Florida's Market-based Medicaid Reform Demonstration: Cost and Quality Issues

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From 1975 to 2010, Medicaid costs grew 1.8 percent faster than GDP. At this pace, over the next 75 years, federal Medicaid expenditures will rise to almost 6 percent of GDP. In 2005, a reform was approved for Florida which was designed to increase beneficiaries' access and quality of care at no greater cost than traditional Medicaid. The federal waiver allowed the state to move about 413,000 Medicaid beneficiaries in five demonstration counties into health plans run by private providers and insurers. This article details the reform area's progress.

INTRODUCTION

Medicaid, the federal-state health care program for the poor, was created almost as an after-thought as part of the Medicare Act of 1965. The federal portion of the program's funding has grown from 0.4 percent of gross domestic product (GDP) in 1973 to 1.6 percent in 2012. Historically, states have contributed around 43 percent of costs under a formula based on average state income.

The Congressional Budget Office (CBO) projects that the federal component of Medicaid spending will rise by an average of 8 percent annually through 2023. From 1975 to 2010, Medicaid costs grew 1.8 percent faster than GDP. If this pace continues over the next 75 years, federal Medicaid expenditures will rise to almost 6 percent of GDP.[1] The program is unsustainable in both federal and state budgets.

THE GROWTH OF FLORIDA MEDICAID

Florida exemplifies the states' Medicaid budget problems. From 1990 through 2010, Florida Medicaid expenditures grew at an annual rate of 10.1 percent,[2] while GDP increased only 5.4 percent, before adjusting for inflation.[3] As a result, Medicaid accounted for 29 percent of state expenditures in 2010. With these growth rates, the program will consume the state's entire budget in less than 30 years.[4] Fortunately, legislators recognized the problem and developed a plan to deal with the enormous unfunded liabilities — but the legislation was enacted before the passage of the Affordable Care Act (ACA), which will potentially expand Medicaid.

Access and Quality of Care Issues

Compounding the program's fiscal problems, Medicaid also suffers from serious quality and access issues. Research has consistently shown that recipients of Medicaid experience more severe health outcomes than individuals with any other type of medical coverage. The program's enrollees suffer worse outcomes than those with private health insurance and, in some cases, worse than those who have no insurance at all. For example, a recent study examined outcomes for almost 900,000 individuals who underwent major surgical procedures during a five-year period, from 2003 to 2007.[5] The study examined patient outcomes based on the type of their insurance coverage (including private, Medicare or Medicaid), as well as the uninsured. The results were then adjusted for age, sex, income, region, procedure and existing conditions. The study found that the in-hospital death rate for surgical patients varied by type of insurance coverage. Compared to patients with private health coverage:

- Medicare, uninsured and Medicaid patients were 54 percent, 74 percent and 97 percent, respectively, more likely to die than those with private insurance.
- The average length of hospital stay was 5 percent shorter than average for the uninsured; 19 percent longer than average for Medicare patients; and 42 percent longer than average for Medicaid patients.
- Medicare patients cost 10 percent more than the privately insured, on average, and Medicaid patients cost 26 percent more.

Medicaid enrollees often experience significant difficulty finding a physician, clinic or hospital to treat them, leading to unfavorable health outcomes. The access problem is not surprising, given that Medicaid reimbursements to physicians are more than 40 percent less than private insurance pays.[6] For example, the 2008 Health Tracking Physician Survey found that internists were more than eight times as likely to refuse Medicaid patients than those with private insurance.[7]

Even when Medicaid patients gain access to doctors, the quality of care may rate below average. A University of California – Los Angeles study found that Medicaid patients were far more likely to be treated in low-volume surgical centers of questionable quality, whereas research suggests that high-volume centers have consistently superior outcomes.[8] The most recent findings come from a controlled experiment in Oregon which concluded, astonishingly, that moving the uninsured into Medicaid coverage had no effect on physical health outcomes.[9] The ACA and the accompanying expansion of Medicaid can only exacerbate these problems.

FLORIDA'S MEDICAID REFORM DEMONSTRATION

In October 2005, the Centers for Medicaid and Medicare Services (CMS) approved a reform initiative called the 1115 Research and Demonstration Waiver. Under this program, Florida's Medicaid reform has operated as a comprehensive demonstration project. Florida's Medicaid reform demonstration project has affected medical cost inflation, and beneficiary health and satisfaction outcomes.

Medicaid traditionally has reimbursed participating health care providers (doctors and hospitals) on a fee-for-service (FFS) basis — paying for each service providers perform — but at lower rates than Medicare pays, and much lower rates than private insurers. Any provider who was willing to accept those payment rates could participate in the program.

Due to rising treatment costs, a growing number of state Medicaid programs are moving some (or most) of their enrollees into health plans administered by private entities. These managed care programs require patients to use providers that are part of networks created by the health plan administrator. The plans promise better access to providers and coordinated care for patients treated by multiple providers, for the same average cost to taxpayers as fee-for-service medicine.

Demonstration Plans, Benefits and Complaints

Florida's demonstration project began with a pilot effort in Broward and Duval Counties on July 1, 2006, then expanded to Baker, Clay and Nassau Counties on July 1, 2007. The 2012 fiscal year showed

Medicaid enrollment in the five reform counties was around 413,000, including approximately 232,000 in Broward County and 146,000 in Duval County. The remaining 35,000 are in Nassau, Baker and Clay Counties.[10] CMS has approved a waiver extension through June 30, 2014.

The demonstration's features included comprehensive choice counseling, customized benefit packages, enhanced benefits for participating in healthy behaviors, risk-adjusted premiums based on enrollee health status and creation of a low-income health insurance pool.

Medicaid enrollees in these counties have been offered a choice of competing, privately-administered health plans. Around 52 percent of the five counties' beneficiaries are enrolled in Health Management Organizations (HMOs) sponsored, for example, by hospital systems; 48 percent are enrolled in or Provider Service Networks (PSNs), such as those organized by private insurers. As of the end of 2012, nine HMOs and three PSNs were operating in Broward County. This is an increase of three plans since the program launched. Duval County also saw an increase of three plans from 2006 to 2012. The growth in the number of plans offered indicates that reform has succeeded in increasing consumers' choices in these two counties.[11]

Because no single plan design can serve all patients, plans have some flexibility in designing benefit packages. For instance, 43 percent of the Florida plans required no copayments from Medicaid beneficiaries in the first year of the demonstration, increasing to 68 percent of plans by the end of 2012. Out of 16 categories of patient treatment, such as hospital inpatient care and mental health care, copayments declined for 11, there was no change in four, and copayments increased in only one. On balance, enrollees seem to have benefited modestly from copayment decreases.

Competition among plans has clearly led to a welcome addition of services to beneficiaries beyond the original Medicaid benefits package. The expanded services include an over-the-counter drug benefits of $25 per household per month, adult preventive dental care, circumcisions for male newborns, and additional adult vision and nutritional counseling.

Federal law requires Florida to track complaints about private Medicaid plans. In the five reform counties, the latest data, from the fourth quarter of 2012, showed 206 complaints about PSN plans and 538 complaints regarding HMO coverage. This is a decrease from 828 total complaints in the previous quarter to 744 in the fourth quarter. While there were significantly more grievances against HMOs than PSNs, complaints overall trended downward. Further, the number of complaints must be compared to the total number of enrollees. In the reform counties, 744 complaints represent just 0.2 percent of enrollees.

To assist beneficiaries with plan selection and other Medicaid issues, Florida created a Choice Counseling Program. Among other services, this program provides a call center for enrollees. The latest quarter of available data shows the center received almost 58,000 calls. According to surveys, program satisfaction ranges from a low of 76 percent for "ease of understanding information" to a high of 98 percent for "being treated respectfully." Responses to the remaining eight survey questions ranged from 86 percent to 96 percent satisfaction.

In the latest reported quarter, more than 69 percent of enrollees made an active plan selection, a number that has remained around 70 percent since 2010. (Enrollees in reform counties who do not make a plan selection are automatically enrolled in a plan assigned by Medicaid. If enrollees are satisfied with this plan they do not need to make a selection.)

Reverse Health Savings Accounts and Healthy Behaviors.

Florida's reform introduced an innovative new program to enhance beneficiaries' Medicaid accounts: reverse Health Savings Accounts (HSAs) that begin with a zero balance. Beneficiaries earn credits to these accounts by engaging in "healthy activities." (See Table I.) Thus:

- In the fourth quarter of 2012, 164,544 Florida Medicaid enrollees received $3,913,000 in credits for healthy behaviors, and a total of $62.5 million since the program's inception.
- With these credits, beneficiaries purchased more than $33.4 million worth of goods — essentially nonfood items available at pharmacies.
- The credits are forfeited if an enrollee leaves Florida Medicaid for more than three years; however, only around $26,000 has been returned to the program thus far.

TABLE 1
"REVERSE HEALTH SAVING ACCOUNT" CREDITS FOR HEALTHY BEHAVIOR

Health Behavior	Number of Enrollees Granted Credits	Amount
Childhood Preventive Care	974,258	$24,256,427.50
Office Visit-Adult/Child	1,084,764	$13,236,262.50
Dental Preventive	242,587	$6,033,025.00
Prescription Compliance	459,646	$3,417,857.50
Vision Exam-Adult/Child	109,586	$2,729,165.00
Pap Smear	75,075	$1,871,972.50
Child/Adult Preventive Care	57,235	$1,041,510.00
Diabetes Management	24,732	$369,845.00
Adult Preventive Care	17,502	$261,430.00
Mammography	8,592	$211,975.00
Colorectal Screening	4,551	$112,722.50
Prostate Specific Antigen (PSA)	6,318	$94,392.50
Healthy Start 1st Trimester	3,581	$53,715.00
Hypertension Management	1,487	$36,157.50
Diabetes Management	1,064	$25,732.50
Asthma Management	817	$20,170.00
Adult BMI Assessment	749	$18,632.50
HIV/AIDS Management	465	$11,572.50
Congestive Heart Management	153	$3,712.50
Other Disease Management	141	$3,470.00
Flu Shot	11	$275.00
Dental Preventive Service-Adult	16	$237.50
Exercise Program	8	$200.00
Weight Management	3	$75.00
Weight Management 6 Months	5	$75.00
Smoking Cessation Program	2	$50.00
Exercise Program 6 Months	3	$45.00
Smoking Cessation 6 Months	2	$30.00
Alcoholics Anonymous Program	1	$25.00
Narcotics Anonymous Program	1	$25.00

The hope is that patients who participate in these activities will develop fewer serious (and expensive) health problems, and will better manage existing issues. For example, obesity is associated with an increased incidence of such chronic health problems as diabetes and cardiovascular disease. During the 1960s and 1970s, an estimated 15 percent to 17 percent of U.S. adults were obese, compared to 34 percent today. The figure is almost certainly higher for Medicaid patients. Americans are nearly twice as likely to

be obese as their counterparts in Europe. If the United States could bring its obesity rates more in line with Europe's, health costs could decrease by $100 billion a year or more, potentially rising to more than $300 billion by 2018, according to researchers.[12]

Controlling Costs per Beneficiary

As with all 1115 waivers, the federal government requires that the changes it approves be "budget neutral." That is, the reform cannot cost the federal government more than the original program for Medical Eligible Groups enrolled in the reform plans. Thus, expenditures are monitored for individuals receiving Supplemental Security Income (SSI) — the federal program for individuals who do not qualify for Social Security — or Temporary Assistance to Needy Families (TANF), the federal welfare program. As of Fiscal Year 2010, approximately 72 percent of the roughly 3.7 million Medicaid enrollees in Florida were also enrolled in TANF. (Individuals in the Low Income Pool, who receive funding from a variety of provider groups, have been excluded in this analysis.) To monitor budget neutrality, Florida compares the per capita cost per month (PCCM) under the reform program to costs without the waiver.

TABLE 2
PERCENTAGE OF STATEWIDE AVERAGE COST PER FLORIDA HEALTH PLAN ENROLLEE FOR INDIVIDUALS RECEIVING OTHER BENEFITS COMPARED TO REGULAR MEDICAID

Year	Supplemental Security Income	Temporary Assistance to Needy Families
1	102.46%	80.32%
2	99.75%	78.84%
3	95.59%	71.76%
4	90.14%	66.42%
5	84.95%	61.56%
6	81.03%	60.80%
7	61.58%	53.22%

Table 2 shows that expenditures in the two beneficiary groups have consistently remained far below the "budget neutral" amount. Over the first seven years of reform:

- The cost for each private plan enrollee receiving Supplemental Security Income has fallen from 102 percent to 62 percent of statewide average Medicaid expenditures.
- The cost for each private plan enrollee receiving Temporary Assistance to Needy Families has fallen from 80 percent to 53 percent of statewide average Medicaid expenditures.

One way to gage whether the reform has actually produced savings is to compare per capita expenditures in the reform counties with total state per capita Medicaid expenditures. According to available CMS data, during the 2006 to 2009 period per capita Medicaid expenditures in Florida increased 5.2 percent, whereas per capita costs in the reform counties increased only 1.4 percent. While this change does not prove that reform lowered Medicaid cost inflation, the slower growth in the reform counties is encouraging. Research by the University of Florida also found relative savings from the reform:

> "In conclusion, it appeared that the demonstration resulted in reductions in PMPM [Per Member Per Month] expenditures when examining all SSI and TANF enrollees. Demonstration PSNs, in particular, appeared to control expenditures better than both demonstration HMOs and Medicaid programs in control counties. Therefore, results of this analysis suggested that the key demonstration attribute of requiring all Medicaid enrollees to enroll in either an HMOs or PSNs may control PMPM expenditures better than standard FFS Medicaid or non-demonstration Medicaid HMOs (the programs being operated in the control counties)."[13]

Unnecessary Emergency Room Visits

A cost-controlling goal of Medicaid reform is to reduce the use of emergency rooms for nonemergency care. Emergency room treatment is the most expensive treatment setting for nonemergency care. In addition, unnecessary visits clog the ER, complicating access for patients with emergencies. Yet, Medicaid patients typically make unnecessary visits due to the difficulty of accessing nonemergency care providers. The statewide average for nonemergency care is 16.4 ER visits per 1,000 Medicaid enrollees. By contrast, according to a preliminary AHCA analysis, the unadjusted average for the reform health plans is 15.1 visits per 1,000 enrollees.[14]

Controlling Prescription Drug Costs

Many states are moving Medicaid enrollees to privately-administered managed care plans. In doing so, they are also reversing outdated policies that required state Medicaid programs to administer drug benefits on a fee-for-service basis separately from any health plan.[15] Since 2011, the number of prescription drugs dispensed through Medicaid managed care has more than doubled nationwide.[16] Nationally, just over half of Medicaid drugs are now provided under FFS; but nearly two-thirds of drugs are FFS in Florida.[17]

Medicaid programs that carve-out drug benefits often ignore drug therapy coordination and management, though the state essentially takes this responsibility away from health plans. Such policies could harm patients.[18] For instance, the state of New Hampshire implemented an arbitrary prescription limit on psychiatric drugs in 1990 that led to an increase in the use of emergency mental health services and hospitalizations for people with schizophrenia. The additional medical costs associated with poor medication management was 17 times the savings from limiting prescriptions.[19]

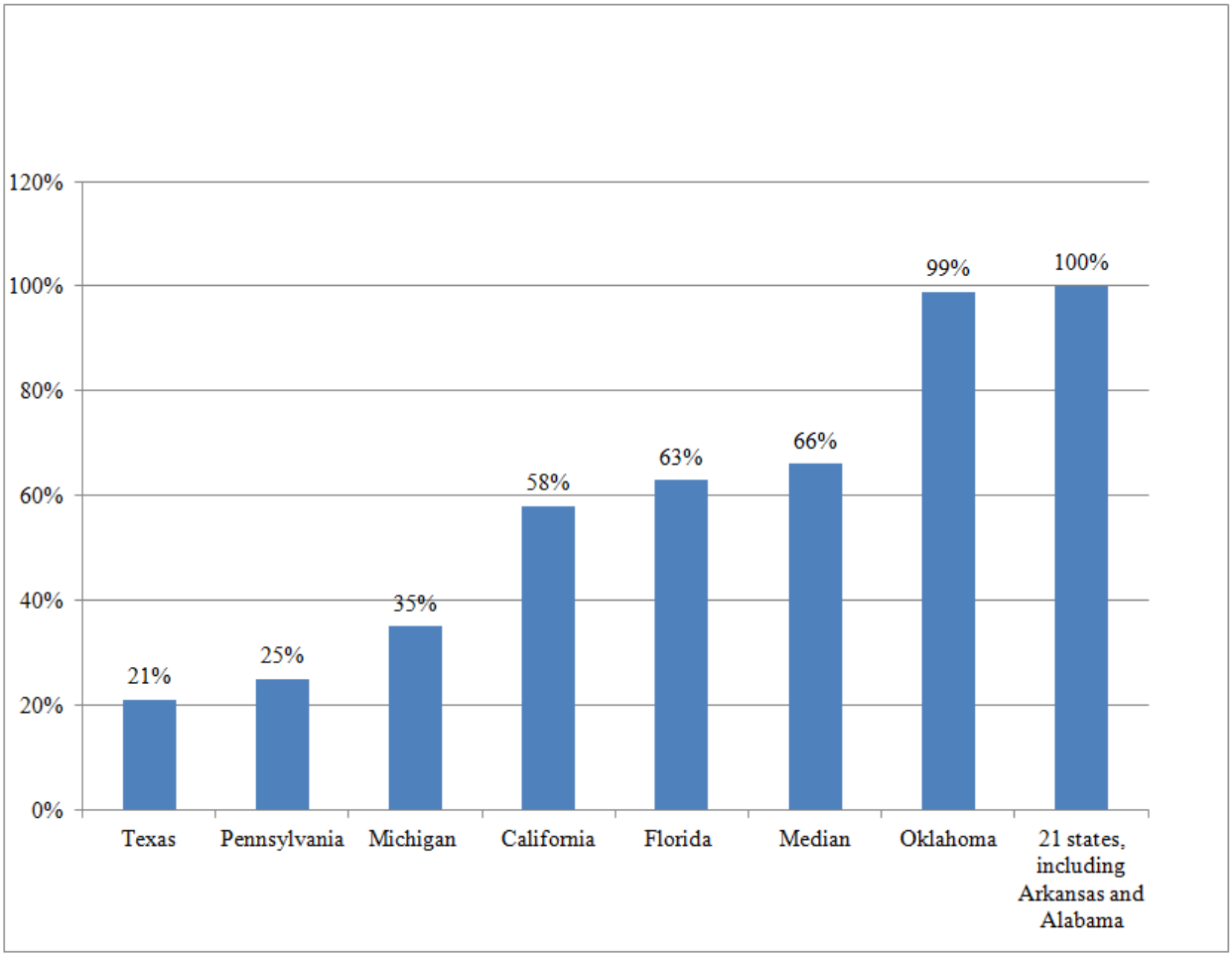
Many states "carve-out" pharmacy benefits and administer them separately from health plans. Virtually all state Medicaid programs distribute some drugs in this way, and nearly half of the states distribute all Medicaid drugs this way. (See Figure 1) Nationwide, nearly three-fourths (73 percent) of Medicaid drug spending is reimbursed and administered separately from a health plan.[20]

Integrating prescription drugs benefits into managed care plans improves quality and increases efficiency. A Lewin Group study found that integrating drug benefits with privately-run health plans is more cost-effective than administering separately.[21] Indeed, a Lewin analysis for Medicaid Health Plans of America, a trade association of managed care providers, found that integrating health plan and drug benefits in 14 states that currently carve-out drug benefits would collectively save nearly $12 billion over a decade.[22]

Drug therapies often substitute for more expensive surgical treatments, reduce the need for hospitalization, and avoid expensive emergency room visits and medical complications — especially for such chronic conditions as asthma, diabetes and schizophrenia. An analysis of Medicaid managed pharmacy benefits in a number of states by IMS Health found utilization rates for many of these therapies is higher under managed care than fee-for-service.[23] For instance, use of generic versions of antipsychotic medications was 3 percent to 14 percent higher than in fee-for-service Medicaid, on average. Drug utilization for diabetes was also higher. Private health plans that provide medical care to Medicaid enrollees are the logical entities to manage drug benefits. The health plans are paid a set fee per enrollee

to provide Medicare care; thus, the health plans are liable for the cost of non-drug therapies, whereas a drug regime is often a less costly substitute for surgery or other treatment.

FIGURE 1
PERCENTAGE OF MEDICAID DRUGS DISPENSED FEE-FOR-SERVICE
(ESTIMATE FOR 2014)



Source: Joel Menges, Menges Group, "Medicaid Pharmacy Savings Opportunities: National and State-Specific Estimates," The Menges Group, May

The Role of Drug Plans

Medicaid managed care plans frequently contract with pharmacy benefit managers (PBMs), private firms that act as third-party prescription drug plan administrators. PBMs process and reimburse claims, and negotiate drug prices and rebates with drug manufacturers. They also negotiate dispensing fees — the amount paid to pharmacies for the service of filling a prescription.[24]

Private health plans use a variety of techniques to control drug costs, including preferred-drug lists (PDL), formularies, required use of mail-order drug suppliers, negotiated prices with drug companies and drug distributors, and contracting with exclusive pharmacy network providers.[25] Regardless of how the program is structured, Medicaid enrollees still usually purchase their drugs at a local pharmacy, which is reimbursed for each prescription filled.[26]

A recent analysis by the Menges Group, another consultancy, also identified ways in which state Medicaid drug programs are less efficient than privately-administered Medicaid drug benefits.[27] Prices for the same drug often differ from one state to the next — sometimes from one pharmacy to the next. Rather than negotiating with pharmacy networks, state FFS Medicaid programs often arbitrarily pay much higher dispensing fees than they would in a competitive market. Utilization of generic drugs is often lower in FFS Medicaid and the number of prescriptions per members is higher.

Florida should avoid the mistake of allowing *any willing pharmacy* to participate in the Medicaid drug program rather than negotiating exclusive networks of pharmacies willing to provide lower prices. *Any willing pharmacy* laws reduces the bargaining power of managed care to negotiate lower prices and unnecessarily facilitates waste, fraud and abuse among Medicaid drug programs. For example, having an unlimited supply of pharmacies allows unscrupulous patients to "shop" for multiple doctors willing to prescribe narcotics — avoiding detection by filling each prescription at a different pharmacy. Requiring Medicaid drug plans to reimburse large networks (with numerous small pharmacies) also makes it more difficult to detect billing fraud by pharmacy operators (or fake pharmacies).

Numerous benefits can be derived from integrating drug benefits and coordinating care. For instance:[28]

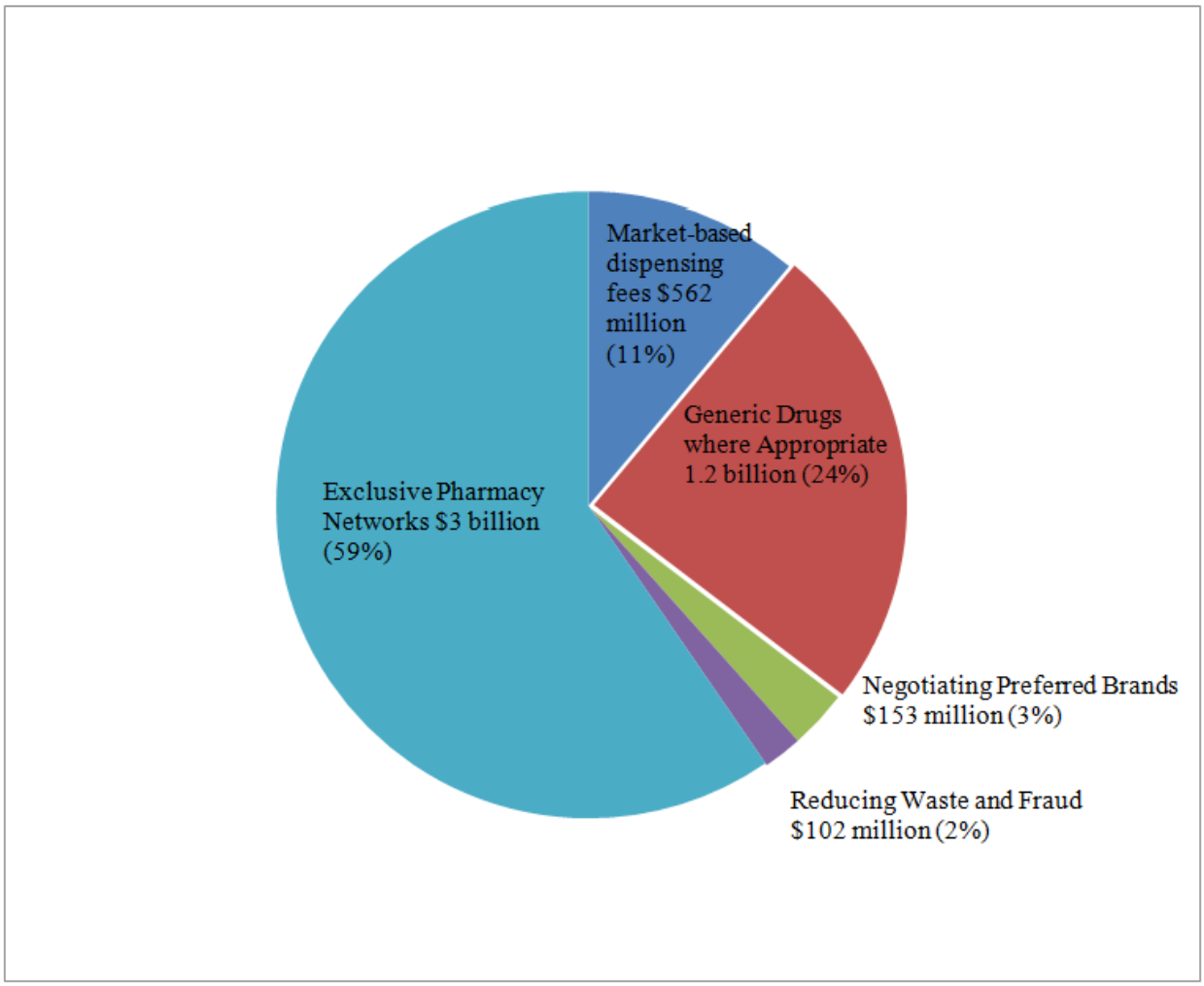
- About two-thirds (67 percent) of drug prescriptions in Florida's FFS Medicaid are filled with generic drugs, whereas the national average for managed Medicaid drug benefits is about 80 percent.
- Florida FFS pays pharmacies $3.73 to dispense a prescription, whereas the average for private Medicare Part D plans is just over half as much – about $2.00.
- The number of prescriptions per Medicaid enrollee is generally higher among enrollees in the Fee-for-Service Medicaid program compared to managed care.

According to Menges, by integrating drug and health benefits in a statewide managed care program, Florida Medicaid could save $5.1 billion over 10 years ($3 billion in lower federal spending and $2.1 billion less in state spending). Specifically (See Figure 2):

- 11 percent would come from paying market-based, competitive dispensing fees.
- Nearly one-quarter (24 percent) would come from use of generic drugs where appropriate.
- More than half (59 percent) would come from negotiating steep discounts with exclusive (limited) networks.

Despite the potential savings, community pharmacists and pharmacy trade association often oppose moving from FFS Medicaid drug programs to privately-managed Medicaid drugs. Small, community pharmacies often specialize in serving Medicaid beneficiaries and depend on Medicaid dispensing fees for their livelihood. Community pharmacists cannot compete on price and efficiency without reducing profitability, so they fight to maintain the status quo. Community pharmacists are small business owners. As such, they are a sympathetic group when they lobby state legislators to protect them from competition. Trade associations for small pharmacies advocate laws that prohibit exclusive Medicaid pharmacy networks, which pharmacy benefit managers use to negotiate lower drug prices (and dispensing fees) for taxpayers. Community pharmacists also lobby lawmakers to discourage cost-efficient, mail-order drug programs commonly found under managed care.

FIGURE 2
POTENTIAL 10-YEAR SAVINGS FROM EFFICIENT MANAGEMENT OF FLORIDA MEDICAID DRUG PROGRAM



Source: Joel Menges, "Medicaid Pharmacy Savings Opportunities: National and State-Specific Estimates," Menges Group, May 2013.

QUALITY OF CARE AND HEALTH OUTCOMES

Medicaid reform isn't just about controlling costs, but improving patient access to care and health outcomes. The Florida demonstration is ongoing, but there are preliminary indicators of improvement.

Access to Specialists

Access to specialists has been and remains a major issue in Medicaid.31 In the reform demonstration counties, there has been a modest increase in specialist access, measured by the number of patients who receive those types of specialty services. The most recent analysis by ACHA measured patient access to three types of specialty care — orthopedics, neurology and dermatology — in 2009 to 2010 budget years and compared those figures to the 2010 to 2011 budget years. The number of patients in reform plans receiving dermatological care rose from about 10 per thousand beneficiaries to 13 per thousand; neurological care rose from about 21 to 27 per thousand; and orthopedic care rose from 25 to 27.

Beneficiary Health Outcomes

Obviously, improvement in the overall health status of enrollees is a key goal of reform. Long-term health improvements only appear with time, but it is known that better management of chronic health conditions reduces the number and severity of complications. Examples include control of levels of insulin, cholesterol and blood pressure.

More than 90 percent of the nation's health plans use the Healthcare Effectiveness Data and Information Set (HEDIS) to measure performance of care and service. The latest HEDIS report consists of 75 measures across 8 domains of care. HEDIS allows the performance of health plans in the demonstration counties to be compared to the performance of conventional Medicaid in the unreformed counties, and to national averages.[29] Furthermore, for each performance measure where they fall below the national average, Medicaid in the unreformed counties and the health plans in the reform counties are required to formulate improvement plans.[30]

The latest HEDIS data available, for 2011, show that plans in the demonstration counties improved their performance in more categories than the counties with conventional Medicaid (see the Appendix). Specifically, looking at measures for diabetic care:

- The national average for glucose testing (HbA1c) is 80.60 percent, whereas the average for the Florida five demonstration counties was 81.90 percent, and the below-average performance in the nonreform counties was 79.60 percent.
- Control of glucose levels by diabetics in the reform counties (48.60 percent) exceeded both the national average (44.90 percent) and the below-average performance in nonreform counties (42.50 percent).

Since 2008, of the 30 measures for the plans that needed to improve performance, outcomes have improved in 24 categories and declined in five.

NEXT STEPS IN REFORM

On December 15, 2011, CMS approved Florida's request to extend the waiver for three years, from December 16, 2011, through June 30, 2014. The state has also requested that the reform be expanded statewide, and has received tentative approval from CMS to proceed.[31] In addition, CMS has approved a waiver for the creation of a managed care demonstration for long-term care recipients.[32]

CONCLUSION

Florida's five-county demonstration project has shown results in three key areas: patient access to specialists, a reduction in unnecessary emergency room use and health improvement. Cost-efficient use of generic drugs has also increased. Though estimates of total cost saving are not yet available, it appears that costs have been contained.

Thus, expanding privately administered Medicaid health and drug plans statewide has the potential for substantial savings to Florida taxpayers and better care for the poor and disabled.

ENDNOTES

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APPENDIX

Florida Healthcare Effectiveness Data and Information Set (HEDIS) Performance Measures										
bold = Reform and/or non-reform counties better than the national mean										
	Non-Reform				Reform					
Measure	2008	2009	2010	2011	2008	2009	2010	2011	Trend	National Mean**
Annual Dental Visit	n/a	n/a	***	16.10%	15.20%	28.50%	33.40%	34.00%	+	45.70%
Adolescent Well-Care	41.90%	46.00%	45.70%	**49.20%**	44.20%	46.50%	46.30%	46.20%	-	47.70%
Controlling Blood Pressure	52.70%	51.60%	53.00%	**54.70%**	46.30%	55.90%	53.40%	46.30%	-	55.30%
Cervical Cancer Screening	56.60%	53.80%	55.30%	55.60%	48.20%	52.20%	50.80%	53.20%	+	65.80%
Diabetes – HbA1c Testing	74.70%	75.10%	76.40%	79.60%	78.90%	80.10%	82.80%	**81.90%**	-	80.60%
Diabetes – HbA1c Poor Control INVERSE	48.50%	51.70%	46.40%	42.50%	48.30%	46.80%	44.90%	**48.60%**	-	44.90%
Diabetes – Eye Exam	36.30%	41.90%	48.30%	52.10%	35.70%	44.00%	45.40%	49.30%	+	52.70%
Diabetes – LDL Screening	75.60%	76.30%	77.90%	**80.00%**	80.00%	80.20%	83.50%	**81.80%**	-	74.20%
Diabetes – LDL Control	29.50%	29.40%	**33.80%**	32.80%	29.30%	**35.90%**	36.10%	**36.90%**	+	33.50%
Diabetes Nephropathy	77.10%	76.10%	77.10%	**79.00%**	79.20%	80.30%	81.90%	**83.10%**	+	76.90%
Follow-Up after Mental Health Hospital – 7-day	30.50%	37.20%	24.20%	28.40%	20.60%	29.30%	25.40%	23.10%	-	42.90%
Follow-Up after Mental Health Hospital – 30-day	47.00%	51.70%	41.40%	47.90%	35.50%	46.60%	41.30%	44.30%	+	60.20%
Prenatal Care	71.70%	69.10%	69.50%	71.70%	66.60%	67.40%	75.20%	68.40%	-	83.40%

Postpartum Care	58.50%	50.10%	52.70%	54.60%	53.00%	51.50%	52.10%	49.30%	-	64.10%
Well-Child First 15 Months – Zero Visits INVERSE	2.80%	3.00%	4.20%	3.20%	4.90%	1.60%	6.00%	3.00%	+	2.30%
Well-Child First 15 Months – Six Visits	44.00%	51.00%	46.10%	51.40%	44.40%	49.30%	35.40%	46.50%	+	59.40%
Well-Child 3-6 years	71.10%	72.50%	74.90%	**74.80%**	71.30%	75.70%	72.70%	**75.00%**	+	71.60%
Adults' Access to Preventive Care – 20-44 Years	n/a	69.30%	67.90%	68.10%	n/a	71.80%	71.20%	71.20%	flat	80.50%
Adults' Access to Preventive Care – 45-64 Years	n/a	82.20%	81.20%	81.50%	n/a	84.70%	84.90%	**85.50%**	+	85.30%
Adults' Access to Preventive Care – 65+ Years	n/a	74.70%	66.90%	69.90%	n/a	83.60%	83.70%	84.20%	+	84.70%
Antidepressant Medication Mgmt – Acute	n/a	45.60%	46.80%	47.00%	n/a	52.00%	56.30%	**56.30%**	flat	49.60%
Antidepressant Medication Mgmt – Continuation	n/a	31.20%	29.20%	31.40%	n/a	29.80%	43.80%	**44.00%**	+	33.00%
Appropriate Medications for Asthma	n/a	87.00%	87.00%	86.60%	n/a	83.60%	87.60%	86.00%	-	88.60%
Breast Cancer Screening	n/a	47.50%	50.10%	50.90%	n/a	51.40%	56.90%	**59.20%**	+	52.40%
Childhood Immunization Combo 2	n/a	61.80%	71.40%	73.80%	n/a	63.60%	70.00%	72.60%	+	74.30%
Childhood Immunization Combo 3	n/a	52.00%	63.70%	67.90%	n/a	53.80%	62.70%	65.70%	+	69.40%

Frequency of Prenatal Care	n/a	51.60%	54.30%	**60.60%**	n/a	52.60%	46.90%	44.00%	-	61.60%
Lead Screening	n/a	46.00%	53.10%	53.50%	n/a	54.80%	52.00%	54.10%	+	66.40%
Adult BMI Assessment	n/a	n/a	31.20%	**48.30%**	n/a	n/a	41.90%	**52.70%**	+	34.60%
Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase	n/a	n/a	37.80%	**37.10%**	n/a	n/a	43.60%	**44.50%**	+	36.60%
Follow-Up Care for Children Prescribed ADHD Medication – Continuation & Maintenance	n/a	n/a	46.60%	**46.70%**	n/a	n/a	n/a	n/a	n/a	41.70%