State of Illinois
Department of Healthcare and Family Services

SFY 2009-2010 External Quality Review Technical Report

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3133 East Camelback Road, Suite 300 ◆ Phoenix, AZ 85016
Phone 602.264.6382 ◆ Fax 602.241.0757

HSAG HEALTH SERVICES ADVISORY GROUP

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ACKNOWLEDGMENTS AND COPYRIGHTS

BBA refers to the Balanced Budget Act of 1997.

CAHPS® refers to the Consumer Assessment of Healthcare Providers and Systems and is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

CMS refers to the Centers for Medicare & Medicaid Services.

CRMS refers to CareEnhance® Resource Management Software.

EPSDT refers to Early and Periodic Screening, Diagnosis, and Treatment includes preventive health services and is the child health component of Medicaid.

HEDIS® refers to the Healthcare Effectiveness Data and Information Set and is a registered trademark of the National Committee for Quality Assurance (NCQA).

MCO refers to managed care organization.

MRG refers to Medical Review Group.

NCQA HEDIS Compliance Audit™ is a trademark of the NCQA.

PIP refers to Performance Improvement Projects which are required for managed care organizations by CMS.

QAP refers to the quality assessment program.

QAPI refers to quality assessment and performance improvement activities required of MCOs in the BBA.

Introduction

Since June 2002, Health Services Advisory Group, Inc. (HSAG), has served as the external quality review organization (EQRO) for the Illinois Department of Healthcare and Family Services (HFS or the Department), formerly known as the Illinois Department of Public Aid (IDPA). The State fiscal year (SFY) 2009–2010 Illinois External Quality Review (EQR) Technical Report describes the manner in which data from EQR activities conducted in accordance with the Code of Federal Regulations (CFR), at 42 CFR 438.358, were aggregated and analyzed. The report also describes how conclusions were drawn as to the quality and timeliness of, and access to, care furnished to participants of the Illinois Medical Assistance Program. These beneficiaries were enrolled in one of Illinois' three contracted managed care organizations (referred to as HFS managed care organizations or MCOs): **Family Health Network, Inc.** (**FHN**), **Harmony Health Plan of Illinois, Inc.** (**Harmony**), and **Meridian Health Plan, Inc.** (**Meridian**). This executive summary outlines the mandatory and optional EQR activities performed by HSAG in SFY 2009–2010.

Compliance Monitoring—QAP Structure and Operations—SFY 2009–2010

HSAG conducted on-site, comprehensive compliance reviews of **FHN** and **Harmony** in SFY 2007–2008. In SFY 2008–2009, the MCOs were required to complete corrective action plans (CAPs) for elements that did not fully meet standards. In SFY 2009–2010 HSAG conducted an on-site review of **Harmony** and **FHN** to review compliance with implementation of their CAPs. The on-site review found that **Harmony** had successfully addressed all of the requirements of its compliance monitoring CAP, while **FHN** had not fully implemented the CAPs for the requirements of the case management care coordination standard.

Throughout SFY 2009–2010 **FHN** continued implementation of the case management software and continued to work on the requirements of its CAP. **FHN** should continue to work with the State to implement case management software and follow HSAG's recommendations to achieve compliance with quality assessment program (QAP) standards.

Meridian did not require an on-site review during SFY 2009–2010 as they were compliant with all the readiness review requirements.

HSAG will conduct a focused compliance review for all three MCOs in SFY 2010–2011. **FHN** will require a focused review of the Case Management Care Coordination Standard requirements to ensure implementation of the case management software and compliance with contract and the Balanced Budget Act of 1997 (BBA) requirements.

Validation of Performance Measures—NCQA HEDIS Compliance Audit—SFY 2009–2010

HSAG performed an independent audit of **FHN**'s, **Harmony**'s, and **Meridian**'s 2010 Healthcare Effectiveness Data and Information Set (HEDIS) data. Three HEDIS measures were selected for validation:

- *Childhood Immunization Status*
- *Well-Child Visits in the First 15 Months of Life*
- *Prenatal and Postpartum Care*

Relatively new to the Medicaid program, and due to lower enrollment, **Meridian** only reported on *Children's and Adolescent's Access to Primary Care Practitioners, Adults' Access to Preventive/Ambulatory Health Services, and Prenatal and Postpartum Care* measures. **FHN** and **Harmony** reported on other HEDIS measures that HSAG did not validate during the audit, although HSAG did validate the processes for collecting and calculating each measure. The report includes the rates for **FHN** and **Harmony** for the following HEDIS measures:

- *Lead Screening in Children*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life*
- *Adolescent Well-Care Visits*
- *Immunizations for Adolescents (Combined Rate)*
- *Children's and Adolescent's Access to Primary Care Practitioners (PCPs)*
- *Adults' Access to Preventive/Ambulatory Health Services*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Chlamydia Screening in Women*
- *Frequency of Ongoing Prenatal Care*
- *Controlling High Blood Pressure*
- *Comprehensive Diabetes Care*
- *Use of Appropriate Medications for People With Asthma*
- *Follow-up After Hospitalization for Mental Illness*

The 2010 HEDIS compliance audit showed that the MCOs successfully prepared the selected performance measures in accordance with *HEDIS 2010 Technical Specifications*. The MCOs had information systems in place that met HEDIS standards, with no significant impact on the reliability of HEDIS reporting, valid medical record review processes, and performance measures (for those included in the audit) that followed HEDIS specifications and provided reportable rates. Encounter data submission was still low. The MCOs should continue efforts to increase the submission of encounter data.

While both **FHN** and **Harmony** have shown some improvements in HEDIS rates over time, overall, declines and/or low performance levels indicated that the health plans need additional interventions to ensure the quality and timeliness of, and access to, care provided to HFS beneficiaries. Due to **Meridian**'s low population, **Meridian** did not have more than 30 eligible members for any of the

reported HEDIS measures. In accordance with NCQA, the rates for these measures are not applicable (NA). Therefore, **Meridian**'s rates are not presented for this year. **Meridian** is expected to have a larger population in in the HEDIS 2011 reporting year and should be able to report rates for some measures.

FHN has improved 27 of the 35 measures since the previous reporting cycle. The *Frequency of Ongoing Prenatal Care (<21 Visits)* and *Diabetes Care (LDL-C Level <100 mg/Dl)* measures demonstrated the strongest improvements. The largest decline was seen for *Controlling High Blood Pressure (Combined Rate).*

Harmony has improved 24 of the 35 measures since the previous reporting cycle. The *Frequency of Ongoing Prenatal Care (<21 Visits)* measure demonstrated the strongest improvement. The relative decline in the *Diabetes Care (BP < 130/80 mm/Hg)* measure (12.8 percent) showed the most room for improvement for the 35 measures.

Both **FHN** and **Harmony** have continued to improve their performance for both children and adolescent care measures. The rates for *Lead Screening in Children* are above the 50th percentile for both MCOs. **FHN** reported a rate above the 75th percentile for *Well-Child Visits (3–6 Years),* and above the 50th percentile for the *Adolescent Well-Care Visit* rate.

The rates for both MCOs for measures in the preventive screenings for women category improved over last year but still remain fairly low. **FHN** showed improvement over last year for all the measures. **Harmony** continued to show improvement with *Cervical Cancer Screening*, but the other rates remained about the same as last year.

For the maternity-related measures *Frequency of Ongoing Prenatal Care, Timeliness of Prenatal Care, and Postpartum Care,* both MCOs continued to report rates well below the 10th percentile. Both *Timeliness of Prenatal Care* and *Frequency of Ongoing Prenatal Care* are measures related to access to care. In addition, low rates for *Children's Access to PCPs* and *Adults' Access to Preventive/Ambulatory Health Services* indicate that both MCOs need to improve access to care.

The chronic conditions/disease management category has produced mixed results, with some rates increasing and several measures declining. **FHN** demonstrated notable improvement with *Comprehensive Diabetes Care—HbA1c Testing*, *LDL-C Screening*, and *Monitoring of Diabetic Nephropathy*. However, **FHN's** performance declined for *Controlling High Blood Pressure (Combined Rate)*, *Comprehensive Diabetes Care—Poor HbA1c Control*, *Blood Pressure <140/90 mm/Hg*, and *Blood Pressure <130/80 mm/Hg*. **Harmony**'s rates all demonstrated increases or decreases of less than 5.0 percentage points over last year.

The two measures related to mental health continue to represent an area of strength for **FHN**, with the 7-day rate now exceeding the 90th percentile and the 30-day rate exceeding the 75th percentile. The 7-day rate for **Harmony** was above the 50th percentile, but only 1.3 percentage points higher than the HEDIS 2007 rate. The 30-day rate for **Harmony** showed little improvement and remains below the initial baseline rate. The MCOs have initiated a collaborative PIP that incorporates this measure, and it is expected to have a positive impact on rates in the following years.

Performance Improvement Projects—SFY 2009–2010

PIP Validation Results

Table 1-1 displays the PIPs conducted by each MCO for SFY 2009–2010 and the overall validation score for each PIP. The table shows **Meridian** with the highest percentage of completed elements scored as *Met*; however, **Meridian** is in the early stages of the PIP validation process as indicated by the total number of elements validated in Table 1-2 below.

Table 1-1—Percent of All Elements *Met*			
PIP Topics	FHN	Harmony	Meridian
EPSDT Screening	94%	85%	100%
Perinatal Care and Depression Screening	92%	87%	100%
Improving Ambulatory Follow-Up and PCP Communication	100%	91%	100%

Table 1-2 shows the number of elements in each PIP that were scored in SFY 2009–2010.

Table 1-2—Number of Elements Assessed for Each PIP and MCO			
PIP Topics	FHN	Harmony	Meridian
EPSDT Screening	45	41	17
Perinatal Care and Depression Screening	48	45	18
Improving Ambulatory Follow-Up and PCP Communication	17	21	17

Table 1-2 shows that the three highest-scoring PIPs were for projects that were the least far into the assessed activities (i.e., 17 or 18 elements scored). The next assessment of **Meridian** should show more comparative results. For the present results, however, both **FHN** and **Harmony** could improve their PIP validation scores.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys—SFY 2009–2010

The Myers Group administered the adult Medicaid and child Medicaid CAHPS surveys on behalf of **FHN** and **Harmony.** Reports generated by The Myers Group were forwarded to HSAG. **Meridian** was allowed to conduct a non-CAHPS consumer satisfaction survey due to insufficient eligible HFS beneficiaries needed to conduct the CAHPS survey.

The 2010 CAHPS scores and **Meridian's** non-CAHPS reported results indicated that HFS beneficiaries statewide were satisfied with how well their doctors communicate with them regarding the care of adults. Both **FHN** and **Harmony** scored below the national averages for *Getting Needed Care,* and *Ratings of All Health Care, Personal Doctor, Specialist Seen Most Often,* and *Health Plan*, suggesting widespread opportunities for improvement. As **Meridian**'s survey and results were non-CAHPS, the results could not be compared to CAHPS national averages. The MCOs should continue efforts to meet HFS beneficiaries' expectations regarding their health care experiences.

Overall Conclusions and Recommendations

Harmony showed strong performance in implementing the recommendations for improvement and maintaining compliance with the QAP standards. **FHN** should focus on completing the development and implementation of a basic system that promotes continuity of care and case management.

Achieving further improvements in the MCOs' performance on HEDIS measures should be a top priority. The low rates for *Children's Access to PCPs* and *Adults' Access to Preventive/Ambulatory Health Services* and the maternity-related measures indicate that both **FHN** and **Harmony** need to continue to improve access to care just as they have been doing between the most recent measurement cycles.

Encounter data submission is still low for **FHN**, with only two measures scoring more than 80 percent data completeness and six measures with less than 50 percent data completeness. **Harmony**'s encounter data submission was much higher, especially for the measures related to early well-child care (i.e., *Childhood Immunizations*, *Lead Screening in Children*, and *Well-Child Visits in the First 15 Months of Life*), maternity care, and diabetes care. Both MCOs should continue efforts toward improving the submission of encounter data.

Both **FHN** and **Harmony** should also continue to improve PIP evaluation element scores so that the validation status reflects a high level of confidence in the reported PIP results. **Meridian** showed strong performance on conducting activities for its PIPs but is still in the early stages of the required activities for all three PIPs.

Overall, **FHN** has shown significant improvement for five of the eight measures for the *EPSDT Screening* collaborative PIP since the baseline reporting period. However, the three highest-scoring measures from the baseline period—health history, nutritional assessment, and growth measurement—have declined. **FHN** may be focusing on improving the lower rates but not ensuring that providers still perform and document the components for the other measures. **Harmony** showed improvement for one measure (i.e., nutritional assessment) out of the eight *EPSDT Screening* collaborative PIP measures. The rates for developmental screening, anticipatory guidance, and physical exam declined fewer than 4 percentage points. The other four measures demonstrated statistically significant declines in the rates. Both MCOs should continue efforts toward improving the EPSDT screening rates.

For the *Perinatal Care and Depression Screening* collaborative PIP, the total number of women screened for depression and the amount of depression screening documented have improved since the PIP was initiated in SFY 2005–2006. The use of objective depression screening and the clinician review of the depression screens have also been very successful. However, the follow-up for positive depression screens rate has remained about the same as the baseline rate, with the MCOs moving away from treatment and providing more referrals for services. At this time, because of the success that has been accomplished, it is recommended that the MCOs continue with their current interventions. The maternity measures for this PIP continue to show low rates for *Timeliness of Prenatal Care*, *Frequency of Ongoing Prenatal Care*, and *Postpartum Care* and represent a significant area for improvement as the rates remain below the Medicaid 10th percentile.

However, all of the rates have had significant improvement for both the first and second remeasurement periods.

FHN’s and **Harmony**’s 2010 adult and child Medicaid CAHPS results indicated that quality improvement initiatives should focus on improving *Getting Needed Care,* and *Ratings of All Health Care, Personal Doctor, Specialist Seen Most Often,* and *Health Plan* measure results.

Meridian’s non-CAHPS survey results indicated satisfaction in 6 of the 11 measures. Opportunities for improvement were seen for providers discussing medications to help the member to quit smoking as well as offering strategies other than medications for smokers to quit, beyond the doctor’s recommendation to do so. In addition, **Meridian** HFS beneficiaries expressed some dissatisfaction with office wait times. **Meridian** should implement initiatives to improve HFS beneficiaries’ dissatisfaction with office wait times and to educate providers regarding smoking cessation programs.

2. Background

Purpose of the EQR Technical Report

The SFY 2009–2010 EQR Technical Report provides an evaluation of the data sources reviewed by HSAG. As the EQRO, HSAG assessed the progress made in fulfilling the Department's goals for the quality and timeliness of, and access to, care furnished to Illinois Medical Assistance Program recipients for the Department-contracted MCOs for the SFY 2009–2010 evaluation period. A goal of this report is to ascertain whether health plans have met the intent of the BBA and State requirements.

The BBA requires that states contract with an EQRO to conduct an annual evaluation of MCOs that serve Medicaid recipients. The purpose of this annual evaluation is to determine each MCO's compliance with federal quality assessment and performance improvement standards. CMS regulates requirements and procedures for the EQRO.

Pursuant to the BBA, 42 CFR 438.364 calls for the production by each state of a detailed technical report on EQR results. In accordance with 42 CFR 438.358, the EQR technical report describes the manner in which the data from EQR activities were aggregated and analyzed. The report also describes how conclusions were drawn as to the quality and timeliness of, and access to, care furnished to Illinois Medical Assistance Program recipients by Department-contracted MCOs. Information released in this technical report does not disclose the identity of any recipient, in accordance with 438.350(f) and 438.364(a)(b). This report specifically addresses the following for each EQR activity conducted:

- Objectives
- Technical methods of data collection and analysis
- Description of data obtained
- Conclusions drawn from the data

In addition, this report includes an assessment of each MCO's strengths and weaknesses with respect to the quality and timeliness of, and access to, health care services furnished to HFS beneficiaries, and offers recommendations for improving the quality of health care services furnished by each MCO. Comparisons of MCO performance related to quality, timeliness, access, and performance improvement are also included.

History of State Medicaid

Managed care is a voluntary program in Illinois and has been a health care option for medical assistance participants since 1976. MCOs include health maintenance organizations (HMOs) and managed care community networks (MCCNs). The Department contracts with the MCOs to manage the provision of health care for HFS beneficiaries. The contracts require the MCOs to offer the same comprehensive set of services to their HFS beneficiaries that are available to the fee-for-service

population. Except for financial solvency and licensing requirements, HMOs and MCCNs have the same contractual requirements. The Department of Insurance licenses HMOs, which contract on an at-risk basis to provide medical services to their HFS beneficiaries. MCCNs are provider-sponsored organizations within Illinois certified by the Department as meeting its requirements for such organizations.

Illinois' All Kids program offers health insurance coverage to income-eligible children and pregnant women. All children enrolled in All Kids get 12 months of continuous financial eligibility both upon initial determination of eligibility and upon renewal of eligibility. The State's FamilyCare program broadens coverage to eligible parents or caretaker relatives, as well as children. Children with family incomes of up to 200 percent of the federal poverty level (FPL) can qualify, regardless of available insurance. Children in families above 200 percent of the FPL must be uninsured to qualify. Parents can qualify with a family income of up to 185 percent of the FPL. The Department increased the income standard for parents to 185 percent of the FPL in January 2006.

Both All Kids and FamilyCare programs provide health insurance coverage to children, parents, and pregnant women who are eligible based on their income and who meet other nonfinancial eligibility requirements. At the end of SFY 2010, approximately 2.65 million were provided comprehensive health care coverage through the HFS Medical Program. [2-1]

Illinois Medicaid Demographics

The Illinois Medical Assistance Program's managed care initiative in Illinois operates in selected counties throughout the State. Enrollment in the program is voluntary. The Department's overall goal for its managed care system is to appropriately respond to the health care needs of Illinois Medical Assistance Program beneficiaries. Specifically, the goal is to respond to HFS beneficiaries in a timely manner, ensure adequate access to covered services, provide quality health care, improve health outcomes, and conduct ongoing internal monitoring and oversight. The focus is on quality improvement and providing a delivery system alternative available to certain population groups on a voluntary basis. During the report period, the Department contracted with three MCOs—**FHN**, **Harmony,** and **Meridian**—to provide health care services to Medicaid managed care beneficiaries.

Harmony is an HMO and **FHN** is a not-for-profit, provider-sponsored organization that operates as an MCCN. Both health plans operated in Cook County in SFY 2009–2010. **Harmony** also operated in the southern counties of Kane, Madison, Perry, Randolph, St. Clair, Washington, Jackson, and Williamson in SFY 2009–2010. **Meridian** is a physician-owned and operated MCO that began providing services to HFS beneficiaries in Adams, Brown, Henry, Mercer, Pike, Rock Island, and Scott counties in January 2009.[2-2] In SFY 2009–2010, **Meridian** was approved to expand into Cook County. [2-3]

Through its contracts with the MCOs, the Department strives to ensure the accessibility and availability of appropriate health care, provide for continuity of care, and provide quality care to

[2-1] http://www.hfs.illinois.gov/annualreport/
[2-2] http://www.hfs.illinois.gov/managedcare/managedcare_enrollment.html
[2-3] http://www.hfs.illinois.gov/annualreport/

HFS beneficiaries. The major focus is on timely preventive and primary care, health promotion, disease prevention, and improving health outcomes.

Table 2–1 shows enrollment in the Illinois program in May 2010, when the total enrollment was 195,026.[2-4]

Table 2–1—May 2010 MCO Enrollment in Illinois			
MCO	Cook	Downstate	Total Enrollment
FHN	49,281	-	49,281
Harmony	132,287	12,677	144,964
Meridian	-	781	781
Total Enrollment	**181,568**	**13,458**	**195,026**

Scope of the Report

Mandatory EQR Activities

The SFY 2009–2010 EQR Technical Report focuses on the three federally-mandated EQR activities that HSAG performed for the MCOs over a 12-month period (June 1, 2009, to May 31, 2010). As set forth in 42 CFR 438.352, these mandatory activities were:

- Compliance with QAP standards. During SFY 2009–2010, HSAG reviewed the MCOs' mandatory CAPs for standards not met during the SFY 2007–2008 comprehensive review of MCO compliance with the QAP standards.
- Validation of performance measures. The State contracted with HSAG to conduct a HEDIS compliance audit of 2010 data for the MCOs. The process of validating performance measures includes two elements: (1) validation of an MCO's data collection process and (2) a review of performance measure results compared with other MCOs and national benchmarks.
- Validation of PIPs**.** As part of the SFY 2009–2010 review, HSAG validated PIPs conducted by the MCOs regarding compliance with requirements set forth in 42 CFR 438.240(b)(1). In SFY 2009–2010, the MCOs continued their PIPs on the topics of EPSDT screening, perinatal care and depression screening, and improving ambulatory follow-up and PCP communication.

Optional EQR Activities

Other EQR activities conducted by HSAG included:

- Assessment of consumer satisfaction surveys. Each year, the MCOs are required to independently administer a consumer satisfaction survey. As part of its SFY 2009–2010 review, HSAG evaluated the results of adult and child CAHPS surveys conducted in 2010 by The Meyers Group to identify trends, strengths, and opportunities for improvement. **Meridian** was

[2-4] 2010 EnrollmentReport.xls

allowed to conduct its own survey due to insufficient enrollment to meet the CAHPS eligibility criteria.

- Collaborative PIPs. Health plans are required to initiate a new quality improvement project each year, and projects typically have a cycle of two to four years. HSAG provides support and assistance to the MCOs in developing, implementing and evaluating each of the improvement initiatives.
- Provision of technical assistance. HSAG has provided ongoing technical assistance to the MCOs at the request of the Department.

Summary of State Quality Strategy Objectives and Incentives

Throughout SFY 2009–2010, HFS has increased its focus on setting MCO quality assurance goals, measuring progress and outcomes, and establishing thresholds for improved performance. In addition, HFS has placed emphasis on ensuring that MCOs have quality assurance processes in place, adequate resources and demonstrated commitment toward ongoing quality improvement. HFS is working on revisions to the State Quality Strategy to address the comments and recommendations from the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS).

Quality Performance Withhold

HFS offered quality performance payments to encourage the improvement of certain quality-of-care indicators. The HEDIS measures used to determine the quality performance payments were:

- *Childhood Immunization Status—Combo 3*
- *Well-Child Visits in the First 15 Months of Life—six or more visits*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *Cervical Cancer Screening*
- *Timeliness of Prenatal Care*
- *Postpartum Care*
- *Use of Appropriate Medications for People With Asthma—Combined Rate*
- *Comprehensive Diabetes Care—HbA1C Testing*

Illinois Managed Care Delivery Systems

Illinois has three managed care delivery systems, Voluntary Managed Care (VMC), Integrated Care Program (ICP), and Primary Care Case Management (PCCM).

Voluntary Managed Care

All Kids, Moms and Babies, and FamilyCare clients living in certain counties can choose a PCP in an MCO for their medical home. An MCO is an HMO or HMO-like health plan that has its own

network of doctors and hospitals. Clients that enroll in an MCO get all of their services from the doctors and hospitals that are in the MCO network unless they get approval from the MCO. Clients can get their healthcare and may get additional benefits by enrolling in a Managed Care Organization.

Integrated Care Program

After many months of development and input from multiple stakeholders, in February 2010, HFS released a Request for Proposal (RFP) for qualified, experienced and financially sound MCOs to enter into risk-based contracts to provide approximately 40,000 older adults and adults with disabilities residing in the counties of Lake, Kane, DuPage, Will, Kankakee, and suburban Cook the full spectrum of Medicaid covered services through an integrated care delivery system. MCOs responding to the RFP to provide integrated care services underwent a bidder's review to determine preliminary readiness to provide the services. Based on the RFP response and the bidder's review, the MCOs were selected for participation with the anticipated client enrollment and implementation of the Service Package I in early 2011, which covers all non-long-term care services and mental health and substance abuse services. Service Packages II and III will be implemented in future years. Service Package II includes all long-term care services and care provided through HCBS waivers, excluding waivers designed for individuals with developmental disabilities. Service Package III includes Developmental Disability Waiver services and intermediate care facility/developmentally disabled (ICF/DD) services.

The Integrated Care Program will bring together local primary care physicians, specialists, hospitals, nursing homes, and other providers, with all care being centered on the needs of the patient to achieve improvements in health through care coordination. HFS will ensure that quality safeguards are in place by contractually requiring the MCOs to track performance measures and by offering pay for performance (P4P) incentives to meet performance goals. These performance measures create an incentive for the MCOs to spend money toward care that produces valued outcomes.

Primary Care Case Management Program

Illinois' Primary Care Case Management (PCCM) Program, called Illinois Health Connect, is a statewide health plan that is available to most persons covered by an HFS Medical Program. Illinois Health Connect (IHC) is based on the American Academy of Pediatricians' initiative to create medical homes to make sure that primary and preventive healthcare is provided in the best setting. People who are enrolled in Illinois Health Connect will have a "medical home" through a Primary Care Provider (PCP).[2-5]

Eligible clients who must select a PCP for their medical home include most children enrolled in the All Kids program, adults enrolled in the FamilyCare program, and seniors and disabled adults. Some populations, such as participants who have Medicare, are excluded from enrolling in IHC. In the voluntary managed care counties, eligible clients may opt out of IHC to enroll with a PCP in an MCO for their medical home. IHC has over 5,600 medical homes with total available panel capacity

[2-5] http://www.hfs.illinois.gov/managedcare/ihc.html

to serve over 5.3 million HFS medical assistance program-eligible clients statewide. With this expansive network, over 2 million clients have been enrolled or assigned to a medical home.

Through the Health Connect Referral System, clients are seen by their own IHC PCP (or an affiliated physician or clinic) whenever appropriate. PCPs seeing IHC clients who are not enrolled on their (or an affiliate's) panel on the date of service must obtain a referral from the client's PCP in order to be reimbursed by HFS for services provided.

Organization of the Report

The EQR technical report is organized as follows:

- Section 1 (Executive Summary) of this report outlines EQR activities, conclusions, and recommendations for compliance monitoring, validation of performance measures, PIPs, CAHPS, IS Review, the Illinois quality strategy and work plan, and the PTT. Section 1 also summarizes overall conclusions and recommendations.
- Section 2 (Background) describes the purpose of the EQR technical report, the history of State Medicaid, Illinois Medicaid demographics, the scope of the report (mandatory and optional EQR activities), the State quality strategy objectives and incentives, development of the integrated care program, and the organization of the report.
- Section 3 (Description of EQR Activities) describes for each EQR activity the objectives, technical methods of data collection and analysis, plan-specific findings, and conclusions drawn from the data.
- Section 4 (Plan Comparisons) compares the results and findings from the three mandatory EQR activities and the optional customer satisfaction surveys for the MCOs and offers recommendations.
- Section 5 (Conclusions and Recommendations) provides overall conclusions and recommendations for the State and the MCOs based on the MCO comparisons and a synthesis of historical and current EQR data.
- Appendix A displays trended graphs for HEDIS 2005–2010.
- Appendix B displays the Illinois HEDIS 2010 Medicaid rates for Child and Adolescent Care and Adults' Access to Preventive/Ambulatory Health Services Measures.
- Appendix C displays the Illinois HEDIS 2010 Medicaid rates for Preventive Screening for Women and Maternity-Related Measures.
- Appendix D displays the HEDIS 2010 Medicaid rates for Chronic Conditions/Disease Management Measures.
- Appendix E displays the Medicaid HEDIS 2009–2010 percentiles.
- Appendix F displays the Illinois Trended HEDIS Rates 2006 through 2010.

Introduction

This section describes the EQR activities conducted in accordance with 42 CFR 438.358 for each of the three Department-contracted Medicaid MCOs. For each of the activities, the report presents the objectives, technical methods of data collection and analysis, description of data obtained and findings for each plan, and conclusions drawn from the data. Additional details about the results of the EQR activities are included in the individual and aggregate MCO reports prepared by HSAG.

Compliance Monitoring—QAP Structure and Operations—SFY 2009–2010

Compliance monitoring is designed to determine an MCO's compliance with its contract, State and federal regulations, and various compliance monitoring standards.

In SFY 2009–2010, HSAG conducted an on-site review of **Harmony** and **FHN** to assess implementation and compliance with CAPs resulting from the SFY 2007–2008 comprehensive compliance reviews. The MCOs were required to submit CAPs for standards *Not Met* and *Partially Met*.

Objectives

Private accreditation organizations, state licensing and Medicaid agencies, and the federal Medicare program all recognize that having standards is only the first step in promoting safe and effective health care. Making sure that the standards are followed is the second step. According to 42 CFR 438.358, a state or its EQRO must conduct a review within a three-year period to determine health plan compliance with QAP standards. A primary objective of the CAP reviews was to determine the MCOs' compliance with QAP-related contractual standards specified in the April 1, 2006, Illinois Department of Public Aid Contract for Furnishing Health Services by a Health Maintenance Organization. A particular focus of this review was to determine how each MCO implemented and complied with their corrective action plans through written procedures, as appropriate, and how compliance was maintained with the corrective action plan.

The State and the individual MCOs are using the information and findings from the compliance reviews to:

- Evaluate the quality and timeliness of, and access to, health care furnished by the MCOs to medical assistance program participants.
- Identify, implement, and monitor system interventions to improve quality.
- Evaluate current performance processes.
- Plan and initiate activities to sustain and enhance current performance processes.

Technical Methods of Data Collection and Analysis

HSAG used the CAP Document Request Tracking Tool in its on-site review of the MCOs' responses regarding standards that were *Not Met* or *Partially Met* in the comprehensive monitoring review. The tool tracked standards, documents, dates that documents were requested and submitted, document titles, and HSAG's comments with respect to whether each standard was *Met*.

Plan-Specific Findings

Family Health Network

HSAG's December 2009 on-site review was designed to determine **FHN's** compliance with implementation of their CAP. The on-site review found that **FHN** remained out of compliance with the case management and care coordination requirements. **FHN** continued to work toward the implementation of case management software that will assist the MCO in meeting standards that remain out of compliance with contract and BBA requirements. During SFY 2009–2010 **FHN** selected and implemented the McKesson CareEnhance Clinical Management Software (CCMS). In addition, **FHN** continued to work to customize the existing software to include member eligibility, provider information, pharmacy information, and claims data. HSAG is scheduled to conduct a focused review for **FHN** of standards identified by the State during SFY 2010–2011. The review for **FHN** will be focused on compliance with case management and care coordination requirements.

Harmony Health Plan

HSAG's December 2009 on-site review was designed to determine **Harmony's** compliance with implementation of their CAP. The on-site review found that all CAP's were implemented as documented in the **Harmony** CAP response. HSAG is scheduled to conduct a focused review for **Harmony** of standards identified by the State during SFY 2010–2011.

Harmony worked throughout SFY 2009–2010 to evaluate the process for member referrals to case management. **Harmony** improved the identification process using an algorithm and improved data mining. The algorithm evaluated and scored members on three primary drivers: severity, utilization and cost. Through data mining, members were flagged if identified as having certain chronic care conditions and evaluated for case management services. **Harmony** reported increased enrollment into case management as a result of the implementation of the identification and stratification methods described above.

Harmony also reported increased referrals to the **Harmony** HUGS program, a pregnancy outreach program aimed at identifying members who are classified as high risk and are subsequently referred to the obstetrical high-risk case management program. **Harmony** reported increased referrals to the obstetrical high-risk program during the year under review.

Meridian

HSAG did not conduct a compliance review for **Meridian** during SFY 2009–2010 as all the requirements of the readiness review were met. HSAG is scheduled to conduct a focused review for **Meridian** of standards identified by the State during SFY 2010–2011.

Validation of Performance Measures—HEDIS Compliance Audit—SFY 2009–2010

Objectives

HEDIS performance measures are a nationally-recognized set of performance measures developed by NCQA. Health care purchasers use these measures to assess the quality and timeliness of care and service delivery to members of managed care delivery systems. This section describes the evaluation of the MCOs' ability to collect and accurately report on the performance measures.

A key element of improving health care services is the ability to provide easily understood, comparable information on the performance of the MCOs. Systematically measuring performance provides a common language based on numeric values and allows the establishment of benchmarks, or points of reference, for performance. Performance measure results allow the MCO to make informed judgments about the effectiveness of existing processes and procedures, identify opportunities for improvement, and determine if interventions or redesigned processes are meeting objectives.

The Department requires the MCOs to monitor and evaluate the quality of care through the use of HEDIS and Department-defined performance measures. The MCOs must establish methods by which to determine if the administrative data are accurate for each measure. In addition, the MCOs are required by contract to continually track and monitor each performance measure and applicable performance goal, and to implement a quality improvement initiative addressing compliance until the MCOs meet the performance goal.

NCQA licenses organizations and certifies selected employees of licensed organizations to conduct performance measure audits using NCQA's standardized audit methodology. The NCQA HEDIS Compliance Audit indicates the extent to which MCOs have adequate and sound capabilities for processing medical, member, and provider information for accurate and automated performance measurement, including HEDIS reporting. The validation addresses the technical aspects of producing HEDIS data, including:

- Information practices and control procedures
- Sampling methods and procedures
- Data integrity
- Compliance with HEDIS specifications
- Analytic file production

Technical Methods of Data Collection and Analysis

During 2010, the Department required that an NCQA-licensed audit organization conduct an independent audit of each MCO's measurement year (MY) 2009 data. The State contracted with HSAG to audit **FHN**, **Harmony,** and **Meridian**. The audits were conducted in a manner consistent with the 2010 NCQA *HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. The audit incorporated two main components:

- A detailed assessment of the MCO's IS capabilities for collecting, analyzing, and reporting HEDIS information.
- A review of the specific reporting methods used for HEDIS measures, including computer programming and query logic used to access and manipulate data and to calculate measures; databases and files used to store HEDIS information; medical record abstraction tools and abstraction procedures used; and any manual processes employed for 2010 HEDIS data production and reporting. The audit extends to include any data collection and reporting processes supplied by vendors, contractors, or third parties, as well as the MCO's oversight of these outsourced functions.

For each MCO, a specific set of performance measures was selected. This selection was based on factors such as Department-required measures, a full year of data, previously audited measures, and past performance. The measures selected for validation through the HEDIS compliance audits were the following:

- *Childhood Immunization Status*
- *Well-Child Visits in the First 15 Months of Life*
- *Prenatal and Postpartum Care*

The MCOs also reported on other HEDIS measures that were not validated during the audit, although the processes for collecting and calculating each measure were validated. Relatively new to the Medicaid program, and due to lower enrollment, **Meridian** only reported on *Children's and Adolescent's Access to Primary Care Practitioners, Adults' Access to Preventive/Ambulatory Health Services, and Prenatal and Postpartum Care* measures. The rates for these HEDIS measures are included in this report and consist of the following performance measures:

- *Lead Screening in Children*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life*
- *Adolescent Well-Care Visits*
- *Immunizations for Adolescents (Combined Rate)*
- *Children's and Adolescents' Access to Primary Care Practitioners (PCPs)*
- *Adults' Access to Preventive/Ambulatory Health Services*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Chlamydia Screening in Women*
- *Frequency of Ongoing Prenatal Care (<21 Percent Visits and ≤81Percent Visits)*
- *Controlling High Blood Pressure*

- *Comprehensive Diabetes Care*
- *Use of Appropriate Medications for People With Asthma*
- *Follow-up After Hospitalization for Mental Illness (7-Day Follow-Up and 30-Day Follow-Up)*

HSAG used a number of different methods and information sources to conduct the audits, including:

- Teleconference calls with MCO personnel and vendor representatives, as necessary.
- Detailed review of each MCO's completed responses to the HEDIS Record of Administration, Data Management and Processes (HEDIS RoadMap) published by NCQA as Appendix 2 to HEDIS Volume 5, and updated information communicated by NCQA to the audit team directly.
- On-site meetings in the MCOs' offices, including staff interviews, live system and procedure documentation, documentation review and requests for additional information, primary HEDIS data source verification, programming logic review and inspection of dated job logs, computer database and file structure review, and discussion and feedback sessions.
- Detailed evaluation of computer programming used to access administrative data sets and calculate HEDIS measures.
- If the hybrid method was used, re-abstraction of a sample of medical records selected by the auditors, with a comparison of the results to the MCO's review determinations for the same records.
- Requests for corrective actions and modifications to the MCO's HEDIS data collection and reporting processes and data samples, as necessary, and verification that actions were taken.
- Accuracy checks of the final HEDIS rates completed by the MCO.
- Interviews of a variety of individuals whose department or responsibilities played a role in the production of HEDIS data. Typically, such individuals included the HEDIS manager, IS director, quality management director, enrollment and provider data manager, medical records staff, claims processing staff, programmers, analysts, and others involved in the HEDIS preparation process. Representatives of vendors that provided or processed HEDIS 2010 (and earlier historical) data may also have been interviewed and asked to provide documentation of their work.

Each of the audited measures reviewed by the audit team received a final audit result consistent with the NCQA categories listed below. Table 3-1 provides the audit finding results that are applicable to the HEDIS measures.

Table 3-1—HEDIS Measure Audit Findings

Rate/Result	Comment
0-XXX	Reportable rate or numeric result for HEDIS measures
NR	Not Reported: 1. Plan chose not to report 2. Calculated rate was materially biased 3. Plan not required to report
NA	Small Denominator: The organization followed the specifications but the denominator was too small to report a valid rate
NB	No Benefit: The organization did not offer the health benefits required by the measure (e.g., mental health or chemical dependency)

For measures reported as percentages, NCQA has defined significant bias as a deviation of more than 5 percentage points from the true percentage. (For certain measures, a deviation of more than 10 percentage points in the number of reported events determines a significant bias.)

For some measures, more than one rate is required for HEDIS reporting (e.g., *Childhood Immunization Status* and *Well-Child Visits in the First 15 Months of Life*). It is possible that the MCO prepared some of the rates required by the measure appropriately but had significant bias in others. According to NCQA guidelines, the MCO would receive a reportable result for the measure as a whole, but significantly biased rates within the measure would receive an "NR" result in the Interactive Data Submission System (IDSS) portion of the measure, where appropriate.

After completing the audit, HSAG prepared a final audit report for the MCOs that included a completed and signed final audit statement. The reports were forwarded to the Department for review.

For the discussions that follow regarding conclusions drawn from the data for each MCO, full compliance is defined as the lack of any findings that would significantly bias HEDIS reporting by more than 5 percentage points. Additionally, when discussing rates for *Well-Child Visits in the First 15 Months of Life,* assessments were made for *0 Visits* and *6 or More Visits*, as those measures are most indicative of the range of quality of health care. *Frequency of Ongoing Prenatal Care* was also assessed using the two categories of *<21 Percent Visits* and *≤81 Percent Visits*.

To validate the medical record review (MRR) portion of the audit, NCQA policies and procedures require auditors to perform two steps: (1) review the MRR processes employed by the MCO, including staff qualifications, training, data collection instruments/tools, interrater reliability (IRR) testing, and the method used for combining MRR data with administrative data; and (2) re-abstract and compare the audit team's results to the MCO's abstraction results for a selection of hybrid measures.

HSAG's audit team reviewed the processes in place at each MCO for MRR performance for all measures reported using the hybrid method. The audit team reviewed data collection tools and training materials to verify that all key HEDIS data elements were captured. Feedback was provided to each MCO's staff if the data collection tools appeared to be missing necessary data elements.

HSAG's audit team also performed a re-abstraction of records selected for MRRs and compared the results to each MCO's findings for the same medical records. This process completed the medical record validation process and provided an assessment of actual reviewer accuracy. HSAG reviewed up to 30 records identified by each MCO as meeting numerator event requirements (determined through MRR) for measures selected for audit and MRR validation. Records were randomly selected from the entire population of MRR numerator positives identified by the MCO, as indicated on the MRR numerator listings submitted to the audit team. If fewer than 30 medical records were found to meet numerator requirements, all records were reviewed. Reported discrepancies only included "critical errors," defined as an abstraction error that affected the final outcome of the numerator event (i.e., changed a positive event to a negative one or vice versa).

For each of the selected measures where the hybrid methodology was used, auditors determined the impact of the findings from the validation process on the MCO's audit designation. The goal of the

MRR validation was to determine whether the MCO made abstraction errors that significantly biased its final reported rate. HSAG used the standardized protocol developed by NCQA to validate the integrity of the MRR processes of audited MCOs. The NCQA-endorsed *t*-test was employed to test the difference between the MCO's estimate of the positive rate and the audited estimate of the positive rate. If the test revealed that the difference was greater than 5 percent, the MCO's estimate of the positive rate was rejected and the measure could not be reported using the hybrid methodology.

Plan-Specific Findings

Family Health Network

The Medicaid HEDIS 2010 rates for **FHN** and the National Medicaid 2009 HEDIS 50th percentiles are presented below (Table 3-2). As a visual aid for quick reference, numbers highlighted in yellow indicate the rates that were at or above the 50th percentile.

FHN had eight measures with rates that exceeded the 50th percentiles. Three of those measures were in the Child and Adolescent Care category. One measure was in *Preventive Screening for Women*, and the four other measures were in the *Chronic Conditions/Disease Management* category. **FHN** performed the lowest on measures related to maternity care and access.

Table 3-2—FHN HEDIS 2010 Rates

HEDIS Measures	FHN	2009 HEDIS 50th Percentiles
Child and Adolescent Care		
Childhood Immunizations—Combo 2	75.5	77.9
Childhood Immunizations— Combo 3	69.7	71.8
Lead Screening in Children	82.2	70.5
*Well-Child Visits in the First 15 Months (0 Visits)**	5.1	1.5
Well-Child Visits in the First 15 Months (6+ Visits)	48.4	60.6
Well-Child Visits (3–6 Years)	79.2	70.4
Adolescent Well-Care Visits	45.7	45.1
Immunizations for Adolescents (Combined Rate)	18.2	NA
Children's and Adolescents' Access to PCPs		
12–24 Months	84.1	96.3
25 Months–6 Years	70.6	88.3
7–11 Years	47.8	89.0
12–19 Years	46.7	87.2
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years of Age	65.4	81.5
45–64 Years of Age	69.9	87.5
Preventive Screening for Women		
Breast Cancer Screening (Combined Rate)	44.9	50.5
Cervical Cancer Screening	63.9	67.6
Chlamydia Screening (Combined Rate)	56.4	54.8

Table 3-2—FHN HEDIS 2010 Rates		
HEDIS Measures	**FHN**	**2009 HEDIS 50th Percentiles**
Maternity-Related Measures		
*Frequency of Ongoing Prenatal Care (<21% Visits)**	16.9	8.3
Frequency of Ongoing Prenatal Care (≥81% Visits)	26.1	62.8
Timeliness of Prenatal Care	49.2	85.6
Postpartum Care	39.3	63.9
Chronic Conditions/Disease Management		
Controlling High Blood Pressure (Combined Rate)	27.0	58.0
Comprehensive Diabetes Care (HbA1C Testing)	77.6	80.7
Comprehensive Diabetes Care (Good HbA1c Control)	30.9	45.6
*Comprehensive Diabetes Care (Poor HbA1c Control)**	69.1	42.6
Comprehensive Diabetes Care (Eye Exam)	25.0	55.4
Comprehensive Diabetes Care (LDL-C Screening)	69.1	76.1
Comprehensive Diabetes Care (LDL-C Level <100 mg/Dl)	27.0	35.1
Comprehensive Diabetes Care (Monitoring for Diabetic Nephropathy)	85.5	78.1
Comprehensive Diabetes Care (BP <140/90 mm/Hg)	40.8	61.1
Comprehensive Diabetes Care (BP <130/80 mm/Hg)	13.8	31.6
Use of Appropriate Medications for People With Asthma (Combined Rate)	93.0	89.2
Follow-up After Hospitalization for Mental Illness—7-Day Follow-Up	66.9	44.5
Follow-up After Hospitalization for Mental Illness—30-Day Follow-Up	79.8	64.3
* Lower rates indicate better performance for these measures.		

Encounter Data Completeness for FHN

Table 3-3 provides an estimate of the data completeness for **FHN**'s hybrid performance measures. These measures use administrative encounter data and supplement the results with medical record data. The rates in the table represent the percentage of the final HEDIS rate that was determined solely through the use of administrative encounter data. A rate of 100 percent for the last column indicates that the encounter data was complete for that HEDIS measure. Rates listed in red text had less than a 50.0 percent encounter data completion rate.

Table 3-3—FHN Estimated Encounter Data Completeness for Hybrid Measures		
Performance Measures	Final HEDIS Rate	Percent Encounter Data
Childhood Immunizations— Combo 2	75.5	**0.9**
Childhood Immunizations— Combo 3	69.8	**0.3**
Lead Screening in Children	82.2	63.5
Well-Child Visits in the First 15 Months (6+ Visits)	48.3	**39.2**
Well-Child Visits (3–6 Years)	79.2	84.0
Adolescent Well-Care Visits	45.7	83.8
Immunizations for Adolescents (Combined Rate)	18.2	72.2
Breast Cancer Screening (Combined Rate)	44.9	55.8
Cervical Cancer Screening	63.9	67.0
Chlamydia Screening in Women (Combined Rate)	56.4	65.3
Frequency of Ongoing Prenatal Care (≥81% Visits)	26.1	75.2
Timeliness of Prenatal Care	49.2	62.9
Postpartum Care	39.3	60.6
Comprehensive Diabetes Care (HbA1c Testing)	77.6	**16.1**
Comprehensive Diabetes Care (Eye Exam)	25.0	52.6
Comprehensive Diabetes Care (LDL-C Screening)	69.1	**19.0**
Comprehensive Diabetes Care (Monitoring for Diabetic Nephropathy)	85.5	**40.0**

Overall, the results show that **FHN** did not receive all of their encounter data. Six measures had less than a 50.0 percent encounter data completeness rate. Although 11 of the 17 HEDIS measures had more than a 50.0 percent encounter data completeness rate, none of the measures were above 90.0 percent, two were above 80.0 percent, two were above 70.0 percent, and the remaining seven measures were above 50.0 percent.

FHN continued to demonstrate some difficulty in obtaining complete encounter data for childhood immunizations and lab-related measures for diabetes care. Childhood immunizations may have been provided at locations other than the provider's office (e.g., health fairs, schools), making data for the measure difficult to collect administratively.

Compliance Audit Results for FHN

The HEDIS 2010 compliance audit indicated that **FHN** was in full compliance with the *HEDIS 2010 Technical Specifications* (Table 3-4). Membership data supported all necessary HEDIS calculations, medical data were fully compliant with the audit standards, and measure calculations resulted in rates that were not significantly biased. Furthermore, all selected HEDIS performance measures attained an *R* designation.

Table 3-4—FHN 2009 HEDIS Compliance Audit Results			
Main Information Systems			Selected 2007 HEDIS Measures
Membership Data	Medical Data	Measure Calculation	All of the selected HEDIS measures received an *R* audit designation.
Fully Compliant	Fully Compliant	Fully Compliant	

The rationale for full compliance with membership data, medical data, and measure calculation was based on the findings summarized below for the IS standards. Any deviation from the standards that could bias the final results was identified. Recommendations for improving MCO processes were also identified.

IS 1.0—Medical Services Data—Sound Coding Methods and Data Capture, Transfer and Entry

FHN was not compliant with all of the IS 1.0 standards. **FHN** did not have a formal claims/encounter data processing system. The encounter data was stored in a Microsoft Access database. **FHN** did perform some encounter data edits; however, the edits were not comprehensive or current (i.e., during the on-site audit, the edit code set consisted of 2007 data). As a result, FHN was found to be noncompliant with IS Standards 1.4 and 1.5.

That **FHN** had no formal data checking processes in place; and, given that encounter data contained invalid codes and/or inaccurate provider IDs, the MCO was not in compliance with IS Standards 1.2, 1.4, 1.5, 1.6, and 1.7.

Due to the lack of encounter data and the significant amount of data with issues (according to **FHN**, approximately 25 percent of submitted encounter data were rejected from the State), using this data for HEDIS and State submission purposes was problematic. However, **FHN** continues to educate providers on the importance of encounter data completeness and submission, often traveling to their offices to discuss submission issues.

At a minimum, **FHN** must update to current code sets and implement a formal process for data entry standards for claims/encounters by next year.

IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry

FHN was compliant with IS 2.0 standards and met HEDIS reporting requirements. A monthly 834 file was received by **FHN** from the State, uploaded, and reconciled appropriately. **FHN** also reconciled the 820 capitation file to the 834 file. Membership increased 4 percent, a slight increase over the past year.

IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry

FHN was not compliant with all of the IS 3.0 standards. **FHN** was able to determine primary care practitioners (PCPs) and specialists, which was important for the measures under review. However, not all encounter data was submitted with a valid provider ID as required for HEDIS reporting by IS Standard 3.3 (i.e., data entry processes are timely and accurate and include edit checks to ensure accurate entry of submitted data in transaction files). In addition, IS Standard 3.4 requires plans to ensure complete submission and entry of provider data. To report on the measures, **FHN** did not use numerator positive hits when the provider type could not be determined, and instead, relied on

medical record review. The lack of valid provider IDs contributed to a significant amount of rejected encounter data submission to the State, which could result in **FHN** becoming noncompliant with State contractual obligations.

IS 4.0—Medical Record Review Processes—Training, Sampling, Abstraction and Oversight

FHN was fully compliant with IS 4.0 standards and meets HEDIS reporting requirements. **FHN** did not use certified software; in-house staff members stored medical record data in a Microsoft Access database designed by the health plan. HSAG reviewed the data abstraction tools and corresponding instructions. The data abstraction tools contained all of the required HEDIS measure-specific data elements and appropriate edits. The processes in place for training, procurement, abstraction, IRR and data entry were sufficient to ensure reliability of the data collected. There were no changes to the medical record process for 2010; therefore, a convenience sample was not required. As shown in Table 3-5 below, **FHN** passed the over-read requirement for *Childhood Immunization Status (Combination 3)* and *Timeliness of Prenatal Care*.

Table 3-5—FHN Selected HEDIS Measures for Medical Record Validation

Measure	Product Line	Number of Records	*t*-test	Pass/Fail
Childhood Immunization Status (Combo 3)	Medicaid	30	N/A	Pass
Timeliness of Prenatal Care	Medicaid	30	N/A	Pass

IS 5.0—Supplemental Data—Capture, Transfer and Entry

FHN is compliant with IS 5.0 standards. Supplemental data from the State includes immunization data (from the CornerStone system) and from the Healthy Kids program. External standard data, both of these datasets were audited in prior years, including an on-site State audit. The immunization data for rotavirus did not contain the CPT code to map to the 2-dose or 3-dose series of the immunization. However, the combinations with rotavirus were not under the scope of the audit for this year. Last year's audited medical record data was also retained for use this year, although it did not apply to the measures under review for this audit.

IS 6.0—Member Call Center Data—Capture, Transfer, and Entry

Member call center data was not applicable under the scope of the audit.

IS 7.0—Data Integration—Accurate HEDIS Reporting, Control Procedures That Support HEDIS Reporting Integrity

FHN was compliant with IS 7.0 standards and met HEDIS reporting requirements. **FHN** had adequate data reconciliation steps in place with all sources of data including vendor and supplemental data. A HEDIS repository was not used as data were queried from several Microsoft Access databases. Primary source verification was performed for all three measures under the scope of the audit. HSAG noted no issues with primary source verification. In addition, **FHN** passed the source code review.

The results from the HEDIS compliance audit indicated there were deficiencies in several areas as of the HEDIS 2010 reporting period ending June 15, 2010. HFS, **FHN**, and HSAG discussed corrective actions that **FHN** needed to perform in order to attain compliance with the audit

standards. **FHN** has since implemented these corrective actions, which will be validated and discussed in the next annual report.

FHN Trended Results

Table 3-6 provides the results of **FHN**'s trended performance measures for 2008, 2009 and 2010. The last column of the table denotes the difference in the rates between the HEDIS 2008 rate and HEDIS 2010 results.

Table 3-6—FHN Trended HEDIS Results

HEDIS Measures	HEDIS 2008	HEDIS 2009	HEDIS 2010	Difference from Baseline
Childhood Immunizations—Combo 2	68.9	72.0	75.5	**6.6**
Childhood Immunizations—Combo3	53.0	65.8	69.7	**16.7**
Lead Screening in Children	70.4	69.5	82.2	**11.8**
*Well-Child Visits in the First 15 Months (0 Visits)**	10.0	7.7	5.1	-4.9*
Well-Child Visits in the First 15 Months (6+ Visits)	29.0	43.5	48.4	**19.4**
Well-Child Visits (3–6 Years)	68.4	74.8	79.2	**10.8**
Adolescent Well-Care Visits	32.2	36.9	45.7	**13.5**
Children's and Adolescents' Access to PCP (12–24 Months)	77.3	81.8	84.1	**6.8**
Children's and Adolescents' Access to PCP (25 Months–6 Years)	65.2	68.9	70.6	**5.4**
Children's and Adolescents' Access to PCP (7–11 Years)	52.4	49.5	47.8	-4.6
Children's and Adolescents' Access to PCP (12–19 Years)	48.4	49.9	46.7	-1.7
Adults' Access to Preventive/Ambulatory Health Services (20–44 Years)	56.6	59.4	65.4	**8.8**
Adults' Access to Preventive/Ambulatory Health Services (45–64 Years)	48.6	58.8	69.9	**21.3**
Breast Cancer Screening (Combined Rate)	27.8	33.9	44.9	**17.1**
Cervical Cancer Screening	68.0	55.4	63.9	-4.1
Chlamydia Screening in Women (Combined Rate)	47.7	53.7	56.4	**8.7**
*Frequency of Ongoing Prenatal Care (<21% Visits)**	29.4	39.3	16.9	**-12.5***
Frequency of Ongoing Prenatal Care (≥81% Visits)	33.4	25.6	26.1	**-7.3**
Timeliness of Prenatal Care	45.4	49.4	49.2	3.8
Postpartum Care	32.3	32.9	39.3	**7.0**
Controlling High Blood Pressure (Combined Rate)	45.3	54.6	27.0	**-18.3**
Comprehensive Diabetes Care (HbA1C Testing)	68.5	66.9	77.6	**9.1**
Comprehensive Diabetes Care (Good HbA1c Control)	12.0	27.0	30.9	**18.9**
*Comprehensive Diabetes Care (Poor HbA1c Control)**	56.5	65.5	69.1	**12.6***
Comprehensive Diabetes Care (Eye Exam)	22.8	24.3	25.0	2.2

Table 3-6—FHN Trended HEDIS Results				
HEDIS Measures	HEDIS 2008	HEDIS 2009	HEDIS 2010	Difference from Baseline
Comprehensive Diabetes Care (LDL-C Screening)	56.5	60.8	69.1	**12.6**
Comprehensive Diabetes Care (LDL-C Level <100 mg/Dl)	15.2	19.6	27.0	**11.8**
Comprehensive Diabetes Care (Monitoring for Diabetic Nephropathy)	57.6	79.7	85.5	**27.9**
Comprehensive Diabetes Care (BP <140/90 mm/Hg)	51.1	45.3	40.8	**-10.3**
Comprehensive Diabetes Care (BP <130/80 mm/Hg)	22.8	27.0	13.8	**-9.0**
Use of Appropriate Medications for People With Asthma (Combined Rate)	79.3	85.0	93.0	**13.7**
Follow-up After Hospitalization for Mental Illness—7-Day Follow-Up	56.4	64.2	66.9	**10.5**
Follow-up After Hospitalization for Mental Illness—30-Day Follow-Up	67.9	76.5	79.8	**11.9**
* **Lower rates indicate better performance for these measures.**				

The results show that 25 of the 33 trended measures improved since HEDIS 2008, and 22 measures improved by more than 5.0 percentage points. *Comprehensive Diabetes Care* (*Monitoring for Diabetic Nephropathy*) and *Adult's Access to Preventive/Ambulatory Health Services (45–64 Years)* each improved by more than 20.0 percentage points. Despite the improvements over time, results for the majority of the rates were still below the national Medicaid 2009 HEDIS 50th percentiles.

Rates for 8 of the 33 measures had declined. Four of those declines were more than 5.0 percentage points. Of particular concern was the 18.3 percentage point decrease for *Controlling High Blood Pressure* and the 12.6 percent decline for *Comprehensive Diabetes Care (Poor HbA1c Control).*

Harmony Health Plan

The Medicaid HEDIS 2010 rates for **Harmony** and the national Medicaid 2009 HEDIS 50th percentiles are presented in Table 3-7. As a visual aid for quick reference, numbers highlighted in yellow indicate the rates that were at or above the 50th percentile.

Harmony reported three measures with rates above the 50th percentiles: *Lead Screening in Children*, *Cervical Cancer Screening*, and *Follow-up After Hospitalization for Mental Illness—7-Day Follow-Up*. **Harmony** generally performed the lowest on the diabetes care measures.

Table 3-7—Harmony HEDIS 2010 Rates		
HEDIS Measures	Harmony	2009 HEDIS 50th Percentiles
Child and Adolescent Care		
Childhood Immunizations— Combo 2	67.4	77.9
Childhood Immunizations— Combo 3	60.6	71.8
Lead Screening in Children	74.7	70.5
*Well-Child Visits in the First 15 Months (0 Visits)**	4.1	1.5

Table 3-7—Harmony HEDIS 2010 Rates		
HEDIS Measures	**Harmony**	**2009 HEDIS 50th Percentiles**
Well-Child Visits in the First 15 Months (6+ Visits)	45.7	60.6
Well-Child Visits (3–6 Years)	69.8	70.4
Adolescent Well-Care Visits	37.2	45.1
Immunizations for Adolescents (Combined Rate)	23.4	NA
Children's and Adolescents' Access to PCPs		
12–24 Months	82.2	96.3
25 Months–6 Years	73.1	88.3
7–11 Years	69.3	89.0
12–19 Years	68.6	87.2
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years of Age	67.3	81.5
45–64 Years of Age	67.6	87.5
Preventive Screening for Women		
Breast Cancer Screening (Combined Rate)	31.5	50.5
Cervical Cancer Screening	69.3	67.6
Chlamydia Screening in Women (Combined Rate)	49.9	54.8
Maternity-Related Measures		
*Frequency of Ongoing Prenatal Care (<21% Visits)**	17.8	8.3
Frequency of Ongoing Prenatal Care (≥81% Visits)	39.4	62.8
Timeliness of Prenatal Care	65.2	85.6
Postpartum Care	49.6	63.9
Chronic Conditions/Disease Management		
Controlling High Blood Pressure (Combined Rate)	43.3	58.0
Comprehensive Diabetes Care (HbA1C Testing)	67.0	80.7
Comprehensive Diabetes Care (Good HbA1c Control)	28.8	45.6
*Comprehensive Diabetes Care (Poor HbA1c Control)**	64.2	42.6
Comprehensive Diabetes Care (Eye Exam)	15.0	55.4
Comprehensive Diabetes Care (LDL-C Screening)	58.2	76.1
Comprehensive Diabetes Care (LDL-C Level <100 mg/Dl)	18.6	35.1
Comprehensive Diabetes Care (Monitoring for Diabetic Nephropathy)	68.4	78.1
Comprehensive Diabetes Care (BP <140/90 mm/Hg)	51.3	61.1
Comprehensive Diabetes Care (BP <130/80 mm/Hg)	23.9	31.6
Use of Appropriate Medications for People With Asthma (Combined Rate)	86.5	89.2
Follow-up After Hospitalization for Mental Illness—7-Day Follow-up	49.2	44.5
Follow-up After Hospitalization for Mental Illness—30-Day Follow-Up	58.7	64.3
* **Lower rates indicate better performance for these measures.**		

Encounter Data Completeness for Harmony

Table 3-8 provides an estimate of the data completeness for **Harmony**'s hybrid performance measures. These measures use administrative encounter data and supplement the results with medical record data. The rates in the table represent the percentage of the final HEDIS rate that was determined solely through the use of administrative encounter data. A rate of 100 percent for the last column indicates that the encounter data was complete for that HEDIS measure.

Table 3-8–Harmony Estimated Encounter Data Completeness for Hybrid Measures

Performance Measures	Final HEDIS Rate	Percent Encounter Data
Childhood Immunizations—Combo 2	67.4	74.4
Childhood Immunizations— Combo 3	60.6	62.7
Lead Screening in Children	74.7	84.0
Well-Child Visits in the First 15 Months (6+ Visits)	45.7	78.7
Well-Child Visits (3–6 Years)	69.8	93.4
Adolescent Well-Care Visits	37.2	92.8
Cervical Cancer Screening	69.3	93.0
Frequency of Ongoing Prenatal Care (≥81% Visits)	39.4	86.4
Timeliness of Prenatal Care	65.2	86.9
Postpartum Care	49.6	76.0
Comprehensive Diabetes Care (HbA1c Testing)	67.0	78.7
Comprehensive Diabetes Care (Eye Exam)	15.0	69.5
Comprehensive Diabetes Care (LDL-C Screening)	58.2	77.1
Comprehensive Diabetes Care (Monitoring for Diabetic Nephropathy)	68.4	93.9

The rates indicate **Harmony** demonstrated sound encounter data completeness. Four measures had more than a 90.0 percent data completion rate, three were above 80.0 percent, five were above 70.0 percent, and the remaining two measures were above 60.0 percent.

As with **FHN**, **Harmony** continued to demonstrate some difficulty in obtaining complete encounter data for childhood immunizations and some lab-related measures for diabetes care. Childhood immunizations may have been provided at locations other than the provider's office (e.g., health fairs, schools), making data for the measure difficult to collect administratively. **Harmony** should continue to work toward obtaining complete lab data.

Compliance Audit Results for Harmony

The HEDIS 2010 compliance audit indicated that **Harmony** was in full compliance with the *HEDIS 2010 Technical Specifications* (Table 3-9). Membership data supported all necessary HEDIS calculations, medical data were fully compliant with the audit standards, and measure calculations resulted in rates that were not significantly biased. Furthermore, all selected HEDIS performance measures attained an *R* designation.

Table 3-9—Harmony HEDIS 2009 Compliance Audit Results			
Main Information Systems			Selected 2007 HEDIS Measures
Membership Data	Medical Data	Measure Calculation	All of the selected HEDIS measures received an *R* audit designation.
Fully Compliant	Fully Compliant	Fully Compliant	

The rationale for full compliance with membership data, medical data, and measure calculation was based on the findings summarized below for the IS standards. Any deviation from the standards that could bias the final results was identified. Recommendations for improving MCO processes were also identified.

IS 1.0—Medical Services Data—Sound Coding Methods and Data Capture, Transfer and Entry

Harmony was fully compliant with IS Standard 1.0. Edit checks were appropriately employed throughout both claim and encounter systems. Industry standard codes (e.g., ICD-9-CM, CPT, DRG, HCPCS) were used; and all characters were captured, principle codes were identified and secondary codes were captured. Nonstandard coding schemes were not used. **Harmony** used standard submission forms and was able to capture all fields relevant to HEDIS reporting. There were no proprietary forms used to capture data, and electronic transmission procedures conformed to industry standards. **Harmony** met all data entry standards, and their processes were timely and accurate. Processes included sufficient edit checks to ensure accurate entry of submitted data in transaction files for HEDIS reporting. **Harmony** regularly monitored performance against expected performance standards. The auditor did not find any issues with this standard.

IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry

Harmony was fully compliant with IS 2.0. There were no concerns with the processing of the enrollment file received from the State. Monthly files were received and loaded into the data system.

Membership information processing complied with standards. There were sufficient edits checks in place to ensure files loaded did not contain errors. Each month, the enrollment files were reconciled against the capitation file as an additional validation check to ensure that all eligible members were being flagged for service and payment. The auditor did not find any issues with this standard.

IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry

Harmony was fully compliant with IS 3.0. **Harmony** used Visual Cactus and Peradigm software for provider credentialing and provider directory storage. Specialties are accounted for in this system as well as subspecialties. Provider board certifications are also captured for all specialties

associated with a provider. Sufficient provider identifiers are in place to appropriately monitor and count providers. All provider mappings are sent to Visual Cactus and McKesson for use in the administrative measures. The auditor did not find any issues with this standard.

IS 4.0—Medical Record Review Processes—Training, Sampling, Abstraction and Oversight

Harmony was fully compliant with the IS 4.0 reporting process. CRMS was used as the plan's certified software vendor and Outcomes as their medical record vendor. Outcomes review staff used the Outcomes data abstraction tools to collect hybrid data. Data integration was reviewed during the audit and met IS 4.10 requirements. HSAG reviewed Outcomes tools and corresponding instructions. The data abstraction tools contained all of the required HEDIS measure-specific data elements and appropriate edits. The processes in place for training, procurement, abstraction, IRR, and data entry were sufficient to ensure reliability of the data collected. There were no changes to the medical record process for 2010; therefore, a convenience sample was not required. As shown in Table 3-10 below, **Harmony** passed the over-read requirement for *Well-Child Visits in the First 15 Months of Life (6+ Visits)*, and *Postpartum Care*. During over-read of the *Frequency of Ongoing Prenatal Care* measure, one critical error was identified. A *t*-test did not detect a bias, nor was there an impact to the measure.

Table 3-10—Harmony Selected HEDIS Measures for Medical Record Validation

Measure	Product Line	Number of Records	T-test	Pass/Fail
Well-Child Visits in the First 15 Months of Life (6+ Visits)	Medicaid	30	-3.958	Pass
Postpartum Care	Medicaid	30	-11.272	Pass

IS 5.0—Supplemental Data—Capture, Transfer and Entry

Harmony was fully compliant with IS 5.0. **Harmony** used two nonstandard supplemental data sources for reporting Medicaid measures. The immunization registries Cornerstone and Harmony Kids were received monthly and there were no reported issues during 2009. During the load process to the data warehouse, edit checks ensured that members in the registry are actual members of the health plan. The edit checks also determined if standard codes were being submitted. Both databases did not provide significant hits for inclusion in the final rates. This may be a source of valuable data in the future. The auditor did not find any issues with this standard.

IS 6.0—Member Call Center Data—Capture, Transfer, and Entry

Member call center data was not applicable to the scope of the audit.

IS 7.0—Data Integration—Accurate HEDIS Reporting, Control Procedures That Support HEDIS Reporting Integrity

Harmony was fully compliant with IS 7.0. **Harmony** consolidated data from several different data sources and platforms. **Harmony** maintained sufficient processes to integrate these data sources for HEDIS reporting. **Harmony** was using McKesson certified software to report its measures. **Harmony** provided sufficient mapping documents to ensure that appropriate fields were mapped. Initial rates were available from McKesson and seemed to be on target compared to the previous years' rates. The audit team conducted primary source verification on a select set of measures and found all to be compliant. The auditor did not find any issues with this standard.

Harmony Trended Results

Table 3-11 provides the results of **Harmony**'s trended performance measures for 2008, 2009, and 2010. The last column of the table denotes the difference in the rates between the first reportable HEDIS rate and HEDIS 2010 results.

Table 3-11—Harmony Trended HEDIS Results				
HEDIS Measures	HEDIS 2008	HEDIS 2009	HEDIS 2010	Difference from Baseline
Childhood Immunizations—Combo 2	53.8	62.5	67.4	**13.6**
Childhood Immunizations—Combo 3	42.8	51.6	60.6	**17.8**
Lead Screening in Children	65.9	69.8	74.7	**8.8**
*Well-Child Visits in the First 15 Months (0 Visits)**	9.2	4.6	4.1	**-5.1**
Well-Child Visits in the First 15 Months (6+ Visits)	21.7	40.4	45.7	**24.0**
Well-Child Visits (3–6 Years)	57.4	65.9	69.8	**12.4**
Adolescent Well-Care Visits	37.7	37.7	37.2	-0.5
Children's and Adolescents' Access to PCP (12–24 Months)	82.5	83.3	82.2	-0.3
Children's and Adolescents' Access to PCP (25 Months–6 Years)	65.7	70.1	73.1	**7.4**
Children's and Adolescents' Access to PCP (7–11 Years)	60.7	61.6	69.3	**8.6**
Children's and Adolescent's Access to PCP (12–19 Years)	58.7	60.8	68.6	**9.9**
Adults' Access to Preventive/Ambulatory Health Services (20–44 Years)	57.5	66.3	67.3	**9.8**
Adults' Access to Preventive/Ambulatory Health Services (45–64 Years)	54.6	63.3	67.6	**13.0**
Breast Cancer Screening (Combined Rate)	35.5	32.5	31.5	-4.0
Cervical Cancer Screening	59.1	62.0	69.3	**10.2**
Chlamydia Screening in Women (Combined Rate)	49.3	48.8	49.9	0.6
*Frequency of Ongoing Prenatal Care (<21% Visits)**	21.9	27.0	17.8	-4.1
Frequency of Ongoing Prenatal Care (≥81% Visits)	31.4	33.6	39.4	**8.0**
Timeliness of Prenatal Care	56.4	56.4	65.2	**8.8**
Postpartum Care	35.0	40.1	49.6	**14.6**
Controlling High Blood Pressure (Combined Rate)	34.3	39.7	43.3	**9.0**
Comprehensive Diabetes Care (HbA1C Testing)	57.7	68.1	67.0	**9.3**
Comprehensive Diabetes Care (Good HbA1c Control)	15.6	24.6	28.8	**13.2**
*Comprehensive Diabetes Care (Poor HbA1c Control)**	72.7	67.3	64.2	**-8.5**
Comprehensive Diabetes Care (Eye Exam)	9.0	13.3	15.0	**6.0**
Comprehensive Diabetes Care (LDL-C Screening)	52.3	58.0	58.2	**5.9**
Comprehensive Diabetes Care (LDL-C Level <100 mg/Dl)	12.4	17.7	18.6	**6.2**
Comprehensive Diabetes Care (Monitoring for Diabetic Nephropathy)	59.9	69.9	68.4	**8.5**

Table 3-11—Harmony Trended HEDIS Results				
HEDIS Measures	HEDIS 2008	HEDIS 2009	HEDIS 2010	Difference from Baseline
Comprehensive Diabetes Care (BP <140/90 mm/Hg)	45.0	54.0	51.3	**6.3**
Comprehensive Diabetes Care (BP <130/80 mm/Hg)	23.6	27.4	23.9	0.3
Use of Appropriate Medications for People With Asthma (Combined Rate)	84.1	86.6	86.5	2.4
Follow-up After Hospitalization for Mental Illness—7-Day Follow-Up	20.0	43.2	49.2	**29.2**
Follow-up After Hospitalization for Mental Illness—30-Day Follow-Up	32.3	55.6	58.7	**26.4**
*** Lower rates indicate better performance for these measures.**				

The results show that 26 of the 33 trended measures improved since HEDIS 2008, and ten measures improved by more than 10.0 percentage points. *Follow-up After Hospitalization for Mental Illness—7-day Follow-Up and 30-day Follow-Up*) improved by more than 25.0 percentage points. Despite the improvements over time, results for the majority of the rates were still below the national Medicaid 2009 HEDIS 50th percentiles.

Rates for seven of the 33 measures have declined. However, none of those declines were more than 5.0 percentage points, and four measures declined by less than one percentage point.

Meridian Health Plan

Meridian received a final audit statement indicating that the selected performance measures for the audit were prepared in accordance with the *HEDIS 2010 Technical Specifications* and presented fairly the MCO's performance with respect to these specifications. HSAG found that **Meridian** had:

- Information systems that met HEDIS standards with no significant impact on the reliability of HEDIS reporting.
- Valid MRR processes.
- Performance measures (for those included in the audit) that followed HEDIS specifications and provided a reportable rate for the measure.

Due to its low population, **Meridian** did not have more than 30 eligible members for any of the reported HEDIS measures. In accordance with NCQA, the rates for these measures are not applicable (NA). Therefore, **Meridian**'s rates are not presented for this year.

Meridian is expected to have a larger population next year and should be able to report rates for some measures. Measures that rely on more than one year of continuous enrollment may still have a low volume.

Compliance Audit Results for Meridian

The HEDIS 2010 compliance audit indicated that **Meridian** was in full compliance with the *HEDIS 2010 Technical Specifications* (Table 3-12). Membership data supported all necessary HEDIS calculations, medical data were fully compliant with the audit standards, and measure calculations resulted in rates that were not significantly biased. Furthermore, all selected HEDIS performance measures attained an *R* designation.

Table 3-12—Meridian HEDIS 2009 Compliance Audit Results			
Main Information Systems			Selected 2007 HEDIS Measures
Membership Data	Medical Data	Measure Calculation	All of the selected HEDIS measures received an *R* audit designation.
Fully Compliant	Fully Compliant	Fully Compliant	

The rationale for full compliance with membership data, medical data, and measure calculation was based on the findings summarized below for the IS standards. Any deviation from the standards that could bias the final results was identified. Recommendations for improving MCO processes were also identified.

IS 1.0—Medical Services Data—Sound Coding Methods and Data Capture, Transfer and Entry

Meridian was compliant with I.S. Standard 1.0 and met HEDIS reporting requirements. No issues were identified with the claims processing system. **Meridian** used optical character recognition (OCR) and vertexing to process data into MCS. All data (e.g., claims, provider, and enrollment) were stored in MCS, allowing for a completely integrated system. Approximately 40 percent of data received were paper claims. All claims that were vertexed were audited at a rate of 5 percent; however, **Meridian** did not differentiate between the Health Plan of Michigan (HPM) and **Meridian**. For next year, **Meridian** should be able to show that data for Illinois were included in this audit. Reports from **Meridian** this year found some data were audited. Given the enrollment was less than 600 as of the end of the year, the low volume of claims (i.e., <300 per month) and that most data were EDI, there was no impact on HEDIS reporting for this year. **Meridian** has since implemented changes to address auditing claims data for Illinois. These changes will be validated and discussed in the next annual report.

IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry

Meridian was compliant with I.S. Standard 2.0 and met HEDIS reporting requirements. No issues were identified with enrollment data. **Meridian** was able to maintain enrollment history and link across product lines if necessary, although **Meridian** only supports Medicaid in Illinois.

IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry

Meridian was compliant with I.S. Standard 3.0 and met HEDIS reporting requirements. **Meridian** was able to distinguish provider types and specialties required for HEDIS reporting. All providers were paid on a fee-for service (FFS) basis, and data completion was not an issue.

IS 4.0—Medical Record Review Processes—Training, Sampling, Abstraction and Oversight

Meridian was technically compliant with IS 4.0 and met HEDIS reporting requirements. **Meridian** did not use a certified software vendor. The medical record vendor, MRG, used its data abstraction

tools for medical record data collection. The data abstraction tools contained all of the required HEDIS measure specific data elements and appropriate edits. The processes in place for training, procurement, abstraction, IRR, and data entry were sufficient to ensure reliability of the data collected. The only measure that involved medical record pursuit was the *Prenatal and Postpartum Care (PPC)* measure. **Meridian** only needed to pursue one case out of the entire PPC sample of 24 members. Due to the small sample size, **Meridian** decided to collect the PPC data for the one member using an administrative spreadsheet instead of the MRG tool. The plan calculated compliance manually for the one member. Given there was only one case, HSAG approved this process. Furthermore, the one member represented a numerator negative case, so medical record over-read was not necessary.

IS 5.0—Supplemental Data—Capture, Transfer and Entry

Meridian was compliant with I.S. Standard 5.0 and met HEDIS reporting requirements. There were no issues identified with the supplemental data. Supplemental data from the State was validated by asking the provider for a copy from the medical record. The State mapped the data to the appropriate codes (except for rotavirus, which is not under the scope of this audit). **Meridian's** 35 supplemental data records were then entered and became administrative data for the measures (i.e., were combined with claims data).

IS 6.0—Member Call Center Data—Capture, Transfer, and Entry

Member call center data was not applicable to the scope of this audit.

IS 7.0—Data Integration—Accurate HEDIS Reporting, Control Procedures That Support HEDIS Reporting Integrity

Meridian was compliant with I.S. Standard 7.0 and met HEDIS reporting requirements. There were no issues identified with data integration. Supplemental data was acceptable, as discussed above, and there were valid data integration processes and procedures in place. The source code passed review, although **Meridian** chose to calculate the PPC rate manually due to the small denominator size of 24 cases. The primary source validation did not identify any issues.

Validation of Performance Improvement Projects—SFY 2009–2010

Objectives

As part of its quality assessment and performance improvement program, the Department requires each health plan to conduct PIPs in accordance with 42 CFR 438.240. The purpose of a PIP is to achieve through ongoing measurements and intervention significant improvements in clinical and nonclinical areas of care that are sustained over time. This structured method of assessing and improving health plan processes can have a favorable effect on health outcomes and member satisfaction. Additionally, as one of the mandatory EQR activities under the BBA, the State is required to validate the PIPs conducted by its contracted MCOs and prepaid inpatient health plans (PIHPs). The Department contracted with HSAG to meet this validation requirement.

The primary objective of PIP validation was to determine each health plan's compliance with requirements set forth in 42 CFR 438.240(b)(1), including:

- Measurement of performance using objective quality indicators.
- Implementation of systematic interventions to achieve improvement in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

For such projects to achieve real improvements in care and member satisfaction, as well as confidence in the reported improvements, PIPs must be designed, conducted, and reported using sound methodology and must be completed in a reasonable time period.

Beginning in SFY 2004–2005, the Department required each MCO to participate in a mandatory statewide PIP focused on improving performance related to EPSDT screenings and visits, including the content of care for children younger than 3 years of age. Following the baseline EPSDT study, the MCOs were required to implement interventions to improve EPSDT rates. The intervention period was to be conducted during SFY 2005–2006, with a remeasurement phase scheduled for SFY 2006–2007. Based on the findings from the baseline EPSDT study, however, the Department and the HFS MCOs decided to continue their intervention efforts through SFY 2006–2007. Furthermore, the Department and the MCOs agreed that an EPSDT provider survey should be conducted in SFY 2006–2007 to help identify potential barriers providers may encounter in providing EPSDT services. With the results of this analysis, the HFS MCOs could pinpoint areas to target for intervention. Administration of the survey was initiated on May 4, 2007, and completed on July 20, 2007. In 2009, HSAG validated Remeasurement 1 for **FHN** and **Harmony**, and **Meridian** began conducting initial EPSDT PIP activities.

At the request of the health plans and approved by HFS, HSAG postponed PIP evaluation activities to a point that would better correspond to health plans' reporting cycles. Due to this shift in the timing of the PIP evaluation activities, approximately 18 months elapsed between evaluation cycles. As a result, the current report does not include the updated 2009 PIP results.

In SFY 2005–2006, the Department implemented a requirement that each MCO participate in a statewide PIP with a study topic and methodology established by the Department in collaboration with the MCOs. The SFY 2005–2006 Department-specified PIP, which continued in SFY 2006–2007, focused on perinatal care and depression screening. During SFY 2006–2007 the MCOs were in the intervention phase of the perinatal care and depression screening PIP. Remeasurement 3 took place for women in **FHN** and **Harmony** who had live births between November 6, 2007, and November 5, 2008. **Meridian** began conducting initial perinatal care and depression screening PIP activities in 2009.

In SFY 2005–2006, **FHN** and **Harmony** began conducting PIPs on asthma care (i.e., increasing the use of appropriate medications for members with asthma), and both MCOs performed Remeasurement 2 in 2008.

In SFY 2008–2009, the Department required that each MCO participate in a statewide PIP on improving ambulatory follow-up and PCP communication. The Department, in collaboration with the MCOs, established the study topic and methodology.

In SFY 2009–2010, **FHN, Harmony**, and **Meridian** continued their *Improving Ambulatory Follow-Up and PCP Communication* and *EPSDT Screening* PIP activities. **Meridian** also was engaged with a *Perinatal Care and Depression Screening* PIP.

Table 3-13 displays the baseline and remeasurement periods for the collaborative PIPs.

Table 3-13—Collaborative PIP Baseline and Remeasurement Periods

Family Health Network	Baseline	Remeasurement 1	Remeasurement 2	Remeasurement 3	Remeasurement 4
Ambulatory Follow-Up	1/1/09-12/31/09	1/1/10-12/31/2010	1/1/11-12/31/11	1/1/12-12/31/12	
EPSDT	1/1/04-12/31/04	1/1/07-12/31/07	1/1/09-12/31/09	1/1/10-12/31/10	
Perinatal	11/6/04-11/5/05	11/6/05-11/5/06	11/6/06-11/5/07	11/6/07-11/5/08	11/6/08-11/5/09
Harmony	**Baseline**	**Remeasurement 1**	**Remeasurement 2**	**Remeasurement 3**	**Remeasurement 4**
Ambulatory Follow-Up	1/1/09-12-31/09	1/1/10-12/31/2010	1/1/11-12/31/11	1/1/12-12/31/12	
EPSDT	1/1/04-12/31/04	1/1/07-12/31/07	1/1/08-12/31/08	1/1/09-12/31/09	
Perinatal	11/6/04-11/5/05	11/6/05-11/5/06	11/6/06-11/5/07	11/6/07-11/5/08	11/6/08-11/5/09
Meridian	**Baseline**	**Remeasurement 1**	**Remeasurement 2**	**Remeasurement 3**	
Ambulatory Follow-Up	1/1/09-12/31/09	1/1/10-12/31/2010	1/1/11-12/31/11	1/1/12-12/31/12	
EPSDT	1/1/09-12/31/09	1/1/10-12/31/2010	1/1/11-12/31/11	1/1/12-12/31/12	
Perinatal	1/1/09-12/31/09	1/1/10-12/31/2010	1/1/11-12/31/11	1/1/12-12/31/12	

To continue the objective of enhancing the MCOs' knowledge and expertise in conducting PIPs, HSAG provided ongoing technical assistance to the Department and the MCOs on study methodology development, including study question selection, study indicator identification, and data analysis plan establishment throughout the PIP process. Furthermore, through a statewide collaborative, HSAG served as an advisor to the MCOs and provided technical assistance on sampling methodology, medical record abstraction, and data submission format.

Technical Methods of Data Collection and Analysis

The methodology used to validate PIPs was based on CMS guidelines as outlined in the CMS publication, *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities,* Final Protocol, Version 1.0, May 1, 2002 (CMS PIP Protocol). Using this protocol, HSAG, in collaboration with the Department, developed the PIP Summary Form, which each health plan completed and submitted to HSAG for review and evaluation. The PIP Summary Form standardized the process for submitting information regarding PIPs and ensured that the projects addressed all CMS PIP Protocol requirements.

HSAG, with the Department's input and approval, developed a PIP validation tool to ensure uniform validation of PIPs. Using this tool, HSAG reviewed each of the PIPs for the following 10 CMS PIP Protocol activities:

- Activity I. Appropriate Study Topic
- Activity II. Clearly Defined, Answerable Study Question
- Activity III. Clearly Defined Study Indicator(s)
- Activity IV. Correctly Identified Study Population
- Activity V. Valid Sampling Techniques (if Sampling Was Used)
- Activity VI. Accurate/Complete Data Collection
- Activity VII. Appropriate Improvement Strategies
- Activity VIII. Sufficient Data Analysis and Interpretation
- Activity IX. Real Improvement Achieved
- Activity X. Sustained Improvement Achieved

HSAG calculated the percentage score of evaluation elements met for each MCO by dividing the total elements *Met* by the total elements *Met*, *Partially Met*, and *Not Met*. Any evaluation element that received a *Not Applicable* or *Not Assessed* designation was not included in the overall score. While all elements are important in assessing a PIP, HSAG designated some elements as critical to producing valid and reliable results and for demonstrating high confidence in the PIP findings. These critical elements must be *Met* for the PIP to be in compliance. The percentage score of critical elements *Met* was calculated by dividing the total *Met* critical elements by the total critical elements *Met*, *Partially Met*, and *Not Met*. A *Partially Met* validation status indicates low confidence in the reported PIP results.

Table 3-14 shows the current evaluation scoring for the PIPs. The table presents each MCO, the PIPs for which each MCO is responsible, and the current validation status of each PIP.

Table 3-14—Percent of All Elements Met

PIP Topics	FHN	Harmony	Meridian
EPSDT Screening	94%	85%	100%
Perinatal Care and Depression Screening	92%	87%	100%
Improving Ambulatory Follow-Up and PCP Communication	100%	91%	100%

Both **FHN** and **Harmony** PIP scores show a basic overall understanding of the quality improvement process, which is the generalized process underlying PIP evaluation and measurement.

Annually, HSAG's PIP Review Team meets to discuss and enhance the PIP review, including the evaluation process; and a validation tool is used to document the PIP review results. The PIP process includes the review and revision (if appropriate) of all documents used throughout the validation cycle. HSAG provides ongoing technical assistance to HFS and the MCOs for prioritizing, selecting, planning, intervening, analyzing, and fully documenting the PIPs.

During SFY 2009–2010 HSAG conducted an analysis of the *EPSDT Screening* and *Perinatal Care and Depression Screening* PIP data to evaluate the MCOs' performance on the PIP indicators. The following is a result of that analysis.

EPSDT Screening PIP

EPSDT is a specific health care program within Medicaid for people from birth through 20 years of age. EPSDT is designed to detect and treat health problems early through three methods: (1) regular medical, dental, vision, and hearing screening and blood lead testing; (2) immunizations; and (3) education. EPSDT provides a comprehensive child health program to help ensure that health problems are identified, diagnosed, and treated early, before they become more complex and treatment becomes more costly. The goals of the SFY 2004–2005 EPSDT PIP were to:

- Provide baseline results of EPSDT screening indicators for targeting interventions and improving rates.
- Improve the quantity and quality of EPSDT examinations through a collaborative process.
- Enhance the MCOs' knowledge and expertise in conducting PIPs while meeting both State and CMS requirements for PIPs.

During the baseline EPSDT PIP reporting period, the Department contracted with five HFS MCOs to provide health care services to HFS managed care beneficiaries. These were **UnitedHealthcare of Illinois, Inc./AmeriChoice** (**AmeriChoice**); **AMERIGROUP, Illinois** (**AMERIGROUP**); **Family Health Network**, **Inc.** (**FHN**); **Harmony Health Plan of Illinois**, **Inc.** (**Harmony**); and **Humana Inc.** (**Humana**). However, **AmeriChoice**, **AMERIGROUP**, and **Humana** have since terminated their HFS contracts and are no longer participating in the EPSDT PIP. In SFY 2008–2009 a new MCO, **Meridian Health Plan** (**Meridian**), joined the Medicaid managed care program. This was **Meridian**'s first year to participate in the EPSDT PIP; but, because the plan had fewer than 30 eligible members, the results are not displayed.

The results from the baseline study indicated several areas of deficiencies for the EPSDT indicators. Based on the data collection methodology, however, it was not possible to determine if the deficiencies were due to the lack of documented services or to member noncompliance (e.g., members not keeping appointments for EPSDT visits, or not using services).

Following the original baseline study, it was determined that additional programming efforts and analysis could provide additional insight into the actual EPSDT services documented during an EPSDT visit. This analysis was conducted by identifying *only the EPSDT visits* for the members in the original statewide collaborative EPSDT PIP. Hence, the unit of analysis became the EPSDT visit, rather than the member. These EPSDT visits were then analyzed to specifically determine what services were provided during each visit.

The additional analysis considered only the eight EPSDT services that were required for each visit and did not include blood lead testing, dental/oral evaluation, hemoglobin/hematocrit testing, and immunizations, since these services are not necessarily required on each EPSDT visit. The following is a list of EPSDT services, or components, used for the additional analysis:

- Health history
- Developmental screening (subjective or objective)
- Nutritional assessment
- Physical examination
- Growth measurement
- Anticipatory guidance
- Vision screening (subjective or objective)
- Hearing screening (subjective or objective)

Following the intervention phases, including the EPSDT Provider Survey, both **FHN** and **Harmony** conducted two remeasurements of the baseline study indicators. The findings represent the second remeasurement period of SFY 2009–2010. The goals of this remeasurement study were to:

- Determine what progress has been made in providing and documenting EPSDT services.
- Determine if interventions have been successful in improving the EPSDT study indicator rates, compared to the baseline results.
- Determine if improving EPSDT rates have contributed to corresponding rate increases for HEDIS measures such as childhood immunizations and well-child visits.

Results

Based on a comparison of the original baseline findings to the EPSDT study and the subsequent addendum analysis, HFS and the MCOs decided to focus on improving EDSDT visit services. Therefore, for the remeasurement study, only visits specifically denoted as EPSDT visits were analyzed. To make the proper comparison, these results were compared to the baseline addendum analysis using EPSDT visits as the unit of analysis. Low rates indicate that specific EPSDT services were either not provided during the EPSDT visit, and/or the medical record documentation was inadequate.

Table 3-15—Percentage of EPSDT Visits with Documented EPSDT Services

Study Indicator	FHN			Harmony		
	2004–2005	2009–2010	Change	2004–2005	2009–2010	Change
Total Number of EPSDT Visits	N = 2,255	N = 2,620	**+365**	N = 1,705	N = 3,954	**+2,249**
Average Number of EPSDT Services Documented Per Visit	5.4	5.9	**+0.5**	6.4	5.9	**-0.5**
Percent of EPSDT Visits with all Eight Services Documented	30.8%	29.3%	**-1.5%**	50.1%	39.0%	**-11.1%**
Measures Dependent on Documentation						
Health History	87.2%	67.8%	**-19.4%**	88.1%	81.3%	**-6.8%**
Nutritional Assessment	69.8%	58.1%	**-11.7%**	75.5%	82.9%	**+7.4%**

Table 3-15—Percentage of EPSDT Visits with Documented EPSDT Services						
Study Indicator	FHN			Harmony		
	2004–2005	2009–2010	Change	2004–2005	2009–2010	Change
Developmental Screen (Objective/Subjective)	65.4%	77.2%	**+11.8%**	76.7%	76.3%	**-0.4%**
Anticipatory Guidance	61.7%	69.5%	**+7.8%**	68.1%	64.7%	**-3.4%**
Measures Related to Performing a Service						
Comprehensive Physical Exam	68.7%	84.0%	**+15.3%**	88.1%	81.2%	**-6.9%**
Growth Measurement	92.4%	87.4%	**-5.0%**	95.8%	84.8%	**-11.0%**
Vision Screening (Objective or Subjective)	47.2%	75.6%	**+28.4%**	77.8%	60.3%	**-17.5%**
Hearing Screening (Objective or Subjective)	45.9%	73.7%	**+27.8%**	78.4%	56.5%	**-21.9%**

Overall, **FHN** has shown significant improvement for five of the eight measures since the baseline reporting period. However, the highest three measures from the baseline period—health history, nutritional assessment, and growth measurement—have declined. **FHN** may be focusing on improving the lower rates but not ensuring that providers still perform and document the components for the other measures.

Out of the eight measures, **Harmony** showed improvement for one measure (i.e., nutritional assessment). Developmental screening, anticipatory guidance, and physical exam rates declined fewer than 4 percentage points. Rates for the other four measures experienced statistically significant declines.

Conclusions and Recommendations

The number of EPSDT visits for both MCOs has increased. However, the average number of services documented during an EPSDT visit has remained about the same as the baseline rate for both MCOs.

Eight services should be performed during each EPSDT visit; however, 1,157 of the total 6,574 EPSDT visits during this second remeasurement period (17.6 percent) had documented three or fewer services. This demonstrates that providers either are not performing all the necessary services, not documenting the services, or both.

HEDIS rates for *Childhood Immunizations (Combo 2 and Combo 3) measures* have improved significantly for both MCOs. *Well-Child Visits in the First 15 Months (0 visits and 6+ visits)* measures have both improved, with a significant decrease in the zero-visit rate and an increase in the six (or more) visits rate. Similarly, *Well-Child Visits (3–6 Years)* has also shown notable improvement since this EPSDT PIP began, and **FHN** has exceeded the national Medicaid 75th percentile for HEDIS 2010.

Due to the significant increase in the number of EPSDT visits and improvement in HEDIS rates, it is reasonable to assume that MCO efforts to improve member compliance have had a positive effect. Therefore, because the lack of improvement appears to be the result of provider noncompliance, the MCOs should direct interventions toward providers.

Perinatal Care and Depression Screening PIP

The MCOs and HFS chose *Perinatal Care and Depression Screening* as their PIP topic. HFS has identified improving birth outcomes as one of its health care priorities. The risks from untreated major depression during pregnancy may include decreased prenatal care, decreased nutritional quality, increased use of addictive substances, and increased risk of becoming a victim of violence. Antenatal depression can lead to low birth weight, preterm delivery, preeclampsia, neonatal irritability, and excessive crying by the infant. It is recognized that prematurity, infant mortality, complications of pregnancy, and perinatal depression are reduced through adequate perinatal care that includes risk-appropriate screenings, ongoing health care according to practice guidelines, management of conditions that impact birth outcomes, and referrals (as needed) for risk-appropriate specialty care. Improving participation in prenatal and postpartum care, as well as ensuring that perinatal depression screening occurs, are key components of HFS' program. Information detailing HFS' plan to improve birth outcomes is located at http://www.hfs.illinois.gov/mch/report.html.

The baseline PIP was conducted during SFY 2005–2006. Following the baseline PIP results, the MCOs implemented specific interventions to improve perinatal care and depression screening in this population. The first remeasurement period occurred during SFY 2007–2008. This aggregate PIP report represents the second remeasurement phase of this study, which occurred during SFY 2009–2010.

Both the baseline and remeasurement studies used the *Timeliness of Prenatal Care* and *Postpartum Care* HEDIS measures to identify the eligible population and to improve rates for these two measures. In addition to the HEDIS measures, the State and the MCOs chose to determine the percentage of women who were enrolled in an Illinois Medicaid MCO and who were screened for depression during the prenatal and/or postpartum period. The goals of the *Perinatal Care and Depression Screening* PIP were to determine baseline rates for these measures and, following implementation of quality improvement strategies, perform a remeasurement of the study indicators to answer the following questions:

- Will interventions result in increased rates for *Timeliness of Prenatal Care* and *Postpartum Care* measures?
- Will interventions result in increased screening of pregnant women for depression and increased treatment for women who screen positive for depression?

Although this was a statewide collaborative PIP for the Illinois Medicaid MCOs, each MCO conducted its own background research, medical record collection, data abstraction, and data analysis. HSAG provided technical assistance, when necessary, but did not conduct the project for the MCOs.

The primary purpose of this collaborative PIP was to determine if MCO interventions have helped to improve the baseline rates for the perinatal HEDIS measures, along with depression screening for these women. A secondary goal was to determine potential opportunities to improve the rate of *objective* depression screening, along with appropriate treatment when depression is identified through screening and assessment. The study indicators for this PIP were as follows:

Table 3–16—Study Indicators	
Indicator	**Description of Indicator**
1	Timeliness of Prenatal Care (*HEDIS 2010 Technical Specifications*)
2	Postpartum Care (*HEDIS 2010 Technical Specifications*)
3	Frequency of Ongoing Prenatal Care (*HEDIS 2010 Technical Specifications*)
4a	Women in the denominator who were screened for depression during the pregnancy and prior to delivery, while enrolled in the health plan.
4b	Women in the denominator who were screened for depression within 56 days after delivery, while enrolled in the health plan.
4c	Women in the denominator who were screened for depression either prior to or within 56 days after delivery.
5	Follow-up Within 7 Days for Pregnant Women With a Positive Depression Screen
6a	Follow-up Within 14 Days for Pregnant Women With a Positive Depression Screen
6b	Follow-up Within 30 Days for Pregnant Women With a Positive Depression Screen

The first three indicators follow the HEDIS technical specifications, while the remaining measures examine depression screening and treatment. The depression screening data were based on information not contained in administrative data, requiring medical record review for every beneficiary in the sample. However, the MCOs were allowed to use administrative data to supplement the rates for the HEDIS measures. Following data collection and abstraction, each of the MCOs calculated the rates for the study indicators and submitted those rates to HSAG for the aggregate report. HSAG also requested the raw data files used to calculate the rates to verify the results and conduct additional analysis, if necessary. The MCOs were to differentiate whether the perinatal depression screening was performed through a subjective screening by the provider, or through an objective screening process, using a recognized objective screening instrument, such as the Edinburgh Postnatal Depression Scale (EPDS), the Beck Depression Inventory (Beck) or the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PHQ).

Findings

Table 3–17 below displays the results for the primary indicators for this perinatal depression study. The rates for **Harmony** are provided for the two distinct services areas (Cook and Southern) along with the overall rate for the HFS MCOs.

Table 3–17—Study Indicators								
	FHN		Harmony (Cook)		Harmony (South)		Overall	
	2006	2010	2006	2010	2006	2010	2006*	2010
Final Sample Size (Women)	452	433	329	358	118	53	1,347	844
Timeliness of Prenatal Care	33.0%	49.2%	51.4%	63.7%	74.6%	75.5%	43.1%	57.0%
Frequency of Ongoing Prenatal Care (81–100% of Recommended Visits)	9.5%	26.3%	24.3%	34.6%	64.4%	71.7%	18.7%	32.7%
Postpartum Care Visits	23.2%	39.3%	30.1%	47.8%	52.5%	62.3%	29.0%	44.3%
Depression Screening								
No Depression Screen	84.3%	41.8%	66.0%	51.7%	36.4%	64.2%	70.7%	47.4%
Depression Screen Prior to Delivery	11.1%	15.5%	30.4%	42.2%	61.9%	50.9%	22.3%	29.0%
Depression Screen Within 56 Days After Delivery	10.2%	34.4%	11.9%	29.9%	15.3%	28.3%	13.4%	32.1%
Depression Screen Either Before or Within 56 Days After Delivery	15.7%	40.9%	34.0%	51.1%	63.6%	62.3%	29.3%	46.6%
Depression Screen Before and Within 56 Days After Delivery	5.5%	9.0%	8.2%	21.0%	13.6%	17.0%	6.5%	14.6%
Unique Women Screened for Depression	71 15.7%	177 40.9%	112 34.0%	183 51.1%	75 63.6%	33 62.3%	394 29.3%	393 46.6%
Total Number of Depression Screens	122	302	208	385	161	57	686	744
Percentage of Subjective Screens	10.7%	0.0%	69.7%	44.2%	83.2%	70.2%	59.6%	28.2%
Percentage of Objective Screens	89.3%	100.0%	30.3%	55.8%	16.8%	29.8%	40.4%	71.8%
Positive Screens for Depression	20 16.4%	33 18.6%	43 20.7%	32 17.5%	26 16.1%	4 12.1%	95 13.8%	69 17.6%
Follow-up (Treatment or Referral) Documented in the Medical Record	9 45.0%	13 39.4%	27 62.8%	28 87.5%	11 42.3%	2 50.0%	50 52.6%	43 62.3%

*Overall 2006 numbers includes Medicaid health plans no longer in the Medicaid program.

The following observations can be derived from the summary results:

- The low rates for *Timeliness of Prenatal Care*, *Frequency of Ongoing Prenatal Care*, and *Postpartum Care* continue to represent a significant area for improvement. However, as the trended results show, all of these rates had significant improvement between the baseline rates and the second remeasurement periods.
- There continues to be a significant difference in rates between **Harmony**'s two service areas (Cook and Southern); the Southern area usually has better HEDIS measure rates, while the Cook area appears to show better depression screening results. Of the 844 women for this study period, 47.4 percent did not have a depression screen. This rate has improved 23.3 percentage points from SFY 2006.

- The percentage of women who had a depression screen both before delivery and within 56 days after delivery has more than doubled (from 6.5 percent to 14.6 percent), but still presents an opportunity for improvement.
- The percentage of objective screening has increased significantly since the baseline and remains fairly high at 71.8 percent. In SFY 2006, only 40.4 percent of the depression screens were objective.
- The total number of women screened for depression and the amount of depression screenings documented have improved. The use of objective depression screening and the clinician review of the depression screens have also been very successful. However, the rate for positive depression screen follow-up has remained about the same as the baseline rate, with the MCOs moving away from treatment and providing more referrals for services.
- For the baseline and both remeasurement periods, when follow-up for a positive depression screen was documented, most cases had follow-up within seven days. However, there continues to be a large percentage of positive depression screening without any follow-up documented in the medical record.

Recommendations

The MCOs followed several of the recommendations provided in the baseline report, and the rates for the measures have improved. At this time, because of the success that has been accomplished, it is recommended that the MCOs continue with their current interventions and consider the following as possible areas to strengthen interventions. The following are recommendations made in the baseline and first remeasurement reports:

- The MCOs should track and monitor pregnant beneficiaries through claims/encounter data, case management, or other available data. These women should be encouraged to have regular prenatal care appointments and a postpartum care visit.
- The MCOs should continue their case management strategies for pregnant enrollees. The MCOs should work more closely with the Family Case Management Program to assure coordination of services.
- Case managers should consider making postpartum care appointments while women are in the hospital following delivery or should follow up immediately after hospital discharge.
- The MCOs should continue with incentives for women completing the recommended number of visits prior to delivery and for women who receive their postpartum care visit.
- The MCOs should continue to regularly conduct provider profiling (e.g., once per quarter) to determine the rates for the three HEDIS measures, by provider. This information should be given to the providers to help improve results.
- The MCOs should continue to educate providers about the importance of depression screening for women before and after delivery. The MCOs should also educate their network providers on screening, assessment, treatment, or referral for further assessment and treatment, as needed. At a minimum, providers should specifically attempt to screen for depression during the initial visit and periodically during subsequent prenatal care visits, as well as during the postpartum care visit.

- The MCOs demonstrated considerable success improving the use of objective depression screening tools. The MCOs should continue their intervention in this area to maintain the current level of achievement.
- The MCOs should continually educate their providers about the availability of behavioral health services covered by the MCO and behavioral health resources. The MCOs should also monitor referrals for and treatment of perinatal depression.
- The MCOs should reinforce for providers the importance of documenting depression screening and any follow-up, including treatment and referrals. Depression screening should be documented even if the result does not indicate the woman has depression.
- The MCOs should continue to give providers information on how to treat perinatal depression. As noted in the baseline report, sources may include the following:
  - The MCO's behavioral health subcontractor.
  - The UIC Perinatal Depression Consultation Service: 800.573.6121.
  - The UIC Perinatal Depression Project Web site: www.psych.uic.edu/clinical/HRSA.
  - The Enhancing Developmentally Oriented Primary Care (EDOPC) project, which is a collaborative partnership between the Illinois Chapter of the American Academy of Pediatrics (ICAAP), the Advocate Health System's Healthy Steps for Young Children Program, the Illinois Academy of Family Physicians (IAFP), the Ounce of Prevention Fund, and HFS.
  - Postpartum Depression Illinois Alliance: 847.205.4455.
  - National Alliance for Mentally Ill: 800.346.4572.
  - Healthcare Alternative Systems, Inc. (H.A.S.): 773.252.3100, Ext.147—the program is designed to provide psychological and psychiatric services to new and/or expectant mothers who are suffering from or are at risk for developing postpartum depression.
  - The Perinatal Depression Program Consumer Crisis Hotline: 866.ENH.MOMS (866.364.6667)—Evanston Northwestern Healthcare (ENH) provides a hotline for perinatal mothers and their loved ones who seek immediate crisis counseling and triage services for perinatal depression, and for obstetric or pediatric providers who need mental health referrals for their perinatal patients. This hotline is free, confidential, multilingual, and operates 24 hours a day, seven days a week.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys—SFY 2009–2010

The CAHPS surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. **FHN** and **Harmony** were responsible for obtaining a CAHPS vendor to administer the CAHPS surveys on their behalf. **FHN**'s and **Harmony**'s results were forwarded to HSAG for analysis. Due to its size, **Meridian** was allowed to create and administer its own, consumer satisfaction survey.

Objectives

The overarching objective of the CAHPS surveys was to effectively and efficiently obtain information on patients' levels of satisfaction with their health care experiences. **Meridian**'s survey results are included following those of **FHN** and **Harmony**.

Technical Methods of Data Collection and Analysis

For **FHN** and **Harmony**, the adult Medicaid and child Medicaid populations were surveyed. The Myers Group administered the CAHPS surveys on behalf of **FHN** and **Harmony**. **Meridian** administered its survey and interpreted the resultant data.

The technical method of data collection was through administration of the CAHPS 4.0H Adult Medicaid Survey to the adult population and the CAHPS 4.0H Child Medicaid Survey to the child population. Both plans used a mixed methodology for data collection, which included both a mail and telephone phase for data collection. The surveys could be completed in English or Spanish.

The survey questions were categorized into nine measures of satisfaction. These measures included four global ratings and five composite scores. The global ratings reflected patients' overall satisfaction with their personal doctor, specialist, health plan, and all health care. The composite scores were derived from sets of questions to address different aspects of care (e.g., getting needed care and how well doctors communicate). When a minimum of 100 responses for a measure was not achieved, the result of the measure was "Not Applicable" (NA).

For each of the four global ratings, the percentage of respondents who chose the top satisfaction ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage was referred to as a question summary rate (or top-box response). In addition to the question summary rate, a three-point mean was calculated. Response values of 0 to 6 were given a score of 1, response values of 7 and 8 were given a score of 2, and response values of 9 and 10 were given a score of 3. The three-point mean was the sum of the response scores (1, 2, or 3) divided by the total number of responses to the global rating question.

For each of the five composite scores, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices in the adult Medicaid survey fell into one of the following two categories: (1) "Never," "Sometimes," "Usually," and "Always," or (2)

"Definitely No," "Somewhat No," "Somewhat Yes," and "Definitely Yes." For the child Medicaid survey, response choices fell into one of the following two categories: (1) "Never," "Sometimes," "Usually," and "Always," or (2) "A Big Problem," "A Small Problem," and "Not a Problem."

A positive or top-box response for the composites was defined as a response of "Always," "Not a Problem," or "Definitely Yes." The percentage of top-box responses was referred to as a global proportion for the composite scores.

In addition to the global proportion, a three-point mean was calculated for each of the composite scores. Scoring was based on a three-point scale. Responses of "Always," "Not a Problem," and "Definitely Yes" were given a score of 3, responses of "Usually," "A Small Problem," or "Somewhat Yes" were given a score of 2, and all other responses were given a score of 1. The three-point mean was the average of the mean score for each question included in the composite.

Plan-Specific Findings

Family Health Network

Adult Medicaid

The Myers Group collected 250 valid surveys from the eligible **FHN** adult Medicaid population from January through May 2010, yielding a response rate of 18.9 percent. The overall NCQA target number of valid surveys is 411. **FHN**'s 2010 adult Medicaid CAHPS top-box percentages and three-point means are presented in Table 3-18, along with NCQA's 2010 CAHPS top-box national averages (percentage of 9 and 10 response values).

Table 3-18—FHN 2010 Adult Medicaid CAHPS Results

	Top-Box Percentages	Three-Point Mean Scores	2010 NCQA CAHPS National Averages
Composite Measures			
Getting Needed Care	48.8%	2.25	49.4%
Getting Care Quickly	55.9%	2.34	55.2%
How Well Doctors Communicate	73.6%	2.62	67.7%
Customer Service	61.8%	2.39	58.2%
Shared Decision Making	65.8%	2.59	59.6%
Global Ratings			
Rating of All Health Care	45.6%	2.20	47.2%
Rating of Personal Doctor	56.1%	2.38	60.4%
Rating of Specialist Seen Most Often	55.6%	2.31	60.8%
Rating of Health Plan	46.3%	2.28	52.8%

FHN scored above the 2010 NCQA CAHPS top-box national averages for four measures: *Getting Care Quickly, How Well Doctors Communicate*, *Customer Service,* and *Shared Decision Making*.

Child Medicaid

The Myers Group collected 332 valid surveys from the eligible **FHN** child Medicaid population from January through May 2010, yielding a response rate of 20.6 percent. The overall NCQA target number of valid surveys is 411. **FHN**'s 2010 child Medicaid CAHPS top-box percentages and three-point means are presented in Table 3-19, along with NCQA's 2010 CAHPS top-box national averages (percentage of 9 and 10 response values).

Table 3-19—FHN 2010 Child Medicaid CAHPS Results			
	Top-Box Percentages	Three-Point Mean Scores	2010 NCQA CAHPS National Averages
Composite Measures			
Getting Needed Care	51.3%	2.16	53.2%
Getting Care Quickly	59.6%	2.38	68.0%
How Well Doctors Communicate	71.8%	2.61	73.2%
Customer Service	62.3%	2.48	61.5%
Shared Decision Making	62.3%	2.53	65.4%
Global Ratings			
Rating of All Health Care	59.9%	2.45	60.0%
Rating of Personal Doctor	70.0%	2.60	69.8%
Rating of Specialist Seen Most Often	58.3%	2.33	66.5%
Rating of Health Plan	61.8%	2.50	65.4%

FHN scored above the 2010 NCQA CAHPS top-box national averages for two measures: *Customer Service* and *Rating of Personal Doctor.*

Harmony Health Plan

Adult Medicaid

The Myers Group collected 496 valid surveys from the eligible **Harmony** adult Medicaid population from January through May 2010, yielding a response rate of 19 percent (reported to the precision listed by The Myers Group). The overall NCQA target number of valid surveys is 411. **Harmony**'s 2010 adult Medicaid CAHPS top-box percentages and three-point means are presented in Table 3-20, along with NCQA's 2010 CAHPS top-box national averages (percentage of 9 and 10 response values).

Table 3-20—Harmony 2010 Adult Medicaid CAHPS Results			
	Top-Box Percentages	Three-Point Mean Scores	2010 NCQA CAHPS National Averages
Composite Measures			
Getting Needed Care	32.5%	1.88	49.4%
Getting Care Quickly	51.8%	2.27	55.2%
How Well Doctors Communicate	70.9%	2.58	67.7%
Customer Service	57.1%	2.33	58.2%
Shared Decision Making	60.6%	NA	59.6%
Global Ratings			
Rating of All Health Care	36.5%	2.05	47.2%
Rating of Personal Doctor	52.2%	2.30	60.4%
Rating of Specialist Seen Most Often	58.2%	2.35	60.8%
Rating of Health Plan	36.4%	2.04	52.8%
A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as NA.			

Harmony scored above the 2010 NCQA CAHPS top-box national averages for two measures: *How Well Doctors Communicate* and *Shared Decision Making.*

Child Medicaid

The Myers Group collected 557 valid surveys from the eligible **Harmony** child Medicaid population from January through May 2010, yielding a response rate of 17.2 percent. The overall NCQA target number of valid surveys is 411. **Harmony**'s 2010 child Medicaid CAHPS top-box percentages and three-point means are presented in Table 3-21, along with NCQA's 2010 CAHPS top-box national averages (percentage of 9 and 10 response values).

Table 3-21—Harmony 2010 Child Medicaid CAHPS Results			
	Top-Box Percentages	Three-Point Mean Scores	2010 NCQA CAHPS National Averages
Composite Measures			
Getting Needed Care	40.8%	2.04	53.2%
Getting Care Quickly	65.8%	2.47	68.0%
How Well Doctors Communicate	70.0%	2.55	73.2%
Customer Service	56.6%	2.33	61.5%
Shared Decision Making	63.0%	2.54	65.4%
Global Ratings			
Rating of All Health Care	47.5%	2.29	60.0%
Rating of Personal Doctor	59.2%	2.44	69.8%
Rating of Specialist Seen Most Often	69.2%	2.64	66.5%
Rating of Health Plan	50.0%	2.28	65.4%
A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as NA.			

Harmony scored above the 2010 NCQA CAHPS top-box national averages for one measure: *Rating of Specialist Seen Most Often.*

Meridian Health Plan

Member Medicaid

After securing agreement from the State to implement its own member experience survey, **Meridian** conducted its annual Member Experience Survey for 2009 in May 2010. The survey consisted of a random sample of 112 members, which was a mix of adults and children who were selected from claims data from the eligible participation. The sampling eligibility criteria was as follows for the selected member: (a) must have been eligible with **Meridian** since June 2009, (b) must be currently eligible with **Meridian** without any pending termination notifications, and (c) must have had one or more visits with an **Meridian** primary care physician within calendar year 2009. The survey was conducted telephonically using a standardized electronic survey tool. The results were captured and analyzed by the director of quality & utilization management. Of the 112 member selected, 75 members elected to participate yielding a 67 percent participation rate.

Table 3-22 presents the results from the member experience survey for each survey question. These questions were not sufficiently congruent with the NCQA CAHPS questions to juxtapose **Meridian**'s results with the NCQA CAHPS benchmark rates. Furthermore, **Meridian**'s results do not include sufficient members to disaggregate the results to adult versus child members.

Table 3-22—Meridian 2009 Membership Experience Survey Results	Percent
1. Respondents stating they are always or usually able to get in to see the doctor as soon as needed	91%
2. Respondents stating they never had to wait more than 30 minutes to see their doctor	63%
3. Respondents stating their doctor always or usually listens to them and explains things in a way they can understand	90%
4. Respondents stating the office staff is always courteous and helpful to them	92%
5. Respondents stating their doctor always or usually shows respect for what they have to say	92%
6. Respondents stating their doctor always or usually spends enough time with them	87%
7. Respondents identified as smokers (14 enrollees)	19%
a. The identified smokers stating their doctor recommended they quit smoking	93%
b. The identified smokers stating their doctor discussed medications to help them quit	57%
c. The identified smokers stating their doctor discussed strategies other than medication to help them quit	50%
8. Respondents stating they would rate their doctor as an 8, 9, or 10 on a scale of 0-10 with 10 being the best	85%
9. Respondents stated they would rate **Meridian** as an 8, 9, or 10 on a scale of 0-10 with 10 being the best	93%

An analysis of the results in Table 3-22 presents both strengths and some opportunities for improvement. Six of the 11 measures (not including the percentage of identified smokers) show rates at or above 90 percent for respondents of the survey, which are the recognized strengths. These measures include:

1. Getting in to see the doctor as soon as needed.
2. Doctors who listen and explain in understandable ways.
3. Courteous and helpful office staff.

4. Doctors who always or usually show respect for what patients say.
5. Identified smokers who say their doctor recommended that they quit.
6. Respondents who rate **Meridian** as 8, 9, or 10 on a 0-10 scale with 10 being the best.

Two readily noticeable opportunities for improvement were regarding doctors discussing medications to assist with smoking cessation and other cessation strategies, beyond the doctor's recommendation to do so. **Meridian** could assist physicians with these smoker education improvement opportunities by providing additional materials to physicians in the languages needed for their members. Physicians should also be encouraged to recommend that their patients who smoke use the Illinois Quit Line for support and further information.

Furthermore, office wait-time is an area where **Meridian** saw just 63 percent of respondents agree that they never had to wait more than 30 minutes to see their doctor. Perhaps the word 'never' functioned to somewhat lower the respondents' rate of agreement. Nonetheless, more than one respondent in three indicated having waited more than 30 minutes to see their doctors. Physician offices should try to schedule their patients with enough time for each so that long waits are somewhat rare occurrences, instead of for more than a third of responding members.

Performance Tracking Tool (PTT)

Modifications to the PTT were completed in SFY 2009–2010. The modifications included current benchmarks along with the new quality incentive measures and methodology, as well as the performance measure goals for SFY 2010–2011.

The PTT includes the following:

- A key timeline for reporting requirements.
- Compliance monitoring activities, including areas for targeted improvement for the MCOs.
- A simplified process for entering rates for the various activities (e.g., HEDIS, CAHPS, PIPs).
- Links to automatically trend, graph, determine HEDIS percentile rankings, determine next goals, and calculate incentive payment qualification.
- PIP summary tables to determine validation status and improvements on individual PIP quality indicators.
- A Chi-square and *p* value calculator to facilitate the MCOs' ability to determine if changes were statistically significant.

FHN, **Harmony**, and **Meridian** have begun to use the PTT for tracking and monitoring of rates and activities, quality improvement efforts, comparisons to benchmarks, setting and achieving goals, and internal and external reporting (e.g., the MCO's annual report to HFS).

HFS may use the PTT to enhance reporting to CMS and to the State legislature, as well as to enhance other interdepartmental reporting and determine areas that need focused attention (e.g., HFS can use the PTT to develop collaborative PIPs). The PTT may soon be expanded to include the Primary Care Case Management (PCCM) population, facilitating comparisons between the MCOs and PCCM.

Technical Assistance

As requested by the Department, HSAG has continued to provide technical guidance to the MCOs to assist them in conducting the mandatory EQR activities—particularly, to establish scientifically sound PIPs and develop effective corrective action plans (CAPs). HSAG, at the request of the Department, provided technical assistance training to the MCOs in conducting root-cause analyses and implementing meaningful interventions to address the findings outlined in the MCO annual program evaluations and the results of PIPs and performance measures.

Introduction

This section of the report contains comparisons among MCOs' results for four EQR activities (compliance monitoring CAPs, validation of performance measures, validation of PIPs, and assessment of consumer satisfaction surveys). As a result of the comparative analysis, in Section 5 of this report HSAG offers conclusions and recommendations to facilitate the continued quality and timeliness of, and access to, services available to Illinois Medical Assistance Program beneficiaries.

The methodology used for the comparison of the MCOs' results for each of the EQR activities involved an analysis of the MCOs' overall performance scores as well as the specific standards and/or elements used to assess the MCOs' performance. Common areas for improvement among the MCOs were also identified for each EQR activity by reviewing all previous report findings.

The validity of this type of comparative analysis is possible due to the systematic, methodological approach, including the use of standardized data collection tools by HSAG in conducting the EQR activities.

Compliance Monitoring—QAP Structure and Operations—SFY 2009–2010

During SFY 2009–2010 **Harmony** continued to enhance its case and disease management software programs and was compliant with all aspects of the corrective action plan as a result of the comprehensive review. The implementation of case and disease management software has been a major focus for **FHN** throughout SFY 2009–2010. Implementation began in September 2009 with roll-out of the program scheduled for the first quarter of 2010. **FHN** has added resources to the medical management program. HSAG is scheduled to conduct a focused on-site review of the case and disease management programs in the first quarter of SFY 2010-2011.

Validation of Performance Measures—HEDIS Compliance Audit—FY 2009–2010

This section of the report compares the performance measure results for **FHN** and **Harmony** based on the HEDIS 2010 measures listed in Table 4–1. The measures have been classified into related categories for discussion purposes.

Table 4–1—Classification of HEDIS 2010 Measures	
Category	**HEDIS 2010 Measure**
Child and Adolescent Care	*Childhood Immunization Status (Combinations 2 and 3)*
	Lead Screening in Children
	Well-Child Visits in the First 15 Months of Life
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
	Adolescent Well-Care Visits
	Immunizations for Adolescents (Combined Rate)
Access to Care	*Children and Adolescents' Access to Primary Care Practitioners (PCP)*
	Adults' Access to Preventive/Ambulatory Health Services
Maternity-Related Care	*Frequency of Ongoing Prenatal Care (<21 Percent Visits and ≤81 Percent Visits)*
	Timeliness of Prenatal Care
	Postpartum Care
Preventive Screening for Women	*Breast Cancer Screening*
	Cervical Cancer Screening
	Chlamydia Screening in Women (Combined Rate)
Chronic Conditions/Disease Management	*Controlling High Blood Pressure (Combined Rate)*
	Comprehensive Diabetes Care
	Use of Appropriate Medications for People With Asthma (Combined Rate)

The *Immunizations for Adolescents* measure was new for HEDIS 2010. Although the rates are presented in Section 3, a graphical representation is not presented and trending is not available for this measure.

Children and Adolescent Care

This section addresses HEDIS measures regarding care for children and adolescents. The HEDIS measures were: *Childhood Immunization Status*; *Lead Screening in Children; Well-Child Visits in the First 15 Months of Life*; *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life*; and *Adolescent Well-Care Visits*.

Childhood Immunization Status

Figure 4–1 displays comparative rates for *Childhood Immunizations—Combination 2* (i.e., diphtheria, tetanus toxoids, and acellular pertussis/diphtheria-tetanus toxoid [DTaP/DT]; inactivated poliovirus vaccine [IPV]; measles-mumps-rubella [MMR]; Haemophilus influenzae type b [HIB]; hepatitis B [Hep B]; and varicella-zoster virus [VZV]) for the past five years.

Overall, **FHN** has improved from 47.2 percent in 2005 to 75.5 percent for 2010. This represents a gain of 28.3 percentage points since 2005, and **FHN**'s rate is approaching the National Medicaid HEDIS 2009 50th percentile of 77.9 percent. The rate for **Harmony** has also shown improvement, increasing from 49.5 percent in 2005 to 67.4 percent for 2010, for a gain of 17.9 percentage points. This year resulted in an additional 4.9 percentage point gain over last year for **Harmony**.

Figure 4–1—Comparison of HFS MCO Performance for *Childhood Immunizations—Combination 2*

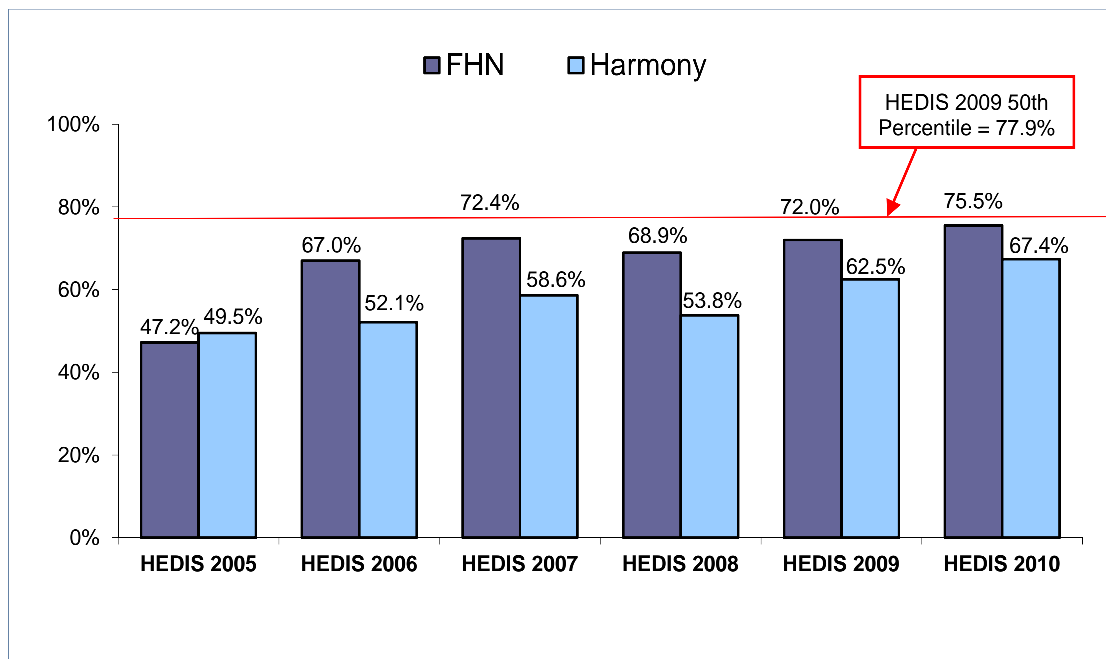
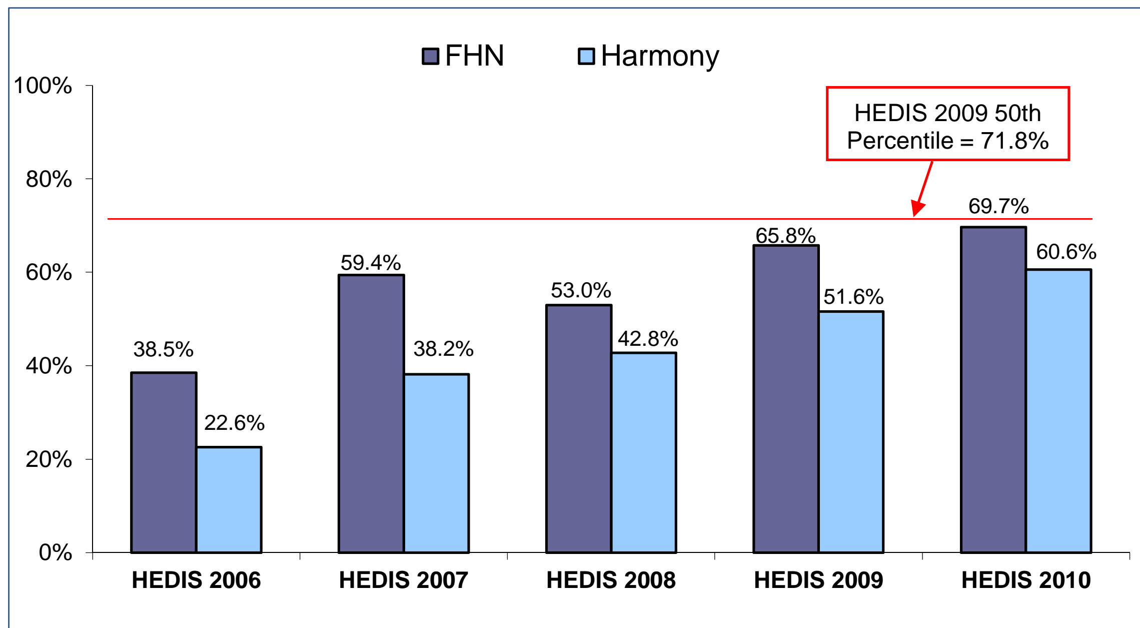


Figure 4–2 displays comparative rates for *Childhood Immunizations—Combination 3* (i.e., DTaP/DT, IPV, MMR, HIB, Hep B, VZV, and pneumococcal conjugate vaccine [PCV]). This measure was new for HEDIS 2006, so comparisons were limited to four years.

FHN's rate improved 3.9 percentage points over last year, and has increased 31.2 percentage points since HEDIS 2006. The rate for **Harmony** demonstrated similar improvement, increasing 9.0 percentage points this year, and 38.0 percentage points since HEDIS 2006. The rates for both MCOs were still below the National Medicaid HEDIS 50th percentile, but it appears the benchmark should be obtainable in the near future.

Figure 4–2—Comparison of HFS MCO Performance for *Childhood Immunizations—Combination 3*



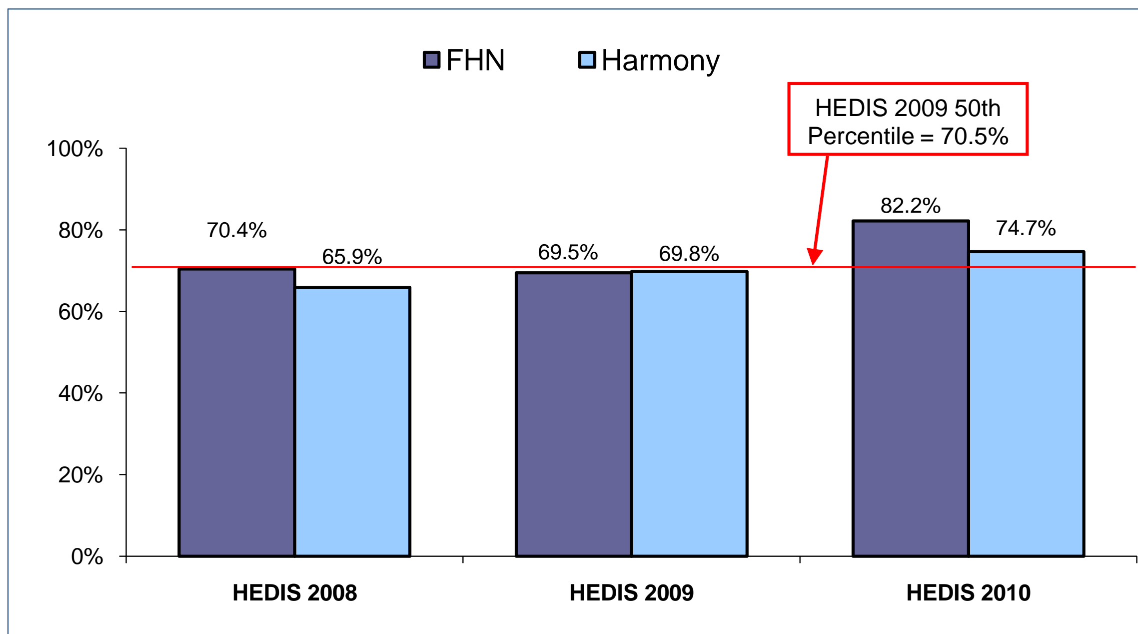
Lead Screening in Children

Figure 4–3 presents the comparative performance of the MCOs for *Lead Screening in Children*. This became a new HEDIS measure for 2008.

Both MCOs have demonstrated notable results for this measure. The rates for both MCOs exceeded the National Medicaid HEDIS 2009 50th percentile of 70.5 percent. **FHN** improved 12.7 percentage points over last year, while **Harmony** improved by 4.9 percentage points.

These rates have continued to improve for this measure, which may be due to the current EPSDT PIP. Both MCOs should continue to link improvement activities with the EPSDT PIP.

Figure 4–3—Comparison of HFS MCO Performance for Lead Screening in Children

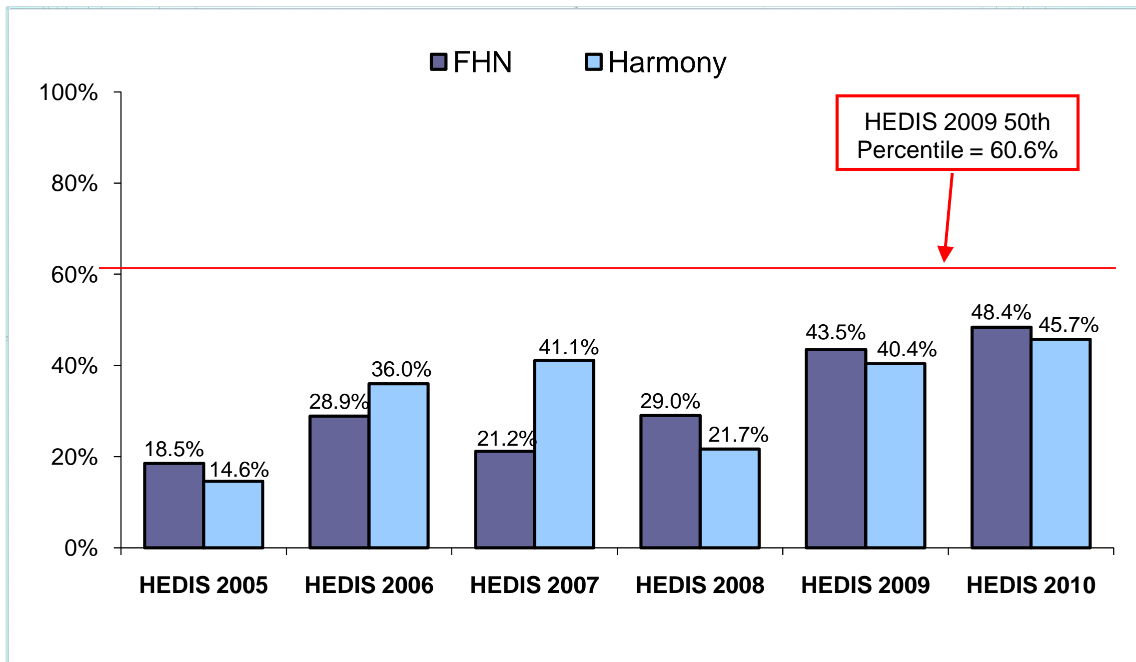


Well-Child Visits in the First 15 Months of Life

Figure 4–4 presents the comparative performance of the MCOs for *Well-Child Visits in the First 15 Months of Life—Six or More Visits*. Neither MCO achieved a rate above the national HEDIS 2009 Medicaid 50th percentile of 60.6 percent.

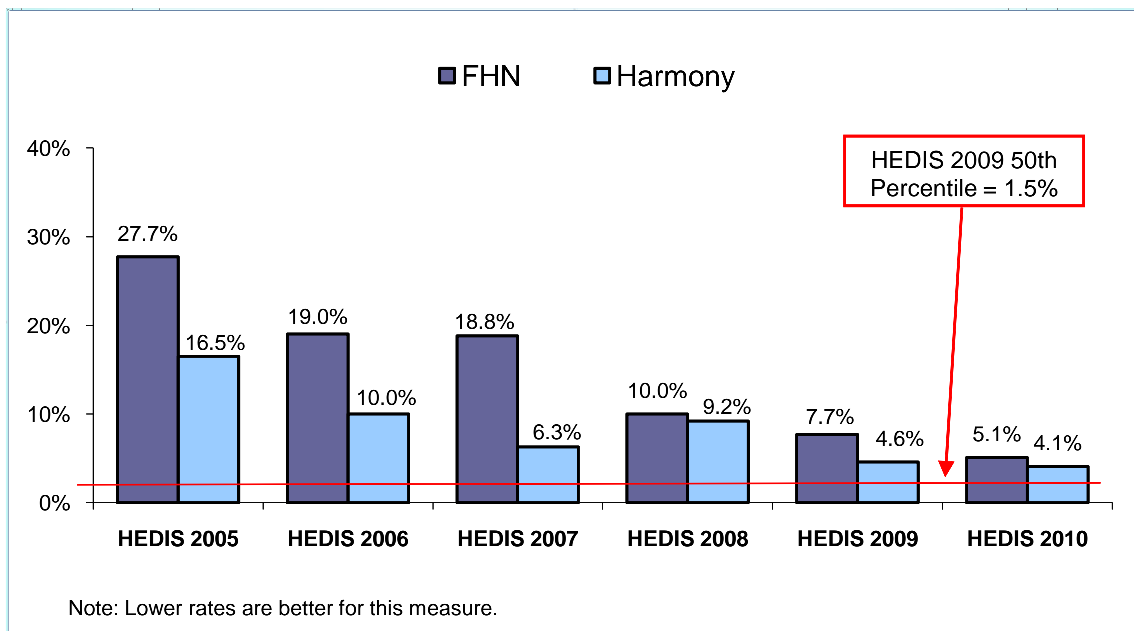
Since HEDIS 2005, **FHN**'s rate has improved by 29.9 percentage points. **Harmony**'s rate has improved by 31.1 percentage points since 2005, increasing from 14.6 percent to 45.7 percent. Despite the improvements, the rates for both MCOs are well below the National Medicaid HEDIS 2009 50th percentile of 60.6 percent.

Figure 4–4—Comparison of HFS MCO Performance for *Well-Child Visits During the First 15 Months of Life—Six or More Visits*



For the *Well-Child Visits in the First 15 Months of Life—Zero Visits* measure, lower rates indicate better performance. **FHN** has continued to improve on this measure each year. Overall, **FHN** has improved by 22.6 percentage points since HEDIS 2005. **Harmony** has also continued to improve with this measure, going from 16.5 percent in 2005 to 4.1 percent in 2010. These results indicate approximately 95.0 percent of the eligible children receive at least one well-child visit in their first 15 months of life.

Figure 4–5—Comparison of HFS MCO Performance for *Well-Child Visits During the First 15 Months of Life—Zero Visits*



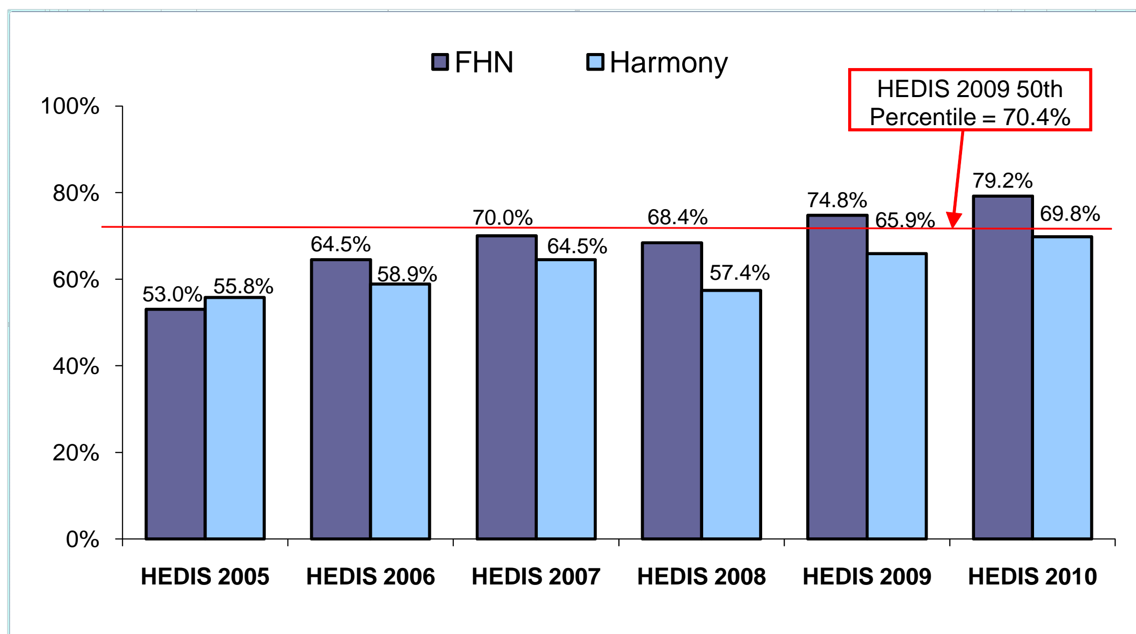
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life

Figure 4–6 presents the comparative rates for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life*. Both MCOs showed improvement this year, and the trend for this measure has also demonstrated continued improvement.

The rate for **FHN** improved by 4.4 percentage points this year, and is above the National Medicaid HEDIS 2009 50th percentile of 70.4 percent, as shown in Figure 4–6 below. **FHN**'s current rate is also above the National Medicaid HEDIS 2009 75th percentile of 75.9 percent. Overall, **FHN** has improved 26.2 percentage points since HEDIS 2005.

The rate for **Harmony** improved by 3.9 percentage points this year, and is just 0.6 percentage points below the National Medicaid HEDIS 2009 50th percentile. Overall, **Harmony** has improved 14.0 percentage points since HEDIS 2005.

Figure 4–6—Comparison of HFS MCO Performance for *Well-Child Visits During the Third, Fourth, Fifth, and Sixth Year of Life*

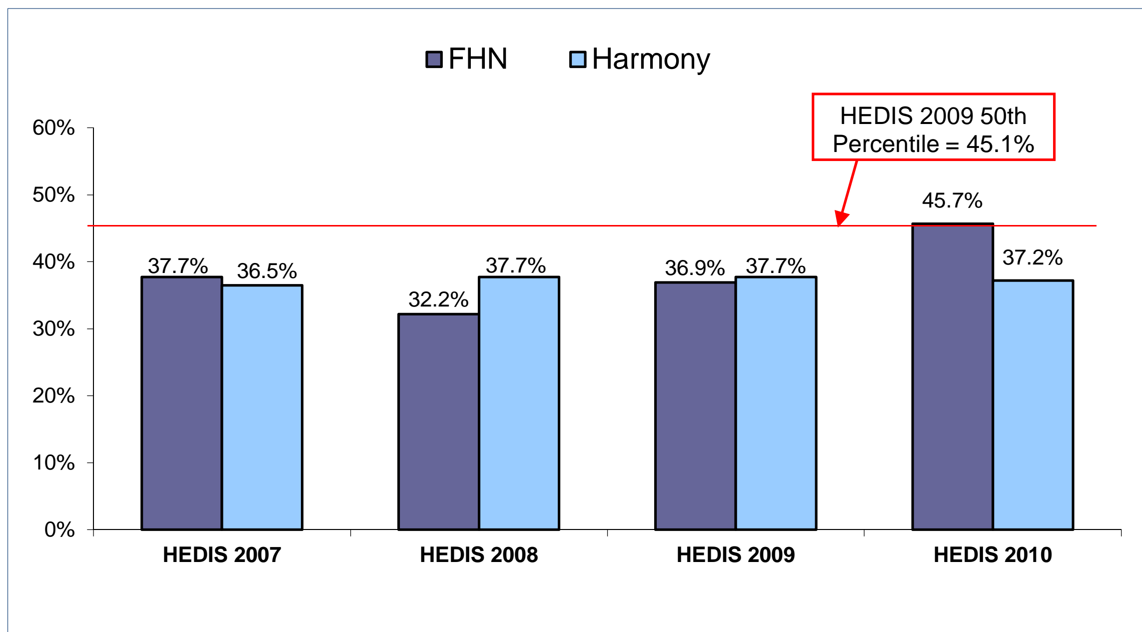


Adolescent Well-Care Visits

Figure 4–7 presents the comparative rates for *Adolescent Well-Care Visits*. Although **FHN** and **Harmony** internally calculate this HEDIS measure each year, the MCOs did not publicly report this rate until HEDIS 2007.

FHN's rate this year improved by 8.8 percentage points and exceeded the National Medicaid HEDIS 2009 50th percentile of 45.1 percent. **Harmony**'s rate has shown no real improvement and has remained nearly the same for all four years.

Figure 4–7—Comparison of HFS MCO Performance for *Adolescent Well-Care Visits*



Access to Care

This section addresses HEDIS measures regarding access to care. The HEDIS measures were: *Children and Adolescents' Access to Primary Care Practitioners (PCPs)*, and *Adults Access to Preventive/Ambulatory Health Services (20–44 Years of Age, and 45–64 Years of Age)*.

Children and Adolescent's Access to PCPs

Figure 4–8 presents the comparative rates for *Children and Adolescent's Access to PCPs (12–24 Months).* The MCOs first reported this measure for HEDIS 2008.

Overall, the rate for **FHN** has improved by 6.8 percentage points. The rate for **Harmony** has remained nearly identical to its baseline rate. The rates for both MCOs remained well below the National Medicaid HEDIS 2009 50th percentile of 96.3 percent.

Figure 4–8—Comparison of HFS MCO Performance for *Children and Adolescents' Access to PCPs (12–24 Months)*

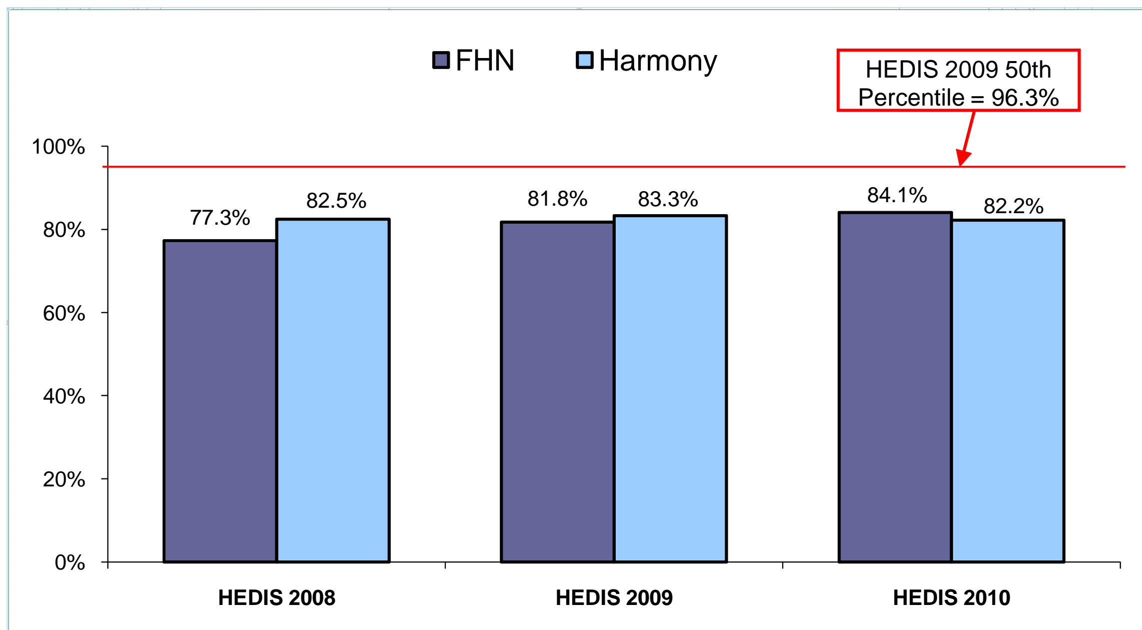


Figure 4–9 presents the comparative rates for *Children and Adolescents' Access to PCPs (25 Months–6 Years)*. The MCOs first reported this measure for HEDIS 2008.

Overall, the rate for **FHN** has improved by 5.4 percentage points, while the rate for **Harmony** has improved 7.4 percentage points since HEDIS 2008. The rates for both MCOs remained well below the National Medicaid HEDIS 2009 50th percentile of 88.3 percent.

Figure 4–9—Comparison of HFS MCO Performance for *Children and Adolescents' Access to PCPs (25 Months–6 Years)*

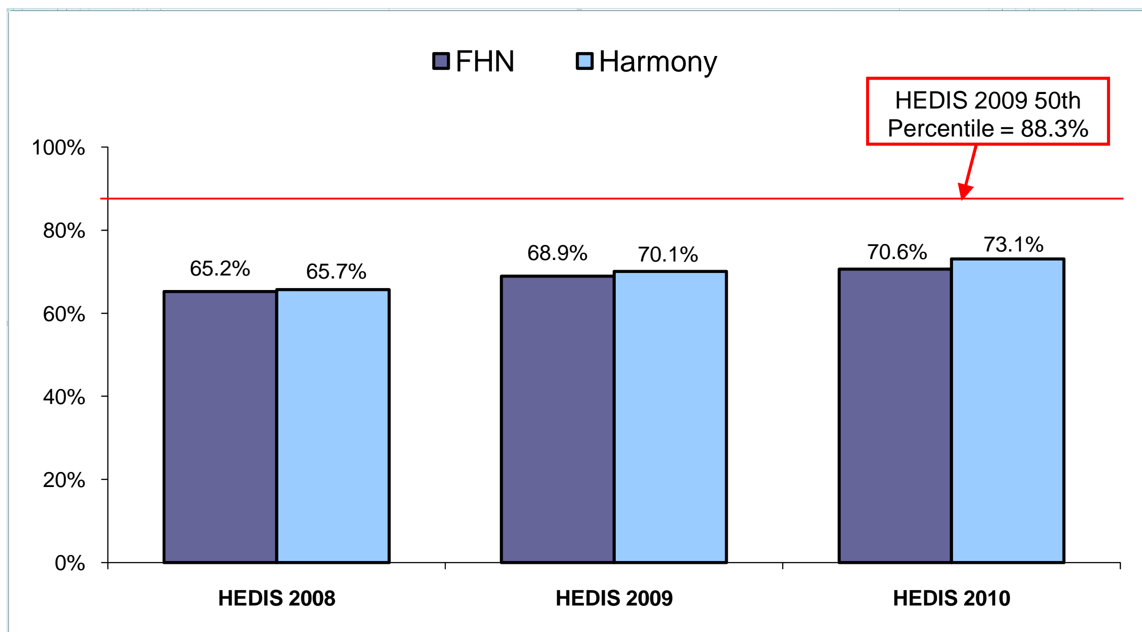


Figure 4–10 presents the comparative rates for *Children and Adolescents' Access to PCPs (7–11 Years).* The MCOs first reported this measure for HEDIS 2008.

The rate for **FHN** declined the last two years, resulting in a rate this year that was 4.6 percentage points lower than the HEDIS 2008 rate. The rate for **Harmony** was 8.6 percentage points above the baseline rate of 60.7 percent. The rates for both MCOs remained well below the National Medicaid HEDIS 2009 50th percentile of 89.0 percent.

Figure 4–10—Comparison of HFS MCO Performance for *Children and Adolescents' Access to PCPs (7–11 Years)*

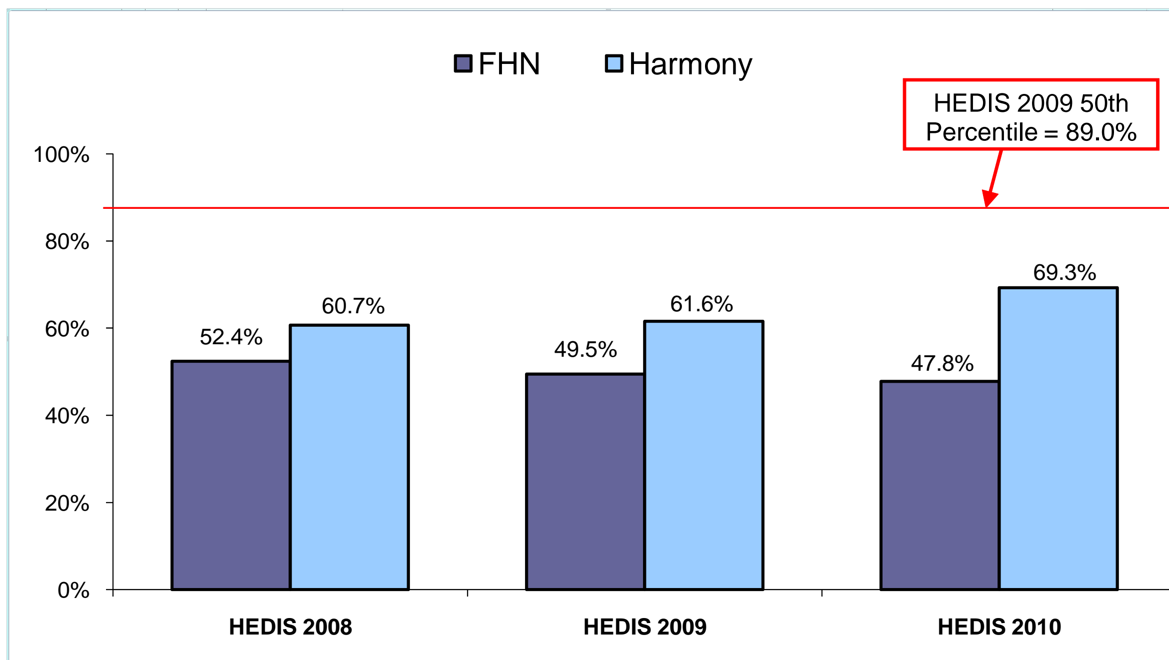
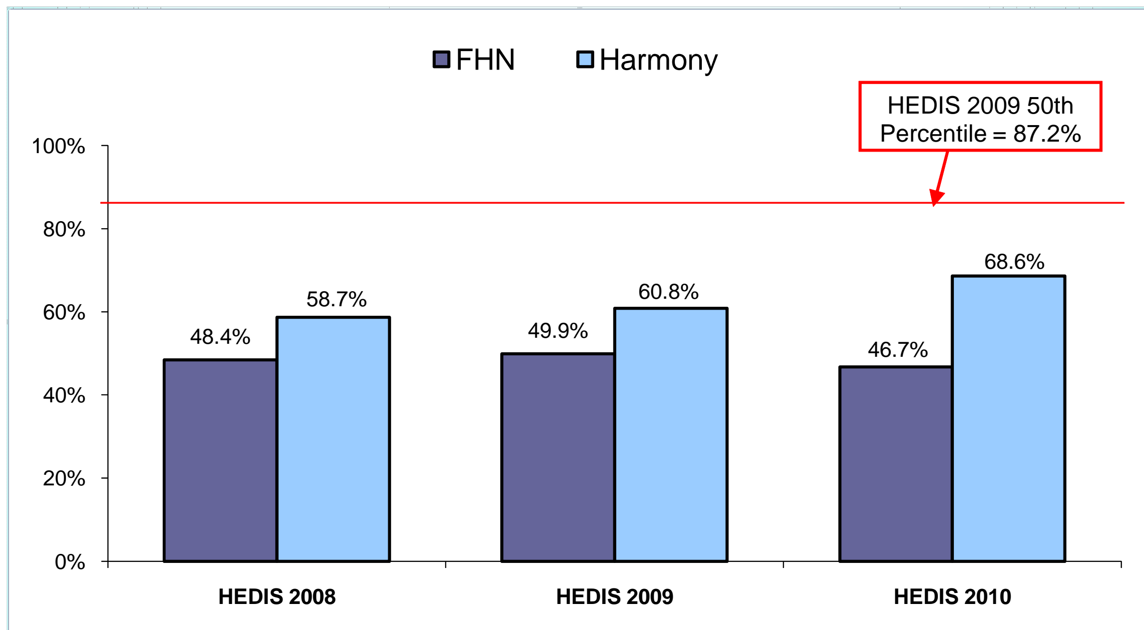


Figure 4–11 presents the comparative rates for *Children and Adolescents' Access to PCPs (12–19 Years).* The MCOs first reported this measure for HEDIS 2008.

FHN's rate declined from 48.4 percent for HEDIS 2008 to 46.7 percent for HEDIS 2010. The rate for **Harmony** showed a consistent improvement, increasing from 58.7 percent to 68.6 percent. The rates for both MCOs remained well below the National Medicaid HEDIS 2009 50th percentile of 87.2 percent.

Figure 4–11—Comparison of HFS MCO Performance for *Children and Adolescents' Access to PCPs (12–19 Years)*



Adults' Access to Preventive/Ambulatory Health Services

Figure 4–12 presents the comparative rates for *Adults' Access to Preventive/Ambulatory Health Services (Ages 20–44)*. The MCOs first reported this measure for HEDIS 2007.

Overall, the rate for **FHN** has improved 5.2 percentage points over the baseline rate of 60.2 percent reported for HEDIS 2007. **Harmony**'s rate also has improved 5.2 percentage points since HEDIS 2007, and remains slightly higher than **FHN**'s rate. The rates for both MCOs were well below the National Medicaid HEDIS 2009 50th percentile of 81.5 percent.

Figure 4–12—Comparison of HFS MCO Performance for *Adults' Access to Preventive/Ambulatory Health Services (Ages 20–44)*

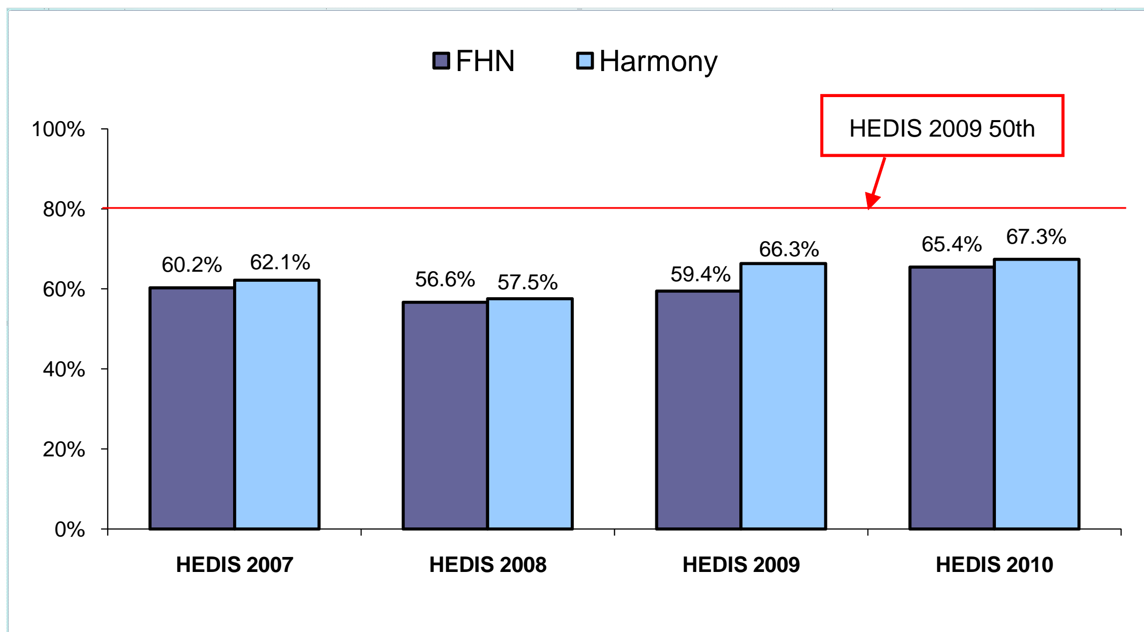
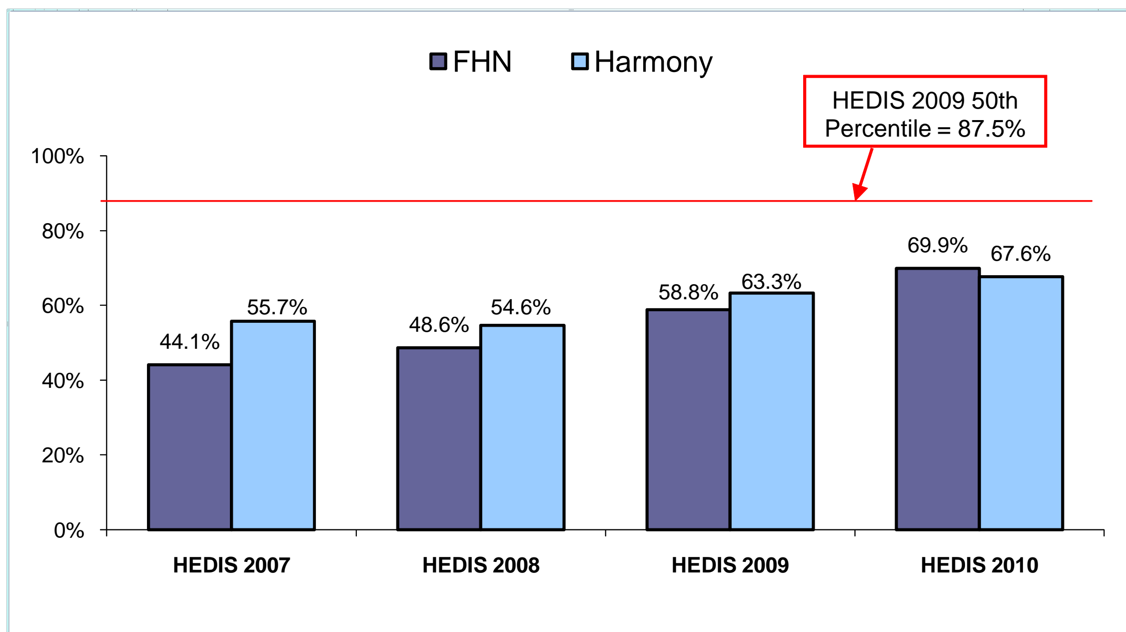


Figure 4–13 presents the comparative rates for *Adults' Access to Preventive/Ambulatory Health Services (Ages 45–64)*. The MCOs first reported this measure for HEDIS 2007.

The rate for **FHN** improved by 11.1 percentage points this year, and 25.8 percentage points since HEDIS 2007. The rate for **Harmony** improved 4.3 percentage points, and is 11.9 percentage points above the baseline rate. Both rates remain below the National Medicaid 50th percentile of 87.5 percent.

Figure 4–13—Comparison of HFS MCO Performance for *Adults' Access to Preventive/Ambulatory Health Services (Ages 45–64)*



The rates for measures related to access have improved, but still remain low. This indicates both **FHN** and **Harmony** need to improve access to care. Although a portion of this low rate may be attributed to member noncompliance, there may also be internal factors that need to be addressed, such as provider noncompliance and access-to-care barriers. The recommendation remains the same: both **FHN** and **Harmony** should examine their network provider coverage along with potential access-to-care barriers, and evaluate internal policies regarding member and provider education.

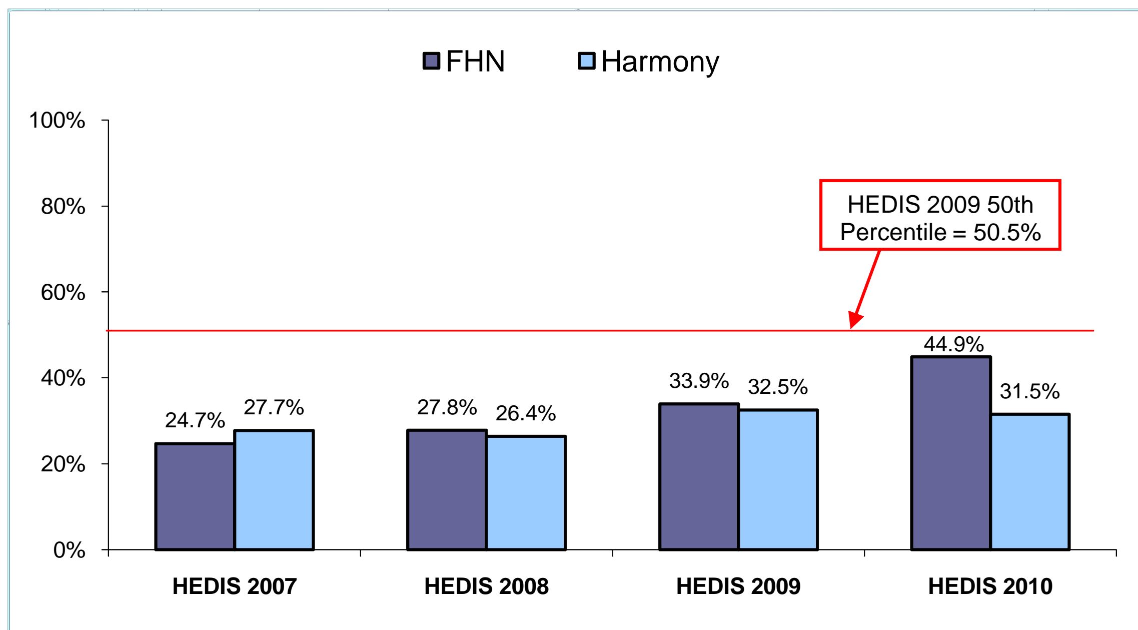
Preventive Screenings for Women

This section addresses HEDIS measures regarding preventive screenings for women. The HEDIS measures were *Breast Cancer Screening*, *Cervical Cancer Screening*, and *Chlamydia Screening in Women*.

Breast Cancer Screening

Figure 4–14 compares the *Breast Cancer Screening* rates for women enrolled in **FHN** or **Harmony**. The MCOs first reported rates from this measure for HEDIS 2007. The rate for **FHN** improved 20.2 percent since the baseline rate and 11.0 percentage points over last year. The rate for **Harmony** declined by one percentage point over last year, and is only 3.8 percentage points higher than the rate for HEDIS 2007.

Figure 4–14—Comparison of HFS MCO Performance for *Breast Cancer Screening (Combined Rate)*

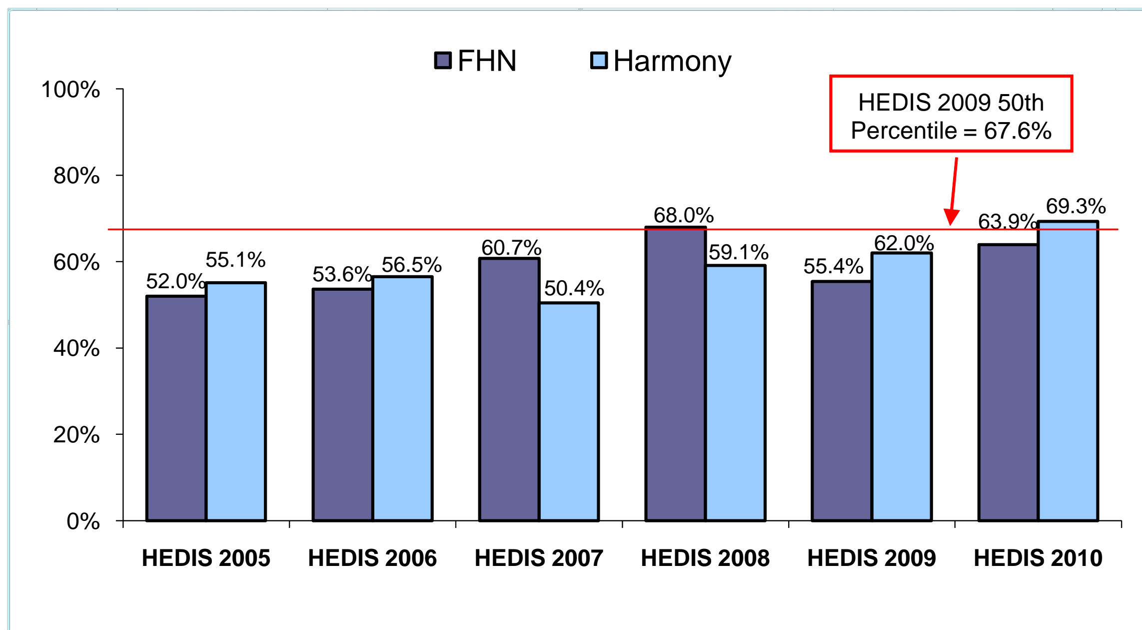


Cervical Cancer Screening

The rates for *Cervical Cancer Screening* are displayed in Figure 4–15. This measure was first reported for HEDIS 2005.

The rate for **FHN** improved by 8.5 percentage points this year, and 11.9 percentage points since HEDIS 2005. The rate for **Harmony** improved 7.3 percentage points this year, and is 14.2 percentage points above the baseline rate. **Harmony**'s rate for this year exceeded the National Medicaid 50th percentile of 67.6 percent.

Figure 4–15—Comparison of HFS MCO Performance for *Cervical Cancer Screening*

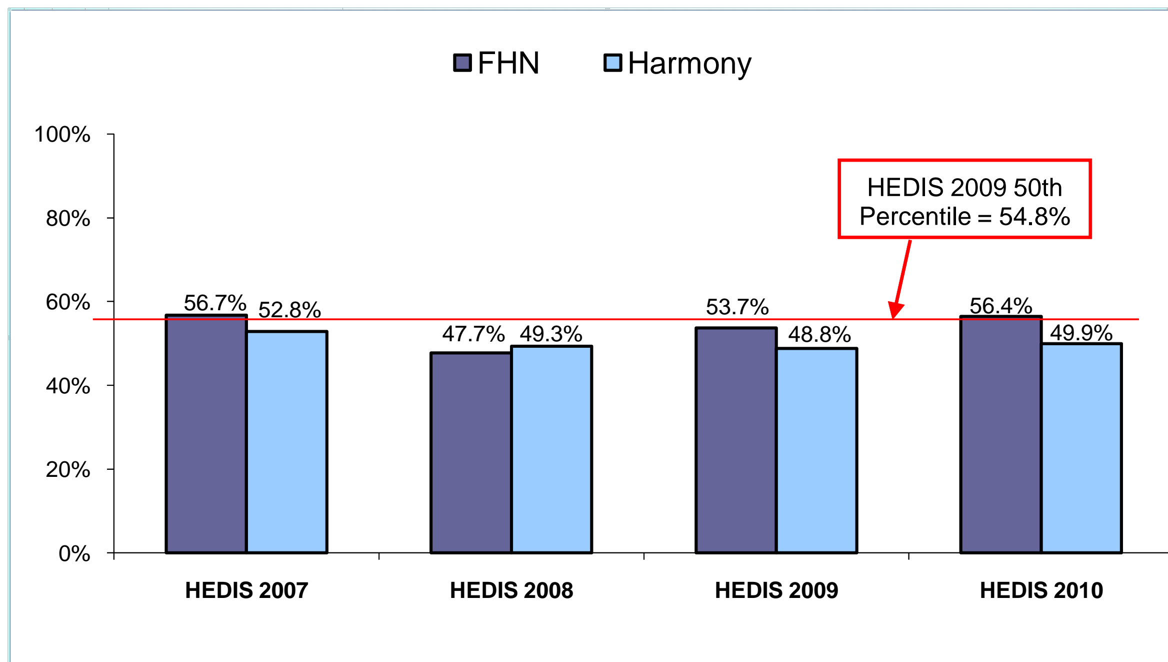


Chlamydia Screening in Women

Figure 4–16 presents the comparative rates for *Chlamydia Screening in Women.* The MCOs first reported this measure for HEDIS 2007.

Neither MCO has shown real improvement for this measure. Although **FHN**'s rate of 56.4 percent exceeded the National Medicaid 50th percentile of 54.8 percent, the rate was 0.3 percentage points lower than the baseline rate. **Harmony**'s rate had a slight increase of 1.1 percentage points over last year, but was still lower than the baseline rate by 2.9 percentage points.

Figure 4–16—Comparison of HFS MCO Performance for *Chlamydia Screening in Women (Combined Rate)*



Maternity-Related Care

This section addresses HEDIS measures related to maternity care. The HEDIS measures were *Frequency of Ongoing Prenatal Care, Timeliness of Prenatal Care,* and *Postpartum Care.*

Frequency of Ongoing Prenatal Care

Figure 4–17 presents the comparative rates for *Frequency of Ongoing Prenatal Care (<21 Percent Visits)*. The MCOs first reported this measure for HEDIS 2007. Lower rates are better for this measure since this measure evaluates the percentage of women who received 0–21 percent of their total recommended prenatal care visits.

Both MCOs showed notable improvement with this measure, but still reported rates above the National Medicaid HEDIS 2009 50th percentile of 8.3 percent. **FHN** improved by 22.4 percentage points over last year and **Harmony**'s rate improved by 9.2 percentage points. These significant improvements may be related to the current PIP the MCOs have been conducting.

Figure 4–17—Comparison of HFS MCO Performance For *Frequency of Ongoing Prenatal Care (<21 Percent Visits)*

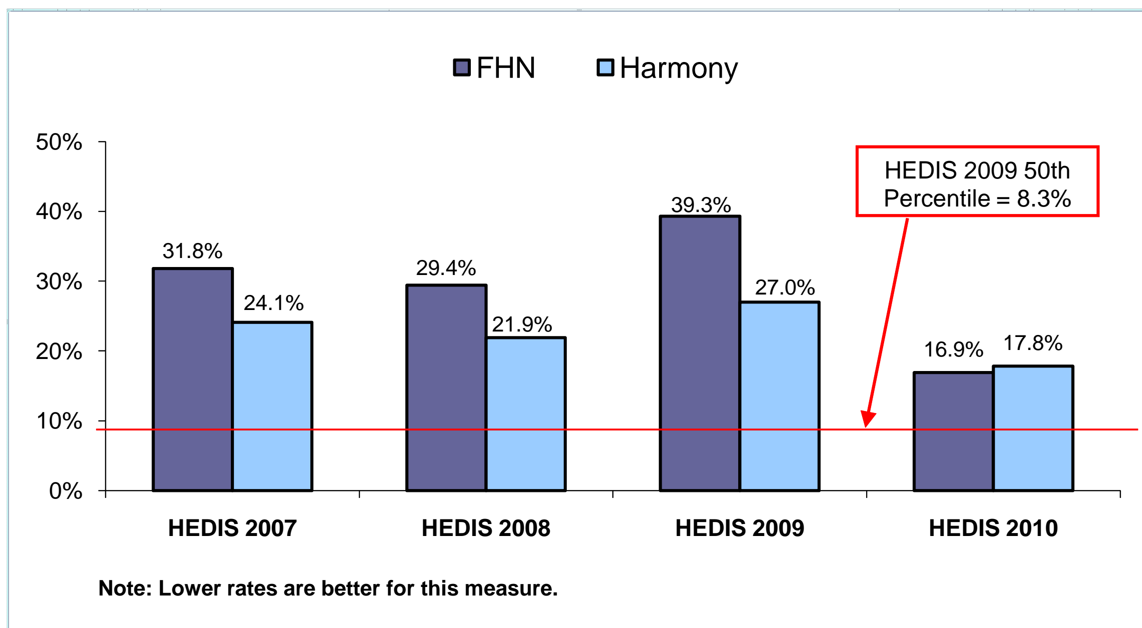
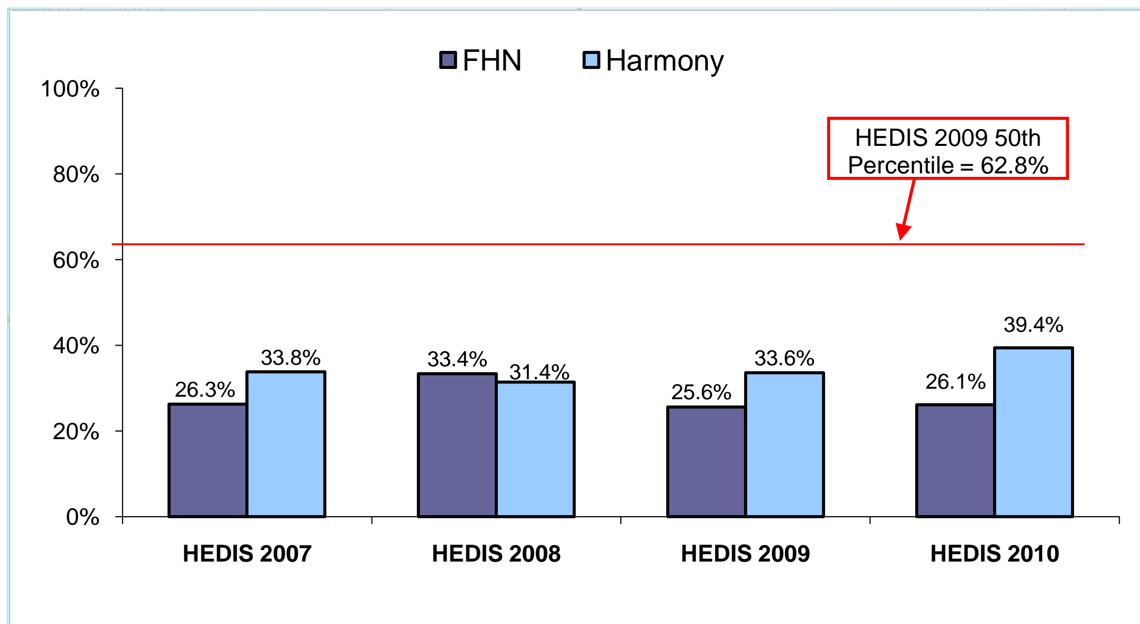


Figure 4–18 presents the comparative rates for *Frequency of Ongoing Prenatal Care (≥81 Percent Visits).* The MCOs first reported this measure for HEDIS 2007. In contrast to the previous measure (0–21 percent of visits), higher rates are better for this measure.

The rate for **FHN** improved just 0.5 percentage points this year, and was still below the rate reported for HEDIS 2007. **Harmony**'s rate improved 5.8 percentage points from last year. The rates for both MCOs are well below the National Medicaid HEDIS 2009 50th percentile of 62.8 percent.

Figure 4–18—Comparison of HFS MCO Performance For *Frequency of Ongoing Prenatal Care (≥81 Percent Visits)*



While the percentage of women receiving less than 21 percent of recommended visits has improved, those receiving 81–100 percent of the recommended visits has shown very little improvement. This measure is related to access to care; as already seen in this report, the other measures that are related to access tend to have low rates. In prior years, there were several potential issues identified as probably causes for the poor rates for this measure: the encounter data may be incomplete, the MCO may have had difficulty identifying pregnant members, there may have been an issue with access to OB/GYNs, there may have been an issue with member compliance, or there may have been a combination of these factors. It is strongly recommended both MCOs explore this issue (i.e., conduct a root-cause analysis) to determine the reason for low compliance, and develop interventions to improve this rate.

Timeliness of Prenatal Care

Figure 4–19 presents the comparative performance of the HFS MCOs for *Timeliness of Prenatal Care*. **FHN**'s rate was nearly the same as last year, with a slight decline of 0.2 percentage points this year. The general trend for **FHN** has been relatively flat, indicating no real improvement. **Harmony**'s rate has also been about the same each year since HEDIS 2005, but this year the rate improved by 8.8 percentage points over last year. Both MCOs were well below the National HEDIS 2009 Medicaid 50th percentile of 85.6 percent.

Figure 4–19—Comparison of HFS MCO Performance for *Timeliness of Prenatal Care*

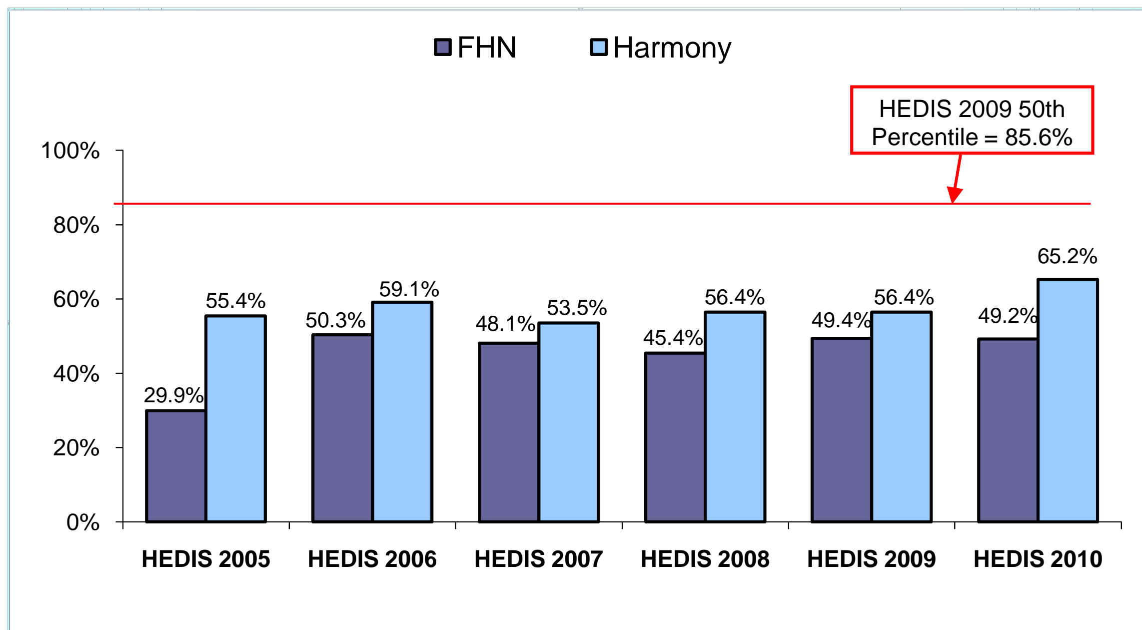
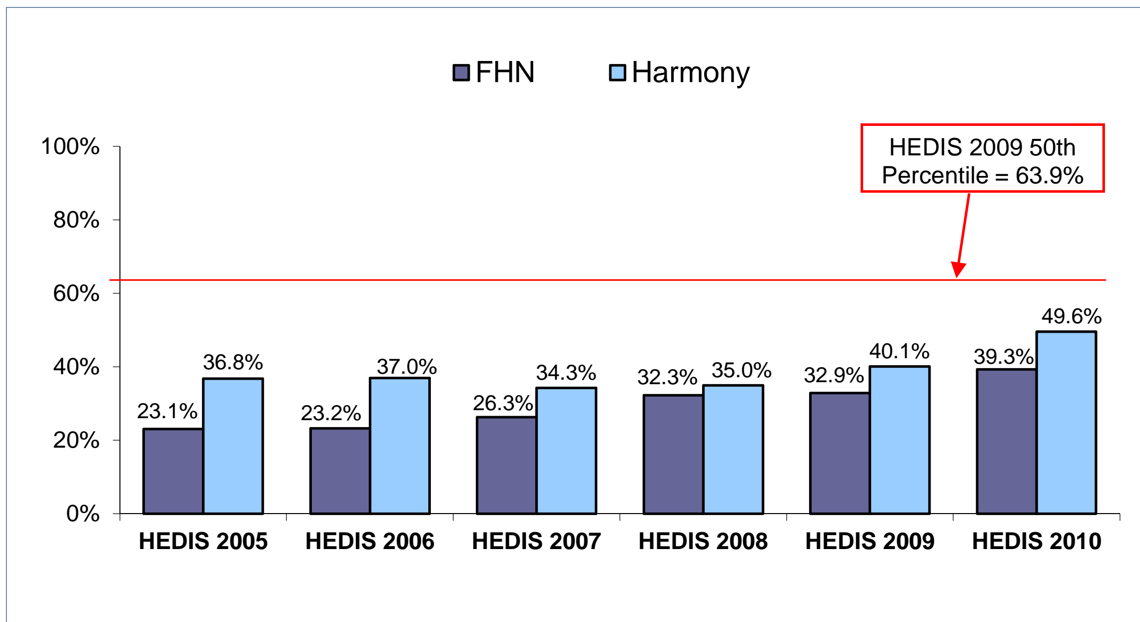


Figure 4–20 presents the comparative performance of the HFS MCOs for *Postpartum Care*. **FHN**'s rate increased by 6.4 percentage points over last year. Overall, **FHN**'s rate has improved 16.2 percentage points since HEDIS 2005. **Harmony**'s rate increased by 9.5 percentage points this year and is now 12.8 percentage points above the reported rate for HEDIS 2005. Both MCOs are well below the National HEDIS 2009 Medicaid 50th percentile of 63.9 percent.

Figure 4–20—Comparison of HFS MCO Performance for *Postpartum Care*



As discussed in prior technical reports, both MCOs continue to report rates well below the 10th percentile for these maternity-related measures. In response, the State and the MCOs began a collaborative perinatal depression screening PIP in 2006–2007. All of these maternity-related measures were included as part of the PIP, as well as several non-HEDIS measures addressing depression and follow-up (for positive depression screening) for these women.

The interventions **FHN** and **Harmony** have implemented were expected to result in higher rates for these HEDIS measures. For most of these measures, the rates did, in fact, improve. **Harmony** improved on every measure. However, **FHN** had only limited success, improving on just the *Postpartum Care* measure and remaining about the same on the other three measures.

Chronic Conditions/Disease Management

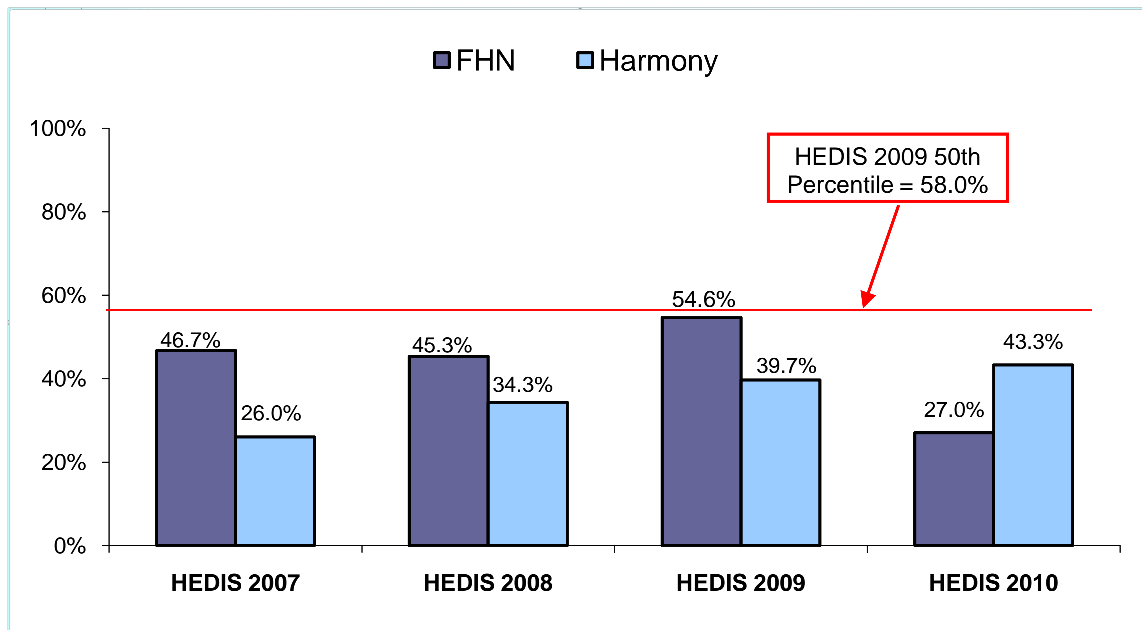
This section addresses HEDIS measures regarding chronic conditions/disease management. The HEDIS measures were *Controlling High Blood Pressure, Comprehensive Diabetes Care, Use of Appropriate Medications for People With Asthma,* and *Follow-up After Hospitalization for Mental Illness*.

Controlling High Blood Pressure

Figure 4–21 presents the comparative rates for *Controlling High Blood Pressure*. The MCOs first reported this measure for HEDIS 2007.

From HEDIS 2007 through HEDIS 2009, both MCOs showed steady improvement with this measure. For HEDIS 2010, however, **FHN**'s rate declined by 27.6 percentage points. The MCO should explore the reason for this significant decline. By contrast, **Harmony**'s rate continued to steadily increase, improved by 3.6 percentage points over last year, and was 17.3 percentage points higher than their HEDIS 2007 reported rate.

Figure 4–21—Comparison of HFS MCO Performance for *Controlling High Blood Pressure (Combined Rate)*



Comprehensive Diabetes Care

Figure 4–22 through Figure 4–30 show comparisons for the performance measures under *Comprehensive Diabetes Care*. The performance measures were *HbA1c Testing*, *Poor HbA1c Control, Eye Exam*, *LDL-C Screening, LDL-C Level <100 mg/Dl, Monitoring for Diabetic Nephropathy, Blood Pressure <140/90 mm/Hg,* and *Blood Pressure < 130/80 mm/Hg*.

Figure 4–22 presents the comparative rates for *Comprehensive Diabetes Care—HbA1c Testing*. Neither MCO had a rate above the national Medicaid HEDIS 2009 50th percentile of 80.7 percent. Overall, **FHN**'s rates have consistently improved, gaining 44.3 percentage points with this measure since HEDIS 2005. **Harmony**'s rate has also shown steady improvement and is 18.7 percentage points higher than HEDIS 2005. However, **Harmony** had a slight decline of 1.1 percentage points for this year.

Figure 4–22—Comparison of HFS MCO Performance for *Comprehensive Diabetes Care—HbA1c Testing*

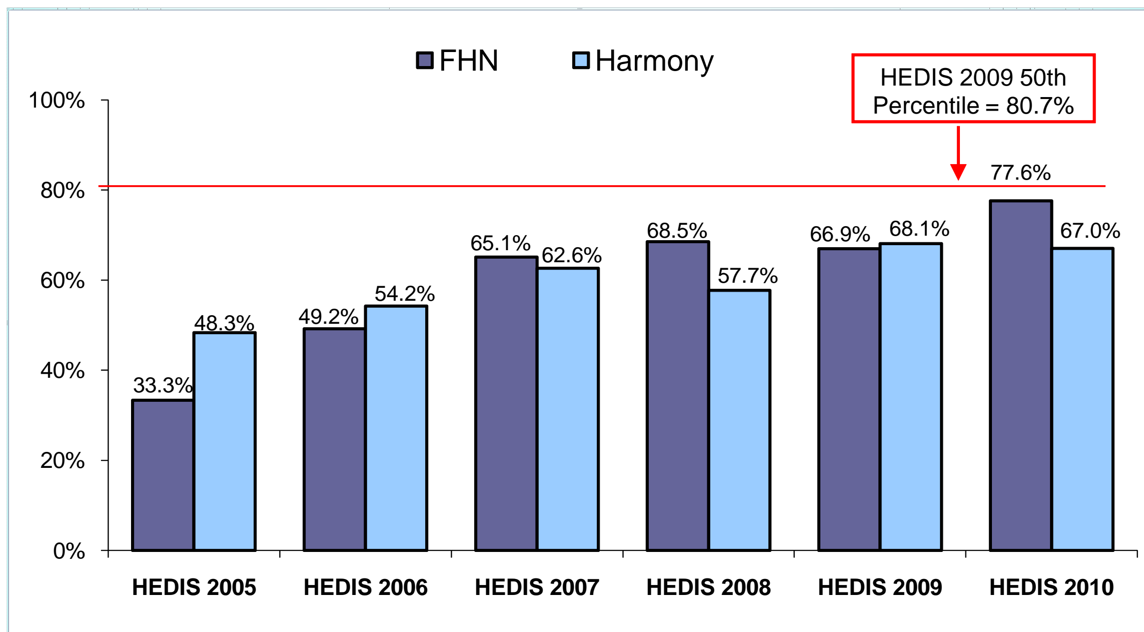


Figure 4–23 presents the comparative rates for *Comprehensive Diabetes Care—Good HbA1c Control*. The MCOs first reported this measure for HEDIS 2007. The rate for **FHN** increased by 3.9 percentage points this year, while **Harmony**'s rate improved by 4.2 percentage points. Both rates continue to improve, but are well below the National Medicaid HEDIS 2009 50th percentile of 45.8 percent.

Figure 4–23—Comparison of HFS MCO Performance for *Comprehensive Diabetes Care—Good HbA1c Control*

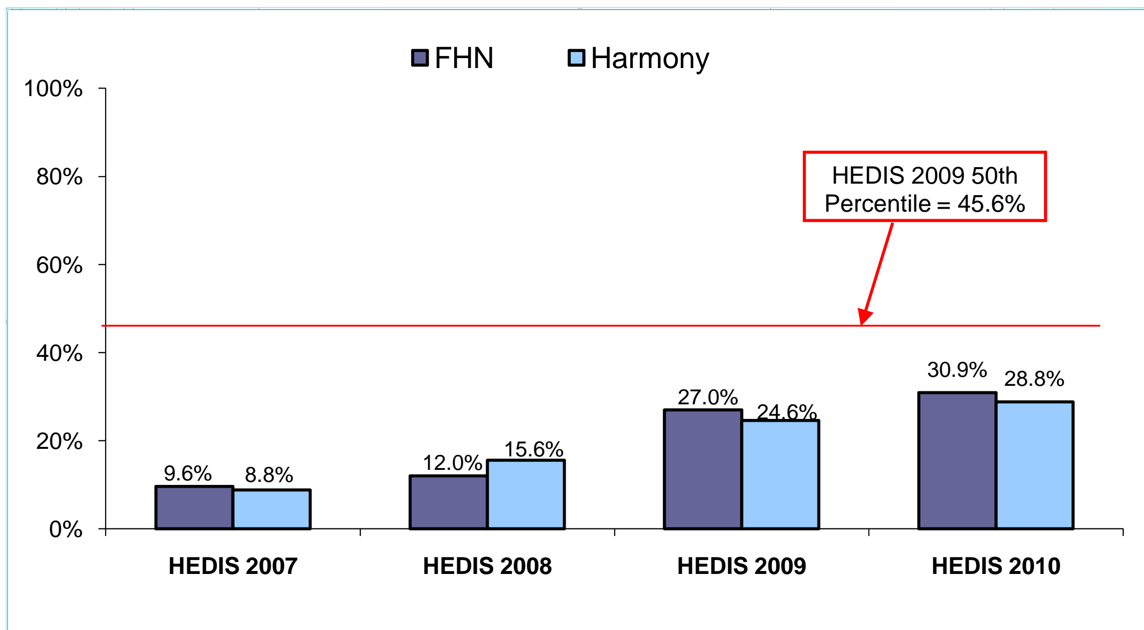


Figure 4–24 presents the comparative rates for *Comprehensive Diabetes Care—Poor HbA1c Control*. Lower rates are better for this measure since this measure evaluates the percentage of members who were in poor control of their diabetes.

Overall, the rate for **FHN** has improved 10.9 percentage points since HEDIS 2005. However, the rate for **FHN** increased this year by 3.6 percentage points, and marks the second year in a row that the rate has increased. **Harmony**'s rate has demonstrated a steady improvement with this measure, decreasing its rate by 25.8 percentage points since HEDIS 2005. Neither MCO is below the National Medicaid 50th percentile of 42.6 percent.

Figure 4–24—Comparison of HFS MCO Performance for *Comprehensive Diabetes Care—Poor HbA1c Control*

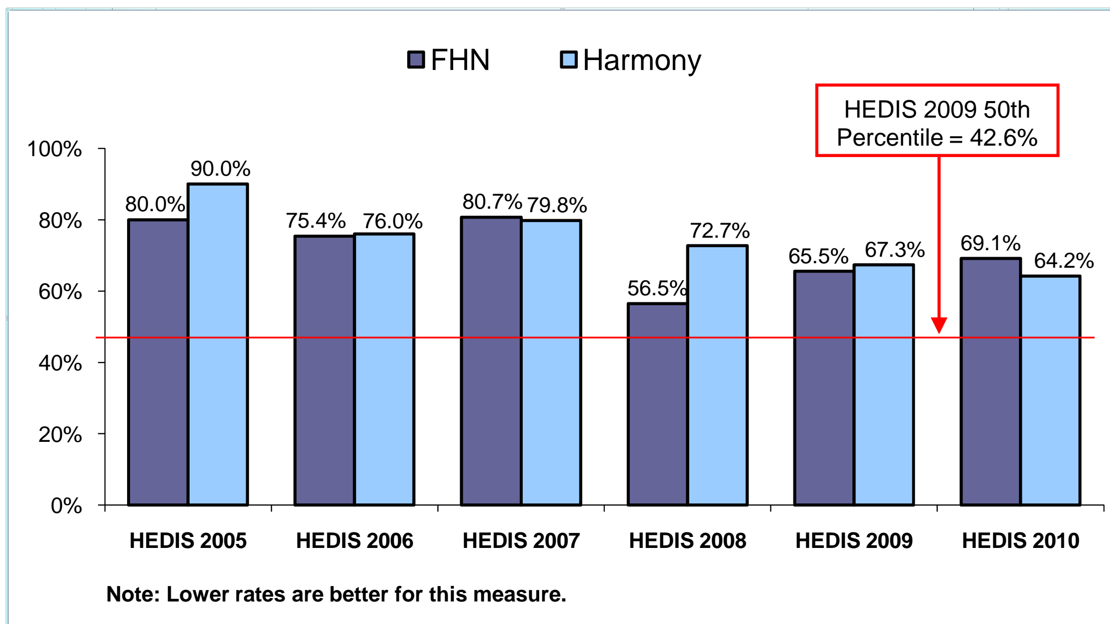
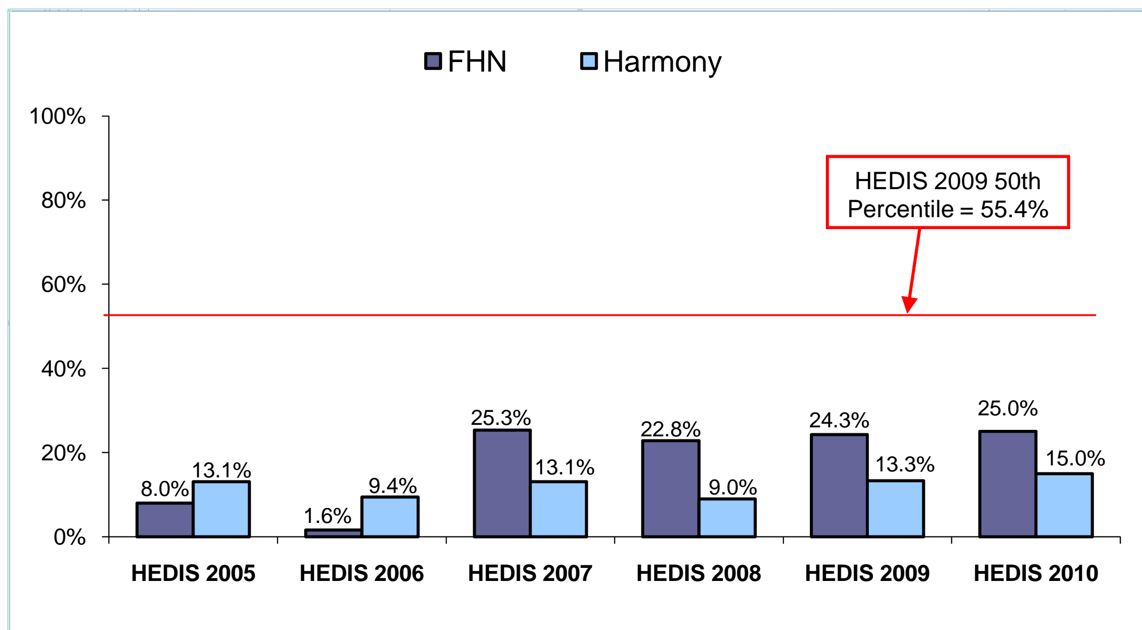


Figure 4–25 presents the comparative rates for *Comprehensive Diabetes Care—Eye Exam*. Both MCOs have struggled to improve on this measure since HEDIS 2005.

Both MCOs showed a very small gain this year for this measure. The rates continue to remain well below the National Medicaid HEDIS 2009 50th percentile of 55.4 percent. Overall, **FHN**'s rate has improved 17.0 percentage points from HEDIS 2005, while the rate for **Harmony** has improved by 1.9 percentage points.

Figure 4–25—Comparison of HFS MCO Performance for *Comprehensive Diabetes Care—Eye Exam*



This measure has continued to show little to no real improvement. Both **Harmony** and **FHN** need to conduct an analysis to determine why this particular rate is so low. The MCOs and the State should also consider conducting a PIP around this measure.

Figure 4–26 presents the comparative rates for *Comprehensive Diabetes Care—LDL-C Screening*. **FHN**'s rate has continued to improve each year and has improved significantly (46.4 percentage points) since HEDIS 2005. This year's rate improved by 8.3 percentage points. By contrast, **Harmony**'s rate declined each year from HEDIS 2006 through HEDIS 2008. The rate for this year is 0.2 percentage points higher than last year but is lower than the HEDIS 2005 rate. Both MCOs had rates below the National Medicaid HEDIS 2009 50th percentile of 76.1 percent.

Figure 4–26—Comparison of HFS MCO Performance for *Comprehensive Diabetes Care—LDL-C Screening*

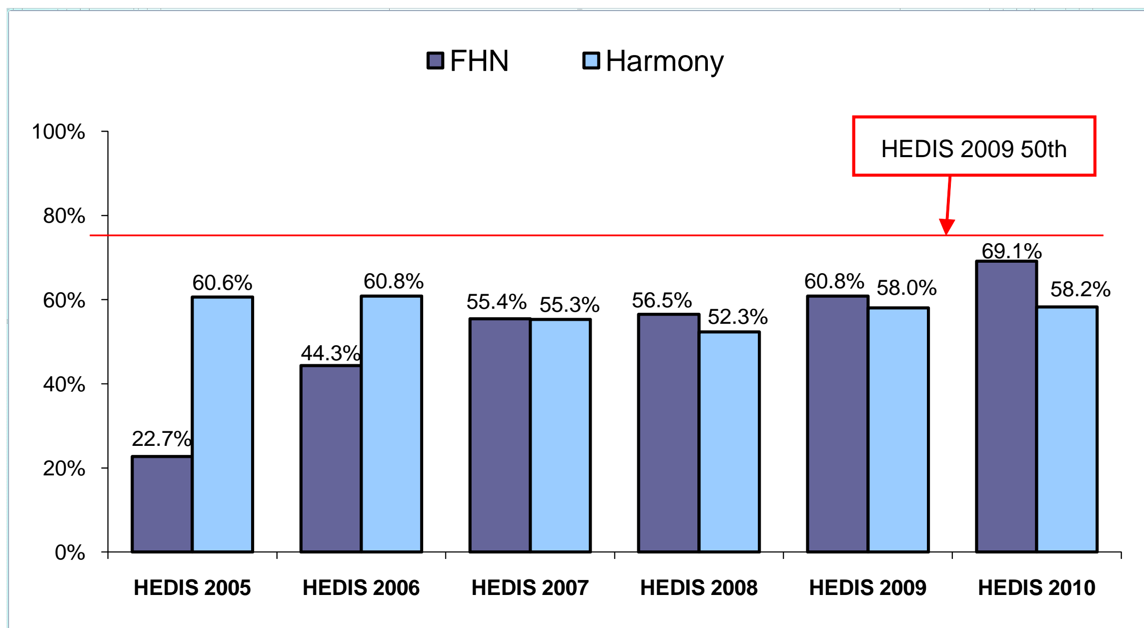


Figure 4–27 presents the comparative rates for *Comprehensive Diabetes Care—LDL-C Level <100mg/Dl*. **FHN**'s rate has generally shown a small improvement each year, but this year the rate improved by 7.4 percentage points. **Harmony**'s rate improved by just 0.9 percentage points. Both MCOs had rates well below the National Medicaid HEDIS 2009 50th percentile of 35.1 percent. The low rates for this measure may be due to lack of encounter data from laboratories.

Figure 4–27—Comparison of HFS MCO Performance for *Comprehensive Diabetes Care—LDL-C Level <100mg/Dl*

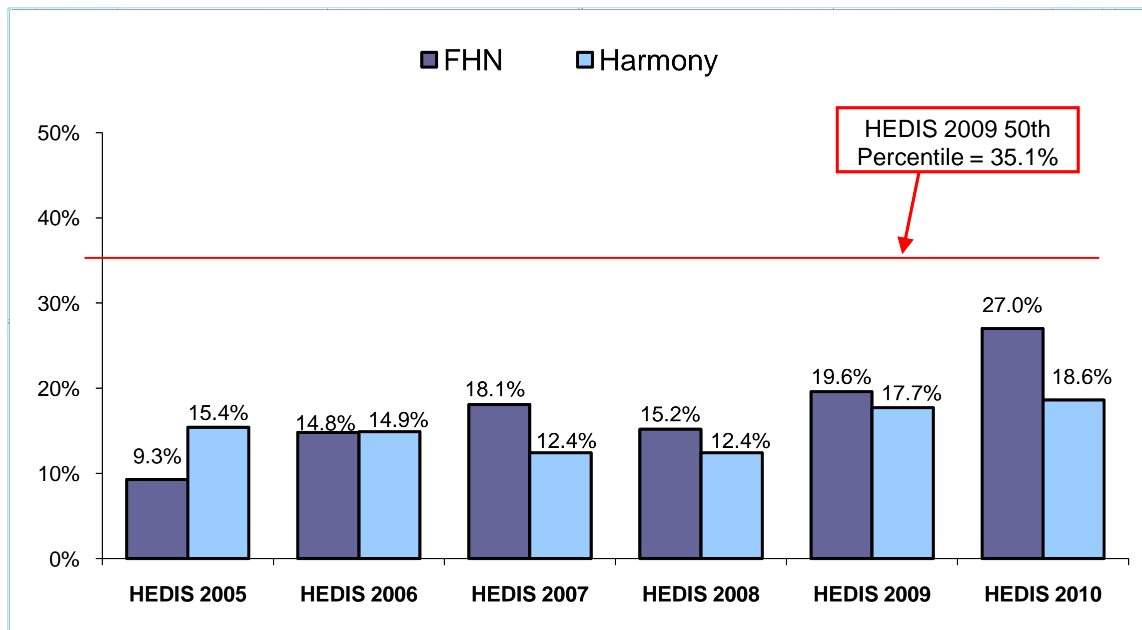


Figure 4–28 presents the comparative rates for *Comprehensive Diabetes Care—Monitoring for Diabetic Nephropathy*. The HEDIS technical specifications for this measure changed for HEDIS 2007; therefore, rates are only comparable for the past three years.

FHN's rate improved 5.8 percentage points over last year and 14.4 percentage points since HEDIS 2007. The current rate is above the National Medicaid HEDIS 2009 50th percentile of 78.1 percent. The rate for **Harmony** declined by 1.5 percentage points from last year but has improved by 6.3 percentage points since HEDIS 2007.

Figure 4–28—Comparison of HFS MCO Performance for *Comprehensive Diabetes Care—Monitoring for Diabetic Nephropathy*

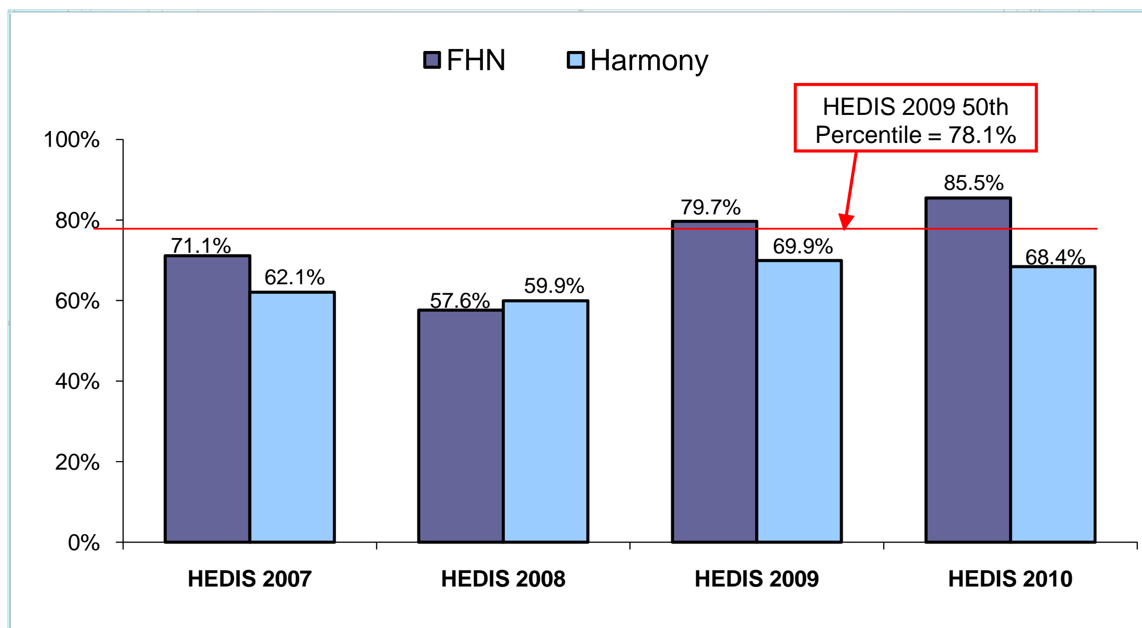


Figure 4–29 presents the comparative rates for *Comprehensive Diabetes Care—Blood Pressure (Less than 140/90 mm/Hg and 130/80 mm/Hg).* The MCOs first reported these two measures for HEDIS 2007. **FHN**'s rate for this measure has declined each year, including another 4.5 percentage point decrease this year. **Harmony**'s rate has generally improved each year, but this year the MCO showed a small decline of 2.7 percentage points from last year. Both rates are below the National Medicaid 2009 50th percentile of 61.1 percent.

Figure 4–29—Comparison of HFS MCO Performance for *Comprehensive Diabetes Care—Blood Pressure* <140/90 mm/Hg

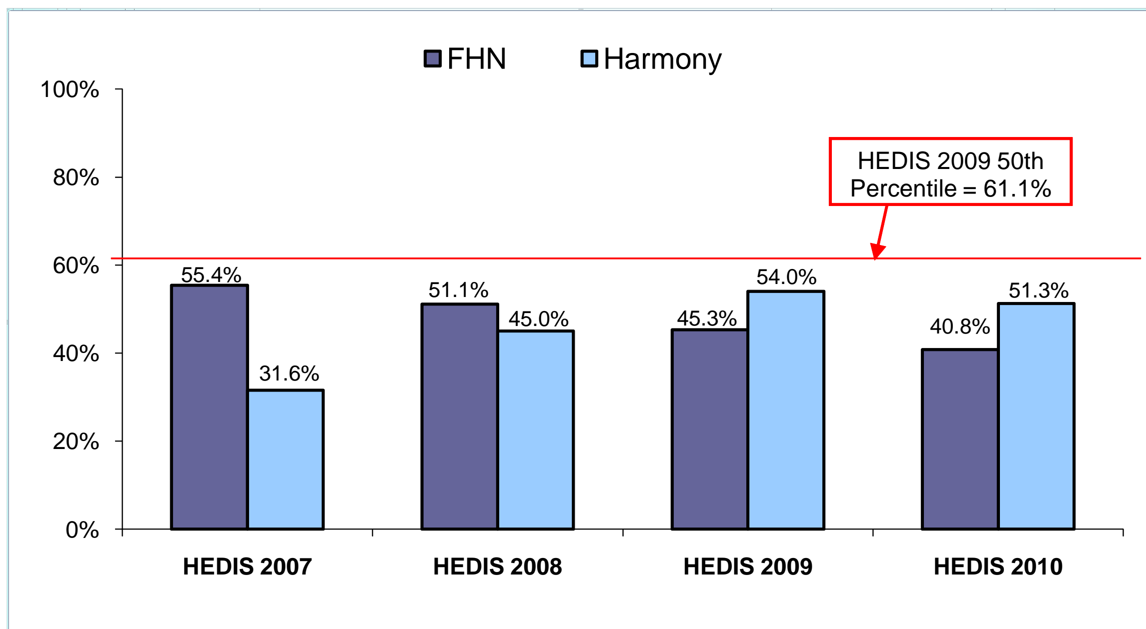
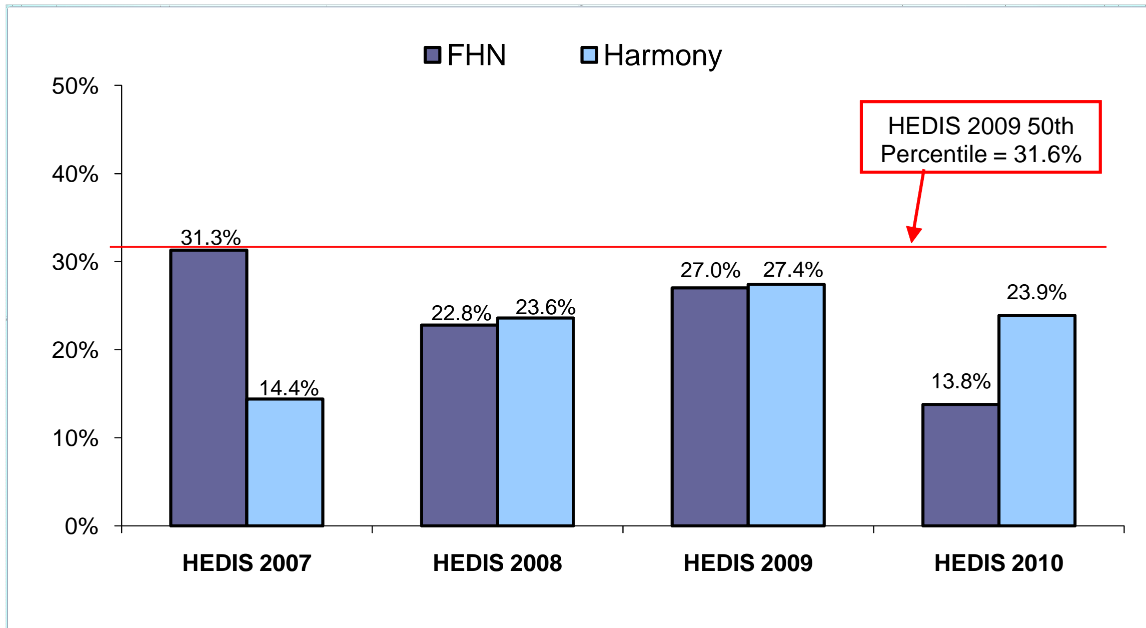


Figure 4–30 presents the comparative rates for *Comprehensive Diabetes Care—Blood Pressure <130/80 mm/Hg*. The rate for **FHN** had a sharp decline this year of 13.2 percentage points and is lower than the baseline rate by 17.5 percentage points. The rate for **Harmony** declined by 3.5 percentage points, though the rate remains higher than the baseline rate.

Figure 4–30—Comparison of HFS MCO Performance for *Comprehensive Diabetes Care—Blood Pressure <130/80 mm/Hg*

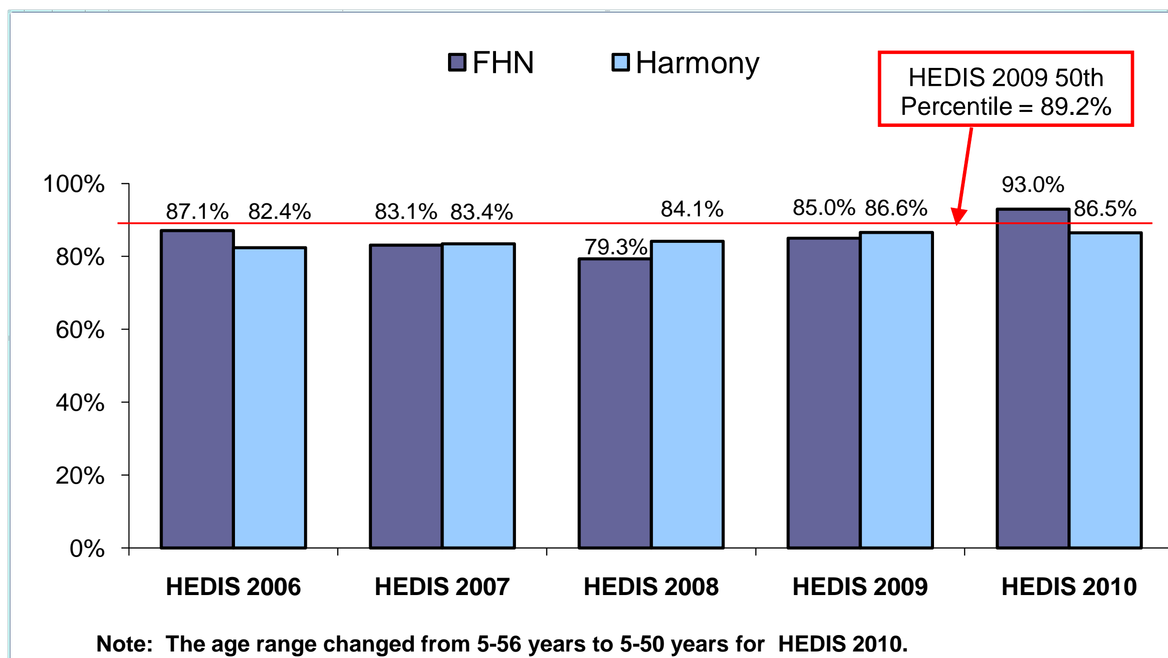


Use of Appropriate Medications for People With Asthma

Figure 4–31 presents the comparative performance of **FHN** and **Harmony** for *Use of Appropriate Medications for People With Asthma (Combined)*. The HEDIS technical specifications changed for this measure beginning with HEDIS 2006, so trending was limited to four years. For HEDIS 2010, the HEDIS technical specifications were modified for the age range; the age range was changed from 5–56 years of age to 5–50 years of age. NCQA did not expect this to have much impact on the rates for this measure; therefore, this measure was still trended for this year.

The rate for **FHN** improved this year by 8.0 percentage points and exceeded the National Medicaid 50th percentile of 89.2 percent. Overall, the rate for **FHN** has improved 5.9 percentage points, increasing from 87.1 percent for HEDIS 2006 to 93.0 percent for HEDIS 2010. The rate for **Harmony** remained nearly identical to last year's rate; the MCO has generally shown a slight but steady increase in its rate since HEDIS 2006.

Figure 4–31—Comparison of HFS MCO Performance for *Use of Appropriate Medications for People With Asthma (Combined)*

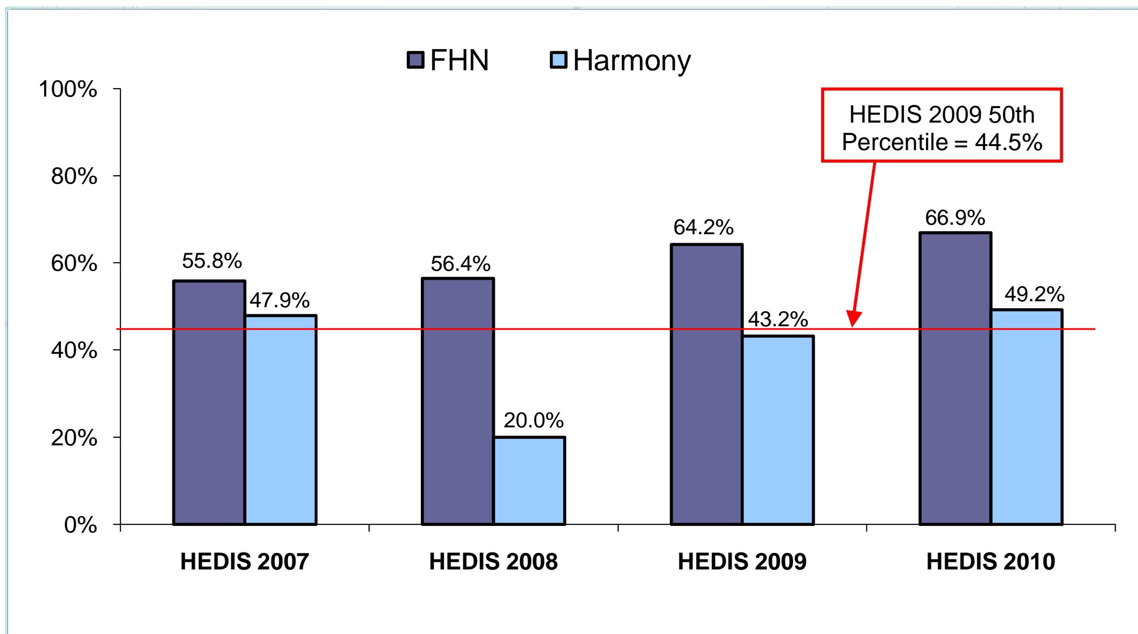


Follow-up After Hospitalization for Mental Illness

Figure 4–32 and Figure 4–33 below present the comparative rates for *Follow-up After Hospitalization for Mental Illness (7-Day Follow-Up and 30-Day Follow-Up)*. The MCOs first reported these measures for HEDIS 2007.

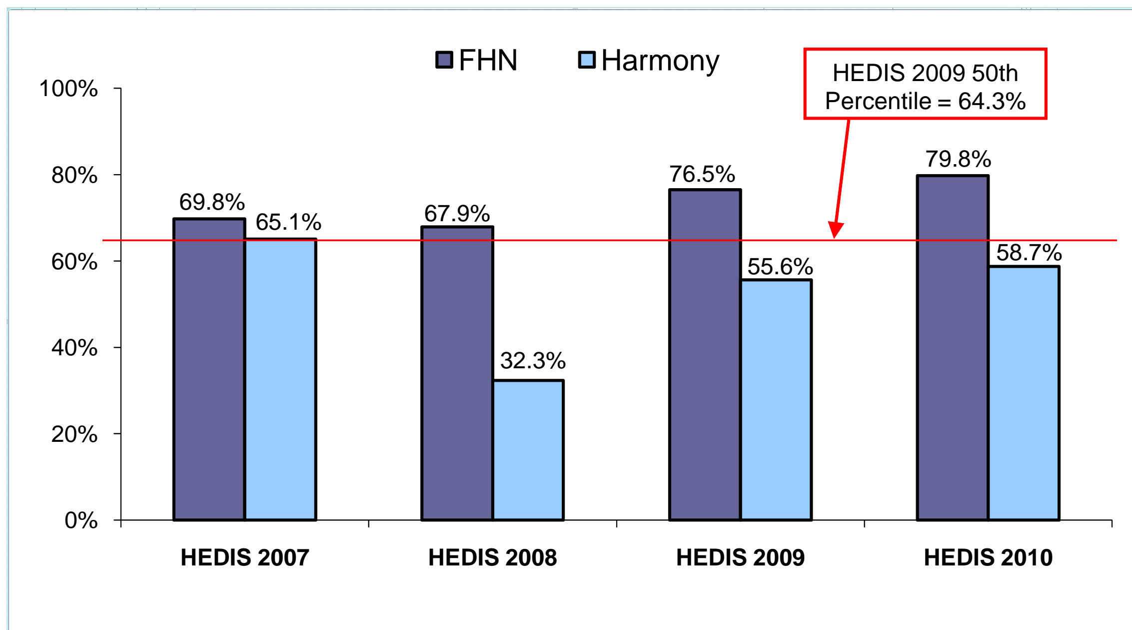
FHN's rate of 66.9 percent was well above the National Medicaid HEDIS 2009 50th percentile of 44.5 percent, and has improved by 11.1 percentage points since HEDIS 2007. **Harmony**'s rate improved after having a significant decline in HEDIS 2008 and is also above the National Medicaid 50th percentile.

Figure 4–32—Comparison of HFS MCO Performance for *Follow-up After Hospitalization for Mental Illness (7-Day Follow-Up)*



For 30-day follow-up, **FHN**'s rate improved from 69.8 percent to 79.8 percent since the baseline year, and is well above the National Medicaid HEDIS 2009 50th percentile of 64.3 percent. **Harmony**'s rate improved by 3.1 percentage points over last year but is still 6.4 percentage points lower than the rate reported for HEDIS 2007. **Harmony**'s rate has not exceeded the HEDIS 2009 50th percentile since HEDIS 2007.

Figure 4–33—Comparison of HFS MCO Performance for *Follow-up After Hospitalization for Mental Illness (30-Day Follow-Up)*



Encounter Data Completeness

Table 4–2 provides an estimate of the data completeness for the hybrid performance measures. These measures use administrative encounter data and supplement the results with medical record data. The rates in the table represent the percentage of the final HEDIS rate that was determined solely through the use of administrative encounter data. A rate of 100 percent for the last two columns indicates that the encounter data was complete for that HEDIS measure. The higher rate of encounter data completeness appears in green text.

Table 4–2—Estimated Encounter Data Completeness for Hybrid Measures

Performance Measures	Final HEDIS Rate		Percent Encounter Data	
	FHN	Harmony	FHN	Harmony
Childhood Immunizations—Combo 2	75.5	67.4	0.9	**74.4**
Childhood Immunizations—Combo 3	69.8	60.6	0.3	**62.7**
Lead Screening in Children	82.2	74.7	63.5	**84.0**
Well-Child Visits in the First 15 Months (6+ Visits)	48.3	45.7	39.2	**78.7**
Well-Child Visits (3–6 Years)	79.2	69.8	84.0	**93.4**
Adolescent Well-Care Visits	45.7	37.2	83.8	**92.8**
Breast Cancer Screening	44.9	31.5	55.8	NA
Cervical Cancer Screening	63.9	69.3	67.0	**93.0**
Chlamydia Screening in Women(Combined Rate)	56.4	49.9	65.3	NA
Frequency of Ongoing Prenatal Care (≥81% Visits)	26.1	39.4	75.2	**86.4**
Timeliness of Prenatal Care	49.2	65.2	62.9	**86.9**
Postpartum Care	39.3	49.6	60.6	**76.0**
Diabetes Care (HbA1c Testing)	77.6	67.0	16.1	**78.7**
Diabetes Care (Eye Exam)	25.0	15.0	52.6	**69.5**
Diabetes Care (LDL-C Screening)	69.1	58.2	19.0	**77.1**
Diabetes Care (Monitoring for Diabetic Nephropathy)	85.5	68.4	40.0	**93.9**

The percentage of the rate that was captured using administrative encounter data was substantially lower for **FHN. FHN**'s encounter data completeness was over 80.0 percent for *Well-Child Visits (3–6 Years)*, and *Adolescent Well-Care Visits*. However, eight measures had encounter data completeness rates of less than 60.0 percent. These results indicate that **FHN** continues to have difficulty obtaining complete encounter data. This concern was mentioned in the prior EQR technical report, and **FHN** is strongly encouraged to focus efforts on improving encounter data submission.

Compared to **FHN**, **Harmony**'s encounter data submission was much higher, especially for the measures related to early well-child care (i.e., *Childhood Immunizations*, *Lead Screening in Children*, and *Well-Child Visits in the First 15 Months of Life*), maternity care, and diabetes care.

Harmony should continue to reinforce efforts to improve submission of encounter data to maintain this level of encounter data submission.

Summary of Findings

The following is a brief summary of the findings and recommendations regarding the performance measures in this report:

- Due to **Meridian**'s low population, **Meridian** did not have more than 30 eligible members for any of the reported HEDIS measures. In accordance with NCQA, the rates for these measures are not applicable (NA). Therefore, **Meridian**'s rates are not presented for this year.
- **Meridian** is expected to have a larger population next year and should be able to report rates for some measures. Measures that rely on more than one year of continuous enrollment may still have a low volume.
- Both MCOs have continued to improve with the children and adolescent care measures. The rates for *Lead Screening in Children* are above the 50th percentile for both MCOs. **FHN** reported a rate above the 75th percentile for *Well-Child Visits (3–6 Years),* and above the 50th percentile for the *Adolescent Well-Care Visit* rate.
- The low rates for *Children's Access to PCPs* and *Adults' Access to Preventive/Ambulatory Health Services* indicate that both MCOs need to improve access to care.
- The rates for both MCOs for measures in the preventive screenings for women category improved over last year but remain fairly low. **FHN** showed improvement over last year for all the measures. **Harmony** continued to show improvement with *Cervical Cancer Screening*, but the other rates remained about the same as last year.
- Both MCOs continue to report rates well below the 10th percentile for maternity-related measures *Frequency of Ongoing Prenatal Care, Timeliness of Prenatal Care,* and *Postpartum Care*. In 2007, the MCOs began a PIP that includes these maternity-related measures, and **Harmony** has improved on every measure. However, **FHN** has had only limited success, improving on the *Postpartum Care* measure only and remaining about the same on the other two measures. Both *Timeliness of Prenatal Care* and *Frequency of Ongoing Prenatal Care* are also related to access; as already seen, **FHN** and **Harmony** have shown difficulty attaining access-to-care measure improvements.
- The chronic conditions/disease management category has produced mixed results, with some rates increasing and several measures declining. **FHN** demonstrated notable improvement with *Diabetes Care—HbA1c Testing*, *LDL-C Screening*, and *Monitoring of Diabetic Nephropathy*. However, **FHN** experienced rate declines for *Controlling High Blood Pressure*, *Comprehensive Diabetes Care—Poor HbA1c Control*, *Blood Pressure <140/90 mm/Hg*, and *Blood Pressure <130/80 mm/Hg*. **Harmony**'s rates all demonstrated increases or decreases of less than 5.0 percentage points over last year.
- The two measures related to mental health continue to represent an area of strength for **FHN**, with the 7–day rate now exceeding the 90th percentile and the 30–day rate exceeding the 75th percentile. The 7–day rate for **Harmony** was above the 50th percentile, but only 1.3 percentage points higher than the HEDIS 2007 rate. The 30-day rate for **Harmony** showed little improvement and remains below the initial baseline rate. The MCOs have initiated a PIP that

incorporates this measure, and it is expected to have a positive impact on rates in the following years.

- Encounter data submission is still low for **FHN**, with only two measures scoring more than 80 percent data completeness and eight measures with less than 60 percent data completeness. **Harmony**'s encounter data submission was much higher, especially for the measures related to early well-child care (i.e., *Childhood Immunizations*, *Lead Screening in Children*, and *Well-Child Visits in the First 15 Months of Life*), maternity care, and diabetes care.
- Both MCOs showed a general overall improvement. **FHN**'s rates improved on 28 out of 35 measures, while **Harmony**'s rates improved for 27 out of 35 measures this year.

Validation of Performance Improvement Projects—SFY 2009–2010

Table 4–3 shows the current evaluation scoring for the PIPs that span all MCOs. The table presents each MCO, the PIPs for which each MCO is responsible, and the current validation status of each PIP.

Table 4–3—Percent of All Elements *Met*			
PIP Topics	**FHN**	**Harmony**	**Meridian**
EPSDT Screening	94%	85%	100%
Perinatal Care and Depression Screening	92%	87%	100%
Improving Ambulatory Follow-Up and PCP Communication	100%	91%	100%

Although Table 4–3 shows higher percentages of elements met, it does not show the progress of each MCO through each PIP. The earlier activities in the PIP are almost universally scored as *Met* a higher proportion of the time than later activities. This effect can be seen in Table 4–4, showing the number of elements assessed for each PIP and MCO.

Table 4–4—Number of Elements Assess for Each PIP and MCO			
PIP Topics	**FHN**	**Harmony**	**Meridian**
EPSDT Screening	45	41	17
Perinatal Care and Depression Screening	48	45	18
Improving Ambulatory Follow-Up and PCP Communication	17	21	17

Table 4–4 begins to demonstrate the differences in scoring across MCOs according to the number of elements scored. The correlation between scores and elements scored is -0.760 ($p = .017$). That statistically significant correlation means that somewhat over half the variation in PIP scores can be explained by the number of elements on which each PIP was scored ($0.760^2 = 0.578 = 57.8\%$). The remaining variation in scoring is explained by differences in PIPs and MCOs that cannot be reliably split across the MCOs with the amount of data available.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys—SFY 2009–2010

Adult Medicaid

Table 4–5 presents the 2010 adult Medicaid CAHPS results for **FHN** and **Harmony**, as well as the 2010 NCQA national averages. Because of its small size, **Meridian** was allowed to conduct its own survey Due to differences in the exact wording of the questions, **Meridian**'s results are not directly comparable with those of **FHN** and **Harmony**. For this reason, **Meridian**'s results are not displayed in this section of the report.

Table 4–5—2010 Adult Medicaid CAHPS Results			
	FHN	Harmony	2010 NCQA CAHPS National Averages
Composite Measures			
Getting Needed Care	48.8%	32.5%	49.4%
Getting Care Quickly	55.9%	51.8%	55.2%
How Well Doctors Communicate	73.6%	70.9%	67.7%
Customer Service	61.8%	57.1%	58.2%
Shared Decision Making	65.8%	60.6%	59.6%
Global Ratings			
Rating of All Health Care	45.6%	36.5%	47.2%
Rating of Personal Doctor	56.1%	52.2%	60.4%
Rating of Specialist Seen Most Often	55.6%	58.2%	60.8%
Rating of Health Plan	46.3%	36.4%	52.8%

Both **FHN** and **Harmony** scored above the 2010 NCQA Adult CAHPS top-box national averages for *How Well Doctors Communicate* and *Shared Decision Making*. **FHN** scored above the national average for *Getting Care Quickly* and *Customer Service.*

Harmony scored more than 10 percentage points below the national averages for *Getting Needed Care, Rating of All Health Care,* and *Rating of Health Plan.*

Both **FHN** and **Harmony** scored below the national averages for *Getting Needed Care;* and *Ratings of All Health Care, Personal Doctor, Specialist Seen Most Often,* and *Health Plan.*

Child Medicaid

Table 4–6 presents the 2010 child Medicaid CAHPS results for **FHN** and **Harmony**, as well as the 2010 NCQA national averages.

Table 4–6—2010 Child Medicaid CAHPS Results

	FHN	Harmony	2010 NCQA CAHPS National Averages
Composite Measures			
Getting Needed Care	51.3%	40.8%	53.2%
Getting Care Quickly	59.6%	65.8%	68.0%
How Well Doctors Communicate	71.8%	70.0%	73.2%
Courteous and Helpful Office Staff	62.3%	56.6%	61.5%
Customer Service	62.3%	63.0%	65.4%
Global Ratings			
Rating of All Health Care	59.9%	47.5%	60.0%
Rating of Personal Doctor	70.0%	59.2%	69.8%
Rating of Specialist Seen Most Often	58.3%	69.2%	66.5%
Rating of Health Plan	61.8%	50.0%	65.4%

There were no measures where both **FHN** and **Harmony** scored above the 2010 NCQA Child CAHPS top-box national averages. **FHN** scored above the national averages for *Courteous and Helpful Office Staff* and *Rating of Personal Doctor*. **Harmony** scored above the national average for *Rating of Specialist Seen Most Often*.

Harmony scored more than 10 percentage points below the national averages for *Getting Needed Care, Rating of All Health Care, Rating of Personal Doctor,* and *Rating of Health Plan.*

Both **FHN** and **Harmony** scored below the national averages for *Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, Rating of All Health Care,* and *Rating of Health Plan.*

5. Conclusions and Recommendations

State

- The HEDIS compliance audit indicated that the HFS MCOs successfully prepared the selected performance measures in accordance with *HEDIS 2009 Technical Specifications* and presented fairly the MCOs' performance with respect to these specifications. All MCOs had information systems that met HEDIS standards with no significant impact on the reliability of HEDIS reporting, valid MRR processes, and performance measures (for those included in the audit) that followed HEDIS specifications and provided reportable rates. However, encounter data submission was still low, although improvements were noted compared to the previous year, especially for **Harmony**. The State should emphasize the importance of the MCOs' efforts to increase the submission of encounter data.
- Both **FHN** and **Harmony** continued to improve the children and adolescent care measures. The rates for *Lead Screening in Children* were above the 50th percentile for both MCOs. **FHN** reported a rate above the 75th percentile for *Well-Child Visits (3–6 Years),* and above the 50th percentile for the *Adolescent Well-care Visits* rate. The low rates for children's and adolescents' access to PCPs and adults' access to preventative ambulatory care services indicate that both **FHN** and **Harmony** need to improve access to care.
- **FHN** and **Harmony** had some *Partially Met* or *Not Met* elements for activities in the later stages of their PIPs. The State should emphasize the importance of the MCOs' seeking technical assistance as needed and implementing recommendations to ensure successful interventions, accurate statistical analyses, and true improvements that are sustained over time. Although **Meridian** has achieved 100 percent *Met* scores for its three PIPs, their early stage of development results suggest that technical assistance might benefit them as well. In addition, **Meridian's** PIPs were still in their early stages of the required activities.
- The 2010 CAHPS scores indicated that patients statewide are satisfied with how well their doctors communicate with them regarding the care of adults. In contrast, specialist ratings were below the national averages for adults and children. The State should reinforce with MCOs the importance of meeting patients' expectations regarding their health care experiences, since satisfaction can impact compliance and encourage members to access needed care in a timely manner.

MCOs

Family Health Network

- Substantial work remains for **FHN** to complete its compliance monitoring CAP. **FHN** must continue to work with the State on implementing case management software and follow HSAG's recommendations to achieve compliance with QAP standards.
- **FHN** has shown significant improvement for five of the eight measures in the *EPSDT Screening* PIP since the baseline reporting period. However, the highest three measures from the baseline period—health history, nutritional assessment, and growth measurement—have declined. **FHN**

may be focusing on improving the lower rates but not ensuring that providers still perform and document the components for the other measures.

- For the *Perinatal Care and Depression Screening* PIP the percentage of women who had a depression screen both before delivery and within 56 days after delivery has more than doubled (from 6.5 percent to 14.6 percent), but still presents an opportunity for improvement.
- **FHN** demonstrated progress in improving HEDIS results on measures related to the care of children and adolescents, and should continue efforts to increase these rates.
- **FHN** showed improvement over last year for all the measures in the preventative screenings for women category.
- Low HEDIS scores indicated that **FHN** continued to report rates well below the 10th percentile for maternity-related measures *Frequency of Ongoing Prenatal Care, Timeliness of Prenatal Care,* and *Postpartum Care* and should focus improvement efforts in those areas.
- There have been mixed results for measures in the chronic conditions/disease management category, with some rates increasing and several measures declining. **FHN** achieved noticeable improvement in these *Comprehensive Diabetes Care* categories: *HbA1c Testing*, *LDL-C Screening*, and *Monitoring for Diabetic Nephropathy*. However, **FHN** experienced rate declines for *Controlling High Blood Pressure*, *Diabetes Care—Poor HbA1c Control*, *Blood Pressure <140/90 mm/Hg*, and *Blood Pressure <130/80 mm/Hg*.
- **FHN**'s adult CAHPS results were strongest for *How Well Doctors Communicate, Customer Service,* and *Shared Decision Making,* but lower than the national average for *Getting Needed Care, Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often,* and *Rating of Health Plan.* **FHN** scored above the child CAHPS national averages for *Courteous and Helpful Office Staff* and *Rating of Personal Doctor.* **FHN** should continue to implement strategies to continually improve patient satisfaction.

Harmony

- **Harmony** has successfully addressed all of the requirements of its compliance monitoring CAP.
- **Harmony** showed improvement for one measure of the eight measures for the *EPSDT Screening* PIP (i.e., nutritional assessment). Developmental screening, anticipatory guidance, and physical exam rates declined fewer than 4 percentage points. Rates for the other four measures experienced statistically significant declines.
- For the *Perinatal Care and Depression Screening* PIP the percentage of women who had a depression screen both before delivery and within 56 days after delivery has more than doubled (from 6.5 percent to 14.6 percent), but still presents an opportunity for improvement.
- **Harmony** continued to show improvement with the *Cervical Cancer Screening* measure.
- In SFY 2006-2007, the MCOs began a PIP that includes maternity-related measures *Frequency of Ongoing Prenatal Care, Timeliness of Prenatal Care, and Postpartum Care*; **Harmony** has improved on every measure.
- For *Diabetes Care —HbA1c Testing*, *LDL-C Screening*, and *Monitoring for Diabetic Nephropathy*, **Harmony**'s rates all had increases or decreases of less than 5.0 percentage points over last year.

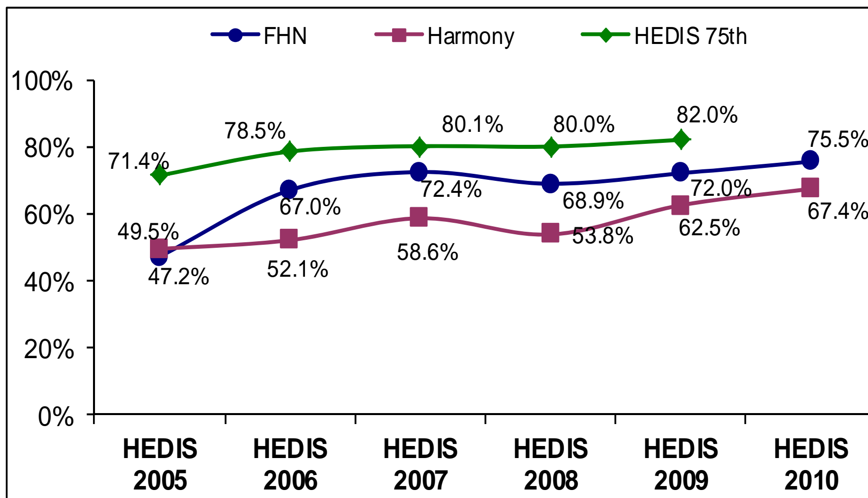
- For the two measures related to mental health for **Harmony**, the 7-day rate was above the 50th percentile, and the 30-day rate showed little improvement and remains below initial baseline rate.
- **Harmony**'s adult CAHPS results were strongest for *How Well Doctors Communicate* and *Shared Decision Making*. However, **Harmony** scored below the national averages for *Getting Needed Care, Getting Care Quickly, Customer Service, Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often* and *Rating of Health Plan*.
- **Harmony** scored above the child CAHPS national average for *Rating of Specialist Seen Most Often* and lower than the national average for every other measure. **Harmony** should continue to implement strategies to continually improve patient satisfaction.

Meridian

- **Meridian**'s strong performance on its readiness review and the initial validation activities in its *EPSDT Screening*, *Perinatal Care and Depression Screening*, and *Improving Ambulatory Follow-Up and PCP Communication* PIPs indicate that the MCO is well positioned to provide quality and timely care and appropriate access to services for members enrolled in the MCO.

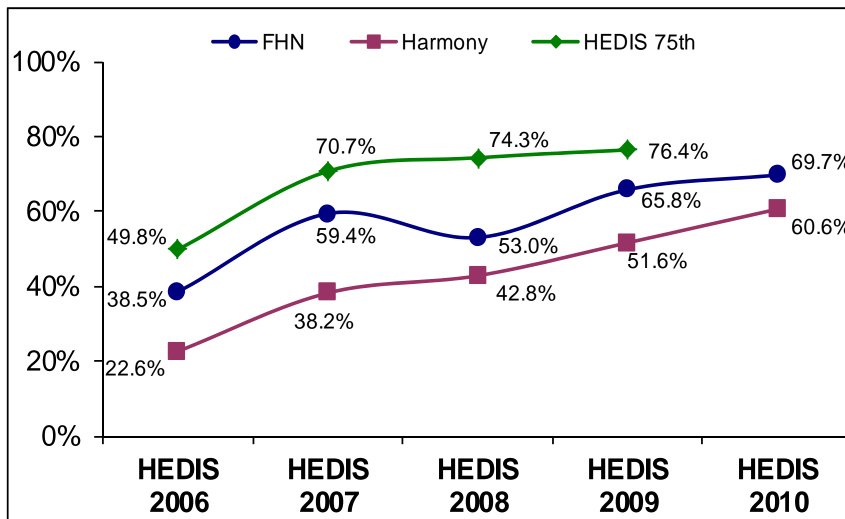
This appendix displays trended line graphs for the performance measures with at least two years of HEDIS reporting compared to the national Medicaid HEDIS 75th percentile for each reporting year. In several cases where lower performance is considered better, the 25th percentile is used for comparison. The national Medicaid HEDIS percentiles for each year are provided in a table to the right of each graph.

Figure A–1—*Childhood Immunizations—Combination #2*



Medicaid HEDIS Percentiles					
HEDIS	**10th**	**25th**	**50th**	**75th**	**90th**
2005	47.8	56.6	66.0	71.4	75.7
2006	53.8	62.7	72.4	78.5	82.7
2007	58.7	68.3	75.2	80.1	84.8
2008	57.2	67.6	75.4	80.0	84.7
2009	56.4	68.5	77.9	82.0	85.4

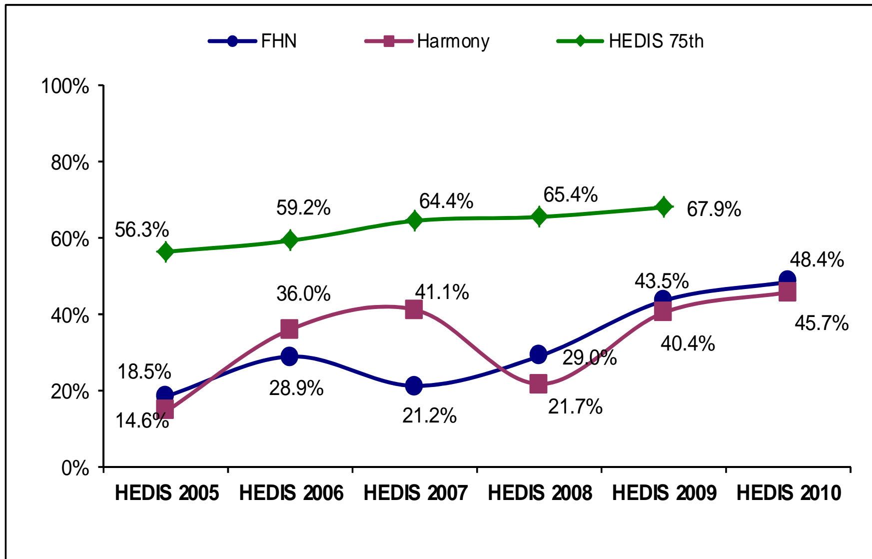
Figure A–2—*Childhood Immunizations—Combination #3*



Note: Combination 3 was a new measure beginning with HEDIS 2006.

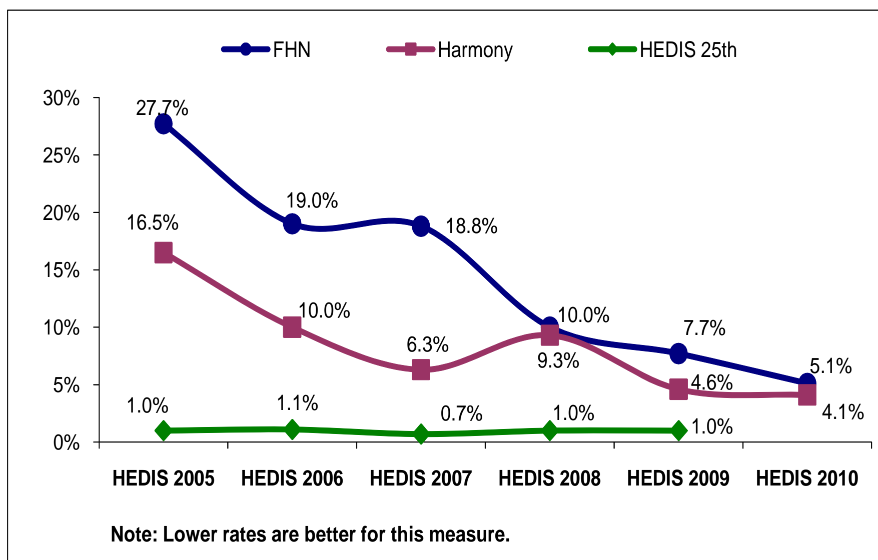
Medicaid HEDIS Percentiles					
HEDIS	**10th**	**25th**	**50th**	**75th**	**90th**
2005	NA	NA	NA	NA	NA
2006	25.1	33.8	42.3	49.8	57.8
2007	41.8	54.3	62.6	70.7	74.5
2008	50.1	59.9	68.6	74.3	78.2
2009	50.9	62.4	71.8	76.4	80.6

Figure A–3—*Well-Child Visits in the First 15 Months of Life (6+ Visits)*



Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2005	15.2	38.7	46.4	56.3	65.7
2006	22.4	41.6	50.0	59.2	68.6
2007	38.0	46.6	56.6	64.4	75.2
2008	29.0	44.5	57.5	65.4	73.7
2009	40.4	51.6	60.6	67.9	73.9

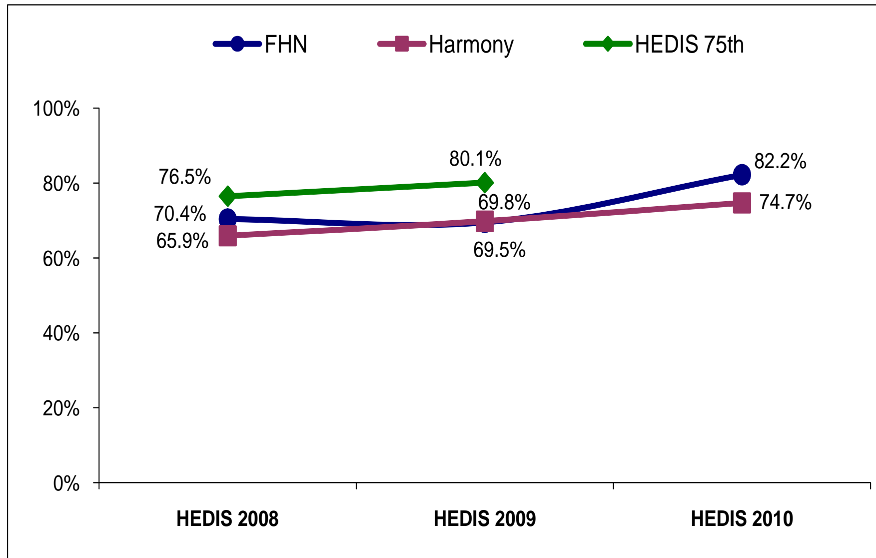
Figure A–4—*Well-Child Visits in the First 15 Months of Life (0 Visits)*



Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2005	0.5	1.0	2.1	3.9	13.1
2006	0.5	1.1	2.0	3.9	10.0
2007	0.4	0.7	1.4	2.9	6.8
2008	0.6	1.0	1.9	3.1	6.8
2009	0.3	1.0	1.5	3.0	5.3

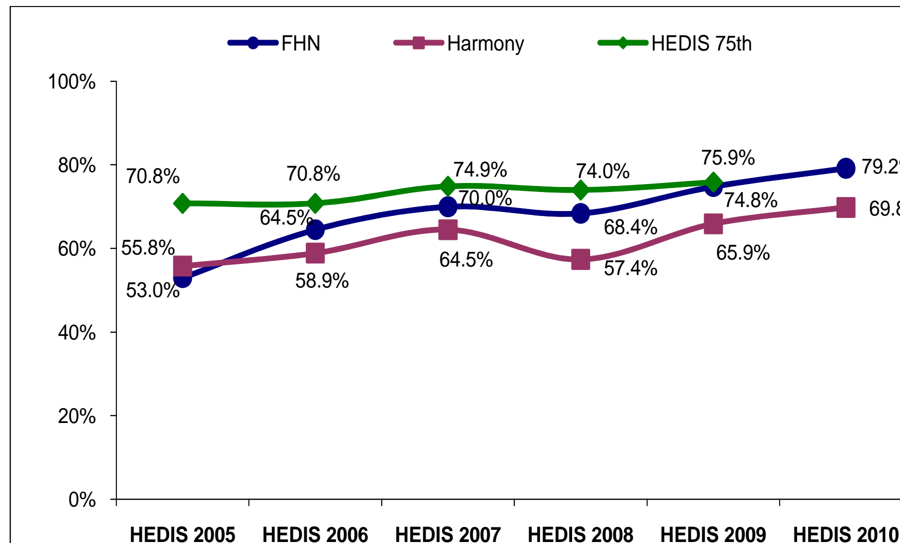
Note: Lower rates are better for this measure.

Figure A–5—*Lead Screening in Children*



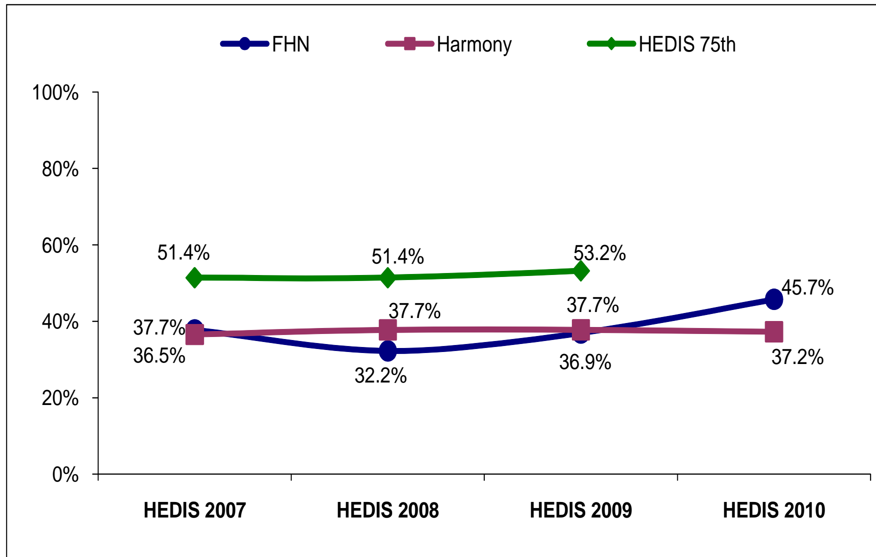
Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2008	32.3	49.3	65.9	76.5	84.0
2009	43.8	56.2	70.5	80.1	87.1

Figure A–6—*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life*



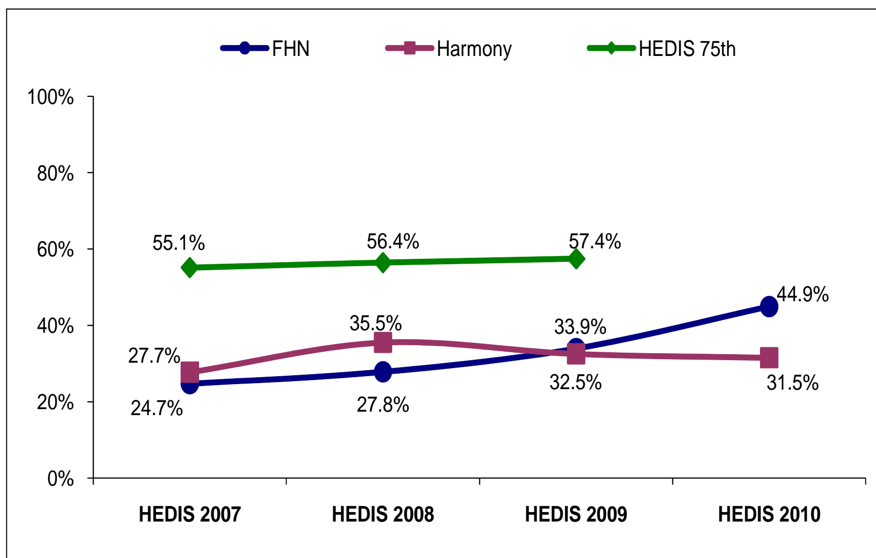
Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2005	48.6	56.3	64.1	70.8	76.7
2006	50.1	56.7	64.8	70.8	77.5
2007	55.7	62.7	67.5	74.9	79.9
2008	52.3	59.8	68.2	74.0	78.9
2009	57.5	64.0	70.4	75.9	80.3

Figure A–7—*Adolescent Well-Care Visits*



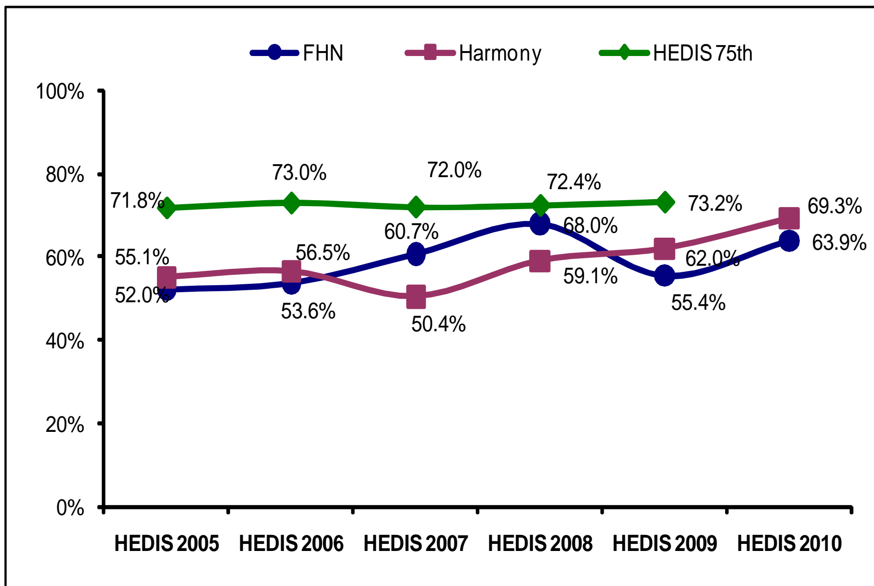
Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2007	31.3	35.3	42.1	51.4	58.9
2008	27.2	35.9	42.1	51.4	56.7
2009	32.8	37.9	45.1	53.2	59.4

Figure A–8—*Breast Cancer Screening*



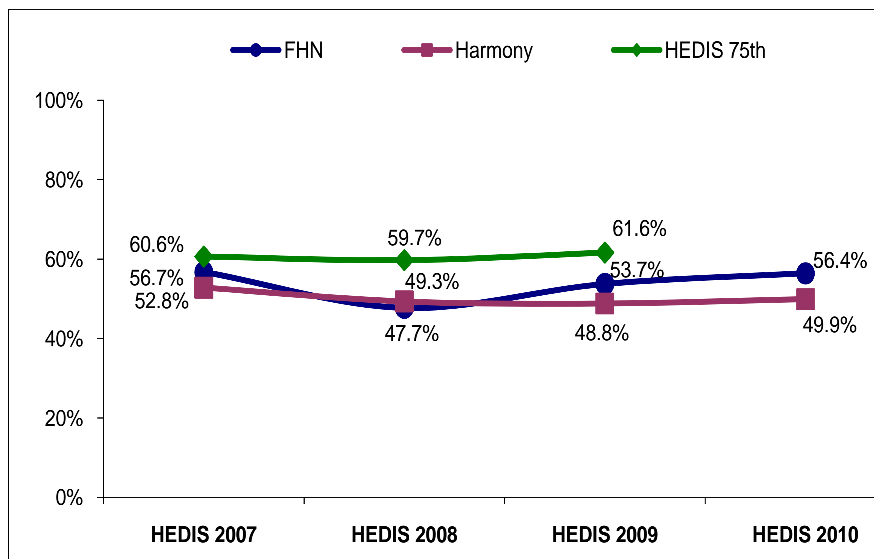
Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2007	39.5	43.2	49.2	55.1	59.6
2008	38.8	44.4	50.1	56.4	61.2
2009	38.6	45.0	50.5	57.4	63.0

Figure A–9—*Cervical Cancer Screening*



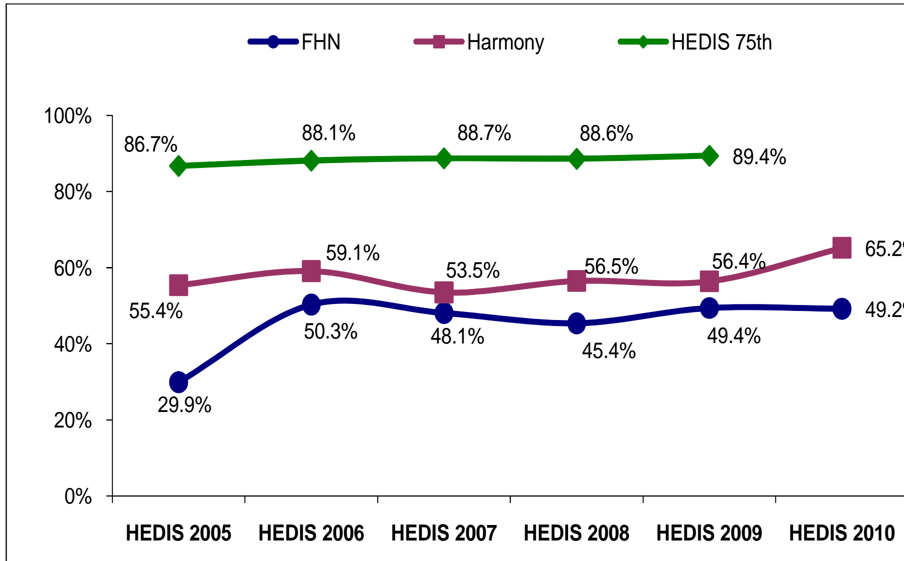
Medicaid HEDIS Percentiles					
HEDIS	**10th**	**25th**	**50th**	**75th**	**90th**
2005	51.1	58.6	64.5	71.8	76.6
2006	49.9	59.7	66.1	73.0	76.6
2007	53.7	60.2	66.5	72.0	77.4
2008	50.5	56.5	67.0	72.4	77.5
2009	52.1	60.9	67.6	73.2	79.5

Figure A–10—*Chlamydia Screening in Women*



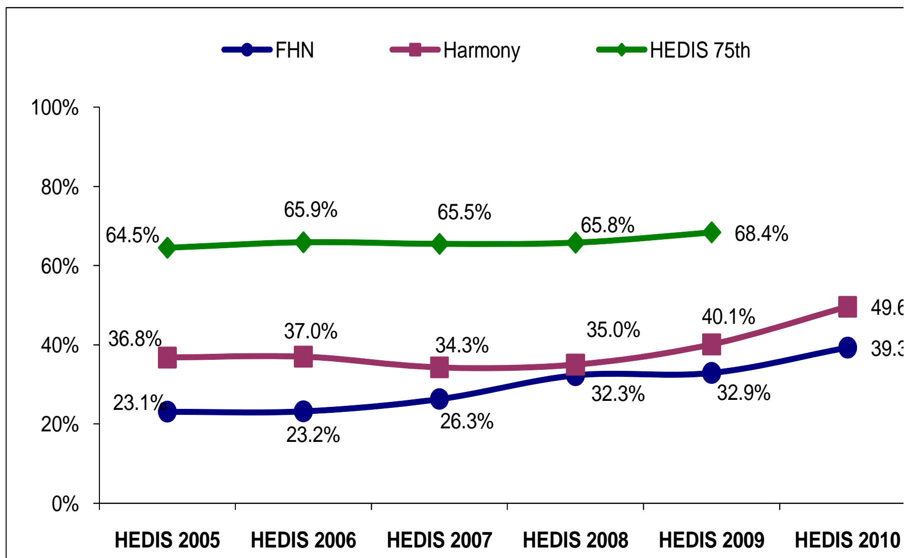
Medicaid HEDIS Percentiles					
HEDIS	**10th**	**25th**	**50th**	**75th**	**90th**
2007	37.7	47.0	52.8	60.6	66.0
2008	32.6	43.7	51.9	59.7	67.0
2009	43.4	48.7	54.8	61.6	68.6

Figure A–11—*Timeliness of Prenatal Care*



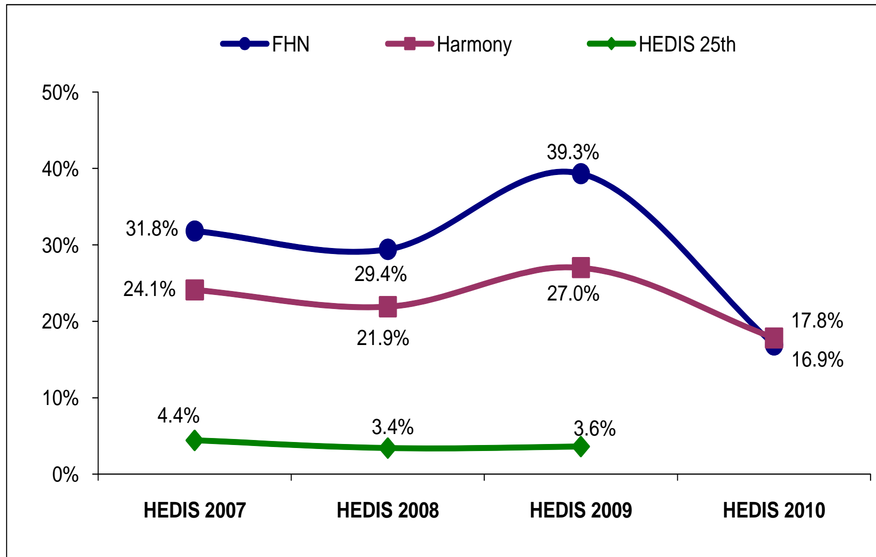
Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2005	63.7	73.8	81.5	86.7	89.5
2006	61.1	74.2	83.3	88.1	91.5
2007	70.3	77.0	84.2	88.7	91.5
2008	68.4	76.6	84.1	88.6	91.4
2009	67.9	78.5	85.6	89.4	92.2

Figure A–12—*Postpartum Care*



Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2005	40.9	51.1	58.4	64.5	69.7
2006	41.8	49.7	58.8	65.9	71.0
2007	47.4	54.3	59.7	65.5	71.1
2008	47.0	54.0	60.8	65.8	70.6
2009	50.3	57.9	63.9	68.4	72.7

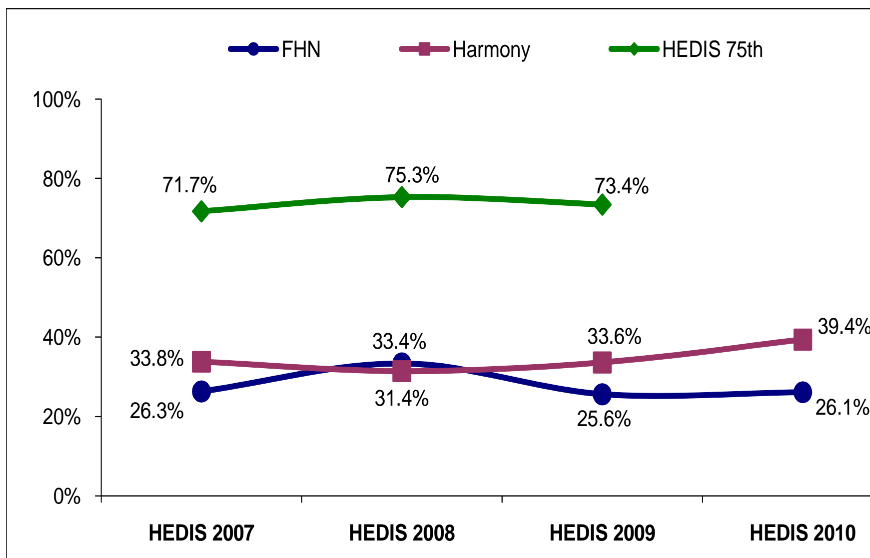
Figure A–13—*Frequency of Ongoing Prenatal Care (<21% Visits)*



Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2007	2.3	4.4	7.6	17.5	32.0
2008	1.9	3.4	7.7	15.1	24.4
2009	2.3	3.6	8.3	15.6	27.3

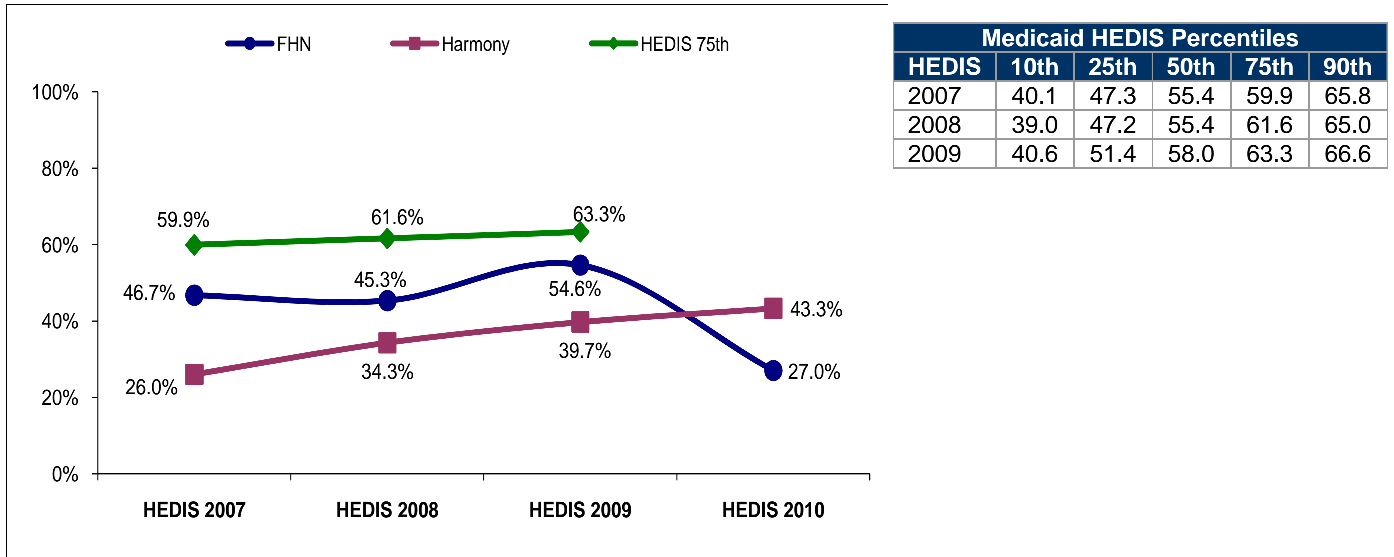
Note: Lower rates are better for this measure.

Figure A–14—*Frequency of Ongoing Prenatal Care (≥81% Visits)*



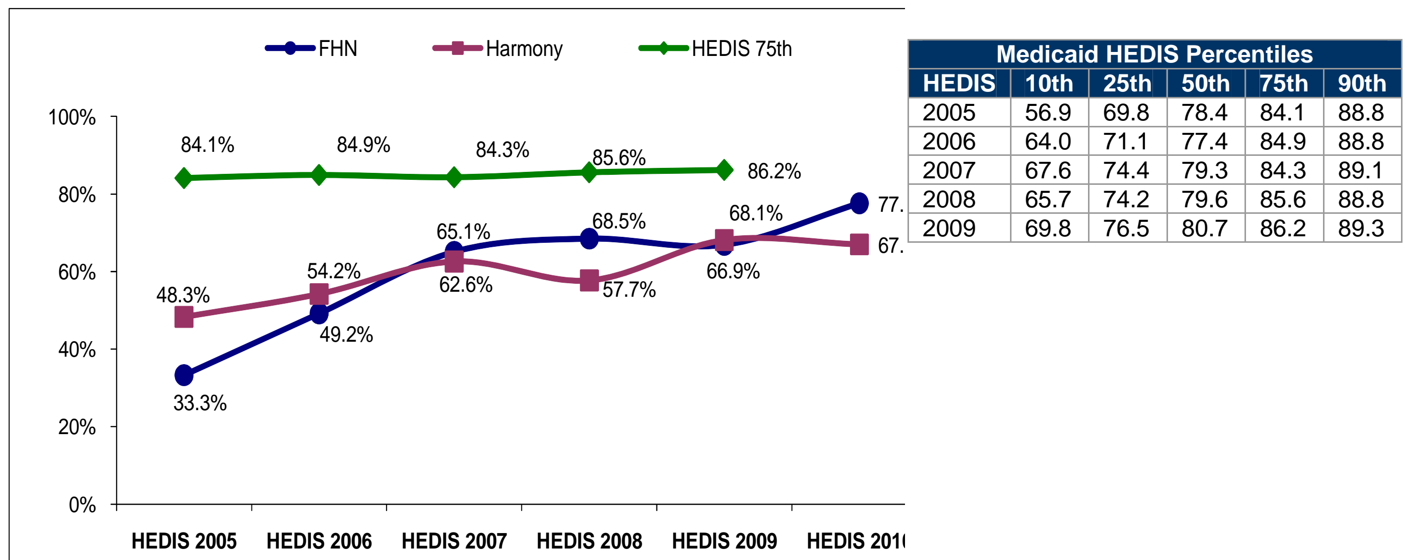
Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2007	33.0	49.4	62.9	71.7	78.6
2008	31.1	50.6	61.5	75.3	80.7
2009	28.9	46.8	62.8	73.4	81.0

Figure A–15—*Controlling High Blood Pressure*



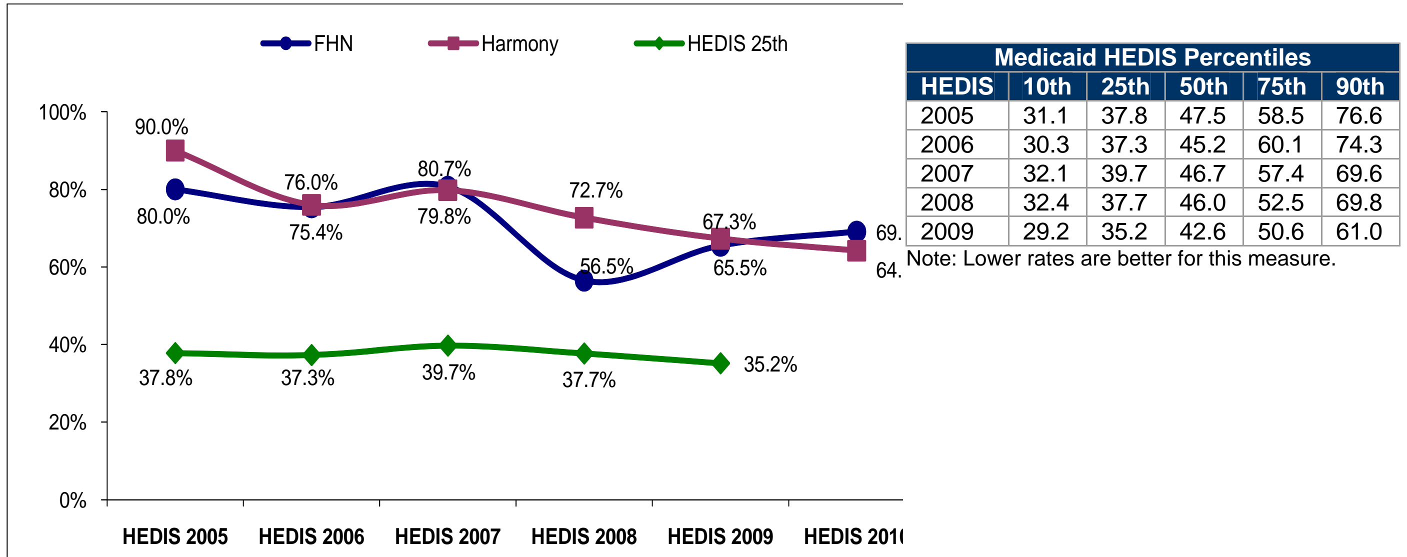
Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2007	40.1	47.3	55.4	59.9	65.8
2008	39.0	47.2	55.4	61.6	65.0
2009	40.6	51.4	58.0	63.3	66.6

Figure A–16—*Comprehensive Diabetes Care—HbA1c Testing*



Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2005	56.9	69.8	78.4	84.1	88.8
2006	64.0	71.1	77.4	84.9	88.8
2007	67.6	74.4	79.3	84.3	89.1
2008	65.7	74.2	79.6	85.6	88.8
2009	69.8	76.5	80.7	86.2	89.3

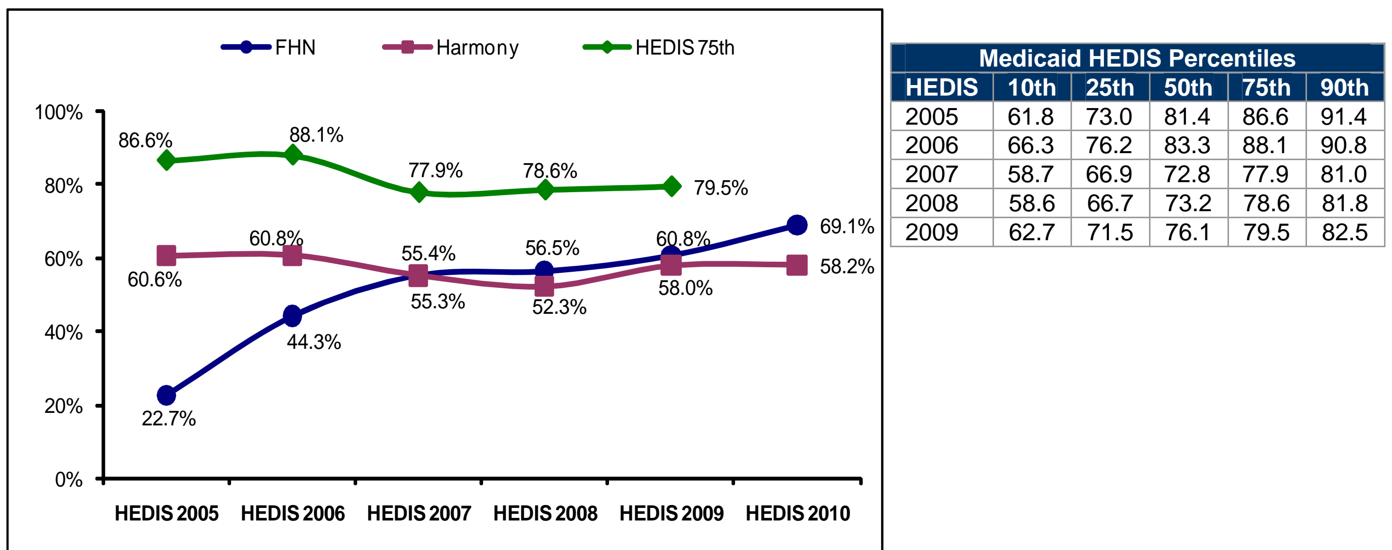
Figure A–17—*Comprehensive Diabetes Care—Poor HbA1c Control*



Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2005	31.1	37.8	47.5	58.5	76.6
2006	30.3	37.3	45.2	60.1	74.3
2007	32.1	39.7	46.7	57.4	69.6
2008	32.4	37.7	46.0	52.5	69.8
2009	29.2	35.2	42.6	50.6	61.0

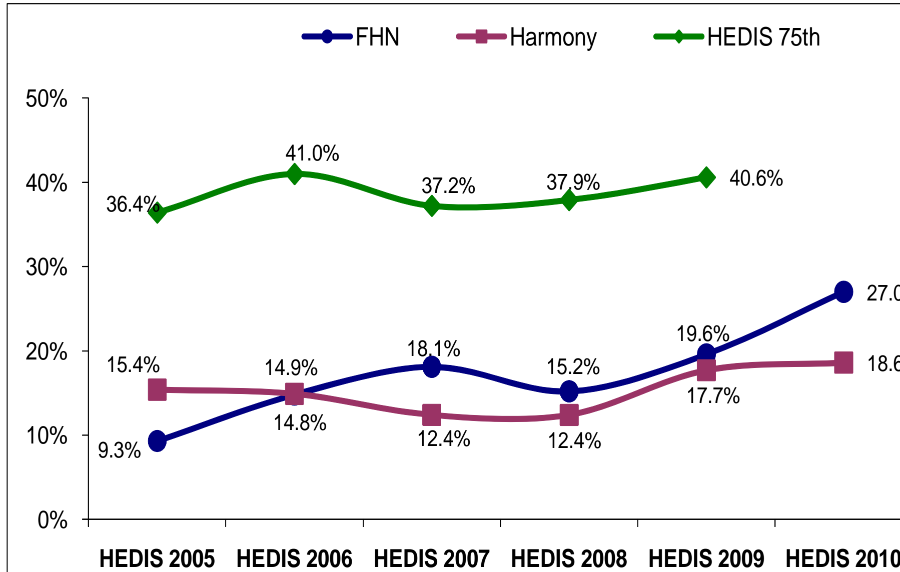
Note: Lower rates are better for this measure.

Figure A–18—*Comprehensive Diabetes Care—LDL-C Screening*



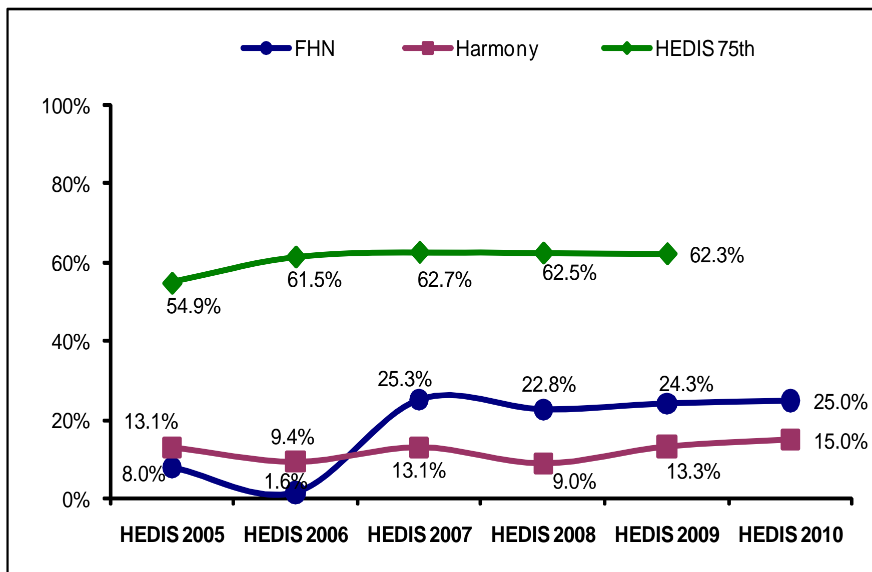
Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2005	61.8	73.0	81.4	86.6	91.4
2006	66.3	76.2	83.3	88.1	90.8
2007	58.7	66.9	72.8	77.9	81.0
2008	58.6	66.7	73.2	78.6	81.8
2009	62.7	71.5	76.1	79.5	82.5

Figure A–19—*Comprehensive Diabetes Care—LDL-C Level <100 mg/Dl*



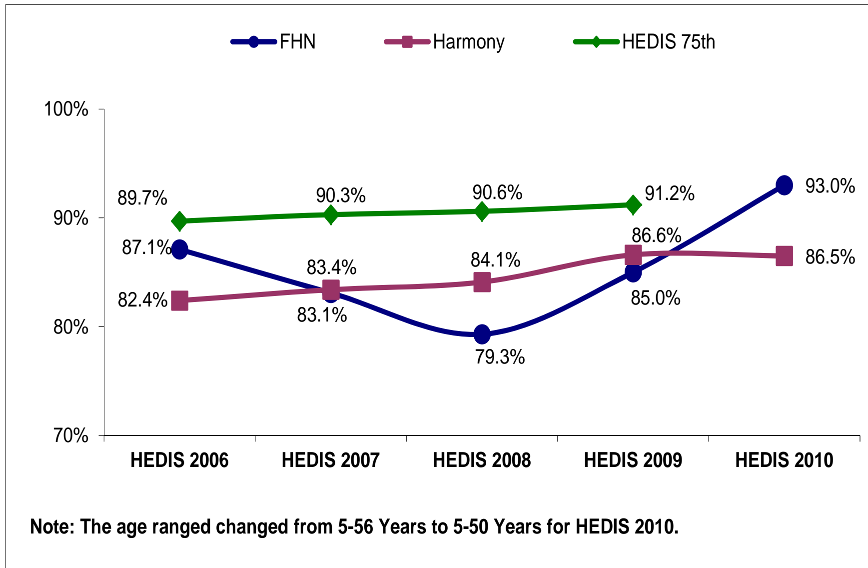
Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2005	14.4	23.7	31.7	36.4	41.6
2006	14.4	26.5	34.1	41.0	46.5
2007	15.2	24.1	31.3	37.2	44.1
2008	16.5	25.1	33.1	37.9	42.6
2009	21.3	27.2	35.1	40.6	44.7

Figure A–20—*Comprehensive Diabetes Care—Eye Exams*



Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2005	18.5	35.3	46.9	54.9	60.9
2006	25.5	35.2	50.8	61.5	68.1
2007	30.6	42.1	53.6	62.7	68.3
2008	24.2	39.7	53.8	62.5	67.6
2009	33.3	44.4	55.4	62.3	70.8

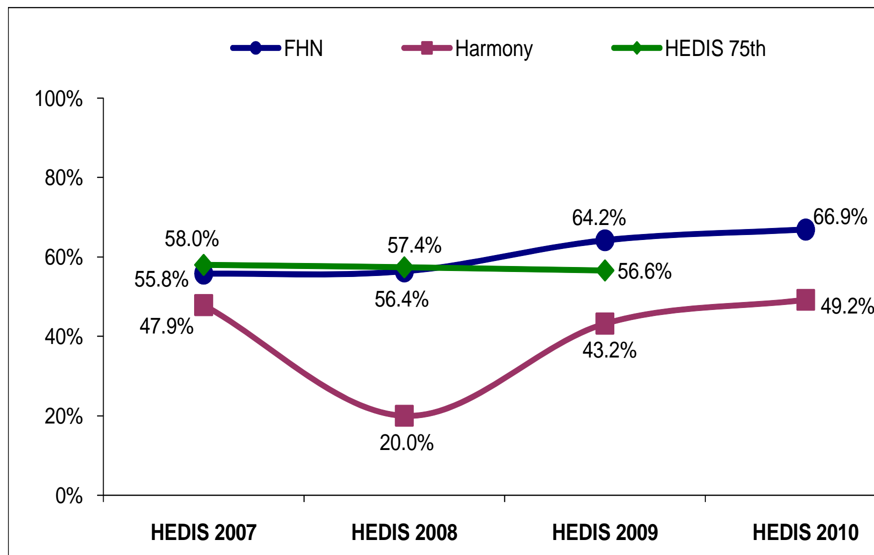
Figure A–21—*Use of Appropriate Medications for People With Asthma (Combined Rate)*



Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2006	78.4	84.0	87.1	89.7	92.5
2007	81.5	85.6	88.4	90.3	92.0
2008	80.4	86.1	88.7	90.6	91.9
2009	84.1	86.6	89.2	91.2	92.1

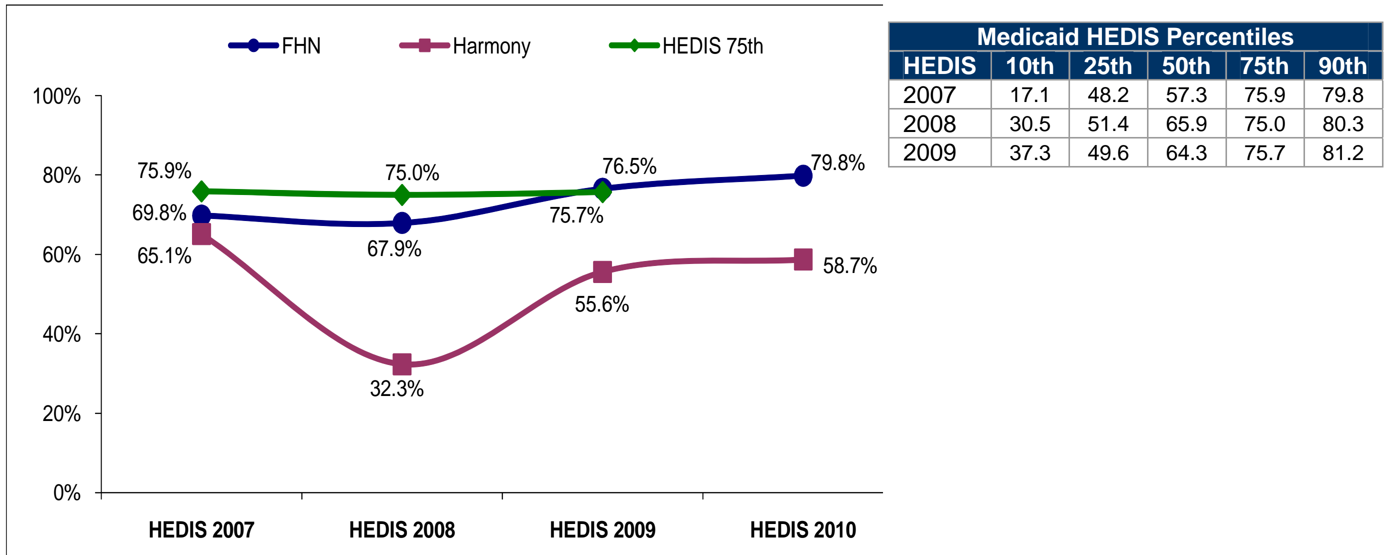
Note: The age range changed from 5-56 Years to 5-50 Years for HEDIS 2010.

Figure A–22—*Follow-up After Hospitalization for Mental Illness (7-Day Follow-Up)*



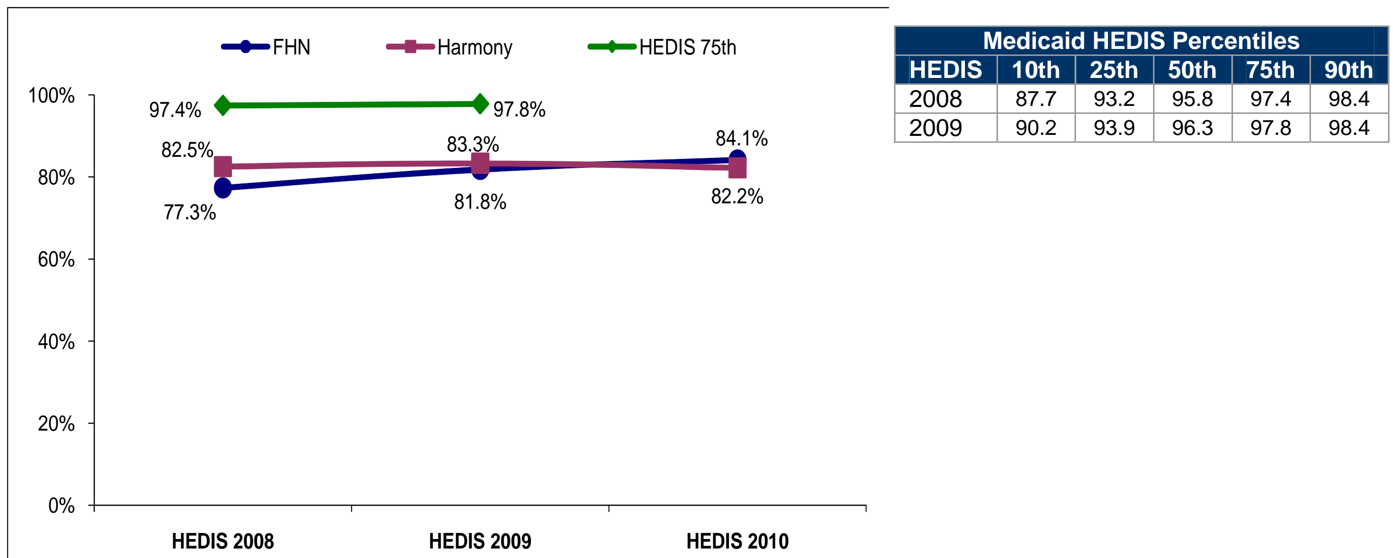
Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2007	11.4	26.0	35.8	58.0	66.2
2008	14.5	27.5	43.2	57.4	65.4
2009	15.5	31.6	44.5	56.6	64.2

Figure A–23—*Follow-up After Hospitalization for Mental Illness (30-Day Follow-Up)*



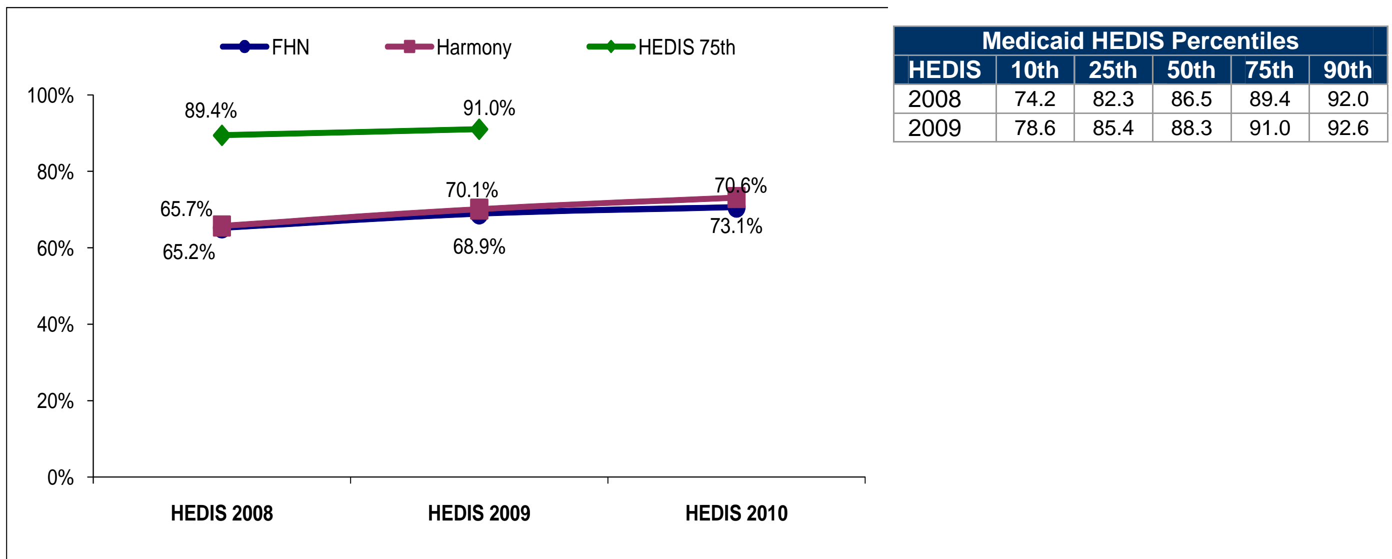
Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2007	17.1	48.2	57.3	75.9	79.8
2008	30.5	51.4	65.9	75.0	80.3
2009	37.3	49.6	64.3	75.7	81.2

Figure A–24—*Children and Adolescents' Access to PCPs (12–24 Months)*



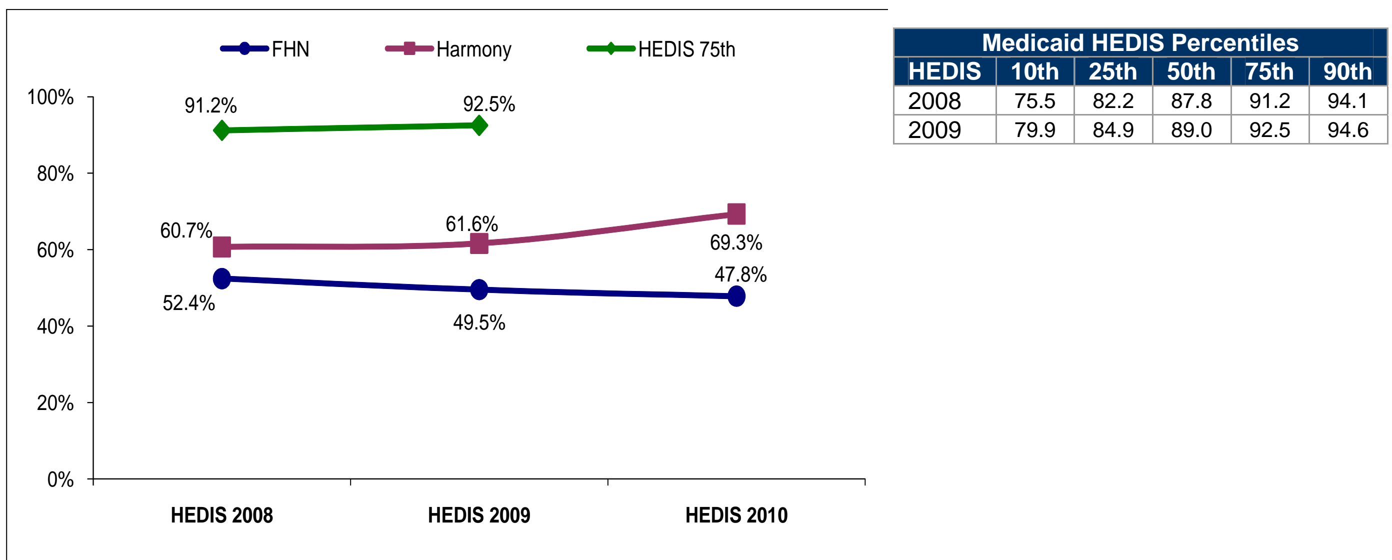
Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2008	87.7	93.2	95.8	97.4	98.4
2009	90.2	93.9	96.3	97.8	98.4

Figure A–25—*Children and Adolescents' Access to PCPs (25 Months to 6 Years)*



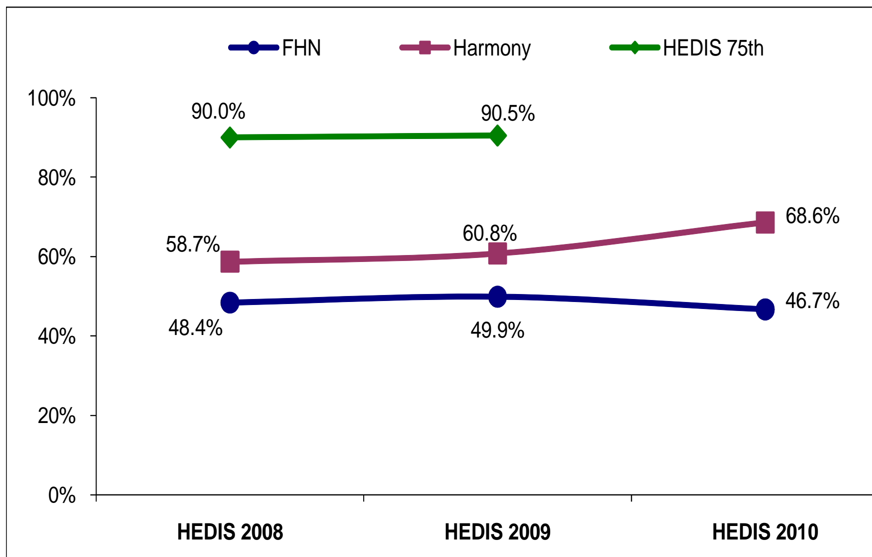
Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2008	74.2	82.3	86.5	89.4	92.0
2009	78.6	85.4	88.3	91.0	92.6

Figure A–26—*Children and Adolescents' Access to PCPs (7–11 Years)*



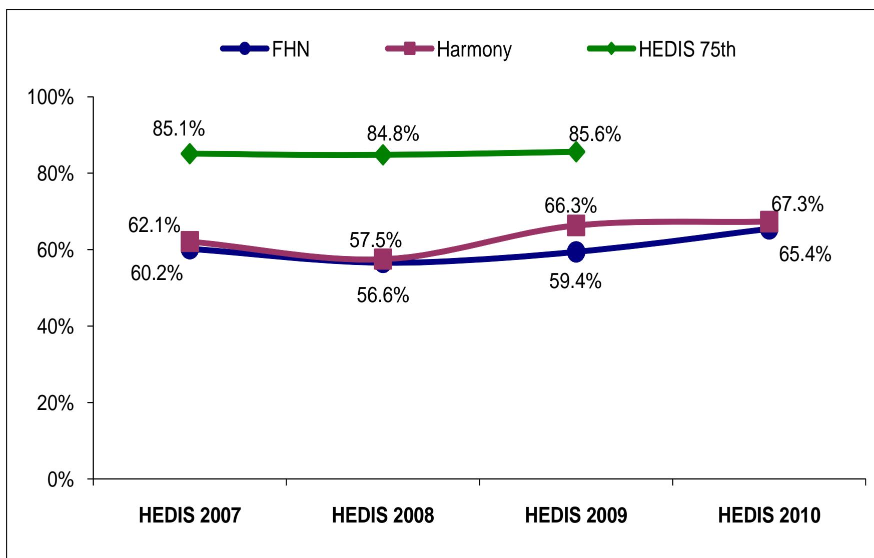
Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2008	75.5	82.2	87.8	91.2	94.1
2009	79.9	84.9	89.0	92.5	94.6

Figure A–27—*Children and Adolescents' Access to PCPs (12–19 Years)*



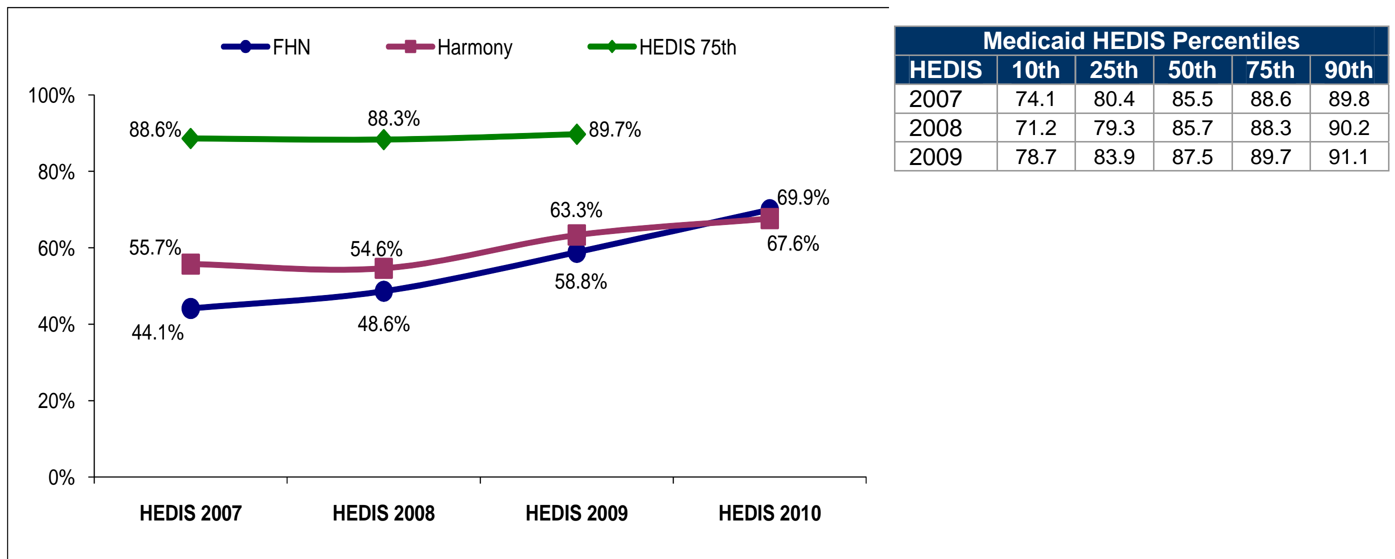
Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2008	70.6	78.1	84.5	90.0	91.9
2009	76.1	82.5	87.2	90.5	92.2

Figure A–28—*Adults'Access to Preventive/Ambulatory Health Services (20–44 Years)*



Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2007	66.3	74.4	79.1	85.1	88.0
2008	60.7	71.6	79.6	84.8	87.6
2009	67.8	77.3	81.5	85.6	88.4

Figure A–29—*Adult's Access to Preventive/Ambulatory Health Services (45–64 Years)*



Medicaid HEDIS Percentiles					
HEDIS	**10th**	**25th**	**50th**	**75th**	**90th**
2007	74.1	80.4	85.5	88.6	89.8
2008	71.2	79.3	85.7	88.3	90.2
2009	78.7	83.9	87.5	89.7	91.1

Child and Adolescent Care and Adults' Access to Preventive/Ambulatory Health Services Measures

This appendix displays the Child and Adolescent Care and Adults' Access to Preventive/Ambulatory Health Services measures for **FHN** and **Harmony** for HEDIS 2010 compared to the HEDIS 2009 national percentiles.

HEDIS Measures	FHN	Harmony	Both MCOs	National Medicaid HEDIS 2009 Percentiles				
				10th	25th	50th	75th	90th
Child and Adolescent Care								
Childhood Immunizations—Combo 2	75.5	67.4	71.6	56.4	68.5	77.9	82.0	85.4
Childhood Immunizations—Combo 3	69.7	60.6	65.3	50.9	62.4	71.8	76.4	80.6
Lead Screening in Children	82.2	74.7	78.6	43.8	56.2	70.5	80.1	87.1
Children's Access to PCPs (12–24 Months)	84.1	82.2	82.7	90.2	93.9	96.3	97.8	98.4
Children's Access to PCPs (25 months–6 Years)	70.6	73.1	72.5	78.6	85.4	88.3	91.0	92.6
Children's Access to PCPs (7–11 Years)	47.8	69.3	64.7	79.9	84.9	89.0	92.5	94.6
Adolescent's Access to PCPs (12–19 Years)	46.7	68.6	64.5	76.1	82.5	87.2	90.5	92.2
*Well-Child Visits in the First 15 Months (0 Visits)**	5.1	4.1	4.6	5.3*	3.0*	1.5*	1.0*	0.3*
Well-Child Visits in the First 15 Months (6+ Visits)	48.4	45.7	47.1	40.4	51.6	60.6	67.9	73.9
Well-Child Visits (3–6 Years)	79.2	69.8	74.6	57.5	64.0	70.4	75.9	80.3
Adolescent Well-Care Visits	45.7	37.2	41.6	32.8	37.9	45.1	53.2	59.4
Immunizations for Adolescents	18.2	23.4	20.7	NA	NA	NA	NA	NA
Adults' Access to Preventative/Ambulatory Health Services								
20–44 Years of Age	65.4	67.3	66.9	67.8	77.3	81.5	85.6	88.4
45–64 Years of Age	69.9	67.6	68.1	78.7	83.9	87.5	89.7	91.1

*** Lower rates indicate better performance for these measures, and therefore, percentiles have been reversed (10th = 90th).**

	National Medicaid HEDIS 2009 Percentile					
	<10	10-24	25-49	50-74	75-89	90-100
Color Code for Percentiles						

Preventive Screening for Women and Maternity-Related Measures

This appendix displays the Preventive Screening for Women and Maternity-Related Measures for **FHN** and **Harmony** for HEDIS 2010 compared to the HEDIS 2009 national percentiles.

HEDIS Measures	FHN	Harmony	Both MCOs	National Medicaid HEDIS 2009 Percentiles				
				10th	25th	50th	75th	90th
Preventative Screening for Women								
Breast Cancer Screening (Combined Rate)	44.9	31.5	33.8	38.6	45.0	50.5	57.4	63.0
Cervical Cancer Screening	63.9	69.3	66.5	52.1	60.9	67.6	73.2	79.5
Chlamydia Screening in Women (16–20 Years of Age)	55.4	45.6	46.9	40.9	46.1	51.8	59.1	67.3
Chlamydia Screening in Women (21–24 Years of Age)	57.5	56.2	56.4	47.3	54.5	59.6	66.3	72.5
Chlamydia Screening in Women (Combined Rate)	56.4	49.9	50.9	43.4	48.7	54.8	61.6	68.6
Maternity-Related Measures								
*Frequency of Ongoing Prenatal Care (<21% Visits)**	16.9	17.8	17.3	27.3*	15.6*	8.3*	3.6*	2.3*
Frequency of Ongoing Prenatal Care (≥81% Visits)	26.1	39.4	32.6	28.9	46.8	62.8	73.4	81.0
Timeliness of Prenatal Care	49.2	65.2	57.0	67.9	78.5	85.6	89.4	92.2
Postpartum Care	39.3	49.6	44.3	50.3	57.9	63.9	68.4	72.7

*** Lower rates indicate better performance for these measures, and therefore, percentiles have been reversed (10th = 90th).**

	National Medicaid HEDIS 2009 Percentile					
	<10	10-24	25-49	50-74	75-89	90-100
Color Code for Percentiles						

Chronic Conditions/Disease Management Measures

This appendix displays the Chronic Conditions/Disease Management measures for **FHN** and **Harmony** for HEDIS 2010 compared to the HEDIS 2009 national percentiles.

HEDIS Measures	FHN	Harmony	Both MCOs	National Medicaid HEDIS 2009 Percentiles				
				10th	25th	50th	75th	90th
Chronic Conditions/Disease Management								
Controlling High Blood Pressure (Combined Rate)	27.0	43.3	38.0	40.6	51.4	58.0	63.3	66.6
Comprehensive Diabetes Care (HbA1C Testing)	77.6	67.0	69.3	69.8	76.5	80.7	86.2	89.3
*Comprehensive Diabetes Care (Poor HbA1c Control)**	69.1	64.2	65.3	61.0*	50.6*	42.6*	35.2*	29.2*
Comprehensive Diabetes Care (Good HbA1c Control)	30.9	28.8	29.3	27.8	37.5	45.6	52.5	60.1
Comprehensive Diabetes Care (Eye Exam)	25.0	15.0	17.1	33.3	44.4	55.4	62.3	70.8
Comprehensive Diabetes Care (LDL-C Screening)	69.1	58.2	60.6	62.7	71.5	76.1	79.5	82.5
Comprehensive Diabetes Care (LDL-C Level <100 mg/Dl)	27.0	18.6	20.4	21.3	27.2	35.1	40.6	44.7
Comprehensive Diabetes Care (Monitoring for Diabetic Nephropathy)	85.5	68.4	72.1	64.5	73.4	78.1	82.2	85.4
Comprehensive Diabetes Care (BP < 140/90 mm/Hg)	40.8	51.3	49.0	37.5	52.3	61.1	66.4	71.2
Comprehensive Diabetes Care (BP < 130/80 mm/Hg)	13.8	23.9	21.7	21.9	26.7	31.6	36.3	41.9
*Use of Appropriate Medications for People With Asthma (Combined)***	93.0	86.5	87.4	84.1	86.6	89.2	91.2	92.1
Follow-up After Hospitalization for Mental Illness—7-Day Follow-Up	66.9	49.2	52.4	15.5	31.6	44.5	56.6	64.2
Follow-up After Hospitalization for Mental Illness—30-Day Follow-Up	79.8	58.7	62.5	37.3	49.6	64.3	75.7	81.2

*** Lower rates indicate better performance for these measures, and therefore, percentiles have been reversed (10th = 90th).**

****HEDIS 2009 percentiles are based on 5-56 age range; HEDIS 2010 uses 5-50 years of age.**

	National Medicaid HEDIS 2009 Percentile					
	<10	10-24	25-49	50-74	75-89	90-100
Color Code for Percentiles						

Appendix E. Medicaid HEDIS 2009–2010 Percentiles

Medicaid HEDIS 2009 Percentiles					
	P10	**P25**	**P50**	**P75**	**P90**
Childhood Immunizations (Combo 2)	56.4	68.5	77.9	82.0	85.4
Childhood Immunizations (Combo 3)	50.9	62.4	71.8	76.4	80.6
Lead Screening in Children	43.8	56.2	70.5	80.1	87.1
*Well-Child Visits in the First 15 Months of Life (0 Visits)**	0.3	1.0	1.5	3.0	5.3
Well-Child Visits in the First 15 Months of Life (6+ Visits)	40.4	51.6	60.6	67.9	73.9
Well-Child Visits (3–6 Years)	57.5	64.0	70.4	75.9	80.3
Adolescent Well-Care Visits	32.8	37.9	45.1	53.2	59.4
Children's Access to PCPs (12–24 Months)	90.2	93.9	96.3	97.8	98.4
Children's Access to PCPs (25 Months–6 Years)	78.6	85.4	88.3	91.0	92.6
Children's Access to PCPs (7–11 Years)	79.9	84.9	89.0	92.5	94.6
Adolescents' Access to PCPs (12–19 Years)	76.1	82.5	87.2	90.5	92.2
Adult's Access to Preventative/Ambulatory Health Services (20–44 Years)	67.8	77.3	81.5	85.6	88.4
Adult's Access to Preventative/Ambulatory Health Services (45–64 Years)	78.7	83.9	87.5	89.7	91.1
Breast Cancer Screening (Combined Rate)	38.6	45.0	50.5	57.4	63.0
Cervical Cancer Screening	52.1	60.9	67.6	73.2	79.5
Chlamydia Screening in Women (16–20 years)	40.9	46.1	51.8	59.1	67.3
Chlamydia Screening in Women (21–24 Years)	47.3	54.5	59.6	66.3	72.5
Chlamydia Screening in Women (Combined)	43.4	48.7	54.8	61.6	68.6
Timeliness of Prenatal Care	67.9	78.5	85.6	89.4	92.2
Postpartum Care	50.3	57.9	63.9	68.4	72.7
*Frequency of Ongoing Prenatal Care (<21% Visits)**	2.3	3.6	8.3	15.6	27.3
Frequency of Ongoing Prenatal Care (≥81% Visits)	28.9	46.8	62.8	73.4	81.0
Controlling High Blood Pressure (Combined Rate)	40.6	51.4	58.0	63.3	66.6
Comprehensive Diabetes Care (HbA1c Testing)	69.8	76.5	80.7	86.2	89.3
*Comprehensive Diabetes Care (Poor HbA1c Control >9)**	29.2	35.2	42.6	50.6	61.0
Comprehensive Diabetes Care (Good HbA1c Control)	27.8	37.5	45.6	52.5	60.1
Comprehensive Diabetes Care (Eye Exams)	33.3	44.4	55.4	62.3	70.8
Comprehensive Diabetes Care (LDL-C Screening)	62.7	71.5	76.1	79.5	82.5
Comprehensive Diabetes Care (LDL-C Level <100 mg/Dl)	21.3	27.2	35.1	40.6	44.7
Comprehensive Diabetes Care (BP <130/80 mm/Hg)	21.9	26.7	31.6	36.3	41.9
Comprehensive Diabetes Care (BP <140/90 mm/Hg)	37.5	52.3	61.1	66.4	71.2
Comprehensive Diabetes Care (Monitoring for Diabetic Nephropathy)	64.5	73.4	78.1	82.2	85.4
Use of Appropriate Medications for People With Asthma (Combined Rate)	84.1	86.6	89.2	91.2	92.1
Follow-up After Hospitalization for Mental Illness (7-Day Follow-Up)	15.5	31.6	44.5	56.6	64.2
Follow-up After Hospitalization for Mental Illness (30-Day Follow-Up)	37.3	49.6	64.3	75.7	81.2

*** A lower rate indicates better performance (e.g., a rate in the 10th percentile is better than a rate in the 90th percentile).**

Medicaid HEDIS 2010 Percentiles					
	P10	**P25**	**P50**	**P75**	**P90**
Childhood Immunizations (Combo 2)	61.8	68.8	76.6	81.6	85.6
Childhood Immunizations (Combo 3)	56.0	63.5	71.0	76.6	82.0
Lead Screening in Children	42.3	57.6	71.6	81.0	88.4
*Well-Child Visits in the First 15 Months of Life (0 Visits)**	0.5	0.7	1.4	2.9	5.1
Well-Child Visits in the First 15 Months of Life (6+ Visits)	40.9	52.2	60.1	69.7	76.3
Well-Child Visits (3–6 Years)	59.9	65.9	71.8	77.3	82.5
Adolescent Well-Care Visits	34.4	38.8	46.8	56.0	63.2
Children and Adolescents' Access to PCPs (12–24 Months)	90.6	95.1	96.8	97.9	98.5
Children and Adolescents' Access to PCPs (25 Months–6 Years)	81.0	87.1	89.8	92.2	94.1
Children and Adolescents' Access to PCPs (7–11 Years)	85.0	87.7	91.3	93.4	95.6
Children and Adolescents' Access to PCPs (12–19 Years)	80.6	85.4	88.9	91.8	93.7
Adult's Access to Preventative/Ambulatory Health Services (20–44 Years)	67.4	78.0	82.9	86.7	88.5
Adult's Access to Preventative/Ambulatory Health Services (45–64 Years)	73.2	83.2	88.1	90.1	91.3
Breast Cancer Screening (Combined Rate)	39.8	46.2	52.0	59.6	63.8
Cervical Cancer Screening	50.4	61.0	67.8	72.9	78.9
Chlamydia Screening in Women (16–20 years)	43.8	48.5	53.0	61.1	66.4
Chlamydia Screening in Women (21–24 Years)	49.5	55.8	62.4	69.1	73.4
Chlamydia Screening in Women (Combined)	44.2	50.6	55.7	63.7	69.5
Timeliness of Prenatal Care	70.6	80.3	86.0	90.0	92.7
Postpartum Care	53.0	58.7	65.5	70.3	74.4
*Frequency of Ongoing Prenatal Care (<21% Visits)**	2.2	3.4	7.0	13.9	22.2
Frequency of Ongoing Prenatal Care (≥81% Visits)	31.5	52.1	64.2	73.7	82.2
Controlling High Blood Pressure (Combined Rate)	41.9	49.4	57.1	63.3	67.2
Comprehensive Diabetes Care (HbA1c Testing)	69.4	76.0	81.1	86.4	90.2
*Comprehensive Diabetes Care (Poor HbA1c Control)**	27.7	33.8	43.2	53.4	63.5
Comprehensive Diabetes Care (HbA1c Control <8)	29.9	38.7	46.6	54.2	58.8
Comprehensive Diabetes Care (HbA1c Control <7)	20.0	27.4	35.5	39.5	44.5
Comprehensive Diabetes Care (Eye Exams)	32.1	41.4	54.0	63.7	70.1
Comprehensive Diabetes Care (LDL-C Screening)	62.6	69.3	75.4	80.1	84.0
Comprehensive Diabetes Care (LDL-C Level <100 mg/Dl)	19.5	27.2	33.6	40.9	45.5
*Comprehensive Diabetes Care (BP <130/80 mm/Hg)***	21.4	27.1	32.5	36.7	44.3
Comprehensive Diabetes Care (BP <140/90 mm/Hg)	43.8	53.5	61.6	68.2	73.4
Comprehensive Diabetes Care (Monitoring for Diabetic Nephropathy)	65.7	72.5	77.7	82.7	86.2
Use of Appropriate Medications for People With Asthma (5–11 Years)	88.2	90.0	92.2	93.9	95.5
Use of Appropriate Medications for People With Asthma (12–50 Years)	79.9	83.8	86.3	89.1	90.7
Use of Appropriate Medications for People With Asthma (Total)	84.6	86.7	88.6	90.8	92.8
Follow-up After Hospitalization for Mental Illness (7-Day Follow-Up)	18.2	29.6	43.5	59.1	64.3
Follow-up After Hospitalization for Mental Illness (30-Day Follow-Up)	31.8	49.0	62.6	74.3	83.6

*** A lower rate indicates better performance (e.g., a rate in the 10th percentile is better than a rate in the 90th percentile).**

**** This measure changed to BP<140/80 for HEDIS 2011.**

HEDIS Measures	HEDIS Rates for Family Health Network					HEDIS Rates for Harmony Health Plan					**HEDIS 2009 National Medicaid Percentiles				
	2006	2007	2008	2009	2010	2006	2007	2008	2009	2010	10th	25th	50th	75th	90th
Child and Adolescent Care															
Childhood Immunizations—Combo 2	67.0	72.4	68.9	72.0	75.5	52.1	58.6	53.8	62.5	67.4	56.4	68.5	77.9	82.0	85.4
Childhood Immunizations—Combo 3	38.5	59.4	53.0	65.8	69.7	22.6	38.2	42.8	51.6	60.6	50.9	62.4	71.8	76.4	80.6
Lead Screening in Children	NA	NA	70.4	69.5	82.2	NA	NA	65.9	69.8	74.7	43.8	56.2	70.5	80.1	87.1
*Well-Child Visits in the First 15 Months (0 Visits)**	19.0	18.8	10.0	7.7	5.1	10.0	6.3	9.2	4.6	4.1	0.3	1.0	1.5	3.0	5.3
Well-Child Visits in the First 15 Months (6+ Visits)	28.9	21.2	29.0	43.5	48.4	36.0	41.1	21.7	40.4	45.7	40.4	51.6	60.6	67.9	73.9
Well-Child Visits (3–6 Years)	64.5	70.0	68.4	74.8	79.2	58.9	64.5	57.4	65.9	69.8	57.5	64.0	70.4	75.9	80.3
Adolescent Well-Care Visits	NA	37.7	32.2	36.9	45.7	NA	36.5	37.7	37.7	37.2	32.8	37.9	45.1	53.2	59.4
Children's Access to PCPs (12–24 Months)	NA	NA	77.3	81.8	84.1	NA	NA	82.5	83.3	82.2	90.2	93.9	96.3	97.8	98.4
Children's Access to PCPs (25 months–6 Years)	NA	NA	65.2	68.9	70.6	NA	NA	65.7	70.1	73.1	78.6	85.4	88.3	91.0	92.6
Children's Access to PCPs (7–11 Years)	NA	NA	52.4	49.5	47.8	NA	NA	60.7	61.6	69.3	79.9	84.9	89.0	92.5	94.6
Adolescent's Access to PCPs (12–19 Years)	NA	NA	48.4	49.9	46.7	NA	NA	58.7	60.8	68.6	76.1	82.5	87.2	90.5	92.2
Adults' Access to Preventative/Ambulatory Health Services															
20–44 Years of Age	NA	60.2	56.6	59.4	65.4	NA	62.1	57.5	66.3	67.3	67.8	77.3	81.5	85.6	88.4
45–64 Years of Age	NA	44.1	48.6	58.8	69.9	NA	55.7	54.6	63.3	67.6	78.7	83.9	87.5	89.7	91.1
Preventive Screening for Women															
Breast Cancer Screening (Combined Rate)	NA	24.7	27.8	33.9	44.9	NA	27.7	35.5	32.5	31.5	38.6	45.0	50.5	57.4	63.0
Cervical Cancer Screening	53.6	60.7	68.0	55.4	63.9	56.5	50.4	59.1	62.0	69.3	52.1	60.9	67.6	73.2	79.5
Chlamydia Screening in Women (16–20 Years of Age)	NA	60.2	47.7	53.6	55.4	NA	49.5	45.1	44.5	45.6	40.9	46.1	51.8	59.1	67.3
Chlamydia Screening in Women (21–24 Years of Age)	NA	54.8	47.7	53.8	57.5	NA	56.0	53.3	54.8	56.2	47.3	54.5	59.6	66.3	72.5
Chlamydia Screening in Women (Combined Rate)	NA	56.7	47.7	53.7	56.4	NA	52.8	49.3	48.8	49.9	43.4	48.7	54.8	61.6	68.6

HEDIS Measures	HEDIS Rates for Family Health Network					HEDIS Rates for Harmony Health Plan					**HEDIS 2009 National Medicaid Percentiles				
	2006	2007	2008	2009	2010	2006	2007	2008	2009	2010	10th	25th	50th	75th	90th
Maternity-Related Measures															
*Frequency of Ongoing Prenatal Care (<21% Visits)**	NA	31.8	29.4	39.3	16.9	NA	24.1	21.9	27.0	17.8	2.3	3.6	8.3	15.6	27.3
Frequency of Ongoing Prenatal Care (≥81% Visits)	NA	26.3	33.4	25.6	26.1	NA	33.8	31.4	33.6	39.4	28.9	46.8	62.8	73.4	81.0
Timeliness of Prenatal Care	50.3	48.1	45.4	49.4	49.2	59.1	53.5	56.4	56.4	65.2	67.9	78.5	85.6	89.4	92.2
Postpartum Care	23.2	26.3	32.3	32.9	39.3	37.0	34.3	35.0	40.1	49.6	50.3	57.9	63.9	68.4	72.7
Chronic Conditions/Disease Management															
Controlling High Blood Pressure (Combined Rate)	NA	46.7	45.3	54.6	27.0	NA	26.0	34.3	39.7	43.3	40.6	51.4	58.0	63.3	66.6
Comprehensive Diabetes Care (HbA1C Testing)	49.2	65.1	68.5	66.9	77.6	54.2	62.6	57.7	68.1	67.0	69.8	76.5	80.7	86.2	89.3
*Comprehensive Diabetes Care (Poor HbA1c Control)**	75.4	80.7	56.5	65.5	69.1	76.0	79.8	72.7	67.3	64.2	29.2	35.2	42.6	50.6	61.0
Comprehensive Diabetes Care (Good HbA1c Control)	NA	NA	12.0	27.0	30.9	NA	NA	15.6	24.6	28.8	27.8	37.5	45.6	52.5	60.1
Comprehensive Diabetes Care (Eye Exam)	1.6	25.3	22.8	24.3	25.0	9.4	13.1	9.0	13.3	15.0	33.3	44.4	55.4	62.3	70.8
Comprehensive Diabetes Care (LDL-C Screening)	44.3	55.4	56.5	60.8	69.1	60.8	55.3	52.3	58.0	58.2	62.7	71.5	76.1	79.5	82.5
Comprehensive Diabetes Care (LDL-C Level <100 mg/Dl)	14.8	18.1	15.2	19.6	27.0	14.9	12.4	12.4	17.7	18.6	21.3	27.2	35.1	40.6	44.7
Comprehensive Diabetes Care (Monitoring for Diabetic Nephropathy)	NA	71.1	57.6	79.7	85.5	NA	62.1	59.9	69.9	68.4	64.5	73.4	78.1	82.2	85.4
Comprehensive Diabetes Care (BP < 140/90 mm/Hg)	NA	55.4	51.1	45.3	40.8	NA	31.6	45.0	54.0	51.3	37.5	52.3	61.1	66.4	71.2
Comprehensive Diabetes Care (BP < 130/80 mm/Hg)	NA	31.3	22.8	27.0	13.8	NA	14.4	23.6	27.4	23.9	21.9	26.7	31.6	36.3	41.9
*Use of Appropriate Medications for People With Asthma (Combined Rate)***	87.1	83.1	79.3	85.0	93.0	82.4	83.4	84.1	86.6	86.5	84.1	86.6	89.2	91.2	92.1
Follow-up After Hospitalization for Mental Illness—7-Day Follow-Up	NA	55.8	56.4	64.2	66.9	NA	47.9	20.0	43.2	49.2	15.5	31.6	44.5	56.6	64.2
Follow-up After Hospitalization for Mental Illness—30-Day Follow-Up	NA	69.8	67.9	76.5	79.8	NA	65.1	32.3	55.6	58.7	37.3	49.6	64.3	75.7	81.2

*** Lower rates are better for these measures.**

**** For HEDIS 2010, the age ranged changed from 5–56 years of age to 5–50 years of age. The National Medicaid Percentiles presented for the asthma measures are based on the 5–56 year age range.**

Blue shaded cells indicate Quality Performance Program Measures.