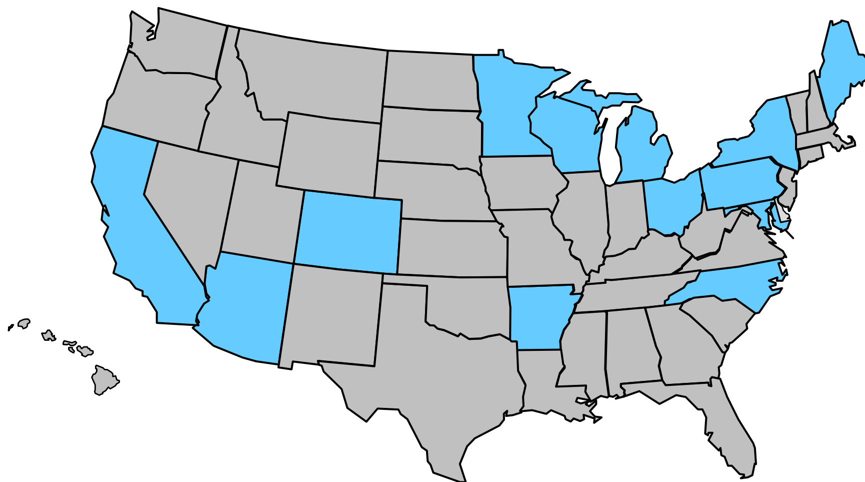
"THIRTEEN STATE MEDICAID CORE PERFORMANCE MEASURE REPORTING SUMMARY: HIGHLIGHTING MODEL PRACTICES"



An Update to the 2005 Ten State Report

Prepared for the
Division of Quality, Evaluation and Health Outcomes

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Center for Medicaid and State Operations

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SUMMARY OF THIRTEEN STATE ANALYSIS

Introduction

The Medicaid Final Rules of June 14, 2002 require that States incorporate performance measurement into their quality strategies for managed care. The Rules also direct the Centers for Medicare & Medicaid Services (CMS) to examine national performance measures.

States face significant challenges generating performance data, thus limiting the availability of performance reports. CMS would like to assist the States in the process of developing core performance measures by surfacing noteworthy quality improvement approaches and providing the States with appropriate tools and guidance.

CMS contracted with Thomson Medstat to undertake several performance measurement activities. As one of these activities, Medstat identified States with leading quality measurement activities and gathered publicly available information on these quality programs. CMS released a report in December 2005 summarizing public performance measurement and reporting noteworthy quality improvement approaches gleaned from a set of ten States, *Ten State Medicaid Core Performance Measure Reporting Summary: Highlighting Model Practices.*

This report expands on that publication by adding three States and adding one year of data, and updating the observations on noteworthy quality improvement approaches. The goal is to provide a profile of the public quality measurement/performance reporting efforts of the 13 States, make overall observations, and identify implications for future quality measurement/ improvement efforts. The goal of the report is *not* to provide comparative performance information.

Each State has a different mix of Medicaid insurance plans including commercial Managed Care Organizations (MCOs), Medicaid-only MCOs, Primary Care Case Management (PCCM), and Fee-For-Service (FFS). The programs and the percent of the total Medicaid population they cover vary significantly from State-to-State. The type of populations served by each program also varies, as well as the range of covered services. All of these factors would affect the inter-State comparability of available publicly reported results.

In addition to the enhancements above, in this report, we included an overview of the performance measure dataset called Quality Compass® that is commercially available from the National Committee for Quality Assurance (NCQA). Specifically, we purchased and reviewed the Medicaid data for the Health Plan Employer Data and Information Set (HEDIS)[1] to determine the breadth of quality measurement data that is available through a nationally recognized data collection organization.

The front section of this report provides a summary of findings that cut across States. State profiles follow in Appendix I. The profiles include publicly reported rate information for both

[1]HEDIS® is a registered trademark of the National Committee for Quality Assurance

Performance Measurement Partnership Project (PMPP) and non-PMPP measures [see Background for PMPP information].

Methodology

For the December 2005 Core Performance Measurement Report, Medstat performed an extensive Web search for publicly available quality/performance information. We limited the performance measurement data to the most recent three years available at that time: 2003, 2002, and 2001. Medstat began investigating the States that were interviewed earlier in 2005 regarding completion of the State survey (a separate task under this contract). Medstat then expanded the search to include all 50 States to ensure that quality measurement activities were identified.

During this screening phase, Medstat created a database summarizing materials collected from all States. Medstat combined this information with data from the aforementioned interviews and statistics from CMS regarding State enrollment and managed care penetration. Variables to identify noteworthy quality improvement approaches included: performance measure characteristics, length of data collection and reporting, and whether States had implemented performance improvement programs.

Medstat selected States that had the greatest depth and longevity of quality measurement, focusing on the NCQA HEDIS and PMPP measures. Medstat also looked for States that had implemented interventions and completed re-measurement and/or had FFS/PCCM information available. Searches occurred in 2005 and 16 candidate States were identified, of which ten were comprehensively reviewed and included in the 2005 report:

1. Arizona
2. Arkansas
3. Colorado
4. Maine
5. Maryland
6. Michigan
7. New York
8. North Carolina
9. Ohio
10. Wisconsin

For the 2006 report, CMS asked Medstat to add performance measurement data for 2004, and to select three additional States from the candidates identified during the screening phase in 2005.

To accomplish this, Medstat conducted a thorough search for publicly available Medicaid program information during Spring and Summer of 2006. We re-visited the Websites for all 16 States and gathered newly published materials on performance results, quality improvement

efforts, External Quality Review Organization (EQRO) Reports, and State program information. The timing of this effort took into consideration the timeline required for States to produce and publish performance reports for the 2004 calendar year.

Once all Medicaid program information and performance measurement and improvement activity reports were collected, Medstat reviewed the materials. Although the intention was to select the new States based upon the same criteria used to select the previous ten States, we identified three States that no longer met criteria for inclusion:

- one State did not publicly report performance data
- one State only reported plan-level results (e.g., no aggregate, State-level results) for the timeframe of this report (2001-2004)
- one State did not report on any of the PMPP measures and only one HEDIS-like performance measure

The three remaining States published State-level performance measure data on PMPP and HEDIS measures, including results for calendar years 2001-2004, and released quality improvement project reports. The new States are:

- California
- Minnesota
- Pennsylvania

Medstat constructed an extensive database summarizing key characteristics of all States' quality reporting efforts. Variables include: measures reported and rates, use of State-specific measures, reporting of trending information, creation of cross-product "roll ups" (MCO, FFS, PCCM), audit requirements, barriers to measure generation and implementation of related State-level quality interventions (as available).

Medstat has informed each State, through voice messages or direct contact, that they have been identified through information on their Website as a State with a noteworthy quality improvement approach in performance measurement, and that their data will be included in this report. It should be noted that many States that were not selected for this report also had advanced quality measurement and reporting systems.

In addition to the enhancements above, in the 2006 report, we included an overview of the performance measure dataset called Quality Compass® that is commercially available from the National Committee for Quality Assurance (NCQA). Specifically, we purchased and reviewed the Medicaid data for the Health Plan Employer Data and Information Set (HEDIS) to determine the breadth of quality measurement data that is available through a nationally recognized data collection organization. The methods that we used to analyze the data and our findings can be found in the Quality Compass section of this report.

Performance Measurement Partnership Project Background

CMS convened the Performance Measurement Partnership Project (PMPP) as a collaborative effort between Federal and State officials to develop a national set of performance measures that State Children's Health Insurance Programs (SCHIP) and State Medicaid programs could report on a voluntary basis. After considerable deliberation, PMPP identified the following set of performance measures for initial implementation:

- Adults' Access to Preventive/Ambulatory Health Services
- Children's and Adolescents' Access to Primary Care Practitioners
- Comprehensive Diabetes Care (hemoglobin A1c (HbA1c) tests)
- Prenatal and Postpartum Care (prenatal visits)
- Use of Appropriate Medications for People with Asthma
- Well Child Visits for Children in the First 15 Months of Life
- Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life

The measures are based on the NCQA HEDIS measurement set. Accordingly, this report focuses on the reporting of these seven measures. In addition, Medstat tracked the reporting of other HEDIS clinical quality measures as well as measures that were created by the States.

Please note the following:

- Analysis in this report includes publicly available information.
- Medstat did not search for or include patient satisfaction measures (e.g., Consumer Assessment of Healthcare Providers and Systems (CAHPS)).

Analysis/Discussion

Although we report on 13 States in this report, one State, Maine, has not produced a performance report for calendar year 2004. We retained Maine in this report because it exhibited noteworthy quality improvement approaches in the public quality measurement/performance reporting efforts in the previously released version of this report.

The following summarizes cross-State observations based on 2004 performance reports.

Reporting of Quality Measurement and Intervention Information

- The summary of PMPP measure reporting by State and type of program are:
  - MCO only: Arizona, California, Maryland, Michigan, Minnesota, New York, Ohio, Pennsylvania, Wisconsin
  - PCCM only: Arkansas, Maine

- MCO/PCCM/FFS combination: Colorado
- PCCM/FFS combination: North Carolina

- The approach to quality reporting for some States is to require MCOs to self-report a specific set of measures (California, Colorado, New York, Maryland, Michigan, and Pennsylvania).
- Seven States used their own administrative data to generate measures: Arizona, Colorado (for PCCM and FFS populations), Maine, Minnesota, North Carolina, Ohio, and Wisconsin.
- Use of administrative data may yield lower rates than those produced by medical record review (e.g., for MCO self-reported rates to the State and/or NCQA).
- Arkansas used their own administrative data for most measures, but reported the EQRO's medical record review results for the Childhood Immunization Measures.
- Note that Wisconsin has developed its own set of measures, the Medicaid Encounter Data Driven Improvement Core Measure Set (MEDDIC-MS). These measures are not HEDIS measures. However, some of the individual MEDDIC-MS measures address the same clinical services as HEDIS measures. Therefore, for the purposes of the summary information presented in this section, relevant Wisconsin MEDDIC-MS measures are counted with HEDIS measures in the PMPP and non-PMPP measure tables.
- A few States have developed statewide baseline quality measures, implemented interventions and conducted re-measurement efforts. These efforts are often related to EQRO activities in managed care populations.

PMPP Measure Reporting

- All States reported at least one PMPP measure; two States, Michigan and North Carolina, reported all seven PMPP measures.
- The seven PMPP measures were among the most frequently reported measures. Table 1 shows the number of States reporting each PMPP measure and the programs for which rates were reported. Of the 91 measure reporting possibilities (seven measures for 13 States), data were available for 55 (60%).

Table 1: Summary of PMPP Measure Reporting, CY 2004

	Measure	Number of States Reporting Measure	Number of States Reporting Only MCO	Number of States Reporting Only PCCM	Number of States Reporting PCCM and FFS	Number of States Reporting MCO and PCCM and FFS
1	Comprehensive Diabetes Care: HbA1c Testing	9	6	1	1	1
2	Prenatal Postpartum Care: Timeliness of Prenatal Care	8	6	0	1	1
3	Well Child Visits Ages 3-6	8	6	1	1	0
4	Well Child Visits in The First 15 Months of Life: Six or More Visits	8	5	1	1	1
5	Children's Access To PCP	8	5	0	1	1
6	Adult Access to Preventive/Ambulatory Health Services	7	6	0	1	0
7	Use of Appropriate Medications for Asthma: All Ages Combined	7	5	1	1	0

Note: For measures with multiple age cohorts (Children's Access, Adults Access, and Asthma), not all reporting States included all age cohorts.

- The most frequently reported PMPP measures were Diabetes (HbA1c Testing), Prenatal Care, Well Child and Infant Visits, and Children's Access to Care. In contrast, Appropriate Use of Asthma Medications and Adult Access to Care were least frequently reported.

Reporting of Non-PMPP HEDIS Measures

Many States reported standard HEDIS measures that were not part of the PMPP measure set. Table 2 summarizes the reporting of non-PMPP HEDIS measures, sorted from highest to lowest frequency.

Table 2: Summary of Non-PMPP HEDIS Measure Reporting, CY 2004

Measure	Number of States Reporting Measure	Number of States Reporting MCO Only	Number of States Reporting Only PCCM	Number of States Reporting PCCM and FFS	Number of States Reporting MCO and PCCM and FFS
Cervical Cancer Screening	10	7	1	1	1
Adolescent Well-Care Visits	9	6	1	1	1
Comprehensive Diabetes Care: Eye Exams	9	6	1	1	1
Comprehensive Diabetes Care: LDL-C Screening	9	6	1	1	1
Breast Cancer Screening	8	5	1	1	1
Childhood Immunization Status: Combo 2	7	5	0	1	1
Annual Dental Visit	6	4	1	0	1
Childhood Immunization Status: Combo 1	6	3	1	1	1
Prenatal Postpartum Care: Postpartum Care	6	5	0	0	1
Well Child Visits in The First 15 Months of Life: Zero Visits	6	3	1	1	1
Childhood Immunization Status: DTP	5	2	1	1	1
Childhood Immunization Status: Hepatitis B	5	2	1	1	1
Childhood Immunization Status: HIB	5	2	1	1	1
Childhood Immunization Status: IPV/OPV	5	2	1	1	1
Childhood Immunization Status: MMR	5	2	1	1	1
Childhood Immunization Status: VZV	5	2	1	1	1
Comprehensive Diabetes Care: Monitoring for Diabetic Nephropathy	5	4	0	0	1
Well Child Visits in The First 15 Months of Life: Five Visits	5	3	1	1	0
Well Child Visits in The First 15 Months of Life: Three Visits	5	3	1	1	0
Adolescent Immunization Status: Combo 1	4	2	0	1	1
Adolescent Immunization Status: Combo 2	4	2	0	1	1
Appropriate Treatment for Children: Upper Respiratory Infection	4	2	1	0	1
Chlamdyia Screening in Women: All Ages Combined	4	3	1	0	0

Table 2: Summary of Non-PMPP HEDIS Measure Reporting, CY 2004 (Continued)

Measure	Number of States Reporting Measure	Number of States Reporting MCO Only	Number of States Reporting Only PCCM	Number of States Reporting PCCM and FFS	Number of States Reporting MCO and PCCM and FFS
Comprehensive Diabetes Care: LDL-C Level < 130	4	3	0	0	1
Comprehensive Diabetes Care: Percent HbA1c Level <= 9.0%	4	3	0	0	1
Controlling High Blood Pressure	4	3	0	0	1
Well Child Visits in The First 15 Months of Life: Four Visits	4	2	1	1	0
Well Child Visits in The First 15 Months of Life: One Visit	4	2	1	1	0
Well Child Visits in The First 15 Months of Life: Two Visits	4	2	1	1	0
Comprehensive Diabetes Care: LDL-C Level < 100	3	3	0	0	0
Adolescent Immunization Status: Hepatitis B	2	1	0	1	0
Adolescent Immunization Status: MMR	2	1	0	1	0
Adolescent Immunization Status: VZV	2	1	0	1	0
Antidepressant Medication Management: Acute Phase Treatment	2	2	0	0	0
Management: Continuation Phase Treatment	2	2	0	0	0
Antidepressant Medication Management: Optimal Practitioner Contacts	2	2	0	0	0
Appropriate Treatment for Children: Pharyngitis	2	1	1	0	0
Chlamdyia Screening in Women: Age 16-20	2	2	0	0	0
Chlamdyia Screening in Women: Age 21-26	2	2	0	0	0
Follow-up After Hospitalization for Mental Illness: 30 Day	2	2	0	0	0
Follow-up After Hospitalization for Mental Illness: 7 Day	2	2	0	0	0
Medical Assistance with Smoking Cessation: Advise to Quit (Survey Measure)	2	1	1	0	0
Cholesterol Management After Acute Cardiovascular Events: LDL-C Screening	1	1	0	0	0
Medical Assistance with Smoking Cessation: Cessation Strategies (Survey Measure)	1	0	1	0	0

- Again, for the calendar year 2004, most States reported the cervical cancer screening measures, diabetes testing measures, and breast cancer screening measures. It may be appropriate to incorporate these measures into the set of Medicaid performance measures as measurement efforts expand.

- The Adolescent Well Care measure was also highly reported in 2004; nine of the 13 States included rates for this measure in their public report.
- Few States reported either of the two mental health measures. However, Medicaid beneficiaries may have access to mental health services provided outside of the scope of their Medicaid programs (e.g., county public/mental health services).
- Few of the 13 States reported HEDIS measures that assess intermediate health outcomes. These measures include: 1) LDL-C control for both the Comprehensive Diabetes Care (CDC) and Cholesterol Management (CHM) measures, 2) HbA1c Control for the CDC measure, and 3) blood pressure control for the Controlling High Blood Pressure measure. In part, this may be due to unavailability of related data sources. HbA1c and LDL-C control measures are developed from lab value data, which few organizations have administratively. Blood pressure readings must be obtained from chart review.

Reporting of State-Specific Measures

Several States either modified HEDIS specifications to better suit their needs and/or developed State-specific measures. Across the 13 States and across all years, Medstat identified 59 modified or State-specific measures (shown in Table 3).

This list is not intended to be comprehensive but rather encapsulates measures that were readily identified in on-going reports of State performance. Many States developed measures for short-term, focused EQRO-related studies of particular conditions or populations which are not summarized here. Additionally, technical specifications for these performance measures may not have been available and, therefore, specification modifications may be incompletely captured.

Table 3: Measure Counts by Clinical Focus, CY 2004

Clinical Focus	Modifications to HEDIS Specifications	State-Specific Measures	Total
Prenatal	4	5	9
Well Care / EPSDT	4	2	6
Satisfaction	0	6	6
Asthma	1	5	6
Access	4	2	6
Cancer	0	5	5
Blood Lead	0	5	5
Utilization	0	4	4
Other	0	3	3
Diabetes	1	2	3
Mental Health	1	1	2
Immunizations	2	0	2
Dental	1	1	2
Total	**18**	**41**	**59**

- The most frequent modifications to HEDIS specifications were relatively minor:
  - Changing age cohorts (for the Asthma, Children's Access, and Adults' Access measures)
  - Requiring seven well infant visits (rather than the six specified by HEDIS)
  - Changing the timing requirements for HEDIS services (for Immunization and Prenatal measures)

  Specifications changes were rarely made to work around data completeness or data quality barriers.
- In general, State-specific measures either addressed clinical areas not covered by HEDIS or provided a deeper level of analysis than HEDIS measures.
- Prenatal care received the most attention with respect to the development of State-specific measures. These measures often assessed quality and/or utilization related to high risk pregnancies.
- In addition to quality measures, a few States reported utilization measures. For example, these included emergency department visits not leading to hospitalization. Note that this project did not explicitly search for the reporting of utilization measures.

Summary of State Measure Reporting

The following table (Table 4) summarizes the data presented in preceding sections. As indicated, PMPP measures accounted for 27% of all measures reported. States also reported a number of non-PMPP HEDIS measures, accounting for 45% of reported measures. A few States have also developed State-specific measures, primarily to address clinical areas not captured by HEDIS or to provider a deeper assessment of quality than afforded by HEDIS. These account for 28% of all measures reported.

Table 4: PMPP, Non-PMPP, and State-Specific Measure Counts by State, CY 2004

State	# PMPP Measures	# Non-PMPP HEDIS Measures Rollup	# State-Specific Measures	Total (All Measures)	NCQA HEDIS Compliance Audit?
AR	4	11	6	21	
AZ	4	2	4	10	
CA	4	7	1	12	
CO	4	12	5	21	Y
ME*					
MD	5	6	7	18	Y
MI	7	12	1	20	Y
MN	6	6	3	15	Y
NC	7	7	0	14	
NY	6	14	5	25	Y
OH	5	6	7	18	
PA	3	5	4	12	
WI	1	6	16	23	
Total	**56**	**94**	**59**	**209**	
Percent	**26.8%**	**45.0%**	**28.2%**	**100%**	

*Maine did not produce a performance report for 2004. In 2003, Maine reported on four PMPP measures and one State-specific Access measure.

Summary of Performance Changes Over Time

PMPP Measure Summary

This section of the report examines changes in measure rates over time. The magnitude and direction of changes for the seven PMPP measures and non-PMPP measures are summarized. Detailed trending information is available in Appendix I.

The following table presents counts of measures with any rate increase, decrease, or no change. Generally, changes are based on the 2004 and 2001 rates. However, when 2001 data were not available, comparisons in measure rate changes were calculated from the earliest year of available data (2002 or 2003) to rates reported for 2004. Counts are based on reported State-program combinations. For example, the same State may report both MCO and FFS rates. In this case, the count of reported measures would be two. First year measures were reported for the first time in 2004; therefore, trending data were not available.

Table 5: Number of PMPP Measures with Rate Changes, CY 2004

	Total	Percent
Number of Measures 2004	175	100%
Number of First Year Measures	4	2%
Number of Measures with No Change	1	1%
Number of Measures with Rate Decrease	40	23%
Number of Measures with Rate Increase	130	74%

As indicated in Table 5, almost 74% of measures increased. However, it is important to examine the magnitude of both increases and decreases to determine if quality has changed substantially over the last two years.

Table 6 depicts the number of State rates that experienced changes greater than five percent for each of the PMPP measures. Counts are based on reported State-program combinations. For example, the same State may report both MCO and FFS rates. In this case, the count of reported measures would be two. In 2004, across all States there were a total of 20 State-program combinations.

Table 6: PMPP Measures with Substantial Rate Differences, CY 2004

PMPP Measure	Number of State Programs Reporting >1 Year	Number of State Programs with 5% or More Improvement	Number of State Programs with >5% Decrease
Adult Access to Preventive/Ambulatory Health Services			
Age 20-44	10	1	
Age 45-64	11	1	
Age 65+	8	2	
Children's Access To PCP			
Age 12-24 Months	15	3	3
Age 25 Months - 6 years	15	4	3
Age 7-11 Years	14	7	3
Age 12-19 Years	10	0	2
Comprehensive Diabetes Care			
HbA1c Testing	16	11	
Prenatal Postpartum Care			
Timeliness of Prenatal Care	13	4	4
Use of Appropriate Medications for Asthma			
Age 5-9	7	6	
Age 10-17	7	2	
Age 18-56	8	1	4
All Ages Combined	10	1	
Well Child Visits			
Ages 3-6	12	4	1
Well Child Visits in The First 15 Months of Life			
Six or More Visits	15	10	3
Total State Programs	**171**	**57**	**23**
Percents	**100%**	**33%**	**13%**

As indicated, 33% of State-program rates increased more than five percent; only 13% of rates decreased by more than five percent. Therefore, 54% of rates remained relatively stable.

The PMPP measures that exhibited the highest number of rate increases were Comprehensive Diabetes Care HbA1c Testing (11 of 16), Well Child Visits in The First 15 Months of Life (10 of 15), Use of Appropriate Medications for Asthma .Ages 5 – 9, (6 of 7). These measures are often the focus of quality improvement efforts. In contrast, the Children's Access to PCP measures and Timeliness of Prenatal Care experienced a number of decreases.

As previously noted, this table includes one year (2003 – 2004), two year (2002 – 2004), and three year (2001 – 2004) calculations, depending on the length of reporting of the measure by the State-program.

Of the PMPP measures reported in 2004, 130 were reported across the three-year period. Of these, 48 (37%) measures experienced increases greater than five percent and 18 (14%) measures experienced decreases greater than five percent.

Therefore, looking at the 130 measures reported across the three-year timeframe, about half of the measures (51%) had relatively stable rates (changes of less than five percent).

On the positive side, rate stability may indicate that data and measurement processes are reliable. Significant data quality or completeness issues would be expected to cause fluctuation in rates. To a large extent, this did not occur. On the other hand, stability may indicate that few States were able to achieve significant increases in quality during the period 2001 – 2004, at least among PMPP measures.

Non-PMPP Measure Summary

Turning to the non-PMPP measures, a similar pattern emerged. As shown in Table 7 below, 55% of non-PMPP measures experienced increases; 39% experienced decreases.

Table 7: Number of Non-PMPP Measures with Rate Changes, CY 2004

	Total	Percent
Number of Measures 2004	311	100%
Number of First Year Measures	18	6%
Number of Measures with No Change	2	1%
Number of Measures with Rate Decrease	121	39%
Number of Measures with Rate Increase	170	55%

Referring to Table 2 (pages 7-8), 46 non-PMPP HEDIS measures were reported by at least one of the 13 States. In total, 311non-PMPP State-program rates were reported in 2004. Of these, 179 rates were reported across the three-year period, 2001 – 2004.

Looking at this subset of 179 State-program rates, 35% experienced increases equal to or greater than five percent. This percentage is higher than the percentage of PMPP measures (27%) that experienced increases greater than five percent over the same period, 2001-2004. This may suggest that States had greater success in improving non-PMPP measure rates.

In contrast, the percentage of rates that experienced decreases greater than five percent were more similar for both PMPP and non-PMPP measures (10% and 15%, respectively).

Finally, half of the non-PMPP HEDIS rates were relatively stable, that is experiencing changes of less than five percent over the period 2001 – 2004.

Due to the large number of non-PMPP measures, measure-specific data are not included in this report. The State sections contain complete data on all rate changes, including identification of the measures that increased the most.

In general, it is difficult to directly attribute the largest rate increases to specific quality improvement interventions. In a few cases, States had programs that directly addressed the most improved measures. More detail on how measure rate performance correlates to improvement programs can be found in the individual State sections in Appendix **I.** For those readers interested in pursuing additional detail, all of the reports referenced in this report are publicly available via each State's Medicaid Website, generally at the Managed Care section.

However, in many cases, the largest increases could not to be associated with specific interventions, beyond public reporting of the measures. It should also be noted that, although half of the rates were relatively stable, large fluctuations in rates may reflect data or measurement issues. Typically, rates increase as new measures mature and data and/or methodological issues are addressed.

The most effective methods to improve quality are difficult to discern from current quality measurement reporting. State quality improvement efforts included focused clinical quality improvement programs, incentive programs, and statewide data reporting systems. EQRO evaluations, more of which should become available as States implement mandated performance improvement projects, have the potential to be a valuable source of identification of quality improvement approaches. Half of the 13 States publicly released EQRO reports, but these mostly address project validation or site visits. Generally, these reports did not provide a rigorous assessment of the impacts of performance improvements projects on process measures or health outcomes. As a result, it is still unknown which quality improvement approaches are particularly effective.

Reporting/Assessment Methodologies and Formats

- Each State has a different mix of Medicaid insurance plans including commercial MCOs, Medicaid-only MCOs, PCCM, and FFS. The programs and the percent of the total Medicaid population they cover vary significantly from State-to-State. The type of populations served by each program also varies, as well as the range of covered services. All of these factors would affect the inter-State comparability of available publicly reported results.
- The most recent performance data had a one and a half year lag, covering services delivered during the 2004 calendar year. However, it should be noted that Medstat's cut-off date for searching for noteworthy quality improvement approaches was July 2006. Across all States:
    - twelve reports included 2004 data (Maine has not yet not released an updated performance report covering calendar year 2004)
    - eleven reports included 2003 data
    - seven reports included 2002 data
    - four reports included 2001 data.

- The average number of years captured in the reports is 3.1 years.
- Apart from EQRO-related interventions, in general, States did not explicitly present on their Website information that shows the State assessed the drivers of quality improvements over time.
- In addition to simply reporting plan performance, States used a variety of methodologies to assess program performance. These included:
  - using national MCO HEDIS benchmarks provided by the NCQA (generally the average, 75th, and 90th percentiles)
  - comparing MCO performance against statewide benchmarks (generally the statewide average rate)
  - comparing intra-State FFS, PCCM and/or managed care performance (Colorado, North Carolina)
  - developing a methodology to place program/plan rates into performance categories: Maryland, Michigan, and New York. However, all States reported raw rates.
- Only Minnesota had developed a "composite measure" that combined rates across component measures.
- Eleven States utilized benchmarking against national NCQA MCO percentiles and eight States benchmarked against statewide averages.
- Overall, States did not report clinical performance rates broken down by specific eligibility or demographic groups. Although, several States conducted focused studies on specific populations groups (e.g., the disabled).
- Finally, it should be noted that the audience for the reports varies. Some States provided consumer "report cards" intended to help consumer choose MCOs. Others made available quality improvement/assessment reports that are oriented primarily toward providers, insurers, and policy makers. These reports contain greater depth of information.

Summary of State Experience and Noteworthy Quality Improvement Approaches

As previously noted, all 13 States included in this report were identified as having noteworthy quality improvement approaches in quality measurement and public dissemination of performance reports.

The identification of an approach as noteworthy was subjective and based upon Medstat's experience in performance measurement. Specifically, we looked for quality improvement efforts that included performance measurement and had multiple years of collection. We noted reports that documented methodology and results of performance improvement projects. We considered the State's efforts at setting standards and monitoring plan compliance. We acknowledged States that created performance measures targeting their own needs and populations. Additionally, we identified effective approaches to reporting directed at consumers, providers, or other stakeholders.

All 13 States have taken a variety of different approaches to different aspects of performance measurement and reporting. Their efforts to broaden and innovate can be seen as noteworthy quality improvement approaches. While the outcome of these approaches may be yet unmeasured or unknown, the States' experiences with implementation of their quality measurement programs hold "lessons learned" for other States. Table 8 outlines the relatively unique experiences and approaches that each State can contribute to spur future quality measurement and improvement efforts. Further detail can be found in the State-specific sections of this report.

Table 8: State Experience and Noteworthy Quality Improvement Approaches

State	Approach 1	Approach 2	Approach 3
AR	Identifying and making available free quality improvement tools.	Attractive design and presentation of performance information in public reports.	Using survey methodology to assess quality of perinatal care.
AZ	Setting and monitoring of compliance to performance standards for both standard Medicaid MCO's and programs serving a variety of sub populations.	Developing managed care claims/encounter databases that are complete and accurate enough to support generation and public reporting of performance. Experience with the acquisition and use of lab value data.	Developing internal expertise required to generate measures and conduct data validation assessments.
CA	Developing statewide collaboratives to conduct quality measurement and improvement activities.	Developing State-specific, focused measures for specific conditions and/or populations.	Setting and monitoring of compliance to performance standards.
CO	Developing and comparing rates for all three major Medicaid models (MCO, PCCM and FFS).	Developing State-specific, focused measures for specific conditions and/or populations.	Developing analytic studies that identify opportunities for targeted quality improvement activities.
MD	Developing consumer report cards containing comparative performance and trending information.	Developing a Value-Based Purchasing Initiative that incorporates incentives tied to HEDIS and other performance measures.	Providing a Medicaid Year-end Review report that includes additional State-specific utilization/access measures.
ME	Developing an Annual Report that includes statewide trending.	Creating the Physician Incentive Program.	Conducting multiple focused studies and related quality improvement programs.
MI	Developing an Annual Report that includes statewide trending.	Conducting multiple focused studies and related quality improvement programs.	Developing State-specific utilization/access measures.
MN	Developing State-specific, focused measures for specific conditions and/or populations.	Conducting multiple focused studies and related quality improvement programs.	Developing State-specific measures targeting administrative agencies responsible for health care oversight.
NC	Generating and comparing rates for PCCM and FFS programs following HEDIS specifications (without significant modification).	Developing regional collaboratives to conduct disease/case management and quality measurement/improvement activities (within a PCCM model).	Conducting multiple focused studies and related quality improvement programs.
NY	Developing an interactive, web-based consumer report card containing comparative performance and trending information.	Developing State-specific utilization/access measures.	Conducting multiple focused studies and related quality improvement programs.
OH	Using managed care encounter databases for performance measure reporting and data completeness and quality validation studies.	Developing State-specific perinatal measures to better address the characteristics and needs of the Medicaid population.	Setting of performance targets which identify required increases in measure rates from year-to-year.
PA	Developing an incentive program to reward Medicaid managed care plans with monetary bonuses for meeting performance goals.	Developing statewide databases to generate HEDIS results.	Designing and publishing Medicaid consumer report cards.
WI	Creating a comprehensive set of State-specific Medicaid measures	Developing statewide databases that integrate managed care encounters with other available data sources.	Designing and publishing Medicaid consumer report cards (and related development of performance categorization methodology)

Quality Compass ® File 6

Medstat obtained Quality Compass 2005® (QC 2005), File 6, from the National Committee for Quality Assurance (NCQA). This dataset contains plan-specific Medicaid performance data and national averages for HEDIS as well as CAHPS data. QC 2005, File 6 includes HEDIS data from Medicaid MCO plans in 23 States. There are eight plans that have no State or region designation; however, it appears that five operate in Puerto Rico. We excluded plans with no State or region designation; our analysis was conducted on the remaining 87 Medicaid plans.

Of the 13 States profiled in this report, eight are included in QC 2005: California, Colorado, Maryland, Michigan, Minnesota, New York, Ohio, and Pennsylvania. We did not expect to find data for two of the States because their Medicaid programs are PCCM only (Arkansas, Maine). The remaining three States included in this report had no Medicaid plans that submitted data to NCQA for inclusion in the Medicaid Quality Compass release: Arizona, North Carolina, and Wisconsin.

Not every Medicaid plan within a State submits data to the NCQA for inclusion in Quality Compass. Participation is at the plan level and is voluntary. A plan may collect and submit data, but may choose not to allow results to be incorporated into the publicly released File 6.

Data for 23 HEDIS measures are included in QC 2005 (Table 9). Of the eight reporting States, two included rates for all measures (Minnesota, New York). Four additional States reported on 19 or more measures (California, Michigan, Ohio, and Pennsylvania). Colorado reported on 17 measures, and Maryland had rates for 13 measures.

PMPP measures were the most frequently reported measures. Once again, just looking at the eight States in QC 2005, each submitted data for all seven PMPP measures. In fact, looking at all States that submitted data to QC, 17 of the 23 States reported all seven PMPP measures.

Table 9: Number of Reporting Plans and Measures by State in Quality Compass 2005

State	Number of Reporting Plans in State	Number of Measures Reported	Number of PMPP Measures Reported
CA	15	19	7
CO	1	17	7
DC	1	18	6
FL	1	22	7
HI	1	20	7
IL	1	15	6
KY	1	20	7
MA	1	21	7
MD	2	13	7
MI	14	20	7
MN	4	23	7
MO	5	20	7
NJ	1	9	3
NM	3	23	7
NY	7	23	7
OH	3	21	7
PA	7	20	7
RI	3	20	7
TN	6	17	6
TX	1	16	7
UT	1	7	3
VA	4	23	7
WA	4	15	5
Average Number of Measures		18.3	6.4
Total Number of Reporting Plans			87
States Reporting Measures			23
States Reporting All 23 Measures			4
States Reporting All 7 PMPP Measures			17

For a complete list of measures reported for each State, please refer to Appendix II.

The following table, Table 10, illustrates the PMPP measures reported by each contributing State. As shown, only data for the Timeliness of Prenatal Care measure was submitted by every State.

Table 10: Quality Compass 2005, File 6: PMPP Measures By State

State	Count of Reporting Plans in State	Number of PMPP Measures Reported	AAP	CAP	CDC	PPC	ASM	W34	W15
CA	15	7	✓	✓	✓	✓	✓	✓	✓
CO	1	7	✓	✓	✓	✓	✓	✓	✓
DC	1	6	✓	✓	✓		✓	✓	✓
FL	1	7	✓	✓	✓	✓	✓	✓	✓
HI	1	7	✓	✓	✓	✓	✓	✓	✓
IL	1	6		✓	✓	✓	✓	✓	✓
KY	1	7	✓	✓	✓	✓	✓	✓	✓
MA	1	7	✓	✓	✓	✓	✓	✓	✓
MD	2	7	✓	✓	✓	✓	✓	✓	✓
MI	14	7	✓	✓	✓	✓	✓	✓	✓
MN	4	7	✓	✓	✓	✓	✓	✓	✓
MO	5	7	✓	✓	✓	✓	✓	✓	✓
NJ	1	3				✓		✓	✓
NM	3	7	✓	✓	✓	✓	✓	✓	✓
NY	7	7	✓	✓	✓	✓	✓	✓	✓
OH	3	7	✓	✓	✓	✓	✓	✓	✓
PA	7	7	✓	✓	✓	✓	✓	✓	✓
RI	3	7	✓	✓	✓	✓	✓	✓	✓
TN	6	6	✓	✓	✓	✓		✓	✓
TX	1	7	✓	✓	✓	✓	✓	✓	✓
UT	1	3			✓	✓	✓		
VA	4	7	✓	✓	✓	✓	✓	✓	✓
WA	4	5			✓	✓	✓	✓	✓
Average		6.5							

Measure Abbreviations

AAP	Adult Access to Preventive/ Ambulatory Health Services
CAP	Children's Access To Primary Care Physician
CDC	Comprehensive Diabetes Care: HbA1c Testing
PPC	Prenatal Postpartum Care: Timeliness of Prenatal Care
ASM	Use of Appropriate Medications for Asthma
W34	Well Child Visits Ages 3-6
W15	Well Child Visits in The First 15 Months of Life: Six or More Visits

In Table 11, we provide national benchmarks for the PMPP measures that we found in the Quality Compass data.

Table 11: Quality Compass 2005, File 6: National Averages and Benchmarks

PMPP Measure	N	Average Rate	25th Percentile	50th Percentile	75th Percentile	90th Percentile
Adult Access to Preventive/Ambulatory Health Services: Age 20-44	55	78.70	73.62	80.12	84.19	86.68
Adult Access to Preventive/Ambulatory Health Services: Age 45-64	55	84.24	81.96	86.41	88.07	89.26
Adult Access to Preventive/Ambulatory Health Services: Age 65+	26	83.37	77.40	86.06	89.12	91.52
Use of Appropriate Medications for Asthma: All Ages Combined	76	67.87	64.21	69.26	72.76	74.32
Use of Appropriate Medications for Asthma: Age 5-9	72	67.78	63.38	68.85	73.58	76.60
Use of Appropriate Medications for Asthma: Age 10-17	73	66.25	61.49	66.76	71.01	73.94
Use of Appropriate Medications for Asthma: Age 18-56	72	68.25	62.28	69.73	73.24	75.96
Children's Access To PCP: Age 12-24 Months	56	94.43	91.86	95.09	97.43	98.44
Children's Access To PCP: Age 25 Months - 6 years	56	83.84	79.21	85.22	88.01	91.95
Children's Access To PCP: Age 7-11 Years	56	84.43	80.48	83.88	89.73	92.98
Children's Access To PCP: Age 12-19 Years	57	81.18	77.47	82.01	88.41	90.65
Comprehensive Diabetes Care: HbA1c Testing	72	79.26	73.50	79.85	86.30	89.27
Prenatal Postpartum Care: Timeliness of Prenatal Care	82	78.59	73.75	83.21	87.97	91.01
Well Child Visits in The First 15 Months of Life: Six or More Visits	74	50.08	41.10	50.99	58.37	68.48
Well Child Visits Ages 3-6	71	64.33	57.61	64.27	71.65	77.55

Not all Medicaid plans in a particular State have data included in File 6. Table 12 shows each of the 13 States, the number of plans included in State reporting (i.e., as summarized in this report), and the number of plans included Quality Compass. As indicated, Quality Compass only captures data on 53 of the 130 plans included in publications available from the 13 States. In fact, only in Pennsylvania did all Medicaid plans have their data incorporated, while 14 of 15 plans in Michigan are represented.

Although many plans do not submit data to NCQA, many States utilize NCQA Medicaid Benchmarks as a gold standard in performance. The lack of comprehensive and consistent reporting to Quality Compass or another national database significantly impairs States' ability to benchmark their performance

Table 12: Quality Compass 2005, File 6 and Thirteen State Public Reports

State	Total Number of Plans Included in Public Report (CY 2004)	Quality Compass		
		Number of Reporting Plans in State	Number of Measures Reported	Number of PMPP Measures Reported
AR	*			
AZ	8			
CA	34	15	19	7
CO	2	1	17	7
MD	6	2	13	7
ME	*			
MI	15	14	20	7
MN	9	4	23	7
NC	*			
NY	29	7	23	7
OH	6	3	21	7
PA	7	7	20	7
WI	14			
Average			19.5	7
Total Number of Reporting Plans in Quality Compass				53
Total Number of Plans in Public Reports				130
* Not Applicable: State Medicaid program is PCCM				

We hoped to have more plans in the 13 States included in File 6, thus allowing us to enhance performance measure data in the State sections of this report; however, this was not the case. We looked at the number of plans reporting in each geographical region and determined that the distribution does not lend itself to creating reliable benchmarks.

Summary of Analysis and Discussion

This section of the report provides a summary of overall observations. The environment for performance measurement and reporting in Medicaid is different from that of commercial plans in a number of key respects:

- Commercial public performance reporting aimed at consumers is designed to foster the valuing of quality within the marketplace by driving market share toward high performing managed care plans. Further, commercial performance reporting is often used by a multitude of employers during the selection of plan options. In Medicaid, the State often more directly arranges for the coverage of Medicaid recipients. However, this

is changing as more States explore methods to involve beneficiaries in choice of providers and assume greater personal responsibility.

- The primary purpose of HEDIS is to provide a basis for comparative performance assessment at an MCO-level. It is not intended to serve as a basis for the development and implementation of quality improvement programs, a prime interest of State Medicaid agencies. It does, however, provide the impetus for improving data collection systems and an understanding of validity issues for statewide reporting. This provides a basis for identifying clinical areas of interest to target for specific improvement efforts statewide.
- Finally, it is likely that the underlying health/demographic characteristics of Medicaid beneficiaries differ from commercial plan members. This is largely due to the more intense health needs of some Medicaid recipients (e.g., disabled populations). Medicaid plans/programs, whether FFS, MCO, or PCCM, are often specifically designed to enroll and address the health needs of unique populations. Accordingly, different sets of performance measures may be best able to assess quality within different plans/programs.

Within this context, the review of publicly reported Medicaid quality information produced several overarching observations:

- States did not always directly tie quality measurement and reporting to active quality improvement efforts. Routine baseline–intervention–re-measurement approaches were generally limited.
- In many cases, the public reporting of performance, especially in the managed care arena, may have been considered an "intervention" by itself, potentially influencing market share and fostering quality competition.
- Most rates were relatively stable over time. Large fluctuations in rates may reflect data or measurement issues.
- The largest increases in measure rates did not seem associated with specific interventions beyond public reporting, as identified by information on State Websites. In addition, publicly released EQRO reports did not provide a rigorous assessment of the impacts of performance improvements projects on process measures or health outcomes. The most effective methods to improve quality are difficult to discern from current quality measurement reporting.
- While States primarily use HEDIS measures to assess quality, the set of measures used varies across States. This inhibits benchmarking against other States and limits the State's ability to understand of its relative performance and identification of problem areas.
- Not every Medicaid plan within a State will submit data to the NCQA for inclusion in Quality Compass. Therefore, Quality Compass did not include all MCO-level performance information that is publicly available via State reports, eroding its usefulness in benchmarking.
- State modifications to HEDIS measures were minor (e.g., changing age cohorts) and were not related to overcoming any barriers inherent in the HEDIS Technical

Specifications. Many States seemed able to generate rates from administrative data for the measures reported without encountering insurmountable data barriers.

- Many States have also developed measures focused on specific conditions and/or populations, enabling a more rigorous analysis of the quality of care provided to Medicaid beneficiaries with specialized needs.
- When States offer a mix of programs, very few have been able to report on the quality of care provided to FFS members or develop statewide rates. Only two States compared FFS to MCO or PCCM and results varied considerably across these populations. However, differences may not be due to true disparities in performance but rather issues with data completeness and quality or perhaps varying characteristics of member populations.
- Given the results of this study, across all Medicaid program-types (FFS, MCO, and PCCM), the time may be ripe to foster noteworthy quality improvement models that
    - expand quality measurement efforts to States that currently do not report comprehensive performance information, and
    - leverage existing quality measurement efforts to drive future quality improvement.

Recommendations

The following identifies recommendations relevant to both CMS and State Medicaid Agencies as possible next steps in Medicaid performance measurement and quality improvement.

Recommendations for CMS

- Catalogue and review the EQRO activities in all States with Managed Care. Synthesize this information to identify commonly addressed clinical areas and frequently used quality improvement/measurement approaches. Summarize the results of available evaluations to identify approaches that have been successful across FFS, MCO, and PCCM models. In addition, track the rapidly expanding set of EQRO quality interventions and evaluations. As appropriate, develop case studies to communicate noteworthy quality improvement approaches.
- Continue to catalogue and review existing or planned Pay-for-Performance initiatives in both Medicaid and Medicare. Assess how pay-for-performance methodologies should be modified to address the unique characteristics of Medicaid enrollees and the varying organization of Medicaid plans/programs and providers.

- Catalogue and review the use of State-specific measures designed to assess the care provided to specific Medicaid subpopulations or within specific program-types (FFS, PCCM, MCO). Promote the adoption and continued development of Medicaid-relevant measures within nationally recognized performance measure sets (e.g., HEDIS), including those at plan/program and provider levels.
- Continue to make available a menu of validated and nationally recognized Medicaid related performance measures from which States can select an appropriate reporting set based on their specific quality strategy priorities, systems development, and evolving regulations. Using these performance measures and benchmarking results will enable States to identify areas for quality improvement within their own State.
- Monitor NCQA's Quality Compass to determine which clinical areas are in need of nationally-focused improvement efforts.
- Use the CMS Medicaid/SCHIP Quality Website to disseminate information that States can use to enhance their performance measurement and quality improvement activities.
- Encourage States to compare plan-level PIPs to rate changes for performance measures in those plans. Monitor and catalogue which activities positively influence performance.
- Building on the information in this report, develop a State-level summary of trended quality information to identify which measures have improved most substantially and noteworthy quality improvement approaches associated with rate increases.

State Related Recommendations

- For States required to contract with an EQRO, establish one or more mandatory MCO performance improvement projects of clinical relevance to that State's Medicaid population that already requires HEDIS reporting within that State. The EQRO report can identify successful health plan initiatives that drive improvement in State-wide performance.
- Maintain claims/encounter-level data warehouses of sufficient completeness and quality to support clinical performance measure development.
- Explore the possibility of incorporating other existing databases such as the CMS Hospital Compare Site into reporting activities.
- Continue to submit Medicaid Management Information System (MSIS) data files to CMS to support development of performance information by CMS. Actively address data completeness and quality problems as surfaced by MSIS validation studies by Medstat and Mathematica Policy Research.
- Promote the adoption of lab results standards and receive lab results data in order to advance quality initiatives, including measurement of intermediate outcomes (e.g., Low-density lipoprotein (LDL) levels) and disease management.
- Develop or enhance existing system or administrative processes to utilize Electronic Health Records (EHR) as health technology advances.

- Develop State-specific approaches to translate aggregate performance measurement results into enrollee/provider-level performance improvement activities (e.g., patient and provider reminder systems, disease management registries etc.).
- Foster the development of quality measurement methodologies that address the underlying characteristics of different Medicaid populations in order to aid the development of targeted interventions.
- Mental Health measures are not regularly included in the publicly available performance reports. An increased effort on measuring the quality of care for the mental health services that are included in a State's Medicaid program may be warranted.
- Actively participate in measure development activities at the national level to ensure measures are developed that meet State needs.
- Participate in a multi-State collaborative to share information, model practices, and lessons learned.
- For States required to contract with an EQRO, establish one or more mandatory MCO performance improvement projects (PIPs) of clinical relevance to that State's Medicaid population that already requires HEDIS reporting within that State. The EQRO report can identify successful health plan initiatives that drive improvement in statewide performance.
- Develop a database of plan-level PIPs and compare to rate changes for performance measures in those plans. Catalogue which activities positively influence performance and share those as "noteworthy quality improvement approaches."
- Require Medicaid plans to submit uniform quality of care performance measurement data to a nationally recognized data collection organization.

Conclusions

Performance measurement potentially provides a wealth of information about the success of programs and activities to identify effective quality improvement programs. However, this type of noteworthy quality improvement approaches information is not consistently made publicly available.

Given the results of this study, across all Medicaid program-types (FFS, MCO, and PCCM), the time may be ripe to foster noteworthy quality improvement models that 1) expand quality measurement efforts to States that currently do not report comprehensive performance information, and 2) leverage existing quality measurement efforts to drive future quality improvement.

APPENDIX I – STATE PROFILES

ARIZONA

State Quality Reporting Background

There are thirteen managed care organizations (MCOs) and two prepaid inpatient health plans (PIHPs) that contract with the Arizona Health Care Cost Containment System (AHCCCS) to provide services to more than one million Medicaid enrollees. However, the vast majority of Arizona's Medicaid recipients are covered by eight MCOs. Elderly and physically disabled populations are served under Arizona's Long Term Care System and the two PIHPs provide behavioral health care and children's rehabilitative services.

Annually, the Arizona Health Care Cost Containment System (AHCCCS), Division of Health Care Management produces a key HEDIS performance report covering the eight major MCOs:

- Quality Management Performance Measures for Acute-care Contractors (November 2005)
- Quality Management Performance Measures for Acute-care Contractors (December 2004)
- Acute-Care Performance Indicators, Results and Analysis (December 2003)

In addition, a number of other documents, primarily EQRO-focused studies, were identified:

- Arizona Long Term Care System Performance Measure, Performance Measures for Diabetes Management (November 2005)
- Quality Assessment and Performance Improvement Strategy (October 2005)
- AHCCCS Performance Improvement Project Children's Oral Health Visits First Re-measurement of Performance (August 2005)
- Acute Care Contractor Performance Improvement Project: Immunization Complete Rates by 24 Months of Age (June 2005)
- EQRO Annual Report, Comprehensive Medical and Dental Program (June 2005)
- EQRO Annual Report, Behavioral Health Services (June 2005)
- EQRO Annual Report, Children's Rehabilitative Services (June 2005)
- 2004-2005 External Quality Review Technical Report for Acute Care Plans (June 2005)
- 2004-2005 External Quality Review Technical Report for DES/DDD (Division of Developmental Disabilities) (June 2005)
- AHCCCS Quality Assessment and Performance Improvement Strategy (October 2004)
- AHCCCS Biennial Report of Immunization Completion Rates by 24 Months of Age (March 2004)

- AHCCCS Children's Oral Health Visits Performance Improvement Project Baseline Measurement (2003)
- Clinical Quality Performance Indicators for Diabetes Care (November 2003)
- Influenza Immunizations/Pneumococcal Vaccinations (October 2002)

Each HEDIS performance report contains two years of MCO-level quality measurement data. Data for the most recent four years, 2001- 2004, are summarized below.

PMPP Reporting Summary

The following table summarizes clinical quality measure results available in public reports for PMPP measures only. Empty cells indicate that the State did not report the measure.

Arizona	Medicaid MCO/PHIP				
	Data Year 2001	Data Year 2002	Data Year 2003	Data Year 2004	Rate Change 2001–2004
Children's Access To PCP: Age 12-24 Months	88.6	91.6	91.8	93.1	4.5
Children's Access To PCP: Age 25 Months - 6 years	77.4	80.9	80.8	82.9	5.5
Children's Access To PCP: Age 7-11 Years	64.4	67.8	66.9	69.2	4.8
Children's Access To PCP: Age 12-19 Years		67.2	67.7	69.4	
Adult Access to Preventive/Ambulatory Health Services: Age 20-44	75.2	74.4	74.1	75.5	0.3
Adult Access to Preventive/Ambulatory Health Services: Age 45-64	82.8	82.3	82.1	83.1	0.3
Adult Access to Preventive/Ambulatory Health Services: Age 65+					
Well Child Visits in The First 15 Months of Life: Six or More Visits	61.2	68.4		66.9	5.7
Well Child Visits Ages 3-6	47.1	51.5		56.4	9.3
Prenatal Postpartum Care: Timeliness of Prenatal Care			73.7		
Comprehensive Diabetes Care: HbA1c Testing					
Use of Appropriate Medications for Asthma: Age 5-9					
Use of Appropriate Medications for Asthma: Age 10-17					
Use of Appropriate Medications for Asthma: Age 18-56					
Use of Appropriate Medications for Asthma: All Ages Combined					

The reports include rates for each of the eight MCOs; the above table contains the statewide MCO average only. Because the State does not have FFS or PCCM programs, the rates above reflect performance on the statewide Medicaid population.

Non-PMPP HEDIS Measure Reporting

The State also reports on non-PMPP HEDIS measures. The following table summarizes the statewide averages.

It is important to note that the specifications for the Adolescent Well-Care Visit (AWC) measure changed. In 2002 and earlier years, an adolescent was required to have at least one visit during a two-year measurement period. Beginning in 2003, the measurement period was reduced to one year. The rates reflect this change. Upon closer examination, AWC performance improved between 2003 and 2004.

The report did not provide any reasons for the substantial rate increase in the Annual Dental Visit measure, although it was noted that performance exceeded HEDIS national averages.

Arizona	Medicaid MCO/PHIP				
	Data Year 2001	Data Year 2002	Data Year 2003	Data Year 2004	Rate Change 2001–2004
Adolescent Well-Care Visits	48.6	50.0	30.9	32.6	-16.0
Annual Dental Visit	43.7	48.5		53.9	10.2
Breast Cancer Screening		55.2	54.6		
Cervical Cancer Screening		50.5	53.2		

Again, rates are available for each of the eight MCOs.

State-Specific Measures and Characteristics

Arizona generates the performance measure rates from the statewide managed care encounter database, Prepaid Medical Management Information System, for all measures.

AHCCCS made some relatively minor modifications to HEDIS specifications as follows:

- For the HEDIS Prenatal Care measure, reporting rates separately for prenatal visits in the first trimester and prenatal visits within 42 days of enrollment (i.e., if member was not enrolled during entire trimester)
- Children’s Access: reporting all age cohorts combined
- Adults’ Access: reporting an age cohort covering ages 21-64
- AHCCCS allows the use of the International Classification of Diseases, Clinical Modification (ICD-9-CM) revenue codes in combination with Current Procedural Terminology (CPT) codes to ensure services were given
- For some measures, additional CPT codes, Uniform Bill 92 (UB-92) revenue codes, or ICD-9-CM revenue are used by AHCCCS

- Occasionally, revenue codes specified in the HEDIS specifications are not used by AHCCCS

Except within EQRO efforts, the State did not develop other (non-HEDIS) measures.

Quality Improvement Efforts

AHCCCS developed a 'Quality Strategy' that identified specific goals and objectives: reward quality of care, support best practices in disease management and preventive health, provide feedback to providers, and provide comparative information to consumers. These efforts are aimed at "increasing its pro-active role as a 'quality of care improver'."

As a central focus of its quality measurement and improvement approach, the State sets measure-specific minimum performance goals and holds contracted MCOs responsible for meeting minimum standards.

For example, the Adult Access to Preventive/Ambulatory Health Services Minimum Performance Standard was set at 80 percent. If this threshold has already been met, then a second, more stringent goal of 82 percent is set. MCOs are required to take remedial action if they fail to meet Minimum Performance Standards.

For the current reporting year (2004), minimum standards were reviewed and raised to encourage continued improvements in the quality of health care provided to Medicaid enrollees. In an effort to sustain continued rate improvement for routine preventive health services, some contracting health plans began 'personal outreach': education materials are offered in multiple languages; motivational phone calls are made to address specific barriers; and gift certificates are offered if all appointments are kept.

In the November 2005 report, one contractor met or exceeded the minimum standard in five of six measures in the 'accountability set', although this is not the same plan that achieved this performance level during the prior reporting period. Even though AHCCCS raised standards, many contractors are meeting these goals. However, across all plans, not one contractor met the minimum performance standards for Adults Access to Preventive Services. AHCCCS identified this area as an opportunity for improvement.

AHCCCS monitors plans that fail to meet standards and requires submissions of quarterly performance reports. It requires MCOs to submit corrective action plans for all measures where standards were not met. The 2004-2005 External Quality Review Technical Report for Acute Care Plans report provides an MCO-level assessment of all corrective action plans, including baseline and re-measurement of performance measures for which MCOs failed to meet the Minimum Performance Standard at baseline.

This report notes that AHCCCS provided technical assistance to contracted MCOs on an individual basis, in order to help improve their performance, including the identification of interventions that would improve scores. Some MCO-level interventions/assistance were described: 1) active outreach through case managers during newborn visits, combining them with

mammography reminders, 2) providing reminder lists to physicians of members requiring services, 3) distributing profiles to practitioners comparing their rates to peers, and 4) recognizing and/or rewarding providers with the highest rates, including "pay-for-performance" arrangements. Finally, Arizona's accountability system also monitors statistically significant decreases in measure rates and requires corrective action plans from MCOs with decreasing rates.

As previously noted, the State has conducted a number of focused studies covering dental care, behavioral health, children's care rehabilitative services, and the disabled. These studies generally focus on types of services or populations served outside the standard medical services provided by MCOs. Baseline and re-measurement data are available. As part of this effort, AHCCCS established direct data links between MCO and laboratories to transmit lab results data. Below is a brief description of recent projects:

- Arizona's Long Term Care System (ALTCS) Performance Measures for Diabetes Management conducted a 2004 study of members with diabetes to determine whether they received clinical services that would "detect and prevent" complications: HbA1c testing, lipid screening, and eye examinations. ALTCS services the elderly and/or physically disabled population and a majority of enrollees (up to 80 percent) are "dual-eligibles," insured by Medicaid and Medicare. This study used HEDIS specifications and hybrid methodology to ensure capture of services for the Medicare patients whose data might not be captured in the Medicaid encounter data. Findings indicate that all contracting ALTCS plans were attaining minimum performance standards for these three measures.
- The Comprehensive Medical and Dental Program (CHDP) is a State operated managed care plan for children and adolescents enrolled in foster care. Similar to its approach to measuring the performance of other Medicaid plans, AHCCCS has established a set of performance measures and criteria which CHDP is required to meet. Performance measures are HEDIS-based: childhood immunizations, children's access, dental visits, well infant, well child, well adolescent, and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) participation. Three performance levels are set: Minimum Performance Standard, Contract Year Goal, and Benchmark. CHDP is expected to improve its rates annually, consistent with AHCCCS increases in Contract Year Goals. The childhood immunization rate is calculated using sampling and chart review. All other measures are calculated by AHCCCS using administrative data.
- The Oral Health Performance Improvement Project (PIP) aims to increase the rate of annual dental visits among members whose ages are three to 20 years old, with a focus on those three to eight years of age. Baseline measurement was taken in 2002 using the HEDIS Annual Dental Visit measure. The project included encounter data validation against chart documentation. AHCCCS synthesized literature on oral health initiatives and made this available to contracted MCOs. MCOs are expected to implement their own quality improvement initiatives. Re-measurement occurred in 2004 and an updated report indicated that statewide, the target benchmark of 57% was achieved. In fact, 57.7% of the PIP re-measurement sample had at least one dental visit during the time-

frame. However, not all individual contractors met the benchmark performance standard and a second re-measurement was scheduled to be conducted in mid-2006.

- AHCCCS routinely evaluates the immunization status of children two years of age are members of the Medicaid and SCHIP programs. The immunization completion rates for 2004 represent the eleventh assessment for this performance improvement project (PIP). AHCCCS collects data using a hybrid method for a random sample of the population to determine the vaccination status for the same immunizations as HEDIS and that are recommended by the Centers for Disease Control. AHCCCS uses the Healthy People 2010 goal of 90% of all children receiving recommended immunizations. The results of the performance measures are used to ascertain whether contractors demonstrated improvement from the baseline assessments. When rates have not improved, contractors must continue this PIP until rates show statistically significant improvement in further assessments. Once the 90% target has been met, contractors must maintain that level of performance.

  The Clinical Quality Management Unit of AHCCCS assists contractors in the design and implementation of interventions that will enhance performance results. Examples of "best practices" include:

  - outreach efforts, such as mail and telephone reminders to parents and providers; including targeted outreach aimed at geographical or demographic areas with traditionally lower immunization rates
  - financial incentives in the form of a gift certificate for parents of children who complete all required vaccinations
  - encouraging parents to complete all doses of vaccines and scheduling "catch-up" visits
  - member education addresses fears of shots and explaining consequences of not having children fully compliant

  The next planned re-measurement for immunization completion rates was scheduled to occur in late 2005.

- To further the quality of children's health care, the State has established an automated vaccination registry, the Arizona State Immunization Information System (ASIIS). Currently, submitting data to the system is voluntary. The State is currently developing materials that will target providers and encourage immunizations reporting to the system.

- AHCCCS establishes PIP criteria for its Division of Developmental Disabilities (DDD). Measures are "rotated," allowing time between baseline and re-measurement. The June 2005 report contains re-measurement results for diabetes HbA1c testing and control, showing substantial improvements. Drivers of improvement are not identified.

- The State contracts with Regional Behavioral Health Authorities (RBHA) which function like MCOs, to deliver behavioral health services. RBHAs are evaluated through program-specific performance measures and PIPs. RBHA performance measures are chosen primarily to evaluate access to services. They are: 1) emergency

appointments available within 24 hours of referral, 2) routine assessment appointments available within seven days of referral, and 3) routine appointments for ongoing services within 23 days of initial assessment. Baseline measurement ended September 2003. The re-measurement period was expected to end in September 2005. The project involves chart review and data validation.

- The Children's Rehabilitative Services Administration (CRS) provides services to children who have certain medical, disabling, or potentially disabling conditions. Because AHCCCS's regular Medicaid quality assessment program is not appropriate to CRS's population, AHCCCS requires that CRS implement three PIP programs, which were in varying stages of completion: 1) increase appropriate cleft lip/cleft palate follow-up visits, 2) increase accuracy of the Functional Independence Measure for Children (WeeFIM) assessments, and 3) improve pediatric to adult transition services for youth.
- The 2002 ALTCS Diabetes Care study used administrative data acquired from AHCCCS' Medicaid encounter database, subsidized with CMS Medicare fee-for-service claims data. Two HEDIS measures, Lipid profiles and HbA1c testing, were used to compare services provided to Medicaid-only members against the dually-enrolled Medicaid and Medicare members. A third rate for the combined population was also generated. Results showed that there were no differences in the rates for the services provided to the Medicaid enrollees versus the dually-enrolled population.
- A 2002 Immunizations/Pneumococcal Vaccinations PIP report for the Arizona Long Term Care System contains six years of trended data on the status of vaccinations for elderly and/or physically disabled members. Health plans were monitored to assure that each meet contractual requirements to improve rates on these performance indicators. Plans implemented varied interventions, such as educational programs.

Among the PMPP measures reported in Arizona, the largest rate difference between 2001 and 2004 was for the Well Child Visits, 3-6 years of age, a 9.3% increase. In response to low Well Child scores in previous years, in early 2004 AHCCCS led a collaborative effort with plans and community agencies to improve the rates of well-child visits in support of the Governor's School Readiness Board. Details of the outreach were not available; however, Arizona gave credit for improved rates to this work.

The largest difference in reported rates for non-PMPP measures was for Annual Dental Visits, a 10.2% increase.

Report Content/Formats

The Quality Management Performance Measures for Acute-Care Contractors (November 2005) report contains rolled-up State-level MCO rates trended for several years. Rolled-up MCO rates are calculated as a simple average of the eight Medicaid MCOs. The report also contains direct comparisons of MCO-level performance over the last two years. State Minimum Performance Standards are identified as well as those MCOs that fail these standards.

Arizona does <u>not</u> require MCOs to self-report audited HEDIS rates. Instead, AHCCCS uses a statewide, automated managed care encounter system (PMMIS). Rates are calculated by AHCCCS using purely administrative data contained within this system. The State conducts validation studies to evaluate the completeness, accuracy, and timeliness of the encounter data. The most recent data validation study found less than six percent of records were inaccurate. There is no indication in the report that AHCCCS rate calculation undergoes an external audit.

Summary of Quality Measure Reporting

In summary, for the 2004 calendar year, clinical quality data are available for six HEDIS measures (not including age cohort and "sub-measure" breakdowns). Rates are "statewide" given that almost all members are covered by the eight MCOs included in the report.

Other States may benefit from Arizona's success in setting and monitoring compliance to performance standards (for standard Medicaid MCOs and a variety of plans for specific subpopulations), developing managed care claims/encounter databases that are complete and accurate enough to support generation and public reporting of performance, developing population-focused Performance Improvement Programs, developing internal expertise required to generate measures and conducting data validation assessments. Further, Arizona's experience with the acquisition and use of lab data also may be beneficial to other States.

ARKANSAS

State Quality Reporting Background

The Arkansas Department of Human Services (ADHS) contracts with the Arkansas Foundation for Medical Care (AFMC) to provide external quality review services for its Medicaid PCCM, ConnectCare. ConnectCare covers more than 61% of the nearly 613,000 Medicaid recipients in the State. Medicaid children are insured through a ConnectCare-operated plan called ARKids First A. Performance measure data presented in this report includes both adults and children enrolled in ConnectCare.

The two agencies, ADHS and AFMC, have worked together for the past five years to jointly produce an annual report regarding the status of the program for the State. The following quality measurement publications were evaluated for this report:

- Measuring More of What Matters, HEDIS® Measures in Arkansas, 2005
- Measuring More of What Matters, HEDIS® Measures in Arkansas, 2004

The HEDIS reports contain four years of quality measurement data, evidence-based strategies for improvements, and, when applicable, a list of patient and provider tools that are available to improve performance. Data for the most recent four calendar years, 2001-2004, are summarized below.

PMPP Reporting Summary

The following table summarizes clinical quality measure results available in public reports for PMPP measures only. Empty cells indicate that the State did not report the measure. Comparisons in measure rate changes are from the earliest year of available data to rates reported for 2004.

Arkansas	ConnectCare				
	PCCM				
	Data Year 2001	Data Year 2002	Data Year 2003	Data Year 2004	Rate Change 2001–2004
Children's Access To PCP: Age 12-24 Months					
Children's Access To PCP: Age 25 Months - 6 years					
Children's Access To PCP: Age 7-11 Years					
Children's Access To PCP: Age 12-19 Years					
Adult Access to Preventive/Ambulatory Health Services: Age 20-44					
Adult Access to Preventive/Ambulatory Health Services: Age 45-64					
Adult Access to Preventive/Ambulatory Health Services: Age 65+					
Well Child Visits in The First 15 Months of Life: Six or More Visits		35.6	38.4	37.4	1.8
Well Child Visits Ages 3-6		33.6	33.9	37.5	3.9
Prenatal Postpartum Care: Timeliness of Prenatal Care					
Comprehensive Diabetes Care: HbA1c Testing	50.3	56.1	53.1	68.6	18.3
Use of Appropriate Medications for Asthma: Age 5-9					
Use of Appropriate Medications for Asthma: Age 10-17					
Use of Appropriate Medications for Asthma: Age 18-56					
Use of Appropriate Medications for Asthma: All Ages Combined			71.7	70.7	-1.0

In summary, data for four of the seven PMPP measures are available in 2004.

The large increase in rates for HbA1c testing may be attributed to Arkansas Medicaid's public awareness campaign aimed at increasing preventive care services for Diabetics. Intervention tools are available for both patients and providers. Patient materials include easy-reading brochures in English or Spanish that outline information about the disease. There are also patient wallet cards and a brochure promoting HbA1c screening. Providers have access to chart stickers that list important aspects of diabetes care.

Non-PMPP HEDIS Measure Reporting

The State also reports on twelve non-PMPP HEDIS measures. Comparisons in measure rate changes are from the earliest year of available data to rates reported for 2004.

In 2003, the definition utilized for the Diabetes Care Eye Exam measure changed and strongly affected the rate. However, in 2004, performance once again showed improvement.

Arkansas	ConnectCare				
	PCCM				
	Data Year 2001	Data Year 2002	Data Year 2003	Data Year 2004	Rate Change
Childhood Immunization Status: Combo 1		61.5	53.5	65.1	3.6
Childhood Immunization Status: MMR		90.4	87.6	91.2	0.8
Childhood Immunization Status: HIB		85.2	78.6	81.7	-3.5
Childhood Immunization Status: VZV		87.7	84.8	91.1	3.4
Childhood Immunization Status: Hepatitis B		86.5	86.7	87.4	0.9
Childhood Immunization Status: DTP		79.0	76.2	86.8	7.8
Childhood Immunization Status: IPV/OPV		91.4	98.4	89.9	-1.5
Well Child Visits in The First 15 Months of Life: Zero Visits		4.7	5.7	5.7	1.0
Well Child Visits in The First 15 Months of Life: One Visit		9.8	10.7	10.1	0.3
Well Child Visits in The First 15 Months of Life: Two Visits		11.6	9.8	10.0	-1.6
Well Child Visits in The First 15 Months of Life: Three Visits		11.3	10.4	10.5	-0.8
Well Child Visits in The First 15 Months of Life: Four Visits		13.3	11.9	11.5	-1.7
Well Child Visits in The First 15 Months of Life: Five Visits		13.9	13.1	14.7	0.9
Adolescent Immunization Status: VZV		14.7	14.8		
Adolescent Well-Care Visits	16.3	14.7	14.8	25.4	9.1
Appropriate Treatment for Children: Pharyngitis				34.3	
Appropriate Treatment for Children: Upper Respiratory Infection				71.0	
Annual Dental Visit	43.5	45.0	44.0	44.3	0.8
Breast Cancer Screening	38.5	38.1	40.2	39.1	0.6
Cervical Cancer Screening	36.2	37.9	43.6	46.4	10.2
Chlamydia Screening in Women: All Ages	48.6	51.5	53.0	38.5	-10.1
Colorectal Cancer Screening			24.6		
Comprehensive Diabetes Care: Eye Exams	56.5	59.6	26.1	32.2	-24.3
Comprehensive Diabetes Care: LDL-C Screening	43.6	49.7	46.9	65.0	21.4
Medical Assistance with Smoking Cessation – (Survey Measure) Advise to Quit			49.8	59.5	9.7
Medical Assistance with Smoking Cessation – (Survey Measure) Discuss Medications			17.2	30.6	13.4
Medical Assistance with Smoking Cessation – (Survey Measure) Cessation Strategies			18.3	25.6	7.3

State-Specific Measures and Characteristics

To address State-specific needs, the State has developed its own measure for Prenatal Care and uses a survey to derive the following measures:

- Percent receiving recommended number of prenatal visits
- Percent of members who felt finding a prenatal care provider was not a problem
- Percent who rated their prenatal care provider 8 or above on a scale of 0-10 (10 is best)
- Percent of prenatal members who felt they were usually or always treated with courtesy and respect
- Percent of prenatal members who believed their provider usually or always listened to them
- Percent of prenatal members who felt their provider offered understandable information

The State also conducts a Satisfaction and Perception of Care Survey to assess how well the program is meeting the needs of its enrollees.

- Overall average quality and satisfaction for PCP, Specialist, Quality of Care
- Percent of members that reported they are highly satisfied with access to a doctor, getting care without long waits, and the ease of finding a doctor
- Percent of members that reported high satisfaction with communication from providers and their staff:
    - Doctor communicated well and spent enough time with patient
    - Office staff treated patient with courtesy and respect

Finally, the State also reports on the diversity of Medicaid membership enrollees by race and gender.

Quality Improvement Efforts

The Department of Human Services assessed the outcome of the transition to a PCCM model through key utilization/access/expenditure measures:

- AFMC determined that since PCCM program inception, use of emergency rooms decreased by more than 50 percent
- A University of Arkansas study showed that physician visits nearly doubled during a 17 month evaluation period
- The same University of Arkansas study also showed a savings of $30 million during the evaluation period over the former Medicaid system

Specific strategies to improve access included providing a centralized, consumer-oriented list of available providers, patient outreach and education about ConnectCare delivered through physicians, television public service announcements, and a 24-hour toll-free telephone hotline.

With assistance from its EQRO, AFMC, on its Website, the State acts as a resource to providers by making available "Free Quality Improvement Intervention Tools." These tools cover more than 20 different clinical areas ranging from well child visits to surgical infection prevention.

Examples of these tools include: patient and family education, referrals, scheduling regular office visits for patients with chronic diseases, improved documentation of services and use of checklists in the medical record, as well as reminders about treatment and screening guidelines. Some tools address topics that are measured by HEDIS: smoking cessation, adult immunization - flu and pneumonia, antibiotic resistance, asthma, breast cancer prevention, cervical cancer screening, chlamydia, diabetes, well child care.

Comparing performance in 2003 to prior years, the Cervical Cancer Screening measure showed the greatest improvement with a 7.4% increase. Although the HEDIS Measures report does not cite a reason for the improvement, Cervical Cancer is one of the clinical areas targeted on AFMC's Website. The Cervical Cancer Project encourages providers to follow cervical cancer guidelines and to develop a plan to increase screening within their practices. Suggestions include sending out reminder postcards when screenings are due, conducting pre-visit screening to identify patients who are due for Pap testing, and "making arrangements with OB/GYN providers to expedite referrals."

In October 2004, Arkansas Medicaid began reimbursing providers for smoking cessation treatments and counseling. The rates for the HEDIS Medical Assistance with Smoking Cessation increased substantially in measurement year 2004, ranging from 7.3% to 13.4% across the three measures. The additional reimbursement may have prompted this increase.

Report Content/Formats

The report includes performance ratings, benchmarking to national data from Medicaid plans that report to NCQA, and plan trending over time. It also provides descriptive analysis of the gender and race distributions in the Arkansas Medicaid population.

The stated goal of the report is to improve service to the people of Arkansas by providing information on where to focus improvement efforts, such as patient outreach and educational efforts.

The report is well designed and offers information on each measure, including tools appropriate for consumers, in a clear and concise layout. The publication enables consumers, researchers, and other decision makers to carefully evaluate the State program.

Summary of Quality Measure Reporting

In summary, clinical quality data are available for 13 HEDIS measures from the Arkansas Medicaid PCCM, ConnectCare, in 2004. Performance measure rates for both PMPP and non-PMPP measures, strategies for improvement, and resources for intervention tools are included in the annual report.

Other States may benefit from the design and layout of Arkansas' Measure More of What Matters report, the State's experience with identifying and making available free quality improvement tools, and using survey methodology to assess perinatal care.

CALIFORNIA

State Quality Reporting Background

The California Department of Health Services (CDHS), Medi-Cal Managed Care Division operates the State's Medicaid Managed Care programs serving 50% of all California Medi-Cal enrollees. In 2004, a total of 22 managed care plans provided services to approximately 3.2 million Medi-Cal managed care beneficiaries in 22 counties. The State reports performance results for all of the MCOs, but does not report performance on its FFS population (approximately 50% of the statewide total).

MCO Medi-Cal enrollees receive their health care through one of three health plan models, determined by county of residence: Two-Plan, County-Organized Health Systems, and Geographic Managed Care. The Geographic Managed Care model provides service through a choice of commercially-operated managed care plans in the area for the Temporary Assistance to Needy Families (TANF) population. The County-Organized Health System is a county-developed managed care system that services "nearly all" of the Medi-Cal eligible population in that county. In the third model, the Two-Plan model, commercial plans or "Local Initiatives" care for the TANF population. A "Local Initiative" is a community-developed managed care plan. Each of the 22 counties offers only one of the three models to its Medi-Cal population.

The Medi-Cal Managed Care Division produced the following quality measurement-related reports that were reviewed for this report:

- Report of the 2005 Performance Measures for Medi-Cal Managed Care Members (August 2005)
- Report of the 2004 Performance Measures for Medi-Cal Managed Care Members (September 2004)
- Results of the HEDIS ® 2002 Performance Measures for Medi-Cal Managed Care Members (February 2003)
- Results of the HEDIS ® 2001 Performance Measures for Medi-Cal Managed Care Members (September 2002)
- Choose the Best Medi-Cal Health Plan, 2005 (a series of 16 county-based report cards)

In addition, a number of other documents, primarily EQRO-focused studies, were identified:

- Quality Strategy (May 2004)
- Asthma Management/Pharmaceutical Utilization 2002 report (March 2003)
- Chlamydia Screening in Women and Data Validation Study (March 2003)
- Investing in Adolescent Health, A Strategic Plan by the California Adolescent Health Collaborative (2000)

The 2005 Performance Measures Report contains four years of plan-level quality measurement and a weighted statewide average. Note that California did not report performance data for calendar year 2002. Performance rates are provided in the report for four years: 2000-2001 and 2003-2004. The results are summarized below.

PMPP Reporting Summary

The following table summarizes clinical quality measure results available in public reports for PMPP measures only. Empty cells indicate that the State did not report the measure. Comparisons in measure rate changes are from the earliest year of data to rates reported for 2004.

California	Medi-Cal Managed Care Average				
	MCO				
	Data Year 2000	Data Year 2001	Data Year 2003	Data Year 2004	Rate Change 2000–2004
Children's Access To PCP: Age 12-24 Months					
Children's Access To PCP: Age 25 Months - 6 years					
Children's Access To PCP: Age 7-11 Years					
Children's Access To PCP: Age 12-19 Years					
Adult Access to Preventive/Ambulatory Health Services: Age 20-44					
Adult Access to Preventive/Ambulatory Health Services: Age 45-64					
Adult Access to Preventive/Ambulatory Health Services: Age 65+					
Well Child Visits in The First 15 Months of Life: Six or More Visits	37.6	38.6	48.2	51.9	14.3
Well Child Visits Ages 3-6	56.5	59.6	65.7	68.7	12.2
Prenatal Postpartum Care: Timeliness of Prenatal Care	69.4	73.0	77.3	79.6	10.2
Comprehensive Diabetes Care: HbA1c Testing					
Use of Appropriate Medications for Asthma: Age 5-9					
Use of Appropriate Medications for Asthma: Age 10-17					
Use of Appropriate Medications for Asthma: Age 18-56					
Use of Appropriate Medications for Asthma: All Ages Combined	56.0	58.6	61.3	62.1	6.1

In summary, data for four of the seven PMPP measures are available from Medi-Cal's MCOs. All measures experienced improvement, with the Well Child measures demonstrating the largest growth. The report does not provide reasons for changes in performance rates, other than to note the plan's ability to capture and report data has an impact on scores.

Non-PMPP HEDIS Measure Reporting

The State also reports non-PMPP HEDIS measures as summarized below. As displayed in the table below, for some measures, rate changes are for 2004 and the earliest year of available data, 2003.

California	Medi-Cal Managed Care Average				
	MCO				
	Data Year 2000	Data Year 2001	Data Year 2003	Data Year 2004	Rate Change
Childhood Immunization Status: Combo 1	56.8	61.7	66.9	68.7	11.9
Childhood Immunization Status: Combo 2	51.5	58.8	65.4	67.6	16.1
Adolescent Well-Care Visits	26.9	28.1	31.9	35.1	8.2
Breast Cancer Screening			54.8	65.2	10.4
Cervical Cancer Screening			61.6	65.9	4.3
Chlamydia Screening in Women: All Ages			43.1	48.0	4.9
Prenatal Postpartum Care: Postpartum Care	47.0	52.9	55.6	58.1	11.1
Comprehensive Diabetes Care: Eye Exams	58.2	62.4	60.8	63.3	5.1

The rates for the Childhood Immunization measures increased the most. Postpartum Care and Breast Cancer Screening results also showed substantial growth. The report does not provide reasons for changes in performance rates.

State-Specific Measures and Characteristics

To address State-specific needs, the State has also developed its own measures as follows:

- Over-utilization of Short-acting Beta-Agonist Control Medications (Persistent Asthmatics with >=8 Dispensed Canisters of Short-acting Beta-Agonists (5-9, 10-17, 18-56, All ages).
- Childhood Blood Lead Screening

Quality Improvement Efforts

Each year, CDHS requires Medi-Cal plans to report audited rates for a selected set of performance measures, called the "External Accountability Set". This set includes HEDIS measures, CAHPS measures, and the two State developed measures (Overuse of Asthma Rescue Medicines and Childhood Blood Lead Screening). The Medi-Cal Managed Care Division (MMCD) uses the External Accountability Set to identify plan-specific and system-wide opportunities for improvement.

All health plans are required to meet the Minimum Performance Level for each HEDIS measure selected. Plans that do not must submit an improvement plan outlining the process it will adopt to improve measure rates the following year. The Department may mandate additional reporting until performance improves.

In addition to the External Accountability Set, MMCD also collected four HEDIS Use of Service measures for an "Under/Over-Utilization Monitoring Measure Set." A report was not available for inclusion in this summary; however, it was noted that the State plans to make managed care utilization information available at a future date.

MMCD requires plans to conduct four quality improvement projects (QIPs) and sets the following specifications for the projects:

- at least one QIP must be plan-specific
- at least one QIP must be a small group collaborative project (with at least one other health plan)
- one QIP must be the statewide collaborative project (e.g., Adolescent Health statewide collaborative)
- additionally, one of the four QIPs must be non-clinical and one must be clinical.

In the May 2004 Quality Strategy report, it was noted that the monitoring of quality improvement activities is being re-structured to include an on-going review and a "mechanism for more comprehensive assessment."

The California Initiative to Improve Adolescent Health by 2010 is a public-private partnership to improve adolescent health across California and includes more than 40 organizations and agencies. The strategic plan and fact sheet are available online under the Maternal, Child and Adolescent Health Branch section of the Department of Health Services' Primary Care and Family Health Division[2].

In 2003, the State, together with the Health Services Advisory Group (HSAG), published the results of two quality improvement studies.

The Chlamydia Screening in Women report, conducted during 2000, was part of the overall Statewide Quality Improvement Collaborative Initiative (QICI) and included reporting of baseline results as well as a data validation study. The collaborative selected the HEDIS Chlamydia Screening measure and collected administrative data to determine rates. The intervention phase varied across the different members of the collaborative and included:

- development and dissemination of clinical practice guidelines for health plans and providers
- member education materials
- provider training programs, including a Web-based option
- provider feedback on screening rates
- financial incentives for providers

[2] http://www.mch.dhs.ca.gov/programs/ciiah/ciiahfacts.htm

The data validation study evaluated the consistency of the administrative information against the medical record to assist in determining data completeness. Remeasurement was planned with HEDIS 2003 collection. No final project report was available online.

The Over-utilization of Short-acting Beta-agonist Control Medications study was conducted during 2002, using 2001 data. The project was intended to help identify people with poorly controlled asthma who could benefit from more intensive case management. Through administrative data, the project identified the sample population using the denominator specifications for the HEDIS asthma measure. The numerator population was determined by those who received prescriptions for eight or more canisters of short-acting beta-agonist inhalers during the measurement year. Although measure reliability and validity were not tested, results showed that a substantial number of Medi-Cal members have poorly controlled asthma and have "sub-optimal medication management." The report authors recommended creating a collaborative improvement project including the development of asthma registries, provider feedback, and case management; and encouraging NCQA to develop asthma care performance measures that incorporates the assessment of beta-agonist over-use.

Report Content/Formats

In 2004, the CDHS chose HEDIS measures to assess the process of care provided in three arenas: women's health, child and adolescent health, and living with illness. In the Performance Measures Report, results are organized and presented in two formats: statewide by plan and model-type by plan. The report did not address reasons for change in performance rates.

The annual performance reports include benchmarking to both Medicaid and Commercial national data, as well as statewide aggregated results for Managed Care. The results are presented in easy-to-read graphical displays showing plan results, statewide averages, minimum performance and high performance levels (25th and 90th percentiles of the NCQA Medicaid benchmarks), and program type. A great deal of detailed information is provided in a user-friendly format.

The State also produced consumer report cards, My Medi-Cal Choice For Healthy Care, that are available for counties where multiple Medi-Cal plans operate (16 counties). In addition to providing information about Medi-Cal services, the guide includes comparisons in plan performance for selected CAHPS survey measures and three HEDIS measures. The 2005 Guides (2004 data) present results in four performance categories: highest, higher, average, and lower.

The five survey measures include: Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Courteous Office Staff, and Plan Customer Service. For comparing quality of care for children, three areas of performance are compared: immunizations, adolescent well care, and asthma medications for children. Comparisons of prenatal care, postpartum care, and appropriate use of asthma medications are available adults. Detailed HEDIS measure information is not available (e.g., age cohort and "sub-measure" breakdowns).

Summary of Quality Measure Reporting

In summary, clinical quality data are available for 11 HEDIS measures (not including age cohort and "sub-measure" breakdowns) for each of the MCOs. Extensive performance measurement information directed at both consumers and providers/insurers/policy makers has been available for several years.

Other States may benefit from California's experience with collaborative initiatives that develop quality improvement projects, including interventions and re-measurement, and the establishment of minimum performance levels based on health plan quality performance, including the requirement of improvement efforts by plans that fail to reach the required benchmark. Also of note is California's development of performance reports with easy-to-read graphical displays depicting plan results, statewide averages, minimum performance and high performance levels (25th and 90th percentiles of the NCQA Medicaid benchmarks), and program type.

COLORADO

State Quality Reporting Background

Colorado's Medicaid enrollees are covered by a combination of all three Medicaid plan types: MCO, PCCM, and FFS. Colorado is the only State that provided consistent quality measurement data across MCO, FFS, and PCCM populations. The Colorado Department of Health Care Policy and Financing has conducted a number of quality measurement efforts.

Annually, the agency produces a key HEDIS performance measurement report:

- Health Plan Employer Data & Information Set, Evaluation of Quality of Care Delivered to Colorado Medicaid Clients in 2004 (November 2005)
- Health Plan Employer Data & Information Set, Evaluation of Quality of Care Delivered to Colorado Medicaid Clients in 2002 and 2003 (November 2004)
- Health Plan Employer Data & Information Set, Evaluation of Quality of Care Delivered to Colorado Medicaid Clients in 2001 (April 2003)

In addition, a number of other documents, primarily EQRO-focused studies, were identified:

- 2004-2005 External Quality Review Technical Report for Colorado Medicaid Managed Care (September 2005)
- Colorado 2004-2005 Focused Study on Access to Preventive Care for Persons With Disabilities (August 2005)
- Colorado 2004-2005 Focused Study Evaluation of EPSDT Services (September 2005)
- Colorado Medicaid 2004 Perinatal Care Focused Study Evaluation (July 2004)
- Colorado Medicaid 2004 Asthma Medication Management Focused Study Evaluation (July 2004)
- National CAHPS Benchmarking Database 2004 (October 2004)
- Quality Assessment and Improvement Strategy (August 2003)
- 2003 – 2004 Quality Strategy Work Plan (August 2003)
- Colorado Medicaid Access to Preventive Care for the Disabled, Focused Study (June 2003)
- Colorado Medicaid 2002 Diabetes Quality-of-Care Focused Study (June 2003)
- Blood Lead Screening Intervention, Final Report (May 2002)

The "HEDIS Evaluation" report contains four years of quality measurement data. Beginning with the 2004 report, the Colorado Department of Health Care Policy and Financing discontinued the reporting of a statewide average covering the FFS, PCCM, and MCO populations. To allow trending of data within this report, we decided to create an average rate.

However, we discovered that the State previously reported weighted averages that we were unable to reproduce. We opted to calculate a simple statewide rate for all years included in our analysis. We also chose to create the MCO average to allow us to look at MCO-only performance. Data for the most recent four years, 2001- 2004, are summarized below.

PMPP Reporting Summary

The following table summarizes clinical quality measure results available in public reports for PMPP measures only. A table containing the combined MCO/PCCM/FFS (statewide) rate appears first followed by separate tables MCO, PCCM, and FFS rates. Comparisons in measure rate changes are from the earliest year of data to rates reported for 2004. Empty cells indicate that the State did not report the measure.

Colorado	Simple State Average MCO/PCCM/FFS				
	Data Year 2001	Data Year 2002	Data Year 2003	Data Year 2004	Rate Change
Children's Access To PCP: Age 12-24 Months	83.9			57.9	-26.0
Children's Access To PCP: Age 25 Months - 6 years	69.4			49.3	-20.1
Children's Access To PCP: Age 7-11 Years	73.7			54.0	-19.7
Children's Access To PCP: Age 12-19 Years					
Adult Access to Preventive/Ambulatory Health Services: Age 20-44	71.1		69.6		
Adult Access to Preventive/Ambulatory Health Services: Age 45-64	75.7		67.0		
Adult Access to Preventive/Ambulatory Health Services: Age 65+	70.6		54.8		
Well Child Visits in The First 15 Months of Life: Six or More Visits	18.5	25.4	34.0	30.9	12.4
Well Child Visits Ages 3-6	45.5	42.9	52.0		
Prenatal Postpartum Care: Timeliness of Prenatal Care		66.5	76.5	27.4	-39.1
Comprehensive Diabetes Care: HbA1c Testing		54.0		64.4	10.4
Use of Appropriate Medications for Asthma: Age 5-9	29.2	67.7	67.8		
Use of Appropriate Medications for Asthma: Age 10-17		72.2	72.3		
Use of Appropriate Medications for Asthma: Age 18-56		72.6	72.7		
Use of Appropriate Medications for Asthma: All Ages Combined		71.5	71.6		

Colorado	Managed Care Organizations Average				
	MCO				
	Data Year 2001	Data Year 2002	Data Year 2003	Data Year 2004	Rate Change
Children's Access To PCP: Age 12-24 Months	83.5			95.2	11.7
Children's Access To PCP: Age 25 Months - 6 years	69.6			83.9	14.3
Children's Access To PCP: Age 7-11 Years	73.7			87.7	14.0
Children's Access To PCP: Age 12-19 Years					
Adult Access to Preventive/Ambulatory Health Services: Age 20-44	72.4		81.6		
Adult Access to Preventive/Ambulatory Health Services: Age 45-64	76.9		86.6		
Adult Access to Preventive/Ambulatory Health Services: Age 65+	77.8		87.5		
Well Child Visits in The First 15 Months of Life: Six or More Visits	12.3	22.1	32.2	39.8	27.4
Well Child Visits Ages 3-6	45.0	53.1	56.5		
Prenatal Postpartum Care: Timeliness of Prenatal Care		79.2	88.7		
Comprehensive Diabetes Care: HbA1c Testing		80.0		84.1	4.1
Use of Appropriate Medications for Asthma: Age 5-9	27.9		63.4		
Use of Appropriate Medications for Asthma: Age 10-17			69.6		
Use of Appropriate Medications for Asthma: Age 18-56			69.9		
Use of Appropriate Medications for Asthma: All Ages Combined			68.4		

Colorado	Primary Care Physician Program				
	PCCM				
	Data Year 2001	Data Year 2002	Data Year 2003	Data Year 2004	Rate Change
Children's Access To PCP: Age 12-24 Months	85.7			26.2	-59.5
Children's Access To PCP: Age 25 Months - 6 years	68.5			19.8	-48.7
Children's Access To PCP: Age 7-11 Years	73.7			29.8	-43.9
Children's Access To PCP: Age 12-19 Years					
Adult Access to Preventive/Ambulatory Health Services: Age 20-44	64.9		67.2		
Adult Access to Preventive/Ambulatory Health Services: Age 45-64	69.8		68.2		
Adult Access to Preventive/Ambulatory Health Services: Age 65+	34.6		32.7		
Well Child Visits in The First 15 Months of Life: Six or More Visits	49.4	37.5	51.8	34.8	-14.6
Well Child Visits Ages 3-6	47.9	39.4	55.2		
Prenatal Postpartum Care: Timeliness of Prenatal Care		68.9	68.9	35.5	-33.4
Comprehensive Diabetes Care: HbA1c Testing		44.3		55.2	10.9
Use of Appropriate Medications for Asthma: Age 5-9	35.5		71.8		
Use of Appropriate Medications for Asthma: Age 10-17			76.0		
Use of Appropriate Medications for Asthma: Age 18-56			74.5		
Use of Appropriate Medications for Asthma: All Ages Combined			74.3		

Colorado	Unassigned Fee-for-Service				
	FFS				
	Data Year 2001	Data Year 2002	Data Year 2003	Data Year 2004	Rate Change
Children's Access To PCP: Age 12-24 Months	66.2			14.8	-51.4
Children's Access To PCP: Age 25 Months - 6 years	41.7			9.6	-32.1
Children's Access To PCP: Age 7-11 Years	48.1			10.7	-37.4
Children's Access To PCP: Age 12-19 Years					
Adult Access to Preventive/Ambulatory Health Services: Age 20-44	16.8		48.1		
Adult Access to Preventive/Ambulatory Health Services: Age 45-64	10.3		26.5		
Adult Access to Preventive/Ambulatory Health Services: Age 65+	6.4		11.5		
Well Child Visits in The First 15 Months of Life: Six or More Visits	34.3	19.7	19.7	9.2	-25.1
Well Child Visits Ages 3-6	37.7	26.0	39.9		
Prenatal Postpartum Care: Timeliness of Prenatal Care		38.9	59.8	19.2	-19.7
Comprehensive Diabetes Care: HbA1c Testing		11.7		34.3	22.6
Use of Appropriate Medications for Asthma: Age 5-9	32.4		72.6		
Use of Appropriate Medications for Asthma: Age 10-17			74.0		
Use of Appropriate Medications for Asthma: Age 18-56			76.6		
Use of Appropriate Medications for Asthma: All Ages Combined			75.2		

Colorado reports four of seven PMPP measures. In prior years, the Adult Access to Care and the Appropriate Use of Medications for Asthma measures were reported; neither measure was reported by Colorado Medicaid plans in 2004.

The PCCM and FFS programs, and therefore statewide averages, presented substantial decreases in Children’s Access, Infant Well Care, and Prenatal Care rates. These measures were not reported in 2002 or 2003, perhaps indicating that there may be technical issues impacting rates. No explanation was provided for rate fluctuations in the report.

Non-PMPP HEDIS Measure Reporting

The State reports a large number of non-PMPP HEDIS measures as summarized below. Note that the comparisons in measure rate changes are from the earliest year of data to rates reported for 2004.

Colorado	Simple State Average				
	MCO/PCCM/FFS				
	Data Year 2001	Data Year 2002	Data Year 2003	Data Year 2004	Rate Change
Childhood Immunization Status: Combo 1	44.2	26.4	50.8	47.3	3.1
Childhood Immunization Status: Combo 2	40.8	24.5	47.7	45.5	4.7
Childhood Immunization Status: MMR	76.8	74.9	78.9	72.6	-4.3
Childhood Immunization Status: HIB	61.3	62.2	67.1	61.0	-0.4
Childhood Immunization Status: VZV	71.6	69.3	73.3	69.7	-1.9
Childhood Immunization Status: Hepatitis B	62.4	66.8	71.5	63.4	0.9
Childhood Immunization Status: DTP	57.3	34.8	61.5	57.9	0.6
Childhood Immunization Status: IPV/OPV	68.1	70.9	75.2	66.3	-1.8
Well Child Visits in The First 15 Months of Life: Zero Visits	8.7	19.7	13.1	26.5	17.8
Well Child Visits in The First 15 Months of Life: One Visit	6.6				
Well Child Visits in The First 15 Months of Life: Two Visits	9.3				
Well Child Visits in The First 15 Months of Life: Three Visits	16.0				
Well Child Visits in The First 15 Months of Life: Four Visits	20.2				
Well Child Visits in The First 15 Months of Life: Five Visits	20.8				
Adolescent Immunization Status: Combo 1	34.1	35.8	29.8	20.2	-13.9
Adolescent Immunization Status: Combo 2	21.4	15.5	16.1	12.1	-9.4
Adolescent Immunization Status: MMR	50.5	50.6	43.5		
Adolescent Immunization Status: Hepatitis B	38.4	39.3	32.0		
Adolescent Immunization Status: VZV	31.2	22.0	22.4		
Adolescent Well-Care Visits		27.6	33.9	24.8	-2.8
Appropriate Treatment for Children: Upper Respiratory Infection				86.1	
Annual Dental Visit				40.6	
Breast Cancer Screening		37.9	39.1	38.3	0.3
Cervical Cancer Screening		44.8	54.1	50.9	6.1
Chlamdyia Screening in Women: All Ages Combined		24.2	32.1		
Chlamdyia Screening in Women: Age 16-20		25.0	32.6		
Chlamdyia Screening in Women: Age 21-26		23.4	31.6		
Prenatal Postpartum Care: Postpartum Care		50.6	56.6	44.2	-6.4
Comprehensive Diabetes Care: Percent HbA1c		58.0		58.9	0.9
Comprehensive Diabetes Care: Eye Exams		35.8		30.2	-5.6
Comprehensive Diabetes Care: LDL-C Screening		52.1		64.9	12.8
Comprehensive Diabetes Care: LDL-C Level < 130		31.0		35.5	4.6
Comprehensive Diabetes Care: Monitoring for Diabetic Nephropathy		35.4		34.2	-1.3
Controlling High Blood Pressure		34.0	37.6	30.6	-3.4

Colorado	Managed Care Organizations Average				
	MCO				
	Data Year 2001	Data Year 2002	Data Year 2003	Data Year 2004	Rate Change
Childhood Immunization Status: Combo 1	43.9	25.3	58.1	65.5	21.5
Childhood Immunization Status: Combo 2	40.7	24.1	54.9	62.7	22.0
Childhood Immunization Status: MMR	77.5	82.2	88.1	88.3	10.8
Childhood Immunization Status: HIB	60.9	69.3	75.2	77.9	17.0
Childhood Immunization Status: VZV	72.2	76.8	82.4	84.3	12.1
Childhood Immunization Status: Hepatitis B	61.0	74.2	79.9	82.8	21.8
Childhood Immunization Status: DTP	57.2	33.6	69.3	76.6	19.4
Childhood Immunization Status: IPV/OPV	67.0	76.7	82.6	85.3	18.3
Well Child Visits in The First 15 Months of Life: Zero Visits	9.1	15.6	13.0	1.7	-7.4
Well Child Visits in The First 15 Months of Life: One Visit	7.3				
Well Child Visits in The First 15 Months of Life: Two Visits	10.0				
Well Child Visits in The First 15 Months of Life: Three Visits	17.9				
Well Child Visits in The First 15 Months of Life: Four Visits	22.1				
Well Child Visits in The First 15 Months of Life: Five Visits	21.3				
Adolescent Immunization Status: Combo 1	33.1				
Adolescent Immunization Status: Combo 2	22.1				
Adolescent Immunization Status: MMR	48.9				
Adolescent Immunization Status: Hepatitis B	37.2				
Adolescent Immunization Status: VZV	32.2				
Adolescent Well-Care Visits		33.6	35.5	35.2	1.6
Breast Cancer Screening		57.1	60.8	54.0	-3.2
Cervical Cancer Screening		66.6	65.9	66.5	-0.1
Chlamdyia Screening in Women: All Ages Combined		36.8	42.8		
Chlamdyia Screening in Women: Age 16-20		38.2	44.4		
Chlamdyia Screening in Women: Age 21-26		35.7	41.3		
Prenatal Postpartum Care: Postpartum Care		57.2	65.4		
Comprehensive Diabetes Care: Percent HbA1c		35.0		32.8	-2.2
Comprehensive Diabetes Care: Eye Exams		58.9		54.7	-4.2
Comprehensive Diabetes Care: LDL-C Screening		80.3		81.7	1.4
Comprehensive Diabetes Care: LDL-C Level < 130		50.2		58.2	8.0
Comprehensive Diabetes Care: Monitoring for Diabetic Nephropathy		54.5		47.0	-7.5

Colorado	Primary Care Physician Program				
	PCCM				
	Data Year 2001	Data Year 2002	Data Year 2003	Data Year 2004	Rate Change
Childhood Immunization Status: Combo 1	45.7	33.3	55.5	41.1	-4.6
Childhood Immunization Status: Combo 2	41.4	29.7	50.4	39.9	-1.5
Childhood Immunization Status: MMR	73.7	73.2	83.2	71.3	-2.4
Childhood Immunization Status: HIB	63.7	59.9	71.8	60.1	-3.6
Childhood Immunization Status: VZV	68.6	68.1	74.9	69.1	0.5
Childhood Immunization Status: Hepatitis B	69.8	65.2	78.1	58.2	-11.6
Childhood Immunization Status: DTP	57.9	43.3	65.9	54.3	-3.6
Childhood Immunization Status: IPV/OPV	73.7	70.1	79.6	62.0	-11.7
Well Child Visits in The First 15 Months of Life: Zero Visits	6.8	12.2	2.2	32.4	25.6
Well Child Visits in The First 15 Months of Life: One Visit	3.2				
Well Child Visits in The First 15 Months of Life: Two Visits	5.4				
Well Child Visits in The First 15 Months of Life: Three Visits	6.3				
Well Child Visits in The First 15 Months of Life: Four Visits	10.9				
Well Child Visits in The First 15 Months of Life: Five Visits	18.0				
Adolescent Immunization Status: Combo 1	39.2	39.4	36.5	31.6	-7.6
Adolescent Immunization Status: Combo 2	18.0	18.5	19.7	17.5	-0.5
Adolescent Immunization Status: MMR	58.9	57.2	53.3		
Adolescent Immunization Status: Hepatitis B	44.3	43.3	39.4		
Adolescent Immunization Status: VZV	26.0	27.3	27.7		
Adolescent Well-Care Visits		19.7	34.3	19.2	-0.5
Appropriate Treatment for Children: Upper Respiratory Infection				84.5	
Annual Dental Visit				54.7	
Breast Cancer Screening		32.1	32.2	32.4	0.3
Cervical Cancer Screening		39.0	52.6	38.1	-0.9
Chlamdyia Screening in Women: All Ages Combined		14.6	23.4		
Chlamdyia Screening in Women: Age 16-20		15.0	21.9		
Chlamdyia Screening in Women: Age 21-26		14.3	24.6		
Prenatal Postpartum Care: Postpartum Care		55.0	55.0	49.1	-5.9
Comprehensive Diabetes Care: Percent HbA1c		72.8		79.1	6.3
Comprehensive Diabetes Care: Eye Exams		21.2		7.8	-13.4
Comprehensive Diabetes Care: LDL-C Screening		39.4		58.2	18.8
Comprehensive Diabetes Care: LDL-C Level < 130		17.3		17.8	0.5
Comprehensive Diabetes Care: Monitoring for Diabetic Nephropathy		22.1		24.6	2.5
Controlling High Blood Pressure		52.1	39.9	41.1	-11.0

Colorado	Unassigned Fee-for-Service				
	FFS				
	Data Year 2001	Data Year 2002	Data Year 2003	Data Year 2004	Rate Change 2001–2003
Childhood Immunization Status: Combo 1	33.8	21.7	31.4	17.3	-16.5
Childhood Immunization Status: Combo 2	29.2	20.2	30.4	16.8	-12.4
Childhood Immunization Status: MMR	58.4	62.0	56.2	42.3	-16.1
Childhood Immunization Status: HIB	48.9	50.4	46.0	28.0	-20.9
Childhood Immunization Status: VZV	52.6	55.5	53.5	40.9	-11.7
Childhood Immunization Status: Hepatitis B	51.3	53.5	48.2	29.7	-21.6
Childhood Immunization Status: DTP	45.7	28.5	41.6	24.1	-21.6
Childhood Immunization Status: IPV/OPV	54.3	60.1	56.2	32.6	-21.7
Well Child Visits in The First 15 Months of Life: Zero Visits	16.3	35.5	24.1	70.1	53.8
Well Child Visits in The First 15 Months of Life: One Visit	8.5				
Well Child Visits in The First 15 Months of Life: Two Visits	7.8				
Well Child Visits in The First 15 Months of Life: Three Visits	10.7				
Well Child Visits in The First 15 Months of Life: Four Visits	9.2				
Well Child Visits in The First 15 Months of Life: Five Visits	13.1				
Adolescent Immunization Status: Combo 1	26.3	32.1	23.1	8.8	-17.5
Adolescent Immunization Status: Combo 2	11.4	12.4	12.4	6.6	-4.8
Adolescent Immunization Status: MMR	37.2	44.0	33.6		
Adolescent Immunization Status: Hepatitis B	29.9	35.3	24.6		
Adolescent Immunization Status: VZV	17.0	16.6	17.0		
Adolescent Well-Care Visits		23.3	30.4	9.5	-13.8
Appropriate Treatment for Children: Upper Respiratory Infection				87.7	
Annual Dental Visit				26.5	
Breast Cancer Screening		5.4	2.8	12.7	7.3
Cervical Cancer Screening		7.1	32.1	32.6	25.5
Chlamdyia Screening in Women: All Ages Combined		8.5	19.4		
Chlamdyia Screening in Women: Age 16-20		8.7	19.6		
Chlamdyia Screening in Women: Age 21-26		8.0	19.1		
Prenatal Postpartum Care: Postpartum Care		32.9	40.7	39.2	6.3
Comprehensive Diabetes Care: Percent HbA1c Level <= 9.0%		89.1		90.8	1.7
Comprehensive Diabetes Care: Eye Exams		4.1		3.6	-0.5
Comprehensive Diabetes Care: LDL-C Screening		8.5		38.2	29.7
Comprehensive Diabetes Care: LDL-C Level < 130		6.3		8.0	1.7
Comprehensive Diabetes Care: Monitoring for Diabetic Nephropathy		10.5		18.0	7.5
Controlling High Blood Pressure		15.8	35.3	20.0	4.2

Although not shown here, the State reports CAHPS measures. The measures reported are: Getting Needed Care, Getting Care Quickly, Doctors Who Communicate Well, Courteous and Helpful Office Staff, Customer Service and Overall Ratings of Personal Doctors, Specialists, Health Care and Health Plan.

The immunization measures, particularly for children, experienced rate decreases. The report does not provide any reasons for performance changes.

State-Specific Measures and Characteristics

To address State-specific needs, the State has also developed its own measures as follows:

- Measures of Adolescent Care: These include immunization, well care and other accessibility, coordination and appropriate care measures
- EPSDT rates for components of well care visits (i.e. vision, hearing, dental, blood lead screening)
- Prostate Cancer Screening for a special study on the disabled population.

Quality Improvement Efforts

As noted previously, the State has conducted a number of EQRO-related studies covering perinatal, asthma, diabetes, blood lead screening, and the disabled. In general, the studies have collected baseline information to support intervention development and future re-measurement. Many studies include measures that go beyond HEDIS, based on accepted clinical guidelines. Brief summaries of recent studies appear below.

In September 2005, the State released the EQRO-authored report, “2004-2005 External Quality Review Technical Report for Colorado Medicaid Managed Care” addressing five performance activities for the MCOs, PIHP, and PCPP programs. The EQRO assessed compliance-monitoring activities, validation of performance measures, plan-level performance improvement projects, focused studies, and the CAPHS survey. This report fulfills the Federal requirements for an annual report on the quality, timeliness, and access to care offered to Medicaid enrollees.

The “Colorado 2004-2005 Focused Study Evaluation of EPSDT Services” sought to identify potential barriers that could contribute to low Early Prevention, Screening, Diagnostic, and Treatment (EPSDT) visits among Colorado Medicaid members. The EQRO gathered information by surveys and interviews, then presented findings along with recommendations for MCOs, Colorado Department of Health Care Policy and Financing, and for both. Recommendations include enhancing the exchange of information between MCOs and providers, as well as the Department and MCOs. The need for correct member contact information was mentioned as a barrier. The EQRO suggested the following interventions might help to successfully improve EPSDT screening rates: provider and patient reminders, and immunizations during routine visits (not just EPSDT visits). However, all organizations believed that immunizations were under-reported, highlighting their desire for a reliable State immunization database.

The July 2004 “Perinatal Care Focused Study Evaluation” developed baseline perinatal measure rates for a one-year study period ending November 2003. Expanding on the HEDIS Prenatal and Postpartum Care measure, a comprehensive set of perinatal measures was developed including: substance abuse screening, tobacco cessation screening, tobacco cessation education, urinalysis with culture testing, prior preterm delivery and history evaluation, preterm birth risk assessment and chlamydia screening. Chart review was used to collect this information. The report calls for activities designed to minimize variation among programs (FFS, PCCM, MCO) including distribution of clinical practice guidelines and provider-specific reporting of guideline compliance. Six specific recommendations are made; however, intervention design/implementation steps are not discussed.

Similar to the Perinatal Study, the July 2004 “Asthma Medication Management Focused Study Evaluation” developed baseline asthma measure rates. Members had to be continuously enrolled for a two-year period: January 1, 2002 through December 31, 2003. Note that, for HEDIS 2006, the NCQA has adopted this two year continuous enrollment requirement. In addition to using the HEDIS Use of Appropriate Medications for People with Asthma measure, the project developed a measure to assess the overuse of short-acting beta agonists. Measure rates were developed by the State’s EQRO using administrative data only and compared FFS, PCCM and MCO plans. The report concludes that the “Colorado Medicaid program performs well for asthma medication management.” However, it highlights the opportunity to identify both members overusing short-term beta agonists and physicians potentially over-prescribing these drugs for intervention.

The June 2003 “Colorado Medicaid Access to Preventive Care for the Disabled, Focused Study” provided baseline assessment of screening rates for the disabled population covering the period ending June 2002. The measures selected were: breast and cervical cancer screening, prostate cancer screening, preventive visits, any of the preceding preventive services, and all of the preceding preventive services. Measure rates were developed by the State’s EQRO using administrative data only and compared FFS, PCCM and MCO plans. Study results showed comparatively low use of preventive services in the disabled population. Given that the FFS program serves almost 50% of the disabled population and had the lowest rates, the report calls for development and provision of data collection instruments to FFS providers and suggests the evaluation of the use of financial incentives (both for providers and patients) and development and distribution of disabled service registries. The report also makes recommendations to identify specific providers and patients for focused interventions based on their preventive service patterns.

In August 2005, the State’s EQRO released the first re-measurement report, “Colorado 2004-2005 Focused Study on Access to Preventive Care for Persons With Disabilities.” Even though the findings indicate that preventive services continue to be underused, statewide Medicaid averages increased in rates for each measure. Preventive Service Visits rates met the project goal increasing results by 10% compared to baseline levels. Although interventions were introduced in 2003, the EQRO recommended refining and focusing them further to achieve better performance across all measures. The timeline for the next measurement period was not specified.

The June 2003 "Medicaid 2002 Diabetes Quality-of-Care Focused Study" provided baseline assessment of diabetes care for the period ending June 2002. Expanding on the HEDIS HbA1c Testing measure, a set of diabetes measures was developed as follows:

- Receipt of two HbA1c tests in measurement year
- Members in poor control (per HEDIS specifications)
- Members who received two HbA1c tests and were in poor control
- Members who received education on diabetes
- Members who received two HbA1c tests and were in poor control and received education on diabetes
- Members who were screened for depression
- Members who received two HbA1c tests and were in poor control and were screened for depression

Measure rates were developed by the State's EQRO using chart review and compared FFS, PCCM, and MCO plans. The report calls for MCOs and the State to identify and implement interventions, leveraging diabetes education programs recognized by the American Diabetes Association (ADA) for their excellence. The report also highlights the need to develop mechanisms to identify, track and monitor diabetic members within the FFS population. Other recommendations include administering a provider survey to identify barriers to compliance with the ADA's recommendations and adoption of a standardized diabetes flow sheet. The study proposes re-measurement in 2005.

Among the PMPP measures reported in Colorado, the largest statewide rate increase between 2001 and 2004 was for the Well Child Visits measure (12.4%). The largest improvement in reported rates for non-PMPP measures was for Cervical Cancer Screening, a 27.7% increase.

Report Content/Formats

Reports include benchmarking to national data from the NCQA. In addition, Colorado is the only State that directly compared FFS, MCO, and PCCM rates in both its ongoing HEDIS/CAHPS performance reports and all focused EQRO studies.

Summary of Quality Measure Reporting

In summary, clinical quality data is available for twelve HEDIS measures (not including age cohort and "sub-measure" breakdowns) across all Medicaid populations (MCO, FFS, PCCM). A number of focused studies and State-specific measures have also been developed.

Other States may benefit from Colorado's experience in developing and comparing rates for all three major Medicaid models (MCO, PCCM, and FFS), the development of focused measures for specific conditions and/or populations, and the development of analytic studies that identify opportunities for targeted improvement.

MAINE

State Quality Reporting Background

Maine has not released an updated Managed Care report covering calendar year 2004. Medstat contacted the Quality Management Unit of the Division of Health Care Management, Bureau of Medical Services, and learned that the State implemented a new claims system in January 2005. The State's efforts to finalize the transition are not complete.

The discussion below relates to Maine's 2003 performance measurement efforts.

Maine's Department of Health and Human Services Office of MaineCare Services (OMS) administers the State's PCCM Medicaid program, covering approximately 61% of Medicaid beneficiaries. The State does not report performance on its FFS population.

OMS Services worked with the Muskie School of Public Service at the University of Southern Maine to produce a managed care performance report. It also worked with the Maine Health Information Center (MHIC) to develop additional reports. The following quality-related reports that were reviewed for this report:

- MaineCare Managed Care Performance Report 2003
- Cardiovascular Disease Prevalence and Health Care Utilization in MaineCare, FY 2003 Report
- Depression Prevalence and Health Care Utilization in MaineCare, FY 2003 Report
- Diabetes Prevalence and Health Care Utilization in MaineCare, FY 2003 Report
- Emergency Department Utilization and the Impact of the MaineCare Interventions, FY 2003 Reporting
- Maine Department of Human Services Bureau of Medical Services Annual Report to the State Legislature

The MaineCare Managed Care Performance Report contains four years of quality performance data. Data for the most recent three years are summarized below. The other reports include focused studies around specific clinical areas as well as public reports aimed at researchers and policy decision makers.

PMPP Reporting Summary

The following table summarizes clinical quality measure results available in public reports for PMPP measures only. Empty cells indicate that the State did not report the measure. Comparisons in measure rate changes are from the earliest year of data (2001) to rates reported for 2003.

Maine	MaineCare			
	PCCM			
	Data Year 2001	Data Year 2002	Data Year 2003	Rate Change 2001–2003
Children's Access To PCP: Age 12-24 Months	98	98	98	0
Children's Access To PCP: Age 25 Months - 6 years	87	86	91	4
Children's Access To PCP: Age 7-11 Years	91	88	93	2
Children's Access To PCP: Age 12-19 Years				
Adult Access to Preventive/Ambulatory Health Services: Age 20-44				
Adult Access to Preventive/Ambulatory Health Services: Age 45-64				
Adult Access to Preventive/Ambulatory Health Services: Age 65+				
Well Child Visits in The First 15 Months of Life: Six or More Visits				
Well Child Visits Ages 3-6	60	61	67	7
Prenatal Postpartum Care: Timeliness of Prenatal Care	58	57	59	1
Comprehensive Diabetes Care: HbA1c Testing	78	73	71	-7
Use of Appropriate Medications for Asthma: Age 5-9				
Use of Appropriate Medications for Asthma: Age 10-17				
Use of Appropriate Medications for Asthma: Age 18-56				
Use of Appropriate Medications for Asthma: All Ages Combined				

Maine reports four of the seven PMPP measures for its PCCM program, covering 61% of enrollees.

Non-PMPP HEDIS Measure Reporting

The State also reports on non-PMPP HEDIS measures as summarized below:

Maine	MaineCare			
	PCCM			
	Data Year 2001	Data Year 2002	Data Year 2003	Rate Change 2001–2003
Childhood Immunization Status: Combo 1	72	77	63	-9
Adolescent Well-Care Visits	38	41	41	3
Cervical Cancer Screening	73	75	79	6
Antidepressant Medication Management: Optimal Practitioner Contacts			15.2	
Antidepressant Medication Management: Acute Phase Treatment			46.9	
Antidepressant Medication Management: Continuation Phase Treatment			31	
Beta Blocker Treatment After a Heart Attack			74	
Cholesterol Management After Acute Cardiovascular Events: LDL-C Screening			74	
Comprehensive Diabetes Care: Eye Exams			60	
Comprehensive Diabetes Care: LDL-C Screening			69	
Comprehensive Diabetes Care: Monitoring for Diabetic Nephropathy			47.5	

State-Specific Measures and Characteristics

To address state-specific needs, the State has also developed its own measures as follows:

- Emergency Room Visits per 1,000 Member Months
- Avoidable Hospital Conditions
- Average Per Member Per Month Costs

Rates for these measures are included in the State's Performance Report, but not summarized in this report.

Quality Improvement Efforts

MaineCare provides a 24-hour toll-free number available to members and providers to assist with understanding MaineCare services. Targeted mailings and educational materials are also used to provide information. In addition to specific QI programs, the Office of MaineCare Services Website Member/Consumer section offers many educational brochures for diabetes, dental care, HIV/AIDS, and tobacco use.

MaineCare quality projects and chronic disease prevention/management initiatives address a variety of conditions/issues:

- diabetes care
- prevention and control of asthma
- cardiovascular disease
- management of depression
- pain management and appropriate use of narcotics
- avoidance of unnecessary emergency department visits
- reduction in Avoidable Hospital Conditions.

The latter two initiatives focus on increasing both access to primary care and the use of preventive services in order to improve health care delivery efficiency.

Patients who repeatedly present themselves in the ER for non-urgent needs receive letters reminding them of availability of care in a provider's office are contacted by a nurse via telephone to discuss any barriers to receiving care in the PCPs office, and are sent reminder cards on care for non-emergent conditions. All MaineCare managed care members receive member education on limiting ER use. Primary care providers receive an incentive payment (PCPIP) for being available to their patients and reducing inappropriate ER use.

The Diabetes initiative looked at prevalence, cost, and utilization of services for MaineCare members diagnosed with the disease. HEDIS diabetes measures were used to monitor care provided to these enrollees. The State also measured the percent of patients who were prescribed an angiotensin converting enzyme (ACE) inhibitor or an angiotensin receptor blocker (ARB). Results of the study highlighted the need to for diabetes-related quality improvement initiatives. In response, the State created the MaineCare Diabetes Registry Program to ensure that members with diabetes receive recommended preventative care services.

The Registry program furnishes information to providers about required screening services. Members receive information to promote self-management of the disease: nutritional planning, exercise, the value of maintaining proper weight, as well as the reminders for screening tests.

The Public Health Action Plan for Asthma is a comprehensive plan intended to improve the health and quality of life of children and adults with asthma in Maine. The plan includes the following goals: 1) surveillance, 2) statewide coordination, 3) community-based asthma system for education, treatment, and management, 4) environmental action and prevention, 5) evaluation, and 6) sustainability. The specific list of activities is available in the State report.

The Maine Cardiovascular Health Program goals include the reduction of death, disability, and health care costs due to cardiovascular disease. The State contracted with the Maine Health Information Center to use enrollment and claims data to study demographics, medical payments, and utilization of services by members with heart disease or who were at risk for heart disease.

Detailed results and rates are available in the Cardiovascular Disease Prevalence and Health Care Utilization in MaineCare report.

Maine Health Care Information Center conducted study of MaineCare members with a diagnosis of depression and published rates for disease prevalence, utilization, and the HEDIS Antidepressant Medication Management measures. Details of the study are available in the Depression Prevalence and Health Care Utilization Report.

MaineCare monitors utilization patterns of members who are prescribed narcotics. The Pain Management Initiative and the Restriction and Narcotic Prescriber Plan address those members who need assistance changing addictive behaviors. An evaluation of the Restriction Plan and Narcotic Prescriber Plan found that limiting use of multiple prescribers reduced narcotic prescriptions and costs. There was also a reduction in emergency room visits after enrolling in the plan. Details of this program and its evaluation are available in the Annual report to the State Legislature.

Among the PMPP measures reported in Maine, the Well Child Visit Ages 3-6 measure experienced a 7% increase. The largest rate improvement for non-PMPP measures was for Cervical Cancer Screening, a 6.0% difference.

Report Content

The MaineCare report presents performance results for four years. Quality measure rates were developed using claims data only. No chart review was conducted.

Rates are compared to national Medicaid benchmarks that were developed by the National HEDIS Benchmarking Project.

Summary of Quality Measure Reporting

In summary, clinical quality data is available for 11 HEDIS measures (not including age cohort and "sub-measure" breakdowns) for the one PCCM program that covers 61% of all beneficiaries.

Other States may benefit from Maine's experience when creating the PCPIP Physician Incentive Program, developing an Annual Report that includes Statewide trending and conducting multiple focused studies and related quality improvement programs.

MARYLAND

State Quality Reporting Background

The Maryland Department of Health and Mental Hygiene (DHMH) operates the State's Medicaid program, called HealthChoice. A total of seven managed care plans currently operate under HealthChoice covering approximately 70% of Medicaid enrollees. The State reports performance results for six of the seven MCOs, but does not report performance on its FFS population.

The State produced the following quality measurement-related reports that were reviewed for this report:

- HealthChoice Evaluation (March 2006)
- Medicaid Managed Care Organization, Value-Based Purchasing Activities Report, Calendar Year 2005 (November 2005)
- HEDIS 2005 Executive Summary for the Statewide Analysis Report (September 2005)
- Medicaid Managed Care Organization, External Quality Review Organization Report Executive Summary, Calendar Year 2004 (July 2005) (EPSDT)/Healthy Kids performance measures)
- HealthChoice Evaluation Final Report and Recommendations, January 2002 (February 2005 Update)
- Report to the General Assembly: Dental Care Access under HealthChoice (October 2004)
- HEDIS 2004 Executive Summary for the Statewide Analysis Report (September 2004)
- Medicaid Managed Care Organization External Quality Review Organization Report Executive Summary, Calendar Year 2003 (July 2004) (EPSDT/Healthy Kids performance measures)

The HEDIS report contains three years of quality measurement data which are summarized below. The other State reports include focused studies around specific clinical areas as well as public reports aimed at consumers.

PMPP Reporting Summary

The following table summarizes clinical quality measure results available in public reports for PMPP measures only. Empty cells indicate that the State did not report the measure. Note that in 2001, the Children's Access to PCP, 12-19 Years of Age rate was not available; the comparison in measure rates are from the earliest year of data (2003) to rates reported for 2004.

Maryland	HealthChoice MCO				
	Data Year 2001	Data Year 2002	Data Year 2003	Data Year 2004	Rate Change 2001–2004
Children's Access To PCP: Age 12-24 Months	91	92	93	94	3
Children's Access To PCP: Age 25 Months - 6 years	79	82	84	86	7
Children's Access To PCP: Age 7-11 Years	81	82	84	89	8
Children's Access To PCP: Age 12-19 Years			82	85	3
Adult Access to Preventive/Ambulatory Health Services: Age 20-44	63	65	73	74	11
Adult Access to Preventive/Ambulatory Health Services: Age 45-64	79	82	84	85	6
Adult Access to Preventive/Ambulatory Health Services: Age 65+					
Well Child Visits in The First 15 Months of Life: Six or More Visits					
Well Child Visits Ages 3-6					
Prenatal Postpartum Care: Timeliness of Prenatal Care	76	82	86	87	11
Comprehensive Diabetes Care: HbA1c Testing	71	76	81	80	9
Use of Appropriate Medications for Asthma: Age 5-9				69	
Use of Appropriate Medications for Asthma: Age 10-17				66	
Use of Appropriate Medications for Asthma: Age 18-56				71	
Use of Appropriate Medications for Asthma: All Ages Combined				69	

Note: The report includes rates for each of the six reporting MCOs; the above table contains the statewide MCO average.

Data for five of the seven PMPP measures are available.

Non-PMPP HEDIS Measure Reporting

The State also reports on non-PMPP HEDIS measures as summarized below. Maryland's HealthChoice MCOs have made substantial improvements in performance rates across the years of this study, 2001-2004. The Department credits the plans' familiarity with activities required for HEDIS reporting: "data collection processes, data completeness, standardization of coding, and commitment of sufficient financial and staff resources."

In 2001, the Comprehensive Diabetes Care: LDL-C Level < 100 measure rate was not available; the comparison in measure rates is from the earliest year of data to rates reported for 2004.

Maryland	HealthChoice				
	MCO				
	Data Year 2001	Data Year 2002	Data Year 2003	Data Year 2004	Rate Change 2001–2004
Childhood Immunization Status: Combo 1	55	58	68	74	19
Childhood Immunization Status: Combo 2	53	56	67	73	20
Childhood Immunization Status: MMR	72	86	91	91	19
Childhood Immunization Status: HIB	69	75	84	86	17
Childhood Immunization Status: VZV	76	83	89	90	14
Childhood Immunization Status: Hepatitis B	69	73	73	86	17
Childhood Immunization Status: DTP	67	70	79	83	16
Childhood Immunization Status: IPV/OPV	79	80	88	90	11
Adolescent Immunization Status: Combo 1	29	37	46	56	27
Adolescent Immunization Status: Combo 2	18	25	37	46	28
Adolescent Immunization Status: MMR	51	66	75	77	26
Adolescent Immunization Status: Hepatitis B	33	39	49	58	25
Adolescent Immunization Status: VZV	32	40	52	58	26
Breast Cancer Screening	50	52	53	52	2
Cervical Cancer Screening	49	54	61	62	13
Prenatal Postpartum Care: Postpartum Care	48	56	59	83	35
Comprehensive Diabetes Care: Percent HbA1c Level <= 9.0%	52	51	44	45	-7
Comprehensive Diabetes Care: Eye Exams	48	47	47	47	-1
Comprehensive Diabetes Care: LDL-C Screening	68	78	86	87	19
Comprehensive Diabetes Care: LDL-C Level < 130	38	45	56	57	19
Comprehensive Diabetes Care: LDL-C Level < 100			35	39	4
Comprehensive Diabetes Care: Monitoring for Diabetic Nephropathy	37	49	51	54	17

Note: For the CDC HbA1c ≤9% measure, lower rates indicate better performance.

State-Specific Measures and Characteristics

To address State-specific needs, the State has developed its own measures as follows:

- Dental Care Access:
    - Availability and Accessibility of Dentists
    - Utilization Target Achievement
    - Allocation and Use of Dental Funding

Rates for these measures are available separately in the HealthChoice Evaluation Report.

Maryland also reports on infant Lead Screening. Rates for this State-specific measure appear in the following table:

Maryland	HealthChoice			
	MCO			
	Data Year 2001	Data Year 2002	Data Year 2003	Data Year 2004
Lead Screening – 24-35 mo	43.2	44.2	46.8	49.2
Lead Screening – 36-47 mo	37.3	38.2	41.2	45.8

Quality Improvement Efforts

The State has a Value Based Purchasing Initiative/Quality program that includes MCO compliance levels for specific measures, targets for eleven performance measures, and a system of incentives/disincentives designed to promote improved performance. The chosen performance measures cover access to care, quality of care, and administration. The goal of the initiative is to streamline and coordinate HealthChoice monitoring activities and to improve health plan performance and quality.

Annually, the State EQRO assesses services provided by contracting MCOs and produces a report that describes findings from the two areas reviewed: system performance and the Healthy Kids Quality Monitoring Program.

The State Healthy Kids/EPSDT-focused medical record review initiative is based on a review of five separate areas. These are:

1. Health and Developmental History
2. Comprehensive Physical Examination
3. Laboratory Tests
4. Immunizations
5. Health Education/Anticipatory Guidance

The State reviews approximately 3,000 medical records to evaluate whether providers are meeting the Federal EPSDT requirements. All seven HealthChoice MCOs are scored on their providers' performance. Nurse reviewers give providers feedback on their performance and provide information to help them link their patients to other public health resources.

The Program requires each MCO to meet a minimum composite compliance rate of 80 percent. Analyses of the review components in the Healthy Kids/EPSDT focused medical record review show that:

- All MCOs exceeded the 80% composite compliance rate.
- The Laboratory Tests indicator aggregate score was 73 percent. Only one MCO met the minimum performance rate. However, in 2004, Laboratory Tests increased 6% from 2003 rates.

The EQRO report also summarizes adherence to the Code of Maryland Regulations (COMAR) after an objective assessment of the structure, process, and outcome of each MCO's internal quality assurance program. All plans were found to have the ability to deliver quality health care. Each MCO is required to have two Quality Improvement Programs (QIPs). Details on the MCO-specific QIPs are not included in this report.

HealthChoice enrollees are mailed the CAHPS survey, which is conducted, analyzed, and reported to DHMH by an NCQA accredited contractor. The contractor is also responsible for the provider satisfaction survey. Both enrollee and provider surveys are required annually by the Federal Centers for Medicare & Medicaid Services (CMS). In addition to the enrollee and provider surveys, DHMH obtains information on satisfaction with HealthChoice by monitoring calls to the Department's HealthChoice enrollee and provider hotlines. Calls are tracked by category and analyzed monthly and quarterly to determine if specific interventions with particular MCOs are required, or if changes in State policies and procedures are necessary. This provides real-time information on any areas that may need to be addressed.

Maryland also produces a consumer report card, comparing health plan rates for six categories of performance:

- access to care
- doctor communication and service
- keeping kids healthy
- care for kids with chronic illness
- taking care of women
- diabetes care

Results are allocated to three performance categories: 1) above State average, 2) the same as State average, and 3) below State average. Plans are allocated one, two, or three stars accordingly.

Across all reporting years, among the PMPP measures reported in Maryland, the Adult Access (Age 20 – 44) and the Prenatal Care measures, experienced a 11% increase. The largest difference in reported rates for non-PMPP measures was for the Postpartum Care measure, a 38% increase.

Report Content/Formats

Maryland has collected and reported audited HEDIS results for its Medicaid Managed Care plans for a number of years. The reports are available online and in hard copy. DHMH requires MCOs to submit selected HEDIS measures each year. The Performance Measure report included three years of comparative rate results for each plan, the statewide average, and NCQA National Medicaid Benchmarks. This provided for trending analyses, as well as comparisons to benchmarks, and gave readers the opportunity to see how performance changed within and between the plans, the State, and the Nation. The State also provided an online version of the

Executive Summary Section of the EQRO Final Report which provides further details on the overall evaluation of plan operations with respect to guidelines.

Summary of Quality Measure Reporting

In summary, clinical quality data is available for nine HEDIS measures (not including age cohort and "sub-measure" breakdowns) for six of the seven MCOs.

Other States may benefit from Maryland's experience when developing financial incentives and disincentives tied to performance results for the Value-Based Purchasing Initiative and the Medicaid consumer report card.

MICHIGAN

State Quality Reporting Background

The Medical Services Administration within the Michigan Department of Community Health (MDCH) contracts with 15 MCOs to provide service for 94% all of its Medicaid enrollees. Michigan has an extensive set of performance measure reports, including HEDIS, EPSDT, Maternal Support Services, Blood Lead Screening, Community Health Assessment, Healthy Kids Dental Assessment, and Critical Health Indicators.

MDCH, through its EQRO, the Health Services Advisory Group (HSAG), produced the following quality measurement-related reports that were reviewed for this report:

- Michigan Medicaid HEDIS 2005 Results: Statewide Aggregate Report (November 2005)
- Michigan Medicaid HEDIS 2004 Results: Statewide Aggregate Report (November 2004)
- Michigan Medicaid HEDIS 2003 Results: Statewide Aggregate Report (December 2003)

In addition, a number of other documents, primarily focused studies, were identified:

  - 2004-2005 External Quality Review Technical Report for Medicaid Health Plans (October 2005)
  - A Guide to Michigan Health Plans, Quality Checkup (January 2005)
  - Michigan Maternal and Child Health County Profiles, 1993 to 2002 (May 2004)
  - 2003 Michigan Medicaid Critical Health Indicators
  - 2002 HIV/AIDS At-A-Glance and Technical Specification Report (December 2003)
  - 2001 Michigan Medicaid External Quality Review, Maternal Support Services Study, (August 2003)
  - 2001 Michigan Medicaid External Quality Review, Early and Periodic Screening, Diagnosis, and Treatment Study(August 2003)

The HEDIS reports contain one year of quality measurement data for each health plan and three years of statewide averages. Data from calendar years 2001 through 2004 are summarized in the following pages.

PMPP Reporting Summary

The following table presents clinical quality measure results available in public reports for PMPP measures only. Empty cells indicate that the State did not report the measure. When data for

2001 were not reported, comparisons in measure rate changes are for 2004 and the earliest year of available data.

Michigan	Medicaid MCO Weighted Avg				
	MCO				
	Data Year 2001	Data Year 2002	Data Year 2003	Data Year 2004	Rate Change 2001–2004
Children's Access To PCP: Age 12-24 Months	85.9	91.0	91.5	92.2	6.3
Children's Access To PCP: Age 25 Months - 6 years	70.9	75.9	78.0	78.2	7.3
Children's Access To PCP: Age 7-11 Years	71.6	74.7	76.7	78.2	6.6
Children's Access To PCP: Age 12-19 Years			74.7	77.1	2.4
Adult Access to Preventive/Ambulatory Health Services: Age 20-44	74.4	74.1	75.0	76.7	2.3
Adult Access to Preventive/Ambulatory Health Services: Age 45-64	82.5	81.4	82.6	83.4	0.9
Adult Access to Preventive/Ambulatory Health Services: Age 65+					
Well Child Visits in The First 15 Months of Life: Six or More Visits	35.5	39.2	36.8	43.0	7.5
Well Child Visits Ages 3-6	52.6	52.0	55.3	58.5	5.9
Prenatal Postpartum Care: Timeliness of Prenatal Care	72.7	66.9	71.5	77.5	4.8
Comprehensive Diabetes Care: HbA1c Testing	68.4	73.2	74.0	79.5	11.1
Use of Appropriate Medications for Asthma: Age 5-9	59.4	59.0	61.0	65.1	5.7
Use of Appropriate Medications for Asthma: Age 10-17	62.7	61.7	62.5	64.2	1.5
Use of Appropriate Medications for Asthma: Age 18-56	68.2	66.9	69.5	71.8	3.6
Use of Appropriate Medications for Asthma: All Ages Combined	64.9	63.8	65.5	67.9	3.0

Note: Reports include rates for each of the 15 MCOs. The above table contains the statewide MCO average only.

Michigan reports all seven of the PMPP measures. The Diabetes HbA1c testing measure experienced the largest rate change. The report did not credit any specific reason for improved performance, but noted that most plans have disease management programs targeting diabetes.

Non-PMPP HEDIS Measure Reporting

The State also reports on non-PMPP HEDIS measures. When data for 2001 were not reported, comparisons in measure rate changes are for 2004 and the earliest year of available data.

Michigan	Medicaid MCO Weighted Avg PCCM				
	Data Year 2001	Data Year 2002	Data Year 2003	Data Year 2004	Rate Change 2001–2004
Childhood Immunization Status: Combo 1	64.7	64.8	70.4		
Childhood Immunization Status: Combo 2	58.4	60.4	67.4	71.7	13.3
Well Child Visits in The First 15 Months of Life: Zero Visits	6.5	5.0	4.2	3.4	-3.1
Adolescent Immunization Status: Combo 1	33.7	38.5	51.0	69.9	36.2
Adolescent Immunization Status: Combo 2	14.8	20.7	34.5	53.0	38.2
Adolescent Well-Care Visits	29.0	32.1	34.2	38.0	9.0
Appropriate Treatment for Children: Upper Respiratory Infection			74.3	75.0	0.7
Breast Cancer Screening	55.5	56.2	54.6	53.7	-1.8
Cervical Cancer Screening	59.4	60.2	62.6	63.4	4.0
Chlamdyia Screening in Women: All Ages Combined	35.8	44.2	50.9	50.3	14.5
Chlamdyia Screening in Women: Age 16-20	33.0	42.1	48.2	47.6	14.6
Chlamdyia Screening in Women: Age 21-26	37.9	45.9	53.8	53.1	15.2
Prenatal Postpartum Care: Postpartum Care	51.2	44.9	44.9	53.7	2.5
Comprehensive Diabetes Care: Percent HbA1c Level <= 9.0%	47.5	47.1	51.2	44.6	-2.9
Comprehensive Diabetes Care: Eye Exams	40.6	44.3	42.3	47.3	6.7
Comprehensive Diabetes Care: LDL-C Screening	62.1	69.2	74.6	81.6	19.5
Comprehensive Diabetes Care: LDL-C Level < 130	36.3	43.8	48.6	56.6	20.3
Comprehensive Diabetes Care: LDL-C Level < 100			29.1	37.8	8.7
Comprehensive Diabetes Care: Monitoring for Diabetic Nephropathy	41.0	47.6	40.7	47.6	6.6
Controlling High Blood Pressure	52.7	52.3	53.9	56.1	3.4
Medical Assistance with Smoking Cessation – (Survey Measure) Advise to Quit		66.2	66.7	68.5	2.3

Note: For the CDC HbA1c $\leq$9% measure, lower rates indicate better performance.

In Michigan, many HEDIS measures demonstrated substantial increases over the past four years. The report author, HSAG, states the improvement, in part, is due to the ability of plans to collect and report HEDIS data.

Most plans have quality improvement programs that include case management, educational materials for both patients and providers, and provider outreach (monthly lists of members overdue for services, lists of members receiving pharmacy services, etc.) A few plans even have member incentives targeted at increasing specific HEDIS rates. For example, parents are

rewarded with gift certificates when their child has received all recommended immunizations. HSAG did not tie the increase in rates to specific quality improvement activities, but instead cited all initiatives as supporting continuous improvements.

Looking at rate increases over the four years, Adolescent Immunizations had the largest growth. HSAG attributes the positive changes, in part, to increasingly complete administrative data.

State-Specific Measures and Characteristics

To address its specific needs, the State has also developed the following measures:

- EPSDT
- Abortions
- Teen Use of Alcohol, Tobacco, and Other Drugs
- Cigarette Smoking
- Overweight
- Teen Pregnancy
- Morbidity and Mortality Indicators
- Vital Statistics

Rates for these measures are available separately from the State.

Quality Improvement Efforts

MDCH has a robust set of External Quality Review, Performance Measurement, and Vital Statistics/Utilization Reports available.

In October 2005, the State released the 2004-2005 External Quality Review Technical Report. Complying with Federal regulations, the EQRO report evaluated health plans' calculation and reporting of related Performance Improvement Projects. In addition, the report included recommendations on strategies to improve the quality of health care services.

HSAG found that none of the Michigan Medicaid health plans had process issues that impacted HEDIS reporting. However, the EQRO recommended that MDCH periodically assess its incentive program that financially rewards health plans based on HEDIS performance. MDCH should assure that goals are appropriately set and consider disincentives for poor performance.

Most plans have valid PIPs; only one plan had a finding of *Not Valid*. HSAG recommended that PIPs be monitored to assure activities provide real and sustained improvement.

Plan-level analyses were included in appendices that were not publicly available on the State's Website.

The Maternal and Child Health Profile provides demographic data on maternal and child health (MCH) by county for calendar years 1993 – 2002, including rates for live births, low birth weight, pre-term births, prenatal care utilization, live births to teen mothers, and fetal, infant, and child mortality.

In addition to collecting and disseminating data, the project included the selection of performance indicators with the intention of a baseline assessment in 2001 and a re-measurement in 2005. A report containing the data has not been released. The selected performance indicators included:

- reduced overall infant mortality rate
- reduced percent of preterm births, reduce the percent of low birth weight births
- reduced maternal mortality ratio in Black women
- reduced percent of live births that are unintended
- reduced percent of repeat births to unwed mothers, 15-19 years of age
- increased percent of Medicaid enrolled children 0-6 years of age who receive lead screening

The 2002 Medicaid HIV/AIDS report summarizes the Consumer Assessment of Health Plans Survey (CAHPS) from two populations: Medicaid members in general and Medicaid members who are HIV positive. Results are compared between the two populations to facilitate quality improvement efforts. Areas of evaluation include, but were not limited to: access to care (routine appointments, urgent appointments, and referrals), emergency room visits, staff assessments, and inclusion in decision making. In general, most Medicaid managed care members who were HIV positive provided a positive evaluation of their access to care and rated their providers better than those in the general Medicaid managed care population. Detailed comparative results are available in the report.

In 1998, the State established a program aimed at providing routine prenatal care to Medicaid enrollees with the purpose of improving prenatal outcomes. The 2001 Maternal Support Services (MSS) Study looked at the adequacy of care provided to Medicaid members participating in the MSS program with non-MSS participants. It also included a medical record review of MSS members enrolled in managed care or FFS. There were four recommendations from the study:

- More MSS visits for teenagers experiencing their first pregnancy
- Outreach to minorities
- Promote referrals to another program, Infant Support Services, in an effort to reduce infant mortality and morbidity
- Improve provider collection of referral follow-up documentation.

Detailed comparative results are available in the MSS report.

Among the PMPP measures reported in Michigan, the largest rate difference between 2001 and 2004 was for the Diabetes HbA1c testing measure experienced the largest rate change, an 11.1% increase. The largest differences in reported rates for non-PMPP measures were for Adolescent Immunizations, Combo 1 and Combo 2 (36.2% and 38.2%, respectively).

Report Content/Formats

The 2005 HEDIS Report includes benchmarking to both national data and statewide averages. The statewide averages are included for the current and two prior years. Comparisons between the current statewide average and the NCQA National Medicaid Benchmarks are provided in a summary format. The State produced the overall statewide aggregate average as a weighted rate, using the eligible population for each measure as the weight.

The State produced a consumer report card, A Guide to Michigan Medicaid Health Plans, Quality Checkup, that compared plan rates for 15 Medicaid health plans in five categories of health plan performance and accreditation:

- doctor communication and service
- getting care
- keeping kids healthy (well-child checkups and immunizations)
- taking care of women (cancer screenings and chlamydia testing)
- living with illness (asthma, diabetes, and high blood pressure tests, checkups, and medications)
- accreditation (e.g., Joint Commission on Accreditation of Healthcare Organizations, National Committee for Quality Assurance)

Results are allocated to three performance categories: above the State average, the same as the State average, and below the State average. Plans are allocated one, two, or three stars accordingly.

Summary of Quality Measure Reporting

In summary, clinical quality data is available for 16 HEDIS measures (not including age cohort and "sub-measure" breakdowns) from each of 15 MCOs. These MCOs cover the majority of the State's Medicaid population; therefore, MCO averages reflect statewide performance.

Other States may benefit from the Michigan's publication of Medicaid consumer report cards, development of focused studies, and its use of State-specific utilization measures to evaluate access to services.

MINNESOTA

State Quality Reporting Background

The Minnesota Department of Human Services (DHS) operates the State's Medicaid Program. There are three components to the program: a Prepaid Medical Assistance Program (PMAP) that provides health care for very low income Minnesotans; the General Assistance Medical Care Hospital Only program for adults without children who are already hospitalized; and MinnesotaCare, a program for uninsured working State residents and their families. These programs cover 65% of Medicaid enrollees.

A total of ten managed care plans operate under PMAP, of which nine report data in the performance reports. There are seven managed care plans currently operating under MinnesotaCare and each contributes data for the reports. Minnesota does not report on the Hospital Only Fee-for-Service populations.

DHS produced the following quality measurement-related reports that were reviewed for this report:

- 2000 – 2004 Performance Measurements
- Minnesota's HEDIS ® 2003 Medicaid Managed Care Results (December 2003)

In addition, a number of other documents, primarily EQRO-focused studies, were identified:

- Analysis of Race-Ethnic Group Disparities in Minnesota Health Care Programs 2000-2004 (March 2006)
- Managed Care Public Programs 2005 Quality Strategy (Revised November 2005)
- Managed Care Public Programs 2005 Quality Strategy (March 2005)
- Child and Teen Checkups 2003, Outreach and Follow-up Activities Performance Report (June 2005)
- 2003 External Quality Review: Sexually Transmitted Diseases: Prevention, Screening, and Treatment of STDs in Minnesota Publicly Funded Managed Care Programs
- 2003 External Quality Review: Sexually Transmitted Disease Study. Final Investigator's Plan
- Lead Poisoning in Minnesota Medicaid Children, 1999-2003

The HEDIS report for calendar year 2004 is no longer produced. However, the State sent the newly formatted performance report upon our request. This report contains five years of quality measurement data. Data for the most recent year, 2004, is summarized below.

PMPP Reporting Summary

The following tables summarize clinical quality measure results available in public reports for PMPP measures only. Empty cells indicate that the State did not report the measure. Comparisons in measure rate changes are from the earliest year of data, 2001, to rates reported for 2004.

Minnesota	MinnesotaCare				
	MCO				
	Data Year 2001	Data Year 2002	Data Year 2003	Data Year 2004	Rate Change 2001–2004
Children's Access To PCP: Age 12-24 Months	97.3	97.7	97.3	98.1	0.8
Children's Access To PCP: Age 25 Months - 6 years	90.0	89.6	90.3	90.3	0.3
Children's Access To PCP: Age 7-11 Years	90.7	91.3	91.7	91.2	0.5
Children's Access To PCP: Age 12-19 Years	91.0	91.8	92.2	92.1	1.1
Adult Access to Preventive/Ambulatory Health Services: Age 20-44	83.3	84.6	85.1	84.0	0.7
Adult Access to Preventive/Ambulatory Health Services: Age 45-64	86.1	87.8	87.7	86.2	0.1
Adult Access to Preventive/Ambulatory Health Services: Age 65+	83.5	82.8	86.3	83.1	-0.4
Well Child Visits in The First 15 Months of Life: Six or More Visits	39.9	39.8	46.1	51.7	11.8
Well Child Visits Ages 3-6	51.1	52.7	53.4	57.2	6.1
Prenatal Postpartum Care: Timeliness of Prenatal Care					
Comprehensive Diabetes Care: HbA1c Testing	82.6	84.5	87.2	86.9	4.3
Use of Appropriate Medications for Asthma: Age 5-9	69.5	72.4	78.6	76.9	7.4
Use of Appropriate Medications for Asthma: Age 10-17	68.3	70.4	74.1	75.0	6.7
Use of Appropriate Medications for Asthma: Age 18-56	67.6	69.8	71.0	71.3	3.7
Use of Appropriate Medications for Asthma: All Ages Combined	68.0	70.3	72.9	73.1	5.1

Minnesota	Prepaid Medicaid Assistance Plan (PMAP)				
	MCO				
	Data Year 2001	Data Year 2002	Data Year 2003	Data Year 2004	Rate Change 2001–2004
Children's Access To PCP: Age 12-24 Months	96.3	96.3	96.8	98.2	1.9
Children's Access To PCP: Age 25 Months - 6 years	87.3	88.8	89.7	89.3	2.0
Children's Access To PCP: Age 7-11 Years	83.0	84.6	87.0	88.0	5.0
Children's Access To PCP: Age 12-19 Years	85.0	85.9	88.3	89.3	4.3
Adult Access to Preventive/Ambulatory Health Services: Age 20-44	87.7	89.0	89.9	89.2	1.5
Adult Access to Preventive/Ambulatory Health Services: Age 45-64	87.9	89.9	90.2	88.5	0.6
Adult Access to Preventive/Ambulatory Health Services: Age 65+	93.1	93.7	93.9	93.2	0.1
Well Child Visits in The First 15 Months of Life: Six or More Visits	30.4	32.7	40.8	41.8	11.4
Well Child Visits Ages 3-6	51.7	54.8	53.9	57.0	5.3
Prenatal Postpartum Care: Timeliness of Prenatal Care					
Comprehensive Diabetes Care: HbA1c Testing	49.9	56.3	67.9	67.4	17.5
Use of Appropriate Medications for Asthma: Age 5-9	58.6	61.3	66.6	67.8	9.2
Use of Appropriate Medications for Asthma: Age 10-17	62.1	62.6	65.9	67.7	5.6
Use of Appropriate Medications for Asthma: Age 18-56	60.6	60.1	61.0	57.3	-3.3
Use of Appropriate Medications for Asthma: All Ages Combined	60.7	61.3	64.2	64.0	3.3

In summary, data for six of the seven PMPP measures are available for the PMAP and MinnesotaCare programs.

MinnesotaCare and PMAP each saw notable increase in performance for the following PMPP Measures: Well Child Visits in the First 15 Months (6+ visits), Well Child Visits Ages 3-6, and Use of Appropriate Medications for Asthma. The PMAP Program also saw a substantial increase for Comprehensive Diabetes Care: HbA1c Testing. The Performance Measurements report did not address reasons for rate changes; however, the State had a Child and Teen Checkups outreach program that may have driven the increases.

Non-PMPP HEDIS Measure Reporting

The State also reports on non-PMPP HEDIS measures as summarized below.

Minnesota	MinnesotaCare				
	MCO				
	Data Year 2001	Data Year 2002	Data Year 2003	Data Year 2004	Rate Change 2001–2004
Well Child Visits in The First 15 Months of Life: Zero Visits	2.8	2.8	2.2	1.0	-1.8
Well Child Visits in The First 15 Months of Life: One Visit	2.5	3.2	2.9	2.0	-0.5
Well Child Visits in The First 15 Months of Life: Two Visits	4.7	4.4	3.5	3.0	-1.7
Well Child Visits in The First 15 Months of Life: Three Visits	6.7	7.1	5.6	4.5	-2.2
Well Child Visits in The First 15 Months of Life: Four Visits	14.5	14.9	12.8	11.4	-3.1
Well Child Visits in The First 15 Months of Life: Five Visits	28.8	27.9	26.9	26.4	-2.4
Adolescent Immunization Status: VZV	24.8	27.0	29.8	29.9	5.1
Cervical Cancer Screening	65.0	57.0	69.1	70.0	5.0
Chlamydia Screening in Women: All Ages	29.1	30.4	32.3	33.4	4.3
Antidepressant Medication Management: Optimal Practitioner Contacts	14.6	14.6	17.2	14.6	0.0
Antidepressant Medication Management: Acute Phase Treatment	40.1	47.0	49.7	50.2	10.1
Antidepressant Medication Management: Continuation Phase Treatment	28.4	34.3	35.8	38.4	10.0
Comprehensive Diabetes Care: LDL-C Screening	73.5	78.6	82.9	86.2	12.7

Minnesota	Prepaid Medicaid Assistance Plan (PMAP)				
	MCO				
	Data Year 2001	Data Year 2002	Data Year 2003	Data Year 2004	Rate Change 2001–2004
Well Child Visits in The First 15 Months of Life: Zero Visits	3.3	2.6	2.1	1.6	-1.7
Well Child Visits in The First 15 Months of Life: One Visit	5.9	4.3	3.4	2.9	-3.0
Well Child Visits in The First 15 Months of Life: Two Visits	7.2	6.6	5.0	4.5	-2.7
Well Child Visits in The First 15 Months of Life: Three Visits	11.1	10.4	8.2	8.2	-2.9
Well Child Visits in The First 15 Months of Life: Four Visits	17.8	17.0	15.1	15.5	-2.3
Well Child Visits in The First 15 Months of Life: Five Visits	24.3	26.5	25.5	25.5	1.2
Adolescent Immunization Status: VZV	26.9	29.2	30.6	31.7	4.8
Cervical Cancer Screening	62.7	66.4	70.8	73.1	10.4
Chlamydia Screening in Women: All Ages Combined	44.3	44.4	48.6	47.8	3.5
Antidepressant Medication Management: Optimal Practitioner Contacts	18.4	13.2	13.4	14.4	-4.0
Antidepressant Medication Management: Acute Phase Treatment	41.7	39.6	37.8	42.4	0.7
Antidepressant Medication Management: Continuation Phase Treatment	31.1	28.7	27.6	32.9	1.8
Comprehensive Diabetes Care: LDL-C Screening	38.7	45.9	57.0	63.2	24.5

Both MinnesotaCare and PMAP experienced considerable rate increases for the Cervical Cancer Screening and Comprehensive Diabetes Care: LDL-C Screening measures. Again, the report did not address reasons for changes in performance rates.

State-Specific Measures and Characteristics

To address State-specific needs, the State has developed its own measures to address two areas of concern, Child and Teen Checkups and Sexually Transmitted Diseases.

Minnesota's EPSDT Program is called Child and Teen Checkups (C&TC) Program. The following performance measures assess the administrative outreach and follow-up activities of this program:

- Staff Caseload: number of actively enrolled Medicaid children divided by the number of full-time employees dedicated to C&TC for each county-based Community Health Board (CHB)
- Resource Allocation, Staffing and Infrastructure: percent of total funds available to each CHB

- Timely Download of CATCH 3 Data: an annual score based upon the accrual of one point for each month that the CHB downloads C&TC data within one or two weeks of availability. This measure emphasizes the importance of current data to assist in administrative outreach, such as introductory letters for newly enrolled children and patient reminders.
- Program Participation
  - Program Participation Contact Rate: percent of active, enrolled families contacted and reached for C&TC participation response.
  - Program Participation "Yes" Response Rate: the percent on contacted families who responded yes to participation.
- Provider Outreach Rate: the percent of county provider clinics that received at least one annual visit. The purpose of the visits is to discuss the Program, the importance of CHB-sponsored training, and to share materials with the providers.
- Summary Score of Outcomes/Indicator Points for the Calendar Year: a composite measure consisting of a sum of scores for the eight C&TC performance measures. The eight measures include the five State-specific measures listed above and two EPSDT measures: EPSDT Screening Participation Rate by CHB and EPSDT Screening Participation Rate for Children in Foster Care.

A statewide collaborative of health plans, hospitals, and medical groups, called the Institute for Clinical Systems Improvement (ICSI), developed clinical guidelines for Preventive Services for Children and Adolescents and Preventive Services for Adults. These ICSI guidelines, together with the Sexually Transmitted Diseases (STD) Treatment Guidelines published by the Centers for Diseases Control were used as a basis for creating the following State-specific measures addressing STDs for use with administrative data:

- STD prevalence rates (by gender, age, race, ethnicity, Medicaid program, region, MCO) for Chlamydia, Gonorrhea, Hepatitis B, Herpes, HPV, Syphilis, and Trichomoniasis
- STD Screening in Population by CPT Code for Gonorrhea and Syphilis. (Note that Minnesota also utilized the HEDIS Chlamydia screening measures.)
- STD Diagnosis by Place of Service
- Adherence by Providers to Prevention Service Guidelines (collection of sexual history; drug and alcohol use; condom use history; STD risk factors assessed; abstinence counseling; and mutual monogamy counseling)
- Adherence to Screening Guidelines for each disease
- Adherence to Treatment Guidelines for each disease
- Adherence to Prenatal STD Screening Guidelines for Chlamydia, Gonorrhea, Hepatitis B, and Syphilis

Minnesota reported several Lead Screening measures for children less than 72 months of age, children 9-30 months old, and all ages combined. All measures were also reported by patient race/ethnicity. The measures include:

- Number of Members Tested
- Percent of Children Tested Who Were Seen For Routine Preventative Care
- Percent of Children With Elevated Blood Lead Levels
- Rate of Three-Month Follow-up Testing

Quality Improvement Efforts

One of the Core Quality Strategy Components established by the State is a quality assessment and performance improvement program. MCOs are required to "adopt, disseminate, and apply practice guidelines." Compliance is assessed by the State-specific performance measures and reported to the State. DHS provides the results to their EQRO for review.

The State's EQRO, Michigan Peer Review Organization (MPRO), examined sexual health care provided to the State's Medicaid population in the 2003 External Quality Review: Sexually Transmitted Diseases report. This study evaluated the prevention, screening, and treatment provided to publicly funded managed care program enrollees who were at risk for acquiring, or were diagnosed with, a STD. In addition to presenting three years of trended results from the comprehensive set of STD performance measures (discussed in the previous section, State-specific Measures), the report included information on prevention efforts by providers, evaluated provider compliance with national and local clinical guidelines, and provided recommendations for improving the quality of care provided to enrollees.

Report Content/Formats

Previous reports produced by the State included results at the MCO, program, and State levels with comparisons to national Medicaid benchmarks. The most recent version of the report made available to Medstat is no longer publicly available via their Website. Additionally, it was produced in a slightly different format. The current version of the report still included results at the MCO, program, and State levels, but no longer included the national Medicaid benchmarks.

Summary of Quality Measure Reporting

In summary, clinical quality data are available for ten HEDIS measures across Minnesota's Medicaid MCO population. A number of focused studies and State-specific measures have also been developed.

Other States may benefit from Minnesota's creation of a comprehensive set of State-specific Medicaid measures and quality improvement activities related to STD's. In addition, the State's development of administrative measures targeted to regional Medicaid organizations (CHBs) to assess the support provided for ESPDT quality improvement is notable.

NORTH CAROLINA

State Quality Reporting Background

The Division of Medical Assistance (DMA) runs two Primary Care Case Management (PCCM) programs, ACCESS and ACCESSII. There is also a small MCO serving one specific county. Approximately 75% of the Medicaid population is enrolled in one of these managed care programs. The State also has a traditional FFS program covering the remaining 25% of the population.

The Division produces a key HEDIS performance measurement report annually:

- Report of HEDIS Measures, Reporting Year 2005; Calendar Year 2004
- Report of HEDIS Measures, Reporting Year 2004; Calendar Year 2003
- Report of HEDIS Measures, Reporting Year 2003; Calendar Year 2002
- Report of HEDIS Measures, Reporting Year 2002; Calendar Year 2001

In addition, a number of other documents, primarily EQRO-focused studies, were identified:

- Medicaid in North Carolina Annual Report, State Fiscal Year 2005 (May 2006)
- North Carolina Quality Assessment and Improvement Strategies Status Report (December 2005)
- External Quality Review 2005 Annual Technical Report (October 2005)
- DMA Managed Care Asthma Improvement Initiative — June 2003 through June 2004: Asthma Training Project – Final Report
- Prevalence of Children with Chronic Asthma and their Use of Health Care Services: A Comparison of Carolina ACCESS I Provider Practices within and outside of the NC DMA Asthma Collaborative (December 2004)
- Medicaid in North Carolina Annual Report, State Fiscal Year 2004 (June 2005)
- Adult Preventive Services Performance Improvement Project, State Fiscal Year 2004 Data Analysis and Comparison
- Executive Summary for the Access & Efficiency Learning Collaborative (July 2004)
- Medicaid in North Carolina Annual Report, State Fiscal Year 2003
- Reducing Antibiotic Prescriptions for Upper Respiratory Infections: Results from an Outpatient Quality Improvement Project (December 2003)
- North Carolina Quality Assessment and Improvement Strategies – Initial Strategy (July 2003)
- Quality Management Prenatal Care Study of Medicaid Mothers Who Delivered in 1999 (July 2003)

- Building and Strengthening Capacity to Promote and Maintain High Quality of Care for Medicaid Beneficiaries, Breakthrough Series Collaborative on Improving Care for Children with Attention Deficit Hyperactivity Disorder (October 2002)
- Building and Strengthening Capacity to Promote and Maintain High Quality Care for Medicaid Beneficiaries, Asthma Learning Collaborative (June 2002)
- Managed Care Diabetes Project – Evaluation Report (June 2002)

The HEDIS reports contain two years of quality measurement data for each PCCM program, the FFS program, and statewide average. Data from calendar years 2001 through 2004 are summarized in the following pages.

PMPP Reporting Summary

The following table summarizes clinical quality measure results available in public reports for PMPP measures only. A table containing the combined PCCM/FFS (statewide rate) appears first, followed by separate tables for each of the two PCCM programs and the FFS program. Empty cells indicate that the State did not report the measure. Comparisons in measure rate changes are from the earliest year of data to rates reported for 2004.

North Carolina	NC State Average				
	FFS/PCCM				
	Data Year 2001	Data Year 2002	Data Year 2003	Data Year 2004	Rate Change
Children's Access To PCP: Age 12-24 Months	95.34	95.67	95.85	96.20	0.86
Children's Access To PCP: Age 25 Months - 6 years	85.35	85.35	86.60	86.80	1.45
Children's Access To PCP: Age 7-11 Years	79.87	81.01	82.45	83.91	4.04
Children's Access To PCP: Age 12-19 Years			80.10	82.03	1.93
Adult Access to Preventive/Ambulatory Health Services: Age 20-44	78.44	78.82	78.71	79.50	1.06
Adult Access to Preventive/Ambulatory Health Services: Age 45-64	82.48	82.41	80.42	81.41	-1.07
Adult Access to Preventive/Ambulatory Health Services: Age 65+	80.24	79.49	75.36	76.47	-3.77
Well Child Visits in The First 15 Months of Life: Six or More Visits	39.01	43.78	47.74	53.97	14.96
Well Child Visits Ages 3-6	55.79	58.77	58.27	59.99	4.20
Prenatal Postpartum Care: Timeliness of Prenatal Care	39.62	41.13	40.59	39.90	0.28
Comprehensive Diabetes Care: HbA1c Testing	27.09	31.34	36.96	27.24	0.15
Use of Appropriate Medications for Asthma: Age 5-9	72.87	70.39	72.92	79.14	6.27
Use of Appropriate Medications for Asthma: Age 10-17	75.55	67.63	69.31	76.97	1.42
Use of Appropriate Medications for Asthma: Age 18-56	73.98	69.20	54.12	61.15	-12.83
Use of Appropriate Medications for Asthma: All Ages Combined		69.1	65.57	72.98	3.93

North Carolina	CA I (Carolina ACCESS I)				
	PCCM				
	Data Year 2001	Data Year 2002	Data Year 2003	Data Year 2004	Rate Change
Children's Access To PCP: Age 12-24 Months	96.03	97.43	97.59	98.23	2.20
Children's Access To PCP: Age 25 Months - 6 years	85.46	87.84	88.54	90.23	4.77
Children's Access To PCP: Age 7-11 Years	78.54	81.27	82.78	85.38	6.84
Children's Access To PCP: Age 12-19 Years			79.43	82.95	3.52
Adult Access to Preventive/Ambulatory Health Services: Age 20-44	80.00	81.10	81.12	83.00	3.00
Adult Access to Preventive/Ambulatory Health Services: Age 45-64	88.30	88.89	88.25	89.56	1.26
Adult Access to Preventive/Ambulatory Health Services: Age 65+	92.56	93.04	87.40	90.68	-1.88
Well Child Visits in The First 15 Months of Life: Six or More Visits	44.42	50.24	53.45	60.80	16.38
Well Child Visits Ages 3-6	58.99	60.10	59.14	62.26	3.27
Prenatal Postpartum Care: Timeliness of Prenatal Care	37.11	38.25	37.67	33.87	-3.24
Comprehensive Diabetes Care: HbA1c Testing	50.14	51.48	52.35	51.75	1.61
Use of Appropriate Medications for Asthma: Age 5-9	68.11	69.53	68.97	78.85	10.74
Use of Appropriate Medications for Asthma: Age 10-17	73.44	65.99	68.92	76.87	3.43
Use of Appropriate Medications for Asthma: Age 18-56	73.62	68.83	53.70	59.90	-13.72
Use of Appropriate Medications for Asthma: All Ages Combined		68.21	63.99	72.47	4.26

North Carolina	CA II/III (Carolina ACCESS II)				
	PCCM				
	Data Year 2001	Data Year 2002	Data Year 2003	Data Year 2004	Rate Change
Children's Access To PCP: Age 12-24 Months	97.74	95.67	95.93	96.48	-1.26
Children's Access To PCP: Age 25 Months - 6 years	89.99	87.81	87.44	87.49	-2.50
Children's Access To PCP: Age 7-11 Years	86.84	87.43	86.28	84.79	-2.05
Children's Access To PCP: Age 12-19 Years			84.38	82.36	-2.02
Adult Access to Preventive/Ambulatory Health Services: Age 20-44	76.42	76.79	74.22	77.72	1.30
Adult Access to Preventive/Ambulatory Health Services: Age 45-64	83.28	84.43	82.61	85.97	2.69
Adult Access to Preventive/Ambulatory Health Services: Age 65+	88.57	88.52	82.58	87.67	-0.90
Well Child Visits in The First 15 Months of Life: Six or More Visits	52.75	55.26	56.17	62.76	10.01
Well Child Visits Ages 3-6	63.14	61.44	61.20	61.73	-1.41
Prenatal Postpartum Care: Timeliness of Prenatal Care	58.73	52.05	47.15	46.08	-12.65
Comprehensive Diabetes Care: HbA1c Testing	48.82	51.34	58.06	58.20	9.38
Use of Appropriate Medications for Asthma: Age 5-9	82.07	76.90	78.49	80.60	-1.47
Use of Appropriate Medications for Asthma: Age 10-17	82.48	73.95	74.00	80.21	-2.27
Use of Appropriate Medications for Asthma: Age 18-56	78.21	70.25	59.97	61.22	-16.99
Use of Appropriate Medications for Asthma: All Ages Combined		74.33	73.86	77.55	3.22

North Carolina	FFS				
	FFS				
	Data Year 2001	Data Year 2002	Data Year 2003	Data Year 2004	Rate Change
Children's Access To PCP: Age 12-24 Months	92.87	94.43	94.99	95.19	2.32
Children's Access To PCP: Age 25 Months - 6 years	81.41	81.41	85.04	84.43	3.02
Children's Access To PCP: Age 7-11 Years	77.21	76.56	80.23	82.98	5.77
Children's Access To PCP: Age 12-19 Years			78.46	81.66	3.20
Adult Access to Preventive/Ambulatory Health Services: Age 20-44	77.52	77.61	78.77	79.53	2.01
Adult Access to Preventive/Ambulatory Health Services: Age 45-64	78.89	78.87	77.65	78.05	-0.84
Adult Access to Preventive/Ambulatory Health Services: Age 65+	79.12	78.32	74.49	75.22	-3.90
Well Child Visits in The First 15 Months of Life: Six or More Visits	29.35	33.39	40.50	46.32	16.97
Well Child Visits Ages 3-6	52.67	56.09	55.53	56.48	3.81
Prenatal Postpartum Care: Timeliness of Prenatal Care	39.36	41.52	40.34	39.82	0.46
Comprehensive Diabetes Care: HbA1c Testing	14.02	20.54	29.60	27.49	13.47
Use of Appropriate Medications for Asthma: Age 5-9	71.08	65.09	71.06	78.27	7.19
Use of Appropriate Medications for Asthma: Age 10-17	73.20	64.03	66.29	74.59	1.39
Use of Appropriate Medications for Asthma: Age 18-56	73.83	69.41	53.27	61.63	-12.20
Use of Appropriate Medications for Asthma: All Ages Combined		67.60	62.25	70.65	3.05

North Carolina reports all seven PMPP measures. The State average reflects performance on the full statewide Medicaid population, including the small one-county MCO.

All programs (ACCESS I, ACCESS II, and FFS) experienced large gains in the Well Infant measure and large decreases in the Adult Asthma measures. Possible reasons for these changes were not identified.

Non-PMPP HEDIS Measure Reporting

The State also reports a number of non-PMPP HEDIS measures, summarized below.

North Carolina	NC State Average				
	FFS/PCCM				
	Data Year 2001	Data Year 2002	Data Year 2003	Data Year 2004	Rate Change 2001–2004
Childhood Immunization Status: Combo 1	58.27	61.16	60.19	57.90	-0.37
Childhood Immunization Status: Combo 2	48.70	52.88	55.81	55.88	7.18
Childhood Immunization Status: MMR				74.60	
Childhood Immunization Status: HIB				81.80	
Childhood Immunization Status: VZV				72.00	
Childhood Immunization Status: Hepatitis B				74.40	
Childhood Immunization Status: DTP				64.50	
Childhood Immunization Status: IPV/OPV				84.20	
Well Child Visits in The First 15 Months of Life: Zero Visits	4.33	3.64	3.55	2.69	-1.64
Well Child Visits in The First 15 Months of Life: One Visit	4.41	3.33	2.95	2.79	-1.62
Well Child Visits in The First 15 Months of Life: Two Visits	6.17	5.24	4.18	3.72	-2.45
Well Child Visits in The First 15 Months of Life: Three Visits	9.61	8.30	7.08	6.35	-3.26
Well Child Visits in The First 15 Months of Life: Four Visits	14.60	14.05	12.60	10.84	-3.76
Well Child Visits in The First 15 Months of Life: Five Visits	21.87	21.66	21.90	19.64	-2.23
Adolescent Immunization Status: Combo 1	26.19	24.45	22.57	21.34	-4.85
Adolescent Immunization Status: Combo 2	1.07	0.99	1.29	1.74	0.67
Adolescent Immunization Status: MMR				46.80	
Adolescent Immunization Status: Hepatitis B				38.80	
Adolescent Immunization Status: VZV				5.10	
Adolscent Well Care	28.12	28.66	27.29	30.86	2.74
Breast Cancer Screening	46.30	46.52	45.10	44.66	-1.64
Cervical Cancer Screening	45.86	50.21	52.31	51.71	5.85
Comprehensive Diabetes Care: Eye Exams	53.76	52.44	33.91	41.57	-12.19
Comprehensive Diabetes Care: LDL-C Screening	26.78	30.15	35.62	39.01	12.23

North Carolina	CA I (Carolina ACCESS I)				
	PCCM				
	Data Year 2001	Data Year 2002	Data Year 2003	Data Year 2004	Rate Change 2001–2004
Childhood Immunization Status: Combo 1	61.99	64.07	65.51	64.33	2.34
Childhood Immunization Status: Combo 2	49.33	53.39	59.84	61.59	12.26
Well Child Visits in The First 15 Months of Life: Zero Visits	4.13	1.93	1.61	0.84	-3.29
Well Child Visits in The First 15 Months of Life: One Visit	3.74	2.49	2.19	1.44	-2.30
Well Child Visits in The First 15 Months of Life: Two Visits	4.60	4.01	3.51	2.47	-2.13
Well Child Visits in The First 15 Months of Life: Three Visits	7.77	6.54	5.93	4.96	-2.81
Well Child Visits in The First 15 Months of Life: Four Visits	13.33	12.59	11.47	9.79	-3.54
Well Child Visits in The First 15 Months of Life: Five Visits	22.01	22.19	21.84	19.70	-2.31
Adolescent Immunization Status: Combo 1	28.74	27.57	26.34	25.14	-3.60
Adolescent Immunization Status: Combo 2	1.12	1.06	1.34	2.00	0.88
Adolscent Well Care	27.44	27.86	26.18	30.15	2.71
Breast Cancer Screening	46.30	52.32	51.19	51.70	5.40
Cervical Cancer Screening	55.36	58.62	61.19	60.07	4.71
Comprehensive Diabetes Care: Eye Exams	54.40	54.26	35.63	42.42	-11.98
Comprehensive Diabetes Care: LDL-C Screening	49.74	52.88	54.55	56.92	7.18

North Carolina	CA II/III (Carolina ACCESS II)				
	PCCM				
	Data Year 2001	Data Year 2002	Data Year 2003	Data Year 2004	Rate Change 2001–2004
Childhood Immunization Status: Combo 1	62.63	65.00	61.92	58.27	-4.36
Childhood Immunization Status: Combo 2	57.36	59.97	58.54	56.63	-0.73
Well Child Visits in The First 15 Months of Life: Zero Visits	1.17	0.97	3.64	2.08	0.91
Well Child Visits in The First 15 Months of Life: One Visit	1.84	1.45	1.44	1.97	0.13
Well Child Visits in The First 15 Months of Life: Two Visits	3.05	2.57	2.29	2.20	-0.85
Well Child Visits in The First 15 Months of Life: Three Visits	6.12	5.12	4.36	3.92	-2.20
Well Child Visits in The First 15 Months of Life: Four Visits	11.44	10.76	9.60	8.13	-3.31
Well Child Visits in The First 15 Months of Life: Five Visits	23.64	23.87	22.49	18.93	-4.71
Adolescent Immunization Status: Combo 1	29.76	26.05	22.59	21.31	-8.45
Adolescent Immunization Status: Combo 2	1.17	1.43	1.29	1.86	0.69
Adolscent Well Care	31.63	31.57	30.03	31.87	0.24
Breast Cancer Screening	52.15	52.19	53.24	53.27	1.12
Cervical Cancer Screening	51.93	58.11	60.07	59.94	8.01
Comprehensive Diabetes Care: Eye Exams	51.18	47.11	33.53	42.38	-8.80
Comprehensive Diabetes Care: LDL-C Screening	48.41	51.54	56.30	60.80	12.39

North Carolina	FFS				
	FFS				
	Data Year 2001	Data Year 2002	Data Year 2003	Data Year 2004	Rate Change 2001–2004
Childhood Immunization Status: Combo 1	52.96	55.94	55.21	54.99	2.03
Childhood Immunization Status: Combo 2	43.02	47.43	50.88	52.85	9.83
Well Child Visits in The First 15 Months of Life: Zero Visits	5.95	6.35	4.47	3.59	-2.36
Well Child Visits in The First 15 Months of Life: One Visit	6.00	4.92	4.12	3.68	-2.32
Well Child Visits in The First 15 Months of Life: Two Visits	8.60	7.39	5.48	5.04	-3.56
Well Child Visits in The First 15 Months of Life: Three Visits	12.36	11.20	9.04	8.28	-4.08
Well Child Visits in The First 15 Months of Life: Four Visits	16.64	16.71	14.71	12.89	-3.75
Well Child Visits in The First 15 Months of Life: Five Visits	21.10	20.04	21.68	20.19	-0.91
Adolescent Immunization Status: Combo 1	20.71	19.76	19.41	19.57	-1.14
Adolescent Immunization Status: Combo 2	1.02	0.59	1.21	1.48	0.46
Adolscent Well Care	27.09	27.74	26.19	30.19	3.10
Breast Cancer Screening	43.48	43.50	42.73	42.42	-1.06
Cervical Cancer Screening	36.10	42.24	46.21	44.26	8.16
Comprehensive Diabetes Care: Eye Exams	53.76	52.22	33.49	41.18	-12.58
Comprehensive Diabetes Care: LDL-C Screening	13.79	18.08	27.27	28.30	14.51

There were varying significant increases and decreases in measure results across the three programs. However, the Cervical Cancer Screening and the Diabetes LDL Screening measures consistently increased, while the Diabetes Eye Exam measure consistently decreased. Although the rate increases were not addressed, a reason was provided for the decrease in the diabetes measure rates.

Specifications changes from NCQA allowed a negative retinal exam in the year prior to the measurement year to count towards a positive result if the member met certain criteria. North Carolina calculates HEDIS rates using eligibility, claims, and encounter data. Since this data warehouse does not include test results, the State decided not to exclude from the numerator population all eye exams performed in the year prior to the measurement year.

State-Specific Measures and Characteristics

North Carolina did not report on State-specific measures. However, the State did report inpatient and ambulatory care utilization measures following HEDIS specifications. Additionally, the State reported a subset of measures separately for Children with Special Health Care Needs (CSHCN) based on eligibility category and self-identification.

Quality Improvement Efforts

A key component of quality improvement efforts in North Carolina was the creation of the ACCESS II program in 1998, which expands the traditional PCCM managed care concept to incorporate targeted case management and disease management. Under the community-based program, physicians are members in one of the administrative networks. Each network collaborates to develop and implement:

- Local collaboration and community focus
- Population-based and enrollee-based risk identification
- Targeted care management initiatives
- Budget and utilization targets and quality indicators
- Strengthened community safety-net services for the indigent population

In addition to the PCCM physician payment, the administrative networks are paid a fee to administer these types of quality improvement initiatives.

The 2005 Annual Report cites an external study that found that, during State fiscal year (SFY) 2003, the State "avoided unnecessary healthcare expenditures in the amount of approximately $60 million through its case management and patient education and outreach efforts." In SFY 2004, the savings were estimated to be $124 million.

In addition, the State has conducted focused studies covering Attention Deficit Hyperactivity Disorder (ADHD) and asthma. Baseline and re-measurement data are available for these efforts. Both of these projects were undertaken through the development of collaboratives.

In a separate collaborative project, the DMA worked with the Center for Children's Healthcare Improvement on the Asthma Training Project (June 2003 through June 2004). The purpose of the study was to "develop and test a training approach" for providers and practices that would improve asthma care delivery to patients. The study identified practices that are 'high-risk' relative to asthma and included the dissemination of a "mini-asthma toolkit." Some of the materials in the provider toolkit were:

- severity assessment/medications sheet
- asthma visit form
- management plans
- smoking cessation tool
- list of asthma Websites for providers and a separate list for patients
- American Academy of Pediatrics' Education in Quality Improvement for Pediatric Practice handout

A report detailing the project is available online at through DMA.

Reports on diabetes, antimicrobial resistance, prenatal care, congestive heart failure, and access/efficiency initiatives are also available. Many of these initiatives also used a collaborative model. Further, re-measurement for an immunization/EPSDT initiative was expected in 2004; however, no evaluation report has yet been released. Finally, an Adult Preventive Services Improvement Project analyzing the utilization of preventative services was scheduled for implementation in 2005. The asthma and ADHD initiatives are summarized below.

The asthma collaborative developed and implemented "three asthma management learning sessions, reinforcement and support conference calls, and evaluation procedures." Twenty ACCESS 1 practices participated. The evaluation published in December 2004 showed that, in comparison to other ACCESS 1 practices, beneficiaries in participating practices were more likely to receive appropriate medications and have increased outpatient visits, and less likely to have emergency department visits and hospitalizations. However, average total spending was similar in both groups. Three years of detailed trend data is available covering fiscal years 2000/2001 to 2002/2003.

The ADHD collaborative involved 20 practices with the objective of early identification, diagnosis, appropriate medication, psychotherapeutic intervention, patient and family education and support, and community collaboration, particularly with school systems. Intervention components included:

- training with the goal of developing action plans for improving ADHD care
- disseminating and implementing tools developed by the National Initiative for Children's Healthcare Quality
- offering support between training sessions, including faculty assisted phone calls and e-mail discussion groups

The evaluation showed substantial increases in all six of the ADHD measures. The evaluation period ended in September 2002.

Among the PMPP measures reported in North Carolina, the largest statewide rate difference between 2001 and 2004 was for the Well Child Visits in The First 15 Months of Life (Six or More Visits) measure, a 14.96% increase. The largest difference in reported rates for non-PMPP measures was for the Comprehensive Diabetes Care, LDL-C Screening measure, a 12.23% increase. As noted above, North Carolina developed a collaborative effort to address diabetes.

Report Content/Formats

Reports include benchmarking to the NCQA national Medicaid MCO average and direct comparison of the two PCCM programs and the FFS program. The State also calculates a combined PCCM rate (not shown in this report).

The report identifies measures that are above the national Medicaid MCO average and identifies measures below this level as "areas for improvement." It does not provide reasons why rates may have changed during the reporting year.

The North Carolina DMA used its claims and enrollment data warehouses to generate these measures. Rates are calculated by DMA using purely administrative data contained within these systems.

There is no indication that DMA rate calculation undergoes an external HEDIS Compliance audit.

Summary of Quality Measure Reporting

In summary, clinical quality data are available for 12 HEDIS measures (not including age cohort and "sub-measure" breakdowns) across all Medicaid populations (PCCM and FFS). Two focused studies are also available (ADHD and asthma), which include baseline and re-measurement data.

Other States may benefit from North Carolina's experience generating and comparing rates for PCCM and FFS programs following HEDIS specifications; developing collaboratives to conduct disease management; case management; quality measurement/improvement activities; and conducting multiple focused studies.

NEW YORK

State Quality Reporting Background

The New York State Department of Health's Office of Medicaid Management contracts with 31 MCOs to provide service for approximately 62% of Medicaid enrollees. The State reports an extensive set of PMPP and non-PMPP measures for the managed care population in a detailed report that is distributed in hard copy and on-line. The State does not report performance on its non-MCO population. New York has been collecting and reporting quality measure results since 1995.

The Office of Managed Care, Bureau of Quality Management and Outcomes Research produced the following quality measurement-related reports that were reviewed for this report:

- 2005 New York State Managed Care Plan Performance
- 2005 New York State Managed Care Plan Performance Supplement
- 2004 New York State Managed Care Plan Performance
- 2004 New York State Managed Care Plan Performance Supplement
- 2003 New York State Managed Care Plan Performance

The 2005 New York State Managed Care Plan Performance report contains three years of quality measurement data for all managed care plans within the State. Of the 31 MCOs that contract with Medicaid, 29 plans are included in this report. Two plans had Medicaid memberships in 2004 that were too small for reliable reporting.

Performance rates for the most recent four years, 2001-2004, are summarized below. The comprehensive report also includes focused studies around specific clinical areas as well as public reports aimed at consumers.

PMPP Reporting Summary

The following table summarizes clinical quality measure results available in public reports for PMPP measures only. Empty cells indicate that the State did not report the measure. Comparisons in measure rate changes are from the earliest year of data to rates reported for 2004.

The PMPP measure with the largest increase between 2001 and 2004 was Use of Appropriate Medications for Asthma Medications. Although the report does not specifically acknowledge reasons for rate changes, New York has an establish Quality Improvement Project aimed at Asthma. Details are provided in the Quality Improvement Effort section below.

New York	Medicaid Managed Care				
	MCO				
	Data Year 2001	Data Year 2002	Data Year 2003	Data Year 2004	Rate Change
Children's Access To PCP: Age 12-24 Months	87	87	91	91	4
Children's Access To PCP: Age 25 Months - 6 years	81	81	85	87	6
Children's Access To PCP: Age 7-11 Years	84	85	86	89	5
Children's Access To PCP: Age 12-19 Years			83	85	2
Adult Access to Preventive/Ambulatory Health Services: Age 20-44	76	76	77	77	1
Adult Access to Preventive/Ambulatory Health Services: Age 45-64	84	84	83	84	0
Adult Access to Preventive/Ambulatory Health Services: Age 65+	80	82	84	88	8
Well Child Visits in The First 15 Months of Life: Six or More Visits					
Well Child Visits Ages 3-6		65	69	71	6
Prenatal Postpartum Care: Timeliness of Prenatal Care	76	78		84	8
Comprehensive Diabetes Care: HbA1c Testing	76	80	84	85	9
Use of Appropriate Medications for Asthma: Age 10-17					
Use of Appropriate Medications for Asthma: Age 18-56					
Use of Appropriate Medications for Asthma: All Ages Combined	56	68	71	72	16
Use of Appropriate Medications for Asthma: All Ages Combined					

Note: Reports include rates for each of the 29 MCOs. The above table contains the statewide MCO average only.

In summary, data for six of the seven PMPP measures are available from 29 MCOs.

Non-PMPP HEDIS Measure Reporting

The State also reports on non-PMPP HEDIS measures as summarized below. Comparisons in measure rate changes are from the earliest year of data to rates reported for 2004.

The Diabetes measures attained the largest rate increases among non-PMPP measures and the magnitude was substantial. Again, the report does not specifically acknowledge reasons for rate changes, but New York has an established Quality Improvement Project aimed at Diabetes. Details are provided in the Quality Improvement Effort section below.

New York	Medicaid Managed Care				
	MCO				
	Data Year 2001	Data Year 2002	Data Year 2003	Data Year 2004	Rate Change
Childhood Immunization Status: Combo 2		57	56		
Well Child Visits in The First 15 Months of Life: Five Visits		57	61	65	8
Adolescent Well-Care Visits		41	43	45	4
Appropriate Treatment for Children: Pharyngitis			45	49	4
Appropriate Treatment for Children: Upper Respiratory Infection			88	84	-4
Annual Dental Visit	31	35	38	44	13
Breast Cancer Screening		66		69	3
Cervical Cancer Screening	74	71		72	-2
Chlamdyia Screening in Women: Age 16-20		38	41	42	4
Chlamdyia Screening in Women: Age 21-26		39	46	47	8
Prenatal Postpartum Care: Postpartum Care	59	63		68	9
Antidepressant Medication Management: Optimal Practitioner Contacts	30	31	29	28	-2
Antidepressant Medication Management: Acute Phase Treatment	40	46	43	46	6
Antidepressant Medication Management: Continuation Phase Treatment	27	32	27	30	3
Cholesterol Management After Acute Cardiovascular Events: LDL-C Screening			73		
Cholesterol Management After Acute Cardiovascular Events: LDL-C Level < 130			49		
Cholesterol Management After Acute Cardiovascular Events: LDL-C Level < 100			36		
Comprehensive Diabetes Care: Percent HbA1c Level <= 9.0%	52	45	42	37	-15
Comprehensive Diabetes Care: Eye Exams	49	54	55	56	7
Comprehensive Diabetes Care: LDL-C Screening	68	82	88	92	24
Comprehensive Diabetes Care: LDL-C Level < 130	38	50	58	63	25
Comprehensive Diabetes Care: LDL-C Level < 100			35	38	3
Comprehensive Diabetes Care: Monitoring for Diabetic Nephropathy	45	50	50	56	11
Controlling High Blood Pressure		59		69	10
Use of Imaging Studies for Low Back Pain				83	
Follow-up After Hospitalization for Mental Illness: 30 Day		65	70	68	3
Follow-up After Hospitalization for Mental Illness: 7 Day		48	52	51	3
Medical Assistance with Smoking Cessation – (Survey Measure) Advise to Quit	70		66		

Note: For the CDC HbA1c $\leq$9% measure, lower rates indicate better performance.

State-Specific Measures and Characteristics

To address state-specific needs, the State has also developed its own measures as follows:

- Prenatal Care Services
  - Risk-Adjusted Primary Cesarean Delivery: percentage of live infants born by cesarean
  - Risk Adjusted Low Birth Weight: percentage of live infants weighing less than 2500 grams among all deliveries
  - Percent of Low Birth Weight Births at Level II/III/IV facilities

New York also reports on infant Lead Screening. Rates for this State-specific measure appear in the following table:

New York	Medicaid Managed Care			
	MCO			
	Data Year 2001	Data Year 2002	Data Year 2003	Data Year 2004
Lead Screening – 24-35 mo	76	74	74	Rotated

Note that the State chose to report the Well Child Visits in The First 15 Months of Life, 5 or more visits rather than the standard 6 or more. In addition, the State reported the Asthma measure rolled up into one category, 5-18, rather than the HEDIS standard 5-9 age group, 10-17 age group or the 18-56 age group.

Quality Improvement Efforts

In 2002, the State implemented an incentive program to reward Medicaid managed care plans with monetary bonuses for meeting performance goals. New York awarded more than $7 million statewide during the fiscal year ending August 2004[3].

In addition to the incentive program, the Department of Health's Office of Medicaid Management has worked with the Island Peer Review Organization (IPRO) to develop initiatives aimed at increasing the quality of health care provided to Medicaid enrollees with asthma and diabetes. Both initiatives identify outstanding performance by healthcare providers and identify areas of concern. Specifically, to

- improve processes of care
- improve patients perceptions of care and knowledge for self-management
- promote and disseminate quality improvement materials
- develop a quality indicator monitoring system.

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[3] The Commonweatlh Fund. *A Case Study of Quality Improvement in Medicaid: New York's Monroe Plan for Medical Care.* http://www.cmwf.org/tools/tools_show.htm?doc_id=275520. (Accessed August 21, 2006)

Asthma

The Outpatient Asthma Management Quality Improvement Project has a series of quality measures specific to the project. These indicators, based upon the National Asthma Education and Prevention Program guidelines, target four areas of asthma care: diagnosis and establishment of a provider-patient partnership, reduction of symptoms, long-term monitoring of the disease, and prompt treatment of asthma episodes.

The IPRO Website describes in detail the ten indicators and offers the data collection tool along with detailed instructions for its use. There are also several asthma tools and materials that are available for download. These include brochures (in English and Spanish), a flow sheet, self-assessment forms, chart stickers, and posters.

The Department of Health released an Outpatient Asthma Management Quality Improvement Project Impact Assessment report presenting baseline and re-measurement data from this project.

As shown in the PMPP measure table above, Appropriate Use of Asthma Medication increased by sixteen percentage points between 2001 and 2004 (56% to 72%, respectively).

Diabetes

The second quality improvement initiative targets diabetes. Using the American Diabetes Association guidelines, this project added three additional indicators to the HEDIS diabetes measures: foot exam, blood pressure control, and an ACE Inhibitor or an anti-platelet administration.

The IPRO Website offers the data collection tool along with detailed instructions for its use. There are also several asthma tools and materials that are available for download. These include brochures (in English and Spanish), a flow sheet, chart stickers, and an exam room poster promoting foot care.

The Department of Health released the Diabetes Management Quality Improvement Project Impact Assessment report presenting baseline and re-measurement data from this project.

Reviewing the tables above, the PMPP measure with the greatest rate difference between 2004 and 2001 is the Comprehensive Diabetes Care, LDL-C Level < 130 measure with an increase of 25 percentage points. Among the non-PMPP measures, all other diabetes care performance improved; both the LDL Screening measures increasing by 24 percentage points.

Report Content/Formats

Reports include performance ratings (comparison to statewide average), benchmarking to national data (NCQA Quality Compass) and plan trending over time. The Managed Care Plan Performance Report is very thorough and enables consumers, researchers, and other decision makers to carefully evaluate the individual plans and the State program overall.

New York provides an interactive, Web-based consumer report card (eQARR) containing comparative performance and trending information for managed care plans throughout the State. A consumer can access performance information on areas of provider network, child and adolescent health, women's health, adults living with illness, behavioral health, and access and service. Plan-specific rates (percentages) are available and statistical significance test is used to allocate rates to two performance categories: 1) statistically significantly above the State average, and 2) statistically significantly below the State average. Users can generate reports statewide or for regional areas within the State.

Summary of Quality Measure Reporting

In summary, clinical quality data are available for 18 HEDIS measures (not including age cohort and "sub-measure" breakdowns) for each of 29 MCOs. Extensive performance measurement information directed at both consumers and providers/insurers/policy makers has been available for several years.

Other States may benefit from the New York's Web-based consumer report card containing comparative performance and trending information and its development of quality improvement studies (including re-measurement).

OHIO

State Quality Reporting Background

The Ohio Department of Job and Family Services (ODJFS), Office of Ohio Health Plans, Bureau of Managed Health Care is responsible for the administration of the Medicaid Managed Health Care Program. Approximately 31% of the statewide Medicaid population is covered by this program. Ohio does not report on its non-managed care population.

The Program Development & Analysis Section of the Bureau produces the following quality measurement-related reports annually:

- Medicaid Managed Health Care Clinical Performance Measures, January through December 2004 (July 2005)
- Medicaid Managed Health Care Clinical Performance Measures, January through December 2003 (June 2004)
- Ohio Medicaid Managed Health Care Clinical Performance Measures State Fiscal Year 2002 (May 2003)

In addition, a number of other reports were identified:

- ODJFS Methods for Clinical Performance Measures (October 2005)
- ODJFS Methods for Access Performance Measures, (July 2005)
- ODJFS Methods for Encounter data Quality Measures, (July 2005)
- Pregnant Women, Infants, and Children, Ohio Department of Job and Family Services, (April 2005)
- Medicaid Managed Health Care Comprehensive Managed Care Program Membership (December 2004)
- ODJFS Methods for Clinical Performance Measures (July 2004)
- Ohio Medicaid Comprehensive Managed Care Program Progress Report, January through December 2003

The Clinical Performance Measures report format changed from reporting data for State fiscal years to calendar years beginning with 2003. Under the new format, each report contains two years of quality measurement data by plan and rolled-up into a State-level MCO average. Clinical Performance data from the past three years, 2002 through 2004, are summarized in the following pages.

PMPP Reporting Summary

The following table summarizes clinical quality measure results available in public reports for PMPP measures only. Comparisons in measure rate changes are from the earliest year of data to rates reported for 2004. Empty cells indicate that the State did not report the measure.

Ohio	Managed Care Plans			
	MCO			
	Data Year 2002	Data Year 2003	Data Year 2004	Rate Change 2002–2004
Children's Access To PCP: Age 12-24 Months				
Children's Access To PCP: Age 25 Months - 6 years				
Children's Access To PCP: Age 7-11 Years		92.0		
Children's Access To PCP: Age 12-19 Years				
Adult Access to Preventive/Ambulatory Health Services: Age 20-44				
Adult Access to Preventive/Ambulatory Health Services: Age 45-64				
Adult Access to Preventive/Ambulatory Health Services: Age 65+				
Well Child Visits in The First 15 Months of Life: Six or More Visits	40.3	41.9	43.5	3.2
Well Child Visits Ages 3-6	61.0	62.0	62.2	1.2
Prenatal Postpartum Care: Timeliness of Prenatal Care	82.0	84.4	85.4	3.4
Comprehensive Diabetes Care: HbA1c Testing	58.5	59.4	59.4	0.9
Use of Appropriate Medications for Asthma: Age 5-9				
Use of Appropriate Medications for Asthma: Age 10-17				
Use of Appropriate Medications for Asthma: Age 18-56				
Use of Appropriate Medications for Asthma: All Ages Combined	53.9	56.0	55.9	2.0

Data for five of the seven PMPP measures are available. The Clinical Performance Measure report did not offer discussions on rate improvements; however, it is interesting to note that the Prenatal Care measure and both Well Child measures have minimum performance standards. These measures are also used to determine if a plan qualifies for financial incentives based on performance results.

Non-PMPP HEDIS Measure Reporting

The State also reports on non-PMPP HEDIS measures as summarized below.

Ohio	Managed Care Plans			
	MCO			
	Data Year 2002	Data Year 2003	Data Year 2004	Rate Change 2002–2004
Childhood Immunization Status: Combo 1	15.5	17.7	23.6	8.1
Childhood Immunization Status: Combo 2	13.2	15.1	20.9	7.7
Childhood Immunization Status: MMR	69.5	70.1	69.4	-0.1
Childhood Immunization Status: HIB	51.1	60.1	57.5	6.4
Childhood Immunization Status: VZV	57.8	61.2	64.0	6.2
Childhood Immunization Status: Hepatitis B	41.9	41.2	48.8	6.9
Childhood Immunization Status: DTP	22.0	23.9	31.5	9.5
Childhood Immunization Status: IPV/OPV	33.6	32.6	39.1	5.5
Well Child Visits in The First 15 Months of Life: Zero Visits	3.5	2.7	3.0	-0.5
Well Child Visits in The First 15 Months of Life: One Visit	4.5	3.9	3.2	-1.3
Well Child Visits in The First 15 Months of Life: Two Visits	6.3	6.2	2.9	-3.4
Well Child Visits in The First 15 Months of Life: Three Visits	9.9	10.0	9.3	-0.6
Well Child Visits in The First 15 Months of Life: Four Visits	15.0	15.5	13.7	-1.3
Well Child Visits in The First 15 Months of Life: Five Visits	20.4	19.7	21.3	0.9
Adolescent Well-Care Visits	34.5	35.8	36.6	2.1
Annual Dental Visit	40.4	41.0	44.3	3.9
Prenatal Postpartum Care: Postpartum Care	45.1	49.4	52.8	7.7
Comprehensive Diabetes Care: Eye Exams	26.5	25.6	26.2	-0.3
Comprehensive Diabetes Care: LDL-C Screening	53.9	56.8	61.5	7.6
Comprehensive Diabetes Care: Monitoring for Diabetic Nephropathy	27.3	27.6	28.0	0.7

Again, the report did not customarily offer discussion on rate results, with one exception: Childhood Immunization Status (CIS). The Bureau acknowledged that plans have reported difficulty in obtaining immunization encounter data from the various providers that offer these services. The report cites incomplete data as a reason why overall results are low. However, the report also credits improved submission of immunization encounter data for the reason why rates increased.

Seven of the top improvers were CIS measures, all of which experienced more than a five percentage point increase (ranging from 5.5% to 9.5 %). Other measures with the largest increase in rates were Comprehensive Diabetes Care: LDL-C Screening and the Postpartum Care measure (7.6% and 7.7% increase, respectively).

State-Specific Measures and Characteristics

To address its needs, the State has developed performance measures as follows:

- Low Birth Weight Risks and Very Low Birth Weight Risks:
  - No prenatal care
  - Teen pregnancy
  - Unmarried
  - Non-white
  - Less than 12 years education
  - Birth spacing less than 12 months
  - Delivery of >4th child
  - Tobacco consumers
  - Alcohol consumers
  - Maternal weight gain <23 lbs
  - Gestational weeks <37
  - Prevalence of low birth weights
- Pregnancy-related services: prenatal and postpartum utilization
- Asthma Medication: Emergency Room or Hospital Visit
- Incomplete For Last Menstrual Period for Members with Live Birth (encounter data assessment measure)
- Incomplete Birth Weight data for Live Newborns (encounter data assessment measure)
- Rejected/Accepted Encounters per quarter (encounter data assessment measure)

Ohio also reports on infant Lead Screening. Rates for this State-specific measure appear in the following table:

Ohio	Managed Care Plans		
	MCO		
	Data Year 2002	Data Year 2003	Data Year 2004
Lead Screening – 12-23 mo	36.6	40.3	43.0
Lead Screening – 24-35 mo	22.1	23.3	24.2

The Bureau of Managed Health Care, Program Development & Analysis Section calculates the rates for all performance measures (State-specific and HEDIS) using encounter data submissions.

Quality Improvement Efforts

As a central focus of Ohio's quality measurement and improvement approach, the State sets measure-specific minimum performance goals and holds contracted MCOs responsible for meeting them. The State compares performance results to standards and identifies areas that plans should target for further improvement. Plans that do not meet these standards are subject to "a system of progressive penalties."

The Quality Coordination Section (QCS) is responsible for the assessment of the quality of health care services provided to Medicaid managed care enrollees. Activities include: the management of the external quality review contract; review of each Managed Care Plan's (MCP) internal quality improvement program; development of clinical standards and guidelines; and the assessment of various tools, including utilization reports and encounter data, to determine quality performance and identify possible MCP deficiencies. Section staff works with the Contract Administration Section (CAS) to develop MCP quality improvement plans and assist in determining subsequent compliance. The Section also conducts research on related issues and serves as a clinical resource for all sections within the Bureau. The QCS is the link to other Medicaid quality improvement programs.

To encourage complete and correct encounter data submissions, selected measures are eligible for financial incentives based on performance results. For calendar year 2004, two clinical performance measures qualified for financial incentives: Initiation of Prenatal Care for New Enrollees and Frequency of Ongoing Prenatal Care.

The Bureau of Managed Health Care placed primary focus on the validity of the data. A series of data quality edits and checks were developed assure data validity on encounter data submission. After the data quality assessment, efforts expanded to include improvement of clinical performance.

Additionally, the Department planned two EQRO studies focusing on encounter data. The Encounter Data Omission Study will look at under-reporting of ambulatory encounter from PCPs. Additional details on these measures were not available. The second EQRO project will assess whether payments made to plans for the delivery of a newborn have corresponding delivery and medical record document. These studies were schedule for 2005 and 2006, respectively.

Childhood Immunization Status: DTP was the performance measure with the greatest change over the past three years. Childhood Immunization Combo 1 and Combo 2 were also top improvers. The Clinical Performance Measures report credits the improved rates to the submission of immunization encounter data. It is interesting to note that there is no minimum performance standard for the Childhood Immunization measures, nor is there monetary compensation for improved rates.

With respect to PMPP measures, the Prenatal Postpartum Care: Timeliness of Prenatal Care measure exhibited the greatest improvement, with an increase of 3.4 percentage points. This measure has a minimum performance standard and results are used to determine whether a managed care plan is eligible for financial incentives. The corresponding non-PMPP measure, Postpartum Care, also experienced an increase, gaining 7.7 percentage points.

Finally, it is interesting to note that during 2006, Ohio is transitioning to mandatory managed care enrollment for the entire Medicaid population. Through this effort, Ohio aims to enhance access to and quality of health care provided to members.

Report Content/Formats

The report includes benchmarking to national data and the State averages across two years, 2004 and 2003, for the measures across all areas of care: Perinatal Care, Child Health Care, and Chronic Care.

The report also includes a detailed methods section containing all measure specifications and denoting deviations from the HEDIS methods.

Summary of Quality Measure Reporting

In summary, clinical quality data is available for eight HEDIS measures across Ohio's Medicaid MCO population. A number of focused studies and State-specific measures have also been developed.

Other States may benefit from Ohio's use of managed care encounter databases to support performance measure reporting and the development of data validation studies to assess the impact of encounter data completeness/quality problems. Also of note is the development of State-specific perinatal measures to better address the characteristics and needs of the Medicaid population. In addition, the State sets performance targets identifying required increases in measure rates from year-to-year and incorporates these minimum performance standards into the MCO contract.

PENNSYLVANIA

State Quality Reporting Background

The Pennsylvania Department of Public Welfare (DPW), Office of Medical Assistance Programs (OMAP) contracts with twelve managed care organizations to provide service for approximately 98% of Medicaid enrollees. All Medicaid eligible persons, except dual-eligibles, are covered under managed care.

HealthChoices is the State's mandatory managed care program, covering approximately 80% of people serviced through managed care. There are seven MCOs contracted with OMAP to provide physical health care. In counties where HealthChoices is not available, Pennsylvania offers an enhanced primary care case management program, ACCESS Plus, through five health plans. ACCESS Plus covers the remaining 20% of the managed health care enrollees.

The State reports selected PMPP and non-PMPP measures for the HealthChoices population in a detailed report that is distributed online. The State does not report performance on its PCCM population. Pennsylvania has been collecting and reporting quality measure results since 1999.

The Division of Quality Management within the Office of Medical Assistance Programs produced the following quality measurement-related reports that were reviewed for this report:

- Health Choices: Performance Trending Report 2005 (December 2005)
- HealthChoices: A Consumer's Guide to the HealthChoices Health Plans 2005 (October 2005)
- Health Choices: Performance Trending Report 2004 (January 2005)
- HealthChoices: A Consumer's Guide to the HealthChoices Health Plans 2004 (November 2004)

In addition, a number of other documents were also reviewed:

- Managed Care Statistical Information (April 2005)
- Department of Public Welfare's Office of Medical Assistance Programs Fiscal Year 2004/2005 Annual Report
- HealthChoices: Physical Health Update (July 2003)

The 2005 Performance Trending Report contains three years of quality measurement data for each of the seven managed care plans operating within HealthChoices and a weighted statewide average. Performance rates for the most recent four years, 2001-2004, are summarized below.

PMPP Reporting Summary

The following table summarizes clinical quality measure results available in public reports for PMPP measures only. Empty cells indicate that the State did not report the measure.

Pennsylvania	HealthChoices				
	MCO				
	Data Year 2001	Data Year 2002	Data Year 2003	Data Year 2004	Rate Change 2001–2004
Children's Access To PCP: Age 12-24 Months	93.3	95.5	95.6	95.1	1.8
Children's Access To PCP: Age 25 Months - 6 years	80.6	82.8	83.8	82.9	2.3
Children's Access To PCP: Age 7-11 Years					
Children's Access To PCP: Age 12-19 Years					
Adult Access to Preventive/Ambulatory Health Services: Age 20-44					
Adult Access to Preventive/Ambulatory Health Services: Age 45-64	81.6	82.1	83.0	84.4	2.8
Adult Access to Preventive/Ambulatory Health Services: Age 65+	68.5	70.7	73.3	76.0	7.5
Well Child Visits in The First 15 Months of Life: Six or More Visits					
Well Child Visits Ages 3-6					
Prenatal Postpartum Care: Timeliness of Prenatal Care	78.6	79.7	82.1	82.3	3.7
Comprehensive Diabetes Care: HbA1c Testing					
Use of Appropriate Medications for Asthma: Age 5-9					
Use of Appropriate Medications for Asthma: Age 10-17					
Use of Appropriate Medications for Asthma: Age 18-56					
Use of Appropriate Medications for Asthma: All Ages Combined					

In summary, data for three of the seven PMPP measures are available.

Non-PMPP HEDIS Measure Reporting

The State also reports on non-PMPP HEDIS measures as summarized below:

Pennsylvania	HealthChoices				
	MCO				
	Data Year 2001	Data Year 2002	Data Year 2003	Data Year 2004	Rate Change 2001–2004
Well Child Visits in The First 15 Months of Life: Three Visits	89.5	93.2	91.7	94.0	4.5
Cervical Cancer Screening	61.1	62.3	63.6	64.0	2.9
Cholesterol Management After Acute Cardiovascular Events: LDL-C Screening	57.0	63.9	61.4	64.7	7.7
Comprehensive Diabetes Care: Eye Exams	53.1	55.1	51.8	55.9	2.8
Controlling High Blood Pressure	51.9	58.1	63.6	67.6	15.7

State-Specific Measures and Characteristics

To address State-specific needs, the State has also developed its own measures as follows:

- Finding Cervical Cancer in Women with HIV
- Dental Services
  - Regular Dental Care, Ages 3-20 Years Old
  - Dental Sealants for Children
  - Annual Dental Visits for Members with Developmental Disabilities
- Emergency Room Visits for Asthma

Pennsylvania also reports on infant Lead Screening for members birth to 19 months. Rates for this State-specific measure appear in the following table:

Pennsylvania	HealthChoices	
	MCO	
	Data Year 2003	Data Year 2004
Lead Screening – 0-19 mo	63.4	61.5

Quality Improvement Efforts

Pennsylvania's mandatory managed care program, HealthChoices, operates a telephone hotline, Clinical Sentinel Hotline that assists Medicaid enrollees on how to "maneuver through a system that may be perceived as difficult to understand." Telephone calls are answered by Department nurses who act as a point of contact for communication with the health plan.

HealthChoices also operates an Internet Website to answer frequently asked questions about managed care: enrolling, choosing a Primary Care Provider, and obtaining care.

Each health plan that contracts with HealthChoices conducts routine performance improvement projects. These include health education materials and consumer newsletters with care information on targeted conditions. HealthChoices credits overall improvement in performance measure rates to plan disease management efforts. The example cited is the large increase in the number of members with diabetes who received an eye exam since 1999[4].

OMAP provided Medstat with additional information and reports that are not yet publicly available for inclusion in this summary.

DPW is in the process of developing new quality initiatives targeting childhood obesity, smoking cessation in pregnant women, and domestic violence. The workgroups have made significant progress on the initiatives, though at this time only a few details are available:

- The smoking cessation effort will be focused on provider education about available resources.
- The childhood obesity workgroup also focused on education for providers and consumers. A provider toolkit is being developed and the workgroup is reviewing OMAP policy on the treatment of obesity.
- The domestic violence initiative already began with the distribution of a screening tool to primary care providers in 2005. Articles addressing the topic of domestic violence have been included in the consumer newsletter for both HealthChoices and ACCESS Plus.

The Department is also working to implement financial incentives for its Medical Assistance programs. HealthChoices will provide monetary rewards for meeting targeted goals on a specific set of HEDIS measures. Baseline data was collected in 2005. The goal will be assessed for each plan and re-measurement will be the basis for the rewards. The HealthChoices financial incentives program started with a set of ten HEDIS measures for which baseline data was collected. NCQA made significant measure specification changes to one of these measures, so rewards will be based on a set of nine measures. If a plan attains the target results for all nine measures, a bonus will be rewarded.

ACCESS Plus will provide goals for five measures and a financial reward provided for those that attain measure rate goals. ACCESS Plus will also provide financial “dis-incentives” when providers do not meet required improvements.

Additionally, a physician-level pay-for-performance program was also established within ACCESS Plus that provides tiered reward payments to physicians who actively attain goals within specific disease management programs.

In 2005, the DPW instituted the Hospital Quality Assessment Pilot Project, which tied the rate of payment increases to a set of performance indicators, including:

- re-admission rates for chronic diseases

[4] HealthChoices: Physical Health Update (July 2003)

- progress towards use of a formal pharmacy error reduction program
- implementation of a single electronic medical record
- participation in one of the hospital quality measurement programs (Leapfrog, the Joint Commission on Accreditation of Healthcare Organizations, or CMS' Premier Hospital Quality Demonstration project)

This pilot study also distributed $1 million in grant monies to promote quality-related technology programs to participating hospitals.

Pennsylvania will begin reporting performance measures for its ACCESS Plus (PCCM) program in 2006. Thirty HEDIS measures, some using hybrid methodology, will be included in the report that is scheduled for release in September 2006.

Overall, the Department sees financial incentives as a useful tool for focusing plans on improving the health status of its members on a long-term basis.

Report Content/Formats

Each year, DPW requires plans to submit performance data for a selected set of measures. The Department uses CAHPS, HEDIS, and its own Pennsylvania Performance Measures to create the annual performance report. There is no indication in the report that the Department rate calculation undergoes an external audit.

The report includes plan-level performance measure rates, NCQA Medicaid 75th and 50th percentile benchmarks, and trending over time. Plans with results that exceed these benchmarks are identified, although reasons for high rates are not provided.

The Department of Public Welfare sees performance measure reports as a "powerful tool to improve the clinical quality of it managed care program." Since virtually all Medicaid members in Pennsylvania are enrolled in managed care, the report provides a good overview of the health care quality provided to Pennsylvania's Medicaid population.

The State also produces an annual consumer report card, A Consumer's Guide to the HealthChoices Health Plans, which compares rates for the HealthChoices plans in three categories of health plan performance:

- quality of care
- access to care
- special needs

Results are graphically depicted for the same 27 measures that are included in the Performance Trending Report. Plan results are color coded for easy identification and a short description of the measure is provided for each chart. The brochure also includes contact numbers for the MCOs providing care under HealthChoices.

Summary of Quality Measure Reporting

In summary, clinical quality data are available for eight HEDIS measures (not including age cohort and "sub-measure" breakdowns) for each of the seven HealthChoices MCOs. Extensive performance measurement information directed at both consumers and providers has been available for several years.

Other States may benefit from Pennsylvania's experience when developing financial incentives for MCOs based upon meeting targeted goals on a HEDIS measures and the State's ability to generate performance results through its own data system. Also of note is Pennsylvania's annual consumer report card.

WISCONSIN

State Quality Reporting Background

The Wisconsin Bureau of Managed Health Care Programs (BMHCP) operates a Medicaid HMO program for low-income families with children. Thirteen HMO's participate in this program (2004). Almost all of Wisconsin's Medicaid recipients are covered by these MCOs. The State also runs three managed care programs to meet the needs of specialized populations.

Wisconsin developed its own set of standardized performance measures for Medicaid called the Medicaid Encounter Data Driven Improvement Core Measure Set (MEDDIC-MS). Use of MEDDIC-MS was approved by CMS in August 2003. In many cases, MEDDIC-MS measures assess clinical quality in a manner similar to HEDIS; however, the State's measures generally go beyond HEDIS measures to incorporate deeper clinical measurement or additional age/demographic groups.

Annually, the Bureau produces two key performance measurement reports:

- 2004 HMO Performance Data – Wisconsin Family Medicaid and BadgerCare (Volumes 1 and 2, November 2005)
- Wisconsin Medicaid and BadgerCare 2005 HMO Report Card
- 2003 HMO Performance Data – Wisconsin Medicaid and BadgerCare Programs (Volumes 1 – 3, December 2004)
- Wisconsin Medicaid and BadgerCare 2004 HMO Report Card
- 2002 HMO Performance Data – Wisconsin Medicaid and BadgerCare Programs (Volumes 1 – 3, February 2004)

In addition, a number of other documents were identified:

- Wisconsin Medicaid Program, Wisconsin Department of Health and Family Services (July 2006)
- Wisconsin Medicaid Program, Wisconsin Department of Health and Family Services (May 2005)
- Profile of Preventive Care of Children in Medicaid Managed Care, Reporting Period: Calendar Year 2004 (February 2006)
- Profile of Chronic Conditions in Medicaid Managed Care, Reporting Period: Calendar Year 2004 (February 2006)
- Profile of Women's Healthcare in Medicaid Managed Care, Reporting Period: Calendar Year 2004 (February 2006)
- Profile of Mental Health and Substance Abuse Services in Medicaid Managed Care, Reporting Period: Calendar Year 2004 (February 2006)

- Enrollee Satisfaction: Wisconsin Medicaid BadgerCare HMO Program 2004, CAHPS® Enrollees Satisfaction Survey, Executive Summary Report (May 2005)
- Profile of Preventive Care of Children in Medicaid Managed Care, Reporting Period: Calendar Year 2003 (March 2005)
- Profile of Chronic Conditions in Medicaid Managed Care, Reporting Period: Calendar Year 2003 (March 2005)
- Profile of Women's Healthcare in Medicaid Managed Care, Reporting Period: Calendar Year 2003 (April 2005)
- Profile of Mental Health and Substance Abuse Services in Medicaid Managed Care, Reporting Period: Calendar Year 2003 (June 2005)
- Medicaid/BadgerCare HMO Performance Improvement Projects – 1997-2004
- Profile of Preventive Care of Children in Medicaid Managed Care, Reporting Period: Calendar Year 2002 (December 2003)
- Profile of Chronic Conditions in Medicaid Managed Care, Reporting Period: Calendar Year 2002 (March 2004)
- Profile of Women's Healthcare in Medicaid Managed Care, Reporting Period: Calendar Year 2002 (December 2003)
- Profile of Mental Health and Substance Abuse Services in Medicaid Managed Care, Reporting Period: Calendar Year 2002 (May 2004)

The performance data reports contain detailed plan-level rates and State averages for each measure. The report cards are consumer-oriented summaries of performance.

The 2004 HMO Aggregate Performance Data report contains up to four years of quality measurement data, depending on the measure. Data from this report are summarized below.

PMPP Reporting Summary

The State's MEDDIC-MS contains measures that could be mapped to equivalent HEDIS measures. It is important to note that measures follow MEDDIC-MS specifications, not HEDIS specifications. Although the State reports only one PMPP measure, it also reports State-specific measures that are similar to the PMPP well care measures (see ahead).

The following table summarizes clinical quality measure results available in public reports for PMPP measures only. Empty cells indicate that the State did not report the measure.

Wisconsin	Medicaid HMO Aggregate			
	MCO			
	Data Year 2002	Data Year 2003	Data Year 2004	Rate Change 2002–2004
Children's Access To PCP: Age 12-24 Months				
Children's Access To PCP: Age 25 Months - 6 years				
Children's Access To PCP: Age 7-11 Years				
Children's Access To PCP: Age 12-19 Years				
Adult Access to Preventive/Ambulatory Health Services: Age 20-44				
Adult Access to Preventive/Ambulatory Health Services: Age 45-64				
Adult Access to Preventive/Ambulatory Health Services: Age 65+				
Well Child Visits in The First 15 Months of Life: Six or More Visits				
Well Child Visits Ages 3-6				
Prenatal Postpartum Care: Timeliness of Prenatal Care				
Comprehensive Diabetes Care: HbA1c Testing	74.8	78.3	82.3	7.5
Use of Appropriate Medications for Asthma: Age 5-9				
Use of Appropriate Medications for Asthma: Age 10-17				
Use of Appropriate Medications for Asthma: Age 18-56				
Use of Appropriate Medications for Asthma: All Ages Combined				

Reports include rates for each of the 13 MCOs and the BadgerCare (SCHIP) program. The above table contains the statewide MCO/BadgerCare average only. Medicaid-only averages (i.e., excluding SCHIP) are not included. Because the State does not have FFS or PCCM programs, the above rates reflect performance on the statewide Medicaid population (with the exception of members in the three managed care programs that serve specialized needs).

Non-PMPP Measure Reporting

The State also reports performance measures that are similar to non-PMPP HEDIS measures as summarized below. Again, it is important to note that the measures follow MEDDIC-MS specifications, not HEDIS specifications.

Wisconsin	Medicaid HMO Aggregate			
	MCO			
	Data Year 2002	Data Year 2003	Data Year 2004	Rate Change 2002–2004
Annual Dental Visit	26.8	26.3	25.8	-1.0
Breast Cancer Screening	37.1	32.6	28.2	-8.9
Cervical Cancer Screening	42.8	37.6	36.0	-6.8
Childhood Immunization Status: Combo 2	59.3	53.4	54.5	-4.8
Comprehensive Diabetes Care: LDL-C Screening	55.5	61.9	67.1	11.6
Follow-up After Hospitalization for Mental Illness: 30 Day	42.8	50.7	45.2	2.4
Follow-up After Hospitalization for Mental Illness: 7 Day	27.2	24.5	24.3	-2.9

Dental care is covered by three of the 13 HMOs; they are included in the above calculation. Enrollees in other HMOs receive dental care through a fee-for-service basis.

The diabetes testing measures showed the most improvement since 2002. Seven of the contracted HMOs have conducted performance improvement projects targeting diabetes care and eleven plans have diabetes disease management programs. In addition, DHFS set an improvement goal for the Diabetes measures beginning in 2004. Details about the goals were not available.

Reasons for decreases in performance were not specified; however, the report noted that these rates indicated clinical areas where the Department should focus efforts to improve health care services.

State-Specific Measures and Characteristics

As noted above, to address State-specific needs, the State has developed a large number of measures under its MEDDIC-MS system as follows:

- Asthma Ages 0-20 and 21+: Prevalence, IP Care, ED Care
- Dental (Preventative) Services: Ages 3-20, Ages 21+
- General & Specialty Care OP: ER visit without Admission, Primary Care Visit, Vision Care Encounter, Audiology Encounter, Dental (General)
- General & Specialty Care Inpatient: Maternity, Surgery, Medical, Psychiatric, Substance Abuse.
- Maternity Care: C-Section Rate, Substance Abuse Care, Voluntary HIV Test
- Mental Health/Substance Abuse Evaluation OP Care by Provider Type (PCP, SPC, Other): Ages 0-18, Ages 19+

A number of the State-specific MEDDIC-MS measures, while addressing clinical areas similar to HEDIS measures, provide a deeper analysis of quality. These measures are identified below:

- Mammogram Screening and Malignancies Detected: Ages 40-49, 50+
- Mental Health Follow-Up after Hospitalization 7-day and 30-day by Provider Type: PCP, Specialist, Unspecified
- Pap Test and Malignancy Detected 18-65
- Pap Test and HPV Detected
- Immunizations for Children, Status by Age 2: Full, Substantial, Incomplete
- Immunizations for Children, Status by Age 2: Four doses of the Pneumococcal Vaccine
- Diabetes Care Ages 0-18 and 18-75: HbA1c Test, Lipid Test
- EPSDT (HealthCheck) 0-24 months: 5 Visits, 6 Visits, 7 Visits
- EPSDT (Health Check) at least One Visit: Ages 3-5, 6-14, 15-20
- Non-HealthCheck Well Child: Ages <1, 1-2, 3-5, 6-14, 15-20

In addition, the State has developed a subset of the MEDDIC-MS measures to evaluate quality in its Independent Care program, which serves enrollees eligible for Supplemental Security Income (SSI). Using this administrative data, the State has produced a report containing Independent Care rates for this subset of MEDDIC-MS measures.

To address State-specific needs, the State developed its own measure for Lead Screening. Rates for this State-specific measure appear in the following table:

Wisconsin	Medicaid HMO Aggregate		
	MCO		
	Data Year 2002	Data Year 2003	Data Year 2004
Lead Screening – 12-23 mo	66.9	69.1	69.9
Lead Screening – 24-35 mo	52.2	50.9	52.3

The State also reports MCO CAHPS patient satisfaction scores for four member-rating measures: customer service, getting needed care, health plan, and health care.

Quality Improvement Efforts

As with other States, Wisconsin monitors MCO fulfillment of EQRO requirements for implementation of two Performance Improvement Projects. However, in addition, BMHCP has implemented a Care Analysis Program (CAP) that, using administrative data, identifies enrollee-specific health care needs and shares this information with the enrollee's MCO. CAP focuses on several chronic conditions (congestive heart failure, asthma, and diabetes) and key preventive services.

In addition, because the MEDDIC-MS uses encounter data, it affords flexibility in both the development of new measures and the timeframes during which measures are run. As a result,

the State can drive rapid-cycle measurement and improvement efforts that respond to existing and emerging areas of clinical concern.

Results of State monitoring of Performance Improvement Projects (PIP) indicates "HMO interventions on topics of performance improvement projects resulted in some degree of improvement." In the 2004 performance report, measures that showed the most significant improvements were clinical areas addressed by multiple improvement efforts (PIPs, disease management programs, data sharing, etc.).

Specific performance improvement efforts identified in Wisconsin reports are noted below:

- Eight of thirteen HMOs indicated that they had conducted PIPs on asthma care since 2000. Nine of thirteen HMOs indicated that they have asthma disease management programs in place. A Care Analysis Project (CAP) on asthma has been in place since 2001.
- In 2001, the CAP starting sharing recipient-specific lead screening with the child's HMO for follow up by the HMO. Five of thirteen HMOs have conducted PIPs on lead screening since 2000.
- Seven of thirteen HMOs have conducted PIPs on diabetes since 2000 and diabetes has been a CAP topic since 2001. Eleven of thirteen HMOs report having diabetes disease management programs.
- Under the Federal Early, Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, Wisconsin created the HealthCheck program. HealthCheck visits should include unclothed physical examination, immunizations, lab work (including blood lead screening), health and developmental history, vision and hearing tests, and oral assessment beginning at age three. These visit components go beyond those required by the HEDIS Well Care measures. The State sets a target of nine health check visits by age two. Ten of thirteen HMOs have conducted HealthCheck PIPs since 2000.
- The General and Specialty Care-Outpatient measures track emergency department (ED) visits that do not result in hospitalization and, for those patients, examines access/use of primary care, vision, audiology, and dental care. The percent of members having at least one ED visit is also tracked. The intent is to assess whether access problems are resulting in avoidable ED visits.
- For Childhood Immunization, the State immunization measure assesses immunization status within the following categories: 1) full immunization, 2) substantial immunization (receipt of most but not all of the doses of certain multi-dose vaccines), 3) incomplete status, and 4) pneumococcal vaccine (four doses). Shortages are thought to have affected results in 2002 and 2003. DHFS implemented goals for improving performance in 2004 in an effort to further increase rate results.

For most of the above measures, trended data is available for 2000, 2002, 2003, and 2004.

The only PMPP-like measure reported by Wisconsin, HbA1c Testing, experienced a 7.5 % increase between 2002 and 2004. As noted, 11 of 13 HMOs had diabetes performance

improvement programs. Among non-PMPP measures, the LDL screening measure also increased (11.6%), the most improved measure. The Follow-up After Hospitalization for Mental Illness: 30 Day measure increased by 2.4% since 2002.

Report Content/Formats

The consumer report card compares plan rates to statewide MCO averages for five measures: Health Checks, Immunizations, Lead Screening, Cervical Cancer Screening, and Mental Health/Substance Abuse Screening. A statistical significance test is used to allocate rates to three performance categories: 1) statistically significantly above the State average, 2) statistically the same as the State average, and 3) statistically significantly below the State average. Plans are allocated one, two, or three stars accordingly. CAHPS patient satisfaction scores are also included in this report card and scored in the same manner.

The State also publishes attractive, consumer-oriented, two-page 'Profiles' by clinical area of service. For example, the "Profile of Women's Healthcare in Medicaid Managed Care" presents HMO-specific results graphically for easy comparison of plan performance.

Wisconsin does not require MCOs to self-report audited HEDIS rates. Instead, BMHCP has developed a database incorporating HMO encounter data and other State-controlled electronic data sources to support MEDDIC-MS. Other electronic data sources included the State's immunization registry and fee-for-service claims. Rates are calculated by BMHCP using purely administrative data contained within this system. In conjunction with an EQRO, the State conducts data validity audits to assess the quality and completeness of the database.

There is no indication that BMHCP rate calculation undergoes an external audit.

Summary of Quality Measure Reporting

In summary, clinical quality data is available for six MEDDIC-MS measures (not including age cohort and "sub-measure" breakdowns) that are similar to HEDIS measures. In addition, BMHCP has developed a large number of State-specific measures to assess quality. Except for members covered by three specialized managed care programs, rates are "statewide" given that all members are covered by the 13 MCOs included in the report.

Other States may benefit from Wisconsin's creation of a comprehensive set of State-specific Medicaid measures, its design, and publication of Medicaid consumer report cards (and related performance categorization methodology) and its development of statewide databases that integrate managed care encounters with other available data sources affording rapid-cycle quality measurement.

APPENDIX II– QUALITY COMPASS: MEASURES REPORTED BY STATE

List of Measures and Measure Abbreviations

Measure	Measure Abbreviation
Adult Access to Preventive/Ambulatory Health Services	AAP
Children's Access To PCP	CAP
Prenatal Postpartum Care	PPC
Annual Dental Visit	ADV
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	IET
Well Child Visits in The First 15 Months of Life	W15
Well Child Visits Ages 3-6	W34
Adolescent Well-Care Visits	AWC
Childhood Immunization Status	CIS
Adolescent Immunization Status	AIS
Appropriate Treatment for Children: Upper Respiratory Infection	URI
Appropriate Treatment for Children: Pharyngitis	CWP
Breast Cancer Screening	BCS
Cervical Cancer Screening	CCS
Chlamydia Screening in Women	CHL
Controlling High Blood Pressure	CBP
Beta Blocker Treatment After a Heart Attack	BBH
Cholesterol Management After Acute Cardiovascular Events	CHM
Comprehensive Diabetes Care	CDC
Use of Appropriate Medications for Asthma	ASM
Follow-up After Hospitalization for Mental Illness	FUH
Antidepressant Medication Management	AMM
Medical Assistance with Smoking Cessation	MSC

Measures Included in Quality Compass 2005 by State

State	Number of Measures Reported	Measures
AR		
AZ		
CA	19	AAP, CAP, PPC, W15, W34, AWC, CIS, AIS, URI, CWP, BCS, CCS, CHL, CBP, BBH, CHM, CDC, ASM, MSC
CO	17	AAP, CAP, PPC, W15, W34, AWC, CIS, AIS, URI, CWP, BCS, CCS, CHL, CBP, CDC, ASM, MSC
DC	18	AAP, CAP, ADV, IET, W15, W34, AWC, CIS, AIS, URI, CWP, BCS, CCS, CHL, CBP, CDC, ASM, FUH
FL	22	AAP, CAP, PPC, IET, W15, W34, AWC, CIS, AIS, URI, CWP, BCS, CCS, CHL, CBP, BBH, CHM, CDC, ASM, FUH, AMM, MSC
HI	20	AAP, CAP, PPC, IET, W15, W34, AWC, CIS, AIS, URI, CWP, BCS, CCS, CHL, CBP, CDC, ASM, FUH, AMM, MSC
IL	15	CAP, PPC, IET, W15, W34, AWC, CIS, AIS, URI, CWP, CCS, CHL, CDC, ASM, FUH
KY	20	AAP, CAP, PPC, ADV, W15, W34, AWC, CIS, AIS, URI, CWP, BCS, CCS, CHL, CBP, BBH, CHM, CDC, ASM, MSC
MA	21	AAP, CAP, PPC, IET, W15, W34, AWC, CIS, AIS, URI, CWP, BCS, CCS, CHL, CBP, CHM, CDC, ASM, FUH, AMM, MSC
MD	13	AAP, CAP, PPC, W15, W34, AWC, CIS, AIS, BCS, CCS, CDC, ASM, MSC
ME		
MI	20	AAP, CAP, PPC, W15, W34, AWC, CIS, AIS, URI, CWP, BCS, CCS, CHL, CBP, BBH, CHM, CDC, ASM, AMM, MSC
MN	23	AAP, CAP, PPC, ADV, IET, W15, W34, AWC, CIS, AIS, URI, CWP, BCS, CCS, CHL, CBP, BBH, CHM, CDC, ASM, FUH, AMM, MSC
MO	20	AAP, CAP, PPC, ADV, IET, W15, W34, AWC, CIS, AIS, URI, CWP, BCS, CCS, CHL, CBP, CDC, ASM, FUH, AMM
NC		
NJ	9	PPC, W15, W34, AWC, CIS, AIS, BCS, CCS, MSC
NM	23	AAP, CAP, PPC, ADV, IET, W15, W34, AWC, CIS, AIS, URI, CWP, BCS, CCS, CHL, CBP, BBH, CHM, CDC, ASM, FUH, AMM, MSC
NY	23	AAP, CAP, PPC, ADV, IET, W15, W34, AWC, CIS, AIS, URI, CWP, BCS, CCS, CHL, CBP, BBH, CHM, CDC, ASM, FUH, AMM, MSC
OH	21	AAP, CAP, PPC, ADV, IET, W15, W34, AWC, CIS, AIS, URI, CWP, BCS, CCS, CHL, CBP, CDC, ASM, FUH, AMM, MSC
PA	20	AAP, CAP, PPC, ADV, W15, W34, AWC, CIS, AIS, URI, CWP, BCS, CCS, CHL, CBP, BBH, CHM, CDC, ASM, MSC
RI	20	AAP, CAP, PPC, IET, W15, W34, AWC, CIS, AIS, URI, CWP, BCS, CCS, CHL, CBP, CDC, ASM, FUH, AMM, MSC
TN	17	AAP, CAP, PPC, W15, W34, AWC, CIS, AIS, CWP, BCS, CCS, CHL, CBP, BBH, CHM, CDC, MSC
TX	16	AAP, CAP, PPC, IET, W15, W34, AWC, CIS, AIS, URI, CWP, CCS, CHL, CDC, ASM, FUH
UT	7	PPC, BCS, CCS, CBP, CDC, ASM, MSC
VA	23	AAP, CAP, PPC, ADV, IET, W15, W34, AWC, CIS, AIS, URI, CWP, BCS, CCS, CHL, CBP, BBH, CHM, CDC, ASM, FUH, AMM, MSC
WA	15	PPC, W15, W34, AWC, CIS, AIS, URI, CWP, BCS, CCS, CHL, CBP, CDC, ASM, MSC
WI		