

# **Quality of Care: Health and Dental Plan Performance Measures**

**Health Plan Contract Year 2008-2009**

**Prepared for the  
Florida Healthy Kids Corporation**

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## Executive Summary

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The purpose of this report is to summarize at the plan level Florida Healthy Kids Program (FHKP) enrollees' quality of care during health plan contract year 2008-2009, which covers the period October 1, 2008 through September 30, 2009. As part of the contracts effective October 1, 2008, health plans were required to adhere to more stringent claims and encounter data reporting requirements to the Institute for Child Health Policy. As this measurement period was the first year that the quality measures were run under these new reporting requirements, the results in this report should be considered baseline measures against which future results are compared to evaluate performance improvement over time.

Quality of care was assessed using Healthcare Effectiveness Data and Information Set (HEDIS<sup>®</sup>) measures, using National Committee for Quality Assurance (NCQA) certified software. Many of these measures also were included in the *CHIPRA Initial, Recommended Core Set of Children's Healthcare Quality Measures for Voluntary Use by Medicaid and CHIP Programs (CHIPRA Recommended Quality Measures)*. Because there is only one HEDIS<sup>®</sup> measure for dental care, two additional dental measures in the *CHIPRA Recommended Quality Measures* were also calculated.

### Performance Summary

The Florida Healthy Kids Program performed above the national Medicaid HEDIS<sup>®</sup> average by more than five percentage points for the following quality measures:

- Children and Adolescents' Access to Primary Care Practitioners
- Adolescent Well-Care Visits
- Follow-Up Care for Children Prescribed ADHD Medication
- 30-Day Follow-Up after Hospitalization for Mental Illness

However, three of the above measures (all except for Follow-Up Care for Children Prescribed ADHD Medication) require validation of the provider specialty against the type of service rendered before a beneficiary can be considered eligible for inclusion. Due to insufficient data about provider specialty in the claims data submitted, the ICHP modified the NCQA specifications to lift these provider constraints when determining eligibility; therefore, the reported rates on these measures are inflated.

The Florida Healthy Kids Program was within five percentage points of the national Medicaid HEDIS<sup>®</sup> average for the following quality measures:

- Appropriate testing for Children with Pharyngitis
- Appropriate testing for Children with Upper Respiratory Infection
- 7-Day Follow-Up after Hospitalization for Mental Illness
- Annual Dental Visit

The Florida Healthy Kids Program performed below the national Medicaid HEDIS<sup>®</sup> average by more than five percentage points for the following quality measures:

- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Well-Child Visits in the 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup>, and 6<sup>th</sup> Years of Life
- Chlamydia Screening in Women 16-20 Years

### Recommendations

- Two of the three measures for which performance was below the national Medicaid HEDIS<sup>®</sup> average, Chlamydia Screening in Women 16-20 Years and Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, rely on claims data that is often submitted by vendors or delegated entities to the health plans (e.g., pharmacy, laboratory, and behavioral health). It is possible that some of the performance gap is due to the quality of the data submitted. Therefore, the health plans should ensure that they are receiving complete and accurate data from their delegated entities.

- At the program level, the FHKP should work with the health plans and the ICHP to identify performance improvement initiatives that target areas of low or marginal performance at the program level.
- At the plan level, measures for which a plan performed more than two standard deviations below the FHKP mean or below the 25<sup>th</sup> percentile of the national Medicaid mean should be considered for performance improvement initiatives.

### Summary

For most of the quality measures, the FHKP performed at or above the national Medicaid mean. However, there are performance gaps both at the program level and at the plan level that can be targeted for performance improvement initiatives. This report provides baseline data for tracking the effectiveness of quality improvement efforts.

## 1. Introduction

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The Children's Health Insurance Program Reauthorization Act (CHIPRA) places increased emphasis on measuring and monitoring the quality of care in states' Children's Health Insurance Programs (CHIP). The quality indicator most frequently used by Medicaid and CHIP programs are the Healthcare Effectiveness Data and Information Set (HEDIS<sup>®</sup>) measures.<sup>1</sup> The HEDIS<sup>®</sup> measurement system is a set of standardized health plan performance measures produced by the National Committee for Quality Assurance (NCQA) and used to evaluate important dimensions of health care. HEDIS<sup>®</sup> measures were featured prominently in the *CHIPRA Initial, Recommended Core Set of Children's Healthcare Quality Measures for Voluntary Use by Medicaid and CHIP Programs (CHIPRA Recommended Quality Measures)*.<sup>2</sup>

The purpose of this report is to summarize at the plan level Florida Healthy Kids Program (FHKP) enrollees' quality of care during health plan contract year 2008-2009. Quality of care was assessed using HEDIS<sup>®</sup> measures that can be reliably calculated from administrative data, using NCQA-certified software. Dental plan quality measures also were included for the same time period. There is only one HEDIS<sup>®</sup> measure for dental care; therefore, two additional measures in the *CHIPRA Recommended Quality Measures* were calculated.

The following quality of care measures were included; measures that were included in the *CHIPRA Recommended Quality Measures* are indicated by an asterisk(\*).

- 1) Descriptive Information
  - Health Plan Enrollment, Total Unduplicated Members
- 2) Health Plan Quality of Care Measures
  - A. Access/Availability of Care:
    - HEDIS<sup>®</sup> Children and Adolescents' Access to Primary Care Practitioners\*
    - HEDIS<sup>®</sup> Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
    - HEDIS<sup>®</sup> Prenatal and Postpartum Care\*
  - B. Use of Services
    - HEDIS<sup>®</sup> Frequency of Ongoing Prenatal Care\*
    - HEDIS<sup>®</sup> Well-Child Visits in the 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup>, and 6<sup>th</sup> Years of Life\*
    - HEDIS<sup>®</sup> Adolescent Well-Care Visits\*
  - C. Effectiveness of Care – Prevention and Screening
    - HEDIS<sup>®</sup> Chlamydia Screening in Women\*
  - D. Effectiveness of Care – Respiratory Conditions
    - HEDIS<sup>®</sup> Appropriate Testing for Children with Pharyngitis\*
    - HEDIS<sup>®</sup> Appropriate Treatment for Children with Upper Respiratory Infection (URI)
    - HEDIS<sup>®</sup> Use of Appropriate Medications for People with Asthma
  - E. Effectiveness of Care - Behavioral Health
    - HEDIS<sup>®</sup> Follow-Up Care for Children Prescribed ADHD Medication\*
    - HEDIS<sup>®</sup> Follow-Up after Hospitalization for Mental Illness\*
- 3) Dental Plan Quality of Care Measures
  - HEDIS<sup>®</sup> Annual Dental Visit
  - Unduplicated Children Receiving Dental Preventive Services\*
  - Unduplicated Children Receiving Dental Treatment Services\*

This report provides results for the quality indicators for the program overall and by health or dental plan. Comparisons to other KidCare programs and to national data also are provided.

## 2. Data Sources and Measures

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### Data Sources

Three data sources were used to calculate the quality of care indicators: (1) child-level enrollment information, (2) child-level health care claims and encounter data, and (3) child-level pharmacy data. The enrollment files contain information about the child's age, the plan in which the child is enrolled, and the number of months the child has been enrolled. The person-level claims and encounter data contain Current Procedural Terminology (CPT) codes, International Classification of Diseases, 9th Revision (ICD-9-CM) codes, place of service (POS) codes, and other information necessary to calculate the quality of care indicators. The child-level pharmacy data contain information about filled prescriptions, including the drug name, dose, date filled, and refill information. The measurement period was health plan contract year 2008-2009, covering the period October 1, 2008 through September 30, 2009. A 6-month time lag was used for the claims and encounter data, which provides a sufficient lag period for claims submission and processing.

### Plans Included

Total Health Choice, which accounted for <1% of all FHKP enrollees, was excluded from the calculation of the HEDIS<sup>®</sup> measures due to lack of claims data during the measurement period. Reporting was combined for the two Blue Cross and Blue Shield of Florida (BCBS) products, Health Options and Blue Options, because of errors in the enrollment database that misclassified some enrollees into the wrong BCBS plan during the measurement period. Thus, HEDIS<sup>®</sup> measures are reported for the following plans: Amerigroup, Blue Cross and Blue Shield of Florida (both Health Options and Blue Options), Florida Health Care Plans, HealthEase, Staywell, Vista, and United Healthcare.

Dental plan quality measures were included for Atlantic Dental Inc. (ADI), CompBenefits, and MCNA Dental Plans. United Healthcare Dental was excluded from the dental plan measures because it began serving the FHKP on July 1, 2009 and, therefore, did not have data for 9 months of the measurement period.

### Measurement

An NCQA-certified software tool was used to calculate the measures. Following the HEDIS<sup>®</sup> 2010 specifications,<sup>3</sup> rates are not reported for measures with a denominator less than 30. Therefore, a plan with a denominator less than 30 for a specific measure has been reported as "Low Denominator" (LD). However, eligible individuals in LD plans were included in the overall FHKP averages.

### Data Limitations for Measures Requiring Provider Specialty

Due to data limitations in the health plans' claims and encounter data, a modification to the NCQA specifications was required. Following NCQA specifications, the NCQA certified software requires validation of the provider specialty against the type of service rendered before a beneficiary can be considered eligible for inclusion in certain HEDIS<sup>®</sup> measures. The ICHP modified the NCQA specifications to lift these provider constraints when determining eligibility due to insufficient data about provider specialty. Provider specialty codes are an important component for some HEDIS<sup>®</sup> measures and lifting the provider constraint may result in rate inflation for these measures. For example, NCQA specifications require that a mental health provider be the provider of record for a beneficiary to be considered compliant with the HEDIS<sup>®</sup> measures for 7-day and 30-day follow-up after an inpatient mental health stay. Lifting the provider constraint allows any physician provider to count toward compliance with the mental health follow-up measures. This is only one example. The following HEDIS<sup>®</sup> measures contained in this report rely on specific provider specialty codes:

- HEDIS<sup>®</sup> Children and Adolescents' Access to Primary Care Practitioners
- HEDIS<sup>®</sup> Well-Child Visits in the 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup>, and 6<sup>th</sup> Years of Life
- HEDIS<sup>®</sup> Adolescent Well-Care Visits
- HEDIS<sup>®</sup> Follow-Up after Hospitalization for Mental Illness

## Effect of Plan County Changes in October 2008

As a result of a statewide rebidding process that occurred during state fiscal year 2008, there were changes in which plans served which counties effective October 1, 2008 with more children switching plans than normally occurs. The following HEDIS<sup>®</sup> measures require data from the year prior to the measurement year:

- HEDIS<sup>®</sup> Children and Adolescents' Access to Primary Care Practitioners
- HEDIS<sup>®</sup> Use of Appropriate Medications for People with Asthma
- HEDIS<sup>®</sup> Appropriate Testing for Children with Pharyngitis
- HEDIS<sup>®</sup> Appropriate Treatment for Children with Upper Respiratory Infection

Therefore, children who switched plans did not meet the plan-specific enrollment requirement for these measures. Consequently, there may be a higher proportion of plans reporting Low Denominator for these measures than would normally be the case.

## Comparison Data

To provide a context for the performance indicators, three levels of comparisons were made:

1. **Florida Healthy Kids Program Average.** The plans were compared to the FHKP mean score. Rates that were higher or lower than the program average by more than one standard deviation have been highlighted.
2. **Other KidCare Programs.** The FHKP overall program average was compared to the program average for the following KidCare program components (as applicable): Medicaid Fee-for-Service (FFS), Medicaid Primary Care Case Management (PCCM), Medicaid Reform, MediKids, and the Children's Medical Services Network (CMSN). The HEDIS<sup>®</sup> rates for the other KidCare program components were calculated by the ICHP for the measurement period calendar year 2008. MediKids is designed for children ages 1-4 years old; therefore, the program does not have rates reported for measures that are restricted to older age groups. There is significant turnover in the Florida Medicaid FFS program because a large percentage of FFS enrollees are enrolled in the FFS program temporarily before being assigned to the PCCM program or an MCO. The high turnover in the Medicaid FFS program may contribute to lower rates on the performance measures. More details can be found in the State Fiscal Year 2008-2009 Annual KidCare Evaluation Report.<sup>4</sup>
3. **National Medicaid HEDIS<sup>®</sup> Means and Percentiles.** Comparisons are made to national data. Although there are no direct national comparisons available for CHIP, information is available nationally from Medicaid Managed Care Organizations (MCOs) who elect to report their results to NCQA.<sup>5</sup> The submission of HEDIS<sup>®</sup> data to NCQA is a voluntary process; therefore, health plans that submit HEDIS<sup>®</sup> data are not fully representative of the industry. Health plans participating in NCQA HEDIS<sup>®</sup> reporting tend to be older, are more likely to be federally qualified, and are more likely to be affiliated with a national managed care company than the overall population of health plans in the United States.<sup>6</sup> NCQA reports the national results as a mean and at the 10<sup>th</sup>, 25<sup>th</sup>, 50<sup>th</sup>, 75<sup>th</sup>, and 90<sup>th</sup> percentiles for the participating plans. The Medicaid Managed Care Plans 2009 mean results are provided in this report for descriptive purposes and are shown and labeled "HEDIS<sup>®</sup> Mean" in the charts. In addition, we have indicated where each plan falls within four percentile categories (0-25, 25.01-50, 50.01-75, 75.01-100). Because the national data reflect the HEDIS<sup>®</sup> 2009 specifications and the FHKP rates in this report reflect HEDIS<sup>®</sup> 2010 specifications, measures for which the specifications were significantly different between the two years are not compared to national data.

The use of multiple comparisons allows for a more comprehensive evaluation of plan-level and overall program performance.

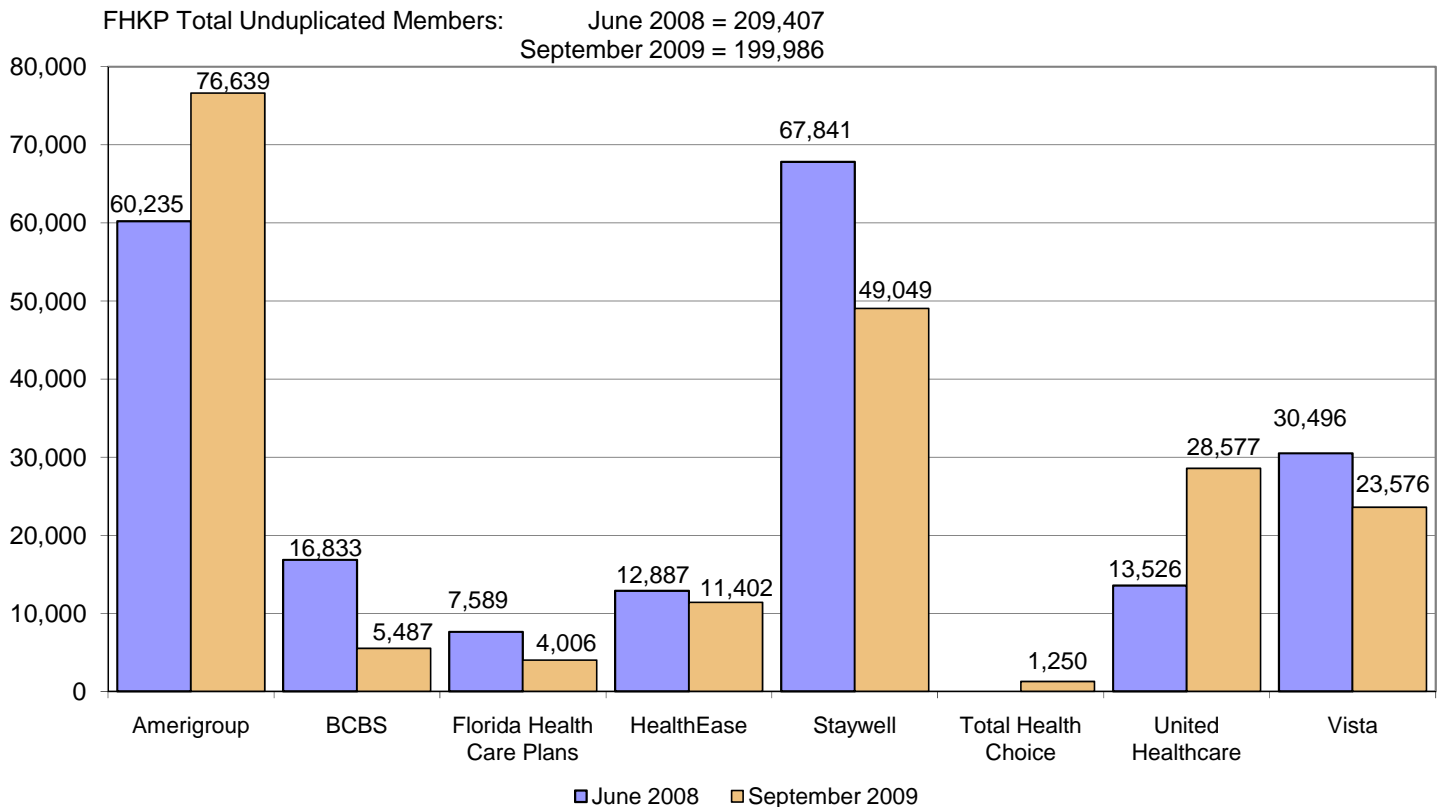
### 3. Health Plan Descriptive Information

#### Health Plan Enrollment

##### Key Points:

- Figure 1 provides the total number of unduplicated members enrolled in the FHKP by health plan. Total enrollment in September 2009 was 199,986 enrollees.
- There were significant changes in the membership of many of the plans between the prior quality of care measurement period (07/01/07-06/30/08) and the current measurement period (10/01/08-09/30/09) due to the statewide rebidding process that resulted in changes in the counties that each plan serves, effective October 1, 2008.
- The plan with the largest membership during the measurement period was Amerigroup at 38% of all enrollees, followed by Staywell at 25%, and United Healthcare at 14%.
- The plan with the smallest enrollment was Total Health Choice, which served Miami-Dade County, with only 1,250 enrollees in September 2009.

**Figure 1: Health Plan Enrollment, Total Unduplicated Members  
June 2008 and September 2009**





## 4.1 Health Plan Quality of Care Measures: Access and Availability of Care

### HEDIS® Children and Adolescents' Access to Primary Care Practitioners

#### Significance:

- Access to a primary care provider is a basic and necessary (but not sufficient) requirement in establishing a medical home for a child.<sup>7</sup>
- Access to primary care is associated with reduced hospital use and more appropriate use of specialists.<sup>8</sup>

#### Measurement:

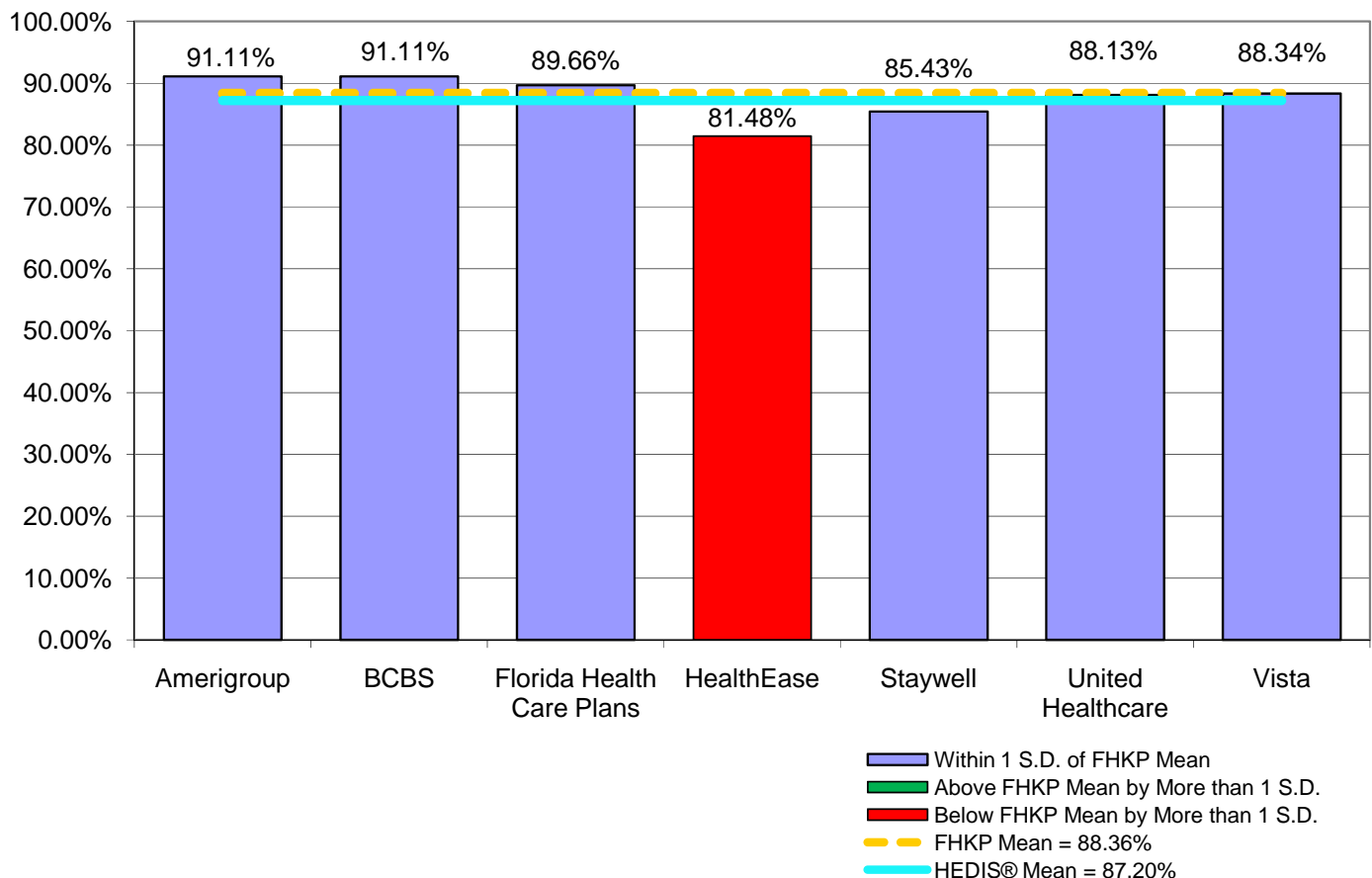
- Access to Primary Care Practitioners is measured as the percentage of FHKP enrollees who had a visit with a PCP during the measurement period for children ages 2-6 years and those who had a PCP visit during the measurement period or the prior year for children ages 7-11 years and adolescents ages 12-19 years.

- This measure requires visits with a primary care practitioner specifically. Due to insufficient data on provider specialty type in the claims and encounter data, the provider type constraint was removed. Consequently, the percentages shown here are inflated, which should be taken into consideration when making comparisons with the national Medicaid HEDIS® means and percentiles.

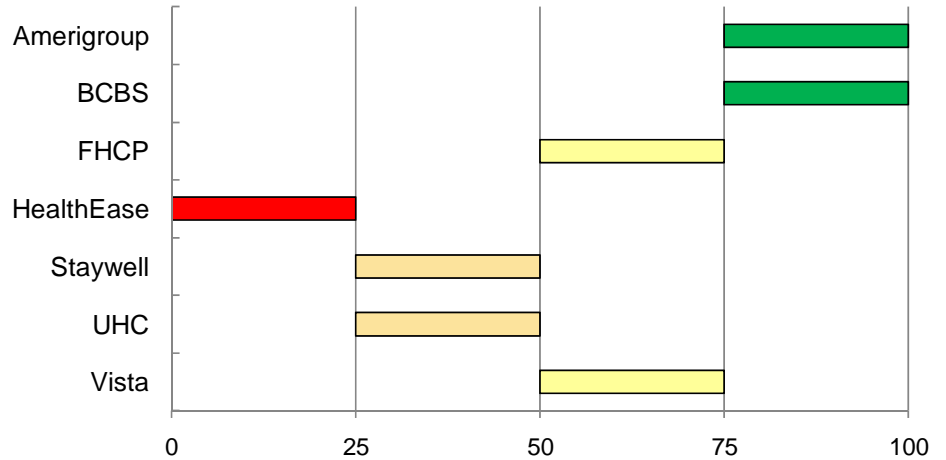
#### Key Findings – Children 2-6 Years Old:

- Overall, the FHKP performed about the same as the national Medicaid HEDIS® average for children ages 2-6 years (which includes only children ages 5-6 years in the FHKP).
- HealthEase performed below the FHKP mean by more than two standard deviations.

**Figure 2: HEDIS® Children and Adolescents' Access to Primary Care Practitioners  
Ages 2-6 Years (Eligibles = 5,051)**



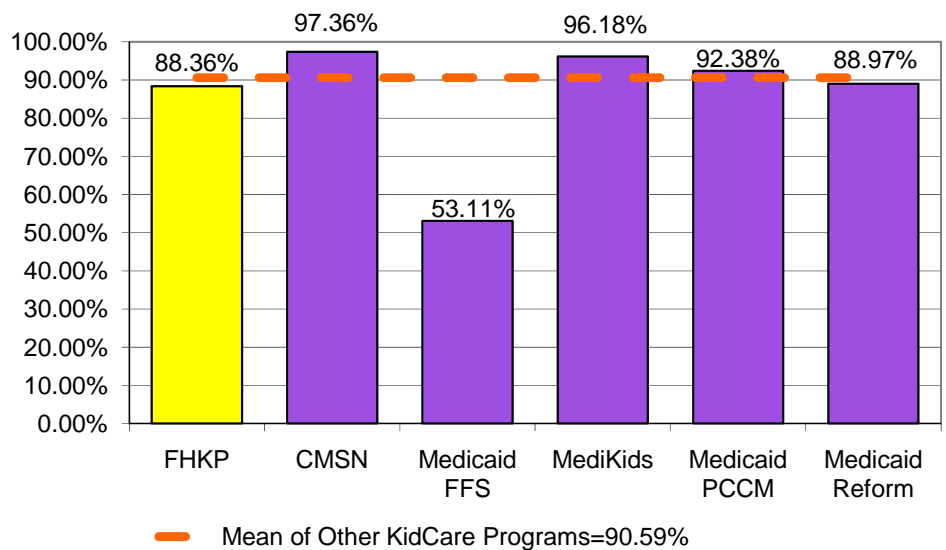
**Figure 3: Children and Adolescents' Access to Primary Care Practitioners, Ages 2-6 Years Comparison to National Medicaid Percentiles**



**Plan Performance Compared to National Medicaid Percentiles:**

- Four plans performed above the national Medicaid 50<sup>th</sup> percentile for this measure. Amerigroup and BCBS performed above the 75<sup>th</sup> percentile. However, the FHCP rates are inflated due to lifting the provider specialty constraint.
- One plan, HealthEase, performed below the 25<sup>th</sup> percentile.

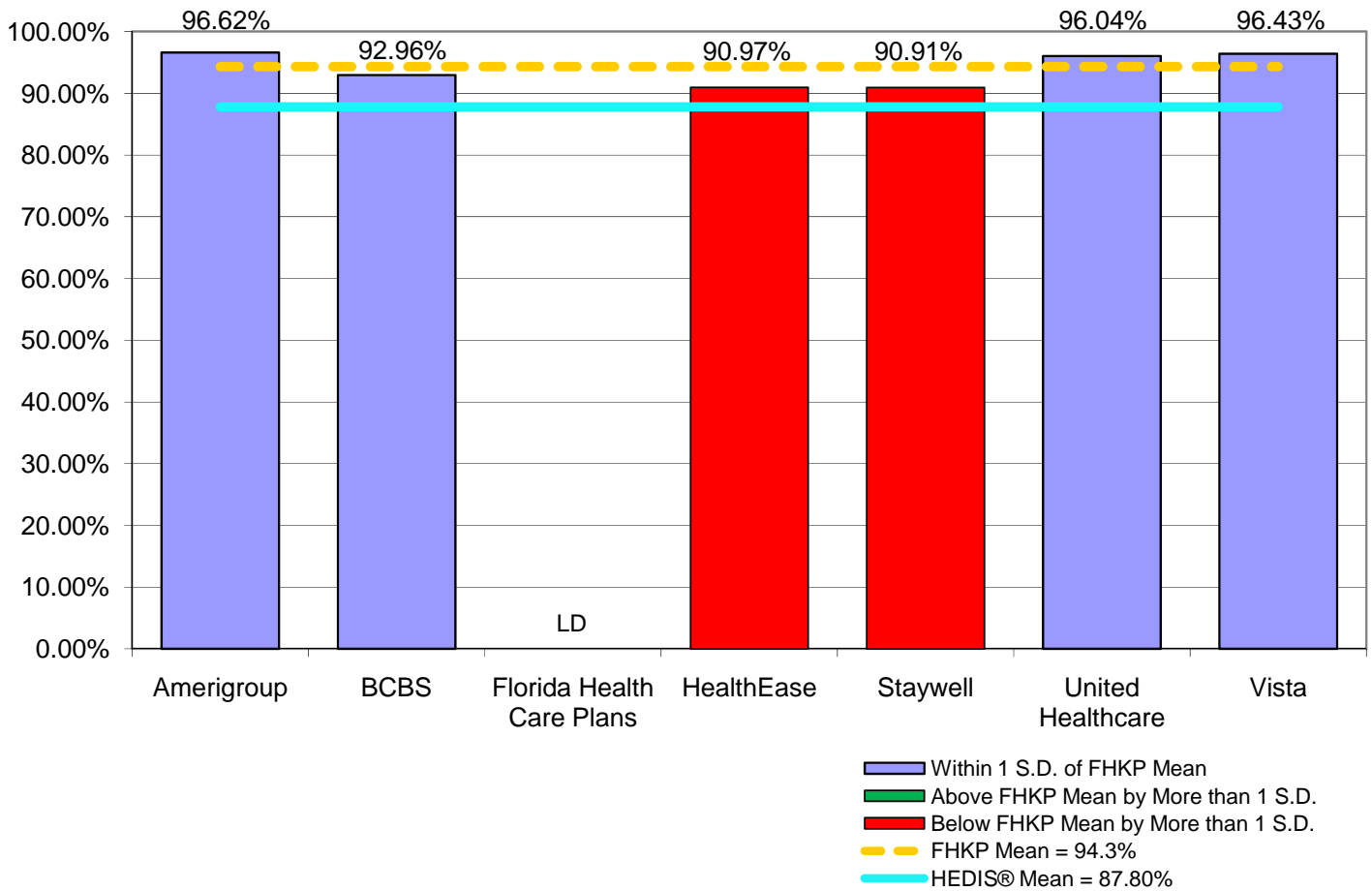
**Figure 4: Children and Adolescents' Access to Primary Care Practitioners, Ages 2-6 Years Comparison to Other KidCare Programs**



**FHKP Performance Compared to Other KidCare Programs:**

The FHKP performed slightly below the mean of 90.59% for the other KidCare Programs.

**Figure 5: HEDIS® Children and Adolescents' Access to Primary Care Practitioners  
Ages 7-11 Years (Eligibles = 18,291)**



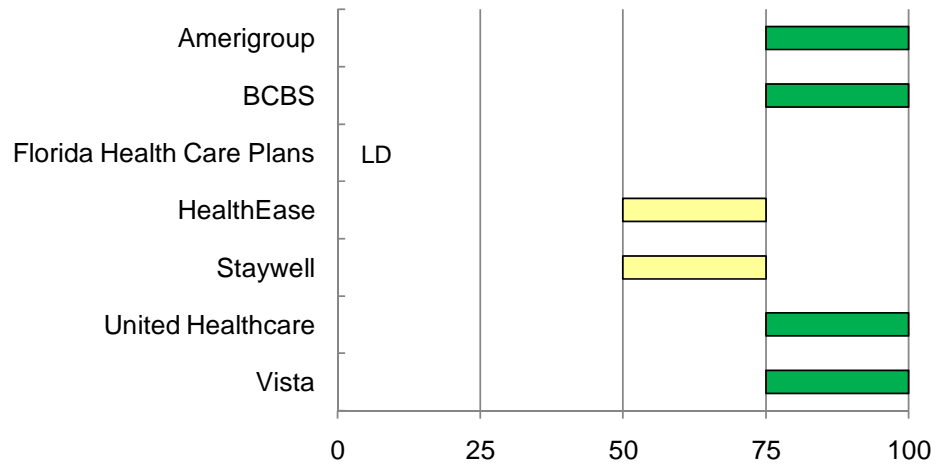
**Key Findings – Children 7-11 Years Old:**

- Overall, the FHKP mean of 94.3% was above the national Medicaid HEDIS® average of 87.8% for children ages 7-11 years. However, the FHKP rates are inflated due to lifting the provider specialty constraint.
- Both HealthEase and Staywell performed below the FHKP mean by more than one standard deviation, but were within two standard deviations.
- Florida Health Care Plans had too few eligible members (<30) to report its rate for this measure.

**Plan Performance Compared to National Medicaid Percentiles:**

Four plans performed above the national Medicaid 75<sup>th</sup> percentile and two plans performed above the 50<sup>th</sup> percentile for this measure. However, the FHKP rates are inflated due to lifting the provider specialty constraint.

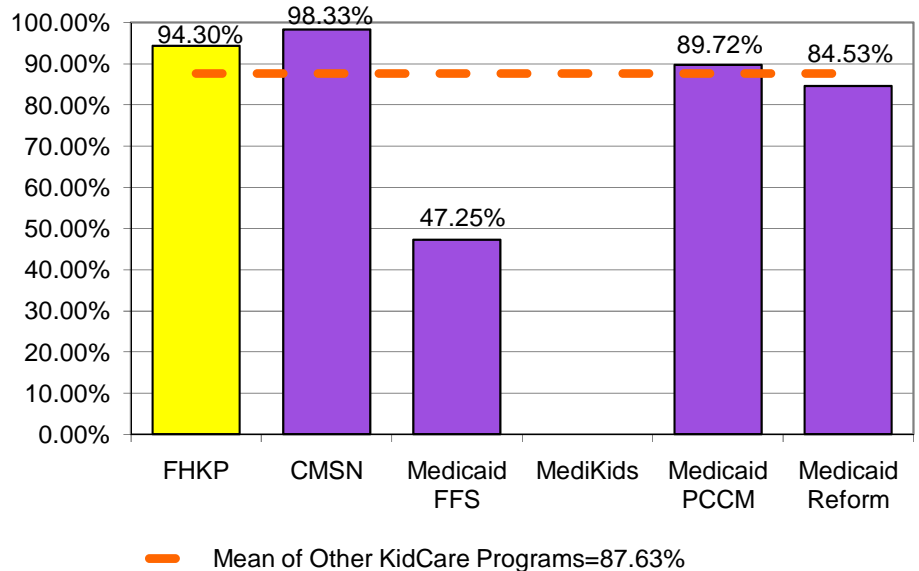
**Figure 6: Children and Adolescents' Access to Primary Care Practitioners, Ages 7-11 Years Comparison to National Medicaid Percentiles**



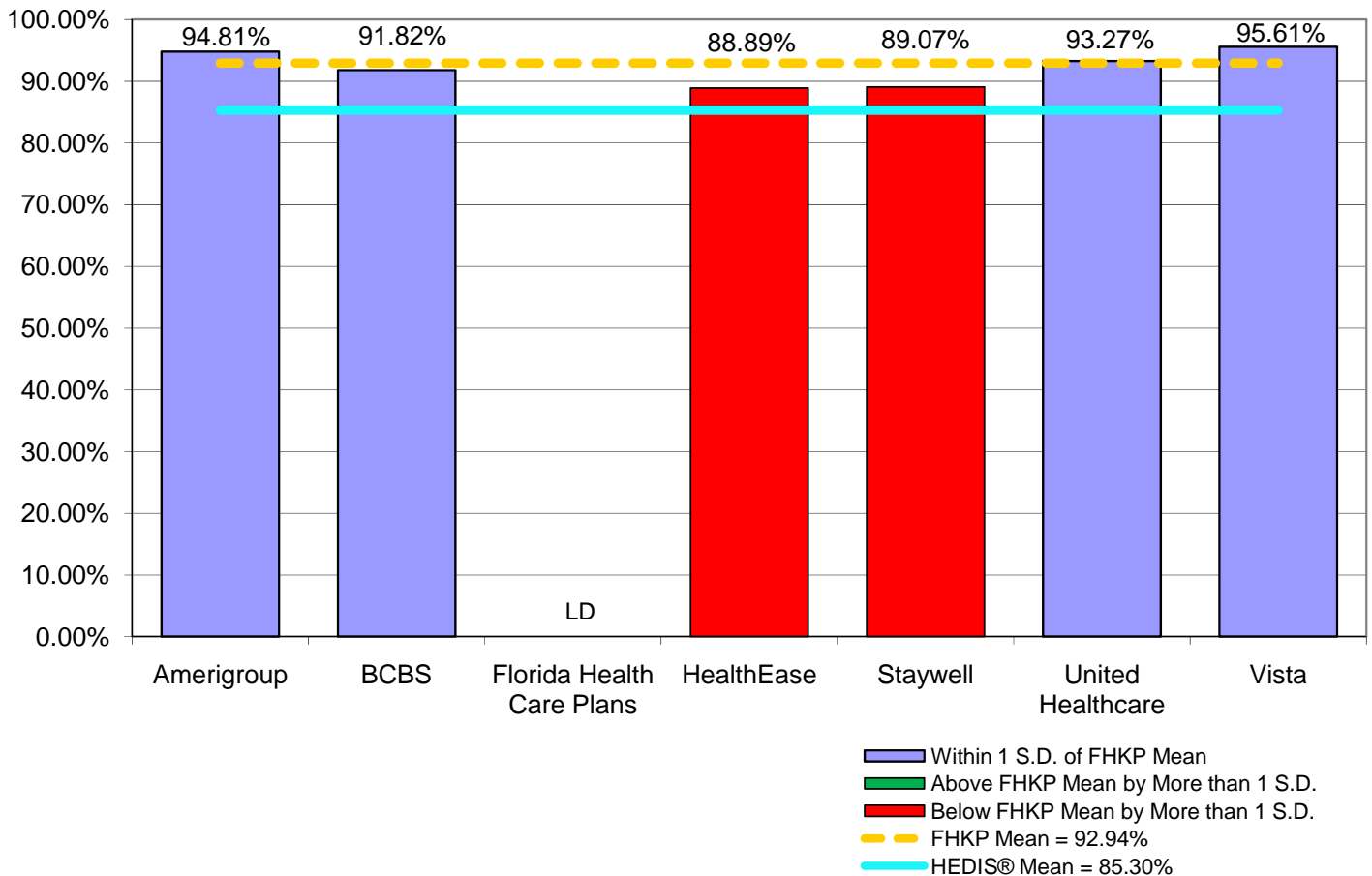
**FHKP Performance Compared to Other KidCare Programs:**

The FHKP performed almost 7 percentage points above the mean of 87.63% for the other KidCare Programs. However, the FHKP rates are inflated due to lifting the provider specialty constraint.

**Figure 7: Children and Adolescents' Access to Primary Care Practitioners, Ages 7-11 Years Comparison to Other KidCare Programs**



**Figure 8: HEDIS® Children and Adolescents' Access to Primary Care Practitioners  
Ages 12-19 Years (Eligibles = 32,334)**



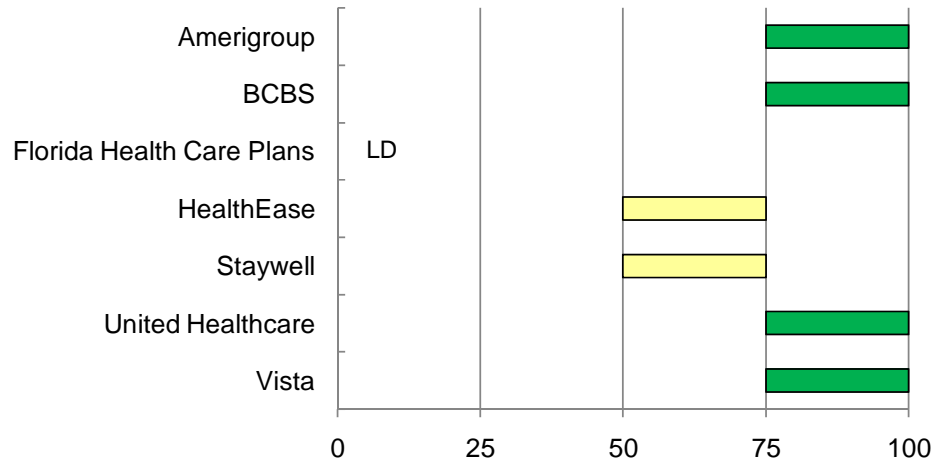
**Key Findings – Children 12-19 Years Old:**

- Overall, the FHKP mean of 92.9% was above the national Medicaid HEDIS® average of 85.3% for children ages 12-19 years. However, the FHKP rates are inflated due to lifting the provider specialty constraint.
- Both HealthEase and Staywell performed below the FHKP mean by more than one standard deviation, but were within two standard deviations.
- Florida Health Care Plans had too few eligible members (<30) to report its rate for this measure.

**Plan Performance Compared to National Medicaid Percentiles:**

Four plans performed above the Medicaid 75<sup>th</sup> percentile and two plans performed above the 50<sup>th</sup> percentile for this measure. However, the FHKP rates are inflated due to lifting the provider specialty constraint.

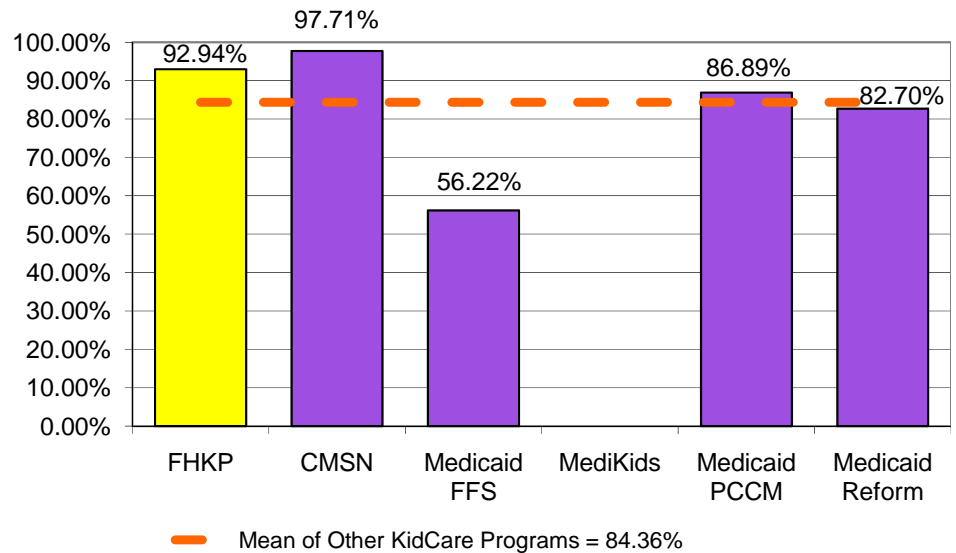
**Figure 9: Children and Adolescents' Access to Primary Care Practitioners, Ages 12-19 Years Comparison to National Medicaid Percentiles**



**FHKP Performance Compared to Other KidCare Programs:**

The FHKP performed more than 8 percentage points above the mean of 84.36% for the other KidCare Programs. However, the FHKP rates are inflated due to lifting the provider specialty constraint.

**Figure 10: Children and Adolescents' Access to Primary Care Practitioners, Ages 12-19 Years Comparison to Other KidCare Programs**



## HEDIS® Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, 13-17 Years

### Significance:

- Alcohol and substance abuse among adolescents has negative health consequences and is a contributing factor to deaths due to unintentional injury, homicide, and suicide, which are the leading causes of mortality among 15-19 year olds.<sup>9-10</sup>
- Several national goals in *Healthy People 2010* target reducing alcohol and substance abuse among adolescents.<sup>11</sup>
- Identifying adolescents with alcohol and other drug dependency is an important first step in care provision; however, identification frequently does not result in treatment.
- Once treatment is initiated, those who follow through with their treatment typically have better outcomes than those who discontinue treatment prematurely.<sup>12</sup>

### Measurement:

**Initiation** is measured as the percentage of 13-17 year olds diagnosed with alcohol or other drug (AOD) dependence who initiated treatment for a new episode of AOD during the reporting period through an AOD inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis. This percentage is calculated as the number of patients who initiated treatment divided by the total number of patients with a new diagnosis of AOD during the measurement year. A diagnosis is established by an inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification, or emergency department visit with any diagnosis of AOD.

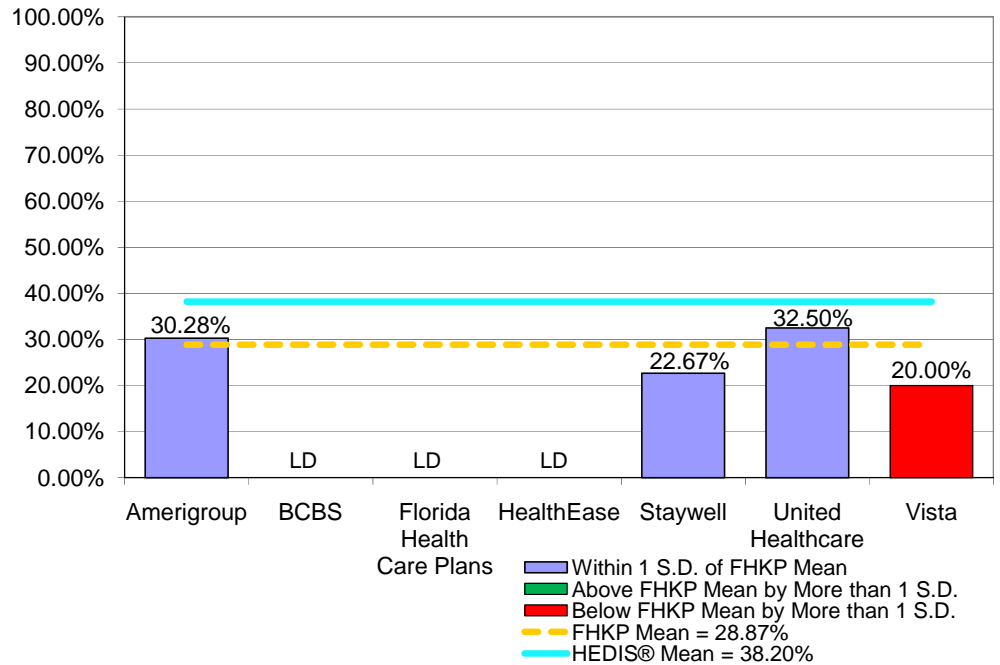
**Engagement** is measured as the percentage of 13-17 year olds diagnosed with AOD dependence who had two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with an AOD diagnosis within 30 days of the date of the initiation encounter. This percentage is calculated as the number of patients who initiated treatment and had two or more additional AOD services within 30 days of the initiation encounter divided by the total number of patients with a new diagnosis of AOD during the measurement year.

**Key Findings:**

**Initiation:**

- Overall, 28.9% of FHKP enrollees, ages 13-17 years, with an AOD dependence diagnosis initiated treatment within 14 days of diagnosis, compared with the national Medicaid HEDIS® mean of 38.2%.
- Vista performed below the FHKP mean by more than one standard deviation, but was within two standard deviations.

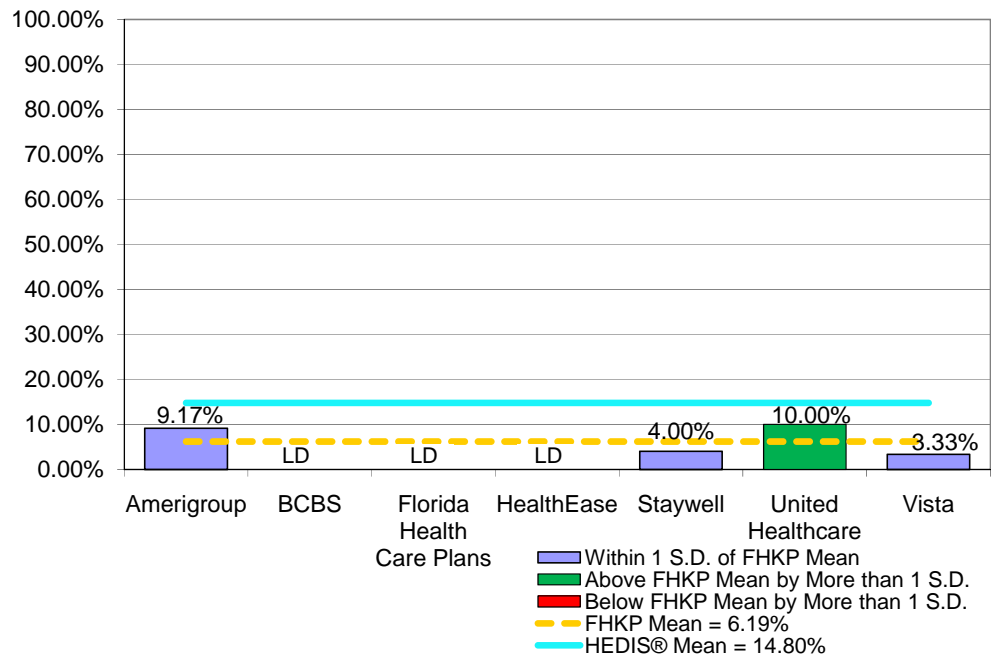
**Figure 11: HEDIS® Initiation and Engagement of Alcohol and Other Drug Dependence Treatment  
Initiation, 13-17 Year Olds (Eligibles = 291)**



**Engagement:**

- Only 6.2% of 13-17 year olds in the FHKP with an AOD dependence diagnosis both initiated treatment within 14 days of diagnosis and had continuing treatment as measured by two additional AOD encounters within 30 days of the initial treatment date. This is below the national Medicaid HEDIS® mean of 14.8%.
- United Healthcare performed above the FHKP mean by more than one standard deviation.

**Figure 12: HEDIS® Initiation and Engagement of Alcohol and Other Drug Dependence Treatment  
Engagement, 13-17 Year Olds (Eligibles = 291)**

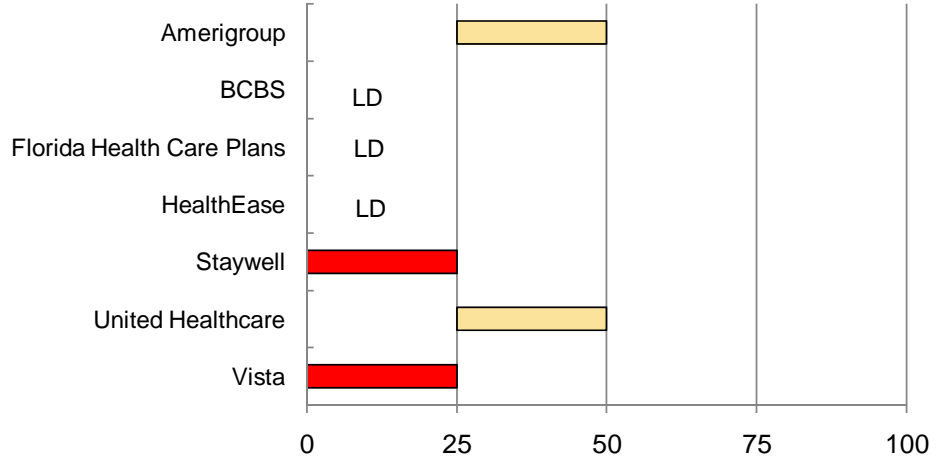




**Figure 13: Initiation of Alcohol and Other Drug Dependence Treatment  
Comparison to National Medicaid Percentiles**

**Initiation - Plan Performance Compared to National Medicaid Percentiles:**

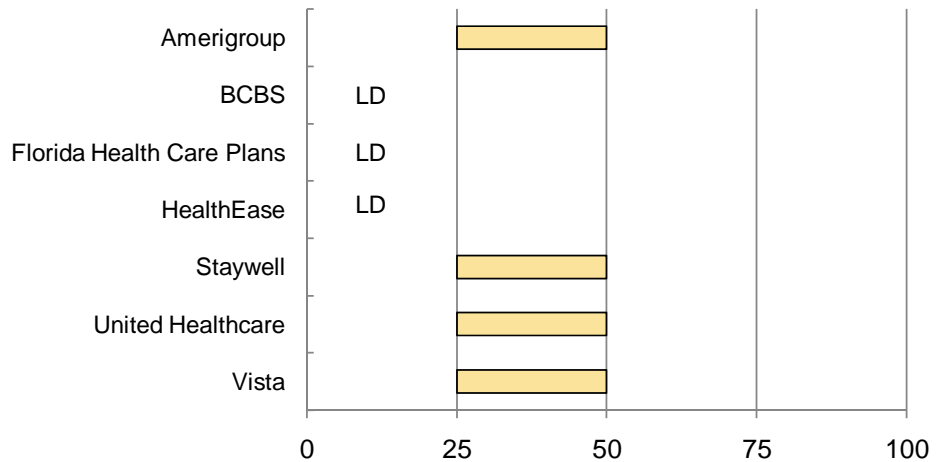
All four plans with a sufficient denominator ( $\geq 30$ ) to report this measure performed below the national Medicaid 50<sup>th</sup> percentile, two of which were below the 25<sup>th</sup> percentile.



**Figure 14: Engagement of Alcohol and Other Drug Dependence Treatment  
Comparison to National Medicaid Percentiles**

**Engagement - Plan Performance Compared to National Medicaid Percentiles:**

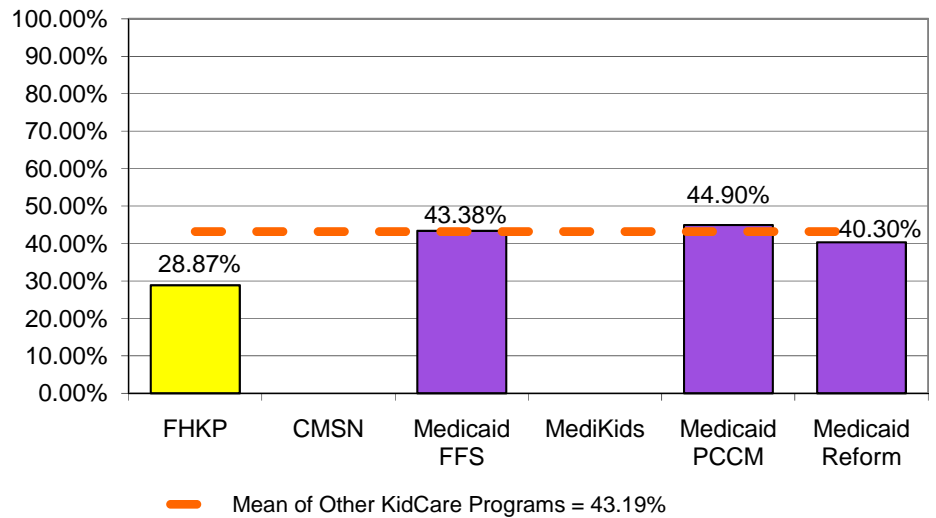
All four plans with a sufficient denominator to report this measure ( $\geq 30$ ) performed below the national Medicaid 50<sup>th</sup> percentile.



**Initiation - FHKP Performance Compared to Other KidCare Programs:**

At 28.87%, the FHKP performed significantly below the mean of 43.19% for the other KidCare programs.

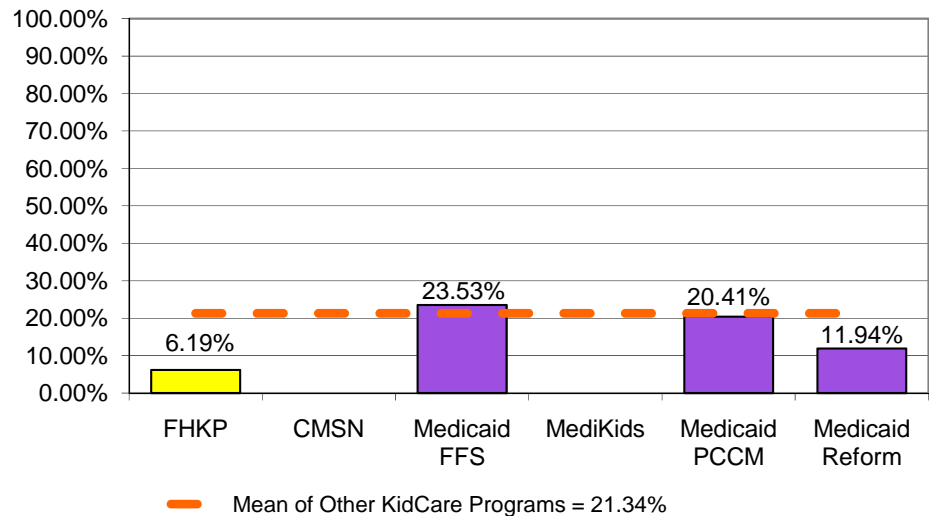
**Figure 15: Initiation of Alcohol and Other Drug Dependence Treatment Comparison to Other KidCare Programs**



**Engagement - FHKP Performance Compared to Other KidCare Programs:**

At 6.19%, the FHKP performed significantly below the mean of 21.34% for the other KidCare programs.

**Figure 16: Engagement of Alcohol and Other Drug Dependence Treatment Comparison to Other KidCare Programs**



**Reporting Notes:** The KidCare program rates reported here represent only those enrollees ages 13-17 years old for comparison purposes. The KidCare Annual Evaluation Report provides the rates for all ages. The CMSN had too few children (<30) eligible for these measures.

## HEDIS® Prenatal and Postpartum Care

### Significance:

- The National Institute of Child Health and Human Development recommends early and regular prenatal care to promote a healthy pregnancy.<sup>13</sup> Prenatal health care visits involve physical exams, education and counseling about nutrition, physical activity and health behaviors, lab tests and screenings, and childbirth education.
- Professional organizations, such as the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists recommend a postpartum care visit for women between four to six weeks after giving birth.<sup>14</sup> The primary goals of postpartum care visits are to assess women for postpartum depression, evaluate their overall health, address any preexisting or developing health problems, and provide education about infant care and development.

### Measurement:

Three measures are reported:

**1. Timeliness of prenatal care** is measured as the percentage of deliveries that received a prenatal care visit as a plan enrollee in the first trimester or within 42 days of enrollment in the health plan

**2. Frequency of ongoing prenatal care** is measured as the percentage of deliveries that had 81 percent or more of expected visits.

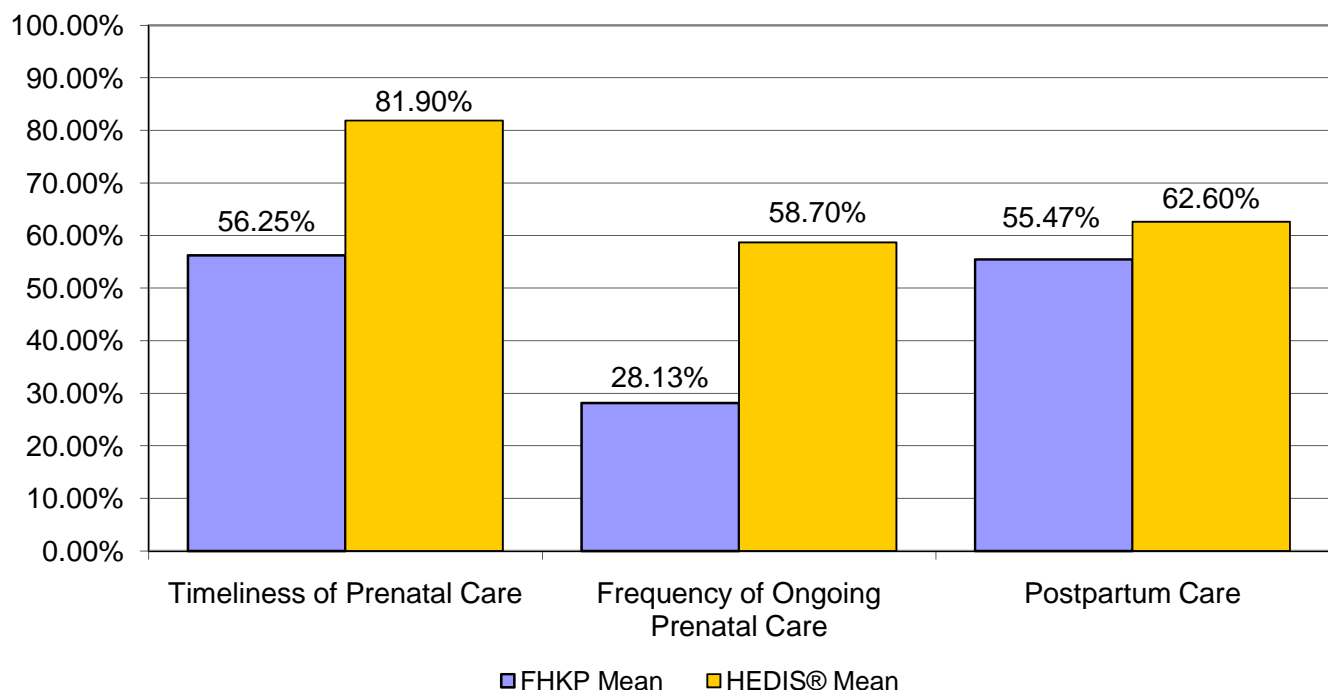
**3. Postpartum care** is measured as the percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.

### Reporting Note:

Only one health plan had at least 30 enrollees who met the eligibility criteria for each of the three measures. Therefore, results are reported only at the program level, which includes eligible enrollees from all plans.

**Key Findings:** The FHKP mean was below the national Medicaid HEDIS® mean for all three measures, with the greatest disparity in the prenatal measures.

**Figure 17: HEDIS® Prenatal and Postpartum Care Measures**  
(Eligibles = 128)



## 4.2 Health Plan Quality of Care Measures: Use of Services

### HEDIS® Well-Child Visits in the 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup>, and 6<sup>th</sup> Years of Life

#### Significance:

- Access to preventive care visits is a fundamental component of pediatric health care for children and adolescents.
- Preventive care visits that meet the American Academy of Pediatrics periodicity schedule are associated with a decrease in avoidable inpatient admissions for infants across various racial and ethnic groups, income levels, and health status.<sup>15</sup>
- A decrease in avoidable hospitalizations decreases overall cost as well as improves the overall health and quality of life of the child.

#### Measurement:

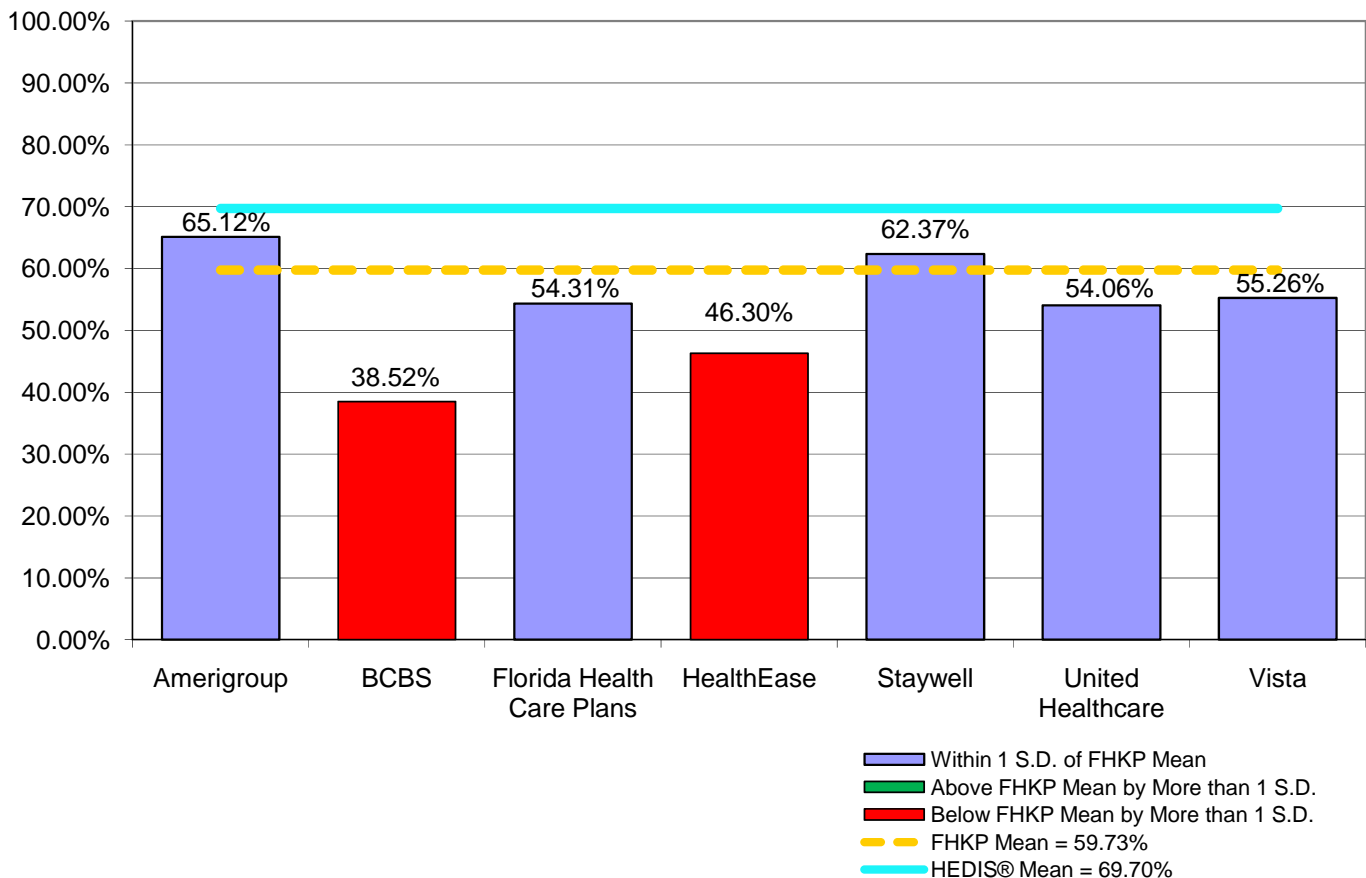
- Well-Child Visits are measured as the percentage of enrollees between three and six years old who received one or more well-child visits with a PCP during the measurement period. For the FHKP, this measure only includes 5-6 year olds.

- This HEDIS® measure requires visits with a primary care practitioner specifically. Due to insufficient data on provider specialty type in the claims data, the provider type constraint was removed. Therefore, the percentages shown here are inflated, which should be taken into consideration when making comparisons with the national Medicaid HEDIS® mean and percentiles.

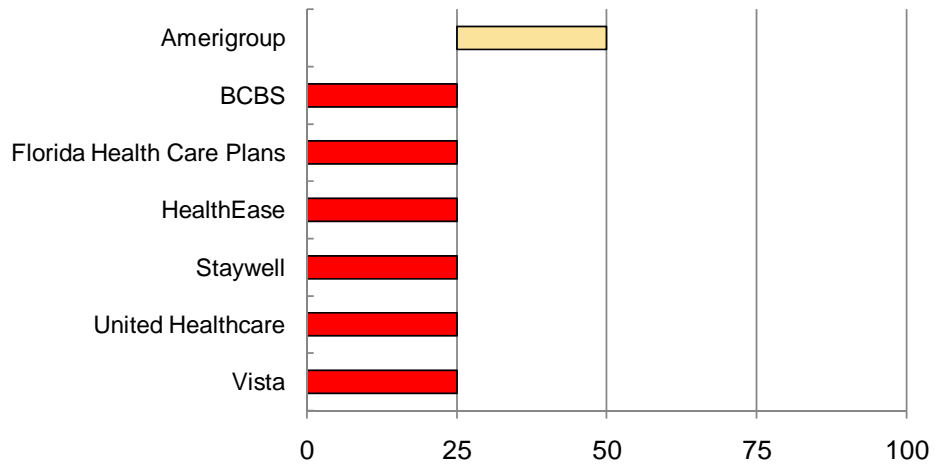
#### Key Findings:

- Overall, 59.7% of FHKP enrollees younger than 7 years had a well-child visit during the measurement year, which was below the national Medicaid HEDIS® mean of 69.7%.
- HealthEase performed below the FHKP mean by more than one standard deviation, and BCBS performed below the FHKP mean by more than two standard deviations.

**Figure 18: HEDIS® Well-Child Visits in the 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup>, and 6<sup>th</sup> Years of Life (Eligibles = 5,051)**



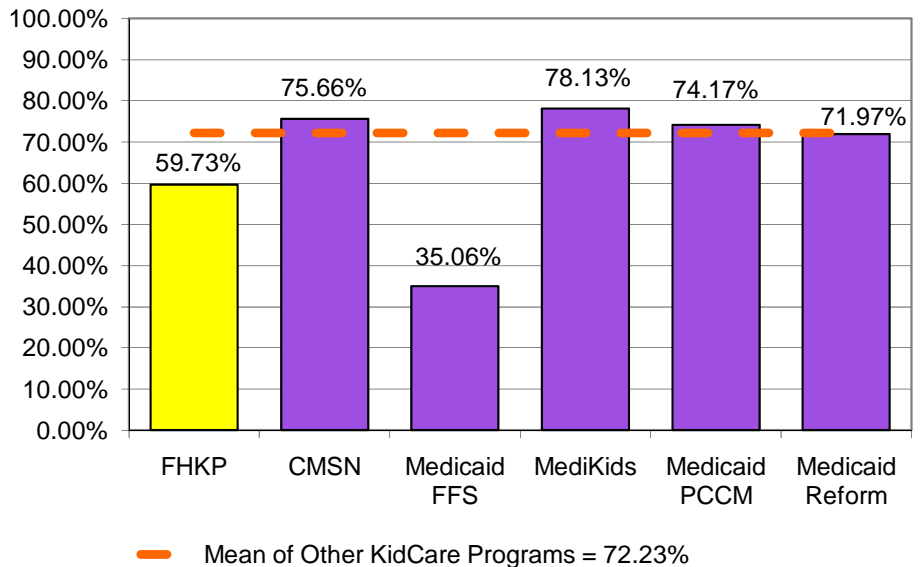
**Figure 19: Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life  
Comparison to National Medicaid Percentiles**



**Plan Performance Compared to National Medicaid Percentiles:**

No plans performed above the national Medicaid 50<sup>th</sup> percentile, and all except Amerigroup performed below the 25<sup>th</sup> percentile.

**Figure 20: Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life  
Comparison to Other KidCare Programs**



**FHKP Performance Compared to Other KidCare Programs:**

The FHKP performed more than 12 percentage points below the mean of 72.23% for the other KidCare Programs.

## HEDIS® Adolescent Well-Care Visits

### Significance:

- Access to preventive care visits is a fundamental component of pediatric health care for children and adolescents.
- Adolescence is a significant transitional developmental stage between childhood and adulthood. Accidents, homicide, and suicide are the leading causes of mortality among adolescents.<sup>16</sup>
- The American Academy of Pediatrics and Bright Futures identifies adolescence as an important time for screenings and risk assessment related to risky behaviors, such as alcohol and drug use and sexual activity.<sup>17</sup>
- Bright Futures and the American Academy of Pediatrics recommend annual preventive health care visits for adolescents to include physical examination, risk assessments, and anticipatory guidance.<sup>18</sup>

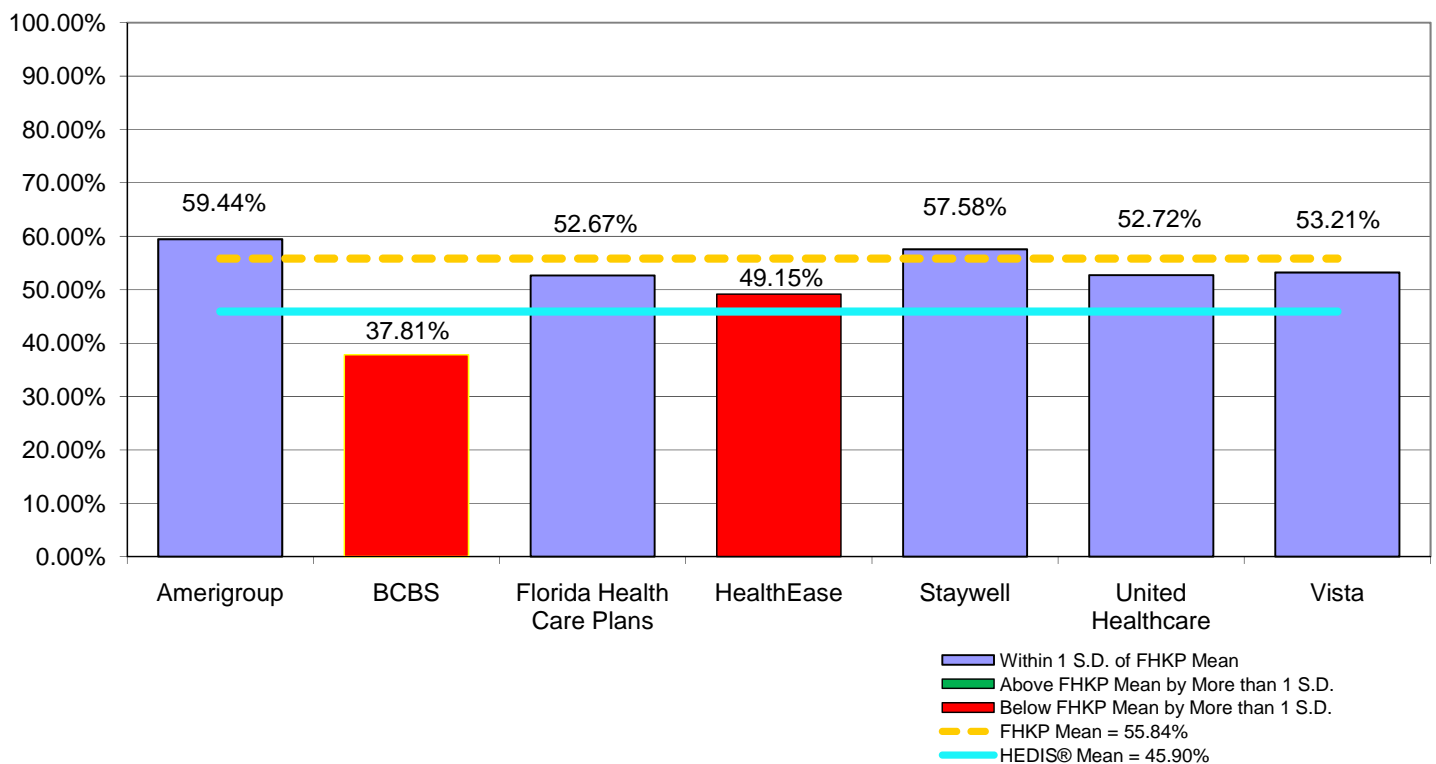
### Measurement:

- Adolescent Well-Care Visits are measured as the percentage of enrollees 12 to 21 years old who received one or more comprehensive adolescent well-care visits with a physician provider during the measurement year.
- The HEDIS® measure requires visits with a primary care practitioner or OB/GYN practitioner. Due to insufficient data on provider specialty type in the claims and encounter data, the provider type constraint was removed. After lifting the provider constraint, the percentages shown here are inflated, which should be taken into consideration when making comparisons with the national Medicaid HEDIS® mean and percentiles.

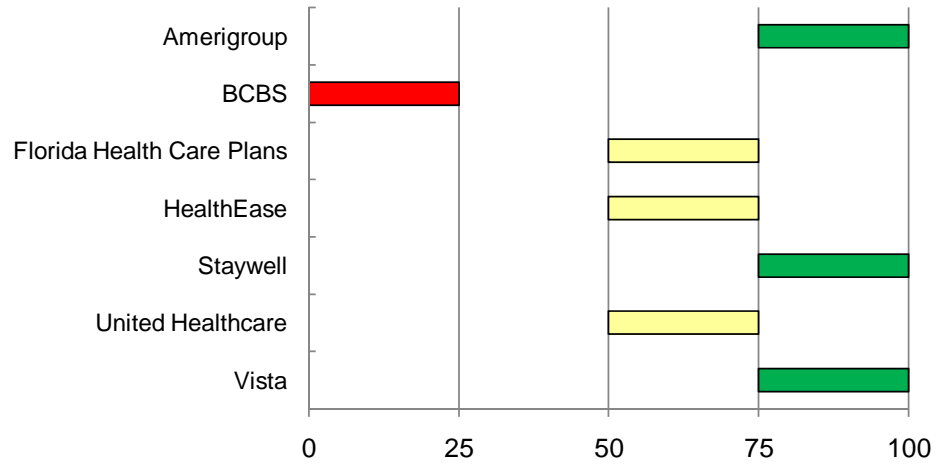
### Key Findings:

- Overall, 55.8% of FHKP adolescents 12 years and older had a comprehensive well-care visit during the measurement year, which is greater than the national Medicaid HEDIS® mean of 45.9%.
- HealthEase performed below the FHKP mean by more than one standard deviation, and BCBS performed below the FHKP mean by more than two standard deviations.

**Figure 21: HEDIS® Adolescent Well-Care Visits**  
(Eligibles = 66,923)



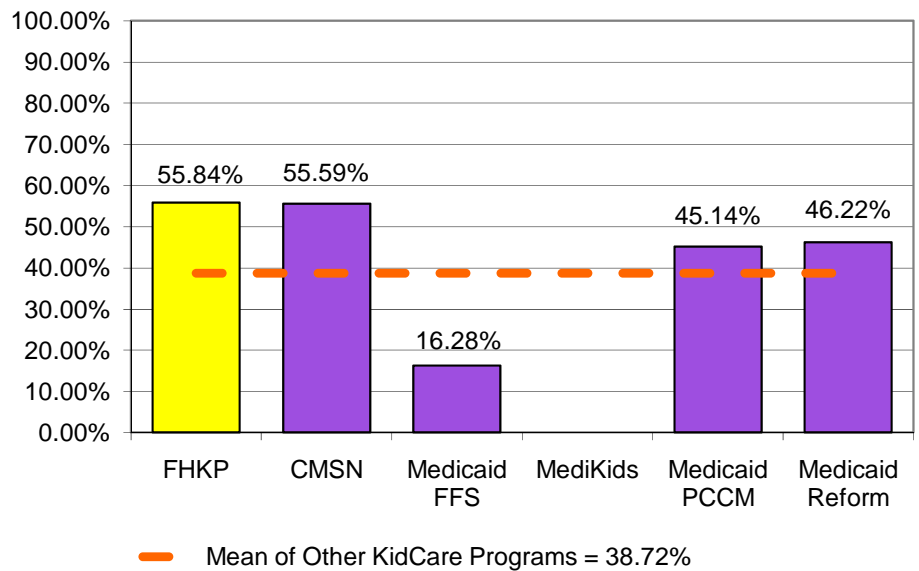
**Figure 22: Adolescent Well-Care Visits Comparison to National Medicaid Percentiles**



**Plan Performance Compared to National Medicaid Percentiles:**

All plans except BCBS performed above the national Medicaid 50<sup>th</sup> percentile for this measure, and three plans performed above the 75<sup>th</sup> percentile. However, the FHKP rates are inflated due to lifting the provider specialty constraint.

**Figure 23: Adolescent Well-Care Visits Comparison to Other KidCare Programs**



**FHKP Performance Compared to Other KidCare Programs:**

The FHKP performed more than 17 percentage points above the mean of 38.72% for the other KidCare programs. However, the FHKP rates are inflated due to lifting the provider specialty constraint.

### 4.3 Health Plan Quality of Care Measures: Effectiveness of Care – Prevention and Screening

#### HEDIS® Chlamydia Screening in Women, 16-20 Years

##### Significance:

- Chlamydia is a common sexually transmitted disease (STD) and the most frequently reported bacterial STD in the U.S.<sup>19</sup>
- Chlamydia often goes undetected because the symptoms are mild or absent. However, left untreated, Chlamydia can cause serious harm to the reproductive system and lead to pelvic inflammatory disease, chronic pelvic pain, and infertility.
- Consequently, annual screening for Chlamydia is recommended for sexually active women 25 years old and younger.<sup>20</sup>

##### Measurement:

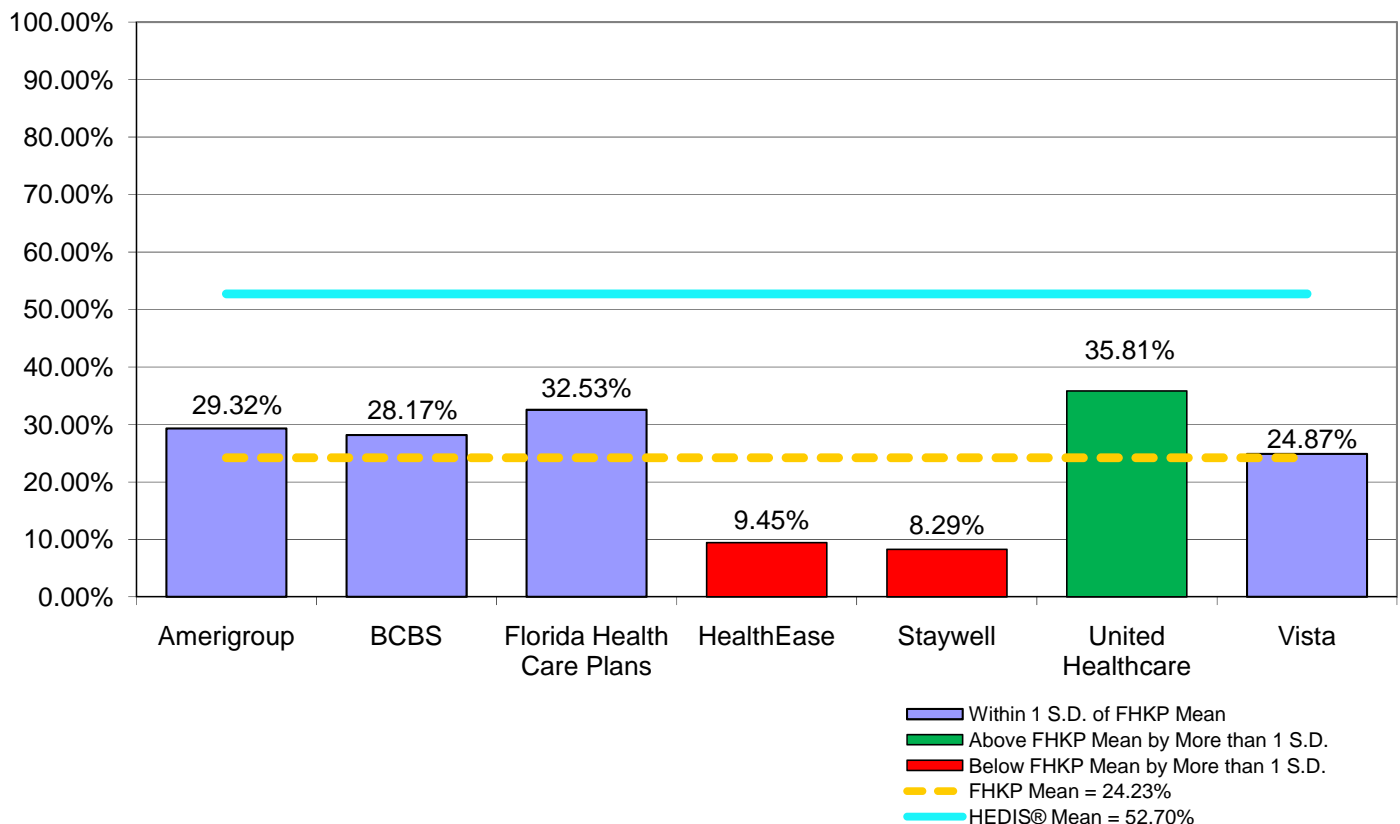
- Chlamydia Screening in Women is measured as the percentage of female enrollees 16 to 20 years old who were identified as sexually active and who had at least one test for Chlamydia during the measurement year.

- This percentage is calculated as the percentage of women who had at least one Chlamydia test during the measurement year divided by those identified as sexually active. Sexually active women are identified through pharmacy data (e.g., dispensed prescription contraceptives) or through claims/encounter procedure and diagnosis codes.

##### Key Findings:

- Overall, the FHKP performance of 24.2% was significantly below the national Medicaid HEDIS® mean of 52.7%.
- United Healthcare performed above the FHKP mean by more than one standard deviation.
- HealthEase and Staywell performed below the FHKP mean by more than one standard deviation, but were within two standard deviations. These lower rates were attributed, in part, to missing encounter data from the plans' laboratory vendor. This data issue is being addressed.

**Figure 24: HEDIS® Chlamydia Screening in Women 16-20 Years**  
(Eligibles = 4,663)



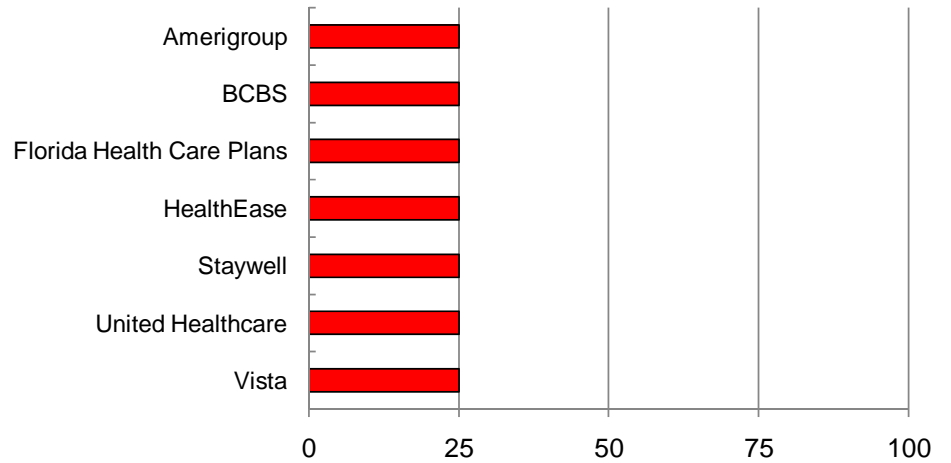


**Figure 25: Chlamydia Screening in Women 16-20 Years**

**Comparison to National Medicaid Percentiles**

**Plan Performance Compared to National Medicaid Percentiles:**

All plans performed below the national Medicaid 25<sup>th</sup> percentile for this measure.



[Comparisons for other KidCare program components were not available for this measure.]

## 4.4 Health Plan Quality of Care Measures: Effectiveness of Care – Respiratory Conditions

### HEDIS® Appropriate Testing for Children with Pharyngitis

#### Significance:

- Pharyngitis (sore throat) is a common diagnosis among children and adolescents.<sup>21</sup>
- Most cases of pharyngitis are viral, rather than bacterial, illnesses.<sup>22</sup> Consequently, clinical practice guidelines recommend testing for group A streptococcus (strep) before prescribing an antibiotic to reduce unwarranted antibiotic treatment.

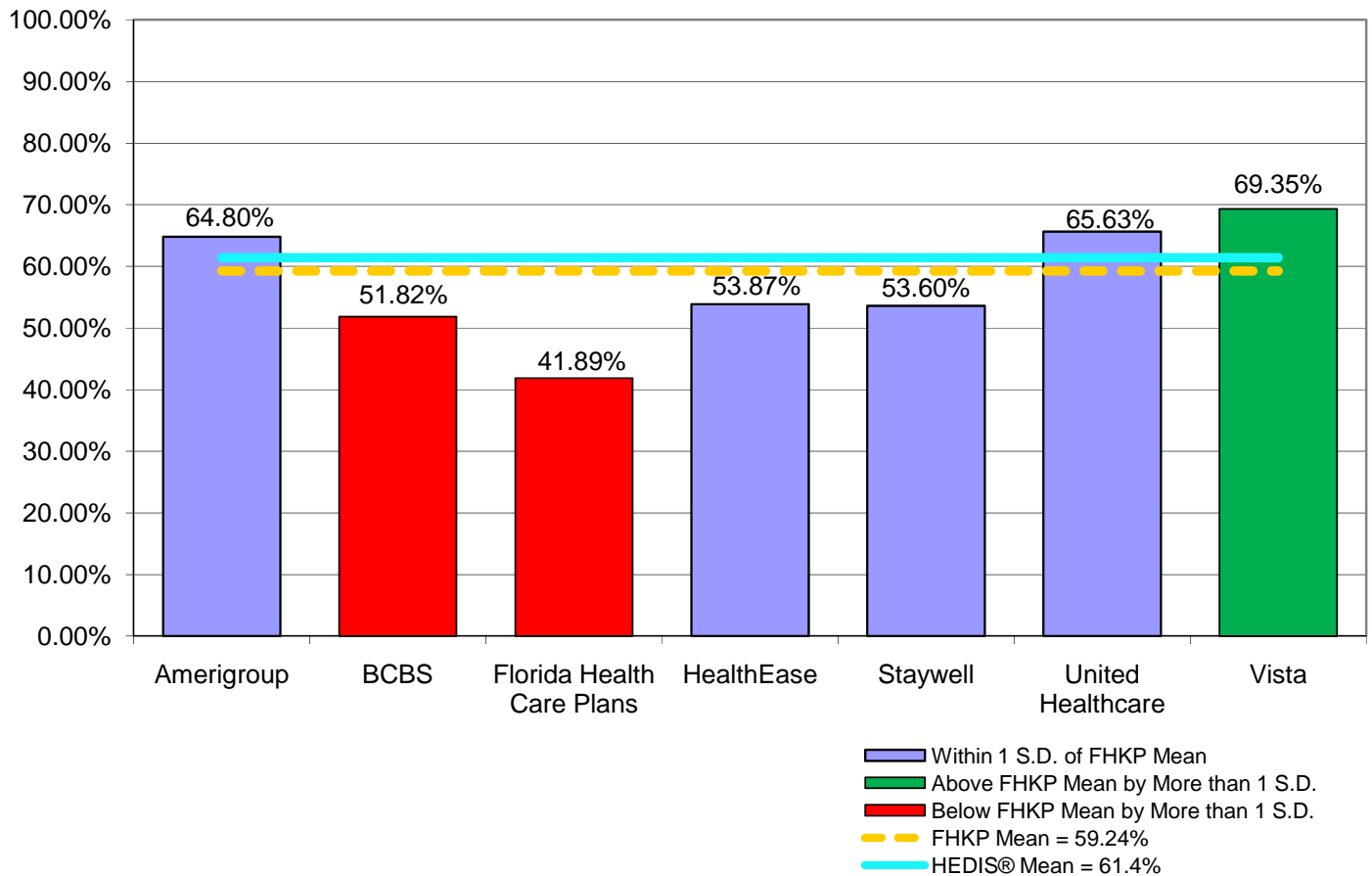
#### Measurement:

Appropriate Testing for Children with Pharyngitis is measured as the percentage of children ages 2-18 years who received a group A streptococcus test among those who had a diagnosis of pharyngitis and were dispensed an antibiotic for that episode of care.

#### Key Findings:

- Overall, the FHKP performance of 59.2% approximated the national Medicaid HEDIS® average of 61.4%.
- Vista performed above the FHKP mean by more than one standard deviation.
- BCBS performed below the FHKP mean by more than one standard deviation, and Florida Health Care Plans performed below the FHKP mean by more than two standard deviations.

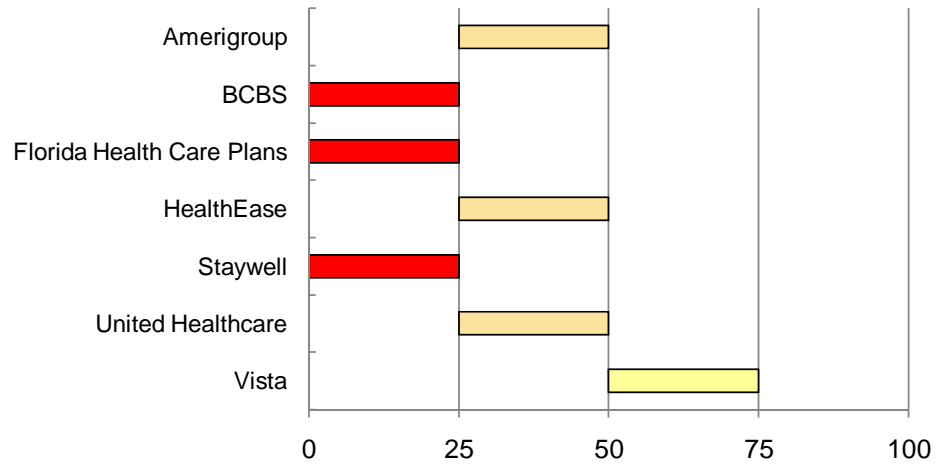
**Figure 26: HEDIS® Appropriate Testing for Children with Pharyngitis (Eligibles = 5,682)**



**Figure 27: Appropriate Testing for Children with Pharyngitis  
Comparison to National Medicaid Percentiles**

**Plan Performance Compared to National Medicaid Percentiles:**

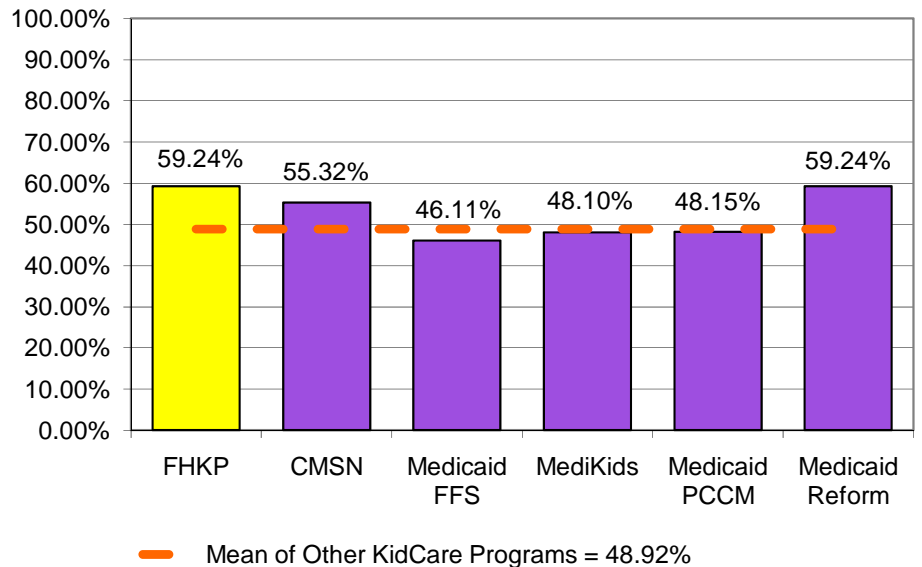
Only Vista performed above the national Medicaid 50<sup>th</sup> percentile for this measure. Three plans performed below the 25<sup>th</sup> percentile.



**Figure 28: Appropriate Testing for Children with Pharyngitis  
Comparison to Other KidCare Programs**

**FHKP Performance Compared to Other KidCare Programs:**

The FHKP performed more than 10 percentage points above the mean of 48.92% for the other KidCare programs.



## HEDIS® Appropriate Treatment for Children with Upper Respiratory Infection

### Significance:

- Upper respiratory infection (URI), also known as the common cold, is one of the most common reasons children see a physician.
- Clinical practice guidelines recommend against the use of antibiotics for treating URI in children based on evidence from controlled trials.<sup>23</sup>
- Although the rates have decreased, inappropriate antibiotic prescriptions for URI persist.<sup>24</sup> Consequently, the appropriate treatment for URI with respect to antibiotic use has been established as an important performance measure.<sup>25</sup>

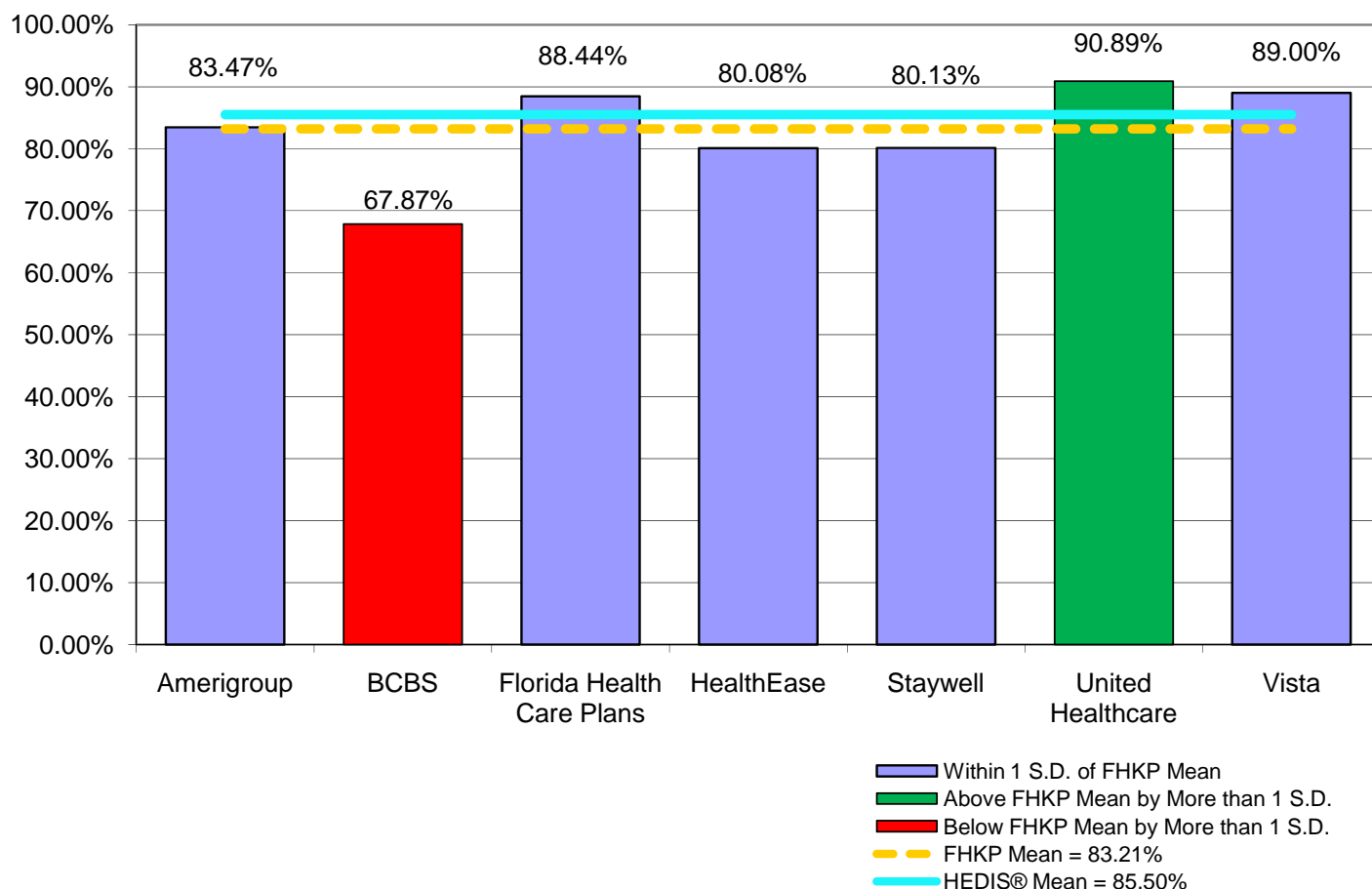
### Measurement:

Appropriate Treatment for Children with Upper Respiratory Infection is measured as the percentage of children ages 3 months to 18 years who were diagnosed with URI and were not dispensed an antibiotic prescription.

### Key Findings:

- Overall, the FHKP performance of 83.2% approximated the national Medicaid HEDIS® average of 85.5%.
- United Healthcare performed above the FHKP mean by more than one standard deviation.
- BCBS performed below the FHKP mean by more than two standard deviations.

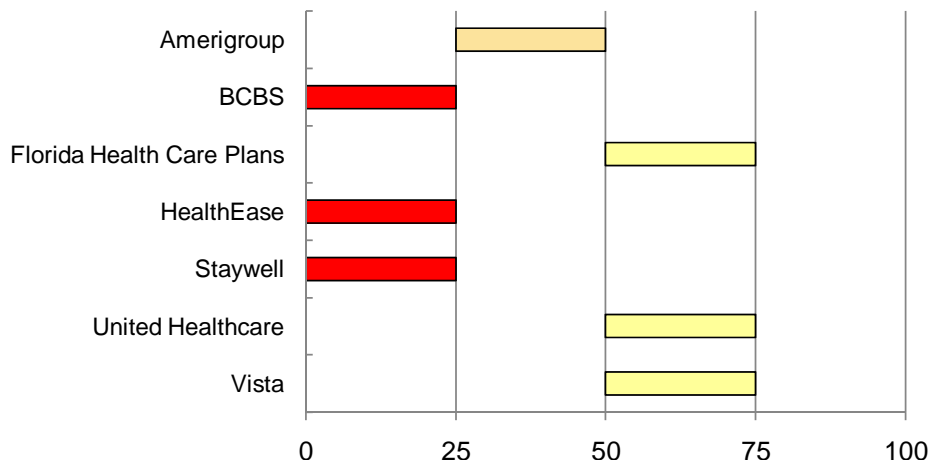
**Figure 29: HEDIS® Appropriate Treatment for Children with Upper Respiratory Infection (Eligibles = 9,287)**



**Figure 30: Appropriate Treatment for Children with Upper Respiratory Infection  
Comparison to National Medicaid Percentiles**

**Plan Performance Compared to National Medicaid Percentiles:**

Three plans performed above the national Medicaid 50<sup>th</sup> percentile for this measure. Four plans performed below the 50<sup>th</sup> percentile with three of those plans below the 25<sup>th</sup> percentile.



[Comparisons for other KidCare program components were not available for this measure.]

## HEDIS® Use of Appropriate Medications for People with Asthma

### Significance:

- Asthma is one of the most common diseases of childhood and adolescence and a leading cause of school absenteeism.<sup>26</sup>
- Many asthma-related hospitalization, emergency department visits, and missed school days can be avoided with appropriate medication use.
- Despite advances in the treatment of asthma, including the development of new therapies to control symptoms and prevent exacerbations, and clinical guidelines developed by the National Heart, Lung and Blood Institute, effective therapies are not uniformly used in the pediatric health care community.<sup>27</sup>

### Measurement:

- Use of Appropriate Medications for People with Asthma is measured as the percentage of members with persistent asthma who were appropriately prescribed medications during the measurement period overall and by age group.
- Age stratifications were modified for HEDIS® 2010 to 5-11 years and 12-50 years (previous age cohorts were 5-9 years, 10-17 years, and 18-56 years).

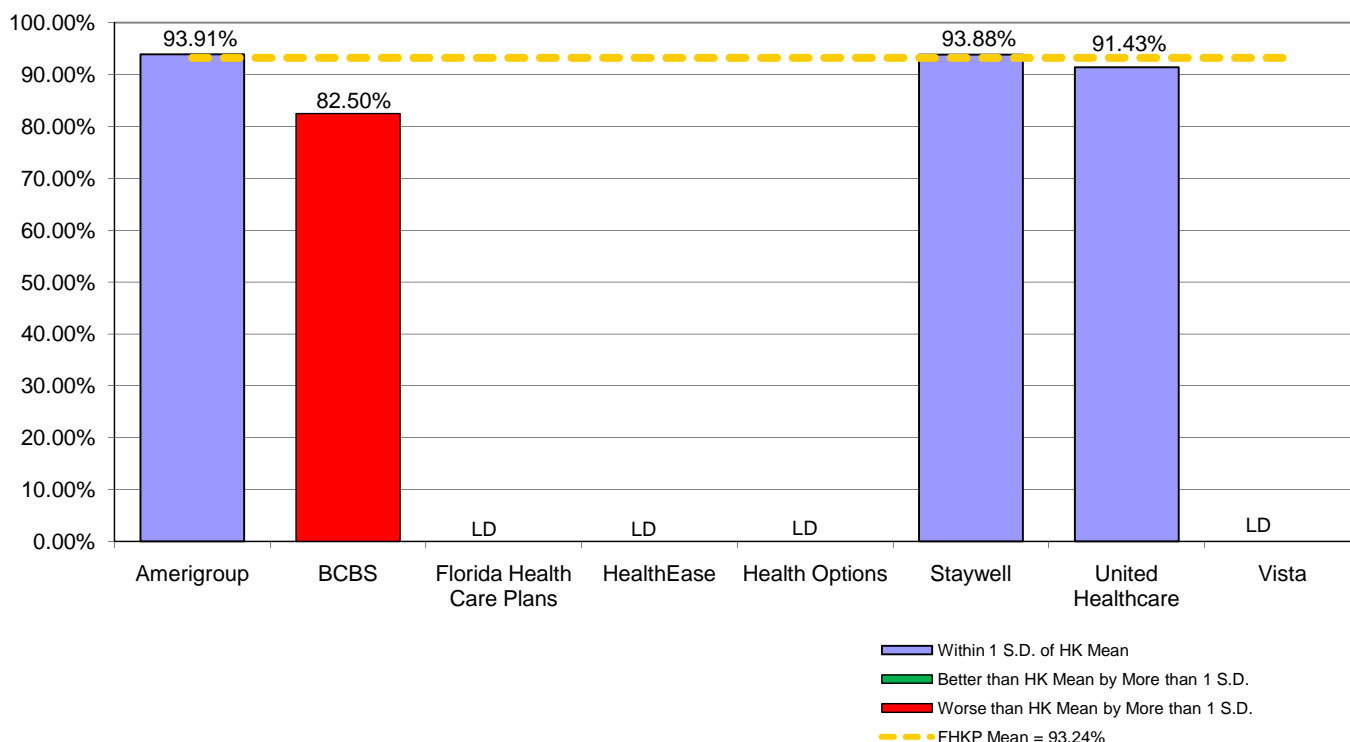
### Reporting Notes:

- Because this measure requires two years of enrollment data and many enrollees switched plans in the middle of the 2-year enrollment period due to the statewide re-contracting, only two plans had a sufficient denominator ( $\geq 30$ ) to report rates by age cohort. Therefore, just the total rates for all ages combined are reported.
- Because there were several changes to the HEDIS® technical specifications for this measure, FHKP rates are not compared to the national Medicaid rates or to the 2008 KidCare Annual Evaluation rates, both of which were calculated using the HEDIS® 2009 specifications.

### Key Findings:

- There was strong performance on this measure overall, with a program mean of 93.2%.
- BCBS performed below the FHKP mean by more than two standard deviations.
- Florida Health Care Plans, HealthEase, and Vista had too few eligible members (<30) to report their rates for this measure

**Figure 31: HEDIS® Use of Appropriate Medications for People with Asthma (Eligibles = 903)**



## **4.5 Health Plan Quality of Care Measures: Effectiveness of Care – Behavioral Health**

### **HEDIS® Follow-Up Care for Children Prescribed ADHD Medication**

#### **Significance:**

- Attention Deficit Hyperactivity Disorder (ADHD) is one of the more commonly treated chronic conditions of childhood.
- Children with ADHD often have behavioral problems and experience difficulty in school and in their personal relationships.
- The American Academy of Pediatrics Clinical Practice Guidelines recommend that primary care providers recognize ADHD as a chronic condition, develop a treatment program that may include medication and/or behavioral therapy, and engage in systematic follow-up to monitor the effects of treatment.<sup>28</sup>

#### **Measurement:**

- Follow-Up Care for Children Prescribed ADHD Medication is measured as the percentage of children 6-12 years of age newly prescribed ADHD medication who have at least three follow-up visits within a 10-month period.
- This measure is separated into two rates by phase of care:

**Initiation** is measured as the percentage of children 6-12 years of age prescribed ADHD medication who had one follow-up visit with a provider with prescribing authority within 30 days of the prescription.

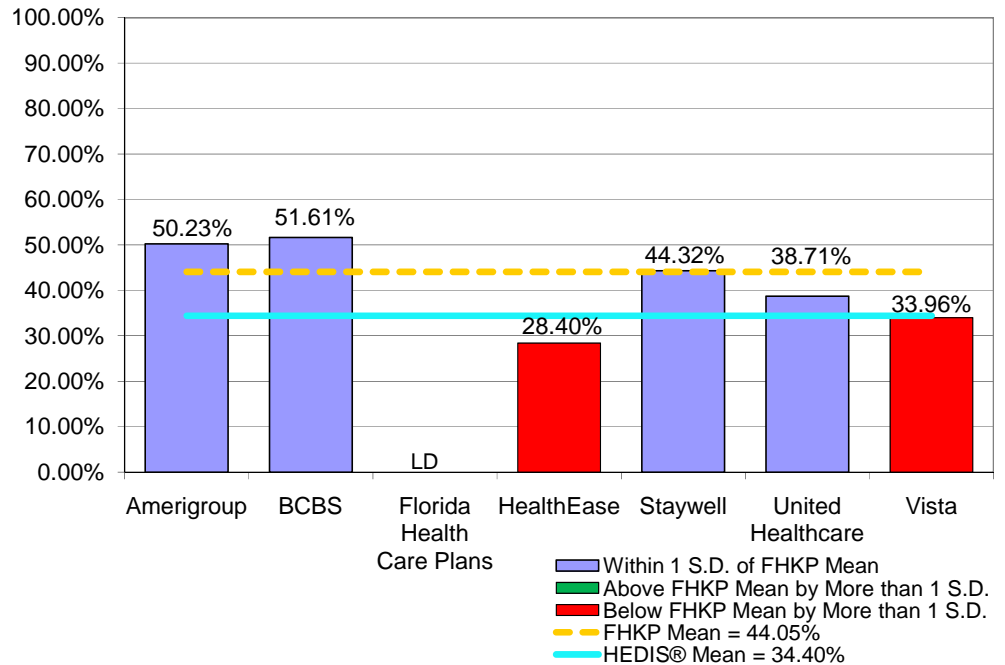
**Continuation and Maintenance** is measured as the percentage of children 6-12 years of age prescribed ADHD who have remained on the medication for at least 210 days and who had at least two additional follow-up visits with a provider within 270 days (9 months) after the end of the Initiation Phase.

**Key Findings:**

**Initiation:**

- Overall, 44.1% of FHKP enrollees who were prescribed medication for ADHD received follow-up care in the initiation phase, which is almost 10 percentage points above the national Medicaid HEDIS® mean of 34.4%.
- HealthEase and Vista performed below the FHKP mean by more than one standard deviation, but were within two standard deviations.

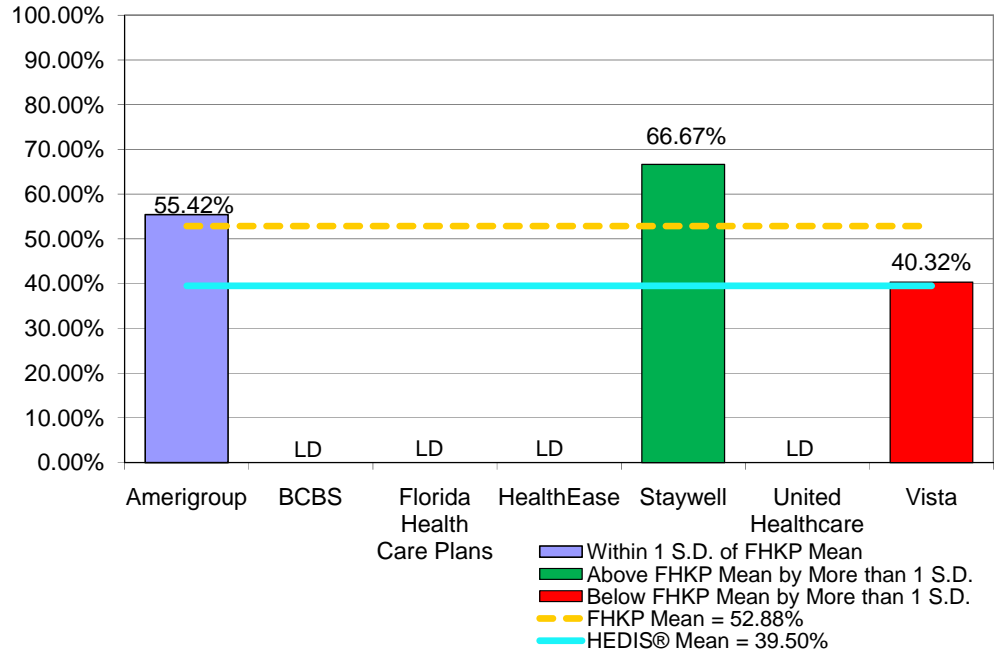
**Figure 32: HEDIS® Follow-Up Care for Children Prescribed ADHD Medication  
Initiation Phase (Eligibles = 1,278)**



**Continuation and Maintenance Phase:**

- Among those who initiated treatment and remained on the medication for at least 210 days, 52.9% had at least two follow-up visits, which is 13 percentage points above the national Medicaid HEDIS® mean of 39.5%.
- There was significant variation among the three health plans with reportable rates. Staywell had the strongest performance at 66.67%, which was more than one standard deviation above the FHKP mean. Vista performed below the program mean by more than one standard deviation, but was within two standard deviations.

**Figure 33: HEDIS® Follow-Up Care for Children Prescribed ADHD Medication  
Continuation and Maintenance Phase (Eligibles = 191)**

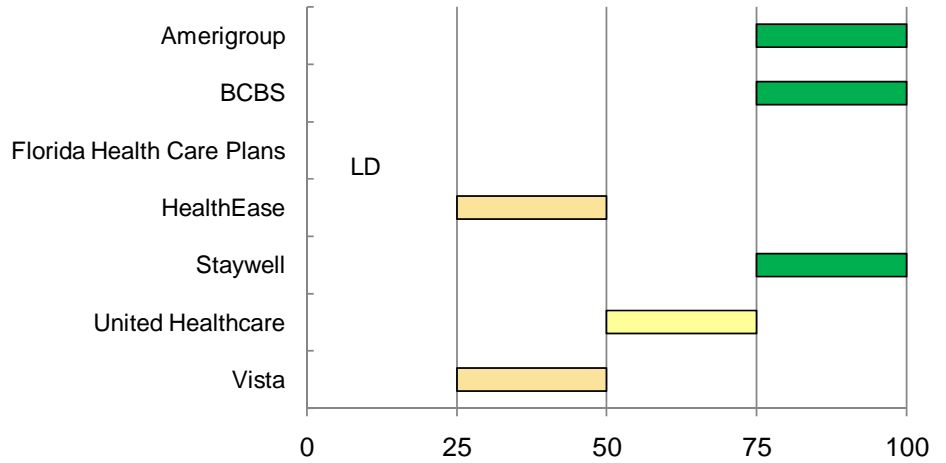




**Figure 34: Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase  
Comparison to National Medicaid Percentiles**

**Initiation - Plan Performance Compared to National Medicaid Percentiles:**

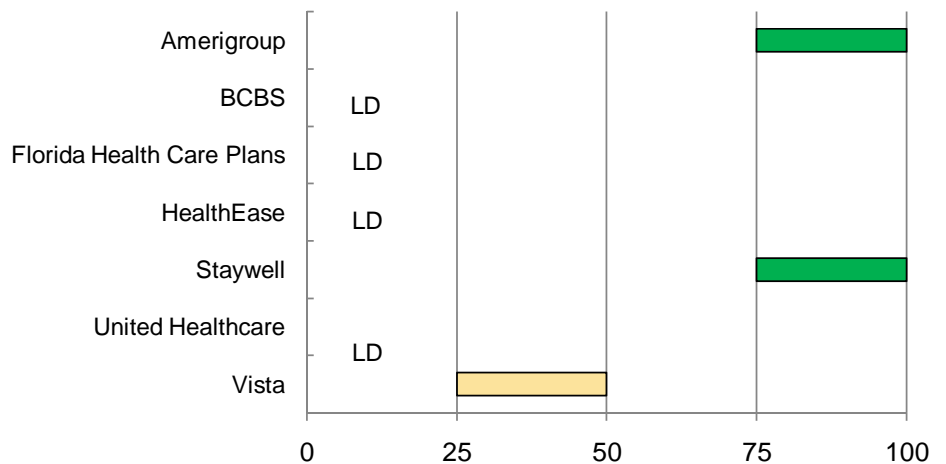
Four plans performed above the national Medicaid 50<sup>th</sup> percentile, three of which were above the 75<sup>th</sup> percentile. Two plans performed below the 50<sup>th</sup> percentile.



**Figure 35: Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase  
Comparison to National Medicaid Percentiles**

**Continuation and Maintenance - Plan Performance Compared to National Medicaid Percentiles:**

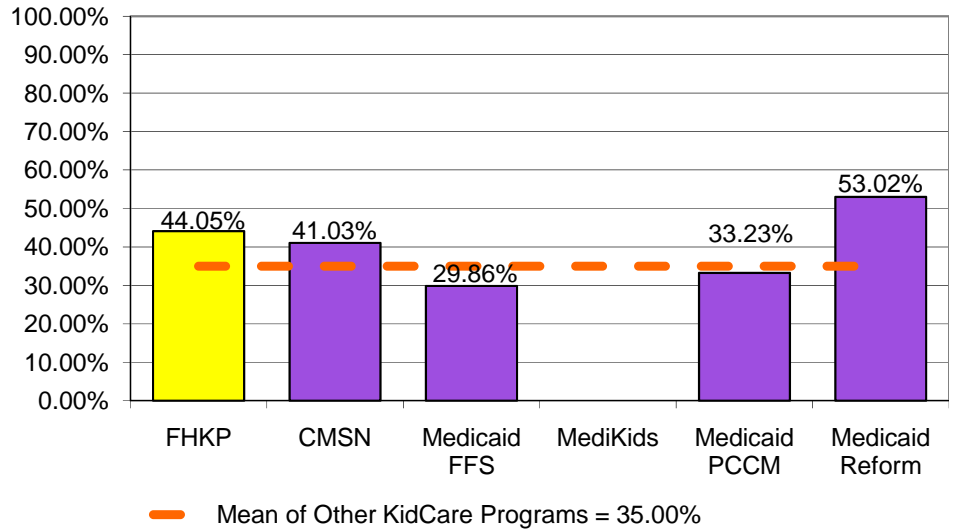
Of the three plans with reportable rates (denominator  $\geq 30$ ), Amerigroup and Staywell performed above the national Medicaid 75<sup>th</sup> percentile, and Vista performed below the 50<sup>th</sup> percentile.



**Figure 36: Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase Comparison to Other KidCare Programs**

**Initiation - FHKP Performance Compared to Other KidCare Programs:**

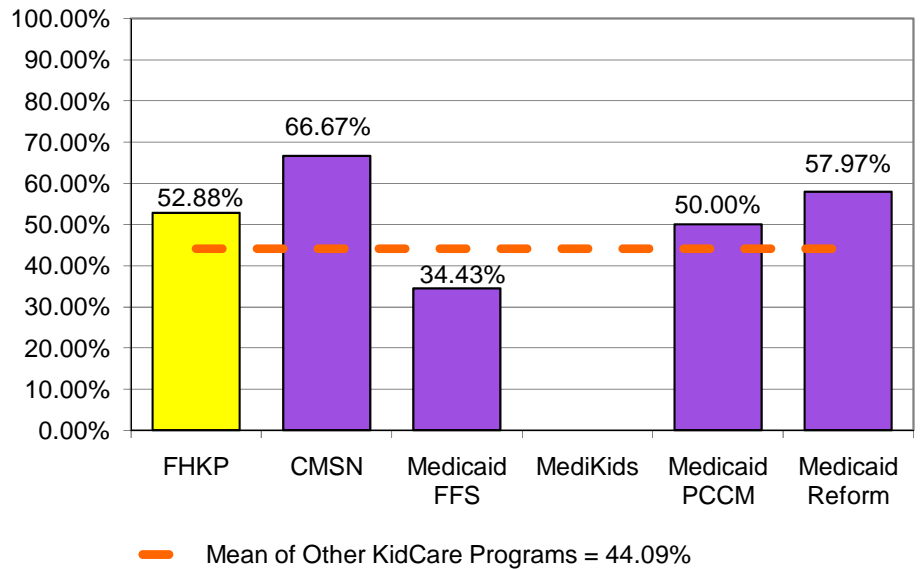
At 44.05%, the FHKP performed 9 percentage points above the mean of 35.00% for the other KidCare programs.



**Figure 37: Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase Comparison to Other KidCare Programs**

**Continuation and Maintenance - FHKP Performance Compared to Other KidCare Programs:**

At 52.88%, the FHKP performed more than 8 percentage points above the mean of 44.09% for the other KidCare programs.



## HEDIS® Follow-Up after Hospitalization for Mental Illness

### Significance:

Ensuring continuity of care and providing follow-up therapy with a mental health practitioner after an inpatient stay for mental illness is important in facilitating enrollees' transitions back to their regular environment and in reducing the likelihood of recurrence.

### Measurement:

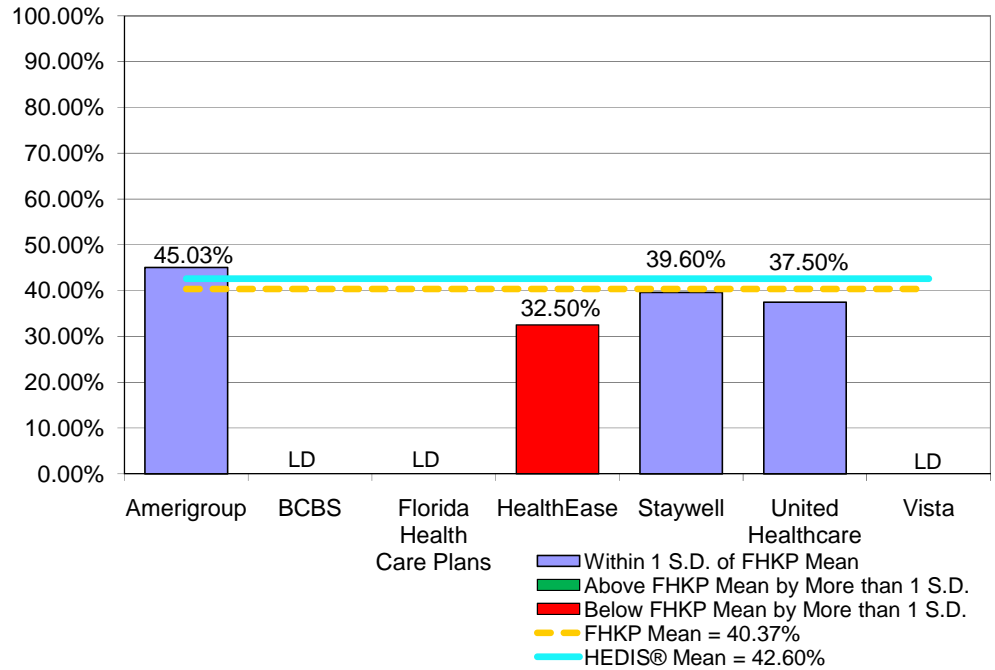
- Follow-Up after Hospitalization for Mental Illness is measured as the percentage of members  $\geq 6$  years of age who were hospitalized for mental illness and who had an outpatient visit, an intensive outpatient encounter, or a partial hospitalization with a mental health practitioner during the measurement period.
- Two rates are reported: (1) follow-up within 7 days of discharge and (2) follow-up within 30 days of discharge.
- These measures specify that follow-up occur with a mental health provider. Due to insufficient information on provider type in the claims and encounter data, this provider type restriction was lifted. Therefore, the rates for this measure are inflated, which should be taken into consideration when comparing rates with the national Medicaid HEDIS® means and percentiles.

**Key Findings:**

**7 Day Follow-Up:**

- Overall, 40.4% of FHKP enrollees  $\geq 6$  years of age who were hospitalized for mental illness had a follow-up visit within 7 days, which approximates the national Medicaid HEDIS<sup>®</sup> mean of 42.6%. However, the FHKP rates are inflated due to lifting the provider specialty constraint.
- HealthEase performed below the FHKP mean by more than one standard deviation, but was within two standard deviations.

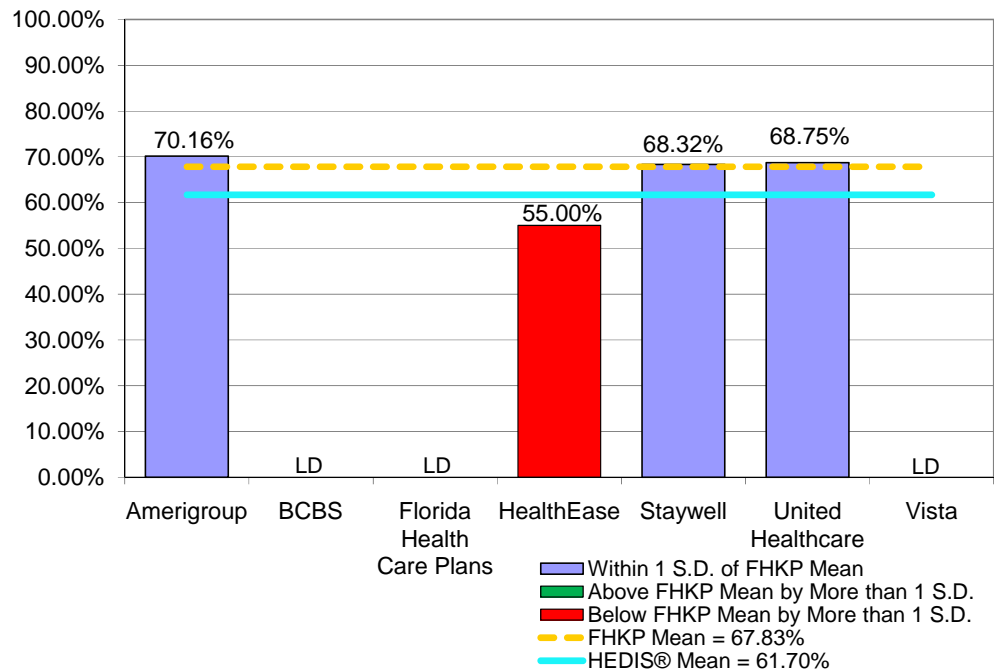
**Figure 38: HEDIS<sup>®</sup> Follow-Up after Hospitalization for Mental Illness 7 Days (Eligibles = 488)**



**30 Day Follow-Up:**

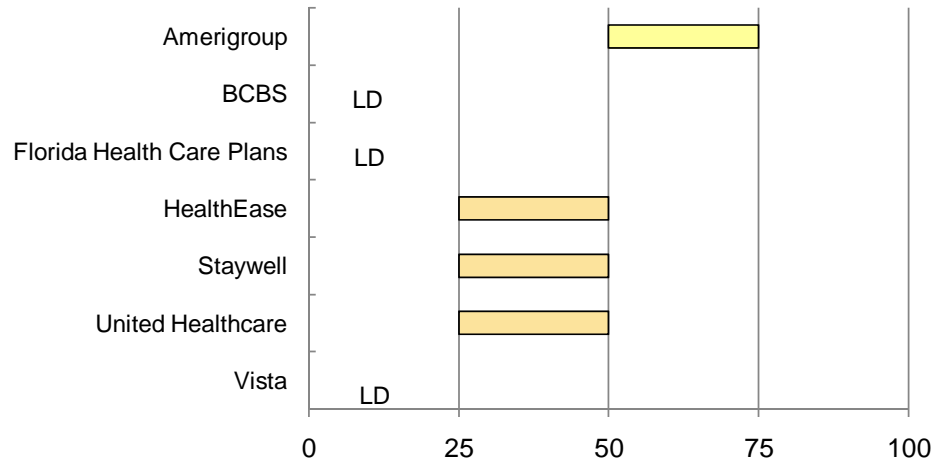
- Overall, 67.8% of FHKP enrollees  $\geq 6$  years of age who were hospitalized for mental illness had a follow-up visit within 30 days, which is 6 percentage points above the national Medicaid HEDIS<sup>®</sup> mean of 61.7%. However, the FHKP rates are inflated due to lifting the provider specialty constraint.
- HealthEase performed below the FHKP mean by more than two standard deviations.

**Figure 39: HEDIS<sup>®</sup> Follow-Up after Hospitalization for Mental Illness 30 Days (Eligibles = 488)**



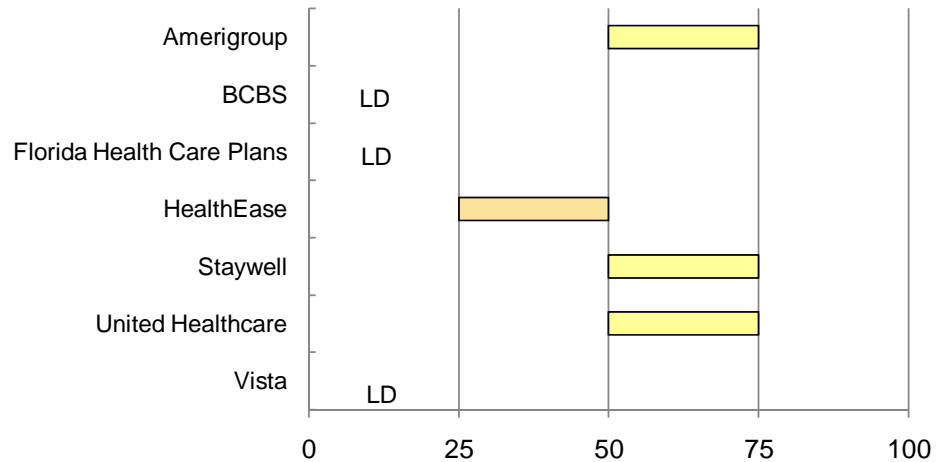
**Figure 40: 7-Day Follow-Up after Hospitalization for Mental Illness  
Comparison to National Medicaid Percentiles**

**7-Day Follow-Up - Plan Performance Compared to National Medicaid Percentiles:**  
Of the four plans with reportable rates (denominator  $\geq 30$ ), only one performed above the national Medicaid 50<sup>th</sup> percentile.



**Figure 41: 30-Day Follow-Up after Hospitalization for Mental Illness  
Comparison to National Medicaid Percentiles**

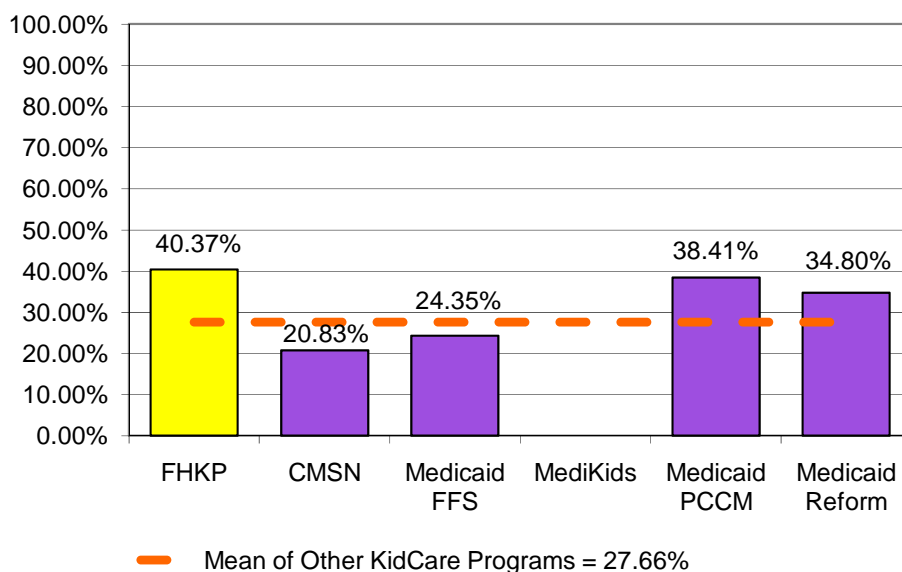
**30 Day Follow-Up - Plan Performance Compared to National Medicaid Percentiles:**  
Of the four plans with reportable rates (denominator  $\geq 30$ ), three performed above the national Medicaid 50<sup>th</sup> percentile.



**Figure 42: 7-Day Follow-Up after Hospitalization for Mental Illness Comparison to Other KidCare Programs**

**7 Day Follow-Up - FHKP Performance Compared to Other KidCare Programs:**

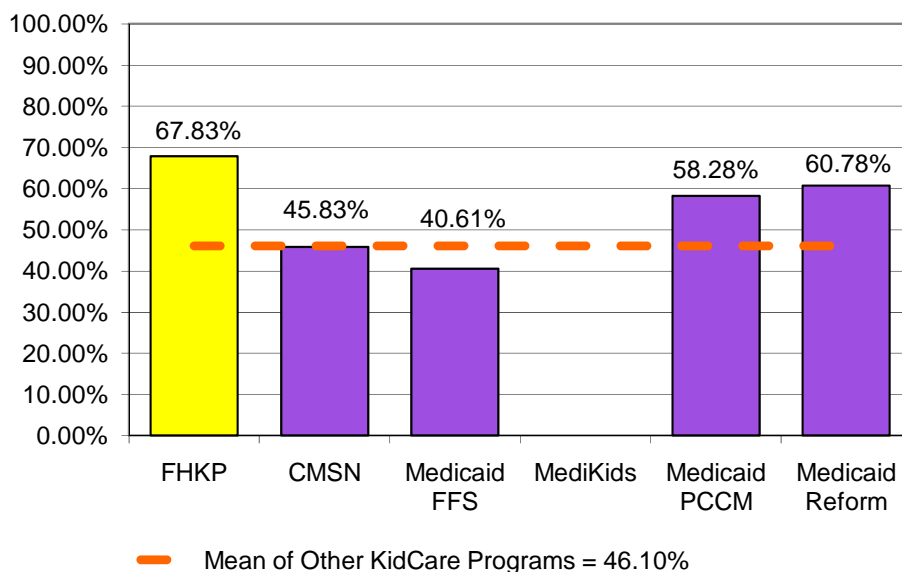
At 40.37%, the FHKP performed significantly above the mean of 27.66% for the other KidCare programs. However, the FHKP rates are inflated due to lifting the provider specialty constraint.



**Figure 43: 30-Day Follow-Up after Hospitalization for Mental Illness Comparison to Other KidCare Programs**

**30 Day Follow-Up - FHKP Performance Compared to Other KidCare Programs:**

At 67.83%, the FHKP performed significantly above the mean of 46.10% for the other KidCare programs. However, the FHKP rates are inflated due to lifting the provider specialty constraint.



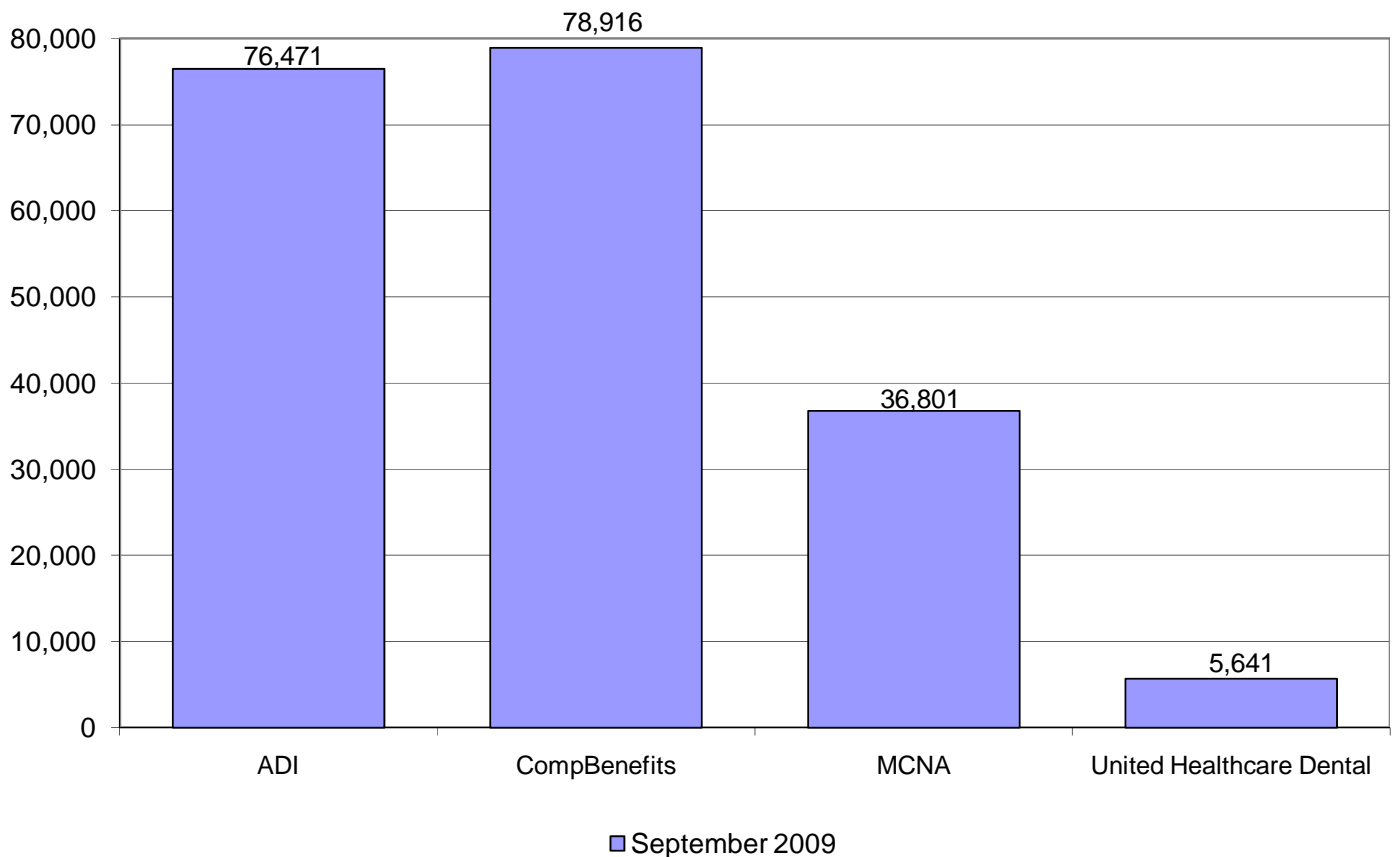
## 5. Dental Plan Quality of Care Measures

### Dental Plan Enrollment

#### Key Points:

- Figure 44 provides the total number of unduplicated members enrolled in each dental plan.
- The plan with the largest membership during the measurement period was CompBenefits at 40% of all enrollees, followed by ADI at 39%, and MCNA at 19%.
- The plan with the smallest enrollment was United Healthcare Dental, which began serving FHKP enrollees on July 1, 2009. Because United Healthcare Dental was not a participating plan during the entire measurement period, it was excluded from quality measure reporting.

**Figure 44: Dental Plan Enrollment, Total Unduplicated Members  
September 2009**



## HEDIS® Annual Dental Visit

### Significance:

- Dental caries is one of the most common, yet preventable, diseases of childhood.<sup>29</sup>
- Approximately one-half of children 6-11 years of age have caries in their primary teeth, and 25% have untreated tooth decay in their primary teeth. One-half of adolescents 12-15 years of age have dental caries, and 17% have untreated tooth decay in their permanent teeth. Among teenagers 16-19 years of age, two-thirds have dental caries and 22% have untreated tooth decay.<sup>30</sup>
- Dental caries has significant adverse consequences for child health and overall well-being, including increased risk of future caries, hospitalization and emergency room visits, and missed school days.<sup>31</sup>
- Preventive measures initiated during infancy and continued throughout childhood and adolescence can significantly reduce the risk of developing caries.
- The American Dental Association (ADA), the American Academy of Pediatric Dentistry (AAPD), and the American Academy of Pediatrics (AAP) all recommend that a child have a dental visit by 12 months of age and receive screening and preventive care visits at regular intervals thereafter.<sup>32</sup> Compliance with recommended dental visits is one indicator of the quality of dental care received.

### Measurement:

- Annual Dental Visit is measured as the percentage of members 2-21 years of age who were continuously enrolled during the measurement year (allowing for a single gap of up to 45 days) who had at least one dental visit during the measurement year. The measure is reported by age cohort.
- Comparisons to other KidCare program components were not available for this measure.

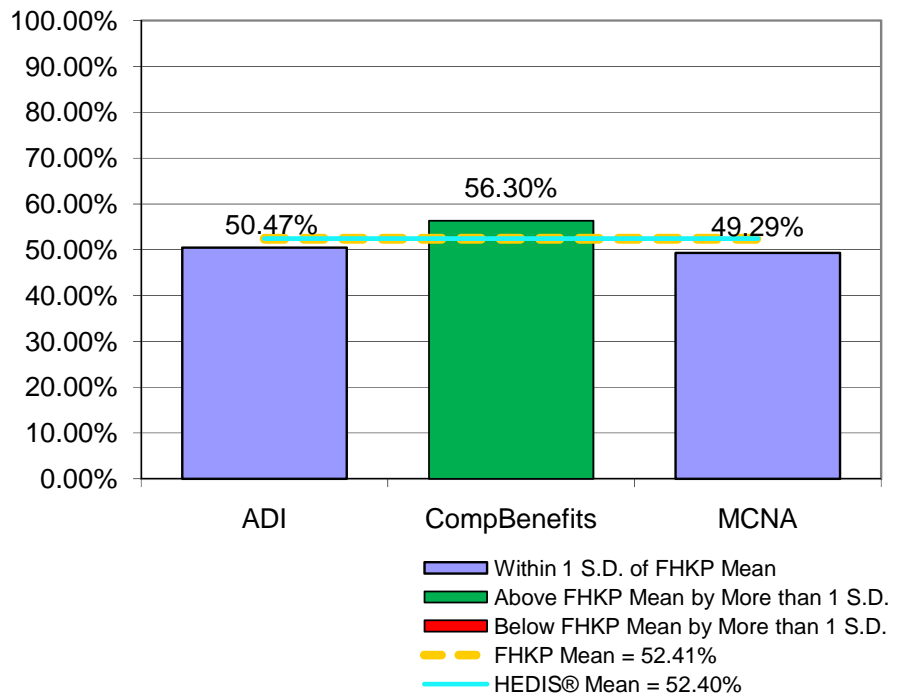


**Key Findings:**

**4-6 Years Old:**

- Overall, 52.4% of FHKP enrollees 4-6 years of age had a dental visit during the measurement year, which is equal to the national Medicaid HEDIS® mean.
- CompBenefits performed above the FHKP mean by more than one standard deviation.

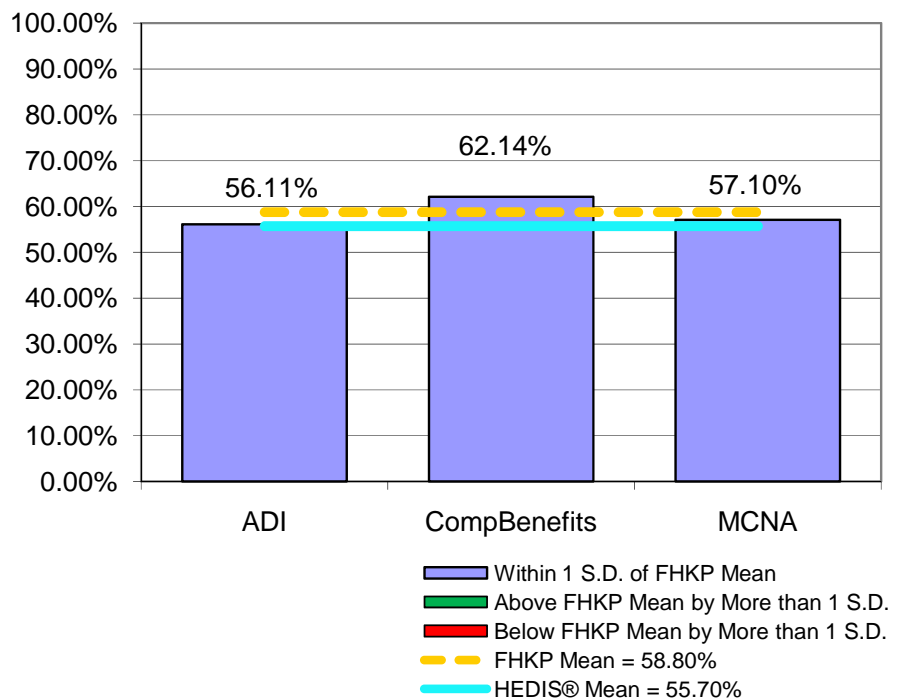
**Figure 45: HEDIS® Annual Dental Visit  
4-6 Years (Eligibles = 4,864)**



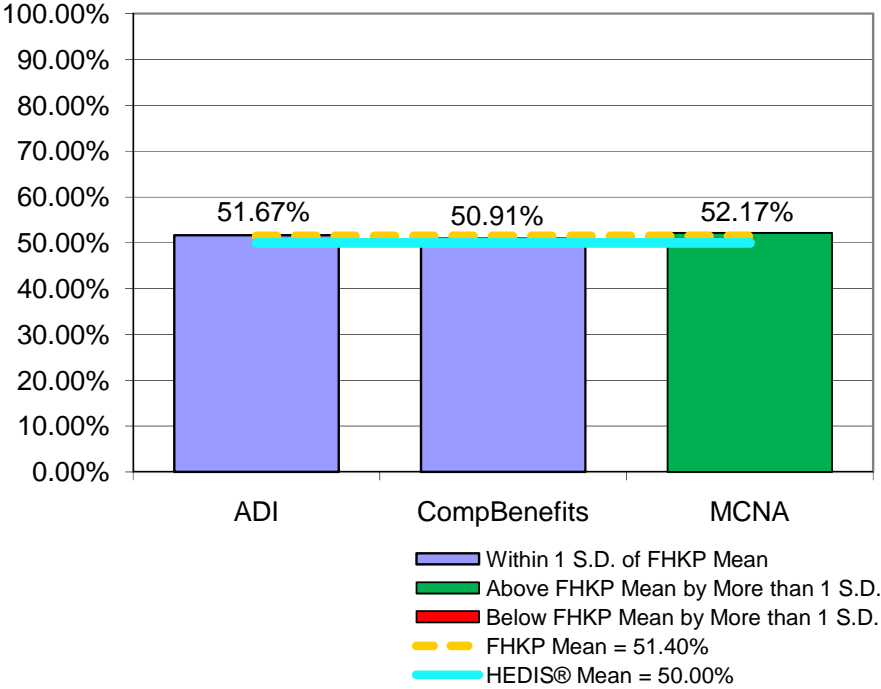
**7-10 Years Old:**

- Overall, 58.8% of FHKP enrollees 7-10 years of age had a dental visit during the measurement year, which is slightly above the national Medicaid HEDIS® mean of 55.7%.

**Figure 46: HEDIS® Annual Dental Visit  
7-10 Years (Eligibles = 32,013)**



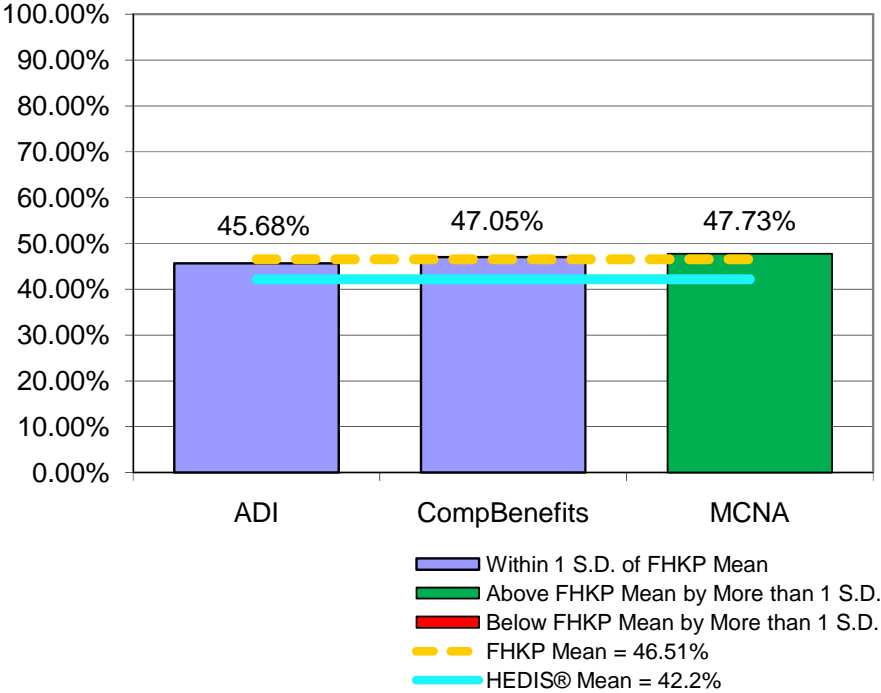
**Figure 47: HEDIS® Annual Dental Visit  
11-14 Years (Eligibles = 37,134)**



**11-14 Years Old:**

- Overall, 51.4% of FHKP enrollees 11-14 years of age had a dental visit during the measurement year, which is slightly above the national Medicaid HEDIS® mean of 50.0%.
- MCNA performed above the FHKP mean by more than one standard deviation.

**Figure 48: HEDIS® Annual Dental Visit  
15-18 Years (Eligibles = 34,942)**



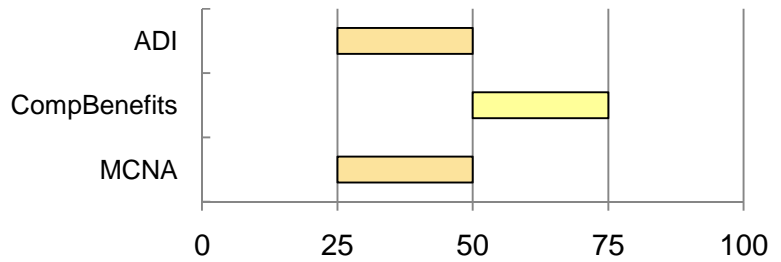
**15-18 Years Old:**

- Among the four age groups reported for this measure, annual dental visit rates are lowest among 15-18 year olds.
- Overall, 46.5% of FHKP enrollees 15-18 years of age had a dental visit during the measurement year, which is 4 percentage points above the national Medicaid HEDIS® mean of 42.2%.

**4 -6 Years - Plan Performance Compared to National Medicaid Percentiles:**

Only CompBenefits performed above the national Medicaid 50<sup>th</sup> percentile on this measure for children ages 4-6 years.

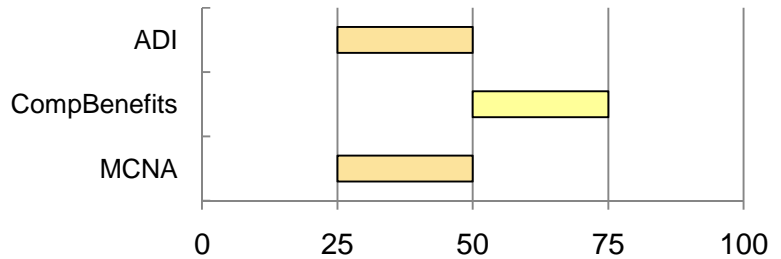
**Figure 49: Annual Dental Visit, 4-6 Years Comparison to National Medicaid Percentiles**



**7 -10 Years - Plan Performance Compared to National Medicaid Percentiles:**

Only CompBenefits performed above the national Medicaid 50<sup>th</sup> percentile on this measure for children ages 7-10 years.

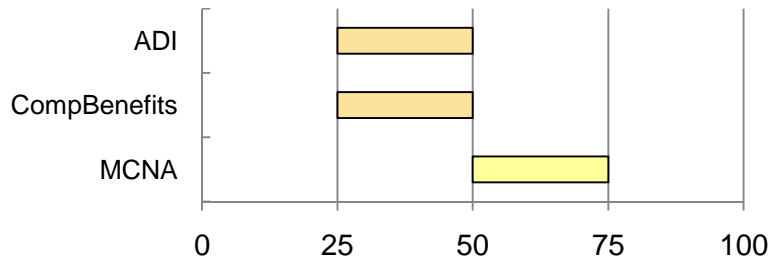
**Figure 50: Annual Dental Visit, 7-10 Years Comparison to National Medicaid Percentiles**



**11-14 Years - Plan Performance Compared to National Medicaid Percentiles:**

Only MCNA performed above the national Medicaid 50<sup>th</sup> percentile on this measure for children ages 11-14 years.

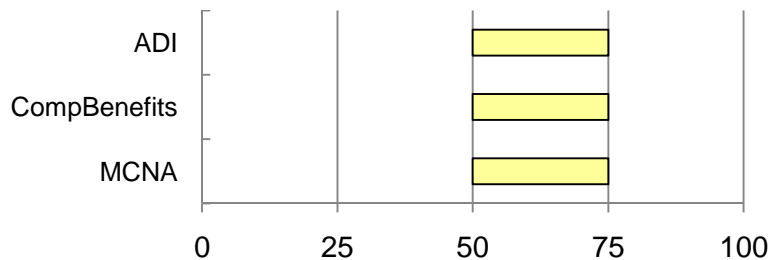
**Figure 51: Annual Dental Visit, 11-14 Years Comparison to National Medicaid Percentiles**



**15 -18 Years - Plan Performance Compared to National Medicaid Percentiles:**

All three dental plans performed above the national Medicaid 50<sup>th</sup> percentile on this measure for children ages 15-18 years.

**Figure 52: Annual Dental Visit, 15-18 Years Comparison to National Medicaid Percentiles**



## Enrolled Children Receiving Dental Preventive Services

### Significance:

- Dental caries is one of the most common, yet preventable, diseases of childhood.<sup>29</sup> However, preventive measures initiated during infancy and continued throughout childhood and adolescence can significantly reduce the risk of developing caries.
- The American Academy of Pediatric Dentistry recommends that children visit a dentist every six months (or more often for high-risk children) for routine and preventive care.<sup>32</sup>

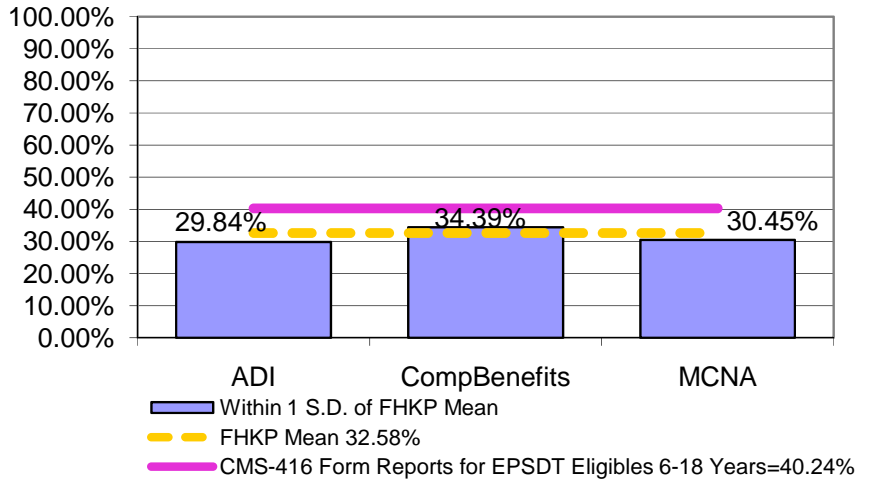
### Measurement:

- Dental Preventive Services are measured as the percentage of unduplicated children who received a dental preventive service (CDT codes D1000-D1999) where unduplicated means that each child is counted only once even if multiple services were received.
- We report this measure using three different enrollment criteria:
  - (1) children enrolled at least one month in the plan,
  - (2) children with at least 6 months continuous enrollment in the plan, and
  - (3) children enrolled for the entire 12 months of the measurement period.
- Because practice guidelines call for a preventive dental visit every six months, reporting based on enrollment criteria is useful for evaluating performance relative to care guidelines.
- The ICHP used administrative enrollment and claims and encounter data to calculate this measure. A variant of this measure was included in the *CHIPRA Recommended Quality Measures* instead of the HEDIS<sup>®</sup> Annual Dental Visit. The CHIPRA recommended measure references the EPSDT measure that assesses the percentage of unduplicated EPSDT eligibles enrolled for any length of time during the measurement period that received a dental preventive service, using data collected on the CMS-416 Form. The *CHIPRA Recommended Quality Measures* background report noted that Medicaid and CHIP officials were concerned about variation in EPSDT reporting across states, which could threaten the validity and reliability of cross-state comparisons for this measure.<sup>2</sup>

**Figure 53: Enrollees Receiving Dental Preventive Services  
Any Enrollment Length (Eligibles = 291,834)**

**Any Enrollment Length:**

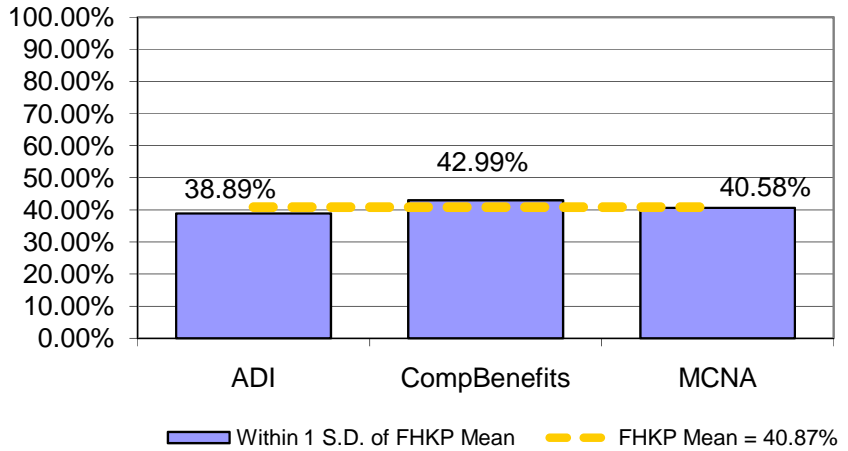
Overall, 32.58% of FHKP enrollees who were enrolled for at least one month received a dental preventive service during the measurement period. This is less than the average rate of 40.24% as reported by states on the CMS-416 Form for Medicaid EPSDT eligibles ages 6-18 years old for fiscal year 2008.



**Figure 54: Enrollees Receiving Dental Preventive Services  
Enrolled at Least 6 Months (Eligibles = 192,536)**

**Enrolled at Least 6 Months:**

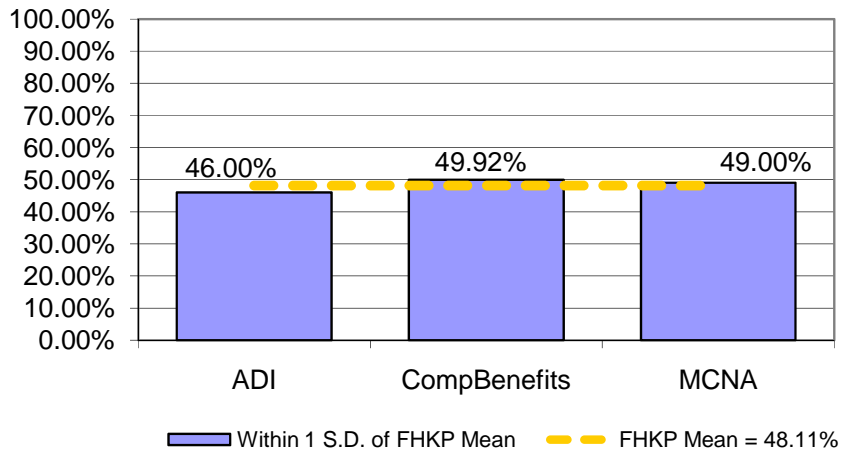
Overall, 40.87% of FHKP enrollees who were enrolled for at least 6 months continuously received a dental preventive service during the measurement year with small variations between dental plans.



**Figure 55: Enrollees Receiving Dental Preventive Services  
Enrolled 12 Months (Eligibles = 92,215)**

**Enrolled All 12 Months:**

Overall, 48.11% of FHKP enrollees who were enrolled for the entire year received a dental preventive service during the measurement year with small variations between dental plans.



## Enrolled Children Receiving Dental Treatment Services

### Significance:

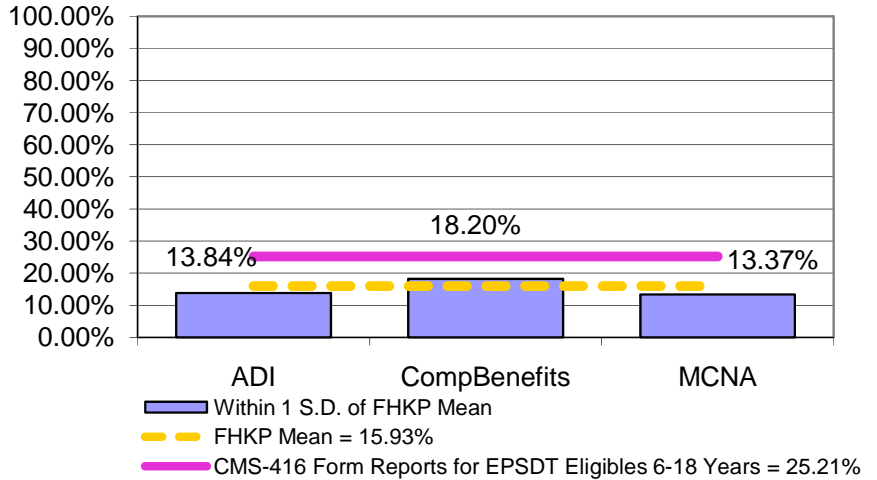
Approximately one-half of children 6-11 years old have untreated tooth decay in their primary teeth, 17% of adolescents 12-15 years of age have untreated tooth decay in their permanent teeth, and 22% of teenagers 16-19 years old have untreated tooth decay.<sup>30</sup>

### Measurement:

- Dental Treatment Services are measured as the percentage of unduplicated children who received a dental treatment service (CDT codes D2000-D9999) where unduplicated means that each child is counted only once even if multiple services were received.
- We report this measure using three different enrollment criteria:
  - (1) children enrolled at least one month in the plan,
  - (2) children with at least 6 months continuous enrollment in the plan, and
  - (3) children enrolled for the entire 12 months of the measurement period.
- The ICHP used administrative enrollment and claims and encounter data to calculate this measure. A variant of this measure was included in the *CHIPRA Recommended Quality Measures*. The CHIPRA recommended measure references the EPSDT measure that assesses the percentage of unduplicated EPSDT eligibles enrolled for any length of time during the measurement period that received a dental treatment service, using data collected on the CMS-416 Form.
- The intent of this measure is to measure access to dental treatment. However, as the noted in the *CHIPRA Recommended Quality Measures* background report, “[t]he need for performance improvement on this measure is difficult to assess, given the denominator used, which does not reflect the number of children in need of dental treatment services.”<sup>2</sup> The report also noted that Medicaid and CHIP officials were concerned about variation in EPSDT reporting across states, which could threaten the validity and reliability cross-state comparisons for this measure.

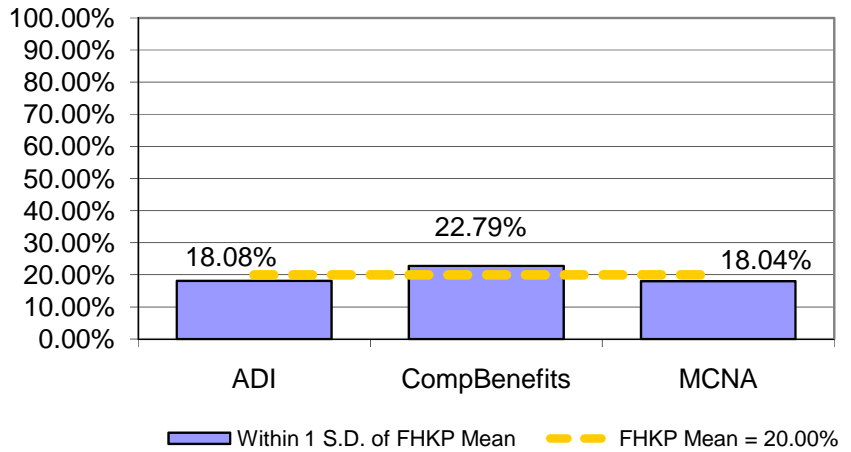
**Figure 56: Enrollees Receiving Dental Treatment Services  
Any Enrollment Length (Eligibles = 291,834)**

**Any Enrollment Length:**  
Overall, 15.93% of FHKP enrollees who were enrolled for at least one month received a dental treatment service during the measurement period. This is below the average rate of 25.21% as reported by states on the CMS-416 Form for Medicaid EPSDT eligibles ages 6-18 years old for fiscal year 2008.



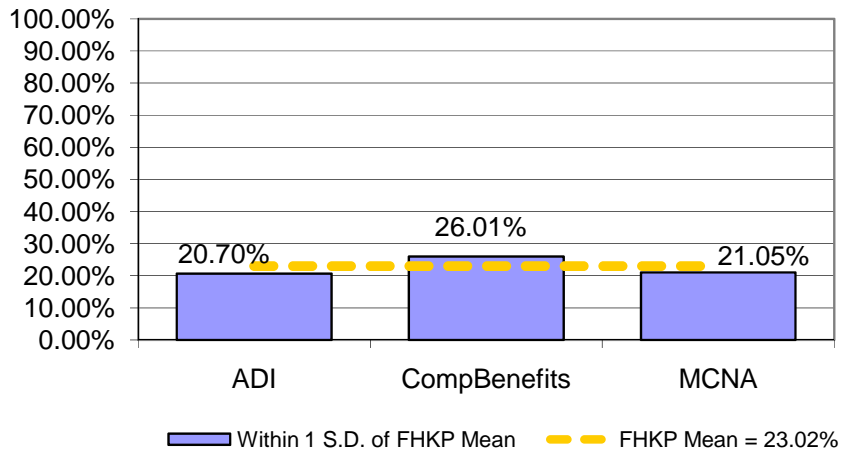
**Figure 57: Enrollees Receiving Dental Treatment Services  
Enrolled at Least 6 Months (Eligibles = 192,536)**

**Enrolled at Least 6 Months:**  
Overall, 20.00% of FHKP enrollees who were enrolled for at least 6 months continuously received a dental treatment service during the measurement year.



**Figure 58: Enrollees Receiving Dental Treatment Services  
Enrolled 12 Months (Eligibles = 92,215)**

**Enrolled All 12 Months:**  
Overall, 23.02% of FHKP enrollees who were enrolled for the entire year received a dental treatment service.



## End Notes

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