

# **Quality of Care: HEDIS<sup>®</sup> Measures**

## **Fiscal Year 2008**

### **A Chart Book Prepared for the Florida Healthy Kids Corporation**

**Jill Boylston Herndon, Ph.D.  
Institute for Child Health Policy  
University of Florida**

**Elizabeth A. Shenkman, Ph.D.  
Director, Institute for Child Health Policy  
Professor and Chair, Department of Epidemiology and Health Policy Research  
University of Florida**



## Table of Contents

Introduction .....	3
Data Sources and Measures .....	4
Chart 1. Total Unduplicated Members .....	5
Chart 2. HEDIS® Children and Adolescents' Access to Primary Care Practitioners.....	6
Chart 3. HEDIS® Initiation and Engagement of Alcohol and Other Drug Dependence Treatment .....	8
Chart 4. 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.....	10
Chart 5. HEDIS® Adolescent Well-Care Visits .....	11
Chart 6. HEDIS® Appropriate Testing for Children with Pharyngitis .....	12
Chart 7. HEDIS® Use of Appropriate Medications for People with Asthma .....	13
Chart 8. HEDIS® Follow-Up Care for Children Prescribed ADHD Medication .....	15
Chart 9. HEDIS® Follow-Up after Hospitalization for Mental Illness .....	17
Endnotes .....	19

## Introduction

Assessing the quality of care provided to children in the Florida Healthy Kids Program (FHKP) is an essential component of evaluating overall program performance. As part of the state fiscal year 2009 evaluation, the Florida Healthy Kids Corporation Board of Directors requested that the Institute for Child Health Policy (IChP) prepare a quality of care chart book with plan-level information.

The purpose of this report is to summarize FHKP enrollees' quality of care during state fiscal year 2008, covering the period July 1, 2007 through June 30, 2008. Quality of care is assessed using the Healthcare Effectiveness Data and Information Set (HEDIS<sup>®</sup>) measures, following the National Committee for Quality Assurance (NCQA) specifications. The HEDIS<sup>®</sup> measurement system is a set of health plan performance measures used to evaluate important dimensions of health care. HEDIS<sup>®</sup> measures are the quality of care measures most frequently used by state Medicaid and SCHIP programs.<sup>1</sup>

This chart book contains the following indicators:

- 1) Descriptive Information
  - Total Unduplicated Members
  
- 2) HEDIS<sup>®</sup> Quality of Care Measures
  - A. Access to 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
  - B. Prevention
    - 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. Appropriateness of Care
    - HEDIS<sup>®</sup> Appropriate Testing for Children with Pharyngitis
    - HEDIS<sup>®</sup> Use of Appropriate Medications for People with Asthma
  - D. Behavioral Health Care
    - HEDIS<sup>®</sup> Follow-Up Care for Children Prescribed ADHD Medication
    - HEDIS<sup>®</sup> Follow-Up after Hospitalization for Mental Illness

The charts provide results for the above-listed indicators for the program overall and by health plan to allow for comparisons between the plans that serve the FHKP. Comparisons to national data also are provided.

## Data Sources and Measures

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.

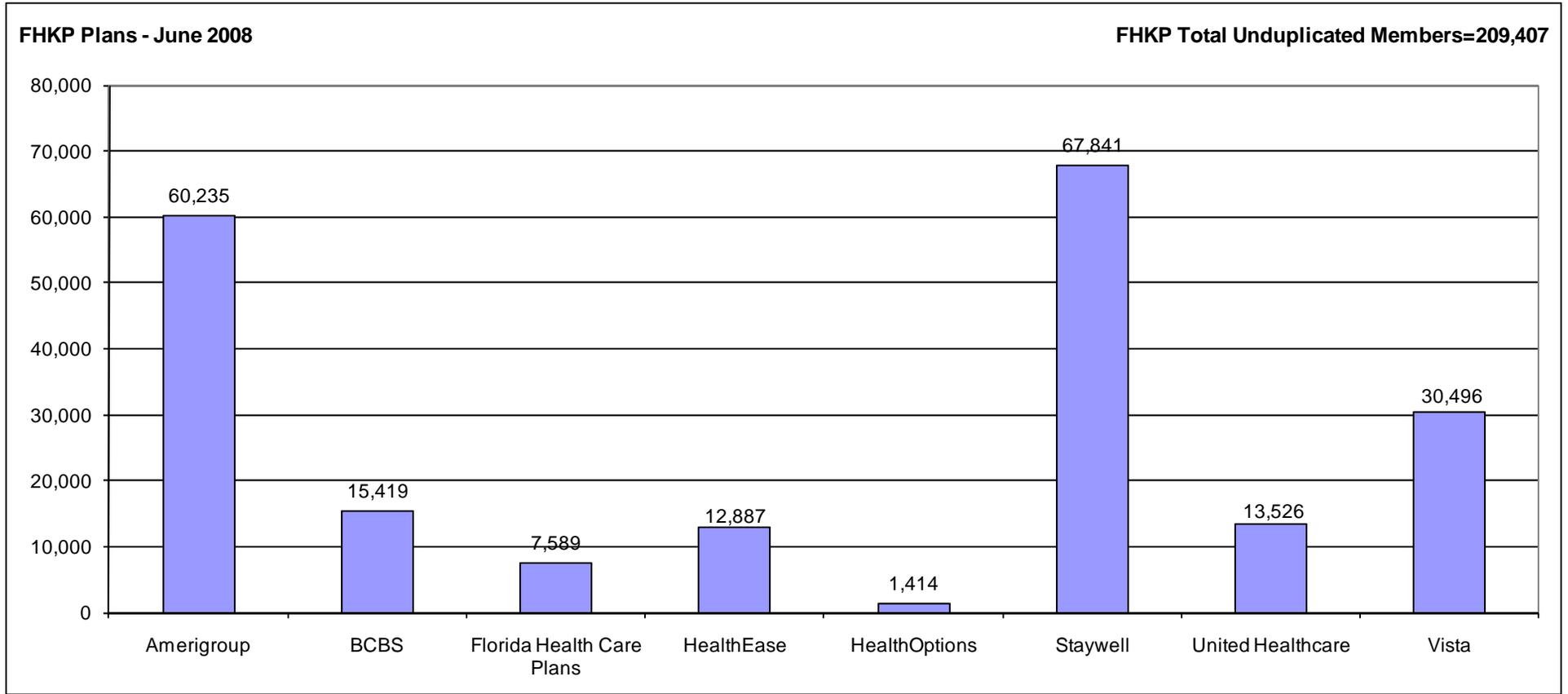
To provide a context for these measures, comparisons are made to national data. Although there are no direct national comparisons available for Children's Health Insurance Programs (CHIP), information is available nationally from Medicaid Managed Care Organizations (MCOs) who elect to report their results to NCQA.<sup>2</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>3</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 2008 mean results are provided in this report for descriptive purposes only and are shown and labeled "HEDIS<sup>®</sup> Mean" in the charts.

Due to data limitations in the health plans' claims and encounter data, a modification to the NCQA specifications was required. NCQA specifications require 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 some 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 seven-day and 30-day follow-up after an inpatient mental health stay. Lifting the provider constraint allows any visit with a 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 chart book 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

A 12-month time lag was used for the claims and encounter data, which provides a sufficient lag period for claims submission and processing. Florida Health Care Plans, which accounted for 3.6% of all FHKP enrollees, was excluded from the calculation of the HEDIS measures due to limitations in its claims data during the measurement period. HEDIS measures are reported for the following plans that participated in the FHKP during the reporting time period: Amerigroup, Blue Cross and Blue Shield (BCBS), HealthEase, Health Options, Staywell, Vista, and United Healthcare. Following the HEDIS specifications, rates are not reported for measures when the denominator is less than 30. Therefore, a plan with a denominator less than 30 for a specific measure will be reported as "Low Denominator" (LD) and will not have that measure reported. However, eligible individuals in LD plans are included in the overall FHKP measures.

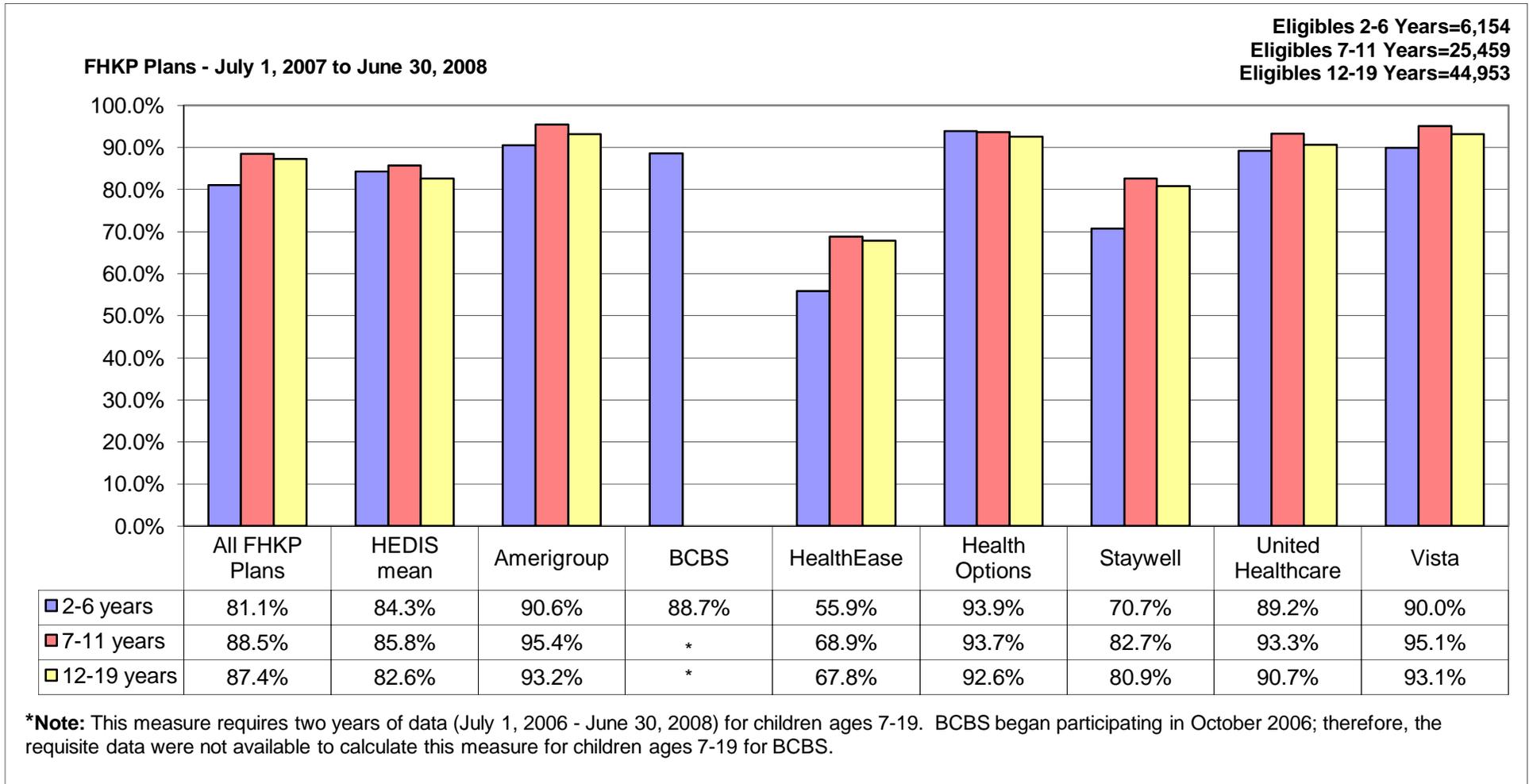
**Chart 1. Total Unduplicated Members**



**Key Points:**

1. Chart 1 provides the total number of unduplicated members enrolled in the FHKP by health plan. In June 2008, there were 209,407 enrollees.
2. The plan with the largest membership was Staywell at 32% of all enrollees, followed by Amerigroup at 29%, and Vista at 15%.
3. The plan with the smallest enrollment was Health Options, which served only Santa Rosa County during the measurement period.

**Chart 2. HEDIS® Children and Adolescents' Access to Primary Care Practitioners**

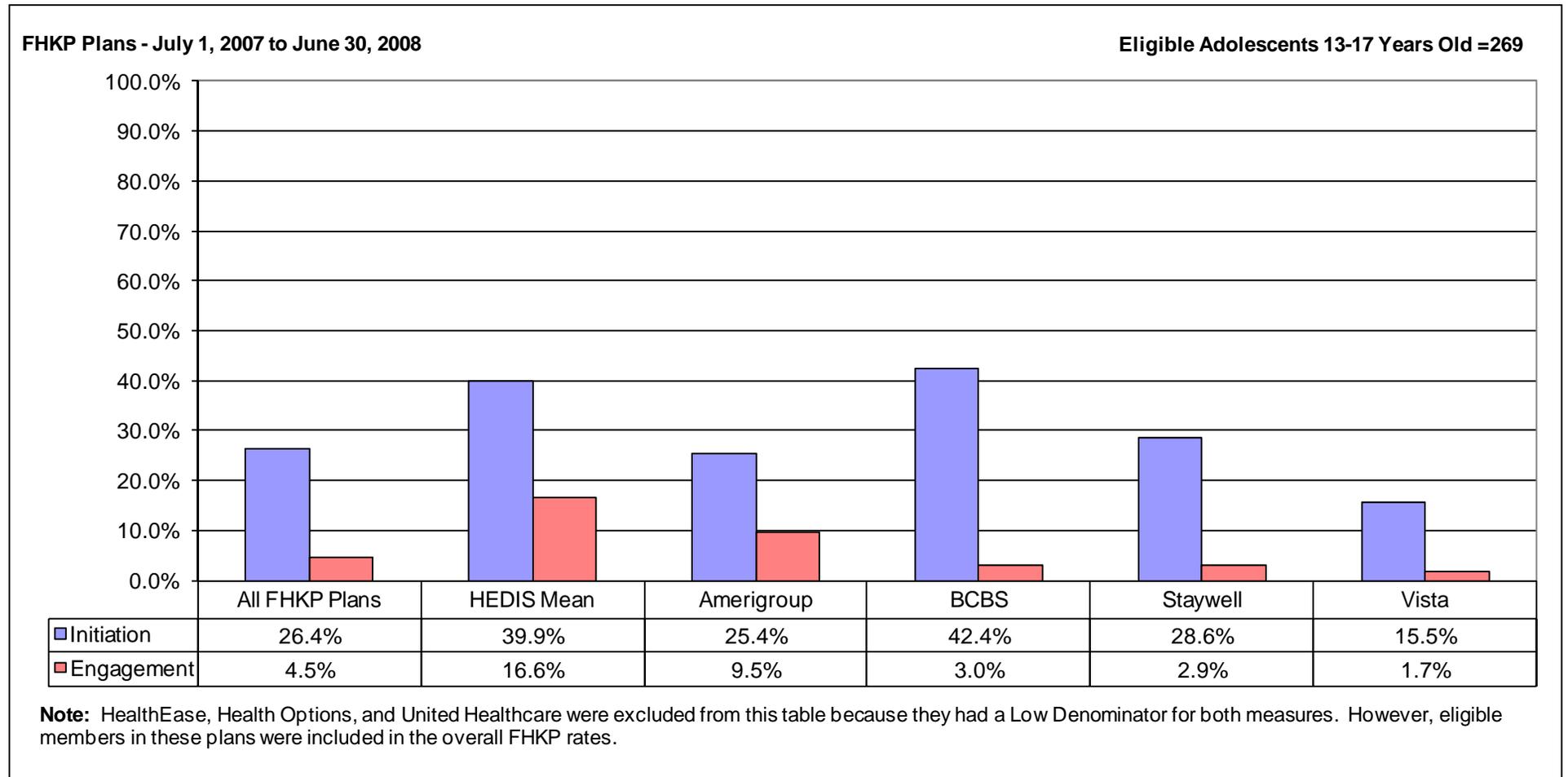


**Key Points:**

1. Access to a primary care provider is a basic and necessary (but not sufficient) requirement in establishing a medical home for a child.<sup>4</sup> Access to primary care also is associated with reduced hospital use and more appropriate use of specialists.<sup>5</sup>

2. Chart 2 provides the percentage of FHKP enrollees by age who had a visit with a physician provider during the measurement period for children ages 2-6 and those who had a visit with a physician provider during the measurement period or the previous year for children ages 7-11 and adolescents ages 12-19. Percentages were calculated using the HEDIS<sup>®</sup> measure, Children and Adolescents' Access to Primary Care Practitioners. This HEDIS<sup>®</sup> 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. After lifting provider constraints, the percentages shown here are inflated, which should be taken into consideration when making comparisons with the national Medicaid HEDIS<sup>®</sup> means.
3. Overall, the FHKP performed better than the national Medicaid HEDIS<sup>®</sup> average for children ages 7-19 and slightly worse than the national Medicaid HEDIS<sup>®</sup> average for children ages 2-6 years old (which includes only children age 5 in the FHKP). However, some plans performed better than the national Medicaid HEDIS<sup>®</sup> mean for all age groups. Amerigroup, Health Options, United Healthcare, and Vista all performed better than the national mean whereas HealthEase performed significantly below the national mean.

**Chart 3. HEDIS® Initiation and Engagement of Alcohol and Other Drug Dependence Treatment**

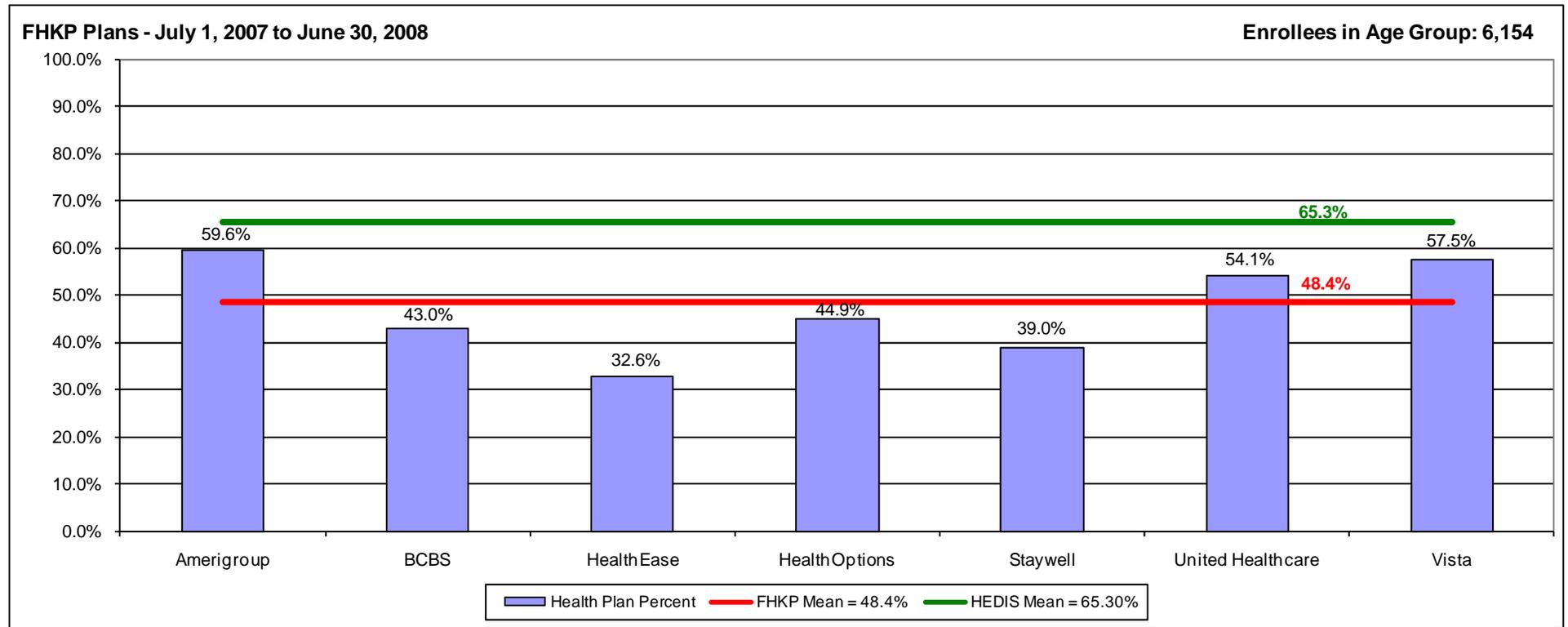


**Key Points:**

1. 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>6</sup> Several national goals in *Healthy People 2010* target reducing alcohol and substance abuse among adolescents.<sup>7</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>8</sup>

2. Chart 3 shows two percentages: (1) the percentage of adolescents 13-17 years of age 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 and (2) the percentage of adolescents 13-17 years of age diagnosed with AOD dependence who had two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis within 30 days of the date of the initiation encounter. The initiation percentage is calculated as the number of patients who initiated treatment divided by the total number of patients with a diagnosis of AOD. The engagement 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 diagnosis of AOD dependence. A diagnosis is established by an inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification, or emergency department encounter with any diagnosis of AOD.
3. Overall, about one-fourth of FHKP enrollees with an AOD dependence diagnosis initiated treatment within 14 days of diagnosis, compared to the national Medicaid HEDIS<sup>®</sup> mean of 39.9%. Only BCBS performed above the national Medicaid HEDIS<sup>®</sup> mean with 42.4% of enrollees ages 13-17 years diagnosed with AOD initiating treatment.
4. Less than 5% 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 substantially below the national HEDIS<sup>®</sup> mean of 16.6%.

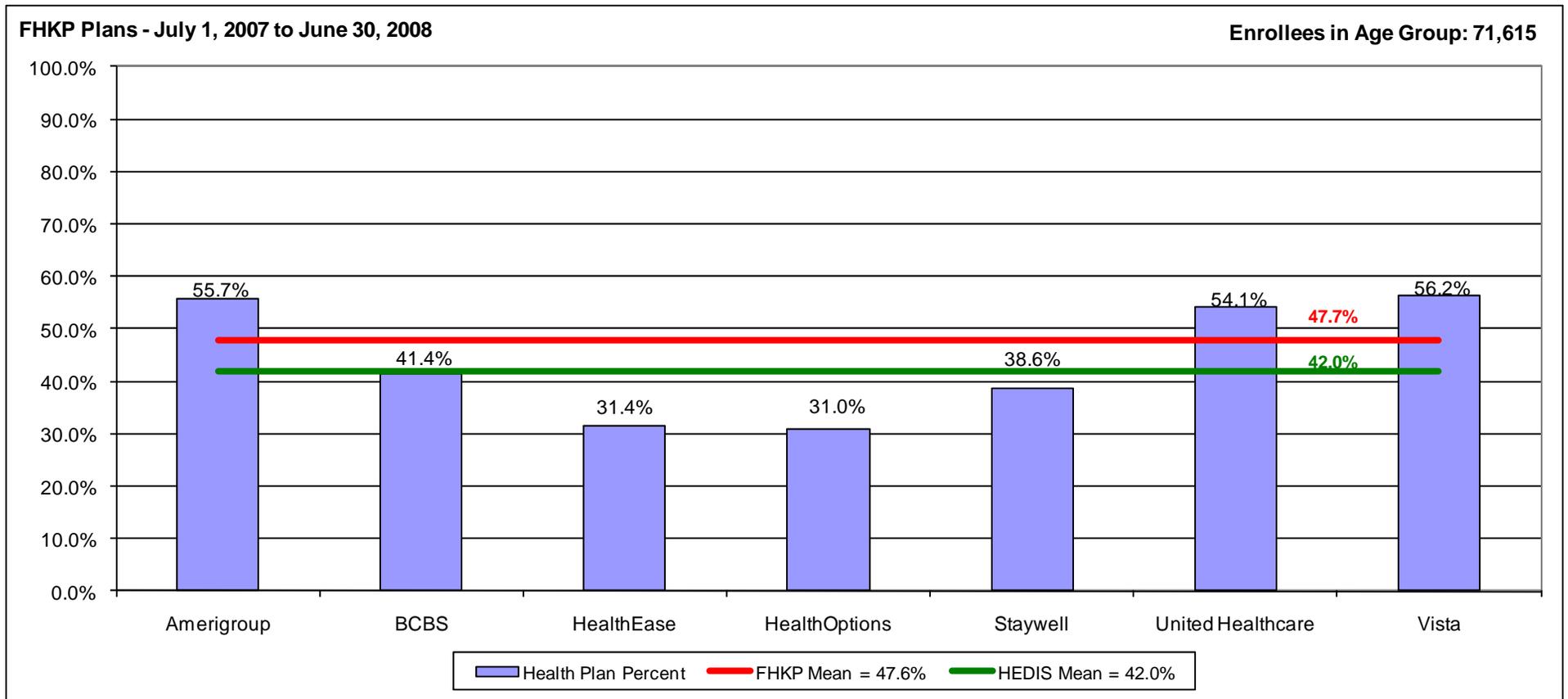
**Chart 4. HEDIS® Well-Child Visits in the 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup>, and 6<sup>th</sup> Years of Life**



**Key Points:**

1. 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>9</sup> A decrease in avoidable hospitalizations decreases overall cost as well as improves the overall health and quality of life of the child.
2. Chart 4 provides the percentage of FHKP enrollees between three and six years old who received one or more well-child visits with a physician provider during the measurement period. 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.
3. Overall, 48% of FHKP enrollees under age 7 had a well-child visit during the measurement year, which is less than the national Medicaid HEDIS® mean of 65%. There was significant variation among the plans with a difference of 27 percentage points between the highest performing plan (Amerigroup at 59.6%) and the lowest performing plan (HealthEase at 32.6%).

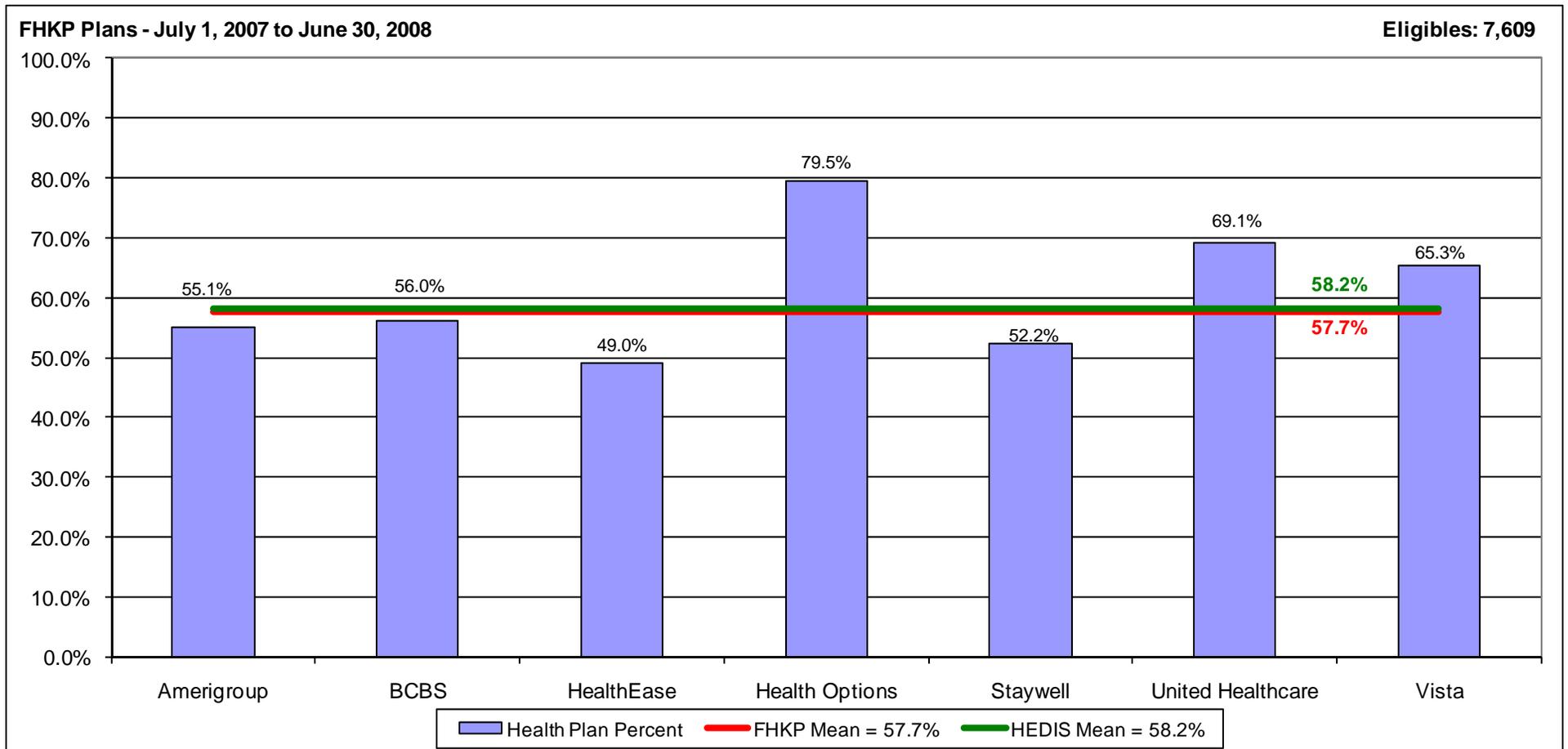
## Chart 5. HEDIS<sup>®</sup> Adolescent Well-Care Visits



### Key Points:

1. Chart 5 provides the percentage of FHKP enrollees 12 to 19 years old who received one or more comprehensive adolescent well-care visits with a physician provider during the measurement year. Note that the HEDIS<sup>®</sup> 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<sup>®</sup> mean.
2. Overall, 48% of FHKP adolescents age 12 and older had a comprehensive well-care visit during the measurement year, which is greater than the national Medicaid HEDIS<sup>®</sup> mean of 42%. As was the case with well-child visits, there was significant variation among the plans with a difference of 25 percentage points between the highest performing plans (Amerigroup and Vista at 56%) and the lowest performing plans (HealthEase and Health Options at 31%).

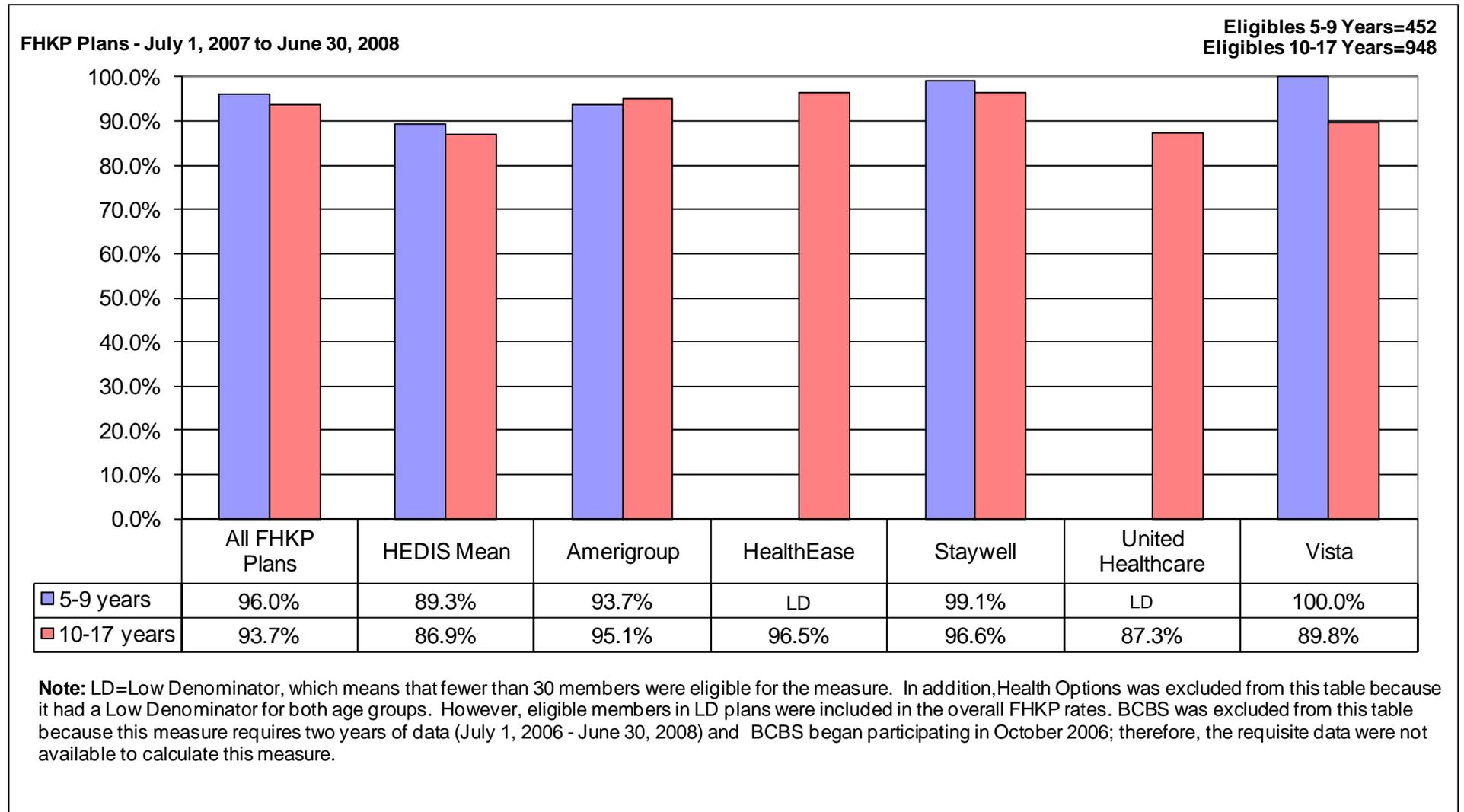
**Chart 6. HEDIS® Appropriate Testing for Children with Pharyngitis**



**Key Points:**

1. Pharyngitis (sore throat) is a common diagnosis among children and adolescents.<sup>10</sup> Most cases are viral, rather than bacterial, illnesses.<sup>11</sup> Consequently, clinical practice guidelines recommend testing for group A streptococcus (strep) before prescribing an antibiotic to reduce unwarranted antibiotic treatment.
2. Chart 6 provides the percentage of children ages 5-18 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.
3. Overall, the FHKP performed at the national Medicaid HEDIS® average of 58%. Health Options performed much better than this average: almost 80% of children who received an antibiotic for a sore throat were tested for strep.

**Chart 7. HEDIS® Use of Appropriate Medications for People with Asthma**

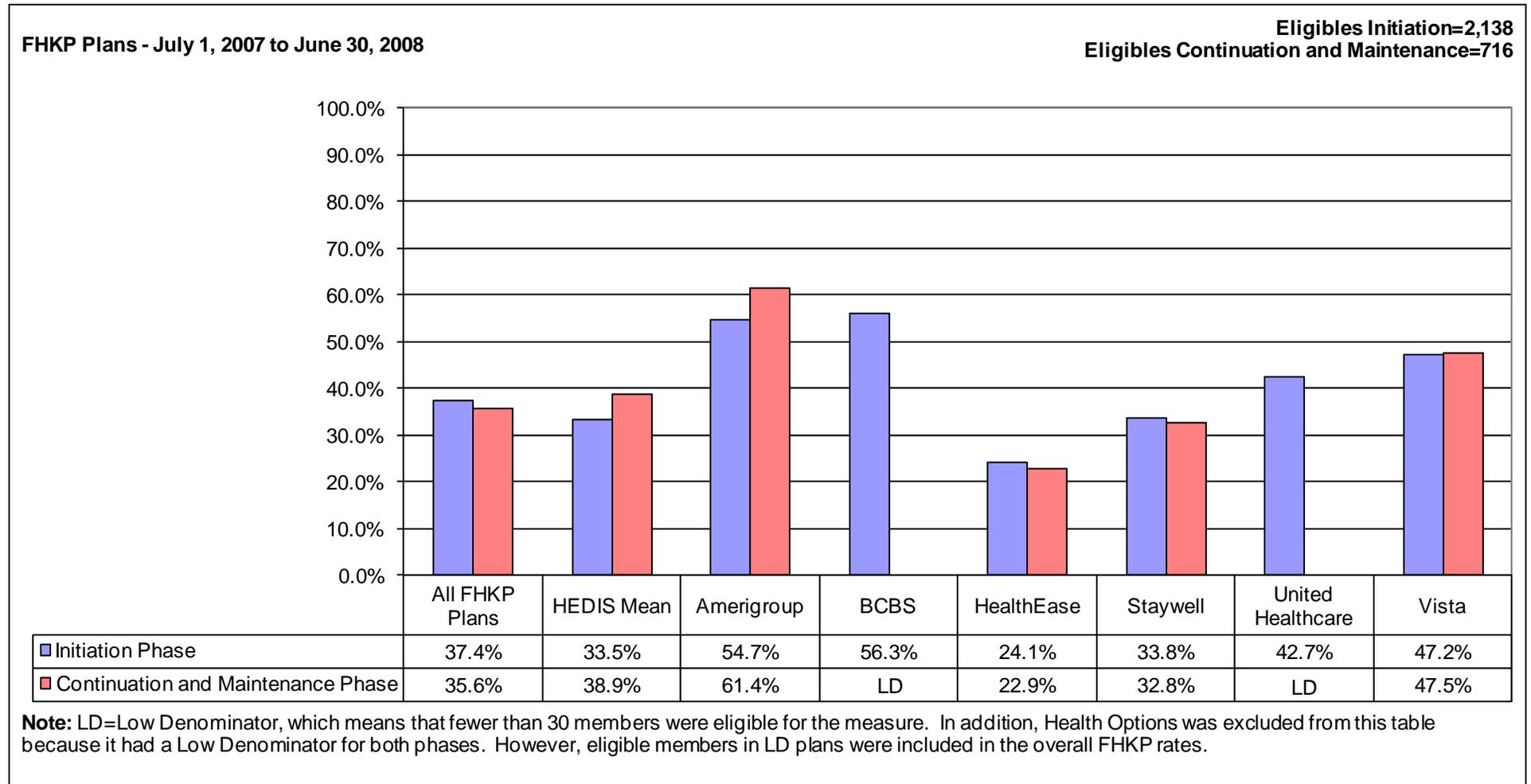


**Key Points:**

1. Asthma is one of the most common diseases of childhood and adolescence and a leading cause of school absenteeism.<sup>12</sup> Many asthma-related hospitalization, emergency department visits, and missed school days can be avoided with appropriate medication use. Despite major advances in understanding asthma, 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>13</sup>

2. Chart 7 gives the percentage of members with persistent asthma who were appropriately prescribed medications during state fiscal year 2008 by age group.
3. The findings for this indicator are positive. The FHKP overall and each of the individual plans performed better than the national Medicaid HEDIS® average. Ninety-six percent of children 5-9 years old and 94% of children 10-17 years old with persistent asthma were appropriately prescribed medication.

**Chart 8. HEDIS® Follow-Up Care for Children Prescribed ADHD Medication**

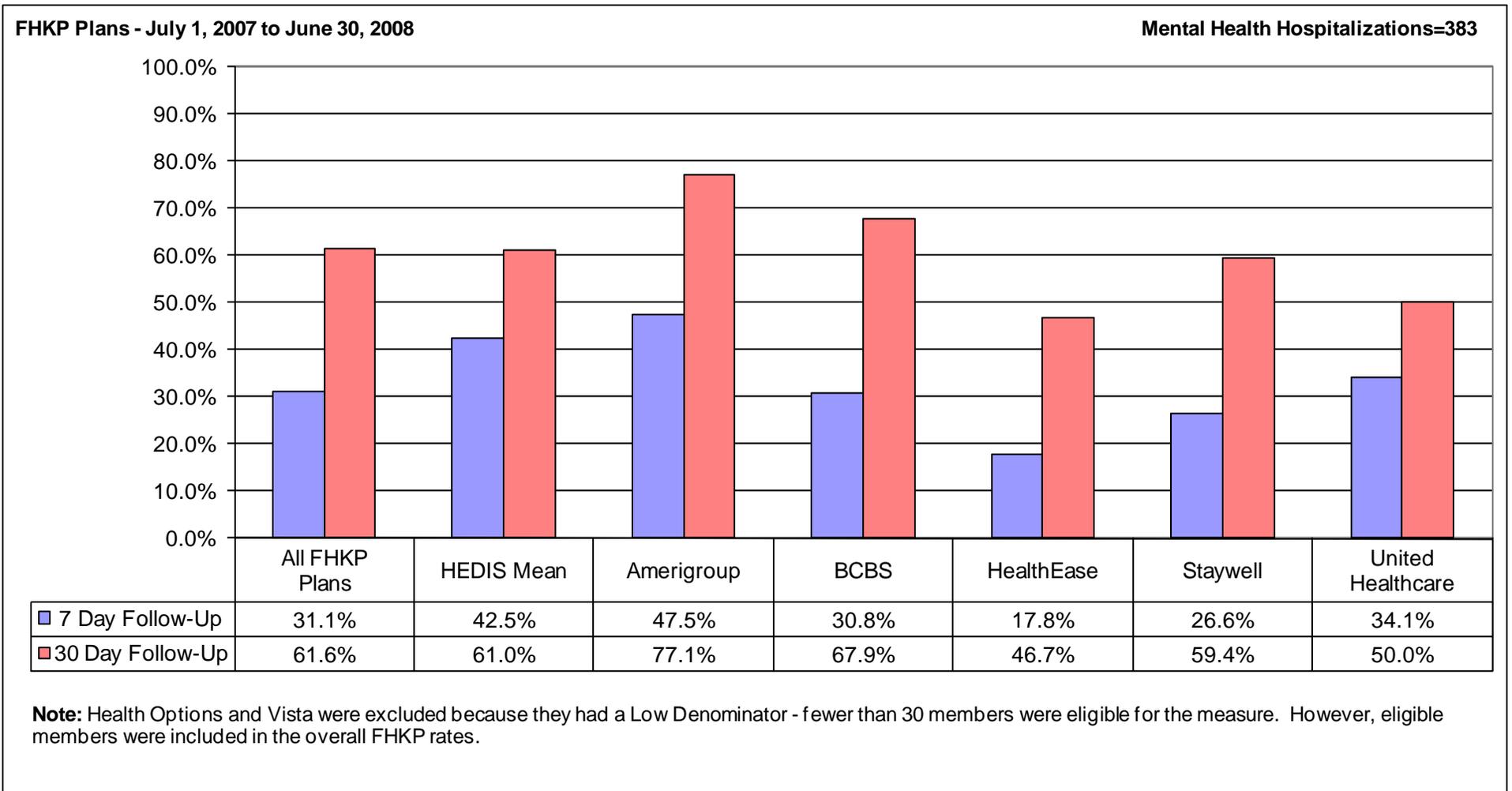


**Key Points:**

1. 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>14</sup>

2. Chart 8 gives the percentage of children who have been newly prescribed medication for ADHD and who have had at least 3 follow-up care visits within ten months. The initiation phase gives the percentage of children with ADHD medication who had one follow-up visit with a provider with prescribing authority within 30 days of their prescription. The continuation and maintenance phase is the percentage of children who had at least two additional visits after the initiation phase between the second and tenth months after the start of the medication. Children included in the continuation and maintenance measure must have remained on the medication for at least 210 days.
3. Overall, the FHKP performed at approximately the national Medicaid HEDIS® mean: 37% of FHKP enrollees who were prescribed medication for ADHD received follow-up care in the initiation phase and 36% of those who remained on the medication for at least 210 days received follow-up care in the continuation and maintenance phase. There was significant variation by health plan. The highest performing health plans were BCBS (55% of eligible enrollees received follow-up care in the initiation phase and Amerigroup (55% of eligible enrollees received follow-up care in the initiation phase and 61% received follow-up care in the continuation and maintenance phase), and the lowest performing plan was HealthEase with less than one-fourth of eligible enrollees receiving follow-up care in each phase.

**Chart 9. HEDIS® Follow-Up after Hospitalization for Mental Illness**



**Key Points:**

1. 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.

2. Chart 9 provides the percentage of FHKP enrollees six years of age or older who were hospitalized for mental illness and who had an outpatient visit, an intensive outpatient encounter, or a partial hospitalization with a physician provider during the measurement period. Two percentages are shown: (1) one for follow-up within seven days of discharge and (2) one for 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 HEDIS<sup>®</sup> means.
3. The FHKP performed lower than the national average for Medicaid Managed Care Plans reporting to NCQA on this measure at the seven-day follow-up period, with 31.1% of enrollees receiving follow-up within seven days of discharge compared to 42.5% percent nationally. However, 61.6% of enrollees received follow-up within 30 days of discharge, which is similar to the national mean of 61.0%. Results varied across the health plans. Amerigroup was the highest performing plan with a seven-day follow-up of 48% and a thirty-day follow-up of 77%. HealthEase was the lowest performing plan.

## Endnotes

- <sup>1</sup> Duchon L. and Smith V. 2006. *Quality Performance Measurement in Medicaid and SCHIP: Results of a 2006 National Survey of State Officials*. (Prepared for the National Association of Children's Hospitals). Lansing, MI: Health Management Associates. Available at: <http://www.childrenshospitals.net/AM/Template.cfm?Section=Publications2&CONTENTID=46835&TEMPLATE=/CM/ContentDisplay.cfm>.
- <sup>2</sup> The information that NCQA compiles for Medicaid Managed Care Programs can be viewed at [www.ncqa.org](http://www.ncqa.org).
- <sup>3</sup> Beaulieu ND and Epstein AM. 2002. "National Committee on Quality Assurance Health-Plan Accreditation: Predictors, Correlates of Performance, and Market Impact." *Medical Care* 40 (4): 325-337.
- <sup>4</sup> American Academy of Pediatrics. *Children's Health Topics: Medical Home*. Available at: <http://www.aap.org/healthtopics/medicalhome.cfm>.
- <sup>5</sup> Bodenheimer T and Fernandez A. 2005. "High and Rising Health Care Costs. Part 4: Can Costs be Controlled While Preserving Quality?" *Annals of Internal Medicine*. 143(1):26-31.
- <sup>6</sup> Kulig JW. 2005. "Tobacco, Alcohol, and Other Drugs: The Role of the Pediatrician in Prevention, Identification, and Management of Substance Abuse." *Pediatrics* 115(3):816-821; and National Center for Injury Prevention and Control. *WISQARS Leading Causes of Death Reports, 1999-2006*. Available at: <http://webappa.cdc.gov/sasweb/ncipc/leadcaus10.html>.
- <sup>7</sup> US Department of Health and Human Services. *Healthy People 2010. Understanding and Improving Health and Objectives for Improving Health*. Vols I and II. 2nd ed. Washington, DC: US Government Printing Office; 2000. Available at: <http://www.healthypeople.gov/>.
- <sup>8</sup> McLellan AT, Belding M, McKay JR, Zanis D, Alterman AI. Can the Outcomes Research Literature Inform the Search for Quality Indicators in Substance Abuse. In: Margaret Edmunds, editor. *Managing Managed Care : Quality Improvements in Behavioral Health*. Washington, DC: National Academy Press, 1997.
- <sup>9</sup> Hakim, R., and B. Bye. 2001. "Effectiveness of Compliance with Pediatric Preventive Care Guidelines among Medicaid Beneficiaries." *Pediatrics* 108: 90-97.
- <sup>10</sup> Gerber, M.A. 1998. "Diagnosis of Group A Streptococcal Pharyngitis." *Pediatric Annals* 27: 269-73.
- <sup>11</sup> Vincent, M.T. 2004. "Pharyngitis." *American Family Physician* 69: 1465-70.
- <sup>12</sup> Centers of Disease Control and Prevention. *Manage Asthma at School*. Available at: <http://www.cdc.gov/Features/ManageAsthma/>.

<sup>13</sup> Swartz, M. K., N. C. Banasiak, and M. Meadows-Oliver. 2005. "Barriers to Effective Pediatric Asthma Care." *Journal of Pediatric Health Care* 19 (2): 71-79.

<sup>14</sup> American Academy of Pediatrics. 2001. "Clinical Practice Guideline: Treatment of the School-Aged Child with Attention-Deficit/Hyperactivity Disorder." *Pediatrics* 108(4):1033-1044.

The Florida Healthy Kids Corporation (Corporation) is one component of the Florida KidCare Program, Florida's state Children's Health Insurance Program (CHIP) as created under Title XXI of the Social Security Act. CHIP was originally authorized under the Balanced Budget Act of 1997 and Florida's first plan amendment, which expanded the Healthy Kids program, was implemented in March 1998. Effective July 1, 2010, the annual cap on dental benefits for the Healthy Kids program was removed. Enrollees in the program now have access to the full range of dental benefits without having to manage those services within a pre-determined benefit level based upon the state fiscal year. To date, the quality of child care space and infrastructure has been considered a main factor in promoting child well-being and development (Evans, 2006). It is argued that children should have spaces big enough for their needs, and that resources should be accessible so as to stimulate engagement and play in the learning environment (Evans, 2006). For example, providing attention to the children might be more significant for the very young age group rather than providing them with educational tools (Trevarthen et al., 2003); and for pre-schoolers who begin to use objects in more complex situations, materials that offer opportunities for more advanced learning may be increasingly important.

Staff qualification. Assessment a. quality and appropriateness of care procedures for race, ethnicity & primary language eqro technical assistance report on enrollee race/ethnicity and primary language b. the level of contract compliance of mco(s)/pihp(s) mco/pihp requirements C. detailed information related to access to care standards standards for structure & operations and contract provisions D. detailed information related to florida s. The list of the Florida Medicaid Reform public meeting dates including meeting External Quality Review Summary of Findings During State Fiscal Year (SFY) , the state Health Care Quality Measures Durham Humphrey Amendment Of 1951 National Committee For Quality Assurance Adverse Event Reporting System Pure Food And Drug Act. Terms in this set (18). Agency for Healthcare Research and Quality (AHRQ). Where are the diagnoses recorded? (2) What is the source of the diagnosis (claims, medical charts, etc.)? (3) If the source is claims, what claims should be considered (IP, OP, Lab, etc.)? (4) If the claim contains more than one diagnosis, how many diagnoses will be considered for identification? (5) Over what time span, and how often, will a diagnosis have to appear in claims for that diagnosis to be incorporated? (6) What procedures may be useful for determining severity of a diagnosis?