

Statewide Executive Summary
HealthChoice and Primary Adult Care Organizations
HEDIS® 2009



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Background

The Maryland Medicaid program implemented HealthChoice, a comprehensive managed care program, in June of 1997 after receiving a waiver from the Centers for Medicare and Medicaid Services (CMS) of the requirements in §1115 of the Social Security Act. HealthChoice allows eligible Medicaid recipients to enroll in the participating managed care organization of their choice. There are currently seven organizations participating in HealthChoice, with a total of 538,024 enrollees as of December 31, 2008.

In July 2006, the Maryland Department of Health and Mental Hygiene (DHMH) combined two of its programs, Maryland Pharmacy Assistance and Maryland Primary Care, to form a new Medical Assistance program called Primary Adult Care (PAC). PAC offers health care services to low-income Maryland residents, 19 years of age and older, who are not eligible for full Medicaid benefits. Four organizations currently participate in PAC, with a total of 26,469 enrollees by the close of as of December 31, 2008.

Within DHMH, the HealthChoice & Acute Care Administration is responsible for the quality oversight of the HealthChoice and PAC programs. DHMH continues to measure HealthChoice program clinical quality performance and enrollee satisfaction using initiatives including HEDIS and CAHPS® reporting. Performance is measured at the organization level and on a statewide basis. HEDIS and CAHPS results are incorporated annually into a HealthChoice Health Plan Performance Report Card developed to assist HealthChoice enrollees to make comparisons when selecting a health plan. In 2007, DHMH announced its intention to collect HEDIS results from each organization offering Primary Adult Care (PAC) for a subset of the HEDIS measures already being reported by HealthChoice organizations. All seven HealthChoice organizations reported HEDIS in 2009. Three PAC organizations reported HEDIS in 2009; the fourth intends to report in 2010.

Organizations reporting HEDIS in 2009

Acronym used in this report	Organization name	HealthChoice	PAC
ACC	AMERIGROUP Community Care	X	
DIA	Diamond Plan	X	
JMS	Jai Medical Systems	X	X
MPC	Maryland Physicians Care	X	X
MSFC	MedStar Family Choice	X	
PP	Priority Partners	X	
UHC	UnitedHealthcare	X	X

Healthcare Effectiveness Data and Information Set (HEDIS) is one of the most widely used sets of health care performance measures in the United States. The program is developed and maintained by the National Committee for Quality Assurance (NCQA). NCQA develops and publishes specifications for data collection and results calculation in order to promote a high degree of standardization of HEDIS results. NCQA requires that the reporting entity register with NCQA and undergo a HEDIS Compliance Audit™. To ensure standardized audit methodology, only NCQA-licensed organizations using NCQA-certified auditors may conduct a HEDIS Compliance Audit. The audit conveys sufficient integrity to HEDIS data, such that it can be released to the public to provide consumers and purchasers with a means of comparing health care organization performance.

HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

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DHMH contracted with HealthcareData Company, LLC (HDC), an NCQA-certified Licensed Organization, to conduct HEDIS Compliance Audits of all HealthChoice and PAC organizations and to create audit summary and HEDIS results analysis reports.

The Consumer Assessment of Health Plans Survey (CAHPS) is also sponsored by NCQA. DHMH contracts with a certified NCQA survey vendor to administer the survey to a random selection of HealthChoice and PAC enrollees.

Measures selected by DHMH for HealthChoice Reporting

DHMH required HealthChoice managed care organizations to report 20 HEDIS measures for services rendered in calendar year 2008 to Maryland Medical Assistance HealthChoice enrollees. DHMH selected these measures because they provide meaningful managed care organization comparative information and they measure performance pertinent to DHMH's priorities and goals.

Effectiveness of Care

- Childhood Immunization Status (CIS)
- Breast Cancer Screening (BCS)
- Cervical Cancer Screening (CCS)
- Comprehensive Diabetes Care (CDC), all indicators except HbA1c good control (<7.0%)
- Use of Appropriate Medications for People with Asthma (ASM)
- Appropriate Treatment for Children with Upper Respiratory Infection (URI)
- Appropriate Testing for Children with Pharyngitis (CWP)
- Chlamydia Screening in Women (CHL)

Access/Availability of Care

- Adults' Access to Preventive/Ambulatory Health Services (AAP)
- Children and Adolescents' Access to Primary Care Practitioners (CAP)
- Prenatal and Postpartum Care (PPC)
- Call Answer Timeliness (CAT)
- Call Abandonment (CAB)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment¹ (IET)

Use of Services

- Frequency of Ongoing Prenatal Care (FPC)
- Well-Child Visits in the First 15 Months of Life (W15)
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
- Adolescent Well-Care Visits (AWC)
- Ambulatory Care (AMB)
- Identification of Alcohol and Other Drug Services¹ (IAD)

Measures selected by DHMH for Primary Adult Care (PAC) performance reporting

Three organizations participated in DHMH's Quality and Performance Evaluation System. For 2009, measures were selected for reporting based on applicability to NCQA Accreditation scoring as well as survey or administrative-only data capture.

- Breast Cancer Screening (BCS)
- Cervical Cancer Screening (CCS)
- Comprehensive Diabetes Care (CDC), all indicators except HbA1c good control (<7.0%)
- Adults' Access to Preventive / Ambulatory Health Services (AAP)

1. Since these are new test measures, they will not be publicly reported for HEDIS 2009. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

I. HEDIS Methodology

Guidelines for data collection and measure calculation are described in *Volume 2: Technical Specifications*. Measure-specific HEDIS specifications are also contained in *Volume 2*.

Data collection: The organization or contracted vendor pulls together all data sources, typically into a data warehouse, against which HEDIS software programs are applied to calculate measures. Three approaches may be taken for data collection:

Administrative data: Data from transaction systems (claims, encounters, enrollment, practitioner) is collected in an ongoing manner.

Supplemental data: Supplemental data is considered administrative data for HEDIS calculation purposes. Supplemental data, including immunization databases, public agency databases, laboratory results, historical data, vendor data, and disease/case management data may be used in accordance with NCQA guidelines.

Medical record data: Data abstracted from paper or electronic medical records may be applied to certain measures. HEDIS specifications describe statistically sound methods of sampling, so that only a subset of the eligible population's medical records needs to be chased. Sample size reduction is an option put forth by NCQA to help organizations reduce the cost of medical record review.

Measure calculation: Administrative calculation methods are specified for all measures selected by DHMH for reporting. Hybrid calculation methods are specified, in addition to administrative methods, for the following measures selected by DHMH for HEDIS reporting:

Childhood Immunization Status (CIS)

Cervical Cancer Screening (CCS)

Comprehensive Diabetes Care (CDC)—HbA1c testing; HbA1c poor control >9.0;
HbA1c control <8.0*

Comprehensive Diabetes Care (CDC)—Eye exam

Comprehensive Diabetes Care (CDC)—LDL-C screening; LDL-C level <100mg/dL*

Comprehensive Diabetes Care (CDC)—Medical attention for nephropathy

Comprehensive Diabetes Care (CDC)—Blood pressure level <140/90 mm Hg;
Blood pressure level <130/80 mm Hg*

Prenatal and Postpartum Care (PPC)

Frequency of Ongoing Prenatal Care (FPC)

Well-Child Visits in the First 15 Months of Life (W15)

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

Adolescent Well-Care Visits (AWC)

* An organization must use the same method for these indicators.

No one approach to measure calculation or data collection is considered superior to another and the use of the hybrid method is optional. From organization to organization, the percentages of data obtained from one data source versus another are highly variable, making it inappropriate to make across-the-board statements about the need for, or positive impact of one method versus another. In fact, an organization's yield from the hybrid method may impact the final rate by only a few percentage points, an impact that is also achievable through improvement of administrative data systems.

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Supplemental data sources used by various organizations included the Maryland ImmuNet (state immunization registry), laboratory results data (provided by laboratory services vendor), QI department medical record review data, and case management data for diabetes and prenatal care.

The following table shows the use of the administrative or hybrid method.

	ACC	DIA	JMS- HC	MPC- HC	MSFC	PP	UHC- HC	JMS- PAC	MPC- PAC	UHC- PAC
CIS	H	H	H	H	H	H	H			
CCS	H	H	H	H	H	H	H	A	A	A
CDC– HbA1c testing and/or control	H	H	H	H	H	H	H	A	H	A
CDC– Eye exam	H	H	H	H	H	H	H	A	H	A
CDC– LDL- C testing and/or control	H	H	H	H	H	H	H	A	H	A
CDC– Nephropathy	H	H	H	H	H	H	H	A	H	A
CDC–Blood pressure	H	H	H	H	H	H	H	A	H	A
PPC	H	H	H	H	H	H	H			
FPC	H	H	H	H	H	H	H			
W15	H	H	H	H	H	H	H			
W34	H	H	H	H	H	H	H			
AWC	H	H	H	H	H	H	H			

H- Hybrid; A-Administrative

II. HEDIS Audit Protocol

NCQA publishes *Volume 5: HEDIS Compliance Audit™: Standards, Policies, and Procedures*. The main components of the audit are described below.

Offsite preparation for the onsite audit:

Conference call: A conference call is held early in the audit season to introduce key personnel, review the onsite agenda, identify session participants, and determine a plan to audit data sources used for HEDIS.

HEDIS Roadmap review: The auditor reviews the Roadmap prior to the onsite audit in order to make preliminary assessments regarding IS compliance and to identify areas requiring follow-up at the onsite audit.

Information Systems (IS) standards compliance: The onsite portion of the HEDIS Audit expands upon information gleaned from the HEDIS Roadmap to enable the auditor to make conclusions about the organization's compliance with IS standards. IS standards, describing the minimum requirements for information systems and processes used in HEDIS data collection, are the foundation on which the auditor assesses the organization's ability to report HEDIS data accurately and reliably. The auditor reviews data collection and management processes, including the monitoring of vendors, and makes a determination regarding data soundness and completeness of data to be used for HEDIS reporting.

HEDIS Measure Determination (HD) standards compliance: Both onsite and offsite activities are used to determine compliance with HD standards. HD standards are used to assess the organization's adherence to HEDIS Technical Specifications and report-production protocols. The auditor confirms the use of NCQA-certified software. (As of HEDIS 2009, all Maryland Medicaid organizations used certified software to produce HEDIS reports.) The auditor reviews the organization's sampling protocols (if the hybrid method is used). Later in the audit season, the auditor reviews HEDIS results for algorithmic compliance and performs benchmarking against NCQA-published means and percentiles.

Supplemental data (IS 5.0) audit: This HEDIS audit protocol includes primary source verification of any nonstandard data sources. The auditor determines if the data is external-standard, external-nonstandard, or internal-nonstandard. The auditor performs a primary source verification of nonstandard data before approving it for HEDIS use.

Medical record review validation: The HEDIS Compliance Audit™ includes a protocol to validate the integrity of data obtained from medical record review (MRR) for any measures calculated using the hybrid method. Medical record findings are compared to the respective completed abstraction forms for a sample of positive numerator events. If any errors are found, a statistical T-test is used to determine if the measure is biased. As an additional validation, exclusions may be validated for hybrid measures specifying exclusions (CIS, CCS, CDC).

The audit may also include a *convenience sample* of medical records for the purpose of finding procedural errors early in the medical record abstraction process so that timely corrective action can be made.

Audit designations: A HEDIS audit results in audited rates or calculations at the measure level and indicate if the measure can be publicly reported. All measures selected for reporting or required by a state or federal program must have a final, audited result. The auditor approves the rate or report status of each measure included in the report, as shown in the following table of audit results for HEDIS measures.

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Rate/Result	Comment
<i>0-XXX</i>	Reportable rate or numeric result for HEDIS measures
<i>NR</i>	Not Reported: <ol style="list-style-type: none"> 1. Plan chose not to report * 2. Calculated rate was materially biased 3. Plan not required to report
<i>NA</i>	Small Denominator: The organization followed the specifications but the denominator was too small to report a valid rate
<i>NB</i>	No Benefit: The organization did not offer the health benefits required by the measure (e.g., mental health or chemical dependency)

* An organization may exercise this option only for those measures not included in the measurement set required by DHMH.

Bias Determination: If the auditor determines that a measure is biased, the organization cannot report a rate for that measure and the auditor assigns the designation of NR. Bias is based on the degree of data completeness for the data collection method used. NCQA has defined three bias determination rules, specific to measures, as delineated in Appendix 8 of *Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures*.

Final audit opinion: At the close of the audit, the auditor renders the Final Audit Opinion, containing a Final Audit Statement along with measures rates/designations and comments housed in the Audit Review Table.

III. Measures Designated for Reporting

Annually DHMH determines the set of measures required for HEDIS reporting. Measures are selected because they provide meaningful comparative information relevant to DHMH priorities and goals.

For HealthChoice performance reporting in 2009, DHMH selected 20 measures for data collection and calculation. DHMH also announced to the participating organizations the department's intent to report 18 of these measures. Two of the measures, Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) and Identification of Alcohol and Other Drug Services (IAD), are newly required for data collection and calculation in 2009, considered "test" measures, and will not be publicly reported. After reviewing first-year (2009) results, DHMH intends to make a decision whether or not to publicly report these measures' results in 2010. For PAC performance reporting in 2009, DHMH selected four measures for data collection and calculation.

Measures designated for HEDIS 2009 data collection and calculation are listed in the following table. The table shows the first year of trending (found in Section V. of this report). A notation of ≤ 2005 is used to indicate that the measure has been reported since at least 2005. (Additional historical trending can be found in Statewide Analysis Reports from prior years. Measures discontinued by NCQA are not displayed in this table or in Section V.)

HEDIS Measures Reporting History

NCQA Domain ¹	NCQA Abbreviation	Measure name	Indicators (Indicators reported for HEDIS but not included in this report are italicized.)	HealthChoice reporting history	PAC reporting history
EOC	CIS	Childhood Immunization Status	<i>DTaP</i> <i>IPV</i> <i>MMR</i> <i>Hib</i> <i>Hepatitis B</i> <i>VZV</i> Combination 2 (DTaP, IPV, MMR, Hib, hepatitis B, VZV)	≤ 2005	
EOC	CIS	Childhood Immunization Status	<i>Pneumococcal conjugate</i> Combination 3 (DTaP, IPV, MMR, Hib, hepatitis B, VZV, pneumococcal conjugate)	2006 Pneumococcal conjugate was introduced by HEDIS in 2006 and adopted by DHMH for reporting that year. A new Combination 3 included this antigen.	
UOS	W15	Well-Child Visits in the First 15 Months of Life ²	<i>Zero visits</i> <i>One visit</i> <i>Two visits</i> <i>Three visits</i> <i>Four visits</i> <i>Five visits</i> <i>Six or more visits</i> DHMH nonHEDIS measure: Five visits and six or more visits (additive rate)	≤ 2005	

1. EOC: Effectiveness of Care; AAC: Access/Availability of Care; UOS: Use of Services

2. NCQA considers these to be EOC-like measures.

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NCQA Domain ¹	NCQA Abbreviation	Measure name	Indicators (Indicators reported for HEDIS but not included in this report are italicized.)	HealthChoice reporting history	PAC reporting history
UOS	W34	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life ²		≤ 2005	
UOS	AWC	Adolescent Well-Care Visits ²		≤ 2005	
EOC	CWP	Appropriate Testing for Children with Pharyngitis		2007	
EOC	URI	Appropriate Treatment for Children with Upper Respiratory Infection		2007	
EOC	ASM	Use of Appropriate Medications for People with Asthma	5-9 years of age 10-17 years of age 18-56 years age Total	2006 with revised NCQA specifications	
AAC	CAP	Children and Adolescents' Access to Primary Care Practitioners ²	12-24 months of age 25 months to 6 years of age 7-11 years of age 12-19 years of age	2007 with revised specifications	
AAC	AAP	Adults' Access to Preventive /Ambulatory Health Services ²	20-44 years of age 45-65 years of age	2007 with revised specifications	2009
EOC	BCS	Breast Cancer Screening		2007 with revised specifications	2009
EOC	CCS	Cervical Cancer Screening		2007	2009
EOC	CHL	Chlamydia Screening in Women	16-20 years of age	2007	
EOC	CHL	Chlamydia Screening in Women	2009: 21-25 years of age 2007-2008: 21-24 years of age	2007	
EOC	CHL	Chlamydia Screening in Women	2009: Total (16-24 years of age) 2007-2008: Total (16-25 years of age)	2007	
AAC	PPC	Prenatal and Postpartum Care ²	Timeliness of prenatal care	≤ 2005	
AAC	PPC	Prenatal and Postpartum Care ²	Postpartum care	≤ 2005	
UOS	FPC	Frequency of Ongoing Prenatal Care ²	<21 percent of expected visits <i>21 percent of expected visits</i> <i>41 percent of expected visits</i> <i>61 percent of expected visits</i> ≥81 percent of expected visits	≤ 2005	
EOC	CDC	Comprehensive Diabetes Care	HbA1c testing	≤ 2005	2009
EOC	CDC	Comprehensive Diabetes Care	HbA1c poor control (>9.0%)	≤ 2005	2009

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NCQA Domain ¹	NCQA Abbreviation	Measure name	Indicators <i>(Indicators reported for HEDIS but not included in this report are italicized.)</i>	HealthChoice reporting history	PAC reporting history
EOC	CDC	Comprehensive Diabetes Care	HbA1c control (<8.0%)	2009 introduction by NCQA with adoption by DHMH for public reporting	2009
EOC	CDC	Comprehensive Diabetes Care	Eye exam (retinal) performed	< 2005	2009
EOC	CDC	Comprehensive Diabetes Care	LDL-C screening	2007 with revised specifications	2009
EOC	CDC	Comprehensive Diabetes Care	LDL-C control (<100mg/dL)	2007 with revised specifications	2009
EOC	CDC	Comprehensive Diabetes Care	Medical attention for nephropathy	2007 with revised specifications	2009
EOC	CDC	Comprehensive Diabetes Care	Blood pressure control (<130/90 mm Hg)	2007 introduction by NCQA with adoption by DHMH for public reporting	2009
EOC	CDC	Comprehensive Diabetes Care	Blood pressure control (<140/90 mm Hg)	2007 introduction by NCQA with adoption by DHMH for public reporting	2009
AAC	IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Initiation: 13-17 years of age 18+ years of age Total (ages 13-65)	2009	
UOS	IAD	Identification of Alcohol and Other Drug Services	Any services Inpatient services Intensive Outpatient/Partial Hospitalization Outpatient/ED	2009	
UOS	AMB	Ambulatory Care	Outpatient visits ED visits Ambulatory Surgery/Procedures Observation Room Stays	2007; continued as a testing measure through 2008	
AAC	CAB	Call Abandonment		2006	
AAC	CAT	Call Answer Timeliness		2006	

1. EOC: Effectiveness of Care; AAC: Access/Availability of Care; UOS: Use of Services

IV. Measure-Specific Findings – Explanation

Metrics: Two metrics are calculated to accompany the organization-specific scores:

- Maryland Average Reportable Rate (MARR)
- National HEDIS Mean (NHM)*

Maryland Average Reportable Rate (MARR): The MARR is an average of the HealthChoice organization’s rates, as reported to NCQA. In most cases, all seven organizations contributed a rate to the average. Where one or more organizations reported NA or NR instead of a rate, the average consisted of fewer than seven component rates. A MARR was not calculated for PAC organizations as only three organizations reported; with this few organizations reporting, an average could be easily be skewed by one unusual rate.

National HEDIS Mean (NHM)*: The mean value is taken from NCQA’s HEDIS Audit Means, Percentiles and Ratios – Medicaid, posted in the first quarter of each year to the NCQA Web site, <http://www.ncqa.org/tabid/334/Default.aspx>. The NCQA data set shows prior-year rates for each measure displayed as the mean rate and the rate at the 10th, 25th, 50th, 75th, and 90th percentiles. *HEDIS 2008 Means, Percentiles, and Ratios* pertinent to this report can be found in Appendix A.

NCQA averages the rates of all organizations submitting data via the IDSS system, regardless of the method of calculation (administrative or hybrid) and regardless of whether the organization elected to publicly report its data. NCQA’s method is the same as that used for the MARR, but on a larger scale.

Note: Certain table rows (e.g., age categories) are not displayed if fewer than 30 organizations report valid rates. However, organizations without enough members in a specific age group for reporting could have enough members dispersed through all the age categories to report a total; therefore, in these reports, the totals are not necessarily equal to the sum of the age categories.

NCQA’s Means, Percentiles, and Ratios can be found in Appendix A.

Cautionary note in regards to application of the NHM: Based on what HDC has learned through the HEDIS audit process about state enrollment practices, there are two distinct groups of Medicaid HEDIS reporting entities: those from states that cease Medicaid eligibility upon Medicare eligibility (age 65), i.e., Maryland, and those that do not. In our experience auditing CAHPS sample frames, health plans that do not cease enrollment at age 65 have approximately 20% of members age 65 and older.

The effect of this large older cohort on an organization’s rates has not been studied.

Among measures selected by DHMH for HEDIS/CAHPS reporting, the following HEDIS specifications include (or do not exclude) members over the age of 65 (listed here with the age specification):

- Breast Cancer Screening (ages 40-69)
- Comprehensive Diabetes Care (ages 18-75)
- CAHPS 4.0H Adult Survey (ages 18 and older)

* This was referred to as the National Medicaid HEDIS Mean (NMH) in previous Statewide Analysis Reports.

Year-to-year trending: Year-to-year trending is possible when specifications remain consistent from year to year, with the exception of expected updates to industry-wide coding systems. For each measure, up to a five-year trend is displayed, where available.

In Statewide Analysis Reports through 2008, prior-year results were removed from trending tables upon NCQA's significant revision of specifications. Beginning with 2009, prior-year results will be retained in the trending tables, regardless of specification changes. The prior-year results under different specifications will be shown in italics.

Performance trends at the organization level are juxtaposed with the trends for the MARR and the NHM for the same measurement year. Trending for Diamond Plan (DIA) started in 2006 because the number of members did not become significant until 2005.

Rounding of figures: Beginning with 2008, rates are rounded to one decimal point using the rate/ratio reported to NCQA. In addition, the 2007 NHM is displayed at one decimal point of specificity. This rounding corresponds to the rounding used by NCQA for the NHM. Where any two or more rates are identical at this level of detail, an additional decimal place of detail is provided.

Audit designation other than a rate/ratio: According to NCQA reporting protocols, NA or NR may replace a rate. Please see page 6 for defined uses of these audit designations.

Organization of data: Comparative results for HEDIS 2009 are shown on the following pages. In this report, an attempt was made to group and sequence measures by like populations or functions as follows:

Children's Prevention and Screening: CIS, W15, W34, AWC

Respiratory Conditions: CWP, URI, ASM

Member Access: CAP, AAP

Women's Health: BCS, CCS, CHL

Prenatal and Postpartum Care: PPC, FPC

Diabetes: CDC

Ambulatory Care (utilization): AMB

Call Services: CAB, CAT

Sources of accompanying information:

Description – The source of the text, with minimal editing, is NCQA's *HEDIS 2009 Volume 2: Technical Specifications*.

Rationale – For all measures, except for Call Answer Timeliness (CAT) and Call Abandonment (CAB), the source of the text is the Agency for Healthcare Research and Quality (AHRQ) citations of NCQA as of July 2008. These citations appear under the *Brief Abstract* on the Web site of the National Quality Measures Clearinghouse, <http://www.qualitymeasures.ahrq.gov/>. For CAT and CAB the rationale was adapted from *HEDIS 2004 Vol. 2: Technical Specifications*, Appendix 2.

Summary of Changes for HEDIS 2008 – The source of the text, is the *HEDIS 2009 Volume 2: Technical Specifications*, incorporating additional changes published in the *HEDIS 2009 Volume 2: "October" Technical Update*.

V. Measure-Specific Findings

Children's Prevention and Screening

Childhood Immunization Status (CIS)

Description: The percentage of children two years of age who had four diphtheria, tetanus and acellular pertussis (DTaP), three polio (IPV), one measles, mumps and rubella (MMR), two H influenza type B (Hib), three hepatitis B, one chicken pox (VZV), and four pneumococcal conjugate vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.

Rationale: A basic method for prevention of serious illness is immunization. Childhood immunizations help prevent serious illnesses such as polio, tetanus and hepatitis. Vaccines are a proven way to help a child stay healthy and avoid the potentially harmful effects of childhood diseases like mumps and measles. Even preventing "mild" diseases saves hundreds of lost school days and work days, and millions of dollars.

Immunizations are the safest, most effective way to protect children from a variety of potentially serious childhood diseases. It is widely agreed that if immunization practices were to cease, most infectious diseases currently prevented by vaccinations would reemerge as serious health threats. The importance of vaccines is shown by the reappearance of diseases when immunization coverage drops. Despite established guidelines, well-known benefits of vaccination and high coverage, many children still do not receive their recommended immunizations. In 2007, almost one quarter of children age two to three lacked one or more recommended vaccinations.

Summary of Changes to HEDIS 2009:

- Revised the required number of doses for the Hib vaccine, per ACIP recommendations to defer the third Hib booster during vaccine shortage.
- Deleted ICD-9-CM Procedure code 99.37 from Table CIS-A. Vaccine for acellular pertussis antigen only is no longer produced.
- Clarified medical record review requirements for immunizations documented using a generic header of *DTaP/DTP/DT*.
- Table CIS-A, deleted CPT codes 90702, 90703, 90719 and delete ICD-9-CM Procedure codes 99.36, 99.38. Rationale: Because the member needs four DTaP immunizations for numerator compliance and because the vaccine for acellular pertussis antigen only is no longer produced, these codes cannot be used to demonstrate numerator compliance.

On the next page, tables show results for Combination 2 and Combination 3.

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Childhood Immunization Status (CIS) – Combination 2 (DTaP/DT, IPV, MMR, Hib, Hepatitis B, VZV)

	2005	2006	2007	2008	2009
ACC	80%	88%	88%	89.8%	82.1%
DIA		NA	74%	68.1%	73.0%
JMS	76%	77%	75%	85.0%	87.1%
MPC	66%	70%	71%	72.2%	74.7%
MSFC	73%	74%	81%	84.7%	89.2%
PP	76%	80%	82%	86.5%	82.1%
UHC	65%	71%	73%	78.0%	84.8%
MARR	73%	77%	78%	80.6%	81.9%
NHM	63%	70%	73.3%	72.3%	

Childhood Immunization Status (CIS) – Combination 3 (DTaP/DT, IPV, MMR, Hib, Hepatitis B, VZV, pneumococcal conjugate)

	2005	2006	2007	2008	2009
ACC		72%	75%	81.0%	74.6%
DIA		NA	66%	59.9%	69.4%
JMS		63%	74%	82.7%	80.6%
MPC		44%	62%	67.8%	70.1%
MSFC		44%	69%	78.1%	87.8%
PP		45%	72%	77.4%	77.4%
UHC		38%	60%	72.2%	78.7%
MARR		51%	68%	74.1%	76.9%
NHH		43%	60.6%	65.6%	

Well-Child Visits in the First 15 Months of Life (W15)

Description: The percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: no well-child visits; one, two, three, four, five, six-or-more well-child visits.

Rationale: This measure looks at the adequacy of well-child care for infants. Regular check-ups are one of the best ways to detect physical, developmental, behavioral and emotional problems. They also provide an opportunity for the clinician to offer guidance and counseling to the parents.

These visits are of particular importance during the first year of life, when an infant undergoes substantial changes in abilities, physical growth, motor skills, hand-eye coordination and social and emotional growth. The American Academy of Pediatrics (AAP) recommends six well-child visits in the first year of life: the first within the first month of life, and then at around 2, 4, 6, 9, and 12 months of age.

Summary of Changes to HEDIS 2009

- Removed two data elements from Table W15-1/2: Number of administrative and medical records excluded.
- Eligible Population – Continuous Enrollment: replaced the last sentence with the following: For example, a child born on January 9, 2007, and included in the rate of “six or more well-child visits” must have had six well-child visits by April 8, 2008.

Well-Child Visits in the First 15 months of Life (W15) – Zero visits*

	2005	2006	2007	2008	2009
ACC	1%	1%	1%	1.1%	2.4%
DIA		10%	7%	3.1%	2.6%
JMS	6%	4%	3%	5.3%	2.6%
MPC	4%	2%	1%	1.1%	0.7%
MSFC	2%	1%	2%	1.8%	1.1%
PP	2%	2%	1%	0.7%	1.5%
UHC	0%	2%	2%	1.7%	1.8%
MARR	2%	3%	2%	2.1%	1.8%
NHM	6%	5%	3.8%	5.6%	

* A lower rate indicates better performance.

Well-Child Visits in the First 15 months of Life (W15) – DHMH Five plus six-or-more visits rates (additive)

	2005	2006	2007	2008	2009
ACC	85%	93%	97%	85.4%	83.0%
DIA		65%	71%	70.7%	77.1%
JMS	76%	81%	94%	82.0%	81.8%
MPC	81%	85%	83%	87.1%	87.3%
MSFC	83%	81%	78%	82.3%	81.0%
PP	84%	83%	86%	81.3%	86.4%
UHC	79%	84%	87%	86.2%	86.0%
MARR	81%	82%	85%	82.1%	83.2%
NHM	64%	68%	72.9%	70.2%	

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

Description: The percentage of members 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.

Rationale: This measure looks at the use of routine check-ups by preschool and early school-age children. Well-child visits during the preschool and early school years are particularly important. A child can be helped through early detection of vision, speech and language problems. Intervention can improve communication skills and avoid or reduce language and learning problems. The American Academy of Pediatrics (AAP) recommends annual well-child visits for 2 to 6 year-olds.

Summary of Changes to HEDIS 2009

Removed two data elements from *Table W34-1/2: Number of administrative and medical records excluded*.

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

	2005	2006	2007	2008	2009
ACC	79%	80%	80%	77.5%	74.2%
DIA		49%	69%	66.4%	70.0%
JMS	79%	84%	88%	89.1%	89.9%
MPC	68%	70%	76%	79.1%	73.1%
MSFC	75%	66%	74%	74.1%	79.4%
PP	71%	70%	73%	77.4%	75.3%
UHC	68%	70%	80%	76.3%	75.4%
MARR	73%	70%	77%	77.1%	76.8%
NHM	62%	63%	66.8%	65.3 %	

Adolescent Well-Care Visits (AWC)

Description: The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Rationale: This measure looks at the use of regular check-ups by adolescents. Adolescents benefit from an annual preventive health care visit that addresses the physical, emotional and social aspects of their health.

Adolescence is a time of transition between childhood and adult life and is accompanied by dramatic changes. Accidents, homicide and suicide are the leading causes of adolescent deaths. Sexually transmitted diseases, substance abuse, pregnancy and antisocial behavior are important causes of, or result from, physical, emotional and social adolescent problems.

The American Medical Association's (AMA) *Guidelines for Adolescent Preventive Services*, the federal government's Bright Futures program and the American Academy of Pediatrics' (AAP) guidelines all recommend comprehensive annual check-ups for adolescents.

Summary of Changes to HEDIS 2009

Removed two data elements from *Table AWC-1/2: Number of administrative and medical records excluded*.

Adolescent Well-Care Visits (AWC)

	2005	2006	2007	2008	2009
ACC	57%	58%	57%	50.3%	54.1%
DIA		35%	50%	44.6%	49.7%
JMS	59%	72%	76%	73.3%	76.1%
MPC	48%	54%	60%	51.3%	49.5%
MSFC	55%	49%	59%	45.7%	52.8%
PP	46%	48%	54%	52.6%	53.4%
UHC	50%	50%	59%	52.5%	47.3%
MARR	52%	52%	59%	52.9%	54.7%
NHM	39%	41%	43.7%	42.0%	

Respiratory Conditions

Appropriate Testing for Children with Pharyngitis (CWP)

Description: The percentage of children 2-18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode.

Rationale: Pharyngitis is the only condition among upper respiratory infections (URIs) whose diagnosis can easily be objectively validated through administrative and laboratory data, and it can serve as an important indicator of appropriate antibiotic use among all respiratory tract infections. Overuse of antibiotics has been directly linked to the prevalence of antibiotic resistance in the community; promoting judicious use of antibiotics is important to reducing levels of antibiotic resistance. Pediatric clinical practice guidelines recommend that only children with diagnosed group A streptococcus (strep) pharyngitis based on appropriate lab tests be treated with antibiotics. A strep test (rapid assay or throat culture) is the definitive test of group A strep pharyngitis. Excess use of antibiotics is highly prevalent for pharyngitis; about 35 percent of the total nine million antibiotics prescribed for pharyngitis in 1998 were estimated to be in excess.

Summary of Changes to HEDIS 2009

- Deleted CPT code 99499 from Table CWP-B.
- Table CWP-D: Add LOINC code 49610-9. Delete LOINC code 11475-1.

Appropriate Testing for Children with Pharyngitis (CWP)

	2005	2006	2007	2008	2009
ACC			68%	67.8%	66.4%
DIA			54%	47.9%	69.4%
JMS			73%	50.0%	67.3%
MPC			71%	74.8%	75.6%
MSFC			54%	75.8%	78.9%
PP			76%	78.2%	72.0%
UHC			65%	67.4%	69.8%
MARR			66%	66.0%	71.4%
NHM			55.7%	58.2%	

Appropriate Treatment for Children with Upper Respiratory Infection (URI)

Description The percentage of children 3 months–18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription.

Rationale The common cold (upper respiratory infection [URI]) is a frequent reason for children visiting the doctor's office. Though existing clinical guidelines do not support the use of antibiotics for the common cold, physicians often prescribe them for this ailment. Pediatric clinical practice guidelines do not recommend antibiotics for a majority of upper respiratory tract infections due to viral etiology of these infections, including the common cold.

A performance measure of antibiotic use for URI sheds light on the prevalence of inappropriate antibiotic prescribing in clinical practice and raises awareness of the importance of reducing inappropriate antibiotic use to combat antibiotic resistance in the community.

Summary of Changes to HEDIS 2009

Deleted CPT code 99499 from Table URI-B.

Appropriate Treatment for Children with Upper Respiratory Infection (URI)

	2005	2006	2007	2008	2009
ACC			86%	87.1%	85.0%
DIA			87%	82.9%	82.9%
JMS			82%	87.3%	95.5%
MPC			83%	85.1%	84.0%
MSFC			85%	86.2%	86.3%
PP			94%	96.6%	84.4%
UHC			79%	80.6%	80.6%
MARR			85%	86.5%	85.5%
NHM			83.3%	84.1%	

Use of Appropriate Medications for People with Asthma (ASM)

Description: The percentage of members 5–56 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.

Rationale: Asthma is one of the nation's most common and costly diseases. More than 30 million Americans, including almost 9 million children, will suffer from asthma at some point in their life. Asthma medications reduce underlying airway inflammation and relieve or prevent airway narrowing. Many asthma-related hospitalizations, emergency room visits, and missed work and school days can be avoided if patients' medications are managed appropriately.

Summary of Changes to HEDIS 2009

- Clarified dispensing event and inhaler dispensing event criteria.
- Clarified in step 2 that a member prescribed a leukotriene modifier only needs at least one diagnosis of asthma in the same year as the leukotriene modifier dispensing event.
- Deleted CPT code 99499 from Table ASM-B.
- Definitions – Dispensing Event: Add the following sentence to the end of the paragraph: For two different prescriptions dispensed on the same day, sum the days' supply to determine the number of dispensing events.

Use of Appropriate Medications for People with Asthma (ASM) – Age 5-9 years

	2005	2006	2007	2008	2009
ACC		88%	88%	91.7%	90.0%
DIA		NA	NA	NA	NA
JMS		NA	NA	NA	NA
MPC		90%	91%	90.5%	91.5%
MSFC		91%	92%	91.5%	94.0%
PP		88%	89%	87.8%	91.9%
UHC		92%	92%	92.0%	91.8%
MARR		90%	90%	90.7%	91.8%
NHM		88%	89.6%	89.3%	

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Use of Appropriate Medications for People with Asthma (ASM) – Age 10-17 years

	2005	2006	2007	2008	2009
ACC		88%	89%	88.4%	88.7%
DIA		NA	NA	NA	NA
JMS		79%	77%	83.3%	72.5%
MPC		89%	89%	89.0%	88.7%
MSFC		85%	90%	92.0%	93.4%
PP		86%	88%	85.2%	88.2%
UHC		90%	89%	90.3%	89.8%
MARR		86%	87%	88.1%	86.9%
NHM		86%	87.0%	86.9%	

Use of Appropriate Medications for People with Asthma (ASM) – Age 18-56 years

	2005	2006	2007	2008	2009
ACC		87%	87%	87.9%	86.0%
DIA		NA	NA	NA	92.3%
JMS		91%	85%	94.0%	91.7%
MPC		75%	85%	86.5%	84.0%
MSFC		91%	92%	85.1%	92.9%
PP		76%	76%	78.7%	88.8%
UHC		86%	86%	86.0%	88.6%
MARR		84%	85%	86.4%	89.2%
NHM		83%	84.7%	84.5%	

Use of Appropriate Medications for People with Asthma (ASM) – Total rate

	2005	2006	2007	2008	2009
ACC		87%	88%	89.6%	88.6%
DIA		NA	NA	NA	91.6%
JMS		85%	83%	91.6%	87.3%
MPC		84%	88%	88.7%	87.9%
MSFC		89%	91%	89.5%	93.4%
PP		84%	86%	85.0%	89.5%
UHC		89%	89%	89.6%	90.1%
MARR		87%	88%	89.0%	89.8%
NHM		86%	87.1%	86.9%	

Member Access

Children and Adolescents' Access to Primary Care Practitioners (CAP)

Description: The percentage of members 12 months–19 years of age who had a visit with a primary care practitioner (PCP):

- Children 12–24 months and 25 months–6 years of age who had a visit with a PCP during the measurement year
- Children 7–11 years and adolescents 12–19 years of age who had a visit with a PCP during the measurement year or the year prior to the measurement year

Rationale: While the access to primary care has been shown to correlate with reduced hospital use while preserving quality (Bindham 1995, Bodenheimer 2005), this measure does not explicitly measure a member's access to primary care. However, studies show that inappropriate care and overuse of new technologies can be reduced through shared decision-making between well-informed physicians and patients. Physicians have a central role to play in fostering these quality-enhancing strategies that can help to slow the growth of health care expenditures (Bodenheimer 2005).

Continued rising health care costs in the U.S. affect all levels of the health care delivery system. Encouraging and making available access to primary care services is one potential strategy to lower hospital utilization while maintaining the quality of care delivered. Studies show that access to primary care is correlated with reduced hospital use while preserving quality (Bodenheimer 2005, Bindham 1995).

Summary of Changes to HEDIS 2009: No changes to this measure.

Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 12-24 months

	2005	2006	2007	2008	2009
ACC			97%	96.7%	97.4%
DIA			90%	92.2%	91.8%
JMS			91%	91.7%	88.3%
MPC			96%	96.5%	96.6%
MSFC			97%	96.9%	96.8%
PP			95%	94.2%	97.8%
UHC			95%	95.8%	96.3%
MARR			94%	94.9%	95.0%
NHM			94.1%	93.4%	

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Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 25 months to 6 years

	2005	2006	2007	2008	2009
ACC			91%	91.1%	91.7%
DIA			82%	82.9%	85.5%
JMS			89%	88.4%	89.5%
MPC			91%	90.0%	91.1%
MSFC			89%	89.8%	91.6%
PP			85%	86.5%	91.7%
UHC			89%	90.8%	92.2%
MARR			88%	88.5%	90.4%
NHM			84.9%	84.3%	

Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 7-11 years

	2005	2006	2007	2008	2009
ACC			92%	92.3%	92.6%
DIA			81%	82.7%	84.6%
JMS			90%	89.3%	93.7%
MPC			92%	91.2%	91.6%
MSFC			92%	92.2%	92.2%
PP			87%	88.0%	92.9%
UHC			90%	92.1%	92.2%
MARR			89%	89.7%	91.4%
NHM			86.0%	85.8%	

Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 12-19 years

	2005	2006	2007	2008	2009
ACC			89%	88.4%	87.3%
DIA			80%	84.9%	81.0%
JMS			92%	92.8%	91.9%
MPC			88%	89.2%	88.4%
MSFC			89%	90.0%	88.7%
PP			83%	84.0%	89.0%
UHC			86%	88.6%	87.6%
MARR			87%	88.3%	87.7%
NHM			83.2%	82.6%	

Adults’ Access to Preventive/Ambulatory Health Services (AAP)

Description: The percentage of members 20 years of age and older who had an ambulatory or preventive care visit during the measurement year. The organization reports three age stratifications (20-44 years, 45-65 years, 65 years and older) and a total rate.

Rationale: While access to primary care has been shown to correlate with reduced hospital use while preserving quality (Bodenheimer, 2005, Bindham, 1995), this measure does not explicitly measure a member’s access to primary care. However, studies show that inappropriate care and overuse of new technologies can be reduced through shared decision-making between well-informed physicians and patients. Physicians have a central role to play in fostering these quality-enhancing strategies that can help to slow the growth of health care expenditures (Bodenheimer, 2005).

Continued rising health care costs in the U.S. affect all levels of the health care delivery system. Encouraging and making available access to primary and preventive care services is one potential strategy to lower hospital utilization while maintaining the quality of care delivered. Studies show that access to primary care is correlated with reduced hospital use while preserving quality (Bodenheimer, 2005, Bindham, 1995).

Summary of Changes to HEDIS 2009

- Deleted CPT codes 99301–99303, 99311–99313, 99321–99323, 99331-99333 from Table AAP-A.
- Added CPT codes 99315, 99316 to Table AAP-A.
- Consolidated rows and descriptions in Table AAP-A.
- Eligible Population – Ages: Add “and a total rate” at the end of the second sentence. Add a fourth bullet and the following sentence below the bullets “•Total. The total rate is the sum of the three numerators divided by the sum of the three denominators.”
- Data Elements for Reporting: Replace all references of “For each age stratification” with “For each age stratification and total.”

Adults’ Access to Preventive/Ambulatory Health Services (AAP) – Age 20-44 years

	2005	2006	2007	2008	2009	2009 PAC
ACC			77%	76.7%	77.3%	
DIA			72%	71.3%	75.2%	
JMS			74%	76.1%	77.2%	72.0%
MPC			77%	74.4%	79.0%	62.5%
MSFC			76%	74.8%	79.2%	
PP			77%	77.0%	79.3%	
UHC			72%	73.8%	75.7%	60.9%
MARR			75%	74.9%	77.6%	
NHM			78.2%	76.8%		

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Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 45-64 years

	2005	2006	2007	2008	2009	2009 PAC
ACC			84%	83.8%	83.9%	
DIA			76%	78.6%	78.6%	
JMS			87%	85.8%	86.9%	80.9%
MPC			85%	85.0%	87.5%	73.1%
MSFC			83%	84.1%	85.5%	
PP			87%	87.1%	87.5%	
UHC			84%	85.3%	85.6%	69.4%
MARR			84%	84.2%	85.1%	
NHM			83.1%	82.4%		

Women’s Health

Breast Cancer Screening (BCS)

Description: The percentage of women 40–69 years of age who had a mammogram to screen for breast cancer.

Rationale: Breast cancer is the second most common type of cancer among American women, with approximately 178,000 new cases reported each year. It is most common in women over 50. Women whose breast cancer is detected early have more treatment choices and better chances for survival. Mammography screening has been shown to reduce mortality by 20% to 30% among women 40 and older.

The U.S. Preventive Services Task Force, the American Academy of Family Physicians and the American College of Preventive Medicine recommend mammograms as the most effective method for detecting breast cancer when it is most treatable. When high quality equipment is used and well trained radiologists read the x-rays, 85% to 90% of cancers are detectable.

Summary of Changes to HEDIS 2009

- Removed age stratifications.
- Added HCPCS codes G0204, G0206 to Table BCS-A.
- Added UB Revenue code 0401 to Table BCS-A.
- Deleted CPT code 76083 from Table BCS-A.

Breast Cancer Screening (BCS)

	2005	2006	2007	2008	2009	2009 PAC
ACC			44%	42.0%	41.3%	
DIA			27%	32.8%	39.9%	
JMS			56%	64.3%	64.4%	44.6%
MPC			46%	45.6%	46.1%	28.8%
MSFC			49%	50.9%	57.6%	
PP			42%	42.3%	42.2%	
UHC			46%	51.4%	51.2%	23.0%
MARR			44%	47.0%	49.0%	
NHM			49.1%	50.0%		

Cervical Cancer Screening (CCS)

Description: The percentage of women 21–64 years of age who received one or more Pap tests to screen for cervical cancer.

Rationale: Cervical cancer is the second most common cancer worldwide and the third leading cause of cancer-related death. An estimated 11,000 new cases of cervical cancer will be diagnosed in 2008, resulting in more than 3,800 deaths. Most of these deaths could have been avoided with timely and effective screening and treatment. Cervical cancer is a preventable and treatable cancer, as precancerous lesions can usually be found through regular screening.

Cervical cancer can be detected in its early stages by regular screening using a Pap test. A number of organizations, including the American College of Obstetricians and Gynecologists, the American Medical Association and the American Cancer Society, recommend Pap testing every one to three years for all women who have been sexually active or who are over 21 years of age.

Summary of Changes to HEDIS 2009

- Added LOINC code 47528-5 to Table CCS-A.
- Added CPT codes 58570–58573 to Table CCS-B.
- Table CCS-A: Delete HCPCS code G0101.

Cervical Cancer Screening (CCS)

	2005	2006	2007	2008	2009	2009 PAC
ACC			71%	61.4%	67.9%	
DIA			44%	48.0%	62.7%	
JMS			78%	73.8%	78.0%	54.1%
MPC			62%	64.1%	66.3%	33.5%
MSFC			58%	64.7%	66.4%	
PP			63%	65.6%	63.0%	
UHC			61%	64.8%	66.1%	29.6%
MARR			62%	63.2%	67.2%	
NHM			65.7%	64.8%		

Chlamydia Screening in Women (CHL)

Description: The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for Chlamydia during the measurement year.

Rationale: Chlamydia trachomatis is the most common sexually transmitted disease (STD) in the United States (U.S.). The Centers for Disease Control and Prevention (CDC) estimate that approximately three million people are infected with chlamydia each year. Risk factors associated with becoming infected with chlamydia are the same as risks for contracting other STDs (e.g., multiple sex partners). Chlamydia is more prevalent among adolescent (15 to 19) and young adult (20 to 24) women. Over two million Americans 14 to 39 years of age have chlamydia. Chlamydia is called a "silent" sexually transmitted disease; three in four infected women and half of all infected men do not realize they have the infection; there are no symptoms until one to three weeks after infection occurs. Left untreated, chlamydia can cause permanent damage to a woman's fallopian tubes, uterus and surrounding tissue. Other effects of chlamydia include urethritis, cervicitis, pelvic inflammatory disease (PID), infertility, ectopic pregnancy or chronic pelvic pain. Women that are pregnant and have a chlamydial infection are at higher risk for miscarriage, a premature rupture of membranes, preterm labor, low birth weight and infant mortality. Twenty to twenty-five percent of newborns exposed to their mother's chlamydia develop chlamydial conjunctivitis.

Chlamydia screening is one of the most effective and underutilized screening services. Screening for chlamydia is essential because the majority of women who have the condition do not experience symptoms. The main objective of chlamydia screening is to prevent PID, infertility and ectopic pregnancy, all of which have very high rates of occurrence among women with untreated chlamydia infection. The specifications for this measure are consistent with current clinical guidelines, such as those of the U.S. Preventive Services Task Force.

Summary of Changes to HEDIS 2009

- Decreased upper age limit to 24 years.
- Added ICD-9-CM Diagnosis code V73.81 to Table CHL-B.
- Deleted ICD-9-CM Diagnosis code 078.10, 078.19 from Table CHL-B.
- Added LOINC codes 47527-7, 47528-5 to Table CHL-B.
- Table CHL-C: Add LOINC codes 44806-8, 44807-6, 45067-6, 45068-4, 45069-2, 45070-0, 45074-2, 45076-7, 45078-3, 45080-9, 45084-1, 45091-6, 45095-7, 45098-1, 45100-5, 47211-8, 47212-6, 49096-1, 50387-0.
- Table CHL-C: Delete LOINC codes 16602-5, 20993-2.

Chlamydia Screening in Women (CHL) – Age 16-20 years

	2005	2006	2007	2008	2009
ACC			60%	55.6%	58.3%
DIA			45%	52.2%	46.4%
JMS			69%	79.5%	81.0%
MPC			60%	57.7%	58.6%
MSFC			52%	56.6%	52.0%
PP			57%	58.0%	58.1%
UHC			49%	46.0%	50.3%
MARR			56%	58.0%	57.8%
NHM			50.5%	48.7%	

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Chlamydia Screening in Women (CHL) – Age 21-24 years

	2005	2006	2007*	2008*	2009
ACC			70%	66.0%	68.7%
DIA			57%	65.2%	56.8%
JMS			70%	70.9%	73.9%
MPC			72%	67.7%	68.2%
MSFC			56%	64.3%	63.4%
PP			67%	64.7%	63.6%
UHC			58%	55.8%	59.3%
MARR			64%	64.9%	64.8%
NHM			55.0%	54.1%	

*Rates for 2008 and the prior year were for ages 21-25.

Chlamydia Screening in Women (CHL) – Total (16-24) years

	2005	2006	2007*	2008*	2009
ACC			63%	59.2%	61.3%
DIA			51%	57.8%	50.2%
JMS			69%	76.6%	78.7%
MPC			63%	60.5%	61.1%
MSFC			53%	58.9%	55.1%
PP			60%	59.7%	59.4%
UHC			52%	48.6%	52.5%
MARR			59%	60.2%	59.8%
NHM			52.4%	50.8%	

*Rates for 2008 and the prior year were for ages 16-25.

Prenatal and Postpartum Care

Prenatal and Postpartum Care (PPC)

Description: The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care:

Timeliness of Prenatal Care: The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester *or* within 42 days of enrollment in the organization.

Postpartum Care: The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.

Rationale:

Timeliness of Prenatal Care: Preventive medicine is fundamental to prenatal care. Healthy diet, counseling, vitamin supplements, identification of maternal risk factors and health promotion all need to occur early in pregnancy to have a maximum impact on outcome. Poor outcome includes spontaneous abortion, low-birth-weight babies, large-for-gestational-age babies and neonatal infection. Early prenatal care is also an essential part of helping a pregnant woman prepare to become a mother. Ideally, a pregnant woman will have her first prenatal visit during the first trimester of pregnancy. Some women enroll in a health plan at a later stage of pregnancy; in this case, it is essential for the health plan to begin providing prenatal care as quickly as possible.

Postpartum Care: The American College of Obstetricians and Gynecologists recommends that women see their health care provider at least once between four and six weeks after giving birth. The first postpartum visit should include a physical examination and an opportunity for the health care practitioner to answer parents' questions and give family planning guidance and counseling on nutrition.

Summary of Changes to HEDIS 2009

- Deleted DRGs from Table PPC-B.
- Added LOINC codes 47527-7, 47528-5 to Table PPC-E.
- Deleted CPT codes 88144, 88145 from Table PPC-E.
- Added examples of medical record documentation that meet criteria for *notation of postpartum care*.
- Clarified that two rates are reported (Table PPC-1/2).
- Removed two data elements from Table PPC-1/2: Number of administrative and medical records excluded.
- Table PPC-C—Decision Rule 2 and Decision Rule 3: Perform the following for both Decision Rule 2 and Decision Rule 3. Add LOINC codes 47307-4, 45326-6, 47363-7, 47430-4, 49539-0, 52976-8, 52984-2 to the Cytomegalovirus row. Add LOINC codes 43180-9, 44008-1, 44480-2, 44494-3, 44507-2, 45210-2, 47230-8, 48784-3, 49848-5, 50758-2, 51915-7, 51916-5, 52977-6, 52981-8, 53377-8, 53560-9 to the Herpes simplex row. Add LOINC codes 40667-8, 43810-1, 49107-6, 50694-9, 51931-4, 52986-7 to all Rubella rows. Add LOINC codes 40697-5, 41123-1, 41124-9, 47389-2, 47390-0 to the Toxoplasma row. Delete LOINC codes 15396-5, 23484-9, 24398-0, 24399-8, 33337-7, 40676-9 from the Toxoplasma row.

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Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care

	2005	2006	2007	2008	2009
ACC	94%	94%	98%	90.9%	90.9%
DIA		68%	89%	85.0%	87.3%
JMS	83%	83%	88%	89.7%	88.4%
MPC	86%	85%	87%	84.0%	87.0%
MSFC	90%	90%	90%	90.0%	87.2%
PP	82%	82%	87%	91.1%	91.4%
UHC	87%	90%	88%	91.7%	89.7%
MARR	87%	85%	89%	88.9%	88.8%
NHM	78%	79%	81.2%	81.4%	

Prenatal and Postpartum Care (PPC) – Postpartum Care

	2005	2006	2007	2008	2009
ACC	74%	84%	85%	61.9%	64.3%
DIA		39%	52%	52.9%	52.8%
JMS	55%	51%	72%	68.2%	72.6%
MPC	61%	62%	60%	60.3%	62.1%
MSFC	64%	55%	55%	67.4%	71.9%
PP	61%	63%	63%	64.6%	63.5%
UHC	63%	61%	64%	64.3%	67.6%
MARR	63%	59%	64%	62.8%	65.0%
NHM	56%	57%	59.1%	58.7%	

Frequency of Ongoing Prenatal Care (FPC)

Description: The percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year where the mother received the following number of expected prenatal visits:

- < 21 percent of expected visits
- 21 percent–40 percent of expected visits
- 41 percent–60 percent of expected visits
- 61 percent–80 percent of expected visits
- ≥ 81 percent of expected visits

This measure uses the same denominator as the *Prenatal and Postpartum Care* measure.

Rationale This measure looks at the use of prenatal care services. It tracks Medicaid-enrolled women who had live births during the past year to determine the percentage of recommended prenatal visits they had.

Complications can arise at any time during pregnancy. For that reason, continued monitoring throughout pregnancy is necessary. Frequency and adequacy of ongoing prenatal visits are important factors in minimizing pregnancy problems.

The American College of Obstetricians and Gynecologists recommends that prenatal care begin as early as possible in the first trimester of pregnancy. Visits should follow a schedule:

- Every 4 weeks for the first 28 weeks of pregnancy
- Every 2 to 3 weeks for the next 7 weeks
- Weekly thereafter until delivery

Summary of Changes to HEDIS 2009

Removed two data elements from Table FPC-1: *Number of administrative and medical records excluded.*

Frequency of Ongoing Prenatal Care (FPC) – Less than 21% of expected visits

	2005	2006	2007	2008	2009
ACC	2%	1%	1%	1.3%	2.4%
DIA		19%	8%	6.2%	7.1%
JMS	6%	6%	4%	1.5%	2.3%
MPC	4%	4%	7%	6.2%	3.3%
MSFC	2%	4%	6%	3.2%	2.7%
PP	5%	1%	6%	3.4%	4.3%
UHC	9%	7%	5%	6.0%	4.5%
MARR	5%	6%	5%	4.0%	3.8%
NHM	19%	17%	13.5%	12.5%	

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Frequency of Ongoing Prenatal Care (FPC) – Greater than or equal to 81% of expected visits

	2005	2006	2007	2008	2009
ACC	78%	88%	87%	75.7%	74.3%
DIA		48%	61%	61.4%	62.2%
JMS	66%	79%	80%	84.6%	81.9%
MPC	70%	78%	62%	78.7%	71.6%
MSFC	70%	81%	82%	85.9%	92.1%
PP	44%	60%	70%	75.3%	76.6%
UHC	66%	75%	72%	75.3%	78.2%
MARR	66%	73%	73%	76.7%	76.7%
NHM	51%	56%	58.6%	59.3%	

Diabetes Care

Comprehensive Diabetes Care (CDC)

Description: The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:

- Hemoglobin A1c (HbA1c) testing
- HbA1c poor control (>9.0%)
- HbA1c control (<8.0%)
- Eye exam (retinal) performed
- LDL-C screening
- LDL-C control (<100 mg/dL)
- Medical attention for nephropathy
- Blood pressure control (<130/80 mm Hg)
- Blood pressure control (<140/90 mm Hg)

Rationale: Diabetes is a group of diseases characterized by high blood glucose levels caused by the body's inability to correctly produce or use the hormone insulin. It is one of the leading causes of death and disability in the U.S. More than 20 million Americans live with diabetes today. One-third of people with diabetes are not diagnosed. Much of the burden of illness and cost of diabetes treatment is attributed to potentially preventable long-term complications including heart disease, blindness, kidney disease and stroke. Timely screening and treatment can significantly reduce the disease burden.

Summary of Changes to HEDIS 2009

Eligible population for all indicators:

- Added amylin analogs category to Table CDC-A.
- Deleted CPT code 99499 from Table CDC-C.

HbA1c control (<8.0%): First-year indicator. Specifications published in the HEDIS 2009 Volume 2 Technical Update

Eye exam (retinal) performed:

- Removed the requirement that HCPCS S0625 (Table CDC-G) be billed by an optometrist or ophthalmologist.
- Added CPT codes 67041-67043, 67113 to Table CDC-G.
- Clarified the use of CPT Category II code 3072F in Table CDC-G.

LDL-C screening:

- Deleted CPT codes 83715, 83716 from Table CDC-H.

Nephropathy:

- Deleted DRGs from Tables CDC-B, CDC-K.
- Added UB Type of Bill code 72x to Table CDC-K.
- Added POS code 65 to Table CDC-K.
- Table CDC-J: Add LOINC codes 47558-2, 49023-5, 50561-0, 50949-7, 53121-0, 53525-2, 53530-2, 53531-0, 53532-8.
- Table CDC-K: Add LOINC codes 50556-0, 50561-0, 50564-4 to the Urine macroalbumin test row.

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Comprehensive Diabetes (CDC) – Hemoglobin A1c (HbA1c) Testing

	2005	2006	2007	2008	2009	2009 PAC
ACC	83%	88%	78%	73.2%	78.8%	
DIA		68%	64%	68.0%	67.8%	
JMS	84%	86%	85%	89.7%	90.7%	83.6%
MPC	81%	76%	76%	78.4%	74.2%	77.4%
MSFC	79%	83%	84%	87.7%	85.1%	
PP	77%	85%	82%	78.3%	77.7%	
UHC	75%	72%	74%	74.7%	71.0%	64.4%
MARR	80%	80%	78%	78.6%	77.9%	
NHM	75%	76%	78.0%	77.4%		

Comprehensive Diabetes (CDC) – HbA1c Poor Control (>9.0%) *

	2005	2006	2007	2008	2009	2009 PAC
ACC	44%	34%	45%	52.5%	49.6%	
DIA		52%	50%	52.6%	52.1%	
JMS	38%	39%	38%	32.6%	30.3%	39.0%
MPC	51%	53%	61%	55.5%	57.9%	51.4%
MSFC	43%	40%	35%	38.2%	33.8%	
PP	52%	39%	47%	38.7%	47.3%	
UHC	42%	43%	46%	50.9%	56.4%	83.3%
MARR	45%	43%	46%	45.9%	46.8%	
NHM	50%	49%	48.7%	47.7%		

* A lower rate indicates better performance.

Comprehensive Diabetes (CDC) – HbA1c Control (< 8.0%)*

	2005	2006	2007	2008	2009	2009 PAC
ACC					43.6%	
DIA					42.1%	
JMS					57.8%	49.2%
MPC					36.4%	38.6%
MSFC					54.6%	
PP					45.8%	
UHC					37.2%	13.1%
MARR					45.4%	
NHM*						

* This is a first-year measure. There is no NHM from HEDIS 2008 reporting.

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Comprehensive Diabetes (CDC) – Eye Exam (Retinal) Performed

	2005	2006	2007	2008	2009	2009 PAC
ACC	50%	76%	73%	57.5%	50.1%	
DIA		10%	43%	43.3%	52.1%	
JMS	62%	74%	72%	75.3%	77.2%	48.0%
MPC	41%	50%	54%	54.4%	65.8%	31.9%
MSFC	39%	66%	63%	66.2%	72.2%	
PP	40%	52%	55%	63.3%	54.6%	
UHC	50%	55%	57%	58.2%	65.9%	25.6%
MARR	47%	55%	59%	59.7%	62.6%	
NHM	44%	47%	51.4%	50.1%		

Comprehensive Diabetes (CDC) – LDL-C Screening

	2005	2006	2007	2008	2009	2009 PAC
ACC			73%	72.7%	74.5%	
DIA			57%	64.9%	66.9%	
JMS			84%	90.3%	93.3%	88.7%
MPC			76%	72.7%	73.9%	70.9%
MSFC			80%	82.8%	81.7%	
PP			72%	73.7%	73.9%	
UHC			74%	71.8%	71.5%	59.5%
MARR			74%	75.6%	76.5%	
NHM			71.1%	70.9%		

Comprehensive Diabetes (CDC) – LDL-C Control (<100 mg/dL)

	2005	2006	2007	2008	2009	2009 PAC
ACC			37%	33.5%	34.9%	
DIA			20%	27.8%	28.1%	
JMS			53%	48.2%	47.2%	42.7%
MPC			27%	28.6%	28.9%	31.2%
MSFC			43%	42.3%	43.8%	
PP			38%	37.5%	42.5%	
UHC			36%	30.2%	29.2%	10.4%
MARR			36%	35.4%	36.4%	
NHM			30.6%	31.4%		

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Comprehensive Diabetes (CDC) – Medical Attention for Nephropathy

	2005	2006	2007	2008	2009	2009 PAC
ACC			83%	80.3%	78.8%	
DIA			63%	75.3%	75.2%	
JMS			91%	95.9%	93.3%	86.5%
MPC			79%	74.8%	75.8%	82.8%
MSFC			85%	87.4%	86.6%	
PP			77%	83.9%	78.3%	
UHC			75%	77.6%	73.7%	70.1%
MARR			79%	82.2%	80.2%	
NHM			74.6%	74.4%		

Comprehensive Diabetes (CDC) – Blood Pressure Control (<130/90 mm Hg)

	2005	2006	2007	2008	2009	2009 PAC*
ACC			26%	31.1%	27.2%	
DIA			16%	25.8%	25.6%	
JMS			29%	25.9%	23.6%	NR*
MPC			26%	25.8%	25.6%	21.2%
MSFC			36%	31.0%	36.3%	
PP			45%	35.8%	33.6%	
UHC			26%	26.0%	28.2%	0.0%*
MARR			29%	28.8%	28.6%	
NHM			30.4%	29.6%		

*calculated administratively; no administrative data

Comprehensive Diabetes (CDC) – Blood Pressure Control (<140/90 mm Hg)

	2005	2006	2007	2008	2009	2009 PAC
ACC			56%	56.8%	54.7%	
DIA			41%	40.2%	45.5%	
JMS			53%	52.1%	47.2%	NR*
MPC			45%	49.2%	51.2%	45.3%
MSFC			61%	63.3%	65.7%	
PP			66%	65.2%	58.8%	
UHC			50%	55.7%	55.7%	0.0%*
MARR			53%	54.6%	54.1%	
NHM			30.4%	55.5%		

*calculated administratively; no administrative data

Ambulatory Care (utilization)

Ambulatory Care (AMB)

Description: This measure summarizes utilization of ambulatory care in the following categories:

- Outpatient Visits
- ED Visits
- Ambulatory Surgery/Procedures
- Observation Room Stays

Rationale: Outpatient visits include office visits or routine visits to hospital outpatient departments. Emergency rooms often deliver nonemergency care. An organization that promotes effective ambulatory treatment of patients should be able to keep the number of emergency room visits relatively low. Looking at inpatient surgery and ambulatory surgery together can help assess how much outpatient surgery is performed.

Summary of Changes to HEDIS 2009

- Deleted redundant wording from the measure specification; the language edits are not intended to change the intent of the measure specification.
- Deleted CPT codes 99301–99303, 99311–99313, 99321–99323, 99331–99333, 99354, 99355, 99499 from Table AMB-A.
- Added CPT codes 99304–99310, 99315, 99316, 99318, 99324–99328, 99334–99337 to Table AMB-A.
- Consolidated rows and descriptions in Table AMB-A.
- Deleted CPT codes 93534-93536 from Table AMB-C.
- Converted exclusion criteria into table format.

Ambulatory Care (AMB) – Outpatient Visits

	2005	2006	2007	2008	2009
ACC					374.0
DIA					330.5
JMS					364.2
MPC					375.2
MSFC					380.0
PP					382.2
UHC					365.1
MARR					367.3
NHM					

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Ambulatory Care (AMB) – Emergency Department

	2005	2006	2007	2008	2009
ACC					60.3
DIA					88.0
JMS					78.8
MPC					71.8
MSFC					76.6
PP					62.4
UHC					59.3
MARR					71.0
NHM					

Ambulatory Care (AMB) – Ambulatory Surgery

	2005	2006	2007	2008	2009
ACC					6.5
DIA					13.5
JMS					14.0
MPC					9.0
MSFC					13.3
PP					10.8
UHC					9.1
MARR					10.9
NHM					

Ambulatory Care (AMB) – Observation Room Stays

	2005	2006	2007	2008	2009
ACC					2.0
DIA					1.8
JMS					2.4
MPC					1.5
MSFC					0.3
PP					3.7
UHC					1.4
MARR					1.9
NHM					

Call Services

Call Answer Timeliness (CAT)

Rationale: Health care providers, organization members, and purchasers increasingly recognize the importance of customer service as a factor in patient satisfaction. The collected data will provide opportunities for organization comparisons, as well as quality improvement initiatives.

Description: The percentage of calls received by the organization's Member Services call centers (during operating hours) during the measurement year that were answered by a live voice within 30 seconds.

Summary of Changes to HEDIS 2009

- Clarified reporting of calls that are sent directly to voicemail.

Call Answer Timeliness (CAT)

	2005	2006	2007	2008	2009
ACC		47%	67%	52.0%	75.8%
DIA		87%	90%	85.7%	91.4%
JMS		NR	85%	86.0%	89.9%
MPC		75%	76%	74.5%	82.7%
MSFC		58%	86%	84.2%	94.3%
PP		NR*	NR*	NR*	68.2%
UHC		74%	60%	89.1%	81.5%
MARR		68%	77%	78.6%	83.4%
NHM		74%	74.4%	79.4%	

*This organization was unable to report the Call Answer Timeliness measure for HEDIS 2008 because its call system was not able to track calls answered within 30 seconds until August 2007.

Call Abandonment (CAB)

Rationale: See Call Answer Timeliness

Description: The percentage of calls received by the organization’s Member Services call centers (during operating hours) during the measurement year that were abandoned by the caller before being answered by a live voice. Lower rates represent better performance.

Summary of Changes to HEDIS 2009

Clarified reporting of calls that are sent directly to voicemail.

Call Abandonment (CAB)*

	2005	2006	2007	2008	2009
ACC		16%	10%	9.3%	3.6%
DIA		1%	1%	1.1%	0.8%
JMS		NR	14%	3.9%	3.3%
MPC		4%	3%	2.9%	2.0%
MSFC		5%	2%	2.2%	1.6%
PP		9%	NR	5.0%	4.2%
UHC		3%	8%	1.2%	3.1%
MARR		6%	6%	3.7%	2.7%
NHM		5%	5.8%	5.5%	

* A lower rate indicates better performance.

VI. HealthChoice and Primary Adult Care HEDIS 2009 Results

General Observations

HEDIS is a widely used and respected set of standardized quality indicators. But as with any measurement tool, it is important to understand proper uses and limitations. HEDIS results can be used as markers of care, but cannot be used, on their own, to draw conclusions about the quality of care. A comparison among organizations on the basis of HEDIS rates, alone, would not take into account population differences, such as age, health status, or catchment area (urban vs. rural). For example: Maryland Medicaid organizations are dissimilar in location served; two organizations operate statewide, four are regional, and one operates in Baltimore City and parts of Baltimore County. The effect of these geographic locations on HEDIS rates is unknown.

Trends in rates can indicate genuine improvement or could indicate something else, e.g., familiarity with HEDIS reporting or improved data systems. A decrease in rates could indicate care issues but also could indicate something else, e.g., population factors or subtle changes in specifications.

For HealthChoice organizations, there has been some “flattening of rates” across many HEDIS measures as reporting matures. However, there is also room for improvement by many of the HealthChoice organizations, particularly where the organization’s score does not at least meet or exceed the NHM. Measures where this occurs are: URI, CAP, BCS, CCS, CDC, CAB, and CAT.

Some changes in the 2009 MARR performance scores that deserve special attention are mentioned below:

Well-Child Visits in the First 15 months of Life (W15) – DHMH Five plus six-or-more visits rates (additive): The MARR increased from 82.1 to 83.2 largely attributable to marked increases in the scores by DIA (70.7 to 77.1) and PP (81.3 to 86.4).

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34): The MARR decreased from 77.1 to 76.8 largely attributable to decreases noted by ACC, MPC, PP, and UHC.

Adolescent Well-Care Visits (AWC): The MARR increased from 52.9 to 54.7 largely attributable to marked increases in the scores by ACC (50.3 to 54.1), DIA (44.6 to 49.7), JMS (73.3 to 76.1), and MSFC (45.7 to 52.8). The MARR would have increased more except for decreases noted in UHC and MPC.

Appropriate Testing for Children with Pharyngitis (CWP): The MARR had a marked increase from 66.0 to 71.4 largely attributable to significant increases posted by DIA (47.9 to 69.4) and JMS (50.0 to 67.3).

Use of Appropriate Medications for People with Asthma (ASM) – Age 18-56 years: The MARR increased from 86.4 to 89.2 largely attributable to significant increases recorded by MSFC (85.1 to 92.9) and PP (78.7 to 88.8).

Prenatal and Postpartum Care (PPC) – Postpartum Care: The MARR increased from 62.8 to 65.0 largely attributable to increases in the measure by ACC (61.9 to 64.3), JMS (68.2 to 72.6), MSFC (67.4 to 71.9), and UHC (64.3 to 67.6).

Comprehensive Diabetes (CDC) – Eye Exam (Retinal) Performed: The MARR increased from 59.7 to 62.6 largely attributable to increases recorded by DIA (43.3 to 52.1), MPC (54.4 to 65.8), MSFC (66.2 to 72.2), and UHC (58.2 to 65.9). A higher increase in the MARR would have occurred except for decreases recorded by ACC and PP.

Future considerations and recommendations

The HEDIS 2009 audits continued to reflect a period of stability and continuity in terms of measures being reported. DHMH moved the Ambulatory Care measure to a public-reporting status after allowing two years for organizations to examine processes and identify any data issues. For 2009, two new administrative-only measures (IET and IAD) were added as testing measures. (Public reporting may be a consideration for the future.) Also new this year was the reporting of a limited set of HEDIS measures by three PAC organizations. (Please see the table, HEDIS Measures Reporting History in Section III for a measure-specific reporting history.)

Given what has been learned about HEDIS reporting within the Maryland Medicaid community, the following recommendations are provided:

- There are a number of reasons why organizations may want to explore expanded HEDIS reporting. Organizations should remain proactive in anticipating DHMH decisions to expand the set of required measures. Organizations seeking NCQA accreditation and have already increased the number of reported measures to match the set required for accreditation. With all organizations now contracting with an NCQA-certified software vendor, production of additional HEDIS measures can readily be achieved. These results can be highly useful for internal quality purposes, as well as for an expanded familiarity with HEDIS reporting. Organizations will have a good tool to determine where data anomalies or clinical/service issues are present.
- Internal and external drivers to promote improvement in HEDIS scores should be recognized and encouraged. As the HEDIS reporting has matured and organizations have become very familiar with the HEDIS reporting processes, they have been able to concentrate on the improvement of performance scores through clinical and service interventions, as well as through analyses of provider coding. The implementation of the DHMH Valued Based Purchasing initiative has serviced as an external factor encouraging a proactive approach to performance improvement among all organizations.
- It is recommended that all organizations continue to look at opportunities to enhance administrative scores in order to reduce medical record review burdens as well as to ensure that administrative rates reflect total service provision. All organizations used some type of administrative database to supplement existing clinical data, to varying degrees. Organizations should plan ahead to seek HEDIS auditor approval of supplemental databases by conferring with the auditor at the inception of any database development to ensure data is captured and can be validated according to HEDIS audit protocol.
- Publication of PAC performance scores may motivate all PAC organizations to allocate sufficient resources to use the hybrid method for HEDIS 2010. (Please refer the table in Section I., HEDIS Methodology, showing organization-specific use of the administrative or hybrid method, by measure.) HEDIS performance scores for PAC organizations fell below scores for the HealthChoice product at the same organization. For the CCS and CDC measure, this is primarily attributable to nonuse of the hybrid method.

HEDIS 2009 Reported Rates

The HealthChoice HEDIS 2009 results are displayed in Table A for the seven HealthChoice organizations. The table presents the audited results for each measure for the current and past two years and includes:

- ❖ Names of organizations submitting reportable results
- ❖ Maryland Average Reportable Rate (MARR) for all Maryland HealthChoice organizations that provided audited and reportable data
- National HEDIS Mean (NHM)

For a five-year history and for information concerning any specification changes over that period of time, please see the measure-specific findings in Section III of this report.

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Table A – HealthChoice Organization HEDIS® 2009 Measures – Reported Rates

	ACC 2007	ACC 2008	ACC 2009	DIA 2007	DIA 2008	DIA 2009	JMS 2007	JMS 2008	JMS 2009	MPC 2007	MPC 2008	MPC 2009	MSFC 2007	MSFC 2008	MSFC 2009	PP 2007	PP 2008	PP 2009	UHC 2007	UHC 2008	UHC 2009	MARR 2009	NHM 2008
Children's Prevention and Screening																							
Childhood Immunization Status (CIS) – Combination 2 (DtaP/DT, IPV, MMR, HIB, Hepatitis B, VZV)	88%	89.8%	82.1%	74%	68.1%	73.0%	75%	85.0%	87.1%	71%	72.2%	74.7%	81%	84.7%	89.2%	82%	86.5%	82.1%	73%	78.0%	84.8%	81.9%	72.3%
Childhood Immunization Status (CIS) – Combination 3 (DtaP/DT, IPV, MMR, HIB, Hepatitis B, VZV, pneumococcal conjugate)	75%	81.0%	74.6%	66%	59.9%	69.4%	74%	82.7%	80.6%	62%	67.8%	70.1%	69%	78.1%	87.8%	72%	77.4%	77.4%	60%	72.2%	78.7%	76.9%	65.6%
Well Child Visits in the First 15 months of Life (W15) – Zero visits *	1%	1.1%	2.4%	7%	3.1%	2.6%	3%	5.3%	2.6%	1%	1.1%	0.7%	2%	1.8%	1.1%	1%	0.7%	1.5%	2%	1.7%	1.8%	1.8%	5.6%
Well Child Visits in the First 15 months of Life (W15) – DHMH Five plus six-or-more visits rates (additive)	97%	85.4%	83.0%	71%	70.7%	77.1%	94%	82.0%	81.8%	83%	87.1%	87.3%	78%	82.3%	81.0%	86%	81.3%	86.4%	87%	86.2%	86.0%	83.2%	70.2%
Well Child Visits in the Third, Fourth, Fifth and Sixth Year of Life (W34)	80%	77.5%	74.2%	69%	66.4%	70.0%	88%	89.1%	89.9%	76%	79.1%	73.1%	74%	74.1%	79.4%	73%	77.4%	75.3%	80%	76.3%	75.4%	76.8%	65.3%
Adolescent Well Care Visits (AWC)	57%	50.3%	54.1%	50%	44.6%	49.7%	76%	73.3%	76.1%	60%	51.3%	49.5%	59%	45.7%	52.8%	54%	52.6%	53.4%	59%	52.5%	47.3%	54.7%	42.0%
Respiratory Conditions																							
Appropriate Testing for Children with Pharyngitis (CWP)	68%	67.8%	66.4%	54%	47.9%	69.4%	73%	50.0%	67.3%	71%	74.8%	75.6%	54%	75.8%	78.9%	76%	78.2%	72.0%	65%	67.4%	69.8%	71.4%	58.2%
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	86%	87.1%	85.0%	87%	82.9%	82.9%	82%	87.3%	95.5%	83%	85.1%	84.0%	85%	86.2%	86.3%	94%	96.6%	84.4%	79%	80.6%	80.6%	85.5%	84.1%
Use of Appropriate Medications for People with Asthma (ASM) – Age 5-9 years	88%	91.7%	90.0%	NA	NA	NA	NA	NA	NA	91%	90.5%	91.5%	92%	91.5%	94.0%	89%	87.8%	91.9%	92%	92.0%	91.8%	91.8%	89.3%
Use of Appropriate Medications for People with Asthma (ASM) – Age 10-17 years	89%	88.4%	88.7%	NA	NA	NA	77%	83.3%	72.5%	89%	89.0%	88.7%	90%	92.0%	93.4%	88%	85.2%	88.2%	89%	90.3%	89.8%	86.9%	86.9%
Use of Appropriate Medications for People with Asthma (ASM) – Age 18-56 years	87%	87.9%	86.0%	NA	NA	92.3%	85%	94.0%	91.7%	85%	86.5%	84.0%	92%	85.1%	92.9%	76%	78.7%	88.8%	86%	86.0%	88.6%	89.2%	84.5%
Use of Appropriate Medications for People with Asthma (ASM) – Total Rate	88%	89.6%	88.6%	NA	NA	91.6%	83%	91.6%	87.3%	88%	88.7%	87.9%	91%	89.5%	93.4%	86%	85.0%	89.5%	89%	89.6%	90.1%	89.8%	86.9%
Member Access																							
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 12-24 months	97%	96.7%	97.4%	90%	92.2%	91.8%	91%	91.7%	88.3%	96%	96.5%	96.6%	97%	96.9%	96.8%	95%	94.2%	97.8%	95%	95.8%	96.3%	95.0%	93.4%
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 25 months to 6 years	91%	91.1%	91.7%	82%	82.9%	85.5%	89%	88.4%	89.5%	91%	90.0%	91.1%	89%	89.8%	91.6%	85%	86.5%	91.7%	89%	90.8%	92.2%	90.4%	84.3%
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 7-11 years	92%	92.3%	92.6%	81%	82.7%	84.6%	90%	89.3%	93.7%	92%	91.2%	91.6%	92%	92.2%	92.2%	87%	88.0%	92.9%	90%	92.1%	92.2%	91.4%	85.8%
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 12-19 years	89%	88.4%	87.3%	80%	84.9%	81.0%	92%	92.8%	91.9%	88%	89.2%	88.4%	89%	90.0%	88.7%	83%	84.0%	89.0%	86%	88.6%	87.6%	87.7%	82.6%

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HEALTHCHOICE ORGANIZATION HEDIS 2009 MEASURES – REPORTED RATES																							
	ACC 2007	ACC 2008	ACC 2009	DIA 2007	DIA 2008	DIA 2009	JMS 2007	JMS 2008	JMS 2009	MPC 2007	MPC 2008	MPC 2009	MSFC 2007	MSFC 2008	MSFC 2009	PP 2007	PP 2008	PP 2009	UHC 2007	UHC 2008	OHC 2009	MARR 2009	NHM 2008
Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 20-44	77%	76.7%	77.3%	72%	71.3%	75.2%	74%	76.1%	77.2%	77%	74.4%	79.0%	76%	74.8%	79.2%	77%	77.0%	79.3%	72%	73.8%	75.7%	77.6%	76.8%
Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 45-64	84%	83.8%	83.9%	76%	78.6%	78.6%	87%	85.8%	86.9%	85%	85.0%	87.5%	83%	84.1%	85.5%	87%	87.1%	87.5%	84%	85.3%	85.6%	85.1%	82.4%
Women's Health																							
Breast Cancer Screening (BCS)	44%	42.0%	41.3%	27%	32.8%	39.9%	56%	64.3%	64.4%	46%	45.6%	46.1%	49%	50.9%	57.6%	42%	42.3%	42.2%	46%	51.4%	51.2%	49.0%	50.0%
Cervical Cancer Screening (CCS)	71%	61.4%	67.9%	44%	48.0%	62.7%	78%	73.8%	78.0%	62%	64.1%	66.3%	58%	64.7%	66.4%	63%	65.6%	63.0%	61%	64.8%	66.1%	67.2%	64.8%
Chlamydia Screening in Women (CHL) – Age 16-20 years	60%	55.6%	58.3%	45%	52.2%	46.4%	69%	79.5%	81.0%	60%	57.7%	58.6%	52%	56.6%	52.0%	57%	58.0%	58.1%	49%	46.0%	50.3%	57.8%	48.7%
Chlamydia Screening in Women (CHL) – Age 21-24 years (Note: Rates for 2008 and prior year were for ages 21-25.)	70%	66.0%	68.7%	57%	65.2%	56.8%	70%	70.9%	73.9%	72%	67.7%	68.2%	56%	64.3%	63.4%	67%	64.7%	63.6%	58%	55.8%	59.3%	64.8%	54.1%
Chlamydia Screening in Women (CHL) – Total, 16-24 years of age (Note: Rates for 2008 and prior year were for ages 16-25.)	63%	59.2%	61.3%	51%	57.8%	50.2%	69%	76.6%	78.7%	63%	60.5%	61.1%	53%	58.9%	55.1%	60%	59.7%	59.4%	52%	48.6%	52.5%	59.8%	50.8%
Prenatal and Postpartum Care																							
Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care	98%	90.9%	90.9%	89%	85.0%	87.3%	88%	89.7%	88.4%	87%	84.0%	87.0%	90%	90.0%	87.2%	87%	91.1%	91.4%	88%	91.7%	89.7%	88.8%	81.4%
Prenatal and Postpartum Care (PPC) – Postpartum Care	85%	61.9%	64.3%	52%	52.9%	52.8%	72%	68.2%	72.6%	60%	60.3%	62.1%	55%	67.4%	71.9%	63%	64.6%	63.5%	64%	64.3%	67.6%	65.0%	58.7%
Frequency of Ongoing Prenatal Care (FPC) – Less than 21% of expected visits*	1%	1.3%	2.4%	8%	6.2%	7.1%	4%	1.5%	2.3%	7%	6.2%	3.3%	6%	3.2%	2.7%	6%	3.4%	4.3%	5%	6.0%	4.5%	3.8%	12.5%
Frequency of Ongoing Prenatal Care (FPC) – Greater than or equal to 81% of expected visits	87%	75.7%	74.3%	61%	61.4%	62.2%	80%	84.6%	81.9%	62%	78.7%	71.6%	82%	85.9%	92.1%	70%	75.3%	76.6%	72%	75.3%	78.2%	76.7%	59.3%
Diabetes Care																							
Comprehensive Diabetes (CDC) – Hemoglobin A1c Testing	78%	73.2%	78.8%	64%	68.0%	67.8%	85%	89.7%	90.7%	76%	78.4%	74.2%	84%	87.7%	85.1%	82%	78.3%	77.7%	74%	74.7%	71.0%	77.9%	77.4%
Comprehensive Diabetes (CDC) – HbA1c Poor Control (>9.0%) *	45%	52.5%	49.6%	50%	52.6%	52.1%	38%	32.6%	30.3%	61%	55.5%	57.9%	35%	38.2%	33.8%	47%	38.7%	47.3%	46%	50.9%	56.4%	46.8%	47.7%
Comprehensive Diabetes (CDC) – Eye Exam (Retinal) Performed	73%	57.5%	50.1%	43%	43.3%	52.1%	72%	75.3%	77.2%	54%	54.4%	65.8%	63%	66.2%	72.2%	55%	63.3%	54.6%	57%	58.2%	65.9%	62.6%	50.1%

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HEALTHCHOICE ORGANIZATION HEDIS 2009 MEASURES – REPORTED RATES																							
	ACC 2007	ACC 2008	ACC 2009	DIA 2007	DIA 2008	DIA 2009	JMS 2007	JMS 2008	JMS 2009	MPC 2007	MPC 2008	MPC 2009	MSFC 2007	MSFC 2008	MSFC 2009	PP 2007	PP 2008	PP 2009	UHC 2007	UHC 2008	UHC 2009	MARR 2009	NHM 2008
Comprehensive Diabetes (CDC) – LDL-C Screening	73%	72.7%	74.5%	57%	64.9%	66.9%	84%	90.3%	93.3%	76%	72.7%	73.9%	80%	82.8%	81.7%	72%	73.7%	73.9%	74%	71.8%	71.5%	76.5%	70.9%
Comprehensive Diabetes (CDC) – LDL-C Control (<100 mg/dL)	37%	33.5%	34.9%	20%	27.8%	28.1%	53%	48.2%	47.2%	27%	28.6%	28.9%	43%	42.3%	43.8%	38%	37.5%	42.5%	36%	30.2%	29.2%	36.4%	31.4%
Comprehensive Diabetes (CDC) – Medical Attention for Nephropathy	83%	80.3%	78.8%	63%	75.3%	75.2%	91%	95.9%	93.3%	79%	74.8%	75.8%	85%	87.4%	86.6%	77%	83.9%	78.3%	75%	77.6%	73.7%	80.2%	74.4%
Comprehensive Diabetes (CDC) – Blood Pressure Control (<130/90 mm Hg)	26%	31.1%	27.2%	16%	25.8%	25.6%	29%	25.9%	23.6%	26%	25.8%	25.6%	36%	31.0%	36.3%	45%	35.8%	33.6%	26%	26.0%	28.2%	28.6%	29.6%
Comprehensive Diabetes (CDC) – Blood Pressure Control (<140/90 mm Hg)	56%	56.8%	54.7%	41%	40.2%	45.5%	53%	52.1%	47.2%	45%	49.2%	51.2%	61%	63.3%	65.7%	66%	65.2%	58.8%	50%	55.7%	55.7%	54.1%	55.5%
Ambulatory Care (Utilization)																							
Ambulatory Care (AMB) – Outpatient Visits			374.0			330.5			364.2			375.2			380.0			382.2			365.1	367.3	317.8
Ambulatory Care (AMB) – Emergency Department			60.3			88.0			78.8			71.8			76.6			62.4			59.3	71.0	60.9
Ambulatory Care (AMB) – Ambulatory Surgery			6.5			13.5			14.0			9.0			13.3			10.8			9.1	10.9	5.5
Ambulatory Care (AMB) – Observation Room Stays			2.0			1.8			2.4			1.5			0.3			3.7			1.4	1.9	2.0
Call Services																							
Call Answer Timeliness (CAT)	67%	52.0%	75.8%	90%	85.7%	91.4%	85%	86.0%	89.9%	76%	74.5%	82.7%	86%	84.2%	94.3%	NR	NR	68.2%	60%	89.1%	81.5%	83.4%	79.4%
Call Abandonment (CAB) *	10%	9.3%	3.6%	1%	1.1%	0.8%	14%	3.9%	3.3%	3%	2.9%	2.0%	2%	2.2%	1.6%	NR	5.0%	4.2%	8%	1.2%	3.1%	2.7%	5.5%

* A lower rate indicates better performance.

ACC = AMERIGROUP Community Care
DIA = Diamond Plan Coventry Health Care of Delaware
JMS = Jai Medical Systems, Inc.
MSFC = MedStar Family Choice, Inc.
MPC = Maryland Physicians Care
PP = Priority Partners

MARR = Maryland Average Reportable Rate
NHM = National HEDIS Mean