X	X		X	
Arizona	7									X	X	X	X	X	X			X							
Arkansas	13					X	X	X		X	X	X	X		X	X			X			X		X	X
California	11					X	X			X	X	X	X	X	X	X		X							X
Colorado	12	X				X		X		X	X	X	X	X	X			X	X						X
Connecticut	14	X	X				X		X	X	X	X	X	X	X			X	X			X			X
Delaware	0																								
D.C.	13	X	X			X	X	X		X	X	X	X	X	X	X		X							
Florida	20	X	X	X	X	X	X	X		X	X	X	X	X	X	X		X	X		X	X		X	X
Georgia	19	X	X	X	X	X	X	X		X	X	X	X	X	X	X		X	X		X	X		X	
Hawaii	12	X				X	X			X	X	X		X	X			X				X		X	X
Idaho	6										X	X	X	X	X			X							
Illinois	17	X	X	X		X	X	X	X	X	X	X	X	X	X	X		X	X		X				
Indiana	14	X	X			X	X			X	X	X	X	X	X	X		X				X		X	

Appendix Table E.1 (continued)

	Number of Measures Reported by State[a]	Prenatal and Postpartum Care: Timeliness of Prenatal Care (#1)	Frequency of Ongoing Prenatal Care (#2)	Percentage of Live Births Weighing Less than 2,500 Grams (#3)	Cesarean Rate for Nulliparous Singleton Vertex (Low-Risk First Birth Women) (#4)	Childhood Immunization Status (#5)	Immunizations for Adolescents (#6)	Body Mass Index Assessment for Children and Adolescents (#7)	Developmental Screening in the First Three Years of Life (#8)	Chlamydia Screening (#9)	Well-Child Visits in the First 15 Months of Life (#10)	Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (#11)	Adolescent Well-Care Visits (#12)	Percentage of Eligibles who Received Preventive Dental Services (#13)	Child and Adolescent Access to Primary Care Practitioners (#14)	Appropriate Testing for Children with Pharyngitis (#15)	Otitis Media with Effusion – Avoidance of Inappropriate Use of Systemic Antimicrobials in Children – Ages 2-12 (#16)	Percentage of Eligibles who Received Dental Treatment Services (#17)	Ambulatory Care: Emergency Department Visits (#18)	Pediatric Central-Line Associated Blood Stream Infections – NICU and PICU (#19)	Annual Percentage of Asthma Patients (2-20 years old) with 1 or More Asthma-Related Emergency Room Visits (#20)	Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (#21)	Annual Pediatric Hemoglobin A1C Testing (#22)	Follow-Up After Hospitalization for Mental Illness (#23)	Consumer Assessment of Healthcare Providers And Systems (CAHPS®) Health Plan Survey (#24)
Iowa	18			X	X	X	X	X	X	X	X	X	X	X	X	X		X	X		X			X	X
Kansas	5									X		X		X				X							X
Kentucky	14	X	X			X	X	X		X	X	X	X	X	X	X		X							X
Louisiana	6										X	X	X	X	X										X
Maine	14									X	X	X	X	X	X	X		X	X		X	X	X	X	X
Maryland	12	X	X			X	X			X	X	X	X	X	X	X		X							
Massachusetts	11	X	X			X				X	X	X	X	X				X						X	
Michigan	16	X				X	X	X		X	X	X	X	X	X	X		X	X			X	X		X
Minnesota	3										X	X			X										
Mississippi	8									X		X	X		X	X			X					X	
Missouri	12	X				X	X			X	X	X	X	X				X	X					X	X
Montana	5										X	X			X	X			X						
Nebraska	5										X	X		X	X			X							
Nevada	7					X					X	X	X		X									X	X
New Hampshire	11										X	X	X	X	X	X		X	X		X	X		X	

Appendix Table E.1 (continued)

	Number of Measures Reported by State[a]	Prenatal and Postpartum Care: Timeliness of Prenatal Care (#1)	Frequency of Ongoing Prenatal Care (#2)	Percentage of Live Births Weighing Less than 2,500 Grams (#3)	Cesarean Rate for Nulliparous Singleton Vertex (Low-Risk First Birth Women) (#4)	Childhood Immunization Status (#5)	Immunizations for Adolescents (#6)	Body Mass Index Assessment for Children and Adolescents (#7)	Developmental Screening in the First Three Years of Life (#8)	Chlamydia Screening (#9)	Well-Child Visits in the First 15 Months of Life (#10)	Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (#11)	Adolescent Well-Care Visits (#12)	Percentage of Eligibles who Received Preventive Dental Services (#13)	Child and Adolescent Access to Primary Care Practitioners (#14)	Appropriate Testing for Children with Pharyngitis (#15)	Otitis Media with Effusion – Avoidance of Inappropriate Use of Systemic Antimicrobials in Children – Ages 2-12 (#16)	Percentage of Eligibles who Received Dental Treatment Services (#17)	Ambulatory Care: Emergency Department Visits (#18)	Pediatric Central-Line Associated Blood Stream Infections – NICU and PICU (#19)	Annual Percentage of Asthma Patients (2-20 years old) with 1 or More Asthma-Related Emergency Room Visits (#20)	Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (#21)	Annual Pediatric Hemoglobin A1C Testing (#22)	Follow-Up After Hospitalization for Mental Illness (#23)	Consumer Assessment of Healthcare Providers And Systems (CAHPS®) Health Plan Survey (#24)
New Jersey	6	X				X					X	X	X		X										
New Mexico	15	X	X			X	X	X		X	X	X	X	X	X	X		X	X			X			
New York	12	X	X			X		X		X	X	X	X		X	X			X			X			
North Carolina	13							X	X	X	X	X	X	X	X			X	X		X	X	X		
North Dakota	8						X					X	X	X	X	X		X						X	
Ohio	11	X	X	X							X	X	X		X						X	X		X	X
Oklahoma	4										X	X	X		X										
Oregon	24	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Pennsylvania	13		X			X	X	X			X	X	X		X	X			X			X		X	X
Rhode Island	17	X	X	X		X	X	X		X	X	X	X	X	X	X		X	X			X		X	
South Carolina	18	X	X			X	X			X	X	X	X	X	X	X		X	X		X	X	X	X	X
South Dakota	1										X														
Tennessee	23	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X	X	X
Texas	12	X	X							X	X	X	X	X	X	X			X			X		X	
Utah	8					X	X				X	X	X		X	X									X

Appendix Table E.1 (continued)

	Number of Measures Reported by State[a]	Prenatal and Postpartum Care: Timeliness of Prenatal Care (#1)	Frequency of Ongoing Prenatal Care (#2)	Percentage of Live Births Weighing Less than 2,500 Grams (#3)	Cesarean Rate for Nulliparous Singleton Vertex (Low-Risk First Birth Women) (#4)	Childhood Immunization Status (#5)	Immunizations for Adolescents (#6)	Body Mass Index Assessment for Children and Adolescents (#7)	Developmental Screening in the First Three Years of Life (#8)	Chlamydia Screening (#9)	Well-Child Visits in the First 15 Months of Life (#10)	Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (#11)	Adolescent Well-Care Visits (#12)	Percentage of Eligibles who Received Preventive Dental Services (#13)	Child and Adolescent Access to Primary Care Practitioners (#14)	Appropriate Testing for Children with Pharyngitis (#15)	Otitis Media with Effusion – Avoidance of Inappropriate Use of Systemic Antimicrobials in Children – Ages 2-12 (#16)	Percentage of Eligibles who Received Dental Treatment Services (#17)	Ambulatory Care: Emergency Department Visits (#18)	Pediatric Central-Line Associated Blood Stream Infections – NICU and PICU (#19)	Annual Percentage of Asthma Patients (2-20 years old) with 1 or More Asthma-Related Emergency Room Visits (#20)	Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (#21)	Annual Pediatric Hemoglobin A1C Testing (#22)	Follow-Up After Hospitalization for Mental Illness (#23)	Consumer Assessment of Healthcare Providers And Systems (CAHPS®) Health Plan Survey (#24)
Vermont	7			X							X	X	X	X	X			X							
Virginia	11	X		X		X					X	X	X	X	X			X						X	X
Washington	8					X					X	X	X	X				X	X						
West Virginia	16	X				X	X	X		X	X	X	X	X	X			X	X		X		X	X	
Wisconsin	0																								
Wyoming	14					X	X	X		X	X	X	X	X	X	X	X	X	X				X		

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

Note: Wisconsin did not submit a CARTS report for FFY 2011. Delaware submitted an FFY 2011 CARTS report but did not submit data on any of the core CHIPRA quality measures. For the eight states (Colorado, Iowa, Kentucky, Michigan, New York, Pennsylvania, Tennessee, and West Virginia) that submitted initial core set measure data using both the Medicaid Children's Quality Core Measures Report and the CARTS Annual Report, the state was counted as reporting a measure if either report included data for that measure.

[a] X indicates that a state reported a performance rate for the Medicaid population, CHIP population, or both.

Appendix Table E.2. Percentage of Children and Adolescents Who had a Visit with a Primary Care Practitioner, as Reported by States in Their FFY 2011 CARTS Reports (n=43)

			Population			Sample Size				Data Source		Percentage of Children Who Had a Visit with a PCP			
State	Methodology	Date Range	Medicaid	CHIP	CHIP Program Type	12-24 Months	25 Months to 6 Years	7-11 Years	12-19 Years	Administrative	Hybrid	12-24 Months	25 Months to 6 Years	7-11 Years	12-19 Years
Alabama	HEDIS 2011	Jan-10 - Dec-10		X	Separate	683	8,451	13,902	24,359	X		98.2	84.3	88.3	86.1
Alaska	HEDIS 2010	Jan-10 - Dec-10	X	X	Medicaid Expansion	3,931	15,493	10,270	13,223	X		95.8	84.7	86.4	85.1
Arizona	HEDIS 2011	Oct-09 - Sept-10		X	Separate	255	4,432	5,099	6,038	X		96.9	89.3	91.0	89.3
Arkansas	HEDIS 2010	Oct-09 - Sep-10	X	X	Combination	23,724	109,476	83,368	96,597	X		93.3	84.9	89.5	85.7
California	HEDIS 2011	Jan-10 - Dec-10		X	Combination	12,380	135,105	142,190	210,034	X		97.5	90.2	90.4	87.5
Colorado	HEDIS 2011	Jan-10 - Dec-10	X		Separate	21,240	84,522	41,143	38,366	X		95.6	83.5	85.4	85.5
Connecticut	HEDIS 2011	Jan-11 - Dec-11	X	X	Separate	13,043	64,034	43,899	56,510	X		98.4	92.5	94.8	93.5
D.C.	HEDIS 2011	Jan-10 - Dec-10	X	X	Medicaid Expansion	3,343	13,842	9,261	14,447		X	94.7	87.0	92.2	85.1
Florida	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	32,980	162,562	91,384	410,942	X		95.9	79.5	88.0	84.5
Georgia	HEDIS 2011	Jan-10 - Dec-10	X	X	Separate	64,175	279,479	183,513	204,152	X		93.6	86.4	88.1	83.7
Hawaii	HEDIS 2011	Jan-10 - Dec-10	X	X	Medicaid Expansion	7,981	33,584	23,578	30,185	X		95.7	87.9	89.3	87.4
Idaho	HEDIS 2010	Sep-10 - Sep-11	X	X	Combination	10,642	43,954	36,906	40,568	X		91.6	74.8	61.0	59.7
Illinois	HEDIS 2009	Jan-10 - Dec-10	X	X	Combination	191,146	374,656	359,700	455,612	X		85.8	75.2	79.2	76.4
Indiana	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	34,166	123,416	70,410	76,647	X		95.8	86.9	90.8	91.5
Iowa	HEDIS 2010	Jan-10 - Dec-10	X		Combination	16,454	64,132	42,548	50,330	X		94.2	84.5	83.6	83.0
Kentucky	HEDIS 2010	Jan-10 - Dec-10	X	X	Combination	6,397	25,468	15,520	18,207	X		98.2	90.6	92.9	91.3
Louisiana	HEDIS 2011	Jul-10 - Jun-11	X	X	Combination	45,597	206,149	168,419	215,331	X		96.5	88.1	90.0	89.2
Maine	HEDIS 2011	Oct-10 - Sep-11	X	X	Combination	7,183	32,012	26,415	37,233	X		96.8	87.5	91.1	89.5
Maryland	HEDIS 2011	Jan-10 - Dec-10	X	X	Medicaid Expansion	NR	NR	NR	NR	X		96.1	90.6	92.6	89.9
Michigan	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	38,256	171,847	112,078	142,647	X		96.7	89.9	91.2	89.6
Minnesota	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	15,764	15,100	13,988	35,743	X		98.6	85.7	90.6	92.8
Mississippi	HEDIS 2011	Jan-10 - Dec-10		X	Separate	103	5,926	6,184	11,144	X		97.1	91.7	95.0	92.3
Montana	HEDIS 2010	Jan-10 - Dec-10		X	Separate	351	2,549	1,779	2,687	X		97.2	82.6	84.9	89.0
Nevada	HEDIS 2011	Jul-10 - Jun-11		X	Separate	249	3,034	2,226	2,009	X		97.6	93.7	94.7	91.8
New Hampshire	HEDIS 2011	Jul-09 - Jun-10		X	Combination	NR	NR	NR	NR	X		100.0	94.2	93.1	96.3
New Jersey	HEDIS 2011	Jan-10 - Dec-11	X	X	Combination	25,896	121,262	99,720	117,018	X		87.0	82.0	86.0	83.0
New Mexico	HEDIS 2010	Jan-10 - Dec-10	X	X	Medicaid Expansion	14,324	69,800	49,874	57,428		X	97.5	85.3	88.8	88.6
New York	HEDIS 2011	Jan-10 - Dec-10	X	X	Separate	87,220	391,376	262,069	371,408	X		96.6	93.4	95.8	92.8
North Carolina	HEDIS 2011	Jan-10 - Dec-10	X		Combination	66,283	260,960	150,836	182,742	X		98.2	91.1	77.8	75.0
North Dakota	HEDIS 2011	Jan-10 - Dec-10		X	Combination	16	151	588	895	X		93.8	96.0	80.4	90.5

Appendix Table E.2 (continued)

State	Methodology	Date Range	Population		CHIP Program Type	Sample Size				Data Source		Percentage of Children Who Had a Visit with a PCP			
			Medicaid	CHIP		12-24 Months	25 Months to 6 Years	7-11 Years	12-19 Years	Administrative	Hybrid	12-24 Months	25 Months to 6 Years	7-11 Years	12-19 Years
Ohio	HEDIS 2011	Jan-10 - Dec-10	X	X	Medicaid Expansion	74,252	304,166	230,789	282,518	X		95.6	86.0	87.3	86.1
Oklahoma	HEDIS 2011	Jan-09 - Dec-10	X	X	Combination	29,576	111,919	77,761	83,152	X		97.2	88.4	90.9	89.9
Oregon	HEDIS 2011	Jan-10 - Dec-10	X	X	Separate	19,525	76,536	60,041	69,981	X		96.9	85.8	86.5	86.8
Pennsylvania	HEDIS 2011	Jan-10 - Dec-10		X	Separate	1,612	22,120	27,041	48,513	X		96.0	91.6	94.9	94.4
Rhode Island	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	4,312	16,723	11,897	15,977	X		98.4	95.0	96.6	95.0
South Carolina	HEDIS 2011	Oct-10 - Sep-11		X	Medicaid Expansion	4,796	15,156	6,497	6,267	X		99.1	91.4	94.3	96.3
Tennessee															
Medicaid	HEDIS 2011	Jan-10 - Dec-10	X			NR	NR	NR	NR	X		97.1	89.9	92.8	88.6
CHIP	HEDIS 2011	Jan-10 - Dec-10		X	Combination	626	6,450	5,770	8,241	X		98.4	92.2	93.1	90.1
Texas	HEDIS 2011	Sep-09 - Aug-10		X	Separate	1,128	36,544	43,115	64,021	X		92.6	91.6	94.0	92.3
Utah	HEDIS 2011	Jul-10 - Jun-11		X	Separate	290	290	290	290	X		99.0	85.2	86.9	86.2
Vermont	HEDIS 2010	Jan-10 - Dec-10	X	X	Separate	3,344	15,764	13,301	17,427	X		98.2	91.6	94.0	93.5
Virginia	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	35,867	144,955	77,300	85,816		X	95.5	88.4	89.0	87.0
West Virginia	HEDIS 2011	Jan-10 - Dec-10		X	Separate	58	1,218	3,046	4,581	X		98.3	96.5	88.4	84.9
Wyoming	HEDIS 2010	Oct-10 - Sep-11		X	Separate	32	460	1,102	1,168	X		87.5	76.7	67.9	67.6

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

Notes: This table includes 43 states that used HEDIS specifications and excludes Nebraska which used other specifications to calculate this measure. Wisconsin did not submit a CARTS report for FFY 2011. Delaware submitted an FFY 2011 CARTS report, but did not submit data on any of the initial core set of children's health care quality measures. Kansas, Massachusetts, Missouri, South Dakota, and Washington submitted a CARTS report with data for other measures but did not report on measure 14.

State-specific comments:

AK: Rates are provisional since Alaska is new to reporting quality metrics.

FL: Rates exclude Title XXI Children's Medical Services CHIP enrollees and children enrolled in Medicaid managed care plans.

IN: Rates are weighted average of data from three MCOs. The results have been certified by HEDIS auditors.

KY: Rates for the CHIP program include the managed care region of Kentucky, representing about 20 percent of the CHIP population.

LA: Rates include data from Federally Qualified Health Centers and Rural Health Centers. Rates may not be comparable to rates in previous years because rates now include the Medicaid program as well as the Phase V Separate CHIP expansion population (with household income up to 250 percent of the FPL).

ME: Rates are provisional because providers have up to one year to submit claims and another year for adjustments and some claims may not be included in reported data.

NH: Rates include children up to age 18 due to CHIP eligibility.

NC: Rates may include a small percentage of children who were dually eligible for Medicaid and Medicare, partially eligible for Medicaid, or covered by a major third party insurance. Rates are provisional because North Carolina is still validating the data.

OK: Rates exclude children who were enrolled in a Home and Community Based Section 1915(c) waiver. For continuous enrollment, any gap of enrollment of up to 45 days: could be any number of gaps, but must not exceed 45 days.

OR: Rates are provisional because Oregon is still validating the data.

Appendix Table E.2 (continued)

PA: Rates include data from nine managed care plans.

SC: South Carolina ended its Separate CHIP program effective October 1, 2010. At that time, the state transitioned all CHIP enrollees to a Medicaid Expansion CHIP.

TN (Medicaid): Statewide rates are weighted based on the size of eligible population in each MCO.

NR = not reported.

Appendix Table E.3. Percentage of Children Receiving Well-Child Visits in the First 15 Months of Life, as Reported by States in Their FFY 2011 CARTS Reports (n=45)

State	Methodology	Date Range	Population		CHIP Program Type	Sample Size	Data Source		Percentage of Children Receiving Well-Child Visits (Number of Visits)						
			Medicaid	CHIP			Administrative	Hybrid	0	1	2	3	4	5	6
Alabama	HEDIS 2011	Jan-10 - Dec-10		X	Separate	380	X		1.8	3.2	4.2	10.0	19.7	27.1	33.9
Alaska	HEDIS 2010	Jan-10 - Dec-10	X	X	Medicaid Expansion	3,452	X		3.4	5.1	5.9	7.2	9.4	12.2	56.8
Arizona	HEDIS 2011	Oct-09 - Sep-10		X	Separate	271	X		0.4	0.4	1.1	5.9	7.7	16.6	67.9
Arkansas	HEDIS 2010	Oct-09 - Sep-10	X	X	Combination	21,150	X		6.7	6.3	7.9	9.6	13.2	15.6	40.7
California	HEDIS 2011	Jan-10 - Dec-10		X	Combination	8,204	X	X	1.5	1.5	1.8	4.0	9.8	19.9	61.5
Colorado															
Medicaid	HEDIS 2011	Jan-10 - Dec-10	X			1,309		X	1.4	1.6	1.6	4.0	7.6	14.6	69.2
CHIP	HEDIS 2011	Jan-10 - Dec-10		X	Separate	688	X		2.3	1.2	1.7	5.5	9.6	16.0	32.8
Connecticut	HEDIS 2011	Jan-10 - Dec-10	X	X	Separate	NR		X	0.7	0.7	2.3	1.8	7.7	12.4	74.4
D.C.	HEDIS 2011	Jan-10 - Dec-10	X	X	Medicaid Expansion	2,193	X		2.0	2.0	2.3	6.1	10.9	13.1	62.3
Florida	HEDIS 2011	Jan-10 - Dec-10	X		Combination	29,409	X	X	3.0	2.2	3.1	5.4	10.4	16.7	58.4
Georgia	HEDIS 2011	Jan-10 - Dec-10	X	X	Separate	58,677	X		7.6	4.4	4.9	7.1	11.8	19.1	45.1
Hawaii	HEDIS 2011	Jan-10 - Dec-10	X	X	Medicaid Expansion	6,463		X	2.8	1.9	2.5	4.9	8.8	17.9	61.1
Idaho	HEDIS 2010	Oct-10 - Sep-11	X	X	Combination	9,117	X		5.8	7.2	8.5	11.0	14.4	18.7	34.4
Illinois	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	91,367	X		2.8	2.5	3.3	4.7	6.8	9.7	70.2
Indiana	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	1,248		X	2.7	1.8	4.2	7.2	8.1	18.3	57.6
Iowa	HEDIS 2010	Jan-10 - Dec-10	X		Combination	15,217	X		10.6	15.5	27.0	30.2	11.8	3.4	1.6
Kentucky	HEDIS 2010	Jan-10 - Dec-10	X	X	Combination	5,210	X		0.7	1.2	2.1	3.8	6.7	13.2	72.3
Louisiana	HEDIS 2011	Jul-10 - Jun-11	X	X	Combination	41,624	X		2.5	3.1	4.4	6.3	10.5	15.9	57.2
Maine	HEDIS 2011	Oct-10 - Sep-11	X	X	Combination	6,409	X		2.1	1.6	2.8	4.3	9.5	16.9	62.8
Maryland	HEDIS 2011	Jan-10 - Dec-10	X	X	Medicaid Expansion	NR		X	2.0	0.0	0.0	0.0	0.0	0.0	82.4
Massachusetts	HEDIS 2010	Jul-08 - Dec-09	X	X	Combination	See comments		X	0.4	0.4	0.4	1.3	4.3	7.0	85.5
Michigan															
Medicaid	HEDIS 2011	Jan-10 - Dec-10	X			5,299		X	1.0	2.2	3.3	5.0	7.4	11.4	69.7
CHIP	HEDIS 2011	Jan-10 - Dec-10		X	Combination	94	X		38.3	19.1	10.6	11.7	12.8	12.8	4.3
Minnesota	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	12,713	X		NR	NR	NR	NR	11.3	21.5	55.2
Missouri	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	NR	X	X	2.2	2.9	5.0	6.7	10.3	15.7	57.4
Montana	HEDIS 2010	Jan-10 - Dec-10		X	Separate	179	X		4.5	6.7	3.4	10.6	24.0	34.6	16.2

Appendix Table E.3 (continued)

State	Methodology	Date Range	Population		CHIP Program Type	Sample Size	Data Source		Percentage of Children Receiving Well-Child Visits (Number of Visits)						
			Medicaid	CHIP			Administrative	Hybrid	0	1	2	3	4	5	6
Nevada	HEDIS 2011	Jul-10 - Jun-11		X	Separate	NR		X	NR	NR	NR	NR	NR	NR	56.6
New Hampshire	HEDIS 2011	Jul-09 - Jun-10		X	Combination	326	X		NR	0.6	2.1	2.1	7.1	13.8	74.2
New Jersey	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	1,234		X	2.0	1.9	2.8	5.6	8.3	11.2	68.2
New Mexico	HEDIS 2010	Jan-10 - Dec-10	X	X	Medicaid Expansion	1,705		X	1.7	1.5	3.0	5.5	9.9	17.3	61.1
New York	HEDIS 2011	Jan-10 - Dec-10	X	X	Separate	68,931	X		1.7	1.9	3.4	5.7	9.7	17.0	60.5
North Carolina	HEDIS 2011	Jan-10 - Dec-10	X		Combination	59,254	X		0.9	1.4	2.6	4.7	9.4	19.3	61.6
Ohio	HEDIS 2011	Jan-10 - Dec-10	X	X	Medicaid Expansion	66,592	X		3.8	3.0	4.7	6.2	9.5	12.7	60.2
Oklahoma	HEDIS 2011	Oct-08 - Sep-09	X	X	Combination	28,133	X		1.7	2.5	4.0	6.7	10.0	16.0	59.0
Oregon	HEDIS 2011	Jan-10 - Dec-10	X	X	Separate	18,032	X		2.3	2.5	4.5	6.9	12.4	21.1	50.3
Pennsylvania	HEDIS 2011	Jan-10 - Dec-10		X	Separate	892	X	X	1.9	1.1	1.7	1.8	6.4	20.0	67.2
Rhode Island	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	905	X		0.6	1.1	1.5	2.7	6.0	10.4	77.8
South Carolina	HEDIS 2011	Oct-10 - Sep-11		X	Medicaid Expansion	3,860	X		0.9	1.5	2.6	5.5	11.0	22.9	55.6
South Dakota	HEDIS 2008	Jan-10 - Dec-10		X	Combination	127	X		11.8	22.8	39.4	18.1	4.7	3.1	NR
Tennessee															
Medicaid	HEDIS 2011	Jan-10 - Dec-10	X			NR	X	X	NR	NR	NR	NR	NR	NR	55.8
CHIP	HEDIS 2011	Jan-10 - Dec-10		X	Combination	466	X		1.1	NR	1.9	3.2	6.4	17.8	69.5
Texas	HEDIS 2011	Sep-09 - Aug-10		X	Separate	71	X		4.2	2.8	2.8	12.7	12.7	22.5	42.3
Utah	HEDIS 2011	Jul-10 - Jun-11		X	Separate	NR		X	NR	NR	NR	NR	NR	NR	65.9
Vermont	HEDIS 2011	Jan-10 - Dec-10	X	X	Separate	2,966	X		2.2	1.6	1.7	3.0	6.7	12.6	72.2
Virginia	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	822		X	1.3	1.7	3.3	2.6	5.4	7.5	78.2
Washington	HEDIS 2011	Oct-08 - Dec-10	X	X	Separate	2,075		X	1.4	2.2	4.2	6.1	13.4	18.9	53.7
West Virginia	HEDIS 2011	Jan-10 - Dec-10		X	Separate	10	X		NR	NR	NR	10.0	10.0	30.0	40.0
Wyoming	HEDIS 2010	Oct-10 - Sep-11		X	Separate	10	X		NR	NR	NR	10.0	40.0	30.0	20.0

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

Notes: This table includes 45 states that used HEDIS specifications and excludes Nebraska which used other specifications to calculate this measure. Wisconsin did not submit a CARTS report for FFY 2011. Delaware submitted an FFY 2011 CARTS report, but did not submit data on any of the initial core set of children's health care quality measures. Kansas, Mississippi, and North Dakota submitted a CARTS report with data for other measures but did not report on measure 10.

State-specific comments:

AK: Rates are provisional since Alaska is new to reporting quality metrics.

CA: Rates include data from 20 of 24 managed care plans because four plans had sample sizes too small to report for this measure. Some plans used hybrid methodology and some used administrative data.

CO (Medicaid): Data from Federally Qualified Health Centers may be incomplete.

CO (CHIP): Reported percentages do not total 100 percent because there was an error in the calculation when adding each managed care plan's data for this measure. Colorado was waiting for corrected information at the time of this report.

Appendix Table E.3 (continued)

FL:	Rates include data from multiple Medicaid managed care plans. Some plans used administrative data and some used a hybrid methodology.
IL:	Rates are provisional because providers have up to one year to submit claims.
KY:	Rates for the CHIP program include the managed care region of Kentucky, representing about 20 percent of the CHIP population.
MA:	Massachusetts reported different sample sizes for each rate: 0 visits - 1,250; 1 visit - 1,750; 2 visits - 1,500; 3 visits - 1,385; 4 visits - 1,279; 5 visits - 1,614; 6+ visits - 1,375.
MO:	Rates are based on unweighted averages from the annual HEDIS reports submitted by MCOs in Missouri. MCOs have the option of using hybrid methodology or administrative data when allowed by NCQA. Rate is provisional because Missouri is still validating data.
NV:	Rates are based on claims data and medical records; administrative data represent 90 percent of each rate.
NH:	In New Hampshire, infants with household income between 185% and 300% FPL are covered under the Medicaid Expansion CHIP program. Therefore, rates are based on combined Medicaid Expansion and Separate CHIP data. Specifically, the Medicaid Expansion data captured those children from birth up to 12 months of age. Separate CHIP data captured those children from 12-15 months in age.
NJ:	The rates for 0 to 5 visits include data from three out of four HMOs. One HMO only submitted the rate for children receiving 6 or more visits. Therefore, the 6+ visits rate is the only rate that reflects the performance of all four HMOs (and this measure has a larger denominator).
NC:	Rates may include a small percentage of children who were dually eligible for Medicaid and Medicare, partially eligible for Medicaid, or covered by a major third party insurance.
OK:	Rates exclude enrollees in Home and Community-Based Section 1915(c) waivers as well as well-child visits occurring in the emergency room or inpatient settings.
OR:	Rates are provisional because Oregon is still validating the data.
PA:	Rates are based on a combination of hybrid methodology (seven managed care plans) and administrative data (two managed care plans).
SC:	South Carolina ended its Separate CHIP program effective October 1, 2010. At that time, the state transitioned all CHIP enrollees to a Medicaid Expansion CHIP.
TN (Medicaid):	Rates are based on data from seven MCOs. Four MCOs used hybrid methodology and three used administrative data. Statewide rates are weighted based on the eligible population of each MCO.
WA:	All rates represent statewide averages for five managed care plans.

NR = not reported.

Appendix Table E.4. Percentage of Children Receiving Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life, as Reported by States in Their FFY 2011 CARTS Reports (n=47)

			Population				Data Source		
State	Methodology	Date Range	Medicaid	CHIP	CHIP Program Type	Sample Size	Administrative	Hybrid	Percentage of Children Receiving 1+ Well-Child Visits in the 3rd, 4th, 5th, and 6th years of Life
Alabama	HEDIS 2011	Jan-10 - Dec-10		X	Separate	7,343	X		44.9
Alaska	HEDIS 2010	Jan-10 - Dec-10	X	X	Medicaid Expansion	12,438	X		47.6
Arizona	HEDIS 2011	Oct-09 - Sep-10		X	Separate	3,603	X		75.9
Arkansas	HEDIS 2010	Oct-09 - Sep-10	X	X	Combination	88,106	X		62.5
California	HEDIS 2011	Jan-10 - Dec-10		X	Combination	115,975	X	X	74.0
Colorado									
Medicaid	HEDIS 2011	Jan-10 - Dec-10	X			1,581		X	66.9
CHIP	HEDIS 2011	Jan-10 - Dec-10		X	Separate	4,810	X		63.1
Connecticut	HEDIS 2011	Jan-10 - Dec-10	X	X	Separate	NR		X	61.7
D.C.	HEDIS 2011	Jan-10 - Dec-10	X	X	Medicaid Expansion	8,670	X		79.5
Florida	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	294,813		X	70.5
Georgia	HEDIS 2011	Jan-10 - Dec-10	X	X	Separate	225,933	X		57.7
Hawaii	HEDIS 2011	Jan-10 - Dec-10	X	X	Medicaid Expansion	26,780		X	66.2
Idaho	HEDIS 2010	Oct-10 - Sep-11	X	X	Combination	35,694	X		49.3
Illinois	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	374,667	X		69.6
Indiana	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	1,186		X	69.7
Iowa	HEDIS 2010	Jan-10 - Dec-10	X		Combination	51,358	X		62.4
Kansas	NR	Jan-11 - Dec-11	X	X	Separate	10,183		X	48.7
Kentucky	HEDIS 2010	Jan-10 - Dec-10	X	X	Combination	20,444	X		75.3
Louisiana	HEDIS 2011	Jul-10 - Jun-11	X	X	Combination	166,521	X		64.0
Maine	HEDIS 2011	Oct-10 - Sep-11	X	X	Combination	25,984	X		62.8
Maryland	HEDIS 2011	Jan-10 - Dec-10	X	X	Medicaid Expansion	NR		X	80.7
Massachusetts	HEDIS 2010	Jan-09 - Dec-09	X	X	Combination	17,720		X	85.5
Michigan									
Medicaid	HEDIS 2011	Jan-10 - Dec-10	X			4,841		X	74.9
CHIP	HEDIS 2011	Jan-10 - Dec-10		X	Combination	2,556	X		67.6
Minnesota	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	38,451	X		67.3
Mississippi	HEDIS 2011	Jan-10 - Dec-10		X	Separate	5,000	X		35.9
Missouri	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	NR	X	X	59.4

Appendix Table E.4 (continued)

State	Methodology	Date Range	Population		CHIP Program Type	Sample Size	Data Source		Percentage of Children Receiving 1+ Well-Child Visits in the 3rd, 4th, 5th, and 6th years of Life
			Medicaid	CHIP			Administrative	Hybrid	
Montana	HEDIS 2010	Jan-10 - Dec-10		X	Separate	2,107	X		44.5
Nevada	HEDIS 2011	Jul-10 - Jun-11		X	Separate	843		X	77.9
New Hampshire	HEDIS 2011	Jul-09 - Jun-10		X	Combination	NR	X		79.0
New Jersey	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	1,389		X	81.3
New Mexico	HEDIS 2010	Jan-10 - Dec-10	X	X	Medicaid Expansion	1,643		X	62.6
New York	HEDIS 2011	Jan-10 - Dec-10	X	X	Separate	315,878	X		80.6
North Carolina	HEDIS 2011	Jan-10 - Dec-10	X		Combination	164,601	X		71.3
North Dakota	HEDIS 2011	Jan-10 - Dec-10		X	Combination	154	X		28.6
Ohio	HEDIS 2011	Jan-10 - Dec-10	X	X	Medicaid Expansion	244,839	X		62.4
Oklahoma	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	90,067	X		59.8
Oregon	HEDIS 2011	Jan-10 - Dec-10	X	X	Separate	60,730	X		55.4
Pennsylvania	HEDIS 2011	Jan-10 - Dec-10		X	Separate	5,979	X	X	74.9
Rhode Island	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	2,079	X		77.2
South Carolina	HEDIS 2011	Oct-10 - Sep-11		X	Medicaid Expansion	11,545	X		63.5
Tennessee									
Medicaid	HEDIS 2011	Jan-10 - Dec-10	X			NR	X	X	71.8
CHIP	HEDIS 2011	Jan-10 - Dec-10		X	Combination	5,516	X		64.4
Texas	HEDIS 2011	Sep-09 - Aug-10		X	Separate	31,049	X		68.1
Utah	HEDIS 2011	Jul-10 - Jun-11		X	Separate	2,413	X		56.5
Vermont	HEDIS 2010	Jan-10 - Dec-10	X	X	Separate	12,794	X		69.0
Virginia	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	959		X	74.9
Washington	HEDIS 2011	Jan-09 - Dec-10	X	X	Separate	2,504		X	61.5
West Virginia	HEDIS 2011	Jan-10 - Dec-10		X	Separate	1,026	X		73.3
Wyoming	HEDIS 2010	Oct-10 - Sep-11		X	Separate	406	X		48.5

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

Notes: This table includes 47 states that used HEDIS specifications and excludes Nebraska which used other specifications to calculate this measure. Wisconsin did not submit a CARTS report for FFY 2011. Delaware submitted an FFY 2011 CARTS report, but did not submit data on any of the initial core set of children's health care quality measures. South Dakota submitted a CARTS report with data for one measure but did not report on measure 11.

Appendix Table E.4 (continued)
State-specific comments:

AK:	Rates are provisional since Alaska is new to reporting quality metrics.
CA:	Statewide rate is weighted based on eligible population of each managed care plan. Some plans used hybrid methodology and some used administrative data.
CT:	Rate is a weighted average across three managed care plans.
FL:	Rate excludes Title XXI Children's Medical Services enrollees.
IL:	Rate is provisional because providers have up to one year to submit claims.
IN:	Rate is weighted average of data from three MCOs. The results have been certified by HEDIS auditors.
KS:	Rate includes data from only one MCO and is based on interim data from the second quarter 2011 update on that MCO's Performance Improvement Project.
KY:	Rate for the CHIP program includes the managed care region of Kentucky, representing about 20 percent of the CHIP population.
LA:	Rate includes data from Federally Qualified Health Centers and Rural Health Centers. Rate may not be comparable to rate reported in previous years, because rate now includes the Medicaid program as well as the Phase V Separate CHIP expansion population (with household income up to 250 percent of the FPL).
ME:	Rate is provisional because providers have up to one year to bill for services and another year for adjustments and some claims may not be included in reported data. Rate is based on HEDIS 2011 specifications, but Maine included retired codes from HEDIS 2007-2010 so that the same program could be used to calculate rates on claims data from 2007 through 2011.
MA:	Statewide rate is weighted to account for differences in plan size.
MO:	Rate is based on unweighted average from the annual HEDIS reports submitted by MCOs in Missouri. MCOs have the option of using hybrid methodology or administrative data when allowed by NCQA. Rate is provisional because Missouri is still validating data.
NV:	Rate is based on claims data and medical records; administrative data represent 90 percent of each rate.
NJ:	Rate includes data from all four contracted HMOs. One HMO rotated the measure for 2011.
NC:	Rate may include a small percentage of children who were dually eligible for Medicaid and Medicare, partially eligible for Medicaid, or covered by a major third party insurance. Rate is provisional because North Carolina is still validating data.
OK:	Rate excludes enrollees in Home and Community-Based Section 1915(c) waivers as well as well-child visits occurring in the emergency room or inpatient settings.
OR:	Rate is provisional because Oregon is still validating the data.
PA:	Rate is based on a combination of hybrid methodology (seven managed care plans) and administrative data (two managed care plans).
SC:	South Carolina ended its Separate CHIP program effective October 1, 2010. At that time, the state transitioned all CHIP enrollees to a Medicaid Expansion CHIP.

Appendix Table E.4 (continued)

TN (Medicaid): Rate is based on data from seven MCOs. Four MCOs used hybrid methodology and three used administrative data. Statewide rate is weighted based on eligible population of each MCO.

NR = not reported.

Appendix Table E.5. Percentage of Adolescents Receiving Well-Care Visits, as Reported by States in Their FFY 2011 CARTS Reports (n=43)

			Population				Data Source		
State	Methodology	Date Range	Medicaid	CHIP	CHIP Program Type	Sample Size	Administrative	Hybrid	Percentage of Adolescents Ages 12 to 21 Receiving One or More Well-Child Visits
Alabama	HEDIS 2011	Jan-10 - Dec-10		X	Separate	30,798	X		25.1
Alaska	HEDIS 2010	Jan-10 - Dec-10	X	X	Medicaid Expansion	18,746	X		29.4
Arizona	HEDIS 2011	Oct-09 - Sep-10		X	Separate	10,094	X		52.9
Arkansas	HEDIS 2010	Oct-09 - Sep-10	X	X	Combination	124,274	X		33.7
California	HEDIS 2011	Jan-10 - Dec-10		X	Combination	278,665	X	X	47.3
Colorado									
Medicaid	HEDIS 2011	Jan-10 - Dec-10	X			1,644		X	47.1
CHIP	HEDIS 2011	Jan-10 - Dec-10		X	Separate	11,404	X		42.6
Connecticut	HEDIS 2011	Jan-10 - Dec-10	X	X	Separate	NR		X	61.7
D.C.	HEDIS 2011	Jan-10 - Dec-10	X	X	Medicaid Expansion	11,093	X		51.7
Florida	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	372,552		X	47.4
Georgia	HEDIS 2011	Jan-10 - Dec-10	X	X	Separate	272,718	X		32.1
Idaho	HEDIS 2010	Oct-10 - Sep-11	X	X	Combination	42,632	X		28.5
Illinois	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	570,318	X		43.8
Indiana	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	1,254		X	61.2
Iowa	HEDIS 2010	Jan-10 - Dec-10	X		Combination	70,545	X		31.4
Kentucky	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	27,749	X		56.8
Louisiana	HEDIS 2011	Jul-10 - Jun-11	X	X	Combination	252,748	X		39.0
Maine	HEDIS 2011	Oct-10 - Sep-11	X	X	Combination	46,988	X		38.4
Maryland	HEDIS 2011	Jan-10 - Dec-10	X	X	Medicaid Expansion	NR		X	62.8
Massachusetts	HEDIS 2010	Jan-09 - Dec-09	X	X	Combination	43,279		X	66.7
Michigan									
Medicaid	HEDIS 2011	Jan-10 - Dec-10	X			5,475		X	56.8
CHIP	HEDIS 2011	Jan-10 - Dec-10		X	Combination	5,877	X		50.1

Appendix Table E.5 (continued)

State	Methodology	Date Range	Population		CHIP Program Type	Sample Size	Data Source		Percentage of Adolescents Ages 12 to 21 Receiving One or More Well-Child Visits
			Medicaid	CHIP			Administrative	Hybrid	
Mississippi	HEDIS 2011	Jan-10 - Dec-10		X	Separate	22,424	X		21.9
Missouri	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	NR	X	X	40.0
Nevada	HEDIS 2011	Jul-10 - Jun-11		X	Separate	843		X	49.2
New Hampshire	HEDIS 2011	Jul-09 - Jun-10	X		Combination	NR	X		61.9
New Jersey	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	1,646		X	62.9
New Mexico	HEDIS 2010	Jan-10 - Dec-10	X	X	Medicaid Expansion	19,731		X	40.2
New York	HEDIS 2011	Jan-10 - Dec-10	X	X	Separate	569,631	X		58.6
North Carolina	HEDIS 2011	Jan-10 - Dec-10	X		Combination	224,476	X		36.5
North Dakota	HEDIS 2011	Jan-10 - Dec-10		X	Combination	1,069	X		45.7
Ohio	HEDIS 2011	Jan-10 - Dec-10	X	X	Medicaid Expansion	374,722	X		34.2
Oklahoma	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	107,199	X		33.5
Oregon	HEDIS 2011	Jan-10 - Dec-10	X	X	Separate	78,269	X		26.7
Pennsylvania	HEDIS 2011	Jan-10 - Dec-10		X	Separate	17,089	X	X	55.9
Rhode Island	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	2,835		X	59.7
South Carolina	HEDIS 2011	Oct-10 - Sep-11		X	Medicaid Expansion	8,315	X		41.4
Tennessee									
Medicaid	HEDIS 2011	Jan-10 - Dec-10	X			NR		X	46.2
CHIP	HEDIS 2011	Jan-10 - Dec-10		X	Combination	13,183	X		36.5
Texas	HEDIS 2011	Sep-09 - Aug-10		X	Separate	115,385	X		49.6
Utah	HEDIS 2011	Jul-10 - Jun-11		X	Separate	2,431		X	37.3
Vermont	HEDIS 2010	Jan-10 - Dec-10	X	X	Separate	22,022	X		46.3
Virginia	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	2,179		X	44.8
Washington	HEDIS 2011	Jan-09 - Dec-10	X	X	Separate	2,714		X	36.5
West Virginia	HEDIS 2011	Jan-10 - Dec-10		X	Separate	4,851	X		33.9
Wyoming	HEDIS 2010	Oct-10 - Sep-11		X	Separate	1,168	X		67.6

Appendix Table E.5 (continued)
Source: Mathematica analysis of FFY 2011 CARTS reports as of June 20, 2012.

Notes: This table includes 43 states that used HEDIS specifications. Wisconsin did not submit a CARTS report for FFY 2011. Delaware submitted an FFY 2011 CARTS report, but did not submit data on any of the initial core set of children's health care quality measures. Hawaii, Kansas, Minnesota, Montana, Nebraska, and South Dakota submitted a CARTS report with data for other measures but did not report on measure 12.

State-specific comments:

AK: Rates are provisional since Alaska is new to reporting quality metrics.

AZ: Rate includes adolescents ages 12-19.

CA: Statewide rate is weighted based on eligible population of each managed care plan. Some plans used hybrid methodology and some used administrative data. Numerator of the rate includes adolescents ages 12 - 18. The denominator includes adolescents ages 12 - 19.

CT: Rate is weighted average across three managed care plans.

FL: Rate excludes Title XXI Children's Medicaid Services enrollees. The numerator includes adolescents ages 12 - 18. Rate is based on administrative data and hybrid methodology.

IL: Rate includes adolescents ages 12-20. Rate is provisional because providers have one year to submit claims.

IN: Rate is weighted average of data from three MCOs. The results have been certified by HEDIS auditors.

KY: Rate for the CHIP program includes the managed care region of Kentucky, representing about 20 percent of the CHIP population.

LA: Rate includes data from Federally Qualified Health Centers and Rural Health Centers. Rate may not be comparable to rate reported in previous years, because rate now includes the Medicaid program as well as the Phase V Separate CHIP expansion population (with household income up to 250 percent of the FPL). Rate includes CHIP and Medicaid enrollees as of June 2011.

ME: Rate is provisional because providers have up to one year to bill for services and another year for adjustments. Rates are based on HEDIS 2011 specifications, but Maine included retired codes from HEDIS 2007-2010 so that the same programs could be used to calculate rates on claims data from 2007 through 2011.

MA: Statewide rate is weighted to account for differences in plan size.

MO: Rate is based on unweighted average from the annual HEDIS reports submitted by MCOs in Missouri. MCOs have the option of using hybrid methodology or administrative data when allowed by NCQA. Rate is provisional because Missouri is still validating data.

NV: Rate includes adolescents up to age 19. Rate is based on claims data and medical records; administrative data represent 90 percent of each rate.

NH: Numerator includes adolescents ages 12-18.

NC: Rate may include a small percentage of children who were dually eligible for Medicaid and Medicare, partially eligible for Medicaid, or covered by a major third party insurance. Rate is provisional because North Carolina is still validating data.

ND: Numerator includes adolescents ages 12-18.

OK: Rate excludes enrollees in Home and Community-Based Section 1915(c) waivers as well as well-child visits occurring in the emergency room or inpatient settings.

Appendix Table E.5 (continued)

OR: Rate is provisional because Oregon is still validating the data.

PA: Rate includes adolescents ages 12-19. Rate is based on a combination of administrative data (two managed care plans) and hybrid methodology (seven managed care plans).

SC: South Carolina ended its Separate CHIP program effective October 1, 2010. At that time, the state transitioned all CHIP enrollees to a Medicaid Expansion CHIP.

TN (Medicaid): Statewide rate is weighted based on eligible population of each MCO.

VA: The denominator of the rate excludes adolescents who received services through primary care case management (PCCM) or on a fee-for-service basis (number of excluded adolescents is not available). Rate is the sum of unweighted samples from each of the five MCOs.

WV: Numerator of the rate includes adolescents ages 12-19.

Appendix Table E.6. Percentage of Children Receiving Combination Three Immunization, as Reported by States in Their FFY 2011 CARTS Reports (n=28)

State	Methodology	Date Range	Population		CHIP Program Type	Sample Size	Data Source		Immunization Rate (Combination #3)[a]
			Medicaid	CHIP			Administrative	Hybrid	
Alabama	HEDIS 2011	Jan-10 - Dec-10		X	Separate	1,351	X		55.3
Arkansas	HEDIS 2010	Oct-09 - Sep-10	X	X	Combination	22,159	X		32.8
California	HEDIS 2011	Jan-10 - Dec-10		X	Combination	15,908		X	74.5
Colorado									
Medicaid	HEDIS 2011	Jan-10 - Dec-10	X			1,644		X	77.4
CHIP	HEDIS 2011	Jan-10 - Dec-10		X	Separate	811		X	74.1
D.C.	HEDIS 2011	Jan-10 - Dec-10	X	X	Medicaid Expansion	2,612	X		78.8
Florida	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	76,386		X	65.8
Georgia	HEDIS 2011	Jan-10 - Dec-10	X	X	Separate	54,931	X		23.0
Hawaii	HEDIS 2011	Jan-10 - Dec-10	X	X	Medicaid Expansion	7,097		X	65.8
Illinois	HEDIS 2010	Jan-10 - Dec-10	X	X	Combination	94,315	X		58.0
Indiana	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	1,254		X	62.3
Iowa	HEDIS 2010	Jan-10 - Dec-10	X		Combination	14,749	X		7.7
Kentucky									
Medicaid	HEDIS 2010	Jan-10 - Dec-10	X	X		452		X	77.4
CHIP	HEDIS 2010	Jul-10 - Jun-11	X	X	Combination	452		X	77.4
Maryland	HEDIS 2011	Jan-10 - Dec-10	X	X	Medicaid Expansion	NR		X	76.3
Massachusetts	HEDIS 2010	Jan-07 - Dec-09	X	X	Combination	1,949		X	79.2
Michigan									
Medicaid	HEDIS 2011	Jan-10 - Dec-10	X			11,232		X	71.8
CHIP	HEDIS 2011	Jan-10 - Dec-10		X	Combination	331	X		29.9
Missouri	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	NR	X	X	57.2
Nevada	HEDIS 2011	Jan-08 - Dec-10		X	Separate	340	X		80.3
New Jersey	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	1,316		X	64.8
New Mexico	HEDIS 2010	Jan-10 - Dec-10	X	X	Medicaid Expansion	1,727		X	71.0
New York	HEDIS 2010	Jan-09 - Dec-09	X		Separate	62,975		X	73.3

Appendix Table E.6 (continued)

State	Methodology	Date Range	Population		CHIP Program Type	Sample Size	Data Source		Immunization Rate (Combination #3)[a]
			Medicaid	CHIP			Administrative	Hybrid	
Oregon	HEDIS 2011	Jan-10 - Dec-10	X	X	Separate	17,783	X		62.5
Pennsylvania	HEDIS 2011	Jan-10 - Dec-10		X	Separate	2,485		X	74.3
Rhode Island	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	1,199		X	81.1
Tennessee									
Medicaid	HEDIS 2011	Jan-10 - Dec-10	X			NR		X	70.3
CHIP	HEDIS 2011	Jan-10 - Dec-10		X	Combination	582	X		37.6
Utah	HEDIS 2011	Jul-10 - Jun-11		X	Separate	290		X	74.1
Virginia	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	814		X	77.9
Washington	HEDIS 2011	Jan-08 - Dec-10	X	X	Separate	2,076		X	65.9
West Virginia	HEDIS 2011	Jan-10 - Dec-10		X	Separate	44	X		61.4

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

Notes: This table includes 28 states that used HEDIS specifications and excludes South Carolina which used other specifications to calculate this measure. This table also does not include Wyoming which reported on Measure 5 but did not provide data for Combination #3. Wisconsin did not submit a CARTS report for FFY 2011. Delaware submitted an FFY 2011 CARTS report, but did not submit data on any of the initial core set of children's health care quality measures. Alaska, Arizona, Connecticut, Idaho, Kansas, Louisiana, Maine, Minnesota, Mississippi, Montana, Nebraska, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, South Dakota, Texas, and Vermont submitted a CARTS report with data for other measures but did not report on measure 5.

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

State-specific comments:

AL: Rate is based on data from the Alabama immunization registry for children meeting the denominator definition.

CA: Rate includes data from all managed care plans. One plan used administrative data and all other plans used hybrid methodology.

CO: Rate is based on claims, encounters, and registry data.

IL: Rate is based on administrative (claims data) and registry data. Rate is provisional because providers have up to one year to submit claims.

IN: Rate is weighted average of data from three MCOs. The results have been certified by HEDIS auditors.

KY: Rate for the CHIP program includes the managed care region of Kentucky, representing about 20 percent of the CHIP population.

MD: Numerator includes children ages 10-17.

MA: Statewide rate is weighted to account for differences in plan size.

Appendix Table E.6 (continued)

MO:	Rate is based on unweighted average from the annual HEDIS reports submitted by MCOs in Missouri. MCOs have the option of using hybrid methodology or administrative data when allowed by NCQA. Rate is provisional because Missouri is still validating data.
NV:	Rate is based on data from measurement year and for two years prior to measurement year.
NJ:	Rate is based on the weighted average of data from all four HMOs.
OR:	Rate is based on claims and encounter data and registry data.
PA:	Rate is based on hybrid methodology from nine managed care plans.
TN (Medicaid):	Statewide rate is weighted based on eligible population of each MCO.
TN (CHIP):	Rate includes data from the Tennessee Immunization Registry to supplement the immunization utilization records available from the insurer.
UT:	Rate is based on chart review.
VA:	Rate is based on data from Virginia Immunization Registry.
WA:	Rate is based on claims and medical record data as well as data from the Washington Immunization Registry "CHILD Profile".
WV:	This measure cannot meet a 95 percent confidence level test due to small sample (n=44).

NR= not reported.

Appendix Table E.7. Percentage of Adolescents Receiving Combination Immunization, as Reported by States in Their FFY 2011 CARTS Reports (n=22)

State	Methodology	Date Range	Population		CHIP Program Type	Sample Size	Data Source		Immunization Rate Combination[a]
			Medicaid	CHIP		Combination	Administrative	Hybrid	
Alabama	HEDIS 2011	Jan-10 - Dec-10		X	Separate	4,211	X		27.5
Arkansas	HEDIS 2010	Oct-09 - Sep-10	X	X	Combination	16,700	X		17.2
California	HEDIS 2011	Jan-10 - Dec-10		X	Combination	41,024	X	X	54.4
Connecticut	HEDIS 2011	Jan-10 - Dec-10	X	X	Separate	NR		X	50.8
D.C.	HEDIS 2011	Jan-11 - Dec-11	X	X	Medicaid Expansion	1,771	X		76.9
Florida	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	48,251		X	52.4
Georgia	HEDIS 2011	Jan-10 - Dec-10	X	X	Separate	39,330	X		52.9
Hawaii	HEDIS 2011	Jan-10 - Dec-10	X	X	Medicaid Expansion	4,692		X	32.0
Illinois	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	56,866	X		25.9
Indiana	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	1,254		X	58.1
Iowa	HEDIS 2010	Jan-10 - Dec-10	X		Combination	8,770	X		14.2
Kentucky									
Medicaid	HEDIS 2010	Jan-10 - Dec-10	X	X		452		X	60.0
CHIP	HEDIS 2010	Jul-10 - Jun-11	X	X	Combination	452		X	60.0
Maryland	HEDIS 2011	Jan-10 - Dec-10	X	X	Medicaid Expansion	NR		X	51.8
Michigan	HEDIS 2011	Jan-10 - Dec-10	X		Combination	10,565		X	51.9
Missouri	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	NR	X	X	27.1
North Dakota	HEDIS 2011	Jan-10 - Dec-10		X	Combination	139	X		68.3
Oregon	HEDIS 2011	Jan-10 - Dec-10	X	X	Separate	10,814	X		42.3
Pennsylvania	HEDIS 2011	Jan-10 - Dec-10		X	Separate	3,188		X	72.5
Rhode Island	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	925		X	77.5
Tennessee									
Medicaid	HEDIS 2011	Jan-10 - Dec-10	X			NR	X	X	43.2
CHIP	HEDIS 2011	Jan-10 - Dec-10		X	Combination	1,765	X		32.7
West Virginia	HEDIS 2011	Jan-10 - Dec-10		X	Separate	1,872	X		72.2
Wyoming	HEDIS 2010	Oct-10 - Sep-11		X	Separate	236	X		35.2

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

Appendix Table E.7 (continued)

Notes: This table includes 22 states that used HEDIS specifications and excludes South Carolina which used other specifications to calculate this measure. This table also does not include New Mexico or Utah that reported on Measure 6 but did not provide data for the Combination. Wisconsin did not submit a CARTS report for FFY 2011. Delaware submitted an FFY 2011 CARTS report, but did not submit data on any of the initial core set of children's health care quality measures. Alaska, Arizona, Colorado, Idaho, Kansas, Louisiana, Maine, Massachusetts, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oklahoma, South Dakota, Texas, Vermont, Virginia, and Washington submitted a CARTS report with data for other measures but did not report on measure 6.

State-specific comments:

CA: Some plans used hybrid methodology and some used administrative data.

CT: Rate is a weighted average across three managed care plans.

IN: Rate is weighted average of data from three MCOs. The results have been certified by HEDIS auditors.

KY: Rate for the CHIP program includes the managed care region of Kentucky, representing about 20 percent of the CHIP population.

MI: Rate counts meningococcal conjugate, polysaccharide, and Tdap or Td only if there is evidence of the antigen or combination vaccine.

MO: Rate is based on unweighted average from the annual HEDIS reports submitted by MCOs in Missouri. MCOs have the option of using hybrid methodology or administrative data when allowed by NCQA. Rate is provisional because Missouri is still validating data.

OR: Rate is based on claims and encounter data and registry data.

PA Rate is based on hybrid methodology from nine managed care plans.

TN (Medicaid): Rate includes data from seven MCOs. Four MCOs used administrative data and three used hybrid methodology. Statewide rate is weighted based on enrollment size of each MCO.

NR= not reported.

Appendix Table E.8. Percentage of Sexually Active Women Ages 16 Through 20 Who Were Tested for Chlamydia, as Reported by States in Their FFY 2011 CARTS Reports (n=32)

State	Methodology	Date Range	Population		CHIP Program Type	Sample Size	Data Source		Percentage of Women Screened
			Medicaid	CHIP			Administrative	Hybrid	
Alabama	HEDIS 2011	Jan-10 - Dec-10		X	Separate	3,198	X		32.4
Alaska	HEDIS 2010	Jan-10 - Dec-10	X	X	Medicaid Expansion	2,129	X		16.6
Arizona	HEDIS 2011	Oct-09 - Sep-10		X	Separate	432	X		26.4
Arkansas	HEDIS 2010	Oct-09 - Sep-10	X	X	Combination	17,614	X		55.7
California	HEDIS 2011	Jan-10 - Dec-10		X	Combination	13,469	X		47.7
Colorado	HEDIS 2011	Jan-10 - Dec-10	X		Separate	17,969	X		55.8
Connecticut	HEDIS 2011	Jan-10 - Dec-10	X	X	Separate	19,197	X		64.4
Dist. of Col.	HEDIS 2011	Jan-10 - Dec-10	X	X	Medicaid Expansion	3,805	X		74.1
Florida	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	37,469	X		50.8
Georgia	HEDIS 2011	Jan-10 - Dec-10	X	X	Separate	30,596	X		44.6
Hawaii	HEDIS 2011	Jan-10 - Dec-10	X	X	Medicaid Expansion	4,309	X		56.5
Illinois	HEDIS 2009	Jan-10 - Dec-10	X	X	Combination	140,488	X		20.9
Indiana	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	16,536	X		45.8
Iowa	HEDIS 2010	Jan-10 - Dec-10	X		Combination	14,970	X		44.4
Kansas	NR	Oct-09 - Jan-12	X	X	Separate	2,394	X		46.4
Kentucky	HEDIS 2010	Jan-10 - Dec-10	X	X	Combination	3,646	X		67.5
Maine	HEDIS 2011	Oct-10 - Sep-11	X	X	Combination	8,782	X		42.0
Maryland	HEDIS 2011	Jan-10 - Dec-10	X	X	Medicaid Expansion	NR	X		63.0
Massachusetts	HEDIS 2010	Jan-09 - Dec-09	X	X	Combination	16,427	X		63.9
Michigan	HEDIS 2011	Jan-10 - Dec-10	X		Combination	33,372	X		60.7
Mississippi	HEDIS 2011	Jan-10 - Dec-10		X	Separate	2,376	X		32.0
Missouri	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	NR	X	X	58.4
New Mexico	HEDIS 2010	Jan-10 - Dec-10	X	X	Medicaid Expansion	9,228		X	45.0
New York	HEDIS 2011	Jan-10 - Dec-10	X		Separate	57,060	X		66.7
North Carolina	HEDIS 2011	Jan-10 - Dec-10	X		Combination	76,971	X		38.2

Appendix Table E.8 (continued)

State	Methodology	Date Range	Population		CHIP Program Type	Sample Size	Data Source		Percentage of Women Screened
			Medicaid	CHIP			Administrative	Hybrid	
Oregon	HEDIS 2011	Jan-10 - Dec-10	X	X	Separate	11,204	X		44.0
Rhode Island	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	3,290	X		55.4
South Carolina	HEDIS 2011	Oct-10 - Sep-11		X	Medicaid Expansion	1,323	X		49.1
Tennessee									
Medicaid	HEDIS 2011	Jan-10 - Dec-10	X			NR	X		53.9
CHIP	HEDIS 2011	Jan-10 - Dec-10		X	Combination	1,028	X		33.4
Texas	HEDIS 2011	Sep-09 - Aug-10		X	Separate	5,078	X		30.5
West Virginia	HEDIS 2011	Jan-10 - Dec-10		X	Separate	791	X		7.5
Wyoming	HEDIS 2010	Oct-10 - Sep-11		X	Separate	162	X		11.1

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

Notes: This table includes 32 states that used HEDIS specifications. Wisconsin did not submit a CARTS report for FFY 2011. Delaware submitted an FFY 2011 CARTS report, but did not submit data on any of the initial core set of children's health care quality measures. Idaho, Louisiana, Minnesota, Montana, Nebraska, Nevada, New Hampshire, New Jersey, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Utah, Vermont, Virginia, and Washington submitted a CARTS report with data for other measures but did not report on measure 9.

State-specific comments:

AK: Rates are provisional since Alaska is new to reporting quality metrics.

CA: Rate is based on the whole eligible enrolled population, but the numerator includes children 2½ years or older.

FL: Rate excludes Title XXI Children's Medicaid Services enrollees.

GA: Rate may be underestimated because lab information was unavailable which resulted in a lack of LOINC codes (per HEDIS specifications).

IL: Numerator includes treatments of Sephradine and Erythromycin Estolate, which are not included in the Initial Core Set measure specifications. Rate is provisional because providers have up to one year to submit claims.

IN: Rate is weighted average of data from three MCOs. The results have been certified by HEDIS auditors.

KY: Rate for the CHIP program includes the managed care region of Kentucky, representing about 20 percent of the CHIP population.

PA: Rate is based on data from nine managed care plans.

SC: South Carolina ended its Separate CHIP program effective October 1, 2010. At that time, the state transitioned all CHIP enrollees to a Medicaid Expansion CHIP.

TN (Medicaid): Statewide rate is weighted based on eligible population of each MCO.

NR = not reported.

Appendix Table E.9. Percentage of Children Diagnosed with Pharyngitis Who Received Appropriate Testing, as Reported by States in Their FFY 2011 CARTS Reports (n=28)

State	Methodology	Date Range	Population		CHIP Program Type	Sample Size	Data Source		Percentage of Children Receiving Appropriate Testing
			Medicaid	CHIP			Administrative	Hybrid	
Alabama	HEDIS 2011	Jan-10 - Dec-10		X	Separate		X		76.2
Alaska	HEDIS 2010	Jan-10 - Dec-10	X	X	Medicaid Expansion	1,742	X		39.3
Arkansas	HEDIS 2010	Oct-09 - Sep-10	X	X	Combination	19,372	X		48.5
California	HEDIS 2011	Jan-10 - Dec-10		X	Combination	31,172	X		38.5
D.C.	HEDIS 2011	Jan-10 - Dec-10	X	X	Medicaid Expansion	669	X		66.8
Florida	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	54,437	X		52.8
Georgia	HEDIS 2011	Jan-10 - Dec-10	X	X	Separate	58,488	X		67.1
Illinois	HEDIS 2009	Jul-09 - Jun-10	X	X	Combination	86,111	X		39.2
Indiana	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	21,411	X		56.8
Iowa									
Medicaid	HEDIS 2010	Jan-10 - Dec-10	X			7,820	X		46.3
CHIP	HEDIS 2010	Oct-09 - Sep-10		X	Combination	343	X		61.2
Kentucky	HEDIS 2010	Jan-10 - Dec-10	X	X	Combination	7,312	X		62.1
Maine	HEDIS 2011	Oct-10 - Sep-11	X	X	Combination	1,283	X		80.4
Maryland	HEDIS 2011	Jan-10 - Dec-10	X	X	Medicaid Expansion	NR	X		71.1
Michigan	HEDIS 2011	Jan-10 - Dec-10	X	X	Combination	55,148	X		59.5
Mississippi	HEDIS 2011	Jan-10 - Dec-10		X	Separate	8,497	X		47.9
Montana	HEDIS 2010	Jan-10 - Dec-10		X	Separate	1,029	X		63.7
New Hampshire	HEDIS 2011	Jul-09 - Jun-10		X	Combination	179	X		78.2
New Mexico	HEDIS 2011	Jan-10 - Dec-10	X	X	Medicaid Expansion	9,698		X	62.5
New York	HEDIS 2011	Jan-10 - Dec-10	X	X	Separate	98,039	X		84.6
North Dakota	HEDIS 2011	Jan-10 - Dec-10		X	Combination	151	X		50.3

Appendix Table E.9 (continued)

State	Methodology	Date Range	Population		CHIP Program Type	Sample Size	Data Source		Percentage of Children Receiving Appropriate Testing
			Medicaid	CHIP			Administrative	Hybrid	
Oregon	HEDIS 2011	Jan-10 - Dec-10	X	X	Separate	8,125	X		67.4
Pennsylvania	HEDIS 2011	Jan-10 - Dec-10		X	Separate	10,723	X		70.7
Rhode Island	HEDIS 2011	Jul-09 - Jun-10	X	X	Combination	4,175	X		76.0
South Carolina	HEDIS 2011	Oct-10 - Sep-11		X	Medicaid Expansion	2,514	X		74.9
Tennessee									
Medicaid	HEDIS 2011	Jul-09 - Jun-10	X			NR	X		72.1
CHIP	HEDIS 2011	Jan-10 - Dec-10		X	Combination	2,587	X		79.6
Texas	HEDIS 2011	Sep-09 - Aug-10		X	Separate	23,879	X		54.2
Utah	HEDIS 2011	Jul-10 - Jun-11		X	Separate	540	X		76.1
Wyoming	HEDIS 2010	Oct-10 - Sep-11		X	Separate	1,171	X		37.3

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

Notes: This table includes 28 states that used HEDIS specifications. Wisconsin did not submit a CARTS report for FFY 2011. Delaware submitted an FFY 2011 CARTS report, but did not submit data on any of the initial core set of children's health care quality measures. Arizona, California, Colorado, Hawaii, Idaho, Kansas, Louisiana, Massachusetts, Minnesota, Missouri, Nebraska, Nevada, New Jersey, North Carolina, Ohio, Oklahoma, South Dakota, Vermont, Virginia, Washington, West Virginia submitted a CARTS report with data for other measures but did not report on measure 15.

State-specific comments:

AK: Rates are provisional since Alaska is new to reporting quality metrics.

AZ: Rate includes adolescents ages 12-19.

CA: Rate includes adolescents age 19 and younger.

FL: Rate includes adolescents age 18 and younger.

IL: Rate includes adolescents ages 16 - 24. Rate is provisional because providers have up to one year to submit claims.

IN: Rate is weighted average of data from three MCOs. The results have been certified by HEDIS auditors.

KS: Rate is based on preliminary data from one MCO and includes adolescents ages 16 – 24 (based on age as of September 30, 2009).

KY: Rate for the CHIP program includes the managed care region of Kentucky, representing about 20 percent of the CHIP population.

ME: Rate is provisional because providers have up to one year to bill for services and another year for adjustments. Rates are based on HEDIS 2011 specifications, but Maine included retired codes from HEDIS 2007-2010 so that the same program could be used to calculate measures on claims data from 2007 through 2011.

Appendix Table E.9 (continued)

MA: Statewide rate is weighted to account for differences in plan size.

MO: Rate is based on unweighted average from the annual HEDIS reports submitted by MCOs in Missouri. MCOs have the option of using hybrid or administrative data when allowed by NCQA. Rate is provisional because Missouri is still validating data.

NC: Rate excludes children who were dually eligible for Medicaid and Medicare, partially eligible for Medicaid, or covered by a major third party insurance. Rate is provisional because North Carolina is still validating data.

SC: South Carolina ended its Separate CHIP program effective October 1, 2010. At that time, the state transitioned all CHIP enrollees to a Medicaid Expansion CHIP.

TN (Medicaid): Statewide rate is weighted based on eligible population of each MCO.

WV: Rate includes adolescents up to age 19.

NR = not reported.

APPENDIX F

EXTERNAL QUALITY REVIEW ORGANIZATIONS WITH STATE MEDICAID CONTRACTS IN 2012

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Appendix Table F.1. External Quality Review Organizations with State Medicaid Contracts in 2012

EQRO Name	States Contracting with EQROs
Acumentra	OR, WA
APS Healthcare	MA
Behavioral Health Concepts (BHC)	MO
Burns & Associates	IN
Delmarva Foundation for Medical Care	DC, MD, ND, VA, WV
HCE Quality Quest (QQ)	AZ (for behavioral health and children's rehab services only), UT
Health Services Advisory Group (HSAG)	AZ, CA, CO, FL, GA, HI, IL, MI, NV, OH, VT
Institute for Child Health Policy (ICHP)	TX
IPRO	KY, LA, NE, NY, PA, PR, RI
Kansas Foundation for Medical Care	KS
Mercer	DE
MetStar, Inc.	WI
MPRO	MN, NJ
New Mexico Medical Review Association	NM
Quality Improvement Professional Research Organization	PR
QSOURCE	TN
Telligen	IA
The Carolinas Center for Medical Excellence	NC, SC

Notes: The following states/territories do not contract with MCOs or PIHPs: AL, AK, AR, CT, GU, ID, ME, MT, NH, OK, SD, WY.

ND only has CHIP managed care.

Information is reported as of July 1, 2012.

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APPENDIX G

DETAILED FINDINGS FROM STATE EQRO

PERFORMANCE IMPROVEMENT PROJECTS

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Appendix Table G.1. Performance Measures of Medicaid and CHIP Managed Care Plans that Evaluate Care Provided to Children and Pregnant Women, as Reported in External Quality Review Organization (EQRO) Technical Reports, 2011-2012 Reporting Cycle

Performance Measures Evaluating Children or Pregnant Women	HEDIS Measure	Number of States Reporting Measure	AZ	CA	CO	DE	DC	FL	GA	HI	IL	IN	IA	KS	KY	MD	MA	MI	MN	MO	NE	NV	NJ	NM	NY	OH	OR	PA	PR	RI	SC	TN	TX	UT	VT	VA	WA	WV	WI
ADHD Measures																																								
Follow-up Care for Children Prescribed ADHD Medication: Initiation Phase	X*	10					X	X	X																X			X	X	X		X	X						X
Follow-up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase	X	8					X	X	X																X			X	X				X						X
Asthma Measures																																							
Use of Appropriate Medications for People with Asthma	X	22					X	X	X		X			X	X	X		X	X			X	X	X	X	X		X	X	X			X	X	X	X			X
Members with ER/Urgent Care Office Visits for Asthma in the Past Six Months		2							X																			X											
Asthma Admission Rate (per 100,000)		2							X																								X						
Adverse Chronic Disease Outcome, Including Asthma	X	1					X																																
Behavioral Health Measures																																							
Initiation and Engagement of Alcohol and other Drug Dependence Treatment: Initiation 13–17 years	X	3														X													X										X
Initiation and Engagement of Alcohol and other Drug Dependence Treatment: Engagement 13–17 years	X	3														X													X										X
Number of Members Eligible to Receive Behavioral Health Case Management: 3 – 12, 13 – 17		1										X																											
Number of Members Receiving Behavioral Health Case Management: 3– 12, 13 – 17		1										X																											

Appendix Table G.1 (continued)

Performance Measures Evaluating Children or Pregnant Women	HEDIS Measure	Number of States Reporting Measure	AZ	CA	CO	DE	DC	FL	GA	HI	IL	IN	IA	KS	KY	MD	MA	MI	MN	MO	NE	NV	NJ	NM	NY	OH	OR	PA	PR	RI	SC	TN	TX	UT	VT	VA	WA	WV	WI
Penetration Rates (by BHOs): Overall, by Service Category, by Age Category (12 and under, 13–17)		1			X																																		
Childhood Immunization Measures																																							
Childhood Immunization Status: Rates Include, DTap, IPV, MMR, HiB, Hepatitis B, VZV, Pneumococcal Conjugate, Hepatitis A, Rotavirus, Influenza, Combination 2, 3, 4, 5, 6, 7, 8, 9, or 10	X*	27		X	X	X	X	X	X	X	X			X	X	X	X	X	X		X	X	X	X		X		X	X	X				X		X	X	X	X
Immunizations for Adolescents: Meningococcal, Tdap/Td, Combo 1	X*	10						X	X		X					X		X			X							X	X	X								X	
Dental Care Measures																																							
Annual Dental Visits: 2–21 years	X	14	X				X	X	X						X					X		X		X	X	X		X	X						X				X
Dental Sealants for Children		2																				X						X											
Annual Dental Visits for Members with Developmental Disabilities (2 –21 years)		1																										X											
Lead Screening Measure																																							
Lead Screening in Children	X	15					X	X	X		X			X	X			X				X	X			X		X		X					X			X	X
Mental Health Measures																																							
Follow-up After Hospitalization for Mental Illness within 7 Days or 30 Days	X*	17			X		X	X	X		X						X	X		X		X		X	X			X	X	X			X			X	X		
Preadmission Screening: Children		1																X																					
Percentage of children and adolescents with one or more acute, mental health inpatient hospitalizations		1		X																																			

Appendix Table G.1 (continued)

Performance Measures Evaluating Children or Pregnant Women	HEDIS Measure	Number of States Reporting Measure	AZ	CA	CO	DE	DC	FL	GA	HI	IL	IN	IA	KS	KY	MD	MA	MI	MN	MO	NE	NV	NJ	NM	NY	OH	OR	PA	PR	RI	SC	TN	TX	UT	VT	VA	WA	WV	WI
Readmission within 30 days after an inpatient stay for mental health: Children up to age 18		2																X														X						
Pharyngitis Treatment Measure																																							
Appropriate Treatment for Children with Pharyngitis	X*	9		X			X		X							X		X										X				X	X				X
Prenatal Perinatal Care Measures																																							
Timeliness of Prenatal Care	X*	24	X	X	X		X	X	X		X			X	X	X		X			X	X	X	X	X	X		X	X	X			X	X		X		X	
Postpartum Care	X	24		X	X		X	X	X		X			X	X	X		X			X	X	X	X	X	X		X	X	X			X	X		X	X	X	
Frequency of Prenatal Care: <21%, 21–40%, 41–60%, 61–80%, 81%+ of Expected Visits	X*	15					X		X		X				X	X					X	X		X	X	X		X	X	X			X					X	
Cesarean Delivery Rates		2							X																X														
Adverse Perinatal Outcomes		1					X																																
Rate of Infants with Low Birth Weight (AHRQ Measure)		1							X																														
Perinatal Screening and Education/Counseling		1													X																								
Prenatal Smoking and Education/Counseling		1																										X											
Perinatal Depression Screening and Education/Counseling		1																										X											
Teen Delivery Rate (Rate/1,000 Females 15 –19 Years Old)		1																												X									
Risk-adjusted Low Birth Weight		1																							X														
Prenatal Care in the First Trimester		1																							X														
Vaginal Birth After Cesarean		1																							X														
Primary Care Access Measure																																							
Children and Adolescents' Access to PCPs: 12–24 months; 25 months to 6 years; 7–11 years; 12–19 years	X*	22	X		X		X		X		X			X	X	X		X	X		X	X		X	X	X		X	X	X			X	X	X			X	

Appendix Table G.1 (continued)

Performance Measures Evaluating Children or Pregnant Women	HEDIS Measure	Number of States Reporting Measure	AZ	CA	CO	DE	DC	FL	GA	HI	IL	IN	IA	KS	KY	MD	MA	MI	MN	MO	NE	NV	NJ	NM	NY	OH	OR	PA	PR	RI	SC	TN	TX	UT	VT	VA	WA	WV	WI
STI Measure Chlamydia Screening: 16–20 Years, 20–24 Years, Total 16 – 24	X*	20	X	X	X		X		X	X	X				X	X	X	X	X						X			X	X	X			X	X				X	X
URI Treatment Measure Appropriate Treatment for Children with Upper Respiratory Infection	X	11		X			X		X							X	X	X										X	X				X	X					X
Weight Assessment /BMI Measures																																							
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (BMI Percentile): 3–11 Years, 12–17 Years, Total	X*	13		X	X	X	X		X						X			X			X				X			X	X	X						X	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Counseling for Physical Activity): 3–11 Years, 12–17 Years, Total	X	10		X	X	X	X		X												X							X	X	X							X	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Counseling for Nutrition): 3–11 Years, 12–17 Years, Total	X	9		X	X	X	X		X												X							X	X	X								
Well-Child Care Measures																																							
Well-Child Visits (First 15 Months): 0, 1, 2, 3, 4, 5, or 6+ Visits	X*	25	X		X		X	X	X		X			X	X	X		X	X		X	X	X	X		X		X	X	X			X	X	X	X	X	X
Well-Child Visits 3–6 Years of Life	X*	26	X	X	X		X	X	X		X			X	X	X		X	X		X	X	X	X		X		X	X	X			X	X	X	X	X	X
Adolescent Well-Care Visits	X*	25	X	X	X		X	X	X		X				X	X		X	X	X	X	X	X		X	X		X		X			X	X	X	X	X	X
Other Measures EPSDT: Visit Rates, Vision Screening, Hearing Screening, Developmental Screening		2	X												X																							
Tonsillectomy: Ages 0 – 9, 10 – 19	X	1																										X										

Appendix Table G.1 (continued)

Performance Measures Evaluating Children or Pregnant Women	HEDIS Measure	Number of States Reporting Measure	AZ	CA	CO	DE	DC	FL	GA	HI	IL	IN	IA	KS	KY	MD	MA	MI	MN	MO	NE	NV	NJ	NM	NY	OH	OR	PA	PR	RI	SC	TN	TX	UT	VT	VA	WA	WV	WI
Children with Special Health Care Needs: Grievance and Appeals in Contractual Time Frame		1																												X									
Number of Sentinel Events During Six-month Period per 1,000 Beneficiaries by Population: Children with Mental Illness		1																X																					
Children with Special Health Care Needs: Initial Health Screen Completed within 45 Days		1																												X									
Percentage of children and adolescents who were discharged to an out-of-home placement (foster care, group home, residential treatment facility)		1		X																																			
Utilization of Ambulatory Care per 1,000 member months: infants under age 1, ages 1 – 9 years, 10 – 19 years		2																									X						X						
Emergency Department Utilization per 1,000 member months: infants, ages 1 – 9 years, 10 – 19 years		2																									X						X						
AHRQ Pediatric Quality Indicators for diabetes short-term complications, gastroenteritis, and urinary tract infections: children up to age 17		1																															X						

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

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

Some performance measures include multiple rates. States reporting a performance measure may not have reported all possible rates.

Analysis includes performance measures listed in the EQRO technical report for each state that specifically evaluate children or pregnant women.

* Initial core set children's health care quality measure

ADHD = Attention Deficit Hyperactivity Disorder; AHRQ = Agency for Healthcare Research and Quality; BHO = Behavioral Health Organization (PIHP); BMI = Body Mass Index; EPSDT = Early Periodic Screening, Diagnosis, and Treatment; ER = Emergency Room; STI = Sexually Transmitted Infection; URI = Upper Respiratory Infection.

Appendix Table G.2. Progress on Weight Assessment Performance Improvement Projects, as Reported in External Quality Review Organization (EQRO) Technical Reports, 2011-2012 Reporting Cycle

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
California			
CenCal Health Plan – San Luis Obispo	PIP aims to improve documentation of three weight assessment and counseling rates for children and adolescents: 1. BMI percentile 2. Referrals for physical activity counseling 3. Referrals for nutrition counseling The EQRO technical report did not include baseline or post-intervention performance rates.	NR	NR
CenCal Health Plan – Santa Barbara	PIP aims to improve documentation of three weight assessment and counseling rates for children and adolescents: 1. BMI percentile 2. Referrals for physical activity counseling 3. Referrals for nutrition counseling The EQRO technical report did not include baseline or post-intervention performance rates.	NR	NR
Contra Costa Health Plan	PIP aims to improve documentation of three weight assessment and counseling rates for children: 1. BMI percentile 2. Referrals for physical activity counseling 3. Referrals for nutrition counseling The EQRO technical report did not include baseline or post-intervention performance rates.	NR	NR
Kaiser Permanente – Sacramento	PIP aims to improve documentation of three weight assessment and counseling rates for children: 1. BMI percentile 2. Referrals for physical activity counseling 3. Referrals for nutrition counseling The EQRO technical report did not include baseline or post-intervention performance rates.	NR	NR
Santa Clara Family Health Plan	PIP aims to increase the percentage of children with at least one BMI calculated and documented by a primary care practitioner.	NR	NR

Appendix Table G.2 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
Georgia			
Amerigroup	Performance on two measures had statistically significant increases from CY 2009 to CY 2010: 1. Percentage of children with BMI documentation increased from 13.7% to 28.5%. 2. Percentage of children with counseling for nutrition increased from 40.7% to 48.8%. The percentage of children with counseling for physical activity decreased from 35.6% to 30.1%.	NR	Met Validation Criteria: Overall, the MCO designed scientifically sound studies that were supported by the use of key research principles. MCO demonstrated an even stronger application of intervention strategies. MCO did not document barrier analysis and interventions. MCO should only document interventions that address identified barriers, select interventions for system change that increase the likelihood of achieving and sustaining improvement, develop and document a method to evaluate the efficacy of each intervention, and use the results of the interventions' evaluation to determine whether each intervention should be continued or revised.
Peach State	Performance on two measures increased from CY 2009 to CY 2010: 1.Percentage of children with counseling for nutrition increased from 36.7% to 45.5% (statistically significant increase). 2. Percentage of children with counseling for physical activity increased from 28.2% to 32.0%. The percentage of children with BMI documentation decreased from 32.1% to 29.0%.	NR	Met Validation Criteria: Overall, the MCO designed scientifically sound studies that were supported by the use of key research principles. MCO demonstrated an even stronger application of intervention strategies. MCO should only document interventions that address identified barriers, select interventions for system change that increase the likelihood of achieving and sustaining improvement, develop and document a method to evaluate the efficacy of each intervention, and use the results of the interventions' evaluation to determine whether each intervention should be continued or revised.

Appendix Table G.2 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
WellCare	Performance on two measures decreased from CY 2009 to CY 2010: 1. Percentage of children with BMI documentation decreased from 36.5% to 30.4%. 2. Percentage of children with counseling for physical activity decreased from 38.7% to 30.9% (statistically significant decrease). The percentage of children with counseling for nutrition increased from 42.3% to 48.9%.	NR	Met Validation Criteria: Overall, the MCO designed scientifically sound studies that were supported by the use of key research principles. MCO demonstrated an even stronger application of intervention strategies. The MCO did not properly define its study indicators according to HEDIS methodology. MCO should only document interventions that address identified barriers, select interventions for system change that increase the likelihood of achieving and sustaining improvement, develop and document a method to evaluate the efficacy of each intervention, and use the results of the interventions' evaluation to determine whether each intervention should be continued or revised.
Hawaii			
AlohaCare	The percentage of children with weight and height recorded on the EPSDT form decreased significantly from 97.7% (FY 2009) to 94.2% (FY 2010). The percentage of children with BMI recorded on the EPSDT form increased significantly from 55.1% (FY 2009) to 62.0% (FY 2010). Starting in 2010, PIP also aims to increase the percentage of children with BMI percentile recorded on the EPSDT form from 33.0% (FY 2010) and the percentage of children with referral for weight counseling if BMI percentile is greater than or equal to 95 from 1.2% (FY 2010), but post-intervention performance for these measures was not available at the time of the EQRO review.	Provider outreach/education: provider newsletter, including an EPSDT Quick Reference Guide	Met Validation Criteria: The MCO should ensure that the barriers to improvement are specific to the MCO's population and that the targeted interventions directly address those barriers. The MCO should conduct subgroup analysis to determine whether any subgroup within its population had a disproportionately lower rate. The MCO should also implement a method to study the efficacy of the interventions to determine which interventions are most successful and which have not produced the desired effect.

Appendix Table G.2 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
Hawaii Medical Service Association	Performance on three measures increased significantly from FY 2009 to FY 2010: 1. Percentage of children with weight and height recorded on the EPSDT form increased from 83.5 to 98.5% 2. Percentage of children with BMI recorded on the EPSDT form increased from 48.7 to 64.7% 3. Percentage of children with BMI percentile recorded on the EPSDT form increased from 0.0 to 30.4%. Percentage of children with referral for weight counseling if BMI percentile equal to or greater than 95 decreased significantly from 1.9 to 1.0%.	Member outreach/education: mailings to parents Provider outreach/education: mailings to providers, launched new EPSDT forms (which added documentation of BMI and BMI percentile as requirements for enhanced EPSDT payment), and educated providers about the forms System change: initiative to ensure MCOs use common language to describe obesity screenings	Met Validation Criteria: The MCO should build on existing momentum and implement new and/or enhanced quality improvement interventions. The MCO should also implement a method to study the efficacy of the interventions to determine which interventions are most successful and which ones have not produced the desired effect, identify study outcome barriers and target interventions to reduce and overcome the effects of the barriers, conduct a "drill-down" analysis before and after the implementation of any intervention to determine whether any subgroup has a disproportionately lower rate that negatively affected the overall rate, and perform interim evaluations of the results in addition to the formal annual evaluation.
Kaiser Permanente Hawaii	Performance on four measures increased from FY 2009 to FY 2010: 1. Percentage of children with weight and height recorded on the EPSDT form increased from 98.2 to 99.0%. 2. Percentage of children with BMI percentile recorded on the EPSDT form increased from 69.0 to 74.0%. 3. Percentage of children with referral for weight counseling if BMI percentile equal to or greater than 95 increased from 17.5 to 100.0% 4. Percentage of children with BMI recorded on the EPSDT form increased from 98.3 to 99.1%, but the increase was not statistically significant	Provider outreach/education: EPSDT compliance monitoring and education, including monthly chart reviews for compliance with documentation of all EPSDT elements.	Met Validation Criteria: The MCO should build on existing momentum and implement new and/or enhanced quality improvement interventions. The MCO should also implement a method to study the efficacy of the interventions to determine which interventions are most successful and which ones have not produced the desired effect, identify study outcome barriers and target interventions to reduce and overcome the effects of the barriers, conduct a "drill-down" analysis before and after the implementation of any intervention to determine whether any subgroup has a disproportionately lower rate that negatively affected the overall rate, and perform interim evaluations of the results in addition to the formal annual evaluation.
Kentucky			
Passport Health Plan	PIP aims to improve weight assessment and counseling rates for children and adolescents from HEDIS 2010 baseline rates for three measures: 1. BMI screening rate (baseline of 6.2%) 2. Physical activity counseling rate (baseline of 42.5%) 3. Nutrition counseling rate (baseline of 51.1%) The EQRO technical report did not include post-intervention performance rates.	Provider outreach/education: provider measurement and feedback, toolkits and references Community outreach/education: partner with the University of Louisville weight management programs for morbidly obese individuals	Validated: The MCO should provide additional clarification of specifications (HEDIS or Healthy Kentuckian), specify the number of members eligible for the measure, and improve BMI screening.

Appendix Table G.2 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
Michigan			
BlueCaid of Michigan	For children ages 3–17 years, PIP aims to achieve goal rates for three HEDIS weight assessment and counseling rates: 1. BMI percentile documentation (MCO exceeded goal at baseline) 2. Nutrition counseling (MCO fell below goal 3. Physical activity counseling (MCO fell below goal) The EQRO technical report did not include baseline rates and goals for each measure. Post-intervention performance was not available at the time of the EQRO review.	NR: EQRO noted that MCO completed a root cause analysis to identify barriers and implemented interventions for members and providers, but PIP interventions were not included in the EQRO technical report.	High Confidence: The MCO should estimate the completeness of administrative data used in the performance measures.
CareSource Michigan	For children ages 3–17 years, PIP aims to achieve goal rates for the HEDIS measure on BMI percentile documentation (MCO fell below goal at baseline). The EQRO technical report did not include baseline rates and goals for each measure. Post-intervention performance was not available at the time of the EQRO review.	NR: EQRO noted that MCO completed a root cause analysis to identify barriers and implemented interventions for members and providers, but PIP interventions were not included in the EQRO technical report.	High Confidence
United Healthcare Great Lakes Plan, Inc.	For children ages 3–17 years, PIP aims to achieve goal rates for three HEDIS weight assessment and counseling rates: 1. BMI percentile documentation (MCO fell below goal at baseline) 2. Nutrition counseling (MCO fell below goal) 3. Physical activity counseling (MCO fell below goal) The EQRO technical report did not include baseline rates and goals for each measure. Post-intervention performance was not available at the time of the EQRO review.	NR: EQRO noted that MCO completed a root cause analysis to identify barriers and implemented interventions for members and providers, but PIP interventions were not included in the EQRO technical report.	High Confidence: The MCO should document the completeness of administrative data and present and discuss final hybrid data.
Health Plan of Michigan, Inc.	For children ages 3–17 years, PIP aims to achieve goal rates for three HEDIS weight assessment and counseling rates: 1. BMI percentile documentation (MCO fell below goal at baseline) 2. Nutrition counseling (MCO fell below goal) 3. Physical activity counseling (MCO fell below goal) The EQRO technical report did not include baseline rates and goals for each measure. Post-intervention performance was not available at the time of the EQRO review.	NR: EQRO noted that MCO completed a root cause analysis to identify barriers and implemented interventions for members and providers, but PIP interventions were not included in the EQRO technical report.	High Confidence: The MCO should revise the numerator for Study Indicator 1 and correct the reported rate for Study Indicator 3.
HealthPlus Partners	For children ages 3–17 years, PIP aims to achieve goal rates for the HEDIS measure on BMI percentile documentation (MCO fell below goal at baseline). The EQRO technical report did not include baseline rate and goal for the measure. Post-intervention performance was not available at the time of the EQRO review.	NR: EQRO noted that MCO completed a root cause analysis to identify barriers and implemented interventions for members and providers, but PIP interventions were not included in the EQRO technical report.	High Confidence

Appendix Table G.2 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
McLaren Health Plan	For children ages 3–17 years, PIP aims to achieve goal rate for the HEDIS measure on BMI percentile documentation (MCO fell below goal at baseline). The EQRO technical report did not include baseline rate and goal for the measure. Post-intervention performance was not available at the time of the EQRO review.	NR: MCO identified primary barriers for members and providers and implemented interventions to address these barriers, but PIP interventions were not included in the EQRO technical report.	High Confidence
Midwest Health Plan	For children ages 3–17 years, PIP aims to achieve goal rates for three HEDIS weight assessment and counseling rates: 1. BMI percentile documentation (MCO exceeded goal at baseline) 2. Nutrition counseling (MCO exceeded goal) 3. Physical activity counseling (MCO exceeded goal) The EQRO technical report did not include baseline rate and goal for the measure. Post-intervention performance was not available at the time of the EQRO review.	NR: MCO identified primary barriers for members and providers and implemented interventions to address these barriers, but PIP interventions were not included in the EQRO technical report.	High Confidence
Molina Healthcare of Michigan	For children ages 3–17 years, PIP aims to achieve goal rates for three HEDIS weight assessment and counseling rates: 1. BMI percentile documentation 2. Nutrition counseling 3. Physical activity counseling The EQRO did not include the baseline rates for the measures. Post-intervention performance was not available at the time of the EQRO review.	NR: MCO documented interventions for members and providers, but PIP interventions were not included in the EQRO technical report.	Confidence: The MCO should include a complete interpretation of findings, document date ranges, include the goal for each indicator, and document date ranges for measurement. MCO should specify goal rates for each performance measure.
OmniCare Health Plan	For children ages 3–17 years, PIP aims to achieve goal rates for three HEDIS weight assessment and counseling rates: 1. BMI percentile documentation (MCO fell below goal at baseline) 2. Nutrition counseling (MCO exceeded goal) 3. Physical activity counseling (MCO exceeded goal) The EQRO technical report did not include the baseline rates and goals for each measure. Post-intervention performance was not available at the time of the EQRO review.	NR: MCO implemented a combination of interventions at the member, provider, and system levels, but PIP interventions were not included in the EQRO technical report.	High Confidence: The MCO should state study goals in terms of percentage and report age parameters consistently.
Physicians Health Plan of Mid-Michigan Family Care	For children ages 3–17 years, PIP aims to achieve goal rates for three HEDIS weight assessment and counseling rates: 1. BMI percentile documentation (MCO fell below goal at baseline) 2. Nutrition counseling (MCO fell below goal) 3. Physical activity counseling (MCO fell below goal) The EQRO technical report did not include the baseline rates and goals for each measure. Post-intervention performance was not available at the time of the EQRO review.	NR: MCO implemented interventions at the member and provider levels, but PIP interventions were not included in the EQRO technical report.	High Confidence

Appendix Table G.2 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
Priority Health Government Programs	For children ages 3–17 years, PIP aims to achieve goal rate for the HEDIS measure on the percentage of members with BMI percentile documentation (MCO fell below goal at baseline). The EQRO technical report did not include the baseline rate and goal for the measure. Post-intervention performance was not available at the time of the EQRO review.	NR: MCO developed and implemented interventions for providers, but PIP interventions were not included in the EQRO technical report.	High Confidence
ProCare Health Plan	For children ages 3–17 years, PIP aims to achieve goal rate for the HEDIS measure on the percentage of members with BMI percentile documentation (MCO fell below goal at baseline). The EQRO technical report did not include the baseline rate and goal for the measure. Post-intervention performance was not available at the time of the EQRO review.	NR: MCO developed and implemented interventions for providers, but PIP interventions were not included in the EQRO technical report.	High Confidence: The MCO should revise numerator and denominator text and state the percentage for the study goal. The MCO should also consider using a Chi-square or Fisher's exact test–instead of a t-test–to determine statistical significance.
Total Health Care	For children ages 3–17 years, PIP aims to achieve goal rate for the HEDIS measure on the percentage of members with BMI percentile documentation (MCO fell below goal at baseline). The EQRO technical report did not include the baseline rate and the goal for the measure. Post-intervention performance was not available at the time of the EQRO review.	NR: MCO implemented several interventions for members and providers, but PIP interventions were not included in the EQRO technical report.	High Confidence: The MCO should consider revising the study question and provide a percentage for the study goal.
Upper Peninsula Health Plan	For children ages 3–17 years, PIP aims to achieve goal rate for the HEDIS measure on the percentage of members with BMI percentile documentation (MCO fell below goal at baseline). The EQRO technical report did not include the baseline rate and goal for the measure. Post-intervention performance was not available at the time of the EQRO review.	NR: MCO implemented a combination of interventions for members and providers, but PIP interventions were not included in the EQRO technical report.	High Confidence
Minnesota			
IMCare	PIP aims to improve obesity diagnosis and management. The EQRO technical report did not include target population, performance measures for assessing progress, or baseline or post-intervention performance.	NR	Validation Rating Not Reported: The MCO terminated the PIP because it did not result in significant improvement that could be sustained over time and its efforts to resolve project barriers were unsuccessful.

Appendix Table G.2 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
Nebraska			
Coventry Health Care of Nebraska	PIP aims to improve the prevention, identification, and management of pediatric obesity for children ages 3–17. PIP will measure performance using HEDIS weight assessment and counseling for nutrition and physical activity rates as well as MCO performance on identifying and managing care for at-risk children, and MCO community collaboration. The PIP will also measure modified HEDIS Weight Assessment and Counseling for Nutrition; and physical activity for at-risk children/adolescents at the practice level. Baseline and post-intervention performance were not available at the time of the EQRO.	Provider outreach/education: educational campaign for collaborative practice based on identified practice needs in prevention, identification, and management of pediatric obesity, promotion of the Nebraska Medical Association (NMA) Clinician Pediatric Obesity toolkit, comprehensive Training for Healthcare Providers DVD, educational pamphlets, distribution of prescription pad formatted to prescribe the 5-4-3-2-1 Go! Program, training for office staff (academic detailing and Continuing Medical Education programs), and preparation of a compendium of available referral/community resources Community outreach/education: collaboration with community groups or schools for improvement efforts, Care delivery change: development of policies and procedures for pediatric obesity case management programs Member outreach/education: outreach	PIP Not Fully Implemented
United Healthcare of the Midlands	PIP aims to improve care for pediatric members ages 3–17 with obesity. PIP will measure performance using three HEDIS measures: 1. BMI percentile documentation 2. Nutrition counseling 3. Physical activity counseling Baseline and post-intervention performance were not available at the time of the EQRO.	Provider outreach/education: educational campaign for collaborative practice based on identified practice needs in prevention, identification, and management of pediatric obesity, pediatric obesity tool kit, a compendium of available referral/community resources, training for office staff (academic detailing and Continuing Medical education programs), dissemination of provider education materials, encouraging providers to perform fasting lipid profiles on overweight and obese children age 10 or older Member outreach/education: Member tool kit and educational materials, website resources, “reading corners” at provider offices that use Sesame Street tables and chairs and Sesame Street nutritional flyers Care delivery change: development of pediatric obesity case management programs Community outreach/education: collaboration with community groups or schools for improvement efforts	PIP Not Fully Implemented

Appendix Table G.2 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
New York			
AMERIGROUP Community Care	For school-aged children, the PIP demonstrated improvement in the percentage of children with documentation of BMI and BMI percentile, maintained the baseline performance level for documentation of counseling for nutrition, and demonstrated improvement with documentation of counseling for physical activity. The EQRO technical report did not include baseline and post-intervention performance rates.	Provider outreach/education: medical record review with feedback to providers of 20 records per site, educational site visits and telephone follow-up, and resources such as BMI wheels and Power Zone Paks Member outreach/education: telephone calls and mailings to encourage well-care visits among members without well visits Community outreach/education: two four-week educational sessions at community after-school programs	Validated
Capital District Physicians' Health Plan	For children ages 5 –17, the PIP demonstrated improvement with three HEDIS measures: 1. Documentation of BMI and BMI percentile 2. Nutrition counseling 3. Physical activity counseling Performance declined for documentation of BMI and BMI percentile coded via V-codes and LDL tests for members with BMI percentile indicating obesity was not measurable due to lack of valid data. Performance was maintained for well-child visits for children ages 3–6 and ages 12–21. For members with newborns, the percentage with evidence of breastfeeding demonstrated improvement. The EQRO technical report did not include baseline and post-intervention performance rates.	Provider outreach/education: BMI toolkits, education on BMI calculation, nutritional and physical activity education (for low performing providers), gap reports for providers on members in need of a well visit, wellness sessions Member outreach/education: Body Works (eight-week educational program for parents/caregivers of members ages 9–14 years), mailings and direct phone calls, including outreach to parents of child members who were identified as obese, educational efforts to provide pregnant members with information about appropriate weight gain and breastfeeding, including a breastfeeding toolkit Community outreach/education: distributed educational material to community groups, such as Boys and Girls Clubs, participated in local health fairs, sponsored Radio Disney's Move It! program in local schools, partnered with local community gardens to sponsor Veggie Mobile traveling farmer's market, sponsored Dr. R U Well radio program Care delivery change: partnered with high-volume OB/GYN practices in the Pregnancy Notification Program and enrolled pregnant members in Case Management/Stork Program; partnered with Text4Baby to create the Mom2be text message program; collaborated with behavioral health vendor to provide educational/support materials related to obesity for both members and providers	Validated

Appendix Table G.2 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
Health Insurance Plan of Greater New York	For members ages 3–11 and 12–17, PIP demonstrated improvement on three HEDIS rates: 1. Documentation of BMI and BMI percentile 2. Nutrition counseling 3. Physical activity counseling The EQRO was unable to assess performance on the number of members ages 3–17 years with overweight/obesity identified in claims data and on eight process measures because the MCO did not report rates for the measures. The EQRO technical report did not include baseline and post-intervention performance rates.	Member outreach/education: direct mailing and electronic messaging to plan members, health promotion newsletters Provider outreach/education: academic detailing, participation in community events to promote BMI screening and education Community outreach/education: collaboration with the American Academy of Pediatrics	Validated: The validation findings generally indicated that the credibility of the PIP results was not at risk as it relates to the HEDIS/Quality Assurance Reporting Requirements (QARR) performance indicators. However, the plan did not report rates for the non- HEDIS/QARR measures, and therefore the EQRO was unable to determine the credibility of the results for these measures. Key strengths of this PIP included use of HEDIS/QARR measures as project indicators and the implementation of provider and member interventions.
Health Plus Prepaid Health Services Plan	For children and adolescents in Sunset Park, NY, the PIP maintained the baseline performance level for the percentage of LFHC children (undefined group in EQRO technical report) with a BMI recorded, the percentage of children with a BMI greater than 85% who were appropriately counseled and/or referred for specialty care, and the percentage of children with a BMI greater than 85% who have appropriate lab tests. The PIP demonstrated improvement in the percentage of HP children (undefined group in EQRO technical report) who have BMI recorded. The EQRO was unable to determine progress on the percentage of children with diabetes who had a follow-up endocrine visit and the number refusing to enter or who drop out of the program because the MCO did not report rates for these measures. The EQRO technical report did not include baseline and post-intervention performance rates.	Provider outreach/education: development of a clinical algorithm for providers Community outreach/education: implemented a school-based exercise program	Validated: Key strengths of this PIP included the intervention strategy, well-thought-out and clearly stated objective, and collaborating with a health care system. There were no validation findings that indicated that the credibility of the PIP was at risk.

Appendix Table G.2 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
HealthFirst PHSP	For children ages 2–18, PIP demonstrated improvement on six measures: 1. BMI percentile documentation 2. Nutrition counseling 3. Physical activity counseling 4. QARR weight assessment 5. QARR nutrition 6. QARR physical activity The EQRO technical report did not include baseline and post-intervention performance rates.	Member outreach/education: telephone calls, targeted Got 2B Fit Program to members who were identified as at risk for overweight or obese by their providers, website resources, and newsletter articles Community outreach/education: billboard advertisement, participation in a farmer's market series, parent-teacher appreciation events, and a health fair Provider outreach/education: on-site education, clinical assessment tools, and community resources on MCO's provider portal and newsletter Expand provider availability: granted funding to two providers to support additional positions at their sites (Health Educator, Case Manager, Nutritionist)	Validated: Key strengths of the PIP included multiple targeted interventions to members, providers, and the community. There were no validation findings that indicated that the credibility of the PIP results was at risk. The PIP had six indicators but no data was reported.
Community Blue: BCBS of Western New York (Health Now New York)	PIP demonstrated improvements for: 1. BMI percentile documentation 2. Nutrition counseling 3. Physical activity counseling 4. BMI assessments 5. Well-child visit rates for children ages 3–6 Baseline performance was maintained for adolescent well-care visits. PIP also conducted 60 reviews of medical records before the intervention and 162 reviews of medical records post-intervention (in 2009 and 2010 combined). The EQRO technical report did not include baseline and post-intervention performance rates.	Provider outreach/education: adult and pediatric BMI Wheels, provider toolkit, guidance and assessments for BMI measurement and documentation in provider newsletter, provider incentives for improvement in rates of well-care visits System change: revised medical record documentation standards for providers to include annual assessment of weight (BMI), physical activity, and nutrition; created downloadable chart labels for documentation for providers with paper medical record systems; distributed printable BMI forms for providers with electronic medical records systems Care delivery change: contracted with a case management vendor to address Medicaid member-specific needs related to preventive health and perinatal care, established prenatal care program to promote breastfeeding (includes education, case management, phone counseling, and written materials) Member outreach/education: telephoned parents of children and adolescents lacking well-child visits and sent reports on gaps in well-care visits to 842 families (2010), member education and links to resources via the member newsletter and website (1,002	Validated: Key strengths of this PIP included a clear, well-written abstract and report with detail that describes the robust nature of this project; a comprehensive list of both outcome and process measures; a varied, broad-based, and intensive intervention strategy that targets all stakeholders; and multiple partnerships and collaborations in the planning and execution of the intervention strategy. There were no validation findings that indicated the credibility of the PIP results was at risk.

Appendix Table G.2 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
		members received prenatal counseling on nutrition and breastfeeding in 2009 and 2010), parenting booklet to 7,964 parents of newborns in 2009 and 2010, web-posted tool to calculate children's BMI and an educational library, distributed 506 Healthy Family toolkits (2010), received completed Health Risk Assessments from 6,417 members (2009 and 2010), linked 50 Niagara Falls schoolchildren with a primary care physician Community outreach/education: educational outreach at 10 youth community health education classes and hospital-based and community Lamaze programs/breastfeeding classes; collaborated with Foundation for Healthy Living (New York State Department of Health grant program) Center for Best Practices for the Prevention of Childhood Obesity to promote education and awareness among members, families, providers, and the Western New York community; established Family Fitness Discount Program for varied physical activity programs (dance, gymnastics, and karate) and Wellness Centers; sponsored What Moves U with the Buffalo Bills, Buffalo Schools, and the American Heart Association; partnered with the Buffalo Sabers for A Game Plan for the Mind, Body, and Spirit program; adopted Buffalo Public School to promote good nutrition and physical activity; provided a grant to Niagara Falls City Schools for an outreach worker to assist families/children with obtaining insurance coverage and well care; sponsored Middle School's 5K Run; co-sponsored Country Market to bring fresh, locally grown produce to downtown Buffalo; sponsored Grass Roots Garden to create and sustain community gardens in vacant lots in the city; partnered with regional health network and clinic to promote healthy family lifestyles to minority populations; sponsored community sports leagues for underprivileged children (PAL basketball, sports clinic); supported the Buffalo Boys and Girls Club community programs for nutrition and meal preparation, as well as the Run in the Mist 5K run and Canal Fest 5K run; and worked with Olean YMCA on	

Appendix Table G.2 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
		Corn Fest and Wellness Rally fitness events, members, families, providers, and the Western New York community; established Family Fitness Discount Program for varied physical activity programs (dance, gymnastics, and karate) and Wellness Centers; sponsored What Moves U with the Buffalo Bills, Buffalo Schools, and the American Heart Association; partnered with the Buffalo Sabers for A Game Plan for the Mind, Body, and Spirit program; adopted Buffalo Public School to promote good nutrition and physical activity; provided a grant to Niagara Falls City Schools for an outreach worker to assist families/children with obtaining insurance coverage and well care; sponsored Middle School's 5K Run; co-sponsored Country Market to bring fresh, locally grown produce to downtown Buffalo; sponsored Grass Roots Garden to create and sustain community gardens in vacant lots in the city; partnered with regional health network and clinic to promote healthy family lifestyles to minority populations; sponsored community sports leagues for underprivileged children (PAL basketball, sports clinic); supported the Buffalo Boys and Girls Club community programs for nutrition and meal preparation, as well as the Run in the Mist 5K run and Canal Fest 5K run; and worked with Olean YMCA on Corn Fest and Wellness Rally fitness events	
Hudson Health Plan	For children, the PIP demonstrated improvement for five HEDIS measures: 1. BMI percentile documentation 2. Nutrition counseling 3. Physical activity counseling 4. Identification of BMI 5. Health literacy rates (non-HEDIS) The EQRO technical report did not include baseline and post-intervention performance rates.	Provider outreach/education: provider toolkit Community outreach/education: multiple community presentations	Validated: Key strengths of this PIP include comprehensive interventions for providers and the community. There were no validation findings that indicate that the credibility of the PIP results is at risk.

Appendix Table G.2 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
Independent Health Association	For school-aged children, the PIP demonstrated improvement in rates for obtaining blood pressure rates, dietary behavior reviews, physical activity reviews, and family history reviews. Rates of BMI calculations declined. The MCO did not report data on obtaining height and weight and on billing appropriate diagnosis codes. The EQRO technical report did not include baseline and post-intervention performance rates.	Community outreach/education: implemented the Fitness for Kids Challenge Program (addresses obesity through education and physical activity programs and incentives in partnership with schools and community groups) Care delivery change: incorporated evidence-based identification and diagnosis of overweight and obese children into Patient Centered Medical Homes	Validated: Key strengths included incorporation of pediatric obesity identification and diagnosis into Patient Centered Medical Home, and effective partnering with schools and community groups. The validation findings generally indicated that the credibility of the PIP was not at risk.
MetroPlus Health Plan	PIP demonstrated improvement for three HEDIS measures for children at five sites: 1. BMI percentile documentation 2. Nutrition counseling 3. Physical activity counseling Performance improved on ICD-9 coding in 2009–2010 overall and for chart review for BMI, BMI percentile, and physical activity counseling. Chart review for nutrition counseling, referral for physical activity, and obesity labs completed had a performance decline. The EQRO technical report did not include baseline and post-intervention performance rates.	Provider outreach/education: provider toolkit, on-site in-services for providers, on-site assessments of four facilities to identify strategies to improve obesity measure performance Member outreach/education: educational mailings	Validated: Key strengths of this PIP included the development of the Facility Assessment Tool and the conduct of facility assessments. the validation findings generally indicated that the credibility of the PIP results was not at risk.
SCHC Total Care	PIP maintained baseline performance rates for two HEDIS measures for children: 1. BMI percentile documentation 2. Nutrition counseling Physical activity counseling declined. The EQRO technical report did not include baseline and post-intervention performance rates.	Provider outreach/education: BMI Wall Charts and BMI "wheels," newsletter, developed medical record documentation tool (met with staff at three provider groups to determine needs for tools and worked with provider groups to implement tools), trained clinical staff who perform the BMI measurement Member outreach/education: member newsletters, Obesity Toolkits for high-risk members (educational materials, information on available community resources, and reminders for scheduling physician visits) Community outreach/education: worked with local Public Health Departments and regional Department of Health offices to identify resources to distribute to providers and members	Validated: Key strengths of this PIP included multiple interventions to address both members and providers, incorporating multifaceted intervention programs in different counties. Other key strengths included a clearly stated rationale, aim statement, and methodology, as well as barrier analysis. The validation findings generally indicated that the credibility of the PIP results were not at risk. Results must be interpreted with some caution due to the fact that the percentage of the members at the three provider groups comprising the QARR hybrid sample decreased in 2010 as compared with 2008.

Appendix Table G.2 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
United HealthCare Community Plan	PIP demonstrated improvement for three HEDIS measures for children: 1. BMI percentile documentation 2. Nutrition counseling 3. Physical activity counseling The EQRO technical report did not include baseline and post-intervention performance rates.	Care delivery change: proactive case management/disease management for high-risk patients Member outreach/education: educational materials, targeted materials to members diagnosed with obesity, member newsletters, compendium of community resources for members and clinicians for weight management and nutrition resources, Provider outreach/education: materials on nutrition and exercise for distribution to members, provider newsletters, BMI calculators/BMI charts Community outreach/education: collaborated with Bronx Lebanon on the Early Childhood Obesity Pilot Study, partnered with the Sesame Street initiative on a bilingual, multimedia educational outreach program	Validated: Key strengths of this PIP included a clearly stated rationale and results. There were no validation findings that indicated that the credibility of the PIP results was at risk.
Univera Community Health	For children in the 2nd and 3rd grade in the Buffalo public school system, PIP improved performance on three HEDIS measures: 1. BMI percentile documentation 2. Nutrition counseling 3. Physical activity counseling The EQRO was unable to assess the 2nd and 3rd grade pre- and post-survey results for parents and children due to data collection and survey design flaws. The EQRO technical report did not include baseline and post-intervention performance rates.	Community outreach/education: integrated the Fun 2B Fit program into the Buffalo public school system Provider outreach/education: academic detailing for 10 provider offices in the Buffalo City school district.	Validated: Key strengths of this PIP included use of HEDIS/QARR measures and academic detailing and partnering with schools. The validation findings generally indicated that the credibility of the PIP results was not at risk.
WellCare of New York	PIP demonstrated improvement for three HEDIS measures for children: 1. BMI percentile documentation 2. Nutrition counseling 3. Physical activity counseling The EQRO technical report did not include baseline and post-intervention performance rates.	Member outreach/education: educational material, newsletters, and offers of gift card incentives, education by telephone, information on free or low-cost local exercise and/or diet management programs Provider outreach/education: electronic educational material, newsletters, and letters that identified their members who were diagnosed as being overweight or obese, one-on-one education Care delivery change: expanded periodicity letters for children 6–12 years and 13–20 years to include BMI, nutrition counseling, and exercise counseling in the well visit	Validated: Key strengths of this PIP included a clearly stated rationale, aim statement, and methodology, as well as barrier analysis. There were no validation findings that indicated that the credibility of the PIP results was at risk.

Appendix Table G.2 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
Neighborhood Health Providers	PIP demonstrated improvement for three HEDIS measures for children: 1. BMI percentile documentation 2. Nutrition counseling 3. Physical activity counseling The EQRO technical report did not include baseline and post-intervention performance rates.	Member outreach/education: member newsletters, direct mailings, and plan website, targeted mailings to parents of children with a diagnosis of obesity Care delivery change: proactive case management for high-risk patients Provider outreach/education: BMI charts, provider newsletters, and MCO website, direct mailing to primary care physicians with patients diagnosed with obesity Community outreach/education: referred members to Brookdale University Hospital and Medical Center program with free nutrition and fitness activities, offered assistance to school health clinics with weight management efforts	Validated: Key strengths of this PIP included a clearly stated rationale and results. There were no validation findings that indicated that the credibility of the PIP results was at risk.
Oregon			
Quality Healthcare Alliance	PIP aims to improve rates for three HEDIS measures for children: 1. BMI percentile documentation 2. Nutrition counseling 3. Physical activity counseling The EQRO technical report did not include baseline and post-intervention performance rates.	Provider outreach: provider education	Validation Rating Not Reported in EQRO technical report
West Virginia			
Mountain Health Trust	For children ages 2–17, performance on three HEDIS weight counseling measures decreased from CY 2009 to CY 2010: 1. BMI percentile documentation rate decreased from 1.5 to 1.1% 2. Nutrition counseling decreased from 0.9 to 0.5% 3. Physical activity counseling decreased from 0.8 to 0.5%	Provider outreach/education: one-on-one discussion with physician/appropriate office staff at 200 offices regarding the provider education packet which includes BMI chart, BMI percentile graph worksheets, and Childhood Obesity Program information, updated Practitioner Procedural Manual on the provider website Community outreach/education: participated in community-based health fairs with BMI screenings and counseling, BMI screenings at schools Member outreach/education: added wellness information on nutrition, activity, and weight loss initiatives to the MCO website	Met Validation Criteria: There was no noted improvement in any of the project indicators. The MCO should continue to assess barriers to improvement and develop specific, targeted interventions based on this analysis. The effectiveness of each intervention should be assessed and adjusted accordingly. The MCO should also strengthen its quantitative analysis to provide a more comprehensive project assessment.

Appendix Table G.2 (continued)

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

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

* State-mandated PIP topic.

[a] EQRO validation rating is the summary validation assessment assigned by the EQRO. EQROs used different rating scales for PIPs. In general, ratings of "Met" and "High Confidence" indicate that the PIP met most of the validation criteria, including all essential criteria. Ratings of "Partially Met" and "Moderate Confidence" indicate that the PIP did not meet some validation criteria. Ratings of "Not Met" and "Low Confidence" indicate that the EQRO identified substantive methodological or data reporting issues with the PIP. New PIPs that were not fully implemented at the time of the EQRO were not always assigned validation ratings. EQRO technical reports contain more detailed descriptions of the rating system used by the EQRO.

NR = Not Reported; PIP = Performance Improvement Project; QARR = Quality Assurance Reporting Requirement.

Appendix Table G.3. Progress on Dental Care Performance Improvement Projects, as Reported in External Quality Review Organization (EQRO) Technical Reports, 2011-2012 Reporting Cycle

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
Florida			
Molina (Non-Reform Plan)	PIP aims to improve dental visit rates. The EQRO technical report did not include target population, performance measures for assessing progress, and baseline and post-intervention performance rates.	NR	Partially Met Validation Criteria: The MCO should report hybrid HEDIS rates unless administrative rates are shown to be the same. The MCO should document only the targeted interventions implemented to address the specific barriers identified.
Molina (Reform Plan)	PIP aims to improve dental visit rates. The EQRO technical report did not include target population, performance measures for assessing progress, and baseline and post-intervention performance rates.	NR	Partially Met Validation Criteria: The MCO should report hybrid HEDIS rates unless administrative rates are shown to be the same. The MCO should document only the targeted interventions implemented to address the specific barriers identified.
First Coast Advantage (Reform Plan)	PIP aims to improve dental visit rates. The EQRO technical report did not include target population, performance measures for assessing progress, and baseline and post-intervention performance rates.	NR	Met Validation Criteria: The MCO should report hybrid HEDIS rates unless administrative rates are shown to be the same. The MCO should document only the targeted interventions implemented to address the specific barriers identified.
Georgia			
Amerigroup	PIP increased the percentage of members ages 2–21 with a dental visit from 66.8% in CY 2009 to 69.1% in CY 2010 (statistically significant increase).	NR	Met Validation Criteria: Overall, the MCO designed scientifically sound studies that were supported by the use of key research principles. MCO demonstrated an even stronger application of intervention strategies. The MCO did not include one of the two mandatory study indicators in PIP. MCO did not document barrier analysis and interventions. MCO should only document interventions that address identified barriers, select interventions for system change that increase the likelihood of achieving and sustaining improvement, develop and document a method to evaluate the efficacy of each intervention, and use the results of the interventions' evaluation to determine whether each intervention should be continued or revised.

Appendix Table G.3 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
Peach State	Performance on two measures had statistically significant increase from CY 2009 to CY 2010: 1.Percentage of children ages 2–3 with a dental visit increased from 33.8% to 38.8%. 2. Percentage of children ages 2–21 with a dental visit increased from 60.2% to 63.6%.	NR	Met Validation Criteria: Overall, the MCO designed scientifically sound studies that were supported by the use of key research principles. MCO demonstrated an even stronger application of intervention strategies. MCO should only document interventions that address identified barriers, select interventions for system change that increase the likelihood of achieving and sustaining improvement, develop and document a method to evaluate the efficacy of each intervention, and use the results of the interventions' evaluation to determine whether each intervention should be continued or revised.
WellCare	Performance on two measures had statistically significant increase from CY 2009 to CY 2010: 1.Percentage of children ages 2–3 with a dental visit increased from 65.2% to 67.5%. 2. Percentage of children ages 2–21 with a dental visit increased from 40.4% to 45.5%.	NR	Met Validation Criteria: Overall, the MCO designed scientifically sound studies that were supported by the use of key research principles. MCO demonstrated an even stronger application of intervention strategies. The MCO did not properly define its study indicators according to HEDIS methodology. MCO should only document interventions that address identified barriers, select interventions for system change that increase the likelihood of achieving and sustaining improvement, develop and document a method to evaluate the efficacy of each intervention, and use the results of the interventions' evaluation to determine whether each intervention should be continued or revised.
Kentucky			
Passport Health Plan	PIP aims to improve annual dental visit rate for children with special health care needs from a baseline of 51% in 2010.	Member outreach/education: telephone and written outreach for children with special health care needs who have no dental visits, including outreach in the appropriate language and coordinating care from providers who meet the children's cultural needs Care Delivery Change: incorporate preventive dental care into treatment plans for children with special health care needs who are enrolled in care coordination	PIP Not Fully Implemented: Based on the EQRO of the PIP proposal, the MCO should document HEDIS rates to strengthen the PIP rationale and clarify that all children with special health care needs who require a dental visit will receive outreach.
Missouri*			
Molina	PIP aims to improve the annual dental visit rate for children ages 2–20 by 3% from a baseline of 31.7% in HEDIS 2010. PIP met goal with a 4% rate increase (based on preliminary, unaudited data).	Member outreach/education: member education Provider outreach/education: provider education	Low Confidence: EQRO found that MCO did not provide information or any interpretation about why this PIP was successful, or how interventions contributed to rate improvements. MCO provided vague descriptions of PIP interventions, and EQRO could not determine what the MCO intended to measure or even count as focused interventions. MCO did not identify barriers to improving annual dental visit rates.

Appendix Table G.3 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
Healthcare USA	PIP aims to improve the annual dental visit rate for children ages 2–20 by 3%. The EQRO technical report shows that the PIP met its goal, but the EQRO technical report did not include baseline or post-intervention performance rates.	Expand provider availability: floating dentists who rotate through rural areas, implement after hours/weekend scheduling for office visits Community outreach/education: collaborate with schools and school nurses	Moderate Confidence: The MCO should develop narrative information about the PIP and address how the PIP is related to all managed care regions.
Harmony	PIP aims to improve two rates for children ages 2–21: 1. Annual Dental Visit rate 2. Percentage of EPSDT medical records with documentation of primary care physician discussion about oral health (denominator of 75 records) The EQRO technical report did not include baseline or post-intervention performance rates.	Member outreach/education: reminder postcards and follow-up telephone calls and letters for eligible members who have not had a dental visit Provider outreach/education: EPSDT and dental education through Fax Blast and mailings to pediatricians and primary care providers to encourage outreach efforts to increase annual dental exams, outreach to dental providers on the importance of dental screening and completing all EPSDT/HCY examinations	Low Confidence: PIP did not meet Missouri's 2009 deadline for baseline data collection. Interventions were delayed when MCO changed dental subcontractors. Study questions, performance measures, and sampling strategy for identifying EPSDT visits did not meet EQRO validation criteria. Data collection strategy was identified as unacceptable by EQRO, because data will include individuals from Harmony Health Plan in Illinois as well as Missouri. The MCO should also develop and conduct its PIP in accordance with PIP protocols and assess how each intervention contributes to the PIP's success.
Missouri Care	PIP increased the Annual Dental Visit Rate for children ages 2–20 and pregnant women from 38.2% (HEDIS 2010) to 42.2% (HEDIS 2011), meeting PIP goal of a 3% increase.	Expand provider availability: dental van for mobile services and outreach Community outreach/education: collaborate with Show-Me Smiles program Care delivery change: partner with Head Start, daycares, and preschools to provide early education, oral health information, and distribute toothbrushes and toothpaste to children	Moderate Confidence: The MCO should ensure that there is adequate documentation to explain the impact of the interventions on the findings and outcomes.
Children's Mercy Family Health Partners	PIP increased the annual dental visit rate for children ages 2–20 from 45.3% (HEDIS 2010) to 47.7% (HEDIS 2011), meeting PIP goal of a 3% increase.	Provider outreach/education: add dental information to the website, including dental podcast, collaborate with Bridgeport (Dental vendor) to share electronic materials and information with dental providers Member outreach/education: dental information on Facebook, member, provider and teen newsletters Community outreach/education: dental posters and educational materials in primary care offices, Women Infant and Children offices, YMCA sites, and Head Start Schools, collaborate with Head Start by participating in the Oral Health Roundtable, teach proper dental hygiene in the community	High Confidence: The MCO study question includes pregnant women and the EQRO questioned how the PIP addresses this population. The EQRO concluded that the number of interventions made it difficult to determine the effectiveness of each intervention.

Appendix Table G.3 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
Blue Advantage Plus	PIP increased the annual dental visit rate from 31.7% (HEDIS 2010) to 40.9% (HEDIS 2011).	Member outreach/education: member newsletters, MCO website resources, Customer Service telephone information on dental coverage, new member materials, member handbook, reminder letters to members with no preventive dental visits in six months, assist members with finding a dental provider and with making appointments, outreach to members at annual well-child visits Care delivery change: participate in the Health Start Dental Home Initiative Provider outreach/education: remind providers to ask parents to get a checkup for all children	Confidence: The number of interventions made it difficult for the EQRO to determine the effectiveness of each intervention.
New Jersey*			
Americhoice	PIP aims to increase by 20% the percentage of children with an initial dental visit by their second birthday.	Provider outreach/education: dental events at dental offices focusing on preventive care for enrollees ages 1–2	PIP Not Fully Implemented
Amerigroup	PIP aims to increase from 5.3 to 35.3% the percentage of children ages 1–2 years with a preventive or restorative dental visit.	NR	PIP Not Fully Implemented
Healthfirst	PIP aims to increase from 27 to 33% the percentage of children ages 2–3 years with an annual dental visit.	NR	PIP Not Fully Implemented
Healthnet [b]	PIP increased the annual dental visit rate for children ages 13–21 from 37.2% (CY 2008) to 40.8% (CY 2009). Dental visit rate for children ages 3–12 dropped from 45.6% (CY 2008) to 45.4% (CY 2009).	Member outreach/education: distribute Health Risk Questionnaire to members to complete, Interactive Voice Response calls	Confidence: MCO tied rate increase for children ages 13–21 directly to the PIP interventions. Interventions did not appear to have had an impact on enrollees ages 3–12 years, as the final rate was lower than the baseline.
Horizon NJ Health	PIP aims to increase from 45.2 to 60% the percentage of children ages 0.5–6.99 years with an annual dental visit.	Provider outreach/education: fully engage physicians in the prevention and management of dental disease	PIP Not Fully Implemented
University Health Plans [b]	PIP increased Annual Dental Visit rates for several age groups of children between 2007 and 2009: Ages 2–21 increased from 40.0 to 44.3% Ages 2–3 increased from 22.1 to 26.4% Ages 4–6 increased from 45.0 to 51.1% Ages 7–10 increased from 47.9 to 53.7% Ages 11–14 increased from 43.3 to 48.1% Ages 15–18 increased from 37.9 to 38.9% Ages 19–21 decreased from 31.6 to 27.8%	Member outreach/education: educational mailings, outreach programs, telephone outreach, care management outreach, System change: form an EPSDT workgroup Community outreach/education: participate in health fairs Provider outreach/education: provider fax-back forms	Confidence: The EQRO was unable to determine whether the interventions had a true impact on the rates or whether a combination of external factors influenced those rates.

Appendix Table G.3 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
New Mexico			
Molina	PIP increased annual dental visit rate from 59.8% (2009) to 67.3% (2010). The EQRO technical report did not include ages of children targeted by PIP.	NR	Validated: MCO attributed most of rate increase to corrected encounter data loading; performance in 2009 was incorrect (too low) because encounter data was not reported correctly.
Ohio			
Amerigroup	Percentage of members ages 2–20 years who had at least one dental visit decreased from 44.0% in 2007 to 43.0% in 2009.	NR	Partially Met Validation Criteria: MCO should provide details about the quality improvement process used to identify barriers.
Molina	Percentage of members ages 2–20 years who had at least one dental visit increased from 42.0% in 2007 to 45.1% in 2009 (increase was statistically significant).	NR	Partially Met Validation Criteria: MCO should provide details about the quality improvement process used to identify barriers. MCO should also complete a data analysis plan.
United Healthcare	Percentage of members ages 2–20 years who had at least one dental visit increased from 46.8% in 2007 to 49.7% in 2009 (increase was statistically significant).	NR	Partially Met Validation Criteria: MCO should complete a data analysis plan.
WellCare	Percentage of members ages 2–20 years who had at least one dental visit increased from 39.3% in 2007 to 45.8% in 2009 (increase was statistically significant).	NR	Met Validation Criteria
Pennsylvania			
United Healthcare	PIP increased annual dental visit rate for children ages 2–6 from 31.4% (January–June 2008) to 33.1% (January–June 2010). Annual dental visit rate decreased from 2008 to 2009. MCO adjusted interventions, and performance rate increased in 2010.	Member outreach/education: monthly auto messaging to parents/caregivers of members ages 2–6 to recommend a dental screening, targeted outreach calls (to discuss member benefits, preventive services, and the importance of dental care at an early age, as well as to offer assistance with accessing services), bi-annual educational mailings Care delivery change: dental fluoride varnish incentive program for pediatricians in two sites to apply varnish and encourage members to visit the dentist Provider outreach/education: fax blast to 450 providers regarding EPSDT dental guidelines Expand provider availability: mobile dental van and event with a post-screening concert ticket initiative, discuss with the dental benefits vendor the need for dentists who speak Asian languages	Validated: The EQRO concluded that some interventions were timely and affected a large portion of the target population. However, a number of interventions did not meet these criteria. Interventions aimed at providers were less targeted (for example, fax blasts) or reached fewer providers.

Appendix Table G.3 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
Gateway Health Plan	PIP increased annual dental visit rate for children ages 2–21 from 14.0% (January–June 2008) to 37.9% (January–June 2010), meeting PIP goal of increasing performance to 14.2%	System change: MCO workgroup on improving dental visit rates, reviewed dental claims and records to identify all dental services Member outreach/education: automated message for members calling into MCO that offers assistance with finding a dentist, telephone outreach to members to assist with scheduling appointments (effort later targeted specific zip codes with higher percentages of members with no screening) Expand provider availability: coordinated a dental day at a number of providers for MCO members, operate mobile dental units for a dental event	Validated: EQRO noted limited documentation by MCO of member outreach efforts. The EQRO concluded that the identification and resolution of incomplete data submissions was likely the biggest contributor to the rate increase.
United Healthcare	PIP increased annual dental visit rate for children ages 2 –21 from 33.9% (January–June 2008) to 37.8% (January–June 2010). PIP did not meet its goal of achieving a 42.9% visit rate.	Member outreach/education: calls from the EPSDT outreach program to members with no dental exams, mailed an educational flyer to all parents/caregivers of members ages 2–3 years, offered incentives to complete dental visits to all members who were at least two years overdue for an exam Expand provider availability: operate mobile dental van that visited schools (mailed advance flyers to parents/caregivers), recruited and added 49 new providers to network Provider outreach/education: distributed EPSDT Dental Guidelines to pediatric and family practice providers	Validated: The MCO encountered barriers, when Pennsylvania determined that a planned dental contest was not allowable under the MCO contract. The revised activity (dental incentive program) was implemented later than the MCO had originally planned.

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

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

* State-mandated PIP topic.

[a] EQRO validation rating is the summary validation assessment assigned by the EQRO. EQROs used different rating scales for PIPs. In general, ratings of "Met" and "High Confidence" indicate that the PIP met most of the validation criteria, including all essential criteria. Ratings of "Partially Met" and "Moderate Confidence" indicate that the PIP did not meet some validation criteria. Ratings of "Not Met" and "Low Confidence" indicate that the EQRO identified substantive methodological or data reporting issues with the PIP. New PIPs that were not fully implemented at the time of the EQRO were not always assigned validation ratings. EQRO technical reports contain more detailed descriptions of the rating system used by the EQRO.

[b] MCO terminated.

NR = not reported; PIP = Performance Improvement Project.

Appendix Table G.4. Progress on Prenatal Performance Improvement Projects, as Reported in External Quality Review Organization (EQRO) Technical Reports, 2011-2012 Reporting Cycle

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
California			
Anthem–Alameda	PIP aims to improve the rate of postpartum care visits.	NR	NR
Anthem–Contra Costa	PIP aims to improve the rate of postpartum care visits.	NR	NR
Anthem–Fresno	PIP aims to improve the rate of postpartum care visits.	NR	NR
Anthem –Sacramento	PIP aims to improve the rate of postpartum care visits.	NR	NR
Anthem–San Francisco	PIP aims to improve the rate of postpartum care visits.	NR	NR
Anthem–San Joaquin	PIP aims to improve the rate of postpartum care visits.	NR	NR
Anthem–Santa Clara	PIP aims to improve the rate of postpartum care visits.	NR	NR
Anthem–Stanislaus	PIP aims to improve the rate of postpartum care visits.	NR	NR
Anthem–Tulare	PIP aims to improve the rate of postpartum care visits.	NR	NR
Community Health Group–San Diego	PIP aims to increase the percentage of women who are screened for postpartum depression.	NR	NR
Health Plan of San Mateo	PIP aims to increase the rate of first prenatal visits occurring within the first trimester of pregnancy.	NR	NR
Kaiser Permanente–San Diego	PIP aims to increase the rate of postpartum care within the first 21–56 days after delivery.	NR	NR

Appendix Table G.4 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
Delaware*			
Delaware Physicians Care	Performance on two HEDIS rates for pregnant women and infants dropped between 2008 and 2010: 1. Timeliness of postpartum care rate dropped from 88.2 to 87.5% 2. Postpartum care visit rate dropped from 70.6 to 65.4% Performance on three rates improved: 1. Neonatal intensive care unit (NICU) admission percentage dropped from 11.5 to 10.2% 2. Rate of low birth weight infants dropped from 10.9 to 7.8% 3. Frequency of ongoing prenatal care improved from 72.4 to 78.7%	Care delivery changes: improvements to the Perinatal Appointment Compliance Tool (PACT, a text message program providing pre-natal and postpartum educational information and appointment reminders) and PROMISE (case management and rewards for completing prenatal visits)	High Confidence: This PIP has been in place for several years and during that time, the MCO has improved the overall project document, barrier analysis, and statistical rigor required to form a strong foundation for ongoing performance improvement. However, since the initial remeasurement period, there has been no significant quantifiable improvement in the outcomes documented. In part, the EQRO attributes this stability to interventions that are passive by nature or have not been implemented in a timely fashion so as to reap the benefits in the next measurement cycle. The MCO should solicit more physician input, and target interventions and education to members who are in populations found to be at higher risk for poor outcomes.
State of Delaware United HealthCare Community Plan	Performance on two rates for pregnant women and infants dropped between 2008 and 2010: 1. Timeliness of postpartum care rate dropped from 80.3 to 78.3% 2. Postpartum care visit rate dropped from 53.3 to 52.1% Preterm delivery rate increased from 7.9 to 9.3% (inverse measure). The rate of low birth weight infants (inverse measure) dropped from 7.7 to 6.3%.	Member outreach/education: letters, newsletters, and publications on the MCO website, incentives for completion of risk assessment within five days of prenatal visit Care delivery change: case management interventions	Moderate Confidence: The PIP results indicate a decline in outcomes for all four measures. The deterioration in rates are statistically significant for timeliness of prenatal and postpartum care. The MCO should complete a timely and robust data/barrier analysis to address additional barriers and effectively validate the measurement results based on the interventions selected. The MCO reported that one explanation for the decline was the shift from the locally managed Miracles prenatal case management program to the national Healthy First Steps (HFS) program. The Miracles program interacted with all known maternity cases, but HFS includes only high-risk pregnancy cases. This approach is being reconsidered and may be modified at the local level.

Appendix Table G.4 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
District of Columbia*			
Chartered Health Plan	PIP aims to improve perinatal care outcomes. The rate of adverse perinatal outcomes for pregnant women and infants declined from 292/1,000 in 2009 to 256/1,000 in 2010.[b]	Member outreach/education: initiated preconception/interconception education and counseling (on the impact of spacing pregnancies) Care delivery changes: outsourced pregnancy case management for high-risk members, implemented mandatory use of perinatal needs assessment form (linked to provider payment)	Met Validation Criteria: Interventions were based on identified barriers to quality improvement including, high care management staff turnover, lack of provider community understanding of the value of prenatal assessment, and inconsistent methodology to identify high-risk pregnant enrollees. The MCO should include specific adverse event indicators and provide a full analysis of each indicator.
HSCSN	PIP aims to improve perinatal care outcomes. The rate of adverse perinatal outcomes for pregnant women and infants dropped from 370/1,000 in 2009 to 251/1,000 in 2010.[b]	Care delivery changes: pregnant members received case management from an obstetric coordinator (including an in-person visit), implemented Baby and Me prenatal program (focused on member identification and case management) Provider outreach/education: outreach to obstetric providers (various methods) to introduce and address collaborative goals, accomplishments, risk assessment tools, forms, etc.	Met Validation Criteria: PIP documented improved performance. The MCO should expand the study question beyond case management activities and include the impact of specific interventions in its qualitative analysis.
Unison Health Plan	PIP aims to improve perinatal care outcomes, but performance declined in 2010 with an increase in the rate of adverse perinatal outcomes for pregnant women and infants from 103/1,000 in 2009 to 174/1,000 in 2010.[b]	Care delivery change: adopted Healthy First Steps (HFS) case management program Member outreach/education: hosted quarterly baby showers (with education regarding perinatal care and HIV testing) Provider outreach/education: held orientation sessions to educate obstetric practitioners and other hospital staff on the HFS program, the perinatal outcomes PIP, available resources, risk assessment forms, etc.	Met Validation Criteria: The MCO should modify performance goals, as the targets have been met. Although the PIP met the validation requirements, MCO performance did not improve from 2009 to 2010. The increased rate of adverse events is attributed to a lack of HIV testing in the prenatal period.
Florida			
Medica Health Plans of Florida (Non-Reform Plan)	The rate of satisfaction with obstetric care among pregnant women during the prenatal period dropped from 69% (HEDIS SFY 2010–2011) to 56% (HEDIS SFY 2010–2011).	NR	Partially Met Validation Criteria: The MCO should report hybrid HEDIS rates unless administrative rates are shown to be the same. The MCO should document only the targeted interventions implemented to address the specific barriers identified.

Appendix Table G.4 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
Medica Health Plans of Florida (Reform Plan)	The rate of satisfaction with obstetric care among pregnant women during the prenatal period dropped from 69% (HEDIS SFY 2010–2011) to 56% (HEDIS SFY 2010–2011).	NR	Partially Met Validation Criteria: The MCO should report hybrid HEDIS rates unless administrative rates are shown to be the same. The MCO should document only the targeted interventions implemented to address the specific barriers identified.
Illinois*			
Family Health Network	PIP increased six perinatal care rates for pregnant women between 2006 (SFY) and 2010 (SFY): 1. Timeliness of prenatal care rate increased from 33.0 to 49.2% 2. Postpartum care rate increased from 23.2 to 39.3% 3. Frequency of ongoing prenatal care increased from 9.5 to 26.3% 4. Percentage of women who were screened for depression during the pregnancy and prior to delivery increased from 5.5 to 9.0% 5. Percentage of women who were screened for depression within 56 days after delivery increased from 10.2 to 34.4% 6. Percentage of women who were screened for depression either prior to or within 56 days after delivery increased from 15.7 to 40.9% The percentage of pregnant women with a positive depression screening who had any follow-up care dropped from 45.0 to 39.4%	Care delivery change: implemented objective depression screening and clinician review of the depression screens	Met Validation Criteria: The EQRO found that the low rates for Timeliness of Prenatal Care, Frequency of Ongoing Prenatal Care, and Postpartum Care continue to represent a significant area for improvement. However, as the trended results show, all of these rates had significant improvement between the baseline rates and the second remeasurement periods. The MCO should track and monitor pregnant beneficiaries with data and encourage them to have regular prenatal care appointments and a postpartum visit, assure coordination of services with case management, continue with incentives for members receiving prenatal and postpartum care visits, continue to regularly conduct provider profiling, and continue provider education.

Appendix Table G.4 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
Harmony	PIP increased seven perinatal care rates for pregnant women between 2006 (SFY) and 2010 (SFY) in the Cook and South regions of the MCO: 1. Timeliness of prenatal care rate increased from 51.4 to 63.7% in the Cook region and from 74.6 to 75.5% in the South region 2. Postpartum care rate increased from 31.1 to 47.8% in the Cook region and from 52.5 to 62.3% in the South region 3. Frequency of ongoing prenatal care increased from 24.3 to 34.6% in the Cook region and from 64.4 to 71.7% in the South region 4. Percentage of women who were screened for depression during the pregnancy and prior to delivery increased from 8.2 to 21.0% in the Cook region and from 13.6 to 17.0% in the South region 5. Percentage of women who were screened for depression within 56 days after delivery increased from 11.9 to 29.9% in the Cook region and 15.3 to 28.3% in the South region 6. Percentage of women who were screened for depression either prior to or within 56 days after delivery increased from 34.0 to 51.1% in the Cook region and decreased from 63.6 to 62.3% in the South region 7. The percentage of pregnant women with a positive depression screening who had any follow-up care increased from 62.8 to 87.5% in the Cook region and from 42.3 to 50.0% in the South region	NR	Met Validation Criteria: The low rates for Timeliness of Prenatal Care, Frequency of Ongoing Prenatal Care, and Postpartum Care continue to represent a significant area for improvement. However, as the trended results show, all of these rates had significant improvement between the baseline rates and the second remeasurement periods. There continues to be a significant difference in rates between MCO's two service areas (Cook and Southern). The MCO should track and monitor pregnant beneficiaries with data and encourage them to have regular prenatal care appointments and a postpartum visit, assure coordination of services with case management, continue with incentives for members receiving prenatal and postpartum care visits, continue to regularly conduct provider profiling, and continue provider education.

Appendix Table G.4 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
Meridian	PIP aims to improve seven perinatal care rates among pregnant women: 1. Timeliness of prenatal care 2. Postpartum care 3. Frequency of ongoing prenatal care 4. Percentage of women who were screened for depression during the pregnancy and prior to delivery 5. Percentage of women who were screened for depression within 56 days after delivery 6. Percentage of women who were screened for depression either prior to or within 56 days after delivery 7. Percentage of pregnant women with a positive depression screening who had any follow-up care The EQRO technical report did not include the baseline performance or post-intervention performance rates.	NR	Met Validation Criteria: The EQRO found that the low rates for Timeliness of Prenatal Care, Frequency of Ongoing Prenatal Care, and Postpartum Care continue to represent a significant area for improvement. However, as the trended results show, all of these rates had significant improvement between the baseline rates and the second remeasurement periods. The MCO should track and monitor pregnant beneficiaries with data and encourage them to have regular prenatal care appointments and a postpartum visit, assure coordination of services with case management, continue with incentives for members receiving prenatal and postpartum care visits, continue to regularly conduct provider profiling, and continue provider education.
Indiana			
Managed Health Services	PIP improved two HEDIS rates for pregnant women from reporting year 2007 to reporting year 2011: 1. Percentage of members with a timely prenatal visit during pregnancy increased from 87.5 to 90.6% 2. Percentage of members with a timely postpartum visit increased from 63.5 to 70.7%	Care delivery change: prenatal 17P program (coordinates the administration of injections to prevent preterm delivery), implemented Start Smart program to identify pregnant members as early as possible, provided limited-use cell phones to pregnant women at high risk to abuse drugs or alcoholoto contact their providers and MCO, provided access to on-the-ground outreach coordinators, and a specified unit for high-risk obstetric case management Provider outreach/education: profiles of members with gaps in service	Confidence: The EQRO technical reported confidence in the PIP results because the data are based upon annually audited HEDIS data. The initial re-measures have exceeded the goal of the HEDIS 75th percentile and the MCO should increase the goal to the HEDIS 90th percentile. The MCO reported that the most successful intervention was the introduction of the Start Smart Connections Plus programs.

Appendix Table G.4 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
Kentucky			
Passport Health Plan	PIP aims to improve provider compliance with perinatal clinical practice guidelines. Rates for four measures declined from 2007 to 2009: (1) nutrition counseling, (2) drug abuse counseling/education, (3) alcohol abuse counseling/education, and (4) use of prescription/over-the-counter drugs. The EQRO technical report did not include baseline and post-intervention rates for these measures. Two rates increased: (1) smoking cessation counseling increased from 64 to 73% and (2) domestic violence assessments improved from 45 to 52%.	Provider outreach/education: update and distribute perinatal guidelines, clinical practice guideline audits, provider group reports of compliance with perinatal guidelines, provider office visits by Mommy and Me care management program nurses, added data collection fields related to assessment/counseling to obstetric Global Authorization Form to address provider lack of interest in documentation tools that MCO developed. Member outreach/education: newsletters Care delivery change: Mommy and Me care management program	Met Validation Criteria: Domestic violence and smoking cessation rates increased in 2008 and then declined in 2009, but still exceed plan's goals. The decline in rates for this PIP was likely impacted by more stringent review criteria that were introduced in reviewer retraining conducted for the 2009 review. The MCO cited the use of Electronic Health Records (EHRs) as possibly contributing to the decline in rates, because EHRs were found to be lacking specific screening and counseling fields, such as those contained in the American Congress of Obstetricians and Gynecologist form. The MCO should enhance and clarify medical record abstraction tools and refine the smoking cessation measure to delineate smokers and nonsmokers.
Missouri			
Molina HealthCare of Missouri	PIP aims to improve obstetric case management for pregnant women at high risk for Cesarean wound infections. To measure performance, the MCO tracked the number of pregnant women who were admitted to the hospital with specific diagnosis codes and the number of members who deliver by Cesarean section and have one or more wound infection risk factors. The EQRO technical report did not include baseline or post-intervention rates for these measures.	Care delivery change: home health visits for members delivering by cesarean section (including assessment of the member's educational level and understanding of proper wound care as well as signs and symptoms of infections) Member outreach/education: education about postpartum wound infections and the necessary education tools prior to discharge and/or during the first home health visit Provider outreach/education: help providers identify members who have one or more of the factors that increase Cesarean section wound infections (CSWIs), tools for providers to distribute to members who are at risk of developing CSWIs, education of MCO provider services in promoting provider compliance in completing prenatal assessment forms and returning them to the MCO, discuss purpose of the PIP in the provider newsletter System change: data analysis to ensure that the CSWI rate is not due to individual provider or facility issues	High Confidence: The EQRO noted a decrease of 22% in the total number of hospitalizations from 2008 to 2010, but it was not statistically significant , partly because there are small numbers in the population.

Appendix Table G.4 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
Blue Advantage Plus	PIP measured participation in prenatal program for pregnant women under age 18. The number of pregnant teens who agreed to engage in the program increased from 26.7 to 40.8% from 2009 to 2010. The number of pregnant teens who complete the prenatal program assessment process, actively engage in the program, and complete the second assessment increased from 20.9 to 65%.	Care delivery change: implement enhanced medical services for pregnant teens toward a goal of creating positive health outcomes for the mother and baby	High Confidence: The EQRO found that the increase in the first measure is not statistically significant but exceeds the stated goal of 38.5%. The increase for the second indicator was a statistically significant improvement and exceeded the stated goal of 30.85%. Providing interventions that focused on outreach to both parents and teens, including a personal interaction with a nurse /case manager, proved to have the desired impact.
Nebraska			
United Healthcare of the Midlands	PIP improved two HEDIS rates for pregnant women from measurement year 2009 to measurement year 2010: 1. Timely prenatal care increased from 86.9 to 88.1% 2. Postpartum care increased from 67.5 to 68.6% Frequency of prenatal care rate dropped from 66.0 to 62.8%	Member outreach/education: automated telephone calls to encourage postpartum visits (initiated 769 calls and left 382 messages), newsletter articles about the diaper rewards program, healthy pregnancy education through cell phones, welcome calls with Health Risk Assessments (650 pregnant members identified) Provider outreach/education: provider incentives of $25 for completing OB risk assessments Care delivery change: the Diaper Incentive Program (409 members) and the HFS Program to 324 members in Level 1 (mild to moderate risk), 87 members in Level 2 (medium risk), and 33 members in the Level 3 (high risk) based on OB risk assessment.	Met Validation Criteria: The EQRO did not result in any findings that indicate that the credibility of the PIP results is at risk. The MCO should explore whether any access to care issues exist, given the decline in frequency of prenatal care visits.
New Jersey*			
AmeriChoice	PIP aims to improve the percentage of low birth weight babies. The EQRO did not include baseline and post-intervention performance rates.	NR	PIP Not Fully Implemented
Amerigroup	PIP aims to improve dental visit rates among pregnant women from the baseline rate of 13.6%.	NR	PIP Not Fully Implemented
Healthfirst	PIP aims to improve three prenatal care measures: 1. Timely prenatal care (baseline of 66%) 2. Frequency of prenatal care (baseline of 20%) 3. Percentage of low birth weight babies (baseline of 6%).	NR	PIP Not Fully Implemented

Appendix Table G.4 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
Horizon New Jersey Health	PIP aims to improve two prenatal care measures: 1. Timely prenatal care (baseline of 78.4%) 2. Postpartum care (baseline of 58.4%)	NR	PIP Not Fully Implemented
New Mexico			
Lovelace	PIP improved the percentage of pregnant women with at least 81% of expected prenatal visits from 7% in 2005 to 71% in 2010.	Member outreach/education: member education Care delivery changes: Baby Love program (handbook and 24-hour telephone advice service available for pregnant women through the first few months of baby's life), incentives to members for prenatal visits System changes: revised data collection process Provider outreach/education: incentives to providers for prenatal visits	Full Compliance: PIP has targeted Medicaid enrollees since 2005 and was expanded to include adults in the State Coverage Initiative (SCI) program in 2010 (these adults are not included in baseline or post-intervention performance rates). The MCO should consider looking at the impact of increased prenatal visits on improved birth outcomes, such as fewer low birth weight babies or fewer "Failure to Thrive" diagnoses in these populations.
Molina HealthCare of New Mexico	PIP improved the timeliness of postpartum care rate from 32% in 2009 to 64.7% in 2010.	System change: shift from administrative data to hybrid data measurement	Full Compliance: Molina doubled the rate of women who receive postpartum care. EQRO found that small numbers in the population for the PIP may affect interpretations of improvements in postpartum care.
New York*			
MVP Health Plan	PIP improved performance on four rates of prenatal and postpartum care: 1. Nutrition referrals for excessive weight gain 2. Pregnancy BMI documented 3. Intent to breastfeed at delivery 4. Breastfeeding at postpartum follow-up Performance declined for the percentage of women gaining weight in excess of Institute of Medicine guidelines EQRO technical report did not include baseline or post-intervention performance rates.	Care delivery change: implemented the Baby Basics Program (including diaper bank, community support, education) in eight OB/GYN practices, Community outreach/education: partnered with community organizations to provide education: Staying in the Range program at Healthy Start Center sites, University of Rochester Medical Center's Baby Love program (peer home visiting, care coordination, interventions for behavioral and social issues, health care referral and appointment transportation, and other support services), Healthy MOMs program (10-session weekly program focused on education and parenting skills) Member outreach/education: Member education through MCO case management Provider outreach/education: provider office detailing	Validated: Key strengths of this PIP included multiple interventions to address both members and providers, incorporating multifaceted intervention programs in different counties. The validation findings generally indicated that the credibility of the PIP results is not at risk. Results must be interpreted with some caution for the Breastfeeding at Postpartum Follow-up indicator due to missing data.

Appendix Table G.4 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
Excellus Health Plan	PIP improved performance on four rates of prenatal and postpartum care: 1. Nutrition referrals for excessive weight gain 2. Pregnancy BMI documented 3. Intent to breastfeed at delivery 4. Breastfeeding at postpartum follow-up Performance declined for the percentage of women gaining weight in excess of Institute of Medicine guidelines EQRO technical report did not include baseline or post-intervention performance rates.	Community outreach/education: supported the Staying in the Range Program at Healthy Start Center site (program to help women maintain a healthy weight gain during pregnancy), Healthy MOMs program Care delivery change: implemented the Baby Basics Program in eight OB/GYN practices, case management Provider outreach/education: office visits	Validated: EQRO identified key strengths of this PIP, including multiple interventions to address both members and providers, incorporating multifaceted intervention programs in different counties. Results must be interpreted with some caution for the Breastfeeding at postpartum follow-up due to missing data.
Fidelis Care New York	PIP improved performance on rates of prenatal weight gain (but increase was not statistically significant). Performance was maintained for rate of breastfeeding at six months. EQRO technical report did not include baseline or post-intervention performance rates.	Member outreach/education: updated and distributed a resource manual of community agencies in New York, newsletters to members Care delivery change: intensive counseling by case managers (including educational literature, self management tools, and referrals) Provider outreach/education: provider newsletters, information on pregnancy weight gain and breastfeeding for pediatric and OB/GYN providers to distribute to members, information to providers about the obesity project and the Baby Care Program, assisted providers with connecting members to the program Community outreach/education: targeted three communities with large populations of members, attended community health events.	Validated: Key strengths of this PIP included multiple interventions to address both members and providers, incorporating multifaceted intervention programs in different counties. Key strengths of this PIP included a clearly stated rationale, barrier analysis, and detailed results. There were no validation findings that indicate that the credibility of the PIP results is at risk.

Appendix Table G.4 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
Pennsylvania			
AmeriHealth Mercy Health Plan	PIP maintained performance at a rate of 100% for three measures between January–June 2009 and January–June 2010: 1. Percentage of pregnant women screened for perinatal depression 2. Percentage of pregnant women with a positive screening for perinatal depression and referred by three-way call with case manager, member, and behavioral health MCO contact 3. Percentage of referred members with the first behavioral health appointment documented in the care coordination database The percentage of referred members who attended the first scheduled behavioral health appointment increased from 18 to 83%.	Member outreach/education: mailed educational sheet about pregnancy and depression to members identified with depression, mailed topical newsletter to all households, included a Pregnancy and Depression Resource Guide (educates members on how to ensure healthy pregnancy with positive outcome) in the WeeCare packet to all identified pregnant members, calls by case managers to remind members with a scheduled behavioral health appointment and to help remove potential barriers to attending the appointment Care delivery changes: depression screening for every member in the WeeCare program, added the Edinburgh Postnatal Depression Scale (EPDS) screening to the case management/care coordination documentation database, implemented Text4baby (educational information through text messages) Expand provider availability: hired a new staff person	Met Validation Criteria: EQRO found that all indicators were again higher than the baseline rate, indicating Sustained Improvement.
Keystone Mercy Health Plan	For pregnant women who delivered between August and October, the annual dental visit rate increased from 13.0% in January–June 2008 to 25.0% in January–June 2010.	Member outreach/education: gift card incentive for pregnant members with a dental screening, outreach to prenatal case management members, assistance to members with scheduling and/or transportation to dental appointments for pregnant members; Community outreach/education: participate in community events that include dental screening Provider outreach/education: educational outreach to primary care physicians and obstetricians Expand provider availability: worked with selected dentists to allocate specific times for MCO members to receive dental screening	Validated: PIP increased visit rates among target population over two remeasurement periods (2009 and 2010). The interventions, which consisted primarily of outreach, appeared to have contributed to the rate increase.

Appendix Table G.4 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
Keystone Mercy Health Plan	PIP improved performance for two measures between January–June 2009 and January–June 2010: 1. Percentage of pregnant women screened for perinatal depression increased from 14 to 20.8% 2. Percentage of pregnant women with a positive screening for perinatal depression and referred by three-way call with case manager, member, and behavioral health MCO contact increased from 3 to 57.1% Percentage of referred members with the first behavioral health appointment documented in the care coordination database dropped from 100% to 8%. Percentage of referred members who attended the first scheduled behavioral health appointment stayed at 100%.	Care delivery changes: depression screening for pregnant members, training for case management staff on the EPDS tool, focused efforts to utilize the EPDS tool for depression screening of every pregnant member in Delaware County Member outreach/education: newsletter to all households addressing the topic of depression, inclusion of a Pregnancy and Depression Resource Guide in the MCO prenatal packet sent to all identified pregnant members, System change: enhanced the MCO's maternity database to capture relevant measurement elements	Met Validation Criteria: EQRO found that populations for measures 2–4 were very small, and that changes in the rates for these measures should be interpreted with caution
Rhode Island			
Blue Cross Blue Shield of Rhode Island	The percentage of pregnant women with at least 81% of expected prenatal visits dropped from 69.0% in HEDIS 2009 to 59.3% in HEDIS 2010.	Member outreach/education: member preconception and prenatal self-assessments on the MCO website (used as a source of referral to the Maternity Program), distributed Prenatal Kits to pregnant mothers (including booklet that addressed nutrition, exercise, postpartum depression, dental care, breastfeeding, and an infant survey), monthly mailing to pregnant women with letter, brochure, and invitation to participate in health coaching via telephone	Met Validation Criteria: The EQRO identified no validation findings to indicate that the credibility of the PIP was at risk. Performance on the measure declined, and the MCO did not achieve its internal goal of 95%. In fact, it lowered the goal to 90%. The MCO should implement provider or MCO-level interventions. Several interventions were not implemented due to the MCO's discontinued participation in Medicaid.
South Carolina			
Absolute Total Care	PIP aims to improve timeliness of prenatal care. The EQRO technical report did not include baseline and post-intervention performance rates.	NR	High Confidence: The MCO should add a study question for the PIP.
Select Health of South Carolina	PIP aims to improve prenatal/postpartum care and prenatal outcomes. The EQRO technical report did not include baseline and post-intervention performance rates.	NR	Confidence: The MCO should update information about PIP interventions, add a study question for the PIP, and add current HEDIS measure data.

Appendix Table G.4 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
Unison Health Plan of South Carolina	PIP aims to improve prenatal/postpartum care and prenatal outcomes. The EQRO technical report did not include baseline and post-intervention performance rates.	NR	High Confidence
Tennessee			
BlueCare—East	The percentage of pregnant women who delivered a live birth and are screened for postpartum depression with the Edinburgh Postnatal Depression Scale (EPDS) screening tool increased from 2.7% in CY 2008 to 18.9% in CY 2010.	Member outreach/education: telephone and mailed screenings, newsletters on pregnancy, prenatal care, case management, disease management, depression and postpartum depression, online health information library for Mental Health and Postpartum Depression, "baby showers" (education focused on specific topics) Community outreach/education: educational community outreach events Care delivery changes: CaringStart Maternity Management Program, new behavioral health referral line	Did Not Meet Validation Criteria: Increases in screening rates were statistically significant. The MCO should identify goals for its study indicator, strengthen its PIP by focusing on interventions that are truly systemwide changes as described in the CMS PIP validation protocol, describe how the PIP interventions were the result of data analysis and quality improvement processes, and avoid identifying (as improvement strategies) processes that were in place prior to the start of the PIP.
BlueCare—West	The percentage of pregnant women who delivered a live birth and are screened for postpartum depression with the Edinburgh Postnatal Depression Scale (EPDS) screening tool increased from 1.5% in CY 2008 to 20.6% in CY 2010.	Member outreach/education: telephone and mailed screenings, newsletters on pregnancy, prenatal care, case management, disease management, depression and postpartum depression, online health information library for Mental Health and Postpartum Depression, "baby showers" (education focused on specific topics) Community outreach/education: educational community outreach events Care delivery changes: CaringStart Maternity Management Program, new behavioral health referral line	Did Not Meet Validation Criteria: Increases in screening rates were statistically significant. The MCO should identify goals for its study indicator, strengthen its PIP by focusing on interventions that are truly systemwide changes as described in the CMS PIP validation protocol, describe how the PIP interventions were the result of data analysis and quality improvement processes, and avoid identifying (as improvement strategies) processes that were in place prior to the start of the PIP.

Appendix Table G.4 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
TennCare Select	The percentage of pregnant women who delivered a live birth and are screened for postpartum depression with the Edinburgh Postnatal Depression Scale (EPDS) screening tool increased from 2.4% in CY 2008 to 14.8% in CY 2010.	Member outreach/education: telephone and mailed screenings, newsletters on pregnancy, prenatal care, case management, disease management, depression and postpartum depression, online health information library for Mental Health and Postpartum Depression, "baby showers" (education focused on specific topics) Community outreach/education: educational community outreach events Care delivery changes: CaringStart Maternity Management Program, new behavioral health referral line	Did Not Meet Validation Criteria: Increases in screening rates were statistically significant. The MCO should identify goals for its study indicator, strengthen its PIP by focusing on interventions that are truly systemwide changes as described in the CMS PIP validation protocol, describe how the PIP interventions were the result of data analysis and quality improvement processes, and avoid identifying (as improvement strategies) processes that were in place prior to the start of the PIP.

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

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

* State-mandated PIP Topic.

[a] EQRO validation rating is the summary validation assessment assigned by the EQRO. EQROs used different rating scales for PIPs. In general, ratings of "Met" and "High Confidence" indicate that the PIP met most of the validation criteria, including all essential criteria. Ratings of "Partially Met" and "Moderate Confidence" indicate that the PIP did not meet some validation criteria. Ratings of "Not Met" and "Low Confidence" indicate that the EQRO identified substantive methodological or data reporting issues with the PIP. New PIPs that were not fully implemented at the time of the EQRO were not always assigned validation ratings. EQRO technical reports contain more detailed descriptions of the rating system used by the EQRO.

[b] Adverse events include birth weight less than 2,500 grams, birth at gestational age of 32 weeks or fewer, pregnant women not tested for HIV prior to giving birth, pregnancies ending in miscarriage or fetal loss (early or late), pregnancies for which no outcome is known, and death of infant.

NR = not reported; PIP = Performance Improvement Project.

Appendix Table G.5. Progress on Adolescent Well-Care Performance Improvement Projects, as Reported in External Quality Review Organization (EQRO) Technical Reports, 2011-2012 Reporting Cycle

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
Colorado			
Rocky Mountain Health Plans	PIP aims to improve well-care visit rates for adolescents to a rate of 55.8%. The EQRO technical report did not include baseline and post-intervention performance rates.	Member outreach/education: mailings to parents	Met Validation Criteria: Although the PIP achieved real and sustained improvement compared with the baseline, the results continued to be below MCO's goal and the improvement was not statistically significant. The MCO should analyze its data to determine whether any subgroup within its population has a disproportionately lower rate that negatively affects the overall rate. The MCO also plans to add provider education to the PIP, and the MCO should provide more information about the process used to determine that the new intervention will address the barriers to well care.
Florida*			
Children's Medical Services—Broward (Reform)	PIP aims to address the disparity in well-care visit rates between younger and older children. The EQRO technical report did not include target population, performance measures for assessing progress, and performance rates.	NR	Met Validation Criteria
South Florida Community Care Network (Non-Reform)	PIP aims to address the disparity in well-care visit rates between younger and older children. The EQRO technical report did not include target population, performance measures for assessing progress, and performance rates.	NR	Met Validation Criteria
South Florida Community Care Network (Reform)	PIP aims to address the disparity in well-care visit rates between younger and older children. The EQRO technical report did not include target population, performance measures for assessing progress, and performance rates.	NR	Met Validation Criteria

Appendix Table G.5 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
Hawaii*			
Aloha Care	PIP aims to improve primary care visit rates for children ages 12 months to 19 years. From 2008–2010, however, rates for all age groups declined. Among members ages 12–19 years, the percentage with a visit to a primary care provider dropped from 84.5 to 81.2%.	Member outreach/education: incentive gift card to parents for completing an EPSDT visit with primary care provider (pilot program with one high-volume provider) Provider outreach/education: MCO's EPSDT nurse coordinator visited PCP offices to perform medical record reviews and educate providers and staff on the importance of EPSDT documentation, continued to send provider newsletters with information on appointment standards	Met Validation Criteria: The PIP did not achieve an improvement in performance on any performance measures. The MCO should ensure that targeted interventions directly address barriers to access, conduct subgroup analysis to determine whether any population had a disproportionately lower rate that negatively affected the overall rate, and implement a method to study the efficacy of the interventions.
Indiana			
MDwise	PIP increased two rates of for adolescents between (reporting years) 2008 and 2010: 1. Adolescent well-care visit rate (ages 12–21) increased from 36.2 to 57.7% 2. Children's primary care visit rate (ages 12–19) increased from 88.3 to 92.8%	Provider outreach/education: Network Improvement Team held in-person meetings with large provider groups and delivered reports on gaps in care, providers received pay-for-performance incentives for conducting visits, enhanced provider education Member outreach/education: $20 member incentive for visits Community outreach/education: enhanced community outreach	Confidence: The improvement in both measures was statistically significant. The MCO implemented the PIP because performance was below the 25th percentile for the HEDIS measures nationally. The MCO identified the Network Improvement Team and the member incentive as the most effective interventions. The MCO should also conduct a stratified analysis to measure the effectiveness of specific interventions.
New Jersey			
AmeriChoice	PIP aims to improve adolescent well-care visit rate for adolescents ages 12–21 from a baseline of 53.66% (year unknown).	NA	PIP Not Fully Implemented
HealthNet	Age-appropriate comprehensive exam rate for adolescents (ages 12–21 years) decreased from 51.1% in CY 2007 to 50.7% in CY 2009.	Member outreach/education: educational initiatives and welcome calls Provider outreach/education: quarterly provider reports	Confidence
University Health Plans	The age-appropriate comprehensive exam rate for adolescents (ages 12–21 years) increased from 42.4% (CY 2007) to 42.6% (CY 2009).	Member outreach/education: educational mailings, outreach programs, telephone outreach, care management outreach Provider outreach/education: provider fax-back forms Community outreach/education: health fairs System change: formation of EPSDT workgroup	Not Credible: The EQRO review found several major concerns with the PIP. The PIP was not developed using methodologically sound principles. The PIP documentation by the MCO did not demonstrate whether the PIP interventions had a true impact on the performance rate or whether external factors caused the increase.

Appendix Table G.5 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
Oregon			
Kaiser Permanente Northwest	PIP aims to improve adolescent well-care visit rates. EQRO technical report did not include baseline or post-intervention performance rates.	Member outreach/education: automated telephone reminders for well-care visits	Validation Rating Not Reported in EQRO technical report
Washington*			
Community Health Plan	PIP aims to improve well-child visit rates. The EQRO report did not include target population and baseline and post-intervention performance rates.	NR	Partially Met Validation Criteria: Statistical tests showed no significant improvement in WCC visit rates from the previous year.
Columbia United Providers	PIP aims to improve well-child visit rates. The EQRO report did not include target population and baseline and post-intervention performance rates.	NR	Partially Met Validation Criteria: EQRO identified the MCO's analysis of the impact of multiple interventions on the HEDIS rates as an ongoing area of weakness for this PIP. The MCO should reduce the number of interventions for the PIP and reassess the interventions over time.
Group Health Cooperative	PIP aims to improve well-child and adolescent well-care visit rates. The EQRO report did not include baseline and post-intervention performance rates.	Provider outreach/education: Panel Support Tool (graphically displays care gaps on an intranet website)	Met Validation Criteria: EQRO found that the PIP demonstrates generally robust and system-oriented interventions to improve care over time. EQRO also found that although five-year data for the PIP show significant improvement in well-child care visit rates, more recent three-year data show a plateau or downward trend.
Kaiser Permanente Northwest	PIP aims to improve well-child visit rates. The EQRO technical report did not include target population and baseline and post-intervention performance rates.	Provider outreach/education: Panel Support Tool (graphically displays care gaps on an intranet website), bundled incentives for providers to improve well-child care measures Member outreach/education: interactive voice response telephone contact in conjunction with a second reminder mailing after missed appointments	Met Validation Criteria: The EQRO found that although the PIP focuses on improving visit rates for adolescents, the documentation does not make clear whether the bundled incentive package applies to care for adolescents. The EQRO identified the PIP's interventions for providers as “best practices”
Molina Healthcare of Washington	PIP aims to improve well-child visit rates. The EQRO technical report did not include target population and baseline and post-intervention performance rates.	Member outreach/education: incentives, such as bicycle helmets and video-store cards, for completion of well-child care visits	Partially Met Validation Criteria: EQRO found that the ongoing interventions for the PIP are mostly passive, involving educational and reminder information sent to providers and members. The MCO should consider using more active interventions to achieve and sustain improvement in well-child care measures.

Appendix Table G.5 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQRO Validation Rating: Discussion and Recommendations[a]
Regence Blue Shield/Asuris Northwest Health	PIP aims to address the disparity in well-child visit rates among the Hispanic population. The EQRO technical report did not include the target population (by age groups) and baseline and post-intervention performance rates.	NR	Partially Met Validation Criteria: The MCO should implement more active interventions to drive future improvement. The EQRO found that the rationale for the PIP is weak; literature citations are outdated and need to be refreshed.

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

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

* State-mandated PIP Topic.

[a] EQRO validation rating is the summary validation assessment assigned by the EQRO. EQROs used different rating scales for PIPs. In general, ratings of "Met" and "High Confidence" indicate that the PIP met most of the validation criteria, including all essential criteria. Ratings of "Partially Met" and "Moderate Confidence" indicate that the PIP did not meet some validation criteria. Ratings of "Not Met" and "Low Confidence" indicate that the EQRO identified substantive methodological or data reporting issues with the PIP. New PIPs that were not fully implemented at the time of the EQRO were not always assigned validation ratings. EQRO technical reports contain more detailed descriptions of the rating system used by the EQRO.

NR = not reported; PIP = Performance Improvement Project.