

**Improving Health Outcomes for Children (IHOC)  
Summary of Pediatric Quality Measures  
For Children Enrolled in MaineCare  
FFY 2009-FFY 2014**

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August 2015



## About this Report

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

This report presents the results of the 13 CHIPRA Core Measures that were collected using MaineCare claims, Vital Statistics or survey data and reported to the Centers for Medicare and Medicaid Services (CMS) for FFY 2009 - FFY 2014. Also included in this report are several retired CHIPRA Core Measures and three measures from the Improving Health Outcomes for Children (IHOC) project's Master List of Pediatric Measures. In addition to presenting results in graphs and narrative, this report also provides measure definitions and background information about each measure topic.

This work was conducted under a Cooperative Agreement between the Maine Department of Health and Human Services and the Muskie School of Public Service at the University of Southern Maine and is funded under grant CFDA 93.767 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) authorized by Section 401(d) of the Child Health Insurance Program Reauthorization Act (CHIPRA). These contents do not necessarily represent the policy of the U.S. Department of Health and Human Services, and you should not assume endorsement by the Federal Government.

The views expressed are those of the author's and do not necessarily represent the views of either the Department or the School. For further information regarding this report, please contact Mary Lindsey Smith at [mlsmith@usm.maine.edu](mailto:mlsmith@usm.maine.edu). For more information about the IHOC project, please contact Kyra Chamberlain at [kyra.chamberlain@maine.edu](mailto:kyra.chamberlain@maine.edu).

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## Introduction

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

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

Although reporting of the Core Measures is currently not required by CMS, MaineCare reported results for 15 of the measures in the Federal Fiscal Year 2014 (FFY 2014), with support from the IHOC project. Of the 15 initial core set measures MaineCare is currently reporting on, 9 are claims-based, 3 are registry-based, 2 based on CMS 416 data and one survey measure. Thirteen of these measures are reported through the CHIP Annual Reporting System (CARTS) and the remaining two will be calculated by CMS using data from Maine’s CMS Form 416 reports.

This document presents the results of the 13 CHIPRA Core Measures that were collected using MaineCare claims, Vital Statistics or survey data and reported to CMS. These measures include:

- Well-child visits (3 measures)
- Access to primary care practitioners
- Chlamydia screening
- Emergency Department (ED) visits
- Follow-up care for children with ADHD medication
- Follow-up after hospitalization for mental illness
- Prenatal Care (2 measures)
- Live Births Weighing Less than 2,500 Grams

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

- Developmental screening
- Patient Experience of Care

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

- Preventative dental and
- Dental treatment services<sup>2</sup>

Maine Continues to report on the following CHIPRA Core Measures that have been retired:

- Appropriate testing for children with pharyngitis
- Annual pediatric hemoglobin A1c testing
- Asthma ED visits

In addition to the CHIPRA Core Measures, Maine providers collaborating with the IHOC project identified other quality measures to support quality improvement at the practice-level. Through a stakeholder feedback process, measures drawn from *Bright Futures* guidelines, Meaningful Use, and other sources were added to the CHIPRA Core Measures to create the IHOC Measures List, totaling 52 pediatric quality measures.

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

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

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

Most of the measures use a 12-month measurement period. To fulfill requirements of the CHIP Annual Report we used measurement periods that correspond to Federal Fiscal Years (FFY). Federal Fiscal Years run from October 1st of the prior year through September 30th of the year being described. For example, FFY 2014 represents the period from October 1, 2013 through September 30, 2014.

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<sup>2</sup> The dental treatment measure (TDENT) was part of the CMS Child Core Set during the current reporting period but was recently retired (March of 2015).

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

Where available, we also include national 2013 HEDIS averages from Medicaid managed care plans along with Maine's results. The Health Plan Employer Data and Information Set (HEDIS) is a set of performance measures developed by the National Committee for Quality Assurance (NCQA). HEDIS measures are widely used by employers, consumers, and Medicaid agencies to compare and monitor performance of health plans. Many of the CHIPRA Core Measures are HEDIS measures, and the NCQA publishes average results for selected measures each year.<sup>4</sup> HEDIS averages are included to provide a point of comparison for the Maine results.

### Well-Child Visits (WCVs)

*CHIPRA Measures W15-CH, W34-CH, AWC-CH*  
*IHOC Measures 31, 32, 33, 34, 35*

#### Background<sup>5</sup>

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

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

#### Measure Definition

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

For the youngest group, children who turn 15 months during the measurement year and are continuously

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<sup>4</sup> National Committee for Quality Assurance (Full release October 2015). *The State of Health Care Quality 2014*. Available at: <http://www.ncqa.org/ReportCards/HealthPlans/StateofHealthCareQuality/2014TableofContents.aspx>

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

enrolled from 31 days after birth to 15 months of age are in the measure denominator.<sup>6</sup> The number of visits is counted (0, 1, 2, 3, 4, 5, 6 or more visits) for this age group.

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

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

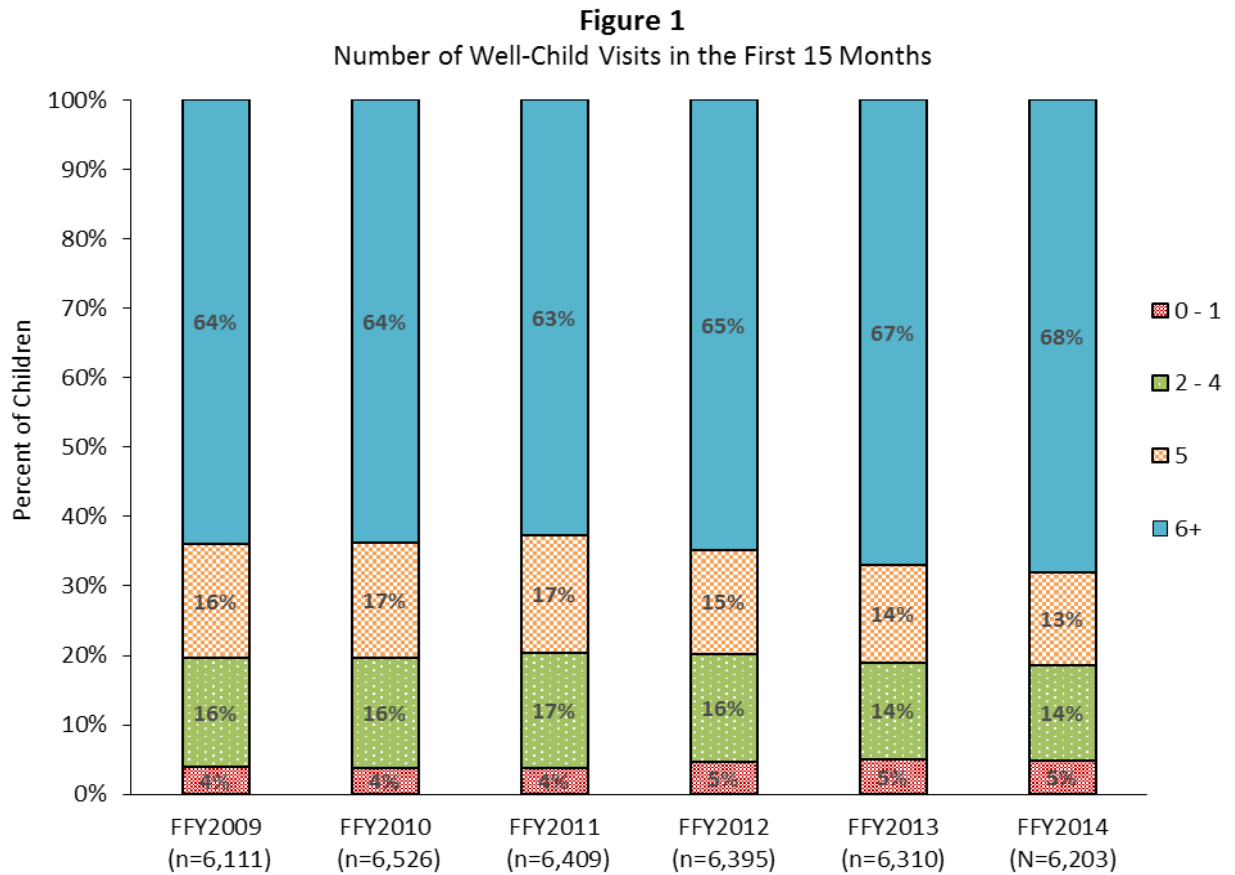
### Results

The results of the WCV measures for FFY 2009 through FFY 2014 are shown in Figures 1 – 3 and Table 1. Rates of well-child visits remained relatively constant over the 5-year measurement period.

Figure 1 shows the percentage of children enrolled in MaineCare with 0-1, 2-4, 5 or 6 or more total WCVs in the first 15 months of life. In 2014, two-thirds of enrolled children (68%) had at least 6 visits in the first 15 months, and 81 percent had 5 or more visits. MaineCare's rates for children having six or more WCVs were slightly higher than the 2013 HEDIS average of 62 percent.

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



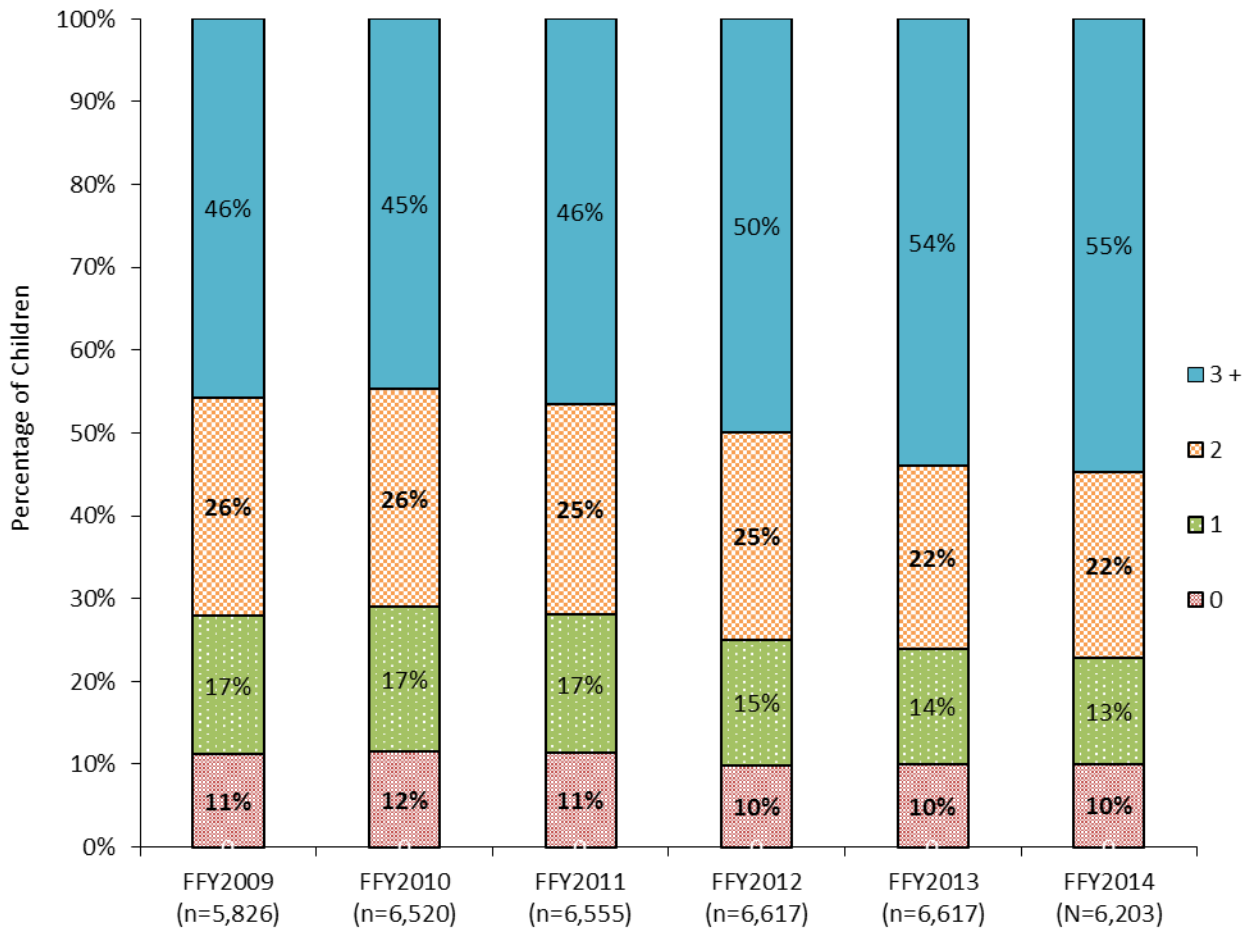
*Source: MaineCare Claims Data*

Figure 2 shows the percentage of children age 15 months to 3 years with 0, 1, 2, or 3 or more total WCVs. The 3+ age rate has steadily increased since FFY 2011, however, the rate of growth between 2013 and 2014 was minimal. Over the past six years the number of children between the ages of 15 months and 3 years receiving the recommended number of well-child visits has increased by 9 percent, yet ten percent of the children in this age range had no WCVs which is consistent with national averages.<sup>7</sup>

<sup>7</sup> The Child Trends Databank report is available: [http://www.childtrends.org/wpcontent/uploads/2014/02/93\\_Well\\_Child\\_Visits.pdf](http://www.childtrends.org/wpcontent/uploads/2014/02/93_Well_Child_Visits.pdf)



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



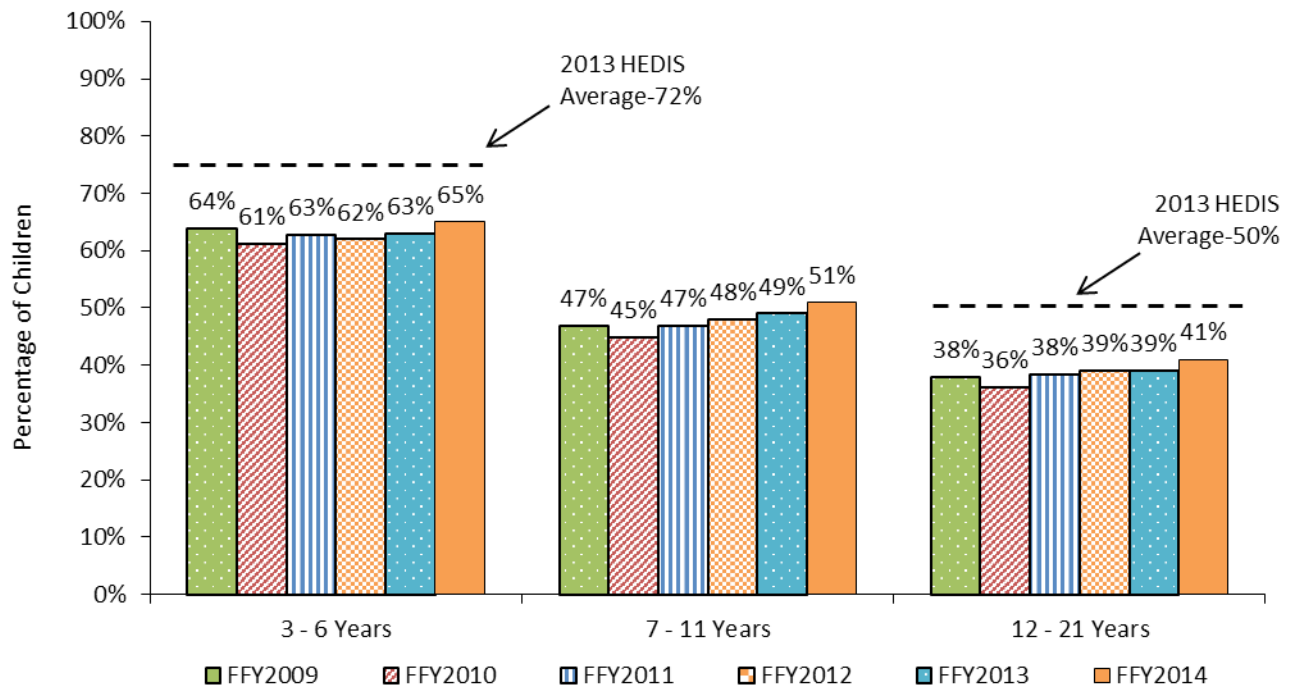
Source: MaineCare Claims Data

Figure 3 shows the percentage of children who had at least one WCV in the measurement year, by three different age ranges: ages 3–6, ages 7–11, and ages 12–21; although there were slight increases in all age categories in 2014, rates have remained fairly stable over the past 6 years. Notably, WCV rates decline considerably as children get older. For 3 to 6 year olds, about 65 percent had at least one visit during the measurement year. For 7 to 11 year olds, the rate falls to 51 percent, and for adolescents, it falls further still to 41 percent. Note that MaineCare rates are lower than the HEDIS national average for FFY 2013: 7 percent lower for 3-6 year olds and 9 percent lower for adolescents.<sup>8</sup>

<sup>8</sup> HEDIS did not measure visits for ages 7-11.

Summary of Pediatric Quality Measures for Children Enrolled in MaineCare

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



Source: MaineCare Claims Data

**Table 1**

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

Measure Description	FFY2009		FFY2010		FFY2011		FFY2012		FFY2013		FFY2014	
	At least 1 visit	Total	At least 1 visit	Total	At least 1 visit	Total	At least 1 visit	Total	At least 1 visit	Total	At least 1 visit	Total
WCVs, 3-6 Years	14,762	23,124	15,505	25,304	16,308	25,984	16,492	26,526	16,176	25,788	15,829	24,385
WCVs, 7-11 Years	12,754	27,246	12,950	28,856	13,868	29,618	14,713	30,811	14,768	30,432	15,383	29,979
WCVs, 12-21 Years	16,502	43,402	16,785	46,469	18,058	46,988	18,528	47,990	18,008	46,350	18,512	44,696

Source: MaineCare Claims Data

## Access to Primary Care Practitioners (PCPs)

### *CHIPRA Measure CAP-CH / IHOC Measure 45*

#### **Background**

The CHIPRA legislation specified that measures of availability of services be included in the CHIPRA Core measure set. Availability of services is an important topic, given the many reports from national studies on the lack of providers and some providers' unwillingness to serve Medicaid patients. The expert panel convened by the federal Agency for Healthcare Research and Quality (AHRQ) and CMS to review and make recommendations for the CHIPRA Core measures noted that "...realized access to care (e.g., utilization of primary care practitioners) [is an] incomplete measure of availability because the reasons for lack of utilization could go well beyond lack of availability (e.g., parents don't perceive a need for the service). However, realized access is a piece of availability and a way to measure access under capitated primary care arrangements."<sup>9</sup>

The panel also noted that the Access to PCP measure is only a proxy measure for availability of services; it cannot be considered a true availability of services measure because it deals with only primary care, and because the reasons for non-use of primary care services may vary, from lack of availability, to lack of time, to lack of perceived need, and other factors.<sup>10</sup>

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

#### **Measure Definition**

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

#### **Results**

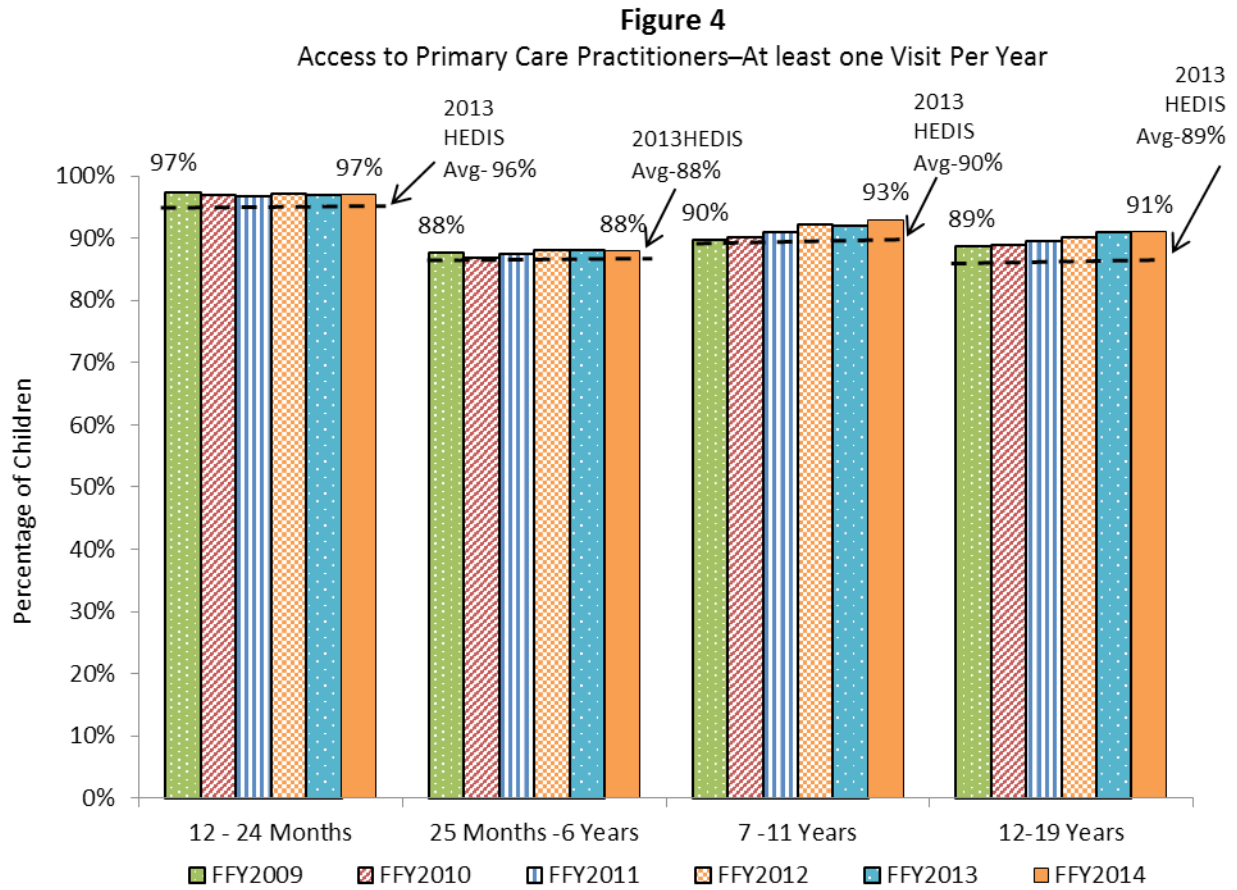
Figure 4 shows the percentage of children in each age group who had at least one visit with their PCP in the 6 measurement years. MaineCare's performance on this measure is excellent across all age categories. Realized access among the youngest children is nearly universal, at 97 percent and rates of access to PCPs are around 90

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<sup>9</sup> Report available at: <http://www.ahrq.gov/policymakers/chipra/overview/background/next-steps3.html>

<sup>10</sup> Report available at: <http://www.ahrq.gov/policymakers/chipra/overview/background/next-steps3.html>

percent for the other three age groups as well. These rates are at or above the FFY 2014 rates reported by states in the 2013 Annual Report on the Quality of Care for Children in Medicaid and CHIP and are also at or above the 2013 HEDIS Averages.<sup>11</sup>



<sup>11</sup> Report available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2012-Ann-Sec-Rept.pdf>

## Chlamydia Screening for Women age 16 – 20 Years

### *CHIPRA Measure CHL-CH / IHOC Measure 37*

#### **Background**

Screening to identify health conditions for early intervention with effective treatments is a primary purpose of preventive (well-care) visits. Screening for chlamydia, a sexually transmitted infection, of sexually active females ages 16-20 was identified as an important screening because, if left untreated, it can cause pelvic inflammatory disease in women, a condition that can result in sterility. Chlamydia is easy-to-treat, but widespread. In 2010, 1,307,893 cases of chlamydia infection were reported to the Centers for Disease Control (CDC), which is the largest number of cases ever reported to the CDC for any condition.<sup>12</sup> This corresponds to a rate of 426 cases per 100,000 population, an increase of 5.1% since 2009 and rates for women are over two and a half times the rate among men.<sup>13</sup> Although Maine ranks 48th in reported chlamydia cases (3,094 in 2011), screening is essential to ensure that cases are not being missed and going untreated.<sup>14</sup>

#### **Measure Definition**

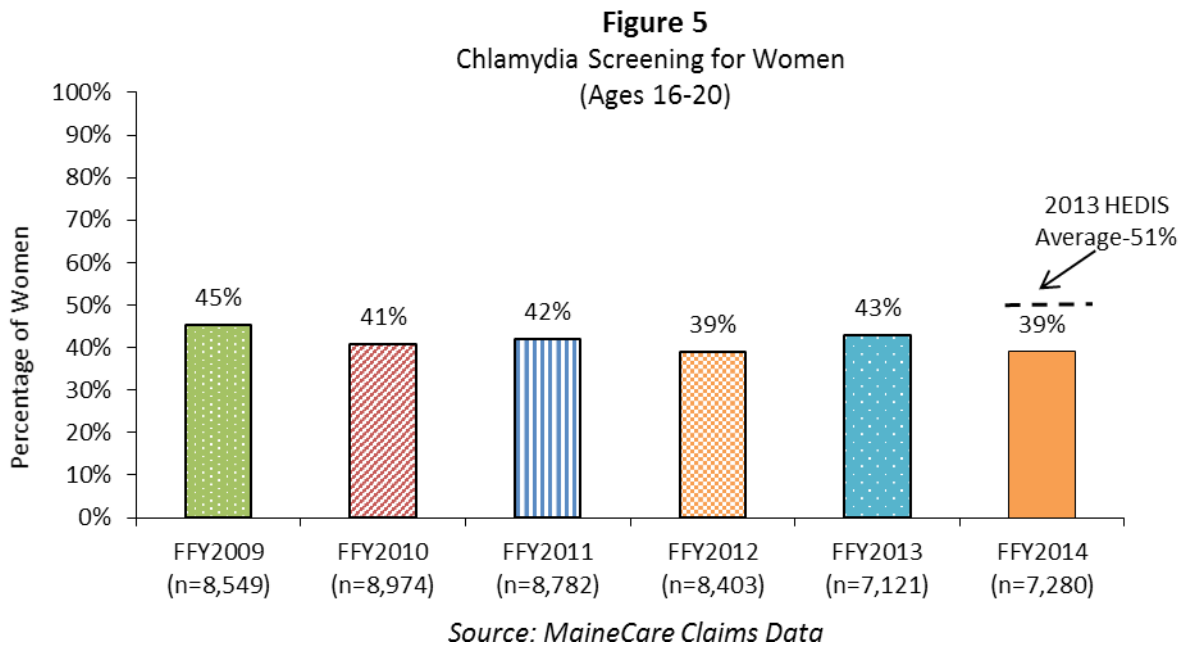
This measure assesses the extent to which at least one chlamydia test is given during the measurement year to women 16-20 years of age who were identified as sexually active and were enrolled in MaineCare for at least 11 out of the 12 months during the measurement year.

#### **Results**

Figure 5 shows that 39 percent of sexually active women age 16 – 20 years enrolled in MaineCare had a chlamydia screening in FFY 2014. Screening rates were very similar from 2009-2013, however, screening rates declined by 4 percent in 2014. Each year screening rates in Maine have fallen below the HEDIS average rates which have consistently topped 50 percent since FFY 2009.

<sup>12&13</sup> Information gathered from the Center for Disease Control, National Overview of Sexually Transmitted Disease (STDs), 2010 at: <http://www.cdc.gov/std/stats10/natoverview.htm>

<sup>14</sup> Information gathered from the Kaiser Family Foundation, State Health Facts.org at: <http://kff.org/other/state-indicator/chlamydia-cases/#>



## Preventive Dental and Dental Treatment Services

### CHIPRA Measures PDENT-CH, TDENT-CH / IHOC Measures 38, 39

#### Background

Oral health problems are common, painful, and preventable. According to the CDC Oral Health Division, tooth decay affects 20 percent of U.S. children aged 5–5-11 years and 13 percent of those aged 12–15 years. Rates of tooth decay among children ages 5–19 years from lower-income families is twice as high compared to children in higher income families.<sup>15</sup> Ongoing dental services are essential to improve children’s oral health.

Dental services are a required benefit for most Medicaid-eligible individuals under the age of 21, as a component of the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program, and with the advent of CHIPRA, dental services are also a required benefit for CHIP enrollees. Two dental measures reported through CMS-416 (a required report submitted by all EPSDT programs to CMS each year) are included in the CHIPRA core set: children receiving preventive dental services (CHIPRA PDENT / IHOC #38), and children receiving dental treatment services (CHIPRA TDENT<sup>16</sup>, IHOC #39).

<sup>15</sup> [http://www.cdc.gov/oralhealth/children\\_adults/child.htm](http://www.cdc.gov/oralhealth/children_adults/child.htm)

<sup>16</sup> The dental treatment measure (TDENT) was part of the CMS Child Core Set during the current reporting period but was recently retired (March of 2015).

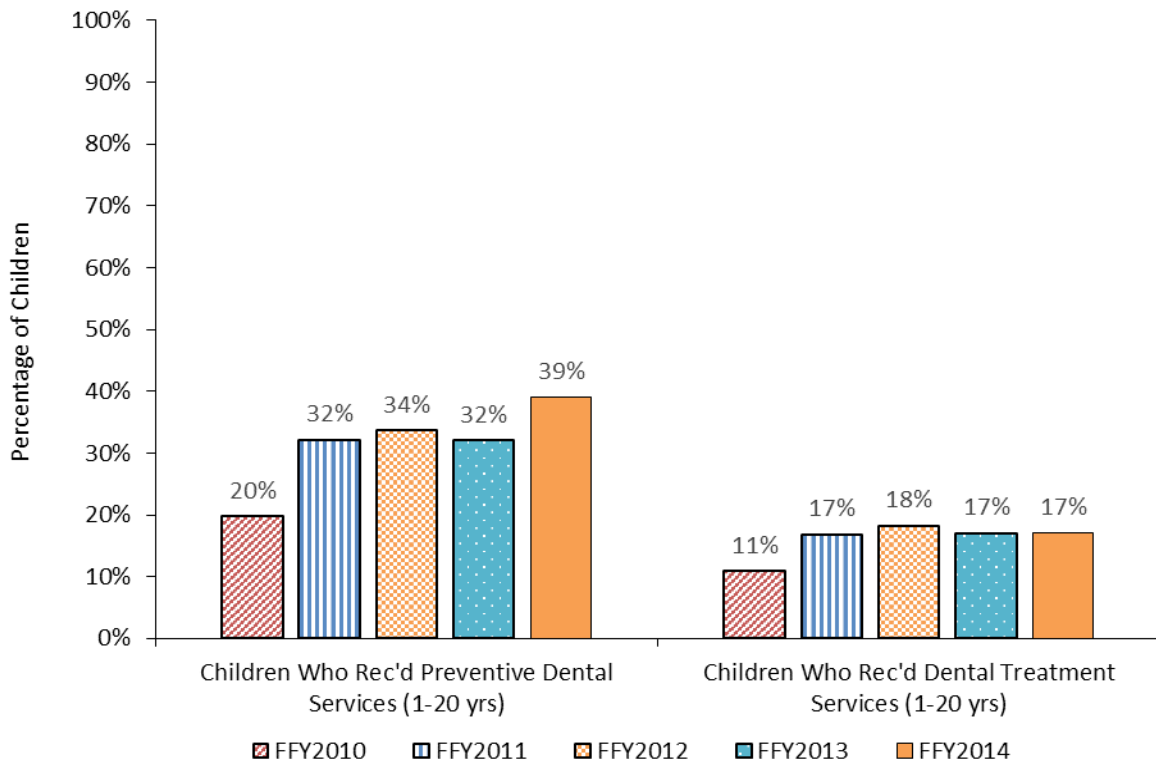
### Measure Definition

Two EPSDT measures, *Receipt of Preventive Dental Services* and *Dental Treatment Service* assess the percent of children ages 1 to 20 who received dental services as a function of the number of children eligible for EPSDT services as shown on line 1 of the CMS-416 form.<sup>17</sup> Children are counted as eligible for EPSDT services if they were enrolled in MaineCare for at least 3 consecutive months during the measurement year.

### Results

Figure 6 shows results for the two measures related to dental services for children age 1-20 that are eligible for EPSDT services. Rates for dental preventative services rose by 7 percentage points between FFY 2013 and 2014 however, the rate of treatment services have remained relatively stable. Just over 39 percent of eligible children received preventive dental services in FFY 2014, up from 20 percent in FFY 2010. Over the past five years, the provision of dental treatment services has increased by 6 percent from 11 percent in FFY 2010 to 17 percent of eligible children receiving dental treatment in FFY 2014.

**Figure 6**  
Dental Services—Prevention and Treatment



Source: MaineCare Claims Data

<sup>17</sup> “Dental Services” are identified using CDT or HCPCS codes D0100 – D9999. “Preventive Dental” are codes D1000 – D1999, and “Dental Treatment” are codes D2000 – D09999.

## Appropriate Testing for Children with Pharyngitis and Prescribed an Antibiotic

*CHIPRA Measure CWP (retired) / IHOC Measure 30*

### Background

Upper respiratory infections (URIs), including pharyngitis (inflammation of the throat), are among the most common reasons for children's acute care encounters with health care providers. URIs often present opportunities for the overuse of antibiotics even though most URIs are time-limited and, if viral, cannot be cured with antibiotics. The purpose of the measure is to monitor and help reduce the unnecessary use of antibiotics by ensuring that antibiotics were not given without a diagnosis of streptococcal (strep) bacteria. Pharyngitis is measured because it was the leading diagnosis for 6.4 million visits to physician offices and hospital outpatient departments for all children under age 15 in 2006 nationally, providing many opportunities for inappropriate antibiotic use.<sup>18</sup>

### Measure Definition

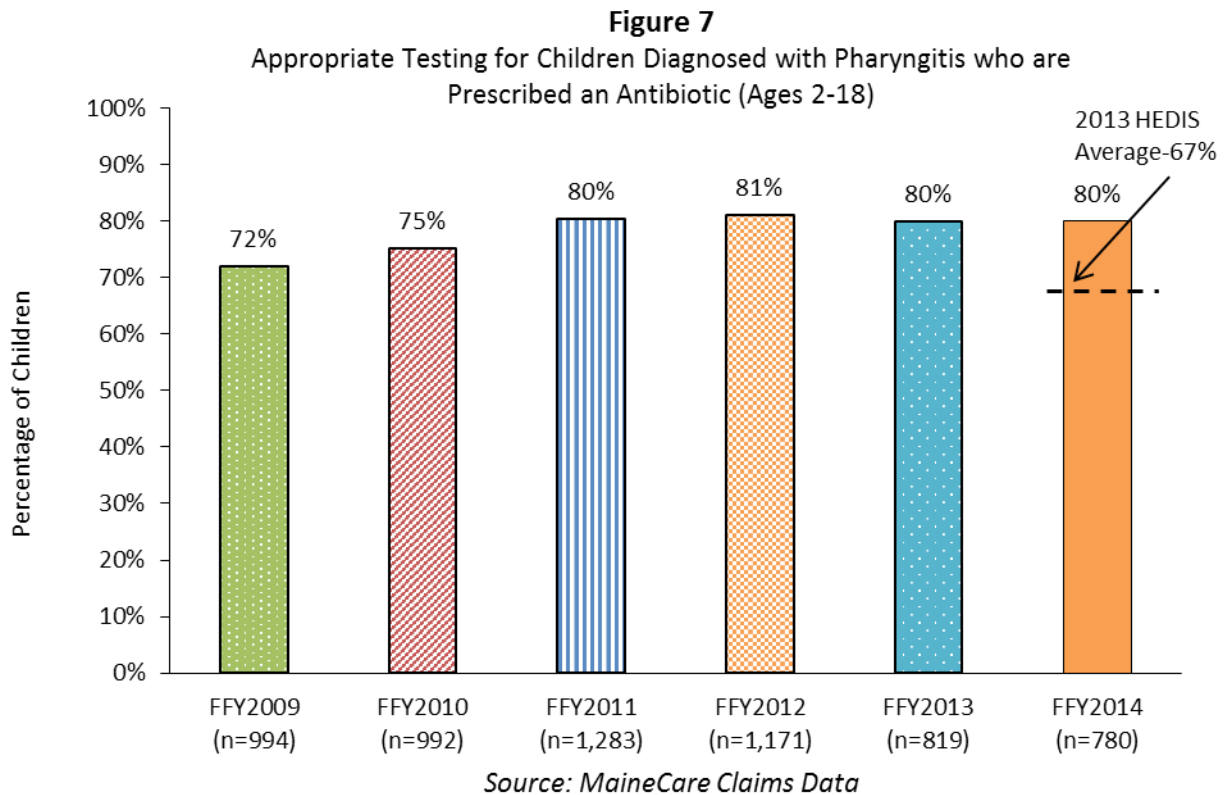
This measure assesses whether a strep test was administered for children 2-18 years in the 7-day period from 3 days prior through 3 days after the first eligible episode date. An eligible episode is an outpatient visit with a diagnosis of pharyngitis at which an antibiotic was dispensed. The measure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

### Results

Figure 7 shows the rates of appropriate testing for children diagnosed with pharyngitis have increased slightly over the past six years (up 8%). In FFY 2014, 80 percent of children enrolled in MaineCare who were diagnosed with pharyngitis and prescribed an antibiotic had received a strep test. MaineCare's rates for appropriate testing for children with pharyngitis have continually exceeded national HEDIS averages for testing; in 2014 MaineCare's rates were 13 percent higher than the HEDIS average of sixty-seven percent.

<sup>18</sup> *Background Report for the Initial, Recommended Core Set of Children's Healthcare Quality Measures for Voluntary Use by Medicaid and CHIP Programs.* Available at: <http://www.ahrq.gov/policymakers/chipra/overview/background/index.html>





## Emergency Department (ED) Visits

### CHIPRA Measure AMB-CH / IHOC Measure 41

#### Background

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

The measure is potentially important to MaineCare, given that in 2006, Medicaid paid for 62 percent of all ED visits of children less than age 1 and they paid for 42 percent of all ED visits of children 1-17 years.<sup>19</sup>

<sup>19</sup> Kilbreth, B., C. McGuire, C. Gray, T. Chitashviliand, and K. Finison (2009). Analysis of 2006 Maine. Emergency Department Utilization. Portland, ME: University of Southern Maine, Muskie School of Public Service.

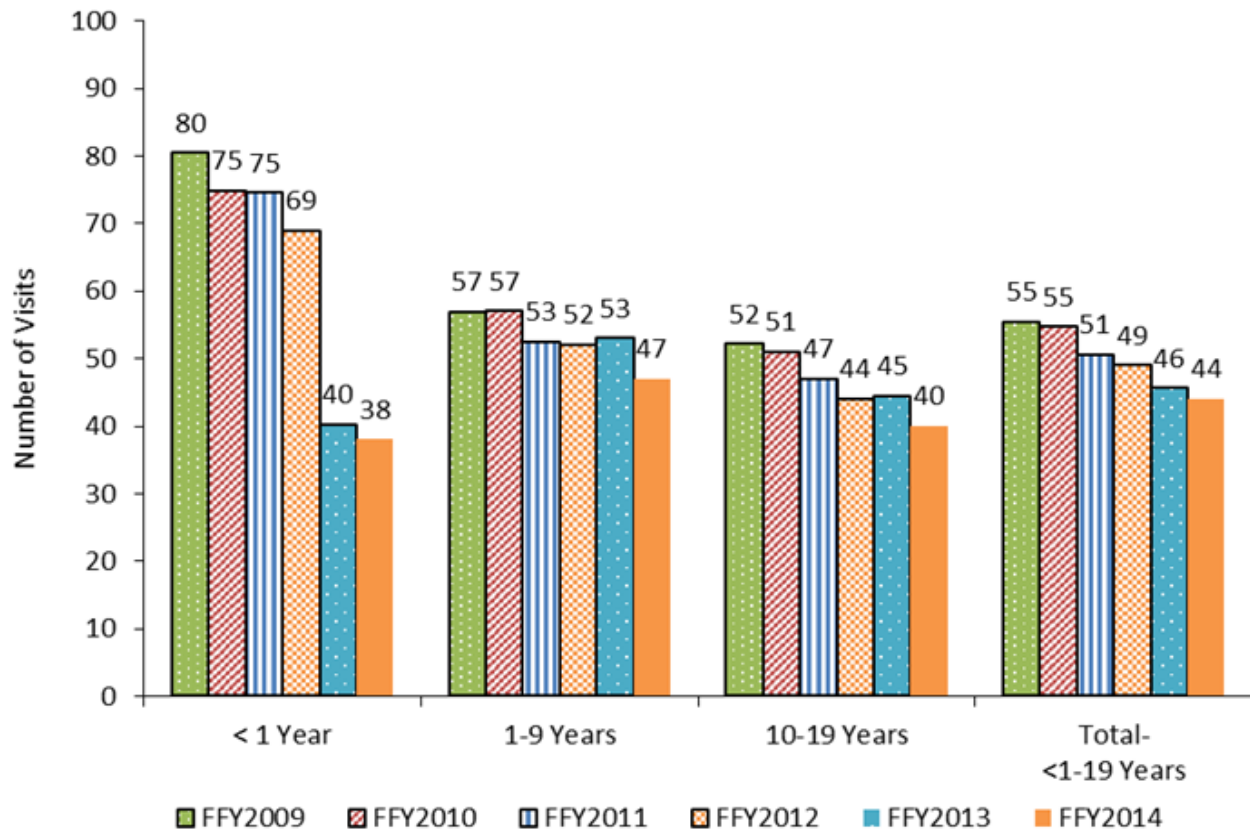
### Measure Definition

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

### Results

The results in Figure 8 show that the children ages 1-9 years report the most ED visits however, the rates have continued to drop for all age categories over the past half-decade. For children under the age of one, rates dropped from a high of 80 visits per 1,000 member months in 2009 to only 38 visits in 2014. Between 2009 and 2014 rates for individuals in the various age cohorts have dropped between 3 to 8 percent; in 2014 the overall average number of ED visits for all age cohorts was 44.

**Figure 8**  
Emergency Department Visits Per 1,000 Member Months



Source: MaineCare Claims Data

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

*CHIPRA Measures ASMER (Retired) / IHOC Measures 42, 61*

### Background

Asthma is the most prevalent chronic physical condition among children. In 2010, 7 million children had asthma, which is equal to one out of every eleven children.<sup>20</sup> As of 2007, 12.9 percent of children covered by Medicaid reported currently having asthma.<sup>21</sup> In 2008, the CDC reported that 9.4 percent of Maine children currently had asthma.<sup>22</sup>

Children with asthma have higher rates of healthcare utilization and costs, in 2009 the average yearly cost of care for a child with asthma was \$1,039.<sup>23</sup> In the same year, one in five children with asthma went to an emergency department for an asthma related incident.<sup>24</sup> Emergency department visits for asthma are important to measure because they are expensive and provide a gateway to hospitalization.

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

### Measure Definition

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

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

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20 Information gathered from the Center for Disease Control, Asthma's Impact on the Nation: Data from the CDC National Asthma Control Program available at: [http://www.cdc.gov/asthma/impacts\\_nation/asthmafactsheet.pdf](http://www.cdc.gov/asthma/impacts_nation/asthmafactsheet.pdf)

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

22 Information gathered from the Center for Disease Control, Asthma in Maine available at: [http://www.cdc.gov/asthma/stateprofiles/Asthma\\_in\\_ME.pdf](http://www.cdc.gov/asthma/stateprofiles/Asthma_in_ME.pdf)

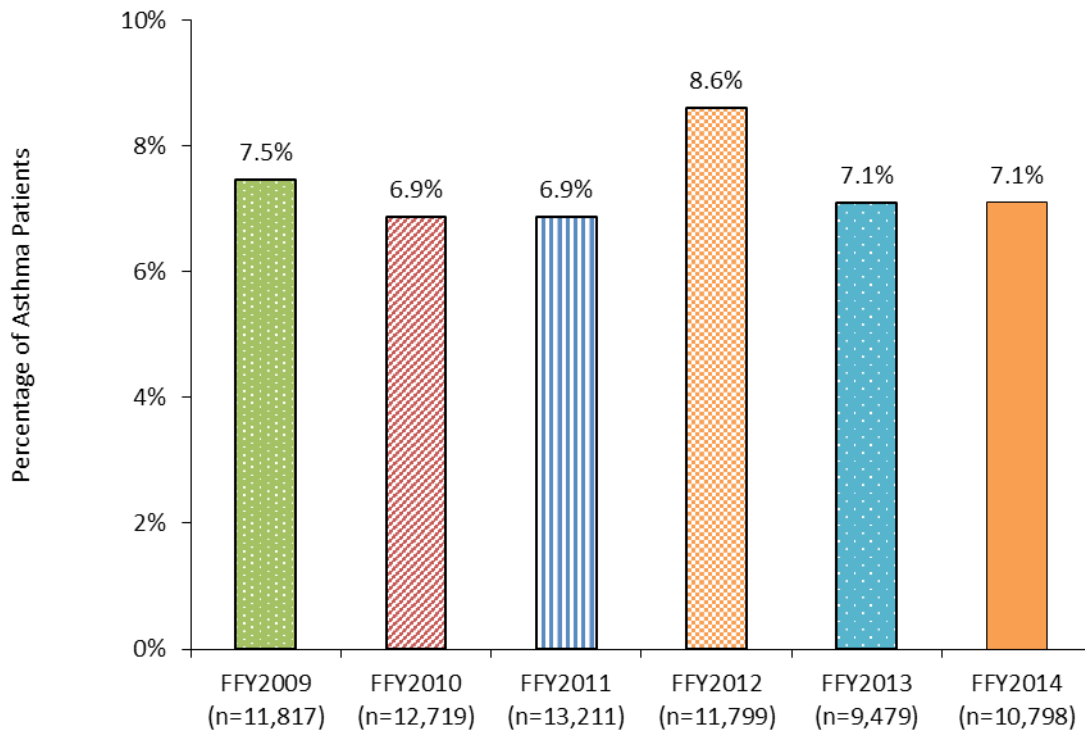
23 Information gathered from the Center for Disease Control, Asthma's Impact on the Nation: Data from the CDC National Asthma Control Program available at: [http://www.cdc.gov/asthma/impacts\\_nation/asthmafactsheet.pdf](http://www.cdc.gov/asthma/impacts_nation/asthmafactsheet.pdf)

24 Information gathered from the Center for Disease Control, Asthma's Impact on the Nation: Data from the CDC National Asthma Control Program available at: [http://www.cdc.gov/asthma/impacts\\_nation/asthmafactsheet.pdf](http://www.cdc.gov/asthma/impacts_nation/asthmafactsheet.pdf)

**Results**

Figure 9 shows that in FFY 2014, there were 10,798 children ages 2 – 20 enrolled in MaineCare who were identified as having asthma; of those, just over 7 percent had one or more visits to the ED because of their asthma during the year. Rates for asthma-related ED visits have remained just above or below 7 percent since FFY 2009 with the exception of FFY 2012 when rates increased slightly – nearly 9 percent.

**Figure 9**  
Asthma Patients with at Least 1 Asthma-Related  
Emergency Department Visit

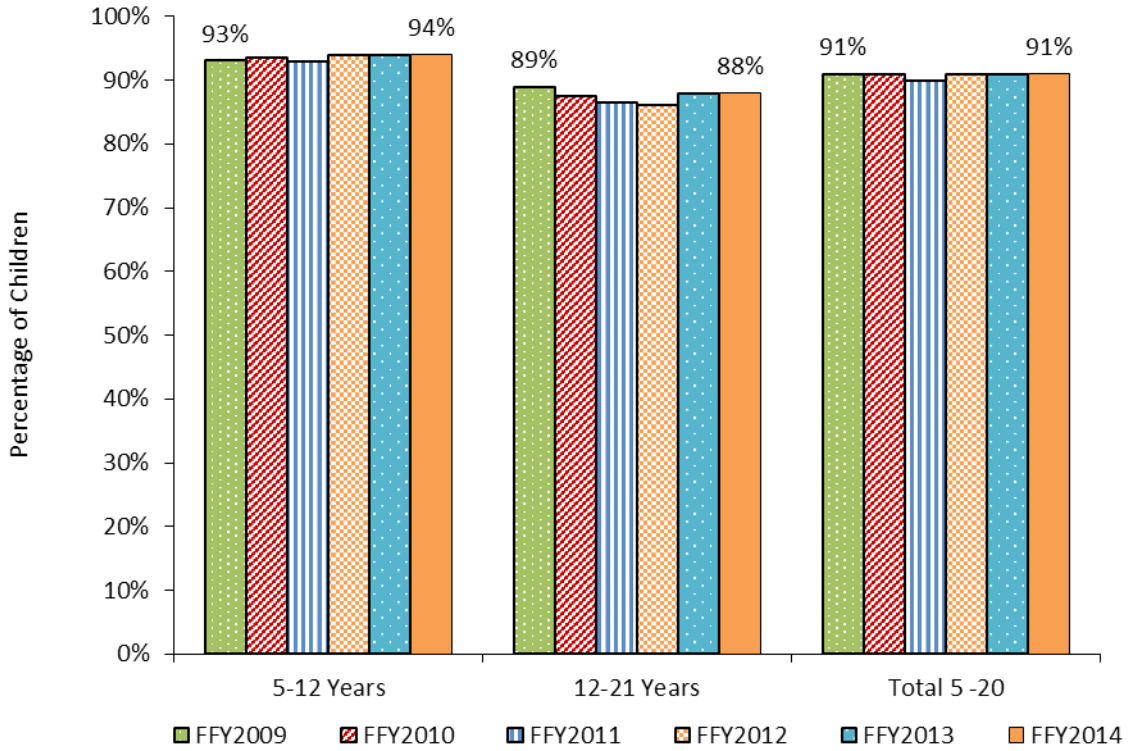


Source: MaineCare Claims Data

Figure 10 shows the number of active asthma patients who were appropriately prescribed controller medications during the measurement year. Two age groups were measured, children ages 5-12 years and 12-21 years. Over 90 percent of 5-12 year old children with asthma were prescribed controller medications in all six measurement years. Among the older age group (12-21 years) controller medication rates were slightly lower ranging from 89 percent in FFY 2009 to 88 percent in FFY 2014. These rates were comparable to 2013 HEDIS Rates which were 90% for children ages 5 – 11 and 87% for children 12 - 18.<sup>25</sup>

<sup>25</sup> National Committee for Quality Assurance (Full release October 2015). *The State of Health Care Quality 2014*. Available at: <http://www.ncqa.org/ReportCards/HealthPlans/StateofHealthCareQuality/2014TableofContents.aspx>

**Figure 10**  
Children with Asthma Prescribed  
Controller Medication



Source: MaineCare Claims Data

## Follow-up Care for Children Prescribed ADHD Medication

### *CHIPRA Measure ADD-CH / IHOC Measure 36*

#### Background

The percentage of children estimated to have attention deficit hyperactivity disorder (ADHD) continues to grow, up from 3 percent in 2003 to 11 percent in 2011.<sup>26</sup> This translates into more than 1 and 10 children ages 4 – 17 having been diagnosed with ADHD in 2011.<sup>27</sup> Estimates show that approximately six percent of children nationally take medication for ADHD. In 2011, 10.1% of children in Maine had a current diagnosis of ADHD, and 6.6% of those children were currently taking a medication for the disorder.<sup>28</sup> Since medications affect children differently, follow-up care for medicated children is critical for their health and well-being, as well as the treatment of their ADHD.

#### Measure Definition

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

#### Results

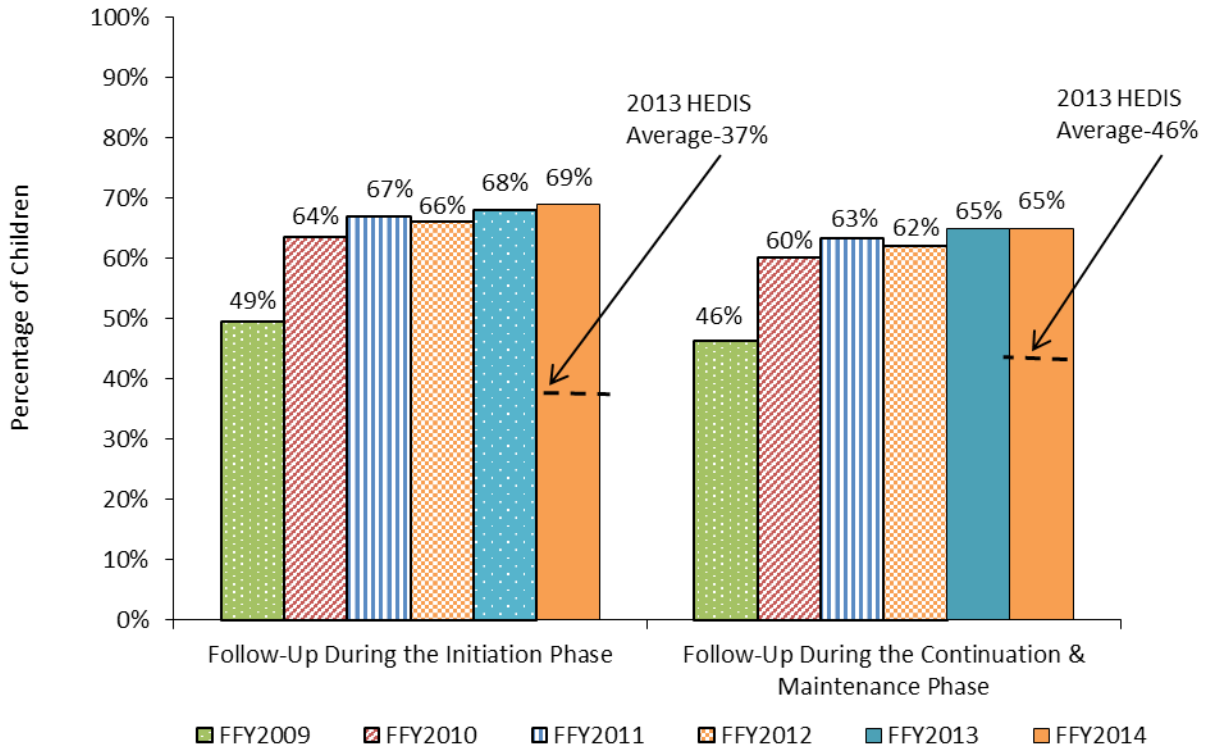
Follow-up care for children prescribed ADHD medication has increased over the past six years during both the initiation phase and in continuation and care maintenance stage. Rates for both measures have improved significantly over the past six years (increasing nearly 20%) and far exceed the 2013 HEDIS averages. In FFY 2014, there were a total of 1,039 children ages 6 – 12 enrolled in MaineCare who were identified as having received a prescription for ADHD and over two-thirds of those children (69%) received appropriate follow-up care during the Initiation Phase. The results for the C&M phase are similar, with 65 percent of children in MaineCare receiving appropriate follow-up care for ADHD medications in FFY 2014.

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

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

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

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



Source: MaineCare Claims Data

## Annual Pediatric Hemoglobin A1c Testing and Comprehensive Diabetes Care

*CHIPRA Measure PA1C (Retired) / IHOC Measure 43*

### Background

Health care providers and others are raising concerns about the rising rate of diabetes among children and adolescents. In 2010, the CDC reports that about 215,000 people younger than 20 years of age are diagnosed with diabetes (type 1 or type 2). This represents 0.26 percent of all people in this age group.<sup>29</sup> That figure doesn't include the substantial number of young people that are undiagnosed or considered to be pre-diabetic. Hemoglobin A1c (HbA1c) testing measures how close to normal blood glucose levels are maintained over time; therefore, it is an important indicator of management of the diabetic patient.

### Measure Definition

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

### Results

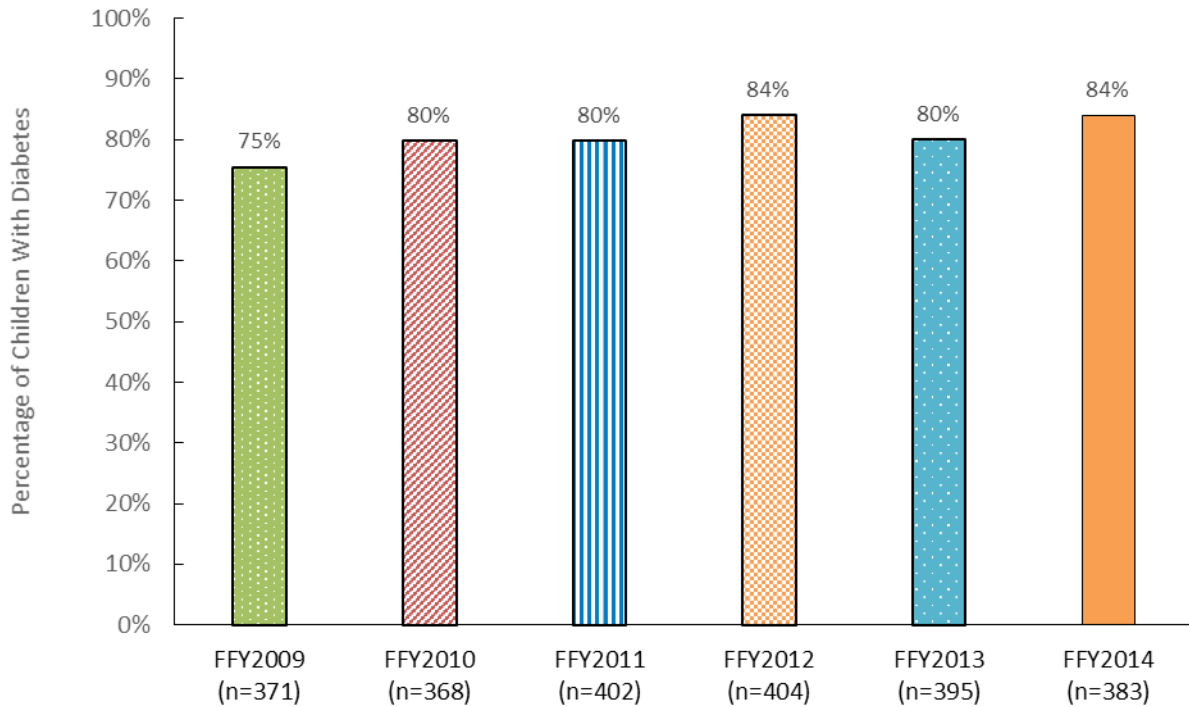
Figure 12 shows the results for the diabetes testing measure, rates have remained fairly stable over the past six years. With the exception of a low of 75 percent in 2009, rates for annual HbA1c testing for children between the ages of 5 and 17 with diabetes have consistently hovered at or slightly above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

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<sup>29</sup> 2011 *National Diabetes Fact Sheet*. Available at: [http://www.cdc.gov/diabetes/pubs/pdf/ndfs\\_2011.pdf](http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf).



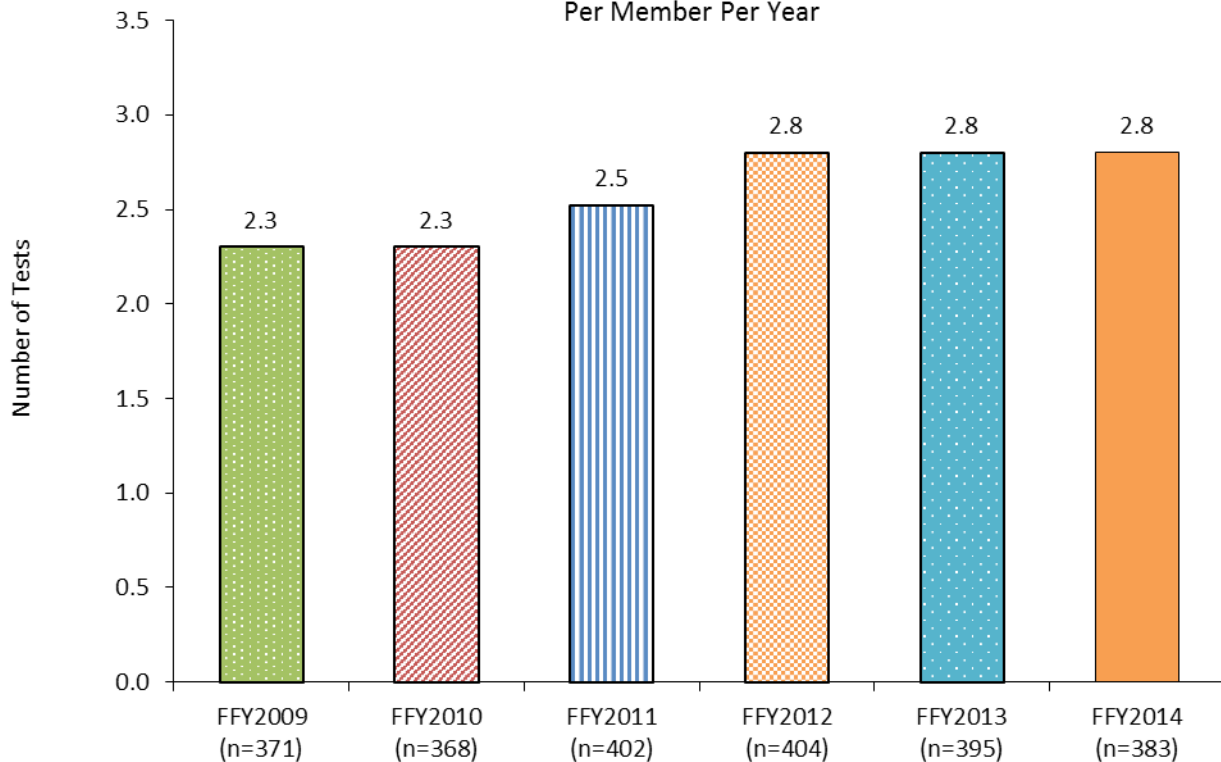
**Figure 12**  
Annual HbA1c Testing for Children with Diabetes  
(Ages 5-17)



Source: MaineCare Claims Data

The average number of tests per child was 2.8 in FFY 2014, the same as in FFYs 2012 and 2013. Also notable is the fact that there are relatively few children enrolled in MaineCare identified as having diabetes—ranging from 371 in FFY 2009 to 383 in FFY 2014.

**Figure 13**  
Average Number of Diabetes Tests  
Per Member Per Year



Source: MaineCare Claims Data

## Follow-up after Hospitalization for Mental Illness

*CHIPRA Measure FUH-CH / IHOC Measure 44*

### Background

Mental health disorders are an important public health issue because of their prevalence, early onset, and impact on child, their families and the community, with an estimated total annual cost of \$247 billion.<sup>30</sup> In any given year, between 13 to 20 percent of children living in the United States experience a mental disorder and research shows that the prevalence of these conditions among children has continued to increase over the past

<sup>30</sup> Information gathered from the Center for Disease Control report, Mental Health Surveillance Among Children- United States, 2005 – 2011. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/su6202a1.htm>

two decades.<sup>31</sup> Attention-deficit/hyperactivity disorder (6.8%) was the most prevalent parent-reported current diagnosis among children aged 3–17 years, followed by behavioral or conduct problems (3.5%), anxiety (3.0%), depression (2.1%), and autism spectrum disorders (1.1%).<sup>32</sup> In 2006, the most common conditions for which children with Medicaid were hospitalized in community hospitals were mood disorders and ADHD/disruptive behaviors.<sup>33</sup> Follow-up care after hospitalization is necessary to maintain children’s mental health and continuity of care in the community. In addition, follow-up care aids in reducing health care cost by decreasing the rate of re-hospitalizations.

### Measure Definition

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

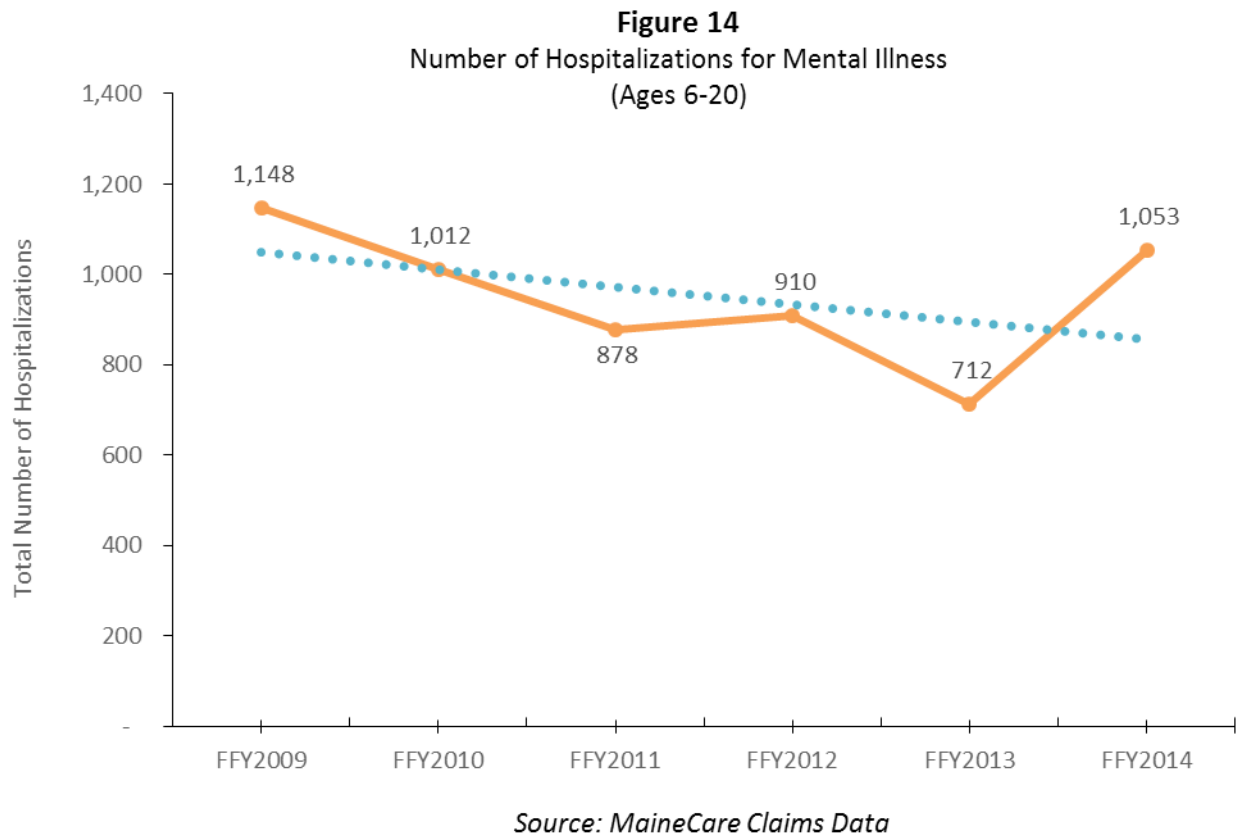
### Results

Figure 14 shows the total number of hospitalizations for mental illness for FFY 2009 through 2014; this is the denominator for the measure. Hospitalizations had been steadily decreasing between FFYs 2009 to 2013 but there was a marked increase in visits in 2014 up from 718 in FFY 2013 to 1,053 in FFY 2014.

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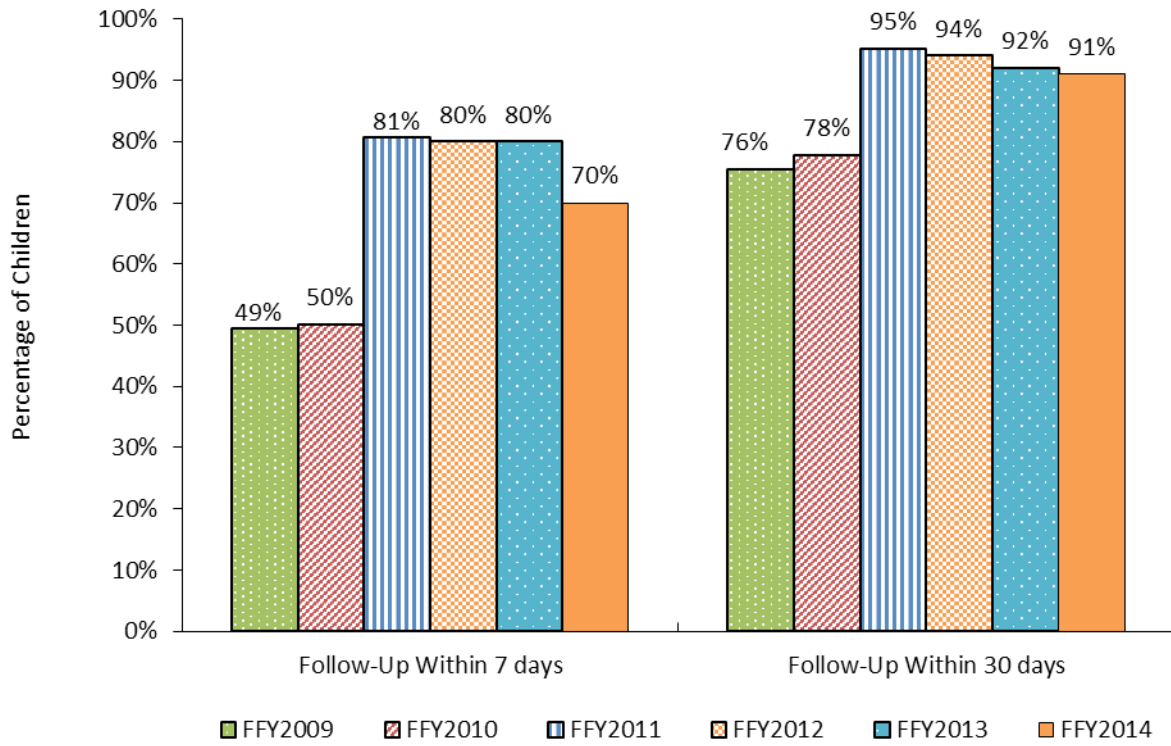
31-32 Information gathered from the Center for Disease Control report, Mental Health Surveillance Among Children- United States, 2005 – 2011. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/su6202a1.htm>

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



The actual measure results are displayed in Figure 15, and show that in FFY 2014 the 7-day follow-up rates decreased by 10 percentage points since FFY 2013 to 70 percent, and the 30-day follow-up rate remained stable at 91 percent.

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



Source: MaineCare Claims Data

## Timeliness and Frequency of Prenatal Care

*CHIPRA Measures PPC-CH, FPC-CH / IHOC Measures 46, 47*

### Background

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

### Measure Definition

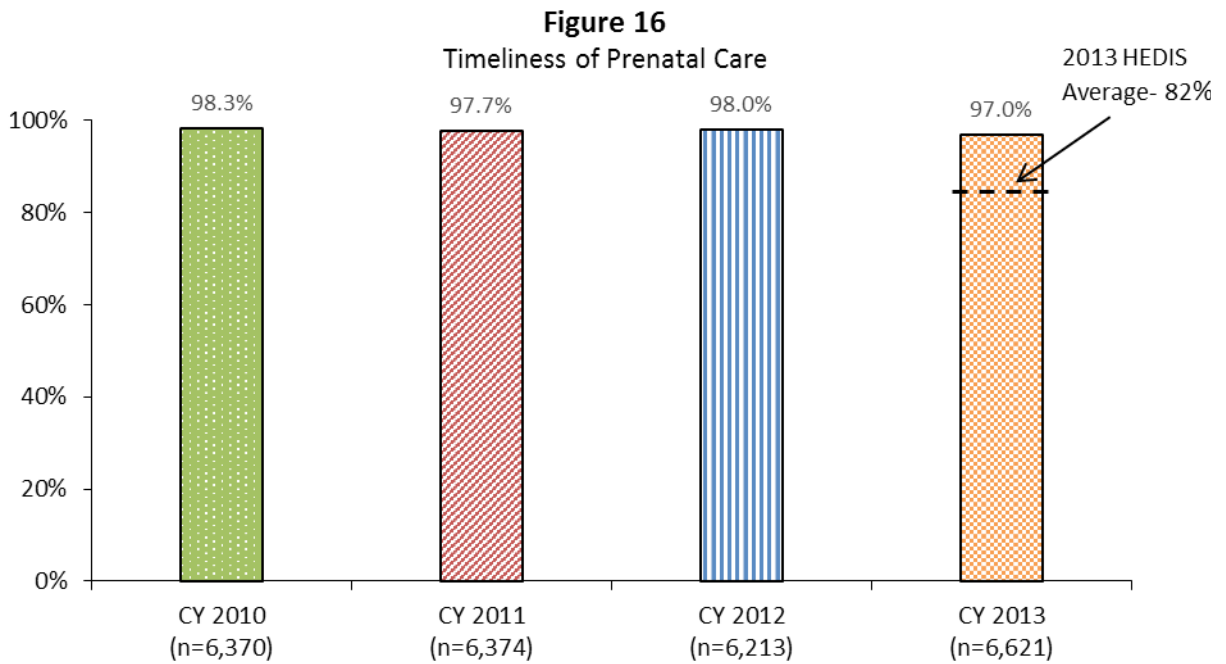
These measures assess the timeliness and frequency of prenatal care that MaineCare-enrolled women received for all deliveries during the measurement year (calendar year). Timeliness measures the number of MaineCare-enrolled women in the denominator sample who had a prenatal visit in the first trimester or within 42 days of enrollment.<sup>34</sup>

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

### Results

Vital statistics data for 2014 are currently not available so the results presented below only include information on the timeliness and frequency of prenatal care for FFYs 2010 -2013. Figure 16 shows that almost 100 percent of MaineCare deliveries were to mothers who received prenatal care in the first trimester of their pregnancy, 15 percentage points higher than the HEDIS average.

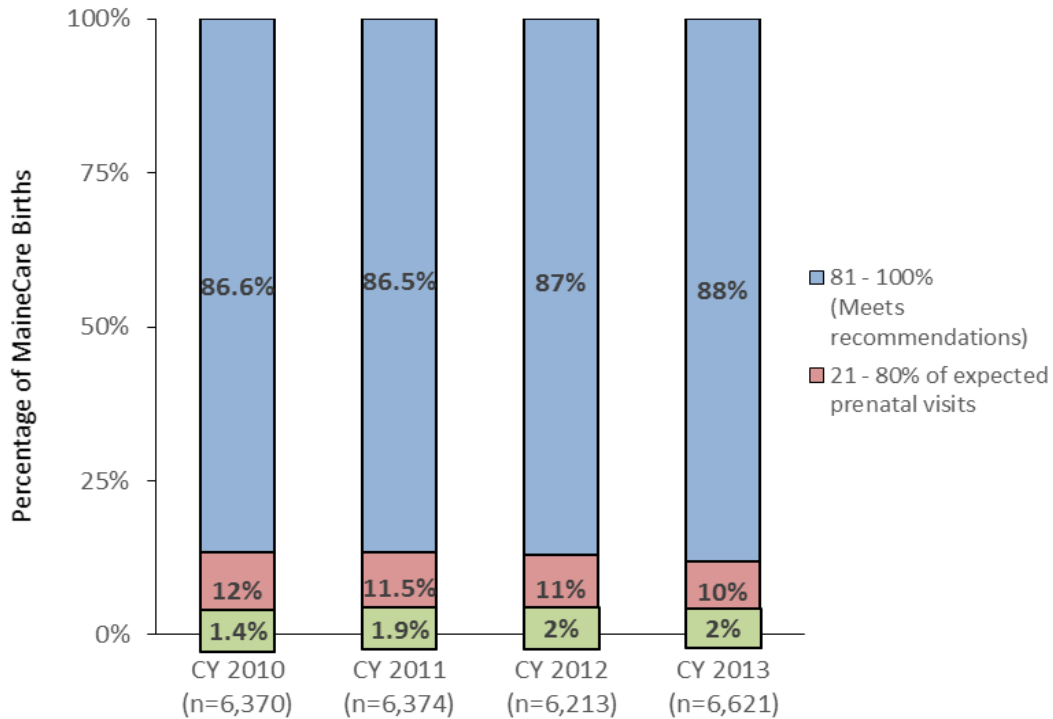
<sup>34</sup> Because of limitations with the self-reported prenatal care information available in the Vital Statistics data, we had to make some modifications to the CHIPRA measure specifications to compute these two measures. The Vital Statistics data only included a total count of prenatal visits received during the pregnancy, and the month in which the first visit was received (e.g. 1 through 9). For the timeliness measure, we counted all mothers who reported their first prenatal visit in month 1,2 or 3 OR who reported their first visit as taking place within 2 months of MaineCare enrollment as meeting numerator criteria. For the frequency of ongoing prenatal care measure, we only adjusted the number of expected visits based on gestational age at delivery (with no adjustment for date of enrollment in MaineCare). Essentially, we made a simplifying assumption that all prenatal care visits were covered by MaineCare for deliveries identified in the denominator.



Source: MaineCare Eligibility and Vital Statistics Data

The frequency of prenatal care among MaineCare recipients has remained consistent since 2010. Figure 17 shows that over the four years, approximately 88 percent of those deliveries who received an “adequate” number of prenatal visits according to the AAP/ACOG.

**Figure 17**  
Frequency of Ongoing Prenatal Care  
(Expected Visits)



Source: MaineCare Eligibility and Vital Statistics Data

## Live Births Weighing Less than 2,500 Grams

CHIPRA Measure LBW-CH / IHOC Measure 48

### Background

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

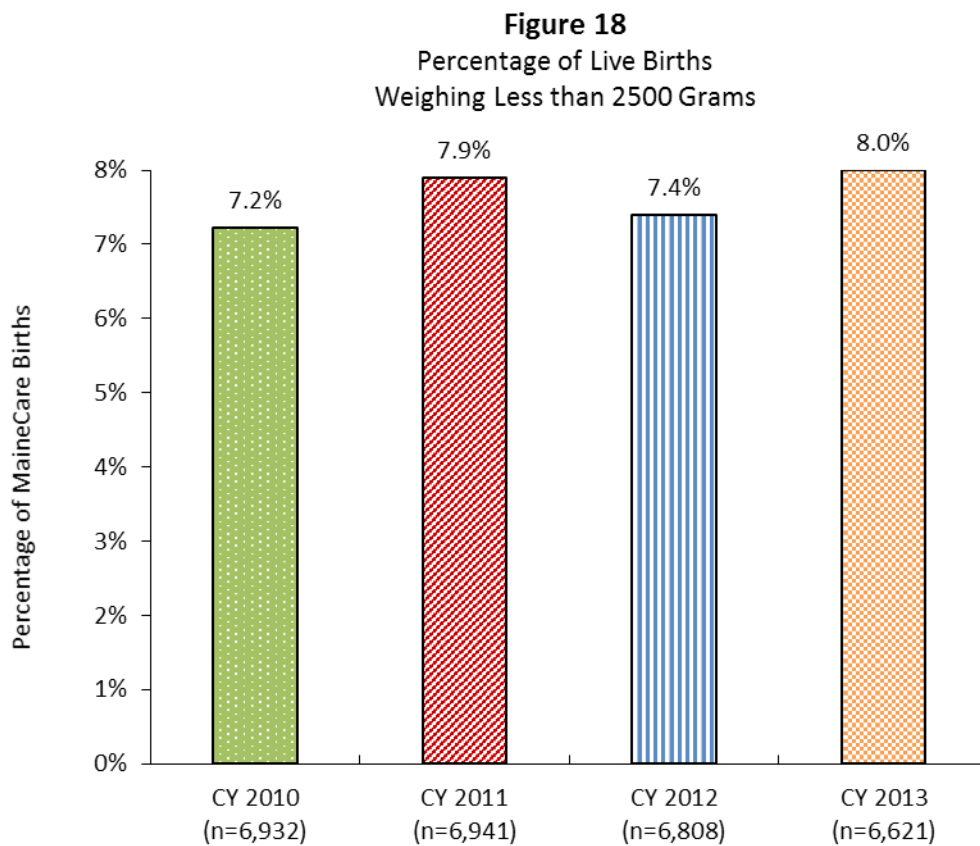


### Measure Definition

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

### Results

Vital statistics data for 2014 is currently not available so the results presented below only include information for FFYs 2010 -2013. Figure 18 shows that just over 8 percent of babies born to MaineCare-enrolled mothers in calendar year 2013 were low birth weight, a slight increase from 2012 where rates were just above 7 percent.



Source: MaineCare Eligibility and Vital Statistics Data

## Developmental Screening in the First Three Years of Life

### *CHIPRA Measure DEV-CH / IHOC Measures 7, 8 and 10*

#### **Background**

In the United States, about 13 percent of children 3 to 17 years of age have a developmental or behavioral disability such as autism, intellectual disability or ADHD.<sup>35</sup> An estimated 9.5 million Medicaid- and CHIP-enrolled preschool children are eligible for developmental screening. In the United States, 17 percent of children (12 million children) were found to have a behavioral disability such as autism, mental retardation, or attention-deficit/hyperactivity disorder. Medicaid serves more than 25 percent of all children in the United States (and more than half of all poor and low-income children). Children from poor families are at greater risk than those from non-poor families for poorer outcomes, including those related to mental development. The 2007 National Survey of Children's Health (NSCH) found that publicly insured children were 1.9 times as likely as privately insured children (18.3 percent versus 9.7 percent, respectively) to have one or more of six specified learning, developmental, or behavioral conditions.<sup>36</sup>

#### **Measure Definition**

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

#### **Results**

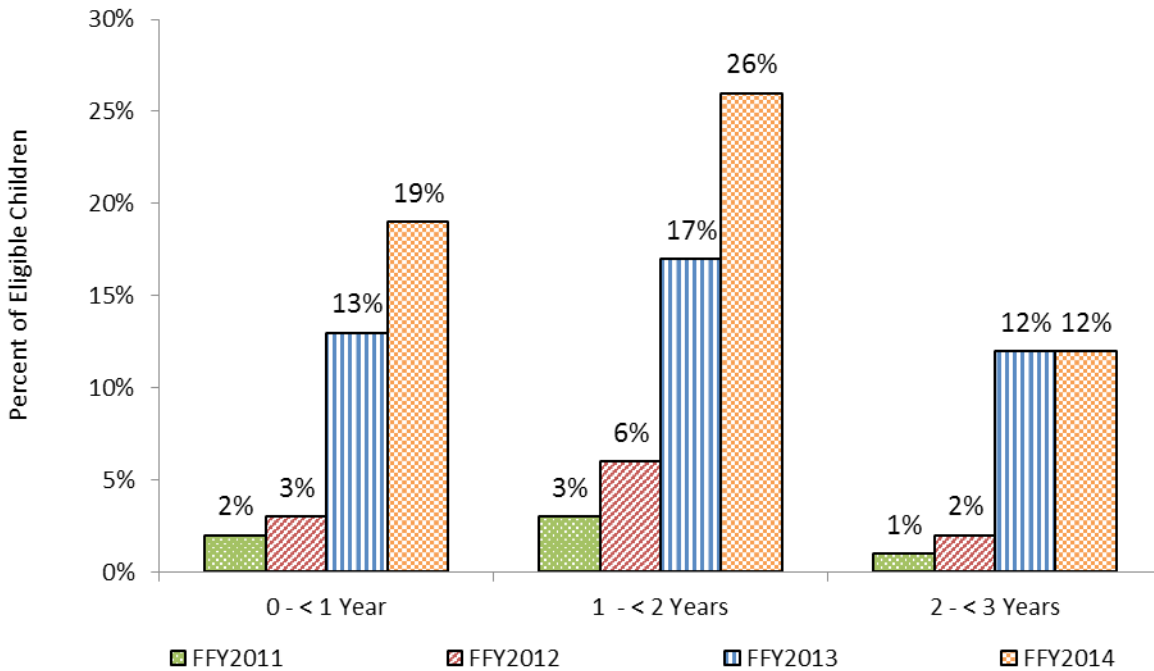
The results for the developmental screening of children who turn 1, 2 and 3 years old during the measurement year are shown in Figures 19 and 20. The rates have significantly increased over the past three years.

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<sup>35</sup> Information gathered from the Center for Disease Control report, Developmental Monitoring and Screening. Available at: <http://www.cdc.gov/ncbddd/childdevelopment/screening.html>

<sup>36</sup> *Background Report for the Initial, Recommended Core Set of Children's Healthcare Quality Measures for Voluntary Use by Medicaid and CHIP Programs.* Available at: <http://archive.ahrq.gov/policymakers/chipra/coreset/coreset.pdf>

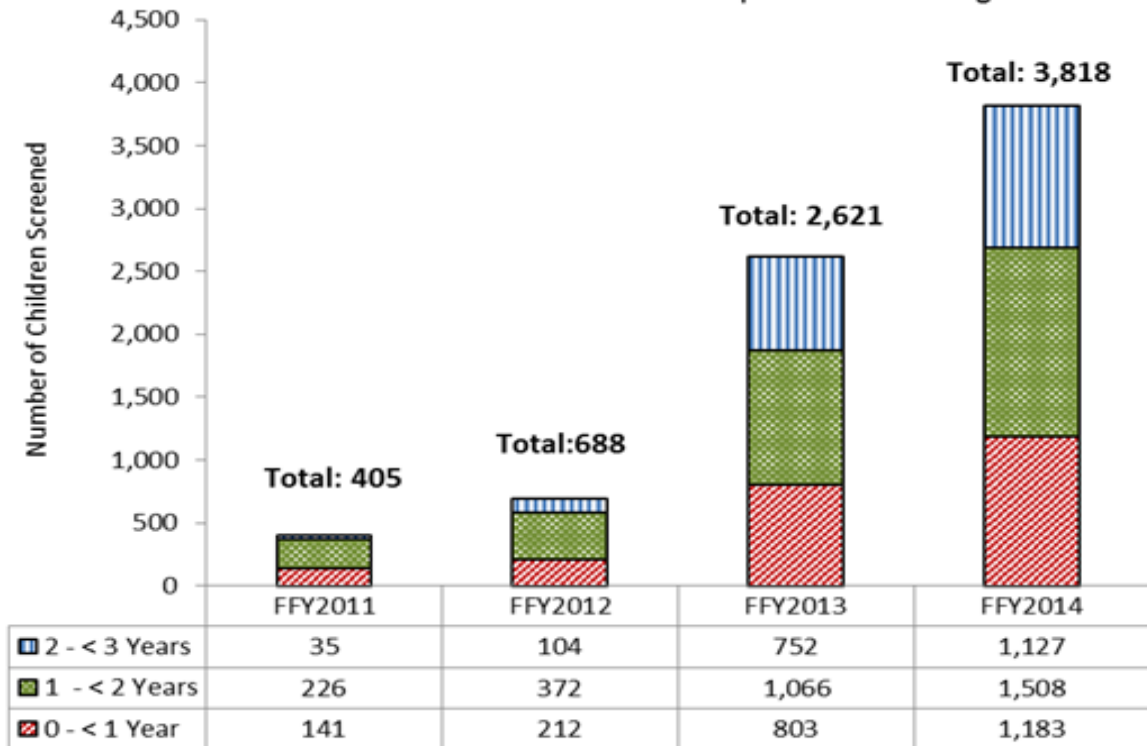
**Figure 19**  
Developmental Screening Rate among MaineCare-Enrolled Children



Source: MaineCare Claims Data

The percentage of children who were screened for risk of developmental, behavioral and social delays using a standardized tool on or before their 1st birthday increased from 1.7 percent in FFY 2011 to 18.5 percent in FFY 2014. One year old screening rates were over 9 times higher in 2014 than they were in 2011. Rates of screening for children after their 1st birthday and on or by their second birthday were also nearly 9 times higher in FFY 2014 than they were in FFY 2011, increasing from 2.48 percent to 25.6 percent. For children between their 2nd and 3rd birthday's rates increased nearly tenfold going from 1.14 percent in FFY 2011 to 11.93 percent in FFY 2013 but remained stable in FFY 2014. Finally, the total number of screenings for all children has increased dramatically from just over 400 screens in FFY 2011 to nearly 4,000 screens in FFY 2014.

**Figure 20**  
Number of Children With Developmental Screening



Source: MaineCare Claims Data

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

### CHIPRA Measure CPC / IHOC Measure 51

#### Background

The main purpose of the annual Survey of Children Served by MaineCare is to monitor the quality of services delivered by MaineCare, the state of Maine’s Medicaid and Child Health Insurance (CHIP) program. The 2014 survey uses a standardized instrument—the Consumer Assessment of Healthcare Providers and Systems (CAHPS 5.0H)—as its primary means of examining the experiences of families with children enrolled in MaineCare. The CAHPS 5.0H is designed to provide feedback to Medicaid fee-for-service and managed care plans by identifying performance dimensions in which they excel and areas in which they need improvement.

The 2013 survey included children aged 17 or younger who were enrolled in MaineCare for at least 5 months between September 2013 and February 2014.

In addition to CAHPS, Maine's annual survey includes supplemental questions that focus on priority areas for the Department including the degree to which providers discuss recommended preventive topics at well-child visits, the prevalence of childhood obesity anti- tobacco use/second-hand smoke exposure among children served by MaineCare, oral health access and unmet need, the affordability of Children's Health Plan premiums, and availability/access to employer-sponsored health insurance. Of the total 2,535 eligible families who were contacted, 1,108 interviews were completed, for an overall response rate of 43.7 percent.

### Measure Definition

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

### Results

- ***MaineCare higher than the national average on most patient experience measures.*** As in the previous year, MaineCare's patient experience scores compared favorably to those of other state child Medicaid programs<sup>37</sup> on CAHPS measures related to providing needed care, providing care quickly, doctor's communication skills, and doctor's knowledge of the child, with ratings at or above the 75th percentile on all the composites and individual items in these four areas. Overall ratings of the child's personal doctor and of health care professionals' provision of information were also among the highest nationally (at or above the 75th percentile).
- ***MaineCare below the national average on care coordination.*** The percentage of those stating that they received help with care coordination also remained stable between 2013 and 2014 at 50 percent which is below the national average of 66% and places MaineCare in the lowest percentile range nationally (less than 25th percentile).
- ***MaineCare lower than national average on customer service, availability of treatment choices, and care coordination among providers.*** As in the previous year's survey, only half (50%) of parents reported that customer service at MaineCare consistently provided the information or help they needed. MaineCare's score on this item fell in the less than 25th percentile range nationally. In addition, 63 percent of parents said that customer service staff were always courteous and respectful, a slight decrease from last year (69%) which is below the current national average of 76%.
- ***Many MaineCare children have special health care needs.*** Thirty-seven percent of children enrolled in MaineCare have special health care needs, according to the 2014 survey. Although this is consistent with the number of children with special health care needs identified in the 2013 survey (35%), it still far

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<sup>37</sup> National comparisons are based on the latest available national CAHPS data available as of the writing of this report, which was for 2014.

exceeds the prevalence of special health care needs in the general population of children in Maine (20%).

- ***MaineCare higher than the national average on providing access to specialized services for children with chronic conditions.*** MaineCare scored above the national average on providing easy access to special therapy (67%), treatment or counseling (67%) and medications (76%) for children with chronic conditions placing Maine in the 90th percentile nationally. However, MaineCare scored fair on providing easy access to special medical equipment or devices for children (62%) which is at the national average but only in the 25th-50th percentile.
- ***For nearly three quarters of MaineCare children, physicians discussed physical activity, nutrition/diet, avoiding sugar-sweetened drinks.*** Physicians also discussed television viewing and other screen time with two thirds of Maine Care Children. Survey results indicate that for children who are overweight, providers are even more likely to discuss issues to encourage healthy behaviors. These rate were comparable or slightly higher, although not significantly, than in the prior year survey.
- ***The majority of respondent's reported having conversations about mental health and substance use during well-child visits.*** Fifty-eight percent of parents indicated that their child's provider discussed mental health issues with the child or parent. Discussions of use of tobacco products (59%) as well as drug and alcohol use (53%) at recommended ages during well-child visits remained consistent between 2013 and 2014.
- ***Majority of MaineCare children get dental care and give high ratings on quality of care received.*** Nearly two-thirds (65%) of all children enrolled in MaineCare received dental services in the past six months, and the majority of children (80%) reported having a regular dentist or dental clinic. By comparison, in a study using 2008 Medicaid administrative data from nine states, 34 percent of children had a dental preventive service and 19 percent had used a dental treatment service provided by Medicaid in the past year.<sup>38</sup>

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38 Bouchery, E. Utilization of dental services among Medicaid-enrolled children. *Medicare and Medicaid Research Review*, 2013; 3:E1-E15. Available at [http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/Downloads/MAX\\_IB9\\_DentalCare.pdf](http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/Downloads/MAX_IB9_DentalCare.pdf)

## APPENDIX A: IHOC AND CHIPRA RESULTS FOR FFYs 2009-2014

Specs	Measure Name	CHIPRA Name	NOTE	Measure Description	FFY2009			FFY2010			FFY2011			FFY2012			FFY2013			FFY2014		
					Numerator	Denominator	%or Rate	Numerator	Denominator	%or Rate	Numerator	Denominator	%or Rate	Numerator	Denominator	%or Rate	Numerator	Denominator	%or Rate	Numerator	Denominator	%or Rate
HEDIS	ADD_NI_PCT	ADD-CH		Follow-Up Care for Children Prescribed ADHD Medication	628	1,271	49.41%	855	1,346	63.52%	875	1,463	59.84%	1,026	1,365	65.56%	1,114	1,645	67.72%	1,039	1,514	68.63%
HEDIS	ADD_CM_PCT	ADD-CH		Follow-Up Care for Children Prescribed ADHD Medication	551	1,189	46.34%	765	1,274	60.09%	878	1,387	63.30%	922	1,482	62.21%	1,008	1,564	64.49%	940	1,429	65.82%
HEDIS	ASM_5_PCT	MMA-CH		Use of Appropriate Medications for People With Asthma (5-12)	1,259	1,363	93.05%	1,369	1,465	93.49%	1,512	1,626	92.99%	1,523	1,612	94.48%	684	729	93.83%	1,213	1,295	93.67%
HEDIS	ASM_12_PCT	MMA-CH		Use of Appropriate Medications for People With Asthma (12-21)	1,160	1,304	88.96%	1,213	1,386	87.52%	1,239	1,437	86.22%	1,240	1,438	86.23%	597	675	88.44%	1,167	1,329	87.81%
HEDIS	ASM_TOT_PCT	MMA-CH		Use of Appropriate Medications for People With Asthma	2,419	2,667	91.04%	2,582	2,851	90.59%	2,751	3,063	89.81%	2,763	3,060	90.59%	1,281	1,404	91.24%	2,380	2,624	90.70%
HEDIS	AWO_PCT	AWO-CH		Adolescent Well-Care Visits	16,502	43,402	38.02%	16,738	46,469	36.12%	19,434	49,188	39.51%	18,528	47,980	38.61%	18,008	46,350	38.89%	18,512	44,696	41.42%
HEDIS	CAP_12M_PCT	CAP-CH		Children and Adolescents' Access to Primary Care Reconciliation	6,643	6,822	97.38%	7,111	7,329	97.03%	7,259	7,528	96.41%	6,860	7,043	97.19%	6,498	6,736	96.47%	6,299	6,512	96.73%
HEDIS	CAP_24M_PCT	CAP-CH		Children and Adolescents' Access to Primary Care Reconciliation	25,177	28,715	87.68%	27,153	31,229	86.99%	29,153	33,116	88.03%	28,548	32,438	88.01%	27,552	31,302	88.02%	25,985	29,537	87.97%
HEDIS	CAP_T_PCT	CAP-CH		Children and Adolescents' Access to Primary Care Reconciliation	21,483	23,901	89.80%	22,517	24,999	90.07%	24,769	27,109	91.44%	25,999	27,768	92.12%	25,668	27,821	92.26%	25,428	27,428	92.70%
HEDIS	CAP_12_PCT	CAP-CH		Children and Adolescents' Access to Primary Care Reconciliation	30,530	34,467	88.75%	30,068	36,025	89.02%	34,960	38,590	89.82%	35,173	38,996	90.21%	35,035	38,802	90.79%	34,075	37,481	90.96%
CHIPRA	CDC_HS_P1M_T		retired-IHOC use only	Comprehensive Diabetes Care	230	371	75.47%	294	368	79.89%	329	408	80.64%	339	404	83.91%	314	395	79.49%	320	383	83.55%
HEDIS	CDC_HS_ATRM		retired-IHOC use only	Comprehensive Diabetes Care - HDAIC Average number of tests per member	854	371	2.30	928	368	2.30	1,024	408	2.51	1,117	404	2.76	926	395	2.76	1,055	383	2.75
HEDIS	CHL_16_PCT	CHL-CH		Chlamydia Screening	3,877	8,549	45.35%	3,663	8,974	40.82%	3,891	9,216	42.21%	3,315	8,403	39.45%	3,039	7,121	42.69%	2,845	7,230	39.08%
HEDIS	CWP_PCT		retired-IHOC use only	Appropriate Testing for Children With Rheingitis	716	994	72.03%	745	992	75.10%	1,040	1,303	79.82%	946	1,171	80.79%	651	819	79.49%	655	730	83.97%
HEDIS	FUH_30D_PCT	FUH-CH		Follow-Up After Hospitalization for Mental Illness	867	1,148	75.52%	787	1,012	77.77%	827	878	94.19%	854	910	93.85%	655	712	91.99%	958	1,053	90.96%
HEDIS	FUH_70D_PCT	FUH-CH		Follow-Up After Hospitalization for Mental Illness	567	1,148	49.39%	507	1,012	50.10%	701	878	79.84%	729	910	80.11%	567	712	79.63%	733	1,053	69.61%
HEDIS	W34_PCT	W34-CH		Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	14,762	23,124	63.84%	15,505	25,304	61.27%	17,241	26,846	64.22%	16,492	26,526	62.17%	16,176	25,788	62.73%	15,829	24,385	64.91%
HOC	W0711		IHOC Measure only	Well-Child Visits between 7 years of age and 11 years of age	12,754	27,246	46.81%	12,950	28,856	44.89%	14,743	30,590	48.21%	14,713	30,811	47.75%	14,768	30,432	48.53%	15,383	29,975	51.31%
CHIPRA	DPS	PDENT-CH	reported using CMS 416	Total Eligibles Who Received Preventive Dental Services	48,869	137,836	35.45%	51,557	143,052	36.04%	61,769	140,732	43.89%	64,797	143,014	45.30%	64,797	131,968	49.10%	65,240	130,146	50.13%
CHIPRA	DTS	IDENT-CH	reported using CMS 416	Total Eligibles Who Received Dental Treatment Services	15,004	137,836	10.89%	15,790	143,052	11.04%	17,395	140,732	12.36%	20,134	143,014	14.08%	18,031	131,968	13.68%	17,480	130,146	13.43%
CHIPRA	FLR		reported using CMS 416	Total Eligibles Who Received Fluoride Treatment Services	11,316	137,836	8.21%	16,263	143,052	11.37%	23,852	146,796	16.25%	30,119	148,962	20.22%	33,527	143,116	23.43%	36,259	139,896	25.92%
CHIPRA	DB3	DEV-CH		Developmental Screening - Age 1						117	6,914	1.69%	212	6,484	3.26%	303	6,425	4.72%	1,183	6,394	18.50%	
CHIPRA	DB3	DEV-CH		Developmental Screening - Age 2						171	6,885	2.48%	372	6,466	5.75%	1,096	6,230	17.43%	1,508	5,884	25.63%	
CHIPRA	DB3	DEV-CH		Developmental Screening - Age 3						78	6,820	1.14%	104	6,617	1.57%	752	6,306	11.93%	1,127	5,928	19.01%	
CHIPRA	APER		retired-IHOC use only	Annual Number of Asthma Patients with > 1 asthma-related Emergency Room Visit	881	11,817	7.46%	874	12,719	6.87%	1,082	11,939	9.06%	1,009	11,799	8.56%	671	8,479	7.92%	880	10,796	7.96%
Local	ERUTL	AIB-CH	Local IHOC only	ER Utilization (Total Visits/Total Members) - Avg # Visits/member	86,152	145,239	0.59	89,374	150,038	0.60	87,000	152,976	0.57	81,545	154,760	0.53	73,895	148,912	0.50	65,070	145,921	0.45

### Number of Well-Child Visits

Specs	Measure Name	CHIPRA Name	Note	Measure Description	FFY2009		FFY2010		FFY2011		FFY2012		FFY2013		FFY2014	
					Visits	# Mors	Visits	# Mors	Visits	# Mors	Visits	# Mors	Visits	# Mors		
HEDIS	W15	W15-CH		Well-Child Visits in the First 15 Months of Life	0	131	0	151	0	159	0	185	0	173	0	205
					1	106	1	97	1	105	1	115	1	109	1	95
					2	165	2	194	2	190	2	188	2	164	2	156
					3	268	3	278	3	288	3	309	3	258	3	234
					4	532	4	562	4	600	4	499	4	468	4	468
					5	1,001	5	1,082	5	1,110	5	991	5	869	5	835
					6+	3,903	6+	4,162	6+	4,206	6+	4,148	6+	4,249	6+	4,220
HEDIS	W024		IHOC Only	Well-Child Visits between 15 months and 3 years of age	0	663	0	753	0	810	0	655	0	597	0	587
					1	972	1	1,138	1	1,140	1	1,000	1	861	1	749
					2	1,538	2	1,712	2	1,724	2	1,680	2	1,382	2	1,314
					3+	2,663	3+	2,917	3+	3,146	3+	3,302	3+	3,357	3+	3,198

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

## APPENDIX A: IHOC AND CHIPRA RESULTS FOR FFYS 2009-2014 (CONTINUED)

### Perinatal Measures- Run 1/17/2013

NOTE: Prenatal measures are based on vital statistics data and are reported retrospectively (1 year behind); all perinatal measures run based on calendar years (not FFY)

NOTE: 2013 frequency and timeliness of prenatal care measures were calculated using a subset of the Vital stats data from 1/1/2013 to 7/31/2013 birth due to the prenatal care number not reported on the record (changed over to New Birth Certificate)

Specs	Measure Name	CHIPRA Name	Note	Measure Description	CY2010			CY2011			CY2012			CY2013		
					Num	Denom	% or Rate	Num	Denom	% or Rate	Num	Denom	% or Rate	Num	Denom	% or Rate
CHIPRA	TPC	PPO-CH	Modified CHIPRA Specs	Timeliness of Prenatal Care (all ages)	4,332	4,370	99.36%	4,330	4,374	97.16%	4,041	4,315	93.65%	3,332	3,423	97.37%
CHIPRA	TPC_>16weeks	PPO-CH	Modified CHIPRA Specs	Timeliness of Prenatal Care (mother > 16 year at delivery)	137	142	96.48%	142	144	98.61%	133	131	98.00%	48	70	68.57%
CHIPRA	TPC_<16weeks	PPO-CH	Modified CHIPRA Specs	Timeliness of Prenatal Care (mother < 16 year at delivery)	4,195	4,228	99.22%	4,188	4,230	97.12%	3,908	4,184	93.43%	3,284	3,353	97.94%
CHIPRA	PLB	LBW-CH		Percentage of live births weighing less than 3,500 grams (all ages)	201	4,432	4.53%	214	4,441	4.82%	220	4,432	4.96%	224	4,753	4.71%
CHIPRA	PLB_>16weeks	LBW-CH		Percentage of live births weighing less than 3,500 grams (mother > 16 year at delivery)	10	171	5.85%	14	142	9.86%	17	144	11.81%	4	142	2.82%
CHIPRA	PLB_<16weeks	LBW-CH		Percentage of live births weighing less than 3,500 grams (mother < 16 year at delivery)	191	4,261	4.49%	200	4,299	4.65%	203	4,288	4.73%	220	4,611	4.77%

Specs	Measure Name	CHIPRA Name	Note	Measure Description	CY2010		CY2011		CY2012		CY2013	
					# Mothers	% of Mothers	# Mothers	% of Mothers	# Mothers	% of Mothers	# Mothers	% of Mothers
CHIPRA	FPC_0_30	PPO-CH	Modified CHIPRA Specs	Frequency of Prenatal Care: 0 - 30% of expected prenatal visits	46	1.32%	13	1.32%	134	2.00%	71	2.07%
	FPC_31_40	PPO-CH		Frequency of Prenatal Care: 31 - 40% of expected visits	35	0.99%	43	0.99%	50	1.00%	21	0.64%
	FPC_41_50	PPO-CH		Frequency of Prenatal Care: 41 - 50% of expected visits	137	3.98%	146	3.07%	146	3.00%	69	2.00%
	FPC_51_60	PPO-CH		Frequency of Prenatal Care: 51 - 60% of expected visits	271	8.00%	445	7.77%	449	8.00%	369	7.18%
	FPC_61_P	PPO-CH		Frequency of Prenatal Care: >60% of expected visits	2,219	66.63%	2,214	66.81%	2,342	66.00%	2,462	67.32%
TOTAL					4,370	100.00%	4,374	100.00%	4,215	100.00%	3,423	100.00%

### Prenatal Measures Calculations:

PPO-CH	Timeliness of Prenatal Care	Denominator: Members with continuous enrollment 42 days prior to the delivery through 56 days after. Data From Vital Stats file and MHMS MaineCare Eligibility File Numerator: Based on member reported month of prenatal care in the Vital Stats data and MaineCare Eligibility data. Member reported PNC when PNC was in first trimester OR reported month of prenatal care when visit was within 2 months of MaineCare enrollment.
PPO-CH	Frequency of Ongoing Prenatal Care	Denominator: Members with continuous enrollment 42 days prior to the delivery through 56 days after. Data From Vital Stats file and MHMS MaineCare Eligibility File (1/1/2012 to 7/31/2012) Numerator: Based on Vital Stats data and MaineCare Eligibility as well as HGIS specifications Table PPO-A in the HGIS contained recommended visits based on the 9th month of pregnancy (not there for 2010) and had an additional line for 42 weeks gestational age.
LBW-CH	Percentage of Live Births weighing less than 3,500 grams.	Denominator: Number of Live Births in the State. Mother or Child enrolled in a Full Benefit MaineCare PAC on the baby's dob. Data From Vital Stats file and MHMS MaineCare Eligibility File Numerator: Number of resident live births less than 3,500 grams (reported in the Vital Stats data) from the denominator