Medicaid Managed Care Organization

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medical Record Review Annual Report

Calendar Year 2011

Submitted by:
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HealthChoice and Acute Care Administration
Division of HealthChoice Management
and Quality Assurance

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medical Record Review 2011 Annual Report

Introduction

This Annual Report summarizes the findings from the EPSDT medical record review for Calendar Year (CY) 2011. Approximately 540,432 children were enrolled in the HealthChoice Program during this period.

The seven Managed Care Organizations (MCOs) evaluated for CY 2011 were:

- AMERIGROUP Community Care (ACC)
- Diamond Plan from Coventry Health Care, Inc. (DIA)
- MedStar Family Choice, Inc. (MSFC)
- Jai Medical Systems (JMS)
- Maryland Physicians Care (MPC)
- Priority Partners (PPMCO)
- UnitedHealthcare (UHC)

Program Oview

The EPSDT Program is the federally mandated Medicaid program for screening, prevention, diagnosis, and treatment of physical and mental health conditions in children and adolescents through 20 years of age [as defined by Omnibus Budget Reconciliation Act (OBRA) 1989]. Each State determines its own periodicity schedule for services including periodic physical and mental health screening, vision, dental, and hearing services.

The Program's philosophy is to provide quality health care that is patient focused, prevention oriented, coordinated, accessible, and cost effective. The foundation of this is based on providing a "medical home" for each enrollee. This is accomplished by connecting each enrollee with a primary care provider (PCP) who is responsible for providing preventive and primary care services, managing referrals, and coordinating all necessary care for the enrollee. The Program emphasizes health promotion and disease prevention, and requires that enrollees be provided health education and outreach services.

As the External Quality Review Organization (EQRO) for the Division of HealthChoice Management and Quality Assurance (DHMQA), Delmarva Foundation annually evaluates the quality assurance program and activities of each MCO contracting with the State of Maryland to provide care to Medical Assistance enrollees

in the HealthChoice Program. The medical records review findings assist the Department in evaluating the degree to which HealthChoice children are receiving timely screening and preventive care.

Program Objectives

The Maryland EPSDT Program's mission is to promote access to and assure availability of quality health care for Medical Assistance children, and adolescents through 20 years of age. In support of the program's mission, the primary objective of the EPSDT medical record review is to collect and analyze data to assess the timely delivery of EPSDT services to children and youth enrolled in an MCO. The review includes an assessment of MCO performance for the following EPSDT components and their respective subcategories:

Health and developmental history requires a comprehensive evaluation and includes documentation of:

- Annual medical, immunization, family, and psychosocial histories with yearly updates.
- Perinatal history up through 2 years of age.
- Developmental history/surveillance through 20 years of age.
- Mental health assessment beginning at 3 years of age.
- Substance abuse screening beginning at 12 years of age, younger if indicated.

Comprehensive physical examination requires evaluation and includes documentation of:

- A complete assessment of no fewer than five body systems.
- Age appropriate vision and hearing assessments at every visit.
- Nutritional assessment at every age.
- Oral assessment at all ages.
- Height and weight measurement with graphing through 20 years of age.
- Head circumference measurement and graphing through 2 years of age.
- BMI calculation and graphing for ages 2 years of age through 20 years of age.
- Blood pressure measurement beginning at 3 years.

Laboratory tests/at risk screenings require documentation of:

- Hereditary/metabolic screening test results at birth and again by 1 month* of age.
- Age appropriate risk assessment results for tuberculosis, cholesterol, and sexually transmitted diseases.
- Counseling and/or laboratory test results for at risk recipients.
- Anemia tests at 12** and 24*** months of age.
- Lead risk assessment for 6 months through 6 years of age.
- Referral to the lab for lead testing at appropriate ages.
- Blood lead tests results at 12** and 24*** months of age.
- Blood lead test results for ages 3 through 5 years of age when not done at 12 or 24 months of age.

NOTES: *accepted until 8 weeks of age, **accepted from 9-23 months of age, ***accepted from 24-35 months of ag

Immunizations require assessment of need and documented administration that:

- The Department of Health and Mental Hygiene (DHMH) Immunization Schedule is being implemented in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines.
- Age appropriate vaccines are not postponed for inappropriate reasons.
- Children are brought current with the periodicity schedule of preventive care who are delayed in their immunizations.

Health education and anticipatory guidance requires documentation of:

- Age appropriate guidance with a minimum of three anticipatory guidance items or two major topics documented per visit.
- Counseling/referrals for health issues identified by parent or provider during the visit.
- Oral health assessment following eruption of teeth; yearly dental education and referrals beginning at 2 years of age.
- Educating recipient and/or parent regarding schedule of preventive care visits.
- Return appointments documented according to the Maryland Schedule of Preventive Health Care.

CY 2011 EPSDT Review Process

Sampling Methodology

The sample frame was drawn from preventive care encounters occurring during calendar year 2011 for children from birth through 20 years of age. The sampling methodology includes the following criteria:

- A random sample of preventive care encounters per MCO including a 10% over sample.
- Sample size per MCO provides a 95 percent confidence level and 5 percent margin of error.
- Sample includes only recipients through 20 years of age as of the last day of the measurement year.
- Sample includes encounter data for recipients enrolled on last day of measurement year, and for at least 320 days in the same MCO. ***Exception*** – If the recipient's age on the last day of selected period is less than 365 days, the criteria is modified to read same MCO for 180 days, with no break in eligibility.
- Sample includes recipients who had a preventive care encounter (CPT 99381-85 or 99391-95) with a diagnostic code of V20 or V70 (For children less than 2 years of age who may have had 4-6 preventive visits within a 12-month period, only one date of service was selected.)
- Sample includes recipients when visits with CPT 99381-85 or 99391-95 were provided by primary care providers and clinics with the following specialties: pediatrics, family practice, internal medicine, nurse practitioner, general practice or a Federally Qualified Health Center (FQHC).

Scoring Methodology

Data from the medical record reviews were entered into Delmarva Foundation's EPSDT Evaluation Tool. The analysis of the data was organized by the following age groupings:

- birth through 11 months,
- 12 through 35 months,
- 3 through 5 years,
- 6 through 11 years, and
- 12 through 20 years of age.

Within each age group, specific elements were scored based on medical record documentation. A score of two meant the element was complete; a score of one meant that the element was incomplete; a score of zero meant the element was missing. When an element is not applicable to a child such as a vision assessment for a blind child or a documented refusal for a flu vaccine by a parent, a score of two was given.

Elements, each weighted equally, within a component were scored and added together to derive the final component score. Similarly, the composite score (or overall score) follows the same methodology.

The scoring methodology produced a result that reflected the percentage of possible points obtained in each component, for each age group, and for each MCO. The minimum per component compliance score is 75%. If the minimum compliance score is not met, a Corrective Action Plan (CAP) is required.

Medical Record Review Process

Medical records were randomly selected in order to assess compliance with the program standards. Nurse reviewers conducted all medical record reviews in the provider offices with the exception of providers with only one child in the sample. These providers were given the option to mail or fax a complete copy of the medical record to Delmarva Foundation for review. In total, 2,721 medical records were reviewed for CY 2011.

The review criteria used by Delmarva Foundation's review nurses was the same as those developed and used by the Department. Delmarva Foundation completed annual training and conducted inter-rater reliability (IRR). The review nurses achieved a score of 92% prior to the beginning of the CY 2011 EPSDT Medical Record Review.

EPSDT Review Results

EPSDT review indicators are based on current pediatric preventive care guidelines and DHMH identified priority areas. The guidelines and criteria are divided into five component areas. Each MCO was required to meet a minimum compliance rate of 75% for each of the five components. If an MCO did not achieve the minimum compliance rate, the MCO was required to submit a CAP. Five of the seven MCOs met the minimum compliance rate of 75% in each of the five component areas for the CY 2011 review. CAPs for the Laboatory Tests/At Risk Screenings component were required from two MCOs.

Findings for the CY 2011 EPSDT review by component area are described in Table 1.

Table 1. CY 2011 EPSDT Component Results by MCO

Component	ACC	DIA	JMS	MPC	MSFC	PPMCO	UHC	HealthChoice Aggregate CY 2009 Jan – Dec 2009 Encounter Data	HealthChoice Aggregate CY 2010 Jan – Dec 2010 Encounter Data	HealthChoice Aggregate CY 2011 Jan – Dec 2011 Encounter Data
Health & Developmental History	84%	90%	97%	88%	90%	88%	85%	86%	89%	89%
Comprehensive Physical Examination	89%	90%	98%	92%	92%	90%	89%	93%	88%	92%
Laboratory Tests/At Risk Screenings	77%	76%	97%	79%	81%	70%*	73%*	80%	82%	79%
Immunizations	89%	83%	90%	87%	90%	90%	89%	85%	89%	88%
Health Education/ Anticipatory Guidance	88%	90%	97%	89%	88%	90%	88%	88%	90%	90%

*Denotes that the minimum compliance score of 75% was unmet

The following section provides a description of each component along with a summary of HealthChoice MCOs' performance.

Health and Developmental History

Rationale: A comprehensive personal and family medical history assists the provider in determining health risks and providing appropriate laboratory testing and anticipatory guidance.

Components: Personal history includes medical, developmental, psychosocial, and mental health information, as well as the immunization record. Psychosocial history assesses support systems and exposure to family and/or community violence which may adversely affect the child's mental health. Developmental, mental health and substance abuse screenings determine the need for referral and/or follow-up services. The mental health assessment provides an overall view of the child's personality, behaviors, social interactions, affect, and temperament.

Documentation: Annual updates for personal, family, and psychosocial histories are required to ensure the most current information is available. The use of a standard, age appropriate history form, such as the Maryland Healthy Kids Program Medical/Family History or a similarly comprehensive history form are recommended, such as the CRAFFT Assessment Tool from Children's Hospital Boston.

Health and Developmental History Results

- All MCO's scores exceeded the minimum compliance rate of 75% for the Health and Developmental History component in CY 2011.
- The HealthChoice Aggregate score increased by 3 percentage points from CY 2009 to CY 2010 for this component and for the current CY 2011 remains unchanged. The current CY 2011 HealthChoice Aggregate score for the Health and Developmental History component is 89%.

Comprehensive Physical Examination

Rationale: The comprehensive physical exam by a review of systems method requires documentation of a minimum of five systems to meet EPSDT standards.

Components & Documentation: A comprehensive physical exam includes documentation of:

- Subjective or objective vision and hearing assessments at every well-child visit.
- Measuring and graphing head circumference through 2 years of age.
- Recording blood pressure annually for children 3 years of age and older.
- Oral assessment including a visual exam of the mouth, gums, and teeth.
- Nutritional assessment including typical diet, physical activity, and education provided with graphing of weight and height through 20 years of age on the growth chart.
- Calculating and graphing BMI for 2 years of age through 20 years of age.
- Appropriate referrals for nutrition services and/or counseling due to identified nutrition or growth problems.

Comprehensive Physical Examination Results

- All MCO's scores exceeded the minimum compliance rate of 75% for the Comprehensive Physical Exam component for CY 2011.
- The HealthChoice Aggregate score decreased 5 percentage points from CY 2009 to CY 2010. Calculation and graphing of BMI was included in the scoring of this component for the first time in CY 2010. The CY 2011 HealthChoice Aggregate score for the Comprehensive Physical Exam component is 92% which represents an increase from CY 2010 of 4 percentage points.

Laboratory Tests/At Risk Screenings

Rationale: The Healthy Kids Program requires assessments of risk factors associated with heart disease, anemia, tuberculosis, lead exposure, and sexually transmitted infection/human immunodeficiency virus (STI/HIV).

Components: Assessment of risk factors includes:

- Tuberculosis risk assessment beginning at 1 year of age. Beginning in CY 2012 this risk assessment requirement will begin at 1 month of age.
- Heart disease/cholesterol risk assessment beginning at 2 years of age.
- Sexually Transmitted Infection (STI)/HIV risk assessment beginning at 12 years of age.
- Lead risk assessment 6 months – 6 years of age (A positive lead risk assessment necessitates blood lead testing at any age. In addition, blood lead levels must be obtained at 12** and 24*** months.)
- Blood testing of hematocrit or hemoglobin at 12** and 24*** months of age, at the same time as the blood lead test (On the initial visit for all children 2 through 5 years of age, unless previous test results are available, a hematocrit or hemoglobin is required.)
- A second hereditary/metabolic screen (lab test) by 2-4 weeks* of age.

Notes: *accepted until 8 weeks of age; **accepted from 9-23 months of age; ***accepted from 24-35 months of age

Laboratory/ At Risk Screening Results

- Five of the seven MCO scores exceeded the minimum compliance rate of 75% for the Laboratory Tests/At Risk Screenings component for CY 2011. Two of the seven MCOs scored below the minimum compliance rate and were required to submit corrective action plans. Historically this component score has represented an area in need of improvement and MCO specific recommendations for quality improvement focus at the element level are shared with each MCO each year in the EPSDT Medical Record Review Report.
- The HealthChoice Aggregate score increased for this component for two consecutive years, however most recently from CY 2010 to CY 2011 the aggregate score decreased by 3 percentage points. The current CY 2011 HealthChoice Aggregate score for the Laboratory Tests/At Risk Screenings component is 79%.

Immunizations

Rationale: Children on Medical Assistance must be immunized according to the Maryland DHMH Recommended Childhood Immunization Schedule. The immunization schedule is endorsed by The Maryland State Medical Society, and is based on the current recommendations of the U.S. Public Health Service's Advisory Committee on Immunization Practices and the American Academy of Pediatrics. Primary care providers who see Medicaid recipients up to 19 years of age must participate in the Department's Vaccines for Children (VFC) Program.

Documentation: The VFC Program requires completion of the VFC Patient Eligibility Screening Record for each patient receiving free vaccines. Additionally, federal law requires documentation of date, dosage, site of administration, manufacturer, lot number, publication date of Vaccine Information Statement (VIS), and name/location of provider. All required vaccines must be available at the provider sites to ensure that children will receive needed vaccines to avoid a missed opportunity to vaccinate.

Immunizations Results

- All MCO's scores exceeded the minimum compliance rate of 75% for this component for CY 2011.
- The HealthChoice Aggregate score for this component increased 4 percentage points from CY 2009 to CY 2010. The current CY 2011 aggregate score of 88% represents a slight 1 percentage decrease from the previous year. MCOs were encouraged to continue efforts to improve administration immunizations according to the Maryland Department of Health and Mental Hygiene Recommended Childhood and Adolescent Immunization Schedule.

Health Education/Anticipatory Guidance

Rationale: Health education enables the patient and family to make informed decisions about their own health. Anticipatory guidance provides the family with information on what to expect in terms of the child's current and next developmental stage. Information should be provided about the benefits of healthy lifestyles and practices, as well as injury and disease prevention.

Components: A minimum of three topics must be discussed at each Healthy Kids Preventive Care visit. These topics may include, but are not limited to social interactions, parenting, nutrition, health, play, communication, sexuality, and injury prevention. Annual routine dental referrals beginning at 2 years of age for the purpose of educating the parents about appropriate dental care, providing a cursory view of the child's dental health, and familiarizing the child with the dental equipment are required. Scheduling the next preventive care visit and educating the family about the schedule of preventive care increases the chances of having the child/adolescent return for future preventive care visits. Additionally, follow-up for missed appointments needs to occur as soon as possible when the well child visit is missed to prevent the child/adolescent from becoming "lost to care."

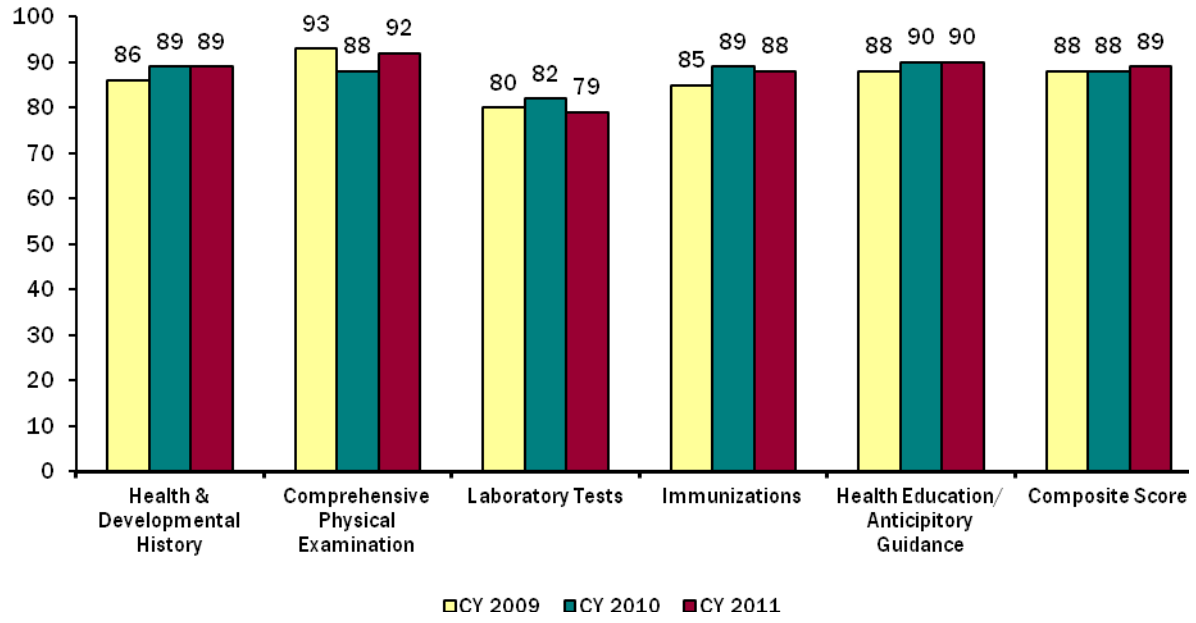
Documentation: The primary care provider must document whenever 2-year intervals for preventive care are the usual and customary schedule of the practice instead of annual visits.

Health Education/Anticipatory Guidance Results

- All MCO's scores exceeded the minimum compliance rate for the Health Education/Anticipatory Guidance component for CY 2011.
- The HealthChoice Aggregate score for this component increased 2 percentage points from CY 2009 to CY 2010. The CY 2011 score of 90% is unchanged from CY 2010.

Figure 1. compares the HealthChoice Aggregate Rates for three reporting periods: January 1 – December 31, 2009 (CY 2009), January 1 – December 31, 2010 (CY 2010), and January 1 – December 31, 2011 (CY 2011).

Figure 1. HealthChoice Aggregate Rates for EPSDT Program Review Components for CY 2009 through CY 2011



From CY 2009 to CY 2010, the HealthChoice Aggregate rates increased for four components and decreased for one component. These changes had no effect on the total Composite Score for CY 2010.

From CY 2010 to CY 2011 the HealthChoice Aggregate rates increased four percentage points for one component and decreased or remained the same for four components. This resulted in a 1 percentage point increase to the total Composite Score for CY2011.

Corrective Action Plan Process

DHMH sets high performance standards for the Healthy Kids Program. Five of the seven MCOs scored above the 75% minimum compliance score for all five components. Two MCOs scored below the 75% minimum compliance score for the Laboratory Tests/At Risk Screenings component and were required to submit CAPs. The CAPs were evaluated by Delmarva Foundation to determine whether the plans were acceptable. In the event that a CAP was deemed unacceptable, Delmarva Foundation provided technical assistance to the MCO until an acceptable CAP was submitted. All MCOs have submitted adequate CAPs for the areas where deficiencies occurred for CY 2011.

Required Contents of EPSDT CAPs

It is expected that each required CAP will include, at a minimum, the following components:

- Methodology for assessing and addressing the problem.
- Threshold(s) or benchmark(s).
- Planned interventions.
- Methodology for evaluating effectiveness of actions taken.
- Plans for re-measurement.
- Timeline for the entire process, including all action steps and plans for evaluation.

EPSDT CAP Evaluation

The review team will evaluated the effectiveness of any CAPs initiated as a result of the prior year's review. A review of all required EPSDT components are completed annually for each MCO. Since CAPs related to the review can be directly linked to specific components, the annual EPSDT review will determine whether the CAPs were implemented and effective. In order to make this determination, Delmarva Foundation will evaluate all data collected or trended by the MCO through the monitoring mechanism established in the CAP. In the event that an MCO has not implemented or followed through with the tasks identified in the CAP, DHMH will be notified for further action.

Conclusions

The result of the EPSDT review demonstrates strong compliance with the timely screening and preventive care requirements of the HealthChoice/ EPSDT Program. Scores for three of the five components increased or remained unchanged from CY 2010 to CY 2011. The two components that declined in CY 2011 were:

- Immunizations - after increasing by four percentage points for CY 2010, this component showed a slight one percentage point decline

- Laboratory Tests/At Risk Screenings - after increasing by two percentage points for CY 2010, this component showed a three percentage point decline. Historically the Laboratory Tests/At Risk Screenings component score has represented an area in most need of improvement. MCO specific recommendations for quality improvement continue to be shared with MCOs annually.

The total Composite Score increased by one percentage point from CY 2010 to CY 2011. Overall scores demonstrate that the PCP and MCOs are committed to providing care that is patient focused and prevention oriented.