

2013

2013 Statewide Executive Summary of Managed Care in New York State

A Report on Quality Performance by Type of Health Insurance Product

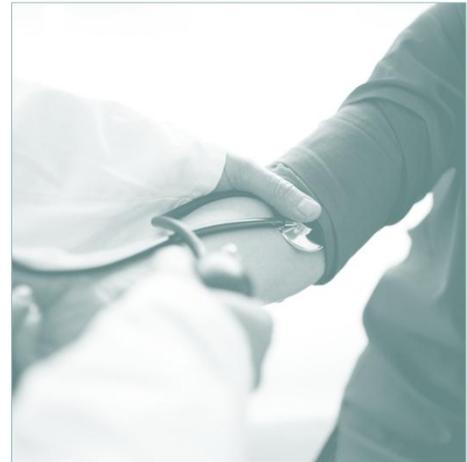


Table of Contents

Chapter 1	Executive Summary /Overview	page 2
Chapter 2	Managed Care Plan Information	page 7
Chapter 3	Provider Network	page 10
Chapter 4	Child & Adolescent Health	page 13
Chapter 5	Women’s Health	page 19
Chapter 6	Adult Health	page 24
Chapter 7	Behavioral Health	page 31
Chapter 8	Satisfaction with Care	page 35
Chapter 9	Access to Care	page 34
Chapter 10	Statewide Trends and National Benchmarks	page 42

Chapter 1: Executive Summary

In 2012, there were an estimated 16.8 million people under the age of 65 living in New York. This report covers the quality of care for approximately 12 million people receiving health insurance through a managed care plan or a preferred provider organization. This is the first in a series of reports that examines 2013 Managed Care Performance. The results of this report demonstrate the continuing commitment of New York State's health plans and providers to provide high quality health care.



National Comparison

The latest results indicate the quality of care provided by New York State health plans is consistently meeting or exceeding national averages. Measures of health care quality for children and adolescents, such as immunizations, well-child visits, and follow-up care for children with Attention Deficit Hyperactive Disorder exceeded national averages. New York State managed care plans also surpassed national benchmarks in follow-up after hospitalization for mental illness, and several women's preventive care measures such as breast cancer, cervical cancer, and *Chlamydia* screening.

Medicaid Performance

When comparing performance among types of insurance within New York State, Medicaid performance results match or exceed commercial results for over 65 percent of all measures, and differences between Medicaid and Commercial Managed Care Plans has continued to diminish in numerous areas of care including: preventive care, prenatal care, women's health, and care for people with chronic conditions. In comparison, Medicaid plans nationally match or exceed their commercial counterparts only 30 percent of the time. Further, a recent State of Health Care Quality report published by the National Committee for Quality Assurance (NCQA) notes that the quality of New York's Medicaid product continues to increase with rates matching or exceeding national benchmarks for over 80 percent of all measures.

Highlights

Improvement in assessment of body weight

Obesity and overweight are currently the second leading, preventable cause of death nationally. Health care to treat obesity-related conditions and illnesses cost the United States an estimated \$150 billion and New York State more than \$7.6 billion every year. An important first step in addressing the obesity epidemic is being assessed for weight issues. This year (2012) the rate for adults with an outpatient visit who had their body mass index (BMI) documented saw major improvements across all types of insurance.

Chapter 1: Executive Summary

Seventy-nine percent of Medicaid, 70 percent of commercial HMO, and 65 percent of commercial PPO adults had their BMI percentile measured and documented by their provider. These rates represent 9, 14, and 39 respective point increases from the 2010 rates for these measures.

Improvement in satisfaction

Results from the most recent Consumer Assessment of Healthcare Providers and Systems CAHPS® survey reflect high levels of satisfaction for parents of children in Medicaid managed care and in Child Health Plus. Member satisfaction collected through CAHPS® is included in the core set of measures reported by states to the Centers for Medicare & Medicaid Services (CMS) as part of the Children's Health Insurance Program Reauthorization Act (CHIPRA). Additional information about the experience of care for children with chronic conditions was also gathered using this tool.

Improvement Opportunities

Despite many gains in the quality of health care in New York State, opportunities for improvement still exist. While disparities between the care received under commercial and Medicaid plans continue to shrink, there remain areas where quality care for Medicaid recipients is lower than those who are commercially insured, particularly the control of chronic conditions. There are also areas where the quality of care needs to be improved for all New Yorkers regardless of insurance type, including Chronic Obstructive Pulmonary Disease and asthma care. Despite being a recommendation of the U.S. Preventive Services Task Force, only 53% of the people living with COPD have had recommended lung function testing to assess their disease in the last year. Asthma also remains a major public health concern--ranking within the top ten prevalent conditions causing limitation of activity. It is estimated that asthma costs our nation \$16.1 billion in health care annually. One in every twelve adults and one in every nine children currently has asthma in NYS. Only half of all children in New York State with persistent asthma receive appropriate controller medications, which indicates a clear opportunity for better medication management of this disease.

Uses of the data

This report is intended to be used for informational purposes by the public, health plans, and policy makers interested in learning about how New York State managed care plans are measuring and improving the quality of health care in the state. It is designed to be a high level summary of results from a statewide perspective. It will allow plans and purchasers of health care to gauge New York State performance against national benchmarks. This report also supports the department's mission to increase transparency of health care quality, and can be used to help drive better outcomes for all. Data will also be collected for all qualified health plans operating in the NY State of Health- Official Health Plan Marketplace, allowing comparison across all managed care products offered to New Yorkers beginning in 2015.

Chapter 1: Executive Summary

Quality Measurement in New York State

As a way of monitoring managed care plan performance and improving the quality of care provided to New York State residents, the New York State Department of Health (NYSDOH) implemented a public reporting system in 1994 called the Quality Assurance Reporting Requirements (QARR). In 2008, the requirements were expanded to include preferred provider organizations. In 2015 data will begin to be collected for qualified health plans in the NY State of Health Official Health Plan Marketplace. QARR is largely based on measures of quality established by the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®). QARR also includes information collected using a national satisfaction survey methodology called CAHPS® (Consumer Assessment of Healthcare Providers and Systems). CAHPS data are collected every year for commercial adult enrollees. The NYSDOH sponsors a CAHPS survey for Medicaid managed care adult and child enrollees alternating every other year. The most recent survey was completed in 2012 and was specific to child enrollees in Medicaid and Child Health Medicaid Plus.



The Data Source and Year

This report contains results from standardized quality of care measures, consumer satisfaction surveys, and information about providers in the plans' networks. Health plans have their information validated by a licensed audit organization prior to sending it to the NYSDOH. The data presented in this report are largely from care provided to members during the 2012 calendar year.

The focus of the Statewide Managed Care Performance Report is to briefly highlight quality achievements, compare New York State results to national benchmarks, track performance over time, and identify areas for quality improvement. The data presented in this report represent a subset of all of the measures collected as a part of QARR. For more information on additional measures not covered in this report, please reference the resources listed under "Other Department of Health reports and websites" below.

New Measures

Establishment of standardized, evidence-based, metrics provides a significant opportunity to examine the quality of care across populations, as well as, highlight areas for improvement and help identify members at risk for adverse outcomes.

Chapter 1: Executive Summary

This year, the following new measures were added to the HEDIS measurement set: Human Papillomavirus (HPV) Vaccine for Female Adolescents; Asthma Medication Ratio; Continuity of Antipsychotic Medications for Treatment of Schizophrenia; Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications; Diabetes Monitoring for People With Diabetes and Schizophrenia; and Cardiovascular Health Monitoring for People With Cardiovascular Disease and Schizophrenia. First year measures are only released in aggregate and can be found in the corresponding sections of this report.

Statewide Trends and National Benchmarks

Tables presenting New York's performance over time are included in the trends section at the end of this report. Because of changes in measure specifications, not all measures are included. When available, commercial and Medicaid benchmarks are obtained from the NCQA's State of Healthcare Quality Report, available online at <http://www.ncqa.org>. Benchmarks are not available for NYS specific measures or for those measures with definitions that differ from HEDIS. There are currently no available national benchmarks for Child Health Plus or HIV SNP health plans.

Other Department of Health Reports and Websites

Managed Care plan performance, and related data is available electronically. All reports described below are available on the Department's website at <http://www.nyhealth.gov>.

eQARR

Looking for detailed health plan performance information? Detailed information on the performance of health plans contributing to this report is available on the Department's website as an interactive report card for health care consumers. eQARR consists of web pages with results for related measures presented in tables. The tables are categorized by domains of adult health, behavioral health, care for children and adolescents, provider network, satisfaction, and women's health care. Commercial HMO, Commercial PPO, Medicaid, and Child Health Plus data are all available on eQARR.

Consumer Guides

Looking to choose a health plan? The consumer guides contain summarized information on quality and satisfaction ratings in a condensed, user-friendly format for people evaluating the quality of health plans. Guides for 2013 are available for six regions of the state: New York City, Long Island, Hudson Valley, Northeast, Central, and Western New York. Guides for Medicaid, Commercial HMO, Commercial PPO, and Child Health Plus enrollees can all be obtained free of charge at the Department's website.

Chapter 1: Executive Summary

Health Plan Service Use in New York State

Looking for utilization information? The 2013 Health Plan Service Use in New York State Report presents additional information on access and utilization of certain services. Acute inpatient utilization, potentially preventable hospitalization, and readmission data are contained in this report. This report includes data on Commercial HMO, Commercial PPO, Medicaid and Child Health Plus members' access to care for children and adults, use of hospitals and ERs, rates of various surgical procedures, and rates of antibiotic utilization.

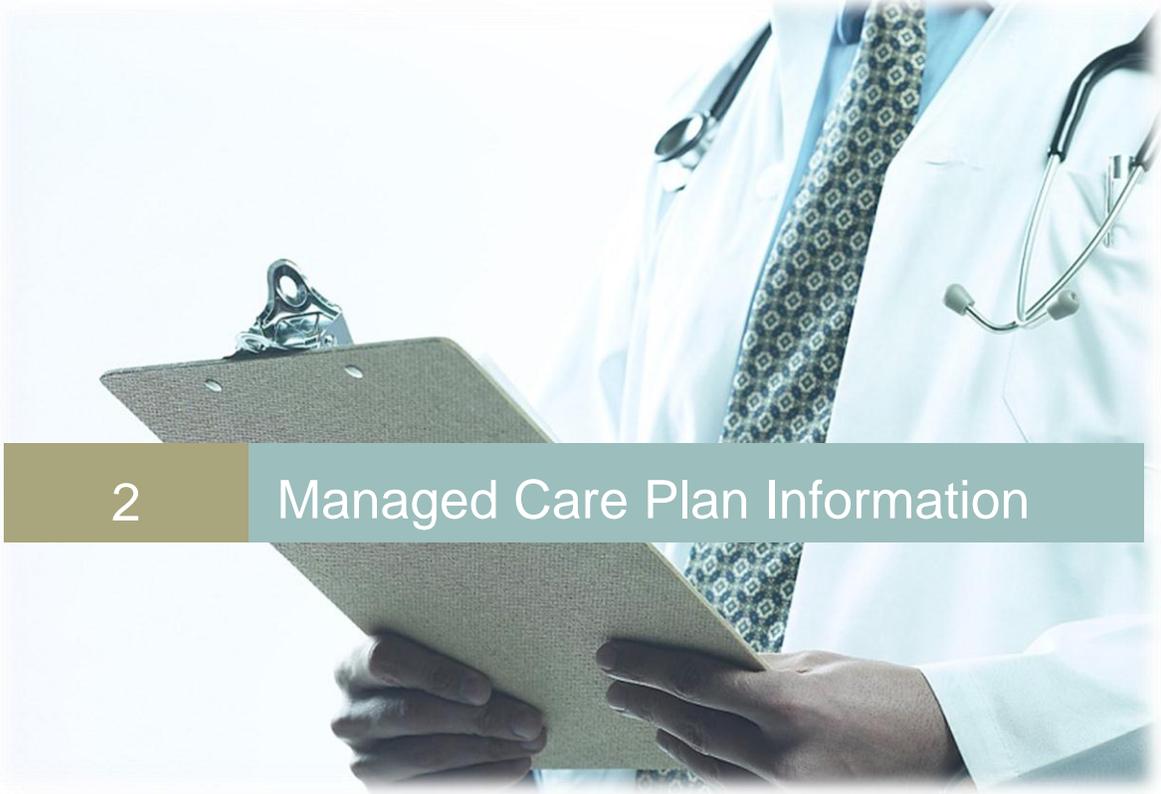
Healthcare Disparities in Medicaid Managed Care

Looking for disparities in healthcare quality? The 2013 report provides information about variation in quality of care received by select demographic characteristics such as gender, age, race/ethnicity, aid category, mental health status, and region. The report contains Medicaid managed care and Child Health Plus data only.

Feedback

We welcome suggestions and comments on this publication. Please contact us at:

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2

Managed Care Plan Information

Chapter 2: Managed Care Plan Information

Types of Insurance

Information on five types of managed care plans is included in this report.

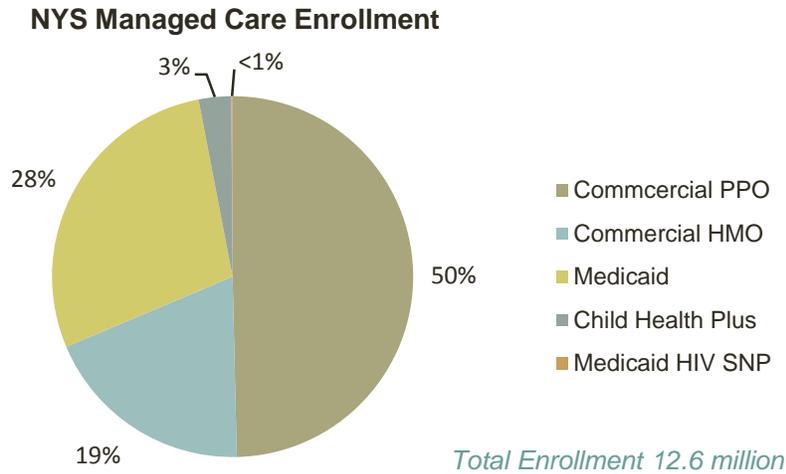
Insurance Type	Description	Number of Health Plans Operating in NYS
Commercial HMO	Individual or employer sponsored health insurance. This is a form of health insurance where a health plan contracts with a network of providers to provide care; the member selects a primary care provider to coordinate care; and referrals to some services or specialists may be required.	11
Commercial PPO	Individual or employer sponsored health insurance. This is a form of health insurance where a health plan contracts with a network of providers to provide care; there is no primary care provider assignment; and referrals to some services or specialists are not usually required.	10
Medicaid	Government sponsored health insurance. This is a form of health insurance where a health plan contracts with a network of providers to provide care; the member selects a primary care provider to coordinate care; and referrals to some services or specialists may be required. This includes people who are eligible for Medicaid managed care and Family Health Plus (NYS's expansion program for adults age 19 and older).	17
Child Health Plus	Government sponsored health insurance, although individuals may pay part of premium for some eligibility levels. This is a form of health insurance where a health plan contracts with a network of providers to provide care; the member selects a primary care provider to coordinate care; and referrals to some services or specialists may be required. This is NYS's version of the federal State Children's Health Insurance Program (SCHIP) for people up to age 19.	18
HIV SNP	Government sponsored health insurance. This is a specific form of Medicaid coverage for persons living with HIV/AIDS. The SNP contracts with a network of providers to coordinate medical care; access to other services important for the care of HIV/AIDS, such as substance abuse counselors, and social service coordinators may also be part of the SNP.	3

For more information about the health plans serving New York State residents see eQARR and the Managed Care Regional Consumer guides available on the Department's website at <http://www.health.ny.gov>.

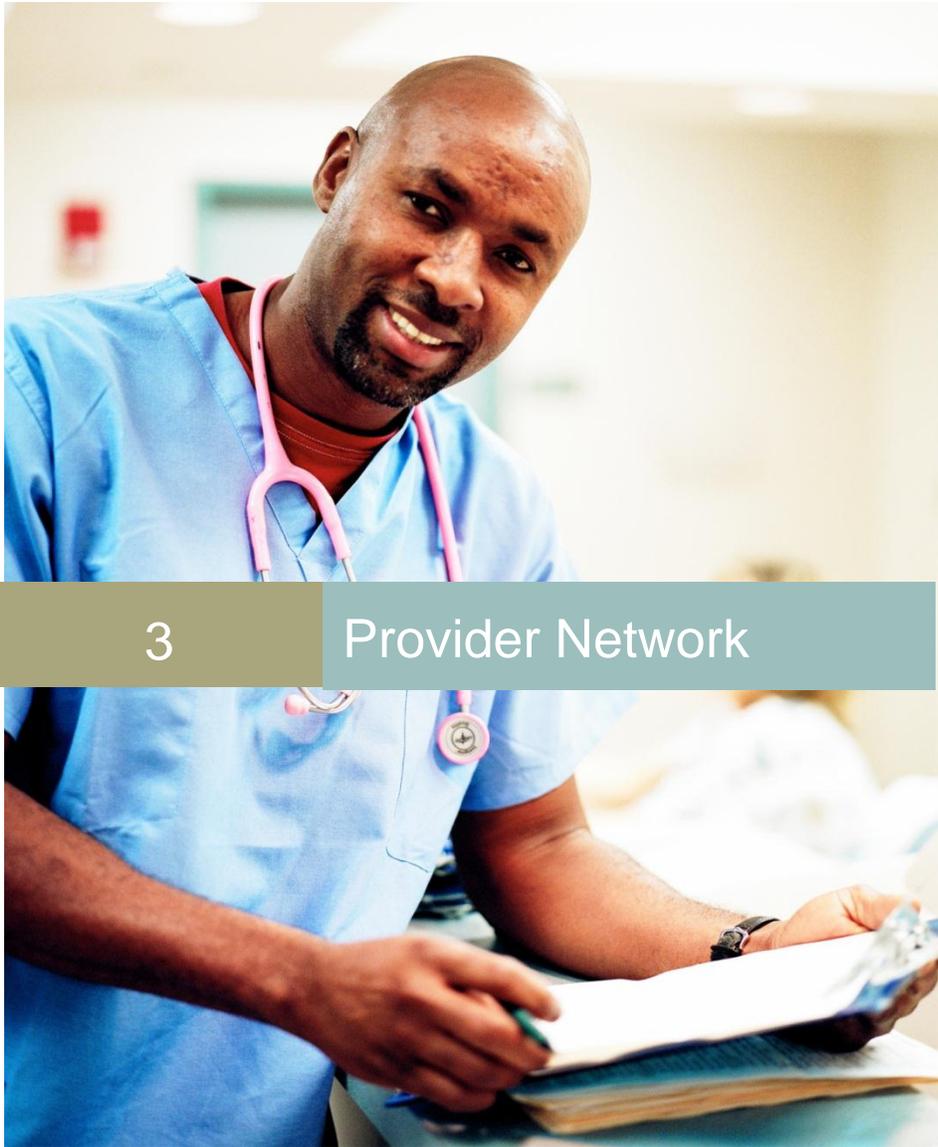
Chapter 2: Managed Care Plan Information

Managed Care Enrollment

Out of the 16.8 million people, under the age of 65, living in New York State, this report covers the quality of care for approximately 12 million receiving their health insurance through a managed care plan or a preferred provider organization.



Note: The total number of enrollees in the health plan as of December 31, 2012. While this report presents quality of care data for commercial, Medicaid, and Child Health Plus enrollees, plans may also have membership in other products. The enrollment figures presented here include membership in all products that are included in QARR measures. Commercial membership may include Health Maintenance Organization (HMO), and Point of Service (POS) members and some PPO membership if the health plan reports as combined. Total may not sum to 100.



3

Provider Network

Chapter 3 Provider Network

New York State collects information on health plans' provider networks and how consumers feel about the care they receive from their providers. Measures also include board certification rates for several physician specialties as established by various medical boards based on education, experience, and clinical and/or written testing.

Satisfaction with Personal Doctor or Specialist

Satisfaction with personal doctors and with specialists are questions asked in satisfaction surveys. A personal doctor is the healthcare provider a person uses for their routine health care needs, such as a check-up, while a specialist is a healthcare provider who focuses on this one area of health care whom a person would see for a specific problem. The percentage of members responding 8, 9, or 10 (on a scale of 0 to 10, where 0 is the worst possible doctor and 10 is the best possible doctor) when asked, "How would you rate your personal doctor?" Or "How would you rate the specialist seen most often?"

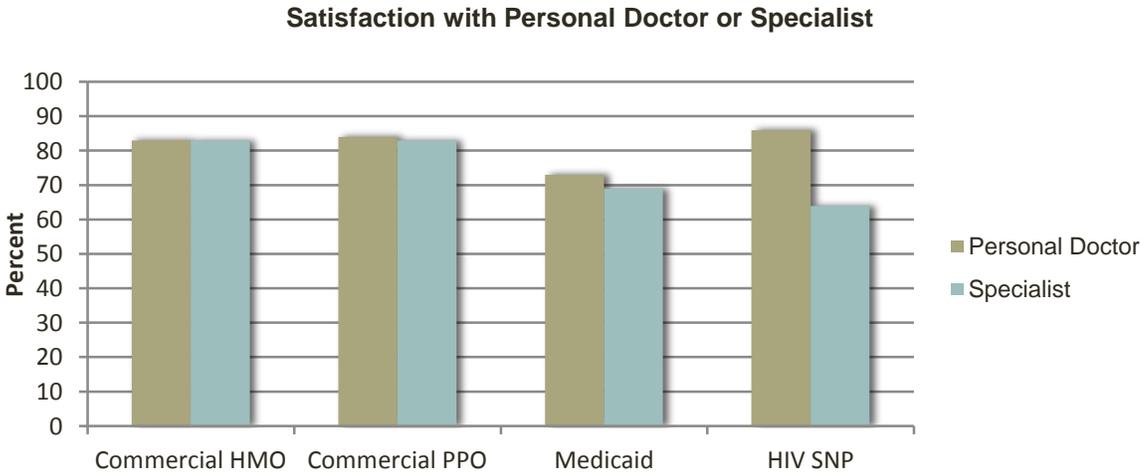
Why is Patient Satisfaction with Providers Important?

- There is a growing demand among patients for an enhanced service experience and greater participation in their health care.

Highlights

- Satisfaction with providers (personal doctors and specialists) is high for both commercial (HMO and PPO) members.
- Members of Medicaid and HIV SNP health plans surveyed are less satisfied with their specialists than with their personal doctors.

Satisfaction with Personal Doctor or Specialist



Chapter 3 Provider Network

Improvement opportunities

- Survey results suggest that there is room for improvement in the following: Keeping up-to-date provider directory information to allow members to search for providers by location and specialty.
- Survey results can also be used by health plans to define qualitative characteristics of personal doctors and specialists that are associated with member dissatisfaction to help direct improvement activities.

Did you know?



A patient-centered medical home model of care has been endorsed by NCQA as a way to improve access, care coordination, clinical quality, and the patient experience.



In New York, Medicaid plans have the most NQCA-recognized Patient-Centered Medical Homes (PCMHs) of any state -- and twice the number of PCMH sites and clinicians of the number 2 state.



Overall, 39 percent of Medicaid patients have an assigned PCP in a PCMH certified practice, which improves the delivery of primary care, including increased care coordination and access.



4

Child & Adolescent Health

Chapter 4: Child & Adolescent Health

Immunizations for Adolescents

Promoting preventive care is important for the health of children of all ages, from infants to adolescents. Each of these populations has unique preventive care needs. Four measures developed by New York State address assessment and counseling for several areas of concern related to adolescent health, including risks associated with sexual activity, depression, tobacco, and substance use. Appropriate treatment for children and adolescents with illnesses is also important. Limiting the use of unnecessary antibiotics, adequate treatment of acute illnesses, and follow-up of newly diagnosed behavioral disorders, are also being measured in New York State.

Immunizations for Adolescents- Combination Rate

New York State measures the percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday as one means of evaluating preventive care.

Why Are Immunizations for Adolescents Important?

As children get older, protection from some childhood vaccines begins to wear off. In addition, older children can also develop risks for other diseases.

- Meningococcal meningitis (swelling of the brain) can spread quickly, and be fatal.
- Pertussis (also called whooping cough) can occur at any age. Teens can transmit this disease to unprotected infants who are at the greatest risk of hospitalization and even death.
- Most cases of tetanus in the United States happen when people who have not been properly immunized get a cut or puncture wound.

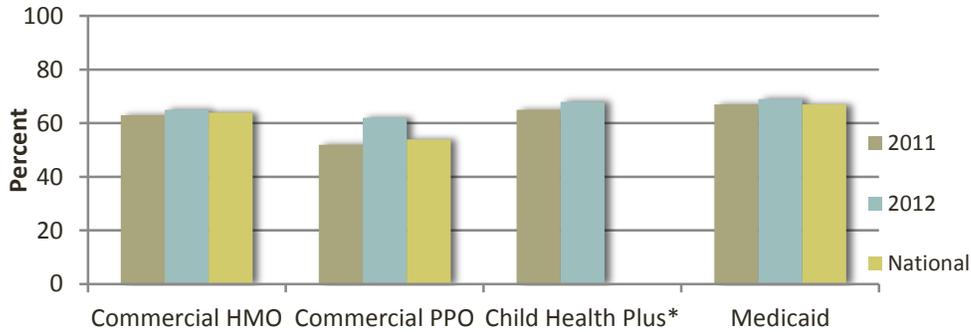
Highlights

- Immunization rates in adolescents 13 years of age continue to improve, particularly in commercial PPOs.
- New York State immunization rates are on par with or exceed national benchmarks for all types of insurance.

Chapter 4: Child & Adolescent Health

Immunizations for Adolescents

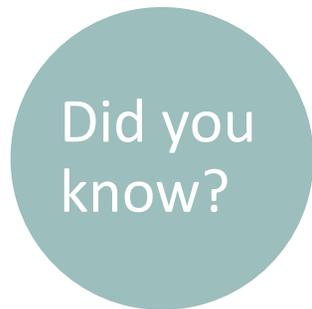
Immunizations for Adolescents - Combination Rate



* No national data available for Child Health Plus.

Improvement opportunities

- Aim to increase the number of preteens receiving the Tdap/Td, Meningococcal, and the series of HPV vaccines at age 11 or 12, by educating parents about the diseases that can be prevented by adolescent immunizations.
- Capitalize on any visit to the doctor (annual health checkup, physical for sports, or sick visit) as a good time for preteens and teens to get the recommended vaccinations.



Preteens and teens still need vaccines.



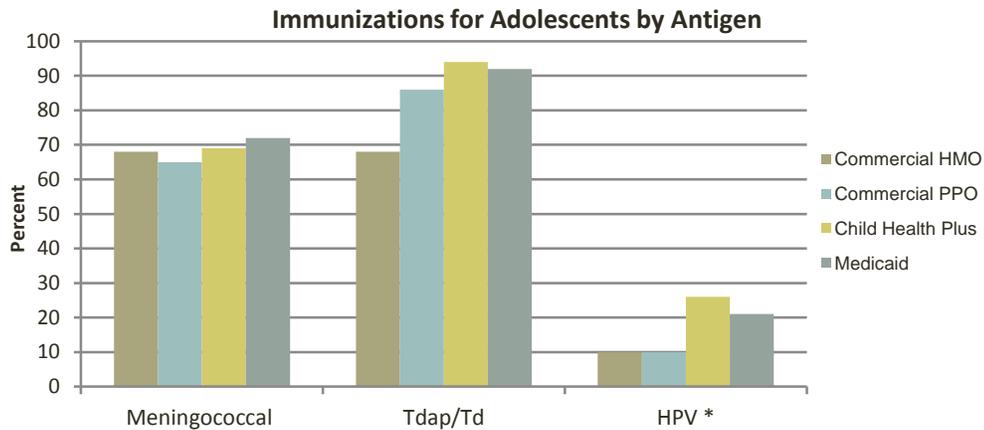
The HPV vaccine is cancer prevention.



For more resources see pre-teen and teen vaccines on the CDC website at: <http://www.cdc.gov/vaccines/who/teens/>.

Chapter 4: Child & Adolescent Health

Immunizations for Adolescents



* This is a new measure. First year data reported in aggregate only.

New Measure

In addition to recommended vaccinations for vaccine-preventable diseases (e.g. meningococcal meningitis and tetanus, diphtheria and pertussis) newly released guidance from the Centers for Disease Control and Prevention (CDC) and the Advisory Committee for Immunization Practice (ACIP) recommends that adolescent females be vaccinated against human papillomavirus (HPV). HPV is a common virus and is most common in people in their teens and early 20s. It is also the major cause of cervical cancer in women and genital warts in women and men.¹ The new human papillomavirus vaccine (HPV) measure for female adolescents examines the percentage of female adolescents 13 years of age who had three doses of the human papillomavirus (HPV) vaccine by their 13th birthday.

¹ CDC. Vaccine-preventable diseases and the vaccines that prevent them. Accessed October 2013 <http://www.cdc.gov/vaccines/who/teens/downloads/parent-version-schedule-7-18yrs.pdf>

Chapter 4: Child & Adolescent Health

Why Is Asthma Important?

- Anyone can develop asthma, but children are especially vulnerable. The majority of children who develop asthma do so before the age of five.²
- Asthma is one of the most common chronic childhood diseases. Nearly five million asthma sufferers in the United States are under age 18.
- Asthma is the leading cause of school absenteeism.³
- Asthma currently affects about 11% (428,000) of children and 9.8% (1.4 million) of adults in New York.⁴
- In 2011, asthma accounted for approximately 165,000 emergency department visits and 37,000 hospitalizations in NYS.⁵

Health plans in New York collect four measures that evaluate the use of controller medications for children with persistent asthma. These medications are used to prevent asthma attacks from occurring. Together these measures provide information about the proportion of children with asthma who get any controller medication, those with continued controller medication, those with controller medication being dispensed at least equally to reliever medication, and those who have had ongoing controller medication dispensed to cover at least half of the treatment days. Each measure is described in detail below.

Use of Appropriate Medications for Asthma (Ages 5-18): The percentage of members, ages 5 to 18 years, with persistent asthma who received at least one appropriate medication to control their condition during the measurement year.

Appropriate Asthma Medications- 3 or more controller dispensing events (Ages 5-18): The percentage of members, ages 5 to 18 years, with persistent asthma who had three or more controller medication dispensing events in the last year.

Asthma Medication Ratio (Ages 5-18): The percentage of members, ages 5 to 18 years, with persistent asthma and who have had at least one reliever or controller medication, who have had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Medication Management of Asthma (Ages 5-18): The percentage of members, ages 5 to 18 years, with persistent asthma and who have had at least one controller medication, who remained on an asthma controller medication for at least 50% of the treatment period.

² American Academy of Allergy Asthma & Immunology. Asthma Overview, Accessed November 2013 from <http://www.aaaai.org/conditions-and-treatments/asthma.aspx>.

³ CDC National Asthma Control Program. America Breathing Easier. Accessed October 2013 at: http://www.cdc.gov/asthma/pdfs/breathing_easier_brochure.pdf

⁴ New York State Behavioral Risk Factor Surveillance System, Asthma Call-Back Survey data, 2006-2010.

⁵ New York State Department of Health, Public Health Information Group, Information on Asthma in New York State. Available from: http://www.health.state.ny.us/statistics/ny_asthma

Chapter 4 Child & Adolescent Health

Highlights

- Medicaid continues to lag behind Commercial HMO and Commercial PPO health plans in the appropriate management of children with asthma.
- While a large percentage of the children are receiving at least one controller medication during the year, only half are getting ongoing controller medication to cover 50% of the treatment days.

	Commercial HMO	Commercial PPO	Medicaid	CHP
Use of Appropriate Medications for Asthma (5-18)	92	93	85	90
Appropriate Asthma Medications - three or more controller dispensing events (5-18)	74	75	66	72
Asthma Medication Ratio (5-18) *	74	77	55	67
Medication Management of Asthma 50% (5-18)	52	56	48	50

* This is a new measure. First year data reported in aggregate only. **Note:** The change in denominator criteria for this measure prevents trending of this data.

Improvement Opportunities

- Health plans should monitor asthma medication fills for members and prescribing practices among health care providers.
- Health care providers need to complete an individual Asthma Action Plan with all patients who have asthma.
- Schools and childcare settings need updated, individual Asthma Action Plans and medication administration authorization forms on file for students and children with asthma.

Use of Appropriate Medications for Asthma

Did you know?



National guidelines recommend inhaled corticosteroids as the preferred first line treatment to improve asthma control for all age groups, at all steps of care for persistent asthma.



The Asthma Action Plan is a written step-by-step plan that is developed jointly with the patient and updated at every visit.



The NYS Department of Health has translated the National Asthma Guidelines into a decision support tool and an educational DVD.



5

Women's Health

Chapter 5: Women's Health

There are a number of conditions which can lead to serious illness if not caught early. Breast and cervical cancers are serious health concerns and early detection of these cancers greatly increases a woman's chance of survival. Mammograms and pap tests are recommended for women in order to screen for these cancers. Chlamydia is the most common sexually transmitted disease in the United States. To prevent complications of this infection, such as infertility, ectopic pregnancy, and pelvic inflammatory disease (PID), it is recommended that all sexually active women between the ages of 16 and 24 be screened for chlamydia infection.

It is important for pregnant women to obtain early and regular prenatal care to increase the likelihood of healthy outcomes for themselves and their babies. All new mothers need postpartum care to ensure their body is healing and to provide appropriate services, including on-going family planning.

Cervical Cancer Screening

- The percentage of women between the ages of 24 and 64 who received one or more pap tests to screen for cervical cancer within the measurement year or the two years prior.

Why is Cervical Cancer Screening Important?

- Cervical cancer is diagnosed in approximately 910 women in NYS each year and about 270 women die from the disease annually. ⁶
- An increase in timely, age-appropriate screening could prevent many of these deaths by detecting cancer early when it is most treatable.
- The Pap test (or Pap smear) looks for precancerous cell changes on the cervix that might become cervical cancer if they are not treated appropriately.
- A disproportionate number of deaths occur among women of racial, ethnic and cultural minorities. ⁷

Highlights

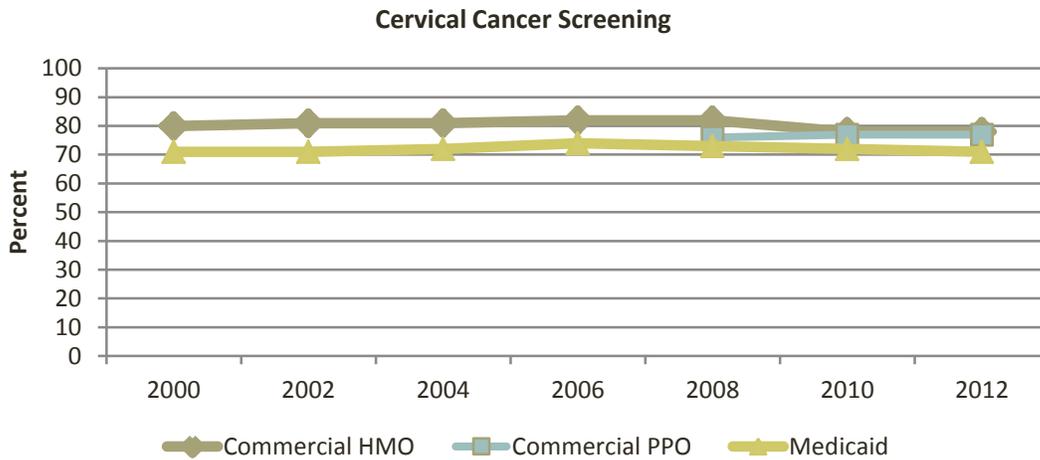
- Cervical cancer screening rates have remained relatively stable over the last decade.
- The gap between commercial enrollees and Medicaid enrollees has remained consistent over the last 12 years, reflecting differences by race, ethnicity, and income.

⁶ New York State Department of Health. Cancer Incidence and Mortality for New York State, 2004-2008. <http://www.nyhealth.gov/statistics/cancer/registry/vol1/v1nys.htm>

⁷ National Cancer Institute, 2008. National Cancer Institute Cancer Fact Sheets: Cancer Health Disparities. <http://www.cancer.gov/cancertopics/factsheet/cancer-health-disparities>

Chapter 5: Women's Health

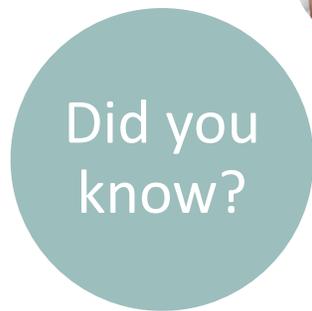
Cervical Cancer Screening



Note: Data collection method changed from hybrid to administrative in 2010, which largely accounts for any decreases in the rates reported in that time period.

Improvement opportunities

- Health care providers and health plans should use client reminders, such as letters, postcards, e-mail messages, or telephone to remind women when their screening is due.
- Educational materials targeting women can help to increase awareness of the importance of screening for cervical cancer, and to allow for early detection of cancer, when it is most easily treated.



The United State Preventive Services Task Force recommends cervical cancer screening.



The Healthy People 2020 goal is for 93 percent of women, aged 21 to 65, to have received a cervical cancer screening within the past three years.



Human papillomavirus (HPV) infection is associated with nearly all cases of cervical cancer. There is a vaccine available for 11- and 12-year-old girls, and for females 13 through 26 years of age who did not get any or all of the shots when they were younger.

Chapter 5: Women's Health

Timeliness of Prenatal Care

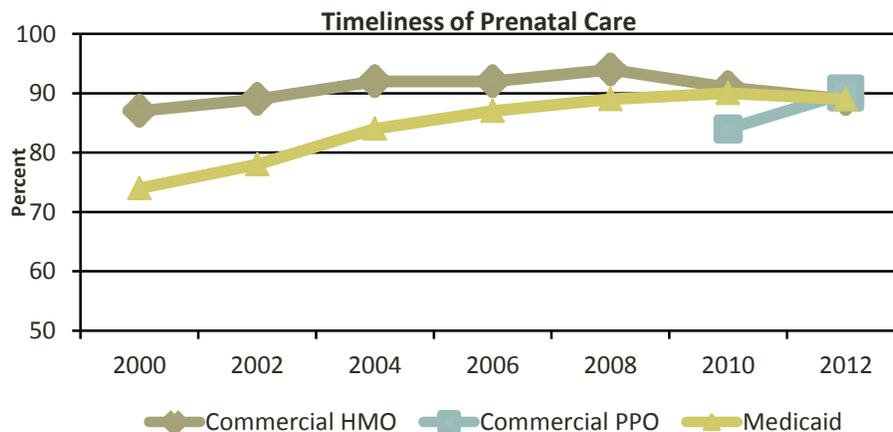
The percentage of women who gave birth in the last year and who had a prenatal care visit in their first trimester, or within 42 days of enrollment in their health plan.

Why is Prenatal Care Important?

- Babies of mothers who do not get any prenatal care are three times more likely to have low birth weight and five times more likely to die than those born to mothers who do get care.⁸
- Pregnancy can provide an opportunity to identify existing health risks in women and to prevent future health problems for women and their children. Every \$1 invested into proper prenatal care results in a savings of \$3.37 in neonatal care.⁹
- Improving the health of mothers and babies is an important public health priority for New York State, and by the year 2013, a goal of the Prevention Agenda for the Healthiest State, is to increase the percentage of women in New York who received prenatal care in the first trimester to at least 90%. (Baseline: 75.4%, Vital Statistics, 2005)

Highlights

- The proportion of NYS women receiving prenatal care in the first trimester has improved in the last decade.
- The Healthy People 2020 goal is for 78 percent of women to receive prenatal care beginning in the first trimester.¹⁰
- The performance gap between Medicaid and commercial health plans continues to narrow.



⁸ Office on Women's Health, U.S. Department of Health and Human Services. Accessed on October 2013 at <http://www.womenshealth.gov/publications/our-publications/fact-sheet/prenatal-care.cfm>

⁹ Lantos JD, Lauderdale DS. What is Behind the Rising Rates of Preterm Birth in the United States? RMMJ

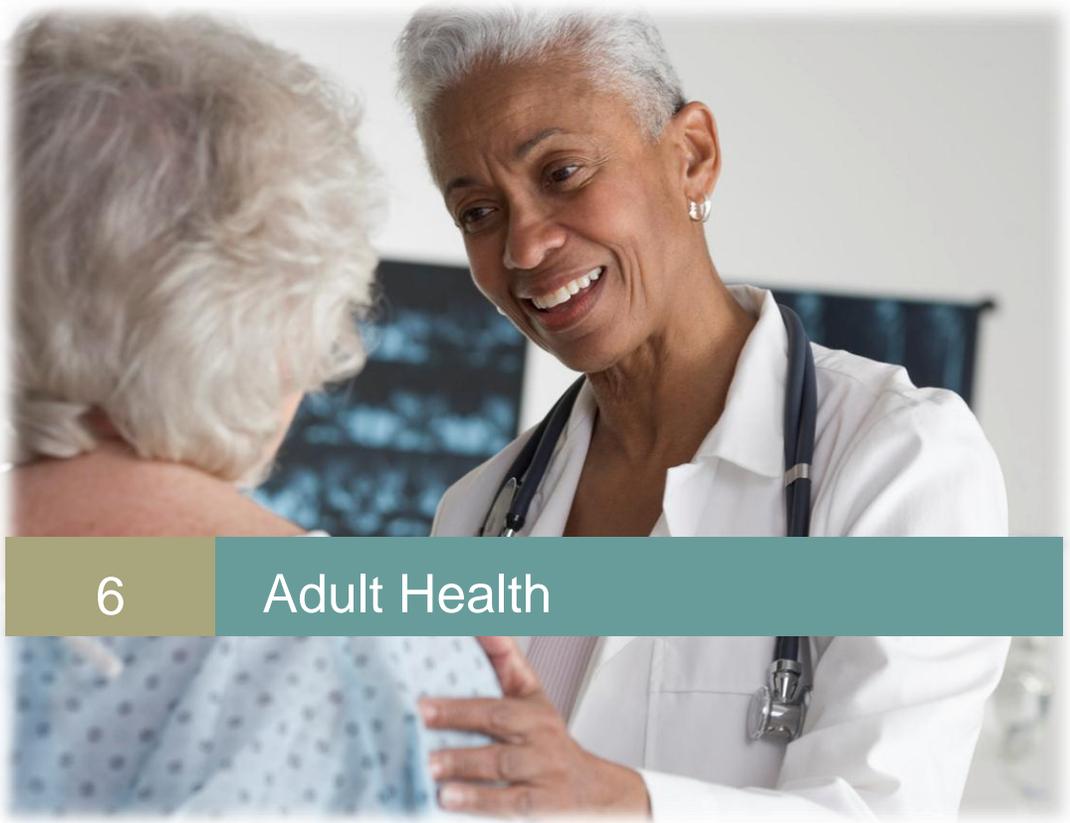
¹⁰ US Department of Health and Human Services. HealthyPeople.gov. Healthy People 2020 Cancer Objectives. <http://www.healthypeople.gov>

Chapter 5: Women's Health

Improvement Opportunities

- Health care providers and health plans should utilize health information technology to facilitate more robust intake/enrollment, screening/risk assessment, referral, follow up and care coordination practices across health and human service providers.
- Health care plans should make providers aware of the 2009 New York State Medicaid Prenatal Care Standards. These standards incorporate evidence-based practices, updated standards of professional practice and guidance from the American Congress of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) and are available on the department website www.health.ny.gov
- The New York State Department of Health promotes the health of child-bearing, pregnant and postpartum women and newborns through the following programs:¹¹
 - [Growing Up Healthy Hotline](#)
 - [Comprehensive Prenatal Perinatal Services Networks \(Networks\)](#)
 - [Community Health Worker Program \(CHWP\)](#)
 - [Perinatal Regionalization Program](#)
 - [Breastfeeding Promotion Program](#)

¹¹ New York State Department of Health. Prenatal Care in New York State. Accessed November 2013 at: http://www.health.ny.gov/community/pregnancy/health_care/prenatal/



6

Adult Health

New York State collects information on how well managed care plans provide care to their adult members, including managing chronic illnesses, providing access to preventive health screenings and treatments, and encouraging appropriate use of health care resources and treatments. Chronic conditions such as cardiovascular disease, respiratory conditions (such as asthma and COPD), and diabetes are a major focus of health care resources and affect a growing number of members enrolled in New York's managed care plans. In addition, members using medications to treat these and other conditions on a long-term basis are at increased risk of harm from side-effects and drug toxicity.

Adult Body Mass Index (BMI) Assessment

The percentage of members, aged 18 to 74 years, with an outpatient visit, who had their body mass index (BMI) documented during the measurement year or the year prior to the measurement year.

Why is BMI assessment important?

- Being assessed for weight issues is an important first step in addressing the obesity epidemic.
- Obesity and overweight are currently the second leading preventable cause of death in the United States.
- The percentage of New York State adults who are overweight or obese increased from 42% in 1997 to 60% in 2008.
- Health care to treat obesity-related illnesses and conditions cost the United States an estimated \$150 billion and New York State more than \$7.6 billion every year.¹²

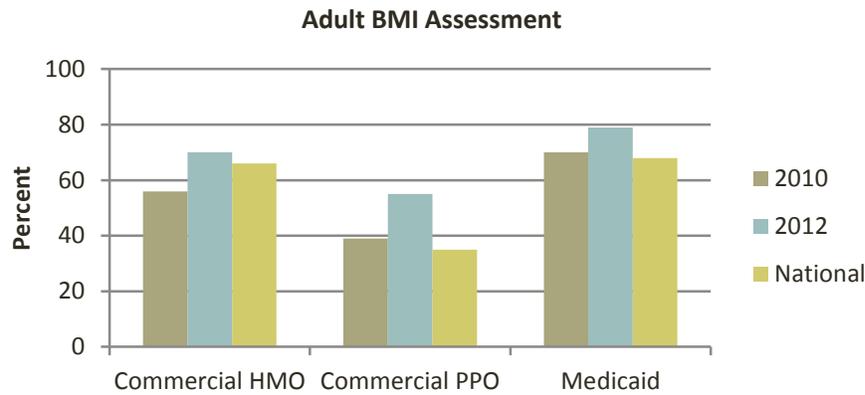
Highlights

- The proportion of adults with an outpatient visit who had their body mass index (BMI) documented saw major improvements this year across all types of insurance.
- New York State continues to exceed national benchmarks across all types of insurance for adult BMI assessment.

¹² New York State Department of Health. Obesity Prevention. Accessed October 2013 at: <http://www.health.ny.gov/prevention/obesity/>

Chapter 6: Adult Health

Adult BMI Assessment



Improvement Opportunities

- The health care sector should play a critical role in addressing obesity and overweight in both children and adults; BMI should be calculated at every visit to a health care provider.
- Health care providers should use BMI screening as an opportunity to offer focused advice or services.
- Creating educational materials to increase the awareness of health risks (hypertension, dyslipidemia, insulin resistance, etc.) and diseases (i.e., diabetes, cardiovascular disease, cancer, arthritis, asthma, disability) associated with overweight and obesity is an important first-step towards improving the management of persons who are at-risk or who are obese.¹³

Did you know?



Two-thirds of adults and nearly one-fifth of children in the United States are overweight.



Where people live, work, and play affects their health.



To reverse the obesity epidemic, places and practices need to support healthy eating and active living in many settings ¹⁴

¹³ New York State Department of Health Strategic Plan for Overweight and Obesity Prevention. Accessed October 2013 at http://www.health.ny.gov/prevention/obesity/strategic_plan/docs/strategic_plan.pdf

Chapter 6: Adult Health

Use of Spirometry Testing in the Assessment and Diagnosis of COPD

Use of Spirometry Testing in the Assessment and Diagnosis of COPD

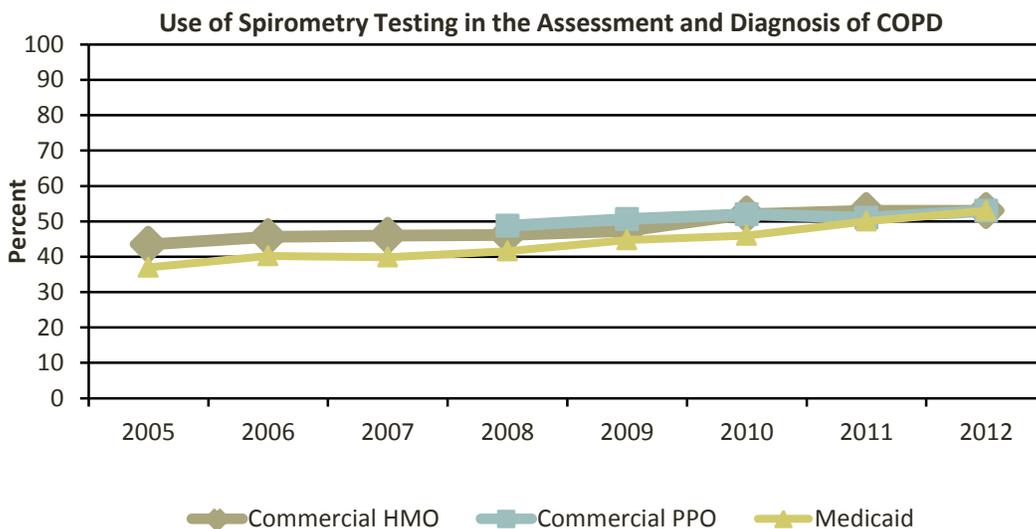
The percentage of members, ages 40 years and older, with a new diagnosis of Chronic Obstructive Pulmonary Disease (COPD) or newly active COPD, who received spirometry testing to confirm the diagnosis.

Why is the assessment and diagnosis of COPD important?

- COPD is the third leading cause of death in the United States, affecting 6.3 percent (approximately 15 million) of adults in the U.S.¹⁴
- Direct medical costs of COPD are approximately \$29.5 billion each year, and an additional \$20.4 billion is lost due to indirect costs of missed work days and lost wages.¹⁵
- Early detection and disease control are essential in reducing these costs.

Highlights

- Medicaid rates are the same as Commercial HMO and PPO rates.
- There has been little improvement in this measure over the past 8 years.



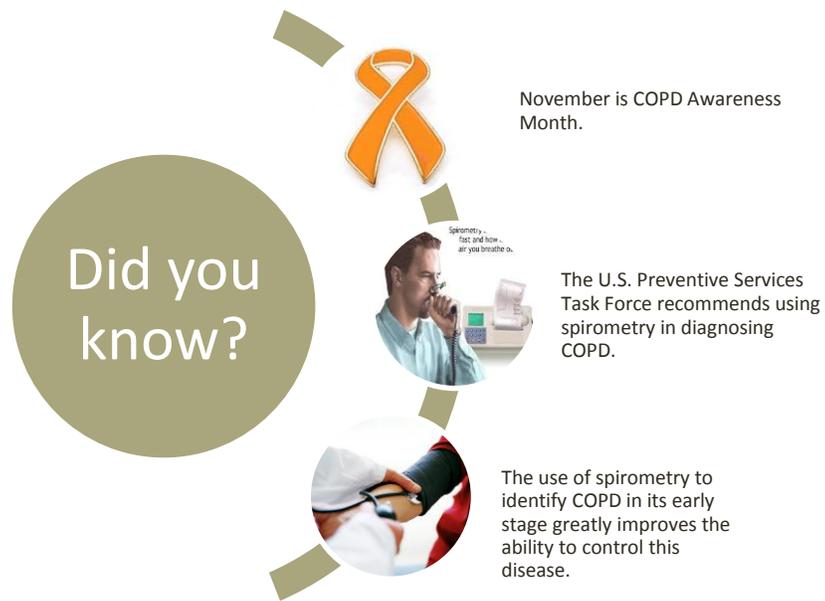
¹⁴ Centers for Disease Control and Prevention. 2012. Chronic Obstructive Pulmonary Disease Among Adults—United States, 2011. *MMWR*; 61(46):938–43. www.cdc.gov/mmwr/preview/mmwrhtml/mm6146a2.htm?s_cid=mm6146a2_e

¹⁵ Global Initiative for Chronic Obstructive Lung Disease. Updated 2013. Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease. www.goldcopd.org/

Chapter 6: Adult Health

Improvement Opportunities

- Health care providers should obtain spirometry from all individuals who have COPD symptoms, have/had a history of smoking and/or environmental exposure to smoke or occupational pollutants, and have a family history of chronic lung disease.¹⁶
- Most people do not know that they have COPD so it is important for health plans and health care providers to provide education to patients about the common triggers or risk factors that put them at increased risk for this disease.



¹⁶ COPD Foundation. Accessed November 2013 at <http://www.copdfoundation.org/Screeners.aspx>

Chapter 6: Adult Health

Medical Assistance with Smoking Cessation

The percentage of members, ages 18 years and older, who are current smokers or tobacco users and who received medical information about smoking or tobacco use cessation within the last 12 months from a health care provider. This measure is collected as part of the CAHPS survey and is calculated as a two year rolling average. This measure was not collected in 2012 for Medicaid; 2011 Medicaid data is presented in this report.

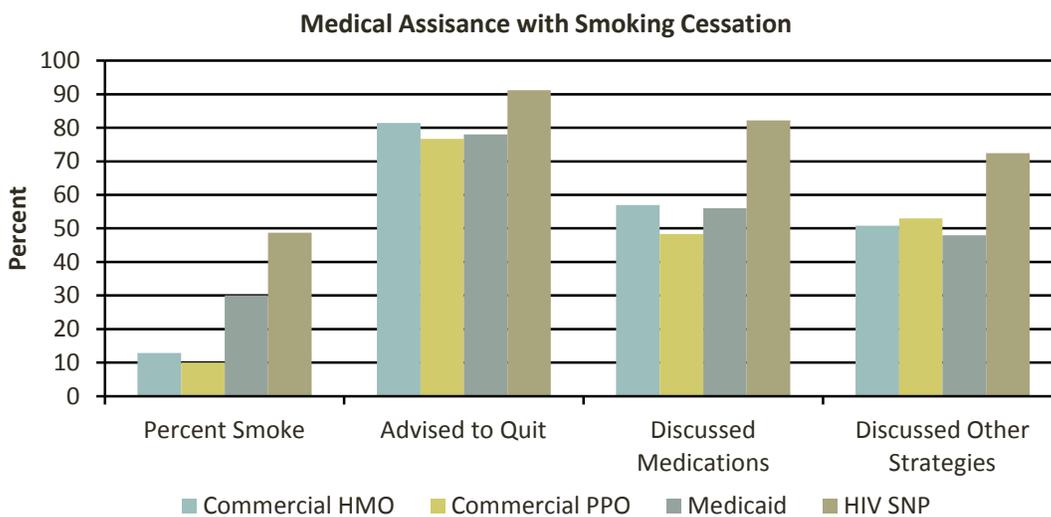
Why is medical assistance with smoking cessation important?

- Tobacco addiction is the leading preventable cause of morbidity and mortality in New York State and in the United States.¹⁷
- The economic costs of tobacco use in NYS are staggering. Smoking-attributable health care costs are \$8.2 billion annually, including \$3.3 billion in annual Medicaid expenditures.¹⁸

Highlights

- The proportion of members who indicated that they were current smokers varied greatly by type of insurance; a higher proportion of smokers in Medicaid and HIV SNP health plans.
- There is room for improvement across all of the different facets of providing medical assistance for smoking and tobacco use cessation, especially for the Medicaid population.

Medical Assistance with Smoking Cessation



¹⁷ U.S. Department of Health and Human Services. *Reducing the Health Consequences of Smoking: 25 Years of Progress. A report of the Surgeon General.* U.S Department of Health and Human Services, Public Health Service.

¹⁸ Centers for Disease Control and Prevention. State Tobacco Activities Tracking and Evaluation (STATE) System. Available at: <http://www.cdc.gov/tobacco/statesystem>.

Chapter 6: Adult Health

Improvement Opportunities

- Health care providers should implement the US Public Health Services Guidelines for Treating Tobacco Use.
- Health care providers and health plans should promote smoking cessation benefits among Medicaid providers and beneficiaries, as well as, facilitate referrals to the NYS Smokers' Quitline.

Medical Assistance with Smoking Cessation

Did you know?



Smoking kills 25,500 people every year in New York State. Secondhand smoke kills 2,500 New Yorkers every year.



NYS envisions a tobacco-free society for all New Yorkers, and for those who want or need help, effective services and treatments are available.



For free help and information in English and Spanish, contact the NYS Smokers' Quitline:
1-866-NYQUITS
(1-866-697-8487)
<http://www.nysmokefree.com>



7 Behavioral Health

Chapter 7: Behavioral Health

Follow-up After Hospitalization for Mental Illness

Mental illness is common and an important cause of morbidity and mortality in New York. It also contributes disability from chronic illnesses as well as school failure, incarceration, and homelessness. New York State collects information on how persons with depression are managed with antidepressant medication and how care is coordinated after hospitalization for a mental illness. By continuing treatment, patients with depressive disorders may prevent a relapse in symptoms and/or prevent future recurrences of depression. Follow-up after a hospitalization for mental illness can be effective in bridging the gap between hospitalization and outpatient care and preventing relapses. Mental and physical health problems are interwoven; Improvements in mental health help improve individuals and populations' physical health. At the same time, some psychopharmacologic treatments lead to higher incidences of metabolic diseases (e.g., diabetes) and cardiovascular concerns (e.g., hyperlipidemia).¹⁹

Follow-up After Hospitalization for Mental Illness

The percentage of discharges for people six years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. The measure separately identifies the percentage of people who received follow-up within seven days and 30 days of discharge.

Why is Follow-up for Mental Illness Important?

- People with serious mental illness die 15 to 25 years earlier on average than the rest of the population. The leading contributors to this disparity are chronic co-occurring physical illnesses, which are not prevented and are treated inadequately.²⁰
- New York's publically funded behavioral health system (which provides specialty care and treatment for mental health and substance use) alone serves over 600,000 people and accounts for about \$7 billion in annual expenditures.²¹
- This represents only a fraction of the true mental health costs to New York, because a major portion of these costs do not take place in mental health care settings, and instead are reflected in costs to the justice system, and physical health care settings.

¹⁹ National Research Council and Institute of Medicine. Preventing Mental, Emotional and Behavioral Disorders Among Young People: Progress and Possibilities, 2009. Washington, DC: The National Academies Press. Available online: http://www.nap.edu/catalog.php?record_id=12480. Accessed October 2013.

²⁰ Colton CW, Manderscheid RW. Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. *Prev Chronic Dis* [serial online] 2006 Apr. Available from: URL: http://www.cdc.gov/pcd/issues/2006/apr/05_0180.htm.

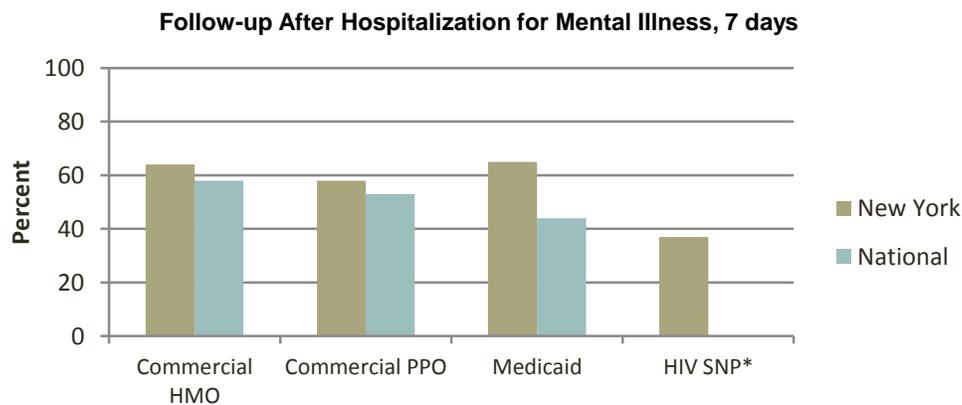
²¹ Medicaid Redesign Team. Behavioral Health Reform Work Group. Available from: http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt_behavioral_health_reform_recommend.pdf

Chapter 7 Behavioral Health

Highlights

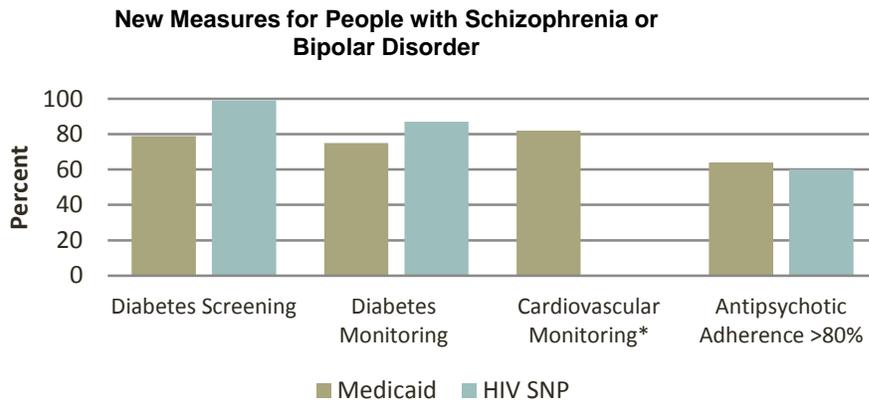
- Medicaid managed care health plans exceed commercial health plans (HMO and PPO) performance in follow-up after hospitalization for both the 7 day and 30 day measure. (See Trends and National Benchmarks table for 30 day rates).
- Follow-up for hospitalization rates in New York State exceed national benchmarks across all types of insurances, but most notably for those enrolled in Medicaid health plans, with a 21% difference between Medicaid and national rates.

Follow-up After Hospitalization for Mental Illness



Improvement Opportunities

- Work with hospital discharge planners to schedule follow-up appointments with a mental health practitioner within 7 days after discharge.
- Integrate both mental and physical health where applicable and link members with both mental health and primary care practitioners.
- Have care coordinators and case managers on staff to help people with serious mental illness better coordinate their appointments.



* HIV SNP health plans did not have sufficient sample size to report this measure.

New Measures

These new measures can help plans highlight clinical outcomes for members with schizophrenia or bipolar disorder, who are disproportionately more likely to suffer chronic diseases and have a significantly shorter lifespan than the general population. The proposed measures also have the potential to identify members at greater risk for morbidity and mortality from adverse outcomes resulting from a lack of adherence to appropriate medications, preventive care and treatment.

Diabetes screening for people with schizophrenia or bipolar disorder (Diabetes Screening) who are using antipsychotic medications is the percentage of members 18–64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

Diabetes monitoring for people with diabetes and schizophrenia (Diabetes Monitoring) is the percentage of members 18–64 years of age with schizophrenia and diabetes, who had both an LDL-C test and an HbA1c test during the measurement year.

Cardiovascular monitoring for people with cardiovascular disease and schizophrenia (Cardiovascular Monitoring) is the percentage of members 18–64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.

Adherence to antipsychotic medications for individuals with schizophrenia (Antipsychotic Medications >80%) is the percentage of members 19–64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

8

Satisfaction with Care

Excellent

Good

Fair

Poor



Chapter 8 Satisfaction with Care

New York State collects patient satisfaction information through the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, which assess three areas of a patient's health care experience: accessing care, interactions with health care providers, and interactions with the health plan.²² In addition to information on adults, survey results including the satisfaction with the care provided to children enrolled in Medicaid and Child Health Plus. This survey also included a supplement to the CAHPS survey, which allows health plans to identify children with chronic conditions and evaluate their experience of care.

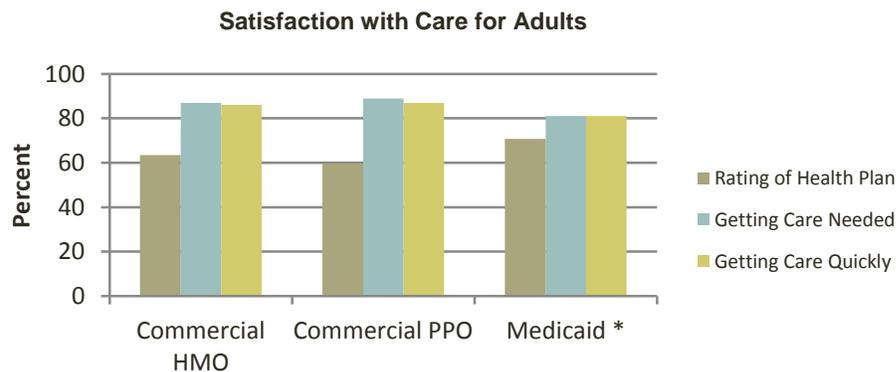
Why is Patient Satisfaction with Care Important?

- Patients' perspective on the health care services they receive provides useful information for individuals to make health care decisions, and for health care organizations to improve the quality of health care services provided to their members.
- There are certain aspects of quality that consumers are best qualified to assess, such as the ease of access to health care services.¹⁸

Satisfaction with Care for Adults

Highlights

- New York State continues to lag behind national ratings of health plans across Commercial HMO and Medicaid plans, but not Commercial PPO health plans. (National rating of health plan: Commercial HMO 65%; Commercial PPO 58%; Medicaid 74%)
- When compared with other patient satisfaction with care measures, such as getting care needed, and getting care quickly, New York State is performing at the same level as national ratings.



* Data is from 2011.

²² Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a program of the U.S. Agency for Healthcare Research and Quality. <https://cahps.ahrq.gov/about-cahps/index.html>

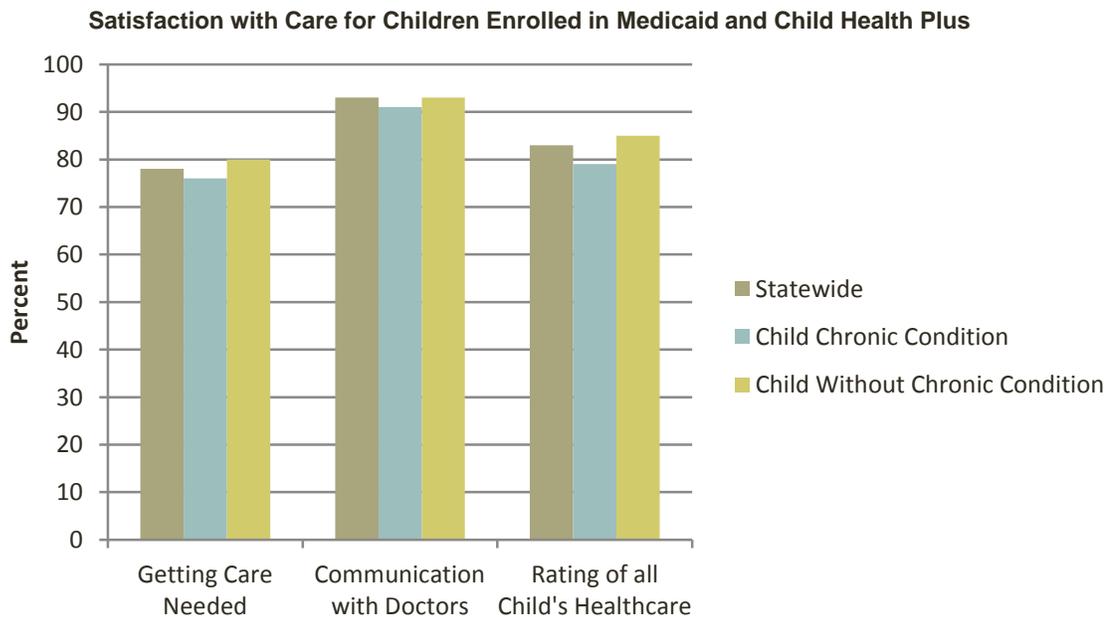
Chapter 8 Satisfaction with Care

Satisfaction with Care for Children

Highlights

- Parents generally felt that they received the care needed for their child, such as appointments with specialists, and care, tests, or treatment.
- Most parents had a favorable assessment of the doctor's interaction with the child, and rating of the child's overall health care
- However, parents of children with chronic conditions were generally less satisfied than parents of children without chronic conditions.²³

Satisfaction with Care



²³ New York State Department of Health. Medicaid and CHP Managed Care Plan Survey Child CAHPS 4.0. Continuous Quality Improvement Report. Accessed October 2013 http://www.health.ny.gov/health_care/managed_care/medicaid_satisfaction_report_2013/docs/c_statewide_2013.pdf

Chapter 8 Satisfaction with Care

Improvement opportunities

- Patient surveys should be used to identify relative strengths and weaknesses in health care and health plan services.
- Children with chronic conditions have been identified as a population that may need additional resources.





9

Access to Care

Chapter 9 Access to Care

Access to Care

Access to care means that health care is available and members know how to obtain health care services when necessary. This section includes utilization measures, as a proxy for access, examining visits to primary care providers within the specified time frame.

Children and Adolescents' Access to Primary Care Practitioners: The percentage of children ages 12 months to 6 years who had a visit with a primary care practitioner within the last year or for children 7-19 years, within the last two years.

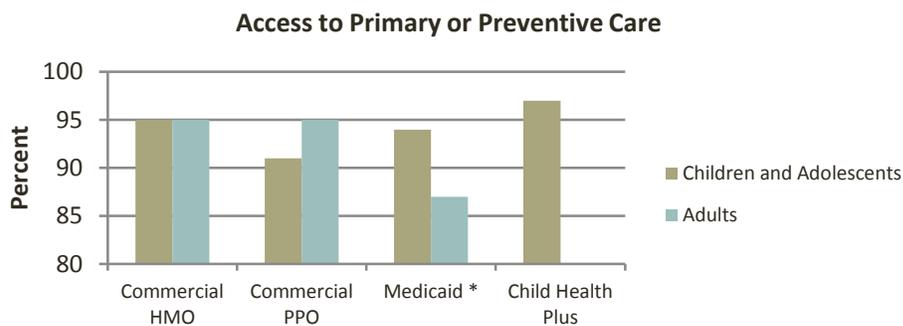
Adults' Access to Preventive and Ambulatory Health Services: The percentage of adults, 20 years of age and older, who had an ambulatory or preventive care visit within the last year if they were insured by Medicaid, or within the last three years if they were commercially insured.

Why is Access to Care Important?

- Access to care impacts members' overall physical, social, mental health status and quality of life; and affects the prevention of disease, preventable death, and detection/treatment of health conditions.
- Disparities in access to care affect both individuals and the whole society. ²⁴

Highlights

- At least 90% of members enrolled in Commercial health plans (HMO and PPO) visited a primary care provider in the last three years regardless of age group.
- Child Health Plus health plans exceeded all types of insurance in Children and Adolescents' access to care.
- Medicaid health plans had high rates of children and adolescents' accessing primary care when compared with other types of insurance.



* Adults access to care for Medicaid cannot be compared to commercial health plans because of differences in the measures. Medicaid requires a visit in the last year, while commercial requires a visit in the last three years.

²⁴ US Department of Health and Human Services. Healthy People 2020 Access to Health Services. Accessed October 2013 <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=1>

Chapter 9 Access to Care

Improvement opportunities

- Increase the percentage of members who have a regular health care provider, the goal is 96% of adult New Yorkers by the year 2013.²⁵
- Increase the use of patient reminders and recall systems to maintain regular preventive care visits.
- Educate parents about the diseases that can be prevented and detected in early stage by regular visits with a primary care provider.

Access to Primary or Preventive Care

Did you know?



People without insurance coverage have worse access to care than people who are insured.

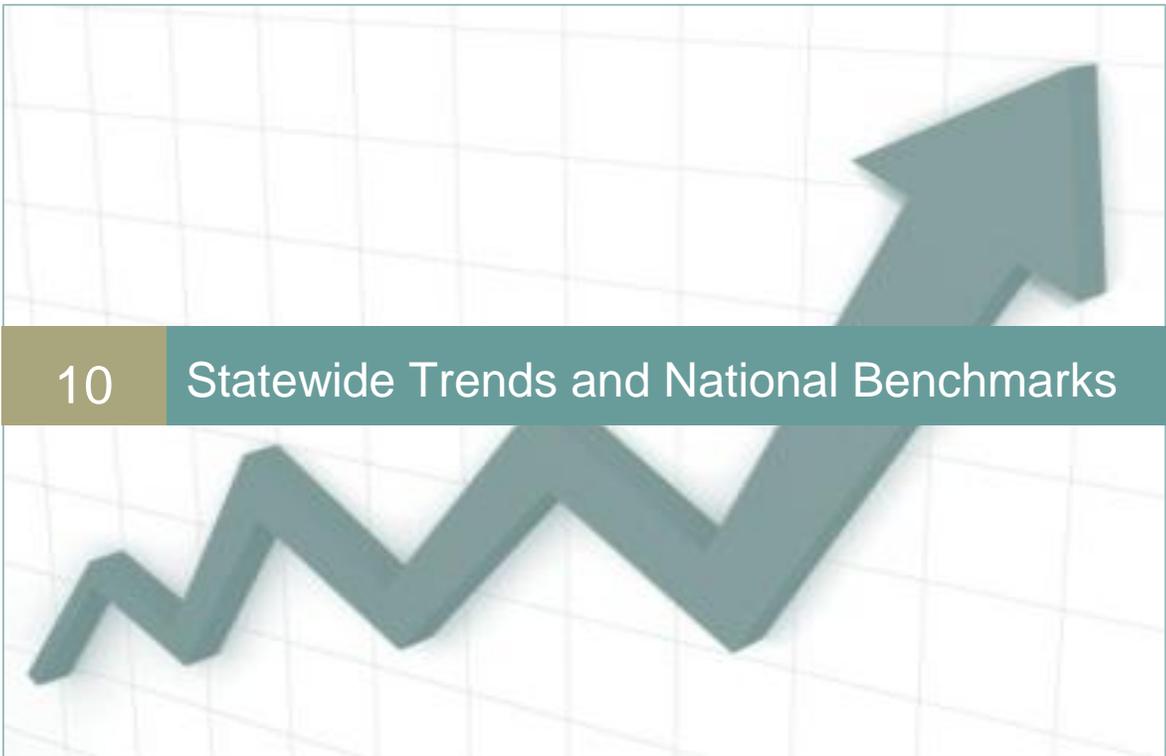


NY State of Health The Official Health Plan Marketplace for New York State Residents is now enrolling.



Individuals and families may qualify for many new, low-cost, quality health insurance options available in the marketplace.

²⁵ New York State Department of Health. Prevention Agenda Toward the Healthiest State. Accessed October 2013 http://www.health.ny.gov/prevention/prevention_agenda/access_to_health_care/



10

Statewide Trends and National Benchmarks

COMMERCIAL HMO STATEWIDE AVERAGES, 2010-2012, COMPARED TO 2012 NATIONAL AVERAGES

	Measure	2010	2011	2012	National
Provider Network	Board Certified Family Medicine	79	79	79	NA
	Board Certified Internal Medicine	79	79	79	NA
	Board Certified OB/GYN	78	76	77	NA
	Board Certified Pediatrics	83	80	81	NA
	Satisfaction with Provider Communication	93	94	94	94
	Satisfaction with Personal Doctor	82	83	83	84
	Satisfaction with Specialist	81	82	83	84
Child and Adolescent Health	Adolescent Immunization-Meningococcal	NA	65	68	66
	Adolescent Immunization-Tdap/Td	NA	89	88	79
	Adolescent Immunization-Combo	NA	63	65	64
	Well-Child & Preventive Care Visits in First 15 Months of Life (5+ Visits)	89	93	92	NA
	Well-Child & Preventive Care Visits in 3rd, 4th, 5th & 6th Year of Life	82	85	84	73
	Adolescent Well-Care Visits	59	60	61	43
	Appropriate Treatment for Upper Respiratory Infection (URI)	88	89	89	84
	Appropriate Testing for Pharyngitis	87	88	87	80
	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	43	44	46	39
	Follow-Up Care for Children Prescribed ADHD Medication: Continuation Phase	47	47	50	46
Women's Health	Breast Cancer Screening	70	70	70	70
	Cervical Cancer Screening	78	78	78	76
	Chlamydia Screening (Ages 16-20)	55	57	57	41
	Chlamydia Screening (Ages 21-24)	60	62	63	49
	Timeliness of Prenatal Care	91	Rotated	89	90
	Postpartum Care	76	Rotated	75	80
	Prenatal Care in the First Trimester	85	85	NA	NA
	Risk-Adjusted Low Birthweight (LBW)	5	5	NA	NA
	Risk-Adjusted Primary Cesarean Delivery	26	25	NA	NA
Vaginal Birth After Cesarean Section (VBAC)	9	8	NA	NA	
Adult Health	Use of Imaging Studies for Low Back Pain	79	79	77	75
	Avoidance of Antibiotics Therapy in Adults with Acute Bronchitis	21	21	23	25
	Advising Smokers to Quit	82	82	81	78
	Discussing Smoking Cessation Medications	59	60	57	53
	Discussing Smoking Cessation Strategies	51	51	51	48
	Adult BMI Assessment	56	Rotated	70	66

COMMERCIAL HMO STATEWIDE AVERAGES, 2010-2012, COMPARED TO 2012 NATIONAL AVERAGES

	Measure	2010	2011	2012	National
Adult Health	Flu Shot for Adults	51	51	53	55
	Controlling High Blood Pressure	66	Rotated	59	63
	Persistence of Beta-Blocker Treatment	79	84	85	84
	Drug Therapy for Rheumatoid Arthritis	84	84	84	88
	Annual Monitoring for Patients on Persistent Medications- ACE Inhibitors/ARBs	84	85	84	83
	Annual Monitoring for Patients on Persistent Medications- Digoxin	85	84	84	87
	Annual Monitoring for Patients on Persistent Medications- Diuretics	83	84	83	83
	Annual Monitoring for Patients on Persistent Medications- Anticonvulsant	60	60	57	59
	Annual Monitoring for Patients on Persistent Medications- Combined Rate	83	84	83	82
	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	52	53	53	44
	Pharmacotherapy Management of COPD Exacerbation- Corticosteroid	71	72	72	74
	Pharmacotherapy Management of COPD Exacerbation- Bronchodilator	78	79	79	81
	Behavioral Health	Antidepressant Medication Management-Effective Acute Phase Treatment	65	65	68
Antidepressant Medication Management-Effective Continuation Phase Treatment		49	50	55	54
Follow-Up After Hospitalization for Mental Illness Within 7 Days		68	70	64	58
Follow-Up After Hospitalization for Mental Illness Within 30 Days		82	81	78	76
Satisfaction With Care	Getting Care Needed	85	84	87	87
	Getting Care Quickly	87	86	87	86
	Claims Processing	85	84	85	89
	Plan Information on Cost	67	61	62	NA
	Customer Service	83	84	86	88
	Rating of Health Plan	62	64	63	65
	Collaborative Decision Making	61	61	73	NA
	Care Coordination	80	80	80	NA
	Wellness Discussion	60	61	76	NA
	Rating of Overall Health care	75	75	76	77
Access to Care	Children and Adolescents' Access to Primary Care Practitioners (Ages 12-24 months)	97	98	97	98
	Children and Adolescents' Access to Primary Care Practitioners (Ages 25 Mos-6 Years)	94	95	95	92
	Children and Adolescents' Access to Primary Care Practitioners (Ages 7-11 Years)	95	96	96	92
	Children and Adolescents' Access to Primary Care Practitioners (Ages 12-19 Years)	92	93	93	90
	Adults' Access to Preventive and Ambulatory Health Services (Ages 20-44)	94	94	95	NA
	Adults' Access to Preventive and Ambulatory Health Services (Ages 45-64)	95	95	96	NA
	Adults' Access to Preventive and Ambulatory Health Services (Ages 65 and over)	96	96	97	NA

COMMERCIAL PPO STATEWIDE AVERAGES, 2010-2012, COMPARED TO 2012 NATIONAL AVERAGES

	Measure	2010	2011	2012	National
Provider Network	Board Certified Family Medicine	76	78	78	NA
	Board Certified Internal Medicine	76	78	79	NA
	Board Certified OB/GYN	76	77	78	NA
	Board Certified Pediatrics	80	81	82	NA
	Satisfaction with Provider Communication	94	94	94	95
	Satisfaction with Personal Doctor	81	83	84	83
	Satisfaction with Specialist	81	83	82	82
Child and Adolescent Health	Adolescent Immunization-Menignococcal	NA	56	65	57
	Adolescent Immunization-Tdap/Td	NA	77	86	70
	Adolescent Immunization-Combo	NA	52	62	54
	Well-Child & Preventive Care Visits in First 15 Months of Life (5+ Visits)	90	90	90	NA
	Well-Child & Preventive Care Visits in 3rd, 4th, 5th & 6th Year of Life	79	80	79	70
	Adolescent Well-Care Visits	52	53	53	40
	Appropriate Treatment for Upper Respiratory Infection (URI)	87	88	89	82
	Appropriate Testing for Pharyngitis	86	87	86	79
	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	42	44	44	38
	Follow-Up Care for Children Prescribed ADHD Medication: Continuation Phase	46	50	50	45
Women's Health	Breast Cancer Screening	68	68	67	67
	Cervical Cancer Screening	77	77	77	74
	Chlamydia Screening (Ages 16-20)	50	52	52	39
	Chlamydia Screening (Ages 21-24)	56	60	60	46
	Timeliness of Prenatal Care	84	Rotated	90	81
	Postpartum Care	68	Rotated	73	70
	Prenatal Care in the First Trimester	87	86	NA	NA
	Risk-Adjusted Low Birthweight (LBW)	5	5	NA	NA
	Risk-Adjusted Primary Cesarean Delivery	26	25	NA	NA
	Vaginal Birth After Cesarean Section (VBAC)	8	9	NA	NA
Adult Health	Use of Imaging Studies for Low Back Pain	75	75	75	74
	Avoidance of Antibiotics Therapy in Adults with Acute Bronchitis	24	24	26	21
	Advising Smokers to Quit	77	76	77	71
	Discussing Smoking Cessation Medications	50	51	53	45
	Discussing Smoking Cessation Strategies	43	45	48	37
	Adult BMI Assessment	39	Rotated	55	35
	Flu Shot for Adults	50	52	54	54
	Controlling High Blood Pressure	59	Rotated	57	57
	Persistence of Beta-Blocker Treatment	75	78	83	80
Drug Therapy for Rheumatoid Arthritis	84	82	81	87	

COMMERCIAL PPO STATEWIDE AVERAGES, 2010-2012, COMPARED TO 2012 NATIONAL AVERAGES

	Measure	2010	2011	2012	National
Adult Health	Annual Monitoring for Patients on Persistent Medications- ACE Inhibitors/ARBs	82	83	82	79
	Annual Monitoring for Patients on Persistent Medications- Digoxin	82	83	82	81
	Annual Monitoring for Patients on Persistent Medications- Diuretics	82	82	82	79
	Annual Monitoring for Patients on Persistent Medications- Anticonvulsant	61	61	59	56
	Annual Monitoring for Patients on Persistent Medications- Combined Rate	82	82	81	79
	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	52	51	53	42
	Pharmacotherapy Management of COPD Exacerbation- Corticosteroid	64	67	72	71
	Pharmacotherapy Management of COPD Exacerbation- Bronchodilator	75	76	79	78
Behavioral Health	Antidepressant Medication Management-Effective Acute Phase Treatment	65	66	70	69
	Antidepressant Medication Management-Effective Continuation Phase Treatment	49	50	56	53
	Follow-Up After Hospitalization for Mental Illness Within 7 Days	61	64	58	53
	Follow-Up After Hospitalization for Mental Illness Within 30 Days	76	79	71	72
Satisfaction With Care	Getting Care Needed	86	87	87	89
	Getting Care Quickly	87	87	86	87
	Claims Processing	84	86	84	88
	Plan Information on Cost	63	64	57	NA
	Customer Service	81	85	86	86
	Rating of Health Plan	60	63	60	58
	Collaborative Decision Making	64	62	74	NA
	Care Coordination	79	80	81	NA
	Wellness Discussion	58	58	75	NA
	Rating of Overall Health care	75	76	76	75
Access to Care	Children and Adolescents' Access to Primary Care Practitioners (Ages 12-24 months)	97	96	95	97
	Children and Adolescents' Access to Primary Care Practitioners (Ages 25 Mos-6 Years)	93	94	92	90
	Children and Adolescents' Access to Primary Care Practitioners (Ages 7-11 Years)	94	94	94	91
	Children and Adolescents' Access to Primary Care Practitioners (Ages 12-19 Years)	90	90	90	88
	Adults' Access to Preventive and Ambulatory Health Services (Ages 20-44)	94	94	95	NA
	Adults' Access to Preventive and Ambulatory Health Services (Ages 45-64)	95	95	96	NA
	Adults' Access to Preventive and Ambulatory Health Services (Ages 65 and over)	96	96	97	NA

MEDICAID STATEWIDE AVERAGES, 2010-2012, COMPARED TO 2012 NATIONAL AVERAGES

	Measure	2010	2011	2012	National	
Provider Network	Board Certified Family Medicine	80	80	78	NA	
	Board Certified Internal Medicine	81	81	80	NA	
	Board Certified OB/GYN	76	77	74	NA	
	Board Certified Pediatrics	82	82	81	NA	
Child and Adolescent Health	Annual Dental Visit (Ages 2-18)	54	55	57	NA	
	Adolescent Immunization-Menignococcal	NA	70	72	69	
	Adolescent Immunization-Tdap/Td	NA	91	92	81	
	Adolescent Immunization-Combo	NA	67	69	67	
	Well-Child & Preventive Care Visits in First 15 Months of Life (5+ Visits)	77	83	83	NA	
	Well-Child & Preventive Care Visits in 3rd, 4th, 5th & 6th Year of Life	80	83	82	72	
	Adolescent Well-Care Visits	56	59	59	50	
	Appropriate Treatment for Upper Respiratory Infection (URI)	91	92	93	85	
	Appropriate Testing for Pharyngitis	84	86	87	68	
	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	58	59	57	39	
	Follow-Up Care for Children Prescribed ADHD Medication: Continuation Phase	64	66	63	45	
	Women's Health	Breast Cancer Screening	68	67	68	52
		Cervical Cancer Screening	72	71	71	65
Chlamydia Screening (Ages 16-20)		67	70	71	54	
Chlamydia Screening (Ages 21-24)		69	72	73	64	
Timeliness of Prenatal Care		90	Rotated	88	83	
Postpartum Care		73	Rotated	70	63	
Frequency of Ongoing Prenatal Care		74	Rotated	70	60	
Prenatal Care in the First Trimester		71	72	NA	NA	
Risk-Adjusted Low Birthweight (LBW)		7	7	NA	NA	
Risk-Adjusted Primary Cesarean Delivery		17	16	NA	NA	
Vaginal Birth After Cesarean Section (VBAC)		14	15	NA	NA	
Adult Health	Use of Imaging Studies for Low Back Pain	79	79	78	76	
	Avoidance of Antibiotics Therapy in Adults with Acute Bronchitis	27	28	24	24	
	Adult BMI Assessment	70	Rotated	79	68	
	Controlling High Blood Pressure	67	Rotated	63	56	
	Persistence of Beta-Blocker Treatment	NA	77	81	82	
	Drug Therapy for Rheumatoid Arthritis	76	77	78	70	
	Annual Monitoring for Patients on Persistent Medications- ACE Inhibitors/ARBs	91	91	92	86	
	Annual Monitoring for Patients on Persistent Medications- Digoxin	94	94	93	90	
	Annual Monitoring for Patients on Persistent Medications- Diuretics	90	90	91	86	
	Annual Monitoring for Patients on Persistent Medications- Anticonvulsant	67	66	68	66	
	Annual Monitoring for Patients on Persistent Medications- Combined Rate	89	90	90	85	

MEDICAID STATEWIDE AVERAGES, 2010-2012, COMPARED TO 2012 NATIONAL AVERAGES

	Measure	2010	2011	2012	National
Adult Health	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	46	50	53	32
	Pharmacotherapy Management of COPD Exacerbation- Corticosteroid	66	68	72	65
	Pharmacotherapy Management of COPD Exacerbation- Bronchodilator	85	84	88	82
	Engaged in Care	80	84	83	NA
	Viral Load Monitoring	58	64	72	NA
	Syphilis Screening	58	66	71	NA
	Annual Dental Visit (Ages 19-21)	43	43	44	NA
Behavioral Health	Antidepressant Medication Management-Effective Acute Phase Treatment	52	51	53	53
	Antidepressant Medication Management-Effective Continuation Phase Treatment	35	34	37	37
	Follow-Up After Hospitalization for Mental Illness Within 7 Days	70	72	65	44
	Follow-Up After Hospitalization for Mental Illness Within 30 Days	85	83	79	64
Access to Care	Children and Adolescents' Access to Primary Care Practitioners (Ages 12-24 months)	96	97	97	96
	Children and Adolescents' Access to Primary Care Practitioners (Ages 25 Mos-6 Years)	93	93	93	88
	Children and Adolescents' Access to Primary Care Practitioners (Ages 7-11 Years)	95	95	96	90
	Children and Adolescents' Access to Primary Care Practitioners (Ages 12-19 Years)	92	92	93	88
	Adults' Access to Preventive and Ambulatory Health Services (Ages 20-44)	82	83	84	NA
	Adults' Access to Preventive and Ambulatory Health Services (Ages 45-64)	89	90	90	NA
	Adults' Access to Preventive and Ambulatory Health Services (Ages 65 and over)	89	90	90	NA

HIV SNP STATEWIDE AVERAGES, 2010-2012

	Measure	2010	2011	2012
Provider Network	Board Certified Family Medicine	86	81	60
	Board Certified Internal Medicine	87	80	62
	Board Certified OB/GYN	76	74	58
	Board Certified Pediatrics	82	75	61
Women's Health	Breast Cancer Screening	69	70	69
	Cervical Cancer Screening	88	82	81
	Chlamydia Screening (Ages 16-20)	78	79	63
	Chlamydia Screening (Ages 21-24)	76	80	76
	Timeliness of Prenatal Care	80	Rotated	79
	Postpartum Care	49	Rotated	36
	Frequency of Ongoing Prenatal Care	63	Rotated	63
Adult Health	Use of Imaging Studies for Low Back Pain	74	81	84
	Adult BMI Assessment	82	Rotated	77
	Controlling High Blood Pressure	59	Rotated	66
	Persistence of Beta-Blocker Treatment	NA	NA	NA
	Annual Monitoring for Patients on Persistent Medications- ACE Inhibitors/ARBs	98	99	99
	Annual Monitoring for Patients on Persistent Medications- Digoxin	100	NA	NA
	Annual Monitoring for Patients on Persistent Medications- Diuretics	98	99	99
	Annual Monitoring for Patients on Persistent Medications- Anticonvulsant	58	82	85
	Annual Monitoring for Patients on Persistent Medications- Combined Rate	97	98	98
	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	26	26	22
	Pharmacotherapy Management of COPD Exacerbation- Corticosteroid	52	59	65
	Pharmacotherapy Management of COPD Exacerbation- Bronchodilator	91	84	91
	Engaged in Care	92	90	89
	Viral Load Monitoring	85	84	81
	Syphilis Screening	74	78	81
	Behavioral Health	Antidepressant Medication Management-Effective Acute Phase Treatment	52	53
Antidepressant Medication Management-Effective Continuation Phase Treatment		40	32	36
Follow-Up After Hospitalization for Mental Illness Within 7 Days		25	34	37
Follow-Up After Hospitalization for Mental Illness Within 30 Days		51	51	51
Access to Care	Adults' Access to Preventive and Ambulatory Health Services (Ages 20-44)	97	97	97
	Adults' Access to Preventive and Ambulatory Health Services (Ages 45-64)	99	98	99
	Adults' Access to Preventive and Ambulatory Health Services (Ages 65 and over)	97	98	100

Child Health Plus Statewide Averages, 2010-2012

	Measure	2010	2011	2012
Provider Network	Board Certified Family Medicine	79	79	77
	Board Certified Internal Medicine	80	80	79
	Board Certified OB/GYN	76	77	75
	Board Certified Pediatrics	81	81	80
Child and Adolescent Health	Annual Dental Visit (Ages 2-18)	63	64	64
	Adolescent Immunization-Menignoccal	NA	67	69
	Adolescent Immunization-Tdap/Td	NA	93	94
	Adolescent Immunization-Combo	NA	65	68
	Well-Child & Preventive Care Visits in First 15 Months of Life (5+ Visits)	85	87	85
	Well-Child & Preventive Care Visits in 3rd, 4th, 5th & 6th Year of Life	82	84	82
	Adolescent Well-Care Visits	66	68	67
	Appropriate Treatment for Upper Respiratory Infection (URI)	87	88	89
	Appropriate Testing for Pharyngitis	87	88	87
	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	53	51	53
	Follow-Up Care for Children Prescribed ADHD Medication: Continuation Phase	58	59	56
Access to Care	Children and Adolescents' Access to Primary Care Practitioners (Ages 12-24 months)	99	99	100
	Children and Adolescents' Access to Primary Care Practitioners (Ages 25 Mos-6 Years)	96	97	96
	Children and Adolescents' Access to Primary Care Practitioners (Ages 7-11 Years)	98	98	98
	Children and Adolescents' Access to Primary Care Practitioners (Ages 12-19 Years)	96	96	96