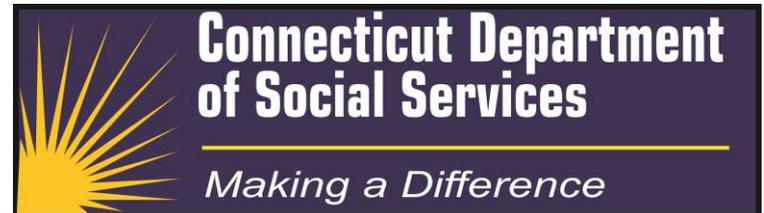


# Medical Assistance Program Oversight Council

## Health Measures and Performance Results April 11, 2014



# Health Measure Reporting - Context

In past meetings, we've profiled:

- The ASO model overview and rationale, emphasizing single access points for service and a unified source of claims and health outcomes data
- Intensive Care Management program
- Person-Centered Medical Home and promotion of preventive care
- Behavioral Health Partnership
- May's meeting will highlight the Dental Health Partnership
- Today:
  - We will discuss Health Measures and Performance Results

# Health Measures

- **How and Why**
  - ❑ Health quality is measured
  - ❑ Provider performance is profiled
- **Summary of findings from calendar year 2012**
- **How these findings are being used**

# Value of Health Measures Reporting

- For the first time the State has a comprehensive view of the effectiveness of care for the entire HUSKY Health membership from a single data source
- Many of the health measures are related to preventive care, treatment of chronic diseases, and member utilization. Examples include:
  - ❑ Getting cancer screenings
  - ❑ Child immunizations
  - ❑ Controlling hypertension
  - ❑ Managing diabetes
- Improving the results of health measures **means improving clinical outcomes and better health for our members.**
- Sharing the results of these measures with our providers, fosters collaboration to achieve the highest standards of care.
- It allows comparison of the Connecticut program to national Medicaid performance

# Health Measures

- Allow comparisons of health outcomes across populations, between states and a year over year comparison of ourselves - how we are doing?
- Reflect care that members actually received, not what was ordered for them
- Help providers identify where there are opportunities for quality improvement

# Program Use of Health Measures

- HUSKY Health (Medicaid and CHIP) uses health measures to:
  - ❑ Assess member health outcomes by:
    - Coverage group (HUSKY A/B, HUSKY C, HUSKY D)
    - Member demographics (age, sex, race, residence)
    - Provider setting (PCMH, Glide Path, FQHC, hospital primary care clinic and community-based practices)
  - ❑ Identify and define opportunities to improve quality of care delivery
  - ❑ Evaluate and constantly improve the HUSKY Health program

# Provider Use of Health Measures

- Providers can use health measures to:
  - Compare their performance with their CT and national peers
  - Identify opportunities to improve health outcomes by utilizing their own results to identify members at risk who:
    - Have not received preventative screenings and tests
    - Experience gaps in care
    - Schedule preventive exams
    - Issue reminders to members to follow up with ordered tests
    - Inform members of supports for chronic conditions and refer members to Intensive Care Management

# Elements of a Health Measure

- Description of the condition or services to be measured
- Population to be measured
- Threshold requirement(s) for minimum enrollment duration
- Procedure/diagnosis codes
- Exclusions based on clinical criteria
- Measurement period
- Means of data collection (claims and/or medical record review)

# Types of Health Measures

- Health Effectiveness Data and Information Set (HEDIS)
- CMS endorsed measures
  - ❑ Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
  - ❑ Children's Health Insurance Program Reauthorization Act (CHIPRA)
  - ❑ Adult Quality Grant Measures
- Connecticut Medical Assistance Program (CMAP) specific measures

# HEDIS

The National Committee for Quality Assurance (NCQA) annually publishes the Health Effectiveness Data and Information Set (**HEDIS**), which is used to measure program performance. Measures are calculated with claims data only or by a hybrid method based on both claims and medical record data. Data collection and reporting is governed by NCQA.

- Examples of administrative HEDIS measures are:
  - ❑ Adults' Access to Preventive/Ambulatory Health Services
  - ❑ Children and Adolescents' Access to Primary Care Practitioners
  - ❑ Breast Cancer Screening
  
- Examples of hybrid HEDIS measures are:
  - ❑ Lead Screening in Children
  - ❑ Comprehensive Diabetes Care
  - ❑ Cervical Cancer Screening

# CMS Endorsed Measures

- **CMS endorsed measures** are claims-based only
  - ❑ Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
  - ❑ CHIPRA measures examples:
    - Developmental Screening In the First Three Years of Life
    - Annual Percentage of Asthma Patients With One or More Asthma-Related Emergency Room Visits
  - ❑ Adult Core Set Measure examples:
    - Congestive Heart Failure Admission Rate
    - Diabetes Short Term Complications Admission Rate

# Connecticut Medical Assistance Program (CMAP) Specific Measures

- The CMAP specific measure results are from claims only
- These measures have been developed and carried forward over the years to assess health conditions of special interest to the Department and MAPOC
- Examples of CMAP specific measure include:
  - ❑ Readmissions within 30 Days
  - ❑ Asthma Patients with One or More Asthma-Related ED Visits
  - ❑ Chlamydia (male)

# Use of Health Measures for Provider Profiling

In 2013, CHNCT produced the first statewide CMAP Provider Profiling Report based on services rendered during 2012. Results from HEDIS, CMS and the CT specific measures were used to produce three distinct reports:

- CT Statewide profile
- Person-Centered Medical Home profiles
- Individual providers within a practice profiles

# Use of Health Measures for Provider Profiling (cont.)

- Connecticut Statewide profile compares:
  - ❑ HEDIS results by program (HUSKY A/B, HUSKY C, HUSKY D) to National Medicaid Averages
  - ❑ Results by practice setting (FQHC, Hospital Primary Care Clinic, PCMH, Glide Path and Non-PCMH Community-based practice) to statewide administrative rates
  - ❑ Results for members attributed to a PCP compared with members who are not yet attributed

# Use of Health Measures for Provider Profiling (cont.)

- The Person-Centered Medical Home (PCMH) Profile compares performance across practices recognized by DSS as a PCMH as of December 31, 2012 amongst themselves and to the other practice settings
- The Individual provider profile compares results within a practice

# Data Collection Challenges

- Challenge: Not all claims include all codes to allow complete reporting
  - ❑ Example: Hospital outpatient department claims do not currently include CPT/HCPC codes
- Example of impacts:

Measure	CT Statewide Rate	Hospital Clinics Rate
Well-Child Visits in the Third, Fourth, Fifth & Sixth Years of Life	70.4%	11.4%
EPSDT Screening Ratio	76%	56%
EPSDT Participation Ratio	62%	52%

- Solution: Hospitals will be required to bill with valid CPT/HCPC procedure codes on outpatient claims in addition to the revenue code effective May 1, 2014

# Data Collection Challenges (cont.)

- Challenge: Some measures require the services be performed by a specific provider specialty. Some of the claims data is incomplete at this time

- Example of impacts:

Measure	CT Statewide Rate	National Medicaid Rate
Frequency of Ongoing Prenatal Care Greater than 81 percent expected # of visits	49.39%	60.45%

- Solution: The ACA Ordering, Prescribing and Referring (OPR) provisions require providers to individually enroll in CMAP. The OPR requirement was implemented in fourth quarter 2013 and helps supply provider type and specialty in claims

# Data Collection Challenges (cont.)

- Challenge: Hybrid measures require receipt of medical records
  - ❑ Some practices unable to extract records from their electronic health records (EHRs)
  - ❑ Some multi-site practices without EHRs have challenges locating records
  - ❑ Some practices/hospitals limit access to records

- Example of impacts:

Measure	CT Statewide	National Medicaid Average
Comprehensive Diabetes Care – Blood Pressure Control (<140/90)	38.72%	59.02%

- Solution: Practices within the Person-Centered Medical Home program are required to have the ability to electronically extract and use data for care improvement. Investigate collaborative arrangements for the use of EHRs and data exchange with hospitals and other provider practices

# Impacting Measure Results

- An example of how a specific health measure is being addressed:

Measure	HUSKY A/B	HUSKY C	HUSKY D	National Medicaid Average
Comprehensive Diabetes Care: HbA1c Poor Control Total (Lower is better)	61.47%	58.76%	62.77%	59.02%

- Identifying members with gaps in care
- Regionalized teams dedicated to PCMH practices which includes onsite support
- Provide individual practices with their own health measure performance results

# Impacting Measure Results (cont.)

- Train providers and staff on accessing new technologies for data analytics and reports to identify members with gaps in care including online member specific reports by practice:
  - ❑ Patient panel
  - ❑ Emergency Department utilization
  - ❑ Inpatient daily census
  - ❑ Inpatient claims
  - ❑ Pharmacy utilization
  
- Intensive Care Management collaboration with providers
  - ❑ ICM participation in multidisciplinary care rounds
  - ❑ Assisting with care coordination and unmet needs
  - ❑ Member health care reminders

# Impacting Measure Results (cont.)

- Provide member specific health education:
  - ❑ Written, Coaching: face to face, telephonic, texting
  - ❑ Medication adherence and consultations with pharmacists
  - ❑ Nurse Advice Line
  - ❑ Community based nutrition classes and individualized nutrition consultations
  
- Leverage new technology through collaborative partnerships to secure:
  - ❑ Hospital admissions, discharges, and transfers
  - ❑ Real time utilization of Emergency Department
  - ❑ Provider encounters
  - ❑ Clinical values and lab results

# Impacting Measure Results (cont.)

- An example of how a maternity health measure is being addressed :

Measure	HUSKY A/B	HUSKY C	HUSKY D	National Medicaid Average
Frequency of Ongoing Prenatal Care $\geq$ 81% Visits	49.39%	Not applicable	Not applicable	60.45%

Note: Not applicable applies based on sample size for measure inclusion

- Recruit and collaborate with OB practices to participate in the implemented OB Pay for Performance program which allows earlier:
  - ❑ Notification of pregnant members through secure web portal
  - ❑ Identification of members with risk factors (both medical and social determinants) for intensive care management
  - ❑ Engagement of the member for ongoing coaching (face to face, telephonic and by text)
  - ❑ Linkage of member to services, appointment reminders, educating on alternatives to ED use and scheduling for prenatal and postpartum care and early linkage of child with PCP

# Impacting Measure Results (cont.)

- Examples of how a well care health measure are being addressed:

Measure	HUSKY A/B	HUSKY C	HUSKY D	National Medicaid Average
Well Child First 15 Months of Life – <i>6 or More Visits</i>	65.26%	Not Applicable	Not Applicable	63.65%
Well Child Third, Fourth, Fifth and Sixth Year of Life	76.67%	Not Applicable	Not Applicable	72.00%
Adolescent Well Care Visits	54.50%	Not Applicable	Not Applicable	49.69%

Note: Measure is not applicable for program based on age of members included in the measure

# Impacting Measure Results (cont.)

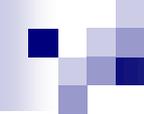
- **Member Directed Initiatives taking a person-centered approach (culture, linguistic, and need for assistive technology)**
  - New member outreach to ensure linkages to care (PCP selection, Welcome calls and screening)
  - Member Services for assisting with provider linkages and appointment.
    - Preventive care reminders with each member service contact
  - Intensive Care Management programs including addressing social determinants of health
  - Collaboration with external community based groups and agencies for member identification for outreach

# Impacting Measure Results (cont.)

- Ongoing member education to address gaps in care and specific health conditions (Online and written health materials, nutrition, medication management, use of nurse advice line)
  - Health Reminders and coaching (face to face, telephonic, social media including web, Facebook, tweets and how to access text reminders via free cell phone)
    - EPSDT and Adult well care
    - Preventive screenings
    - Disease specific care reminders
    - Alternative to ED use
- Collaborate and provide practices with
  - Monthly patient panel reports
  - Access to secure portal for patient specific utilization reports
  - Education to clarify eligible well care services and their frequency

# Other Initiatives

- CT specific and other health measures that CHNCT is obtaining data to analyze and make recommendations:
  - ❑ Hepatitis C screening and treatment
    - Collaborating with CT Department of Health and provider community to analyze data
  - ❑ Use of spirometry testing for assessment and diagnosing of Chronic Obstructive Pulmonary Disease (COPD)
    - Collaborating with CT Lung association and providers on best practices and need for provider education
  - ❑ ADHD Medication Usage
    - Analyzing data for prescribing patterns for both children and adults to compare to national trends



# QUESTIONS?