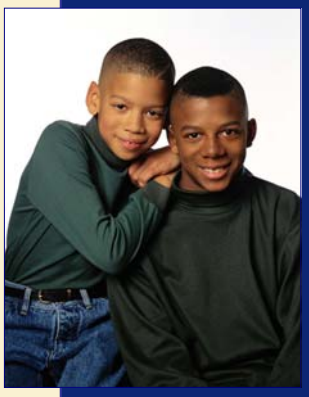
Medicaid Managed Health Care

Covered Families and Children (CFC) Program

THE OHIO DEPARTMENT OF JOB AND FAMILY SERVICES



Clinical Performance Measures

January through December 2006

Medicaid Managed Health Care
Covered Families and Children (CFC) Program

Clinical Performance Measures

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Bureau of Managed Health Care

Performance Review & Business Support Section

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TABLE OF CONTENTS

Appendices

EXECUTIVE SUMMARY

The Ohio Department of Job and Family Services (ODJFS) is the single state agency with responsibility for implementation and administration of the Ohio Medicaid program. As a value purchaser of health care, Ohio Medicaid has incorporated the use of managed care since 1978 to enhance system accountability for access and quality as well as to achieve greater cost predictability. Managed care offers an opportunity to assure access to a primary care provider, emphasize preventive care, and encourage the appropriate utilization of services in the most cost-effective settings.

Managed care plans (MCPs) cover Medicaid consumers in the Covered Families and Children (CFC) category, which includes Healthy Start and Healthy Families. The statewide expansion of mandatory managed care enrollment for CFC consumers began in July 2006. Upon completion, the expansion will include mandatory CFC enrollment for all Ohio counties in eight (8) geographic regions. As of July 2007, the Ohio Medicaid CFC Managed Care Program consisted of nine (9) MCPs operating in eighty-seven (87) counties and seven (7) regions with 1,091,351 Medicaid members.

ODJFS has measures in place to assure that the quality of care and access to care received through MCPs meets or exceeds set standards. These measures include, among others: (1) a federally-required annual quality improvement survey performed by an external quality review organization (EQRO) that includes a medical record audit; (2) a corporate MCP review, which includes a grievance audit, and quality of care studies of clinical processes and access to services; (3) monitoring of provider panels; and (4) monitoring access and clinical performance measures.

This report presents the results of the clinical performance measures for the MCPs for calendar year (CY) 2006. The results were calculated with encounter data, which is essentially administrative claims data that providers send to MCPs who, in turn, send the claims data to ODJFS. Information obtained from medical records, generated by a sample of managed care consumers was not used. The results were calculated using encounter data generated by all managed care consumers, which generally yields lower results than if medical records information generated from a sample was also used.

However, there are limitations in relying only on administrative data to measure clinical performance. Issues may include miscoding of services and incomplete data. Encounter data is essentially a record of each service provided, regardless of the payment arrangement (e.g., capitation, fee-for-service). In payment arrangements other than fee-for-service, there may be a greater risk for incomplete data since there is less incentive for a provider to submit a claim.

Because of these potential data issues, the results presented in this report may not reflect the actual clinical performance of the providers associated with the MCPs. To generate reliable results, many steps are taken to help assure that encounter data is accurate, timely, and complete.

Computer edits are used to reject data such as invalid codes, dates, and provider numbers. The volume of encounter data across various categories of services is monitored quarterly and MCPs are held accountable for meeting volume standards that have been established.

The following table summarizes the results for the clinical performance measures for CYs 2005 and 2006.

Measure	CY 2005	CY 2006
Initiation of Prenatal Care	85.6	86.7
Frequency of Ongoing Prenatal Care	63.9	69.9
Cesarean Section Rate*	24.8	25.9
Low Birth Weight Rate*	10.0	11.0
Very Low Birth Weight Rate*	2.0	2.7
Postpartum Visit	52.1	57.3
Well Child Visit in First 15 Months of Life (Had 6 visits)	46.7	48.5
Well Child Visit (3-6 years old)	62.7	64.0
Adolescent Well Care Visit (12-21 years old)	35.9	36.4
Annual Dental Visit	46.7	50.5
Lead Testing for 1 Year Olds	45.9	48.4
Lead Testing for 2 Year Olds	26.7	29.1
Asthma Medication Management	84.8	87.3
Diabetes Care (Had HbA1c Test)*	63.0	63.2
Diabetes Care (Received Eye Exam)*	31.3	33.3
Diabetes Care (Received LDL-C Screening)*	65.1	66.3
Diabetes Care (Were Monitored for Nephropathy)*	34.5	34.4
Diabetes Care (Received All)*	11.4	12.2

Highlights of CY 2006 Report*:*

- Among MCP members who had a live birth in CY 2006, 70% received 81% or more of the recommended number of prenatal visits. This is an increase for the fourth consecutive year in a row. In comparison, the national average is 56% (see note below) receiving 81% or more of the recommended prenatal visits.

- The percentage of children ages 15 months who received a Well-Child visit with a PCP increased from 47% in CY 2005 to 49% in CY 2006. This is the fourth consecutive year of continued improvement.

- The percentage of children and adolescents who received an annual dental visit increased from 47% in CY 2005 to 51% in CY 2006, which is the fourth consecutive year of improvement. Ohio's Managed Care Clinical Performance Measure result is higher than the national average of 41% (see note below).

- Lead screening rates for one and two year olds increased from CY 2005 (46% and 27%, respectively). In CY 2006, 48% of one year olds and 29% of two year olds had a lead screening test through their managed care plan. Both one and two year old lead testing rates have steadily improved for the last four consecutive calendar years.

- The postpartum visit rate increased from 52% in CY 2005 to 57% in CY 2006 and matches the national average.

Areas Identified for Improvement*:*

- The result for the well-child visits in the 12-21 year olds measure remained stable from CY 2005 to CY 2006. The CY 2006 result of 36%, indicates that there is opportunity for improvement.

- The postpartum care rates have increased over the last three calendar years. For CY 2006 the statewide results and national average were even, which indicates that there is an opportunity for improvement.

Note: The national Medicaid managed care results presented in this report for comparative purposes were obtained from the NCQA's website. NCQA has indicated that the data and methods used to calculate the results were audited and that the results were calculated using the "hybrid" (combines information obtained from medical records with encounter data) and administrative specifications (relies only on encounter data information). Results calculated using hybrid specifications are generally higher than those calculated using administrative specifications. Therefore, comparing the results in this report to the national Medicaid results is not an exact comparison and should be made with caution.

I. INTRODUCTION

The Ohio Medicaid Managed Health Care Clinical Performance Measures Report is based solely on encounter data submitted by Managed Care Plans (MCPs) contracted to provide health services to Medicaid consumers. The Ohio Department of Job & Family Services (ODJFS) began collecting encounter data on July 1, 1996.

Encounter data captures face-to-face visits between the MCPs Medicaid enrollees and a provider. Clinical performance measurement is one component of a multifaceted monitoring program designed to assure access to quality health services. The results will be compared to standards specified in the MCPs provider agreement with the ODJFS and will be reported to MCPs, consumers, and other interested parties. This report presents results for those MCPs that were serving Medicaid members during CY 2006 and compares results for CY 2006 to results for CY 2005. These measures were modeled and calculated based on HEDIS 2006 technical specifications for performance measures. Use of this standard methodology allows comparison of Ohio's results with other Medicaid managed care populations in the nation.

Due to data quality issues, these results may not be reflective of actual clinical performance. ODJFS is focusing on improving the quality of the data with the goal of using these data to hold MCPs accountable for the quality of care delivered to Medicaid recipients enrolled in MCPs. Data quality issues are common in the early years of collecting encounter data. The following sections outline some considerations that should be taken into account when reviewing the results and describes the data quality measures that are currently in place.

Technical Considerations
Subsequent to an enrollee encounter with a provider there are several events that might influence the validity of the encounter data. The encounter must first be documented by the provider by completing a claim requesting reimbursement or by completing a shadow claim if there is a capitated arrangement with the MCP. Next, the provider submits the encounter to the MCP where they confirm that all information on the claim is complete and in an acceptable format. Following acceptance, the MCP processes the encounter and transfers it to their information system. Finally, the encounter is submitted to ODJFS where an edit process assures proper format and valid data elements (e.g., Medicaid ID and procedure codes). Any error at a data transfer point (e.g., coding the encounter on the claim or data entry into an electronic format) or break in this chain of events (e.g., rejected encounters submitted to the MCP or to ODJFS) results in inaccurate and/or incomplete data.

Related to encounter data reporting, provider compliance is a chief concern of MCP's. In a capitated delivery system, providers have less incentive to submit encounter data because the claim submission is not tied to a payment process. Also, providers must be willing to use the appropriate codes as defined in their agreement with MCP's. In order to ensure physician compliance, MCP's develop encounter data reporting policies, offer financial incentives, and provide technical assistance.

Once the encounter is submitted to the MCP, their management information system must allow for the processing for payment, collection and storage of claims and allow for the production of the data in the proper format for submission to ODJFS. Before ODJFS required encounter data submissions, many MCPs had limited experience collecting and reporting data for this purpose.

Data Quality Measures

The evaluation of each MCP's results, whereby the results are compared to the standards, identifies areas needing improvement. To encourage standard level performance, each MCP that is not compliant with the standard faces a system of progressive penalties. This system's first objective is to improve the quality of the encounter data. In this complex data collection system, it is expected in the first several years of data collection that there will be many data quality issues identified and resolved. Once the data quality is to a level where ODJFS is confident that the results reflect the services being delivered, then this monitoring tool can be used to improve clinical performance.

Data quality measures were developed to evaluate and improve the completeness, accuracy, and timeliness of each MCPs encounter data set. These measures include:

1. Validation Studies, where submitted encounters are compared to medical records for accuracy;

2. Omission Studies, where an enrollee's medical record is compared to the encounter data to check completeness of the submitted data;

3. Encounter Volume Report, to assure the expected number of encounters are being submitted timely; and

4. Minimum level performance measures results, where results below this minimum level indicate data errors.

ODJFS maintains an ongoing dialogue and an information sharing process with MCPs concerning encounter data reporting. ODJFS offers MCPs technical assistance and provides feedback on submissions.

Results will be presented for the performance measures listed below. Standards are established for many of these measures and the MCPs are held accountable for achieving the standard. If a measure is a contract measure and included in the provider agreement between the MCP and ODJFS, this will be noted when the measure is discussed.

Perinatal Measures

♦ Initiation of Prenatal Care
The percentage of women who delivered (a) live birth(s) during the reporting year, who were enrolled in the MCP no more than 279 days but at least 43 days prior to delivery with no gaps in MCP enrollment, and had their first prenatal visit within 42 days of enrollment or by the end of the first trimester for those women enrolled in the MCP during the early stage of pregnancy.

♦ Frequency of Ongoing Prenatal Care
The percentage of Medicaid-enrolled women who had a live birth during the reporting year and who received less than 21%, 21% through 40%, 41% through 60%, 61% through 80%, or greater than or equal to 81% of the expected number of prenatal care visits, adjusted for gestational age and the month the member enrolled in the MCP.

♦ Low Birth Weight Rate/Very Low Birth Weight
The percentage of women who delivered a live birth during the reporting year, who had at least five months of continuous enrollment immediately prior to the birth, and who had a low birth weight or very low birth weight baby.

♦ Postpartum Care
The percentage of enrolled women who delivered (a) live birth(s) during the reporting year who were continuously enrolled for 56 days after delivery and who had a postpartum visit on or between 21 days and 56 days after delivery.

♦ Cesarean Section Rate
The percentage of enrolled women who had a live birth during the reporting year who delivered by a Cesarean Section.

Child Health Care Measures

♦ Well-Child Visits in the First 15 Months of Life
The percentage of enrolled members who turned 15 months old during the reporting year, who were enrolled from the month after the month in which they were born through their 15th month of life (allowing for a one month gap in MCP enrollment), were enrolled during their 15th month of life, and who received either zero, one, two, three, four, five, or six or more well-child visits with a primary care practitioner during their first 15 months of life.

♦ Well-Child Visits for Children Aged 3 Through 6
The percentage of members who were three, four, five, or six years old during the reporting year, who were enrolled for at least 11 months with the plan during the measurement year, were enrolled during the last month of the measurement year, and who received one or more well-child visit(s) with a primary care practitioner during the reporting year.

♦ Adolescent Well-Care Visits

The percentage of enrolled members who were ages 12 through 21 during the reporting year, who were enrolled for at least 11 months with the plan during the reporting year, were enrolled during the last month of the measurement year, and who received at least one comprehensive well-care visit with a primary care practitioner during the reporting year.

♦ Annual Dental Visit

The percentage of enrolled members ages 4 through 21 who were enrolled for at least 11 months with the plan during the reporting year, were enrolled during the last month of the measurement year, and who had at least one dental visit during the reporting year.

♦ Lead Testing For 1 Year Olds

The percentage of enrolled members who turned 15 months old during the reporting year, who were enrolled in the MCP from 9 months through 15 months of age (allowing for a one month gap in MCP enrollment), who were enrolled in the MCP during their 15th month of life, and who received a lead screening test.

♦ Lead Testing For 2 Year Olds

The percentage of enrolled members who turned 27 months old during the reporting year, who were enrolled in the MCP from 21 months through 27 months of age (allowing for a one month gap in MCP enrollment), who were enrolled in the MCP during their 27th month of life, and who received a lead screening test.

Chronic Care Measures

♦ Use of Appropriate Medications for People with Asthma

The percentage of members ages 5 through 56 with persistent asthma who were enrolled for at least 11 months with the plan during the reporting year, who were enrolled for at least 11 months during the year prior to the reporting year, were enrolled during the last month of the reporting year, and who received prescribed medications acceptable as primary therapy for long-term control of asthma.

♦ Comprehensive Diabetes Care

The percentage of members with diabetes (Types 1 or 2) ages 18 through 75 who were enrolled for at least 11 months with the plan during the reporting year, who were enrolled during the last month of the reporting year, and who received each of the following: (1) Hemoglobin A1c (HbA1c) testing; (2) a retinal exam by an optometrist or ophthalmologist; (3) LDL-C screening; and (4) screening or treatment for nephropathy.

Results are reported for the following managed care plans:

Managed Care Plan	Abbreviation Used in Graphs
Anthem[I] (previously QualChoice)	**AT**
Buckeye Community Health Plan[II]	**BE**
CareSource	**CS**
Paramount Advantage	**PAR**
Weighted Average of all MCPs	**AVG**
National Medicaid Average	**USA**

[I] Anthem assumed QualChoice membership effective September 1, 2006.

[II] Buckeye assumed Mediplan membership effective June 1, 2006.

II. PERINATAL CARE MEASURES

Initiation of Prenatal Care for New Enrollees

(MCP Contract Measure)

Purpose

This measure assesses whether new enrollees received prenatal care early in pregnancy (during the first trimester). Thus, this measure looks at the timing of prenatal care as opposed to the frequency of such care. Both factors, however, are thought to be related to the outcome of pregnancy.

ODJFS Expectations
Managed care plans must meet a minimum performance standard for this measure for the CY 2006 report period, in accordance with the MCP provider agreement dated July 1, 2006, Appendix M, Performance Evaluation. The results for this measure are also used to determine if an MCP qualifies for financial incentives in accordance with Appendix O, Performance Incentives, of the Provider Agreement.

Minimum Performance Standard: The level of improvement must result in at least a 10% decrease in the difference between the target (90%) and the previous year's results.

Methods

Measure: The percentage of women who delivered (a) live birth(s) during the reporting year, who were enrolled in the MCP no more than 279 days but at least 43 days prior to delivery with no gaps in MCP enrollment, and who had their first prenatal visit within 42 days of enrollment or by the end of the first trimester for those women who enrolled in the MCP during the early stage of pregnancy.

Numerator: One (or more) prenatal care visit(s) within 42 days of enrollment in the MCP or within the first trimester if the member enrolled more than 42 days prior to the end of the first trimester.

Denominator: The eligible population.

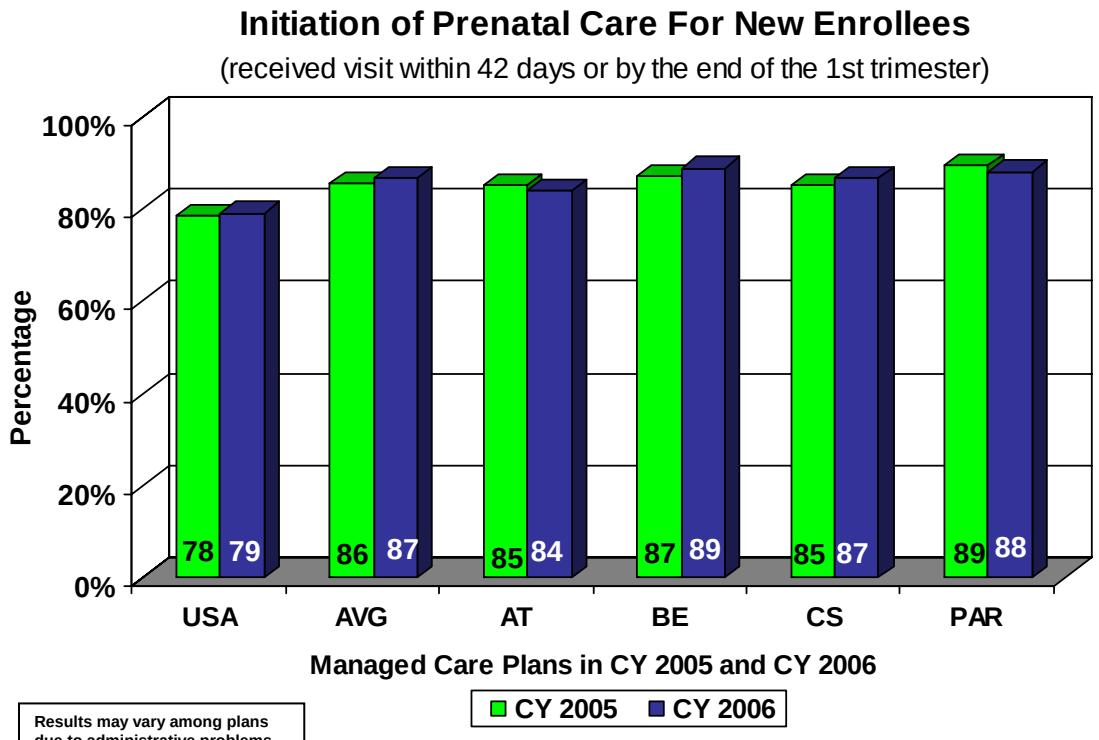
Data Source: Encounter Data

See Appendix A for more detailed information on the methods for calculating this measure.

Results

As shown in Graph A-1, the percentage of Medicaid members enrolled in MCPs who had a prenatal visit within 42 days of enrollment, or by the end of the first trimester for those women who enrolled in the MCP during the early stage of pregnancy, increased from 86% in CY 2005 to 87% in CY 2006. The results in CY 2006 ranged from a low of 84% to a high of 89%. The bar labeled "USA" provides the national Medicaid results (obtained from NCQA website) for calendar years 2005 and 2006 as a frame of reference, which are the most recent results available.

Graph A-1.



Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Source of Data:
Encounter Data and NCQA (Measurement Year 2005, 2006)

Frequency of Ongoing Prenatal Care

(MCP Contract Measure)

Purpose

This measure assesses whether recipients received a sufficient number of prenatal visits. Periodic care throughout pregnancy helps to promote a good pregnancy outcome. During the visits, providers monitor the health of the woman and the fetus and teach the woman about the childbearing and delivery process. Specifically, routine prenatal care typically includes taking the history of the woman, performing a physical examination and chemical urinalysis, and recording the woman's weight, blood pressure, and fetal heart tones. It is important that periodic monitoring occur since a mother's risk status can change throughout pregnancy.

The measure adjusts for the length of gestation as well as the timing of the first prenatal visit. For example, a recipient who had a full term pregnancy of 44 weeks and who began care in the first month of pregnancy would be expected to have 18 visits while a recipient who had a pregnancy of 33 weeks and who began care in the fifth month of pregnancy would be expected to have only three visits. The expected number of visits is based on guidelines set forth by the American College of Obstetricians and Gynecologists.

ODJFS Expectations
Managed care plans must meet a minimum performance standard for this measure for the CY 2006 report period, in accordance with the MCP provider agreement dated July 1, 2006, Appendix M, Performance Evaluation. The results for this measure are also used to determined if an MCP qualifies for financial incentives in accordance with Appendix O, Performance Incentives, of the Provider Agreement.

Minimum Performance Standard: The level of improvement must result in at least a 10% decrease in the difference between the target (80%) and the previous year's results.

Methods

Measure: The percentage of Medicaid-enrolled women who had a live birth during the reporting year and who received less than 21%, 21% through 40%, 41% through 60%, 61% through 80%, or greater than or equal to 81% of the expected number of prenatal care visits, adjusted for gestational age and the month the member enrolled in the MCP.

Numerator: Women who had an unduplicated count of less than 21%, 21% through 40%, 41% through 60%, 61% through 80%, or greater than or equal to 81% of the expected number of prenatal care visits, adjusted for gestational age and the month the member enrolled in the MCP.

Denominator: The number of Medicaid MCP members who had a live birth during the reporting year.

Data Source: Encounter Data

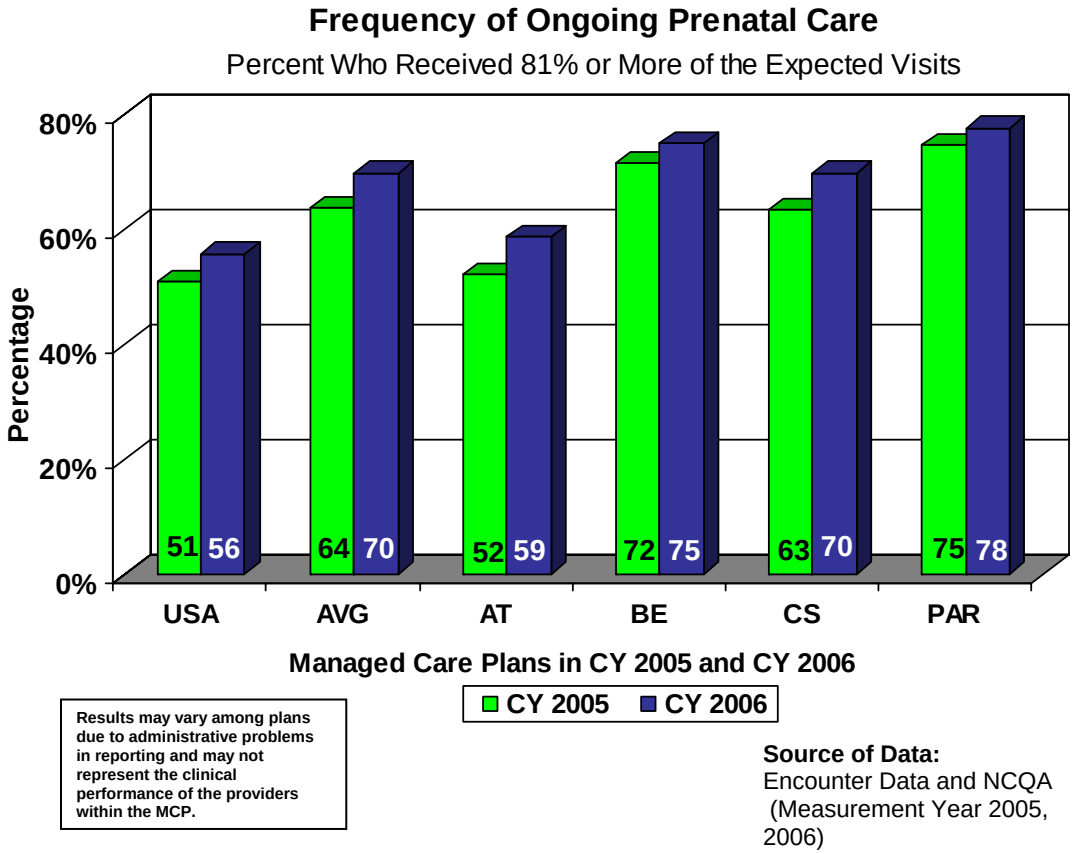
See Appendix A for more detailed information on the methods for calculating this measure.

Results

As shown in Graph B-1, the percentage of women with a live birth who received 81% or more the expected number of prenatal care visits, adjusted for gestational age and the month the member enrolled in the MCP, increased from 64% in CY 2005 to 70% in CY 2006. In CY 2006, the results ranged from 59% to 75%.

Graph B-2 shows the percentage of women in the denominator who received less than 21%, 21-40%, 41-60%, 61-80%, or 81% or more of the expected number of visits. As shown, the weighted average of the Medicaid serving MCPs in Ohio exceeded the national Medicaid average regarding the percentage of members who received 81% or more of the expected number of prenatal visits. Furthermore, the percentage of Ohio MCP members who received very little or no prenatal care (i.e., less than 21% of the expected number of prenatal visits) was significantly lower than the national average.

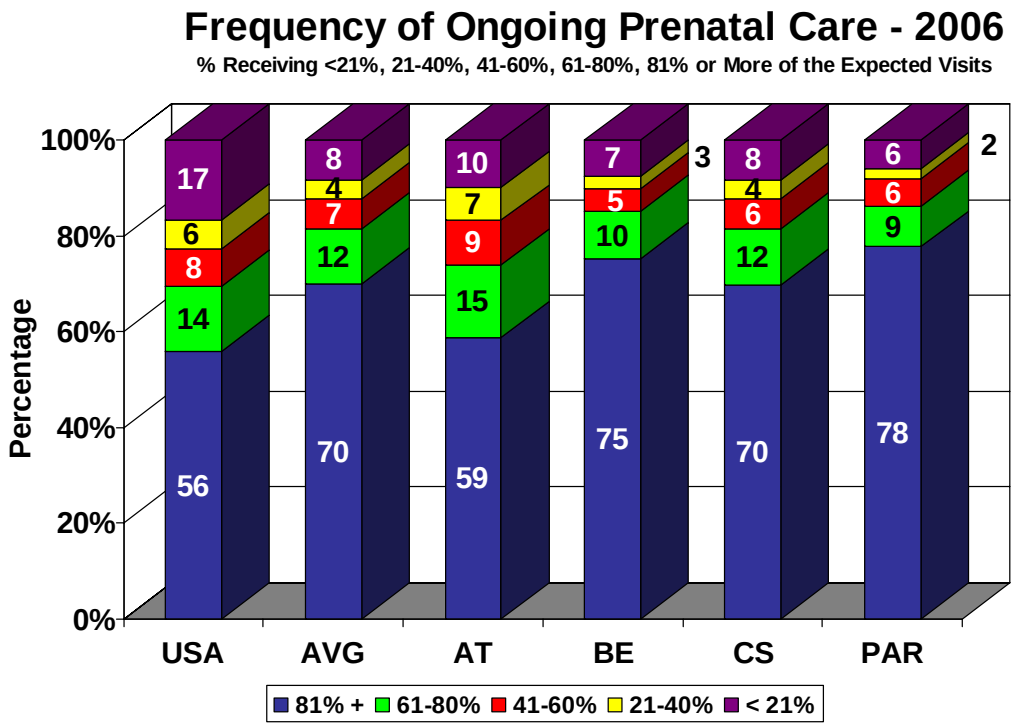
Graph B-1.



Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Source of Data:
Encounter Data and NCQA (Measurement Year 2005, 2006)

Graph B-2.



Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Source of Data: Encounter Data and NCQA (Measurement Year 2006)

Cesarean Section Rate

Purpose

This measure assesses the percentage of live births that were delivered by a cesarean section. A cesarean section is a surgical procedure whereby a baby is delivered through an incision in the abdominal and uterine walls. Not only can reducing the rate decrease health care costs, but also the risk to mothers. Cesarean sections are associated with a higher risk of mortality and complications as well as a longer hospital stay than with vaginal deliveries.

After declining for many years, the rate of cesarean delivery in the United States began to rise in 1997. By 2006, the nationwide rate of cesarean delivery was reported as an all-time high of 31.1% of all live births.[1]

Minimum Performance Standard: There is no performance standard for this measure.

Methods

Measure: The percentage of women who had a live birth during the reporting year who delivered by a Cesarean Section.

Numerator: Number of discharges for women who had a C-section resulting in a live birth during the measurement year.

Denominator: Number of discharges for women who had a delivery (vaginal or C-section) resulting in a live birth during the reporting year.

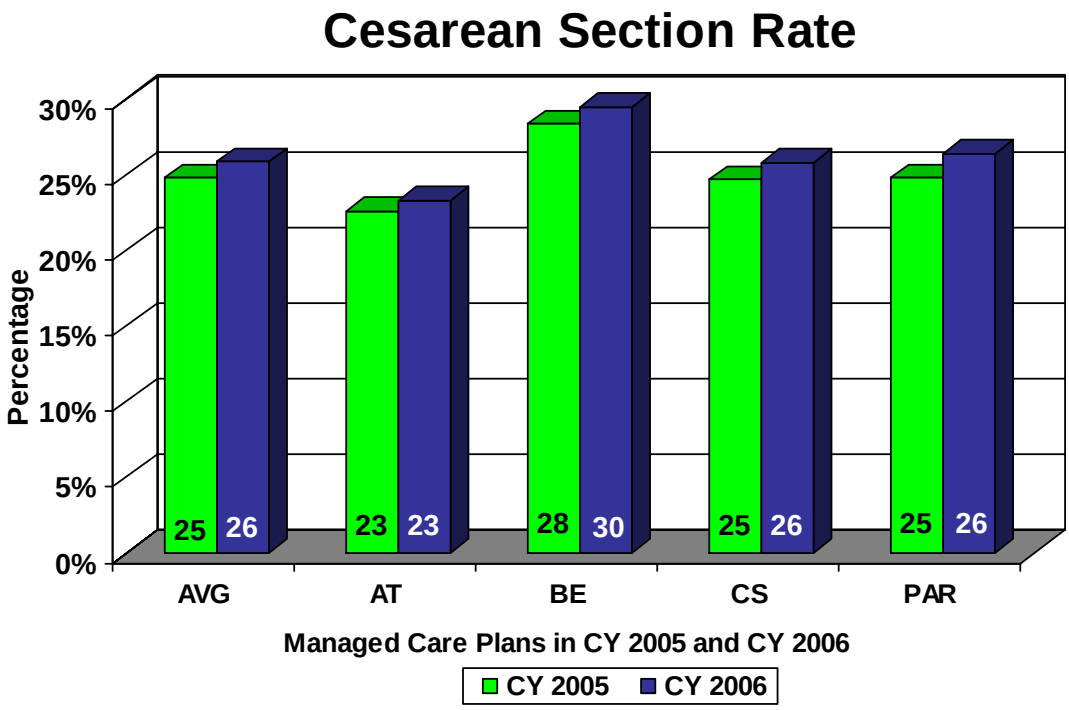
Data Source: Encounter Data

See Appendix A for more detailed information on the methods for calculating this measure.

Results

The percentage of Medicaid MCP members who had a repeat or primary cesarean section delivery was 25% in CY 2005 and increased to 26% by CY 2006 (Note: Graph C-1). The results for CY 2006 ranged from 23% to 30%.

Graph C-1.



Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Source of Data:
Encounter Data and NCQA (Measurement Year 2005, 2006)

Low Birth Weight Measure

Purpose

This measure indirectly measures the outcome of care since low birth weight (defined as being less than 2,500 grams or about 5.5 pounds) is correlated with various adverse events. Not only are low birth weight infants more likely to experience neurodevelopmental handicaps, congenital anomalies, and respiratory disorders than are infants of normal birth weight,[2] but they also are 40 times more likely to die.[3] Various risk factors have been associated with delivering a low birth weight infant. These include maternal age (less than 18 or greater than 35), ethnicity, low socioeconomic status, parity greater than 4, poor obstetrical history, prior LBW birth history, cigarette smoking, substance abuse, poor nutrition, various medical illnesses such as hypertension, and absence of prenatal care.[4,5]

For 2006, the low birth weight rate for the United States was 8.3% and has increased nineteen percent since 1990.[1]

Minimum Performance Standard: There is no performance standard for this measure.

Methods

Measure: The percentage of women who gave birth to a low-birth weight newborn during the reporting year.

Numerator: The number of births in the denominator with a birth weight less than or equal to 2,500 grams.

Denominator: The number of Medicaid MCP members who had a live birth during the reporting year and who had at least five months of continuous enrollment immediately prior to the birth.

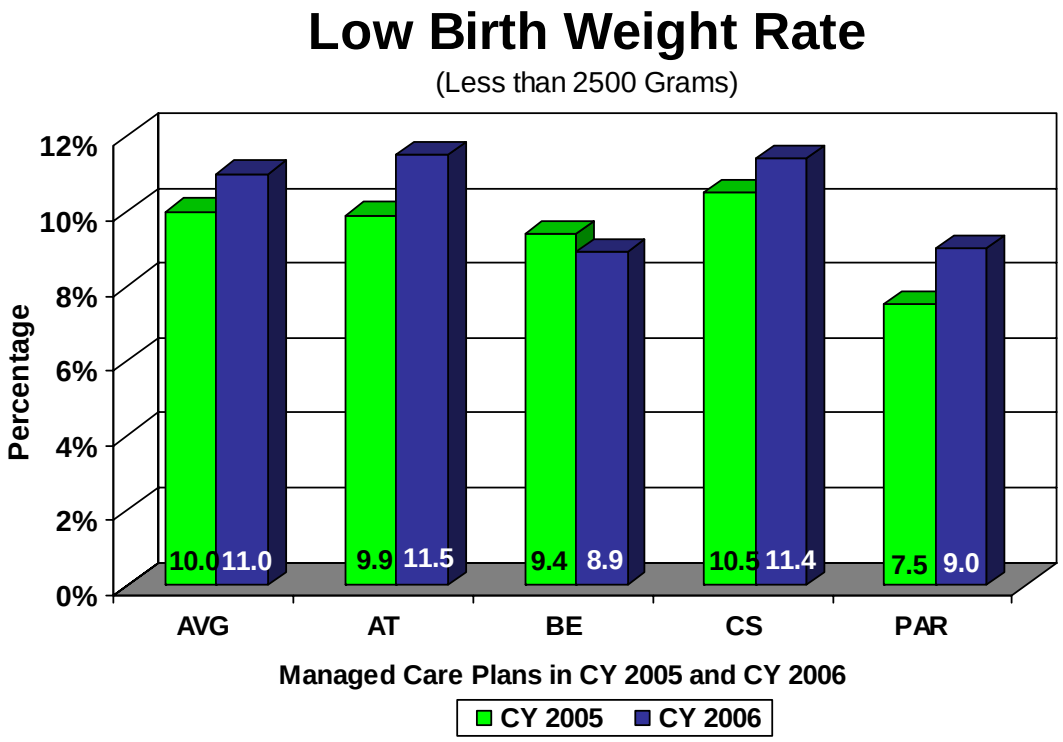
Data Source: Encounter Data

See Appendix A for more detailed information on the methods for calculating this measure.

Results

The percentage of MCP Medicaid members who had a low birth weight baby was 10% in CY 2005 and 11% in CY 2006.

Graph D-1.



Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Source of Data:
Encounter Data and NCQA (Measurement Year 2005, 2006)

On this graph, lower rates indicate better performance.

Very Low Birth Weight Measure

Purpose

See discussion for Low Birth Weight measure.

Minimum Performance Standard: There is no performance standard for this measure.

Methods

Measure: The percentage of women who gave birth to a very low-birth weight newborn during the reporting year.

Numerator: The number of births in the denominator with a birth weight less than or equal to 1,500 grams.

Denominator: The number of Medicaid MCP members who had a live birth during the reporting year and who had at least five months of continuous enrollment immediately prior to the birth.

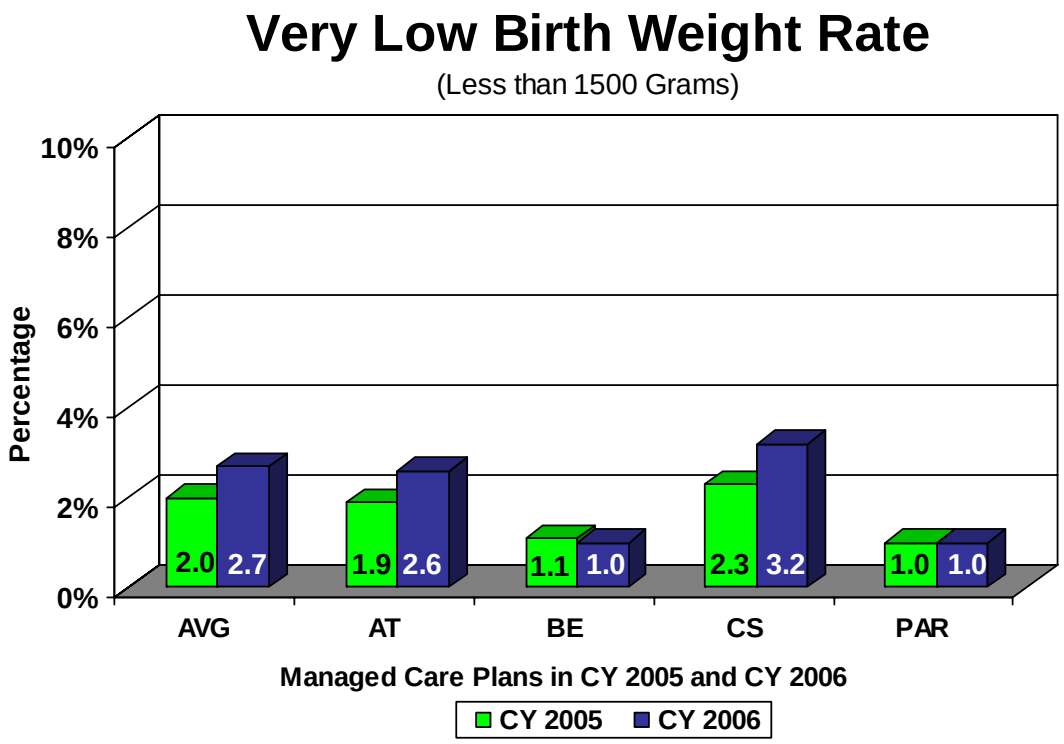
Data Source: Encounter Data

See Appendix A for more detailed information on the methods for calculating this measure.

Results

The very low birth weight MCP average was 2.0% in CY 2005 and 2.7% in CY 2006.

Graph E-1.



Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Source of Data:
Encounter Data and NCQA (Measurement Year 2004, 2005)

On this graph, lower rates indicate better performance.

Postpartum Care

(MCP Contract Measure)

Purpose

The American College of Obstetricians and Gynecologists recommends that women have a postpartum visit from four to six weeks after delivery.[6] Women undergo physiological, emotional, and social changes during the period after delivery. The purpose of the postpartum visit is to evaluate the condition of the mother, to provide assistance and answer questions, and to provide guidance regarding family planning and nutrition. The physical examination that is performed during the visit should include an evaluation of weight, blood pressure, breasts, abdomen, and pelvic examination.[7]

ODJFS Expectations
Managed care plans must meet a minimum performance standard for this measure for the CY 2006 report period, in accordance with the MCP provider agreement dated July 1, 2006, Appendix M, Performance Evaluation. The results for this measure are also used to determined if an MCP qualifies for financial incentives in accordance with Appendix O, Performance Incentives, of the Provider Agreement.

Minimum Performance Standard: The level of improvement must result in at least a 5% decrease in the difference between the target (80%) and the previous year's results.

Methods

Measure: The percentage of enrolled women who delivered (a) live birth(s) during the reporting year, who were continuously enrolled for 56 days after delivery, and who had a postpartum visit on or between 21 days and 56 days after delivery.

Numerator: A postpartum visit on or between 21 and 56 days after delivery.

Denominator: The eligible population.

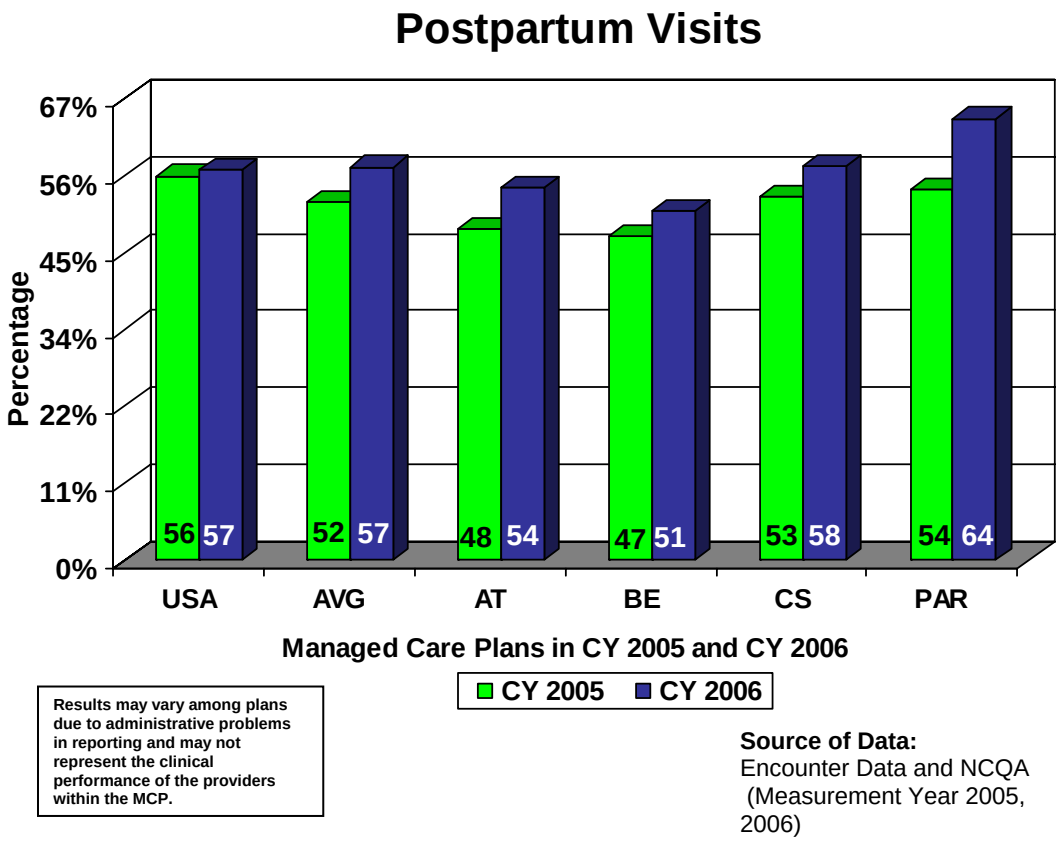
Data Source: Encounter Data

See Appendix A for more detailed information on the methods for calculating this measure.

Results

For the statewide MCP average, the percentage of members in the denominator who had a visit between 21 and 56 days after delivery increased from 52% in CY 2005 to 57% in CY 2006. The statewide average matched the national Medicaid average (57%). The MCP-specific results in CY 2006 ranged from 51% to 64%.

Graph F-1.



III. CHILD HEALTH CARE MEASURES

Well-Child Visit Measures

- **First 15 Months of Life**
- **3 to 6 Years of Age**
- **Adolescent (12 to 21 Years of Age)**

(MCP Contract Measures)

Purpose

Periodic preventive exams provide an opportunity for physicians and other health professionals to prevent and identify physical, developmental, and behavioral problems. The American Academy of Pediatrics (AAP) Periodicity Schedule recommends annual well-child visits for two to six year olds.[8] The AAP also recommends that adolescents (12 to 21 years old) receive comprehensive preventive examinations annually.[8] Preventive exams are particularly important during the first year of life when an infant undergoes significant changes in cognitive abilities, growth, motor skills, hand-eye coordination, as well as social and emotional growth.[9]

ODJFS Expectations
Managed care plans must meet a minimum performance standard for this measure for the CY 2006 report period, in accordance with the MCP provider agreement dated July 1, 2006, Appendix M, Performance Evaluation. The results for this measure are also used to determined if an MCP qualifies for financial incentives in accordance with Appendix O, Performance Incentives, of the Provider Agreement.

Minimum Performance Standard: The level of improvement must result in at least a 10% decrease in the difference between the target (80%) and the previous year's results.

Methods (First 15 months of life)

Measure: The percentage of enrolled members who turned 15 months old during the reporting year, who were enrolled in the MCP from the month following the month in which they were born through their 15 month of life (allowing for a one month gap in MCP enrollment), who were enrolled during their 15 month of life, and who received either zero, one, two, three, four, five, or six or more well-child visits with a primary care practitioner during their first 15 months of life.

Numerator: Seven separate numerators are calculated, corresponding to the number of members who received: zero, one, two, three, four, five, and six or more well-child visits with a primary care practitioner during their first 15 months of life. A child is included in only one numerator (e.g., a child receiving six well child visits is not included in the rate for five, four, or fewer well child visits). The primary care practitioner does not have to be the practitioner assigned to the child.

Denominator: The eligible population.

Data Source: Encounter Data

See Appendix A for more detailed information on the methods for calculating this measure.

Methods (3-6 years of age)

Measure: The percentage of members who were three, four, five, or six during the reporting year, who were enrolled for at least 11 months with the plan during the measurement year, who were enrolled during the last month of the reporting year, and who received one or more well-child visit(s) with a primary care practitioner during the reporting year.

Numerator: At least one well-child visit with a primary care practitioner during the reporting year. The primary care practitioner does not have to be the practitioner assigned to the child.

Denominator: The eligible population.

Data Source: Encounter Data

See Appendix A for more detailed information on the methods for calculating this measure.

Methods (12-21 years of age)

Measure: The percentage of enrolled members who were age 12 through 21 during the reporting year, who were enrolled for at least 11 months with the plan during the reporting year, who were enrolled during the last month of the reporting year, and who received at least one comprehensive well-care visit with a primary care practitioner during the reporting year.

Numerator: At least one well-child visit with a primary care practitioner during the reporting year. The primary care practitioner does not have to be the practitioner assigned to the child.

Denominator: The eligible population.

Data Source: Encounter Data

See Appendix A for more detailed information on the methods for calculating this measure.

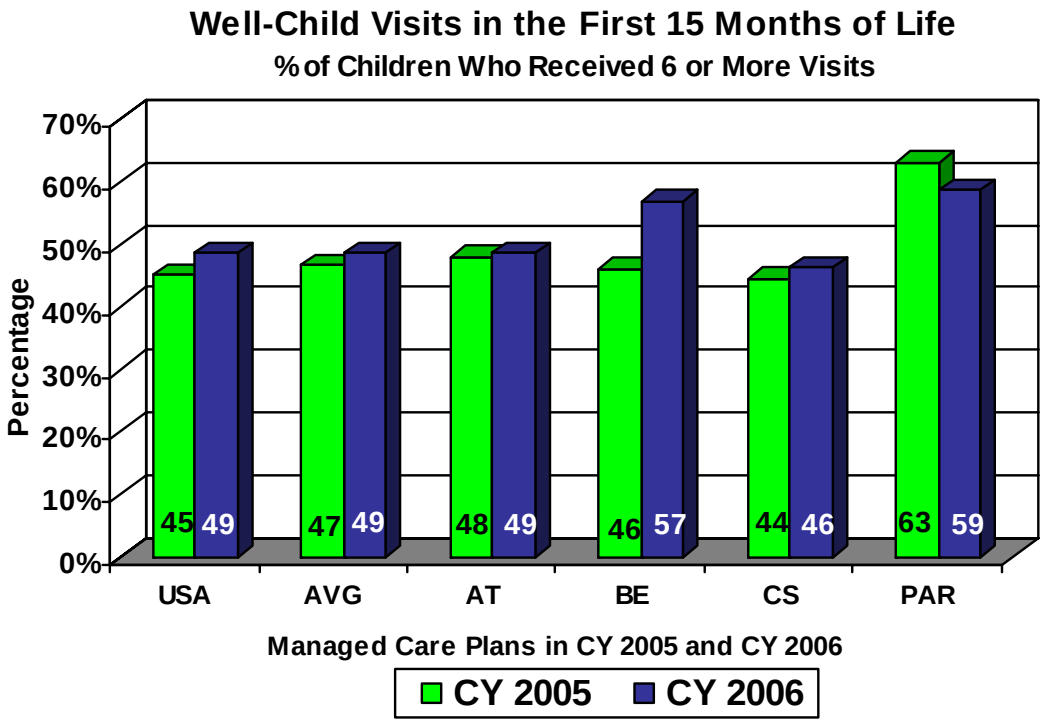
Results

The percentage of members who received six or more well-child visits with a primary care practitioner during their first 15 months of life increased from 47% in CY 2005 to 49% in CY 2006 (See Graph G-1). Graph G-2 shows the percentage of children who received zero, one, two, three, four, five, or six or more well-child visits. The national average for the percentage of children who received six or more visits is 49%. The percentage of children who received no visits was lower in Ohio than nationally (2% versus 5%, respectively).

The percentage of members who were age three through six during CY 2006, and who received one or more well-child visit(s) with a primary care practitioner, increased from 63% in CY 2005 to 64% in CY 2006. (Note Graph G-3) The Ohio Medicaid MCP average was higher the national Medicaid average (63%)

The percentage of enrolled members who were age 12 through 21 during CY 2006, and who received at least one well-care visit with a primary care practitioner, remained steady from CY 2005 to CY 2006 at 36%. (Note Graph G-4) The Ohio Medicaid MCP average is a little less than national Medicaid average (41%).

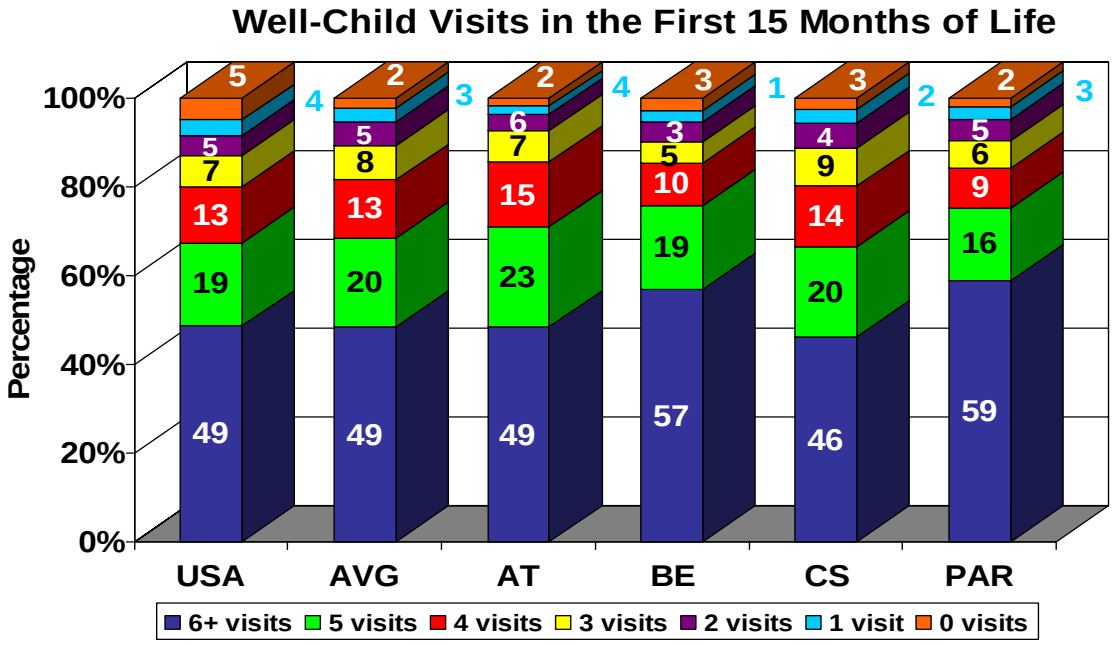
Graph G-1.



Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Source of Data: Encounter Data and NCQA (Measurement Year 2005, 2006)

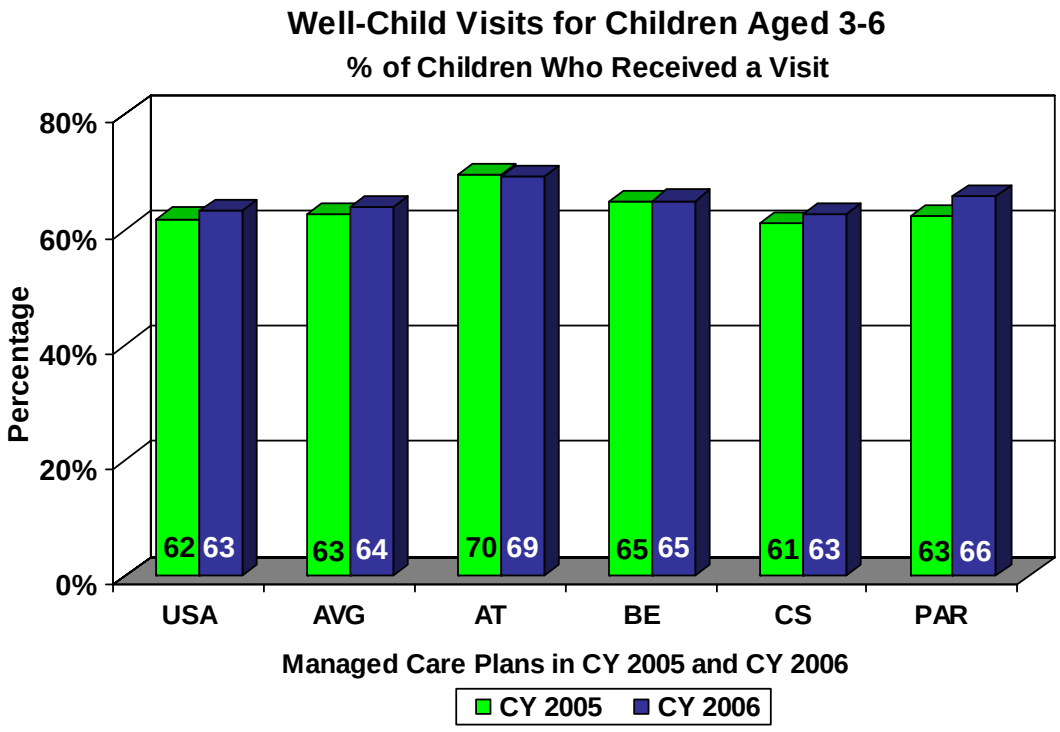
Graph G-2.



Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Source of Data: Encounter Data and NCQA (Measurement Year 2006)

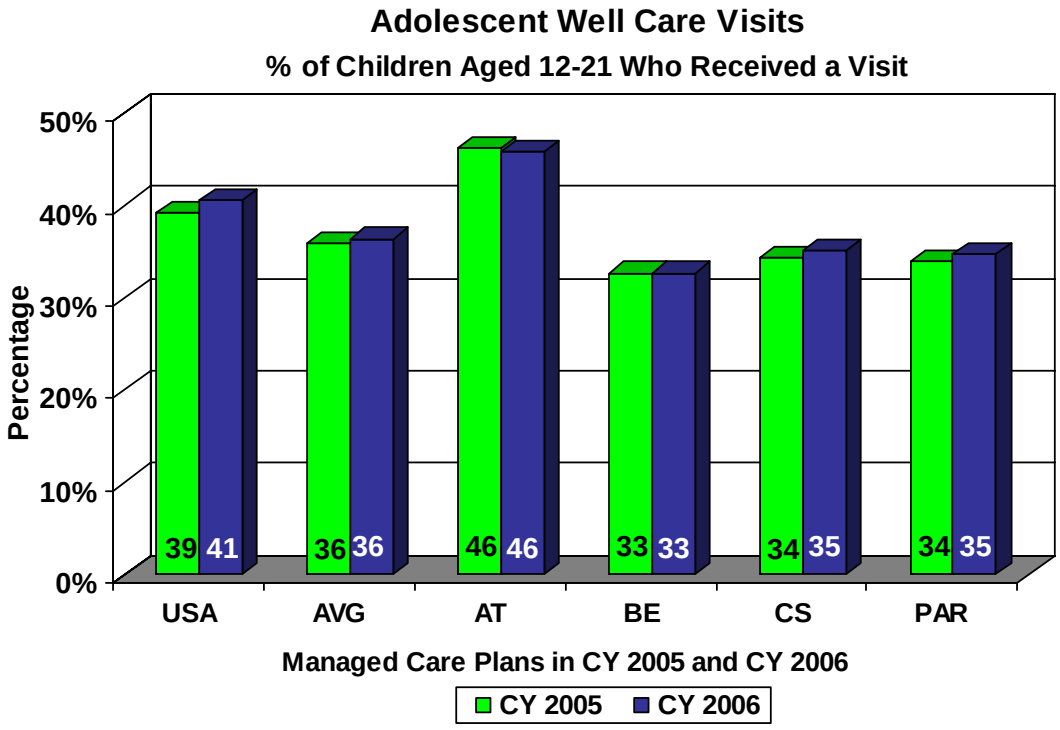
Graph G-3.



Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Source of Data: Encounter Data and NCQA (Measurement Year 2005, 2006)

Graph G-4.



Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Source of Data: Encounter Data and NCQA (Measurement Year 2005, 2006)

Annual Dental Visit

(MCP Contract Measure)

Purpose

Great progress has been made over the last 50 years in understanding and treating oral diseases such as dental caries (tooth decay) and periodontal (gum) diseases. However, dental caries continue to be the single most common chronic childhood disease (5 times more common than asthma and 7 times more common than hay fever). Over half of children aged 5-9 have at least one cavity or filling and that percentage increased to 78% by age 17. According to the Surgeon General:

> There are striking disparities in dental disease by income. Poor children suffer twice as much dental caries as their more affluent peers, and their disease is more likely to be untreated. These poor/non-poor differences continue into adolescence. One out of four children in America is born into poverty, and children living below the poverty line (annual income of $17,000 for a family of four) have more severe and untreated decay.[10]

Regular visits to the dentist provide access to early diagnosis and treatment and educate children about oral health.

ODJFS Expectations
Managed care plans must meet a minimum performance standard for this measure for the CY 2006 report period, in accordance with the MCP provider agreement dated July 1, 2006, Appendix M, Performance Evaluation. The results for this measure are also used to determined if an MCP qualifies for financial incentives in accordance with Appendix O, Performance Incentives, of the Provider Agreement.

Minimum Performance Standard: The level of improvement must result in at least a 10% decrease in the difference between the target (60%) and the previous year's results.

Methods

Measure: The percentage of enrolled members ages 4 through 21 who were enrolled for at least 11 months with the plan during the reporting year, who were enrolled during the last month of the reporting year, and who had at least one dental visit during the reporting year.

Numerator: One (or more) dental visits with a dental practitioner during the reporting year.

Denominator: The eligible population.

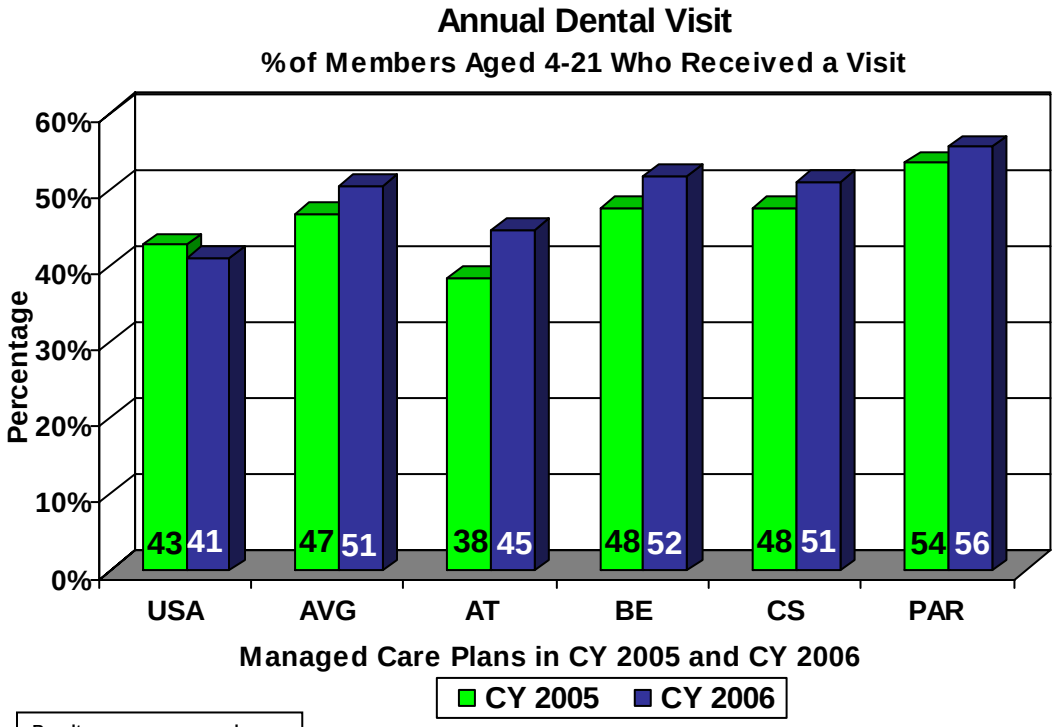
Data Source: Encounter Data

See Appendix A for more detailed information on the methods for calculating this measure.

Results

The percentage of members ages 4-21 years of age who received at least one dental visit increased from 47% in CY 2005 to 51% in CY 2006. The average for the Medicaid serving plans in Ohio was higher than the national average (41%) – see Graph H-1.

Graph H-1.



Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Source of Data: Encounter Data and NCQA (Measurement Year 2005, 2006)

Lead Testing (for 1 Year Olds and for 2 Year Olds)

(MCP Contract Measure)

Purpose

Since Ohio is a highly industrialized state with older housing, the risk of lead exposure and lead poisoning for children in Ohio is higher than for children in states with newer housing. Lead poisoning in children can reduce IQ and cause learning disabilities. At higher exposures, lead can damage a child's kidneys and central nervous system and cause anemia, coma, convulsions, and even death.

Within the Ohio Medicaid program, blood lead screening is required as part of Healthchek (the Early and Periodic Screening and Diagnostic Testing (EPSDT) program). According to EPSDT standards, blood lead screening is required of all Medicaid children at ages one and two years.

ODJFS Expectations
Managed care plans must meet a minimum performance standard for this measure for the CY 2006 report period, in accordance with the MCP provider agreement dated July 1, 2006, Appendix M, Performance Evaluation. The results for this measure will also be used to help determine if an MCP qualifies for financial incentives in accordance with Appendix O, Performance Incentives, of the Provider Agreement.

Minimum Performance Standard: The level of improvement must result in at least a 10% decrease in the difference between the target (80%) and the previous year's results.

Methods (1 Year Olds)

Measure: The percentage of enrolled members who turned 15 months old during the reporting year, who were enrolled in the MCP from 9 months through 15 months of age (allowing for a one month gap in MCP enrollment), who were enrolled in the MCP during their 15th month of life, and who received a lead screening test.

Numerator: The number of children in the denominator who received a lead screening test.

Denominator: The number of enrolled members who turned 15 months old during the reporting year, who were enrolled in the MCP from 9 months through 15 months of age (allowing for a one month gap in MCP enrollment), and who were enrolled in the MCP during their 15th month of life.

Data Source: Encounter Data

See Appendix A for more detailed information on the methods for calculating this measure.

Methods (2 Year Olds)

Measure: The percentage of enrolled members who turned 27 months old during the reporting year, who were enrolled in the MCP from 21 months through 27 months of age (allowing for a one month gap in MCP enrollment), who were enrolled in the MCP during their 27th month of life, and who received a lead screening test.

Numerator: The number of children in the denominator who received a lead screening test.

Denominator: The number of enrolled members who turned 27 months old during the reporting year, who were enrolled in the MCP from 21 months through 27 months of age (allowing for a one month gap in MCP enrollment), and who were enrolled in the MCP during their 27th month of life.

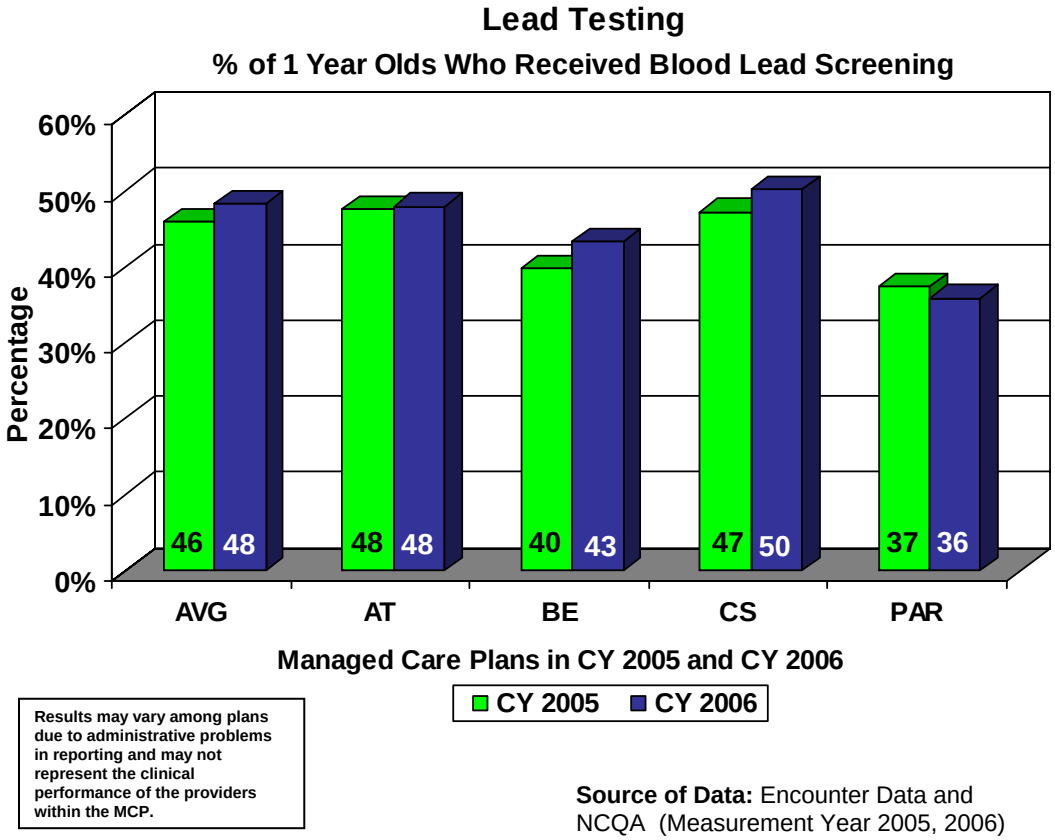
Data Source: Encounter Data

See Appendix A for more detailed information on the methods for calculating this measure.

Results

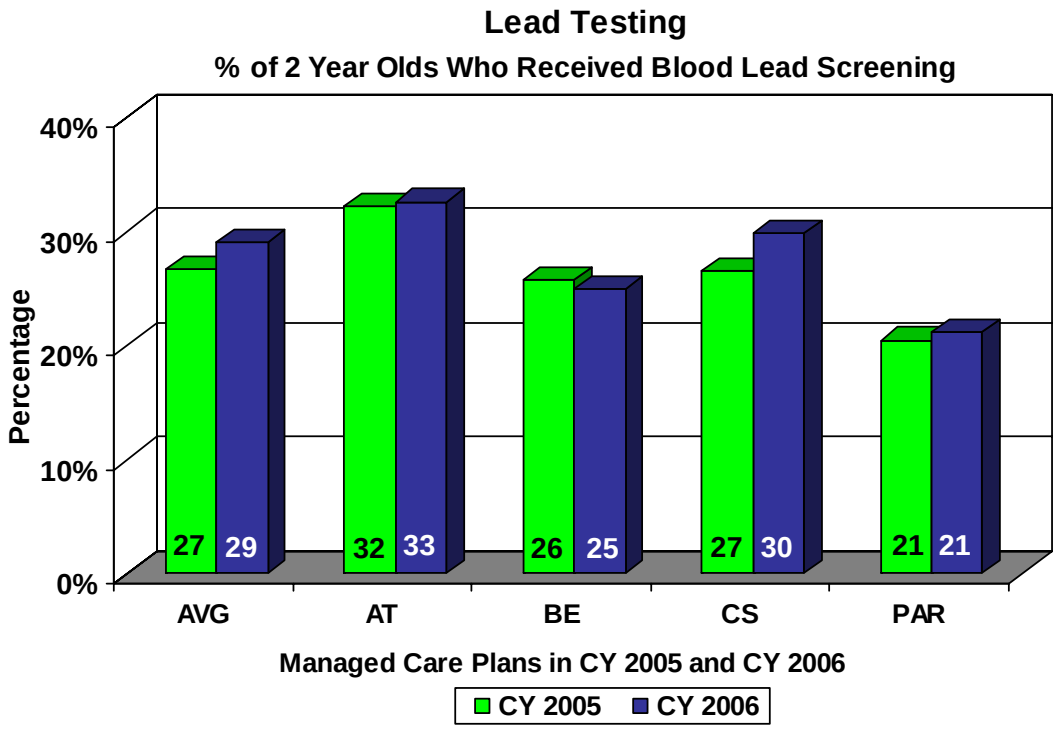
The percentage of enrolled members who turned 15 months old during the reporting year and who received a lead test between the ages of 9 months and the end of their 15 month of life was 46% in CY 2005 and increased to 48% in CY 2006. The percentage of enrolled members who turned 27 months old during the reporting year and who received a lead test between the ages of 21 months and the end of their 27 month of life was 27% in CY 2005 and increased to 29% in CY 2006 (Note Graph I-2).

Graph I-1.



Source of Data: Encounter Data and NCQA (Measurement Year 2005, 2006)

Graph I-2.



Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Source of Data: Encounter Data and NCQA (Measurement Year 2005, 2006)

IV. CHRONIC CARE MEASURES

Use of Appropriate Medication for People With Asthma

(MCP Contract Measure)

Purpose

Asthma is a chronic, inflammatory disease of the respiratory system. The symptoms of asthma are coughing, wheezing, chest tightness, and difficulty breathing. These symptoms are usually reversible, but can be severe. Anti-inflammatory medications such as inhaled corticosteriods and cromolyn sodium are the primary therapy for the chronic care of moderate and severe asthma. The medications are used to reverse and prevent airflow obstruction. Corticosteriods are currently the most effective anti-inflammatory drugs for the treatment of asthma.[11] Cromolyn sodium is a non-steroidal, inhaled anti-inflammatory drug. Without proper medication management and control of the factors which trigger attacks, patients may experience potentially life threatening attacks and have high rates of emergency room utilization.

ODJFS Expectations

Managed care plans must meet a minimum performance standard for this measure for the CY 2006 report period, in accordance with the MCP provider agreement dated July 1, 2006, Appendix M, Performance Evaluation. The results for this measure are also used to determined if an MCP qualifies for financial incentives in accordance with Appendix O, Performance Incentives, of the Provider Agreement.

Minimum Performance Standard: The level of improvement must result in at least a 10% decrease in the difference between the target (80%) and the previous year's results.

Methods

Measure: The percentage of members ages 5 through 56 with persistent asthma who were enrolled for at least 11 months with the plan during the reporting year, who were enrolled at least 11 months during the year prior to the reporting year, who were enrolled during the last month of the reporting year, and who received prescribed medications acceptable as primary therapy for long-term control of asthma.

Numerator: For each member in the denominator, those who had at least one dispensed prescription of the recommended medications during the reporting year. The NDC list provided on NCQA's Web site at http://www.ncqa.org is used to identify these medications.

Denominator: The eligible population.

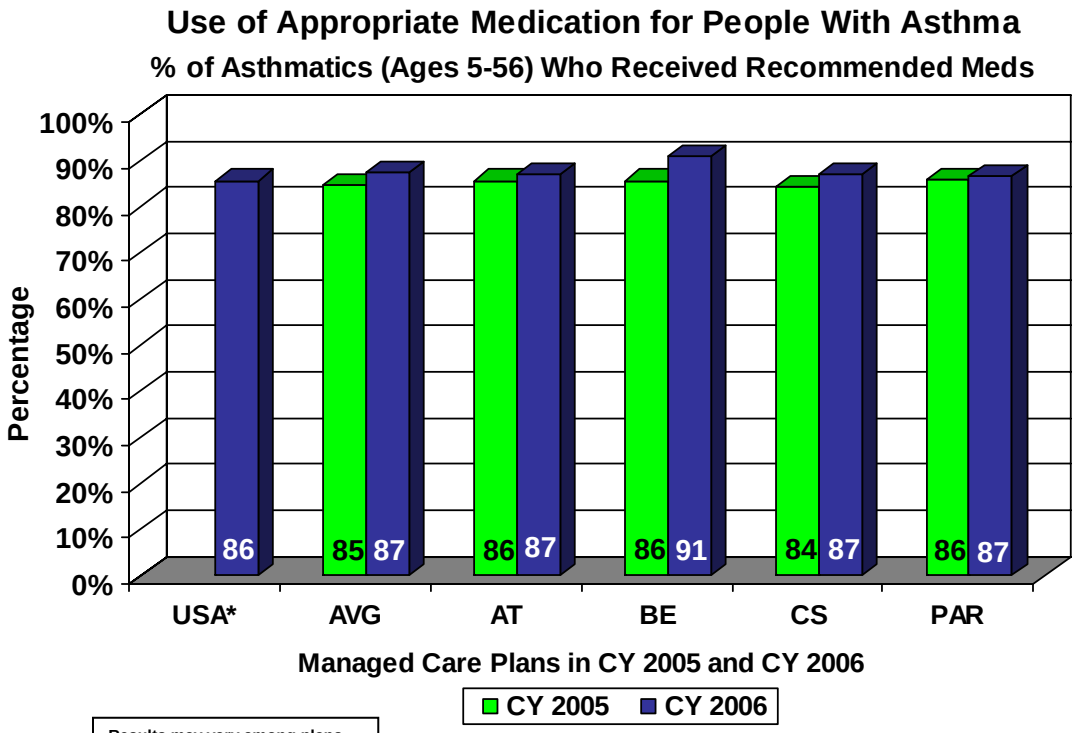
Data Source: Encounter Data

See Appendix A for more detailed information on the methods for calculating this measure.

Results

The percentage of members with persistent asthma who received prescribed medications acceptable as primary therapy for long-term control of asthma increased from 85% in CY 2005 to 87% in CY 2006. This rate is greater than the national Medicaid average of 86%.

Graph K-1.



Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Source of Data: Encounter Data and NCQA (Measurement Year 2005, 2006)

** USA not reported for 2005 due to methodology change*

Comprehensive Diabetes Care

Purpose

From 1950 through 2003, diabetes has been one of the top ten leading causes of death in the United States.[12] It was estimated that 7% of the general U.S. population had diabetes in 2005.[13] Individuals with diabetes have almost two times the risk of death, compared to someone without diabetes.[14] Many of the complications from diabetes, including blindness, nephropathy, and neuropathy, can be prevented if detected and addressed in the early stages. Since diabetes affects multiple organs and requires the involvement of a multidisciplinary team, the performance measure has multiple components. When taken together, the various components provide an overview of the care that is being provided to persons with diabetes.

Minimum Performance Standard: There is no performance standard for this measure.

Methods

Measure: The percentage of members with diabetes (Types 1 or 2) ages 18 through 75 who were enrolled for at least 11 months with the plan during the reporting year, who were enrolled during the last month of the reporting year, and who received each of the following: (1) Hemoglobin A1c (HbA1c) testing; (2) a retinal exam by an optometrist or ophthalmologist; (3) LDL-C screening; and (4) screening or treatment for nephropathy.

Numerator: The number of members in the denominator who received each of the following: (1) HbA1c testing during the reporting year; (2) a retinal exam by an optometrist or ophthalmologist during the reporting year; (3) LDL-C screening during the reporting year or the year prior to the reporting year; and (4) screening or treatment for nephropathy.

Denominator: The number of members with diabetes (Types 1 or 2) ages 18 through 75 who were enrolled for at least 11 months with the plan during the reporting year and who were enrolled during the last month of the reporting year.

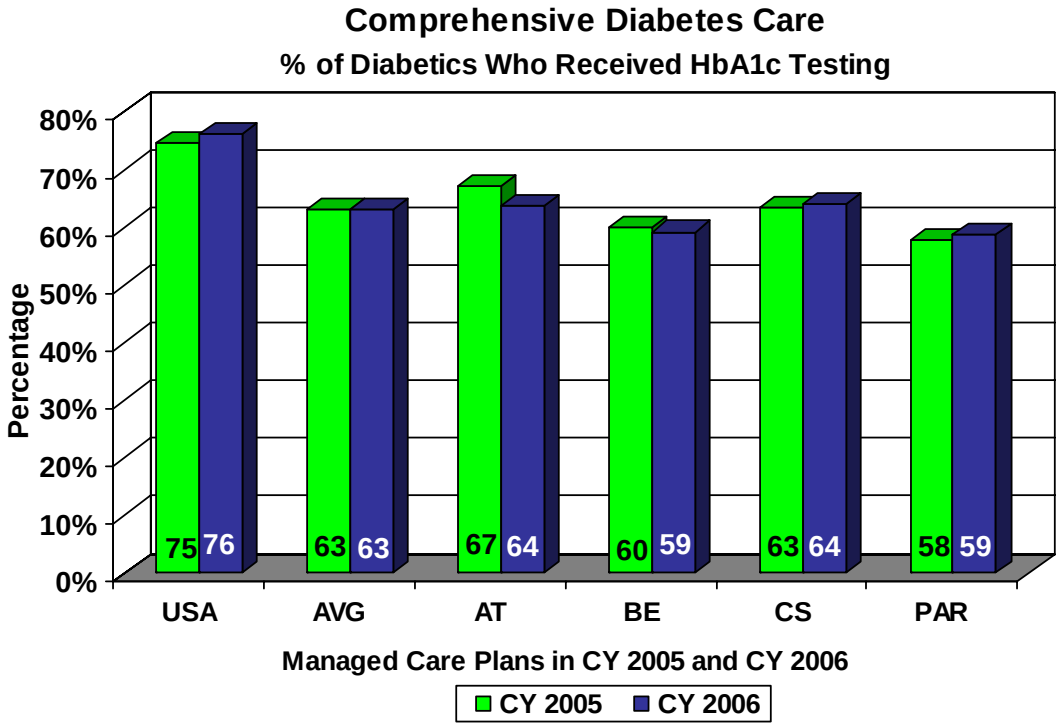
Data Source: Encounter Data

See Appendix A for more detailed information on the methods for calculating this measure.

Results

As shown in Graph L-1, the percentage of members (ages 18-75) with diabetes mellitus who received HbA1c testing remained steady from CY 2005 to CY 2006 (63%). The percentage of diabetics who received an eye exam increased from 31% in CY 2005 to 33% in CY 2006 (Note Graph L-2). LDL-C screening rates increased slightly (see Graph L-3), going from 65% in CY 2005 to 66% in CY 2006. The percentage of diabetics who were monitored for nephropathy decreased from 35% in CY 2005 to 27% in CY 2006 (Graph L-4).

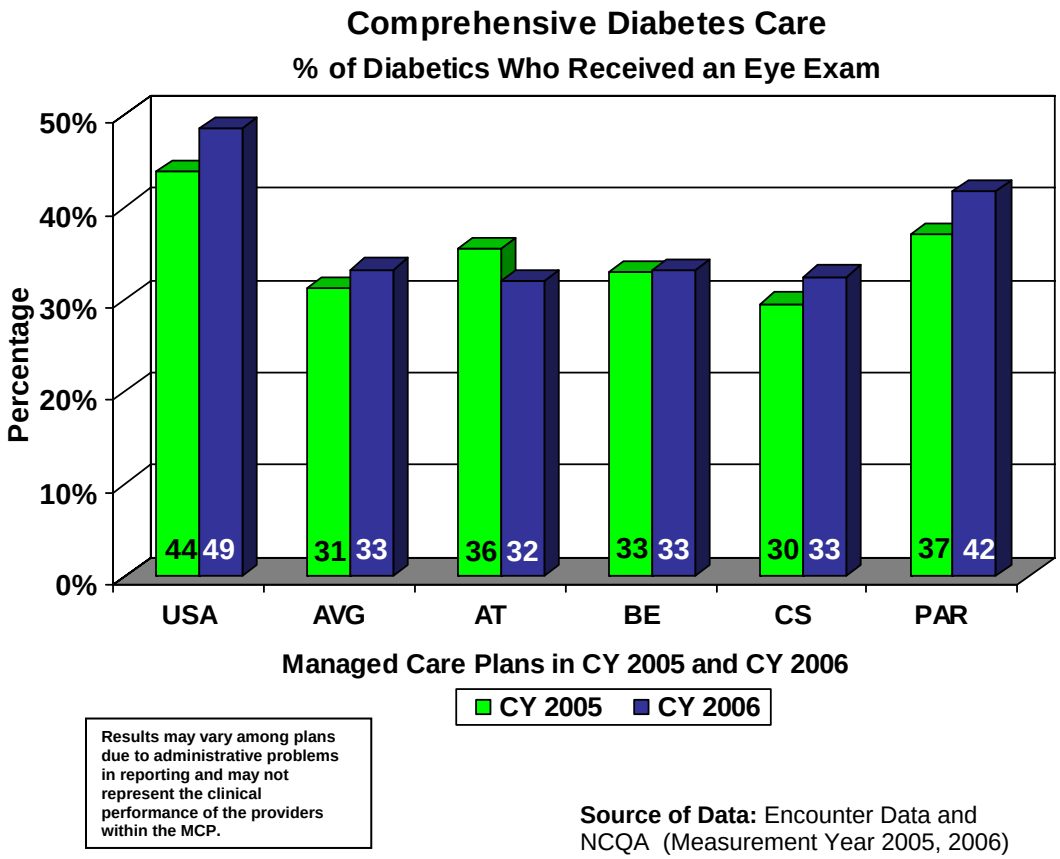
Graph L-1.



Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Source of Data: Encounter Data and NCQA (Measurement Year 2005, 2006)

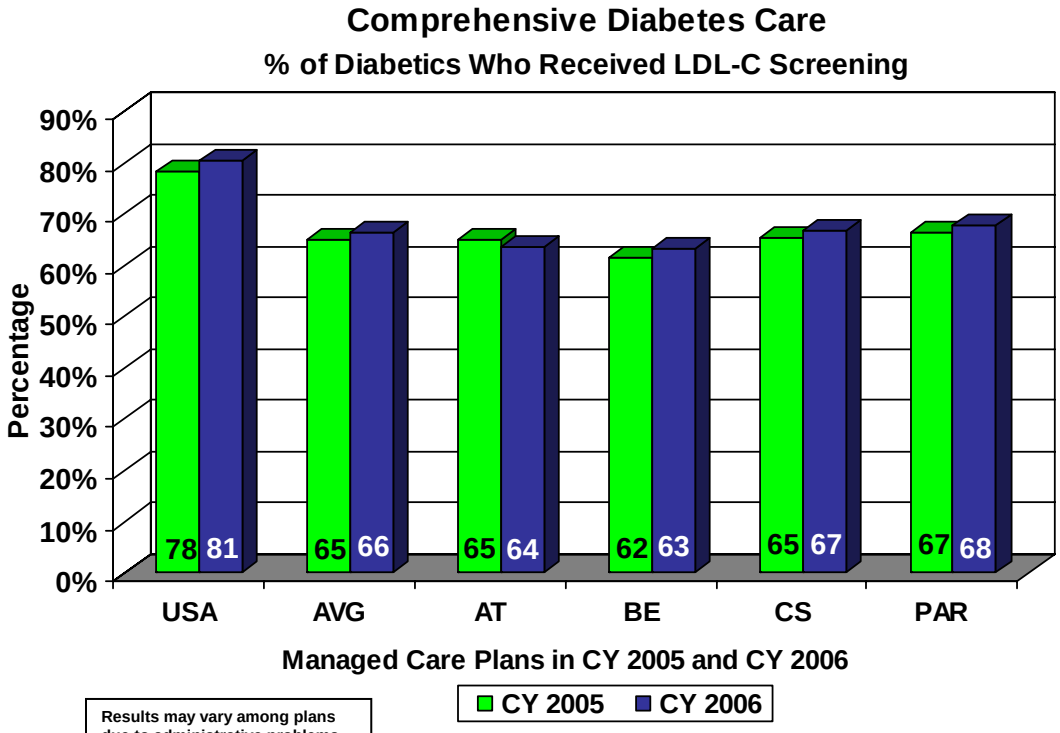
Graph L-2.



Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Source of Data: Encounter Data and NCQA (Measurement Year 2005, 2006)

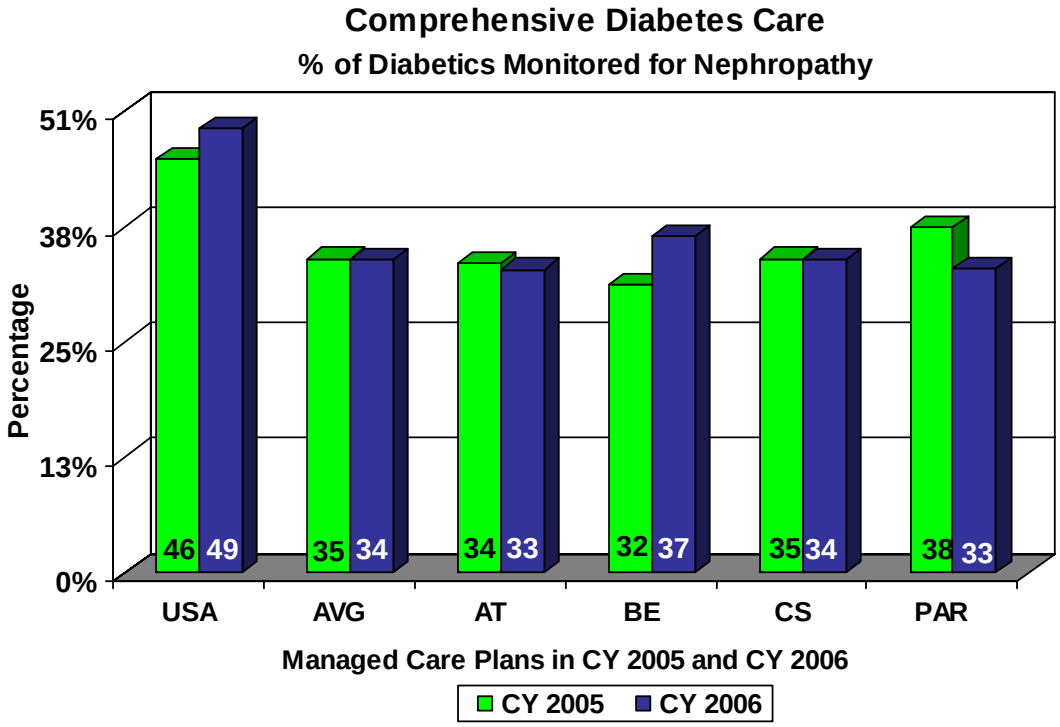
Graph L-3.



Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Source of Data: Encounter Data and NCQA (Measurement Year 2005, 2006)

Graph L-4.



Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.

Source of Data: Encounter Data and NCQA (Measurement Year 2005, 2006)

Appendix A

ODJFS Methods for Clinical Performance Measures

Covered Families & Children (CFC) Program

These methods are, for the most part, consistent with the HEDIS performance measurement methods, as outlined in NCQA HEDIS 2006 Technical Specifications manual. The main difference between the ODJFS methods and the HEDIS methods is that, in some cases, it has been necessary to include additional codes that are not listed in the HEDIS methods. Codes that are not listed in HEDIS, but have been added are identified with the symbol '+'.

The source of the data is as follows:
(1) MCP submitted encounter data to obtain encounters.
(2) ODJFS provider master file to identify primary care practitioners.
(3) ODJFS recipient master file to obtain recipient demographic and eligibility information.

Initiation of Prenatal Care

The percentage of women who delivered (a) live birth(s) during the reporting year, who were enrolled in the MCP no more than 279 days but at least 43 days prior to delivery with no gaps in MCP enrollment, and who had their first prenatal visit within 42 days of enrollment or by the end of the first trimester for those women who enrolled in the MCP during the early stage of pregnancy.

Numerator: One (or more) prenatal care visit(s) within 42 days of enrollment in the MCP or within the first trimester if the member enrolled more than 42 days prior to the end of the first trimester.
Denominator: The eligible population.

Data Source: Encounter Data

Report Period: January 1, 2006 - December 31, 2006

The last menstrual period (LMP) field is used to determine the end date of the first trimester. If no last menstrual period date is provided, as required, or the date is invalid, then the length of the pregnancy is set at 38.5 weeks except if an encounter is found for the newborn indicating a pre-term birth. The length of the pregnancy is set at 28 weeks where the diagnosis was 7650.x (Extreme immaturity). If there was a diagnosis of 7651.x (Other preterm infants) then the length of the pregnancy is set at 33 weeks.

If the LMP date is from 119 to 315 days before the date the recipient gave birth, then the LMP date is considered a valid date. The LMP date is obtained from encounter data.

Codes to Identify Live Births

ICD-9-CM Diagnosis Codes
650 - Normal Delivery
V27.0 - Single liveborn
V27.2 - Twins, both liveborn
V27.3 - Twins, one liveborn and one stillborn
V27.5 - Other multiple birth, all liveborn
V27.6 - Other multiple birth, some liveborn

ICD-9-CM Diagnosis Codes*
V30 - Single liveborn
V31 - Twin, mate liveborn
V32 - Twin, mate stillborn
V33 - Twin, unspecified
V34 - Other multiple, mates all liveborn
V35 - Other multiple, mates all stillborn
V36 - Other multiple, mates live- and stillborn
V37 - Other multiple, unspecified
V39 - Unspecified

* These codes must have a matching delivery encounter to be included.

The infant record contains (or is supposed to contain) the infant's Medicaid identification number. Therefore, it is necessary to match these encounters against the delivery encounters to obtain the mother's recipient identification number, which is used to obtain the prenatal and postpartum visits and to identify whether a C-section delivery occurred. Listed below are the codes used to identify deliveries (these are the same codes used to reimburse the plans for deliveries as part of the delivery payment).

Codes Used To Identify Deliveries

ICD-9 Procedure Codes:

72.x Forceps, vacuum, and breech delivery
73.x Other procedures inducing or assisting delivery
74.0 Cesarean section and removal of fetus; Classical cesarean section
74.1 Cesarean section and removal of fetus; Low cervical cesarean section
74.2 Cesarean section and removal of fetus; Extraperitoneal cesarean section
74.4 Cesarean section and removal of fetus; Cesarean section of other specified type
74.99 Cesarean section of unspecified type

ICD-9 Diagnosis Codes:

650 Normal Delivery
V27.0 Single liveborn
V27.2 Twins, both liveborn
V27.3 Twins, one liveborn and one stillborn
V27.5 Other multiple birth, all liveborn
V27.6 Other multiple birth, some liveborn

The following codes must have a 5th digit equal to 1 or 2:

640-648; Complications mainly related to pregnancy
651-659; Normal delivery and other indications for care in pregnancy, labor, and delivery
660-669; Complications occurring mainly during the course of labor and delivery
670-676; Complications of the puerperium.

CPT Codes:

59409 Vaginal delivery (with or without episiotomy and/or forceps)
59514 Cesarean delivery only
59612 Vaginal delivery only, after previous cesarean delivery (with or with our episiotomy and/or forceps)
59620 Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery

Births are included in the denominator only if the provider type (from the ODJFS provider master file) is 01 (General Hospital), 15 (Birthing Center), 71 (Nurse Midwife) or the provider type is 20 (Physician, Ind.), 21 (Physician, Group), 22 (Osteopath, Ind.), 23 (Osteopath, Group) with a specialty code of 01 (General Practice) , 15 (Internal Medicine) , 16 (Pediatrics) , 51 (General Surgery) , 53 (OB/GYN-MD) , 60 (Emergency Medicine) , or 71 (OB/GYN-DO).

Methods for Matching Infants and Mothers Encounters

The infants and mothers encounters are matched using the following two methods:

1) Same last name, same three digit submitter number, and the infant's admission date is within 14 days before or 14 days after the mother's delivery stay;

OR

2) Same address and zip code, same three digit submitter number, and the infant's admission date is within 14 days before or 14 days after the mother's delivery stay.

If a newborn encounter matches to more than one mother delivery encounter and, consequently, it is not possible to determine which mother the newborn is associated with, then the matched encounter will not be included in the denominator. However, it continues to be possible for the mother's encounter to be included in the denominator if the mother's encounter contains one of the following diagnosis codes:

650 - Normal Delivery
V27.0 - Single liveborn
V27.2 - Twins, both liveborn
V27.3 - Twins, one liveborn and one stillborn
V27.5 - Other multiple birth, all liveborn
V27.6 - Other multiple birth, some liveborn

Prenatal Care Visit Codes

HEDIS 2006 outlines four decision rules for identifying prenatal visits. The first decision rule includes using codes specific to antepartum care such as CPT-4 code 59425. The second rule requires a visit to a midwife or OB provider with procedure or diagnosis based evidence of prenatal care. The third decision rule requires a visit to a family practitioner or other primary care provider with diagnostic and procedure based evidence of prenatal care. The fourth decision rule uses CPT-4 codes in conjunction with a plan's internal codes.

In an attempt to capture all prenatal visits, ODJFS used decision rule one and a modified version of decision rule two to select prenatal visits. Under the first ODJFS decision rule, a visit was selected if any of the codes listed below were present, the visit occurred not more than 44 weeks prior to delivery, and the visit date preceded the hospital admission date in which the baby was delivered. This latter requirement was imposed since some of the same codes cover antepartum care, intrapartum care, and postpartum care.

Decision Rule 1:

CPT-4	Description
59400	Routine obstetric care including antepartum care, vaginal delivery and postpartum care
59425	Antepartum care only; 4-6 visits
59426	Antepartum care, 7 or more visits
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
59610	Routine obstetric care including antepartum care, vaginal delivery, and postpartum care, after previous cesarean delivery
59618	Routine obstetric care including antepartum care, vaginal delivery, and postpartum care following attempted vaginal delivery after previous cesarean delivery

The CPT codes listed above are global codes (i.e., more than one visit is billed under the same code) that are not reimbursed under the fee-for-service system. However, a number of MCPs submitted these codes and so they were included. It is not possible for ODJFS to determine the number of visits that occurred unless there is a separate date of service for each visit that is included in the global code. As a result, the only visits that were counted under these codes were those where there was a separate date of service. For example, if code 59425 was submitted and had one date of service then only one prenatal visit was counted. However, if this same code was submitted along with three dates of service for the MCP member, then three prenatal visits were counted.

Under the second ODJFS decision rule, a visit was selected if all of the following criteria were met and the date of the visit preceded the hospital admission date in which the baby was delivered:

Decision Rule 2:

CPT-4 = 99201-99205 (office visit) **or** 99211-99215 **or** 99241-99245 **or** 99271-99275
or Revenue Code 514 (OB/GYN Clinic)

with either

CPT-4 = 76801 (ultrasound, pregnant uterus),
76802 (ultrasound, each additional gestation),
76805 (ultrasound, pregnant uterus),
76810 (ultrasound, pregnant uterus, each additional gestation)
76811 (ultrasound, pregnant uterus),
76812 (ultrasound, each additional gestation),
76815 (limited echography, pregnant uterus),
76816 (follow-up or repeat echography, pregnant uterus),
76817 (ultrasound, pregnant uterus),
76818 (fetal biophysical profile),
80055 (obstetric panel lab),
86644 (CMV,IgM) & (86694 or 86695 or 86696 (herpes simplex)) & 86762 (rubella) & 86777 (toxoplasma),
86762 (rubella immunoassay) with 86900 (Blood Typing; ABO),
86762 (rubella immunoassay) with 86901 (Blood Typing; RhD),

OR

ICD-9-CM = (640.0x-648.9x or 651.0x-659.9x) where x (fifth digit) = 3;
V code = V22-V23 or V28; or Occurrence code=10.

Under decision rule two, HEDIS only includes the visits if they were made to a midwife or OB provider. At this time, this requirement will not be imposed to ensure that all visits are counted.

Frequency of Ongoing Prenatal Care

The percentage of Medicaid-enrolled women who had a live birth during the reporting year and who received less than 21%, 21% through 40%, 41% through 60%, 61% through 80%, or greater than or equal to 81% of the expected number of prenatal care visits, adjusted for gestational age and the month the member enrolled in the MCP.

Numerator: Women who had an unduplicated count of less than 21%, 21% through 40%, 41% through 60%, 61% through 80%, or greater than or equal to 81% of the expected number of prenatal care visits, adjusted for gestational age and the month the member enrolled in the MCP.

Denominator: The number of Medicaid MCP members who had a live birth during the reporting year.

Data Source: Encounter Data

Report Period: January 1, 2006 -December 31, 2006

Prenatal care visits are selected using the same codes as outlined in the 'Initiation of Prenatal Care' measure. When calculating the Frequency of Ongoing Prenatal Care measure, a prenatal visit on the date of delivery can count as a prenatal visit.

The ODJFS made adjustments for the length of gestation and the length of time that a member was in the MCP prior to giving birth. For example, a recipient who enrolled in the MCP during the first month of pregnancy and who had a pregnancy lasting 38 weeks would be expected to have 12 prenatal visits whereas a recipient who enrolled in the MCP during the fifth month of pregnancy with a pregnancy of 30 weeks would be expected to have only two prenatal visits. The ODJFS used the index (shown below) to determine the expected number of visits, which is based on recommendations from the American College of Obstetricians and Gynecologists (ACOG).

Expected Number of Prenatal Visits for a Given Gestational Age and Month the Member Enrolled in the MCP																	
Month of Pregnancy Member Enrolled in the MCP	Gestational Age in Weeks																
	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44
9th	-	-	-	-	-	-	-	-	-	-	-	1	1	2	3	4	5
8th	-	-	-	-	-	-	1	1	1	2	3	4	5	6	7	8	9
7th	-	-	1	1	1	1	2	2	3	4	5	6	7	8	9	10	11
6th	1	1	1	1	2	2	3	3	4	5	6	7	8	9	10	11	12
5th	1	1	2	2	3	3	4	4	5	6	7	8	9	10	11	12	13
4th	3	3	4	4	5	5	6	6	7	8	9	10	11	12	13	14	15
3rd	4	4	5	5	6	6	7	7	8	9	10	11	12	13	14	15	16
2nd	5	5	6	6	7	7	8	8	9	10	11	12	13	14	15	16	17
1st	6	6	7	7	8	8	9	9	10	11	12	13	14	15	16	17	18

For deliveries with a gestational age less than 28 weeks, the expected number of visits is calculated based on the month of pregnancy the member enrolled in the MCP and ACOG's recommended schedule of visits (one visit every four weeks).

The last menstrual period field is used to help determine the 'gestational age'. Gestational age is defined as the number of completed weeks that have elapsed between the first day of the last menstrual period and the date of deliver. If gestational age is calculated in fractions of a week, then the number is rounded down to the lower whole number.

Cesarean Section Rate

The percentage of women who had a live birth during the reporting year who delivered by a Cesarean Section.

Numerator: Number of discharges for women who had a C-section resulting in a live birth during the reporting year.

Denominator: Number of discharges for women who had a delivery (vaginal or C-section) resulting in a live birth during the reporting year. Live births are identified using the same codes outlined in the 'Initiation of Prenatal Care' measure.

Data Source: Encounter Data

Report Period: January 1, 2006 -December 31, 2006

Codes to Identify C-Sections

ICD-9-CM
74.0-74.2, 74.4 or 74.99

CPT Codes
59510, 59514, 59515, 59618, 59620, 59622

Low Birth Weight Measure

The percentage of women who gave birth to a low-birth weight newborn during the reporting year.

Numerator: The number of births in the denominator with a birth weight less than or equal to 2,500 grams.

Denominator: The number of Medicaid MCP members who had a live birth during the reporting year and who had at least five months of continuous enrollment immediately prior to the birth. Live births are identified using the same codes outlined in the Initiation of Prenatal Care measure.

Data Source: Encounter Data, birth weight is obtained from condition code fields.

Report Period: January 1, 2006 -December 31, 2006

Very Low Birth Weight Measure

The percentage of women who gave birth to a very low-birth weight newborn during the reporting year.

Numerator: The number of births in the denominator with a birth weight less than or equal to 1,500 grams.

Denominator: The number of Medicaid MCP members who had a live birth during the reporting year and who had at least five months of continuous enrollment immediately prior to the birth. Live births are identified using the same codes outlined in the Initiation of Prenatal Care measure.

Data Source: Encounter Data, birth weight is obtained from condition code fields.

Report Period: January 1, 2006 -December 31, 2006

Postpartum Care

The percentage of enrolled women who delivered (a) live birth(s) during the reporting year who were continuously enrolled for 56 days after delivery and who had a postpartum visit on or between 21 days and 56 days after delivery.

Numerator: A postpartum visit on or between 21 and 56 days after delivery.

Denominator: The eligible population. Live births are identified using the same codes outlined in the 'Initiation of Prenatal Care' measure.

Data Source: Encounter Data

Report Period: January 1, 2006-December 31, 2006

Codes to Identify Postpartum Visits

ICD-9 Codes

91.46	Microscopic exam of specimen from female genital tract
V24.1	Lactating mother
V24.2	Routine postpartum follow-up
V25.1	Insertion of intrauterine contraceptive device
V72.3	Gynecological exam
V76.2	Special screening for malignant neoplasm (cervix)

Revenue Codes

923 (Pap Smear)

CPT-4	Description
57170	Diaphragm cervical cap fitting
58300	Insertion of intrauterine device
59400	Routine obstetric care including antepartum care, vaginal delivery, and postpartum care
59410	Vaginal delivery, including postpartum care
59430	Postpartum care only
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
59515	Cesarean delivery only, including postpartum care
59610	Routine obstetric care including antepartum care, vaginal delivery, and postpartum care after previous cesarean delivery
59614	Vaginal delivery only, after previous cesarean delivery, including postpartum care
59618	Routine obstetric care including antepartum care, vaginal delivery, and postpartum care following attempted vaginal delivery after previous cesarean delivery
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery, including postpartum care
88141-88145	Cytopathology, cervical or vaginal
88147-88148	Cytopathology smears
88150-88155	Cytopathology slides
88164-88167	Cytopathology slides
88174-88175	Cytopathology, cervical or vaginal

Well Child Visits in the First 15 Months of Life

The percentage of enrolled members who turned 15 months old during the reporting year, who were enrolled in the MCP from the month after the month in which they were born through their 15th month of life (allowing for a one month gap in MCP enrollment), who were enrolled during their 15th month of life, and who received either zero, one, two, three, four, five, or six or more well-child visits with a primary care practitioner during their first 15 months of life.

Numerator: Seven separate numerators are calculated, corresponding to the number of members who received: zero, one, two, three, four, five, and six or more well-child visits with a primary care practitioner during their first 15 months of life. A child is included in only one numerator (e.g., a child receiving six well child visits is not included in the rate for five, four, or fewer well child visits).

Denominator: The eligible population.

Data Source: Encounter Data

Report Period: January 1, 2006-December 31, 2006

Codes to Identify Well-Child Visits

CPT-4 Codes

99381 Initial preventive medicine - New Patient (Age Group Infant)
99382 Initial preventive medicine - New Patient (Age Group 1-4 year old)
99391 Periodic preventive medicine - Established Patient (Age Group Infant)
99392 Periodic preventive medicine - Established Patient (Age Group 1-4 year old)
99432 Other than Hospitals or Birthing Rooms (Age Group Newborn)

ICD-9-CM Codes

V20.2 Routine Infant or Child Health Check
V70.0 Routine general medical exam at a health care facility
V70.3 Other Medical Examination for Administrative Purposes
V70.5 Health examination of defined subpopulation
V70.6 Health examination in population surveys
V70.8 Other specified general medical examinations
V70.9 Unspecified general medical examinations

The provider number currently given on the encounter data claim is incorrectly, in some cases, the provider number of the hospital where the physician gives services and is not the provider number of the physician who provided services. Therefore, it was not possible to match the PCPs listed in the Provider Verification System against the encounter data claims as a way of identifying visits that were made to PCPs. For this reason, it was necessary to use the ODJFS Provider Master File as the source of the PCP information. The following codes were used to accomplish this task:

Codes to Identify Primary Care Practitioners

Provider Type
01 (General Hospital)
04 (Outpatient Health Facility)
05 (Rural Health Facility)
09 (Maternal/Child Health Clinic - 9 mo.)
12 (Federally Qualified Health Center)
50 (Comprehensive Clinic)
52 (Public Health Dept. Clinic)
72 (Nurse, Practitioner)

OR

Physician Specialty Code
01 (General Practice)
15 (Internal Medicine)
16 (Pediatrics)
18 (Preventative Medicine)
53 (Obstetrics & Gynecology)
71 (Obstetrics & Gynecology – Osteopath)

OR

Provider Type of 20 (Physician, Individual), 21 (Physician, Group), 22 (Osteopath, Individual), or 23 (Osteopath, Group) where specialty code is 99 (unspecified) or is not indicated.

If a provider was identified on the Provider Master File with any of the preceding codes, then they were recognized as a PCP.

Well Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life

The percentage of members who were three, four, five, or six during the reporting year, who were enrolled for at least 11 months with the plan during the reporting year, who were enrolled during the last month of the reporting year, and who received one or more well-child visit(s) with a primary care practitioner during the reporting year.

Numerator: At least one well-child visit with a primary care practitioner during the reporting year. The primary care practitioner does not have to be the practitioner assigned to the child.

Denominator: The eligible population.

Data Source: Encounter Data

Report Period: January 1, 2006-December 31, 2006

Codes to Identify Well-Child Visits

CPT-4 Codes

99382 Initial preventive medicine - New patient - (Age Group 1 through 4)
99383 Initial preventive medicine - New patient (Age Group 5 through 11)
99392 Periodic preventive medicine - Established Patient (Age Group 1 through 4)
99393 Periodic preventive medicine - Established Patient (Age Group 5 through 11)

ICD-9-CM Codes

V20.2 Routine Infant or Child Health Check
V70.0 Routine general medical exam at a health care facility
V70.3 Other Medical Examination for Administrative Purposes
V70.5 Health examination of defined subpopulation
V70.6 Health examination in population surveys
V70.8 Other specified general medical examinations
V70.9 Unspecified general medical examinations

See codes for identifying primary care practitioners under 'Well Child Visits in the First 15 Months of Life' performance measure.

Adolescent Well-Care Visits

The percentage of enrolled members who were age 12 through 21 during the reporting year, who were enrolled for at least 11 months with the plan during the reporting year, who were enrolled during the last month of the reporting year, and who received at least one comprehensive well-care visit with a primary care practitioner during the reporting year.

Numerator: At least one well-child visit with a primary care practitioner during the reporting year. The primary care practitioner does not have to be the practitioner assigned to the member.

Denominator: The eligible population.

Data Source: Encounter Data

Report Period: January 1, 2006-December 31, 2006

Codes to Identify Adolescent Well-Care Visits

CPT-4 Codes

99383 Initial preventive medicine - New patient (Age Group 5 through 11)
99384 Initial preventive medicine - New patient (Age Group 12 through 17)
99385 Initial preventive medicine - New patient (Age Group 18 through 39)
99393 Periodic preventive medicine - Established Patient (Age Group 5 through 11)
99394 Periodic preventive medicine - Established Patient (Age Group 12 through 17)
99395 Periodic preventive medicine - Established Patient (Age Group 18 through 39)

ICD-9-CM Codes

V20.2 Routine Infant or Child Health Check
V70.0 Routine General Medical Examination at a Health Care Facility (Health Checkup)
V70.3 Other Medical Examination for Administrative Purposes
V70.5 Health examination of defined subpopulation
V70.6 Health examination in population surveys
V70.8 Other specified general medical examinations
V70.9 Unspecified general medical examinations

See codes for identifying primary care practitioners under 'Well Child Visits in the First 15 Months of Life' performance measure.

Annual Dental Visit:

The percentage of enrolled members age 4 through 21 who were enrolled for at least 11 months with the plan during the reporting year, who were enrolled during the last month of the reporting year, and who had at least one dental visit during the reporting year.

Numerator: One (or more) dental visits with a dental practitioner during the reporting year.

Denominator: The eligible population.

Data Source: Encounter Data

Report Period: January 1, 2006-December 31, 2006

Codes to Identify Annual Dental Visits		
CPT Codes	**ICD-9-CM Codes**	**HCPCS Codes**
70300, 70310, 70320, 70350, 70355	23, 24, 87.11, 87.12, 89.31, 93.55, 96.54, 97.22, 97.33-97.35, 99.97	D0120-D0999, D1110-D1550, D2140-D2999, D3110-D3999, D4210-D4999, D5110-D5899, D6010-D6205, D7111-D7999, D8010-D8999, D9110-D9999, T1015+ with a modifier of U2

+ Code not in HEDIS Methods.

Lead Testing For 1 Year Olds

The percentage of enrolled members who turned 15 months old during the reporting year, who were enrolled in the MCP from 9 months through 15 months of age (allowing for a one month gap in MCP enrollment), who were enrolled in the MCP during their 15th month of life, and who received a lead screening test.

Numerator: The number of children in the denominator who received a lead screening test. CPT-4 codes of 83655 or 83660 are used to identify that the member had a lead screening test.

Denominator: The number of enrolled members who turned 15 months old during the reporting year, who were enrolled in the MCP from 9 months through 15 months of age (allowing for a one month gap in MCP enrollment), and who were enrolled in the MCP during their 15th month of life.

Data Source: Encounter Data

Report Period: January 1, 2006-December 31, 2006

Lead Testing For 2 Year Olds

The percentage of enrolled members who turned 27 months old during the reporting year, who were enrolled in the MCP from 21 months through 27 months of age (allowing for a one month gap in MCP enrollment), who were enrolled in the MCP during their 27th month of life, and who received a lead screening test.

Numerator: The number of children in the denominator who received a lead screening test. CPT-4 codes of 83655 or 83660 are used to identify that the member had a lead screening test.

Denominator: The number of enrolled members who turned 27 months old during the reporting year, who were enrolled in the MCP from 21 months through 27 months of age (allowing for a one month gap in MCP enrollment), and who were enrolled in the MCP during their 27th month of life.

Data Source: Encounter Data

Report Period: January 1, 2006-December 31, 2006

Use of Appropriate Medications for People with Asthma

The percentage of members aged 5 through 56 with persistent asthma who were enrolled for at least 11 months with the plan during the reporting year, who were enrolled at least 11 months during the year prior to the reporting year, and who received prescribed medications acceptable as primary therapy for long-term control of asthma.

Members are identified as having persistent asthma by having ANY of the following during <u>both</u> the reporting year and the year prior to the reporting year:
1. at least four asthma medication dispensing events* (i.e., an asthma medication was dispensed on four occasions)*
OR
2. at least one Emergency Department (ED) visit based on the visit codes below with asthma (ICD-9 code 493) as the principal diagnosis
OR
3. at least one hospitalization based on the visits codes below with asthma (ICD-9 code 493) as the principal diagnosis
OR
4. at least four outpatient asthma visits based on the visit codes below with asthma (ICD-9 code 493) as one of the listed diagnoses AND at least two asthma medication dispensing events.**

* *Exclusions: Members who were prescribed monotherapy of leukotriene modifiers and who do not have a diagnosis of asthma are excluded from the denominator.*

** *Note: A dispensing event is defined as one prescription of an amount lasting 30 days or less. Two different prescriptions dispensed on the same day are counted as two different dispensing events. To calculate dispensing events for prescriptions lasting longer than 30 days, ODJFS divided the drug quantity by 30 and rounded up to convert. For example, a 100-day prescription is equal to 4 dispensing events (100/30=3.33, rounded up to 4). Inhalers count as one dispensing event; for example, an inhaler with a 90-day supply is considered one dispensing event. In addition, multiple inhalers of the same medication filled on the same date of service are counted as one dispensing event; for example, a member may obtain two inhalers on the same date (one for home and one for work), but intend to use both during the same 30-day period.*

Use of Appropriate Medications for People with Asthma (*cont.*)

Numerator: For each member in the denominator, those who had at least one dispensed prescription for inhaled corticosteroids, nedocromil, cromolyn sodium, leukotriene modifiers, or methylxanthines in the reporting year. The NDC list provided on NCQA's Web site at http://www.ncqa.org/Programs/HEDIS/2006/Volume2/NDC/FinalList/index.htm is used to identify these medications.

Denominator: The eligible population.
Data Source: Encounter Data
Report Period: January 1, 2006-December 31, 2006

Codes to Identify ED and Inpatient Asthma Encounters		
Description	**CPT Codes**	**UB-92 Revenue Codes**
Acute Inpatient	99221-99223, 99231-99233, 99238-99239, 99251-99255, 99261-99263, 99291-99292, 99356, 99357	10X-16X, 20X-22X, 72X, 80X, 987
Emergency Department (ED) services	99281-99285	450, 451, 452**,** 459, 981
Outpatient Visit	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99271-99275	456, 510, 515, 516, 517, 520, 521, 523, 526, 76X, 770, 779, 982, 983, 988

Comprehensive Diabetes Care

The percentage of members with diabetes (Types 1 and 2) age 18 through 75 who were enrolled for at least 11 months with the plan during the reporting year, who were enrolled during the last month of the reporting year, and who received each of the following: (1) Hemoglobin A1c (HbA1c) testing; (2) a retinal exam by an optometrist or ophthalmologist; (3) LDL-C screening; and (4) screening or treatment for nephropathy. Individual rates are also calculated.

Numerator: The number of members in the denominator who received each of the following: (1) HbA1c testing during the reporting year; (2) a retinal exam by an optometrist or ophthalmologist during the reporting year; (3) LDL-C screening during the reporting year or the year prior to the reporting year; and (4) screening or treatment for nephropathy.

Denominator: The number of members with diabetes (Types 1 or 2) age 18 through 75 who were enrolled for at least 11 months with the plan during the reporting year and who were enrolled during the last month of the reporting year.

Data Source: Encounter Data

Report Period: January 1, 2006-December 31, 2006

Two methods are provided to identify diabetic members - pharmacy encounter data and non-pharmacy encounter data. Both methods are used to identify the eligible population. However, a member only needs to be identified in one method to be included in the measure. Members may be identified as having diabetes during the reporting year or the year prior to the reporting year.

Pharmacy Encounter Data: Those who were dispensed insulin and/or oral hypoglycemics/antihyperglycemics on an ambulatory basis during the reporting year or the year prior to the reporting year. A list of these medications and the corresponding NDC codes can be found at http://www.ncqa.org/Programs/HEDIS/2006/Volume2/NDC/FinalList/index.htm

Medical Encounter Data: Those who had <u>two</u> face-to-face encounters with different dates of service in an ambulatory setting or non-acute setting or <u>one</u> face-to-face encounter in an acute inpatient or emergency department (ED) setting during the reporting year or the year prior to the reporting year with a diagnosis (principal or secondary) of diabetes. The following codes are used to identify ambulatory or non-acute inpatient and acute inpatient or ED encounters:

Codes to Identify Diabetics Using Encounter Data			
Description	**ICD-9-CM Codes**	**UB-92 Revenue Codes**	**CPT Codes**
Diabetes Diagnosis	250, 357.2, 362.0, 366.41, 648.0		
Outpatient/non-acute inpatient		19X, 456, 49X-53X, 55X-59X, 65X, 66X, 76X, 77X, 82X-85X, 88X, 92X, 94X, 96X, 972-979, 982-986, 988, 989	92002-92014, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99271-99275, 99301-99303, 99311-99313, 99321-99323, 99331-99333, 99341-99355, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99499
Acute inpatient/ED		10X-16X, 20X-22X, 450, 451, 452, 459, 72X, 80X, 981, 987	99221-99223, 99231-99233, 99238-99239, 99251-99255, 99261-99263, 99281-99285, 99291-99292, 99356-99357

Exclusions: Members with steroid induced or gestational diabetes are excluded.

Codes to Identify Steroid Induced and Gestational Diabetes	
Description	ICD-9-CM Codes
Polycystic Ovaries	256.4
Steroid Induced	251.8, 962.0
Gestational Diabetes	648.8

Numerator(s):

1. HBA1c Testing: One (or more) HBA1c test(s) conducted during the reporting year identified through encounter data. CPT code of 83036 (hemoglobin, glycated) is used to identify the test.

2. Eye Exam: An eye screening for diabetic retinal disease during the reporting year by an eye care professional (optometrist or ophthalmologist).

Codes to Identify Eye Exams*	
CPT Codes	ICD-9-CM Codes
67101, 67105, 67107-67108, 67110, 67112, 67141, 67145, 67208, 67210, 67218, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92225, 92226, 92230, 92235, 92240, 92250, 92260, 92287, 99203, 99204, 99205, 99213, 99214, 99215, 99242-99245	14.1-14.5, 14.9, 95.02-95.04, 95.11, 95.12, 95.16, V72.0

* These eye exams by eye care professionals are a proxy for dilated eye examinations because administrative claims alone cannot determine that a dilated exam was performed.

Codes to Identify Eye Care Professionals		
Provider Type		Specialty Code
'35' (Optometrist, Individual) '55' (Professional School Clinic - Optometry) '61' (Optometrist, Group)	**OR**	'54' (Ophthalmology) '72' (Ophthalmology, Otology, Laryngology)

The provider type and specialty code information is obtained from the ODJFS provider master file.

3. LDL-C Screening: An LDL-C test done during the reporting year or the year prior to the reporting year.

Codes to Identify LDL-C Screening
CPT Codes
80061, 83715, 83716, 83721

4. Monitoring for Diabetic Nephropathy: Screening or treatment for nephropathy. This measure is intended to assess whether diabetic patients are being monitored for nephropathy. The following are counted toward the numerator:

- those patients who have been screened for microalbuminuria during the reporting year.
- those patients who already have evidence of nephropathy, as demonstrated by evidence of medical attention for nephropathy during the reporting year or the year prior to the reporting year.

Codes to Identify Microalbuminuria Test
CPT Codes
82042, 82043, 82044, 83518, 84156, 84160*,84165*, 84166* * Codes must be accompanied by CPT 81050 to indicate the test was urinalysis.

Codes to Identify Diabetic Nephropathy			
Description	**CPT Codes**	**ICD-9-CM Codes**	**Revenue Codes**
Evidence of diagnosis and/or treatment of nephropathy	36800, 36810, 36815, 36818, 36819, 36820, 36821, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90920, 90921, 90924, 90925, 90935, 90937, 90945, 90947, 90989, 90993, 90997, 90999, 99512	39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, 55.4-55.6, 250.4, 403, 404, 405.01, 405.11, 405.91, 581.81, 582.9, 583.81, 584-586, 588, 753.0, 753.1, 791.0, V42.0, V45.1, V56	800-804, 809, 820-825, 829-835, 839-845, 849-855, 859-882, 889

Appendix B

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