APPENDICES

The Department of Health and Human Services
2011 Annual Report on the Quality of Care for Children in Medicaid and CHIP

Appendix A: NCQA, URAC and AAAHC Medicaid Accreditation

Appendix B: States Recognizing NCQA and Other Medicaid Accreditation

Appendix C: Public-Private Partnerships to Improve Quality Measurement

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

Appendix E: State-Specific Tables (E.1–E.6)

Appendix F: External Quality Review Organizations with State Medicaid Contracts in 2010

Appendix G: Findings from External Quality Review Organizations' Validation Studies

Appendix H: CHIPRA Title IV - Strengthening Quality of Care and Health Outcomes

Appendix I: Overview and Updates on Recent Federal Laws Related to Quality Measurement in Medicaid/CHIP

Appendix A: NCQA, URAC and AAAHC Medicaid Accreditation

NCQA

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

URAC

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

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

AAAHC

AAAHC (the Accreditation Association for Ambulatory Health Care) also publishes a crosswalk which sets forth areas where its accredited managed care organizations (MCOs) can use their proof of AAAHC accreditation to partially meet the requirements for Medicaid MCOs which are set forth in 42 CFR, Part 438, Subsection D. MCOs accredited by AAAHC should consult the AAAHC website at http://www.aaahc.org/eweb/docs/Managed_Care_Assist_011110.pdf to investigate the extent to which AAAHC standards overlap with applicable Medicaid regulations. Individual States will set forth in their required State Quality Strategy the State's policy with regard to "deeming" of regulatory compliance by the use of accreditation status from any of the three allowed MCO accreditation agencies.

Appendix B: States Recognizing NCQA and Other Medicaid Accreditation

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

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

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

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

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

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

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

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

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

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

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

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

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

- * **Missouri:** Missouri's request for proposals for Medicaid managed care requires that plans obtain NCQA health plan accreditations within 2 years of the effective date of the contract (REQ NO.: NR 886 25799006134 – http://oa.mo.gov.bids/b3z09135.htm).

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

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

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

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

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

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

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

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

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

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

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

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

Source: 2011 NCQA Medicaid Managed Care Toolkit

Appendix C: Public-Private Partnerships to Improve Quality Measurement

The 2010 Secretary's report highlighted a number of collaborative efforts that support States, and there continues to be great momentum in the growing number of organizations collaborating with CMS and individual State Medicaid and CHIP Programs to improve the quality of care of children. This section highlights examples that represent recent collaborative efforts.

The CHIPRA Pediatric Quality Measures Program Centers of Excellence are one the most comprehensive partnerships to emerge in 2011. In collaboration with CMS, the Agency for Healthcare Research and Quality (AHRQ) awarded seven cooperative grant awards funded by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) as part of the establishment of the CHIPRA Pediatric Quality Measures Program. While this work is just getting started, the extensive partnerships across academia, health care systems, providers, and professionals in quality measurement, research, and patient advocacy, are critical to the success of this effort with State Medicaid and CHIP programs.

A summary of the national experts that have joined AHRQ and CMS to improve and strengthen the initial core set of measures to assess improvement in health care quality and health outcomes for children through the seven Centers of Excellence is available at: http://www.ahrq.gov/chipra/pqmpfact.htm.

The first CMS Medicaid and CHIP Quality Conference on Improving Care and Lowering Costs was held in August 2011, to support initial State efforts in collecting and reporting quality measures and information on their programs. Over 240 participants attended to support States in quality measurement, including Federal and National partners. Organizations that presented or attended that conference to network and offer support to States included (but were not limited to):

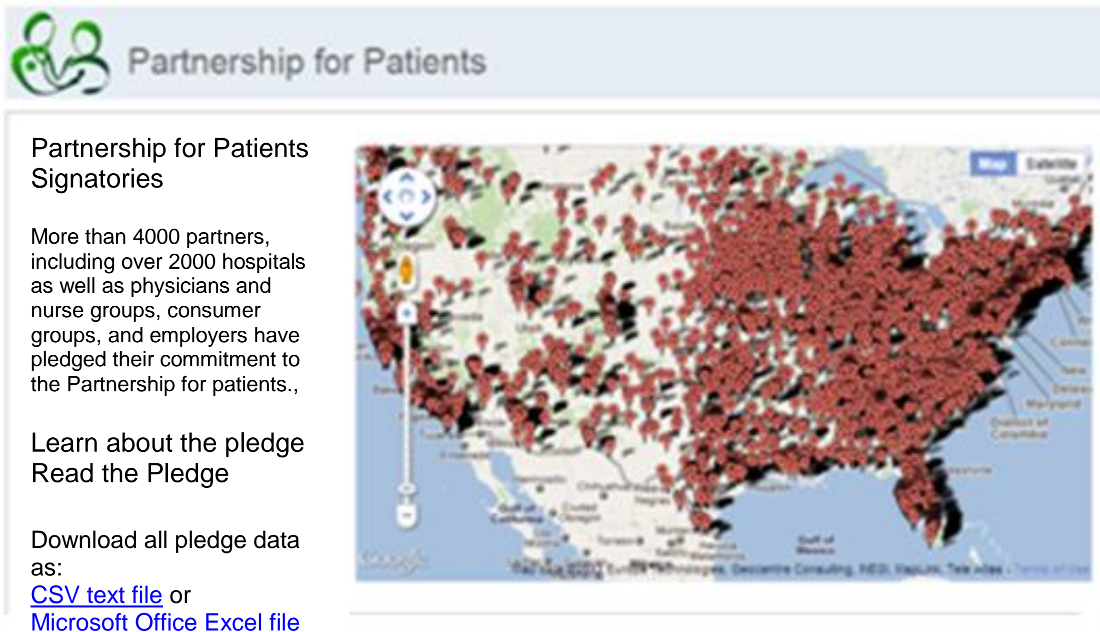
Academy Health
American Academy of Pediatrics & American Academy of Pediatric Dentistry
American Dental Education Association, Center for Public Policy and Advocacy
Association for Community Affiliated Plans
Association for Maternal and Child Health Programs
Center for Health Care Strategies
Children's Dental Health Project
Delmarva Foundation External Quality Review Organization
Family Voices
Health Management Associates
Mathematica Policy Research
Merck Childhood Asthma Network
National Assembly on School-Based Health care
National Academy for State Health Policy
National Association of Children's Hospitals and Related Institutions
National Committee for Quality Assurance
National Initiative for Children's Healthcare Quality
National Partnership for Women and Families
Nemours, National Office of Policy and Prevention
URAC
Voices for America's Children

National Partnership for Patients Safety Initiative was announced in April, 2011 by Secretary Sebelius to promote a partnership between the administration, private sector, hospitals and providers to improve the

quality of healthcare, make it safer, and potentially save up to $50 billion dollars. To kick off this unprecedented partnership, two goals have been identified:

- 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.

The CMS has identified a significant opportunity to promote these partnership opportunities with State Medicaid and CHIP programs, and at the time of this report, was just beginning work to support those state efforts. Current Partners that have pledged with the initiative are available at: http://partnershippledge.healthcare.gov/



Just a few "examples" of state and national partners that have pledged in this effort, and have the opportunity to work with State Medicaid Programs include (but not limited to):

Colorado Patient Safety Coalition Association of Women's Health, Obstetric and Neonatal Nurses
Nursing Alliance for Quality Care
National Association of Pediatric Nurse Practitioners
American Academy of Developmental Medicine and Dentistry
Perinatal Quality Collaborative of North Carolina
National Partnership for Women and Families
Maryland Patient Safety Center

The CMS Educational Series on Medicaid/CHIP Efforts to Improve Clinical Care was established in 2011 by the Center for Medicaid, CHIP and Survey & Certification to host a series of sessions with national partners for State Medicaid and CHIP programs to learn more about evidenced-based interventions and collaborative partnerships to improve patient care.

Perinatal Outcomes Improvement Symposium, May 2011

This CMS symposium highlighted the following successful perinatal improvement initiatives:

- University of Texas Southwestern Medical Center at Dallas - Parkland Hospital Case Study – cut its rate of preterm births by more than half in the past 15 years
    - http://www.utsouthwestern.edu/utsw/cda/dept353744/files/519019.html
    - http://www.midwivesoftexas.org/nursemidwivesarticle-premature.htm
- St. Agnes Hospital Ascension Healthcare Case Study – reducing elective inductions before 39 weeks
    - http://www.marylandpatientsafety.org/html/collaboratives/perinatal/stories/st_agnes.html
- Nurse Family Partnership – improving perinatal outcomes through nurse home visits
    - http://www.nursefamilypartnership.org/about/fact-sheets
    - http://www.nursefamilypartnership.org/assets/PDF/Fact-sheets/NFP_Nurses-Mothers
- Urban Institute – presented research on maternal and infant outcomes for women cared for by midwives at a freestanding birth center in Washington, D.C. (The Family Health and Birth Center).

Improving Birth Outcomes in Medicaid: Healthy Babies, Lower Costs, June 2011 Webinar

This CMS webinar highlighted opportunities to improve birth outcomes in Medicaid with highlights presented by Dr. Jeffrey Schiff, Medical Director for the Minnesota Department of Health Care Programs and Dr. Scott Berns, Sr. Vice President, Chapter Programs for the March of Dimes Foundation.

- Preventing Elective Inductions Before 39 weeks – http://www.minnesotamedicine.com/tabid/3597/Default.aspx
- Toward Improving the Outcome of Pregnancy III http://www.marchofdimes.com/TIOPIII_FinalManuscript.pdf

Using Evidence-based Interventions and Collaborative Partnerships to Improve Asthma Care and Lower costs, July 2011 Webinar

This CMS webinar highlighted opportunities to improve birth outcomes in Medicaid with highlights presented by Dr. Floyd Malveux, Merck Childhood Asthma Network, Inc. and Dr. Mary McIntyre, Medical Officer, Bureau of Communicable Disease, Alabama Department of Public Health.

- Dr. Malveaux provided an overview of evidence-based interventions that can be used to improve the health of children with asthma and potentially reduce the number of emergency room visits. http://www.mcanonline.org/apha/data/resources/Using_Interventions_to_Improve_Childhood_Asthma_Outcomes.pdf; http://www.mcanonline.org/
- Dr. McIntyre described how the State is leveraging the partnership between two of its State Agencies, the Alabama Department of Public Health and the Alabama Medicaid Agency, to improve asthma outcomes through the development, implementation, and evaluation of Asthma care coordination and use of care coordinators/care managers.

The Robert Wood Johnson Foundation, highlighted in last year's report, continues to support developing leadership for Medicaid Directors. The *Medicaid Leadership Institute* is a national initiative of the Robert Wood Johnson Foundation, but is run by the Center for Health Care Strategies. The Institute provides a year-long curriculum for Medicaid directors to develop and enhance the skills and expertise to enhance their State programs as well as maximize Medicaid's contributions to transform the nation's health care system. The Medicaid directors competitively selected for the most recent class of 2012 are highlighted below.

Robert Wood Johnson Foundation Medicaid Director Leadership Institute Fellows

Medicaid Director	State
Jennifer Vermeer	Iowa
Kathryn Dunn	New Hampshire
Valerie Harr	New Jersey
Julie Weinberg	New Mexico
Elena Nicolella	Rhode Island
Billy Millwee	Texas

"The Medicaid Leadership Institute curriculum is designed to be dynamic and relevant to the interests of participating Fellows as well as the current environment at both the federal and state levels. It focuses on broad macroeconomic and health policy issues, Medicaid operational issues, and leadership development."[i] More information on this initiative is available at: http://www.medicaidleaders.org/

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

Prevention and Health Promotion

Measure	Measure Steward	Description
Frequency of Ongoing Prenatal Care	NCQA/HEDIS	Percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that received the following number of visits: < 21 percent of expected visits 21 percent – 40 percent of expected visits 41 percent – 60 percent of expected visits 61 percent – 80 percent of expected visits ≥ 81 percent of expected visits
Prenatal and Postpartum Care: Timeliness of Prenatal Care	NCQA/HEDIS	The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year that received a prenatal care visit in the first trimester or within 42 days of enrollment in the organization.
Percent of live births weighing less than 2,500 grams	Centers for Disease Control and Prevention	The measure assesses the number of resident live births less than 2,500 grams as a percentage of the number of resident live births in the State reporting period.
Cesarean rate for nulliparous singleton vertex	California Maternal Quality Care Collaborative	Percentage of women who had a cesarean section among women with first live singleton births [also known as nulliparous term singleton vertex (NTSV) births] at 37 weeks of gestation or later.
Childhood Immunization Status	NC National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) QA/HEDIS	Percentage of patients who turned 2 years old during the measurement year who had four DTaP/DT, three IPV, one MMR, three H influenza type B, three hepatitis B, one chicken pox vaccine (VZV), four pneumococcal conjugate (PCV), two hepatitis (HepA), two or three rotavirus (RV); and two influenza vaccines by the child's second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.

Prevention and Health Promotion

Measure	Measure Steward	Description
Immunizations for Adolescents	NCQA/HEDIS	Percentage of patients who turned 13 years old during the measurement year who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and a cellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their thirteenth birthday; a second dose of MMR and three hepatitis B vaccinations; and one varicella vaccination by their thirteenth birthday. The measure calculates a rate for each vaccine and one combination rate.
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents	NCQA/HEDIS	Percentage of children, 3 through 17 years of age, whose weight is classified based on body mass index percentile for age and gender.
Developmental Screening in the First Three Years of Life	Child and Adolescent Health Measurement Initiative and NCQA	Assesses the extent to which children at various ages from 0-36 months were screened for social and emotional development with a standardized, documented tool or set of tools.
Chlamydia Screening	NCQA/HEDIS	Percentage of women 16 through 20 who were identified as sexually active who had at least one test for Chlamydia during the measurement year.
Well-Child Visits in the First 15 Months of Life	NCQA/HEDIS	Percentage of members who received zero, one, two, three, four, five, and six or more well-child visits with a primary care practitioner during their first 15 months of life.
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	NCQA/HEDIS	Percentage of members ages 3 through 6 years old who received one or more well-child visits with a primary care practitioner during the measurement year.
Adolescent Well-Care Visit	NCQA/HEDIS	Percentage of members ages 12 through 21 years who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.
Total Eligibles Who Received Preventive Dental Services	CMS	Total eligible children 1 through 20 years of age who received preventive dental services.

Management of Acute Conditions

Measure	Measure Steward	Description
Appropriate Testing for Children with Pharyngitis	NCQA/HEDIS	Percentage of patients who were diagnosed with Pharyngitis, dispensed an antibiotic, and who received a group A streptococcus test for the episode.
Otitis media with effusion (OME) – avoidance of inappropriate use of systemic antimicrobials in children – ages 2 through 12	American Medical Association /PCPI[1]	Percentage of patients ages 2 months through 12 years with a diagnosis of OME who were not prescribed systemic antimicrobials.
Total Eligibles who Received Dental Treatment Services	CMS	Total eligible children 1 through 20 years of age who received dental treatment services.
Ambulatory Care: Emergency Department Visits	NCQA/HEDIS	The number of visits per member per year as a function of all child and adolescent members enrolled and eligible during the measurement year.
Pediatric central-line associated blood stream infections – Neonatal Intensive Care Unit and Pediatric Intensive Care Unit	Centers for Disease Control and Prevention	Rate of central line-associated blood stream infections (CLABSI) identified during periods selected for surveillance as a function of the number of central line catheter days selected for surveillance in pediatric and neonatal intensive care units.

Management of Chronic Conditions

Measure	Measure Steward	Description
Annual number of asthma patients ages 2 through 20 years old with 1 or more asthma-related emergency room visits	Alabama Medicaid	Asthma emergency department utilization for for patients ages 2 through 20 years old diagnosed with asthma or treatment with at least 2 short-acting beta adrenergic agents during the measurement year who also had one or more asthma-related emergency room visits.
Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication	NCQA/HEDIS	Percentage of children ages 6 through 12 years of age with newly prescribed ADHD medication who had at least 3 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.
Follow-up after hospitalization for mental illness	NCQA/HEDIS	Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner.
Annual Pediatric hemoglobin A1C testing	NCQA	Percentage of pediatric patients with diabetes who had a hemoglobin A1c test in a 12-month measurement period.

Family Experiences of Care

Measure	Measure Steward	Description
CAHPS® 4.0 (child version including Medicaid and Children with chronic conditions supplemental items)	NCQA/HEDIS	Survey on an individual's experiences with health care.

Availability

Measure	Measure Steward	Description
Child and Adolescent Access to Primary Care Practitioners	NCQA/HEDIS	Percentage of enrollees 12 months through 19 years of age who had a visit with a primary care practitioner (PCP). Four separate percentages are reported: Children 12 months through 24 months and 25 months through 6 years who had a visit with a PCP during the measurement year. Children 7 through 11 years and adolescents 12 through 19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year.

Appendix E: State-Specific Tables (E.1–E.6)

Table E.1. CHIPRA Quality Measures Reported by States in FFY 2010 CARTS Reports

	Number of Measures Reported by State[a]	Prenatal and Postpartum Care: Timeliness of Prenatal Care (#1)	Frequency of Ongoing Prenatal Care (#2)	Percent of Live Births Weighing Less Than 2500 grams (#3)	Cesarean Rate for Nulliparous Singleton Vertex (#4)	Childhood Immunization Status (#5)	Immunizations for Adolescents (#6)	Weight Assessment and Counseling for Nutrition (#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 Third, Fourth, Fifth, and Sixth Years of Life (#11)	Adolescent Well-Care Visits (#12)	Total Eligibles Who Received Preventive Dental Services (#13)	Children and Adolescents' Access to Primary Care Practitioners (#14)	Appropriate Testing for Children with Pharyngitis (#15)	Otitis Media with Effusion - Avoidance of Inappropriate Use of Systemic Antimicrobials (#16)	Total Eligibles Who Received Dental Treatment Services (#17)	Ambulatory Care: Emergency Department Visits (#18)	Pediatric Central-Line Associated Bloodstream Infections (#19)	Annual Number of Asthma Patients with > 1 Asthma-Related Emergency Room Visit (#20)	Follow-Up Care for Children Prescribed ADHD Medication (#21)	Annual Pediatric Hemoglobin Testing and Control (#22)	Follow-Up After Hospitalization for Mental Illness (#23)	CAHPS Health Plan Survey 4.0H, child version (#24)[d]
States Reporting		15	12	3	2	20	12	10	2	21	40	42	29	22	40	20	1	19	15	0	5	15	8	11	1
Alabama	13									✓	✓	✓	✓	✓	✓	✓		✓	✓		✓	✓	✓	✓	
Alaska	14			✓	✓					✓	✓	✓	✓	✓	✓	✓		✓	✓		✓	✓		✓	
Arizona	8					✓				✓	✓	✓	✓	✓	✓			✓							
Arkansas[b]	0																								
California	9					✓				✓	✓	✓	✓	✓	✓	✓		✓							
Colorado	5					✓		✓			✓	✓	✓												
Connecticut	10	✓	✓						✓	✓	✓	✓	✓		✓				✓				✓		
Delaware[c]	0																								
Dist. Of Col.	12	✓	✓			✓	✓			✓	✓	✓	✓	✓	✓	✓		✓							
Florida	12		✓					✓		✓	✓	✓	✓	✓	✓	✓			✓			✓		✓	
Georgia	18	✓	✓	✓	✓	✓		✓		✓	✓	✓	✓	✓	✓	✓		✓	✓		✓	✓		✓	
Hawaii[b]	0																								
Idaho[b]	0																								
Illinois	7	✓	✓			✓			✓		✓	✓			✓										
Indiana	14	✓	✓			✓	✓			✓	✓	✓	✓	✓	✓	✓		✓				✓		✓	
Iowa	3										✓	✓			✓										
Kansas[b]	0																								
Kentucky	13	✓	✓			✓	✓	✓		✓	✓	✓	✓	✓	✓	✓		✓							
Louisiana	5										✓	✓	✓	✓	✓										
Maine	11									✓	✓	✓	✓	✓	✓			✓	✓		✓	✓	✓		
Maryland	12	✓	✓			✓	✓			✓	✓	✓	✓	✓	✓	✓		✓							
Massachusetts[b]	0																								
Michigan	12	✓				✓	✓	✓		✓	✓	✓	✓		✓	✓						✓	✓		
Minnesota	3										✓	✓			✓										
Mississippi	8					✓				✓		✓	✓		✓	✓						✓		✓	
Missouri	12	✓				✓	✓			✓	✓	✓	✓	✓				✓	✓					✓	✓
Montana	7										✓	✓		✓	✓	✓		✓	✓						
Nebraska	5										✓	✓		✓	✓			✓							
Nevada	3										✓	✓			✓										
New Hampshire	5										✓	✓	✓		✓	✓									

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)	Percent of Live Births Weighing Less Than 2500 grams (#3)	Cesarean Rate for Nulliparous Singleton Vertex (#4)	Childhood Immunization Status (#5)	Immunizations for Adolescents (#6)	Weight Assessment and Counseling for Nutrition (#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 Third, Fourth, Fifth, and Sixth Years of Life (#11)	Adolescent Well-Care Visits (#12)	Total Eligibles Who Received Preventive Dental Services (#13)	Children and Adolescents' Access to Primary Care Practitioners (#14)	Appropriate Testing for Children with Pharyngitis (#15)	Otitis Media with Effusion - Avoidance of Inappropriate Use of Systemic Antimicrobials (#16)	Total Eligibles Who Received Dental Treatment Services (#17)	Ambulatory Care: Emergency Department Visits (#18)	Pediatric Central-Line Associated Bloodstream Infections (#19)	Annual Number of Asthma Patients with > 1 Asthma-Related Emergency Room Visit (#20)	Follow-Up Care for Children Prescribed ADHD Medication (#21)	Annual Pediatric Hemoglobin Testing and Control (#22)	Follow-Up After Hospitalization for Mental Illness (#23)	CAHPS Health Plan Survey 4.0H, child version (#24)[d]
States Reporting		15	12	3	2	20	12	10	2	21	40	42	29	22	40	20	1	19	15	0	5	15	8	11	1
New Jersey	6	✓				✓					✓	✓	✓		✓										
New Mexico	15	✓	✓			✓	✓	✓		✓	✓	✓	✓	✓	✓	✓		✓	✓			✓			
New York	9					✓		✓			✓	✓	✓		✓	✓			✓			✓			
North Carolina	2											✓			✓										
North Dakota	2											✓			✓										
Ohio	3										✓	✓			✓										
Oklahoma	4										✓	✓	✓		✓										
Oregon[b]	0																								
Pennsylvania	9					✓	✓				✓	✓	✓		✓	✓			✓			✓			
Rhode Island	15	✓	✓			✓	✓	✓		✓	✓	✓	✓	✓	✓	✓		✓				✓		✓	
South Carolina	9	✓								✓	✓				✓	✓			✓			✓	✓	✓	
South Dakota	4										✓	✓		✓	✓										
Tennessee	15	✓	✓			✓	✓	✓		✓	✓	✓	✓		✓	✓			✓			✓	✓	✓	
Texas[b]	0																								
Utah	3										✓	✓			✓										
Vermont	9	✓	✓	✓							✓	✓	✓	✓	✓			✓							
Virginia	3										✓	✓			✓										
Washington	6										✓	✓	✓	✓	✓			✓							
West Virginia	15					✓	✓	✓		✓	✓	✓	✓	✓	✓			✓	✓		✓	✓	✓	✓	
Wisconsin	2										✓	✓													
Wyoming	13					✓	✓			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓				✓		

Source: Mathematica analysis of CARTS FFY2010 Reports, as of June 30, 2011.

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

[b]Arkansas, Hawaii, Idaho, Kansas, Massachusetts, Oregon, and Texas submitted CARTS reports for FFY 2010, but did not submit data on any of the core CHIPRA quality measures.

[c]Delaware did not submit a CARTS report for FFY 2010.

[d]For Measure 24, States have the option of attaching their CAHPS results to the CARTS report or submitting the data directly to AHRQ.

Table E.2. Percentage of Children Receiving Well-Child Visits in the First 15 Months of Life, as Reported by States in their FFY 2010 CARTS Reports (N=40)

			Population Included in Measure			Data Source		Percentage of Children Receiving Well-Child Visits (Number of Visits)						
State	Program Type	Year of Data	CHIP	Medicaid (Title XIX)	Sample Size	Administrative	Hybrid	0	1	2	3	4	5	6+
Reported Using HEDIS Methodology (N=38)														
Alabama	S-CHIP	2010	√		318	√		4.7	3.5	3.8	8.2	13.2	22.3	44.3
Alaska	M-CHIP	2009	√	√	3,384	√		4.2	5.9	6.6	7.6	10.4	11	54.4
Arizona	S-CHIP	2009	√		1,050	√		0.3	0.2	0.9	2.9	7.5	16.5	71.4
California	COMBO	2009	√		4,613	√	√	1.0	0.9	2.0	4.9	11.2	21.5	57.5
Colorado	S-CHIP	2010	√		466	√		3.4	2.6	6.9	6.7	13.9	23	43.6
Connecticut	S-CHIP	NR	√	√	411		√	0.5	0.0	0.7	1.7	3.6	13.1	56.7
Dist. Of Col.	M-CHIP	2009	√	√	NR	√		1.7	2.2	2.3	6	10.9	12.4	64.6
Florida	COMBO	2010	√		NR	√		60.9	21.1	7.7	5.2	1.5	1.5	2.1
Georgia	S-CHIP	2009	√	√	58,629	√		8.7	5.4	6.8	9.7	14.4	20.1	34.9
Illinois	COMBO	2010	√	√	92,013	√		4.4	3.3	4.4	6.3	9.2	13	59.4
Indiana	COMBO	2009	√	√	1,233		√	3.2	2.7	4.9	6.3	10.5	15.9	56.2
Kentucky	COMBO	2009	√	√	4,432	√		0.7	1.2	1.8	3.1	6.8	13.9	72.5
Louisiana	COMBO	2010	√		2,937	√		1.3	1.5	2.8	3.8	7.5	15.1	68
Maine	COMBO	2010	√	√	325	√		4.3	2.5	4.6	5.5	9.5	18.2	55.4
Maryland	M-CHIP	2009	√	√	NR		√	2.0	NR	NR	NR	NR	NR	83.2
Michigan	COMBO	2009		√	NR		√	0.7	1.9	3.1	4.7	7.6	12.4	69.5
Minnesota	COMBO	2009	√	√	11,000	√		1.0	2.2	3.6	6.7	12.4	21.8	53.3
Missouri	COMBO	2009	√	√	NR	√		3.2	3.1	4.8	6.8	11.4	16.9	53.8
Montana	S-CHIP	2009	√		157	√		7.0	4.5	3.8	12.7	21.7	36.3	14.0
Nevada	S-CHIP	2009	√		129		√	NR	NR	NR	NR	NR	NR	52.7
New Hampshire	COMBO	2009	√	√	285	√		0.4	0.7	1.8	3.2	0.7	15.4	72.3
New Jersey	COMBO	2009	√	√	1,580		√	2.0	1.7	2.2	5.0	8.7	13.2	67.2
New Mexico	M-CHIP	2009	√	√	3,917	√		1.4	1.7	3.6	6.4	11.2	17.9	57.9
New York	S-CHIP	2009	√		1,591	√		0.7	1.0	2.3	4.0	10.1	20.9	61.2
Ohio	M-CHIP	2009	√	√	62,734	√		3.9	3.2	4.8	6.4	9.8	12.6	59.4
Oklahoma	COMBO	2009	√	√	10,034	√		2.6	3.1	4.7	7.5	12.5	17.7	51.9
Pennsylvania	S-CHIP	2009	√		878	√	√	2.4	0.9	1.0	2.2	6.5	20.5	66.5
Rhode Island	COMBO	2009	√	√	899	√		0.2	0.9	1.6	2.7	6.6	11.5	76.6
South Carolina	COMBO	2010	√		320	NR	NR	0.9	0.9	3.1	4.4	11.6	28.1	50.9
South Dakota	COMBO	2009	√		123	√		17.1	18.7	14.6	17.9	11.4	8.1	12.2

Table E.2 *(continued)*

State	Program Type	Year of Data	Population Included in Measure: CHIP	Population Included in Measure: Medicaid (Title XIX)	Sample Size	Data Source: Administrative	Data Source: Hybrid	Percentage of Children Receiving Well-Child Visits (Number of Visits): 0	1	2	3	4	5	6+
Reported Using HEDIS Methodology (N=38)														
Tennessee	COMBO	2009	√		319	√		0.3	0.6	1.3	3.4	9.7	19.1	65.5
Utah	S-CHIP	2009	√		308	√		2.9	0.6	1.6	3.2	12.0	18.8	60.7
Vermont	S-CHIP	2009	√	√	2,729	√		2.2	2.5	5.2	11.9	22.2	24.4	31.6
Virginia	COMBO	2009	√	√	822		√	1.1	5.5	4.3	6.3	10.6	17.3	55.0
Washington	S-CHIP	2009	√	√	2,102		√	0.6	1.7	2.9	7.6	13.2	21.4	52.6
West Virginia	S-CHIP	2009	√		9	√		0.0	11.1	0.0	11.1	11.1	44.4	22.2
Wisconsin	COMBO	2009	√	√	16,416	√		2.2	2.8	4.7	7.8	13.9	19.9	48.8
Wyoming	S-CHIP	2010	√		15	√		0.0	0.0	13.3	6.7	20.0	40.0	20.0
Reported Using Other Methodology (N=2)														
Iowa	COMBO	2008	√		210	Administrative Data. Iowa reports the percentage of children with a well-visit within 5-7 months of turning 15 months old.		Other Rate Reported: 76.2 percent						
Nebraska	M-CHIP	2009	√		2,989	Administrative Data. CMS 416 EPSDT criteria. Rate is number of actual well-child visits to expected number of visits.		Other Rate Reported: 59.4 percent						

Source: Mathematica analysis of FFY 2010 CARTS Reports as of June 30, 2011. Delaware did not submit a CARTS report for FFY 2010. Arkansas, Hawaii, Idaho, Kansas, Massachusetts, Oregon, and Texas submitted FFY 2010 CARTS Reports, but did not submit data on any of the core CHIPRA quality measures. Mississippi, North Carolina, and North Dakota submitted CARTS reports with data for some measures but did not report Measure 10.

NR = Not Reported.

State-Specific Comments:

CA: Rate is based on information from multiple Managed Care Organizations (MCOs). Some MCOs used administrative claims data. Others used hybrid data including both administrative claims and medical record data. Excludes MCOs with sample sizes that were too small to report.

CT: Includes one of three MCOs (two MCOs were too new to report this measure).

IL: Providers have up to one year to submit claims. All claims may not be included in reported data.

KY: Includes one region of the state, representing 20 percent of the CHIP population.

LA: Denominator includes CHIP population only.

ME: Providers have up to one year to submit claims. All claims may not be included in reported data. Performance is based on 11 months of data, due to new data system.

MO: Performance rate represents unweighted average across multiple MCOs.

NJ: Includes 4 of 5 MCOs.

OH: Specifications allow for only one visit per day.

PA: Rate is based on information from multiple health plans. Some plans used administrative claims data. Others used hybrid data including both administrative claims and medical record data.

Table E.3. Percentage of Children Receiving Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life, as Reported by States in their FFY 2010 CARTS Reports (N=42)

State	Program Type	Year of Data	Population Included in Measure		Sample Size	Data Source		Percentage of Children Receiving 1+ Well-Child Visits in the 3rd, 4th, 5th, and 6th years of life
			CHIP	Medicaid (Title XIX)		Administrative	Hybrid	
Reported Using HEDIS Methodology (N=40)								
Alabama	S-CHIP	2010	√		5,898	√		46.4
Alaska	M-CHIP	2009	√	√	11,536	√		51.0
Arizona	S-CHIP	2009	√		5,448	√		74.1
California	COMBO	2009	√		118,538	√	√	76.8
Colorado	S-CHIP	2010	√		4,022	√		61.1
Connecticut	S-CHIP	NR	√	√	NR		√	77.0
Dist. Of Col.	M-CHIP	2009	√	√	NR	√		73.6
Florida	COMBO	2010	√		6,301	√		63.3
Georgia	S-CHIP	2009	√	√	211,677	√		53.4
Illinois	COMBO	2010	√	√	378,710	√		61.1
Indiana	COMBO	2009	√	√	822		√	69.1
Iowa	COMBO	2009	√		3,132	√		58.8
Kentucky	COMBO	2009	√	√	16,199	√		76.7
Louisiana	COMBO	2010	√		15,593	√		65.5
Maine	COMBO	2010	√		2,561	√		58.9
Maryland	M-CHIP	2009	√	√	NR		√	81.8
Michigan	COMBO	2009		√	NR		√	75.9
Minnesota	COMBO	2009	√	√	NR	√		65.6
Mississippi	S-CHIP	2009	√		2,919	√		33.6
Missouri	COMBO	2009	√	√	NR	√		60.2
Montana	S-CHIP	2009	√		1,993	√		44.4
Nevada	S-CHIP	2009	√		796		√	70.7
New Hampshire	COMBO	2009	√		NR	√		80.4
New Jersey	COMBO	2009	√	√	1,284		√	77.4
New Mexico	M-CHIP	2009	√	√	1,576	√		60.9
New York	S-CHIP	2009	√		39,089	√		81.0
North Carolina	COMBO	2009	√		358	√		26.3
Ohio	M-CHIP	2009	NR	NR	222,480	√		61.2
Oklahoma	COMBO	2009	√	√	64,923	√		64.9
Pennsylvania	S-CHIP	2009	√		6,075	√	√	75.5
Rhode Island	COMBO	2009	√	√	4,690	√		76.5
South Dakota	COMBO	2009	√		975	√		46.6
Tennessee	COMBO	2009	√		3,869	√		59.5
Utah	S-CHIP	2009	√		2,589	√		50.0
Vermont	S-CHIP	2009	√	√	11,233	√		70.6

Table E.3 *(continued)*

State	Program Type	Year of Data	Population Included in Measure: CHIP	Population Included in Measure: Medicaid (Title XIX)	Sample Size	Data Source: Administrative	Data Source: Hybrid	Percentage of Children Receiving 1+ Well-Child Visits in the 3rd, 4th, 5th, and 6th years of life
Reported Using HEDIS Methodology (N=40)								
Virginia	COMBO	2009	√	√	977		√	72.7
Washington	S-CHIP	2009	√	√	2,559		√	62.1
West Virginia	S-CHIP	2009	√		987	√		73.5
Wisconsin	COMBO	2009	√	√	58,207	√		63.1
Wyoming	S-CHIP	2010	√		390	√		45.6
Reported Using Other Methodology (N=2)								
Nebraska	M-CHIP	2009	√		5,539	Numerator: The number of well-child screenings received by CHIP-eligible children in the age group, per CMS 416 EPSDT criteria. Denominator: The expected number of screenings for CHIP-eligible children in the age group, per CMS 416 EPSDT criteria.		Other Rate Reported: 64.8
North Dakota	COMBO	2009	√		127	Hybrid administrative and medical record data. Methodology not specified.		Other Rate Reported: 30.7

Source: Mathematica analysis of CARTS FFY2010 reports, as of June 30, 2011. Delaware did not submit a CARTS report for FFY 2010. Arkansas, Hawaii, Idaho, Kansas, Massachusetts, Oregon, and Texas submitted FFY 2010 CARTS Reports, but did not submit data on any of the core CHIPRA quality measures. South Carolina submitted a CARTS report with data for some measures but did not report Measure 11.

NR = Not Reported.

State-Specific Comments:

CA: Rate is based on information from multiple Managed Care Organizations (MCOs). Some MCOs used administrative claims data. Others used hybrid data including both administrative claims and medical record data. Rate excludes MCOs with sample sizes that were too small to report.

IL: Providers have up to one year to submit claims. All claims may not be included in reported data.

IN: Performance rate includes data from 2 of 3 MCOs.

KY: Includes one region in state, representing about 20 percent of the CHIP population.

LA: Denominator includes CHIP population only

ME: Providers have up to one year to submit claims. All claims may not be included in reported data. Performance rate includes 11 months of data, due to new data system.

MO: Performance rate is unweighted average across multiple MCOs.

NJ: Includes 4 of 5 MCOs.

NC: Population includes only 6-year-olds.

PA: Rate is based on information from multiple health plans. Some plans used administrative claims data. Others used hybrid data including both administrative claims and medical record data.

Table E.4. Percentage of Children who had a Visit with a Primary Care Practitioner, as Reported by States in their FFY 2010 CARTS Reports (N=40)

State	Program Type	Year of Data	Population Included in Measure		Sample Size				Data Source		Percentage of Children who had a Visit with a PCP			
			CHIP	Medicaid (Title XIX)	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
Reported Using HEDIS Methodology (N=38)														
Alabama	S-CHIP	2010	√		646	6,890	9,520	17,072	√		97.5	91.0	93.5	91.4
Alaska	M-CHIP	2009	√	√	3,874	11,770	7,869	12,470	√		95.3	86.4	87.3	85.3
Arizona	S-CHIP	2009	√		1,028	6,663	5,225	5,502	√		93.0	89.0	89.8	88.8
California	COMBO	2010	√		14,168	141,232	133,228	193,641	√		97.9	91.0	90.8	88.0
Connecticut	S-CHIP	NR	√	√	47,395	24,515	9,241	52,448	√		86.7	83.2	94.6	86.9
Dist. Of Col.	M-CHIP	2009	√	√	NR	NR	NR	NR		√	92.4	84.5	90.9	84.8
Florida	COMBO	2010	√		NR	6,625	18,291	32,334	√		NR	90.1	94.3	92.9
Georgia	S-CHIP	2009	√	√	68,245	264,528	161,082	181,235	√		93.7	85.9	86.5	81.9
Illinois	COMBO	2010	√	√	192,326	378,553	363,292	461,625	√		84.1	72.1	78.1	75.1
Indiana	COMBO	2009	√	√	30,753	99,391	56,007	61,620	√		95.6	88.3	89.2	88.9
Iowa	COMBO	2009	NR	NR	48	3,677	2,544	3,659	√		95.8	90.8	93.7	95.0
Kentucky	COMBO	2009	√	√	5,641	20,339	13,270	16,010	√		98.0	90.9	92.3	89.5
Louisiana	COMBO	2010	√		3,042	18,802	30,167	44,572	√		98.6	92.9	93.1	91.1
Maine	COMBO	2010	√		472	3,064	3,201	4,789	√		95.8	85.9	90.5	90.2
Maryland	M-CHIP	2009	√	√	NR	NR	NR	NR	√		96.2	90.9	92.2	89.0
Michigan	COMBO	2009		√	NR	NR	NR	NR	√		96.7	88.8	89.1	87.0
Minnesota	COMBO	2009	√	√	13,937	36,585	18,799	24,058	√		98.6	93.2	93.1	93.1
Mississippi	S-CHIP	2009	√		73	3,450	5,317	9,113	√		97.3	93.1	93.3	90.0
Montana	S-CHIP	2009	√		311	2,410	2,316	8,439	√		93.2	81.7	82.3	85.2
Nevada	S-CHIP	2009	√		259	3,149	1,764	1,565	√		95.8	91.6	93.7	91.0
New Hampshire	COMBO	2009	√		NR	NR	NR	NR	√		100.0	94.4	92.3	94.2
New Jersey	COMBO	2009	√	√	28,875	136,345	112,347	132,664	√		85.7	80.8	84.2	81.2
New Mexico	M-CHIP	2009	√	√	13,166	62,130	42,896	49,802	√		97.9	90.2	93.1	91.8
New York	S-CHIP	2009	√		3,285	45,504	57,758	95,072	√		98.8	96.1	97.7	95.4
North Carolina	COMBO	2009	√		0	358	18,771	28,834	√		NR	76.0	91.5	88.4
North Dakota	COMBO	2009	√		23	151	523	738		√	95.7	80.1	81.8	89.4
Ohio	M-CHIP	2009	√	√	70,429	278,491	207,803	252,832	√		95.6	86.6	87.2	85.2
Oklahoma	COMBO	2009	√	√	19,861	81,393	45,515	46,500	√		96.2	86.9	87.6	85.8
Pennsylvania	S-CHIP	2009	√		1,807	21,692	26,177	47,445	√		96.5	92.2	94.6	94.0
Rhode Island	COMBO	2009	√	√	4,312	16,723	11,186	14,766	√		98.4	95.0	96.5	94.0

Table E.4 *(continued)*

State	Program Type	Year of Data	Population Included in Measure: CHIP	Population Included in Measure: Medicaid (Title XIX)	Sample Size: 12-24 Months	Sample Size: 25 Months to 6 Years	Sample Size: 7-11 Years	Sample Size: 12-19 Years	Data Source: Administrative	Data Source: Hybrid	Percentage of Children who had a Visit with a PCP: 12-24 Months	Percentage: 25 Months to 6 years	Percentage: 7-11 Years	Percentage: 12-19 Years
Reported Using HEDIS Methodology (N=38)														
South Carolina	COMBO	2010	√		911	8,250	9,643	11,833	NR	NR	86.4	75.6	85.4	81.5
South Dakota	COMBO	2009	√		92	1,187	2,460	3,089	√		95.7	86.3	64.3	63.0
Tennessee	COMBO	2009	NR	NR	533	4,757	3,004	4,279	√		98.7	92.5	92.2	88.6
Utah	S-CHIP	2009	√		525	4,785	4,975	5,397	√		97.5	85.8	86.0	87.8
Vermont	S-CHIP	2009	√	√	3,192	13,936	10,772	14,127	√		98.2	93.0	94.1	93.9
Virginia	COMBO	2009	√	√	35,415	129,672	66,775	76,472	√		95.6	89.9	88.3	86.6
West Virginia	S-CHIP	2009	√		58	1,197	2,980	4,409	√		98.3	97.2	91.2	88.3
Wyoming	S-CHIP	2010	√		31	487	1,057	1,047	√		96.8	83.6	67.7	73.6
Reported Using Other Methodology (N=2)														
Nebraska	M-CHI(P	2010	√		Administrative claims data. Nebraska reports percentage of children who are automatically assigned a PCP in managed care.						Other rate: 52.5			
Washington	S-CHIP	2009	√		Source was CAHPS						Other rate: 41.7			

Source: Mathematica analysis of CARTS FFY 2010 reports, as of June 30, 2011. Delaware did not submit a CARTS report for FFY 2010. Arkansas, Hawaii, Idaho, Kansas, Massachusetts, Oregon, and Texas submitted FFY 2010 CARTS Reports, but did not submit data on any of the core CHIPRA quality measures. Colorado, Missouri, and Wisconsin submitted CARTS reports with data for some measures but did not report Measure 14.

NR = Not Reported.

State-Specific Comments:

IL: Providers have up to one year to submit claims. Some claims may not be included in reported data.

KY: Performance rate only includes one region in state, representing about 20 percent of CHIP population.

LA: Denominator includes CHIP population only.

ME: Providers have up to one year to submit claims. Some claims may not be included in reported data. Performance rate includes 11 months of data, due to new data system.

NV: Rates for children ages 7 to 19 excludes one of two MCOs with sample sizes that were too small to report for these age groups.

PA: Includes data from 9 health plans.

Table E.5. Percentage of Children Ages 12-21 Receiving Well-Child Visits, as Reported by States in their FFY 2010 CARTS Reports (N=29)

State	Program Type	Year of Data	Population Included in Measure: CHIP	Population Included in Measure: Medicaid (Title XIX)	Sample Size	Data Source: Administrative	Data Source: Hybrid	Percentage of Adolescents age 12-21, Receiving Well-Child Visits
Reported Using HEDIS Methodology (N=29)								
Alabama	S-CHIP	2010	√		25,579	√		24.2
Alaska	M-CHIP	2009	√	√	17,840	√		29.3
Arizona	S-CHIP	2009	√		NR	√		51.7
California	COMBO	2009	√		269,703	√	√	46.3
Colorado	S-CHIP	2010	√		9,965	√		44.6
Connecticut	S-CHIP	NR	√	√	NR		√	60.1
Dist. Of Col.	M-CHIP	2009	√	√	NR	√		51.1
Florida	COMBO	2209	√		66,923	√		55.8
Georgia	S-CHIP	2009	√	√	250,837	√		28.4
Indiana	COMBO	2009	√	√	1,233		√	49.4
Kentucky	COMBO	2009	√	√	22,795	√		55.8
Louisiana	COMBO	2010	√		48,589	√		47.0
Maine	COMBO	2010	√	√	5,854	√		37.4
Maryland	M-CHIP	2009		√	NR		√	62.6
Michigan	COMBO	2009		√	NR		√	56.3
Mississippi	S-CHIP	2009	√		14,989	√		22.2
Missouri	COMBO	2009	√	√	NR	√		39.3
New Hampshire	COMBO	2009	√		NR	√		60.2
New Jersey	COMBO	2009	√	√	1,661		√	57.5
New Mexico	M-CHIP	2009	√	√	17,635	√		41.3
New York	S-CHIP	2009	√		136,346	√		63.9
Oklahoma	COMBO	2009	√	√	NR	√		40.1
Pennsylvania	S-CHIP	2010	√		16,296	√	√	56.7
Rhode Island	COMBO	2009	√	√	2,811		√	58.5
Tennessee	COMBO	2009	√		9,891	√		31.2
Vermont	S-CHIP	2009	√	√	19,381	√		45.6
Washington	S-CHIP	2009	√	√	2,654		√	36.6
West Virginia	S-CHIP	NR	√		4,409	√		37.2
Wyoming	S-CHIP	2010	√		1,047	√		73.6

Source: Mathematica analysis of FFY 2010 CARTS reports, as of June 30, 2011. Delaware did not submit a CARTS report for FFY 2010. Arkansas, Hawaii, Idaho, Kansas, Massachusetts, Oregon, and Texas submitted FFY 2010 CARTS Reports, but did not submit data on any of the core CHIPRA quality measures. Illinois, Iowa, Minnesota, Montana, Nebraska, Nevada, North Carolina, North Dakota, Ohio, South Carolina, South Dakota, Utah, Virginia, and Wisconsin submitted CARTS reports with data for some measures but did not report Measure 12.

NR = Not Reported.

State-Specific Comments:

AZ: Performance rate includes ages 12-19.

CA: Rate is based on information from multiple Managed Care Organizations (MCOs). Some MCOs used administrative claims data. Others used hybrid data including both administrative claims and medical record data. Some MCOs did not report due to small sample sizes. Performance rate includes ages 12-18.

FL: Performance rate includes ages 12-18.

KY: Only includes one region of the state, representing about 20 percent of CHIP population.

LA: Excludes separate CHIP population.

ME: Providers have up to one year to submit claims. All claims may not be included in reported data. Performance rate includes 11 months of data, due to new data system.

MO: Performance rate is an unweighted averaged across MCOs.

NH: Performance rate includes ages 12-18.

NJ: Performance rate includes 4 of 5 MCOs.

PA: Performance rate is based on information from multiple health plans. Some plans used administrative claims data. Others used hybrid data including both administrative claims and medical record data. Rate includes ages 12-19.

WV: Performance rate includes ages 12-18.

Table E.6. Percentage of Children Age 2 with Up-to-Date Immunizations, as Reported by States in their FFY 2010 CARTS Reports (N=20)

State	Program Type	Year of Data	Population Included in Measure		Sample Size	Data Source		Percentage of Children age 2 who are up-to-date on Immunizations
			CHIP	Medicaid (Title XIX)		Administrative	Hybrid	
Reported Using HEDIS Methodology (N=19)								
Arizona	S-CHIP	2009	√		772		√	88.2
California	COMBO	2009	√		15,837	√	√	77.7
Colorado	S-CHIP	2010	√		791		√	74.6
Dist. Of Col.	M-CHIP	2009	√	√	NR	√		83.5
Georgia	S-CHIP	2009	√	√	50,131	√		34.9
Illinois	COMBO	2010	√	√	NR		√	61.4
Indiana	COMBO	2009	√	√	1,233		√	65.5
Kentucky	COMBO	2009	√	√	452		√	20.8
Maryland	M-CHIP	2009	√	√	NR		√	80.2
Michigan	COMBO	2009	√		NR		√	78.7
Missouri	COMBO	2009	√	√	NR	√		64.3
New Jersey	COMBO	2009	√	√	1,665	√	√	55.7
New Mexico	M-CHIP	2009	√	√	1,322	√		77.5
New York	S-CHIP	2009	√		3,093		√	11.8
Pennsylvania	S-CHIP	2009	√		2,161	√	√	76.4
Rhode Island	COMBO	2009	√	√	1,199		√	80.7
Tennessee	COMBO	2009	√		379	√		35.4
West Virginia	S-CHIP	2009	√		17	√		70.6
Wyoming	S-CHIP	2010	√		146	√		68.5
Reported Using Other Methodology (N=1)								
Mississippi	S-CHIP	2009	√		2,127	Specifications from Mississippi Department of Health. Source is Administrative data.		68.5

Source: Mathematica analysis of FFY 2010 CARTS reports, as of June 30, 2011. Delaware did not submit a CARTS report for FFY 2010. Arkansas, Hawaii, Idaho, Kansas, Massachusetts, Oregon, and Texas submitted FFY 2010 CARTS Reports, but did not submit data on any of the core CHIPRA quality measures. Alabama, Alaska, Connecticut, Florida, Iowa, Louisiana, Maine, Minnesota, Montana, Ohio, Oklahoma, Nebraska, Nevada, New Hampshire, North Carolina, North Dakota, South Carolina, South Dakota, Utah, Vermont, Virginia, Washington, and Wisconsin submitted CARTS reports with data for some measures but did not report Measure 5.

NR = Not Reported.

State-Specific Comments:

CA: Performance rate is based on information from multiple MCOs. Some MCOs used hybrid of administrative claims and medical record data. Some MCOs reported based only on administrative data.

IL: Providers have up to one year to submit claims. All claims may not be included in reported data. IL used state and local immunization tracking systems in addition to claims data. Population includes state-funded group.

KY: Includes one region of state, representing about 20 percent of CHIP population.

MO: Performance rate is unweighted average across all MCOs.

NJ: Performance rate is based on information from multiple MCOs. Some MCOs used hybrid of administrative claims and medical record data. Some MCOs reported based only on administrative data.

PA: Performance rate is based on information from multiple health plans. Some plans used hybrid of administrative claims and medical record data. Some plans reported based only on administrative data.

Appendix F: External Quality Review Organizations with State Medicaid Contracts in 2010

EQRO Name	STATES
Acumentra	OR, WA
APS Healthcare	MA
Behavioral Health Concepts (BHC)	MO
Burns & Associates	IN
Delmarva Foundation for Medical Care	DC, MD, VA, WV
HCE Quality Quest	UT
Health Services Advisory Group (HSAG)	AZ, CA, CO, FL, GA, HI, IL, MI, NV, OH, VT
Institute for Child Health Policy (ICHP)	TX
Iowa Foundation for Medical Care	IA
IPRO	KY, NE, NY, PA, RI
Kansas Foundation for Medical Care	KS
Medical Review of North Carolina	NC
Mercer	CT, DE
MetStar, Inc.	WI
MPRO	MN, NJ
New Mexico Medical Review Association	NM
Quality Improvement Professional Research Organization	PR
QSOURCE	TN
The Carolinas Center for Medical Excellence	NC, SC

Appendix G: Findings from External Quality Review Organizations' Validation Studies 2009 Data

State	State Specified Performance Measures	Findings & Follow-up	Performance Improvement Projects	Validation Issues
AL	1) % of Low Birth Weight Infants 2) % of Very Low Birth Weight Infants (VLBWI) 3) % of VLBWI born at Facilities with a NICU	NONE	This is a PIHP for pregnant women. While it has PMs and PIPs for obstetrics, it has no pediatric ones.	NONE
AK	*Not required*			
AZ	1) Adolescent Well-Care Visits 2) Annual Dental Visits – 2-21 years 3) Children's Access to Primary Care Practitioners (PCPs) (total) 4) Children's Access to PCPs (12-24 months) 5) Children's Access to PCPs (25 months – 6 years) 6) Children's Access to PCPs (7-11 years) 7) Children's Access to PCPs (12-19 years) 8) Well-Child Visits in the First 15 Months of Life 9) Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life 10) Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Participation	41.6% 60.9% 80.8% 85.0% 81.6% 78.4% 80.0% 59.5% 66.2% 76.0%	New PIP based on Adolescent Well-Care Visits (focused on increasing the rate of annual well-care visits among members 12-21 years of age and reducing any disparities in preventive care visits between non-Hispanic White members and members from other races or with other ethnicities). Baseline average rate was 36.3%.	NONE

State	State Specified Performance Measures	Findings & Follow-up	Performance Improvement Projects	Validation Issues
	11) Chlamydia Screening in Women Ages 16-24 (*measure not stratified by age*)	39.9%		
AR	*Not required*			
CA	1) Adolescent Well-Care Visits 2) Appropriate Treatment for Children with Upper Respiratory Infection (URI) 3) Childhood Immunization Status (Combo 3) 4) Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index (BMI) Assessment 5) Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Nutrition Counseling 6) Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Physical Activity Counseling 7) Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life 8) Appropriate Testing for Children with Pharyngitis (*this measure is only used by one Prepaid Health Plan*)	45.1% 87.1% 74.5% 56.8% 63.6% 47.9% 76.2% 80.0%	1) Reducing Avoidable Emergency Room Visits by Members 1 year of age and older (Statewide Collaborative) 2) Appropriate Treatment for Children with Upper Respiratory Infection (Small Group Collaborative) 3) Decrease Return Emergency Room Visits for Asthmatic Exacerbations in Children (plan specific) 4) Weight Assessment and Counseling for Nutrition and Physical Activity for Children & Adults (plan specific) 5) Reducing Health Disparities in Pediatric Obesity (plan specific) 6) Attention Deficit Hyperactivity Disorder (ADHD) Management (plan specific) 7) Adolescent Obesity Prevention (plan specific)	Of the 7 QIPs validated, 1 received an overall Partially Met validation status, and 1 received an overall Not Met validation status. QIPs with a Not Met or Partially Met validation status must be resubmitted. A resubmission is a plan's update of a previously submitted QIP with additional documentation.
CT	1) Appropriate Treatment for Children with URI 2) Access to PCP 12-24 months 3) Access to PCP 25-months to six years	93% 94% 89.5%	1) Well Child Visits 1st 15 Months (6 or more) 2) Adolescent Well Care Visits 3) Well Child 3-6	NONE

State	State Specified Performance Measures	Findings & Follow-up	Performance Improvement Projects	Validation Issues
	4) Access to PCP 7-11 years 5) Access to PCP 12-19 years 6) Well-Child Visits in the First 15 Months of Life 7) Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life 8) Adolescent Well-Care Visits	94.6% 93.1% 74.9% 77% 60%	4) NICU days as a percentage of total newborn days	
DE	*NONE specific to children*	N/A	Low Birth Weight Infants reduced to 10% from 10.6% in one year	NONE
FL	1) Annual Dental Visit 2)Adolescent Well-Care 3)Well-Child-(first 15 Months-6-visits 4) Well-Child 3-6 yrs. 5) Immunization-Combo 2 6) Immunization –Combo 3 7) Lead Screening 8) F/U ADHD Med-Initiation 9) F/U ADHD MED- Continuation	Non-Reform/ Reform N/A/ 33.4% 45.7%/46.3% 46.1%/35.4% 74.9%/72.7% 71.4%/70% 63.7%/62.7% 53.1%/52% 37.8%/43.6% 46.6%/N/A	1) Well Child Birth to 15 Months of Life, 6 or more visits - collaborative 2) Childhood Immunizations 3) Lead Screening in Children 4) Child Health Check Up: 2-20 years 5) Improving the Management of Pediatric Asthma 6) Prenatal Care 7) Improving the rate of Child and Adolescent Dental Care 8) Improve the rate of HbA1c among Children and Adolescents with Diabetes	PMs have validity issues due to small sample size PIPs: Initial submission year, validated through Activity IV, but this year, as Activities V-X commenced, there have been validation issues.
GA	1) 6 or more Well-Child Visits in the First 15 Months of Life (H)	MCO A – 55.04% MCO B – 52.31% MCO C – 57.42%	1) Improving Childhood Lead Screening Rates	NONE

State	State Specified Performance Measures	Findings & Follow-up	Performance Improvement Projects	Validation Issues
	2) Well Child Visits (3-6 yrs) (H)	MCO A – 64.05% MCO B – 63.75% MCO C – 58.88%	2) Improving Well-Child Visits in the First 15 Months of Life (collaborative) 3) Improving Childhood Immunization Rates	
	3) Adolescent well-care visits (12-21 yrs) (H)	MCO A – 40.51% MCO B – 37.23% MCO C – 32.85%		
	4) Lead Screening in Children (H)	MCO A – 67.82% MCO B – 62.29% MCO C – 67.40%		
	5) Child- Access to Care ♦ 12-24 mos.	MCO A – 96.26% MCO B – 95.79% MCO C – 96.72%		
	♦ 25 mos.-6yrs.	MCO A – 91.65% MCO B – 90.59% MCO C – 91.39%		
	♦ 7-11 yrs.	MCO A – 92.86% MCO B – 90.45% MCO C – 91.16%		
	♦ 12-19 yrs.	MCO A – 89.72% MCO B – 87.12% MCO C – 88.31%		
	6) Childhood Immunization Status (Combo 2) (H)	MCO A – 71.99% MCO B – 67.64% MCO C – 81.02%		
	7) Child Annual Dental Visit (2-21 yrs)	MCO A – 66.73% MCO B – 60.15% MCO C – 65.21%		

State	State Specified Performance Measures	Findings & Follow-up	Performance Improvement Projects	Validation Issues
	8) Weight Assessment (3 -17 yrs) ♦ BMI (H)	MCO A – 13.72% MCO B – 32.12% MCO C – 36.50%		
	♦ Counseling for Nutrition (H)	MCO A – 40.70% MCO B – 36.74% MCO C – 42.34%		
	♦ Counseling for Physical Activity (H)	MCO A – 35.58% MCO B – 28.22% MCO C – 38.69%		
	9) Follow-up for ADHD medication (6-12 yrs) ♦ Initiation	MCO A – 37.63% MCO B – 46.99% MCO C – 43.34%		
	♦ Continuation	MCO A – 50.70% MCO B – 57.33% MCO C – 51.43%		
	10) Follow-up After Hospitalization for Mental Illness (≥6 yrs) ♦ 7 days	MCO A – 48.58% MCO B – 59.62% MCO C – 52.80%		
	♦ 30 days	MCO A – 71.63% MCO B – 74.88% MCO C – 73.19%		
	11) Use of appropriate medications for Asthma (5-11 yrs)	MCO A – 92.89% MCO B – 91.82% MCO C – 91.76%		
	12) Appropriate treatment for Children with upper respiratory infection	MCO A – 78.65% MCO B – 79.13% MCO C – 77.90%		
	13) Asthma admission rate/ 100,000 (2-17 yrs)	MCO A – 68.43%		

State	State Specified Performance Measures	Findings & Follow-up	Performance Improvement Projects	Validation Issues
	   14) Diabetes Short Term Complications rate/100,000 (6-17 yrs)	MCO B –136.89% MCO C –104.73% MCO A – 14.02% MCO B – 34.58% MCO C – 28.59%		
HI	1) Childhood Immunization Status (Combo 2) 2) Childhood Immunization Status (Combo 3) 3) Emergency Department Use <1 Year of Age 4) Emergency Department Use Ages 1-9 5) Emergency Department Use Ages 10-19 6) Chlamydia Screening in Women 16-20 Years	MCO A - 53.5% MCO B – 67.2% MCO C – 88.6% MCO A – 50.9% MCO B – 57.9% MCO C – 86.6% MCO A –98.7% MCO B –72.3% MCO C –49.4% MCO D –78.5% MCO E –69.0% MCO A –41.4% MCO B –36.0% MCO C –24.9% MCO D –66.0% MCO E –66.0% MCO A –30.2% MCO B –26.2% MCO C –18.7% MCO D –35.6% MCO E–46.2% MCO A –52.4% MCO B –50.7% MCO C –72.6%	1) Assessment of BMI or Height and Weight Using EPSDT Form 2) Children's and Adolescents' Access to Primary Care 3) Well-Child Visits in the First 15 Months of Life 4) Assessing the Documentation of BMI 5) Improving Care for Members with Obesity 6) Access to Care 7) Diabetes Care 8) Improving Comprehensive Diabetes Care	Childhood immunization rates for two MCOs were not available due to small denominators

State	State Specified Performance Measures	Findings & Follow-up	Performance Improvement Projects	Validation Issues
		MCO D –31.3% MCO E –26.4%		
ID	*Not required*			
IL	1) Childhood Immunization Status (Combo #2) 2) Childhood Immunization Status (Combo #3) 3) Well-Child Visits in the First 15 Months of life(0) 4) Well-Child Visits in the first 15 mos. Of life(6) 5) Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life 6) Adolescent Well-Care Visits 7) Lead Screening 8) Children's access to PCPs-12-24 months 9) Children's access to PCPs-(25 months-six years) 10) Children's access to PCPs (7-11 years) 11) Adolescent access to PCPs 12) Appropriate medication for asthma-(5-9) 13) Appropriate medication for asthma (10-17)	67.5% 59% 42% 6.3% 70.6% 37.3% 69.7% 82.8% 69.8% 59.3% 59.2% 87.8% 87.2%	EPSDT Screening (validation report shows 13 of 13 elements met for 2 MCOs)	NONE

State	State Specified Performance Measures	Findings & Follow-up	Performance Improvement Projects	Validation Issues
IN	*NONE specific to children* (State has some data on children elsewhere but not in the EQR)	NONE	Lead screening in children; Follow-up care for children prescribed ADHD medication, initiation phase; Adolescent well care visits	NONE
IA	Iowa's managed care program is available to those who need mental health and substance abuse services *NONE specific to children*	NONE	*NONE specific to children*	NONE
KY	1) % of children and adolescents who saw a PCP and received and assessment/counseling for physical activity 2) % of children and adolescents who saw a PCP and received a nutritional assessment /counseling referral 3) % of children and adolescents whose medical records contain weight and height 4) % of children who received an anemia screening between 8-13 mos. of age 5) % of children identified with anemia who received counseling or treatment/referral 6) Lead screening in children before 2 yrs 7) Well-Child Visits in the First 15 Months of Life 8) Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life 9) Adolescent Well-Care Visits 10) Childhood Immunization Status (Combo # 2)	42.18% 67.40% 80.10% 70.59% 61.36% 77.70% 70.10% 72.89% 52.03% 83.85%	EPSDT Screening	NONE
LA	*Not required*			

State	State Specified Performance Measures	Findings & Follow-up	Performance Improvement Projects	Validation Issues
ME	*Not required*			
MD	1) Childhood Immunization Status (Combo #2)	80.2%	*NONE specific to children*	NONE
	2) Childhood Immunization Status (Combo #3)	76%		
	3) Well-Child Visits in the First 15 Months of Life (zero visits)	2%		
	4) Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	81.8%		
	5) Adolescent Well-Care Visits	62.6%		
	6) Appropriate Testing for Children with Pharyngitis	71.1%		
	7) Appropriate Treatment for Children with URI	85.3%		
	8) Children and Adolescents' Access to PCP	96.2%		
	9) Appropriate medication for asthma-5-9	91.2%		
	10) Access to primary care- 12-24 months	96.2%		
	11) Access to Primary Care-25 months to 6 years	90.9%		
	12) Access to Primary Care-7-11	92.2%		
	13) Access to Primary Care- 12-19 years	89%		

State	State Specified Performance Measures	Findings & Follow-up	Performance Improvement Projects	Validation Issues
MA	1) Appropriate Treatment for Children with URI 2) Childhood Immunization Status (Combo 2) 3) Childhood Immunization Status (Combo 3) 4) Well-Child Visits in the First 15 Months of Life 5) Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life 6) Adolescent Well-Care Visits 7) Use of Appropriate Medications for People with Asthma (ages 5-11 years) 8) 7 Day Follow-up After Hospitalization for Mental Illness (age range 6+ years) 9) 30 Day Follow-up After Hospitalization for Mental Illness (age range 6+ years)	92.6% 82.7% 79.2% 85.5% 88.6% 66.7% 94.7% 58.3% 78.3%	Increasing Well Child Visits Three of the four plans that engaged in the well-child visit project provided evidence of improvement for the well-child project; however, such improvement was not statistically significant across all the well-child measures.	The EQRO confirmed the methods and techniques for calculating performance measures for five plans. The EQRO was able to confirm the appropriate methods and implementation for three of the four plans conducting the well-child PIP. The fourth plan had a opportunities to improve indicator definitions, analysis plans and the examination of barriers to implementation.
MI	1) Childhood Immunization Status (Combo 2) 2) Childhood Immunization Status (Combo 3) 3) Lead Screening	78.7% 74% 76.5%	*NONE specific to children*	NONE

State	State Specified Performance Measures	Findings & Follow-up	Performance Improvement Projects	Validation Issues
	4) Well-Child Visits in the First 15 Months of Life 5) Adolescent Well-Care Visits 6) Appropriate Treatment for Children with URI 7) Appropriate Testing for Children w/ Pharyngitis 8) Use of Appropriate Medication for Children w/ Asthma 5-11 9) Children's Access to PCP- 24 mos to 6 yrs 10) Adolescent Access to PCP- 12 to 19 yrs	69.5% 56.3% 82.3% 51.9% 90.4% 96.7% 87%		
MN	1) Adolescent Well-Care Visits 2) Childhood Immunization Status (Combo 2) 3) Childhood Immunization Status (Combo 4) Well-Child Visits in the First 15 Months of Life 5) Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life 6) Children Primary Care Practitioners Visits 12 – 24 months 25 months – 6 years 7 – 11 years 12 – 19 years	36.9% 67.5% 64.3% 52.8% 65.6% 98.6% 93.2% 93.1% 93.1%	1) Improving rates of HPV immunization (Ages 11-12) 2) Improving Asthma Management and Treatment in HealthPartners' PMAP Population (Ages 5 – 17) 3) Interventions to Improve Blood Lead Screening at 24 Months Lead Screening (Age 24 Months)	NONE
MS	*Not required*			

State	State Specified Performance Measures	Findings & Follow-up	Performance Improvement Projects	Validation Issues
MO	1) Annual Dental Visit 2) Adolescent Well-Care Visits	35.05% 35.63%	1) Improving Adolescent Well Care 2) Improving Dental Health Screening Rates 3) Lead Screening	One health plan failed to define the population or provide narrative on how the study methodology would capture the population for its PIP
MT	*Not required*			
NE	1) Adolescent BMI 2) Adolescent Counseling for Nutrition 3) Adolescent Counseling for Physical Activity 4) Adolescent Immunization (Combo 1) 5) Child Immunization Status (Combo 2) 6) Childhood Immunization Status (Combo 3) 7) Well-Child Visits in the First 15 Months of Life 8) Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life 9) Adolescent Well-Care Visits 10) Access to PCP – 12-24 months 11) Access to PCP – 2-6 years 12) Access to PCP – 7-11 years 13) Access to PCP – 12-19 years	13.14% 32.60% 31.39% 61.10% 75.43% 68.37% 56.84% 66.33% 47.84% 98.49% 90.71% 89.54% 91.98%	1) Well Child Visits during the First 15 Months of Life 2) Childhood Immunizations Combo 2 and 3	NONE

State	State Specified Performance Measures	Findings & Follow-up	Performance Improvement Projects	Validation Issues
NV	1) Childhood Immunization Status (Combo 2) 2) Childhood Immunization Status (Combo 3) 3) Lead Screening in Children 4) Children's & Adolescents' Access to PCPs (12 – 24 months) 5) Children's & Adolescents' Access to PCPs (25 months – 6 years) 6) Children's & Adolescent's Access to PCPs (7-11 years) 7) Children's & Adolescent's Access to PCPs (12-19 years) 8) Well-Child Visits in the First 15 Months of Life 9) Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life 10) Adolescent Well-Care Visits 11) Annual Dental Visit – Combined Rate 12) Use of Appropriate Medications for People with Asthma (5-11 years)	65.3% 58.0% 23.4% 93.1% 82.8% 82.9% 81.0% 47.0% 57.4% 34.1% 53.7% 91.5%	1) Improving Childhood Immunization Rates 2) Lead Screening in Children	NONE
NH	*Not required for Medicaid* Required for CHIP – CHIP EQR not started yet			
NJ	1) Childhood Immunization Status (Combo 2) 2) Childhood Immunization Status (Combo 3) 3) Well-Child Visits in the First 15 Months of Life	74.62% 64.41% 66.76%	1) Annual Dental Visit-met 2) Age appropriate EPSDT visits-met	NONE

State	State Specified Performance Measures	Findings & Follow-up	Performance Improvement Projects	Validation Issues
	4) Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life 5) Adolescent Well-Care Visits 6) Annual Dental Visit 7) Lead screening	77.99% 59.25% 48% 77.43%		
NM	1) Annual Preventive Dental Visit (Combined Ages 2-21 years) 2) Annual Preventive Dental Visit (Ages 4-6 years) 3) Annual Preventive Dental Visit (Ages 7-10 years) 4) Annual Preventive Dental Visit (Ages 11-14 years) 5) Annual Preventive Dental Visit (Ages 15-18 years) 6) Annual Preventive Dental Visit (Ages 19-21 years) 7) Well-Child Visits in the First 15 Months of Life	MCO A – 66% MCO B – 60% MCO C – 66% MCO A – 73% MCO B – 64% MCO C – 72% MCO A – 77% MCO B – 69% MCO C – 77% MCO A – 71% MCO B – 65% MCO C – 70% MCO A – 58% MCO B – 54% MCO C – 57% MCO A – 38% MCO B – 33% MCO C – 38% MCO A – 55% MCO B – 63% MCO C – 59%	1) Annual Preventive Dental Visits 2) Childhood Immunization Status 3) Use of Appropriate Medications for People with Asthma (Ages 5-9 years) 4) Individuals with Special Health Care Needs Outpatient Follow-up (included adolescents ages 17 to 20 who have received residential or inpatient services with the last six months)	Rates for a fourth MCO were not available due to a small sample size

State	State Specified Performance Measures	Findings & Follow-up	Performance Improvement Projects	Validation Issues
	8) Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	MCO A – 72% MCO B – 68% MCO C – 69%		
	9) Access to PCP 12-24 months	MCO A – 98% MCO B – 98% MCO C – 98%		
	10) Access to PCP 25-months to six years	MCO A – 90% MCO B – 90% MCO C – 90%		
	11) Access to PCP 7-11 years	MCO A – 93% MCO B – 93% MCO C – 93%		
	12) Access to PCP 12-19 years	MCO A – 92% MCO B – 92% MCO C– 91%		
	13) Childhood Immunization Status (Combo 2)	MCO A – 82% MCO B – 78% MCO C – 74%		
	14) Use of Appropriate Medications for People with Asthma Ages 5-9 Years	MCO A – 95% MCO B – 90% MCO C – 92%		
	15) Use of Appropriate Medications for People with Asthma Ages 10-17 Years	MCO A – 90% MCO B – 84% MCO C – 87%		
NY	1) Annual Dental Visit 2) Access to PCP 12-24 months	48% 95%	All plans were compliant with conducting Performance Improvement Projects; & plans participated in a learning collaborative to	NONE

State	State Specified Performance Measures	Findings & Follow-up	Performance Improvement Projects	Validation Issues
	3) Access to PCP 25-months to six years 4) Access to PCP 7-11 years 5) Access to PCP 12-19 years 6) Follow-up for ADHD Medication- Initiation 7) Follow-up for ADHD Medication- Continuation	91% 94% 90% 54% 61%	improve ADHD diagnosis and follow-up. Other plan topics included adolescent care, depression, lead, women's health and satisfaction.	
NC	*NONE specific to children* NC has only 1 PIHP that does MH/SA and MRDD only	No separate child measures	*NONE specific to children*	NONE
ND	*Not required for Medicaid* Required for CHIP – CHIP EQR not started yet			
OH	1) Childhood Immunization Status (Combo 3) 2) Well-Child Visits in the First 15 Months of Life	62.5% 51%	1) Identifying Children with special health needs- met 2) Well Child Visits -15 mos.-met 3) Annual Dental Visit-met	NONE
OK	*Not required*			
OR	*2010 Physical Health EQRO Report not available at the time*		*2010 Physical Health EQRO Report not*	

State	State Specified Performance Measures	Findings & Follow-up	Performance Improvement Projects	Validation Issues
	of publication No applicable 2010 Mental Health PMs		*available at the time of publication* 2010 Mental Health PIPs include: 1) Community-Based Crisis Intervention, which seeks to expand community-based assessment and interventions for children and adolescents in order to divert acute care admissions and reduce overall utilization of institutionalized care. 2) Increasing the number of children in child welfare custody who access mental health services 3) Assuring Better Child Health and Development (ABCD III) Program, which aims to improve identification and referral of Medicaid children with behavioral, developmental, and emotional delays and impairments	
PA	1) Access to PCP (12-19) 2) Well-Child Visits in the First 15 Months of Life 3) Childhood Immunization Status (Combo 3) 4) Adolescent Well-Care Visits 5) Annual BMI (12-17) 6) Lead Screening 7) Annual Dental Visits 8) Appropriate Testing for Children with Pharyngitis	88.1% 62.3% 70.3% 59.6% 44.1% 72.2% 49.5% 61.6%	Increasing Dental Utilization for children Coordination between PH/BH services for members under the age of 18 on BH medication	NONE

State	State Specified Performance Measures	Findings & Follow-up	Performance Improvement Projects	Validation Issues
	9) Appropriate Treatment for Children with URI 10) Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	85.4% 75.7%		
RI	1) Childhood Immunization Status (Combo 3) 2) Children's access to PCPs-(12-19) 3) Follow-up care for children on ADHD meds 4) Well-Child Visits in the First 15 Months of Life 5) Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life 6) Adolescent Well-Care Visits 7) Children's access to PCPs 12-24 months 8) Children's access to PCPs 25 months-six years 9) Children's access to PCPs (7-11)	77% 92% 46% 84% 81% 60% 99% 93% 95% Other finding: Overall performance very good	1) Asthma Management 2) Childhood Immunization	NONE
SC	All HEDIS® measures collected.	HEDIS® measures done and valid, but data not reported	Pediatric Preventive Health Screening-age3-6	NONE
SD	*Not required*			
TN	1) Childhood Imm. Status) CIS)-DPT 2) CIS-IPV	81.52% 91.22%	*NONE specific to children*	NONE

State	State Specified Performance Measures	Findings & Follow-up	Performance Improvement Projects	Validation Issues
	3) CIS-MMR 4) CIS-HiB 5) CIS-HepB 6)CIS-VZV 7) CIS-Pneumococcal 8) CIS-combo2 9)CIS-combo3 10) Chlamydia 16-20 11) Pharyngitis-proper testing 12) URI-proper treatment 13) Proper Asthma Meds 5-9 14)Proper Asthma Med 10-17 15) Access to PCP-12-24 mos 16) Access to PCP 25mo-6yrs 17) Access to PCP 7-11 yrs. 18) Access to PCP 12-19 yrs. 19) Well-Child 15mos. 20) Well Child 3-6 yrs. 21) Adolescent Well-Care	92.15% 95.97% 91.26% 91.97% 81.05% 77.17% 72.6% 47.49% 69.52% 75.06% 96.76% 93.29% 95.18% 85.93% 86.13% 80.95% 46.61% 60.79% 35.77% 59.76%		

State	State Specified Performance Measures	Findings & Follow-up	Performance Improvement Projects	Validation Issues
	22) Lead-Screening 23) ADHD F/U Initiation 24) ADHD F/U Maintenance 25) D/A Tx-Initiation 26) D/A Tx- Engagement 27) BMI 3-11 28) BMI 12-17 29) Nutrition 3-11 30) Nutrition 12-17 31) Physical Activity 3-11 32) Physical activity 12-17	36.4% 72.48% 56.4% 40.0% 10.5% 14.67% 40.83% 36.25% 23.41% 27.11%		
TX	2010 EQRO Report not available at the time of publication (*Annual Summary being revised to provide a trending analysis of data years)*			
UT	1) Percentage of Members 12 to 24 Months who had a visit with an MCO PCP 2) Percentage of Members 7 to 11 Years who had a visit with an MCO PCP 3) Percentage of Members 12 to 19 Years who had a visit with an MCO PCP 4) Childhood Immunization Status (Combo 2)	98.41% 91.22% 91.54% 78.47%	Improving Coordination of Care for members with ADHD/ADD	Regarding the PIP- did not fully meet the criteria of an unambiguously defined study population because it could not ensure that the lists of enrollees included in the study were accurate and

State	State Specified Performance Measures	Findings & Follow-up	Performance Improvement Projects	Validation Issues
	5) Percentage of members 12-21 Years of age and who had at least one comprehensive well-care visit with a PCP or an OB/GYN during the measurement year 6) Percentage of members ages 3-6 who received one or more well-child visit with a PCP during the measurement year 7) Percentage of members who turned 15 months old during the measurement year and who had 6 or more well-child visits with a PCP during their first 15 months of life 8) Percentage of members 2-18 who were diagnosed with Pharyngitis, dispensed an antibiotic and received a group A streptococcus test for the episode 9) Percentage of members ages 3 months to 18 years who were given a diagnosis of URI and were not dispensed an antibiotic prescription on or three days after the Episode date 10) Percentage of members 5-11 during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year	1.16% 69.44% 62.04% 75.81% 92.09% 96.20%		complete, or if it consistently applied the criteria used to produce the lists of enrollees with ADHD/ADD between measurements
VT	1) Well-Child Visits in the First 15 Months of Life 2) Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life 3) Annual Dental Visits 4) Children's Access to PCP- (12-24 mos.) 5) Adolescent Well-Care Visits 6) Lead-Screening	31.6% 70.6% 68.4% 98.2% 45.6% 63.7%	Early Identification of children's health needs- met goal	NONE
VA	1) Childhood Immunization Status (Combo 3)	71.48%	1) Well-Child visits	NONE

State	State Specified Performance Measures	Findings & Follow-up	Performance Improvement Projects	Validation Issues
	2) Well-Child Visits in the First 15 Months of Life 3) Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life 4) Adolescent Well-Care Visits 5) Lead Screening 6) Appropriate use asthma meds-children	65.2% 71.2% 44.5% 56.6% 91.8%	2) Asthma management 3) Children and adolescent access to primary care	
WA	1) Adolescent Well-Care Visits 2) Childhood Immunization Status (Combo 2) 3) Childhood Immunization Status (Combo 3) 4) Well-Child Visits in the First 15 Months of Life 5) Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	36.62% 76.72% 71.610% 59.95% 62.15%	Current contract requires each MCO to conduct at least one clinical and one nonclinical PIP. An MCO must conduct a PIP to improve immunization and/or well-child care rates if the MCO's rates fall below established benchmarks.	NONE
WV	1) Childhood Immunization Status (Combo #2) 2) Childhood Immunization Status Combo 3 3) Access to PCP- (12-24 mos) 4) Well-Child Visits in the First 15 Months of Life 5) Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	62.2% 55.2 % 97.7% 62.7% 72.4%		NONE

State	State Specified Performance Measures	Findings & Follow-up	Performance Improvement Projects	Validation Issues
	6) Adolescent Well-Care Visits 7) Lead Screening 8) Weight Assessment for children and adolescents	41.6% 51.5% 13.9%		
WI	1) Childhood immunization status 2) Lead screening in one year olds 3) Lead screening in two year olds 4) Appropriate testing for children with pharyngitis 5) Appropriate Treatment for Children with URI 6) Appropriate medication for children with asthma 7) Follow-up care children prescribed ADHD medication 8) Seven and thirty day follow-up after hospitalization for mental illness 9) Annual monitoring for patients on persistent medications 10) Annual dental visits 11) Mental health utilization 12) Tobacco cessation 13) Identification of Alcohol and Other Drug Abuse Services	No state measures data reported Specific EQRO review comments included: -2 MCOs still lack encryption of email	1) Immunizations by age 2 – Five of 16 HMOs conducted PIPs on this topic. Four of the 5 PIPs were required by WI DHS. 2. Blood lead level screening 1 and 2 yr. olds Fourteen of 16 HMOs conducted PIPs on this topic with 9 of the 14 required by WI DHS. The State assigned stretch goals for the required PIPs for 2009 based on CY 2007 performance in the immunization (10% relative improvement) and blood lead level testing (15% relative improvement). *EQRO PIP validation conclusions from the 2010 EQRO Technical Report (6/21/10)*: The HMOs overall understanding of the PIP process and their ability to document their efforts to improve the identified outcomes has progressed. The HMOs in general continue to struggle with determining the correct data to collect to validate improvement, purposeful analysis of the collected data and how to create an ongoing plan to monitor for continued or sustained improvement.	Recommendations included: The State and its vendor, HP should continue assessment of documentation and ongoing improvements to ensure consistency. Conduct an ISCA of the encounter reporting and eligibility/enrollment systems to verify accuracy of processes and maintain data integrity. Formalize a process to compare measurement rates calculated by HP and the HP to support CY 2011 options for measure calculation and reporting.

State	State Specified Performance Measures	Findings & Follow-up	Performance Improvement Projects	Validation Issues
WY	*Not required for Medicaid* Required for CHIP – CHIP EQR not started yet			

Notes:

*****In Hawaii, no state average was available for the performance measures. MCO A is AlohaCare, MCO B is HMSA, MCO C is Kaiser, MCO D is Evercare, and MCO E is Ohana.

******In Kansas, no state average was available for the collected performance measures. MCO A is Children's Mercy Family Health Partners and MCO B is UniCare Health Plan of Kansas.

Appendix H: TITLE IV - STRENGTHENING QUALITY OF CARE AND HEALTH OUTCOMES

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

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

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

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

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

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

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

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

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

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

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

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

(4) ENCOURAGE VOLUNTARY AND STANDARDIZED REPORTING.—Not later than 2 years after the date of enactment of the Children‘s Health Insurance Program Reauthorization Act of 2009, the Secretary, in consultation with States, shall develop a standardized format for reporting information and procedures and approaches that encourage States to use the initial core measurement set to voluntarily report information regarding the quality of pediatric health care under titles XIX and XXI.

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) ADVANCING AND IMPROVING PEDIATRIC QUALITY MEASURES.—

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

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

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

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

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

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

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

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

(D) periodically updated; and

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

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

(A) States;

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

(C) dental professionals, including pediatric dental professionals;

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

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

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

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

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

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

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

(B) award grants and contracts for—

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

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

(iii) the updating of such measures as necessary.

(5) REVISING, STRENGTHENING, AND IMPROVING INITIAL CORE MEASURES.— Beginning no later than January 1, 2013, and annually thereafter, the Secretary shall publish recommended changes to the core measures described in subsection (a) that shall reflect the testing, validation, and consensus process for the development of pediatric quality measures described in subsection paragraphs (1) through (4).
(6) DEFINITION OF PEDIATRIC QUALITY MEASURE. — In this subsection, the term ‗pediatric quality measure' means a measurement of clinical care that is capable of being examined through the collection and analysis of relevant information, that is developed in order to assess 1 or more aspects of pediatric health care quality in various institutional and ambulatory health care settings, including the structure of the clinical care system, the process of care, the outcome of care, or patient experiences in care.
(7) CONSTRUCTION.—Nothing in this section shall be construed as supporting the restriction of coverage, under title XIX or XXI or otherwise, to only those services that are evidence- based.

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

(1) ANNUAL STATE REPORTS.—Each State with a State plan approved under title XIX or a State child health plan approved under title XXI shall annually report to the Secretary on the—
(A) State-specific child health quality measures applied by the States under such plans, including measures described in subparagraphs (A) and (B) of subsection (a)(6); and
(B) State-specific information on the quality of health care furnished to children under such plans, including information collected through external quality reviews of managed care organizations under section 1932 of the Social Security Act (42 U.S.C. 1396u–4) and benchmark plans under sections 1937 and 2103 of such Act (42 U.S.C. 1396u–7, 1397cc).
(2) PUBLICATION.—Not later than September 30, 2010, and annually thereafter, the Secretary shall collect, analyze, and make publicly available the information reported by States under paragraph (1).

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

(1) IN GENERAL. During the period of fiscal years 2009 through 2013, the Secretary shall award not more than 10 grants to States and child health providers to conduct demonstration projects to evaluate promising ideas for improving the quality of children's health care provided under title XIX or XXI, including projects to—
(A) experiment with, and evaluate the use of, new measures of the quality of children's health care under such titles (including testing the validity and suitability for reporting of such measures);
(B) promote the use of health information technology in care delivery for children under such titles;
(C) evaluate provider-based models which improve the delivery of children's health care services under such titles, including care management for children with chronic conditions and the use of evidence-based approaches to improve the effectiveness, safety, and efficiency of health care services for children; or
(D) demonstrate the impact of the model electronic health record format for children developed and disseminated under subsection (f) on improving pediatric health,including the effects of chronic childhood health conditions, and pediatric health care quality as well as reducing health care costs.
(2) REQUIREMENTS.—In awarding grants under this subsection, the Secretary shall ensure that—
(A) only 1 demonstration project funded under a grant awarded under this subsection shall be conducted in a State; and
(B) demonstration projects funded under grants awarded under this subsection shall be conducted evenly between States with large urban areas and States with large rural areas.
(3) AUTHORITY FOR MULTISTATE PROJECTS.—A demonstration project conducted with a grant awarded under this subsection may be conducted on a multistate basis, as needed.
(4) FUNDING.—$20,000,000 of the amount appropriated under subsection (i) for a fiscal year shall be used to carry out this subsection.

(e) CHILDHOOD OBESITY DEMONSTRATION PROJECT.

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

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

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

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

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

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

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

(B) A local or tribal educational agency.

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

(D) A federally-qualified health center.

(E) A local health department.

(F) A health care provider.

(G) A community-based organization.

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

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

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

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

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

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

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

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

(I) after hours physical activity programs; and

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

(ii) providing education and training to educational professionals regarding how to promote a healthy lifestyle and a healthy school environment for children;

(iii) planning and implementing a healthy lifestyle curriculum or program with an emphasis on healthy eating behaviors and physical activity; and

(iv) planning and implementing healthy lifestyle classes or programs for parents or guardians, with an emphasis on healthy eating behaviors and physical activity for children;

(C) carry out educational, counseling, promotional, and training activities through the local health care delivery systems including by—

(i) promoting healthy eating behaviors and physical activity services to treat or prevent eating disorders, being overweight, and obesity;

(ii) providing patient education and counseling to increase physical activity and promote healthy eating behaviors;

(iii) training health professionals on how to identify and treat obese and overweight individuals which may include nutrition and physical activity counseling; and

(iv) providing community education by a health professional on good nutrition and physical activity to develop a better understanding of the relationship between diet, physical activity, and eating disorders, obesity, or being overweight; and

(D) provide, through qualified health professionals, training and supervision for community health workers to—

(i) educate families regarding the relationship between nutrition, eating habits, physical activity, and obesity;

(ii) educate families about effective strategies to improve nutrition, establish healthy eating patterns, and establish appropriate levels of physical activity; and

(iii) educate and guide parents regarding the ability to model and communicate positive health behaviors.

(4) PRIORITY.—In awarding grants under paragraph (1), the Secretary shall give priority to awarding grants to eligible entities—

(A) that demonstrate that they have previously applied successfully for funds to carry out activities that seek to promote individual and community health and to prevent the incidence of chronic disease and that can cite published and peer-reviewed research demonstrating that the activities that the entities propose to carry out with funds made available under the grant are effective;

(B) that will carry out programs or activities that seek to accomplish a goal or goals set by the State in the Healthy People 2010 plan of the State;

(C) that provide non-Federal contributions, either in cash or in-kind, to the costs of funding activities under the grants;

(D) that develop comprehensive plans that include a strategy for extending program activities developed under grants in the years following the fiscal years for which they receive grants under this subsection;

(E) located in communities that are medically underserved, as determined by the Secretary;

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

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

(i) community-based organizations;

(ii) local governments;

(iii) local educational agencies;

(iv) the private sector;

(v) State or local departments of health;

(vi) accredited colleges, universities, and community colleges;

(vii) health care providers;

(viii) State and local departments of transportation and city planning; and

(ix) other entities determined appropriate by the Secretary.

(5) PROGRAM DESIGN.—

(A) INITIAL DESIGN.—Not later than 1 year after the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2009, the Secretary shall design the demonstration project. The demonstration should draw upon promising, innovative models and incentives to

reduce behavioral risk factors. The Administrator of the Centers for Medicare & Medicaid Services shall consult with the Director of the Centers for Disease Control and Prevention, the Director of the Office of Minority Health, the heads of other agencies in the Department of Health and Human Services, and such professional organizations, as the Secretary determines to be appropriate, on the design, conduct, and evaluation of the demonstration.

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

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

(7) DEFINITIONS.—In this subsection:

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

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

(C) SELF-ASSESSMENT.—The term _self-assessment‘ means a form that—

(i) includes questions regarding

(I) behavioral risk factors;

(II) needed preventive and screening services; and

(III) target individuals‘ preferences for receiving follow-up information;

(ii) is assessed using such computer generated assessment programs; and

(iii) allows for the provision of such ongoing support to the individual as the Secretary determines appropriate.

(D) ONGOING SUPPORT.—The term _ongoing support‘ means—

(i) to provide any target individual with information, feedback, health coaching, and recommendations regarding—

(I) the results of a self-assessment given to the individual;

(II) behavior modification based on the self assessment; and

(III) any need for clinical preventive and screening services or treatment including medical nutrition therapy;

(ii) to provide any target individual with referrals to community resources and programs available to assist the target individual in reducing health risks; and

(iii) to provide the information described in clause (i) to a health care provider, if designated by the target individual to receive such information.

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

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

(1) IN GENERAL.—Not later than January 1, 2010, the Secretary shall establish a program to encourage the development and dissemination of a model electronic health record format for children enrolled in the State plan under title XIX or the State child health plan under title XXI that is—

(A) subject to State laws, accessible to parents, caregivers, and other consumers for the sole purpose of demonstrating compliance with school or leisure activity requirements, such as appropriate immunizations or physicals;

(B) designed to allow interoperable exchanges that conform with Federal and State privacy and s ecurity requirements;

(C) structured in a manner that permits parents and caregivers to view and understand the extent to which the care their children receive is clinically appropriate and of high quality; and

(D) capable of being incorporated into, and otherwise compatible with, other standards developed for electronic health records.

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

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

(1) IN GENERAL.—Not later than July 1, 2010, the Institute of Medicine shall study and report to Congress on the extent and quality of efforts to measure child health status and the quality of health care for children across the age span and in relation to preventive care, treatments for acute conditions, and treatments aimed at ameliorating or correcting physical, mental, and developmental conditions in children. In conducting such study and preparing such report, the Institute of Medicine shall—

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

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

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

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

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

(h) RULE OF CONSTRUCTION.

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

(i) APPROPRIATION.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) STANDARDIZED REPORTING FORMAT.—

(1) IN GENERAL.— Not later than 1 year after the date of enactment of this Act, the Secretary shall specify a standardized format for States to use for reporting the information required under section 2108(e) of the Social Security Act, as added by subsection (a)(2).

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

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

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

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

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

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

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

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

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

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

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

(2) REPORT. Not later than 2 years after the date of enactment of this Act, the Comptroller General shall submit a report to the Committee on Finance of the Senate and the Committee on Energy and Commerce of the House of Representatives on the study conducted under paragraph (1) that includes recommendations for such Federal and State legislative and administrative changes as the Comptroller General determines are necessary to address any barriers to access to children's care under Medicaid and CHIP that may exist.

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

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

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

---

[i] http://www.medicaidleaders.org/about-institute/curriculum-overview

Appendix I: Overview and Update on New Federal Laws Related to Quality Measurement in Medicaid and CHIP

Since 2009, significant opportunities have evolved for States and the Federal government to engage in quality-improvement activities for Medicaid/CHIP, as well as for public and private health care systems. The signing into law of CHIPRA, ARRA, and the Affordable Care Act has created unprecedented opportunities to improve the quality of care. These laws renew the Federal commitment to ensure health care quality and provide new opportunities for States to improve the measurement and quality of care children receive in Medicaid/CHIP and private insurance. These new laws have also resulted in the implementation of innovative quality-related activities such as the National Quality Strategy and the Partnership for Patients.

Children's Health Insurance Reauthorization Act, P. L. 111-3 (CHIPRA)

Section 1139A(a) of the Act, as amended by section 401(a) of CHIPRA, establishes the foundation for building a comprehensive, high quality system of care for children by addressing key components essential to quality improvement strategies. CMS is collaborating with States to establish the infrastructure for a quality measures program in which data are collected and reported in a standardized way for children enrolled in Medicaid/CHIP. Provisions of CHIPRA related to quality measurement and improvement include:

- Establishment of an initial core set of child quality performance measures for voluntary use by State programs (Section 1139A(a)(1));
- Creation of a pediatric quality measures program to test and refine the core quality measures and develop additional quality measures (Section 1139A(b)(1));
- Appropriation of $100 million (over 5 fiscal years) for State demonstration projects that test and evaluate approaches to assess the quality of care that children in Medicaid/CHIP receive (Section 1139A(d)(4));
- Development of a standardized reporting format for the voluntary core performance measures by February 2011 (Section 1139A(a)(4));
- Requirement for State CHIP programs to annually report on quality of care and consumer satisfaction measures included in the CAHPS® Medicaid survey starting in 2013 (CHIPRA Section 402(s), adding new section 2108(e)(4) of the Act);
- Requirement that CHIP managed care programs have an independent annual external quality review (HHS/CMS State Health Official Letter #09-008 CHIPRA#4);
- Creation and testing of a model pediatric electronic health record (EHR) format (Section 1139A(f)(1));
- Provision of technical assistance to States as they implement quality measures (Section 1139A(a)(7)).

Current Status: To assist in identifying the initial core set of child performance measures to monitor and improve children's health care services, AHRQ's National Advisory Council on Research and Quality established a Subcommittee on Children's Healthcare Quality Measures for Medicaid and CHIP (also referred to as the SNAC) in 2009. The SNAC, consisting of representatives of key stakeholder groups and experts in children's health care and quality measurement, convened in public sessions in July and September 2009. In December 2009, the HHS Secretary posted for public comment in the *Federal Register* 24 of the SNAC recommended core set of children's health care quality measures for voluntary use by Medicaid/CHIP programs.

In February 2011, CMS released a State Health Official letter outlining the 24 initial core measures. Later that same month, CMS released a technical specifications manual for the core measures so that States could begin collecting and reporting the measures. In April 2011, AHRQ working on behalf of CMS, created the CHIPRA-required Pediatric Quality Measures Program (PQMP). The PQMP is comprised of seven Centers of Excellence that will work with CMS to improve and enhance existing measures and develop new measures for priority topics such as behavioral health, Emergency Department use, and patient safety. CMS is also working with ONC to electronically specify the initial core measures and develop new measures for possible inclusion in the updated CHIPRA core measures set to be released in 2012.

As described in the 2010 Secretary's Report, CMS announced grants to 10 States and multi-State collaboratives in February 2010. Through the grant program States conduct demonstrations that address multiple aspects of quality improvement, including performance measurement, health information technology, and service delivery models. A total of $100 million was appropriated for these grants, with $20 million to be awarded in each of 5 years for State and multi-State collaborations. In February 2011 the grantees completed the planning phase and are now beginning to implement their project activities. The 10 grantees, Colorado (with New Mexico), Florida (with Illinois), Maine (with Vermont), Maryland (with Georgia and Wyoming), Massachusetts, North Carolina, Oregon (with Alaska and West Virginia), Pennsylvania, South Carolina, and Utah (with Idaho) have already begun collecting the child health quality measures and implementing health information technology (IT) strategies. Two of the grantees (North Carolina and Pennsylvania) will test the new pediatric EHR format being developed as required by CHIPRA.

Patient Protection and Affordable Care Act (Affordable Care Act)

The Affordable Care Act expands sources of health insurance for millions of Americans and includes health care delivery system reforms designed to improve the quality of care and lower costs. Among the provisions designed to substantially improve the quality of care provided to all Americans, the Affordable Care Act provides substantial new funding for developing a Medicaid adult quality measurement program to complement CHIPRA children's quality measurement program. CMS will leverage the knowledge gained through CHIPRA quality activities to ensure adult and child quality activities are aligned. The Affordable Care Act also includes provisions that both expand Federal-State partnerships in disease prevention and quality improvement in health care and bolster the role of the private sector in promoting higher quality care for children and all Americans, including:

- Improved data collection for measuring and evaluating health care disparities in Medicaid and CHIP by race, ethnicity, sex, primary language, and disability status (Section 4302(b));
- Development of performance measures and a Medicaid policy regarding payment for health care acquired conditions (Section 2702);
- Demonstration grants to States to test approaches that encourage healthier lifestyles among Medicaid enrollees with chronic health problems (Section 4108);
- Incentive payments to States that eliminate Medicaid cost-sharing requirements for certain clinical preventive services (Section 4106);
- Provisions assuring preventive care for children and adults is a covered benefit in private insurance (Section 1001; Section 1302); and
- Assuring that Qualified Health Plans offered in Exchanges address quality, safety, wellness and disparities issues (Section 1311 (g) & (h)).

Current Status: AHRQ, on behalf of CMS, convened a meeting of a Subcommittee to its National Advisory Council on Healthcare Research and Quality (the Subcommittee) in October 2010 to provide guidance on quality measures for Medicaid adults for States to voluntarily report to CMS. The workgroups prioritized measures based on importance to Medicaid and the evidence base, and considered potential measurement opportunities across the Institute of Medicine's domains of quality. CMS published the draft initial 51 measures in the *Federal Register* for public comment on January 1, 2011. AHRQ reconvened its Subcommittee in August 2011 to review the public comment and recommend to CMS a final list of initial core measures for adults. HHS will release the initial core set of measures for adults enrolled in Medicaid by January 1, 2012.

Over the next several months, CMS will finalize a longer-term plan for annual quality reporting by State Medicaid programs on adults in consultation with the States. It is also expected that a number of the adult quality measures will be electronically specified and, therefore, calculated using an EHR. CMS will coordinate with HITECH planning efforts to assure that opportunities to demonstrate meaningful use of quality measures overlap as much as possible with the initial core set of adult quality measures.

As part of the Affordable Care Act, the Center for Consumer Information and Insurance Oversight (CCIIO) must develop a number of reporting requirements to support the delivery of high quality care by health insurance issuers in the Exchanges, including the development of a quality rating system that rates health plans on the basis of quality, coverage, and price. CCIIO will also implement other quality-related activities to support how health care quality provided in the Exchanges is measured and evaluated. CMS is working closely with CCIIO to share experiences in benefit design, the quality rating system used by Medicare Advantage health plans, and quality metrics for children and adults. The shared goal, to the extent possible, is to create a near seamless experience in the level of health care quality available to consumers across Medicaid, Medicare, and the Exchanges.

Since the 2010 Report, HHS also made progress on three of the other legislatively required activities designed to improve quality of care and the health of Medicaid/CHIP enrollees. In July 2011, CMS released its final rule requiring States to implement non-payment policies for health care-acquired conditions (ACA Section 2702). The rule uses existing authorities to introduce the umbrella term "provider preventable conditions (PPC)" which allows States to recognize conditions other than those defined in the Statute as health care acquired conditions.[i] In addition, a solicitation for demonstration grants for States to test approaches that encourage healthier lifestyles, *Medicaid Incentives for Prevention of Chronic Diseases, w*as issued by the Center for Medicare and Medicaid Innovation (ACA section 4108) and standards for data collection for measuring and evaluating health disparities were released in the Federal Register notice for public comments (ACA section 4302). Efforts related to both of these provisions are currently underway.