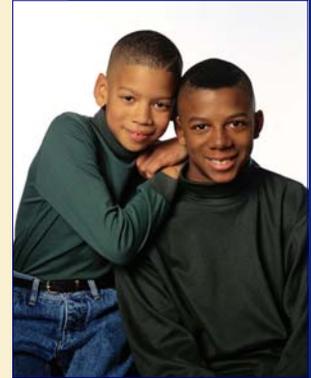


Medicaid Managed Health Care



Clinical Performance Measures

January through December 2004





Clinical Performance Measures

January through December 2004

**Bureau of
Managed Health Care**

**Program Development
& Analysis Section**

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EXECUTIVE SUMMARY

The Ohio Department of Job and Family Services (ODJFS) is the single state agency with responsibility for implementation and administration of the Ohio Medicaid program. As a value purchaser of health care, Ohio Medicaid has incorporated the use of managed care since 1978 to enhance system accountability for access and quality as well as to achieve greater cost predictability. Managed care offers an opportunity to assure access to a primary care provider, emphasize preventive care, and encourage the appropriate utilization of services in the most cost-effective settings.

Managed care plans (MCPs) cover Medicaid consumers in the Covered Families and Children category, which includes Healthy Start and Healthy Families. As of June 2005, the Ohio Medicaid Managed Care Program consisted of six MCPs operating in 15 counties with 530,164 Medicaid members.

ODJFS has measures in place to assure that the quality of care and access to care received through MCPs meets or exceeds set standards. These measures include, among others: (1) a federally-required annual quality improvement survey performed by an external quality review organization (EQRO) that includes a medical record audit; (2) a corporate MCP review, which includes a grievance audit, and quality of care studies of clinical processes and access to services; (3) monitoring of provider panels; and (4) monitoring of access and clinical performance measures.

This report presents the results of the clinical performance measures for the MCPs for calendar year (CY) 2004. The results were calculated with encounter data, which is essentially administrative claims data that providers send to MCPs who, in turn, send the claims data to ODJFS. Information obtained from medical records, generated by a sample of managed care consumers was not used. The results were calculated using encounter data generated by all managed care consumers, which generally yields lower results than if medical records information generated from a sample was also used.

However, there are limitations in relying only on administrative data to measure clinical performance. Issues may include miscoding of services and incomplete data. Encounter data is essentially a record of each service provided, regardless of the payment arrangement (e.g., capitation, fee-for-service). In payment arrangements other than fee-for-service, there may be a greater risk for incomplete data since there is less incentive for a provider to submit a claim.

Because of these potential data issues, the results presented in this report may not reflect the actual clinical performance of the providers associated with the MCPs. To generate reliable results, many steps are taken to help assure that encounter data is accurate, timely, and complete. Computer edits are used to reject data such as invalid codes, dates, and provider numbers. The volume of encounter data across various categories of services is monitored quarterly and MCPs are held accountable for meeting volume standards that have been established.

The following table summarizes the results for the clinical performance measures for CYs 2003 and 2004.

Measure	CY 2003	CY 2004
Initiation of Prenatal Care	84.4%	85.4%
Frequency of Ongoing Prenatal Care	58.6%	58.9%
Cesarean Section Rate	21.5%	23.5%
Low Birth Weight Rate	7.6%	9.6%
Very Low Birth Weight Rate	1.6%	2.4%
Postpartum Visit	49.4%	52.8%
Well Child Visit in First 15 Months of Life (Had 6 visits)	41.9%	43.5%
Well Child Visit (3-6 years old)	62.0%	62.2%
Adolescent Well Care Visit (12-21 years old)	35.8%	36.6%
Childhood Immunization Status – Combination 1 (received all recommended vaccines by age 2)	17.7%	23.6%
Annual Dental Visit	41.0%	44.3%
Lead Testing for 1 Year Olds	40.3%	43.0%
Lead Testing for 2 Year Olds	23.3%	24.2%
Asthma Medication Management	56.0%	55.9%
Diabetes Care (Had HbA1c Test)	59.4%	59.8%

Highlights of CY 2004 Report:

- ◆ Approximately 85% of new members who had a live birth received a prenatal visit within 42 days of enrolling in the MCP or by the end of the first trimester if the member enrolled in the MCP during the early stage of pregnancy.
- ◆ Approximately 60% of members with a live birth received 81% or more of the recommended number of prenatal visits, which is much higher than the national Medicaid average of 48% (see note below).
- ◆ The percentage of members with a live birth who received a postpartum visit increased from 49% in CY 2003 to 53% in CY 2004.

Note: The national Medicaid managed care results presented in this report for comparative purposes were obtained from the NCQA's website. NCQA has indicated that the data and methods used to calculate the results were audited and that the results were calculated using the "hybrid" (combines information obtained from medical records with encounter data) and administrative specifications (relies only on encounter data information). Results calculated using hybrid specifications are generally higher than those calculated using administrative specifications. Therefore, comparing the results in this report to the national Medicaid results is not an exact comparison and should be made with caution.

- ◆ The percentage of children and adolescents aged 4 to 21 who received an annual dental visit increased from 41% in CY 2003 to 44% in CY 2004.
- ◆ The percentage of children who received a blood lead screening test increased from 40% to 43% in the one year old group and from 23% to 24% in the two year old age group.

Areas Identified for Improvement:

- ◆ The results for the Well-Child Visits in the 3rd/4th/5th and 6th years of life measure improved slightly from CY 2003 to CY 2004. Although the CY 2004 result was 62%, there is still significant room for improvement with this measure.
- ◆ Although the lead screening rate increased from CY 2003 to CY 2004 for both the one year and two year olds, there is still significant room for improvement with this measure for both age groups, especially for the two year old age group. CY 2004 results for the one and two year old age groups are 43% and 24%, respectively.
- ◆ The percentage of members with persistent asthma who received prescribed medications acceptable as primary therapy for long-term control of asthma remained relatively constant in CY 2003 and CY 2004 at 56%. However, this rate is less than the national Medicaid average of 64%, indicating that there is room for improvement.

I. INTRODUCTION

The Ohio Medicaid Managed Health Care Clinical Performance Measures Report is based solely on encounter data submitted by Managed Care Plans (MCPs) contracted to provide health services to Medicaid consumers. The Ohio Department of Job & Family Services (ODJFS) began collecting encounter data on July 1, 1996.

Encounter data captures every face-to-face visit between the MCPs Medicaid enrollees and a provider. Clinical performance measurement is one component of a multifaceted monitoring program designed to assure access to quality health services. The results will be compared to standards specified in the MCPs provider agreement with the ODJFS and will be reported to MCPs, consumers and other interested parties. This report presents results for those MCPs that were serving Medicaid members during CY 2004 and compares results for CY 2004 to results for CY 2003. These measures were modeled and calculated based on HEDIS 2004 technical specifications for performance measures. Use of this standard methodology allows comparison of Ohio's results with other Medicaid managed care populations in the nation.

Due to data quality issues, these results may not be reflective of actual clinical performance. ODJFS is focusing on improving the quality of the data with the goal of using these data to hold MCPs accountable for the quality of care delivered to Medicaid recipients enrolled in MCPs. Data quality issues are common in the early years of collecting encounter data. The following sections outline some considerations that should be taken into account when reviewing the results and describes the data quality measures that are currently in place.

Technical Considerations

Subsequent to an enrollee encounter with a provider there are several events that might influence the validity of the encounter data. The encounter must first be documented by the provider by completing a claim requesting reimbursement or by completing a shadow claim if there is a capitated arrangement with the MCP. Next, the provider submits the encounter to the MCP where they confirm that all information on the claim is complete and in an acceptable format. Following acceptance, the MCP processes the encounter and transfers it to their information system. Finally, the encounter is submitted to ODJFS where an edit process assures proper format and valid data elements (e.g., Medicaid ID and procedure codes). Any error at a data transfer point (e.g., coding the encounter on the claim or data entry into an electronic format) or break in this chain of events (e.g., rejected encounters submitted to the MCP or to ODJFS) results in inaccurate and/or incomplete data.

Related to encounter data reporting, provider compliance is a chief concern of MCP's. In a capitated delivery system, providers have less incentive to submit encounter data because the claim submission is not tied to a payment process. Also, providers must be willing to use the appropriate codes as defined in their agreement with MCP's. In order to ensure physician compliance, MCP's develop encounter data reporting policies, offer financial incentives, and provide technical assistance.

Once the encounter is submitted to the MCP, their management information system must allow for the processing for payment, collection and storage of claims and allow for the production of the data in the proper format for submission to ODJFS. Before ODJFS required encounter data submissions, many MCP's had limited experience collecting and reporting data for this purpose.

Data Quality Measures

The evaluation of each MCP's results, whereby the results are compared to the standards, identifies areas needing improvement. To encourage standard level performance each MCP that is not compliant with the standard faces a system of progressive penalties. This system's first objective is to improve the quality of the encounter data. In this complex data collection system, it is expected in the first several years of data collection that there will be many data quality issues identified and resolved. Once the data quality is to a level where ODJFS is confident that the results reflect the services being delivered, then this monitoring tool can be used to improve clinical performance.

Data quality measures were developed to evaluate and improve the completeness, accuracy, and timeliness of each MCPs encounter data set. These measures include:

1. Validation Studies, where submitted encounters are compared to medical records for accuracy;
2. Omission Studies, where an enrollee's medical record is compared to the encounter data to check completeness of the submitted data;
3. Encounter Volume Report, to assure the expected number of encounters are being submitted timely; and
4. Minimum level performance measures results, where results below this minimum level indicate data errors.

ODJFS maintains an ongoing dialogue and an information sharing process with MCPs concerning encounter data reporting. ODJFS offers MCPs technical assistance and provides feedback on submissions.

Results will be presented for the performance measures listed below. Standards are established for many of these measures and the MCPs are held accountable for achieving the standard. If a measure is a contract measure and included in the provider agreement between the MCP and ODJFS, this will be noted when the measure is discussed.

Perinatal Measures

◆ Initiation of Prenatal Care

The percentage of women who delivered (a) live birth(s) during the reporting year, who were enrolled in the MCP no more than 279 days but at least 43 days prior to delivery with no gaps in MCP enrollment, and had their first prenatal visit within 42 days of enrollment or by the end of the first trimester for those women enrolled in the MCP during the early stage of pregnancy.

◆ Frequency of Ongoing Prenatal Care

The percentage of Medicaid-enrolled women who had a live birth during the reporting year and who received less than 21%, 21% through 40%, 41% through 60%, 61% through 80%, or greater than or equal to 81% of the expected number of prenatal care visits, adjusted for gestational age and the month the member enrolled in the MCP.

◆ Low Birth Weight Rate/Very Low Birth Weight

The percentage of women who delivered a live birth during the reporting year, who had at least five months of continuous enrollment immediately prior to the birth, and who had a low birth weight or very low birth weight baby.

◆ Postpartum Care

The percentage of enrolled women who delivered (a) live birth(s) during the reporting year who were continuously enrolled for 56 days after delivery and who had a postpartum visit on or between 21 days and 56 days after delivery.

◆ Cesarean Section Rate

The percentage of enrolled women who a live birth during the reporting year who delivered by a Cesarean Section..

Child Health Care Measures

◆ Well-Child Visits in the First 15 Months of Life

The percentage of enrolled members who turned 15 months old during the reporting year, who were enrolled from the month after the month in which they were born through their 15 month of life (allowing for a one month gap in MCP enrollment), and who received either zero, one, two, three, four, five, or six or more well-child visits with a primary care practitioner during their first 15 months of life.

◆ Well-Child Visits for Children Aged 3 Through 6

The percentage of members who were three, four, five, or six years old during the reporting year, who were enrolled for at least 11 months with the plan during the measurement year, and who received one or more well-child visit(s) with a primary care practitioner during the reporting year.

◆ Adolescent Well-Care Visits

The percentage of enrolled members who were age 12 through 21 during the reporting year, who were enrolled for at least 11 months with the plan during the reporting year, and who received at least one comprehensive well-care visit with a primary care practitioner during the reporting year.

◆ Childhood Immunization Status

The percentage of enrolled children who turned two years old during the reporting year, who were enrolled for 12 months immediately preceding their second birthday (allowing for one month gap in MCP enrollment), and who received four DTP/DTaP, three IPV/OPV, one MMR, two Hemophilus influenza b, and two hepatitis B vaccines by their second birthday.

◆ Annual Dental Visit

The percentage of enrolled members age 4 through 21 who were enrolled for at least 11 months with the plan during the reporting year and who had at least one dental visit during the reporting year.

◆ Lead Testing For 1 Year Olds

The percentage of enrolled members who turned 15 months old during the reporting year, who were enrolled in the MCP from 9 months through 15 months of age (allowing for a one month gap in MCP enrollment), who were enrolled in the MCP during their 15th month of life, and who received a lead screening test.

◆ Lead Testing For 2 Year Olds

The percentage of enrolled members who turned 27 months old during the reporting year, who were enrolled in the MCP from 21 months through 27 months of age (allowing for a one month gap in MCP enrollment), who were enrolled in the MCP during their 27th month of life, and who received a lead screening test.

Chronic Care Measures

◆ Use of Appropriate Medications for People with Asthma

The percentage of members ages 5 through 56 with persistent asthma who were enrolled for at least 11 months with the plan during the reporting year, who were enrolled for at least 11 months during the year prior to the reporting year, and who received prescribed medications acceptable as primary therapy for long-term control of asthma.

◆ Comprehensive Diabetes Care

The percentage of members with diabetes (Type 1 and 2) age 18 through 75 who were enrolled for at least 11 months with the plan during the reporting year, who were enrolled during the last month of the reporting year, and who received each of the following: (1) Hemoglobin A1c (HbA1c) testing; (2) a retinal exam by an optometrist or ophthalmologist; (3) LDL-C screening; and (4) screening or treatment for nephropathy.

Results will be reported on the following plans:

<u>Managed Care Plan</u>	<u>Abbreviation Used in Graphs</u>
CareSource	CS
Paramount Health Care	PAR
QualChoice Health Plan	QC
SummaCare	SC
Weighted Average of all MCPs	AVG
National Medicaid Average	USA

II. PERINATAL CARE MEASURES

Initiation of Prenatal Care for New Enrollees

(MCP Contract Measure)

Purpose

This measure assesses whether new enrollees received prenatal care early in pregnancy (during the first trimester). Thus, this measure looks at the timing of prenatal care as opposed to the frequency of such care. Both factors, however, are thought to be related to the outcome of pregnancy.

ODJFS Expectations

Managed care plans must meet a minimum performance standard for this measure, in accordance with the MCP provider agreement dated July 1, 2004, Appendix M, Performance Evaluation. The results for this measure are also used to determine if an MCP qualifies for financial incentives in accordance with Appendix O, Performance Incentives, of the Provider Agreement.

Minimum Performance Standard: The level of improvement must result in at least a 10% decrease in the difference between the target (90%) and the previous year's results.

Methods

Measure: The percentage of women who delivered (a) live birth(s) during the reporting year, who were enrolled in the MCP no more than 279 days but at least 43 days prior to delivery with no gaps in MCP enrollment, and who had their first prenatal visit within 42 days of enrollment or by the end of the first trimester for those women who enrolled in the MCP during the early stage of pregnancy.

Numerator: One (or more) prenatal care visit(s) within 42 days of enrollment in the MCP or within the first trimester if the member enrolled more than 42 days prior to the end of the first trimester.

Denominator: The eligible population.

Data Source: Encounter Data

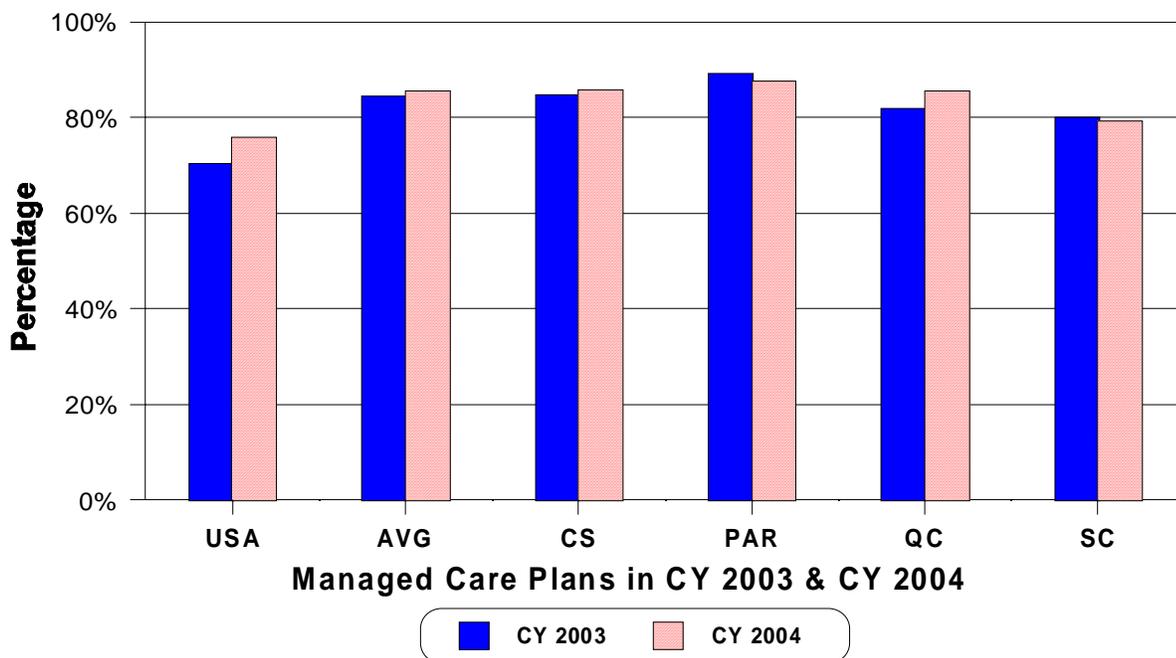
See Appendix A for more detailed information on the methods for calculating this measure.

Results

As shown in Graph A-1, the percentage of Medicaid members enrolled in MCPs who had a prenatal visit within 42 days of enrollment, or by the end of the first trimester for those women who enrolled in the MCP during the early stage of pregnancy, increased from 84% in CY 2003 to 85% in CY 2004. The results in CY 2004 ranged from a low of 79% to a high of 88%. The bar labeled "USA" provides the national Medicaid results (obtained from NCQA website) for calendar year 2003 as a frame of reference, which are the most recent results available.

Graph A-1.

Initiation of Prenatal Care for New Enrollees (received visit within 42 days or by end of 1st trimester)



Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Source of Data: Encounter Data and NCQA (Measurement Year 2003, 2004)

Frequency of Ongoing Prenatal Care

(MCP Contract Measure)

Purpose

This measure assesses whether recipients received a sufficient number of prenatal visits. Periodic care throughout pregnancy helps to promote a good pregnancy outcome. During the visits providers monitor the health of the woman and the fetus and teach the woman about the childbearing and delivery process. Specifically, routine prenatal care typically includes taking the history of the woman, performing a physical examination and chemical urinalysis, and recording the woman's weight, blood pressure, and fetal heart tones. It is important that periodic monitoring occur since the mother's risk status can change throughout pregnancy.

The measure adjusts for the length of gestation as well as the timing of the first prenatal visit. For example, a recipient who had a full term pregnancy of 44 weeks and who began care in the first month of pregnancy would be expected to have 18 visits while a recipient who had a pregnancy of 33 weeks and who began care in the fifth month of pregnancy would be expected to have only three visits. The expected number of visits is based on guidelines set forth by the American College of Obstetricians and Gynecologists.

ODJFS Expectations

Managed care plans must meet a minimum performance standard for this measure, in accordance with the MCP provider agreement dated July 1, 2004, Appendix M, Performance Evaluation. The results for this measure are also used to determine if an MCP qualifies for financial incentives in accordance with Appendix O, Performance Incentives, of the Provider Agreement.

Minimum Performance Standard: The level of improvement must result in at least a 10% decrease in the difference between the target (80%) and the previous year's results.

Methods

Measure: The percentage of Medicaid-enrolled women who had a live birth during the reporting year and who received less than 21%, 21% through 40%, 41% through 60%, 61% through 80%, or greater than or equal to 81% of the expected number of prenatal care visits, adjusted for gestational age and the month the member enrolled in the MCP.

Numerator: Women who had an unduplicated count of less than 21%, 21% through 40%, 41% through 60%, 61% through 80%, or greater than or equal to 81% of the expected number of prenatal care visits, adjusted for gestational age and the month the member enrolled in the MCP.

Denominator: The number of Medicaid MCP members who had a live birth during the reporting year.

Data Source: Encounter Data

See Appendix A for more detailed information on the methods for calculating this measure.

Results

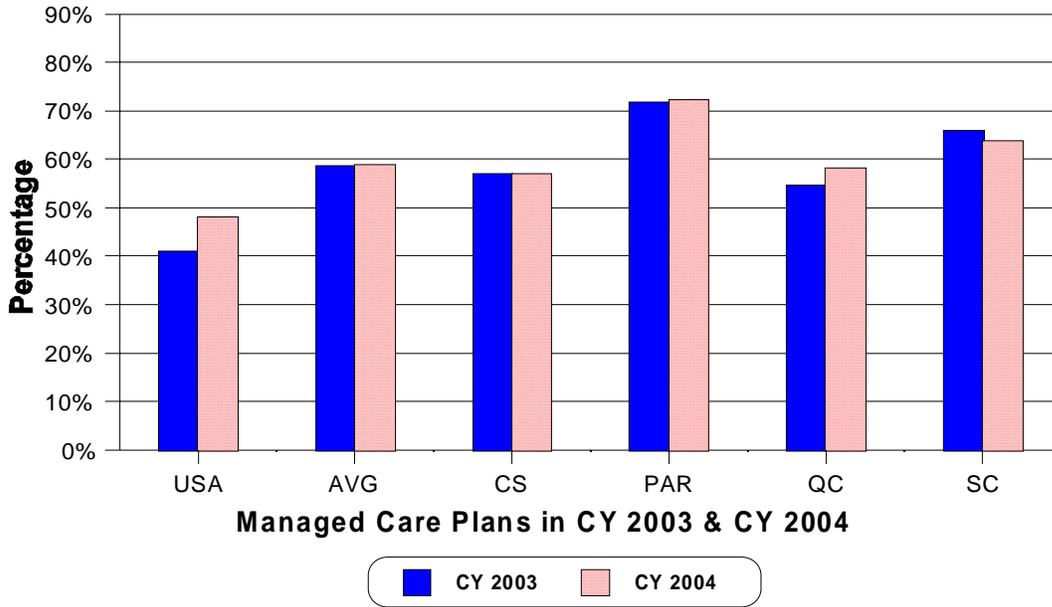
As shown in Graph B-1, the percentage of women with a live birth who received 81% or more the expected number of prenatal care visits, adjusted for gestational age and the month the member enrolled in the MCP, increased from 58.6% in CY 2003 to 58.9% in CY 2004. In CY 2004, the results ranged from 57% to 72%.

Graph B-2 shows the percentage of women in the denominator who received less than 21%, 21-40%, 41-60%, 61-80%, or 81% or more of the expected number of visits. As shown, the weighted average of the Medicaid serving MCPs in Ohio exceeded the national Medicaid average regarding the percentage of members who received 81% or more of the expected number of prenatal visits. Furthermore, the percentage of Ohio MCP members who received very little or no prenatal care (i.e., less than 21% of the expected number of prenatal visits) was significantly lower than the national average.

Graph B-1.

Frequency of Ongoing Prenatal Care

Percent Who Received 81% or More of the Expected Visits



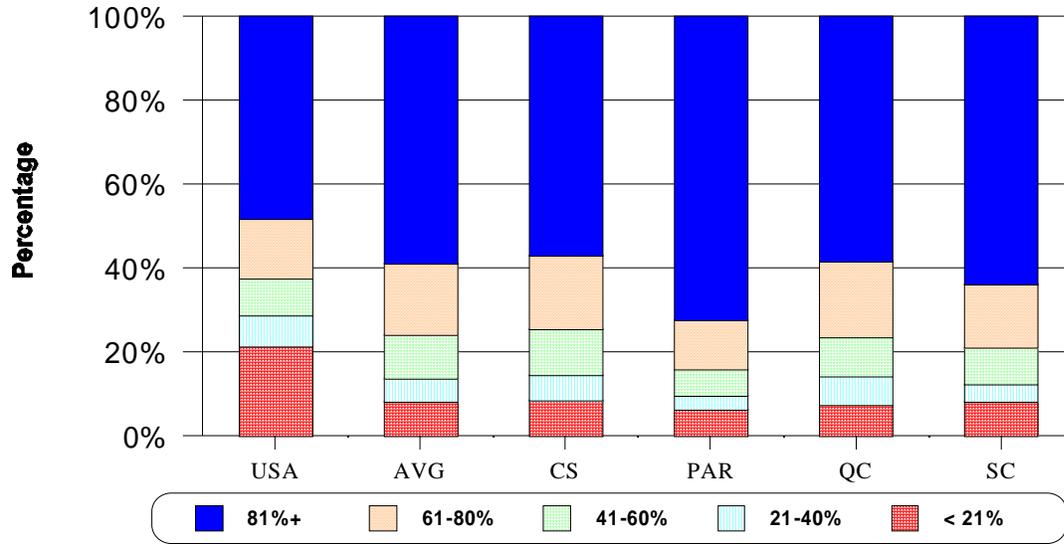
Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Source of Data: Encounter Data and NCQA (Measurement Year 2003, 2004)

Graph B-2.

Frequency of Ongoing Prenatal Care - 2004

% Receiving <21%, 21-40%, 41-60%, 61-80%, 81% or More of the Expected Visits



Cesarean Section Rate

Purpose

This measure assesses the percentage of live births that were delivered by a cesarean section. A cesarean section is a surgical procedure whereby a baby is delivered through an incision in the abdominal and uterine walls. Not only can reducing the rate reduce health care costs, but also the risk to mothers can be reduced since there is a higher risk of mortality and complications and a longer hospital stay associated with cesarean section deliveries than with vaginal deliveries.

After declining for many years, the rate of cesarean delivery in the United States began to rise in 1997. By 2003, the nationwide rate of cesarean delivery for Medicaid members had increased to 23% of all live births.¹

Minimum Performance Standard: There is no performance standard for this measure.

Methods

Measure: The percentage of women who had a live birth during the reporting year who delivered by a Cesarean Section.

Numerator: Number of discharges for women who had a C-section resulting in a live birth during the measurement year.

Denominator: Number of discharges for women who had a delivery (vaginal or C-section) resulting in a live birth during the reporting year.

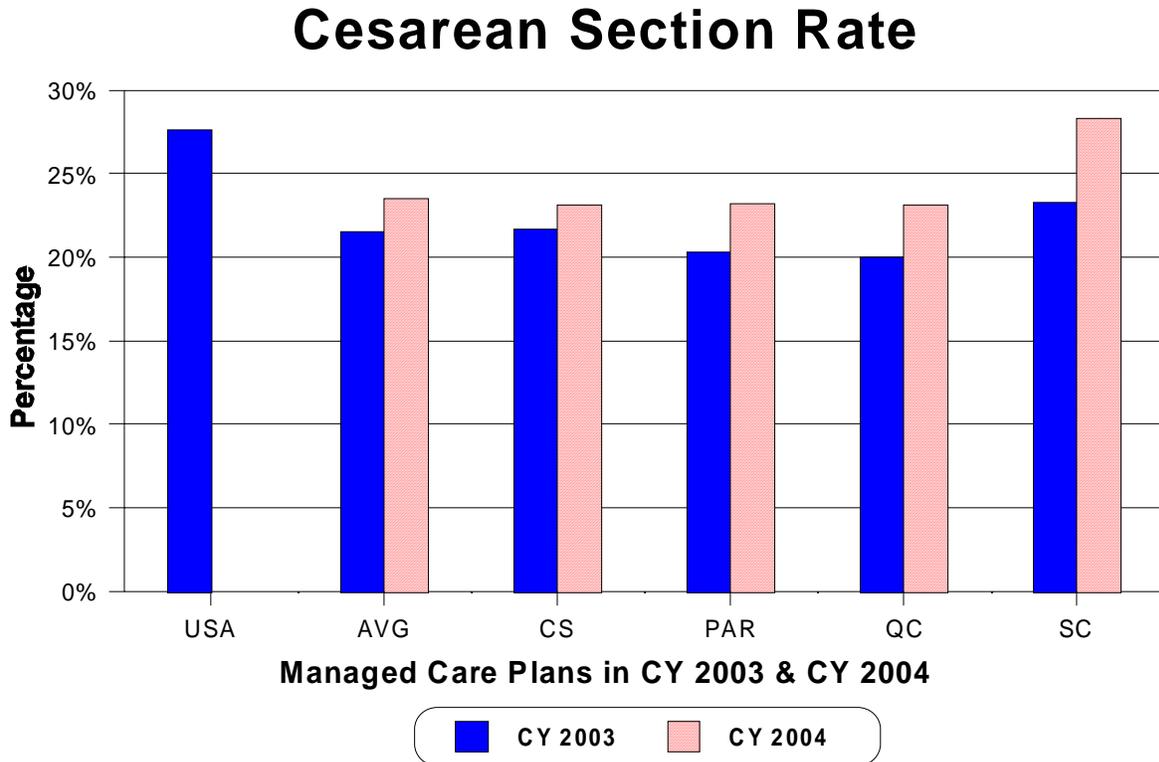
Data Source: Encounter Data

See Appendix A for more detailed information on the methods for calculating this measure.

Results

The percentage of Medicaid MCP members who had a repeat or primary cesarean section delivery was 22% in CY 2003 and increased to 24% by CY 2004. The results for CY 2004 ranged from 23% to 28%.

Graph C-1.



Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Source of Data: Encounter Data and National Vital Statistics System (Calendar Year 2003)

Low Birth Weight Measure

Purpose

This measure indirectly measures the outcome of care since low birth weight (defined as being less than 2,500 grams or about 5.5 pounds) is correlated with various adverse events. Not only are low birth weight infants more likely to experience neurodevelopmental handicaps, congenital anomalies, and respiratory disorders than are infants of normal birthweight,² but they also are 40 times more likely to die.³ Various risk factors have been associated with delivering a low birth weight infant. These include maternal age (less than 18 or greater than 35), ethnicity, low socioeconomic status, parity greater than 4, poor obstetrical history, smoking, substance abuse, poor nutrition, various medical illnesses such as hypertension, and absence of prenatal care.^{4,5}

In recent years (1998-2000), low birth weight rates in the United States increased have remained relatively constant at 7.6%.⁶

Minimum Performance Standard: There is no performance standard for this measure.

Methods

Measure: The percentage of women who gave birth to a low-birth weight newborn during the reporting year.

Numerator: The number of births in the denominator with a birth weight less than or equal to 2,500 grams.

Denominator: The number of Medicaid MCP members who had a live birth during the reporting year and who had at least five months of continuous enrollment immediately prior to the birth.

Data Source: Encounter Data

See Appendix A for more detailed information on the methods for calculating this measure.

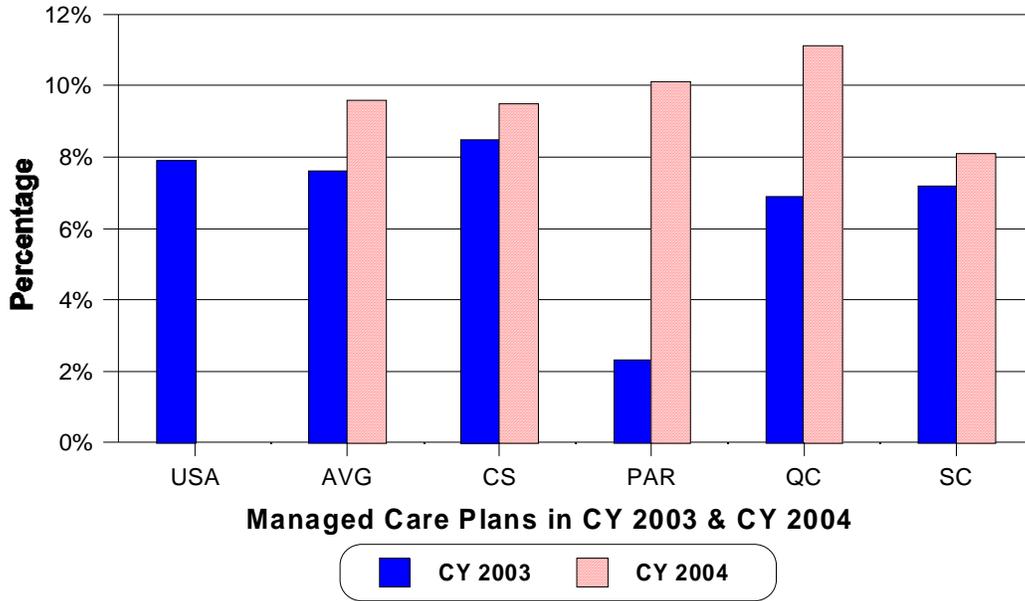
Results

The percentage of MCP Medicaid members who had a low birth weight baby was 8% in CY 2003 and 10% in CY 2004.

Graph D-1.

Low Birth Weight Results

(Less Than 2500 Grams)



Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Source of Data: Encounter Data and National Vital Statistics System (Calendar Year 2003)

↓ On this graph, lower rates indicate better performance.

Very Low Birth Weight Measure

Purpose

See discussion for Low Birth Weight measure.

Minimum Performance Standard: There is no performance standard for this measure.

Methods

Measure: The percentage of women who gave birth to a very low-birth weight newborn during the reporting year.

Numerator: The number of births in the denominator with a birth weight less than or equal to 1,500 grams.

Denominator: The number of Medicaid MCP members who had a live birth during the reporting year and who had at least five months of continuous enrollment immediately prior to the birth.

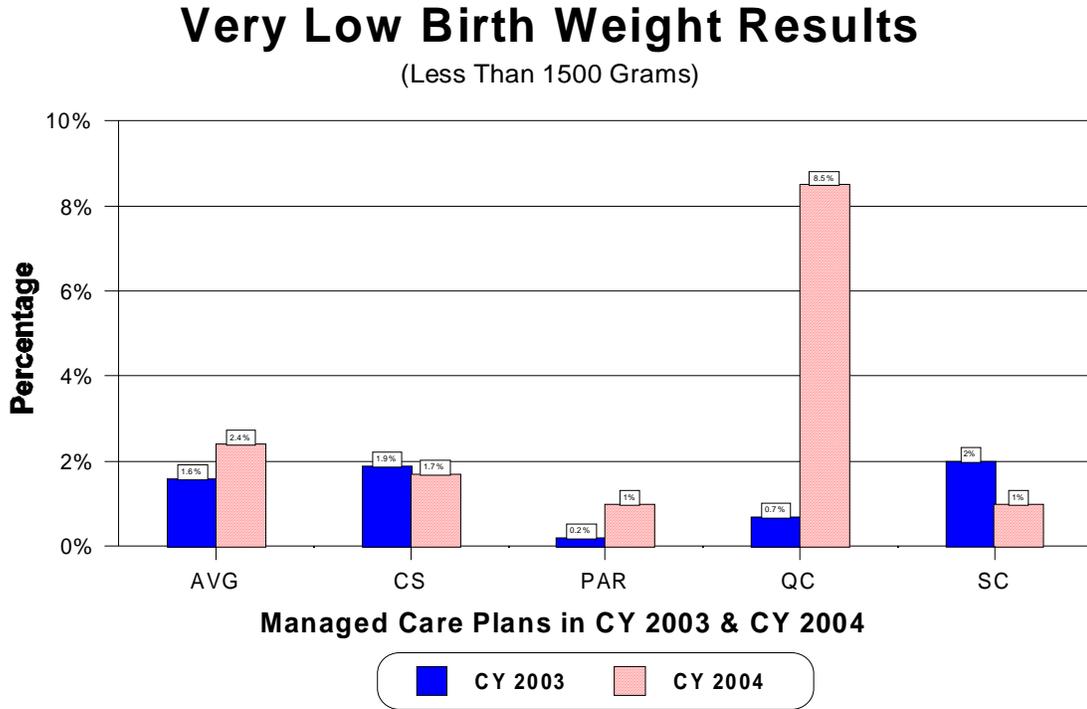
Data Source: Encounter Data

See Appendix A for more detailed information on the methods for calculating this measure.

Results

The very low birth weight MCP average was 1.6% in CY 2003 and 2.4% in CY 2004.

Graph E-1.



Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Source of Data: Encounter Database and Recipient Master File.

↓ On this graph, lower rates indicate better performance.

Postpartum Care (MCP Contract Measure)

Purpose

The American College of Obstetricians and Gynecologists recommends that women have a postpartum visit from four to six weeks after delivery.⁷ Women undergo physiological, emotional, and social changes during the period after delivery. The purpose of the postpartum visit is to evaluate the condition of the mother, to provide assistance and answer questions, and to provide guidance regarding family planning and nutrition. The physical examination that is performed during the visit should include an evaluation of weight, blood pressure, breasts, abdomen, and pelvic examination.⁸

ODJFS Expectations

Managed care plans must meet a minimum performance standard for this measure, in accordance with the MCP provider agreement dated July 1, 2004, Appendix M, Performance Evaluation. The results for this measure are also used to determine if an MCP qualifies for financial incentives in accordance with Appendix O, Performance Incentives, of the Provider Agreement.

Minimum Performance Standard: The level of improvement must result in at least a 5% decrease in the difference between the target (80%) and the previous year's results.

Methods

Measure: The percentage of enrolled women who delivered (a) live birth(s) during the reporting year who were continuously enrolled for 56 days after delivery and who had a postpartum visit on or between 21 days and 56 days after delivery.

Numerator: A postpartum visit on or between 21 and 56 days after delivery.

Denominator: The eligible population.

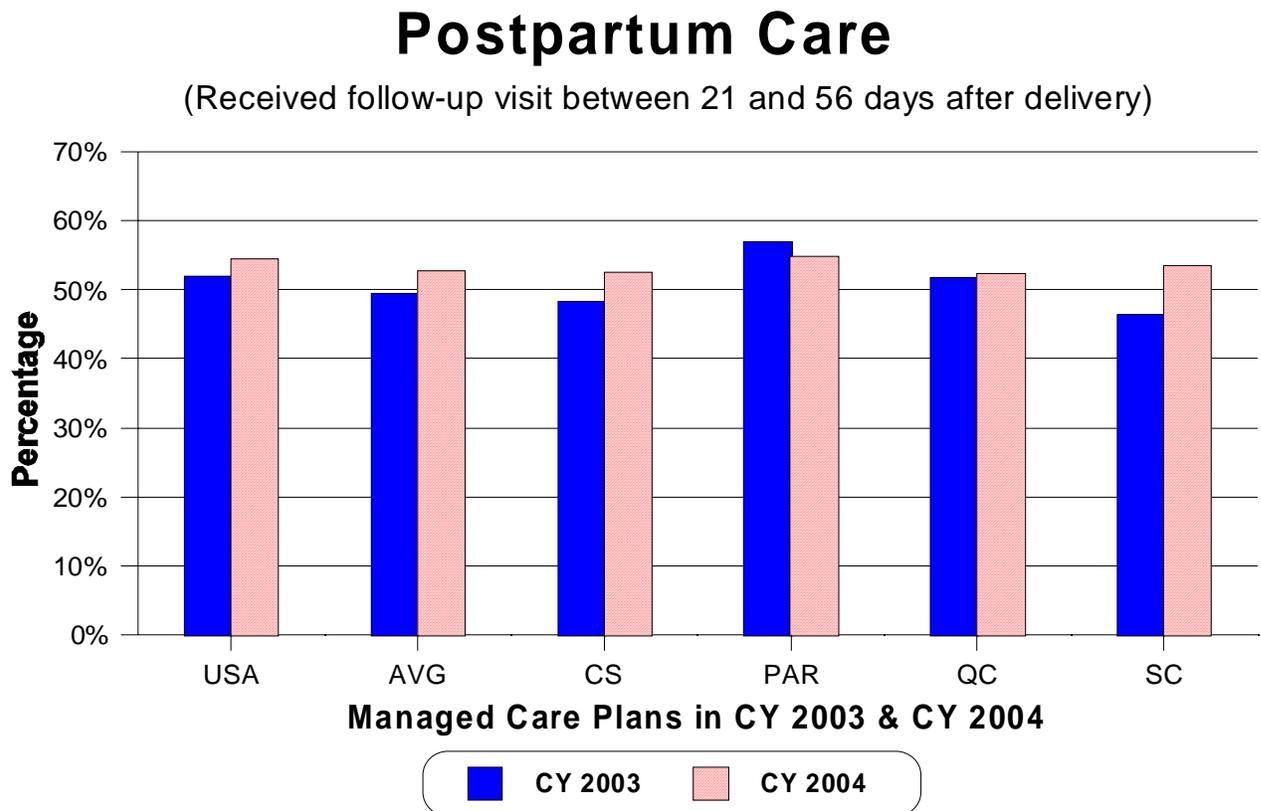
Data Source: Encounter Data

See Appendix A for more detailed information on the methods for calculating this measure.

Results

For the statewide MCP average, the percentage of members in the denominator who had a visit between 21 and 56 days after delivery increased from 49% in CY 2003 to 53% in CY 2004. The statewide average was less than the national Medicaid average (54%). The MCP-specific results in CY 2004 ranged from 52% to 55%.

Graph F-1.



Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

III. CHILD HEALTH CARE MEASURES

Well-Child Visit Measures

(MCP Contract Measure)

Purpose

Periodic preventive exams provide an opportunity for physicians and other health professionals to prevent and identify physical, developmental, and behavioral problems.

The American Academy of Pediatrics (AAP) Periodicity Schedule recommends annual well-child visits for two to six year olds.⁹ The AAP also recommends that adolescents receive comprehensive preventive examinations annually.¹⁰ Preventive exams are particularly important during the first year of life when an infant undergoes significant changes in cognitive abilities, growth, motor skills, hand-eye coordination, and social and emotional growth.¹¹

ODJFS Expectations

Managed care plans must meet a minimum performance standard for this measure, in accordance with the MCP provider agreement dated July 1, 2004, Appendix M, Performance Evaluation. The results for this measure are also used to determine if an MCP qualifies for financial incentives in accordance with Appendix O, Performance Incentives, of the Provider Agreement.

Minimum Performance Standard: The level of improvement must result in at least a 10% decrease in the difference between the target (80%) and the previous year's results.

Methods

Measure: The percentage of enrolled members who turned 15 months old during the reporting year, who were enrolled in the MCP from the month following the month in which they were born through their 15 month of life (allowing for a one month gap in MCP enrollment), who were enrolled during their 15 month of life, and who received either zero, one, two, three, four, five, or six or more well-child visits with a primary care practitioner during their first 15 months of life.

Numerator: Seven separate numerators are calculated, corresponding to the number of members who received: zero, one, two, three, four, five, and six or more well-child visits with a primary care practitioner during their first 15 months of life. A child is included in only one numerator (e.g., a child receiving six well child visits is not included in the rate for five, four, or fewer well child visits).

Denominator: The eligible population.

Data Source: Encounter Data

See Appendix A for more detailed information on the methods for calculating this measure.

Methods

Measure: The percentage of members who were three, four, five, or six during the reporting year, who were enrolled for at least 11 months with the plan during the measurement year, who were enrolled during the last month of the reporting year, and who received one or more well-child visit(s) with a primary care practitioner during the reporting year.

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

Denominator: The eligible population.

Data Source: Encounter Data

See Appendix A for more detailed information on the methods for calculating this measure.

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

Denominator: The eligible population.

Methods

Measure: The percentage of enrolled members who were age 12 through 21 during the reporting year, who were enrolled for at least 11 months with the plan during the reporting year, who were enrolled during the last month of the reporting year, and who received at least one comprehensive well-care visit with a primary care practitioner during the reporting year.

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

Denominator: The eligible population.

Data Source: Encounter Data

See Appendix A for more detailed information on the methods for calculating this measure.

Results

The percentage of members who received six or more well-child visits with a primary care practitioner during their first 15 months of life increased from 42% in CY 2003 to 44% in CY 2004. Graph G-2 shows the percentage of children who received zero, one, two, three, four, five, or six or more well-child visits. The percentage of children who received six or more visits national average is 45%. The percentage of children who received no visits was lower in Ohio than nationally (3% versus 6%).

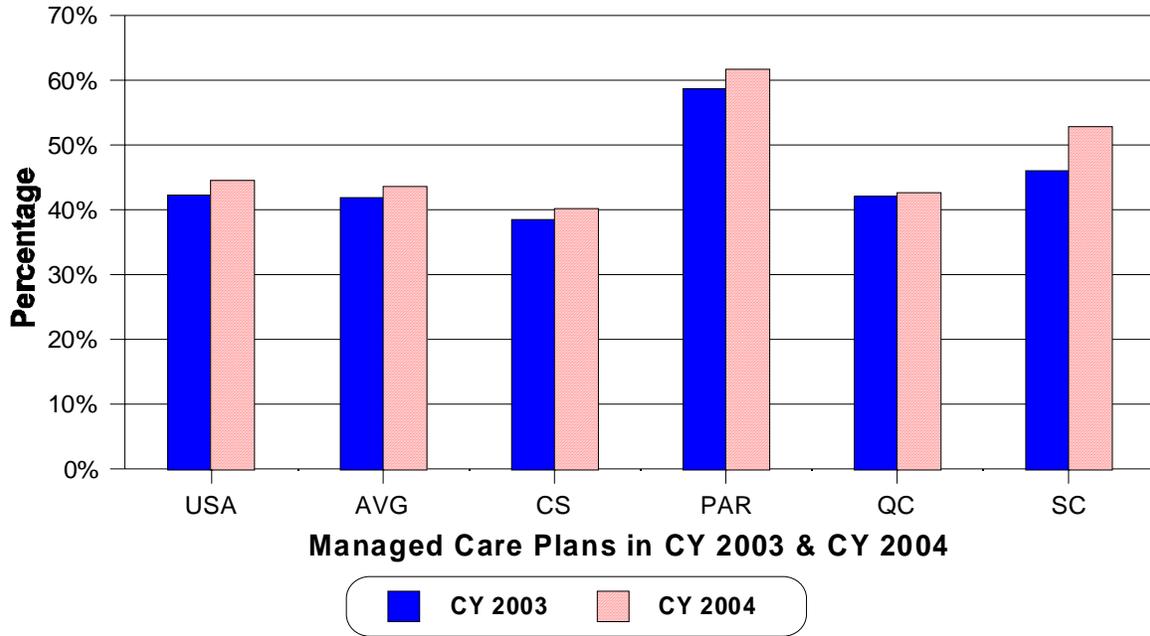
The percentage of members who were age three through six during CY 2004, and who received one or more well-child visit(s) with a primary care practitioner, increased from 62.0% in CY 2003 to 62.2% in CY 2004. The Ohio Medicaid MCP average exceeded the national Medicaid average (59.9%)

The percentage of enrolled members who were age 12 through 21 during CY 2004, and who received at least one well-care visit with a primary care practitioner, increased slightly from 36% in CY 2003 to 37% in CY 2004. The Ohio Medicaid MCP average is slightly less than national Medicaid average (38%).

Graph G-1.

Well-Child Visits in the First 15 Months of Life

% of Children Who Received 6 or More Visits



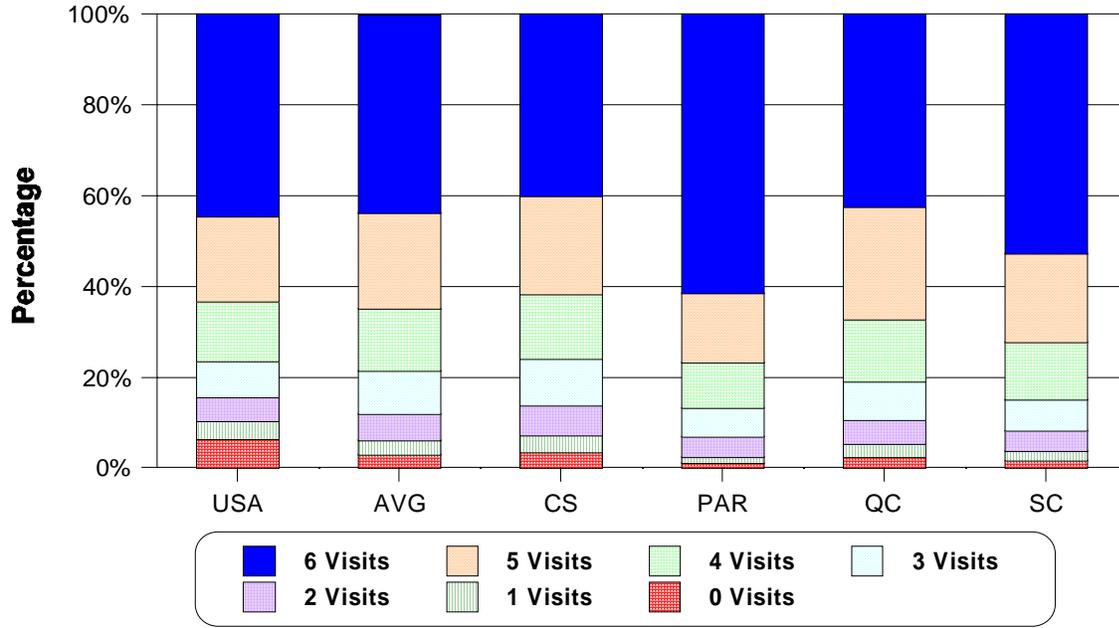
Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Graph G-2.

Well-Child Visits in the First 15 Months of Life

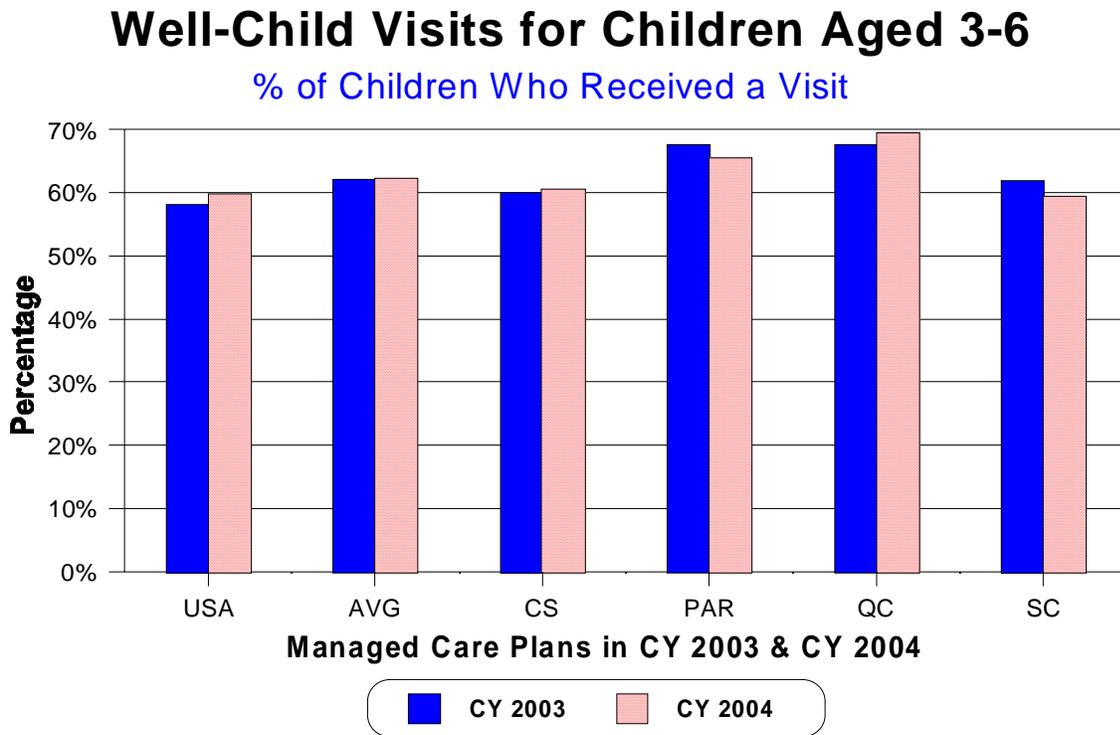
% of Children Who Received 0,1,2,3,4,5,6 Visits

CY 2004



Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Graph G-3.

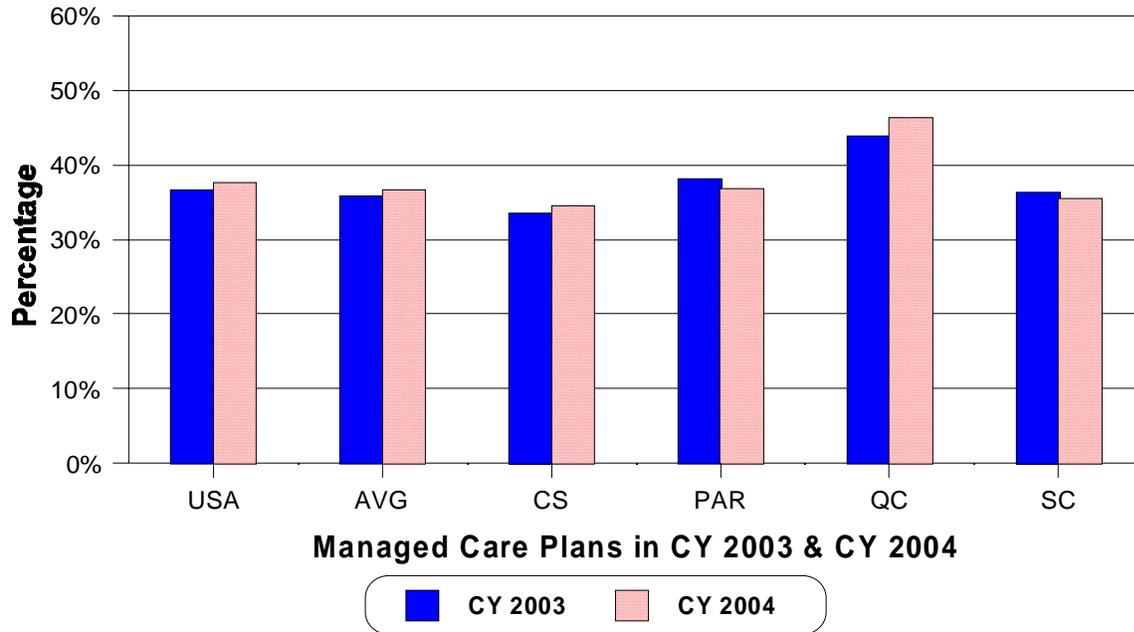


Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Graph G-4.

Adolescent Well Care Visits

% of Children Aged 12-21 Who Received a Visit



Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Childhood Immunization Status

Purpose

Despite progress that has been made in fighting infectious diseases during the past 100 years, these diseases remain a significant cause of illness and death. The very young, older adults, and members of minority groups are at increased risk for many infectious diseases.¹² Vaccines are one of the safest and most effective measures for preventing illness from infectious diseases.

Measuring compliance with immunization schedules is challenging for a number of reasons. First, it is possible that an infant received a vaccine even if no encounter was submitted to the ODJFS. For example, a “free” vaccine may have been received in a clinic. Second, even though there is a specific CPT code for each type of vaccine, providers, in some cases, may use inappropriate codes which can skew the results.

Minimum Performance Standard: There is no performance standard for this measure.

Methods

Measure: The percentage of enrolled children who turned two years old during the reporting year, who were enrolled for 12 months immediately preceding their second birthday (allowing for one month gap in MCP enrollment), who were enrolled during the last month of the reporting year, and who were identified as having four DTP/DTaP, three IPV/OPV, one MMR, two H influenza b, and two hepatitis B vaccines by the second birthday. The measure also calculates individual rates.

Numerator: Children who received four DTP or DTaP vaccinations and three OPV or IPV vaccinations and one MMR and two HiB vaccinations and two hepatitis B vaccinations.

Denominator: The eligible population.

Data Source: Encounter Data

See Appendix A for more detailed information on the methods for calculating this measure.

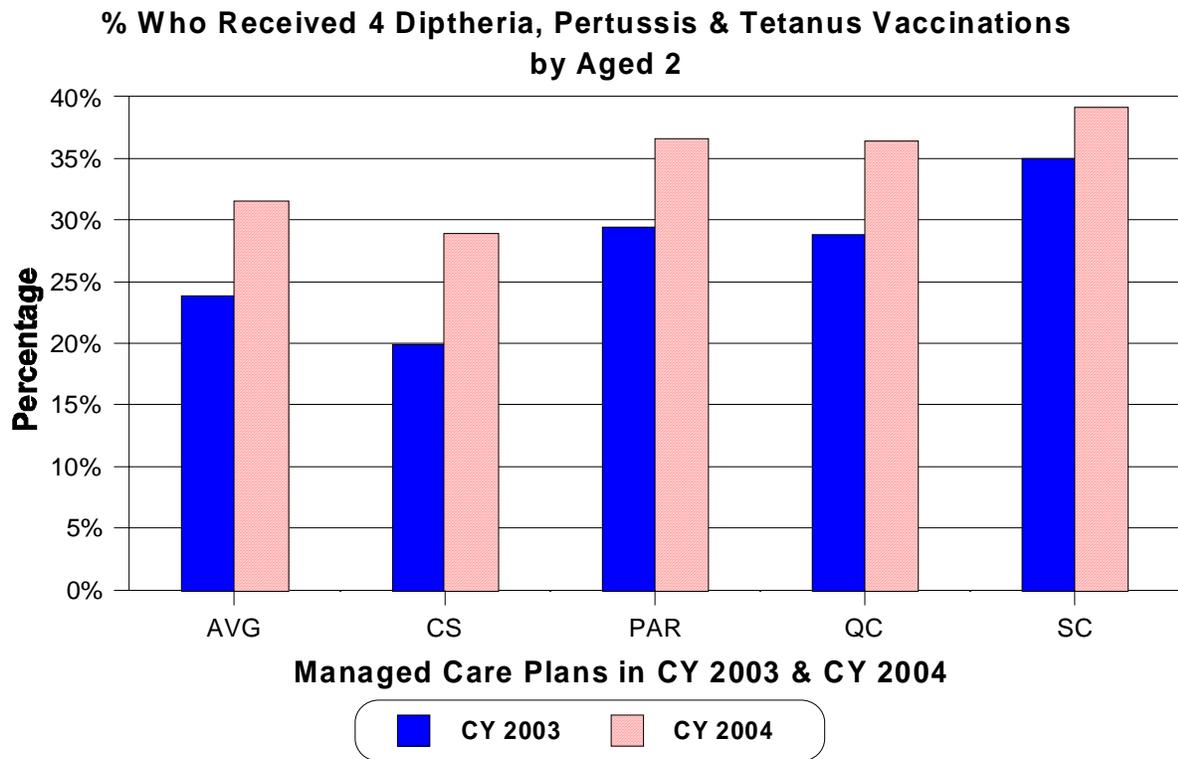
Results

MCPs in Ohio have indicated that they have great difficulty in obtaining immunization encounters from all of the various providers of immunization services, such as public health clinics. Immunization encounter data is the least complete of all of the encounter data that is collected by the MCPs. The results shown in the graphs reflect the incompleteness of the data.

Regarding CY 2004, by age two, 32% of the children received four diphtheria, tetanus, pertussis (DTP/DTaP) vaccines, 39% received three polio (IPV/OPV) vaccines, 69% received one measles, mumps and rubella (MMR) vaccine, 68% received two Hemophilus influenza b (HIB) vaccines, and 49% received two hepatitis B (HBV) vaccines. 24% of the children received all of the preceding vaccines, which are referred to in graph H-6 as the "Combination 1" group. In CY 2003, 18% had received all of the Combination 1 vaccines, demonstrating that some improvement has occurred regarding the submission of immunization encounter data.

By including information from medical records in addition to encounter data the results would be much higher. In a SFY 2003 External Quality Review study, The Health Services Advisory Group found that 70% of eligible two-year old children in Medicaid managed care had documentation of a complete immunization schedule. Seventy one point four percent of the children received four DPT vaccines, 81% received three OPV vaccines, 87% received one MMR vaccine, and 82% received three HIB vaccines, and 81% received three HBV vaccines.

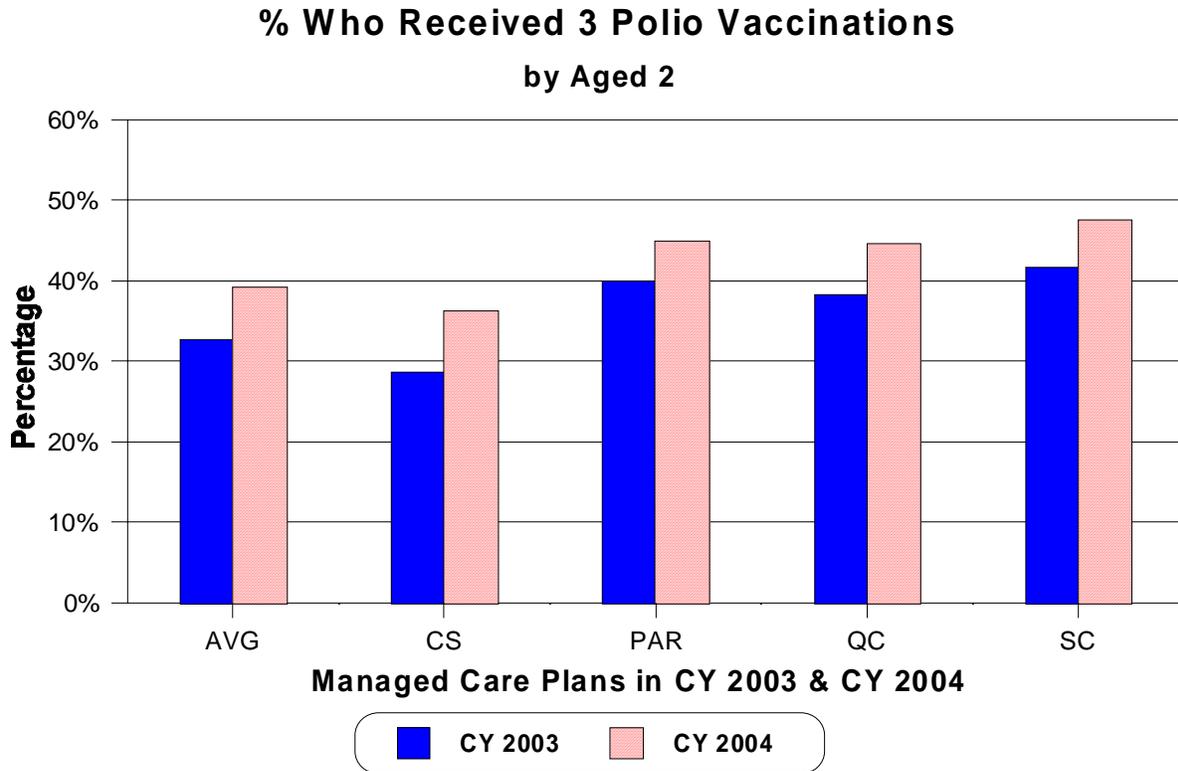
Graph H-1.



Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Source of Data: Encounter Data

Graph H-2.

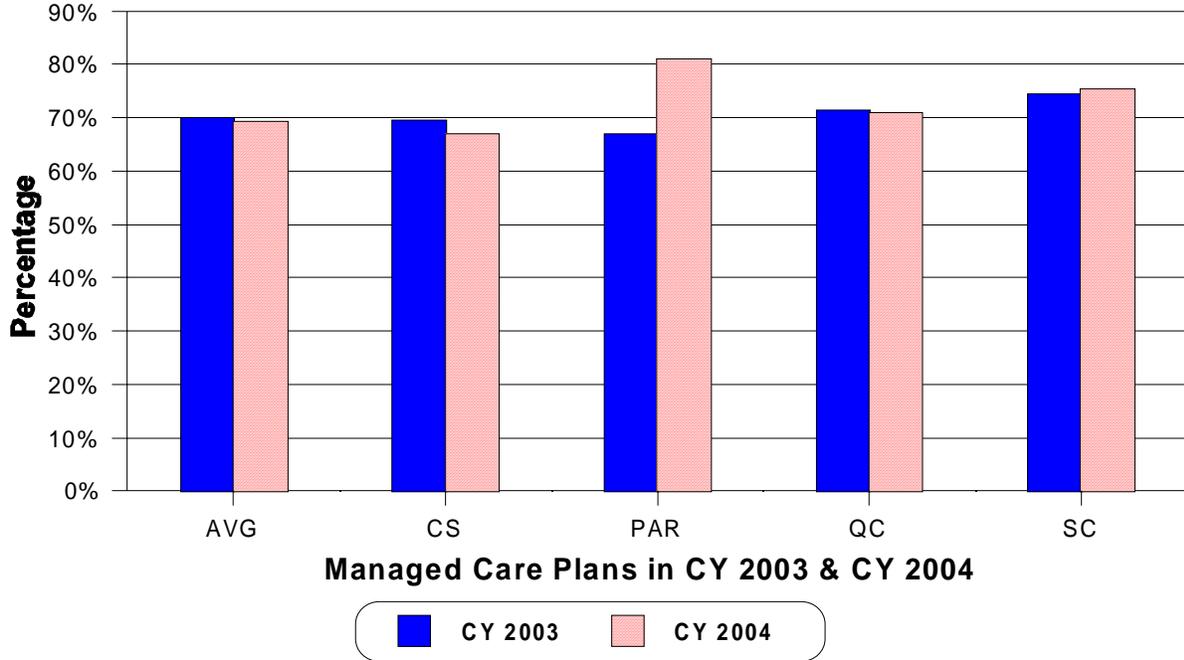


Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Source of Data: Encounter Data

Graph H-3.

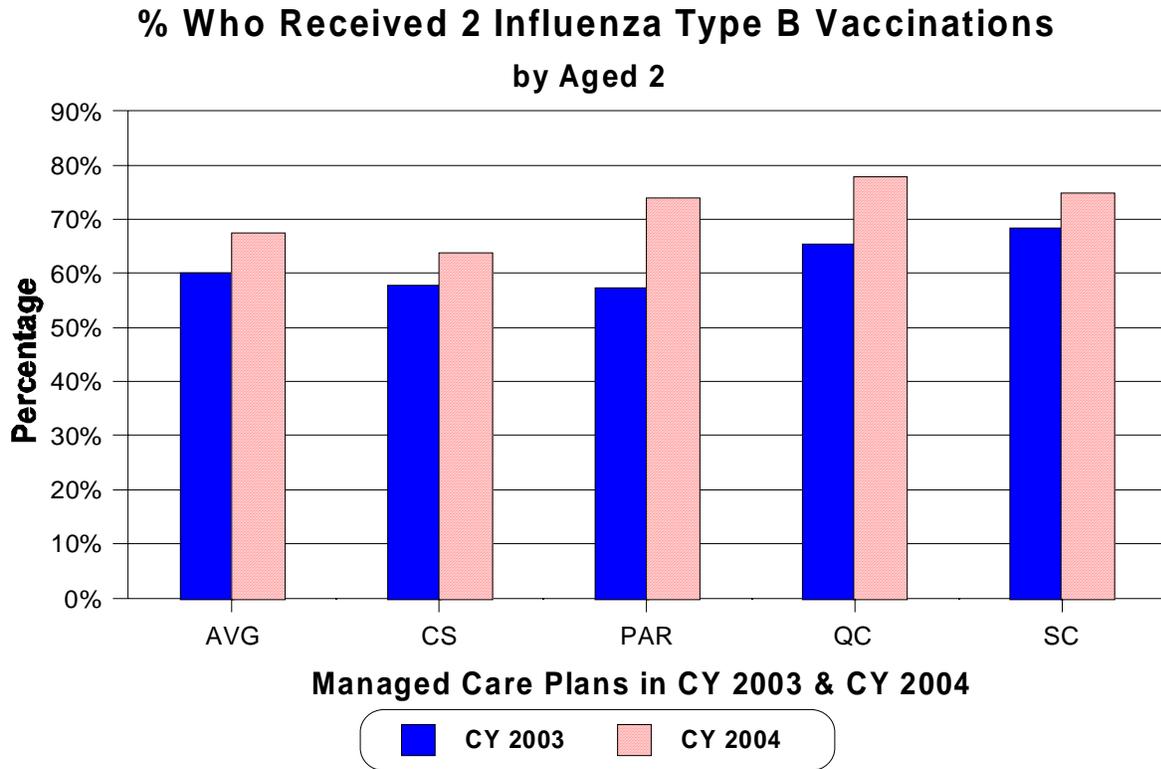
**% Who Received 1 Measles, Mumps & Rubella Vaccination
by Aged 2**



Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Source of Data: Encounter Data

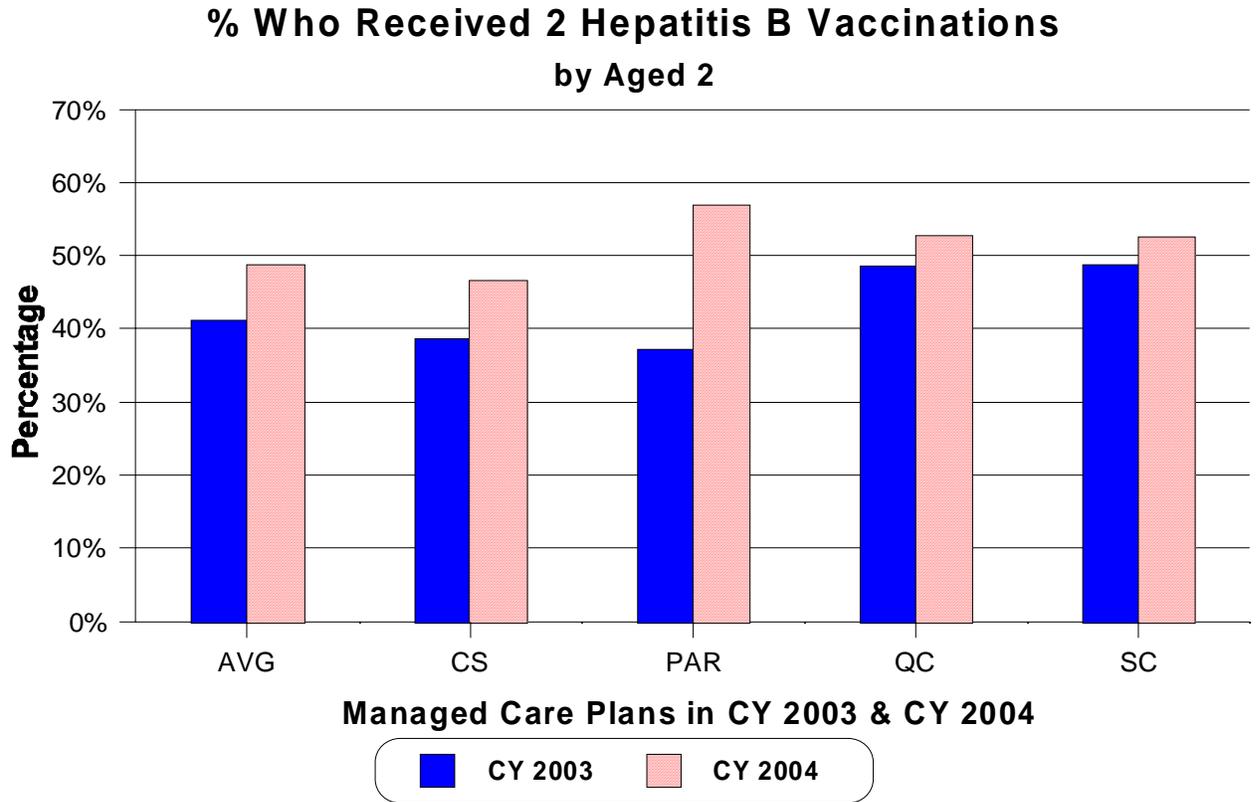
Graph H-4.



Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Source of Data: Encounter Data

Graph H-5.

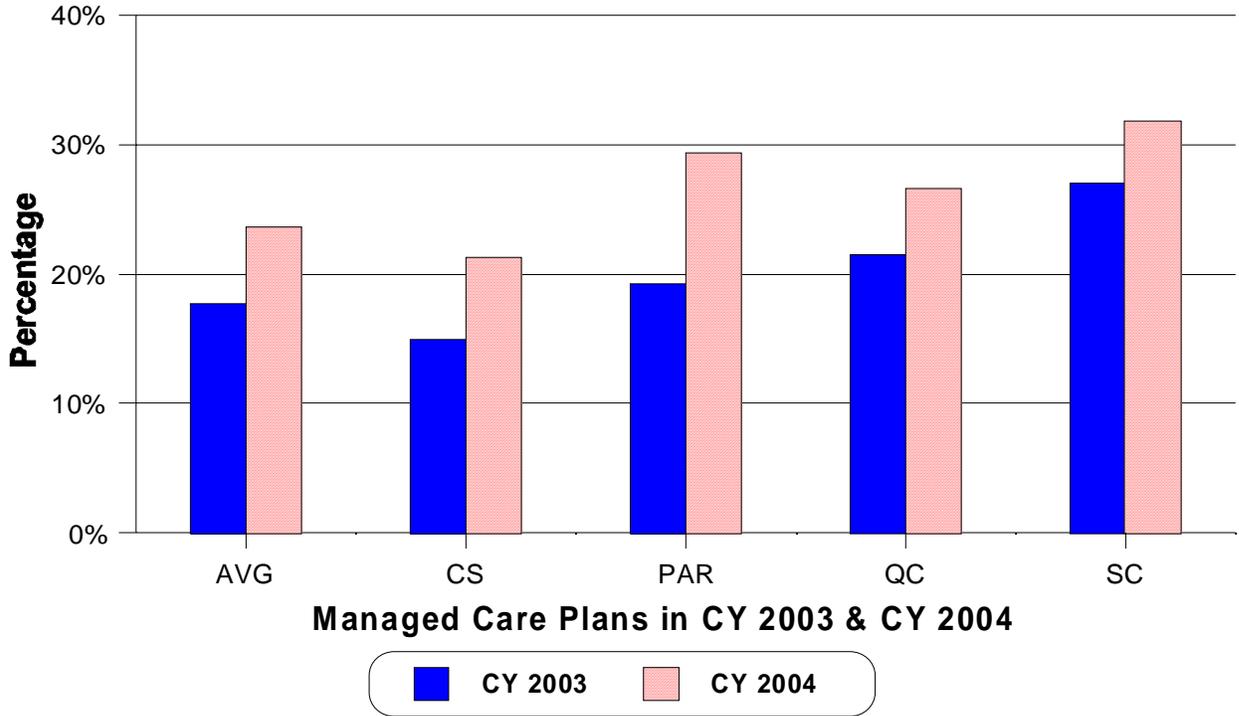


Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Source of Data: Encounter Data

Graph H-6.

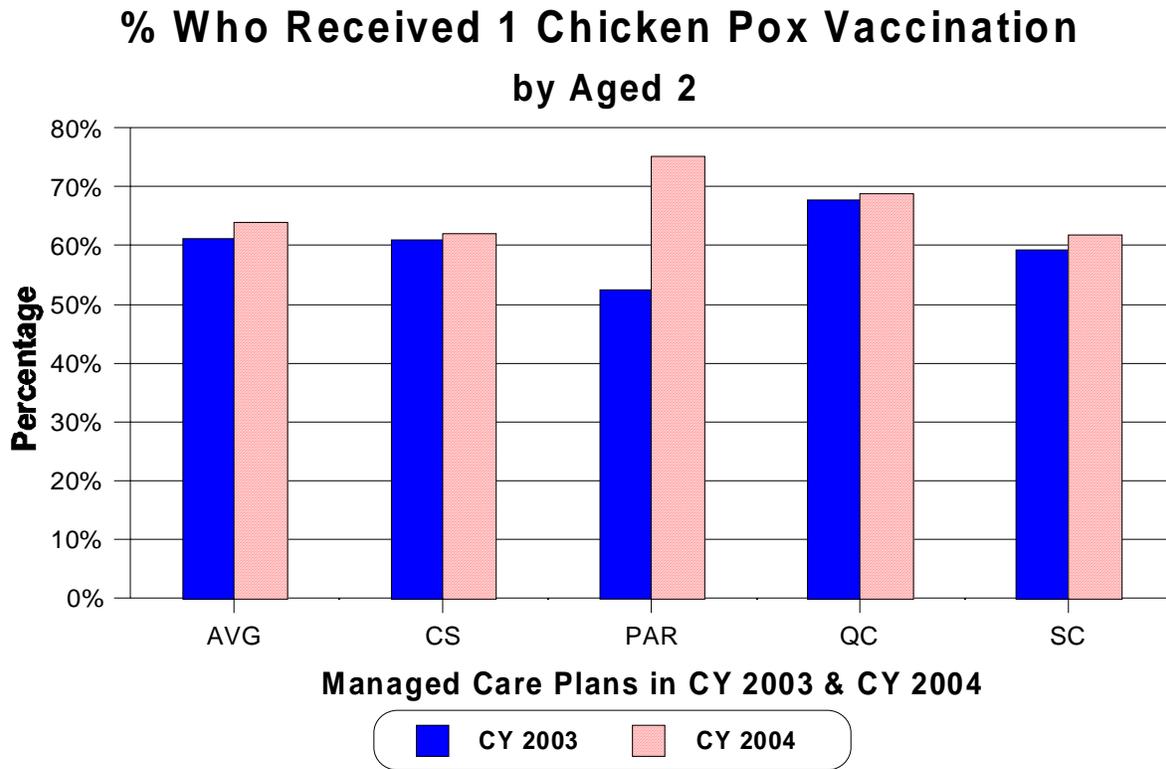
% Who Received All Combination 1 Vaccinations by Aged 2



Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Source of Data: Encounter Data

Graph H-7.



Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Source of Data: Encounter Data

Annual Dental Visit

(MCP Contract Measure)

Purpose

Great progress has been made over the last 50 years in understanding and treating oral diseases such as dental caries (tooth decay) and periodontal (gum) diseases. However, dental caries continues to be the single most common chronic childhood disease (5 times more common than asthma and 7 times more common than hay fever). Over half of children aged 5-9 have at least one cavity or filling and that percentage increased to 78% by age 17. According to the Surgeon General:

There are striking disparities in dental disease by income. Poor children suffer twice as much dental caries as their more affluent peers, and their disease is more likely to be untreated. These poor-nonpoor differences continue into adolescence. One out of four children in America is born into poverty, and children living below the poverty line (annual income of \$17,000 for a family of four) have more severe and untreated decay.¹³

Regular visits to the dentist provide access to early diagnosis and treatment and educate children about oral health.

ODJFS Expectations

Managed care plans must meet a minimum performance standard for this measure, in accordance with the MCP provider agreement dated July 1, 2004, Appendix M, Performance Evaluation. The results for this measure are also used to determine if an MCP qualifies for financial incentives in accordance with Appendix O, Performance Incentives, of the Provider Agreement.

Minimum Performance Standard: The level of improvement must result in at least a 10% decrease in the difference between the target (60%) and the previous year's results.

Methods

Measure: The percentage of enrolled members age 4 through 21 who were enrolled for at least 11 months with the plan during the reporting year, who were enrolled during the last month of the reporting year, and who had at least one dental visit during the reporting year.

Numerator: One (or more) dental visits with a dental practitioner during the reporting year.

Denominator: The eligible population.

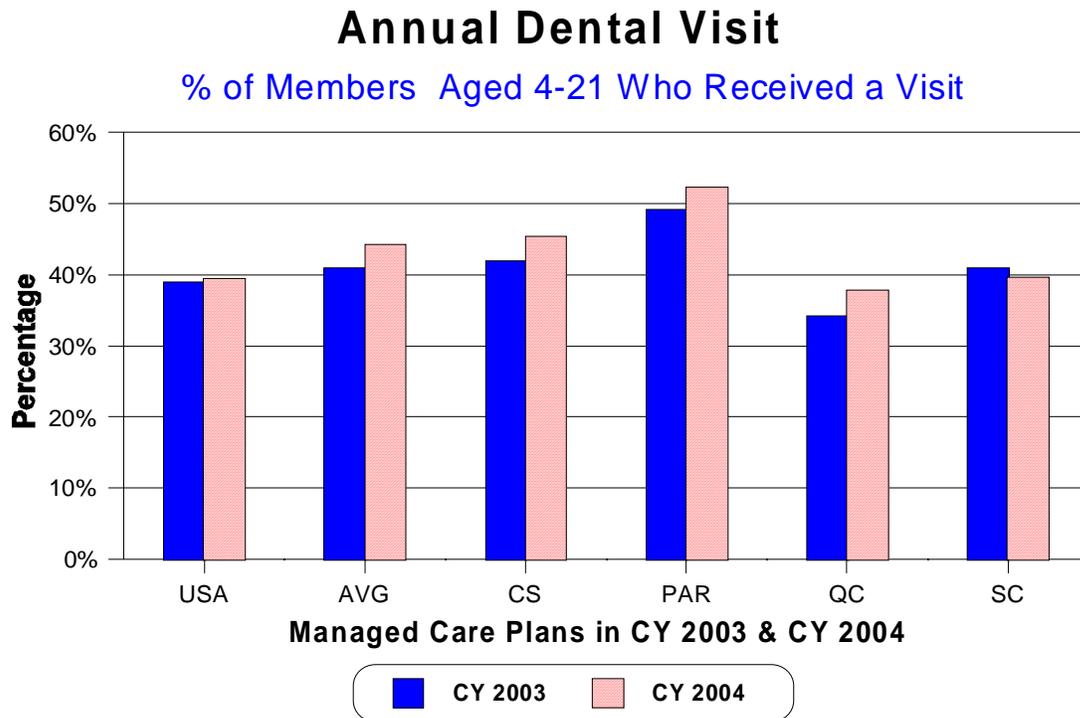
Data Source: Encounter Data

See Appendix A for more detailed information on the methods for calculating this measure.

Results

The percentage of members who received at least one dental visit increased from 41% in CY 2003 to 44% in CY 2004. The average for the Medicaid serving plans in Ohio was higher than the national average (39%).

Graph I-1.



Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Source of Data: Encounter Data and NCQA (Measurement Year 2002)

Lead Testing

(MCP Contract Measure)

Purpose

Since Ohio is a highly industrialized state with older housing, the risk of lead exposure and lead poisoning for children in Ohio is higher than for children in states with newer housing. Lead poisoning in children can reduce IQ and cause learning disabilities. At higher exposures, lead can damage a child's kidneys and central nervous system and cause anemia, coma, convulsions and even death.

Within the Ohio Medicaid program, blood lead screening is required as part of Healthchek (the Early and Periodic Screening and Diagnostic Testing (EPSDT) program). According to EPSDT standards, blood lead screening is required of all Medicaid children at ages one and two years.

ODJFS Expectations

Managed care plans must meet a minimum performance standard for this measure, in accordance with the MCP provider agreement dated July 1, 2005, Appendix M, Performance Evaluation. The results for this measure will also be used to help determine if an MCP qualifies for financial incentives in accordance with Appendix O, Performance Incentives, of the Provider Agreement.

Minimum Performance Standard: The level of improvement must result in at least a 10% decrease in the difference between the target (80%) and the previous year's results.

Methods

Measure: The percentage of enrolled members who turned 15 months old during the reporting year, who were enrolled in the MCP from 9 months through 15 months of age (allowing for a one month gap in MCP enrollment), who were enrolled in the MCP during their 15th month of life, and who received a lead screening test.

Numerator: The number of children in the denominator who received a lead screening test.

Denominator: The number of enrolled members who turned 15 months old during the reporting year, who were enrolled in the MCP from 9 months through 15 months of age (allowing for a one month gap in MCP enrollment), and who were enrolled in the MCP during their 15th month of life.

Data Source: Encounter Data

See Appendix A for more detailed information on the methods for calculating this measure.

Methods

Measure: The percentage of enrolled members who turned 27 months old during the reporting year, who were enrolled in the MCP from 21 months through 27 months of age (allowing for a one month gap in MCP enrollment), who were enrolled in the MCP during their 27th month of life, and who received a lead screening test.

Numerator: The number of children in the denominator who received a lead screening test.

Denominator: The number of enrolled members who turned 27 months old during the reporting year, who were enrolled in the MCP from 21 months through 27 months of age (allowing for a one month gap in MCP enrollment), and who were enrolled in the MCP during their 27th month of life.

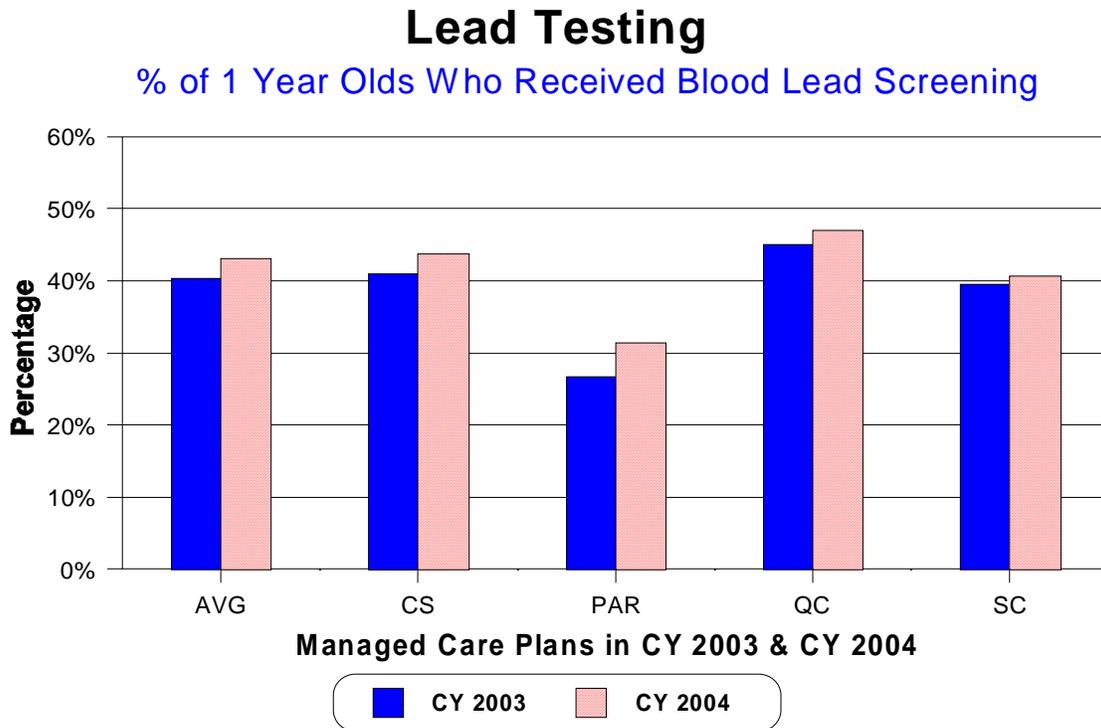
Data Source: Encounter Data

See Appendix A for more detailed information on the methods for calculating this measure.

Results

The percentage of enrolled members who turned 15 months old during the reporting year and who received a lead test between the ages of 9 months and the end of their 15 month of life was 40% in CY 2003 and increased to 43% in CY 2004. The percentage of enrolled members who turned 27 months old during the reporting year and who received a lead test between the ages of 21 months and the end of their 27 month of life was 23% in CY 2003 and increased to 24% in CY 2004.

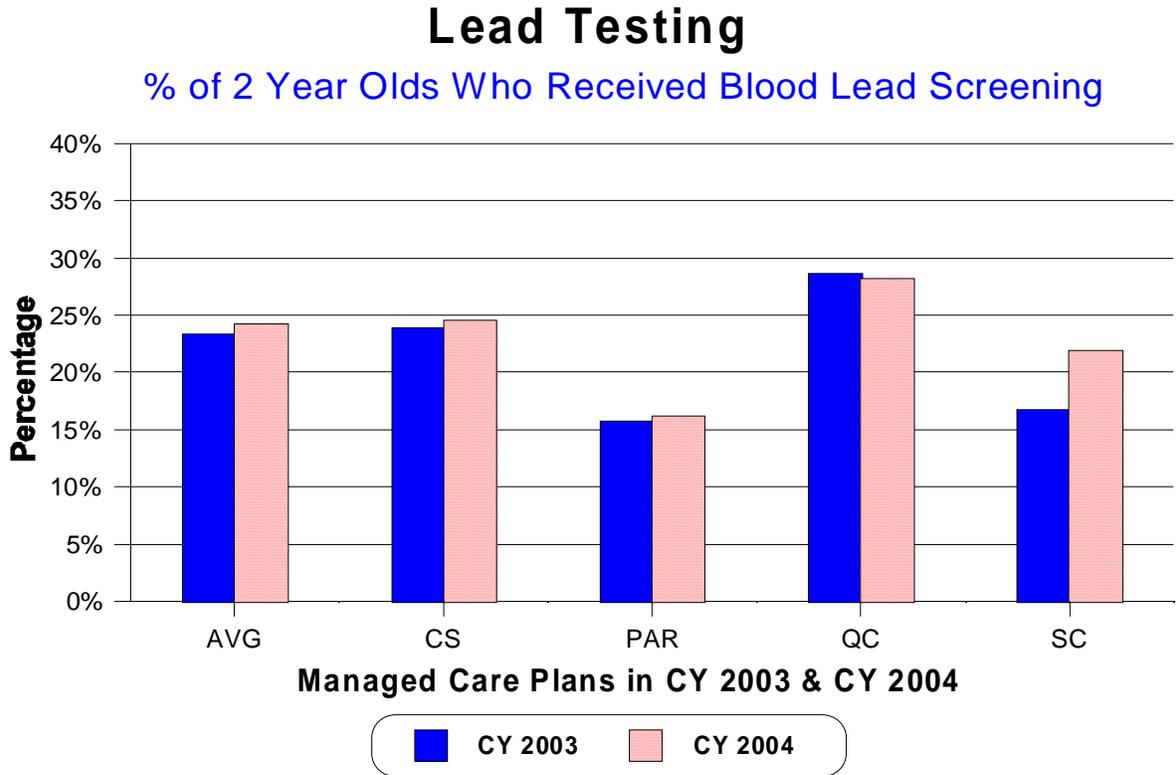
Graph J-1.



Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Source of Data: Encounter Data

Graph J-2.



Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Source of Data: Encounter Data

IV. CHRONIC CARE MEASURES

Use of Appropriate Medication for People With Asthma

(MCP Contract Measure)

Purpose

Asthma is a chronic, inflammatory disease of the respiratory system. The symptoms of asthma are coughing, wheezing, chest tightness, and difficulty breathing. These symptoms are usually reversible, but can be severe. Anti-inflammatory medications such as inhaled corticosteroids and cromolyn sodium are the primary therapy for the chronic care of moderate and severe asthma. The medications are used to reverse and prevent airflow obstruction. Corticosteroids are currently the most effective anti-inflammatory drugs for the treatment of asthma.¹⁴ Cromolyn sodium is a non-steroidal, inhaled anti-inflammatory drug. Without proper medication management and control of the factors which trigger attacks, patients may experience potentially life threatening attacks and have high rates of emergency room utilization.

ODJFS Expectations

Managed care plans must meet a minimum performance standard for this measure, in accordance with the MCP provider agreement dated July 1, 2004, Appendix M, Performance Evaluation. The results for this measure are also used to determine if an MCP qualifies for financial incentives in accordance with Appendix O, Performance Incentives, of the Provider Agreement.

Minimum Performance Standard: The level of improvement must result in at least a 10% decrease in the difference between the target (80%) and the previous year's results.

Methods

Measure: The percentage of members aged 5 through 56 with persistent asthma who were enrolled for at least 11 months with the plan during the reporting year, who were enrolled at least 11 months during the year prior to the reporting year, and who received prescribed medications acceptable as primary therapy for long-term control of asthma.

Numerator: For each member in the denominator, those who had at least one dispensed prescription of the recommended medications during the reporting year. The NDC list provided on NCQA's Web site at <http://www.ncqa.org> is used to identify these medications.

Denominator: The eligible population.

Data Source: Encounter Data

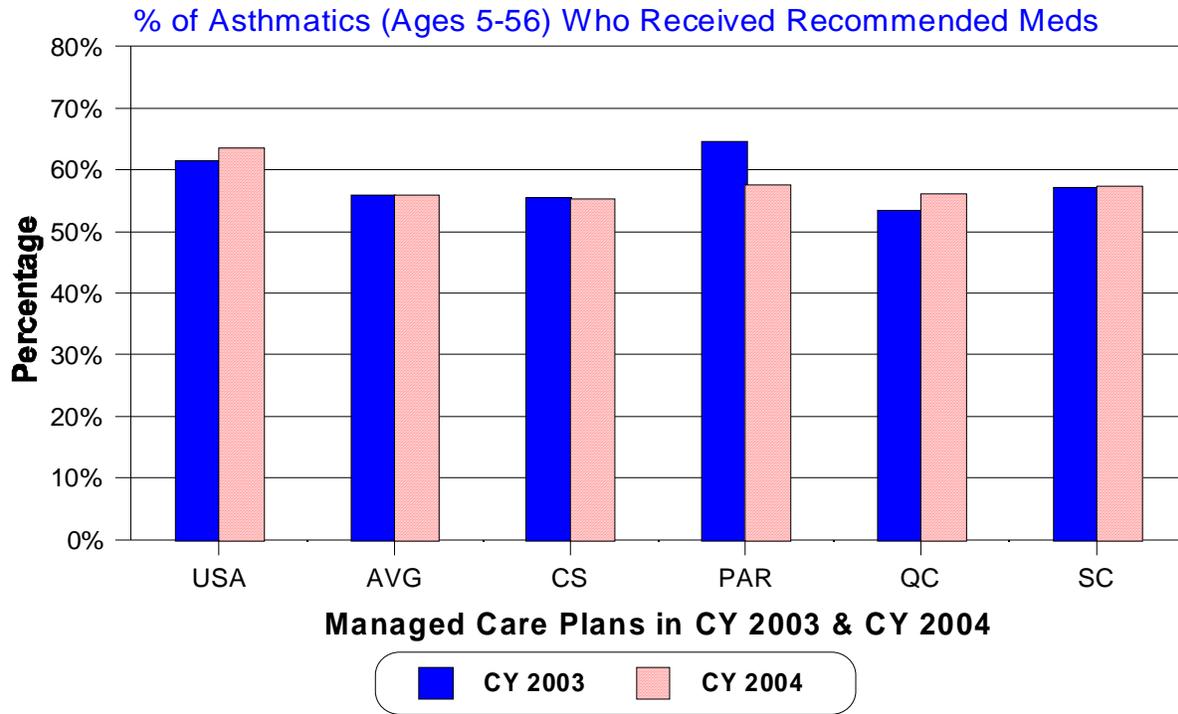
See Appendix A for more detailed information on the methods for calculating this measure.

Results

The percentage of members with persistent asthma who received prescribed medications acceptable as primary therapy for long-term control of asthma remained constant in CY 2003 and CY 2004 (56%). This rate is less than the national Medicaid average of 64%, indicating that there is room for improvement.

Graph K-1.

Use of Appropriate Medication for People With Asthma



Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Source of Data: Encounter Data and NCQA (Measurement Year 2002)

Comprehensive Diabetes Care

Purpose

Diabetes accounts for almost 20 percent of all deaths in persons over age 25.¹⁵ Many of the complications from diabetes, including blindness, nephropathy, and neuropathy, can be prevented if detected and addressed in the early stages. Since diabetes affects multiple organs and requires the involvement of a multidisciplinary team, the performance measure has multiple components. When taken together, the various components provide an overview of the care that is being provided to persons with diabetes.

Minimum Performance Standard: There is no performance standard for this measure.

Methods

Measure: The percentage of members with diabetes (Type 1 and 2) age 18 through 75 who were enrolled for at least 11 months with the plan during the reporting year, who were enrolled during the last month of the reporting year, and who received each of the following: (1) Hemoglobin A1c (HbA1c) testing; (2) a retinal exam by an optometrist or ophthalmologist; (3) LDL-C screening; and (4) screening or treatment for nephropathy. Individual rates are also calculated.

Numerator: The number of members in the denominator who received each of the following: (1) HbA1c testing during the reporting year; (2) a retinal exam by an optometrist or ophthalmologist during the reporting year; (3) LDL-C screening during the reporting year or the year prior to the reporting year; and (4) screening or treatment for nephropathy.

Denominator: The number of members with diabetes (Type 1 or 2) age 18 through 75 who were enrolled for at least 11 months with the plan during the reporting year and who were enrolled during the last month of the reporting year.

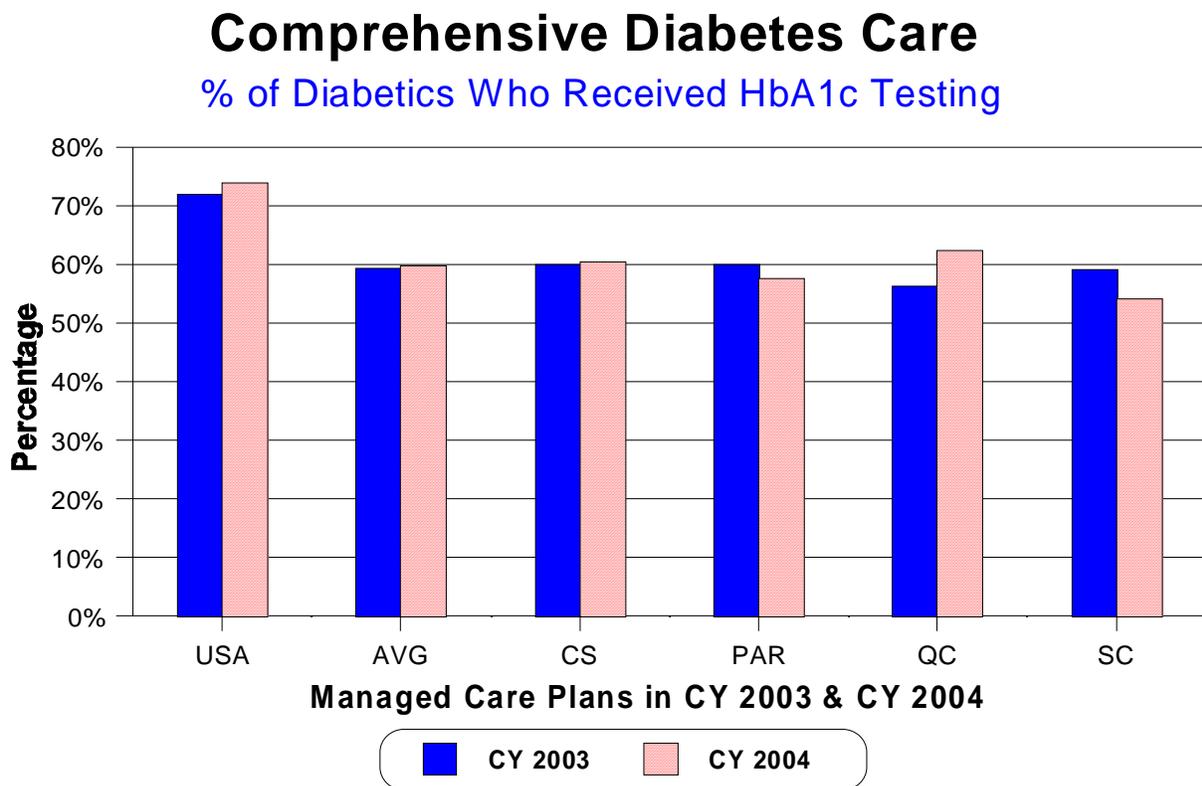
Data Source: Encounter Data

See Appendix A for more detailed information on the methods for calculating this measure.

Results

The percentage of members (aged 18-75) with diabetes mellitus who received HbA1c testing increased from 59% in CY 2003 to 60% in CY 2004. The percentage of diabetics who received an eye exam remained relatively constant from CY 2003 to CY 2004. LDL-C screening rates increased, going from 57% in CY 2003 to 62% in CY 2004. The percentage of diabetics who were monitored for nephropathy increased from 27.6% in CY 2003 to 28.0% in CY 2004.

Graph L-1.



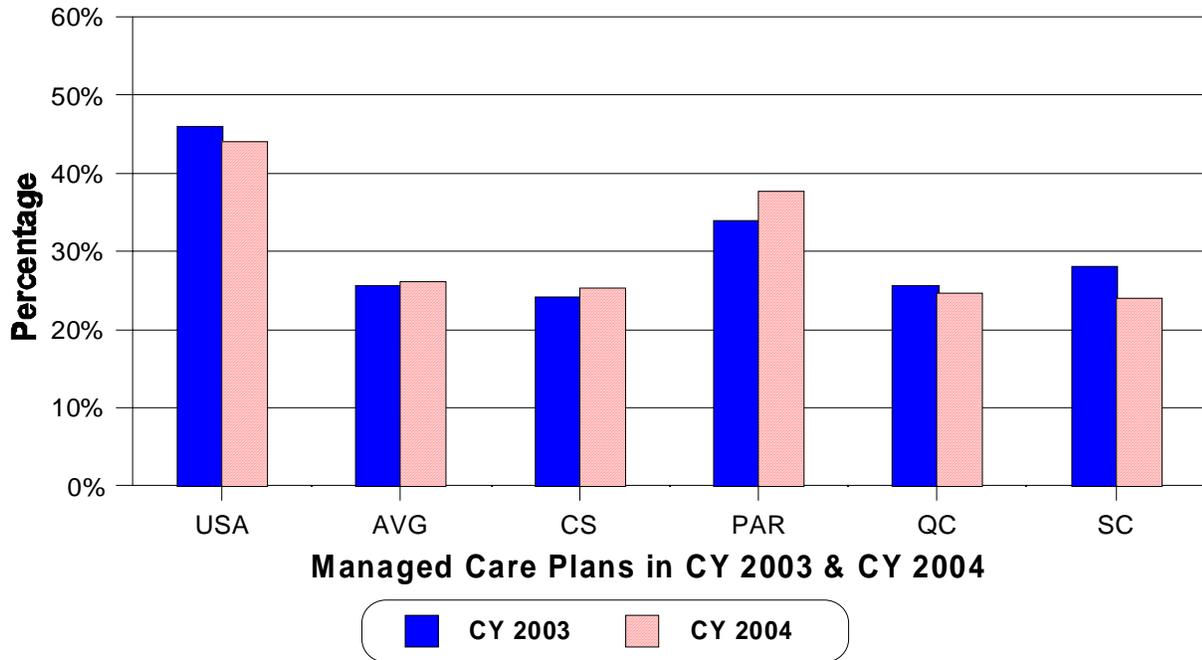
Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Source of Data: Encounter Data and NCQA (Measurement Year 2003, 2004)

Graph L-2.

Comprehensive Diabetes Care

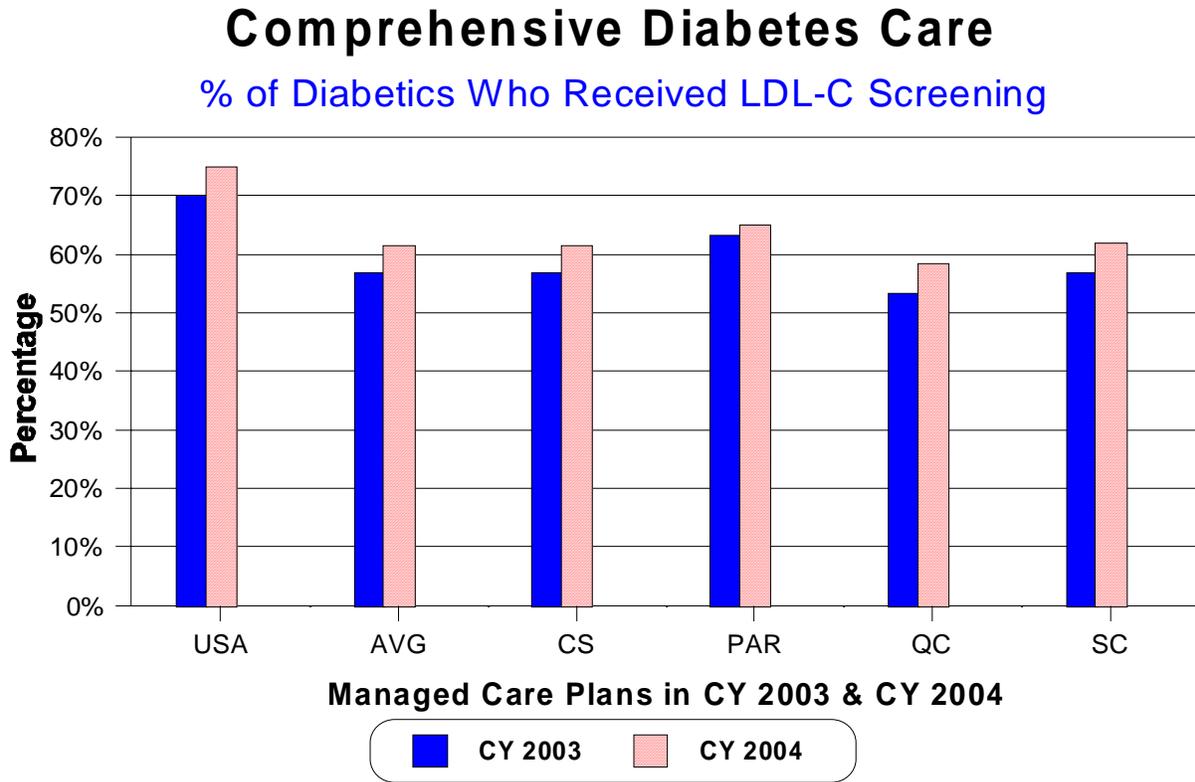
% of Diabetics Who Received Eye Exam



Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Source of Data: Encounter Data and NCQA (Measurement Year 2002)

Graph L-3.



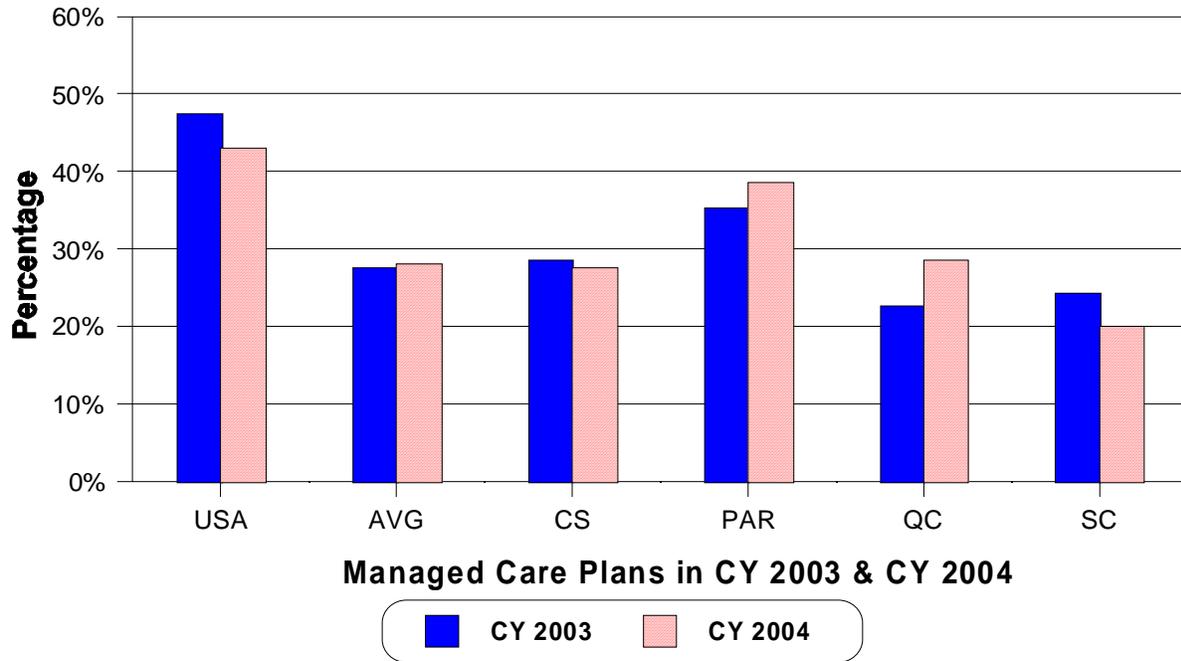
Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Source of Data: Encounter Data and NCQA (Measurement Year 2003, 2004)

Graph L-4.

Comprehensive Diabetes Care

% of Diabetics Monitored for Nephropathy



Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Source of Data: Encounter Data and NCQA (Measurement Year 2003, 2004)

Appendix A

ODJFS Methods for Clinical Performance Measures

These methods are, for the most part, consistent with the HEDIS performance measurement methods, as outlined in NCQA's HEDIS 2004 "Technical Specifications" manual. The main difference between the ODJFS methods and the HEDIS methods is that, in some cases, it has been necessary to include additional codes that are not listed in the HEDIS methods. Codes that are not listed in HEDIS, but have been added are identified with the symbol '+'.

The source of the data is as follows:

- (1) MCP submitted encounter data to obtain encounters.
- (2) ODJFS provider master file to identify primary care practitioners.
- (3) ODJFS recipient master file to obtain recipient demographic and eligibility information.

Initiation of Prenatal Care

The percentage of women who delivered (a) live birth(s) during the reporting year, who were enrolled in the MCP no more than 279 days but at least 43 days prior to delivery with no gaps in MCP enrollment, and who had their first prenatal visit within 42 days of enrollment or by the end of the first trimester for those women who enrolled in the MCP during the early stage of pregnancy.

Numerator: One (or more) prenatal care visit(s) within 42 days of enrollment in the MCP or within the first trimester if the member enrolled more than 42 days prior to the end of the first trimester.

Denominator: The eligible population.

Data Source: Encounter Data

Report Period: January 1, 2004-December 31, 2004

The last menstrual period (LMP) field is used to determine the end date of the first trimester. If no last menstrual period date is provided, as required, or the date is invalid, then the length of the pregnancy is set at 38.5 weeks except if an encounter is found for the newborn indicating a pre-term birth. The length of the pregnancy is set at 28 weeks where the diagnosis was 7650.x (Extreme immaturity). If there was a diagnosis of 7651.x (Other preterm infants) then the length of the pregnancy is set at 33 weeks.

If the LMP date is from 119 to 315 days before the date the recipient gave birth, then the LMP date is considered a valid date. The LMP date is obtained from encounter data.

Codes to Identify Live Births

ICD-9-CM Diagnosis Codes

650 - Normal Delivery
V27.0 - Single liveborn
V27.2 - Twins, both liveborn
V27.3 - Twins, one liveborn and one stillborn
V27.5 - Other multiple birth, all liveborn
V27.6 - Other multiple birth, some liveborn

ICD-9-CM Diagnosis Codes*

V30 - Single liveborn
V31 - Twin, mate liveborn
V32 - Twin, mate stillborn
V33 - Twin, unspecified
V34 - Other multiple, mates all liveborn
V35 - Other multiple, mates all stillborn
V36 - Other multiple, mates live- and stillborn
V37 - Other multiple, unspecified
V39 - Unspecified

* These codes must have a matching delivery encounter to be included.

The infant's record contains (or is supposed to contain) the infant's Medicaid identification number. Therefore, it is necessary to match these encounters against the delivery encounters to obtain the mother's recipient identification number, which is used to obtain the prenatal and postpartum visits and to identify whether a C-section delivery occurred. Listed below are the codes used to identify deliveries (these are the same codes used to reimburse the plans for deliveries as part of the delivery payment).

CODES USED TO IDENTIFY DELIVERIES

ICD-9 Procedure Codes:

- 72.x Forceps, vacuum, and breech delivery
- 73.51 Manually assisted delivery; Manual rotation of fetal head
- 73.59 Manually assisted delivery; Other
- 74.0 Cesarean section and removal of fetus; Classical cesarean section
- 74.1 Cesarean section and removal of fetus; Low cervical cesarean section
- 74.2 Cesarean section and removal of fetus; Extraperitoneal cesarean section
- 74.4 Cesarean section and removal of fetus; Cesarean section of other specified type

ICD-9 Diagnosis Codes:

- 650 Normal Delivery
- V27.x Outcome of Delivery

The following codes must have a 5th digit equal to 1 or 2:

- 640-648; Complications mainly related to pregnancy
- 651-659; Normal delivery and other indications for care in pregnancy, labor, and delivery
- 660-669; Complications occurring mainly during the course of labor and delivery
- 670-676; Complications of the puerperium.

CPT Codes:

- 59409 Vaginal delivery (with or without episiotomy and/or forceps)
- 59514 Cesarean delivery only
- 59612 Vaginal delivery only, after previous cesarean delivery (with or with our episiotomy and/or forceps)
- 59620 Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery

Births are included in the denominator only if the provider type (from the ODJFS provider master file) is 01 (General Hospital), 15 (Birthing Center), 71 (Nurse Midwife) or the provider type is 20 (Physician, Ind.), 21 (Physician, Group), 22 (Osteopath, Ind.), 23 (Osteopath, Group) with a specialty code of 01 (General Practice) , 15 (Internal Medicine) , 16 (Pediatrics) , 51 (General Surgery) , 53 (OB/GYN-MD) , 60 (Emergency Medicine) , or 71 (OB/GYN-DO)

Methods for Matching Infants and Mothers Encounters

The infants and mothers encounters are matched using the following two methods:

- 1) Same last name, same three digit submitter number, and the infant's admission date is within 14 days before or 14 days after the mother's delivery stay; **OR**
- 2) Same address and zip code, same three digit submitter number, and the infant's admission date is within 14 days before or 14 days after the mother's delivery stay.

If a newborn encounter matches to more than one mother delivery encounter and, consequently, it is not possible to determine which mother the newborn is associated with, then the matched encounter will not be included in the denominator. However, it continues to be possible for the mother's encounter to be included in the denominator if the mother's encounter contains one of the following diagnosis codes:

- 650 - Normal Delivery
- V27.0 - Single liveborn
- V27.2 - Twins, both liveborn
- V27.3 - Twins, one liveborn and one stillborn
- V27.5 - Other multiple birth, all liveborn
- V27.6 - Other multiple birth, some liveborn

Prenatal Care Visit Codes

HEDIS 2004 outlines four decision rules for identifying prenatal visits. The first decision rule includes using codes specific to antepartum care such as CPT-4 code 59425. The second rule requires a visit to a midwife or OB provider with procedure or diagnosis based evidence of prenatal care. The third decision rule requires a visit to a family practitioner or other primary care provider with diagnostic and procedure based evidence of prenatal care. The fourth decision rule uses CPT-4 codes in conjunction with a plan’s internal codes.

In an attempt to capture all prenatal visits, ODJFS used decision rule one and a modified version of decision rule two to select prenatal visits. Under the first ODJFS decision rule, a visit was selected if any of the codes listed below were present, the visit occurred not more than 44 weeks prior to delivery, and the visit date preceded the hospital admission date in which the baby was delivered. This latter requirement was imposed since some of the same codes cover antepartum care, intrapartum care, and postpartum care.

Decision Rule 1:

<u>CPT-4</u>	<u>Description</u>
59400	Routine obstetric care including antepartum care, vaginal delivery and postpartum care
59420+	Antepartum visit (this code is included since ODJFS continued to accept this code from fee-for-service providers until 7-1-03)
59425	Antepartum care only; 4-6 visits
59426	Antepartum care, 7 or more visits
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
59610	Routine obstetric care including antepartum care, vaginal delivery, and postpartum care, after previous cesarean delivery
59618	Routine obstetric care including antepartum care, vaginal delivery, and postpartum care following attempted vaginal delivery after previous cesarean delivery
+ Code not in HEDIS methods.	

With the exception of CPT Code 59420 (the department’s old local code) the other CPT codes are global codes (i.e., more than one visit is billed under the same code) that are not reimbursed under the fee-for-service system. However, a number of MCPs submitted these codes and so they were included. It is not possible for ODJFS to determine the number of visits that occurred unless there is a separate date of service for each visit that is included in the global code. As a result, the only visits that were counted under these codes were those where there was a separate date of service. For example, if code 59425 was submitted and had one date of service then only one prenatal visit was counted. However, if this same code was submitted along with three dates of service for the MCP member, then three prenatal visits were counted.

Under the second ODJFS decision rule, a visit was selected if all of the following criteria were met and the date of the visit preceded the hospital admission date in which the baby was delivered:

Decision Rule 2:

CPT-4 = 99201-99205 (office visit) or 99211-99215 or Revenue code 514 (OB/GYN Clinic)

with either

CPT-4= 76801 (ultrasound, pregnant uterus), 76802 (ultrasound, each additional gestation), 76805 (echography, pregnant uterus), 76811 (ultrasound, pregnant uterus), 76812 (ultrasound, each additional gestation), 76815 (limited echography, pregnant uterus), 76816 (follow-up or repeat echography, pregnant uterus), 76817 (ultrasound, pregnant uterus), 76818 (fetal biophysical profile), 80055 (obstetric panel lab), 80090 (TORCH antibody panel) or (86762 (rubella immunoassay) with 86900 (Blood Typing; ABO) or 86901 Rh(D);

OR

ICD-9-CM = (640.0x-648.9x or 651.0x-659.9x) where x (fifth digit) = 3;

V code = V22-V23 or V28; or Occurrence code=10.

Under decision rule two, HEDIS only includes the visits if they were made to a midwife or OB provider. At this time, this requirement will not be imposed to ensure that all visits are counted.

Frequency of Ongoing Prenatal Care

The percentage of Medicaid-enrolled women who had a live birth during the reporting year and who received less than 21%, 21% through 40%, 41% through 60%, 61% through 80%, or greater than or equal to 81% of the expected number of prenatal care visits, adjusted for gestational age and the month the member enrolled in the MCP.

Numerator: Women who had an unduplicated count of less than 21%, 21% through 40%, 41% through 60%, 61% through 80%, or greater than or equal to 81% of the expected number of prenatal care visits, adjusted for gestational age and the month the member enrolled in the MCP.

Denominator: The number of Medicaid MCP members who had a live birth during the reporting year.

Data Source: Encounter Data

Report Period: January 1, 2004-December 31, 2004

Prenatal care visits are selected using the same codes as outlined in the “Initiation of Prenatal Care” measure. The ODJFS made adjustments for the length of gestation and the length of time that a member was in the MCP prior to giving birth. For example, a recipient who enrolled in the MCP during the first month of pregnancy and who had a pregnancy lasting 38 weeks would be expected to have 12 prenatal visits whereas a recipient who enrolled in the MCP during the fifth month of pregnancy with a pregnancy of 30 weeks would be expected to have only two prenatal visits. The ODJFS used the index (shown below) to determine the expected number of visits, which is based on recommendations from the American College of Obstetricians and Gynecologists (ACOG).

**Expected Number of Prenatal Visits for a Given Gestational Age
and Month the Member Enrolled in the MCP**

Month of Pregnancy Member Enrolled in the MCP	Gestational Age in Weeks																
	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44
9th	-	-	-	-	-	-	-	-	-	-	-	1	1	2	3	4	5
8th	-	-	-	-	-	-	1	1	1	2	3	4	5	6	7	8	9
7th	-	-	1	1	1	1	2	2	3	4	5	6	7	8	9	10	11
6th	1	1	1	1	2	2	3	3	4	5	6	7	8	9	10	11	12
5th	1	1	2	2	3	3	4	4	5	6	7	8	9	10	11	12	13
4th	3	3	4	4	5	5	6	6	7	8	9	10	11	12	13	14	15
3rd	4	4	5	5	6	6	7	7	8	9	10	11	12	13	14	15	16
2nd	5	5	6	6	7	7	8	8	9	10	11	12	13	14	15	16	17
1st	6	6	7	7	8	8	9	9	10	11	12	13	14	15	16	17	18

For deliveries with a gestational age less than 28 weeks, the expected number of visits is calculated based on the month of pregnancy the member enrolled in the MCP and ACOG’s recommended schedule of visits (one visit every four weeks).

The last menstrual period field is used to help determine the “gestational age”. Gestational age is defined as the number of completed weeks that have elapsed between the first day of the last menstrual period and the date of delivery. If gestational age is calculated in fractions of a week, then the number is rounded down to the lower whole number.

Cesarean Section Rate

The percentage of women who had a live birth during the reporting year who delivered by a Cesarean Section.

Numerator: Number of discharges for women who had a C-section resulting in a live birth during the measurement year.

Denominator: Number of discharges for women who had a delivery (vaginal or C-section) resulting in a live birth during the reporting year. Live births are identified using the same codes outlined in the “Initiation of Prenatal Care” measure.

Data Source: Encounter Data

Report Period: January 1, 2004-December 31, 2004

Codes to Identify C-Sections

<u>ICD-9-CM</u>

74.0-74.2, 74.4 or 74.99

<u>CPT Codes</u>

59510, 59514, 59515, 59618, 59620, 59622
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Low Birth Weight Measure

The percentage of women who gave birth to a low-birth weight newborn during the reporting year.

Numerator: The number of births in the denominator with a birth weight less than or equal to 2,500 grams.

Denominator: The number of Medicaid MCP members who had a live birth during the reporting year and who had at least five months of continuous enrollment immediately prior to the birth. Live births are identified using the same codes outlined in the “Initiation of Prenatal Care” measure.

Data Source: Encounter Data, birth weight is obtained from condition code fields.

Report Period: January 1, 2004-December 31, 2004

Very Low Birth Weight Measure

The percentage of women who gave birth to a very low-birth weight newborn during the reporting year.

Numerator: The number of births in the denominator with a birth weight less than or equal to 1,500 grams.

Denominator: The number of Medicaid MCP members who had a live birth during the reporting year and who had at least five months of continuous enrollment immediately prior to the birth. Live births are identified using the same codes outlined in the “Initiation of Prenatal Care” measure.

Data Source: Encounter Data, birth weight is obtained from condition code fields.

Report Period: January 1, 2004-December 31, 2004

Postpartum Care

The percentage of enrolled women who delivered (a) live birth(s) during the reporting year who were continuously enrolled for 56 days after delivery and who had a postpartum visit on or between 21 days and 56 days after delivery.

Numerator: A postpartum visit on or between 21 and 56 days after delivery.

Denominator: The eligible population. Live births are identified using the same codes outlined in the “Initiation of Prenatal Care” measure.

Data Source: Encounter Data

Report Period: January 1, 2004-December 31, 2004

Codes to Identify Postpartum Visits

ICD-9 Codes

91.46	Microscopic exam of specimen from female genital tract
V24.1	Lactating mother
V24.2	Routine postpartum follow-up
V25.1	Insertion of intrauterine contraceptive device
V72.3	Gynecological exam
V76.2	Special screening for malignant neoplasm (cervix)

Revenue Codes

923 (Pap Smear)

CPT-4

Description

57170	Diaphragm cervical cap fitting
58300	Insertion of intrauterine device
59400	Routine obstetric care including antepartum care, vaginal delivery, and postpartum care
59410	Vaginal delivery, including postpartum care
59430	Postpartum care only
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
59515	Cesarean delivery only, including postpartum care
59610	Routine obstetric care including antepartum care, vaginal delivery, and postpartum care after previous cesarean delivery
59614	Vaginal delivery only, after previous cesarean delivery, including postpartum care
59618	Routine obstetric care including antepartum care, vaginal delivery, and postpartum care following attempted vaginal delivery after previous cesarean delivery
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery, including postpartum care
88141-88145	Cytopathology, cervical or vaginal
88147-88148	Cytopathology smears
88150-88158	Cytopathology slides
88164-88167	Cytopathology slides
88174-88175	Cytopathology, cervical or vaginal

Well Child Visits in the First 15 Months of Life

The percentage of enrolled members who turned 15 months old during the reporting year, who were enrolled in the MCP from the month after the month in which they were born through their 15 month of life (allowing for a one month gap in MCP enrollment), who were enrolled during their 15 month of life, and who received either zero, one, two, three, four, five, or six or more well-child visits with a primary care practitioner during their first 15 months of life.

Numerator: Seven separate numerators are calculated, corresponding to the number of members who received: zero, one, two, three, four, five, and six or more well-child visits with a primary care practitioner during their first 15 months of life. A child is included in only one numerator (e.g., a child receiving six well child visits is not included in the rate for five, four, or fewer well child visits).

Denominator: The eligible population.

Data Source: Encounter Data

Report Period: January 1, 2004-December 31, 2004

Codes to Identify Well-Child Visits

CPT-4 Codes

- 99381 Initial preventive medicine - New Patient (Age Group Infant)
- 99382 Initial preventive medicine - New Patient (Age Group 1-4 year old)
- 99391 Periodic preventive medicine - Established Patient (Age Group Infant)
- 99392 Periodic preventive medicine - Established Patient (Age Group 1-4 year old)
- 99432 Other than Hospitals or Birthing Rooms (Age Group Newborn)

ICD-9-CM Codes

- V20.2 Routine Infant or Child Health Check
- V70.0 Routine general medical exam at a health care facility
- V70.3 Other Medical Examination for Administrative Purposes
- V70.5 Health examination of defined subpopulation
- V70.6 Health examination in population surveys
- V70.8 Other specified general medical examinations
- V70.9 Unspecified general medical examinations

The provider number currently given on the encounter data claim is incorrectly, in some cases, the provider number of the hospital where the physician gives services and is not the provider number of the physician who provided services. Therefore, it was not possible to match the PCPs listed in the Provider Verification System against the encounter data claims as a way of identifying visits that were made to PCPs. For this reason, it was necessary to use the ODJFS Provider Master File as the source of the PCP information. The following codes were used to accomplish this task:

Codes to Identify Primary Care Practitioners

Provider Type

- 01 (General Hospital)
- 04 (Outpatient Health Facility)
- 05 (Rural Health Facility)
- 09 (Maternal/Child Hlth Clinic - 9 mo.)
- 12 (Federally Qualified Health Center)
- 50 (Comprehensive Clinic)
- 52 (Public Health Dept. Clinic)
- 72 (Nurse, Practitioner)

or

Physician Specialty Code

- 01 (General Practice)
- 15 (Internal Medicine)
- 16 (Pediatrics)
- 18 (Preventive Medicine)
- 53 (Obstetrics & Gynecology)
- 71 (Obstetrics & Gynecology - Osteopath)

or

Provider Type of 20 (Physician, Individual), 21 (Physician, Group), 22 (Osteopath, Individual), or 23 (Osteopath, Group) where the specialty code is 99 (unspecified) or is not indicated.

If a provider was identified on the Provider Master File with any of the preceding codes, then they were recognized as a PCP.

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

The percentage of members who were three, four, five, or six during the reporting year, who were enrolled for at least 11 months with the plan during the measurement year, who were enrolled during the last month of the reporting year, and who received one or more well-child visit(s) with a primary care practitioner during the reporting year.

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

Denominator: The eligible population.

Data Source: Encounter Data

Report Period: January 1, 2004-December 31, 2004

Codes to Identify Well-Child Visits

CPT-4 Codes

- 99382 Initial preventive medicine - New patient - (Age Group 1 through 4)
- 99383 Initial preventive medicine - New patient (Age Group 5 through 11)
- 99392 Periodic preventive medicine - Established Patient (Age Group 1 through 4)
- 99393 Periodic preventive medicine - Established Patient (Age Group 5 through 11)

ICD-9-CM Codes

- V20.2 Routine Infant or Child Health Check
- V70.0 Routine general medical exam at a health care facility
- V70.3 Other Medical Examination for Administrative Purposes
- V70.5 Health examination of defined subpopulation
- V70.6 Health examination in population surveys
- V70.8 Other specified general medical examinations
- V70.9 Unspecified general medical examinations

See method for identifying primary care practitioners under “Well Child Visits in the First 15 Months of Life” performance measure.

Adolescent Well-Care Visits

The percentage of enrolled members who were age 12 through 21 during the reporting year, who were enrolled for at least 11 months with the plan during the reporting year, who were enrolled during the last month of the reporting year, and who received at least one comprehensive well-care visit with a primary care practitioner during the reporting year.

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

Denominator: The eligible population.

Data Source: Encounter Data

Report Period: January 1, 2004 -December 31, 2004

Codes to Identify Adolescent Well-Care Visits

CPT-4 Codes

- 99383 Initial preventive medicine - New patient (Age Group 5 through 11)
- 99384 Initial preventive medicine - New patient (Age Group 12 through 17)
- 99385 Initial preventive medicine - New patient (Age Group 18 through 39)
- 99393 Periodic preventive medicine - Established Patient (Age Group 5 through 11)
- 99394 Periodic preventive medicine - Established Patient (Age Group 12 through 17)
- 99395 Periodic preventive medicine - Established Patient (Age Group 18 through 39)

ICD-9-CM Codes

- V20.2 Routine Infant or Child Health Check
- V70.0 Routine General Medical Examination at a Health Care Facility (Health Checkup)
- V70.3 Other Medical Examination for Administrative Purposes
- V70.5 Health examination of defined subpopulation
- V70.6 Health examination in population surveys
- V70.8 Other specified general medical examinations
- V70.9 Unspecified general medical examinations

See method for identifying primary care practitioners under “Well Child Visits in the First 15 Months of Life” performance measure.

Childhood Immunization Status

The percentage of enrolled children who turned two years old during the reporting year, who were enrolled for 12 months immediately preceding their second birthday (allowing for one month gap in MCP enrollment), who were enrolled during the last month of the reporting year, and who were identified as having four DTP/DTaP, three IPV/OPV, one MMR, two H influenza b, and two hepatitis B vaccines by the second birthday. The measure also calculates individual rates.

Numerator: Children who received four DTP or DTaP vaccinations and three OPV or IPV vaccinations and one MMR and two HiB vaccinations and two hepatitis B vaccinations.

Denominator: The eligible population.

Data Source: Encounter Data

Report Period: January 1, 2004-December 31, 2004

Codes to Select Immunizations

Immunization	CPT Codes	ICD-9-CM Codes
DTP/DTaP	90698, 90700, 90701, 90702*, 90703*, 90711+ (old code), 90719*, 90720, 90721, 90723	V02.4*, V03.5*+, V03.6*+, V03.7*+, V06.1+, V06.2+, V06.3+, V06.5*+, 032*, 033*, 037*, 99.36*, 99.37*, 99.38*, 99.39
IPV/OPV	90698, 90711(old code), 90712, 90713, 90723	V04.0+, V06.3+, V12.02, 045, 99.41
MMR	90704 (Mumps vaccine) with 90708 (Measles & rubella vaccine) 90705 (Measles vaccine) with 90709 (Rubella & mumps vaccine) 90706 (Rubella vaccine) with 90704 (Mumps vaccine) and 90705 (Measles vaccine) 90707 (Measles, mumps, & rubella vaccine) 90710 (Measles, mumps, rubella, & varicella vaccine)	V04.2*+, V04.3*+, V04.6*+, V06.4+, 055*, 056*, 072*, 99.45*, 99.46*, 99.47*, 99.48
HiB	90645, 90646, 90647, 90648, 90698, 90720, 90721, 90737, 90748	041.5, 038.41, 320.0, 482.2, V03.81+
Hepatitis B	90731+ (old code), 90723, 90740, 90744, 90745+ (old code), 90747, 90748	V02.61, 070.2, 070.3, V05.3+
VZV	90710, 90716	052, 053, V05.4+

** This code must be used in conjunction with codes that identify the remaining antigen requirements in order to satisfy the measure.*

+ Code not in HEDIS methods.

Children who are identified as being immunocompromised for a specific vaccine are excluded from the denominator for all antigen rates and the combination rates. The denominator for all rates is equal. As specified in HEDIS, immunocompromised children are excluded only if the encounter data does not indicate that the particular immunization for which the child was contraindicated was rendered.

Codes to Identify Exclusions for Childhood Immunizations		
Immunization	Contraindication	ICD-9-CM Code
Any particular vaccine	anaphylactic reaction to the vaccine or its components	999.4
DTP/DTaP	encephalopathy within 7 days of previous dose of DTP/DTaP	323.5
OPV, VZV, and MMR	immunodeficiency, including genetic immunodeficiency syndromes	279
OPV, VZV, and MMR	HIV-infected or household contact with HIV infection	infection V08, symptomatic 042
OPV, VZV, and MMR	cancer of lymphoreticular or histiocytic tissue	200-202
OPV, VZV, and MMR	multiple myeloma	203.xx
OPV, VZV, and MMR	leukemia	204.xx-208.xx
IPV	anaphylactic reaction to streptomycin, polymixin B or neomycin	E9306, E9308, E9460, E9465, E9466
HiB	none	
VZV, MMR	anaphylactic reaction to neomycin	E9306

Annual Dental Visit:

The percentage of enrolled members age 4 through 21 who were enrolled for at least 11 months with the plan during the reporting year, who were enrolled during the last month of the reporting year, and who had at least one dental visit during the reporting year.

Numerator: One (or more) dental visits with a dental practitioner during the reporting year.

Denominator: The eligible population.

Data Source: Encounter Data

Report Period: January 1, 2004-December 31, 2004

Codes to Identify Annual Dental Visits		
CPT Codes	ICD-9-CM Codes	HCPCS Codes
70300, 70310, 70320, 70350, 70355	23, 24, 87.11, 87.12, 89.31, 93.55, 96.54, 97.22, 97.33-97.35, 99.97	D0120-D0999, D1110-D1550, D2110-D2999, D3110-D3999, D4210-D4999, D5110-D5899, D6010-D6199, D7110-D7999, D8010-D8999, D9110-D9999, W0002+ (OHF Dental Encounter), Y0005+ (FQHC Dental Encounter), Y1352+ (Sealant), Y8988+ (Orthodontic Treatment) T1015+ with a modifier of U2

+ Code not in HEDIS Methods.

Lead Testing For 1 Year Olds

The percentage of enrolled members who turned 15 months old during the reporting year, who were enrolled in the MCP from 9 months through 15 months of age (allowing for a one month gap in MCP enrollment), who were enrolled in the MCP during their 15th month of life, and who received a lead screening test.

Numerator: The number of children in the denominator who received a lead screening test. CPT-4 codes of 83655 or 83660 are used to identify that the member had a lead screening test.

Denominator: The number of enrolled members who turned 15 months old during the reporting year, who were enrolled in the MCP from 9 months through 15 months of age (allowing for a one month gap in MCP enrollment), and who were enrolled in the MCP during their 15th month of life.

Data Source: Encounter Data

Report Period: January 1, 2004-December 31, 2004

Lead Testing For 2 Year Olds

The percentage of enrolled members who turned 27 months old during the reporting year, who were enrolled in the MCP from 21 months through 27 months of age (allowing for a one month gap in MCP enrollment), who were enrolled in the MCP during their 27th month of life, and who received a lead screening test.

Numerator: The number of children in the denominator who received a lead screening test. CPT-4 codes of 83655 or 83660 are used to identify that the member had a lead screening test.

Denominator: The number of enrolled members who turned 27 months old during the reporting year, who were enrolled in the MCP from 21 months through 27 months of age (allowing for a one month gap in MCP enrollment), and who were enrolled in the MCP during their 27th month of life.

Data Source: Encounter Data

Report Period: January 1, 2004-December 31, 2004

Use of Appropriate Medications for People with Asthma

The percentage of members aged 5 through 56 with persistent asthma who were enrolled for at least 11 months with the plan during the reporting year, who were enrolled at least 11 months during the year prior to the reporting year, and who received prescribed medications acceptable as primary therapy for long-term control of asthma.

Members are identified as having persistent asthma by having ANY of the following in the year prior to the measurement year:

1. at least four asthma medication dispensing events* (i.e., an asthma medication was dispensed on four occasions) OR
2. at least one Emergency Department (ED) visit based on the visit codes below with asthma (ICD-9 code 493) as the principal diagnosis OR
3. at least one hospitalization based on the visits codes below with asthma (ICD-9 code 493) as the principal diagnosis OR
4. at least four outpatient asthma visits based on the visit codes below with asthma (ICD-9 code 493) as one of the listed diagnoses AND at least two asthma medication dispensing events.*

** Note: A dispensing event is defined as one prescription of an amount lasting 30 days or less. Two different prescriptions dispensed on the same day are counted as two different dispensing events. To calculate dispensing events for prescriptions lasting longer than 30 days, ODJFS divided the drug quantity by 30 and rounded up to convert. For example, a 100-day prescription is equal to 4 dispensing events ($100/30=3.33$, rounded up to 4).*

Numerator: For each member in the denominator, those who had at least one dispensed prescription for inhaled corticosteroids, nedocromil, cromolyn sodium, leukotriene modifiers, or methylxanthines in the reporting year. The NDC list provided on NCQA's Web site at http://www.ncqa.org/Programs/HEDIS/hedis_2004_volume_2_technical_sp.htm is used to identify these medications.

Denominator: The eligible population.

Data Source: Encounter Data

Report Period: January 1, 2004-December 31, 2004

Codes to Identify ED and Inpatient Asthma Encounters		
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Description	CPT Codes	UB-92 Revenue Codes
Acute Inpatient	99221-99223, 99231-99233, 99238-99239, 99251-99255, 99261-99263, 99291-99292	10X-16X, 20X-22X, 987
Emergency Department (ED) services	99281-99285, 99288	450, 451, 452, 459, 981
Outpatient Visit	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99271-99275	456, 510, 515, 516, 517, 520, 521, 523, 526, 76X, 770, 779, 982, 983, 988

Exclusions: Members who were prescribed monotherapy of leukotriene modifiers and who do not have a diagnosis of asthma are excluded from the denominator.

Comprehensive Diabetes Care

The percentage of members with diabetes (Type 1 and 2) age 18 through 75 who were enrolled for at least 11 months with the plan during the reporting year, who were enrolled during the last month of the reporting year, and who received each of the following: (1) Hemoglobin A1c (HbA1c) testing; (2) a retinal exam by an optometrist or ophthalmologist; (3) LDL-C screening; and (4) screening or treatment for nephropathy. Individual rates are also calculated.

Numerator: The number of members in the denominator who received each of the following: (1) HbA1c testing during the reporting year; (2) a retinal exam by an optometrist or ophthalmologist during the reporting year; (3) LDL-C screening during the reporting year or the year prior to the reporting year; and (4) screening or treatment for nephropathy.

Denominator: The number of members with diabetes (Type 1 or 2) age 18 through 75 who were enrolled for at least 11 months with the plan during the reporting year and who were enrolled during the last month of the reporting year.

Data Source: Encounter Data

Report Period: January 1, 2004-December 31, 2004

Two methods are provided to identify diabetic members - pharmacy encounter data and non-pharmacy encounter data. Both methods are used to identify the eligible population. However, a member only needs to be identified in one method to be included in the measure. Members may be identified as having diabetes during the reporting year or the year prior to the reporting year.

Pharmacy Encounter Data: Those who were dispensed insulin and/or oral hypoglycemics/antihyperglycemics on an ambulatory basis during the reporting year or the year prior to the reporting year. A list of these medications and the corresponding NDC codes can be found at http://www.ncqa.org/Programs/HEDIS/hedis_2004_volume_2_technical_sp.htm

Medical Encounter Data: Those who had two face-to face encounters with different dates of service in an ambulatory setting or non-acute setting or one face-to-face encounter in an acute inpatient or emergency department (ED) setting during the reporting year or the year prior to the reporting year with a diagnosis (principal or secondary) of diabetes. The following codes are used to identify ambulatory or non-acute inpatient and acute inpatient or ED encounters:

Codes to Identify Diabetics Using Encounter Data

Description	ICD-9-CM Codes	UB-92 Revenue Codes	CPT Codes
Diabetes Diagnosis	250, 357.2, 362.0, 366.41, 648.0		
Outpatient/non-acute inpatient		49X-53X, 55X-59X, 65X, 66X, 76X, 77X, 82X-85X, 88X, 92X, 94X, 96X, 972-979, 982-986, 988, 989	92002-92014, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99271-99275, 99288, 99289-99290, 99301-99303, 99311-99313, 99321-99323, 99331-99333, 99341-99355, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420-99429, 99499
Acute inpatient/ED		10X-16X, 20X-22X, 45X, 72X, 80X, 981, 987	99221-99223, 99231-99233, 99238-99239, 99251-99255, 99261-99263, 99281-99288, 99291-99292, 99356-99357

Exclusions: Members with steroid induced or gestational diabetes are excluded.

Codes to Identify Steroid Induced and Gestational Diabetes

Description	ICD-9-CM Codes
Polycytic Ovaries	256.4
Steroid Induced	251.8, 962.0
Gestational Diabetes	648.8

Numerator(s):

1. HBA1c Testing: One (or more) HBA1c test(s) conducted during the reporting year identified through encounter data. CPT code of 83036 (hemoglobin, glycated) is used to identify the test.
2. Eye Exam: An eye screening for diabetic retinal disease during the reporting year by an eye care professional (optometrist or ophthalmologist).

Codes to Identify Eye Exams*	
CPT Codes	ICD-9-CM Codes
67101, 67105, 67107-67108, 67110, 67112, 67141, 67145, 67208, 67210, 67218, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92225, 92226, 92230, 92235, 92240, 92250, 92260, 92287, 99204, 99205, 99214, 99215, 99242-99245	14.1-14.5, 14.9, 95.02-95.04, 95.11, 95.12, 95.16

* These eye exams by eye care professionals are a proxy for dilated eye examinations because there is no way from administrative claims to determine that a dilated exam was performed.

Codes to Identify Eye Care Professionals		
Provider Type	OR	Specialty Code
'35' (Optometrist, Individual)		'54' (Ophthalmology) '72' (Ophthalmology, Otology, Laryngology)
'55' (Professional School Clinic - Optometry)		
'61' (Optometrist, Group)		

The provider type and specialty code information is obtained from the ODJFS provider master file.

3. LDL-C Screening: An LDL-C test done during the reporting year or the year prior to the reporting year.

Codes to Identify LDL-C Screening
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CPT Codes

80061, 83715, 83716, 83721

4. Monitoring for Diabetic Nephropathy: Screening or treatment for nephropathy. This measure is intended to assess whether diabetic patients are being monitored for nephropathy. The following are counted toward the numerator:

- ◆ those patients who have been screened for microalbuminuria during the reporting year.
- ◆ those patients who already have evidence of nephropathy, as demonstrated by evidence of medical attention for nephropathy during the reporting year or the year prior to the reporting year.

Codes to Identify Microalbuminuria Test
--

CPT Codes

82042, 82043, 82044, 84155*, 84160*, 84165*

* Codes must be accompanied by CPT 81050 to indicate the test was urinalysis.

Codes to Identify Diabetic Nephropathy

Description	CPT Codes	ICD-9-CM Codes	Revenue Codes
Evidence of diagnosis and/or treatment of nephropathy	36800, 36810, 36815, 50300, 50340, 50360, 50365, 50370, 50380, 90920, 90921, 90924, 90925, 90935, 90937, 90945, 90947, 90989, 90993, 90997, 90999	39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, 55.4-55.6, 250.4, 403, 404, 405.01, 405.11, 405.91, 581.81, 582.9, 583.81, 584-586, 588, 753.0, 753.1, 791.0, V42.0, V45.1, V56	800-804, 809, 820-825, 829-835, 839-845, 849-855, 859-882, 889

Appendix B NOTES

1. Results obtained from the website of the National Committee for Quality Assurance (www.ncqa.org).
2. Siu A et al. *Choosing Quality of Care Measures*, pg. 7; 1992.
3. McLaughlin F, Altemeier W, Christensen, M, et al. Randomized trial of comprehensive care for low-income women: Effect of infant birth weight. *Pediatrics* 89:128-132; 1992.
4. U.S. Public Health Service, Expert Panel on the Content of Prenatal Care. *Caring for Our Future: The Content of Prenatal Care*. Washington, DC: U.S. Department of Health and Human Services; 1989.
5. U.S. Public Health Service, *Healthy People 2000*, p. 375; 1990.
6. Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System.
7. American Academy of Pediatrics and American College of Obstetricians and Gynecologists. *Guidelines for Perinatal Care*; p. 112; 1992.
8. *Standards for Obstetric-Gynecologic Services*, Seventh Edition, published by the American College of Obstetricians and Gynecologists, Washington, DC; 1989; p. 21.
9. American Academy of Pediatrics. *Recommendations for Preventive Health Care*. Committee on Practice and Ambulatory Medicine. Elk Grove Village, IL:AAP; 1995.
10. American Academy of Pediatrics. *Recommendations for Preventive Health Care*; 1995.
11. Green M. (ed). *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. Arlington, VA: National Center for Education in Maternal And Child Health; 1994.
12. U.S. Public Health Service, *Healthy People 2000*, p. 512; 1990.
13. Oral Health in America: A Report of the Surgeon General, Summer 2000. Statistics and comments from the Executive Summary.
14. National Heart, Lung, and Blood Institute, National Institutes of Health, U.S. Department of Health and Human Services, *International Consensus Report on Diagnosis and Treatment of Asthma*, June 1992; pg. 10.
15. National Committee for Quality Assurance, *HEDIS 2001 Narrative, Health Plan Employer Data & Information Set*, Vol. 1, p. 42.

Appendix C

**Medicaid Managed Health Care
Clinical Performance Measurement Results For Each Plan**

Calendar Year 2004

Shading Identifies Contract Measures

White letters Identifies New Contract Measures

STATEWIDE Medicaid MCP Results Clinical Performance Measurement Calendar Year 2004

Frequency of Ongoing Prenatal Care (Percent of Expected Visits Received) Adjusted for Length of Pregnancy & Length of Time Enrolled in Plan During Pregnancy																		
MCP Target ¹ = 80 %	CY 03						CY 04						CY 05					
RESULTS	81% or more	61-80%	41-60%	21-40%	< 21%	Total	81% or more	61-80%	41-60%	21-40%	< 21%	Total	81% or more	61-80%	41-60%	21-40%	<21%	Total
Numerator	9,429	2,623	1,572	1,010	1,445	16,079	10,868	Diff. From 03	3,134	1,894	1,057	1,498	18,451	Diff. From 04				
Denominator	16,079	16,079	16,079	16,079	16,079		18,451		18,451	18,451	18,451	18,451						
Measure (percentage)	58.6%	16.3%	9.8%	6.3%	9.0%	100.0%	58.9%	0.3%	17.0%	10.3%	5.7%	8.1%	100.0%					
MCP Standard																		
Statewide MCP Avg.	58.6%	16.3%	9.8%	6.3%	9.0%	100.0%	58.9%	0.3%	17.0%	10.3%	5.7%	8.1%	100.0%					

¹ At least 80% of the recipients should have received 81% or more of their expected number of visits.

MCP Targets Initiation = 90 % Postpartum = 80 %	Initiation of Prenatal Care				Cesarean Section Rate			Low Birth Weight				Very Low Birth Weight			Postpartum Visits (21-56 Days)			
RESULTS	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	CY03	CY04	CY05	Diff. From 03
Numerator	6,166	6,771			3,457	4,328		511	801			108	200		7,479	9,232		
Denominator	7,307	7,924			16,079	18,451		6,719	8,311			6,719	8,311		15,148	17,473		
Percentage	84.4%	85.4%		1.0%	21.5%	23.5%		7.6%	9.6%		2.0%	1.6%	2.4%		49.4%	52.8%		3.4%
MCP Standard																		
Statewide MCP Avg.	84.4%	85.4%			21.5%	23.5%		7.6%	9.6%			1.6%	2.4%		49.4%	52.8%		

Shading Identifies Contract Measures

White letters Identifies New Contract Measures

STATEWIDE Medicaid MCP Results Clinical Performance Measurement Calendar Year 2004

Well-Child Visits in the First 15 Months of Life																					
MCP Target = 80 %	CY 03							CY 04							CY 05						
RESULTS	6 or more Visits	5 Visits	4 Visits	3 Visits	2 Visits	1 Visit	No Visits	6 or more Visits	5 Visits	4 Visits	3 Visits	2 Visits	1 Visit	No Visits	6 or more Visits	5 Visits	4 Visits	3 Visits	2 Visits	1 Visit	No Visits
Numerator	3,832	1,801	1,418	916	571	358	251	5,090	Diff. From 03	2,494	1,609	1,092	693	379	346						
Denominator	9147	9147	9147	9147	9147	9147	9147	11703		11703	11703	11703	11703	11703							
Measure (percentage)	41.9%	19.7%	15.5%	10.0%	6.2%	3.9%	2.7%	43.5%	1.6%	21.3%	13.7%	9.3%	5.9%	3.2%	3.0%						
MCP Standard																					
Statewide MCP Avg.	41.9%	19.7%	15.5%	10.0%	6.2%	3.9%	2.7%	43.5%	21.3%	13.7%	9.3%	5.9%	3.2%	3.0%							

MCP Targets Well-Child, Asthma= 80 % Dental = 60 %	Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life				Adolescent Well-Child Visits Ages 12 - 21 Years				Asthmatic Medication Management				Annual Dental Visit							
	Received Medication		ER Visit or Hospital Admission		Children Aged 4 - 21 Who Received a Visit															
RESULTS	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03				
Numerator	34309	40268			26727	32308			4461	6588			1,993	2,801			72559	91392		
Denominator	55330	64753			74597	88349			7970	11790			7970	11790			176831	206464		
Measure (percentage)	62.0%	62.2%		0.2%	35.8%	36.6%		0.8%	56.0%	55.9%		-0.1%	25.0%	23.8%			41.0%	44.3%		3.3%
MCP Standard																				
Statewide MCP Avg.	62.0%	62.2%			35.8%	36.6%			56.0%	55.9%			25.0%	23.8%			41.0%	44.3%		

Childhood Immunization Status																						
RESULTS	CY 03							CY 04							CY 05							
	DTP	OPV	MMR	HIB	HBV	VZV	Comb 1	Comb 2	DTP	OPV	MMR	HIB	HBV	VZV	Comb 1	Comb 2	Comb 1	Comb 2	Comb 1	Comb 2	Comb 1	
Numerator	3153	4308	9257	7945	5448	8090	2,334	1,990	4,991	6195	11011	10711	7736	10145	3,746	3,320	Diff. From 03					
Denominator	13212	13212	13212	13212	13212	13212	13212	13212	15859	15859	15859	15859	15859	15859	15859	15859						Diff. From 04
Measure (percentage)	23.9%	32.6%	70.1%	60.1%	41.2%	61.2%	17.7%	15.1%	31.5%	39.1%	69.4%	67.5%	48.8%	64.0%	23.6%	20.9%	5.9%					
MCP Standard																						
Statewide MCP Avg.	23.9%	32.6%	70.1%	60.1%	41.2%	61.2%	17.7%	15.1%	31.5%	39.1%	69.4%	67.5%	48.8%	64.0%	23.6%	20.9%						

Shading Identifies Contract Measures

White letters Identifies New Contract Measures

Statewide Medicaid MCP Results Clinical Performance Measurement Calendar Year 2004

Received Lead Testing								
MCP Target = 80 %	1 Year Olds				2 Year Olds			
RESULTS	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03
Numerator	7,021	8,640			3,845	4,582		
Denominator	17,414	20,102			16,492	18,912		
Percentage	40.3%	43.0%		2.7%	23.3%	24.2%		0.9%
MCP Standard								
Statewide MCP Avg.	40.3%	43.0%			23.3%	24.2%		

Comprehensive Diabetes Care																				
	Received HBA1c Testing				Received Eye Exam				Received LDL-C Screening				Were Monitored for Nephropathy				Received All			
RESULTS	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03	CY03	CY 03	CY05	Diff. From 03
Numerator	1,635	2,140			704	937			1,564	2,199			761	1,001			186	257		
Denominator	2,753	3,578			2,753	3,578			2,753	3,578			2,753	3,578			2,753	3,578		
Percentage	59.4%	59.8%		0.4%	25.6%	26.2%		0.6%	56.8%	61.5%		4.7%	27.6%	28.0%		0.4%	6.8%	7.2%		0.4%
MCP Standard																				
Statewide MCP Avg.	59.4%	59.8%			25.6%	26.2%			56.8%	61.5%			27.6%	28.0%			6.8%	7.2%		

Shading Identifies Contract Measures

White letters Identifies New Contract Measures

CareSource Medicaid MCP Results Clinical Performance Measurement Calendar Year 2004

Frequency of Ongoing Prenatal Care (Percent of Expected Visits Received) Adjusted for Length of Pregnancy & Length of Time Enrolled in Plan During Pregnancy																		
MCP Target ¹ = 80 %	CY 03						CY 04						CY 05					
RESULTS	81% or more	61-80%	41-60%	21-40%	< 21%	Total	81% or more	61-80%	41-60%	21-40%	< 21%	Total	81% or more	61-80%	41-60%	21-40%	< 21%	Total
Numerator	6,590	1,942	1,191	727	1,101	11,551	7,681	Diff. From 03	2,378	1,488	811	1,133	13,491	Diff. From 04				
Denominator	11,551	11,551	11,551	11,551	11,551	11,551	13,491		13,491	13,491	13,491	13,491						
Measure (percentage)	57.1%	16.8%	10.3%	6.3%	9.5%	100.0%	56.9%	-0.2%	17.6%	11.0%	6.0%	8.4%	100.0%					
MCP Standard	Increase by:						2.3%						Increase by:					
Statewide MCP Avg.	58.6%	16.3%	9.8%	6.3%	9.0%	100.0%	58.9%		17.0%	10.3%	5.7%	8.1%	100.0%					

¹ At least 80% of the recipients should have received 81% or more of their expected number of visits.

MCP Targets Initiation = 90 % Postpartum = 80 %	Initiation of Prenatal Care				Cesarean Section Rate			Low Birth Weight				Very Low Birth Weight			Postpartum Visits (21-56 Days)			
RESULTS	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	CY03	CY04	CY05	Diff. From 03
Numerator	4,581	5,073			2,505	3,111		396	568			90	104		5,231	6,678		
Denominator	5,413	5,917			11,551	13,491		4,651	5,977			4,651	5,977		10,799	12,740		
Percentage	84.6%	85.7%		1.1%	21.7%	23.1%		8.5%	9.5%		1.0%	1.9%	1.7%		48.4%	52.6%		4.2%
MCP Standard	Increase by:			0.5%								Increase by:			1.6%			
Statewide MCP Avg.	84.4%	85.4%			21.5%	23.5%		7.6%	9.6%			1.6%	2.4%		49.4%	52.8%		

Shading Identifies Contract Measures

White letters Identifies New Contract Measures

CareSource Medicaid MCP Results Clinical Performance Measurement Calendar Years 2004

Well-Child Visits in the First 15 Months of Life																						
MCP Target = 80 %	CY 03							CY 04							CY 05							
RESULTS	6 or more Visits	5 Visits	4 Visits	3 Visits	2 Visits	1 Visit	No Visits	6 or more Visits	5 Visits	4 Visits	3 Visits	2 Visits	1 Visit	No Visits	6 or more Visits	5 Visits	4 Visits	3 Visits	2 Visits	1 Visit	No Visits	
Numerator	2201	1149	926	596	405	266	186	3150	Diff. From 03	1697	1132	806	509	290	274							
Denominator	5729	5729	5729	5729	5729	5729	5729	7858	7858	7858	7858	7858	7858	7858								
Measure (percentage)	38.4%	20.1%	16.2%	10.4%	7.1%	4.6%	3.2%	40.1%	1.7%	21.6%	14.4%	10.3%	6.5%	3.7%	3.5%							
MCP Standard								Increase by: 4.2%							Increase by:							
Statewide MCP Avg.	41.9%	19.7%	15.5%	10.0%	6.2%	3.9%	2.7%	43.5%		21.3%	13.7%	9.3%	5.9%	3.2%	3.0%							

MCP Targets Well-Child, Asthma= 80 % Dental = 60 %	Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life				Adolescent Well-Child Visits Ages 12 - 21 Years				Asthmatic Medication Management					Annual Dental Visit					
									Received Medication			ER Visit or Hospital Admission		Children Aged 4 - 21 Who Received a Visit					
	RESULTS	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	CY03	CY04	CY05
Numerator	21768	27407			16713	21391			2705	4100			1147	1669		49210	65453		
Denominator	36301	45198			49905	61848			4862	7409			4862	7409		117180	144078		
Measure (percentage)	60.0%	60.6%		0.6%	33.5%	34.6%		1.1%	55.6%	55.3%		-0.3%	23.6%	22.5%		42.0%	45.4%		3.4%
MCP Standard	Increase by:			2.0%	Increase by:			4.7%	Increase by:			2.4%	Increase by:				1.8%		
Statewide MCP Avg.	62.0%	62.2%			35.8%	36.6%			56.0%	55.9%			25.0%	23.8%		41.0%	44.3%		

Childhood Immunization Status																										
MCP Target = 80 %		CY 03							CY 04							CY 05										
RESULTS	DTP	OPV	MMR	HIB	HBV	VZV	Comb 1	Comb 2	DTP	OPV	MMR	HIB	HBV	VZV	Comb 1	Comb 2	Comb 1	DTP	OPV	MMR	HIB	HBV	VZV	Comb 1	Comb 2	Comb 1
Numerator	1665	2385	5802	4822	3222	5089	1245	1053	3154	3950	7320	6955	5083	6762	2328	2081	Diff. From 03									Diff. From 04
Denominator	8348	8348	8348	8348	8348	8348	8348	8348	10919	10919	10919	10919	10919	10919	10919	10919	10919									
Measure (percentage)	19.9%	28.6%	69.5%	57.8%	38.6%	61.0%	14.9%	12.6%	28.9%	36.2%	67.0%	63.7%	46.6%	61.9%	21.3%	19.1%	6.4%									
MCP Standard																										
Statewide MCP Avg.	23.9%	32.6%	70.1%	60.1%	41.2%	61.2%	17.7%	15.1%	31.5%	39.1%	69.4%	67.5%	48.8%	64.0%	23.6%	20.9%										

Shading Identifies Contract Measures

White letters Identifies New Contract Measures

CareSource Medicaid MCP Results Clinical Performance Measurement Calendar Years 2004

Received Lead Testing								
MCP Target = 80 %	1 Year Olds				2 Year Olds			
RESULTS	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03
Numerator	4,844	6,329			2,566	3,292		
Denominator	11,801	14,481			10,741	13,373		
Percentage	41.0%	43.7%		2.7%	23.9%	24.6%		0.7%
MCP Standard	Increase by:			3.9%	Increase by:			5.6%
Statewide MCP Avg.	40.3%	43.0%			23.3%	24.2%		

Comprehensive Diabetes Care																				
	Received HBA1c Testing				Received Eye Exam				Received LDL-C Screening				Were Monitored for Nephropathy				Received All			
RESULTS	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03
Numerator	1,084	1,483			436	621			1,026	1,512			514	677			116	154		
Denominator	1,804	2,457			1,804	2,457			1,804	2,457			1,804	2,457			1,804	2,457		
Percentage	60.1%	60.4%		0.3%	24.2%	25.3%		1.1%	56.9%	61.5%		4.6%	28.5%	27.6%		-0.9%	6.4%	6.3%		-0.1%
MCP Standard																				
Statewide MCP Avg.	59.4%	59.8%			25.6%	26.2%			56.8%	61.5%			27.6%	28.0%			6.8%	7.2%		

Shading Identifies Contract Measures

White letters Identifies New Contract Measures

Paramount Medicaid MCP Results Clinical Performance Measurement Calendar Year 2004

Frequency of Ongoing Prenatal Care (Percent of Expected Visits Received) Adjusted for Length of Pregnancy & Length of Time Enrolled in Plan During Pregnancy																			
MCP Target ¹ = 80 %	CY 03						CY 04						CY 05						
RESULTS	81% or more	61-80%	41-60%	21-40%	< 21%	Total	81% or more	61-80%	41-60%	21-40%	< 21%	Total	81% or more	61-80%	41-60%	21-40%	<21%	Total	
Numerator	919	161	67	48	85	1,280	1,154	Diff. From 03	191	97	53	102	1,597		Diff. From 04				
Denominator	1,280	1,280	1,280	1,280	1,280		1,597		1,597	1,597	1,597	1,597							
Measure (percentage)	71.8%	12.6%	5.2%	3.8%	6.6%	100.0%	72.3%	0.5%	12.0%	6.1%	3.3%	6.4%	100.0%						
MCP Standard							Increase by: 0.8%												
Statewide MCP Avg.	58.6%	16.3%	9.8%	6.3%	9.0%	100.0%	58.9%		17.0%	10.3%	5.7%	8.1%	100.0%						

¹ At least 80% of the recipients should have received 81% or more of their expected number of visits.

MCP Targets Initiation = 90 % Postpartum = 80 %	Initiation of Prenatal Care				Cesarean Section Rate			Low Birth Rate			Very Low Birth Weight			Postpartum Visits (21-56 Day)				
RESULTS	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	CY03	CY04	CY05	Diff. From 03
Numerator	549	664			260	370		14	78			1	8		698	847		
Denominator	616	758			1,280	1,597		620	776			620	776		1,225	1,542		
Percentage	89.1%	87.6%		-1.5%	20.3%	23.2%		2.3%	10.1%		7.8%	0.2%	1.0%		57.0%	54.9%		-2.1%
MCP Standard	Increase by:				0.1%								Increase by:				1.2%	
Statewide MCP Avg.	84.4%	85.4%			21.5%	23.5%		7.6%	9.6%			1.6%	2.4%		49.4%	52.8%		

Shading Identifies Contract Measures

White letters Identifies New Contract Measures

Paramount Medicaid MCP Results Clinical Performance Measurement Calendar Year 2004

Well-Child Visits in the First 15 Months of Life																								
MCP Target = 80 %	CY 03							CY 04							CY 05									
RESULTS	6 or more Visits	5 Visits	4 Visits	3 Visits	2 Visits	1 Visit	No Visits	6 or more Visits	Diff. From 03	5 Visits	4 Visits	3 Visits	2 Visits	1 Visit	No Visits	6 or more Visits	Diff. From 04	5 Visits	4 Visits	3 Visits	2 Visits	1 Visit	No Visits	
Numerator	542	139	107	64	26	30	17	681		154	99	63	44	15	11									
Denominator	925	925	925	925	925	925	925	1004	1004	1004	1004	1004	1004	1004	1004									
Measure (percentage)	58.6%	15.0%	11.6%	6.9%	2.8%	3.2%	1.8%	61.6%	3.0%	15.3%	9.9%	6.3%	4.4%	1.5%	1.1%									
MCP Standard	Increase by:							2.1%							Increase by:									
Statewide MCP Avg.	41.9%	19.7%	15.5%	10.0%	6.2%	3.9%	2.7%	43.5%		21.3%	13.7%	9.3%	5.9%	3.2%	3.0%									

MCP Targets	Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life				Adolescent Well-Child Visits Ages 12 - 21 Years				Asthmatic Medication Management Received Medication				Annual Dental Visit ER Visit or Hospital Admission Children Aged 4 - 21 Who Received a Visit							
Well-Child, Asthma= 80 % Dental = 60 %	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	CY03	CY04	CY05	Diff. From 03	
RESULTS																				
Numerator	2674	3024			1793	2114			373	597			170	229		5757	7231			
Denominator	3963	4624			4698	5747			578	1039			578	1039		11690	13817			
Measure (percentage)	67.5%	65.4%		-2.1%	38.2%	36.8%		-1.4%	64.5%	57.5%		-7.0%	29.4%	22.0%		49.2%	52.3%		3.1%	
MCP Standard	Increase by:				1.3%				4.2%				1.6%				Increase by:			
Statewide MCP Avg.	62.0%	62.2%			35.8%	36.6%			56.0%	55.9%			25.0%	23.8%		41.0%	44.3%			

Childhood Immunization Status																											
RESULTS	CY 03								CY 04								CY 05										
	DTP	OPV	MMR	HIB	HBV	VZV	Comb 1	Comb 2	DTP	OPV	MMR	HIB	HBV	VZV	Comb 1	Comb 2	Comb 1	DTP	OPV	MMR	HIB	HBV	VZV	Comb 1	Comb 2	Comb 1	
Numerator	359	487	817	702	455	642	235	193	457	560	1010	922	709	936	366	319	Diff. From 03										Diff. From 04
Denominator	1222	1222	1222	1222	1222	1222	1222	1222	1247	1247	1247	1247	1247	1247	1247	1247	1247										
Measure (percentage)	29.4%	39.9%	66.9%	57.4%	37.2%	52.5%	19.2%	15.8%	36.6%	44.9%	81.0%	73.9%	56.9%	75.1%	29.4%	25.6%	10.2%										
MCP Standard																											
Statewide MCP Avg.	23.9%	32.6%	70.1%	60.1%	41.2%	61.2%	17.7%	15.1%	31.5%	39.1%	69.4%	67.5%	48.8%	64.0%	23.6%	20.9%											

Shading Identifies Contract Measures

White letters Identifies New Contract Measures

Paramount Medicaid MCP Results Clinical Performance Measurement Calendar Year 2004

Received Lead Testing								
MCP Target = 80 %	1 Year Olds				2 Year Olds			
RESULTS	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03
Numerator	384	471			219	236		
Denominator	1,436	1,501			1,399	1,455		
Percentage	26.7%	31.4%		4.7%	15.7%	16.2%		0.5%
MCP Standard	Increase by:			5.3%	Increase by:			6.4%
Statewide MCP Avg.	40.3%	43.0%			23.3%	24.2%		

Comprehensive Diabetes Care																				
	Received HBA1c Testing				Received Eye Exam				Received LDL-C Screening				Were Monitored for Nephropathy				Received All			
RESULTS	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03
Numerator	129	184			73	120			136	206			76	123			24	45		
Denominator	215	319			215	319			215	319			215	319			215	319		
Percentage	60.0%	57.7%		-2.3%	34.0%	37.6%		3.6%	63.3%	64.9%		1.6%	35.3%	38.6%		3.3%	11.2%	14.1%		2.9%
MCP Standard																				
Statewide MCP Avg.	59.4%	59.8%			25.6%	26.2%			56.8%	61.5%			27.6%	28.0%			6.8%	7.2%		

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QualChoice
Medicaid MCP Results
Clinical Performance Measurement
Calendar Year 2004

Frequency of Ongoing Prenatal Care (Percent of Expected Visits Received) Adjusted for Length of Pregnancy & Length of Time Enrolled in Plan During Pregnancy																			
MCP Target ¹ = 80 %	CY 03						CY 04						CY 05						
RESULTS	81% or more	61-80%	41-60%	21-40%	< 21%	Total	81% or more	61-80%	41-60%	21-40%	< 21%	Total	81% or more	61-80%	41-60%	21-40%	<21%	Total	
Numerator	1,070	341	222	153	172	1,958	1,167	Diff. From 03	361	191	137	150	2,006		Diff. From 04				
Denominator	1,958	1,958	1,958	1,958	1,958		2,006		2,006	2,006	2,006	2,006							
Measure (percentage)	54.6%	17.4%	11.4%	7.8%	8.8%	100.0%	58.2%	3.6%	18.0%	9.5%	6.8%	7.5%	100.0%						
MCP Standard	Increase by:						2.5%						Increase by:						
Statewide MCP Avg.	58.6%	16.3%	9.8%	6.3%	9.0%	100.0%	58.9%		17.0%	10.3%	5.7%	8.1%	100.0%						

¹ At least 80% of the recipients should have received 81% or more of their expected number of visits.

MCP Targets Initiation = 90 % Postpartum = 80 %	Initiation of Prenatal Care				Cesarean Section Rate			Low Birth Rate			Very Low Birth Weight			Postpartum Visits (21-56 Days)				
RESULTS	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	CY03	CY04	CY05	Diff. From 03
Numerator	595	599			391	463		65	107			7	82		977	1,017		
Denominator	727	700			1,958	2,006		946	964			946	964		1,890	1,939		
Percentage	81.8%	85.6%		3.8%	20.0%	23.1%		6.9%	11.1%		4.2%	0.7%	8.5%		51.7%	52.4%		0.7%
MCP Standard	Increase by:			0.8%										Increase by:			1.4%	
Statewide MCP Avg.	84.4%	85.4%			21.5%	23.5%		7.6%	9.6%			1.6%	2.4%		49.4%	52.8%		

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QualChoice Medicaid MCP Results Clinical Performance Measurement Calendar Year 2004

Well-Child Visits in the First 15 Months of Life																						
MCP Target = 80 %	CY 03							CY 04							CY 05							
RESULTS	6 or more Visits	5 Visits	4 Visits	3 Visits	2 Visits	1 Visit	No Visits	6 or more Visits	5 Visits	4 Visits	3 Visits	2 Visits	1 Visit	No Visits	6 or more Visits	5 Visits	4 Visits	3 Visits	2 Visits	1 Visit	No Visits	
Numerator	635	322	240	153	88	38	31	745	Diff. From 03	430	241	148	92	50	42	Diff. From 04						
Denominator	1507	1507	1507	1507	1507	1507	1507	1748		1748	1748	1748	1748	1748								
Measure (percentage)	42.1%	21.4%	15.9%	10.2%	5.8%	2.5%	2.1%	42.6%	0.5%	24.6%	13.8%	8.5%	5.3%	2.9%	2.4%							
MCP Standard								Increase by: 3.8%									Increase by:					
Statewide MCP Avg.	41.9%	19.7%	15.5%	10.0%	6.2%	3.9%	2.7%	43.5%		21.3%	13.7%	9.3%	5.9%	3.2%	3.0%							

MCP Targets Well-Child, Asthma= 80 % Dental = 60 %	Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life				Adolescent Well-Child Visits Ages 12 - 21 Years				Asthmatic Medication Management					Annual Dental Visit						
	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03	Received Medication		ER Visit or Hospital Admission			Children Aged 4 - 21 Who Received a Visit						
RESULTS	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03
Numerator	6509	6681			5567	6107			914	1272			418	578			10433	11701		
Denominator	9633	9617			12680	13186			1708	2264			1708	2264			30478	30896		
Measure (percentage)	67.6%	69.5%		1.9%	43.9%	46.3%		2.4%	53.5%	56.2%		2.7%	24.5%	25.5%			34.2%	37.9%		3.7%
MCP Standard	Increase by:				Increase by:				Increase by:		Increase by:			Increase by:						
Statewide MCP Avg.	62.0%	62.2%			35.8%	36.6%			56.0%	55.9%			25.0%	23.8%			41.0%	44.3%		

Childhood Immunization Status																										
CY 03									CY 04									CY 05								
RESULTS	DTP	OPV	MMR	HIB	HBV	VZV	Comb 1	Comb 2	DTP	OPV	MMR	HIB	HBV	VZV	Comb 1	Comb 2	Comb 1	DTP	OPV	MMR	HIB	HBV	VZV	Comb 1	Comb 2	Comb 1
Numerator	675	895	1672	1535	1140	1590	504	448	855	1046	1668	1828	1238	1616	625	573	Diff. From 03									
Denominator	2346	2346	2346	2346	2346	2346	2346	2346	2349	2349	2349	2349	2349	2349	2349	2349										
Measure (percentage)	28.8%	38.2%	71.3%	65.4%	48.6%	67.8%	21.5%	19.1%	36.4%	44.5%	71.0%	77.8%	52.7%	68.8%	26.6%	24.4%	5.1%									
MCP Standard																										
Statewide MCP Avg.	23.9%	32.6%	70.1%	60.1%	41.2%	61.2%	17.7%	15.1%	31.5%	39.1%	69.4%	67.5%	48.8%	64.0%	23.6%	20.9%										

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QualChoice Medicaid MCP Results Clinical Performance Measurement Calendar Year 2004

Received Lead Testing								
MCP Target = 80 %	1 Year Olds				2 Year Olds			
RESULTS	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03
Numerator	1,164	1,220			799	721		
Denominator	2,586	2,593			2,789	2,560		
Percentage	45.0%	47.0%		2.0%	28.6%	28.2%		-0.4%
MCP Standard	Increase by:			3.5%	Increase by:			5.1%
Statewide MCP Avg.	40.3%	43.0%			23.3%	24.2%		

Comprehensive Diabetes Care																				
	Received HBA1c Testing				Received Eye Exam				Received LDL-C Screening				Were Monitored for Nephropathy				Received All			
RESULTS	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03
Numerator	249	295			113	117			236	276			100	135			29	43		
Denominator	442	473			442	473			442	473			442	473			442	473		
Percentage	56.3%	62.4%		6.1%	25.6%	24.7%		-0.9%	53.4%	58.4%		5.0%	22.6%	28.5%		5.9%	6.6%	9.1%		2.5%
MCP Standard																				
Statewide MCP Avg.	59.4%	59.8%			25.6%	26.2%			56.8%	61.5%			27.6%	28.0%			6.8%	7.2%		

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SummaCare Medicaid MCP Results Clinical Performance Measurement Calendar Year 2004

Frequency of Ongoing Prenatal Care (Percent of Expected Visits Received) Adjusted for Length of Pregnancy & Length of Time Enrolled in Plan During Pregnancy																				
MCP Target ¹ = 80 %	CY 03						CY 04						CY 05							
RESULTS	81% or more	61-80%	41-60%	21-40%	< 21%	Total	81% or more	Diff. From 03	61-80%	41-60%	21-40%	< 21%	Total	81% or more	Diff. From 04	61-80%	41-60%	21-40%	< 21%	Total
Numerator	850	179	92	82	87	1,290	866		204	118	56	113	1,357							
Denominator	1,290	1,290	1,290	1,290	1,290		1,357		1,357	1,357	1,357	1,357								
Measure (percentage)	65.9%	13.9%	7.1%	6.4%	6.7%	100.0%	63.8%	-2.1%	15.0%	8.7%	4.1%	8.3%	100.0%							
MCP Standard	Increase by:						1.4%						Increase by:							
Statewide MCP Avg.	58.6%	16.3%	9.8%	6.3%	9.0%	100.0%	58.9%		17.0%	10.3%	5.7%	8.1%	100.0%							

¹ At least 80% of the recipients should have received 81% or more of their expected number of visits.

MCP Targets Initiation = 90 % Postpartum = 80 %	Initiation of Prenatal Care				Cesarean Section Rate			Low Birth Weight				Very Low Birth Weight			Postpartum Visits (21-56 Days)			
RESULTS	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	CY03	CY04	CY05	Diff. From 03
Numerator	441	435			301	384		36	48			10	6		573	690		
Denominator	551	549			1,290	1,357		502	594			502	594		1,234	1,288		
Percentage	80.0%	79.2%		-0.8%	23.3%	28.3%		7.2%	8.1%		0.9%	2.0%	1.0%		46.4%	53.6%		7.2%
MCP Standard	Increase by:			1.0%							Increase by:			1.7%				
Statewide MCP Avg.	84.4%	85.4%			21.5%	23.5%		7.6%	9.6%			1.6%	2.4%		49.4%	52.8%		

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SummaCare Medicaid MCP Results Clinical Performance Measurement Calendar Year 2004

Well-Child Visits in the First 15 Months of Life																						
MCP Target = 80 %	CY 03							CY 04							CY 05							
RESULTS	6 or more Visits	5 Visits	4 Visits	3 Visits	2 Visits	1 Visit	No Visits	6 or more Visits	5 Visits	4 Visits	3 Visits	2 Visits	1 Visit	No Visits	6 or more Visits	5 Visits	4 Visits	3 Visits	2 Visits	1 Visit	No Visits	
Numerator	454	191	145	103	52	24	17	577	Diff. From 03	213	137	75	48	24	19							
Denominator	986	986	986	986	986	986	986	1093	Diff. From 03	1093	1093	1093	1093	1093	1093							
Measure (percentage)	46.0%	19.4%	14.7%	10.4%	5.3%	2.4%	1.7%	52.8%	Diff. From 03	6.8%	19.5%	12.5%	6.9%	4.4%	2.2%	1.7%						
MCP Standard	Increase by:							3.4%							Increase by:							
Statewide MCP Avg.	41.9%	19.7%	15.5%	10.0%	6.2%	3.9%	2.7%	43.5%		21.3%	13.7%	9.3%	5.9%	3.2%	3.0%							

MCP Targets	Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life				Adolescent Well-Child Visits Ages 12 - 21 Years				Asthmatic Medication Management				Annual Dental Visit											
Well-Child, Asthma= 80 % Dental = 60 %									Received Medication				ER Visit or Hospital Admission											
RESULTS	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03				
Numerator	3358	3156			2654	2696			469	619			258	325			7159	7007						
Denominator	5433	5314			7314	7568			822	1078			822	1078			17483	17673						
Measure (percentage)	61.8%	59.4%		-2.4%	36.3%	35.6%		-0.7%	57.1%	57.4%		0.3%	31.4%	30.1%		-1.3%	40.9%	39.6%		-1.3%				
MCP Standard	Increase by:				1.8%				4.4%				2.3%				Increase by:				1.9%			
Statewide MCP Avg.	62.0%	62.2%			35.8%	36.6%			56.0%	55.9%			25.0%	23.8%			41.0%	44.3%						

Childhood Immunization Status																											
CY 03										CY 04							CY 05										
RESULTS	DTP	OPV	MMR	HIB	HBV	VZV	Comb 1	Comb 2		DTP	OPV	MMR	HIB	HBV	VZV	Comb 1	Comb 2	Comb 1	DTP	OPV	MMR	HIB	HBV	VZV	Comb 1	Comb 2	Comb 1
Numerator	454	541	966	886	631	769	350	296		525	639	1013	1006	706	831	427	347	Diff. From 03									Diff. From 04
Denominator	1296	1296	1296	1296	1296	1296	1296	1296		1344	1344	1344	1344	1344	1344	1344	1344	Diff. From 03									
Measure (percentage)	35.0%	41.7%	74.5%	68.4%	48.7%	59.3%	27.0%	22.8%		39.1%	47.5%	75.4%	74.9%	52.5%	61.8%	31.8%	25.8%	4.8%									
MCP Standard																											
Statewide MCP Avg.	23.9%	32.6%	70.1%	60.1%	41.2%	61.2%	17.7%	15.1%		31.5%	39.1%	69.4%	67.5%	48.8%	64.0%	23.6%	20.9%										

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SummaCare Medicaid MCP Results Clinical Performance Measurement Calendar Year 2004

Received Lead Testing								
MCP Target = 80 %	1 Year Olds				2 Year Olds			
RESULTS	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03
Numerator	629	620			261	333		
Denominator	1,591	1,527			1,563	1,524		
Percentage	39.5%	40.6%		1.1%	16.7%	21.9%		5.2%
MCP Standard	Increase by:			4.1%	Increase by:			6.3%
Statewide MCP Avg.	40.3%	43.0%			23.3%	24.2%		

Comprehensive Diabetes Care																				
	Received HBA1c Testing				Received Eye Exam				Received LDL-C Screening				Were Monitored for Nephropathy				Received All			
RESULTS	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03	CY03	CY04	CY05	Diff. From 03
Numerator	173	178			82	79			166	204			71	66			17	15		
Denominator	292	329			292	329			292	329			292	329			292	329		
Percentage	59.2%	54.1%		-5.1%	28.1%	24.0%		-4.1%	56.8%	62.0%		5.2%	24.3%	20.1%		-4.2%	5.8%	4.6%		-1.2%
MCP Standard																				
Statewide MCP Avg.	59.4%	59.8%			25.6%	26.2%			56.8%	61.5%			27.6%	28.0%			6.8%	7.2%		