Medicaid
Managed Care Organization

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

Calendar Year 2008

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HealthChoice and Acute Care Administration
Division of HealthChoice Management and Quality Assurance

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Introduction

This Annual Report describes the findings from the EPSDT review for Calendar Year (CY) 2008, which marks the end of HealthChoice's eleventh, and beginning of its twelfth year of operation. The HealthChoice Program served approximately 538,024 enrollees during this period.

The seven MCOs evaluated for CY 2008 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 second year that the EPSDT review was completed by an independent review organization. Prior to 2007, the Department's Healthy Kids nurse consultants conducted the EPSDT medical record reviews. The EPSDT Program is the federally mandated Medicaid program for screening, prevention, diagnosis, and treatment of physical and mental health conditions in children and youth 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 the plan hinges 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 (Delmarva) annually evaluates the quality assurance

program and activities of each managed care organization (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 screens 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, teens and young adults less than 21 years of age. In support of the program's mission, the primary objective of the EPSDT focused review is to assess the degree to which timely EPSDT services are provided to children and adolescents enrolled in a managed care plan. 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 to 2 years of age.
- Developmental history/screening at each visit.
- Mental health assessment beginning at 3 years of age.
- Substance abuse screening beginning at 12 years of age, younger if indicated.

Comprehensive, unclothed, physical exam 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 11 months of age.

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 age

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.

Sampling Methodology

The sample frame was drawn from preventive care encounters occurring during calendar year 2008 for children from birth through 20 years of age. The sampling methodology includes the following criteria:

- A random sample of preventive care encounters per Managed Care Organization (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 less than 21 years of age as of the last day of the measurement year.
- Sample includes encounter data where the selected enrollee is enrolled on the last day of measurement year, and for at least for 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 where visits with CPT 99381-85 or 99391-95 were provided by primary care providers and clinics with the following specialty codes: 16 (pediatrics), 29 (family practice), 30 (internal medicine), 171 (nurse practitioner), 28 (general practice) or a Federally Qualified Health Center (FQHC).
- Sample excludes recipients seen by specialists who reported preventive encounters (CPT 99381-85 or 99391-95).

Medical Record Review Process

Records were randomly selected in order to assess compliance with the program standards. Nurse reviewers conducted all medical record reviews in the provider offices. A total of 2,619 medical records were reviewed.

The review criteria used by Delmarva review nurses was the same as those developed and used by the Department. In addition, Delmarva nurse reviewers were trained with input from the Department's nurse consultants. Delmarva completes annual inter-rater reliability (IRR) and achieved a score of 88% after training and prior to the beginning of the CY 2008 EPSDT Medical Record Review. IRR scores increased to over 94% during the review process.

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

- birth to 11 months,
- 12 to 35 months,
- 3 to 5 years,
- 6 to 11 years, and
- 12 to 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 was 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, full credit was given.

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 70% for each of the five components. If an MCO did not achieve the minimum compliance rate, the MCO was required to submit a Corrective Action Plan (CAP). All MCOs met the minimum compliance rate of 70% in each of the five component areas for the CY 2008 review. Therefore, no CAPs were required.

Findings for the CY 2008 EPSDT review by component area are described in Table 1.

Table 1. CY 2008 EPSDT Component Results by MCO

Component	ACC	DIA	JMS	MPC	MSFC	PPMCO	UHC	MCO Aggregate Composite Score CY 2007 Jan – Dec 2007 Encounter Data	MCO Aggregate Composite Score CY 2008 Jan – Dec 2008 Encounter Data
Health & Developmental History	81%	86%	97%	83%	84%	83%	80%	81%	85%
Comprehensive Physical Examination	89%	90%	95%	91%	95%	92%	90%	91%	92%
Laboratory Tests/At Risk Screenings	77%	76%	94%	80%	70%	79%	74%	74%	78%
Immunizations	92%	91%	94%	94%	94%	94%	92%	93%	93%
Health Education/ Anticipatory Guidance	88%	87%	97%	88%	90%	88%	86%	88%	89%

*Denotes that the minimum compliance score of 70% for CY 2008 was not met.

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 for the Health and Developmental History component in CY 2008.

- The MCOs' Aggregate Composite Score increased by four percentage points from CY 2007 to CY 2008 for the Health and Developmental History component.

Comprehensive Physical Exam

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 11 months 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.
- Appropriate referrals for nutrition services and/or counseling due to identified nutrition or growth problems.

Comprehensive Physical Exam Results

- All MCO's scores exceeded the minimum compliance rate for the Comprehensive Physical Exam component for CY 2008.

- The MCOs' Aggregate Composite Score increased by one percentage point from CY 2007 to CY 2008 for the Comprehensive Physical Exam component.

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 disease/human immunodeficiency virus (STD/HIV).

Components: Assessment of risk factors includes:

- Tuberculosis risk assessment beginning at 1 year of age.
- Heart disease/cholesterol risk assessment beginning at 2 years of age.
- Sexually Transmitted Disease (STD)/HIV risk assessment beginning at 12 years of age.
- Lead risk assessment (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

- All MCO's scores exceeded the minimum compliance rate for the Laboratory Tests/At Risk Screenings component for CY 2008.

- The MCOs' Aggregate Composite Score increased by four percentage points from CY 2007 to CY 2008 for the Laboratory Tests/At Risk Screenings component.

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 for the Immunizations component for CY 2008.

- The following Immunizations were not included in the Immunizations component score, however, were reported to the MCOs for the first time in CY 2008 as baseline measures:
  - Meningococcal Vaccine (MCV4) – baseline MCOs' Aggregate score was 70%.
  - Hepatitis A Vaccine – baseline MCOs' Aggregate score was 81%.
  - Varicella Vaccine (2nd dose requirement) – baseline MCOs' Aggregate score was 85%.

- The following Immunizations were not included in the Immunizations component score however, were reported to the MCOs for the first time in CY 2008 for informational purposes:
  - Rotavirus Vaccine(s) per Schedule – MCOs' Aggregate score was 79%.
  - Human Papillomavirus Vaccine(s) – MCOs' Aggregate score was 55%.

- The MCOs' Immunization Aggregate Composite Score remained unchanged from CY 2007 to CY 2008.

- The MCOs' Aggregate score for the Influenza Vaccine was 69%. MCOs were encouraged to continue efforts to improve administration of this vaccine 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.

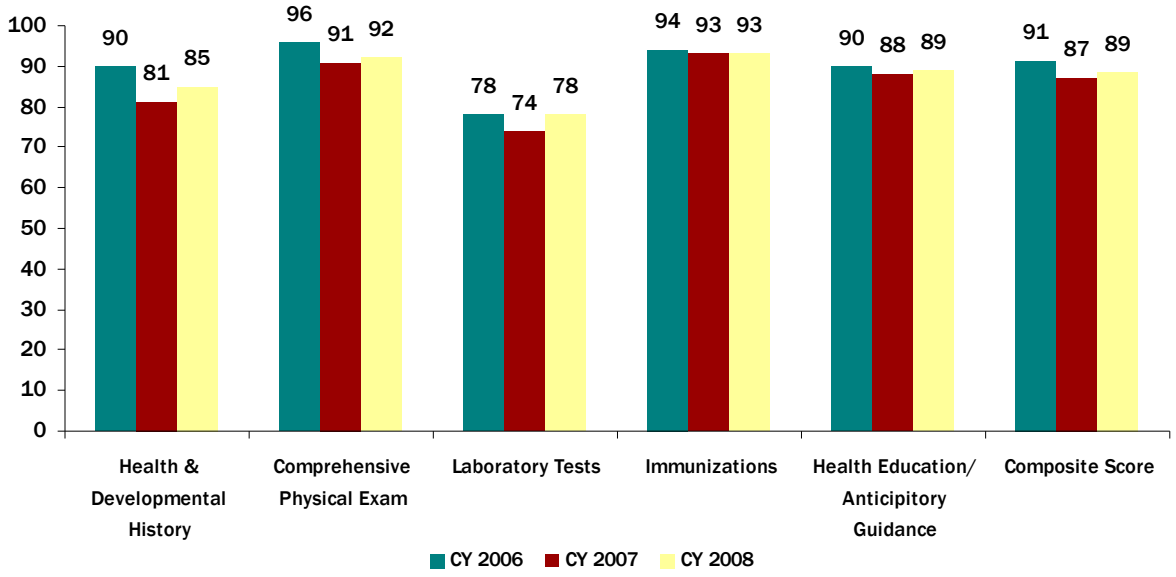
Health Education/Anticipatory Guidance Results

- All MCO's scores exceeded the minimum compliance rate for the Health Education/Anticipatory Guidance component for CY 2008.

- The MCOs' Aggregate Composite Score increased by one percentage point from CY 2007 to CY 2008 for the Health Education/Anticipatory Guidance component.

Figure 1 compares the MCO Aggregate Rates for three reporting periods: January 1 – December 31, 2006 (CY 2006), January 1 – December 31, 2007 (CY 2007), and January 1 – December 31, 2008 (CY 2008).

Figure 1. HealthChoice Aggregate Rates for EPSDT Program Review Components for CY 2006 through CY 2008



From CY 2006 to CY 2007, State Aggregate scores decreased for each component causing the total composite score to decrease by 4%. From CY 2007 to CY 2008, State Aggregate scores increased from 1% to 4% for all components except for the Immunizations (IMM) component which remained unchanged. For CY 2008, the State Aggregate Composite score improved 2%; however it remained below the CY 2006 performance rate.

Corrective Action Plan Process

Each year the CAP process is discussed during the annual audit orientation meeting. This process requires MCOs not meeting the minimum component score of 70% to submit a CAP detailing the actions to be taken to correct any deficiencies identified. CAPs must be submitted within 45 calendar days of receipt of the preliminary report and 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. For CY 2008, no MCO EPSDT CAPs were required.

During the EPSDT review, all previous year CAPs are reviewed for implementation. Delmarva evaluates 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

DHMH sets high performance standards for the Healthy Kids Program. All MCOs scored above the 70% minimum compliance score for all five components; therefore, no corrective action plans were required. The results of the EPSDT review demonstrate strong MCO compliance with the screening requirements, with the exception of the Laboratory Tests/At Risk Screenings component which has scored below 80% for the past three years. Laboratory Tests/At Risk Screenings and Immunization components represent an opportunity for improvement as rates have remained static year after year. In an effort to improve these components, MCOs were encouraged to notify a child's current PCP when a child is transferred to another PCP within the MCO's network. This would facilitate the transfer of immunization and laboratory records to the newly assigned PCP.

During the medical record data collection, nurse reviewers observed continued movement toward electronic medical records (EMRs). During the review, nurses indicated whether a record was electronic or paper in format. It is noteworthy that MCOs having at least 20% of their sample in electronic format consistently scored better on electronic vs. paper records.