2013 Performance Measure Comparative Analysis Report

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

December 2013

HCA Contract No. 0834-34555

Presented by

Acumentra Health
2020 SW Fourth Avenue, Suite 520
Portland, Oregon 97201-4960
Phone 503-279-0100
Fax 503-279-0190

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Director, State and Private Services.....Michael Cooper, RN, MN
Project Manager.....Susan Yates Miller
Project Coordinator.....Lisa Warren
Data Analyst.....Sara Hallvik, MPH
Editor.....Greg Martin

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Executive Summary

The Medicaid program in Washington, administered by the Health Care Authority (HCA), provides healthcare benefits for just over 1 million low-income residents, 81% of whom are enrolled in managed care. In addition, about 3,800 beneficiaries are enrolled in the Washington Medicaid Integration Partnership (WMIP) program, which serves categorically needy aged, blind, and disabled clients in Snohomish County.

This report presents the 2013 findings for managed care enrollees in Healthcare Effectiveness Data and Information Set (HEDIS®) performance measures.* HCA has used HEDIS measures to assess health plan performance since 1998.

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

Acumentra Health produced this report under its contract with HCA as the External Quality Review Organization for Washington. The report covers health care performance measures reported by five managed care organizations (MCOs) in 2013:

- Amerigroup Washington Inc. (AMG)
- Community Health Plan of Washington (CHP)
- Coordinated Care Corp. (CCC)
- Molina Healthcare of Washington (MHW)
- UnitedHealthcare Community Plan (UHC)

Amerigroup, Coordinated Care, and UnitedHealthcare began contracting with HCA on July 1, 2012. This report analyzes the first HEDIS measures reported for those MCOs as part of the Washington Medicaid program.

During the transition to service delivery by the new set of MCOs, HCA required each MCO to report only inpatient and ambulatory care utilization measures, covering the period from July 1 through December 31, 2012. Consequently, no performance data are available for childhood immunizations, well-child care, diabetes care, and other measures analyzed in previous reports. For 2014–2015, MCOs will be required to report a full set of clinical care measures. Note: This year's data for WMIP cover 12 months, January–December 2012.

For the first time in 2013, HCA required CHP to report three HEDIS measures for the Medical Care Services (MCS) population: ambulatory care utilization, antidepressant medication management, and race/ethnicity diversity of membership. The MCS program, previously called Disability Lifeline/GA-U, provides limited medical benefits for people who are physically or mentally disabled and cannot work for 90 days from the date of application.

HCA also required CHP to report seven measures of services delivered for Washington Health Program (WHP) enrollees. The state began offering this plan on November 1, 2012, to provide

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

reduced-cost coverage for qualified residents before the Health Benefit Exchange becomes operational on January 1, 2014.

Results

- In 2013, the emergency room (ER) visit rate for WMIP enrollees fell significantly for the third straight year. MHW's current clinical performance improvement project (PIP), if successful, could further reduce the rate of avoidable ER visits. The intervention features follow-up by MCO or clinical staff with enrollees who visit an ER in Snohomish County. Follow-ups focus on helping these enrollees obtain resources and on linking them to care from primary care providers and within their respective medical homes.
- The percentages of WMIP enrollees receiving effective antidepressant medication management fell in 2013, though the declines were not statistically significant. The WMIP program may want to closely monitor enrollees who receive those services.
- Little or no improvement has occurred in diabetes care for WMIP enrollees over the past five years. HbA1c testing for this population has dropped for the past two years, to 82.18% in 2013. The percentages of those receiving other preventive services—LDL-C screening and monitoring for nephropathy—were significantly lower in 2013 than in 2009.
- Fewer than half of WMIP enrollees (47.66%) had good control of their HbA1c levels in 2013, a significantly lower percentage than in 2010 when NCQA introduced this indicator. Almost as high a percentage of enrollees (44.32%) had poor control of their HbA1c levels in 2013.
- The average rates of outpatient and ER visits by enrollees of the five Washington MCOs in 2013 were significantly lower than the national average rates.
- The state average rates of general hospital/acute care utilization (medical, surgical, and total) were also significantly lower than the national average rates, as were the average lengths of stay for Washington enrollees receiving that care.
- Race was reported as "unknown" for nearly 14% of MCS enrollees, and ethnicity was reported as unknown for 93% of enrollees. About 68% of the 21,482 enrollees were identified as White, with smaller percentages identified for other racial groups.
- Both race and ethnicity were reported as unknown for nearly 95% of the 13,413 WHP enrollees. About 73% of WHP enrollees reportedly expressed a preference for English as the spoken language for health care.
- WMIP enrollees' utilization of mental health services decreased from 2012 to 2013. The WMIP program may want to closely monitor enrollees who receive those services.

Recommendations

Previous reports in this series have outlined recommendations for HCA and the MCOs, aimed at improving access to care and the quality and timeliness of care. Many of those recommendations remain valid, although their current feasibility may be limited by the resource constraints facing the Washington Medicaid program.

The following recommendations apply to HCA's ongoing contracts with the new roster of MCOs that began serving Medicaid enrollees in July 2012.

To sustain long-term improvement in performance measures, Acumentra Health recommends that HCA

- continue to foster public health initiatives and partnerships such as the Washington State Collaborative to Improve Care and the CHILD Profile immunization registry
- collaborate with health plans to provide performance feedback to clinics and providers
- consider requiring the MCOs to incorporate utilization reports from the Emergency Department Information Exchange (EDIE) into their care coordination and transition programs to ensure that enrollees receive timely care at the appropriate levels
- consider requiring the MCOs to engage in a formal activity to share best practices aimed at reducing the performance gaps among health plans for specific measures

In addition, Acumentra Health recommends that the MCOs

- conduct validation studies to improve the quality of encounter data, to ensure that MCOs can accurately measure whether enrollees are receiving appropriate interventions
- dedicate resources to improve the collection, retention, and completeness of race/ethnicity data to inform potential interventions that address healthcare disparities
- 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

Finally, Acumentra Health recommends that MHW conduct a root cause analysis or other investigation to determine why WMIP enrollees' utilization of mental health services decreased from 2012 to 2013.

Introduction

The Washington Medicaid program, administered by HCA, now provides healthcare benefits for slightly more than 1 million low-income residents. Traditionally, the state has provided managed medical care primarily for children, mothers, and pregnant women through Healthy Options, the Children's Health Insurance Program (CHIP), and Basic Health Plus, and for a small number of adult SSI or SSI-related clients through the WMIP program in Snohomish County.

Since July 1, 2012, HCA has enrolled into Healthy Options approximately 90,000 disabled and blind SSI recipients, who previously received fee-for-service medical care. HCA has brought additional new populations into managed care through the Medical Care Services (MCS) program and the Washington Health Program (WHP). The MCS program, formerly Disability Lifeline/General Assistance-Unemployable (GA-U), serves eligible adults who cannot work for physical or mental reasons and those eligible for state-funded alcohol and drug addiction treatment. HCA began offering the WHP statewide on November 1, 2012, to provide reduced-cost coverage for qualified residents in the interim before the state Health Benefit Exchange becomes operational. The net effect has been a major shift toward adult enrollment.

Table 1 shows the name and acronym of each MCO and the number of enrollees by service population during 2012.

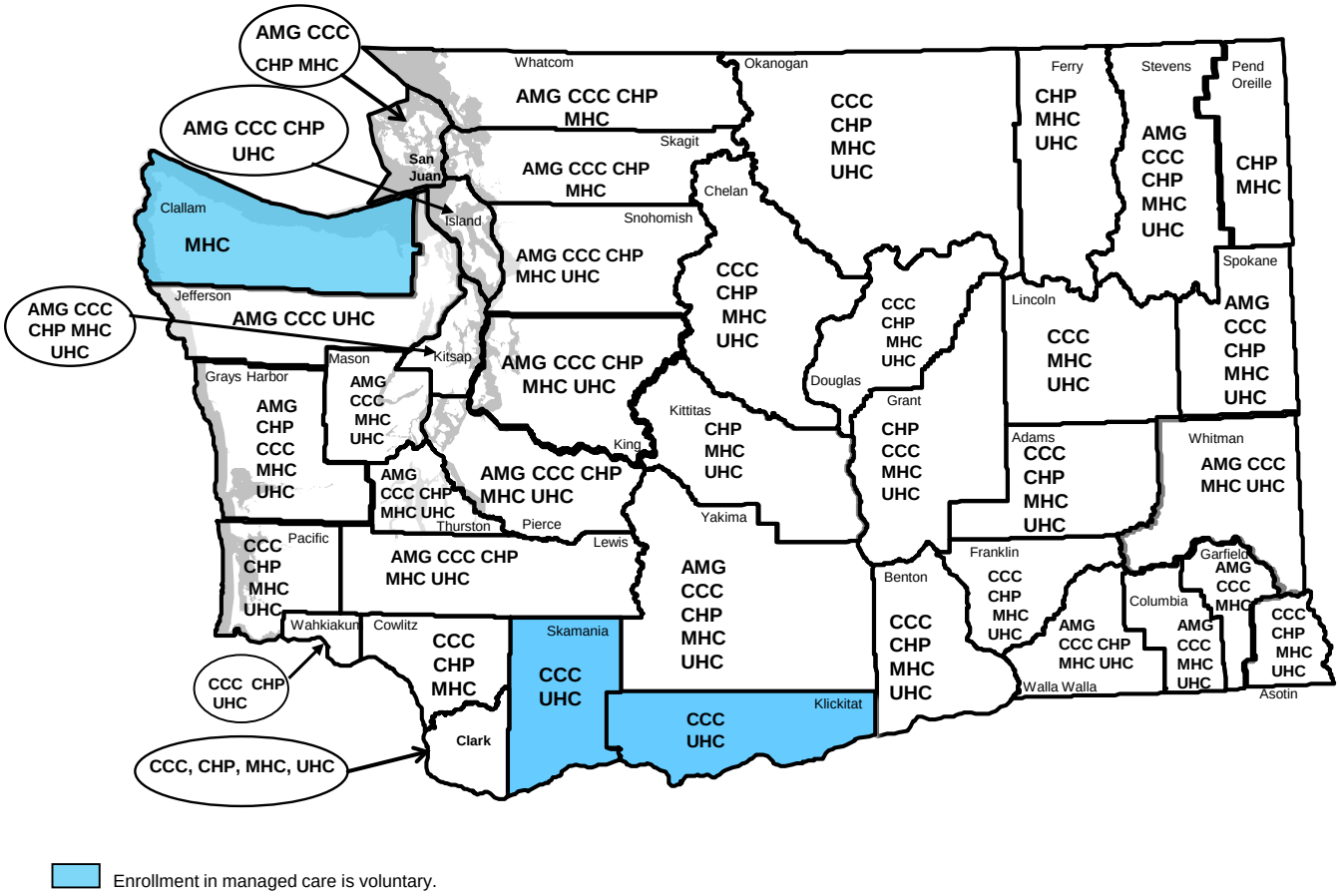
Table 1. Washington Medicaid managed care plans and enrollees.[a]

	2012 enrollment		
Health plan	**July**	**November**	**December**
Amerigroup Washington Inc. (AMG)			
Healthy Options/CHIP/Basic Health Plus	16,512	25,172	25,734
SSI recipients (included in above)	*2,352*	*10,898*	*10,443*
Community Health Plan of Washington (CHP)			
Healthy Options/CHIP/Basic Health Plus	277,616	269,923	267,644
SSI recipients (included in above)	*14,313*	*20,035*	*21,907*
Medical Care Services (formerly GA-U)	7,238	6,986	6,979
Washington Health Program	n.a.	9,307	9,640
CHP total	284,854	276,909	274,623
Coordinated Care Corp. (CCC)			
Healthy Options/CHIP/Basic Health Plus	33,714	53,288	55,074
SSI recipients (included in above)	*4,898*	*15,335*	*14,973*
Molina Healthcare of Washington (MHW)			
Healthy Options/CHIP/Basic Health Plus	372,837	392,454	392,466
SSI recipients (included in above)	*12,512*	*24,807*	*26,144*
WMIP	4,312	3,884	3,822
MHW total	377,149	396,338	396,288
UnitedHealthcare Community Plan (UHC)			
Healthy Options/CHIP/Basic Health Plus	24,627	40,155	51,865
SSI recipients (included in above)	*3,590*	*12,948*	*12,937*
Total	**736,856**	**791,862**	**803,584**

[a] Healthy Options includes SSI recipients in the Blind/Disabled and Foster Care populations.

Source: Washington Health Care Authority.

Figure 1 shows the geographical distribution of MCO services throughout the state as of November 1, 2012.



Note: Healthy Options coverage includes blind/disabled and foster care populations.

Figure 1. Coverage of Healthy Options and CHIP enrollees by health plan, November 2012.

Medicaid expansion under the federal Affordable Care Act takes effect on January 1, 2014. At that time, the existing populations served by Washington Medicaid will be rolled up with many thousands of newly eligible enrollees under Apple Health.

This report presents results for reporting year 2013 (measurement year 2012) for the HEDIS measures that HCA required the MCOs to report. These measures allow comparison of the Washington plans' performance with national averages for the Medicaid population. Results for the WMIP program appear in bar charts that display all available data since 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 each 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 Audit™ assures purchasers and health plans of fair and accurate comparisons of plan performance. HCA funds the HEDIS audit for the MCOs 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 utilization measures by adding individual plan numerators and denominators, dividing the aggregate numerator by the aggregate denominator, and multiplying the resulting proportion by 100. The 2013 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 nine measures in 2013. These measures underwent an audit as part of the certified HEDIS audit for MHW.

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.

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 the Medicaid client base.

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. 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. 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 December 2012, about 3,800 individuals were enrolled in WMIP.

For 2013, MHW reported nine HEDIS measures for the WMIP population:

- comprehensive diabetes care
- inpatient care utilization—general hospital/acute care
- ambulatory care utilization
- mental health utilization
- follow-up after hospitalization for mental illness
- antidepression medication management
- use of high-risk medications for the elderly
- identification of alcohol and other drug services
- initiation and engagement of alcohol and other drug dependence treatment

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

Comprehensive diabetes care

Indicators for this measure assess the percentage of enrollees with diabetes (type 1 or type 2) who were continuously enrolled during the measurement year and who had:

- Hemoglobin A1c (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; exams performed prior to the measurement year must meet the following criteria for inclusion:
  - the exam had a negative outcome (no evidence of retinopathy)
  - the enrollee was not prescribed or dispensed insulin during 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 (<140/80 mm Hg) for the most recent blood pressure reading

Figure 2 presents the WMIP results for comprehensive diabetes care in reporting years 2009–2013, including Acumentra Health's analysis of the statistical significance of five-year changes in these indicators.

The 2013 results reflect little or no improvement in diabetes care over this five-year period. HbA1c testing for WMIP enrollees has dropped for the past two years, to 82.18% in 2013. Similarly, the percentages of those receiving other preventive services—LDL-C screening and monitoring for nephropathy—were significantly lower in 2013 than in 2009. Fewer than half of WMIP enrollees (47.66%) had good control of their HbA1c levels in 2013, a significantly lower percentage than in 2010 when NCQA introduced this indicator. Almost as high a percentage of enrollees (44.32%) had poor control of their HbA1c levels in 2013.

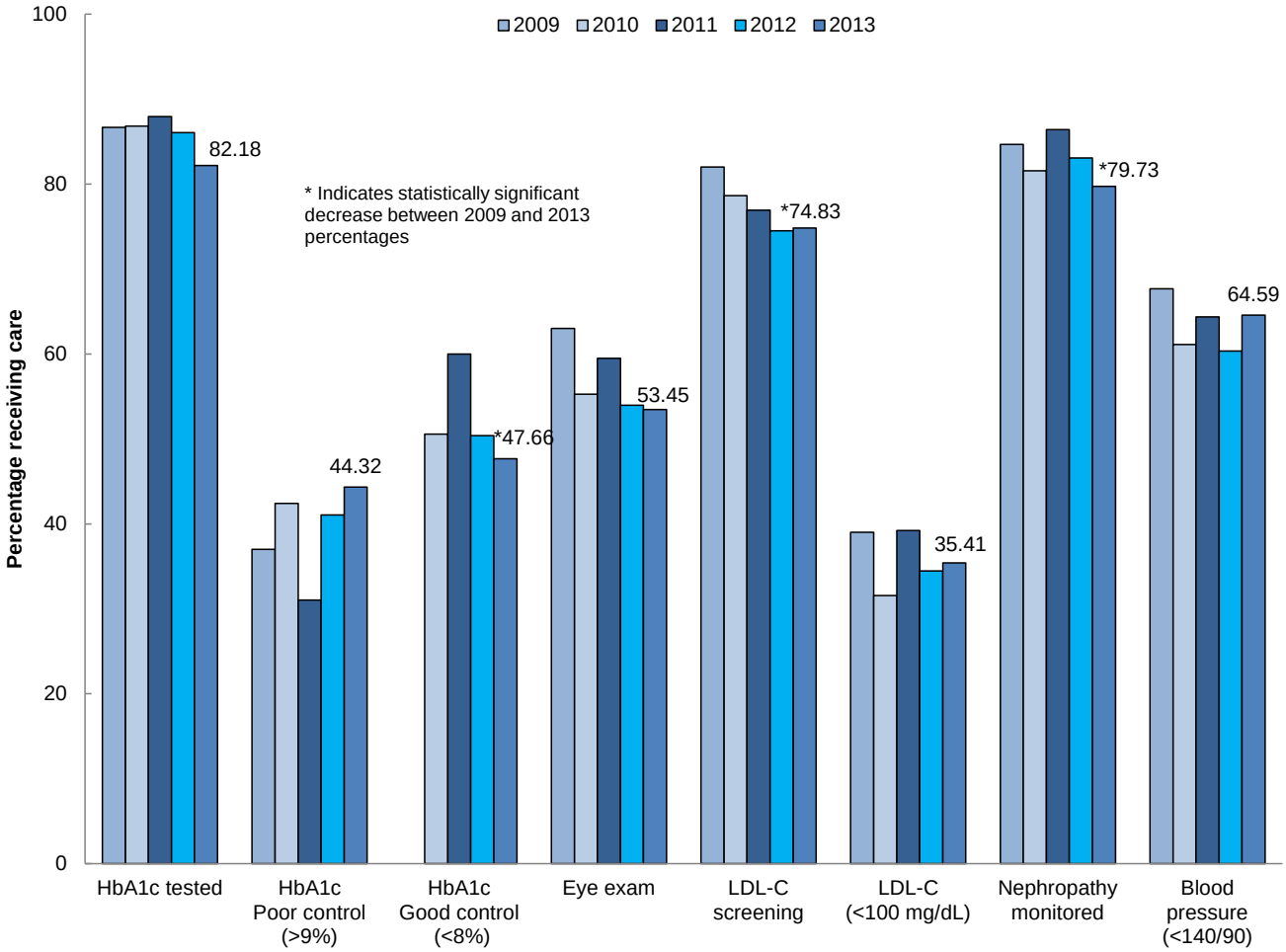


Figure 2. WMIP comprehensive diabetes care measures, reporting years 2009–2013.

Physical healthcare utilization measures

Figures 3–6 present the results of WMIP utilization measures since 2009:

- inpatient utilization discharges, days, and average length of stay—total inpatient (acute), medical, and surgical
- ambulatory care visits—outpatient and ER

Compared with the 2012 rates, discharge rates rose slightly in 2013 for both medical and surgical care, but the changes were not statistically significant (Figure 3).

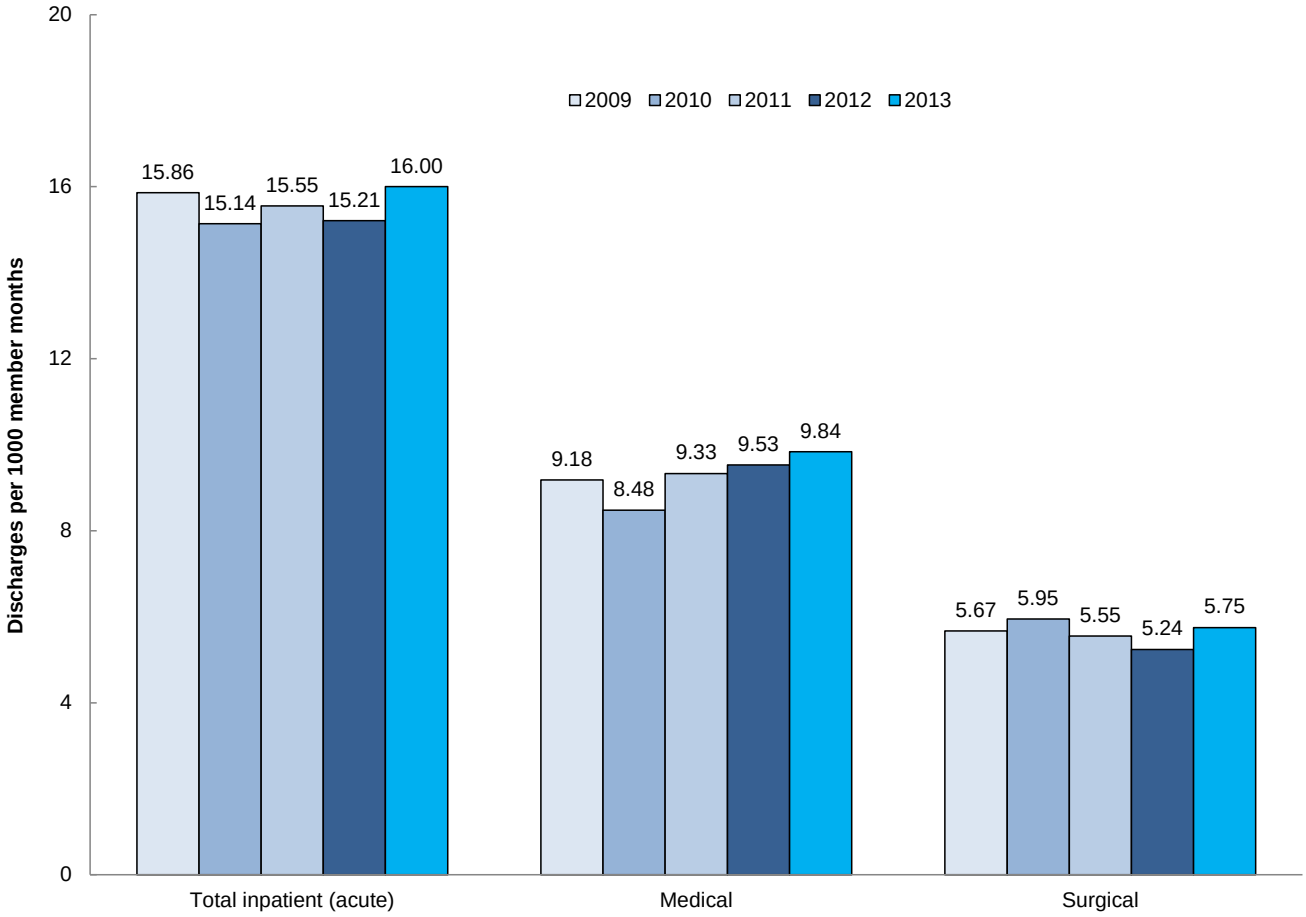


Figure 3. WMIP inpatient utilization discharges, reporting years 2009–2013.

Total inpatient (acute) and surgical days for WMIP enrollees rose significantly from 2012 to 2013, while medical days dipped slightly (Figure 4).

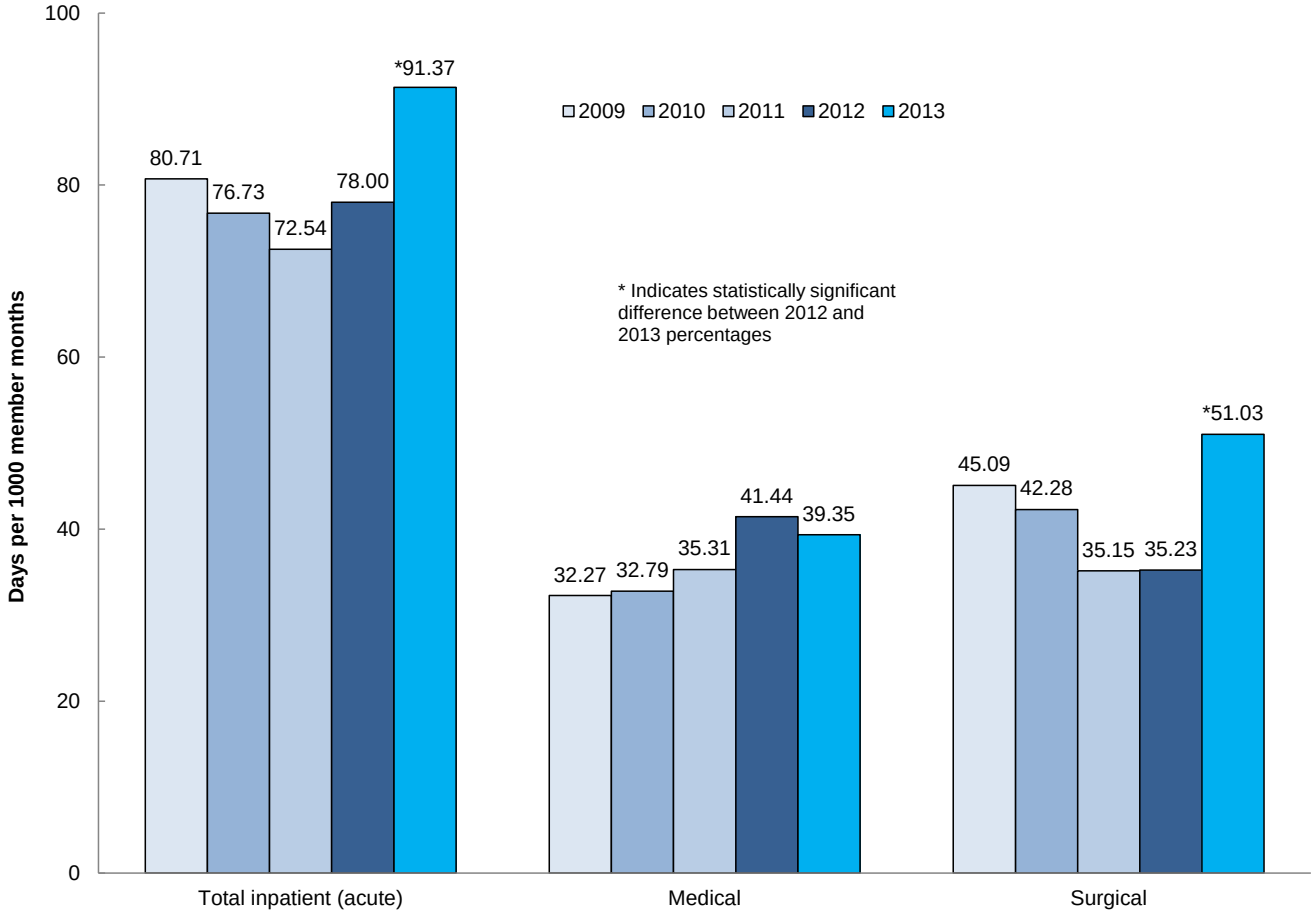


Figure 4. WMIP inpatient utilization days, reporting years 2009–2013.

WMIP enrollees' average length of stay (ALOS) for surgical care and for total inpatient (acute) care rose significantly in 2013, while the ALOS for medical care declined (Figure 5).

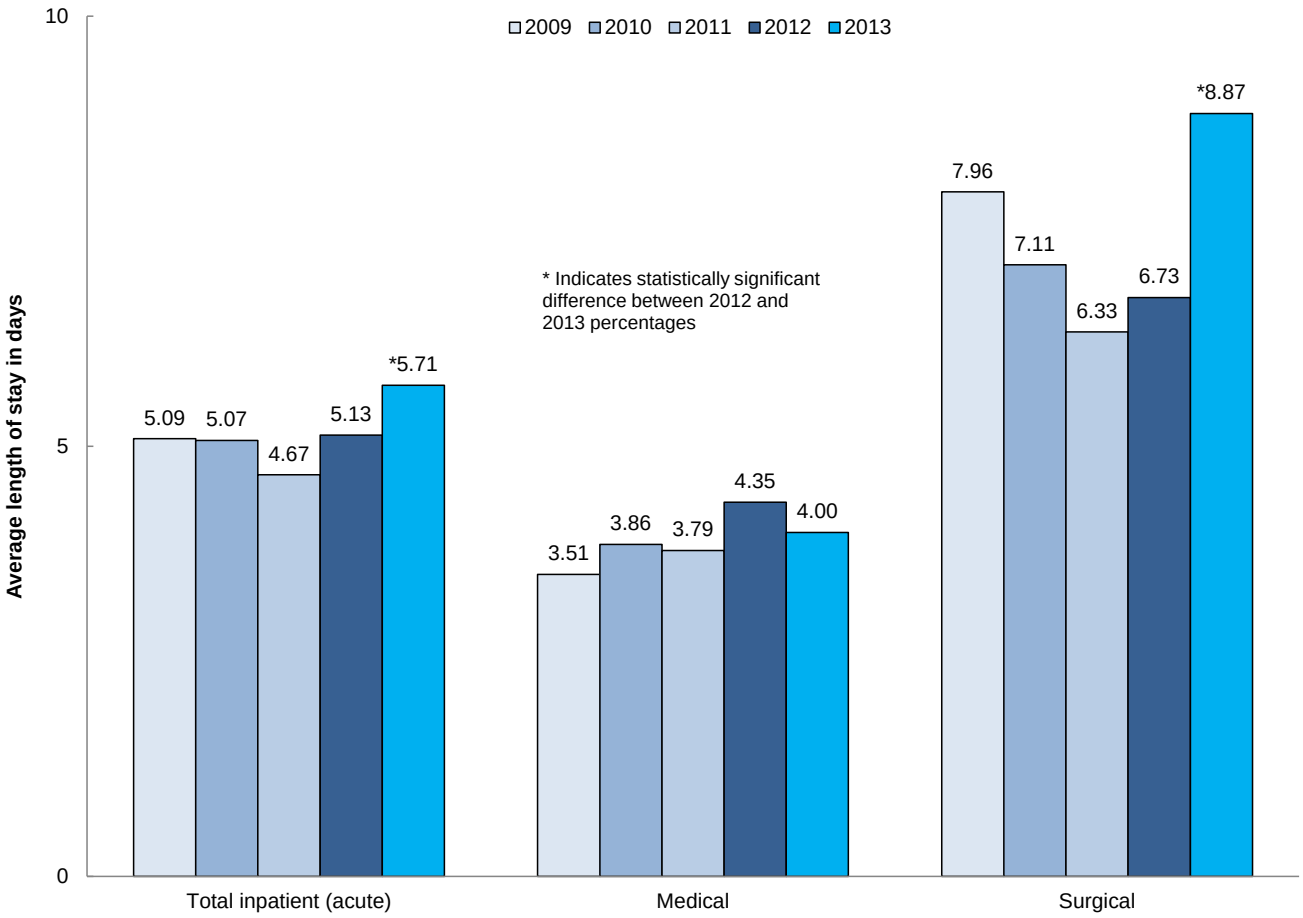


Figure 5. WMIP inpatient utilization average length of stay, reporting years 2009–2013.

MHW is conducting a multi-year PIP targeting care transitions in one hospital serving WMIP enrollees, with the goal of reducing readmissions within 30 days following discharge. A Registered Nurse coach visits hospitalized enrollees and makes follow-up home visits or phone calls to assist in post-discharge coordination of care. Community health workers also are involved.

Looking at the ambulatory care measures, the ER visit rate for WMIP enrollees fell significantly for the third straight year in 2013, while the outpatient visit rate rose significantly (Figure 6).

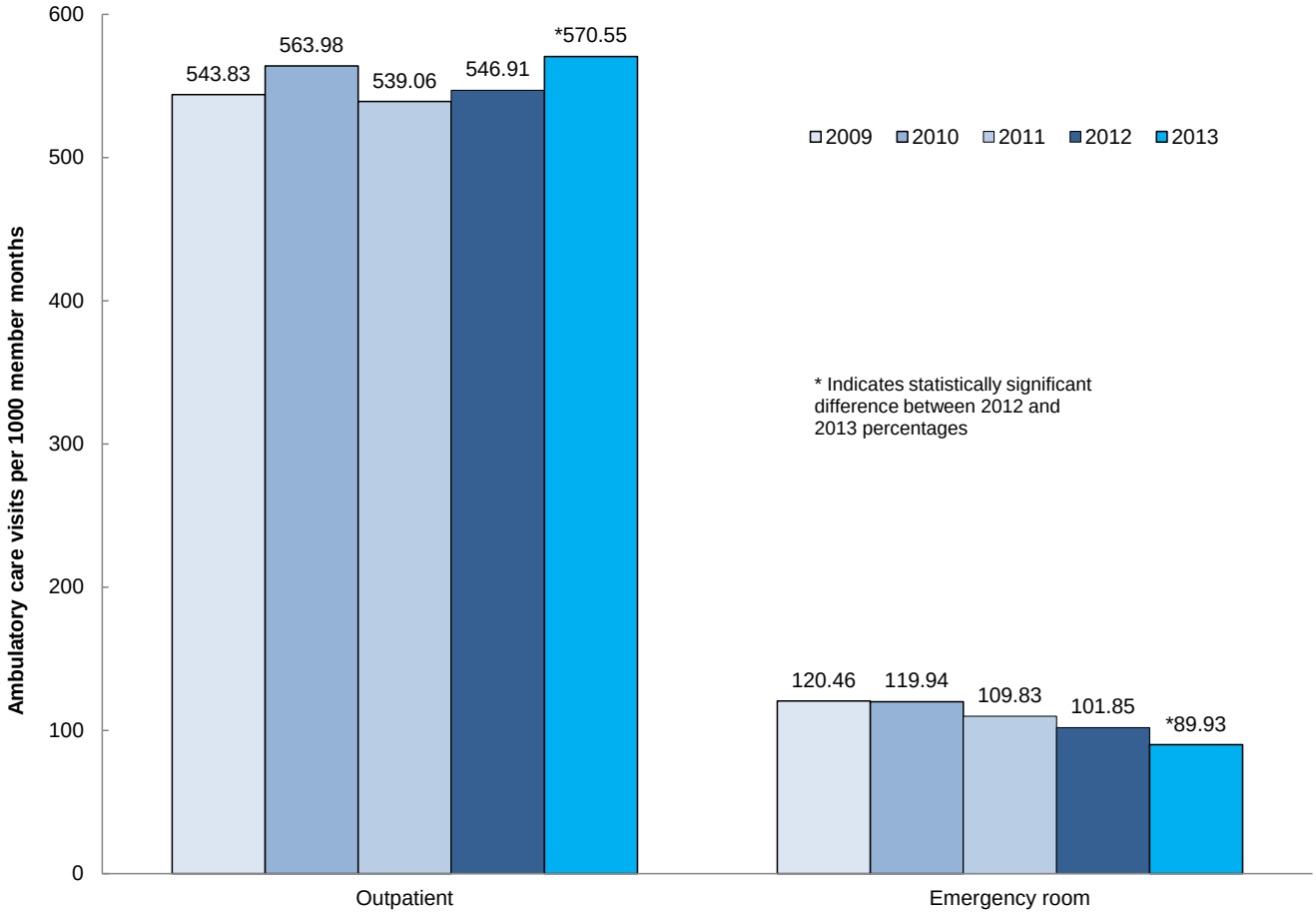


Figure 6. WMIP ambulatory care visits, outpatient and emergency room, reporting years 2009–2013.

MHW is conducting a PIP, now in its second year, aimed at reducing avoidable ER visits by WMIP enrollees. The intervention features follow-up by MCO or clinical staff with enrollees who visit an ER in Snohomish County. Follow-ups focus on helping these enrollees obtain resources and on linking them to care from primary care providers and within the medical home. According to TEAMonitor, which reviewed the PIP in 2013, results so far have been mixed. Early results demonstrated significant reductions in avoidable ER visit rates; however, rates rose in the third and fourth quarters of 2012.

Mental healthcare utilization and follow-up measures

The *mental health utilization* measure summarizes the percentage of enrollees who received mental health services during the measurement year. HCA first required MHW to report this measure for the WMIP population in 2012.

"Any service" includes at least one of the following, and some enrollees received services in multiple categories:

- inpatient
- intensive outpatient or partial hospitalization
- outpatient or ER

Note: "Any" service is person-based; the other categories are visit-based.

Figure 7 shows mental health utilization in each category for all WMIP enrollees age 18 and older for the past two reporting years.

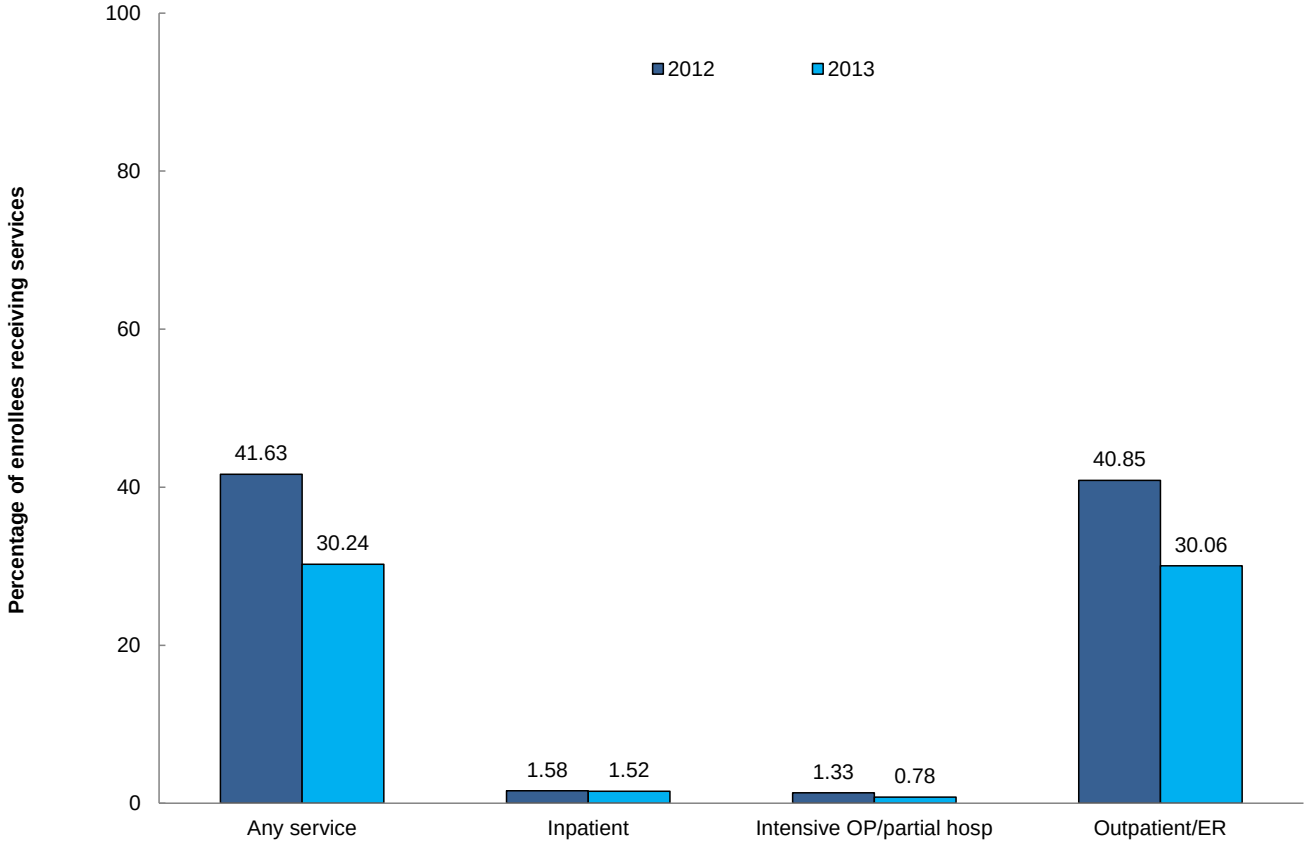


Figure 7. WMIP mental health utilization, reporting years 2012–2013.

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 care provider within 30 days or within 7 days after their discharge from the hospital.

As shown in Figure 8, the percentage of WMIP enrollees receiving follow-up care within 7 days dipped to 56.00% in 2013, while the 30-day follow-up rate rose slightly to 72.00%, though neither change was statistically significant. Five-year trend testing for these indicators revealed no significant changes.

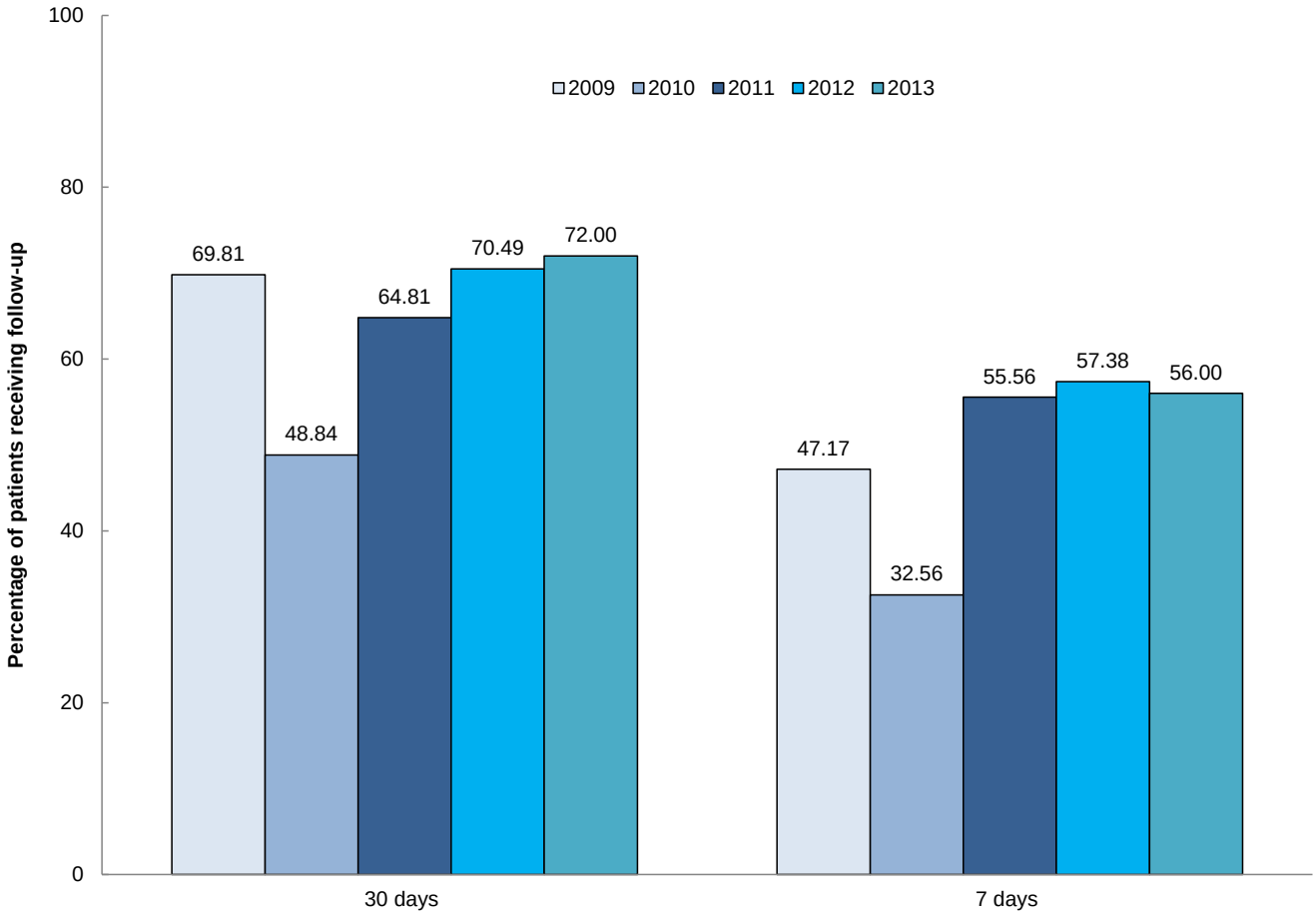


Figure 8. WMIP follow-up after hospitalization for mental illness, reporting years 2009–2013.

Medication measures

Figure 9 presents WMIP results for *antidepressant medication management* from 2009 through 2013. This 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 WMIP enrollees receiving effective acute phase treatment and effective continuation phase treatment turned down in 2013, to 63.89% and 47.22%, respectively, though the declines were not statistically significant. Five-year trend testing for these indicators revealed no significant changes.

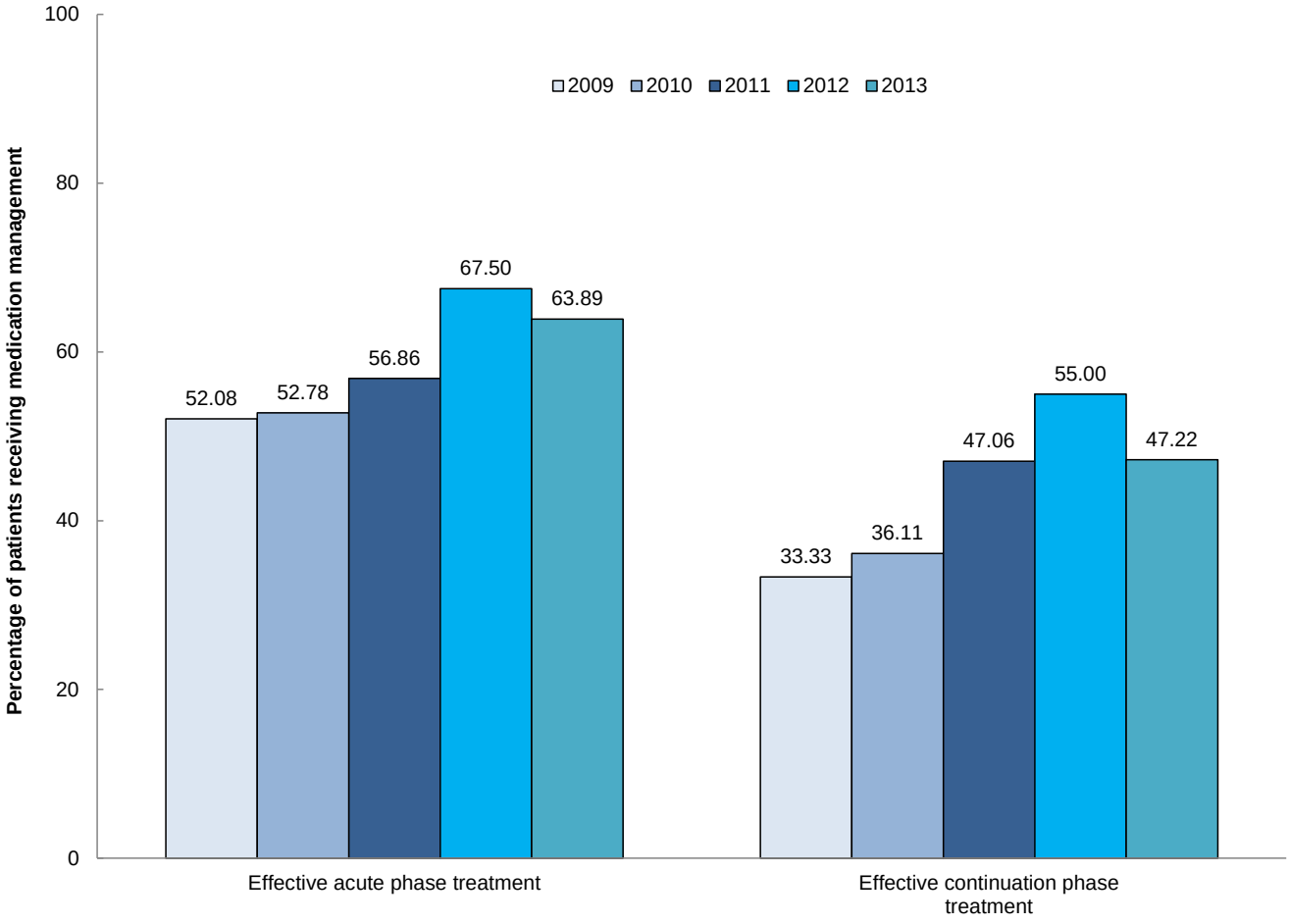


Figure 9. WMIP antidepressant medication management, reporting years 2009–2013.

The HEDIS measure of *use of high-risk medications in the elderly* expresses the percentage of elderly enrollees who received at least one high-risk prescription, or at least two different prescriptions. From 2008 through 2012, MHW reported increasingly positive results on this measure, pointing to better management of these medications for WMIP enrollees.

NCQA revised the methodology for calculating this measure in 2013. As a result, the 2013 results are not comparable with data from previous years. NCQA will not publicly report this measure for HEDIS in 2013. Changes this year include:

- revised age range from ≥65 years to ≥66 years
- updated list of high-risk medications
- added days' supply and average daily dose criteria for select medications, and clarified the numerator specifications to accommodate the new criteria

Table 2. WMIP use of high-risk medications in the elderly, reporting year 2013.

At least one high-risk medication (n=480)	7.08%
At least two different high-risk medications (n=480)	2.29%

Dependence treatment measures

Figure 10 displays the first two years of data on *identification of alcohol and other drug services* for WMIP enrollees. This utilization measure summarizes the percentage of enrollees with an alcohol or other drug (AOD) claim who received various types of chemical dependency services during the measurement year. An AOD claim contains a diagnosis of AOD abuse or dependence and a specific AOD-related service.

"Any service" includes at least one of the following, and some enrollees received services in multiple categories:

- Inpatient
- Intensive outpatient or partial hospitalization
- Outpatient or ER

Note: "Any" service is person-based; the other categories are visit-based.

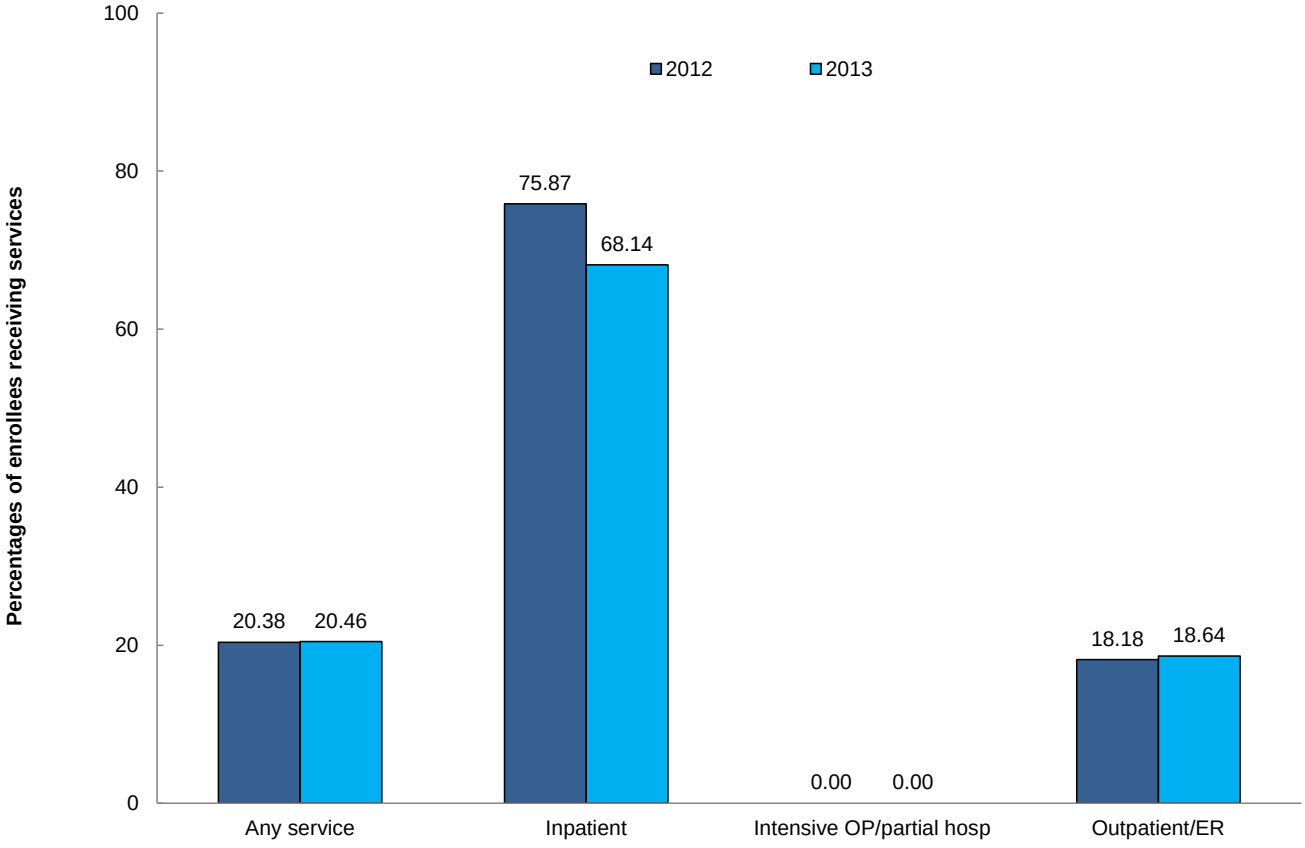


Figure 10. WMIP identification of alcohol and other drug services, reporting years 2012–2013.

Initiation and engagement of alcohol and other drug dependence treatment measures the percentage of enrollees with a new episode of AOD dependence who received the following care.

- *Initiation of AOD treatment:* percentage of people who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis
- *Engagement in AOD treatment:* percentage of people with a diagnosis of AOD use or dependence who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

In 2012, MHW reported that 26.32% of WMIP enrollees initiated treatment for AOD dependence and that 2.63% of enrollees met the criteria for engagement in treatment or services. In 2013, this measure was not calculated because the denominator for the measure was not large enough to support the calculation of a meaningful measure.

Discussion

Although the indicators of diabetes care for WMIP enrollees have fluctuated over the past five years, the 2013 results reflect little or no improvement during this period. HbA1c testing has dropped to 82.18%, the lowest level since HEDIS measurements began for this program in 2007. Similarly, the percentages of those receiving other preventive services—LDL-C screening and monitoring for nephropathy—were significantly lower in 2013 than in 2009. The percentage of enrollees with poor control of their HbA1c levels in 2013 (44.32%) was almost as high as the percentage of those with good control (47.66%).

The percentages of WMIP enrollees receiving effective antidepressant medication management turned down in 2013, though the declines were not statistically significant. The WMIP program may want to closely monitor enrollees who receive those services.

More encouragingly, the ER visit rate for WMIP enrollees fell significantly for the third straight year in 2013. MHW's current clinical PIP, if successful, could further reduce the rate of avoidable ER visits. About 7 out of 10 enrollees are receiving follow-up mental health care within 30 days of discharge from psychiatric hospitalization, and more than half of enrollees are receiving follow-up care within seven days of discharge.

Other HEDIS measures for this population are generally too new for any significant trends to have become apparent yet.

The WMIP program has pioneered the integration of primary, acute, behavioral, and long-term care for dual-eligible (Medicare and Medicaid) patients. Successful care integration for this complex population has presented substantial challenges. MHW is contracted to continue conducting this program in 2014.

Medical Care Services measures

The MCS program, previously called Disability Lifeline/GA-U, operates in all 39 Washington counties. HCA contracts with CHP to provide managed medical and mental health services for MCS recipients, including primary care, referral coordination, other medically necessary services, and pharmaceutical drugs.

MCS provides limited medical benefits to incapacitated eligible adults and to those eligible for state-funded alcohol and drug addiction treatment. Incapacitated adults are people between ages 18 and 65 who cannot work for short-term physical or mental reasons. Income and resource limits are more restrictive than for the family Categorically Needy medical program.

HCA required CHP to report three HEDIS measures for the MCS population in 2013:

- ambulatory care visits—outpatient and ER
- antidepressant medication management (see measure definitions on page 16)
- race/ethnicity diversity of membership

Table 3 reports first-year results of the first two measures.

Table 3. MCS ambulatory care and antidepressant medication management measures, reporting year 2013.

Ambulatory care	Visits	Visits/MM
Outpatient visits	44,327	484.97
Emergency room visits	11,776	128.84
Antidepressant medication management		**Percent**
Effective acute-phase treatment (n=159)		59.75%
Effective continuation-phase treatment (n=159)		45.91%

Visits/MM = visits per 1000 member months.

Table 4 presents the initial race and ethnicity data reported for MCS enrollees. As shown, about 68% of the 21,482 enrollees were identified as White, with smaller percentages identified for other racial groups. Race was unknown for nearly 14% of MCS enrollees, and ethnicity was unknown for 93% of enrollees.

Table 4. Race/ethnicity diversity of MCS enrollees, reporting year 2013.

	Hispanic/Latino		Not Hispanic/Latino		Unknown Ethnicity		Total	
Race	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
White	16	1.02%	0	NR	14,597	73.31%	14,613	68.02%
Black/African American	3	0.19%	0	NR	2,320	11.65%	2,323	10.81%
American-Indian and Alaska Native	0	0.00%	0	NR	174	0.87%	174	0.81%
Asian	2	0.13%	0	NR	320	1.61%	322	1.50%
Native Hawaiian/Other Pacific Islander	1	0.06%	0	NR	248	1.25%	249	1.16%
Some other race	20	1.27%	0	NR	784	3.94%	804	3.74%
Two or more races	0	0.00%	0	NR	0	0.00%	0	0.00%
Unknown	1,530	97.33%	0	NR	1,467	7.37%	2,997	13.95%
Declined	0	0.00%	0	NR	0	0.00%	0	0.00%
Total	**1,572**	**100.00%**	**0**	**NR**	**19,910**	**100.00%**	**21,482**	**100.00%**

NR = Not reported.

Washington Health Program measures

HCA began offering the WHP statewide on November 1, 2012, to provide reduced-cost coverage for qualified residents before the Health Benefit Exchange becomes operational on January 1, 2014. The plan provides limited annual benefits ($75,000 or $100,000) subject to a monthly premium, an annual deductible, and coinsurance, with an out-of-pocket maximum. Coverage is available to any Washington resident who

- is not eligible for free or purchased Medicare
- is not receiving the Medicaid or Basic Health benefit
- at the time of enrollment, is not confined to an institution
- is ineligible for coverage under the Washington State Health Insurance Pool or qualifies to bypass the standard health questionnaire under state law

HCA required CHP to report seven HEDIS measures for the WHP population in 2013. Table 5 displays the results for these measures:

- antidepressant medication management (acute phase and continuation phase)
- comprehensive diabetes care (eye exam, LDL-screening, HbA1c testing, monitoring for nephropathy
- cholesterol management for patients with cardiovascular conditions (LDL-C screening only)
- controlling high blood pressure
- follow-up after hospitalization for mental illness
- race/ethnicity diversity of membership
- language diversity of membership

Table 5. WHP clinical care measures, reporting year 2013.

Comprehensive diabetes care (n=336)	
HbA1c testing	90.77%
Eye exam	49.40%
LDL-C screening	78.57%
Monitoring for nephropathy	85.12%
Cholesterol management for patients with cardiovascular conditions (n=11)	
LDL-C screening	n.a.
Controlling high blood pressure (n=411)	**59.12%**
Antidepressant medication management (n=80)	
Effective acute-phase treatment	67.50%
Effective continuation-phase treatment	50.00%
Follow-up after hospitalization for mental illness (n=8)	
30-day follow-up	n.a.

Table 6 presents the initial race and ethnicity data reported for WHP enrollees. Both race and ethnicity were reported as "unknown" for nearly 95% of the 13,413 enrollees. As shown in Table 7, about 73% of enrollees reportedly expressed a preference for English as the spoken language for health care, with nearly all of the remainder unknown. No preferences were reported regarding the language for written materials or other language needs.

Table 6. Race/ethnicity diversity of WHP enrollees, reporting year 2013.

	Hispanic/Latino		Not Hispanic/Latino		Unknown Ethnicity		Total	
Race	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
White	0	0.00%	0	NR	383	2.87%	383	2.86%
Black/African American	0	0.00%	0	NR	30	0.22%	30	0.22%
American-Indian and Alaska Native	0	0.00%	0	NR	2	0.01%	2	0.01%
Asian	0	0.00%	0	NR	79	0.59%	79	0.59%
Native Hawaiian/Other Pacific Islander	0	0.00%	0	NR	12	0.09%	12	0.09%
Some other race	0	0.00%	0	NR	194	1.45%	194	1.45%
Two or more races	0	0.00%	0	NR	0	0.00%	0	0.00%
Unknown	49	100.00%	0	NR	12,664	94.76%	12,713	94.78%
Declined	0	0.00%	0	NR	0	0.00%	0	0.00%
Total	**49**	**100.00%**	**0**	**NR**	**13,364**	**100.00%**	**13,413**	**100.00%**

Table 7. Language diversity of WHP enrollees, reporting year 2013.

	Spoken language preferred for health care		Language preferred for written materials		Other language needs	
Race	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
English	9,846	73.41%	0	0.00%	0	0.00%
Non-English	57	0.42%	0	0.00%	0	0.00%
Unknown	3,504	26.12%	13,413	100.00%	13,413	100.00%
Declined	6	0.04%	0	0.00%	0	0.00%
Total	**13,413**	**100.00%**	**13,413**	**100.00%**	**13,413**	**100.00%**

MCO utilization measures

For 2013, the first reporting year under the new MCO contract, HCA required the five MCOs to report only service utilization measures. The new MCOs (AMG, CCC, and UHC) reported these measures for the first time, whereas CHP and MHW had reported the measures historically. The results are displayed in Tables 8–12.

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

- **Inpatient utilization—general hospital/acute care:** total services, medical services, surgical services, and maternity services used: discharges, days, and average length of stay (ALOS)
- **Ambulatory care services—**outpatient and ER

Utilization data can provide an indication of how a health plan manages and expends its resources. However, because service utilization is affected by many enrollee characteristics that can vary greatly among health plans—including age and gender, current medical condition, socioeconomic status, race, and geographic location—generalizations about the relationship between utilization and healthcare quality are difficult to support. NCQA states that it "does not view higher or lower service counts as indicating better or worse performance," and recommends that healthcare organizations use this information for internal evaluation only.[4]

Table 8. General hospital/acute care: Total inpatient discharges, days, and average length of stay by health plan, reporting year 2013.

Health plan	Discharges	Discharges/MM	Days	Days/MM	ALOS
AMG	813	6.97 ▲	3,022	25.89	3.72 ▲
CCC	1,836	6.82 ▲	5,955	22.12	3.24
CHP	9,523	5.52	30,694	17.80	3.22
MHW	12,882	5.37 ▼	39,528	16.47	3.07 ▼
UHC	1,256	6.47 ▲	4,204	21.66	3.35
State average		5.59 *		17.73 *	3.17 *
NCQA average		8.75		35.23	3.77
NCQA 90th percentile		11.30		46.07	4.43

Discharges/MM = discharges per 1000 member months.
Days/MM = days per 1000 member months.
ALOS = average length of stay (in days).
▲▼ Indicates statistically significant difference in MCO vs. state percentage in 2013 (p<0.05).
* State percentage is significantly higher or lower than NCQA Quality Compass average (p<0.05).

Table 9. General hospital/acute care: Medical discharges, days, and average length of stay by health plan, reporting year 2013.

Health plan	Discharges	Discharges/MM	Days	Days/MM	ALOS
AMG	325	2.78 ▲	1,192	10.21	3.67
CCC	675	2.51 ▲	2,142	7.95	3.17
CHP	2,785	1.62	9,875	5.73	3.55 ▲
MHW	3,284	1.37 ▼	10,460	4.36	3.19 ▼
UHC	458	2.36 ▲	1,512	7.79	3.30
State average		1.60 *		5.35 *	3.35 *
NCQA average		4.19		16.20	3.59
NCQA 90th percentile		6.05		22.11	4.20

Discharges/MM = discharges per 1000 member months.
Days/MM = days per 1000 member months.
ALOS = average length of stay (in days).
▲▼ Indicates statistically significant difference in MCO vs. state percentage in 2013 (p<0.05).
* State percentage is significantly higher or lower than NCQA Quality Compass average (p<0.05).

Table 10. General hospital/acute care: Surgical discharges, days, and average length of stay by health plan, reporting year 2013.

Health plan	Discharges	Discharges/MM	Days	Days/MM	ALOS
AMG	177	1.52 ▲	992	8.50	5.60
CCC	363	1.35 ▲	1,886	7.00	5.20
CHP	1,653	0.96	8,601	4.99	5.20
MHW	2,129	0.89 ▼	12,128	5.05	5.70
UHC	261	1.34 ▲	1,364	7.03	5.23
State average		0.97 *		5.31 *	5.45 *
NCQA average		1.67		11.48	6.34
NCQA 90th percentile		2.81		18.01	8.18

Discharges/MM = discharges per 1000 member months.
Days/MM = days per 1000 member months.
ALOS = average length of stay (in days).
▲▼ Indicates statistically significant difference in MCO vs. state percentage in 2013 (p<0.05).
* State percentage is significantly higher or lower than NCQA Quality Compass average (p<0.05).

Table 11. General hospital/acute care: Maternity discharges, days, and average length of stay by health plan, reporting year 2013.

Health plan	Discharges	Discharges/MM	Days	Days/MM	ALOS
AMG	311	3.99	838	10.75	2.69 ▲
CCC	798	4.85	1,927	11.71	2.41
CHP	5,084	5.50	12,217	13.21	2.40
MHW	7,469	6.00	16,940	13.61	2.27 ▼
UHC	537	4.42	1,328	10.94	2.47
State average		3.02		7.07	2.34 *
NCQA average		5.05		13.11	2.66
NCQA 90th percentile		8.53		23.11	2.95

Discharges/MM = discharges per 1000 member months.
Days/MM = days per 1000 member months.
ALOS = average length of stay (in days).
▲▼ Indicates statistically significant difference in MCO vs. state percentage in 2013 (p<0.05).
* State percentage is significantly higher or lower than NCQA Quality Compass average (p<0.05).

Table 12. Ambulatory care: Outpatient and emergency room visits by health plan, reporting year 2013.

	Outpatient		Emergency room	
Health plan	Visits	Visits/MM	Visits	Visits/MM
AMG	29,004	248.50 ▼	7,120	61.00 ▲
CCC	76,243	283.15 ▼	16,182	60.10 ▲
CHP	581,348	337.16 ▲	81,030	46.99 ▼
MHW	833,307	347.27 ▲	109,224	45.52 ▼
UHC	49,118	253.06 ▼	10,478	53.98 ▲
State average		333.55 *		47.63 *
NCQA average		376.06		65.58
NCQA 90th percentile		469.74		85.99

Visits/MM = visits per 1000 member months.
▲▼ Indicates statistically significant difference in MCO vs. state percentage in 2013 (p<0.05).
* State percentage is significantly higher or lower than NCQA Quality Compass average (p<0.05).

Conclusions

HCA's limited requirement for reporting HEDIS measures in the 2012 measurement year (covering only 6 months) has provided an opportunity for the new MCOs to plan and implement processes for capturing data before the required measure set expands again in 2014. The environment for reporting Medicaid quality measures will change dramatically in 2014, given the addition of the blind and disabled population, new health plan partnerships, tightened audit timelines, and closer scrutiny of supplemental data by NCQA.

The 2013 HEDIS audits revealed challenges related to the MCOs' ability to demonstrate comprehensive review and evaluation of their data. Delegation and vendor oversight proved especially challenging for the MCOs.

The WMIP results were mixed this year. Diabetes care indicators were static or showed significant long-term declines, whereas ER utilization continued a more positive trend.

Although results for the MCS population are not directly comparable to those for the Healthy Options population, it is notable that service utilization rates for the higher-risk MCS population were 30% higher than those reported for Healthy Options enrollees. The MCS population will be incorporated into Medicaid managed care in 2014, as will WHP recipients. The addition of these new populations could significantly influence the reported HEDIS outcomes.

Recommendations

The following recommendations apply to HCA's ongoing contracts with the new roster of MCOs that began serving Medicaid enrollees in July 2012.

To sustain long-term improvement, Acumentra Health recommends that HCA

- consider requiring the MCOs to incorporate utilization reports from the Emergency Department Information Exchange (EDIE) into their care coordination and transition programs to ensure that enrollees receive timely care at the appropriate levels
- consider requiring the MCOs to engage in a formal activity to share best practices aimed at reducing the performance gaps among health plans for specific measures

In addition, Acumentra Health recommends that the MCOs

- closely monitor and evaluate incoming data and data transmission from vendors and delegated entities
- conduct validation studies to improve the quality of encounter data to ensure that enrollees are receiving appropriate interventions
- dedicate resources to improve the collection, retention, and completeness of race/ethnicity data so appropriate interventions may be established to address healthcare disparities
- 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

Finally, Acumentra Health recommends that the WMIP program and MHW

- explore techniques to increase engagement in alcohol and drug dependence treatment, since a high number of WMIP enrollees receive AOD services
- conduct a root cause analysis or other investigation to determine why WMIP enrollees' utilization of mental health services decreased from 2012 to 2013

References

[1] National Committee for Quality Assurance. *NCQA HEDIS 2013 Technical Specifications. Volume 2.* Washington, DC. 2012.
[2] The NCQA HEDIS Interactive Data Submission System© is a computer application used by health plans to enter HEDIS results and submit them to NCQA.
[3] National Committee for Quality Assurance. *Quality Compass® 2013.* Washington, DC. 2013.
[4] National Committee for Quality Assurance. HELP > Interpreting the Measures. Available online at www.qualitycompass.org/QcsExternal/docs/InterpretingtheMeasures.pdf. Accessed October 18, 2013.