FRAMEWORK FOR THE ANNUAL REPORT OF THE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble
Section 2108(a) and Section 2108(e) of the Social Security Act (the Act) provides that each state and territory *must assess the operation of its state child health plan in each federal fiscal year and report to the Secretary, by January 1 following the end of the federal fiscal year, on the results of the assessment. In addition, this section of the Act provides that the state must assess the progress made in reducing the number of uncovered, low-income children. The state is out of compliance with CHIP statute and regulations if the report is not submitted by January 1. The state is also out of compliance if any section of this report relevant to the state's program is incomplete.

The framework is designed to:

- Recognize the ***diversity*** of state approaches to CHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their CHIP programs, **AND**
- Provide ***consistency*** across states in the structure, content, and format of the report, **AND**
- Build on data ***already collected*** by CMS quarterly enrollment and expenditure reports, **AND**
- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

The CHIP Annual Report Template System (CARTs) is organized as follows:

- Section I: Snapshot of CHIP Programs and Changes
- Section II: Program's Performance Measurement and Progress
- Section III: Assessment of State Plan and Program Operation
- Section IV: Program Financing for State Plan
- Section V: Program Challenges and Accomplishments

* - When "state" is referenced throughout this template, it is defined as either a state or a territory.

***Disclosure. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, write to: CMS, 7500 Security Blvd., Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.**

FRAMEWORK FOR THE ANNUAL REPORT OF THE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

DO NOT CERTIFY YOUR REPORT UNTIL ALL SECTIONS ARE COMPLETE.

State/Territory: **IL**
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a) and Section 2108(e)).

Signature:

Felicia F. Norwood

CHIP Program Name(s): **All Kids**

CHIP Program Type:

- ☐ CHIP Medicaid Expansion Only
- ☐ Separate Child Health Program Only
- ☒ Combination of the above

Reporting Period: **2015** *Note: Federal Fiscal Year 2015starts 10/1/2014 and ends 9/30/2015.*

Contact Person/Title: **Lynne Thomas/Chief, Bureau of All Kids**

Address: **Illinois Dept. of Healthcare and Family Services**

201 South Grand Avenue East

City: **Springfield** State: **IL** Zip: **62763-0001**

Phone: **(217) 524-7156** Fax: **(217) 557-4274**

Email: **lynne.thomas@illinois.gov**

Submission Date: **12/23/2015**

(Due to your CMS Regional Contact and Central Office Project Officer by January 1st of each year)

SECTION I: SNAPSHOT OF CHIP PROGRAM AND CHANGES

1) To provide a summary at-a-glance of your CHIP program , please provide the following information. If you would like to make any comments on your responses, please explain in narrative below this table.

☐Provide an assurance that your state's CHIP program eligibility criteria as set forth in the CHIP state plan in section 4, inclusive of PDF pages related to Modified Adjusted Gross Income eligibility, is accurate as of the date of this report.

Please note that the numbers in brackets, e.g., **[500]** are character limits in the Children's Health Insurance Program (CHIP) Annual Report Template System (CARTS). You will not be able to enter responses with characters greater than the limit indicated in the brackets.

	CHIP Medicaid Expansion Program	**Separate Child Health Program**
	*** Upper % of FPL (federal poverty level) fields are defined as <u>Up to and Including</u>**	

Does your program require premiums or an enrollment fee?	☐	No			☐	No		
	☒	Yes			☒	Yes		
	Enrollment fee amount		0		Enrollment fee amount		0	
	Premium amount		0		Premium amount		40	
	If premiums are tiered by FPL, please breakout by FPL				If premiums are tiered by FPL, please breakout by FPL			
	Premium Amount				Premium Amount			
	Range from	Range to	From	To	Range from	Range to	From	To
	$	$	% of FPL	% of FPL	$15	$ 40	% of FPL 158	% of FPL 209
	$	$	% of FPL	% of FPL	$40	$ 80	% of FPL 210	% of FPL 318
	$	$	% of FPL	% of FPL	$	$	% of FPL	% of FPL
	$	$	% of FP L	% of FPL	$	$	% of FPL	% of FPL
	If premiums are tiered by FPL, please breakout by FPL				If premiums are tiered by FPL, please breakout by FPL			
	Yearly Maximum Premium Amount per family		$		Yearly Maximum Premium Amount per family		$960	
	Range from	Range to	From	To	Range from	Range to	From	To
	$	$	% of FPL	% of FPL	$180	$480	% of FPL 158	% of FPL 209
	$	$	% of FPL	% of FPL	$480	$960	% of FPL 210	% of FPL 318
	$	$	% of FPL	% of FPL	$	$	% of FPL	% of FPL
	$	$	% of FPL	% of FPL	$	$	% of FPL	% of FPL
	If yes, briefly explain fee structure in the box below **[500]**				If yes, briefly explain fee structure in the box below (including premium/enrollment fee amounts and include Federal poverty levels where appropriate) **[500]**			

			Families with income from 158 to 209% pay a premium of $15/month for 1 child, $25 for 2, $30 for 3, $35 for 4 and $40 for 5 or more children. Families with income from 210 to 318% FPL pay a monthly premium of $40 for 1 child or $80 for 2 or more.	
	☐	N/A	☐	N/A

Which delivery system(s) does your program use?	☒	Managed Care	☒	Managed Care
	☒	Primary Care Case Management	☒	Primary Care Case Management
	☒	Fee for Service	☒	Fee for Service
	Please describe which groups receive which delivery system **[500]** Initally, all children are FFS. They are given a period of 60 days to choose an MCO where available, or a PCP where MCOs are not available or mandatory.		Please describe which groups receive which delivery system **[500]** Initally, all children are FFS. They are given a period of 60 days to choose an MCO where available, or a PCP where MCOs are not available or mandatory.	

2) Have you made changes to any of the following policy or program areas during the reporting period? Please indicate "yes" or "no change" by marking the appropriate column.

For FFY 2015, please include only the program changes that are in addition to and/or beyond those required by the Affordable Care Act.

For each topic you responded "yes" to below, please explain the change and why the change was made.

	Medicaid Expansion CHIP Program			**Separate Child Health Program**		
	Yes	No Change	N/A	Yes	No Change	N/A
a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	☐	☒	☐	☐	☒	☐
b) Application	☐	☒	☐	☐	☒	☐
c) Benefits	☐	☒	☐	☐	☒	☐
d) Cost sharing (including amounts, populations, & collection process)	☐	☒	☐	☐	☒	☐
e) Crowd out policies	☐	☒	☐	☐	☒	☐
f) Delivery system	☐	☒	☐	☐	☒	☐
g) Eligibility determination process	☐	☒	☐	☐	☒	☐
h) Implementing an enrollment freeze and/or cap	☐	☐	☒	☐	☐	☒
i) Eligibility levels / target population	☐	☒	☐	☐	☒	☐
j) Eligibility redetermination process	☐	☒	☐	☐	☒	☐

k)	Enrollment process for health plan selection	☐	☒	☐	☐	☒	☐
l)	Outreach (e.g., decrease funds, target outreach)	☐	☒	☐	☐	☒	☐
m)	Premium assistance	☐	☐	☒	☐	☐	☒
n)	Prenatal care eligibility expansion (Sections 457.10, 457.350(b)(2), 457.622(c)(5), and 457.626(a)(3) as described in the October 2, 2002 Final Rule)	☐	☐	☒	☐	☐	☒
o)	Expansion to "Lawfully Residing" children	☐	☒	☐	☐	☒	☐
p)	Expansion to "Lawfully Residing" pregnant women	☐	☒	☐	☐	☒	☐
q)	Pregnant Women state plan expansion	☐	☒	☐	☐	☒	☐
r)	Methods and procedures for prevention, investigation, and referral of cases of fraud and abuse	☐	☒	☐	☐	☒	☐
s)	Other – please specify						
a)	_____	☐	☐	☐	☐	☐	☐
b)	_____	☐	☐	☐	☐	☐	☐
c)	_____	☐	☐	☐	☐	☐	☐

B. Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	
C. Application	
D. Benefits	
E. Cost sharing (including amounts, populations, & collection process)	
F. Crowd out policies	
G. Delivery system	
H. Eligibility determination process	

I. Implementing an enrollment freeze and/or cap	
J. Eligibility levels / target population	
K. Eligibility redetermination process	
L. Enrollment process for health plan selection	
M. Outreach	
N. Premium assistance	
O. Prenatal care eligibility expansion (Sections 457.10, 457.350(b)(2), 457.622(c)(5), and 457.626(a)(3) as described in the October 2, 2002 Final Rule)	
P. Expansion to “Lawfully Residing” children	
Q. Expansion to “Lawfully Residing” pregnant women	
R. Pregnant Women State Plan Expansion	
S. Methods and procedures for prevention, investigation, and referral of cases of fraud and abuse	
T. Other – please specify	
a.	
b.	
c.	

Enter any Narrative text below. **[7500]**

SECTION II: PROGRAM'S PERFORMANCE MEASUREMENT AND PROGRESS

This section consists of two subsections that gather information about the CHIP and/or Medicaid program. Section IIA captures your enrollment progress as well as changes in the number and/or rate of uninsured children in your state. Section IIB captures progress towards meeting your state's general strategic objectives and performance goals.

SECTION IIA: ENROLLMENT AND UNINSURED DATA

1. The information in the table below is the Unduplicated Number of Children Ever Enrolled in CHIP in your state for the two most recent reporting periods. The enrollment numbers reported below should correspond to line 7 (Unduplicated # Ever Enrolled Year) in your state's 4th quarter data report (submitted in October) in the CHIP 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 CARTS through a link to SEDS. Please wait until you have an enrollment number from SEDS before you complete this response.

Program	FFY 2014	FFY 2015	Percent change FFY 2014-2015
CHIP Medicaid Expansion Program	176340	112231	-36.36
Separate Child Health Program	205271	217629	6.02

A. Please explain any factors that may account for enrollment increases or decreases exceeding 10 percent. **[7500]**

HFS has identified a factors that we believe contribute to the decline in enrollment of children.

- Illinois has made a concerted effort to improve program integrity in its Medicaid and CHIP eligibility. Actions include:

  - Working to catch up on overdue redeterminations.

  - Switching from allowing a totally passive redetermination process for most children to one that requires active electronic verification of income eligibility and state residence.

  - More actively monitoring for families that have relocated outside of Illinois.

2. The tables below show trends in the number and rate of uninsured children in your state. Three year averages in Table 1 are based on the Current Population Survey. The single year estimates in Table 2 are based on the American Community Survey (ACS). CARTS will fill in this information automatically, and 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.

Table 1: Number and percent of uninsured children under age 19 below 200 percent of poverty, Current Population Survey

	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	277	34.4	7.7	1.0
1998 - 2000	269	33.5	7.4	.9
2000 - 2002	228	26.5	6.9	.8
2002 - 2004	243	27.2	7.1	.8
2003 - 2005	230	26.8	6.7	.8
2004 - 2006	217	26.0	6.4	.7
2005 - 2007	180	24.0	5.3	.7
2006 - 2008	146	22.0	5.0	.7
2007 - 2009	175	23.0	5.2	.7
2008 - 2010	181	16.0	5.4	.5
2009-2011	171	16.0	5.2	.5
2010-2012	142	14.0	4.4	0

Table 2: Number and percent of uninsured children under age 19 below 200 percent of poverty, American Community Survey

	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 (In Thousands)	Margin of Error	Rate	Margin of Error
2013	79	7.0	2.5	.2
2014	61	6.0	2.0	.2
Percent change 2013 vs. 2014	0%	NA	0%	NA

A. Please explain any activities or factors that may account for increases or decreases in your number and/or rate of uninsured children. **[7500]**

The Affordable Care Act, outreach and growing awareness of the health care coverage available to children contributed to the decrease in uninsured children.

B. Please note any comments here concerning ACS data limitations that may affect the reliability or precision of these estimates. **[7500]**

3. Please indicate by checking the box below whether your state has an alternate data source and/or methodology for measuring the change in the number and/or rate of uninsured children.

☐ Yes (please report your data in the table below)

☒ No (skip the rest of the question)

Please report your alternate data 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)	
Reporting period (2 or more points in time)	
Methodology	
Population (Please include ages and income levels)	
Sample sizes	
Number and/or rate for two or more points in time	
Statistical significance of results	

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

B. What is your 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]**

C. What are the limitations of the data or estimation methodology? **[7500]**

D. How does your state use this alternate data source in CHIP program planning? **[7500]**

SECTION IIB: STATE STRATEGIC OBJECTIVES AND PERFORMANCE GOALS

This subsection gathers information on your state's general strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your CHIP state plan. (If your goals reported in the annual report now differ from Section 9 of your CHIP state plan, please indicate how they differ in "Other Comments on Measure." Also, the state plan should be amended to reconcile these differences). The format of this section provides your state with an opportunity to track progress over time. This section contains templates for reporting performance measurement data for each of five categories of strategic objectives, related to:

- Reducing the number of uninsured children
- CHIP enrollment
- Medicaid enrollment
- Increasing access to care
- Use of preventative care (immunizations, well child care)

Please report performance measurement data for the three most recent years for which data are available (to the extent that data are available). In the first two columns, data from the previous two years' annual reports (FFY 2013 and FFY 2014) will be populated with data from previously reported data in CARTS. If you reported data in the two previous years' reports and you want to update/change the data, please enter that data. If you reported no data for either of those two years, but you now have data available for them, please enter the data. In the third column, please report the most recent data available at the time you are submitting the current annual report (FFY 2015).

In this section, the term performance measure is used to refer to any data your state provides as evidence towards a particular goal within a strategic objective. For the purpose of this section, "objectives" refer to the five broad categories listed above, while "goals" are state-specific, and should be listed in the appropriate subsections within the space provided for each objective.

NOTES: Please do not reference attachments in this section. 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.

In addition, please do not report the same data that were reported in Section IIA above or for Child Core Set Reporting. The intent of this section is to capture goals and measures that your state did not report elsewhere.

Additional instructions for completing each row of the table are provided below.

Goal:

For each objective, space has been provided to report up to three goals. Use this section to provide a brief description of each goal you are reporting within a given strategic objective. **All new goals should include a direction and a target. For clarification only, an <u>example</u> goal would be**: "Increase (direction) by 5 percent (target) the number of CHIP beneficiaries who turned 13 years old during the measurement year who had a second dose of MMR, three hepatitis B vaccinations and one varicella vaccination by their 13th birthday."

Type of Goal:

For each goal you are reporting within a given strategic objective, please indicate the type of goal, as follows:

- <u>New/revised:</u> Check this box if you have revised or added a goal. Please explain how and why the goal was revised.

- Continuing: Check this box if the goal you are reporting is the same one you have reported in previous annual reports.
- Discontinued: Check this box if you have met your goal and/or are discontinuing a goal. Please explain why the goal was discontinued.

Status of Data Reported:

Please indicate the status of the data you are reporting for each goal, as follows:

- **Provisional**: Check this box if you are reporting performance measure data for a goal, but the data are currently being modified, verified, or may change in any other way before you finalize them for FFY 2015.

  Explanation of Provisional Data – When the value of the Status of Data Reported field is selected as "Provisional", the state must specify why the data are provisional and when the state expects the data will be final.

- **Final**: Check this box if the data you are reporting are considered final for FFY 2015.
- **Same data as reported in a previous year's annual report**: Check this box if the data you are reporting are the same data that your state reported for the goal in another annual report. Indicate in which year's annual report you previously reported the data.

Measurement Specification:

This section is included for only two of the objectives— objectives related to increasing access to care, and objectives related to use of preventative care—because these are the two objectives for which states may report using the HEDIS® measurement specification. In this section, for each goal, please indicate the measurement specification used to calculate your performance measure data (i.e., were the measures calculated using the HEDIS® specifications or some other method unrelated to HEDIS®).

Please indicate whether the measure is based on HEDIS® technical specifications or another source. If HEDIS® is selected, the HEDIS® Version field must be completed. If "Other" measurement specification is selected, the explanation field must be completed.

HEDIS® Version:

Please specify HEDIS® Version (example 2014). This field must be completed only when a user select the HEDIS® measurement specification.

"Other" measurement specification explanation:

If "Other", measurement specification is selected, please complete the explanation of the "Other" measurement specification. The explanation field must be completed when "Other" measurement specification has been selected.

Data Source:

For each performance measure, please indicate the source of data. The categories provided in this section vary by objective. For the objectives related to reducing the number of uninsured children and CHIP or Medicaid enrollment, please indicate whether you have used eligibility/enrollment data, survey data (specify the survey used), or other source (specify the other source). For the objectives related to access to care and use of preventative care, please indicate whether you used administrative data (claims) (specify the kind of administrative data used), hybrid data (claims and medical records) (specify how the two were used to create the data source), survey data (specify the survey used), or other source (specify the other source). In all cases, if another data source was used, please explain the source.

Definition of Population Included in Measure:

Numerator: Please indicate the definition of the population included in the numerator for each measure (such as the number of visits required for inclusion, e.g., one or more visits in the past year).

Denominator: Please indicate the definition of the population included in the denominator for each measure.

For measures related to increasing access to care and use of preventative care, please check one box to indicate whether the data are for the CHIP population only, or include both CHIP and Medicaid (Title XIX) children combined.

- check one box to indicate whether the data are for the CHIP population only, or include both CHIP and Medicaid (Title XIX) children combined.
- If the denominator reported is not fully representative of the population defined above (the CHIP population only, or the CHIP and Medicaid (Title XIX) populations combined), please further define the denominator. For example, denominator includes only children enrolled in managed care in certain counties, technological limitations preventing reporting on the full population defined, etc.). Please report information on exclusions in the definition of the denominator (including the proportion of children excluded), The provision of this information is important and will provide CMS with a context so that comparability of denominators across the states and over time can occur.

Deviations from Measure Specification

For the measures related to increasing access to care and use of preventative care.

If the data provided for a measure deviates from the measure specification, please select the type(s) of measure specification deviation. The types of deviation parallel the measure specification categories for each measure. Each type of deviation is accompanied by a comment field that states must use to explain in greater detail or further specify the deviation when a deviation(s) from a measure is selected..

The five types (and examples) of deviations are:

- Year of Data (e.g., partial year),
- Data Source (e.g., use of different data sources among health plans or delivery systems),
- Numerator (e.g., coding issues),
- Denominator (e.g., exclusion of MCOs, different age groups, definition of continuous enrollment),
- Other.

When one or more of the types are selected, states are required to provide an explanation.

Please report the year of data for each performance measure. The year (or months) should correspond to the *period in which enrollment or utilization took place*. Do *not* report the year in which data were collected for the measure, or the version of HEDIS® used to calculate the measure, both of which may be different from the period corresponding to enrollment or utilization of services.

Date Range: available for 2015 CARTS reporting period.

Please define the date range for the reporting period based on the "From" time period as the month and year which corresponds to the beginning period in which utilization took place and please report the "To" time period as the month and year which corresponds to the end period in which utilization took place. Do *not* report the year in which data were collected for the measure, or the version of HEDIS® used to calculate the measure, both of which may be different from the period corresponding to utilization of services.

Performance Measurement Data (HEDIS® or Other):

In this section, please report the numerators and denominators, rates for each measure (or component). The template provides two sections for entering the performance measurement data, depending on whether you are reporting using HEDIS® or other methodologies. The form fields have been set up to

facilitate entering numerators and denominators for each measure. If the form fields do not give you enough space to fully report on the measure, please use the "additional notes" section.

The preferred method is to calculate a "weighted rate" by summing the numerators and denominators across plans, and then deriving a single state-level rate based on the ratio of the numerator to the denominator). The reporting unit for each measure is the state as a whole. If states calculate rates for multiple reporting units (e.g., individual health plans, different health care delivery systems), States must aggregate data from all these sources into one State rate before reporting the data to CMS. In the situation where a state combines data across multiple reporting units, all or some of which use the hybrid method to calculate the rates, the state should enter zeroes in the "Numerator" and "Denominator" fields. In these cases, it should report the state-level rate in the "Rate" field and, when possible, include individual reporting unit numerators, denominators, and rates in the field labeled "Additional Notes on Measure," along with a description of the method used to derive the state-level rate.

Explanation of Progress:

The intent of this section is to allow your state to highlight progress and describe any quality-improvement activities that may have contributed to your progress. Any quality-improvement activity described should involve the CHIP program, benefit CHIP enrollees, and relate to the performance measure and your progress. An example of a quality-improvement activity is a state-wide initiative to inform individual families directly of their children's immunization status with the goal of increasing immunization rates. CHIP would either be the primary lead or substantially involved in the project. If improvement has not occurred over time, this section can be used to discuss potential reasons for why progress was not seen and to describe future quality-improvement plans. In this section, your state is also asked to set annual performance objectives for FFY 2016, 2017 and 2018. Based on your recent performance on the measure (from FFY 2013 through 2015), use a combination of expert opinion and "best guesses" to set objectives for the next three years. Please explain your rationale for setting these objectives. For example, if your rate has been increasing by 3 or 4 percentage points per year, you might project future increases at a similar rate. On the other hand, if your rate has been stable over time, you might set a target that projects a small increase over time. If the rate has been fluctuating over time, you might look more closely at the data to ensure that the fluctuations are not an artifact of the data or the methods used to construct a rate. You might set an initial target that is an average of the recent rates, with slight increases in subsequent years. In future annual reports, you will be asked to comment on how your actual performance compares to the objective your state set for the year, as well as any quality-improvement activities that have helped or could help your state meet future objectives.

Other Comments on Measure:

Please use this section to provide any other comments on the measure, such as data limitations, plans to report on a measure in the future, or differences between performance measures reported here and those discussed in Section 9 of the CHIP state plan.

Objectives Related to Reducing the Number of Uninsured Children (Do not report data that was reported in Section IIA, Questions 2 and 3)

FFY 2013	FFY 2014	FFY 2015
Goal #1 (Describe) Reduce the uninsured rate of children in Illinois.	**Goal #1 (Describe)** Reduce the uninsured rate of children in Illinois.	**Goal #1 (Describe)** Reduce the rate of uninsured children in Illinois
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data ☒ Survey data. *Specify*: ☐ Other. *Specify*: American Community Survey	**Data Source:** ☐ Eligibility/Enrollment data ☒ Survey data. *Specify*: ☐ Other. *Specify*: American Community Survey	**Data Source:** ☐ Eligibility/Enrollment data ☒ Survey data. *Specify*: ☐ Other. *Specify*: American Community Survey
Definition of Population Included in the Measure: Definition of denominator: Children under age 19 in the survey Definition of numerator: Children under age 19 in the survey with no health insurance.	**Definition of Population Included in the Measure:** Definition of denominator: Children under age 19 in the survey. Definition of numerator: Children under age 19 in the survey with no health insurance.	**Definition of Population Included in the Measure:** Definition of denominator: Children under age 19 in the survey. Definition of numerator: Children under age 19 in the survey with no health insurance.
Date Range: **From: (mm/yyyy)** 01/2012 **To: (mm/yyyy)** 12/2012	**Date Range:** **From: (mm/yyyy)** 01/2013 **To: (mm/yyyy)** 12/2013	**Date Range:** **From: (mm/yyyy)** 01/2014 **To: (mm/yyyy)** 12/2014
Performance Measurement Data: Described what is being measured: ACS state-level uninsured estimates Numerator: 101466 Denominator: 3059055 Rate: 3.3	**Performance Measurement Data:** Described what is being measured: ACS state-level uninsured estimates Numerator: 125351 Denominator: 3017960 Rate: 4.2	**Performance Measurement Data:** Described what is being measured: ACS state-level uninsured estimates Numerator: 99502 Denominator: 2980902 Rate: 3.3
Additional notes on measure:	Additional notes on measure:	Additional notes/comments on measure: Our goal was 3.0, but we only achieved 3.3.
Explanation of Progress: **How did your performance in 2013 compare with the Annual Performance Objective documented in your 2012 Annual Report?** The goal was 3.5. We achieved 3.3.	**Explanation of Progress:** **How did your performance in 2014 compare with the Annual Performance Objective documented in your 2013 Annual Report?** Our goal was 3.2%, but we only achieved 4.2%	**Explanation of Progress:** **How did your performance in 2015 compare with the Annual Performance Objective documented in your 2014 Annual Report?** Our goal was 3.0, but we only achieved 3.3.

FFY 2013	FFY 2014	FFY 2015
What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal? Continued program funding is essential.	**What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2014:** 3.0 **Annual Performance Objective for FFY 2015:** 2.8 **Annual Performance Objective for FFY 2016:** 2.6 *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2015:** 3.0 **Annual Performance Objective for FFY 2016:** 2.8 **Annual Performance Objective for FFY 2017:** 2.6 *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2016:** 3.0 **Annual Performance Objective for FFY 2017:** 2.8 **Annual Performance Objective for FFY 2018:** 2.6 *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to Reducing the Number of Uninsured Children (Do not report data that was reported in Section IIA, Questions 2 and 3) (Continued)

FFY 2013	FFY 2014	FFY 2015
Goal #2 (Describe)	**Goal #2 (Describe)**	**Goal #2 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Date Range: **From: (mm/yyyy) To: (mm/yyyy)**	**Date Range:** **From: (mm/yyyy) To: (mm/yyyy)**	**Date Range:** **From: (mm/yyyy) To: (mm/yyyy)**
Performance Measurement Data: Described what is being measured: Numerator: Denominator: Rate:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate:
Additional notes on measure:	Additional notes on measure:	Additional notes/comments on measure:
Explanation of Progress: **How did your performance in 2013 compare with the Annual Performance Objective documented in your 2012 Annual Report?**	**Explanation of Progress:** **How did your performance in 2014 compare with the Annual Performance Objective documented in your 2013 Annual Report?**	**Explanation of Progress:** **How did your performance in 2015 compare with the Annual Performance Objective documented in your 2014 Annual Report?**

FFY 2013	FFY 2014	FFY 2015
What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?	**What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2014:** **Annual Performance Objective for FFY 2015:** **Annual Performance Objective for FFY 2016:** *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2015:** **Annual Performance Objective for FFY 2016:** **Annual Performance Objective for FFY 2017:** *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2016:** **Annual Performance Objective for FFY 2017:** **Annual Performance Objective for FFY 2018:** *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to Reducing the Number of Uninsured Children (Do not report data that was reported in Section IIA, Questions 2 and 3) (Continued)

FFY 2013	FFY 2014	FFY 2015
Goal #3 (Describe)	**Goal #3 (Describe)**	**Goal #3 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Date Range: **From: (mm/yyyy) To: (mm/yyyy)**	**Date Range:** **From: (mm/yyyy) To: (mm/yyyy)**	**Date Range:** **From: (mm/yyyy) To: (mm/yyyy)**
Performance Measurement Data: Described what is being measured: Numerator: Denominator: Rate:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate:
Additional notes on measure:	Additional notes on measure:	Additional notes/comments on measure:
Explanation of Progress: **How did your performance in 2013 compare with the Annual Performance Objective documented in your 2012 Annual Report?**	**Explanation of Progress:** **How did your performance in 2014 compare with the Annual Performance Objective documented in your 2013 Annual Report?**	**Explanation of Progress:** **How did your performance in 2015 compare with the Annual Performance Objective documented in your 2014 Annual Report?**

FFY 2013	FFY 2014	FFY 2015
What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal? **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2014:** **Annual Performance Objective for FFY 2015:** **Annual Performance Objective for FFY 2016:** *Explain how these objectives were set:*	**What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2015:** **Annual Performance Objective for FFY 2016:** **Annual Performance Objective for FFY 2017:** *Explain how these objectives were set:*	**What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2016:** **Annual Performance Objective for FFY 2017:** **Annual Performance Objective for FFY 2018:** *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to CHIP Enrollment

FFY 2013	FFY 2014	FFY 2015
Goal #1 (Describe) Increase enrollment of children with income above 133% and at or below 200% by .5%	**Goal #1 (Describe)** Increase enrollment of children with income above 133% and at or below 200% by .5%	**Goal #1 (Describe)** Increase enrollment of children with income above 147% and at or below 209% by .5%
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☒ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: The FPLs were revised to reflect MAGI equivalent income standards.
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☒ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*: Number of children enrolled as of 7/31/12 compared to the number of children enrolled as of 7/31/13 in families with income above 133% and at or below 200%.	**Data Source:** ☒ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*: Number of children enrolled as of 7/31/13 compared to the number of children enrolled as of 7/31/14 in families with income above 133% and at or below 200%.	**Data Source:** ☒ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*: Number of children enrolled as of 7/31/14 compared to the number of children enrolled as of 7/31/15 in families with income above 133% and at or below 200%.
Definition of Population Included in the Measure: Definition of denominator: Number of children enrolled as of 7/31/12 Definition of numerator: Number of children enrolled as of 7/31/13	**Definition of Population Included in the Measure:** Definition of denominator: Number of children enrolled as of 7/31/13 Definition of numerator: Number of children enrolled as of 7/31/14	**Definition of Population Included in the Measure:** Definition of denominator: Number of children enrolled as of 7/31/14 Definition of numerator: Number of children enrolled as of 7/31/15
Date Range: **From: (mm/yyyy)** 01/2012 **To: (mm/yyyy)** 07/2013	**Date Range:** **From: (mm/yyyy)** 07/2013 **To: (mm/yyyy)** 07/2014	**Date Range:** **From: (mm/yyyy)** 07/2014 **To: (mm/yyyy)** 07/2015
Performance Measurement Data: Described what is being measured: Enrollment of children as of 7/31/12 compared to 7/31/13. Numerator: 67880 Denominator: 72267 Rate: 93.9	**Performance Measurement Data:** Described what is being measured: Enrollment of children as of 7/31/13 compared to 7/31/14. Numerator: 72267 Denominator: 73957 Rate: 97.7	**Performance Measurement Data:** Described what is being measured: Enrollment of children as of 7/31/14 compared to 7/31/15. Numerator: 73996 Denominator: 75662 Rate: 97.8

FFY 2013	FFY 2014	FFY 2015
Additional notes on measure: Enrollment increased by 6.1%	Additional notes on measure: increased by 2.3%	Additional notes/comments on measure: Enrollment increased by 2.2%
Explanation of Progress: **How did your performance in 2013 compare with the Annual Performance Objective documented in your 2012 Annual Report?** Increased more than expected. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2014 compare with the Annual Performance Objective documented in your 2013 Annual Report?** Incresed more than expected **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2015 compare with the Annual Performance Objective documented in your 2014 Annual Report?** The goal was to increase enrollment by 1%. Enrollment increased by 2.2%. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2014:** 1% **Annual Performance Objective for FFY 2015:** 1% **Annual Performance Objective for FFY 2016:** 1% *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2015:** 1% **Annual Performance Objective for FFY 2016:** 1% **Annual Performance Objective for FFY 2017:** 1% *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2016:** 1% **Annual Performance Objective for FFY 2017:** 1% **Annual Performance Objective for FFY 2018:** 1% *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to CHIP Enrollment (Continued)

FFY 2013	FFY 2014	FFY 2015
Goal #2 (Describe)	**Goal #2 (Describe)**	**Goal #2 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Date Range: **From: (mm/yyyy) To: (mm/yyyy)**	**Date Range:** **From: (mm/yyyy) To: (mm/yyyy)**	**Date Range:** **From: (mm/yyyy) To: (mm/yyyy)**
Performance Measurement Data: Described what is being measured: Numerator: Denominator: Rate:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate:
Additional notes on measure:	Additional notes on measure:	Additional notes/comments on measure:

FFY 2013	FFY 2014	FFY 2015
Explanation of Progress: **How did your performance in 2013 compare with the Annual Performance Objective documented in your 2012 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2014 compare with the Annual Performance Objective documented in your 2013 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2015 compare with the Annual Performance Objective documented in your 2014 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2014:** **Annual Performance Objective for FFY 2015:** **Annual Performance Objective for FFY 2016:** *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2015:** **Annual Performance Objective for FFY 2016:** **Annual Performance Objective for FFY 2017:** *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2016:** **Annual Performance Objective for FFY 2017:** **Annual Performance Objective for FFY 2018:** *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to CHIP Enrollment (Continued)

FFY 2013	FFY 2014	FFY 2015
Goal #3 (Describe)	**Goal #3 (Describe)**	**Goal #3 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Date Range: **From: (mm/yyyy) To: (mm/yyyy)**	**Date Range:** **From: (mm/yyyy) To: (mm/yyyy)**	**Date Range:** **From: (mm/yyyy) To: (mm/yyyy)**
Performance Measurement Data: Described what is being measured: Numerator: Denominator: Rate:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate:
Additional notes on measure:	Additional notes on measure:	Additional notes/comments on measure:
Explanation of Progress: **How did your performance in 2013 compare with the Annual Performance Objective documented in your 2012 Annual Report?**	**Explanation of Progress:** **How did your performance in 2014 compare with the Annual Performance Objective documented in your 2013 Annual Report?**	**Explanation of Progress:** **How did your performance in 2015 compare with the Annual Performance Objective documented in your 2014 Annual Report?**

FFY 2013	FFY 2014	FFY 2015
What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?	**What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2014:** **Annual Performance Objective for FFY 2015:** **Annual Performance Objective for FFY 2016:** *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2015:** **Annual Performance Objective for FFY 2016:** **Annual Performance Objective for FFY 2017:** *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2016:** **Annual Performance Objective for FFY 2017:** **Annual Performance Objective for FFY 2018:** *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to Medicaid Enrollment

FFY 2013	FFY 2014	FFY 2015
Goal #1 (Describe) Increase enrollment of children in families with income at or below 133% by 2%.	**Goal #1 (Describe)** Increase enrollment of children in families with income at or below 133% by 2%.	**Goal #1 (Describe)** Increase enrollment of children in families with income at or below 147% by 1%.
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☒ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: FPL adjusted to reflect MAGI equivalent income standard.
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☒ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☒ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☒ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Enrollment as of July 2012 Definition of numerator: Enrollment as of July 2013	**Definition of Population Included in the Measure:** Definition of denominator: Enrollment as of July 2013 Definition of numerator: Enrollment as of July 2014	**Definition of Population Included in the Measure:** Definition of denominator: Enrollment as of July 2015 Definition of numerator: Enrollment as of July 2014
Date Range: **From: (mm/yyyy)** 07/2012 **To: (mm/yyyy)** 07/2013	**Date Range:** **From: (mm/yyyy)** 07/2013 **To: (mm/yyyy)** 07/2014	**Date Range:** **From: (mm/yyyy)** 07/2014 **To: (mm/yyyy)** 07/2015
Performance Measurement Data: Described what is being measured: Increase in enrollment of children in families with income at or below 133% from 7/31/12 to 7/31/13. Numerator: 1272706 Denominator: 1283390 Rate: 99.2	**Performance Measurement Data:** Described what is being measured: Increase in enrollment of children in families with income at or below 133% from 7/31/13 to 7/31/14. Numerator: 1283390 Denominator: 1137936 Rate: 112.8	**Performance Measurement Data:** Described what is being measured: Increase in enrollment of children in families with income at or below 147% from 07/31/2014 to 07/31/2015. Numerator: 1138183 Denominator: 1077012 Rate: 105.7
Additional notes on measure: Increased by .8%	Additional notes on measure: Decreased by 12.8%	Additional notes/comments on measure: Enrollment decreased by 7.1%.

FFY 2013	FFY 2014	FFY 2015
Explanation of Progress: **How did your performance in 2013 compare with the Annual Performance Objective documented in your 2012 Annual Report?** Increased by less than expected **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2014 compare with the Annual Performance Objective documented in your 2013 Annual Report?** Decreased significantly. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2015 compare with the Annual Performance Objective documented in your 2014 Annual Report?** We saw a decrease rather than an increase in enrollment. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2014:** 2% **Annual Performance Objective for FFY 2015:** 1% **Annual Performance Objective for FFY 2016:** 1% *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2015:** 2% **Annual Performance Objective for FFY 2016:** 1% **Annual Performance Objective for FFY 2017:** 1% *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2016:** 1% **Annual Performance Objective for FFY 2017:** 1% **Annual Performance Objective for FFY 2018:** 1% *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to Medicaid Enrollment (Continued)

FFY 2013	FFY 2014	FFY 2015
Goal #2 (Describe)	**Goal #2 (Describe)**	**Goal #2 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Date Range: **From: (mm/yyyy) To: (mm/yyyy)**	**Date Range:** **From: (mm/yyyy) To: (mm/yyyy)**	**Date Range:** **From: (mm/yyyy) To: (mm/yyyy)**
Performance Measurement Data: Described what is being measured: Numerator: Denominator: Rate:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate:
Additional notes on measure:	Additional notes on measure:	Additional notes/comments on measure:

FFY 2013	FFY 2014	FFY 2015
Explanation of Progress: **How did your performance in 2013 compare with the Annual Performance Objective documented in your 2012 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2014 compare with the Annual Performance Objective documented in your 2013 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2015 compare with the Annual Performance Objective documented in your 2014 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2014:** **Annual Performance Objective for FFY 2015:** **Annual Performance Objective for FFY 2016:** *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2015:** **Annual Performance Objective for FFY 2016:** **Annual Performance Objective for FFY 2017:** *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2016:** **Annual Performance Objective for FFY 2017:** **Annual Performance Objective for FFY 2018:** *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to Medicaid Enrollment (Continued)

FFY 2013	FFY 2014	FFY 2015
Goal #3 (Describe)	**Goal #3 (Describe)**	**Goal #3 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Date Range: **From: (mm/yyyy) To: (mm/yyyy)**	**Date Range:** **From: (mm/yyyy) To: (mm/yyyy)**	**Date Range:** **From: (mm/yyyy) To: (mm/yyyy)**
Performance Measurement Data: Described what is being measured: Numerator: Denominator: Rate:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate:
Additional notes on measure:	Additional notes on measure:	Additional notes/comments on measure:

FFY 2013	FFY 2014	FFY 2015
Explanation of Progress: **How did your performance in 2013 compare with the Annual Performance Objective documented in your 2012 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2014 compare with the Annual Performance Objective documented in your 2013 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2015 compare with the Annual Performance Objective documented in your 2014 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2014:** **Annual Performance Objective for FFY 2015:** **Annual Performance Objective for FFY 2016:** *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2015:** **Annual Performance Objective for FFY 2016:** **Annual Performance Objective for FFY 2017:** *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2016:** **Annual Performance Objective for FFY 2017:** **Annual Performance Objective for FFY 2018:** *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Increasing Access to Care (Usual Source of Care, Unmet Need)

FFY 2013	FFY 2014	FFY 2015
Goal #1 (Describe) Reduce the state's infant mortality rate.	**Goal #1 (Describe)** Reduce the state's infant mortality rate.	**Goal #1 (Describe)** Reduce the state's infant mortality rate.
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2012	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☒Other. *Explain*: Infant mortality rate is defined as the rate at which Illinois newborns die during the first year of life, per 1,000 live births.	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☒Other. *Explain*: Infant mortality rate is defined as the rate at which Illinois newborns die during the first year of life, per 1,000 live births.	**Measurement Specification:** ☐HEDIS. *Specify HEDIS® Version used*: ☒Other. *Explain*: Infant mortality rate is defined as the rate at which Illinois newborns die during the first year of life, per 1,000 live births.
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☒ Other. *Specify*: Illinois Department of Public Health - Vital Records	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☒ Other. *Specify*: Illinois Department of Public Health - Vital Records	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☒ Other. *Specify*: Illinois Department of Public Health - Vital Records
Definition of Population Included in the Measure: Definition of numerator: Numerator = Infant Deaths (statewide) Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: Denominator = Live Births (statewide)	**Definition of Population Included in the Measure:** Definition of numerator: Numerator = Infant Deaths (statewide) Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: Denominator = Live Births (statewide)	**Definition of Population Included in the Measure:** Definition of numerator: Numerator = Infant deaths (statewide) Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: Denominator = Live births (statewide)
Date Range: **From: (mm/yyyy)** 01/2009 **To: (mm/yyyy)** 12/2009	**Date Range:** **From: (mm/yyyy)** 01/2010 **To: (mm/yyyy)** 12/2010	**Date Range:** **From: (mm/yyyy)** 01/2012 **To: (mm/yyyy)** 12/2012

FFY 2013	FFY 2014	FFY 2015
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS)* Numerator: Denominator: Rate:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS)* Numerator: Denominator: Rate:
Deviations from Measure Specifications: ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☐ Numerator,. *Explain*. ☐Denominator, *Explain*. ☐ Other, *Explain*.	Deviations from Measure Specifications: ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☐ Numerator,. *Explain*. ☐Denominator, *Explain*. ☐ Other, *Explain*.	Deviations from Measure Specifications: ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☐ Numerator,. *Explain*. ☐Denominator, *Explain*. ☐ Other, *Explain*.
Additional notes on measure:	Additional notes on measure:	Additional notes on measure:
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: 1176 Denominator: 171077 Rate: 6.9 Additional notes on measure: The measure is a rate per 1,000 live births.	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: 1116 Denominator: 164998 Rate: 6.8 Additional notes on measure: The measure is a rate per 1,000 live births.	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: 1032 Denominator: 159152 Rate: 6.5 Additional notes on measure: The measure is a rate per 1,000 live births.
Explanation of Progress: **How did your performance in 2013 compare with the Annual Performance Objective documented in your 2012 Annual Report?** Data from Dept. of Public Health Vital Records are uncertified for CY2010-CY2012. So, updated data are not available beyond that reported in FFY2012 (CY2009 data). **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** Within state government, HFS shares responsibility for maternal and child health	**Explanation of Progress:** **How did your performance in 2014 compare with the Annual Performance Objective documented in your 2013 Annual Report?** There was a slight decrease in the overall rate from 6.9/1,000 live births to 6.8/1,000 live births. However, this does not achieve the Performance Objective of 6.56/1,000 live births projected in the FFY2013 Annual Report.	**Explanation of Progress:** **How did your performance in 2015 compare with the Annual Performance Objective documented in your 2014 Annual Report?** There was a decrease in the infant mortality rate from CY2010 to CY2011 (6.8 and 6.6 deaths per 1,000 live births, respectively) and from CY2011 to CY2012 (6.6 and 6.5 per 1,000 live births, respectively). The annual report projection from FFY2014 was to achieve a rate of 6.53 measured by CY2012 data and achieved by the FFY2016 annual report. Certified data for CY2012 are available for this FFY2015 annual report and show the CY2012 infant mortality rate achieved the FFY2014 annual report projection.

FFY 2013	FFY 2014	FFY 2015
programs with the Department of Public Health and the Department of Human Services. Per legislative mandate (2004), these agencies were tasked with improving birth outcomes. Biennially, HFS reports to the legislature on on-going and completed activities. All of the reports are available on our HFS' Web site: http://www.hfs.illinois.gov/mch/report.html. The 2014 report is being drafted for submission to the legislature by January 1, 2014. Please refer to the Perinatal Report 2014 that will be available on the aforementioned Web site for details on our initiatives to improve birth outcomes (i.e., infant mortality, low birth weight, very low birth weight). **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2014:** 6.56 per 1,000 live births statewide (2010 data) - same as reported in FFY2012 **Annual Performance Objective for FFY 2015:** 6.23 per 1,000 live births statewide (2011 data) - same as reported in FFY2012 **Annual Performance Objective for FFY 2016:** 6.10 per 1,000 live births statewide (2012 data) - same as reported in FFY2012 *Explain how these objectives were set:* FFY for CARTS DATA Year Baseline 100th Percentile Difference % Improve-ment Annual Improve-ment Projection for Following Year 2012 2009 6.9 0 -6.90 5% -0.35 6.56	**What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** Within state government, HFS shares responsibility for maternal and child health programs with the Department of Public Health (DPH) and the Department of Human Services (DHS). Per legislative mandate (2004), these agencies are tasked with improving birth outcomes. Biennially, HFS reports to the legislature on on-going and completed activities. Reports are on HFS' web site: http://www.hfs.illinois.gov/mch/report.html. Please refer to the Perinatal Report 2014 available on the aforementioned web site for details on initiatives to improve birth outcomes (i.e., infant mortality, LBW, VLBW). A specific activity uses predictive analytics to identify women with previous high cost births who are identified as currently pregnant. Once identified a flag is set in a data file transferred weekly to DHS. The list is used for case finding to outreach to women and engage them in early and intensive prenatal care through the Family Case Management and Better Birth outcomes programs. **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2015:** 6.66 per 1,000 live births statewide (2011 data) **Annual Performance Objective for FFY 2016:** 6.53 per 1,000 live births statewide (2012 data)	**What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** Using predictive analytics to identify women with a previous high cost birth who are currently pregnant weekly an electronic data exchange transfers data to DHS to outreach to these women and engage them in early, intensive prenatal care. During the past year the algorithm identifying high-risk pregnant women expanded to include additional indicators beyond having a previous high cost birth. These indicators include conditions that are associated with a poor birth outcome (LBW, VLBW, infant demise). The addition of these indicators means identification of high-risk pregnant women is not based exclusively on having a previous high cost birth. This means women experiencing a first birth and who have an identified condition(s) are included in the case finding sent to DHS. HFS also shares the case finding list with managed care entities to outreach to the identified women and provide needed intensive prenatal care. **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2016:** 6.37 per 1,000 live births statewide (CY2013 data) **Annual Performance Objective for FFY 2017:** 6.24 per 1,000 live births statewide (CY2014 data)

FFY 2013	FFY 2014	FFY 2015
2013 2010 6.56 0 -6.56 5% -0.33 6.23 2014 2011 6.23 0 -6.23 2% -0.12 6.10 2015 2012 6.10 0 -6.10 2% -0.12 5.98 2016 2013 5.98 0 -5.98 2% -0.12 5.86 2017 2014 5.86 0 -5.86 2% -0.12 5.74 2018 2015 5.74 As of December 2013, CY2009 are the most recent data published by the IL Dept. of Public Health	**Annual Performance Objective for FFY 2017:** 6.40 per 1,000 live births statewide (2013 data) *Explain how these objectives were set:* FFY for CARTS DATA Year Baseline 100th Percentile Difference % Improve-ment Annual Improve-ment Projection for Following Year 2014 2012 6.8 0 -6.80 2% -0.14 6.66 2015 2013 6.66 0 -6.66 2% -0.13 6.53 2016 2014 6.53 0 -6.53 2% -0.13 6.40 2017 2015 6.40 0 -6.40 2% -0.13 6.27 2018 2016 6.27 0 -6.27 2% -0.13 6.15 2019 2017 6.15 0 -6.15 2% -0.12 6.02 2020 2018 6.02 As of December 2014, 2010 are the most recent data published by the IL Dept. of Public Health	**Annual Performance Objective for FFY 2018:** 6.12 per 1,000 live births statewide (CY2015 data) *Explain how these objectives were set:* FFY for CARTS DATA Year Baseline 100th Percentile Difference % Improve-ment Annual Improve-ment Projection for Following Year 2015 2012 6.5 0 -6.50 2% -0.13 6.37 2016 2013 6.37 0 -6.37 2% -0.13 6.24 2017 2014 6.24 0 -6.24 2% -0.12 6.12 2018 2015 6.12 0 -6.12 2% -0.12 6.00 2019 2016 6.00 0 -6.00 2% -0.12 5.88 2020 2017 5.88 0 -5.88 2% -0.12 5.76 2021 2018 5.76 As of November 2015, 2012 are the most recent certified data published by the IL Dept. of Public Health
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:** Per legislative mandate (2004), HFS, public health and human services agencies are tasked with improving birth outcomes. Biennially, HFS reports to the legislature on activities to improve birth outcomes (i.e., LBW, VLBW, infant demise). Reports are on HFS' web site: http://www.illinois.gov/hfs/info/reports/Pages/default.aspx.

Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need) (Continued)

FY 2013	FFY 2014	FFY 2015
Goal #2 (Describe) Reduce the number/percent of children with elevated blood levels exceeding 10 mcg/dL.	**Goal #2 (Describe)** Reduce the number/percent of children with elevated blood levels exceeding 10 mcg/dL.	**Goal #2 (Describe)** Reduce the number/percent of children with elevated blood levels exceeding 10 mcg/dL.
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☒Other. *Explain*: The measure is of Medicaid children, ages 6 and younger, with elevated blood lead levels exceeding 10 mcg/dL as reported by the Illinois Department of Public Health, Illinois Lead Program Surveillance report.	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☒Other. *Explain*: The measure is of Medicaid children, ages 6 and younger, with elevated blood lead levels exceeding 10 mcg/dL as reported by the Illinois Department of Public Health, Illinois Lead Program Surveillance report.	**Measurement Specification:** ☐HEDIS. *Specify HEDIS® Version used*: ☒Other. *Explain*: The measure is of Medicaid children, ages 6 and younger with elevated blood lead levels exceeding 10 mcg/dL reported by the Illinois Department of Public Health (IDPH), Illinois Lead Program Surveillance report.
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*:

FY 2013	FFY 2014	FFY 2015
medical record data). ☐ Survey data. *Specify*: ☒ Other. *Specify*: Illinois Department of Public Health (IDPH) Childhood Lead Poisoning Prevention Program Surveillance Report and personal communication (for numerator and denominator).	☒ Other. *Specify*: Illinois Department of Public Health (IDPH) Childhood Lead Poisoning Prevention Program Surveillance Report and personal communication (for numerator and denominator).	☒ Other. *Specify*: IDPH Childhood Lead Poisoning Prevention Program Surveillance Report and personal communication (for numerator and denominator).
Definition of Population Included in the Measure: Definition of numerator: Medicaid enrolled children, ages 6 and younger, with elevated blood lead levels exceeding 10 mcg/dL. The Illinois data includes capillary and venous tests. It also accounts for test results obtained with hand-held analyzers. Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: Medicaid enrolled children (ages 6 and younger) screened for childhood lead poisoning.	**Definition of Population Included in the Measure:** Definition of numerator: Medicaid enrolled children, ages 6 and younger, with elevated blood lead levels exceeding 10 mcg/dL. The Illinois data includes capillary and venous tests. It also accounts for test results obtained with hand-held analyzers. Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: Medicaid enrolled children (ages 6 and younger) screened for childhood lead poisoning.	**Definition of Population Included in the Measure:** Definition of numerator: Medicaid/CHIP enrolled children, ages 6 and younger, with elevated blood lead levels exceeding 10 mcg/dL. The Illinois data includes capillary and venous tests. It also accounts for test results obtained with hand-held analyzers. Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: Medicaid/CHIP enrolled children (ages 6 and younger) screened for childhood lead poisoning.

FY 2013	FFY 2014	FFY 2015
Date Range: **From: (mm/yyyy)** 01/2012 **To: (mm/yyyy)** 12/2012	**Date Range:** **From: (mm/yyyy)** 01/2013 **To: (mm/yyyy)** 12/2013	**Date Range:** **From: (mm/yyyy)** 01/2014 **To: (mm/yyyy)** 12/2014
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS)* Numerator: Denominator: Rate:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS)* Numerator: Denominator: Rate:
Deviations from Measure Specifications: ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☐ Numerator,. *Explain*. ☐Denominator, *Explain*. ☐ Other, *Explain*.	**Deviations from Measure Specifications:** ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☐ Numerator,. *Explain*. ☐Denominator, *Explain*. ☐ Other, *Explain*.	**Deviations from Measure Specifications:** ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☐ Numerator,. *Explain*. ☐Denominator, *Explain*. ☐ Other, *Explain*.
Additional notes on measure:	Additional notes on measure:	Additional note/commentss on measure:

FY 2013	FFY 2014	FFY 2015
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: 2440 Denominator: 221859 Rate: 1.1 Additional notes on measure: The numerator and denominator were provided by the Illinois Department of Public Health (IDPH) Childhood Lead Poisoning Prevention Program via personal communication, 11/12/2013.	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: 1468 Denominator: 211607 Rate: Additional notes on measure: 0.7,The numerator and denominator were provided by the Illinois Department of Public Health (IDPH) Childhood Lead Poisoning Prevention Program via personal communication, 12/5/2014. IDPH staff notes that in May 2012, the CDC changed the "level of concern" of 10 mcg/dL to a "reference value" to be revised on a four-year cycle based on the National Health and Nutrition Examination Survey (NHANES). Currently, the reference value is 5 mcg/dL. For comparison, the data reported here are for 10 mcg/dL.	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: 1924 Denominator: 213769 Rate: .9 Additional notes on measure: Data are from the IDPH Childhood Lead Poisoning Prevention Program via personal communication, 11/19/2015. IDPH staff note that May 2012 the CDC "…concurred with the...Federal Advisory Committee on Childhood Lead Poisoning Prevention to change the 'level of concern' of 10 mcg/dL and greater to a 'reference value' to be revised on a four-year cycle based on the National Health and Nutrition Examination Survey (NHANES). Currently, the reference value is 5 mcg/dL." Data reported are for 10 mcg/dL.
Explanation of Progress: **How did your performance in 2013 compare with the Annual Performance Objective documented in your 2012 Annual**	**Explanation of Progress:** **How did your performance in 2014 compare with the Annual Performance Objective documented in your 2013 Annual Report?** From FFY2013 (2012 data) to FFY2014 (2013 data), there was a percent change decrease of -36.36 in the rate of children with a blood lead level of 10 mcg/dL or higher. The 2013 rate (0.7%) surpasses the Performance Objective of 0.9 percent projected in the FFY2013 Annual Report.	**Explanation of Progress:** **How did your performance in 2015 compare with the Annual Performance Objective documented in your 2014 Annual Report?** From FFY2014 (2013 data) to FFY2015 (2014 data), there was a percent change increase of +28.6 (0.2 percentage points) in the rate of children with a blood lead level of 10 mcg/dL or higher. The 2014 rate (0.9%) does not achieve the Performance Objective of 0.5 percent projected in the FFY2014 Annual Report.

FY 2013	FFY 2014	FFY 2015
Report? From FFY2012 (2011 data) to FFY2013 (2012 data), there was a percent change decrease of -8.3 in the rate of Medicaid children with an blood lead level exceeding 10 mcg/dL; from 1.2 to 1.1, respectively. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward**	**What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**HFS is a member of the Illinois Department of Public Health (IDPH) Lead Poisoning Elimination Advisory Council and sits on the Evaluation sub-committee. IDPH sends test results to HFS' Enterprise Data Warehouse (EDW). Lead screening info is available to the child's primary care provider via two routes. If in PCCM, the patient profile identifies children due for a lead screening. With the move to a predominantly managed care healthcare delivery system, a Care Coordination Claims Database (CCCD) is made available by HFS to the managed care organizations. The CCCD includes seven years of lead screening information. The files are updated monthly. CCCD info available at: http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/ClaimsData.aspx A bonus payment strategy was implemented to incentivize providers to complete the series of recommended visits based on the periodicity schedule for children birth to age 5. **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2015:** 0.50% (2014 data) **Annual Performance Objective for FFY 2016:** 0.30% (2015 data)	**What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**HFS is a member of the Illinois Department of Public Health (IDPH) Lead Poisoning Elimination Advisory Council and sits on the Evaluation sub-committee. IDPH sends test results to HFS' Enterprise Data Warehouse (EDW). Lead screening info is available to the child's primary care provider via two routes. If in PCCM, the patient profile identifies children due for a lead screening. With the move to a predominantly managed care healthcare delivery system, a Care Coordination Claims Database (CCCD) is made available by HFS to the managed care organizations. The CCCD includes seven years of lead screening information. The files are updated monthly. CCCD info available at: http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/ClaimsData.aspx. HFS works with plans to use their data to drive quality. A bonus payment strategy was implemented to incentivize providers to complete the series of recommended visits based on the periodicity schedule for children birth to age 5. **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2016:** 0.7 (CY2015 data) **Annual Performance Objective for FFY 2017:** 0.5 (CY2016 data)

FY 2013	FFY 2014	FFY 2015
your goal? HFS is a member of the Illinois Department of Public Health (IDPH) Lead Poisoning Elimination Advisory Council and sits on the Evaluation sub-committee. The Advisory Council provides guidance and input to IDPH. IDPH sends results to HFS' Enterprise Data Warehouse. The child's lead screening information is made available to the child's primary care provider for appropriate medical management. Additionally, the patient profile identifies children due for a lead screening, but for whom no evidence exists of having received the screening. A bonus payment strategy was implemented to incentivize providers to complete the series of recommended visits based on the periodicity schedule for children birth to age 5. The PCCM program uses several strategies to encourage comprehensive services; patient	**Annual Performance Objective for FFY 2017:** 0.10% (2016 data) *Explain how these objectives were set:* FFY for CARTS DATA Year Baseline Annual % Reduction Projection for Following Year 20142013 0.7 0.2 0.50 20152014 0.50 0.2 0.30 20162015 0.30 0.2 0.10 20172016 0.10 0.1 0.00 20182017 0.00 Data source: Illinois Department of Public Health-Illinois Lead Program Surveillance Database; unpublished report	**Annual Performance Objective for FFY 2018:** 0.3 (CY2017 data) *Explain how these objectives were set:* FFY for CARTS DATA Year Baseline Annual % Reduction Projection for Following Year 2015 2014 0.9 0.2 0.70 2016 2015 0.70 0.2 0.50 2017 2016 0.50 0.2 0.30 2018 2017 0.30 0.1 0.20 2019 2018 0.20 Data source: Illinois Department of Public Health-Illinois Lead Program Surveillance Database; unpublished report

FY 2013	FFY 2014	FFY 2015
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need) (Continued)

FFY 2013	FFY 2014	FFY 2015
Goal #3 (Describe) To increase the percentage of HFS continuously enrolled children who receive at least one capillary or venous blood lead screening test on or before their second birthday.	**Goal #3 (Describe)** To increase the percentage of HFS continuously enrolled children who receive at least one capillary or venous blood lead screening test on or before their second birthday.	**Goal #3 (Describe)** To increase the percentage of HFS continuously enrolled children who receive at least one capillary or venous blood lead screening test on or before their second birthday.
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: 2013 ☐Other. *Explain*:	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: 2014 ☐Other. *Explain*:	**Measurement Specification:** ☒HEDIS. *Specify HEDIS® Version used*: 2015 ☐Other. *Explain*:
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☒ Other. *Specify*: Administrative claims data, including CPTs	**Data Source:** ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☒ Other. *Specify*: Administrative claims data, including CPTs 36415 or 36416 with U1 modifier or CPT 83655 with QW modifier. Also accept Illinois Department of Public Health blood lead program testing data.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☒ Other. *Specify*: Administrative claims data, including CPTs 36415 or 36416 with U1 modifier or CPT 83655 with QW modifier. Also accept Illinois Department of Public Health blood lead program testing data.

FFY 2013	FFY 2014	FFY 2015
36415 or 36416 with U1 modifier or CPT 83655 with QW modifier. In addition to claims data, also accept Dept. of Public Health blood lead testing program data. This has been the case for some years. So, previous reporting indicating claims as the only data source is in error.		
Definition of Population Included in the Measure: Definition of numerator: HFS continuously enrolled children (Title XIX, Title XXI) who are 24 months of age and received at least one capillary or venous blood test on or before their second birthday. Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: HFS continuously enrolled children (Title XIX, Title XXI) who are 24 months of age.	**Definition of Population Included in the Measure:** Definition of numerator: HFS continuously enrolled children (Title XIX, Title XXI) who are 24 months of age and received at least one capillary or venous blood test on or before their second birthday. Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: HFS continuously enrolled children (Title XIX, Title XXI) who are 24 months of age.	**Definition of Population Included in the Measure:** Definition of numerator: HFS continuously enrolled children (Title XIX, Title XXI) who are 24 months of age and received at least one capillary or venous blood test on or before their second birthday. Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: HFS continuously enrolled children (Title XIX, Title XXI) who are 24 months of age.
From: (mm/yyyy) 01/2012 **To: (mm/yyyy)** 12/2012	**Date Range:** **From: (mm/yyyy)** 01/2013 **To: (mm/yyyy)** 12/2013	**Date Range:** **From: (mm/yyyy)** 01/2014 **To: (mm/yyyy)** 12/2014

FFY 2013	FFY 2014	FFY 2015
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: 68792 Denominator: 88902 Rate: 77.4	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS)* Numerator: 65317 Denominator: 82961 Rate: 78.7	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS)* Numerator: 61318 Denominator: 77753 Rate: 78.9
Deviations from Measure Specifications: ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☒ Numerator,. *Explain*. Counts include CPTs 36415 or 36416 with U1 modifier or CPT 83655 with QW modifier. In addition to claims data, also accept Dept. of Public Health blood lead testing program data. ☐Denominator, *Explain*. ☐ Other, *Explain*.	**Deviations from Measure Specifications:** ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☒ Numerator,. *Explain*. Counts include CPTs 36415 or 36416 with U1 modifier or CPT 83655 with QW modifier. In addition to claims data, also accept Illinois Department of Public Health blood lead testing program data. ☐Denominator, *Explain*. ☐ Other, *Explain*.	**Deviations from Measure Specifications:** ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☒ Numerator,. *Explain*. Counts include CPTs 36415 or 36416 with U1 modifier or CPT 83655 with QW modifier. In addition to claims data, also accept Illinois Department of Public Health blood lead testing program data. ☐Denominator, *Explain*. ☐ Other, *Explain*.
Additional notes on measure:	Additional notes on measure: This measure was audited by HSAG during fall 2014.	Additional notes/comments on measure: This measure was audited by HSAG during 2015.
Other Performance Measurement Data: Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:

FFY 2013	FFY 2014	FFY 2015
Explanation of Progress: **How did your performance in 2013 compare with the Annual Performance Objective documented in your 2012 Annual Report?** From FFY2012 (2011 data) to FFY2013 (2012 data), there was a percent change increase of +2.5 in the percent of 24 month olds who received at least one blood lead screening. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this**	**Explanation of Progress:** **How did your performance in 2014 compare with the Annual Performance Objective documented in your 2013 Annual Report?** From FFY2013 (2012 data) to FFY2014 (2013 data), there was a percent change increase of +1.5 in the percent of 24 month olds who received at least one blood lead screening. However, the rate (78.7%) does not achieve the Performance Objective of 79.66 percent projected in the FFY2013 Annual Report. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** HFS is a member of the Illinois Department of Public Health (IDPH) Lead Poisoning Elimination Advisory Council and sits on the Evaluation sub-committee. IDPH sends test results to HFS' Enterprise Data Warehouse (EDW). Lead screening info is available to the child's primary care provider via two routes. If in PCCM, the patient profile identifies children due for a lead screening. With the move to a predominantly managed care healthcare delivery system, a Care Coordination Claims Database (CCCD) is made available by HFS to the managed care organizations. The CCCD includes seven years of lead screening information. The files are updated monthly. CCCD info available at: http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/ClaimsData.aspx A bonus payment strategy was implemented to incentivize providers to complete the series of recommended visits based on the periodicity schedule for children birth to age 5. **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2015:** 80.86% (2014 data) **Annual Performance Objective for FFY 2016:** 82.77% (2015 data)	**Explanation of Progress:** **How did your performance in 2015 compare with the Annual Performance Objective documented in your 2014 Annual Report?** From FFY2014 (CY2013 data) to FFY2015 (CY2014 data), there was a percent change increase of only +0.1 in the percent of 24 month olds who received at least one blood lead screening. The CY2014 rate (78.9%) does not achieve the Performance Objective of 80.86 percent projected in the FFY2015 Annual Report. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** HFS is a member of the Illinois Department of Public Health (IDPH) Lead Poisoning Elimination Advisory Council and sits on the Evaluation sub-committee. IDPH sends test results to HFS' Enterprise Data Warehouse (EDW). Lead screening info is available to the child's primary care provider via two routes. If in PCCM, the patient profile identifies children due for a lead screening. With the move to a predominantly managed care healthcare delivery system, a Care Coordination Claims Database (CCCD) is made available by HFS to the managed care organizations. The CCCD includes seven years of lead screening information. The files are updated monthly. CCCD info available at: http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/ClaimsData.aspx. HFS works with plans to use their data to drive quality. A bonus payment strategy was implemented to incentivize providers to complete the series of recommended visits based on the periodicity schedule for children birth to age 5. **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2016:** 81.0 (CY2015 data) **Annual Performance Objective for FFY 2017:** 82.9 (CY2016 data)

FFY 2013	FFY 2014	FFY 2015
measure, or make progress toward your goal? HFS is a member of the Illinois Department of Public Health (IDPH) Lead Poisoning Elimination Advisory Council and sits on the Evaluation sub-committee. The Advisory Council provides guidance and input to IDPH. IDPH sends results to HFS' Medical Data Warehouse. The child's lead screening information is made available to the child's primary care provider for appropriate medical management. Additionally, the patient profile identifies children due for a lead screening, but for whom no evidence exists of having received the screening. A bonus payment strategy was implemented to incentivize providers to complete the series of recommended visits based on the periodicity schedule for children birth to age 5. The PCCM program uses several strategies to encourage	**Annual Performance Objective for FFY 2017:** 84.49% (2016 data) *Explain how these objectives were set:* FFY for CARTS DATA Year Baseline 100th Percentile Difference % Improve-ment Annual Improve-ment Projection for Following Year 2014 2013 78.73 100 21.27 10% 2.13 80.86 2015 2014 80.86 100 19.14 10% 1.91 82.77 2016 2015 82.77 100 17.23 10% 1.72 84.49 2017 2016 84.49 100 15.51 10% 1.55 86.04 2018 2017 86.04	**Annual Performance Objective for FFY 2018:** 84.6 (CY2017 data) *Explain how these objectives were set:* HFS Continuously Enrolled FFY for CARTS DATA Year Baseline 100th Percentile Difference % Improve-ment Annual Improve-ment Projection for Following Year 2015 2014 78.86 100 21.14 10% 2.11 80.97 2016 2015 80.97 100 19.03 10% 1.90 82.88 2017 2016 82.88 100 17.12 10% 1.71 84.59 2018 2017 84.59 100 15.41 10% 1.54 86.13 2019 2018 86.13

FFY 2013	FFY 2014	FFY 2015
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)

FFY 2013	FFY 2014	FFY 2015
Goal #1 (Describe)	**Goal #1 (Describe)**	**Goal #1 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐Other. *Explain*:	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐Other. *Explain*:	**Measurement Specification:** ☐HEDIS. *Specify HEDIS® Version used*: ☐Other. *Explain*:
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of numerator: Definition of denominator: ☐ Denominator includes CHIP population only. ☐ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded:	**Definition of Population Included in the Measure:** Definition of numerator: Definition of denominator: ☐ Denominator includes CHIP population only. ☐ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded:	**Definition of Population Included in the Measure:** Definition of numerator: Definition of denominator: ☐ Denominator includes CHIP population only. ☐ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded:
Date Range: **From: (mm/yyyy) To: (mm/yyyy)**	**Date Range:** **From: (mm/yyyy) To: (mm/yyyy)**	**Date Range:** **From: (mm/yyyy) To: (mm/yyyy)**
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS)* Numerator: Denominator: Rate:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS)* Numerator: Denominator: Rate:
Deviations from Measure Specifications: ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*.	**Deviations from Measure Specifications:** ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*.	**Deviations from Measure Specifications:** ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*.

FFY 2013	FFY 2014	FFY 2015
☐ Numerator,. *Explain*. ☐Denominator, *Explain*. ☐ Other, *Explain*.	☐ Numerator,. *Explain*. ☐Denominator, *Explain*. ☐ Other, *Explain*.	☐ Numerator,. *Explain*. ☐Denominator, *Explain*. ☐ Other, *Explain*.
Additional notes on measure:	Additional notes on measure:	Additional notes/comments on measure:
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:
Explanation of Progress: **How did your performance in 2013 compare with the Annual Performance Objective documented in your 2012 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2014:** **Annual Performance Objective for FFY 2015:** **Annual Performance Objective for FFY 2016:** *Explain how these objectives were set:*	**Explanation of Progress:** **How did your performance in 2014 compare with the Annual Performance Objective documented in your 2013 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2015:** **Annual Performance Objective for FFY 2016:** **Annual Performance Objective for FFY 2017:** *Explain how these objectives were set:*	**Explanation of Progress:** **How did your performance in 2015 compare with the Annual Performance Objective documented in your 2014 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2016:** **Annual Performance Objective for FFY 2017:** **Annual Performance Objective for FFY 2018:** *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care) (Continued)

FFY 2013	FFY 2014	FFY 2015
Goal #2 (Describe) Eighty percent (80%) of enrolled children will be appropriately immunized at age two (less than 36 months of age at the end of the calendar year).	**Goal #2 (Describe)** Eighty percent (80%) of enrolled children will be appropriately immunized at age two (less than 36 months of age at the end of the calendar year).	**Goal #2 (Describe)** Eighty percent (80%) of enrolled children will be appropriately immunized at age two (less than 36 months of age at the end of the calendar year).
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☒ Provisional. *Explanation of Provisional Data: The FFY2013 data are provisional since the measure was re-programmed and sample testing has not yet been completed.* ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional.. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: 2013 ☐Other. *Explain*:	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: 2014 ☐Other. *Explain*:	**Measurement Specification:** ☒HEDIS. *Specify HEDIS® Version used*: 2015 ☐Other. *Explain*:
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☒ Other. *Specify*: Administrative (claims data) and registry data.	**Data Source:** ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*: Administrative (claims data) and registry data.	**Data Source:** ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☒ Other. *Specify*: Administrative (claims data) and registry data
Definition of Population Included in the Measure: Definition of numerator: HFS continuously enrolled children (Title XIX, Title XXI) who turn 36 months of age by the end of the calendar year and achieve the vaccine series. Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: HFS continuously enrolled children (Title XIX, Title XXI) who turn 36 months of age by the end of the calendar year.	**Definition of Population Included in the Measure:** Definition of numerator: HFS continuously enrolled children (Title XIX, Title XXI) who turn 36 months of age by the end of the calendar year and achieve the vaccine series. Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: HFS continuously enrolled children (Title XIX, Title XXI) who turn 36 months of age by the end of the calendar year.	**Definition of Population Included in the Measure:** Definition of numerator: HFS continuously enrolled children (Title XIX, Title XXI) who turn 36 months of age by the end of the calendar year and achieve the vaccine series. Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: HFS continuously enrolled children (Title XIX, Title XXI) who turn 36 months of age by the end of the calendar year.
Date Range: **From: (mm/yyyy)** 01/2012 **To: (mm/yyyy)** 12/2012	**Date Range:** **From: (mm/yyyy)** 01/2013 **To: (mm/yyyy)** 12/2013	**Date Range:** **From: (mm/yyyy)** 01/2014 **To: (mm/yyyy)** 12/2014

FFY 2013	FFY 2014	FFY 2015
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: 00 Denominator: 00 Rate:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS)* Numerator: 00 Denominator: 00 Rate:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS)* Numerator: 0.0 Denominator: 0.0 Rate:
Deviations from Measure Specifications: ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☒ Numerator,. *Explain*. Accepting 2 Hep B not 3 since first vaccine is often given to newborns in hospital and billed under mother's RIN. Using Cornerstone Immunization codes in addition to CPT, ICD codes. ☐Denominator, *Explain*. ☐ Other, *Explain*.	**Deviations from Measure Specifications:** ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☒ Numerator,. *Explain*. Accepting 2 Hep B not 3 since first vaccine is often given to newborns in hospital and billed under mother's RIN. Using Cornerstone Immunization codes in addition to CPT, ICD codes. ☐Denominator, *Explain*. ☐ Other, *Explain*.	**Deviations from Measure Specifications:** ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☒ Numerator,. *Explain*. Accepting 2 Hep B not 3 since first vaccine is often given to newborns in hospital and billed under mother's RIN. ☐Denominator, *Explain*. ☐ Other, *Explain*.
Additional notes on measure: Vaccine combo data are provided as Numerator / Denominator = Rate. Combo 2: 66,476/92,166 = 72.13% Combo 3: 62,223/92,166 = 67.51% Combo 4: 42,328/92,166 = 45.93% Combo 5: 46,034/92,166 = 49.95% Combo 6: 31,559/92,166 = 34.24% Combo 7: 33,475/92,166 = 36.32% Combo 8: 24,693/92,166 = 26.79% Combo 9: 25,203/92,166 = 27.35% Combo 10: 20,309/92,166 = 22.04% Individual vaccine rates also available, but not reported here.	Additional notes on measure: Vaccine combo data are provided as Numerator / Denominator = Rate. Combo 2: 60,002/81,270 = 73.8% Combo 3: 55,983/81,270 = 68.9% Combo 4: 50,643/81,270 = 62.3% Combo 5: 43,065/81,270 = 53.0% Combo 6: 32,551/81,270 = 40.1% Combo 7: 40,090/81,270 = 49.3% Combo 8: 30,886/81,270 = 38.0% Combo 9: 26,755/81,270 = 32.9% Combo 10: 25,688/81,270 = 31.6% Individual vaccine rates also available, but not reported here.	Additional notes/comments on measure: Vaccine combo data are provided as Numerator / Denominator = Rate. Combo 2: 56,997/76,879 = 74.1% Combo 3: 53,470/76,879 = 69.6% Combo 4: 48,995/76,879 = 63.7% Combo 5: 43,160/76,879 = 56.1% Combo 6: 30,347/76,879 = 39.5% Combo 7: 40,452/76,879 = 52.6% Combo 8: 29.128/76,879 = 37.9% Combo 9: 25,833/76,879 = 33.6% Combo 10: 24,994/76,879 = 32.5% Individual vaccine rates also available, but not reported here.
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:
Explanation of Progress: **How did your performance in 2013 compare with the Annual Performance Objective documented in your 2012 Annual Report?** Between FFY2012 (2011 data)	**Explanation of Progress:** **How did your performance in 2014 compare with the Annual Performance Objective documented in your 2013 Annual Report?** Between FFY2013 (2012 data)	**Explanation of Progress:** **How did your performance in 2015 compare with the Annual Performance Objective documented in your 2014 Annual Report?** HFS focuses the comparison on

FFY 2013	FFY 2014	FFY 2015
and FFY2013 (2012 data) the Combo 2 and Combo 3 immunization rates increased by a percent change of +3.93 and +4.50, respectively. The FFY2013 immunization rate (2012 data) for all vaccine combinations is higher among those less than 36 months of age compared to those less than 24 months of age (the CHIPRA core measure). The measure of those 36 months of age permits a "catch-up" period during which young children are able to receive the appropriate immunizations. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** Childhood immunizations (by age 2) is a bonus payment strategy within the managed care program (MCO and PCCM). Making child-specific immunization data available in the expanded format (e.g., all available data sources) is viewed as a best practice strategy to promote appropriate immunization status. HFS' Quality Strategy priority measures for Voluntary Managed Care include childhood immunization combo 3 as a key measure with a target of 10 percent improvement in performance compared to the previous year. **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2014:** Combo 2: 73.52% Combo 3: 69.13% (2013 data) **Annual Performance Objective for FFY 2015:** Combo 2: 74.85% Combo 3: 70.68% (2014 data) **Annual Performance Objective for FFY 2016:** Combo 2: 76.10% Combo 3: 72.14% (2015 data)	and FFY2014 (2013 data) the Combo 2 immunization rate increased by a percent change of +0.42. The Combo 3 rate decreased by -0.35%. The FFY2014 Combo 2 rate (73.8%) only slightly surpasses the Performance Objective of 73.5 percent projected in the FFY2013 Annual Report. The Combo 3 rate (68.9%) does not surpass the Performance Objective of 69.1 percent set in the FFY2013 Annual Report. The FFY2013 immunization rate (2012 data) for all vaccine combinations is higher among those less than 36 months of age compared to those less than 24 months of age (the core measure). The measure of those 36 months of age permits a "catch-up" period during which young children are able to receive the appropriate immunizations. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** Immunization by age 2 is a bonus payment strategy. Care Coordination Claims Data (CCCD) are available to HFS care coordination partners for their enrolled recipients and contains the most recent two years of claims data, and seven years of immunization and lead data - updated monthly. The data set aggregates information from various sources. The PCCM program continues quality improvement activities by distributing provider panel roster information containing claims, immunization and blood lead data similar to that contained in the CCCD. Making child-specific immunization data available in these formats (e.g., all available data sources) is viewed as a best practice strategy to promote appropriate immunization status. HFS' Quality Strategy priority measures for Managed Care include childhood immunization combo 3 as a key measure with a target of 10 percent improvement in performance compared to the previous year. **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2015:**	the Combo 2 and Combo 3 vaccination rates. Between FFY2014 (CY2013 data) and FFY2015 (CY2014 data) the Combo 2 immunization rate decreased by a percent change of -0.13. The Combo 3 rate increased by +0.58%. The FFY2015 Combo 2 rate (74.1%) does not achieve the Performance Objective of 75.1 percent projected in the FFY2014 Annual Report. The FFY2015 Combo 3 rate (69.6%) does not achieve the Performance Objective of 70.5 percent set in the FFY2014 Annual Report. The FFY2015 immunization rate (CY2014 data) for all vaccine combinations is higher among those less than 36 months of age compared to those less than 24 months of age (the core measure, data not reported into CARTS). The measure of those 36 months of age permits a "catch-up" period during which young children are able to receive the appropriate immunizations. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** HFS' draft Quality Strategy proposes measurement of immunization combos 2-10 within the FHP/ACA population and establishes an improvement target set at the HEDIS® 75th percentile. The PCCM, Care Coordination Entity (CCE) and Accountable Care Entities (ACE) priority measures also include measurement of childhood immunization status. (Note, per Quality Strategy: Pursuant to P.A. 98-104, the ACEs and CCEs must become a licensed HMO or MCCN.) Immunization by age 2 is a bonus payment strategy. Care Coordination Claims Data (CCCD) are available to HFS care coordination partners for their enrolled recipients and contains the most recent two years of claims data, and seven years of immunization and lead data - updated monthly. The PCCM program continues quality improvement activities by distributing provider panel roster information containing claims, immunization and blood lead data similar to that contained in the CCCD. **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2016:**

FFY 2013	FFY 2014	FFY 2015
Explain how these objectives were set: Combo 2: Enrolled children (36 Month Olds) will be appropriately immunized HFS Continuously Enrolled FFY for CARTS 100th Percentile DATA Year Difference Baseline % Improve-mentAnnual Improve-ment Projection for Following Year 2013 2012 72.13 100 27.87 5% 1.39 73.52 2014 2013 73.52 100 26.48 5% 1.32 74.85 2015 2014 74.85 100 25.15 5% 1.26 76.10 2016 2015 76.10 100 23.90 5% 1.19 77.30 2017 2016 77.30	Combo 2: 75.1% Combo 3: 70.5% (CY2014 data) **Annual Performance Objective for FFY 2016:** Combo 2: 76.4% Combo 3: 71.9% (CY2015 data) **Annual Performance Objective for FFY 2017:** Combo 2: 77.6% Combo 3: 73.3% (CY2016 data) *Explain how these objectives were set:* Combo 2: Enrolled children (36 Month Olds) will be appropriately immunized HFS Continuously Enrolled FFY for CARTS 100th Percentile DATA Year Difference Baseline % Improve-ment Annual Improve-ment Projection for Following Year 2014 2013 73.83 100 26.17 5% 1.31 75.14 2015 2014 75.14 100 24.86 5% 1.24 76.38 2016 2015 76.38 100 23.62 5% 1.18 77.56 2017 2016 77.56 100 22.44 5% 1.12 78.68 2018 2017 78.68 (Combo 2 used as example of calculations used)	Combo 2: 75.4 (CY2015 data) Combo 3: 71.1 (CY2015 data) **Annual Performance Objective for FFY 2017:** Combo 2: 76.6 (CY2016 data) Combo 3: 72.6 (CY2016 data) **Annual Performance Objective for FFY 2018:** Combo 2: 77.8 (CY2017 data) Combo 3: 73.9 (CY2017 data) *Explain how these objectives were set:* Combo 2: Enrolled children (36 Month Olds) will be appropriately immunized HFS Continuously Enrolled FFY for CARTS 100th Percentile DATA Year Difference Baseline % Improve-ment Annual Improve-ment Projection for Following Year 2015 2014 74.1 100 25.90 5% 1.30 75.40 2016 2015 75.40 100 24.61 5% 1.23 76.63 2017 2016 76.63 100 23.37 5% 1.17 77.79 2018 2017 77.79 100 22.21 5% 1.11 78.90 2019 2018 78.90 (Combo 2 used as example of calculations used0
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:** This measure was audited by HSAG during 2015.

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care) (Continued)

FFY 2013	FFY 2014	FFY 2015
Goal #3 (Describe) Improve the health status of Illinois' children. Eighty percent of children as measured by the CMS-416 guidance will participate in well child screenings.	**Goal #3 (Describe)** Improve the health status of Illinois' children. Eighty percent of children as measured by the CMS-416 guidance will participate in well child screenings.	**Goal #3 (Describe)** Improve the health status of Illinois' children. Eighty percent of children as measured by the CMS-416 guidance will participate in well child screenings.
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. *Explanation of Provisional Data:* ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☒Other. *Explain*: The annual EPSDT report (Form CMS-416), defined by CMS using the March 2010 guidance document revision, as providing information to assess the effectiveness of State EPSDT programs in terms of the number of children provided child health screening services, are referred for corrective treatment, and receive dental services.	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☒Other. *Explain*: The annual EPSDT report (Form CMS-416), defined by CMS using the March 2010 guidance document revision, as providing information to assess the effectiveness of State EPSDT programs in terms of the number of children provided child health screening services, are referred for corrective treatment, and receive dental services.	**Measurement Specification:** ☐HEDIS. *Specify HEDIS® Version used*: ☒Other. *Explain*: The annual EPSDT report (Form CMS-416), defined by CMS using the November 2014 guidance document revision, as providing information to assess the effectiveness of State EPSDT programs in terms of the number of children provided child health screening services, are referred for corrective treatment, and receive dental services.
Data Source: ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of numerator: Per the CMS-416 guidance revised March 2010, "Line 9 - Total Eligibles Receiving at Least One Initial or Periodic Screen - Enter the unduplicated count of individuals, including those enrolled in managed care arrangements, who received at least one documented initial or periodic screen during the year." Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: This is a report for Medicaid	**Definition of Population Included in the Measure:** Definition of numerator: Per the CMS-416 guidance revised March 2010, "Line 9 - Total Eligibles Receiving at Least One Initial or Periodic Screen - Enter the unduplicated count of individuals, including those enrolled in managed care arrangements, who received at least one documented initial or periodic screen during the year." Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: This is a report for Medicaid	**Definition of Population Included in the Measure:** Definition of numerator: Per CMS-416 guidance (11/2014), "Line 9 -- Total Eligibles Receiving at Least One Initial or Periodic Screen - Enter the unduplicated number of individuals under age 21 with at least 90 days continuous enrollment within the federal fiscal year from Line 1b, including those in fee-for-service, prospective payment, managed care, and other payment arrangements, who received at least one documented initial or periodic screen during the year, based on an unduplicated paid, unpaid, or denied claim." Definition of denominator: ☐ Denominator includes CHIP population only.

FFY 2013	FFY 2014	FFY 2015
(Title XIX) only. Per the CMS-416 guidance revised March 2010, "Line 8 - Total Eligibles Who Should Receive at Least One Initial or Periodic Screen...." This calculation includes Line 1b and therefore is based on those enrolled for at least 90 continuous days.	(Title XIX) only. Per the CMS-416 guidance revised March 2010, "Line 8 - Total Eligibles Who Should Receive at Least One Initial or Periodic Screen...." This calculation includes Line 1b and therefore is based on those enrolled for at least 90 continuous days.	☒ Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded: This is a report for Medicaid (Title XIX) only. Per the CMS-416 guidance revised November 2014, "Line 8 -- Total Eligibles Who Should Receive at Least One Initial or Periodic Screen -- The number of individuals who should receive at least one initial or periodic screen...."
Date Range: **From: (mm/yyyy)** 10/2011 **To: (mm/yyyy)** 09/2012	**Date Range:** **From: (mm/yyyy)** 10/2012 **To: (mm/yyyy)** 09/2013	**Date Range:** **From: (mm/yyyy)** 10/2013 **To: (mm/yyyy)** 09/2014
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS)* Numerator: Denominator: Rate:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS)* Numerator: Denominator: Rate:
Deviations from Measure Specifications: ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☐ Numerator,. *Explain*. ☐Denominator, *Explain*. ☐ Other, *Explain*.	**Deviations from Measure Specifications:** ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☐ Numerator,. *Explain*. ☐Denominator, *Explain*. ☐ Other, *Explain*.	**Deviations from Measure Specifications:** ☐ Year of Data, *Explain*. ☐ Data Source, *Explain*. ☐ Numerator,. *Explain*. ☐Denominator, *Explain*. ☐ Other, *Explain*.
Additional notes on measure:	Additional notes on measure:	Additional notes/comments on measure:
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: 810613 Denominator: 1098631 Rate: 74.0 Additional notes on measure: Includes Title XIX only	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: 781141 Denominator: 1070331 Rate: 73.0 Additional notes on measure: We are currently investigating the CMS-416 report to comply with revised guidance from CMS (November 2014) for FFY2014 reporting (due April 1, 2015). Future reports will reflect programming changes as the report is reviewed and updated.	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: 799153 Denominator: 1035178 Rate: 77 Additional notes on measure:

FFY 2013	FFY 2014	FFY 2015
Explanation of Progress: **How did your performance in 2013 compare with the Annual Performance Objective documented in your 2012 Annual Report?** From FFY2012 (FFY2011 data) to FFY2013 (FFY2012 data), there was a percent change decrease of -2.63 in the rate of children who received at least one initial or periodic screening. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** The Medicaid reform law [PA 96-1501], requires that by January 1, 2015, at least 50 percent of the individuals covered under Medicaid be enrolled in a care coordination program that organizes care around their medical needs. In January 2014, Illinois Medicaid will expand the care coordination program to the other populations we serve: children, their parents, and newly-eligible Medicaid enrollees under the Affordable Care Act. It is expected that care coordination for these populations will be provided by some or all of the current managed care entities on contract with the state, as well as others who are likely to apply (including MCOs, CCEs and MCCNs). The traditional managed care organizations serving Illinois Medicaid clients are also likely to offer private health insurance on the Illinois Health Insurance Exchange, thereby providing continuity of care, as clients go on or off Medicaid. Bonus payments and provider quality tools continue to be implemented. **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2014:** 76.60% (FFY2013 data) **Annual Performance Objective for FFY 2015:** 78.94% (FFY2014 data) **Annual Performance Objective for FFY 2016:** 81.05% (FFY2015 data)	**Explanation of Progress:** **How did your performance in 2014 compare with the Annual Performance Objective documented in your 2013 Annual Report?** From FFY2013 (FFY2012 data) to FFY2014 (FFY2013 data), there was a percent change decrease of -1.35 in the rate of children who received at least one initial or periodic screening. The CMS-416 FFY2013 rate (73.0%) does not achieve the Performance Objective of 76.60 percent projected in the FFY2013 Annual Report. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** The Medicaid reform law [PA 96-1501] requires that 50% of clients be enrolled in care coordination programs by 2015. In Illinois, care coordination will be provided to most Medicaid clients by a variety of "managed care entities," a general term that includes Coordinated Care Entities (CCEs), Managed Care Community Networks (MCCNs), Managed Care Organizations (MCOs) and Accountable Care Entities (ACEs). HFS strengthened its managed care contracts to specify content of care expected for children and implemented a withhold/pay for performance strategy. Bonus payments have been available to incentivize providers to complete the series of recommended visits based on the periodicity schedule for children birth to age 5. The PCCM program uses several strategies to encourage comprehensive services: patient panels indicating when the child is due for screening services, data monitoring and provider feedback, on-line access to claims data, provider education and on-going assistance. **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2015:** 75.70% (FFY2014 data) **Annual Performance Objective for FFY 2016:** 78.13% (FFY2015 data)	**Explanation of Progress:** **How did your performance in 2015 compare with the Annual Performance Objective documented in your 2014 Annual Report?** From FFY2014 (FFY2013 data) to FFY2015 (FFY2014 data), there was a percent change increase of +5.5% in the rate of children who received at least one initial or periodic screening. The CMS-416 FFY2014 rate (77.0%) achieves the Performance Objective of 75.7 percent projected in the FFY2014 CHIP Annual Report. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** The Medicaid reform law [PA 96-1501] requires that 50% of clients be enrolled in care coordination programs by 2015. HFS strengthened its managed care contracts to specify content of care expected for children and implemented a withhold/pay for performance strategy. HFS' draft Quality Strategy proposes measurement well child visits in FHP/ACA population and establishes an improvement target set at the HEDIS® 75th percentile. Bonus payments have been available to incentivize providers to complete the series of recommended visits based on the periodicity schedule for children birth to age 5. The PCCM program uses several strategies to encourage comprehensive services: patient panels indicating when the child is due for screening services, data monitoring and provider feedback, on-line access to claims data, provider education and on-going assistance. **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2016:** 79.3 (FFY2015 data) **Annual Performance Objective for FFY 2017:** 81.4 (FFY2016 data)

FFY 2013	FFY 2014	FFY 2015
Explain how these objectives were set: CMS-416 Line 10: Eighty percent of children measured by Form CMS-416 will participate in well child screenings FFY for CARTS 100th Percentile Annual Improve-ment Projection for Following Year / DATA Year (FFY) Baseline Difference / % Improve-ment 2013 2012 74 100 26.00 10% 2.60 76.60 2014 2013 76.60 100 23.40 10% 2.34 78.94 2015 2014 78.94 100 21.06 10% 2.11 81.05 2016 2015 81.05 100 18.95 10% 1.90 82.94 2017 2016 82.94 Rates based on total, not age-specific population	**Annual Performance Objective for FFY 2017:** 80.32% (FFY2016 data) *Explain how these objectives were set:* FFY for CARTS 100th Percentile Annual Improve-ment Projection for Following Year / DATA Year (FFY) Baseline Difference / % Improve-ment 2014 2013 73 100 27.00 10% 2.70 75.70 2015 2014 75.70 100 24.30 10% 2.43 78.13 2016 2015 78.13 100 21.87 10% 2.19 80.32 2017 2016 80.32 100 19.68 10% 1.97 82.29 2018 2017 82.29 Rates based on the total, not age-specific population	**Annual Performance Objective for FFY 2018:** 83.2 (FFY2017 data) *Explain how these objectives were set:* FFY for CARTS 100th Percentile Annual Improvement Projection for Following Year / DATA Year (FFY) Baseline Difference / % Improvement 2015 2014 77 100 23.00 10% 2.30 79.30 2016 2015 79.30 100 20.70 10% 2.07 81.37 2017 2016 81.37 100 18.63 10% 1.86 83.23 2018 2017 83.23 100 16.77 10% 1.68 84.91 2019 2018 84.91 Rates based on the total, not age-specific population
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

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

Access to and improved content of care is to be achieved by reframing the healthcare delivery system as a result of legislation [PA 96-1501] (known as "Medicaid Reform"). In compliance with the Medicaid reform law as of January 1, 2015, well over 50 percent of Medicaid enrollees are in a care coordination program that organizes care around the individuals' medical needs. Illinois Medicaid expanded the care coordination program to children, their parents, and newly-eligible Medicaid enrollees under the Affordable Care Act. Care coordination for these populations is provided by managed care entities (MCE) (managed care organizations (MCO), Care Coordination Entities (CCE) and Managed Care Community Networks (MCCN)). The traditional managed care organizations serving Illinois Medicaid clients also are likely to offer private health insurance on the Illinois Health Insurance Exchange, thereby providing continuity of care, as clients go on or off Medicaid.

HFS strengthened its managed care contracts to specify content of care expected for children and implemented a withhold/pay for performance (P4P) strategy. These contracts include performance measures that are aligned with a sub-set of Child and Adult Core Set measures. HFS is moving toward using HEDIS benchmarks, where available, for P4Ps to drive performance improvement.

A Care Coordination Claims Database (CCCD) is made available by HFS to the MCEs for their enrolled recipients. The CCCD contains the most recent two years of claims data, and seven years of immunization and blood lead level data. The database is updated monthly. The data set aggregates information from various sources (e.g., lead data, immunization registries). CCCD info is available at: http://www.illinois.gov/hfs/MedicalProviders/cc/Pages/ClaimsData.aspx.

The Primary Care Case Management (PCCM) program uses these quality strategies: patient panel rosters indicating when the child is due for screening services, data monitoring and provider feedback, on-line access to claims data, provider education and on-going assistance. Additionally, there are several strategies targeted at the individual child and his family. There also are P4P incentives.

HFS annually conducts the CAHPS® 5.0H with CCC supplemental questions. The survey over samples for Medicaid and CHIP populations. The 2015 CAHPS data were submitted to the AHRQ survey database so HFS has access to the ARQH data base. With such access HFS can compare our result to other Medicaid programs.

HFS programmed the developmental measure of contraception use and submitted FFY2014 results for Adult Core Set measure reporting. HFS staff conducted additional analyses around the measure to assess the impact of using survey data as an adjustment methodology. The results and HFS' staff comments were accepted by CDC/OPA in consideration for further updates to the measure.

Public Act 93-0536 (305 ILCS 5/5 – 5.23) was enacted with the goal of improving birth outcomes for the over 80,000 births covered by HFS annually. The law states HFS may provide reimbursement for all prenatal and perinatal health care services provided under Medicaid to prevent low birth weight infants, reduce need for neonatal intensive care hospital services, and promote perinatal health. HFS is required to report to the General Assembly on the effectiveness of prenatal and perinatal health care services every two years. The biennial reports identify steps HFS has taken with its partners (other state agencies, advocate groups, maternal and child health experts, local funding resources and others) to address the Perinatal health and health disparities; detail the progress made on priority recommendations in PA93-0536; review the available trend data on infant mortality, low birth weight and very low birth weight outcomes; identify the progress made to address poor birth outcomes through analysis of trend data; and identify next steps in improving birth outcomes. These reports are available on-line at http://www.illinois.gov/hfs/MedicalProviders/MaternalandChildHealth/Pages/report.aspx. The 2016

Perinatal Report will be submitted to the legislature January 1, 2016 and will be posted on the above web site.

The SMART Act (Public Act 097-0689) also includes a focus on improving birth outcomes. Changes resulting from this 2012 legislation include paying Cesarean deliveries at the normal vaginal rate when there is no indication of medical necessity. Related to care coordination, the legislation mandated the development of a statewide multi-agency initiative to improve birth outcomes and reduce costs associated with poor birth outcomes (e.g., low birth weight, very low birth weight or infant demise).

The CHIPRA Quality Demonstration Grant includes a focus on improving birth outcomes. A number of interventions have been developed, including a prenatal minimum electronic data set, a prenatal care quality tool, both of which were pilot tested during 2015. Best practices for perinatal care transitions were distributed to HFS enrolled perinatal providers through a Provide Notice dated September 29, 2015. The Perinatal Education Toolkit, with materials for educating women about preconception, prenatal, postpartum and inter-conception care, was pilot tested during 2015 and is now available to any health care or social service provider in the state on the EverThrive Illinois website. A postpartum care study was conducted in partnership with the University of Illinois at Chicago and the findings are being used to consider policy and reimbursement changes to improve the number of women who receive a postpartum visit. CHIPRA supported the creation of the Illinois Perinatal Quality Collaborative (ILPQC), a voluntary hospital-focused quality improvement collaborative that uses best practices and quality improvement science to improve the quality of perinatal care and birth outcomes for women and infants with focus on both obstetrical and neonatal care. ILPQC completed project focused on reducing early elective deliveries and improving the weight of infants at discharge from the NICU through a nutrition and feeding initiative. Both projects demonstrated improvement. Projects implemented in 2015 include an initiative to improve the accuracy of 17 key variables on birth certificates and an initiative to improve outcomes of very low birth weight infants requiring resuscitation and stabilization by taking specific actions during the “golden hour”, the first hour after birth.

HFS contracts with eQ Health Solutions, a federally recognized Quality Improvement Organization, for external utilization review and quality assurance, primarily monitoring inpatient care, and to perform special projects/quality reviews in the fee for service arena. Findings on various components of the review process are available in their ongoing reporting to HFS. HFS contracts with Health Services Advisory Group for the federally required external quality monitoring of managed care. In compliance with the BBA, HFS has developed a quality strategy for managed care and its contracts with managed care providers require ongoing internal monitoring and quality improvement in the area of access to and quality of care (EQRO). HFS's contracts with managed care entities require meeting performance standards and improving outcomes.

Ongoing monitoring of key indicators and provider feedback are among HFS' strategies to improve outcomes.

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

Through the CHIPRA Quality Demonstration grant, Illinois currently reports the majority of Child Core Set measures related to access, quality and outcomes. The CHIPRA Quality Demonstration grant ends in CY2016. In the future, Child Core Set measures will be reported to CMS as they align with a set of measures (measures set) included in MCE contracts. The satisfaction survey in the PCCM program was replaced with the CAHPS survey beginning in 2013 and will be used in the future; procuring a NCQA-certified vendor to conduct CAHPS surveying and reporting annually beginning in FFY2013; and HFS instituting other supports to sustain measurement (e.g., improvements in programming, coordination among staff, work groups focused on measurement and data issues).

HFS contracted with a vendor to secure the use of software as a service (SaaS) based healthcare data analytics and reporting platform. As described in the request for proposal, "A Data Analytics and Reporting Platform will streamline the process by which complex data structures are converted into actionable information. It will centralize all data elements in a single location and provide easily understood definitions of all data elements. Moreover, it will empower end users with a state of the art report writing tool as well comprehensive pre-developed dashboard and standard reports proven to promote a state Medicaid agency's mission to improve quality of care and lower costs."

Core set measure programming will transition from the Enterprise Data Warehouse (EDW) to the data analytics reporting platform during CY2016. The aforementioned measures set will be programmed during CY2016 with reporting to CMS on those measures during FFY2017. Efforts are currently on-going for this transition to assure that use of data and adherence to specifications is consistent between current and future reporting products.

HFS publishes the Child Core Set Data Book annually. The report includes each Child Core Set measure reported in CARTS, but provides information for our entire covered population (i.e., Title XIX, Title XXI, state-only funded). The report is available on HFS' web site at: http://www.illinois.gov/hfs/info/reports/Pages/default.aspx. HFS compares progress with national HEDIS® benchmarks and includes these comparisons in the report.

With the move to a predominantly managed care healthcare delivery system, a Care Coordination Claims Database (CCCD) is made available by HFS to the care coordination partners for their enrolled recipients. The CCCD contains the most recent two years of claims data, and seven years of immunization and lead data. The database is updated monthly. The data set aggregates information from various sources (e.g., lead data, immunization registries). CCCD info is available at: http://www.illinois.gov/hfs/MedicalProviders/cc/Pages/ClaimsData.aspx.

Focusing on improving birth outcomes, the Illinois Department of Human Services (DHS) and HFS are collaborating to share data on women identified as high-risk for a poor birth outcome. First, HFS identifies women as potentially pregnant by culling through claims for data indicative of pregnancy (e.g., pharmacy claims for prenatal vitamins). Once identified as pregnant a flag is set in a data file transferred weekly to DHS. The list is used for case finding to outreach to women and engage them in early and intensive prenatal care through the Family Case Management (FCM) and Better Birth Outcomes (BBO) programs.

During the past year the algorithm identifying high-risk pregnant women expanded to include additional indicators beyond having a previous high cost birth. These indicators include conditions that are associated with a poor birth outcome, including social determinants of health, e.g., mental health, substance abuse. The addition of these indicators means identification of high-risk pregnant women is not based exclusively on having a previous high cost birth. This means women experiencing a first birth and who have an identified condition(s) are included in the case finding sent to DHS for involvement in the FCM/BBO program. During the upcoming year (FFY2016), the algorithm will further expand to include additional high-risk indicators. Evaluation measurement of women in the BBO program were programmed (e.g., timely prenatal/postpartum care, frequency of prenatal care, perinatal depression screening, birth outcome) to determine whether women identified through this process receive needed prenatal care and have improved birth outcomes.

HFS imports other data sources (e.g., immunization tracking system data and lead screening results) that are not available in HFS claims data in order to have a more complete picture of utilization and outcomes. HFS collaborates with the Illinois Department of Human Services and Illinois Department of Public Health, and the Division of Specialized Care for Children to incorporate additional data into the HFS Enterprise Data Warehouse (EDW). Data acquisitions include blood lead screening laboratory results, I-CARE immunization data, Vital Records that include matching birth data with claims information, and other data.

These external data sources are matched with HFS recipient-level data providing a robust data warehouse.

HFS continues to pursue additional data sources to integrate into the EDW. This provides opportunities to match recipient-level data across sources to improve quality measurement and to enhance care coordination and conduct risk stratification. For example, HFS is matching data from IDPH's Early Hearing Detection and Intervention (EHDI) program with HFS provider data. IDPH EHDI staff use the matched data to identify the primary care provider assigned to infants with potential hearing loss so that outreach, care coordination and intervention activities can be conducted in a timely manner to improve outcomes. Program evaluation conducted, in the current scenario, by the IDPH EHDI program will track whether there are improvements in infants achieving the program benchmarks. We anticipate expanding this in the future to link PCPs providing care to infants identified with various risk factors (e.g., newborns with genetic disorders) to assure follow-up care by the assigned PCP.

HFS is interested in securing laboratory results from IDPH for recipients covered by HFS. These data would provide useful clinical information to measure outcomes related to service provision, to wrap-around case management service and to identify needed intervention services for those identified with abnormal laboratory results.

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

The CHIP population is included in managed care or, if not enrolled with a MCE, in the PCCM program. In the MCE program, there have been focused quality studies on children's health issues, such as appropriate care for asthma; improving the rate of well child visits, lead screening and childhood immunizations; as well as ensuring that content of care is in compliance with well child screening guidelines for children under age three. MCEs are engaging in a collaborative performance improvement project (PIP) focused on access to behavioral health.

Public Act 93-0536 (305 ILCS 5/5 – 5.23) was enacted with the goal of improving birth outcomes for the over 80,000 births covered by HFS annually. The law states that HFS may provide reimbursement for all prenatal and perinatal health care services that are provided under Medicaid for the purpose of preventing low birth weight infants, reducing the need for neonatal intensive care hospital services, and promoting perinatal health. Additionally, HFS was required to develop a plan for prenatal and perinatal health care for presentation to the General Assembly by January 1, 2004. HFS is required to report to the General Assembly on the effectiveness of prenatal and perinatal health care services, on or before January 1, 2006, and every two years thereafter. The biennial reports identify steps HFS has taken with its partners (other state agencies, advocate groups, maternal and child health experts, local funding resources and others) to address the Perinatal health care needs and racial health disparities in Illinois; detail the progress made in addressing the priority recommendations as outlined in the Report to the General Assembly as a result of Public Act 93-0536; review the available trend data on infant mortality, low birth weight and very low birth weight outcomes; identify the progress made to address poor birth outcomes through analysis of trend data; and identify next steps in improving birth outcomes. These reports are available on-line at http://www.illinois.gov/hfs/info/reports/Pages/default.aspx. The 2016 Perinatal Report will be submitted to the legislature January 1, 2016. The report is posted on the above web site.

The SMART Act (Public Act 097-0689) also includes a focus on improving birth outcomes. Changes resulting from this 2012 legislation include paying Cesarean deliveries at the normal vaginal rate when there is no indication of medical necessity. Related to care coordination, the legislation mandated the development of a statewide multi-agency initiative to improve birth outcomes and reduce costs associated with poor birth outcomes (e.g., low birth weight, very low birth weight or infant demise).

The CHIPRA Quality Demonstration Grant includes a focus on improving birth outcomes. A number of interventions have been developed, including a prenatal minimum electronic data set, a prenatal care quality tool, both of which were pilot tested during 2015. Best practices for perinatal care transitions were distributed to HFS enrolled perinatal providers through a Provide Notice dated September 29, 2015. The Perinatal Education Toolkit, with materials for educating women about preconception, prenatal, postpartum and inter-conception care, was pilot tested during 2015 and is now available to any health care or social service provider in the state on the EverThrive Illinois website. A postpartum care study was conducted in partnership with the University of Illinois at Chicago and the findings are being used to consider policy and reimbursement changes to improve the number of women who receive a postpartum visit. CHIPRA supported the creation of the Illinois Perinatal Quality Collaborative (ILPQC), a voluntary hospital-focused quality improvement collaborative that uses best practices and quality improvement science to improve the quality of perinatal care and birth outcomes for women and infants with focus on both obstetrical and neonatal care. ILPQC completed project focused on reducing early elective deliveries and improving the weight of infants at discharge from the NICU through a nutrition and feeding initiative. Both projects demonstrated improvement. Projects implemented in 2015 include an initiative to improve the accuracy of 17 key variables on birth certificates and an initiative to improve outcomes of very low birth weight infants requiring resuscitation and stabilization by taking specific actions during the “golden hour”, the first hour after birth.

Recognizing the impact comprehensive, quality family planning services has on improving birth outcomes, HFS developed a first-ever family planning policy to reinforce its support and commitment to ensure all Medicaid beneficiaries have access. A provider notice was released on June 26, 2014, to inform enrolled providers of HFS’ new policy – Quality Family Planning and Reproductive Health Care Services.

This effort was part of a larger initiative HFS undertook to enhance family planning care for Medicaid beneficiaries. On August 20, 2014, HFS’ Director announced the Department’s new Illinois Family Planning Action Plan (IFPAP) at the Illinois Contraceptive Equity Summit held in Chicago. The IFPAP goal was to “increase access to family planning services for women and men in the Medicaid Program by providing comprehensive coverage to ensure pregnancy is a planned pregnancy” – Action #1, Payments and operational policies reflect the value HFS places on providing the most effective form of contraception (policy and payment reform), and Action #2, Health plans and providers in the Medicaid Program make all forms of family planning available to Medicaid clients in a convenient and seamless manner (remove service/financial/inventory barriers). Among the actions taken, the new policy for immediate postpartum LARC (long-acting reversible contraceptives) should have the most impact on reducing unintended pregnancies—women leaving the hospital after delivery with a very effective contraceptive method in place. This action will also provide the optimum opportunity to increase the birth interval spacing between pregnancies. A new page was added to the Department’s web site and made available for providers, clients and the public to obtain additional information about family planning. Recent studies by the Guttmacher Institute conclude that for every public dollar spent on family planning, seven dollars are saved.

HFS is involved with the Screening Assessment and Support Services (SASS) initiative, a cooperative partnership between the Department of Children and Family Services (DCFS), HFS and the Department of Human Services (DHS). The development of the tri-department SASS program created a single, statewide system to serve children experiencing a mental health crisis whose care will require public funding from one of the three agencies. This program features a single point of entry (Crisis and Referral Entry Service, CARES) for all children entering the system and ensures that children receive crisis services in the most appropriate setting.

4. Please attach any additional studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your CHIP program’s performance. Please include any analyses or descriptions of any efforts designed to reduce the number of uncovered

children in the state through a state health insurance connector program or support for innovative private health coverage initiatives health coverage initiatives. **[7500]**

A specific activity uses predictive analytics to identify women with previous high cost births who are identified as currently pregnant. Once identified a flag is set in a data file transferred weekly to DHS. The list is used for case finding to outreach to women and engage them in early and intensive prenatal care through the Family Case Management (FCM) and Better Birth Outcomes (BBO) programs.

During the past year the algorithm identifying high-risk pregnant women expanded to include additional indicators beyond having a previous high cost birth. These indicators include conditions that are associated with a poor birth outcome, including social determinants of health, e.g., mental health, substance abuse. The addition of these indicators means identification of high-risk pregnant women is not based exclusively on having a previous high cost birth. This means women experiencing a first birth and who have an identified condition(s) are included in the case finding sent to DHS for involvement in the FCM/BBO program.

With the move to a predominately managed care health care delivery system in CY2015, HFS also shares the case finding list of women at high-risk for a poor birth outcome with managed care entities via the Care Coordination Claims Data (CCCD) file. The MCEs can outreach to the identified women to involve them in needed intensive prenatal care. We intend to expand the CCCD data to include an indicator so MCEs know when women are already managed in the BBO program so services can be coordinated and not duplicated.

In compliance with the Medicaid reform law, as of January 1, 2015, well over 50 percent of the individuals covered under Medicaid are enrolled in a care coordination program that organizes care around the individuals' medical needs. In January 2014, Illinois Medicaid expanded the care coordination program to children, their parents, and newly-eligible Medicaid enrollees under the Affordable Care Act. The traditional managed care organizations serving Illinois Medicaid clients are also likely to offer private health insurance on the Illinois Health Insurance Exchange, thereby providing continuity of care, as clients go on or off Medicaid.

Public Act 93-0536 (305 ILCS 5/5 – 5.23) was enacted with the goal of improving birth outcomes for the over 80,000 births covered by HFS annually. The law states that HFS may provide reimbursement for all prenatal and perinatal health care services that are provided under Medicaid for the purpose of preventing low birth weight infants, reducing the need for neonatal intensive care hospital services, and promoting perinatal health. Additionally, HFS was required to develop a plan for prenatal and perinatal health care for presentation to the General Assembly by January 1, 2004. HFS is required to report to the General Assembly on the effectiveness of prenatal and perinatal health care services, on or before January 1, 2006, and every two years thereafter. The biennial reports identify steps HFS has taken with its partners (other state agencies, advocate groups, maternal and child health experts, local funding resources and others) to address the Perinatal health care needs and health disparities in Illinois; detail the progress made in addressing the priority recommendations as outlined in the Report to the General Assembly as a result of Public Act 93-0536; review the available trend data on infant mortality, low birth weight and very low birth weight outcomes; identify the progress made to address poor birth outcomes through analysis of trend data; and identify next steps in improving birth outcomes. These reports are available on-line at http://www.illinois.gov/hfs/MedicalProviders/MaternalandChildHealth/Pages/report.aspx. The 2016 Perinatal Report will be submitted to the legislature January 1, 2016 and will be posted on the above web site.

HFS collaborated with the CDC and Office of Population Affairs (OPA) to program the developmental measure of contraception use among women 15-44 years of age. The measure was submitted for FFY2014 into CARTS for Adult Core Set measure reporting. In addition to reporting the measure, HFS staff conducted additional analyses around the measure to assess the impact of using survey data as an

adjustment methodology. The results and HFS' staff comments were graciously accepted by CDC/OPA in consideration for further updates to the measure.

HFS conducts many initiatives, including provider outreach training and technical assistance, to promote the medical home, improve provider compliance with best practice guidelines, EPSDT content of care, and promote appropriate medical follow-up and referral.

Enter any Narrative text below **[7500]**.

SECTION III: ASSESSMENT OF STATE PLAN AND PROGRAM OPERATION

Please reference and summarize attachments that are relevant to specific questions

A. OUTREACH

1. How have you redirected/changed your outreach strategies during the reporting period? **[7500]**

   Illinois has continued its highly successful All Kids Application Agent (AKAA) program. Most other outreach activities for CHIP have been rolled into the state's ACA marketing strategies. A website, www.getcoveredillinois.gov, is available for individuals, families and small businesses to learn about Medicaid, CHIP and FFM options. That is the starting place for anyone in Illinois who needs healthcare coverage. Earned and paid media make the website and phone number for Get Covered Illinois available to all. All types of assisters, including navigators, AKAAs, and community partners can be found through the website and call center.

2. What methods have you found most effective in reaching low-income, uninsured children (e.g., T.V., school outreach, word-of-mouth)? How have you measured effectiveness? **[7500]**

   All Kids Application Agents and other assisters are our most effective way to help families apply and enroll into the program.

3. Which of the methods described in Question 2 would you consider a best practice(s)**? [7500]**

   All Kids Appliation Agents

4. Is your state targeting outreach to specific populations (e.g., minorities, immigrants, and children living in rural areas)?

   ☒ Yes

   ☐ No

   Have these efforts been successful, and how have you measured effectiveness? **[7500]**

   Illinois continues to use a variety of strategies to reach families who speak languages other than English. Fact Sheets are available in many languages. The All Kids Hotline uses a language translation service that allows staff to talk to callers who speak any language. All written client communications are available in both English and Spanish. These strategies are critical to reaching those for whom English is not their primary language. AKAAs are also community-based/integrated and many are very active in reaching out to the populations in their respective communities.

5. What percentage of children below 200 percent of the Federal poverty level (FPL) who are eligible for Medicaid or CHIP have been enrolled in those programs? [5]

   (Identify the data source used). **[7500]**

B. SUBSTITUTION OF COVERAGE (CROWD-OUT)

All states should answer the following questions. Please include percent calculations in your responses when applicable and requested.

1. **Table 1.**

Does your program require a child to be uninsured for a minimum amount of time prior to enrollment (waiting	☐	No
	☒	Yes
	Specify number of months	3

period)?	To which groups (including FPL levels) does the period of uninsurance apply? **[1000]** The period of uninsurance applies to children in families with income above 209% FPL.	
	List all exemptions to imposing the period of uninsurance **[1000]** Newborn under age 1 who does not have private or employer-sponsored insurance coverage; Child lost benefits under All Kids Assist, Share or Premium Level 1 in the 12 months prior to the month of application; Premium paid for coverage of the child under a health plan exceeded 5% of household income; Child's parent is determined eligible for a premium tax credit for enrollment in a health plan through the FFM because the employer sponsored insurance in which the family was enrolled is determined unaffordable; The cost of family coverage exceeds 9.5% of the household income; Lost coverage because the employer that had sponsored the coverage stopped offering coverage of dependents; Change in parent's employment, including involuntary separation, resulted in the child's loss of employer-sponsored insurance; Child has special health care needs; or Child lost insurance due to the parent's death or the noncustodial parent canceled the insurance as part of a divorce.	
	☐	N/A

Does your program match prospective enrollees to a database that details private insurance status?	☒	No
	☐	Yes
	If yes, what database? **[1000]**	
	☐	N/A

2. At the time of application, what percent of CHIP applicants are found to have Medicaid [(# applicants found to have Medicaid/total # applicants) * 100] **[5]**
   and what percent of applicants are found to have other group insurance [(# applicants found to have other insurance/total # applicants) * 100] **[5]**?
   Provide a combined percent if you cannot calculate separate percentages. **[5]**

3. What percent of CHIP applicants cannot be enrolled because they have group health plan coverage **[5]**

a. Of those found to have had other, private insurance and have been uninsured for only a portion of the state's waiting period, what percent meet your state's exemptions to the waiting period (if your state has a waiting period and exemptions) [(# applicants who are exempt/total # of new applicants who were enrolled)*100]? **[5]**

4. Do you track the number of individuals who have access to private insurance?

☐ Yes
☒ No

If yes, what percent of individuals that enrolled in CHIP had access to private health insurance at the time of application during the last federal fiscal year [(# of individuals that had access to private health insurance/total # of individuals enrolled in CHIP)*100]? **[5]**

C. ELIGIBILITY

This subsection should be completed by all states. Medicaid Expansion states should complete applicable responses and indicate those questions that are non-applicable with N/A.

Section IIIC: Subpart A: Eligibility Renewal and Retention

1. Do you have authority in your CHIP state plan to provide for presumptive eligibility, and have you implemented this? ☒ Yes ☐ No

If yes

a) What percent of children are presumptively enrolled in CHIP pending a full eligibility determination? [5] 50

b) Of those children who are presumptively enrolled, what percent of those children are determined eligible and enrolled upon completion of the full eligibility determination those children are determined eligible and enrolled? [5] 86

2. Select the measures from those below that your state employ to simplify an eligibility renewal and retain eligible children in CHIP?

☐ Conducts follow-up with clients through caseworkers/outreach workers

☐ Sends renewal reminder notices to all families

- How many notices are sent to the family prior to disenrolling the child from the program? **[500]**

- At what intervals are reminder notices sent to families (e.g., how many weeks before the end of the current eligibility period is a follow-up letter sent if the renewal has not been received by the state?) **[500]**

☒ Other, *please explain*: **[500]**

A letter is sent two weeks before the redetermination form letting the family know it's time to renew and that they should watch for the renewal in the mail.

3. Which of the above strategies appear to be the most effective? Have you evaluated the effectiveness of any strategies? If so, please describe the evaluation, including data sources and methodology. **[7500]**

We have had a good response using the pre-notice.

Section IIIC: Subpart B: Eligibility Data

Table 1. Data on Denials of Title XXI Coverage in FFY 2015

States are required to report on all questions (1,1.a.,1.b., and 1.c) in FFY 2015. Please enter the data requested in the table below and the template will tabulate the requested percentages.

Measure	Number	Percent
1. Total number of denials of title XXI Coverage		100
a. Total number of procedural denials		
b. Total number of eligibility denials		
i. Total number of applicants denied for title XXI and enrolled in title XIX		
(Check here if there are no additional categories ☐) c. Total number of applicants denied for other reasons Please indicate:		

2. Please describe any limitations or restrictions on the data used in this table: We have a single application and processing system. Every application is considered first as a Medicaid application and then as a CHIP application. When our new system is fully implemented in 2016, we should be able to report on child applicants denied for Medicaid due to income who were then considered for CHIP.

Definitions:

1. The "the total number of denials of title XXI Coverage" is defined as the total number of applicants that have had an eligibility decision made for title XXI and denied enrollment for title XXI in FFY 2015. This definition only includes denials for title XXI at the time of initial application (not redetermination).
   a. The "total number of procedural denials" is defined as the total number of applicants denied for title XXI procedural reasons in FFY 2015 (i.e., incomplete application, missing documentation, missing enrollment fee, etc.).
   b. The "total number of eligibility denials" is defined as the total number of applicants denied for title XXI eligibility reasons in FFY 2015 (i.e., income too high, income too low for title XXI referred for Medicaid eligibility determination/determined Medicaid eligible , obtained private coverage or if applicable, had access to private coverage during your state's specified waiting period, etc.)
      i. The total number of applicants that are denied eligibility for title XXI and determined eligible for title XIX
   c. The "total number of applicants denied for other reasons" is defined as any other type of denial that does not fall into 2a or 2b. Please check the box provided if there are no additional categories.

Table 2. Redetermination Status of Children

For this table, reporting is required for FFY 2015.

Table 2a. Redetermination Status of Children Enrolled in Title XXI

Please enter the data requested in the table below in the "Number" column, and the template will automatically tabulate the percentages.

	Number	**Percent**			
1. Total number of children who are	101508	100%			

enrolled in title XXI and eligible to be redetermined					
2. Total number of children screened for redetermination for title XXI			100%		
3. Total number of children retained in title XXI after the redetermination process					
4. Total number of children disenrolled from title XXI after the redetermination process				100%	
a. Total number of children disenrolled from title XXI for failure to comply with procedures					
b. Total number of children disenrolled from title XXI for failure to meet eligibility criteria					100%
I. Disenrolled from title XXI because income too high for title XXI (If unable to provide the data, check here ☐)					
II. Disenrolled from title XXI because income too low for title XXI (If unable to provide the data, check here ☐)					
iii. Disenrolled from title XXI because application indicated access to private coverage or obtained private coverage (If unable to provide the data or if you have a title XXI Medicaid expansion and this data is not relevant check here ☐)					
iv. Disenrolled from title XXI for other eligibility reason(s) Please indicate: (If unable to provide the data check here ☐)					
c. Total number of children					

disenrolled from title XXI for other reason(s) Please indicate: (Check here if there are no additional categories ☐)					

5. If relevant, please describe any limitations or restrictions on the data entered into this table. Please describe any state policies or procedures that may have impacted the redetermination outcomes data.
   Our legacy data system is not able to report redetermination data. Our new eligibility system will process redeterminations beginning later in 2016 and we expect to be able to report on redeterminatnions in detail in the FFY 2017 report.

Definitions:

1. The "total number of children who are eligible to be redetermined" is defined as the total number of children due to renew their eligibility in federal fiscal year (FFY) 2015, and did not age out (did not exceed the program's maximum age requirement) of the program by or before redetermination. This total number may include those children who are eligible to renew prior to their 12 month eligibility redetermination anniversary date. This total must include ex parte redeterminations, the process when a state uses information available to it through other databases, such as wage and labor records, to verify ongoing eligibility. This total number must also include children whose eligibility can be renewed through administrative redeterminations, whereby the state sends the family a renewal form that is pre-populated with eligibility information already available through program records and requires the family to report any changes.
2. The "total number of children screened for redetermination" is defined as the total number of children that were screened by the state for redetermination in FFY 2015 (i.e., ex parte redeterminations and administrative redeterminations, as well as those children whose families have returned redetermination forms to the state).
3. The "total number of children retained after the redetermination process" is defined as the total number of children who were found eligible and remained in the program after the redetermination process in FFY 2015.
4. The "total number of children disenrolled from title XXI after the redetermination process" is defined as the total number of children who are disenrolled from title XXI following the redetermination process in FFY 2015. This includes those children that states may define as "transferred" to Medicaid for title XIX eligibility screening.
   a. The "total number of children disenrolled for failure to comply with procedures" is defined as the total number of children disenrolled from title XXI for failure to successfully complete the redetermination process in FFY 2015 (i.e., families that failed to submit a complete application, failed to provide complete documentation, failed to pay premium or enrollment fee, etc.).
   b. The "total number of children disenrolled for failure to meet eligibility criteria" is defined as the total number of children disenrolled from title XXI for no longer meeting one or more of their state's CHIP eligibility criteria (i.e., income too low, income too high, obtained private coverage or if applicable, had access to private coverage during your state's specified waiting period, etc.). If possible, please break out the reasons for failure to meet eligibility criteria in i.-iv.
   c. The "total number of children disenrolled for other reason(s)" is defined as the total number of children disenrolled from title XXI for a reason other than failure to comply with procedures or failure to meet eligibility criteria, and are not already captured in 4.a. or 4.b.
      The data entered in 4.a., 4.b., and 4.c. should sum to the total number of children disenrolled from title XXI (line 4).

Table 2b. Redetermination Status of Children Enrolled in Title XIX

Please enter the data requested in the table below in the "Number" column, and the template will automatically tabulate the percentages.

	Number	**Percent**			
1.Total number of children who are enrolled in title XIX and eligible to be redetermined	1332291	100%			
2. Total number of children screened for redetermination			100%		

for title XIX					
3. Total number of children retained in title XIX after the redetermination process					
4. Total number of children disenrolled from title XIX after the redetermination process				100%	
a. Total number of children disenrolled from title XIX for failure to comply with procedures					
b. Total number of children disenrolled from title XIX for failure to meet eligibility criteria					100%
v. Disenrolled from title XIX because income too high for title XIX (If unable to provide the data, check here ☐)					
vi. Disenrolled from title XXI for other eligibility reason(s) Please indicate: (If unable to provide the data check here ☐)					
c. Total number of children disenrolled from title XXI for other reason(s) Please indicate: (Check here if there are no additional categories ☐)					

5. If relevant, please describe any limitations or restrictions on the data entered into this table. Please describe any state policies or procedures that may have impacted the redetermination outcomes data.
Our legacy data system is not able to report redetermination data. Our new eligibility system will process redeterminations beginning later in 2016 and we expect to be able to report on redeterminatnions in detail in the FFY 2017 report.

Definitions:

1. The "total number of children who are eligible to be redetermined" is defined as the total number of children due to renew their eligibility in federal fiscal year (FFY) 2015, and did not age out (did not exceed the

program's maximum age requirement) of the program by or before redetermination. This total number may include those children who are eligible to renew prior to their 12 month eligibility redetermination anniversary date. This total must include ex parte redeterminations, the process when a state uses information available to it through other databases, such as wage and labor records, to verify ongoing eligibility. This total number must also include children whose eligibility can be renewed through administrative redeterminations, whereby the state sends the family a renewal form that is pre-populated with eligibility information already available through program records and requires the family to report any changes.

2. The "total number of children screened for redetermination" is defined as the total number of children that were screened by the state for redetermination in FFY 2015 (i.e., ex parte redeterminations and administrative redeterminations, as well as those children whose families have returned redetermination forms to the state).
3. The "total number of children retained after the redetermination process" is defined as the total number of children who were found eligible and remained in the program after the redetermination process in FFY 2015.
4. The "total number of children disenrolled from title XIX after the redetermination process" is defined as the total number of children who are disenrolled from title XIX following the redetermination process in FFY 2015. This includes those children that states may define as "transferred" to CHIP for title XXI eligibility screening.
    a. The "total number of children disenrolled for failure to comply with procedures" is defined as the total number of children disenrolled from title XIX for failure to successfully complete the redetermination process in FFY 2014 (i.e., families that failed to submit a complete application, failed to provide complete documentation, failed to pay premium or enrollment fee, etc.).
    b. The "total number of children disenrolled for failure to meet eligibility criteria" is defined as the total number of children disenrolled from title XIX for no longer meeting one or more of their state's Medicaid eligibility criteria (i.e., income too high, etc.).
    c. The "total number of children disenrolled for other reason(s)" is defined as the total number of children disenrolled from title XIX for a reason other than failure to comply with procedures or failure to meet eligibility criteria, and are not already captured in 4.a. or 4.b.

    The data entered in 4.a., 4.b., and 4.c. should sum to the total number of children disenrolled from title XIX (line 4).

Table 3. Duration Measure of Selected Children, Ages 0-16, Enrolled in Title XIX and Title XXI, Second Quarter FFY 2014

The purpose of tables 3a and 3b is to measure the duration, or continuity, of Medicaid and CHIP enrollees' coverage. This information is required by Section 402(a) of CHIPRA. **Reporting on this table is required.**

Because the measure is designed to capture continuity of coverage in title XIX and title XXI beyond one year of enrollment, the measure collects data for 18 months of enrollment. This means that reporting spans two CARTS reports over two years. The duration measure uses a cohort of children and follows the enrollment of the same cohort of children for 18 months to measure continuity of coverage. **States identify a new cohort of children every two years. States identified newly enrolled children in the second quarter of FFY 2014 (January, February, and March of 2014). If your eligibility system already has the capability to track a cohort of enrollees over time, an additional "flag" or unique identifier may not be necessary.**

[Note that the first cohort of newly enrolled children was identified in the second quarter of FFY 2012 (January, February and March of 2012), was followed for 18 months (through FFY 2013), and stopped. The current cohort of children was identified in the second quarter of FFY 2014 (January, February and March of 2014), will be followed for 18 months (through FFY 2015), and will stop. The next cohort of children will be identified in the second quarter of FFY 2016 (January, February and March of 2016).]

The FFY 2015 CARTS report is the second year of reporting in the cycle of two CARTS reports on the cohort of children identified in the second quarter of FFY 2014. States will continue to report on the same table for the two years of CARTS reports.

Instructions: For this measure, please identify newly enrolled children in both title XIX and title XXI in the second quarter of FFY 2014, ages 0 months to 16 years at time of enrollment. Children enrolled in January 2014 must have birthdates after July 1997 (e.g., children must be younger than 16 years and 5 months) to ensure that they will not age out of the program at the 18th month of coverage. Similarly, children enrolled in February 2014 must have birthdates after August 1997, and children enrolled in March 2014 must have birthdates after September 1997. Each child newly enrolled during this time frame needs a unique identifier or "flag" so that the cohort can be tracked over time. If your eligibility system already has the capability to track a cohort of enrollees over time, an additional "flag" or unique identifier may not be necessary. Please follow the child based on the child's age category at the time of enrollment (e.g., the child's age at enrollment creates an age cohort that does not change over the 18 month time span).

Please enter the data requested in the tables below, and the template will tabulate the percentages. The tables are pre-populated with the 6-month data you reported last year; in this report you will enter data on the 12- and 18-month enrollment status. **Only enter a "0" (zero) if the data are known to be zero. If data are unknown or unavailable, leave the field blank.**

Note that all data must sum correctly in order to save and move to the next page. The data in each individual row must add across to sum to the total in the "All Children Ages 0-16" column for that row. And in each column, the data within each time period (6, 12 and 18 months) must each sum up to the data in row 1, which is the number of children in the cohort. This means that in each column, rows 2, 3 and 4 must sum to the total in row 1; rows 5, 6 and 7 must sum to the row 1; and rows 8, 9 and 10 must sum to row 1. Rows numbered with an "a" (*e.g.*, rows 3a and 4a) are excluded from the total because they are subsets of their respective rows.

Table 3a. Duration Measure of Children Enrolled in Title XIX

☐**Not Previously Enrolled in CHIP or Medicaid—"**Newly enrolled" is defined as not enrolled in either title XXI or title XIX in the month before enrollment (i.e., for a child enrolled in January 2015, he/she would not be enrolled in either title XXI or title XIX in December 2014, etc.)

☐**Not Previously Enrolled in Medicaid**—"Newly enrolled" is defined as not enrolled in title XIX in the month before enrollment (i.e., for a child enrolled in January 2015, he/she would not be enrolled in title XIX in December 2014, etc.)

Duration Measure, Title XIX		**All Children Ages 0-16**		**Age Less than 12 months**		**Ages 1-5**		**Ages 6-12**		**Ages 13-16**	
		Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
1.	**Total number of children newly enrolled in title XIX in the second quarter of FFY 2014**	58616	100%	20126	100%	15457	100%	15170	100%	7863	100%
Enrollment Status 6 months later											
2.	Total number of children continuously enrolled in title XIX	53099	90.59	18863	93.72	13864	89.69	13445	88.63	6927	88.1
3.	Total number of children with a break in title XIX coverage but re-enrolled in title XIX	353	0.6	51	0.25	123	0.8	108	0.71	71	0.9
	3.a. Total number of children enrolled in CHIP (title XXI) during title XIX coverage break (If unable to provide the data, check here ☐)	68	0.12	11	0.05	16	0.1	24	0.16	17	0.22
4.	Total number of children disenrolled from title XIX	5164	8.81	1212	6.02	1470	9.51	1617	10.66	865	11
	4.a. Total number of children enrolled in CHIP (title XXI) after being disenrolled from title XIX (If unable to provide	523	0.89	159	0.79	123	0.8	159	1.05	82	1.04

	the data, check here ☐)										
Enrollment Status 12 months later											
5.	Total number of children continuously enrolled in title XIX	50032	85.36	17743	88.16	13085	84.65	12664	83.48	6540	83.17
6.	Total number of children with a break in title XIX coverage but re-enrolled in title XIX	891	1.52	187	0.93	272	1.76	270	1.78	162	2.06
	6.a. Total number of children enrolled in CHIP (title XXI) during title XIX coverage break (If unable to provide the data, check here ☐)	136	0.23	39	0.19	27	0.17	39	0.26	31	0.39
7.	Total number of children disenrolled from title XIX	7693	13.12	2196	10.91	2100	13.59	2236	14.74	1161	14.77
	7.a. Total number of children enrolled in CHIP (title XXI) after being disenrolled from title XIX (If unable to provide the data, check here ☐)	821	1.4	324	1.61	174	1.13	217	1.43	106	1.35
Enrollment Status 18 months later											
8.	Total number of children continuously enrolled in title XIX	41402	70.63	15214	75.59	10708	69.28	10343	68.18	5137	65.33
9.	Total number of children with a break in title XIX coverage but re-enrolled in title XIX	2129	3.63	661	3.28	695	4.5	514	3.39	259	3.29
	9.a. Total number of children enrolled in CHIP (title XXI) during title XIX coverage break (If unable to provide the data, check here ☐)	663	1.13	280	1.39	228	1.48	99	0.65	56	0.71

10.	Total number of children disenrolled from title XIX	15085	25.74	4251	21.12	4054	26.23	4313	28.43	2467	31.37
	10.aTotal number of children enrolled in CHIP (title XXI) after being disenrolled from title XIX (If unable to provide the data, check here ☐)	2310	3.94	669	3.32	754	4.88	579	3.82	308	3.92

Definitions:

1. The "total number of children newly enrolled in title XIX in the second quarter of FFY 2014" is defined as those children either new to public coverage or new to title XIX, in the month before enrollment. Please define your population of "newly enrolled" in the Instructions section.

2. The total number of children that were continuously enrolled in title XIX for 6 months is defined as the sum of:
   the number of children with birthdates after July 1997, who were newly enrolled in January 2014 and who were continuously enrolled through the end of June 2014
   + the number of children with birthdates after August 1997, who were newly enrolled in February 2014 and who were continuously enrolled through the end of July 2014
   + the number of children with birthdates after September 1997, who were newly enrolled in March 2014 and who were continuously enrolled through the end of August 2014

3. The total number who had a break in title XIX coverage during 6 months of enrollment (regardless of the number of breaks in coverage) but were re-enrolled in title XIX by the end of the 6 months, is defined as the sum of:
   the number of children with birthdates after July 1997, who were newly enrolled in January 2014 and who disenrolled and re-enrolled in title XIX by the end of June 2014
   + the number of children with birthdates after August 1997, who were newly enrolled in February 2014 and who disenrolled and re-enrolled in title XIX by the end of July 2014
   + the number of children with birthdates after September 1997, who were newly enrolled in March 2014 and who disenrolled and re-enrolled in title XIX by the end of August 2014

   3.a. From the population in #3, provide the total number of children who were enrolled in title XXI during their break in coverage.

4. The total number who disenrolled from title XIX, 6 months after their enrollment month is defined as the sum of:
   the number of children with birthdates after July 1997, who were newly enrolled in January 2014 and were disenrolled by the end of June 2014
   + the number of children with birthdates after August 1997, who were newly enrolled in February 2014 and were disenrolled by the end of July 2014
   + the number of children with birthdates after September 1997, who were newly enrolled in March 2014 and were disenrolled by the end of August 2014

   4.a. From the population in #4, provide the total number of children who were enrolled in title XXI in the month after their disenrollment from title XIX.

5. The total number of children who were continuously enrolled in title XIX for 12 months is defined as the sum of:
   the number of children with birthdates after July 1997, who were newly enrolled in January 2014 and were continuously enrolled through the end of December 2014

+ the number of children with birthdates after August 1997, who were newly enrolled in February 2014 and were continuously enrolled through the end of January 2015
+ the number of children with birthdates after September 1995, who were newly enrolled in March 2012 and were continuously enrolled through the end of February 2015

6. The total number of children who had a break in title XIX coverage during 12 months of enrollment (regardless of the number of breaks in coverage), but were re-enrolled in title XIX by the end of the 12 months, is defined as the sum of:
the number of children with birthdates after July 1997, who were newly enrolled in January 2014 and who disenrolled and then re-enrolled in title XIX by the end of December 2014
+ the number of children with birthdates after August 1995, who were newly enrolled in February 2012 and who disenrolled and then re-enrolled in title XIX by the end of January 2015
+ the number of children with birthdates after September 1995, who were newly enrolled in March 2012 and who disenrolled and then re-enrolled in title XIX by the end of February 2015

6.a. From the population in #6, provide the total number of children who were enrolled in title XXI during their break in coverage.

7. The total number of children who disenrolled from title XIX 12 months after their enrollment month is defined as the sum of:
the number of children with birthdates after July 1997, who were enrolled in January 2014 and were disenrolled by the end of December 2014
+ the number of children with birthdates after August 1997, who were enrolled in February 2014 and were disenrolled by the end of January 2015
+ the number of children with birthdates after September 1997, who were enrolled in March 2014 and were disenrolled by the end of February 2015

7.a. From the population in #7, provide the total number of children, who were enrolled in title XXI in the month after their disenrollment from title XIX.

8. The total number of children who were continuously enrolled in title XIX for 18 months is defined as the sum of:
the number of children with birthdates after July 1997,who were newly enrolled in January 2014 and were continuously enrolled through the end of June 2015
+ the number of children with birthdates after August 1997, who were newly enrolled in February 2014 and were continuously enrolled through the end of July 2015
+ the number of children with birthdates after September 1997, who were newly enrolled in March 2014 and were continuously enrolled through the end of August 2015

9. The total number of children who had a break in title XIX coverage during 18 months of enrollment (regardless of the number of breaks in coverage), but were re-enrolled in title XIX by the end of the 18 months, is defined as the sum of:
the number of children with birthdates after July 1997, who were newly enrolled in January 2014 and who disenrolled and re-enrolled in title XIX by the end of June 2015
+ the number of children with birthdates after August 1997, who were newly enrolled in February 2014 and who disenrolled and re-enrolled in title XIX by the end of July 2015
+ the number of children with birthdates after September 1997, who were newly enrolled in March 2014 and who disenrolled and re-enrolled in title XIX by the end of August 2015

9.a. From the population in #9, provide the total number of children who were enrolled in title XXI during their break in coverage.

10. The total number of children who were disenrolled from title XIX 18 months after their enrollment month is defined as the sum of:
the number of children with birthdates after July 1997, who were newly enrolled in January 2014 and disenrolled by the end of June 2015
+ the number of children with birthdates after August 1997, who were newly enrolled in February 2014 and disenrolled by the end of July 2015
+ the number of children with birthdates after September 1997, who were newly enrolled in March 2014 and disenrolled by the end of August 2015

10.a. From the population in #10, provide the total number of children who were enrolled in title XXI (CHIP) in the month after their disenrollment from XIX.

Table 3b. duration Measure of Children Enrolled in Title XXI

Specify how your "newly enrolled" population is defined:

☐**Not Previously Enrolled in CHIP or Medicaid—"**Newly enrolled" is defined as not enrolled in either title XXI or title XIX in the month before enrollment (i.e., for a child enrolled in January 2015, he/she would not be enrolled in either title XXI or title XIX in December 2014, etc.)

☐**Not Previously Enrolled in CHIP**—"Newly enrolled" is defined as not enrolled in title XXI in the month before enrollment (i.e., for a child enrolled in January 2015, he/she would not be enrolled in title XXI in December 2014, etc.)

Duration Measure, Title XXI		**All Children Ages 0-16**		**Age Less than 12 months**		**Ages 1-5**		**Ages 6-12**		**Ages 13-16**	
		Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
1.	**Total number of children newly enrolled in title XXI in the second quarter of FFY 2014**	8663	100%	230	100%	2633	100%	3860	100%	1940	100%
Enrollment Status 6 months later											
2.	Total number of children continuously enrolled in title XXI	6385	73.7	180	78.26	2000	75.96	2813	72.88	1392	71.75
3.	Total number of children with a break in title XXI coverage but re-enrolled in title XXI	50	0.58	0		20	0.76	20	0.52	10	0.52
	3.a. Total number of children enrolled in Medicaid (title XXI) during title XXI coverage break (If unable to	18	0.21	0		8	0.3	7	0.18	3	0.15

	provide the data, check here ☐)										
4.	Total number of children disenrolled from title XXI	2228	25.72	50	21.74	613	23.28	1027	26.61	538	27.73
	4.a. Total number of children enrolled in Medicaid (title XXI) after being disenrolled from title XXI (If unable to provide the data, check here ☐)	600	6.93	11	4.78	193	7.33	263	6.81	133	6.86
Enrollment Status 12 months later											
5.	Total number of children continuously enrolled in title XXI	3514	40.56	107	46.52	1130	42.92	1518	39.33	759	39.12
6.	Total number of children with a break in title XIX coverage but re-enrolled in title XXI	192	2.22	4	1.74	55	2.09	82	2.12	51	2.63
	6.a. Total number of children enrolled in Medicaid (title XXI) during title XXI coverage break (If unable to provide the data, check	49	0.57	1	0.43	12	0.46	21	0.54	15	0.77

	here ☐)										
7.	Total number of children disenrolled from title XXI	4957	57.22	119	51.74	1448	54.99	2260	58.55	1130	58.25
	7.a. Total number of children enrolled in Medicaid (title XXI) after being disenrolled from title XXI (If unable to provide the data, check here ☐)	1945	22.45	37	16.09	595	22.6	876	22.69	437	22.53
Enrollment Status 18 months later											
8.	Total number of children continuously enrolled in title XXI	2828	32.64	88	38.26	931	35.36	1212	31.4	597	30.77
9.	Total number of children with a break in title XXI coverage but re-enrolled in title XXI	450	5.19	13	5.65	130	4.94	203	5.26	104	5.36
	9.a. Total number of children enrolled in Medicaid (title XXI) during title XXI coverage break (If unable to provide the data, check here ☐)	120	1.39	4	1.74	31	1.18	50	1.3	35	1.8
10.	Total number of children disenrolled	5385	62.16	129	56.09	1572	59.7	2445	63.34	1239	63.87

from title XXI										
10.aTotal number of children enrolled in Medicaid (title XXI) after being disenrolled from title XXI (If unable to provide the data, check here ☐)	2308	26.64	38	16.52	717	27.23	1035	26.81	518	26.7

Definitions:

1. The "total number of children newly enrolled in title XXI in the second quarter of FFY 2014" is defined as those children either new to public coverage or new to title XXI, in the month before enrollment. Please define your population of "newly enrolled" in the Instructions section.

2. The total number of children that were continuously enrolled in title XXI for 6 months is defined as the sum of:
   the number of children with birthdates after July 1997, who were newly enrolled in January 2014 and who were continuously enrolled through the end of June 2014
   + the number of children with birthdates after August 1997, who were newly enrolled in February 2014 and who were continuously enrolled through the end of July 2014
   + the number of children with birthdates after September 1997, who were newly enrolled in March 2014 and who were continuously enrolled through the end of August 2014

3. The total number who had a break in title XXI coverage during 6 months of enrollment (regardless of the number of breaks in coverage) but were re-enrolled in title XXI by the end of the 6 months, is defined as the sum of:
   the number of children with birthdates after July 1997, who were newly enrolled in January 2014 and who disenrolled and re-enrolled in title XXI by the end of June 2014
   + the number of children with birthdates after August 1997, who were newly enrolled in February 2014 and who disenrolled and re-enrolled in title XXI by the end of July 2014
   + the number of children with birthdates after September 1997, who were newly enrolled in March 2014 and who disenrolled and re-enrolled in title XXI by the end of August 2014

   3.a. From the population in #3, provide the total number of children who were enrolled in title XIX during their break in coverage.

4. The total number who disenrolled from title XXI, 6 months after their enrollment month is defined as the sum of:
   the number of children with birthdates after July 1997, who were newly enrolled in January 2014 and were disenrolled by the end of June 2014
   + the number of children with birthdates after August 1997, who were newly enrolled in February 2014 and were disenrolled by the end of July 2014
   + the number of children with birthdates after September 1997, who were newly enrolled in March 2014 and were disenrolled by the end of August 2014

   4.a. From the population in #4, provide the total number of children who were enrolled in title XIX in the month after their disenrollment from title XXI.

5. The total number of children who were continuously enrolled in title XXI for 12 months is defined as the sum of:

the number of children with birthdates after July 1997, who were newly enrolled in January 2014 and were continuously enrolled through the end of December 2014
+ the number of children with birthdates after August 1997, who were newly enrolled in February 2014 and were continuously enrolled through the end of January 2015
+ the number of children with birthdates after September 1997, who were newly enrolled in March 2014 and were continuously enrolled through the end of February 2015

6. The total number of children who had a break in title XXI coverage during 12 months of enrollment (regardless of the number of breaks in coverage), but were re-enrolled in title XXI by the end of the 12 months, is defined as the sum of:
the number of children with birthdates after July 1997, who were newly enrolled in January 2014 and who disenrolled and then re-enrolled in title XXI by the end of December 2014
+ the number of children with birthdates after August 1997, who were newly enrolled in February 2014 and who disenrolled and then re-enrolled in title XXI by the end of January 2015
+ the number of children with birthdates after September 1997, who were newly enrolled in March 2014 and who disenrolled and then re-enrolled in title XXI by the end of February 2015

6.a. From the population in #6, provide the total number of children who were enrolled in title XIX during their break in coverage.

7. The total number of children who disenrolled from title XXI 12 months after their enrollment month is defined as the sum of:
the number of children with birthdates after July 1997, who were enrolled in January 2014 and were disenrolled by the end of December 2014
+ the number of children with birthdates after August 1997, who were enrolled in February 2014 and were disenrolled by the end of January 2015
+ the number of children with birthdates after September 1997, who were enrolled in March 2014 and were disenrolled by the end of February 2015

7.a. From the population in #7, provide the total number of children, who were enrolled in title XIX in the month after their disenrollment from title XXI.

8. The total number of children who were continuously enrolled in title XXI for 18 months is defined as the sum of:
the number of children with birthdates after July 1997, who were newly enrolled in January 2014 and were continuously enrolled through the end of June 2015
+ the number of children with birthdates after August 1997, who were newly enrolled in February 2014and were continuously enrolled through the end of July 2015
+ the number of children with birthdates after September 1997, who were newly enrolled in March 2014 and were continuously enrolled through the end of August 2015

9. The total number of children who had a break in title XXI coverage during 18 months of enrollment (regardless of the number of breaks in coverage), but were re-enrolled in title XXI by the end of the 18 months, is defined as the sum of:
the number of children with birthdates after July 1997 , who were newly enrolled in January 2014 and who disenrolled and re-enrolled in title XXI by the end of June 2015
+ the number of children with birthdates after August 1997, who were newly enrolled in February 2014 and who disenrolled and re-enrolled in title XXI by the end of July 2015
+ the number of children with birthdates after September 1997, who were newly enrolled in March 2014 and who disenrolled and re-enrolled in title XXI by the end of August 2015

9.a. From the population in #9, provide the total number of children who were enrolled in title XIX during their break in coverage.

10. The total number of children who were disenrolled from title XXI 18 months after their enrollment month is defined as the sum of:
the number of children with birthdates after July 1997, who were newly enrolled in January 2014 and disenrolled by the end of June 2015
+ the number of children with birthdates after August 1997, who were newly enrolled in February 2014 and disenrolled by the end of July 2015
+ the number of children with birthdates after September 1997, who were newly enrolled in March 2014 and disenrolled by the end of August 2015

10.a. From the population in #10, provide the total number of children who were enrolled in title XIX (Medicaid) in the month after their disenrollment from XXI.

D. COST SHARING

1. Describe how the state tracks cost sharing to ensure enrollees do not pay more than 5 percent aggregate maximum in the year?

    a. Cost sharing is tracked by:

    ☒ Enrollees (shoebox method)
    If the state uses the shoebox method, please describe informational tools provided to enrollees to track cost sharing. **[7500]**
    At approval and renewal, families are sent a letter and a form to complete, along with an envelope to use when submitting receipts for copayments. The copay cap is set at a level low enough so that the copays, along with the 12 months of premiums for a year, will never exceed 5%.

    ☐ Health Plan(s)
    ☐ State
    ☐ Third Party Administrator
    ☐ N/A (No cost sharing required)
    ☐ Other, please explain. **[7500]**

2. When the family reaches the 5% cap, are premiums, copayments and other cost sharing ceased? **[7500]** ☒ Yes ☐ No

3. Please describe how providers are notified that no cost sharing should be charged to enrollees exceeding the 5% cap. **[7500]**
    The systems providers use to verify eligibility is updated with a message that copays can no longer be charged.

4. Please provide an estimate of the number of children that exceeded the 5 percent cap in the state's CHIP program during the federal fiscal year. **[500]**
    None

5. Has your state undertaken any assessment of the effects of premiums/enrollment fees on participation in CHIP?
    ☐ Yes
    ☒ No

    If so, what have you found? **[7500]**

6. Has your state undertaken any assessment of the effects of cost sharing on utilization of health services in CHIP?
    ☐ Yes
    ☒ No

    If so, what have you found? **[7500]**

7. If your state has increased or decreased cost sharing in the past federal fiscal year, has the state undertaken any assessment of the impact of these changes on application, enrollment, disenrollment, and utilization of children's health services in CHIP. If so, what have you found? **[7500]**

    No changes in cost sharing were made in the past year.

E. EMPLOYER SPONSORED INSURANCE PROGRAM (INCLUDING PREMIUM ASSISTANCE PROGRAM(S)) UNDER THE CHIP STATE PLAN OR A SECTION 1115 TITLE XXI DEMONSTRATION

1. Does your state offer an employer sponsored insurance program (including a premium assistance program) for children and/or adults using Title XXI funds?

   ☐ Yes, please answer questions below.
   ☒ No, skip to Program Integrity subsection.

Children

☐ Yes, Check all that apply and complete each question for each authority.

☐ Purchase of Family Coverage under the CHIP state plan (2105(c)(3))
☐ Additional Premium Assistance Option under CHIP state plan (2105(c)(10))
☐ Section 1115 demonstration (Title XXI)
☐ Premium Assistance Option (applicable to Medicaid expansion) children (1906)
☐ Premium Assistance Option (applicable to Medicaid expansion) children (1906A)

Adults

☐ Yes, Check all that apply and complete each question for each authority.

☐ Purchase of Family Coverage under the CHIP state plan (2105(c)(10))
☐ Section 1115 demonstration (Title XXI)
☐ Premium Assistance option under the Medicaid state plan (1906)
☐ Premium Assistance option under the Medicaid state plan (1906A)

2. Please indicate which adults your State covers with premium assistance. (Check all that apply.)

   ☐ Parents and Caretaker Relatives
   ☐ Pregnant Women

3. Briefly describe how your program operates (e.g., is your program an employer sponsored insurance program or a premium assistance program, how do you coordinate assistance between the state and/or employer, who receives the subsidy if a subsidy is provided, etc.) **[7500]**

4. What benefit package does the ESI program use? **[7500]**

5. Are there any minimum coverage requirements for the benefit package?

   ☐ Yes
   ☐ No

6. Does the program provide wrap-around coverage for benefits?

   ☐ Yes
   ☐ No

7. Are there any limits on cost sharing for children in your ESI program?

   ☐ Yes
   ☐ No

8. Are there any limits on cost sharing for adults in your ESI program?

☐ Yes
☐ No

9. Are there protections on cost sharing for children (e.g., the 5 percent out-of-pocket maximum) in your premium assistance program?

   ☐ Yes ☐ No

   If yes, how is the cost sharing tracked to ensure it remains within the 5 percent yearly aggregate maximum [7500]?

10. Identify the total number of children and adults enrolled in the ESI program for whom Title XXI funds are used during the reporting period (provide the number of adults enrolled in this program even if they were covered incidentally, i.e., not explicitly covered through a demonstration).

    _____ Number of childless adults ever-enrolled during the reporting period

    _____ Number of adults ever-enrolled during the reporting period

    _____ Number of children ever-enrolled during the reporting period

11. Provide the average monthly enrollment of children and parents ever enrolled in the premium assistance program during FFY 2015

    Children _____

    Parents _____

12. During the reporting period, what has been the greatest challenge your ESI program has experienced? **[7500]**

13. During the reporting period, what accomplishments have been achieved in your ESI program? **[7500]**

14. What changes have you made or are planning to make in your ESI program during the next fiscal year? Please comment on why the changes are planned. **[7500]**

15. What do you estimate is the impact of your ESI program (including premium assistance) on enrollment and retention of children? How was this measured? **[7500]**

16. Provide the average amount each entity pays towards coverage of the dependent child/parent under your ESI program:

Children		Parent	
State:		State:	
Employer:		Employer:	

Employee: Employee:

17. Indicate the range in the average monthly dollar amount of premium assistance provided by the state on behalf of a child or parent.

Children	Low	High
Parents	Low	High

18. If you offer a premium assistance program, what, if any, is the minimum employer contribution? **[500]**

19. Please provide the income levels of the children or families provided premium assistance.

	From	To
Income level of Children:	% of FPL[5]	% of FPL[5]
Income level of Parents:	% of FPL[5]	% of FPL[5]

20. Is there a required period of uninsurance before enrolling in premium assistance? **[500]**

☐ Yes
☐ No

If yes, what is the period of uninsurance? **[500]**

21. Do you have a waiting list for your program?

☐ Yes
☐ No

22. Can you cap enrollment for your program?

☐ Yes
☐ No

23. What strategies has the state found to be effective in reducing administrative barriers to the provision of premium assistance in ESI? **[7500]**

Enter any Narrative text below. **[7500]**

F. PROGRAM INTEGRITY (COMPLETE ONLY WITH REGARD TO SEPARATE CHIP PROGRAMS (I.E. THOSE THAT ARE NOT MEDICAID EXPANSIONS)

1. Does your state have a written plan that has safeguards and establishes methods and procedures for:

(1) prevention: ☒ Yes ☐ No

(2) investigation: ☒ Yes ☐ No

(3) referral of cases of fraud and abuse? ☒ Yes ☐ No

Please explain: **[7500]**

The State of Illinois, Department of Healthcare and Family Services (HFS) does not have separate procedures in place for preventing or investigating fraud and abuse for CHIP cases. When investigating possible fraud and abuse cases for providers and recipients, HFS reviews both CHIP and regular Medicaid services which were rendered or received.

The HFS Office of Inspector General (OIG) does utilize a variety of techniques to both prevent and detect possible fraud and abuse associated with all types of public assistance including Medicaid, CHIP, cash assistance and food stamps. These activities include provider post-

payments compliance audits, provider quality assurance reviews, quality control measurements, client eligibility investigations, fraud prevention investigations, long term care-asset discovery investigations and recipient utilization reviews.

Do managed health care plans with which your program contracts have written plans?

☒ Yes

☐ No

Please Explain: **[500]**

The Illinois managed care organizations are required to have in place a Fraud and Abuse Compliance Plan.

2. For the reporting period, please report the

_____ Number of fair hearing appeals of eligibility denials

_____ Number of cases found in favor of beneficiary

3. For the reporting period, please indicate the number of cases investigated, and cases referred, regarding fraud and abuse in the following areas:

a. Provider Credentialing

_____ Number of cases investigated

_____ Number of cases referred to appropriate law enforcement officials

b. Provider Billing

580 Number of cases investigated

73 Number of cases referred to appropriate law enforcement officials

c. Beneficiary Eligibility

904 Number of cases investigated

24 Number of cases referred to appropriate law enforcement officials

Are these cases for:

CHIP ☐

Medicaid and CHIP Combined ☒

4. Does your state rely on contractors to perform the above functions?

☒ Yes, please answer question below.

☐ No

5. If your state relies on contractors to perform the above functions, how does your state provide oversight of those contractors? Please explain : **[7500]**
The OIG adjusts its audit plans to maximize the effectiveness of its program integrity activities;

including the use of data mining, fraud science routines, and internal and external audits. When the OIG identifies improper billing patterns or fraud schemes, it adjusts its audit plan to allocate resources between internal and external auditors to maximize its impact on program vulnerabilities.

The OIG utilizes the services of a contractual, private detection agency to perform Fraud Prevention Investigations (FPI). These investigations are conducted to prevent ineligible persons from receiving benefits. FPI targets assistance applications that either contain suspicious information or meet error prone criteria. The OIG contracts with physician consultants of various specialties to perform provider's quality assurance reviews and physician and pharmacy consultants to perform Medicaid recipient utilizations reviews. Diagnosis Related Group (DRG) Inpatient Audits involve the conduct of a statewide audit program of inpatient hospital services reimbursed under the Diagnosis Related Grouping Prospective Payment System (DRG PPS). Medicaid Integrity Contractor (MIC) Audits utilize the OIG's partnership with the federal Centers for Medicaid and Medicare Services' Center for Public Integrity (CPI). CPI offers states the use of MIC auditors, in order to perform targeted audits at no cost to the state. Long Term Care Audits are financial audits of a long term care facility's non-medical records and balances. Federal law requires states to establish programs to contract with Recovery Audit Contractors (RAC) to audit payments to Medicaid providers. Payment to the RAC vendor is a statutorily mandated contingency fee based on the overpayments collected.

The OIG performs regular quality control checks of cases handled by contractors to ensure they have adequately performed their services. It should be noted the above referenced types of investigations or reviews are not identified as to the type of funding allocation (CHIP or Medicaid).

6. Do you contract with managed care health plans and/or a third party contractor to provide this oversight?

☐ Yes

☒ No

Please explain: **[500]**

G. DENTAL BENEFITS – Please ONLY report data in this section for children in Separate CHIP programs and the Separate CHIP part of Combination programs. Reporting is required for all states with Separate CHIP programs and Combination programs.

If your state has a Combination program or a Separate CHIP program but you are not reporting data in this section on children in the Separate CHIP part of your program, please explain why.

Explain: [7500]

1. Information on Dental Care Children in Separate CHIP Programs (including children in the Separate CHIP part of Combination programs). Include all delivery system types, e.g., MCO, PCCM, FFS.

Data for this table are based on the definitions provided on the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416)

a. Annual Dental Participation Table for Children Enrolled in Separate CHIP programs and the Separate CHIP part of Combination programs (for Separate CHIP programs, please include ONLY children receiving full CHIP benefits and supplemental benefits).

State: IL **FFY:** 2015	**Age Group**						
	Total	**< 1**	**1-2***	**3-5**	**6-9**	**10-14**	**15-18**
Total individuals enrolled for at least 90 continuous days[1]	45396	12386	13446	5720	3558	5186	5100
Total Enrollees Receiving Any Dental Services[2] [7]	12258	511	3681	2151	1707	2310	1898
Total Enrollees Receiving Preventive Dental Services[3]	11297	392	3391	2031	1613	2172	1698
Total Enrollees Receiving Dental Treatment Services[4]	3803	8	251	627	834	1103	980

[1] **Total Individuals Enrolled for at Least 90 Continuous Days** – Enter the total unduplicated number of children who have been continuously enrolled in a separate CHIP program or the separate CHIP part of a combination program for at least 90 continuous days in the Federal fiscal year, distributed by age. For example, if a child was enrolled January 1st to March 31st, this child is considered continuously enrolled for at least 90 continuous days in the Federal fiscal year. If a child was enrolled from August 1st to September 30th and from October 1st to November 30th, the child would not be considered to have been enrolled for 90 continuous days in the federal fiscal year. Children should be counted in age groupings based on their age at the end of the fiscal year. For example, if a child turned 3 on September 15th, the child should be counted in the 3-6 age grouping.

[2]**Total Eligibles Receiving Any Dental Services** - Enter the unduplicated number of children enrolled in a separate CHIP program or the separate CHIP part of a combination program for at least 90 continuous days who received at least one dental service by or under the supervision of a dentist as defined by HCPCS codes D0100 - D9999 (or equivalent CDT codes D0100 - D9999 or equivalent CPT codes) based on an unduplicated paid, unpaid, or denied claim.

[3]**Total Eligibles Receiving Preventive Dental Services** - Enter the unduplicated number of children enrolled in a separate CHIP program or the separate CHIP part of a combination program for at least 90 continuous days who received at least one preventive dental service by or under the supervision of a dentist as defined by HCPCS codes D1000 - D1999 (or equivalent CDT codes D1000 - D1999 or equivalent CPT codes, that is, only those CPT codes that are for

preventive dental services and only if provided by or under the supervision of a dentist), based on an unduplicated paid, unpaid, or denied claim.

[4]**Total Eligibles Receiving Dental Treatment Services** - Enter the unduplicated number of children enrolled in a separate CHIP program or the separate CHIP part of a combination program for at least 90 continuous days who received at least one treatment service by or under the supervision of a dentist, as defined by HCPCS codes D2000 - D9999 (or equivalent CDT codes D2000 - D9999 or equivalent CPT codes, that is, only those CPT codes that involve periodontics, maxillofacial prosthetics, implants, oral and maxillofacial surgery, orthodontics, adjunctive general services, and only if provided by or under the supervision of a dentist), based on an unduplicated paid, unpaid, or denied claim.

Report all dental services data in the age category reflecting the child's age at the end of the federal fiscal year even if the child received services while in two age categories. For example, if a child turned 10 on September 1st, but had a cleaning in April and a cavity filled in September, both the cleaning and the filling would be counted in the 10-14 age category.

b. For the age grouping that includes children 8 years of age, what is the number of such children who have received a sealant on at least one permanent molar tooth[5]? [7]

524

[5]**Receiving a Sealant on a Permanent Molar Tooth --** Enter the unduplicated number of children enrolled in a separate CHIP program or the separate CHIP part of a combination program for 90 continuous days and in the age category of 6-9 who received a sealant on a permanent molar tooth, as defined by HCPCS code D1351 (or equivalent CDT code D1351), based on an unduplicated paid, unpaid, or denied claim. For this line, include sealants placed by any dental professional for whom placing a sealant is within his or her scope of practice. Permanent molars are teeth numbered 2, 3, 14, 15, 18, 19, 30, 31, and additionally, for those states that cover sealants on third molars, also known as wisdom teeth, the teeth numbered 1, 16, 17, 32.

Report all sealant data in the age category reflecting the child's age at the end of the Federal fiscal year even if the child was factually a different age on the date of service. For example, if a child turned 6 on September 1st, but had a sealant applied in July, the sealant would be counted in the age 6-9 category.

2. Does the state provide supplemental dental coverage? ☐ Yes ☒ No

If yes, how many children are enrolled? [7]

What percent of the total number of enrolled children have supplemental dental coverage? [5]

H. CHIPRA CAHPS REQUIREMENT

CHIPRA section 402(a)(2), which amends reporting requirements in section 2108 of the Social Security Act, requires Title XXI Programs (i.e., CHIP Medicaid expansion programs, separate child health programs, or a combination of the two) to report CAHPS results to CMS starting December 2013. While Title XXI Programs may select any CAHPS survey to fulfill this requirement, CMS encourages these programs to align with the CAHPS measure in the Children's Core Set of Health Care Quality Measures for Medicaid and CHIP (Child Core Set). Starting in 2013, Title XXI Programs should submit summary level information from the CAHPS survey to CMS via the CARTS attachment facility. We also encourage

states to submit raw data to the Agency for Healthcare Research and Quality's CAHPS Database. More information is available in the Technical Assistance fact sheet, Collecting and Reporting the CAHPS Survey as Required Under the CHIPRA: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/CAHPSFactSheet.pdf.

If a state would like to provide CAHPS data on both Medicaid and CHIP enrollees, the agency must sample Title XIX (Medicaid) and Title XXI (CHIP) programs separately and submit separate results to CMS to fulfill the CHIPRA Requirement.

Did you Collect this Survey in Order to Meet the CHIPRA CAHPS Requirement? ☒Yes ☐No

If Yes, How Did you Report this Survey (select all that apply):
☒ Submitted raw data to AHRQ (CAHPS Database)
☒ Submitted a summary report to CMS using the CARTS attachment facility (NOTE: do not submit raw CAHPS data to CMS)
☐ Other. Explain:

If No, Explain Why:
Select all that apply (Must select at least one):

☐ Service not covered

☐ Population not covered

- ☐ Entire population not covered
- ☐ Partial population not covered
  Explain the partial population not covered:

☐ Data not available

Explain why data not available
- ☐ Budget constraints
- ☐ Staff constraints
- ☐ Data inconsistencies/accuracy
  Please explain:
- ☐ Data source not easily accessible
  Select all that apply:
  - ☐ Requires medical record review
  - ☐ Requires data linkage which does not currently exist
  - ☐ Other:
- ☐ Information not collected.
  Select all that apply:
  - ☐ Not collected by provider (hospital/health plan)
  - ☐ Other:
- ☐ Other:

☐ Small sample size (less than 30).

Enter specific sample size:

☐ Other. *Explain:*

Definition of Population Included in the Survey Sample:

Definition of Population Included in the Survey Sample:

☒ Denominator includes CHIP (Title XXI) population only.

☒ Survey sample includes CHIP Medicaid Expansion population.
☐ Survey sample includes Separate CHIP population.
☐ Survey sample includes Combination CHIP population.

If the denominator is a subset of the definition selected above, please further define the denominator, and indicate the number of children excluded:

Data submitted include both the CHIP (Title XXI) and Medicaid (Title XIX) populations with over-sampling for each population.

Which Version of the CAHPS® Survey was Used?

☐ CAHPS® 5.0
☒ CAHPS® 5.0H
☐ Other.

Explain:

Which Supplemental Item Sets were Included in the Survey?

☐ No supplemental item sets were included
☒ CAHPS Item Set for Children with Chronic Conditions
☐ Other CAHPS Item Set. Explain:

Which Administrative Protocol was Used to Administer the Survey?

☒ NCQA HEDIS CAHPS 5.0H administrative protocol
☐ AHRQ CAHPS administrative protocol
☐ Other administrative protocol. Explain:

SECTION IV: PROGRAM FINANCING FOR STATE PLAN

1. Please complete the following table to provide budget information. Describe in narrative any details of your planned use of funds below, including the assumptions on which this budget was based (per member/per month rate, estimated enrollment and source of non-Federal funds). (*Note: This reporting period =Federal Fiscal Year 2015. If you have a combination program you need only submit one budget; programs do not need to be reported separately.)*

COST OF APPROVED CHIP PLAN

Benefit Costs	**2015**	**2016**	**2017**
Insurance payments	0	0	0
Managed Care	109629102	251014936	288499204
Fee for Service	315061611	228467551	191821139
Total Benefit Costs	424690713	479482487	480320343
(Offsetting beneficiary cost sharing payments)	-22110432	-19179300	-19212814
Net Benefit Costs	$ 402580281	$ 460303187	$ 461107529

Administration Costs			
Personnel	11774777	16030571	16055283
General Administration	17011679	23160263	23195966
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/Marketing costs			
Other (e.g., indirect costs)	2814749	3832092	3838000
Health Services Initiatives	3597807	4898173	4905724
Total Administration Costs	35199012	47921099	47994973
10% Administrative Cap (net benefit costs ÷ 9)	44731142	51144799	51234170

Federal Title XXI Share	286876771	450388362	451166637
State Share	150902522	57835924	57935865

TOTAL COSTS OF APPROVED CHIP PLAN	437779293	508224286	509102502

2. What were the sources of non-federal funding used for state match during the reporting period?

- ☒ State appropriations
- ☒ County/local funds
- ☐ Employer contributions
- ☐ Foundation grants
- ☐ Private donations
- ☒ Tobacco settlement
- ☐ Other (specify) **[500]**

3. Did you experience a short fall in CHIP funds this year? If so, what is your analysis for why there were not enough federal CHIP funds for your program? **[1500]**

N/A

4. In the table below, enter 1) number of eligibles used to determine per member per month costs for the current year and estimates for the next two years; and, 2) per member per month (PMPM) cost rounded to a whole number. If you have CHIP enrollees in a fee for service program, per member per month cost will be the average cost per month to provide services to these enrollees.

	2015		2016		2017	
	# of eligibles	$ PMPM	# of eligibles	$ PMPM	# of eligibles	$ PMPM
Managed Care	61904	$ 147	73812	$ 157	81193	$ 157
Fee for Service	172459	$ 152	164080	$ 157	156707	$ 157

Enter any Narrative text below. **[7500]**

SECTION V: PROGRAM CHALLENGES AND ACCOMPLISHMENTS

1. For the reporting period, please provide an overview of your state's political and fiscal environment as it relates to health care for low income, uninsured children and families, and how this environment impacted CHIP. **[7500]**

   Support for health care for low income, uninsured children and families remained fairly constant in federal fiscal year 2015.

2. During the reporting period, what has been the greatest challenge your program has experienced? **[7500]**

   Continuing to struggle with changes in the new eligibility system, MAGI budgeting methodology and working through the increased volume of applications and redeterminations have been our biggest challenges.

3. During the reporting period, what accomplishments have been achieved in your program? **[7500]**

   The second open enrollment period went more smoothly than the first. Communication between our eligibility system and the FFM have gone well. The number of applications has stabilized. Work is progressing on the development and testing of the second phase of our new integrated eligibility system.

4. What changes have you made or are planning to make in your CHIP program during the next fiscal year? Please comment on why the changes are planned. **[7500]**

   No changes are planned.

Enter any Narrative text below. **[7500]**