HEDIS 2005

Health Plan Employer Data & Information Set
Evaluation of Quality of Care
Delivered to Colorado Medicaid Clients in 2004

State of Colorado Department of Health Care Policy and Financing Health Benefits Division
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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 2004, the Colorado Medicaid program was represented by five health plans. The Managed Care Organizations (MCO) are Colorado Access (Access), Rocky Mountain Health Plan (RMHP), Denver Health and Hospital Authority's Denver Health Medicaid Choice (DHMC) and the Department's two programs are the 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 certify 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. To correctly sample the DHMC population, the health plans need a minimum of one year of population data. Since DHMC did not enter Colorado's Medicaid managed care programs until October 2004, they did not complete HEDIS measures in 2005. DHMC will collect HEDIS measures in 2006.

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 2004, and are reported for the HEDIS year 2005. HEDIS uses sampling techniques. The National Committee for Quality Assurance (NCQA) outlines the specifications and sample size. Nationally, all health plans that report HEDIS data must comply with the specifications and each health plan is audited to ensure compliance. Performance measures are collected by two methods: Administrative and Hybrid. The HEDIS Specifications indicate the type of collection method. Administrative collection is based on evaluating claims data reported to the plans or Department by the providers. Hybrid collection involves a medical record review at the provider office or clinic where the client records are reviewed to determine if the activity was completed. Measures utilizing member month calculations include a health 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. NCQA recommends that results include a four year data trend. In this report, there will be four years of data presented where available.

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

Medicaid Benchmarking

Benchmarking is the process of identifying, sharing, and using knowledge of best practices among organizations. 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, the 2004 HEDIS National Medicaid benchmarking rates at the 50th percentile are reported. 2005 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.

Report Organization

This report is organized into three sections: Background and Introduction, Individual Performance Measure Results and Summary Table Comparison.

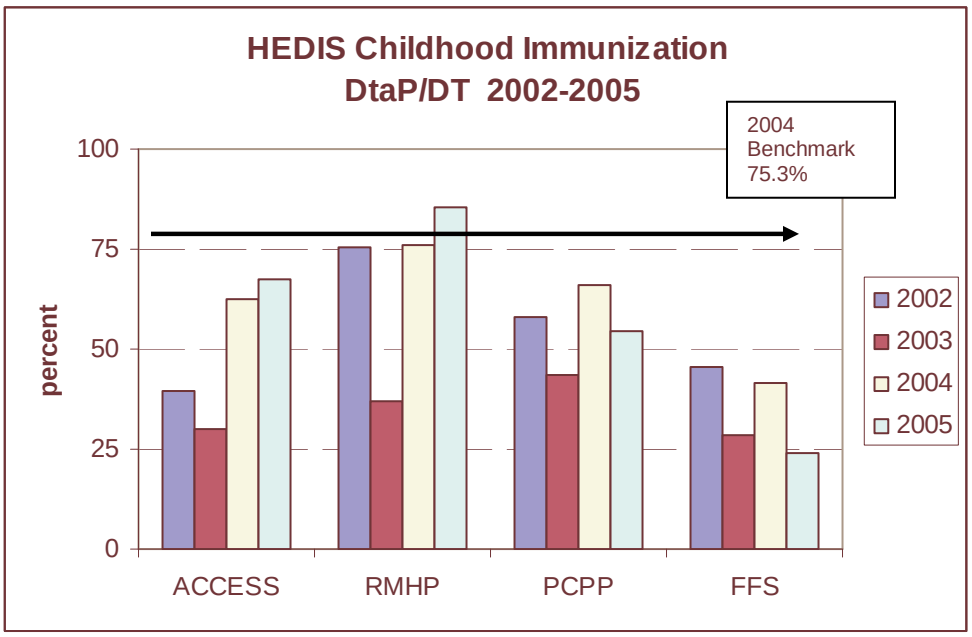
1. Background and Introduction includes an explanation of the performance measure process, plan participation and interpretation information is included.
2. Individual Performance Measure Results provides detailed information about selected Colorado Medicaid measures for 2005. This section includes:
    a. Description of the measures.
    b. Importance of the measure.
    c. Comparison of findings across the health plans.
    d. Description of quality activities related to the findings.
3. Summary Tables are tables comparing the overall findings for the performance measures for 2005.

Individual Performance Measure Results

Childhood Immunizations

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 at a minimal cost. 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); 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. 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 Table 1, the rates by the MCO's have continued to improve with RMHP exceeding the 2004 national 50% percentile benchmarking. The FFS and PCPP demonstrated a decline in 2005.

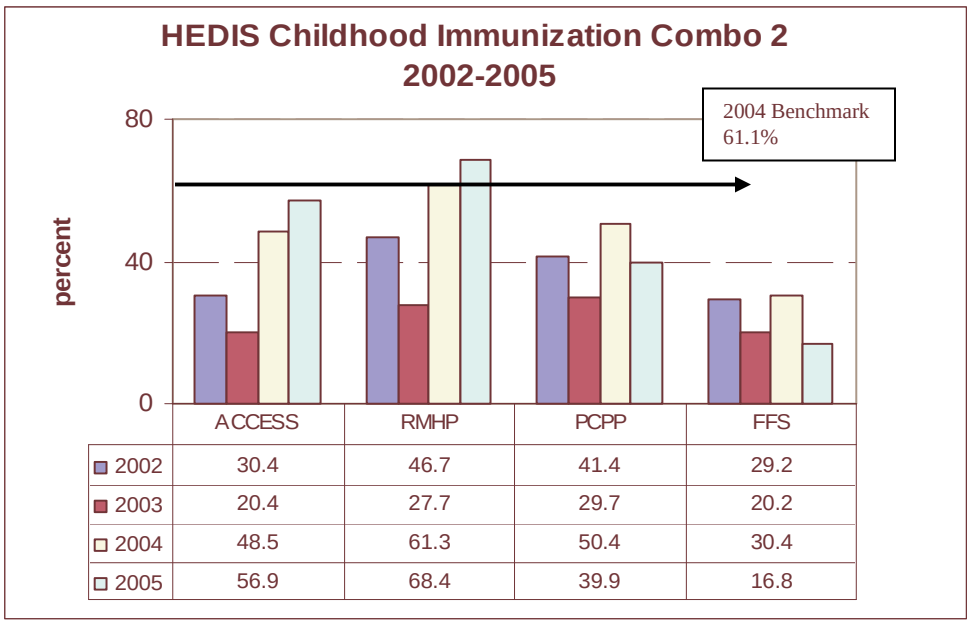
Table 1: Total Colorado DTaP/DT Results compared from 2002 to 2005.



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

Combination 2 rates determine children who are fully immunized for all recommended vaccines before the age of two years. The managed care organizations (MCO's) continue to increase the rate of member immunization (Table 2). Notable is RMHP which has exceeded the national benchmark for the last two years.

Table 2: Comparison of Combination 2 Immunization Results from 2002 to 2005.



	ACCESS	RMHP	PCPP	FFS
2002	30.4	46.7	41.4	29.2
2003	20.4	27.7	29.7	20.2
2004	48.5	61.3	50.4	30.4
2005	56.9	68.4	39.9	16.8

The decrease in the immunization numbers for PCPP and FFS warrants attention; however, this may also reflect challenges in data collection for these groups. Children may obtain their immunizations at a variety of settings, including schools, public health clinics and their primary care practitioner. At this time there is no common tracking mechanism that records immunizations at a central location. A tracking system that can be used by all providers was funded in the 2004-05 legislative session and is being developed by the Colorado Department of Public Health and Environment. HEDIS collection for immunizations includes a review of client records at the provider's office. If the parent obtained the immunization at a different location and did not bring the child's record to the provider office, the Primary Care Physician (PCP) is unable to document the immunization. Therefore, immunizations not obtained by the provider may not be recorded when the chart is audited for HEDIS.

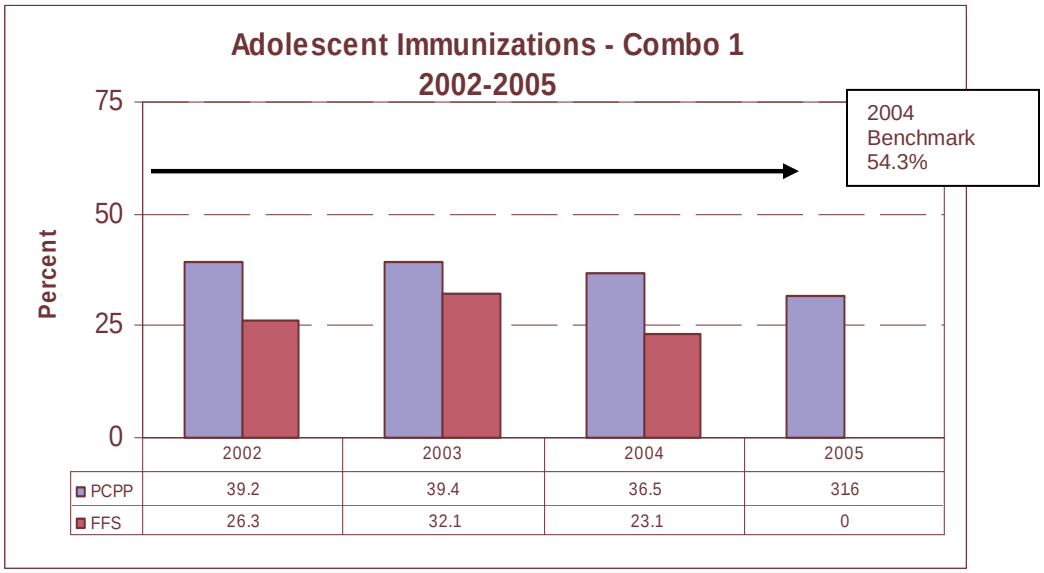
Quality Activities: The Department and health plans are supportive of the registry development and are currently developing additional interventions to increase the rates of immunization by providers.

Adolescent Immunizations

Measured in PCPP/FFS only

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] HEDIS Combination 1 rates determine adolescents who are immunized with a second dose, MMR and all three hepatitis B and varicella (chicken pox) by the age of thirteen. Nationally the rates of adolescent immunization have been steadily increasing while Colorado PCPP and FFS rates remain low. In 2004, the Department conducted a focused study that included questions to providers regarding obstacles to immunization. The primary obstacles identified by the respondents were: Parents do not comply with schedule, immunization records are not available, the low reimbursement rates for providers and the ability for members to obtain immunizations at other sites such as the local health department.

Table 3: Adolescent Immunizations for PCPP and FFS from 2002 to 2005 (FFS was not measured in 2005).



	2002	2003	2004	2005
PCPP	39.2	39.4	36.5	316
FFS	26.3	32.1	23.1	0

Quality Activities: As discussed in child immunizations, the Department and the health plans are developing interventions to increase immunization rates.

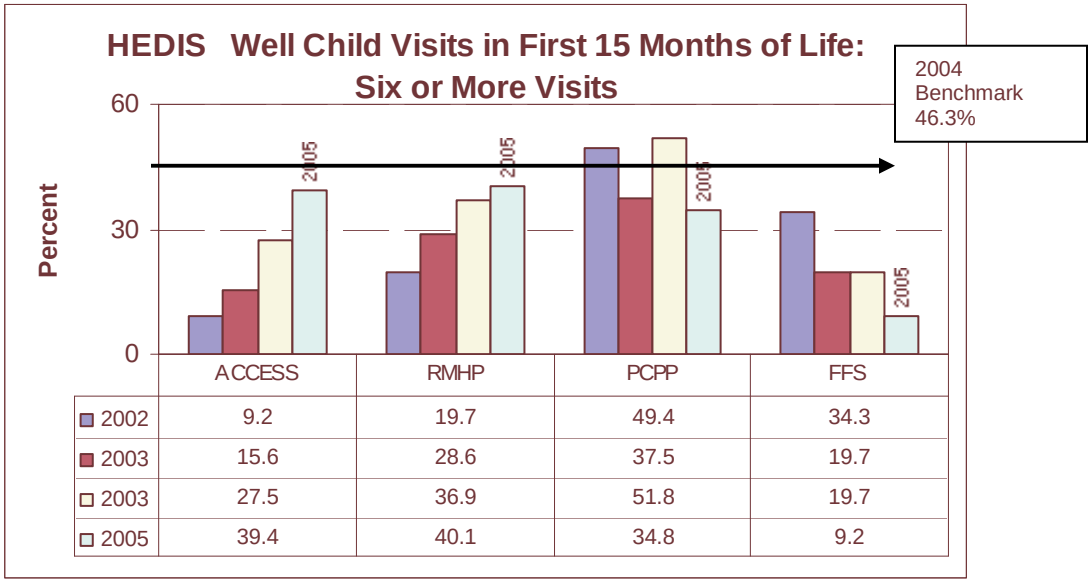
[3] Centers for Disease Control, National Immunization Program web site: http://www.cdc.gov/nip/recs/teen-schedule.htm

[4] Centers for Disease Control, National Center for Infectious diseases web site: http://www.cdc.gov/ncidod/diseases/hepatitis/index.htm .

Well Child Visits in the First 15 Months of Life

The Colorado Early Periodic Screening, Diagnosis and Treatment (EPSDT) program adopts recommendations from the American Academy of Pediatrics for well child care.[5] 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. The MCOs have continued to show improvement each year in this measure, (Table 4) although none met the HEDIS 2004 benchmark. The PCP Program results remain inconsistent and the FFS providers continue to demonstrate poor performance in this area.

Table 4: Comparison of Well-Child Visits in the first 15 months from 2002 to 2005.



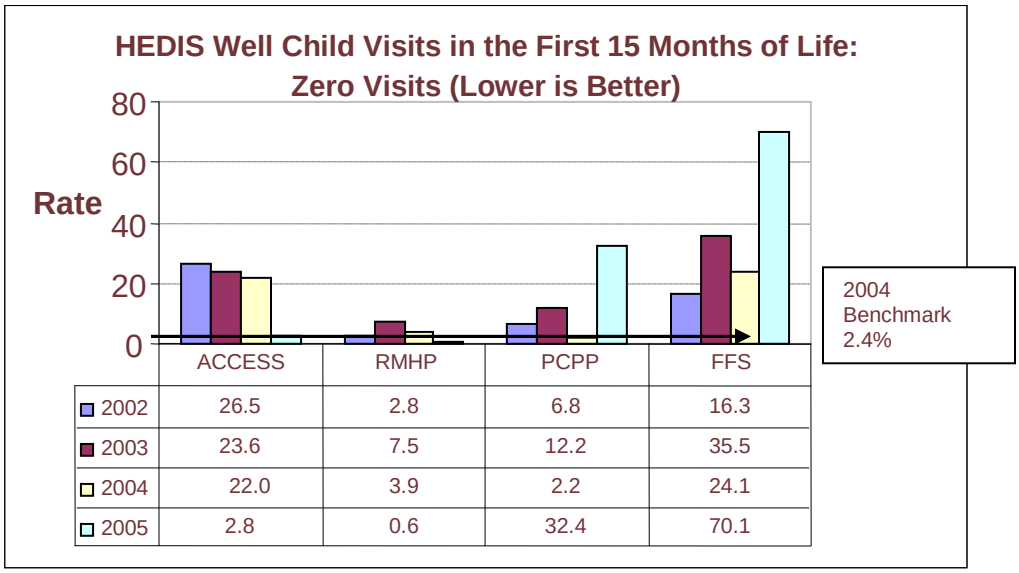
	ACCESS	RMHP	PCPP	FFS
2002	9.2	19.7	49.4	34.3
2003	15.6	28.6	37.5	19.7
2003	27.5	36.9	51.8	19.7
2005	39.4	40.1	34.8	9.2

HEDIS also measures the number of children with no (zero) identified visits to a provider (Table 5). No provider visits indicates children age less than 15 months are not receiving preventive well care, and any rate above zero percent indicates room for improvement. Both MCOs demonstrated consistent improvement. The MCO's have implemented numerous interventions to increase the number of children less than 15 months who receive well child care. Success by both plans is evident in the 2005 HEDIS results for children with no provider visits.

[5] AAP, Committee on Practice and Ambulatory Medicine, Recommendations for Preventive Pediatric Health Care. *Pediatrics* 1995:96 373-374.

RMHP measured below the 2004 benchmark with Access very close to the benchmark (a lower number indicates better performance). The PCPP demonstrated a significant improvement in 2004 but an increase in the number of children who did not receive well care in 2005. The reason for the decline in FFS and PCPP are not apparent at this time and warrant further review by the Department's EPSDT staff.

Table 5: Comparison of Zero Well Child Visits (lower is better) from 2002 to 2005.



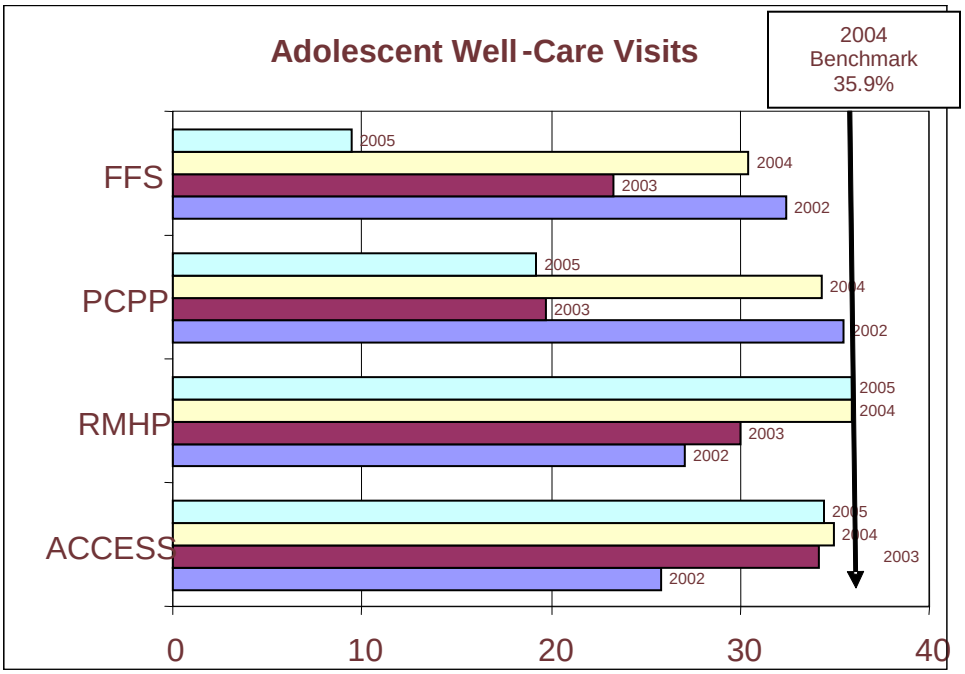
	ACCESS	RMHP	PCPP	FFS
2002	26.5	2.8	6.8	16.3
2003	23.6	7.5	12.2	35.5
2004	22.0	3.9	2.2	24.1
2005	2.8	0.6	32.4	70.1

Quality Activities: The health plans have implemented a variety of interventions during the past four years to increase well-child care. These include provider reminders, member reminders, member incentives and provider education. In 2005, the Department's Quality Section, together with the health plans, conducted a focused study to address the EPSDT care in Colorado. Based on the results, additional state-wide interventions are being developed to assist providers in the delivery of well care for all children.

Adolescent Well Care Visits

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,[6] 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. The total number of adolescents who have received preventive care has decreased over the last year. The trend for preventive care for adolescents is mixed. In 2003, the Department participated in an Adolescent Well-Care study to understand the breadth of adolescent well care in Colorado Medicaid and identify actions needed to improve rates. As noted in Table 6, rates in 2004 did improve 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. However, rates did decrease in all programs in 2005, with RMHP the only plan to meet the national benchmark. An additional qualitative study is planned for 2006 to identify other barriers to care and interventions that have been successfully adopted to increase participation by Medicaid members.

Table 6: Comparison of Adolescent Well Care Visit Rates from 2002-2005.



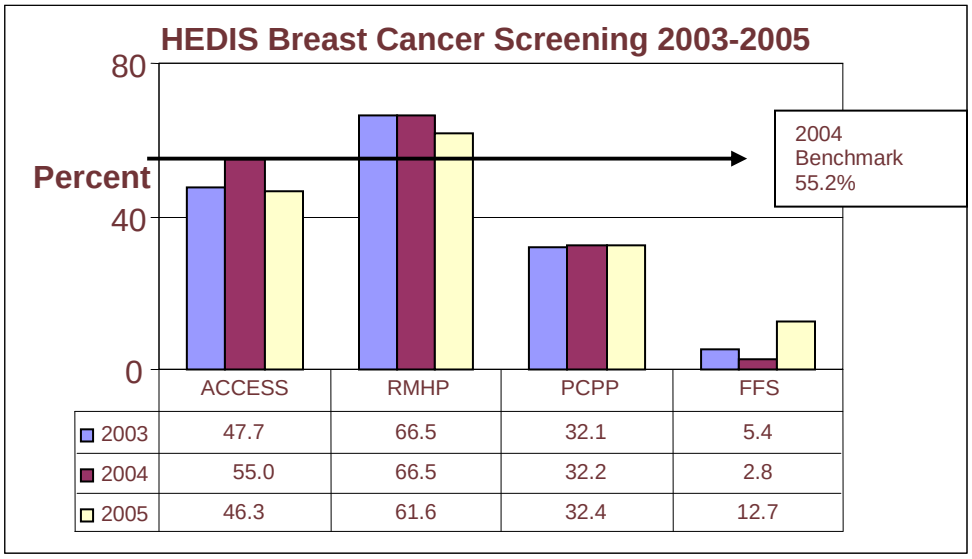
Quality Activities: Adolescent preventive care is part of the state QIP. An additional qualitative study is planned for 2006 to identify other barriers to care and interventions that have been successfully adopted to increase participation by Medicaid members

[6] AAP, Committee on Practice and Ambulatory Medicine, Recommendations for Preventive Pediatric Health Care. *Pediatrics* 1995:96 373-374.

Breast Cancer Screening

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.[7] 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. HEDIS measures the percentage of women 50-69 years of age who had a mammogram during the measurement year (2004) or the year prior (2003). Rates are calculated using medical record or claims review. In 2005, only FFS had an increased rate while the other health plans remained the same or declined (Table 7). RMHP has consistently exceeded the national benchmarking rates for the past three years as a result of ongoing member and provider interventions. Rates clearly indicate there is room to improve screening rates for Medicaid women enrolled in PCPP, FFS and Access.

Table 7: Comparison of Breast Cancer Screening from 2003-2005.



	ACCESS	RMHP	PCPP	FFS
2003	47.7	66.5	32.1	5.4
2004	55.0	66.5	32.2	2.8
2005	46.3	61.6	32.4	12.7

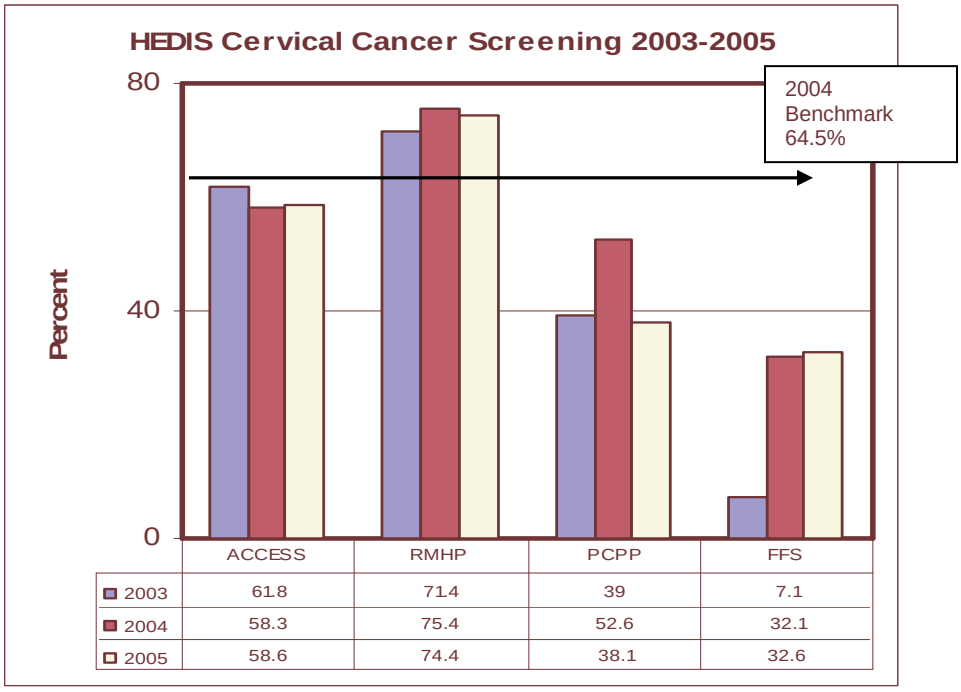
Quality Activities: In 2004, the state completed a focus study that assessed access to preventive services by the disabled Medicaid population. Breast cancer screening was among the categories reviewed. Based on the outcomes, the health plans and the Department developed targeted interventions and presentations related to increasing screening in this population. Additionally, the Department will provide a focused PCPP newsletter on adult preventive care.

[7] The State of Health Care Quality, 2004. NCQA. http://www.ncqa.org.communication/SOMC/SOHS2004.pdf

Cervical Cancer Screening

With early detection, 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.[8] 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.[9] Pap testing is a benefit under Colorado Medicaid. HEDIS measures the percent of women who received one or more Pap tests during the measurement year (2004) or the two years prior (2002 and 2003). Rates are calculated using medical record or administrative review. Results demonstrate the number of women screened for cervical cancer is improving. As noted in Table 8, Access and RMHP continue to show improvement with RMHP rated above 90th percentile for national benchmarks, indicating that 90% of women enrolled in RMHP receive Pap testing. Overall, there is an opportunity for improvement for Medicaid women enrolled in PCPP and FFS.

Table 8: Comparison of Cervical Cancer Screening from 2003-2005.



	ACCESS	RMHP	PCPP	FFS
2003	61.8	71.4	39	7.1
2004	58.3	75.4	52.6	32.1
2005	58.6	74.4	38.1	32.6

Quality Activities: The Department is developing a provider profile which will include member activities related to adult preventive care. (The provider profile will be a list of clients who are identified as needing Pap tests and breast cancer screening). The health plans also mail provider profiles with preventive care rates. The 2004 focused study "Preventive Services for Medicaid Members with Disabilities" was a remeasure of a 2002 and found increases in cancer screening in the disabled Medicaid population.

[8] The State of Health Care Quality, 2004. NCQA. at http://www.ncqa.org/communications/SOMC/SOHC2004.pdf .
[9] The State of Health Care Quality (2004)

Comprehensive Diabetes Care for Adults

Measured in 2003 and 2005

The HEDIS measures for comprehensive diabetes care are based on recommendations from the American Academy of Diabetes (ADA) and include measures that monitoring high blood sugar levels (HgbA1c), blood lipid levels (LDL-C), as well as HgbA1c and lipid control if the levels are above normal recommendations.[10] Additional measures include an eye exam which monitors for retinopathy and measuring urine chemistries for kidney function (nephropathy). This type of comprehensive care will improve the quality of life, health and reduces the onset of complications for the diabetic client. The 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. [11] HEDIS measures the percentage of members ages 18-75 years with diabetes (type 1 and type 2) who had each of the following:

- Hemoglobin A1c
- Hemoglobin A1c controlled (less than 9.0%)
- Eye exam performed
- LDL-C screening
- LDL-C controlled (to a level less than 130mg/dL)
- Kidney disease (nephropathy) monitored

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 to 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 affects 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. 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. Following the 2003 study, Access and RMHP developed and implemented interventions with their members and providers. Some of these were successful, others were not. Table 9 reports a comparison between the 2003 first measurement period and the 2005 remeasurement for each of the plans. Additionally, the table identifies if the plans increased, decreased or remained the same in each measurement after interventions were implemented. There were mixed results, while each plan improved in testing the HgbA1c and increasing lipid control, all had less success with completing annual eye exams.

[10] Clinical Practice Guidelines, January 2005. http://care.diabetesjournals.org/content/vol28, suppl_1/
[11] Colorado Medicaid FY 03 Diabetes Quality of Care Focused Study

The HEDIS specifications for eye exams include the number of members with diabetes in the measurement year that had a retinal exam by an ophthalmologist or optometrist obtained by a record review at the primary care provider office. Obtaining the data can be a challenge for the provider office. The client cannot receive this service at the primary care physician office, so the client compliance in completing the referral to the optometrist impacts the HEDIS results. The PCPP and FFS programs remain low in each area; however, there have been some gains in the overall monitoring. RMHP is noted for meeting or exceeding national benchmarks in all areas.

Table 9: Comprehensive Diabetes Care for Medicaid Adults.
Comparison of 2003 and 2005 measures for each health plan

		Access	RMHP	PCPP	FFS
HbA1c Testing	2003	74.5	85.4	44.3	11.7
National Benchmark (2004) 77.6%	2005	75.9↑	92.2↑	55.2↑	34.3↑
Poor HbA1C Control (lower is better)	2003	44.3	25.6	72.8	89.1
National Benchmark (2004) 47.4%	2005	49.1↑	16.5↓	79.1↑	90.8↑
Eye Exam	2003	48.4	69.3	21.2	4.1
National Benchmark (2004) 46.5%	2005	44.3↓	65↓	7.8↓	3.6↓
Lipid Profile	2003	85.2	75.4	39.4	8.5
National Benchmark (2004) 77.5%	2005	76.2↓	87.1↑	17.8↓	8↔
Lipid Control (LDL-C level<130mg/dL)	2003	46.5	53.8	17.3	6.3
National Benchmark (2004) 50.3%	2005	47.4↑	68.9↑	17.8↑	8.0↑
Monitoring for Nephropathy	2003	44.5	64.5	17.3	10.5
National Benchmark (2004) 43.8%	2005	35.8↓	58.2↓	24.6↑	18↑

- Shading indicates the plan performance was equal to or greater than 2005 national average.
- Arrows indicate if the individual plan increased or decreased the measure from 2003-2005.

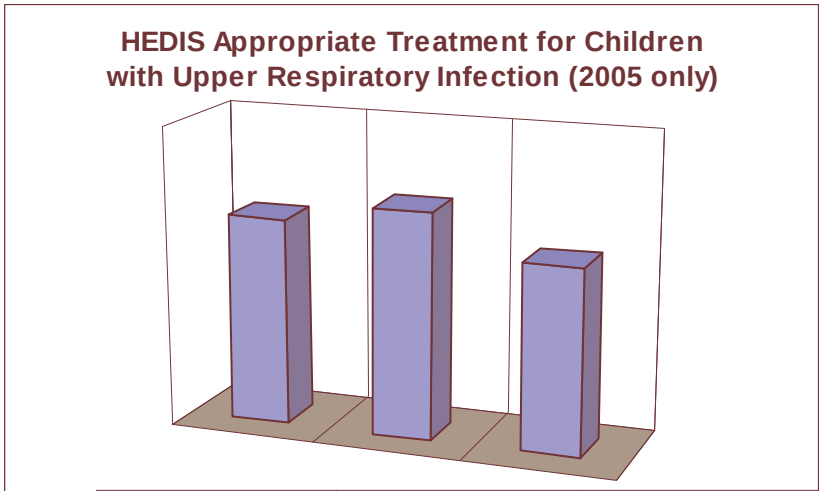
Quality Activities: RMHP has developed a variety of programs and performance improvement activities for members with diabetes and has an active case management program. RMHP and Access both send profiles to providers on a semiannual or quarterly basis with information about client needs related to diabetes. Access did not see as much improvement in these measures. As a result, Access is in the process of conducting a performance improvement project specifically addressing lipid control and HgbA1c measurement and control. The PCPP program mails newsletters quarterly, and diabetes care has been a topic in these newsletters.

Appropriate Treatment for Children with Upper Respiratory Infections

PCPP and FFS only, First measure collection, 2005

This measure addresses the inappropriate use of antibiotics. Upper respiratory infections (URI) are common in childhood. The evidence based recommendations are to monitor and treat URIs symptomatically and only use antibiotics when certain criteria are met.[12] Studies indicate that this may not be the standard practice for providers who care for children. Inappropriate use of antibiotics increases the antibiotic resistance to some drugs. Potential consequences of antibiotic resistance are the risk of infection by a drug-resistant pathogen.[13] This is a potential public health issue as more individuals develop drug resistance to some antibiotics the possibility of developing an infection for which there is no effective antibiotic increases. The HEDIS measure is the percentage of children age 3 months to 18 years of age who were diagnosed with an upper respiratory infection (URI) and did *not* receive an antibiotic prescription for that episode of care within 3 days of the visit. Higher rates indicate more appropriate use of antibiotics. The Colorado Medicaid Population FFS and PCPP measured this for the first time during 2005 (Table 10). Both plans exceeded the 2004 benchmark with FFS exceeding the 75th percentile, indicating that 75% of children with a URI diagnoses received appropriate care. These results show the use of best practices by a majority of providers in the FFS and PCPP programs.

Table 10: Care of Children with Upper Respiratory Infection (2005 only)



	PCPP	FFS	2004 HEDIS Benchmark
Series1	84.5	87.7	80.9

Quality Activities: The Department will continue to monitor antibiotic use in pediatric URI, trend the results and then determine appropriate interventions.

[12] Principles of Appropriate Use for Upper Respiratory Tract Infections. AAP Redbook, 2003 695-697.
[13] 2005 NCQA State of Health Care Quality Report. http://ncqa.org/doc/SOHCQ_2005.pdf

Prenatal and Postpartum Care

Measured in 2003 & 2004 for all plans, in 2005 only for FFS and PCPP

High-risk pregnancy, newborns 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 the 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.

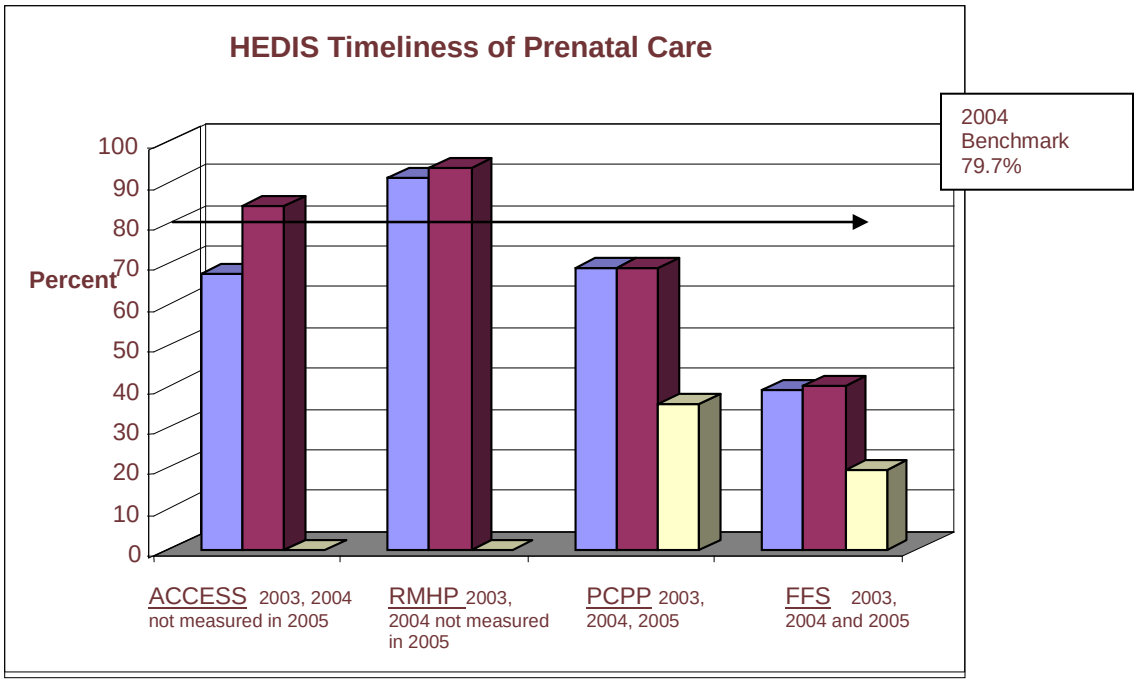
Prenatal Care

Timeliness of prenatal care in Colorado Medicaid has demonstrated improvement by all health plans through 2004 (Table 11) The MCOs continue to provide interventions for the members and providers to meet the goal of early and ongoing prenatal care. In 2004, one health plan, RMHP, exceeded the 90th percentile national benchmark. This indicates that more than 90 percent of pregnant women enrolled in RMHP receive timely prenatal care. Comparing 2003 to 2004, the rise in rates indicated that Access and RMHP have continued to exceed national benchmarks and they were therefore not required to submit these measures in 2005. Rates for all the plans will be measured in 2006. The decrease in the PCPP and FFS numbers was unpredicted and may have been impacted by the changes in the state Medicaid enrollment system during 2004. The HEDIS specifications require very limited gaps in enrollment during the measurement period; therefore, the numbers collected may reflect system related changes, not care. Most of these system issues have been resolved and the 2006 measurement period should more accurately represent prenatal and postpartum care.

Postpartum Care

In 2003 to 2004, there was a statewide rise in rates of women receiving postpartum care visits as recommended by the American Association of Obstetricians and Gynecologists. In 2005, the FFS and PCPP programs were the only health plans measured. As with the timeliness of prenatal care, the HEDIS measures for postpartum care decreased for these programs. The combined rate of the PCPP and FFS was 44.1 percent. This is below the National 25th percentile. Postpartum care will be measured by all plans in 2006.

Table 11: 2003-2005 Timeliness of Prenatal Care
FFS and PCPP were the only plans measured in 2005.



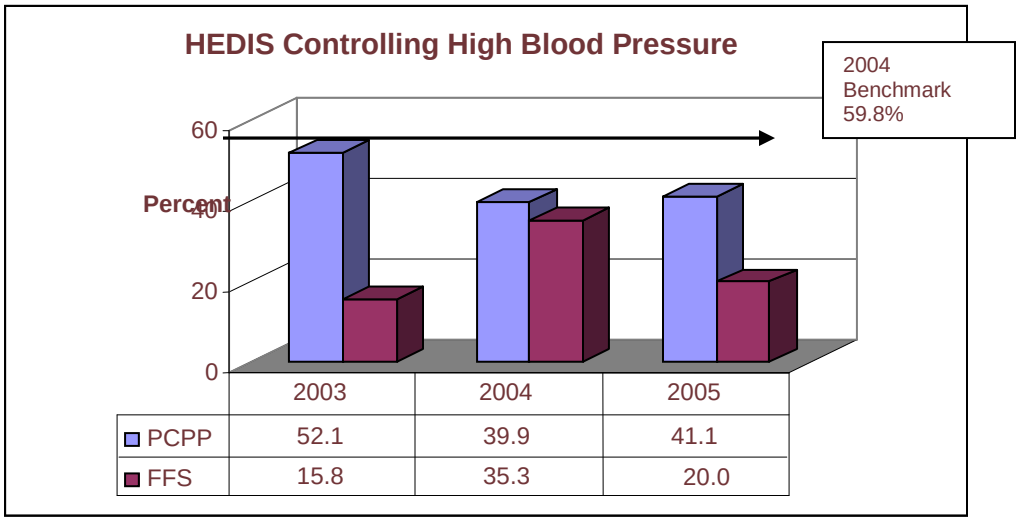
Quality Activities: The Department participated in a perinatal study to understand the extent of prenatal and postpartum care for women enrolled in Colorado Medicaid. Several actions were recommended to improve rates. A statewide intervention included a flyer about prenatal care that was sent to all new Medicaid members, posted on the Department's web page, utilized by the MCOs and sent to all the PCPP providers. The MCOs have incorporated interventions into their case management processes and RMHP has developed a performance improvement project to increase postpartum care.

Controlling High Blood Pressure

Measured in 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] 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] HEDIS measures the percent of 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. Rates were obtained using the hybrid methodology.

Table 12: Comparison of Controlling High Blood Pressure in FFS and PCCP populations 2003 and 2005



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 and a small increase in 2005. Rates for the FFS population increased during the same time period with a significant decrease in 2005.

Quality Activities: As a result of lower numbers, a quality intervention for PCPP providers was implemented in late 2004. The PCPP quarterly newsletter featured information and recommendations on the care of clients with hypertension and a provider profile listing clients with diagnosed hypertension was included. Controlling High Blood Pressure will be re-measured by all plans in 2006.

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

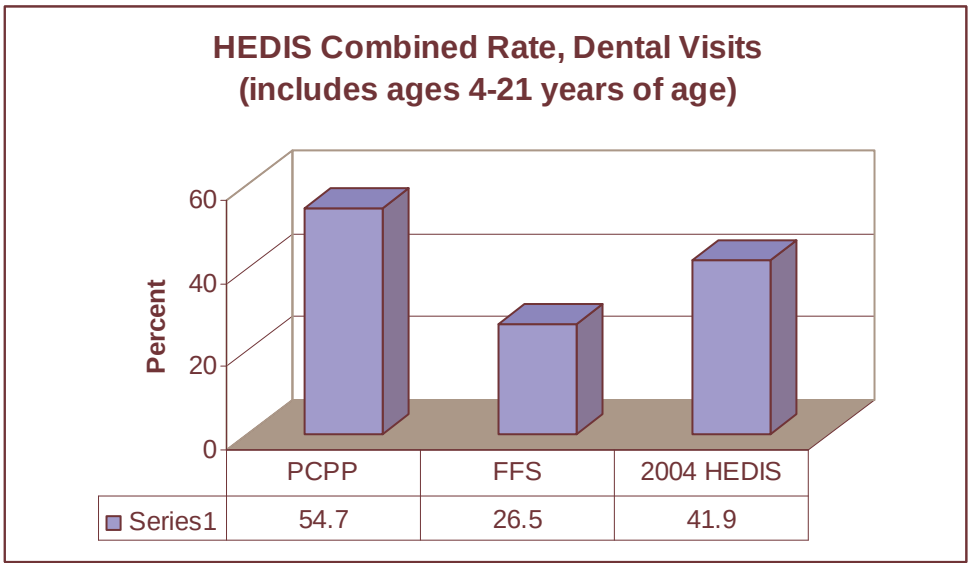
Dental Care for Children

PCPP and FFS only

Dental care is a benefit for Medicaid clients under age 21. All dental care is provided through the PCPP or Fee for Service program. Dental visits are recommended semiannually beginning at age 3. This enables the dentist to evaluate for oral disease and to provide dental hygiene to reduce problems. HEDIS specification for dental visits is the percentage of members 4-21 years of age who had at least one dental visit during the measurement year.

PCPP and FFS collected dental visit measures for the population for the first time in 2005. The PCP Program exceeded the 50th percentile benchmark in all age groups. The FFS program measures were below the 25th percentile of the national benchmark in all categories.

Table 13: Pediatric Combined Rate for Dental Visits in PCPP and FFS (2005 only)



Summary Tables

Indicates performance equal to or higher than national average

2005 HEDIS Results (data collected in 2004) and the HEDIS 2004 Benchmark					
HEDIS Measure	**CO Access 2005**	**RMHP 2005**	**PCPP 2005**	**FFS 2005**	**HEDIS 2004 50th Percentile Benchmark**
Diptheria, Tetanus, Pertussis (DTP or DTaP) {total 4}	67.6%	85.5%	54.3%	24.1%	75.3%
Measles, Mumps, Rubella (MMR) {total 1}	84.3%	92.3%	71.3%	42.3%	88.3%
Polio Immunizations (IPV) {total 3}	81.3%	89.3%	62.0%	32.6%	84.9%
Haemophilus Influenzae Type B (Hib) {total 2}	70.6%	85.2%	60.1%	28.0%	79.6%
Hepatitis B (Hep B) {total 3}	75.2%	90.3%	58.2%	29.7%	82.3%
Varicella (VZV) {total 1}	84.7%	83.9%	69.1%	40.9%	84.2%
Childhood Immunization Status – Combo 1 (4 DaTP or DTP, 3 IPV,1 MMR, 2 Heb B and 1 Hib)	57.4%	73.5%	41.1%	17.3%	64.8%
Childhood Immunization Status – Combo 2 (3 IPV, 1 MMR, 2 Hep B, 1 Hib, 1 VZV)	56.9%	68.4%	39.9%	16.8%	61.1%
Breast Cancer Screening	46.3%	61.6%	32.4%	12.7%	55.2%
Cervical Cancer Screening	58.6%	74.4%	38.1%	32.6%	64.5%
Comprehensive Diabetes Care – HbA1c Testing	75.9%	92.2%	55.2%	34.3%	77.6%
Comprehensive Diabetes Care – Poor HbA1c Control (Lower Is Better)	49.1%	16.5%	79.1%	90.8%	47.4%
Comprehensive Diabetes Care – Eye Exam	44.3%	65.0%	7.8%	3.6%	46.5%
Comprehensive Diabetes Care – Lipid Profile	76.2%	87.1%	58.2%	38.2%	77.5%
Comprehensive Diabetes Care – Lipid Control (LDL-C Level<130mg/dL)	47.4%	68.9%	17.8%	8.0%	50.3%
Comprehensive Diabetes Care – Monitoring for Nephropathy	35.8%	58.2%	24.6%	18.0%	43.8%
Children's Access to Primary Care Practitioners, 12–24 Months	91.3%	99.1%	26.2%	14.8%	94.9%
Children's Access to Primary Care Practitioners, 25 Months–6 Years	78.4%	89.3%	19.8%	9.6%	84.7%
Children's Access to Primary Care Practitioners, 7–11 Years	82.4%	92.9%	29.8%	10.7%	83.3%

HEDIS Measure	CO Access 2005	RMHP 2005	PCPP 2005	FFS 2005	HEDIS 2004 50th Percentile Benchmark
Well-Child Visits in the First 15 Months of Life Zero Visits (lower percentage is better)	2.8%	0.6%	32.4%	70.1%	2.4%
Well-Child Visits in the First 15 Months of Life Six or More Visits	39.4%	40.1%	34.8%	9.2%	46.3%
Adolescent Well-Care Visits	34.4%	35.9%	19.2%	9.5%	35.9%
Ambulatory Care Utilization					
Outpatient Visits/1,000 Member Months	304.69	407.77	299.74	220.27	289.5
Ambulatory Surgery Procedures/ 1000 Member Months	6.18	9.83	8.72	4.68	4.4
Emergency Room Visits/ 1,000 Member Months	56.83	45.34	53.76	39.27	51.7
Observation Room Stays Resulting in Discharge/ 1000 Member Months	2.22	1.88	2.97	3.67	1.0

2005 HEDIS Measures Conducted Only for the PCPP and FFS Population					
HEDIS Measure	**CO Access 2005**	**RMHP 2005**	**PCPP 2005**	**FFS 2005**	**HEDIS 2004 50th Percentile Benchmark**
Adolescent Immunization Status – Combo 1	NA	NA	31.6%	8.8%	54.3%
Adolescent Immunization Status – Combo 2	NA	NA	17.5%	6.6%	33.2%
Timeliness of Prenatal Care	NA	NA	35.5%	19.2%	79.7%
Postpartum Care	NA	NA	49.1%	39.2%	55.3%
Appropriate Treatment for Children with Upper Respiratory Infection	NA	NA	84.5%	87.7%	80.9%
Annual Dental Visit, 4–6 Years of Age	NA	NA	56.6%	27.7%	43.3%
Annual Dental Visit, 7–10 Years of Age	NA	NA	61.5%	28.4%	46.0%
Annual Dental Visit, 11–14 Years of Age	NA	NA	55.0%	26.5%	41.4%
Annual Dental Visit, 15–18 Years of Age	NA	NA	46.8%	24.5%	36.0%
Annual Dental Visit, 19–21 Years of Age	NA	NA	33.4%	19.6%	25.3%
Annual Dental Visit, Combined Rate	NA	NA	54.7%	26.5%	41.9%
Controlling High Blood Pressure	NA	NA	41.1%	20.0%	59.8%
Inpatient Utilization – General Hospital/Acute Care (Total)					
Discharges/ 1,000 Member Months	NA	NA	8.25	10.71	7.6
Days/ 1,000 Member Months	NA	NA	34.63	32.72	27.4
Average Length of Stay	NA	NA	4.20	3.05	3.5