CY 2007 EPSDT Annual Report

Introduction

The Maryland Department of Health and Mental Hygiene (DHMH) is required to evaluate the quality of care (QOC) provided to Maryland Medical Assistance enrollees in HealthChoice Managed Care Organizations (MCOs), annually. DHMH, pursuant to Title 42, Code of Federal Regulations, 438.204, is responsible for monitoring the QOC provided to MCO enrollees when delivered pursuant to the Code of Maryland Regulations (COMAR) 10.09.65.

Under Federal law [Section 1932(c)(2)(A)(i) of the Social Security Act], DHMH is required to contract with an External Quality Review Organization (EQRO) to perform an independent annual review of services provided under each MCO contract. To ensure that the services provided to the enrollees meet the standards set forth in the regulations governing the HealthChoice Program, DHMH contracts with Delmarva Foundation (Delmarva).

Purpose and Objectives

The mission of the Healthy Kids program is to promote healthy child development and to ameliorate conditions that disable children. As an at-risk population, Medicaid children have a higher risk for lifelong disability; by providing preventive care, and early identification and treatment of health problems beginning at birth through the age of 20, the affect of impairment can often be reduced.

The Healthy Kids program publicizes various standards the Department expects MCO providers of child medical services to follow, as well as trains and certifies new primary care physicians on the program. To determine the level of adherence to the EPSDT standards, independent medical record reviews are conducted by Delmarva. Once the data is collected and subsequently analyzed, reports are generated for each MCO that detail how their primary care providers are providing preventive health care to children.

This Annual Report describes the findings from the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) review for Calendar Year (CY) 2007, which marks the end of HealthChoice's tenth, and beginning of its eleventh year of operation. The HealthChoice program served approximately 490,761 enrollees during this period.

The seven MCOs evaluated for CY 2007 were:

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

This was the first year that the EPSDT review was completed by an independent review organization; previous to 2007, the Department's Healthy Kids nurse consultants conducted onsite medical record reviews of EPSDT services provided. The review criteria used by Delmarva nurses remained the same as those developed and used by the Department. In addition, Delmarva reviewers were trained with input from the Department's nurse consultants. An overall inter-rater reliability (IRR) score of 91% prior to the beginning of the EPSDT review was reached, with IRR scores increasing during the review process.

Medical Record Review Process

Records were randomly selected in order to assess compliance with the program standards. If a provider office had 20 or more medical records in the sample, reviewers conducted onsite (in the provider office) medical record reviews. Twenty-two provider sites met the criteria for onsite review, totaling 1,071 medical records, which represented 41% of the total medical records reviewed. For offices not meeting the onsite criteria, providers had the option of submitting medical records by fax or by mail. The Delmarva Review Team requested 1,673 medical records from providers, but received and reviewed 1,553 medical records, which represent 59% of the total medical records reviewed. A total of 2,624 medical records were reviewed.

After preliminary results were reviewed from the initial desktop and onsite reviews, it was determined that Delmarva would re-solicit information from providers who received a score of less than 70% in any component area. Requests went out to 479 providers for a total of 1,467 medical records in an effort to ensure that *all* necessary data was made available to reflect an accurate measurement of services rendered and health quality, especially since these performance measures are publicly reported. As a result of the re-solicited request, a total of 697 records (48%) were received with additional documentation. After reviewing the additional documentation, results positively impacted 282 records (40%) and did not affect the remaining 415 records (60%).

Results of this year's review process yielded the following observations:

- **Results may have been affected by the change to reviews being conducted both onsite at provider offices and through a mailed in desktop record review.**

- **Providers were in various phases of implementing electronic medical records (EMRs). There were reported issues during this transition such as a loss of documentation, providers changing from one EMR vendor to another, provider staff undergoing a learning curve when changing EMR vendors, data being stored in various places in EMRs and staff not always being knowledgeable regarding the alternative location in the record.**

EPSDT Review Results

The indicators for the EPSDT review are based on current pediatric preventive care guidelines and DHMH identified priority areas. Those guidelines and criteria are divided into five review components. Each MCO was required to meet a minimum compliance rate of 70% for each of the five components. If an MCO did not achieve the minimum, the MCO was required to submit a Corrective Action Plan (CAP). Findings related to key components for the EPSDT review for CY 2007 are described in Table 1.

Table 1. CY 2007 EPSDT Component Results by MCO

Component	ACC	DIA	JMS	MPC	MSFC	PPMCO	UHC	MCO Aggregate Composite Score CY 2006 Jan – Dec 2006 Encounter Data	MCO Aggregate Composite Score CY 2007 Jan – Dec 2007 Encounter Data
Health & Developmental History	76%	85%	93%	82%	81%	78%	75%	90%	81%
Comprehensive Physical Examination	90%	92%	96%	92%	93%	87%	88%	96%	91%
Laboratory Tests	69%*	80%	91%	72%	70%	69%*	68%*	78%	74%
Immunizations	94%	92%	96%	91%	94%	90%	94%	94%	93%
Health Education/ Anticipatory Guidance	87%	89%	96%	87%	92%	85%	84%	90%	88%

***Denotes that the minimum compliance score of 70% for CY 2007 was not met.**

The following section provides a description of each component along with a summary of the MCOs performance and any opportunities for improvement as a result of CAPs.

Health and Developmental History

A comprehensive personal and family medical history assists the provider in determining health risks and providing appropriate laboratory testing and anticipatory guidance. Personal history includes medical, developmental, psychosocial, and mental health information, as well as the immunization record. The perinatal history, collected for children up to two years of age, consists of a history of the pregnancy and birth outcome. Family history includes information about both the medical and mental health of immediate and

extended family members, which may affect the health and well being of the child. Psychosocial history consists of family constellation and dynamics, housing, assessment of support systems, and exposure to family and/or community violence which may adversely affect a child's mental health. Documented annual updates of the personal, family, and psychosocial histories are required in the record 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 is recommended. Developmental, mental health and substance abuse assessments determine the need for referral and/or follow-up services. Developmental assessments for infants and young children include the evaluation of developmental milestones. For school age children, this assessment incorporates cognitive, social, and emotional development. The mental health assessment provides an overall view of the child's personality, behavior, social interactions, affect, and temperament. In general, substance abuse assessments begin at 12 years of age and are repeated annually; however, assessment at earlier ages is recommended for the at-risk child.

Since CY 2004, the Maryland Healthy Kids program has recommended the use of the CRAFFT Assessment Tool from Children's Hospital Boston. In addition, the Maryland Healthy Kids program has developed age appropriate mental health questionnaires for use beginning at 3 years of age, to assist providers in assessing emotional well being.

- **All MCO's scores exceeded the minimum compliance rate for the Health and Developmental History component in CY 2007.**
- **The MCO Aggregate Composite Score decreased by nine percentage points from CY 2006 to CY 2007 for the Health and Developmental History component.**

Comprehensive Physical Exam

The comprehensive physical exam requires documentation of a minimum of five anatomical systems to meet EPSDT standards. A comprehensive physical exam includes documentation of subjective or objective vision and hearing assessments at every well-child visit. Additional required documentation includes measuring and graphing head circumference up to 11 months of age, and measuring and recording blood pressure annually for children 3 years of age and older.

Oral assessment as part of the physical requires documentation of a visual exam of the mouth, gums, and teeth. Providers should note at least one of the following: a dental exam within normal limits ("WNL"), the number of teeth as they are erupting during infancy, and/or the condition of the teeth and gums. Identifying dental caries allows for early intervention before the first referral to the dentist at 2 years of age.

The documentation of nutritional status should include an assessment of the typical diet, physical activity, and education provided with graphing of weight and height through 20 years of age on a growth chart. Identified

nutrition or growth problems require appropriate referrals for nutrition services and/or counseling. Notation of referrals and resulting feedback is required in the record.

- **All MCO's scores exceeded the minimum compliance rate for the Comprehensive Physical Exam component for CY 2007.**
- **The MCO Aggregate Composite Score decreased by five percentage points from CY 2006 to CY 2007 for the Comprehensive Physical Exam component.**

Laboratory Tests

The Healthy Kids program follows national standards and recommendations from the Centers for Disease Control and Prevention (CDC) and the American Heart Association to assess performance on screening by questionnaire and laboratory testing compliance.

The Healthy Kids program requires assessments of risk factors associated with heart disease, tuberculosis, and sexually transmitted disease/human immunodeficiency virus (STD/HIV) exposure. The tuberculosis risk assessment begins at age 1, the heart disease/cholesterol risk assessment begins at age 2, and the STD/HIV risk assessment begins at age 12. These assessments are standardized questions regarding health habits, family history, and environmental factors that may place the child at risk. Assessments resulting in a positive risk for disease require appropriate laboratory testing, educational intervention, and/or treatment. The Maryland Healthy Kids program has developed the Preventive Screen Questionnaire to assist providers with these assessments.

As determined by the CDC, children enrolled in the Medicaid program are at greater risk of lead exposure than the general population. Therefore, a lead risk assessment, also included as part of the Preventive Screen Questionnaire, is required at each well-child visit between the ages of 6 months and 6 years. A positive lead risk assessment necessitates blood lead testing at any age. Regardless of the result of the lead risk assessment, blood lead levels must be obtained at 12 and 24 months. All children entering the practice from 2 through 5 years of age need at least one blood lead test result in the record, either obtained on the initial visit or noted in records from a previous provider.

All children also need a hematocrit or hemoglobin at 12 and 24 months of age. A hematocrit or hemoglobin is required on the initial visit for all children 2 through 5 years of age, unless previous test results are available. The Maryland Healthy Kids program requires a second hereditary/metabolic screen between 2 to 4 weeks of age.

- **Four MCO's scores exceeded the minimum compliance rate for the Laboratory Tests component for CY 2007.**

- **The MCO Aggregate Composite Score decreased by four percentage points from CY 2006 to CY 2007 for the Laboratory Tests component.**
- **Three MCOs demonstrated opportunities for improvement in the Laboratory Tests component; those opportunities included the risk assessments for Cholesterol and TB along with the three laboratory values - 12 Month Lead, Second Hereditary/Metabolic Screening, and Baseline Lead Testing.**

Immunizations

Children on Medical Assistance must be immunized according to the current Maryland DHMH recommended Childhood Immunization Schedule. The immunization schedule is endorsed by The Maryland State Medical Society, and is based on current recommendations of the U.S. Public Health Service's ACIP and the American Academy of Pediatrics.

Primary care providers who see Medicaid enrollees up to 19 years of age must participate in the Maryland Vaccines for Children (VFC) program. 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.

- **All MCO's scores exceeded the minimum compliance rate for the Immunizations component for CY 2007.**
- **The MCO Aggregate Composite Score decreased by one percentage point from CY 2006 to CY 2007 for the Immunizations component**.

Health Education/Anticipatory Guidance

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. The Maryland Healthy Kids program requires that a minimum of three general topics 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.

The Maryland Healthy Kids program requires that routine dental referrals begin 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. Thereafter, at a minimum, an annual referral

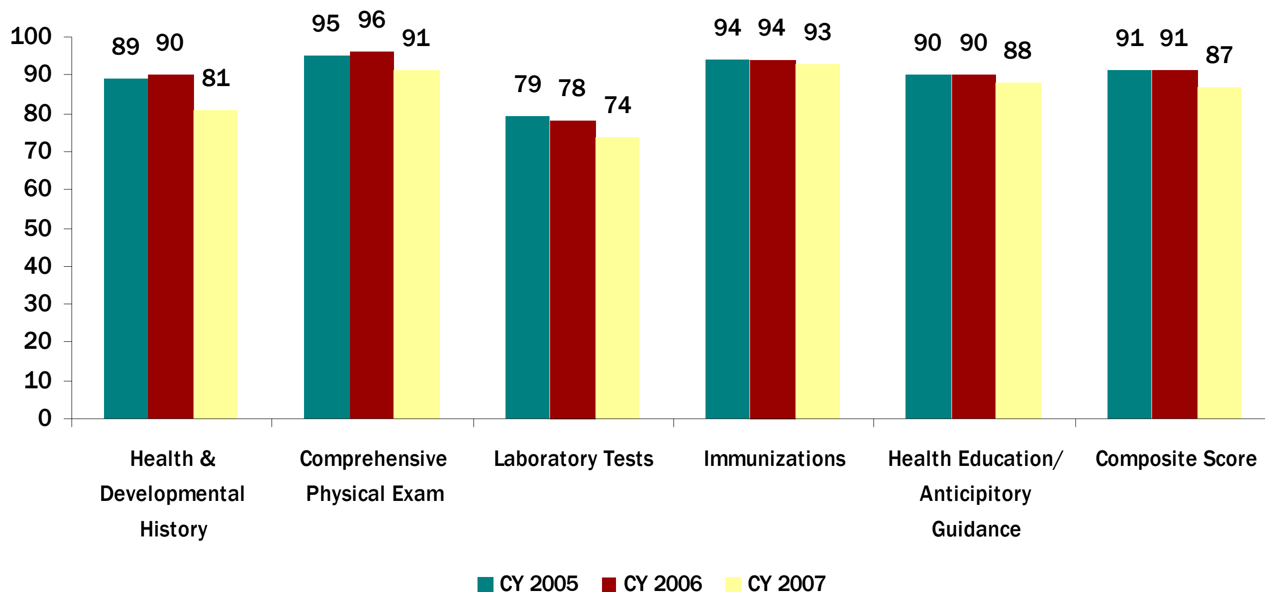
must be made to a dentist for cleaning, fluoride treatment, and examinations. Identified dental problems require referral at any age.

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

- **All MCO's scores exceeded the minimum compliance rate for the Health Education/Anticipatory Guidance component for CY 2007.**
- **The MCO Aggregate Composite Score decreased by two percentage points from CY 2006 to CY 2007 for the Health Education/Anticipatory Guidance component.**

Figure 1 compares the MCO Aggregate Rates for three reporting periods January 1 – December 31, 2005 (CY2005), January 1 – December 31, 2006 (CY2006), and January 1 – December 31, 2007 (CY 2007).

Figure 1. HealthChoice Aggregate Rates for EPSDT Program Review Components for CY 2005 through CY 2007



An analysis of the review results from CY 2005 and CY 2006 indicates that the MCOs maintained rates in two components, improved rates in two components, and decreased scores in one component. The overall composite score remained stable. However, an analysis of the review results from CY 2006 to CY 2007 indicates that all 5 components decreased in scores ranging from 1 to 9 percentage points. The largest decrease was seen in the Health & Developmental History component which decreased 9 percentage points. The Comprehensive Physical Exam component decreased by 5 percentage points and the Laboratory Test Component decreased by 4 percentage points. As a result of these component decreases, the overall MCO Composite Score dropped 4 percentage points from the CY 2006 to CY 2007.

Corrective Action Plan Process

Each year the CAP process is discussed during the annual audit orientation meeting. This process requires that each MCO that does not meet the minimum component score of 70% must submit a CAP which details the actions to be taken to correct any deficiencies identified. CAPs must be submitted within 45 calendar days of receipt of the preliminary report. The CAPs are evaluated by Delmarva to determine whether the plans are acceptable. In the event that a CAP is deemed unacceptable, Delmarva will provide technical assistance to the MCO until an acceptable CAP is submitted. All MCOs have submitted adequate CAPs for the areas where deficiencies occurred for CY 2007.

During the EPSDT review, all previous year CAPs are reviewed for implementation. Delmarva 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 results of the EPSDT review demonstrate strong MCO compliance with the screening requirements. With the exception of the laboratory component where three MCOs were required to submit CAPs, each MCO achieved the minimum 70% compliance rate for each of the five components. The three MCOs Laboratory Component CAPs were approved by the Delmarva Team.

DHMH sets high performance standards for the Healthy Kids program. Until this year's review, the HealthChoice MCOs continued to make steady improvements in their EPSDT compliance rates. There appears to be a significant opportunity for improvement in the Health and Developmental History Component. The downward trend from 2006 to 2007 is notable, although the change can be attributed to a myriad of causes including, but not limited to:

- **The change to an independent review organization;**
- **The use of objective review tools (database collection tools);**
- **The variable implementation status of office based electronic medical records. Providers are in various phases of implementing electronic medical records (EMRs). There were reported issues during this transition such as a lost documentation, providers changing from one EMR vendor to another, provider office staff undergoing a learning curve when changing EMR vendors, data being stored in various places in EMRs and staff not always being knowledgeable regarding the alternative location in the record.**