Primary Care Clinician Report Cards

User Guide

June 2018
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1. Introduction

Background

The Ohio Department of Medicaid (ODM) collaborated with Health Services Advisory Group, Inc. (HSAG) to develop a Clinician Report Card that displays individual primary care clinician information on your linked Medicaid patients and on your peer group’s linked Medicaid patients. The goal of the Clinician Report Card is to provide meaningful information to those who provide healthcare services in an effort to improve quality of care and health outcomes. The report cards will be available to Medicaid clinicians on the Medicaid Information Technology System (MITS) portal and will continue to evolve over time to include expanded metrics.

Overview

The Clinician Report Card metrics were calculated using managed care and fee-for-service (FFS) administrative data (enrollment and claims/encounter). This User Guide will provide you with direction and guidance on how to interpret the Clinician Report Card metrics. The guide consists of four main sections:

- **Medicaid Patient Characteristics and Total Cost of Care**: This section describes the methods and appropriate interpretation of the metrics presented on page 1 of the Clinician Report Card, such as *Your Medicaid Patients’ Population Streams* and *Your Medicaid Patients’ Total Cost of Care*.

- **Utilization and Cost**: This section describes the methods and appropriate interpretation of the metrics presented on page 2 of the Clinician Report Card, such as *Your Medicaid Patients’ Average Cost per Year for Emergency Department Visits* and *Your Medicaid Patients’ Average Number of Prescription Fills per Year*.

- **Condition Prevalence**: This section describes the methods and appropriate interpretation of the metrics presented on page 3 of the Clinician Report Card, such as *Most Common Behavioral Health Conditions for Your Medicaid Patients* and *Most Common Emergency Department Visit Conditions for Your Medicaid Patients*.

- **Healthy Children, or Healthy Adults and Women’s Health**: This section describes the methods and appropriate interpretation of the metrics presented on page 4 of the Clinician Report Card, each measure shows the percentage of members compared to the peer group average.

A Primary Care Clinician Report Card user guide and frequently asked questions document will be available on the Ohio Department of Medicaid’s website at [http://medicaid.ohio.gov/providers.aspx](http://medicaid.ohio.gov/providers.aspx) when the reports are posted on the MITS portal. Please direct any questions or comments about this initiative to ReportCards@medicaid.ohio.gov or by calling Provider Assistance at 1-800-686-1516.
2. Medicaid Patient Characteristics and Total Cost of Care

The Medicaid Patient Characteristics and Total Cost of Care section (page 1) of the Clinician Report Card presents the following metrics:

- Your Medicaid Patients’ Demographics
- Number of Clinicians in Your Peer Group
- Your Medicaid Patients’ Relative Risk Score
- Age Distribution
- Population Streams
- Most Common Zip Codes
- Total Cost of Care

Figure 2-1—Clinician Report Card Page 1
Your Medicaid Patients’ Demographics

Figure 2-2—Your Medicaid Patients’ Demographics

<table>
<thead>
<tr>
<th>Your Medicaid Patients’ Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of Medicaid Patients</strong> 34</td>
</tr>
<tr>
<td><strong>Gender Distribution</strong> Female 57% Male 43%</td>
</tr>
</tbody>
</table>

**Number of Medicaid Patients**

Medicaid patients linked to you for the purposes of this report card are identified using administrative data and a combination of member choice and managed care plans’ assignment files, similar to the attribution methodology employed for the Comprehensive Primary Care Quarterly Report. However, for the Clinician Report Card, patients were linked to you only if they were initially attributed to you using the method described above and if they had a visit (claim) with you during the measurement period. Dual eligible patients were excluded from this analysis. At this time, patients in the neonatal intensive care unit (NICU) are included; however, ODM may consider removing them from the analysis in future report card releases.

You must have a minimum of 30 Medicaid patients linked to you in order to receive a report card.

**Gender Distribution**

Patient gender was determined through administrative data. The gender distribution displayed in the Clinician Report Card is only for your Medicaid patients. A comparison to peer groups is not presented.

**Number of Clinicians in Your Peer Group**

Figure 2-3—Number of Clinicians in Your Peer Group

| Number of Family Medicine Clinicians in Your Peer Group 3,527 |

To standardize practice type definitions and create comparison groups, you were categorized as one of the following practice types:

- **Pediatrician Practice**: More than 85 percent of the Medicaid patients linked to you were less than 18 years of age.
- **Adult Medicine Practice**: More than 90 percent of the Medicaid patients linked to you were 18 years of age or older.
- **Family Practice**: You did not meet the criteria for the other practice types.

Your peer group is defined as all primary care clinicians in Ohio eligible to receive a Clinician Report Card within your practice type.
Your Medicaid Patients’ Relative Risk Score

The relative risk score for your Medicaid patients provides a measure of the expected cost/utilization of Medicaid patients linked to you, relative to the cost/utilization for an average patient linked to a clinician in the same peer group. Patient risk scores were “normalized” so that a risk score of 1.000 is average for your peer group. A patient with a risk score below 1.000 means the patient is at lower risk of requiring healthcare services, and so the annual cost of care for this patient is expected to be less than average. Conversely, a patient with a risk score above 1.000 means the patient has a higher risk of requiring healthcare services, with the result that the annual cost of care is expected to be greater than average.

For example, a patient with a risk score of 1.100 is projected to incur healthcare costs and utilization totaling 10 percent more than an average patient (with a risk score of 1.000). A patient with a risk score of 0.800 is projected to incur healthcare costs and utilization totaling only 80 percent of the average patient (with a risk score of 1.000).

The risk score is used to adjust the cost and utilization figures reported in the Clinician Report Card. This adjusts for clinicians whose linked patients are at higher risk of incurring healthcare costs/utilization than the average. The cost and utilization figures reflected in this report are adjusted by dividing by the total costs/utilization figures for your patients by your relative risk score.

Risk adjustment for the Utilization and Cost metrics was performed using 3M™ Clinical Risk Grouping Software. The risk score was calculated based on each patient’s demographic characteristics and health conditions using 24 months of claims history with 6 months of claims run-out.

1-2 3M is a trademark of 3M Company.
Age Distribution

Figure 2-5—Age Distribution

<table>
<thead>
<tr>
<th>Age Category</th>
<th>Your Medicaid Patients</th>
<th>Your Peer Group’s Medicaid Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1 Year</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>1-3 Years</td>
<td>9%</td>
<td>8%</td>
</tr>
<tr>
<td>4-9 Years</td>
<td>17%</td>
<td>18%</td>
</tr>
<tr>
<td>10-19 Years</td>
<td>22%</td>
<td>25%</td>
</tr>
<tr>
<td>20-44 Years</td>
<td>34%</td>
<td>30%</td>
</tr>
<tr>
<td>45+ Years</td>
<td>17%</td>
<td>18%</td>
</tr>
</tbody>
</table>

The age distribution figure presents the percentage of your Medicaid patients in each age category as well as the percentage of your peer group’s Medicaid patients in each age category. Age distributions are presented according to peer group as described below:

- **Pediatric Practice** patient age categories are <1 year, 1-3 years, 4-6 years, 7-12 years, 13-18 years, and ≥19 years old.
- **Adult Medicine Practice** patient age categories are <18 years, 18-25 years, 26-35 years, 36-45 years, 46-55 years, and ≥56 years old.
- **Family Practice** patient age categories are <1 year, 1-3 years, 4-9 years, 10-19 years, 20-44 years, and ≥45 years old.

The patient’s date of birth is used to identify the patient’s age as of the end of the measurement period.

Population Streams

Figure 2-6—Population Streams
The Population Streams figure presents the percentage of your Medicaid patients in each of the four population streams during the measurement period: Women of Reproductive Age, Behavioral Health, Chronic Conditions, and Healthy Adults/Children. Additionally, the percentage of Medicaid patients in each of the four population streams of your peer group is presented.

Population Streams and condition prevalence is determined using the Agency for Healthcare Research and Quality’s (AHRQ’s) single-level Clinical Classifications Software (CCS) classification system. CCS maps approximately 70,000 International Statistical Classification of Diseases, Tenth Revision (ICD-10) diagnosis codes (and approximately 14,000 ICD-9 diagnosis codes) into mutually exclusive and clinically meaningful categories.

Population Streams are mutually exclusive (i.e., a patient can only be grouped into one stream) and are determined using a hierarchical algorithm developed by ODM with the goal of organizing programs around population health.

**Most Common Zip Codes**

The Most Common Zip Codes figure presents the five zip codes in which your Medicaid patients most commonly reside, based on the latest demographic data available at the time the report was produced. Patients’ zip codes were determined through administrative data and the five most common zip codes for your patients are shaded orange.
Total Cost of Care

Figure 2-8—Total Cost of Care for all Medicaid Healthcare Services

The Total Cost of Care figure presents the average cost per year of your Medicaid patients (dark blue box with white font). The light blue area consists of vertical lines representing the average cost per year of Medicaid patients for each of the clinicians in your peer group. Within the distribution of clinicians in your peer group, the average cost per year for your Medicaid patients is indicated by the orange vertical line.

The total cost of care was calculated across all categories of service and risk adjusted. Additional information on the risk scores can be found in the subsection titled “Your Relative Risk Score” above.
The *Utilization and Cost* section (Page 2) of the Clinician Report Card presents the following metrics:

- Number and Cost of ED Visits
- Number and Cost of Inpatient Admissions
- Number and Cost of Prescriptions

All cost and utilization metrics have been risk adjusted.

**Figure 3-1—Clinician Report Card Page 2**

Utilization and Cost metrics are risk-adjusted using the clinician’s relative risk score.
**Number and Cost of ED Visits**

**Number of ED Visits**

The Number of ED Visits figure presents the average number of ED visits per patient per year for your Medicaid patients (dark blue box with white font). The grey area consists of vertical lines representing the average number of ED visits per patient for each clinician in your peer group. Within the distribution of clinicians in your peer group, the average number of visits per year for your Medicaid patients is indicated by the orange vertical line.

Multiple ED visits on the same date count as one visit and ED visits resulting in an inpatient admission were excluded.

**Average Cost for ED Visits**

The Cost of ED Visits figure presents the average cost per patient per year for ED visits for your Medicaid patients (dark blue box with white font). The grey area consists of vertical lines representing the average cost of ED visits per patient for each clinician in your peer group. Within the distribution of clinicians in your peer group, the average cost per year for your Medicaid patients is indicated by the orange vertical line.

ED visits resulting in an inpatient admission were excluded.
Number and Cost of Inpatient Admissions

**Number of Inpatient Admissions**

The Number of Inpatient Admissions figure presents the average number of inpatient admissions per patient per year for your Medicaid patients (dark blue box with white font). The light blue area consists of vertical lines representing the average number of inpatient admissions per patient for each clinician in your peer group. Within the distribution of clinicians in your peer group, the average number of admissions per year for your Medicaid patients is indicated by the orange vertical line.

**Average Cost for Inpatient Admissions**

The Cost of Inpatient Admissions figure presents the average cost per patient per year for inpatient admissions for your Medicaid patients (dark blue box with white font). The light blue area consists of vertical lines representing the average cost of inpatient admissions per patient per clinician in your peer group. Within the distribution of clinicians in your peer group, the average cost per year for your Medicaid patients is indicated by the orange vertical line.
Number and Cost of Prescriptions

Number of Prescription Fills

The Number of Prescription Fills figure presents the average number of prescription fills per patient per year for your Medicaid patients (dark blue box with white font). The light orange area consists of vertical lines representing the average number of prescription fills per patient for each clinician in your peer group. Within the distribution of clinicians in your peer group, the average number of prescription fills per year for your Medicaid patients is indicated by the dark orange vertical line.

Average Cost for Prescriptions

The Cost of Prescriptions figure presents the average cost per patient per year of prescriptions for your Medicaid patients (dark blue box with white font). The light orange area consists of vertical lines representing the average cost of prescriptions per patient for each clinician in your peer group. Within the distribution of clinicians in your peer group, the average cost per year for your Medicaid patients is indicated by the dark orange vertical line.
4. Condition Prevalence

The *Condition Prevalence* section (Page 3) of the Clinician Report Card presents the following metrics:

- Chronic and Behavioral Health Condition Prevalence
- Most Common Chronic Conditions for Your Medicaid Patients
- Most Common Behavioral Health Conditions for Your Medicaid Patients
- Most Common Emergency Department Visits for Your Medicaid Patients
- Most Common Inpatient Admission Conditions for Your Medicaid Patients

![Figure 4-1—Clinician Report Card Page 3](image-url)
**Chronic and Behavioral Health Conditions Prevalence**

The Chronic and Behavioral Health Conditions Prevalence figure presents the percentage of your Medicaid patients with evidence of 1) only a chronic medical condition(s), 2) only a behavioral health condition(s), and 3) both chronic medical and behavioral health conditions. Additionally, the percentage of your Medicaid patients without a chronic or behavioral health condition is also presented. The same percentages are presented for your peer group.

Condition prevalence is determined using AHRQ’s CCS classification system (as described in above sections) and is unrelated to the derivation of the Population Streams. Therefore, there may be differences between the condition prevalence and the Population Streams.

**Most Common Chronic Conditions**

The Most Common Chronic Conditions figure presents the top five most common chronic conditions for your Medicaid patients, along with the percentage of patients with each condition (orange column). For those same five conditions, the figure also displays the percentage of patients with each condition for your peer group (blue column).

Condition prevalence is determined using AHRQ’s CCS classification system (as described in above sections) and is not restricted to the Population Streams hierarchical algorithm. In this table, behavioral health conditions are grouped under a single condition titled “Any Behavioral Health Condition.” A breakout of behavioral health conditions is presented in the Most Common Behavioral Health Conditions table (described below).
Most Common Behavioral Health Conditions

The Most Common Behavioral Health Conditions figure presents the top five most common Behavioral Health Conditions for your Medicaid patients, along with the percentage of patients with each condition (orange column). For those same five conditions, the figure also displays the percentage of patients with each condition for your peer group (blue column).

Most Common Emergency Department Visit Conditions for Your Medicaid Patients

The Most Common ED Visits figure presents the top five most common ED visit primary diagnoses for your Medicaid patients, along with the percentage of patients with each diagnosis category (orange bars). For those same five categories, the figure also displays the percentage of patients with each diagnosis for your peer group (blue bars).

ED visit primary diagnoses were determined using AHRQ’s single-level CCS classification system. Comparative analysis was performed on raw values; values presented in the report card are rounded for presentation purposes only.
Most Common Inpatient Admission Conditions for Your Medicaid Patients

Figure 4-6—Most Common Inpatient Admission Conditions

The Most Common Inpatient Admission Conditions figure presents the top five most common inpatient conditions for your Medicaid patients, along with the percentage of patients with each condition (orange bars). For those same five conditions, the figure also displays the percentage of patients with each condition for your peer group (blue bars).

Primary diagnoses were determined using AHRQ’s single-level CCS classification system. Comparative analysis was performed on raw values; values presented in the report card are rounded for presentation purposes only.
Page 4 of the Clinician Report Card presents measures related to child and adult health and will differ depending on whether you were categorized as a Pediatrician Practice, Adult Medicine Practice, or Family Practice.

**Figure 5-1—Clinician Report Card Page 4**

- **Pediatrician Practice**
  - Well-Child Visits in the First 15 Months of Life
  - Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
  - Adolescent Well-Care Visits
  - Weight Assessment and Counseling for Children/Adolescents BMI Percentile

- **Adult Practice**
  - Adults’ Access to Preventive/Ambulatory Health Services
  - Adult BMI Assessment
  - Breast Cancer Screening
  - Cervical Cancer Screening

- **Family Practice**
  - Adults’ Access to Preventive/Ambulatory Health Services
  - Adult BMI Assessment
  - Breast Cancer Screening
  - Cervical Cancer Screening

For the performance measures, rates may not be presented for all measures because there is not enough of your Medicaid patients who meet the measure criteria. In order to have a rate reported for these measures, you need to have at least 30 patients in the measure numerator. Figure 5-2 is an example of the display on page 4 if you did not meet the criteria.

**Figure 5-2—Measure Did Not Meet Criteria Example**

- **Adult BMI Assessment (ABA)**

  Rates are not presented for this measure because not enough of your Medicaid patients met the measure criteria.
Figure 5-3—Healthy Children Clinician Report Card Page 4

Healthy Children

Well-Child Visits

<table>
<thead>
<tr>
<th>Well-Child Visits in the First 15 Months of Life (W15) Six or More Well-Child Visits</th>
<th>Adolescent Well-Care Visits (AWC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Medicaid Patients: 92.8%</td>
<td>Your Medicaid Patients: 79.0%</td>
</tr>
</tbody>
</table>

Percent of Members Who Had Six or More Well-Child Visits

- Peer Group Average
- National Medicaid 25th Percentile
- National Medicaid 50th Percentile
- National Medicaid 75th Percentile

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)

<table>
<thead>
<tr>
<th>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)</th>
<th>Weight Assessment for Children and Adolescents (WCC) BMI Percentile Documentation - Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Medicaid Patients: 79.5%</td>
<td>Your Medicaid Patients: 24.3%</td>
</tr>
</tbody>
</table>

Percent of Members Who Had a Well-Child Visit

- Peer Group Average
- National Medicaid 25th Percentile
- National Medicaid 50th Percentile
- National Medicaid 75th Percentile

Percent of Members Who Had a Documented BMI Percentile
Well-Child Visits

Well-Child Visits in the First 15 Months of Life

The well-child visits in the first 15 months of life figure presents the percentage of your Medicaid patients who turned 15 months old during the measurement year and who had six or more well-child visits. The orange arrow indicates the rate for your Medicaid patients. The dotted blue vertical line represents the rate for your peer group. The red and green dotted vertical lines represent the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) Audit Means and Percentiles national Medicaid 25th Percentile (in red) and national Medicaid 75th Percentile (in green) for Health Plans.

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

The well-child visits in the third, fourth, fifth and sixth years of life figure presents the percentage of your Medicaid patients aged 3 to 6 years who had one or more well-child visits. The orange arrow indicates the rate for your Medicaid patients. The dotted blue vertical line represents the rate for your peer group. The red and green dotted vertical lines represent NCQA’s HEDIS Audit Means and

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2 HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)
Percentiles national Medicaid 25th Percentile (in red) and national Medicaid 75th Percentile (in green) for Health Plans.

**Adolescent Well-Care**

**Adolescent Well-Care Visits**

![Figure 5-6—Adolescent Well-Care Visits](image)

The adolescent well-care visits figure presents the percentage of your Medicaid patients aged 12 to 21 years who had at least one comprehensive well-care visit. The orange arrow indicates the rate for your Medicaid patients. The dotted blue vertical line represents the rate for your peer group. The red and green dotted vertical lines represent NCQA’s HEDIS Audit Means and Percentiles national Medicaid 25th Percentile (in red) and national Medicaid 75th Percentile (in green) for Health Plans.

**Weight Assessment for Children/Adolescents Body Mass Index (BMI) Percentile Documentation—Total**

![Figure 5-7—Weight Assessment for Children/Adolescents BMI Percentile Documentation—Total](image)

The weight assessment and counseling for children/adolescents BMI percentile figure presents the percentage of your Medicaid patients aged 3 to 17 years who had an outpatient visit with a primary care practitioner or OB/GYN during the measurement year and had evidence of BMI percentile documentation. The orange arrow indicates the rate for your Medicaid patients. The dotted blue vertical
line represents the rate for your peer group. The red and green dotted vertical lines represent the NCQA’s HEDIS Audit Means and Percentiles national Medicaid 25th Percentile (in red) and national Medicaid 75th Percentile (in green) for Health Plans.

**Adult Practice and Family Practice**

*Figure 5-8—Healthy Adults and Women’s Health Page 4*
Healthy Adults

Adults’ Access to Preventive/Ambulatory Health Services

The adults’ access to preventive/ambulatory health services figure presents the percentage of your Medicaid patients who had an ambulatory or preventive care visit. The orange arrow indicates the rate for your Medicaid patients. The dotted blue vertical line represents the rate for your peer group. The red and green dotted vertical lines represent NCQA’s Quality Compass® national Medicaid 25th Percentile (in red) and national Medicaid 75th Percentile (in green) for Health Plans.  

Adult BMI Assessment

The adult BMI assessment figure presents the percentage of your Medicaid patients aged 18 to 74 who had an outpatient visit in the past two years and had their body mass index documented. The orange arrow indicates the rate for your Medicaid patients. The dotted blue vertical line represents the rate for your peer group. The red and green dotted vertical lines represent NCQA’s HEDIS Audit Means and Percentiles national Medicaid 25th Percentile (in red) and national Medicaid 75th Percentile (in green) for Health Plans.

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3 Quality Compass® is a registered trademark of the National Committee for Quality Assurance (NCQA).
**Women’s Health**

*Breast Cancer Screening*

**Figure 5-11—Breast Cancer Screening**

The breast cancer screening figure presents the percentage of your Medicaid patients who had a mammogram to screen for breast cancer. The orange arrow indicates the rate for your Medicaid patients. The dotted blue vertical line represents the rate for your peer group. The red and green dotted vertical lines represent NCQA’s Quality Compass national Medicaid 25th Percentile (in red) and national Medicaid 75th Percentile (in green) for Health Plans.

*Cervical Cancer Screening*

**Figure 5-12—Cervical Cancer Screening**

The cervical cancer screening figure presents the percentage of your female Medicaid patients who met either of the following criteria:

- Women aged 21–64 who had cervical cytology performed every 3 years
- Women aged 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.
The orange arrow indicates the rate for your Medicaid patients. The dotted blue vertical line represents the rate for your peer group. The red and green dotted vertical lines represent NCQA’s HEDIS Audit Means and Percentiles national Medicaid 25th Percentile (in red) and national Medicaid 75th Percentile (in green) for Health Plans.