COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

REPORT TO JOINT HEALTH AND HUMAN SERVICES COMMITTEE

STATUS OF PEDIATRIC HEALTH CARE QUALITY PERFORMANCE MEASURES

C.R.S. 25.5-5-109.5(9)

JULY 1, 2010

Cc: Representative Sara Gagliardi, Vice-Chairman, House Health and Human Services Committee
Representative Cindy Acree, House Health and Human Services Committee
Representative Dennis Apuan, House Health and Human Services Committee
Representative Cheri Gerou, House Health and Human Services Committee
Representative John Kefalas, House Health and Human Services Committee
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Representative Dianne Primavera, House Health and Human Services Committee
Representative Ellen Roberts, House Health and Human Services Committee
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COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

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Bill Ritter, Jr., Governor • Joan Henneberry, Executive Director

July 1, 2010

The Honorable Jim Riesberg, Chair
House Health and Human Services Committee
200 E. Colfax Avenue, Room 271
Denver, CO 80203

Dear Representative Riesberg:

Enclosed please find the Colorado Department of Health Care Policy and Financing's submission to the House Health and Human Services Committee on progress in the development and implementation of Pediatric Clinical Standards that improve health outcomes.

Section 25.5-1-109.5, C.R.S. (2009) requires the Department to submit a report, by July 1 each fiscal year, assessing health outcomes for pediatric programs administered by the state department based on, but not limited to, clinical standards including immunization rates, medical home standards, clinical care guidelines, care coordination, case management, disease management, and coordination and integration of mental health services. The standards and methods shall be consistent with national guidelines and standards regarding the collection and analysis of health data, where feasible, and shall meet the federal reporting requirements established under Titles XIX and XXI of the federal "Social Security Act", 42 U.S.C. secs. 1396 and 1397.

The statute also requires the Department to recommend to the health and human services committees of the Colorado Senate and House of Representatives, or any successor committees, strategies to improve health outcomes.

Questions regarding this report should be addressed to Beverly Hirsekorn, Manager of Health Outcomes and Quality Management, at Beverly.Hirsekorn@state.co.us or 303-866-6320.

Sincerely,

Sue Williamson for

Joan Henneberry
Executive Director

BH:JH/tr

Enclosure: Colorado Medicaid Clinical Standards Report

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Bill Ritter, Jr., Governor • Joan Henneberry, Executive Director

July 1, 2010

The Honorable Betty Boyd, Chairman
Senate Health and Human Services Committee
200 E. Colfax Avenue, Room 346
Denver, CO 80203

Dear Senator Boyd:

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Enclosure: Colorado Medicaid Clinical Standards Report

Executive Summary

Section 25.5-1-109.5, C.R.S. (2009) requires the Department of Health Care Policy and Financing (Department) to submit a report, by July 1 each fiscal year, assessing health outcomes for pediatric programs administered by the Department based on, but not limited to, clinical standards including immunization rates, medical home standards, clinical care guidelines, care coordination, case management, disease management, and coordination and integration of mental health services. Where feasible, the standards and methods shall be consistent with national guidelines and standards regarding the collection and analysis of health data. This report is intended to give a succinct view of the Department's priorities and areas of focus, in its efforts to improve the health of the children served by Departmental programs.

The Department continues to build upon the efforts of the Performance Measure Advisory Group (PMAG) and identify opportunities to build these metrics into provider contracts. The Department also continues to "mine" encounter data to analyze the measures. The vision has been extended to be able to incorporate health outcome priorities into Department activities and contractor activities.

Between the Medicaid Medical Home for Children program and the upcoming Accountable Care Collaborative (ACC), the Department's effort to bring an outcomes-focused and whole-person centered focal point of care for every client currently in Fee-For-Service Medicaid, will depend on a subset of these measures. The intention is for this subset of measures to drive improved health outcomes and cost containment by identifying the status of health determinants and incentivizing providers to seek improvements in these determinants.

It is expected that increased chart review, a major source of data, will become less burdensome as use of health information technology becomes common practice. The ACC will incorporate the Colorado Regional Health Information Organization (CORHIO) connectivity efficiencies, as they develop, to allow more efficient and more complete data flow for performance measures. Budget challenges continue to limit resource ability to extract and analyze Department data sources as resources are reallocated to maintain basic services. The Medicaid Management Information System (MMIS) data set is difficult to maneuver and does not collect all pertinent information.

The intent is to draw from the larger "menu" of measures for specific contracts based on the population served, types of service provided, Department and contractor priorities, regional health concerns, or other similar interests. The chosen measures will be used to hold contractors accountable for the quality of care and health outcomes of the clients they serve. The Department hopes to associate an accountable payment methodology for discrete measures to specific contracts to reinforce outcomes-based health care delivery through incentives and gain-shares. It is expected that the Department and contractors will negotiate those measures deemed most suitable for assessing high performance depending on the population being served, regional interests, priorities and potential incentive or gain-share payments. The list of measures will continue to be reviewed at least annually for alignment with Department priorities, client needs, provider quality improvement activities, and government reporting requirements.

As systems are initiated, mature and are enhanced, performance measures will also evolve. As an evolving effort to identify the best measures for quality and care of the children it serves, the Department is identifying how the Managed Care Measures and Standards Advisory Committee (MCMSA) and other stakeholder recommendations can be incorporated into contracts and other accountability processes. In the interim, the Department is using all available data sources which can inform the recommended measures. The Department will continue to promote better health outcomes in the most efficient and cost-effective manner through its providers by measuring their success in terms of the selected performance measure sets.

Clinical Standards Development and Progress

Over the last two years, the Department of Health Care Policy and Financing (Department) has reported on C.R.S. Section 25.5-1-109.5, C.R.S. (2009). These previous reports have described the process that created the initial recommended pediatric health care clinical standards and subsequent success on reporting those standards. The clinical experts, system experts, health policy experts and health agency experts from the Colorado Clinical Guidelines Collaborative (CCGC) and the Performance Measure Advisory Group (PMAG) developed strategies and recommended initial measures that would be most representative of pediatric health outcomes.

Ongoing work has occurred to ensure representative measures were included through a series of gauges:

- HEDIS (Health Effectiveness Data and Information Set), the nationally recognized benchmark for health care performance measures developed and maintained by the National Committee for Quality Assurance (NCQA), a not-for-profit organization committed to assessing, reporting on and improving the quality of health care. Annual HEDIS measures become available after June 30th.
- CMS EPSDT 416, which is the federal requirement for reporting EPSDT services.
- The Department's Balanced Score Card, an internal Department tool measuring program and individual employee efforts to achieve positive health outcomes.
- Performance measures that have been integrated into managed care contracts.

Among Colorado HEDIS measures, the Haemophilus Influenzae Type B (*HiB*) was the only pediatric care measure to rank above the national HEDIS 2008 Medicaid 50th percentile. A number of measures, including *Childhood Immunization Status-IPV*, *Hepatitis B*, and *MMR*; *Well-Child Visits in the First 15 Months of Life-Zero Visits, Six or More Visits*; and, *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*, all demonstrated declines in the statewide averages from 2008 to 2009 without statistical significance. The *Adolescent Well-Care Visits and Childhood Immunization Status-HiB* measures showed statistically significant improvements while the remaining six Childhood Immunizations Status measures, *Combination #2, Combination #3, DTaP, VSV, Hepatitus B,* and *Pneumococcal conjugate* showed improvement that was not statistically significant.

For new measures, some proposed performance measures had outcomes. Other measures had preliminary data. For some limited number of proposed measures, adequate data sources had not yet been identified.

Having gone through that process, the Department determined that health outcomes need to be better incorporated into performance benchmarks for all Medicaid programs. The initial work over the last two years evolved into a more broad-based effort with the express purpose of building accountability into the Department's managed care contracts. This was achieved by working with community partners to develop a menu of standards and measures specific to the unique needs of children served by publically funded health care programs. At the same time, these standards and measures were aligned with the Department's goals of improving health outcomes, increasing access to health care, and containing health care costs.

The Department convened clinical and professional partners as well as clients from current managed care plans including Colorado Access, Denver Health, Rocky Mountain Health Plan, Kaiser Permanente and our behavioral health organization community. Other clinical and professional partners who reviewed, considered and refined recommended measures included original members of PMAG, primary care providers, safety net representatives, academics, quality improvement professionals including CCGC staff, researchers, and key Department staff. This group was called the Managed Care Measures and Standards Advisory Committee (MCMSA).

MCMSA strategically chose measures over a course of meetings based on the following criteria:

- Validity and reliability
- Alignment with evidence-based guidelines
- Credibility of the measure's source
- Feasibility of data collection
- Current and planned quality improvement activities
- Current and anticipated reporting requirements
- Alignment with performance-based contracting and payment reform activities

Preference was given to health and health care outcome measures over process measures with the intent to express the value of outcomes of care, efficacy and efficiency of care, and to reduce unwarranted care.

The intent is to draw from the larger "menu" of measures for specific contracts based on the population served, types of service provided, Department and contractor priorities, regional health concerns, or other similar interests. The chosen measures will be used to hold contractors accountable for the quality of care and health outcomes of the clients they serve. The Department hopes to associate an accountable payment methodology for discrete measures to specific contracts to reinforce outcomes-based health care delivery through incentives and gain-shares. It is expected that the Department and contractors will negotiate those measures deemed most suitable for assessing high performance depending on the population being served, regional interests, priorities and potential incentive or gain-share payments. The list of measures will continue to be reviewed at least annually for alignment with Department priorities, client needs, provider quality improvement activities, and government reporting requirements.

The following list of measures has been recommended to the Department. Where there are current methodologies, sources, and statistics, they have been noted.

Preventative Care

Measure #1

The percentage of recipients who receive age-appropriate well-child checks, including: vision, hearing, developmental, behavioral/mental health, oral health, newborn screening, immunizations (based on Early Periodic Screening, Diagnosis and Treatment [EPSDT] or HEDIS well-child schedule)

PMAG, EPSDT, NCQA, and the Children's Health Insurance Program Reauthorization Act (CHIPRA), recommended this measure. Based on children's participation in EPSDT for FY 2007-08, 56 percent of total eligible children, ages 0 through 20, received at least one initial or periodic screen, ages 0 through 20. For FY 2008-09, 73 percent of total eligible children, ages 0 through 20, received at least one screen.

Measure #2

The percentage of children who turned two years old during the measurement year who had 4DTaP/DT, 3 IPV, 1 MMR, 3H influenza type B, 3 Hep B, and 1 VZV immunizations by the time period specified and by the child's second birthday (4:3:1:3:3:1) (This is an existing PMAG Measure.)

This measure will use NCQA methodology and has been recommended by CHIPRA. While Colorado has had poor immunization coverage and ranked 50th among the states in 2003, most recent data has Colorado moving to 28th in 2006 with a coverage rate of 80.3 percent. Between 2008 and 2009, one managed care plan increased their immunization rate from 85.2 percent to 87.6 percent. The other plan's immunization rate decreased from 81.5 percent to 78.3 percent. Immunization rates for Fee-For-Service (FFS) clients improved from 66.4 percent to 70.1 percent, but rates for Primary Care Physician Program (PCPP) clients decreased from 78.6 percent to 70.1 percent. Overall, the Colorado Medicaid weighted average, from 2008 to 2009, is trending towards more children being vaccinated. It is expected that with the launching of the ACC in 2011, children that were part of FFS or PCPP will become part of a Regional Integrated Care Collaborative that will promote comprehensive vaccinations. This should result in increased performance.

Measure #3

The percentage of eligible adolescents who have received recommended MMR and Tdap boosters by their 15th birthday

The measure will use HEDIS Adolescent Immunization methodology, or alternatively will survey the total number of 11-15 year olds in a plan or region. This measure has been of interest to PMAG, NCQA and the National Institute of Health. Additionally, there was interest by the recommending stakeholders to add the human papillomavirus (HPV) vaccine to this measure. NCQA treats the HPV vaccine as a separate measure from adolescent immunizations. The Center on Disease Control recommends the HPV vaccine for all adolescents. There are several barriers to the collection of this measure, including the fact that many of these immunizations are not documented in claims data. Physicians will often give the vaccine, but will write off the charge rather than bill for it, which they see as a burdensome process. Further, there is not a specialized code for identification of these boosters. This second barrier will be mitigated when the International Classification of Diseases-10 (ICD-10) system is fully implemented. This measure will need further definition.

Measure #4

Evidence of psychosocial screening in all ages using a standardized, validated tool (e.g., Pediatric Symptom Checklist [PSC], Guidelines for Adolescent Preventative Services [GPS])

Assessment tools for this measure have been identified by PMAG and CHIPRA. PMAG, the American Academy of Pediatrics, and the National Academy for State Health Policy's Assuring Better Child Health and Development Program, have all recommended this measure. The Colorado Medicaid Medical Home program has been able to track psychosocial screening for children, aged 12-60 months. In FY 2006-07, 7.6 percent of children who had an EPSDT screening, also had psychosocial screening. The percent of children who had EPSDT and psychosocial screening in FY 2007-2008, increased to 17.5 percent. If a psychosocial screening is done, a standardized, validated tool is required to be used; specific tools have not been mandated.

Colorado Pediatric Medical Home Standards

Measure #5
Provides 24 hours per day, 7 days per week access to a provider or trained triage service

This measure is monitored by practice/plan/region and is a Colorado Pediatric Medical Home contractual requirement. The Department verified that all but three providers out of 504 maintained 24 hours per day, 7 days per week access to a provider or trained triage service. The providers who were not meeting the requirement are now using the Department Nurse Advice Line. The Department a third party contractor to verify this incentivized standard.

Measure #6
The practice/plan/region has a continuous quality improvement plan

This measure is monitored by practice/plan/region and is a Colorado Pediatric Medical Home contractual requirement. Standards are under development by the Department and CDPHE. The Department has verified that 100 percent of Medical homes have continuous quality improvement plans. Pay for Performance is not granted until at least one quality improvement cycle has been completed.

Dental Measures

Measure #7
Dental Caries ages 1-8 years of age

The measurement methodology has been created by the Department's Data Analysis Section and is a Balanced Score Card measure of health outcomes for the Department. Currently, the Department is measuring the percentage of Medicaid children, ages 2 to 4, who have dental caries. While more children are receiving preventive dental services, in May 2009, the caries rate was 32.9 percent and in May 2010, the rate was 29.7 percent. Reducing this percentage is one of the Department's Strategic Plan goals and will continue to be pursued by a collaborative team of Department staff.

Measure #8
The percentage of children who have received protective sealants on their first permanent molars by age 6 (or when adequately erupted)

CDPHE reported that for the 2006-2007 school year, 35 percent of Colorado children in the third grade had a dental sealant applied to at least one tooth. CDPHE identified that only twelve counties were close to meeting the Healthy Persons in 2010 target of 50 percent of children. The rest of Colorado's counties (52) were some distance from the target standard. It is expected that this measure will become available next year for children on Medicaid. Pursuing this target will be part of the Department's ongoing Strategic Plan efforts.

Measure #9
Total EPSDT eligible children receiving preventative dental services

For children who are eligible for EPSDT and receive any preventive dental services, the percentage of children receiving at least one preventive dental service had increased from 19.5 percent in FY 2005-06 to 23.5 percent in FY 2007-08. Increasing attention to dental needs through Medical Home activities was expected to increase this metric, and has done so. In FY 2008-09, the percentage of children receiving at least one preventative dental service had increased to 45.3 percent, almost doubling the number of children receiving dental services from the year before. Medical Home is helping to coordinate care by breaking down traditional care silos. Medical Home pediatricians are improving oral health among Medicaid children, who typically have 2-3 times as many cavities as children not on Medicaid. Encouraging oral health training for Medical Home pediatricians is expanding dental health access in communities that often have few or no pediatric dentists. Medical Home focuses on keeping children healthy, rather than merely paying for procedures.

Measure #10
Annual Dental Visit

Annual dental visits will use HEDIS methodology as developed by NCQA. Further work will need to be done to differentiate Measure #9 and Measure #10.

Smoking Exposure, Screening & Cessation

Measure #11
Adolescent tobacco use

This measure will utilize Healthy People 2010 methodology. A data source has not yet been established for this measure.

Measure #12
Exposure to tobacco smoke at home among children

This measure will utilize Healthy People 2010 methodology. The National Survey of Children's Health (NSCH), funded through the U.S. Department of Health and Human Services, reports that

the households of children on Medicaid have more than twice the rate of tobacco exposure, compared to households with children covered by private insurance, at 42 percent and 16 percent, respectively. The overall rate for children across the US is 26 percent. The Healthy People 2010 goal is 10 percent.

Mental Health Care

Measure #13
The percentage of children with a diagnosed mental health condition based on the Diagnostic and Statistical Manual of Mental Disorders IV (DSM IV) or the International Clarification of Diseases-9 (ICD- 9), who received mental/behavioral health services in the past six months

Behavioral Health Organizations are now responsible for incorporating this data into a measure, tested for validity before implementation. Data is not yet being collected on this measure, but will be available for this report next year.

Measure #14
Focal point of behavioral care established and identified for children with Severe and Persistent Mental Illness (SPMI)

This measure is under development for all BHO members with SPMI. Data is not yet being collected on this measure, but will be available for this report next year.

Measure #15
Follow-up appointments within seven and thirty days after hospital discharge for both BHO-covered and medical admissions

The current BHO follow-up measure is "Follow-up appointments within seven and thirty days after discharge." The baseline measurement established for FY 2008-09, the seven-day all-hospital average rate, was 49.7 percent. The thirty day all-hospital average rate is 67.3 percent. At this time, the measure has measured only BHO-covered admissions.

Measure #16
Alcohol-related hospital emergency department visits

The measure will use Healthy People 2010 methodology with the survey group being the number of 12-20 year old youth in a plan or region. A data source has not yet been established for this measure, but will be available for this report next year.

Measure #17
Drug-related hospital emergency department visits

The measure will use Healthy People 2010 methodology with the survey group being the number of 12-20 year old youth in a plan or region. A data source has not yet been established for this measure, but will be available for this report next year.

Measure #18
Compliance with behavioral health medications

A data source has not yet been established for this measure, but will be available for this report next year.

Measure #19
Of the children who remained on an ambulatory prescribed Attention-Deficit Hyperactivity Disorder (ADHD) medication for at least 210 days (seven months), the percentage of children 6-12 years of age as of the Index Prescription Episode Start Date who, in addition to the visit in the Initiation Phase, had at least two additional follow-up visits with a practitioner within 270 days (nine months) after the Initiation Phase Ends

Behavioral Health Organizations, under new contracts, are responsible for incorporating this data into a test measure, to be tested for validity before implementation. Data is not yet being collected on this measure but will be available for this report next year.

Weight Assessment & Obesity

Measure #20
Weight Assessment and counseling for nutrition and physical activity for children and adolescents

This measure is a HEDIS measure. 2010 is the first year that the measure will be reported. The Department will not use this as a publically reportable measure until it is considered reliable, which will most likely occur in the second year of implementation.

Measure #21
The percentage of children, 2-18 years of age, whose weight is classified based on Body Mass Index percentile for age and gender (HEDIS provisional measure)

This measure is more likely to be incorporated into a contracted data set when it is no longer considered provisional.

Sick Care and Incidence of Illness

Measure # 22
The percentage of clients who where given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after episode date

The last year that this data was reported as a HEDIS measure was in 2007. In that year, 9.3 percent of children served by Medicaid did not receive appropriate treatment. The Colorado HEDIS rate for appropriate treatment, 90.7 percent, was higher than the 2006 HEDIS National Average Median of 82.4 percent. This measure has been replaced to explore alternate measures with opportunities for higher improvements for health outcomes.

Measure #23
The incidence of vaccine-preventable diseases

This measure is derived from Healthy People 2010. Data was last collected and reported by DPHE in 2007. It did not separately identify cases of vaccine-preventable diseases for children receiving Medicaid. The top three largest incidence of vaccine-preventable diseases for all Colorado children, 0-19 years of age, was 1036 cases of chicken pox (varicella), 182 cases of influenza-hospitalized and 181 cases of pertussis.

Measure #24
Access specific injury rates (specify ICD-9/10 and E-codes.) This measure was originally identified by PMAG.

The Colorado Health Information Dataset maintained by CDPHE has this information through FY 2007-08. The data is broken down by age increments of less than 5, 5-9, 10-14, 15-19, and 20-24 years. Injuries are reported as "injury-related hospitalizations by unintentional" including "other injury", transportation, motor vehicle traffic, other transportation, poisoning, fall, fire/burn, and natural/environmental. "Intentional injury hospitalizations" are reported as suicide/self-inflicted, assault/legal intervention, undetermined intent and firearm-related. The predominant unintended identifiable sources for injuries experienced by children less than 5 years of age are poisoning and falls. For children ages 5-9, 10-14, 15-19 and 20-24 years, the largest identifiable unintended injury source is transportation/motor vehicle. Intentional injuries occur most often as assault/legal intervention for children less than 5 and 5-9 years of age. Suicide/self-inflicted is the majority intentional injury category impacting older children, 10-14, 15-19 and 20-24 years of age. Attempted and completed adolescent suicides are of particular interest to the Managed Care Measures and Standards Advisory Committee (MCMSA) participants. Behavioral Health Organizations, under new contracts, are responsible for incorporating this data into an observational measure that will apply to a broad population - in this case, as it applies to the general behavioral health of the population. DPHE conducts a Colorado High School Survey on a number of health-related topics including suicide. Its most recent published data for 2007 reported that 9 percent of respondents actually attempted suicide one or more times during the prior 12 months. The largest proportion of that group came from the 10^{th} grade.

The preponderance of children who responded positively also indicated their race/ethnicity as Hispanic/Latino. The data reported was non-weighted and is a validated sample of Colorado high school students. Data sources are under development for children on Medicaid with depression, or who have attempted suicide, or who have completed suicide.

Utilization

Measure #25
Antibiotic Utilization

This is a 2009 HEDIS measure. This measure was monitored for the adult Medicaid population and has yet to be collected as a measure for children on Medicaid.

Measure #26
Emergency Room utilization per 1000 member months (FTE)

This measure is calculated through the Department's Data Analysis Section and may be analyzed at the plan or region level. It is a Department Balanced Score Card measure. Department data shows that for the 2nd Quarter FY 2009-10, ER utilization per 1000 FTE for children on Medicaid was 1,958. For the 2nd Quarter FY 2008-09, ER utilization per 1000 FTE for children on Medicaid was 1,650. During this coming year, the Department will continue current efforts, and also develop and implement new efforts, to reduce unnecessary ER visits based on such data analysis.

Measure #27
Inpatient rates per 1000 member months (FTE)

This measure is calculated through the Department's Data Analysis Section and may be analyzed at the plan or region level. It is a Department Balanced Score Card measure. The current Balanced Score Card measure related to inpatient rates is the number of discharges per 1000 FTE. In the 2nd Quarter of FY 2009-10, discharges for children on Medicaid were 497 per 1000 FTE. In the 2nd Quarter of FY 2008-09, discharges for children on Medicaid were 561 per 1000 FTE.

Measure #28
Readmission rate per 1000 member months (FTE)

This measure is calculated through the Department's Data Analysis Section and may be analyzed at the plan or region level. This Department Balanced Score Card measure needs further development to identify children's data.

Measure #29
Inpatient admission for ambulatory care sensitive conditions

This measure will use Agency for Healthcare Research and Quality (AHRQ) Pediatric Quality Indicators (PDIs) that are more robust than the AHRQ Quality Indicators which have only one pediatric metric, low birth weight. PDIs are used to screen for problems that pediatric patients experience as a result of health care system problems. There are thirteen provider-level indicators and five area-level indicators. It has not yet been determined which indicators are of interest to the Department. The provider-level PDIs include: accidental puncture or laceration, decubitus ulcer, foreign body left during procedure, iatrogenic pneumothorax in neonates at risk, iatrogenic pneumothorax in non-neonates, pediatric heart surgery mortality, pediatric heart surgery volume, postoperative hemorrhage or hematoma, postoperative respiratory failure, postoperative sepsis, postoperative wound dehiscence, selected infections due to medical care and transfusion reaction. The area-level PDIs are asthma admission rate, diabetes short-term complication rate, gastroenteritis admission rate, perforated appendix admission rate, and urinary tract infection admission rate. Those indicators of interest to the Department will be incorporated into managed care contracts as they are renewed or specified for inclusion into the ACC Initiative.