

Alaska Medicaid Redesign Quality and Cost Effectiveness Targets Report

August 2017

Submitted to Valerie Davidson, Commissioner, Alaska Department
of Health and Social Services

Prepared by the Alaska Medicaid Redesign Quality and Cost
Effectiveness Targets Stakeholder Workgroup



GOALS FOR MEDICAID REDESIGN + EXPANSION

IMPROVE
HEALTH



OPTIMIZE
ACCESS



INCREASE
VALUE



CONTAIN
COSTS



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FOREWORD

This report is submitted to Valerie Davidson, Commissioner, Alaska Department of Health and Social Services, from the Alaska Medicaid Redesign Quality and Cost Effectiveness Targets Stakeholder Workgroup.

ALASKA MEDICAID REDESIGN QUALITY AND COST EFFECTIVENESS TARGETS STAKEHOLDER WORKGROUP

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EXECUTIVE SUMMARY

Passage of Alaska Senate Bill 74 (SB74) in 2016 laid the groundwork for Medicaid redesign efforts to improve the quality, performance and cost effectiveness of Alaska's Medicaid program. The Department of Health and Social Services (the Department) has been working diligently to implement reforms that will have a positive impact on Medicaid recipient health outcomes and the overall health care delivery system.

One of the elements in SB74 directs the Department to establish annual quality and cost effectiveness targets that will drive continuous improvements in Medicaid program performance. The Department convened the Medicaid Redesign Quality and Cost Effectiveness Targets Stakeholder Workgroup (Q&CE) to develop recommendations on measures the Department could use to evaluate and monitor the overall quality of the Medicaid program, and help determine the cost effectiveness of program expenditures. The 16-member work group, which includes representatives of health care providers, facilities, tribal health organizations, and consumers, first met in October 2016, meeting several more times before concluding its work August 1, 2017.

The workgroup focused on two primary tasks to produce its recommendations:

- Identify measures to evaluate desired performance; and
- Establish performance goals and targets for each measure.

As a result of its deliberations, the workgroup identified 18 quality and cost effectiveness measures it believes will help the Department monitor program quality as Medicaid redesign efforts move forward. The workgroup also identified corresponding five-year performance targets for each measure, from which annual targets have been calculated. This report transmits the workgroup's measure and target recommendations to the Department (Appendix A).

Throughout the course of its work, the workgroup encountered several issues that impacted selection of the final measures and targets. The more significant of these issues are also included in the report along with recommendations that may help the Department develop more comprehensive measures in the future.

PROJECT BACKGROUND

Recent activities at both the state and national level have provided the Department with unique opportunities to drive changes within the Medicaid program that improve both Medicaid enrollee health and cost effectiveness of the program. Medicaid expansion under the federal Affordable Care Act and a downturn in Alaska's economy has increased program enrollment in Alaska to 183,000¹ enrollees, with new enrollees being added each week. With this growth, the Department has a significant opportunity to focus on program outcomes to support a healthier population that will require less costly health care services.

Coinciding with Medicaid expansion, the state has experienced an economic downturn that has forced reductions in the state budget that are impacting the Medicaid program. The Department's budget has been cut more than 17 percent over the past two years and more cuts are expected. To date these budget cuts have not led to reductions in the level of health care services provided to recipients. However, if program changes are not made to improve recipient health and reduce the need for higher cost services, the Department may be required to reduce services to recipients in the near future.

In 2016, the Legislature passed Senate Bill 74 (SB74) focusing on broad redesign of the Medicaid program to improve health outcomes and program efficiency. Maintaining and improving quality while also improving efficiency will be a cornerstone of redesign efforts.

Although the program annually submits results of performance on national Medicaid quality measures to the federal Centers for Medicare and Medicaid Services² (CMS), SB74 calls for the Department to develop annual targets for quality and cost effectiveness measures identified by the Department. Rather than simply adopting the CMS measures, the Department chose to develop measures that will follow the progress of Alaska's Medicaid program as it evolves in response to reform efforts. An external stakeholder workgroup was formed to help the Department accomplish this goal by developing recommendations for quality and cost effectiveness measures and identifying corresponding annual performance targets.

¹ Medicaid in Alaska Dashboard: <http://dhss.alaska.gov/HealthyAlaska/Pages/dashboard.aspx>. Reviewed June 7, 2017.

² Quality of Care for Children in Medicaid and CHIP: Findings from the 2015 Child Core Set. Reviewed June 22, 2017. <https://www.medicare.gov/medicaid/quality-of-care/downloads/performance-measurement/2016-child-chart-pack.pdf>

METHODOLOGY

The 16-member Quality and Cost Effectiveness Targets Stakeholder Workgroup began meeting in October 2016. Members of the workgroup include volunteers representing providers and provider organizations, tribal health organizations, and members of the public. The workgroup had two primary tasks: identify measures to evaluate desired Medicaid program performance and establish annual performance targets the program should meet for each measure.

In addition to the external stakeholder workgroup, an internal workgroup of Department staff representing the Medicaid program, behavioral health, public health and health information technology services, provided technical assistance at key points throughout the process. The internal workgroup discussed and provided responses to stakeholder questions regarding the Medicaid program, identified data sources and other quality resources, and served as key points of communication within their divisions in an effort to keep Department leadership abreast of stakeholder activities.

MEASURE DEVELOPMENT

For structure, the Department provided the workgroup with three basic criteria each potential measure was required to meet:

1. Each measure must track outcomes on a Medicaid covered service;
2. The program must be able to influence performance on the measure; and
3. Data used to calculate performance must be readily accessible from an existing source (e.g. data necessary to identify performance on a measure must be available through Medicaid claims or other state resource, the measure may not require new reporting from providers).

The stakeholder workgroup created additional criteria to help identify initial measures that included items such as “must be based on scientific evidence” and “should demonstrate a change in program costs” (Table 1).

Table 1. Workgroup Criteria for Selecting Performance Measures

WORKGROUP CRITERIA FOR SELECTING PERFORMANCE MEASURES	
<ul style="list-style-type: none"> • Must focus on a Medicaid covered service • Medicaid program must be able to influence performance • Data to support the measure must be readily available • Must improve health and add value • Should emphasize preventive care • Must be meaningful to the public 	<ul style="list-style-type: none"> • Must demonstrate a change in program costs • Should link to Healthy Alaskans 2020 • Should align with measures already reported by providers • Should reduce the burden on providers • Should be based on scientific evidence for medical necessity

Note: These criteria were used to help evaluate potential measures, but each measure was not expected to meet all criteria.

Workgroup members submitted more than 100 measures for initial consideration

To begin development of the measures, workgroup members reviewed existing national measures from sources such as the National Center for Quality Assurance (NCQA), Centers for Medicare and Medicaid Services (CMS) and the Health Resources and Services Administration (HRSA); as well as measures developed in other states including Arizona, New Mexico and Washington. In total, members reviewed information on potential measures from 13 national and state sources. Appendix B includes a complete list of measure sources reviewed.

INDEPENDENT WORKGROUP MEMBER SUBMISSIONS

After reviewing existing sources, workgroup members were asked to independently submit measures they believed could best demonstrate quality in the Alaska Medicaid program. Members were encouraged to use sources reviewed as well as other information they deemed helpful to identify a relevant measure. As a result of this process, stakeholders submitted more than 100 measures for initial consideration. Submitted measures were grouped into categories including access and cost, and then internally reviewed by the Department to ensure each measure met the three primary criteria noted above.

During the internal Department review, it was discovered that not all measures submitted were ready for implementation without changes to current Medicaid program policies. As an example, workgroup members submitted several measures pertaining to preventive services. A limitation in current Medicaid regulations restricts payment to just those services that are medically necessary, thereby prohibiting Medicaid reimbursement for many preventive services. Until Medicaid regulations are revised, this restriction impedes the utility of measures focusing on prevention.

LIMITATIONS IMPACTING MEASURES

As the workgroup further refined the list of potential measures, members noted that a significant impediment to selecting measures focused on a specific disease, chronic illness, or other high cost drivers in the system, is the program's current lack of guidance or requirements regarding treatments for such. The Alaska Medicaid program operates a fee-for-service reimbursement structure that allows interested qualified providers to deliver services to Medicaid recipients with minimal direction from the program.

The fee-for-service reimbursement model limits the program's ability to require providers to deliver a specific set of services, follow specific treatment protocols, or monitor patient adherence to treatment recommendations. Measures intending to monitor provider treatment of conditions such as high blood pressure, asthma or diabetes could not move forward because there is no current way for the program to either require the provider or the patient to adhere to a specific treatment protocol, and no way for the program to determine whether specific protocols are being followed.

Lack of program data identifying basic information such as how many Medicaid recipients have diabetes or are tobacco users, and how much the program spends on care for these individuals, also limited the workgroup's ability to select measures directly connected to program expenditures. To overcome these limitations, the workgroup selected measures that will in the interim monitor negative outcomes attributed to poor health that should help track the evolution and impact of redesign efforts. For example,

while it is too early for the program to measure patient adherence to a recommended diabetic medication regimen, the workgroup is recommending a measure that identifies the number of Medicaid recipients hospitalized due to a diabetic condition. As redesign efforts aimed at improving overall health are implemented, the Department should see a steady decline in hospital admissions attributed to a diabetic condition. Should performance not improve, the Department can then develop strategies to address needs specific to the population to derive better recipient health outcomes and reduce costs.

PUBLIC COMMENT ON PROPOSED MEASURES

To gather additional public input on potential Medicaid quality and cost effectiveness measures, the Department and stakeholder workgroup presented the final draft list of measures for public comment on March 16, 2017. Comments received from members of the public included broad support for the draft list as well as suggestions for ways the program can reduce costs without jeopardizing quality.

FINAL LIST OF MEASURES

After review of public comment and further refinements, the workgroup produced a list of 18 measures, categorized in Table 2:

Table 2. Categories of Alaska’s 18 Quality and Cost Effectiveness Targets

CATEGORY	MEASURES
Access	A.1 Child and Adolescents’ Access to Primary Care
	A.2 Ability to Get Appointment With Provider As Needed
Behavioral Health	B.1 Follow-up After Hospitalization for Mental Illness
	B.2 Medical Assistance with Smoking and Tobacco Cessation
	B.3 Alcohol and Other Drug Dependence Treatment
Chronic Health	CH.1 Emergency Department Utilization
	CH.2 Diabetic A1C Testing
	CH.3 Hospital Readmission Within 30 days - All Diagnoses
Cost	C.1 Medicaid Spending Per Enrollee
	C.2 Number of Hospitalizations for Chronic Obstructive Pulmonary Disease
	C.3 Number of Hospitalizations Attributed to a Diabetic Condition
	C.4 Number of Hospitalizations Attributed to Congestive Heart Failure
Maternal Health	M.1 Live Births Weighing Less Than 2,500 Grams
	M.2 Follow-up After Delivery
	M.3 Prenatal Care During First Trimester
Preventive Health	P.1 Childhood Immunization Status
	P.2 Well-Child Visits for Children 0-6 by Age
	P.3 Developmental Screening in the First Three Years of Life

The majority of measures recommended by the workgroup were selected from measures promoted by national sponsoring entities such as NCQA or CMS. However, several were also independently developed by the workgroup. These latter measures reflect the workgroup member's priorities for the program and place emphasis on issues more specific to Alaskan health needs. As an example, CMS currently counts the number of visits children have with a primary care provider, but this measure fails to identify the average number of visits for all children in the cohort. Due to interest in making sure each child enrolled in the program receives adequate preventive services each year, the workgroup recommends instead that the program monitor the percentage of children who had a well-child visit each year. This measure (P.2 – Average Number of Well-Child Visits by Age), combined with others, could help identify the number of children who may not be receiving the services necessary for sustained good health.

PERFORMANCE TARGETS

The second task undertaken by the workgroup was to develop annual performance targets for each of the final measures. Lack of available program data during this part of the selection process was especially challenging.

To help address this issue, the Department contracted with Milliman, Inc., a health care actuarial firm, to calculate current program performance on the draft measures. To calculate current performance levels, Milliman used a robust but not complete data set that was originally extracted for use in a separate Medicaid redesign project. To guide their work, they used technical specifications from the national group sponsoring the identified measure, or in the case of workgroup created measures, they developed technical specifications by modifying specifications from an existing similar measure.

Many of the measures sponsored by national sources are recommended by multiple entities. For example, a measure recommended by NCQA may also be recommended by the Health Resources and Services Administration (HRSA), and also used by the State of Washington to monitor performance in that state. For those measures selected by the workgroup that were consistent among different sponsors, the technical specifications for the calculation of the measures were taken from the Centers for Medicare and Medicaid Services Core Set of Health Care Quality Measures for Medicaid (either the Adult Core or Children's Core set).

The CMS technical specifications are already modified specifically to the Medicaid program and provided a more straightforward approach to calculating measure results. The use of the CMS technical specifications as the basis for the measure calculations gives the appearance that a disproportionate number of the measures are derived from CMS but in fact, many of the selected measures are recommended by multiple entities. The measures themselves are consistent across national sources, but the technical specifications that apply specifically to the Medicaid program are from CMS.

Prior to setting annual performance targets, the workgroup chose to establish a five-year performance period and ultimate performance goals that should be met at the end of that period. This longer performance period will provide the program with the opportunity to develop more meaningful performance improvement strategies in areas where the program fails to make annual progress.

After much deliberation, the workgroup established a 10 percent performance improvement goal that each measure should either meet or exceed by the end of the five-year performance period. Corresponding annual performance targets represent the program performance necessary to achieve the 10 percent improvement goals within the five-year timeframe.

PUBLIC COMMENT ON PERFORMANCE TARGETS

An invitation for public comment on the performance objectives and annual targets was published on July 5, 2017. Public comment received was positive and supportive of the workgroup's recommendations. One comment was submitted that suggested the program may benefit from ensuring the measures align more closely with Healthcare Effectiveness Data and Information Set (HEDIS) measures in order for the program to track performance against other state Medicaid programs. The workgroup was highly supportive of this comment and is recommending that the department consider this approach as the performance measures evolve over the next few years.

RECOMMENDATIONS

RECOMMENDATION 1: MEASURES AND TARGETS

The workgroup selected 18 measures to track improvement in the quality and cost effectiveness of the Alaska Medicaid program as it transitions in response to Medicaid redesign efforts. As outlined above, each of the measures meets the three basic criteria identified by the Department and can be tracked over time as the program evolves.

In addition to the measures, the workgroup also developed corresponding performance goals and annual targets, and is recommending that the first reporting period cover anticipated program performance in state fiscal year 2018.

RECOMMENDATION 1: 18 Measures and Targets. The workgroup presents its recommendations for Medicaid Quality and Cost Effectiveness Performance Measures and corresponding performance goals and annual targets in Appendix A, which includes a description of each measure, current performance (as available), corresponding five-year goals and annual targets.

The workgroup further recommends that the first results of performance against the recommended measures be reported within six months of the close of state fiscal year 2018 and each year thereafter for at least six years of performance.

RECOMMENDATION 2: COMMITMENT TO THE FUTURE

The workgroup presents its recommendations amid uncertainty regarding future program funding levels. State budget deficits have already forced Department cuts that could threaten program services, and actions at the national level threaten Medicaid expansion efforts as well as critical federal program funding. Given that the Department is already balancing efforts to do more with less, the workgroup is concerned efforts to improve Medicaid quality will become a lower priority and momentum gained through this effort will be lost. The loss of focus and momentum will lead to increased program costs that will further strain program resources and the state budget. However, by staying the course, improvements in overall recipient health driven by improved quality of care will help the program weather future budget reductions and stabilize costs.

RECOMMENDATION 2: Department Commitment to Ongoing Work. As the Department develops the strategies necessary to adapt to potential program funding and/or service reductions, the workgroup recommends that the Department maintain its focus on quality and sustain efforts that drive improvements on each of the recommended performance measures.

RECOMMENDATION 3: DATA NECESSARY TO SUPPORT PROGRAM PERFORMANCE

Due to staffing and resource issues, the Department was unable to provide the workgroup with data elements necessary to determine cost drivers within the program. This lack of information prohibited the workgroup's ability to critically analyze program expenditures, identify the proportion of Medicaid recipients with chronic illnesses, and evaluate the corresponding costs expended for chronic care. This

lack of data limited the scope of measures the workgroup could recommend and represents a lost opportunity for the Department to have stakeholders help identify measures leading to greater improvements in both program quality and efficiency.

RECOMMENDATION 3: Dedicate Staff Resources to Future Performance Measurement. The workgroup recommends that the Department identify specific staff who can be trained to calculate the program’s annual performance relative to the measures, and generally support future activities of this workgroup to monitor performance and revise measures accordingly. Ideally, staff should be trained in health informatics.

RECOMMENDATION 4: MEASURES RECOMMENDED FOR FUTURE IMPLEMENTATION

During development of the initial measures, the workgroup identified two significant issues that precluded use of some measures members felt could drive significant improvements in recipient health and contain overall Medicaid costs. The first issue restricting potential measures is existing state law that limits Medicaid payment to “medically necessary” services. This restriction inhibits the program’s ability to authorize payment for services such as preventive colonoscopies, a service which has proven highly effective in early detection of colon cancer, improving survivability for the individual and reducing necessary costs for cancer treatments. Although colonoscopies are a covered Medicaid service, the service is payable only when medically necessary.

The second restriction identified by the workgroup is that the program’s current payment structure impedes the ability to track provider and patient behavior to identify whether either group is complying with recommended treatment strategies. The current payment structure limits the selection of measures focusing on issues such as asthma or diabetes medication management as there is no currently no way to track adherence through the Medicaid claims system and no established provider reporting requirement to collect compliance information.

As Medicaid redesign efforts move forward and broad strategies such as care management are implemented, the Department will have an opportunity to adopt measures that can better monitor provider treatment strategies and recipient adherence to treatment recommendations. The workgroup has prepared a list of measures (Appendix C) the Department should develop once related barriers have been eliminated.

RECOMMENDATION 4: Remove Barriers Restricting Desired Measures. The workgroup recommends that the Department address barriers prohibiting the adoption of measures included in Appendix C and begin tracking those measures as quickly as possible to more closely monitor the quality and cost effectiveness of services provided to Medicaid enrollees with one or more chronic conditions.

RECOMMENDATION 5: INTRADEPARTMENTAL COLLABORATION

As the Medicaid program focuses on program redesign activities to improve health outcomes for its recipients, several other Department initiatives are working in tandem to improve overall population health. Performance on several of the recommended Medicaid measures may especially benefit from

greater connection and collaboration with population health activities managed by the Division of Public Health and Division of Senior and Disabilities Services. To maximize the impact of all Department initiatives as well as make more substantive progress toward Medicaid performance goals, the Department should ensure there is a focused effort within the divisions to collaborate on activities that will influence performance on the recommended measures.

Recommendation 5: Align Internal Medicaid Redesign Efforts. The workgroup recommends that the Department develop a collaborative process to connect Medicaid performance goals with other Department efforts aimed at improving population health.

RECOMMENDATION 6: ALIGN PERFORMANCE MEASURES WITH HEDIS

An essential component of monitoring quality is the ability to measure performance against peers, such as other states' Medicaid programs, or national averages. Current aspects of the Alaska Medicaid program, such as the fee-for-service payment structure, limit the Department's ability to make apple-to-apple comparisons of performance with peer states or national averages. However, as the program changes in response to Medicaid redesign efforts, greater emphasis should be placed on aligning the Alaska Medicaid program's performance measures with comparable measures like HEDIS, so that performance can be compared to programs outside of Alaska. Peer comparisons will help ensure that Alaska Medicaid is continuously striving toward the highest possible level of program performance.

RECOMMENDATION 6: Monitor Medicaid Performance in Other States Using HEDIS Comparisons. The workgroup recommends that the Department monitor the performance of other state Medicaid programs on HEDIS measures that are similar or like the measures recommended by the workgroup.

APPENDIX A: Alaska Medicaid Quality and Cost Effectiveness Measures and Performance Targets

Alaska Medicaid Program Quality and Cost Effectiveness Measure ACCESS A.1 Child and Adolescents' Access to Primary Care					
NUMBER	MEASURE	COHORT	2016 RATE	2018 TARGET	2023 TARGET
A.1	Child and Adolescents' Access to Primary Care Practitioners	a: Age 12-24 mos	a: 87.0%	a: 88.5%	a: 95.7%
		b: Age 25 mos-6 yrs	b: 77.6%	b: 78.8%	b: 85.4%
		c: Age 7-11 yrs	c: 82.6%	c: 84.0%	c: 90.9%
		d: Age 12-19 yrs	d: 83.7%	d: 85.1%	d: 92.1%
<p>Description: Percentage of children 12 months to 19 years who had a visit with a primary care practitioner during the reporting year.</p> <p>Measure Origin: Centers for Medicare and Medicaid Services (CMS): Core Set of Children's Health Care Quality Measures for Medicaid and CHIP</p> <p>Data Source: Medicaid claims data</p> <p>Peer Performance: a: 96.4%; b: 88.6%; c: 91.2%; and d: 90.6%</p> <p>U.S. Department of Health and Human Services, 2015 Annual Report on the Quality of Care for Children in Medicaid and CHIP. https://www.medicare.gov/medicaid/quality-of-care/downloads/2015-child-sec-rept.pdf</p> <p>Comparable HEDIS Measure: Yes http://www.ncqa.org/Portals/0/HEDISQM/HEDIS2017/List%20of%20Physician%20Measures.pdf</p> <p>Notes: The data set utilized by Milliman Inc. to calculate this measure did not include the information necessary to identify a rendering provider. Calculation of the 2016 rate could be underreported as a result of limited data.</p>					

Alaska Medicaid Program Quality and Cost Effectiveness Measure ACCESS A.2 Ability to Get Appointment With Provider As Needed					
NUMBER	MEASURE	COHORT	2016 RATE	2018 TARGET	2023 TARGET
A.2	Ability to Get an Appointment for Care As Needed	a: Age 0-21 yrs	a: 67.2%	a: 68.1%	a: 73.9%
		b: Age 21+ yrs	b: 60.6%	b: 61.3%	b: 66.7%
<p>Description: Adult's perception of whether they were able to get an appointment as quickly as the adult felt was necessary. Parent's perception of whether they were able to get an appointment for their child as quickly as the parent felt was necessary.</p> <p>Measure Origin: National Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey</p> <p>Data Source: Annual CAHPS Survey</p> <p>Peer Performance: None identified</p> <p>Comparable HEDIS Measure: No</p>					

Alaska Medicaid Program Quality and Cost Effectiveness Measure BEHAVIORAL HEALTH B.1 Follow-up After Hospitalization for Mental Illness					
NUMBER	MEASURE	COHORT	2016 RATE	2018 TARGET	2023 TARGET
B.1	Follow-up After Hospitalization for Mental Illness	a: Child - Acute	a: 63.3%	a: 64.1%	a: 69.6%
		b: Child - Psych	b: 67.7%	b: 68.6%	b: 74.4%
		c: Adult - Acute	c: 78.8%	c: 80.1%	c: 86.7%
		d: Adult - Psych	d: 74.9%	d: 76.0%	d: 82.4%
<p>Description: Percent of discharges for children ages 6-20 and adults age 21+ years hospitalized for treatment of a mental health diagnosis who had an outpatient visit, intensive outpatient encounter, or partial hospitalization with a mental health practitioner w/in 30 days of discharge.</p> <p>Measure Origin: CMS: Core Set of Children’s Health Care Quality Measures for Medicaid and CHIP; Core Set of Adult Health Care Quality Measures for Medicaid</p> <p>Data Source: Medicaid claims data</p> <p>Peer Performance: b: 64.2% and d: 56.7%</p> <p>Note: Peer performance available only for children discharging from psychiatric hospital. U.S. Department of Health and Human Services, 2015 Annual Report on the Quality of Care for Children in Medicaid and CHIP. https://www.medicare.gov/medicaid/quality-of-care/downloads/2015-child-sec-rept.pdf</p> <p>Comparable HEDIS Measure: Yes http://www.ncqa.org/Portals/0/HEDISQM/HEDIS2017/List%20of%20Physician%20Measures.pdf</p> <p>Notes: The data set utilized by Milliman Inc. to calculate the overall number of hospitalizations was incomplete. Calculation of the 2016 rate could be underreported as a result of limited data.</p>					

Alaska Medicaid Program Quality and Cost Effectiveness Measure BEHAVIORAL HEALTH B.2 Medical Assistance with Smoking and Tobacco Cessation	
NUMBER	MEASURE
B.2	Medical Assistance with Smoking and Tobacco Cessation
<p>DISCUSSION: The Quality and Cost Effectiveness Stakeholder Workgroup requests that the Department find a way to measure whether assistance is being offered to Medicaid enrollees who use tobacco. Given that smoking and tobacco use significantly contribute to increases in chronic illness and heart disease, each of which are cost drivers within the Medicaid program, the workgroup feels strongly that the Department must annually monitor tobacco cessation assistance provided to recipients. Due to limitations of the existing Medicaid data system, although a number of different measures to address this issue were discussed by the workgroup, the data collected by the program does not yet include a means to identify all recipients who smoke, nor identify when a provider offers cessation services to those who smoke.</p> <p>RECOMMENDATION: The Workgroup recommends that the Department establish a means to: 1) track the rate of tobacco use among Medicaid beneficiaries and 2) identify both the offer and utilization of cessation services provided to Medicaid recipients who use tobacco products. When the Department is able to identify Medicaid enrollees who use tobacco and tobacco cessation services, the workgroup will establish appropriate performance targets.</p>	

Alaska Medicaid Program Quality and Cost Effectiveness Measure BEHAVIORAL HEALTH B.3 Alcohol and Other Drug Dependence Treatment					
NUMBER	MEASURE	COHORT	2016 RATE	2018 TARGET	2023 TARGET
B.3	Initiation and Engagement of Alcohol and Other Drug Dependent Treatment	Age 18+ yrs			
		a: Initiation	a: 57.6%	a: 58.3%	a: 63.4%
		b: Engagement	b: 11.4%	b: 11.5%	b: 12.5%
<p>Description: Percentage of Medicaid enrollees age 18 and older with a new episode of alcohol or other drug (AOD) dependence who received the following: treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis; or initiated treatment and had two or more additional services with a diagnosis of AOD within 30 days of initiating visit.</p> <p>Measure Origin: CMS: Core Set of Adult Health Care Quality Measures for Medicaid</p> <p>Data Source: Medicaid claims data</p> <p>Peer Performance: None identified</p> <p>Comparable HEDIS Measure: Yes http://www.ncqa.org/Portals/0/HEDISQM/HEDIS2017/List%20of%20Physician%20Measures.pdf</p> <p>Notes: <i>Initiation</i> identifies individuals with a new episode of alcohol or other drug dependence who initiated treatment within 14 days of diagnosis. <i>Engagement</i> identifies individuals who both initiated treatment and engaged in two or more additional services within 30 days of the initial diagnosis.</p>					

Alaska Medicaid Program Quality and Cost Effectiveness Measure CHRONIC HEALTH CH.1 Emergency Department Utilization					
NUMBER	MEASURE	COHORT	2016 RATE	2018 TARGET	2023 TARGET
CH.1	Emergency Department Utilization (visits per 1,000)	All program enrollees	496.9	486.9	447
<p>Description: The number of emergency department visits per 1,000 Medicaid enrollees.</p> <p>Measure Origin: Quality and Cost Effectiveness Targets Stakeholder Workgroup</p> <p>Data Source: Medicaid claims data</p> <p>Peer Performance: None identified</p> <p>Comparable HEDIS Measure: No</p> <p>Notes: The data set utilized by Milliman Inc. to calculate this measure was limited. Calculation of the 2016 rate could be underreported as a result of limited data.</p>					

Alaska Medicaid Program Quality and Cost Effectiveness Measure CHRONIC HEALTH CH.2 Diabetic A1C Testing					
NUMBER	MEASURE	COHORT	2016 RATE	2018 TARGET	2023 TARGET
CH.2	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C)	a: Age 18-64 yrs	a: 71.9%	a: 72.9%	a: 79.1%
		b: Age 65+ yrs	b: 52.8%	b: 53.4%	b: 58.1%
<p>Description: Percentage of Medicaid enrollees ages 18 to 75 with diabetes (type 1 and type 2) who had a hemoglobin A1c (HbA1c) test during the reporting year.</p> <p>Measure Origin: CMS: Core Set of Adult Health Care Quality Measures for Medicaid</p> <p>Data Source: Medicaid claims data</p> <p>Peer Performance: None identified</p> <p>Comparable HEDIS Measure: Yes</p> <p>http://www.ncqa.org/Portals/0/HEDISQM/HEDIS2017/List%20of%20Physician%20Measures.pdf</p>					

Alaska Medicaid Program Quality and Cost Effectiveness Measure CHRONIC HEALTH CH.3 Hospital Readmission Within 30 days - All Diagnoses					
NUMBER	MEASURE	COHORT	2016 RATE	2018 TARGET	2023 TARGET
CH.3	Hospital readmission within 30 days - all diagnoses	Age 18+ yrs			
		a: Mental illness admits	a: 40.0%	a: 39.5%	a: 36.0%
		b: All other admits	b: 15.3%	b: 15.1%	b: 13.8%
<p>Description: For Medicaid enrollees age 18 and older, the number of acute inpatient stays during the reporting year that were followed by an unplanned acute readmission for any diagnosis within 30 days.</p> <p>Measure Origin: CMS: Core Set of Adult Health Care Quality Measures for Medicaid</p> <p>Data Source: Medicaid claims data</p> <p>Peer Performance: None identified.</p> <p>Note: National results exist for private payer types, PPO and HMO, but results for Medicaid were not found.</p> <p>Comparable HEDIS Measure: Yes</p> <p>http://www.ncqa.org/Portals/0/HEDISQM/HEDIS2017/List%20of%20Physician%20Measures.pdf</p> <p>Notes: The data set utilized by Milliman Inc. to calculate the overall number of hospitalizations was incomplete. Calculation of the 2016 rate could be underreported as a result of limited data.</p>					

Alaska Medicaid Program
Quality and Cost Effectiveness Measure
COST | C.1 Medicaid Spending Per Enrollee

NUMBER	MEASURE	COHORT	2016 RATE	2018 TARGET	2023 TARGET
C.1	Medicaid spending per enrollee	a: Age 0-21 yrs	a: \$5,828	a: \$5,711	a: \$5,245
		b: Age 21+ yrs	b: \$10,436	b: \$10,227	b: \$9,392

Description: Consistent with information currently provided, the Department will produce per member and aggregate costs for non-waiver services by service category.

Measure Origin: Quality and Cost Effectiveness Targets Stakeholder Workgroup

Data Source: Medicaid claims data

Peer Performance: None identified

Comparable HEDIS Measure: No

Alaska Medicaid Program
Quality and Cost Effectiveness Measure
COST | C.2 Number of Hospitalizations for Chronic Obstructive Pulmonary Disease (COPD)

NUMBER	MEASURE	COHORT	2016 RATE	2018 TARGET	2023 TARGET
C.2	Number of hospitalizations for Chronic Obstructive Pulmonary Disease	a: Age 40-64 yrs	a: 40.8	a: 40.0	a: 36.7
		b: Age 65+ yrs	b: 46.2	b: 45.3	b: 41.6

Description: Per 100,000 enrollee months, number of hospitalizations due to COPD during the reporting period

Measure Origin: CMS: Core Set of Adult Health Care Quality Measures for Medicaid

Data Source: Medicaid claims data

Peer Performance: None identified

Comparable HEDIS Measure: No

Notes: The data set utilized by Milliman Inc. to calculate the overall number of hospitalizations was incomplete. Calculation of the 2016 rate could be underreported as a result of limited data.

Alaska Medicaid Program
Quality and Cost Effectiveness Measure
COST | C.3 Number of Hospitalizations Attributed to a Diabetic Condition

NUMBER	MEASURE	COHORT	2016 RATE	2018 TARGET	2023 TARGET
C.3	Number of hospitalizations attributed to a diabetic condition	a: Age 18-64 yrs	a: 20.1	a: 19.7	a: 18.1
		b: Age 65+ yrs	b: 16.8	b: 16.5	b: 15.1

Description: Per 100,000 enrollee months, number of hospitalizations due to a diabetic condition during reporting period.

Measure Origin: Quality and Cost Effectiveness Targets Stakeholder Workgroup

Data Source: Medicaid claims data

Peer Performance: None identified

Comparable HEDIS Measure: No

Notes: The data set utilized by Milliman Inc. to calculate the overall number of hospitalizations was incomplete. Calculation of the 2016 rate could be underreported as a result of limited data.

Alaska Medicaid Program Quality and Cost Effectiveness Measure COST C.4 Number of Hospitalizations Attributed to Congestive Heart Failure					
NUMBER	MEASURE	COHORT	2016 RATE	2018 TARGET	2023 TARGET
C.4	Number of hospitalizations due to Congestive Heart Failure	a: Age 18-64 yrs	a: 11.3	a: 11.1	a: 10.1
		b: Age 65+ yrs	b: 42.8	b: 41.9	b: 38.5
<p>Description: Per 100,000 enrollee months, number of hospitalizations due to Congestive Heart Failure during reporting period. Measure Origin: CMS: Core Set of Adult Health Care Quality Measures for Medicaid Data Source: Medicaid claims data Peer Performance: None identified Comparable HEDIS Measure: No Notes: The data set utilized by Milliman Inc. to calculate the overall number of hospitalizations was incomplete. Calculation of the 2016 rate could be underreported as a result of limited data.</p>					

Alaska Medicaid Program Quality and Cost Effectiveness Measure MATERNAL HEALTH M.1 Live Births Weighing Less Than 2,500 Grams					
NUMBER	MEASURE	COHORT	2016 RATE	2018 TARGET	2023 TARGET
M.1	Live Births Weighing Less Than 2,500 Grams	All live births within program	6.8%	6.7%	6.1%
<p>Description: Percentage of live births weighing less than 2,500 grams delivered to Medicaid recipients in the state during the reporting period. Measure Origin: CMS: Core Set of Children’s Health Care Quality Measures for Medicaid and CHIP Data Source: Alaska’s Indicator-Based Information System for Public Health Data (IBIS) Peer Performance: 9.0% Comparable HEDIS Measure: Yes http://www.ncqa.org/Portals/0/HEDISQM/HEDIS2017/List%20of%20Physician%20Measures.pdf</p>					

Alaska Medicaid Program Quality and Cost Effectiveness Measure MATERNAL HEALTH M.2 Live Births Weighing Less Than 2,500 Grams					
NUMBER	MEASURE	COHORT	2016 RATE	2018 TARGET	2023 TARGET
M.2	Follow-up after delivery	All live births within program	39.2%	39.5%	43.1%
<p>Description: Percentage of women who had live births during the reporting year that also had a postpartum visit on or between 21 and 56 days after delivery. Measure Origin: CMS: Core Set of Adult Health Care Quality Measures for Medicaid Data Source: Medicaid claims data Peer Performance: None identified Comparable HEDIS Measure: Yes http://www.ncqa.org/Portals/0/HEDISQM/HEDIS2017/List%20of%20Physician%20Measures.pdf Notes: Calculated results may be lower than actuals due to differences in the codes providers use to identify these services.</p>					

Alaska Medicaid Program
Quality and Cost Effectiveness Measure
MATERNAL HEALTH | M.3 Prenatal Care During First Trimester

NUMBER	MEASURE	COHORT	2016 RATE	2018 TARGET	2023 TARGET
M.3	Prenatal Care During First Trimester	All live births within program	76.4%	77.1%	84.0%

Description: Percentage of newborns whose mothers had a prenatal visit during first trimester.
Measure Origin: CMS: Core Set of Children’s Health Care Quality Measures for Medicaid and CHIP
Data Source: Medicaid claims data
Peer Performance: None identified
Comparable HEDIS Measure: Yes. <http://www.ncqa.org/Portals/0/HEDISQM/HEDIS2017/List%20of%20Physician%20Measures.pdf>
Notes: Calculated results may be lower than actuals due to differences in the codes providers use to identify these services.

Alaska Medicaid Program
Quality and Cost Effectiveness Measure
PREVENTIVE HEALTH | P.1 Childhood Immunization Status

NUMBER	MEASURE	COHORT	2016 RATE	2018 TARGET	2023 TARGET
P.1	Childhood Immunization Status	Age 0-24 mos	TBD	TBD	TBD

Description: Percentage of children age 0-24 months receiving recommended immunizations for age.
Measure Origin: Quality and Cost Effectiveness Targets Stakeholder Workgroup
Data Source: VacTrAK Immunization Registry of Alaska
Peer Performance: None identified
Comparable HEDIS Measure: No
Notes: Performance calculation to be developed after consistent data source is identified.

Alaska Medicaid Program
Quality and Cost Effectiveness Measure
PREVENTIVE HEALTH | P.2 Well-Child Visits for Children 0-6 by Age

NUMBER	MEASURE	COHORT	2016 RATE	2018 TARGET	2023 TARGET
P.2	Average Number of Well Child Visits by Age	a: Second yr of life	a: 1.98	a: 2.0	a: 2.2
		b: Third yr of life	b: 0.90	b: 0.91	b: 1.0
		c: Fourth yr of life	c: 0.51	c: 0.52	c: 0.56
		d: Fifth yr of life	d: 0.56	d: 0.57	d: 0.62
		e: Sixth yr of life	e: 0.52	e: 0.53	e: 0.57

Description: Average number of well child visits during the reporting period, reported by age for children ages 0 to 6.
Measure Origin: CMS: Core Set of Adult Health Care Quality Measures for Medicaid
Data Source: Medicaid claims data
Peer Performance: None identified
Comparable HEDIS Measure: No
Notes: The workgroup acknowledges that children may be seen more frequently but that the claim submitted by the provider reflects a different purpose for the visit. The workgroup’s recommendation is to specifically monitor those visits focused on wellness of the child as a means to evaluate opportunities for early detection of adverse health conditions.

Alaska Medicaid Program
Quality and Cost Effectiveness Measure

PREVENTIVE HEALTH | P.3 Developmental Screening in the First Three Years of Life

NUMBER	MEASURE	COHORT	2016 RATE	2018 TARGET	2023 TARGET
P.3	Developmental Screening in First Three Years of Life	a: First yr of life	a: 12.9%	a: 13.1%	a: 14.2%
		b: Second yr of life	b: 11.8%	b: 12.0%	b: 13.0%
		c: Third yr of life	c: 8.8%	c: 8.9%	c: 9.7%
		d: Ages 0-3 combined	d: 11.3%	d: 11.4%	d: 12.4%

Description: Percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthday.

Measure Origin: CMS: Core Set of Children’s Health Care Quality Measures for Medicaid and CHIP

Data Source: Medicaid claims data

Peer Performance: None identified

Comparable HEDIS Measure: No

Notes: The data set utilized by Milliman Inc. to calculate this measure was incomplete. Calculation of the 2016 rate could be overreported as a result of limited data.

APPENDIX B: Measure Sources Reviewed by Medicaid Redesign Quality and Cost Effectiveness Targets Stakeholder Workgroup

Arizona Health Care Cost Containment System (AHCCCS) Measures

<https://www.azahcccs.gov/Resources/OversightOfHealthPlans/quality.html>

CMS Core Set of Adult Health Care Quality Measures for Medicaid

<https://www.medicaid.gov/medicaid/quality-of-care/downloads/2016-adult-core-set.pdf>

CMS Core Set of Children’s Health Care Quality Measures for Medicaid and Chip, 2016

<https://www.medicaid.gov/medicaid/quality-of-care/downloads/2016-child-core-set.pdf>

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/>

Government Performance and Results Act (GPRA) Performance Measures

https://www.ihs.gov/crs/includes/themes/newihstheme/display_objects/documents/gpra/2017/2015-2017_Matrix.pdf

Health Resources and Services Administration (HRSA), Quality Improvement Measures

<https://bphc.hrsa.gov/qualityimprovement/performance/qualitycare.html>

Healthcare Effectiveness Data and Information Set (HEDIS), 2016

<http://www.ncqa.org/Portals/0/HEDISQM/HEDIS2016/HEDIS%202016%20List%20of%20Measures.pdf>

Healthy Alaskans 2020, 25 Leading Health Indicators

<http://hss.state.ak.us/ha2020/25LHI.htm>

National Center for Quality Assurance, Patient-Centered Medical Home Standards and Guidelines

http://www.acofp.org/acofpimis/Acofporg/Apps/2014_PCMH_Finals/Tools/1_PCMH_Recognition_2014_Front_Matter.pdf

New Mexico Medicaid Quality and Cost Indicators

https://www.nmlegis.gov/Entity/LFC/Documents/Program_Evaluation_Reports/Medicaid%20Accountability%20Report%202015.pdf

Physician Quality Reporting System (PQRS), 2016 Crosscutting Measures

https://www.cms.gov/apps/ama/license.asp?file=/PQRS/downloads/2016_PQRS-Crosscutting.pdf

Uniform Data System, Clinical Quality Measures, 2015

<https://bphc.hrsa.gov/datareporting/reporting/2015udsmanual.pdf>

Washington State Common Measure Set for Health Care Performance

<https://www.hca.wa.gov/assets/program/2016.12.20.Common-Measure-Set-Health-Care-Quality-Cost-Approved.pdf>

APPENDIX C: Potential Future Measures Recommended by Medicaid Redesign Quality and Cost Effectiveness Targets Stakeholder Workgroup

The Medicaid Redesign Quality and Cost Effectiveness Targets Stakeholder Workgroup requests that the Department of Health and Social Services adopt the following Medicaid program performance measures as soon as possible following elimination of program impediments:

AFTER PASSAGE OF PREVENTIVE SERVICES REGULATIONS

- Child /Adolescent Major Depressive Disorder: Suicide Risk Assessment
- Chlamydia Screening in Women
- HIV Screening - All Ages
- Breast Cancer Screening (BCS)
- Cervical Cancer Screening (CCS)
- Mammogram Screening
- Colorectal Cancer Screening
- LDL-C Screening
- Flu Vaccinations for Adults Age 18 and Older (FVA)
- Flu Vaccinations for Children Age 18 and Under
- HPV Vaccinations for Children Age 18 and Under
- Pneumonia Vaccine for Older Adults
- Alcohol Screening in Pregnant Women
- HIV Screening - Pregnant Women
- Diabetes Care - Eye Exam
- Diabetes Care - LDL Assessment
- Diabetes Care - Screening for Nephropathy
- Hypertension - Screening for Nephropathy
- Nephropathy - Screening for Nephropathy
- Heart Failure - Screening for Nephropathy

AFTER CONSISTENT DATA SOURCE IS IDENTIFIED

- Child /Adolescent Major Depressive Disorder: Suicide Risk Assessment
- Screening for Clinical Depression and Follow-Up Plan (CDF)
- Body Mass Index Assessment (ABA) for Adults
- Body Mass Index Assessment (ABA) for Children/Adolescents
- Behavioral Health Risk Assessment for Pregnant Women (BHRA)
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
- Controlling High Blood Pressure
- Percent of Adult Medicaid Recipients that Smoke
- Medication Management for People with Asthma
- Annual cost of Medicaid per member vs annual cost of Private/Exchange premium
- Adherence to HIV Viral Load Suppression Therapy