# 2018 Regional Analysis Report

## Washington Apple Health

## Washington Health Care Authority

December 2018

QUALIS HEALTH™

As Washington's Medicaid external quality review organization (EQRO), Qualis Health provides external quality review and supports quality improvement for enrollees of Washington Apple Health managed care programs and the State's managed mental health and substance use disorder treatment services.

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For more information, visit us online at www.QualisHealth.org/WAEQRO.
PO Box 33400
Seattle, Washington 98133-0400
Toll-Free: (800) 949-7536
Office: (206) 364-9700

# Table of Contents

**Executive Summary** ..... **5**
Report Objectives ..... 5
Key Highlights ..... 6
Access to Care ..... 6
Preventive Care ..... 6
Chronic Care Management ..... 7
Medical Utilization ..... 7
Recommendations ..... 8
**Introduction** ..... **9**
HEDIS Performance Measures ..... 9
Administrative Versus Hybrid Data Collection ..... 9
Member-Level Data ..... 10
Measure Selection ..... 10
Areas of Analysis for Variation ..... 11
Determination of Statistical Significance ..... 13
Overview of Apple Health Enrollment ..... 14
Apple Health Enrollment by Region ..... 17
Program Enrollment ..... 17
Enrollee Age Distribution ..... 18
Language and Race ..... 19
**Regional Comparison** ..... **20**
**How to Read the *Regional Analysis Report* Charts** ..... **21**
**Access to Care** ..... **28**
Adults' Access to Preventive/Ambulatory Health Services ..... 29
Adults' Access to Preventive/Ambulatory Health Services (20–44) ..... 29
Adults' Access to Preventive/Ambulatory Health Services (45–64) ..... 35
Children and Adolescents' Access to Primary Care Practitioners ..... 40
Children and Adolescents' Access to Primary Care Practitioners (12–24 months) ..... 40
Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years) ..... 43
Children and Adolescents' Access to Primary Care Practitioners (7–11 Years) ..... 46
Children and Adolescents' Access to Primary Care Practitioners (12–19 years) ..... 49
Prenatal and Postpartum Care—Timeliness of Prenatal Care ..... 52
Prenatal and Postpartum Care—Postpartum Visit ..... 54
**Preventive Care** ..... **56**
Breast Cancer Screening ..... 57
**Chronic Care Management** ..... **61**
Antidepressant Medication Management—Acute Treatment Phase ..... 62
Antidepressant Medication Management—Continuation Treatment Phase ..... 64
Comprehensive Diabetes Care—HbA1c Control (< 8.0%) ..... 68
**Medical Care Utilization** ..... **70**
Appropriate Treatment for Children with Upper Respiratory Infection ..... 71
Appropriate Testing for Children with Pharyngitis ..... 73
**Appendix A: Regional Scorecards** ..... **A-1**

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# Executive Summary

As part of its work as the external quality review organization (EQRO) for the Washington State Health Care Authority (HCA), Qualis Health reviewed Apple Health managed care organization (MCO) performance for the calendar year (CY) 2017. The MCOs were required to report on 57 Healthcare Effectiveness Data and Information Set (HEDIS®)[1] measure items reflecting the levels of quality, timeliness, and accessibility of healthcare services they furnished to the state's Medicaid enrollees. HEDIS measures are developed and maintained by the National Committee for Quality Assurance (NCQA), whose database of HEDIS results for health plans, the Quality Compass®[2], enables benchmarking against other Medicaid managed care health plans nationwide.

During 2017 CY, five MCOs provided care for Apple Health enrollees:

- Amerigroup Washington (AMG)
- Community Health Plan of Washington (CHPW)
- Coordinated Care of Washington (CCW)
- Molina Healthcare of Washington (MHW)
- United Healthcare Community Plan (UHC)

To be consistent with NCQA methodology, the 2017 calendar year is referred to as the 2018 reporting year (RY) in this report.

## Report Objectives

The goal of this report is to identify and articulate opportunities for improvement in the delivery of Medicaid services in Washington by examining variation and trends in HEDIS measure performance across the state's regions and demographic groups. This report is a companion to the *Comparative Analysis Report*, which provides overall HEDIS measure performance by Apple Health MCOs.

The populations in this report represent Apple Health members enrolled with an MCO in Washington State between January 1, 2017, and December 31, 2017. The HEDIS measures were not risk-adjusted for differences in enrollee demographics.

This report explores variations in performance measure outcomes in the following areas:

- geographic regions
- patient demographics
- Medicaid programs

These analyses identify performance improvements as well as opportunities for improvement. The section below outlines the key regional variations identified in four primary measure domains: Access to Care, Preventive Care, Chronic Care Management, and Medical Care Utilization. Later chapters will explore these variations in greater detail.

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[1] The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.
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# Key Highlights

## Access to Care

Health plans are responsible for ensuring care is available for their members. This is achieved by establishing an adequate provider network, providing good customer service and guidance, and educating members on the importance of engaging with providers for their routine care. In this report, the access measures presented are adults' access to preventive/ambulatory health services, children and adolescents' access to primary care practitioners, and select prenatal and postpartum care measures.

- **Adults' access to preventive/ambulatory health services:** Performance on both sub-measures included in this analysis (ages 20–44 and 45–64) increased slightly statewide and in almost every region since 2017 RY. Rates were highest in the North Central region on both measures, and higher generally in the eastern regions of the state, continuing a trend noted the previous year. Analysis of variation by language and program identified higher rates for non-English-speaking enrollees than for English-speaking enrollees, and higher rates for enrollees of Apple Health Family (traditional Medicaid) compared to enrollees of Apple Health Adult Coverage (Medicaid expansion).
- **Children and adolescents' access to primary care practitioners:** Rates for this measure (also referred to as child/adolescent access to primary care in this report) decreased for every age group at the state level except for the 12–24 months age range. Rates were consistently the highest in the North Central region (except for the 12–24 months group) and, as in 2017 RY, in the eastern part of the state in general. Rates continued to be lowest in Southwest Washington, although rates in this region showed considerable improvement in the 7–11 and 12–19 age groups, where almost every other region showed a decline in performance. Analysis by language showed higher rates for non-English speakers in most regions on all measures.
- **Maternal health measures:** As reported in the *2018 Comparative Analysis Report*, statewide performance on maternal health measures is poor. Timeliness of prenatal care dropped by 5.3 percent statewide between 2017 RY and 2018 RY, and postpartum care did not show improvement; both measures rank below the 33rd national percentile. Further analysis also revealed wide regional variation on the maternal health measures, with 14.7–22 percentage points separating the highest and lowest regional rates for each measure. North Central and Cascade Pacific AA rates were substantially higher than elsewhere, and were the only regional rates (with East King) to show improvement since 2017 RY on both measures. Rates in Southwest Washington remain the lowest in the state, but Better Health Together, Greater Columbia, and Olympic showed dramatic declines in performance on both measures since 2017 RY.

## Preventive Care

Effective preventive care is delivered proactively, before the onset of disease. Cancer screenings in particular enable early detection of disease, which in turn may allow for additional treatment options that can lead to better outcomes. This report includes analyses relating to the breast cancer screening measure.

- **Breast cancer screenings:** Statewide performance on the breast cancer screening measure improved slightly since 2017 RY; rates also improved in every region, most notably in Southwest Washington, where the rate increased 13.5 percentage points. However, the rate for this measure remains below the 50th national percentile. Regional analysis showed similar trends as identified for 2017 RY, with higher rates in the eastern regions of the state than in the west. Analysis of

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variation by language and race also continued to show considerably lower screening rates for white women and English speakers than for other races and for those enrollees with a non-English-language preference. These disparities could present opportunities to focus efforts on improving performance on this measure.

## Chronic Care Management

Health plans can enhance quality of care and outcomes by helping providers coordinate care so that chronic illness is effectively managed and unnecessary care is avoided. This report includes measures relating to antidepressant medication management and comprehensive diabetes care—HbA1c control (< 8.0%).

- **Antidepressant medication management:** Performance on this measure (both acute and continuation treatment phases) increased slightly statewide since 2017 RY. Regionally, rates continued to be generally higher in the western part of the state, although the overall performance gap between western and eastern regions narrowed since 2017 RY, with most western regions showing slightly declining rates and eastern regions showing slight increases. Rates in Cascade Pacific AA surpassed those in all other regions on both measures, and North Central showed the lowest rates on both measures. Additional analyses for the continuation phase measure showed higher rates for enrollees ages 40–60 than for enrollees ages 20–40, and higher rates for the Apple Health Adult Coverage population (Medicaid expansion) than for Apple Health Family (traditional Medicaid).
- **Comprehensive diabetes care—HbA1c control (< 8.0%):** Performance on the HbA1c control measure, which has decreased statewide since 2017 RY, varied widely across the state, with 11.3 percentage points separating the highest (Seattle) and lowest (North Sound) regional rates. Regional rates also showed considerable variation year to year, with rates in several regions increasing or decreasing by 5–10 percentage points. Notably, the rate in Southwest Washington and Better Health Together increased by 7.8 points, the rate in North Central declined by 9.6, and the rate in Cascade Pacific AA and Pierce declined by 6.8 and 5.9, respectively.

## Medical Utilization

One important method of controlling costs is to limit the provision of inappropriate or unnecessary care. This report assesses appropriate treatment for children with upper respiratory infection and appropriate testing for children with pharyngitis.

- **Appropriate treatment for children with upper respiratory infection:** Data for 2018 showed good performance statewide in avoiding inappropriate antibiotics use for children with upper respiratory infection, with little regional variation and little change since 2017 RY.
- **Appropriate testing for children with pharyngitis:** Rates for this measure varied more widely across the state, with rates above the national average in the western regions of the state, and rates at or below the state average in the eastern regions of Greater Columbia, Better Health Together, and North Central. The highest (Southwest Washington) and lowest (North Central) regional rates differed by 25.6 percent. In several regions, rates for English-speaking enrollees were substantially higher than for enrollees with all other language preferences.

# Recommendations

Statewide rates for adult access to care improved slightly in 2018 RY; those for child/adolescent access decreased. Overall, access rates in the eastern regions of the state continued to surpass those in the western regions of the state.

- The State should consider examining root causes of low performance rates on access measures in the western regions of the state. Performance on access to primary care for both adults and children/adolescents were all particularly low in these regions of the state compared to the state average and should be a focus of improvement. HCA should consider requiring underperforming MCOs to have a plan in place, ideally with timelines and deliverables, to improve performance.

Although performance on the antidepressant medication management measures improved slightly in the eastern regions of the state in 2018 RY, rates here (except for Better Health Together) still lag behind those in the western regions of the state.

- The State should consider examining root causes of low performance on these behavioral health measures in the eastern part of the state and determine whether focused improvement efforts may be necessary, including examining the number and types of behavioral health practitioners and provider organizations available in the underperforming regions. Success for some of the measures may require sophisticated and specialized care potentially not readily available in rural areas. Depending on the results of these analyses, HCA should consider maximizing collaboration with the behavioral health integration efforts, priorities, and resources of Healthier Washington to better facilitate behavioral health integration across the state, particularly in the eastern regions.

Numerous measures, including most access measures and the breast cancer screening measure, showed lower performance rates for English-speaking enrollees; on other measures, particularly appropriate treatment for children with pharyngitis, performance was lower for those enrollees with a non-English-language preference.

- Language preference plays a critical role in healthcare delivery, yet currently, methods for collecting enrollees' preferred language data vary among the plans and do not collect optimally detailed data. To further understand the specific language challenges present in delivering equitable care and to ensure enrollees are obtaining care and information in language they understand, HCA should consider the following options: asking MCOs to expand options for capturing enrollees' preferred language data beyond "other" to include a variety of languages, standardizing collection of this information among the plans, and evaluating whether the language capture is accurate. Obtaining an enhanced level of enrollee data may assist in identifying regions where additional or specialized outreach may be concentrated.

# Introduction

As part of its work as the Washington State EQRO, Qualis Health reviewed Apple Health MCO performance for the calendar year 2017 (reporting year 2018). To enable a reliable measurement of performance, the MCOs were required to report 57 HEDIS measures, representing 141 submeasures. HEDIS measures were developed and are maintained by the NCQA, whose database of HEDIS results for health plans —the Quality Compass®—enables benchmarking against other Medicaid managed care health plans nationwide.

The purpose of this report is to identify opportunities for improvement in the delivery of Medicaid services in Washington by examining variation in MCO performance across geographic, Medicaid program, and demographic categories. It draws from MCO performance on selected HEDIS measures Apple Health MCOs reported on in 2017 RY and 2018 RY. It is a companion report to the *Comparative Analysis Report*, which provides overall HEDIS measure performance with comparisons to state and national benchmarks.

## HEDIS Performance Measures

HEDIS measures are widely used performance measures reported by health plans. HEDIS results can be used by the public to compare plan performance over six domains of care; they also allow plans to determine where quality improvement efforts may be needed.

The select national benchmarks included in this report are derived from the Quality Compass and represent the national average among all Medicaid plans. The average includes non-managed care plans as well as plans in states that opted not to expand Medicaid. As a result, national comparisons are not always pertinent, but they represent a benchmark of care occurring across the US.

### Administrative Versus Hybrid Data Collection

HEDIS measures draw from clinical data sources, utilizing either a fully “administrative” collection method or a “hybrid” collection method. The administrative collection method relies solely on clinical information that is collected from the electronic records generated in the normal course of business, such as claims, registration systems, or encounters, among others. In some delivery models, such as under-capitated models, healthcare providers may not have an incentive to report all patient encounters, so rates based solely on administrative data may be artificially low. For measures that are particularly sensitive to this gap in data availability, the hybrid collection method supplements administrative data with a valid sample of carefully reviewed chart data, allowing MCOs to correct for biases inherent in administrative data gaps. Hybrid measures therefore allow MCOs to overcome missing or erroneous administrative data by using sample-based adjustments. As a result, hybrid performance scores will nearly always be the same or better than scores based solely on administrative data.

In order to determine regional differences in the quality of care provided to enrollees, selected measures needed to have sufficient volumes in each region to be included in the analyses. Only a few hybrid measures had sufficient volumes in each region to be analyzed at the regional level. As a result, this report focuses on variation in measures collected using the administrative methodology.

## Member-Level Data

As part of the HEDIS audit process, each MCO was required to produce a patient-level data (PLD) file based on prior-year NCQA specifications. These files provide member-level information for all HEDIS quality measures.

HCA requested that each MCO's member-level data (MLD) file be submitted to the State for mapping to enrollee demographic information (race/ethnicity, language, and ZIP code of residence). These collective member-level data were provided to Qualis Health for analysis and are a principal data source for this report. Because the statewide rates for this report are derived from member-level data, some statewide results may differ slightly from those presented in the *2018 Comparative Analysis Report*, which are derived from HEDIS data.

The populations underlying each measure in this report represent Apple Health members enrolled with an MCO in Washington State between January 1, 2017, and December 31, 2017. Of note: Only individuals who are in the denominator of at least one HEDIS measure are included in the member-level data. As a result, individuals with short tenures in their plans or individuals with little to no healthcare utilization may not be included in this report. The HEDIS measures were not risk-adjusted for any differences in enrollee demographic characteristics. Prior to performing regional analysis, member-level data were aggregated to the MCO level and validated against the reported HEDIS measures.

## Measure Selection

As stated above, this report focuses on variation in measures collected using the administrative methodology. The HEDIS performance measures included in this report are listed in Table 1. Abbreviations for the measure names are included in the table and used throughout the text.

***Table 1: Select HEDIS Administrative Measures and Abbreviations***

| Abbreviation | HEDIS Measure |
|---|---|
| ***Access to Care*** | |
| **AAP** | Adults' Access to Preventive/Ambulatory Health Services |
| **CAP** | Children and Adolescents' Access to Primary Care Practitioners |
| ***Preventive Care*** | |
| **BCS** | Breast Cancer Screening |
| ***Chronic Care Management*** | |
| **AMM-a** | Antidepressant Medication Management (Effective Acute Phase Treatment) |
| **AMM-b** | Antidepressant Medication Management (Effective Continuation Phase Treatment) |
| ***Medical Care Utilization*** | |
| **URI** | Appropriate Treatment for Children with Upper Respiratory Infection |
| **CWP** | Appropriate Testing for Children With Pharyngitis |

While the focus of this report is on administrative measures, it does include limited references to select measures collected through the hybrid methodology, as outlined in Table 2.

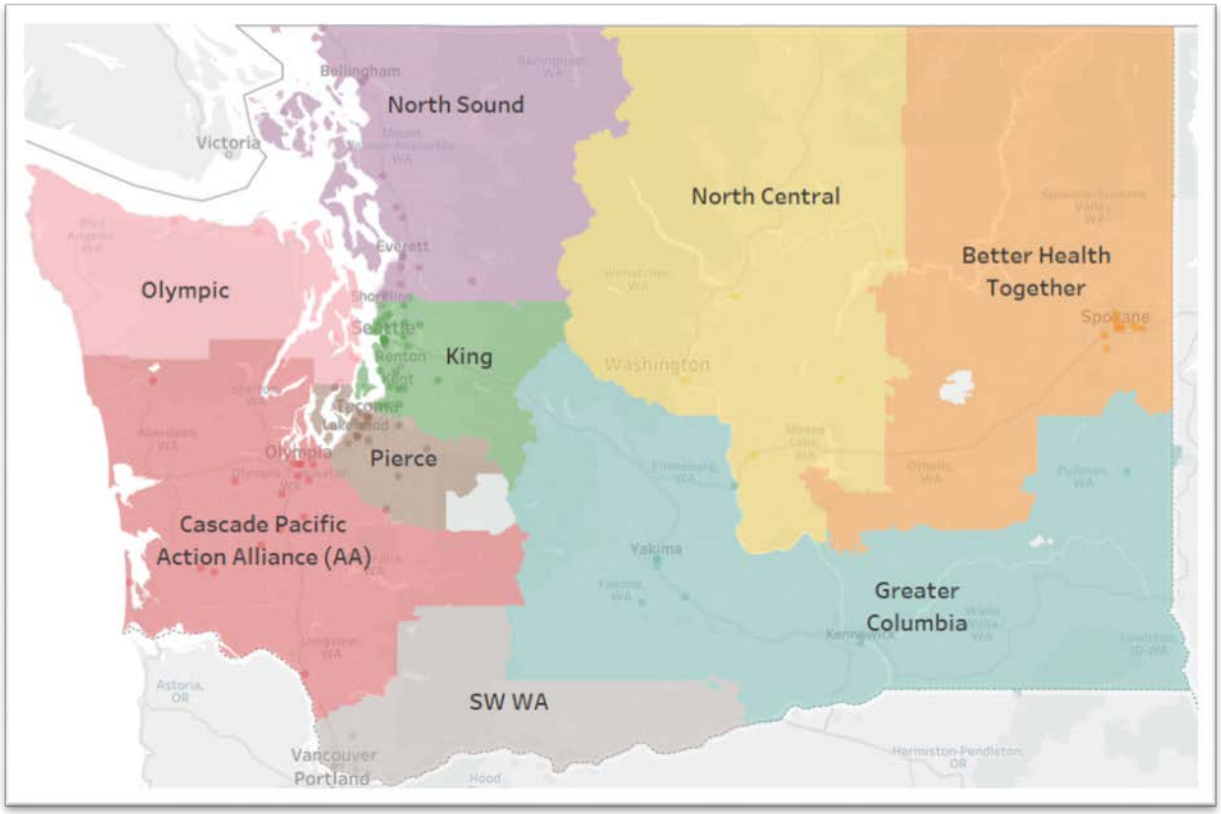
***Table 2: Select HEDIS Hybrid Measures and Abbreviations***

| Abbreviation | HEDIS Measure |
|---|---|
| ***Access to Care*** | |
| **PPC** | Prenatal and Postpartum Care |
| ***Chronic Care Management*** | |
| **CDC** | Comprehensive Diabetes Care—HbA1c Control (< 8.0%) |

More information on MCO comparative performance on hybrid measures can be found in the *2018 Comparative Analysis Report.*

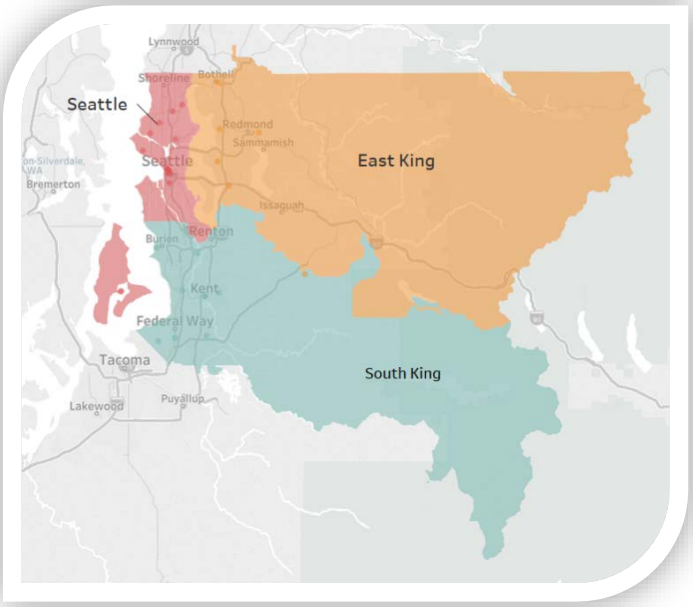
# Areas of Analysis for Variation

- **Geographic Regions:** The regions delineated in this report are the Accountable Community of Health (ACH) boundaries for 2018, defined by the HCA as of May 2018.[3] Enrollees were assigned to ACHs based on their residence ZIP code and not where care is provided. Note that the grey area near Pierce is a national park and does not contain any beneficiaries.




[3] https://www.hca.wa.gov/assets/program/ach-map.pdf

- **King County Subdivision:** Because of the dense population of King County and the heterogeneous nature of this ACH's population, we subdivided this region into three distinct areas: East King, Seattle, and South King.




- **Medicaid Enrollment:** Plan enrollment was derived from data submitted by the MCOs. Program enrollment was derived by HCA and submitted to Qualis Health as supplemental information.
    - MCO (AMG, CCW, CHPW, MHW, UHC)
    - Program
        - Apple Health Family (traditional Medicaid)
        - Apple Health Adult Coverage (Medicaid expansion)
        - Apple Health Blind/Disabled
        - Integrated Managed Care (IMC)
        - State Children's Health Insurance Program (CHIP)
        - Apple Health Foster Care

- **Demographics:** Enrollee demographic information, such as race, sex, ZIP code of residence, and primary language, was derived from data submitted by the MCOs. Where MCO-supplied demographic information was missing, demographic data supplied by HCA were used.
    - Age
        - 20-year age ranges
    - Sex
        - Male/Female
    - Race
        - White
        - Black
        - Asian
        - American Indian/Alaska Native
        - Native Hawaiian/other Pacific Islander
        - Hispanic/Latino other
        - Unknown
    - Preferred language
        - English
        - Non-English

## Determination of Statistical Significance

In this report, the words “significant” or “significantly” refer to measure performance in each region or demographic group compared to the overall state-level rate. A Wilson Score Interval Test, with a 95 percent confidence interval, was used to test for statistical significance. The Wilson Score Interval Test yields confidence intervals that have been shown to be accurate for most values (e.g., performance measure scores) and small samples (e.g., numbers of eligible enrollees).

# Overview of Apple Health Enrollment

It is important to note that MCOs' members are not homogenous. MCOs serve different populations with a varying mix of demographics and program enrollment.

Most members in the Apple Health Family program (traditional Medicaid) are under the age of 20 (84.1 percent), while the majority of members in the Apple Health Adult Coverage program (Medicaid expansion) are between the ages of 20 and 50 (73.4 percent), and 32 percent of members in that program are between the ages of 20 and 30.

The IMC population served by CHPW and MHW in Southwest Washington accounts for 7.6 percent of all Medicaid enrollees, and the age distribution for this population is relatively evenly distributed, with a higher concentration only of enrollees under the age of 10 (26.96 percent). Eventually all plans and populations will transition to the IMC model, which incorporates administration of physical healthcare, mental health services, and substance use disorder treatment under one health plan.

Tables 3, 4, and 5 show the distribution of Apple Health enrollees by program, age, and both program and age.

***Table 3: 2018 RY Enrollee Population by Apple Health Program***
***1,646,117 Enrollees in Total***

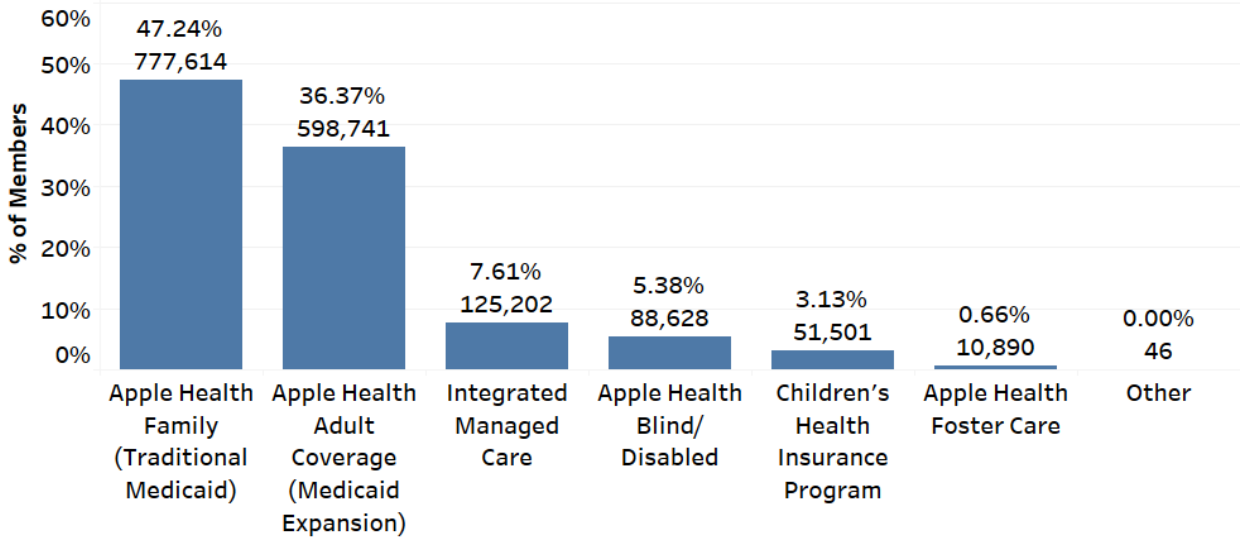


***Table 4: 2018 RY Enrollee Population by Age***

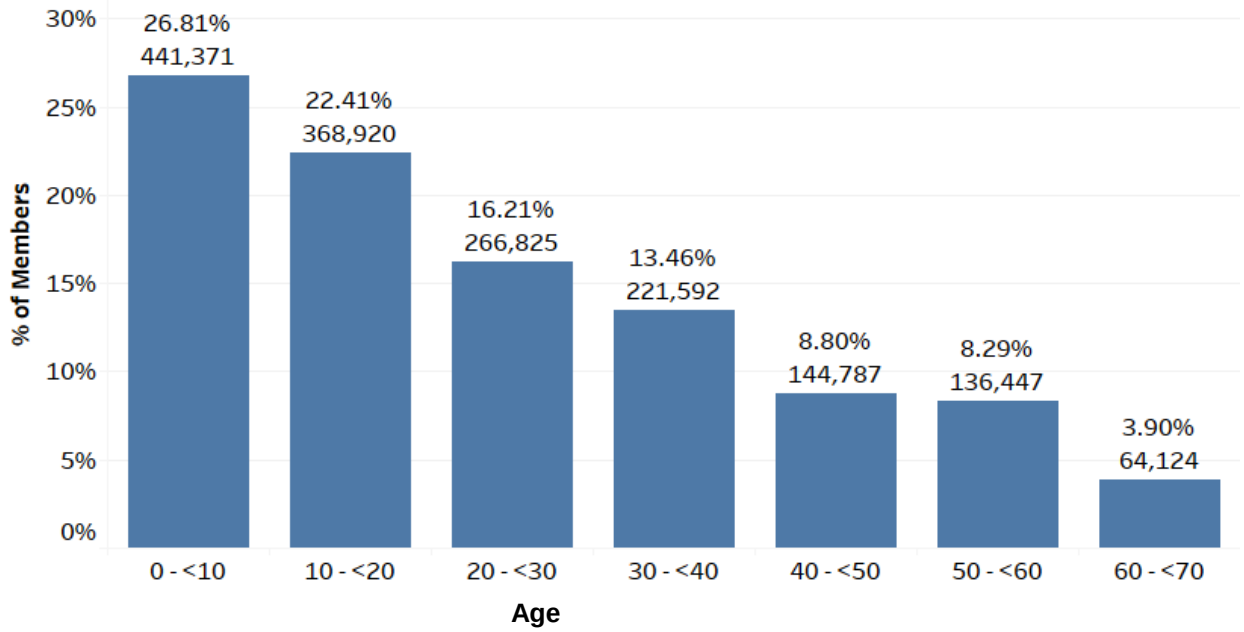
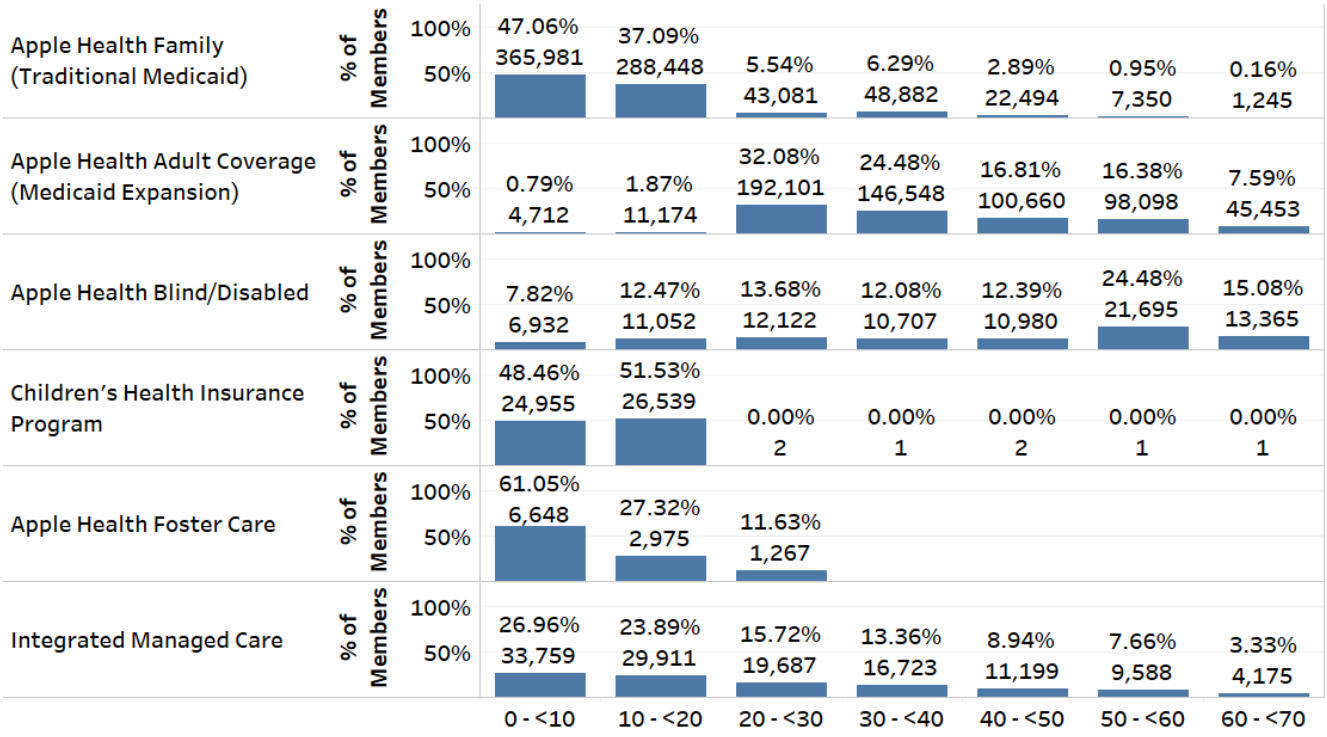
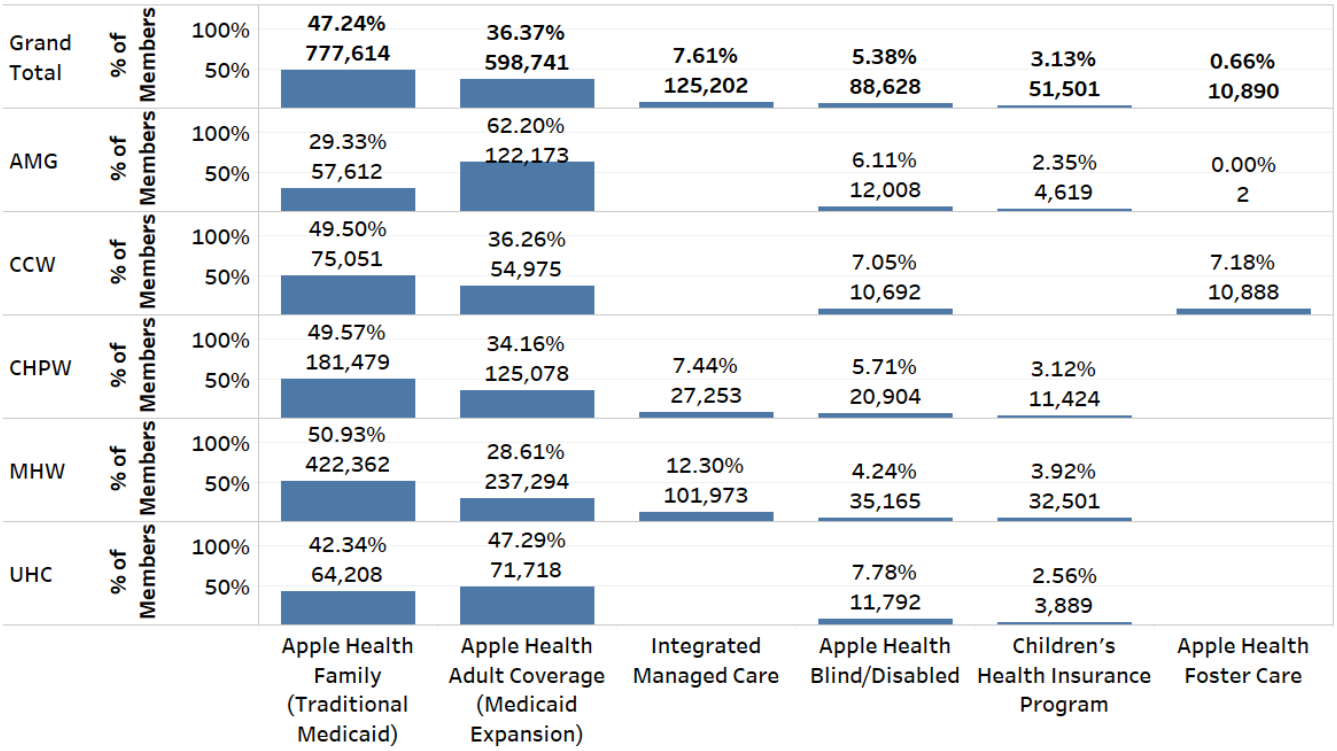



***Table 5: 2018 RY Enrollee Population by Apple Health Program and Age***




The relative distribution of these members is not uniform across MCOs. For example, 62.2 percent of AMG's members are enrolled in Apple Health Adult Coverage (Medicaid expansion), while only 28.6 percent of MHW's members are enrolled in that program. Additionally, only CHPW and MHW administered IMC in 2017. This variation in Medicaid program mix by MCO can affect HEDIS performance outcomes, so it is important to monitor performance at both the plan level and at the plan and program level. Table 6 shows Apple Health enrollee population distribution by program and plan.

***Table 6: 2018 RY Member Population by Apple Health Program and Plan***




Overall, Apple Health MCOs experienced a total growth rate of 0.10 percent from December 2016 to December 2017 CY. MHW grew by 4.54 percent during this time, while all other plans decreased in total published enrollment from 2016 to 2017 CY. Table 7 shows Apple Health enrollment by plan for the 2014, 2015, 2016, and 2017 calendar years.

***Table 7: Apple Health Enrollment, December 2014, December 2015, December 2017 CY[4]***

| | December 2014 CY Enrollment | December 2015 CY Enrollment | December 2016 CY Enrollment | December 2017 CY Enrollment | Percent Change | |
|---|---|---|---|---|---|---|
| | | | | | Dec 2015 to Dec 2016 CY | Dec 2016 to Dec 2017 CY |
| **AMG** | 128,369 | 141,571 | 149,314 | 145,135 | 5.19% | -2.88% |
| **CHPW** | 332,456 | 294,141 | 297,725 | 277,185 | 1.20% | -7.41% |
| **CCW** | 175,353 | 181,801 | 207,342 | 201,006 | 12.31% | -3.15% |
| **MHW** | 486,524 | 566,201 | 697,392 | 730,571 | 18.81% | 4.54% |
| **UHC** | 180,225 | 204,078 | 224,973 | 224,450 | 9.29% | -0.23% |
| **Total** | 1,302,927 | 1,445,093 | 1,576,746 | 1,578,347 | 8.35% | 0.10% |

MCOs are also represented to varying degrees in the regions throughout Washington, as detailed in the following section.

[4] www.hca.wa.gov/about-hca/apple-health-medicaid-reports

# Apple Health Enrollment by Region

## Program Enrollment

The distribution of enrollees among different Medicaid programs differs by region. For example, Southwest Washington's members are almost exclusively enrolled in IMC, while the majority of enrollees in the Seattle region are in Apple Health Adult Coverage (Medicaid expansion). East King and Olympic regions also have higher levels of Apple Health Adult Coverage enrollees compared to other regions. North Central, South King, and Greater Columbia have the highest percentages of traditional Medicaid enrollees, at greater than 59 percent.

***Table 8: Apple Health Program Enrollment by Region***

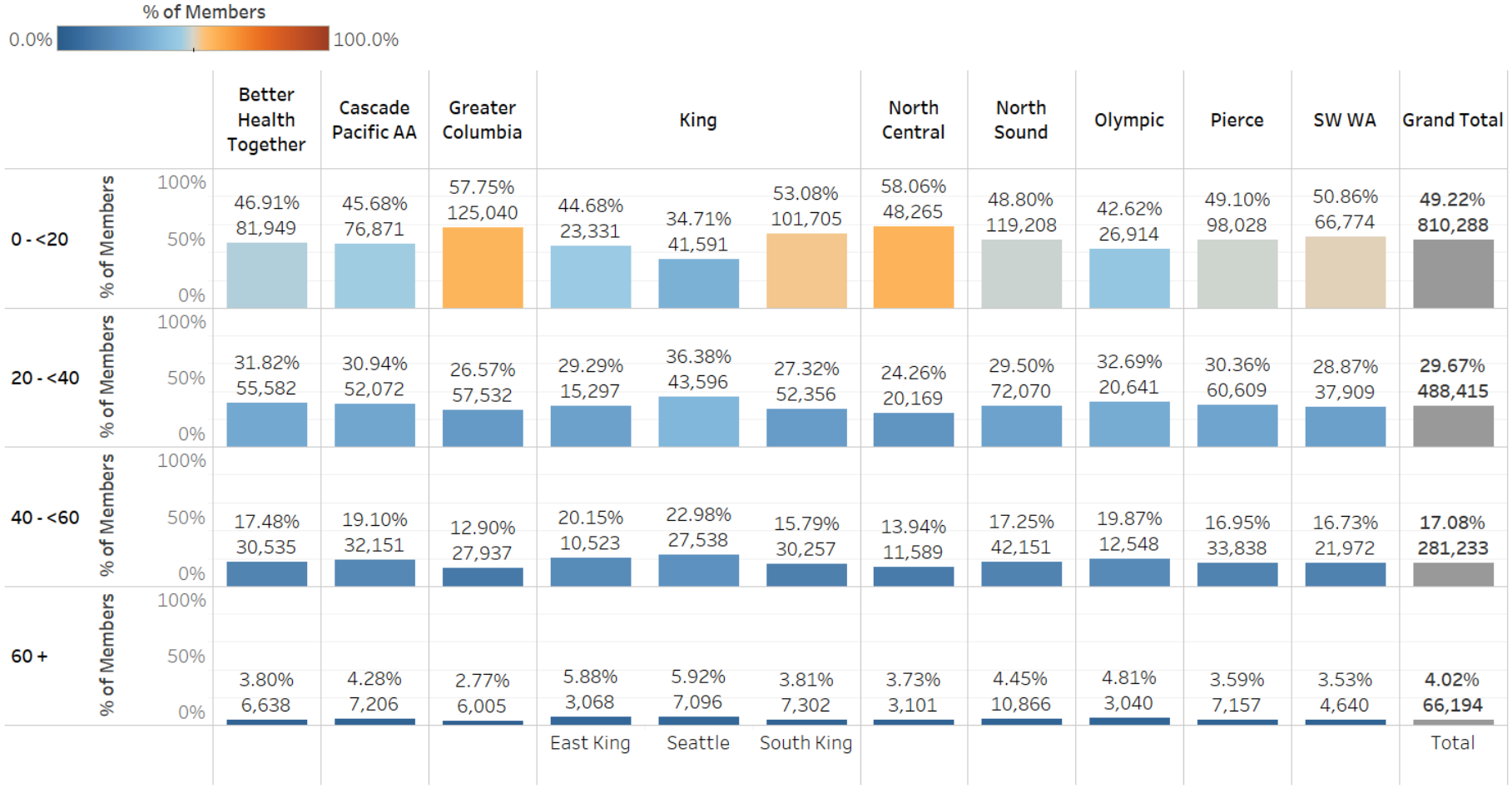
% of Members
0.0% 100.0%

| | | | Better Health Together | Cascade Pacific AA | Greater Columbia | King | | | North Central | North Sound | Olympic | Pierce | SW WA | Grand Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Apple Health Family (Traditional Medicaid) | % of Members | 100% | 48.65% | 49.00% | | 45.63% | 36.35% | 55.00% | | 49.85% | 45.11% | 52.05% | | 47.24% |
| | | 50% | 84,985 | 82,469 | 59.86% | 23,827 | 43,560 | 105,382 | 59.38% | 121,777 | 28,484 | 103,915 | 2.49% | 777,614 |
| | | 0% | | | 129,607 | | | | 49,357 | | | | 3,270 | |
| Apple Health Adult Coverage (Medicaid Expansion) | % of Members | 100% | 41.19% | 40.79% | 32.08% | 44.84% | 53.78% | 35.82% | 32.38% | 40.15% | 44.58% | 37.66% | | 36.37% |
| | | 50% | 71,961 | 68,650 | 69,447 | 23,416 | 64,435 | 68,635 | 26,912 | 98,082 | 28,152 | 75,178 | 2.57% | 598,741 |
| | | 0% | | | | | | | | | | | 3,376 | |
| Apple Health Blind/Disabled | % of Members | 100% | 6.61% | 7.30% | 5.06% | 4.48% | 6.82% | 5.07% | 4.39% | 5.08% | 6.71% | 6.35% | 0.38% | 5.38% |
| | | 50% | 11,540 | 12,282 | 10,950 | 2,339 | 8,166 | 9,715 | 3,653 | 12,400 | 4,240 | 12,678 | 494 | 88,628 |
| | | 0% | | | | | | | | | | | | |
| Apple Health Foster Care | % of Members | 100% | 0.90% | 0.79% | 0.62% | 0.50% | 0.49% | 0.48% | 0.57% | 0.66% | 0.99% | 0.75% | 0.51% | 0.66% |
| | | 50% | 1,574 | 1,331 | 1,341 | 259 | 586 | 915 | 476 | 1,613 | 623 | 1,502 | 670 | 10,890 |
| | | 0% | | | | | | | | | | | | |
| Children's Health Insurance Program | % of Members | 100% | 3.05% | 2.43% | 2.58% | 4.80% | 2.74% | 3.95% | 3.64% | 4.54% | 2.89% | 3.48% | 0.16% | 3.13% |
| | | 50% | 5,337 | 4,091 | 5,596 | 2,506 | 3,284 | 7,576 | 3,025 | 11,095 | 1,822 | 6,953 | 211 | 51,501 |
| | | 0% | | | | | | | | | | | | |
| Integrated Managed Care | % of Members | 100% | 0.02% | 0.41% | 0.05% | 0.04% | 0.04% | 0.02% | 0.03% | 0.03% | 0.04% | 0.03% | 94.03% | 7.61% |
| | | 50% | 38 | 682 | 109 | 20 | 46 | 42 | 24 | 69 | 26 | 55 | 123,459 | 125,202 |
| | | 0% | | | | | | | | | | | | |
| | | | | | | East King | Seattle | South King | | | | | | Total |

## Enrollee Age Distribution

Similar to the regional variation in member distribution by Medicaid program, variations also exist by age group. In the Seattle region, 36.38 percent of enrollees are between the ages of 20 and 40, while in South King, only 27.32 percent of members are in that age group, and 53.08 percent of members are younger than 20. North Central and Greater Columbia have the highest percentages of members under 20 at 58.06 percent and 57.75 percent, respectively.

***Table 9: Enrollee Age Distribution by Region***



## Language and Race

North Central and Greater Columbia stand out in an analysis of enrollee variation by language and race. Both regions have higher percentages of members who prefer a non-English language, and in both regions, more than 20 percent of enrollees identify as Hispanic or Latino. In Seattle, 24.19 percent of members identify as black, higher than in all other regions.

***Table 10: Enrollee Language Preference and Race by Region***

% of Members
0.00% 30.00%

Language

| | | Better Health Together | Cascade Pacific AA | Greater Columbia | King | | | North Central | North Sound | Olympic | Pierce | SW WA | Grand Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Non-English | % of Members | 4.86% 8,491 | 5.51% 9,266 | 24.19% 52,370 | 12.34% 6,442 | 12.63% 15,138 | 20.19% 38,693 | 26.13% 21,719 | 11.36% 27,742 | 2.75% 1,736 | 7.09% 14,158 | 9.98% 13,105 | **12.69% 208,973** |
| | | | | | East King | Seattle | South King | | | | | | Total |

Race

| | | Better Health Together | Cascade Pacific AA | Greater Columbia | King | | | North Central | North Sound | Olympic | Pierce | SW WA | Grand Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Hispanic | % of Members | 5.58% 9,749 | 5.97% 10,051 | 34.19% 74,016 | 5.56% 2,902 | 5.80% 6,953 | 8.71% 16,693 | 21.96% 18,253 | 9.10% 22,233 | 4.64% 2,931 | 4.50% 8,991 | 3.42% 4,489 | **10.78% 177,455** |
| Black | % of Members | 4.05% 7,077 | 2.95% 4,960 | 1.82% 3,943 | 5.93% 3,098 | 24.19% 28,985 | 16.53% 31,684 | 0.90% 747 | 4.56% 11,137 | 4.71% 2,971 | 13.11% 26,175 | 3.71% 4,873 | **7.64% 125,750** |
| Asian | % of Members | 2.24% 3,917 | 2.75% 4,625 | 1.27% 2,740 | 14.56% 7,604 | 14.09% 16,877 | 13.36% 25,599 | 0.67% 559 | 5.80% 14,180 | 3.62% 2,285 | 7.94% 15,849 | 4.32% 5,670 | **6.07% 99,954** |
| American Indian and Alaska Native | % of Members | 1.85% 3,238 | 1.65% 2,770 | 0.87% 1,893 | 0.62% 325 | 0.87% 1,037 | 0.80% 1,527 | 1.34% 1,110 | 1.39% 3,400 | 1.53% 966 | 1.09% 2,179 | 0.86% 1,128 | **1.19% 19,600** |
| Native Hawaiian/Pacific Islander | % of Members | 0.81% 1,414 | 0.94% 1,585 | 0.39% 840 | 1.15% 602 | 1.86% 2,229 | 3.04% 5,827 | 0.16% 133 | 1.20% 2,932 | 2.53% 1,600 | 2.24% 4,464 | 0.89% 1,166 | **1.39% 22,813** |
| Unknown | % of Members | 12.04% 21,028 | 15.73% 26,480 | 21.73% 47,056 | 23.24% 12,133 | 14.08% 16,871 | 22.81% 43,706 | 36.50% 30,340 | 17.81% 43,512 | 12.03% 7,593 | 19.72% 39,374 | 23.08% 30,298 | **19.38% 319,087** |
| Other | % of Members | 1.39% 2,427 | 1.43% 2,406 | 3.48% 7,532 | 2.69% 1,404 | 3.02% 3,624 | 4.42% 8,472 | 1.31% 1,088 | 2.64% 6,447 | 1.58% 1,000 | 2.07% 4,140 | 0.61% 803 | **2.39% 39,369** |
| | | | | | East King | Seattle | South King | | | | | | Total |

# Regional Comparison

The following sections—Access to Care, Preventive Care, Chronic Care Management, and Medical Care Utilization—offer a comparison of regional performance on select HEDIS measures, broken out additionally by race, language, and Apple Health program.

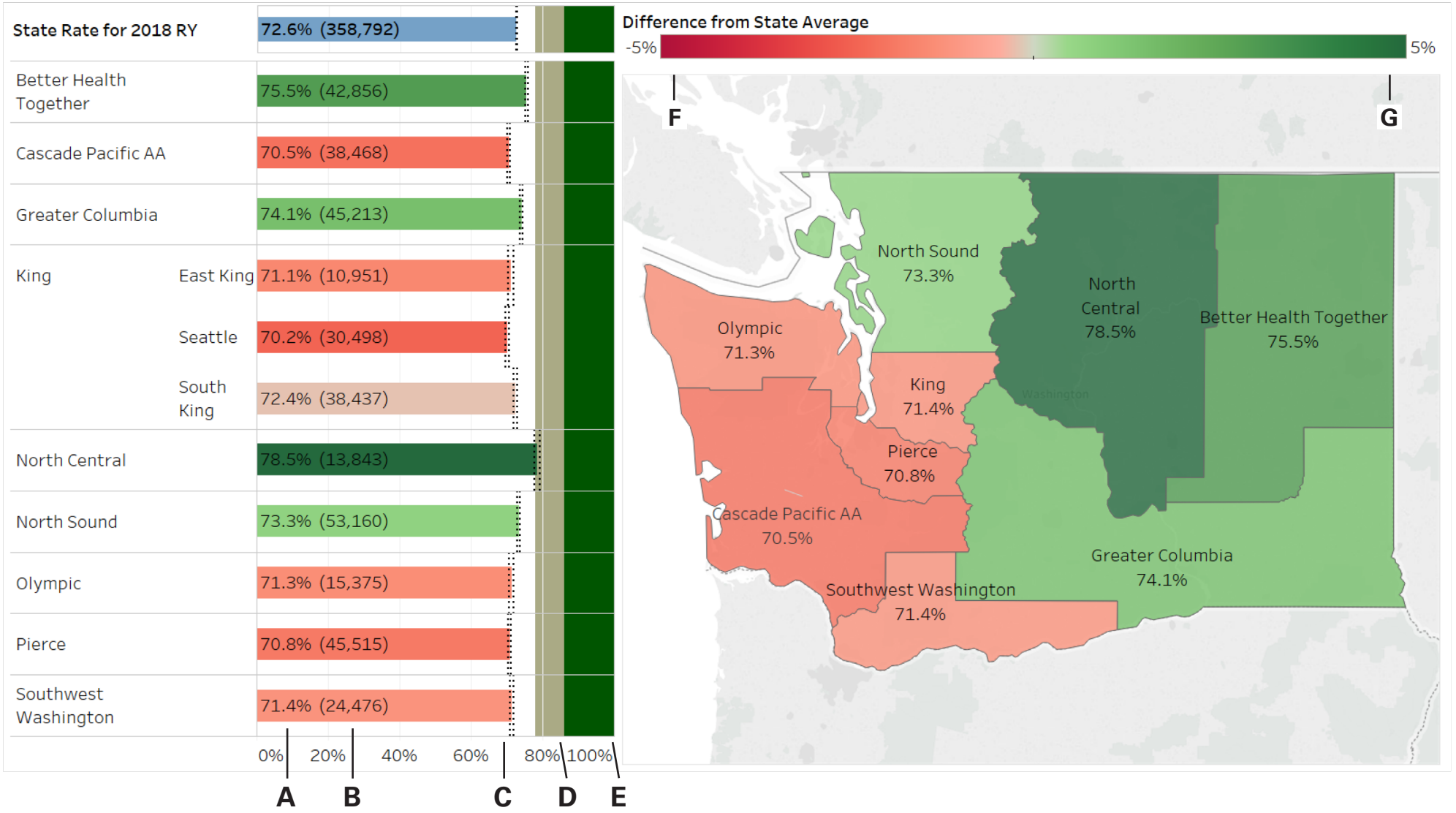
NOTE: Because the statewide rates for this report are derived from member-level data, some statewide results may differ slightly from those presented in the *2018 Comparative Analysis Report*, which are derived from HEDIS data.

# How to Read the *Regional Analysis Report* Charts

The following pages illustrate how to read and interpret the maps and charts within the Regional Comparison section. In each of three sample charts (featuring analyses appearing in the Access to Care section), core elements are annotated, and a corresponding key provides an explanation of each element. The concepts described here can be translated to any of the charts appearing in the Regional Comparison section.

**Table 11: Adults' Access to Preventive/Ambulatory Health Services (20–44), Performance by Region**

This map and chart compare regional rates for the adult AAP measure for 20–44-year-olds with the state rate for this measure.



**A** - Rate of Apple Health enrollees ages 20 - 44 residing in the Southwest Washington region having a primary care appointment in 2018 RY

**B** - Number of people who fell into the denominator in this region for this measure in 2018 RY (Apple Health enrollees ages 20 - 44 who resided in Southwest Washington during the reporting year)

**C** - Confidence interval, which varies depending on sample size (number of people eligible for inclusion in the measure)

**D** - 50th - 90th national percentile

**E** - Above the 90th national percentile

**F** - Red indicates that the regional rate is below the state rate for this measure (the darker the color, the greater the difference between the regional rate and the state rate)

**G** - Green indicates that the regional rate is above the state rate for this measure (the darker the color, the greater the difference between the regional rate and the state rate)

**Table 12: AAP (20–44) Performance Statewide and by Region, 2016 RY to 2018 RY**

This chart compares regional rates to prior-year regional rates; i.e., the rate for a given region in 2018 RY in comparison to the rate for the same region for 2017 RY, and each rate for 2017 RY in comparison to the rate for 2016 RY.

**A** - Rate of Apple Health enrollees ages 20 - 44 residing in the Southwest Washington region having a primary care appointment in 2017 RY

**B** - Number of people who fell into the denominator in this region for this measure in 2017 RY (Apple Health enrollees ages 20 - 44 who resided in Southwest Washington during the reporting year)

**C** - Rate of Apple Health enrollees ages 20 - 44 residing in the Southwest Washington region having a primary care appointment in 2018 RY

**D** - Number of people who fell into the denominator in this region for this measure in 2018 RY (Apple Health enrollees ages 20 - 44 who resided in Southwest Washington during the reporting year)

**E** - Confidence interval, which varies depending on sample size (number of people eligible for inclusion in the measure)

**F** - Red indicates that the rate for a given region and reporting year is below the rate for the same region in the previous reporting year (the darker the color, the greater the difference between the rate and the previous-year rate)

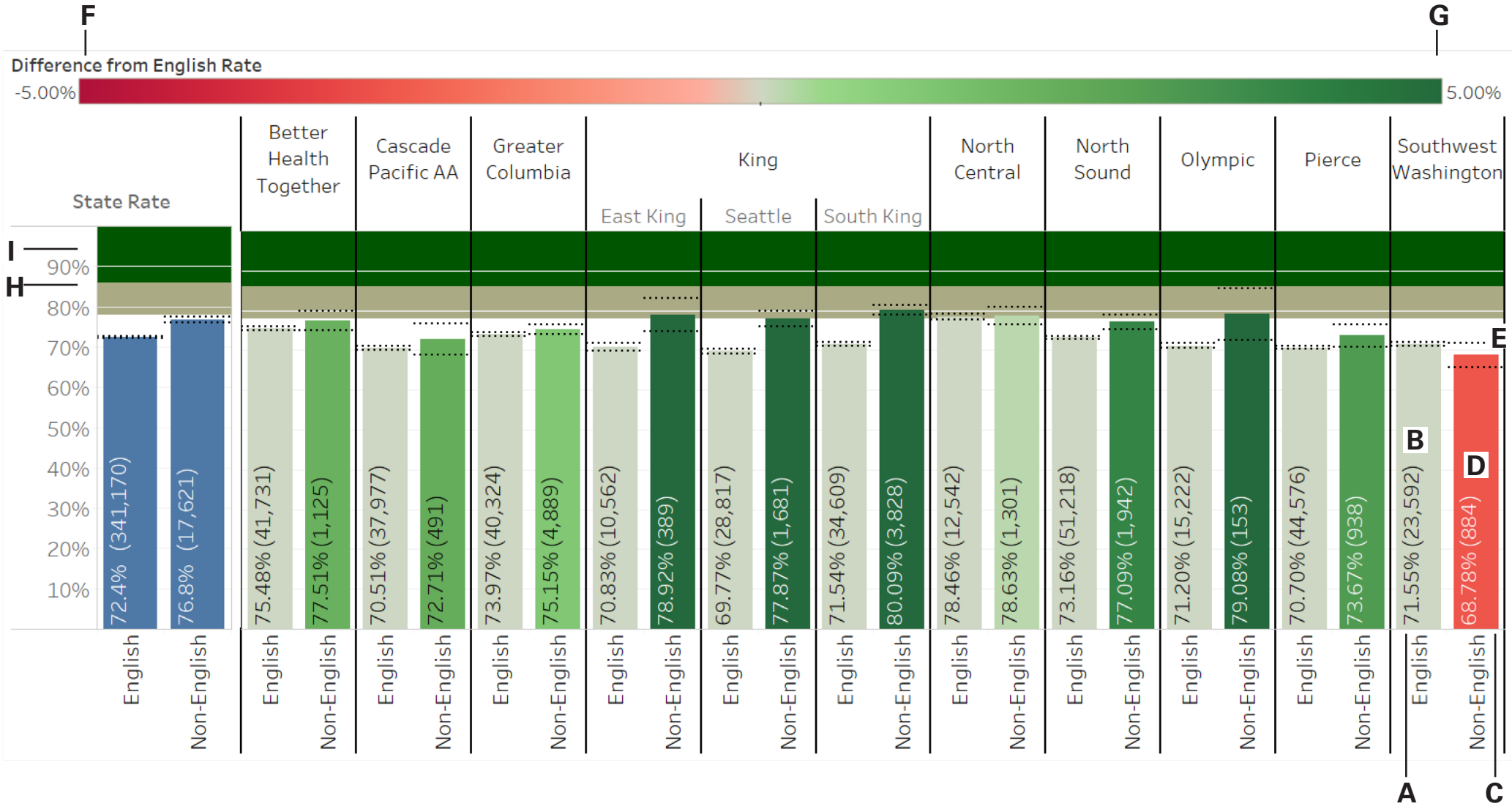
**G** - Green indicates that the rate for a given region and reporting year is above the rate for the same region in the previous reporting year (the darker the color, the greater the difference between the rate and the previous-year rate)

**H** - 50th - 90th national percentile

**I** - Above the 90th national percentile

**Table 13: AAP (20–44) Performance Variation by Region and Language**

This chart compares the rate for non-English-speaking enrollees in each region to the rate for English-speaking enrollees in the same region.



**A** - Rate of Apple Health enrollees with an English-language preference residing in the Southwest Washington region having a primary care appointment in 2018 RY

**B** - Number of people who fell into the denominator in this region for this measure in 2018 RY (Apple Health enrollees ages 20 - 44 who identified an English-language preference and resided in Southwest Washington during the reporting year)

**C** - Rate of Apple Health enrollees with a non-English-language preference residing in the Southwest Washington region having a primary care appointment in 2018 RY

**D** - Number of people who fell into the denominator in this region for this measure in 2018 RY (Apple Health enrollees ages 20 - 44 who identified a non-English-language preference and resided in Southwest Washington during the reporting year)

**E** - Confidence interval, which varies depending on sample size (number of people eligible for inclusion in the measure)

**F** - Red indicates that the rate for enrollees with a non-English-language preference in a given region is below the rate for enrollees with an English-language preference in the same region (the darker the color, the greater the difference between the rate for non-English-speaking enrollees and English-speaking enrollees)

**G** - Green indicates that the rate for enrollees with a non-English-language preference in a given region is above the rate for enrollees with an English-language preference in the same region (the darker the color, the greater the difference between the rate for non-English-speaking enrollees and English-speaking enrollees)

**H** - 50th - 90th national percentile

**I** - Above the 90th national percentile

# Access to Care

Access to primary care depends on the ability of consumers to locate healthcare providers and receive services. Therefore, it is important that MCOs establish sufficient provider networks to ensure adequate access to care. The reported measures in this section include:

- Adults' access to preventive/ambulatory health services
- Children and adolescents' access to primary care practitioners
- Prenatal and postpartum care

A higher score indicates better performance.

**In this section, the following key applies:**


50th to 90th national percentile


90th+ national percentile


Confidence interval around measure outcome

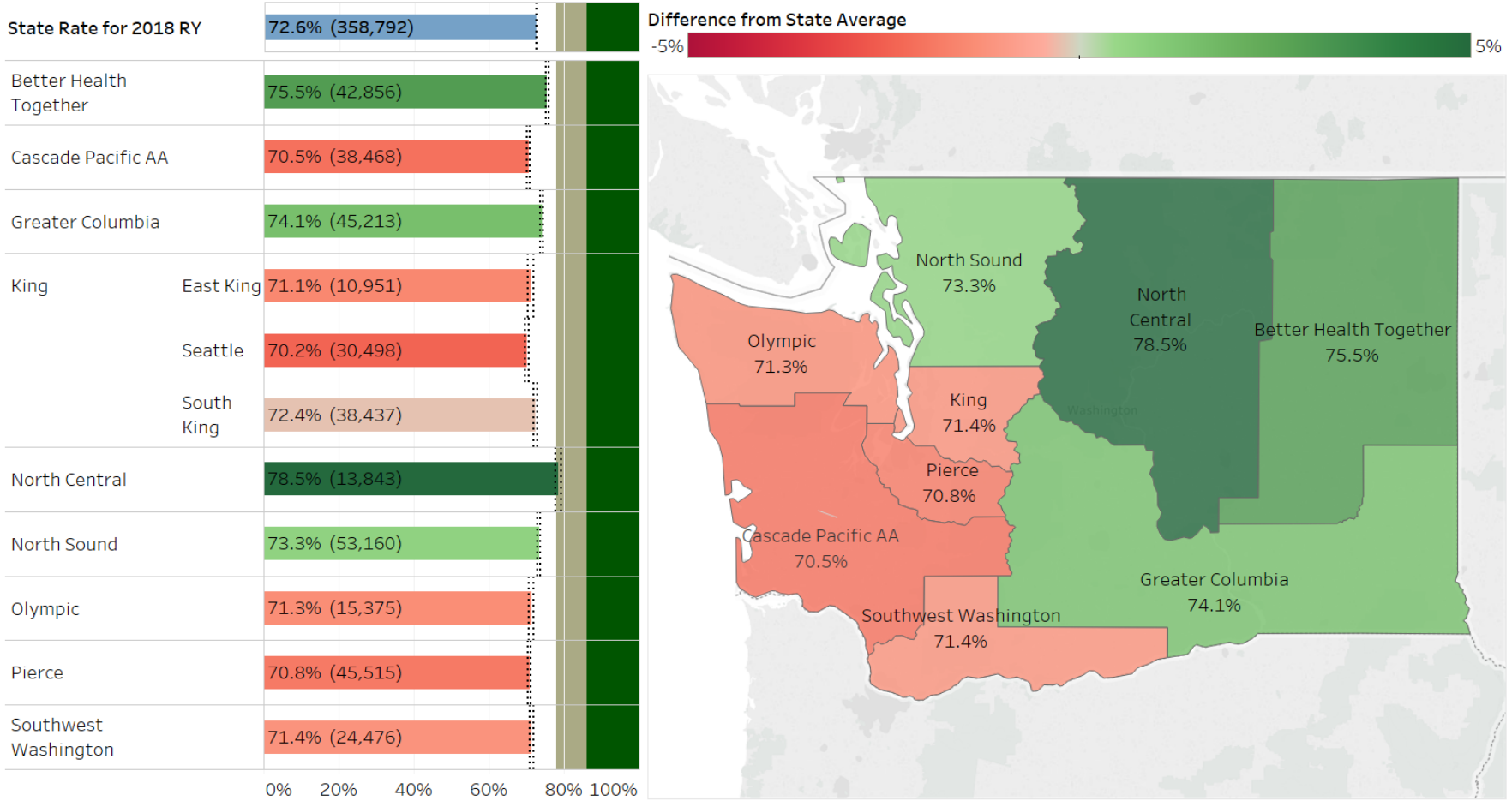
# Adults' Access to Preventive/Ambulatory Health Services

Adults' access to preventive/ambulatory health services (AAP) is defined as the percentage of enrollees age 20 years and older who had an ambulatory or preventive care visit in the last year. This measure excludes acute inpatient encounters and emergency department (ED) visits. This section includes results for two submeasures: enrollees ages 20–44 and enrollees ages 45–64.

## Adults' Access to Preventive/Ambulatory Health Services (20–44)

Performance on this measure was highest in the North Central region, as shown in Table 11, with the western regions showing a rate more than 7 percent lower. Performance was the lowest in Seattle, with only 70.2 percent of members having an ambulatory or preventive care visit in the last year. Performance on this measure varied widely, suggesting improvement opportunities in regions with lower performance.

***Table 11: Adults' Access to Preventive/Ambulatory Health Services (20–44), Performance by Region***

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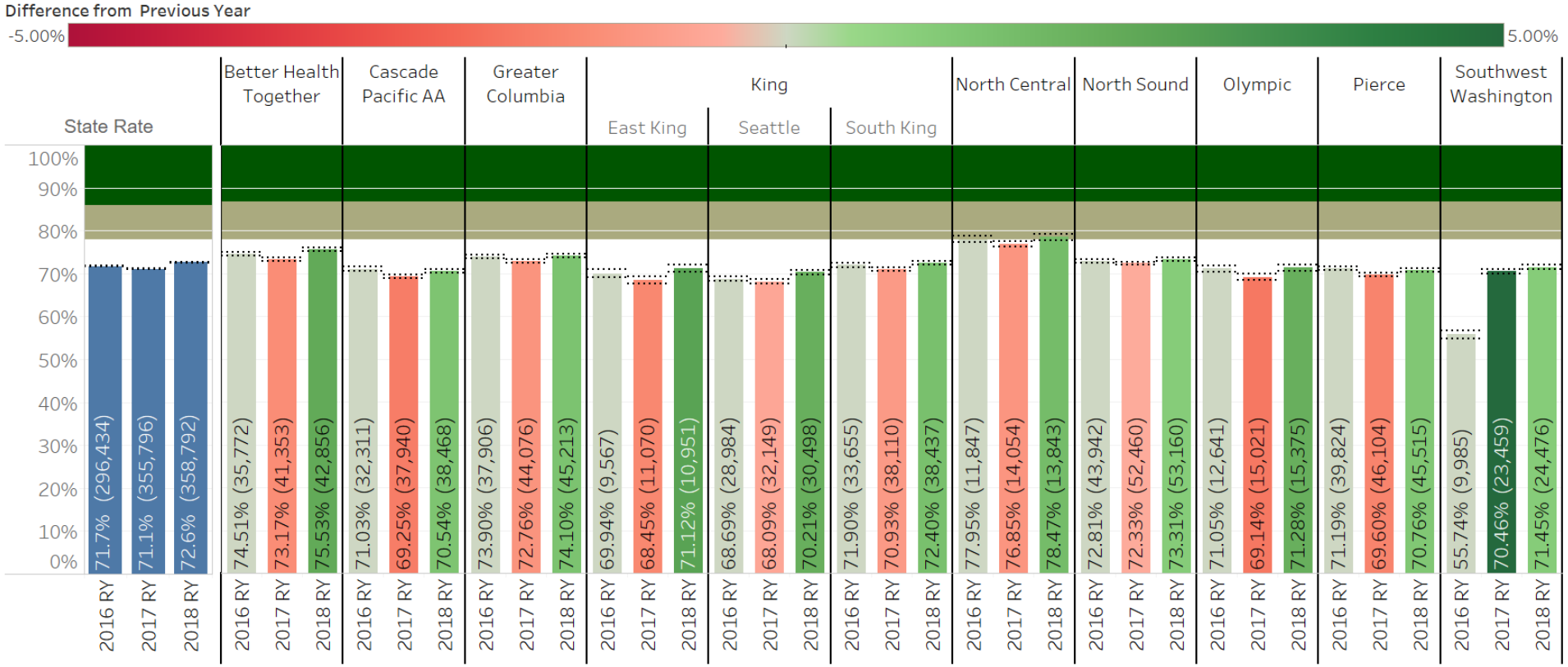
## Year-to-Year Performance

Since 2017 RY, statewide performance on the AAP measure increased slightly yet significantly (because of the large population size, even a small shift may be a statistically significant change). Performance increased in every region for this measure.

***Table 12: AAP (20–44) Performance Statewide and by Region, 2016 RY to 2018 RY***

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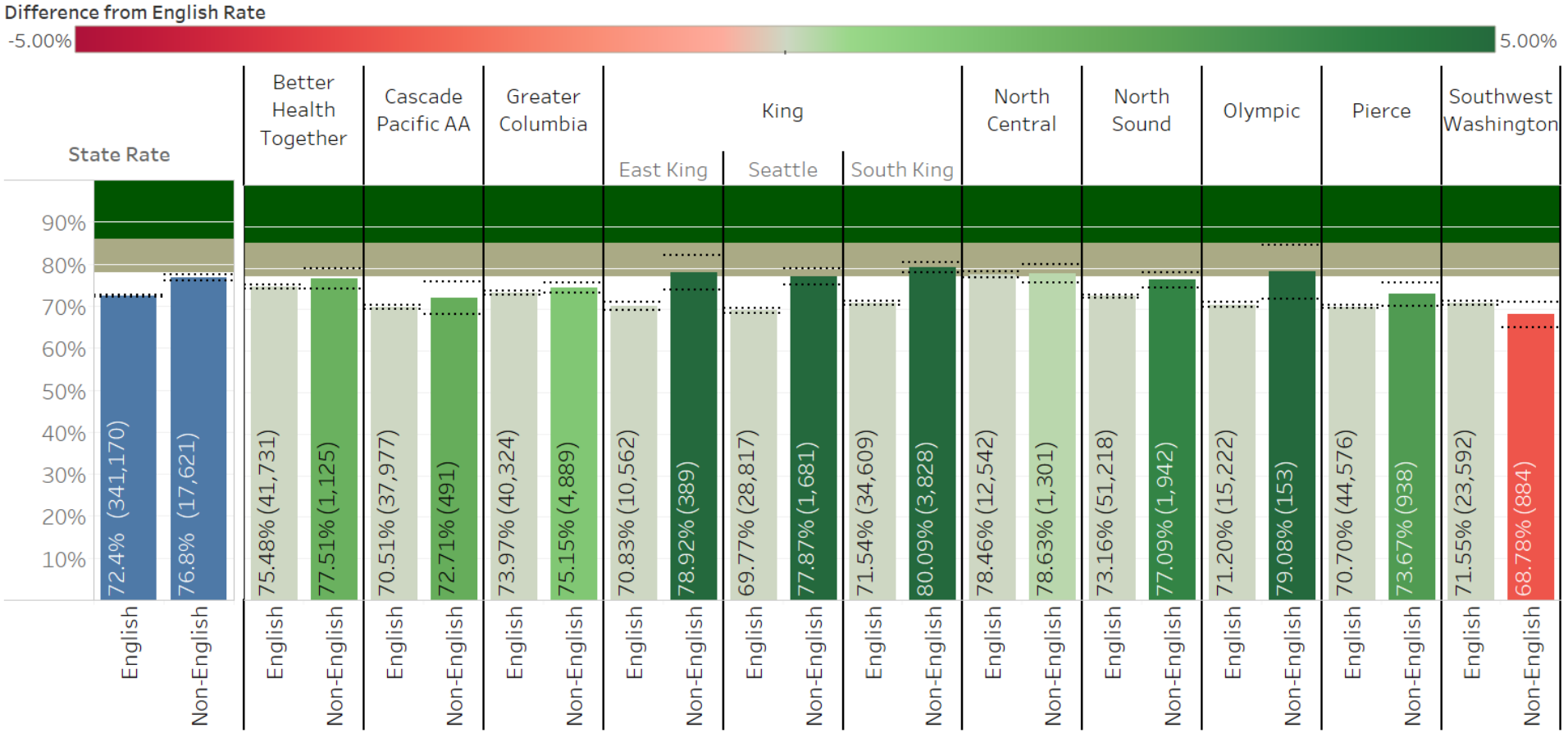
## *Variation by Language*

Most regions showed higher rates on this measure for enrollees with a non-English-language preference compared to those enrollees who prefer English.

***Table 13: AAP (20–44) Performance Variation by Region and Language***

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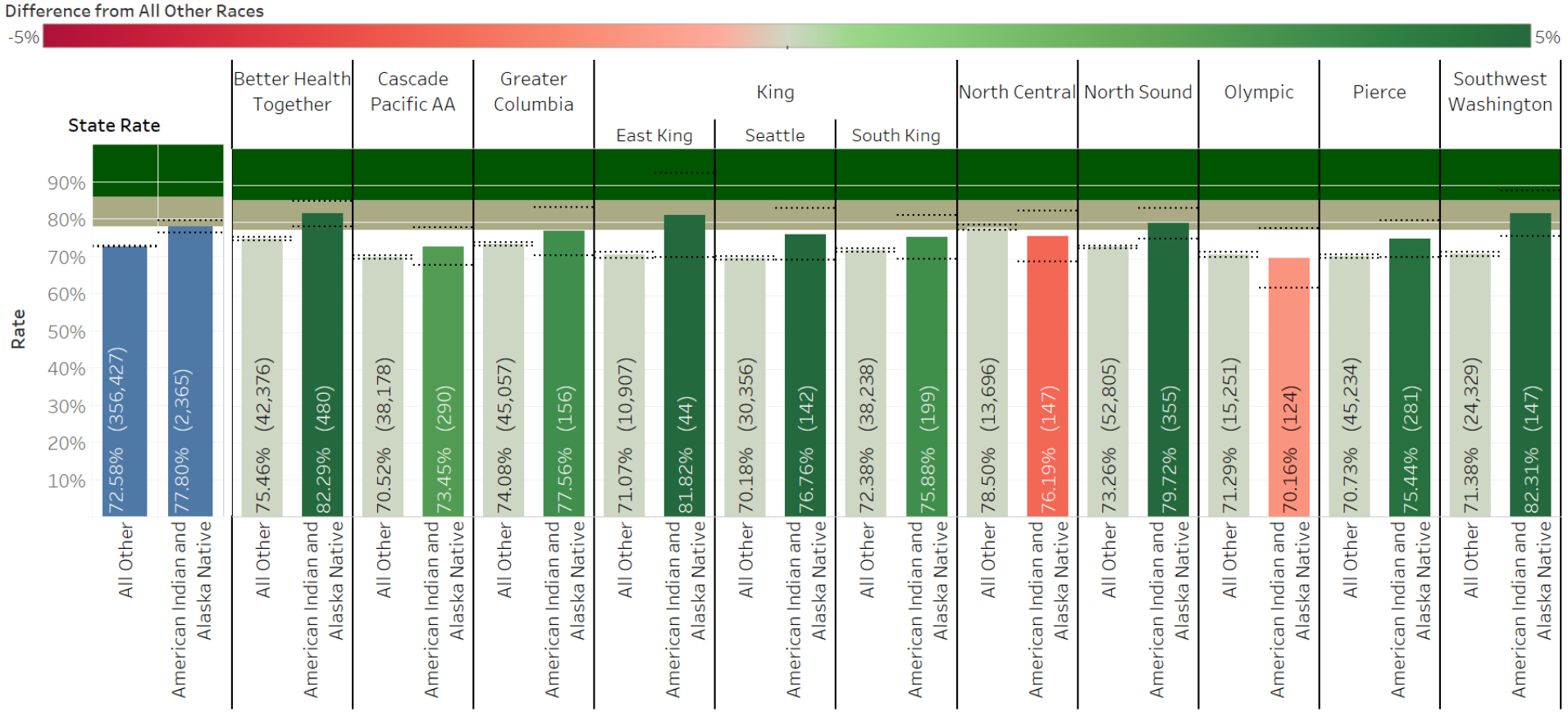
## *Variation by Race*

The AAP (20–44) rate for those enrollees who identified as American Indian or Alaska Native were also higher than the combined rate for all other races in every region except North Central and Olympic.

***Table 15: AAP (20–44) Performance Variation by Region and Race***

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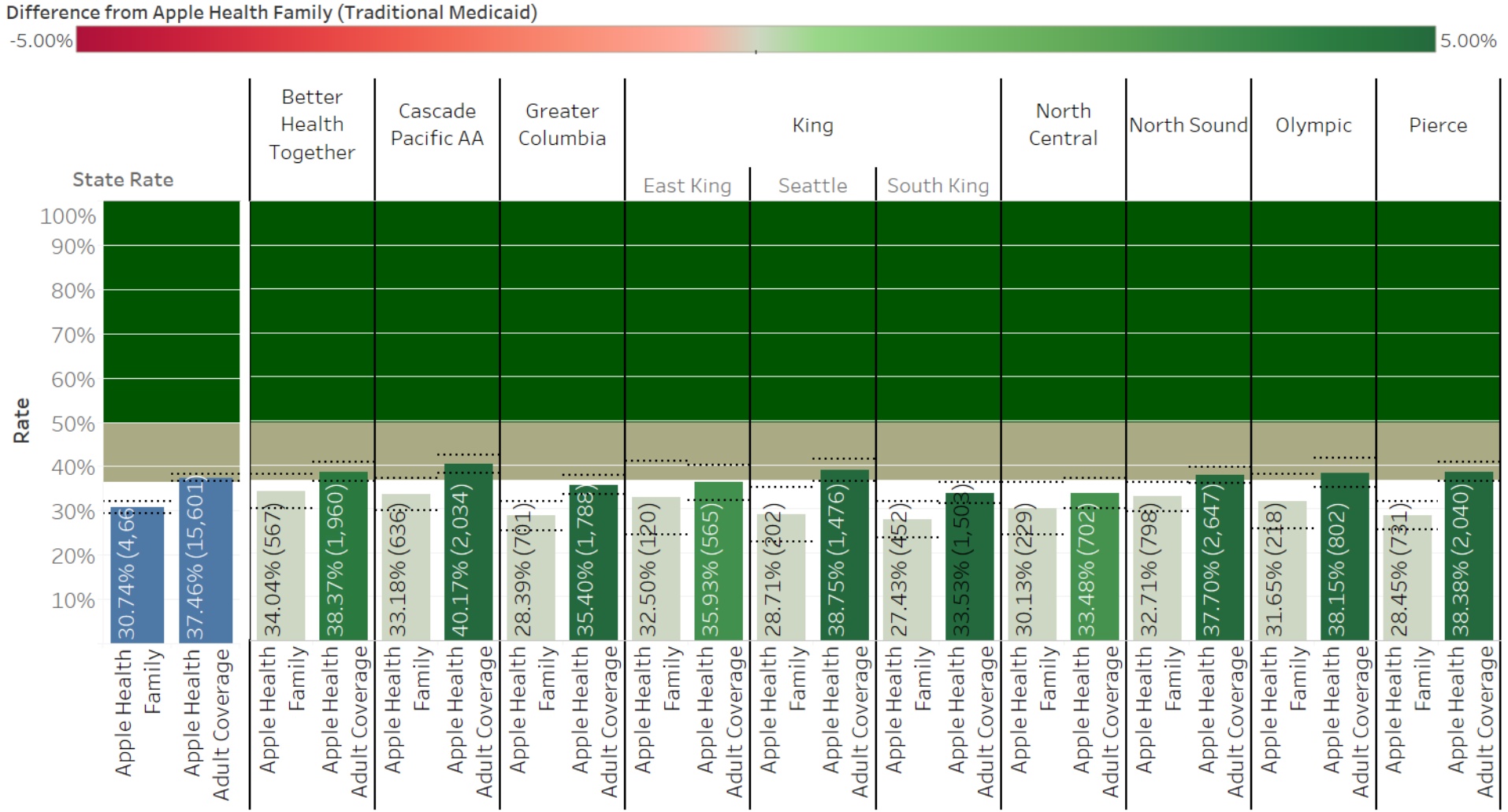
## *Apple Health Family (Traditional Medicaid) vs Apple Health Adult Coverage (Medicaid Expansion)*

In a comparison of access rates by program enrollment, enrollees in Apple Health Family (traditional Medicaid) appear to be more likely to have a preventative visit than those in Apple Health Adult Coverage (Medicaid expansion). All regions in the state showed lower rates for enrollees in AHAC, who comprise the majority of eligible enrollees for this measure.

***Table 16: AAP (20–44) Performance Variation by Region and Program***

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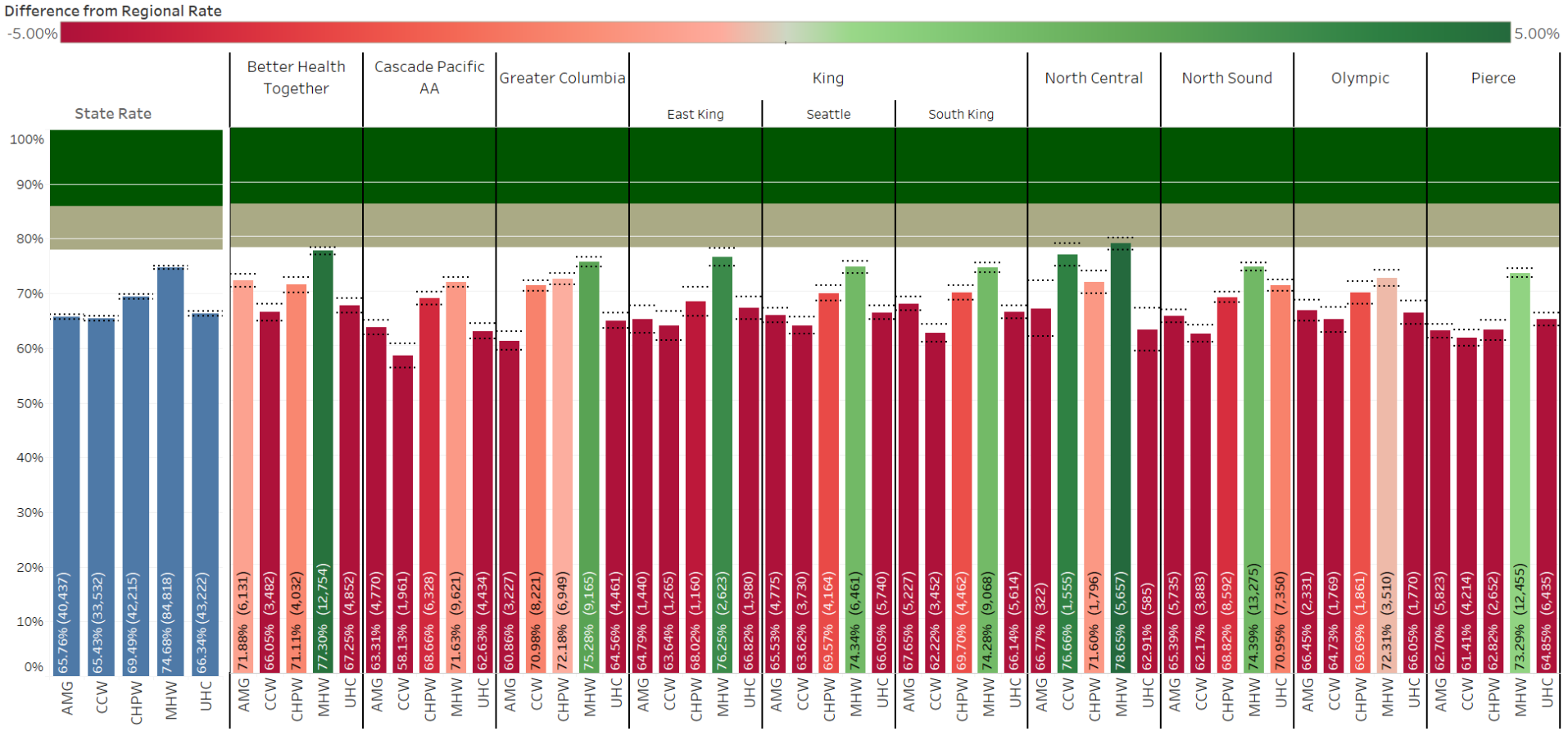
## *Apple Health Adult Coverage (Medicaid Expansion) Rates by Plan*

A comparison of MCO performance on this measure for the Apple Health Adult Coverage (Medicaid expansion) population shows MHW performing higher than the other MCOs in most regions statewide.

***Table 17: AAP (20–44) Performance Variation for Apple Health Adult Coverage (Medicaid Expansion), by Region and MCO***

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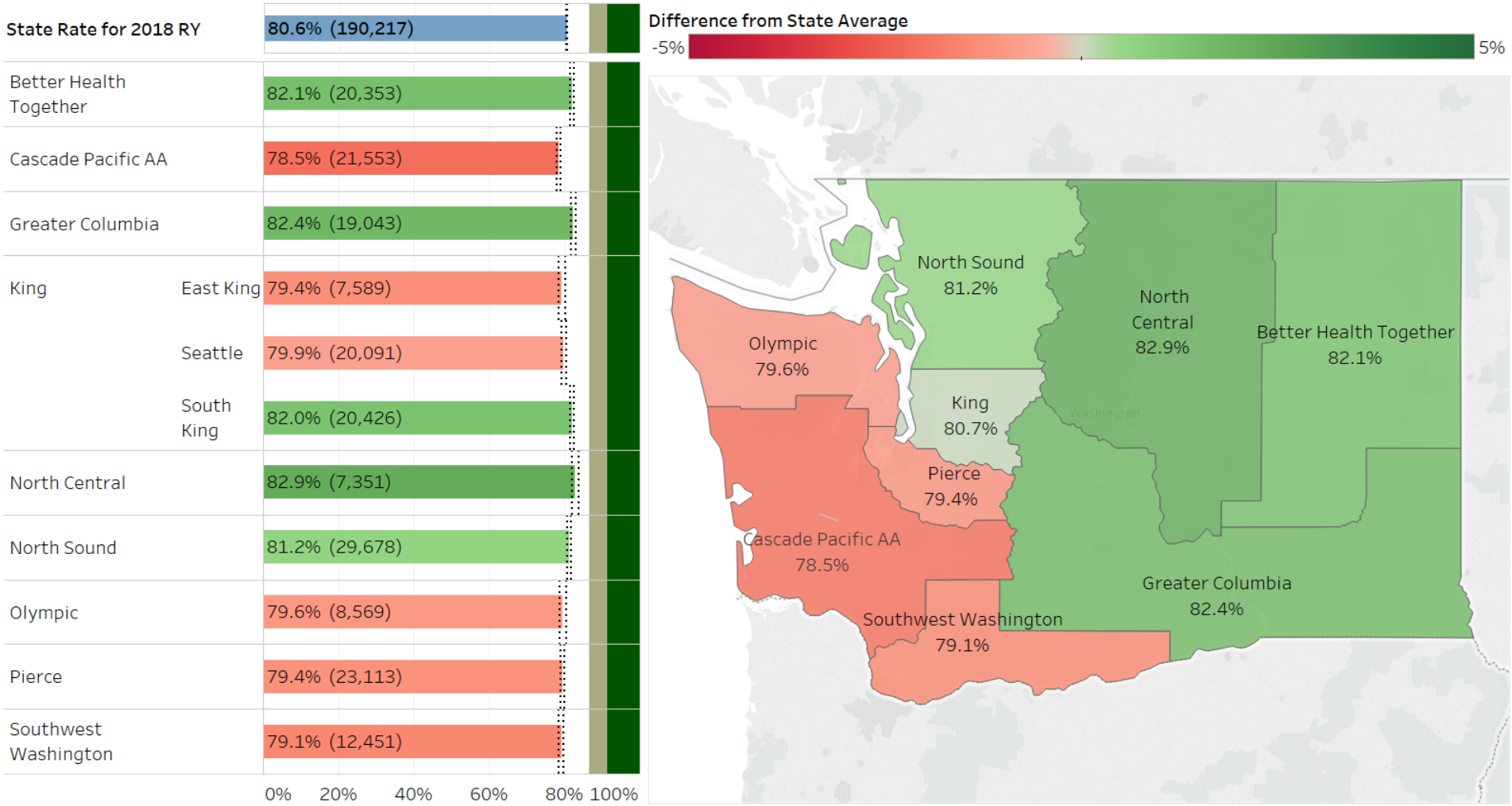
## Adults' Access to Preventive/Ambulatory Health Services (45–64)

For the AAP measure for enrollees ages 45–64, North Central had the highest performance, at 82.9 percent. Several regions in the western part of the state showed comparatively lower rates, around 78–79 percent. Note that the variation for this measure was not as wide as for the AAP measure for enrollees ages 20–44.

***Table 18: Adults' Access to Preventive/Ambulatory Health Services (45–64), Performance by Region***

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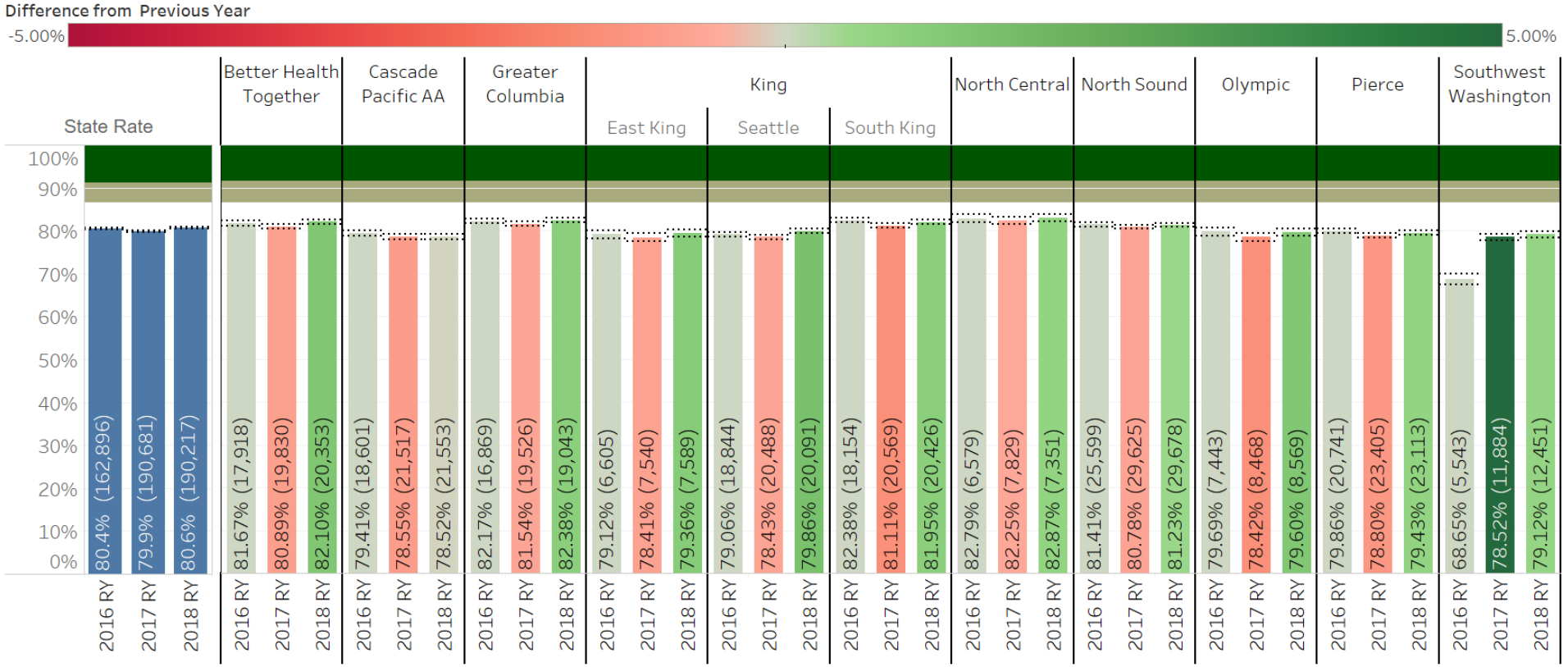
## Year-to-Year Performance

Over time, rates for this measure have increased slightly yet significantly (a result of the large population size). Almost every region showed an increase on this measure in 2018 RY.

***Table 19: AAP (45–64) Performance Statewide and by Region, 2016 RY to 2018 RY***

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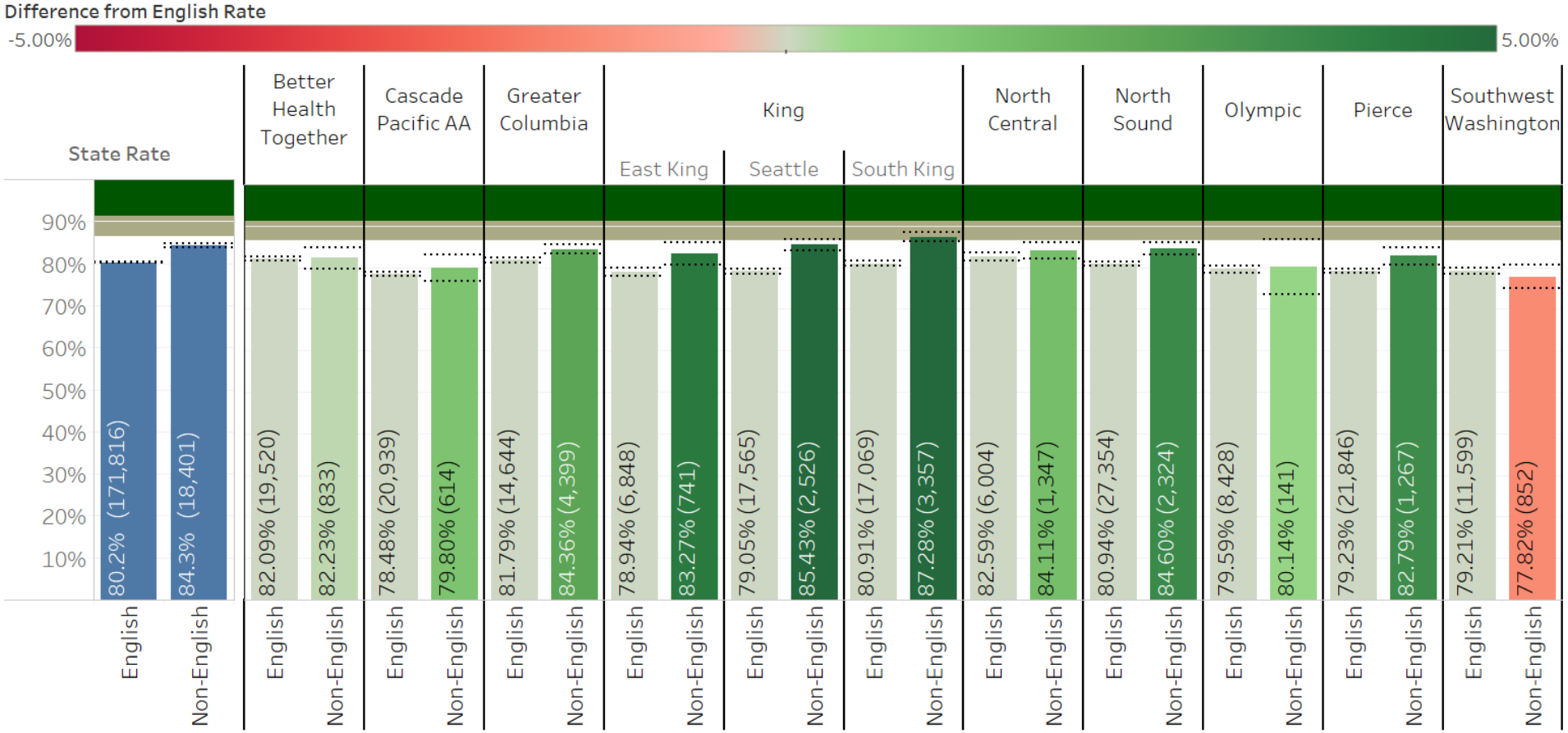
## *Variation by Language*

Similar to AAP measure results for enrollees ages 20–44, access rates were higher for non-English speakers ages 45–64 than for English speakers of that age range in all but one region (Southwest).

***Table 20: AAP (45–64) Performance Variation by Region and Language***

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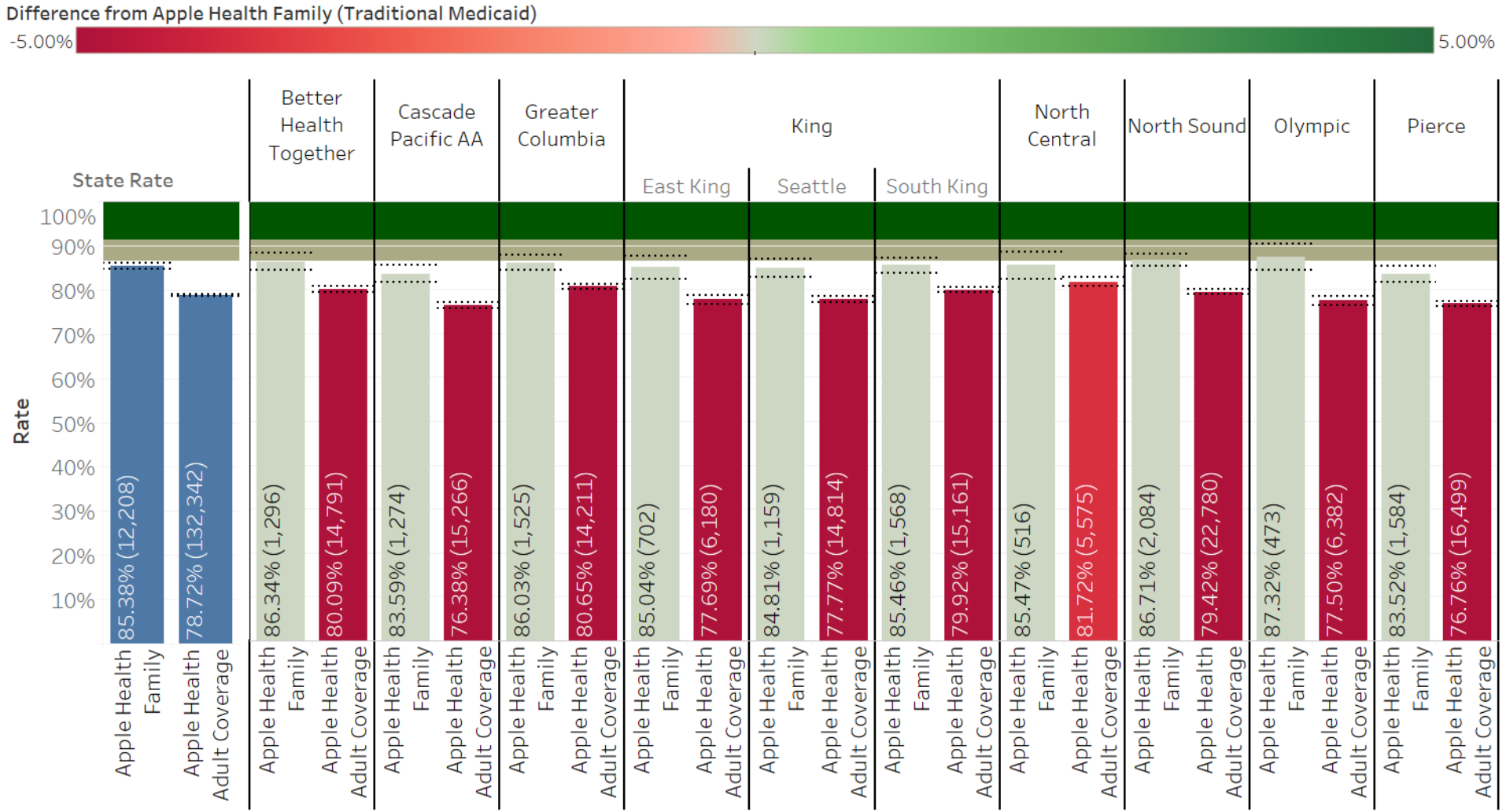
## *Apple Health Family (Traditional Medicaid) vs Apple Health Adult Coverage (Medicaid Expansion)*

Additionally, as with the 20–44 years age group, all regions showed lower access rates for Apple Health Adult Coverage enrollees ages 45–64 than for Apple Health Family enrollees of that age range.

***Table 21: AAP (45–64) Performance Variation by Region and Program***

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## *Apple Health Adult Coverage (Medicaid Expansion) by Plan*

In an analysis of AAP measure performance isolated to Apple Health Adult Coverage enrollees in the 45–64 years age group, MHW showed higher rates in most regions. CCW also showed comparatively high rates for this group in North Central and Greater Columbia. CHPW showed high rates in Greater Columbia, Olympic, and King (Seattle and South King). UHC showed high rates in North Sound, and AMG showed relatively high rates in North Central.

***Table 22: AAP (45–64) Performance Variation for Apple Health Adult Coverage (Medicaid Expansion), by Region and MCO***


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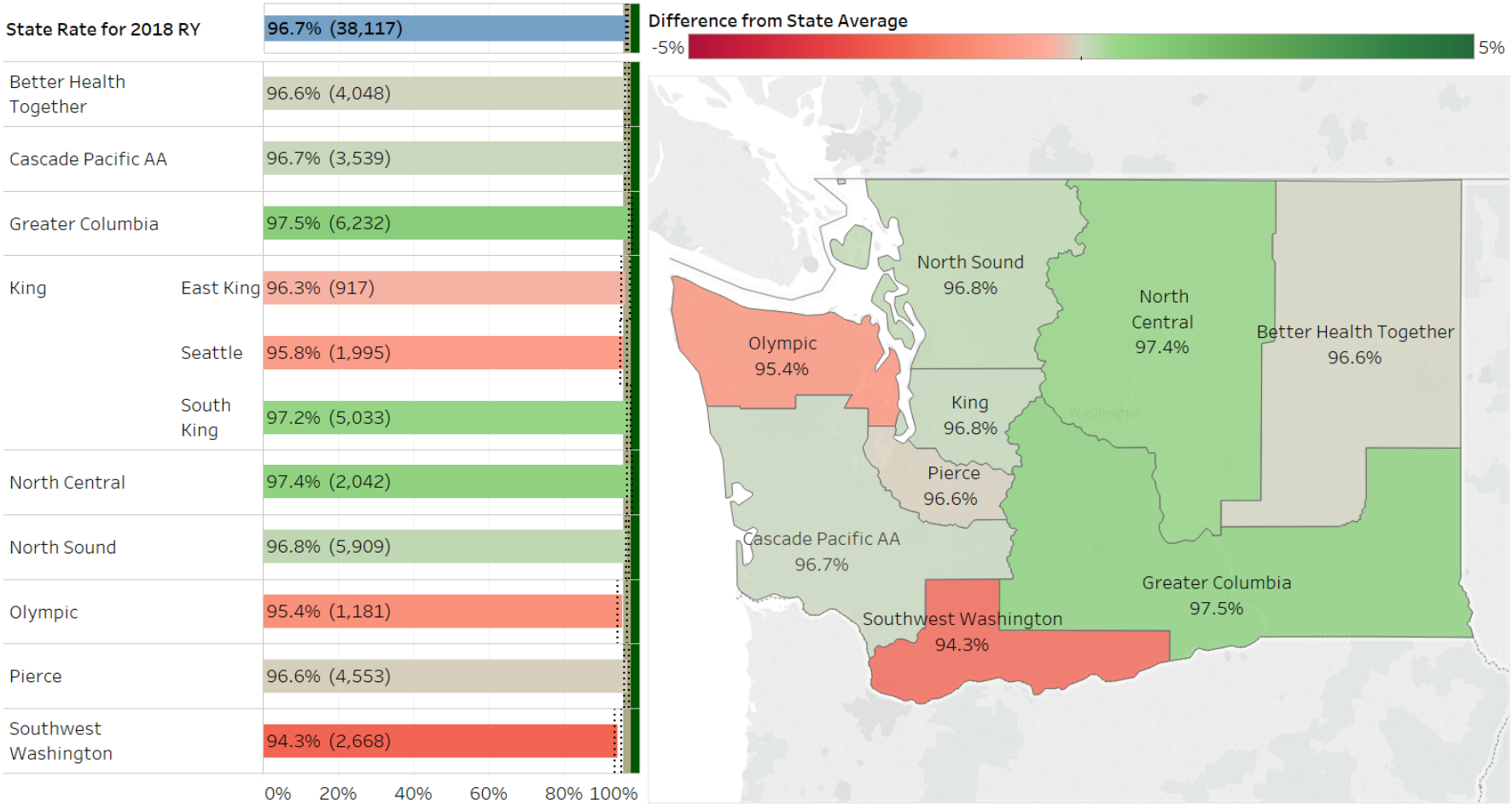
# Children and Adolescents' Access to Primary Care Practitioners

Children and adolescents' access to primary care practitioners (CAP) is defined as the percentage of children ages 12 months–19 years who had a visit with a primary care practitioner in the last year (or the year prior for 7–19-year-olds). A higher score indicates better performance. This section includes results for four submeasures: enrollees ages 12–24 months, 25 months–6 years, 7–11 years, and 12–19 years.

## Children and Adolescents' Access to Primary Care Practitioners (12–24 months)

Regional analysis of this measure showed narrow variation in performance. The difference in highest and lowest rates among regions was less than 3 percent, with Southwest Washington at 94.3 percent and North Central and Greater Columbia at 97.4 and 97.5 percent, respectively.

***Table 23: Children and Adolescents' Access to Primary Care Practitioners (12–24 months), Performance by Region***

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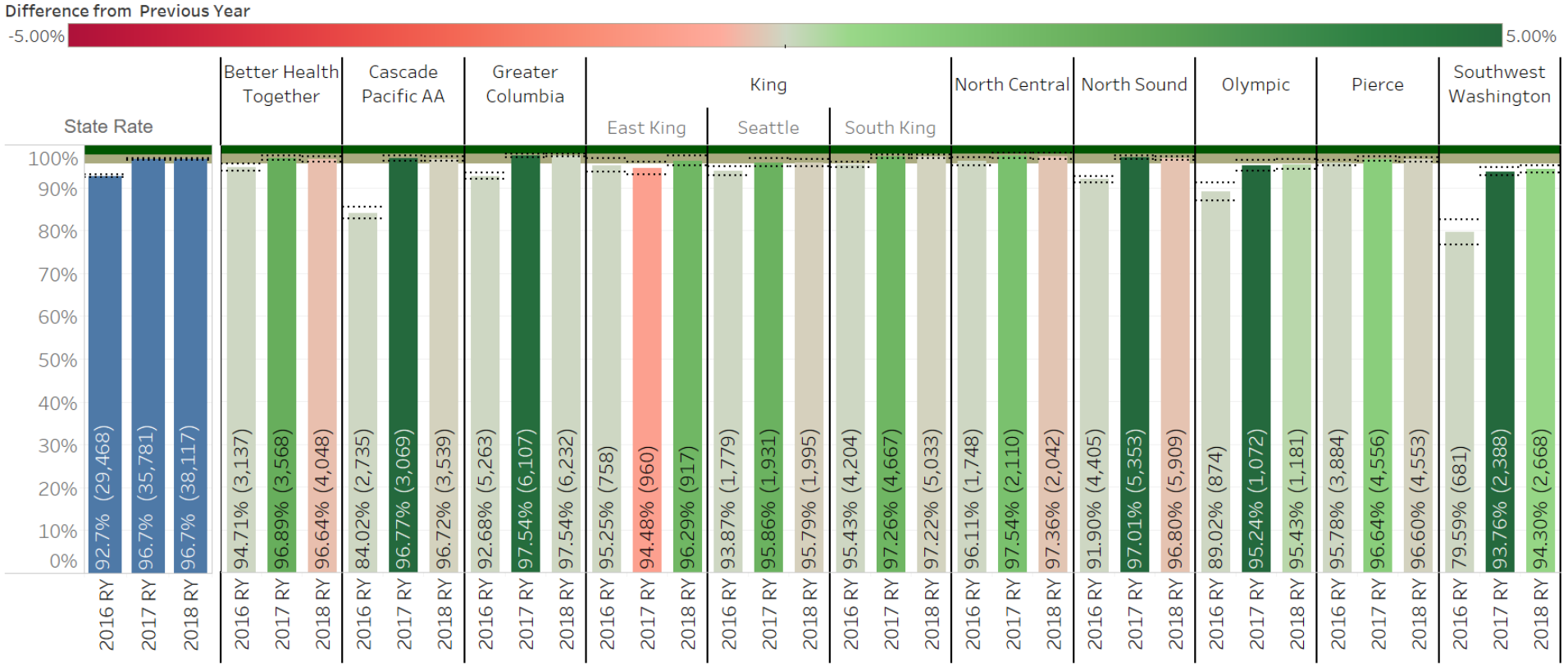
## Year-to-Year Performance

Over time, performance on this measure has remained steady or trended up in most regions.

***Table 24: CAP (12–24 months) Performance Statewide and by Region, 2016 RY to 2018 RY***

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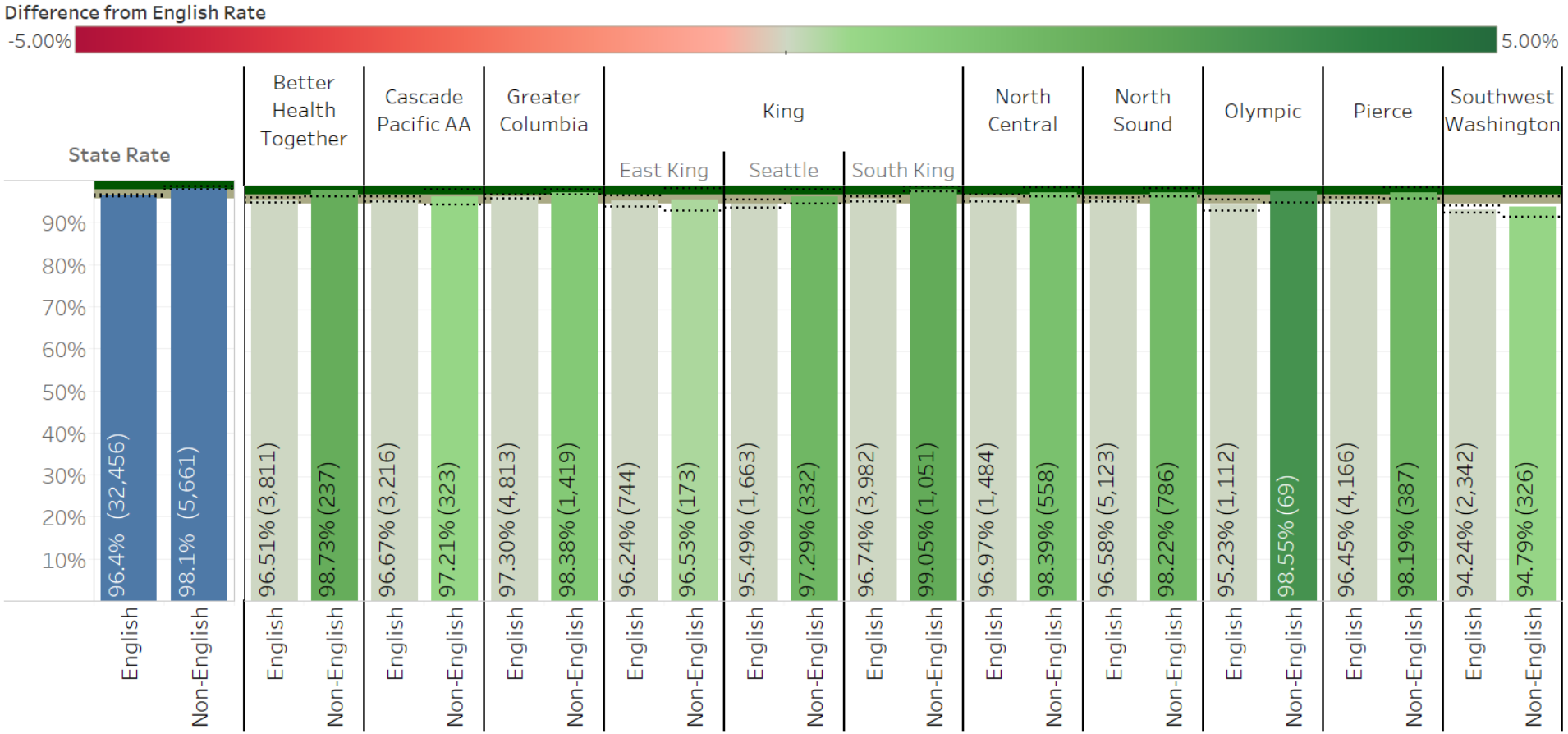
## *Variation by Language*

As with the adult access measures, analysis of variation by language for this measure indicated no barriers for non-English speakers in accessing child and adolescent care. In all regions, rates were slightly higher for non-English speakers than for English speakers.

***Table 25: CAP (12–24 months) Performance Variation by Region and Language***

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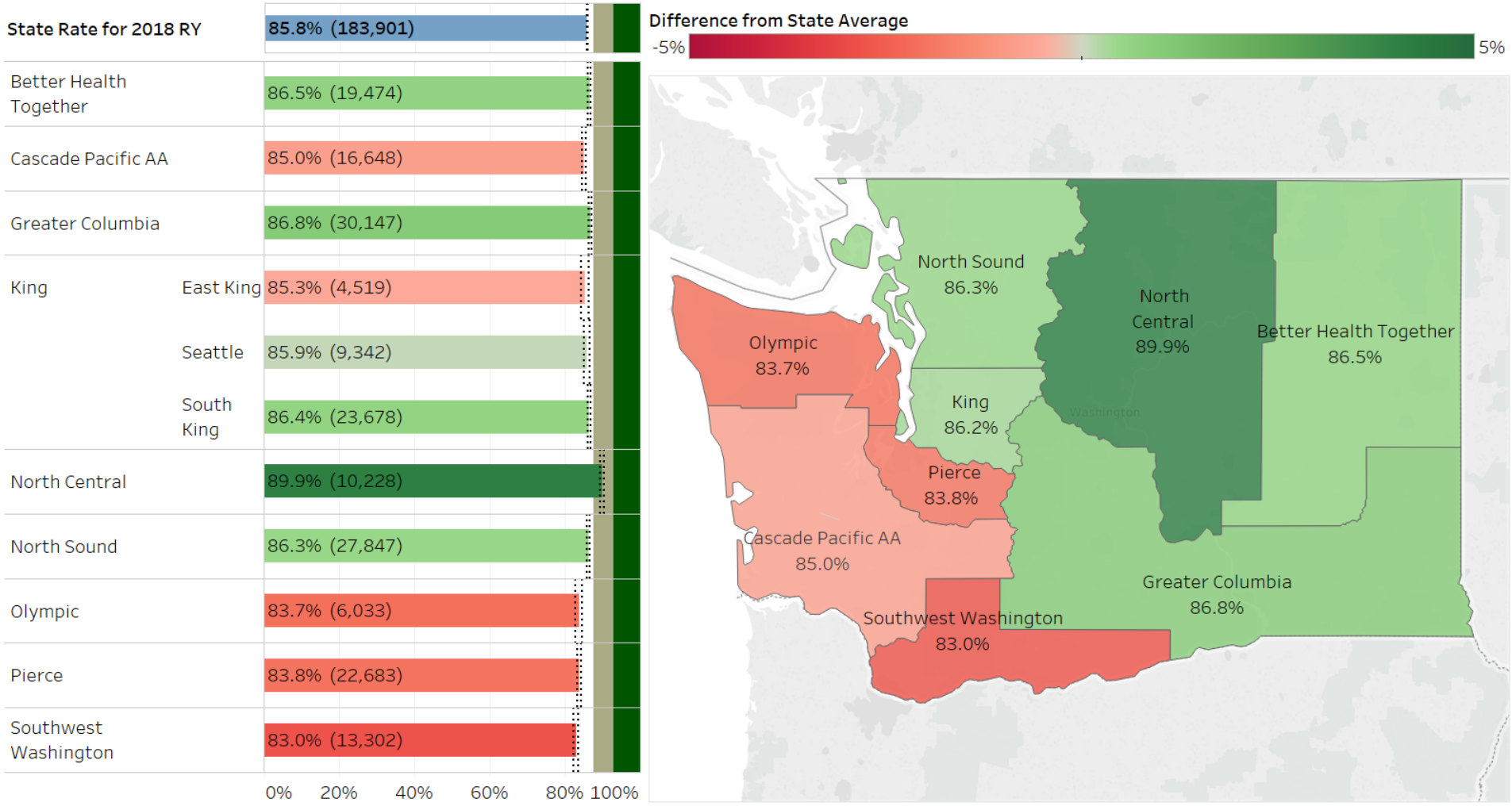
## Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)

As with most other access measures, North Central showed the highest rates of access in the state for this measure in the 25 months–6 years age group, with 89.9 percent. In contrast, Southwest Washington and Olympic showed the lowest rates. The regional variation for this measure was slightly greater than for the 12–24 months age group.

***Table 26: Children and Adolescents' Access to Primary Care Practitioners (25 months–6 years), Performance by Region***

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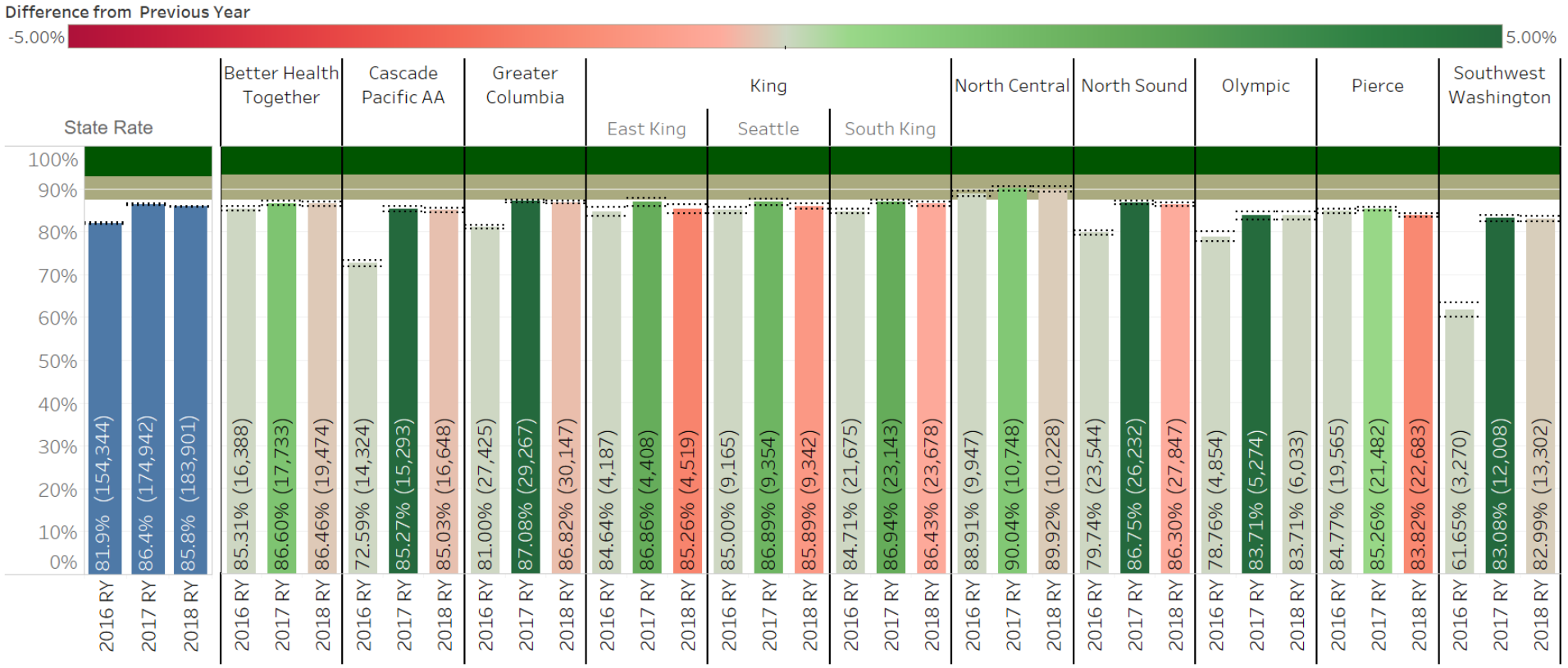
## Year-to-Year Performance

Year to year, this measure trended down in every region but Olympic, where the rate did not change since 2017 RY. This was a trend reversal from 2017 RY, when rates in most regions improved from 2016 RY.

***Table 27: CAP (25 months–6 years) Performance Statewide and by Region, 2016 RY to 2018 RY***

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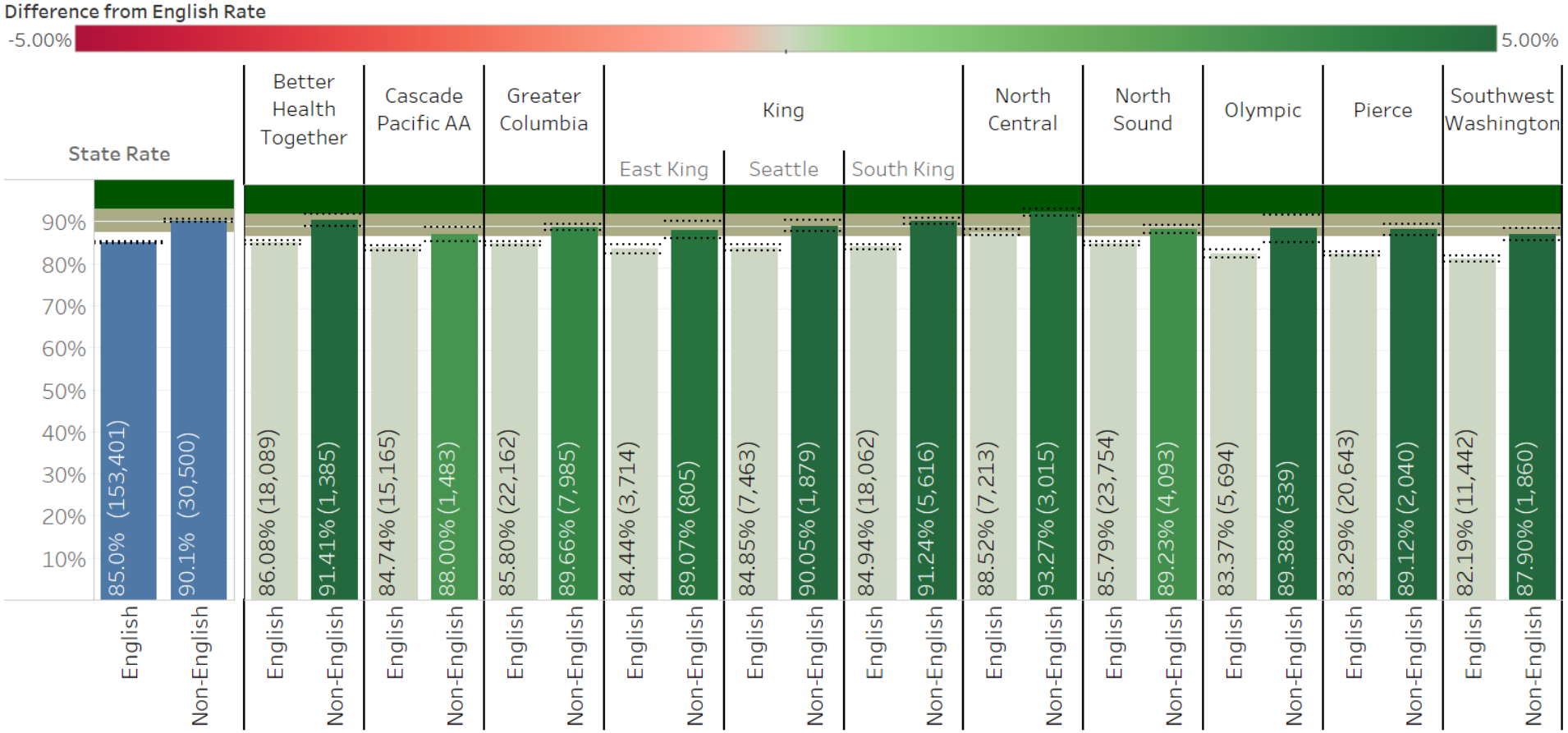
## *Variation by Language*

In all regions, rates for the 25 months–6 years age group were higher for those enrollees with a non-English language preference than for those who prefer English.

***Table 28: CAP (25 months–6 years) Performance Variation by Region and Language***

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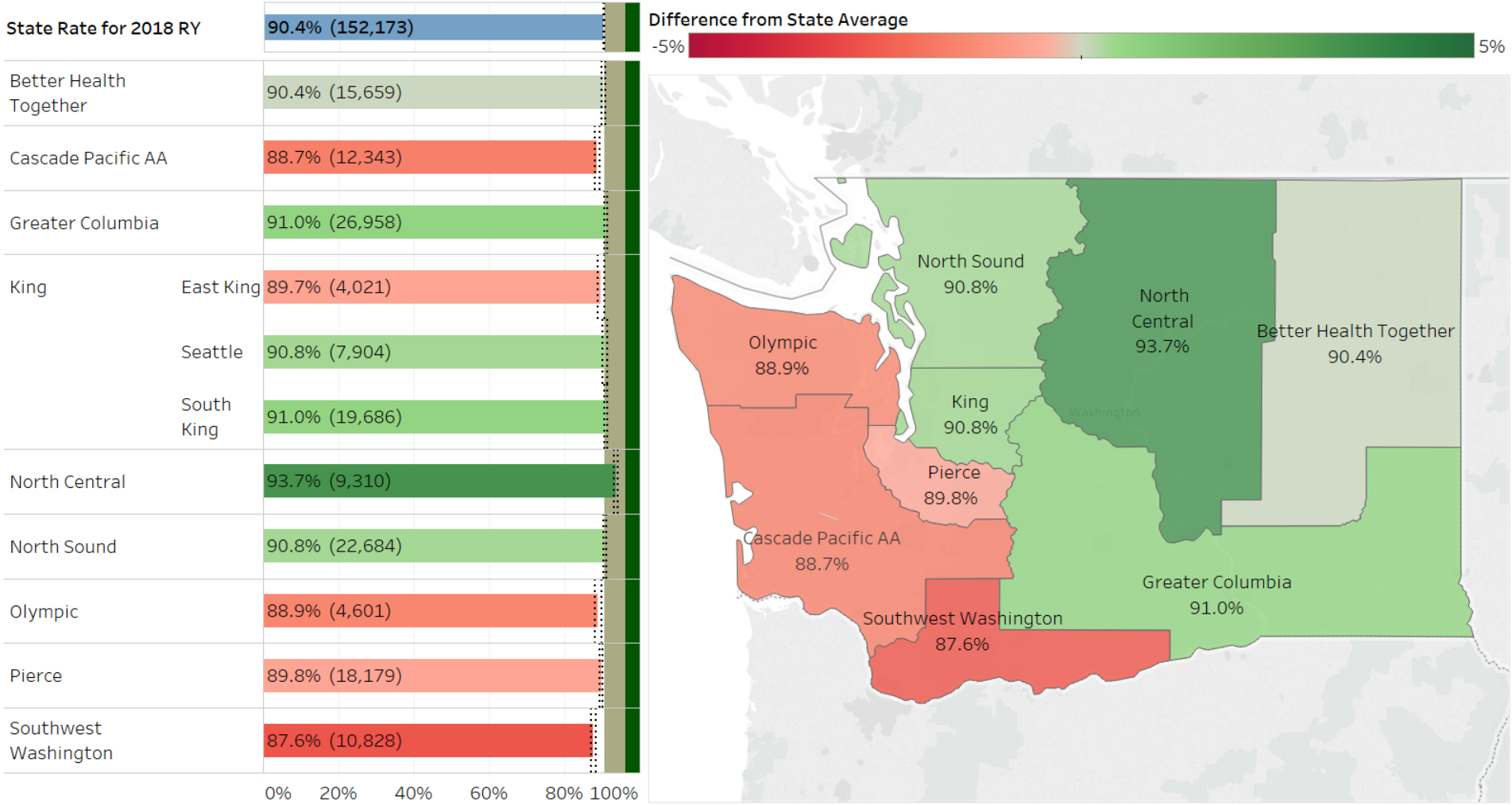
## Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)

Rates for the 7–11 years age group, as with other age groups, continued to be highest in North Central. The rate in Southwest Washington remained the lowest in the state; however, as shown on the next page, it was the only region to show improvement since 2017 RY.

***Table 29: Children and Adolescents' Access to Primary Care Practitioners (7–11 years), Performance by Region***

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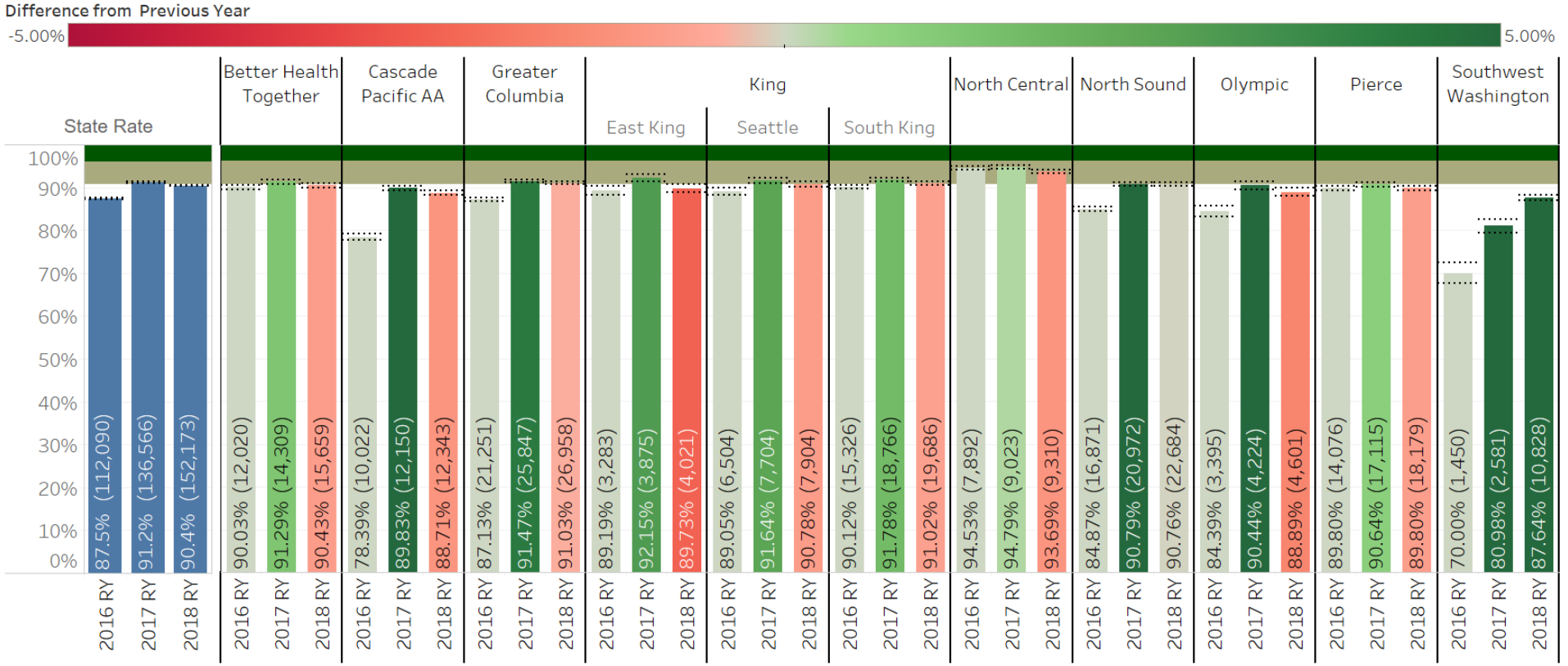
## Year-to-Year Performance

Reversing the trend seen in 2017 RY, performance on this measure decreased statewide and in every region except for Southwest Washington, where the rate climbed by more than 6 percentage points.

***Table 30: CAP (7–11 years) Performance Statewide and by Region, 2016 RY to 2018 RY***

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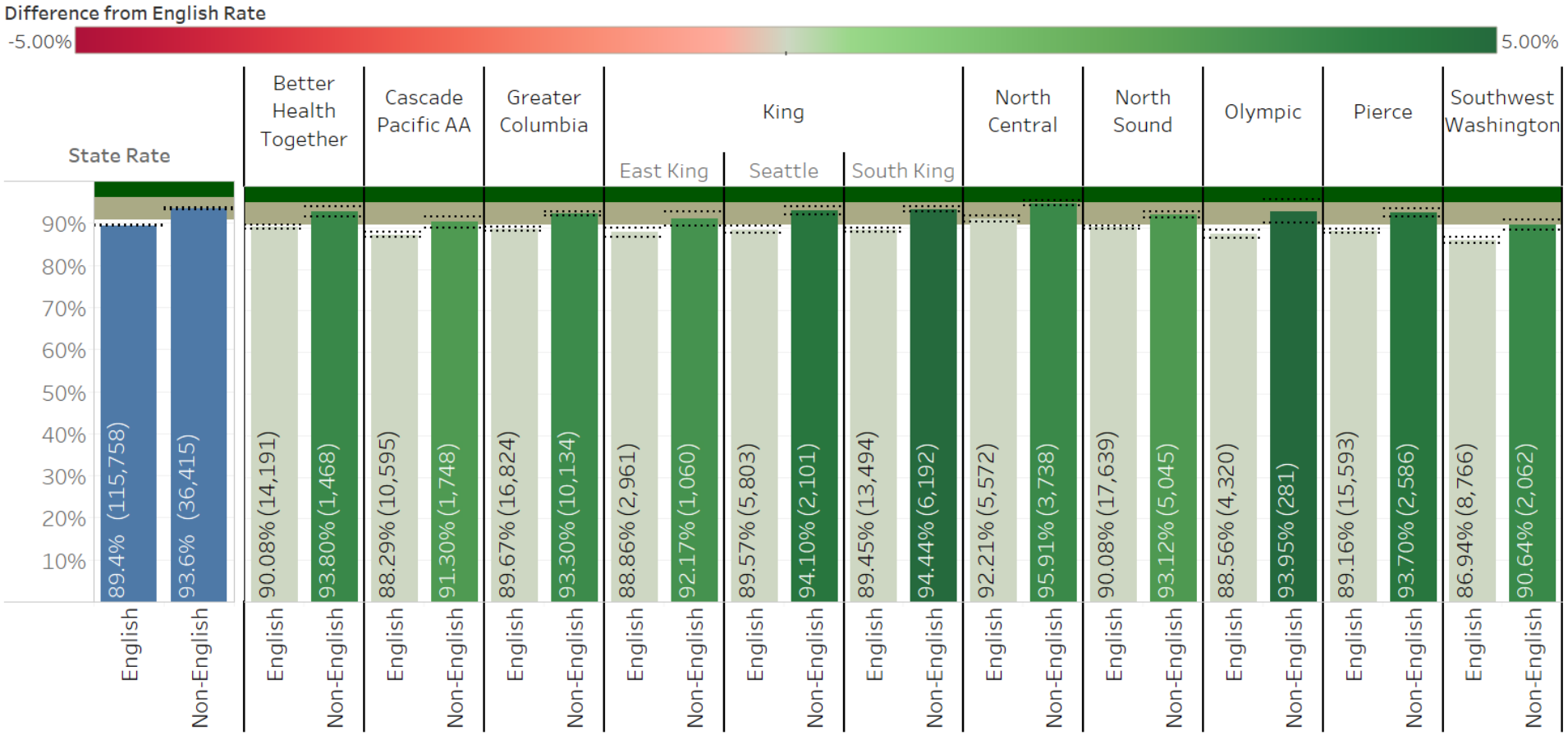
## *Variation by Language*

As seen on the other CAP measures, a non-English-language preference does not appear to be a barrier to accessing child and adolescent care in the 7–11 years age group. All regions showed better access rates for non-English than English speakers.

***Table 31: CAP (7–11 years) Performance Variation by Region and Language***

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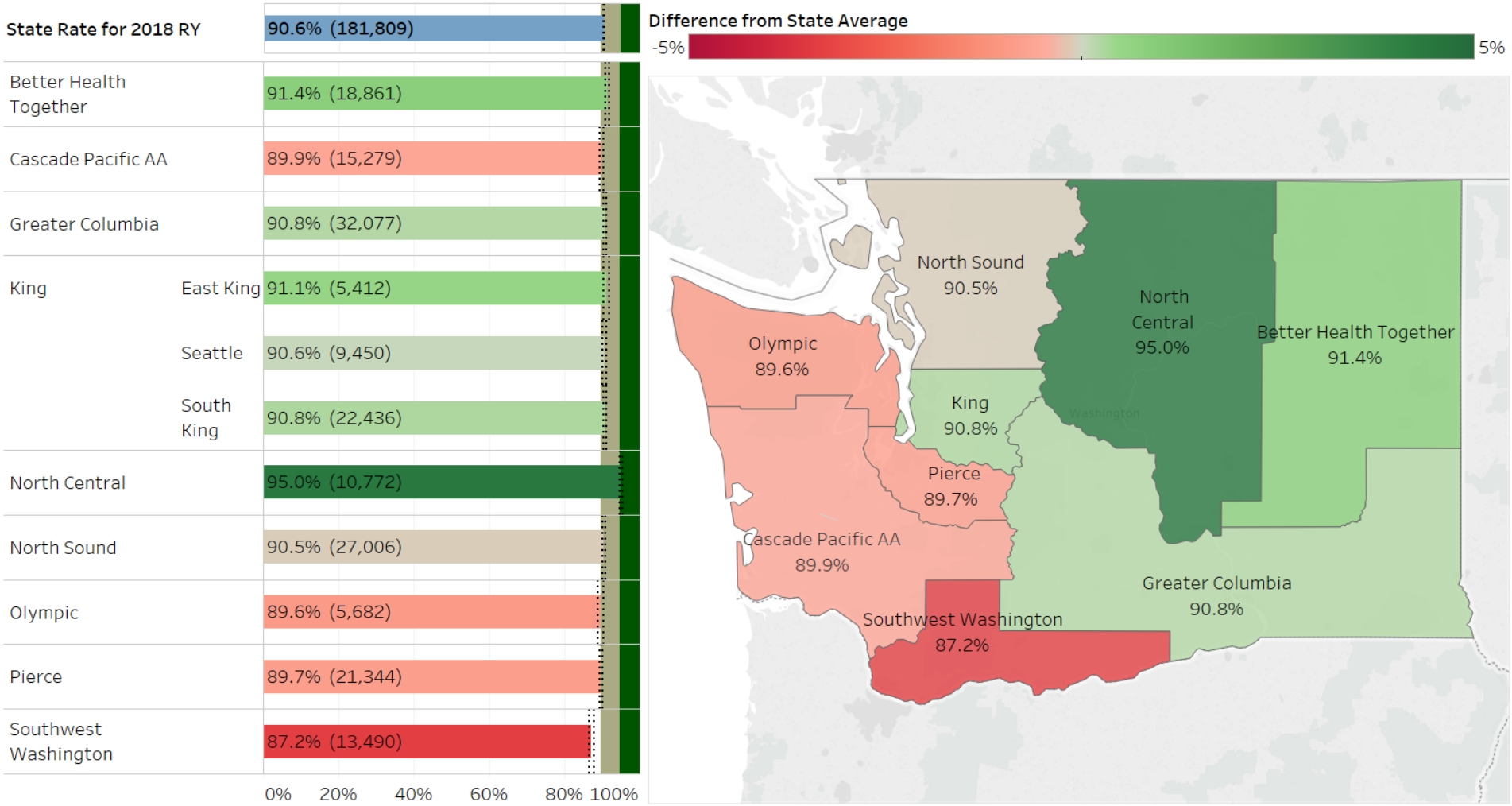
## Children and Adolescents' Access to Primary Care Practitioners (12–19 years)

Again, the rate in North Central for the 12–19 years age group surpassed those in all other regions.

***Table 32: Children and Adolescents' Access to Primary Care Practitioners (12–19 years), Performance by Region***

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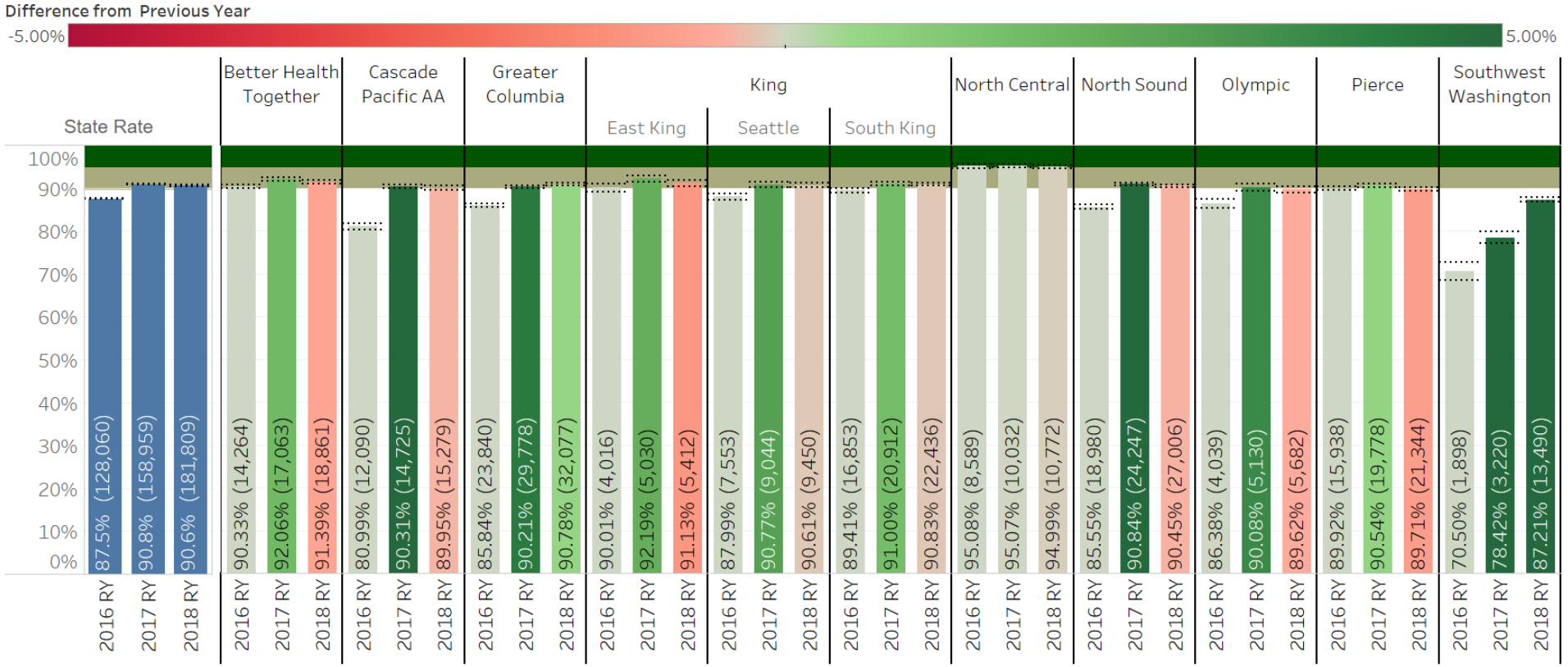
## Year-to-Year Performance

Performance on this measure decreased slightly statewide since 2017 RY after an uptick the previous year. As for the CAP measure for the 7–11 years age group, Southwest Washington was one of only two regions to show improvement. The rate in Greater Columbia increased slightly.

***Table 33: CAP (12–19 years) Performance Statewide and by Region, 2016 RY to 2018 RY***

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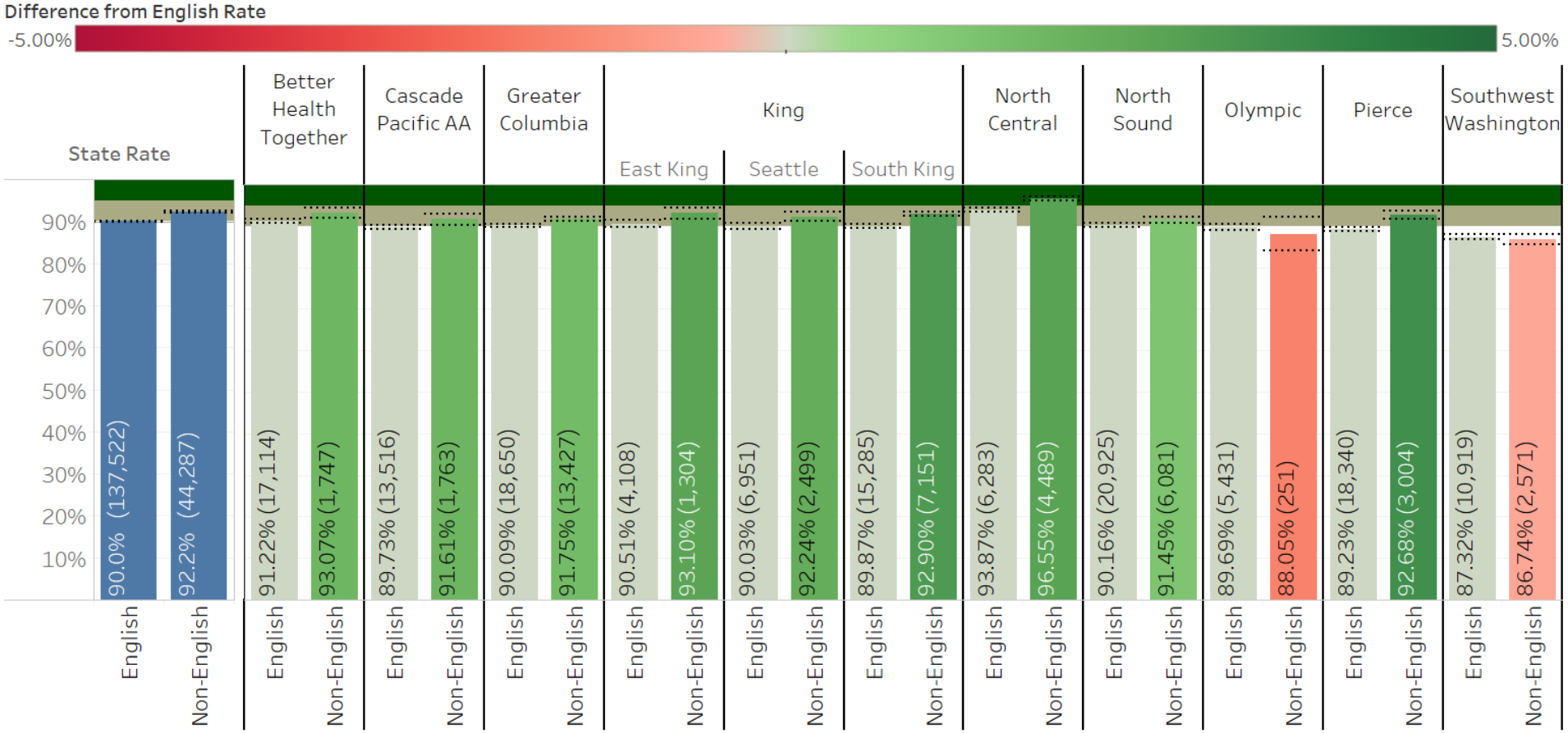
## *Variation by Language*

Continuing a trend noted on most other access measures, analysis of variation by language showed better rates of access for non-English-speaking enrollees than for English-speaking enrollees in all but two regions (Olympic and Southwest Washington).

***Table 33: CAP (12–19 years) Performance Variation by Region and Language***

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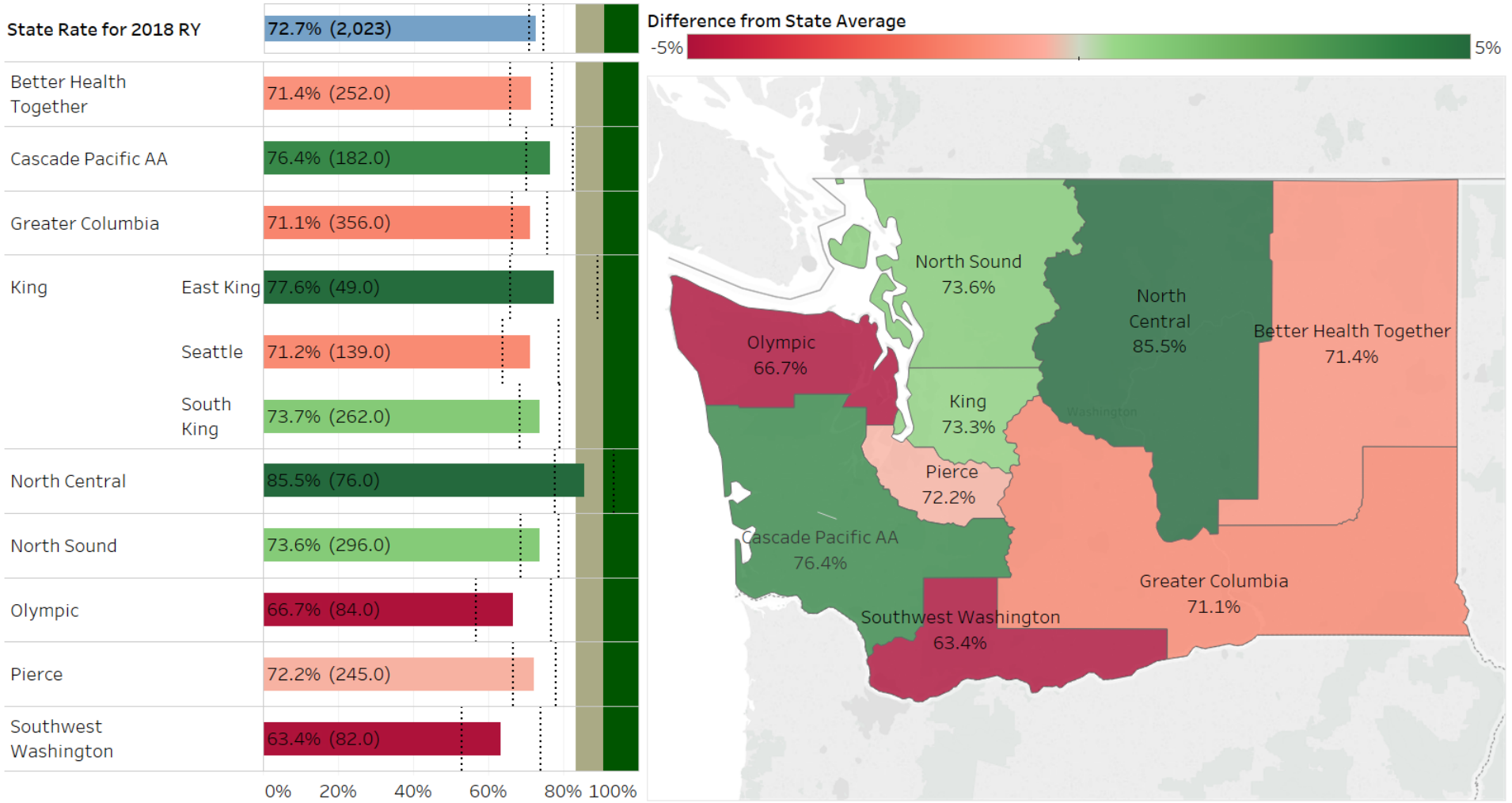
# Prenatal and Postpartum Care—Timeliness of Prenatal Care

Timeliness of prenatal care measures the percentage of eligible enrollees who received their first prenatal visit during the first trimester or within 45 days of enrollment in Apple Health. A higher score indicates better performance. The Apple Health rate for this measure is still significantly below the national average (below the 33rd national percentile). Analysis did not identify any statistically significant differences in MCO performance for this measure by race.

Regional variation was fairly wide, with more than 22 percentage points separating the highest rate (North Central) from the lowest (Southwest Washington).

***Table 34: Timeliness of Prenatal Care, Performance by Region***

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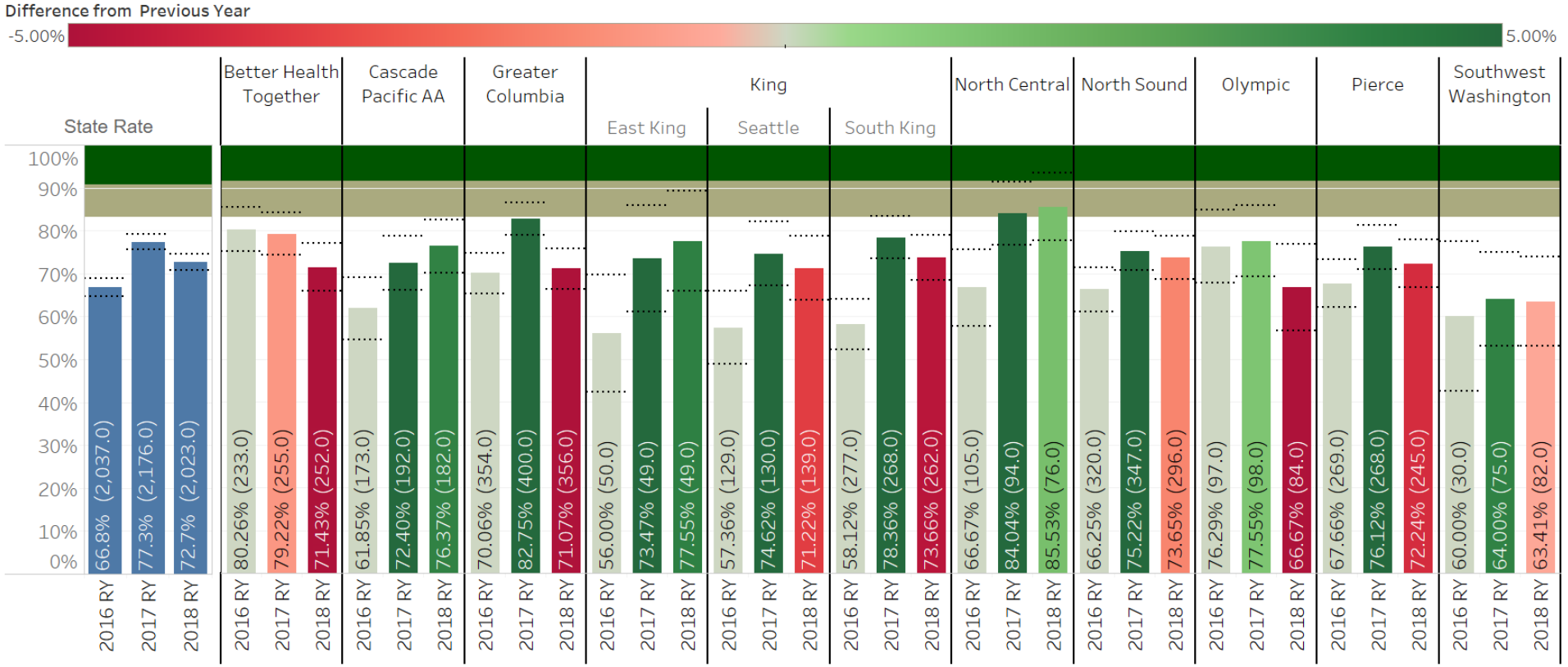
## Year-to-Year Performance

Performance on this measure decreased in most regions since 2017 RY, by as much as 11 percentage points. Cascade Pacific AA, North Central, and East King were the only regions to show improvement. The statewide rate also decreased, after an improvement the previous year.

***Table 35: Timeliness of Prenatal Care Performance Statewide and by Region, 2016 RY to 2018 RY***

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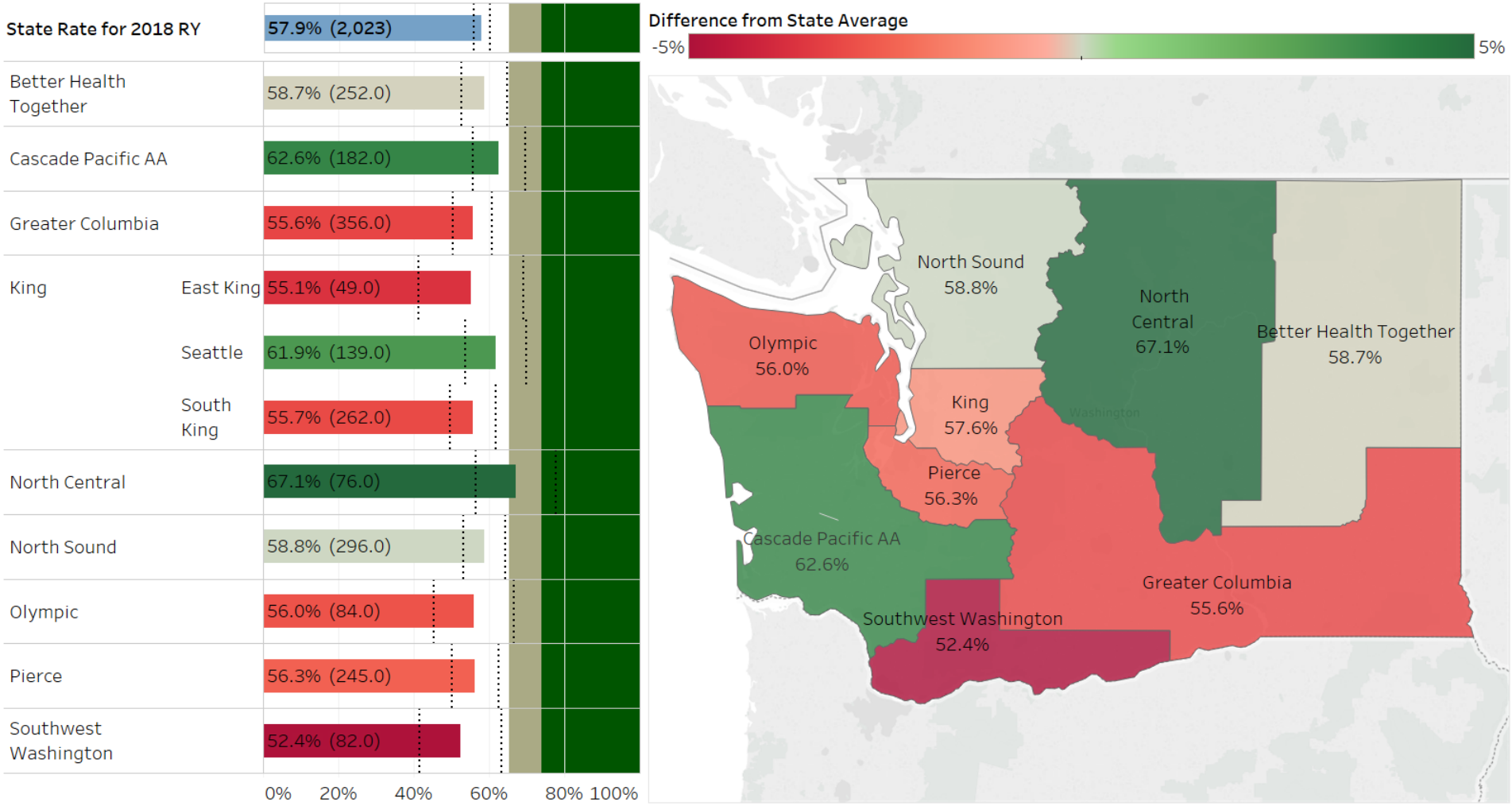
# Prenatal and Postpartum Care—Postpartum Visit

The postpartum visit measure reflects whether women received at least one visit during the postpartum period. A higher score indicates better performance. The 2018 RY Apple Health average is still significantly lower than the national average (below the 33rd national percentile). Qualis Health's analysis did not provide evidence of racial disparities in the receipt of adequate postpartum care.

***Table 38: Postpartum Visit, Performance by Region***

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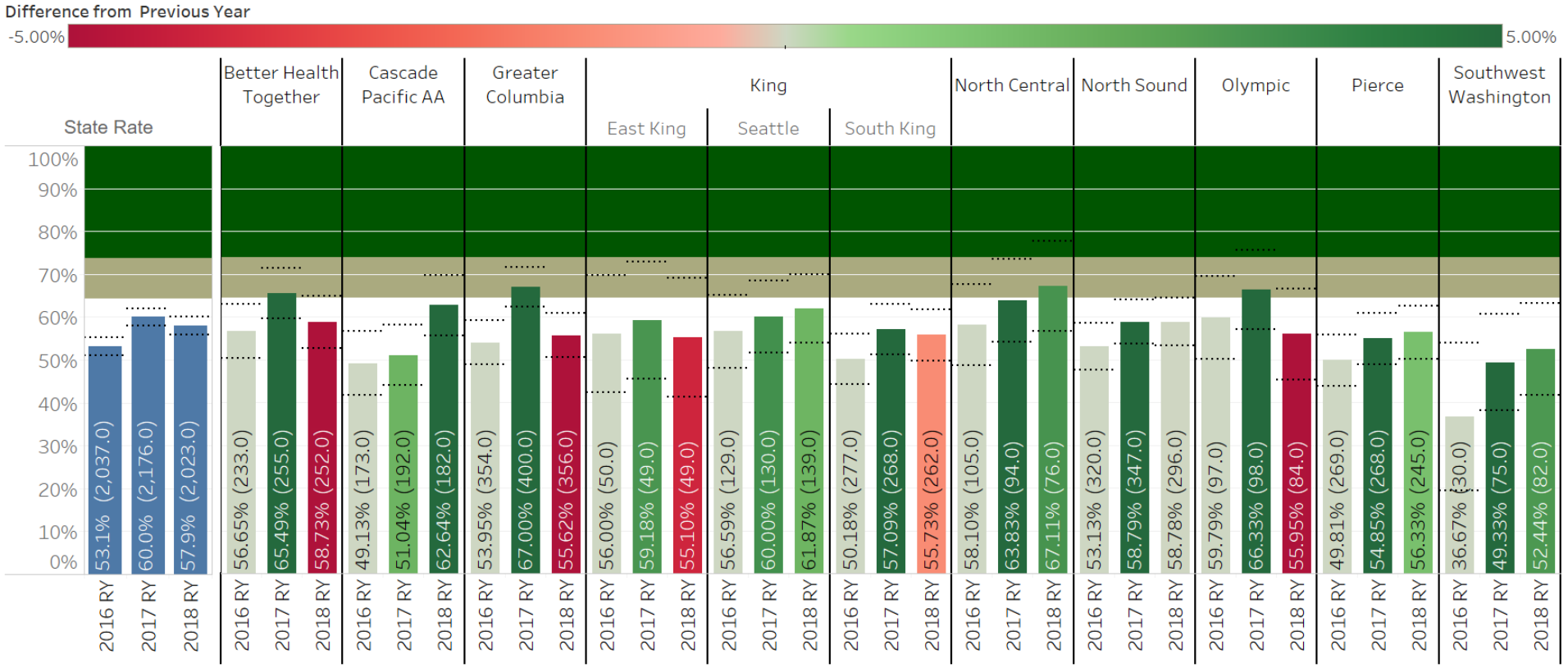
## Year-to-Year Performance

Regionally, rates declined in several regions on this measure: in Better Health Together, Greater Columbia, East King, and Olympic. However, Pierce, Southwest Washington, Seattle, Cascade Pacific AA, and North Central showed improvement. *Note that because of variations in MCO-submitted member-level data from HEDIS data, the state rates reflected here differ slightly from the rate presented in the *2018 Comparative Analysis Report* (the rates presented there remained steady from 2017 to 2018 RY).

***Table 39: Postpartum Visit, Performance Statewide and by Region, 2016 RY to 2018 RY***

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# Preventive Care

Access to care is only the first step toward establishing a healthy population. Enrollees must also receive proactive preventive services delivered within an appropriate timeframe, such as well-care visits that promote healthy behaviors in areas such as weight management, immunizations to prevent disease, and adult screenings for early detection of cancer and other serious illness. This section includes several analyses related to the breast cancer screening measure.

**In this section, the following key applies:**

50th to 90th national percentile

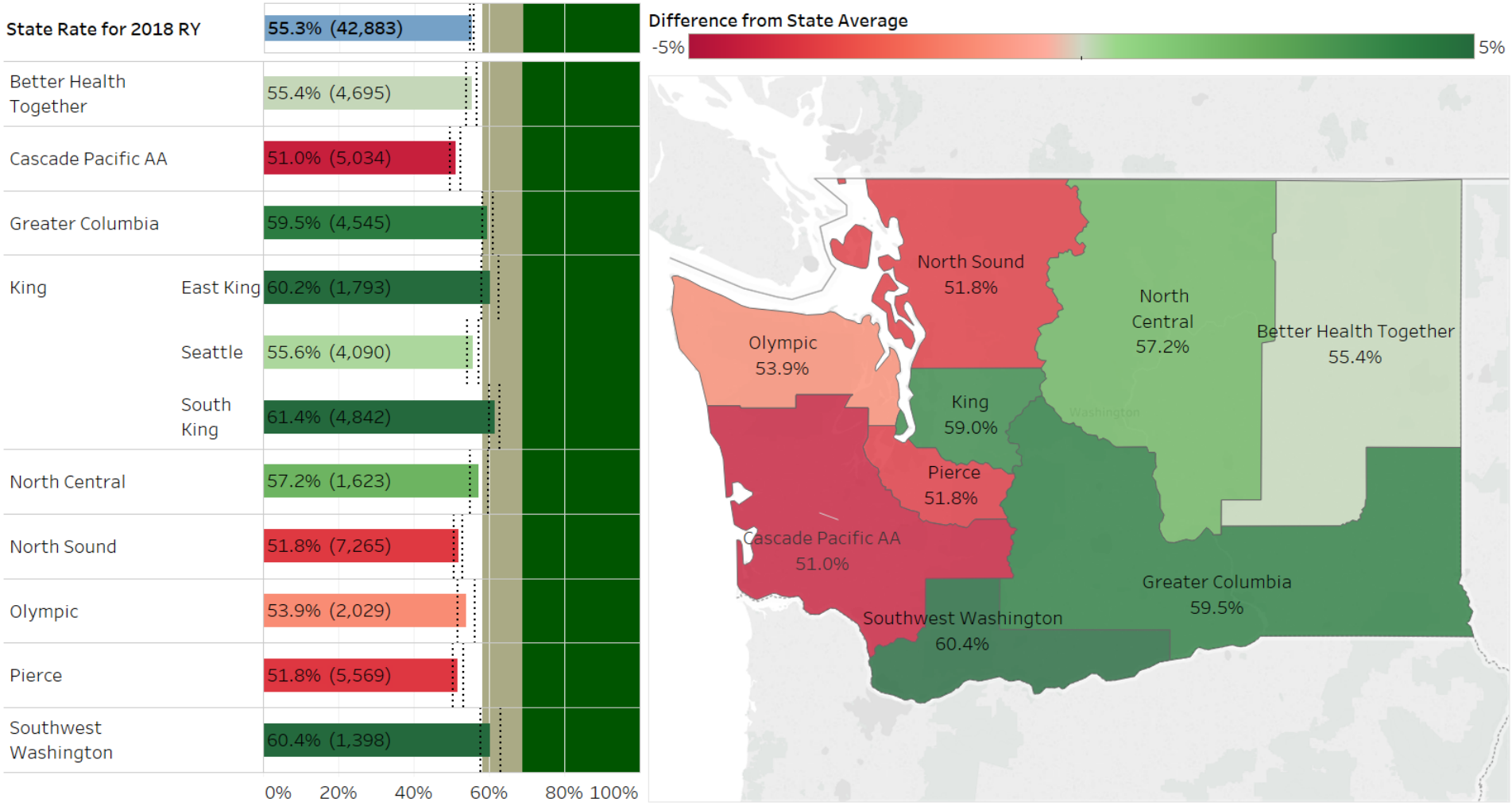
90th+ national percentile

Confidence interval around measure outcome

# Breast Cancer Screening

The breast cancer screening measure is defined as the percentage of women ages 50–74 who had a mammogram within the last two years. A higher score indicates better performance. Regional performance was stronger in the eastern regions of the state, as noted in 2017 RY.

***Table 40: Breast Cancer Screening, Performance by Region***

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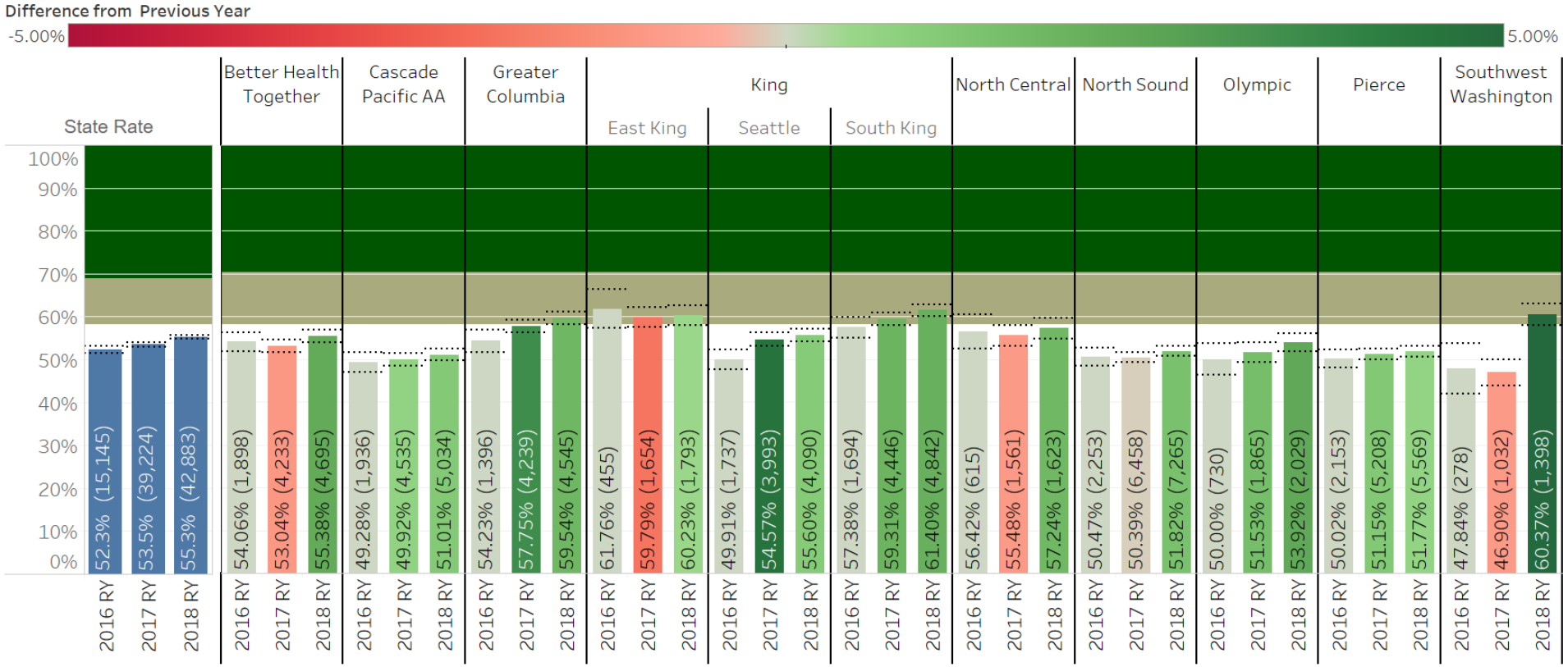
## Year-to-Year Performance

Performance on this measure improved slightly in every region since 2017 RY, most notably in Southwest Washington, where the rate increase by more than 13 points.

***Table 41: Breast Cancer Screening, Performance Statewide and by Region, 2016 RY to 2018 RY***

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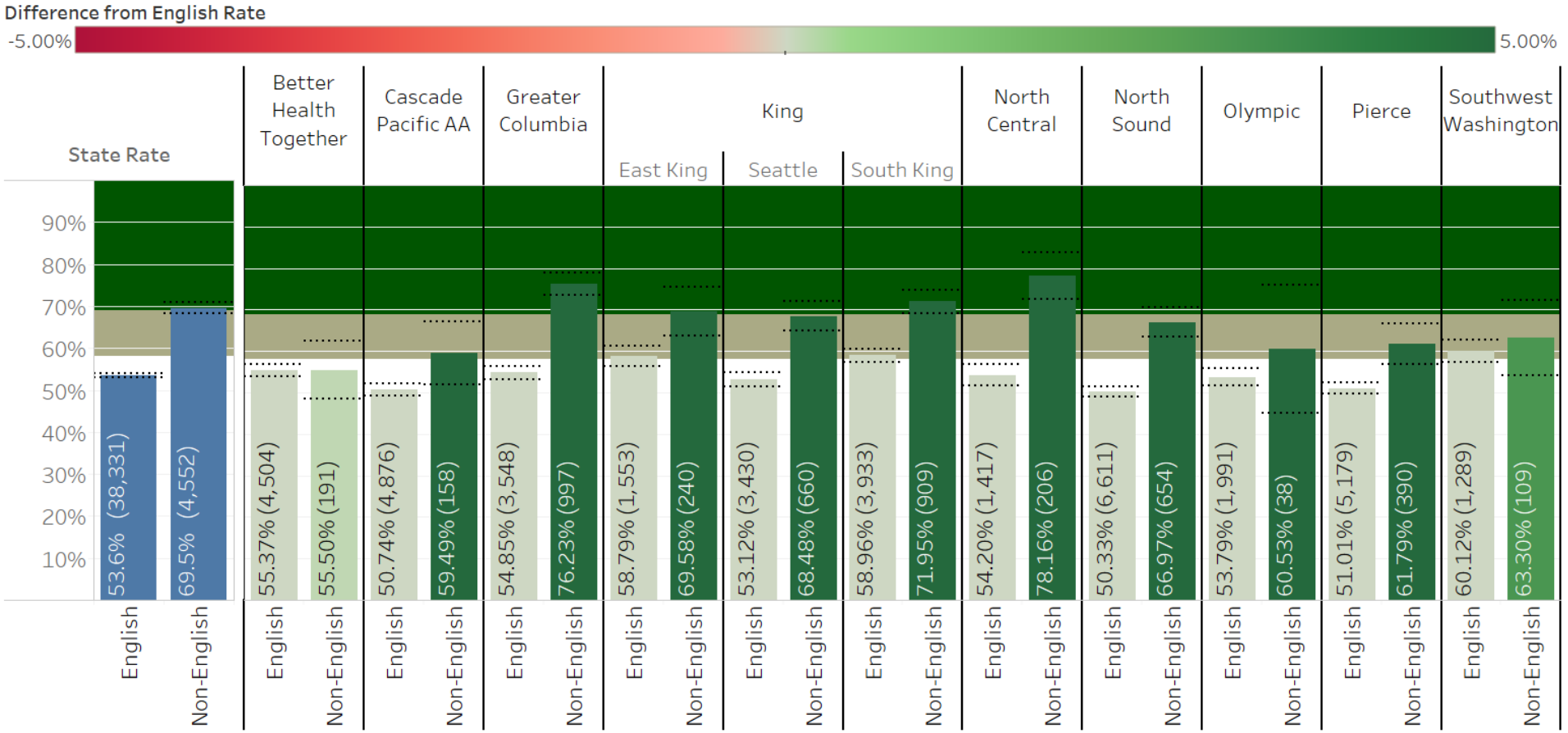
## *Variation by Language*

Analysis of variation by language for this measure indicated that, as in 2017 RY, non-English speakers are more likely to get breast cancer screenings than English-speaking women.

***Table 42: Breast Cancer Screening, Performance Variation by Region and Language***

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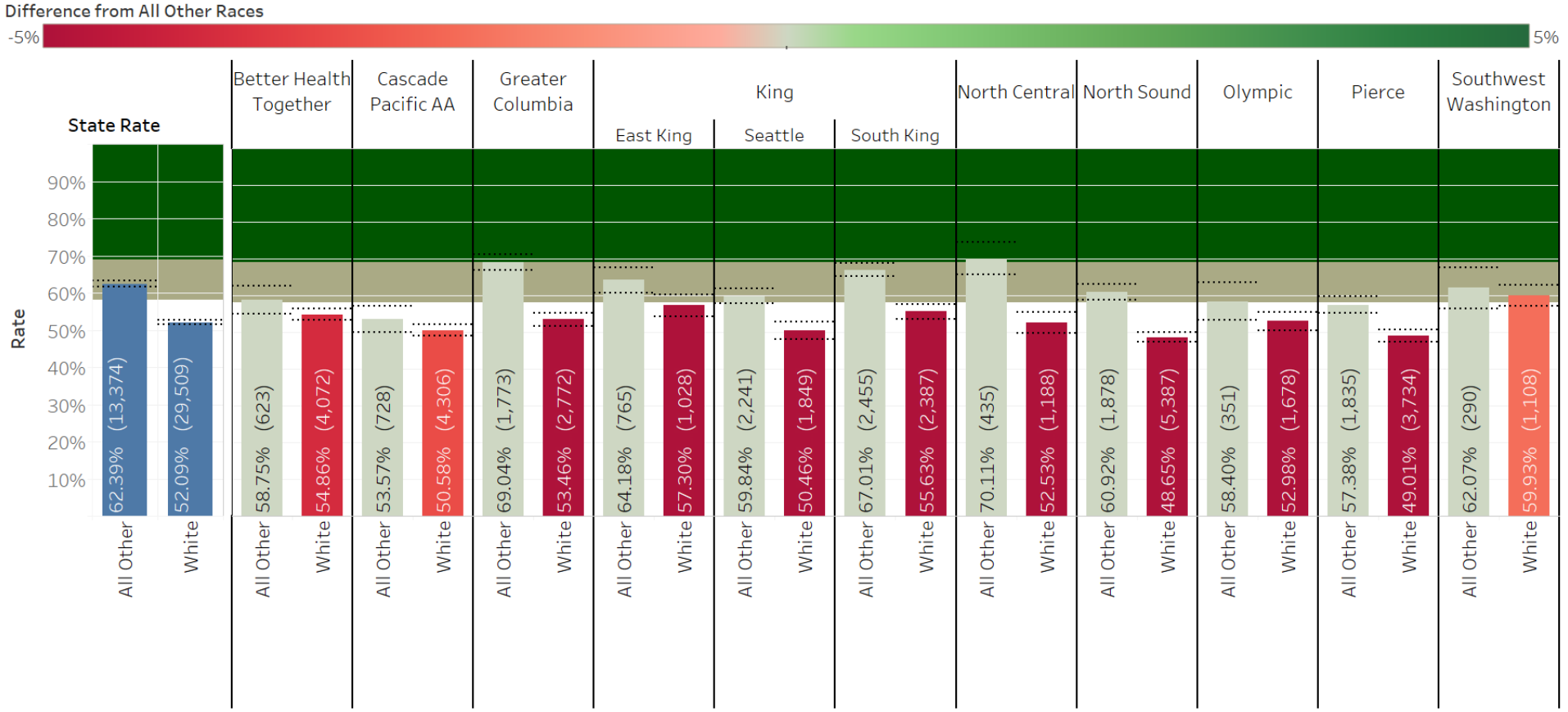
## *Variation by Race*

Performance on this measure also showed variation by race. In all regions, white women were less likely to complete a breast cancer screening than all other groups, as identified in the previous year.

***Table 43: Breast Cancer Screening, Performance Variation by Region and Race***

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# Chronic Care Management

Adequate management of chronic conditions can delay morbidity and mortality and improve enrollee quality of life. It may also prevent more costly emergency department visits and inpatient stays. Measures reported in this section include:

- Antidepressant medication management—acute treatment phase
- Antidepressant medication management—continuation treatment phase
- Comprehensive diabetes care—HbA1c control (< 8.0%)

**In this section, the following key applies:**


50th to 90th national percentile


90th+ national percentile

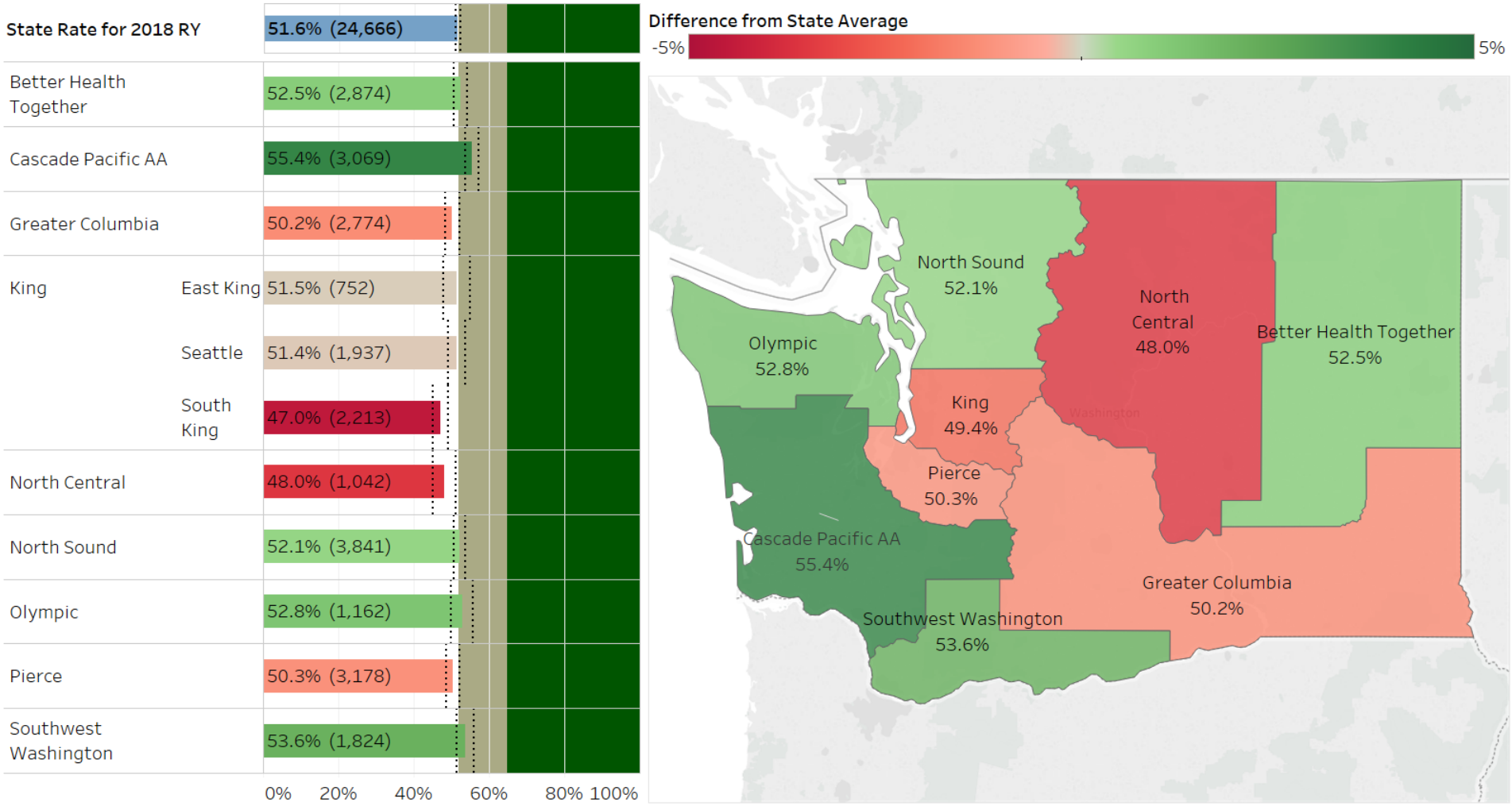

Confidence interval around measure outcome

## Antidepressant Medication Management—Acute Treatment Phase

Antidepressant medication management (AMM)—acute treatment phase is defined as the percentage of enrollees newly diagnosed with major depression who remained on an antidepressant medication during the entire 84-day acute treatment phase. A higher score indicates better performance.

For this measure, the western regions show higher rates than central and eastern regions (except for Better Health Together), with Cascade Pacific AA having the highest rate of 55.4 percent. The rate was lowest in South King at 47 percent, more than 4 percent below the state average.

***Table 45: Antidepressant Medication Management—Acute Treatment Phase, Performance by Region***

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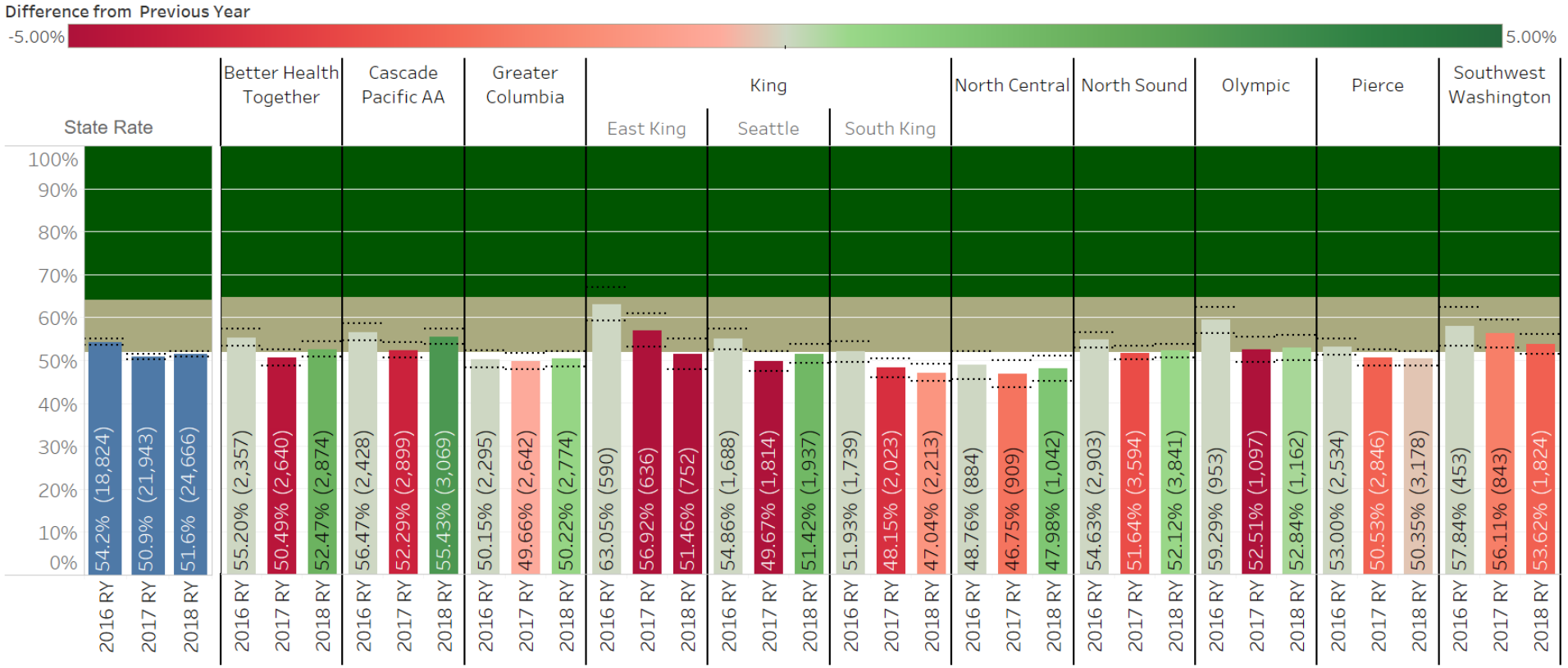
## Year-to-Year Performance

Performance on this measure increased slightly statewide, with a number of regions showing some, if slight, improvement.

***Table 46: AMM–Acute Treatment Phase, Performance Statewide and by Region, 2016 RY to 2018 RY***

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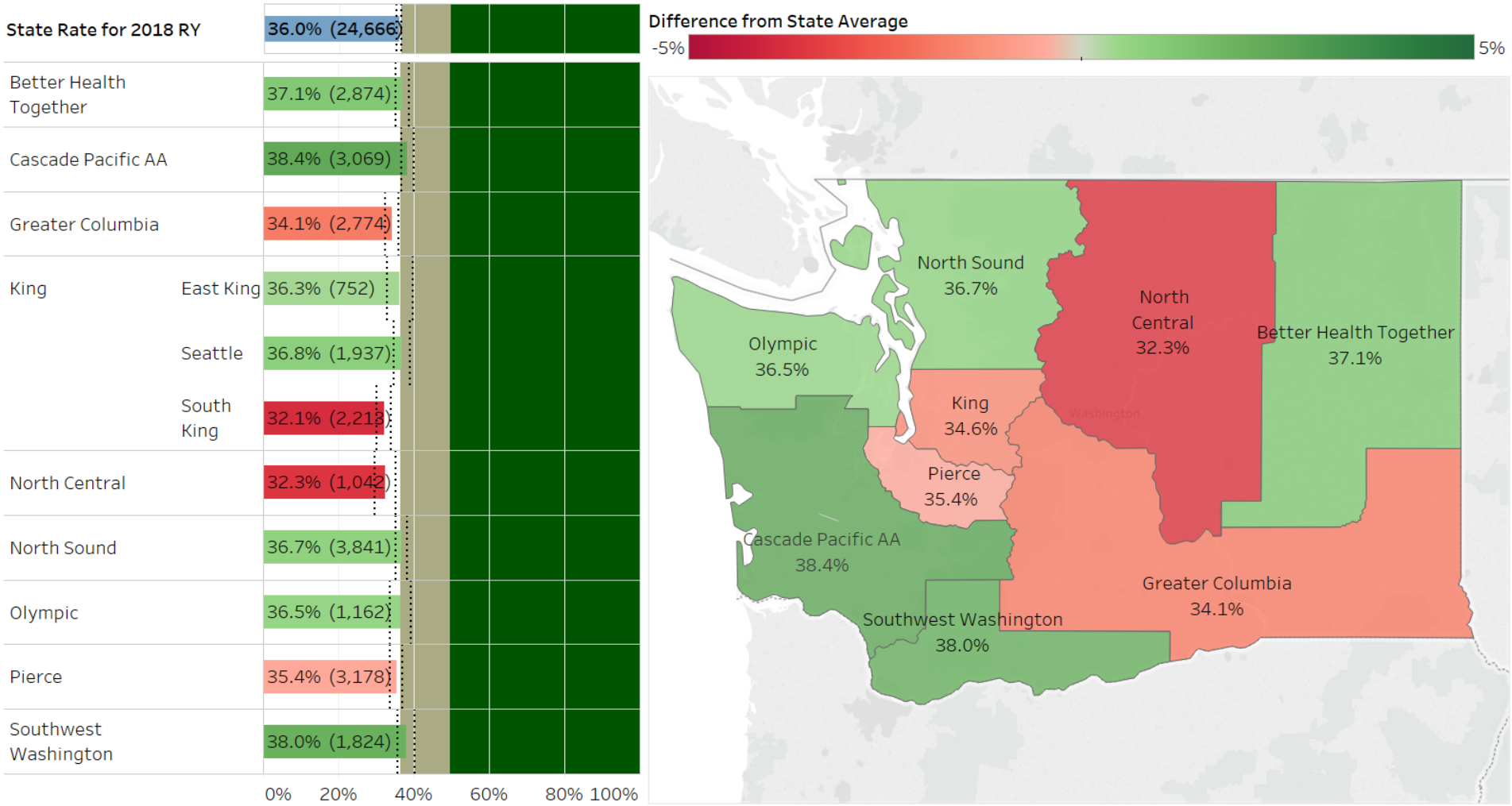
## Antidepressant Medication Management—Continuation Treatment Phase

Antidepressant medication management—continuation treatment phase is defined as the percentage of enrollees newly diagnosed with major depression who remained on an antidepressant medication for the 180-day continuation phase. A higher score indicates better performance for this measure.

Regional variation for this measure was similar to that of the acute treatment phase measure, with Cascade Pacific AA and South King at high and low ends of the performance spectrum, respectively.

***Table 48: Antidepressant Medication Management—Continuation Treatment Phase, Performance by Region***

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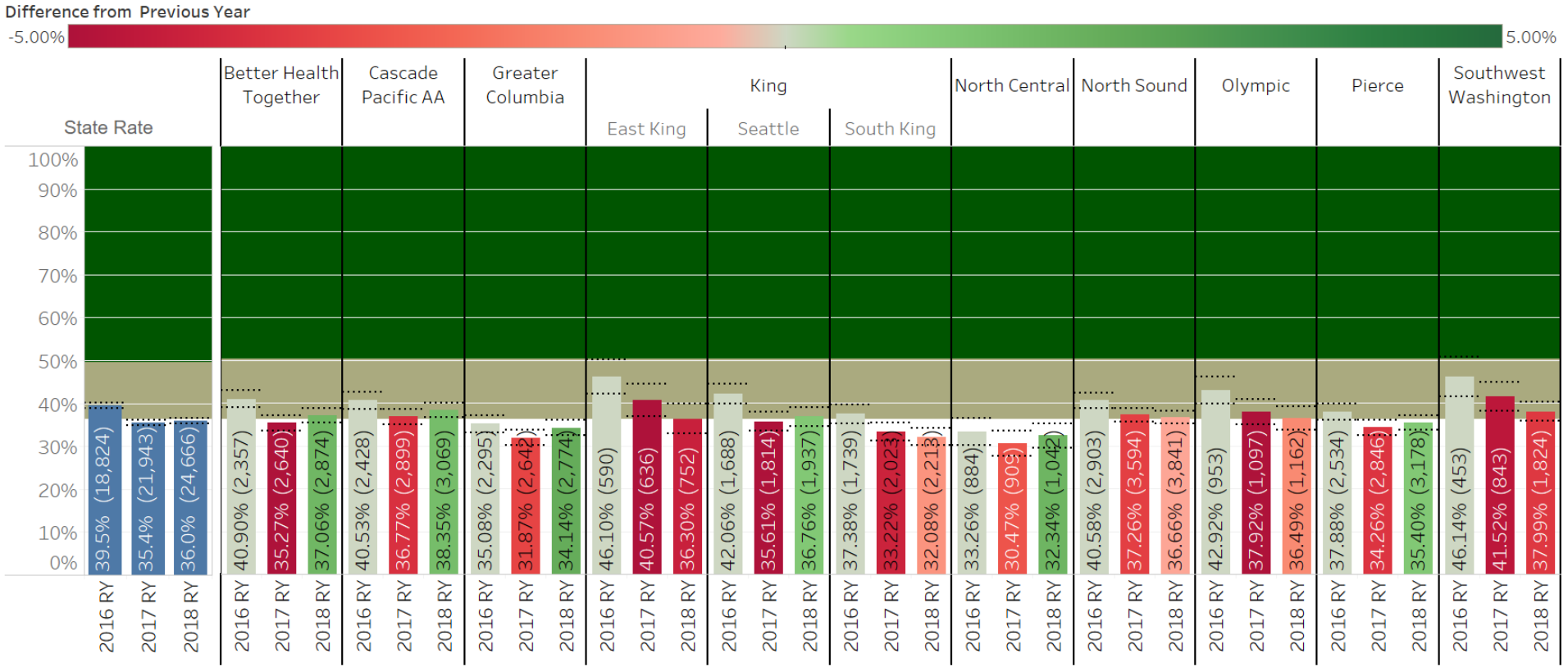
## Year-to-Year Performance

Similar to the acute treatment phase measure, performance on this measure increased statewide but varied by region.

***Table 49: AMM—Continuation Treatment Phase, Performance Statewide and by Region, 2016 RY to 2018 RY***

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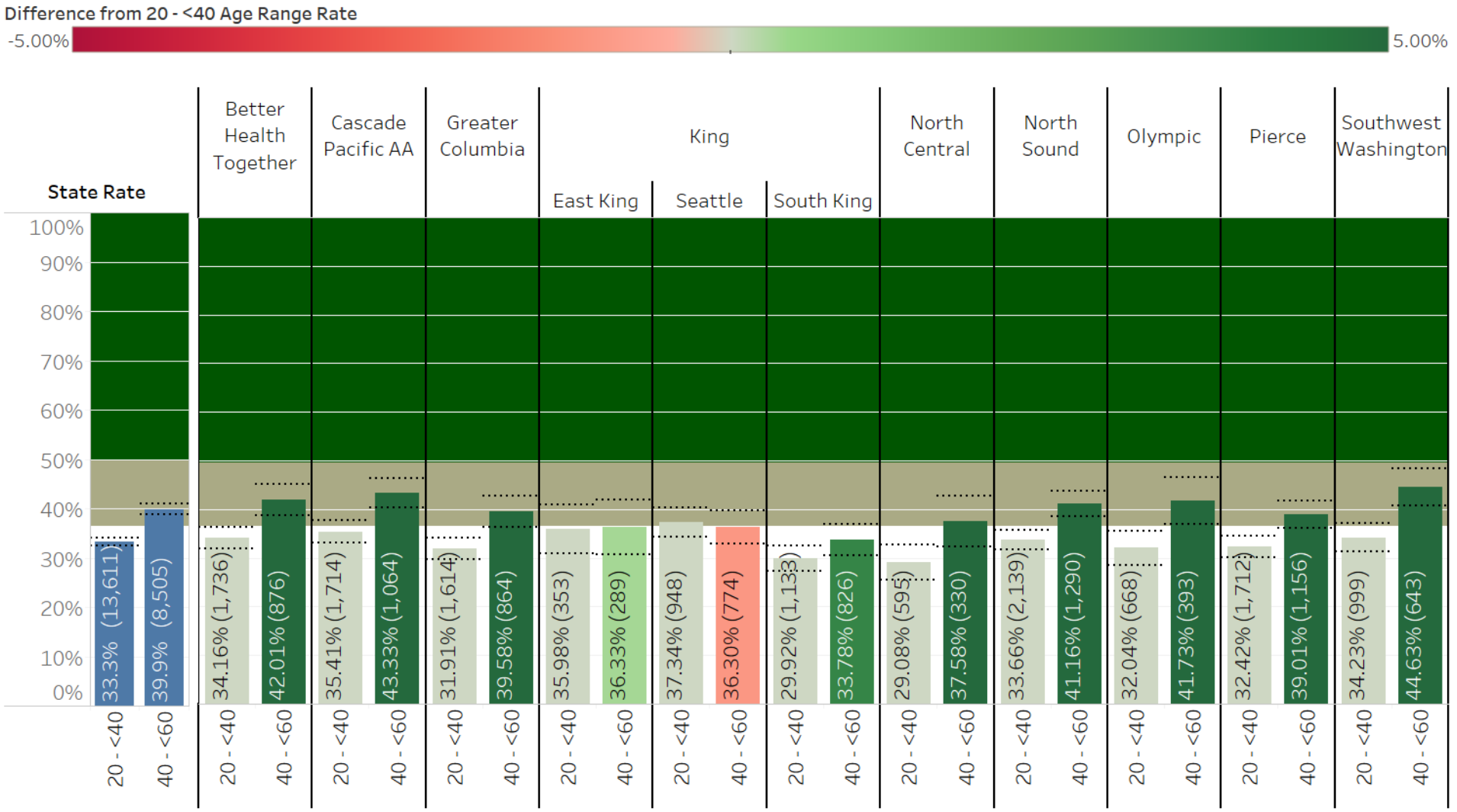
## *Variation by Age*

In contrast with the acute treatment phase measure, which did not show any significant difference in performance rates by age, rates for this measure for enrollees 20–40 were lower than for those enrollees ages 40–60.

***Table 51: AMM–Continuation Treatment Phase, Variation by Region and Age***

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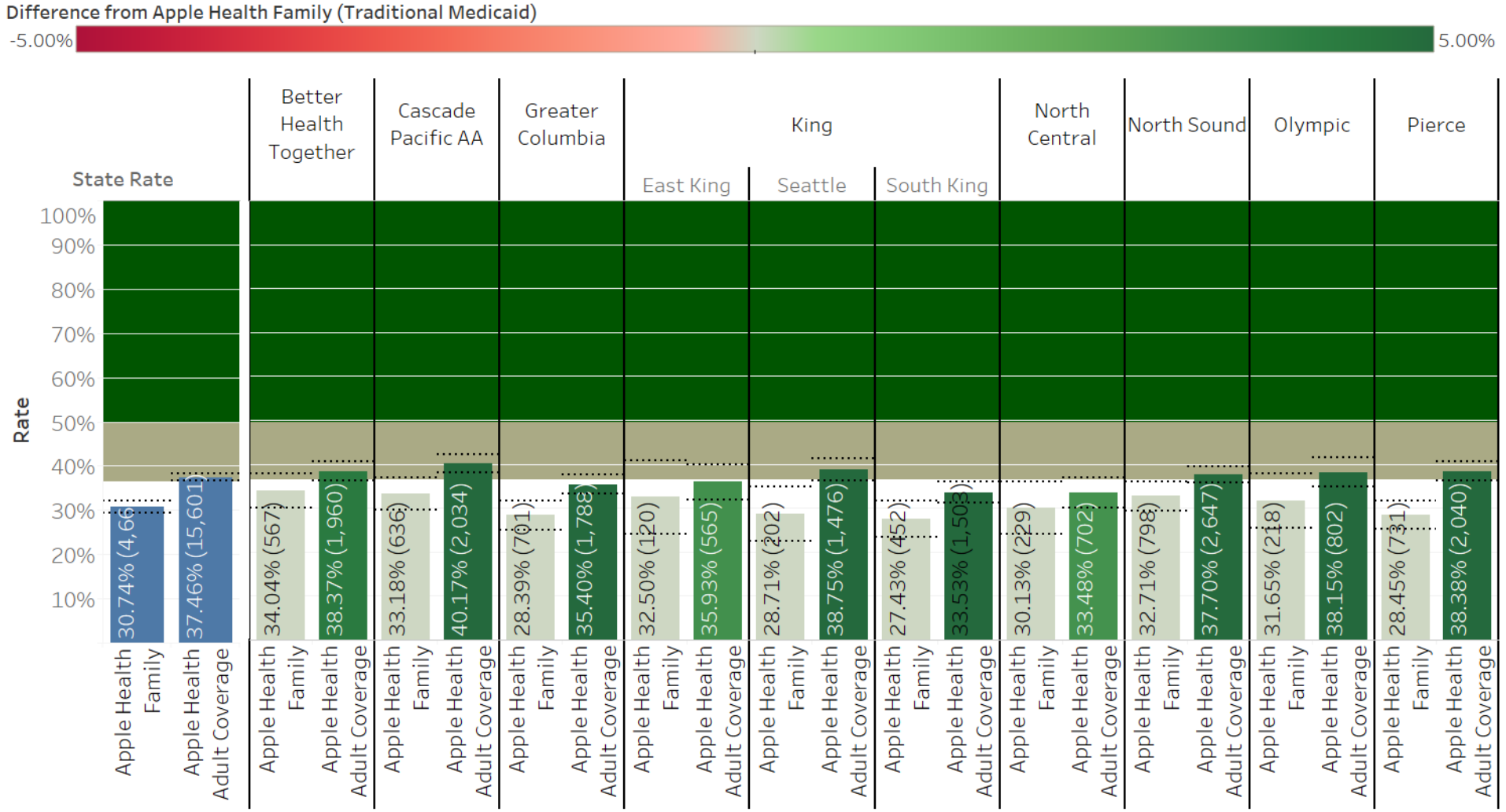
## *Apple Health Family (Traditional Medicaid) vs Apple Health Adult Coverage (Medicaid Expansion)*

The AMM—continuation phase measure also showed higher rates for enrollees of Apple Health Adult Coverage than for Apple Health Family.

***Table 52: AMM–Continuation Treatment Phase, Variation by Region and Program***

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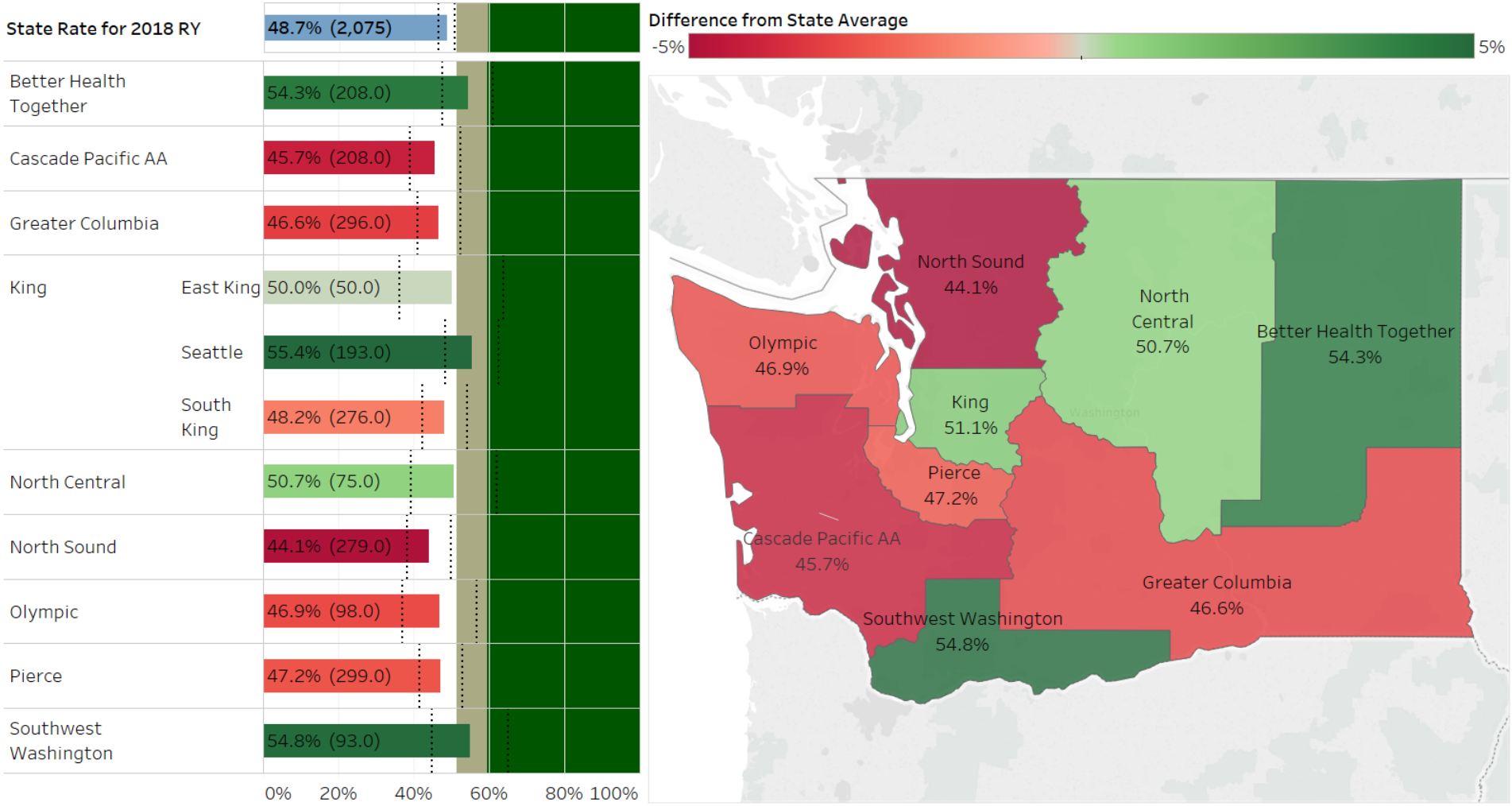
## Comprehensive Diabetes Care—HbA1c Control (< 8.0%)

The HbA1c control measure assesses the rate of adults ages 18–75 with diabetes (type 1 and type 2) whose HbA1c level was less than 8.0% (in other words, whose HbA1c was "in control"). This measure is one component of a set of measures evaluating the care of individuals with diabetes. Regional analysis showed wide variation on this measure, with more than 11 percentage points separating the highest (Seattle) and lowest (North Sound) regional rates.

***Table 53: Comprehensive Diabetes Care—HbA1c Control (< 8.0%), Performance by Region***

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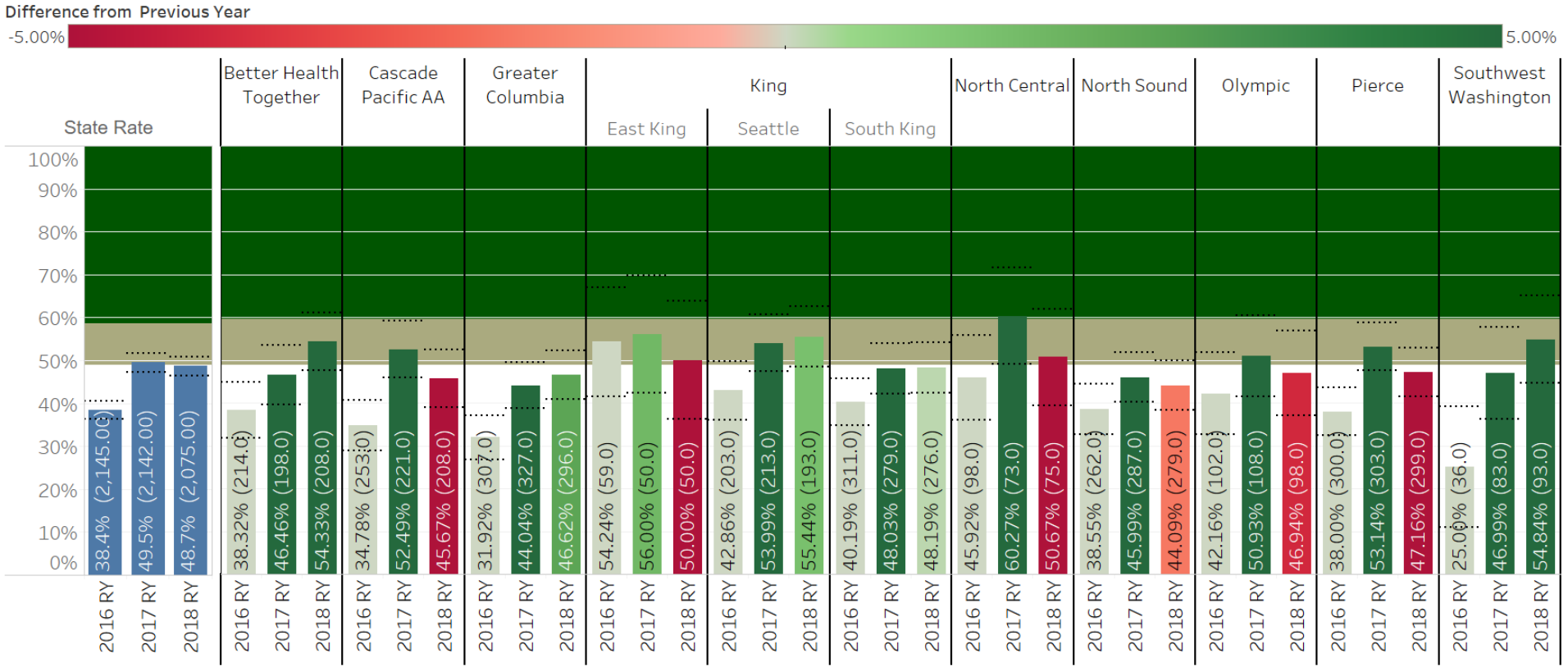
## Year-to-Year Performance

Performance on this measure varied by region: rates in Better Health Together, Greater Columbia, Seattle, South King, and Southwest Washington showed improvement, but the rates in Cascade Pacific AA, East King, North Central, North Sound, Olympic, and Pierce declined. *Note that because of variations in MCO-submitted member-level data from HEDIS data, the state rates reflected here differ slightly from the rates presented in the *2018 Comparative Analysis Report* (the rates presented there remained steady from 2017 to 2018 RY).

***Table 54: Comprehensive Diabetes Care—HbA1c Control (< 8.0%), Performance Statewide and by Region, 2016 RY to 2018 RY***

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# Medical Care Utilization

Limiting cost growth while maximizing health coverage is essential for the Medicaid program to be sustainable. One method of doing so is to limit waste and unnecessary care provided in the healthcare system. Measures in this analysis included:

- Appropriate treatment for children with upper respiratory infection
- Appropriate testing for children with pharyngitis

*Note: In the* 2017 Regional Analysis Report*, data for utilization measures related to ambulatory utilization (outpatient and emergency department visits), inpatient utilization, and readmissions were gathered independently and included in this section. However, this information was not included in the MLD submitted by the MCOs and therefore was not available for regional analysis. MCO and overall statewide performance on these measures may be viewed in the* 2018 Comparative Analysis Report*.*

**In this section, the following key applies:**

$50^{th}$ to $90^{th}$ national percentile

$90^{th}$+ national percentile

Confidence interval around measure outcome

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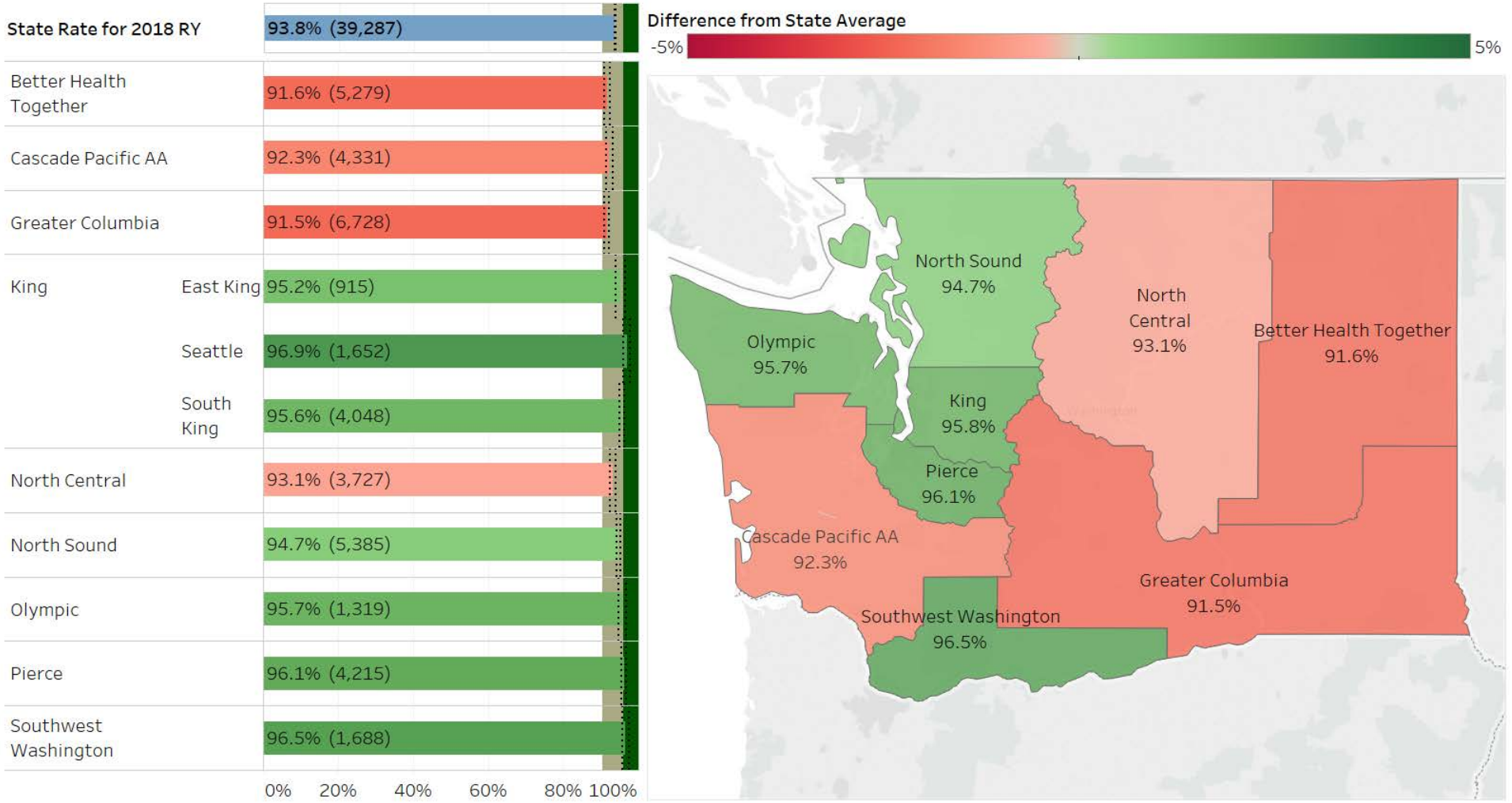
# Appropriate Treatment for Children with Upper Respiratory Infection

Appropriate treatment for children with upper respiratory infection is defined as the percentage of children ages 3 months–18 years with a diagnosis of upper respiratory infection who were *not* dispensed an antibiotic within three days of diagnosis. Specifically, this measure reports the proportion of eligible children for whom antibiotics were not prescribed. A higher score indicates better performance.

Regional variation for this measure was low, with rates in all regions above the national average. The rate was highest in Seattle.

***Table 55: Appropriate Treatment for Children with Upper Respiratory Infection, Performance by Region***

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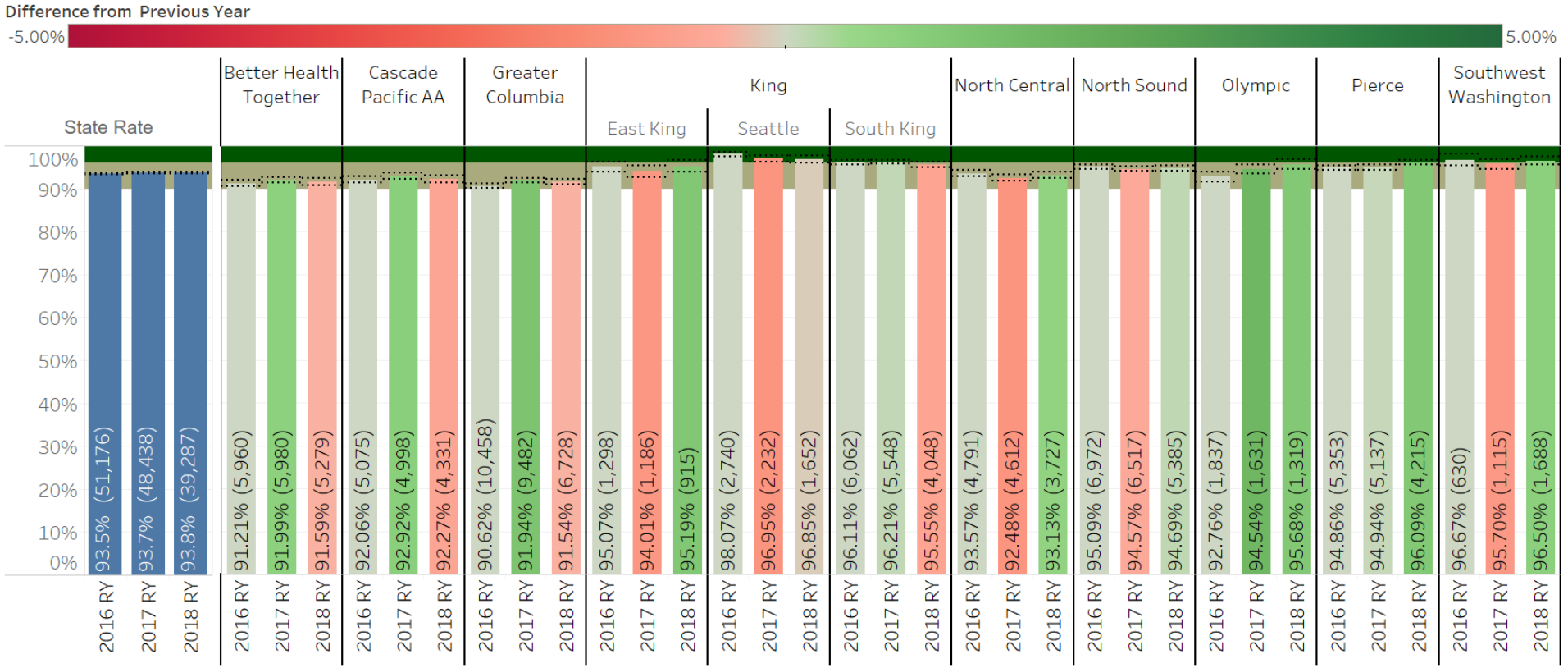
## Year-to-Year Performance

Statewide performance on this measure has remained steady since 2017 RY, without any significant rate changes by region.

***Table 56: Appropriate Treatment for Children with Upper Respiratory Infection, Performance Statewide and by Region, 2016 RY to 2018 RY***

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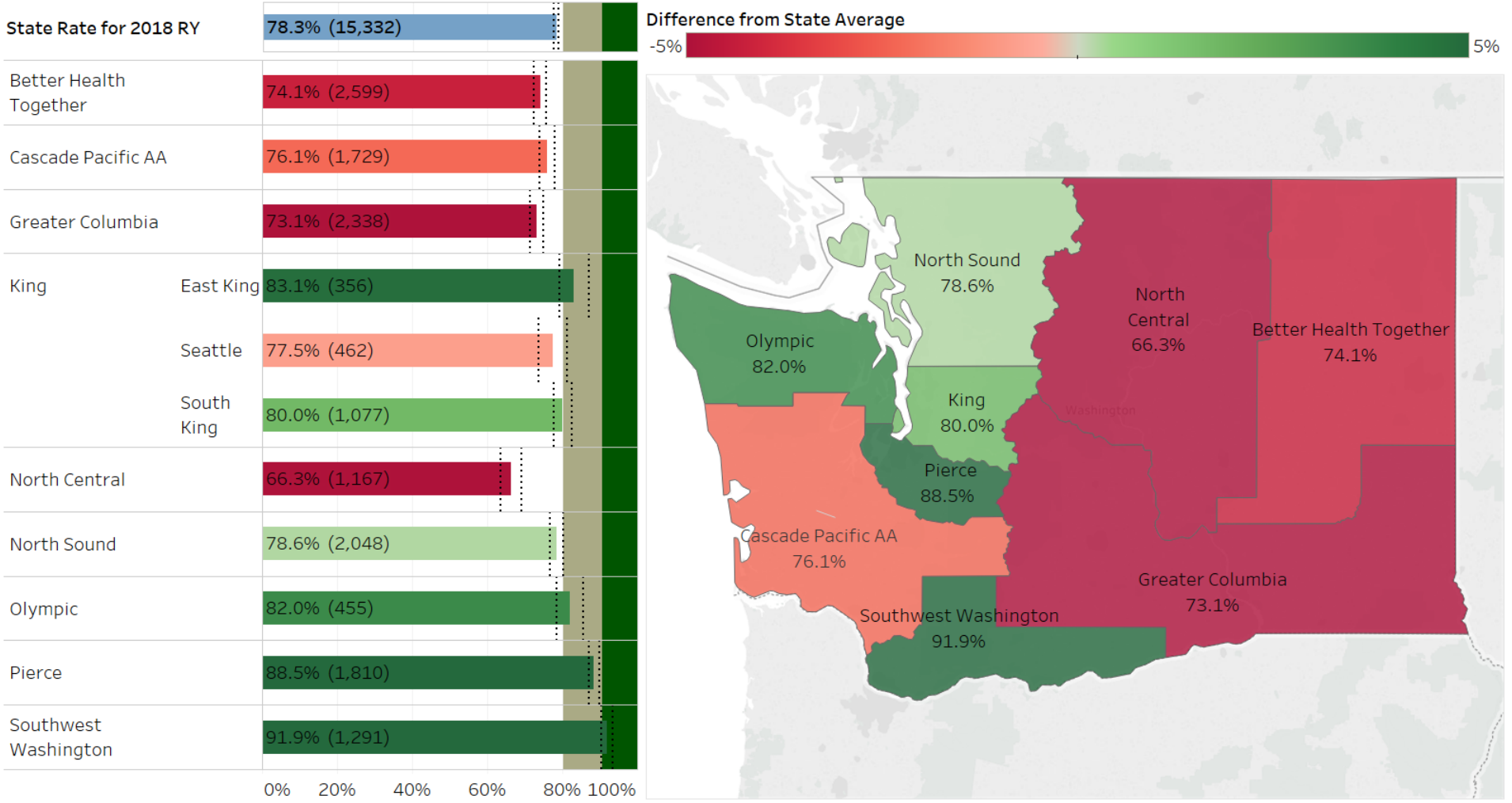
## Appropriate Testing for Children with Pharyngitis

Appropriate testing for children with pharyngitis measures the percentage of children 2–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A strep test for the episode. A higher rate indicates better performance. Rates on this measure varied widely by region, with 25.6 percentage points separating the highest (Southwest Washington) and lowest (North Central) performance rates.

***Table 57: Appropriate Treatment for Children with Pharyngitis, Performance by Region***

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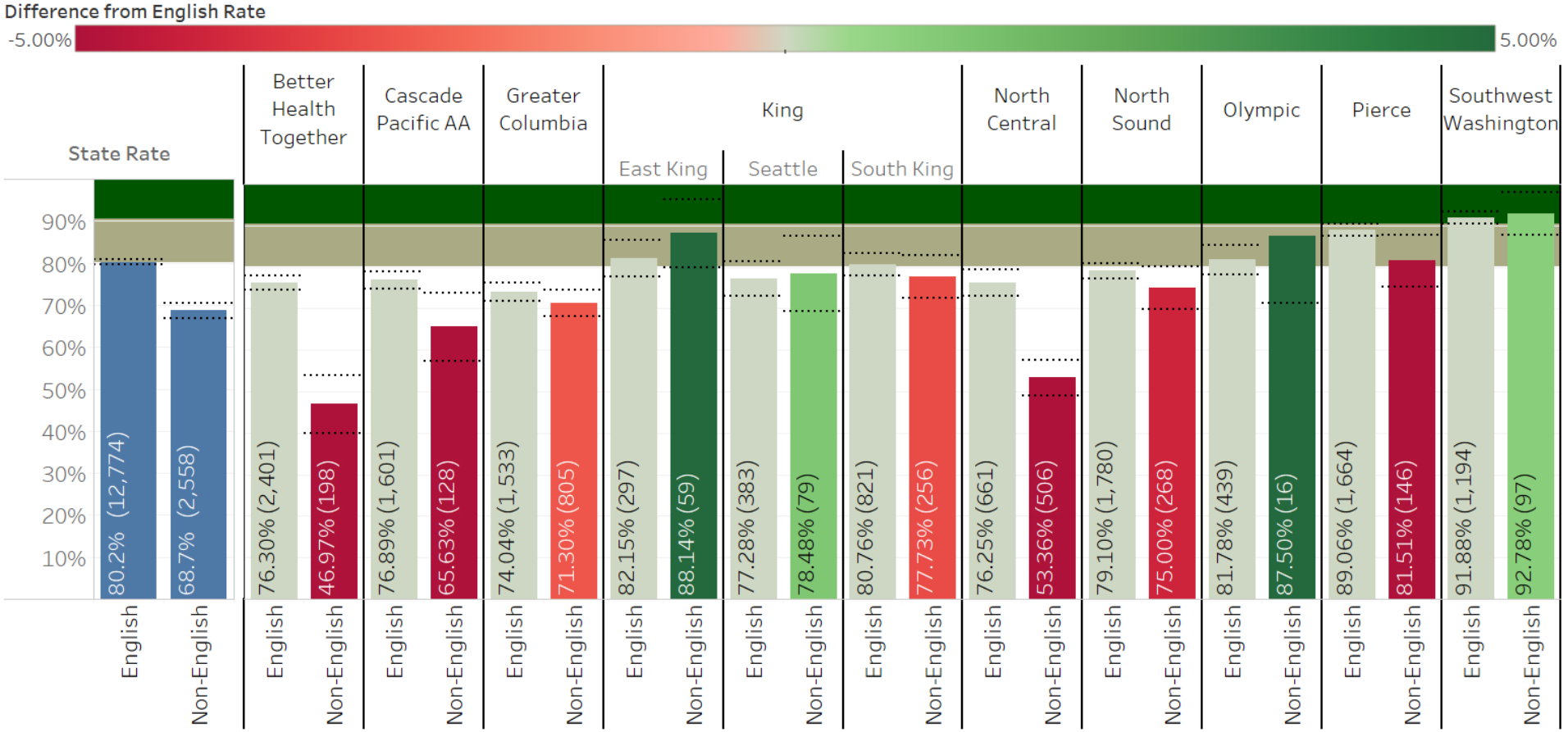
## *Variation by Language*

Unlike most other analyses of variation by language, rates for this measure were much higher for English speakers than for non-English speakers. Only in Seattle, East King, Seattle, Olympic, and Southwest Washington were rates better for non-English-speaking enrollees.

***Table 58: Appropriate Treatment for Children with Pharyngitis, Variation by Language***

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# Appendix A: Regional Scorecards


| | |
|---|---|
| Better Health Together | A-2 |
| Cascade Pacific AA | A-3 |
| Greater Columbia | A-4 |
| King | A-5 |
| East King | A-6 |
| Seattle | A-7 |
| South King | A-8 |
| North Central | A-9 |
| North Sound | A-10 |
| Olympic | A-11 |
| Pierce | A-12 |
| Southwest Washington | A-13 |


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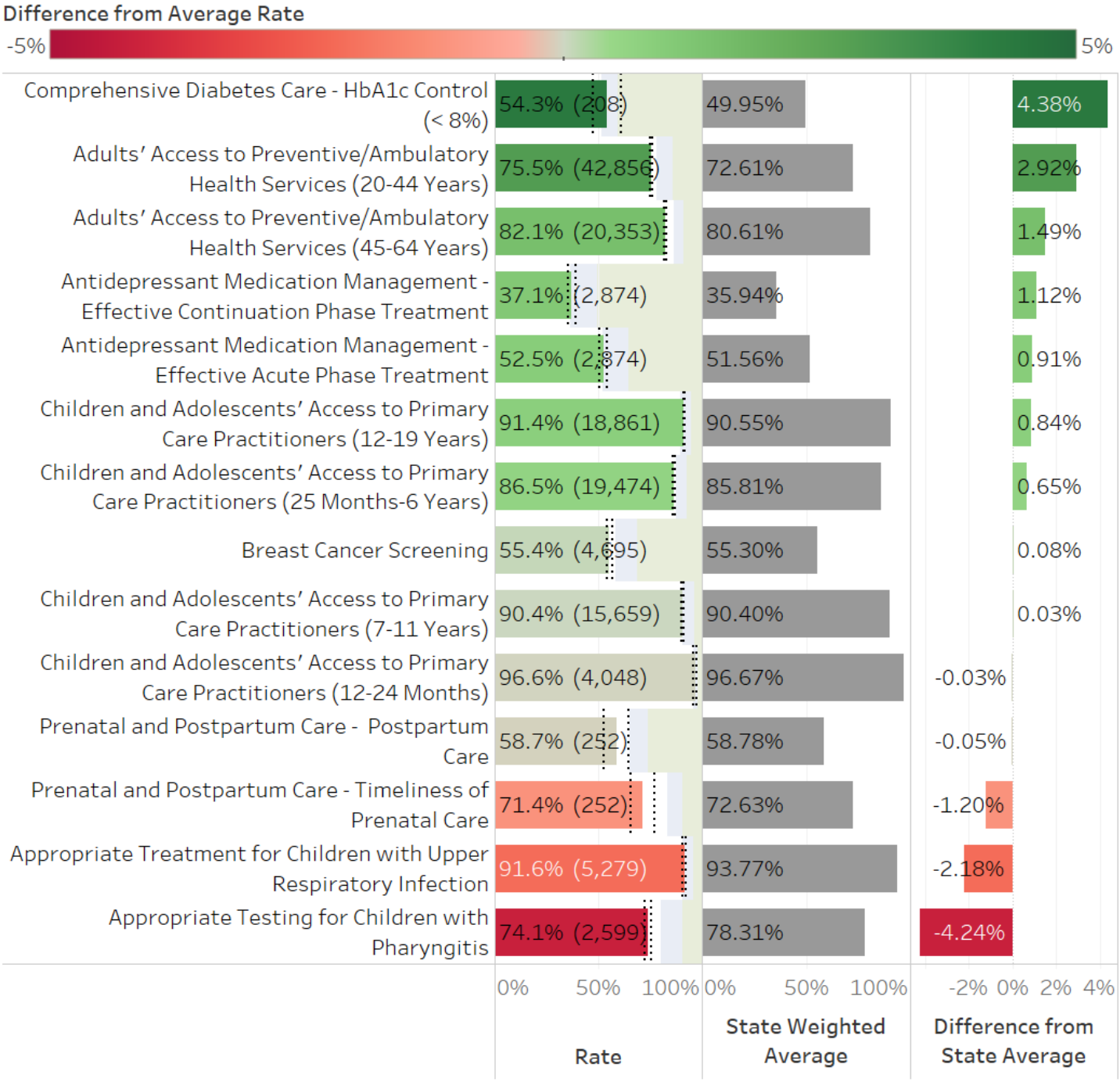
# Regional Scorecard: Better Health Together

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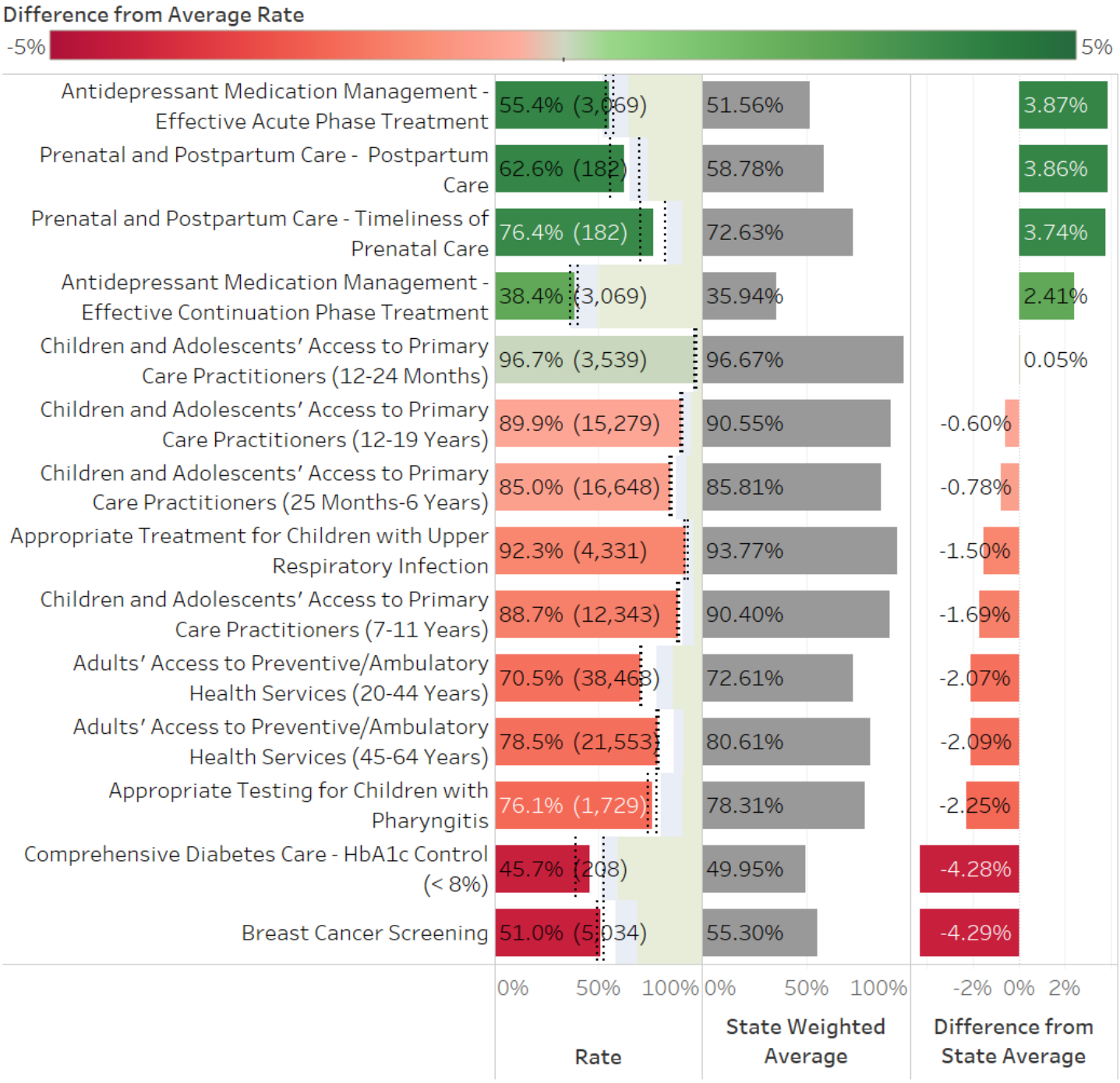
# Regional Scorecard: Cascade Pacific AA

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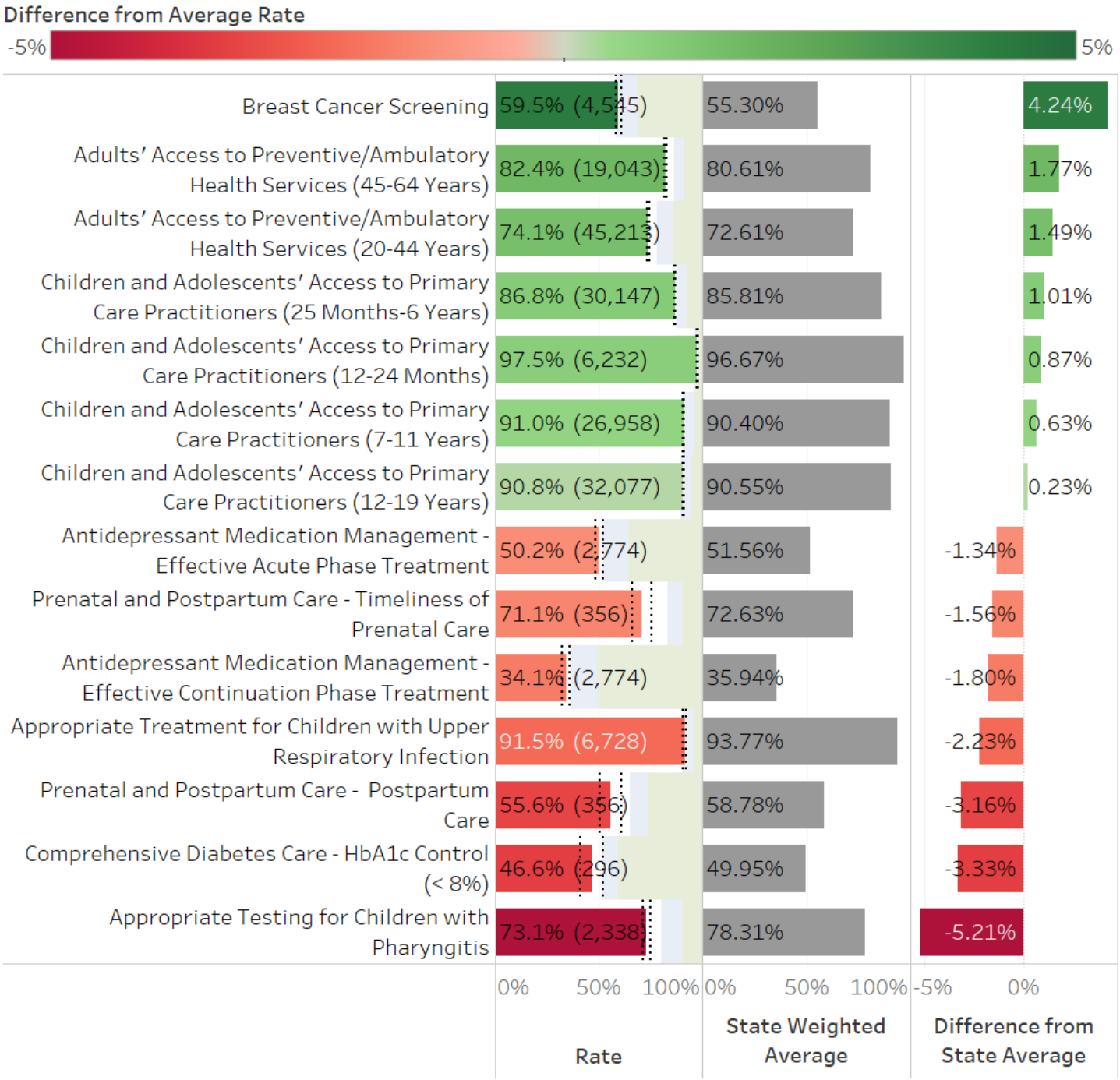
# Regional Scorecard: Greater Columbia

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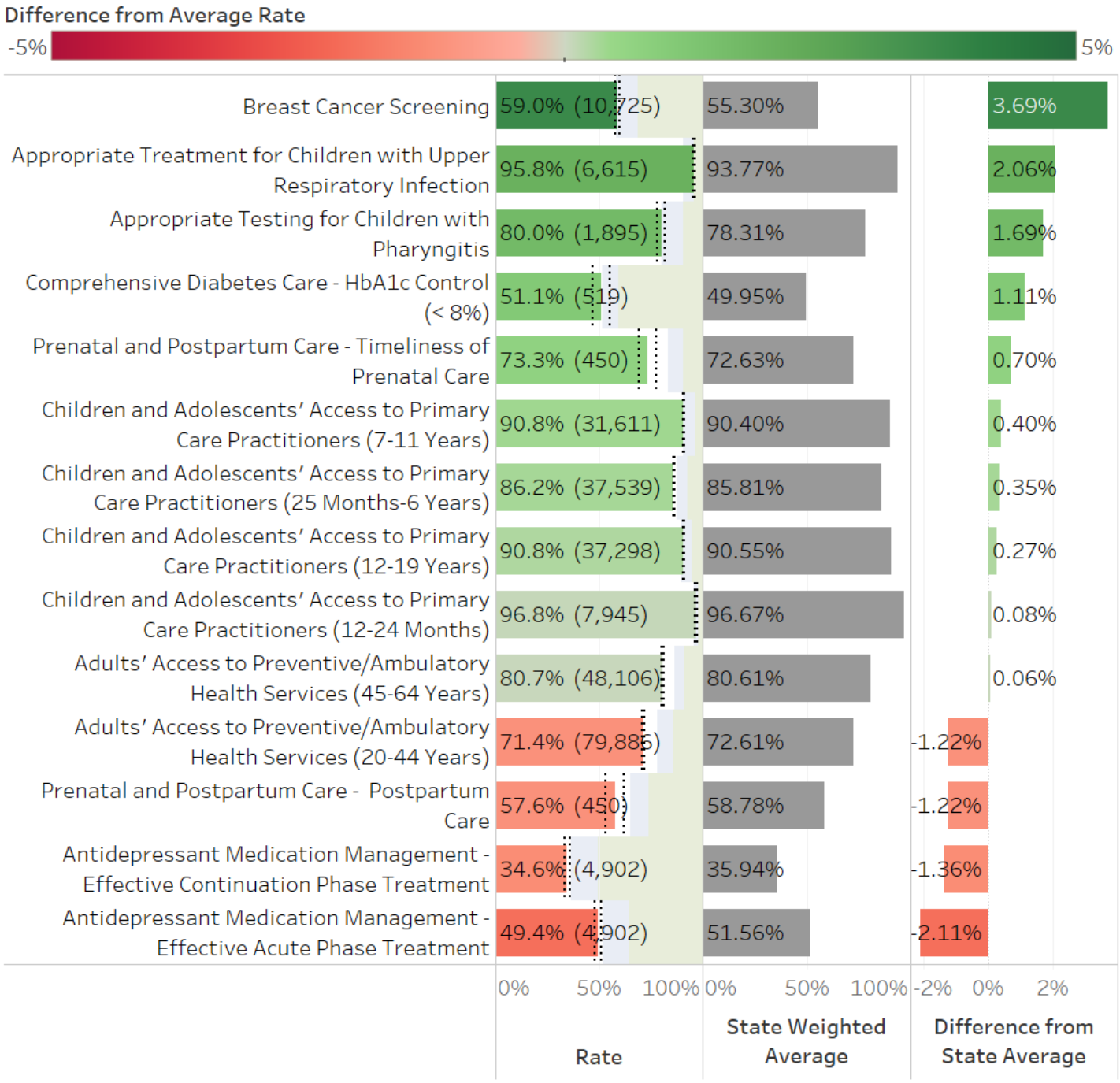
# Regional Scorecard: King

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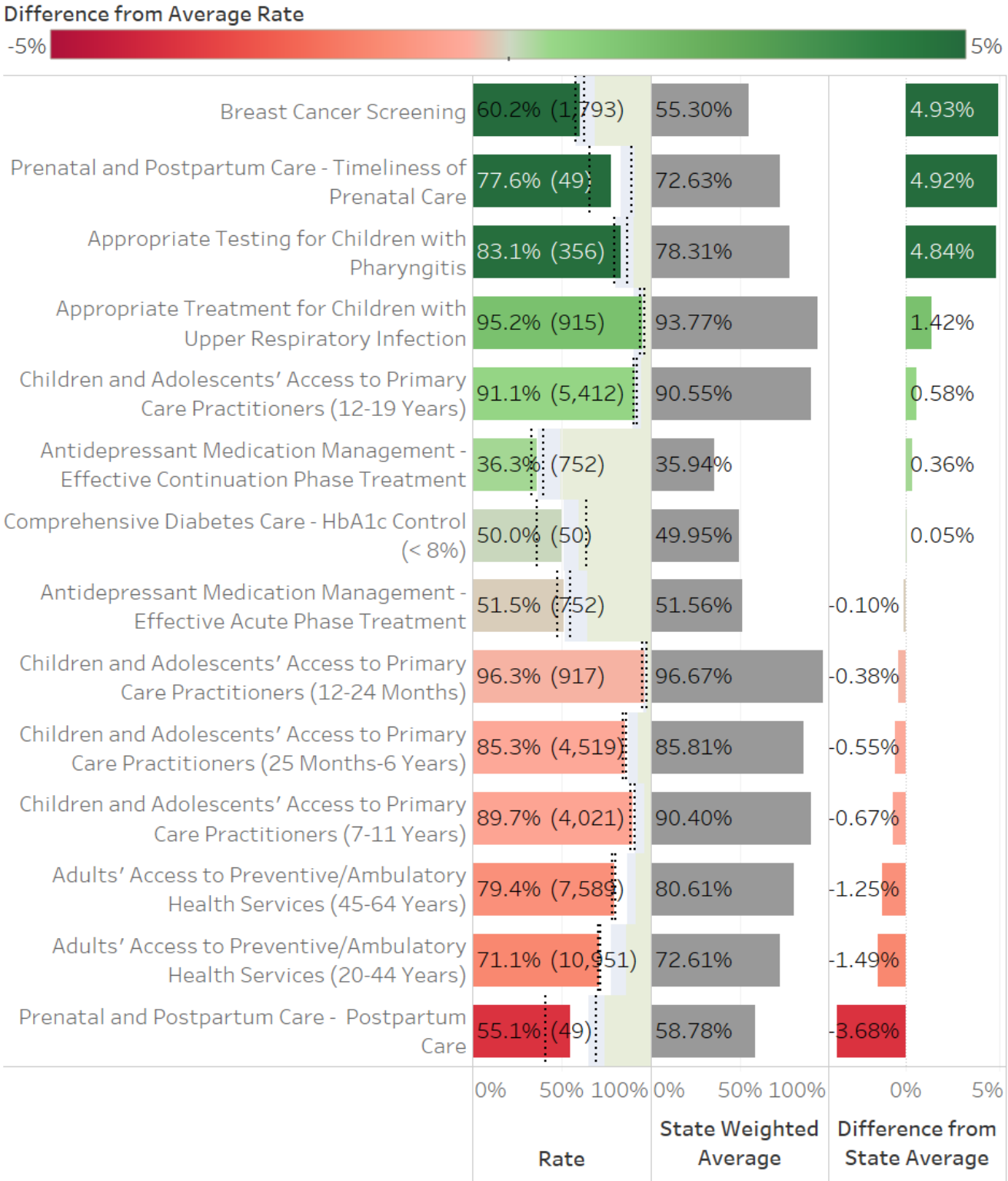
# Regional Scorecard: East King

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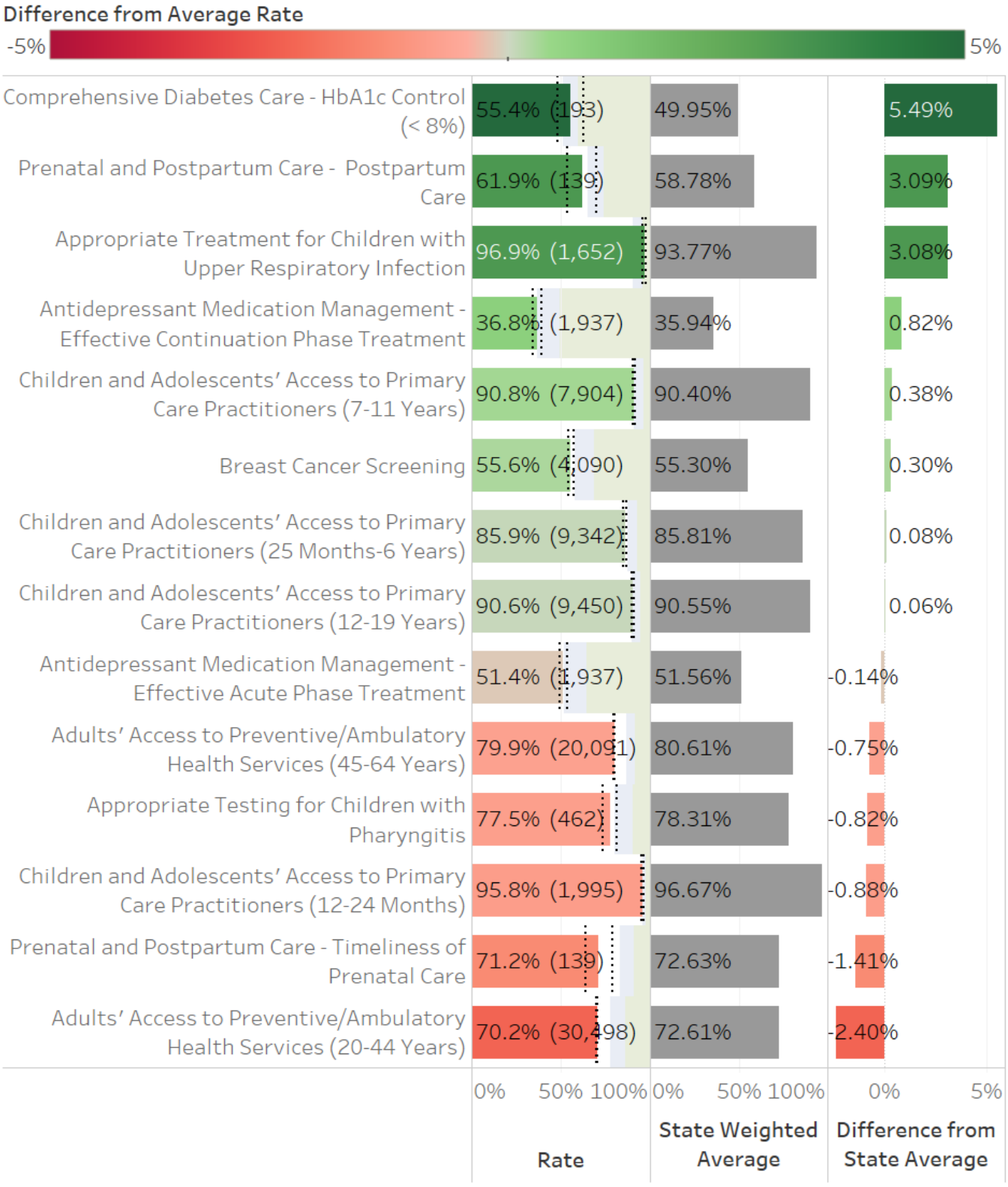
# Regional Scorecard: Seattle

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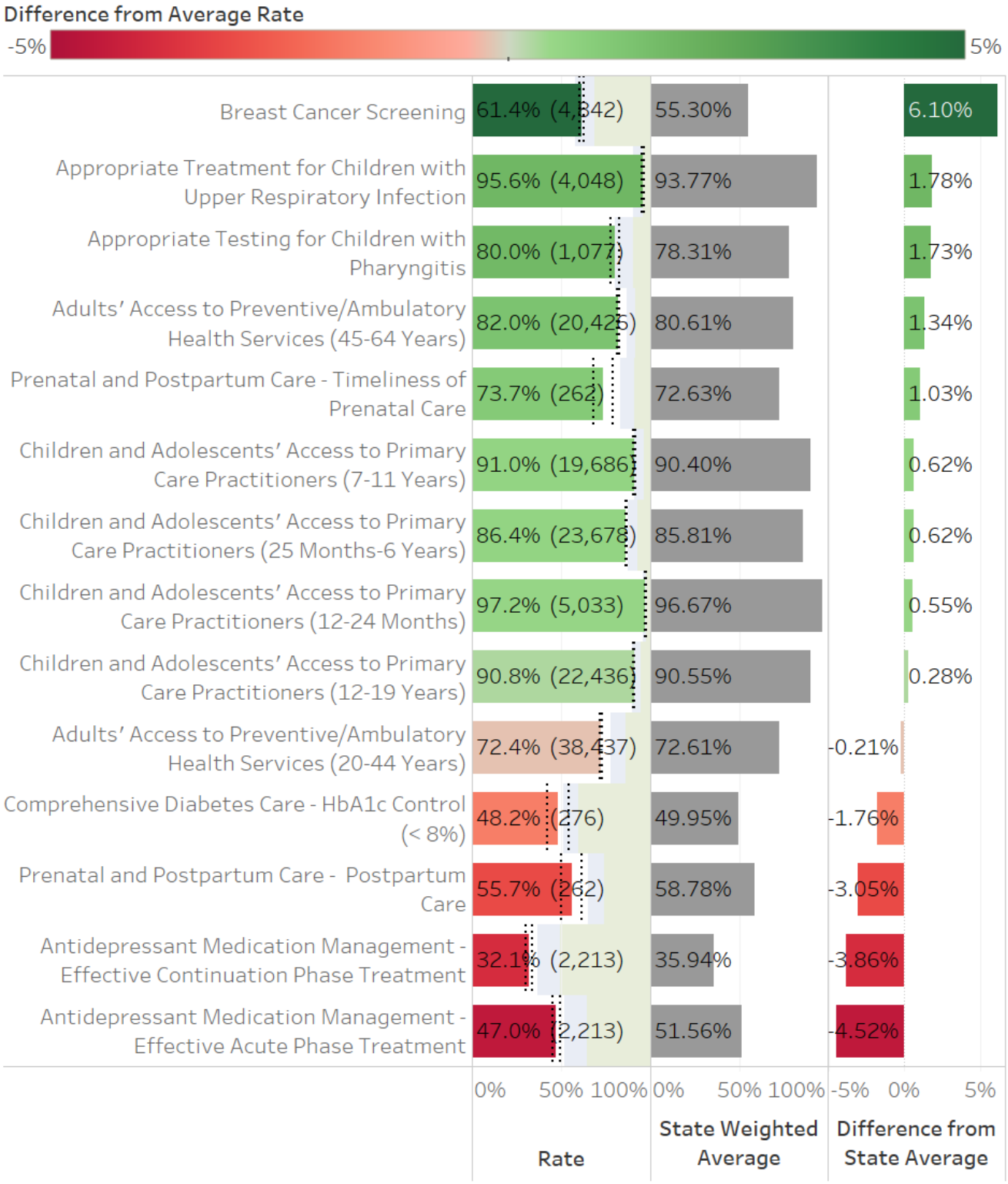
# Regional Scorecard: South King

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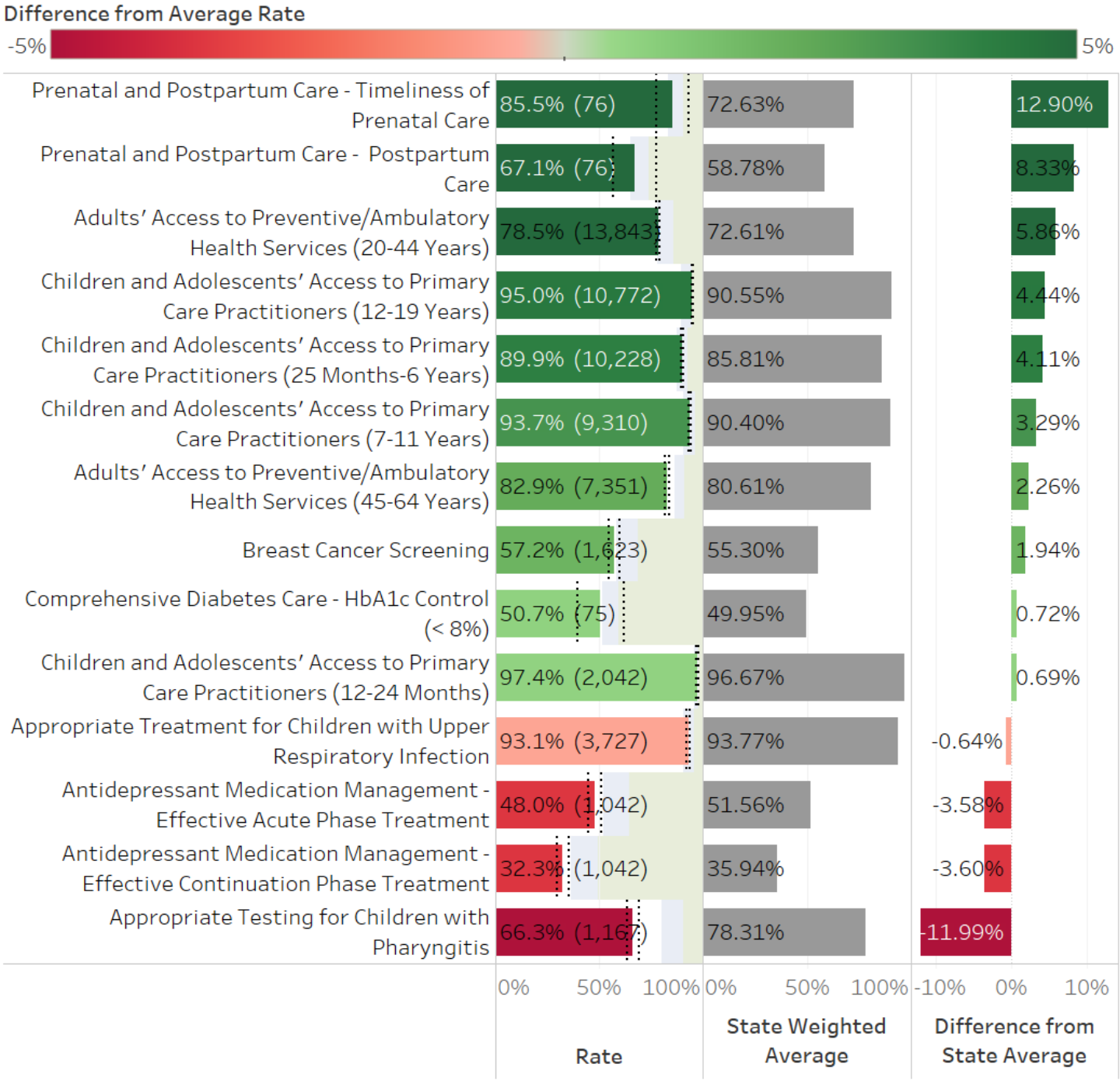
# Regional Scorecard: North Central

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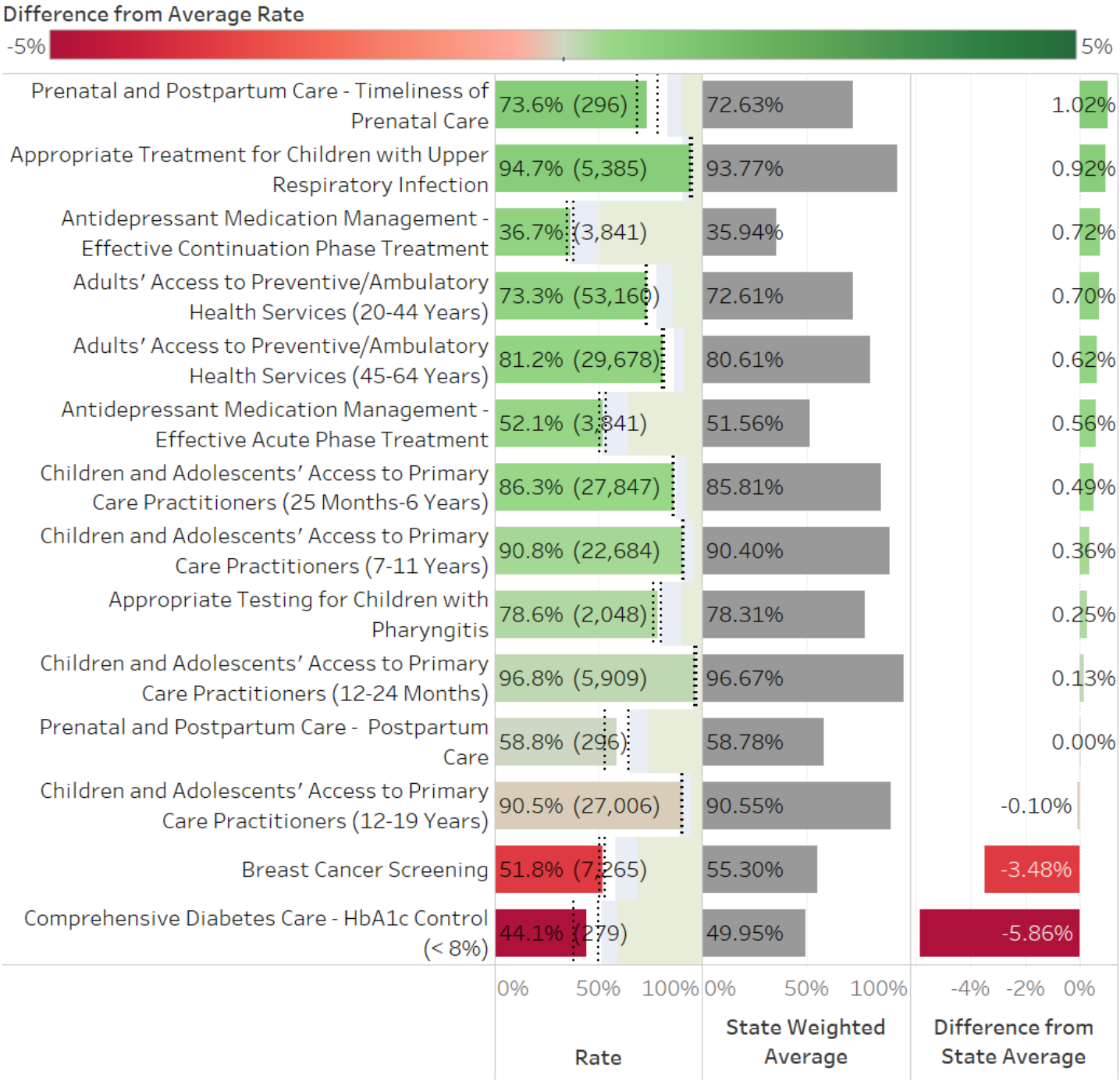
# Regional Scorecard: North Sound

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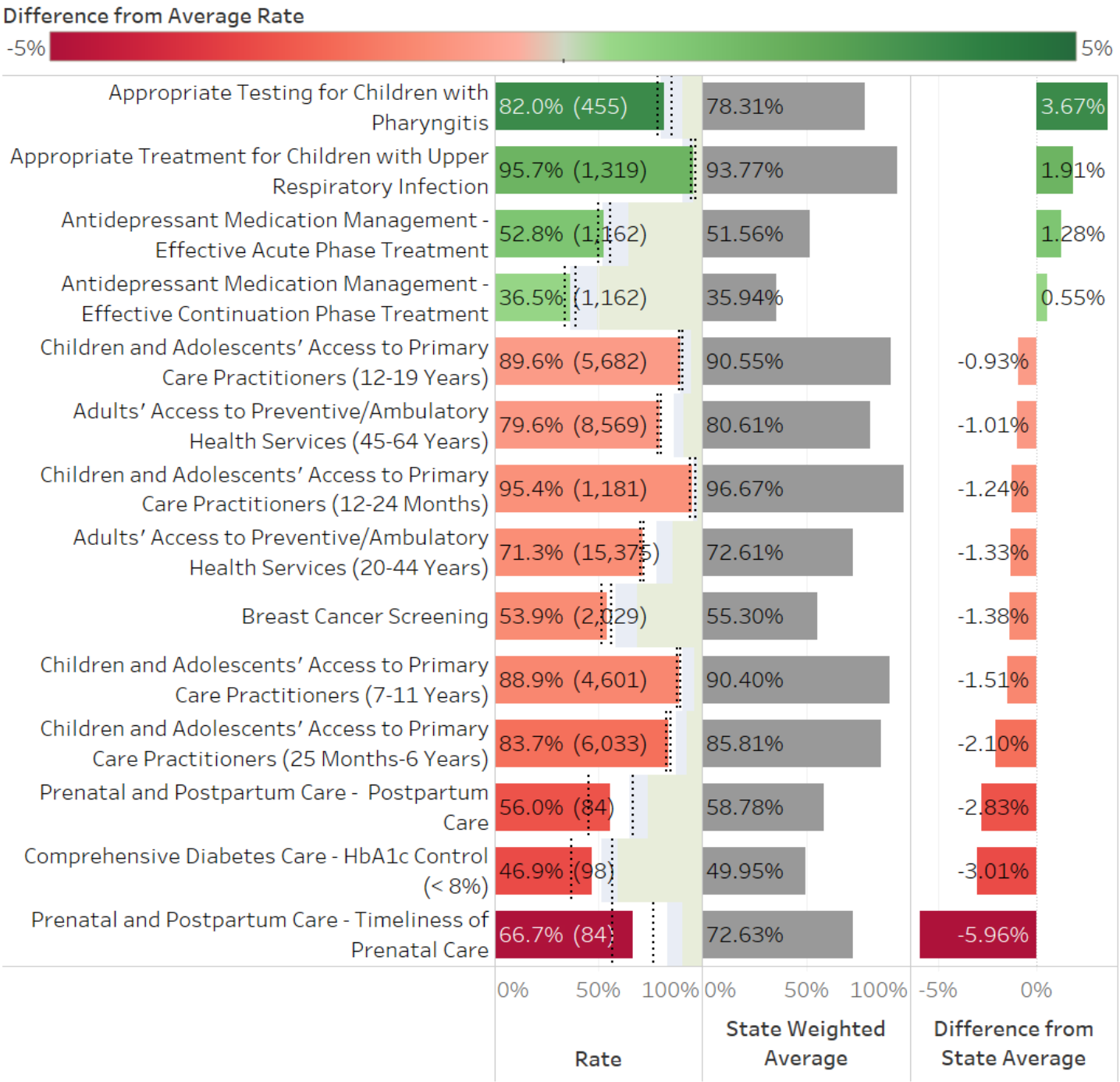
# Regional Scorecard: Olympic

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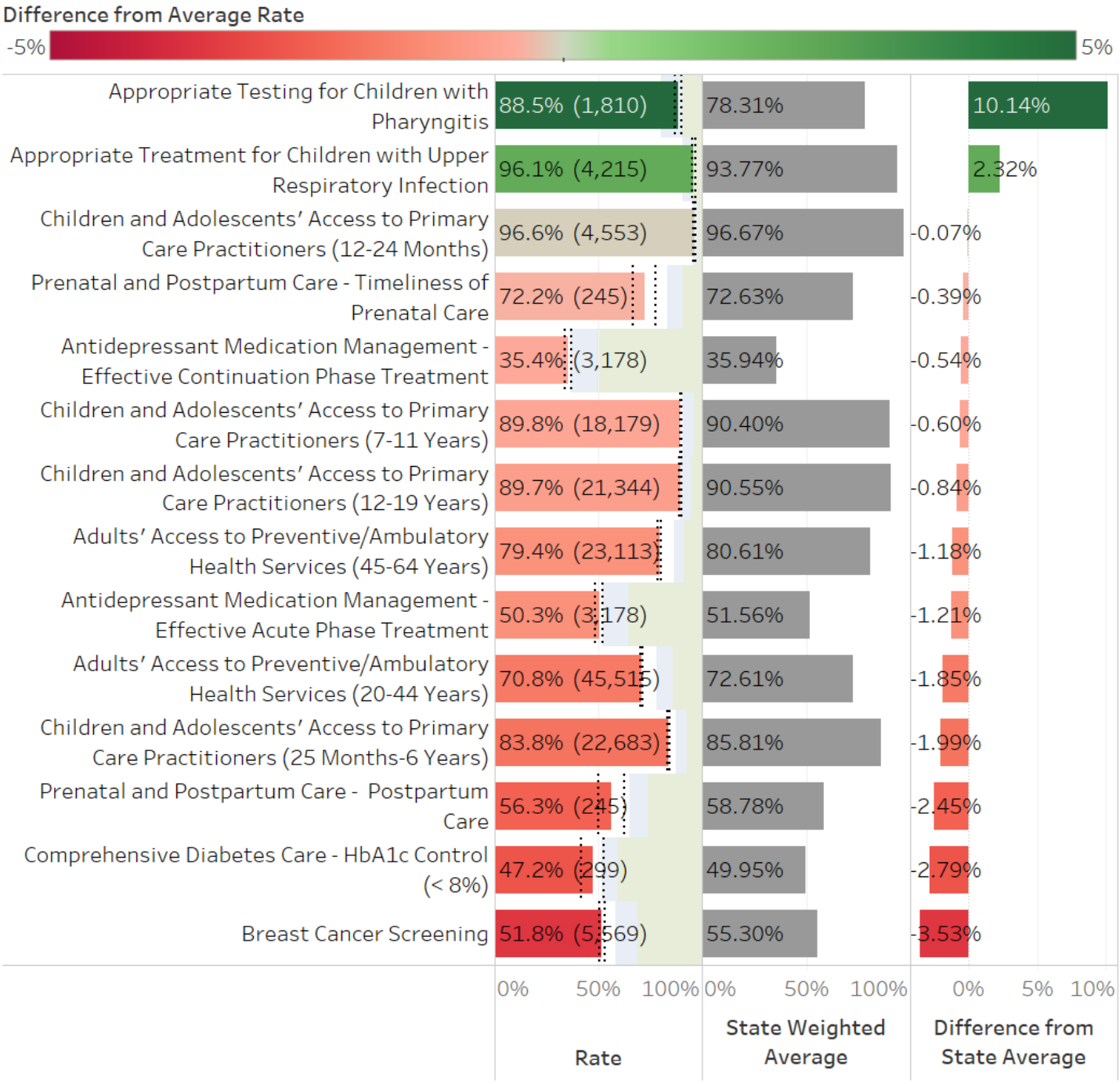
# Regional Scorecard: Pierce

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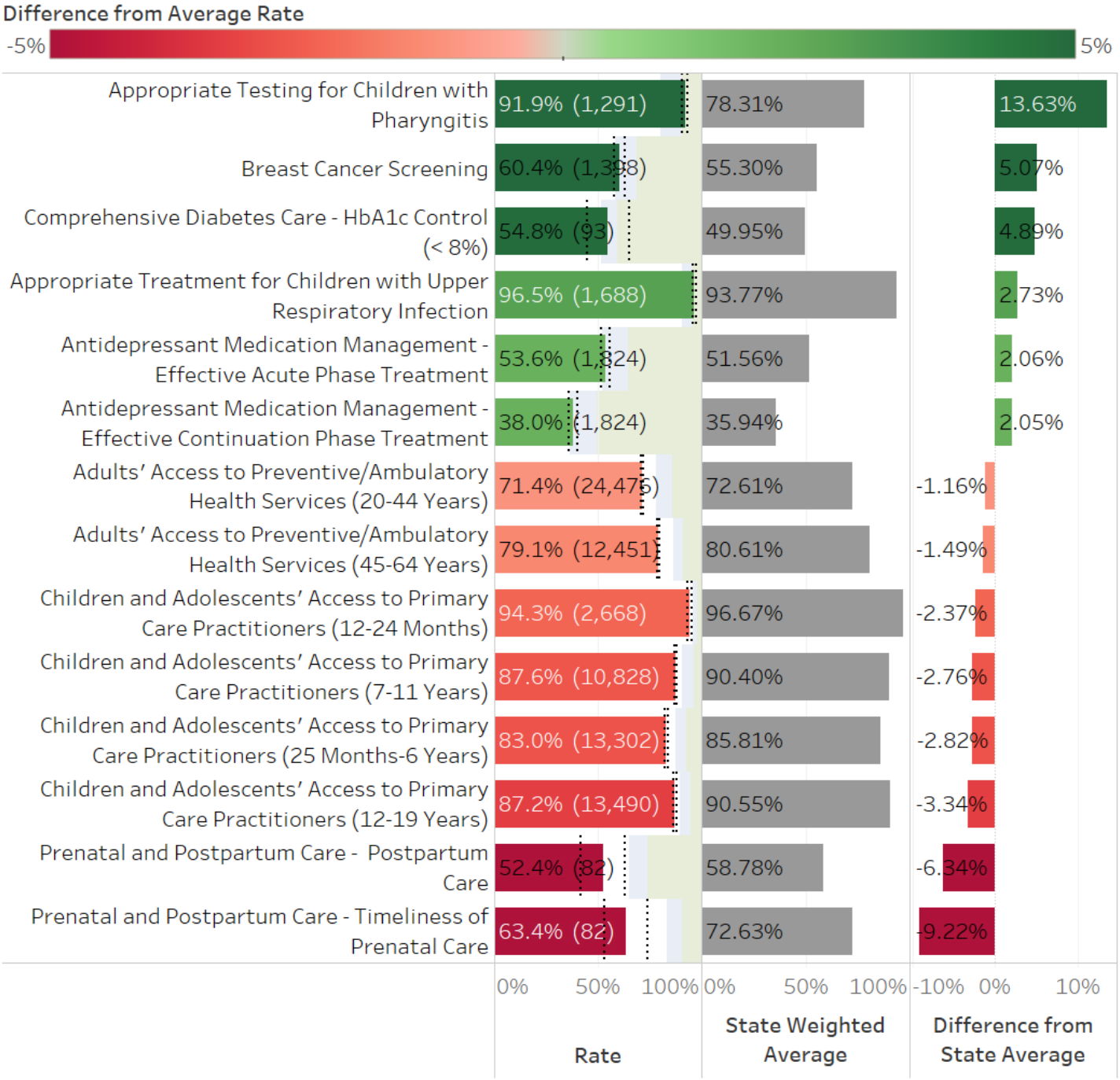
# Regional Scorecard: Southwest Washington

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