Wisconsin Medicaid HMO Comparison Report: 1998/1999

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Introduction

The Wisconsin Medicaid HMO Comparison Report is one of several ways in which the Wisconsin Department of Health and Family Services, Division of Health Care Financing (DHCF), monitors and reports on health care services provided to Medicaid enrollees in HMOs. Enrollees in HMOs include individuals eligible for services through Healthy Start and the former Aid to Families with Dependent Children (AFDC) program. BadgerCare enrollees are not included in this report, since the program was not implemented until July 1999.

This report includes data for both 1998 and 1999 dates of service. This is a change from previous Medicaid comparison reports, which published data for a single year time period. During 1998 and 1999, DHCF continued quality oversight activities such as data validity audits, Quality Improvement studies, and a recipient satisfaction survey. However, the 1998-1999 Medicaid HMO Comparison Report is a biennial report, incorporating trend comparisons from 1996-1999, made possible with a static data collection instrument in 1998 and 1999.

Data are presented as four broad sections:

- Access and Service.
- Staying Healthy.
- Getting Better.
- Living with Illness.

Indicators, such as "HealthCheck screens," organize data within each category. Some of these indicators may be based on Health Plan Employer Data and Information Set measures used to report health plan performance for commercial, Medicaid, and Medicare members. Other measures reflect the characteristics of a population that is predominantly made up of women and children (i.e., Healthy Start and former AFDC programs).

Wisconsin Medicaid HMO-specific data used in findings, graphs, and tables are from multiple sources. HMO utilization data are generated and reported by individual Wisconsin Medicaid HMOs. Eligibility data for enrollees in HMOs are extracted from the Wisconsin Medicaid program's eligibility files.

The data in the *Wisconsin Medicaid HMO Comparison Report: 1998-1999*, like most health care statistical reporting, must be interpreted with recognition of variables that may influence the data. For example, differences between individual Medicaid HMOs may represent either different levels of HMO performance, or simply reflect recipient demographic variances. Comments regarding these variables are noted in the report as appropriate.

Selected Findings

The Wisconsin Medicaid HMO Comparison Report: 1998-1999 identifies health care services provided to Medicaid enrollees in Wisconsin HMOs. The Division of Health Care Financing's managed care quality review oversight program promotes the best possible health outcomes for enrollees.

Selected findings in this report include the following:

- HealthCheck visits for children between the ages of 0-5 years statewide over the three-year period of 1997-1999 were provided at a rate of 80.3% per eligible screened, per eligible year.

- Primary care provider visits for all ages statewide averaged 2.54 visits per eligible year in 1997, 2.75 visits per eligible year in 1998, and increased again to an average of 3.0 visits per eligible year in 1999. Enrollees continue to have access to their primary health care provider, or "medical home" as an entry point for coordinated health care services.

- In 1999, 90.1% of one-year-olds and 71.7% of two-year-olds screened in Wisconsin had a blood lead level less than or equal to 10µg/dl. The Wisconsin Childhood Lead Poisoning Prevention Program recommends public health referral for follow-up at a level greater than or equal to 10µg/dl.

- The average lead-screening rate in 1999 for eligible one- and two-year-olds enrolled in HMOs in Milwaukee County was 51.7% and 48.7%, respectively.

- The average lead-screening rate in 1999 for eligible one- and two-year-olds enrolled in HMOs outside of Milwaukee County was 54.2% and 41.1%, respectively.

- The 1997-1999 statewide teenage delivery rate for 12-20-year olds, as a percentage of total HMO deliveries, ranged from 31.8% to 33.3%. This range remained below the 1996 rate of 36.8%.

- In 1999, 12.0% of Milwaukee County HMO enrollees, ages 0-20 years with a diagnosis of asthma, were admitted to the hospital following an emergency room visit for asthma. This is compared to 4.2% of HMO enrollees outside of Milwaukee County with a diagnosis of asthma, who were admitted to the hospital following an emergency room visit for asthma.

Introduction to Wisconsin Medicaid

What is Medicaid?

Medicaid is a joint federal/state program established in 1965 under Title XIX of the Social Security Act to pay for medical services for the poor and disabled. In Wisconsin, Medicaid is administered in the Department of Health and Family Services (DHFS) by the Division of Health Care Financing.

Who Pays for Medicaid?

Both federal and state tax dollars support Wisconsin Medicaid. For state fiscal year 1998 (1997-1998), Medicaid expenditures were $2.52 billion. Of that amount, $905 million was supplied by the state and $1.61 billion by the federal government. For state fiscal year 1999 (1998-1999), Medicaid expenditures were $2.61 billion. Of that amount, $928 million was contributed by the state and $1.68 billion by the federal government.

Wisconsin Medicaid is the second largest program in the state's budget, representing 13.5% of the total state budget. Increased costs are primarily attributable to expanded eligibility and rising health care costs.

Who is Eligible for Medicaid?

In calendar year 1999, approximately 525,000 Wisconsin residents were eligible for coverage by the Wisconsin Medicaid program for at least some time during the year. The average number of Medicaid enrollees in Wisconsin was 405,000 per month.

Four major groups received medical services through Wisconsin Medicaid in 1998 and 1999: the aged, the blind/disabled, the Healthy Start population, and enrollees who qualified under the former Aid to Families with Dependent Children (AFDC) standards. Of the total Medicaid-eligible enrollees, well over half (57 %) were eligible through AFDC standards or Healthy Start, and this population accounted for 21% of Medicaid expenditures. Of the total Medicaid population, approxmately 41% were aged, blind, and/or disabled, and this population accounted for approximately 78% of the program expenditures.*

The AFDC/Healthy Start recipient group, which is the subject of this report, is comprised of pregnant women, children, and families with children who meet various low-income criteria.

Medicaid Managed Care

Wisconsin was one of the first states to initiate managed care for the AFDC/Healthy Start Medicaid population by receiving a federal waiver to pursue the managed care alternative in the early 1980s. Since that time, many states have adopted managed care as a model of service delivery.

In late 1996, the Wisconsin Medicaid HMO program began expanding from a five county program (Milwaukee, Dane, Kenosha, Waukesha, and Eau Claire) to include almost all other counties in the state. By 1997, the program operated in 70 counties, enrolling over 290,000 Medicaid enrollees in 18 HMOs for at least part of the year. In 1998 and 1999, all 18 HMOs continued to operate in the Wisconsin Medicaid program, managing the care of 278,000 Medicaid enrollees. The drop in HMO enrollment from 1997 to 1998 reflected the general decrease from 1997 to 1998 in the number of all Wisconsin Medicaid enrollees. Map A lists the plans by county.

Table A lists the HMOs included in this report and the average number of months enrollees were enrolled in their respective HMOs in 1998 and 1999. This average is important because it affects an HMO's ability to influence an enrollee's health outcome. In general, Medicaid enrollees are enrolled in HMOs for shorter periods of time than are commercial subscribers, partly because enrollment is dependent on individuals meeting financial eligibility requirements for the Medicaid program.

* Totals do not add up to 100% due to rounding.

Table A

Number of Enrollees Enrolled in Participating Medicaid HMOs and Duration of Enrollment: 1998 and 1999

Managed Care Organization	Milwaukee County				Rest of State				Statewide			
	Number of Enrollees		Average Number of Eligible Months Per Recipient		Number of Enrollees		Average Number of Eligible Months Per Recipient		Number of Enrollees		Average Number of Eligible Months Per Recipient	
	1998	**1999**	**1998**	**1999**	**1998**	**1999**	**1998**	**1999**	**1998**	**1999**	**1998**	**1999**
Atrium Health Plan	N/A	N/A	N/A	N/A	13,795	13,669	6.84	6.81	13,795	13,669	6.84	6.81
Compcare	24,839	24,716	8.52	8.42	22,619	21,970	6.93	6.90	47,249	46,727	7.80	7.70
Coordinated Care Health Plan (Maxicare)	12,183	11,719	8.52	8.60	2,337	2,337	6.70	7.12	14,466	14,076	8.36	8.35
Dean Health Plan	N/A	N/A	N/A	N/A	13,644	14,201	6.60	6.56	13,644	14,201	6.60	6.56
Family Health Plan	2,564	2,585	7.70	7.55	186	179	6.95	6.55	2,746	2,767	7.66	7.48
GHC — Eau Claire	N/A	N/A	N/A	N/A	6,547	6,065	6.99	6.88	6,547	6,065	6.99	6.88
GHC — South Central Wisconsin	N/A	N/A	N/A	N/A	2,515	2,188	7.49	7.59	2,515	2,188	7.49	7.59
Greater La Crosse Health Plan	N/A	N/A	N/A	N/A	4,714	4,577	7.37	7.15	4,714	4,577	7.37	7.15
Humana	25,296	25,239	8.40	8.23	4,753	5,861	6.18	6.63	29,946	31,135	8.08	7.93
Managed Health Services	16,439	15,729	8.38	8.46	15,057	14,352	6.22	6.69	31,288	30,107	7.39	7.62
Mercy Care Health Plan	N/A	N/A	N/A	N/A	3,746	3,556	6.45	6.89	3,746	3,556	6.45	6.89
Network Health Plan	1,454	2,240	5.33	5.96	13,652	12,575	6.66	6.88	15,078	14,836	6.54	6.74
Physicians Plus	N/A	N/A	N/A	N/A	5,306	5,485	6.41	6.55	5,306	5,485	6.41	6.55
Security Health Plan	N/A	N/A	N/A	N/A	22,227	21,458	7.28	7.25	22,227	21,458	7.28	7.25
Touchpoint Health Plan	N/A	N/A	N/A	N/A	14,961	13,910	6.84	6.95	14,961	13,910	6.84	6.95
United Health Plan (PrimeCare)	42,107	40,351	8.70	8.53	5,472	6,241	6.61	6.70	47,378	46,633	8.50	8.29
Unity Health Plans	N/A	N/A	N/A	N/A	8,461	7,787	7.14	7.07	8,461	7,787	7.14	7.07
Valley Health Plan	N/A	N/A	N/A	N/A	6,465	6,345	7.10	7.09	6,465	6,345	7.10	7.09
Unduplicated Total	120,859	119,408	8.80	8.62	158,926	156,678	7.17	7.17	278,613	276,380	7.90	7.79

N/A: Not applicable.

Interpretation of Data

Comparative Data

Comparative data are reported for HMOs in Milwaukee County that participated in the Medicaid program during 1998 and 1999.

Aggregated data for counties in the rest of the state (i.e., non-Milwaukee counties) are reported for 1998 and 1999.

The terms "non-Milwaukee counties," "other counties," and "rest of state" are used interchangeably in this report. This is strictly a report on managed care data provided to the DHFS by Medicaid HMOs for those counties with HMO participation during the reporting years.

Data Definitions

The number of months that individuals are eligible for Medicaid benefits during a given year varies by HMO and area of the state. Some individuals are eligible for Medicaid the entire reporting year, while others may be eligible for only one or two months during the year.

Overall, enrollees in Milwaukee County HMOs tend to be Medicaid eligible for more months of a given year then their Non-Milwaukee County counterparts (Table A).

To compare data from different HMOs or areas of the state, data in this report are displayed as either rates of service provisions per eligible year or percentages. Examples of numerators for the rates are:

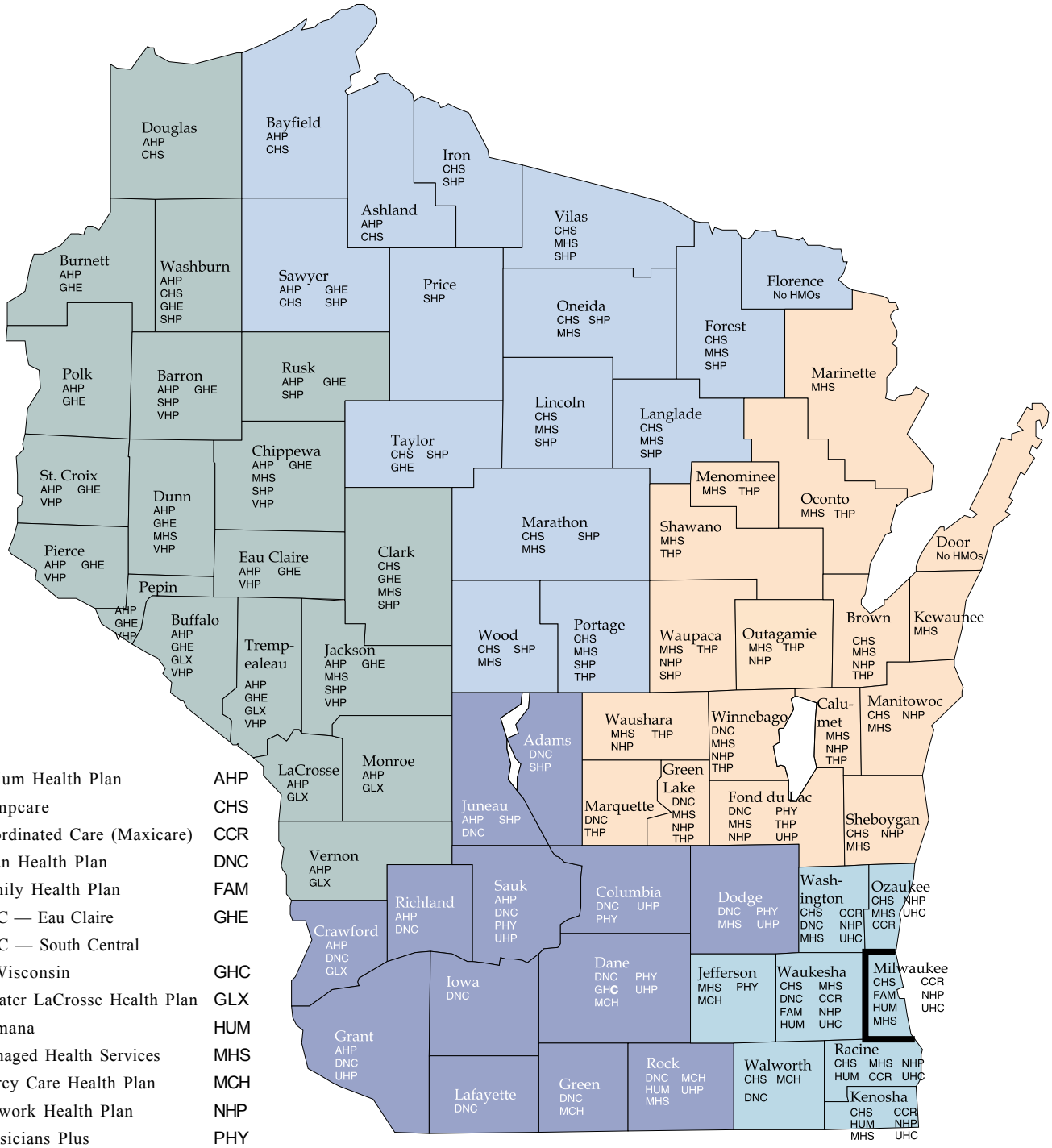
- The sum of the number of visits made by enrollees.
- The sum of tests received by enrollees.
- The count of enrollees receiving a given service.

The eligible year denominator is calculated using:

- The numbers of eligible months during the year for each enrollee in the denominator are added, and this sum is divided by twelve.

Map A

HMO Participation in Wisconsin Medicaid, by County, 1998 and 1999

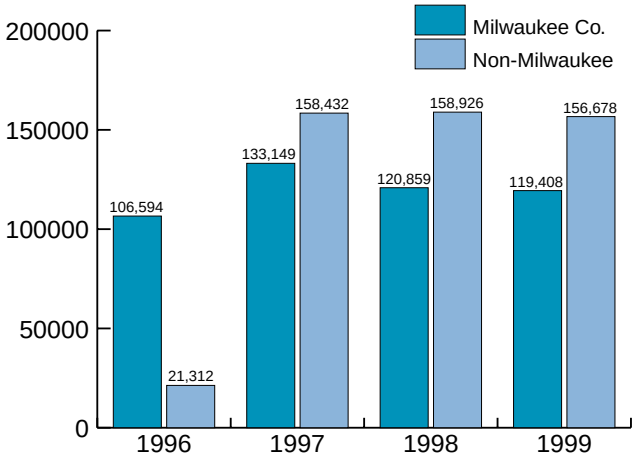


Atrium Health Plan	AHP
Compcare	CHS
Coordinated Care (Maxicare)	CCR
Dean Health Plan	DNC
Family Health Plan	FAM
GHC — Eau Claire	GHE
GHC — South Central Wisconsin	GHC
Greater LaCrosse Health Plan	GLX
Humana	HUM
Managed Health Services	MHS
Mercy Care Health Plan	MCH
Network Health Plan	NHP
Physicians Plus	PHY
Security Health Plan	SHP
Touchpoint Health Plan	THP
United Health Plan (PrimeCare)	UHC
Unity Health Plans	UHP
Valley Health Plan	VHP

Note: These abbreviations appear on various tables throughout this report.

Graph 1

Distribution of Wisconsin Medicaid HMO Enrollees, 1996-1999: Milwaukee County and Non-Milwaukee Counties



Graph 1 shows the distribution of the Wisconsin Medicaid population enrolled in HMOs between Milwaukee County and all other counties in Wisconsin. Prior to statewide expansion in 1997, most Medicaid HMO enrollees were in Milwaukee County.

From 1997 to 1999, the number of enrollees from Milwaukee County enrolled in HMOs declined from 133,149 to 119,408 while the number of enrollees from all other counties enrolled in HMOs has remained relatively stable. This was due in part to implementation of the state Workforce Development Program, reducing the number of enrollees eligible for AFDC.

Demographics of the Population

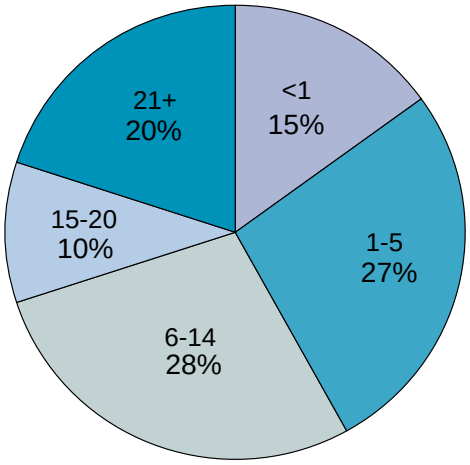
When interpreting the data presented in this report, it is important to keep in mind the composition of the Medicaid AFDC/Healthy Start population. Graphs 2 through 4 represent the distribution of Medicaid HMO enrollees by age and sex in 1999.

- 60% of HMO enrollees were female.
- Only 29% of female enrollees were 21 years of age or older.
- 80% of all HMO enrollees (male and female) were under the age of 21.
- 88% of male HMO enrollees were under the age of 15.

There is no significant difference between the age composition for either males or females in 1999 compared to 1997 or 1998.

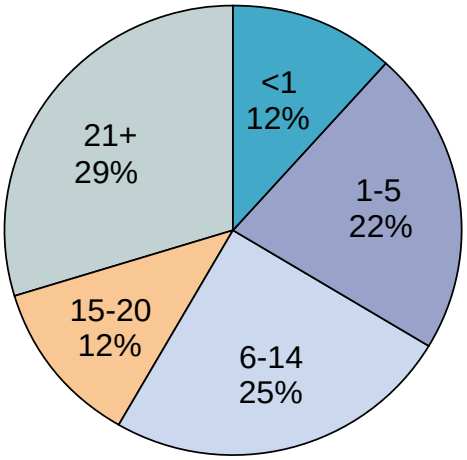
Graph 2

Distribution of AFDC/HS Wisconsin Medicaid Recipients in 1999 by Age (Total Count: 276,380)



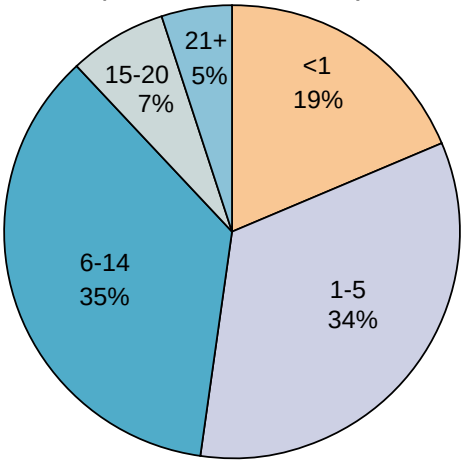
Graph 3

Distribution of Female AFDC/HS Wisconsin Medicaid Recipients in 1999 by Age (Total Count: 165,553)



Graph 4

Distribution of Male AFDC/HS Wisconsin Medicaid Recipients in 1999 by Age (Total Count: 110,827)



Section One

Quality Improvement

Quality Improvement Activities

Wisconsin Medicaid Quality Improvement (QI) activities assure access, choice, and quality for the Medicaid population. Through QI activities, Wisconsin Medicaid is a proactive partner with contracted health plans in achieving the best possible health outcomes for enrollees.

HMO Program Quality Improvement Activities

Quality Improvement activities for the Wisconsin Medicaid HMO program:

- Assure contractual safeguards, such as the requirement that certified HMOs will:
  - Meet licensure standards of the Wisconsin Office of the Commissioner of Insurance.
  - Ensure that enrollees have timely access to primary and specialty care providers.
  - Cover all state-mandated services, either through internal staff or by contracted arrangements.
  - Provide emergency health care services 24 hours a day, seven days a week, and provide a single telephone number through which enrollees are able to access all services.
  - Provide an internal HMO advocate to assist enrollees with using managed care effectively.
  - Have a grievance procedure.
  - Provide specific preventive health care services.
  - Establish a working arrangement with community agencies to facilitate prenatal care coordination, with a goal of decreasing adverse outcomes of pregnancy.
  - Address the health care needs of the Medicaid population in a culturally sensitive manner.
- Use an independent enrollment counselor to ensure that Medicaid enrollees enrolling in HMOs make a fully informed choice when choosing a provider.
- Establish and maintain ongoing methods for public, recipient, and provider evaluation and comments. Examples of this activity include:
  - Quarterly regional forums.
  - Workgroups established to address specific areas of concern.
- Use a Medicaid Ombudsman external to the HMOs.

- Measure recipient satisfaction.
- Produce reports on health care provided by HMOs.
- Monitor HMO disenrollment and grievance procedures.
- Participate in data management and reporting activities, including:
    - The HMO Technical Workgroup.
    - Data Validity Audits.
    - Performance Indicator reporting.

Fee-for-Service Quality Improvement Activities

The Division of Health Care Financing (DHCF) is responsible for monitoring quality of care in the Medicaid fee-for-service area as well as in managed care. The QI activities in fee-for-service include:

- Reviews and audits of health care services delivered to Medicaid enrollees in the outpatient and inpatient setting for appropriateness, medical necessity, and quality of care.
- Prospective review of selected services through prior authorization to assure enrollees receive medically necessary and cost-effective services.
- Reviews of drug utilization in outpatient and nursing home settings to assure that prescribed drugs are appropriate, medically necessary, and not likely to result in adverse medical outcomes.

Medical Chart Audit Review Activities

The DHCF engages in a variety of audits and medical chart reviews to assess the quality of care provided to Wisconsin Medicaid enrollees. Some of these audits/chart reviews are on a case-specific or limited basis, while others encompass a broad spectrum of care. The former usually represents a response to a specific complaint or grievance, while the latter generally reflects pre-planned assessments of areas of interest or concern to the DHCF.

Because the entire state Medicaid population, as well as the Medicaid HMO population, consists primarily of mothers and children, audits and chart reviews are principally designed to monitor the care of that population. Issues include prenatal care, women's health, child health and preventive care, dental, and mental health/substance abuse (alcohol and other drug abuse) care.

The majority of medical audit/chart reviews, from a volume standpoint, are performed by an External Quality Review Organization (EQRO) under contract with DHFS. Quality of care cases identified in managed care delivery by the contractor's physician advisers are referred to the DHCF physician staff for final review and disposition.

A very small number of cases reviewed by the EQRO have resulted in findings of inappropriate care with the potential for adverse effects on the enrollee. Such issues, when identified in a managed care audit, are referred to the HMO for corrective action.

Quality Improvement
Data Management and Reporting

The need for accurate, reliable, and timely data is increasingly important for all participants in the delivery of health care. Enrollees need information to make informed choices about providers and services. Providers need information to make recommendations and decisions about services provided and resource requirements. Payer sources need information to direct inquiries about payment and contract compliance.

To meet the data needs of multiple users, the DHCF has progressively implemented QI initiatives in data management to assure that the data meet user requirements. These include the HMO Technical Workgroup, data validity audits, and performance improvement projects, which are discussed below.

HMO Technical Workgroup

In 1998, the DHCF decided to move toward full reporting of encounter data to permit more complete and accurate reporting. This expanded and complete encounter data set was also mandated by the Balanced Budget Act of 1997 and as part of the federally required Medicaid Statistical Information System reporting from all state Medicaid programs. The HMO Technical Workgroup was established to enlist the help of the HMOs in this and other efforts to improve data management.

All HMOs are expected to have representatives of their information systems staff as well as their QI and claims processing staff in attendance at the Technical Workgroup meetings as topics warrant. Systems and managed care staff represent the DHCF at these meetings. The HMO Technical Workgroup addresses all data collection strategies including those in effect for this report and the new encounter data collection effort.

The HMO Technical Workgroup brings together the information systems and other personnel from the HMOs and the DHCF. The workgroup evaluates the appropriateness and necessity of contract-requested data elements for the measurement of specific health care processes or outcomes. The workgroup gives HMOs an opportunity to request changes in data reporting to help minimize duplication and develop compatible deadlines with both their current reporting structure and other non-Medicaid reporting requirements. The DHCF is afforded the opportunity to explain the data requests and work with HMOs in achieving efficient reporting of accurate and complete data.

Prior to January 1, 2000, summary data was collected from each HMO by using a series of utilization and quality indicators, supported by a limited encounter (history) data set. Subsequent to January 1, 2000, data collection was structured to meet the needs of reporting required by the Balanced Budget Act of 1997 and Wisconsin Medicaid.

In the move away from the collection of summarized data from the HMOs, the DHCF required an expanded and complete encounter data set from all HMOs beginning with dates of service after January 1, 2000. That effort was successfully implemented May 1, 2000.

Data Validity Audits

Accurate data is key to the DHCF's quality management and reporting system. Routine auditing for data completeness and accuracy is necessary for program oversight activities. Data validity audits are an important mechanism used to verify the integrity of plan-specific data.

The DHCF's current HMO data validity audit protocol measures the health plan's information system technical capability, (Part One), as well as the validity and integrity of their submitted data, (Part Two). Part One measures the plan's ability to process Medicaid specific data. The audit is conducted on site, providing an opportunity for the DHCF to provide customized technical assistance on Medicaid specific issues. The Part One technical audit evaluates a health plan by using:

- A description of how the plan identifies Medicaid-specific data.
- A technical description of the plans' information system.
- A technical description of the plans' information system quality control program.
- An evaluation of the plans' service transaction, or billing forms.
- An evaluation of the plans' procedure and diagnosis coding for Medicaid-specific data.
- A technical description of how in-house transactions are processed.
- A technical description of how contracted provider transactions are processed.
- An evaluation of the plan's enrollment information system.
- An evaluation of the plan's provider information system.
- An evaluation of all other information system issues.
- Evaluation of specific performance measure calculations for:
  - Pap test.
  - HealthCheck.
  - Asthma hospitalization.
  - Mental health and/or substance abuse evaluation.
  - Dental service.
- An evaluation of the plans' written instructions, employee training, and feedback processes related to their information system.
- A description of any general information system difficulties.

Part One technical specifications may change in future years to reflect the DHCF's transition to the collection of encounter, rather than summary data.

Part Two of the data validity audit measures the rate of the agreement between the HMO's information system specific data and their medical records. The results are then analyzed to identify patterns of disagreement between the medical record and administrative data. The DHCF selected Pap tests and HealthCheck screens for review because of historical variability in reported rates between health plans and because these services have sufficient volume for review.

Part Two data validity audits are performed biennially. The same HealthCheck and Pap test measurement parameters as in the previous audit will be used to demonstrate the HMO's data management improvement. In the future, evaluation of the encounter data may require an audit of other performance measures in addition to, or in place of, HealthCheck screens and Pap tests.

Performance Improvement Projects

In 1998, the federal Health Care Financing Administration issued draft regulations governing all Medicaid managed care programs. A central focus of this regulation is completion of performance improvement projects (formerly called "focus studies") in clinical and non-clinical areas of managed care activity.

In Wisconsin, HMOs identify issues that are significant to their Medicaid population, that have measurable outcomes or processes, and for which there are possible corrective actions. The HMOs are asked to select at least two such topics annually and to construct a performance improvement project for each.

Medicaid's contracted EQRO has developed an instrument for evaluating HMO performance improvement projects. The EQRO evaluates the projects in order to validate the study design, its conclusion(s), and to assure that the corrective action plan is appropriate and will result in quality improvement of the care provided by HMOs.

In 1998 and 1999, the HMOs participating in Wisconsin Medicaid submitted two performance improvement projects each as required by the contract. Table B displays the topic and the number of studies selected for review by the HMOs.

Most of the HMOs' performance improvement projects measured current performance to form a baseline for future studies designed to improve health care outcomes.

Table B

HMO Performance Indicator Topics

Topic	Number of Studies	
	1998	1999
Immunization	7	7
Prenatal Care	7	4
HealthCheck	6	2
Pediatric Lead Screening	5	7
Mental Health	4	1
Asthma Care	3	5
Tobacco Cessation	2	4
High-Risk Obstetric Initiative	1	Ø
Postnatal Care	1	Ø
Pap Tests	Ø	1
Diabetes Management	Ø	1

Performance improvement projects are an important tool for improving outcomes for Wisconsin Medicaid HMO enrollees. Using the performance improvement projects to identify best practices, the DHCF sponsors a day-long annual forum to provide the HMOs with an opportunity to present their study findings to their peers, obtain feedback from a panel of health care experts, and have their efforts for performing benchmark studies recognized. This forum allows the Medicaid HMOs to bring the performance improvement projects into the center of quality improvement and assure that best practices are recognized and shared.

Quality Improvement
Consumer Assessment of Health Plans Survey

The DHCF completed a consumer satisfaction survey of enrollees receiving health care services by HMOs through the Medicaid managed care program for calendar year 1999. The survey was conducted using the standardized tools and procedures included as part of the Consumer Assessment of Health PLans Survey (CAHPS®) instrument and recommended study design protocol. Survey results using this methodology are considered to be a valid measure of recipient satisfaction with health care. This survey design is useful when comparing across HMO plans, geography, and state, and can be customized for program-specific questions.

Included in this section are two graphs depicting survey results for the questions, "How would you rate all of your health care on a scale of 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible (graph 1.1);" and "In the last six months, how much of a problem, if any, was it to get the care you or a doctor believed was necessary? (Graph 1.2)". A more comprehensive report on the CAHPS® survey results will be published by DHCF at a future date.

Rating of Health Care

On a scale of 0 to 10 enrollees gave all participating HMOs a rating of 8.09 or above with the highest rating of 8.77. The combined average HMO rating is 8.46. This seems to indicate that enrollees are generally satisfied with their health care services. (Graph 1.1)

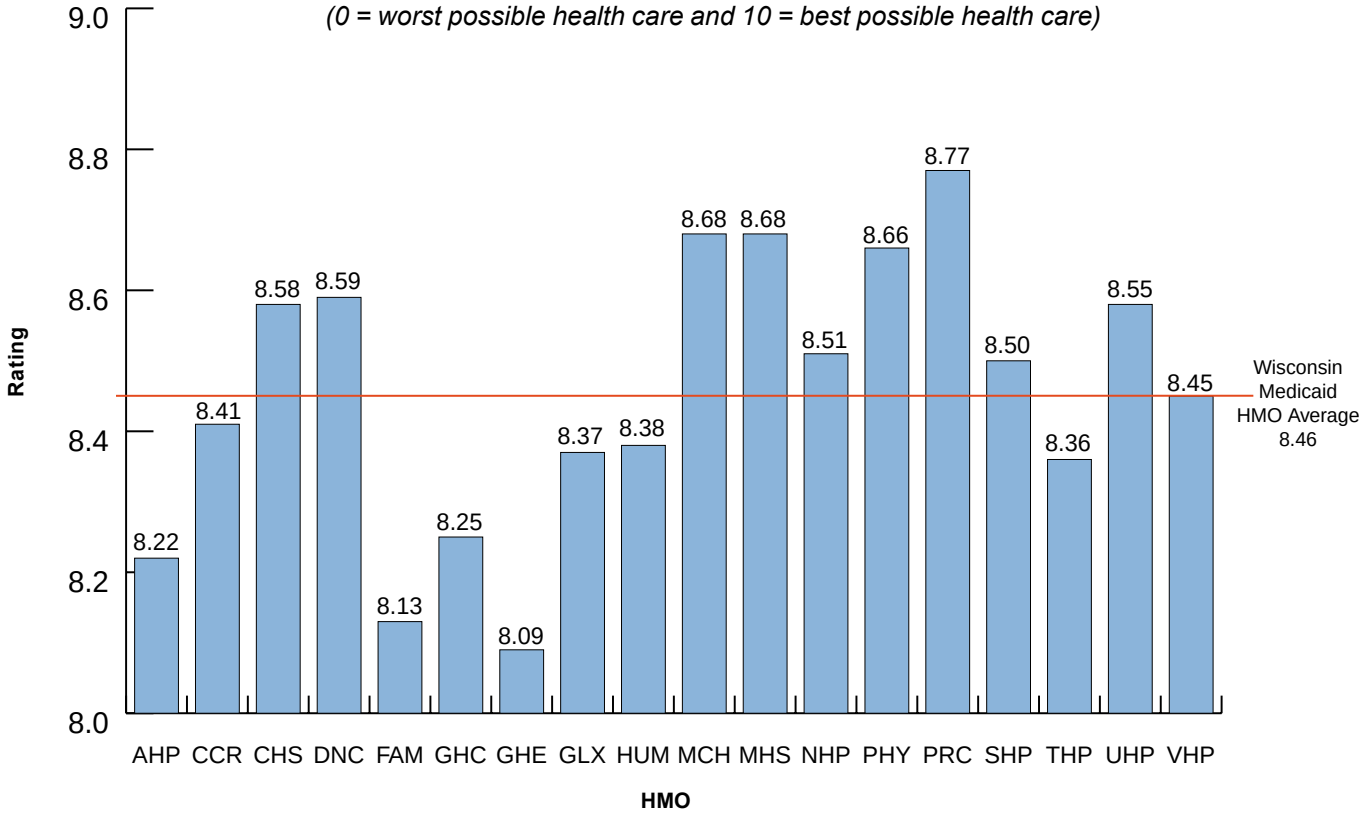
Getting Needed Care

In response to the survey question, "In the last six months, how much of a problem, if any, was it to get the care you or a doctor believed was necessary?," enrollees' average response rate with either "not a problem" or "a small problem" is 93.1%. The percentage response rate ranged from a low of 87.9% to a high of 96.4% (Graph 1.2), with five HMOs receiving a rating above 94%.

Graph 1.1

CAHPS® Overall Rating of Health Care — 1999

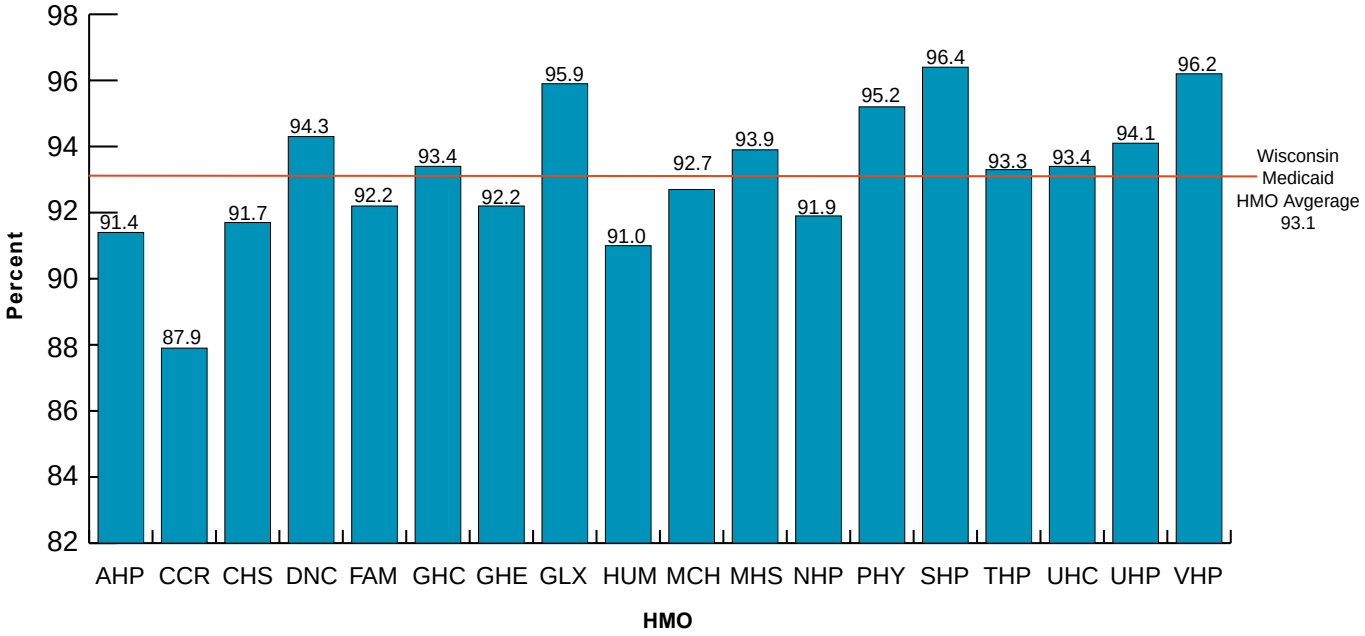
(0 = worst possible health care and 10 = best possible health care)



Graph 1.2

CAHPS® Getting Needed Care — 1999

(Percent responding "not a problem" or "a small problem")



Additional Comments on Consumer Assessment of Health Plans Survey

When asked to rate their HMO on a scale from 0 (worst possible HMO) to 10 (best possible HMO), 35.3% gave their HMO the highest rating possible (10) and 0% rated their HMO a 7 or higher. The average rating was 8.04. There were no measurable differences between the HMOs on this overall rating, each is seen as equally good. Overall, the measures for overall rating of health care (Graph 1.1), and getting needed care (Graph 1.2) are good indicators of recipient satisfaction with health care provided by the contracted HMO plans for Wisconsin Medicaid. Recipient satisfaction with health care services will continue to be an important factor for evaluating the managed care program.

Section Two

Access and Service

The Medicaid HMO/Healthy Start population represents a young, predominately female segment of the Wisconsin Medicaid population. Important services for this group include wellness exams for children, routine office visits, access to emergency care, dental care, and cervical cancer screening (Pap tests).

HealthCheck is the service Wisconsin Medicaid provides to promote and maintain the health of Medicaid-eligible children. The number of HealthCheck visits and routine office visits may indicate access to routine health care through a "medical home" or primary care provider. Non-HealthCheck visits represent routine office visits that do not include all HealthCheck components for children or office visits for adults.

Emergency care is a vital component of services provided to any group of health care enrollees. The use of emergency medical care may indicate enrollees' ease of access to routine and acute care through their HMOs, or the establishment of a "medical home." A "medical home" or primary health care provider should encourage enrollees to use emergency care in the most cost-effective manner.

Preventive dental services for children assure healthy teeth and gums as the child matures. Timely, adequate preventive dental services are cost-effective in preventing significant dental and other health care problems.

Pap testing is important in early detection and treatment of cervical cancer. Routine examinations permit early detection of related gynecologic problems before serious and permanent health concerns arise.

HealthCheck Visits

Components of HealthCheck Visits

Well-child assessments are an essential component in meeting the preventive health care needs of children enrolled in Wisconsin Medicaid. In Wisconsin, federally prescribed well-child assessments are called HealthChecks.[1] A HealthCheck examination helps providers evaluate a child's physical, cognitive, social, and emotional development, identify preventable problems, screen for potential risk factors, provide appropriate immunizations, and make referrals to providers and health care agencies to meet the child's health needs. Additionally, HealthChecks also provide an opportunity to identifying children at risk for neglect, abuse, dietary problems, and elevated blood lead levels, as well as provide an opportunity for teaching and counseling parents. Children ages three and older are referred for preventive and necessary dental care.

Frequency of HealthCheck Visits

The schedule of periodic exams adopted for HealthCheck is based on recommendations by the American Academy of Pediatrics (AAP). The recommendations for the frequency of HealthChecks support a greater intensity of HealthCheck services within the early years of life. Federal recommendations, consistent with their reporting requirements, include six HealthCheck visits within the first year, and 1.2 visits per year for children ages one to five years. This translates to approximately two visits per year for children aged 0-5. These same federal recommendations support 0.56 visits per year for children aged 6-14 years and 0.50 visits per year for children aged 15-20 years. A total of 12 HealthCheck exams are recommended to be given by the time a child reaches the age of six.

HealthCheck visits are especially important in the first years of life to ensure that children receive timely assessments to identify medical conditions that could have long-term consequences if they do not receive early attention.

Table 2.1

Percent of Eligibles Screened Per Eligible Year, 1996-1999

(Ages 0-5 Years)

Year	Milwaukee County	Rest of State
1996	73.0	NA**
1997	75.4	78.9
1998	69.9	79.0
1999	69.3	84.2

**The Rest-of-State 1996 value is omitted since the Medicaid HMO program expansion began late in 1996 and the data is not comparable to more recent data. All of the values in this table are calculated using the denominator definition of age eligibility that was adopted for reporting in 1998 to allow comparison between years. (The 1996 and 1997 values will not be the same as those reported in the *HMO Comparison Report* for those years.)

HealthCheck Services

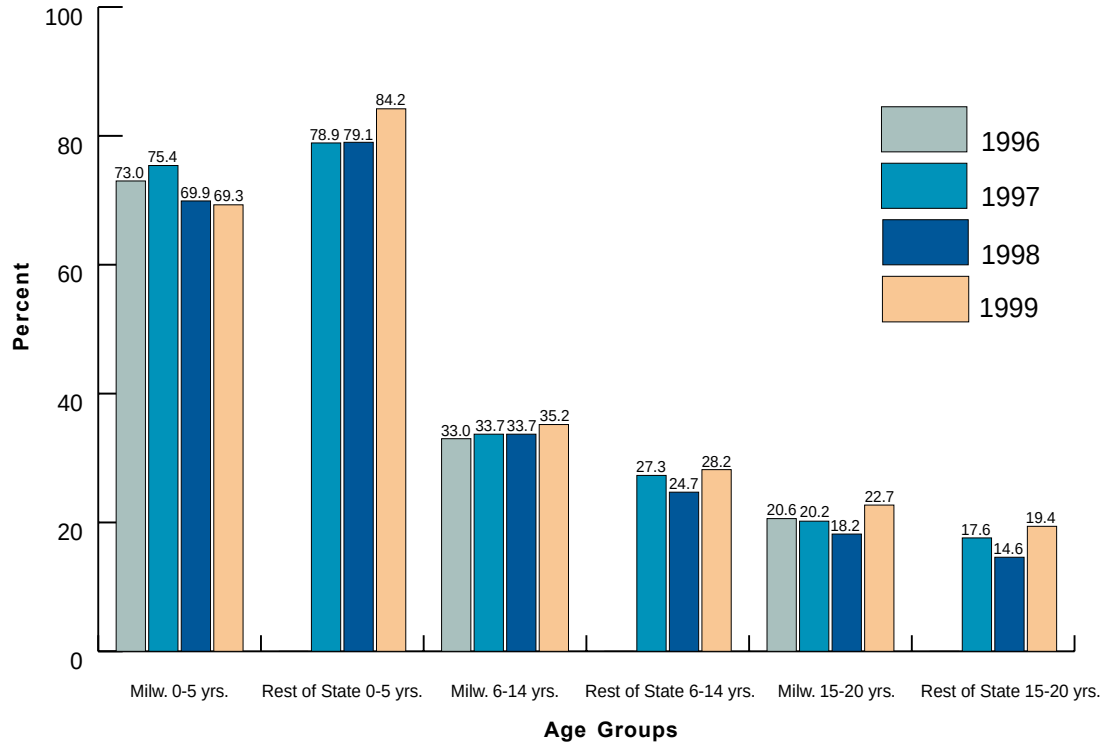
Table 2.1 shows that there has been a decline, which is not statistically significant, in the percent of eligible children receiving HealthCheck services between 1996 and 1999 in Milwaukee County HMOs.

The percent of non-Milwaukee County eligibles receiving HealthCheck services increased between 1997 and 1999.

Graph 2.1

Percent of Eligibles Per Eligible Year Receiving HealthCheck Visits

Milwaukee County and Rest of State by Age Groups



Graph 2.1 shows that a greater percentage of eligible children receive HealthCheck visits during the pre-school years than other years, consistent with the federal recommendations previously cited. The trend analysis shows that the percent of eligibles receiving a HealthCheck visit within each age group has remained fairly constant. The critical age group of 0-5 years receives HealthCheck visits at an all-HMO-weighted average of 78.1%.

Trend data presented in Table 2.2 shows that the number of screens per eligible year reported in both Milwaukee County HMOs and the rest of the state changed very little for 6-14 year olds from 1996 to 1999.

These data do not include visits that may have occurred related to non-HealthCheck visits or services provided by public agencies that do not bill the enrollee's HMO.

Table 2.2

HealthCheck Screens Per Eligible Year Per Enrollee

Age	Milwaukee County				Rest of State		
	1996*	1997	1998	1999	1997	1998	1999
6-14 yrs	.37	.36	.36	.38	.29	.27	.29
15-20 yrs	.24	.22	.20	.25	.22	.17	.20

* HMO expansion began in 1996; 1996 data is not available for rest of state.

Milwaukee County HMOs

Graph 2.2 shows four-year HealthCheck screening data for Milwaukee County HMOs. The Milwaukee County 1999 HMO average for eligible Medicaid children ages 0-5 years is 1.21 screens per enrollee, per eligible year, which is slightly higher than the 1998 level of 1.17 HealthCheck screens per eligible year. The majority of Milwaukee HMOs show a stable level of reported services.

Other County HMOs

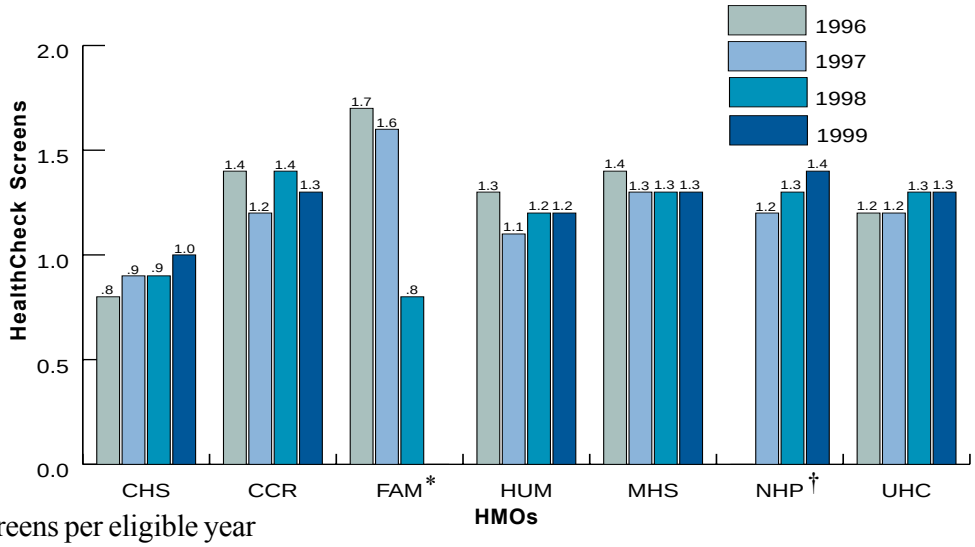
The number of HealthCheck screens per eligible year for children ages 0-5 years in other counties is presented in Graph 2.3.

HealthCheck visit data for non-Milwaukee County HMO enrollees is available for three years. The data presented in this report are slightly different from the data presented in the *HMO Comparison Report: 1997* because the denominator definition was changed to reflect the definition used for reporting in 1998 and 1999.

Graph 2.2

Number of HealthCheck Screens Per Eligible Year, 1996-1999

(Ages 0-5 Years — Milwaukee County)



* Did not report data for this survey indicator in 1999.

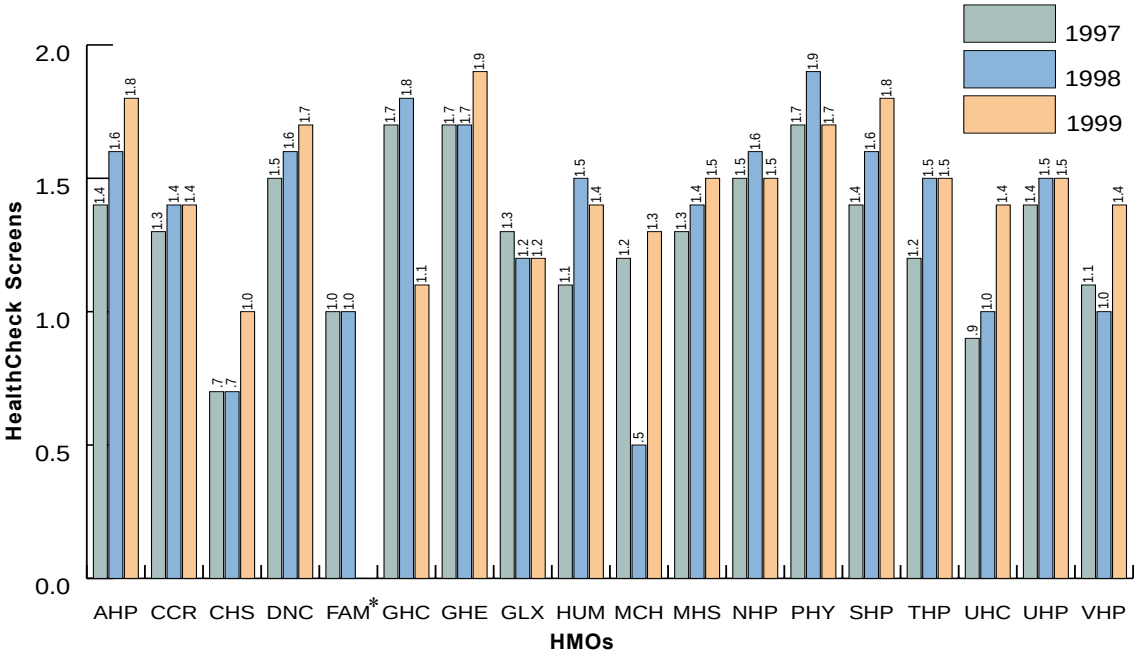
† 1996 Network Health Plan data are excluded because the number of eligible years is too small for rates to be statistically valid.

Using the new method of calculation, in 1997 the rest of state HMO average number of HealthCheck visits per eligible year in the 0-5-year-old age group was 1.27. The 1998 and 1999 rates were 1.39 and 1.51, respectively.

Graph 2.3

Number of HealthCheck Screens Per Eligible Year, 1997-1999

(Ages 0-5 Years — Rest of State)



* Family Health Plan data are excluded in 1999 because the number of eligible years is not comparable to other "Rest of State" HMOs.

These data suggest that HealthCheck visits have increased slightly for most HMOs. The HMOs outside of Milwaukee County have not achieved the federal benchmark of two visits per eligible year for children aged 0-5 years.

External Quality Review Organization Review in 1998

The external quality review organization (EQRO) review of ambulatory managed care services compares the performance between individual HMOs and the HMO average performance, as well as to the fee-for-service (FFS) performance in selected areas. The ambulatory services reviewed in 1998 and 1999 included HealthChecks, well-baby and well-child visits, immunizations, and prenatal care services. Each review included a generic quality of care screen. These findings are included in the *HMO/FFS Quality of Care Audit: 1997-1999, Combined Qualitative Analysis, January 25, 2000* report.

HMOs were scored by the EQRO on the percentage of charts reviewed that documented the completion of the health care service under review. The average score for all HMOs for completion of the components of a HealthCheck visit ranged from a high of 95.7% for physical assessment to a low of 74.9% for blood lead testing. Overall, the average HMO score on the HealthCheck components exceeded the FFS score.

The FFS score was lower than the HMO average score in seven out of the 13 HealthCheck components that were evaluated. In addition to blood lead testing, the HMO average score was less than 90% in the following areas: hearing assessment, 89.3%; fifth series of immunization: Hemophilus Influenza B vaccine (HIB), Diptheria, tetanus toxoids, and pertusus (DTP) vaccines, 88.9%; and immunization for children 11-12 years: measles, mumps, and rubella virus vaccine (MMR) (if not already given), tetanus and diptheria toxoids (Td), Hepatitus B vaccine (Hep B), 83.1%.

The EQRO review was performed using a statistically valid sample for each participating HMO. This permits the DHCF to state that HealthCheck visits performed by managed care exceed the level of completeness of HealthCheck exams performed by FFS providers in every area of review except physical assessment. However, the federal benchmark for all HealthCheck services except physical assessment is 100%, especially because these are services important in promoting a "healthy start" for those people who would have the potential to be a vulnerable population.

[1] A comprehensive HealthCheck screen includes:

- A comprehensive health and developmental history.
- A comprehensive physical exam.
- Appropriate immunizations.
- Laboratory tests (including blood lead screening and testing).
- Vision screening.
- Hearing screening.
- Oral assessment and referral to dentist at age three.

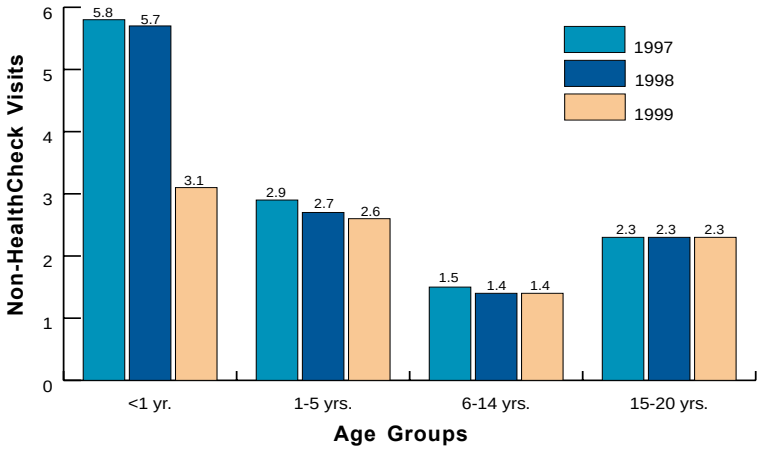
HealthCheck and Non-HealthCheck Visits

Access to Care

The availability of primary care is essential to a child's well-being. The American Academy of Pediatrics (AAP) defines primary care as "accessible and affordable, first contact, continuous and comprehensive, and coordinated to meet the health needs of the individual and family being served."[1] The availability of non-HealthCheck visits helps establish a primary care "medical home" for children enrolled in the HMO Medicaid program. Non-HealthCheck visit utilization data are an indication of the ease with which children receive routine and acute office care.

Graph 2.4a

Number of Non-HealthCheck Visits Per Eligible Year, Milwaukee County, 1997-1999

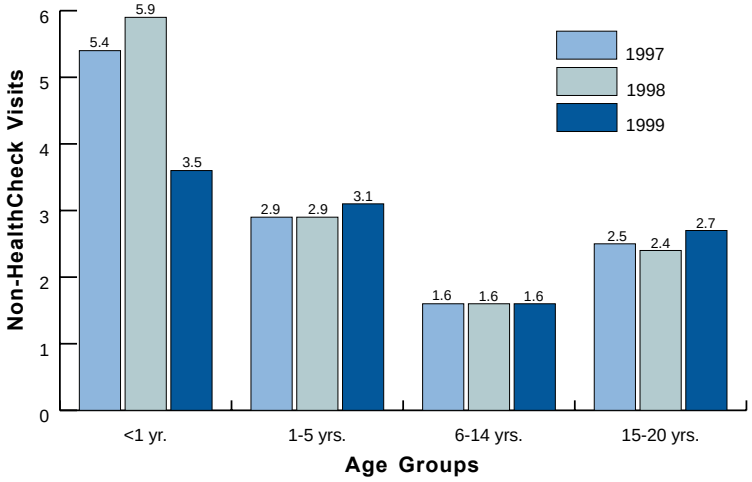


Non-HealthCheck Visits per Eligible Year — Milwaukee County and Non-Milwaukee County

Graphs 2.4a and 2.4b show that the non-Milwaukee County HMOs and the Milwaukee County HMOs delivered approximately the same level of non-HealthCheck services for each age group in 1997 through 1999, except for the less-than-one-year-old age group.

Graph 2.4b

Number of Non-HealthCheck Visits Per Eligible Year, Rest of State, 1997-1999



The Medicaid HMOs outside of Milwaukee County had approximately the same level of non-HealthCheck service delivery as did the Milwaukee County HMOs. This information, coupled with the patient survey performed in Milwaukee County that demonstrated enrollee satisfaction with the availability of appointments[2], suggests that Wisconsin Medicaid enrollees do not have trouble with gaining access to their "medical home."

The largest number of visits occur in the less-than-one-year-old age group, in contrast to the 6-14-year-old age group, who has the lowest number of visits. This utilization pattern is not seen in reported HealthCheck visits where the pattern is one of continued decrease after the 0-5-year-old age group.

Milwaukee County Non-HealthCheck Visits

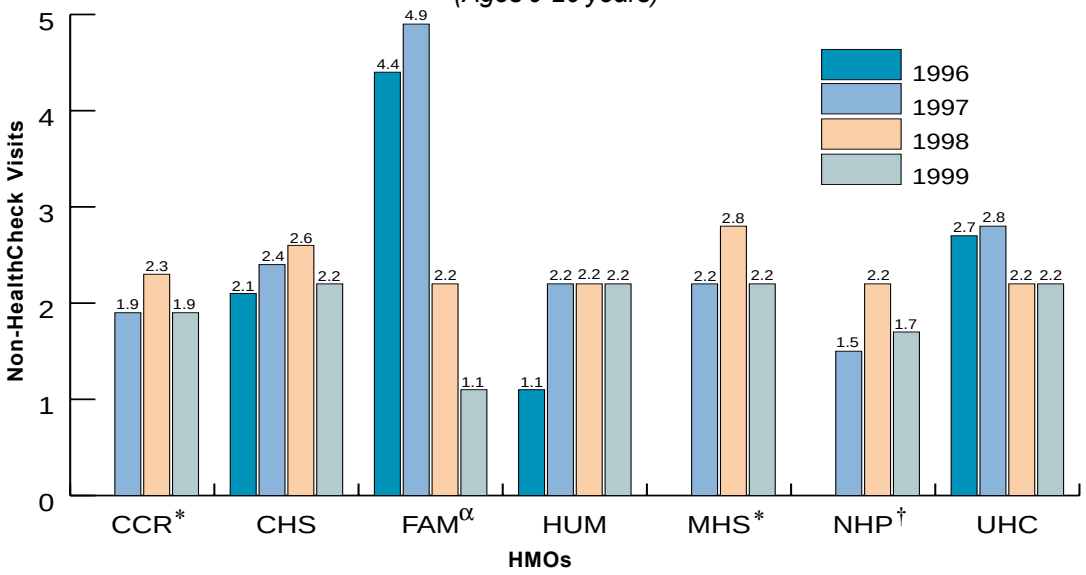
Graph 2.5 shows the four-year trend data of the number of non-HealthCheck visits per eligible year for Milwaukee County HMOs.

The 1999 Milwaukee County HMO average of 2.13 non-HealthCheck visits per eligible year is less than both the 1998 and 1997 averages (2.36 and 2.43, respectively). The rest of the state HMO average of 2.62 visits per eligible year in 1999 is slightly lower than the 2.78 visits in 1998. This results in the all-HMO

Graph 2.5

Number of Non-HealthCheck Visits Per Eligible Year, Milwaukee County, 1996-1999

(Ages 0-20 years)

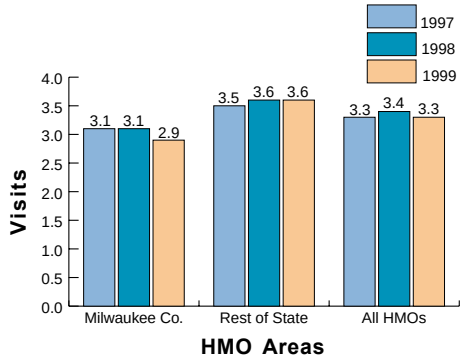


average in 1999 of 2.40 non-HealthCheck visits per eligible year compared to 2.58 in 1998 and 2.57 in 1997.

Graph 2.6

HealthCheck and Non-HealthCheck Visits Per Eligible Year, 1997-1999

(Ages 0-20 Years)



Combined HealthCheck and Non-HealthCheck Visits – Milwaukee County and Other Counties

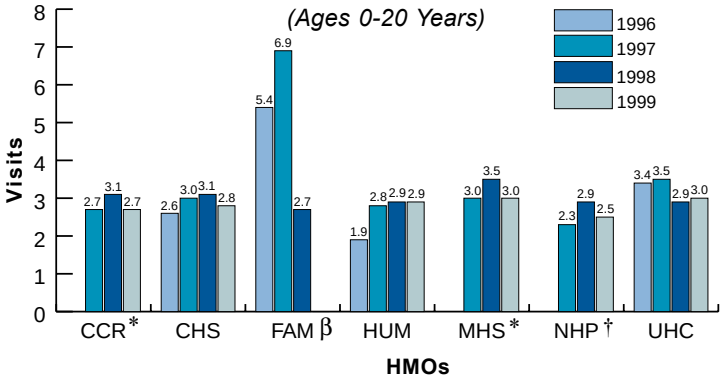
The number of enrollee visits per eligible year is used as an indicator of an HMO's ability to deliver primary care services to enrolled children. The above information coupled with the number of enrollee emergency room visits not resulting in admission per eligible year provides useful information in estimating the availability of primary care providers to see enrollees for acute problems.[3]

Graph 2.6 shows a greater number of visits for the rest of the state HMOs compared to Milwaukee County HMOs. There is a slight decrease in the reported number of visits per eligible year in Milwaukee County and for all HMOs combined from 1998 to 1999.

Graph 2.7

HealthCheck and Non-HealthCheck Visits Per Eligible Year, Milwaukee County, 1996-1999

(Ages 0-20 Years)



Milwaukee County Combined HealthCheck and Non-HealthCheck Visits

Graph 2.7 shows the rate of combined HealthCheck and non-HealthCheck visits for Milwaukee County

* 1996 Coordinated Care Health Plan and Managed Health Services are excluded as an outlier.

† 1996 Network Health Plan data are excluded because the number of eligible years is too small for rates to be statistically valid.

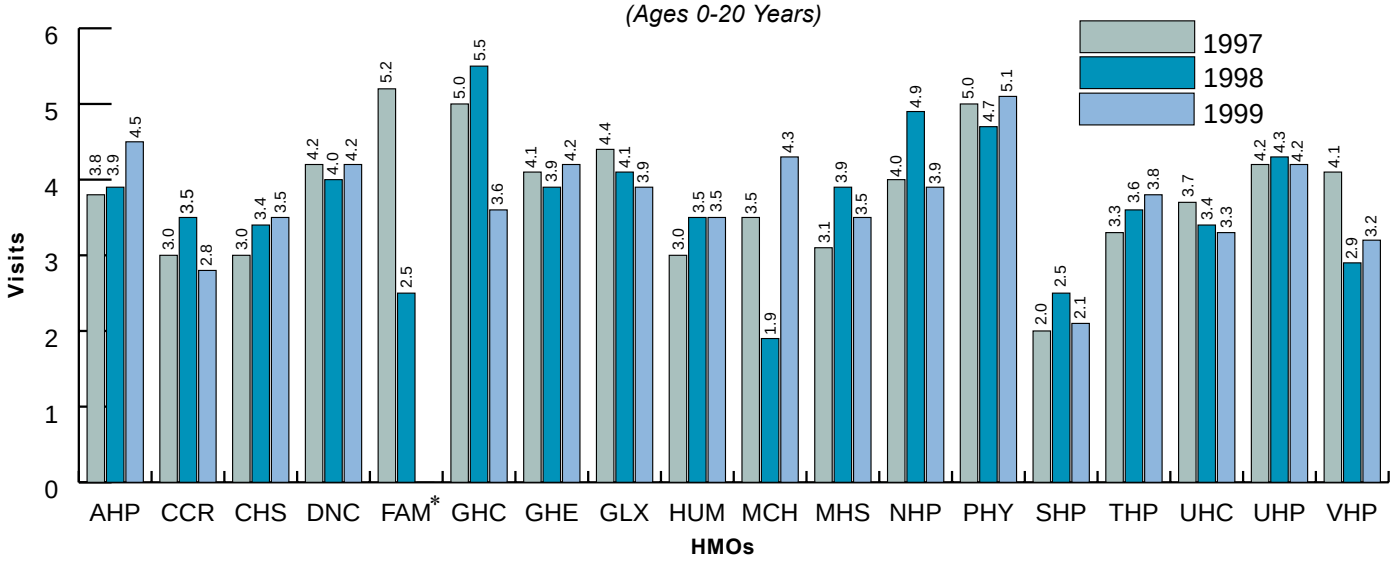
β Did not report data for this survey indicator in 1999.

α Was reported as an outlier in 1999.

Graph 2.8

HealthCheck and Non-HealthCheck Visits Per Eligible Year, Rest of State, 1997-1999

(Ages 0-20 Years)



* 1999 Family Health Plan data are excluded because the number of eligible years is not comparable to the other "Rest of State" HMOs.

enrollees from 1996 through 1999. The Milwaukee County HMOs' trend data is fairly stable within each HMO, and the reported data shows a fairly uniform level of service delivery across the Milwaukee HMOs.

Other Counties Combined HealthCheck and Non-HealthCheck Visits

Graph 2.8 shows that non-Milwaukee County enrollees receive combined HealthCheck and non-HealthCheck visits ranging from approximately two to five visits per eligible year. The average reported service delivery for HMOs outside of Milwaukee County in 1999 was 3.59 visits per eligible year. The 1997 and 1998 rates were 3.50 and 3.64, respectively. Overall, the HMOs provide a "medical home" for children with reasonable access to primary care providers as measured by HealthCheck and non-HealthCheck services.

External Quality Review Organization Review in 1998 and 1999[4]

The EQRO review of ambulatory managed care services compares the performance of each HMO with other HMOs, to the HMO average performance, and to the FFS performance in selected areas of review. The ambulatory services reviewed in 1998 and 1999 included HealthChecks, well-child visits, immunizations, and prenatal care services.

HMOs were scored by the EQRO on the percentage of charts reviewed that documented the completion of the component of health care under review that had been carried out by the HMOs. The HMO average for completion of the components of a well-child visit varied from 52.7% for blood lead testing to 98.1% for the treatment plan developed for any abnormalities. The FFS score was not significantly different from the HMO average score in any component of a well-baby visit. The well-child visit HMO scores varied from a high of 99.3% for treatment plan for any abnormalities to a low of 82.9% for physician advising a dental exam. In addition, the FFS score was significantly lower than the HMO average score for hematocrit, hemoglobin, urinalysis, and blood lead testing.

These findings provide evidence that the quality of services in managed care is not less than that seen in FFS and, in some instances, appears to exceed the performance level of FFS health care.

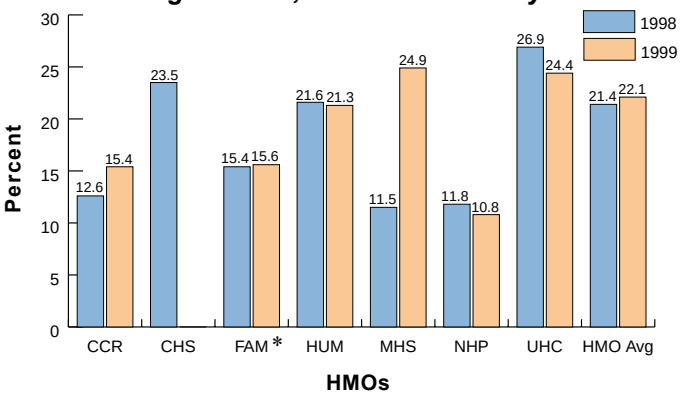
[1] P.W. Newacheck, J.J. Stoddard, D.C. Hughes, M. Pearl, "Health Insurance and Access to Primary Care For Children." New England Journal of Medicine 1998; 338: 513-518 .

[2] HMO Comparison Report: 1997, section 3, page 20.

[3] D.S. Canning, J.J. Alpert, H. Bauchner, "Care-Seeking Patterns of Inner-City Families Using an Emergency Room." Medical Care, 1996; 12:117.

[4] HMO/FFS Quality of Care Audit: 1997-1999, Combined Qualitative Analysis, January 25, 2000.

Graph 2.9
Percent of Eligibles Receiving Dental Visits Per Eligible Year, Milwaukee County



* Did not report data for this survey indicator in 1999.

Oral Health

Improving oral health requires repair of dental caries, treatment of dental disease, and use of proven preventive strategies. Over the past 50 years much has been accomplished in reducing dental decay through water fluoridation. In Wisconsin, 63% of the population is served by water systems with optimal fluoride content.[1] The majority of dental caries in children occur on tooth surfaces that can be protected by the application of dental sealants.

National Healthy People 2000 goals aimed at preventing dental caries in children include:

- 90% of children age 5 will have visited a dentist in the past year.
- 50% of children ages 8-14 will have dental sealants.

Only dental activity for enrollees in Milwaukee County HMOs is included in this report. Although dental services are provided in three additional counties in southeastern Wisconsin, the small number of enrollees in these counties makes comparison between HMOs misleading.

Dental Exams — Milwaukee County Enrollees

The data in Graph 2.9 is not comparable to the data in the 1996 and 1997 report because it includes all dental visits, whether for preventive dental care visits, visits when a sealant was applied, or acute dental care.

The *Wisconsin Family Health Survey 1998* asked Wisconsin residents if they had seen a dentist in the past year. The data reported dental visits for 77% of those interviewed who had insurance all year, 56% with coverage for part of the year, and 42% who were uninsured all year. Among the poor, 50% reported having seen a dentist in the past year, and 66% of the near-poor reported a dental visit within the past year.[2] Many of the poor and near-poor are likely to be enrolled in a Wisconsin Medicaid HMO sometime during the reporting period. The HMOs are increasing referral outreach and education activities in an effort to increase utilization of the dental benefit.

[1] Wisconsin Public Water Supply Fluoridation Census, 1996.

[2] Wisconsin Family Health Survey 1998, Bureau of Health Information, Division of Health Care Financing, Department of Health and Family Services.

Pap Testing

The purpose of performing cervical cancer screening is to detect precancerous lesions. Detection and treatment of precancerous cervical lesions identified by Pap testing can actually prevent cervical cancer. In 1998, it was estimated that nationally 13,700 new cases of invasive cervical cancer were diagnosed and 4,900 women died of the disease.[1]

Table 2.3

HMO Pap Testing Rates

Percent of Eligibles Per Eligible Year Receiving Pap Testing

Age	Milwaukee County			Rest of State		
	1997	1998	1999	1997	1998	1999
15-20 yrs	51.1	39.5	36.1	38.6	43.3	41.1
21+ yrs	52.8	39.9	37.4	42.3	46.5	46.0

HMO Pap Testing Rates

Pap testing should be performed every three years in non-high-risk populations after a baseline of two or more normal Pap smears has been obtained.

Graphs 2.10 and 2.11 show trend data over a four-year period for Milwaukee County HMOs where the data is available.

In 1999, the Milwaukee County HMO average percent of eligibles receiving a Pap test per eligible year for the 15-20-year-old age group was 36.1% compared to 51.1% in 1997 and 39.5% in 1998. (Table 2.3)

In 1999, the Milwaukee County HMO average percent eligibles receiving a Pap test per eligible year for the 21+ year-old age group was 37.4%, compared to 52.8% in 1997 and 39.9% in 1998. (Table 2.3)

While reported service delivery rates for both age groups declined from 1997 to 1998, the percentage remains within the recommended screening rate for a non-high-risk population.[2]

In 1999, HMOs outside of Milwaukee County, for ages 15-20 years, had an average percent of eligibles receiving a Pap test per eligible year percentage of 41.1%. The Pap testing percentage per eligible year for HMO enrolles outside of Milwaukee County, ages 21+, was 46.0%.

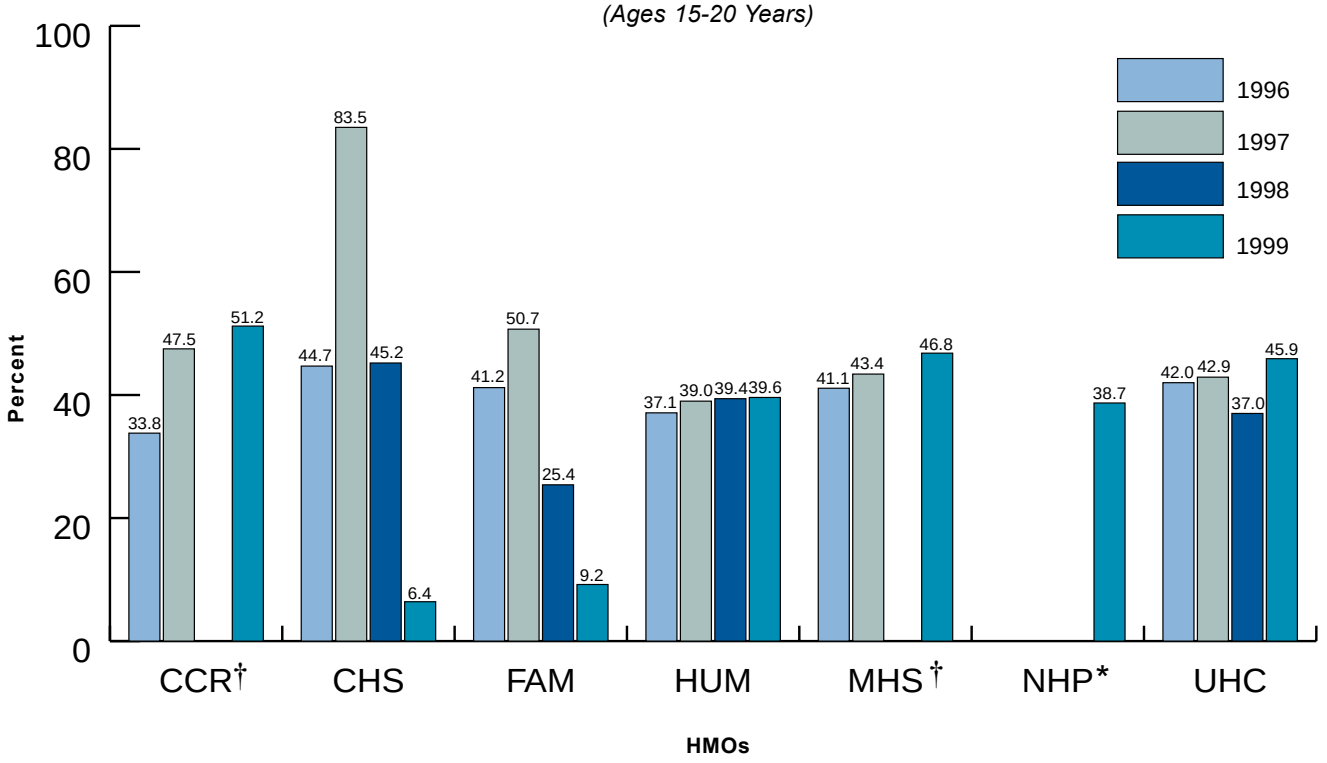
[1] Centers for Disease Control and Prevention. The National Breast and Cervical Cancer Early Detection Program. At-A-Glance, 1998.

[2] Pap test rates for 1998 exclude HMOs not reporting data for this indicator.

Graph 2.10

Percent of Eligibles Receiving Pap Test Per Eligible Year, Milwaukee County, 1996-1999

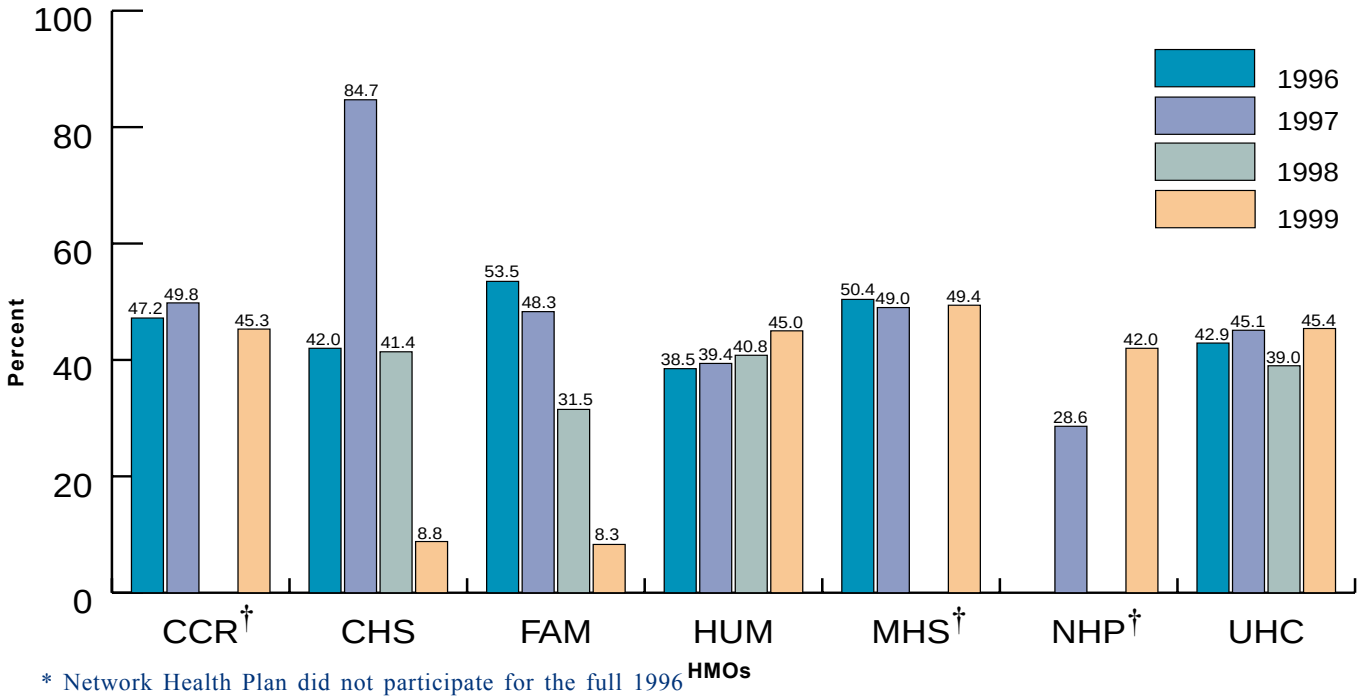
(Ages 15-20 Years)



Graph 2.11

Percent of Eligibles Receiving Pap Test Per Eligible Year, Milwaukee County, 1996-1999

(Ages 21+ Years)



* Network Health Plan did not participate for the full 1996 contracted year.

* Network Health Plan is excluded for 1997-1998 because the number of eligible years is too small for the rates to be statistically valid.

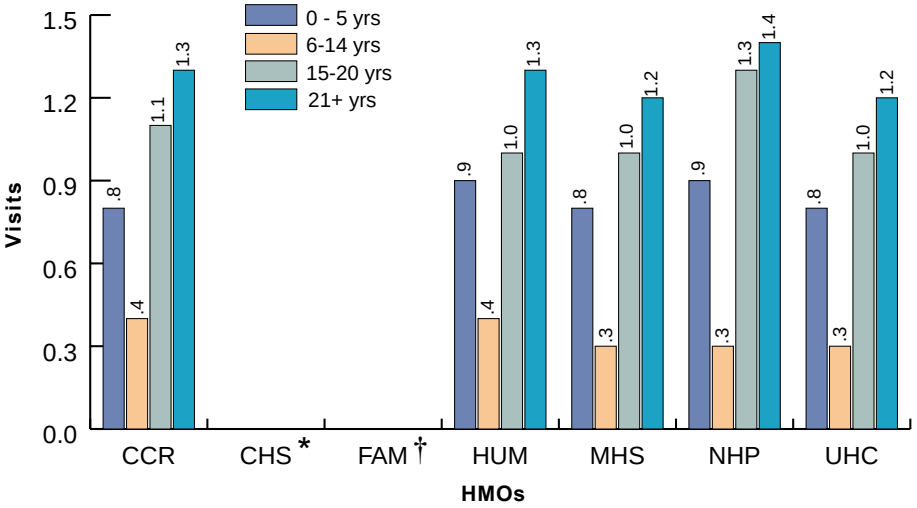
† Did not report data for this survey indicator in 1998.

Emergency Room Visits

Emergency Room Visits Without an Admission

An emergency room (ER) visit that is not followed by an admission can indicate a "non-emergency" and may represent an urgent or routine health problem that may have been better served by a visit to a primary care doctor. The reported number of ER visits without an admission per eligible year in 1999 for HMOs in Milwaukee County and HMOs in the rest of the state is higher than both the 1997 and 1998 rates. The statewide average rate was 0.71 visits without an admission per eligible year in 1999, compared to 0.49 in 1997 and 0.51 in 1998 (Graph 2.12).

Graph 2.13
Average Number of Emergency Room Visits Per Eligible Year Without Admissions, Milwaukee County, 1999



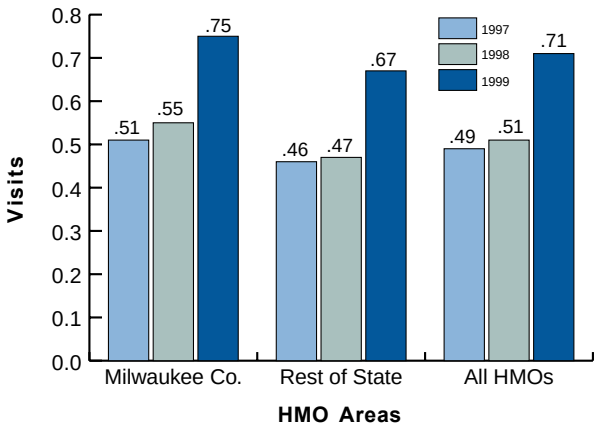
* Did not report data for this survey indicator in 1999.

† Was identified as an outlier in 1999.

Emergency Room Visits Without Admission by Age Group

Graph 2.13 shows the average number of ER visits without admission per eligible year for Milwaukee County by HMO. Typically, 6-14 year olds had the lowest average number of ER visits. The 1998 and 1999 average number reported for the 21+ years age group are higher than those reported in the 1997 *HMO Comparison Report*. The Milwaukee County HMOs reported an average of 1.21 visits without admission in 1999 compared to 0.81 ER visits without admission for this age group in 1997 and 0.87 in 1998. The HMOs in the rest of the state reported an average of 1.00 visits for this age group in 1999 compared to 0.65 visits without admission in 1997 and 0.68 in 1998.

Graph 2.12
Average Number of Emergency Room Visits Per Eligible Year Without Admission, All Ages, Milwaukee County and Rest of State
Number of Visits Per Eligible Year

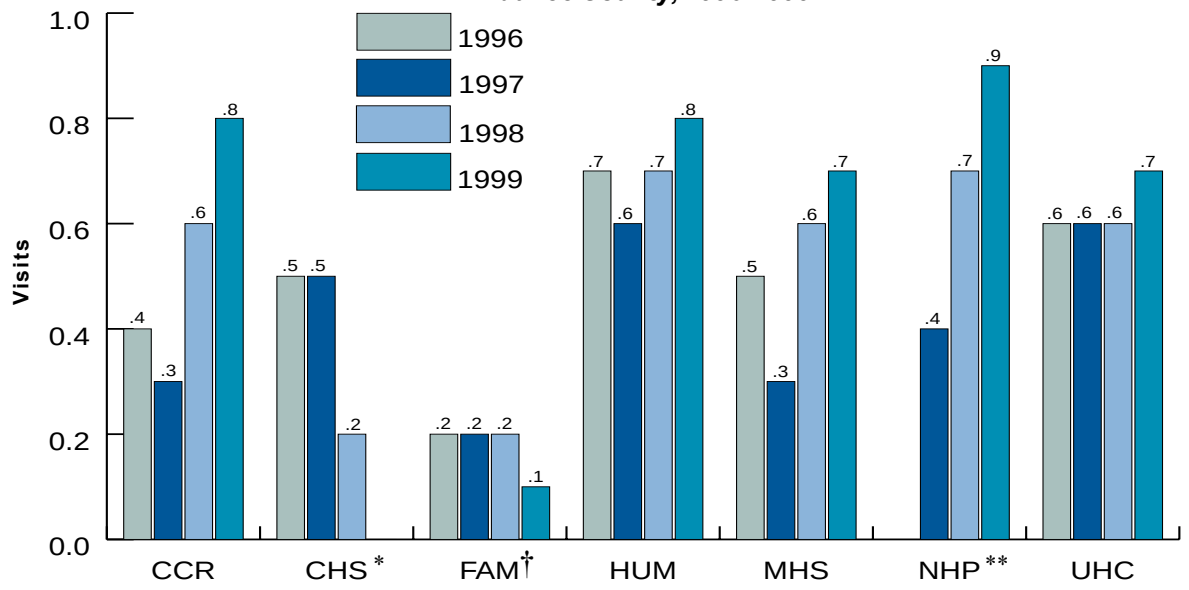


Emergency Room Visits Without Admission — Milwaukee County HMOs

Graph 2.14 shows the average number of visits to the ER without admission per eligible year for each of the Milwaukee County HMOs for a four-year period. A majority of the Milwaukee County HMOs show an increase in ER use from 1998 to 1999. The Milwaukee County HMOs have a stable utilization profile for ER services, as suggested by the 1996 and 1997 data. Continued monitoring of services in this important area will be required to determine whether the access to primary care services has resulted in a change in

Graph 2.14

Average Number of Emergency Room Visits Per Eligible Year Without Admission, All Ages
Milwaukee County, 1996-1999



* Did not report data for this survey indicator in 1999.

** NHP did not report data for this survey indicator in 1996.

† Was identified as an outlier in 1999.

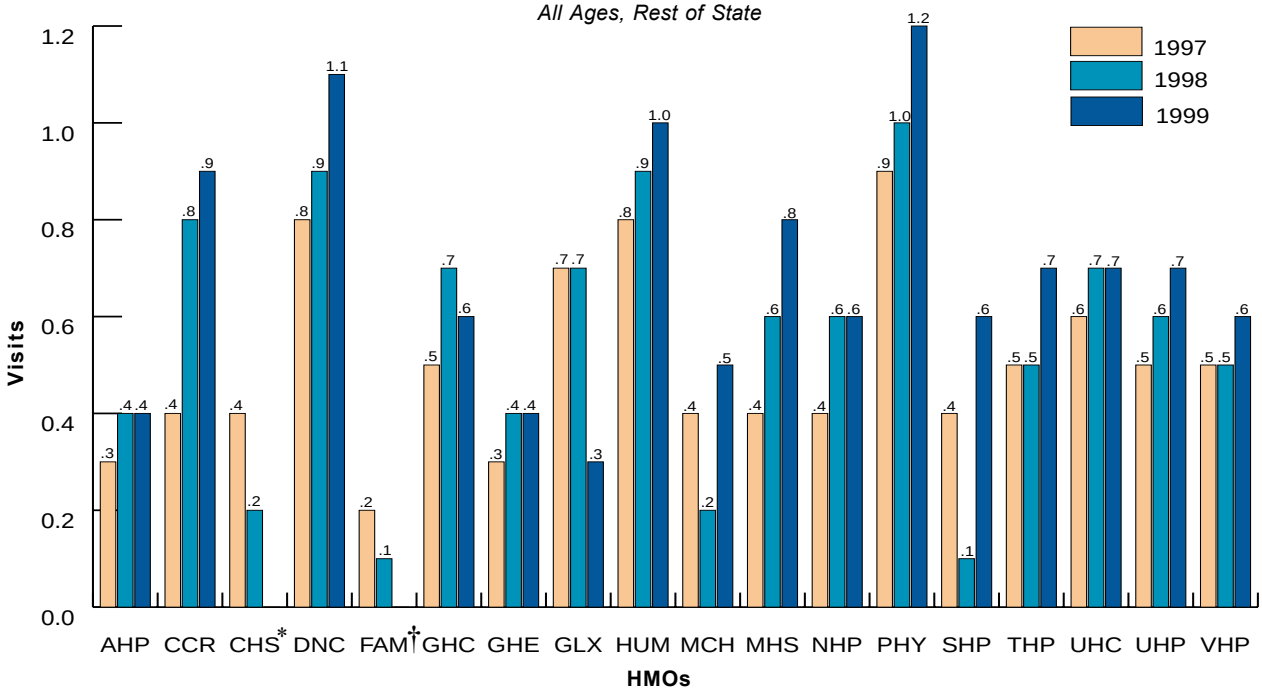
utilization of ER services, especially in the Milwaukee County Medicaid HMOs.

Emergency room use for enrollees in HMOs in the rest of the state is shown in Graph 2.15**.** The 1999 average rate for this group is 0.67 ER visits without admission per eligible year. The average rates in 1997 and 1998 were 0.46 and 0.47, respectively. Graph 2.15 clearly shows that several HMOs had very low rates of ER utilization, while others had fairly large increases in utilization.

Graph 2.15

Average Number of Emergency Room Visits Per Eligible Year Without Admission, 1997-1999

All Ages, Rest of State



* Did not report data for this survey indicator in 1999.

† Family Health Plan data were excluded because the number of eligible years was not comparable to the other "Rest of State" HMOs.

Primary Care Visits

Enrollees who see a primary care provider for routine health care needs should have fewer ER visits. Routine health problems such as headaches, earaches, and colds can be assessed in the primary care provider's office. Only serious problems should be referred to the ER for evaluation and care.

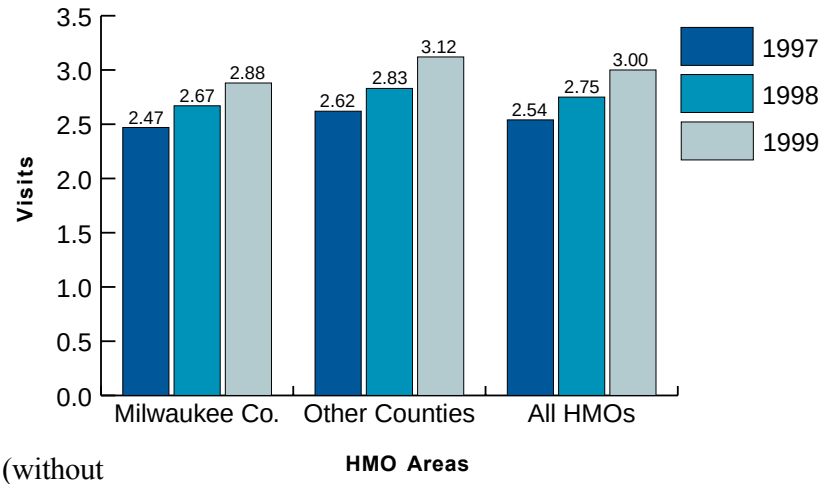
Graph 2.16 shows the 1997, 1998, and 1999 HMO average rates of primary care provider visits per eligible year for all ages. The average over these three years is 2.76 visits per eligible year. The non-Milwaukee County enrollees had a greater number of visits per eligible year than did the Milwaukee County enrollees. Conversely, Milwaukee County enrollees had a greater number of ER visits (without admission) than non-Milwaukee County enrollees. These data appear to support the concept that enrollees who see a primary care provider for routine health care have fewer ER visits.

Graph 2.17 shows the primary care visits per eligible year for the Milwaukee County HMO enrollees. The 1999 average for this group is 2.88 visits per eligible year, which shows an increase from the 1997 and 1998 averages (2.47 and 2.67, respectively).

Graph 2.18 shows the number of visits per eligible year for HMO enrollees in the rest of the state. The 1999 average for this group of HMOs is 3.12, an increase from the 1997 and 1998 averages (2.62 and 2.83, respectively).

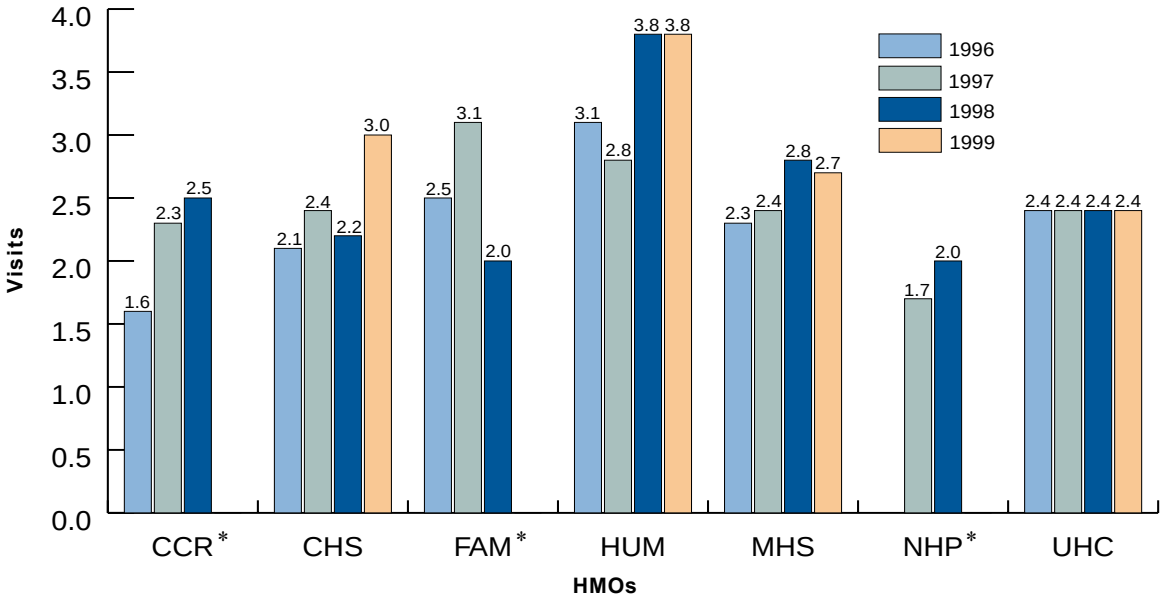
Graph 2.16

Primary Care Visits Per Eligible Year, All Ages, Milwaukee County HMOs and Rest of State, 1997-1999



Graph 2.17

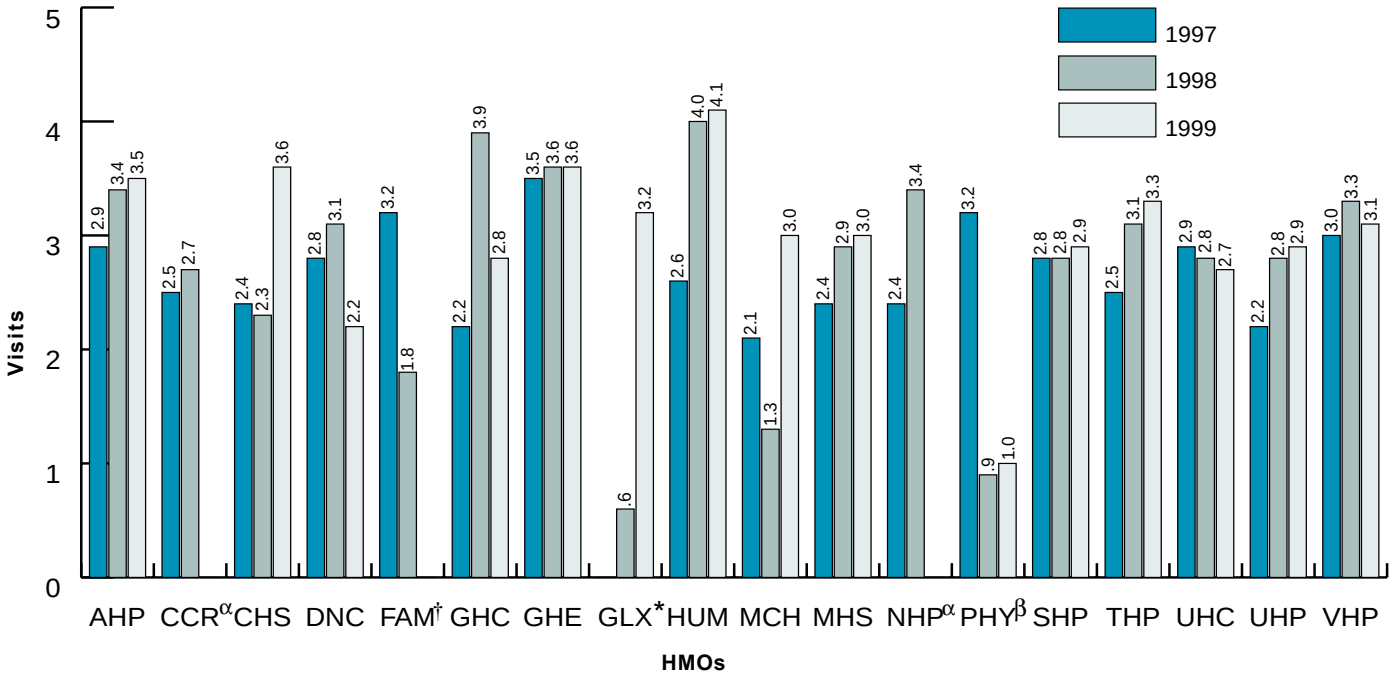
Primary Care Visits Per Eligible Year, All Ages, Milwaukee County HMOs, 1996-1999



* Did not report data for this survey indicator in 1999.

Graph 2.18

Primary Care Visits Per Eligible Year, All Ages, Rest of State, 1997-1999



* Greater La Crosse Health Plan did not report primary care visits in 1997.

† 1999 Family Health Plan data are excluded because the number of eligible years is not comparable to the other Rest of State HMOs.

α Did not report data for this survey indicator in 1999.

β Was identified as an outlier in 1999.

Section Three

Staying Healthy

The principles of managed care as a health care delivery system include promoting health and avoiding illness. These goals may lead to long-term cost savings and can serve as quality of care indicators.

Lead screening of children at an early age may prevent the long-term consequences of untreated lead toxicity. The children in the Medicaid HMO population may be at increased risk because of the housing conditions prevalent among this population. It is important that lead screening be carried out on a routine schedule so that early treatment may be provided when necessary.

The need to provide and document timely immunizations to children is a goal shared by the Division of Health Care Financing (DHCF), Medicaid HMOs, and the state and local public health departments. Reporting on immunizations is hampered by incomplete data capture where private and public providers do not have access to a single database. A goal of the Public Health Department Wisconsin Immunization Registry (WIR) program is to improve data access, which should result in fewer data reporting problems.

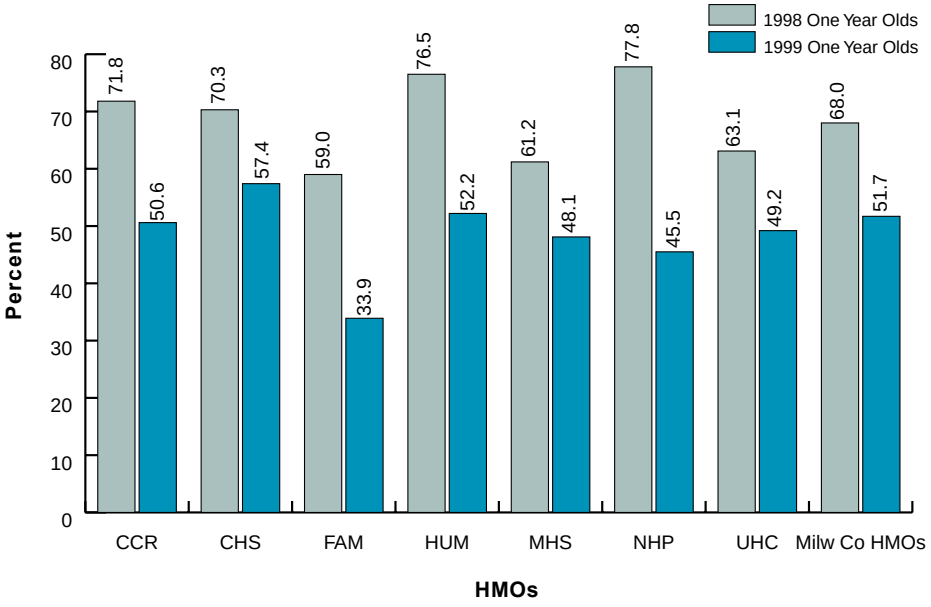
Managing pregnancy to achieve successful birth outcomes is of vital concern for this population because of its high percentage of women of childbearing age.

Lead Screening

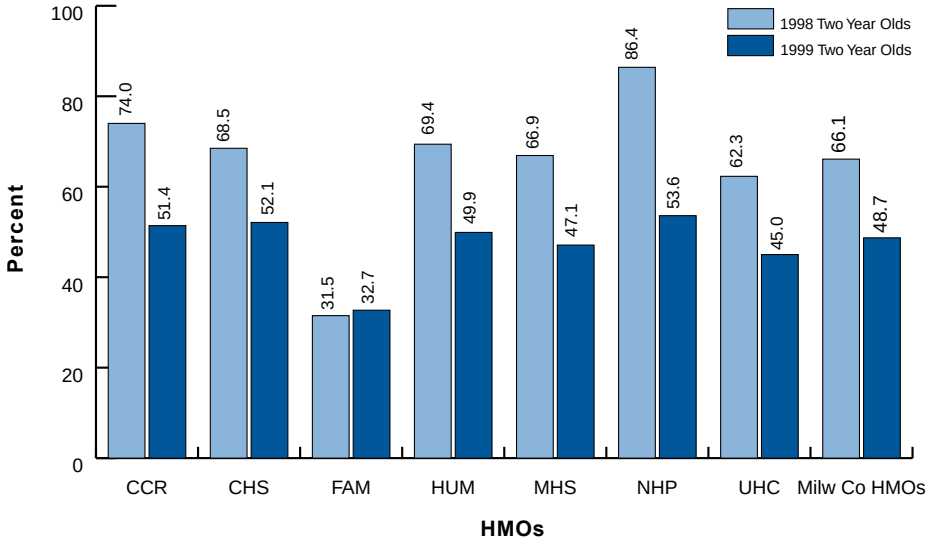
Lead poisoning is a serious threat to the health of children. A major concern for children exposed to lead is the devastating effect lead can have on the developing brain, but lead can adversely affect all systems of the body. The health outcomes of children exposed to lead depend on the amount of exposure and the age of the child at the time of exposure. Exposure in the first three years of life is associated with the most damage. Very high levels of lead exposure may cause seizures, coma, and death, while lower levels may result in developmental delays, learning disabilities, behavioral problems, impaired hearing, and stunted growth. A verified blood lead level of greater than or equal to 20 µg/dl is the level above which diagnostic evaluation and environmental intervention is recommended.[1]

In the mid-1970s in the U.S., as many as 40% of all American children under age 5 may have had average blood lead levels of 20 µg/dl.[2] By 1994, 4.4% of all children ages 1-5 years had blood lead levels of 10 µg/dl,[3] a decreased prevalence of lead in children due primarily to the elimination of lead in paint and gasoline. Three-fourths of all children ages 1-5 years who had elevated blood lead levels in the Center for Disease Control's 1991-1994 survey were enrolled in Medicaid, the Women, Infant, and Children program, or were within the target population for the Centers for Disease Control Health Centers Program.[4]

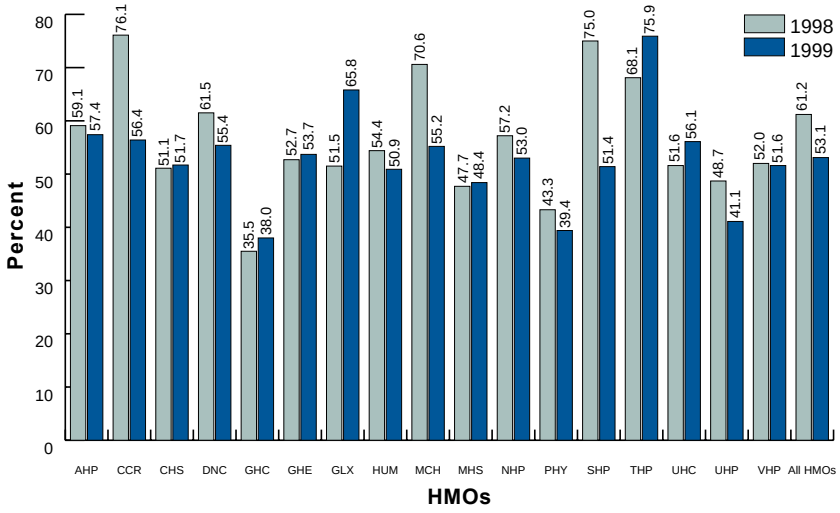
Graph 3.1
Percent of Qualifying One-Year-Olds Tested for Lead, 1998 and 1999
(Milwaukee County HMOs)



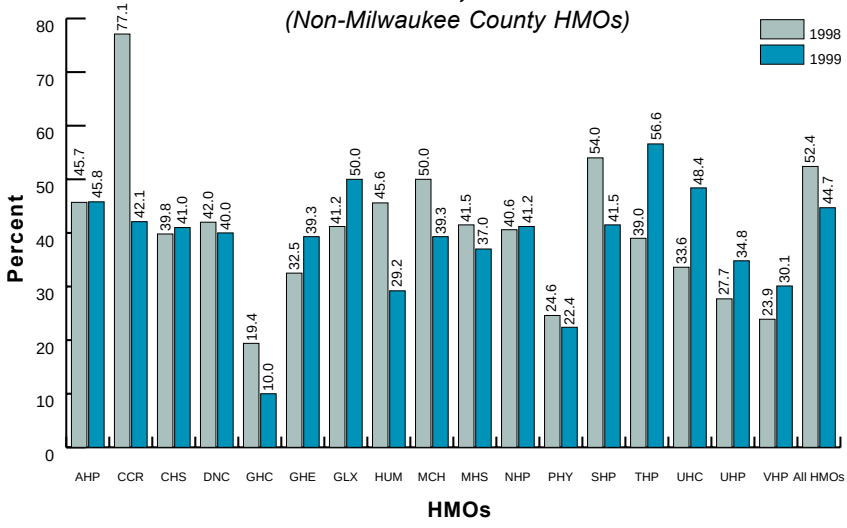
Graph 3.1a
Percent of Qualifying Two-Year-Olds Tested for Lead, 1998 and 1999
(Milwaukee County HMOs)



Graph 3.2
Percent of Qualifying One-Year-Olds Tested for Lead, 1998 and 1999
(Non-Milwaukee County HMOs)



Graph 3.2a
Percent of Qualifying Two-Year-Olds Tested for Lead, 1998 and 1999
(Non-Milwaukee County HMOs)



The federal government requires blood lead testing for all children in Medicaid at approximately one and two years of age. Wisconsin requires that results of all lead testing done in the state be reported to the Wisconsin Division of Public Health Childhood Lead Poisoning Prevention Program (WCLPPP).

Graphs 3.1 and 3.1a show the rate of lead screening for Medicaid-eligible one-and two-year-old children enrolled in Milwaukee County HMOs. The likelihood that these lower values are due to incomplete reporting is minimal since these data incorporate the lead screens that were reported to the Division of Public Health. Overall, the 1998 and 1999 lead testing rates for Milwaukee County HMOs are similar for one-and two-year-olds, 68.0% (1998); 51.7% (1999) and 66.1% (1998); 48.7% (1999), respectively.

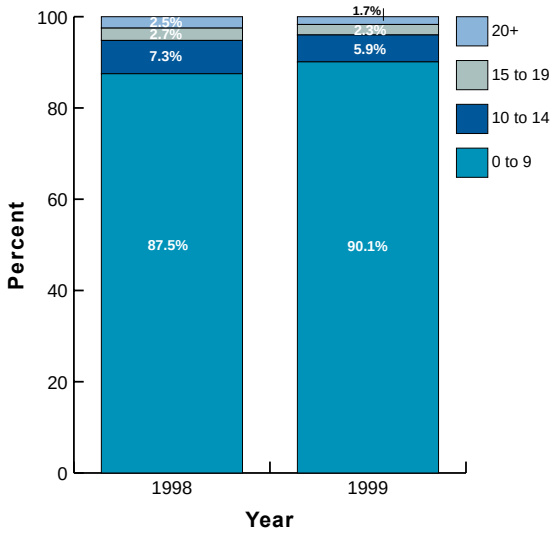
Graph 3.2 and 3.2a show the rate of lead screening for Medicaid-eligible one-and two-year-old children enrolled in HMOs outside of Milwaukee County in 1998 and 1999. The 1999 rates are slightly lower than 1998, and continue to be below the 10 µg/dl level. The average screening rate for non-Milwaukee County HMOs in 1999 was 54.2% for Medicaid-eligible one-year-olds and 41.1% for Medicaid-eligible two-year-olds.

Of the lead screens reported in 1999 for one-year-olds in Wisconsin Medicaid HMOs, 90.1% were below 10 µg/dl, the level at which family education and referral to Public Health is recommended by the WCLPPP. Overall, lead levels for one-year-olds were slightly lower in 1999 than in 1998 (Graph 3.3). Only 1.7% had levels of 20 µg/dl or higher, the level at which medical intervention is recommended.

Graph 3.3

Blood Lead Levels of Qualifying One-Year-Olds Tested for Lead, 1998 and 1999

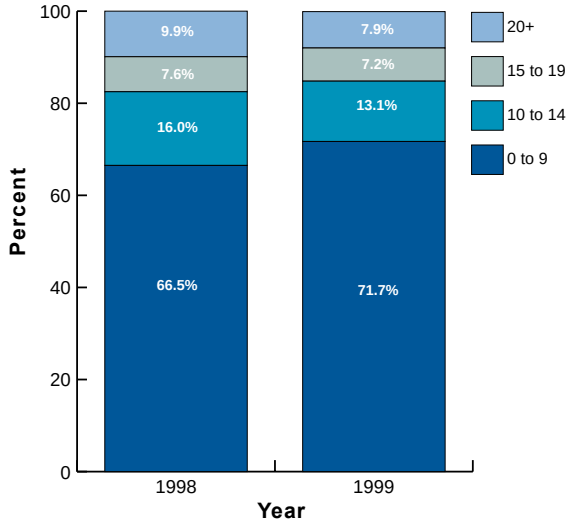
(All HMOs)



Graph 3.4

Blood Lead Levels of Qualifying Two-Year-Olds Tested for Lead, 1998 and 1999

(All HMOs)



Similarly, lead levels for two-year-olds were slightly lower in 1999 than in 1998 (Graph 3.4). Almost 8% of two-year-olds had lead levels of 20 µg/dl or higher in 1999 compared to almost 10% in 1998. The percent of two-year-olds with lead levels below 10 µg/dl increased from 66.5% in 1998 to 71.7% in 1999.

[1] A Physicians Guide to Blood Lead Screening and Treatment of Lead Poisoning in Children, Wisconsin Childhood Lead Poisoning Prevention Program, Department of Health and Family Services.

[2] Bellinger D. New England Journal of Medicine 316 (17): 1037-1043, April 1987.

[3] Centers for Disease Control and Prevention. Update: Blood Lead Levels-United States, 1991-1994. MMWR, February 21, 1997; Vol. 46, No. 07; 141-146.

[4] Lead Poisoning: Federal Health Care Programs Are Not Effectively Reaching At-Risk Children, United States General Accounting Office GAO/HEHS-99-18.

Immunizations

Vaccine-Preventable Illnesses

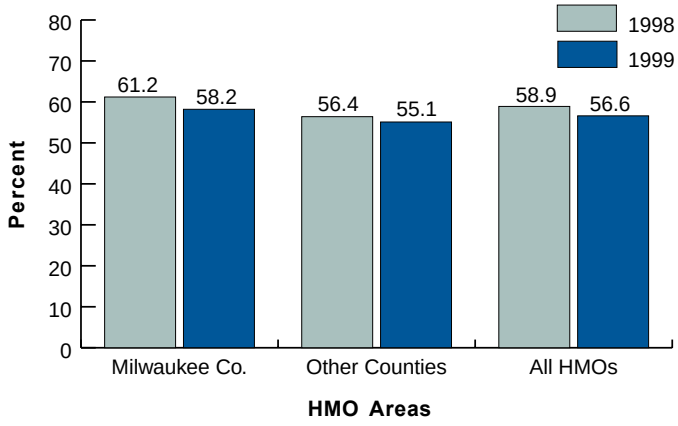
Childhood immunizations help keep children healthy and effectively avoid potential harmful effects of ten vaccine-preventable diseases. For example, measles, which typically cause a rash and high fever, can also cause pneumonia, deafness, or brain damage. Rubella (German Measles) is a mild illness for children but may cause a pregnant woman who acquires it to miscarry the baby or cause the baby to have physical abnormalities or developmental disabilities. Many individuals who get polio will be permanently paralyzed. Tetanus attacks the nervous system causing painful muscle spasms and may result in death. Hepatitis B may cause chronic inflammation of the liver and may cause death as a result of liver failure.

Barriers to Immunization

During 1989-1991, the United States experienced an outbreak of the vaccine-preventable disease measles. The primary cause of such an outbreak or resurgence of a vaccine-preventable disease has not been the failure of the vaccine to protect but rather the failure to protect the vulnerable population by delivery of the necessary vaccine at the recommended ages. Barriers to achieving full immunization of the vulnerable population include both provider and recipient factors.

Availability of health care through Medicaid may be less predictable than in the commercial population. In Medicaid, the need for enrollees to meet eligibility requirements can result in interrupted HMO enrollment periods, leading to greater difficulty with establishing a "medical home." In turn, the lack of a "medical home" makes it difficult to provide and monitor immunizations. To combat this, a centralized, statewide immunization registry is being implemented. The registry will assist health care providers with the task of accurately monitoring the immunization history of children in Wisconsin.

Graph 3.5
Percent of Two-Year-Olds Receiving MMR Vaccinations, 1998 and 1999



Vaccination Monitoring and Goals

The measles, mumps, and rubella (MMR) vaccination is recommended once between 12 and 15 months of age, and again between ages 4 and 6 years. This schedule of MMR vaccinations allows for a reasonable and simple measure for the provision of immunizations in general.

The Department of Health and Family Services' Strategic Business Plan Year 2001 goal is "to increase to 90% the proportion of children who have received their primary vaccinations by their second birthday."

Measles, Mumps, and Rubella Vaccinations

The 1998 and 1999 MMR vaccination rates for HMO enrollees reflect services provided by the Wisconsin Medicaid program for children who reached their second birthday during the reporting period and who were enrolled in Wisconsin Medicaid for at least 10 months in the reporting year. Because our reporting method used in 1998 and 1999 is different from that used in prior years, trending prior to 1998 is not possible for this indicator.

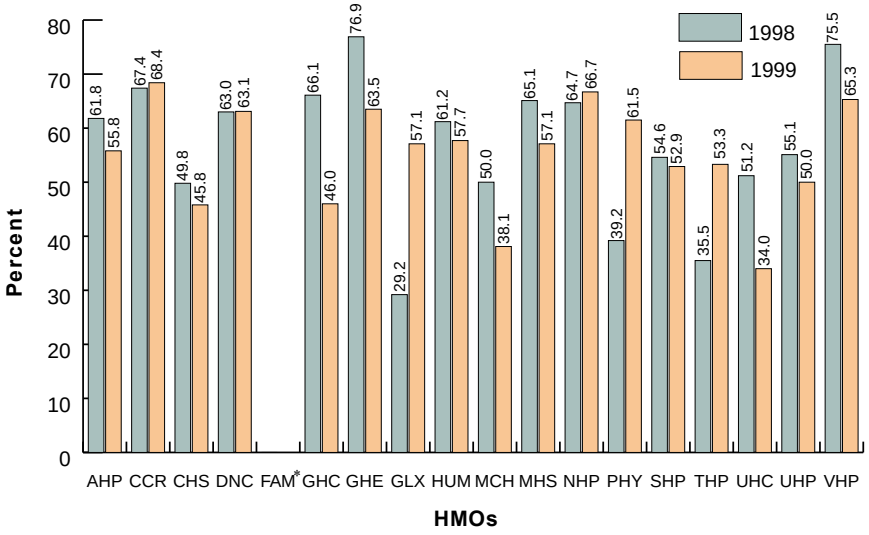
The Milwaukee County HMO average percent of MMR vaccination was 61.2% in 1998 and 58.2% in 1999. For all other counties, the average percent was 56.4% in 1998 and 55.1% in 1999 (Graph 3.5).

Graph 3.6a shows the percents of eligible two-year-olds outside of Milwaukee County who received the MMR immunization in 1998 and 1999. The percentage of MMR vaccinations to non-Milwaukee County HMO enrollees varied from approximately 29% to 77%.

Graph 3.6a

Percent of Two-Year-Olds Receiving MMR Vaccinations, 1998 and 1999

(Enrollees Outside of Milwaukee County)



* Family Health Plan data are excluded because the number of eligibles meeting the criteria is too small for statistical analysis.

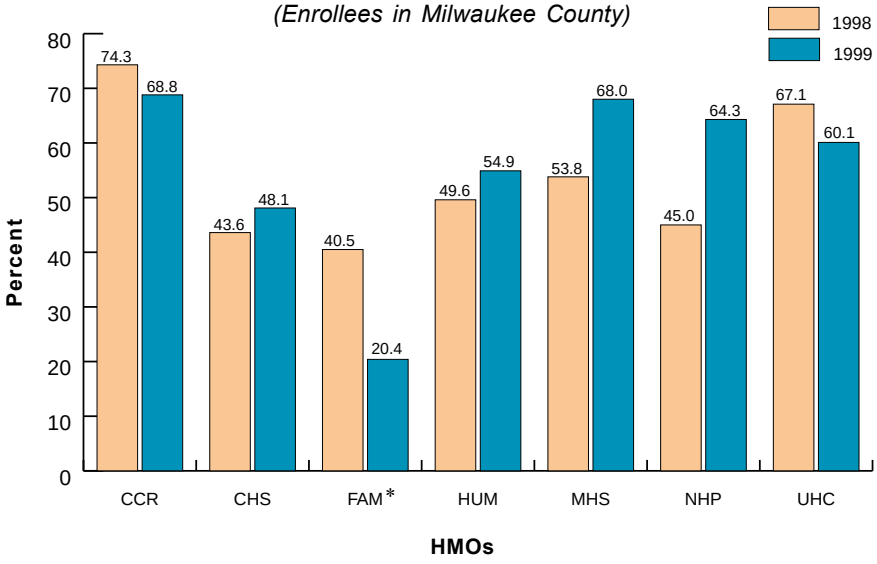
Graph 3.6b shows the percent of eligible two-year-olds in Milwaukee County HMOs that received the MMR immunization in 1998 and 1999. Most Milwaukee County HMOs showed improvement in the delivery of MMR vaccinations from 1998 to 1999.

The MMR vaccination percentage rate does not include the services delivered by public agencies that were not reported or billed to the enrollee's HMO. Since the rate of HealthCheck services delivered to this age group is nearly 80% in non-Milwaukee County HMOs and approximately 70% in Milwaukee County HMOs, and HealthCheck services include a review of immunization status, it is likely that under-reporting of immunizations continues to occur. Statewide implementation of the Department of Public Health WIR should improve the reporting of childhood immunizations.

Graph 3.6b

Percent of Two-Year-Olds Receiving MMR Vaccinations, 1998 and 1999

(Enrollees in Milwaukee County)



* FAM was identified as an outlier.

As was true in 1997, several HMOs chose immunizations as the topic for a performance improvement project in 1998 and 1999. Through performance improvement projects, the HMOs are exploring ways to improve both delivery and recording of immunization services. The DHCF, in cooperation with participating HMOs, may be able to identify a "best practice" which can be shared with all Medicaid providers.

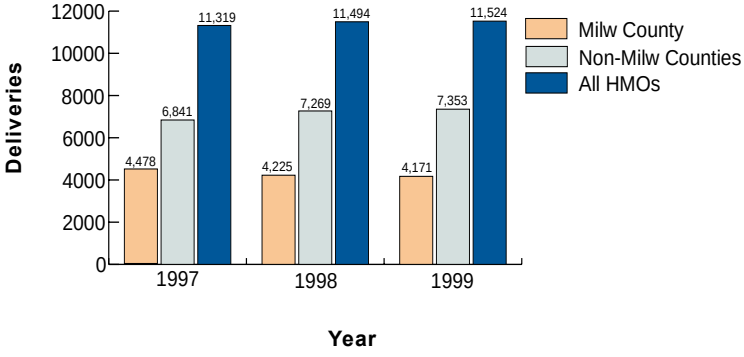
Pregnancy and Birth Outcomes

Medicaid strives to ensure that all pregnant HMO enrollees have access to services that will aid in a healthy birth outcome. Prenatal care coordination programs have been used by the HMOs to assess women at risk and provide health exams, health education, nutrition counseling, and other health promotion activities. In 1998, as in 1997, seven of the HMOs participating in Wisconsin Medicaid chose to study prenatal care more in depth by selecting it as a topic for their performance improvement projects.

The number of obstetrical deliveries to Milwaukee County HMO enrollees has declined from 4,478 in 1997 to 4,171 in 1999. Births to Medicaid managed care enrollees in non-Milwaukee County HMOs increased from 6,841 in 1997 to 7,353 in 1999 (Graph 3.7).

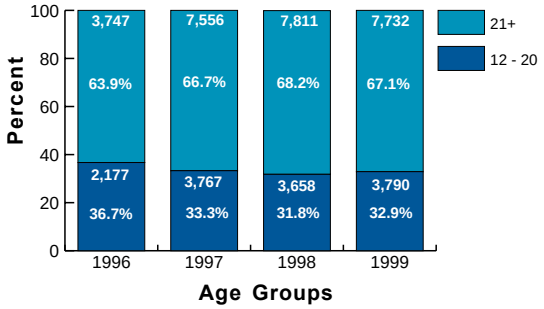
Each year in the U.S., almost 500,000 teenagers give birth. The birth rate for Wisconsin teens aged 15-19 years was 35.1 births per 1,000 females compared to the national rate of 51.1 births per 1,000 females in 1998.[1] Teenage mothers are more likely than older mothers to not receive timely prenatal care, to smoke, and to have a low birth-weight infant.[2]

Graph 3.7
Number of Deliveries



Maternal factors found to be associated with infant mortality include beginning prenatal care after the first trimester of pregnancy, being a teenager or 40 years of age or older, not completing high school, being unmarried, and smoking during pregnancy.[3]

Graph 3.8
Number of Deliveries and Percent of All Deliveries by Age, 1996-1999



In 1999, of the 11,524 deliveries to enrollees, 3,790 births were to females 12-20 years old. Expressed as a percentage of all deliveries, the number of deliveries to women ages 12-20 was 32.9% in 1999, compared to 31.8% in 1998 and 33.3% in 1997.

In 1999, the DHCF provided each HMO with a list of their own enrollees who had a previous unfavorable outcome of pregnancy and who were identified as having risk factors associated with undesirable outcomes of pregnancy, such as low birth weight, admission to Neonatal Intensive Care Unit, etc. This chart will allow HMOs to be able to target prenatal care to this high-risk population and that the services will reflect attention to the identified risk factors for each enrollee. DHCF provides the data in an effort to decrease the incidence of unfavorable pregnancy outcomes (Graph 3.8).

[1] Wisconsin Birth and Infant Deaths; 1998, Bureau of Health Information, Division of Health Care Financing.

[2] National Vital Statistics System. Teenage Births in the United States: National and State Trends, 1990-96 (PHS) 98-1120 (4/30/98).

[3] Center for Disease Control and Prevention/National Center for Health Statistics, Monthly Vital Statistics Report, Vol. 46 No. 12 Aug. 1998.

Cesarean Section and Vaginal Births

Compared to vaginal deliveries, Cesarean sections (C-sections) have been associated with greater mortality, morbidity, and longer lengths of hospital stays. In 1998, 11 out of 100 deliveries in Wisconsin were primary C-section, and 6 out of 100 deliveries were repeat C-section deliveries.[1] The goal of the national Healthy People 2000 initiative is to reduce the Cesarean rate to no more than 15 per 100 deliveries.

Cesarean Sections

In 1998 and 1999, the overall statewide percentage of Cesarean deliveries to Medicaid enrollees (10.6% and 13.0%, respectively) met the Healthy People 2000 goal. The percentage of deliveries that were Cesarean in 1999 was 8.9% for enrollees in Milwaukee County and 15.3% for enrollees in the rest of the state (Graph 3.9).

Graph 3.10 presents the percentage of deliveries that are C-Sections by age group. There was a gradual decrease in C-section deliveries for all age groups from 1996 through 1998, followed by a slight increase in 1999.

Low rates of C-Section deliveries have to be interpreted with caution since the rates have not been adjusted for risk factors and cannot be linked to complication rates and birth outcomes. Low rates of C-Section deliveries are only desirable when safe vaginal deliveries can be assured.

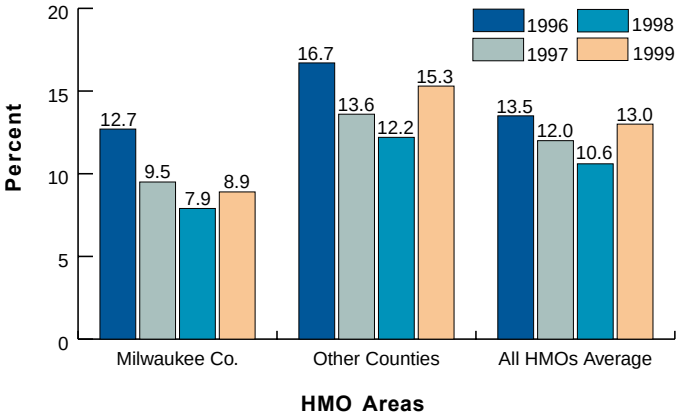
Vaginal Births After Cesarean

In recent years, vaginal births after a C-section (VBACS) delivery have been considered a safe option for many women. As the number of VBACS increase, so will the number of reported complications. The risks of VBACS must be weighed against the risk of complications from C-Section delivery.

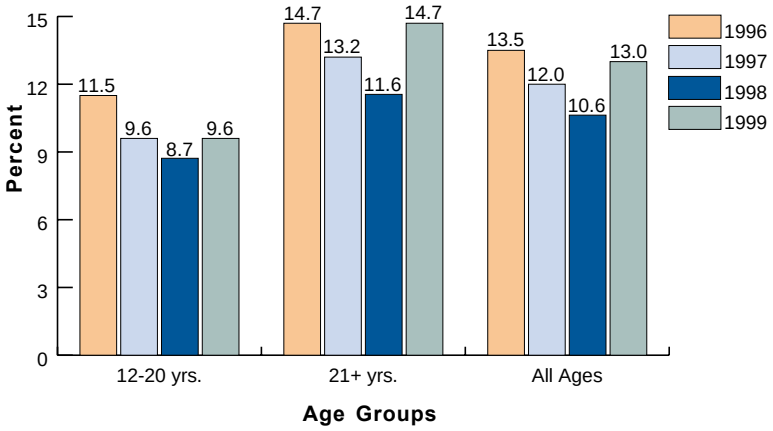
Experts are now contending that strategies proposed to reduce C-Section deliveries by increasing the number of vaginal deliveries among women who have had C-Section deliveries and increasing the number of operative vaginal deliveries may be associated with uterine rupture and neonatal trauma.[2]

The overall rate of VBACS performed for HMO

Graph 3.9
Percentage of Deliveries That are C-Sections, 1996 - 1999



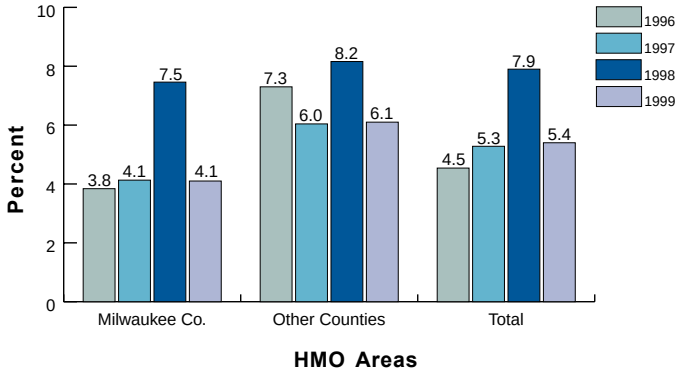
Graph 3.10
Percent of Deliveries That are C-Sections by Age, 1996 - 1999
(All HMOs)



enrollees peaked in 1998. Rates of VBACS were consistently higher for non-Milwaukee County HMOs than for Milwaukee County HMOs (Graph 3.11). Drawing conclusions from the data is difficult without information about outcomes among women undergoing VBACS and complication rates in both the mother and the neonate. Encounter data analysis should permit outcome measurements related to VBACS, thus providing more meaningful information than the number and percentage of C-section deliveries.

Graph 3.11

Percent of Deliveries That are VBACs, 1996 - 1999



[1] Wisconsin Births and Infant Deaths 1998 Bureau of Health Information, Division of Health Care Financing, Department of Health and Family Services.

[2] Sachs B., Castro M., and Frigoletto F. "The Risks of Lowering the Cesarean Delivery Rate." NEJM. Jan. 7, 1999; Vol. 340, No. 1.

Section Four
Getting Better

The ability of HMO enrollees to access care for established diagnoses is essential to achieving wellness. Once a diagnosis is established, a plan of care is usually required to regain normal health.

Mental health and substance abuse (alcohol and other drug abuse) treatment services are important components of care for Wisconsin Medicaid enrollees. The Division of Health Care Financing is continuing to work with providers to respond to the challenges that surround the delivery of these services.

Services may be provided by HMO-subcontracted providers so that complete data are not always available to the HMO for tracking and reporting purposes. In addition, issues of data confidentiality arise when data sharing is requested. Evaluation of the process(es) necessary to achieve good outcomes of treatment is thus impeded.

Prevalence of Mental Health Disorders

"Mental disorders collectively account for more than 15% of the overall burden of disease from *all* causes, and slightly more than the burden associated with all forms of cancer." 15% of adults use some form of mental health service during the year, as do 21% of children ages 9-17 years.[1]

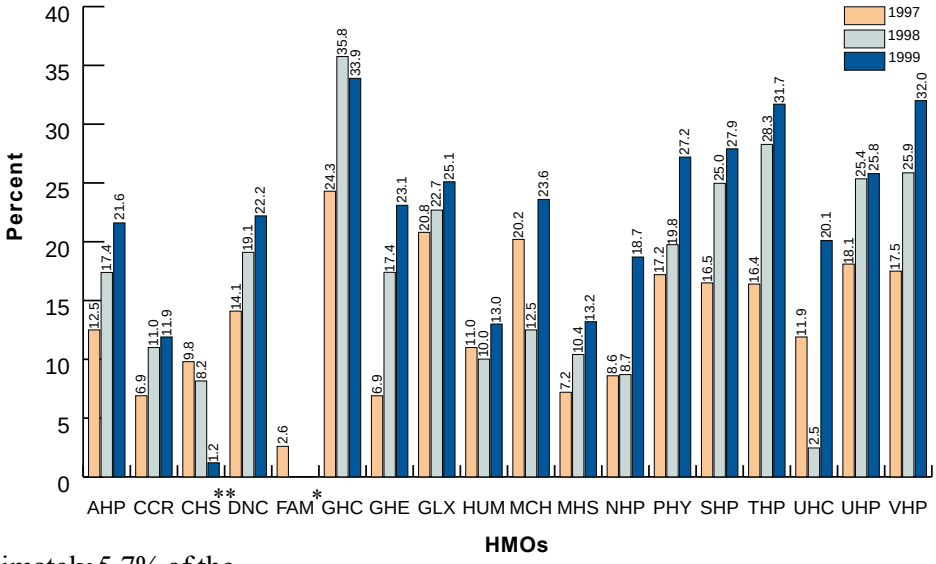
In 1998, estimates of the prevalence of serious mental illness in non-institutionalized adults in Wisconsin ranged from 3.7% in Iron County to 6.9% in Dane County. Statewide, approximately 5.7% of the adult population of Wisconsin had serious mental illness.[2] These statistics represent non-institutionalized individuals only. As is true in the general population, most Medicaid enrollees with severe mental illnesses are cared for elsewhere in the Medicaid program and not in HMOs. As a result, data reporting for institutionalized individuals with severe mental illness is not included in this report.

The reasons for failure to receive care include denial or lack of awareness that a problem exists, a feeling that a stigma is associated with seeking care, refusal of or lack of compliance with suggested treatment, and problems with access to care.

This section presents findings related to services provided in 1998 and 1999 by HMO mental health professionals and providers who are not specialized in mental illness care, such as primary care physicians.

Complete data submission and reporting are difficult due to the variability in provider types, appropriate coding of services, confidentiality concerns, and subcontracted providers' completeness of data submission.

Graph 4.1
Percent of Eligibles Receiving Mental Health Day Treatment and/or Outpatient Services Per Eligible Year
(Ages 21 and Over — Rest of State)



Prevalence of Substance Abuse Services

Alcohol abuse and misuse causes 105,000 deaths and 10 million illnesses and injuries each year in the United States.[1] One in every 10 deaths in the United States is related to alcohol and 20% of the total national hospital costs are attributed to alcohol-related illnesses.[2]

Each year in Wisconsin there are over 800 documented deaths attributable to substance abuse. Substance abuse is the fourth leading cause of death in Wisconsin. The economic impact in Wisconsin attributed to substance abuse is estimated to be over $2.6 billion dollars annually.[3] Approximately 45% of the services are provided to enrollees in the public sector.[4]

Outpatient Mental Health Care

These data reporting follow-up services do not include evaluations or assessments for mental illness. Historically, outpatient mental health care consisted almost entirely of psychotherapy and medication

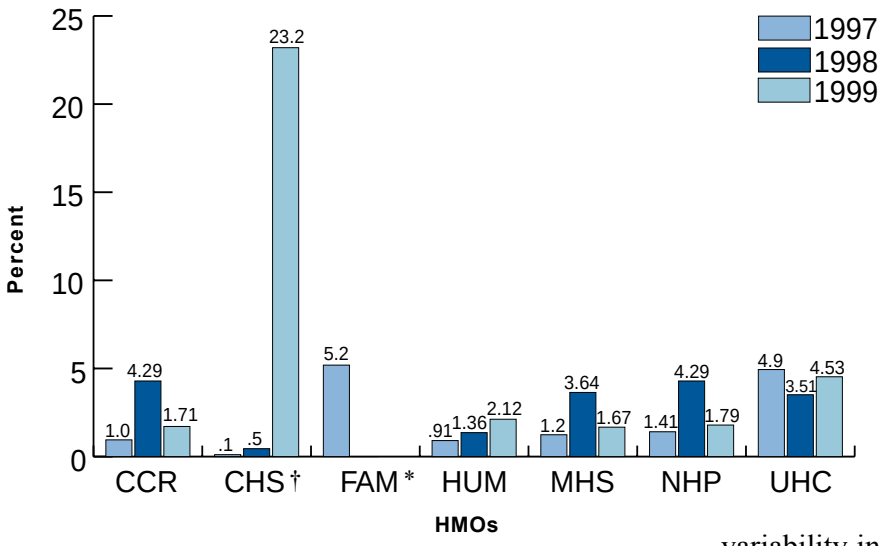
* 1999 FAM data were excluded because the number of eligible years is not comparable to the other rest of state HMOs.

** CHS was identified as an outlier in 1999.

Graph 4.2

Percent of Eligibles Receiving Substance Abuse Day Treatment and/or Outpatient Services Per Eligible Year

(Ages 21 and Over — Milwaukee County)



provided in an outpatient office or clinic on a fairly limited basis (one hour per week or less). Such care is appropriate for a wide range of diagnoses and severity levels, including some with long-term mental illnesses who do not have access to other forms of treatment, such as Community Support Programs.

Day treatment services were developed in response to a need for a level of care more intense than traditional outpatient psychotherapy, yet less invasive than inpatient treatment. Day treatment provides for more treatment hours per week in a structured setting and is appropriate for individuals with more serious or severe mental illness. Mental health day treatment patients are typically persons with long-term mental illness in maintenance, rehabilitation, or stabilization categories. It is also used after an inpatient discharge as a transition to outpatient care and often referred to as "transitional care." Day treatment programs for children and adults are not available in every city or county, so this report presents aggregate day treatment and non-day treatment outpatient care.

Graph 4.4 shows data for mental health day treatment and/or outpatient services for Milwaukee County enrollees for 1996 through 1999, for ages 21 years and older.

The 1999 average for the Milwaukee County HMOs is 8.9% eligibles receiving mental health day treatment and/or outpatient services per eligible year, ages 21 and over. The averages in 1997 and 1998 were 5.1% and 5.4%, respectively. While the averages are similar, there is wide variability from year to year in several of the Milwaukee County HMOs. Whether the variability represents a real difference in level of service delivery or represents a problem with completeness of data reporting is uncertain. Complete data capture and reporting are difficult due to the variability in provider types, appropriate coding of services, confidentiality concerns, and subcontracted providers' completeness of data submission.

Graph 4.1 shows the variation in the rate of HMO enrollees outside Milwaukee County receiving mental health services in 1997 through 1999, varying from 0% to approximately 36%. There is considerable variation within many of the HMOs from year to year, and the above noted caveats concerning data are applicable here as well.

[1] U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General National Institutes of Health 1999.

[2] Draft version Population Estimates Program, Population Division, U.S. Census Bureau Sept. 1999.

[3] Checking the Alcohol and Other Drug Health of Wisconsin Residents: The Final Report of a Statewide Household Survey, 1997, Bureau of Substance Abuse Services. Published March 1999.

[4] Wisconsin Substance Abuse Treatment Capacity Analysis 1996, Bureau of Substance Abuse Services, November 1998.

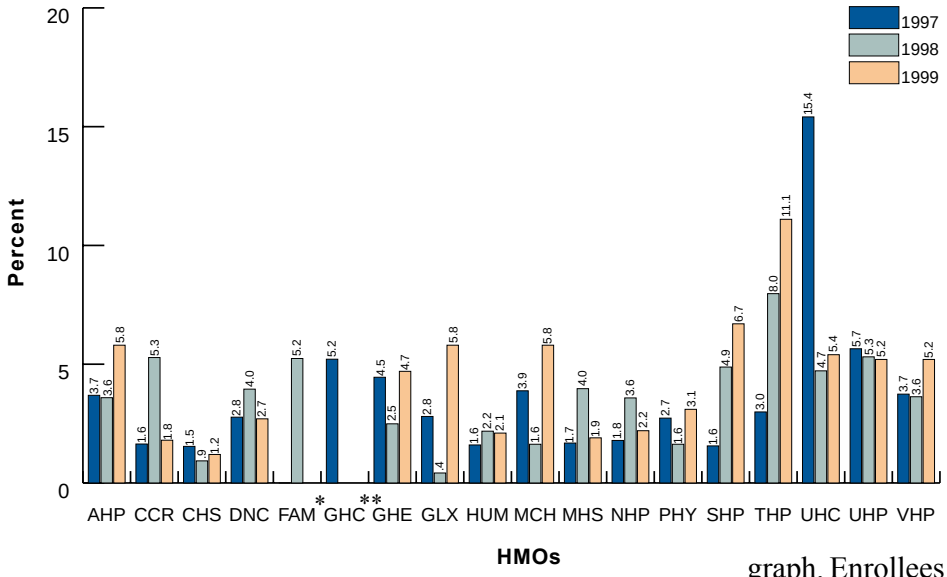
* FAM did not report data for this indicator in 1999.

† CHS was identified as an outlier in 1999.

Graph 4.3

Percent of Eligibles Receiving Substance Abuse Day Treatment and/or Outpatient Services Per Eligible Year

(Ages 21 and Over — Rest of State)



* 1999 FAM data were excluded because the number of eligible years is not comparable to the other rest of state HMOs.

** 1998 and 1999 GHC data excluded because the percentage of eligibles per eligible year is not comparable to the other rest of the state HMOs.

Substance Abuse Treatment

The average percent of enrollees in Milwaukee County receiving substance abuse day treatment or outpatient services is 3.0% per eligible year for ages 21 and over (Graph 4.2). These graphs do not contain data on evaluation or assessments for substance abuse services.

The wide range of the percent of eligibles receiving substance abuse day treatment or outpatient services per eligible year between HMOs serving a single, well-defined population may reflect differences in service delivery, but it may also reflect problems with capturing and reporting data. It is likely that some substance abuse services in the day treatment or outpatient setting are provided by public agencies that do not report the services to the enrollee's HMO. The regional Medicaid Managed Care Mental Health and Substance Abuse workgroups are developing collaborative efforts between HMOs and other public and private agencies to improve collection and sharing of data in this area.

For substance abuse day treatment and/or outpatient services for the enrollees in other counties, the average is 4.4% of eligibles ages 21 and older receiving treatment per eligible year. Note that the 1998 and 1999 data reported by Group Health Cooperative of South Central Wisconsin (45.0 % and 36.6%, respectively) are considered outliers and are not included in the graph. Enrollees receiving services from community or public agencies, where services probably would not be reported to the HMO, are not included in the data (Graph 4.3).

* FAM did not report data for this indicator in 1999.

† CHS was identified as an outlier in 1999.

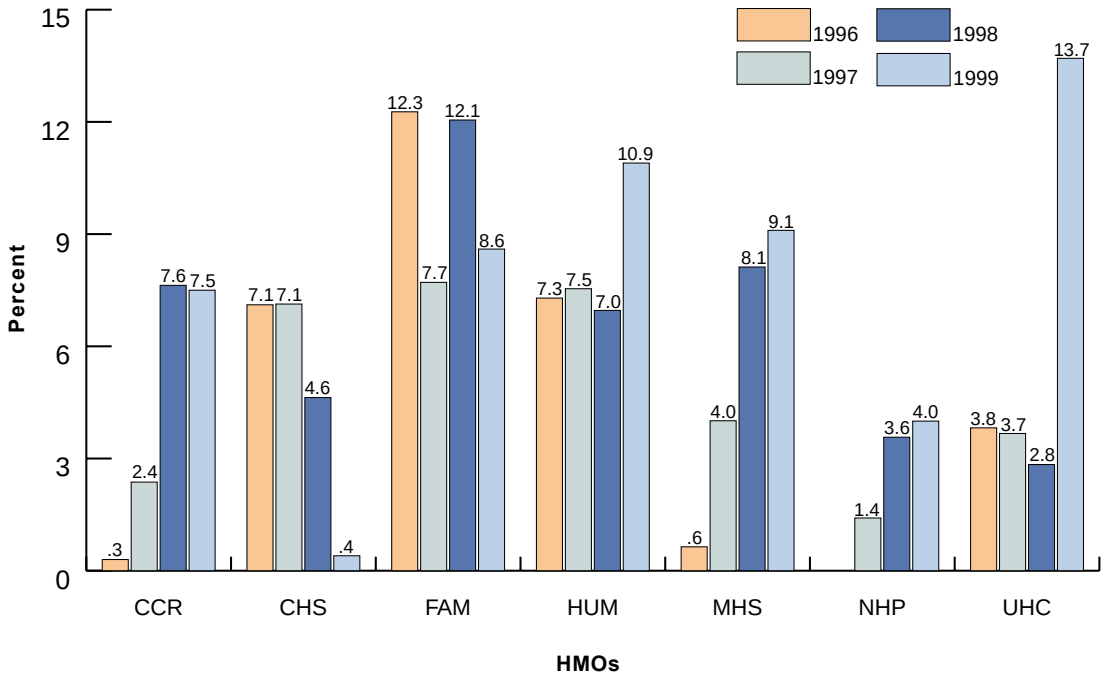
Mental Health and/or Substance Abuse Evalulations

The percent of eligible enrollees receiving mental health and/or substance abuse evaluations age 21 years and over per eligible year increased from 5.9% in 1997 to 8.1% in 1999 for all HMOs (Graph 4.5). Emphasis on prevention and early evaluation may result in improved coordination of mental health and substance abuse services which will help to create a comprehensive and flexible system of care.

Graph 4.4

Percent of Eligibles Receiving Mental Health Day Treatment and/or Outpatient Services Per Eligible Year

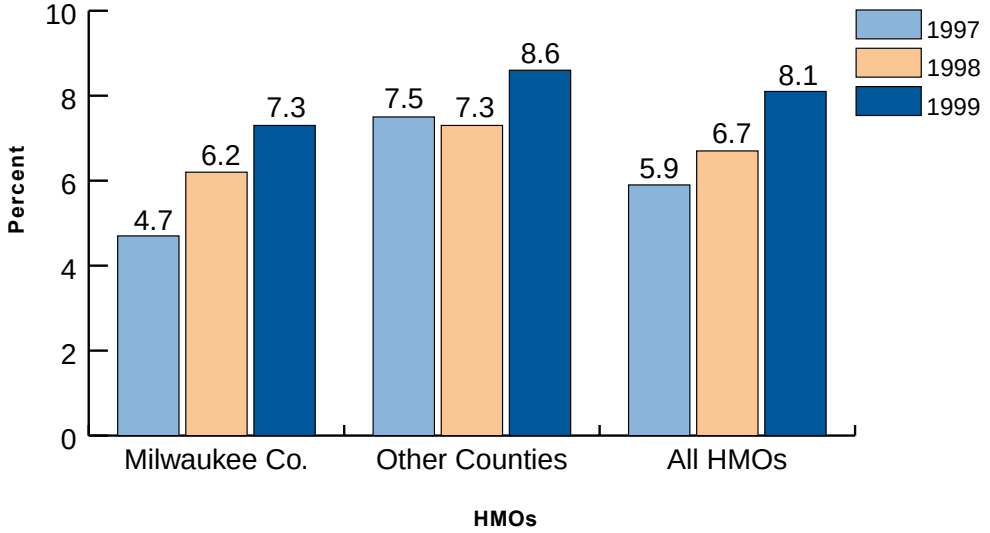
(Ages 21 and Over — Milwaukee County)



Graph 4.5

Percent of Eligibles Receiving Mental Health and/or Substance Abuse Evaluations Per Eligible Year

(Ages 21 and Over — All HMOs)



Section Five

Living with Illness

Certain states of illness do not have an established cure. Treatment is necessary for such conditions in order to maximize quality of life.

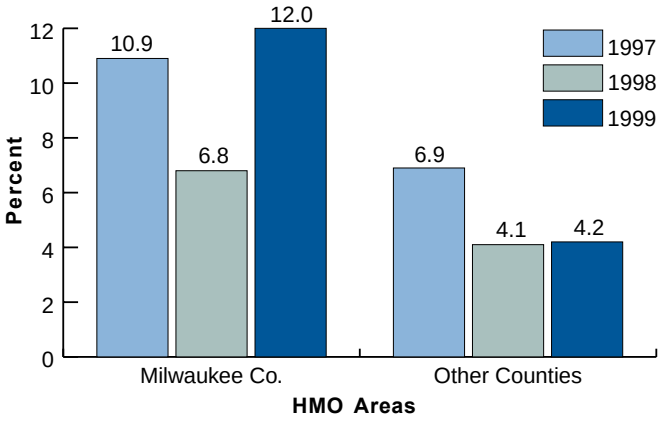
Asthma is amenable to treatment such that the quality of life is markedly improved when treatment is successful. A measure of the quality of care delivered by managed care is the ability of patients with asthma to avoid the use of emergency room services and to especially avoid an inpatient admission.

Asthma

Asthma is a chronic lung disease characterized by temporary obstruction of airflow resulting in difficult breathing. Asthma affects all ages, both sexes, and all racial groups. Risk factors for developing asthma include living in the inner city, having a parent with asthma, living with a smoker, being born prematurely, and having allergies. Asthma is one of the nation's most common and costly diseases and affects more than 15 million Americans, including almost five million children.[1] The prevalence is much higher among blacks than whites.

Asthma is the most common chronic childhood illness, affecting nearly 100,000 Wisconsin children under age 18, a majority of whom live in southeastern Wisconsin.[2]

Graph 5.1
Percent of Enrollees With a Primary Diagnosis of Asthma Admitted to an Inpatient Hospital
(Ages 0 - 20 Years)

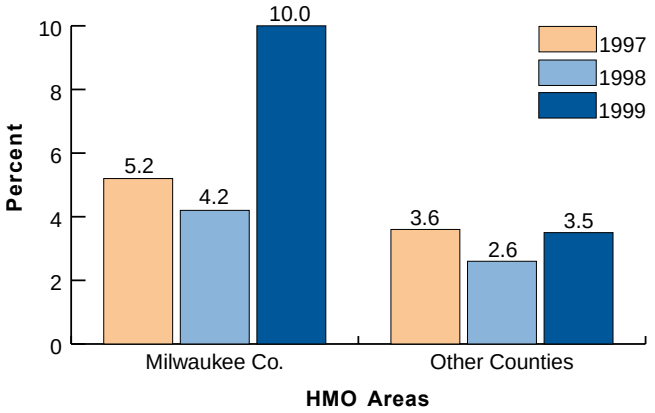


Hospitalizations for Asthma

In 1999, 4,126 non-Milwaukee County HMO enrollees ages 0-20 had a primary diagnosis of asthma, and 175 of those enrollees were admitted to a hospital with that primary diagnosis. This represents an admission rate of 4.2%. This is similar to the 4.1% admission rate reported in 1998 (Graph 5.1).

In the Milwaukee County HMOs, 5,363 enrollees, ages 0-20, had a primary diagnosis of asthma and 644 of that number were hospitalized with that primary diagnosis. 12% of Milwaukee County HMO enrollees with a diagnosis of asthma were hospitalized with that primary diagnosis in 1999 (Graph 5.1). This is higher than the 1997 and 1998 rates of 10.9% and 6.8%, respectively.

Graph 5.2
Percent of Enrollees With a Primary Diagnosis of Asthma Admitted to an Inpatient Hospital
(Ages 21 and Over)



The data for enrollees age 21 and over show that 983 enrollees in non-Milwaukee County HMOs had a diagnosis of asthma, and 34 of that number, or 3.5% of the total, were hospitalized for a diagnosis of asthma. Of the 1,485 Milwaukee County HMO enrollees (21 years of age and over) diagnosed with asthma, 149, or 10.0%, were admitted to the hospital for asthma (Graph 5.2). As in 1997 and 1998, the age group of 21+ years with a diagnosis of asthma is hospitalized less frequently than the 0-20-years age group, but the admission rate remains higher in Milwaukee County than elsewhere in the state.

The Department of Health Care Financing (DHCF) is implementing a care analysis across the Medicaid population, utilizing fee-for-service paid claims and managed care encounter data. The initial project is an analysis of the management of asthma. Case mix

cohorts will be matched for comorbidities and reviewed for level of service, peak volume flow meter use, referral to a specialist, related to outcome measures of emergency room use and hospitalization. Providers who show utilization and/or outcome patterns that are outside the system norm will be provided with an opportunity to implement disease management guidelines to improve outcomes of caring for patients with asthma. This method of care analysis will permit the DHCF to focus intervention where it will most likely result in system improvement.

[1] Centers for Disease Control and Prevention — National Center for Environmental Health, October 1997.

[2] Children's Health System: Milwaukee Allies Against Asthma, April 2000.