



Department
of Health

Medicaid
Redesign Team

NY DSRIP HEDIS[®] Measure Reporting

October 2015

Six HEDIS[®] Hybrid Measures for PPS Reporting

1. Controlling High Blood Pressure (CBP)
2. Comprehensive Diabetes Care (CDC)
3. Prenatal and Postpartum Care (PPC)
4. Frequency of Ongoing Prenatal Care (FPC)
5. Childhood Immunization Status (CIS)
6. Lead Screening in Children (LSC)

Two non-HEDIS[®] measures for PPS Reporting

1. Screening for Clinical Depression (SCD)
2. Viral Load Suppression (VLS)

What is HEDIS®?

HealthCare Effectiveness Data & Information Set

- A collective summary of an organization's annual performance
- Developed by the National Committee for Quality Assurance
- Measurement protocol for the healthcare delivery system, reported by more than 90% of health plans in the U.S.
- 88 measures across 7 domains of care

How is HEDIS® Used?

Nationally

Quality Compass – comparison of health plans regionally and nationally

Component of MCO accreditation

Medicare Advantage plans must report performance for CMS Star rating system

US News and World Report – annual ranking of health plans

New York

Public Reporting

- Annual Managed Care performance – eQARR
- Access and utilization report
- Medicaid consumer guides

Quality Improvement

- Quality improvement matrices
- Focus studies/performance improvement projects

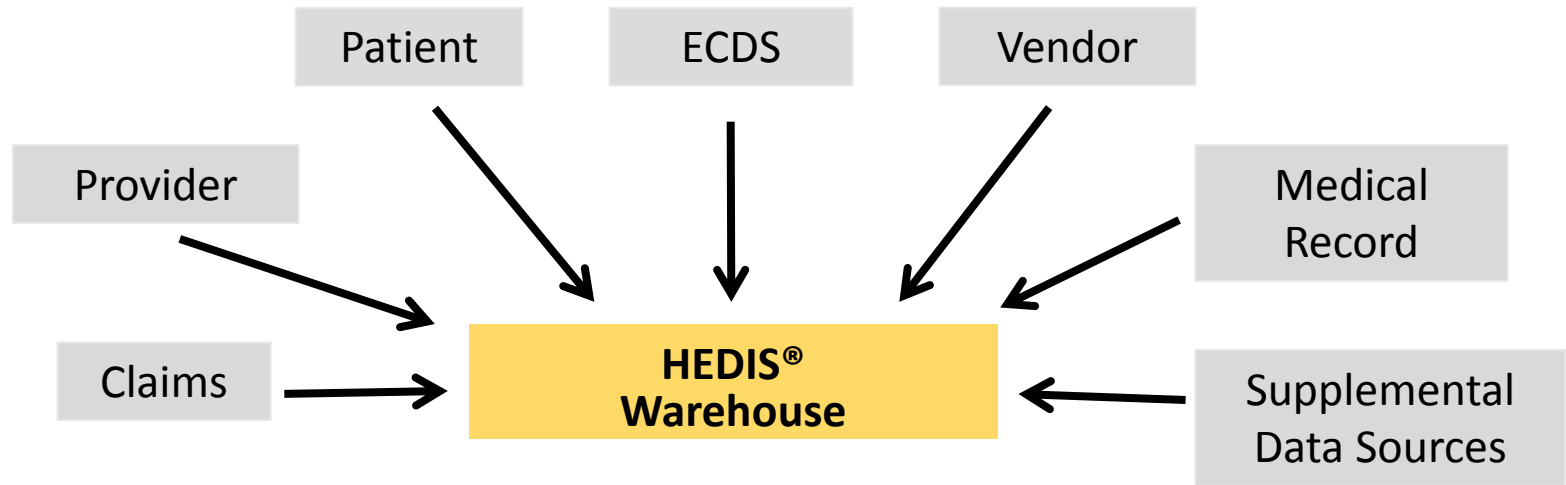
Financial Incentives (Medicaid)

- Auto-assignment preference
- Value-based purchasing (in development)
- Quality incentive

Glossary of Terms

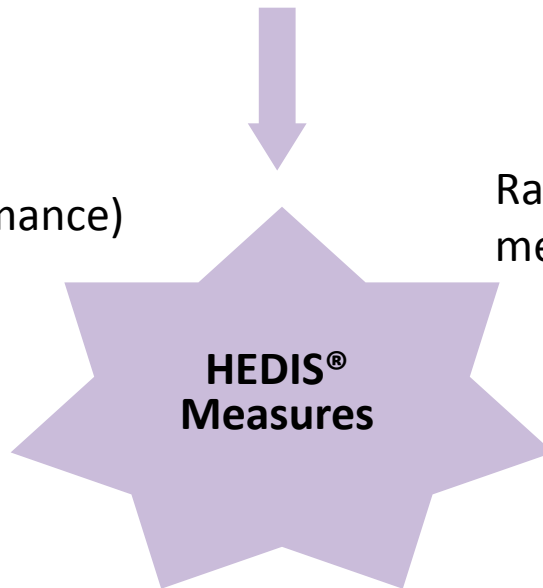
- **Eligible Population (EPOP):** target population (denominator) minus exclusions who could *potentially* receive the service
- **Numerator:** all who receive the service
- **Denominator:** the target population
- **Exclusions:** those in the EPOP who should *not* receive the service (required or optional)
- **Continuous Enrollment:** period of time needed to ensure ample opportunity for the service to be provided
- **Enrollment Gap:** allowable time not enrolled to maximize the size of the EPOP
- **Look Back Period:** time period prior to the measurement period to calculate the measure
 - e.g., Persons with diabetes can be identified in the year prior to the measurement year
 - e.g., For the timeliness of prenatal care measure, 280 days prior to delivery identifies the first trimester

Creating HEDIS® Measures



Numerator/Denominator * 100
(higher results = “better” performance)

Rates: number of events per 1,000 members





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Controlling High Blood Pressure

October 2015

Controlling High Blood Pressure Specifications

Description: Percentage of Medicaid members 18-85 years of age who had a diagnosis of hypertension (HTN) and BP effectively controlled during the MY.

Numerator: Members with effective BP control during the MY as defined by the following criteria: :

- Members 18-59 years of age whose BP was <140/90 mm Hg
- Members 60-85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg
- Members 60-85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg

One rate is reported, and is the sum of all three groups.

Denominator : Members aged 18 to 85 years, who have hypertension confirmed by the medical record. There is a flag for members with and without diabetes.

Exclusions (optional): Members with ESRD or kidney transplant on or prior to June 30th 2015. Pregnant members during MY. Non-acute inpatient admission during MY.

MMC Plan eQARR 2014 Rates ¹	Controlling High Blood Pressure
NY Statewide Average	63%
National Average	56%

¹eQARR 2014 http://www.health.ny.gov/health_care/managed_care/reports/eqarr/2014/statewide/medicaid/managing_cardiovascular_conditions.htm

Controlling High Blood Pressure Importance of the Topic

- Heart disease is the leading cause of death for both men and women. Every year about **610,000 people** die of heart disease in the United States—that's **1 in every 4 deaths**²
- Hypertension is a major modifiable risk factor for cardiovascular disease³
 - Approximately 50% of US adults reported to have inadequately controlled hypertension
 - Estimated annual national cost is \$51 billion

² CDC, NCHS. Underlying Cause of Death 1999-2013 on [CDC WONDER Online Database](https://wonder.cdc.gov/), released 2015. Data are from the Multiple Cause of Death Files, 1999-2013, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed Feb. 3, 2015.

³CDC Million Hearts Campaign. Blood pressure toolkit. <http://millionhearts.hhs.gov/resources/toolkits.html#bpToolkit>

Controlling High Blood Pressure Relevance to DSRIP Goals

- Heart disease is the leading cause of death for NY Medicaid-enrollees, with hypertension among the top ten causes of death
- NYS Prevention Agenda goal to promote evidence-based care to manage chronic disease, specifically blood pressure control.
- Blood pressure management requires engagement of delivery system, patients, providers and communities.
 - Medication-prescribing, adherence, patient-provider communication, team-based care
 - Multidisciplinary teams to facilitate lifestyle changes
- Million Hearts Campaign Hypertension Control Change Package
 - Establish practice foundations for hypertension control
 - Population health management
 - Patient supports

More than half (56%) of the PPSs are participating in a project to address cardiovascular disease (3.b.i and 3.b.ii)



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Comprehensive Diabetes Care

October 2015

Comprehensive Diabetes Care Specifications

Description: Percentage of members aged 18-75 years of age with diabetes (type 1 and type 2) during the MY or the year prior who had following

(4 numerators):

- HbA1c test performed
- HbA1c poor control >9% (lower rate is desirable)
- Dilated eye exam
- Medicaid attention for nephropathy

Denominator: Members 18-75 as of June 30th identified as having diabetes (either by claim/encounter data or by pharmacy data), continuously enrolled with no more than 1 gap of up to 45 days

Exclusions (optional): Non-diabetic members who either had polycystic ovaries anytime in their medical history through June 30th 2015, or had a diagnosis of gestational diabetes or steroid-induced diabetes during the MY or year prior.

MMC Plan eQARR Rates ¹	HbA1c Testing	HbA1c Poor Control*	Dilated Eye Exam	Nephropathy Monitoring
MMC NYS Average	89%	32%	63%	83%
National Average	84%	46%	54%	79%

* Lower rate is desirable

¹eQARR http://www.health.ny.gov/health_care/managed_care/reports/eqarr/2014/statewide/medicaid/managing_diabetes_outcomes.htm

Comprehensive Diabetes Care Importance of the Topic

- Diabetes prevalence in New York is increasing.
- Higher rates of hospitalization and hospital care exist among those with diabetes

Diabetes-Related Medicaid Expenditures in New York State by Category of Service (in millions of dollars)

	SFY 2008-09	SFY 2013-14	Five-Year Change	Percentage Change
Prescription Drugs	\$295.3	\$540.5	\$245.1	83.0%
Personal Care	128.4	234.1	105.7	82.3%
Inpatient	139.2	137.2	-2.1	-1.5%
Home Health	206.5	109.7	-96.8	-46.9%
Physician	23.4	46.1	22.7	97.0%
Clinic (non ER)	36.0	45.4	9.4	26.1%
Nursing	76.7	32.7	-44.0	-57.4%
Emergency Room	1.4	3.2	1.8	125.0%
Other Service Categories	39.1	90.8	51.7	132.2%
Total	\$946.1	\$1,239.8	\$293.7	31.0%

Source: Office of the State Comptroller analysis of Medicaid fee-for-service claims and managed care encounter data from DOH.

Figure 3

Average Medicaid Hospitalizations for Diabetes Among Adult Enrollees (for Calendar Years 2011, 2012 and 2013; unadjusted rates per 100,000 enrollees)

County	Hospitalizations for Diabetes	Medicaid Population	Diabetes Hospitalization Rate
Five Highest			
Seneca	25	4,340	576.0
Bronx	2,908	525,041	553.8
Niagara	155	32,424	478.0
New York (Manhattan)	1,639	364,179	450.0
Chemung	65	16,036	403.3
Five Lowest			
Tioga	11	7,074	160.2
Schuyler	5	3,174	157.5
Washington	12	7,905	151.8
Delaware	9	7,176	125.4
Yates	3	3,486	95.6
Statewide	15,006	3,885,171	386.2

Source: NYS DOH DSRIP performance data.

- Diabetes-related costs for Medicaid members in 2013-14 represented about 10% of DOH's estimated \$12 billion in overall diabetes spending in New York.
- Expenditures for Medicaid beneficiaries with diabetes are 3x higher than adult beneficiaries without diabetes, costing nation \$245 billion.
- Diabetes is especially costly since 25%-45% of diabetes-attributed medical expenditures were spent treating complications.

Aubert RE, Geiss LS, Ballard DJ, Cocanougher B, Herman WH: Diabetes-related hospitalization and hospital utilization. *In Diabetes in America*. 2nd ed. Bethesda, MD, National Institutes of Health, 1995, p. 553-570 (NIH publ. no. 95-1468)

Office of the State Comptroller analysis of Medicaid fee-for-service claims and managed care encounter data from DOH.

<http://content.healthaffairs.org/content/31/1/159.full>

American Diabetes Association. Economic costs of diabetes in the U.S. in 2007. *Diabetes Care* 2008; 31:596-615

American Diabetes Association. Economic Costs of Diabetes in the U.S. in 2012. *Diabetes Care* 2013; 36:1033-1046, 2013.

Comprehensive Diabetes Care DSRIP and Clinical Relevance

- DSRIP affords the opportunity for care coordination in order to improve the consistency and quality of care to patients
- A1c is the primary predictor of diabetic complications.
 - Optimizing a1c control decreases the risk of microvascular (kidney disease and retinopathy) and cardiovascular complications
 - Diabetes self-management education is associated with optimal control
- Monitoring A1C and screening for retinopathy and nephropathy allows for early identification and relevant interventions for these conditions
- **44% of the PPSs are participating in a DSRIP project to address Diabetes care (3.c.i and 3.c.ii)**



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Prenatal and Postpartum Care

October 2015

Prenatal and Postpartum Care Specifications

Description: Percentage of live birth deliveries between May 6th to May 5th of the following year, including:

- **Timeliness of Prenatal Care:**

Numerator: the percentage of deliveries that received a prenatal care visit as a member in the first trimester or within 42 days of enrollment in Medicaid.

- **Postpartum Care:**

Numerator: the percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.

Denominator: Medicaid members who delivered a baby in the last year, continuously enrolled 43 days prior to the delivery through 56 days after delivery.

Exclusion: Non-live births

MMC Plan eQARR Rates ¹	Prenatal Care in the First Trimester	Risk-Adjusted Low Birthweight (LBW)*	Risk-Adjusted Primary Cesarean Delivery*	Vaginal Birth After Cesarean Section (VBAC)
Statewide Average	72.0%	6.6%	16.0%	14.3%

* Lower rate is desirable

¹ eQARR 2014 http://www.health.ny.gov/health_care/managed_care/reports/eqarr/2014/statewide/medicaid/perinatal_health.htm

Prenatal and Postpartum Specifications

Prenatal care visit to an OB/GYN or PCP with diagnosis of pregnancy. Medical record must include the date and *one* of the following:

1. A basic physical obstetrical exam that includes auscultation for fetal heart tone, **or** pelvic exam with obstetric observations, **or** measurement of fundus height.
2. Evidence a prenatal care procedure was performed: screening test in the form of an obstetric panel, **or** TORCH antibody panel alone, **or** a rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, **or** echography of a pregnant uterus
3. Documentation of LMP or EDD in conjunction with *either* prenatal risk assessment and counseling/education **or** complete obstetrical history

Postpartum visit to an OB/GYN practitioner or midwife, family practitioner or other PCP on or between 21 and 56 days after delivery.

Medical record must include the date and *one* of the following:

1. Pelvic exam
2. Evaluation of weight, BP, breasts and abdomen
3. Notation of postpartum care, including, but not limited to notation of “postpartum care,” “PP care,” “PP check,” “6-week check,” **or** a preprinted “Postpartum Care” form in which information was documented during the visit

Prenatal and Postpartum Care Clinical Relevance and Importance

- Late initiation of prenatal care is associated with increased risk for adverse outcomes
 - Delayed identification of complications
 - Delayed evidence-based interventions for prevalent risk factors among Medicaid-enrolled women
 - Tobacco cessation
 - 17 α -hydroxyprogesterone caproate for prior preterm
 - Appropriate gestational weight gain for overweight/obese women
 - Aspirin prophylaxis for women at high risk for preeclampsia
- Postpartum care is essential for maternal and infant health and positive outcomes for subsequent pregnancies
 - Follow-up of pregnancy-associated conditions
 - Reproductive planning for appropriate birth spacing
 - Initiation of inter-conception care

Prenatal and Postpartum Care DSRIP and Clinical Relevance

PPSs can facilitate coordination of care and patient adherence to visits and treatment plans to ensure optimal outcomes.

Prenatal

- Facilitate timely access to appropriate prenatal providers
- Coordinate providers for optimal management of chronic conditions and behavioral risks, such as obesity, depression and tobacco dependence
- Target high risk subpopulations for ongoing support

Postpartum

- Facilitate follow-up assessment and care of pregnancy-associated and chronic conditions, such as diabetes screening, evaluation of hypertension
- Facilitate the initiation of inter-conception care and appropriate birth spacing
 - Coordinate reproductive planning by hospitals and postpartum providers
 - Postpartum weight management programs for overweight and obese women
 - Linkage to ongoing care for chronic conditions

16% of the PPSs are participating in project 3.f.i to address Prenatal and Postpartum care



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Frequency of Ongoing Prenatal Care

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Frequency of Ongoing Prenatal Care Specifications

Description: Percentage of Medicaid deliveries between May 6th to May 5th of the following year that had $\geq 81\%$ of expected visits

Numerator: women who had $\geq 81\%$ of the expected amount of prenatal care visits that were unduplicated, adjusted for the month the member enrolled in Medicaid and gestational age (GA). GA defined as the number of completed weeks that elapsed between the first day of the last normal menstrual period (LMP) and the date of delivery.

Denominator: same as the *Prenatal and Postpartum Care* measure (Medicaid members who delivered a baby who were continuously enrolled 43 days prior to the delivery through 56 days after delivery)

Exclusion: Non-live births

Frequency of Ongoing Prenatal Care Relevance to DSRIP

- Adequate prenatal care ensures early risk identification and management for optimal outcomes
- PPSs can facilitate coordination of appropriate resources for
 - Timely testing for risks associated with adverse outcomes (e.g. asymptomatic bacteriuria, diabetes and Group B strep screening)
 - Assessment, monitoring and self management of chronic and pregnancy-associated conditions (e.g. diabetes, hypertensive disorders)
 - Monitoring and interventions for psychosocial risks (e.g. smoking, depression, intimate partner violence)
 - Appropriate gestational weight gain
 - Adherence to treatment plans
 - Patient self-management

16% of the PPSs are participating in project 3.f.i to address Prenatal and Postpartum care

<https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/Pages/prenatal-care.aspx>

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, "National Quality Measures Clearing House," accessed October 1, 2014,

<http://www.ncqa.org/portals/0/Prenatal%20Postpartum%20Care.pdf>

AAP/ACOG Guidelines for Perinatal Care, 6th Edition 2007





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Childhood Immunization Status

October 2015

Childhood Immunization Status Specifications

Description and eligible population: The percentage of Medicaid children who turn 2 during the MY who received the immunizations outlined in the table below (i.e., combo 3) by their 2nd birthday. These children must have been enrolled in Medicaid for 12 continuous months with a gap of no more than 45 days.

Immunization	Count
Diphtheria, Tetanus and acellular Pertussis (DTaP)	4
Polio (IPV)	3
Measles, Mumps and Rubella (MMR)	1
Haemophilus Influenza Type B (HiB)	3
Hepatitis B (HepB)	3
Chicken Pox (VZV)	1
Pneumococcal Conjugate (PCV)	4

Numerator:

- For all 7 immunizations, count evidence of the antigen or combination vaccine
- For MMR, HepB, and VZV can also count history of the illness or seropositive test result

MMC Plan eQARR Rates ¹	Combo 3
MMC NYS Average	73%
National Average	71 %

Exclusions (optional): Exclude children who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rates. The denominator for all rates must be the same.

¹ eQuarr 2014 http://www.health.ny.gov/health_care/managed_care/reports/eqarr/2014/statewide/medicaid/child_preventive_care.htm

Childhood Immunization Status DSRIP and Importance of Topic

Consistent with DSRIP goal of improving child health through the first two years of life

- Vaccines are among the most cost-effective clinical preventive services
- Immunizations provide a defense against a host of common diseases that can cause severe illness or death, and lead to avoidable hospitalization
 - Nationally, for each birth cohort vaccinated with the routine immunization schedule (this includes DTap, Hib, IPV, MMR, HepB, and VZV):
 - 33,000 lives are saved
 - 14 million cases of disease are prevented
 - \$9.9 billion in direct health care costs are reduced
 - \$33.4 billion in indirect costs are saved

Consistent with NYSDOH Prevention Agenda, Focus Area 2: Child Health

- Objective to increase the proportion of NYS children who receive key recommended preventive health services as part of routine well-child care by December 31, 2017
 - Indicator specific to CIS measure: increase percentage of 19-35 month olds who have received the Combination 3 vaccines to 80% by 2017



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Lead Screening in Children

October 2015

Lead Screening in Children Specifications

Description: Percentage of children who had one or more capillary or venous lead blood tests for lead poisoning by their 2nd birthday

Numerator: At least one lead capillary or venous blood test on or before the child's 2nd birthday as documented through either administrative data or medical record review, including test date and result or finding

Denominator: children who turn 2 during the MY, with 12 months continuous enrollment in Medicaid with a gap of no more than 45 days

MMC Plan eQARR Rates ¹	Lead Screening in Children
MMC NYS Average	87%
National Average	66%

¹eQARR 2014 http://www.health.ny.gov/health_care/managed_care/reports/eqarr/2014/statewide/medicaid/managing_cardiovascular_conditions.htm

Lead Screening in Children DSRIP and Clinical Relevance

- Any level of lead in blood levels can have adverse effects¹
 - Blood lead level testing is required for children 12-24 months
 - Children with blood lead levels of 5 µg/dL or higher require ongoing monitoring
 - Blood lead levels less than 10 µg/dL have been associated with adverse health effects (e.g. IQ deficits, attention-related behaviors, and academic achievement, cardiovascular, endocrine, and immunologic effects)
- New York State children are particularly at risk²
 - More pre-1950 housing containing lead paint than any other state
 - Risk assessment is recommended annually for all children 6 months to 6 years

¹ACCLPP Report. Low level lead exposure harms children: a renewed call for primary prevention. Available at: http://www.cdc.gov/nceh/lead/acclpp/blood_lead_levels.htm

²New York State Lead Poisoning Prevention Program. Information for health care providers. https://www.health.ny.gov/environmental/lead/health_care_providers/index.htm

Domain 3 Clinical Improvement Metrics

Measure Name	Performance Goal	NYS QARR 2014 Rates
Prenatal and Postpartum Care- timeliness of Prenatal care	93.9%	88.0%
Prenatal and Postpartum Care—postpartum visits	81.6%	70.0%
Frequency of Ongoing Prenatal Care (81% or more)	81.4%	70.0%
Childhood Immunization Status (Combination 3)	88.4%	73.0%
Lead Screening in Children	95.3%	87.0%
Comprehensive Diabetes Care (HbA1c testing, dilated eye exam, nephropathy monitoring)	62.5%*	51.0%*
Comprehensive Diabetes Care- HbA1c poor control (>9%) ±	23.2%	32.0%
Controlling High Blood Pressure	73.3%	63.0%

*Includes lipid profile

± Lower rate is desirable

Questions

Please send all questions via email to:

DSRIP@health.ny.gov

OR

Please reach out to your Performance Facilitator

OR

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