Texas Medicaid Quality Initiatives

Billy R. Millwee
Deputy Executive Commissioner
Texas Health and Human Services
OVERVIEW

- Getting Started
- What and How to Measure
- Implementation
Texas Medicaid Quality Initiatives

Getting Started

• Executive support.

• Provider and sister agency support.
  • Quality-based Payment Advisory Committees.
  • Neonatal Intensive Care Unit Council.
  • Physician Payment Committee.

• Consumer support.

• Internal support.
What and How to Measure

- Rates versus individuals.
  - Transparent methodology.
- Accepted professional standards.
Value-Based Purchasing Cycle

1. Specify what to buy (RFP) and select the best contractor(s)
2. Measure
3. Identify opportunities for improvement
4. Set improvement goals
5. Collaborate to improve
6. Remeasure
7. Apply incentives/disenincentives
Implementation

• Delivery system dependant.

• Primary focus: managed care.
Texas Medicaid Quality Initiatives

Implementation

• Managed care
  • 5 percent of premium at risk.
  • Jointly developed metrics thru fiscal year 2013.
  • Move to potentially preventable events beginning in fiscal year 2014.
Texas Medicaid Quality Initiatives

Implementation

• Managed care measures thru fiscal year 2013
  • EPSDT checkups.
  • Prenatal/postpartum care.
  • Asthma Management.
  • Cholesterol management.
  • Nursing facility admission rates.
  • HbA1c testing.
  • Inpatient utilization.
  • Emergency department utilization.
  • Use of consumer directed services.
  • Weight assessment and counseling for nutrition and physical activity for children/adolescents.
  • Follow up care for children prescribed ADHD medication.
  • Antidepressant Medication Management (AMM).
  • Adult body mass index assessment (ABA)
  • Diabetic eye exam.
Texas Medicaid Quality Initiatives

Implementation

• Managed Care Measures Beginning in fiscal year 2014.
  • Relevant specific measures developed by advisory committee.
  • Potentially preventable events (PPE).
    • Potentially Preventable Complications (PPE).
    • Potentially Preventable Readmissions (PPR).
    • Potentially Preventable Admissions (PPA).
    • Potentially Preventable Emergency Room Visits (PPV).
    • Potentially Preventable Ancillary Services (PPS).
Conclusion

• Getting started
• What and how to measure
• Implementation
State All-Payer Claims Database Progress and Future of APCDs (Blowing up the Silos)

November 9, 2011
National Association of Medicaid Directors
Arlington, VA
Patrick Miller, MPH
Welcome to the APCD Council!

The APCD Council, formerly known as the Regional All Payer Healthcare Information Council (RAPHIC), is a federation of government, private, non-profit, and education organizations focused on improving the development and deployment of state-based all payer claims databases (APCD). The APCD Council is convened and coordinated by the Institute of Health Policy and Practice (IHPP) at the University of New Hampshire (UNH) and the National Association of Health Data Organizations (NAHDO).

RAPHIC was first convened in 2006 by UNH, IHPP staff with the goal of engaging future users of the Maine and New Hampshire APCDs in a discussion about multi-state collaboration. Soon after, states across the country joined the group. Currently, there is participation from nearly a dozen states. NAHDO was established in 1986 to promote the uniformity and availability of health care data for cost quality and access purposes. In 2007, NAHDO forged a collaboration with RAPHIC to expand APCD data initiatives beyond the north east region and to lead fund raising for APCD products and conference support. Together, NAHDO and RAPHIC have been coordinating a multistate effort to support state APCD initiatives and shape state reporting systems to be capable of supporting a broad range of information needs.

In response to a shift from a regional to nationwide focus, RAPHIC has changed its name to the APCD Council. The APCD Council will continue to work in collaboration with states to promote uniformity and use of APCDs.
National Activities

- Standards Development
- Technical Assistance
- Web Resources
- Publications and Issue Briefs
- Annual Conference
- AHRQ USHIK Database
- Partners: APCD Council, NAHDO, States, Carriers, AHRQ, AHIP, NCPDP, AcademyHealth State Coverage Initiatives, Commonwealth Fund, NGA, NAIC
Standards Technical Advisory Panel

- Agency for Healthcare Research and Quality (AHRQ)
- All-Payer Claims Database Council (APCD Council)
- American Medical Association (AMA)
- America's Health Insurance Plans (AHIP)
- Individual Payers (e.g., Aetna, Cigna, Harvard Pilgrim Healthcare, Humana, United Health Care)
- Centers for Disease Control and Prevention, National Center for Health Statistics (CDC NCHS)
- Centers for Medicare and Medicaid Services (CMS)
- National Association of Health Data Organizations (NAHDO)
- National Association of Insurance Commissioners (NAIC)
- National Conference of State Legislatures (NCSL)
- National Governors Association (NGA)
- Office of the Assistant for Planning and Evaluation (ASPE)
- State Health Plan Associations - various
Background
Backdrop 2005-2011

• Increased Transparency Efforts
• Employer Coalitions
• Payment Reform
  – Patient Centered Medical Home
  – Accountable Care Organizations
• Health Information Exchange (HITECH)
• Health Reform (PPACA)
Sources of APCD Data

- Commercial & TPAs & PBM & Dental & Medicare Parts C & D
- Medicaid FFS & Managed Care & SCHIP
- Medicare Parts A & B
- Uninsured & TRICARE & VA & IHS & FEHB

Copyright 2009-2011, APCD Council, NAHDO, UNH
September 2011 State Progress Map
Usage Examples
Something for Everyone

- Consumers
- Employers
- Health Plans/Payers
- Providers
- Researchers (public policy, academic, etc.)
- State government (policy makers, Medicaid, public health, insurance department, etc.)
- TBD (Federal government, etc.)
Prevalence of Asthma by Age, NH Medicaid (non-Dual) and NH Commercial Members, 2005

SOURCE: NH DHHS
COPD Prevalence
Rates Standardized for Age

Medicaid Members
- 10.0% - 12.9%
- 13.0% - 14.9%
- 15.0% - 15.9%
- 16.0% - 16.4%

CHIS Commercial
- 0.01%
- 0.02%
- 0.03%

Source: NH DHHS
Prevalence of Asthma by Age, NH Medicaid and Commercial Members, 2005-2009

NH Commercial Asthma Prevalence 2005-2009

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Asthma Prevalence</th>
<th>Age 0-4 Prevalence</th>
<th>Age 5-9 Prevalence</th>
<th>Age 55-59 Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>5.3%</td>
<td>6.8%</td>
<td>7.0%</td>
<td>15.8%</td>
</tr>
<tr>
<td>2006</td>
<td>5.5%</td>
<td>7.1%</td>
<td>7.5%</td>
<td>17.0%</td>
</tr>
<tr>
<td>2007</td>
<td>5.6%</td>
<td>6.7%</td>
<td>7.4%</td>
<td>15.4%</td>
</tr>
<tr>
<td>2008</td>
<td>5.7%</td>
<td>6.7%</td>
<td>7.7%</td>
<td>16.3%</td>
</tr>
<tr>
<td>2009</td>
<td>6.0%</td>
<td>6.8%</td>
<td>8.0%</td>
<td>16.8%</td>
</tr>
</tbody>
</table>

NH Medicaid Asthma Prevalence 2005-2009

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Asthma Prevalence</th>
<th>Age 0-4 Prevalence</th>
<th>Age 5-9 Prevalence</th>
<th>Age 55-59 Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>9.6%</td>
<td>9.5%</td>
<td>8.7%</td>
<td>15.8%</td>
</tr>
<tr>
<td>2006</td>
<td>9.9%</td>
<td>9.5%</td>
<td>8.7%</td>
<td>17.0%</td>
</tr>
<tr>
<td>2007</td>
<td>10.2%</td>
<td>9.5%</td>
<td>8.9%</td>
<td>15.4%</td>
</tr>
<tr>
<td>2008</td>
<td>10.4%</td>
<td>9.7%</td>
<td>9.2%</td>
<td>16.3%</td>
</tr>
<tr>
<td>2009</td>
<td>10.6%</td>
<td>9.3%</td>
<td>9.7%</td>
<td>16.8%</td>
</tr>
</tbody>
</table>

SOURCE: NH DHHS; www.nhchis.org
# Medicaid Payment Rate Benchmarking

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Health Plan 1</th>
<th>Health Plan 2</th>
<th>Health Plan 3</th>
<th>NH Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>99203 Office/Outpatient Visit New Patient, 30min</td>
<td>$124</td>
<td>$115</td>
<td>$130</td>
<td>$42</td>
</tr>
<tr>
<td>99212 Office/Outpatient Visit Established Patient, 10min</td>
<td>$51</td>
<td>$48</td>
<td>$52</td>
<td>$30</td>
</tr>
<tr>
<td>99391 Preventive Medicine Visit Established Patient Age &lt;1</td>
<td>$111</td>
<td>$102</td>
<td>$107</td>
<td>$61</td>
</tr>
<tr>
<td>90806 Individual psychotherapy in office/outpatient, 45-50min</td>
<td>$72</td>
<td>$71</td>
<td>$71</td>
<td>$61</td>
</tr>
</tbody>
</table>

SOURCE: NH DHHS
CY 2011 Composite Hospital Score

Tier 1 = Diamond, Tier 2 = Asterisk

Source: NH Insurance Department
## Top Drugs by Therapeutic Class by Paid Amount 2009-2010

<table>
<thead>
<tr>
<th>Therapeutic Class</th>
<th>2009</th>
<th>2010</th>
<th>PMPM Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Cost</td>
<td>PMPM Cost</td>
<td>Total Cost</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>$1,018,030</td>
<td>$91</td>
<td>$1,253,857</td>
</tr>
<tr>
<td>Antihyperlipidemic Agents</td>
<td>$866,514</td>
<td>$115</td>
<td>$1,089,322</td>
</tr>
<tr>
<td>Proton Pump Inhibitors</td>
<td>$757,566</td>
<td>$211</td>
<td>$811,354</td>
</tr>
<tr>
<td>CNS Stimulants</td>
<td>$552,953</td>
<td>$190</td>
<td>$779,371</td>
</tr>
<tr>
<td>Sex Hormones</td>
<td>$607,203</td>
<td>$64</td>
<td>$743,387</td>
</tr>
<tr>
<td>Antidiabetic Agents</td>
<td>$595,973</td>
<td>$186</td>
<td>$729,592</td>
</tr>
<tr>
<td>Analgesics</td>
<td>$599,848</td>
<td>$71</td>
<td>$593,199</td>
</tr>
<tr>
<td>Immunosuppressive Monoclonal Antibodies</td>
<td>$310,807</td>
<td>$4,144</td>
<td>$550,817</td>
</tr>
<tr>
<td>Bronchodilators</td>
<td>$477,051</td>
<td>$147</td>
<td>$541,940</td>
</tr>
<tr>
<td>Dermatological Agents</td>
<td>$303,467</td>
<td>$89</td>
<td>$371,602</td>
</tr>
<tr>
<td>Anticonvulsants</td>
<td>$326,883</td>
<td>$80</td>
<td>$326,487</td>
</tr>
<tr>
<td>Interferons</td>
<td>$280,646</td>
<td>$6,527</td>
<td>$322,900</td>
</tr>
<tr>
<td>Antirheumatics</td>
<td>$250,400</td>
<td>$2,385</td>
<td>$301,250</td>
</tr>
</tbody>
</table>

Source: UNH
The scattergraph shows the relationship between the rate of payments and the rate of effective and preventive care. The graph's vertical axis displays the rate of payment per member per month (PMPM) adjusted for differences in age, gender, and health status of the population. The graph's horizontal axis displays the combined effective and preventive care score. The crosshair lines display the statewide average for each axis; subpopulations are classified into quadrants based on comparison to the statewide average.

SOURCE: VT BISHCA
### ETGs for Benign Conditions of the Uterus

**Maine Commercial Claims (2006–2007); Full Episodes Outliers Removed**

**Preference Sensitive Care**

<table>
<thead>
<tr>
<th>BENIGN CONDITIONS OF THE UTERUS</th>
<th>HYSTERECTOMY</th>
<th>OTHER SURGICAL PROCEDURES</th>
<th>WITHOUT SURGERY</th>
</tr>
</thead>
<tbody>
<tr>
<td>ETG-Subclass</td>
<td>646</td>
<td>646</td>
<td>647</td>
</tr>
<tr>
<td>Number of Episodes</td>
<td>938</td>
<td>2,183</td>
<td>7,369</td>
</tr>
<tr>
<td>% with CT-Scan</td>
<td>11%</td>
<td>15%</td>
<td>9%</td>
</tr>
<tr>
<td>% with Ultrasound</td>
<td>57%</td>
<td>67%</td>
<td>45%</td>
</tr>
<tr>
<td>% with Hysteroscopy</td>
<td>7%</td>
<td>48%</td>
<td>9%</td>
</tr>
<tr>
<td>% with Colposcopy</td>
<td>1%</td>
<td>2%</td>
<td>17%</td>
</tr>
<tr>
<td>% with Endometrial biopsy</td>
<td>20%</td>
<td>13%</td>
<td>9%</td>
</tr>
<tr>
<td>Average Payment per Episode</td>
<td>$11,074</td>
<td>$7,994</td>
<td>$1,273</td>
</tr>
</tbody>
</table>

The average episode payment for members with abdominal hysterectomy was $11,221, and the average payment for members with vaginal hysterectomy was $10,990. Of members with a hysterectomy, 66% had abdominal and 34% had vaginal hysterectomy. Other surgical procedures included hysteroscopy ablation, laparoscopic removal of lesions, myomectomy, and removal of ovarian cysts.

**SOURCE: ONPOINT HEALTH DATA**
<table>
<thead>
<tr>
<th>PRACTICE</th>
<th>TOTAL COST</th>
<th>TOTAL PMPM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site #1</td>
<td>$1,664,702</td>
<td>$81</td>
</tr>
<tr>
<td>Site #2</td>
<td>$2,666,268</td>
<td>$104</td>
</tr>
<tr>
<td>Site #3</td>
<td>$3,596,334</td>
<td>$147</td>
</tr>
<tr>
<td>Site #4</td>
<td>$4,949,153</td>
<td>$74</td>
</tr>
<tr>
<td>Site #5</td>
<td>$4,314,375</td>
<td>$135</td>
</tr>
<tr>
<td>Site #6</td>
<td>$1,820,459</td>
<td>$148</td>
</tr>
<tr>
<td>Site #7</td>
<td>$911,153</td>
<td>$116</td>
</tr>
<tr>
<td>Site #8</td>
<td>$1,236,719</td>
<td>$87</td>
</tr>
<tr>
<td>Site #9</td>
<td>$2,628,653</td>
<td>$93</td>
</tr>
<tr>
<td>Total</td>
<td>$23,787,817</td>
<td>$103</td>
</tr>
<tr>
<td>Non-Medical Home Sites</td>
<td>$1,010,233,075</td>
<td>$144</td>
</tr>
</tbody>
</table>

*Notes: Excludes pharmacy, preliminary, not risk adjusted, they were not annualized, and they were further not adjusted for contractual differences.
Tri-State Variation in Health Services Utilization & Expenditures in Northern New England, June 2010

Source: State of Vermont
APCD 2.0
APCD 2.0 Addresses:

• Completeness of Data Sets
• Data Collection Standards
• Data Release Standards
• Collection of Direct Patient Identifiers for Linkage Purposes
• Collection of Premium Information
• Collection of Supplemental Financial File
• Collection of Benefits Information
• Master Provider Index
<table>
<thead>
<tr>
<th>State</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorado</td>
<td>Based upon an initial 2011 report to Governor and General Assembly, all data transmitted from the carriers, including patient identifiers will be encrypted during transmission and while stored within the APCD. Data will be decrypted briefly as received from the carriers so that a unique identifier can be attached to each patient, and then re-encrypted. All data will be released without direct patient identifiers.</td>
</tr>
<tr>
<td>Kansas</td>
<td>Not currently allowed for commercial data, but due to the HBE, Kansas expects that within six months there will be an effort to change this. Kansas currently collects identifiable information for state employees and Medicaid.</td>
</tr>
<tr>
<td>Maine</td>
<td>Allowed by law, but prohibited by law from being disclosed; not currently collected. A 2011 legislative proposal intended to allow for release did not pass, but will be evaluated under a legislative study.</td>
</tr>
<tr>
<td>Maryland</td>
<td>Allowed by law. Currently collecting unencrypted patient identifiers.</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>Allowed by law. Currently collecting unencrypted patient identifiers.</td>
</tr>
<tr>
<td>Minnesota</td>
<td>Not currently allowed.</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>Not currently allowed.</td>
</tr>
<tr>
<td>New York</td>
<td>Allowed by law. System not implemented yet.</td>
</tr>
<tr>
<td>Oregon</td>
<td>Currently collecting a subset of unencrypted patient identifiers.</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>Not currently allowed.</td>
</tr>
<tr>
<td>Tennessee</td>
<td>Not currently allowed.</td>
</tr>
<tr>
<td>Utah</td>
<td>Allowed by law. Currently collecting unencrypted patient identifiers.</td>
</tr>
<tr>
<td>Vermont</td>
<td>Allowed by law. Currently collecting encrypted patient identifiers.</td>
</tr>
<tr>
<td>West Virginia</td>
<td>Allowed by law to be collected, but not disclosed.</td>
</tr>
</tbody>
</table>
Source: Vancouver Sun, Cargill Grain Silo, http://www.vancouversun.com/Photos+Alberta+Ogden+grain+elevator+reduced+rubble+after+demolition/5558683/story.html
CER studies; supplement HIE with APCD transactions; etc.

Rate review; MLR review; product /benefit design; etc.

Relationship studies between benefits and care delivery; quality rankings for HBE/HIX; etc.

Linkage Opportunities

APCD (administrative)

HIE/HIO (clinical)

HBE/HIX (insurance)

Shared Services*

* Future shared services opportunities might include master provider or patient indexes or other services.
Proposed Governance Model for Linkage of Direct Patient Identifiers and Data Release

Linkage Review Board Process Request and Conducts Linkage

Data Release Application Function (Board and Data Use Agreement)

De-identified Request 1

De-identified Request 2
Our Team

**Patrick Miller, MPH**, is a Research Associate Professor at the University of New Hampshire and founder and co-chair of the APCD Council. Patrick works with states across all aspects of APCD development, including stakeholder engagement, governance solutions, and analytic needs. For all media inquiries or for direct technical assistance, please contact Patrick at [Patrick.Miller@unh.edu](mailto:Patrick.Miller@unh.edu).

**Denise Love, BSN, MBA**, is the Executive Director at the National Association of Health Data Organizations (NAHDO). For all media inquiries or for direct technical assistance, please contact Denise at [dlove@nahdo.org](mailto:dlove@nahdo.org).

**Amy Costello, MPH**, is a Project Director at the New Hampshire Institute for Health Policy and Practice at the University of New Hampshire and co-chair for the APCD Council. Amy advises organizations and state agencies that are interested in the development, standardization and utility of all-payer healthcare claims databases. For all inquiries regarding standards, please contact Amy at [Amy.Costello@unh.edu](mailto:Amy.Costello@unh.edu).

**Ashley Peters, MPH**, is a Research Associate at the New Hampshire Institute for Health Policy and Practice at the University of New Hampshire. She conducts APCD-related research and manages communications for the Council. For all general inquiries, please contact Ashley at [Ashley.Peters@unh.edu](mailto:Ashley.Peters@unh.edu).

**Josephine Porter, MPH**, serves as Deputy Director for the New Hampshire Institute for Health Policy and Practice at the University of New Hampshire and co-chair for the APCD Council. Jo focuses much of her time on APCD analysis, including an emphasis of using APCD data in public health. For all business development related inquiries, please contact Jo at [Jo.Porter@unh.edu](mailto:Jo.Porter@unh.edu).

**Alan Prysunka**, is the Executive Director of the Maine Health Data Organization and Chair of the National Association of Health Data Organizations (NAHDO) Board of Directors. For direct technical assistance, please contact Alan at [alan.m.prysunka@maine.gov](mailto:alan.m.prysunka@maine.gov).

**Emily Sullivan** is a Research Associate at the National Association of Health Data Organizations (NAHDO). For inquiries related to publications and conference events, please contact Emily at [esullivan@nahdo.org](mailto:esullivan@nahdo.org).
Questions and Answers

Contact Information

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603.536.4265

www.apcadcouncil.org
Making Measuring Health Care Quality Meaningful

National Association of Medicaid Directors
November 9, 2011
Katie Dunn, MPH, NH Medicaid Director
NH Medicaid Enrollment by Health Analysis Area, December 2010

Medicaid Enrollees as a Percent of Total Population

- <10%
- 10.0% - 12.9%
- 13.0% - 15.9%
- 16% +

Eligibility Groups as a Percent of Medicaid Population

Size of Pie Represents Relative Number of Medicaid Enrollees

- Low Income Child
- Low Income Adult
- Severely Disabled Child
- Disabled Physical
- Disabled Mental
- Elderly
- SLMB & QMB

NH Enrollees by Eligibility Groups

- Low Income Child 63%
- Low Income Adult 13%
- Severely Disabled Child 1%
- Disabled Physical 7%
- Disabled Mental 9%
- Elderly 7%

NH DHHS NAMD Presentation 11-9-11
What is the definition of quality care?

The Institute of Medicine (IOM) has defined quality as:

“The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”

Definition suggests that:

- Quality performance occurs on a continuum, theoretically ranging from unacceptable to excellent;
- The focus is on services provided by the health care delivery system;
- Quality may be evaluated from the perspective of individuals or populations;
- Research evidence must be used to identify the services that improve health outcomes; and
- In the absence of scientific evidence regarding effectiveness, professional consensus can be used to develop criteria.

**Key Point: Illustrates the complexity of the concept and its evaluation.**

From *Health Affairs*, “Six Challenges in Measuring the Quality of Health Care” by Elizabeth A McGlynn  May/june 1997. Vol 16, No. 3
What does quality care look like?

- Visible problems of uninsured/underinsured and soaring costs
- Invisible problem is poor quality that takes the form of:
  - Underuse, Overuse and Misuse
- AHRQ:
  - “Doing the right thing for the right patient, at the right time, in the right way to achieve the best possible results.”
- But as Peggy Lee crooned in 1969 “Is That All There Is?”
  - Where does achieving quality health care translate into achieving quality of life?
Is there a health care quality problem in the US?

- Health care quality experts predominantly agree that quality health care is:
  - **Safe.** It does not injure patients; it is supposed to help.
  - **Effective.** It is based on sound science to all who can benefit and refrains from providing services to those who cannot.
  - **Patient-centered.** It is respectful of and responsive to patient's preferences, needs and values.
  - **Timely.** It reduces waiting time and potentially harmful delays.
  - **Efficient.** It does not waste resources.
  - **Equitable.** It does not vary because of someone's race, gender, income or location.

- What does this mean to Medicaid recipients?
Consumer-Purchaser Disclosure Project

Published in September 2011 “Ten Criteria for Meaningful and Usable Measures of Performance

Sample criteria:

1. Make consumer and purchaser needs a priority in performance measurement.
2. Use direct feedback from patients and their families to measure performance.
3. Build a comprehensive “dashboard” of measures that provides a complete picture of the care patients receive.

To read full article: www.healthcaredisclosure.org
What would a Medicaid recipient say is meaningful?

- October 2011 NH Medicaid Stakeholder Engagement Process
- Question re: Quality:
  - Maximized Quality of Life is living in least restricted environment possible, maximizing social and emotional well-being, a life that’s as comfortable as possible and with the least invasive treatments.
  - Providing fair and adequate reimbursement for health care providers is the #1 concern for providers and caregivers/families.
  - People want to be treated like people, not statistics
  - Suggested useful indicators include:
    - Rates of improvement in program user understanding of health and system
    - Rates of change in satisfaction of program users
    - Rates of change in satisfaction of providers
    - Access indicators for prevention activities – reductions in length of time from call until appointment
    - Personal behavior changes/compliance
Application of Comprehensive Health Care Information System (CHIS)

“…to make health care data available as a resource for insurers, employers, providers, purchasers of health care and state agencies to continuously review health care utilization, expenditures and performance in NH and to enhance the ability of NH consumers and employers to make informed and cost-effective health care choices.”

Source: Standard statement in all NH DHHS CHIS reports quoted from NH RSA 420-G:11-a
### Healthcare Effectiveness Data and Information Set (HEDIS) Program Measures

#### NH MEDICAID COMPARED TO NATIONAL MEDICAID

<table>
<thead>
<tr>
<th>Access to Primary Care: Children</th>
<th>NH Medicaid %</th>
<th>National Medicaid %</th>
<th>NH Medicaid %</th>
<th>National Medicaid %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 0 to 11 months</td>
<td>99%</td>
<td>N/A</td>
<td>98%</td>
<td>N/A</td>
</tr>
<tr>
<td>Age 12 to 24 months</td>
<td>98%</td>
<td>93%</td>
<td>98%</td>
<td>93%</td>
</tr>
<tr>
<td>Age 25 months to 6 years</td>
<td>86%</td>
<td>84%</td>
<td>90%</td>
<td>84%</td>
</tr>
<tr>
<td>Age 7 to 11 years</td>
<td>84%</td>
<td>86%</td>
<td>87%</td>
<td>86%</td>
</tr>
<tr>
<td>Age 12 to 18 years</td>
<td>90%</td>
<td>83%</td>
<td>91%</td>
<td>83%</td>
</tr>
</tbody>
</table>

#### Preventive Care: Well Child Visits

| Age 16 to 35 months             | 89%           | N/A                 | 89%           | N/A                 |
| Age 3 to 6 years                | 69%           | 65%                 | 72%           | 65%                 |
| Age 7 to 11 years               | 54%           | N/A                 | 52%           | N/A                 |
| Age 12 to 18 years              | 49%           | 42%                 | 50%           | 42%                 |

#### Access to Preventive/Ambulatory Health Services

| Age 20+                         | 89%           | N/A                 | 91%           | N/A                 |
| Age 20 to 44                    | 88%           | 77%                 | 89%           | 77%                 |
| Age 45 to 64                    | 93%           | 82%                 | 94%           | 82%                 |
| Age 65+                         | 93%           | 79%                 | 90%           | 79%                 |

#### Annual Dental Visit

| Age 2 to 3                      | 44.9%         |                     | 50.1%         |                     |
| Age 4 to 6                      | 70.4%         |                     | 72.8%         |                     |
| Age 7 to 10                     | 75.3%         |                     | 77.9%         |                     |
| Age 11 to 14                    | 71.7%         |                     | 73.8%         |                     |
| Age 15 to 18                    | 66.1%         |                     | 67.5%         |                     |
| Age 19 to 21                    | 37.6%         |                     | 41.6%         |                     |

#### MEDICAID TO COMMERCIAL COMPARE

<table>
<thead>
<tr>
<th>Preventive Care: Adult Preventive Screenings</th>
<th>NH Medicaid %</th>
<th>Commercial</th>
<th>NH Medicaid %</th>
<th>Commercial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Screening</td>
<td>54%</td>
<td>50%</td>
<td>50%</td>
<td>76%</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>60%</td>
<td>65%</td>
<td>58%</td>
<td>73%</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>31%</td>
<td>N/A</td>
<td>31%</td>
<td>47%</td>
</tr>
</tbody>
</table>

| Comprehensive Diabetes Care                |               |            |               |            |
| Eye Exam                                    | 51%           | 50%        | 48%           | 56%        |
| HbA1c testing                               | 80%           | 77%        | 77%           | 81%        |
| LDL testing                                 | 70%           | 71%        | 69%           | 74%        |
| Monitoring for Diabetic nephrology          | 84%           | 74%        | 84%           | 70%        |
Medicaid Report Card

Results for: Use of Appropriate Medications for People with Asthma (ASM)

Measures by Year

Data

<table>
<thead>
<tr>
<th>Year</th>
<th>Measure Numerator</th>
<th>Measure Denominator</th>
<th>Measure Value</th>
<th>NH Benchmark</th>
<th>National Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>1,565</td>
<td>1,788</td>
<td>87.53%</td>
<td>91.4%</td>
<td>88.37%</td>
</tr>
<tr>
<td>2009</td>
<td>1,380</td>
<td>1,583</td>
<td>87.18%</td>
<td>89.9%</td>
<td>88.57%</td>
</tr>
<tr>
<td>2008</td>
<td>1,542</td>
<td>1,751</td>
<td>88.06%</td>
<td>90.7%</td>
<td>86.9%</td>
</tr>
<tr>
<td>Service Group (COS)</td>
<td>Service Sub-group</td>
<td>Sampled Procedures 2007</td>
<td>Rate as % of NH Medicaid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>------------------</td>
<td>------------------------</td>
<td>-------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Current Rate</td>
<td>Total Amount Paid</td>
<td>Total Units (Claims Paid)</td>
<td>NH Medicaid</td>
</tr>
<tr>
<td>Physician Services</td>
<td>Primary Care E&amp;M</td>
<td>$59.60</td>
<td>$2,533,128</td>
<td>42,034</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Primary Care Prevention (99381-99397)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Services</td>
<td>Primary Care Treatment (99201-99215))</td>
<td>$49.56</td>
<td>$6,660,896</td>
<td>133,768</td>
<td>100%</td>
</tr>
<tr>
<td>Psychology (nonCHMC)</td>
<td>Psychotherapy, Office 45-50 min (90806</td>
<td>$65.00</td>
<td>$3,067,350</td>
<td>45,263</td>
<td>100%</td>
</tr>
</tbody>
</table>
Is this data meaningful? If so, to whom?

- For Medicaid programs
  - Yes, if then able to translate the data into actionable initiatives.
  - NH does not have a dedicated quality improvement focused unit and limited analytic capacity. Addressing this is a priority.

- For Medicaid recipients
  - How do we translate this data into something that adds value and results in engagement for recipients?
    - Need to have a way to engage the public, not just Medicaid recipients. How do we establish the common ground and conversation that recognizes our collective humanity?

- Think we need new measures. How can Medicaid Directors help inform the discussion and be at the table for decision making?