HEDIS 2003 and 2004

Health Plan Employer Data & Information Set
Evaluation of Quality of Care
Delivered to Colorado Medicaid Clients in 2002 and 2003

State of Colorado
Department of Health Care Policy and Financing
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Background

As part of a comprehensive quality improvement effort, the Colorado Department of Health Care Policy and Financing (Department) and its contracted Medicaid Managed Care Organizations calculate select Health Plan Employer Data and Information Set (HEDIS®)[1] measures.

Plan Participation
In 2002 and 2003, the Colorado Medicaid program was represented by four health plans: Colorado Access (Access), Rocky Mountain Health Plan (RMHP), and the Department's two programs: Primary Care Physician Program (PCPP) and Unassigned Fee-for-Service (FFS). All health plans used auditors approved by the National Committee for Quality Assurance (NCQA) to independently certified each health plan's measures. Health Service Advisory Group, the Department's External Quality Review Organization, contracted with HEDISHelp to calculate and audit the measures for the PCPP and the FFS.

Interpreting Results
Results are calculated retrospectively and reported the following year. For this report, data was abstracted and calculated for members enrolled in Colorado Medicaid during the calendar year 2002 and 2003, and are reported for the HEDIS years 2003 and 2004.

When evaluating HEDIS results, it is important to remember that for most measures, only a portion of the Medicaid population is represented (sampling). Measures utilizing member month calculations include a plan's total population, but other measures are based on specific member populations. Measures often require a person to be continuously enrolled in the health plan for a set amount of time before the person can be included in a measure's denominator (population). Despite these limitations, HEDIS measures enable the Department to make direct plan-to-plan comparisons on care delivered to clients.

As evidenced in the results, each health plan has its own strengths and weaknesses. HEDIS measures change each year to reflect opportunities for quality improvement as identified in the State Quality Improvement Plan (State QIP). While health plans are required to measure and submit HEDIS rates to the Department, the process of selecting measures is collaborative, taking into account the State QIP, Department initiatives, directives from the Centers for Medicare and Medicaid, and organizational-level quality activities.

Medicaid Benchmarking
Benchmarking is the process of identifying, sharing, and using knowledge of best practices among organizations.

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

Benchmarks are calculated by synthesizing data from national Medicaid health care organizations. The benchmarks included in this report are calculated by NCQA. They allow the Department to understand the extent of effectiveness of care, access and availability of care, and use of services in a Medicaid population. For each measure, 2003 HEDIS National Medicaid benchmarking rates are reported. 2004 benchmarks were not available at the time of this report. Benchmarks can be used as point of reference against which Colorado Medicaid results may be measured.

The goal in using benchmarks is to identify the magnitude of difference required to close a gap and to identify in what areas change is needed to achieve best performance. For example, Childhood Immunizations have been measured each year since 1998 and national benchmarks provide necessary trending to identify performance improvement. One measure, Appropriate Medications for Persons with Asthma, has not been measured in Colorado since 2001. By using national Medicaid benchmarks, this assists Colorado to more adequately rate itself and identify areas of best performance or gaps in performance.

Individual Performance Measure Results

1. Childhood Immunizations

Measured in 2003 & 2004

Vaccines are among the greatest public health achievements of the 20th century. Immunizations can prevent disability and death from infectious diseases for individuals and can help control the spread of infections within communities.

The Centers for Disease Control and Prevention (CDC) recommends immunizing children for ten preventable diseases.[2] These include diphtheria, tetanus, acellular pertussis (DTaP); polio (IPV/OPV); measles, mumps, and rubella (MMR); *Haemophilus influenza* type B (Hib); hepatitis B (hep B); and varicella-zoster vaccine (VZV).

During 2001 and the first half of 2002, the United States experienced severe shortages of five universally recommended vaccines for children, including DTaP and MMR. Of these, HEDIS measurement was most affected by the shortage of DTaP as HEDIS methodology requires documented evidence of four DTaP before the age of two. Prior to national shortages, the Colorado Board of Health rules recommended children receive a total of five DTaP immunizations, four while under the age of two and one before entry into school. In response to the shortage, the Colorado Board of Health temporarily suspended the requirement that Colorado children receive the fourth and fifth doses of DTaP vaccine before school entry in 2001. In 2003, the Centers for Disease Control and Prevention (CDC) determined the national supply of DTaP was adequate and at a June 2003 public rulemaking hearing, the Board of Health lifted the suspension of the rule requiring the 4th and 5th doses of DTaP as a school entry requirement, effective September 15, 2003. During the measurement year 2002, all children were affected by the continued shortage of DTaP.

HEDIS measures and positively counts only those children who have documented evidence of four DTaP so rates reported for this individual antigen may not be an adequate picture of complete vaccine immunization for children under the age of two enrolled in Colorado Medicaid. Total Colorado Rates of DTaP collected and reported for 2003 (Table 1) were most likely affected by the national shortage and statewide temporary suspension. As demonstrated in 2004, rates have rebounded to near 2003 benchmarking rates. Overall, Colorado rates improved 56.4 percent from 2003 to 2004.

Combination 2 rates determine children who are fully immunized for all vaccines before the age of two years. In 2004, Combination 2 rates showed significant improvement over 2003 rates (Table 2). Combination 2 rates have nearly doubled over last year and one plan, RMHP, exceeded the 2003 national benchmark of 57.2 percent.

As demonstrated by these rates, Colorado Medicaid children are receiving required immunizations according to state and national recommendations but rates indicate room for further improvement.

[2] Centers for Disease Control, National Immunization Program: www.cdc.gov/nip/acip .

Table 1: Total Colorado DTaP/DT Results compared from 2003 to 2004 and against national 2003 HEDIS benchmarks.

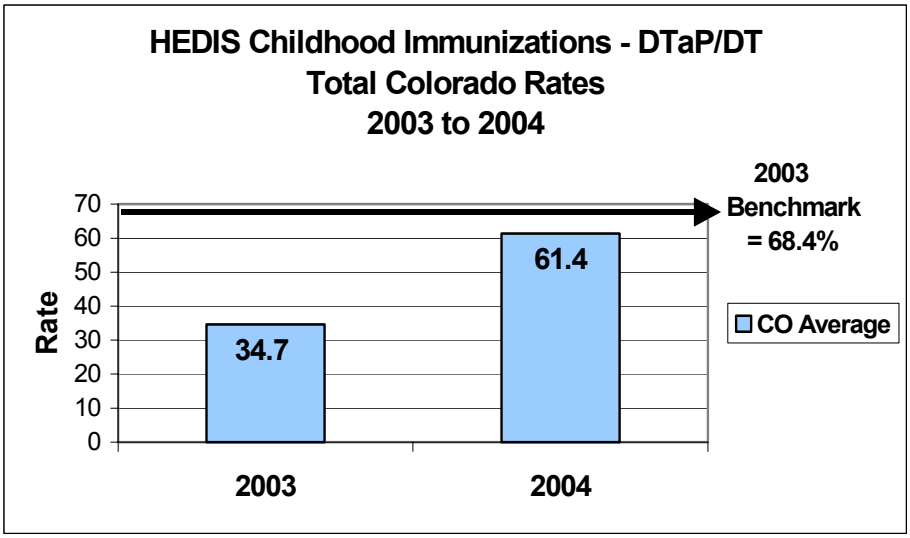
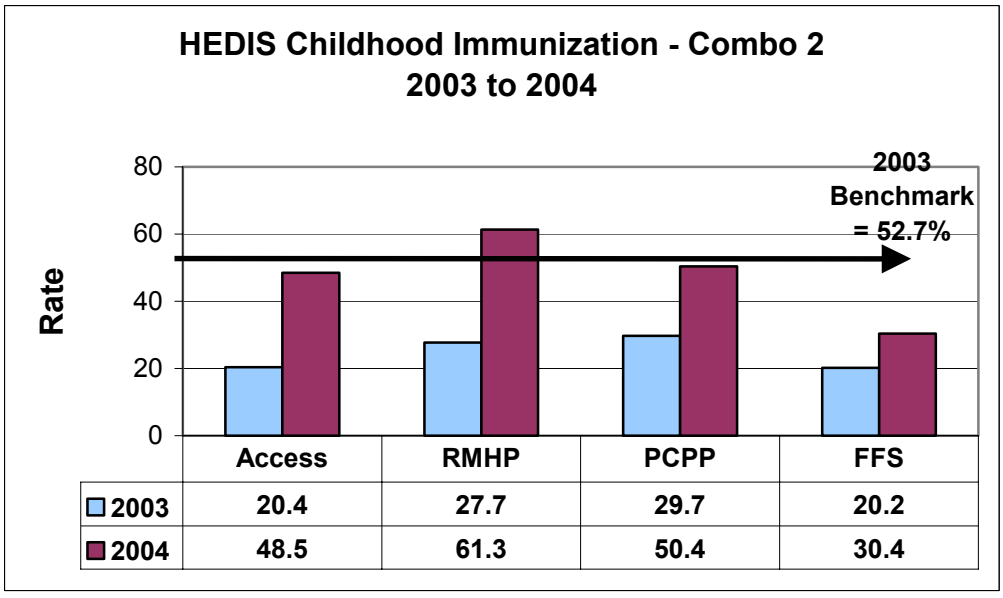


Table 2: 2004 Combination 2 rates for all health plans as compared to Total Colorado and national HEDIS benchmarks.



	Access	RMHP	PCPP	FFS
2003	20.4	27.7	29.7	20.2
2004	48.5	61.3	50.4	30.4

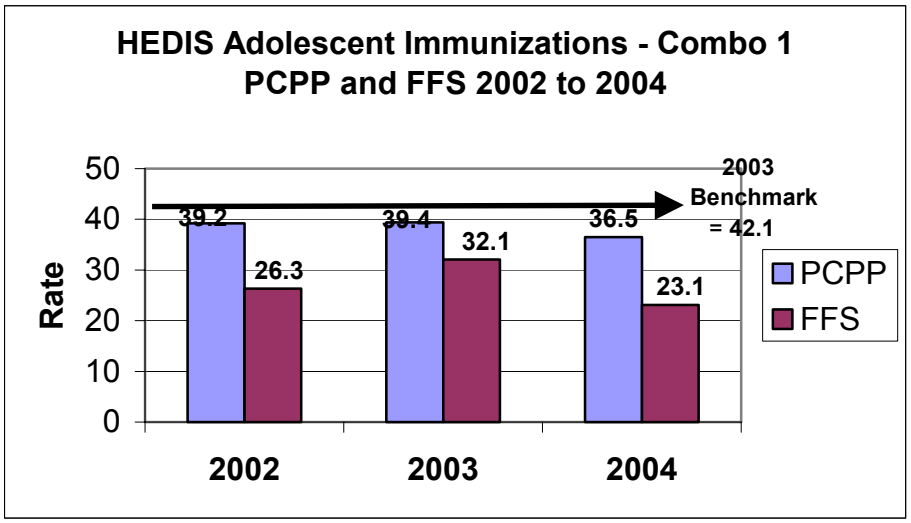
2. Adolescent Immunizations

Measured in 2003 & 2004 PCPP/FFS only

Adequate immunization is one of the most important preventive health services that can be provided for adolescents. The American Academy of Pediatrics recommends the following four vaccines for teenagers: measles, mumps, and rubella (MMR); hepatitis B (hep B); varicella-zoster vaccine (VZV); and tetanus-diphtheria vaccine (Td).[3] According to the CDC, National Center for Infectious Diseases, the total number of new vaccine-preventable infections per year has been declining steadily since 1980. The greatest decline has happened among children and adolescents due to routine hepatitis B vaccination.[4]

Combination 1 rates determine adolescents who are immunized with MMR and hep B before the age of thirteen. Rates in 2004 demonstrate a slight decline in rates for adolescents enrolled in PCPP. Rates also declined for FFS. For adolescents enrolled in the PCPP, individual measures such as MMR and Hepatitis remain below 2003 national benchmarks; rates for FFS are significantly below national benchmarks. These rates highlight and support efforts should continue towards adequate access to preventive health services for Colorado Medicaid adolescent, including necessary immunizations.

Table 3: Adolescent Immunizations for PCPP and FFS from 2002 to 2004



[3] Centers for Disease Control, National Immunization Program web site: http://www.cdc.gov/nip/recs/teen-schedule.htm .
[4] Centers for Disease Control, National Center for Infectious diseases web site: http://www.cdc.gov/ncidod/diseases/hepatitis/index.htm .

3. Well Child Visits in the First 15 Months of Life

Measured in 2003 & 2004

The Colorado Early Periodic Screening, Diagnosis and Treatment (EPSDT) program adopts recommendations from the American Academy of Pediatrics for well child care. Periodic checkups provide opportunities for the primary care providers to detect physical, developmental, behavioral and emotional problems and provide early intervention and treatment, and utilize appropriate referrals to specialists. Providers have a greater chance of detecting and treating permanent physical defects prior to adolescence and adulthood if well-care visits are routinely maintained.

The HEDIS rate for well child visits in the first 15 months of life counts the number of provider visits a child had up to age 15 months. There has been improvement noted in rates from 2003 to 2004 (Table 4). All health plans demonstrated improvement. The PCPP has the best rate for children receiving six or more visits and this rate exceeds the 2003 national benchmarking rate.

The rate also measures the number of children with no (zero) identified visits to a provider. Having no provider visits indicate children age less than 15 months are not receiving preventive well care, and any rate above zero percent indicates room for improvement. All health plans demonstrated improvement. Comparing 2003 to 2004 rates (Table 5), RMHP and the PCPP showed significant improvement in the rate of zero visits, with the PCPP demonstrating a 28 percent decline in the number of children who had no visits. Overall, this indicates more Colorado children are having well care visits in the first 15 months of life.

Colorado Medicaid health plans are meeting Department and national performance expectations for well-child visits in the first 15 months of life but have room for improvement in the number of children having zero and six or more documented visits to a provider.

Table 4: HEDIS Well Child Visits – 6 or More Provider Visits

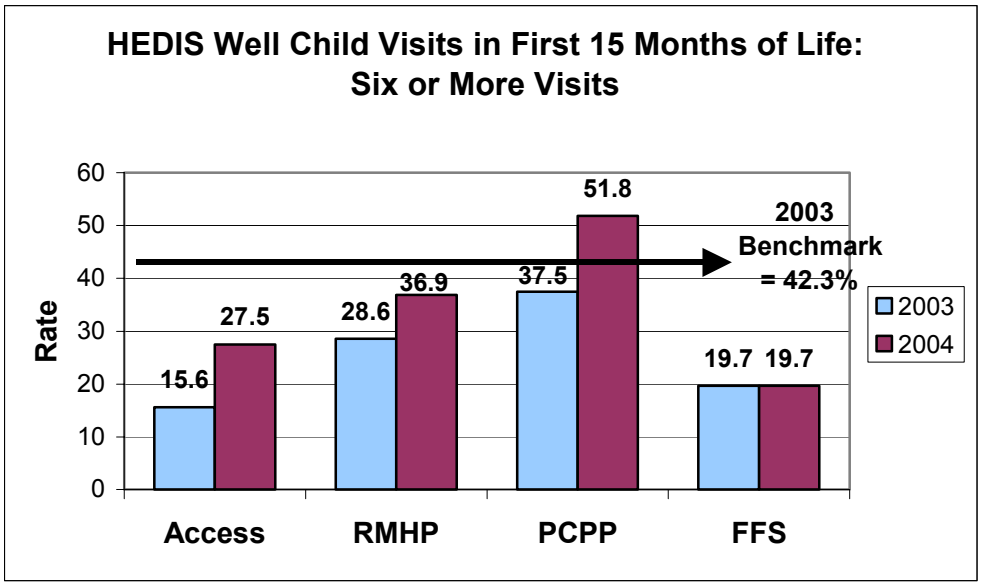
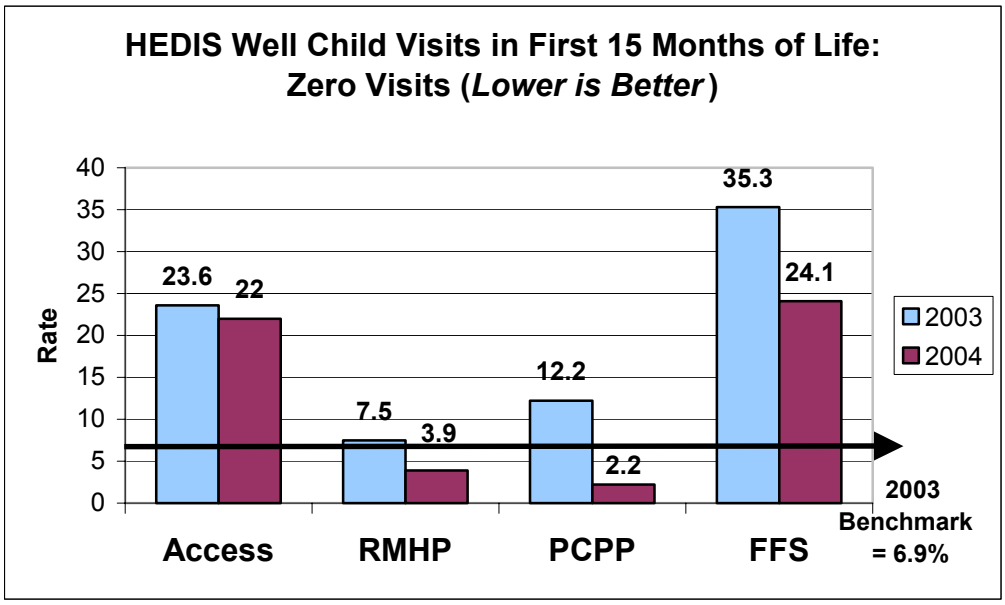


Table 5: Well Child Visits – Zero Provider Visits



4. Well Child Visits in the 3rd, 4th, 5th and 6th Years of Life

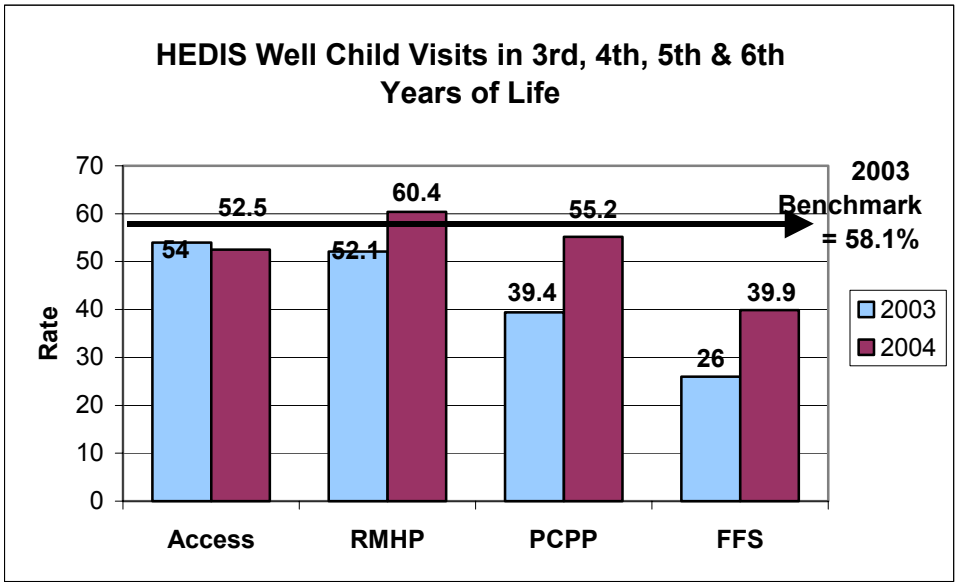
Measured in 2003 & 2004

Periodic screenings for children age three to six years provides an opportunity to detect physical, developmental, behavioral, and emotional problems and offers early intervention, treatment and appropriate referrals to specialists. Providers have a greater chance of detecting and treating permanent physical defects prior to start of school and before adolescence if well-care visits are routinely maintained.

Historically, Colorado Medicaid has lagged behind national benchmarks for this measure. However, Colorado has demonstrated an increase in the number of children aged three to six who are having well care visits. In 2003, no health plan met the national benchmark. Comparing 2003 to 2004 (Table 6), Access had a slight decline in the rate of well care while all other health plans demonstrated improvement.

Although the rate has improved, this indicates most children who are past the timeframe of childhood immunizations and before school age are not accessing medical professionals in appropriate timeframes. There is room for performance improvement for children aged three through six to see providers for well care visits.

Table 6: Well Child Visits from Three to Six Years



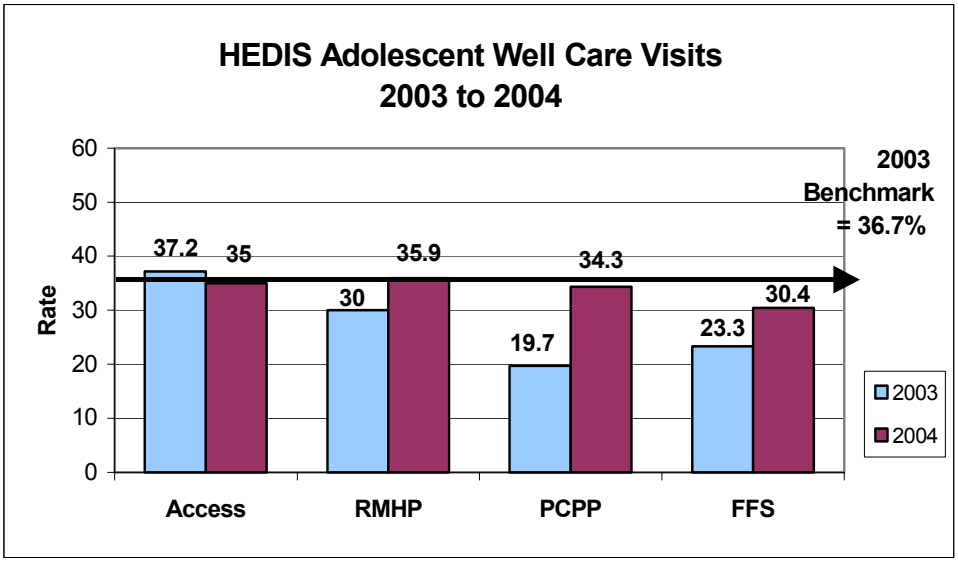
5. Adolescent Well Care Visits

Measured in 2003 & 2004

Adolescence is period of profound change. More changes take place in anatomy, physiology, mental and emotional functioning, and social development during adolescence than in any other life stage except infancy. Issues faced by adolescents during this time range from injuries resulting in death to anti-social behaviors. Numerous national organizations, such as the American Academy of Pediatrics, recommend comprehensive annual well care visits to address these changes and to avert negative health consequences. In Colorado, EPSDT benefits are available to adolescents up to the age of 21.

Adolescent well care in Colorado Medicaid is continually improving. Colorado Medicaid adolescent visits were last reported in 2002 and at that time, 27.6 percent of adolescents in Colorado had a well care visit. The Department participated in an Adolescent Well-Care quality study to understand the breadth of adolescent well care in Colorado Medicaid and identify actions needed to improve rates. As noted in Table 7, rates in 2004 have improved for all but one health plan, demonstrating a positive impact of the focused study and health plan level quality interventions on adolescent well care visit rates.

Table 7: Adolescent Well Care Visit Rates



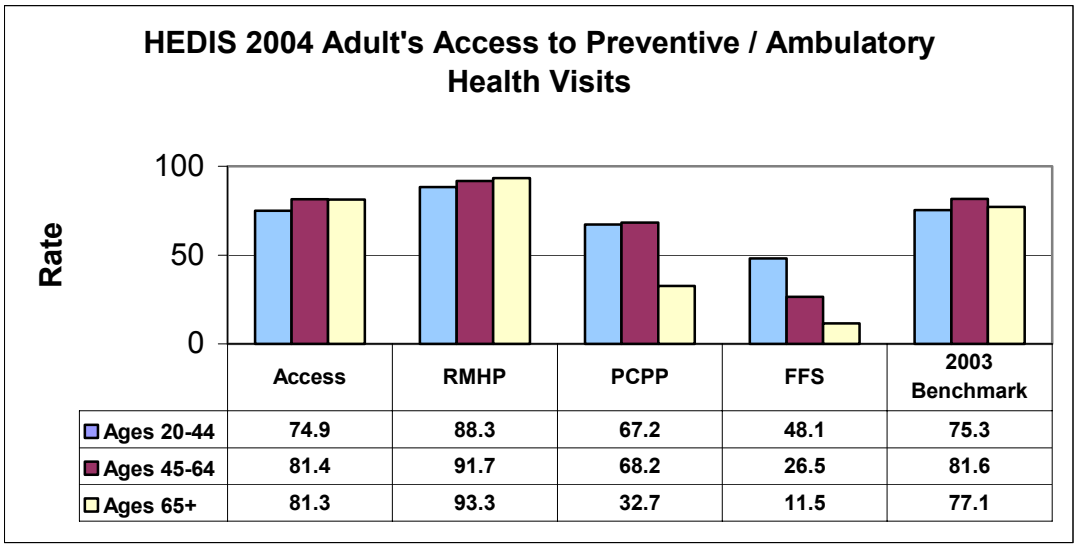
6. Adult's Access to Preventive/Ambulatory Health Services

Measured in 2004

Coverage of routine medical services at the time of an encounter is an effective way to emphasize preventative healthcare for adults. Preventive health services, including physical exams and cancer screenings, are a benefit to enrollees of Access and RMHP. Members enrolled in PCPP and FFS are entitled to cancer screenings only.

Colorado Medicaid rates, along with national benchmarking rates, are increasing for adult's access to preventive/ambulatory care services. As demonstrated in Table 8, RMHP exceed the 2003 national benchmark; Access rates are very close to the benchmarks. Rates for PCPP and FFS are well below national benchmarks and MCOs. While a 2004 national benchmark is not yet available for comparison, Access and RMHP rates are near or above 2003 national benchmarking rates indicating Colorado MCOs are meeting Department performance expectations for adult's access to preventive/ambulatory services. There is room for performance improvement for adults in PCPP and FFS.

Table 8: Adult Access to Preventive or Ambulatory Health Visits in 2004



	Access	RMHP	PCPP	FFS	2003 Benchmark
Ages 20-44	74.9	88.3	67.2	48.1	75.3
Ages 45-64	81.4	91.7	68.2	26.5	81.6
Ages 65+	81.3	93.3	32.7	11.5	77.1

7. Breast Cancer Screening

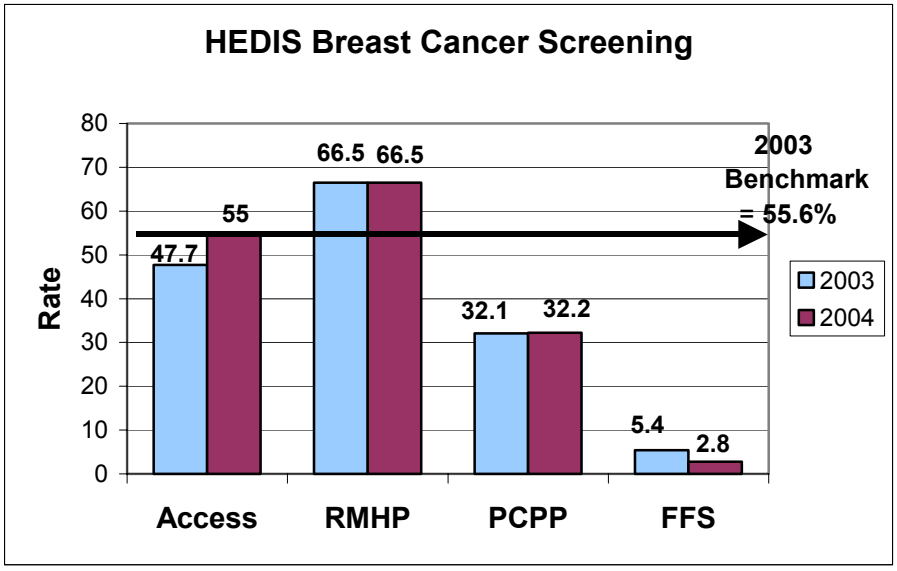
Measured in 2003 & 2004

Breast cancer is one of the most common types of cancer among American women. The 2004 NCQA State of Health Care Quality reports an estimated 211,300 new cases of breast cancer will be diagnosed resulting in 40,200 deaths.[5] Fortunately, deaths resulting from breast cancer have been declining in recent years, due to increased screening and early detection. A mammogram can detect a breast cancer when it is most likely to be treatable and curable – in its earliest stage.

Unfortunately, there are still women who have never had a mammogram or have not had one in over five years. According to the 2004 NCQA State of Health Care Quality, the average Medicaid plan reported that only slightly more than half of the women who should receive mammograms actually do.

In 2004, only one health plan had an increased rate while the other health plans remained the same or declined (Table 9). In 2003, RMHP exceeded the 2003 national benchmarking rate of 55.6 percent. The PCPP and FFS performed significantly less than the 2003 benchmark. Rates clearly indicate there is room to improve screening rates for Medicaid women enrolled in PCPP and FFS.

Table 9: Breast Cancer Screening Rates



[5] The State of Health Care Quality, 2004. NCQA. Accessed October 25, 2004 at http://www.ncqa.org/communications/SOMC/SOHC2004.pdf .

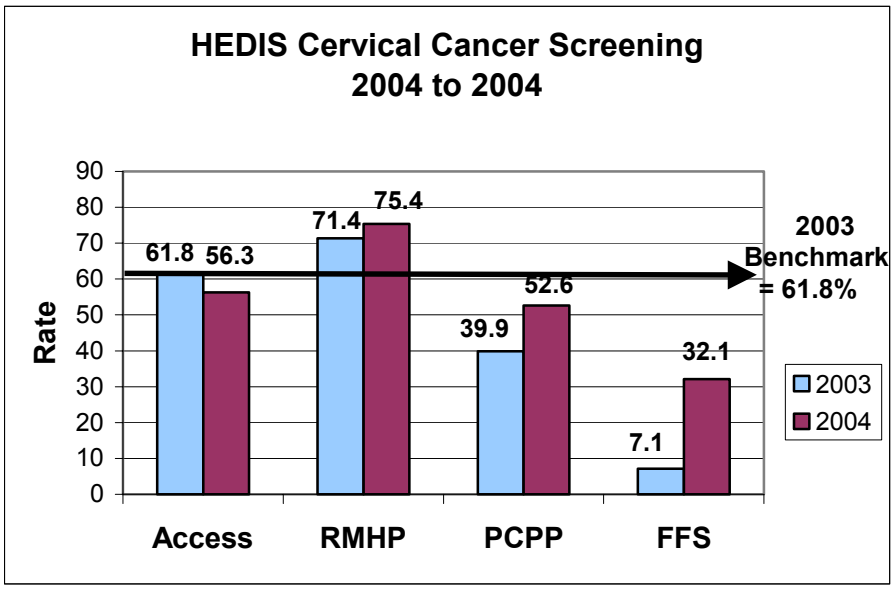
8. Cervical Cancer Screening

Measured in 2003 & 2004

When detected early, cervical cancer is one of the most successfully treatable cancers. Increased screening has resulted in a major overall decline in mortality from cervical cancer over the past several decades. Unfortunately, a significant number of women still develop the disease. An estimated 12,200 new cases of cervical cancer will be diagnosed resulting in 4,100 deaths from the disease.[6] Many or all of these deaths could be eliminated with timely and effective screening. According to NCQA, it is estimated that between 60 and 80 percent of women diagnosed with cervical cancer did not have a Pap test in the 5 years prior to diagnosis.[7] Pap testing is a benefit under Colorado Medicaid.

Results demonstrate screening women for cervical cancer is improving. As noted in Table 10, there has been significant improvement in rates from 2003 to 2004 with only one health plan demonstrating a decline in screening. In 2003, two health plans met or exceeded the national benchmarking rate of 61.8 percent; 2004 benchmarks are not yet available. Of the four health plans, only women enrolled in Access or RMHP are being tested at or above national benchmarks, indicating there is room to improve Pap testing rates for Medicaid women enrolled in PCPP and FFS.

Table 10: Cervical Cancer Screening Rates



[6] The State of Health Care Quality, 2004. NCQA. Accessed October 25, 2004 at http://www.ncqa.org/communications/SOMC/SOHC2004.pdf .

[7] The State of Health Care Quality (2004), page 28.

9. Chlamydia Screening in Women

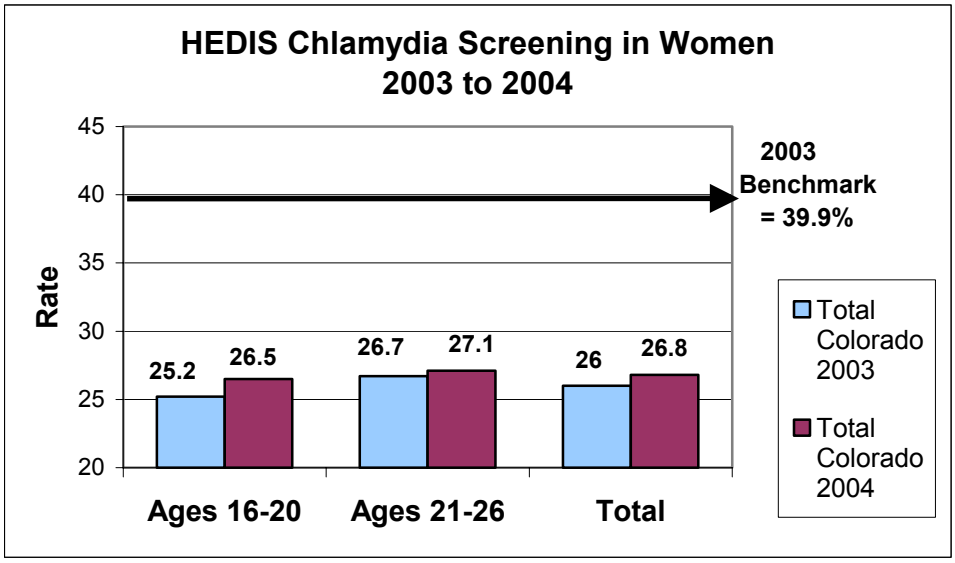
Measured in 2003 & 2004

Chlamydia, a treatable sexually transmitted disease (STD), is the most commonly reported STD in the United States, with approximately three million new cases each year.[8] In 2002, 13,621 cases of genital *Chlamydia trachomatis* infection were reported to the Colorado Department of Public Health and Environment (CDPHE) corresponding to a case count rate of 301.9 cases per 100,000 persons.[9] According to a CDPHE Sexually Transmitted Disease Surveillance Report, the 20 – 24 and 15 – 19 age groups continue to have the highest age-specific chlamydia rates, respectively. By race/ethnicity, Blacks had the highest rate (892.1 per 100,000), followed by Hispanics (360.4 per 100/000). White women have a much lower rate (68.6 per 100,000) than both Blacks and Hispanics.[10]

Untreated chlamydia infection increases a woman's risk for pelvic inflammatory disease (PID), infertility, ectopic pregnancy and HIV infection. Newborn children of untreated women are at greater risk for problems like conjunctivitis, pneumonia and even death. Chlamydia screening is extremely important because most infected women have no discernable symptoms, and because the disease is easily treatable with antibiotics.[11]

As evidenced in Table 11, Colorado Medicaid is performing well below national benchmarks. While chlamydia screening rates from 2003 to 2004 have increased slightly, they remain an average of 32 percent below national benchmarking rates, indicating it is necessary to intervene and improve chlamydia screening rates for all Medicaid women.

Table 11: Chlamydia Screening in Women



[8] The State of Health Care Quality, 2004. NCQA. Accessed October 25, 2004 at http://www.ncqa.org/communications/SOMC/SOHC2004.pdf .
[9] Sexually Transmitted Diseases in Colorado Surveillance Report 2002. Colorado Department of Public Health and Environment. Accessed October 25, 2004 at http://www.cdphe.state.co.us/dc/std2002.pdf .
[10] Sexually Transmitted Diseases in Colorado Surveillance Report (2002), page 7.
[11] The State of Health Care Quality (2004), page 29.

10. Comprehensive Diabetes Care for Adults

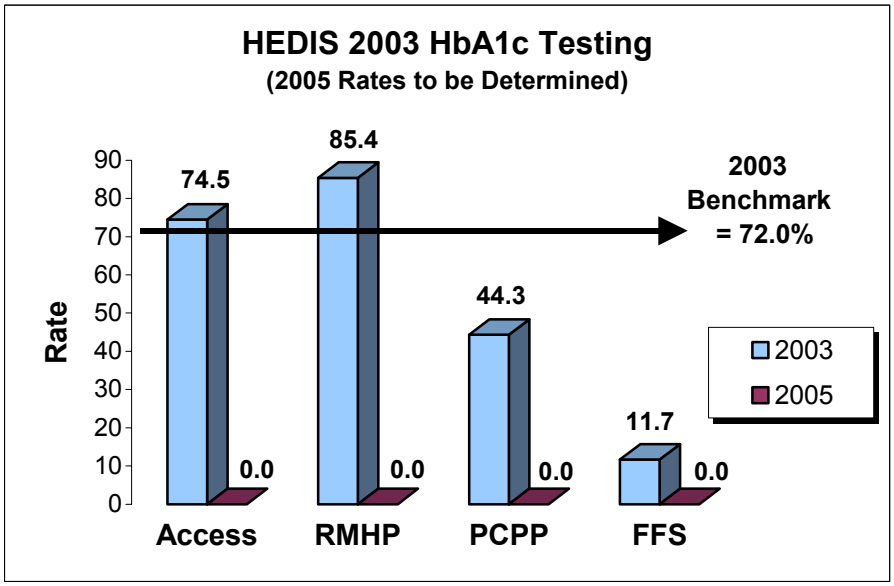
Measured in 2003

In 2003, the Department participated in an Adult Diabetes study to determine how Medicaid enrollees with diabetes were receiving treatment and education regarding the disease and identify actions needed to improve rates. According to the study, diabetes is prevalent in both the total Colorado population and among Medicaid enrollees. The Colorado Department of Public Health and Environment reports diabetes in 4.3 percent of the overall population. However, this proportion rises to 5.9 percent for those with annual household incomes less than $25,000; and it is as high as 6.2 percent for the Hispanic population.[12] According to the State QIP, diabetes ranks number four of ten for all Medicaid ambulatory diagnoses, and is the number one reason for a visit to a primary care provider for enrollees aged 35 to 64 years.

The American Diabetes Association (ADA) expert consensus states, "Perform the A1C test at least two times a year in patients who are meeting treatment goals (and who have stable glycemic control) and quarterly in patients whose therapy has changed or who are not meeting glycemic goals." For every 1 percent reduction in results from an HbA1c blood test, there is a 15-percent to 30-percent reduction of risk for developing complications from the disease.[13]

According to results in Table 12, Access and RMHP exceeded the national benchmarking rate of 72 percent in 2003, demonstrating members enrolled in Access and RMHP are being tested more often for diabetic control. Rates will be re-measured in 2005 to see if diabetes quality interventions at the health plan level had a positive effect on rates.

Table 12: Hemoglobin A1c Testing Rates for 2003



[12] Colorado Medicaid FY03 Diabetes Quality of Care Focused Study
[13] American Diabetes Association. Standards of medical care for patients with diabetes mellitus. Diabetes Care, 2002.

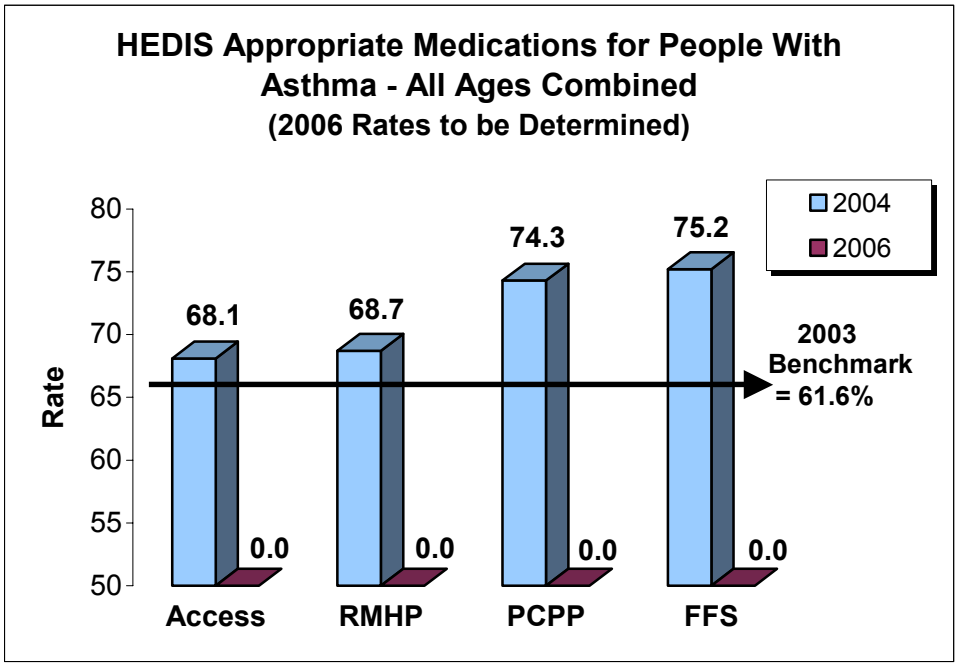
11. Appropriate Medications for People with Asthma

Measured in 2004

Asthma is prevalent in the Medicaid population and adequate treatment can avoid costly emergency room visits and hospitalization. The 2002 National Asthma Education and Prevention Program clinical practice guideline for the diagnosis and treatment of asthma issued new evidence-based recommendations for long-term management of asthma. While there are a number of acceptable therapies for people with persistent asthma, the evidence indicates that inhaled corticosteroids are the preferred primary therapy. For people with moderate-to-severe asthma, inhaled corticosteroids are the only recommended primary therapy.

According to results in Table 13, all participating health plans exceeded the 2003 national benchmarking rate of 61.6 percent, demonstrating enrolled members are receiving appropriate medications for the control of asthma. In 2003, the Department participated in an Asthma study to determine if Medicaid enrollees with asthma were receiving appropriate medication treatment and identify actions needed to improve rates. As can be seen in the table, Colorado health plans perform significantly above 2003 national benchmarking rates; 2004 benchmarks are not yet available. Rates will be re-measured in 2006.

Table 13: Medication Use for Asthma – All Ages 2004



12. Prenatal and Postpartum Care

Measured in 2003 & 2004

High-risk pregnancy and resulting cases of infants with medical problems and low birth weight continue to be prevalent in the United States. According to the Center for Health Care Strategies, Inc., poor birth outcomes are particularly high among Medicaid and State Children's Health Insurance Program (SCHIP) beneficiaries due to socioeconomic factors that present barriers to consistent care.

The National Center for Health Statistics defines early and adequate care as having one's first prenatal visit with a health professional within the first trimester of pregnancy and receiving regular care until delivery. Early and adequate prenatal care can identify mothers at risk of delivering a preterm or growth-retarded infant and provide an array of medical, nutritional and educational interventions. Poor pregnancy outcomes can be costly, though many are preventable with early intervention.

Timeliness of prenatal care in Colorado Medicaid is continually improving (Table 14). One health plan, RMHP, with a rate of 90.7 exceeds the national benchmark; additionally, that rate exceeds the 90th percentile for HEDIS 2003. This indicates that over 90 percent of pregnant women enrolled in RMHP receive timely prenatal care. In 2003, Access and PCPP rates are nearly identical and slightly below national benchmarks. Comparing 2003 to 2004, the rise in rates may indicate Access and RMHP will exceed national benchmarks in 2004. The Department participated in a perinatal study to understand the extent of prenatal care Colorado Medicaid and identify actions needed to improve rates. Rates will be re-measured in 2006.

As demonstrated in Table 15, RMHP and PCPP exceed the national benchmarking rate of 52.0 percent for Timeliness of Prenatal care. Comparing 2003 to 2004, the rise in rates may indicate women are receiving postpartum care visits as required.

Table 14: Timeliness of Prenatal Care

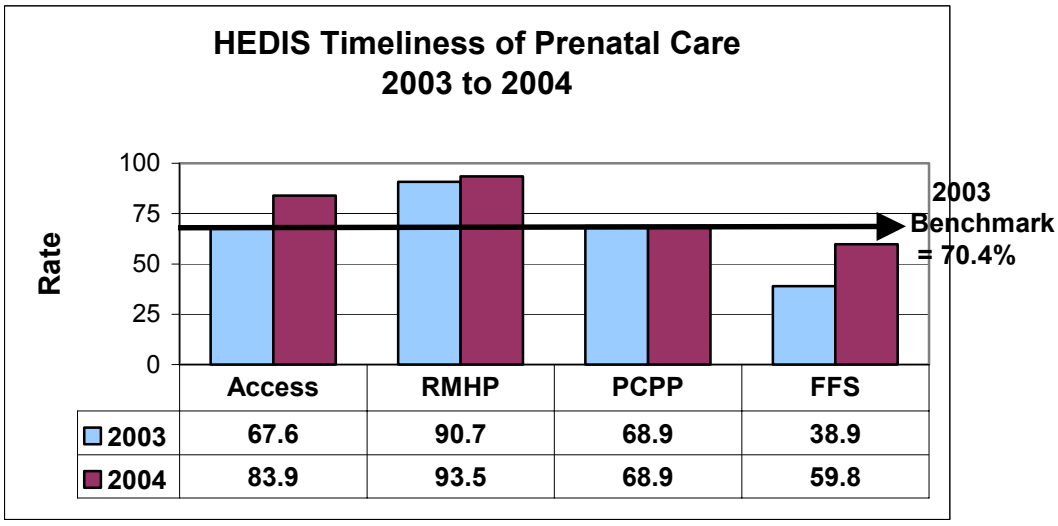
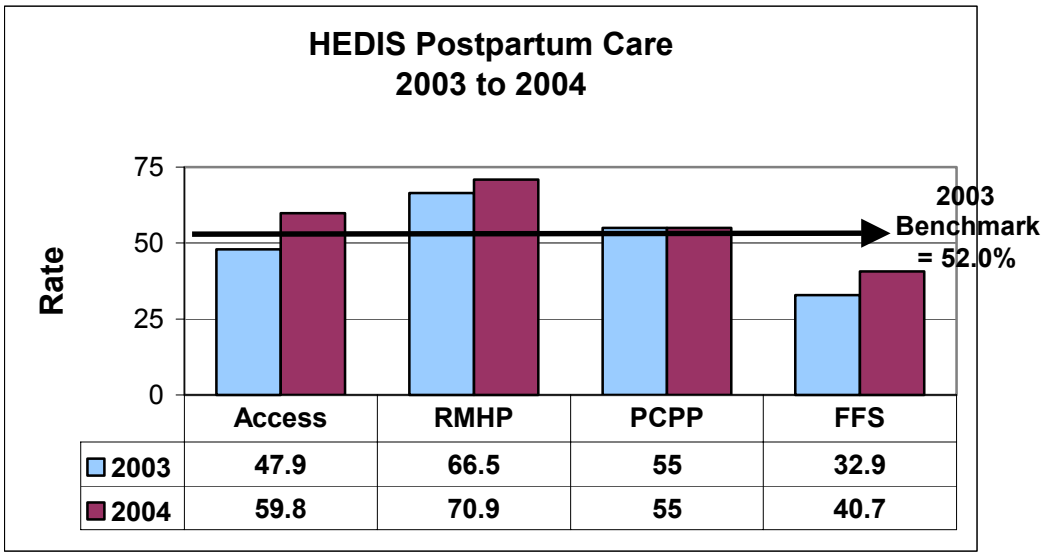


Table 15: Postpartum Care



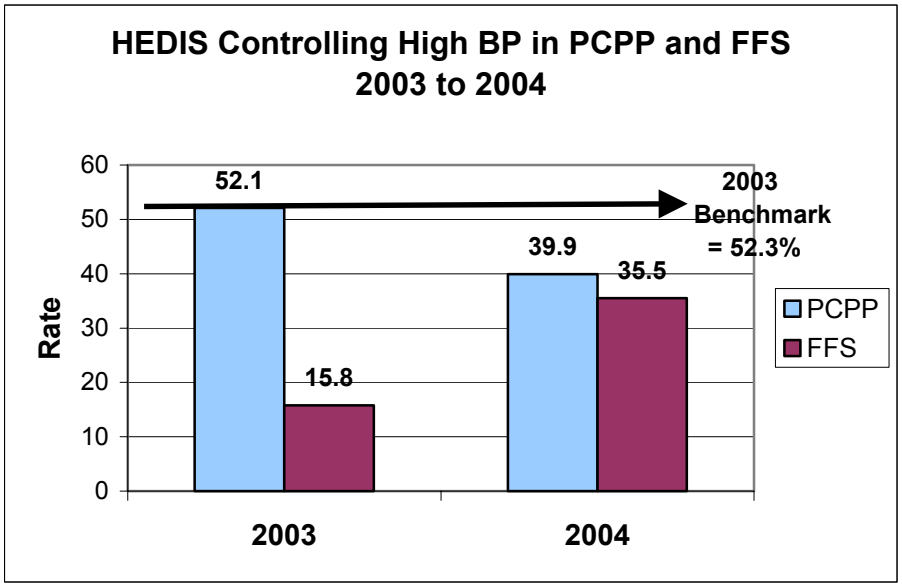
13. Controlling High Blood Pressure

Measured in 2003 & 2004 PCPP/FFS only

More than one-third of Americans age 45 years or older have high blood pressure (hypertension), the most treatable cardiovascular disease. In Colorado Medicaid, it is the second most common reason for an ambulatory visit to a provider for persons age 35 to 64 years of age. Untreated high blood pressure causes stroke, coronary heart disease, kidney failure and blindness. Nearly one-third of adults with high blood pressure do not know that they have it, increasing the risk of associated complications and diseases.[14] Due to adequate treatment of hypertension, stroke death rates have declined over the past 30 years mainly because of improvement in the detection and treatment of hypertension.

The total cost of managing hypertension is lower than the direct and indirect costs that can result from hypertension-associated heart disease, stroke and renal failure, conditions that often lead to expensive hospitalizations, surgical procedures and use of high-cost technologies.[15]

Table 16: Controlling High BP in PCPP and FFS programs



Rates for control of blood pressure in Colorado Medicaid are mixed. In 2003, the PCPP rate was at the national benchmarking rate but saw a sharp decline of 24 percent in 2004. Rates for the FFS population have increased almost 56 percent during the same period. Due to this finding, a quality intervention for PCPP providers was implemented to address hypertensive members in the PCPP. Controlling High Blood Pressure will be re-measured in 2005.

[14] American Heart Association. The low-down on high blood pressure – more focus on prevention and treatment. May 17, 2002. Accessed June 17, 2004 at http://216.185.112.5/presenter.jhtml?identifier=3002752 .

[15] National Heart, Lung and Blood Institute; National Institutes of Health. The Sixth Report of the Joint National Committee on the Prevention, Detection, Evaluation and Treatment of High Blood Pressure, 1997.

14. Ambulatory Care

Measured in 2003 & 2004 PCPP/FFS only

The HEDIS measure on ambulatory care reports visits in an outpatient hospital setting, visits to an emergency department, and non-admission hospital observations resulting in discharge. For all reported measures, FFS has a demonstrated increase in rates from 2003 to 2004 although all rates remain below national benchmarks. This global rise in rates in the FFS may indicate enrollees in FFS are using more hospital-based services than previously identified.

Outpatient Visits

Outpatient visits encompass visits to a hospital clinic for treatment of conditions that do not require an inpatient stay. Nationally, there appears to be an increasing trend in use of outpatient visits in Medicaid populations, but this is not found in Colorado rates. While there was a slight increase in FFS, PCPP rates declined over 14 percent. Overall, the PCPP and FFS continue to utilize hospital outpatient services less than Medicaid members do nationally.

Ambulatory Surgery

Ambulatory surgery visits encompass visit to a hospital for surgical treatment of conditions that do not require an inpatient stay. As was seen in outpatient visits, there is a decrease in utilization of ambulatory surgery procedures in PCPP. Again, an increase was seen in FFS while PCPP experienced a 15 percent decline in utilization, indicating fewer surgical procedures are being performed in the ambulatory care setting for members in the PCPP.

Emergency Department

Emergency Departments (ED) may sometimes be used as a substitute for physician office/clinic encounters and may be reflective of the lack of a primary care provider or an unidentified barrier to access primary health care services. The top 10 diagnoses for Colorado Medicaid clients in the Department's PCPP and FFS program seen in the emergency room[16] are:

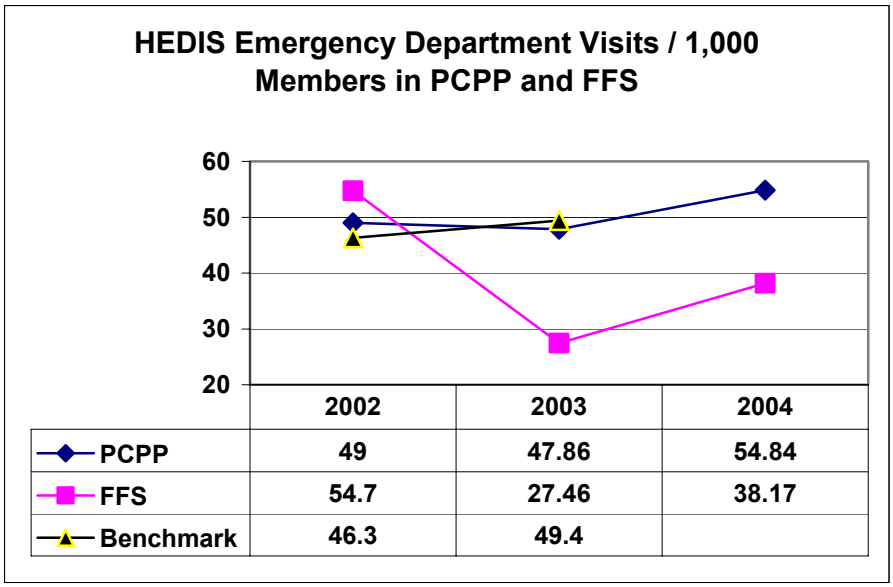
1. Otitis Media, Unspecified;
2. Upper Respiratory Infection (Acute);
3. Pyrexia Unknown Origin;
4. Acute Pharyngitis;
5. Abdominal Pain;
6. Unspecified Viral Infection;
7. Headache;
8. Nutritional Deficiencies related to Pregnancy;
9. Urinary Tract Infection; and
10. Other Non-specified Gastroenteritis and Colitis.

It is important to note that the national benchmark for ED visits has risen from 43.6 visits per 1,000 member months in 2002 to 46.3 visits per 1,000 member months in 2003 (demonstrating a 9.4 percent increase). While the 2004 national benchmark is not

[16] Based on claims paid by the Department of Health Care Policy & Financing between July and September 2002.

available at this time, it appears the trend is for Medicaid members to continue to over utilize ED services.

Table 17: Ambulatory Care Emergency Department Visits for PCPP and FFS



	2002	2003	2004
PCPP	49	47.86	54.84
FFS	54.7	27.46	38.17
Benchmark	46.3	49.4	

As with national trends, ED use continues to rise in Colorado. As noted in Table 13, between 2003 and 2004, the PCPP and FFS rates for ED visits increased. Rates for members in PCPP rose from 47.9 percent to 54.84 percent, demonstrating a 14.6 percent increase and increasing more than national trends. This indicates Colorado PCPP clients use the emergency department more than other states, and may use the emergency department for diagnoses that could be addressed in the primary care setting. FFS rates remain below national benchmarks but are trending upward.

Tables

HEDIS Rates of Clinical Care – 2003 to 2004

HEDIS Measure	Colorado Access	Rocky Mountain Health Plans	Primary Care Physician Program	Unassigned Fee-For-Service	Total Colorado Average	HEDIS National Benchmark
Childhood Immunization Status						
4 Diphtheria, Tetanus, Pertussis						
2003	30.2%	37.0%	43.3%	28.5%	**34.7%**	**68.4%**
2004	62.4%	76.2%	65.9%	41.6%	**61.5%**	**Not Available**
1 Measles, Mumps, Rubella						
2003	78.4%	85.9%	73.2%	62.0%	**74.9%**	**83.9%**
2004	84.5%	90.8%	83.2%	56.2%	**78.7%**	**Not Available**
3 Polio Virus						
2003	72.3%	81.0%	70.1%	60.1%	**70.9%**	**80.1%**
2004	77.0%	88.1%	79.6%	56.2%	**75.2%**	**Not Available**
2 Haemophilus Influenzae Type B						
2003	63.8%	74.7%	59.9%	50.4%	**62.2%**	**73.5%**
2004	69.6%	80.8%	71.8%	46.0%	**67.1%**	**Not Available**
3 Hepatitis B						
2003	67.6%	80.8%	65.2%	53.5%	**66.8%**	**76.1%**
2004	73.8%	85.9%	78.1%	48.2%	**71.5%**	**Not Available**

HEDIS Rates of Clinical Care – 2003 to 2004

HEDIS Measure	Colorado Access	Rocky Mountain Health Plans	Primary Care Physician Program	Unassigned Fee-For-Service	*TOTAL COLORADO AVERAGE*	*HEDIS NATIONAL BENCHMARK*
1 Varicella (Chicken Pox)						
2003	77.4%	76.2%	68.1%	55.5%	**69.3%**	**76.0%**
2004	81.2%	83.5%	74.9%	53.5%	**73.4%**	**Not Available**
Combo 1 Rate -- 4 DTP, 3 Polio, 1 MMR, 2 hepatitis B, and 1 Hib						
2003	21.2%	29.4%	33.3%	21.7%	**26.4%**	**57.2%**
2004	51.0%	65.2%	55.5%	31.4%	**50.8%**	**Not Available**
Combo 2 Rate -- 4 DTP, 3 Polio, 1 MMR, 2 hepatitis B, 1 Hib, and VZV						
2003	20.4%	27.7%	29.7%	20.2%	**24.5%**	**52.7%**
2004	48.5%	61.3%	50.4%	30.4%	**47.7%**	**Not Available**

Description: The percentage of enrolled children two years of age who had four DTaP/DT, three IPV, one MMR, three H influenza type B, three hepatitis B and one chicken pox vaccine (VZV) by the time period specified and by their second birthday. The measure also calculates two separate combination rates. No more than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday is allowed. Rates are calculated using hybrid (medical record) methodology.

Findings: The 2004 national benchmarking rate is not yet available for comparison. Colorado Childhood Immunization Rates demonstrate a significant increase from 2003 to 2004. Slight declines in national benchmarking rates for individual antigens DTaP/DT, MMR and H influenza type B are observed. During the 2003 measurement year, children were affected by the continued shortage of DTaP. It is important to note that HEDIS positively counts only those children who have documented evidence of four DTaP/DT. Hence, rates provided for immunizations in the table may not be an adequate picture of DTaP vaccination.

Quality Activities: The Department has been measuring and reporting Childhood Immunizations since 1998 and will continue to do so. Childhood immunizations are identified as an area of performance improvement on the State QIP and health plans have been performing successful interventions to increase immunization rates for Medicaid children, as evidenced by improved rates over time.

HEDIS Rates of Clinical Care – 2003 to 2004

HEDIS Measure	Colorado Access	Rocky Mountain Health Plans	Primary Care Physician Program	Unassigned Fee-For-Service	*TOTAL COLORADO AVERAGE*	*HEDIS NATIONAL BENCHMARK*
Adolescent Immunization Status						
2 Measles, Mumps, Rubella						
2003	—	—	57.2%	44.0%	**50.6%**	**63.0%**
2004	—	—	53.3%	33.6%	**43.4%**	**Not Available**
1 Hepatitis B						
2003	—	—	43.3%	35.3%	**39.3%**	**46.2%**
2004	—	—	39.4%	24.6%	**32.0%**	**Not Available**
1 Varicella (Chicken Pox)						
2003	—	—	27.3%	16.6%	**21.9%**	**32.1%**
2004	—	—	27.7%	17.0%	**22.4%**	**Not Available**
Combo 1 Rate – 2 MMR and 1 hepatitis B						
2003	—	—	39.4%	32.1%	**35.8%**	**42.4%**
2004	—	—	36.5%	23.1%	**29.8%**	**Not Available**
Combo 2 Rate – 2 MMR, 1 hepatitis B, 1 Varicella						
2003	—	—	18.5%	12.4%	**9.2%**	**24.4%**
2004	—	—	19.7%	12.4%	**16.1%**	**Not Available**

"—" = Not measured.

Description: The percentage of enrolled adolescents 13 years of age, who had a second dose of MMR, three hepatitis B and one chicken pox (VZV) by their 13th birthday. The measure also calculates two separate combination rates. No more than one gap in enrollment of up to 45 days is allowed during the 12 months prior to the 13th birthday. Rates are calculated using hybrid (medical record) methodology.

Findings: The 2004 national benchmarking rate is not yet available for comparison. As evidenced in the reported rates for 2004, rates show a slight downward trend for both PCPP and FFS. Rates remain below 2003 national benchmarks.

Quality Activities: The Department has been measuring and reporting Adolescent Immunizations since 1998 and will continue to do so. Adolescent immunizations are identified as an area of performance improvement on the State QIP.

HEDIS Rates of Clinical Care – 2003 to 2004

HEDIS Measure	Colorado Access	Rocky Mountain Health Plans	Primary Care Physician Program	Unassigned Fee-For-Service	*TOTAL COLORADO AVERAGE*	*HEDIS NATIONAL BENCHMARK*
Well Child Visits in the First 15 Months of Life						
No Visits - Lower is Better						
2003	23.6%	7.5%	12.2%	35.3%	**18.4%**	**6.9%**
2004	22.0%	3.9%	2.2%	24.1%	**13.3%**	**Not Available**
6 or More Visits						
2003	15.6%	28.6%	37.5%	19.7%	**25.7%**	**42.3%**
2004	27.5%	36.9%	51.8%	19.7%	**33.9%**	**Not Available**

Description: The percentage of enrolled members who turned 15 months old during the measurement year, who received either zero, one, two, three, four, five, six or more well-child visits with a primary care practitioner during their first 15 months of life. A child should be included in only one numerator (e.g., a child receiving six well-child visits will not be included in the rate for five, four or fewer visits). No more than one gap in enrollment of up to 45 days during the continuous enrollment period is allowed. Rates may be calculated using hybrid (medical record) or administrative data methodology. *Note:* Only the zero and six or more visit rates are shown here.

Findings: The 2004 national benchmarking rate is not yet available for comparison. As evidenced in the reported rates, Colorado health plans perform below national benchmarks but rates are improving each year. PCPP 2004 rates outperformed all other health plans for both zero and six or more visits and surpassed 2003 national benchmarks. Total Colorado rates for 2004 are improved over 2003 rates.

Quality Activities: Well child visits are identified as an area of performance improvement on the State QIP. Health plans have been performing quality interventions to identify children in their populations through EPSDT and other childhood identification efforts. In 2003, the Department performed a well care profile for 800+ providers in PCPP that identified children up to age two years who did or did not have a billed well care visit. The rates for 2004 indicate significant improvement in children who had no visits and children who had six or more visits.

HEDIS Rates of Clinical Care – 2003 to 2004

HEDIS Measure	**Colorado Access**	**Rocky Mountain Health Plans**	**Primary Care Physician Program**	**Unassigned Fee-For-Service**	*TOTAL COLORADO AVERAGE*	*HEDIS NATIONAL BENCHMARK*
Well Child Visits in the 3rd, 4th, 5th & 6th Years of Life						
2003	54.0%	52.1%	39.4%	26.0%	**39.2%**	**58.1%**
2004	52.5%	60.4%	55.2%	39.9%	**55.4%**	**Not Available**

Description: The percentage of members who were three, four, five or six years of age during the measurement year who received one or more well-child visits with a primary care practitioner during the measurement year. No more than one gap in enrollment of up to 45 days during the continuous enrollment period is allowed. Rates are calculated using the administrative data methodology.

Findings: The 2004 national benchmarking rate is not yet available for comparison. As evidenced in the reported rates, both PCPP and FFS experienced significant increases in the percent of children aged three through age six years who had a well care visit. Only one plan, Access, has a slight decline in rates from 2003 to 2004. Total Colorado rates have improved significantly from 2003 to 2004.

Quality Activities: Well child visits are identified as an area of performance improvement on the State QIP. Health plans have been performing quality interventions to identify children in their populations through EPSDT and other childhood identification efforts.

HEDIS Rates of Clinical Care – 2003 to 2004

HEDIS Measure	**Colorado Access**	**Rocky Mountain Health Plans**	**Primary Care Physician Program**	**Unassigned Fee-For-Service**	*TOTAL COLORADO AVERAGE*	*HEDIS NATIONAL BENCHMARK*
Adolescent Well Care Visits						
2003	37.2%	30.0%	19.7%	23.3%	**23.1%**	**36.7%**
2004	35.0%	35.9%	34.3%	30.4%	**34.7%**	**Not Available**

Description: The percentage of enrolled members who were 12–21 years of age who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year. Members who have had no more than one gap in enrollment of up to 45 days during the measurement year. Rates may be calculated using hybrid (medical record) or administrative data methodology.

Findings: The 2004 national benchmarking rate is not yet available for comparison. As evidenced in the reported rates, rates are nearing national benchmarking rates. Only Access had a slight decline in rates from 2003 to 2004. Total Colorado rates have improved significantly from 2003 to 2004.

Quality Activities: Adolescent well care was the topic for a clinical focused study in 2002 and the measure was used as a reporting benchmark for the study. Adolescent well care has been identified as an area of performance improvement on the State QIP. The measure will be rotated in 2005 to allow for an intervention year. The intervention year – a 12-month period for all health plans to apply quality interventions and improve rates of child and adult asthma – will end with HEDIS re-measurement in 2006.

HEDIS Rates of Clinical Care – 2003 to 2004

HEDIS Measure	Colorado Access	Rocky Mountain Health Plans	Primary Care Physician Program	Unassigned Fee-For-Service	*TOTAL COLORADO AVERAGE*	*HEDIS NATIONAL BENCHMARK*
Adult's Access to Preventive/Ambulatory Health Services						
Ages 20-44						
2003	**Not measured in 2003**					**75.3%**
2004	74.9%	88.3%	67.2%	48.1%	**60.9%**	**Not Available**
Ages 45-64						
2003	**Not measured in 2003**					**81.6%**
2004	81.4%	91.7%	68.2%	26.5%	**49.2%**	**Not Available**
Ages 65 and Above						
2003	**Not measured in 2003**					**77.1%**
2004	81.3%	93.7%	32.7%	11.5%	**22.5%**	**Not Available**

Description: The percentage of enrollees 20–44, 45–64 and 65 years of age and older who had an ambulatory or preventive care visit during the measurement year with no more than one gap in enrollment of up to 45 days during each year of continuous enrollment. Rates are calculated using administrative data methodology.

Findings: The 2004 national benchmarking rate is not yet available for comparison. Adult's Access to Preventive/Ambulatory Health Services measure was not measured and reported for 2003. As evidenced in the reported rates, one Colorado health plan performs above 2003 national benchmarks. Rates for PCPP and FFS were well below other health plans and national benchmarking rates. Total Colorado rates for 2004 are significantly below 2003 national benchmarking rates.

Quality Activities: Adult access to preventive visits was identified as an area of performance improvement on the State QIP. The Department will rotate this measure in 2005 to allow for an intervention year. The intervention year – a 12-month period for all health

plans to apply quality interventions and improve rates of adult's access to preventive visits – will end with HEDIS re-measurement in 2006.

HEDIS Rates of Clinical Care – 2003 to 2004

HEDIS Measure	Colorado Access	Rocky Mountain Health Plans	Primary Care Physician Program	Unassigned Fee-For-Service	*TOTAL COLORADO AVERAGE*	*HEDIS NATIONAL BENCHMARK*
Breast Cancer Screening						
2003	47.7%	66.5%	32.1%	5.4%	**42.4%**	**55.2%**
2004	55.0%	66.5%	32.2%	2.8%	**18.3%**	**Not Available**

Description: The percentage of women 50–69 years of age who had a mammogram during the measurement year or year prior to the measurement year. No more than one gap in enrollment of up to 45 days is allowed during each year of continuous enrollment. Rates may be calculated using hybrid (medical record) or administrative data methodology.

Findings: The 2004 national benchmarking rate is not yet available for comparison. As evidenced in the reported rates, all health plans had increased or maintained plan rates except FFS program. Locating medical records of women continuously enrolled in FFS to verify mammography screening is a difficult task; hence, rates provided for breast cancer screening in the table may not be an adequate picture of all women who received a mammogram.

Quality Activities: The Department has been measuring and reporting Breast Cancer Screening since 1998 and will continue to do so. Breast cancer screening has been identified as an area of performance improvement on the State QIP. MCOs have been performing successful interventions to increase mammography rates for Medicaid women.

HEDIS Rates of Clinical Care – 2003 to 2004

HEDIS Measure	**Colorado Access**	**Rocky Mountain Health Plans**	**Primary Care Physician Program**	**Unassigned Fee-For-Service**	*TOTAL COLORADO AVERAGE*	*HEDIS NATIONAL BENCHMARK*
Cervical Cancer Screening						
2003	61.8%	71.4%	39.0%	7.1%	**25.5%**	**61.8%**
2004	56.3%	75.4%	52.6%	32.1%	**53.2%**	**Not Available**

Description: The percentage of women 18–64 years of age who received one or more Pap tests during the measurement year or the two years prior to the measurement year. No more than one gap in enrollment of up to 45 days is allowed during each year of continuous enrollment. Rates may be calculated using hybrid (medical record) or administrative data methodology.

Findings: The 2004 national benchmarking rate is not yet available for comparison. As evidenced in the reported rates, all except one health plan had increased rates of cervical cancer screening from 2003 to 2004. Total Colorado rates have increased over 50 percent from 2003 to 2004.

Quality Activities: The Department has been measuring and reporting cervical cancer screening since 1998 and will continue to do so. Cervical Cancer Screening has been identified as an area of performance improvement on the State QIP. All health plans have been performing interventions to increase Pap testing rates for Medicaid women.

HEDIS Rates of Clinical Care – 2003 to 2004

HEDIS Measure	Colorado Access	Rocky Mountain Health Plans	Primary Care Physician Program	Unassigned Fee-For-Service	TOTAL COLORADO AVERAGE	HEDIS NATIONAL BENCHMARK
Chlamydia Screening in Women						
Ages 16-20						
2003	43.8%	32.5%	15.0%	8.7%	**25.2%**	**39.8%**
2004	42.0%	46.7%	21.9%	19.6%	**26.5%**	**Not Available**
Ages 21-26						
2003	39.6%	31.7%	14.3%	8.0%	**26.7%**	**40.6%**
2004	42.8%	39.8%	24.6%	19.1%	**27.1**	**Not Available**
Total						
2003	41.5%	32.0%	14.6%	8.5%	**26.0%**	**39.9%**
2004	42.4%	43.1%	23.4%	19.4%	**26.8%**	**Not Available**

Description: The percentage of women 16–26 years of age who were identified as sexually active, who had at least one test for Chlamydia during the measurement year.

Findings: The 2004 national benchmarking rate is not yet available for comparison. Overall, there has been some improvement noted in rates of screening for Chlamydia. Colorado Medicaid remains well below national benchmarking rates for screening.

Quality Activities: Chlamydia screening is identified as an area of performance improvement on the State QIP. Results indicate an area of quality improvement for both the state and individual health plan quality plans.

HEDIS Rates of Clinical Care – 2003 to 2004

HEDIS Measure	Colorado Access	Rocky Mountain Health Plans	Primary Care Physician Program	Unassigned Fee-For-Service	Total Colorado Average	HEDIS National Benchmark
Comprehensive Diabetes for Adults						
HbA1c Testing						
2003	74.5%	85.4%	44.3%	11.7%	**54.0%**	**72.0%**
2004	**Not measured in 2004**					
Poor HbA1c Control (Lower is Better)						
2003	44.3%	25.6%	72.8%	89.1%	**57.9%**	**50.6%**
2004	**Not measured in 2004**					
Eye Exam						
2003	48.4%	69.3%	21.2%	4.1%	**35.8%**	**44.6%**
2004	**Not measured in 2004**					
Lipid Profile						
2003	85.2%	75.4%	39.4%	8.5%	**52.1%**	**64.5%**
2004	**Not measured in 2004**					
Lipid Control						
2003	46.5%	53.8%	17.3%	6.3%	**31.0%**	**37.2%**
2004	**Not measured in 2004**					

HEDIS Rates of Clinical Care – 2003 to 2004

HEDIS Measure	Colorado Access	Rocky Mountain Health Plans	Primary Care Physician Program	Unassigned Fee-For-Service	Total Colorado Average	HEDIS National Benchmark
Monitoring for Diabetic Nephropathy						
2003	44.5%	64.5%	22.1%	10.5%	**35.4%**	**41.1%**
2004	**Not measured in 2004**					

Description: The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:

- Hemoglobin A1c (HbA1c) tested
- HbA1c poorly controlled (>9.0%)
- Eye exam (retinal) performed
- LDL-C screening performed
- LDL-C controlled (LDL<130 mg/dL)
- Kidney disease (nephropathy) monitored.

These measures are consistent with the National Diabetes Quality Improvement Alliance (NDQIA) set of measures. No more than one gap in enrollment of up to 45 days during the measurement year is allowed. Rates are calculated using hybrid (medical record) methodology.

Findings: The 2004 national benchmarking rate is not yet available for comparison. Comprehensive Diabetes of Adults was not measured and reported for 2004 to allow for an intervention year. As evidenced in the reported rates for 2003, Access and RMHP exceeded national benchmarks for all measures. Rates for PCPP and FFS were well below benchmarking rates.

Quality Activities: Adult diabetes has been identified as an area of performance improvement on the State QIP. The Department has been measuring and reporting on adult diabetes care since 1998, rotating this measure for the first time in 2004 to allow for an intervention year. The intervention year – a 12-month period for all health plans to apply quality interventions and improve rates of adult diabetes – will end with HEDIS re-measurement in 2005.

HEDIS Rates of Clinical Care – 2003 to 2004

HEDIS Measure	Colorado Access	Rocky Mountain Health Plans	Primary Care Physician Program	Unassigned Fee-For-Service	Total Colorado Average	HEDIS National Benchmark
Appropriate Medications for People with Asthma						
Ages 5-9						
2003	**Not measured in 2003**					**58.0%**
2004	67.2%	59.6%	71.8%	72.6%	**69.5%**	**Not Available**
Ages10-17						
2003	**Not measured in 2003**					**60.1%**
2004	67.3%	71.9%	76.0%	74.0%	**72.4%**	**Not Available**
Ages 18-56						
2003	**Not measured in 2003**					**63.9%**
2004	69.1%	70.6%	74.5%	76.6%	**73.1%**	**Not Available**
All Ages Combined						
2003	**Not measured in 2003**					**61.6%**
2004	68.1%	68.7%	74.3%	75.2%	**72.1%**	**Not Available**

Description: The percentage of enrolled members 5–56 years of age during the measurement year who were identified as having persistent asthma during the year prior to the measurement year and who were appropriately prescribed medication during the measurement year. No more than one gap in enrollment of up to 45 days is allowed during each year of continuous enrollment. Rates are calculated using administrative data methodology.

Findings: The 2004 national benchmarking rate is not yet available for comparison. Although the Appropriate Medications for People with Asthma measure was not measured and reported for 2003 by the Department, a national benchmark was calculated. As evidenced in the reported rates, all Colorado health plans perform above 2003 national benchmarks.

Quality Activities: Asthma was the topic for a clinical focused study in 2004 and the asthma measure were used as a reporting benchmark for the study. Asthma was identified as an area of performance improvement on the State QIP, due to its prevalence in the Medicaid population and recent guidelines promoting medication therapy. Health plans have also identified asthma as an area of focus on their quality plans and have implemented several interventions in the past few years. The Department has not measured asthma since 2001; it will be rotated in 2005 to allow for an intervention year. The intervention year – a 12-month period for all health plans to apply quality interventions and improve rates of child and adult asthma – will end with HEDIS re-measurement in 2006.

HEDIS Rates of Clinical Care – 2003 to 2004

HEDIS Measure	Colorado Access	Rocky Mountain Health Plans	Primary Care Physician Program	Unassigned Fee-For-Service	Total Colorado Average	HEDIS National Benchmark
Prenatal & Postpartum Care						
Timeliness of Prenatal Care						
2003	67.6%	90.7%	68.9%	38.9%	**66.0%**	**70.4%**
2004	83.9%	93.5%	68.9%	59.8%	**76.4%**	**Not Available**
Postpartum Care						
2003	47.9%	66.5%	55.0%	32.9%	**50.2%**	**52.0%**
2004	59.8%	70.9%	55.0%	40.7%	**56.5%**	**Not Available**

Description: The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care: Timeliness of Prenatal Care – the percentage of deliveries in the denominator that received a prenatal care visit as a member of the MCO in the first trimester or within 42 days of enrollment in the MCO, and Postpartum Care – the percentage of deliveries in the denominator that had a postpartum visit on or between 21 and 56 days after delivery. There is no allowable gap during the continuous enrollment period. Rates may be calculated using hybrid (medical record) or administrative data methodology.

Findings: The 2004 national benchmarking rate is not yet available for comparison. As evidenced in the reported rates, all except Access demonstrated similar or increased rates of timeliness of prenatal care. All health plans met or exceeded rates of postpartum care from 2003 to 2004. One health plan, Rocky, exceeded national benchmarking rates for 2003 and demonstrated increased rates in 2004.

Quality Activities: The Department has been measuring and reporting Prenatal and Postpartum Care since 1998 and will continue to do so. Prenatal and postpartum care was the topic for a clinical focused study in 2004 and the HEDIS prenatal measure were used as a reporting benchmark for the study. Prenatal care has been identified as an area of performance improvement on the State QIP. Health plans have been performing successful interventions to identify pregnant women and get them in for care as soon as possible. MCOs have identified prenatal care as an area of focus on their quality plans and have implemented several interventions in the past few

years. The measure will be rotated in 2005 to allow for an intervention year. The intervention year will end with HEDIS re-measurement in 2006.

HEDIS Rates of Clinical Care – 2003 to 2004

HEDIS Measure	Colorado Access	Rocky Mountain Health Plans	Primary Care Physician Program	Unassigned Fee-For-Service	Total Colorado Average	HEDIS National Benchmark
Controlling High Blood Pressure						
2003	--	--	52.1%	15.8%	**33.9%**	**52.3%**
2004	--	--	39.9%	35.3%	**37.6%**	**Not Available**

Description: The percentage of enrolled members 46–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (≤ 140/90) during the measurement year. This intermediate outcome measure assesses if BP was controlled among adults with diagnosed HTN. Rates are obtained using the hybrid methodology.

Findings: The 2004 national benchmarking rate is not yet available for comparison. Results are mixed: PCPP rates declined from 2003 to 2004 while FFS rates increased significantly. Total Colorado rates remain below national benchmarks.

Quality Activities: Controlling high BP is identified as an area of performance improvement on the State QIP. Results indicate an area of quality improvement for PCPP and FFS. In 2004, the Department performed a clinical profile for 175 providers in PCPP that identified adults with a diagnosis of hypertension. Controlling high BP will be re-measured in 2005.

HEDIS Rates of Clinical Care – 2003 to 2004

HEDIS Measure	Colorado Access	Rocky Mountain Health Plans	Primary Care Physician Program	Unassigned Fee-For-Service	Total Colorado Average	HEDIS National Benchmark
Ambulatory Care						
Outpatient Visits/1,000 Member Months						
2003	--	--	295.82	111.71	**169.35**	**367.6**
2004	--	--	258.60	139.08	**182.42**	**Not Available**
Ambulatory Surgery Procedures/1,000 Member Months						
2003	--	--	6.85	1.87	**3.43**	**5.2**
2004	--	--	5.91	3.19	**4.18**	**Not Available**
Emergency Room Visits/1,000 Member Months						
2003	--	--	47.86	27.46	**33.85**	**49.4**
2004	--	--	54.84	38.17	**43.47**	**Not Available**
Observation Room Stays Resulting in Discharge/ 1,000 Member Months						
2003	--	--	1.16	1.07	**1.10**	**1.5**
2004	--	--	1.11	1.24	**1.23**	**Not Available**

Description: This measure summarizes utilization of ambulatory services in the following categories:

- Outpatient visits
- Emergency department visits
- Ambulatory surgery/procedures performed in hospital, outpatient facilities or freestanding surgical centers
- Observation room stays that result in discharge (observation room stays resulting in an inpatient admission are not counted).

All members eligible for Medicaid during the measurement year are included. Rates are determined using the administrative data methodology.

Findings: The 2004 national benchmarking rate is not yet available for comparison. Colorado's PCPP and FFS perform below national benchmarks for most measures. A rise in ER utilization occurred for both PCPP and FFS when comparing 2003 to 2004 rates.

Quality Activities: Ambulatory Care has been identified as an area of performance improvement on the State QIP. In 2002, the Department performed a clinical profile for 1000+ providers in PCPP that identified member visits to an emergency department. The effect was a decline in rates from 2002 to 2003. No further interventions have occurred and a rise in ER utilization is noted for both PCPP and FFS from 2003 to 2004. Health plans will be required to submit Ambulatory Care rates to the Department in 2005, allowing for comparison of Department programs to MCOs.