State of Illinois
Department of Healthcare and Family Services

2005 Statewide Collaborative EPSDT PIP Aggregate Report

Issued April 2006

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1. Executive Summary

The Centers for Medicare & Medicaid Services (CMS) require state Medicaid agencies and their Medicaid managed care plans (MCOs) to conduct performance improvement projects (PIPs) to assess and improve processes, and subsequently, outcomes of care for Medicaid enrollees. In 2004–2005, the Illinois Department of Healthcare and Family Services (HFS, or the Department) implemented a requirement that each MCO participate in a mandatory statewide PIP with a study topic and methodology established by the Department in collaboration with the five HFS MCOs: **UnitedHealthcare of Illinois, Inc./AmeriChoice (AmeriChoice)**; **AMERIGROUP, Illinois (AMERIGROUP)**; **Family Health Network, Inc. (FHN)**; **Harmony Health Plan of Illinois, Inc. (Harmony)**; and **Humana Inc. (Humana)**. (**AmeriChoice** and **Humana** terminated their Medicaid contracts effective July 31, 2005.)

The Department and the HFS MCOs recognized the difficulty with determining whether or not EPSDT services were being provided in accordance with both CMS and State requirements. In a joint collaboration, HFS and the contracted MCOs decided to conduct a PIP designed to provide information about the EPSDT services provided in Illinois. The goals of the 2004–2005 EPSDT PIP were to:

- Provide baseline results of EPSDT screening indicators for targeting interventions and improving rates.
- Improve the quantity and quality of EPSDT visits through a collaborative process.
- Enhance the MCOs' knowledge and expertise in conducting PIPs while meeting both State and CMS requirements for PIPs.

To achieve the objective of enhancing the MCOs' knowledge and expertise in conducting PIPs, Health Services Advisory Group, Inc. (HSAG) provided technical assistance to HFS on the development of the study methodology, including selection of the study question, identification of study indicators, and establishment of the data analysis plan. The statewide EPSDT PIP collaborative successfully established a standardized manual collection tool, consistent data collection, and analysis processes across all of the HFS MCOs.

Methodology

The EPSDT PIP study population was all Illinois Medicaid children under 36 months of age as of December 31, 2004, and continuously enrolled in an HFS MCO for at least 11 of the 12 months between January 1, 2004, and December 31, 2004. A final minimum sample of 412 eligible cases was chosen for each HFS MCO. One HFS MCO, **Harmony**, had two distinct service areas, and sample cases were selected from each area to total 574 cases. For the purposes of this report, the two service areas are referred to as **Harmony-Cook** and **Harmony-South**.

The training aspect for this EPSDT collaborative project not only covered medical record abstraction, but also an understanding of the step-by-step process necessary to conduct PIPs. Data for this study were obtained from two sources: (1) medical record review and (2) administrative claims and encounter data. However, most of the data needed was based on information not contained in administrative data, so medical record review was required for every member in the sample. HSAG used an intensive training approach for abstractors to ensure the accuracy of the information collected.

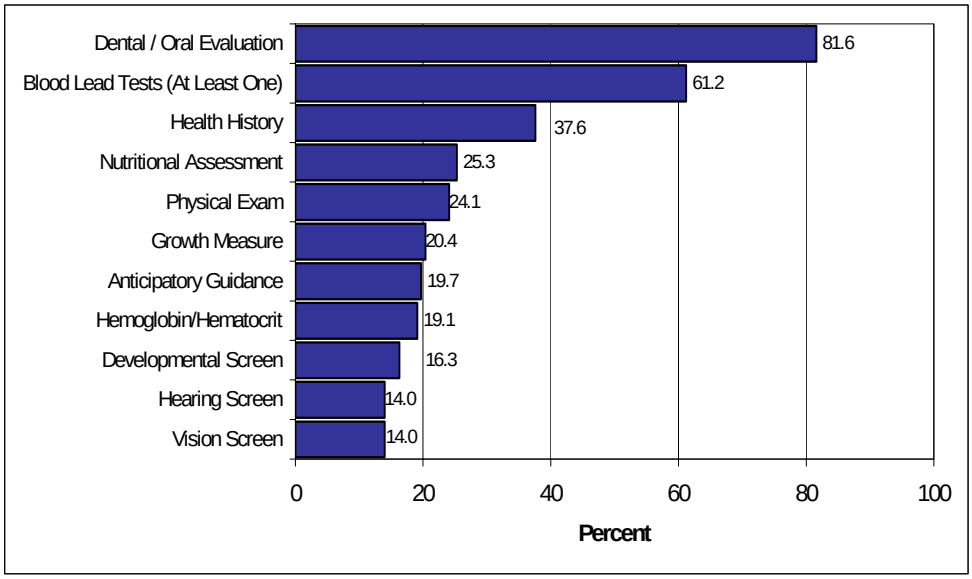
The objective of this study was to ensure Medicaid children were receiving the required EPSDT services, not just having visits. As such, the components of EPSDT visits were counted even if the visit was not an EPSDT visit (e.g., "sick" visits with components of an EPSDT visit were counted as meeting the service for an indicator). A child was considered complete for a study indicator if the EPSDT service was provided the expected number of times by the end of the study period, adjusted for age at the time of enrollment in the HFS MCO. The following is a list of EPSDT components used for the study indicators:

- Health history
- Developmental screening
- Blood lead testing
- Hemoglobin or hematocrit
- Nutritional assessment
- Physical examination
- Dental/oral screening
- Documented growth measurement
- Anticipatory guidance
- Vision screening
- Hearing screening
- Immunizations

Findings

Figure 1-1 displays the overall results for the primary indicators in this baseline EPSDT study. The rates were adjusted according to the expected number of services each child should have received based on the age of the child at the end of the study and the length of enrollment in the HFS MCOs.

Figure 1-1—Overall Rates for EPSDT Study Indicators



The highest performance, at 81.6 percent, was for dental/oral evaluation. The two lowest rates were for vision and hearing screening. The relatively low rates for most indicators suggests the providers did not always document the services provided, the documentation was insufficient (e.g., the only notation was WDWN [well-developed, well-nourished] for a developmental screen), or the child was not seen often enough by the provider to meet the total number of expected services.

The HEDIS 2005 Technical Specifications for the *Childhood Immunization Status* measure was used to report on the combined rates (i.e., Combo 1 and Combo 2), and included an additional combined rate for comparative purposes as follows:

- Combo #1: 4 DTaP, 3 IPV, 1 MMR, 3 HBV, and 3 HIB (HEDIS Combo 1)
- Combo #2: 4 DTaP, 3 IPV, 1 MMR, 3 HBV, 3 HIB and 1 VZV (HEDIS Combo 2)
- Combo #3: 4 DTaP, 3 IPV, 1 MMR, 3 HBV, 3 HIB, 1 VZV and 4 PCV (Future HEDIS Combo 3)

Table 1–1 displays the immunization rates for the various combined rates. With the exception of **AmeriChoice**, all of the combined immunization rates for the HFS MCOs were low. The reported rates for four of the five HFS MCOs were below the national 2004 HEDIS Medicaid 50th percentiles for Combo 1 and Combo 2.

Table 1–1—Combined Rates for Childhood Immunization

HFS MCOs	Sample Size	Combo 1 4:3:1:3:3	Combo 2 4:3:1:3:3:1	Combo 3 4:3:1:3:3:1:4
AmeriChoice	228	72.4%	69.7%	23.3%
AmeriGroup	237	39.7%	38.0%	18.1%
FHN	198	15.7%	13.6%	4.0%
Harmony (Cook)	181	44.2%	43.7%	13.8%
Harmony (South)	106	46.2%	38.7%	20.8%
Humana	222	30.2%	28.4%	18.0%
HFS MCOs	**1,172**	**41.6%**	**39.3%**	**16.3%**
2004 HEDIS Medicaid 50th Percentile	**NA**	**64.8%**	**61.1%**	**NA – New for HEDIS 2006**

Recommendations

The main purpose of this EPSDT PIP was to establish baseline rates and determine to what extent EPSDT services were being provided to HFS MCO members. The following recommendations are based on results from this study:

- HFS MCOs should examine underutilization to determine if there are barriers such as transportation issues that prevent members from receiving EPSDT services.
- HFS MCOs should send information detailing EPSDT visit rates and requirements, and member-level EPSDT visit information, to providers on a regular basis (e.g., quarterly or semi-annually).

- HFS MCOs should encourage use of the standardized forms published by the National Center for Education in Maternal and Child Health found at www.brightfutures.org to assist in determining the components of age-appropriate physician examinations and health education/anticipatory guidance.
- HFS MCOs should remind pediatricians, family practitioners, and internists about the essential components of an EPSDT visit in the provider newsletters.
- HFS MCOs should consider producing semi-annual reports for use by primary care physicians for members who have not visited a health care practitioner in the past 12 months.
- Providers should be encouraged to create standing orders for nursing personnel to perform immunization, dental, nutritional, vision, and hearing assessments when EPSDT services have not been performed within the last year. Physicians should review the findings, complete the physical examination, and complete the necessary health education/anticipatory guidance during his/her session with the member.
- Providers should be given information on Federal and State requirements regarding blood lead testing for children enrolled in Medicaid.
- Providers should be encouraged to perform EPSDT preventive services, such as immunizations, during office visits other than EPSDT visits.

Description of HFS MCOs

The Medicaid managed care program in Illinois operates in selected counties throughout the state. Enrollment in the program is voluntary. HFS' overall goal for its managed care system is to appropriately respond to the health care needs of Medicaid enrollees in a timely manner, ensure adequate access to covered services, provide quality health care, improve health outcomes, and conduct ongoing internal monitoring and oversight, with a focus on quality improvement. During the report period, the Department contracted with five HFS MCOs to provide health care services to Medicaid managed care recipients: **AmeriChoice**, **AMERIGROUP**, **FHN**, **Harmony**, and **Humana**. (**AmeriChoice** and **Humana** terminated their Medicaid contracts effective July 31, 2005.)

All of the HFS MCOs serve Medicaid beneficiaries residing in Cook County. **Harmony** also serves beneficiaries residing in St. Clair, Madison, Franklin, Washington, Williamson, Perry, Randolph, and Jackson counties. Three of the MCOs are multistate health care companies, and two MCOs also serve commercial enrollees. One of the MCOs, **FHN**, operates as a managed care community network (MCCN) and is a not-for-profit, provider-sponsored organization.

Through its contracts with the five MCOs, HFS strives to ensure accessibility and availability to appropriate health care, provide for continuity of care, and provide quality care to enrolled recipients, with a major focus on health promotion and disease prevention.

The current Illinois Medicaid population enrolled in the contracted HFS MCOs encompasses individuals eligible for coverage through Temporary Assistance for Needy Families (TANF) or one of its other family health programs. Children eligible for the State Children's Health Insurance Program (SCHIP or Illinois KidCare) are also eligible to enroll in an MCO. The MCO-enrolled population is mainly composed of women and children. This population benefits from targeted, preventive health care services, the quality and availability of which are monitored and evaluated by the Department in conjunction with HSAG. Traditionally, the Medicaid population in particular is a high-risk, high-volume user of health care services.

Table 2–1 shows enrollment in the Illinois voluntary Medicaid and SCHIP managed care programs by MCO.[1] As of August 2005, total enrollment was 186,851. Overall, enrollment in the HFS MCOs has increased since August 2004.

Table 2–1—HFS MCO Enrollment

HFS MCOs	August 2005	July 2005	August 2004
AmeriChoice	25,869	26,237	28,099
AmeriGroup	42,874	42,385	34,854
FHN	22,337	22,146	20,824
Harmony	76,771	74,697	61,215
Humana	19,000	19,275	19,000
Total	**186,851**	**184,740**	**163,992**

Early and Periodic Screening, Diagnostic, and Treatment Service

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is a specific health care program within Medicaid for people from birth to 20 years of age. EPSDT is designed to detect and treat health problems early through three methods: (1) regular medical, dental, vision, and hearing screening and blood lead testing; (2) immunizations; and (3) education. EPSDT provides a comprehensive child health program to help ensure that health problems are identified, diagnosed, and treated early, before they become more complex and before their treatment becomes more costly.

One difficulty with early and periodic screening is the ability to identify and measure exactly what services have been provided to ensure all necessary services have actually been provided. State Medicaid agencies and their contracted health plans typically use HEDIS® measures, such as *Childhood Immunization Status* and *Well-Child Visits in the First 15 Months of Life*, to determine compliance with providing EPSDT services. However, the requirement for a HEDIS well-child visit is different than an EPSDT visit, and, therefore, the fact that a well-child visit occurred does not, for example, indicate that a growth measurement, nutritional assessment, blood lead test, or vision screening was completed. In addition, a well-child visit may be determined using administrative data (i.e., claims or encounter data), but the data does not provide the level of detail necessary to know what services were actually performed by the physician during the office visit.

CMS requires state Medicaid agencies and their Medicaid MCOs to conduct PIPs to assess and improve processes, and subsequently, outcomes of care for Medicaid enrollees. In 2004-2005, the Department implemented a requirement that each MCO participate in a statewide PIP with a study topic and methodology established by the Department and the HFS MCOs. The Department and the HFS MCOs recognized the difficulty with determining whether or not EPSDT services were being provided in accordance with both CMS and State requirements. The Department and the HFS MCOs collaborated in conducting a PIP designed to provide information about EPSDT services

[1] Enrollment figures are from the Department: www.dpaillinois.com/managedcare/managedcare_enrollment.html

provided in Illinois. Due to the lack of detail in administrative data, the HFS MCOs felt it was necessary to conduct medical record review for all of the selected sample cases and, therefore, glean the most comprehensive picture of the provision of EPSDT services. The goals of the 2004-2005 EPSDT PIP were to:

- Provide baseline results of EPSDT screening indicators for targeting interventions and improving rates.
- Improve the quantity and quality of EPSDT visits through a collaborative process.
- Enhance the MCOs' knowledge and expertise in conducting PIPs while meeting both State and CMS requirements for PIPs.

To achieve the objective of enhancing the MCOs' knowledge and expertise in conducting PIPs, HSAG provided technical assistance to the Department in the development of the study methodology, including selection of the study question, identification of study indicators, and establishment of the data analysis plan. Further, through a statewide collaborative, HSAG served as an advisor to the MCOs and provided technical assistance on sampling methodology, medical record abstraction, data submission format, and data analysis.

Quality improvement is a continually evolving process focused on improving outcomes and health status. The next steps for the EPSDT PIPs conducted by the HFS MCOs will include performing targeted interventions aimed at achieving these goals. A remeasurement will occur in 2007 to determine whether interventions were successful. The HFS MCOs will perform their own analysis and provide a report to the State following remeasurement.

For 2005–2006, the Department has selected two additional PIPs, one related to perinatal care (i.e., increasing rates for postpartum care, timeliness of prenatal care, and screening of pregnant women for depression) and the other related to asthma care (i.e., increasing the use of appropriate medications for members with asthma). It is hoped that the lessons learned from the EPSDT PIP will enhance processes for the two new PIPs, resulting in more effective interventions and increased rates for the quality indicators.

Study Objective

In 2004, HSAG, in conjunction with the HFS and the MCOs, designed a statewide collaborative EPSDT PIP to answer the following question: Do Illinois Medicaid children who are enrolled in a managed care plan and are younger than 36 months of age receive the required EPSDT services? The answer to this question was expected to extend beyond the boundaries of simply satisfying CMS requirements. The goals for this EPSDT study were to:

- Provide baseline results of EPSDT screening indicators for targeting interventions and improving rates.
- Improve the quantity and quality of EPSDT visits through a collaborative process.

In addition to these goals, this collaborative initiative has the potential to improve Medicaid HEDIS rates for childhood immunizations and well-child visits, help develop a framework for future collaborative improvement projects, and improve overall member satisfaction with the HFS MCOs.

Study Population

The study population was all Illinois Medicaid children younger than 36 months of age as of December 31, 2004, and continuously enrolled in an HFS MCO for at least 11 of the 12 months between January 1, 2004, and December 31, 2004. Eligible members should have still been enrolled in the HFS MCO on December 31, 2004, with a one-month gap of enrollment allowed during the year.

Sampling

A final minimum sample of 412 eligible cases was chosen for each HFS MCO. This sample size ensured a maximum 5.0 percent error rate with a 95.0 percent confidence level for each of the HFS MCOs. One HFS MCO, **Harmony**, had two distinct service areas, and sample cases were selected from each area to total 574 cases. The HFS MCOs identified all members who were younger than 36 months of age as of December 31, 2004, and met the enrollment criteria of 11 or 12 months of continuous enrollment in the MCO (i.e., the eligible population). Sampling was conducted in several stages, allowing the HFS MCOs to use some of the eligible members for two HEDIS measures: *Childhood Immunization Status* and *Well-Child Visits in the First 15 Months of Life*.

The sample cases were selected from the eligible population as follows: 103 cases from members who were also eligible for the *Childhood Immunization Status* measure, 103 cases from members who were also eligible for *Well-Child Visits in the First 15 Months of Life*, 103 cases from members between 24 and 35 months of age, and the remaining 103 cases from the entire eligible population. Using this approach reduced costs associated with the EPSDT PIP since the MCOs needed to conduct medical record review for the selected members eligible for the two HEDIS measures.

Data Collection and Reliability

The training aspect for this EPSDT collaborative project not only covered medical record abstraction but also the step-by-step process necessary to conduct PIPs. As part of this training process, HSAG conducted several on-site meetings with the MCOs at the Department, held conference calls, and provided ongoing technical assistance when needed.

Data for this study were obtained from two sources: (1) medical record review and (2) administrative claims and encounter data. However, most of the data needed was based on information not contained in administrative data, so medical record review was required for every member in the sample.

HSAG used an intensive training approach for abstractors to ensure the accuracy of the information collected. A copy of the data collection tool and instructions can be found in Appendix A and Appendix B. To verify that the data collected was accurate, HSAG used interrater reliability (IRR) testing and reabstracted a sample of medical records from each MCO. The purpose of conducting IRR testing was to evaluate whether all questions on the data collection tool were interpreted and abstracted in the same consistent manner across all of the MCOs. HSAG requires the industry standard of a 95-percent agreement rate for medical record review.

Analysis of the Study Indicators

The objective of this study was to ensure Medicaid children were receiving the required EPSDT services, not just having visits. As such, the components of EPSDT visits were counted even if the visit was not an EPSDT visit (e.g., "sick" visits with components of an EPSDT visit were counted as meeting the service for an indicator). The following is a list of these EPSDT components used for the study indicators:

- Health history
- Developmental screening
- Blood lead testing
- Hemoglobin or hematocrit
- Nutritional assessment
- Physical examination
- Dental/oral screening
- Documented growth measurement
- Anticipatory guidance
- Vision screening
- Hearing screening
- Immunizations

The study methodology considered children between 12 and 36 months of age as of December 31, 2004, who were continuously enrolled in the MCO for 12 months (i.e., during 2004), with a one-month gap of enrollment allowed. In general, a child 35 months of age at the end of the study would be expected to have a minimum of nine EPSDT visits (i.e., the above services, or study indicators, should have been performed nine times). However, a child could have turned 13 months old on December 31, 2004, and had 11 months of enrollment during 2004 (e.g., enrolled in February 2004) and be eligible for the study. This child would not be expected to have had nine EPSDT visits. Table 3–1 shows the expected number of EPSDT visits for each member based on the child's age at the time of enrollment in the MCO. The denominator for each indicator was, therefore, based on eligible children and not on EPSDT visits. A child was considered complete for a study indicator if

the EPSDT service was provided the expected number of times by the end of the study period. The reason for adjusting by month of enrollment was to coincide the number of visits with the EPSDT periodicity schedule. Although this type of analysis is more complex than HEDIS measures for well-child visits, information from this study provides a comprehensive overview of the total services provided to Medicaid members enrolled in the MCOs.

Table 3–1—Expected Number of EPSDT Visits, Adjusted by Age at Time of Enrollment in the MCO

Age at Month of Enrollment	Expected Number of EPSDT Visits by Age at End of Study			
	12–14 Months	15–17 Months	18–23 Months	24–35 Months
0 – 3	5	6	8	9
4 – 5	4	5	7	8
6 – 8	3	4	6	7
9 – 11	2	3	5	6
12 – 14	1	2	4	5
15 – 17		1	3	4
18 – 20			2	3
21 – 23			1	2
24				1

Note: The table has been adjusted to allow for the potential one-month gap of enrollment for a member.

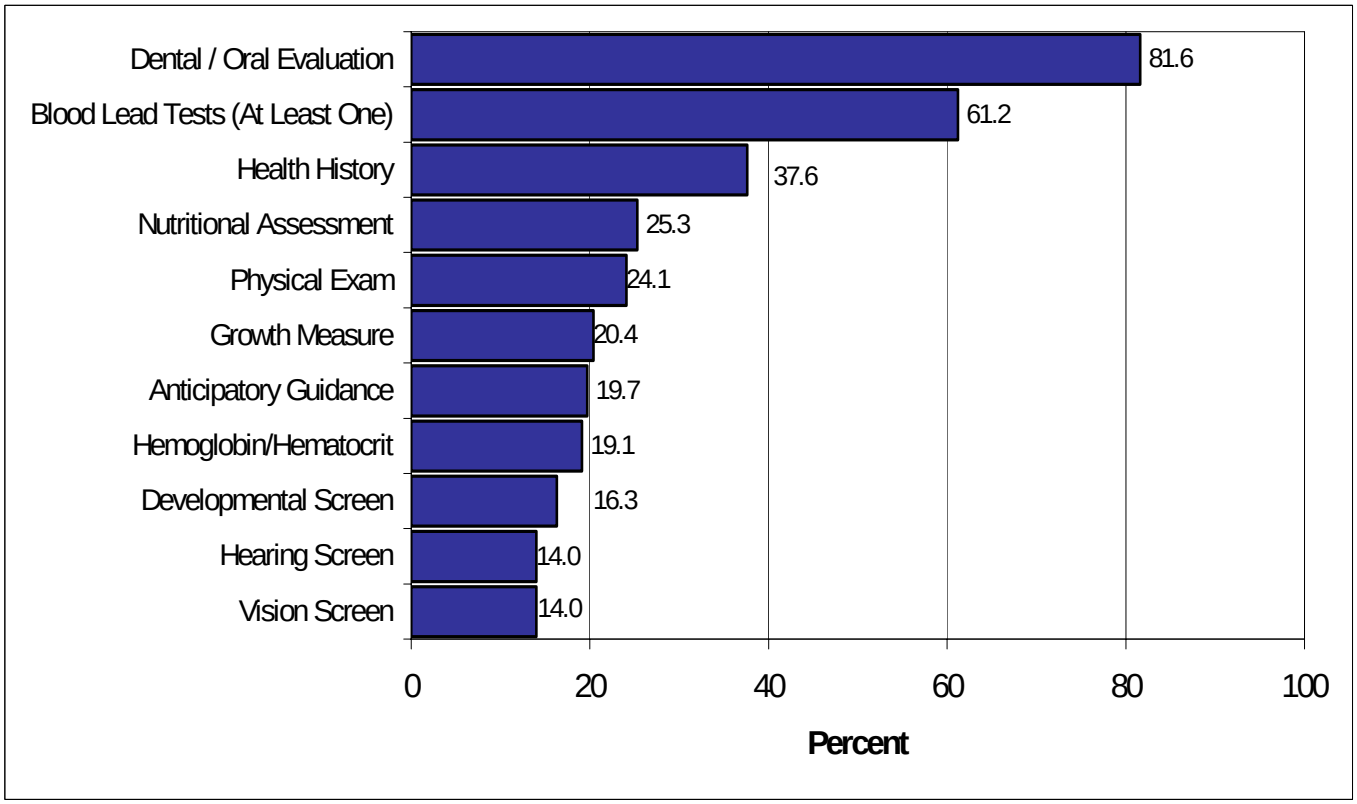
In addition to the main findings of this report, MCO-specific findings can be found following the aggregate results. Data from the HFS MCOs can be found in Section 5 of this report. The MCO-specific findings were grouped into three categories: medical record documentation, examinations/screenings, and laboratory/referrals. The four measures related to medical record documentation included health history, nutritional assessment, anticipatory guidance, and developmental screening. The measures associated with examinations/screenings are comprehensive physical exam, growth measurement, hearing screening, and vision screening. Dental screening/oral evaluation, blood-lead testing, and hemoglobin/hematocrit tests are measures typically performed by vendors or third-party administrators such as laboratories and dentists.

Summary of Findings

According to the Handbook for Healthy Kids Services (HK-205 Record Requirements), providers must maintain an office record for each patient. The record maintained by the provider is to include the essential details of the patient's condition and of each service provided. This section describes the performance of each plan for documentation on the primary study indicators compared to the aggregate performance of the five HFS MCOs. Analysis of individual indicators follows the overall summary.

Figure 4-1 shows the overall results for the primary indicators in this baseline EPSDT study. The rates were adjusted according to the expected number of services each child should have received based on the age of the child at the end of the study and the length of enrollment in the HFS MCO.

Figure 4-1—Overall Rates for EPSDT Study Indicators



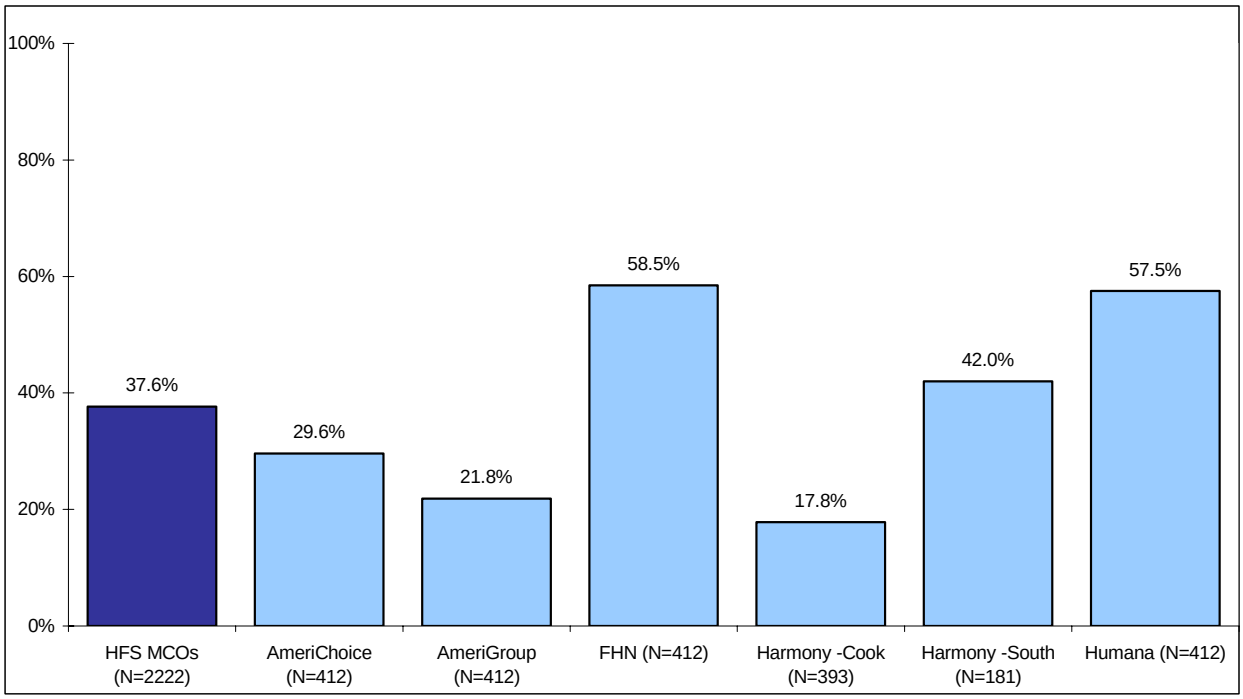
Three EPSDT services were not required on every EPSDT visit (i.e., dental/oral evaluation, blood lead tests, and hemoglobin/hematocrit testing). As might be expected, the highest performance, 81.6 percent, was for dental/oral evaluation. The fact that only one oral evaluation or documented dental referral was required for the children in this study most likely contributed to the high rate. Blood

lead testing had the second-highest rate. However, the rate for hemoglobin/hematocrit testing was low. In addition, the two lowest rates were for vision and hearing screening. The documentation required for these two indicators was minimal (e.g., "the child turned her head toward the sound"). The relatively low rates for most indicators suggests that providers did not always document the services provided, the documentation was insufficient (e.g., providers only noted WDWN for a developmental screen), or the child was not seen often enough by the provider to meet the total number of expected services.

Health History

A comprehensive initial health history should be able to assist the provider in obtaining information regarding past health problems, evaluating the risk for health problems, and obtaining information regarding the child's family and social environment. An interval history should contain information regarding illnesses, accidents, health habits, and developmental changes that may have occurred since the last visit. The notations "no changes" or "no complaints" by providers were considered acceptable as documentation. Figure 4-2 shows the percent of children in the study who had the expected number of health histories documented in the medical record.

Figure 4-2—Percent with a Health History Documented Based on the Total Number of Expected EPSDT Visits



Overall, 37.6 percent of the Medicaid children in this study had health histories documented the appropriate number of times. The rates ranged from 17.8 percent to 58.5 percent.

Table 4–1 shows the percent of the total number of expected health histories that were documented in the medical record. For example, if a child should have had documentation of a health history eight times (based on age of enrollment in the MCO), but only had three health histories documented, then the percentage of expected health histories documented was 37.5 percent, and this rate would fall into the column labeled 21–40% in Table 4–1.

Overall, 26.3 percent of the children in this study had a health history documented 20.0 percent of the time or less. This finding is most likely due to children not having enough office visits (rather than a complete lack of documentation), and represents an area of underutilization that HFS MCOs may focus on with interventions that have the potential to improve well-child visits rates and the provision of EPSDT services.

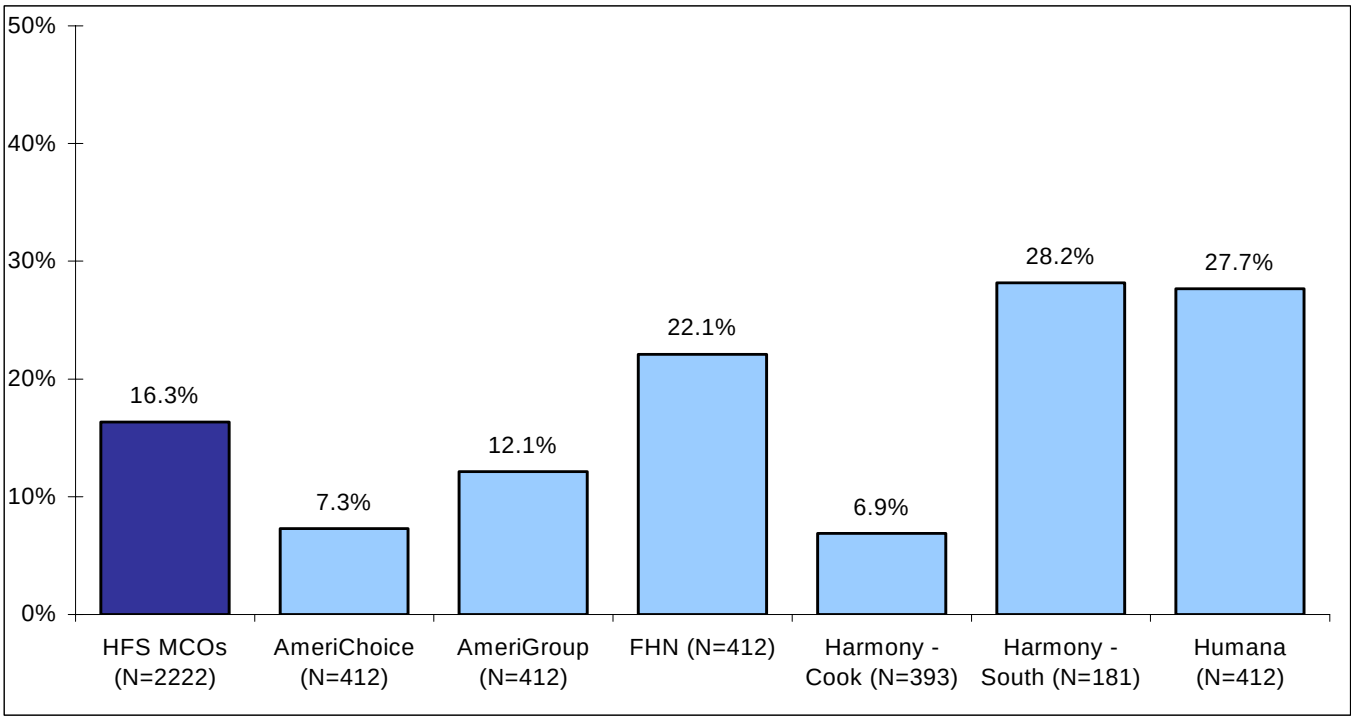
Table 4–1—Percent of Total Expected Health Histories Documented in the Medical Record

HFS MCOs	Sample Size	Percent of Expected Health Histories Documented				
		0%–20%	21%–40%	41%–60%	61%–80%	81%–100%
AmeriChoice	412	40.0%	9.0%	7.5%	9.5%	34.0%
AmeriGroup	412	32.8%	17.5%	14.3%	9.5%	26.0%
FHN	412	13.8%	6.8%	7.3%	9.2%	62.9%
Harmony–Cook	393	33.8%	11.2%	19.3%	13.2%	22.4%
Harmony–South	181	16.6%	8.3%	12.7%	14.9%	47.5%
Humana	412	15.8%	7.0%	5.8%	7.8%	63.6%
HFS MCOs	**2,222**	**26.3%**	**10.1%**	**10.9%**	**10.2%**	**42.4%**

Developmental Screening

This indicator allowed any documentation related to age-appropriate developmental milestones, language development, or the child's social, emotional, or gross motor skills. However, the notation "WDWN" was not considered acceptable documentation. Figure 4-3 shows the percent of children in the study who had the expected number of developmental screenings documented in the medical record.

Figure 4-3—Percent Receiving All Developmental Screenings Based on the Total Number of Expected EPSDT Visits



Overall, approximately one in six children (16.3 percent) received developmental screenings the expected number of times. All of the HFS MCOs reported rates below 30.0 percent.

Table 4–2 shows the percent of the total number of expected developmental screens that were documented in the medical record. For example, if a child should have had documentation of a developmental screen eight times (based on age of enrollment in the MCO), but only had three developmental screens documented, then the percentage of expected developmental screens documented was 37.5 percent, and this rate would fall into the column labeled 21–40% in Table 4–2.

Overall, 21.6 percent of the children in this study had developmental screens documented more than 80 percent of the time, and 38.8 percent of children had documentation 20 percent of the time or less. The low rates indicate that providers did not always document a developmental screening, the documentation was insufficient (e.g., the provider only noted WDWN), or the child was not seen often enough by the provider to meet the total number of expected services.

Table 4–2—Percent of Total Expected Developmental Screens Documented in the Medical Record

HFS MCOs	Sample Size	Percent of Expected Developmental Screens Documented				
		0%–20%	21%–40%	41%–60%	61%–80%	81%–100%
AmeriChoice	412	53.6%	14.3%	11.2%	11.2%	9.7%
AmeriGroup	412	47.6%	14.1%	11.2%	11.4%	15.8%
FHN	412	27.4%	14.8%	15.0%	14.8%	27.9%
Harmony–Cook	393	50.1%	15.8%	13.0%	11.5%	9.7%
Harmony–South	181	19.9%	12.2%	17.7%	16.6%	33.7%
Humana	412	24.0%	9.0%	10.2%	18.0%	38.8%
HFS MCOs	**2,222**	**38.8%**	**13.5%**	**12.6%**	**13.6%**	**21.6%**

Objective Developmental Screening Tools

Table 4–3 displays the types of objective developmental screenings performed. The most common forms used were the Denver Developmental Screening II form, and the Ages and Stages Questionnaire (ASQ) form. For the purposes of this study, a list of HFS-approved objective developmental screening tools (reference HK-203.53 Developmental Screening Tools) can be found in Appendix E. Bright Futures and EPSDT were not considered acceptable objective developmental screening tools.

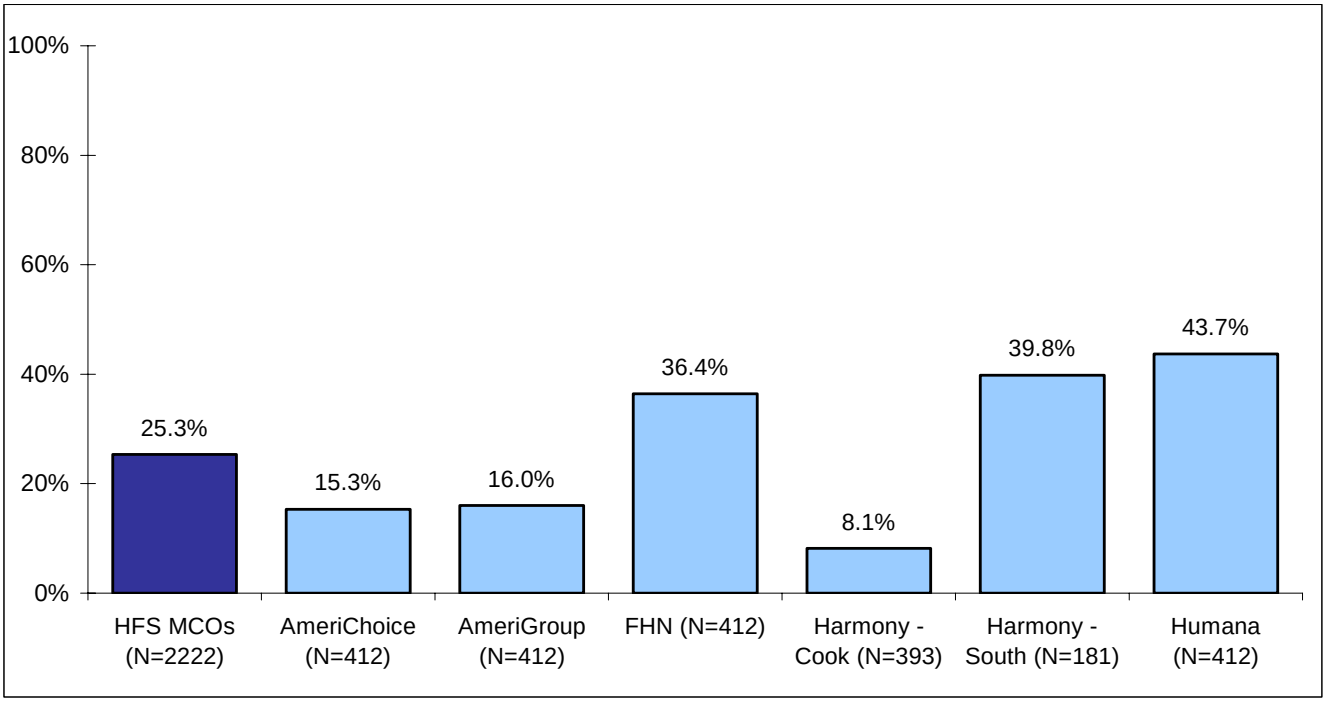
Table 4–3—Types of Objective Developmental Screening Forms

Type of Objective Developmental Screening Form	Number of Times Screening Forms Were Used
Denver Developmental Screening II	111
American Society for Quality	70
Bright Futures	43
EPSDT	6
Battelle Developmental Inventory	1
Total Objective Developmental Screenings Performed	**231**

Nutritional Assessment

The Department requires a nutritional assessment as a component of the EPSDT screening that should be completed at each EPSDT visit. Documentation of dietary evaluation, WDWN, anthropometric measurements, or biochemical measurements all qualified as appropriate documentation for this study indicator. Figure 4-4 shows the percent of children in the study who had the expected number of nutritional assessments documented in the medical record.

Figure 4-4—Percent with a Nutritional Assessment Documented Based on the Total Number of Expected EPSDT Visits



One in four children (25.3 percent) enrolled in the HFS MCOs had nutritional assessments documented the expected number of times. Rates for the HFS MCOs ranged from 8.1 percent to 43.7 percent.

Table 4–4 shows the percent of the total number of expected nutritional assessments that were documented in the medical record. For example, if a child should have had documentation of a nutritional assessment eight times (based on age of enrollment in the MCO), but only had three nutritional assessments documented, then the percentage of expected nutritional assessments documented was 37.5 percent, and this rate would fall into the column labeled 21–40% in Table 4–4.

Overall, 30.2 percent of the children in this study had nutritional assessments documented more than 80 percent of the time, and 34.6 percent of children had documentation 20 percent of the time or less.

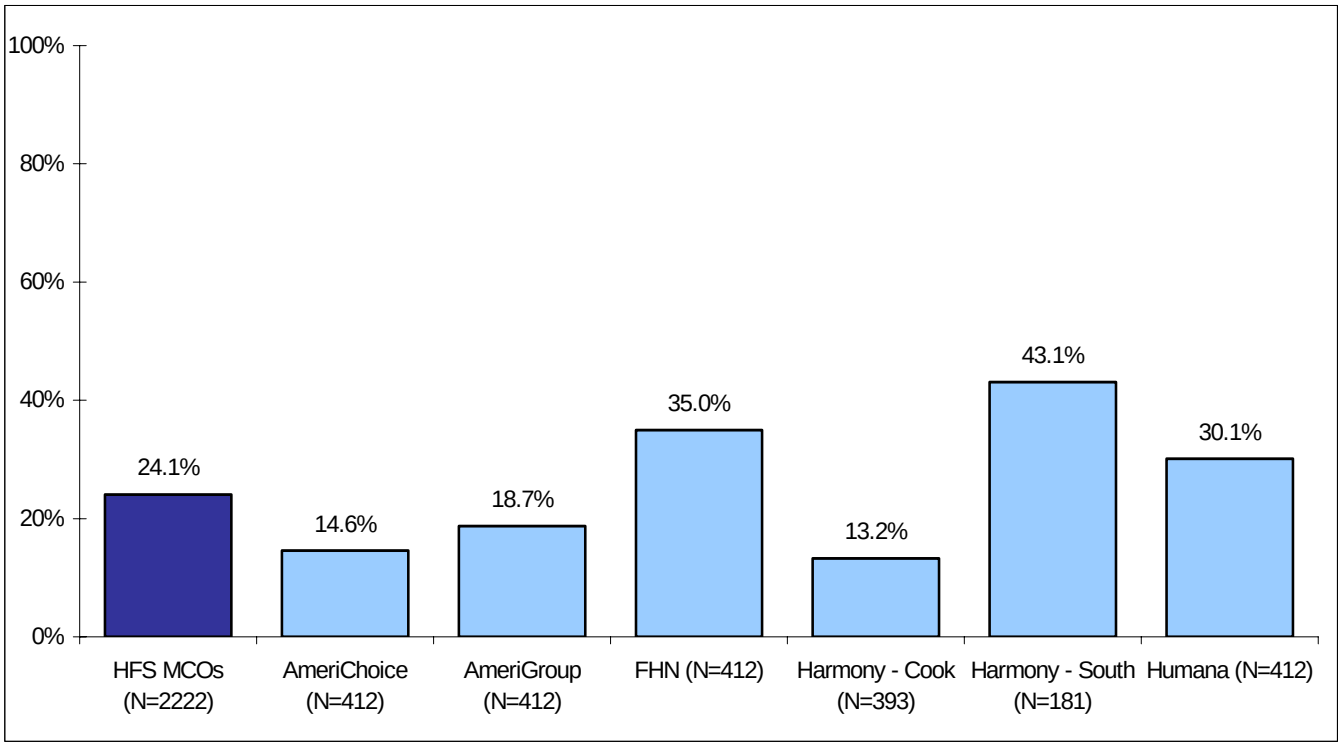
Table 4–4—Percent of Total Expected Nutritional Assessments Documented in the Medical Record

HFS MCOs	Sample Size	Percent of Expected Nutritional Assessments Documented				
		0%–20%	21%–40%	41%–60%	61%–80%	81%–100%
AmeriChoice	412	49.3%	11.9%	11.9%	9.2%	17.7%
AmeriGroup	412	38.8%	15.5%	11.7%	12.4%	21.6%
FHN	412	25.5%	12.1%	10.4%	10.7%	41.3%
Harmony–Cook	393	49.9%	18.6%	11.2%	8.7%	11.7%
Harmony–South	181	17.1%	7.7%	17.7%	13.3%	44.2%
Humana	412	17.7%	9.7%	8.7%	12.4%	51.5%
HFS MCOs	**2,222**	**34.6%**	**13.1%**	**11.3%**	**10.9%**	**30.2%**

Comprehensive Physical Examination

A comprehensive physical examination may include evaluations of the head, neck, eyes, ears, cardiovascular system, respiratory system, gastrointestinal system, reproductive system, nervous system, musculoskeletal system, lymphatic system, and the integument system. To qualify as a comprehensive physical examination, a minimum of 10 of the above evaluations must be assessed and documented. Figure 4-5 shows the percent of children in the study who had the expected number of comprehensive physical examinations documented in the medical record.

Figure 4-5—Percent Receiving All Comprehensive Physical Examinations Based on the Total Number of Expected EPSDT Visits



Overall, 24.1 percent of the Medicaid children in this study had comprehensive physical examinations documented the appropriate number of times. The rates ranged from 13.2 percent to 43.1 percent. The low rates suggest either the providers did not always perform or document a comprehensive physical examination (e.g., the provider did not document at least 10 evaluations), or the child was not seen often enough by the provider to meet the total number of expected services.

Table 4–5 shows the percent of the total number of expected comprehensive physical exams that were documented in the medical record. For example, if a child should have had documentation of a comprehensive physical exam eight times (based on age of enrollment in the MCO), but only had three comprehensive physical exams documented, then the percentage of expected comprehensive physical exams documented was 37.5 percent, and this rate would fall into the column labeled 21–40% in Table 4–5.

Overall, 30.0 percent of the children in this study had comprehensive physical examinations documented more than 80 percent of the time. About one-third of the Medicaid children in this study had a comprehensive physical examination documented 20 percent of the time or less.

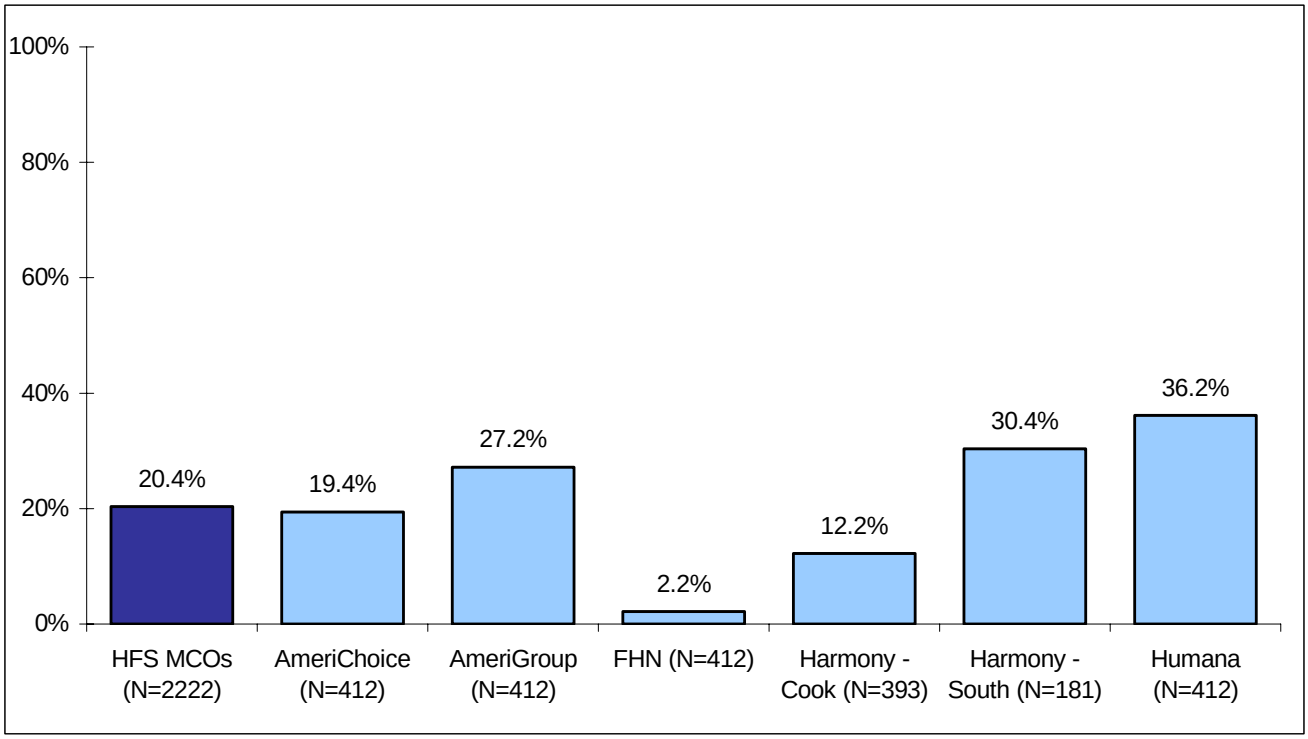
Table 4–5—Percent Receiving Comprehensive Physical Examinations

HFS MCOs	Sample Size	Percent Receiving Expected Comprehensive Physical Examinations				
		0%–20%	21%–40%	41%–60%	61%–80%	81%–100%
AmeriChoice	412	47.6%	14.8%	9.7%	8.3%	19.7%
AmeriGroup	412	39.1%	16.5%	11.2%	10.4%	22.8%
FHN	412	26.2%	15.0%	9.2%	8.3%	41.3%
Harmony–Cook	393	44.0%	15.5%	15.0%	8.1%	17.3%
Harmony–South	181	16.0%	6.6%	16.0%	12.2%	49.2%
Humana	412	20.6%	10.4%	10.9%	18.2%	39.8%
HFS MCOs	**2,222**	**33.8%**	**13.8%**	**11.6%**	**10.8%**	**30.0%**

Growth Measurement

Measurements should be plotted on a standardized growth chart. Height and weight should be measured at each EPSDT visit, while head circumference should be measured at each EPSDT visit until the child reaches 24 months of age. Children over 24 months of age met the requirements for this indicator if height and weight were documented. Figure 4-6 shows the percent of children in the study who had the expected number of growth measurements documented in the medical record.

Figure 4-6—Percent with Growth Measurement Documented Based on the Total Number of Expected EPSDT Visits



Approximately one in five (20.4 percent) Medicaid children in this study had growth measurements documented the appropriate number of times. The rates ranged from 2.2 percent to 36.2 percent. As stated above, the intent of this indicator was to consider plotted growth measurements. However, documentation for height, weight, and head circumference was considered acceptable. The low rates suggest that providers did not document height, weight, and head circumference on a routine basis.

Table 4–6 shows the percent of the total number of expected growth measurements documented in the medical record. For example, if a child should have had documentation of growth measurements eight times (based on age of enrollment in the MCO), but only had three growth measurements documented, then the percentage of expected growth measurements documented was 37.5 percent, and this rate would fall into the column labeled 21–40% in Table 4–6.

Overall, 26.3 percent of the children in this study had growth measurements documented more than 80 percent of the time. About the same percent of children had growth measurements documented 20 percent of the time or less.

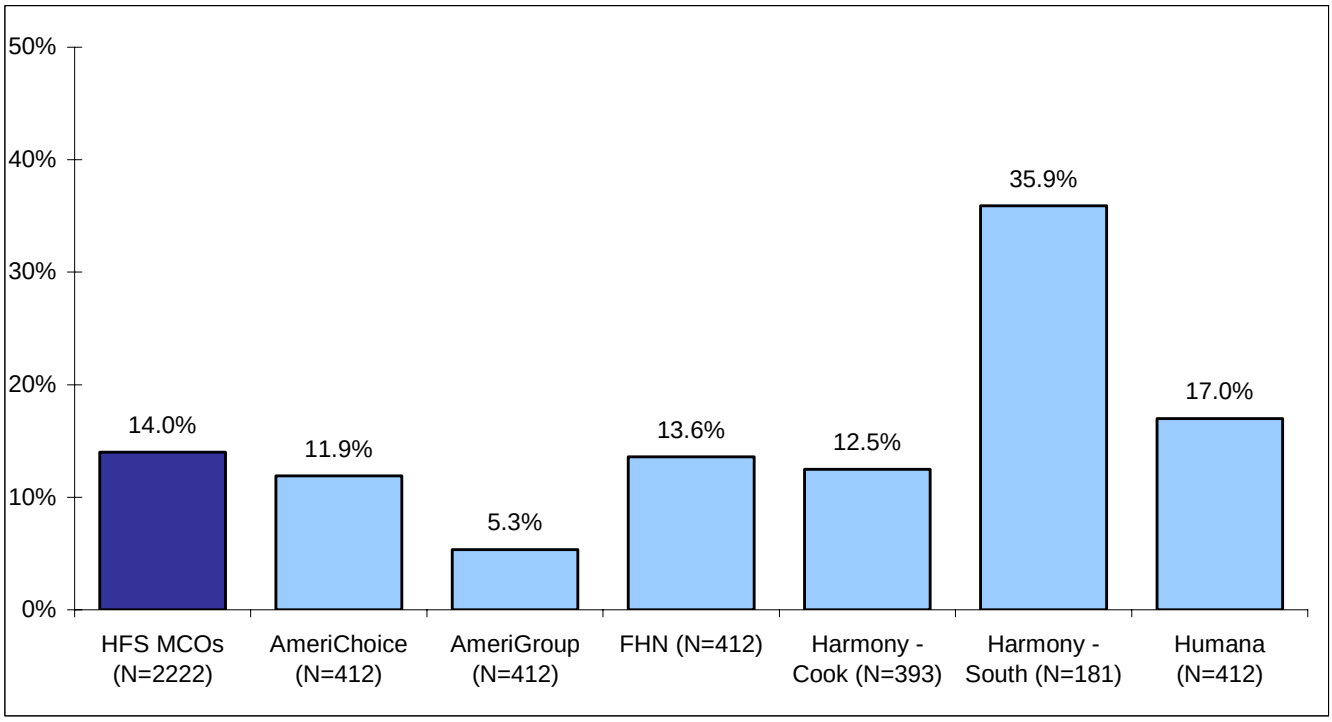
Table 4–6—Percent of Total Expected Growth Measurements Documented in the Medical Record

HFS MCOs	Sample Size	Percent of Expected Growth Measurements Documented				
		0%–20%	21%–40%	41%–60%	61%–80%	81%–100%
AmeriChoice	412	43.0%	11.9%	9.2%	10.9%	25.0%
AmeriGroup	412	28.2%	15.0%	12.9%	10.7%	33.3%
FHN	412	26.5%	15.0%	41.5%	14.6%	2.4%
Harmony–Cook	393	31.0%	17.8%	17.0%	16.3%	17.8%
Harmony–South	181	19.9%	11.0%	18.8%	14.9%	35.4%
Humana	412	17.5%	7.3%	8.3%	18.4%	48.5%
HFS MCOs	**2,222**	**28.4%**	**13.2%**	**17.9%**	**14.2%**	**26.3%**

Vision Screening

The Department requires a subjective vision screening for all infants and toddlers as a component of EPSDT screening. An example of a subjective vision screening is the informal observation by the provider that the child follows lights or faces. The purpose of the vision screening is to identify children who may have an eye defect and refer them for follow-up services (e.g., getting glasses, social services, or specialist care). Figure 4-7 shows the percent of children in the study who had the expected number of vision screenings documented in the medical record.

Figure 4-7—Percent Receiving All Vision Screenings (Subjective or Objective) Based on the Total Number of Expected EPSDT Visits



Overall, 14.0 percent, or approximately one in seven children, received vision screenings the expected number of times. Five of the six reported rates were below 20.0 percent. These low rates indicate that providers did not conduct vision screenings, did not document the vision screenings, or referred the child for vision screening and did not document the referral.

Table 4–7 shows the percent of the total number of expected vision screenings that were documented in the medical record. For example, if a child should have received a vision screening eight times (based on age of enrollment in the MCO), but only had three vision screenings documented, then the percentage of expected visions screening documented was 37.5 percent, and this rate would fall into the column labeled 21–40% in Table 4–7.

Overall, 18.1 percent of the children in this study had vision screenings documented more than 80 percent of the time, and 44.6 percent of children had vision screenings documented 20 percent of the time or less. These low rates support the conclusion that vision screenings are either not performed or not documented.

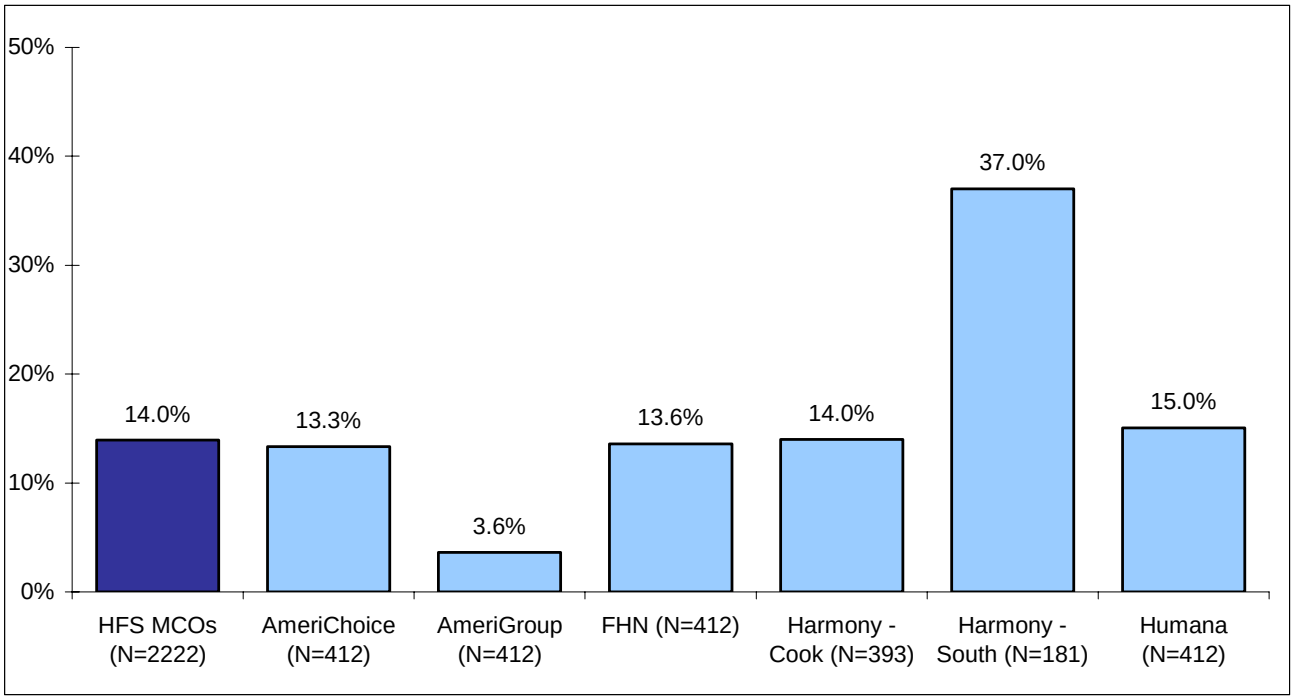
Table 4–7—Percent of Total Expected Vision Screens Documented in the Medical Record

HFS MCOs	Sample Size	Percent of Expected Vision Screens Documented				
		0%–20%	21%–40%	41%–60%	61%–80%	81%–100%
AmeriChoice	412	52.2%	11.9%	11.4%	10.4%	14.1%
AmeriGroup	412	59.5%	14.8%	10.9%	7.3%	7.5%
FHN	412	45.1%	16.3%	9.7%	10.2%	18.7%
Harmony–Cook	393	45.8%	13.5%	14.5%	10.2%	16.0%
Harmony–South	181	22.1%	12.2%	14.4%	12.2%	39.2%
Humana	412	30.3%	13.6%	15.8%	15.5%	24.8%
HFS MCOs	**2,222**	**44.6%**	**13.9%**	**12.6%**	**10.8%**	**18.1%**

Hearing Screening

The Department requires a hearing screening beginning at 12 months of age for children at high risk for hearing problems. A subjective hearing screening is recommended as part of each EPSDT visit. An example of a subjective hearing screening is the informal observation by a provider that a child hears sounds or turns toward sounds. Figure 4-8 shows the percent of children in the study who had the expected number of hearing screenings documented in the medical record.

Figure 4-8—Percent Receiving All Hearing Screenings (Subjective or Objective) Based on the Total Number of Expected EPSDT Visits



The rates for hearing screenings were similar to vision screenings. Overall, 14.0 percent, or approximately one in seven children, received hearing screenings the expected number of times. The rates ranged from 3.6 percent to 37.0 percent. Five of the six reported rates were below 20.0 percent. These low rates indicate that providers did not conduct hearing screenings, did not document hearing screenings, or referred the child for hearing screening and did not document the referral.

Table 4–8 shows the percent of the total number of expected hearing screenings that were documented in the medical record. For example, if a child should have received a hearing screening eight times (based on age of enrollment in the MCO), but only had three hearing screenings documented, then the percentage of expected hearing screenings documented was 37.5 percent, and this rate would fall into the column labeled 21–40% in Table 4–8.

Overall, 17.5 percent of the children in this study had hearing screenings documented more than 80 percent of the time, and 46.2 percent of children had hearing screenings documented 20 percent of the time or less. These low rates support the conclusion that hearing screenings are either not performed or not documented.

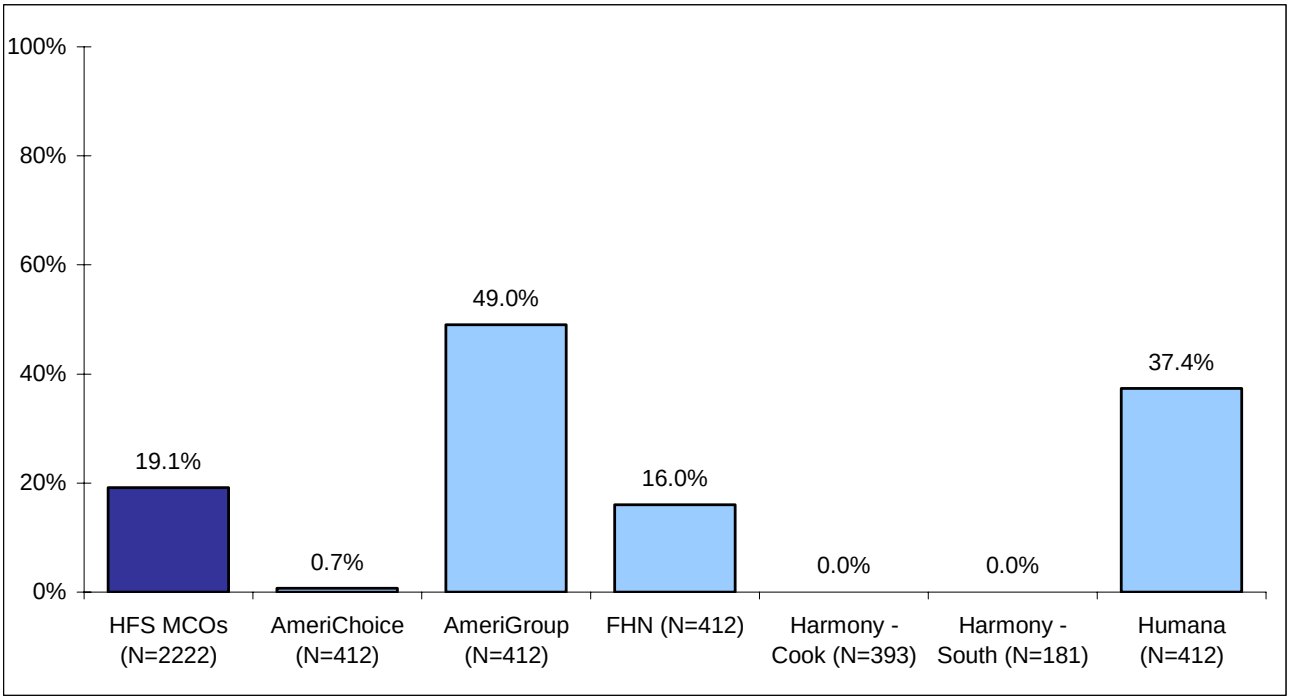
Table 4–8—Percent of Total Expected Hearing Screens Documented in the Medical Record

HFS MCOs	Sample Size	Percent of Expected Hearing Screens Documented				
		0%–20%	21%–40%	41%–60%	61%–80%	81%–100%
AmeriChoice	412	51.9%	11.9%	10.0%	11.4%	14.8%
AmeriGroup	412	65.8%	12.6%	11.4%	4.9%	5.3%
FHN	412	47.8%	16.0%	9.5%	9.5%	17.2%
Harmony–Cook	393	44.0%	14.2%	14.5%	9.9%	17.3%
Harmony–South	181	22.1%	13.3%	12.2%	11.0%	41.4%
Humana	412	31.8%	17.0%	15.5%	13.3%	22.3%
HFS MCOs	**2,222**	**46.2%**	**14.3%**	**12.2%**	**9.9%**	**17.5%**

Hemoglobin or Hematocrit

The Centers for Disease Control and Prevention (CDC) developed recommendations for use by primary care providers to prevent, detect, and treat iron deficiency. For the children in this study, the CDC recommends hemoglobin or hematocrit testing between 9 and 12 months of age. Children should be tested between 15 and 18 months of age, and annually after 24 months of age, if medically necessary or indicated. The easiest test to administer for anemia is a microhematocrit determination from venous blood or a finger stick. Figure 4-9 shows the percent of children in the study who had the expected number of hemoglobin or hematocrit tests documented in the medical record.

Figure 4-9—Percent Receiving Hemoglobin or Hematocrit Testing Based on the Total Number of Expected EPSDT Visits



Overall, 19.1 percent of the Medicaid children in this study had hemoglobin or hematocrit testing conducted the appropriate number of times. The rates ranged from 0.0 percent to 49.0 percent. Three rates were below one percent. The low rates suggest that either providers did not always document a hemoglobin or hematocrit test or laboratory results were not available.

Table 4–9 shows the percent of the total number of hemoglobin/hematocrit tests that were documented in the medical record. For example, if a child should have received hemoglobin/hematocrit testing three times (based on age of enrollment in the MCO), but only had one hemoglobin/hematocrit testing documented, then the percentage of expected hemoglobin/hematocrit testing documented was 33.3 percent, and this rate would fall into the column labeled 21–40% in Table 4–9.

Overall, 19.2 percent of the children in this study had hemoglobin/hematocrit testing documented more than 80 percent of the time, and 60.8 percent of children had hemoglobin/hematocrit testing documented 20 percent of the time or less. The distribution of rates among the categories in Table 4–9 is unusual, showing basically all-or-nothing documentation. These low rates, along with the unusual distribution of rates, support the conclusion that providers did not always document a hemoglobin or hematocrit test, or the laboratory results were not available. Given that this information usually comes from a laboratory, and that rates for indicators that do not come from a laboratory are documented to a much higher degree, it appears several HFS MCOs do not obtain complete laboratory data.

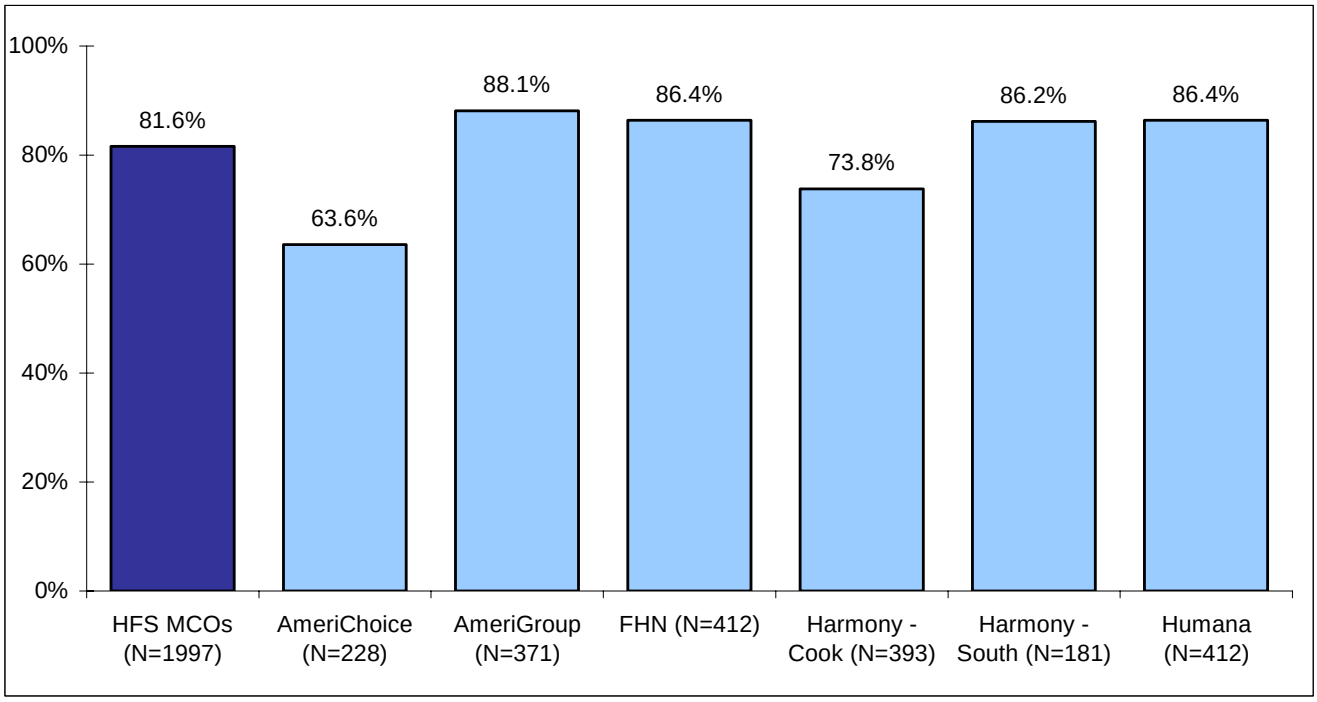
Table 4–9—Percent Receiving Hemoglobin or Hematocrit Testing

HFS MCOs	Sample Size	Percent of Expected Hemoglobin or Hematocrit Testing				
		0%–20%	21%–40%	41%–60%	61%–80%	81%–100%
AmeriChoice	412	77.9%	16.3%	4.6%	0.5%	0.7%
AmeriGroup	412	35.0%	0.0%	16.0%	0.0%	49.0%
FHN	412	64.1%	0.0%	19.9%	0.0%	16.0%
Harmony–Cook	393	79.4%	17.8%	2.3%	0.3%	0.3%
Harmony–South	181	91.2%	8.3%	0.6%	0.0%	0.0%
Humana	412	35.4%	0.0%	27.2%	0.0%	37.4%
HFS MCOs	**2,222**	**60.8%**	**6.8%**	**13.0%**	**0.1%**	**19.2%**

Oral Evaluation and Referrals

An oral evaluation should be performed at least once between 12 and 36 months of age, and appropriate dental referrals made for the child. For the purposes of this analysis, the requirement for this measure was one oral evaluation for children between 24 and 36 months of age. Children under 24 months of age who received an oral evaluation were also considered compliant for this measure. In recognition of current practices, credit for an oral evaluation was also given for primary care providers who referred a child for dental services. Figure 4-10 shows the percent of children who received a dental referral, or the required oral evaluation.

Figure 4-10—Percent Receiving an Oral Evaluation or Referral for Dental Services



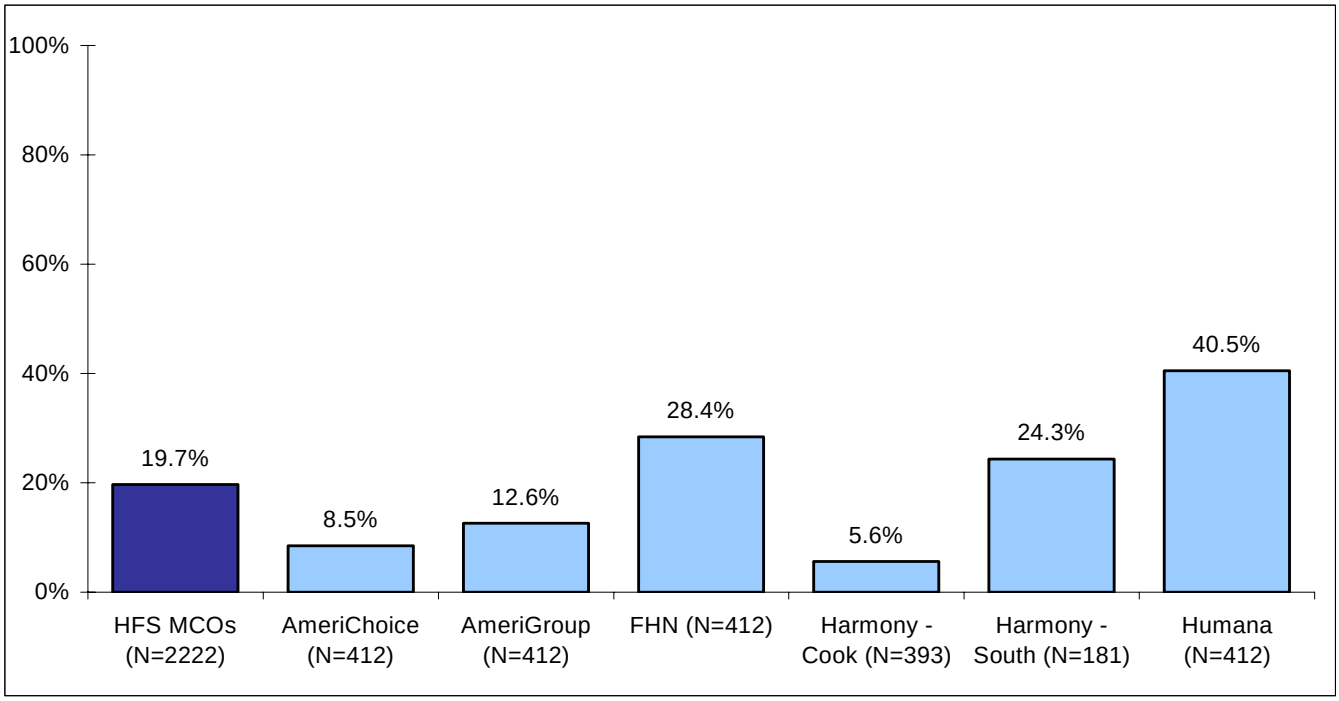
The HFS MCOs showed the best performance with this indicator. Overall, 81.6 percent of the Medicaid children in this study had an oral evaluation or referral for dental services documented the appropriate number of times. The rates ranged from 63.6 percent to 88.1 percent, with rates from four plans above 80.0 percent.

One possible reason for the high level of documentation for this indicator may be due to the Department's recommendations that children be referred to a dentist at 24 months of age. An oral evaluation is part of the physical examination, but does not replace referral to a dentist. Therefore, providers reluctant to perform oral evaluations may simply refer the child to a dentist and document the referral.

Anticipatory Guidance

Health education and anticipatory guidance is designed to help parents and children understand what to expect in terms of child development. In addition, anticipatory guidance should include information about the benefits of healthy lifestyles, accident prevention, and disease prevention. Examples of acceptable documentation included the notation "anticipatory guidance done" or "education provided." Figure 4-11 shows the percent of children with anticipatory guidance documented the expected number of times in the medical record.

Figure 4-11—Percent with Anticipatory Guidance Documented Based on the Total Number of Expected EPSDT Visits



Approximately one in five (19.7 percent) Medicaid children in this study had anticipatory guidance documented the appropriate number of times. The rates ranged from 5.6 percent to 40.5 percent. As noted above, minimal documentation was considered acceptable, suggesting providers do not document anticipatory guidance on a routine basis.

Table 4–10 shows the percent of the total number of times anticipatory guidance was expected to be documented in the medical record. For example, if a child should have had documentation of a anticipatory guidance eight times (based on age of enrollment in the MCO), but only had three documented, then the percentage of expected documentation of anticipatory guidance was 37.5 percent, and this rate would fall into the column labeled 21–40% in Table 4–10.

Overall, 24.5 percent of the children in this study had anticipatory guidance documented more than 80 percent of the time, and 40.8 percent of the children had documentation 20 percent of the time or less.

Table 4–10—Percent of Total Expected Anticipatory Guidance Documented in the Medical Record

HFS MCOs	Sample Size	Percent of Expected Anticipatory Guidance Documented				
		0%–20%	21%–40%	41%–60%	61%–80%	81%–100%
AmeriChoice	412	53.4%	14.1%	10.2%	10.9%	11.4%
AmeriGroup	412	50.7%	12.9%	11.9%	8.5%	16.0%
FHN	412	29.9%	14.3%	10.0%	10.2%	34.7%
Harmony–Cook	393	13.0%	16.3%	10.9%	6.9%	8.9%
Harmony–South	181	5.0%	12.2%	21.0%	13.3%	30.4%
Humana	412	21.6%	7.5%	9.5%	13.3%	48.1%
HFS MCOs	**2,222**	**40.8%**	**12.9%**	**11.5%**	**10.3%**	**24.5%**

Immunizations

Highly effective immunizations are used routinely in childhood for prevention of measles, mumps, rubella, varicella (chicken pox), diphtheria, tetanus, pertussis (whooping cough), polio, hepatitis B, and invasive Hib disease (Haemophilus influenzae type b). Immunizations for these diseases have reduced reported cases to record-low levels. Polio has been eliminated in the United States, and reported cases of diphtheria are near zero. In the last few years, the pneumococcal immunization has been added to the list of recommended immunizations.

For this study, the HFS MCOs used the HEDIS 2005 Technical Specifications for the *Childhood Immunization Status* measure to report on the combined rates (i.e., Combo 1 and Combo 2), and included several additional combined rates for comparative purposes as follows:

- Combo #1: 4 DTaP, 3 IPV, 1 MMR, 3 HBV, and 3 HIB (HEDIS Combo 1)
- Combo #2: 4 DTaP, 3 IPV, 1 MMR, 3 HBV, 3 HIB and 1 VZV (HEDIS Combo 2)
- Combo #3: 4 DTaP, 3 IPV, 1 MMR, 3 HBV, 3 HIB, 1 VZV and 4 PCV (future HEDIS Combo 3)

Table 4–11 shows immunization rates for the various combined rates. With the exception of AmeriChoice, all of the combined immunization rates for the HFS MCOs were low. The reported rates for four of the five HFS MCOs were below the national 2004 HEDIS Medicaid 50th percentiles for Combo 1 and Combo 2.

Table 4–11—Combined Rates for Childhood Immunizations

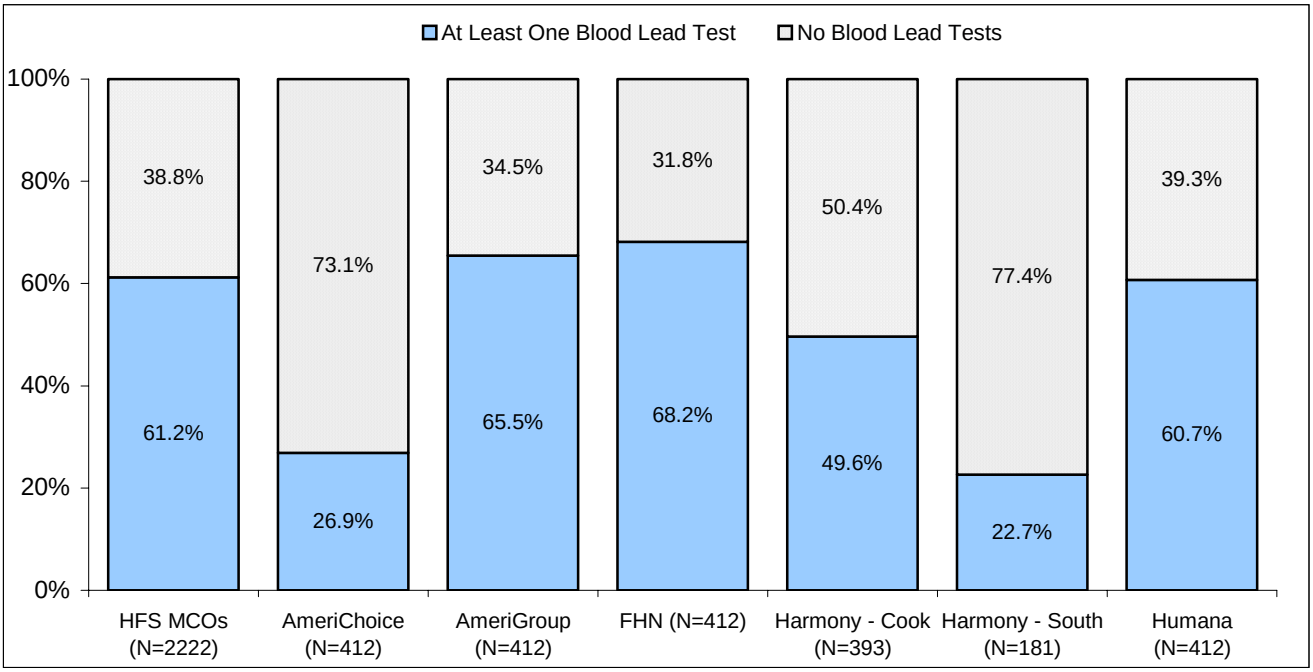
HFS MCOs	Sample Size	Combo 1 4:3:1:3:3	Combo 2 4:3:1:3:3:1	Combo 3 4:3:1:3:3:1:4
AmeriChoice	228	72.4%	69.7%	23.3%
AmeriGroup	237	39.7%	38.0%	18.1%
FHN	198	15.7%	13.6%	4.0%
Harmony–Cook	181	44.2%	43.7%	13.8%
Harmony–South	106	46.2%	38.7%	20.8%
Humana	222	30.2%	28.4%	18.0%
HFS MCOs	**1,172**	**41.6%**	**39.3%**	**16.3%**
2004 HEDIS Medicaid 50th Percentile	**NA**	**64.8%**	**61.1%**	**NA – New for HEDIS 2006**

Childhood immunizations are a basic component of EPSDT preventive services and should be provided during EPSDT visits when appropriate. Assessment of practice-based coverage levels and feedback of those data to providers have been an effective strategy for increasing immunization rates of children served by a given practice. Practice-based assessment has also been recommended by the Advisory Committee on Immunization Practices, the National Vaccine Advisory Committee, the American Academy of Pediatrics, and the American Academy of Family Physicians, as well as the Task Force for Community Preventive Services.

Blood Lead Testing

Guidelines from the CDC define lead poisoning as a blood lead level (BLL) ≥ 10µg/dL. High BLLs (i.e., a blood lead level ≥ 70 µg/dL) can cause serious health effects, including seizures, coma, and death. Blood lead levels as low as 10 µg/dL have been associated with adverse affects on cognitive development, growth, and behavior among children aged 1–5. Both state and federal law considers all children enrolled in Medicaid to be at risk for lead poisoning and requires blood lead testing at 12 and 24 months of age. The Illinois Lead Poisoning Prevention Act requires reporting by laboratories of all blood lead test results to the Department's Childhood Lead Poisoning Prevention Program, and physicians are required to report all blood lead results ≥ 10 µg/dL. Figure 4-12 shows the percent of children in the study who received at least one blood lead test by the end of the study period (i.e., December 31, 2004).

Figure 4-12—Percent with One or More Blood Lead Tests by End of Study



Overall, 61.2 percent of the children in this study received at least one blood lead test, while 38.8 percent did not have any evidence a blood lead test was conducted. The individual HFS MCO rates for no blood lead tests ranged from 22.7 percent to 68.2 percent, indicating that approximately one-third to one-half of children did not receive at least one of the required blood lead tests.

Table 4–12 shows the distribution of children with elevated BLLs, along with the percentage of children who received follow-up services related to blood lead poisoning. Of the 1,360 children who received at least one blood lead test, 62 (or 4.6 percent) were determined to have elevated BLLs, and 43 (69.4 percent) of those children received follow-up services. Nineteen children did not have follow-up services documented in the medical record.

Table 4–12—Percentage of Children Who Received Follow-up Services for Elevated BLLs

HFS MCOs	Number of Children with Elevated BLLs (≥10 µg/dL)	Received Follow-up Services	
		Number	Percent
AmeriChoice	0	NA	NA
AmeriGroup	0	NA	NA
FHN	29	23	79.3%
Harmony–Cook	18	14	77.8%
Harmony–South	0	NA	NA
Humana	15	6	40.0%
HFS MCOs	**62**	**43**	**69.4%**

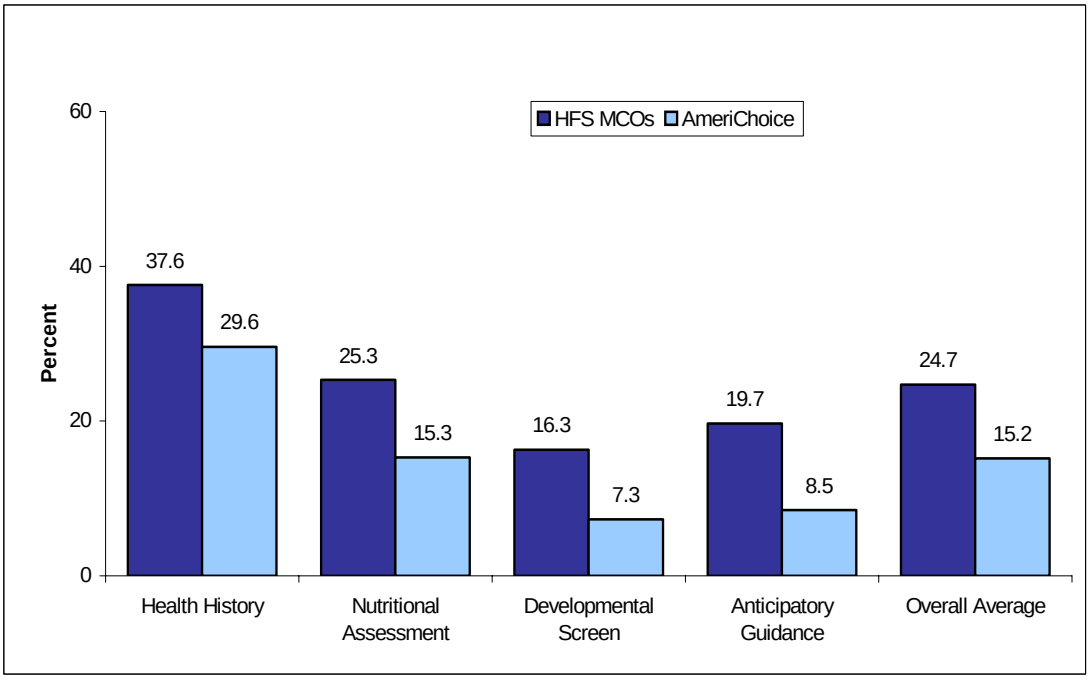
MCO-Specific Results

The following MCO-specific results are compared to State averages (HFS MCOs), which are shown as the first, darker bar in each series. Low rates may be the result of poor member compliance, poor medical record documentation, and/or services not provided the appropriate number of times during the time period.

AmeriChoice

Figure 5-1 shows results for measures that were dependent on medical record documentation. The rates for **AmeriChoice** were below the averages for all HFS MCOs. The most significant difference was for anticipatory guidance, which was 11.2 percentage points below the State average. The overall average for **AmeriChoice** was 9.5 percentage points lower than the State average.

Figure 5-1—Measures Dependent on Medical Record Documentation



Measures related to performing a service are shown in Figure 5-2. **AmeriChoice**'s overall rate of 14.8 percent was 3.3 percentage points below the State average. All of the rates for **AmeriChoice** were below the State averages for the HFS MCOs. The most significant difference was the rate for physical exams, which was 9.5 percentage points below the State average.

Figure 5-2—Measures Related to Performing a Service (e.g., Examinations and Screenings)

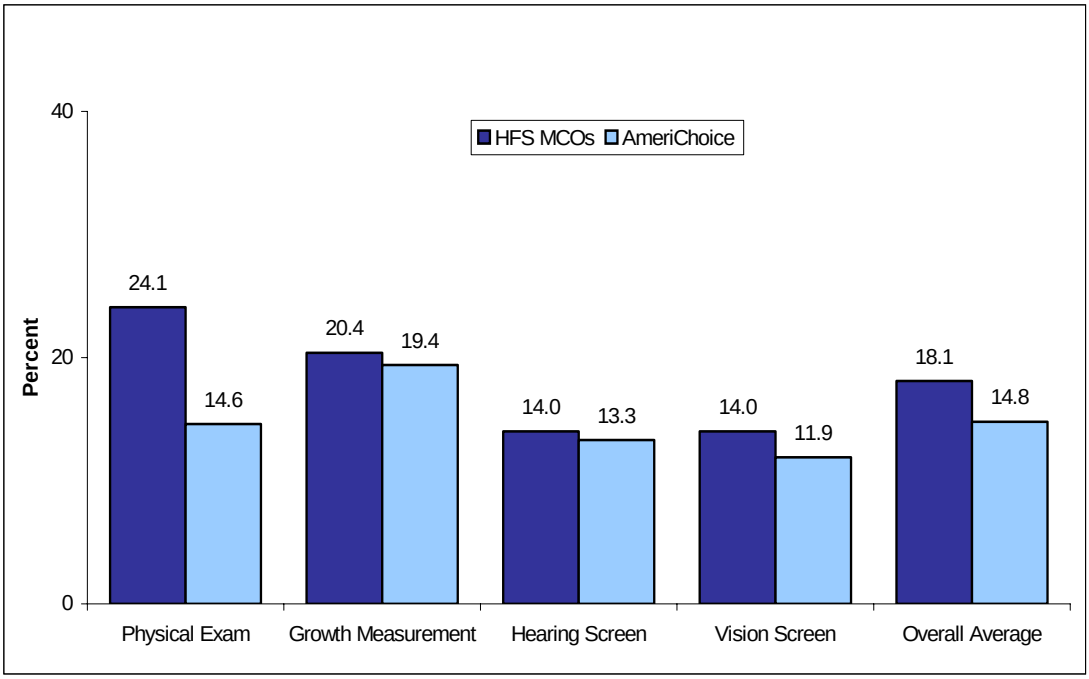
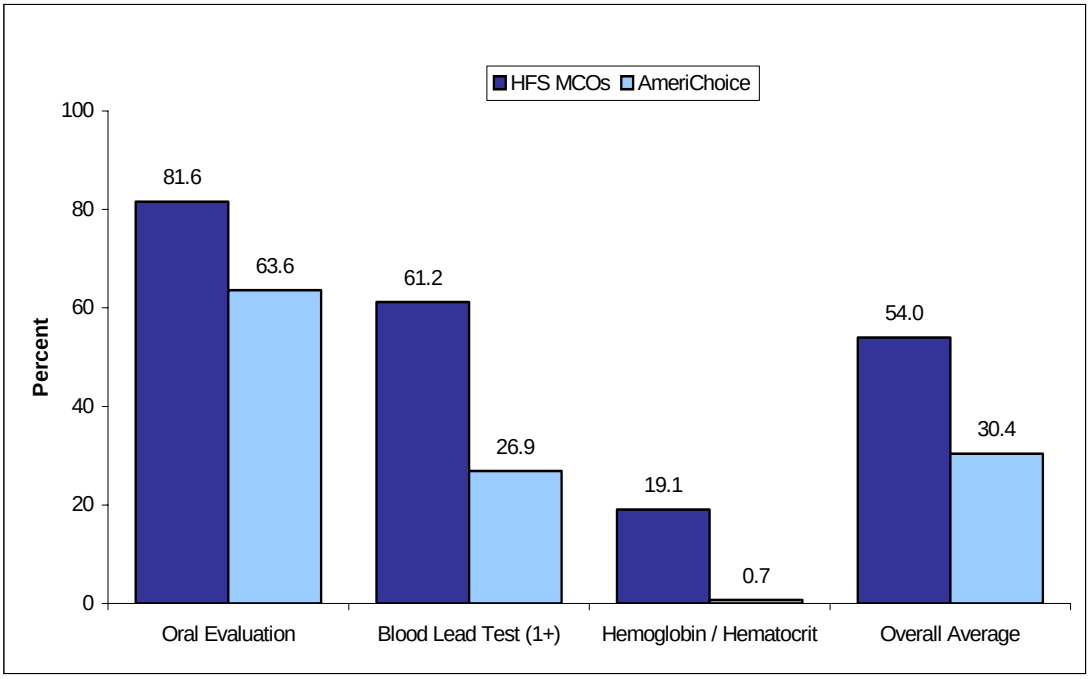


Figure 5-3 shows results for measures that are typically performed by vendors or third-party administrators (TPAs). Overall, **AmeriChoice,** at 30.4 percent, was 23.6 percentage points below the State average of 54.0 percent. None of the three measures was above the State average, and hemoglobin/hematocrit was reported at 0.7 percent. This may indicate that **AmeriChoice** did not receive complete vendor data or that members were not usually compliant with these types of services.

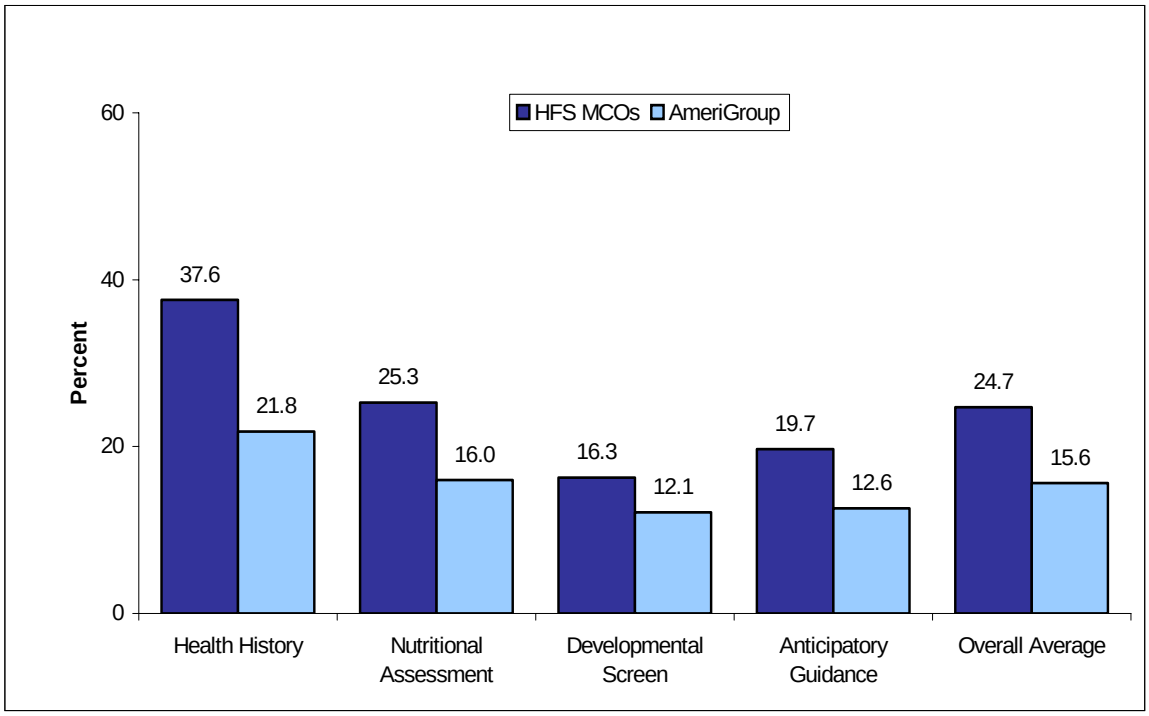
Figure 5-3—Services Typically Performed by Vendors or TPAs



AMERIGROUP, Illinois

Figure 5-4 shows results for measures that were dependent on medical record documentation. The rates for **AMERIGROUP** were all below State averages for the HFS MCOs. The most significant difference was for health history, which was 15.8 percentage points below the State average.

Figure 5-4—Measures Dependent on Medical Record Documentation



Measures related to performing a service included comprehensive physical exam, growth measurement, hearing screen, and vision screen. Results for these measures are shown in Figure 5-5. Growth measurement was above the average for the State. HFS MCOs with high rates for growth measurement typically have providers who routinely have their office staff members record height, weight, and blood pressure on every visit, regardless of the reason for the visit. The other three rates for **AMERIGROUP** were all below the average for all HFS MCOs.

Figure 5-5—Measures Related to Performing a Service (e.g., Examinations and Screenings)

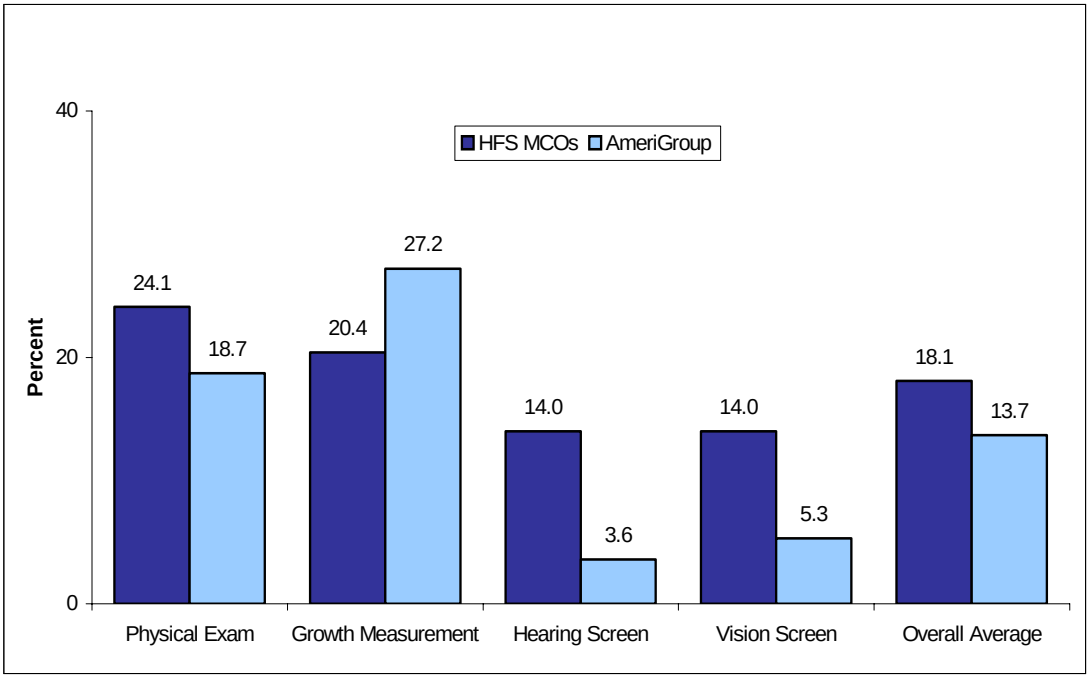
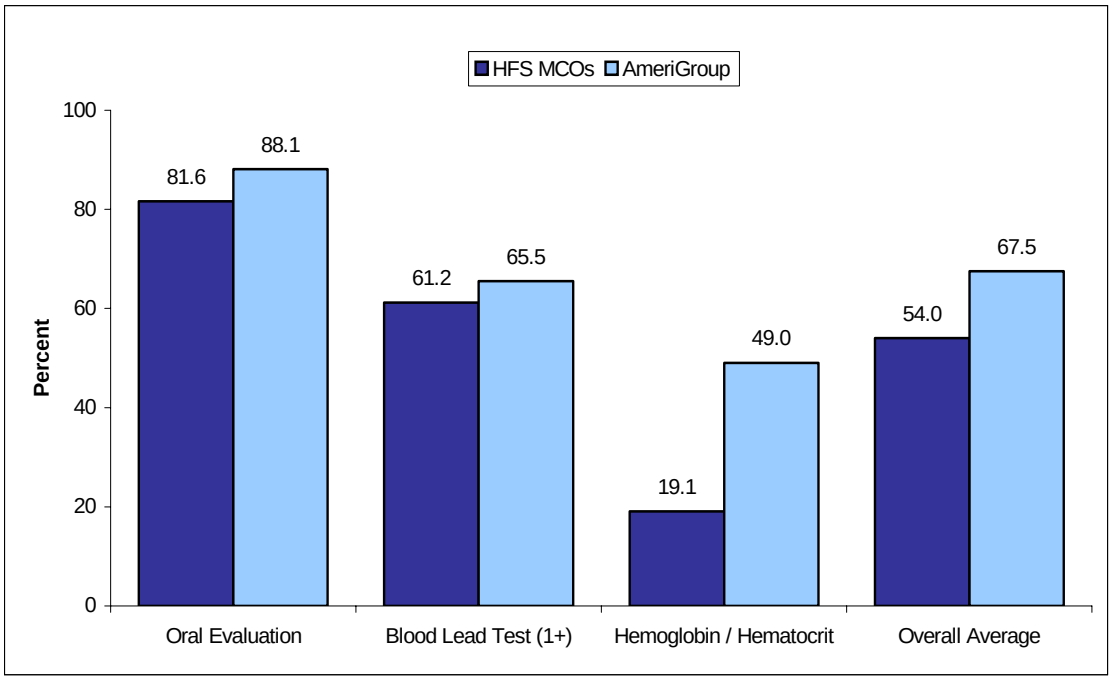


Figure 5-6 shows the results for measures that are typically performed by vendors or TPAs. Overall, **AMERIGROUP**, at 67.5 percent, was 13.5 percentage points higher than the State average of 54.0 percent. All three measures were above the State average, and hemoglobin/hematocrit was more than 2.5 times the State average. This indicates that **AMERIGROUP** received fairly complete vendor data, and that members were usually compliant with these types of services.

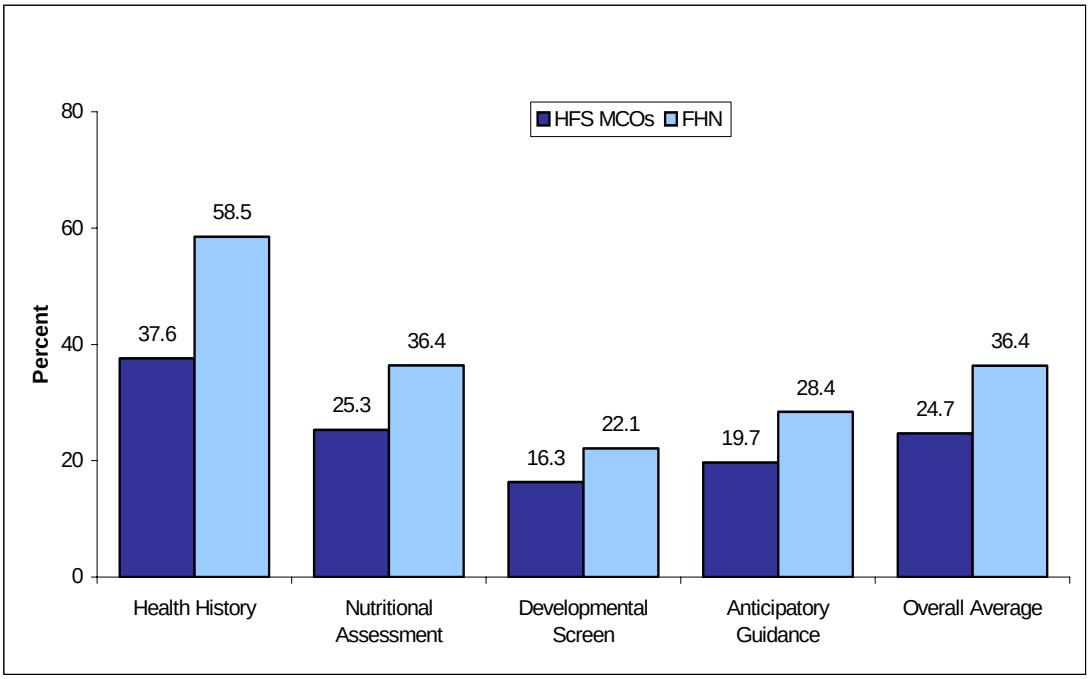
Figure 5-6—Services Typically Performed by Vendors or TPAs



Family Health Network, Inc.

Figure 5-7 shows the results for measures that were dependent on medical record documentation. The rates for **FHN** were all above the State averages for all HFS MCOs. The most significant difference was for health history, which was 20.9 percentage points higher than the State average. Documentation in the medical record of nutritional assessment was 11.1 percentage points higher than the State average. Overall for these measures, **FHN** was 11.7 percentage points above the average.

Figure 5-7—Measures Dependent on Medical Record Documentation



Measures related to performing a service are shown in Figure 5-8. **FHN**'s overall rate of 16.1 percent was 2 percentage points below the State average. The rate for the physical exam measure was 10.9 percentage points above the average, while hearing screen and vision screen were almost equal to the State average. Growth measurement, however, was 18.2 percentage points below the average for the State.

Figure 5-8—Measures Related to Performing a Service (e.g., Examinations and Screenings)

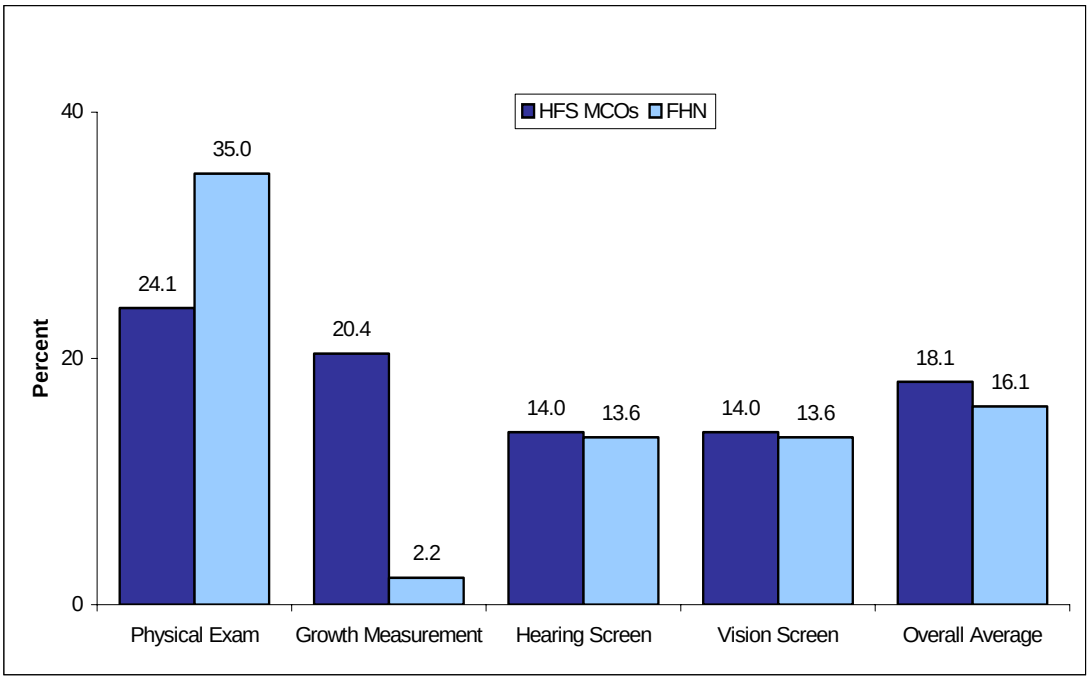
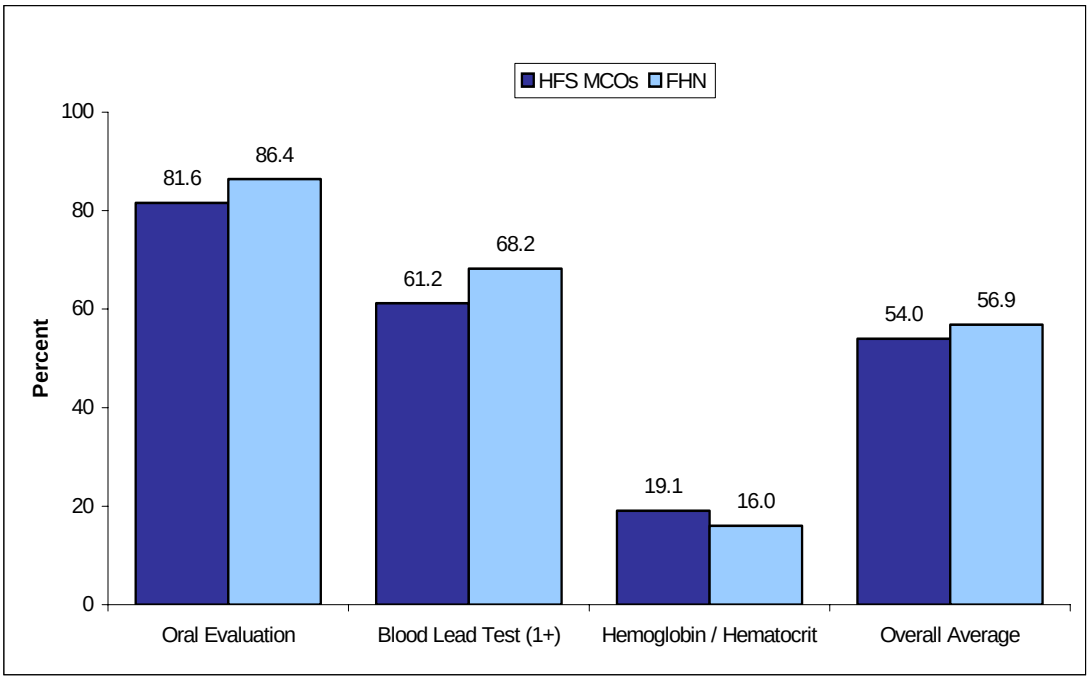


Figure 5-9 shows the results for measures that are typically performed by vendors or TPAs. Overall, **FHN**, at 56.9 percent, was 2.9 percentage points higher than the State average of 54.0 percent. Two of the three measures were above the State average, and hemoglobin/hematocrit was close to (3.1 percentage points below) the State average. This indicates that **FHN** received fairly complete vendor data and that members were usually compliant with these types of services.

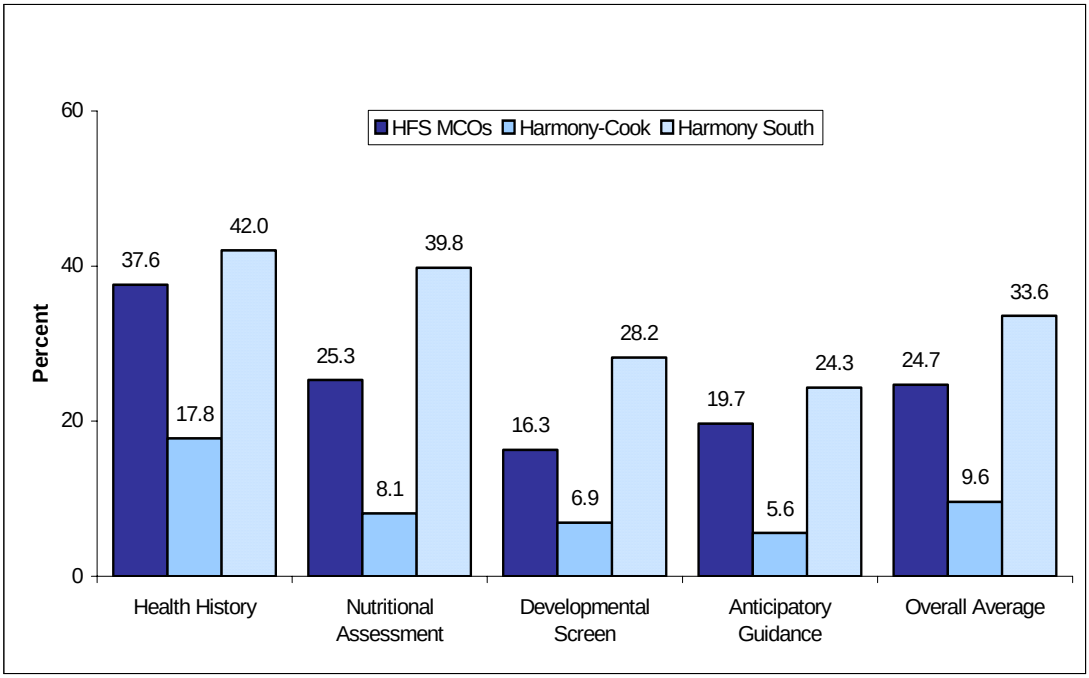
Figure 5-9—Services Typically Performed by Vendors or TPAs



Harmony Health Plan of Illinois, Inc.

Figure 5-10 shows the results for measures that were dependent on medical record documentation. The rates for **Harmony-Cook** were all below the state averages for all HFS MCOs. The most significant difference was for health history, which was 19.8 percentage points below the rate for HFS MCOs. The overall average for **Harmony-Cook** was 15.1 percentage points lower than the overall average.

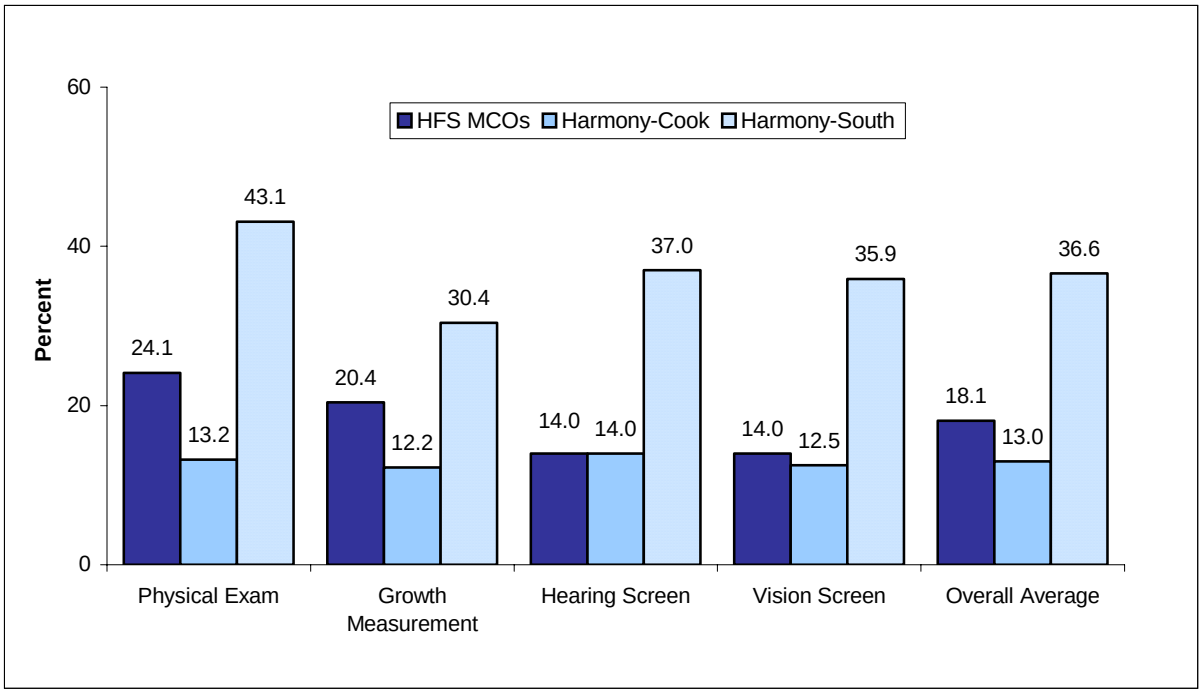
Figure 5-10—Measures Dependent on Medical Record Documentation



In contrast, **Harmony-South** rates were all above the HFS MCO averages. The overall average of 33.6 percent was 8.9 percentage points higher than the overall average for all HFS MCOs, and 24.0 percentage points higher than **Harmony-Cook**. This significant difference within the same MCO demonstrates the two service areas for **Harmony** are distinct, and likely to require different intervention strategies to improve rates in both areas.

Measures related to performing a service are shown in Figure 5-11. The rates for **Harmony-Cook** were below the state averages for physical examination and growth measurement, while hearing screening and vision screening were at or close to the average for HFS MCOs. The overall average for **Harmony-Cook** was 5.1 percentage points lower than the overall average.

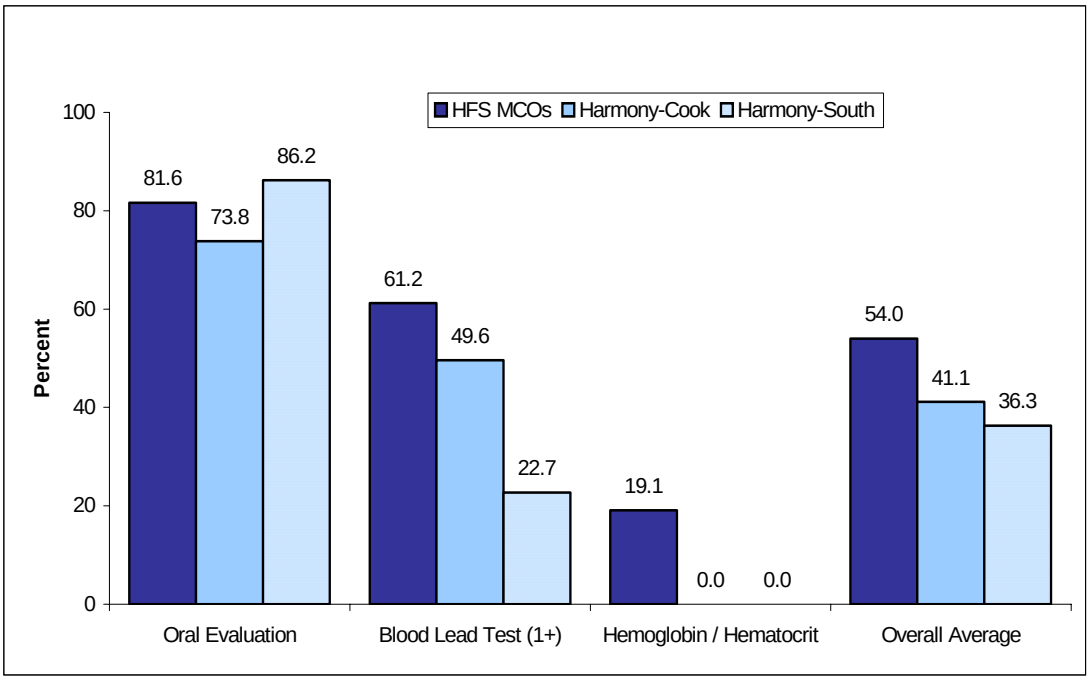
Figure 5-11—Measures Related to Performing a Service (e.g., Examinations and Screenings)



Harmony-South rates were all significantly above the HFS MCO averages. The overall average of 36.6 percent was 18.5 percentage points higher than the overall average for all HFS MCOs, and 23.5 percentage points higher than **Harmony-Cook**. Based on this finding and the rates for measures dependent on documentation, it appears **Harmony-South** routinely performs and documents EPSDT services. The low rates for **Harmony-Cook** may be a result of poor compliance by members, poor documentation, and/or EPSDT services that are not being provided as needed in this area.

Figure 5-12 shows the results for measures that are typically performed by vendors or TPAs. Overall, **Harmony-Cook**, at 41.1 percent, was 12.9 percentage points below the State average of 54.0 percent. Contrary to rates from the other indicators, **Harmony-Cook** outperformed **Harmony-South** with these measures, which are typically performed outside the MCO. This was entirely due to the blood lead testing rate of 49.6 percent for **Harmony-Cook**, which was more than twice as high as the rate for **Harmony-South**. However, the most noticeable feature in the figure is the fact that both service areas reported 0.0 percent for hemoglobin/hematocrit testing. This most likely indicates that **Harmony** (both Cook and South) does not receive complete vendor data, or that members were not usually compliant with these types of services.

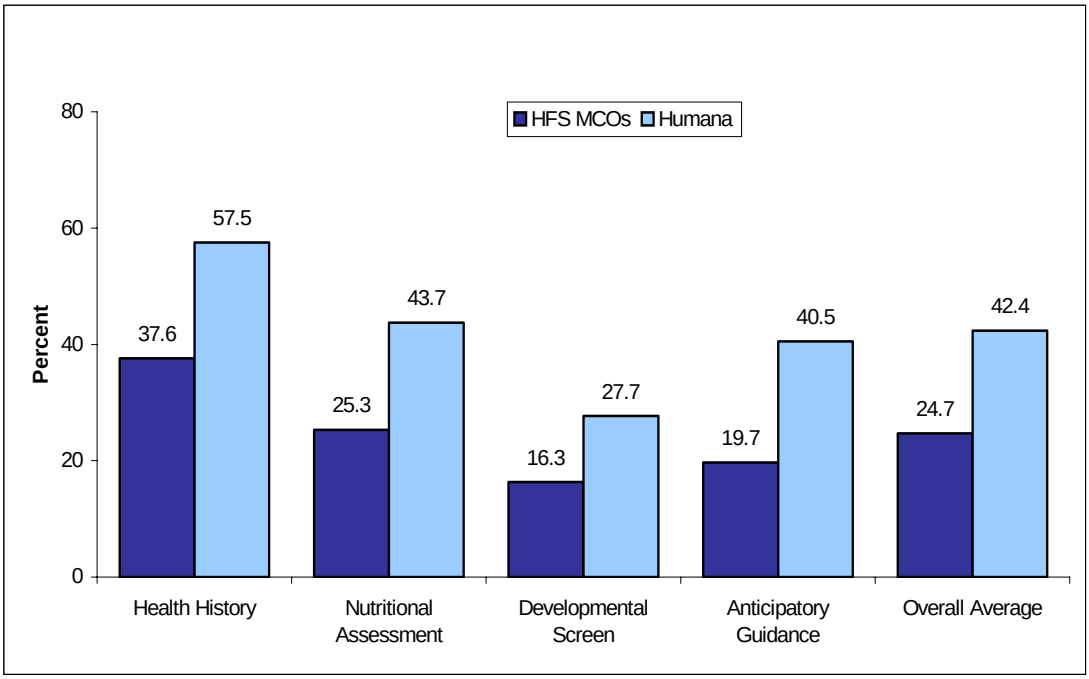
Figure 5-12—Services Typically Performed by Vendors or TPA



Humana Inc.

Figure 5-13 shows the results for measures that were dependent on medical record documentation. The rates for **Humana** were all above the State averages for all HFS MCOs. The most significant difference was for anticipatory guidance, which was 20.8 percentage points higher than the State average. Rates of documentation in the medical record of health history and nutritional assessments were 19.9 and 18.4 percentage points higher than the State average, respectively. Overall for these measures, **Humana** was 17.7 percentage points above the State average.

Figure 5-13—Measures Dependent on Medical Record Documentation



Measures related to performing a service are shown in Figure 5-14. **Humana**'s overall rate of 24.6 percent was 6.5 percentage points above the State average. All of the rates for **Humana** were above State averages for the HFS MCOs. The most significant difference was for growth measurement, which was 15.8 percentage points above the State average.

Figure 5-14—Measures Related to Performing a Service (e.g., Examinations and Screenings)

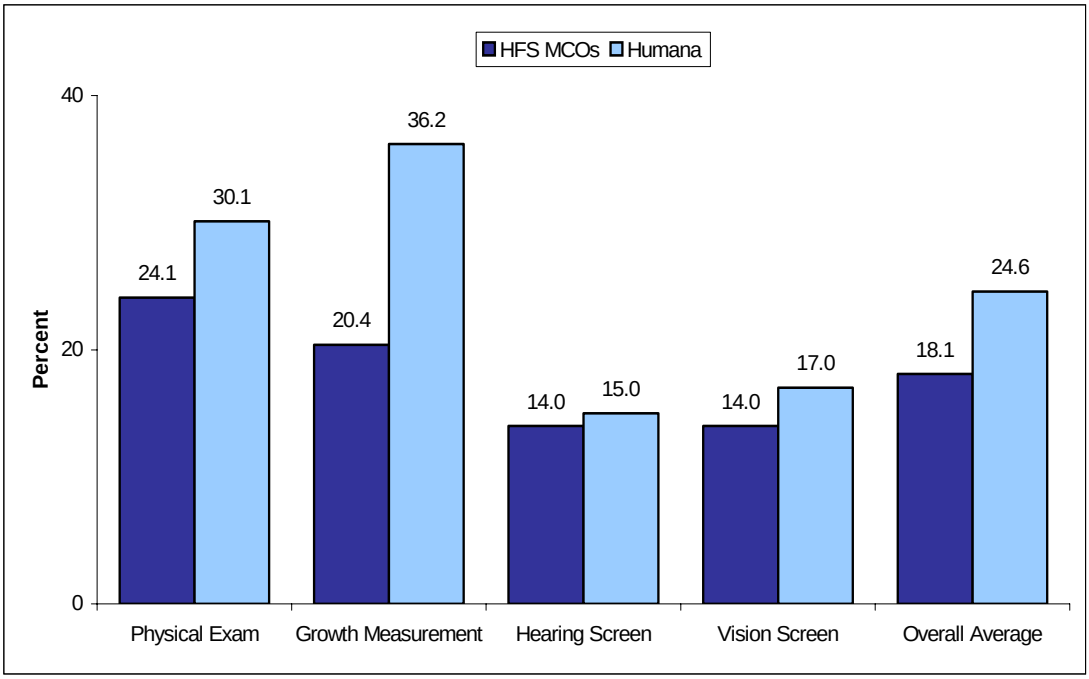
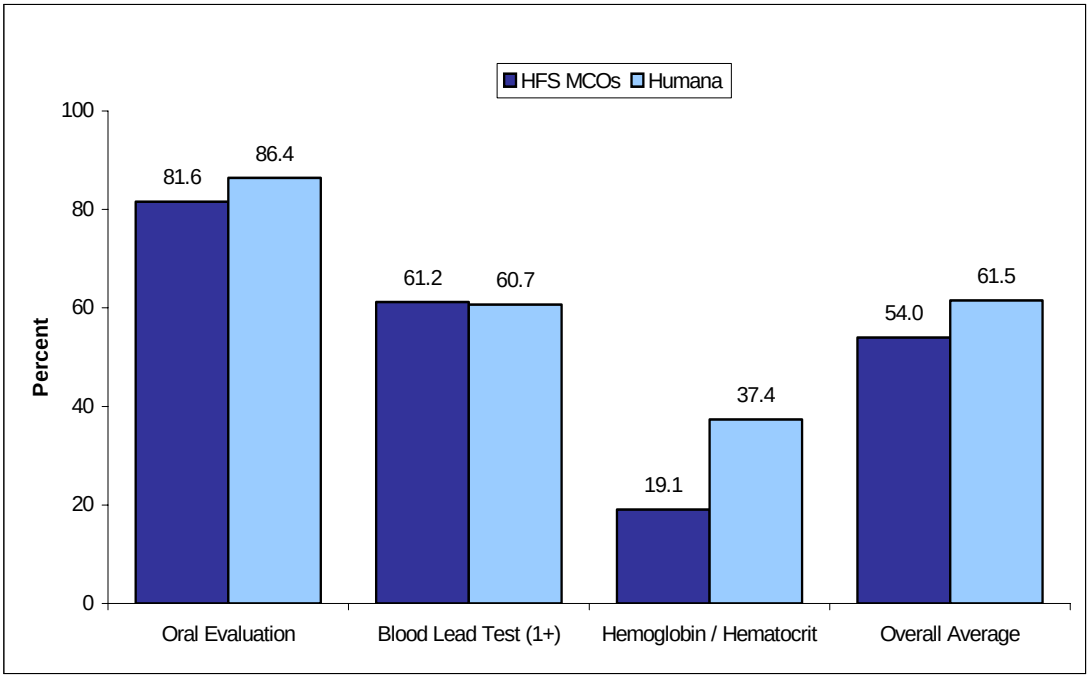


Figure 5-15 shows the results for measures that are typically performed by vendors or TPAs. Overall, **Humana**, at 61.5 percent, was 7.5 percentage points higher than the State average of 54.0 percent. Two of the three measures were above the State average, while blood lead testing was nearly identical to the State average. The rate for hemoglobin/hematocrit testing was nearly twice as high as the State average for this measure. These results indicate that **Humana** received fairly complete vendor data and that members were usually compliant with these types of services.

Figure 5-15—Services Typically Performed by Vendors or TPAs



Recommendations

The main purpose of this EPSDT PIP was to establish baseline rates and determine to what extent EPSDT services were being provided to HFS MCO members. The following recommendations are based on results from this study:

- HFS MCOs should examine underutilization to determine if there are barriers such as transportation issues that prevent members from receiving EPSDT services.
- HFS MCOs should send information detailing EPSDT visit rates and requirements, and member-level EPSDT visit information, to providers on a regular basis (e.g., monthly or quarterly).
- HFS MCOs should encourage use of standardized forms published by the National Center for Education in Maternal and Child Health found at www.brightfutures.org to assist in determining the components of age-appropriate physician examinations and health education/anticipatory guidance.
- HFS MCOs should use provider newsletters to remind pediatricians, family practitioners, and internists about the essential components of an EPSDT visit.
- HFS MCOs should consider producing semi-annual reports for use by primary care physicians for members who have not visited a health care practitioner in the past 12 months. Practitioners should then contact the families during the summer months to remind them of the importance of receiving annual EPSDT visits.
- Providers should be encouraged to create standing orders for nursing personnel to perform immunization, dental, nutritional, vision, and hearing assessments when the EPSDT service has not been performed within the last year. Then the physician will be able to review the findings, complete the physical examination, and complete the necessary health education/anticipatory guidance during his or her session with the member.
- At the end of every EPSDT visit, staff should remind the parents/caregiver about the importance of returning the next year for an EPSDT visit.
- Providers should be given information on federal and state requirements regarding blood lead testing for children enrolled in Medicaid.
- Providers should be encouraged to perform EPSDT preventive services such as immunizations during office visits other than EPSDT visits.

In addition to the above recommendations, HSAG encourages the HFS MCOs to investigate the following Web sites for best practices in EPSDT outreach:

- Iowa produces an electronic newsletter for health professionals that provides information about Iowa's EPSDT Care for Kids Program, health assessment and screening, health conditions and concerns, and billing issues. The newsletter is published three times a year as a project of the

Iowa Department of Human Services, Iowa Department of Public Health, Iowa Prevention of Disabilities Policy Council, and the Center for Disabilities and Development.
http://www.medicine.uiowa.edu/epsdt/index.asp

- Washington and Michigan have developed well-child examination forms in multiple languages to promote standardization of charting and data collection. They are accessed by providers on the Web.
  http://www.healthteam.msu.edu/imc/epsdt/Toolkit_Contents.htm
  http://www.nashp.org/_catdisp_page.cfm?LID=2ED0001D-7622-11D6-BD1500A0CC76FF4C
- Michigan has created a number of camera-ready materials including a trifold brochure, posters, a reminder card and an appointment card. These materials, as well as public service announcements (PSAs) for television were tested with focus groups in 2003. The focus-study recommendations included moving forward with reminder cards, appointment cards and updating existing brochures and the online toolkit. It was recommended to defer development of the PSAs in pursuit of development of materials that are more personal in nature.
  http://www.healthteam.msu.edu/imc/epsdt/Focus%20Group%20Report%20-%20final.doc
- A toolkit from Center for Healthcare Strategies has information on studies conducted by health plans in the following states:
  http://www.chcs.org/usr_doc/ImprovingPreventiveCareServicesToolkit.pdf
  - Community Health Network of Connecticut gave out movie tickets to those who scheduled preventative appointments, raising adolescent participation in EPSDT by 11.8 percent
  - Neighborhood Health Plan in Massachusetts sent out monthly immunization reminders. Of those who received them, 90 percent of those surveyed took action to update immunizations for their children
  - Aloha Care in Hawaii encouraged the selection of a primary care physician for babies during prenatal visits and used various media to promote plan initiatives to providers, resulting in an increase of newborns with PCPs prior to 1 month of age
- Minnesota has an online training module for health professionals and program administrators about the state's EPSDT program. This includes a program description, eligibility requirements, screening schedules, and links to materials for parents. The program is a joint venture of the Minnesota Department of Human Services and the Minnesota Department of Health.
  http://www.health.state.mn.us/divs/fh/mch/webcourse/index.html

Next Steps

Quality improvement is a continually evolving process focused on improving outcomes and health status. The next steps for the EPSDT PIPs conducted by the HFS MCOs will include performing targeted interventions aimed at achieving these goals. A remeasurement will occur in 2007 to determine whether or not interventions were successful. The HFS MCOs will perform their own analysis and provide a report to the State following remeasurement.

Limitations

While attempts were made to accurately report rates for EPSDT services in this focused study, some limitations may have contributed to lower rates. Examples of these limitations include:

- Members may have had EPSDT services provided but not documented in the medical record. In such cases, the missing documentation does not count toward the measures.
- Parents/caregivers may be noncompliant with providers. For example, a provider may schedule an EPSDT appointment but the parent or the caregiver may have chosen not to keep the appointment.

Introduction

The objective of the original Statewide Collaborative EPSDT PIP was to ensure Medicaid children were receiving the required EPSDT services, not just having visits. As such, the components of EPSDT visits were counted even if the visit was not an EPSDT visit (i.e. "sick" visits with components of an EPSDT visit were counted as meeting the service for an indicator). The results from this study indicated several areas of deficiencies for the EPSDT indicators, although it was not possible to determine if the deficiencies were due to the lack of documented services or to member noncompliance (e.g. members not keeping appointments for EPSDT visits or not using services).

After the original study, it was determined that additional programming efforts and analysis could provide additional insight into the actual EPSDT services documented during an EPSDT visit. To accomplish this, all EPSDT visits were identified for the members in the original Statewide Collaborative EPSDT PIP. Hence, the unit of analysis became the EPSDT visit rather than the member. These visits were then analyzed to determine what services were provided during each visit. The analysis considered only the eight EPSDT services that were required for each visit, and did not include blood lead testing, dental/oral evaluation, hemoglobin/hematocrit testing, and immunization, since these services are not necessarily required on each visit. Following is the list of EPSDT services, or components, used for this addendum study:

- Health history
- Developmental screening (subjective or objective)
- Nutritional assessment
- Physical examination
- Growth measurement
- Anticipatory guidance
- Vision screening (subjective or objective)
- Hearing screening (subjective or objective)

For developmental screening, both subjective and objective screenings were allowed. However, the focus was for providers to perform more objective screenings, so analysis was also conducted to determine the number of objective developmental screenings that were documented. Vision and hearing also have both subjective and objective screenings. However, for the age ranges in the Statewide Collaborative EPSDT PIP, only subjective screenings were absolutely required for each EPSDT visit; therefore, subjective and/or objective hearing and vision screenings were allowed in this addendum report.

In addition to fewer indicators in this report, there are also fewer MCOs than the original study. Three of the HFS MCOs elected not to participate in the Medicaid program for this contract year and subsequently did not participate in the addendum study. One MCO, **Harmony**, had two distinct service areas, and sample cases were selected from each area. For the purposes of this report, the two service areas are referred to as **Harmony-Cook** and **Harmony-South**.

Findings

Table I-1 displays the percentage of EPSDT visits that had each EPSDT service documented. Since all eight EPSDT services should be completed at every EPSDT visit, any deviation from 100 percent would indicate a deficiency in providing and/or documenting services. Overall, growth measurement was documented most frequently (93 percent), followed by health history at 85 percent. Vision and hearing screening were the least documented services, at 56.7 percent and 55 percent, respectively. All other EPSDT services were documented less than 80 percent of the time during an actual EPSDT visit. Rates by individual MCOs varied slightly from the overall results, with **AMERIGROUP** reporting physical exam for their second highest rate, and **Harmony-Cook** reporting relatively high rates for vision and hearing, but lower rates than the other MCOs for nutritional assessment and anticipatory guidance.

Table I-1—Percentage of EPSDT Visits that had the EPSDT Service Provided

EPSDT Services	AmeriGroup N = 1,104	FHN N = 2,255	Harmony Cook N =9 82	Harmony South N = 723	Three HFS MCOs N = 5,064
Growth Measurement	90.0%	92.4%	93.7%	98.8%	93.0%
Health History	75.8%	87.2%	83.0%	95.0%	85.0%
Physical Exam	79.7%	68.7%	74.3%	94.9%	75.9%
Nutrition Assessment	74.9%	69.8%	62.1%	93.8%	72.9%
Developmental Screen	68.0%	65.4%	66.3%	90.9%	69.8%
Anticipatory Guidance	63.0%	61.7%	56.5%	83.8%	64.1%
Vision Screen	43.5%	47.2%	70.9%	87.1%	56.7%
Hearing Screen	37.4%	45.9%	71.9%	87.3%	55.0%

Note: The above table allows subjective or objective developmental screenings to count toward the EPSDT developmental screen.

Table I-2 provides a distinction between objective and subjective developmental screens. Developmental screening (subjective and/or objective) was documented 69.8 percent of the time. With the exception of **Harmony-South**, objective developmental screens generally were not documented. Slightly more than one-third (34.2 percent) of the 723 EPSDT visits from **Harmony-South** had documentation of an objective developmental screening.

Table I-2—Objective Versus Subjective Developmental Screening

EPSDT Services	AmeriGroup N = 1,104	FHN N = 2,255	Harmony Cook N =9 82	Harmony South N = 723	Three HFS MCOs N = 5,064
Developmental Screen	68.0%	65.4%	66.3%	90.9%	69.8%
Subjective	67.7%	65.3%	65.8%	90.5%	69.5%
Objective	3.2%	0.8%	5.8%	34.2%	7.1%

Table I-3 shows the percentage for the actual number of services documented on EPSDT visits. All eight of the EPSDT services in this addendum report should have been completed at every EPSDT visit. The percentage of EPSDT visits with all eight services documented was 34.4 percent. The percentage of EPSDT visits with six or more services documented was 59.6 percent (34.4 percent + 13.9 percent + 11.3 percent). Surprisingly, there were some EPSDT visits that did not have any EPSDT services documented, and 11.8 percent (1.2 percent + 3.4 percent + 7.2 percent) had two or fewer EPSDT services documented during an EPSDT visit. The average EPSDT visit had 5.7 services documented, which was positively influenced by **Harmony-South**, which had an average of 7.3 services documented per EPSDT visit.

Table I-3—Actual Number of Services Documented on EPSDT Visits

Number of Services Documented on EPSDT Visits	AmeriGroup N = 1,104	FHN N = 2,255	Harmony Cook N =9 82	Harmony South N = 723	Three HFS MCOs N = 5,064
8	17.7%	30.8%	35.1%	70.4%	34.4%
7	17.6%	12.2%	14.5%	12.5%	13.9%
6	16.1%	9.1%	13.5%	8.0%	11.3%
5	14.3%	8.3%	9.0%	4.2%	9.1%
4	12.7%	12.3%	9.4%	1.2%	10.2%
3	10.3%	12.6%	5.9%	1.7%	9.2%
2	7.7%	9.5%	5.9%	1.0%	7.2%
1	2.7%	4.8%	3.4%	0.4%	3.4%
0	0.9%	0.6%	3.4%	0.7%	1.2%
Average Number of Services Documented	**5.3**	**5.4**	**5.8**	**7.3**	**5.7**

Note: The above table allows subjective or objective developmental screenings to count toward the EPSDT developmental screen.

These findings indicate the deficiencies noted in the original Statewide Collaborative EPSDT PIP report are not entirely due to member noncompliance. As determined from this addendum report, even visits classified by the provider as EPSDT visits are often missing documentation for the primary services of an EPSDT visit, indicating the provider has either not performed the service or has not documented the service.

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix A. Illinois Department of Public Aid
EPSDT Medical Record Abstraction Tool

DATE OF REVIEW:_____ **REVIEWER NAME:**_____

MEMBER NAME:_____ **DATE OF BIRTH:**_____ **ID#:**_____ **# VISITS IN REVIEW PERIOD:** _____

PCP NAME:_____ **PCP ID#:**_____ **PCP ADDRESS:**_____ **PCP PHONE:**_____

Please circle the appropriate response for each date of service.

EPSDT PIP Evaluation Results												
EPSDT VISIT COMPONENTS	**Date of Service**_____			**Date of Service**_____			**Date of Service**_____			**Date of Service**_____		
1. HEALTH HISTORY												
A. Comprehensive Initial History	YES	NO	REF	YES	NO	REF	YES	NO	REF	YES	NO	REF
B. Interval History	YES	NO	REF	YES	NO	REF	YES	NO	REF	YES	NO	REF
2. DEVELOPMENTAL SCREENING												
Subjective	YES	NO	REF	YES	NO	REF	YES	NO	REF	YES	NO	REF
Objective	YES	NO	REF	YES	NO	REF	YES	NO	REF	YES	NO	REF
Name of Objective Instrument:	_____											
3. NUTRITIONAL ASSESSMENT												
	YES	NO	REF	YES	NO	REF	YES	NO	REF	YES	NO	REF
4. COMPREHENSIVE PHYSICAL EXAM												
	YES	NO	REF	YES	NO	REF	YES	NO	REF	YES	NO	REF
5. DOCUMENTED GROWTH												
A. Height	YES	NO	REF	YES	NO	REF	YES	NO	REF	YES	NO	REF
B. Weight	YES	NO	REF	YES	NO	REF	YES	NO	REF	YES	NO	REF
C. Head Circumference (Birth to 24 months)	YES	NO	REF	YES	NO	REF	YES	NO	REF	YES	NO	REF
D. Plotted on a Growth Chart	YES	NO	REF	YES	NO	REF	YES	NO	REF	YES	NO	REF

Please circle the appropriate response for each date of service.

EPSDT PIP Evaluation Results				
EPSDT VISIT COMPONENTS	**Date of Service_____**	**Date of Service_____**	**Date of Service_____**	**Date of Service_____**
6. VISION				
Subjective	YES NO REF	YES NO REF	YES NO REF	YES NO REF
Objective	YES NO REF NOT DOCUMENTED	YES NO REF NOT DOCUMENTED	YES NO REF NOT DOCUMENTED	YES NO REF NOT DOCUMENTED
7. HEARING				
Subjective	YES NO REF	YES NO REF	YES NO REF	YES NO REF
Objective	YES NO REF NOT DOCUMENTED	YES NO REF NOT DOCUMENTED	YES NO REF NOT DOCUMENTED	YES NO REF NOT DOCUMENTED
8. LEAD LEVEL				
A. Ordered	YES NO	YES NO	YES NO	YES NO
B. Performed	YES NO	YES NO	YES NO	YES NO
C. Lead Level Result	_____ REF	_____ REF	_____ REF	_____ REF
D. Follow Up of Elevated Blood Lead Levels	YES NO N/A	YES NO N/A	YES NO N/A	YES NO N/A
9. HEMOGLOBIN or HEMATOCRIT				
A. Ordered	YES NO	YES NO	YES NO	YES NO
B. Performed	YES NO	YES NO	YES NO	YES NO
C. Level	_____ REF	_____ REF	_____ REF	_____ REF
10. DENTAL SCREENING				
	YES NO REF	YES NO REF	YES NO REF	YES NO REF
11. ANTICIPATORY GUIDANCE				
A. Anticipatory Guidance	YES NO REF	YES NO REF	YES NO REF	YES NO REF
B. Age Appropriate Components Discussed	YES NO REF	YES NO REF	YES NO REF	YES NO REF
C. Parenting Skills Discussed	YES NO REF	YES NO REF	YES NO REF	YES NO REF

Please circle the appropriate response for each date of service.

EPSDT PIP Evaluation Results

EPSDT VISIT COMPONENTS	Date of Service_____	Date of Service_____	Date of Service_____	Date of Service_____
12. OTHER REFERRALS and REFERRALS TYPES (Collected from fields #1–#11)				
	YES NO	YES NO	YES NO	YES NO
A. Type				
B. Type				
C. Type				
13. EPSDT DIAGNOSIS (Does this date of service have an EPSDT diagnosis?)				
	YES NO	YES NO	YES NO	YES NO

14. IMMUNIZATIONS (Enter dates of all immunizations administered birth through 12-31-2004)

DPT #1_____ #2_____ #3_____ #4_____

IPV #1_____ #2_____ #3_____

HEP B #1_____ #2_____ #3_____

HIB #1_____ #2_____ #3_____

MMR _____

VARICELLA _____ History of Disease _____

INFLUENZA _____ _____ _____

PNEUMOCOCCAL _____ _____ _____ _____

15. OTHER VISITS, WHICH ARE NON-FACE-TO-FACE ENCOUNTERS (For example, weight checks)

Date of Service _____ Date of Service _____

Date of Service _____ Date of Service _____

Appendix B. EPSDT Medical Record Abstraction Tool Instructions

Verify the member's name, DOB, HP ID #, PCP name, PCP ID, PCP address, and PCP phone.

Date of Service—Capture all dates of service containing EPSDT components (ill/episodic or EPSDT) from birth to 36 months of age, where there is a face-to-face encounter with the provider, Nurse Practitioner, or Physician Assistant. For each date of service being reviewed, enter the date in the space provided and answer the questions #1 through # 15. For any non-face-to-face visits (i.e., weight checks or immunizations only) enter the date of service in the space provided on #15. If a lead, hemoglobin, or hematocrit value is located during the review year, but is not associated with a face-to-face date of service, enter the date of service of the laboratory results at the top of the tool. All fields #1 through #13 will be marked "no," except the fields containing the laboratory information (i.e., fields #8 and #9).

Referral—If the provider directs the member to see any other provider or initiates a referral during the visit, circle the referral ("ref") response associated with the EPSDT component. For example, if the provider documents an abnormal dental screening and initiates a referral to a dentist, circle the "ref" response corresponding to the dental screening category (#10). Write in the referral specialty type in field #12.

1a. Comprehensive Initial History—For each date of service, circle "yes" if there is a comprehensive health history completed by the provider for that date. The history should be able to assist the provider in obtaining information regarding past health problems; evaluating the risk for health problems; and information regarding the child's family and social environment. The initial visit for a newborn should include prenatal, birth, and neonatal history. Circle "no" if there is no comprehensive history documented.

See Exhibit A, which outlines the minimum number and type of initial history components necessary to meet EPSDT guidelines.

1b. Interval History—For each date of service, circle "yes" if there is documentation of an interval history between the current and last visit. An interval history should contain information regarding illnesses, accidents, health habits, and developmental changes which may have occurred since the last visit. If the provider notes "no changes" or "no complaints," this is acceptable for a "yes" response. Circle "no" if there is no documentation of an interval history.

2. Developmental Screening/Subjective—For each date of service, circle "yes" in the "Subjective" category if there is documentation of a subjective developmental screening. Any documentation related to age-appropriate developmental milestones or the child's social, emotional, fine or gross motor skills, or language development would be acceptable. If there is no subjective developmental screening noted, circle "no" in the "Subjective" category. WDWN does not count for developmental screening. See Exhibit B, which lists age-appropriate developmental milestones. If the provider documents "development age appropriate," this is sufficient for a "yes" response.

Developmental Screening/Objective—For each date of service, circle "yes" in the "Objective" category if there is documentation of an objective developmental screening documented. Circle "no" in the "Objective" category if there is no documentation of an objective test. Enter the name of the objective instrument used by the provider on the line provided.

See Exhibit C for a list of acceptable objective developmental tests.

3. **Nutritional Assessment—**For each date of service, circle "yes" if a nutritional assessment was completed. Documentation of well-developed, well-nourished (WDWN), dietary evaluation, anthropometric measurements, or biochemical measurements all qualify for nutritional assessment. If the provider documents "breastfeeding without problems," "good appetite per mom," or "eating table food," these too qualify as nutritional assessment. Enter a "no" if there is no documentation of a nutritional assessment.

4. **Comprehensive Physical Exam—**For each date of service, circle "yes" if a comprehensive physical exam was performed. To qualify as a comprehensive physical, the following components must be met: examination of the head, neck, eyes, ears, cardiovascular, respiratory, gastrointestinal, reproductive, nervous, musculoskeletal, lymphatic, and integument systems. If no physical exam was completed, or some of the components are not met, circle "no." To qualify as a "yes" response, 80 percent, or 10 out of 12 physical exam components, must be addressed.

5. **Documented Weight, Height, and Head Circumference—**For each date of service, circle "yes" if the child's height (#5a), weight (#5b), and head circumference (#5c) are documented in the medical record for the particular visit. Enter "no" if the height, weight, and head circumference are not measured during the visit.
   - Plotted measurements on a growth chart—If the height, weight, and head circumference for children birth to 24 months of age were plotted on a growth chart for that date of service, circle "yes" for #5d. Questions #5a, #5b, and #5c must all be plotted on the growth chart to count as a "yes" response.
   - If the height and weight were plotted on a growth chart for children older than 24 months of age (a head circumference is not required after 24 months of age), circle "yes." Both #5a and #5b must be plotted on the growth chart to count as a "yes" response.
   - If none of the measurements are plotted on a growth chart, circle "no" in #5d for either of the age groups. If only one of the required measurements **is not plotted** on the growth chart, circle "no" in #5d.

6. **Vision/Subjective—**For each date of service, circle "yes" in the "Subjective" category if there is documentation of a subjective vision screening. An example of a subjective vision screening is the informal observation by the provider or parent that the child follows lights or faces. If there is no documentation of subjective vision screening, circle "no" in the "Subjective" category. If the subjective screening was abnormal and the provider refers the child to a specialist under the "Subjective" category, the subjective "ref" will be circled.

   Vision/Objective
   - If the provider performs an objective vision test in the office, circle the "yes" response.
   - If the provider does not perform an objective vision test in the office, circle "no."
   - If the provider completed a subjective screening and made a referral, but there was no evidence in the record that the objective test was performed, circle "not documented."
   - If the provider performs an objective test in the office and notes that it was abnormal and refers the child to a specialist, circle the "ref" response.

7. **Hearing/Subjective—**For each date of service, circle "yes" in the "Subjective" category if there is documentation of a subjective hearing screening. An example of a subjective hearing screening is the informal observation by the provider or parent that the child hears sounds or turns toward sound. If there is no documentation of subjective hearing screening, circle "no" in the "Subjective" category. If the subjective screening was abnormal and the provider refers the child to a specialist under the "Subjective" category, circle "ref."

Hearing/Objective

- If the provider performs an objective hearing test in the office, circle the "yes" response.
- If the provider does not perform an objective hearing test in the office, circle "no."
- If the provider completed a subjective screening and made a referral, but there was no evidence in the record that the objective test was performed, circle "not documented."
- If the provider performs an objective test in the office and notes that it was abnormal and refers the child to a specialist, circle the "ref" response.

8a. and 8b. Lead Testing—For each date of service, circle "yes" in the appropriate row if a blood lead test was either **performed** or **ordered** by the provider. Circle "no" in the appropriate row if no blood lead test was either performed or ordered during the visit. If a lab is performed, the ordered response will also be marked "yes."

8c. **Lead Level Result—**If a blood lead level was documented on the date of service or any time from birth through 12/31/04, enter the level on the line provided. If the provider initiates a referral to a specialist, circle the "ref" response to #8c. If the blood lead level is not associated with an actual visit date, enter the date of the lab result in the date of service space, at the top of the tool. Mark all other components "no" and enter the lab result information in fields #8a, #8b, and #8c. Capture all blood lead levels performed on or before 12/31/04.

8d. Follow Up of Elevated Lead Level—If a blood lead level is ≥ 10μg/dl, it is required that the provider follow up the abnormal result. If the provider advises the parent to repeat the test or any other follow-up advice is given, circle the "yes" response for #8d. If the blood lead level is ≥ 10μg/dl and the provider does not document a referral or a follow-up appointment, circle the "no" response. If the blood lead level is ≤10μg/dl, circle "NA" for #8d.

9a. and 9b. Hemoglobin or Hematocrit—For each date of service, circle "yes" in the appropriate row if a hemoglobin or hematocrit was either **performed** or **ordered** by the provider. Circle "no" in the appropriate row if no hemoglobin or hematocrit was either performed or ordered during the visit. If a lab is performed, the ordered response will also be marked "yes."

9c. **Hemoglobin or Hematocrit Level—**On the line provided enter the level of the hemoglobin or hematocrit performed on or before 12/31/04. If the lab result is not associated with an actual visit date, enter the date of the lab result in the date of service space, at the top of the tool. Mark all other components "no" and enter the lab result information in fields #9a, #9b, and #9c.

Defer to the hemoglobin result if both a hemoglobin and hematocrit were performed.

10. **Dental Screening—**For each date of service, circle "yes" if a dental screening was performed. A dental screening involves the examination of the oral cavity and can be done during the physical exam. If the provider documents "HEENT," credit is given because the mouth is examined to look

into the throat. If the provider documents any information regarding teeth, credit will be given for a dental screening. Circle "no" if no dental screening was performed during the visit. If a referral to a dentist was made during the visit, circle the "ref" response.

11a. Anticipatory Guidance—For each date of service, circle "yes" if health education or anticipatory guidance was documented (see Exhibit D). If the provider documents "anticipatory guidance done," or "education provided," circle the "yes" response. Circle "no" if health education or anticipatory guidance was not documented during the visit.

See Exhibit D for a suggested list of Anticipatory Guidance topics.

11b. Age-Appropriate Components—If the provider documents discussion of **specific** age-appropriate anticipatory guidance or health education components, circle the "yes" response (see Exhibit D). If the provider just documents anticipatory guidance or health education on the date of service, as in #11a, circle the "no" response.

See Exhibit D for examples of age-appropriate topics.

11c. Parenting Skills—For each date of service, if the provider discussed parenting skills such as discipline, rewards, and consistency, circle the "yes" response (see Exhibit D). If the provider does not document that he/she discussed parenting skills at the visit, circle the "no" response.

See Exhibit D, which lists examples of anticipatory guidance, health education, and parenting techniques. An asterisk denotes acceptable parenting topics, which fulfill a "yes" response for #11c. If #11c is "yes," #11a will be "yes." If the parenting skills in #11c are age-appropriate, #11b will also be "yes."

12. Other Referrals and Referral Types—If the provider initiates a referral that is not associated with any of the EPSDT components, #1 through #11, enter the provider type in the space provided. If "ref" is circled in fields #1 through #11, enter the referral types in field #12.

13. EPSDT Diagnosis—For each date of service, circle "yes" if the provider documented a diagnosis of an EPSDT visit. If the diagnosis for the date of service was not an EPSDT diagnosis, circle "no."

14. Immunizations—Fill in the dates of any immunizations administered from birth through 12/31/04. If the record notes the child "had chickenpox," enter the date of the disease on the line marked "History of disease." If the provider documents "had chickenpox in March," enter the month and year and defer to the child's day of birth to complete the date. For example, the child's DOB is 04/15/03 and the provider documents "history of chickenpox in March of this year," the date would appear as 03/15/04. If the abstractor notes "had chickenpox" listed without a date, on a problem log, enter 99/99/99 in the space provided for "history of disease" next to the varicella antigen in #14. "Up to date" (UTD) is not sufficient documentation for any antigen.

15. Other Visits, Which Are Non-Face-to-Face Encounters—If the child does not see the provider during a date of service, enter the date of service in field #14. For example, if the child visits the provider's office for a weight check or an immunization, enter the date of service in field #15.

Appendix C. Required Initial Health History Components

The initial health history should be able to assist the provider in obtaining information regarding past health problems; evaluating the risk for health problems; and regarding the child's family and social environment. The initial visit for a newborn should include prenatal, birth and neonatal history. A new patient questionnaire, when completed by the parent/guardian and is part of the record, is acceptable for the initial history component. At the minimum the initial history must contain the following components (indicated below by an asterisks), **health status (prenatal and neonatal information for a child under one year of age), family history, developmental history, nutritional screening, medications, allergies, past medical health status (includes significant illnesses, hospitalizations and accidents), and social/cultural aspects**.

Initial Health History

As medically and age appropriate, the following topics may be included in the **initial** health history:

- Current complaints*
- Social, cultural aspects*
- Environmental aspects
- Family health history*
- Prenatal, birth, neonatal*
- Development—can be collected from the prenatal or birth history*
- Physical growth—will be covered under the physical examination
- Fluoridation status
- Oral health
- Nutritional screening*
- Parental concerns—will be covered under "current complaints" *
- Medications taken and any adverse effects*
- Allergies*
- Immunizations*
- Past medical history—includes significant illnesses, accidents and hospitalizations*
- Health habits
- Communicable diseases

The following abbreviations and terminology qualify as sufficient documentation for certain components when collecting the initial health history: NKA, immunizations UTD, no past medical history, or "No PMH."

Appendix D. Developmental Milestones

2–4 weeks:[1]

- Raises head momentarily when prone
- Fixes on human face and follows with eyes
- Responds to parent's face and voice; smiles spontaneously
- Responds to sound by blinking, crying, quieting, changing respiration or showing startle response
- Has flexed posture; moves all extremities
- Can sleep for three or four hours at a time; can stay awake for one hour
- Can be consoled most of the time by being spoken to or held

2 months:

- Grasps rattle placed in hand
- Social smiles, smiles responsively
- Coos and reciprocal vocalization
- Shows interest in visual and auditory stimuli
- Demonstrates social interaction; follows moving person with eyes
- When prone, lifts head, neck and upper chest with support of forearms
- Some head control in upright position

4 months:

- Holds head high, raises body on hands when prone, sits when supported
- Controls head well
- Rolls prone to supine
- Plays with hands, holds rattle, reaches for objects, holds own hands
- Looks at mobile, arms active
- Follows object 180 degrees
- Smiles, coos, laughs, babbles; initiates social contact; turns to voice
- May sleep at least six hours
- Able to comfort self, e.g., fall asleep by self

The milestones in this document were taken from *Handbook for Healthy Kids Services (2002)*, Chapter HK-200 Appendix 2.

6 months:

- Rolls from front to back; sits with support
- Bears weight; stands with support
- Transfers objects hand to hand
- Turns to sound and voice; may show stranger anxiety
- Raking hand pattern; grasps and mouths objects
- Vocalizes single consonants ("dada," "baba"); may imitate sounds of speech
- Babbles reciprocally; reacts socially by smiling in response to someone else's smile
- Shows recognition of parents; shows interest in toys
- Starts to self-feed
- First tooth may erupt

9 months:

- Sits independently
- Reaches for objects with one hand
- Crawls, creeps or scoots on bottom
- Pulls to stand; stands holding on
- Inferior pincher grasp; pokes with index finger
- Bangs, throws, and drops objects
- Finger feeds; starts to use cup
- Imitates vocalizations; babbles
- May say "dada" and "mama" nonspecifically
- Responds to own name
- Understands a few words, e.g., "no-no," "bye-bye"—combines syllables
- Can sleep through the night
- May show stranger anxiety
- Enjoys interactive games, e.g., peek-a-boo and pat-a-cake
- Turns towards sound with eyes and head movement

12 months:

- Pulls to stand, stands alone; cruises; may take a few steps alone
- Has precise pincer grasp
- Points, indicates wants
- Has vocabulary of one to three words; uses "mama" and "dada" correctly
- Recognizes caregiver's voice
- Obeys simple requests; waves "bye-bye"

- Feeds self, drinks from a cup
- Actively looks for hidden or dropped objects
- Shows emotions (fear, anxiety, affection)
- Imitates

15 months:

- Walks alone, bends over, may run
- Crawls up stairs
- Stacks two blocks
- Can point to one or more body parts
- Feeds self with fingers; drinks from cup
- Understands simple commands
- Listens to a story
- Has vocabulary of three to six words
- Indicates wants by pointing or grunting
- Imitates activity
- Can remove some clothing

18 months:

- Likes to climb and run; walks backwards; climbs into chair, sits in chair
- Throws/kicks ball; stacks three or four blocks
- Has a vocabulary of 15–20 words; uses two-word phrases; imitates words
- Uses a spoon and cup; can remove clothing
- Listens to a story, looking at pictures and naming objects
- Plays with toys appropriately, e.g., pulls a pull toy, cuddles a doll
- Answers simple questions by pointing; follows simple directions
- Scribbles spontaneously; imitates crayon strokes
- Dumps object from bottle without demonstration
- Shows affection, hug and kisses

24 months:

- Up and down steps holding on with one hand
- Jumps, runs, throws overhand
- Stands on one foot with little support
- Can stack five or six blocks

- Vocabulary 50+ words, 2 word phrases, understands pronouns
- Speech should be intelligible to parents
- Parallel play dominant
- Possessive with toys
- Can follow two step commands; can name some body parts
- Makes or imitates horizontal and circular strokes with crayon
- Imitates adults
- Increasing attention span
- Separation anxiety from parents
- Brushes teeth with help; puts on clothing; washes hands

3 years:

- Jumps in place; kicks a ball; balances on one foot;, stacks blocks
- Rides a tricycle
- Alternates feet ascending stairs
- Knows name, age, and gender
- Copies circle and cross; visually discriminates colors
- Has some self care skills, e.g., feeding and dressing self
- Demonstrates speech that is mostly intelligible
- Pretend play well developed
- Can follow directions
- Names colors

HK-203.53 Developmental Screening Tools

Screening tools for developmental testing; limited, with interpretation and report, CPT code 96110, approved by the Department include:

- Ages & Stages Questionnaires (ASQ)
- Ages & Stages Questionnaires: Social-Emotional (ASQ: SE)
- Battelle Developmental Screener
- Bayley Infant Neurodevelopment Screener
- Brief Infant Toddler Social and Emotional Assessment (BITSEA)
- Brigance Early Preschool
- Chicago Early Developmental Screening Inventory
- Denver DST/Denver II
- Developmental Profile II
- Dial-R Developmental Assessment
- Early Language Milestone Scales Screen
- Early Screening Inventory
- Early Screening Profiles
- Infant-Toddler Symptom Checklist
- Minneapolis Preschool Screening Instrument
- Parent's Evaluation of Development (PEDS)
- Project Memphis DST
- Revised Developmental Screening Inventory
- Revised Parent Developmental Questionnaire
- Temperament and Atypical Behavior Scale (TABS) Screener
- Dial-3

The developmental screening and evaluation tools in this document were taken from *Handbook for Healthy Kids Services Policy and Procedures*, HK-200 April 2002 and 2004 IDPA HK-203.

HK-203.54 Developmental Evaluation Tools

Developmental evaluation is performed when results of screening indicate a more detailed evaluation is needed or when high-risk conditions (e.g., prematurity) are present. Additionally, periodic objective screening is recommended for children under age six. Evaluation tools—which are defined in the CPT as developmental testing; extended, with interpretation and report (e.g., includes assessment of motor, language, social adaptive or cognitive functioning by standardized developmental instrument), CPT code 96111—that have been approved by the Department include:

- Battelle Developmental Inventory
- Bayley Scales of Infant Development
- Child Behavior Checklist 2–3 and Caregiver-Teacher Report Form, Ages 2–5
- Child Development Inventory
- Conners' Rating Scales
- Early Coping Inventory
- Erhardt Development Prehension Assessment
- Hawaii Early Learning Profile
- Infant-Toddler Developmental Assessment
- Infant-Toddler Social and Emotional Assessment (ITSEA)
- McCarthy Screening Test
- Otis-Lenon School Ability Test
- Piers-Harris Children's Self Concept Scale
- Temperament and Atypical Behavior Scale (TABS) Assessment Tool
- Vineland Adaptive Behavior Scales
- Vineland Social-Emotional Early Childhood Scales
- Vineland Social Maturity Scale

Sampling Instructions for the Illinois EPSDT Focused Study

In order to be more efficient and less burdensome on the providers, the sampling will utilize some of the cases the health plans selected from two HEDIS® measures, *Childhood Immunizations* (CI) and the *Well-Child Visits in the First 15 Months of Life* (WCV). Specifically, the health plans will first identify and select the HEDIS samples for members who qualify for the two measures listed above. The health plans will then identify all members who were under 36 months of age as of December 31, 2004, and met the enrollment criteria of 11 or 12 months of continuous enrollment in the health plan. The two HEDIS samples should then be merged with the eligible population to determine which children in the eligible population also meet the criteria for this study. The final 412 sample cases should be selected as follows: 103 cases from *Childhood Immunizations*, 103 cases from *Well-Child Visits in the First 15 Months of Life*, 103 cases from members between 24 and 36 months of age, and the remaining 103 cases from members 12 to 24 months of age. If either or both of the HEDIS measures do not have at least 103 eligible members, then all of the cases for those measures will be chosen and the additional required cases will be selected from the eligible population at large (i.e., all members who qualified for the study).

Please see Page 3 for the list of codes for the EPSDT services.

Steps

1. Determine the HEDIS sample for *Childhood Immunization* (CI).

2. Determine the HEDIS sample for *Well-Child Visits in the First 15 Months of Life* (WCV).

   Note: The hybrid sample sizes for CI and WCV are usually 411 cases, and an oversample may be included. These 411 cases from each HEDIS measure will become a subpopulation for the EPSDT sampling. If your health plan uses the administrative method (i.e., only administrative data are used—no medical record review—so the entire population is used and there is no sampling) for either or both of these two measures, the entire eligible population would become a subpopulation for the EPSDT focused study. The EPSDT focused study will require medical record review on a sample of 103 cases from CI and 103 cases from WCV, even if your health plan is using the administrative method for those measures.

3. Determine the eligible population as follows:

   a. Determine all members born between January 1, 2002, and December 31, 2003.
   b. From Step 3a, determine all currently enrolled members for December 2004.
   c. From Step 3b, determine all members who had 11 or 12 months of continuous enrollment during 2004.

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The resulting file is the total eligible population. The samples will be selected from this file and analysis may be weighted by this file. Therefore, it is important that this file be retained for future reference.

4. Merge the WCV sample with the eligible population and exclude any member who is not in both files. The remaining cases are the eligible WCV subpopulation. Randomly sample 103 cases from this subpopulation. If there are less than 103 cases, then select all cases.

5. Merge the CI sample with the eligible population and exclude any member who is not in both files. The remaining cases are the eligible CI subpopulation. Exclude any member from the CI subpopulation who was selected in the 103 WCV sample cases. Randomly sample 103 cases from the remaining CI subpopulation. If there are less than 103 cases, then select all cases.

6. You should now have 206 cases selected. Merge these cases with the eligible population at large and remove them from the eligible population so they are not accidentally sampled again.

7. From the remaining eligible population, create two age groups: members who are under 24 months of age, and members 24 months of age and older.

8. Randomly sample 103 cases from each of the two age groups, for a total of 206 cases.

9. If less than 103 cases were selected in either Steps 4 or 5, you will need to select additional cases from the eligible population at large. There should be 412 final sample cases.

If you have questions about this sampling method, please contact David Mabb from Health Services Advisory Group, Inc., at dmabb@hsag.com or 602.665.6145.

Codes for EPSDT Services

The following codes may be used administratively to capture information relevant to EPSDT visits. Codes for childhood immunizations and well-child visits use the standard HEDIS codes shown below. Additional codes for lead screening and some individual components of a well-child visit (e.g., a vision screen) are also provided in the table below.

Description	Codes
Well-Child Visits	**V Codes:** V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9 **CPT-4 Codes:** 99381, 99382, 99391, 99392, 99432 **State Code:** W7018
Childhood Immunizations	**CPT-4 Codes:**
DTaP	90698, 90700, 90701, 90720, 90721, 90723
DT	90702
Diphtheria	90719
Tetanus	90703
OPV	90712
IPV	90698, 90713, 90723
MMR	90707, 90710
Measles	90705, 90708
Mumps	90704, 90709
Rubella	90706, 90708, 90709
Hib	90645, 90646, 90647, 90648, 90698, 90720, 90721, 90748
Hepatitis B	90723, 90740, 90744-90747, 90748
VZV	90710, 90716
Lead Screen/Test	**CPT-4 Code:** 83655 Note: Do not include the heavy metal screening code 83015 and urine lead test code 83660 for this measure. **State Code:** W8845

Description	Codes
Vision Screen	**CPT-4 Codes:** 99172, 99173, 92081, 92083 **State Code:** W7087
Hearing Screen	**CPT-4 Code:** 92551 **State Code:** W7020
Anemia Testing	**CPT-4 Codes:** 85007, 85014, 85018, 85022, 85023, 85024, 85025, 85027, 85031, 85032

This code list is not all-inclusive. Managed care plans may use homegrown codes, State Medicaid codes, and/or HCPCS codes for some services. These codes should be cross-walked, or mapped, to an appropriate ICD-9-CM or CPT-4 code in order to count for any potential EPSDT services. If your managed care plan chooses to use additional codes, you will need to submit those codes to HSAG along with the crosswalk.

Note: While these administrative codes may improve some rates, managed care plans will still need to perform medical record review for all sample cases.

UnitedHealthcare of Illinois, Inc./AmeriChoice (AmeriChoice)

Double-click on the embedded link below to open the originally submitted data files from **AmeriChoice**.

Attachment: AmeriChoice Data Submission

AMERIGROUP, Illinois (AMERIGROUP)

Double-click on the embedded link below to open the originally submitted data files from **AMERIGROUP**.

Attachment: AMERIGROUP Data Submission

Family Health Network, Inc. (FHN)

Double-click on the embedded link below to open the originally submitted data files from **FHN**.

FHN Data Submission

Attachment:

Harmony Health Plan of Illinois, Inc. (Harmony)

Double-click on the embedded links below to open the originally submitted data files from **Harmony**.

Attachments:

Harmony Overall Data Submission

Hamrony Cook County Data Submiss

Harmony South Data Submission

Humana Inc. (Humana)

Double-click on the embedded link below to open the originally submitted data files from **Humana**.

Attachment: Humana Data Submission