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Improving Performance Measurement in the State Children's Health Insurance Program

Final Report

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CONTENTS

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TABLES

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IMPROVING PERFORMANCE MEASUREMENT IN THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM

As part of the ongoing effort to assess the progress of the State Children's Health Insurance Program (SCHIP), increasing attention has been devoted to improving the reporting of program performance data by states. The Centers for Medicare & Medicaid Services (CMS) is required by Title XXI and the SCHIP Final Rules to assess progress made by SCHIP plans toward achieving their strategic objectives and performance goals. In 2002, CMS convened the Performance Measurement Partnership Project (PMPP) as a collaborative effort between federal and state officials to explore the development of a national set of performance measures for Medicaid and SCHIP. CMS contracted with the National Academy for State Health Policy (NASHP) to facilitate the workgroup that would develop these measures. The group focused on well-established measures whose results could motivate agencies, providers, and health plans to improve the quality of care delivered to enrollees. After receiving comments from Medicaid and SCHIP officials on an initial set of 19 measures, the PMPP recommended a core set of seven national performance measures consisting of four child health and three adult measures. CMS requested that states report available data on these measures in their federal fiscal year (FFY) 2003 annual SCHIP reports.

CMS contracted with Mathematica Policy Research, Inc. (MPR) to analyze the child health performance measurement data reported in the FFY 2003 annual SCHIP reports and to provide states with the technical assistance needed to improve the completeness and quality of FFY 2004 reporting. In this report, we present the results of our analysis, including tables that display the states' reporting of each child health measure. Also included is a summary of the common questions and challenges encountered by states while completing the FFY 2003 reports, as well as an overview of the technical assistance provided by MPR to improve FFY 2004 reporting.

HEDIS® Methodology Provides a Useful Framework for Performance Measurement Reporting

Of the seven performance measures recommended by the PMPP, only the four child health measures are applicable to most state SCHIP programs.[1] They are:

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. Use of appropriate medications for children with asthma
4. Objectives related to the use of preventive care[2]

These measures are based on the technical specifications provided by the Health Plan Employer Data and Information Set, known as HEDIS®.[3] HEDIS provides a useful framework for defining and measuring performance in addition to allowing for comparison of SCHIP program performance to national or state benchmarks.[4] However, states are not required to use HEDIS and may use a different methodology to report on program performance. States may also modify HEDIS specifications to accommodate data they already collect. The goal is for states to select one methodology and continue using it across subsequent years, thus achieving consistency in the type, and content, of reporting over time.

Discussion of Child Health Measures

This section provides an overview of the four child health measures. Appendix A contains more detailed descriptions of the four child health measures, based on information found at the National Quality Measures Clearinghouse™, a public repository for evidence-

[1] The majority of state SCHIP programs cover only infants and children. However, 8 states covered adults using Title XXI SCHIP funds in FFY 2003. The three adult health performance measures are: adult comprehensive diabetes care (hemoglobin A1c tests); adult access to preventive/ambulatory services; and adult prenatal and postpartum care (prenatal visits).

[2] The FFY 2003 annual report template referred to the fourth measure as "Objectives related to use of preventative care (immunizations, well child care)," which is also a category used by states to report on their progress toward meeting SCHIP state plan strategic objectives. To clarify the intent of the fourth measure, the annual report template was revised for FFY 2004 and the fourth measure is now referred to as "Children's access to primary care practitioners."

[3] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). HEDIS is the most widely used set of performance measures in the managed care industry (NCQA 2003).

[4] For example, states may compare their data to the national benchmarks determined by the American Public Human Services Association (APHSA), which calculated rates of specific HEDIS measures for the Medicaid population; see the APHSA Medicaid HEDIS Database Project, [http://www.nasmd.org/pubs/Medicaid%20HEDIS%202002%20Database%20Report.pdf]. States may also use state commercial benchmarks to assess state progress over time.

based quality measures and measure sets. The Clearinghouse is sponsored by the Agency for Healthcare Research and Quality and is located at [www.qualitymeasures.ahrq.gov].

The first measure, *Well-child visits in the first 15 months of life*, provides an estimate of the number of well-child visits received by infants enrolled in SCHIP. HEDIS defines the eligible population, which is also the denominator for the measure, as infants who turned 15 months old during the measurement year and were continuously enrolled in the program from 31 days of age, with a gap of no more than 45 days. The numerator is defined as the number of children in the eligible population who received a visit with a primary care practitioner during the first 15 months of life. HEDIS specifies that seven separate rates be reported corresponding to the percentage of infants who received zero, one, two, three, four, five, or six or more visits.

The second measure, *Well-child visits in the third, fourth, fifth, and sixth years of life*, assesses the percentage of preschool- and early-school-age children enrolled in SCHIP who received well-child visits during the measurement year. HEDIS defines the eligible population, or denominator, as children who were three, four, five, or six years old during the measurement year and who were continuously enrolled, with a gap of no more than 45 days. The numerator consists of children in the eligible population who had at least one well-child visit with a primary care practitioner during the measurement year. HEDIS specifies that one combined rate be reported for the percentage of children ages three, four, five, or six who received one or more visits.

The third measure, *Use of appropriate medications for children with asthma*, evaluates whether members with persistent asthma are prescribed medications considered acceptable as primary therapy for long-term control of asthma. HEDIS defines the eligible population, or denominator, as continuously enrolled children from two age cohorts, 5 to 9 and 10 to 17 years, who had persistent asthma during the preceding year. HEDIS specifies two years of continuous enrollment, during both the measurement year and the year preceding the measurement year, with a gap of no more than 45 days; persistent asthma is based on the *previous* year's service and medication use, as opposed to a clinical measure of severity.[5] The numerator consists of the number of children in the eligible population who had at least one dispensed prescription for one of the qualified asthma medications.[6] HEDIS requires separate rates for the two age cohorts, as well as a combined rate for children ages 5 to 17.

[5] Persistent asthma is defined by HEDIS as any of the following: at least one emergency department visit with asthma as the principal diagnosis; or at least one acute inpatient discharge with asthma as the principal diagnosis; or at least four outpatient asthma visits with asthma as one of the listed diagnoses and at least two asthma medication-dispensing events; or at least four asthma-dispensing events.

[6] Medications considered acceptable as primary therapy include cromolyn sodium inhaled corticosteroids; leukotriene modifiers; methylxanthines; or nedocromil.

The fourth measure, *Objectives related to the use of preventive care*, is based on the HEDIS performance measure *Children's access to primary care practitioners*.[7] Three age cohorts are identified: children ages 12 to 24 months, 25 months to 6 years, and 7 to 11 years. HEDIS defines the eligible population, or denominator, as children who were continuously enrolled during the measurement period.[8] The numerator includes children in the eligible population who had one or more visits with any primary care practitioner during the measurement period.[9] HEDIS specifies that separate rates be reported for each of the three age groups.

OVERVIEW OF DATA REPORTED IN FFY 2003 ANNUAL REPORTS

States are required to assess the operation of their SCHIP program in each fiscal year and report their assessment to CMS using the SCHIP annual report framework. Section II of the FFY 2003 annual report template is dedicated to the "Program's Strategic Objectives and Performance Goals," and states reported data on the child health measures within the area labeled "Reporting of National Performance Measures." Many states also reported data on the child health measures in separate documents or reports that were attachments to the annual report template. Section II of the FFY 2003 annual report template is presented in Appendix B.

To analyze the information reported for FFY 2003, MPR downloaded the SCHIP annual reports from the CMS website.[10] We compiled the child health measure data reported by each state, including a description of the methodology used, data source and year, and summary of the progress made by each state toward meeting individual performance goals. We augmented these data with additional information referenced by states, such as data located in attachments or another area of the annual report.

FFY 2003 was the first year in which CMS requested that states report available data on the child health measures. States received no training and minimal instruction in how to report the new measures, and the FFY 2003 annual report template did not provide definitions for the new measures. Thus, there was large variation in the type and detail of reporting among states.

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[7] As previously noted, this child health measure was renamed in the FFY 2004 annual report template to reflect the HEDIS measure, "Children's access to primary care practitioners."

[8] According to HEDIS specifications, the measurement period varies by age. Children ages 12 to 24 months and 25 months to 6 years are eligible if continuously enrolled during the measurement year; children ages 7 to 11 years are eligible if continuously enrolled during the measurement year and the year prior to the measurement year.

[9] The following visits are excluded: inpatient procedures, emergency department and specialist visits, and certain mental health and chemical dependency services.

[10] Most of the reports were downloaded from CMS's internal State Annual Report Template System (SARTS). Many of the reports also are posted on the "SCHIP Annual Reports" home page http://www.cms.hhs.gov/schip/annual-reports/year-report.asp?year=2003.

MPR tabulated the number of states that reported data for each child health measure and analyzed the methodology used. States that followed the technical specifications outlined by HEDIS, including the data and reporting elements, were considered to have used either HEDIS or a HEDIS-like methodology, whereas states that used a different methodology were classified as having used another approach.[11] Table 1 indicates the number of measures reported by each state.[12] A majority of states (n = 36) reported at least one child health measure in FFY 2003, and 8 states reported all four measures. Fourteen states reported no measures in FFY 2003; some of these states indicated that data were not yet available or that data collection had only recently begun.

Table 1. Number of Child Health Measures Reported, by State

Number of Measures Reported	States	Number of States Reporting
Four Measures	Arkansas, Hawaii, Indiana, Michigan, Mississippi, Rhode Island, Texas, Wisconsin	8
Three Measures	Alabama, Arizona, Connecticut, Iowa, Kentucky, Maine, Maryland, Massachusetts, Montana, Nevada, New Jersey, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, West Virginia	18
Two Measures	California, Florida, Georgia, Missouri, New Mexico, South Carolina, South Dakota	7
One Measure	Delaware, Idaho, Illinois	3
No Measures	Alaska, Colorado, District of Columbia, Kansas, Louisiana, Minnesota, Nebraska, New Hampshire, Oklahoma, Utah, Vermont, Virginia, Washington, Wyoming	14

Source: FFY 2003 State Title XXI Annual Reports.

As shown in Table 2, the measure most frequently reported was *Well-child visits in the third, fourth, fifth, and sixth years of life* (33 states reported), while *Use of appropriate medications for children with asthma* was reported least frequently (15 states reported). Most states that reported used either HEDIS or HEDIS-like methodology (Table 3). Examples of other methodologies are participant and screening ratios from state Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) reports and measures taken from state survey data.

[11] While some states explicitly indicated they used HEDIS methodology, other states did not specify the methodology used but reported data that appeared to meet HEDIS specifications. Since we could not confirm whether these states followed HEDIS specifications versus modified, or HEDIS-like, specifications, this report does not distinguish between states that used HEDIS versus a HEDIS-like methodology. However, where possible, we have attempted to define data that we considered to be HEDIS-like.

[12] In addition, four states reported the adult comprehensive diabetes care measure (Arizona, Michigan, Rhode Island, and Wisconsin), three reported the adult access to preventive/ambulatory services measure (Arizona, Rhode Island, and Wisconsin), and two reported the prenatal and postpartum care measure (Michigan and Rhode Island).

Table 2. Summary of State Reporting, by Child Health Measure

State	Program Type	Well-Child Visits, First 15 Months	Well-Child Visits, 3 to 6 Years	Use of Appropriate Asthma Medications	Objectives Related to Use of Preventive Care	Total Number of Measures Reported by State
Total Number of States Reporting		28	33	15	27	
Alabama	S-SCHIP	x	x		x	3
Alaska	M-SCHIP					0
Arizona	S-SCHIP	x	x		x	3
Arkansas	M-SCHIP	x	x	x	x	4
California	COMBO		x		x	2
Colorado	S-SCHIP					0
Connecticut	S-SCHIP	x	x		x	3
Delaware	S-SCHIP				x	1
District of Columbia	M-SCHIP					0
Florida	COMBO	x	x			2
Georgia	S-SCHIP		x	x		2
Hawaii	M-SCHIP	x	x	x	x	4
Idaho	M-SCHIP				x	1
Illinois	COMBO			x		1
Indiana	COMBO	x	x	x	x	4
Iowa	COMBO	x	x		x	3
Kansas	S-SCHIP					0
Kentucky	COMBO	x	x		x	3
Louisiana	M-SCHIP					0
Maine	COMBO	x	x		x	3
Maryland	COMBO	x	x		x	3
Massachusetts	COMBO	x	x		x	3
Michigan	COMBO	x	x	x	x	4
Minnesota	M-SCHIP					0
Mississippi	S-SCHIP	x	x	x	x	4
Missouri	M-SCHIP	x	x			2
Montana	S-SCHIP		x	x	x	3
Nebraska	S-SCHIP					0
Nevada	S-SCHIP	x	x		x	3
New Hampshire	COMBO					0
New Jersey	COMBO	x	x		x	3
New Mexico	M-SCHIP	x	x			2
New York	COMBO	x	x	x		3
North Carolina	S-SCHIP		x	x	x	3
North Dakota	COMBO	x	x		x	3
Ohio	M-SCHIP	x	x	x		3
Oklahoma	M-SCHIP					0
Oregon	M-SCHIP	x	x		x	3
Pennsylvania	S-SCHIP		x	x	x	3
Rhode Island	COMBO	x	x	x	x	4
South Carolina	M-SCHIP	x	x			2
South Dakota	M-SCHIP	x	x			2
Texas	S-SCHIP	x	x	x	x	4
Utah	S-SCHIP					0
Vermont	S-SCHIP					0
Virginia	COMBO					0
Washington	S-SCHIP					0
West Virginia	S-SCHIP	x	x		x	3
Wisconsin	M-SCHIP	x	x	x	x	4
Wyoming	S-SCHIP					0

Source: FFY 2003 State Title XXI Annual Reports.

Table 3. Summary of Reporting Methodology, by Child Health Measure

Measure	Reported Using HEDIS or HEDIS-like Methodology	Reported Using Other Methodology	Not Reported
Well-child visits, first 15 months	20 states	8 states	22 states
Well-child visits, 3 to 6 years	28 states	5 states	17 states
Use of appropriate asthma medications	13 states	2 states	35 states
Objectives related to use of preventive care	18 states	9 states	23 states

Source: FFY 2003 State Title XXI Annual Reports.

ANALYSIS OF FFY 2003 DATA REPORTED FOR EACH CHILD HEALTH MEASURE

Our analysis of the data reported in the FFY 2003 SCHIP annual reports revealed significant variation in the type of information provided by states for each child health measure. State reporting varied substantially by data source, methodology, and measurement period. Furthermore, many states did not describe the measurement specifications they used and did not provide the sample size or numerator and denominator. In this section, we present the results for each of the four measures.

Well-Child Visits in the First 15 Months of Life

More than half of all states (n = 28) reported this measure, and most (n = 20) used HEDIS or HEDIS-like methodology (Table 4). States that used HEDIS methodology reported seven rates, corresponding to the number of children who received zero, one, two, three, four, five, or six or more well-child visits.[13] States were considered to have used a HEDIS-like approach if they reported some rates using HEDIS methodology but did not report all seven of the rates described above. Of the eight states that reported using a measure other than HEDIS or HEDIS-like, two reported EPSDT measures.[14]

As shown in Table 4, there is wide variation in the rates reported by the 20 states that used HEDIS or HEDIS-like methodology. For instance, the percentage of children who received six or more well-child visits in the past year ranged from 9 percent in Texas to 71 percent in Arizona.[15] The percentage receiving no visits ranged from 2 percent in Maine to 55 percent in Michigan. The reporting years for these data spanned calendar years 2001 to 2003.

[13] New Mexico reported the rates of well-child visits by health plan instead of providing statewide rates. However, because they reported the numerator and denominator for each health plan, we were able to compute an aggregate, statewide rate corresponding to the number of children that received zero, one, two, three, four, five, or six or more well child visits.

[14] These states (Connecticut and Missouri) reported screening and participant ratios.

[15] Arizona noted that its SCHIP sample size (n = 24) was too small to yield statistically valid conclusions. However, despite the small sample size, the rate of well child visits among this group was very similar to the overall rate of 68 percent for Medicaid-eligible children in Arizona; this represented a statistically significant increase ($p<0.001$) from the previous measurement period.

Table 4. Well-Child Visits in the First 15 Months

State	Program Type	Reporting Year	Data Source	Percentage of Children Receiving Well-Child Visits: Rate(s) Reported
Reported Using HEDIS or HEDIS-like Methodology (n = 20)				
Alabama	S-SCHIP	NR	Blue Cross Blue Shield of Alabama ALL Kids Annual Report	76% with 1+ visits
Arizona	S-SCHIP	10/1/01 to 9/30/02	Enrollment and encounter data	71% with 6+ visits
Arkansas	M-SCHIP	SFY 2002	Claims data	0 visits – 6% 1 visit – 7% 2 visits – 8% 3 visits – 8% 4 visits – 12% 5 visits – 14% 6+ visits – 45%
Hawaii	M-SCHIP	SFY 2003	Claims data	0 visits – 3% 1 visit – 2% 2 visits – 3% 3 visits – 5% 4 visits – 10% 5 visits – 21% 6+ visits – 56%
Indiana	COMBO	2002	Claims data	0 visits – 11% 1 visit – 9% 2 visits – 11% 3 visits – 14% 4 visits – 18% 5 visits – 21% 6+ visits – 17%
Kentucky	COMBO	CY 2001	Claims data (MCO only)	49% received 6+ visits
Maine	COMBO	10/1/02 to 9/30/03	Claims data	0 visits – 2% 1 visit – 1% 2 visits – 5% 3 visits – 5% 4 visits – 8% 5 visits – 13% 6+ visits – 67%
Maryland	COMBO	2003	Administrative and medical record data	75% with 5+ visits
Massachusetts	COMBO	2002	Weighted mean calculated from health plan data	62% with 6+ visits
Michigan	COMBO	2002	Blue Cross Blue Shield of Michigan HEDIS-like data reports	45% with 1+ visits

Table 4 *(continued)*

State	Program Type	Reporting Year	Data Source	Percentage of Children Receiving Well-Child Visits: Rate(s) Reported
Mississippi	S-SCHIP	CY 2002	2002 claims data paid through September 2003	0 visits – 34% 1 visit – 19% 2 visits – 6% 3 visits – 6% 4 visits – 25% 5 visits – 3% 6 visits – 6%
Nevada	S-SCHIP	CY 2003	Claims data	46% with 6+ visits
New Jersey	COMBO	CY 2002	Focused study (medical record review)	67% with 1+ visits
New Mexico	M-SCHIP	2002	Administrative data	0 visits – 7% 1 visit – 9% 2 visits – 10% 3 visits – 10% 4 visits – 15% 5 visits – 17% 6+ visits – 33%
New York	COMBO	2002	Health plan annual QARR	67% with 5+ visits
Ohio	M-SCHIP	2002	Medicaid claims and encounter data	38% with 6+ visits
Oregon	M-SCHIP	CY 2002	MMIS eligibility, claims, and encounter data	83% with 1+ visits
Rhode Island	COMBO	2002	Health plans	77% with 5+ visits
Texas	S-SCHIP	CY 2002	Patient-level encounter data	0 visits – 12% 1 visit – 11% 2 visits – 13% 3 visits – 16% 4 visits – 21% 5 visits – 18% 6+ visits – 9%
West Virginia	S-SCHIP	CY 2002	Claims data	100% with 1+ visits
Reported Using Other Methodology (n = 8)				
State	**Program Type**	**Reporting Year**	**Data Source**	**Rate(s) Reported**
Connecticut	S-SCHIP	NR	Administrative data	Screening ratio[a] for children less than 1 year old: 88% Participant ratio[b] for children less than 1 year old: 75%
Florida	COMBO	NR	Claims data	1,700 enrollees received 3,228 well-child check-ups

Table 4 *(continued)*

State	Program Type	Reporting Year	Data Source	Rate(s) Reported
Iowa	COMBO	FY 2001	Encounter data	Reported rates of MMR immunizations of children born in 1999 and eligible for at least 11 months between the first and second birthday by plan: Iowa Health Solutions: 21% John Deere: 44% Wellmark: 25%
Missouri	M-SCHIP	FFY 2002	EPSDT data	Screening ratio[a] for children less than 1 year old: 100% Screening ratio[a] for children ages 1 to 2: 100% Participant ratio[b] for children less than 1 year old: 88% Participant ratio[b] for children ages 1 to 2: 69%
North Dakota	COMBO	10/01/1999 to 12/31/2002	Claims data	Children with 12 months of continuous coverage and turning age 2 in 2002 who received 4+ office visits from 10/1/99 to 12/31/02, regardless of diagnosis, with a primary care provider: 82%
South Carolina	M-SCHIP	SFY 2002	EPSDT data	Number of PHC/SCHIP children ages 1 to 2 receiving recommended screenings: 2,669
South Dakota	COMBO	FFY 2003	Claims data	84% with 1+ visits[c]
Wisconsin	M-SCHIP	2002	Encounter data	Percentage of children birth to age 2 who received 6+ well-child visits: 73%

Source: Original analysis of FFY 2003 State Title XXI Annual Reports by Mathematica Policy Research, Inc.

Notes: All percentages have been rounded to whole numbers.
M-SCHIP denotes that the state operates a Medicaid expansion program; S-SCHIP denotes that the state operates a separate child health program; COMBO denotes that the state operates both an M-SCHIP and an S-SCHIP program.
NR: Not Reported; CY: Calendar Year; SFY: State Fiscal Year; FFY: Federal Fiscal Year; MCO: Managed Care Organization; EPSDT: Early and Periodic Screening, Diagnosis, and Treatment; QARR: Quality Assurance Reporting Requirements; MMIS: Medicaid Management Information System.

[a]Indicates the extent to which those eligible for EPSDT receive the number of initial and periodic screening services required by the state's periodicity schedule, adjusted by the proportion of the year for which they are eligible.

[b]Indicates the extent to which those eligible for EPSDT receive any initial and periodic screening services during the year.

[c]Children ages 0 through 36 months enrolled in Primary Care Case Management.

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

A total of 33 states reported this measure, and most states that reported used HEDIS or HEDIS-like methodology (n = 28). Interestingly, more states reported this measure using HEDIS or HEDIS-like methodology, compared to the infant measure. A possible explanation is that the HEDIS specifications for this measure require fewer data elements than the infant measure.

States that used HEDIS methodology reported a single rate: the percentage of children ages 3 to 6 receiving one or more well-child visits. States were considered to have used HEDIS-like methodology if they reported these rates within subcategories not specified in HEDIS. For example, they may have reported separate rates for each year of life (Alabama) or separate rates for children in different health plans (Iowa).[16] Seven states reported using another methodology, including the number of visits received by enrollees (Florida), and the number of children who received recommended screenings (South Carolina).

As shown in Table 5, there is wide variation in the rates of visits reported by the 28 states that used HEDIS or HEDIS-like methodology: the rate of children receiving at least one visit ranged from 19 percent (Mississippi) to 75 percent (Massachusetts and New York).

Table 5. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

State	Program Type	Reporting Year	Data Source	Percentage of Children Receiving Well-Child Visits: Rate(s) Reported
Reported Using HEDIS or HEDIS-like Methodology (n = 28)				
Alabama	S-SCHIP	NR	Blue Cross Blue Shield of Alabama ALL Kids Annual Report	3 years old – 30% with 1+ visits 4 years old – 40% with 1+ visits 5 years old – 44% with 1+ visits 6 years old – 13% with 1+ visits
Arizona	S-SCHIP	10/1/01 to 9/30/02	Enrollment and encounter data	57% with 1+ visits
Arkansas	M-SCHIP	7/1/02 to 6/30/03	Claims data	28% with 1+ visits
California	COMBO	CY 2002	Health plan data	63% with 1+ visits
Georgia	S-SCHIP	CY 2002	Claims data	34% with 1+ visits
Hawaii	M-SCHIP	SFY 2003	Claims data	58% with 1+ visits
Indiana	COMBO	2002	Claims data	42%
Iowa	COMBO	FY 2001	Encounter data	John Deere – 43% with 1+ visits Iowa Health Solutions – 35% with 1+ visits Wellmark – 33% with 1+ visits

[16] Although New Mexico reported rates for individual health plans, and West Virginia provided separate rates for each age, we were able to compute a single rate for both states because they reported the numerator and denominator for this measure.

Table 5 *(continued)*

State	Program Type	Reporting Year	Data Source	Percentage of Children Receiving Well-Child Visits: Rate(s) Reported
Kentucky	COMBO	CY 2001	Claims data (MCO only)	55% received 1+ visits
Maine	COMBO	10/1/02 to 9/30/03	Claims data	3 years old – 69% with 1+ visits 4 years old – 71% with 1+ visits 5 years old – 82% with 1+ visits 6 years old – 53% with 1+ visits Total – 69% with 1+ visits
Maryland	COMBO	2003	Administrative and medical record data	68% with 1+ visits
Massachusetts	COMBO	2002	Weighted mean calculated from health plan data	75% with 1+ visits
Michigan	COMBO	2002	Blue Cross Blue Shield of Michigan HEDIS-like data reports	47% with 1+ visits
Mississippi	S-SCHIP	CY 2002	2002 claims data paid through September 2003	19% with 1+ visits
Montana	S-SCHIP	NR	HEDIS data gathered by Blue Cross Blue Shield	31% with 1+ visits
Nevada	S-SCHIP	CY 2003	Claims data	70% with 1+ visits
New Jersey	COMBO	CY 2002	Focused study (medical record review)	35% with 1+ visits[a]
New Mexico	M-SCHIP	2002	Administrative data	42% with 1+ visits
New York	COMBO	2002	Health plan annual QARR	75% with 1+ visits
North Carolina	S-SCHIP	CY 2002	Claims data	56% with 1+ visits
North Dakota	COMBO	CY 2002	Claims data	31% with 1+ visits
Ohio	M-SCHIP	2002	Medicaid claims and encounter data	47% with 1+ visits
Oregon	M-SCHIP	CY 2002	MMIS eligibility, claims and encounter data	39% with 1+ visits
Pennsylvania	S-SCHIP	2003	Claims data	66% with 1+ visits
Rhode Island	COMBO	2002	Health plans	73% with 1+ visits
South Dakota	COMBO	FFY 2003	Claims data	Percentage of children who received 1+ visits: Total SCHIP – 29% M-SCHIP – 27% S-SCHIP – 33%

Table 5 *(continued)*

State	Program Type	Reporting Year	Data Source	Percentage of Children Receiving Well-Child Visits: Rate(s) Reported
Texas	S-SCHIP	CY 2002	Patient-level encounter data	41% with 1+ visits
West Virginia	S-SCHIP	CY 2002	Claims data	56% with 1+ visits
Reported Using Other Methodology (n = 5)				
Connecticut	S-SCHIP	NR	Administrative data	Screening ratio[b] for children ages 3 to 5 years: 82% Participant ratio[c] for children ages 3 to 5 years old: 75%
Florida	COMBO	NR	Claims data	10,073 enrollees received 11,055 well-child check-ups
Missouri	M-SCHIP	FFY 2002	EPSDT data	Screening ratio[b] for children ages 3 to 5: 79% Participant ratio[c] for children ages 3 to 5: 55%
South Carolina	M-SCHIP	SFY 2002	EPSDT data	Number of PHC/SCHIP children ages 3 to 5 receiving recommended screenings: 1,083
Wisconsin	M-SCHIP	2002	Encounter data	Percentage of enrollees ages 3 to 5 receiving 1+ well-child care visits: 96%

Source: Original analysis of FFY 2003 State Title XXI Annual Reports by Mathematica Policy Research, Inc.

Notes: All percentages have been rounded to whole numbers.
M-SCHIP denotes that the state operates a Medicaid expansion program; S-SCHIP denotes that the state operates a separate child health program; COMBO denotes that the state operates both an M-SCHIP and an S-SCHIP program.
NR: Not Reported; CY: Calendar Year; SFY: State Fiscal Year; FFY: Federal Fiscal Year; MCO: Managed Care Organization; EPSDT: Early and Periodic Screening, Diagnosis, and Treatment; QARR: Quality Assurance Reporting Requirements; MMIS: Medicaid Management Information System.

[a]Ages 3 to 11 years.

[b]Indicates the extent to which those eligible for EPSDT receive the number of initial and periodic screening services required by the state's periodicity schedule, adjusted by the proportion of the year for which they are eligible.

[c]Indicates the extent to which those eligible for EPSDT receive any initial and periodic screening services during the year.

Use of Appropriate Medications for Children with Asthma

As shown in Table 6, a total of 15 states reported this measure; of these, 4 reported all three rates as specified by HEDIS, while 9 reported using HEDIS-like methodology and 2 used another approach. A possible explanation for the small number of states using HEDIS methodology is that the specifications are fairly complex for this measure and thus require numerous data elements. For example, in order for states to report using HEDIS

methodology, they must be able to: (1) construct an eligible population that has been continuously enrolled for two years; (2) identify which children in the eligible population met the HEDIS definition of persistent asthma; and (3) identify which asthma medications were dispensed to those children with persistent asthma. The percentage of children receiving appropriate asthma medications clustered between 50 and 76 percent among the 13 states that reported using HEDIS or HEDIS-like methodology (Table 6).

Table 6. Use of Appropriate Medications for Children with Asthma

State	Program Type	Reporting Year	Data Source	Percentage of Children Receiving Appropriate Medications for Asthma: Rate(s) Reported		
				Children 5 to 9 years old	Children 10 to 17 years old	Combined rate for children 5 to 17 years old
Reported Using HEDIS or HEDIS-like Methodology (n = 13)						
Arkansas	M-SCHIP	SFY 2000	Claims data	70%	63%[a]	65%[b]
Georgia	S-SCHIP	CY 2002	Claims data	69%	68%	68%[c]
Hawaii	M-SCHIP	SFY 2003	Claims data	53%	52%	52%[c]
Illinois	COMBO	CY 2002	MMIS data	NR	NR	53%[d]
Michigan	COMBO	2002	Blue Cross Blue Shield of Michigan HEDIS-like data reports	NR	NR	75%[e]
Mississippi	S-SCHIP	CY 2002	2002 claims data paid through September 2003	75%	72%	74%[c]
Montana	S-SCHIP	NR	HEDIS data gathered by Blue Cross Blue Shield	NR	NR	76%[e]
New York	COMBO	2002	Health plan annual QARR	NR	NR	63%[b]
North Carolina	S-SCHIP	CY 2002	Claims data	NR	NR	66%[e]
Ohio	M-SCHIP	2002	Medicaid claims and encounter data	NR	NR	43%
Pennsylvania	S-SCHIP	2003	Claims data	NR	NR	67%
Rhode Island	COMBO	2003	Health plans	NR	NR	66%[f]
Texas	S-SCHIP	CY 2002	Patient-level encounter data	70%	69%	NR

Table 6 *(continued)*

State	Program Type	Reporting Year	Data Source	Rate(s) Reported
Reported Using Other Methodology (n = 2)				
Indiana	COMBO	1/1/01 to 12/31/02	Dataprobe	Average number of primary medical provider and specialist physician visits for asthma per child, ages 0 through 18 years: 10.5 Average number of emergency room visits for asthma per child, ages 0 through 18 years: 0.6 Average number of physician, outpatient, and clinic visits for asthma per child, ages 0 through 18 years: 13.2 Inpatient hospital stays with asthma diagnosis only, ages 0 through 18 years: 3 out of 100 children
Wisconsin	M-SCHIP	2002	Encounter data	Percentage of enrollees ages 0 to 20 with diagnosis of asthma: 5% Percentage of enrollees, ages 0 to 20, with diagnosis of asthma that had inpatient stays: 3% Percentage of enrollees, ages 0 to 20, with diagnosis of asthma that had emergency visits: 19%

Source: Original analysis of FFY 2003 State Title XXI Annual Reports by Mathematica Policy Research, Inc.

Notes: All percentages have been rounded to whole numbers.
M-SCHIP denotes that the state operates a Medicaid expansion program; S-SCHIP denotes that the state operates a separate child health program; COMBO denotes that the state operates both an M-SCHIP and an S-SCHIP program.
NR: Not Reported; CY: Calendar Year; SFY: State Fiscal Year; FFY: Federal Fiscal Year; QARR: Quality Assurance Reporting Requirements; MMIS: Medicaid Management Information System.

[a]Children ages 10 to 18.

[b]Children ages 5 to 18.

[c]Georgia, Hawaii, and Mississippi did not explicitly report the combined rate specified by HEDIS. However, since they provided the numerator and denominator for this measure, we were able to calculate these rates.

[d]All Title XXI children.

[e]Ages not specified.

[f]Children less than 18 years of age.

Objectives Related to the Use of Preventive Care

Although the FFY 2003 SCHIP annual report did not provide a description of the data elements and HEDIS specifications on which this measure is based (*Children's access to primary care practitioners*), 18 of the 27 states reporting used HEDIS or HEDIS-like methodology. As shown in Table 7, 14 states reported on all three of the age groups specified by HEDIS; 4 states reported rates for only one or two of the age groups and were considered to have used HEDIS-like methodology. Nine states reported on a different measure, such as the percentage of enrollees who received immunizations.

As shown in Table 7, the rate of children ages 12 to 24 months receiving at least one visit to a primary care practitioner ranged from 86 to 98 percent among the states that used HEDIS or HEDIS-like methodology. The rate of children ages 25 months to 6 years receiving at least one visit ranged from 76 to 94 percent, and for children ages 7 to 11 years, the rate ranged from 67 to 95 percent.

Table 7. Objectives Related to the Use of Preventive Care

State	Program Type	Reporting Year	Data Source	Percentage of Children Who Had 1+ Visits with a Primary Care Practitioner (PCP): Rate(s) Reported		
				Ages 12 to 24 months	Ages 25 months to 6 years	Ages 7 to 11 years
Reported Using HEDIS or HEDIS-like Methodology						
Arizona	S-SCHIP	10/1/01 to 9/30/02	Enrollment and encounter data	98%	78%	NR
California	COMBO	CY 2002	Health plan data	91%	83%	82%
Hawaii	M-SCHIP	SFY 2003	Claims data	95%	88%	85%
Indiana	COMBO	2002	Claims data	90%	76%	75%
Maine	COMBO	10/1/02 to 9/30/03	Claims data	95%	90%	83%
Maryland	COMBO	2003	Administrative data	92%	82%	82%
Massachusetts	COMBO	2002	Weighted mean calculated from health plan data	93%	89%	95%
Michigan	COMBO	2002	Blue Cross Blue Shield of Michigan HEDIS-like data reports	96%	87%	77%

Table 7 *(continued)*

State	Program Type	Reporting Year	Data Source	Percentage of Children Who Had 1+ Visits with a Primary Care Practitioner (PCP): Rate(s) Reported		
				Ages 12 to 24 months	Ages 25 months to 6 years	Ages 7 to 11 years
Mississippi	S-SCHIP	CY 2002	Claims data	93%	86%	85%
Montana	S-SCHIP	NR	HEDIS data gathered by Blue Cross Blue Shield	95%	80%	83%
Nevada	S-SCHIP	CY 2003	Claims data	98%	93%	93%
New Jersey	COMBO	CY 2002	Focused study (medical record review)	56% [a]	NR	NR
North Carolina	S-SCHIP	CY 2002	Claims data	97%	90%	90%
Oregon	M-SCHIP	CY 2002	MMIS eligibility, claims, and encounter data	86%	76%	67%
Pennsylvania	S-SCHIP	2003	Claims data	NR	NR	85% [b]
Rhode Island	COMBO	2002	Health plans	NR	NR	92% [c]
Texas	S-SCHIP	CY 2002	Patient-level encounter data	94%	88%	92%
West Virginia	S-SCHIP	2002	Claims data	97%	94%	88%
State	**Program Type**	**Reporting Year**	**Data Source**	**Rate(s) Reported**		
Reported Using Other Methodology (n = 9)						
Alabama	S-SCHIP	NR	Pediatric Health History and Continuous Enrollee Surveys	Percentage of enrollees who received at least one preventive/routine care medical service in the previous 12 months of enrollment, age unspecified: 92%		
Arkansas	M-SCHIP	December 2003	MMIS data	Percentage of Medicaid-eligibles, all ages, enrolled with a PCP: 62%		
Connecticut	S-SCHIP	NR	Administrative data	Percentage of children immunized by age 2: 76% Percentage of children meeting or exceeding state standards for well-child visits, age unspecified: 74%		
Delaware	S-SCHIP	NR	Encounter and survey data	Percentage of children that received a well-child visit after enrollment, age unspecified: 80%		

Table 7 *(continued)*

State	Program Type	Reporting Year	Data Source	Rate(s) Reported
Idaho	M-SCHIP	FFY 2002	Claims data	EPSDT wellness visits screening ratio[d] for children younger than age 1: 25% Immunization rate for children who are "ready to go to school": 95%
Iowa	COMBO	FY 2001	Survey data	Percentage of children that always received "needed routine care" after being in the program for one year, age unspecified: 82%
Kentucky	COMBO	CY 2001	Claims data (MCO only)	57% of children turning two received all American Academy of Pediatrics recommended immunizations
North Dakota	COMBO	CY 2002	Claims data	Percentage of children age 2 in 2002 with 24 months of continuous coverage who received immunizations for DTP, MMR, OPV, HIB, and Hep B: 59%
Wisconsin	M-SCHIP	NR	Encounter data	Percentage of enrollees, all ages, with 1+ primary care encounters: 79%

Source: Original analysis of FFY 2003 State Title XXI Annual Reports by Mathematica Policy Research, Inc.

Notes: All percentages have been rounded to whole numbers.
M-SCHIP denotes that the state operates a Medicaid expansion program; S-SCHIP denotes that the state operates a separate child health program; COMBO denotes that the state operates both an M-SCHIP and an S-SCHIP program.
NR: Not Reported; CY: Calendar Year; SFY: State Fiscal Year; FFY: Federal Fiscal Year; MCO: Managed Care Organization; MMIS: Medicaid Management Information System.

[a]Percentage of children ages 0 to 18 months that received 1+ visits, sick or well, to a PCP.

[b]Aggregate percentage for children ages 2 to 11 years.

[c]Percentage of children ages 12 months to 11 years who received an ambulatory or preventive care visit.

[d]Indicates the extent to which EPSDT-eligibles receive the number of initial and periodic screening services required by the state's periodicity schedule, adjusted by the proportion of the year for which they are eligible.

ENHANCEMENTS MADE TO THE FFY 2004 ANNUAL REPORT TEMPLATE

Based on reporting inconsistencies identified in the FFY 2003 reports, MPR worked with CMS to refine the FFY 2004 annual report template to improve states' reporting of the child health measures. The most significant revisions involved Section II, the section dedicated to performance measurement and progress. This section now contains explicit instructions on the type of information states should report. In addition, Section II is now divided into three subsections:

1. Section IIA, which corresponds to the "Reporting of National Performance Measures" in the FFY 2003 template, is now dedicated solely to state reporting on the core performance measures

2. Section IIB, which corresponds to the "Enrollment" subsection of Section III in the FFY 2003 template, now captures data on enrollment progress and changes in the number and/or rate of uninsured children

3. Section IIC, which corresponds to the "Program's Strategic Objectives and Performance Goals" in the FFY 2003 template, is now dedicated to states' reporting of their strategic objectives and performance goals

The new Section IIA is formatted in three columns to provide states with more detailed instructions on how to report. In the first column, states are to indicate if they are unable to report on a given measure by checking one of the following boxes: "Population not covered," "Data not available," "Not able to report due to small sample size," and "Other." If a state checks the "Other" box, space is provided for an explanation of why it is unable to report on the measure. This enhancement was made to reduce the number of measures states left blank with no explanation. In the second column, states are to indicate the measurement specification (HEDIS, HEDIS-like, Other) used for each performance measure. This revision is intended to improve reporting by states on the type of technical specifications used. The third column provides discrete sections for states to use in reporting on specific methodological details of each measure, including data source, population definition, baseline year and measurement (numerator/denominator), performance progress (numerator/denominator) and date, and an explanation of the progress made. Space is also provided for states to note "Other Comments on Measure," including data limitations or comparisons with external benchmarks. The revised FFY 2004 annual report template for Section II is presented in Appendix C.

TECHNICAL ASSISTANCE TO IMPROVE FFY 2004 STATE REPORTING: CHALLENGES AND LESSONS LEARNED

To further enhance the completeness and quality of performance measurement reporting, MPR offered technical assistance to states to help them complete Section II of the FFY 2004 annual report. Technical assistance was voluntary and was initiated by the states. We provided assistance through various strategies, such as: a one-hour training at the SCHIP pre-conference at the NASHP annual meeting in August 2004; in-person meetings with states, during which we reviewed all the data reported in Section II of the FFY 2003 annual

report and provided suggestions for improvement in FFY 2004; conference calls in which we fielded state-specific questions on how to report certain data or measures; participation (by telephone) in CMS on-site visits; and informal email exchanges. We often provided assistance through multiple strategies, such as conference calls followed by email, and spoke with a number of states more than once.

To date, MPR has provided one-on-one technical assistance to 25 states.[17] Additional states participated in group trainings held during the NASHP annual meeting, two NASHP Rapid Response calls, and two conference calls at the regional level—Region V (Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin) and Regions II and III (Delaware, District of Columbia, Maryland, New Jersey, New York, Pennsylvania, Virginia, and West Virginia). We also participated by telephone in performance measurement training of CMS Regional and Central Office staff. Although technical assistance varied by state, we provided general "tips" for improving the quality of performance measurement reporting in FFY 2004 (Table 8). The rest of this section gives further details of the guidance we provided during our technical assistance discussions.

Overall, we emphasized to states that the goal is to maintain consistency in measurement and reporting over time, so that progress can be measured from year to year. We also encouraged states to work with their vendors to produce the data for reporting, and include them in any technical assistance discussions. State collaboration with vendors should help ensure that the necessary data elements are collected and the correct measures are constructed. Moreover, states should have a clear understanding of the services included in their vendor's contract and, if necessary, revise the contract to cover data collection and analysis required for reporting.

One frequently asked question was how, and what, states should report if they do not use HEDIS or do not have data for the current measurement year. We emphasized that reporting "something is better than nothing" and encouraged states that cannot report to use the checkboxes provided to indicate why (for example, "small sample size," "data not available") instead of leaving a blank.

Many states had specific questions about various data elements required by HEDIS, especially the length of continuous enrollment and the definition of the numerator or denominator. We reviewed the HEDIS description of the performance measure(s) and the definitions of the numerator and denominator, and discussed how to relate the technical specifications to each state's unique data characteristics. We advised states to check the "HEDIS-like" box if they followed some, but not all, of the requirements specified by HEDIS.

[17] As of March 2005, the 25 states that have received technical assistance are: Alabama, Alaska, Arkansas, Colorado, District of Columbia, Idaho, Illinois, Iowa, Kentucky, Louisiana, Maryland, Massachusetts, Minnesota, Mississippi, Montana, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Vermont, Virginia, Washington, West Virginia, and Wyoming.

Table 8. Tips for State Reporting of Core Performance Measures in the FFY 2004 SCHIP Annual Reports

- Follow the instructions provided in the annual report template for each column.
- Report the most recent data available for each measure. If new results are expected after the reporting period, use the "Comments" section to specify when they will be available.
- Report on each measure to the extent that data are available. If you cannot report on a measure, indicate the reasons why (for example, small sample size, population not covered, data not available) instead of leaving the section blank.
- Summarize all relevant information from attachments in the space provided for each measure. Do not reference attachments without summarizing their contents in the appropriate space provided.
- Describe the methodology and technical measurement specifications used, if different from HEDIS or HEDIS-like, in the section within each child health measure labeled "Other." Use the "Comments" section within each measure to provide additional information, explanations, or data limitations.
- Report a single state-level rate for each measure. If the data are collected separately for health plans, weight the data by health plan enrollment to develop an aggregate state-level measure.
- Maintain consistency in the reporting methodology used. To measure progress over time, it is important for the same measurement specifications to be used from year to year.
- Include the data or insurance vendor in all technical assistance discussions.

MPR also encountered numerous questions regarding the new format of Section II and the differences between questions in the three subsections. For instance, many state strategic objectives, which are to be reported in Section IIC, overlap the national performance measures to be reported in Section IIA. A number of states asked whether they should report the same information in both sections. We described the basis for the state strategic objectives—that is, they come from the state plan—and advised states to report progress made toward achieving these objectives in Section IIC. We further advised that if they also use a performance measure as a strategic objective, they should report the same information in Section IIC as in Section IIA, rather than leave Section IIC blank.

Another question concerned how to report when Title XXI and Title XIX data are collected together, such that Title XXI data cannot be distinguished from Title XIX data. In these situations, states should use the "Comments" section to indicate that the reported data

are combined. However, we encouraged states, when possible, to report Titles XXI and XIX data separately.

MPR advised states that collect data separately on their different delivery systems (such as managed care and fee-for-service) to report data from the dominant delivery system and to do so consistently over time. Similarly, a number of states that collect data separately for individual health plans asked how to report this information. Rather than report rates for each health plan, we advised these states, if possible, to weight the data for each plan by enrollment, to develop a single, aggregate state-level rate for each measure.

Other questions dealt with how to report the adult performance measures. Some states that do not cover adults through their SCHIP program were uncertain as to whether they are expected to report the adult measures. MPR explained that only those states that cover adults funded by Title XXI through the state plan or a section 1115 demonstration should report the adult measures. States that *do* cover adult populations through the SCHIP program also were uncertain which measures to report—for example, whether they are required to report on the unborn children population and, if so, using which measure. We discussed that states may use their discretion as to whether to report on the unborn children population, and advised that if they choose to report, they should use the *Adult prenatal and postpartum care (prenatal visits)* measure. In further discussion, we advised that, if they decide to report on the unborn population, they should check the appropriate box in Column 1, which indicates coverage is provided to unborn children through the SCHIP program.

Finally, many states told us that they found it difficult to report data for the current measurement year due to the lag between collecting and processing the data and having it ready to be reported by the January 1 deadline. We advised them that if they will not have 2004 data ready to report in the FFY 2004 annual report, to instead report the most recent data available for each measure. We also encouraged these states to use the "Comments" section to identify when more current information would be available.

CONCLUSION

Our analysis of the FFY 2003 SCHIP annual reports suggests that most states reported at least one child health performance measure in FFY 2003. Based on our technical assistance discussions, states are making an effort to improve the completeness and quality of reporting for FFY 2004. Many of them already collect HEDIS or HEDIS-like data, particularly on the well-child measures, and a majority of the states that contacted us for technical assistance indicated that they will be collecting HEDIS data for most or all of the measures in the future. States also indicated that the revised FFY 2004 annual report template will be helpful in providing them guidance on how to improve their reporting of the child health measures.

To assess the extent to which performance measurement reporting has improved, MPR will abstract and analyze the performance measurement data reported in the FFY 2004 annual reports and compare them to the data reported in FFY 2003. MPR also will offer technical assistance to states to help them continue to improve the completeness and quality

of future performance measurement reporting. Technical assistance will be provided as requested by states and will be available at the SCHIP pre-conference at the NASHP annual meeting in August 2005.

A future objective is to develop the capacity to use performance measurement data for quality improvement. Although our analysis found wide variation in the reporting methodologies used by states in the FFY 2003 annual reports, we learned that a large number of states have maintained consistency in their reporting methodology from year to year. This consistency is important because it allows states to track progress from one year to the next. Consistency in reporting also enables states to use their past data to set realistic goals for future SCHIP program performance. Setting these goals is an important step toward greater state accountability for improving access to, and quality of, services delivered to SCHIP enrollees.

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National Committee for Quality Assurance (NCQA). HEDIS 2004. Health Plan Employer Data and Information Set. Vol. 2, Technical specifications. Washington (DC): National Committee for Quality Assurance (NCQA), 2003.

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APPENDIX A

DESCRIPTION OF THE CHILD HEALTH MEASURES

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Summary of Well-Child Visits in the First 15 Months of Life
HEDIS 2004 Measure

TITLE

Well-child visits in the first 15 months of life: 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.

Brief Abstract

DESCRIPTION

This measure assesses the percentage of enrolled members who turned 15 months old during the measurement year, who were continuously enrolled in the managed care organization (MCO) from 31 days of age and who received either zero one, two, three, four, five, six or more well-child visits with a primary care practitioner during their first 15 months of life.

A child should be included in only one numerator (e.g., a child receiving 6 well-child visits will not be included in the rate for five, four or fewer visits). MCOs calculate seven rates for each of the two product lines (Medicaid and commercial).

RATIONALE

Well-care visits are routine visits to the child's physician for the purpose of physical examinations, immunization updates, tracking growth and development, and finding any problems before they become serious.

PRIMARY CLINICAL COMPONENT

Primary care; well-child visit

DENOMINATOR DESCRIPTION

Enrolled members age 15 months old during the measurement year who were continuously enrolled from 31 days through 15 months of age with no more than one gap in enrollment of up to 45 days during the continuous enrollment period

NUMERATOR DESCRIPTION

Seven separate numerators are calculated, corresponding to the number 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. To count toward the measure, the well-child visit must occur with a primary care practitioner, but it does not have to be the practitioner assigned to the child.

Refer to the original measure documentation for Current Procedure Terminology (CPT) and International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes to identify well-child visits.

Numerator Exclusions
Inpatient, emergency room, and specialist visits do not count in this measure. The intent is to capture comprehensive well-child visits only.

Identifying Information

SOURCE(S)

National Committee for Quality Assurance (NCQA). HEDIS 2004. Health plan employer data & information set. Vol. 2, Technical specifications. Washington (DC): National Committee for Quality Assurance (NCQA); 2003. 374 p.

MEASURE AVAILABILITY

The individual measure, "Well-Child Visits in the First 15 Months of Life," is published in "HEDIS 2004. Health plan employer data & information set. Vol. 2, Technical Specifications."

For more information, contact the National Committee for Quality Assurance (NCQA) at 2000 L Street, N.W., Suite 500, Washington, DC 20036; Telephone: 202-955-3500; Fax: 202-955-3599; Web site: www.ncqa.org.

NQMC STATUS

This NQMC summary was completed by ECRI on August 7, 2003. The information was verified by the measure developer on October 24, 2003.

COPYRIGHT STATEMENT

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Date Modified: 7/28/2004

Summary of Well-Child Visits in the 3rd, 4th, 5th and 6th Year of Life HEDIS 2004 Measure

TITLE

Well-child visits in the third, fourth, fifth and sixth years of life: percentage of members age 3 to 6 years old who received one or more well-child visit(s) with a primary care practitioner during the measurement year.

Brief Abstract

DESCRIPTION

This measure assesses the percentage of members who were three, four, five or six years old during the measurement year, who were continuously enrolled during the measurement year and who received one or more well-child visit(s) with a primary care practitioner during the measurement year.

RATIONALE

Well-child visits offer practitioners the opportunity to dispense health promotion information and detect illness, disease and developmental problems at a stage when intervention may still be successful.

PRIMARY CLINICAL COMPONENT

Primary care; well-child visit

DENOMINATOR DESCRIPTION

Members age three, four, five or six years old as of December 31 of the measurement year with no more than one gap in enrollment of up to 45 days during the continuous enrollment period

NUMERATOR DESCRIPTION

At least one well-child visit with a primary care practitioner during the measurement year. The primary care practitioner does not have to be the practitioner assigned to the child.

Refer to the original measure documentation for Current Procedure Terminology (CPT) and International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes to identify well-child visits.

Numerator Exclusions
Inpatient, emergency room, and specialist visits should not be counted in this measure. The intent is to capture comprehensive well-child visits only.

Identifying Information

SOURCE(S)

National Committee for Quality Assurance (NCQA). HEDIS 2004. Health plan employer data & information set. Vol. 2, Technical specifications. Washington (DC): National Committee for Quality Assurance (NCQA); 2003. 374 p.

MEASURE AVAILABILITY

The individual measure, "Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life," is published in "HEDIS 2004. Health plan employer data & information set. Vol. 2, Technical Specifications."

For more information, contact the National Committee for Quality Assurance (NCQA) at 2000 L Street, N.W., Suite 500, Washington, DC 20036; Telephone: 202-955-3500; Fax: 202-955-3599; Web site: www.ncqa.org.

NQMC STATUS

This NQMC summary was completed by ECRI on August 7, 2003. The information was verified by the measure developer on October 24, 2003.

COPYRIGHT STATEMENT

Date Modified: 7/28/2004

Summary of Use of Appropriate Medications for People with Asthma HEDIS 2004 Measure

TITLE

Asthma: percentage of members with persistent asthma who had at least one dispensed prescription for inhaled corticosteroids, nedocromil, cromolyn sodium, leukotriene modifiers, or methylxanthines in the measurement year.

Brief Abstract

DESCRIPTION

This process measure evaluates if members with persistent asthma are prescribed medications acceptable as primary therapy for long-term control of asthma.

RATIONALE

The outcomes of asthma treatment are to reduce the impact of the disease on patient functioning. Anti-inflammatory medications are now considered the first-choice treatment in the pharmacologic management of chronic asthma. This measure promotes appropriate medical management of persons with asthma.

PRIMARY CLINICAL COMPONENT

Asthma; inhaled corticosteroids; nedocromil; cromolyn sodium; leukotriene modifiers; methylxanthines

DENOMINATOR DESCRIPTION

Medicaid, commercial members (report each product line separately), age 15 to 56 years by December 31 of the measurement year, with persistent asthma* who were continuously enrolled (no more than one gap in enrollment of up to 45 days during each year of continuous enrollment) for the reporting year and the year preceding the reporting year in the following age categories and in a combined rate:

- 5- to 9-year-olds
- 10- to 17-year-olds
- 18- to 56-year-olds

The combined rate is the sum of the three numerators divided by the sum of the three denominators.

[*]Members are identified as having persistent asthma by having *any* of the following in the **year prior to the measurement year**:

- at least four asthma medication dispensing events[+] (i.e., an asthma medication was dispensed on four occasions)
- at least one Emergency Department (ED) visit with asthma (International Classification of Diseases, Ninth Revision, Clinical Modification [ICD-9-CM] code 493) as the principal diagnosis
- at least one acute inpatient discharge with asthma (ICD-9 code 493) as the principal diagnosis
- at least four outpatient asthma visits with asthma (ICD-9 code 493) as one of the listed diagnoses *and* at least two asthma medication dispensing events.[+]

Refer to the original measure documentation for Current Procedure Terminology (CPT) and Universal Billing 1992 (UB-92) Revenue codes to identify ED and inpatient asthma encounters.

[+]A dispensing event is one perscription of an amount lasting 30 days or less. Two different prescriptions dispensed on the same day are counted as two different dispensing events. To calculate dispensing events for prescriptions longer than for 30 days, managed care organizations (MCOs) should divide the days' supply by 30 and round up to convert. For example, a 100-day prescription is equal to 4 dispensing events (100/30 = 3.33, rounded up to 4).

Denominator Exclusions
(Optional) The MCO may exclude from the eligible population all members diagnosed with emphysema and chronic obstructive pulmonary disease (COPD) any time on or prior to December 31 of the measurement year.

NUMERATOR DESCRIPTION

For each member in the denominator, those who had at least one dispensed prescription for inhaled corticosteroids, nedocromil, cromolyn sodium, leukotriene modifiers, or methylxanthines in the measurement year. Managed care organizations (MCOs) must use the National Drug Code (NDC) list provided on NCQA's Web site at www.ncqa.org to identify appropriate prescriptions.

Identifying Information

SOURCE(S)

National Committee for Quality Assurance (NCQA). HEDIS 2004. Health plan employer data & information set. Vol. 2, Technical specifications. Washington (DC): National Committee for Quality Assurance (NCQA); 2003. 374 p.

MEASURE AVAILABILITY

The individual measure, "Use of Appropriate Medications for People With Asthma," is published in "HEDIS 2004. Health Plan Employer Data & Information Set. Vol. 2, Technical Specifications."

For more information, contact the National Committee for Quality Assurance (NCQA) at 2000 L Street, N.W., Suite 500, Washington, DC 20036; Telephone: 202-955-3500; Fax: 202-955-3599; Web site: www.ncqa.org.

NQMC STATUS

This NQMC summary was completed by ECRI on July 18, 2003. The information was verified by the measure developer on August 29, 2003.

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Date Modified: 7/28/2004

Summary of Children's Access to Primary Care Practitioners HEDIS 2004 Measure

TITLE

Children's and adolescents' access to primary care practitioners: percentage of enrollees who had a visit with a managed care organization (MCO) primary care practitioner.

Brief Abstract

DESCRIPTION

This measure assesses the percentage of enrollees 12 months through 24 months, 25 months through 6 years, 7 years through 11 years and 12 years through 19 years of age who had a visit with a managed care organization (MCO) primary care practitioner. Eight separate rates are calculated, one for each of the two product lines for each of the four age groups. MCOs report the percentage of:

- Children 12 months through 24 months and 25 months through 6 years who were continuously enrolled during the measurement year and who had a visit with an MCO primary care practitioner during the measurement year
- Children 7 years through 11 years and 12 years through 19 years of age who were continuously enrolled during the measurement year and the year prior to the measurement year and who had a visit with an MCO primary care practitioner during the measurement year or the year prior to the measurement year

RATIONALE

The purpose of this measure is to assess and identify any children's access to primary care practitioners issues.

PRIMARY CLINICAL COMPONENT

Primary care; access

DENOMINATOR DESCRIPTION

Members age 12 months through 24 months, 25 months through 6 years, 7 years through 11 years and 12 years through 19 years of age as of December 31 of the measurement year who were continuously enrolled during the measurement year (and the year prior to the measurement year for members age 7 years through 11 years and 12 years through 19 years) with no more than one gap in enrollment of up to 45 days

NUMERATOR DESCRIPTION

One (or more) visit(s) with a managed care organization (MCO) primary care practitioner during the measurement year (or the year prior to the measurement year for members age 7 years through 11 years and 12 years through 19 years).

Refer to the original measure document for Current Procedure Terminology (CPT) codes and International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes to identify ambulatory or preventive care visits.

Numerator Exclusions

Exclude inpatient procedures, emergency room and specialist visits.

Exclude mental health and chemical dependency services. Refer to the original measure documentation for ICD-9-CM codes and CPT codes to identify excluded mental health and chemical dependency services.

Identifying Information

SOURCE(S)

National Committee for Quality Assurance (NCQA). HEDIS 2004. Health plan employer data & information set. Vol. 2, Technical specifications. Washington (DC): National Committee for Quality Assurance (NCQA); 2003. 374 p.

MEASURE AVAILABILITY

The individual measure, "Children's Access to Primary Care Practitioners," is published in "HEDIS 2004. Health plan employer data & information set. Vol. 2, Technical Specifications."

For more information, contact the National Committee for Quality Assurance (NCQA) at 2000 L Street, N.W., Suite 500, Washington, DC 20036; Telephone: 202-955-3500; Fax: 202-955-3599; Web site: www.ncqa.org.

NQMC STATUS

This NQMC summary was completed by ECRI on August 7, 2003. The information was verified by the measure developer on October 24, 2003.

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APPENDIX B

FFY 2003 ANNUAL REPORT TEMPLATE: PROGRAM'S STRATEGIC OBJECTIVES AND PERFORMANCE GOALS

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SECTION II: PROGRAM'S STRATEGIC OBJECTIVES AND PERFORMANCE GOALS

1. In the table below, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List your State's strategic objectives for your SCHIP program.

Column 2: List the performance goals for each strategic objective.

Column 3: For each performance goal, indicate how performance is being measured and progress toward meeting the goal. Specify if the strategic objective listed is new/revised or continuing, the data sources, the methodology and specific measurement approaches (e.g., numerator and denominator). Please attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was previously reported, please complete columns 1 and 2 and enter "NC" (for no change) in column 3*.

(1) Strategic Objectives	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
Objectives related to Reducing the Number of Uninsured Children		
		New/Revised ☐ Continuing ☐
		Data Sources:
		Methodology:
		Progress Summary:
Objectives Related to SCHIP Enrollment		
		New/Revised ☐ Continuing ☐
		Data Sources:
		Methodology:
		Progress Summary:
Objectives Related to Increasing Medicaid Enrollment		
		New/Revised ☐ Continuing ☐
		Data Sources:
		Methodology:
		Progress Summary:
Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)		
		New/Revised ☐ Continuing ☐
		Data Sources:
		Methodology:
		Progress Summary:
Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)		
		New/Revised ☐ Continuing ☐
		Data Sources:

(1) Strategic Objectives	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		Methodology:
		Progress Summary:
Other Objectives		
		New/Revised ☐ Continuing ☐
		Data Sources:
		Methodology:
		Progress Summary:

2. How are you measuring the access to, or the quality or outcomes of care received by your SCHIP population? What have you found?

3. What plans does your SCHIP program have for future measurement of the access to, or the quality or outcomes of care received by your SCHIP population? When will data be available?

4. Have you conducted any focused quality studies on your SCHIP population, e.g., adolescents, attention deficit disorder, substance abuse, special heath care needs or other emerging health care needs? What have you found?

5. Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here and summarize findings or list main findings.

REPORTING OF NATIONAL PERFORMANCE MEASURES

The Centers for Medicare & Medicaid Services (CMS) convened the Performance Measurement Partnership Project (PMPP) as a collaborative effort between Federal and state officials to develop a national set of performance measures for Medicaid and the State Children's Health Insurance Programs (SCHIP). CMS is directed to examine national performance measures by the SCHIP Final Rules of January 11, 2001 and the Medicaid Final Rules of June 14, 2002 on managed care.

The PMPP's stated goal is to create a short list of performance measures relevant to those enrolled in Medicaid and SCHIP. The group focused on well-established measures whose results could motivate agencies, providers, and health plans to improve the quality of care delivered to enrollees. After receiving comments from Medicaid and SCHIP officials on an initial list of some 19 measures, the PMPP group trimmed the list to the following seven core measures (SCHIP states should report on all applicable measures for covered populations to the extent that data is available):

- Well child visits for children in the first 15 months of life
- Well child visits in the 3rd, 4th, 5th, and 6th years of life
- Use of appropriate medications for children with asthma
- Comprehensive diabetes care (hemoglobin A1c tests)
- Children's access to primary care services
- Adult access to preventive/ambulatory health services
- Prenatal and postpartum care (prenatal visits)

Work remains to resolve technical issues related to implementing the collection, analysis, and reporting of the measures. If your State currently has data on any of these measures, please report them using the format below. Indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator and denominator). Please attach additional narrative if necessary.

Performance Measure	Describe How It Was Measured	Performance Measures and Progress
Well child visits for children in the first 15 months of life		Data Sources:
		Methodology:
		Progress Summary:
Well child visits in the 3rd, 4th, 5th, and 6th years of life		Data Sources:
		Methodology:
		Progress Summary:
Use of appropriate medications for children with asthma		Data Sources:
		Methodology:
		Progress Summary:
Comprehensive diabetes care (hemoglobin A1c tests)		Data Sources:
		Methodology:
		Progress Summary:
Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)		Data Sources:
		Methodology:
		Progress Summary:

Performance Measure	Describe How It Was Measured	Performance Measures and Progress
Adult access to preventive/ambulatory health services		Data Sources:
		Methodology:
		Progress Summary:
Prenatal and postpartum care (prenatal visits)		Data Sources:
		Methodology:
		Progress Summary:

APPENDIX C

FFY 2004 ANNUAL REPORT TEMPLATE: PROGRAM'S PERFORMANCE MEASUREMENT AND PROGRESS

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SECTION II: PROGRAM'S PERFORMANCE MEASUREMENT AND PROGRESS

This section consists of three sub sections that gather information on the core performance measures for the SCHIP program as well as your State's progress toward meeting its general program strategic objectives and performance goals. Section IIA captures data on the core performance measures to the extent data are available. Section IIB captures your enrollment progress as well as changes in the number and/or rate of uninsured children in your State. Section IIC captures progress towards meeting your State's general strategic objectives and performance goals.

Please note that the numbers in brackets, e.g., [500] are character limits in the State Annual Report Template System (SARTS). You will not be able to enter responses with characters greater than the limit indicated in the brackets.

SECTION IIA: REPORTING OF CORE PERFORMANCE MEASURES

CMS is directed to examine national performance measures by the SCHIP Final Rules of January 11, 2001. To address this SCHIP directive, and to address the need for performance measurement in Medicaid, CMS, along with other Federal and State officials, developed a core set of performance measures for Medicaid and SCHIP. The group focused on well-established measures whose results could motivate agencies, providers, and health plans to improve the quality of care delivered to enrollees. After receiving comments from Medicaid and SCHIP officials on an initial list of 19 measures, the group recommended seven core measures, including four child health measures and three adult measures:

Child Health Measures
- Well child visits in the first 15 months of life
- Well child visits in the 3rd, 4th, 5th, and 6th years of life
- Use of appropriate medications for children with asthma
- Children's access to primary care practitioners

Adult Measures
- Comprehensive diabetes care (hemoglobin A1c tests)
- Adult access to preventive/ambulatory health services
- Prenatal and postpartum care (prenatal visits)

These measures are based on specifications provided by the Health Plan Employer Data and Information Set (HEDIS®). HEDIS® provides a useful framework for defining and measuring performance. However, use of HEDIS® methodology is not required for reporting on your measures. The HEDIS® methodology can also be modified based on the availability of data in your State.

The table should be completed as follows:

Column 1: If you cannot provide a specific measure, please check the boxes that apply to your State for each performance measure, as follows:
- Population not covered: Check this box if your program does not cover the population included in the measure. For example, if your State does not cover adults under SCHIP, check the box indicating, "population not covered" for the three adult measures.
- Data not available: Check this box if data are not available for a particular measure in your State. Please provide an explanation of why the data are currently not available.
- Not able to report due to small sample size: Check this box if the sample size (i.e., denominator) for a particular measure is **less than 30**. If the sample size is less 30, your State is not required to report data on the measure. However, please indicate the exact sample size in the space provided.
- Other: Please specify if there is another reason why your state cannot report the measure.

Column 2: For each performance measure listed in Column 1, please indicate the measurement specification (i.e., were the measures calculated using the HEDIS® technical specifications, HEDIS®-like specifications, or some other source with measurement specifications unrelated to HEDIS®). If the measures were calculated using HEDIS® or HEDIS®-like specifications, please indicate which version was used (e.g., HEDIS® 2004).

Column 3: For each performance measure listed in Column 1, please indicate the data source(s); the definition of the population included in the measure (such as age, continuous enrollment, type of delivery system); the baseline measurement and baseline year; and your current performance, including the date of the most recent data reported. For rates, please specify the numerator and denominator that were used to calculate the rates. Please also note any comments on the performance measures or progress, such as data limitations, comparisons with external benchmarks, etc. and an explanation for changes from the baseline. Note: you do not need to report data for all delivery system types. You may choose to report data for only the delivery system with the most enrollees in your program.

NOTE: **Please do not reference attachments in this table. If details about a particular measure are located in an attachment, please summarize the relevant information from the attachment in the space provided for each measure.**

Measure	Measurement Specification	Performance Measures and Progress
Well child visits in the first 15 months of life Not Reported Because: □ Population not covered □ Data not available Explain: □ Not able to report due to small sample size (less than 30) Specify sample size: □ Other Explain: **[500]**	□ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress/Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**

Measure	Measurement Specification	Performance Measures and Progress
Well child visits in children the 3rd, 4th, 5th, and 6th years of life Not Reported Because: □ Population not covered □ Data not available Explain: □ Not able to report due to small sample size (less than 30) Specify sample size: □ Other Explain: **[500]**	□ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress/Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**
Use of appropriate medications for children with asthma Not Reported Because: □ Population not covered □ Data not available Explain: □ Not able to report due to small sample size (less than 30) Specify sample size: □ Other Explain: **[500]**	□ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress/Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**

Measure	Measurement Specification	Performance Measures and Progress
Children's access to primary care practitioners Not Reported Because: □ Population not covered □ Data not available Explain: □ Not able to report due to small sample size (less than 30) Specify sample size: □ Other Explain: **[500]**	□ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress/Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**
Adult Comprehensive diabetes care (hemoglobin A1c tests) Not Reported Because: □ Population not covered □ Data not available Explain: □ Not able to report due to small sample size (less than 30) Specify sample size: □ Other Explain: **[500]**	□ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress/Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**

Measure	Measurement Specification	Performance Measures and Progress
Adult access to preventive/ambulatory health services Not Reported Because: □ Population not covered □ Data not available Explain: □ Not able to report due to small sample size (less than 30) Specify sample size: □ Other Explain: **[500]**	□ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress/Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**
Adult Prenatal and postpartum care (prenatal visits): □ **Coverage for pregnant women over age 19 through a demonstration** □ **Coverage for unborn children through the SCHIP state plan** □ **Coverage for pregnant women under age 19 through the SCHIP state plan** Not Reported Because: □ Population not covered □ Data not available Explain: □ Not able to report due to small sample size (less than 30) Specify sample size: □ Other Explain: **[500]**	□ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress/Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**

SECTION IIB: ENROLLMENT AND UNINSURED DATA

1. The information in the table below is the Unduplicated Number of Children Ever Enrolled in SCHIP in your State for the two most recent reporting periods. The enrollment numbers reported below should correspond to line 7 in your State's 4th quarter data report (submitted in October) in the SCHIP Statistical Enrollment Data System (SEDS). The percent change column reflects the percent change in enrollment over the two-year period. If the percent change exceeds 10 percent (increase or decrease), please explain in letter A below any factors that may account for these changes (such as decreases due to elimination of outreach or increases due to program expansions). This information will be filled in automatically by SARTS through a link to SEDS. Please wait until you have an enrollment number from SEDS before you complete this response.

Program	FFY 2003	FFY 2004	Percent change FFY 2003-2004
SCHIP Medicaid Expansion Program			
Separate Child Health Program			

   A. Please explain any factors that may account for enrollment increases or decreases exceeding 10 percent.

      [7500]

2. Three-year averages in the number and/or rate of uninsured children in each state based on the Current Population Survey (CPS) are shown in the table below, along with the percent change between 1996-1998 and 2001-2003. Significant changes are denoted with an asterisk (*). If your state uses an alternate data source and/or methodology for measuring change in the number and/or rate of uninsured children, please explain in Question #3. SARTS will fill in this information automatically, but in the meantime, please refer to the CPS data attachment that was sent with the FY 2004 Annual Report Template.

	Uninsured Children Under Age 19 Below 200 Percent of Poverty		Uninsured Children Under Age 19 Below 200 Percent of Poverty as a Percent of Total Children Under Age 19	
Period	Number	Std. Error	Rate	Std. Error
1996-1998				
1997-1999				
2000-2002				
2001-2003				
Percent change 1996-1998 vs.		NA		NA

2001-2003				

A. Please note any comments here concerning CPS data limitations that may affect the reliability or precision of these estimates.

[7500]

3. If your State has an alternate data source and/or methodology for measuring change in the number and/or rate of uninsured children, please report in the table below. Data are required for two or more points in time to demonstrate change (or lack of change). Please be as specific and detailed as possible about the method used to measure progress toward covering the uninsured.

Data source(s)	**[500]**
Reporting period (2 or more points in time)	**[200]**
Methodology	**[7500]**
Population	**[500]**
Sample sizes	**[200]**
Number and/or rate for two or more points in time	**[200]**
Statistical significance of results	**[200]**

A. Please explain why the state chose to adopt a different methodology to measure changes in the number and/or rate of uninsured children.
[7500]

B. What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Provide a numerical range or confidence intervals if available.)
[7500]

4. How many children do you estimate have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information. ***(States with only a SCHIP Medicaid Expansion Program should skip this question)***

[7500]

SECTION IIC: STATE STRATEGIC OBJECTIVES AND PERFORMANCE GOALS

In the table below, summarize your State's general strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Use additional pages as necessary. **Please do not reference attachments in this table. If details about a particular measure are located in an attachment, please summarize the relevant information from the attachment in the space provided for each measure.** The table should be completed as follows:

Column 1: List your State's general strategic objectives for your SCHIP program and indicate if the strategic objective listed is new/revised or continuing. If you have met your goal and/or are discontinuing a strategic objective or goal, please continue to list the objective/goal in the space provided below, and indicate that it has been discontinued, and provide the reason why it was discontinued. Also, if you have revised a goal, please check "new/revised" and explain how and why it was revised.

Note: States are required to report objectives related to reducing the number of uninsured children. (This/these measure(s) should reflect what was reported in Section IIB, Question(s) 2 and 3 Section IIB. Progress towards reducing the number of uninsured children should be reported in this section.)

Column 2: List the performance goals for each strategic objective. Where applicable, provide the measurement specification (i.e., were the measures calculated using the HEDIS® technical specifications, HEDIS®-like specifications, or some other source with measurement specifications unrelated to HEDIS®).

Column 3: For each performance goal listed in Column 1, please indicate the data source(s); the definition of the population included in the measure (such as age, continuous enrollment, type of delivery system); the methodology used; the baseline measurement and baseline year; and your current performance, including the date of the most recent data reported. For rates, please specify the numerator and denominator that were used to calculate the rates. Please note any comments on the performance measures or progress, such as data limitations, comparisons with external benchmarks, or the like.

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	**(2) Performance Goals for each Strategic Objective**	**(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)**
Objectives Related to Reducing the Number of Uninsured Children *(Mandatory for all states for each reporting year) (This/these measure(s) should reflect what was reported in Section IIB, Question(s) 2 and 3.)*		
□ New/revised □ Continuing □ Discontinued Explain: **[500]**	Goal #1: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Methodology: **[500]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]**

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		Other Comments on Measure: **[700]**
□ New/revised □ Continuing □ Discontinued Explain: **[500]**	Goal #2: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Methodology: **[500]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**
□ New/revised □ Continuing □ Discontinued Explain: **[500]**	Goal #3: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Methodology: **[500]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**

Objectives Related to SCHIP Enrollment

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	**(2) Performance Goals for each Strategic Objective**	**(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)**
□ New/revised □ Continuing □ Discontinued Explain: **[500]**	Goal #1: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Methodology: **[500]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**
□ New/revised □ Continuing □ Discontinued Explain: **[500]**	Goal #2: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Methodology: **[500]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
□ New/revised □ Continuing □ Discontinued Explain: **[500]**	Goal #3: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Methodology: **[500]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**
Objectives Related to Medicaid Enrollment		
□ New/revised □ Continuing □ Discontinued Explain: **[500]**	Goal #1: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Methodology: **[500]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**
□ New/revised □ Continuing □ Discontinued Explain: **[500]**	Goal #2: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Methodology: **[500]**

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**
□ New/revised □ Continuing □ Discontinued Explain: **[500]**	Goal #3: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Methodology: **[500]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**
Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)		
□ New/revised □ Continuing □ Discontinued Explain: **[500]**	Goal #1: □ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Methodology: **[500]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]**

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		Other Comments on Measure: **[700]**
□ New/revised □ Continuing □ Discontinued Explain: **[500]**	Goal #2: □ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Methodology: **[500]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**
□ New/revised □ Continuing □ Discontinued Explain: **[500]**	Goal #3: □ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Methodology: **[500]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)		
(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	**(2) Performance Goals for each Strategic Objective**	**(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)**
□ New/revised □ Continuing □ Discontinued Explain: **[500]**	Goal #1: □ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Methodology: **[500]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**
□ New/revised □ Continuing □ Discontinued Explain: **[500]**	Goal #2: □ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Methodology: **[500]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	**(2) Performance Goals for each Strategic Objective**	**(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)**
□ New/revised □ Continuing □ Discontinued Explain: **[500]**	Goal #3: □ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Methodology: **[500]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**

1. What other strategies does your state use to measure and report on access to, quality, or outcomes of care received by your SCHIP population? What have you found? **[7500]**

2. What strategies does your SCHIP program have for future measurement and reporting on access to, quality, or outcomes of care received by your SCHIP population? When will data be available? **[7500]**

3. Have you conducted any focused quality studies on your SCHIP population, e.g., adolescents, attention deficit disorder, substance abuse, special heath care needs or other emerging health care needs? What have you found? **[7500]**

4. Please attach any additional studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here and summarize findings or list main findings. **[7500]**