



2009 Performance Measure Comparative Analysis Report

Washington State Healthy Options Program
State Children's Health Insurance Program
Washington Medicaid Integration Partnership

November 2009

DSHS Contract No. 0834-34555

Presented by

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Presented to Washington State Department of Social & Health Services,
Health and Recovery Services Administration

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Executive Summary

The Medicaid program in Washington, administered by the Health and Recovery Services Administration (HRSA), provides healthcare benefits for more than 900,000 low-income residents. More than half of these residents are enrolled in Healthy Options, the state's managed care program. In addition, almost 3,000 beneficiaries are enrolled in the Washington Medicaid Integration Partnership (WMIP), which serves categorically needy aged, blind, and disabled clients in Snohomish County.

This report presents the 2009 findings for Healthy Options plans in several Healthcare Effectiveness Data and Information Set (HEDIS[®]) performance measures.* Developed and maintained by the National Committee for Quality Assurance (NCQA), the HEDIS measures are used by consumers to compare health plan performance; by purchasers to compare plan data with national averages; and by health plans to identify best practices or improvement opportunities. HRSA has used HEDIS measures to assess health plan performance since 1998.

Acumentra Health produced this report under its contract with HRSA as the external quality review organization (EQRO) for Washington. This assessment covers health care delivered in reporting year 2009 by seven managed care health plans:

- Asuris Northwest Health
- Columbia United Providers
- Community Health Plan
- Group Health Cooperative
- Kaiser Permanente Northwest
- Molina Healthcare of Washington
- Regence BlueShield

HEDIS results for a measurement year (the year in which care is given) are gathered, audited, and reported the following year and are based on a statistically valid random sample of health plan enrollees.

Results

As a group, the Healthy Options plans are providing care to enrollees at rates that are nearly identical to, or better than, the NCQA national Medicaid averages for

- six of nine childhood immunization indicators (DTaP, IPV, MMR, HiB, PCV, and Combo 3)
- postpartum care
- well-child care (WCC) visits for infants
- five of eight indicators of diabetes care for which comparison can be made (HbA1c tests, HbA1c control, dilated retinal exams, and two blood-pressure control indicators)

In addition, the reported service utilization rates for Healthy Options enrollees are below the national averages—generally considered a positive trend—in all areas (both inpatient and ambulatory care) except for maternity discharges.

*HEDIS is a registered trademark of the National Committee for Quality Assurance.

On the other hand, the Healthy Options plans as a group continue to perform significantly below the national average in providing WCC visits for children and adolescents, as well as in lipid screening and control and in monitoring for diabetic nephropathy.

This report presents fourth-year performance measurement data for the WMIP. Once again in 2009, higher percentages of WMIP enrollees were reported to have received eye exams and to have their blood pressure controlled in a favorable range. HbA1c testing rose to its highest rate in four years. The results for service utilization measures were mixed. Nonacute care discharges and days declined significantly, while acute care and surgical days increased significantly. The average length of stay for WMIP enrollees in surgical care also rose significantly, as did visits for outpatient and emergency care and for surgery or procedures.

Recommendations

Previous reports in this series have outlined recommendations for HRSA and the Healthy Options plans, aimed at improving access to care and the quality and timeliness of care, as reflected in specific HEDIS measures. Many of those recommendations remain valid. Equally important, however, is the continuity of partnership and collaboration between HRSA and the health plans to improve care for enrollees. Those efforts have led to the statewide gains evident in areas such as childhood immunizations and infant WCC visits over the past six years.

To sustain long-term improvement in performance measures, Acentra Health recommends that HRSA

- continue to foster public health initiatives and partnerships such as the Washington State Collaborative to Improve Care, and the CHILD Profile immunization registry
- consider organizing a statewide performance improvement project (PIP) that would pool health plan resources and capitalize on partnerships to improve WCC visit rates
- continue to use value-based purchasing in its contract with health plans and encourage all plans to reward contracted clinics for improved performance
- collaborate with health plans to provide performance feedback to clinics and providers
- help health plans study and overcome the barriers to collecting administrative data for HEDIS measures so that the plans can report measures more easily and can direct more resources toward improving care for enrollees
- work with health plans to implement the provisions of the Child Health-Care Act (SB 5093), the goal of which is to ensure that all children in Washington have access to appropriate healthcare services by linking children to medical homes
- ensure that all MCOs are reporting race and ethnicity data

Acentra Health recommends that WMIP

- conduct member-level analysis to “drill down” on performance measures and target specific areas of improvement

Introduction

The Medicaid program in Washington, administered by HRSA, provides healthcare benefits for more than 900,000 low-income residents. About half of those residents are enrolled in Healthy Options, the state's managed care program, which covers most of the women and children whose health care is financed by HRSA. Healthy Options enrollees include

- children enrolled in the State Children's Health Insurance Program (SCHIP)
- other categorically eligible children and mothers
- Medicaid-eligible pregnant women
- children of adults who are enrolled in the Basic Health Plus program

This report presents Healthy Options plan results for measurement year 2008 (reporting year 2009) on the HEDIS measures that HRSA requires the plans to report. These widely accepted measures allow comparison of the Washington plans' performance with national averages for the Medicaid population.

As part of the contract for delivering services to Medicaid enrollees, HRSA requires Healthy Options plans to use HEDIS to assess their performance on five measures of care effectiveness, access, and use of services; to examine utilization patterns in two areas of care; and to report information on enrollees' race and ethnicity for reporting year 2009.

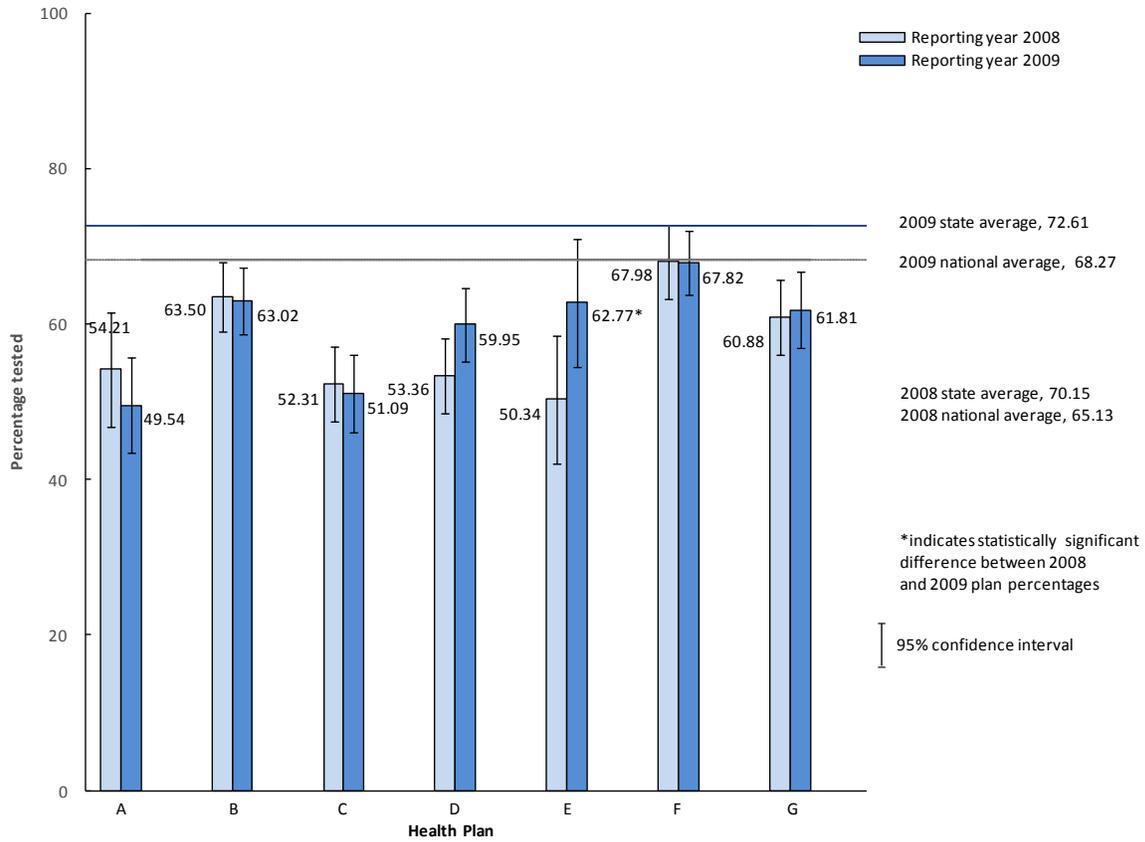
Acumentra Health previously has reported on Healthy Options plans' HEDIS measures for reporting years 2005 through 2008. Overall, these reports have showed ongoing improvement in many measures of care provided to enrollees. For reporting year 2009, the Healthy Options average rates were nearly identical to, or better than, the NCQA national Medicaid averages for the majority of measures. However, variations in health plan performance continue to suggest opportunities for further improvement, peer learning, and partnership among plans.

Table 1 shows the name and acronym of each plan, the number of enrollees, and the percentage of the Healthy Options population served by each plan. The report also presents the results of quality measurements for the WMIP, a pilot project aimed at improving health care for aged, blind, and disabled residents who are eligible for both Medicaid and Medicare coverage and who have complex healthcare needs.

Table 1. Healthy Options health plans and enrollees served as of December 2008.

Health plan	Acronym	Number of enrollees	Percentage of all enrollees
Asuris Northwest Health	ANH	1,786	<1
Community Health Plan	CHP	161,082	32
Columbia United Providers	CUP	31,999	6
Group Health Cooperative	GHC	16,767	4
Kaiser Permanente Northwest	KPNW	751	<1
Molina Healthcare of Washington	MHW	260,098	51
Regence BlueShield	RBS	33,961	6

Asterisks next to the 2009 percentages show statistically significant changes in plan performance from 2008 to 2009. Finally, the state and national averages are shown for 2008 and 2009. Figure 2 shows the information presented in each chart.



National averages are from the National Committee for Quality Assurance

Figure 2. Sample bar chart with fabricated data.

For each plan, Appendix A presents a summary sheet of key measures and indicators displays the plan’s performance and indicates whether the plan’s percentage differed significantly from the state average. An overall summary sheet compares state averages in each measure with the NCQA national averages.

Appendix B, published separately, presents data tables showing changes in plan, state, and national performance in each measure from reporting year 2005 through 2009.

Methods

HEDIS results for a measurement year (the year in which care is given) are gathered, audited, and reported the following year, called the reporting year. Results are based on a statistically valid random sample of health plan enrollees. The HEDIS technical specifications set stringent criteria for identifying the eligible population for each measure.¹

To ensure data integrity, NCQA verifies that a health plan collects data according to the technical specifications. Each plan's data collection process is audited by an NCQA-certified HEDIS auditor. The NCQA HEDIS Compliance AuditTM assures purchasers and health plans of fair and accurate comparisons of plan performance. HRSA funds the HEDIS audit for Healthy Options plans to fulfill the federal requirement for validation of state performance measures.

Acumentra Health compiled individual plan data for the tables and charts in this report from the NCQA-audited Interactive Data Submission System (IDSS) results.² Plans with denominators of fewer than 30 eligible enrollees are identified as such, as are plans that did not report the measure in the reporting year.

Acumentra Health calculated the state average for each measure and indicator by adding individual plan numerators and denominators, dividing the aggregate numerator by the aggregate denominator, and multiplying the resulting proportion by 100. The 2009 national Medicaid averages came from NCQA's *Quality Compass*[®] report, based on data from more than 150 Medicaid managed care health plans.³

For the WMIP program, MHW reported seven HEDIS measures for 2009: comprehensive diabetes care, inpatient care utilization—general hospital/acute care and nonacute care, ambulatory care utilization, anti-depression medication management, follow-up after hospitalization for mental illness, and use of high-risk medications for the elderly. As part of the 2009 HEDIS audit for MHW, the WMIP program underwent a certified HEDIS audit that incorporated the validation of performance measures and the Centers for Medicare & Medicaid Services' Information Systems Capabilities Assessment tool.

Note: HEDIS measures are not designed for case-mix adjustment or risk adjustment for existing co-morbidities, physical or mental disabilities, or severity of disease. Therefore, when reviewing and comparing plan performance, it may be difficult to determine whether differences among plan rates were due to differences in the use of services or quality of care, or to differences in the health of the plan's population.

Administrative vs. hybrid data collection

For four measures—childhood immunizations, postpartum care, WCC visits, and diabetes care—the HEDIS technical specifications allow a health plan to collect data by the administrative or the hybrid method. In the administrative method, a plan identifies the eligible population and uses data from its information systems—such as claims and encounter data—to identify enrollees who received the service(s) for the measure. This method is cost-efficient, but can produce lower rates if providers submit incomplete data. In the hybrid method, a health plan performs supplemental medical chart reviews to identify enrollees who received the service(s) but whose services were not represented in the administrative data. Regardless of the data collection method, eligible enrollees who received services are counted as “numerator events.”

When the hybrid method is an option for calculating HEDIS rates, health plans can minimize the use of expensive medical chart review by capturing a greater percentage of numerator events through valid administrative data. Plans that supplement their administrative data with chart review may boost the number of numerator events and raise their scores on those measures. A sample of hybrid numerator events is validated as part of the HEDIS audit process.

For the past several years, Acentra Health has analyzed and reported on the difference between HEDIS rates calculated through the administrative vs. the hybrid method. The analysis for 2009 revealed essentially the same pattern as in previous years. That is, collecting data from medical charts boosted the state average rates from 12 to 55 percentage points (compared with the rates that would have been reported from administrative data only) for these measures:

- childhood immunizations—IPV, DTaP, PCV, Hep B, Combo 2, and Combo 3 (12 to 21 percentage points)
- diabetes—dilated retinal exams, LDL-C <100 mg/dL, blood pressure <130/90 mm Hg, <140/90 mm Hg (13 to 55 percentage points)
- WCC visits—infants; postpartum care visits (18 to 20 percentage points)

Certain other measures, including WCC visits for children and adolescents, showed gains ranging from 2 to 6 percentage points due to collection of medical chart data.

Member-level data analysis

For 2009, HRSA required the health plans to submit member-level data (including elements for gender, primary language, race/ethnicity, and county) for childhood immunizations. Acentra Health received enough data to analyze and report differences in performance by DSHS region, gender, primary language, and race/ethnicity. These results appear in the immunization section of the report. The DSHS regions are listed on page 20.

Results

Effectiveness of care

Childhood immunization status

Childhood immunizations are one of the most effective ways to prevent and control potentially serious childhood diseases such as diphtheria, polio, rubella, mumps, and pneumococcal disease. The use of these vaccines in the United States has eliminated smallpox and polio and has virtually eliminated measles, rubella, and *Haemophilus influenzae* type b (HiB). Table 2 shows the impact of immunizations in reducing cases of childhood disease.⁴

Table 2. Impact of childhood immunizations in the United States.

Disease	Baseline 20 th century annual cases	2006 cases	Percent decrease
Measles	503,282	55	99.9%
Diphtheria	175,885	0	100.0%
Mumps	152,209	6,584	95.7%
Pertussis	147,271	15,632	89.4%
Smallpox	48,164	0	100.0%
Rubella	47,745	11	99.9%
HiB, invasive	20,000	29	99.9%
Polio	16,316	0	100.0%
Tetanus	1,314	41	96.9%

Childhood vaccines are among the most cost-effective clinical preventive services and one of the few services that save more money, in terms of the clinically preventable burden, than the cost incurred.⁵ DTaP, Td, HiB, IPV, MMR, Hep B, and VZV vaccines result in direct cost savings of almost \$10 billion and societal cost savings (including indirect costs) of more than \$43 billion.⁶

According to the Centers for Disease Control and Prevention (CDC), if immunization practices ceased, most infectious diseases now prevented by vaccines would reemerge as serious health threats. In a case-control study, researchers with Kaiser Permanente of Colorado traced 11 percent of all pediatric pertussis cases back to vaccine refusal by parents.⁷

A shortage of the HiB vaccine occurred during 2008, due to a voluntary recall at the end of 2007. The CDC recommended that doctors temporarily stop administering the booster dose to healthy children age 12 to 15 months who were not at high risk for developing invasive HiB. Children at higher risk for contracting the disease (including those with chronic illness, such as sickle cell disease, cancer, and HIV, as well as American Indian and Alaska Native children) still should have received the vaccine. Also, infants should have received the initial three-dose vaccine series at 2, 4, and 6 months of age.⁸ Two HiB outbreaks in unvaccinated or incompletely vaccinated children younger than 5 years of age were reported in early 2009. In Pennsylvania, three of seven children died, and in Minnesota, one of five children died.⁹ In June 2009, the CDC and other organizations recommended that physicians immediately reinstate the HiB booster dose for children age 12–15 months who completed the three-dose primary series.¹⁰

County and state health organizations throughout Washington use the Department of Health's (DOH) CHILD Profile immunization registry. As of July 2009, 87 percent of all Washington providers—up from 80 percent in July 2008—had data-sharing agreements with CHILD Profile. As of June 2009, the registry contained almost 6 million immunization records, including at least two records for 94 percent of children under age 6. In addition, nearly 228 school districts now participate. CHILD Profile exchanges data with Oregon, Idaho, Arizona, and Louisiana.

Most participating organizations, including clinics, public health departments, and hospitals, enter data into CHILD Profile on a daily or weekly basis, or submit claims or encounter data once or twice a month. School users can view but not add immunization data. Health plans submit claims data monthly, quarterly, or annually, and receive updated registry data during the winter to augment their data collection for the HEDIS immunization measure. All plans take part in activities to increase awareness and use of the registry.

Because of state budget restrictions, Washington is phasing out the state-funded portion of universal vaccine purchasing. Beginning May 1, 2010, state funds will no longer pay for any vaccine for children with private health insurance. State-supplied vaccines will be purchased only for those eligible for the federal Vaccines for Children (VFC) program, and for children in families under 300 percent of the federal poverty level who are enrolled in state-sponsored health programs. VFC-eligible children are those who are eligible for Medicaid, are uninsured or underinsured for the vaccine, or are Native American and Alaskan Native.¹¹ With these changes, private healthcare providers, who administer more than 90 percent of all childhood immunizations, will have to buy vaccine for their privately-insured patients, screen children to see if they are eligible for state-supplied vaccine, and keep separate inventories and records for privately and publicly-purchased vaccines.¹² Current efforts are underway between DOH and a statewide coalition to examine ways to maintain universal vaccine coverage.

AFIX (Assessment, Feedback, Incentive, and Exchange) is the CDC's quality improvement (QI) tool for raising immunization coverage levels and improving practice standards at the provider level. State immunization programs have used the AFIX methodology in public health clinics that administer childhood immunizations, even as the bulk of immunization services have shifted to the private sector. The CDC recommends that federally funded immunization programs conduct annual AFIX site visits in at least 25 percent of provider offices.¹³ The Washington State DOH conducts AFIX visits in conjunction with CHILD Profile.

Measure definition

This measure assesses the percentage of enrolled children who turned two years old during the measurement year, who were continuously enrolled for 12 months immediately preceding their second birthday, and who received the following vaccinations:

- four diphtheria, tetanus, and acellular pertussis (DTaP)
- three polio (IPV)
- one measles, mumps, and rubella (MMR)
- two *Haemophilus influenzae* type b (HiB)^a
- three hepatitis B (Hep B)
- one varicella-zoster virus (VZV)
- four pneumococcal conjugate (PCV)
- Combination #2 (Combo 2) includes all antigens listed above except for PCV; received four
- Combination #3 (Combo 3) includes all antigens listed above; received four

Data collection method: Administrative or hybrid

^aDue to the HiB vaccine shortage, only two of the three doses are required for HEDIS 2009.

Trends for all immunizations

Figure 3 shows the Healthy Options state averages for seven separate immunizations and for the Combo 2 and Combo 3 indicators for reporting years 2005–2009. The 2009 results indicate a continuing stabilization of statewide immunization rates, except for the VZV, HiB, and Hep B vaccines. HiB and VZV rates rose significantly from 2008 to 2009, while the Hep B rate fell significantly. State averages remain above the national averages for DTaP, IPV, MMR, HiB, PCV, and Combo 3. The state averages for Hep B, VZV and Combo 2 are below the national averages.

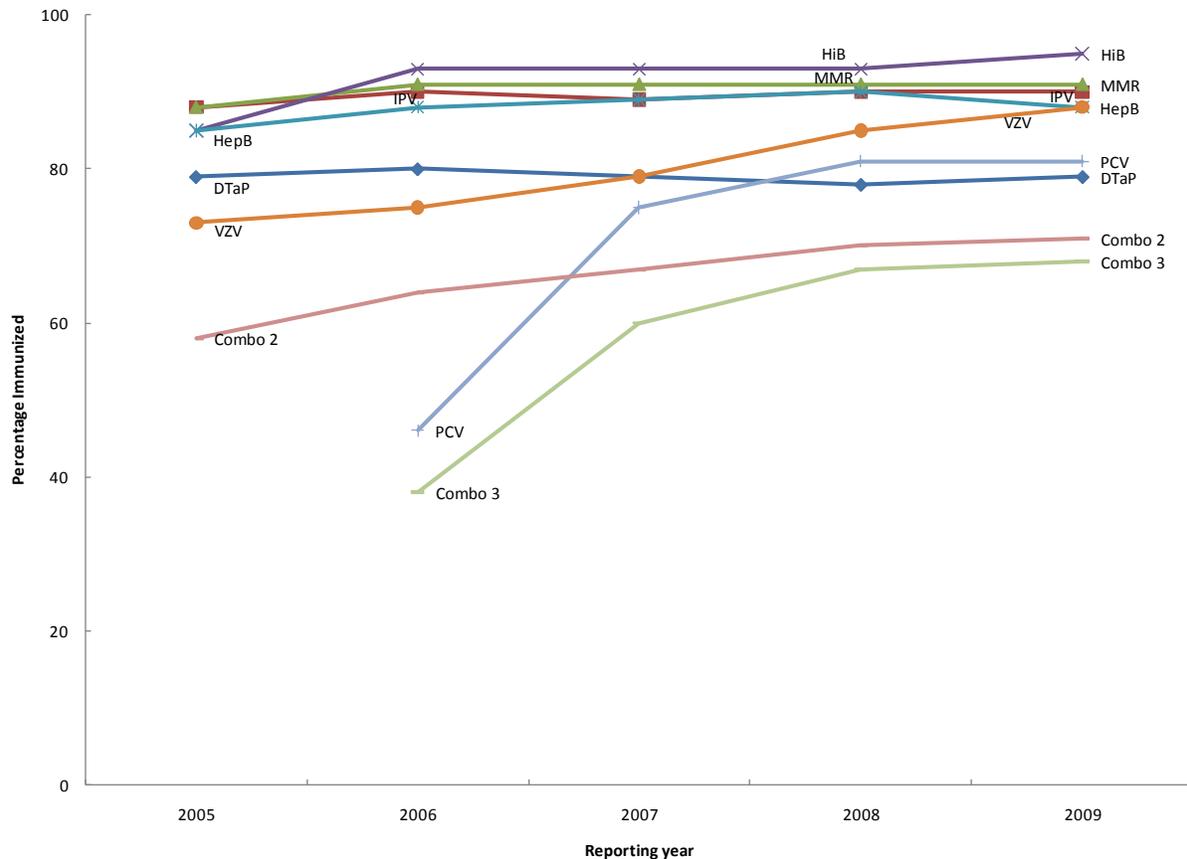
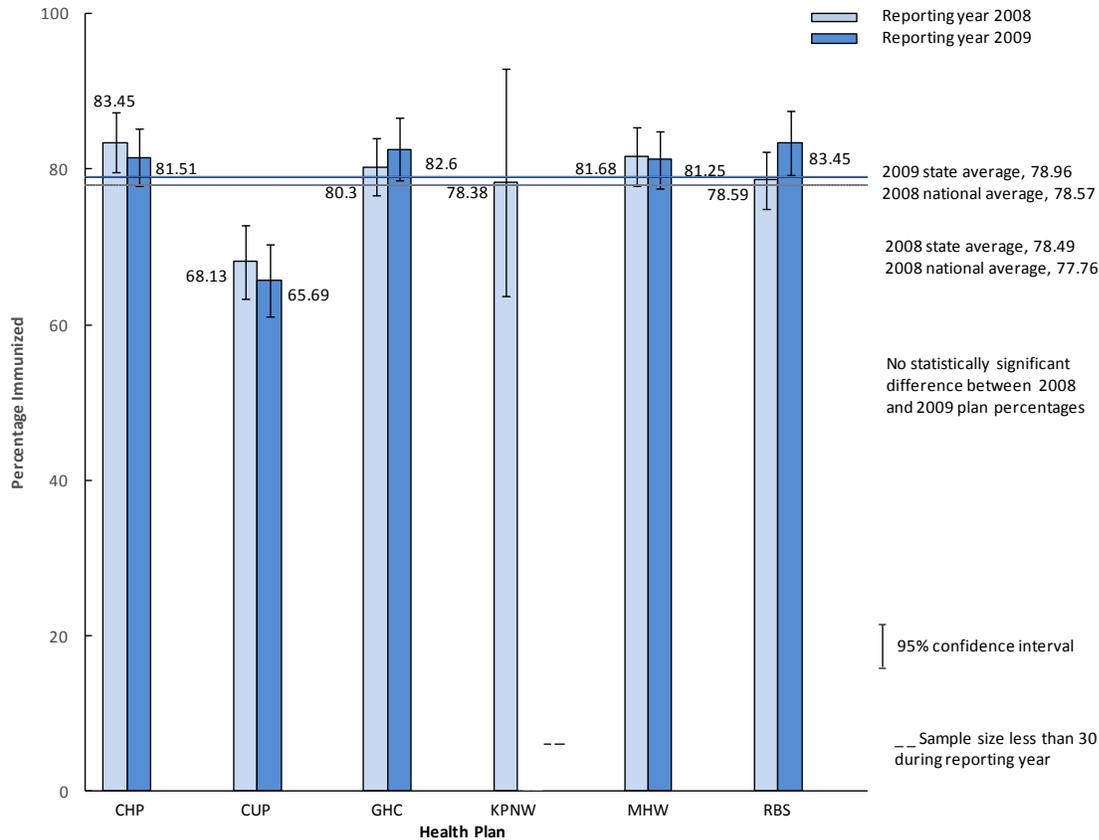


Figure 3. State averages for seven immunizations, Combo 2, and Combo 3, reporting years 2005–2009.

Statewide performance in the six antigens comprising Combo 2 is at 80 percent or higher in reporting year 2009, and two rates are above 90 percent (MMR, HiB). The federal benchmark report, *Healthy People 2010*, sets 80 percent as the target for health plans to achieve by 2010 for DTaP, IPV, MMR, HiB, and HepB, and 90 percent for PCV.¹⁴

Diphtheria, Tetanus, and Pertussis (DTaP)

The 2009 statewide average for this indicator was 78.96 percent, nearly identical to the 2008 rate; the median in 2009 was 81.93 percent. RBS’s DTaP immunization rate significantly exceeded the state average in 2009, while CUP’s rate was significantly below average. The state average was above the national average of 78.57 percent, although the difference was not significant. Figure 4 shows that four plans had percentages above the 2009 national average. No statistically significant changes occurred in plan percentages from 2008 to 2009.

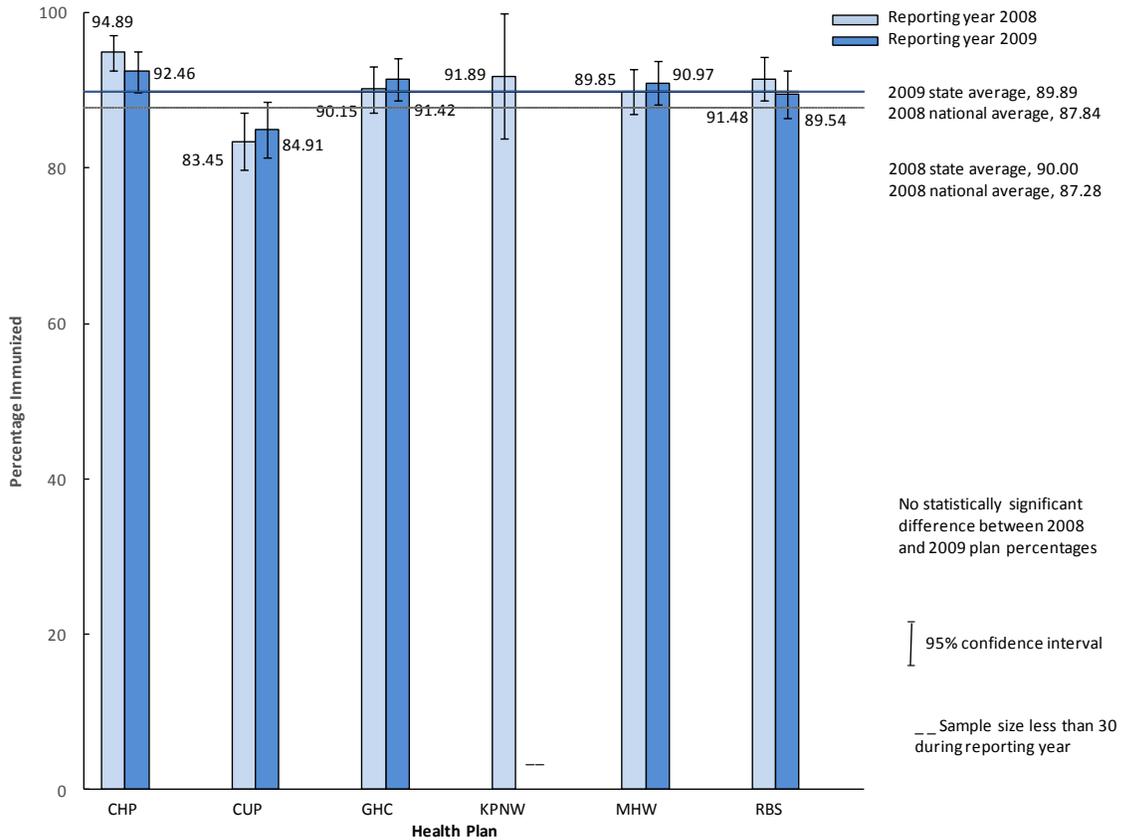


National averages are from the National Committee for Quality Assurance

Figure 4. DTaP immunizations by health plan, reporting years 2008–2009.

Inactivated Polio Vaccine (IPV)

The 2009 statewide average for this indicator was 89.89 percent, slightly below 2008’s 90 percent; the median in 2009 was 90.26 percent. Figure 5 shows that four plans scored higher than the 2009 national average of 87.84 percent; the state average was significantly higher than the national average. CUP’s rate, however, was significantly below the state average. The six-year state average trend shows significant improvement, up from 86.96 percent in 2004.

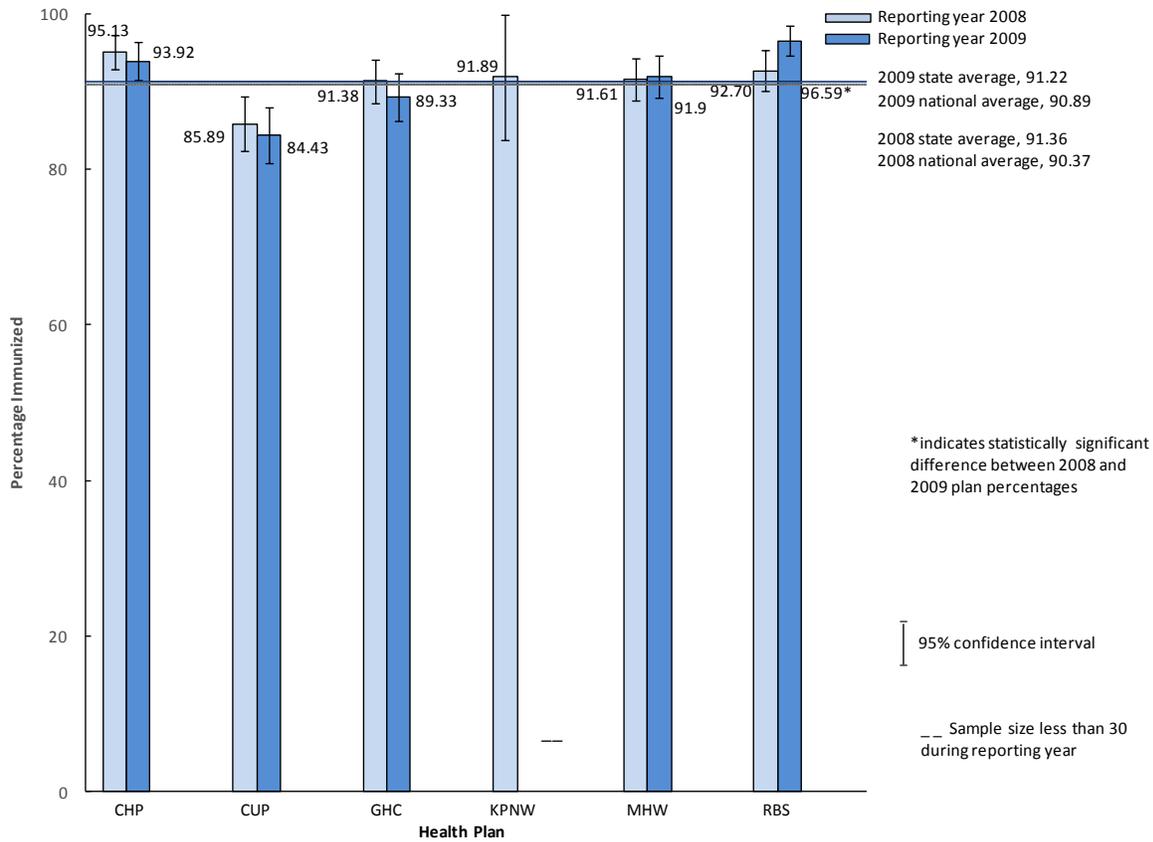


National averages are from the National Committee for Quality Assurance

Figure 5. IPV immunizations by health plan, reporting years 2008–2009.

Measles, Mumps, and Rubella (MMR)

The 2009 statewide average for this indicator was 91.22 percent, slightly below the 91.36 percent average in 2008; the median in 2009 was 90.62 percent. As shown in Figure 6, three plans scored above 90 percent, and RBS reported a significant increase from its 2008 rate. The 2009 state average was higher than the national average of 90.89, though not significantly higher. RBS significantly outperformed the state average, while CUP’s rate was significantly below average. The state average has improved significantly since 2004, up from 88.55 percent.

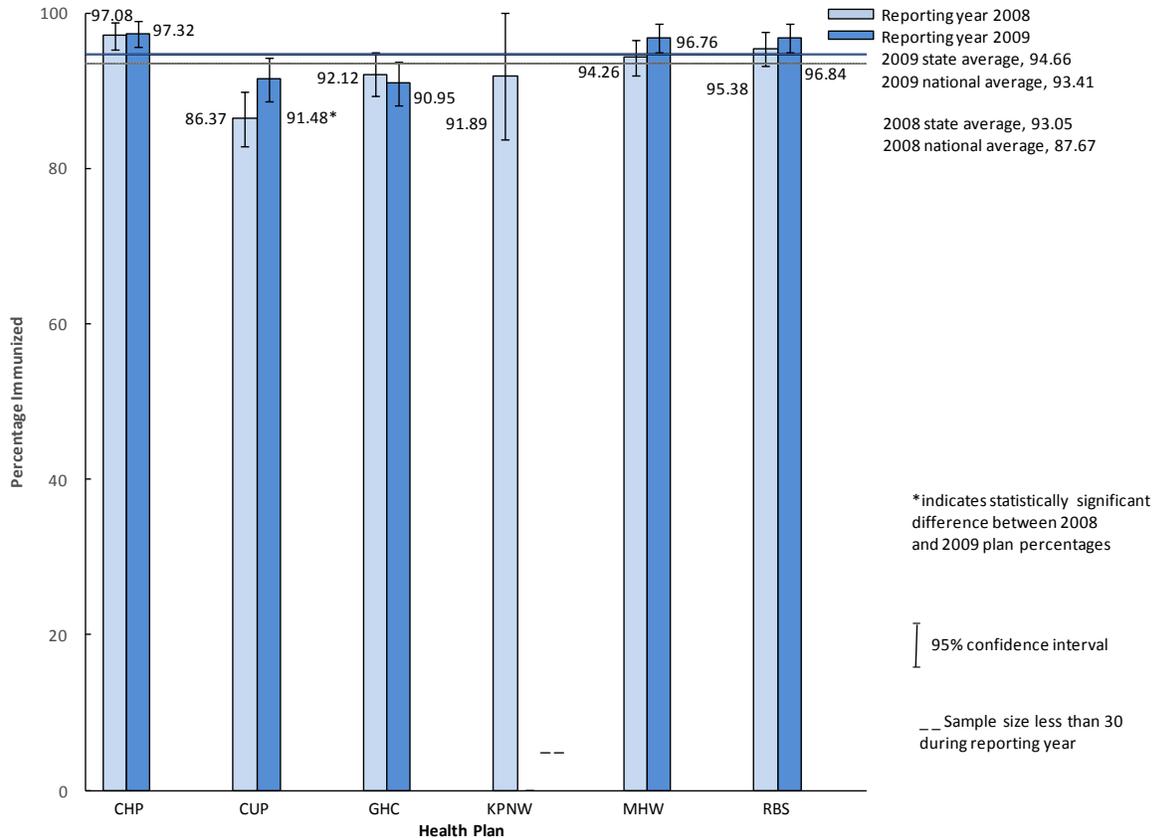


National averages are from the National Committee for Quality Assurance

Figure 6. MMR immunizations by health plan, reporting years 2008–2009.

Haemophilus Influenzae Type B (HiB)

The 2009 statewide average for this indicator was 94.66 percent, significantly higher than the 93.05 percent average in 2008; the median in 2009 was 94.12 percent. Figure 7 shows that three plans' percentages exceeded the 2009 national average of 93.41 percent, the state average being significantly above the NCQA average. CUP's rate improved significantly in 2009 but remained significantly below the state average, as was GHC's rate. CHP reported the highest rate among Healthy Options plans (over 97 percent) and significantly outperformed the state average. The statewide HiB rate has increased by more than 10 percentage points since 2004.

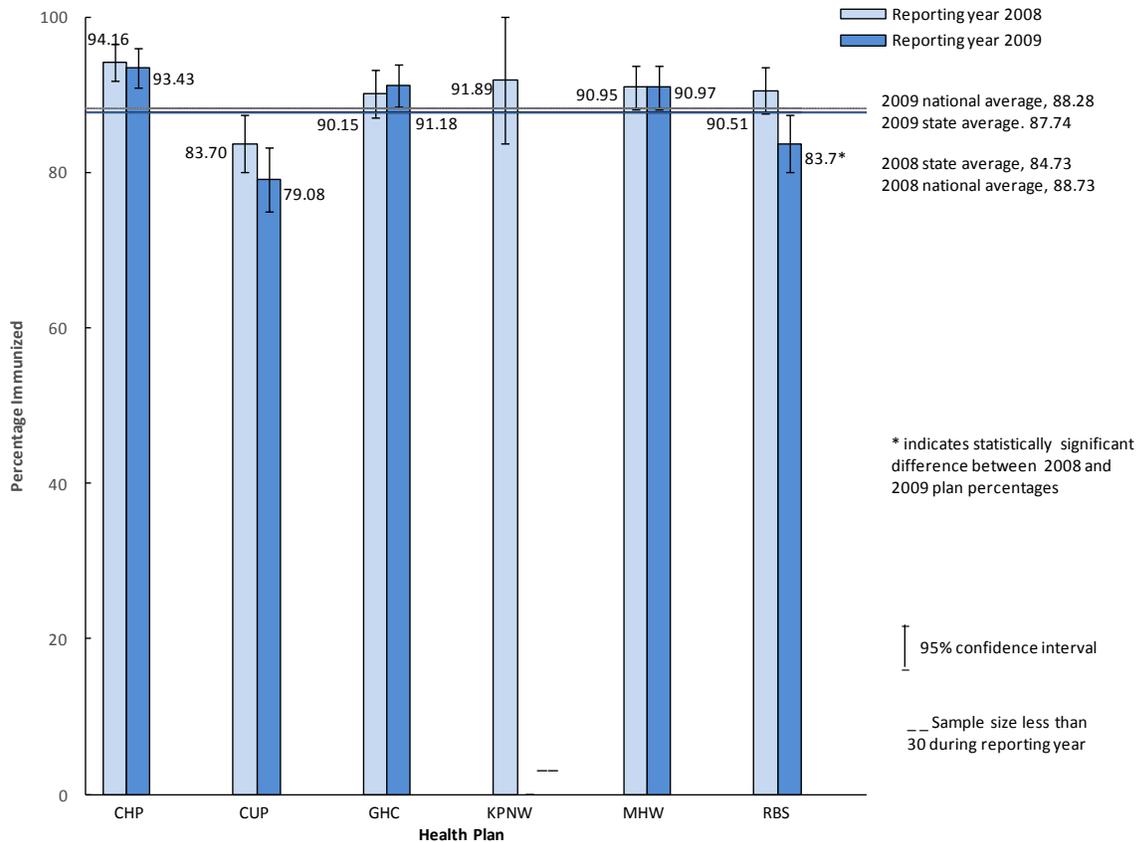


National averages are from the National Committee for Quality Assurance

Figure 7. HiB immunizations by health plan, reporting years 2008–2009.

Hepatitis B (Hep B)

The 2009 statewide average for this indicator was 87.74 percent, down significantly from 89.95 percent in 2008; the median in 2009 was 87.34 percent. This is the first time in four years that the statewide Hep B immunization rate has decreased. Figure 8 shows that three of the plan percentages were above the 2009 national average of 88.28 percent, although the state average was below the NCQA average. RBS’s rate fell significantly, from 90.51 percent in 2008 to 83.7 percent in 2009. Rates for CHP, GHC, and MHW significantly exceeded the state average, while CUP’s and RBS’s rates were significantly below average.

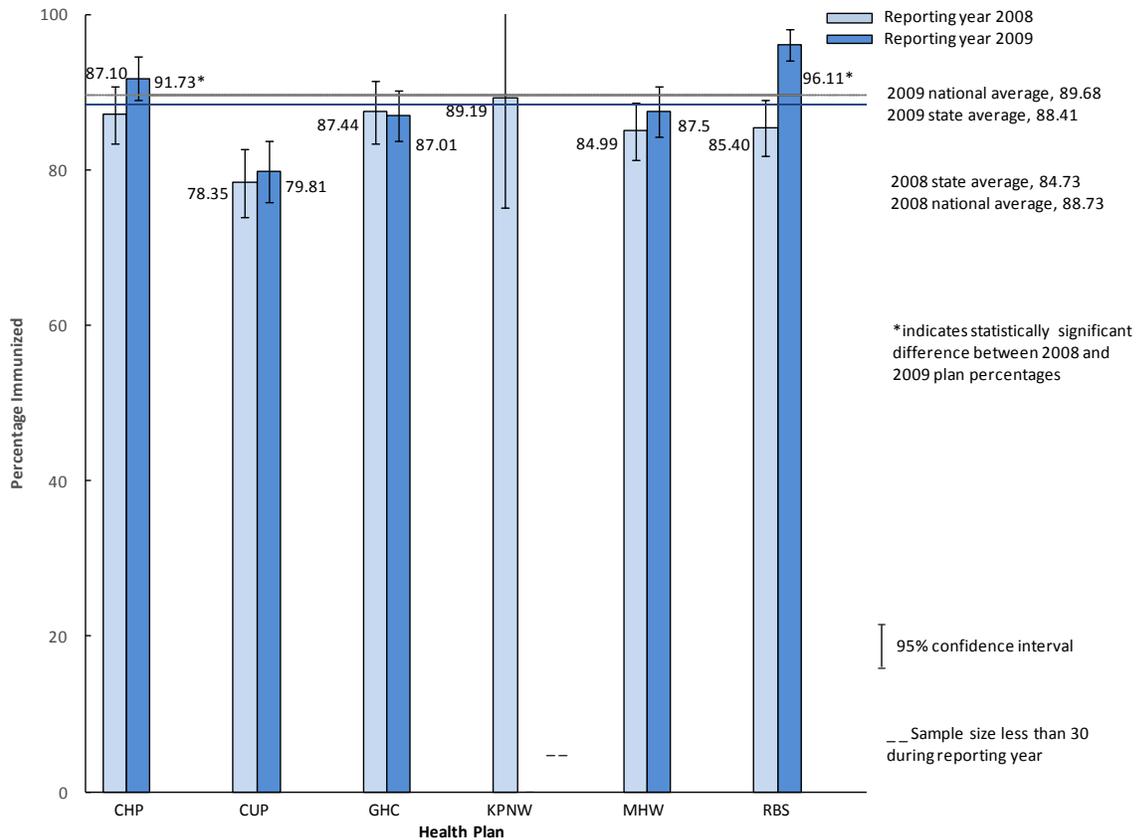


National averages are from the National Committee for Quality Assurance

Figure 8. Hep B immunizations by health plan, reporting years 2008–2009.

Varicella-Zoster Virus (VZV)

The 2009 statewide average for this indicator was 88.41 percent, up significantly from 84.73 percent in 2008; the median in 2009 was 87.26 percent. CHP's and RBS's rates improved significantly from the previous year. Figure 9 shows that CHP and RBS exceeded the 2009 national average, while CUP, GHC, and MHW were below the national average. The state average remained below the NCQA average, but the difference was not statistically significant. Since 2004, the statewide average has risen by about 18 percentage points.

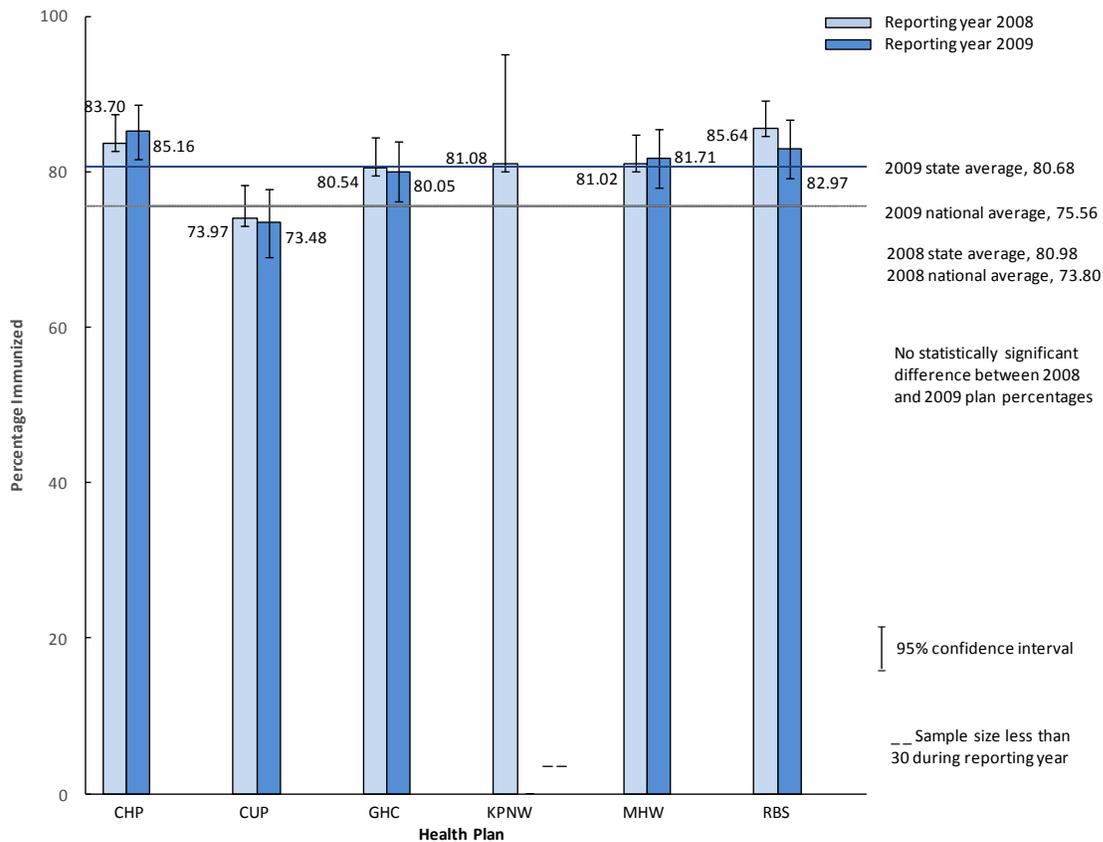


National averages are from the National Committee for Quality Assurance

Figure 9. VZV immunizations by health plan, reporting years 2008–2009.

Pneumococcal Conjugate (PCV)

The 2009 statewide average for this indicator was 80.68 percent, slightly below the 2008 average; the median in 2009 was 80.88 percent. Figure 10 shows that CHP’s rate was significantly higher than the state average, while CUP’s rate was significantly below average. The state average was significantly above the national average of 75.56 percent.

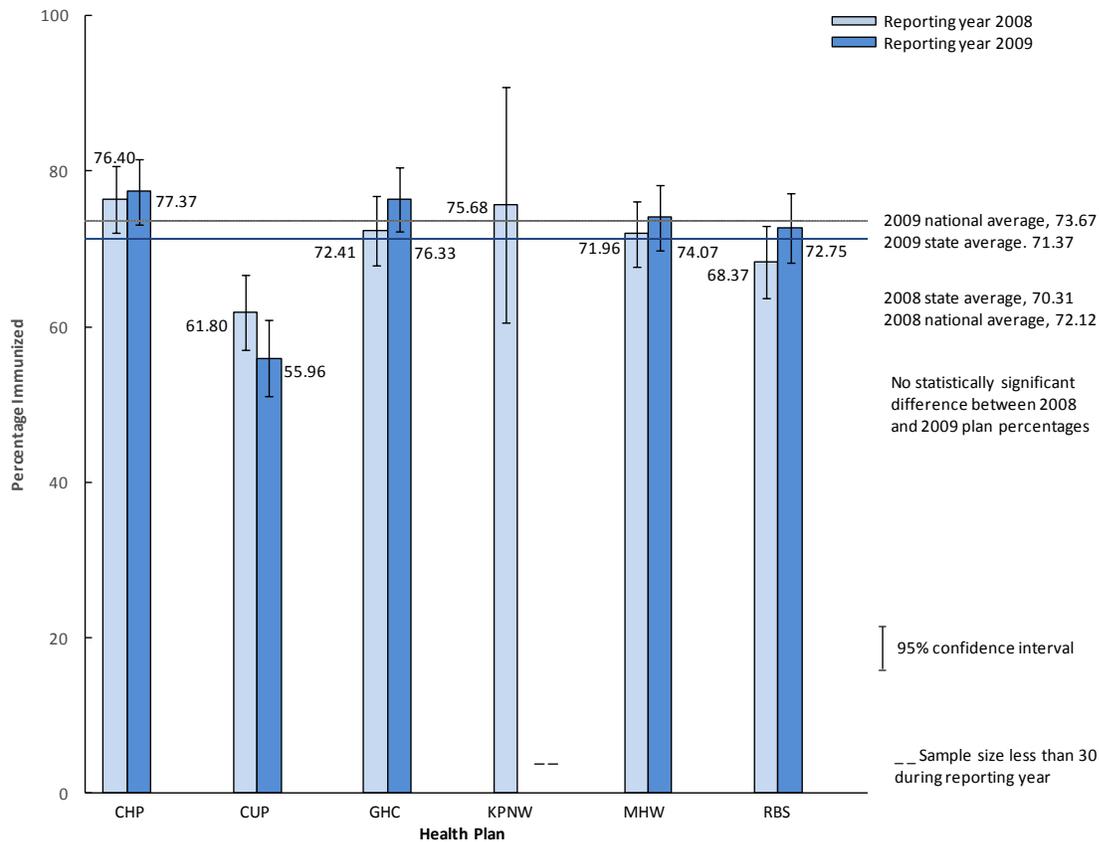


National averages are from the National Committee for Quality Assurance

Figure 10. PCV immunizations by health plan, reporting years 2008–2009.

Combination #2 (Combo 2)

The 2009 statewide average for this combined indicator was 71.37 percent, slightly above the 70.31 percent average in 2008; the median in 2009 was 73.41 percent. Figure 11 shows that CHP's and GHC's rates were significantly higher than the state average, while CUP's rate was significantly lower. The state average was significantly below the 2009 national average of 73.67 percent, although the state average has consistently risen from 54 percent in 2004 to its present level.

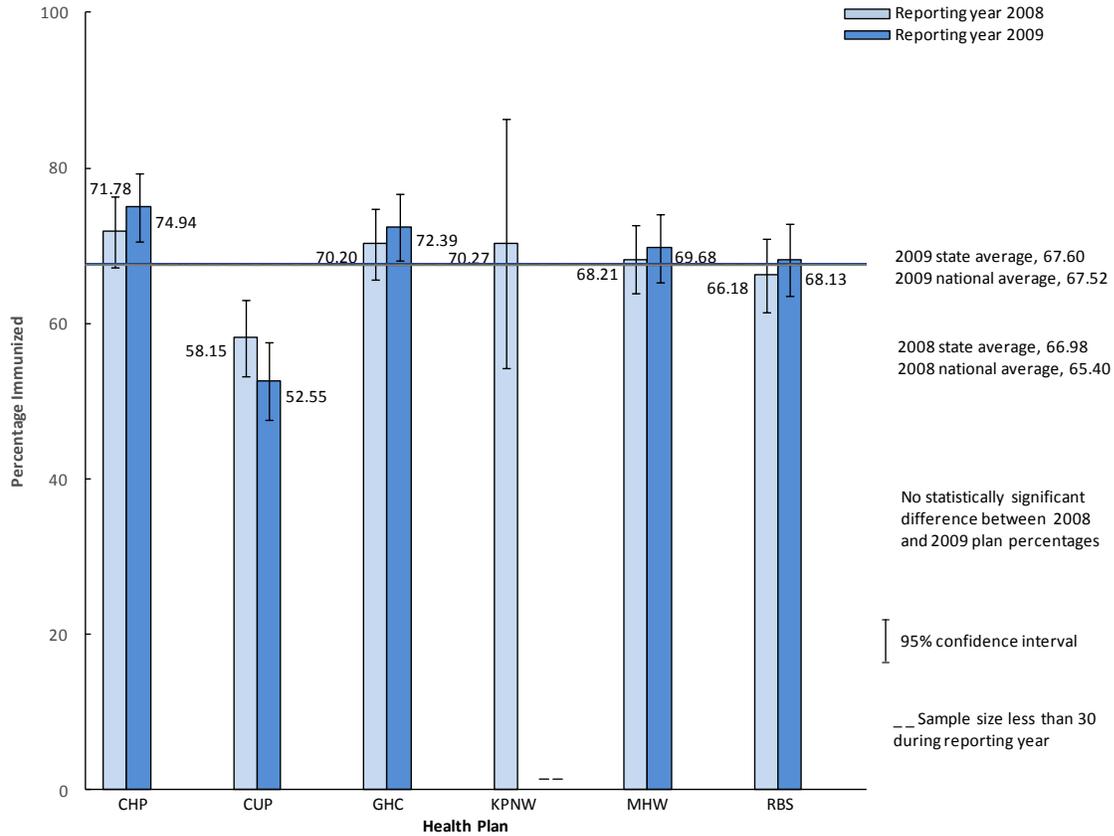


National averages are from the National Committee for Quality Assurance

Figure 11. Combo 2 immunizations by health plan, reporting years 2008–2009.

Combination #3 (Combo 3)

The 2009 statewide average for this indicator was 67.6 percent, slightly above the 66.98 percent average in 2008; the median in 2009 was 72.39 percent. Figure 12 shows that four of the Healthy Options plans increased their Combo 3 immunization rates from 2008. The state average was above the 2009 national average of 67.52 percent, and has risen by more than 30 percentage points since the inception of this measure in 2006.



National averages are from the National Committee for Quality Assurance

Figure 12. Combo 3 immunizations by health plan, reporting years 2008–2009.

Member-level analysis

HRSA required the Healthy Options plans to submit de-identified member-level data on childhood immunization for 2008 and 2009. This year, Acumentra Health received enough data to analyze and report differences in performance by DSHS region, gender, primary language, and race/ethnicity. The DSHS regions are configured as shown below.

Region	Counties
1	Adams, Asotin, Chelan, Douglas, Ferry, Grant, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Whitman
2	Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Yakima
3	Island, San Juan, Skagit, Snohomish, Whatcom
4	King
5	Kitsap, Pierce
6	Clallam, Clark, Cowlitz, Grays Harbor, Jefferson, Klickitat, Lewis, Mason, Pacific, Skamania, Thurston, Wahkiakum

- **Rates by region:**
 - Region 2 rates were higher than every other region in five of the nine measures (DTaP, IPV, MMR, HiB, and VZV). The rates for those measures and for Combo 2 were significantly above the combined rate for other regions. Region 4's rates for DTaP, PCV, Combo 2, and Combo 3 also were significantly above the combined rate for other regions.
 - Region 6 rates were lower than every other region in seven of the nine measures (all but IPV and HiB). Region 6 rates were significantly below the combined rate of other regions for all measures except IPV.
 - Region 1's rate for Hep B was significantly above the other regions' combined rate. However, Region 1's rate for MMR and VZV was significantly below the other regions' combined rate.
- **Rates by gender:**
 - Immunization rates for males were higher in six of nine measures (DTaP, IPV, MMR, HiB, VZV, and PCV), but the differences were not statistically significant.
- **Rates by primary language:**
 - Spanish-speaking enrollees had the highest immunization rate in eight out of nine measures (all but HiB). Russian speakers had the lowest rate in all measures. The HiB rate for Russian speakers was significantly below the aggregate rate.
- **Rates by race/ethnicity:**
 - Hispanic enrollees had the highest immunization rate for all nine measures. The IPV rate for Hispanics was significantly higher than the IPV rates for African Americans and Caucasians. Caucasians had the lowest rate for all measures, but the differences were not statistically significant.

Discussion

The long-term trend of immunization rates has been clearly positive, as shown for Combo 2 and Combo 3. However, results for childhood immunization indicators were mixed in reporting year 2009. The rates for DTaP, IPV, MMR, and PCV immunizations showed signs of leveling off. At the same time, the plans significantly improved their delivery rates for VZV and HiB. CHP and RBS outperformed other plans, improving on five and three measures, respectively, from 2008 to 2009, although not all improved significantly. As a group, the Healthy Options plans significantly outperformed the national average for IPV, HiB, and PCV; aggregate rates for DTaP, MMR, and Combo 3 were above the national average, though not significantly above. The state average rate for Hep B fell significantly from 2008.

The Healthy Options plans' favorable performance, relative to the national averages for most indicators, should not lead to complacency. "Herd immunity" exists when a group resists attack by a disease because a large number of individuals are immune; the more immune individuals, the less likely it is that a susceptible person will come into contact with someone who has the disease. Nevertheless, outbreaks of disease can and do occur even when a high level of herd immunity is reached.¹⁵ The Healthy Options plans need to continue to seek ways to increase their immunization rates.

As reported in the 2009 NCQA *Quality Compass*, Combo 2 and 3 immunization rates in the Pacific Region (Alaska, Washington, Oregon, California, and Hawaii) lagged behind the top-performing region. The New England Region, the top performer for all immunizations, reported average rates of 81.77 percent for Combo 2 and 78.72 percent for Combo 3, compared with 76.58 percent and 72.12 percent for the Pacific Region, respectively. The South Atlantic Region reported the lowest rates, 67.44 percent for Combo 2 and 60.65 percent for Combo 3.

Increasing use of the CHILD Profile registry and contractual incentives for performance improvement have contributed to long-term success in improving immunization rates. The four highest performing Healthy Options plans receive payments based on their performance relative to other plans and on the amount of improvement from previous to current year.

According to the CDC, the following themes have emerged in states with the highest immunization rates:

- insuring the effectiveness of AFIX
- fostering strong leadership and senior management support
- establishing partnerships (i.e., private providers, local-state, finding "common ground")
- creating consistent provider education and communication programs
- sustaining passionate and competent program staff
- building and sustaining community trust and involving community stakeholders/leaders
- using immunization registries
- gaining and promoting program visibility
- developing vaccine safety education programs
- enacting immunization laws for school and child care entry
- creating parental reminder/recall systems¹⁶

In a report to the state legislature, HRSA recommended these strategies for improving immunization rates:

- expand provider and parent education and strengthen quality assurance oversight activities with an enhanced AFIX program
- address the ease with which parents can exempt their children from immunizations
- conduct a research study of immunization performance to help target QI efforts
- increase the vaccine administration fee for Medicaid providers
- implement the planned Medicaid pay-for-performance mechanism for childhood immunizations¹⁷

Recommendations

Further improvement requires a long-term commitment to strategies that have proved effective, as shown by experience with Combo 2. The state and the Healthy Options plans should continue to invest in activities that lead to sustainable change, such as:

- coordinate and fund clinic-level QI projects for preventive care
- dedicate resources for unique ways to provide incentives to clinics and Medicaid enrollees to ensure that children are immunized
- perform a root-cause analysis to identify underlying problems that may interfere with children's ability to receive the recommended antigens
- provide clinic-level performance feedback, including HEDIS administrative data on a quarterly basis
- evaluate administrative data on immunizations quarterly to monitor progress
- target unique interventions at underserved populations, such as parents of Russian-speaking children

For the immunization indicators as a whole, the Healthy Options plans obtained a similar share of their numerator "hits" from medical chart review in 2009 as in 2008. This reliance on administrative sources is in line with Acumentra Health's previous recommendations. We reiterate the recommendation that plans

- conduct encounter validation studies to determine the completeness of encounter data, and take steps to improve the data as necessary
- conduct county-level analysis to determine patterns of lower immunization rates that may be an appropriate target for QI activities
- convene representatives to analyze data and design shared best practices

Comprehensive diabetes care

In 2007 (the most recent year for which information is available), diabetes affected nearly 24 million people in the United States (7.8 percent of the U.S. population, including 5.7 million undiagnosed patients), an increase of more than 3 million in approximately two years.¹⁸ In addition, an estimated 57 million Americans have pre-diabetes, a condition that puts people at increased risk for diabetes. The annual cost of diabetes in the United States is estimated at \$174 billion, including \$116 billion in medical expenditures.¹⁹ Diabetes accounts for nearly 20 percent of all deaths of people over age 25.²⁰

In Washington, about 7 percent of adults have been diagnosed with diabetes, up from 4 percent in 1994. Diabetes affects more than 1.4 million state residents: more than 346,000 adults and young people with diagnosed diabetes, almost 147,000 with undiagnosed diabetes, and more than a million with pre-diabetes.²¹

Because the risk factors associated with complications from diabetes are more common in people with low incomes, early diagnosis and treatment are especially important for Medicaid enrollees.²² Effective monitoring and control of a patient's blood glucose and low-density lipoprotein (LDL) levels can significantly reduce the risk of developing heart disease, blindness, end-stage renal disease, stroke, and lower extremity amputation.

The eligible population for this measure is adults 18–75 years of age. Because children account for more than 80 percent of Washington's Medicaid population, health plans with low overall enrollment have difficulty finding enough adult enrollees eligible for the diabetes measures.

In reporting year 2007, NCQA introduced an indicator of “good control” of blood glucose, defined as an HbA1c level below 7 percent. Studies published since then have raised concerns about patient safety related to aggressive HbA1c management. For the current year, NCQA does not require public reporting of this indicator and has refined it by adding exclusions for members within a specific age cohort and with certain co-morbid conditions. NCQA added an indicator for HbA1c < 8 percent as a measure of adequate control for those not excluded from the < 7 percent indicator. HRSA required the Healthy Options plans to report the new indicator this year.

Measure definition

This measure assesses the percentage of enrollees with diabetes (type 1 or type 2), ages 18–75, who were continuously enrolled during the measurement year and who had:

- HbA1c level tested
- poor control of HbA1c levels (HbA1c > 9.0% or no HbA1c test)
- good control of HbA1c levels (HbA1c < 8.0%)
- lipid profile (LDL-C screening) performed during the measurement year
- LDL-C levels controlled (<100 mg/dL)
- dilated retinal exam during, or prior to, the measurement year*
- monitoring for nephropathy (kidney disease) through screening for microalbuminuria, medical attention for nephropathy, a visit to a nephrologist, a positive macroalbuminuria test, or evidence of ACE inhibitor/ARB therapy
- blood pressure control (<140/90 mm Hg) for the most recent blood pressure reading
- blood pressure control (<130/80 mm Hg) for the most recent blood pressure reading

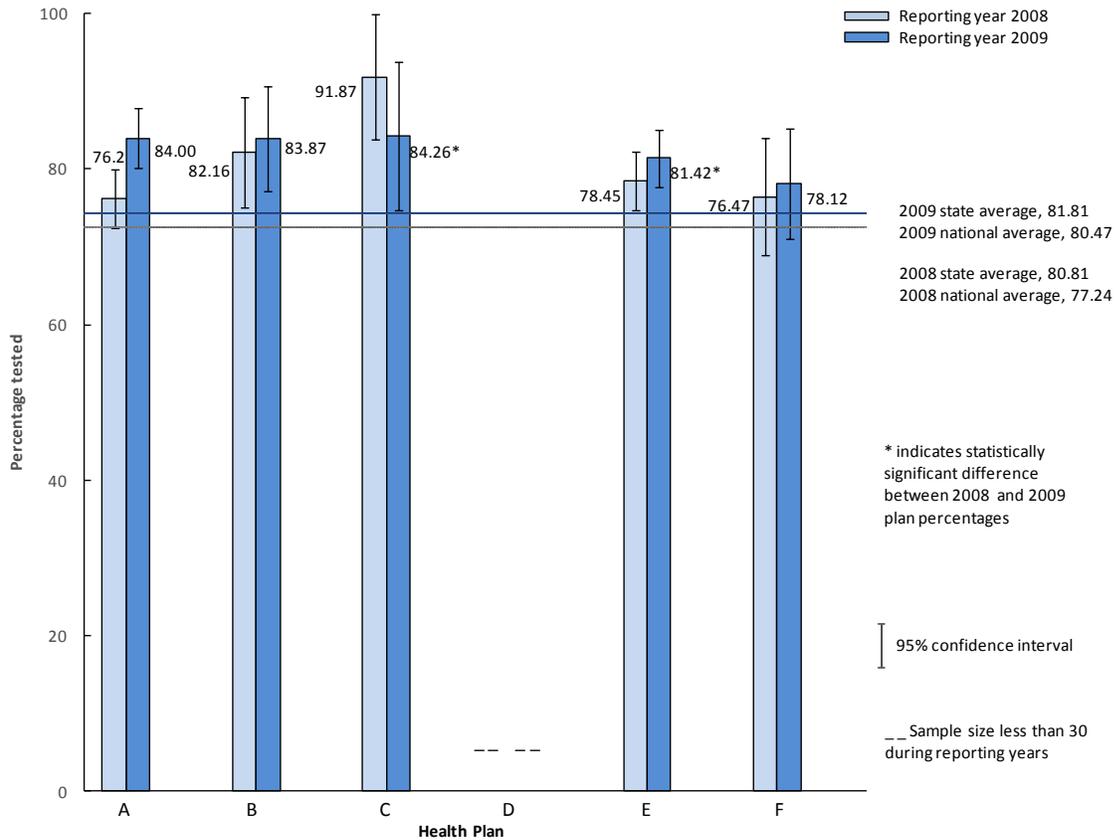
Data collection method: Administrative or hybrid

*Dilated retinal exams performed prior to the measurement year must meet the following criteria for inclusion:

- the dilated retinal exam had a negative outcome (no evidence of retinopathy)
- the enrollee was not prescribed or dispensed insulin during the measurement year

Annual HbA1c test

Between 2005 and 2009, the statewide average for this indicator varied slightly around 80 percent and was higher than the NCQA averages for 2004–2005 and for 2007–2009. Figure 13 shows that the 2009 state average for HbA1c testing was 81.81 percent; the median was 82.00 percent. The state average was slightly higher than the 2009 national average of 80.47 percent.



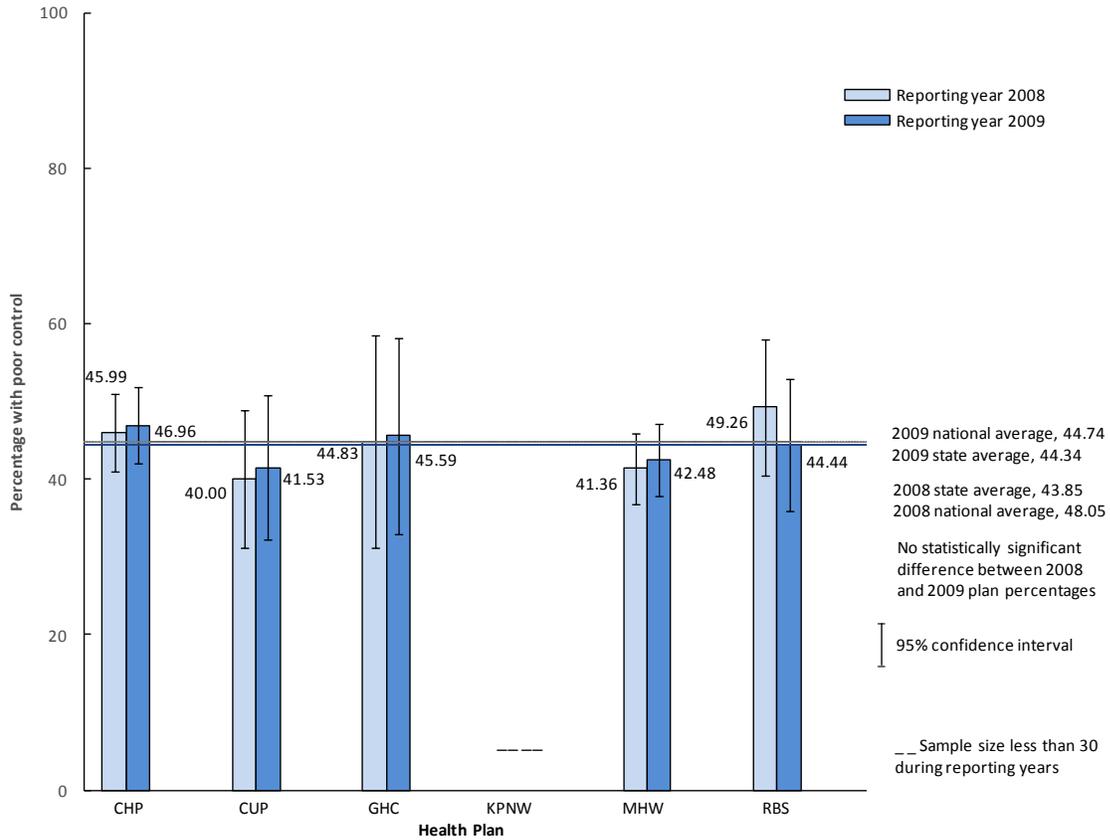
National averages are from the National Committee for Quality Assurance

Figure 13. HbA1c tests by health plan, reporting years 2008–2009.

The HbA1c test shows the average blood glucose level from the previous two to three months. Test results are expressed as a percentage, with 4 to 6 percent considered normal. Maintaining near-normal HbA1c levels can, on average, help people with diabetes gain an extra five years of life, eight years of eyesight, and six years of freedom from kidney disease.²³

Poor HbA1c control (> 9.0%)

The 2009 plan percentages of enrollees with HbA1c levels poorly controlled ranged from a low of 41.53 percent (CUP) to a high of 46.96 percent (CHP). For this indicator, a lower result is favorable. Figure 14 shows that the 2009 statewide average was 44.34 percent; the median was 43.46 percent. The 2009 state average for this measure is slightly lower (i.e., better) than the NCQA average of 44.74 percent. This value has remained fairly static for the past six years.

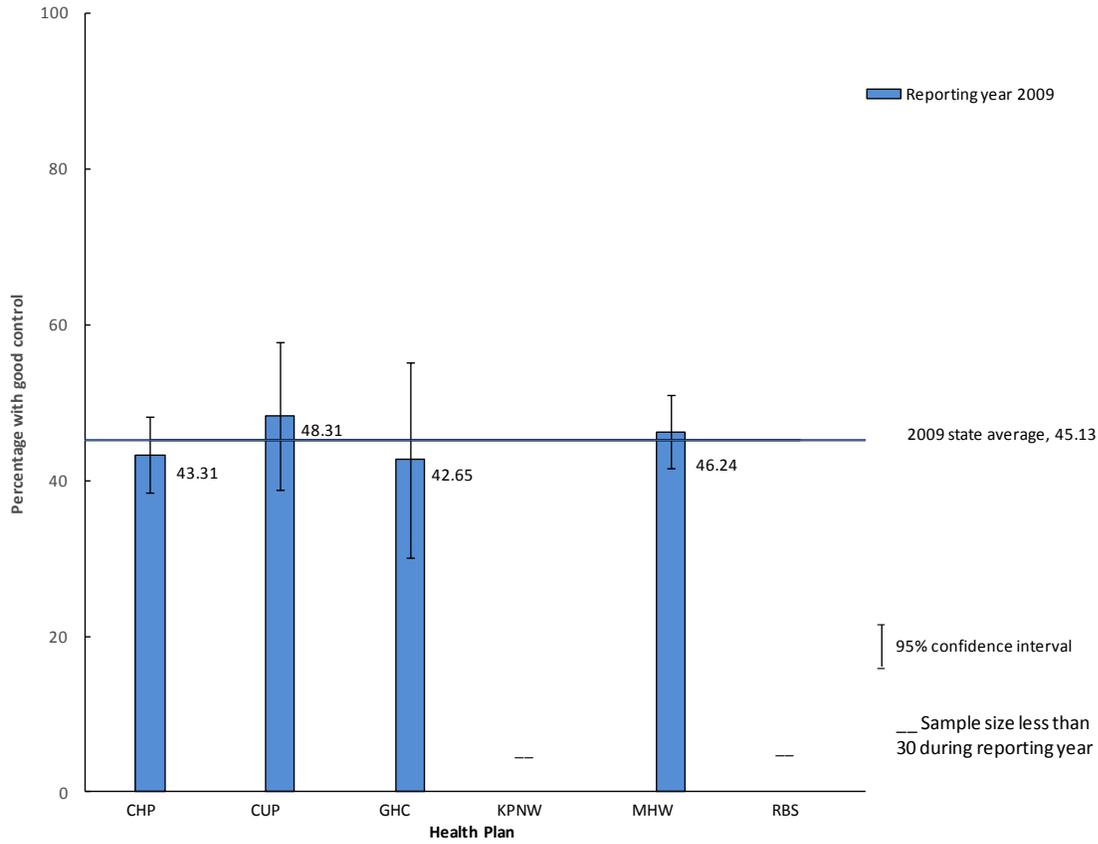


National averages are from the National Committee for Quality Assurance

Figure 14. Enrollees with poor control of HbA1c levels by health plan, reporting years 2008–2009.

Good HbA1c control (< 8.0%)

As noted previously, HRSA required the Healthy Options plans to report this new indicator for the first time in 2009. As shown in Figure 15, four plans reported rates of good HbA1c control for their enrollees, averaging 45.13 percent. CHP and GHC’s averages were less than the state average, while CUP’s and MHW’s were above the average. There is no national comparison at this time.

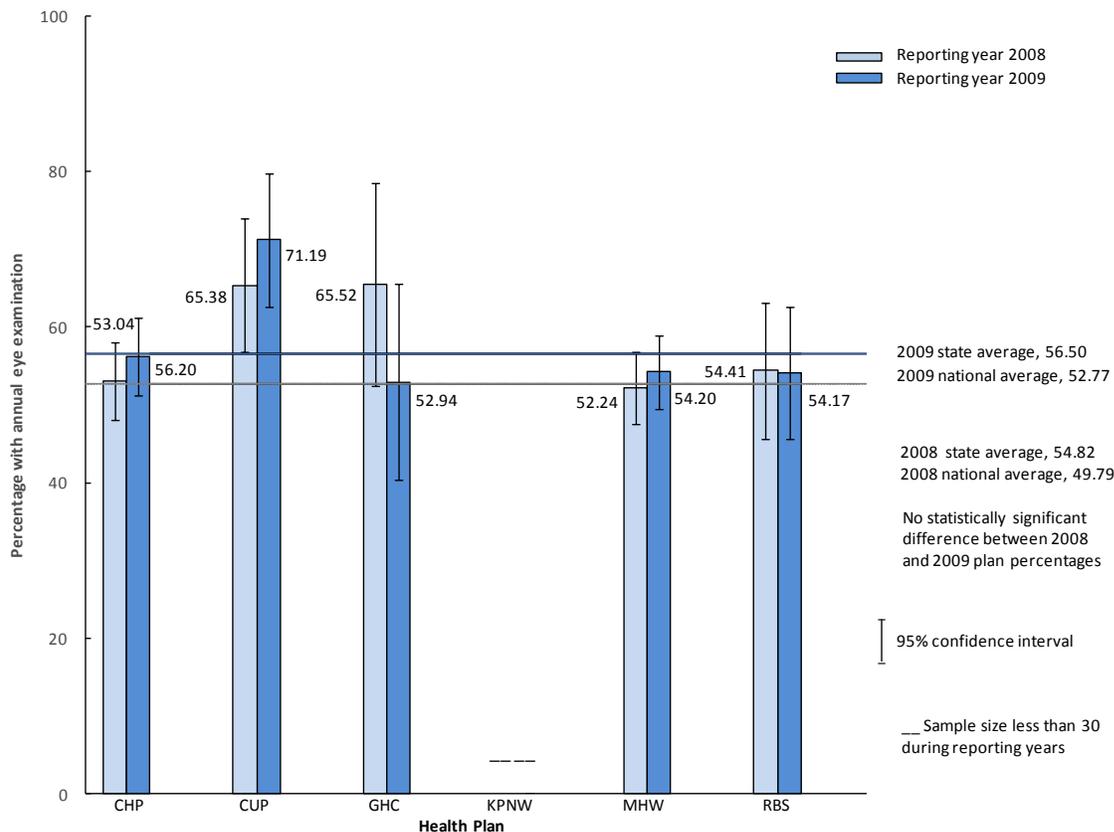


National averages are from the National Committee for Quality Assurance

Figure 15. Enrollees with good control of HbA1c levels by health plan, 2009.

Eye exam

The 2009 statewide average for the proportion of Healthy Options enrollees with an eye exam was 56.5 percent; the median was 54.2 percent. Figure 16 shows that all plans surpassed the national average of 52.77. For the third year in a row, CUP’s performance was significantly better than the state average. The state average was significantly higher than the 2009 national average of 52.77 percent.



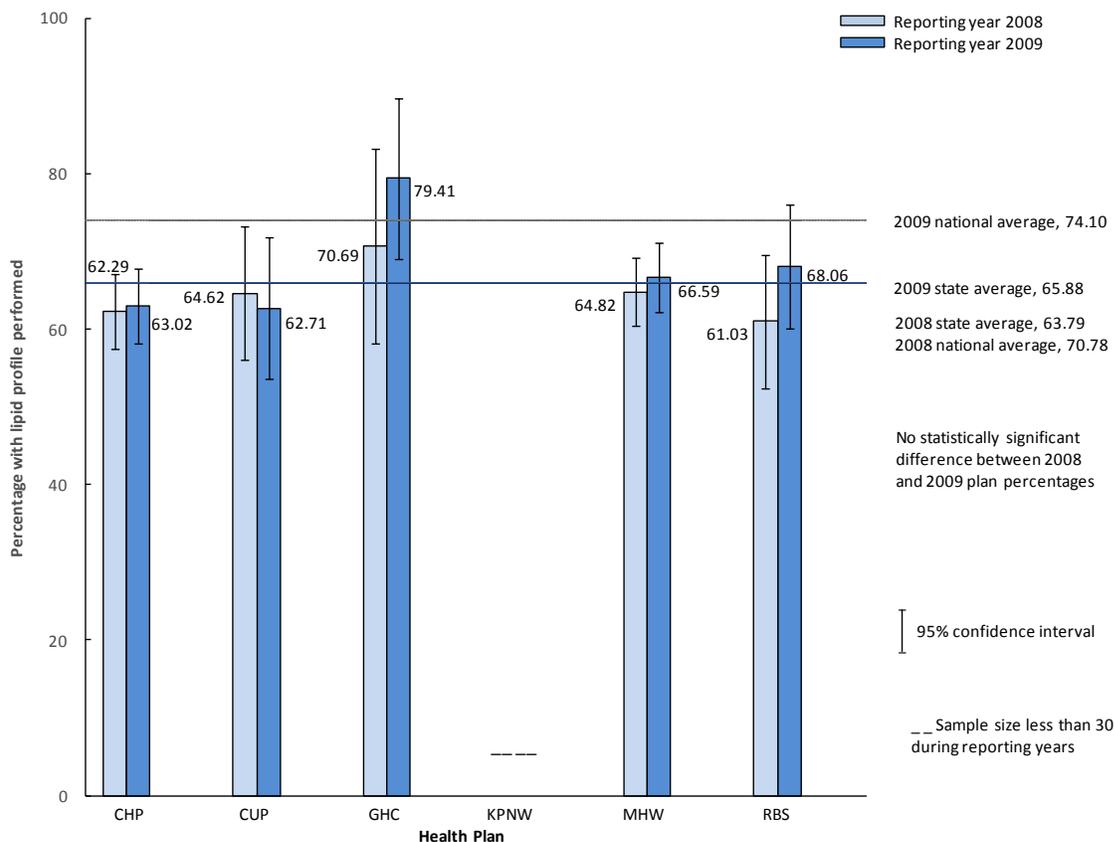
National averages are from the National Committee for Quality Assurance

Figure 16. Dilated retinal exams by health plan, reporting years 2008–2009.

Poor glycemic management and longer duration of diabetes lead to increased rates of diabetic retinopathy (DR), which can result in vision loss and blindness. According to the National Institutes of Health (NIH), management of blood sugar, lipid levels, and blood pressure reduces the risks of DR. Several NIH-supported trials support the benefits of tight glucose control. The Diabetes Control and Complications Trial showed that intensive blood glucose control dramatically delayed or prevented DR and other complications in people with Type 1 diabetes. Another trial showed that lowering blood glucose and blood-pressure levels in people with Type 2 diabetes reduced the risk of DR and other diabetes complications.²⁴

LDL-C screening

The 2009 statewide average for the percentage of Healthy Options enrollees with a lipid profile (LDL-C screening) increased slightly to 65.88 percent; the median in 2009 was 66.59 percent. Figure 17 shows that GHC performed significantly better than the state average. However, the state average was significantly below the 2009 national average of 74.10 percent.



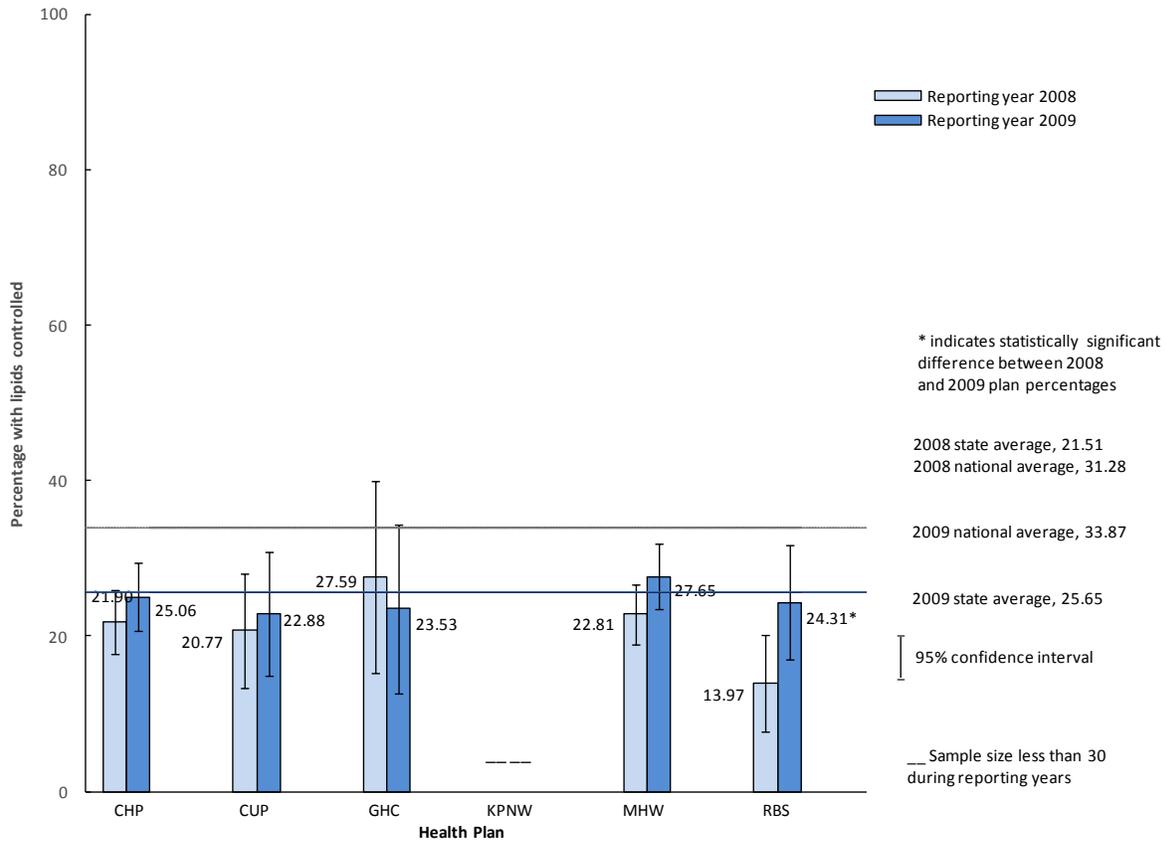
National averages are from the National Committee for Quality Assurance

Figure 17. Lipid profile (LDL-C screening) performed by health plan, reporting years 2008–2009.

LDL can deposit excess cholesterol in the walls of blood vessels, contributing to atherosclerosis (hardening of the arteries) and heart disease. People with Type 2 diabetes and high LDL cholesterol have a higher risk for getting cardiovascular disease, the leading cause of death for patients with diabetes.

LDL-C level <100 mg/dL

The 2009 statewide average for the proportion of enrollees with LDL-C levels below 100 mg/dL was 25.65 percent; the median was 24.31 percent. Figure 18 shows that RBS’s performance improved significantly from 2008. The state average rose significantly from 2008, but remained significantly below the national average of 33.87 percent.



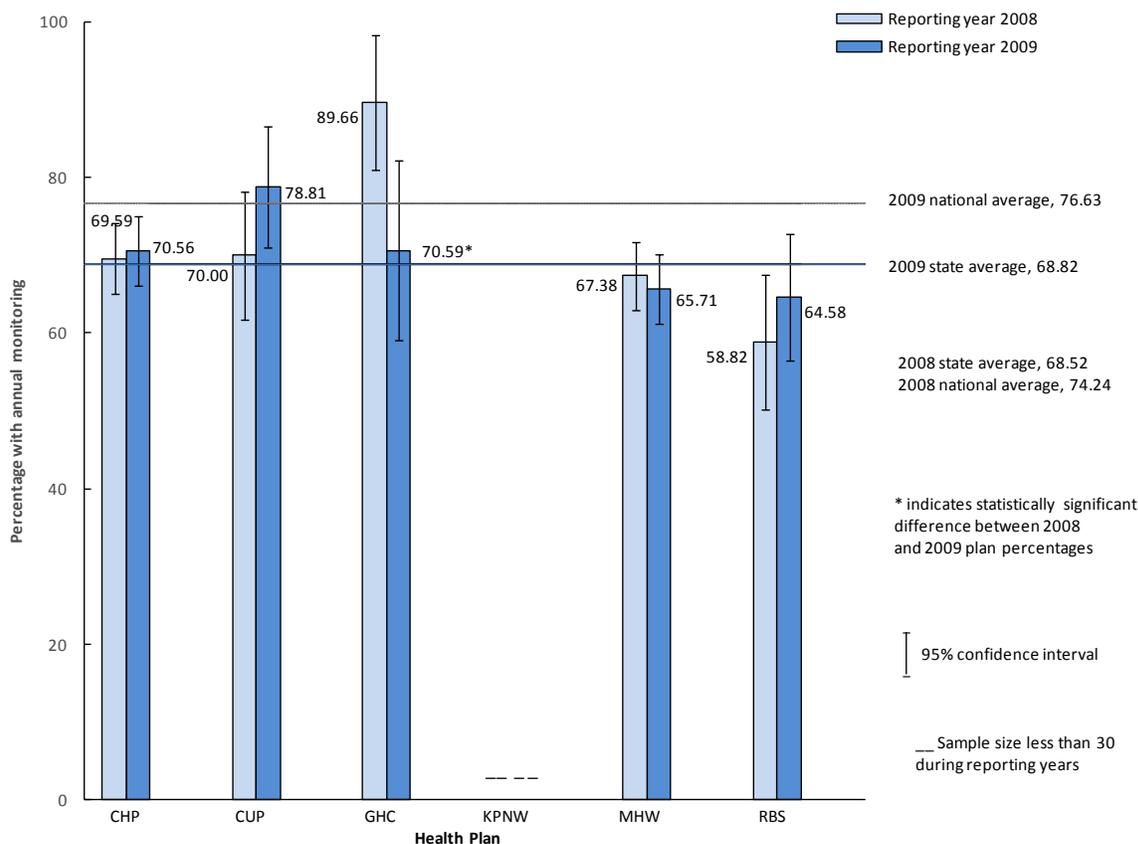
National averages are from the National Committee for Quality Assurance

Figure 18. Lipids controlled (<100mg/dL) by health plan, reporting years 2008–2009.

The American Diabetes Association and the American Heart Association guidelines have recommended since 2001 that patients with diabetes who are at risk for cardiovascular disease maintain lipid levels below 100 mg/dL.^{25,26}

Monitoring for diabetic nephropathy

The 2009 statewide average proportion of enrollees monitored for nephropathy was 68.82 percent; the median was 70.56 percent. Figure 19 shows that CUP significantly outperformed the state average, while GHC’s percentage was significantly lower than in 2008. The 2009 state average was significantly below the national average of 76.63 percent.



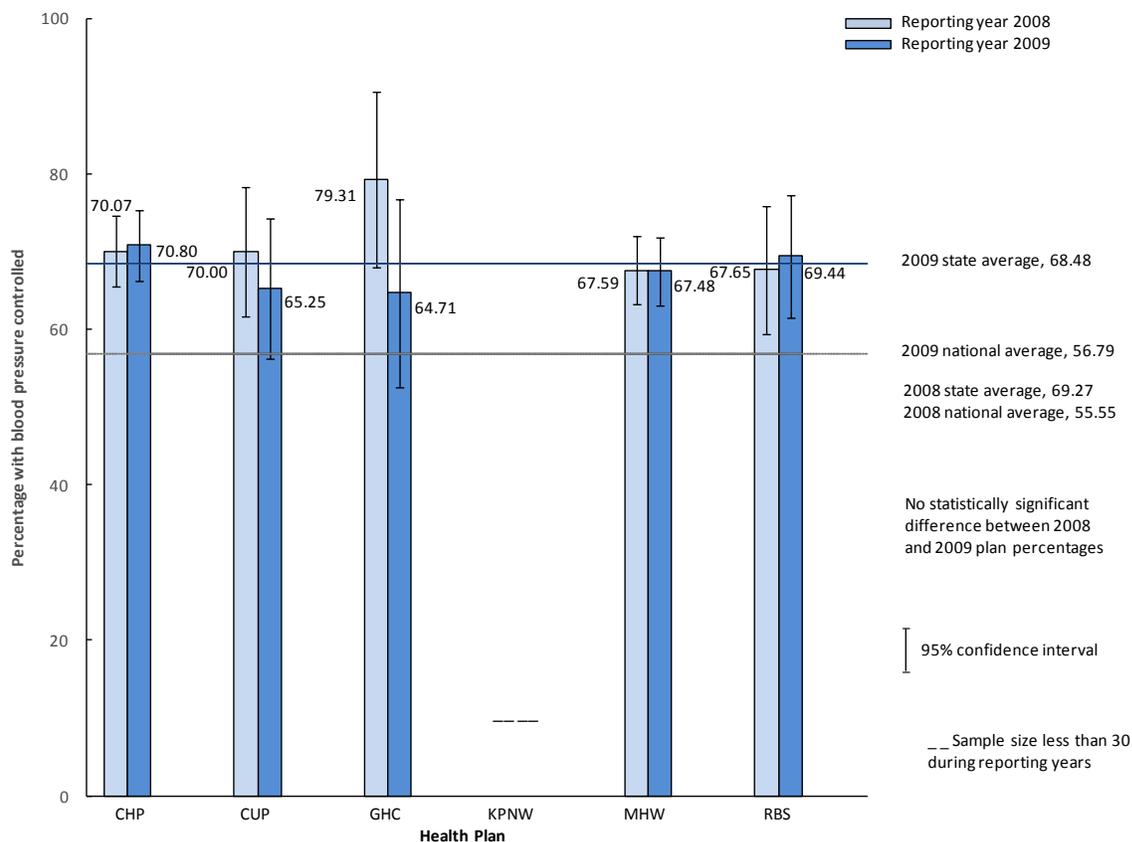
National averages are from the National Committee for Quality Assurance

Figure 19. Nephropathy monitored annually by health plan, reporting years 2008–2009.

Diabetic nephropathy is a progressive disease that can cause kidney failure. Diabetes is the most common cause of kidney failure, which must be treated by dialysis or a kidney transplant. In 2007, according to NIH, diabetes caused more than 180,000 cases of kidney failure, at a health care cost of almost \$32 billion.²⁷ Approximately 20 to 30 percent of patients with diabetes develop evidence of nephropathy, although those with Type 2 diabetes are less likely to develop end-stage renal disease.²⁸

Blood pressure control (<140/90 mm Hg)

The 2009 statewide average proportion of enrollees with diabetes whose blood pressure was controlled below 140/90 mm Hg was 68.48 percent, slightly below the state average in 2008; the median in 2009 was 67.48 percent. Figure 20 shows that CHP and RBS reported modest gains from 2008, while CUP and GHC reported somewhat lower rates than before. The 2009 state average was significantly above the national average of 56.79 percent, and all Healthy Options plans performed above the national average.



National averages are from the National Committee for Quality Assurance

Figure 20. Blood pressure controlled (<140/90 mm Hg) by health plan, reporting years 2008–2009.

High blood pressure is a significant risk factor for developing many complications of diabetes, such as nephropathy and retinopathy. Each reduction of 10 millimeters of mercury in systolic blood pressure reduces the risk of diabetic complications by 12 percent.²⁹

Blood pressure control (<130/80 mm Hg)

The 2009 statewide average proportion of enrollees with diabetes whose blood pressure was controlled below 130/80 mm Hg was 37.13 percent; the median was 36.74 percent. Figure 21 shows that between 35 and 41 percent of enrollees in Healthy Options plans have their blood pressure controlled below this level. The 2009 state average was significantly above the national average of 30.67 percent, and all Healthy Options plans outperformed the national average.

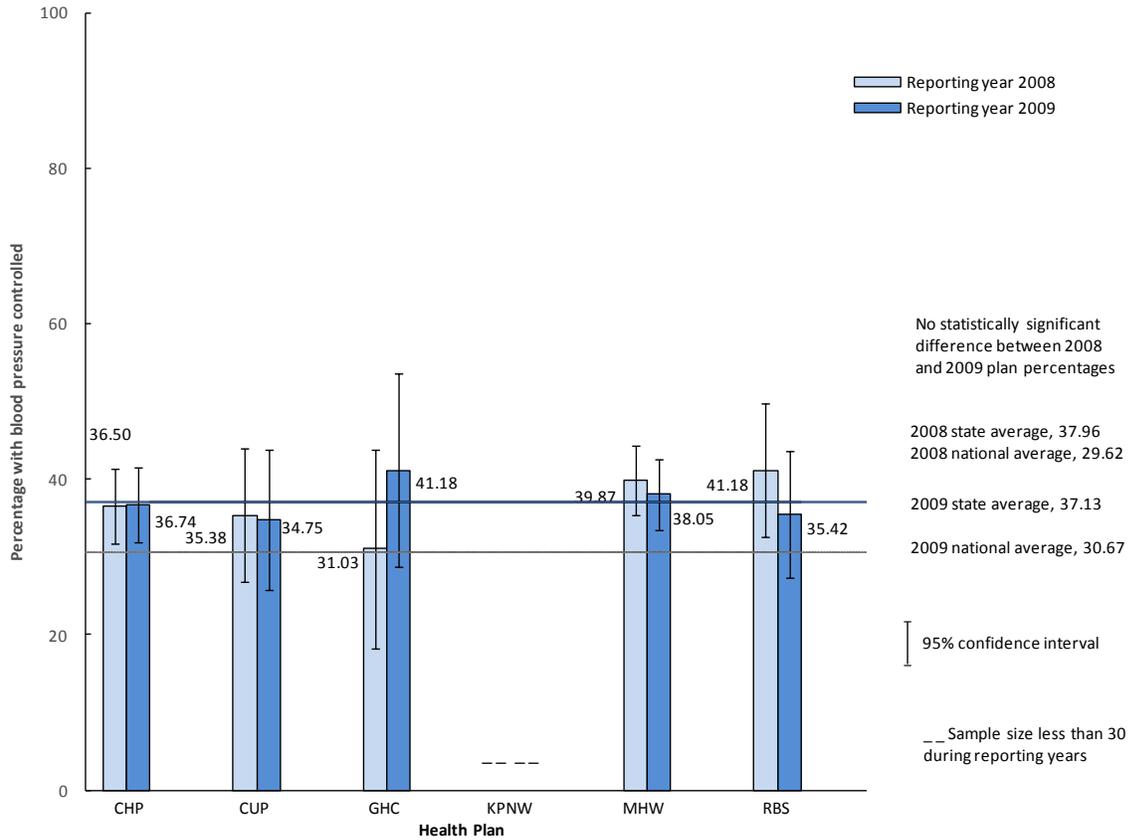


Figure 21. Blood pressure controlled (<130/80 mm Hg) by health plan, reporting years 2008–2009.

The American Diabetes Association and the National Heart, Lung, and Blood Institute recommend that people with diabetes maintain a blood pressure of less than 130/80 mm Hg.

Discussion

Overall, the Healthy Options plans improved their performance on the majority of diabetes care indicators in 2009. Declines in the two blood-pressure control indicators were not significant.

As a group, the Healthy Options plans continue to outperform the national Medicaid average for HbA1c testing and control, dilated retinal exams, and the two blood-pressure control indicators. This trend, consistent with last year's results, will continue to have a positive impact on Healthy Options enrollees. However, the overall performance on most indicators is not robust, leaving room for improvement in delivering eye exams, monitoring for nephropathy, and controlling blood pressure and lipid levels. Changing definitions of the HEDIS measures make it difficult to analyze long-term trends at the state level. Among all indicators, eye exams have shown the most consistent gains.

Recommendations

As a serious and increasingly prevalent chronic disease, diabetes is a critical health issue. The successful interventions to reduce the onset and improve management of diabetes would save lives and reduce costs for Washingtonians.

Acumentra Health recommends that the Healthy Options plans develop care coordination and disease management programs, partnering with providers to implement a proactive approach to diabetes care. The Chronic Care Model (CCM) is a proven model, both nationally and locally, and all plans have received training in this method. Key steps in the CCM include

- identify the population with diabetes
- follow evidence-based guidelines
- provide case management for the high-risk population
- partner with community organizations to combine resources for people with diabetes
- engage patients in self-management and care

In addition, Acumentra Health recommends that the health plans

- partner to create uniform practice guidelines for providers, similar to those for asthma
- provide financial support and training for clinics to implement the Chronic Disease Electronic Management System (CDEMS) and/or an electronic health record
- continue efforts to improve administrative data completeness, and consider creating a case management registry to improve access to relevant data (e.g., laboratory screening and results, most recent blood-pressure results, and pharmacy data)
- encourage use of educational materials from the federal government—for example, the National Diabetes Education Program's "Control Your Diabetes. For Life" campaign³⁰

The health plans also should examine other models of effective diabetes care management. For example, Arkansas' Department of Health and Human Services implemented the Diabetes Disease Management Program, honored by the Utilization Review Accreditation Commission's (URAC) 2009 Best Practices in Health Care Consumer Empowerment and Protection Awards. As part of this program, Medicaid clients receive intensive self-management education from a qualified educator at one of many diabetes education centers throughout the state. Topics include self-examination of the eyes, feet, and skin; making healthy food choices; the importance of exercise; and blood glucose monitoring.

Access to care

Postpartum care

Making certain that pregnant women receive prenatal and postpartum care is essential to ensure that babies are born healthy and remain healthy. In particular, timely postpartum care can help providers detect early signs of problems in the baby's or mother's health.

The American College of Obstetrics and Gynecology strongly encourages pregnant women to schedule an OB/GYN appointment before the 12th week of pregnancy and within 4–7 weeks after the baby's birth.³¹ The HEDIS specifications for this measure align with those time frames. Since 2008, HRSA no longer requires the Healthy Options plans to report rates for delivering prenatal care.

Measure definition

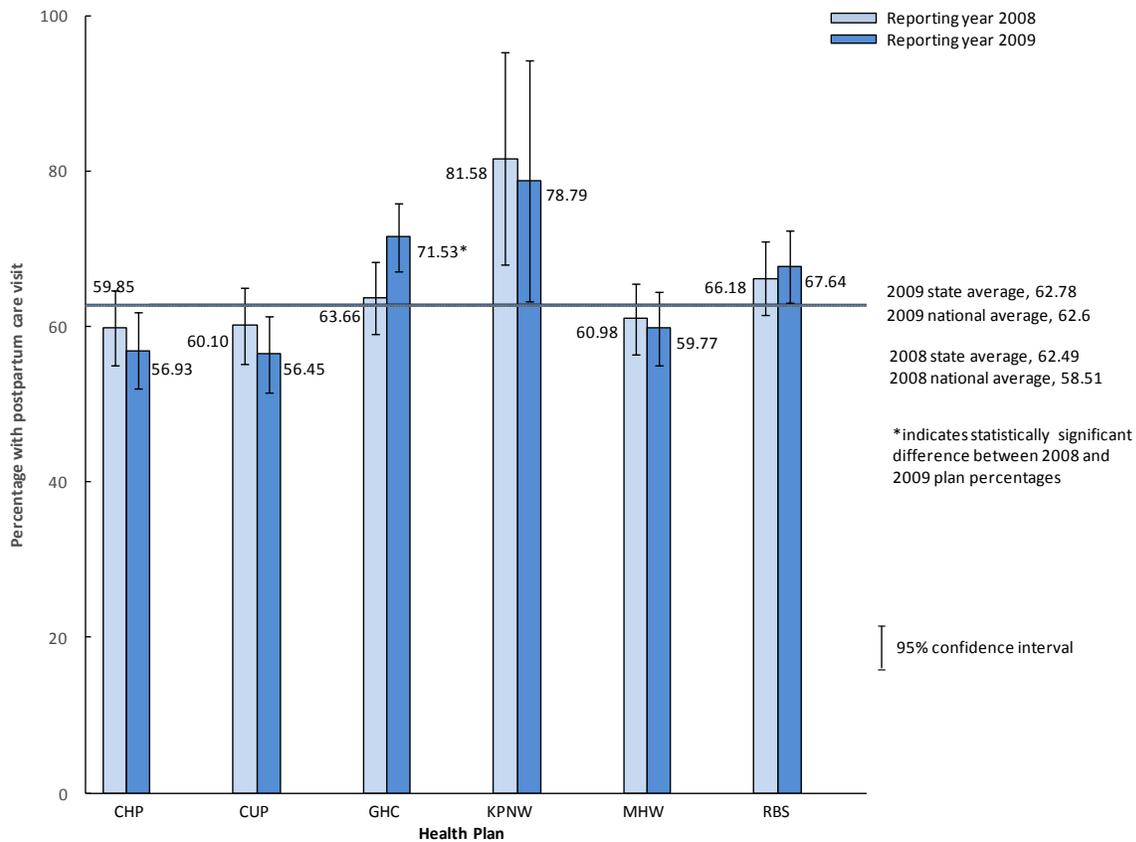
This measure combines timely initiation of prenatal care with a postpartum visit for female enrollees who delivered a live birth between November 6 of the year prior to the measurement year and November 5 of the measurement year. Enrollees had to be continuously enrolled at least 43 days prior to delivery and 56 days after delivery. For these women, the measure assesses

- postpartum care: percentage who had a postpartum visit on or between 21 days and 56 days following delivery

Data collection method: Administrative or hybrid

The percentage of Healthy Options enrollees receiving timely postpartum care has remained stable in the low-60 percent range since 2004. The slight increase during this period is not statistically significant. However, the state average has consistently been above the national average each year.

The 2009 state average for postpartum care was 62.78 percent, up from 62.49 percent in 2008; the median in 2009 was 63.71 percent. Figure 22 shows that the state average, along with GHC’s, KPNW’s, and RBS’s averages, exceeded the national average of 62.60 percent. CHP’s and CUP’s rates were significantly below the state average, while GHC’s rate significantly exceeded both the state average and its own average from 2008.



National averages are from the National Committee for Quality Assurance

Figure 22. Postpartum care visits by health plan, reporting years 2008–2009.

Discussion

The statewide performance on this measure has remained static for several years, while the national average has increased by more than 4 percentage points. However, the 2009 Washington average of 62.78 percent is above the Pacific Region's rate of 62.08 percent.

As noted in previous reports, the HEDIS specifications pose challenges to health plans in capturing accurate data for this measure. The time frame for counting women in the numerator may result in underreporting the number of women who actually receive this care.

While care strategies tend to emphasize the prenatal period, appropriate care during the postpartum period can also prevent complications and deaths. Some women experience emotional instability during the postpartum period that may warrant a follow-up visit with their healthcare provider. Women also may benefit from personalized care during this time to enhance the development of a healthy mother-infant relationship.

Recommendations

Acumentra Health's previous recommendations still apply. HRSA may wish to consider using an alternate methodology to measure postpartum care, such as a focused performance improvement study. Such a study might provide insight into the lack of change in performance on this measure, by ascertaining whether care is or is not received and whether care is received but not within the time frame for the HEDIS measure.

Healthy Options plans may also wish to monitor their utilization data to identify female enrollees who are not receiving postpartum care, within or outside of the HEDIS time frame. Those not receiving care may be a target population for PIPs designed to provide patient education and to use outreach methods to encourage appointments for care.

Use of services

Well-child visits

Professional healthcare organizations recommend that children and adolescents visit the doctor regularly for screening and examinations to support healthy growth and development, as well as for counseling on nutrition and other topics.³² The American Academy of Pediatrics and the American Medical Association recommend comprehensive annual checkups for adolescents to address risk conditions and behaviors, such as obesity, sexually transmitted diseases, substance abuse, and tobacco use.³³ Health plans focus their efforts on outreach to families regarding the availability and benefits of WCC through Medicaid's Early and Periodic Screening, Diagnosis, and Treatment program. The HEDIS measures evaluate the success of health plans in providing these services by assessing the percentage of Medicaid children in each plan with the recommended number of visits for each age group.

Measure definitions

HEDIS measures evaluate the success of health plans in providing well-child services by assessing the percentage of Medicaid children with the recommended number of

- well-child visits in the first 15 months of life: the percentage of enrolled children who turned 15 months old during the measurement year, were continuously enrolled in the plan from 31 days and received between zero and six or more well-child visits with a PCP in their first 15 months of life
- well-child visits in the 3rd, 4th, 5th, and 6th years of life: the percentage of enrolled children who were between three and six years old during the measurement year, were continuously enrolled for 12 months, and received one or more well-child visits with a PCP during the measurement year
- adolescent well-care visits: the percentage of enrolled adolescents ages 12–21 years during the measurement year who were continuously enrolled for 12 months and had at least one comprehensive well-care visit with a PCP or an obstetrics/gynecology practitioner during the measurement year

Data collection method: Administrative or hybrid

Since 2002, HRSA has collaborated with health plans on interventions aimed at increasing WCC visit rates for children in Healthy Options. HRSA's current contract required the health plans to participate in the Washington State Collaborative to Improve Health (WSC), which concluded in May 2009. This group learning project, funded primarily by HRSA and DOH, was part of a multi-year effort to improve health care for Washingtonians with chronic diseases, including preventive care and the establishment of a medical home for children.

Clinics participating in the WSC reported increased WCC visits, with particularly strong gains in providing planned chronic care management visits for children. Overall, the WSC demonstrated that clinics can accomplish substantial improvements in both the quality and effectiveness of preventive and chronic care services delivered to Medicaid children.

The Healthy Options contract includes pay-for-performance incentives based on each health plan's HEDIS rates for WCC during the reporting year and on improvement from the prior year. HRSA also requires plans to formulate corrective action plans when performance on the WCC measure falls below a certain level.

Five-year trends in WCC visits

Figure 23 shows trends for the state averages in WCC visits for infants (six or more visits), children (one visit), and adolescents (one visit). As a group, the Healthy Options plans have reported a significant improvement since 2004 in the percentage of infants and children receiving the recommended number of WCC visits. However, the statewide averages for all three indicators remain below the national averages. In reporting year 2009, about 57 percent of infants received at least six visits in the first 15 months of life, up significantly from 2008. (Asuris does not report data for infants.) Visit rates remained at nearly 59 percent for children age 3 to 6, and at 37 percent for adolescents.

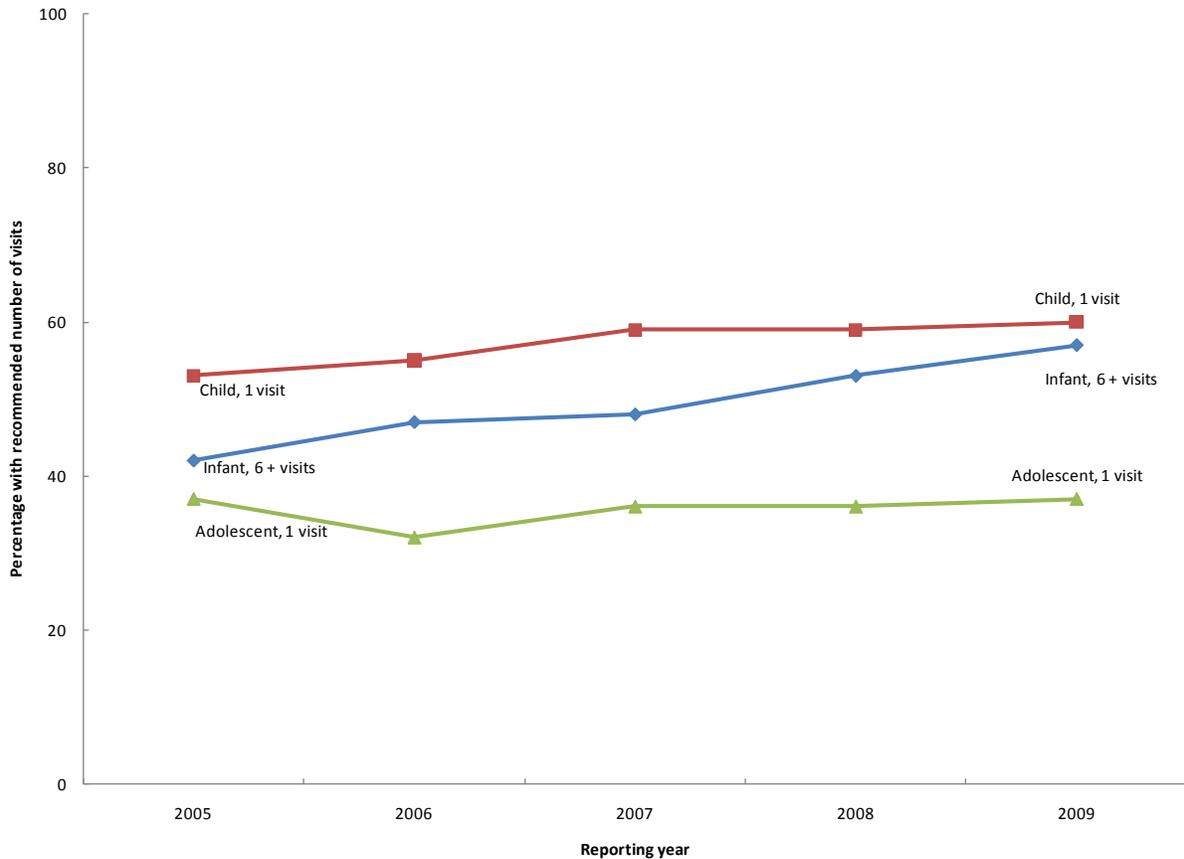
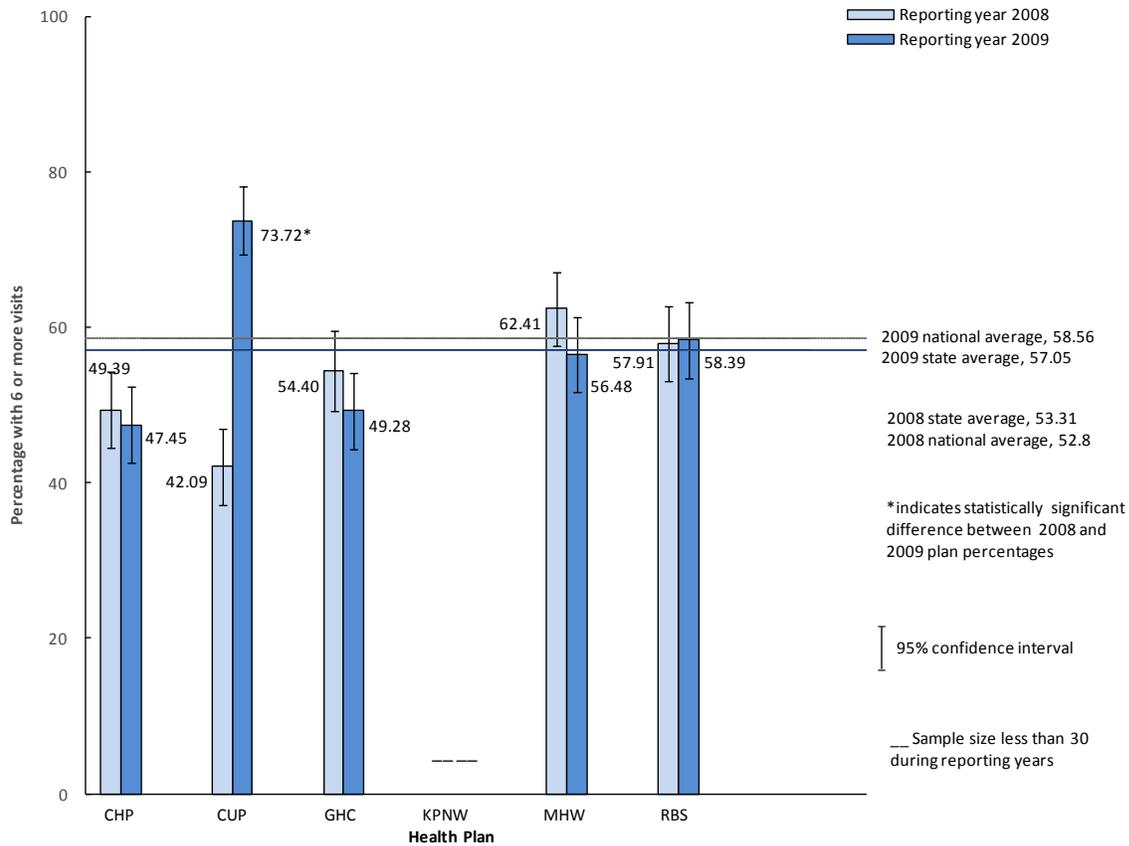


Figure 23. State averages for recommended WCC visits for infants, children, and adolescents, reporting years 2005–2009.

Well-child care in the first 15 months of life

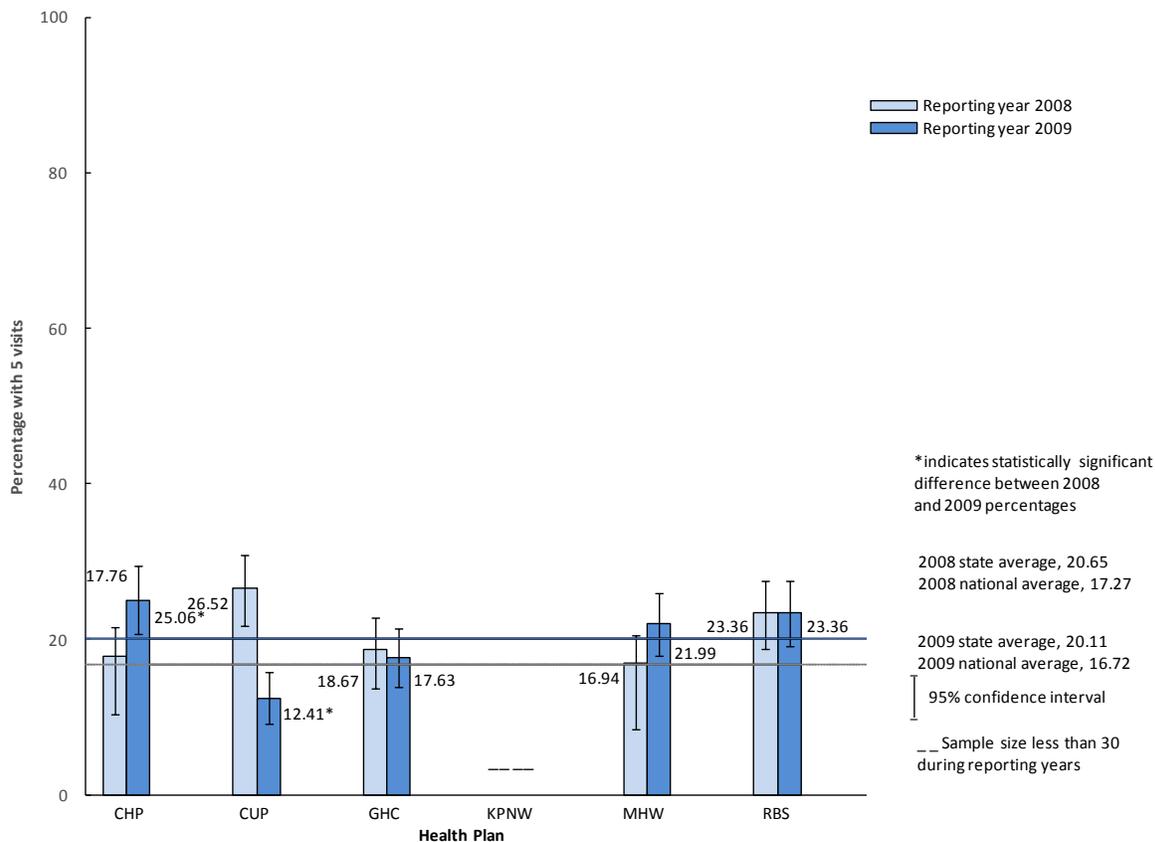
The 2009 statewide average for infants in the first 15 months of life who received six or more WCC visits was 57.05 percent, up significantly from 53.31 percent in 2008; the median in 2009 was 56.48 percent. CUP’s performance was significantly above both the state average and its own 2008 average. CHP and GHC were significantly below the state average. Figure 24 shows that the statewide average remains below the NCQA average of 58.56 percent, although the state average has increased by almost 14 percentage points since 2004.



National averages are from the National Committee for Quality Assurance

Figure 24. Six or more well-child visits in the first 15 months of life by health plan, reporting years 2008–2009.

The 2009 statewide average for infants receiving five WCC visits was 20.11 percent; the median was 21.99 percent. Figure 25 shows that CHP’s rate significantly exceeded both the state average and its own 2008 rate. In contrast, CUP’s 2009 rate was significantly below both the state average and its own 2008 rate. The 2009 state average was significantly above the national average of 16.72 percent.



National averages are from the National Committee for Quality Assurance

Figure 25. Five well-child visits in the first 15 months of life by health plan, reporting years 2008–2009.

Table 3 shows the percentages of enrollees who received *no* infant WCC visits during the measurement year. Lower percentages for this indicator are desirable—fewer infants with no visits means that almost all infants received at least one WCC visit during the year. RBS’s rate in 2009 was significantly below the state average, which, in turn, was significantly lower (i.e., better) than the NCQA average.

Table 3. Percentage of infants who received zero well-child visits, reporting year 2009.

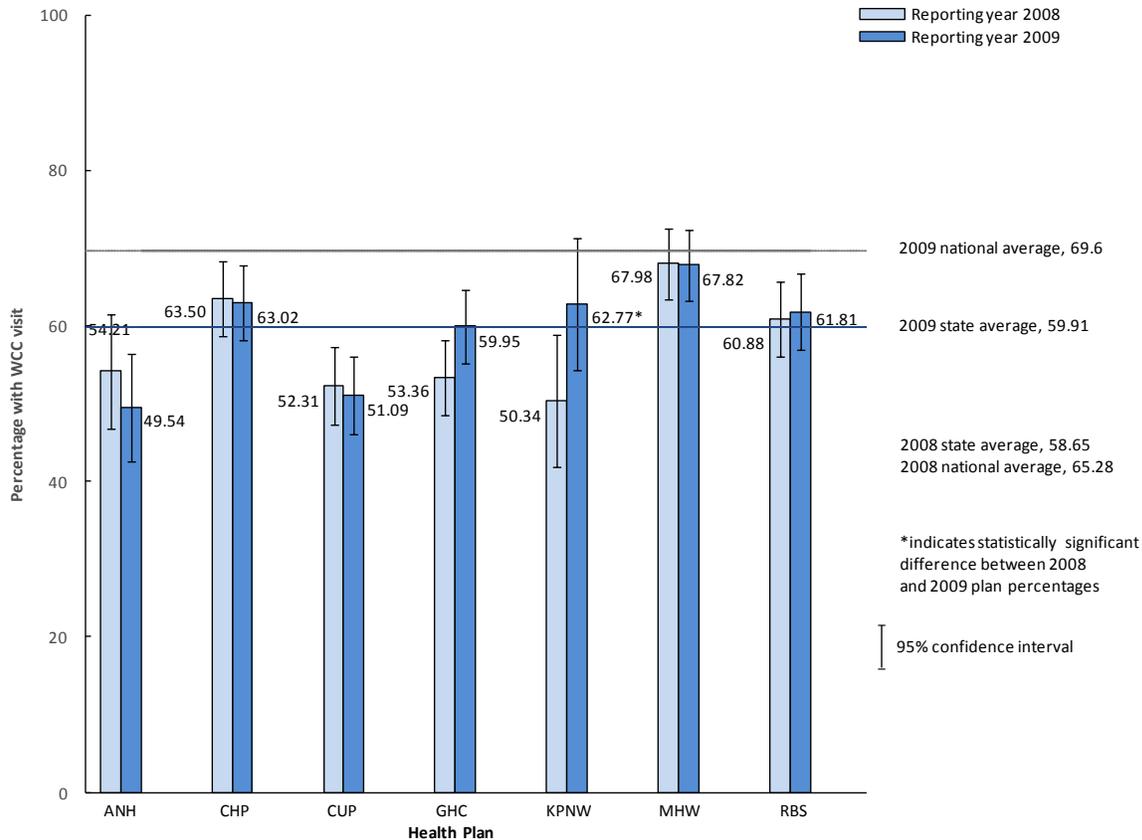
	CHP	CUP	GHC	KPNW	MHW	RBS	State	NCQA
%	1.95	1.22	1.69	—	0.93	0.00	1.15	2.68
n	411	411	414	—	432	411	2,079	*

— Sample size was less than 30 during the reporting year.

*Approximately 150 plans submitted data to NCQA; however, the actual sample size is unknown.

Well-child care for children in the 3rd, 4th, 5th, and 6th years of life

The 2009 rate of WCC visits for children in this age group was 59.91 percent across the state, slightly higher than the 58.65 percent average in 2008; the median in 2009 was 62.77 percent. The state average has improved significantly since 2004, up from 54 percent. However, Figure 26 shows that the state average remained significantly below the national average of 69.60 percent in 2009. MHW significantly outperformed the state average, while ANH's and CUP's rates were significantly below average. KPNW's rate rose significantly from 2008, increasing by almost 13 percentage points.



National averages are from the National Committee for Quality Assurance

Figure 26. Well-child visits in the 3rd, 4th, 5th, and 6th years of life by health plan, reporting years 2008–2009.

Adolescent well-child care

The 2009 statewide average performance for WCC visits for adolescents ages 12–21 was 37.23 percent, slightly above the 2008 average; the median in 2009 was 36.01 percent. MHW’s rate of 45.14 was significantly above the state average. Figure 27 shows that the state average remained significantly below the national average of 45.77 percent in 2009. Since 2004, the gap between the state and national averages has widened to about 8.5 percentage points.

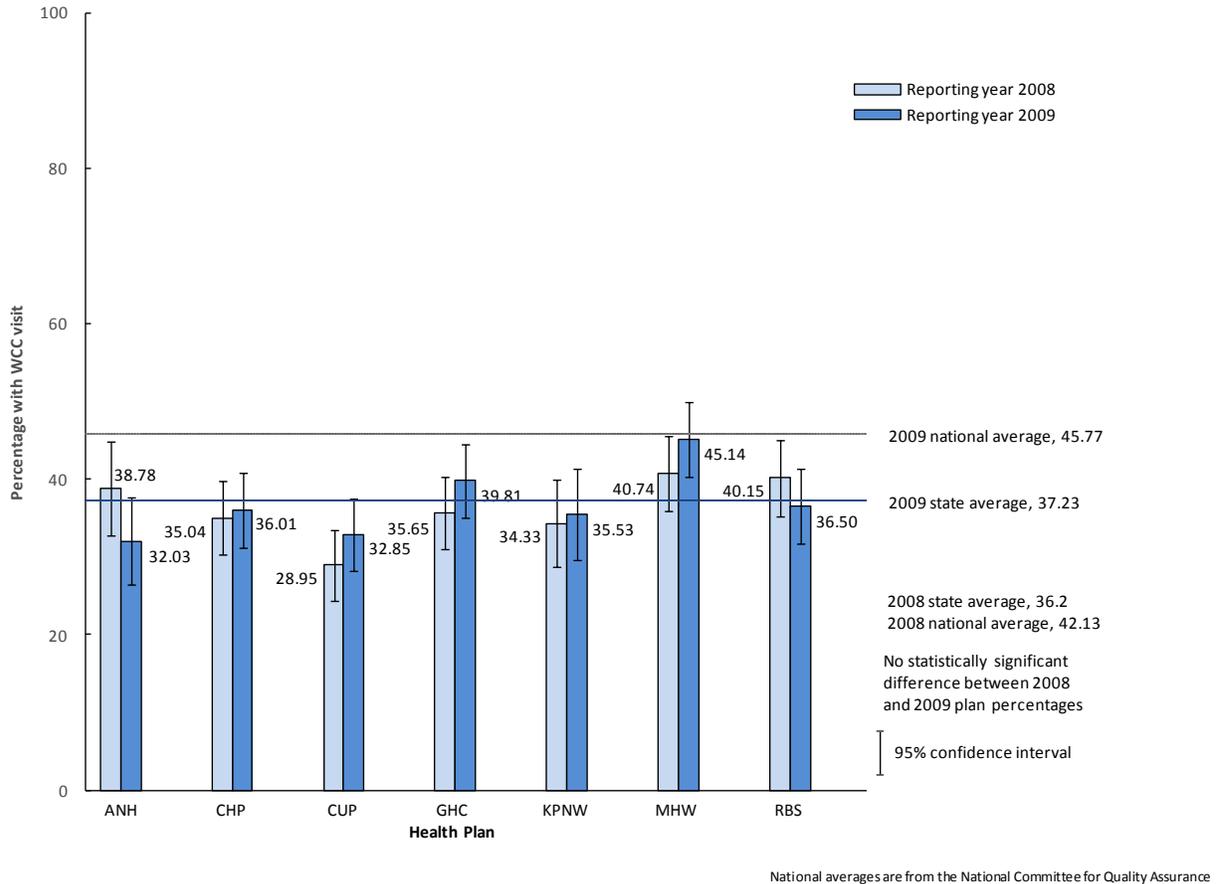


Figure 27. Adolescents ages 12–21 with one or more well-care visits by health plan, reporting years 2008–2009.

Discussion

The Healthy Options plans continue to lag behind the national Medicaid performance in providing WCC visits—significantly below the national averages for children and adolescents. The six-year improvement in WCC visit rates for infants and children is encouraging, and almost 99 percent of infants are receiving at least one WCC visit in the first 15 months of life. Since 2007, the WCC visit rates for children age 3 to 6 and for adolescents have increased slightly. Still, on average, almost half of the infants and children and two-thirds of the adolescents served by the plans are *not* receiving care at the recommended levels.

More positively, considering the percentage of infants with *at least five* WCC visits, more than three-fourths of all enrolled infants are receiving all or almost all of the recommended WCC visits. Providing needed healthcare services for adolescents remains a particular challenge due to barriers noted in our previous reports.

As reported in the 2009 NCQA *Quality Compass*, WCC visit rates for the Pacific Region (Alaska, Washington, Oregon, California, and Hawaii) fall below the top-performing region. The New England Region outperforms other regions for all three age groups, reporting rates of 74.68 percent for infants, 80.93 percent for children, and 61.09 percent for adolescents, compared with the Pacific Region's 61.65 percent for infants, 69.71 percent for children, and 41.24 percent for adolescents.

System improvements are necessary to achieve and sustain improvement in WCC visit rates. HRSA contractually requires health plans to conduct PIPs, and for 2008, all Healthy Options plans conducted PIPs aimed at improving WCC visit rates. The PIP interventions included reminding enrollees about upcoming or overdue visits, providing financial incentives to clinics for meeting performance goals, and giving clinic-specific performance feedback.

Adolescents typically are assumed to be a healthy population, but they often face barriers to care that clinicians should not overlook. The National Adolescent Information Health Center at the University of California–San Francisco has developed a checklist for planning and evaluating the six key components of healthcare services for adolescents in managed care settings:

- access
- age-appropriate quality services
- coordination of services
- age-sensitive authorization and review processes
- coordination with core public health functions
- adolescent participation in the system of care³⁴

Effective March 2009, the U.S. Preventive Services Task Force recommends screening adolescents age 12–18 for major depressive disorder, when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.³⁵

Recommendations

Acumentra Health recommends that HRSA

- continue to provide pay-for-performance incentives to improve WCC visit rates and encourage plans to pass the incentives on to high-performing provider groups

- promote collaboration among health plans to implement best practices at a clinic level, such as reminder/recall notices, structured examination tools, and patient-centered care
- address improving adolescent WCC rates through focused training for providers, alternate delivery mechanisms for care, or collaboration with school-based clinics to capture and count preventive care encounters
- reimburse the Healthy Options plans for adolescent WCC visits on an annual basis rather than every other year, in line with the recommended annual screening schedule reflected in the HEDIS criteria
- investigate WCC rates at the county level to identify best practices among top-performing clinics
- expand sports physical exams to include WCC elements for adolescents who are due or overdue for an exam, perhaps providing a sports-related incentive to teens who get their exams

Frequency of selected procedures

This measure summarizes the number and rate of frequently performed procedures that often show wide regional variation and may indicate potentially inappropriate utilization. For the second year in a row, HRSA required the Healthy Options plans to report the frequency of myringotomies, hysterectomies, mastectomies, and lumpectomies.

Many factors may affect the wide regional variations in usage rates, such as coding practices, demographics, and practice patterns. Some variation may be explained by unnecessary procedures, while some procedures may not be performed often enough. How an organization manages care may be the primary influence on the usage rates.

Measure definition

This measure summarizes the number and rate of several frequently performed procedures. For Medicaid members, the organization reports the absolute number of procedures and the number of procedures per 1,000 member months by age and gender. HRSA required the health plans to report:

- myringotomy or myringotomy and adenoidectomy
- hysterectomy (abdominal or vaginal)
- mastectomy
- lumpectomy

Data collection method: Administrative

Myringotomy

Persistent ear infections can lead to permanent eardrum damage, hearing loss, and speech and balance problems. Myringotomy with tube insertion is the most common treatment for children who have persistent or chronic infections.³⁶

Across the Healthy Options plans, the 2009 frequency of myringotomy for enrollees 0 to 4 years old was 2.51 procedures per 1000 member months; the median was 2.85 procedures. Rates for ANH, CUP, MHW, and RBS were above the state average, which was significantly below the national average of 2.63 procedures per 1000 member months. ANH, CUP, KPNW, and RBS reported lower rates in 2009 than in 2008, while CHP, GHC, and MHW reported higher rates. MHW's increase was statistically significant.

The 2009 statewide frequency of myringotomy for enrollees 5 to 19 years old was 0.47 procedures per 1000 member months; the median was 0.45 procedures. Rates for ANH, CUP, MHW, and RBS were above the state average, which was significantly above the national average of 0.44 procedures per 1000 member months. Rates for CUP, GHC, and KPNW were lower in 2009 than in 2008, while ANH, CHP, MHW, and RBS reported higher rates. RBS's increase was statistically significant.

Abdominal hysterectomy

The 2009 statewide frequency of abdominal hysterectomy for enrollees 15 to 44 years old was 0.21 procedures per 1000 member months; the median was 0.18 procedures. Rates for ANH, CUP, GHC, and MHW were above the state average, which was below the national average of 0.23 procedures per 1000 member months. ANH, CUP, GHC, and MHW reported higher rates in 2009 than in 2008; rates for CHP, KPNW and RBS remained the same.

The 2009 statewide frequency of abdominal hysterectomy, ages 45 to 64 years, was 0.48 procedures per 1000 member months; the median was 0.49 procedures. Rates for CUP, GHC, MHW, and RBS were above the state average, which was above the national average of 0.47 procedures per 1000 member months. GHC and MHW reported higher rates in 2009 than in 2008; the remaining plans' rates were either the same as or lower than in 2008.

Vaginal hysterectomy

Across the state, the 2009 frequency of vaginal hysterectomy for enrollees 15 to 44 years old was 0.20 procedures per 1000 member months; the median was also 0.20 procedures. The 2009 average fell significantly from than the previous year. CHP's and CUP's rates were above the state average, which was significantly above the national average of 0.16 procedures per 1000 member months. All plans' 2009 rates were the same as or lower than the 2008 rates; GHC's rate was significantly lower in 2009 than in 2008.

The 2009 statewide frequency of vaginal hysterectomy, ages 45 to 64 years, was 0.40 procedures per 1000 member months; the median was 0.62 procedures. Rates for CUP, MHW, and RBS were above the state average, which was significantly above the national average of 0.19 procedures per 1000 member months. CUP's and MHW's rates were higher in 2009 than in 2008, while the remaining plans' rates were lower in 2009.

Mastectomy

The 2009 statewide frequency of mastectomy for enrollees 15 to 44 years old was 0.02 procedures per 1000 member months (identical to the national average); the median was 0.03 procedures. Rates for CUP, GHC, and RBS were above the state average, while MHW's rate equaled the state average. CUP's, GHC's, and RBS's averages were higher in 2009 than in 2008; CHP's rates were lower, and ANH's, KPNW's, and MHW's remained the same.

The 2009 statewide frequency of mastectomy, ages 45 to 64 years, was 0.24 procedures per 1000 member months; the median was 0.35 procedures. CHP's and GHC's rates were above the state average, while MHW's rate was below average. The state average exceeded the national average of 0.18 procedures per 1000 member months. CHP's and GHC's rates were higher in 2009 than in 2008; while MHW's rate fell.

Lumpectomy

The 2009 statewide frequency of lumpectomy for enrollees 15 to 44 years old was 0.12 procedures per 1000 member months; the median was also 0.12 procedures. GHC's and RBS's rates were above the state average; ANH's and CUP's rates were below average, and CHP's, KPNW's, and MHW's rates equaled the state average. The state average was significantly below the national average of 0.17 procedures per 1000 member months. Rates for GHC, MHW, and RBS were higher in 2009 than in 2008, while CUP's rate fell.

The 2009 statewide frequency of lumpectomy, ages 45 to 64 years, was 0.42 procedures per 1000 member months; the median was 0.34 procedures. CHP's and GHC's rates were above the state average, while ANH's, CUP's, KPNW's, MHW's, and RBS's rates were below average. The state average was below the national average of 0.60 procedures per 1000 member months, although not significantly below. CHP's, CUP's, KPNW's and RBS's rates were higher in 2009 than in 2008; while the remaining plans' rate were the same as or lower than in 2008.

Discussion

For the majority of selected procedures, the statewide average was at or above the national average. The exceptions were myringotomy (0 to 4 years), abdominal hysterectomy (15 to 44 years), and lumpectomy (both groups). However, most reported frequencies were low, and in several cases, the statewide median was near *zero* procedures during the year.

In comparison with other NCQA regions, the Pacific Region's utilization rates were lowest for 6 out of 10 indicators. Myringotomy (0 to 4 years) showed the greatest variation between the highest- and lowest-performing regions. The South Central Region's rate of 4.46 was highest; the Pacific Region's rate of 2.08 was lowest.

Recommendations

This is the second year that HRSA has required reporting of these procedures. Viewing the utilization of these procedures over time and building on data sets, rather than viewing the data in isolation, may provide more meaningful information for HRSA. Overall utilization patterns may become more evident as the health plans report this measure in subsequent years.

Utilization

Service utilization varies by state, region, and even community. Seasonal, situational, and socioeconomic factors may influence how and when people seek health care.

A recent report by the *New England Journal of Medicine* indicates that although race, income, and health status can affect spending on health care, discretionary decisions by physicians account for most of the regional variation in spending for Medicare beneficiaries. Patients in the highest-spending regions have longer hospital stays, have more frequent physician visits, and undergo more computed tomographic scans and magnetic resonance imaging procedures, compared with patients in the lowest-spending regions. However, health outcomes are not necessarily better for patients in the highest-spending regions.³⁷

Researchers have investigated the connection between service utilization and the quality of care provided. A 2005 study of commercial managed care plans found an inverse correlation between 10 patient quality measures and inpatient and ER utilization, and positive correlations between the 10 quality measures and outpatient care.³⁸ In general, the study findings point to a possible relationship between higher rates of outpatient care and better patient outcomes. However, generalizations about the relationship between utilization and healthcare quality are difficult to support because of patient mix and geographic factors.

Lack of a usual source of medical care can impede access to health care. Cultural and language differences and lack of knowledge or education also may limit access. Transportation can be an issue, particularly for those with lower incomes. Families with incomes below 100 percent of the poverty level cite lack of transportation as the reason for delaying health care at 10 times the rate of families with incomes at or above 200 percent of the poverty level.³⁹

HRSA requires Healthy Options plans to collect inpatient and outpatient utilization data to determine average lengths of stay (ALOS).

Measure definition

The utilization measures summarize enrollee use of services in the following categories:

- inpatient utilization—general hospital/acute care: total services used and percentage of medical, surgical, and maternity services used (HRSA does not require Healthy Options plans to report on the percentage of maternity services used)
- ambulatory care: services used in outpatient clinics, the emergency room, ambulatory surgery/procedures performed in outpatient facilities or freestanding surgical centers, and observation room stays that result in discharges
- births and average lengths of stay, newborns: newborn care from birth to discharge to home for total newborns, well newborns, and complex newborns

Data collection method: Administrative

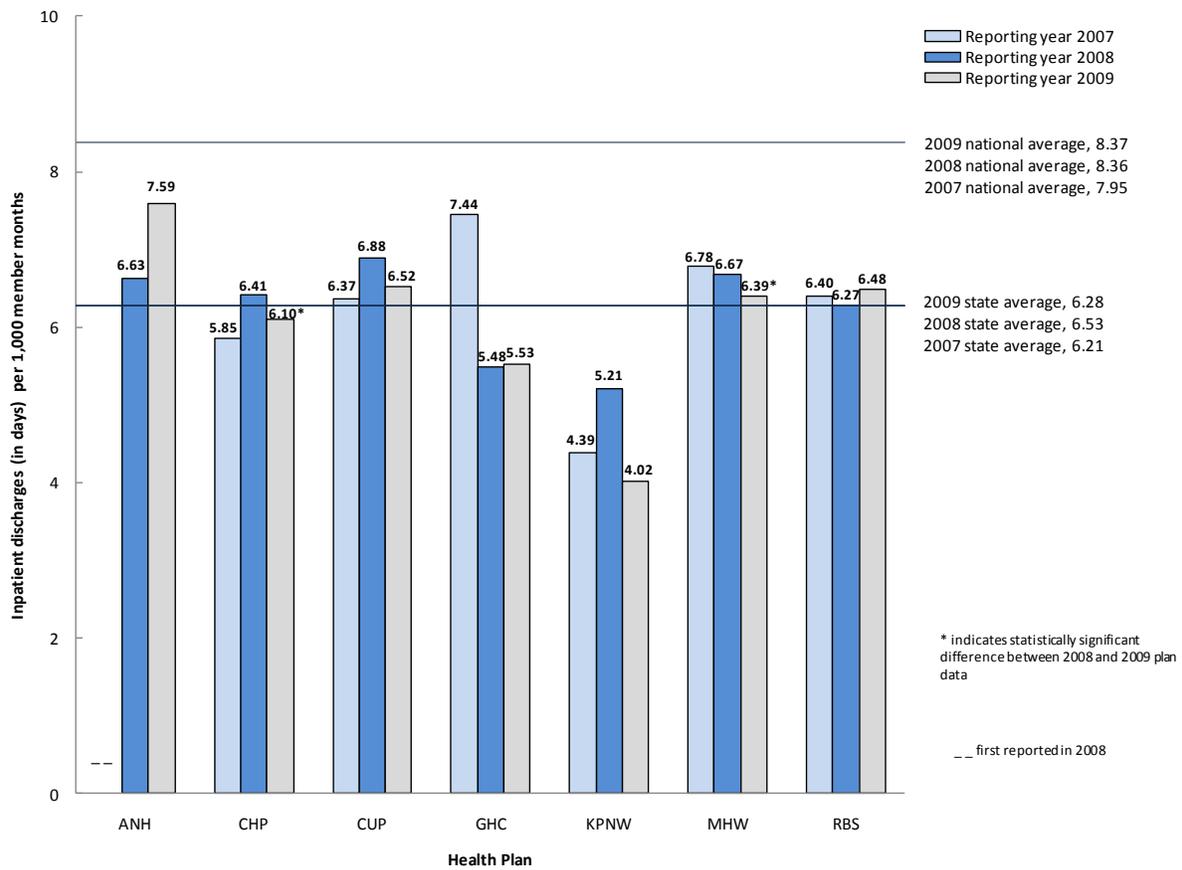
Complete data for 2005–2009 in all categories appear in Appendix B, Tables B-39–B-50.

General hospital/acute care

The 2009 statewide average for total inpatient discharges was 6.28 discharges per 1000 member months, a significant decrease from the 2008 average of 6.53 discharges. CHP and MHW also reported significant decreases from the previous year. CHP’s, GHC’s, and KPNW’s values were significantly below the state average, while ANH’s value was higher. The 2009 statewide average discharge rate was significantly below the national average of 8.37 discharges per 1000 member months.

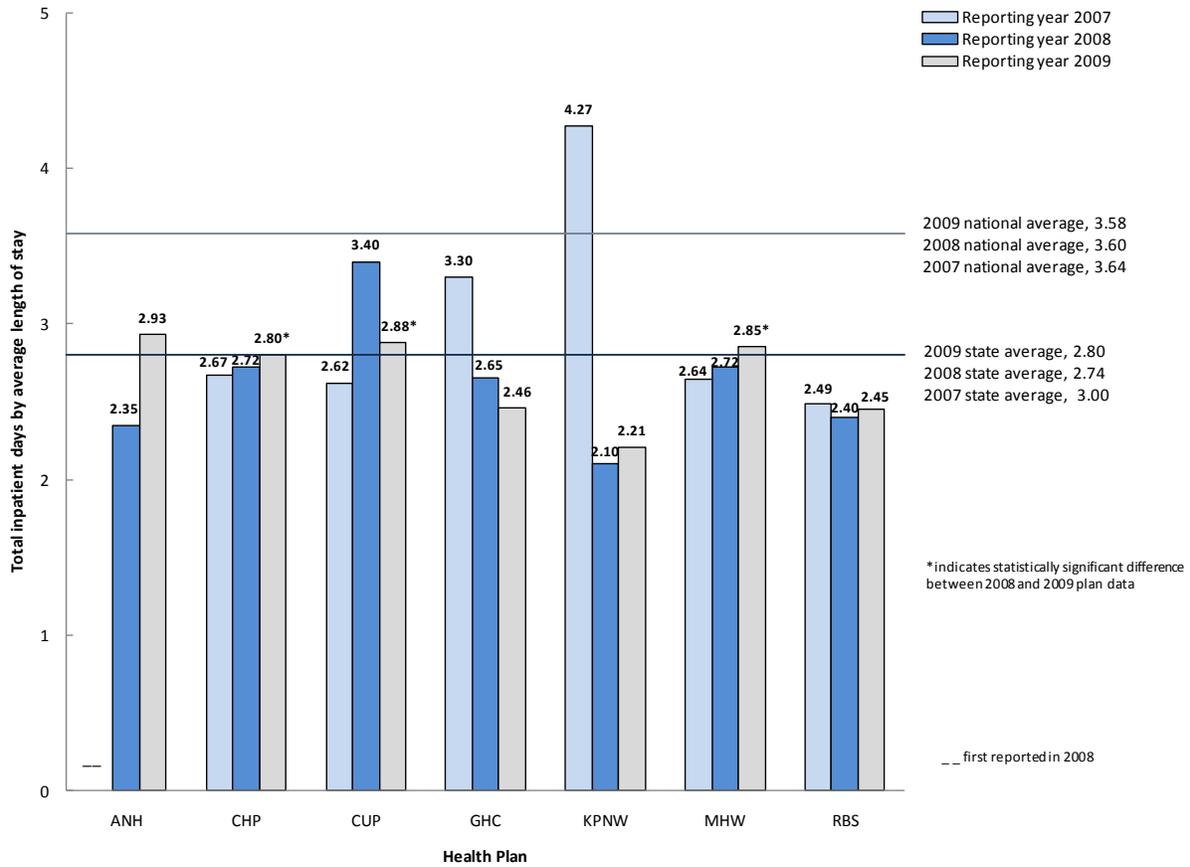
The 2009 statewide ALOS was 2.8 days, up significantly from 2.74 days in 2008. ALOS fell significantly for CUP enrollees while rising significantly for CHP and MHW enrollees. KPNW’s low enrollment may have influenced the plan’s utilization rates. The ALOS for MHW enrollees was significantly higher than the state average, while GHC’s and RBS’s averages were significantly below average. The 2009 statewide ALOS was significantly below the national average of 3.58 days.

Figures 28 and 29 show total inpatient discharges and ALOS, along with state and national averages for the past three years.



National averages are from the National Committee for Quality Assurance

Figure 28. General hospital/acute care total inpatient discharges by health plan, reporting years 2007–2009.



National averages are from the National Committee for Quality Assurance

Figure 29. General hospital/acute care total inpatient average length of stay by health plan, reporting years 2007–2009.

Medical discharges and length of stay

The 2009 statewide average for medical discharges was 1.55 discharges per 1000 member months, down significantly from 1.67 discharges per 1000 member months in 2008. CHP’s and MHW’s averages fell significantly from the previous year. RBS’s average was significantly higher than the state’s average. The 2009 statewide medical discharge rate was significantly below the national average of 3.62 discharges per 1000 member months.

The 2009 statewide ALOS was 2.77 days, down from 2.84 days in 2008 (not a significant change). The ALOS for MHW enrollees fell significantly. The 2009 statewide ALOS was significantly below the national average of 3.67 days.

Figures 30 and 31 show total medical discharges and ALOS, along with state and national averages for the past three years.

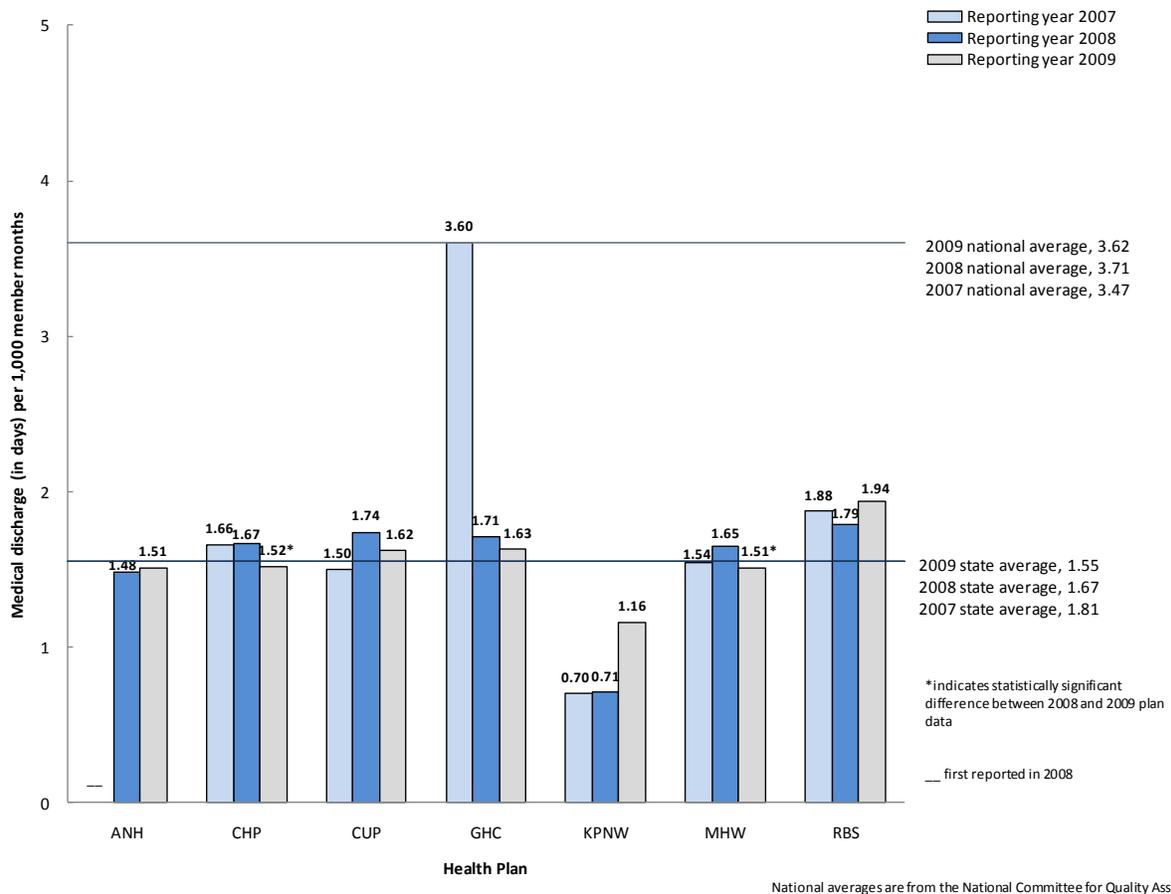
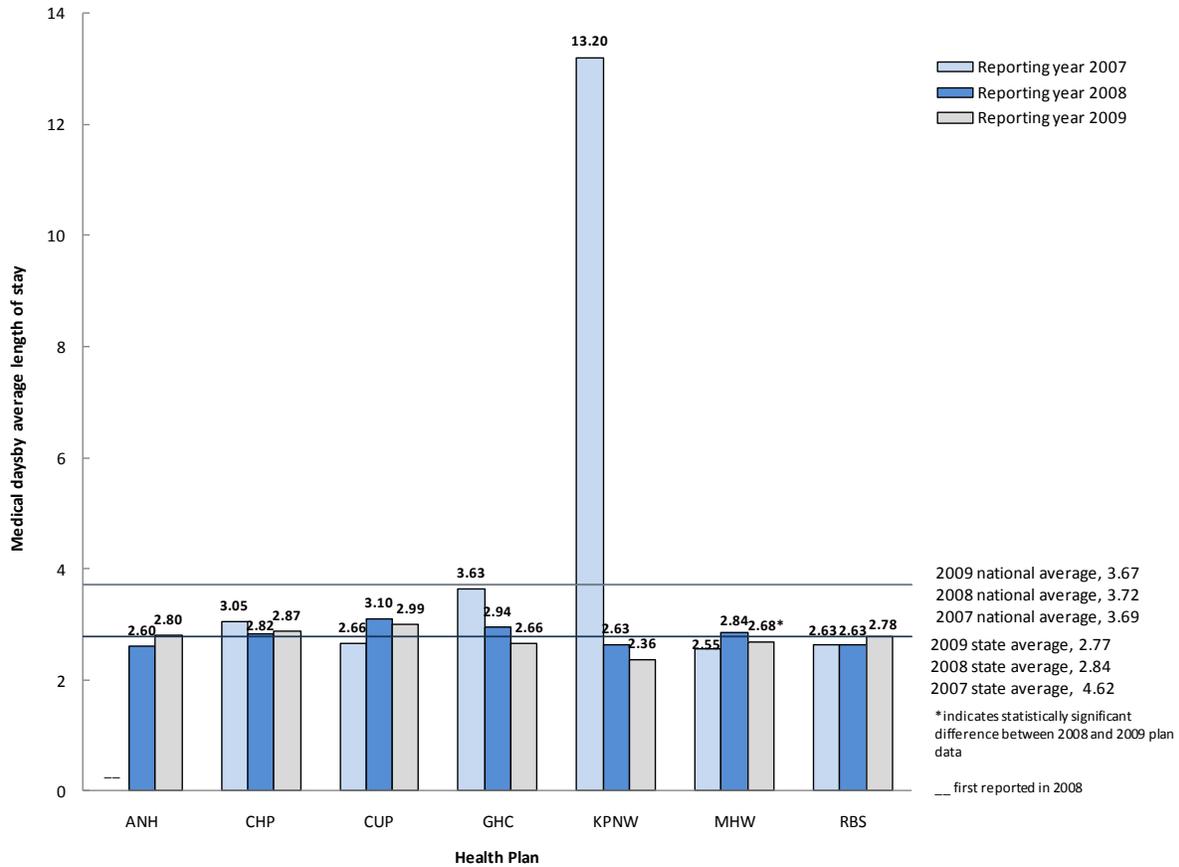


Figure 30. General hospital/acute care medical discharges by health plan, reporting years 2007–2009.



National averages are from the National Committee for Quality Assurance

Figure 31. General hospital/acute care medical average length of stay by health plan, reporting years 2007–2009.

Surgical discharges and length of stay

The 2009 statewide average for surgical discharges was 0.78 discharges per 1000 member months, up from 0.77 discharges per 1000 member months in 2008 (not a significant change). CHP's and KPNW's averages were significantly below the state average, while MHW's was above the state average. The 2009 statewide surgical discharge rate was significantly below the national average of 1.34 discharges per 1000 member months.

The 2009 statewide ALOS was 4.84 days, up significantly from 4.39 days in 2008. MHW's average was significantly higher than 2008. CUP's, KPNW's, and RBS's averages were significantly below the state average, while MHW's average was significantly higher. The 2009 statewide ALOS was significantly below the national average of 5.60 days.

Figures 32 and 33 show total surgical discharges and ALOS, along with state and national averages for the past three years.

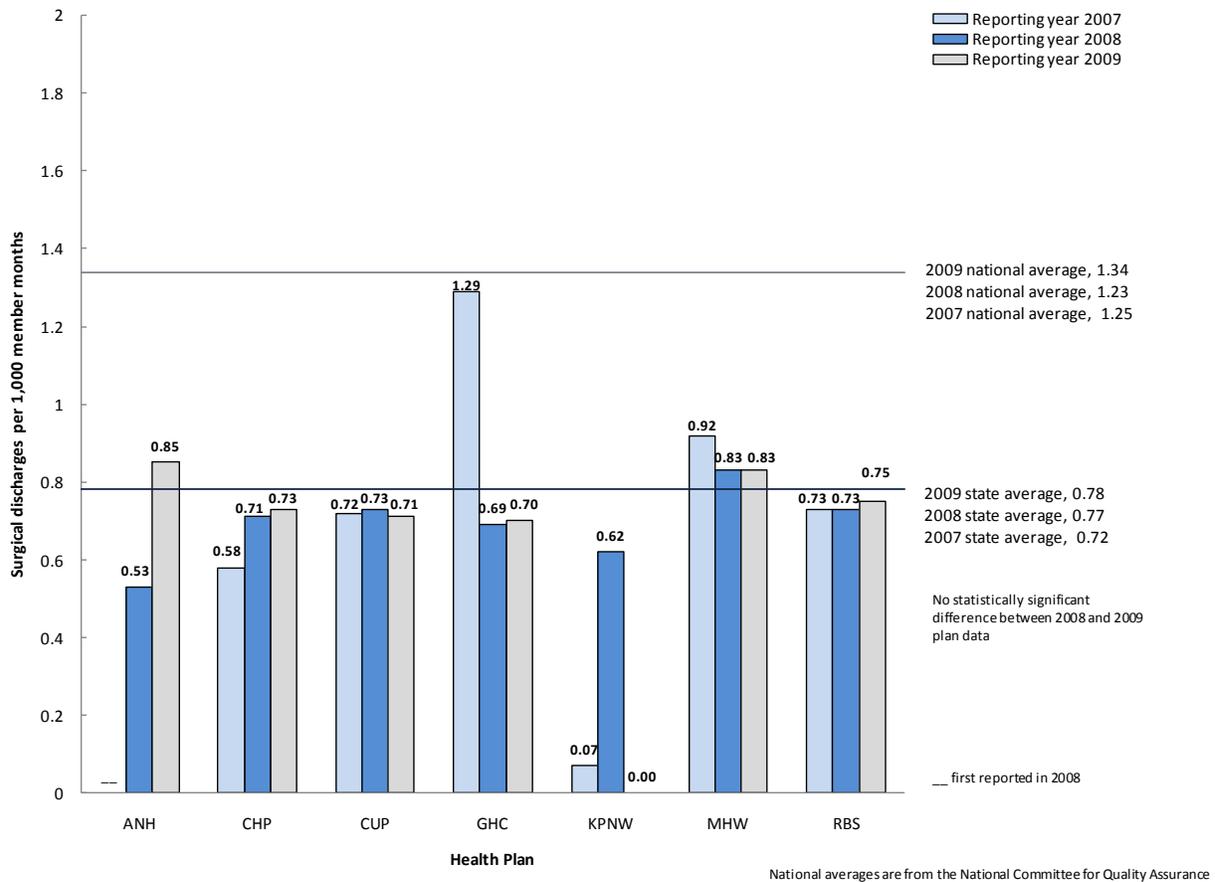
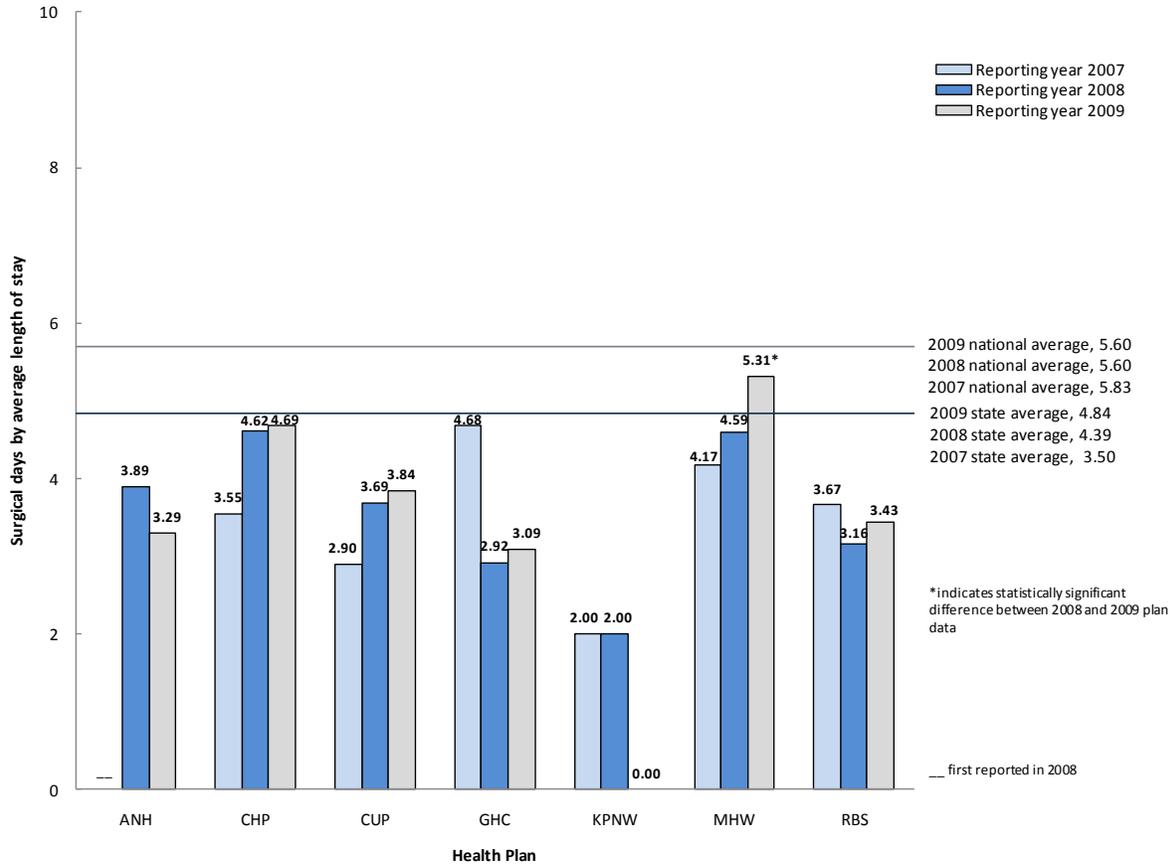


Figure 32. General hospital/acute care surgical discharges by health plan, reporting years 2007–2009.



National averages are from the National Committee for Quality Assurance

Figure 33. General hospital/acute care surgical average length of stay by health plan, reporting years 2007–2009.

Maternity discharges and length of stay

The 2009 statewide average for maternity discharges was 8.39 discharges per 1000 member months, down from 8.45 discharges per 1000 member months in 2008 (not a significant change). CHP, GHC, KPNW, and RBS reported rates below the state average, while ANH and MHW reported rates above the state average. The 2009 statewide average was significantly above the national average of 6.3 discharges per 1000 member months.

The 2009 statewide ALOS was 2.40 days, up slightly (but not significantly) from 2.38 days in 2008. The ALOS for ANH, CHP, and MHW enrollees increased significantly, while CUP’s average fell significantly from 2008. The ALOS for CUP enrollees was significantly higher than the 2009 state average, while the ALOS for GHC and RBS was significantly below average. The 2009 statewide ALOS was significantly below the national average of 2.67 days.

Figures 34 and 35 show total maternity discharges and ALOS, along with state and national averages for the past three years.

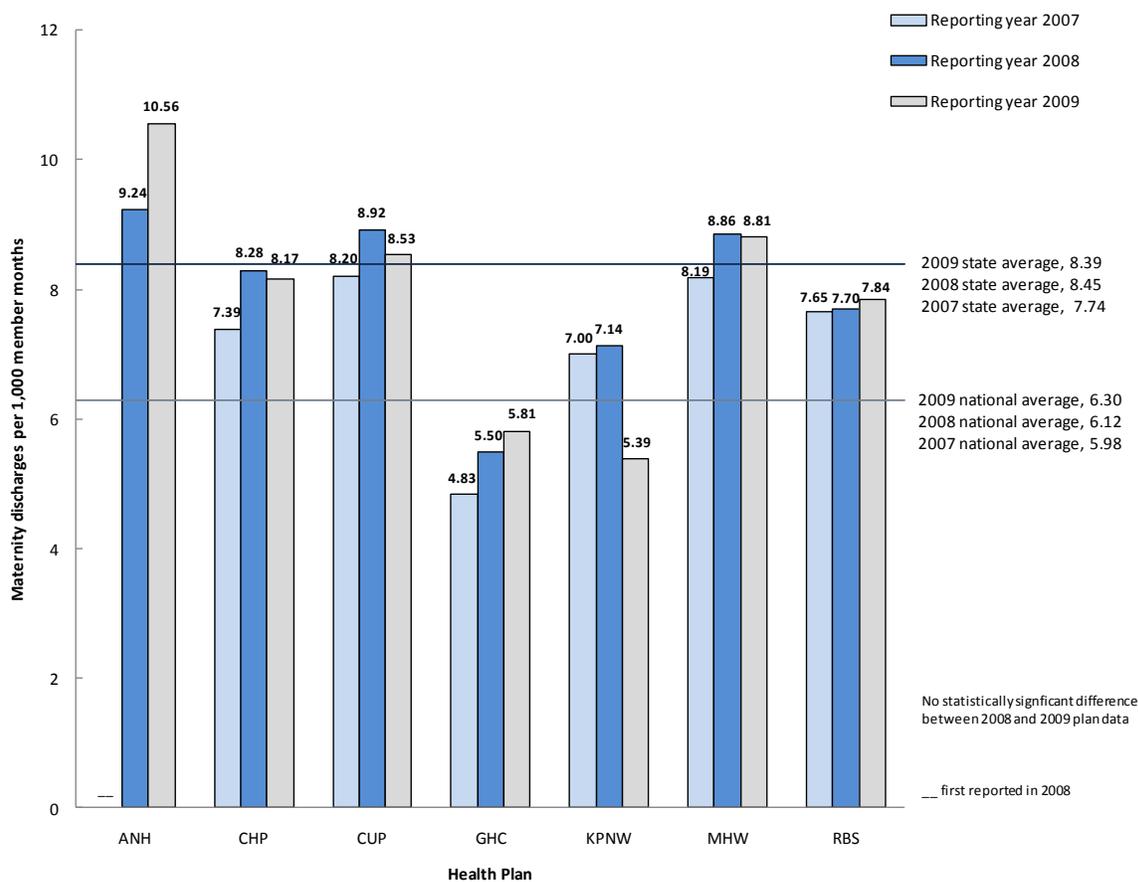
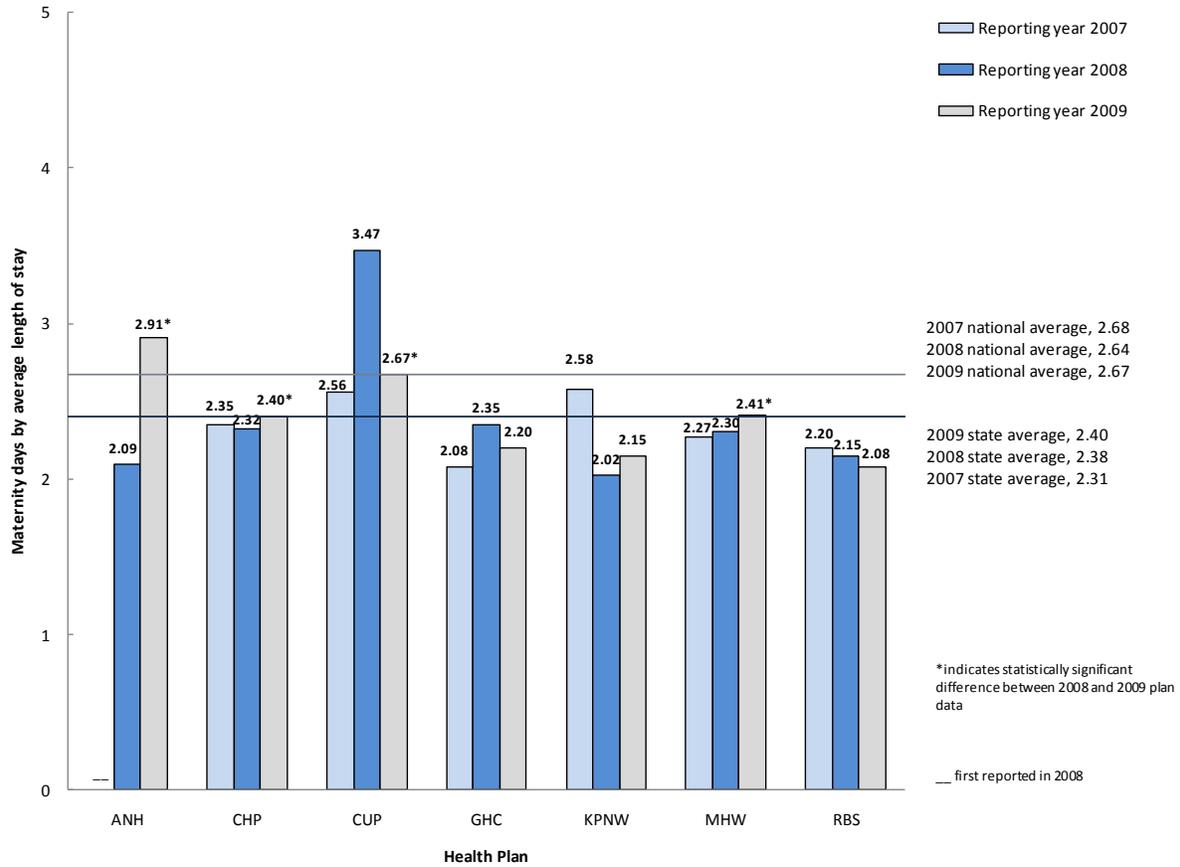


Figure 34. General hospital/acute care maternity discharges by health plan, reporting years 2007–2009.



National averages are from the National Committee for Quality Assurance

Figure 35. General hospital/acute care maternity average length of stay by health plan, reporting years 2007–2009.

Ambulatory care

Outpatient visits

The 2009 statewide average for outpatient visits was 305.68 per 1000 member months, up significantly from 296.26 visits per 1000 member months in 2008. Visit rates rose significantly for CHP, CUP, MHW, and RBS enrollees, while declining significantly for GHC. Visit rates for CHP, CUP, GHC, KPNW, and RBS enrollees were significantly lower than the state average, while the rate for MHW enrollees was significantly above average. The 2009 statewide average for outpatient visits was significantly below the national average of 346.93 visits. Figure 36 shows the state and national three-year trends.

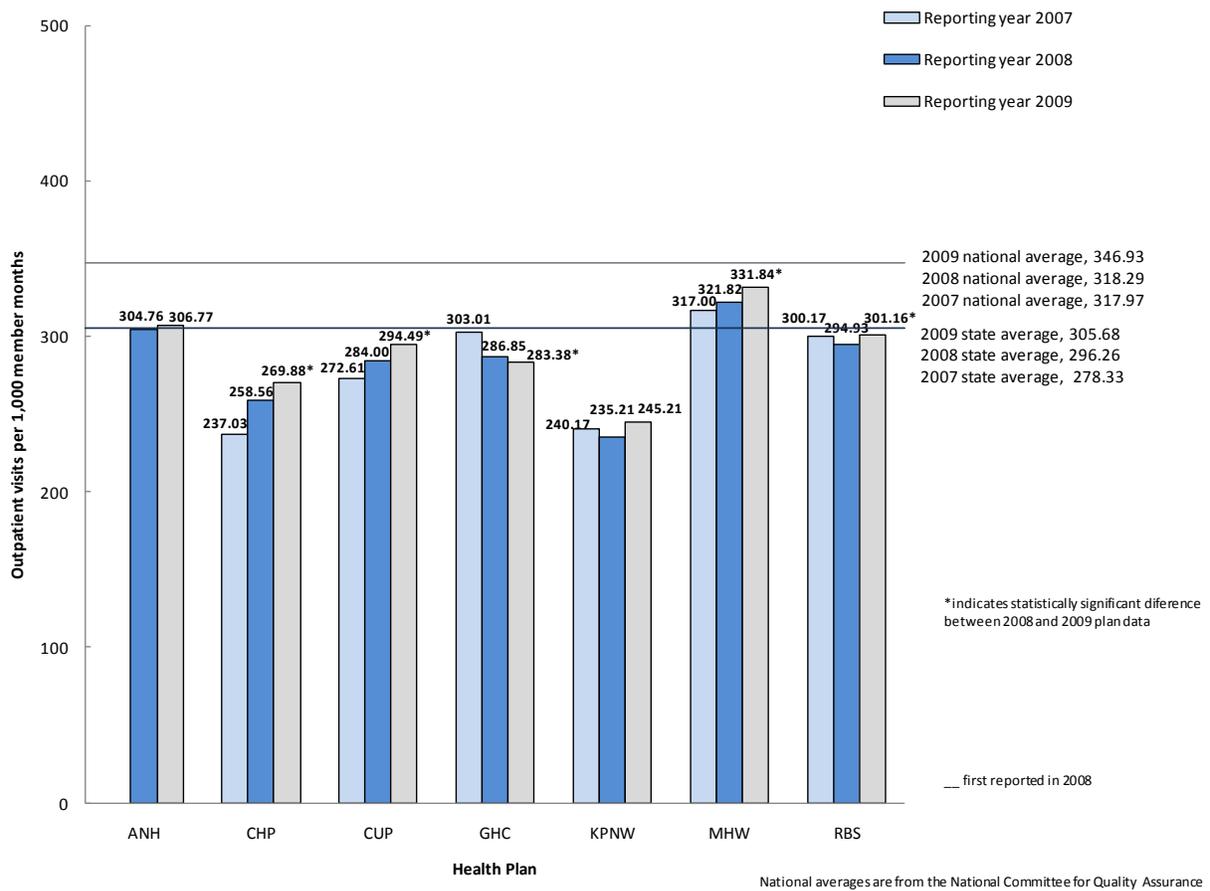


Figure 36. Ambulatory care, outpatient visits by health plan, reporting years 2007–2009.

Emergency room visits

The 2009 statewide average for ER visits was 54.40 visits per 1000 member months, down significantly from 55.20 visits in 2008. Three health plans (CUP, GHC, and MHW) reported significantly lower visit rates than in 2008. Plan-to-state comparisons were mixed. Visit rates for CHP and RBS enrollees were significantly above the 2009 state average, while the rates for ANH, CUP, GHC, KPNW, and MHW were significantly below average. The 2009 statewide average for ER visits was significantly below the national average of 60.28 visits. Figure 37 shows the state and national three-year trends.

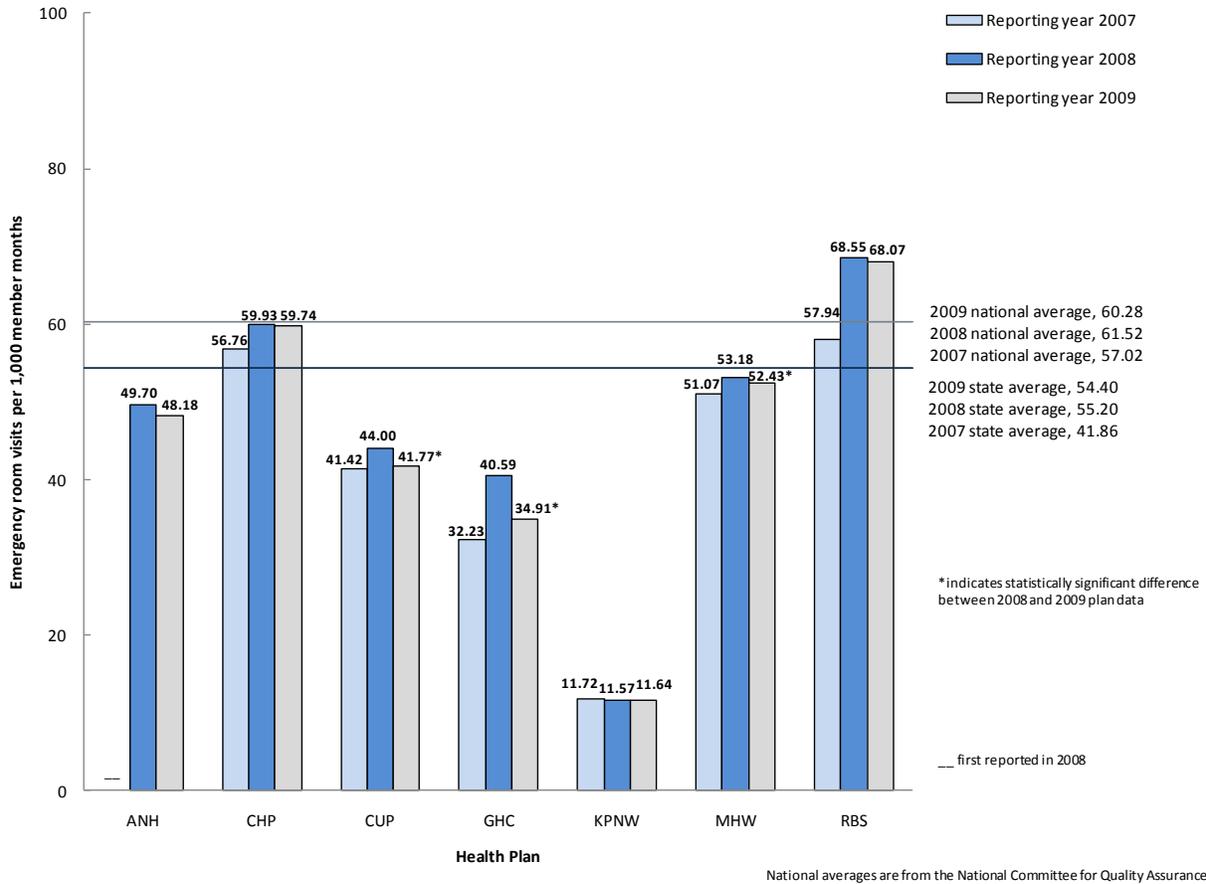


Figure 37. Ambulatory care, emergency room visits by health plan, reporting years 2007–2009.

Surgery or procedures performed

The 2009 statewide average for ambulatory surgery or procedures performed was 6.15 per 1000 member months, up significantly from 3.75 procedures in 2008. Five health plans (ANH, CHP, KPNW, MHW, and RBS) reported significantly higher procedure rates than in 2008, while CUP and GHC reported significantly lower rates.

Plan-to-state comparisons were evenly mixed. CUP, GHC, and KPNW reported rates significantly below the 2009 state average, while the rates for ANH, MHW, and RBS were significantly above average. The 2009 statewide average for surgery or procedures performed was significantly below the national average of 9.18.

Figure 38 shows the state and national three-year trends.

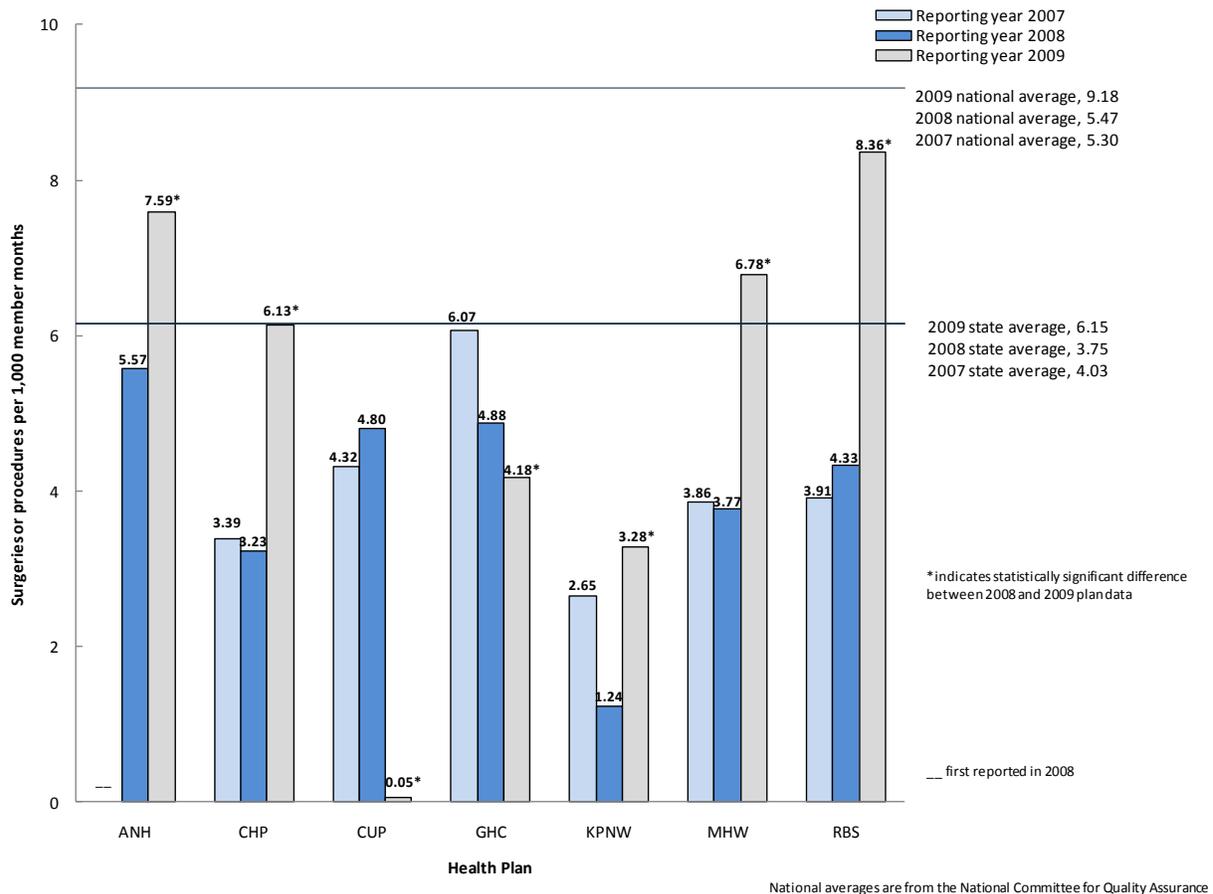


Figure 38. Ambulatory care, surgery or procedures performed by health plan, reporting years 2007–2009.

Observation room stays resulting in discharge

The 2009 statewide average for observation stays resulting in discharge was 1.82 stays per 1000 member months, down significantly from 2.04 stays in 2008. CHP and CUP reported significantly higher rates than in 2008, while MHW and RBS reported significantly lower rates.

Plan-to-state comparisons in 2009 were mixed. Observation room stays per 1000 member months for GHC, KPNW, MHW, and RBS enrollees were significantly below the state average, while the rates for ANH, CHP, and CUP enrollees were significantly above average. The 2009 statewide average for observation room stays was in line with the national average of 1.85.

Figure 39 shows the state and national three-year trends.

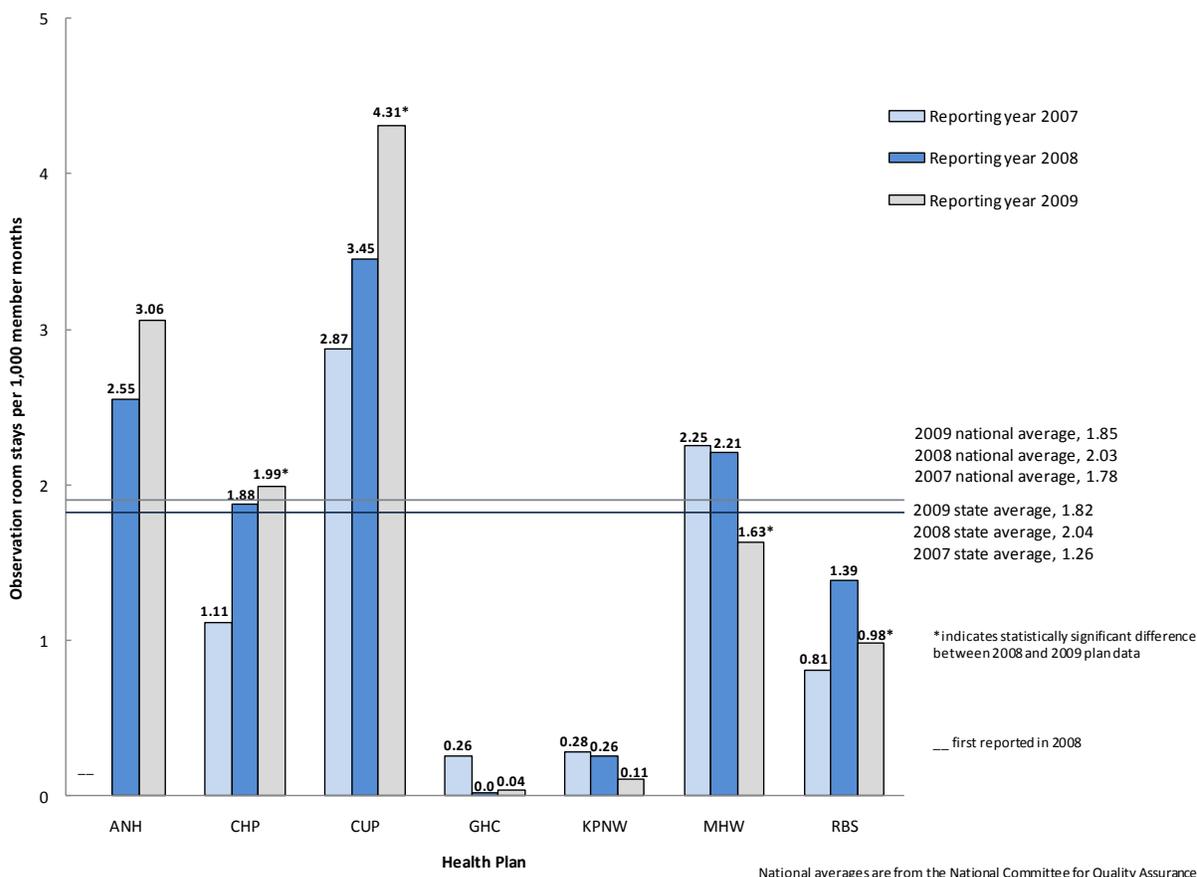


Figure 39. Ambulatory care, observation room stays resulting in discharge by health plan, reporting years 2007–2009.

The HEDIS specifications for observation room stays note that, although the criteria for this indicator were selected to produce comparable data, not all observation services are captured for this indicator—i.e., different billing practices among facilities may account for some of the variation in observation room stay rates.⁴⁰

Focus on ER utilization

As shown in Figure 40, ER utilization by Healthy Options enrollees has remained well below the national Medicaid average since 2005. The difference was statistically significant in 2008 and again in 2009.

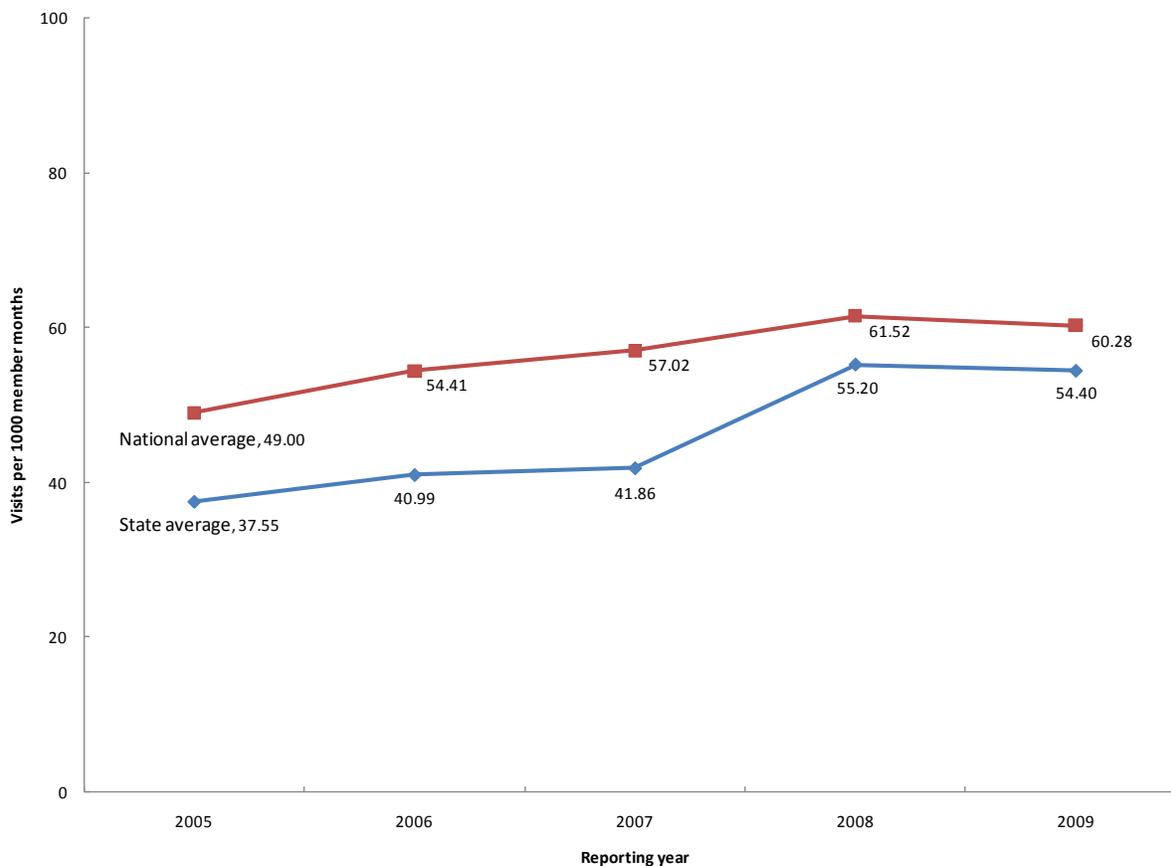


Figure 40. State and national averages for ER utilization, reporting years 2005–2009.

HRSA attributes the state’s below-average ER utilization rates to a strong system of community health clinics (CHCs) and relatively high penetration of Medicaid managed care. Nevertheless, HRSA continues to monitor ER utilization closely because of concerns about quality of care and the rising cost of ER services. Research has shown that quality of care may suffer when ER physicians treat conditions better addressed by a PCP, who can provide continuity of care, follow-up treatment, and preventive services. In addition, Washington Medicaid expenditures for ER care more than doubled in fee-for-service programs from 2000 to 2006.

A patient’s decision to visit an ER instead of a clinic or a physician’s office may result from insufficient access to primary care due to limited office hours, transportation issues, inflexible work schedules for single parents, and/or language barriers. Access to an urgent care center or to primary care clinics with evening hours may reduce the number of nonemergent ER visits.⁴¹

Research suggests that health plans can reduce ER visits and costs by informing providers about their members who use ER services and by educating enrollees (especially non-English-speaking enrollees) about appropriate ER use. Colorado’s Medicaid program has had mixed success with a

rapid cycle improvement activity. Frequent ER users (more than four visits in one quarter) are engaged in conversations to determine their rationale for visiting the ER, and to explain the functions of PCPs. In another program, staff works closely with safety-net providers to better understand the factors driving ER visitation and to seek alternative solutions.⁴²

In an effort to reduce inappropriate ER use, HRSA sought and received funding from the Centers for Medicare & Medicaid Services to establish CHCs as alternate nonemergency service providers for 50,000 Medicaid beneficiaries. Four partnership/collaboratives received about \$200,000 a year for two years to implement ER diversion programs. Each initiative site involves a contracted clinic or hospital working in collaboration with a partner hospital or clinic. All programs include extended clinic hours, telephone triage, a case management system to follow up on ER visits, patient education, and access to behavioral health and dental services. The pilot projects reached full implementation at the end of February 2009. Each involves designing a unique activity and using an existing resource in a novel way. Examples include

- taking advantage of DSHS patient review and coordination data, and receiving monthly information on clinic patients who are frequent users of ER services
- creating a “golden ticket” for nonemergent ER patients to use at an urgent care setting
- using a full-time ER patient liaison to redirect nonemergent patients to the clinic during normal business hours
- partnering with a local fast-food franchise to create tray tables that provide health education to parents about emergent and nonemergent health care⁴³

These initiatives are expected to reduce ER use by 25 percent in the second year; once fully established, the project is expected to reduce HRSA’s ER costs by \$1.27 million a year. HRSA also expects to see care redirected from the ER to the primary care setting, leading to improved patient satisfaction and improved achievement of preventive care standards.

Discussion

Despite small fluctuations from year to year, the Healthy Options plans as a group have consistently reported utilization rates below the national averages for all reported indicators since 2004. Utilization rates have varied among plans, but no plan consistently stands out as over- or underutilizing services. By analyzing service utilization patterns from year to year, a health plan may gain insights as to the quality of care its enrollees are receiving, or the plan may identify areas of under- or overutilization.

Comparisons of plan-to-state or state-to-national data may be possible,^{44,45} but many studies stress that utilization of healthcare services varies by geographic location. Some regional variations in both utilization and outcomes may be due to differences in the local delivery system itself. Important local determinants include the regional supply of healthcare resources, practice styles of physicians, and differences in the delivery and organization of care.⁴⁶ Also, the case mix of clients served by Medicaid managed care programs can vary from state to state. For example, Healthy Options enrollees generally comprise children, women, and pregnant women, whereas many other states’ Medicaid populations include larger proportions of older, chronically ill individuals who require different sets of healthcare services. Therefore, comparing utilization patterns in Washington with national benchmarks may not be highly relevant, and the reader should interpret these patterns with caution.

Descriptive information

Race/ethnicity diversity of health plan membership

Disparities exist among racial and ethnic groups in terms of the incidence of disease, access to health care, receipt of services, and health outcomes. A 2002 study by the Institute of Medicine (IOM) found that members of racial and ethnic minorities receive lower-quality health care than white people, even when insurance status, income, age, and severity of conditions are comparable.⁴⁷ In response to the IOM findings, the federal government has committed to closing the disparity gap, with a goal of eliminating disparities in the burden of disease by 2010.⁴⁸

This is the second year that HRSA has required the Healthy Options plans to report this HEDIS measure as a method to identify characteristics of the Medicaid enrollees served by the plans. The measure reports an unduplicated count and percentage of members enrolled at any time during the measurement year by race and ethnicity.

Tables 51 to 57 in Appendix B present complete demographic data for each health plan. The data should be interpreted with caution because of the wide variation among plans in the consistency of the data reported, evident from Tables 4–6 below.

Table 4. Unduplicated membership and known race and ethnicity by health plan, reporting year 2009.

	ANH	CHP	CUP	GHC	KPNW	MHW	RBS	State
Unduplicated membership	2,729	242,337	47,907	18,913	921	371,285	47,492	731,584
% with known race	87.4	63.5	82.16	0.00	0.98	64.28	89.1	65.15
% with known ethnicity	1.43	100.00	0.00	0.00	1.19	68.42	26.42	69.57

Table 5. Ethnicity of enrollees by health plan, reporting year 2009.

	Hispanic		Not Hispanic		Unknown		Totals	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
ANH	39	1.43	0	0.00	2,690	98.57	2,729	100.00
CHP	48,727	20.11	193,610	79.89	0	0.00	242,337	100.00
CUP	0	0.00	0	0.00	47,907	100.00	47,907	100.00
GHC	0	0.00	0	0.00	18,913	100.00	18,913	100.00
KPNW	0	0.00	11	1.19	910	98.81	921	100.00
MHW	35,201	9.48	218,842	58.94	117,242	31.58	371,285	100.00
RBS	12,547	26.42	0	0.00	34,945	73.58	47,492	100.00
State total	96,514	57.44	412,463	140.02	222,607	502.54	731,584	100.00

Table 6. Race of enrollees by health plan, reporting year 2009.

Race	ANH	CHP	CUP	GHC	KPNW	MHW	RBS	State
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
White	2,068 (75.78)	95,052 (39.22)	31,218 (65.16)	0 (0)	8 (0.87)	189,002 (50.90)	21,222 (44.69)	338,570 (47.57)
African American	71 (2.60)	13,451 (5.55)	1,650 (3.44)	0 (0)	0 (0)	29,840 (8.04)	1,192 (2.51)	46,204 (6.5)
American Indian	24 (0.88)	1,442 (0.60)	176 (0.37)	0 (0)	0 (0)	0 (0)	497 (1.05)	2,139 (0.3)
Asian	26 (0.95)	6,760 (2.79)	606 (1.26)	0 (0)	1 (0.11)	0 (0)	462 (0.97)	7,855 (1.1)
Native Hawaiian	0 (0)	4,117 (1.70)	199 (0.42)	0 (0)	0 (0)	0 (0)	0 (0)	4,316 (0.61)
Some other race	195 (7.15)	33,009 (13.62)	5,510 (11.5)	0 (0)	0 (0)	0 (0)	18,942 (39.88)	57,656 (8.1)
Two or more races	0 (0)	55 (0.02)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	55 (0)
Unknown	345 (12.64)	88,451 (36.5)	8,548 (17.84)	18,913 (100)	912 (99)	132,622 (35.72)	5,177 (10.90)	254,968 (35.82)
Plan total	2,729 (100)	242,337 (100)	47,907 (100)	18,913 (100)	921 (100)	351,464 (100)	47,492 (100)	711,763 (100)

Discussion

Accurate data on race and ethnicity can help healthcare system managers determine the drivers of disparate care, identify opportunities for system improvements, and use resources more efficiently. Patients can benefit from recognition and validation of their different identities and needs, leading to greater patient satisfaction and engagement in treatment, which, in turn, can lead to improved outcomes.

According to the Health Research and Educational Trust (HRET), valid and reliable data on patient race and ethnicity are “fundamental building blocks for identifying differences in care and developing targeted interventions to improve the quality of care delivered to specific populations.” Such data also may help health plans prevent discrimination on the basis of race and national origin.⁴⁹ The IOM’s Subcommittee on Standardized Collection of Race/Ethnicity Data for Healthcare Quality Improvement has recommended collection of more granular data on ethnicity and language needs in addition to race and Hispanic ethnicity categories.⁵⁰

The Healthy Options plans showed marked improvement this year in reporting racial data. All plans except for GHC and KPNW provided racial data for at least 65 percent of their enrollees. However, large gaps remain in reporting ethnicity data. This year’s percentages are in line with last year’s numbers.

The HRET website cited above suggests best practices in collecting and reporting data on race, ethnicity, and primary language. The organization’s Disparities Toolkit offers a uniform framework for obtaining these data directly from enrollees or their caregivers in an efficient, effective, and respectful manner. HRET recommends these practices for healthcare organizations seeking to standardize data collection:

- Information should always be provided by patients or their caretakers, never by observation alone.
- For health plans, data collection should take place at enrollment.
- Use U.S. Census or Office of Management and Budget racial and ethnic categories for reporting purposes.
- Store the data in a standard electronic format for easy linking to clinical data.
- Address patient concerns up front and clearly before obtaining information.
- Provide ongoing training and evaluation for health plan staff.

Washington Medicaid Integration Partnership (WMIP)

The WMIP seeks to integrate medical, mental health, substance abuse, and long-term care services for categorically needy aged, blind, and disabled Medicaid beneficiaries. These beneficiaries, who tend to have complex health conditions, are the fastest growing and most expensive segment of DSHS's client base. That trend is paralleled nationwide. Dual-eligible enrollees represent 18 percent of Medicaid and 16 percent of Medicare enrollees, yet they account for 46 percent of total Medicaid and 25 percent of total Medicare expenditures. In 2005, the total healthcare cost was approximately \$215 billion.⁵¹

Intermediate goals of the WMIP include improving the use of mental health and substance abuse services, which account for a large portion of total healthcare costs.⁵² Longer-term objectives are to improve the patients' quality of life and independence, reduce ER visits, and reduce overall healthcare costs.

The state contracts with MHW to conduct the WMIP in Snohomish County. MHW is expected to

- provide intensive care coordination to help clients navigate the healthcare system
- involve clients in care planning
- assign each client to a care coordination team and have consulting nurses available on the phone 24 hours per day
- use the Chronic Care Model to link medical, pharmacy, and community services
- use standards for preventive health and evidence-based treatment to guide care plan development and improve health outcomes

The WMIP target population is Medicaid enrollees age 21 or older who are aged, blind, or disabled, including Medicaid-only enrollees and those dually eligible for Medicare and Medicaid. WMIP excludes children under 21, Healthy Options enrollees, and recipients of Temporary Assistance for Needy Families. As of October 2009, 2,989 individuals were enrolled in WMIP.

For 2009, MHW reported seven HEDIS measures for the WMIP population: comprehensive diabetes care, inpatient care utilization—general hospital/acute care and nonacute care, ambulatory care utilization, anti-depression medication management, follow-up after hospitalization for mental illness, and use of high-risk medications for the elderly.

In addition, MHW calculated four "HEDIS-like" measures for the WMIP program: chronic dementia, falls, depression, and transition of care. Data collection and calculation were performed according to the specifications as they were written. However, modifications and clarifications to the denominator were made over the reporting cycles. As a result of the modifications, quarterly rates were not eligible for comparison.

Because the WMIP population differs categorically from the Healthy Options population, it is not feasible to compare the WMIP data meaningfully with the data reported by Healthy Options plans or with national data for health plans serving traditional Medicaid recipients.

Comprehensive diabetes care

Figure 41 presents the WMIP results for comprehensive diabetes care in reporting years 2007–2009. For a discussion of these measures and their definitions, see page 23.

The 2009 rates for HbA1c testing and for lipid profile and control were slightly higher than the rates reported in 2008. In addition, the 2009 rate for poor control of HbA1c was slightly lower (i.e., better) than in 2008. The 2009 rates for eye exams, nephropathy monitoring, and blood pressure (<140/90) were significantly higher than in 2008.

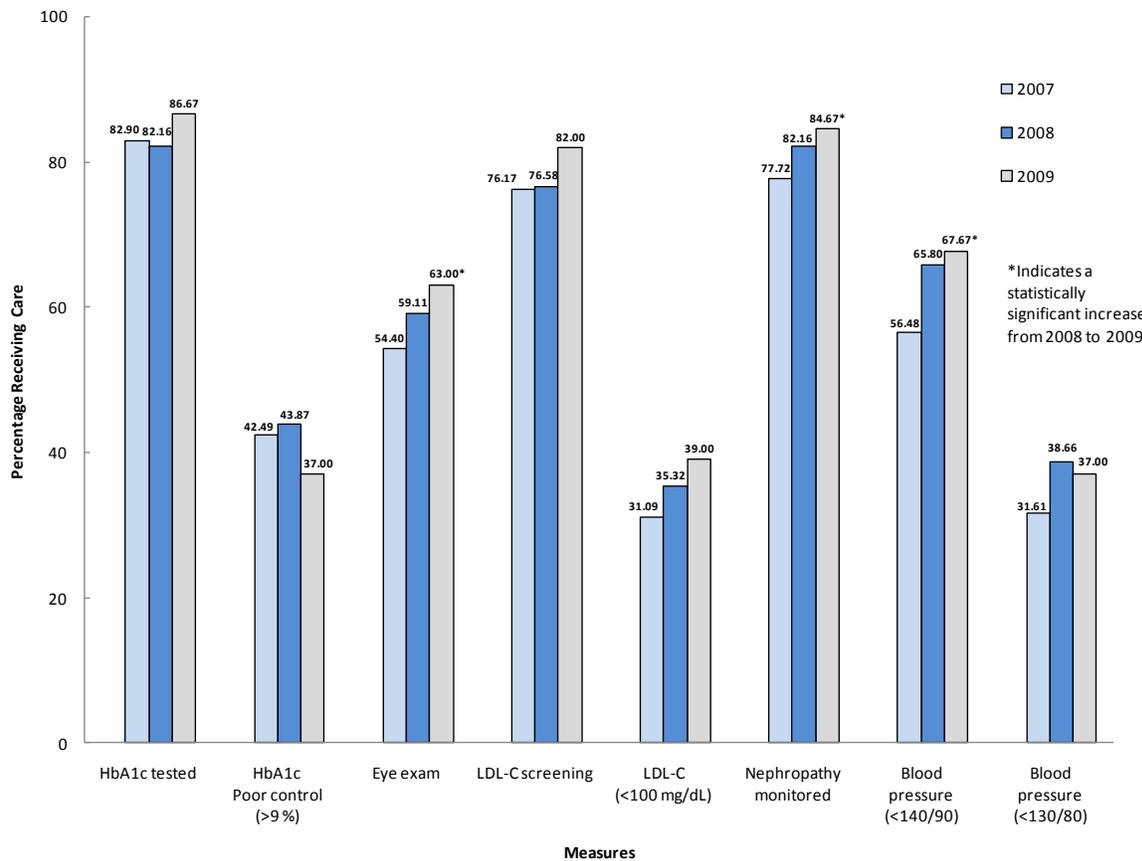


Figure 41. WMIP comprehensive diabetes care, reporting years 2007–2009.

Utilization measures

Figures 42–46 present the results of WMIP utilization measures for the past three years:

- inpatient utilization discharges, days and average length of stay—total inpatient (acute), medical, surgical, and inpatient (nonacute)
- ambulatory care visits (outpatient, ER, surgery or procedure, observation room)

The inpatient nonacute care measure summarizes usage of nonacute care in hospice, nursing home, rehabilitation, skilled nursing facility, transitional care, and respite settings, except for services with a principal diagnosis of mental health and chemical dependency.

In 2009, discharges increased for total inpatient acute care and medical services, and decreased for surgical services; the changes were not statistically significant. Nonacute inpatient discharges decreased significantly from 2008 (Figure 42).

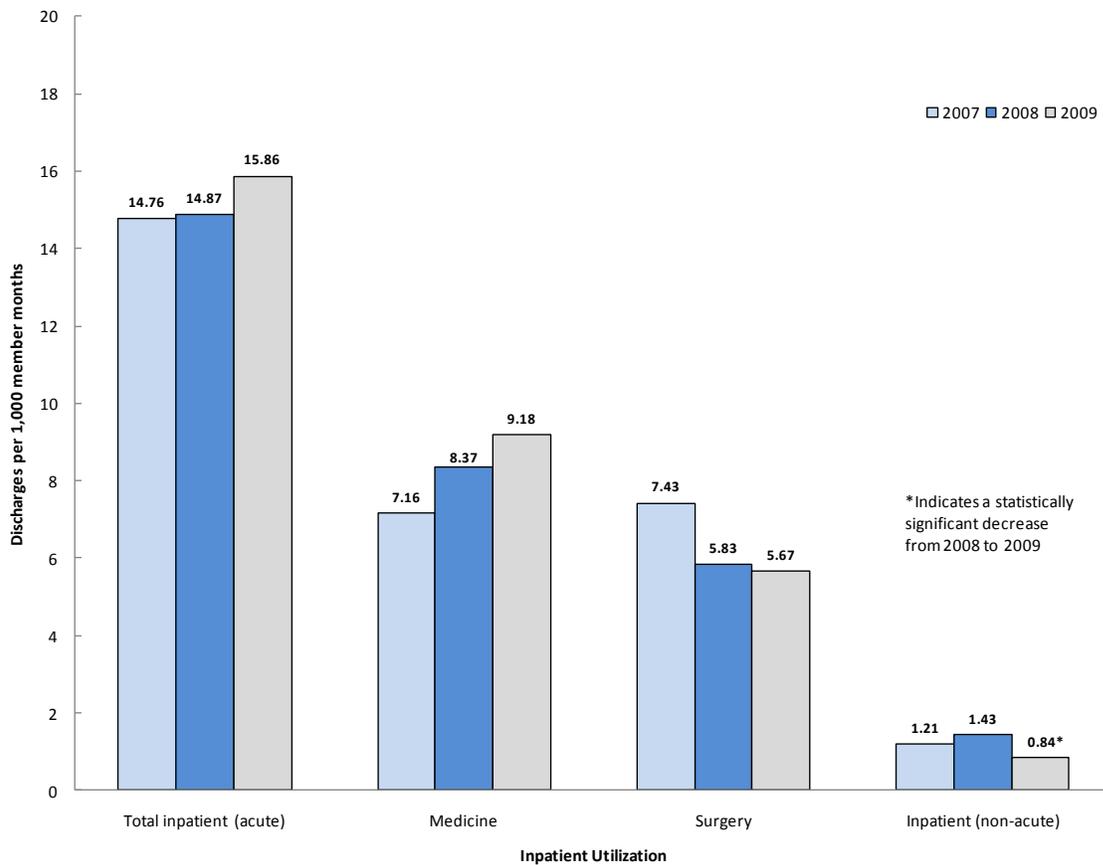


Figure 42. WMIP inpatient utilization discharges, reporting years 2007–2009.

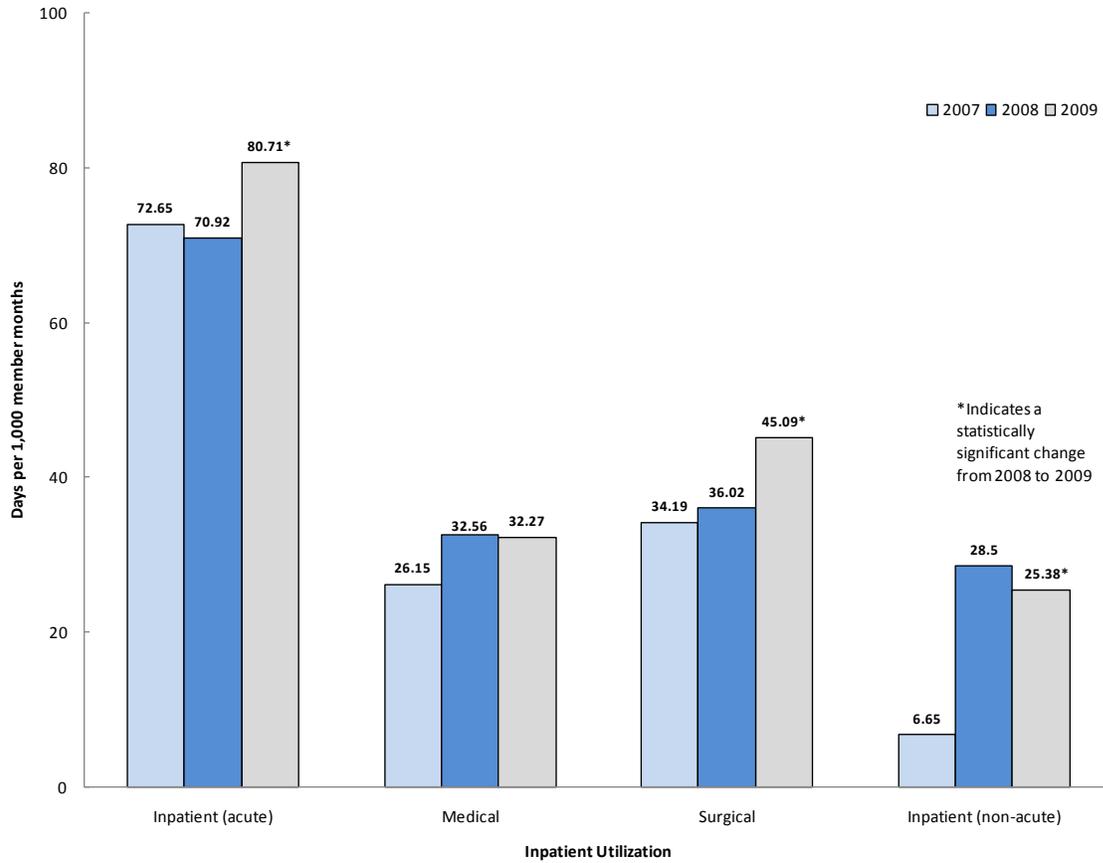


Figure 43. WMIP inpatient utilization days, reporting years 2007–2009.

Inpatient acute days and surgical days increased significantly in 2009. Differences between age groups were tested for both measures. Utilization rates were significantly higher for members under 65 than for those above 65. Inpatient nonacute days fell significantly (Figure 43).

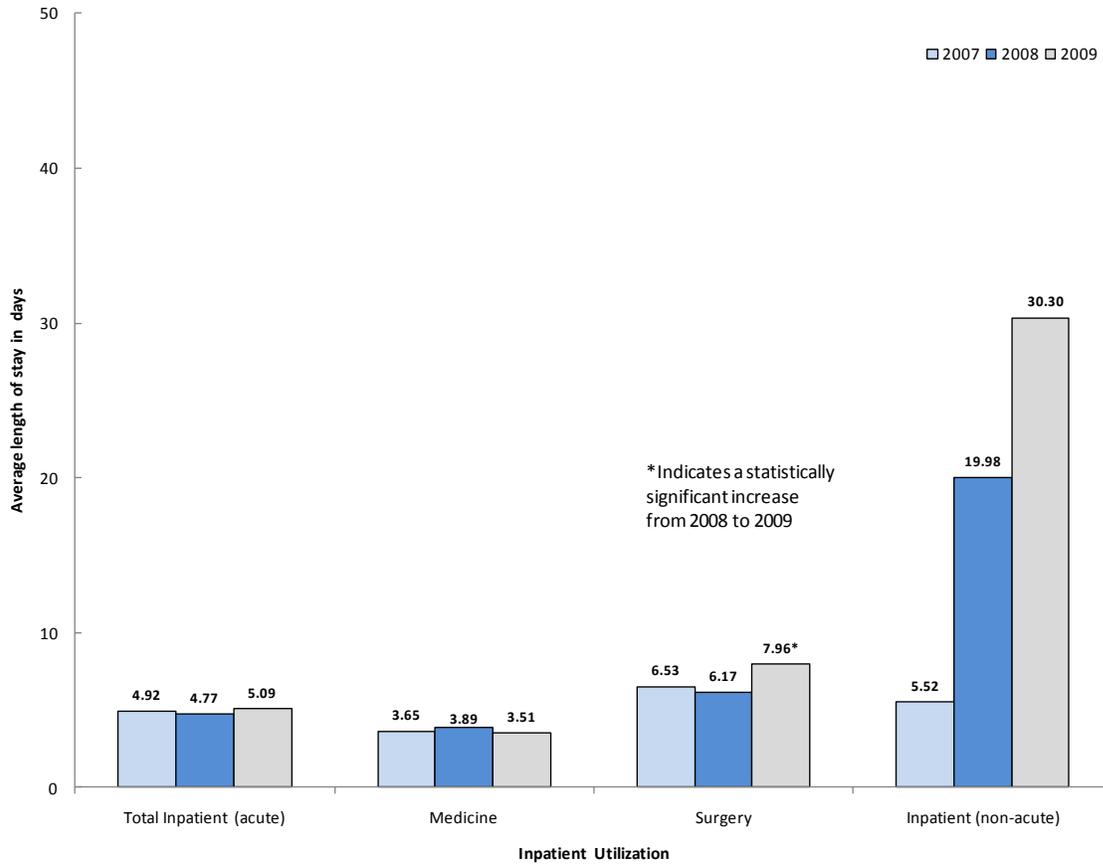


Figure 44. WMIP inpatient utilization average length of stay, reporting years 2007–2009.

The ALOS for enrollees in inpatient surgical care increased significantly from 2008. Total inpatient acute and nonacute ALOS increased, but not significantly. Total inpatient acute care ALOS for those under 65 was significantly higher than for those 65 and over (Figure 44).

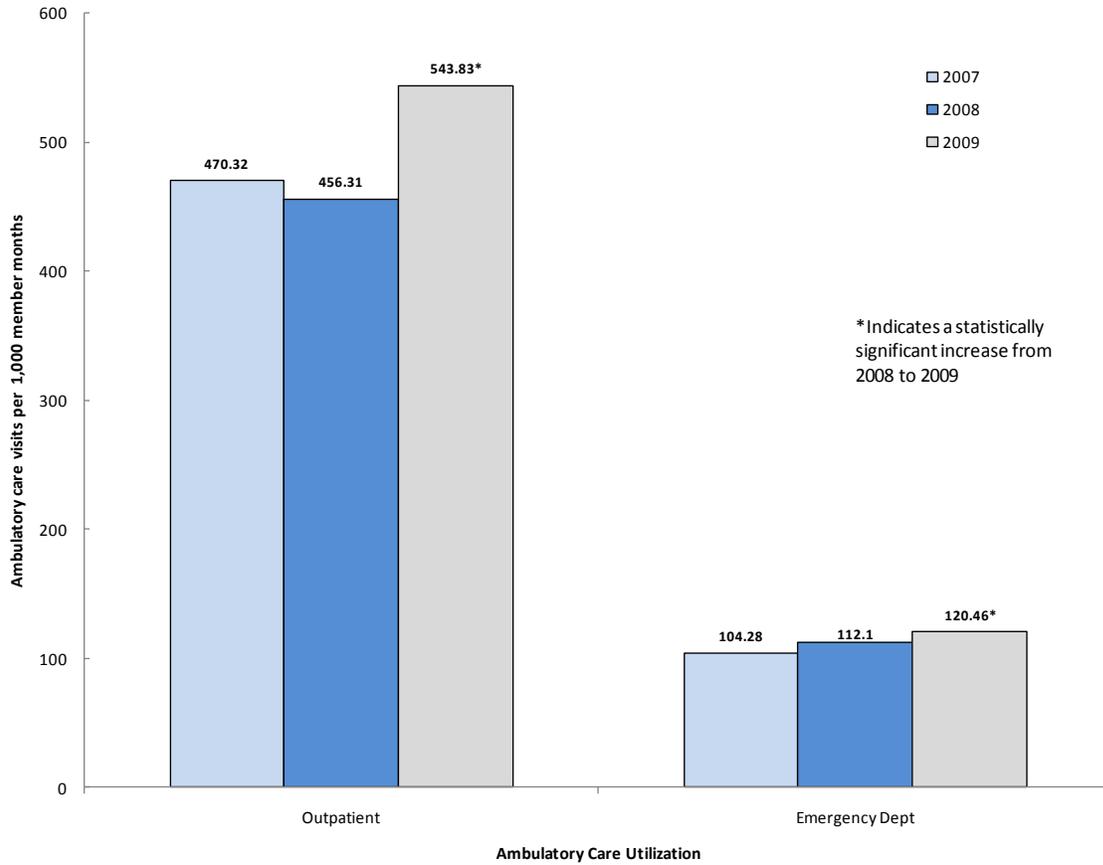


Figure 45. WMIP ambulatory care visits, outpatient and emergency department, reporting years 2007–2009.

Outpatient and ER visits increased significantly in 2009 (Figure 45). Outpatient and ER visits were significantly higher for those under 65 was significantly higher than for those 65 and over (Figure 45).

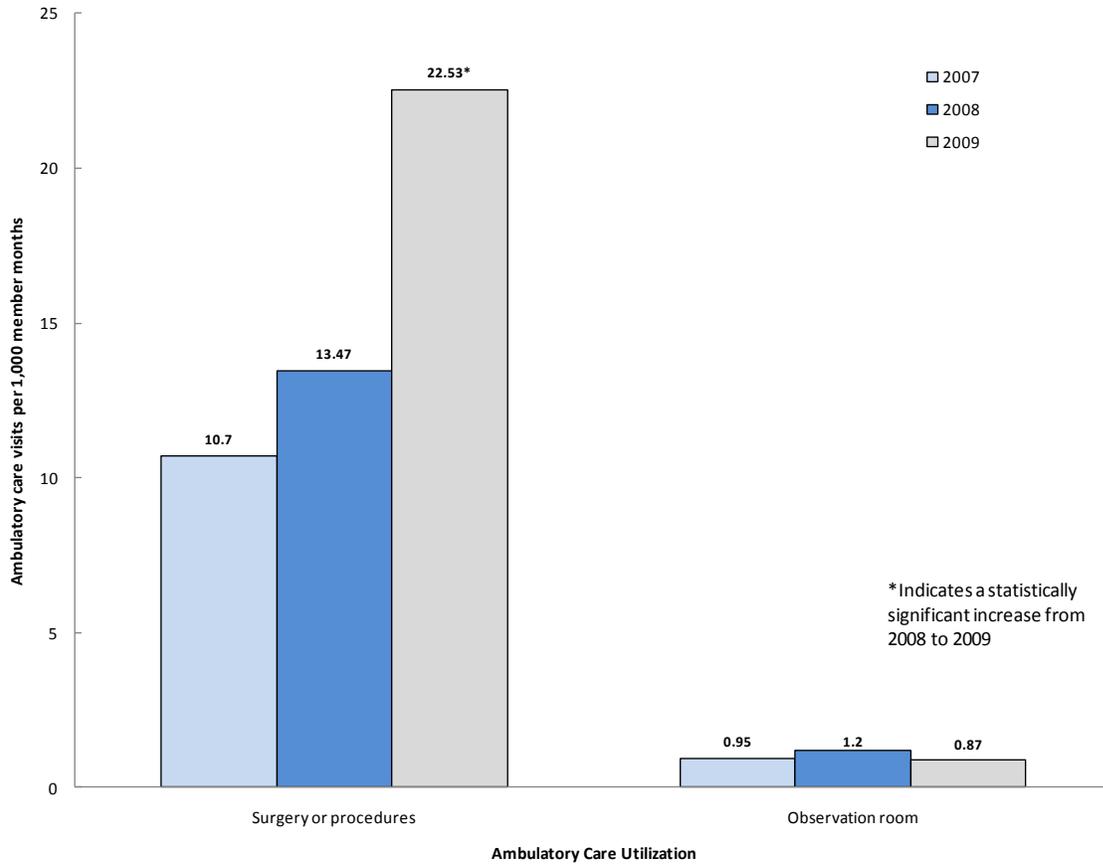


Figure 46. WMIP ambulatory care visits, surgery or procedures and observation room, reporting years 2007–2009.

Surgery or procedures increased significantly in 2009; no significant differences were found between the under 65 and above 65 age groups (Figure 46).

Additional measures

Figures 47 and 48 present WMIP results for two behavioral health measures for the past two years.

The antidepressant medication management measure examines

- the percentage of newly diagnosed and treated patients who remained on an antidepressant medication for the treatment of major depression for at least 12 weeks (effective acute phase treatment)
- the percentage of newly diagnosed and treated patients who remained on an antidepressant medication for the treatment of major depression for at least six months (effective continuation phase treatment)

The percentage of patients receiving effective acute phase treatment increased in 2009, while the percentage receiving effective continuation phase treatment decreased, although neither change percentage was significant (Figure 47).

The measure of follow-up after hospitalization for mental illness looks at continuity of care—the percentage of enrollees age 65 or older who were hospitalized for selected mental disorders and who were seen on an outpatient mental health provider within 30 days or within 7 days after their discharge from the hospital. Although the percentage of enrollees receiving timely follow-up care increased for both populations, only the 30-day group improved significantly (Figure 48).

Figure 49 shows three years of data on the use of high-risk medications in the aged—the percentage of enrollees age 65 or older who received at least one prescription, or at least two different prescriptions. The percentages for both sets of enrollees decreased, but neither change was significant. For this measure, NCQA states that a lower rate represents better performance.

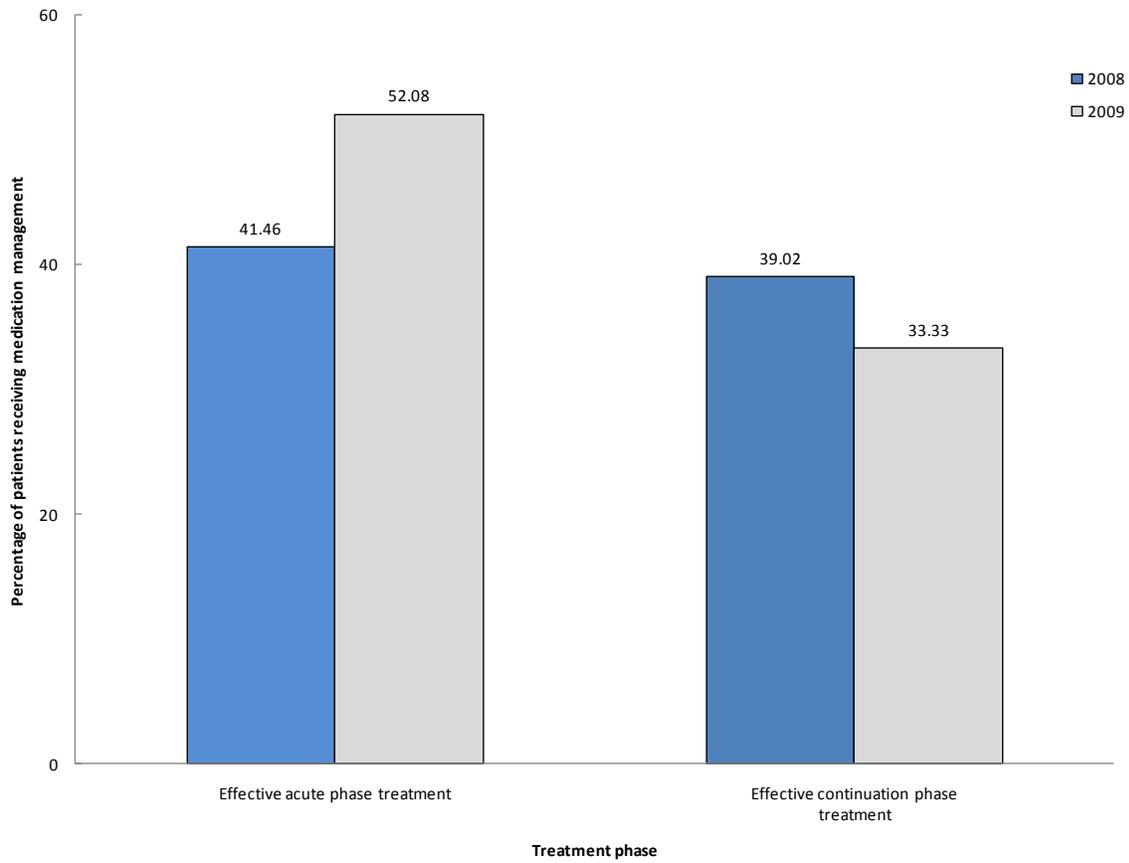


Figure 47. WMIP antidepressant medication management, reporting years 2008–2009.

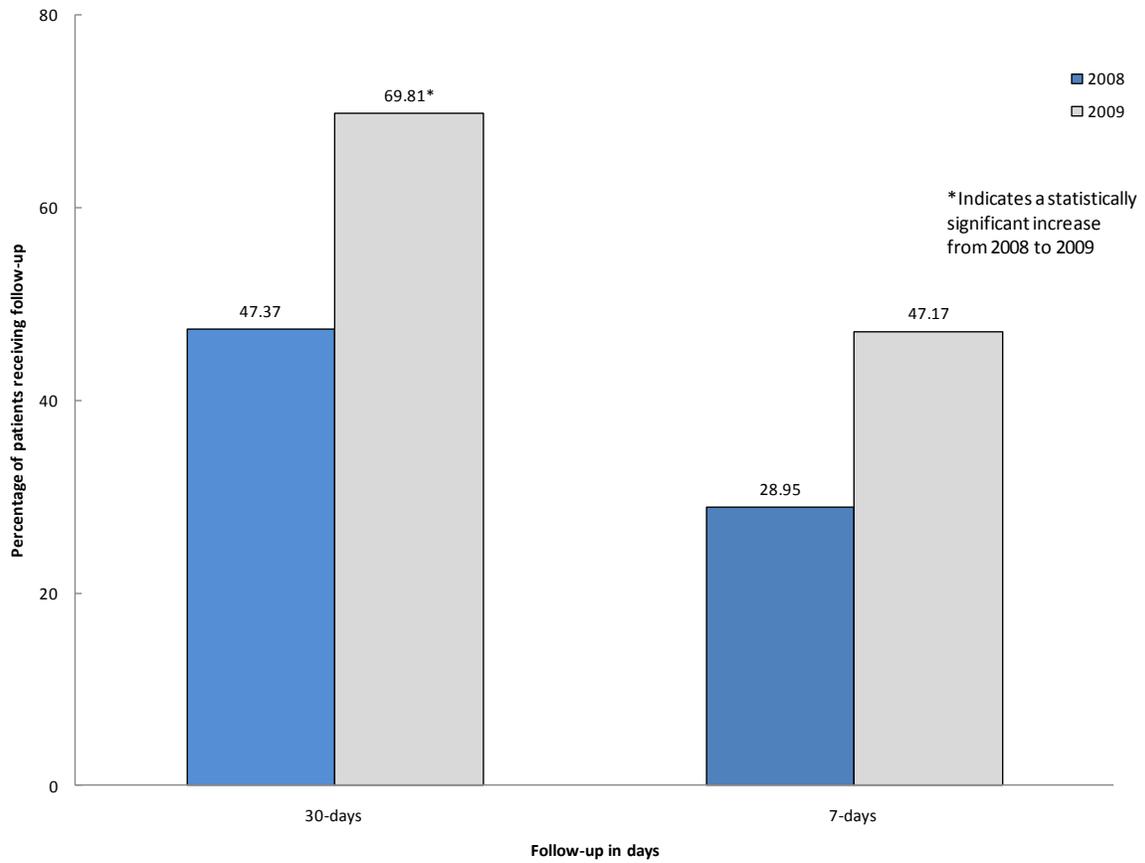


Figure 48. WMIP follow-up after hospitalization for mental illness, reporting years 2008–2009.

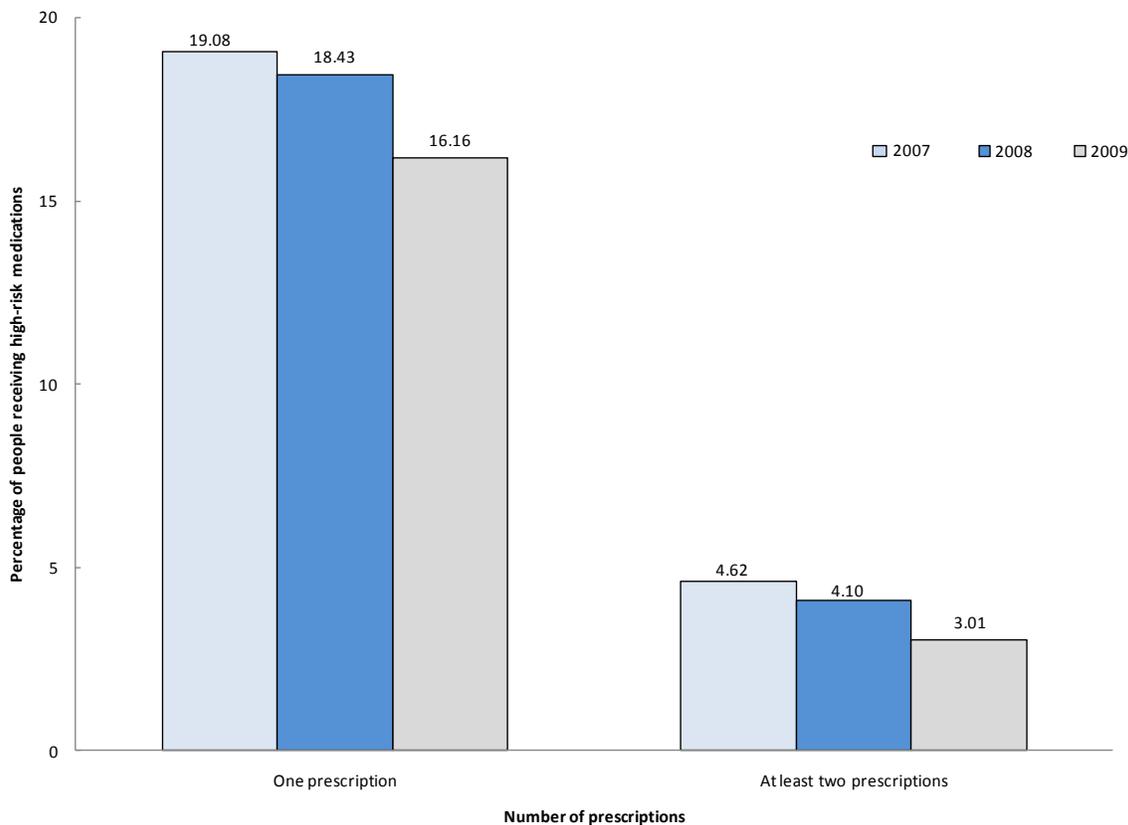


Figure 49. WMIP use of high-risk medications in the aged, reporting years 2007–2009.

Discussion and recommendations

The WMIP program serves enrollees who exhibit complex healthcare issues, including enrollees who receive mental health services and who are in long-term care. According to DSHS, these enrollees typically have received substantial amounts of inappropriate care in hospitals and ER facilities due to lack of care management by physicians and nursing facilities and because the clients were unaware of how to obtain access to the care available to them.

Early results of the WMIP program won recognition from URAC’s Best Practices in Health Care Consumer Empowerment and Protection Awards program. These awards honor organizations that are pursuing practices to advance consumer empowerment and protection in an exceptional, measurable, and reproducible way. In 2008, URAC cited MHW and the WMIP for results that showed “high but stable rates of hospitalization, ER visits, and medication use, as well as rising member satisfaction.”⁵³

Current research regarding the dual-eligible population focuses on reducing hospitalizations and improving outcomes for beneficiaries with multiple chronic illnesses who are not cognitively impaired. Three types of interventions have been demonstrated to be effective:

- **Transitional care interventions** engage patients while they are hospitalized and follow them intensively for four to six weeks after discharge to ensure that patients understand and can adhere to post-discharge instructions for medication and self-care, recognize

symptoms that signify potential complications requiring immediate attention, and make and keep follow-up appointments with their PCPs. These interventions use advanced practice nurses and “transition coaches.” In successful interventions, these professionals had substantial amounts of in-person contact with their patients.

- **Self-management education interventions** engage patients from four to seven weeks in community-based programs (using medical and nonmedical professionals) designed to “activate” them in managing their chronic conditions. Patients learn to self-manage symptoms, participate in activities that maintain function and reduce health declines (e.g., taking their medications properly), participate in diagnostic and treatment choices, and collaborate with their providers.
- **Coordinated care interventions** identify patients with chronic conditions that are at substantial risk of hospitalization in the next 12 months; conduct initial assessments and care planning; and monitor patients’ symptoms and self-care on an ongoing basis. Registered nurses often coordinate this care. However, for some patients, social workers assist with assessing eligibility and arranging services such as transportation, home-delivered meals, emergency response systems, advanced care planning, and coordination with home health agencies. Information is coordinated among the patient, PCP, and caregivers.^{54,55}

The authors suggest that the “optimal” care coordination model includes

- augmenting effective ongoing care coordination with transitional care
- offering group education on self-management, while tailoring educational materials to people with lower educational levels and assessing their comprehension
- establishing high-quality programs using the above-mentioned interventions

Acumentra Health offers this additional recommendation:

- Conduct member-level analysis to “drill down” on performance measures and target specific areas of improvement.

In May 2009, the Center for Health Care Strategies launched an initiative called Transforming Care for Dual Eligibles. Seven states will implement strategies to improve care and control costs for dual-eligible enrollees over 18 months. Colorado, Maryland, Massachusetts, Michigan, Pennsylvania, Texas, and Vermont will receive in-depth technical assistance addressing program design, care models, contracting strategies, and financing mechanisms.⁵⁶ The findings, when they become available, are likely to prove useful for WMIP program managers.

Conclusions

The Healthy Options plans have reported positive six-year trends in many HEDIS rates, reflecting long-term improvements in providing care for enrollees. In 2009, for 15 of the 23 measures or indicators (excluding utilization measures) for which comparisons are possible, the statewide average was higher than in 2008, and 11 of the increases were statistically significant. Of the 8 indicators for which the average fell, 5 fell significantly from 2008.

Utilization measures show a positive pattern. The Healthy Options average is in line with or below the NCQA average for all indicators or measures except for maternity discharges; 13 out of 14 are significantly lower.

The six-year improvement has been significant for childhood immunizations and for WCC visits for infants and children. CHP deserves to be commended for offering performance incentives to its clinics. CHP supports two reward programs: one rewards enrollees for obtaining the health care they need, and the other rewards clinic staff for identifying children who are not up-to-date for immunizations and WCC. Best practices such as these have been shown to improve care significantly for young people.

The relationship between participation in collaboratives and improved performance has been well documented.^{57,58,59} The Healthy Options plans, through their participation in collaboratives and other learning events in Washington, are learning to apply best practices in patient care.

The Healthy Options plans would benefit from improving the accuracy and completeness of their encounter data. Plans that use mostly administrative data collection for measures with the hybrid option can save costs in data reporting. Standard rates for conducting a chart review may range from \$30 to \$50 per chart. Plans incur additional costs when a reviewer visits more than one provider's office in an attempt to verify documentation. However, our analysis suggests that heavy reliance on administrative data may result in generation of less than optimal HEDIS rates unless the reported encounters completely capture all services provided.

For 2009, HRSA required the health plans to submit member-level data (including elements for gender, primary language, race/ethnicity, and county) for childhood immunizations. Systematic reporting of these elements would enable the state and the health plans to analyze details of their populations, providing insight into appropriate targets for QI activities.

Recommendations

Health plans may improve care for their Medicaid enrollees by participating in joint projects or pooling resources to target areas such as childhood immunizations and WCC. Acumentra Health continues to recommend that HRSA consider organizing a statewide PIP or collaborative project that would pool health plan resources and capitalize on partnerships to improve WCC visit rates.

We also recommend that HRSA continue to use value-based purchasing in its contract with health plans and that HRSA extend its incentive programs to clinics and providers. Pay for performance is becoming a central organizing principle for healthcare purchasing and will continue to motivate quality improvement.

The six-year trends in HEDIS rates bear out the incremental nature of change. Ideally, the reported measures should not be considered in isolation to define plan performance; rather, the outcomes present an opportunity for plans to examine additional data sources to determine whether a “drill-down” analysis or targeted QI project may be appropriate. As rates fluctuate from year to year, HRSA and the plans need to design sustainable changes to support continuing improvement. Acumentra Health recommends that the Healthy Options plans

- adopt planned, proactive approaches for managing the care of Medicaid clients
- conduct encounter validation studies to improve the quality of encounter data
- conduct member-level analysis to “drill down” on core preventive measures to identify gaps in care
- provide HEDIS-specific performance feedback to clinics and providers on a frequent and regular schedule
- monitor their HEDIS rates at least quarterly, using administrative data
- implement interventions to improve services to underserved groups, such as Russian-speaking populations
- support and reward providers who develop medical homes for their patients and who improve their quality indicators

Finally, Acumentra Health recommends that HRSA continue to help health plans study and overcome the barriers to collecting administrative data for HEDIS measures. For example, many national laboratories provide lab values through administrative methods, thereby reducing the reliance on medical charts. Identifying alternative methods of obtaining data would enable the plans to redirect some of the resources they spend on data collection toward providing better care for Healthy Options enrollees. HRSA also is encouraged to take steps to ensure that all MCOs report race and ethnicity data.

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Appendix A. Healthy Options Plan Summaries

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Asuris Northwest Health—ANH

Measures	%	Measures	%
Effectiveness of care			
Childhood immunization status		Comprehensive diabetes care, continued	
Combo 2 ^a	—	Eye exam	—
Combo 3 ^b	—	LDL-C screening	—
		LDL-C level <100 mg/dL	—
		Monitoring for diabetic nephropathy	—
Comprehensive diabetes care		Blood pressure <140/90 mm Hg	—
HbA1c testing	—	Blood pressure <130/80 mm Hg	—
Poor HbA1c control [§]	—		
Good HbA1c control	—		
Access to care			
Postpartum care 21–56 days after delivery	—		
Use of services			
Well-child visits in the first 15 months of life		Frequency of selected procedures	Per 1000 MM^c
Six visits or more	—	Myringotomy, ages 0–4	3.96 ▲
Five visits	—	Myringotomy, ages 5–19	1.13
Well-child visits in the 3rd, 4th, 5th, and 6th years of life		Hysterectomy, abdominal, ages 15–44	0.00
Percentage of children ages 3–6 who received one or more visits during the year	49.54 ▼	Hysterectomy, abdominal, ages 45–64	0.00
		Hysterectomy, vaginal, ages 15–44	0.30
Adolescent well-care visits		Hysterectomy, vaginal, ages 45–64	0.00
Percentage of adolescents ages 12–21 with one or more visits during the year	32.03	Mastectomy, ages 15–45	0.00
		Mastectomy, ages 45–64	0.00
		Lumpectomy, ages 15–44	0.00
		Lumpectomy, ages 45–64	0.00
Utilization			
Inpatient—general hospital/acute care	Per 1000 MM		ALOS^d
Inpatient discharges	7.59 ▲		2.93
Medical discharges	1.51		2.80
Surgical discharges	0.85		3.29
Maternity discharges	10.56 ▲		3.29
Ambulatory care	Per 1000 MM		
Outpatient visits	306.77		
Emergency room visits	48.18 ▼		
Ambulatory surgery/procedures	7.59 ▲		
Observation room stays	3.06 ▲		

▲ ▼ Plan percentage is significantly higher or lower than state average ($p < 0.05$).

— ANH did not conduct the measure in reporting year 2009.

[§]Lower percentages are more desirable for this measure.

^aCombo 2 includes DTaP, IPV, MMR, HiB, Hep B, VZV.

^bCombo 3 includes DTaP, IPV, MMR, HiB, Hep B, VZV, PCV.

^cPer 1000 MM indicates the number of procedures, discharges, visits, stays, etc. per 1000 member months.

^dALOS, average length of stay.

Asuris Northwest Health, an "unbranded" subsidiary of Regence BlueShield, was licensed in 2002. ANH provides coverage for Medicaid clients in Spokane County in eastern Washington, serving fewer than 1 percent of Healthy Options enrollees. ANH insures approximately 60,000 lives, 3.15 percent of whom are Medicaid clients. Approximately 83 percent of Medicaid clients are 18 years of age or younger.

Community Health Plan—CHP

Measures	%	Measures	%
Effectiveness of care			
Childhood immunization status		Comprehensive diabetes care, continued	
Combo 2 ^a	77.37 ▲	Eye exam	56.20
Combo 3 ^b	74.94 ▲	LDL-C screening	63.02
		LDL-C level <100 mg/dL	25.06
Comprehensive diabetes care		Monitoring for diabetic nephropathy	70.56
HbA1c testing	82.00	Blood pressure <140/90 mm Hg	70.80
Poor HbA1c control [§]	46.96	Blood pressure <130/80 mm Hg	36.74
Good HbA1c control	43.13		
Access to care			
Postpartum care 21–56 days after delivery	56.93 ▼		
Use of services			
Well-child visits in the first 15 months of life		Frequency of selected procedures	Per 1000 MM^c
Six visits or more	47.45 ▼	Myringotomy, ages 0–4	1.83 ▼
Five visits	25.06 ▲	Myringotomy, ages 5–19	0.42
Well-child visits in the 3rd, 4th, 5th, and 6th years of life		Hysterectomy, abdominal, ages 15–44	0.16
Percentage of children ages 3–6 who received one or more visits during the year	63.02	Hysterectomy, abdominal, ages 45–64	0.40
		Hysterectomy, vaginal, ages 15–44	0.21
Adolescent well-care visits		Hysterectomy, vaginal, ages 45–64	0.17
Percentage of adolescents ages 12–21 with one or more visits during the year	36.01	Mastectomy, ages 15–45	0.01
		Mastectomy, ages 45–64	0.35
		Lumpectomy, ages 15–44	0.12
		Lumpectomy, ages 45–64	0.58
Utilization			
Inpatient—general hospital/acute care		Per 1000 MM	ALOS^d
Inpatient discharges	6.10 ▼		2.80
Medical discharges	1.52		2.87
Surgical discharges	0.73 ▼		4.69
Maternity discharges	8.17 ▼		2.40
Ambulatory care		Per 1000 MM	
Outpatient visits	269.88 ▼		
Emergency room visits	59.74 ▲		
Ambulatory surgery/procedures	6.13		
Observation room stays	1.99 ▲		

▲ ▼ Plan percentage is significantly higher or lower than state average ($p < 0.05$).

[§]Lower percentages are more desirable for this indicator.

^aCombo 2 includes DTaP, IPV, MMR, HiB, Hep B, VZV.

^bCombo 3 includes DTaP, IPV, MMR, HiB, Hep B, VZV, PCV.

^cPer 1000 MM indicates the number of procedures, discharges, visits, stays, etc. per 1000 member months.

^dALOS, average length of stay.

Established in 1992, Community Health Plan is a network of community health centers and affiliated providers covering Medicaid enrollees in 33 counties across Washington. Members receive services from 1,600 primary care providers and 8,000 specialists at more than 300 primary care sites and more than 90 hospitals. CHP is the state's second largest Medicaid provider, serving approximately 31 percent of Healthy Options enrollees, including those with SCHIP and BH+ coverage. CHP insures more than 235,000 lives, 70 percent of whom are insured by Medicaid. About 85 percent of Medicaid clients are 18 years of age or younger.

Columbia United Providers—CUP

Measures	%	Measures	%
Effectiveness of care			
Childhood immunization status		Comprehensive diabetes care, continued	
Combo 2 ^a	55.96 ▼	Eye exam	71.19 ▲
Combo 3 ^b	52.55 ▼	LDL-C screening	62.71
		LDL-C level <100 mg/dL	22.88
Comprehensive diabetes care		Monitoring for diabetic nephropathy	78.81 ▲
HbA1c testing	85.59	Blood pressure <140/90 mm Hg	65.25
Poor HbA1c control [§]	41.53	Blood pressure <130/80 mm Hg	34.75
Good HbA1c control	48.31		
Access to care			
Postpartum care 21–56 days after delivery	56.45 ▼		
Use of services			
Well-child visits in the first 15 months of life		Frequency of selected procedures	Per 1000 MM^c
Six visits or more	73.72 ▲	Myringotomy, ages 0–4	3.09 ▲
Five visits	12.41 ▼	Myringotomy, ages 5–19	0.53
Well-child visits in the 3rd, 4th, 5th, and 6th years of life		Hysterectomy, abdominal, ages 15–44	0.25
Percentage of children ages 3–6 who received one or more visits during the year	51.09 ▼	Hysterectomy, abdominal, ages 45–64	0.49
Adolescent well-care visits		Hysterectomy, vaginal, ages 15–44	0.23
Percentage of adolescents ages 12–21 with one or more visits during the year	32.85	Hysterectomy, vaginal, ages 45–64	0.74
		Mastectomy, ages 15–45	0.04
		Mastectomy, ages 45–64	0.00
		Lumpectomy, ages 15–44	0.00
		Lumpectomy, ages 45–64	0.25
Utilization			
Inpatient—general hospital/acute care	Per 1000 MM		ALOS^d
Inpatient discharges	6.52		2.88
Medical discharges	1.62		2.99
Surgical discharges	0.71		3.84 ▼
Maternity discharges	8.53		2.67 ▲
Ambulatory care	Per 1000 MM		
Outpatient visits	294.49 ▼		
Emergency room visits	41.77 ▼		
Ambulatory surgery/procedures	0.05 ▼		
Observation room stays	4.31 ▲		

▲ ▼ Plan percentage is significantly higher or lower than state average (p<0.05).

§Lower percentages are more desirable for this measure.

^aCombo 2 includes DTaP, IPV, MMR, HiB, Hep B, VZV.

^bCombo 3 includes DTaP, IPV, MMR, HiB, Hep B, VZV, PCV.

^cPer 1000 MM indicates the number of procedures, discharges, visits, stays, etc. per 1000 member months.

^dALOS, average length of stay.

Columbia United Providers was established in 1994 and began providing coverage for Medicaid enrollees in 1995. CUP serves approximately 6 percent of Healthy Options enrollees, including those with SCHIP and BH+ coverage, in Clark County in southwestern Washington. CUP insures 38,163 lives, 89 percent of whom are insured by Medicaid. About 82 percent of Medicaid clients are 18 years of age or younger.

Group Health Cooperative—GHC

Measures	%	Measures	%
Effectiveness of care			
Childhood immunization status		Comprehensive diabetes care, continued	
Combo 2 ^a	76.33 ▲	Eye exam	52.94
Combo 3 ^b	72.39	LDL-C screening	79.41 ▲
		LDL-C level <100 mg/dL	23.53
		Monitoring for diabetic nephropathy	70.59
		Blood pressure <140/90 mm Hg	64.71
		Blood pressure <130/80 mm Hg	41.18
Comprehensive diabetes care			
HbA1c testing	83.82		
Poor HbA1c control [§]	45.59		
Good HbA1c control	42.65		
Access to care			
Postpartum care 21–56 days after delivery	71.53 ▲		
Use of services			
Well-child visits in the first 15 months of life		Frequency of selected procedures	Per 1000 MM^c
Six visits or more	49.28 ▼	Myringotomy, ages 0–4	1.69 ▼
Five visits	17.63	Myringotomy, ages 5–19	0.26 ▼
		Hysterectomy, abdominal, ages 15–44	0.35
		Hysterectomy, abdominal, ages 45–64	0.75
		Hysterectomy, vaginal, ages 15–44	0.13
		Hysterectomy, vaginal, ages 45–64	0.00
		Mastectomy, ages 15–45	0.04
		Mastectomy, ages 45–64	0.75
		Lumpectomy, ages 15–44	0.17
		Lumpectomy, ages 45–64	0.75
Well-child visits in the 3rd, 4th, 5th, and 6th years of life			
Percentage of children ages 3–6 who received one or more visits during the year	59.95		
Adolescent well-care visits			
Percentage of adolescents ages 12–21 with one or more visits during the year	39.81		
Utilization			
Inpatient—general hospital/acute care	Per 1000 MM		ALOS^d
Inpatient discharges	5.53 ▼		2.46 ▼
Medical discharges	1.63		2.66
Surgical discharges	0.70		3.09 ▼
Maternity discharges	5.81 ▼		2.20 ▼
Ambulatory care	Per 1000 MM		
Outpatient visits	283.38 ▼		
Emergency room visits	34.91 ▼		
Ambulatory surgery/procedures	4.18 ▼		
Observation room stays	0.04 ▼		

▲ ▼ Plan percentage is significantly higher or lower than state average ($p < 0.05$).

[§]Lower percentages are more desirable for this measure.

^aCombo 2 includes DTaP, IPV, MMR, HiB, Hep B, VZV.

^bCombo 3 includes DTaP, IPV, MMR, HiB, Hep B, VZV.

^cPer 1000 MM indicates the number of procedures, discharges, visits, stays, etc. per 1000 member months.

^dALOS, average length of stay.

Group Health Cooperative, a nonprofit health care system established in 1947, provides coverage for Medicaid clients in four counties in Washington, serving 4 percent of Healthy Options enrollees, including those with SCHIP and BH+ coverage. More than 87 percent of GHC's Medicaid clients receive care in GHC-owned medical facilities. GHC insures more than 580,000 lives, 3 percent of whom are insured by Medicaid. About 80 percent of Medicaid clients are 18 years of age or younger.

Kaiser Permanente Northwest—KPNW

Measures	%	Measures	%
Effectiveness of care			
Childhood immunization status		Comprehensive diabetes care, continued	
Combo 2 ^a	—	Eye exam	—
Combo 3 ^b	—	LDL-C screening	—
		LDL-C level <100 mg/dL	—
		Monitoring for diabetic nephropathy	—
Comprehensive diabetes care		Blood pressure <140/90 mm Hg	—
HbA1c testing	—	Blood pressure <130/80 mm Hg	—
Poor HbA1c control [§]	—		
Good HbA1c control	—		

Access to care

Postpartum care 21–56 days after delivery 78.79

Use of services

Well-child visits in the first 15 months of life		Frequency of selected procedures	Per 1000 MM ^c
Six visits or more	—	Myringotomy, ages 0–4	1.43
Five visits	—	Myringotomy, ages 5–19	0.42
Well-child visits in the 3rd, 4th, 5th, and 6th years of life		Hysterectomy, abdominal, ages 15–44	0.00
Percentage of children ages 3–6 who received one or more visits during the year	62.77	Hysterectomy, abdominal, ages 45–64	0.00
		Hysterectomy, vaginal, ages 15–44	0.00
Adolescent well-care visits		Hysterectomy, vaginal, ages 45–64	0.00
Percentage of adolescents ages 12–21 with one or more visits during the year	35.53	Mastectomy, ages 15–45	0.00
		Mastectomy, ages 45–64	0.00
		Lumpectomy, ages 15–44	0.00
		Lumpectomy, ages 45–64	0.00

Utilization

Inpatient—general hospital/acute care	Per 1000 MM	ALOS ^d
Inpatient discharges	4.02 ▼	2.21
Medical discharges	1.16	2.36
Surgical discharges	0.00 ▼	NA
Maternity discharges	5.39 ▼	2.15
Ambulatory care	Per 1000 MM	
Outpatient visits	245.21 ▼	
Emergency room visits	11.64 ▼	
Ambulatory surgery/procedures	3.28 ▼	
Observation room stays	0.11 ▼	

▲ ▼ Plan percentage is significantly higher or lower than state average ($p < 0.05$).

§ Lower percentages are more desirable for this measure.

— KPNW did not conduct the measure in reporting year 2009.

^a Combo 2 includes DTaP, IPV, MMR, HiB, Hep B, VZV.

^b Combo 3 includes DTaP, IPV, MMR, HiB, Hep B, VZV, PCV.

^c Per 1000 MM indicates the number of procedures, discharges, visits, stays, etc. per 1000 member months.

^d ALOS, average length of stay.

Kaiser Permanente Northwest, a subsidiary of Kaiser Foundation Health Plan, Inc., was established in 1945 and began providing coverage for Medicaid enrollees in two counties in southwestern Washington in 1993. KPNW serves approximately 5 percent BH+ enrollees. KPNW insures about 479,500 lives, fewer than 1 percent of whom are insured by Washington Medicaid. About 94 percent of Medicaid clients are 18 years of age or younger. KPNW's commercial product line has been accredited by NCQA since May 1995.

Molina Healthcare of Washington—MHW

Measures	%	Measures	%
Effectiveness of care			
Childhood immunization status		Comprehensive diabetes care, continued	
Combo 2 ^a	74.07	Eye exam	54.2
Combo 3 ^b	69.68	LDL-C screening	66.59
Comprehensive diabetes care		LDL-C level <100 mg/dL	27.65
HbA1c testing	81.42	Monitoring for diabetic nephropathy	65.71
Poor HbA1c control [§]	42.48	Blood pressure <140/90 mm Hg	67.48
Good HbA1c control	46.24	Blood pressure <130/80 mm Hg	38.05
Access to care			
Postpartum care 21–56 days after delivery ^c	59.77		
Use of services			
Well-child visits in the first 15 months of life		Frequency of selected procedures	Per 1000 MM^d
Six visits or more	56.48	Myringotomy, ages 0–4	2.85 ▲
Five visits	21.99	Myringotomy, ages 5–19	0.48
Well-child visits in the 3rd, 4th, 5th, and 6th years of life		Hysterectomy, abdominal, ages 15–44	0.22
Percentage of children ages 3–6 who received one or more visits during the year	67.82 ▲	Hysterectomy, abdominal, ages 45–64	0.49
Adolescent well-care visits		Hysterectomy, vaginal, ages 15–44	0.20
Percentage of adolescents ages 12–21 with one or more visits during the year	45.14 ▲	Hysterectomy, vaginal, ages 45–64	0.49
		Mastectomy, ages 15–45	0.02
		Mastectomy, ages 45–64	0.19
		Lumpectomy, ages 15–44	0.12
		Lumpectomy, ages 45–64	0.34
Utilization			
Inpatient—general hospital/acute care	Per 1000 MM	ALOS^e	
Inpatient discharges	6.39	2.85 ▲	
Medical discharges	1.51	2.68	
Surgical discharges	0.83 ▲	5.31 ▲	
Maternity discharges	8.81 ▲	2.41	
Ambulatory care	Per 1000 MM		
Outpatient visits	331.84 ▲		
Emergency room visits	52.43 ▼		
Ambulatory surgery/procedures	6.78 ▲		
Observation room stays	1.63 ▼		

▲ ▼ Plan percentage is significantly higher or lower than state average (p<0.05).

§Lower percentages are more desirable for this measure.

^aCombo 2 includes DTaP, IPV, MMR, HiB, Hep B, VZV.

^bCombo 3 includes DTaP, IPV, MMR, HiB, Hep B, VZV, PCV.

^cMHW rotated this measure in reporting year 2008.

^dPer 1000 MM indicates the number of procedures, discharges, visits, stays, etc. per 1000 member months.

^eALOS, average length of stay.

Established in 1995, Molina Healthcare of Washington provides coverage for Medicaid enrollees in 32 counties across Washington. MHW is the state's largest Medicaid provider, serving approximately 51 percent of Healthy Options enrollees, including those covered by SCHIP and BH+. MHW insures approximately 294,400 lives, 91 percent of whom are insured by Medicaid. About 70 percent of Medicaid clients are 18 years of age or younger. MHW holds an Excellent Accreditation rating from NCQA for its Medicaid product lines.

Regence BlueShield—RBS

Measures	%	Measures	%
Effectiveness of care			
Childhood immunization status		Comprehensive diabetes care, continued	
Combo 2 ^a	72.75	Eye exam	54.17
Combo 3 ^b	68.13	LDL-C screening	68.06
		LDL-C level <100 mg/dL	24.31
		Monitoring for diabetic nephropathy	64.58
Comprehensive diabetes care		Blood pressure <140/90 mm Hg	69.44
HbA1c testing	78.47	Blood pressure <130/80 mm Hg	35.42
Poor HbA1c control [§]	44.44		
Good HbA1c control	—		
Access to care			
Postpartum care 21–56 days after delivery	67.64		
Use of services			
Well-child visits in the first 15 months of life		Frequency of selected procedures	Per 1000 MM^c
Six visits or more	58.39	Myringotomy, ages 0–4	2.91 ▲
Five visits	23.36	Myringotomy, ages 5–19	0.62 ▲
Well-child visits in the 3rd, 4th, 5th, and 6th years of life		Hysterectomy, abdominal, ages 15–44	0.18
Percentage of children ages 3–6 who received one or more visits during the year	61.81	Hysterectomy, abdominal, ages 45–64	0.56
		Hysterectomy, vaginal, ages 15–44	0.15
Adolescent well-care visits		Hysterectomy, vaginal, ages 45–64	0.84
Percentage of adolescents ages 12–21 with one or more visits during the year	36.50	Mastectomy, ages 15–45	0.03
		Mastectomy, ages 45–64	0.00
		Lumpectomy, ages 15–44	0.13
		Lumpectomy, ages 45–64	0.28
Utilization			
Inpatient—general hospital/acute care	Per 1000 MM		ALOS^d
Inpatient discharges	6.48		2.45 ▼
Medical discharges	1.94 ▲		2.78
Surgical discharges	0.75		3.43 ▼
Maternity discharges	7.84 ▼		2.08 ▼
Ambulatory care	Per 1000 MM		
Outpatient visits	301.16 ▼		
Emergency room visits	68.07 ▲		
Ambulatory surgery/procedures	8.36 ▲		
Observation room stays	0.98 ▼		

— RBS did not conduct the measure in reporting year 2009.

▲ ▼ Plan percentage is significantly higher or lower than state average ($p < 0.05$).

§ Lower percentages are more desirable for this measure.

^a Combo 2 includes DTaP, IPV, MMR, HiB, Hep B, VZV.

^b Combo 3 includes DTaP, IPV, MMR, HiB, Hep B, VZV, PCV.

^c Per 1000 MM indicates the number of procedures, discharges, visits, stays, etc. per 1000 member months.

^d ALOS, average length of stay.

Regence BlueShield, incorporated in 1997, provides coverage for Medicaid clients in nine counties in central and western Washington. RBS serves approximately 6 percent of Healthy Options enrollees, including those covered by SCHIP. RBS insures approximately 1,015,000 lives, 3.66 percent of whom are insured by Medicaid. Approximately 80 percent of Medicaid clients are 18 years of age or younger.

Comparison of Statewide Healthy Options and NCQA National Medicaid Averages

	State %	NCQA %		State %	NCQA %
Effectiveness of care					
Childhood immunization status			Comprehensive diabetes care, continued		
Combo 2 ^a	71.37 ▼	73.67	Eye exam	56.50 ▲	52.77
Combo 3 ^b	67.60	67.52	LDL-C screening	65.88 ▼	74.1
			LDL-C level <100 mg/dL	25.65 ▼	33.87
Comprehensive diabetes care			Monitoring for diabetic nephropathy	68.82 ▼	76.63
HbA1c testing	81.81	80.47	Blood pressure <140/90 mm Hg	68.48 ▲	56.79
Poor HbA1c control [§]	44.34	44.74	Blood pressure <130/80 mm Hg	37.13 ▲	30.67
HbA1c (good) control	45.08	—			
Access to care					
Postpartum care 21–56 days after delivery					
	62.78	62.60			
Use of services					
Well-child visits, first 15 months of life			Frequency of selected procedures		Per 1000 MM^c
Six visits or more	57.05	58.56	Myringotomy, ages 0–4	2.51 ▼	2.63
Five visits	20.11 ▲	16.72	Myringotomy, ages 5–19	0.47 ▲	0.44
Well-child visits, 3rd, 4th, 5th, and 6th years of life			Hysterectomy, abdominal, ages 15–44	0.21	0.23
Percentage of children ages 3–6 with one or more visits during the year	59.91 ▼	69.60	Hysterectomy, abdominal, ages 45–64	0.48	0.47
Adolescent well-care visits			Hysterectomy, vaginal, ages 15–44	0.20 ▲	0.16
Percentage of adolescents ages 12–21 with one or more visits during the year	37.23 ▼	45.77	Hysterectomy, vaginal, ages 45–64	0.40 ▲	0.19
			Mastectomy, ages 15–45	0.02	0.02
			Mastectomy, ages 45–64	0.24	0.18
			Lumpectomy, ages 15–44	0.12 ▼	0.17
			Lumpectomy, ages 45–64	0.42	0.60
Utilization					
Inpatient—general hospital/acute care			Per 1000 MM		ALOS^d
Inpatient discharges	6.28 ▼	8.37		2.80 ▼	3.58
Medical discharges	1.55 ▼	3.62		2.77 ▲	3.67
Surgical discharges	0.78 ▼	1.34		4.84 ▼	5.60
Maternity discharges	8.39 ▲	6.30		2.40 ▼	2.67
Ambulatory care			Per 1000 MM		
Outpatient visits	305.68 ▼	346.93			
Emergency room visits	54.40 ▼	60.28			
Ambulatory surgery/procedures	6.15 ▼	9.18			
Observation room stays	1.82	1.85			

▲ ▼ State percentage is significantly higher or lower than NCQA *Quality Compass* average ($p < 0.05$).

[§]Lower percentages are more desirable for this measure.

— NCQA does not require public reporting of this measure.

^aCombo 2 includes DTaP, IPV, MMR, HiB, Hep B, VZV.

^bCombo 3 includes DTaP, IPV, MMR, HiB, Hep B, VZV, PCV.

^cPer 1000 MM indicates the number of procedures, discharges, visits, stays, etc. per 1000 member months.

^dALOS, average length of stay.