New Hampshire CHIS comprehensive health care information system

Comparison of Primary Care Received by NH Medicaid Members at Different Practice Settings
Issue Brief – May 2009

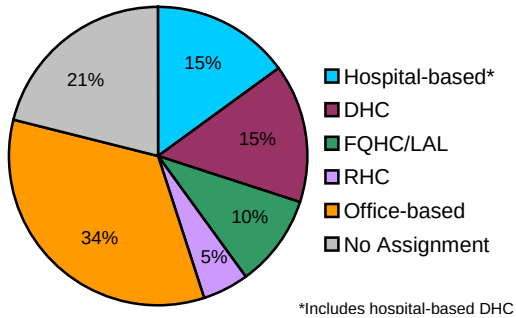
This study evaluates a variety of health care measures to compare the experience of New Hampshire Medicaid members receiving primary care within different practice settings. It is the first of its kind to examine the performance of practices throughout the state on key access, quality, utilization, and cost measures.

Healthcare Effectiveness Data and Information Set (HEDIS) measures were reported based on the NH Medicaid administrative eligibility and claims data from services incurred in calendar year (CY) 2006. NH Medicaid primary care providers were grouped into five practice settings: stand-alone office-based physician practices, hospital-based clinics fully or partially billing a facility cost to Medicaid, Federally Qualified Health Centers (FQHCs) or FQHC Look-Alikes, Rural Health Clinics (RHCs), and physicians affiliated with Dartmouth Hitchcock clinics (DHC). NH Medicaid members were assigned to one of the five primary care practice setting categories based on the provider where they went for the majority of their primary care visits in 2006.

Primary Care Access and Utilization

The largest group of NH Medicaid members received primary care from physician offices (34%). Hospital-based clinics and DHC each provided primary care to approximately 15% of NH Medicaid members, FQHCs or FQHC Look-Alikes provided primary care to 10% of Medicaid members, and 5% of Medicaid members received primary care from RHCs.[1]

NH Medicaid Members by Primary Care Setting, CY2006



*Includes hospital-based DHC

NH Medicaid members seeking care at hospital-based primary care practices are sicker than members served in the other settings. Office-based practices also had a significantly higher average risk score than the rest of the settings, while RHCs and FQHCs had significantly lower risk scores than the average.

Well-Child Visit Rates

Rates of well-child visits were significantly higher for children receiving primary care at office-based practice settings in most age groups. For adolescents aged 12 to 18, well-care visit rates were significantly higher for those who received primary care from DHC. Children receiving primary care at RHCs had significantly lower well-child visit rates.

For children in their first fifteen months of life—when 7 well-child visits are recommended—over half had 6 or more visits across all NH Medicaid providers. Office-based practices were significantly more likely to have 6 or more visits than those receiving primary care in general and compared to most other settings. RHCs were significantly more likely to have children less than 15 months with one or no well-child visits.

Effectiveness of Care Management

Seven HEDIS effectiveness of care measures were evaluated. All NH primary care settings were higher than the national HEDIS rates for appropriate use of medications for children age 5 to 9 with asthma, strep testing for children with pharyngitis, non-use of antibiotics for upper respiratory infections (except RHCs), HbA1c and serum cholesterol testing (except RHCs), and nephropathy screening for diabetics.

For breast cancer screenings, all practice types except RHCs were above national Medicaid HEDIS rates, while for cervical cancer screenings, RHCs, office-based, and hospital-based practice settings had lower rates than the national Medicaid HEDIS average.[2]

Among NH primary care settings, there were no significant differences in diabetes care or breast cancer screening rates. Other effectiveness of care measures varied across primary care setting. Women were significantly more likely to be screened for cervical

[1] Approximately 21% of NH Medicaid members were not assigned to a primary care provider in 2006, either because they had no visits or because they did not seek care at a provider identified as a primary care provider. These members also had shorter lengths of enrollment. Because this group received no primary care, they are excluded from the remainder of the study.

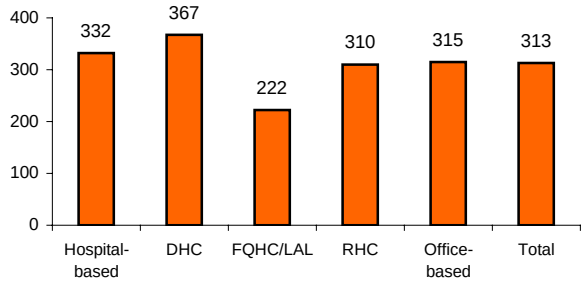
[2] National Medicaid HEDIS rates are based on managed care; NH Medicaid does not have managed care.

cancer at FQHCs and DHC and significantly less likely to be screened at office-based practices.

Mental Health Disorders

Approximately 32% of NH Medicaid members in this study had a diagnosed mental health disorder during CY2006. Adjusting for age and gender, members receiving primary care at RHCs and hospital-based practices had significantly higher mental health prevalence rates than those receiving primary care generally, while members receiving primary care at office-based practices had significantly lower mental health prevalence rates.

Mental Health-related ED Visits, per 1,000 Members with MH Disorder, by Practice Setting, CY2006



Members with a mental health disorder receiving care at DHC had significantly higher use rates of Emergency Department (ED) mental health-related visits than members with mental health disorders seen generally. Members with a mental health disorder receiving care at FQHCs were significantly less likely to have mental health-related ED or inpatient use. Members with mental health disorders receiving care at hospital-based and DHC practices were significantly more likely to have mental health specialist visits, while those receiving care at FQHCs and RHCs were significantly less likely to have mental health specialist visits.

Utilization and Payments

Total service utilization and utilization for specific services by NH Medicaid members receiving primary care varied significantly across settings even after adjusting for age, gender, and risk group. NH Medicaid members receiving primary care at FQHCs and RHCs used significantly fewer overall services than those receiving primary care at other settings, while those receiving services at DHC and hospital-based practices used significantly more services.

Medicaid members receiving primary care incurred $4.1 million for outpatient emergency department visits for conditions more appropriately treated in a primary care setting. As with overall ED use, members receiving primary care at FQHCs and RHCs were significantly more likely to use the ED for these selected conditions, while members receiving care at DHC and office-based practices were significantly less likely to use the outpatient ED for these conditions.

Despite higher cost-based reimbursement of FQHCs and RHCs, Per Member Per Month (PMPM) rates were the lowest in these settings after adjusting for age, gender, and risk, and hospital-based practices had the highest PMPM rates. However, once pregnancy-related admissions and high-cost cases were excluded, differences in PMPMs were not found to be statistically significant.

Limitations

Claims and eligibility data are constructed primarily for administrative purposes, which poses some limitations. Certain information, especially diagnoses, may be under-reported.

Conclusion

This study reveals some noteworthy differences in the types of patients being treated at different primary care practice settings across New Hampshire, with FQHCs disproportionately serving low-income adults and hospital-based providers caring for patients with higher clinical risks. While members receiving primary care at other practice settings appear to have HEDIS rates for most measures that are higher than the national Medicaid HEDIS average, there is still room for improvement.

This study examined the performance of different practice settings in delivering primary care to NH Medicaid beneficiaries on key access, quality, utilization, and cost measures. The purpose of the study was to provide the NH Medicaid program a framework for assessing the degree to which different physician practice arrangements may provide higher quality and more effective and efficient primary care in order to help inform state decisions regarding care coordination and reimbursement models. It also establishes a baseline for potential future efforts to improve care in these settings.

About the New Hampshire Comprehensive Health Care Information System

The New Hampshire Comprehensive Health Care Information System (NH CHIS) is a joint project between the New Hampshire Department of Health and Human Services (NH DHHS) and the New Hampshire Insurance Department (NHID). The NH CHIS was created by state statute (RSA 420-G:11-a) to make health care data "available as a resource for insurers, employers, providers, purchasers of health care, and state agencies to continuously review health care utilization, expenditures, and performance in New Hampshire and to enhance the ability of New Hampshire consumers and employers to make informed and cost-effective health care choices." For more information about the CHIS please visit www.nhchis.org or www.nh.gov/nhchis.