Medicaid Advisory Committee

401 S. Clinton
7th Floor Video-conference Room
Chicago, Illinois
and
201 South Grand Avenue East
3rd Floor Video-conference Room
Springfield, Illinois

January 21, 2011
10 a.m. - 12 p.m.

Agenda

I. Call to Order

II. Introductions

III. Approval of November 19, 2010 Meeting Minutes

IV. Director's Report
- Legislative Update

V. Review Handouts #'s 3 through 8 from November 19, 2010 Meeting

VI. Meeting Schedule Frequency and Topic Formulation

VII. Subcommittee Reports
- Public Education Subcommittee
- Long-Term Care Subcommittee

VIII. Adjournment

Illinois Department of Healthcare and Family Services
Medicaid Advisory Committee
November 19, 2010

401 S. Clinton Street, Chicago, Illinois
201 S. Grand Avenue East, Springfield, Illinois

Members Present
Eli Pick, Chairman
Susan Hayes Gordon, CMH
Kathy Chan, IMCHC
John Shlofrock, Barton Mgt.
Mary Driscoll, DPH
Judy King
Linda Diamond-Shapiro, ACHN
Andrea Kovach, Shriver Center
Edward Pont, ICAAP
Renee Poole, IAFP
Jan Costello, IL Home Care & Hospice Council
Karen Moredock, DCFS
Melissa Vargas, AAPD Head Start DHI

Members Absent
Myrtis Sullivan, DHS
Alice Foss, IL Rural Health Assn.
Sue Vega, Alivio Medical Center

HFS Staff
Julie Hamos
Sharron Mathews
Jacqui Ellinger
James Parker
Lynne Thomas
Ann Lattig
Robyn Nardone
James Monk

Interested Parties
Kendig Bergstresser, Abraxis Bioscience
Mike Krug, Sunovion
Andrew Fairgrieve, Health Mgmt Associates
Susan Melczer, MCHC
Diane Montanez, Alivio Medical
Gary Fitzgerald, Harmony Health Plan
Citseko Staples, Harmony/Wellcare
Mary Capetillo, Lilly
Mandy Ungrittanon, Quest Diagnostics
Diane Fager, CPS
Lora McCurdy, IARF
George Hovanec, Consultant
Kelly Carter, IPHCA
Jill Hayden, IPHCA
Marvin Hazelwood, Consultant
Martha Wright, Comp. Bleeding Disorders Ctr.
John Bullard, Amgen
Mary Reis, DCFS

Illinois Department of Healthcare and Family Services
Medicaid Advisory Committee
November 19, 2010

I. Call to Order

Chairman Pick called the meeting to order at 10:04 a.m.

II. Introductions

Attendees in Chicago and Springfield introduced themselves. Chairman Pick offered a special welcome to new committee members, acknowledging both their willingness to participate and commitment to improve services.

III. Review of the Minutes

Request for changes to the June and September 2010 minutes were made by MAC members Judy King, Mary Driscoll and Jan Costello. The June and September minutes were approved with the understanding that requested changes would be made.

Chairman Pick asked when minutes and handouts should be posted. Ann Lattig, HFS Medical Programs, advised that the draft minutes are posted about a week prior to the next meeting. For the November meeting both the draft minutes and new handouts were posted online. Jacqui Ellinger, Deputy Administrator, advised that the Open Meetings Act requires that minutes be posted within seven days of approval. A motion was made and seconded to provide draft minutes as is currently done just before the next meeting. This motion was brought to a vote and approved.

IV. Director's Report

HFS director, Julie Hamos, provided the report.

Health Care Reform: The Illinois Health Reform Implementation Council has held four public meetings. The Council has posted a paper with choices to consider in designing the Health Information Exchange, such as: Should Illinois operate its' own exchange? The paper may be viewed online at HealthCareReform.Illinois.gov

Director Hamos encouraged all meeting participants to review the key issues and comment by December 3, 2010. Other health care reform activity includes: the state seeking a consultant to craft the Health Information Exchange; conducting an in-depth assessment of eligibility, verification and enrollment functions; and moving to a durable plastic card for enrollees, instead of the costly monthly issued medical cards.

Class Action Lawsuits: The department has settled one of three class action lawsuits. The *Williams v. Quinn* lawsuit dealt with housing choices for persons with mental illness and living in Institutions for Mental Disease (IMDs). The state has a federal monitor to ensure that things are done correctly. The other two class action suits deal with nursing homes. The department is looking at the long term care system and ways to make improvements. An implementation plan is currently being developed. The Nursing Home Taskforce is also looking at recommendations and how these may be funded.

Integrated Care Program: This is a new form of care for seniors and adults with disabilities in suburban Cook County and the Cook collar counties. The department is working with two managed care companies and other providers that will implement the new health care program for about 40,000 persons receiving Medicaid benefits. The department held an open house to introduce the new managed care companies, Aetna and Centene-IlliniCare. There has also been active involvement by stakeholder groups.

Medicaid reform: Director Hamos stated that there might be a new revenue package. State legislative leaders are interested in attaching Medicaid reform to the package. A bipartisan

workgroup has been established to report back by January 3, 2011. The house is also creating a structure around this issue. There is interest in tightening Medicaid eligibility.

The two issues that have sparked the most interest are income verification and passive redetermination. In Illinois, the myths are that one check stub gets you on Medicaid and all the department requires is a passive redetermination to continue eligibility.

The department has looked at how the state of New York handles income verification and redeterminations. New York requests four weeks of income verification as part of the initial application. At the back end, there are computer verifications of earnings. One suggestion is to request tax returns for employed individuals. New York has an active renewal process. A pre-populated renewal form is sent and the family must return the form to continue eligibility. Director Hamos encouraged meeting participants to comment on the New York approach and make recommendations on what HFS should do regarding these issues.

Discussion on income verification: Under the Maintenance of Effort (MOE) provisions in the Affordable Care Act (ACA) states may be prohibited from changing renewal and verification processes. Ms. Ellinger stated that Federal CMS has yet to issue guidance on MOE under ACA and the only written interpretation on what it may mean has come from "think tanks" like the Kaiser Family Foundation. The penalty for violating the MOE requirement is draconian with a loss of all federal funding for Medicaid and CHIP. The law stipulates one exception; that states covering nonpregnant and nondisabled adults with incomes above 133 percent of the federal poverty level (FPL) can scale back coverage for this population beginning in January 2011, if the state declares it faces a budget deficit. If Illinois received federal approval to make changes to its verification requirements, HFS would like to automate as much of the process as possible.

The following ideas and concerns relating to income eligibility were discussed by the committee:

- A member portal is needed to allow enrollees to check their eligibility status.
- Consideration should be given to an electronic income check. Wisconsin has had good results with a back-end check using work telephone numbers.
- Concern was expressed with using tax returns, as the current operations system is overwhelmed.
- An expanded eligibility review like New York would require updating the technical system and adding staff.
- Since many applicants are in service sector jobs the department might consider reaching out to the business community for help in establishing eligibility.
- To ensure patient eligibility for services, a best practice is for providers to check eligibility when the patient calls to make an appointment and then recheck at the time of the appointment.
- The new durable medical card will have a bar code with the RIN encoded; currently there is no plan to use the bar code to verify eligibility, it is there for future enhancements. Providers will continue to verify eligibility by calling or using MEDI.
- Coverage for undocumented children is an important issue that needs to be addressed.

Discussion on redeterminations: About half of the family health plan cases are for children with medical assistance only and no food stamps. Most of these cases are maintained by the Department of Human Services' Family Community Resource Centers. Looking at the renewal process for

children and adults receiving medical only, if there is no response to the renewal form, coverage for the adults is terminated, but children continue to receive an additional twelve months of eligibility.

The following ideas and concerns relating to redeterminations were discussed by the committee:

- The operational system will be key to handling redeterminations if passive redetermination is eliminated.
- Reservations were expressed about implementing an active renewal process due to concerns about adequate staffing and an adequate reporting mechanism; whether it be U.S. mail, Internet or hotline contact.
- There was concern that the automated portion of the eligibility system may result in benefits unnecessarily being lost at renewal.
- Regarding department mail returned because of addressee unknown, a ball park estimate shared was that about twenty-thousand letters are returned of about one million sent.
- Chicago Public Schools (CPS) has received renewal data for 280,000 children. This data was matched with CPS addresses and there was a mismatch for about 40,000 children. CPS would like to share address information with the department but the law limits the sharing.
- Recommendation was made that the department involve the PCP to check a patient's mailing address or to assist in renewal follow-up. At the very least, PCPs would want to know if a patient is losing eligibility.
- To reinforce the concept of having a medical home, state should use all of the modalities to improve compliance and seek different ideas for involving community partners.
- Cell phones and text messages were discussed as an effective and reliable way to contact clients, but with all methods it does have limitations, such as individuals having multiple phone numbers or using limited time prepaid or pay as you go plans.

Director Hamos stated that it may be time to do an active redetermination process for children and adults that includes a back-end review. The department needs a system that provides clients with an easy way to contact us. She anticipates an active renewal system with the durable medical card and it is important to tell people upfront about this requirement.

Sharron Mathews, Assistant HFS Director, suggested that the department look at a phase in process to ensure a smooth transition to active renewal.

Dr. Pont stated that an active renewal system may help weed out people taking advantage of the system and possibly lead to improved reimbursement.

Director Hamos asked that additional questions and comments about the department's income verification and redetermination policies be sent to her at julie.hamos@illinois.gov

IV. Old Business

2011 Meeting Dates: Chairman Pick called for a motion to accept the 2011 meeting dates as shown on Handout #9. The motion was made, seconded and voted on. The motion carried with one member opposed.

Ms. Kovach made a motion calling for an ad hoc meeting from 10 am to 12:00 pm on Friday, January 21, 2011. The motion was seconded. In discussion, Judy King stated that she would like more frequent MAC meetings and also wanted to ensure there was a call in telephone number available to the public. The motion for a meeting on January 21st was voted on and approved.

Agenda suggestions for the January 21st meeting included a general legislative update, review of handouts not yet discussed and a discussion of meeting schedule frequency and how topics are formulated.

VI. New Business

2010 Ethics Training: Shannon Stokes, with the Office of the General Counsel, reviewed the need to read the Ethic training document and complete the Acknowledgement of Participation form. The completed form must be faxed and mailed no later than December 22, 2010. She provider her telephone number and advised that she would also resend the Ethics training package to all MAC members.

Public Education Subcommittee Report: Ms. Chan provided the report. The main discussion was on the durable plastic medical card. There was a chance to look at a sample card as well as materials being developed for providers and clients. Meeting participants were excited about the coming changes.

In addition, there were updates from the CHIPRA grantees including CPS, Beacon Therapeutic and the Chicago Hispanic Health Coalition and a discussion about the member portal. The next meeting of the Public Education Subcommittee is tentatively scheduled for December 15, 2010. Chairman Pick asked if the MAC could get an update on the member portal in January.

Open to Committee: Ms. King asked where a consumer may go with a complaint about a state agent. There was some discussion about filing a grievance through the All Kids Hotline against an All Kids Application Agent or at a DHS office for complaint about DHS office staff. Ms. Ellinger advised that in the future it would be helpful to have DHS staff at the Public Education subcommittee meeting whenever there was a need to address DHS local office issues. She also stated that the department could get more details on the grievance process for the Public Education Subcommittee.

VII. Adjournment

The meeting was adjourned at 12:00 p.m.

Illinois Health Connect
Quality Indicators
(Primary Care Case Management)

	Data Source	Indicator	Definition
1a	Claims, Cornerstone, TOTS and Global	Childhood immunizations	Percentage of 2 year olds with combo 2 immunizations (combo 2 = 4 DTaP/DT, 3 IPV, 1 MMR, 3 HIB, 3 HepB, 1 VZV)
1b	Claims, Cornerstone, TOTS and Global		Percentage of 2 year olds with combo 3 immunizations (combo 3 = 4 DTaP/DT, 3 IPV, 1 MMR, 3 HIB, 3 HepB, 1 VZV, 4 pnuemococcal conjugate vaccinations)
2a	Claims and IDPH Childhood Lead Poisoning Prevention Program	Childhood lead toxicity testing	Percentage of children who received at least one capillary or venous blood test on or before their second birthday.
2b	Claims and IDPH Childhood Lead Poisoning Prevention Program		Percentage of children who received at least two capillary or venous blood tests on or before their second birthday, one of which occurs on or before the first birthday and one of which occurs after the first and on or before the second birthday. (Count as one test, blood lead tests administered within three months of each other.)
3a	Claims	Developmental Screening	Percentage of children with one developmental screenings by the age of 12 months.
3b	Claims		Percentage of children with one developmental screening between the ages of 12 and 24 months.
3c	Claims		Percentage of children with one developmental screening between the ages of 24 and 36 months.
4a	Claims	Appropriate Medications for People with Asthma	Percentage of members 5 – 56 years of age with persistent asthma who were appropriately prescribed medication (inhaled corticosteroids, nedocromil, cromolyn sodium, leukotriene modifiers or methylxanthines)
4b	Claims		Percentage of members 5 – 9 years of age with persistent asthma who were appropriately prescribed medication (inhaled corticosteroids, nedocromil, cromolyn sodium, leukotriene modifiers or methylxanthines)
4c	Claims		Percentage of members 10 – 17 years of age with persistent asthma who were appropriately prescribed medication (inhaled corticosteroids, nedocromil, cromolyn sodium, leukotriene modifiers or methylxanthines)

Illinois Health Connect
Quality Indicators
(Primary Care Case Management)

	Data Source	Indicator	Definition
4d	Claims		Percentage of members 18 - 56 years of age with persistent asthma who were appropriately prescribed medication (inhaled corticosteroids, nedocromil, cromolyn sodium, leukotriene modifiers or methylxanthines)
5	Claims	Diabetes	Percentage of diabetic patients age 18 – 75 years, who have had one HbA1c in the last 12 months
6a	Claims	Well baby visits in the first 15 months of life	Percentage of children with 0 well baby visits in the first 15 months of life
6b	Claims		Percentage of children with 1 well baby visits in the first 15 months of life
6c	Claims		Percentage of children with 2 well baby visits in the first 15 months of life
6d	Claims		Percentage of children with 3 well baby visits in the first 15 months of life
6e	Claims		Percentage of children with 4 well baby visits in the first 15 months of life
6f	Claims		Percentage of children with 5 well baby visits in the first 15 months of life
6g	Claims		Percentage of children with 6 well baby visits in the first 15 months of life
7	Claims	Well child visits in the Third, Fourth, Fifth and Sixth years of Life	Percentage of members who were three, four, five or six years of age who received one or more well-child visits with a primary care practitioner during the measurement year.
8a	Claims	Vision screening	Percentage of 3 year olds with 1 vision screening during the measurement year
8b	Claims		Percentage of 4 year olds with 1 vision screening during the measurement year
8c	Claims		Percentage of 5 year olds with 1 vision screening during the measurement year
8d	Claims		Percentage of 6 year olds with 1 vision screening during the measurement year
9	Claims	Cervical Cancer Screening	Percentage of women 21 – 64 years of age who received one or more Pap tests to screen for cervical cancer during the measurement year

Illinois Health Connect
Quality Indicators
(Primary Care Case Management)

	Data Source	Indicator	Definition
10	Claims	Adolescent Well-Care Visits (AWC)	Percentage of enrolled members who were 12 – 21 years of age and who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year
11a	Claims	Frequency of Ongoing Prenatal Care (FPC)	Percentage of women with deliveries who had an unduplicated count of < 21 percent of the number of expected prenatal visits, adjusted for the month of pregnancy at time of enrollment into the program and gestational age
11b	Claims		Percentage of women with deliveries who had an unduplicated count of 21 – 40 percent of the number of expected prenatal visits, adjusted for the month of pregnancy at time of enrollment into the program and gestational age
11c	Claims		Percentage of women with deliveries who had an unduplicated count of 41 – 60 percent of the number of expected prenatal visits, adjusted for the month of pregnancy at time of enrollment into the program and gestational age
11d	Claims		Percentage of women with deliveries who had an unduplicated count of 61 – 80 percent of the number of expected prenatal visits, adjusted for the month of pregnancy at time of enrollment into the program and gestational age
11e	Claims		Percentage of women with deliveries who had an unduplicated count of ≥ 81 percent of the number of expected prenatal visits, adjusted for the month of pregnancy at time of enrollment into the program and gestational age
12	Claims	Prenatal Timeliness	Percentage of deliveries that received a prenatal care visit in the first trimester or within 42 days of enrollment
13	Claims	Postpartum Care	Percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery
14	Claims	Prenatal and Postpartum screening for depression	Percentage of women screened for depression during a prenatal visit or postpartum visit (up to 1 year postpartum) or during a well child visit or other health care visit

Illinois Health Connect
Quality Indicators
(Primary Care Case Management)

	Data Source	Indicator	Definition
15	Claims	Appropriate treatment for children with Upper Respiratory Infection (URI)	Percentage of children 3 months – 18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the episode date
16	Claims	Antidepressant Medication Management (AMM) – acute phase treatment	Percentage of members 18 years of age and older diagnosed with a new episode of depression, who were treated with antidepressant medication and remained on an antidepressant drug during the entire 84-day (12-week) acute treatment phase
17a	Claims	Adults' Access to Preventive/Ambulatory Health Services (AAP)	Percentage of members 20 -44 years of age who had an ambulatory or preventive care visit during the measurement year
17b	Claims	Adults' Access to Preventive/Ambulatory Health Services (AAP)	Percentage of members 45 - 64 years of age who had an ambulatory or preventive care visit during the measurement year
17c	Claims	Adults' Access to Preventive/Ambulatory Health Services (AAP)	Percentage of members 65 years and older who had an ambulatory or preventive care visit during the measurement year
18	Claims	ER visits per 1000 Enrollees	Percentage of members with a visit to the Emergency Room (without a subsequent inpatient admission)
19	Claims	Ambulatory care sensitive hospital visits for enrollees with HF, CAD, Diabetes, Asthma, COPD, Bacterial Pneumonia and Cellulitis	Number per 1000 enrollees who required an inpatient hospitalization due to one of the following conditions: HF, CAD, Diabetes, Asthma, COPD, Bacterial Pneumonia and Cellulitis
19a	Claims	Ambulatory care sensitive hospital visits: • HF	Number per 1000 enrollees with HF who require an inpatient hospitalization
19b	Claims	Ambulatory care sensitive hospital visits: • CAD	Number per 1000 enrollees with CAD who require an inpatient hospitalization
19c	Claims	Ambulatory care sensitive hospital visits: • Diabetes	Number per 1000 enrollees with Diabetes who require an inpatient hospitalization
19d	Claims	Ambulatory care sensitive hospital visits: • Asthma	Number per 1000 enrollees with Asthma who require an inpatient hospitalization
19e	Claims	Ambulatory care sensitive hospital visits: • COPD	Number per 1000 enrollees with COPD who require an inpatient hospitalization

Illinois Health Connect
Quality Indicators
(Primary Care Case Management)

	Data Source	Indicator	Definition
19f	Claims	Ambulatory care sensitive hospital visits: • Bacterial Pneumonia	Number per 1000 enrollees with Bacterial Pnemonia who require an inpatient hospitalization
19g	Claims	Ambulatory care sensitive hospital visits: • Cellulitis	Number per 1000 enrollees with Cellulitis who require an inpatient hospitalization

Illinois Health Connect
Provider Profile
Report Created Fall 2010
for dates of service from 04/01/2009 through 03/31/2010

PCP:
(Provider Number)
(Provider Name)

Total # of Enrollees Served: 87

Quality of Care Indicators

Indicator		# Eligible Enrollees	# Eligible Events	Current Rate	Prior Rate	IHC State Rate (2009)	Comparison to All IHC PCPs	Bonus Payment Benchmarks
1a.	Immunization status for 2 year olds - Combination 2	1	1	100%	67%	69%	H	NA
1b.	Immunization status for 2 year olds - Combination 3	1	1	100%	67%	63%	H	72%
2a.	Lead toxicity testing: At least one by age 2	1	0	0%		69%	L	NA
2b.	Lead toxicity testing: At least two by age 2	1	0	0%		18%		NA
3a.	Developmental screening by age 12 months	3	0	0%	0%	53%	L	65%
3b.	Developmental screening between age 12 and 24 months	1	0	0%	0%	38%	L	55%
3c.	Developmental screening between age 24 and 36 months	6	4	67%	60%	27%	H	50%
4d.	Appropriate asthma medications for patients age 18 to 56 years	2	1	50%	100%	82%	L	86%
5.	Diabetic HbA1c testing for patients age 18 to 65 years	1	1	100%	0%	76%	H	81%
6a.	Zero well baby visits in the first 15 months of life	3	0	0%	0%	1%		NA
6g.	Six well baby visits in the first 15 months of life	3	1	33%	50%	72%		NA
7.	Well child visit in the 3rd, 4th, 5th and 6th years of life	15	6	40%	43%	69%	L	NA
8a.	Vision screening in the 3rd year of life	2	0	0%	0%	12%	L	NA

NA Not Available / Not Applicable
H PCP performance on this indicator is in the top 10 percentile of all IHC PCPs
L PCP performance on this indicator is in the bottom 10 percentile of all IHC PCPs

Illinois Health Connect
Provider Profile
Report Created Fall 2010
for dates of service from 04/01/2009 through 03/31/2010

PCP: (Provider Number)
(Provider Name)

Total # of Enrollees Served: 87

Quality of Care Indicators, continued

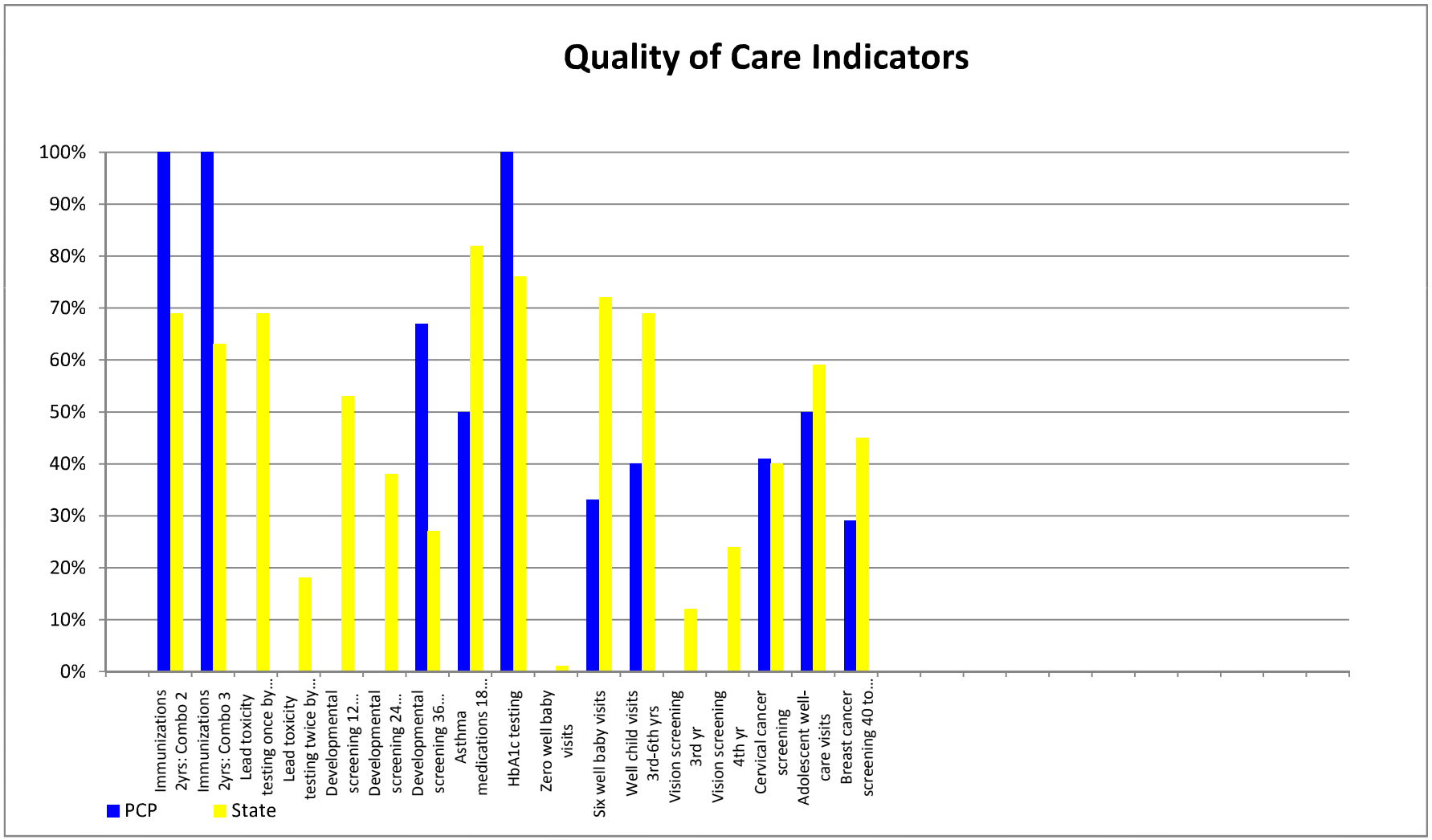
Indicator	# Eligible Enrollees	# Eligible Events	Current Rate	Prior Rate	IHC State Rate (2009)	Comparison to All IHC PCPs	Bonus Payment Benchmarks
8b. Vision screening in the 4th year of life	3	0	0%	20%	24%	L	NA
9. Cervical cancer screening for women age 21 to 64 years	22	9	41%	40%	40%		NA
10. Adolescent well-care visits for patients age 12 to 21 years	18	9	50%	50%	59%		NA
11c. Breast cancer screening for women age 40 to 69 years old	7	2	29%	33%	45%		51%

NA Not Available / Not Applicable
H PCP performance on this indicator is in the top 10 percentile of all IHC PCPs
L PCP performance on this indicator is in the bottom 10 percentile of all IHC PCPs

Illinois Health Connect
Provider Profile
Report Created Fall 2010
for dates of service from 04/01/2009 through 03/31/2010

PCP:
(Provider Number)
(Provider Name)

Total # of Enrollees Served: 87



Your Healthcare Plus - Disease Management Program
Clinical Measures for Elderly and Disabled Populations
July-2010

CHF	Ace inhibitor/ARB/H+I
	Beta blocker
	ASA, other antiplatelet or anticoagulant
	Diuretics
	Pneumococcal Vaccination
	Annual Flu Vaccination
COPD	Acute COPD exacerbation treated with corticosteroids
	Members with COPD hospitalization fills bronchodilator Rx
	At least one spirometry test in requisite period
	Pneumococcal Vaccination
	Annual Flu Vaccination
Diabetes	HbA1C Testing Rate
	Retinal Exams
	ASA, other antiplatelet or anticoagulant
	Annual Microalbuminuria Testing
	Cholesteral Testing Rate
	Annual Flu Vaccination
	Ace Inhibitor/ARB
	Statin Therapy
CAD	Ace Inhibitor/ARB
	Beta Blocker after MI
	ASA, other antiplatelet or anticoagulant
	Statin Therapy
	Cholesteral Testing Rate
	Pneumococcal Vaccination
	Annual Flu Vaccination
ABD-Asthma	Number who have at least one Asthma Controller Rx
	Member w/ uncontrolled Asthma who has one dispensed prescription of ICS w/i 30 days of an event
	Annual Flu Vaccination

Appendix B. HEDIS 2009 Medicaid Rates

CHILD AND ADOLESCENT CARE AND ADULTS' ACCESS TO PREVENTIVE/AMBULATORY CARE MEASURES

This appendix displays the Child and Adolescent Care and Adults' Access to Preventive/ Ambulatory Care measures for **FHN** and **Harmony** for HEDIS 2009 compared to the HEDIS 2008 50th and 90th percentiles.

HEDIS Measures	FHN	HAR	Total for HFS MCOs	2008 HEDIS Percentiles	
				50th	90th
Child and Adolescent Care					
Childhood Immunizations—Combo 2	72.0	62.5	67.5	75.4	84.7
Childhood Immunizations—Combo 3	65.8	51.6	59.0	68.6	78.2
Lead Screening in Children	69.5	69.8	69.7	65.9	84.0
Children's Access to PCPs (12-24 Months)	81.8	83.3	82.8	95.8	98.4
Children's Access to PCPs (25 months – 6 Years)	68.9	70.1	69.8	86.5	92.0
Children's Access to PCPs (7 – 11 Years)	49.5	61.6	59.3	87.8	94.1
Adolescent's Access to PCPs (12-19 Years)	49.9	60.8	59.2	84.5	91.9
*Well-Child Visits in the First 15 Months (0 Visits)**	7.7	4.6	6.3	1.9	6.8
Well-Child Visits in the First 15 Months (6+ Visits)	43.5	40.4	42.0	57.5	73.7
Well-Child Visits (3–6 Years)	74.8	65.9	70.6	68.2	78.9
Adolescent Well-Care Visits	36.9	37.7	37.3	42.1	56.7
Adults' Access to Preventive/Ambulatory Care					
20–44 Years of Age	59.4	66.3	64.8	79.6	87.6
45–64 Years of Age	58.8	63.3	62.4	85.7	90.2

*** Lower rates indicate better performance for these measures.**

	HEDIS 2008 Percentile					
	<10	10-24	25-49	50-74	75-89	90-100
Color Code for Percentiles						

Appendix C. HEDIS 2009 Medicaid Rates

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 2009 compared to the HEDIS 2008 50th and 90th percentiles.

HEDIS Measures	FHN	HAR	Total for HFS MCOs	2008 HEDIS Percentiles	
				50th	90th
Preventive Screening for Women					
Breast Cancer Screening (Combined Rate)	33.9	32.5	32.7	50.1	61.2
Cervical Cancer Screening	55.4	62.0	58.6	67.0	77.5
Chlamydia Screening (16–20 Years of Age)	53.6	44.5	45.7	48.8	65.3
Chlamydia Screening (21–25 Years of Age)	53.8	54.8	54.6	56.4	69.6
Chlamydia Screening (Combined Rate)	53.7	48.8	49.5	51.9	67.0
Maternity-Related Measures					
*Frequency of Ongoing Prenatal Care (<21 Visits)**	39.3	27.0	33.4	7.7	24.4
Frequency of Ongoing Prenatal Care (81–100 Visits)	25.6	33.6	29.4	61.5	80.7
Timeliness of Prenatal Care	49.4	56.4	52.8	84.1	91.4
Postpartum Care	32.9	40.1	36.3	60.8	70.6

*** Lower rates indicate better performance for these measures.**

	HEDIS 2008 Percentile					
	<10	10-24	25-49	50-74	75-89	90-100
Color Code for Percentiles						

Appendix D. HEDIS 2009 Medicaid Rates

Chronic Conditions/Disease Management Measures

This appendix displays the Chronic Conditions/Disease Management measures for **FHN** and **Harmony** for HEDIS 2009 compared to the HEDIS 2008 50th and 90th percentiles.

HEDIS Measures	FHN	HAR	Total for HFS MCOs	2008 HEDIS Percentiles	
				50th	90th
Chronic Conditions/Disease Management					
Controlling High Blood Pressure (Combined Rate)	54.6	39.7	43.3	55.4	65.0
Diabetes Care (HbA1C Testing)	66.9	68.1	67.8	79.6	88.8
*Diabetes Care (Poor HbA1c Control)**	65.5	67.3	67.0	46.0	69.8
Diabetes Care (Good HbA1c Control)	27.0	24.6	25.1	32.8	42.5
Diabetes Care (Eye Exam)	24.3	13.3	15.7	53.8	67.6
Diabetes Care (LDL-C Screening)	60.8	58.0	58.6	73.2	81.8
Diabetes Care (LDL-C Level <100 mg/Dl)	19.6	17.7	18.1	33.1	42.6
Diabetes Care (Nephropathy Monitoring)	79.7	69.9	72.0	76.1	85.4
Diabetes Care (BP < 140/90)	45.3	54.0	52.2	58.2	71.3
Diabetes Care (BP < 130/80)	27.0	27.4	27.3	29.7	41.2
Appropriate Medications for Asthma (5–9 Years)	92.2	86.7	87.8	91.8	96.1
Appropriate Medications for Asthma (10–17 Years)	80.6	88.1	87.2	89.5	93.3
Appropriate Medications for Asthma (18–56 Years)	79.6	84.9	84.3	85.8	90.7
Appropriate Medications for Asthma (Combined Rate)	85.0	86.6	86.4	88.7	91.9
Follow-up After Hospitalization for Mental Illness-7 Days	64.2	43.2	47.4	43.2	65.4
Follow-up After Hospitalization for Mental Illness-30 Days	76.5	55.6	59.8	65.9	80.3
*** Lower rates indicate better performance for these measures.**					

	HEDIS 2008 Percentile					
	<10	10-24	25-49	50-74	75-89	90-100
Color Code for Percentiles						