

May 2009



# **Puget Sound *Community Checkup***

*Differences in Care for Medicaid vs.  
Commercially-Insured Populations*

**COLLABORATION • ACCOUNTABILITY • ACTION**

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**Special Thanks:**

Several organizations helped refine this first report comparing care provided to people on Medicaid versus other coverage. This report would not be possible without the Washington State Department of Social and Health Services / HRSA (Medicaid), health plans and self-insured employers and unions that provide data for the Community Checkup family of reports. Our special thanks to the members of the Alliance Health Information & Technology Committee, in addition to the following organizations that helped the Alliance develop this special report:

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- o Washington State Health Care Authority
- o Washington State Hospital Association
- o Washington State Medical Association

## Executive Summary

The Puget Sound Health Alliance started publishing the *Community Checkup* report in early 2008 to provide performance results for clinics and medical groups in the region based on claims data supplied by health plans, self-insured employers and union trusts. Since then, the Alliance has expanded the report, including the number of organizations supplying data so the report reflects care provided to an even larger percentage of the population in the region. As part of these efforts, the Alliance has incorporated Medicaid fee-for-service data into the multi-payer dataset used to report performance measures. Not only does this increase the portion of the population represented in the data and resulting measures, we are now able to present the results by type of payer – commercial coverage vs. Medicaid.

The large amount of data now in the Alliance’s multi-payer dataset enables us to analyze the results by covered population or coverage type. Because of known and significant differences between the commercially-insured population and those who receive health coverage through Medicaid, it is important to examine the ways in which the performance results differ by these two populations. This report raises questions about *why* there are differences in performance rates between the Medicaid and commercially-insured populations but does not definitively answer them. We welcome community participation in further exploring the differences in results and the reasons that drive those differences. Even if the answers are not yet evident, the purpose of this report is to motivate physicians, patients, health plans, Medicaid, purchasers and others in the community to explore these issues and then work together to improve health care effectiveness for everyone in the region.

Numerous differences in demographic and programmatic issues between the Medicaid and commercially-insured populations need to be considered when interpreting and comparing results for each population. Within the covered populations themselves, there are differences in income, race, ethnicity and other socioeconomic factors that affect access to care, as well as differences that impact those who provide care to each population. Using the Alliance’s aggregated dataset, this report shows the results by population, but does not attempt to definitively determine the reason for those differences. A lower result may indicate that a health care practitioner didn’t offer or provide a recommended service, a provider didn’t code or submit a claim or encounter for a recommended service, a patient didn’t follow through to get a recommended service, or that the data are missing or incomplete. Every instance of inaction by a provider or a patient could be due to a number of reasons as well. Because of these variables and unknowns, results in this report should be interpreted as indicators of patterns of care that spur additional investigation and analyses to determine strategies for improvement.

This report presents performance results for 20 measures of health care provided by medical groups in the Puget Sound region. Categories of care measured are chronic diseases (e.g., diabetes, asthma, heart disease and depression), preventive care, avoidance of unnecessary care and generic prescribing rates. This report compares performance results across the five-county region. Commercially-insured results reflect data from health plans, self-insured employers and union trusts, based on care for covered employees or members and dependents. Medicaid results reflect data from both the managed Medicaid and Medicaid fee-for-service programs. Given that the data used to calculate results in the *Community Checkup* reports thus far have not included Medicaid fee-for-service data, this analysis also compares the impact on the results for medical groups when results are reported separately for commercially-insured and Medicaid versus reporting a single aggregated result based on combined commercially-insured and Medicaid data. As a point of reference, this report also shows performance for the Medicare population using results calculated by the Centers for Medicaid and Medicare Services (CMS).

Key findings in this report include:

- For most measures, the regional average results differ by population type, with higher rates for the commercially-insured population compared to Medicaid
- There are a number of measures (6) where the regional average result for the Medicaid population is comparable to or better than the result for the commercially-insured
- For most measures, there is substantial overlap in the range of medical group results (highest to lowest performers) for both the commercially-insured and Medicaid populations, suggesting that patients in each population receive similar care overall
- There is wide variation in results across the region, for both populations and all measures, indicating that everyone has opportunity to improve for both populations
- Results in this region are most dissimilar between commercially-insured and Medicaid for measures that require lab and radiology services; this warrants further investigation
- The results in this special report, and the overall *Community Checkup*, appear to be consistent with Medicare results calculated by CMS on comparable measures
- Reporting health care performance results separately by population significantly increases the amount of information available to medical groups and the community
- Calculating results separately by population affects each medical group's results for each measure differently, with the largest change in results appearing for diabetes and preventive measures
- When we analyze the data by population, results for medical groups change in different ways based on the number of commercially-insured and Medicaid patients attributed to each specific medical group. Several medical groups treat a relatively large number of

patients on Medicaid. Not surprisingly, results for these medical groups change the most when results are calculated and reported separately by population type.

In many ways, the report findings confirmed expectations – namely that results for the Medicaid population differ from commercially-insured results at the medical group level. This finding is consistent with results for these performance measures at the health plan level. A related finding is that reporting separately by population results in a significant information gain for the community – medical group results for each population versus results for the two populations combined. This report finds that for most measures there is substantial overlap in the range of medical group performance for the commercially-insured and Medicaid populations, suggesting the potential for the two populations to receive similar care across the region. And, even though the Medicaid population presents more challenges for health care treatment, there are medical groups in our region that are high performers in delivering to the Medicaid population the effective care measured in this report. Lastly, this report identifies issues for further inquiry including the need to explore the completeness of lab and radiology data for the Medicaid population, and to further explore the reasons for some of the differences in results presented in this report. Based on this analysis, we recommend the following:

- Given the varying effects of reporting results separately by population type, future *Community Checkup* reports will incorporate population-specific results in addition to continuing to show results for the aggregated dataset.
- Given the overrepresentation of communities of color in the Medicaid population, this report can be used as a first look at measuring health care disparities in this region. We are committed to working with everyone across the community to achieve health equity.
- Everyone must work on doing their part to improve the results, because everyone – regardless of patient population or type of coverage – has room to improve.
- Given that there are high performers for the commercially-insured and the Medicaid populations, medical groups can learn from each other about promising practices to improve results for all patients in the community.
- Given the challenges of treating the Medicaid population, medical groups that perform well with this population will be recognized by the Alliance for their good work. Highlighting the services or approaches taken by medical groups that perform well with the Medicaid population will allow others to learn from their successes.
- Everyone has a role to play in improving health and health care– the health care system is complex and no single doctor, clinic, patient, health plan, employer or union can fix the problems *alone*.

We all need to align our efforts and do our part to achieve a state-of-the-art health care system that provides more effective and affordable care for everyone.

## Introduction

In 2008, the Puget Sound Health Alliance began producing the *Community Checkup* report which shows performance results for medical groups, clinics and hospitals in King, Kitsap, Pierce, Snohomish and Thurston counties. The most recent report, released to the public in November 2008, included 21 measures assessing how consistently patients received recommended care from doctors' offices in the areas of asthma, diabetes, heart disease, depression, low back pain, preventive care and generic drug prescribing. The results reflect whether doctors and other health professionals recommend the care to patients and whether patients follow through with that advice. Patients' actions may be affected by whether they understand why the recommended care is important, whether they can pay for the needed service using health insurance in combination with out-of-pocket costs and whether they can access the service. *Community Checkup* reports are intended to motivate improvement in health care quality and value by informing patients, health care professionals, health plans, employers, unions and the entire community about the results in this region and what each of us can do to help those results improve over time.

### Key findings from the November *Community Checkup* report include:

- In the Puget Sound region large numbers of patients do not receive care recommended by national medical guidelines
- Compared to national results, our community is doing relatively well in care for diabetes, heart disease, low back pain, and avoiding the use of antibiotics for the common cold
- Compared to national results, there are opportunities for improvement in this community regarding preventive care and appropriate use of antibiotics for a sore throat
- In this region, there is a wide range of performance across clinics in many measures, indicating numerous opportunities for improvement, particularly for filling prescriptions using generic medications

Following the November report, the Alliance incorporated data from the Washington State Department of Social and Health Services (DSHS) for care provided to patients covered by the Medicaid fee-for-service (FFS) program. The size of this new population provides sufficient data for the Alliance to analyze the results separately for the commercially-insured and the Medicaid populations. Medicaid results include data from both the managed Medicaid and the Medicaid FFS programs. Although there are differences in results for the two Medicaid sub-populations, comparisons are limited due to measure threshold requirements. Due to the size of the managed

Medicaid population, there is insufficient data to generate statistically reliable results for this sub-group alone, so the data were combined into one Medicaid category. Additionally, the Alliance received performance results on the Medicare population from the Centers for Medicare and Medicaid Services (CMS) for a similar time period. Because the Medicare results were calculated by CMS and the technical process was slightly different, the results are not directly comparable; however, they provide a useful point of reference.

Population differences can significantly affect performance measure results. The Healthcare Effectiveness Data and Information Set (HEDIS®) is a tool used by health plans to measure performance on important dimensions of care and service. At the health plan level, HEDIS performance results are calculated and reported separately for commercial coverage, Medicaid and Medicare because the underlying populations are known to have very different characteristics. The commercially-insured population predominantly includes working adults and their dependents; the Medicaid population primarily includes low-income individuals including pregnant women, families and people with disabilities; and the Medicare population primarily includes people age 65 years and older. Because results can be affected by population differences, HEDIS reports health plan performance measures separately by population.

The addition of Medicaid FFS data to the multi-payer dataset assembled by the Alliance provides the first opportunity to examine performance measure results for our community by population type – beginning with commercially-insured and Medicaid. The primary purpose of this report is to describe how the performance results differ for the commercially-insured and Medicaid populations in our community. Secondly, these findings inform how the Alliance will present the results in future *Community Checkup* reports; in other words, whether results should be presented separately for the commercially-insured and Medicaid populations, shown as a combined result, or presented both ways.

## Data Sources, Methods and Interpretation

### Data Sources

Results for the commercially-insured and Medicaid populations presented in this report are generated from claims or encounter data supplied by 16 health plans, self-insured employers, union trusts and government programs. Submitted data include information about tests, diagnoses and services provided by doctors and other clinicians. The Alliance receives no information that personally identifies any individual patient. Participating data suppliers include:

- The Boeing Company (*via Regence*)
- Carpenters' Trust
- City of Seattle (*via Aetna*)
- Community Health Plan of Washington
- First Choice
- Group Health
- Washington State Health Care Authority Uniform Medical Plan (*via FIServ*)
- King County (*via Aetna*)
- Molina Healthcare of Washington
- Premera Blue Cross
- Recreational Equipment Inc. (*via Aetna*)
- Regence Blue Shield
- Retail Clerks (*via Zenith Administrators*)
- Snohomish County (*via Regence*)
- Washington Mutual (*via United/MedStat*)
- Washington State Department of Social and Health Services (*Medicaid FFS*)

The organizations listed above provided the universe of information currently included in our dataset. This represents care for about 2 million people within the Puget Sound region but it does not include the entire population. Missing from the dataset are data reflecting care to people who have individual insurance policies or who are uninsured, and data from self-insured employers who do not participate in the Alliance, specific books of business (e.g., HMO products) that some data suppliers do not include with their data submission, data from insurers who do not participate in the Alliance, and the Federal government (e.g., Medicare, Veterans Affairs). While Medicare data are not included in the Alliance dataset, this report does include Medicare results obtained from the Centers for Medicare and Medicaid Services (CMS).

After the data were submitted, the Alliance validated the data, calculated measure results, attributed patients to practitioners and assigned practitioners to medical groups to produce the

results in this report. These steps are described in detail in the November 2008 *Community Checkup* report ([www.wacommunitycheckup.org](http://www.wacommunitycheckup.org)). Due to the timing of receipt of the Medicaid FFS data they were not included in the November 2008 report, but instead the draft results for the Medicaid and commercially-insured populations were calculated then privately released for medical group review in mid-December. After the review was complete, the Alliance factored in the medical group input then finalized the results. The commercially-insured and Medicaid results presented in this report are based on claims and encounters from October 2006 through September 2007.

As mentioned above, the Medicare results included in this report were supplied by CMS, which collects and reports selected HEDIS measures on the Medicare FFS population. The Medicare measures in this report are based on claims data from calendar year 2007. Because of differences in methodology, the results are not directly comparable to those generated by the Alliance but they do provide a relevant reference point.

## Methods

The measures used by the Alliance for the *Community Checkup* report are based primarily on HEDIS® specifications developed by the National Committee for Quality Assurance. These measures have detailed specifications for calculating the results, including eligibility definitions, age ranges, procedure codes, specified dates of service, exclusions, continuous eligibility requirements and others. One measure - Cholesterol-Lowering Medication - is from the American College of Cardiology and the American Heart Association. The four generic prescribing measures were developed by the Alliance in response to the significant cost savings potential associated with filling prescriptions using generic rather than brand name drugs.

**Continuous Enrollment.** Many of the measures have a continuous enrollment requirement meaning that individuals need to be enrolled with the same health plan or insurance coverage for a specified time period before the data about their care are included in the measure calculations. This criterion likely affects the commercially-insured and Medicaid populations differently. The commercially-insured population has a higher proportion of people remaining with the same health plan or insurance coverage over a given time period. In contrast, one characteristic of the Medicaid population is that individuals tend to gain and lose eligibility for the program as their status changes (e.g., pregnancy, job loss, job gain). Because of the continuous enrollment requirement, these results reflect care provided to people who have been on Medicaid for a specified period of time and the data about care for individuals who cycle on and off Medicaid during the time period measured are not reflected in the results.

**Attribution to Providers and Medical Groups.** Our data process involves attributing patient data to providers based on their pattern of visits and assigning providers to medical groups to calculate a medical group level result. While the November 2008 *Community Checkup* report

included results for clinic sites, this report shows performance results at the medical group level only. Many medical groups have more than one clinic site. To be named and listed in the report, medical groups must have at least 6 or more clinicians and at least 160 patients appropriate to each measure. Regional averages are calculated using results from all medical groups in the five-county region, regardless of whether there was sufficient data for a given medical group to meet the minimum threshold to be listed separately in the report.

## Interpretation of Results

Performance results for each measure may vary based on many factors including population characteristics and programmatic issues such as benefit structure, provider networks and patient cost sharing. Several factors likely to impact the commercially-insured and Medicaid populations differently are described below.

- **Commercially-insured population** - Data for the commercially-insured population are supplied by health plans, self-insured employers and union trusts. As such, they represent information on care provided to individuals and their dependents in King, Kitsap, Pierce, Snohomish and Thurston counties who have at least one working member of the household who receives health care coverage through their employer. Commercially-insured individuals have health care coverage with a variety of benefit designs, such as health maintenance organizations (HMOs), traditional indemnity insurance, preferred provider plans, health savings accounts and high deductible plans.
- **Medicaid population** - Medicaid is a program funded through the federal and state government that provides health insurance for low-income residents. In 2008, in Washington state, approximately 860,000 citizens depended on Medicaid for their health care coverage. Medicaid/SCHIP generally covers all children in families with income up to 300 percent of the Federal Poverty Level (in 2008 the Federal Poverty Level for a family of four was \$21,200). The major categories of individuals covered by Medicaid include low-income families, children, pregnant women, and the elderly and disabled. Medicaid clients receive health care services through two types of programs: 1) Medicaid managed care (called Medicaid Healthy Options) or prepaid comprehensive care including preventive, primary, specialty and ancillary services; or, 2) Medicaid fee-for-service (FFS). Currently, the Medicaid caseload is divided about equally into both programs. However, it is important to note that clients are not equally distributed across the programs. Medicaid managed care primarily covers needy families, pregnant women and children while Medicaid FFS primarily covers low-income elderly and disabled clients. Under Medicaid managed care, clients are guaranteed access to a primary care provider as well as the health plan's network of

specialists and other providers. Under Medicaid FFS, clients must find their own doctors and are limited to those providers who agree to accept Medicaid rates as total payment for the services provided. Alliance discussions with providers in the Puget Sound region identified access to specialists as a particular challenge for the Medicaid FFS population.

Another important observation is the greater racial and ethnic diversity within the Medicaid population when compared to the general population. Based on 2007 data from the Washington State Department of Social and Health Services, the table below shows that within the Medicaid population, Whites are underrepresented and every other racial group is overrepresented when compared to the statewide population.

Racial/Ethnic Category	General Population	Medicaid Clients
White non-Hispanic	78.2%	52.1%
African American	4.2%	7.9%
American Indian	2.8%	5.2%
Asian/Pacific Islander	5.2%	6.2%
Hispanic, any race	8.3%	18.9%
<b>Any Minority</b>	<b>21.8%</b>	<b>35.9%</b>

*Note: A Medicaid client who self-identifies as one or more minorities is counted in each of those categories, and is counted once in the Any Minority row. Clients who identify as White with no minority group membership are tallied under White non-Hispanic only. Medicaid clients whose race is unknown are not counted in the table above; therefore the Medicaid client categories do not sum to 100%.*

As displayed, the percentage of White (non-Hispanic) people on Medicaid is about one-third lower than the general population in Washington state. For all other races, the percentages are higher on Medicaid than the general population. Overall, minority populations make up over one-third of Medicaid clients compared to about one-fifth of the general statewide population.

There are many socioeconomic factors that differentially affect the low-income population that qualifies for Medicaid compared to the commercially-insured population. Low-income individuals may face additional obstacles to obtaining medical care including transportation, childcare, language, and low literacy. When considering these differences, it is important to note that in the research literature, income is recognized as a significant determinant of health status; people with lower incomes generally experience more illness and have a lower life expectancy.

The numerous differences in population characteristics and programmatic issues between the commercially-insured and Medicaid populations need to be considered when interpreting results based on data from each population. Using our dataset, we can report the results by

population, but we cannot definitively determine the reason for any differences in the results. A lower Medicaid result may indicate that a practitioner or health provider didn't provide a recommended service, a provider didn't code or submit a claim or encounter for a recommended service, a patient didn't follow through to get a recommended service, or that the data are missing or incomplete. Every instance of inaction by a provider or a patient could be due to a number of reasons as well. Because of the number of variables and unknowns, we recommend the results be interpreted as indicators of patterns of care that spur additional investigations and analyses to determine strategies for improving the quality of health care provided to everyone in our community.

## Regional Comparisons for the Medicaid and Commercially-Insured Populations

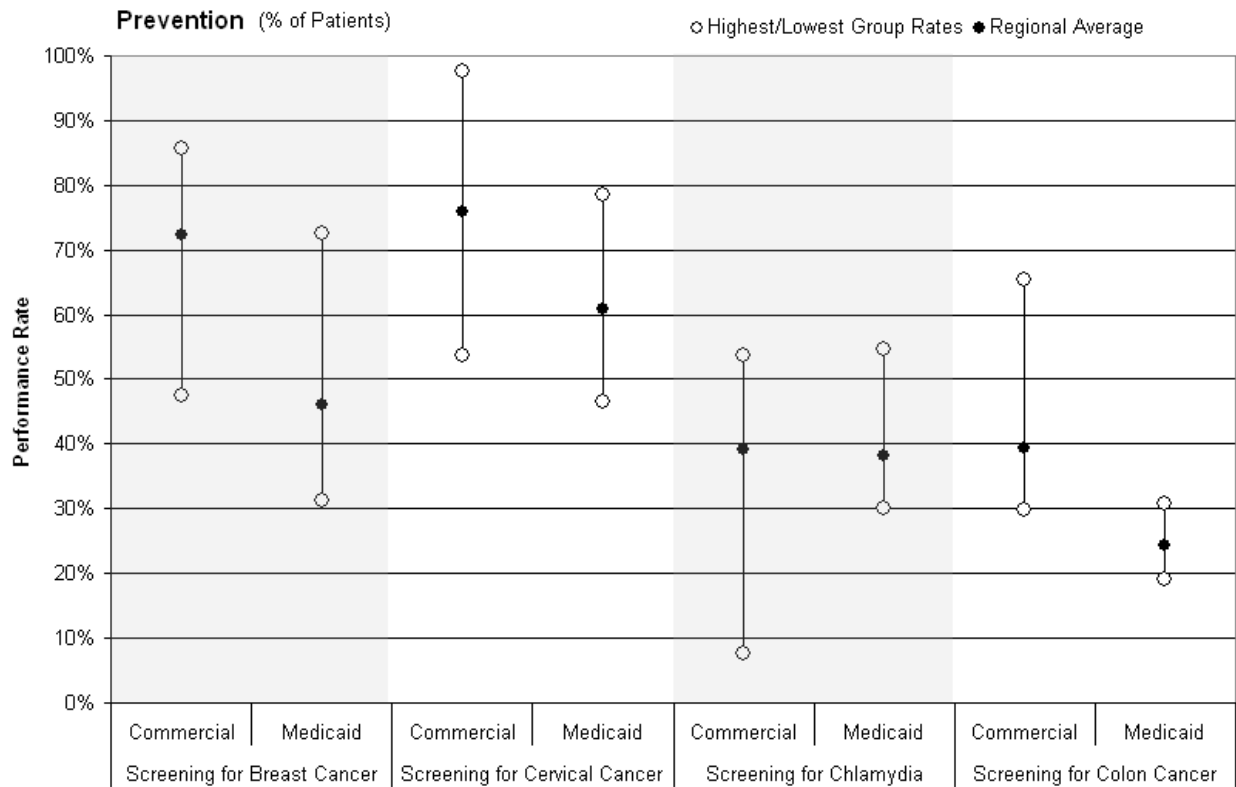
This section of the report presents performance results for care provided within King, Kitsap, Pierce, Snohomish and Thurston counties in the Puget Sound region. The measures indicate how consistently patients received care that the medical community agrees is effective to promote better health, especially for chronic conditions such as asthma, diabetes, heart disease and depression.

### Prevention – Effectively Screening for Disease

Prevention is taking steps to avoid disease or to help find a disease early so it is easier to treat. Our report includes three measures of cancer screening and one measure of screening for Chlamydia, the most commonly reported sexually transmitted disease in the United States. In Washington state:

- Breast cancer is the most frequently diagnosed cancer and the second leading cause of cancer death among Washington women
- In 2005, 63 women in Washington state died from invasive cervical cancer, which is often preventable when caught early with regular screening
- Chlamydia is the most commonly reported sexually transmitted infection with 295 cases per 100,000 persons in 2007 in Washington
- Colorectal cancer is the third most common cancer in Washington state with 2,776 cases diagnosed in 2004

The graph below displays the results for the commercially-insured and Medicaid populations for these preventive measures, showing the high, average and low medical group results. The lines indicate the range of performance for that measure among medical groups in the five-county Puget Sound region. Descriptions of the measures are in the text boxes below the graph.



**Measure Definitions**

**Screening for Breast Cancer**

The percentage of women ages 40 to 69 who had at least one mammogram during the two-year measurement period.

**Screening for Cervical Cancer**

The percentage of women ages 21 to 64 who had at least one Pap test during the three-year measurement period.

**Screening for Chlamydia**

The percentage of sexually active women ages 16 to 25 who had at least one test for Chlamydia during the measurement year.

**Screening for Colon Cancer for the Newly Eligible**

The percentage of adults ages 51 to 54 who had appropriate screening for colon or colorectal cancer.

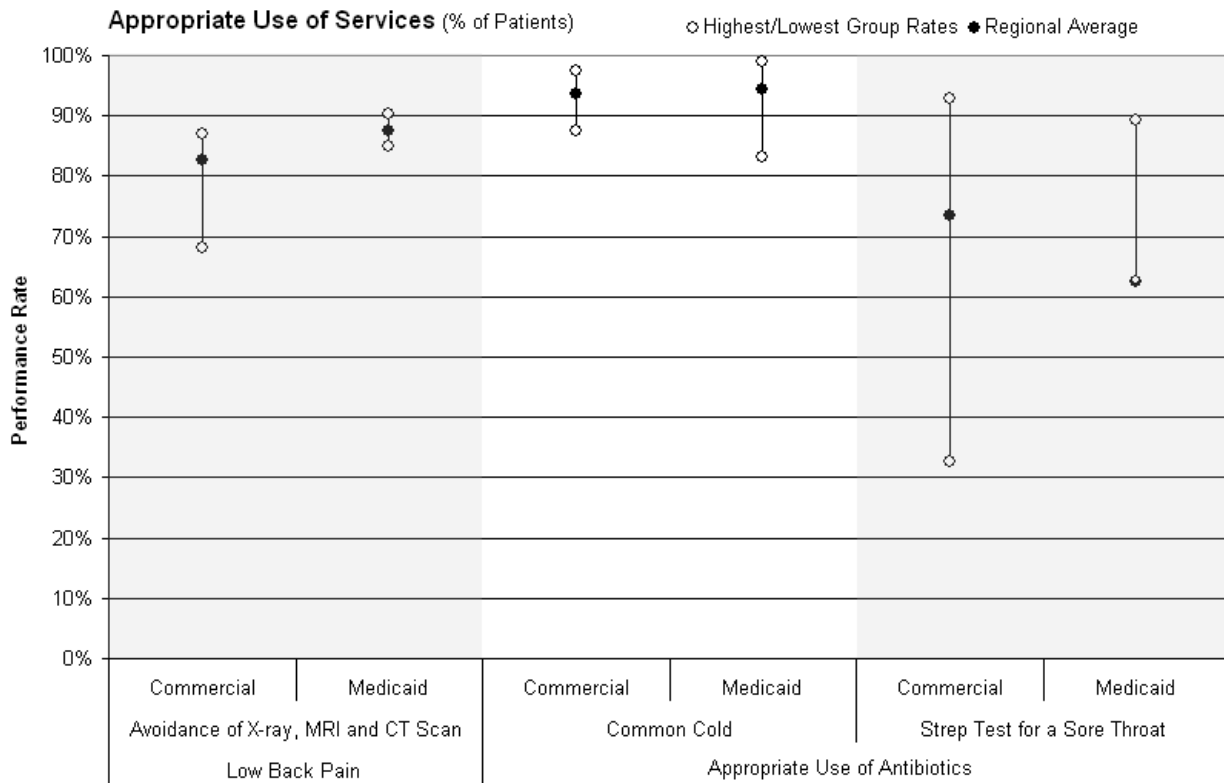
For both populations, the regional average is better for breast and cervical cancer screening and worse for screening for colon cancer and Chlamydia. If we compare the two populations, we find that the average for the commercially-insured substantially exceeds the Medicaid average

for three of the four preventive measures. The commercially-insured and Medicaid averages are very close on screening for Chlamydia. While the commercially-insured average results are higher than the Medicaid averages, all of the measures display substantial overlap in the range of performance of medical groups. This means that despite the challenges inherent in delivering care to the Medicaid population, many medical groups are able to deliver preventive care services at a rate equal to that delivered to the commercially-insured population. In fact, for Chlamydia screening, the top performing medical group for the Medicaid population scores slightly better than the top performing group for the commercially-insured population, indicating that medical groups can – and are – achieving results with a Medicaid population on par with or better than a commercially-insured population. However, it is also important to note that the average rates of just under 40% for this measure indicate substantial opportunity for everyone to improve within and across both populations.

## Appropriate Use of Services – Antibiotics and Imaging

In health care, some services are provided more often than necessary which can increase risk and costs to the patient and to the community. Antibiotics do not cure infections caused by viruses and they have potential side effects. For example, the overuse of antibiotics has been shown to lead to the development of bacteria that are resistant to commonly used antibiotics. Of course, anytime a patient is given a medication or treatment that is unnecessary, that adds to the cost of health care as well. Overuse of imaging services (e.g., x-rays and MRIs) has also emerged as an area of concern due to data showing rapidly increasing use and costs, without a demonstrated benefit to patients. Unnecessary use of imaging increases costs for the patient and the health care system, and exposes patients to unnecessary risks such as exposure to radiation.

This report includes three measures of appropriate use of services: two assessing unnecessary use of antibiotics and one addressing overuse of imaging services such as X-rays and MRIs.



**Measure Definitions**

**Low Back Pain – Avoidance of X-ray, MRI and CT Scan**

The percentage of patients ages 18 to 50 with a new diagnosis of low back pain who did not have an X-ray or other imaging study (MRI, CT scan) in the 28 days after they first visited a health care provider due to low back pain.

**Appropriate Use of Antibiotics – Common Cold**

The percentage of children ages 18 months to 18 years who went to the doctor for a common cold who were not prescribed an antibiotic for three days after the diagnosis.

**Appropriate Use of Antibiotics – Strep Test for a Sore Throat**

The percentage of children ages 2 to 18 who visited a doctor for a sore throat who received a “strep” test (group A streptococcus) before being prescribed an antibiotic.

As shown in the graph above, the region on average is performing well on two of the three measures – Avoidance of X-ray, MRI and CT Scan for Low Back Pain, and Appropriate Use of Antibiotics for the Common Cold. For these two measures, the regional averages for both population types are over 80 percent, with the Medicaid average exceeding the average for the commercially-insured population in avoidance of imaging for low back pain. Additionally, the

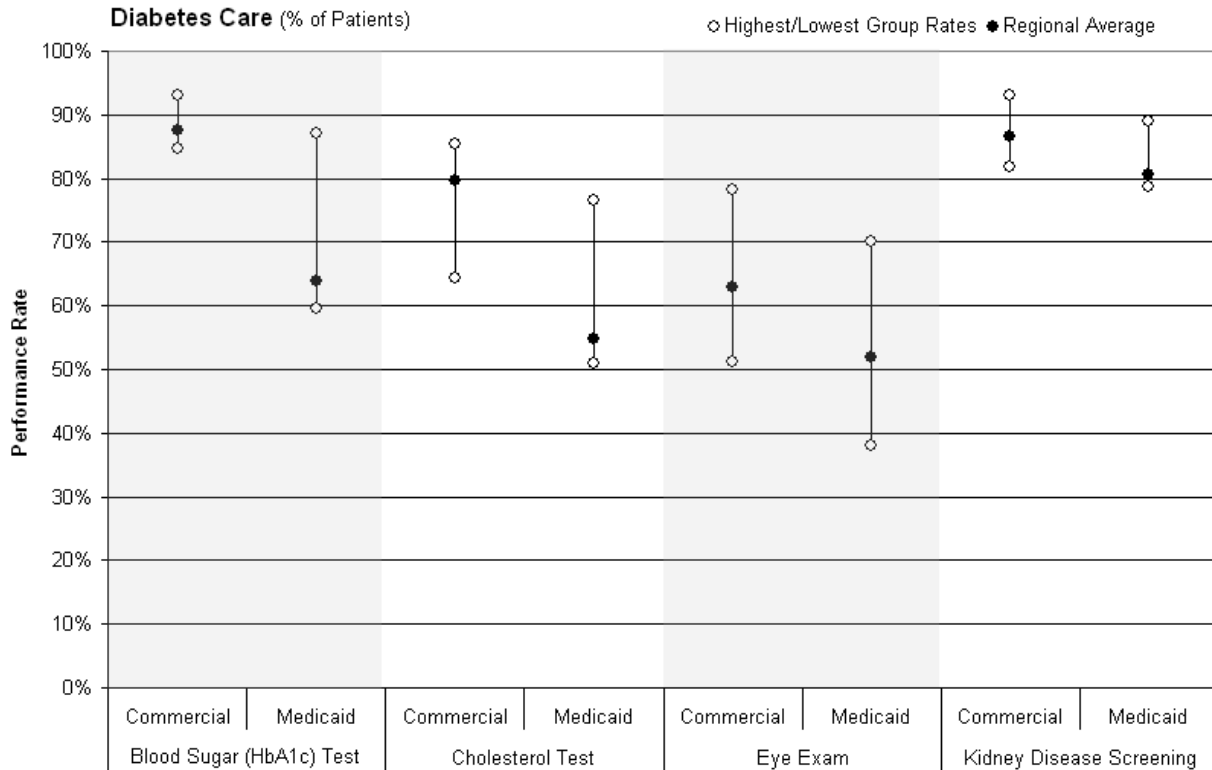
difference between the highest and the lowest scores for these measures is relatively small, indicating that medical groups appear to be consistent in treatment for all patients. The high performance results for the Appropriate Use of Antibiotics for the Common Cold may reflect efforts of the Alliance Working for Antibiotic Resistance Education (AWARE), a comprehensive campaign to reduce the inappropriate use of antibiotics, launched by the Washington State Medical Education and Research Foundation. The measure of Appropriate Use of Antibiotics for Strep Throat displays lower regional rates for both populations and a larger range of scores across medical groups. This suggests that medical groups with lower scores could learn from higher performing medical groups about ways to improve on this measure. Notably, the top score for a medical group for the commercially-insured population is about 60 percentage points higher than the lowest score. Another interesting finding is the overlap in the scores for all medical groups for both Medicaid and commercially-insured populations for these measures, indicating that the high-scoring medical groups consistently provide effective care, regardless of the patients' type of health coverage.

## Care for Patients who have Diabetes

Diabetes is a disease that keeps the body from making or using insulin, a hormone that helps convert sugar, starches and other food into the energy needed for daily life. Diabetes is a public health priority in Washington state, where more than 300,000 people have been diagnosed with diabetes, an estimated additional 125,000 have undiagnosed diabetes, and nearly one million people are estimated to have pre-diabetes.

Diabetes can lead to other problems such as heart disease, kidney disease, blindness and poor circulation which can require limb amputation. People with diabetes have at least two times greater risk of heart disease and stroke than those who do not. Actively managing diabetes can prevent or reduce these risks. Our collective goal is to help people with diabetes to manage their disease and prevent additional health problems.

National guidelines for effective care for diabetes recommend several steps for managing diabetes, including the four key measures below that are essential to regulating blood sugar (i.e., glucose) and cholesterol levels, and maintaining eye and kidney functioning.



**Measure Definitions**

**Diabetes – Blood Sugar (HbA1c) Test**

The percentage of patients ages 18 to 75 with diabetes who had an HbA1c test during the one-year measurement period.

**Diabetes – Cholesterol Test**

The percentage of patients ages 18 to 75 with diabetes who had a test for LDL cholesterol during the one-year measurement period.

**Diabetes – Eye Exam**

The percentage of patients ages 18 to 75 with diabetes who had an eye exam in the two-year measurement period. The eye exam is a retinal or dilated eye exam by an eye care professional.

**Diabetes – Kidney Disease Screening**

The percentage of patients ages 18 to 75 with diabetes who had a kidney disease screening test or were treated for kidney disease during the one-year measurement period.

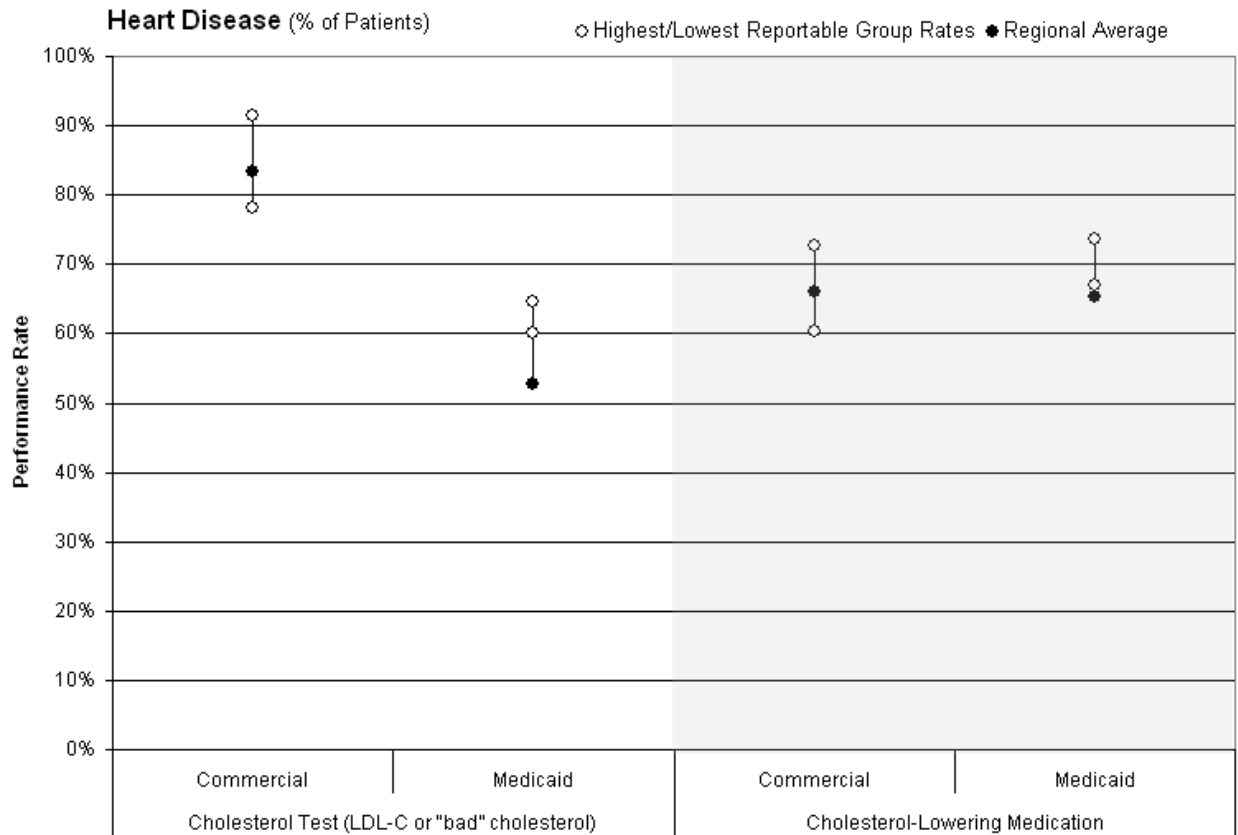
On average in this region, patients who have diabetes appear to be most likely to receive kidney disease screening tests and least likely to receive eye exams as recommended by national

guidelines. Additionally, the average for commercially-insured patients exceeds the Medicaid average for all four diabetes measures. The difference in results for the two populations is substantial for the blood sugar (HbA1c) test and the cholesterol test. Both of these measures require an additional lab service – a blood draw from the patient. The differences between the results for the commercially-insured and Medicaid could indicate that for some reason, Medicaid patients aren't receiving the lab test (not ordered by the physician or not obtained by the patient), or that the lab data are incomplete (not all lab services are appearing in claims data). Again, the larger ranges for some of the measures indicate unwarranted variation and suggest that medical groups with lower scores can learn from high performing medical groups in our region. Finally, there is substantial overlap in the range of medical group performance across both populations, signifying that some medical groups in the region are able to achieve high performance for Medicaid patients in addition to those who are commercially-insured.

## Care for Patients who have Heart Disease

Heart disease refers to conditions that affect the heart's ability to pump blood. The measures in our report focus on coronary artery disease and stroke, which are the second and third leading causes of death in Washington state. Together they accounted for almost 11,000 deaths in 2005 in Washington state.

This report includes two measures of heart disease: whether patients received a cholesterol test after they were discharged from the hospital for an event due to heart disease, and whether patients with heart disease received a prescription for cholesterol-lowering medication.



**Measure Definitions**

**Heart Disease – Cholesterol Test**

The percentage of patients ages 18 to 75 who had at least one LDL cholesterol screening test in the year after they were discharged from the hospital for heart attack, coronary artery bypass graft, percutaneous transluminal coronary angioplasty (PTCA), stroke or aneurysm.

**Heart Disease – Cholesterol-Lowering Medication**

The percentage of patients ages 18 to 75 with heart disease who had at least one prescription filled to lower cholesterol during the one-year measurement period.

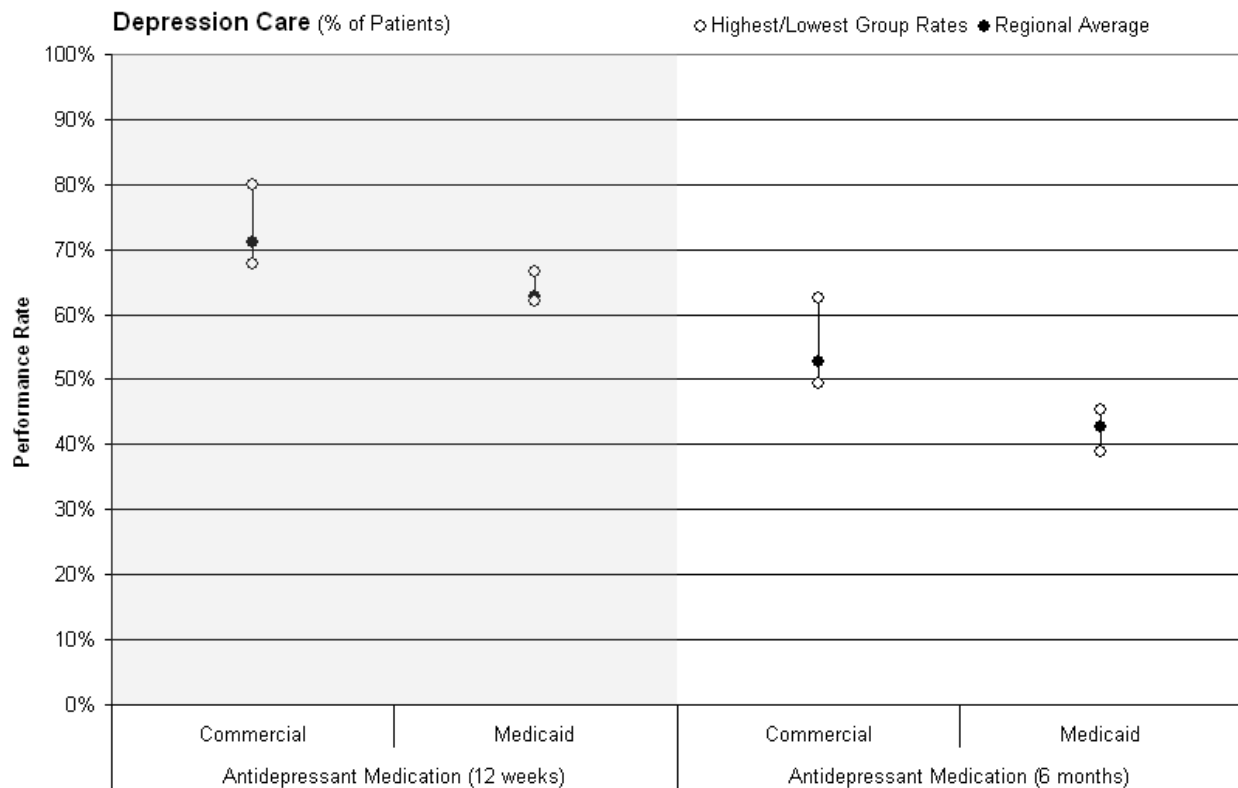
On average in this region, patients with heart disease are more likely to receive a cholesterol test than they are to get cholesterol-lowering medication. The results for the cholesterol test display a large difference between the results for commercially-insured and for Medicaid, similar to the gap in results for the diabetes measures that also require lab data. This could indicate systematic data issues (e.g., incomplete lab data) or that Medicaid patients are not receiving this service for some reason (e.g., requires an additional trip to a lab, potential expense). For both of the heart

disease measures, the average result for Medicaid across the entire region is below the lowest result for any medical group listed in the report. This indicates that the medical groups with a sufficient number of patients to enable the Alliance to publicly report a result perform better than medical groups that don't have enough patients to meet the minimum reporting thresholds. These two measures also differ on the amount of overlap in the range of performance across the two populations. There is no overlap in the results for providing Cholesterol tests, while results for Cholesterol-Lowering Medication display similar regional averages for Medicaid and commercially-insured, and overlapping ranges of high to low performance among medical groups.

## Care for Patients who have Depression

Depression is an illness that affects a person's mood, thoughts and body. Depression is a common and serious illness that often requires treatment to get better. About 20-25% of women and 7-12% of men will experience depression in their lifetimes. Depression is now recognized as an important factor in many other health conditions including heart disease, stroke, cancer and diabetes. Depression is also the most common cause of disability in the United States and annually costs U.S. employers an estimated \$80 billion in health care costs, absenteeism and lost productivity. Many people with depression never seek treatment, which may include antidepressants, psychotherapy or natural remedies. For patients who begin treatment with medication, it is important to continue the medication until the episode has been fully treated.

This report includes two measures of antidepressant medication management – one examining a twelve-week period to address the symptoms of depression and the other examining a six-month period to prevent the depression from becoming chronic.



### Measure Definitions

**Depression – Antidepressant Medication (12 weeks)**

The percentage of patients ages 18 and older who were newly diagnosed with depression and prescribed an antidepressant and remained on an antidepressant for 12 weeks after the diagnosis.

**Depression – Antidepressant Medication (6 months)**

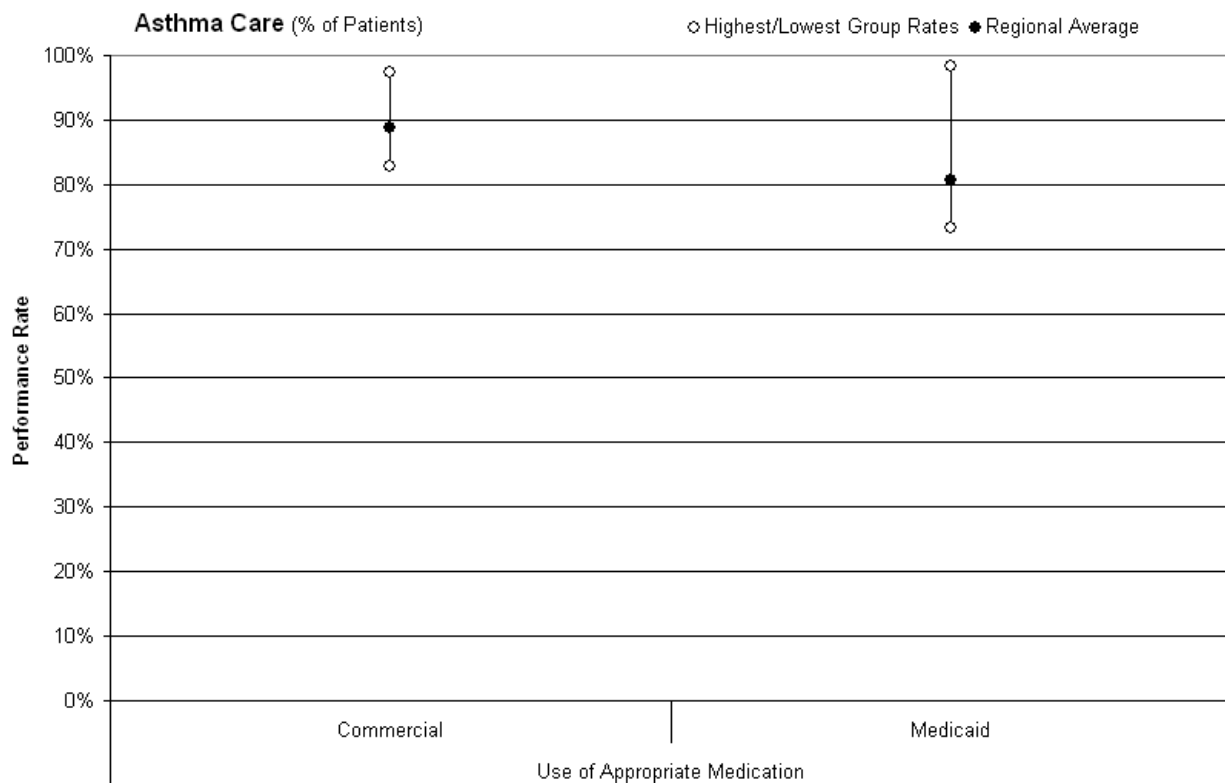
The percentage of patients age 18 and older who were newly diagnosed with depression and prescribed an antidepressant and continued taking an antidepressant for a least 180 days (6 months) after the diagnosis.

As shown in the graph above, the Medicaid regional average for both measures is below the regional average for the commercially-insured. There is little to no overlap in the range of medical group performance across the two populations. **Special note:** The regional average for these measures reflects data for *all* medical groups in the region; however, in the chart above, the Medicaid “highest / lowest group rates” reflects only two medical groups in the dataset for which there were enough Medicaid patients diagnosed with depression to meet the minimum threshold. The chart above shows the regional average for *all* medical groups, plus the results

for those two medical groups. The regional average results for both measures indicate that our community can improve care management for all patients taking antidepressants for depression.

## Care for Patients with Asthma

Asthma is the irritation of the airways or tubes that carry air into and out of the lungs. Symptoms may include cough, wheezing, and chest tightness. Washington state has one of the highest rates of asthma in the country, with almost 1 in 10 Washingtonians suffering from asthma. Medication can help control asthma and avoid serious breathing troubles, fatigue, confusion, visits to the hospital and even death. Asthma can be successfully managed through use of long-term controller medications. Our measure examines whether people with asthma received these important long-term controller medications.



### Measure Definitions

#### Asthma – Use of Appropriate Medication

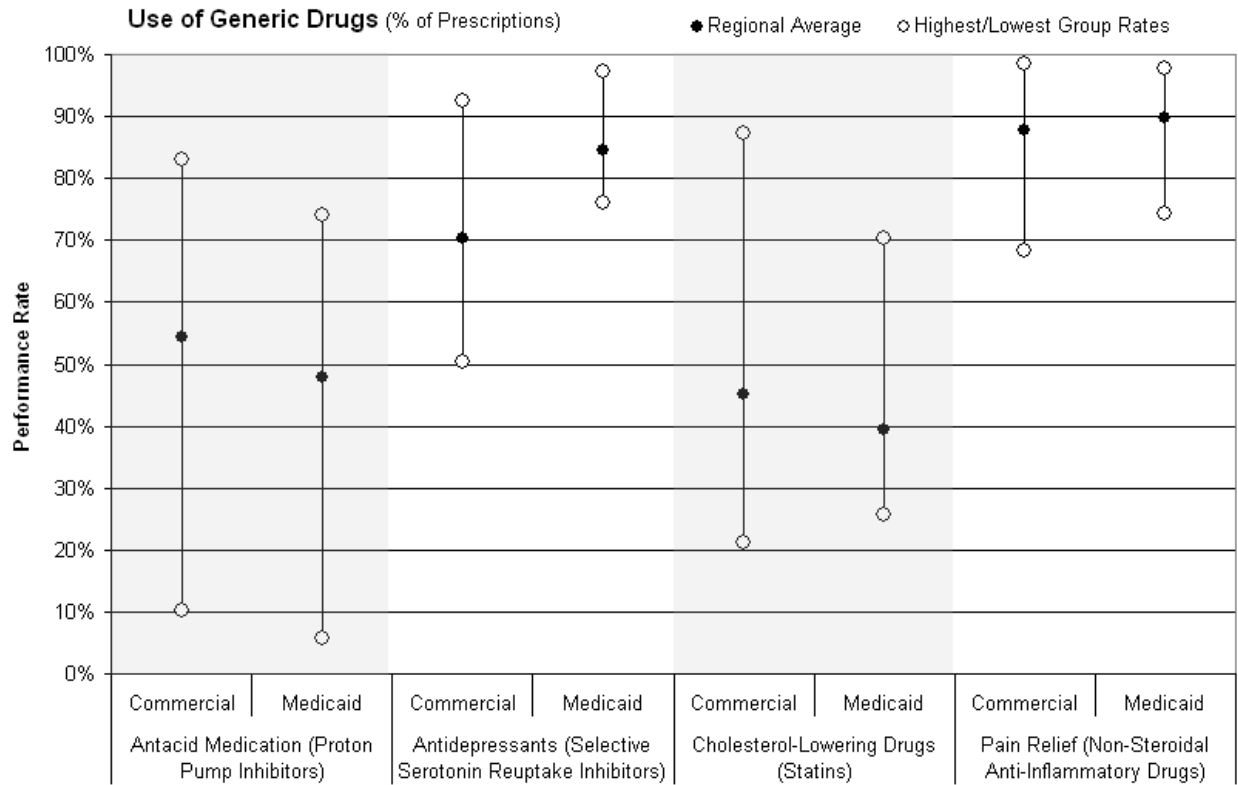
The percentage of patients ages 5 to 56 identified as having persistent asthma and who filled a prescription for long-term controller medication during the measurement year.

As displayed in the graph above, on average the community performs well on this measure of asthma care. The regional average for Medicaid is below the commercially-insured population; however, the range indicates that some medical groups are achieving top results with the Medicaid population, demonstrating that such performance is possible. In fact, the best medical group result in the region is for the Medicaid population. There is significant overlap in the range of medical group performance across both populations. The wider range of medical group performance with Medicaid indicates even more unwarranted variation in care while demonstrating that some medical groups are achieving good results with patients on Medicaid.

## Use of Generic Prescription Drugs

Generic prescription drugs have the same chemical composition and, for most people, work just as well as brand-name drugs. Additionally, generic drugs usually cost less than brand-name prescription drugs. In 2007, the Alliance assessed potential savings from increasing the use of generic prescriptions across four classes of drugs in which many generic drug options are available: cholesterol-lowering medication, antidepressants, pain relief, and antacid medication. The Alliance found that more than \$2.5 million could be saved annually in the five-county region for each percentage point increase in the “generic fill rate” – that is, how often a prescription is filled with a generic rather than a brand-name drug – in these four classes of drugs.

The generic fill rates in these four drug classes for commercially-insured and Medicaid are displayed below.



**Measure Definitions**

**Generic Drugs – Antacid Medication**

The percentage of prescriptions for antacids to reduce stomach or gastric acid (proton pump inhibitors or PPIs) that were filled with a generic PPI during the one-year measurement period.

**Generic Drugs - Antidepressants**

The percentage of prescriptions for antidepressant drugs (all second generation antidepressants) that were filled with a generic antidepressant during the one-year measurement period.

**Generic Drugs – Cholesterol-Lowering Drugs**

The percentage of prescriptions for cholesterol-lowering drugs (statins) that were filled with a generic statin during the one-year measurement period.

**Generic Drugs – Pain Relief**

The percentage of prescriptions for certain pain relief drugs (non-steroidal anti-inflammatory drugs or NSAIDs) that were filled with a generic NSAID during the one-year measurement period.

As shown above, on average our region achieves higher generic fill rates for antidepressants and pain relief drugs compared to antacid and cholesterol-lowering drugs. This pattern is consistent for the commercially-insured and Medicaid populations. Interestingly, the regional average for Medicaid is higher than the commercially-insured for antidepressants and pain relief, indicating larger percentages of these prescriptions for Medicaid are being filled with generic drugs. This could reflect the intense interest in more effectively managing costs for the Medicaid population. Even more striking is the wide range of performance among medical groups across both populations. There is also substantial overlap in the range of performance across the commercially-insured and Medicaid populations, generally indicating that both are equally likely to receive or not receive generic prescriptions. This variation suggests opportunities for improvement in generic fill rate and associated cost reduction across the region; such improvement involves an increase in prescribing of generics instead of brand-name drugs, plus patient education regarding why a generic drug may be the best option.

## Summary of Regional Findings

Table 1 below displays the regional average rate and the size of the denominator population (the “N”) for each measure by type of population or payer. The “Difference” column indicates the difference between the commercially-insured and the Medicaid average rates for each measure.

**Table 1: Regional Average Rates and Denominator Sizes by Payer Type and Measure**

Measure	Commercial		Medicaid		Rate Difference
	Rate	N	Rate	N	
Asthma - Use of Appropriate Medication	89%	8,516	81%	4,874	- 8%*
Depression – Antidepressant Medication (12 weeks)	71%	10,805	63%	2,967	- 8%*
Depression – Antidepressant Medication (6 months)	53%	10,805	43%	2,967	- 10%*
Diabetes – Blood Sugar (HbA1c) Test	87%	44,905	64%	16,500	- 23%*
Diabetes – Cholesterol Test	80%	44,905	55%	16,500	- 25%*
Diabetes – Eye Exam	63%	44,905	52%	16,500	- 11%*
Diabetes – Kidney Disease Screening	87%	44,905	81%	16,500	- 6%*
Heart Disease – Cholesterol Test	83%	9,294	53%	2,742	- 30%*
Heart Disease – Cholesterol-Lowering Medication	66%	13,600	65%	4,400	- 1%
Avoidance of Imaging for Low Back Pain	83%	20,208	87%	4,754	+4%*
Appropriate Use of Antibiotics – Common Cold	94%	19,742	94%	22,735	--
Appropriate Use of Antibiotics – Strep Test for a Sore Throat	73%	7,877	63%	5,688	- 10%*
Screening for Breast Cancer	72%	213,426	46%	31,833	- 26%*
Screening for Cervical Cancer	76%	248,088	61%	71,605	- 15%*
Screening for Chlamydia	39%	30,871	38%	20,129	- 1%
Screening for Colon Cancer for the Newly Eligible	39%	73,869	24%	8,427	- 15%*
Generic Drugs – Antacid Medication	54%	331,576	48%	165,709	- 6%*
Generic Drugs – Antidepressants	70%	324,794	85%	131,182	+15%*
Generic Drugs – Cholesterol-Lowering Medication	45%	464,133	39%	175,600	- 6%*
Generic Drugs – Pain Relief	88%	157,230	90%	109,349	+2%*

\*Indicates statistically significant result (p=.05)

As shown in Table 1 above, the Medicaid regional average rates are substantially below the commercially-insured regional average rates for the majority of measures. This data should spur important questions and discussions about why the differences exist and what can be learned from medical groups who are performing well, especially with the Medicaid population so that everyone in the region can improve. To start the discussion, the following observations are revealed from statistical comparisons between the regional average rates for the commercially-insured and Medicaid populations:

- For the majority of measures (14), the average rate for the commercially-insured population is higher than the average rate for Medicaid
- For three measures, the commercially-insured and Medicaid regional average rates appear to be the same (i.e., they overlap statistically):
  - Heart Disease – Cholesterol-Lowering Medication
  - Appropriate Use of Antibiotics for the Common Cold
  - Screening for Chlamydia
- For three measures, the Medicaid regional average rate exceeds the commercially-insured average rate in the region:
  - Avoidance of Imaging for Low Back Pain
  - Generic Drugs – Antidepressants
  - Generic Drugs – Pain Relief
- The commercially-insured and Medicaid regional average rates are farthest apart for the following measures:
  - Diabetes – Blood Sugar (HbA1c) Test
  - Diabetes – Cholesterol Test
  - Heart Disease – Cholesterol Test
  - Screening for Breast Cancer

Across measures, several themes emerge from these findings.

- First, results for the Medicaid population are relatively high when avoidance of inappropriate care is being measured. This could reflect specific interventions targeting these aspects of care (i.e., educational campaign about inappropriate antibiotic use), issues with access to care for the Medicaid population, or several other factors.
- Second, the measures in which the regional average rates for the commercially-insured and Medicaid populations are farthest apart rely on lab and radiology data to identify when the service has been provided to the patient (i.e., cholesterol test, blood sugar test and mammography). These services may require additional effort from the patient to

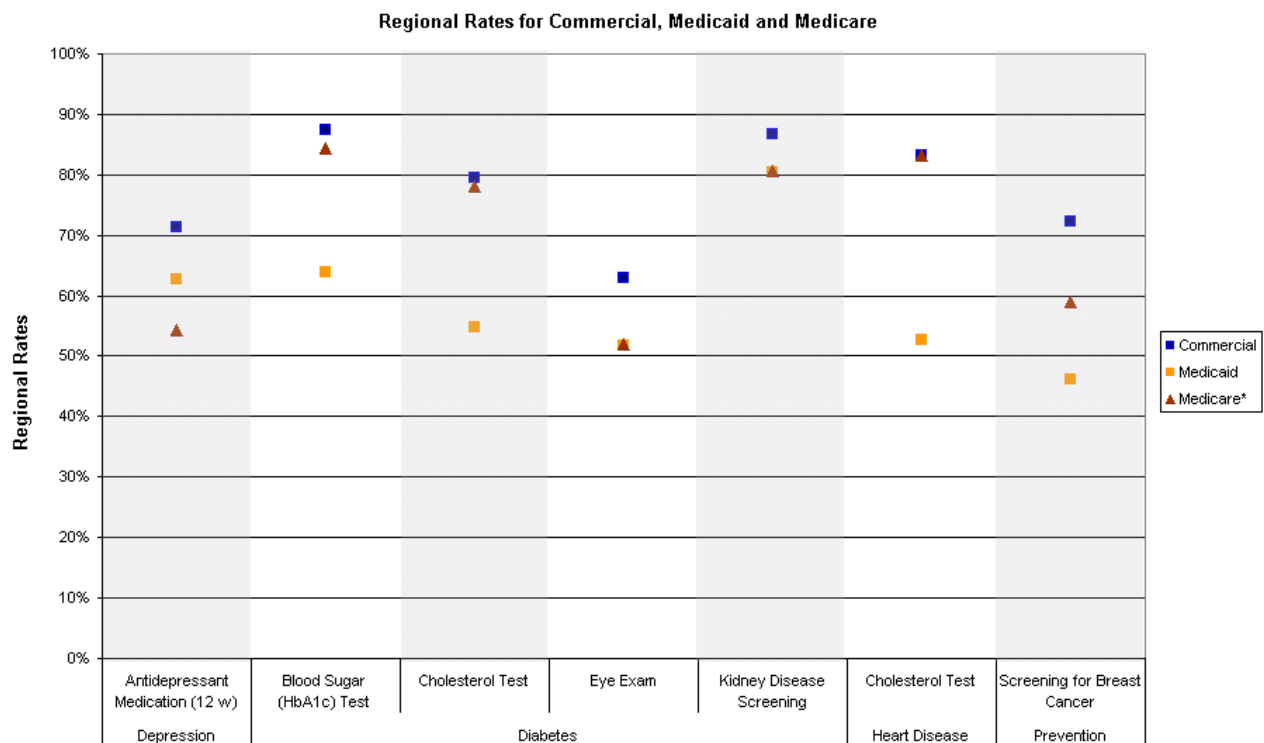
obtain the service or care – for example, go to a lab for a test or go to a separate clinic site for the mammogram. Medicaid results for these services could be lower due to issues of referral, access, patient compliance or data capture. Further analysis is required to determine the reasons for these noted differences.

- Third, for most measures there is substantial overlap in the range of medical group performance for the commercially-insured and Medicaid populations. In other words, for a given measure, the high and low points for the two populations tend to be in a similar place on the scale, and difference between the high and low rates tends to be similar (i.e., if the range from low to high is broad for Medicaid, it is likely broad for commercially-insured too). This report does not assess whether there are differences in care provided to each population within a given medical group; however, the overlap in ranges suggests that, overall, the two populations receive similar care across the region.
- Finally, the range of performance across both populations indicates substantial opportunity for improvement for everyone within our region. To put a finer point on it, the top result for each measure shows that it is possible for medical groups – with the involvement of patients, payers and purchasers – to achieve better results by learning from the medical groups who are achieving these top results now, then applying the lessons to improve the consistency with which effective care is provided and received in this region.

## Alliance Results Compared to Medicare Results

Data collected by the Alliance to calculate performance measures for care provided in medical groups does not currently include data about the Medicare population. However, performance measure results are available from the Centers for Medicare and Medicaid Services (CMS) for a limited set of measures based on Medicare fee-for-service claims. The measure definitions are based on HEDIS specifications as are many of the measures used in the *Community Checkup* report. Because of the differences in methodology used by CMS and by the Alliance, the results for Medicare should not be considered directly comparable but rather used as a reference point to guide interpretation.

The graph below presents regional averages for the commercially-insured, Medicaid and Medicare populations where we have measure results across all payer types. Note that the same methodology was applied to calculate the commercially-insured and Medicaid results, while the Medicare results were calculated and provided to the Alliance by CMS. Further, note that CMS calculates for Medicare only a subset of the measures that are included in the *Community Checkup* report, so not all measures have a result for Medicare.



\* Medicare results from CMS GEM project

As shown in the graph above, the Medicare regional average rate from CMS is within range of the commercially-insured and Medicaid regional average rates generated from the Alliance dataset. With the exception of the measure of Depression – Antidepressant Medication (12 weeks), the Medicare result is between the regional average results for the commercially-insured and Medicaid populations. The Medicare rate is most similar to regional average results for the commercially-insured populations for three measures: Diabetes – Blood Sugar (HbA1c) Test, Diabetes – Cholesterol Test, and Heart Disease Cholesterol Test. The regional average results for Medicare are most dissimilar for three measures: Depression – Antidepressant Medication (12 weeks), Diabetes – Eye Exam, and Screening for Breast Cancer.

## Medical Group Results by Population Type

In this section, we examine the effects of reporting by population type on the results associated with specific medical groups. We address how reporting by population type affects the number of measures for which there is sufficient data to include results in the public report (i.e., there must be data for at least 160 patients for a medical group result to appear in the report), and how aggregating or separating the data by population type affects the actual results associated with each medical group. Specifically, we ask the following questions:

- How does showing results by population type change the number of measures for which there are medical group results that can be included in the report?
- How does showing results by population type change the results for each measure?
- How does showing results by population type change the results associated with each medical group?

Each of these questions is addressed in detail below.

### Population Specific Reporting and the Number of Reportable Measures

Disaggregating data to calculate results by population type effectively imposes an additional minimum data threshold. Rather than data for 160 total patients per measure, the report will show a commercially-insured result for a medical group only if there is data for 160 commercially-insured patients for the measure *and* only show a Medicaid result for that medical group if there is data for 160 Medicaid patients for the measure. Therefore, it is important to consider the effect of population-specific reporting on the number of measures for which there are results that meet this minimum data size test for each medical group. If the affect is to significantly reduce the number of measures for which results can be publicly shared, reporting by population type would lead to a loss of information available to all stakeholders in the community.

Table 2 below displays the effect of population type reporting on the number of results that can be reported for each of the medical groups included in the *Community Checkup* report. The first column displays the number of reportable results when commercially-insured and Medicaid data are combined, the next three columns display the number of reportable results when commercially-insured and Medicaid results are calculated and reported separately. The final column displays the net effect of reporting the results separately by population type. Readers should note that fifteen is the maximum number of measures reportable at the medical group level.

**Table 2: Effect of Population-Specific Reporting on the Number Of Reportable Measures by Medical Group**

Medical Group	Number of Reportable Results				Net Effect
	Commercial + Medicaid Combined	Population Type Reporting			
		Commercial Only	Medicaid Only	Total	
Birth and Family Clinic	4	3	0	3	-1
Evergreen Medical Group	15	13	2	15	0
Franciscan Medical Group	15	15	14	29	+14
Group Health Cooperative	15	15	14	29	+14
Hall Health Primary Care Center	7	3	1	4	-3
Harborview Medical Center	11	1	10	11	0
Highline Medical Group	11	8	6	14	+3
International Community Health Services	7	2	7	9	+2
Kitsap Children's Clinic, LLP	1	0	1	1	0
Lakeshore Clinic PLLC	8	8	0	8	0
Minor & James Medical, PLLC	11	11	2	13	+2
MultiCare	15	14	10	24	+9
Neighborcare Health	13	6	10	16	+3
Northwest Asthma & Allergy Center	1	1	1	2	+1
Northwest Physicians Network	15	14	12	26	+11
Olympia Obstetrics & Gynecology	2	2	0	2	0
Olympia Pediatrics, LLC	1	1	0	1	0
Overlake Internal Medicine Associates	8	8	0	8	0
Overlake Obstetricians and Gynecologists	2	2	0	2	0
Pacific Medical Centers	13	8	7	15	+2
Pediatric Associates	3	3	0	3	0
Planned Parenthood of Western Washington	3	3	2	5	+2
Proliance Surgeons Inc PS	1	1	0	1	0
Providence Physicians Group	15	15	8	23	+8
Puget Sound Family Physicians	14	14	2	16	+2
Renton Pediatric Associates	1	1	1	2	+1
Sea-Mar Community Health Center	9	0	9	9	0
Seattle Ob/GYN Group	2	2	0	2	0
Sound Family Medicine	11	8	3	11	0
Sound Women's Care	3	2	1	3	0
Southlake Clinic, Inc., P.S.	8	8	0	8	0

Medical Group	Number of Reportable Results				Net Effect
	Commercial + Medicaid Combined	Population Type Reporting			
		Commercial Only	Medicaid Only	Total	
Summit View Clinic, Inc., P.S.	7	6	0	6	-1
Swedish Physician Division	15	15	8	23	+8
The Doctors Clinic	11	9	3	12	+1
The Everett Clinic	15	15	11	26	+11
The Polyclinic	14	14	1	15	+1
University of Washington Medical Center	14	13	11	24	+10
UW Medicine Neighborhood Clinics	14	12	6	18	+4
Valley Children's Clinic	2	2	1	3	+1
Valley Medical Center	13	12	8	20	+7
Virginia Mason	15	15	6	21	+6
Western WA Medical Group	8	8	4	12	+4
Womens & Family Health Specialists	3	3	0	3	0
Woodcreek Pediatrics	6	4	2	6	0
Woodinville Pediatrics	2	2	0	2	0
Yelm Family Medicine, PLLC	2	2	1	3	+1
<b>Summary across medical groups:</b>	<b>386</b>	<b>324</b>	<b>185</b>	<b>509</b>	<b>+123</b>

Table 2 above shows that the overall effect of reporting results by population type adds 123 results, across all of the medical groups, which can be included in the *Community Checkup* report. Interestingly, there is a decline in the number of reportable results for only three medical groups – Birth and Family Clinic, Hall Health Primary Care Center and Summit View Clinic – while the number of results to be reported will increase for 25 medical groups. Additionally, for 18 medical groups there is no change in the number of results that will be included in the public report. The five medical groups with the largest increase in number of reportable results are the Franciscan Medical Group, Group Health Cooperative, Northwest Physicians Network, The Everett Clinic and University of Washington Medical Center.

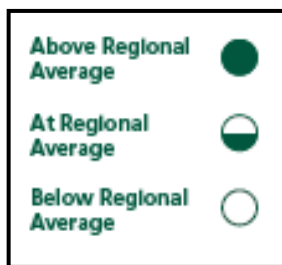
Table 2 also provides insights about the patient population data mix, by medical group, that meets each measure specification in the Alliance’s multi-payer dataset. For example, aggregated data in the Alliance’s dataset for Harborview Medical Center meets thresholds for 11 measures, but when the results are calculated by population type, there is sufficient data to report a result for the commercially-insured population for only one measure and there is enough Medicaid data to report results for ten measures. Similarly, there is only sufficient data to report results for Sea-Mar for the Medicaid population. This analysis indicates that, given the Alliance’s dataset and measures, the performance of these two medical groups is almost exclusively driven

by care delivered to the Medicaid population. The International Community Health Services and Neighborcare Health medical groups display the same pattern although it is less pronounced.

Based on the information in Table 2, reporting performance results by population type expands the number of reportable results and therefore presents a significant gain in transparency of health care performance information for medical groups, patients, health plans, purchasers and all other stakeholders in the Puget Sound region.

## Population Specific Reporting and Results by Measure

To examine the effect of population specific reporting on the results for each measure, we assessed how medical group results changed when the data were reported separately for the commercially-insured and Medicaid populations. The Alliance’s *Community Checkup* report includes performance results for medical groups for each measure, and also a symbol indicating whether the performance range (i.e., numeric result and the associated confidence interval) for a medical group on a given measure is above, at, or below the regional average result. The symbol used for each result is based on a statistical comparison to the regional average. The symbols are important, as many readers of the *Community Checkup* use them to quickly assess differences in care for each medical group. The three symbols used in the *Community Checkup* report are:



The filled circle means that the rate (the full range from lower to upper confidence bounds) for a medical group is entirely above the regional average rate. The open circle means that the rate for the medical group is entirely below the regional average rate. The half-filled circle is used when the rate for a medical group has a range that overlaps with the regional average rate.

To examine how these symbols would change for each medical group if we were to show results by population type in the *Community Checkup* report, we asked the following question: Starting with the symbols assigned to medical groups when results are calculated using aggregated data (commercially-insured plus Medicaid), how do the symbol assignments change when we report results separately for the commercially-insured and Medicaid populations? In other words, when the report results are calculated separately by population, how do the rating symbols change for each medical group for each measure?

Table 3 displays how the symbol assignments change by measure when we report the results separately for each population. The table presents the number of groups whose symbols improve, worsen or stay the same (no change) for particular measures. For example, for the measure of Diabetes – Blood Sugar (HbA1c) Test, reporting separately by population type resulted in 12 groups receiving lower symbol – either moving from “Above Average” to “Average” or from “Average” to “Below Average.” Twelve medical groups had no change in their symbol. For the Medicaid population, eight medical groups would receive an improved symbol and for eight groups there was no change in the symbol.

**Table 3: Effect of Population Type Reporting on Results by Measure**

Condition	Measure	Commercially-Insured Only			Medicaid Only		
		Symbol Improves	No Change	Symbol Worsens	Symbol Improves	No Change	Symbol Worsens
Diabetes	Blood Sugar (HbA1c) Test	1	12	12	8	8	2
	Eye Exam	1	22	2	7	10	1
	Cholesterol Test	0	17	8	6	10	2
	Kidney Disease Screening	0	22	3	7	7	4
Heart Disease	Cholesterol Test	0	11	5	2	0	0
	Cholesterol-Lowering Medication	0	16	2	0	5	0
Appropriate Use of Antibiotics	Common Cold	1	17	0	2	16	3
	Strep Test for a Sore Throat	0	8	2	0	3	1
Depression	Antidepressant Medication (12 weeks)	0	14	0	0	2	0
	Antidepressant Medication (6 months)	0	13	1	0	2	0
Low Back Pain	Avoidance of X-ray, MRI and CT Scan	1	20	0	0	5	3
Prevention	Screening for Breast Cancer	3	28	4	9	8	3
	Screening for Cervical Cancer	0	29	8	9	11	7
	Screening for Chlamydia	1	21	4	5	7	1
Asthma	Use of Appropriate Medication	0	9	6	1	8	0

**Note:** The generic prescribing measures and the colorectal cancer screening measure are excluded from this table because they are reported at the regional level only.

As displayed in Table 3, reporting results separately for commercially-insured and Medicaid will affect the symbols that appear in the report for some medical groups, and the magnitude of the

effect varies by measure. When reported separately by population, per measure, more groups will receive a lower symbol in the commercially-insured category versus the symbol they would be assigned if results were only calculated based on aggregated data. This may be due to the regional average being higher when just considering the commercially-insured population data so the medical group results are compared to that higher average to determine the symbols.

For Medicaid, the effect is mixed, with many symbols improving and some worsening for each measure. The measures most affected by reporting by population type are the four diabetes measures and the preventive screening measures. This finding is consistent with our earlier observation that the average results for commercially-insured and Medicaid populations are furthest apart for two of the diabetes measures and the breast cancer screening measure. The measures for which the symbols will change the least if the results are reported by population type are Heart Disease – Cholesterol-Lowering Medication, both depression measures, and Appropriate Use of Antibiotics – Strep Test for a Sore Throat.

## Population Type Reporting and Medical Group Results

To assess the effect of reporting by population on medical group results, we examined how symbol assignments would change for each medical group. Again we started with the symbols associated with results calculated using the aggregated data and then noted what happens to the symbol assignment when results are calculated separately for the commercially-insured and the Medicaid populations. Table 4 presents the change in symbol assignments across all measures for each medical group. Note that the table below includes only measures for which the medical group has sufficient data (160 patients in the denominator for that measure) to be included in public report. Medical groups with larger numbers in the “no change” column exhibit the least change in their results while medical groups with larger numbers in either the “improves” or “worsens” column exhibit the greatest change when moving to reporting by population type.

**Table 4: Effect of Population Type Reporting on Symbols for Medical Groups**

Medical Group	Commercially-Insured Only			Medicaid Only		
	Symbol Improves	No Change	Symbol Worsens	Symbol Improves	No Change	Symbol Worsens
Birth and Family Clinic	0	3	0	0	0	0
Evergreen Medical Group	0	11	2	0	2	0
Franciscan Medical Group	1	11	3	3	11	0
Group Health Cooperative	0	12	3	0	6	8
Hall Health Primary Care Center	0	2	1	0	0	1
Harborview Medical Center	0	1	0	6	4	0
Highline Medical Group	0	6	2	3	3	0
International Community Health Services	0	1	1	1	6	0
Kitsap Children's Clinic, LLP	0	0	0	0	1	0
Lakeshore Clinic PLLC	0	5	3	0	0	0
Minor & James Medical, PLLC	0	7	4	0	0	2
MultiCare	0	13	1	3	6	1
Neighborcare Health	1	5	0	7	2	1
Northwest Asthma & Allergy Center	0	1	0	0	1	0
Northwest Physicians Network	1	11	2	4	8	0
Olympia Obstetrics & Gynecology	0	2	0	0	0	0
Olympia Pediatrics, LLC	1	0	0	0	0	0
Overlake Internal Medicine Associates	0	5	3	0	0	0
Overlake Obstetricians and Gynecologists	0	2	0	0	0	0
Pacific Medical Centers	1	6	1	2	3	2
Pediatric Associates	0	3	0	0	0	0
Planned Parenthood of Western	1	1	1	0	2	0

Medical Group	Commercially-Insured Only			Medicaid Only		
	Symbol Improves	No Change	Symbol Worsens	Symbol Improves	No Change	Symbol Worsens
Washington						
Proliance Surgeons Inc, PS	0	1	0	0	0	0
Providence Physicians Group	0	12	3	4	4	0
Puget Sound Family Physicians	0	11	3	0	1	1
Renton Pediatric Associates	0	1	0	0	1	0
Sea-Mar Community Health Center	0	0	0	6	2	1
Seattle Ob/GYN Group	0	2	0	0	0	0
Sound Family Medicine	0	6	2	1	2	0
Sound Women's Care	0	2	0	0	1	0
Southlake Clinic, Inc., P.S.	0	5	3	0	0	0
Summit View Clinic, Inc., P.S.	0	3	3	0	0	0
Swedish Physician Division	1	13	1	1	5	2
The Doctors Clinic	0	9	0	0	3	0
The Everett Clinic	0	11	4	1	5	5
The Polyclinic	0	9	5	0	0	1
UW Medical Center	1	12	0	5	6	0
UW Medicine Neighborhood Clinics	0	10	2	2	4	0
Valley Children's Clinic	0	2	0	0	1	0
Valley Medical Center	0	12	0	5	3	0
Virginia Mason	0	11	4	1	4	1
Western WA Medical Group	0	8	0	0	4	0
Womens & Family Health Specialists	0	3	0	0	0	0
Woodcreek Pediatrics	0	4	0	0	1	1
Woodinville Pediatrics	0	2	0	0	0	0
Yelm Family Medicine, PLLC	0	2	0	1	0	0

As shown in Table 4, we found a wide range of effect of population type reporting on medical group results and related symbols. For thirteen medical groups, there would be no change in

their symbols when reporting results by population type. For the commercially-insured results, population specific reporting is more likely to worsen the symbols overall, but the change is relatively moderate. Specifically, three medical groups would receive 4 or 5 negative changes in symbol assignment: The Polyclinic, Minor & James Medical and The Everett Clinic. This could potentially be explained by fact that when Medicaid data is removed, the regional average for the commercially-insured population goes up, thereby 'raising the bar' for a medical group to earn an 'above average' symbol because it is based on a comparison to the regional average.

When calculating results for the Medicaid population only, there is a more significant impact on the medical group symbols. Five medical groups experience substantial improvement in their symbols, with five or more improved symbols and one or no symbols that get worse: Neighborcare Health, Harborview Medical Center, Sea-Mar Community Health Center, UW Medical Center, and Valley Medical Center. Additionally, two medical groups display a substantial worsening of their symbols: Group Health Cooperative and The Everett Clinic.

While the positive effect on results for groups treating larger populations of Medicaid clients was expected, the negative effect was unanticipated and bears further scrutiny. Both Group Health Cooperative and The Everett Clinic treat a sufficient number of Medicaid patients to report results for most measures but both also treat many more commercially-insured patients than Medicaid patients. Both medical groups also operate urgent care clinics which could be a factor in their results. If Medicaid patients with emergent conditions access urgent care at these clinics for treatment but are not ongoing patients of these clinics, it could negatively affect their results for these measures. This finding warrants further investigation into the contributing factors.

## Findings and Recommendations

The examination of the *Community Checkup* report performance measure results separately by the Medicaid and commercially-insured populations has revealed several important findings and recommendations that are described below.

### Key Findings:

- For most measures, the regional average results differ by population type, with the average for the commercially-insured population being higher than Medicaid results
- There are a number of measures (6) for which the regional average results for the Medicaid population are comparable to or higher than the commercially-insured results
- For most measures, there is substantial overlap in the range of medical group performance – both where the range appears on the scale (high, mid or low) and the size of the range (small or large) – for the commercially-insured and Medicaid populations, suggesting that overall the two populations receive similar care across the region.
- Regional average results, both within and across the Medicaid and commercially-insured populations, display substantial variation in health care performance indicating opportunities for improvement in every aspect of care that is measured and for both populations
- Results across the region are most dissimilar between the commercially-insured and Medicaid populations on the measures that require lab and radiology services; this issue warrants further investigation
- The *Community Checkup* results are consistent with Medicare results on comparable measures that are calculated by the Centers for Medicare and Medicaid Services (CMS)
- Reporting results separately by Medicaid and the commercially-insured populations significantly increases the number of measures for which there are medical group results that can be shared with the public in the *Community Checkup* report
- Reporting separately by Medicaid and the commercially-insured populations affects the reported results differently for each measure, with the largest effect on the diabetes and preventive measures
- Reporting separately by Medicaid and the commercially-insured populations affects the results differently for each medical group, based on the number of commercially-insured and Medicaid patients attributed to the particular medical group. Several medical groups emerge with relatively large populations of Medicaid clients in their results. Not

surprisingly, results for these medical groups change the most when results are reported separately by population type.

In many ways, our findings confirm expectations – namely that medical group level results for the Medicaid population differ from commercially-insured population results. This finding is consistent with what has been observed when we report these performance measures at the health plan level. A related finding is that reporting separately by population type significantly increases the amount of comparative information available to the community – results by medical group for each of the two populations versus one set of medical group results for the both population types combined. This analysis also demonstrates that in most cases, the commercially-insured and Medicaid populations receive similar care overall, and that there are medical groups in our region that perform very well in delivering quality care to the Medicaid population. Lastly, our report identifies issues for further inquiry including the need to explore the completeness of lab and radiology data for the Medicaid population, and to further explore the reasons for some of the differences in results presented in this report. As a result of this analysis, we recommend the following:

- Given the varying effects of reporting results separately by population type, future *Community Checkup* reports will incorporate population-specific results in addition to continuing to show results for the aggregated dataset.
- Given the overrepresentation of communities of color in the Medicaid population, this report can be used as a first look at measuring health care disparities in this region. We are committed to working with everyone across the community to achieve health equity.
- Everyone must work on doing their part to improve the results, because everyone - regardless of patient population or type of coverage – has room to improve.
- Given that there are high performers for the commercially-insured and the Medicaid populations, medical groups can learn from each other about promising practices to improve results for all patients in the community.
- Given the challenges of treating the Medicaid population, medical groups that perform well with this population will be recognized by the Alliance for their good work. Highlighting the services or approaches taken by medical groups that perform well with the Medicaid population will allow others to learn from their successes.
- Everyone has a role to play in improving health and health care– the health care system is complex and no single doctor, clinic, patient, health plan, employer or union can fix the problems *alone*.
  - We all need to align our efforts and do our part to achieve a state-of-the art health care system that provides better care at a more affordable cost for everyone.

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