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Summary of Pediatric Quality Measures For Children Enrolled in MaineCare FFY 2009-FFY 2013

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Improving Health Outcomes for Children (IHOC)
Summary of Pediatric Quality Measures
For Children Enrolled in MaineCare
FFY 2009-FFY 2013

UNIVERSITY OF SOUTHERN MAINE
Muskie School of Public Service

April 2014



About this Report

This report was written by Mary Lindsey Smith of the Cutler Institute of Health and Social Policy, Muskie School of Public Service at the University of Southern Maine. We would like to acknowledge our colleagues at the Muskie School of Public Service, Tina Gressani and Apsara Kumarage who conducted the measure programming and calculation for the child health quality measures presented in this report; and Pamela Ford-Taylor for administrative support. We would also like to thank Dr. Amy Belisle, Director of Quality Improvement at Quality Counts for Kids, Dr. Kevin Flanigan, Medical Director of MaineCare Services, Maine Department of Health and Human Services (DHHS), and Amy Dix, Policy and Children's Services Program Manager at MaineCare Services, Maine DHHS, for their feedback and support throughout the development of this report.

This report presents the results of the 18 CHIPRA Core Measures that were collected using MaineCare claims, Vital Statistics or survey data and reported to the Centers for Medicare and Medicaid Services (CMS) for FFY 2013. Also included in this report are an additional three measures from the Improving Health Outcomes for Children (IHOC) project's Master List of Pediatric Measures. In addition to presenting results in graphs and narrative, this report also provides measure definitions and background information about each measure topic.

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The views expressed are those of the authors and do not necessarily represent the views of either the Department or the School. For further information regarding this report, please contact Mary Lindsey Smith at mlsmith@usm.maine.edu. For more information about the IHOC project, please contact Joanie Klayman at jklayman@usm.maine.edu.

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Introduction

In February 2010, Maine and Vermont were awarded a five-year demonstration grant from the Centers for Medicare and Medicaid Services (CMS) to improve the quality of health care for children insured by Medicaid and the Children's Health Insurance Program (CHIP). Maine's Department of Health and Human Services' (DHHS) Office of MaineCare Services (OMS) received the Improving Health Outcomes for Children (IHOC) grant in partnership with the Maine Center for Disease Control, the Muskie School of Public Service at the University of Southern Maine, Vermont's Medicaid Program, and the University of Vermont.

In Maine, a key objective of the IHOC grant is to collect and report on the Initial Core Set of Children's Health Care Quality Measures (referred to as the "CHIPRA Core Measures"), a set of 24 standardized, evidence-based measures identified by CMS for use by State Medicaid and CHIP programs.¹ States submit results of the CHIPRA Core Measures to CMS once each year as a component of the CHIP Annual Report, a web-based reporting system (CARTS) that CMS and its contractors use to monitor the operations of Medicaid and CHIP programs.

Although reporting of the Core Measures is currently not required by CMS, MaineCare reported results for 18 of the measures in the Federal Fiscal Year 2013 (FFY 2013), with support from the IHOC project. Of the 18 initial core set measures MaineCare is currently reporting on, 12 are claims-based, 3 are registry-based, 2 based on CMS 416 data and one survey measure. Sixteen of these measures are reported through the CHIP Annual Reporting System (CARTS) and the remaining two will be calculated by CMS using data from Maine's CMS Form 416 reports.

This document presents the results of the 18 CHIPRA Core Measures that were collected using MaineCare claims, Vital Statistics or survey data and reported to CMS. These measures include:

- Well-child visits (3 measures)
- Access to primary care practitioners
- Chlamydia screening
- Appropriate testing for children with pharyngitis
- Emergency Department (ED) visits
- Asthma ED visits
- Follow-up care for children with ADHD medication
- Annual pediatric hemoglobin A1c testing
- Follow-up after hospitalization for mental illness

¹ For more information about the CHIPRA Core Measures, see: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html>

- Prenatal Care (2 measures)
- Live Births Weighing Less than 2,500 Grams
- Developmental screening
- Preventative dental and dental treatment services²
- Patient Experience of Care

In addition to the CHIPRA Core Measures, Maine providers collaborating with the IHOC project identified other quality measures to support quality improvement at the practice-level. Through a stakeholder feedback process, measures drawn from *Bright Futures* guidelines, Meaningful Use, and other sources were added to the CHIPRA Core Measures to create the Maine IHOC Pediatric Measures List, a set of quality, clinically relevant pediatric measures.

The document also presents results of measures from the IHOC Measure list not included among the CHIPRA Core Measures. The following “IHOC-only” measures were calculated using MaineCare claims:

- Well-child visits between 15 months and 3 years of age (IHOC #32), and between 7 and 11 years of age (IHOC #34).
- Asthma controller medication (IHOC #25)

The goal of this document is to present the claims-based CHIPRA and IHOC measure results in a user-friendly format for IHOC project stakeholders. Measures are grouped by topic. For each topic, a Background section provides a brief description and rationale for collection.³ Next, we provide a general description of how each measure is defined, followed by the results.

Most of the measures use a 12-month measurement period. To fulfill requirements of the CHIP Annual Report we used measurement periods that correspond to Federal Fiscal Years (FFY). Federal Fiscal Years run from October 1st of the prior year through September 30th of the year being described. For example, FFY 2013 represents the period from October 1, 2012 through September 30, 2013.

Where available, we also include national 2012 HEDIS averages from Medicaid managed care plans along with Maine’s results. The Health Plan Employer Data and Information Set (HEDIS) is a set of performance measures developed by the National Committee for Quality Assurance (NCQA). HEDIS measures are widely used by employers, consumers, and Medicaid agencies to compare and monitor performance of health plans. Many of the CHIPRA Core Measures are HEDIS measures, and the NCQA publishes average results for selected measures each year.⁴ HEDIS averages are included to provide a point of comparison for the Maine results.

² The two dental measures included in the CHIPRA core set, which are also EPSDT measures, are now reported with the other EPSDT measures on CMS-416 rather than in the CHIP Annual Report.

³ The background discussion for CHIPRA Core Measures is drawn from the *Background Report for the Initial, Recommended Core Set of Children’s Healthcare Quality Measures for Voluntary Use by Medicaid and CHIP Programs*. Available at: <http://www.ahrq.gov/policymakers/chipra/overview/background/corebackgrnd.pdf>

⁴ National Committee for Quality Assurance (October 2013). *The State of Health Care Quality 2013*. Available at: <http://www.ncqa.org/tabid/836/Default.aspx>.

Well-Child Visits (WCVs)

CHIPRA Measures W15, W34, AWC / IHOC Measures 31, 32, 33, 34, 35

Background⁵

Current American Academy of Pediatrics (AAP) Bright Futures guidelines suggest that all children receive a well-child visit (WCV) at specific intervals depending on age. Well-child visits are the gateway to immunizations and early identification of problems. They provide opportunities to discuss developmental issues with parents and deliver evidence-based and other recommended specific preventive services. The CHIPRA Core measures include three well-child visit measures currently specified by National Committee for Quality Assurance (NCQA): 1) WCVs in the first 15 months of life; 2) WCVs in the 3rd, 4th, 5th, and 6th years of life; 3) WCVs in adolescence (ages 12 – 21).

IHOC stakeholders noted the importance of measuring WCVs for two additional age ranges that are not included in the CHIPRA measures: WCVs between 15 months and 3 years of age (IHOC #32), and WCVs between 7 and 11 years of age (IHOC #34).

Measure Definition

These measures assess, for each age group, the number of children who received a well-child or preventive care visit from a primary care practitioner (including, for adolescents, an obstetrician-gynecologist) during the measurement year.

For the youngest group, children who turn 15 months during the measurement year and are continuously enrolled from 31 days after birth to 15 months of age are in the measure denominator.⁶ The number of visits is counted (0, 1, 2, 3, 4, 5, 6 or more visits) for this age group.

For children between 15 months and 3 years of age, children who turn 3 years old during the measurement year and are continuously enrolled between 15 months and 3 years of age are in the measure denominator. The number of visits is counted (0, 1, 2, 3) for this age group.

For 3-6 year-olds, 7-11 year-olds, and adolescents (12-21 years old) the criterion is at least one well-child visit with a primary care practitioner during the measurement year. The denominator population for each of these measures is defined by the age of the child at the end of the measurement year, and requires that the child be continuously enrolled during the year.

⁵ Throughout this document, much of the background information for each measure is drawn from the *Background Report for the Initial, Recommended Core Set of Children's Healthcare Quality Measures for Voluntary Use by Medicaid and CHIP Programs*. Available at: <http://www.ahrq.gov/policymakers/chipra/overview/background/index.html>.

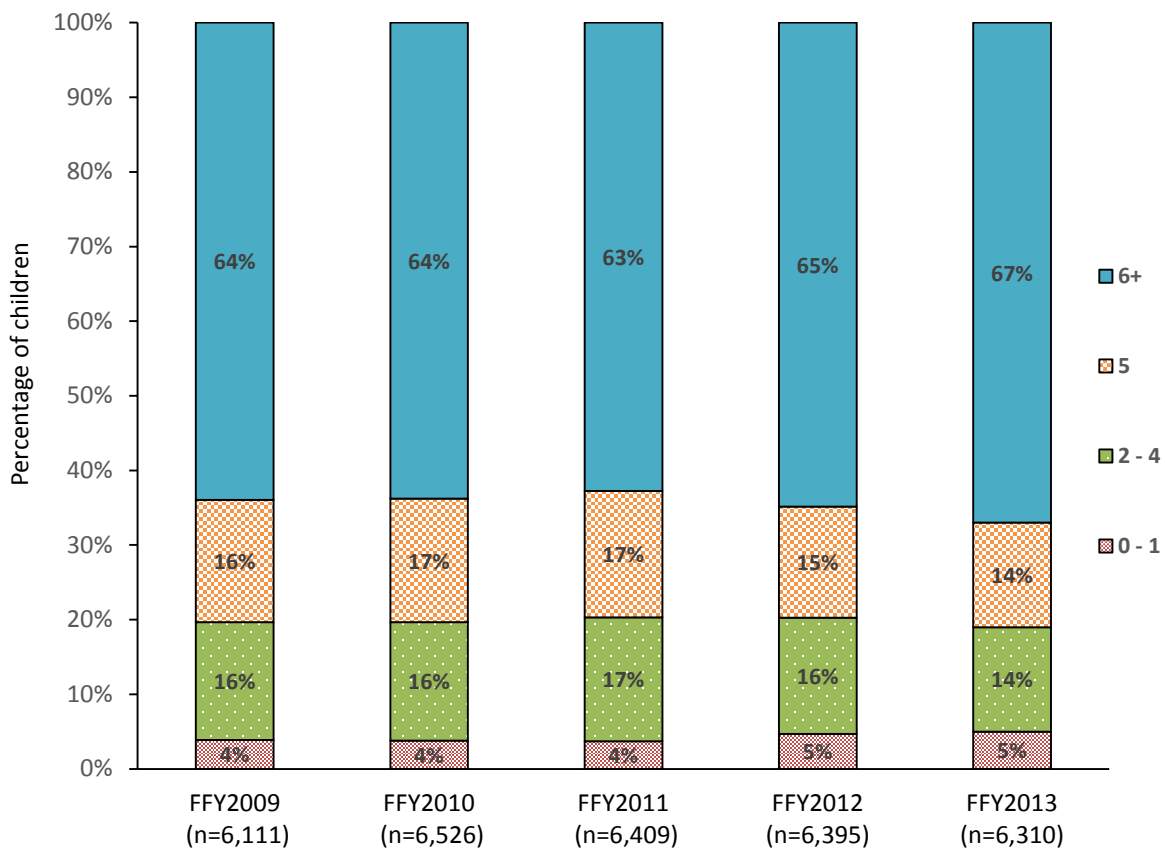
⁶ "Continuously enrolled" means the child missed no more than one month of MaineCare eligibility in the measurement period. For 12 month measurement periods, the child must be enrolled for at least 11 months to be included in the denominator.

Results

The results of the WCV measures for FFY 2009 through FFY 2013 are shown in Figures 1 – 3 and Table 1. Rates of well-child visits remained relatively constant over the 5-year measurement period.

Figure 1 shows the percentage of children enrolled in MaineCare with 0-1, 2-4, 5 or 6 or more total WCVs in the first 15 months of life. Two-thirds of enrolled children (67%) had at least 6 visits in the first 15 months, and 81 percent had 5 or more visits. MaineCare’s rates for children having six or more WCVs were slightly higher than the 2012 HEDIS average of 64 percent.

Figure 1
Number of Well-Child Visits in the First 15 Months

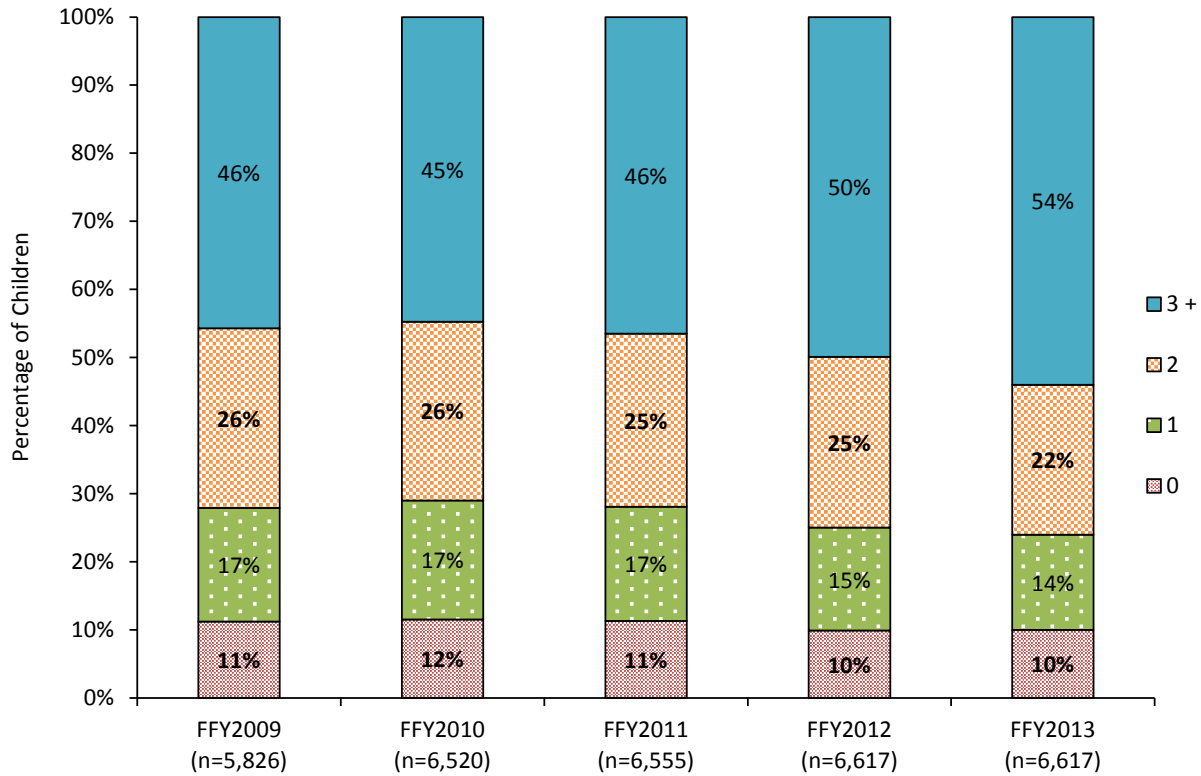


Source: MaineCare Claims Data

Figure 2 shows the percentage of children age 15 months to 3 years with 0, 1, 2, or 3 total WCVs, the rate has steadily increased between FFY 2009 and FFY 2013. The number of children receiving the recommended three well-child visits between 15 months and three years increased by 4 percent between FFY 2012 and FFY

2013, from 50% to 54%. Over the past five years the number of children between the ages of 15 months and 3 years receiving the recommended number of well-child visits has increased by 8 percent over the past five years however, ten percent of the children in this age range had no WCVs.

Figure 2
Number of Well-Child Visits between 15 Months and 3 Years



Source: MaineCare Claims Data

Figure 3 shows the percentage of children who had at least one WCV in the measurement year, by three different age ranges: ages 3 – 6, ages 7 – 11, and ages 12 – 21; rates in all three age categories have remained stable over the past 5 years. Notably, WCV rates decline considerably as children get older. For 3 to 6 year olds, about 63 percent had at least one visit during the measurement year. For 7 to 11 year olds, the rate falls to 49 percent, and for adolescents, it falls further still to 39 percent. Note that MaineCare rates are lower than the HEDIS national average for FFY 2012: 10 percent lower for 3-6 year olds and 11 percent lower for adolescents.⁷

⁷ HEDIS did not measure visits for ages 7-11.

Figure 3
Well-Child Visits- At Least One Visit Per Year

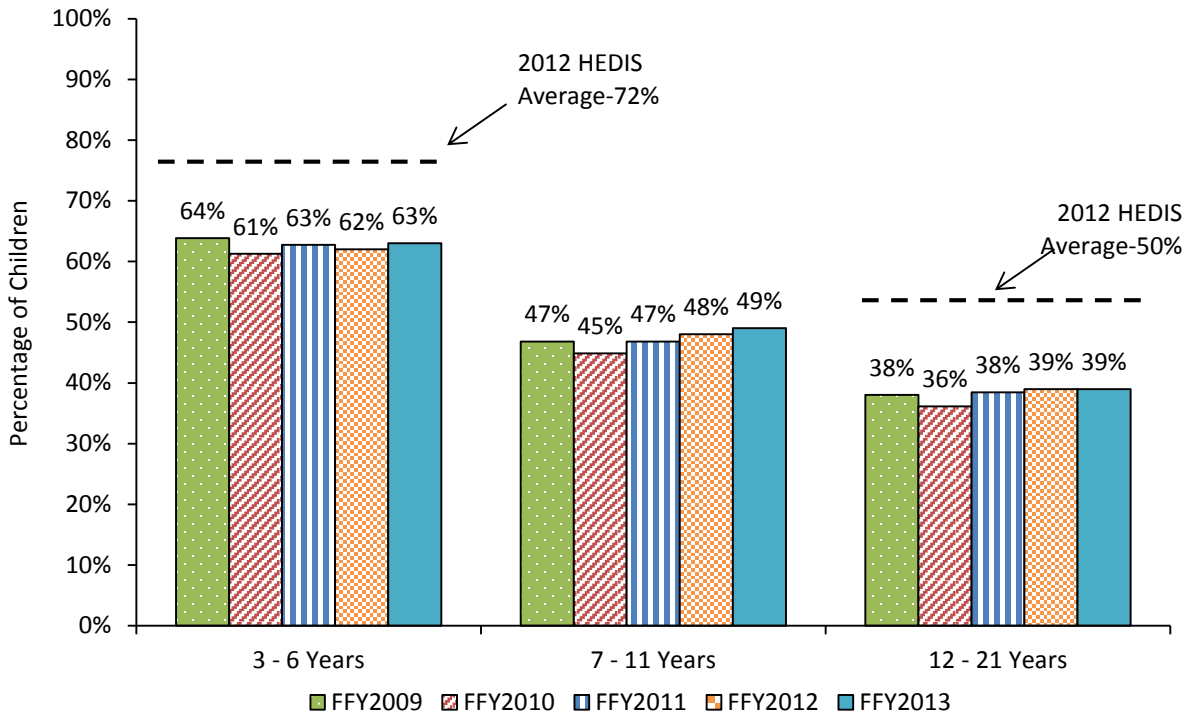


Table 1

Number of Children Who had at Least One Well Child Visit by Age Cohort

Measure Description	FFY2009		FFY2010		FFY2011		FFY2012		FFY2013	
	At least 1 visit	Total	At least 1 visit	Total	At least 1 visit	Total	At least 1 visit	Total	At least 1 visit	Total
WCVs, 3-6 Years	14,762	23,124	15,505	25,304	16,308	25,984	16,492	26,526	16,176	25,788
WCVs, 7-11 Years	12,754	27,246	12,950	28,856	13,868	29,618	14,713	30,811	14,768	30,432
WCVs, 12-21 Years	16,502	43,402	16,785	46,469	18,058	46,988	18,528	47,990	18,008	46,350

Source: MaineCare Claims Data

Access to Primary Care Practitioners (PCPs)

CHIPRA Measure CAP / IHOC Measure 45

Background

The CHIPRA legislation specified that measures of availability of services be included in the CHIPRA Core measure set. Availability of services is an important topic, given the many reports from national studies on the lack of providers and some providers' unwillingness to serve Medicaid patients. The expert panel convened by the federal Agency for Healthcare Research and Quality (AHRQ) and CMS to review and make recommendations for the CHIPRA Core measures noted that "...realized access to care (e.g., utilization of primary care practitioners) [is an] incomplete measure of availability because the reasons for lack of utilization could go well beyond lack of availability (e.g., parents don't perceive a need for the service). However, realized access is a piece of availability and a way to measure access under capitated primary care arrangements."⁸

The panel also noted that the Access to PCP measure is only a proxy measure for availability of services; it cannot be considered a true availability of services measure because it deals with only primary care, and because the reasons for non-use of primary care services may vary, from lack of availability, to lack of time, to lack of perceived need, and other factors.⁹

This measure can be considered important from two perspectives. From a payer perspective, it is good to know whether enrolled children are getting any care. Access to primary care practitioners is essential for children to have well-child visits and the opportunity for social and developmental screening, two measures also included in the CHIPRA Core measure set.

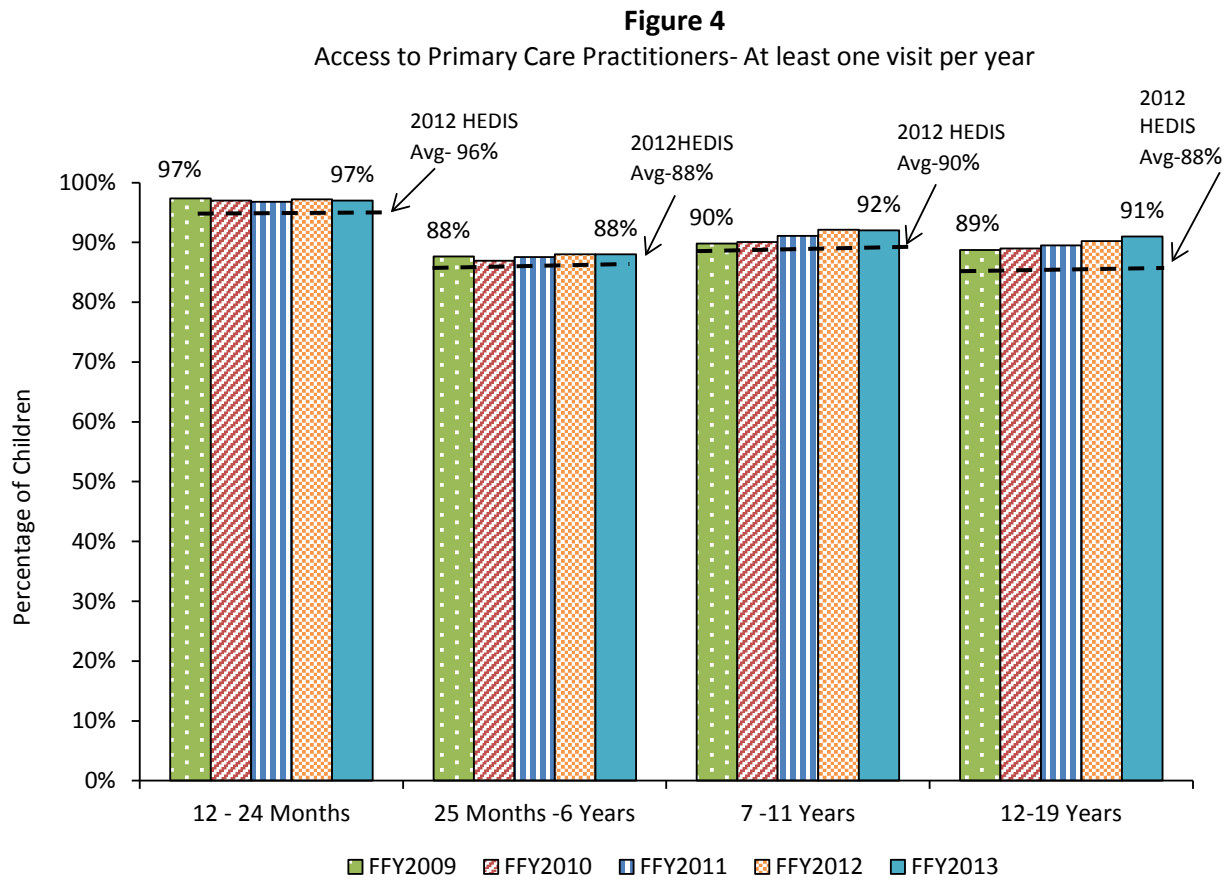
Measure Definition

For children aged 12-24 months, and 25 months-6 years, this measure assesses the receipt of one or more visits with a primary care provider during the measurement year. For children aged 7-11 and 12-19 years, the measure assesses the receipt of one or more visits with a primary care provider during the measurement year or the year prior to the measurement year. Continuous enrollment for the younger two age groups is required for the measurement year. For the two older age groups, continuous enrollment is required for both sequential measurement years.

^{8&9} Report available at: <http://www.ahrq.gov/policymakers/chipra/overview/background/next-steps3.html>.

Results

Figure 4 shows the percentage of children in each age group who had at least one visit with their PCP in the 5 measurement years. MaineCare’s performance on this measure is excellent across all age categories. Realized access among the youngest children is nearly universal, at 97 percent and rates of access to PCPs are around 90 percent for the other three age groups as well. These rates are at or above the FFY 2012 rates reported by states in the 2012 Annual Report on the Quality of Care for Children in Medicaid and CHIP and are also at or above the 2012 HEDIS Averages.¹⁰



Source: MaineCare Claims Data

¹⁰ Report available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2012-Ann-Sec-Rept.pdf>.

Chlamydia Screening for Women age 16 – 20 Years

CHIPRA Measure 9 / IHOC Measure 37

Background

Screening to identify health conditions for early intervention with effective treatments is a primary purpose of preventive (well-care) visits. Screening for chlamydia, a sexually transmitted infection, of sexually active females ages 16-20 was identified as an important screening because, if left untreated, it can cause pelvic inflammatory disease in women, a condition that can result in sterility. Chlamydia is easy-to-treat, but widespread. In 2010, 1,307,893 cases of chlamydia infection were reported to the Centers for Disease Control (CDC), which is the largest number of cases ever reported to the CDC for any condition.¹¹ This corresponds to a rate of 426 cases per 100,000 population, an increase of 5.1% since 2009 and rates for women are over two and a half times the rate among men.¹² Although Maine ranks 48th in reported chlamydia cases (3,094 in 2011), screening is essential to ensure that cases are not being missed and going untreated.¹³

Measure Definition

This measure assesses the extent to which at least one chlamydia test is given during the measurement year to women 16-20 years of age who were identified as sexually active and were enrolled in MaineCare for at least 11 out of the 12 months during the measurement year.

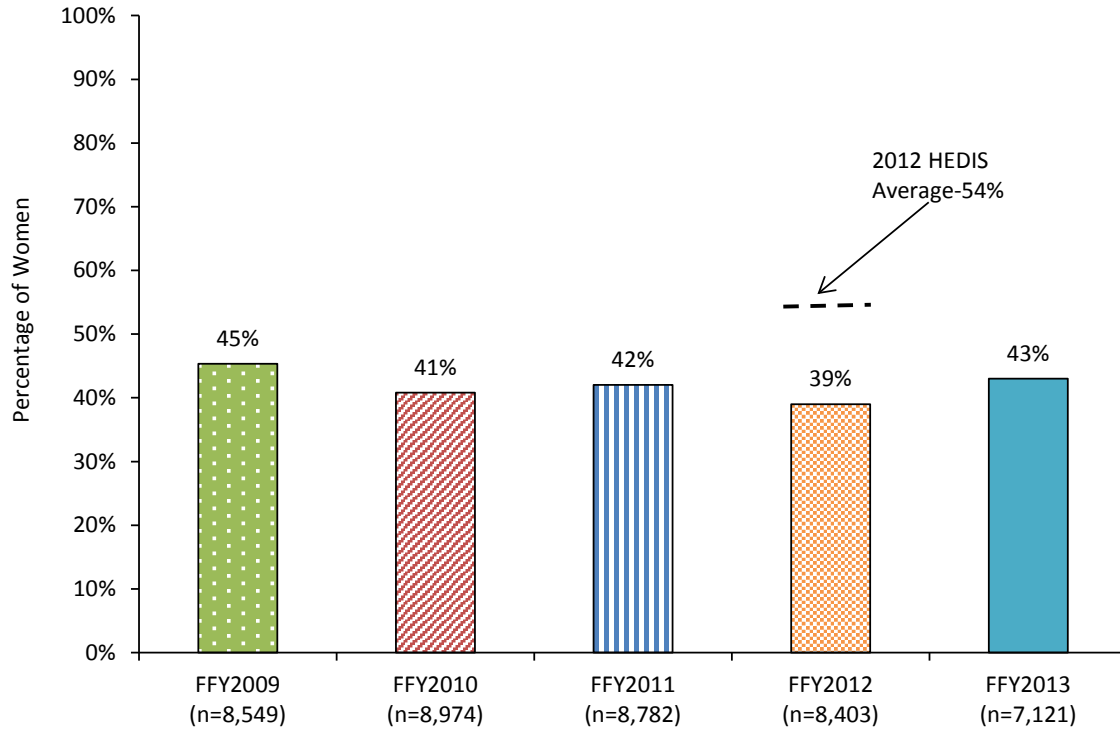
Results

Figure 5 shows that 43 percent of sexually active women age 16 – 20 years enrolled in MaineCare had a chlamydia screening in FFY 2013. Screening rates were very similar across the five measurement years. Each year screening rates in Maine have fallen below the HEDIS average rates which have consistently remained around 55 percent since FFY 2009.

^{11&12} Information gathered from the Center for Disease Control, National Overview of Sexually Transmitted Disease (STDs), 2010 at: <http://www.cdc.gov/std/stats10/natoverview.htm>.

¹³ Information gathered from the Kaiser Family Foundation, State Health Facts.org at: <http://kff.org/other/state-indicator/chlamydia-cases/#>.

Figure 5
Chlamydia Screening for Women
(Ages 16-20)



Source: MaineCare Claims Data

Preventive Dental and Dental Treatment Services

CHIPRA Measures PDENT, TDENT / IHOC Measures 38, 39

Background

Oral health problems are common, painful, and preventable. According to the *CDC Oral Health Report in 2011*, tooth decay affects more than one-fourth of U.S. children aged 2–5 years and half of those aged 12–15 years. About half of all children and two-thirds of adolescents aged 12–19 years from lower-income families have had decay.¹⁴ Ongoing dental services are essential to improve children’s oral health.

Dental services are a required benefit for most Medicaid-eligible individuals under the age of 21, as a component of the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program, and with the advent of CHIPRA, dental services are also a required benefit for CHIP enrollees. Two dental measures reported through CMS-416 (a required report submitted by all EPSDT programs to CMS each year) are included in the CHIPRA core set: children receiving preventive dental services (CHIPRA PDENT / IHOC #38), and children receiving dental treatment services (CHIPRA TDENT, IHOC #39).

Measure Definition

Two EPSDT measures, *Receipt of Preventive Dental Services* and *Dental Treatment Service* assess the percent of children ages 1 to 20 who received dental services as a function of the number of children eligible for EPSDT services as shown on line 1 of the CMS-416 form.¹⁵ Children are counted as eligible for EPSDT services if they were enrolled in MaineCare for at least 3 consecutive months during the measurement year.

Results

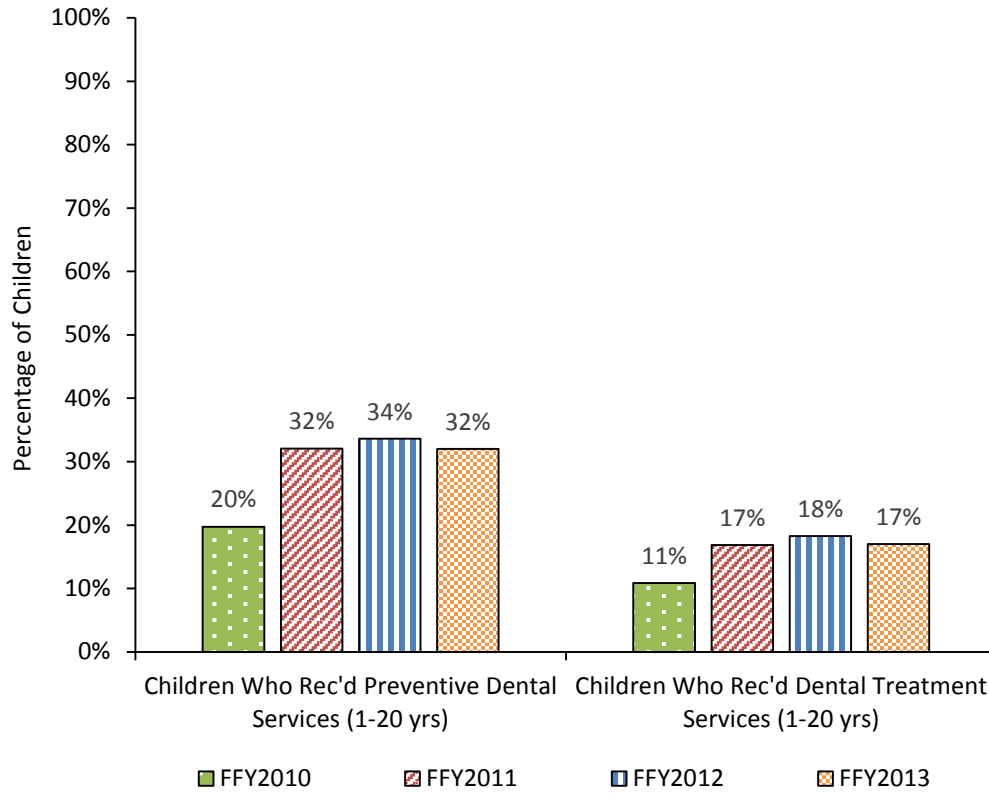
Figure 6 shows results for the two measures related to dental services for children age 1-20 that are eligible for EPSDT services.¹⁶ Rates for both dental preventative and treatment rose between 2010 and 2011 but, since that time rate have remained relatively stable. Just over 32 percent of eligible children received preventive dental services in FFY 2013, up from 20 percent in FFY 2010. Over the past four years, the provision of dental treatment services has increased by 6 percent from 11 percent in FFY 2010 to 17 percent of eligible children received dental treatment in FFY 2013.

¹⁴ <http://www.cdc.gov/chronicdisease/resources/publications/AAG/doh.htm>

¹⁵ “Dental Services” are identified using CDT or HCPCS codes D0100 – D9999. “Preventive Dental” are codes D1000 – D1999, and “Dental Treatment” are codes D2000 – D09999.

¹⁶ Note: The results of the two EPSTD dental measures presented here are data that were included in the FFY 2010 – 2012 CMS 416 Reports. Data for 2013 was run in April of 2014.

Figure 6
Dental Services-
Prevention and Treatment



Source: MaineCare Claims Data

Appropriate Testing for Children with Pharyngitis and Prescribed an Antibiotic

CHIPRA Measure CWP/ IHOC Measure 30

Background

Upper respiratory infections (URIs), including pharyngitis (inflammation of the throat), are among the most common reasons for children's acute care encounters with health care providers. URIs often present opportunities for the overuse of antibiotics even though most URIs are time-limited and, if viral, cannot be cured with antibiotics. The purpose of the measure is to monitor and help reduce the unnecessary use of antibiotics by ensuring that antibiotics were not given without a diagnosis of streptococcal (strep) bacteria. Pharyngitis is measured because it was the leading diagnosis for 6.4 million visits to physician offices and hospital outpatient departments for all children under age 15 in 2006 nationally, providing many opportunities for inappropriate antibiotic use.¹⁷

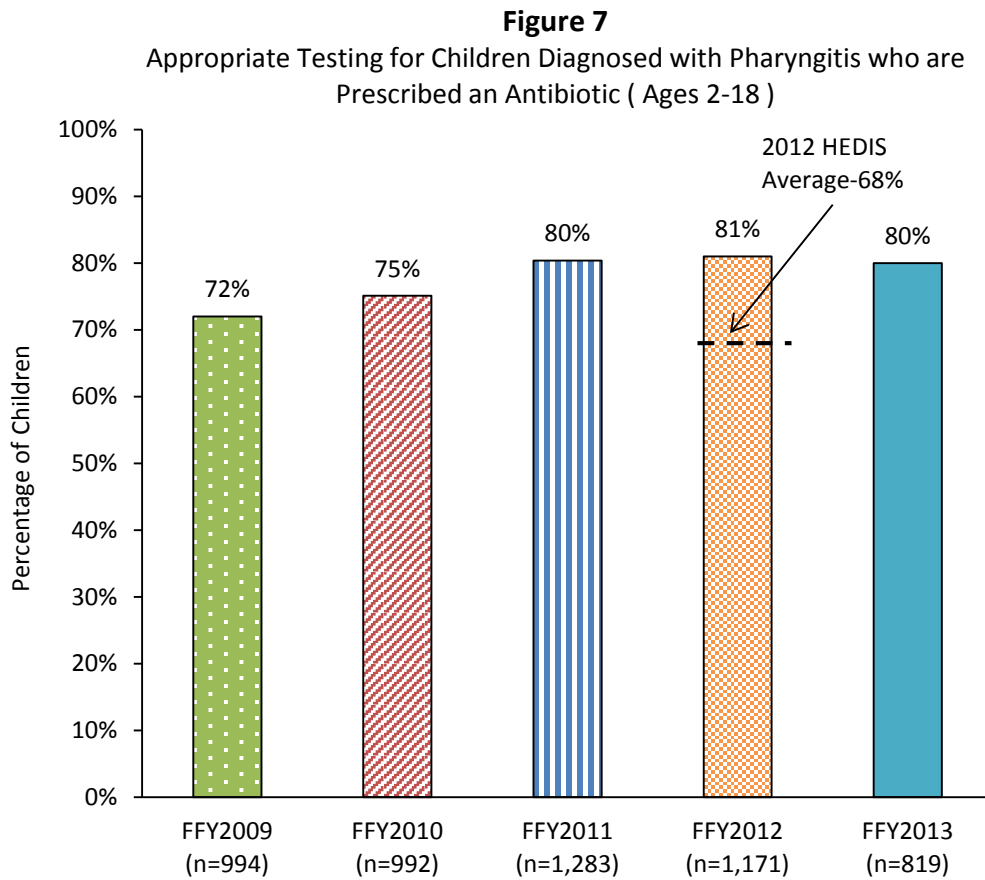
Measure Definition

This measure assesses whether a strep test was administered for children 2-18 years in the 7-day period from 3 days prior through 3 days after the first eligible episode date. An eligible episode is an outpatient visit with a diagnosis of pharyngitis at which an antibiotic was dispensed. The measure counts children who were continuously enrolled 30 days prior to the episode date through 3 days after the episode date.

Results

Figure 7 shows the rates of appropriate testing for children diagnosed with pharyngitis have increased slightly over the past five years (up 8%). In FFY 2013, 80 percent of children enrolled in MaineCare who were diagnosed with pharyngitis and prescribed an antibiotic had received a strep test. MaineCare's rates for appropriate testing for children with pharyngitis have continually exceeded national HEDIS averages for testing; in 2013 MaineCare's rates were 12 percent higher than the HEDIS average of sixty-eight percent.

¹⁷ *Background Report for the Initial, Recommended Core Set of Children's Healthcare Quality Measures for Voluntary Use by Medicaid and CHIP Programs.* Available at: <http://www.ahrq.gov/policymakers/chipra/overview/background/index.html>



Source: MaineCare Claims Data

Emergency Department (ED) Visits

CHIPRA Measure AMB / IHOC Measure 41

Background

Emergency departments are a critical feature of the U.S. health care delivery system. However, their availability and convenience compared to other care settings means that they may be used when traditional care settings would be more appropriate and less costly. The intent of using this measure is to reduce unnecessary ED visits.

The measure is potentially important to MaineCare, given that in 2006, Medicaid paid for 62 percent of all ED visits of children less than age 1 and they paid for 42 percent of all ED visits of children 1-17 years.¹⁸

¹⁸ Kilbreth, B., C. McGuire, C. Gray, T. Chitashviliand, and K. Finison (2009). Analysis of 2006 Maine. Emergency Department Utilization. Portland, ME: University of Southern Maine, Muskie School of Public Service

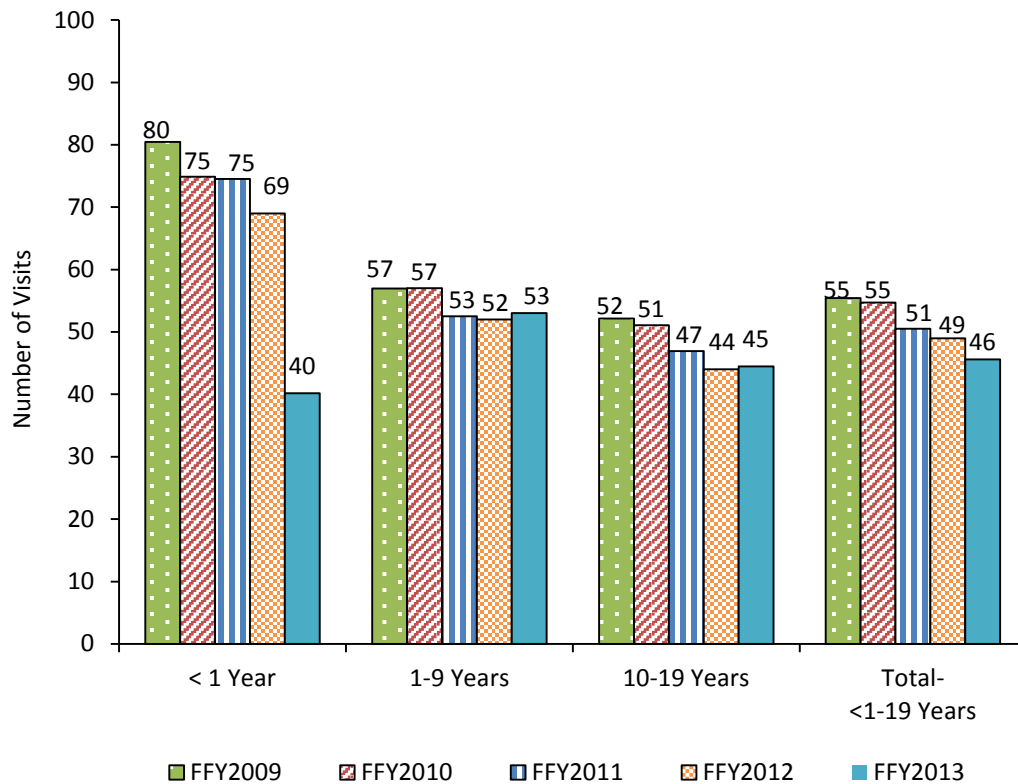
Measure Definition

This measure assesses the average number of ED visits per 1,000 member months (rather than individual members). The measure breaks out the results by age: less than 1 year, 1-9 years, 10-19 years and the total of all ages.

Results

The results in Figure 8 show that the youngest children (under age 1) report the most ED visits however, the rates have continued to drop for all age categories over the past half-decade. For children under the age of one, rates dropped from a high of 80 visits per 1,000 member months in 2009 to only 40 visits in 2013. Rates of ED visits drop consistently as children age. Between 2009 and 2013 rates for individuals in the various age cohorts have dropped between 3 to 8 percent; in 2013 the overall average number of ED visits for all age cohorts was 46.

Figure 8
Emergency Department Visits Per 1,000 Member Months



Source: MaineCare Claims Data

Asthma Emergency Department (ED) Visit and Use of Appropriate Medications

CHIPRA Measure MMA / IHOC Measures 25, 42

Background

Asthma is the most prevalent chronic physical condition among children. In 2010, 7 million children had asthma, which is equal to one out of every eleven children¹⁹ As of 2007, 12.9 percent of children covered by Medicaid reported currently having asthma.²⁰ In 2008, the CDC reported that 9.4 percent of Maine children had asthma.²¹

Children with asthma have higher rates of healthcare utilization and costs, in 2009 the average yearly cost of care for a child with asthma was \$1,039.²² In the same year, one in five children with asthma went to an emergency department for an asthma related incident.²³ Emergency department visits for asthma are important to measure because they are expensive and provide a gateway to hospitalization.

Asthma controller medicines are also important to measure because they help prevent asthma symptoms when taken every day as prescribed. The asthma controller measure (IHOC #25) is not part of the CHIPRA core set, but is included in Meaningful Use.

Measure Definition

The asthma ED visit measure assesses the percentage of children in MaineCare ages 2 through 20 diagnosed with asthma during the measurement year with one or more asthma-related ED visits. The measure does not require that a child be continuously enrolled in MaineCare to be included; the eligible population is defined by the age of the child and diagnosis of asthma, identified using ICD-9 codes in the claims.

The asthma controller medication measure assesses the percentage of children enrolled in MaineCare ages 5 through 21 years who were identified as having persistent asthma who were appropriately prescribed controller medication during the measurement year.

19 Information gathered from the Center for Disease Control, Asthma's Impact on the Nation: Data from the CDC National Asthma Control Program available at: http://www.cdc.gov/asthma/impacts_nation/asthmafactsheet.pdf

20 Information gathered from the Center for Disease Control, Asthma in Maine available at: http://www.cdc.gov/asthma/stateprofiles/asthma_in_me.pdf

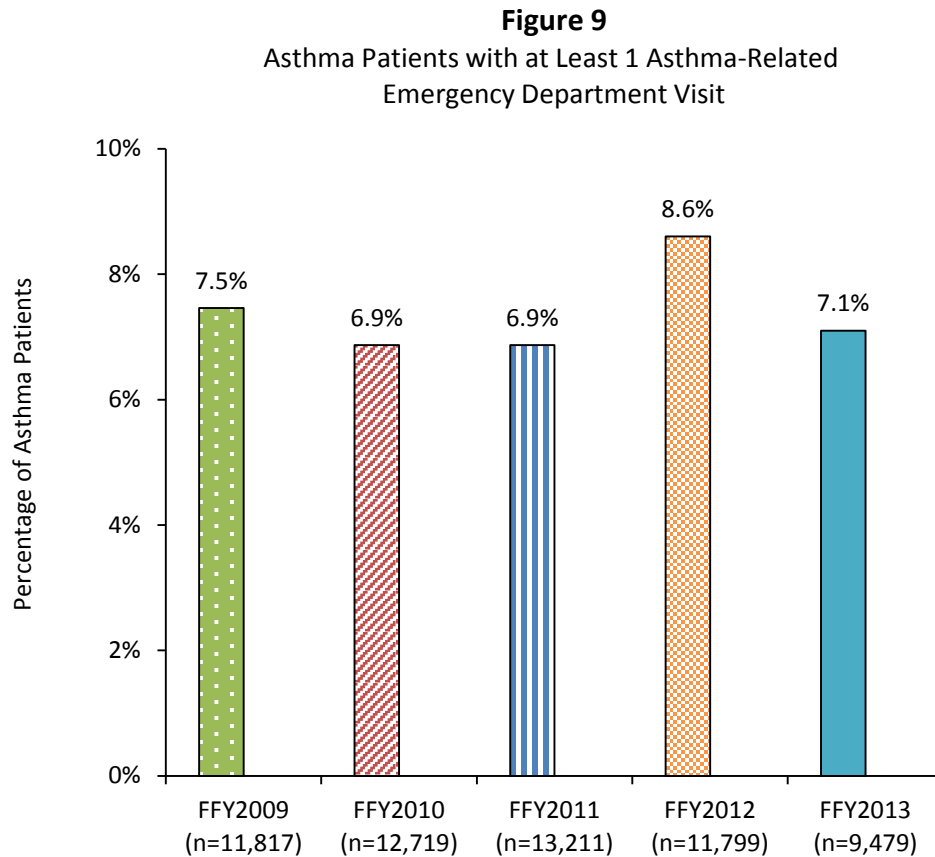
21 Information gathered from the Center for Disease Control, Asthma's Impact on the Nation: Data from the CDC National Asthma Control Program available at: http://www.cdc.gov/asthma/impacts_nation/asthmafactsheet.pdf

22 Information gathered from the Center for Disease Control, Asthma's Impact on the Nation: Data from the CDC National Asthma Control Program available at: http://www.cdc.gov/asthma/impacts_nation/asthmafactsheet.pdf

23 Information gathered from the Center for Disease Control, Asthma's Impact on the Nation: Data from the CDC National Asthma Control Program available at: http://www.cdc.gov/asthma/impacts_nation/asthmafactsheet.pdf

Results

Figure 9 shows that in FFY 2013, there were 9,479 children ages 2 – 20 enrolled in MaineCare who were identified as having asthma; of those, just over 7 percent had one or more visits to the ED because of their asthma during the year. Rates for asthma-related ED visits have remained just above or below 7 percent since FFY 2009 with the exception of FFY 2012 when rates increased slightly – nearly 9 percent.

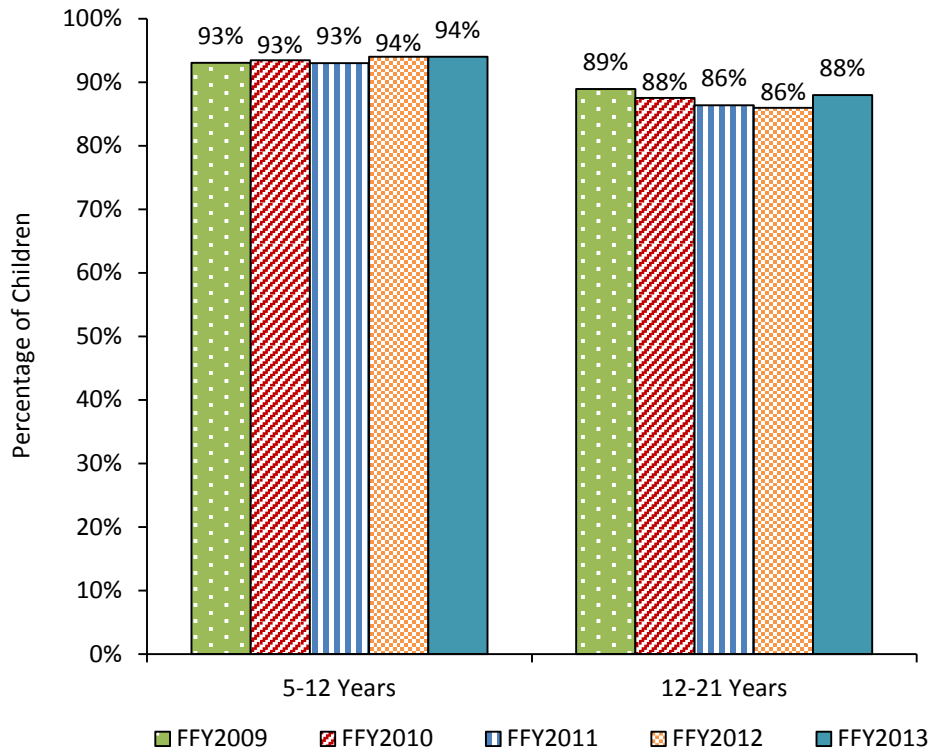


Source: MaineCare Claims Data

Figure 10 shows the number of active asthma patients who were appropriately prescribed controller medications during the measurement year. Two age groups were measured, children ages 5-12 years and 12-21 years. Over 90 percent of 5-12 year old children with asthma were prescribed controller medications in all five measurement years. Among the older age group (12-21 years) controller medication rates were slightly lower ranging from 89 percent in FFY 2009 to 88 percent in FFY 2013. These rates were comparable to 2012

HEIDIS Rates which were 90% for children ages 5 – 11 and 86% for children 12 - 18.²⁴

Figure 10
Children with Asthma Prescribed



Source: MaineCare Claims Data

²⁴ National Committee for Quality Assurance (October 2013). *The State of Health Care Quality 2013*. Available at: <http://www.ncqa.org/tabid/836/Default.aspx>.

Follow-up Care for Children Prescribed ADHD Medication

CHIPRA Measure ADD / IHOC Measure 36

Background

The percentage of children estimated to have attention deficit hyperactivity disorder (ADHD) continues to grow, up from 3 percent in 2003 to 11 percent in 2011.²⁵ This translates into more than 1 out of every 10 children between the ages of 4 – 17 having been diagnosed with ADHD in 2011.²⁶ Estimates show that approximately six percent of children nationally take medication for ADHD. In 2011, 10.1% of children in Maine had a current diagnosis of ADHD, and 6.6% of those children were currently taking a medication for the disorder.²⁷ Since medications affect children differently, follow-up care for medicated children is critical for their health and well-being, as well as the treatment of their ADHD.

Measure Definition

This measure assesses the percentage of children newly prescribed ADHD medication that had at least three follow-up care visits within a 10-month period, one of which was within 30 days from the time the first ADHD medication was dispensed. The first 30 days are referred to as the Initiation Phase and the next nine months are referred to as the Continuation and Maintenance (C&M) phase. The measure is limited to children ages 6 – 12 years. To be included in the denominator for the initiation phase, children must be enrolled in MaineCare continuously for four months prior to the medication dispensing date through 30 days after that date. To be included in the denominator for the C&M phase, children must be enrolled in MaineCare continuously for four months prior to the medication dispensing date through 10 months after that date.

Results

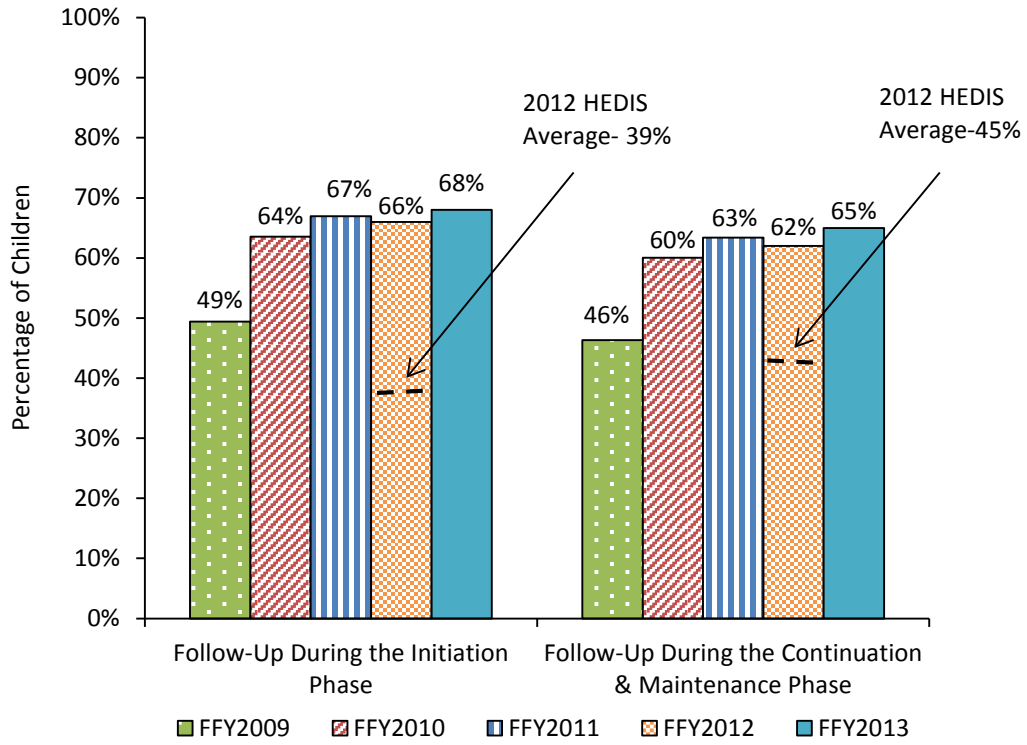
Follow-up care for children prescribed ADHD medication has increased over the past five years during both the initiation phase and in continuation and care maintenance stage. Rates for both measures have improved significantly over the past five years (increasing nearly 20%) and far exceed the 2012 HEDIS averages. In FFY 2013, there were a total of 1,114 children ages 6 – 12 enrolled in MaineCare who were identified as having received a prescription for ADHD and over two-thirds of those children (68%) received appropriate follow-up care during the Initiation Phase. The results for the C&M phase are similar, with 65 percent of children in MaineCare receiving appropriate follow-up care for ADHD medications in FFY 2013.

25 Information gathered from the Centers for Disease Control report: Trends in the Parent-Report of Health Care Provider-Diagnosed and Medicated ADHD: United States, 2003—2011. Available at: <http://www.cdc.gov/ncbddd/adhd/features/key-findings-adhd72013.html>.

26 Information gathered from the Centers for Disease Control report: Trends in the Parent-Report of Health Care Provider-Diagnosed and Medicated ADHD: United States, 2003—2011. Available at: <http://www.cdc.gov/ncbddd/adhd/data.html#cost>.

27 Information gathered from the Centers for Disease Control report: Parent-Reported Diagnosis of ADHD by a Health Care Provider and Medication Treatment. Available at: http://www.cdc.gov/ncbddd/adhd/stateprofiles/stateprofile_maine.pdf

Figure 11
 Follow-Up Care for Children Prescribed
 ADHD medication (Ages 6-12)



Source: MaineCare Claims Data

Annual Pediatric Hemoglobin A1c Testing and Comprehensive Diabetes Care

CHIPRA Measure PA1C / IHOC Measure 43

Background

Health care providers and others are raising concerns about the rising rate of diabetes among children and adolescents. In 2010, the CDC reports that about 215,000 people younger than 20 years of age are diagnosed with diabetes (type 1 or type 2). This represents 0.26 percent of all people in this age group.²⁸ That figure doesn't include the substantial number of young people that are undiagnosed or considered to be pre-diabetic. Hemoglobin A1c (HbA1c) testing measures how close to normal blood glucose levels are maintained over time; therefore, it is an important indicator of management of the diabetic patient.

Measure Definition

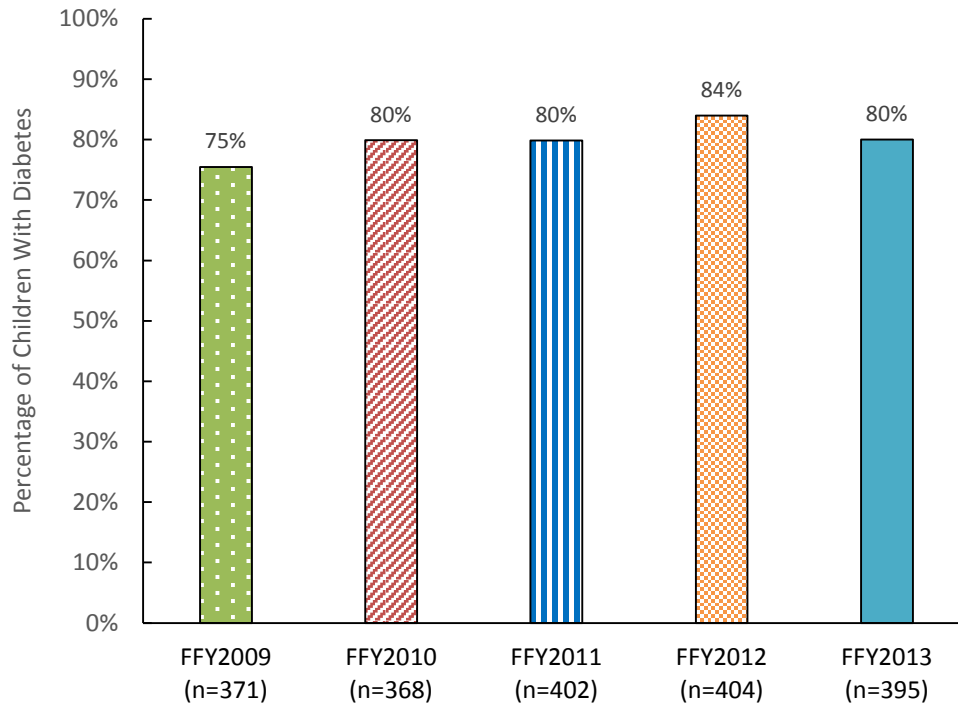
This measure assesses the extent to which patients, ages 5-17 with a diagnosis of diabetes had a Hemoglobin A1c (HbA1c) test during the measurement year. To be included, children must be continuously enrolled in MaineCare (i.e. enrolled for at least 11 out of the 12 months of the measurement year). Children with diabetes can be identified based either on pharmacy data or claims; children who were dispensed insulin or oral hypoglycemics/anti-hyperglycemics or those with a diagnosis of diabetes on one or more claims are used to identify children with diabetes.

Results

Figure 12 shows the results for the diabetes testing measure, rates have remained fairly stable over the past five years. With the exception of a low of 75 percent in 2009 and a high of 84 percent in 2012, rates for annual HbA1c testing for children between the ages of 5 and 17 with diabetes have consistently hovered around 80 percent.

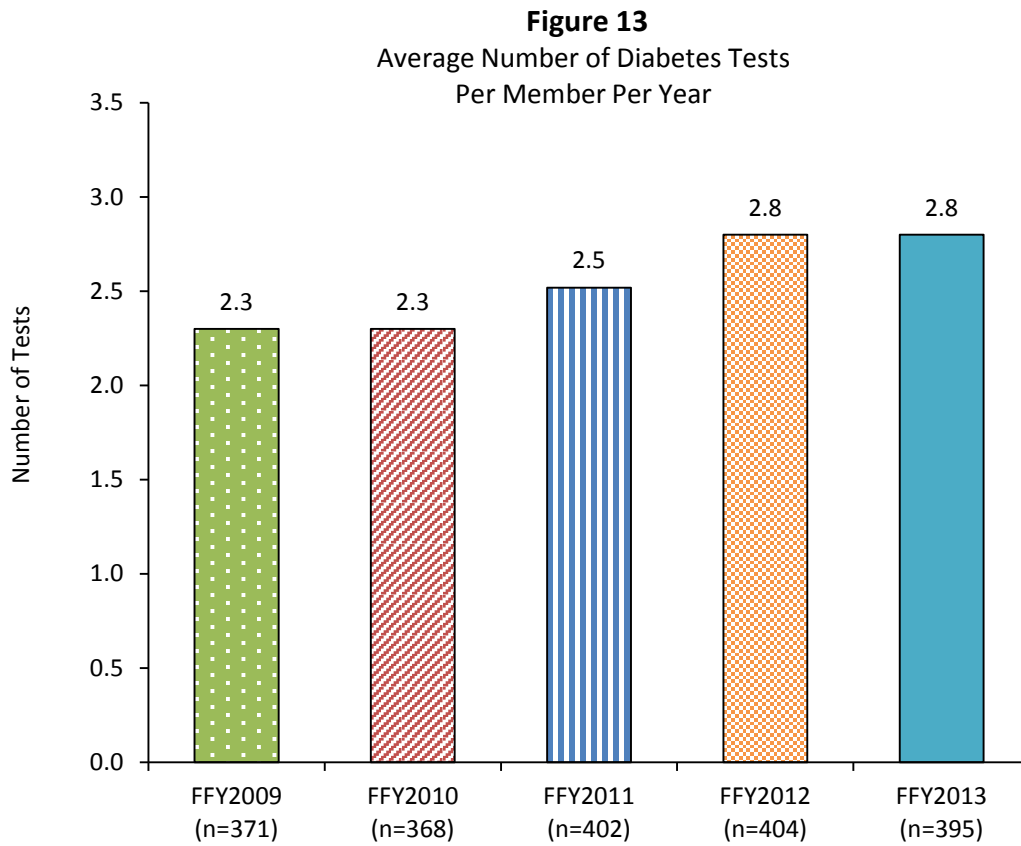
28 2011 National Diabetes Fact Sheet. Available at: http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf.

Figure 12
Annual HbA1c Testing for Children with Diabetes
(Ages 5 - 17)



Source: MaineCare Claims Data

The average number of tests per child was 2.8 in FFY 2013, the same as in FFY 2012 but a slight increase from previous years. Also notable is the fact that there are relatively few children enrolled in MaineCare identified as having diabetes—ranging from 371 in FFY 2009 to 395 in FFY 2013.



Source: MaineCare Claims Data

Follow-up after Hospitalization for Mental Illness

CHIPRA Measure FUH / IHOC Measure 44

Background

Mental health disorders are an important public health issue because of their prevalence, early onset, and impact on child, their families and the community, with an estimated total annual cost of \$247 billion.²⁹ In any given year, between 13 to 20 percent of children living in the United States experience a mental disorder and research shows that the prevalence of these conditions among children has continued to increase over the past two decades.³⁰ Attention-deficit/hyperactivity disorder (6.8%) was the most prevalent parent-reported current diagnosis among children aged 3–17 years, followed by behavioral or conduct problems (3.5%), anxiety (3.0%), depression (2.1%), and autism spectrum disorders (1.1%).³¹ In 2006, the most common conditions for which children with Medicaid were hospitalized in community hospitals were mood disorders and ADHD/disruptive behaviors.³² Follow-up care after hospitalization is necessary to maintain children’s mental health and continuity of care in the community. In addition, follow-up care aids in reducing health care cost by decreasing the rate of re-hospitalizations.

Measure Definition

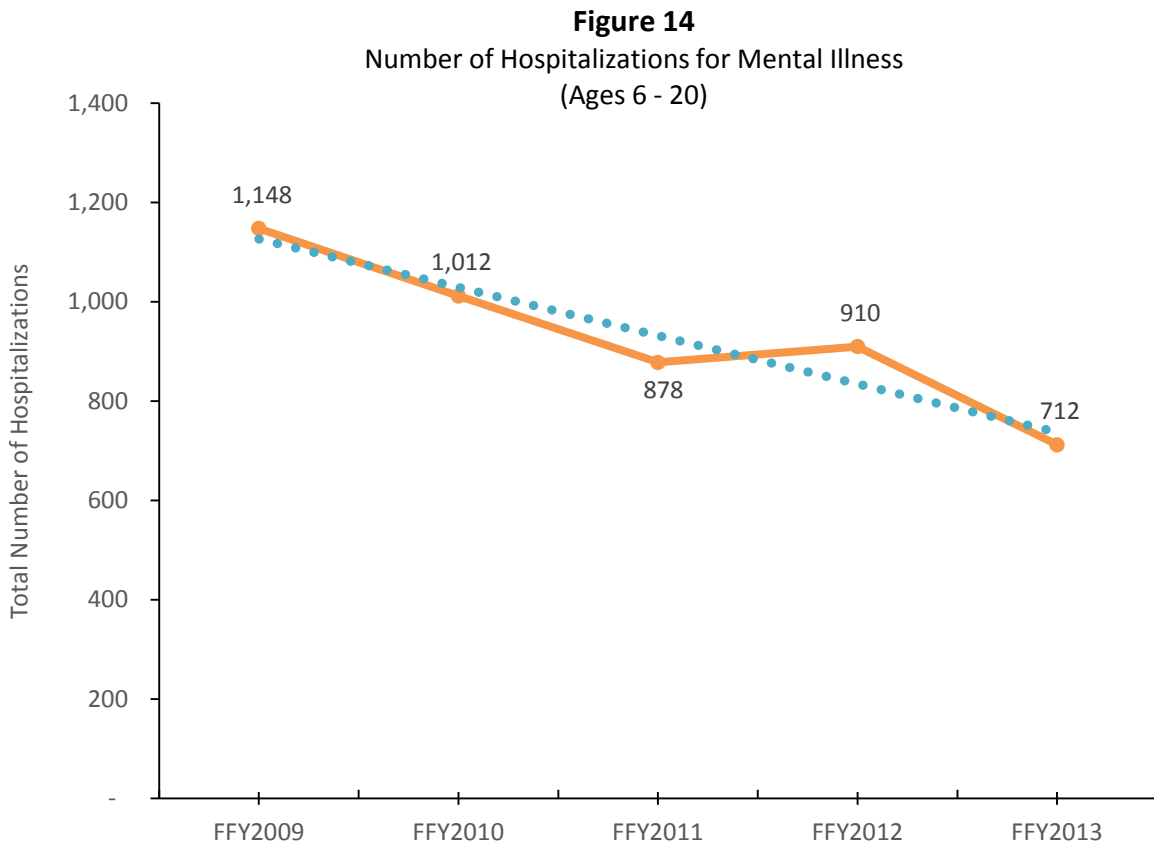
This measure assesses whether individuals aged 6-20 years who have had a mental hospitalization and were discharged from the hospital had an outpatient visit, intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 or 30 days after discharge (two rates are reported). To be eligible for this measure, the child must be continuously enrolled in MaineCare from the day of discharge through 30 days after.

Results

Figure 14 shows the total number of hospitalizations for mental illness for FFY 2009 through 2013; this is the denominator for the measure. Hospitalizations have continued to steadily decrease from 1,148 in FFY 2009 to 712 in 2013.

29-31 Information gathered from the Center for Disease Control report, Mental Health Surveillance Among Children- United States, 2005 – 2001. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/su6202a1.htm>.

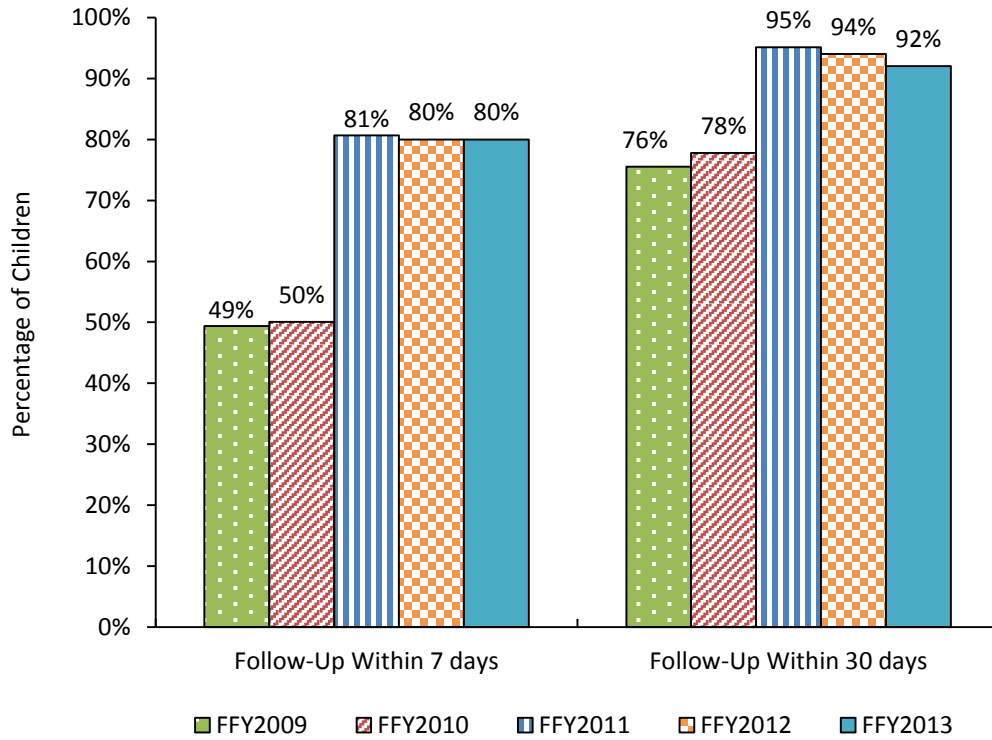
32 Lasky, T., Krieger, A., Elixhauser, A. & Vitiello, B (2011). Children’s hospitalizations with a mood disorder diagnosis in general hospitals in the United States 2000-2006. *Child Adolescent Psychiatry Mental Health*. 2011; 5: 27. Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3162503/>.



Source: MaineCare Claims Data

The actual measure results are displayed in Figure 15, and show that in FFY 2013, the 7-day follow-up rates were 80 percent, and the 30-day follow-up rate was 92 percent. Rate for both 7-day and 30-day follow-up have continued to grow since 2009. Seven day follow-up rates have increased by 21 percent since 2009 and thirty day follow-up rates are up sixteen percent.

Figure 15
Follow-Up After Child's Hospitalization for Mental Illness
(Ages 6 - 20)



Source: MaineCare Claims Data

Timeliness and Frequency of Prenatal Care

CHIPRA Measures PPC, FPC / IHOC Measures 46, 47

Background

Early prenatal care (in the first trimester of pregnancy) helps prevent premature birth and other infant health problems, as well as, helps improve the health of women during pregnancy.

Measure Definition

These measures assess the timeliness and frequency of prenatal care that MaineCare-enrolled women received for all deliveries during the measurement year (calendar year). Timeliness measures the number of MaineCare-enrolled women in the denominator sample who had a prenatal visit in the first trimester or within 42 days of enrollment.³³

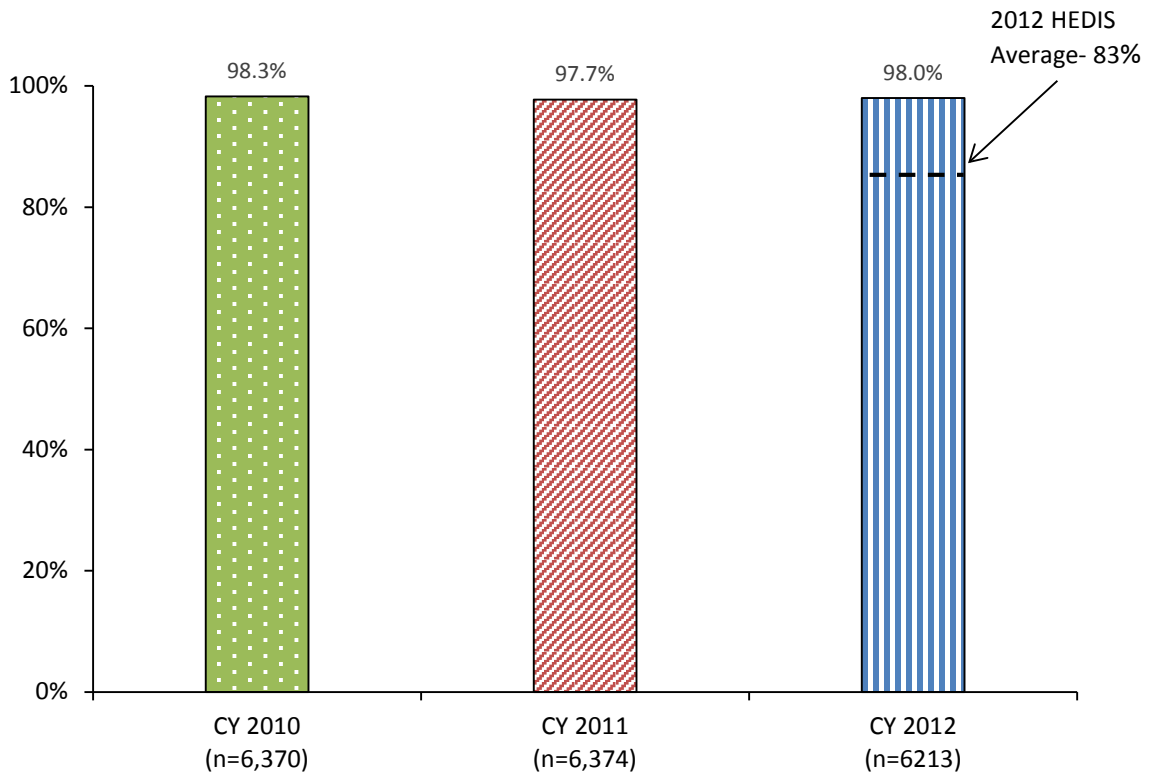
The Frequency of Ongoing Prenatal Care measure is computed based on the number of reported prenatal care visits on the birth certificate and the expected number of visits for the period between when care began and the date of delivery. The expected number of visits is based on guidelines for perinatal care defined by the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG). The measure categorizes births where the mother received less than 21% of the expected visits; 21-80%; or more than 81% of the expected visits. Those in the last category are usually defined as having received “adequate” prenatal care.

Results

Vital statistics data for 2013 is currently not available so the results presented below only include information on the timeliness and frequency of prenatal care for FFYs 2009 -2012. Figure 16 shows that almost 100 percent of MaineCare deliveries were to mothers who received prenatal care in the first trimester of their pregnancy.

³³ Because of limitations with the self-reported prenatal care information available in the Vital Statistics data, we had to make some modifications to the CHIPRA measure specifications to compute these two measures. The Vital Statistics data only included a total count of prenatal visits received during the pregnancy, and the month in which the first visit was received (e.g. 1 through 9). For the timeliness measure, we counted all mothers who reported their first prenatal visit in month 1,2 or 3 OR who reported their first visit as taking place within 2 months of MaineCare enrollment as meeting numerator criteria. For the frequency of ongoing prenatal care measure, we only adjusted the number of expected visits based on gestational age at delivery (with no adjustment for date of enrollment in MaineCare). Essentially, we made a simplifying assumption that all prenatal care visits were covered by MaineCare for deliveries identified in the denominator.

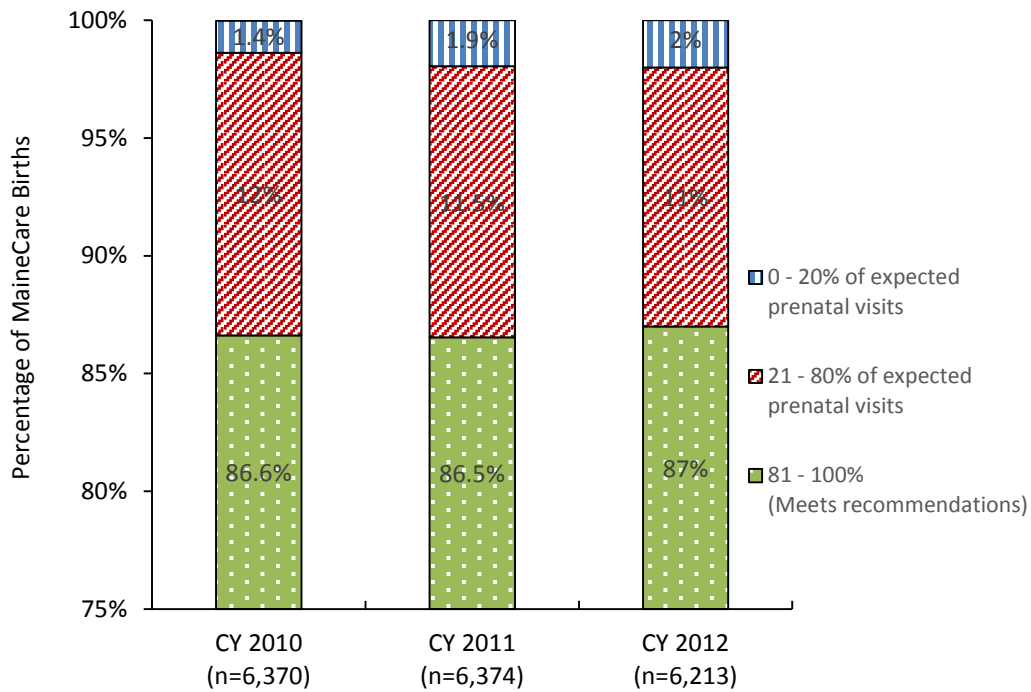
Figure 16
Timeliness of Prenatal Care



Source: MaineCare Eligibility and Vital Statistics Data

The frequency of prenatal care among MaineCare recipients has remained consistent since 2009. Figure 17 shows that over the past five years, approximately 87 percent of those deliveries who received an “adequate” number of prenatal visits according to the AAP/ACOG.

Figure 17
Frequency of Ongoing Prenatal Care
(Expected Visits)



Source: MaineCare Eligibility and Vital Statistics Data

Live Births Weighing Less than 2,500 Grams

CHIPRA Measure LBW / IHOC Measures 48

Background

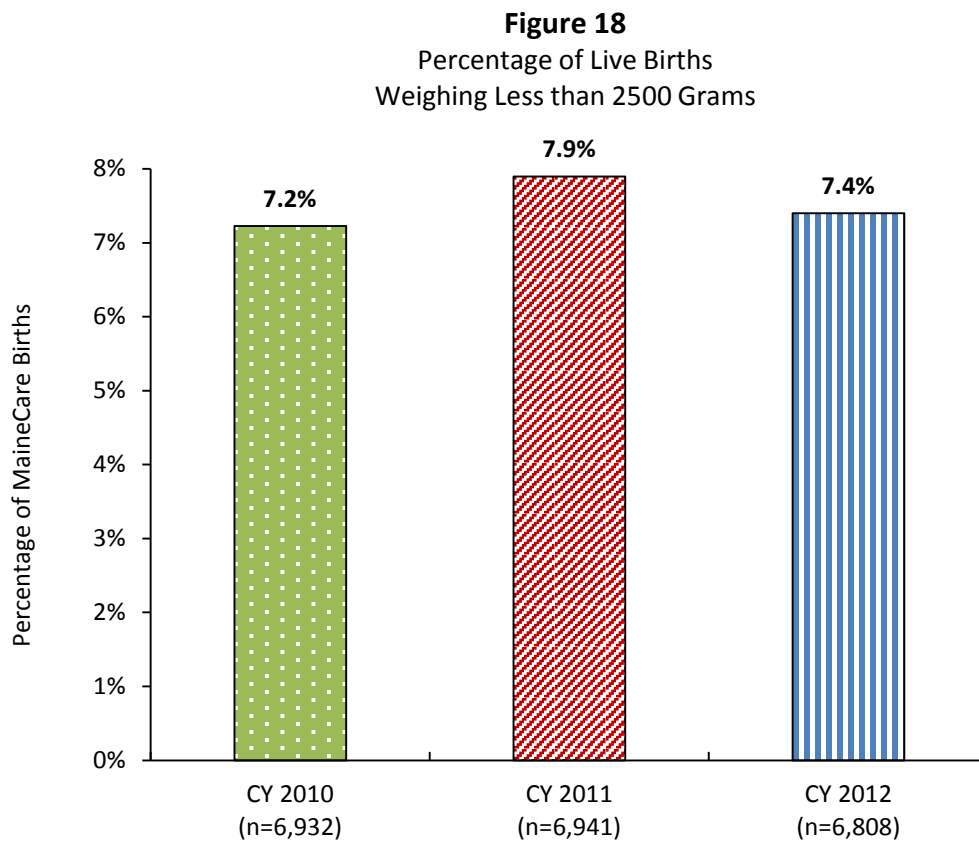
Low birth weight (often used as a proxy for premature birth) is an important condition that is highly prevalent. Low birth weight is an important predictor of health outcomes for infants, and it is costly to the health care system and society.

Measure Definition

This measure assesses the percentage of live births per year to women enrolled in MaineCare that weighed less than 2,500 grams (5.5 pounds) during the calendar year.

Results

Vital statistics data for 2013 is currently not available so the results presented below only include information for FFYs 2009 -2012. Figure 18 shows that just over 7 percent of babies born to MaineCare-enrolled mothers in calendar year 2012 were low birth weight, a slight decrease from 2011 where rates were nearly 8 percent.



Source: MaineCare Eligibility and Vital Statistics Data

Developmental Screening in the First Three Years of Life

CHIPRA Measure DEV / IHOC Measures 7, 8 and 10

Background

In the United States, about 13 percent of children 3 to 17 years of age have a developmental or behavioral disability such as autism, intellectual disability or ADHD.³⁴ An estimated 9.5 million Medicaid- and CHIP-enrolled preschool children are eligible for developmental screening. In the United States, 17 percent of children (12 million children) were found to have a behavioral disability such as autism, mental retardation, or attention-deficit/hyperactivity disorder. Medicaid serves more than 25 percent of all children in the United States (and more than half of all poor and low-income children). Children from poor families are at greater risk than those from non-poor families for poorer outcomes, including those related to mental development. The 2007 National Survey of Children's Health (NSCH) found that publicly insured children were 1.9 times as likely as privately insured children (18.3 percent versus 9.7 percent, respectively) to have one or more of six specified learning, developmental, or behavioral conditions.³⁵

Measure Definition

This measure assesses the extent to which children at various young ages from 0-36 months were screened for social and emotional development with a standardized, documented tool or set of tools. Eligible children include those who turn age 1, age 2, or age 3 and who were enrolled continuously in MaineCare during the measurement year. For claims-based reporting, screening is identified using CPT code 96110.

Results

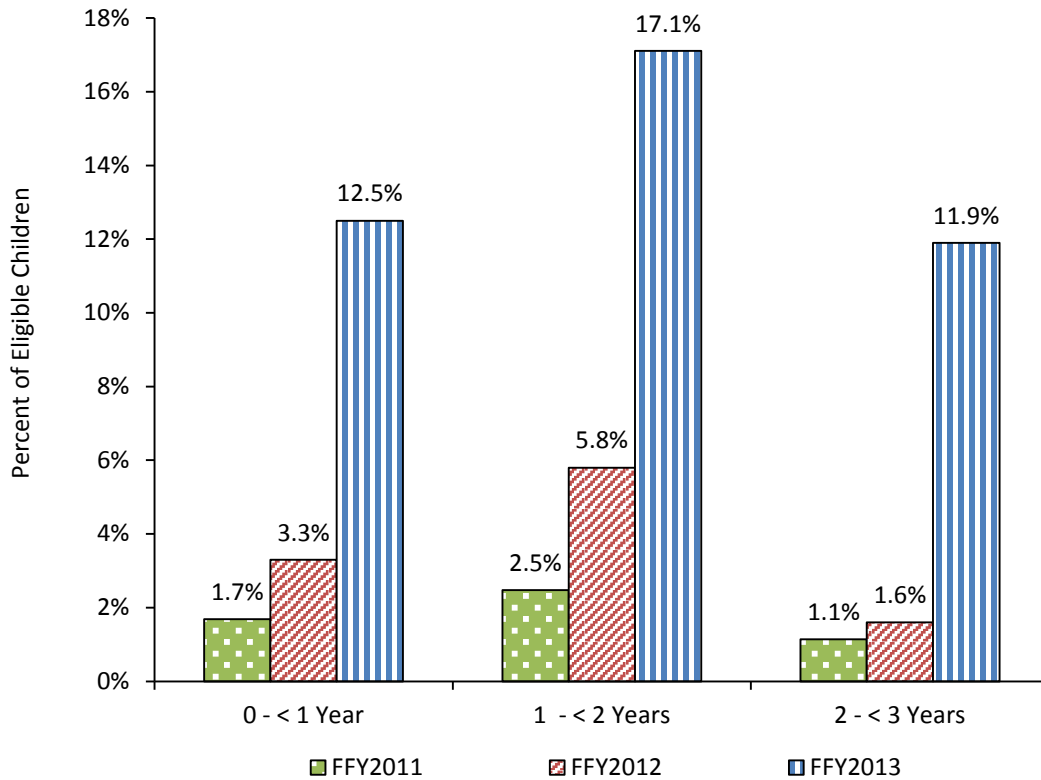
The results for the developmental screening of children who turn 1, 2 and 3 years old during the measurement year are shown in Figures 19 and 20. The rates have significantly increased over the past three years.³⁶

³⁴ Information gathered from the Center for Disease Control report, Developmental Monitoring and Screening. Available at: <http://www.cdc.gov/ncbddd/childdevelopment/screening.html>.

³⁵ *Background Report for the Initial, Recommended Core Set of Children's Healthcare Quality Measures for Voluntary Use by Medicaid and CHIP Programs.* Available at: <http://www.ahrq.gov/policymakers/chipra/overview/background/corebackgrnd.pdf>

³⁶ Because of changes to measure specifications, only comparable data is presented (2011-2012).

Figure 19
Developmental Screening Rates Among
MaineCare-Enrolled Children

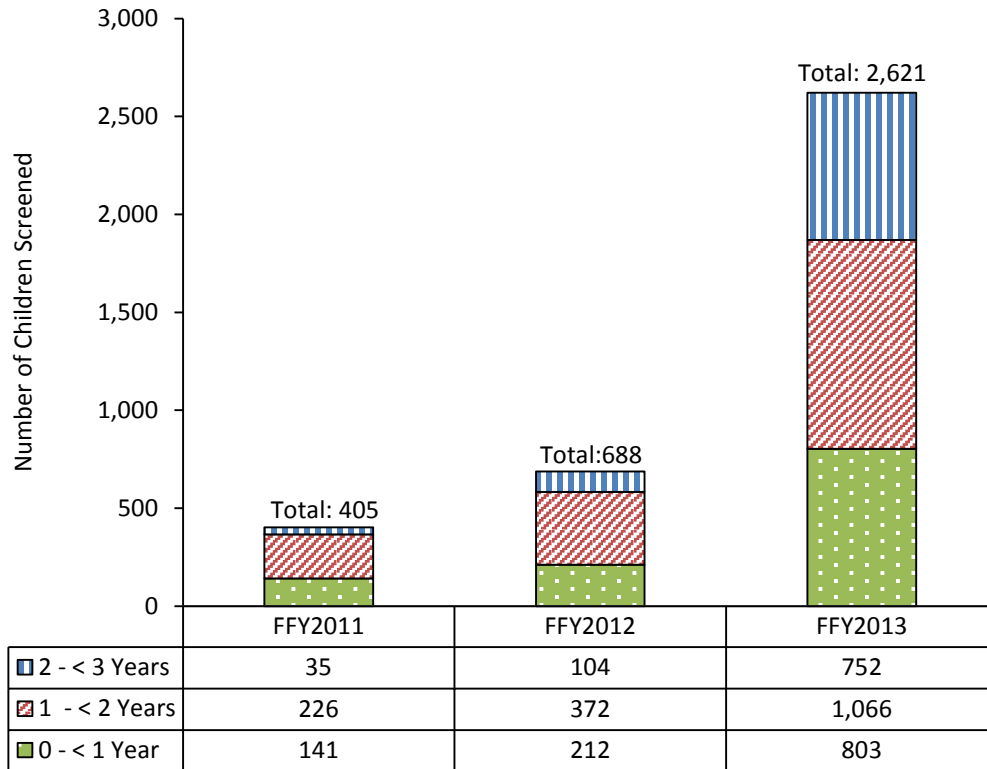


Source: MaineCare Claims Data

The percentage of children who were screened for risk of developmental, behavioral and social delays using a standardized tool on or before their 1st birthday increased from 1.7 percent in FFY 2011 to 12.5 percent in FFY 2013. One year old screening rates were over 6 times higher in 2013 than they were in 2011. Rates of screening for children after their 1st birthday and on or by their second birthday were nearly seven times higher in FFY 2013 than they were in FFY 2011, increasing from 2.48 percent to 17.11 percent. For children between their 2nd and 3rd birthday's rates increased nearly tenfold going from 1.14 percent in FFY 2011 to 11.93 percent in FFY 2013.

Figure 20

Number of Children With Developmental Screening Documented in MaineCare Claims (CPT 96110)



Source: MaineCare Claims Data

Consumer Assessment of Healthcare Providers and Systems® (CAHPS) 4.0h

CHIPRA Measure CPC / IHOC Measures 51

Background

The main purpose of the annual Survey of Children Served by MaineCare is to monitor the quality of services delivered by MaineCare, the state of Maine's Medicaid and Child Health Insurance (CHIP) program. The 2013 survey uses a standardized instrument--the Consumer Assessment of Healthcare Providers and Systems (CAHPS 4.0H)—as its primary means of examining the experiences of families with children enrolled in MaineCare. The CAHPS 4.0H is designed to provide feedback to Medicaid fee-for-service and managed care plans by identifying performance dimensions in which they excel and areas in which they need improvement. The 2013 survey included children aged 17 or younger who were enrolled in MaineCare for at least 5 months between September 2012 and February 2013.

In addition to CAHPS, Maine's annual survey includes supplemental questions that focus on priority areas for the Department including the degree to which providers discuss recommended preventive topics at well-child visits, the prevalence of childhood obesity and tobacco use/second-hand smoke exposure among children served by MaineCare, oral health access and unmet need, the affordability of Children's Health Plan premiums, and availability/access to employer-sponsored health insurance. Of the total 2,413 eligible families who were contacted, 1,077 interviews were completed, for an overall response rate of 44.6 percent.

Measure Definition

This measure provides information on parents' experience with their child's health plan. Results summarize member experiences through ratings, composites and individual question summary rates. Topics covered in the survey include: rating of all health care and personal doctor, customer service, getting care quickly, getting needed care, how well doctors communicate, shared decision making, family centered care, coordination of care for children with chronic conditions, and access to prescription medicines.

Results

- ***MaineCare higher than the national average on most patient experience measures.*** As in the previous year, MaineCare's patient experience scores compared favorably to those of other state child Medicaid programs³⁷ on CAHPS measures related to providing needed care, providing care quickly, doctor's communication skills, and doctor's knowledge of the child, with ratings at or above the 75th percentile on all the composites and individual items in these four areas. Overall ratings of the child's personal doctor and of health care professionals' provision of information were also among the highest nationally (at or above the 75th percentile).

³⁷ National comparisons are based on the latest available national CAHPS data available as of the writing of this report, which was for 2011.

- **Significant improvements in MaineCare provider/family communication and care coordination.** Compared to last year, the percentage of parents who reported that the child's personal doctor consistently spent enough time with the child increased from 75 percent in 2012 to 82 percent in 2013. Moreover, the proportion of parents indicating that providers always answered their questions increased from 80 percent to 85 percent. The percentage of those stating that they received help with care coordination also improved, increasing from 41 percent to 49 percent.
- **MaineCare lower than national average on customer service, availability of treatment choices, and care coordination among providers.** As in the previous year's survey, only half (49%) of parents reported that customer service at MaineCare consistently provided the information or help they needed. MaineCare's score on this item fell in the 25th-50th percentile range nationally. However 69 percent of parents said that customer service staff were always courteous and respectful, which was above the national average and a significant improvement over the prior year (59%).
- **Many MaineCare children have special health care needs.** Thirty-five percent of children enrolled in MaineCare have special health care needs, according to the 2013 survey. Although this prevalence estimate is lower than the 2012 survey's estimate of 39 percent, it still far exceeds the prevalence of special health care needs in the general population of children in Maine (19.4%).
- **For nearly three quarters of MaineCare children, physicians discussed physical activity, nutrition/ diet, avoiding sugar-sweetened drinks.** Physicians also discussed television viewing and other screen time with two thirds of Maine Care Children. Survey results indicate that for children who are overweight, providers are even more likely to discuss issues to encourage healthy behaviors. These rate were comparable or slightly higher, although not significantly than in the prior year survey.
- **Significant increase in discussion of mental health during well-child visits.** Sixty percent of parents indicated that their child's provider discussed mental health issues with the child or parent, which was a significant increase from 53 percent the previous year ($p < 0.05$). Discussions of use of tobacco products (60%), drug and alcohol use (57%) and reproductive health (48%) at recommended ages during well-child visits also all increased over the prior year, although not significantly.
- **Majority of MaineCare children get dental care and give high ratings on quality of care received.** Nearly two-thirds (62%) of all children enrolled in MaineCare received dental services in the past six months, and one in five (20%) had more than one visit with a dental provider. By comparison, in a study using 2008 Medicaid administrative data from nine states, 34 percent of children had a dental preventive service and 19 percent had used a dental treatment service provided by Medicaid in the past year.³⁸ For those MaineCare members that received dental services in 2013, had a usual source of dental care (77%) and the overall rating of the child's dental care was quite high, with a mean score of 8.9 on a scale of 1 to 10, and 68 percent of respondents rating the quality of their child's dental care a 9 or 10.

38 Bouchery, E., Utilization of dental services among Medicaid-enrolled children. *Medicare and Medicaid Research Review*, 2013; 3:E1-E15. Available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/Downloads/MAX_IB9_DentalCare.pdf. [Retrieved 12/14/2013.]

APPENDIX A: IHOC AND CHIPRA RESULTS FOR FFY 2009-2013

CHIPRA Measure	Specifications	Measure Description	FFY 2009			FFY 2010			FFY 2011			FFY 2012			FFY 2013		
			Numerator	Denominator	% or Rate	Numerator	Denominator	% or Rate	Numerator	Denominator	% or Rate	Numerator	Denominator	% or Rate	Numerator	Denominator	% or Rate
ADD_INI_PCT	HEDIS	Follow-Up Care for Children Prescribed ADHD Medication (Initial Phase)	628	1,271	49.41%	855	1,346	63.52%	975	1,463	66.64%	1,026	1,565	65.56%	1,114	1,645	67.72%
ADD_CM_PCT	HEDIS	Follow-Up Care for Children Prescribed ADHD Medication (Continuaiton & Maintenance Phase)	551	1,189	46.34%	765	1,274	60.05%	878	1,387	63.30%	922	1,482	62.21%	1,008	1,564	64.45%
ASM_5_PCT	HEDIS	Use of Appropriate Medications for People With Asthma (5-12)	1,259	1,353	93.05%	1,369	1,465	93.45%	1,512	1,626	92.99%	1,523	1,612	94.48%	684	729	93.83%
ASM_12_PCT	HEDIS	Use of Appropriate Medications for People With Asthma(12-21)	1,160	1,304	88.96%	1,213	1,386	87.52%	1,239	1,437	86.22%	1,240	1,438	86.23%	597	675	88.44%
ASM_TOT_PCT	HEDIS	Use of Appropriate Medications for People With Asthma (Total)	2,419	2,657	91.04%	2,582	2,851	90.56%	2,751	3,063	89.81%	2,763	3,050	90.59%	1,281	1,404	91.24%
AWC_PCT	HEDIS	Adolescent Well-Care Visits	16,502	43,402	38.02%	16,785	46,469	36.12%	19,434	49,188	39.51%	18,528	47,990	38.61%	18,008	46,350	38.85%
CAP_12M_PCT	HEDIS	Children and Adolescents' Access to Primary Care Practitioners	6,643	6,822	97.38%	7,111	7,329	97.03%	7,259	7,529	96.41%	6,850	7,048	97.19%	6,498	6,736	96.47%
CAP_25M_PCT	HEDIS	Children and Adolescents' Access to Primary Care Practitioners	25,177	28,715	87.68%	27,153	31,229	86.95%	29,153	33,116	88.03%	28,548	32,438	88.01%	27,552	31,302	88.02%
CAP_7_PCT	HEDIS	Children and Adolescents' Access to Primary Care Practitioners	21,463	23,901	89.80%	22,517	24,999	90.07%	24,789	27,109	91.44%	25,599	27,788	92.12%	25,669	27,821	92.26%
CAP_12_PCT	HEDIS	Children and Adolescents' Access to Primary Care Practitioners	30,580	34,457	88.75%	32,068	36,025	89.02%	34,660	38,590	89.82%	35,178	38,996	90.21%	35,035	38,602	90.76%
CDC_H5_P1MT	HEDIS	Comprehensive Diabetes Care- HbA1c Testing	280	371	75.47%	294	368	79.89%	329	408	80.64%	339	404	83.91%	314	395	79.49%
CDC_H5_ATPM	HEDIS	Comprehensive Diabetes Care - HbA1c Average number of test per member	854	371	2.30	928	368	2.30	1,024	408	2.51	1,117	404	2.76	926	395	2.76
CHL_16_PCT	HEDIS	Chlamydia Screening	3,877	8,549	45.35%	3,663	8,974	40.82%	3,891	9,218	42.21%	3,315	8,403	39.45%	3,039	7,121	42.68%
CWP_PCT	HEDIS	Appropriate Testing for Children With Pharyngitis	716	994	72.03%	745	992	75.10%	1,040	1,303	79.82%	946	1,171	80.79%	651	819	79.49%

APPENDIX A: IHOC AND CHIPRA RESULTS FOR FFY 2009-2013 (CONTINUED)

CHIPRA Measure	Specifications	Measure Description	FFY 2009			FFY 2010			FFY 2011			FFY 2012			FFY 2013		
			Numerator	Denominator	% or Rate	Numerator	Denominator	% or Rate	Numerator	Denominator	% or Rate	Numerator	Denominator	% or Rate	Numerator	Denominator	% or Rate
DPS	CHIPRA	Total Eligibles Who Received Preventive Dental Services (0 - 20)*				24,399	123,555	19.75%	41,165	128,418	32.06%	41,422	123,250	33.61%	40,957	129,026	31.74%
DTS	CHIPRA	Total Eligibles Who Received Dental Treatment Services (0 - 20)*				13,431	123,555	10.87%	21,635	128,418	16.85%	22,537	123,250	18.29%	21,973	129,026	17.03%
DS3	CHIPRA	Developmental Screening - Age 3							78	6,820	1.14%	104	6,617	1.57%	752	6,306	11.93%
FUH_7D_PCT	HEDIS	Follow-Up After Hospitalization for Mental Illness (7 day flu)	567	1,148	49.39%	507	1,012	50.10%	701	878	79.84%	729	910	80.11%	567	712	79.63%
FUH_30D_PCT	HEDIS	Follow-Up After Hospitalization for Mental Illness (30 day flu)	867	1,148	75.52%	787	1,012	77.77%	827	878	94.19%	854	910	93.85%	655	712	91.99%
PPC	CHIPRA	Timeliness of Prenatal Care (All Ages)				6,259	6,370	98.26%	6,230	6,374	97.74%	6081	6213	98%	Vital Statistics Data for 2013 is Currently Not Available		
FPC	CHIPRA	Frequency of Prenatal Care: 0 - 20% of expected prenatal visits				86	6,370	1.35%	124	6,374	1.95%	136	6213	2%			
FPC	CHIPRA	Frequency of Prenatal Care: 21 - 80% of expected visits				766	6,370	12.03%	734	6,374	11.52%	712	6213	11%			
FPC	CHIPRA	Frequency of Prenatal Care: >=81% of expected visits				5,518	6,370	86.62%	5,516	6,374	86.54%	5365	6213	87%			
LBW	CHIPRA	Percentage of live births weighing less than 2500 grams (All ages)				501	6,932	7.23%	548	6,941	7.90%	503	6808	100%			
W34_PCT	HEDIS	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	14,762	23,124	63.84%	15,505	25,304	61.27%	17,241	26,845	64.22%	16,492	26,526	62.17%	16,176	25,788	62.73%
WC711	IHOC	Well Child Visits between 7 years of age and 11 years of age	12,754	27,246	46.81%	12,950	28,856	44.88%	14,748	30,590	48.21%	14,713	30,811	47.75%	14,768	30,432	48.53%
APER	CHIPRA	Annual Number of Asthma Patients with > 1 asthma-related Emergency Room Visit	881	11,817	7.46%	874	12,719	6.87%	1,082	11,939	9.06%	1,009	11,799	8.55%	671	9,479	7.08%

*Note: Dental measure results come from the CMS 416 / EPSDT Annual Reports (Lines 12b and 12c)

APPENDIX A: IHOC AND CHIPRA RESULTS FOR FFY 2009-2013 (CONTINUED)

CHIPRA Measure	Specifications	Measure Description	FFY 2009			FFY 2010			FFY 2011			FFY 2012			FFY 2013		
			Visits	Member Months	% or Rate	Visits	Member Months	% or Rate	Visits	Member Months	% or Rate	Visits	Member Months	% or Rate	Visits	Member Months	% or Rate
W15	HEDIS	Well-Child Visits in the First 15 Months of Life	0	131	2.1%	0	151	2.3%	0	159	2.1%	0	185	2.9%	0	173	3%
			1	106	1.7%	1	97	1.5%	1	105	1.6%	1	115	1.8%	1	109	2%
			2	165	2.7%	2	194	3.0%	2	190	2.8%	2	188	2.9%	2	154	2%
			3	268	4.4%	3	278	4.3%	3	288	4.3%	3	309	4.8%	3	258	4%
			4	532	8.7%	4	562	8.6%	4	600	9.5%	4	499	7.8%	4	498	8%
			5	1,001	16.4%	5	1,082	16.6%	5	1,110	16.9%	5	951	14.9%	5	869	14%
			6+	3,908	64.0%	6+	4,162	63.8%	6+	4,206	62.8%	6+	4,148	64.9%	6+	4,249	67%
TOTAL			6,111	100%	TOTAL	6,526	100%	TOTAL	6,658	100%	TOTAL	6,395	100%	TOTAL	6,310	100%	
WC24	HEDIS	Well Child Visits between 15 months and 3 years of age	0	653	11.2%	0	753	11.5%	0	810	11.3%	0	655	9.9%	0	597	9.6%
			1	972	16.7%	1	1,138	17.5%	1	1,140	16.7%	1	1,000	15.1%	1	861	13.9%
			2	1,538	26.4%	2	1,712	26.3%	2	1,724	25.4%	2	1,660	25.1%	2	1,382	22.3%
			3+	2,663	45.7%	3+	2,917	44.7%	3+	3,146	46.5%	3+	3,302	49.9%	3+	3,357	54.2%
TOTAL			5,826	100%	TOTAL	6,520	100%	TOTAL	6,820	100%	TOTAL	6,617	100%	TOTAL	6,197	281%	

Measure Description	FFY 2009			FFY 2010			FFY 2011			FFY 2012			FFY 2013		
	Visits	Member Months	Visits/1,000 MM	Visits	Member Months	% or Rate	Visits	Member Months	Visits/1,000 MM	Visits	Member Months	Visits/1,000 MM	Visits	Member Months	Visits/1,000 MM
Emergency Department (ED) Utilization- Average number of ED visits per 1,000 member months (MM)															
age1 (<1)	3,798	47,206	80.5	3,499	46,728	74.9	3,327	44,640	74.5	3,119	45,461	68.6	2,907	46,002	40.2
age1-9 (>=1 to <10)	39,922	701,139	56.9	42,071	737,854	57.0	39,009	742,544	52.5	39,890	768,991	51.9	36,669	750,813	53.4
age10-19 (>=10 to <20)	35,956	689,193	52.2	36,833	721,229	51.1	33,661	717,337	46.9	33,015	743,866	44.4	29,784	724,679	44.5
TOTAL	79,676	1,437,538	55.4	82,403	1,505,811	54.7	75,997	1,504,521	50.5	76,024	1,558,318	48.8	69,360	1,521,494	45.6