2017 Regional Analysis Report

Washington Apple Health

Washington Health Care Authority

December 2017

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.

This report was prepared by Qualis Health under contract K1324 with the Washington State Health Care Authority to conduct external quality review and quality improvement activities to meet 42 CFR §462 and 42 CFR §438, Managed Care, Subpart E, External Quality Review.

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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) 2016. The MCOs were required to report on 46 Healthcare Effectiveness Data and Information Set (HEDIS®)[1] measure items representing 168 submeasures, 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).

During 2016 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 2016 calendar year is referred to as the 2017 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, 2016, and December 31, 2016. 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 Utilization. Later chapters will explore these variations in greater detail.

[1] The HEDIS® measures and specifications were developed and are owned by the National Committee for Quality Assurance ("NCQA). The HEDIS measures and specifications are not clinical guidelines and do not establish standards of medical care. NCQA makes no representations, warranties, or endorsement about the quality of any organization or physician that uses or reports performance measures or any data or rates calculated using the HEDIS measures and specifications and NCQA has no liability to anyone who relies on such measures or specifications. ©2017 National Committee for Quality Assurance, all rights reserved.

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) declined slightly statewide since 2016 RY. Rates were highest in the North Central region on both measures, and higher generally in the eastern regions of the state. Analysis of variation by language and program indicated higher rates for English-speaking enrollees than non-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:** Performance improved slightly statewide on all sub-measures since 2016 RY. Regionally, except for the 12–24 months age group, variation on this measure (including sub-measures for 25 months–6 years, 7–11 years, and 12–19 years) was wide, with rates in the eastern regions considerably higher than rates in the western part of the state. North Central's rates were consistently highest in the state; they were lowest in Southwest Washington. Analysis by language showed higher rates for non-English speakers in most regions on all measures.
- **Maternal care measures:** Regional variation on the maternal care measures was wide, with 17–30 percentage points separating the highest and lowest regional rates for each measure. Generally, rates in the eastern part of the state were substantially higher than those in the west, although the rates in Southwest Washington were consistently and remarkably low. Although state rates are still considerably below the national average, performance improved since 2016 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:** Performance on the breast cancer screening measure varied significantly across the state, with higher rates in the eastern regions than in the west. Analysis of variation by language, race, and program showed substantially lower screening rates for white women and English speakers than for other races and for those enrollees with a non-English-language preference. Additionally, rates were higher for enrollees of Apple Health Adult Coverage (Medicaid expansion) than for enrollees of Apple Health Family (traditional Medicaid).

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 percent).

- **Antidepressant medication management:** Performance on this measure, which has dropped statewide since 2016 RY, revealed regional variation in both the acute and continuing antidepressant medication management submeasures, with higher rates in the western regions of the state. Rates in Southwest Washington outperformed all other regions on both measures, and North Central showed the lowest rates on both measures. Additional analyses showed rates to be lower for individuals whose primary language is Spanish and higher rates for the Apple Health Adult Coverage population (Medicaid expansion).
- **Comprehensive diabetes care—HbA1c control (< 8 percent):** Performance on the HbA1c control measure, which has improved statewide since 2016 RY, varied widely across the state, with 16 percentage points separating the highest (North Central) and lowest (Greater Columbia) regional rates.

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 2017 showed good performance statewide in avoiding inappropriate antibiotics use for children with upper respiratory infections, with little regional variation and little change since 2016 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 28 percent. Rates for English-speaking enrollees were substantially higher than for enrollees with all other language preferences for this measure.

Recommendations

Analysis of 2017 RY performance measure data revealed two distinct trends: Performance rates on physical health measures were considerably higher in the eastern regions of the state than in the western regions, whereas on behavioral health measures, this trend reversed, with rates considerably higher in the western parts of the state. Among the physical health measures, rates in Southwest Washington, where IMC has been implemented, were consistently lowest, often by considerable margins. Other identified variation included lower rates on some measures for enrollees with a non-English-language preference, including adult access to primary care measures and behavioral health measures. Based on these observations, Qualis Health recommends that HCA consider the following options:

- Examine root causes of low performance rates on physical health measures in the western regions of the state and, particularly, in Southwest Washington. Performance on access to primary care, maternal health, and women's health screening measures 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 to MCOs have a plan in place, ideally with timelines and deliverables, to improve performance.

- Examine root causes of low performance on 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.

- Language preference plays a critical role in healthcare delivery, yet currently, methods for collecting enrollees' preferred language data vary among the plans. To further understand the specific language challenges present in delivering equitable care, HCA should consider asking MCOs to expand options for capturing enrollees' preferred language data beyond "other" to include a variety of languages, and should standardize collection of this information among the plans. Obtaining an enhanced level of enrollee data may assist in identifying regions where additional outreach and other language assistance resources 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 2016 (reporting year 2017). To enable a reliable measurement of performance, the MCOs were required to report 46 HEDIS measures, representing 168 submeasures. HEDIS measures were developed and are maintained by the NCQA, whose database of HEDIS results for health plans —the Quality Compass®[2]—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 eight selected HEDIS measures Apple Health MCOs reported on in 2016 RY and 2017 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 eight 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. No hybrid measure 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.

[2] Quality Compass® 2016 is used in accordance with a Data License Agreement with the NCQA.

Member-Level Data

As part of the HEDIS audit process, each MCO was required to produce a patient-level data (PLD) file that conformed to NCQA specifications. These files provide patient-level information for all HEDIS quality measures to assist in the validation process.

HCA requested that each MCO's PLD 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.

The populations underlying each measure in this report represent Apple Health members enrolled with an MCO in Washington State between January 1, 2016, and December 31, 2016. 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 that were requested for analysis by Apple Health MCOs. Selected measures can be found in Table 2.

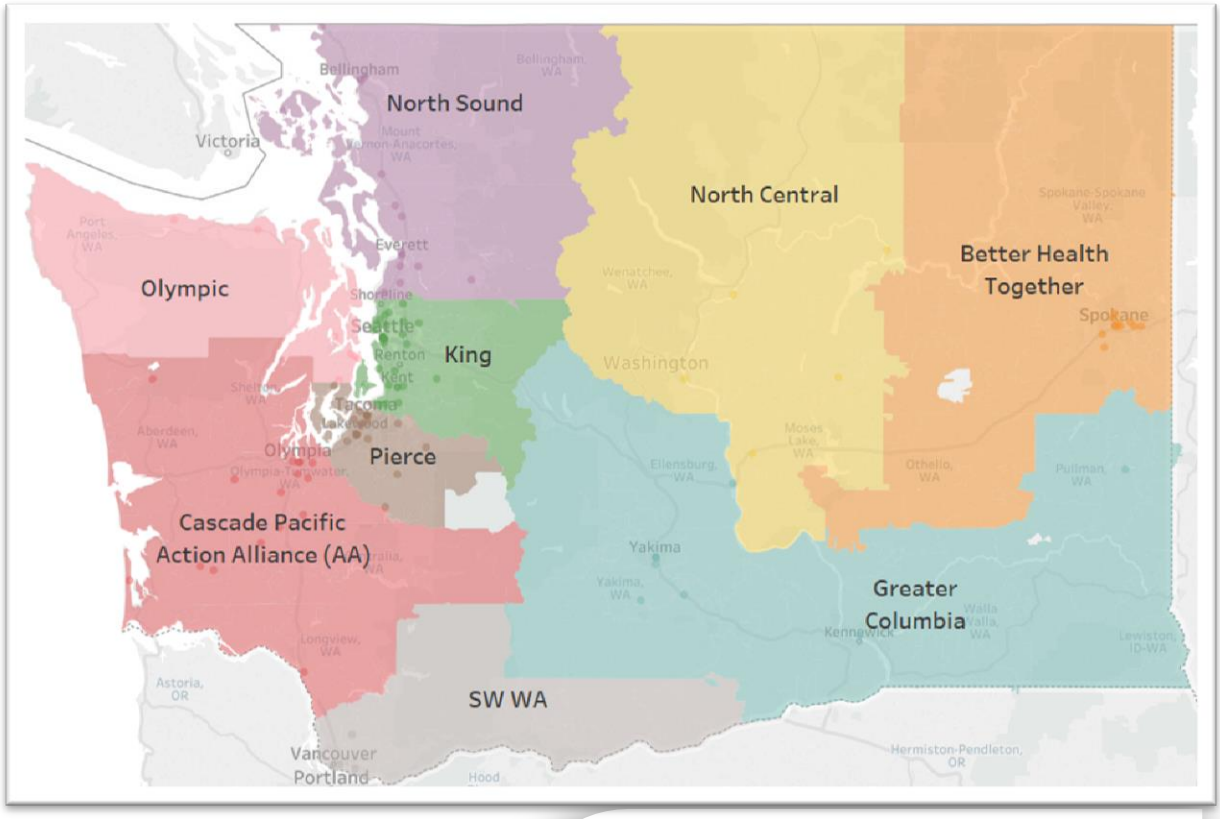
Table 2: Select HEDIS Hybrid Measures and Abbreviations

Abbreviation	HEDIS Measure
Access to Care	
PPC	Prenatal and Postpartum Care
FPC	Frequency of Ongoing Prenatal Care
Chronic Care Management	
CDC	Comprehensive Diabetes Care — HbA1c Control (< 8 Percent)

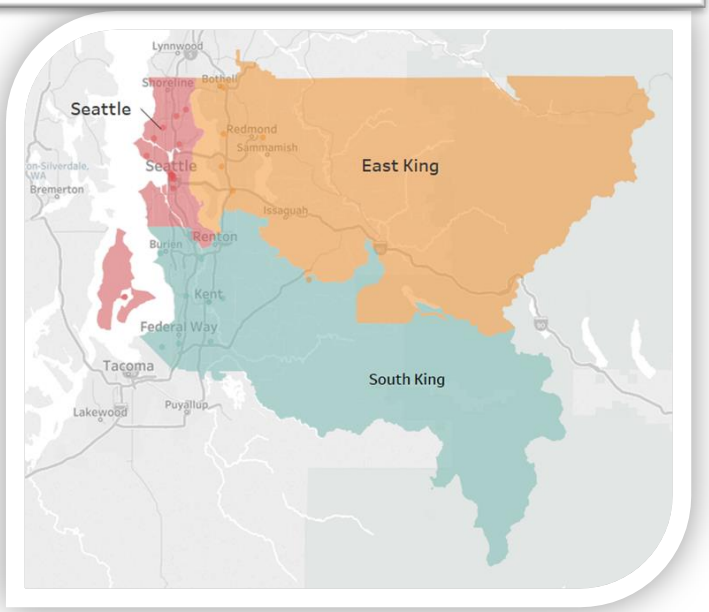
More information on MCO comparative performance on hybrid measures can be found in the *2017 Comparative Analysis Report.*

Areas of Analysis for Variation

- **Geographic Regions:** The regions delineated in this report are the Accountable Community of Health (ACH) boundaries for 2017, defined by the HCA as of May 2017.[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.



- **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.



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

- **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)

- **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. Depending upon the HEDIS measure, the impact of members enrolled in Apple Health Adult Coverage (Medicaid expansion) or Integrated Managed Care (IMC) on measure performance will vary.

It is interesting to note that most members in the Apple Health Family program (traditional Medicaid) are under the age of 20 (82.5 percent), while the majority of members in the Apple Health Adult Coverage program (Medicaid expansion) are between the ages of 20 and 50 (73 percent), and 30 percent of members in that program are between the ages of 20 and 30. With this influx of members highly concentrated in the 20–50 years age range, it is reasonable to see limited to no improvement for adult-focused measures while MCOs adjust to the changing demographics and increase capacity to care for this new population.

Another population to monitor is the IMC program population. While this program is relatively new and administered only by CHPW and MHW, 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. Currently, the IMC population accounts for 4.7 percent of all Medicaid enrollees in Washington, and the age distribution for this population is relatively evenly distributed, with a higher concentration only for enrollees under the age of 10 (26 percent).

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

Table 3: 2017 RY Enrollee Population by Apple Health Program
1,318,385 Enrollees in Total

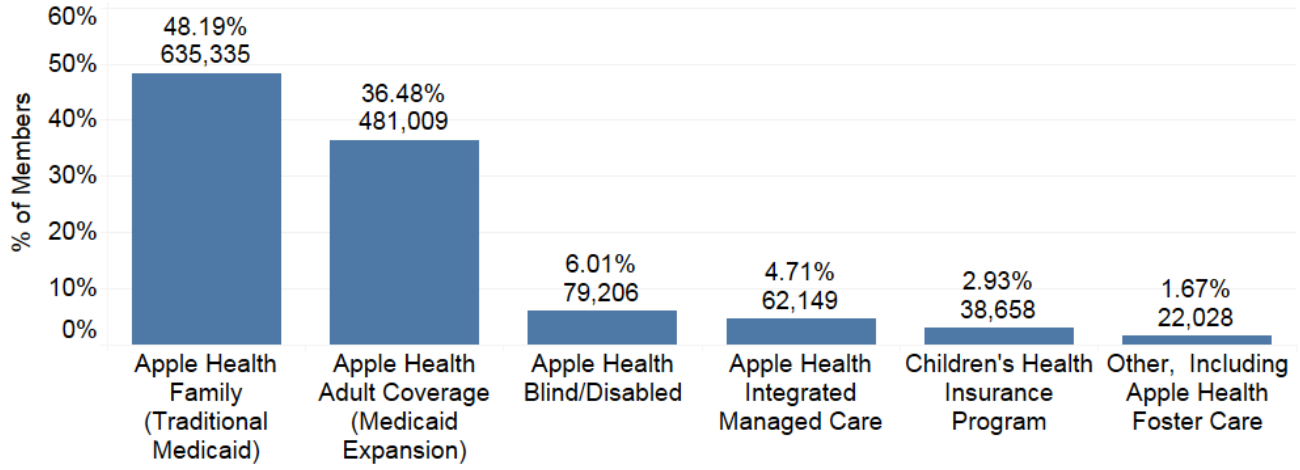


Table 4: 2017 RY Enrollee Population by Age

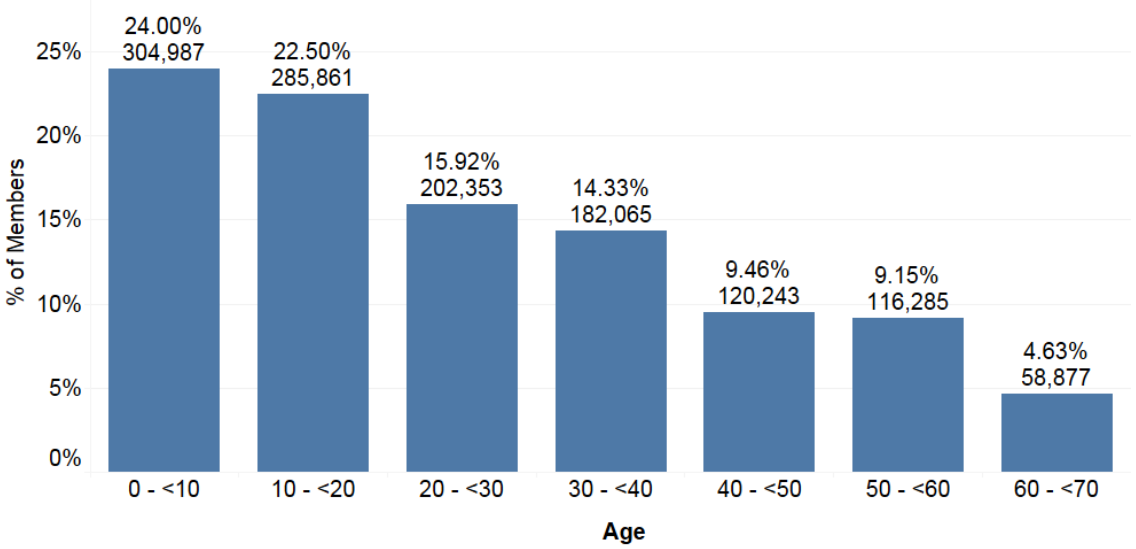
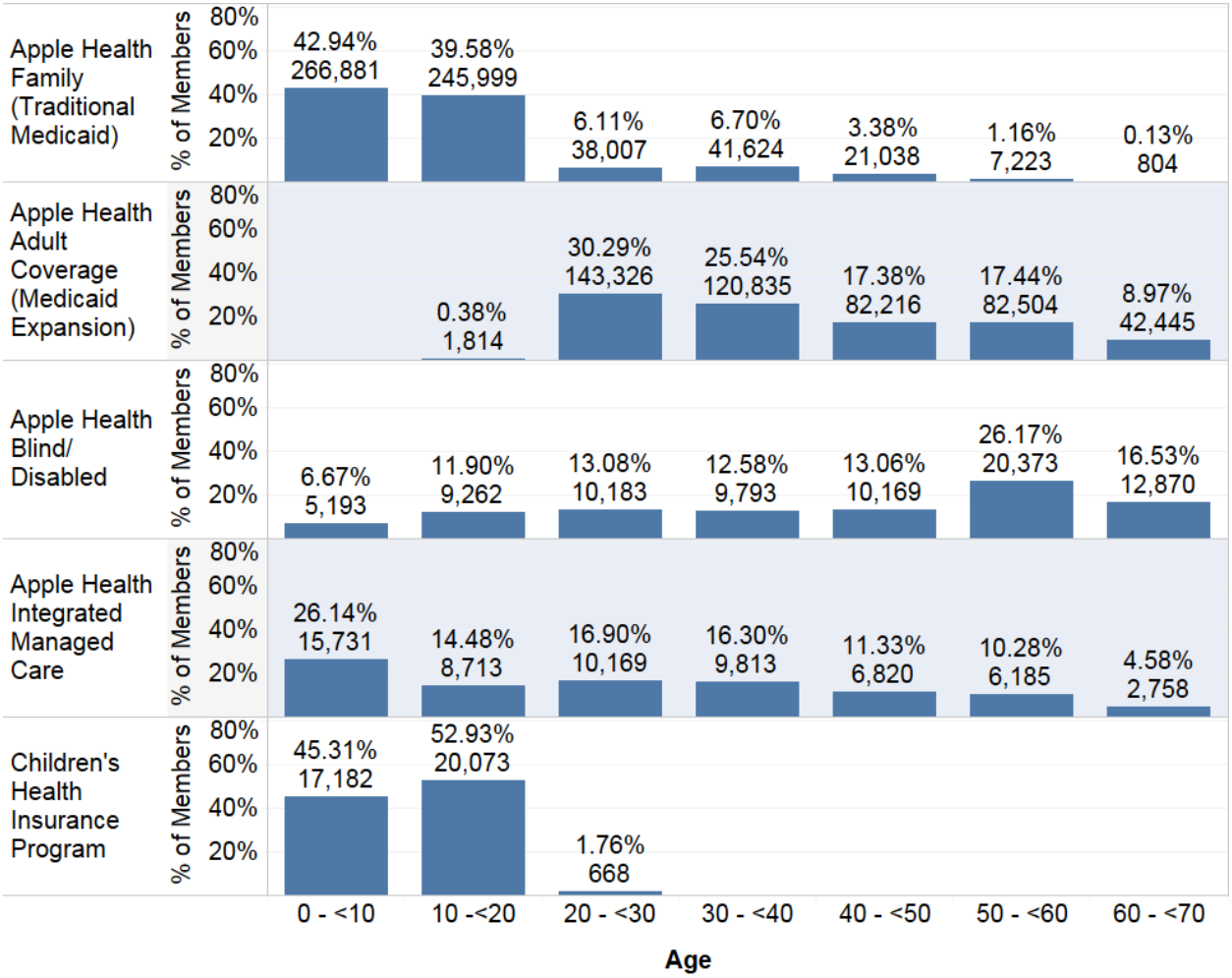
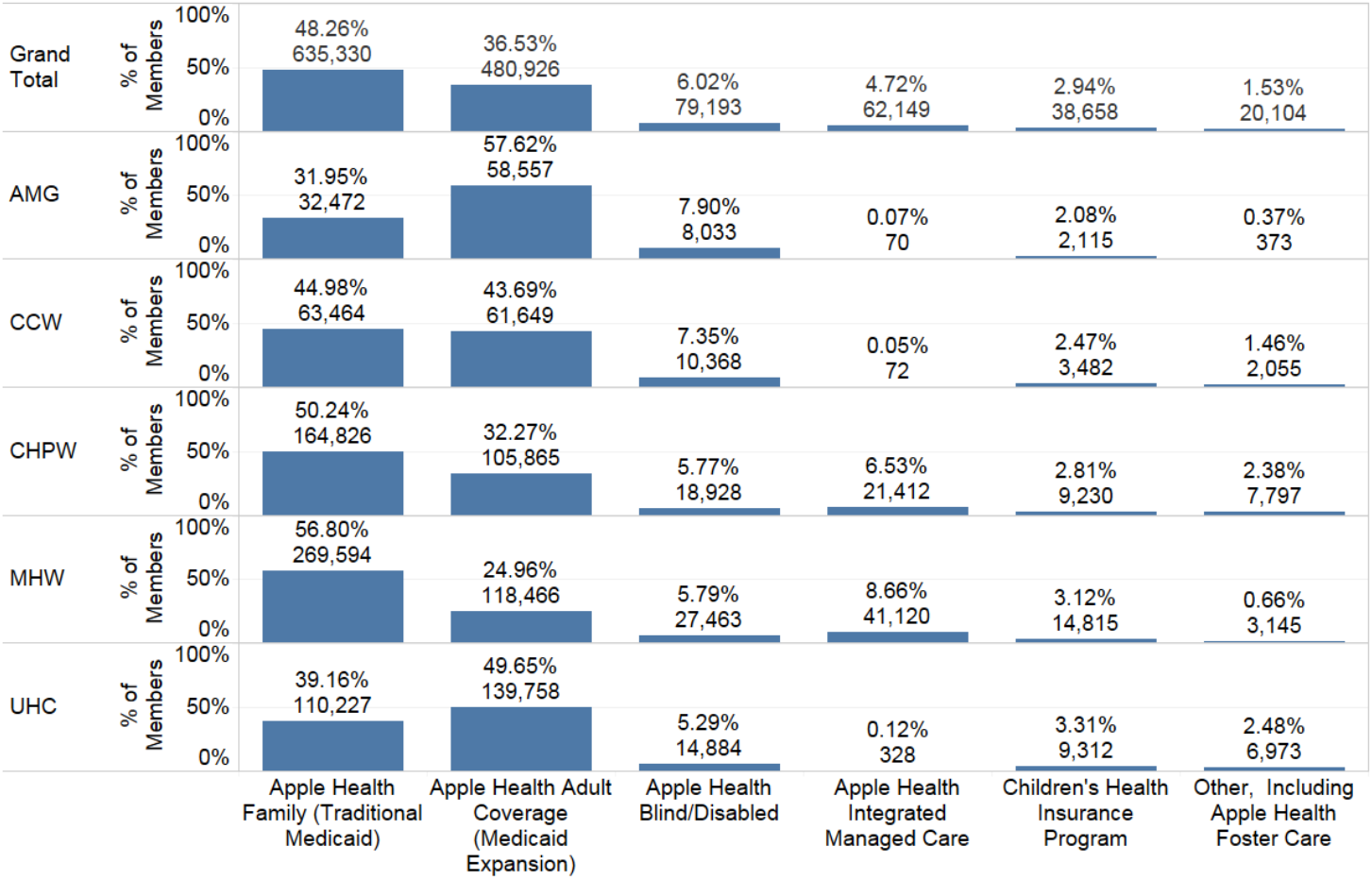


Table 5: 2017 RY Enrollee Population by Apple Health Program and Age



It is important to note that the relative distribution of these members is not uniform across MCOs. For example, 57.6 percent of AMG's members are enrolled in Apple Health Adult Coverage (Medicaid expansion), while only 24.96 percent of MHW members are enrolled in that program. Additionally, only CHPW and MHW administered IMC in 2016 (note that while Table 6 reflects IMC enrollment in other MCOs, this likely reflects enrollees who relocated to different regions during the data pull). 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: 2017 RY Member Population by Apple Health Program and Plan



Overall, Apple Health MCOs experienced a total growth rate of 8.35 percent from December 2015 to December 2016 CY. The largest MCO, MHW, grew by over 18 percent during this time. CCW's enrollee population also grew by more than 10 percent. Note that MHW (the largest MCO) is over four times the size of the smallest MCO (AMG), and MHW is more than double the size of the second-largest MCO (CHPW). Table 7 shows Apple Health enrollment by plan for the 2014, 2015, and 2016 calendar years.

***Table 7: Apple Health Enrollment, December 2014, December 2015, December 2016 CY*[4]**

	December 2014 CY Enrollment	December 2015 CY Enrollment	December 2016 CY Enrollment	Percent Change Dec 2015 to Dec 2016 CY
AMG	128,369	141,571	149,314	5.19%
CHPW	332,456	294,141	297,725	1.20%
CCW	175,353	181,801	207,342	12.31%
MHW	486,524	566,201	697,392	18.81%
UHC	180,225	204,078	224,973	9.29%
Total	1,302,927	1,445,093	1,576,746	8.35%

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 regions are in AHAC (Medicaid expansion). East King and Olympic regions both have higher levels of AHAC enrollees compared to other regions. North Central and Greater Columbia have the highest percentages of traditional Medicaid enrollees, at 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)	49.17% 68,176	48.11% 64,521	59.18% 110,125	43.88% 19,071	35.40% 36,973	54.71% 87,326	59.88% 38,799	49.67% 101,781	43.90% 21,407	51.09% 82,435	6.76% 4,821	**48.23% 635,332**
Apple Health Adult Coverage (Medicaid Expansion)	39.04% 54,125	39.39% 52,834	31.32% 58,280	46.06% 20,021	52.94% 55,292	34.72% 55,423	30.60% 19,828	38.99% 79,897	43.39% 21,159	37.35% 60,260	5.43% 3,875	**36.51% 480,926**
Apple Health Blind/Disabled	7.32% 10,147	8.07% 10,817	5.31% 9,881	4.23% 1,838	7.30% 7,624	5.51% 8,792	5.05% 3,271	5.42% 11,112	7.79% 3,800	7.22% 11,646	1.02% 727	**6.05% 79,644**
Apple Health Integrated Managed Care	0.08% 113	0.55% 744	0.07% 121	0.07% 30	0.06% 62	0.05% 83	0.05% 30	0.06% 132	0.06% 27	0.07% 110	85.11% 60,731	**4.72% 62,167**
Children's Health Insurance Program	2.88% 3,988	2.17% 2,908	2.73% 5,078	4.23% 1,837	2.56% 2,669	3.44% 5,494	3.10% 2,009	4.17% 8,538	2.87% 1,398	2.81% 4,534	0.29% 206	**2.93% 38,658**
				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 sub-region, 36 percent of enrollees are between the ages of 20 and 40, while in South King, 53 percent of members are younger than 20. North Central and Greater Columbia have the highest percentages of members under 20 at 58.9 percent and 57.9 percent, respectively.

Table 9: Enrollee Age Distribution by Region

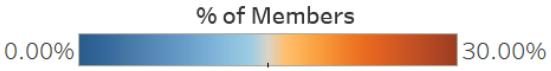
% of Members: 0.0% – 100.0%

	Better Health Together	Cascade Pacific AA	Greater Columbia	King			North Central	North Sound	Olympic	Pierce	SW WA	Grand Total
				East King	Seattle	South King						
0 - <20	46.19% 64,173	44.21% 59,416	57.91% 107,879	42.57% 18,522	33.55% 35,099	52.62% 84,109	58.91% 38,209	48.27% 99,051	40.80% 19,952	47.04% 76,050	41.84% 29,876	**47.92% 632,227**
20 - <40	31.72% 44,072	31.32% 42,099	25.94% 48,323	30.22% 13,150	36.38% 38,058	27.01% 43,179	23.33% 15,133	29.22% 59,949	33.24% 16,253	30.87% 49,914	33.19% 23,699	**29.84% 393,761**
40 - <60	18.42% 25,591	20.26% 27,237	13.42% 25,006	21.37% 9,300	24.13% 25,242	16.69% 26,672	14.34% 9,300	18.21% 37,365	21.11% 10,322	18.47% 29,857	21.11% 15,075	**18.26% 240,932**
60 +	3.66% 5,086	4.18% 5,622	2.71% 5,046	5.76% 2,506	5.90% 6,171	3.64% 5,821	3.39% 2,196	4.28% 8,776	4.83% 2,364	3.61% 5,832	3.83% 2,733	**3.95% 52,152**

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, over 40 percent of enrollees identify as Hispanic or Latino. In Seattle, 24 percent of members identify as black, higher than in all other regions.

Table 10: Enrollee Language Preference and Race by Region



Language

		Better Health Together	Cascade Pacific AA	Greater Columbia	King: East King	King: Seattle	King: South King	North Central	North Sound	Olympic	Pierce	SW WA	Grand Total
Non-English	% of Members	6.09%	6.46%	26.18%	13.18%	12.33%	19.40%	28.43%	11.76%	4.60%	8.21%	9.13%	**13.66%**
		8,465	8,685	48,770	5,736	12,895	31,005	18,439	24,129	2,250	13,281	6,520	**180,164**

Race

		Better Health Together	Cascade Pacific AA	Greater Columbia	King: East King	King: Seattle	King: South King	North Central	North Sound	Olympic	Pierce	SW WA	Grand Total
Hispanic or Latino & Other	% of Members	10.29%	11.19%	46.08%	15.52%	10.95%	20.63%	41.35%	16.73%	8.45%	14.84%	13.81%	**20.12%**
		14,292	15,046	85,854	6,751	11,455	32,980	26,815	34,335	4,132	23,987	9,860	**265,487**
Black	% of Members	3.89%	3.00%	1.89%	5.61%	24.24%	16.64%	1.00%	4.52%	5.24%	13.45%	3.59%	**7.89%**
		5,405	4,031	3,516	2,442	25,352	26,597	651	9,266	2,564	21,738	2,564	**104,114**
Asian	% of Members	1.86%	2.34%	1.03%	12.85%	12.44%	10.88%	0.59%	5.10%	2.73%	6.36%	4.05%	**5.23%**
		2,583	3,142	1,918	5,589	13,016	17,395	382	10,455	1,336	10,282	2,889	**68,985**
American Indian & Alaska Native	% of Members	1.35%	1.14%	0.66%	0.40%	0.60%	0.54%	0.93%	1.06%	1.11%	0.75%	0.52%	**0.85%**
		1,882	1,530	1,235	172	631	856	604	2,177	541	1,218	368	**11,213**
Native Hawaiian & Other Pacific Islander	% of Members	1.23%	1.46%	0.78%	3.19%	3.96%	5.49%	0.29%	2.17%	3.95%	3.70%	1.11%	**2.49%**
		1,713	1,966	1,453	1,388	4,146	8,774	190	4,460	1,931	5,985	791	**32,797**
Unknown	% of Members	6.10%	7.14%	7.94%	11.84%	8.66%	11.80%	7.13%	9.12%	6.56%	7.88%	7.22%	**8.36%**
		8,474	9,590	14,786	5,151	9,057	18,855	4,625	18,709	3,208	12,738	5,155	**110,330**

Regional Comparison: 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
- Frequency of ongoing prenatal care

A higher score indicates better performance.

In this section, the following key applies:

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

90^{th}+ national percentile

Confidence interval around measure outcome

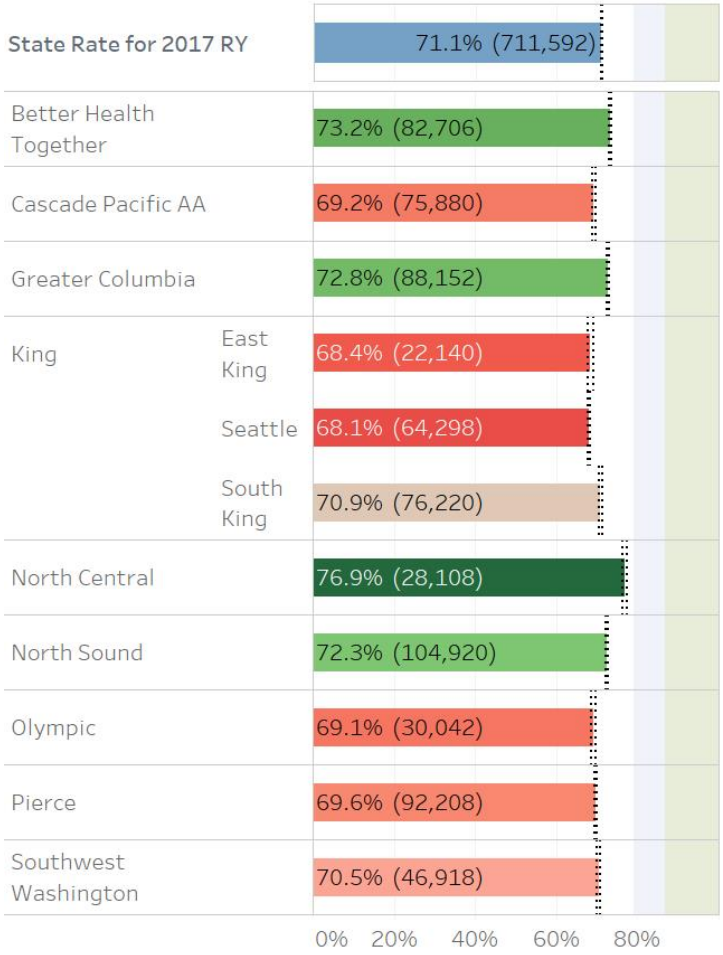
Adults' Access to Preventive/Ambulatory Health Services

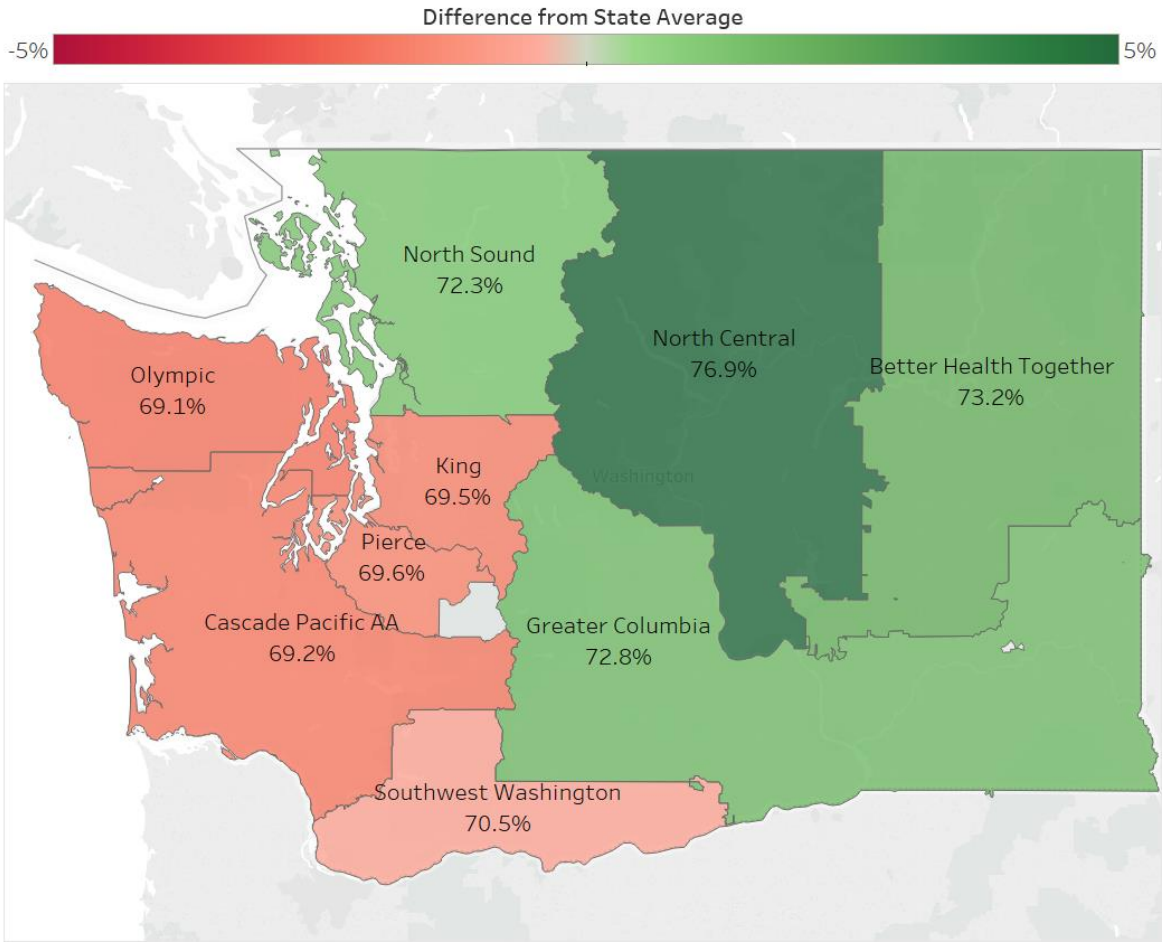
Adults' access to preventive/ambulatory health services (AAP) is defined as the percentage of enrollees ages 20 years and older who had an ambulatory or preventive care visit in the last year. This measure excludes acute inpatient encounters and emergency department (ED) visits. This section includes 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 over 7 percent lower. Performance was the lowest in Seattle, with only 68.1 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

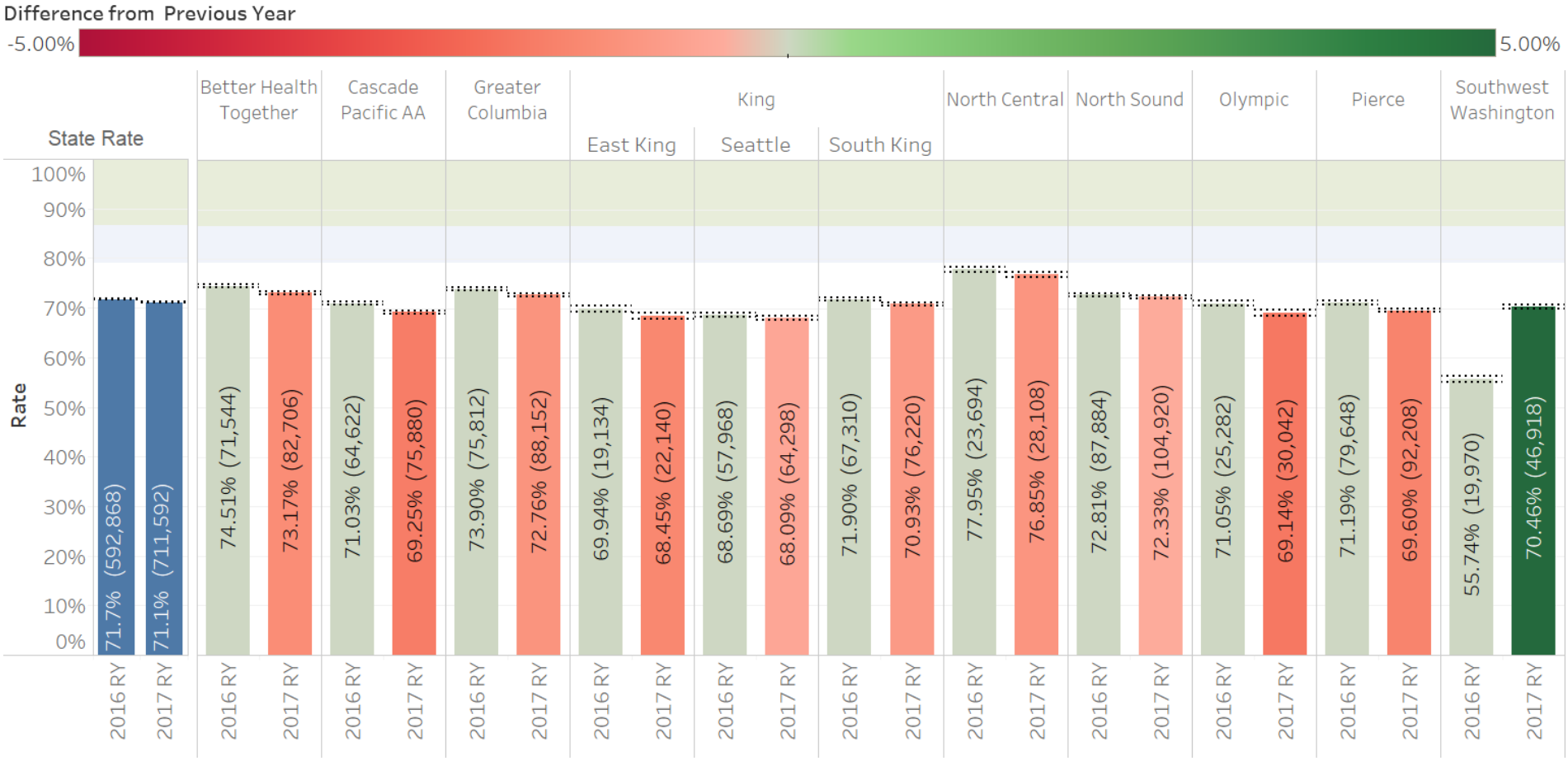




Year-to-Year Performance

Since 2016 RY, statewide performance on the AAP measure dropped slightly yet significantly (because of the large population size, even a small shift may be a statistically significant change). Performance dropped in every region for this measure, except for Southwest Washington, which showed an increase.

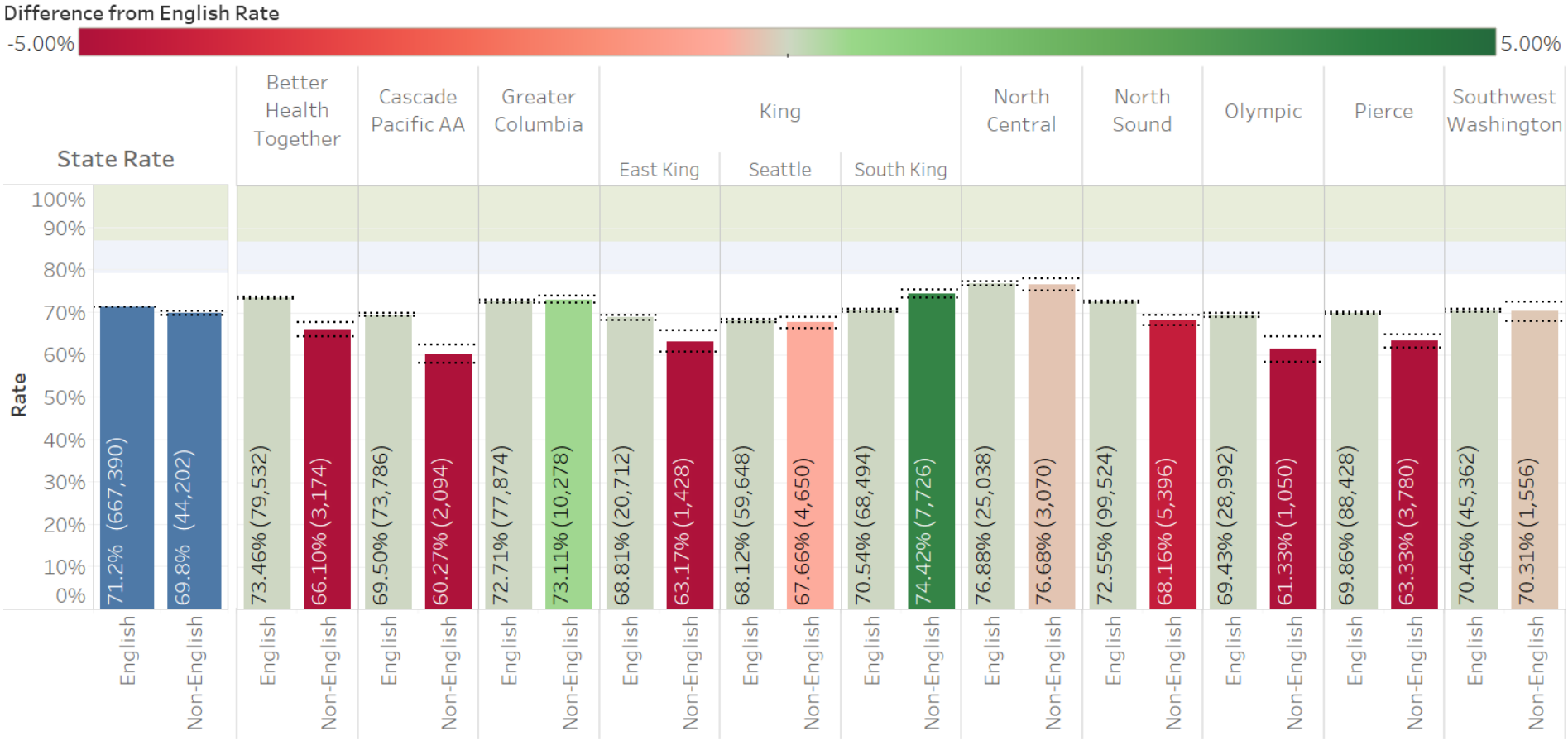
Table 12: AAP (20–44) Performance Statewide and by Region, 2016 RY to 2017 RY



Variation by Language

Several regions showed lower rates on this measure for enrollees with a non-English-language preference compared to those enrollees who prefer English. The Better Health Together, Cascade Pacific AA, Olympic, Pierce, and East King regions all showed rate differences of over 5 percent between English and non-English speakers. Non-English-speaking enrollees in South King showed better rates than English-speaking enrollees for this measure by 4 percent. Greater Columbia and North Central showed high rates for both English and non-English speakers. The range in access rates for non-English speakers across the state was nearly 16 percent. One consideration for the State may be to increase outreach efforts in areas where access rates are lower for enrollees with a non-English-language preference.

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

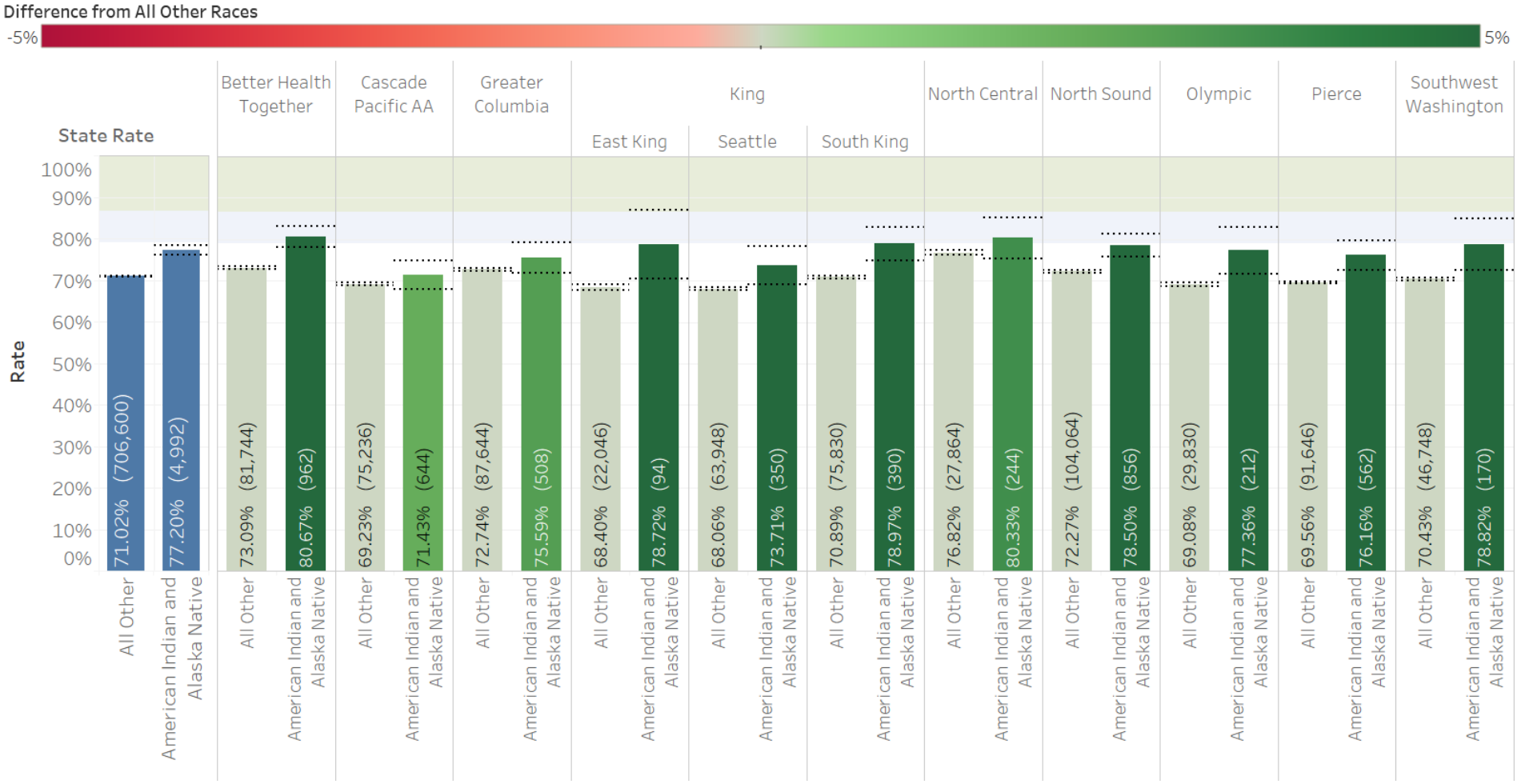


Variation by Race

Analysis of this measure across racial groups identified lower rates for Native Hawaiian and Pacific Islander enrollees statewide. Conversely, as shown in Table 15, rates were notably higher for American Indian and Alaska Native enrollees, with significant differences between rates for American Indian/Alaska Natives and all other groups in most regions.

Table 14: AAP (20–44) Performance Variation by Region and Race

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



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

Apple Health Adult Coverage (Medicaid Expansion) Rates by Plan

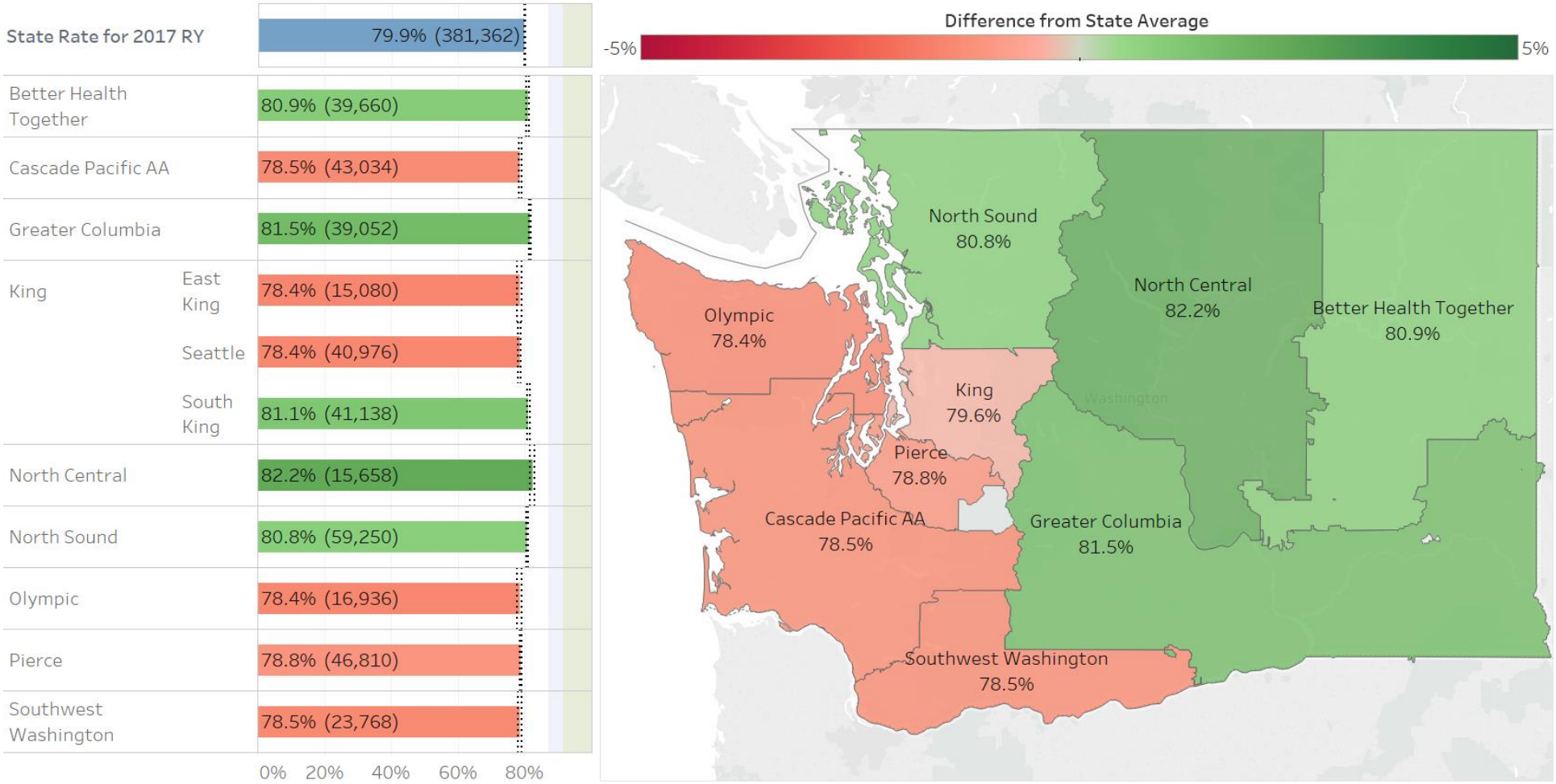
A comparison of MCO performance on this measure for the Apple Health Adult Coverage (Medicaid expansion) population shows MHW performing higher than the other MCOs in most regions statewide. Only CHPW in Greater Columbia and Olympic and CCW in North Central show comparatively high rates.

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

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 82.2 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.

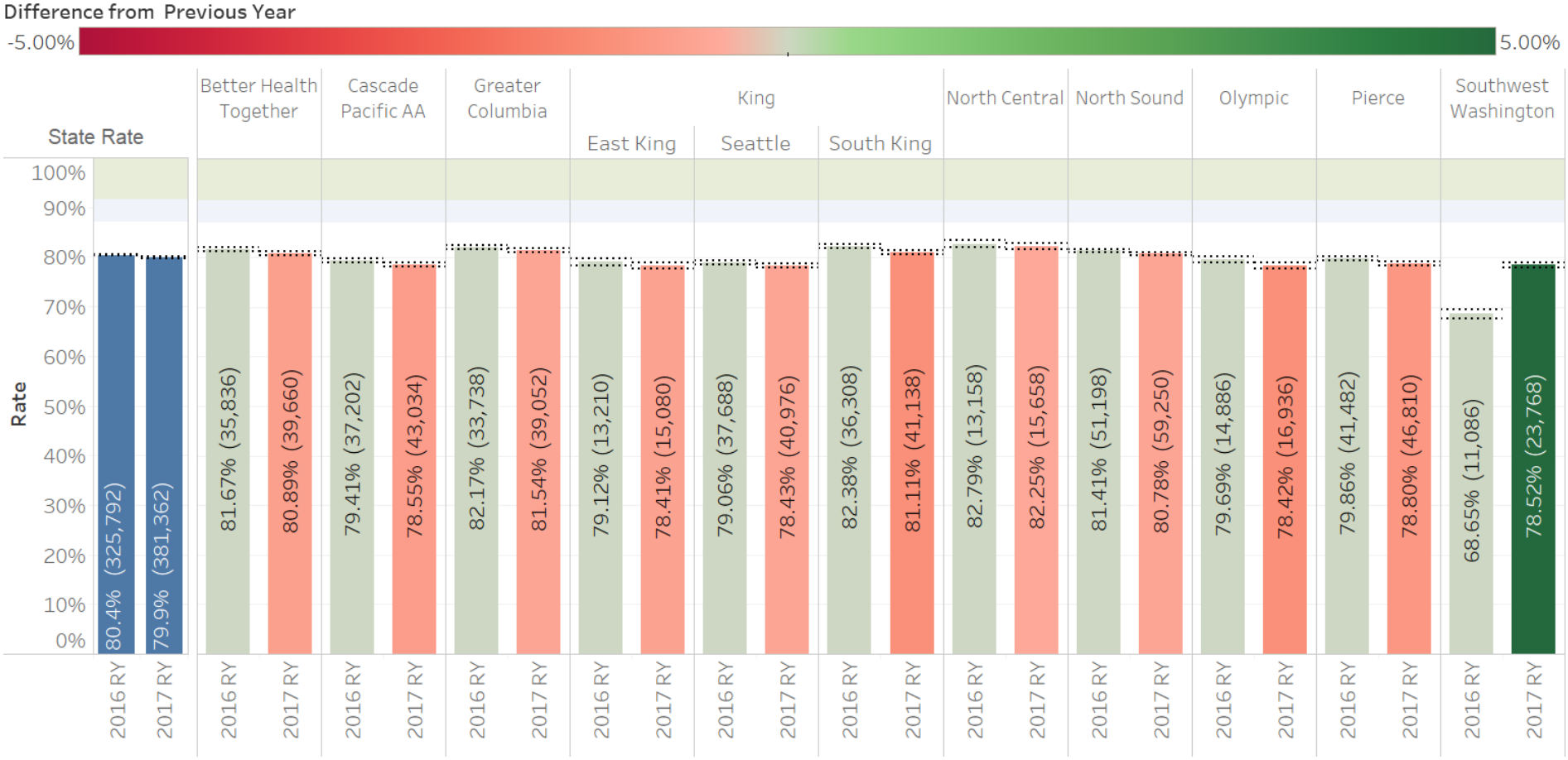
Table 18: Adults' Access to Preventive/Ambulatory Health Services (45–64), Performance by Region



Year-to-Year Performance

Over time, this measure has dropped slightly yet significantly (a result of the large population size). Every region showed a drop in this measure, except for Southwest Washington, which showed an increase.

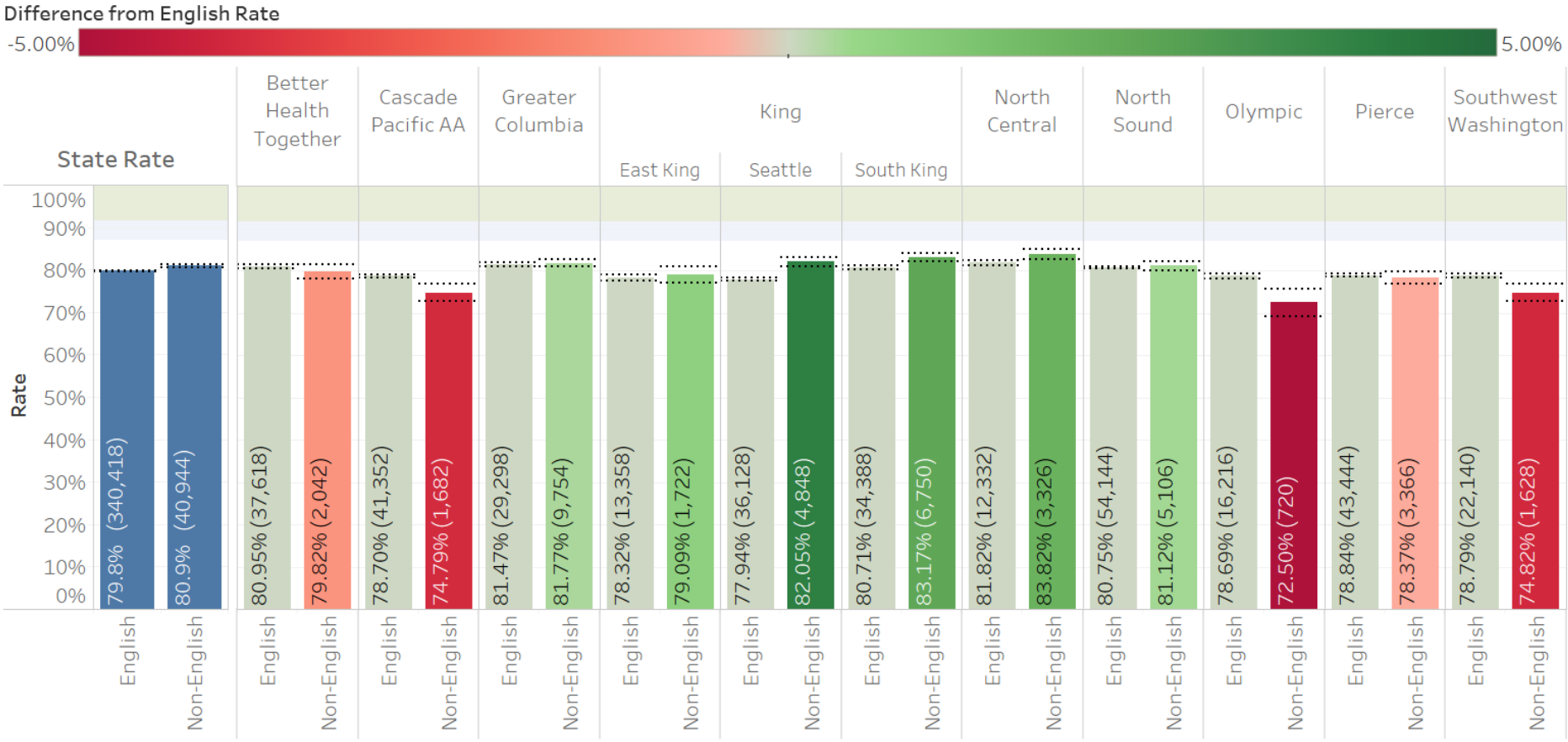
Table 19: AAP (45–64) Performance Statewide and by Region, 2016 RY to 2017 RY



Variation by Language

Similar to the AAP measure for enrollees ages 20–44, the difference in access rates for English and non-English speakers varied across the state. In Cascade Pacific AA, Southwest Washington, and Olympic, non-English-speaking enrollees appear to have less access to primary care, whereas in Seattle, South King, and North Central, access rates for non-English speakers were better than for English speakers. Overall, preferring a non-English language appears to be less of a barrier to access for this age group than for the 20–44 years age group.

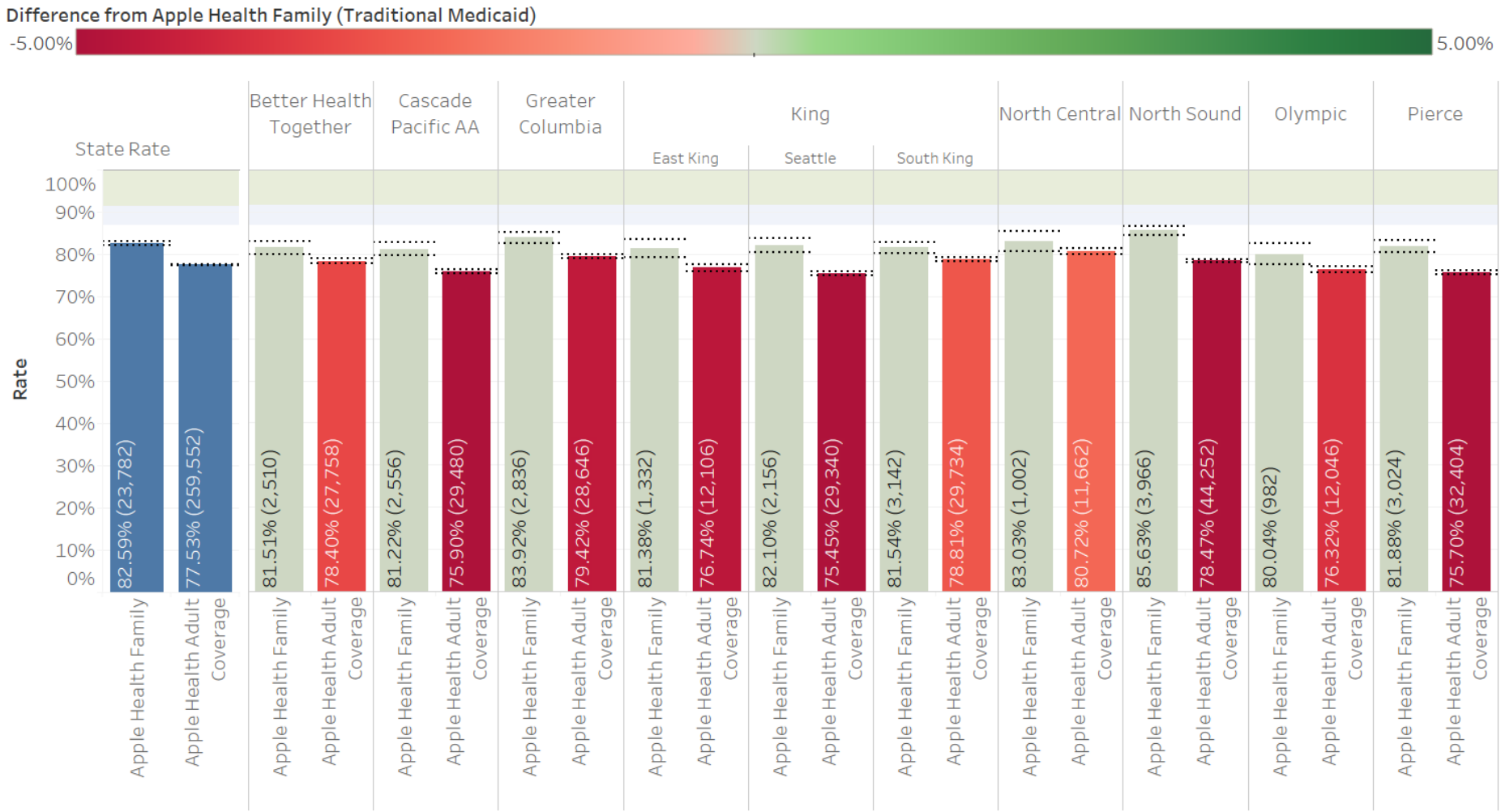
Table 20: AAP (45–64) Performance Variation by Region and Language



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

Similar to the 20–44 years age group, all regions showed lower access rates for AHAC enrollees than for Apple Health Family enrollees.

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



Apple Health Adult Coverage (Medicaid Expansion) by Plan

As for the AAP measure for the 20–44 years age group, MHW showed higher rates for AHAC enrollees in this measure in most regions statewide. CCW also showed comparatively high rates in North Central and Greater Columbia. CHPW showed high rates in Greater Columbia, King, and Olympic. UHC showed high rates in North Sound.

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

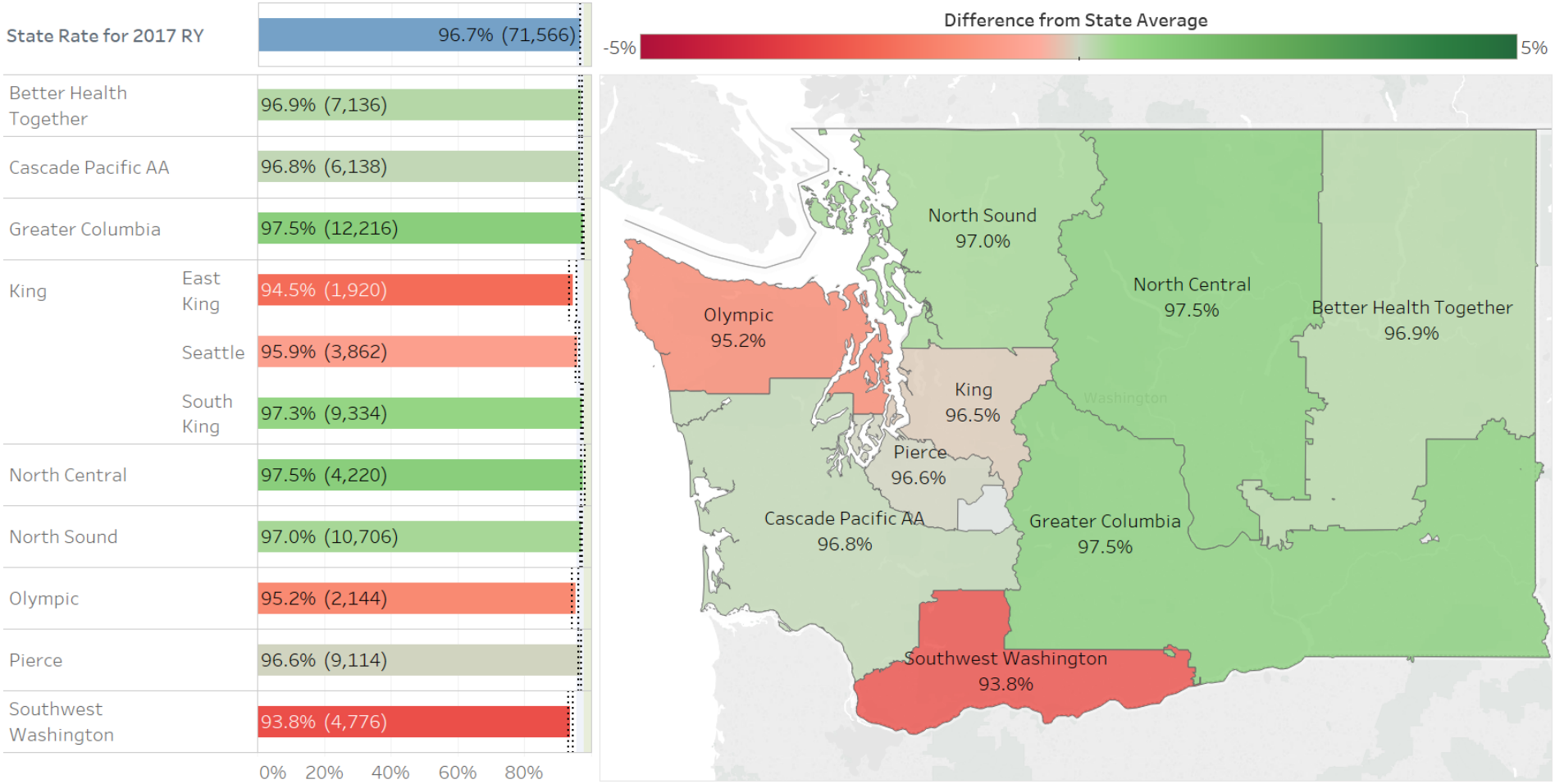
Children and Adolescents' Access to Primary Care Practitioners

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 4 percent, with Southwest Washington at 93.8 percent and North Central and Greater Columbia at 97.5 percent.

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



Year-to-Year Performance

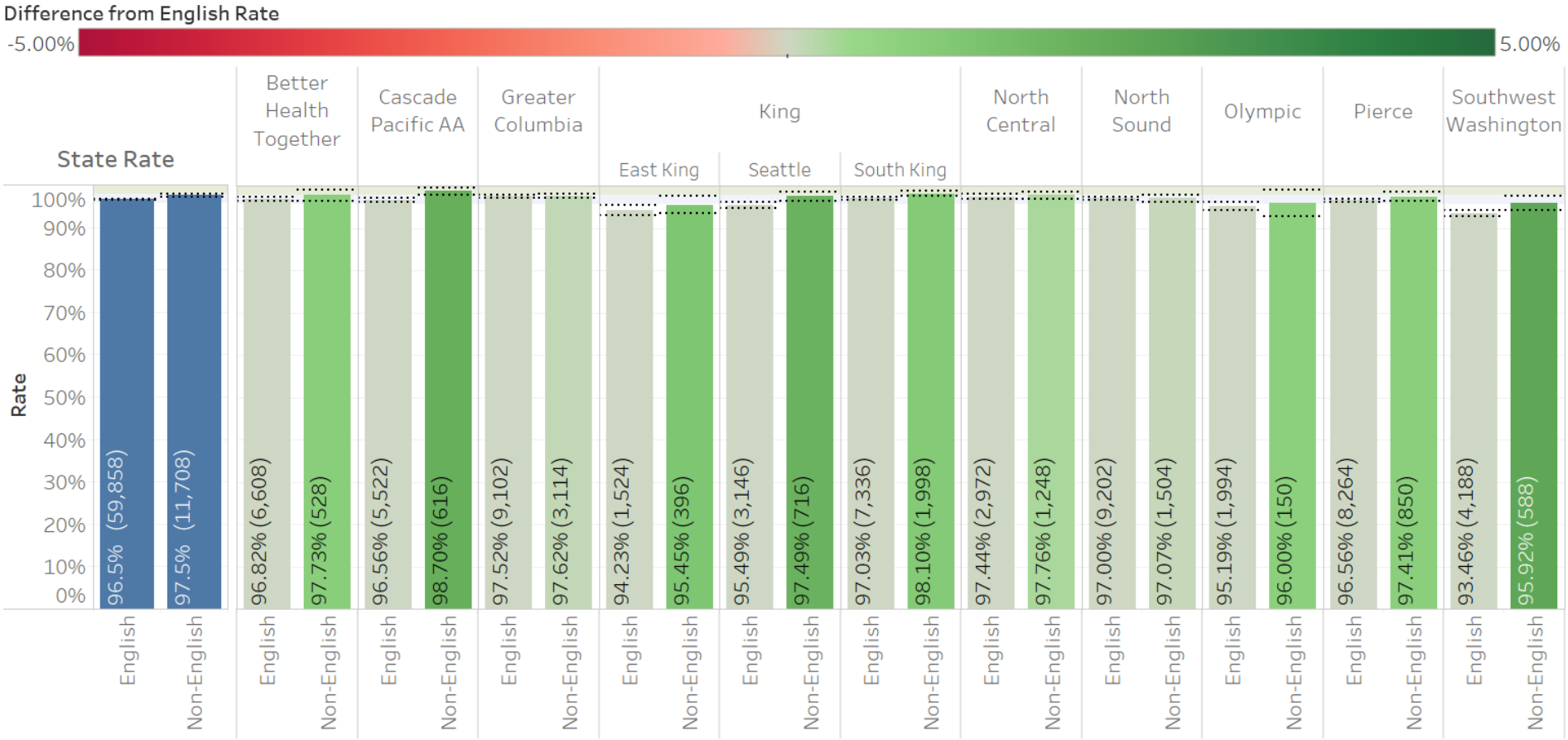
Over time, performance on this measure has trended up in almost all regions except East King. Greater Columbia, Southwest Washington, Cascade Pacific AA, and North Sound showed large improvements since 2016 RY.

Table 24: CAP (12–24 months) Performance Statewide and by Region, 2016 RY to 2017 RY

Variation by Language

In contrast with the adult access measures, analysis of variation by language for this measure indicates no barriers for non-English speakers in getting access to child and adolescent care. In all regions, non-English speakers show slightly higher rates than English speakers.

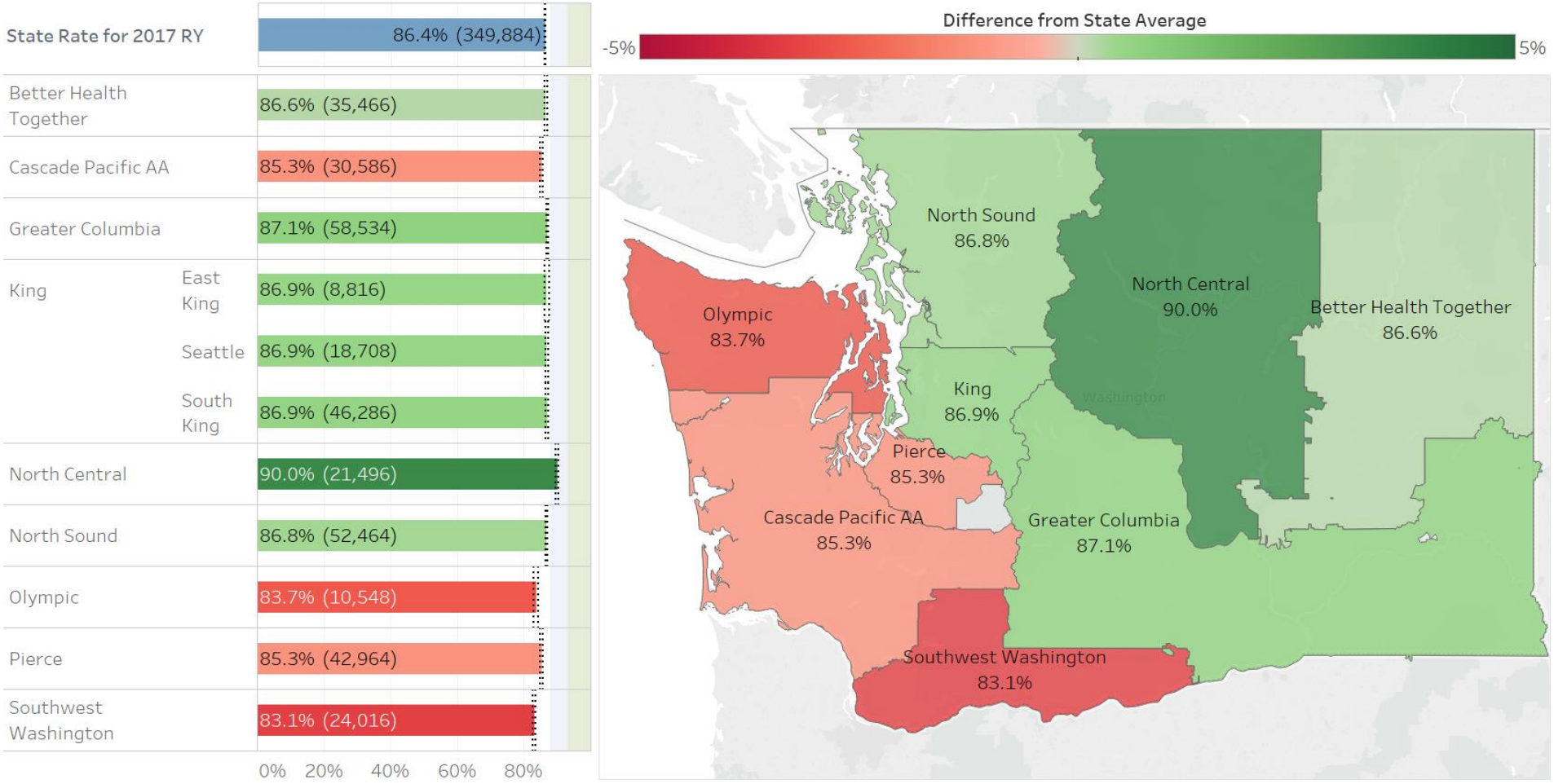
Table 25: CAP (12–24 months) Performance Variation by Region and Language



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, with 90 percent for this measure. In contrast, Southwest Washington and Olympic showed the lowest rates. The variation for this measure is slightly wider than for the 12–24 months age group.

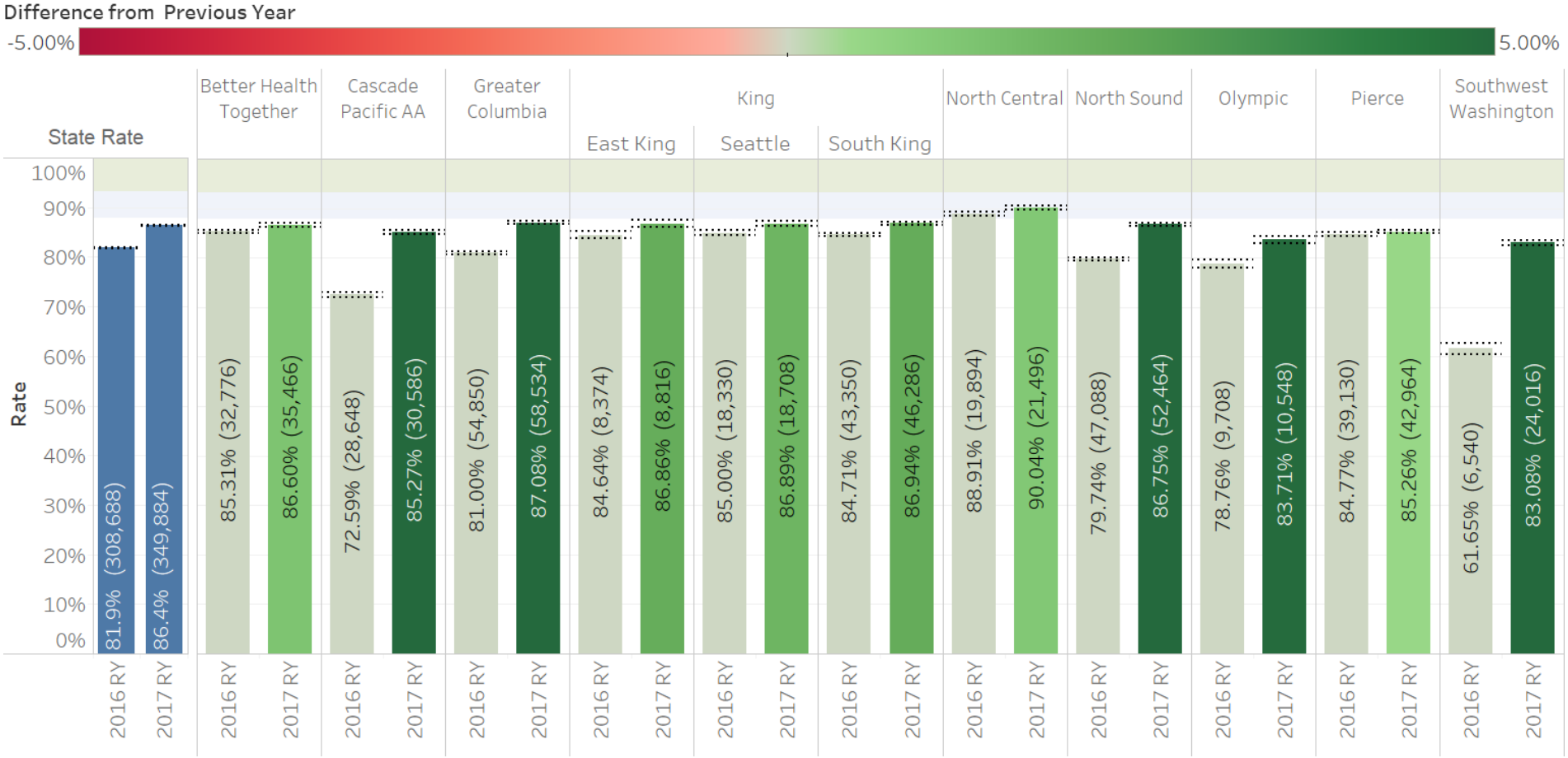
Table 26: Children and Adolescents' Access to Primary Care Practitioners (25 months–6 years), Performance by Region



Year-to-Year Performance

Year to year, this measure has trended up in all regions, with Cascade Pacific AA, Greater Columbia, Southwest Washington, and North Sound showing large improvements.

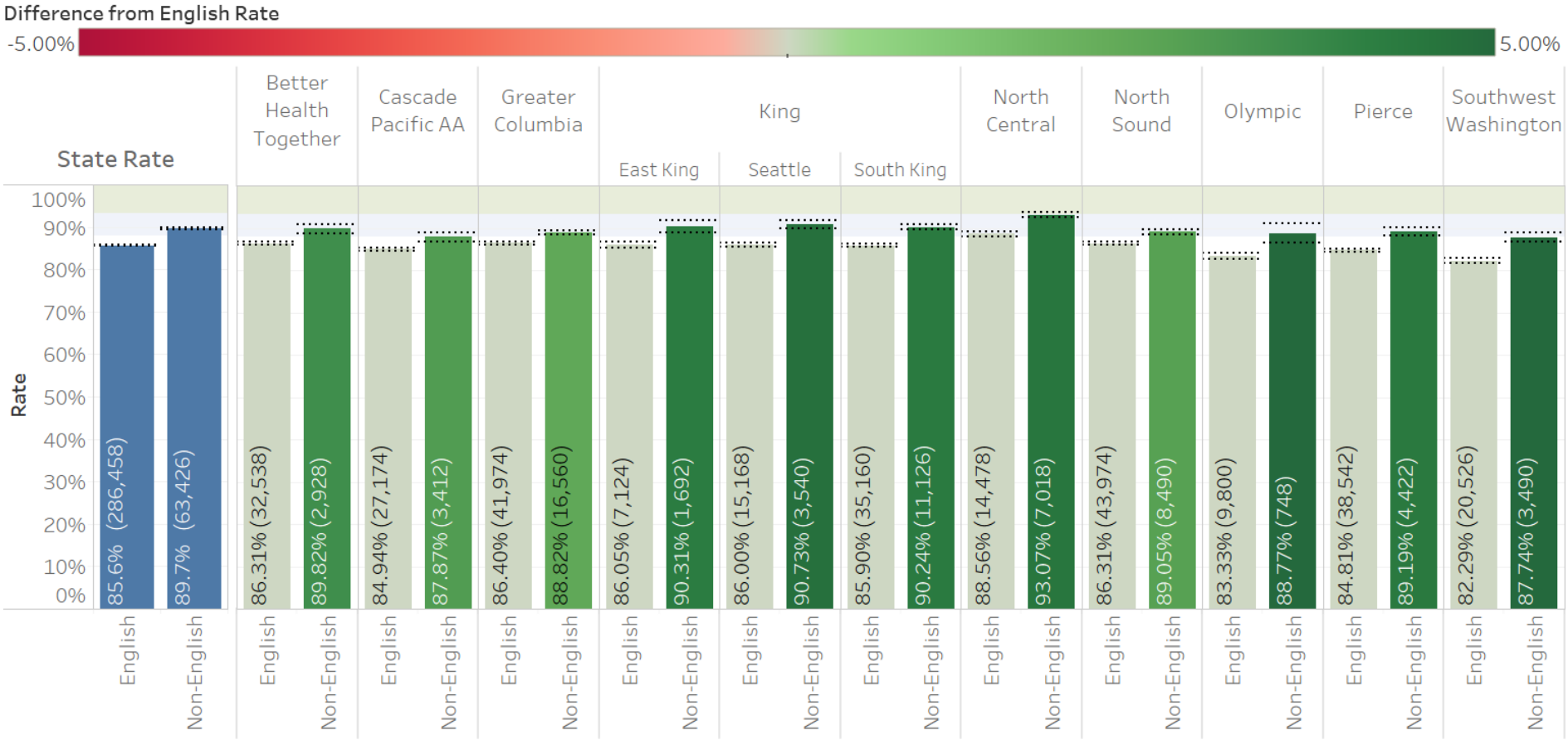
Table 27: CAP (25 months–6 years) Performance Statewide and by Region, 2016 RY to 2017 RY



Variation by Language

For this measure, non-English speakers show considerably better access rates than English speakers in all regions. In Olympic and Southwest Washington, the difference between rates for the two groups is more than 5 percent.

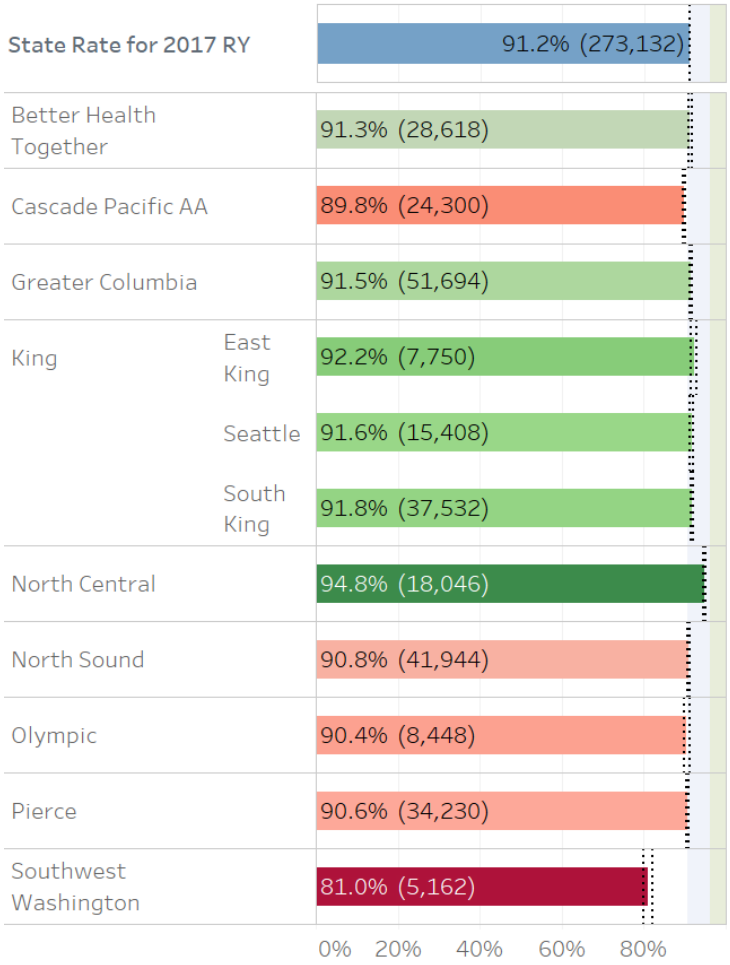
Table 28: CAP (25 months–6 years) Performance Variation by Region and Language

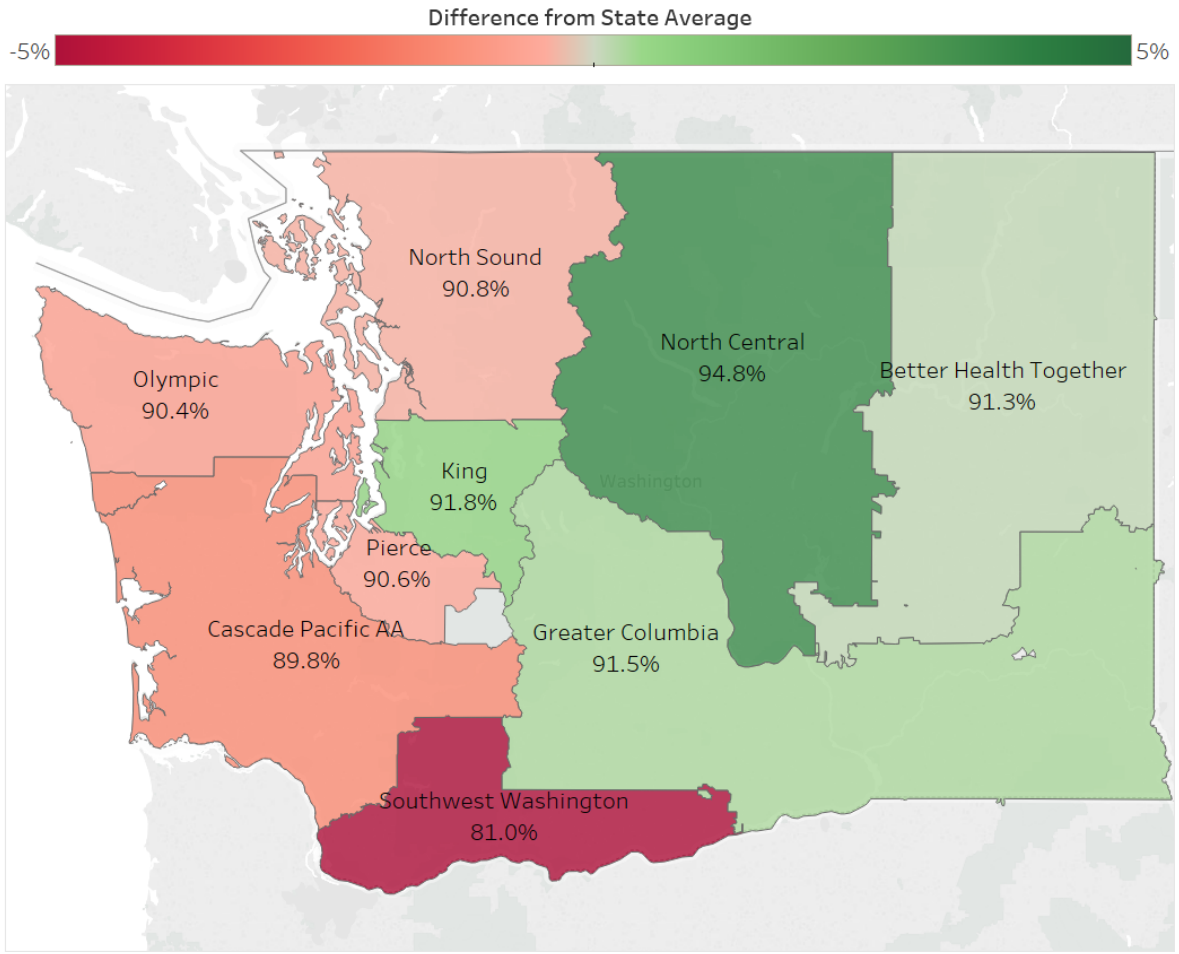


Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)

Again, rates in North Central for access to child and adolescent primary care were substantially higher than in other regions, although variation in performance was wider for the 7–11 years age group than for the 12–24 months and 25 months–6 years age groups. Southwest Washington was a particularly low outlier on this measure, with a rate more than 10 percentage points below the state average.

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





Year-to-Year Performance

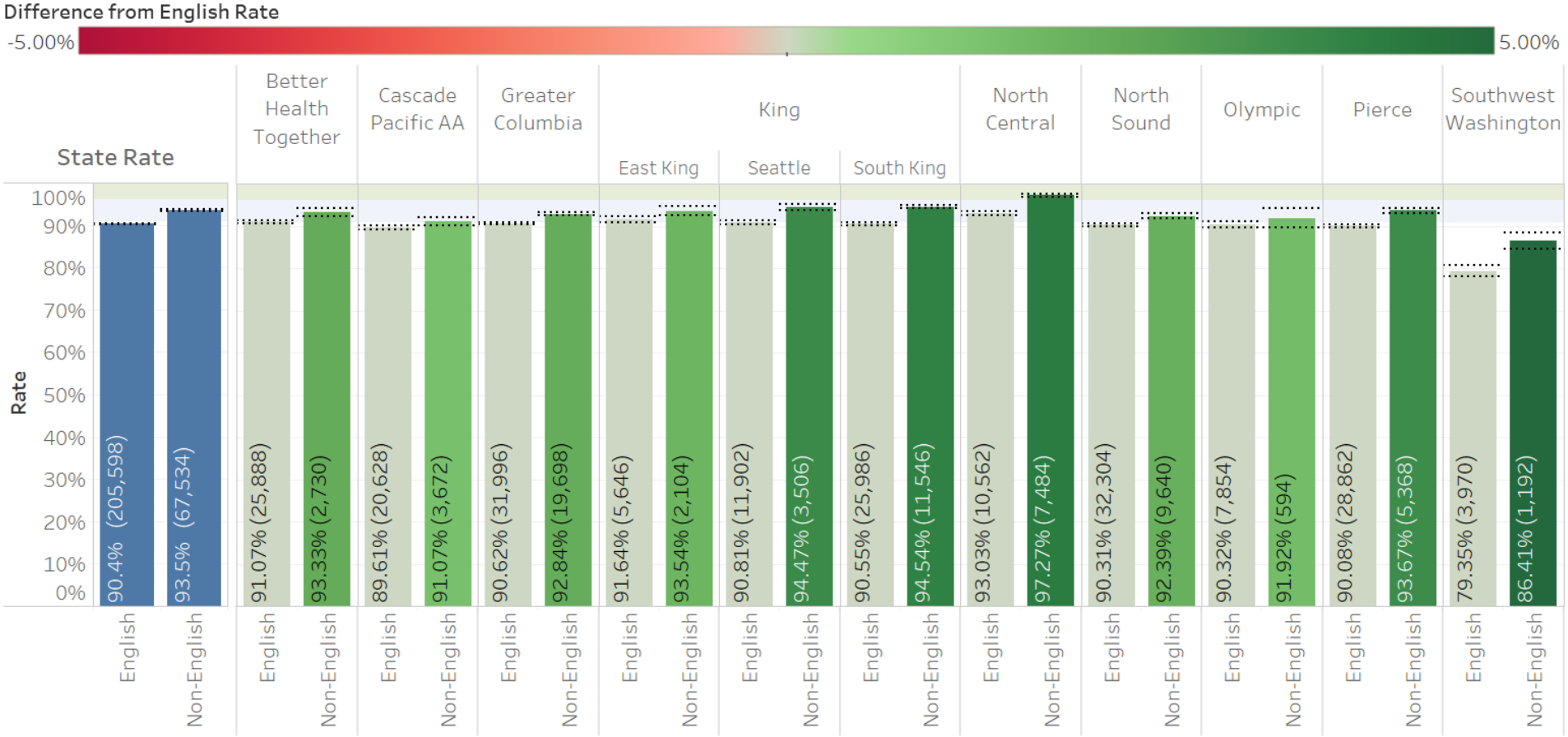
Since 2016 RY, performance on this measure has improved in all regions, with Cascade Pacific AA, Greater Columbia, Olympic, Southwest Washington, and North Sound showing large improvements.

Table 30: CAP (7–11 years) Performance Statewide and by Region, 2016 RY to 2017 RY

Variation by Language

As with the other CAP measures, a non-English-language preference does not appear to be a barrier to accessing child and adolescent care. All regions showed better access rates for non-English than English speakers. In Southwest Washington, the difference between rates for the two groups is more than 7 percent.

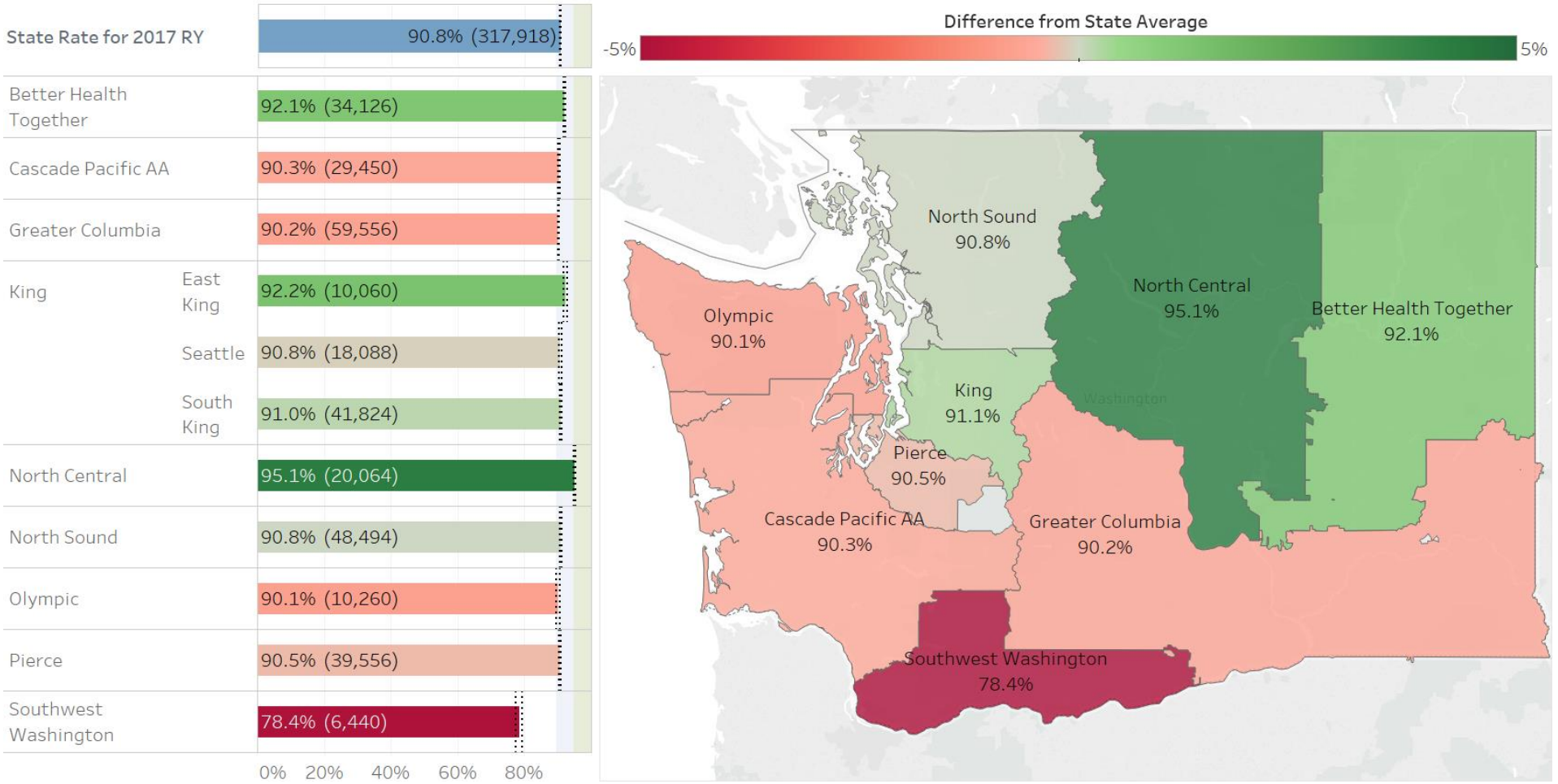
Table 31: CAP (7–11 years) Performance Variation by Region and Language



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

As with other CAP measures, North Central's rates for the 12–19 years age group outperformed all other regions. The regional variation in performance, however, is wider than for the other CAP measures. The rate in Southwest Washington of 78.4 percent is 16.7 percentage points below the rate in North Central and 12.4 percentage points below the state average.

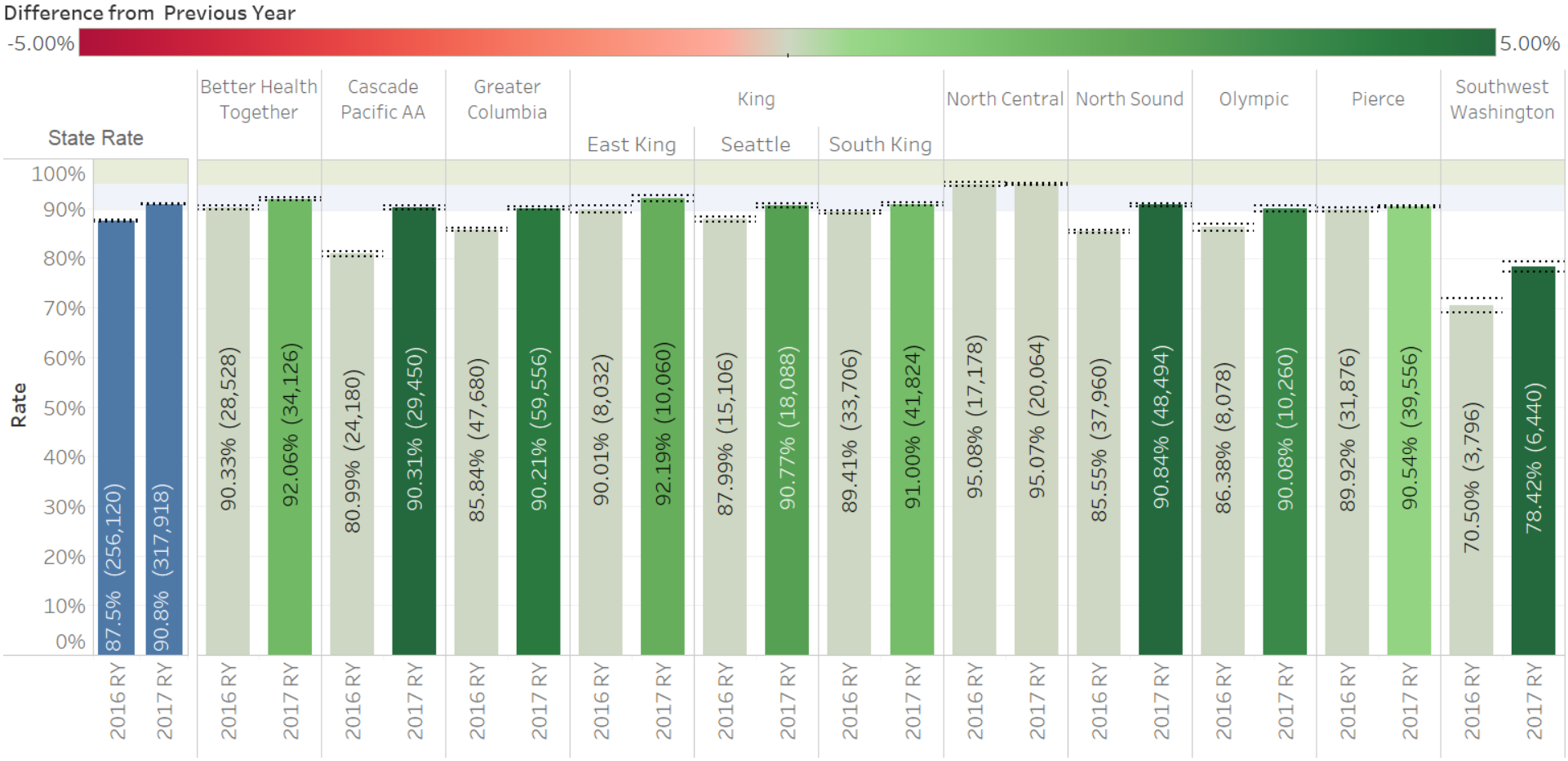
Table 32: Children and Adolescents' Access to Primary Care Practitioners (12–19 years), Performance by Region



Year-to-Year Performance

Overall, performance on this measure has improved statewide. Rates in Cascade Pacific AA, Greater Columbia, Southwest Washington, and North Sound, in particular, have shown large improvements.

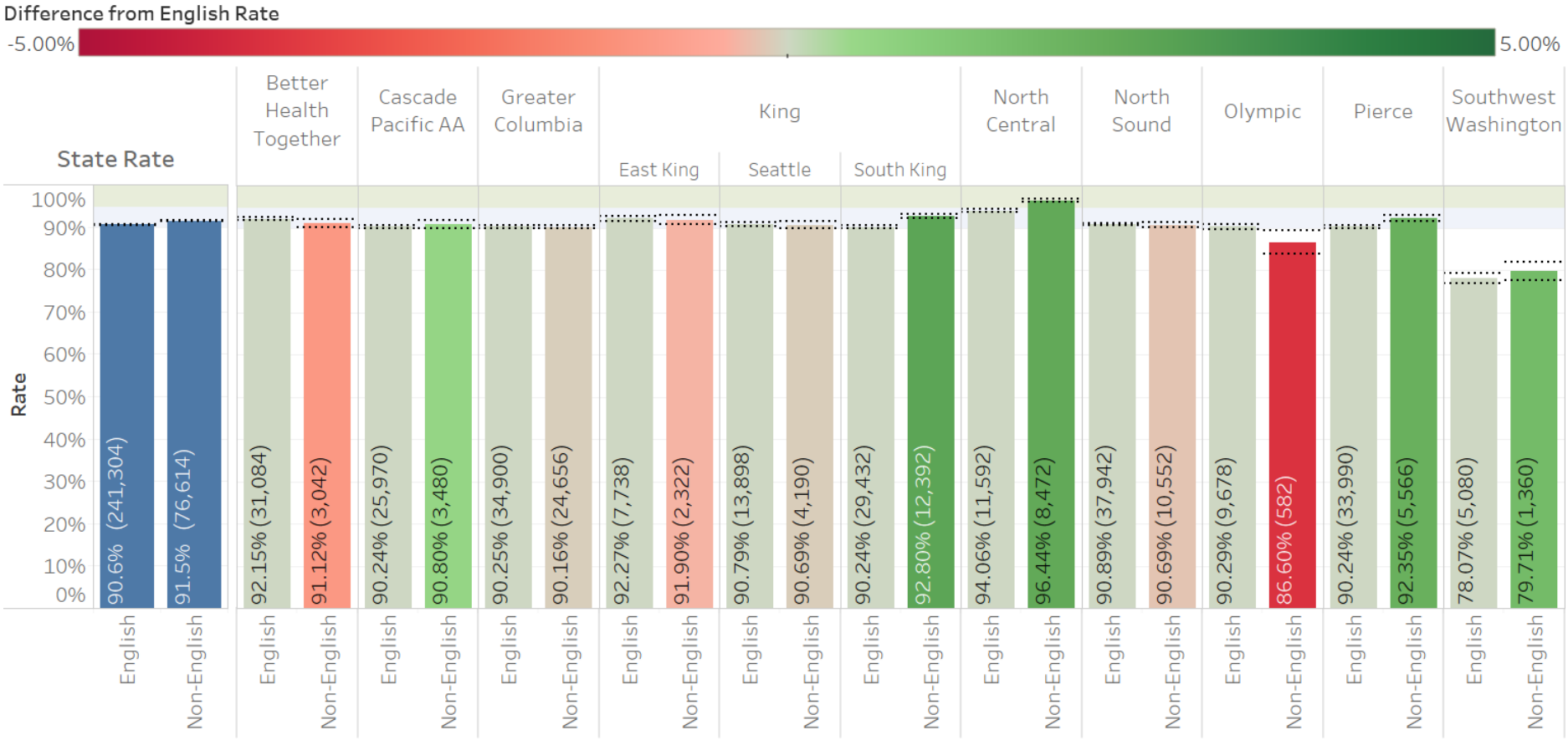
Table 33: CAP (12–19 years) Performance Statewide and by Region, 2016 RY to 2017 RY



Variation by Language

Analysis of variation by language showed some variation for this age group between rates of access for English and non-English-speaking enrollees. The rate in Olympic was significantly better for English speakers than for non-English speakers, but South King and North Central showed significantly better rates for non-English speakers.

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

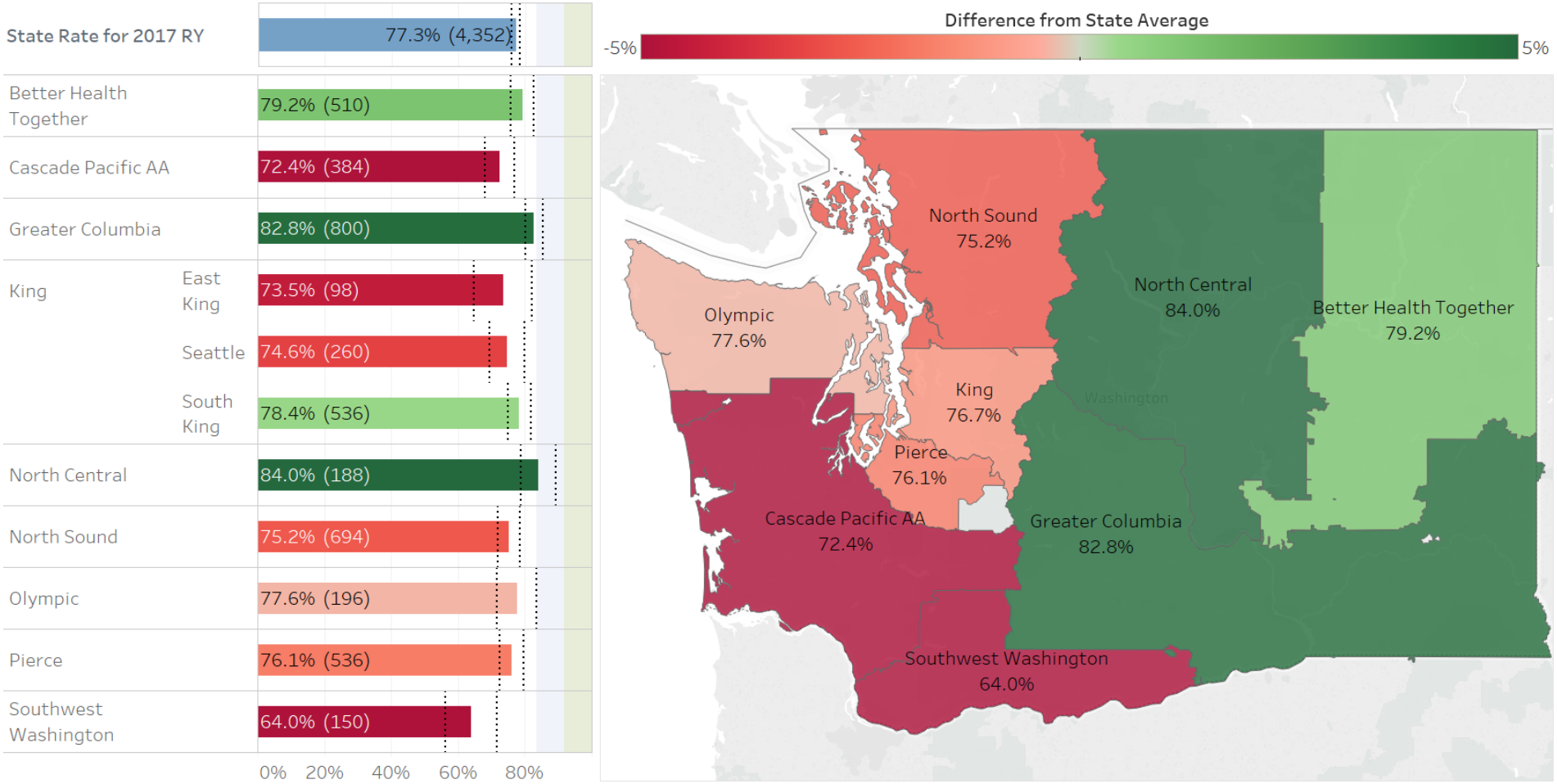


Prenatal and Postpartum Care—Timeliness of Prenatal Care

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. Although statewide performance on this measure has improved over time (as seen on the next page), the Apple Health rate is still significantly below the national average. There were no statistically significant differences in MCO performance for this measure by race.

It is noteworthy that although rates in all western regions are relatively low (North Central is the only region with a rate above the 50th national percentile), the rate in Southwest Washington is more than 13 percent below the state average. The rate in Cascade Pacific AA is 5 percent below the state average.

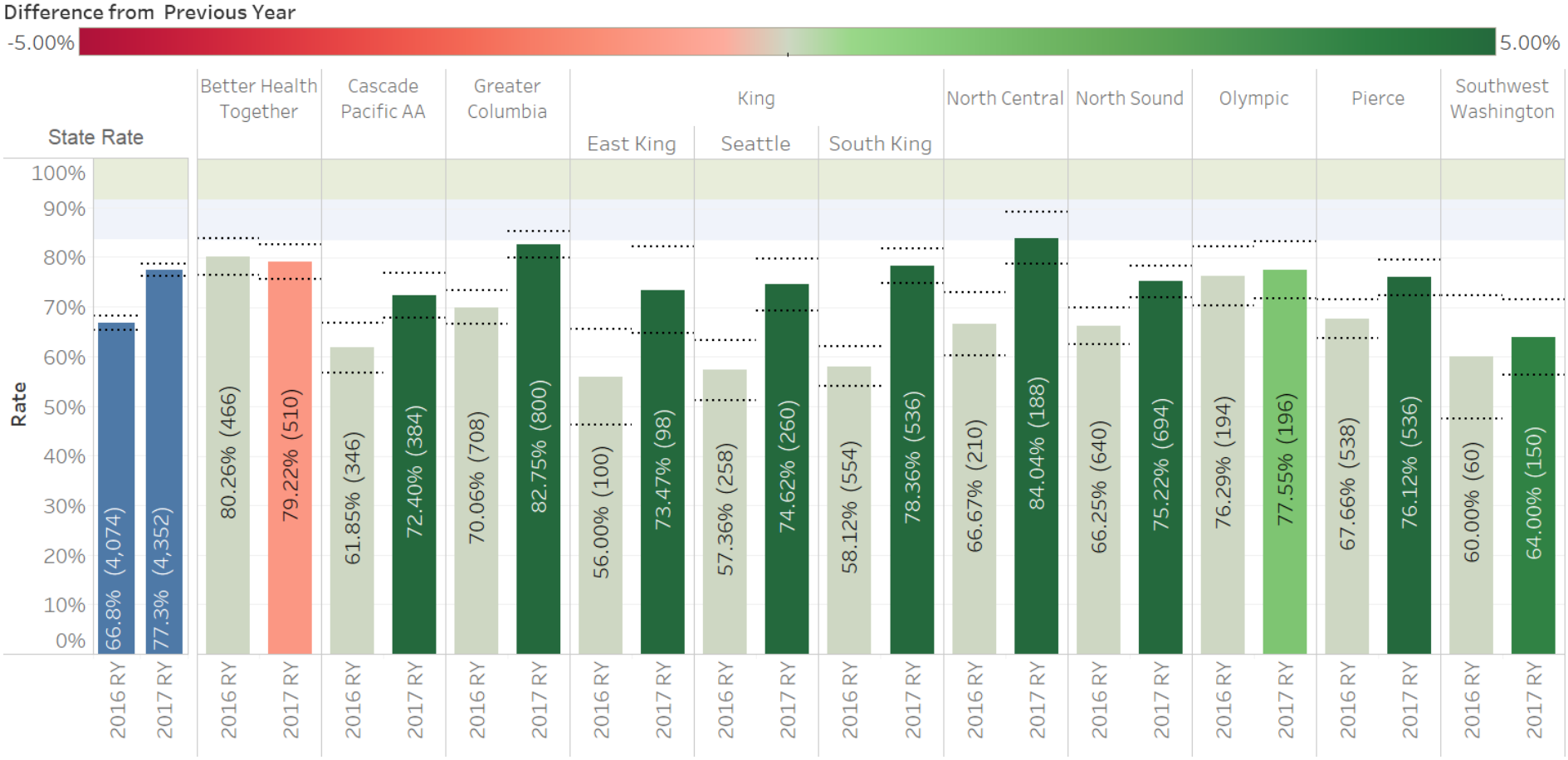
Table 34: Timeliness of Prenatal Care, Performance by Region



Year-to-Year Performance

Statewide performance on this measure has improved since 2016 RY, particularly in Cascade Pacific AA, Greater Columbia, Seattle, South King, North Central, North Sound, and Pierce.

Table 35: Timeliness of Prenatal Care Performance Statewide and by Region, 2016 RY to 2017 RY

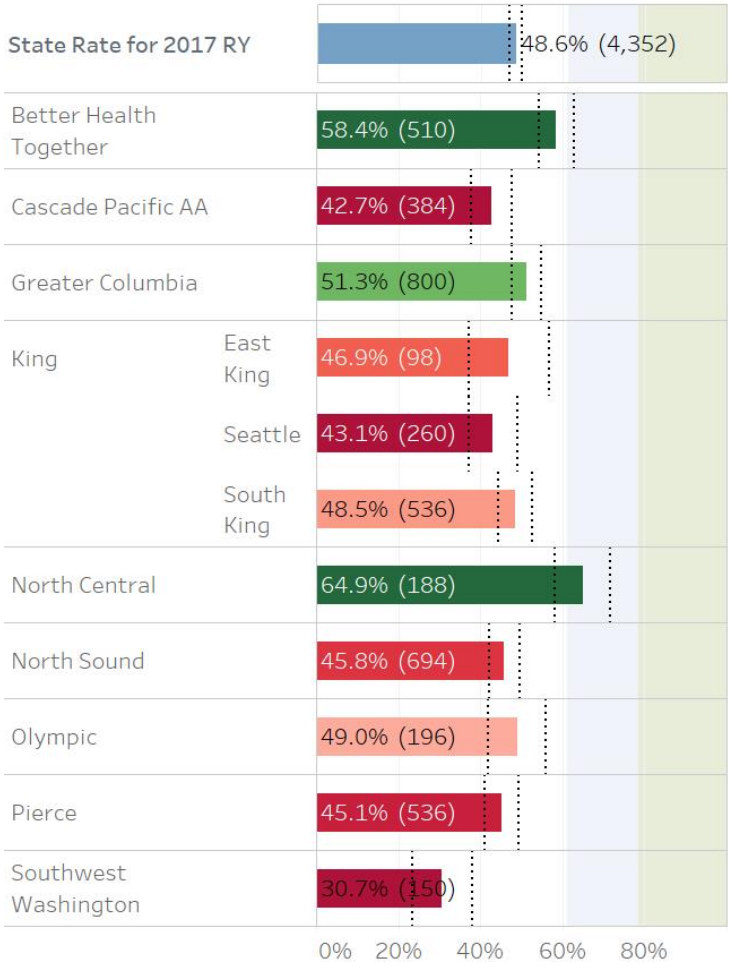


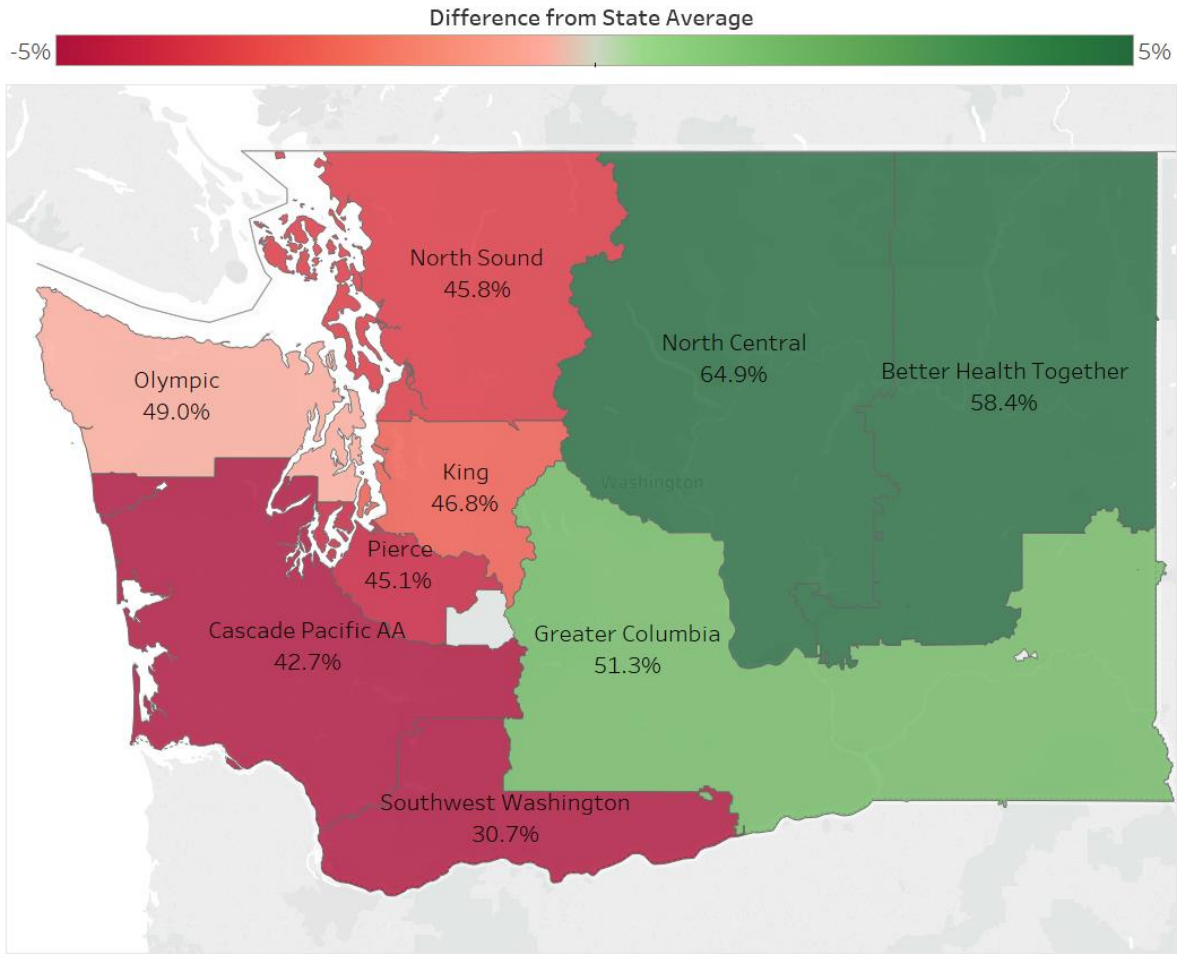
Frequency of Ongoing Prenatal Care—Receipt of At Least 81% of Recommended Visits

This measure determines the percentage of eligible Apple Health enrollees who received at least 81 percent of recommended prenatal care visits during their pregnancies. A higher score indicates better performance.

The variation for this measure was wide, with performance outcomes ranging from 64.9 percent in North Central to 30.7 percent in Southwest Washington. North Central is the only region with a rate above the national 50th percentile. Although the rates in the western regions are generally poor, the rate in Southwest Washington is nearly 18 percent below the state average; the rate in Cascade Pacific AA is nearly 6 percent below.

Table 36: Frequency of Ongoing Prenatal Care, Performance by Region

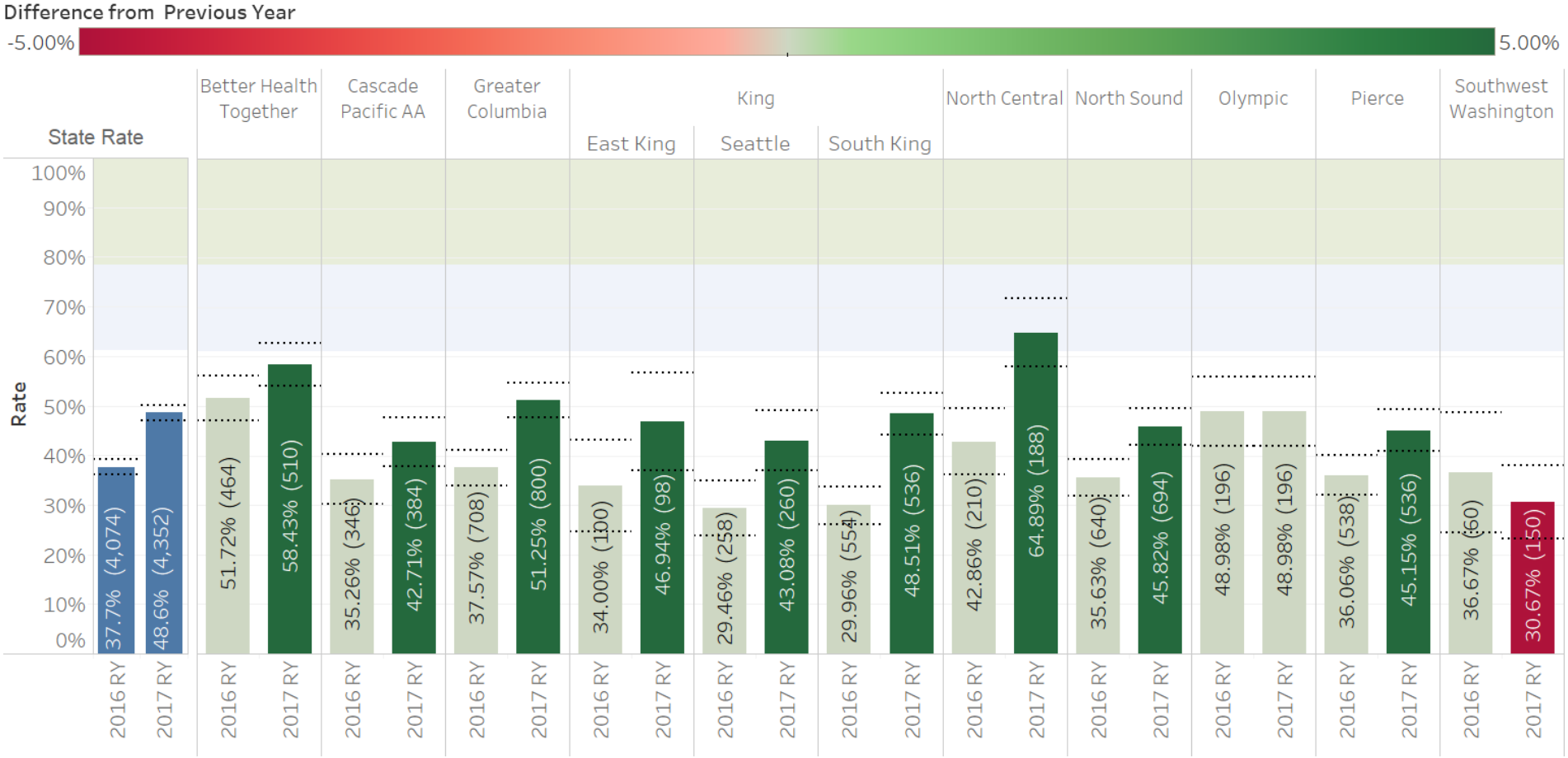




Year-to-Year Performance

Performance on this measure has increased at a state level over time. Since 2016 RY, significant improvements were made in Greater Columbia, Seattle, South King, North Central, North Sound, and Pierce.

Table 37: Frequency of Ongoing Prenatal Care, Performance Statewide and by Region, 2016 RY to 2017 RY

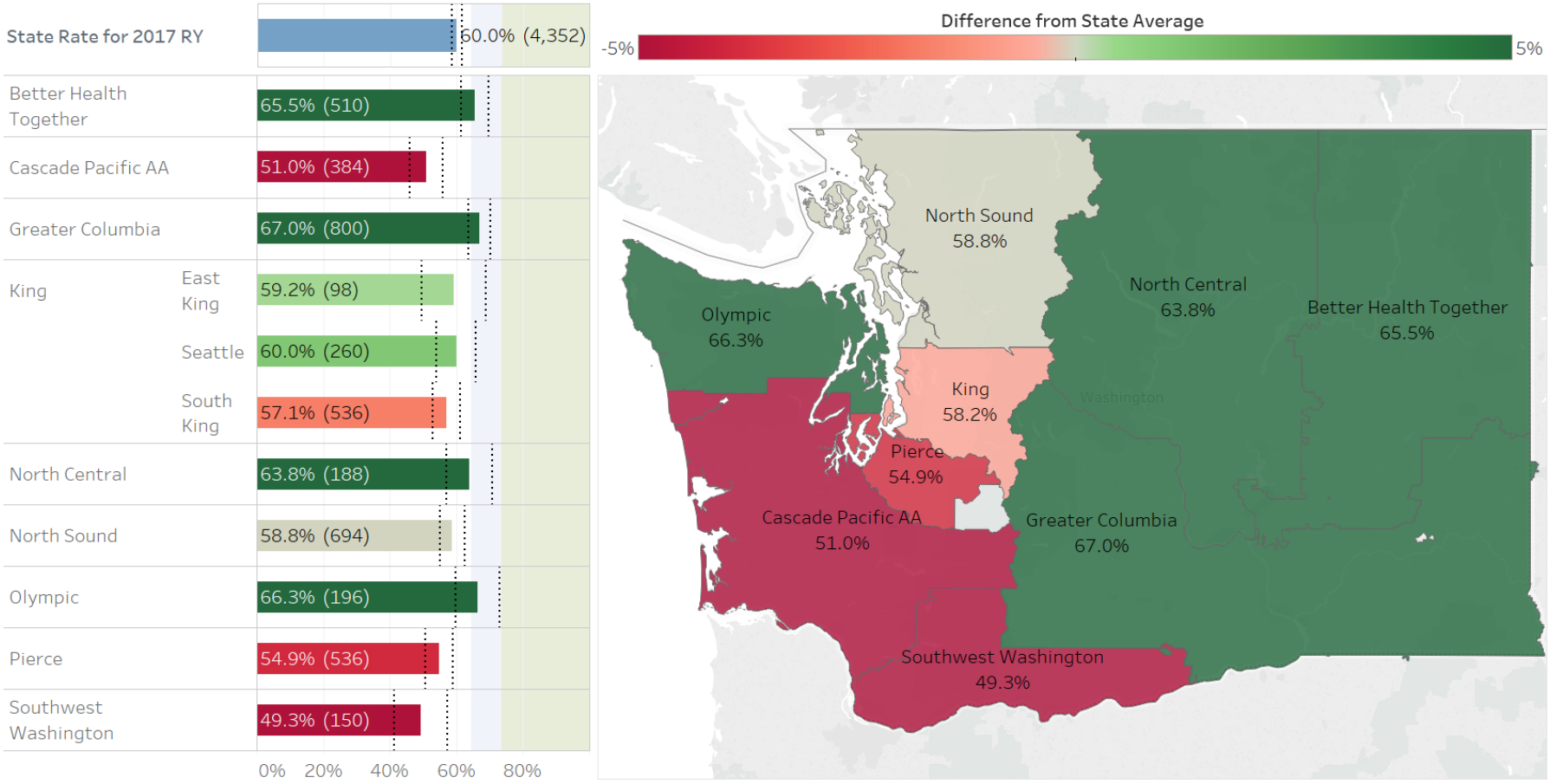


Prenatal and Postpartum Care—Postpartum Visit

This measure determines whether women received at least one visit during the postpartum period. A higher score indicates better performance. Although performance on this measure has improved over time (as shown on the next page), the Apple Health average was still significantly lower than the national average. Qualis Health's analysis did not provide evidence of racial disparities in the receipt of adequate postpartum care; however, it is important to continue monitoring the overall performance on this measure.

Greater Columbia, Better Health Together, and Olympic had the highest rates for this measure; as with other maternal care measures, rates were lowest in Southwest Washington and Cascade Pacific AA, which were, respectively, 10.7 percent and 9 percent below the state average.

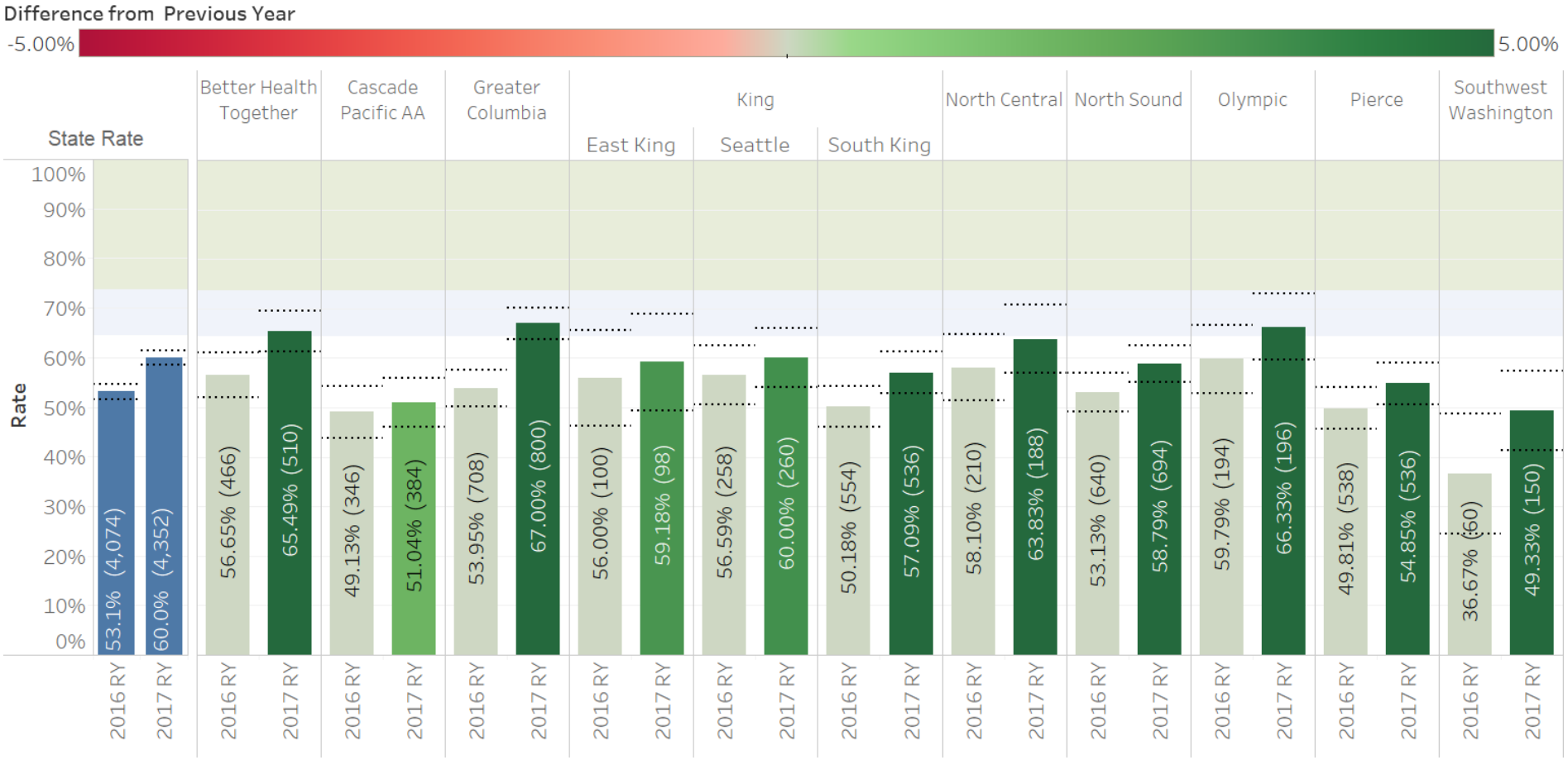
Table 38: Postpartum Visit, Performance by Region



Year-to-Year Performance

Performance on this measure improved statewide since 2016 RY, but significant rate increases can be seen only in Greater Columbia given the small sample size.

Table 39: Postpartum Visit, Performance Statewide and by Region, 2016 RY to 2017 RY



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

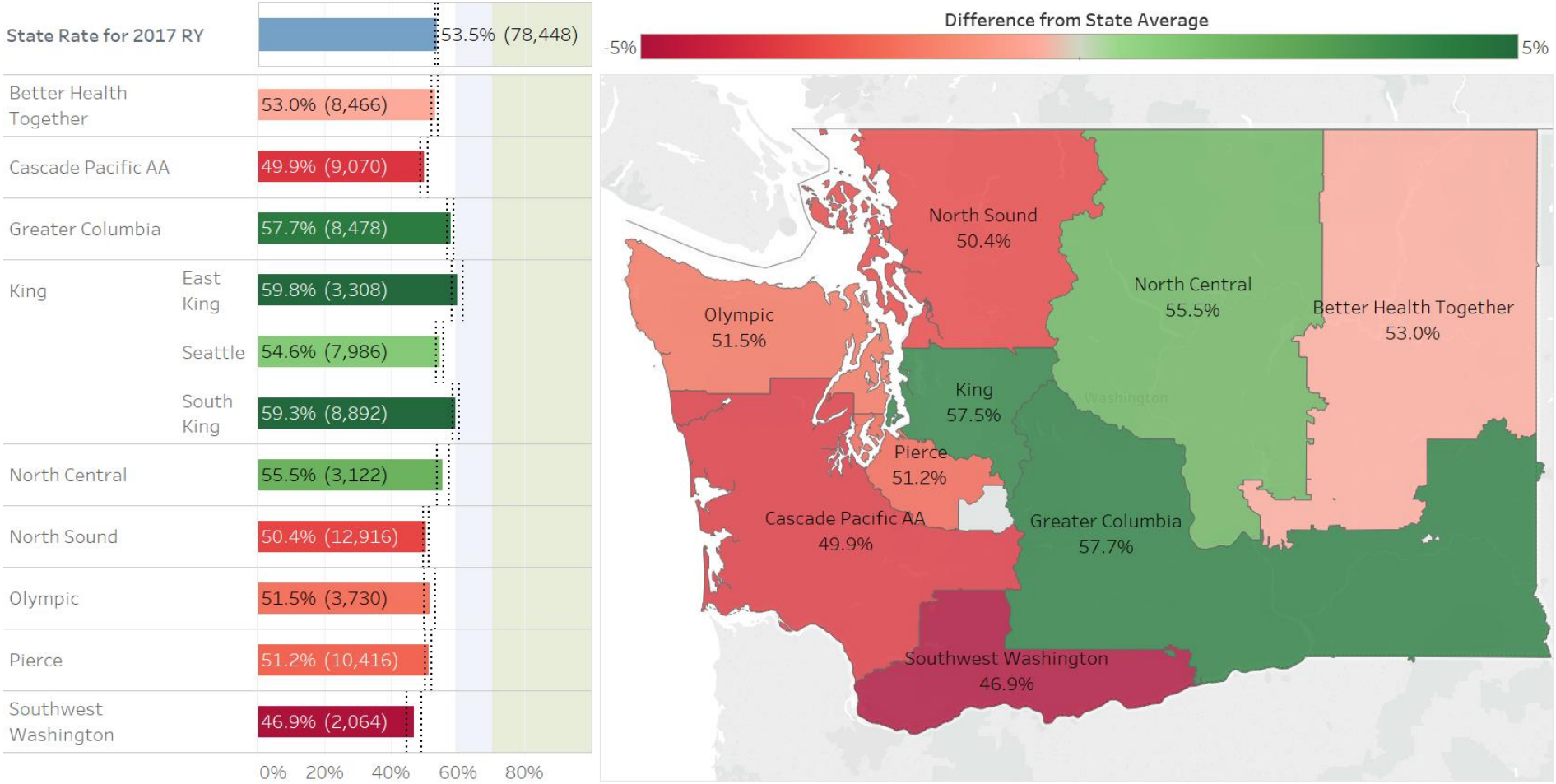
confidence interval around measure outcome

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.

All three subgroups of the King region, as well as Greater Columbia and North Central, had high rates for this measure. The rate was lowest in Southwest Washington, where it was more than 6 percent below the state average.

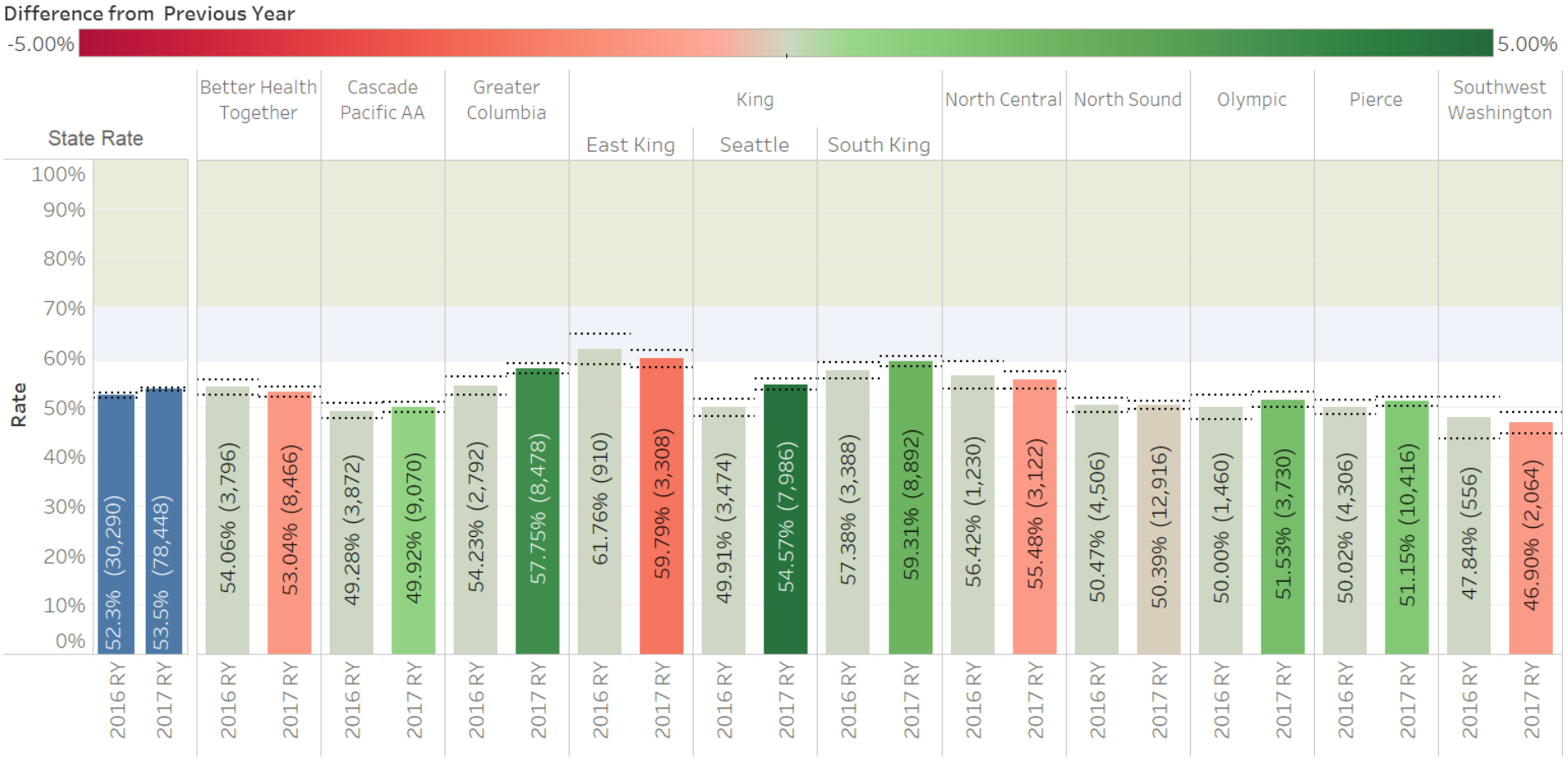
Table 40: Breast Cancer Screening, Performance by Region



Year-to-Year Performance

Performance on this measure improved slightly since 2016 RY, most notably in Greater Columbia and Seattle.

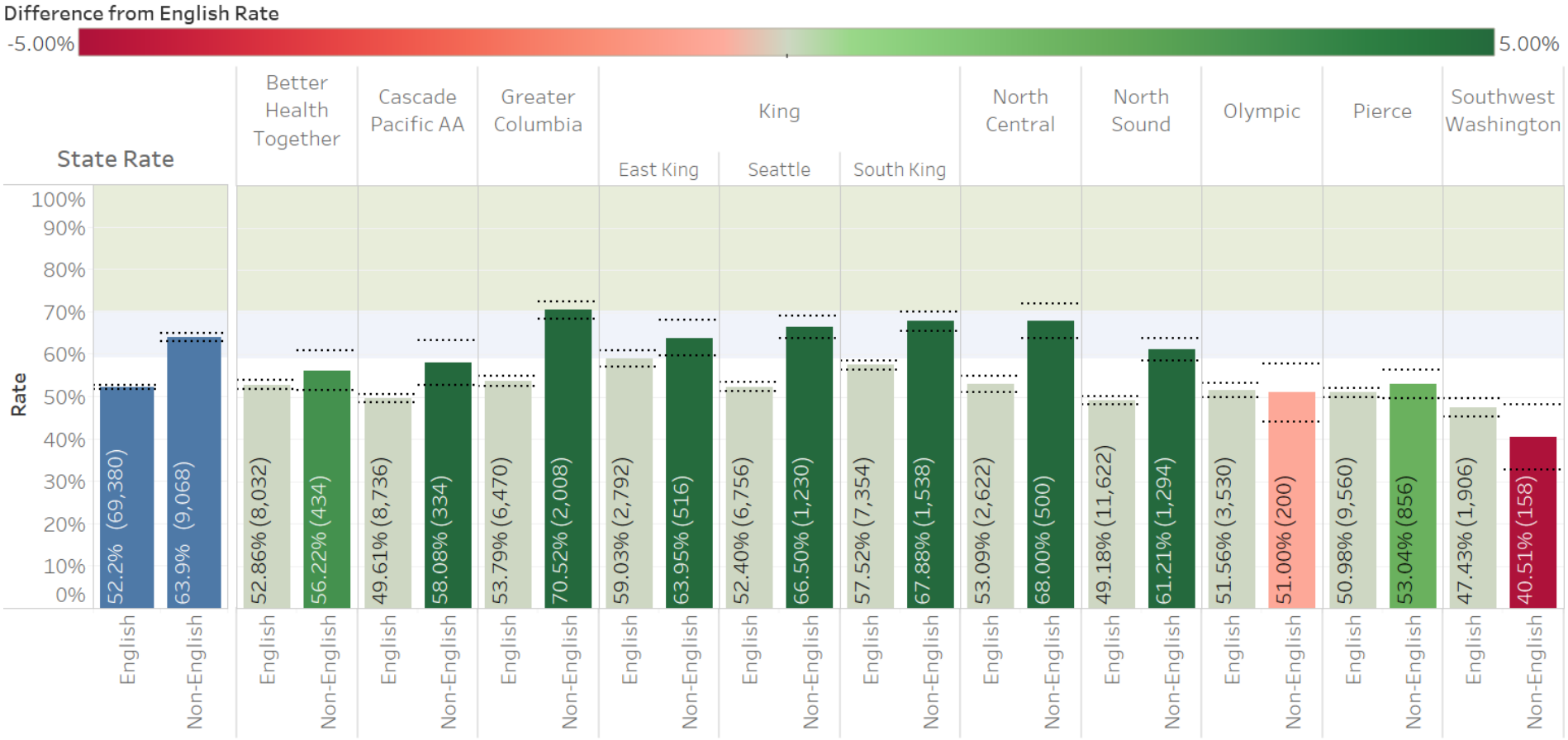
Table 41: Breast Cancer Screening, Performance Statewide and by Region, 2016 RY to 2017 RY



Variation by Language

Analysis of variation by language for this measure indicated that non-English speakers are more likely to get breast cancer screenings than English-speaking women. Significant margins can be seen in Cascade Pacific AA, Greater Columbia, Seattle, South King, North Central, and North Sound.

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



Variation by Race

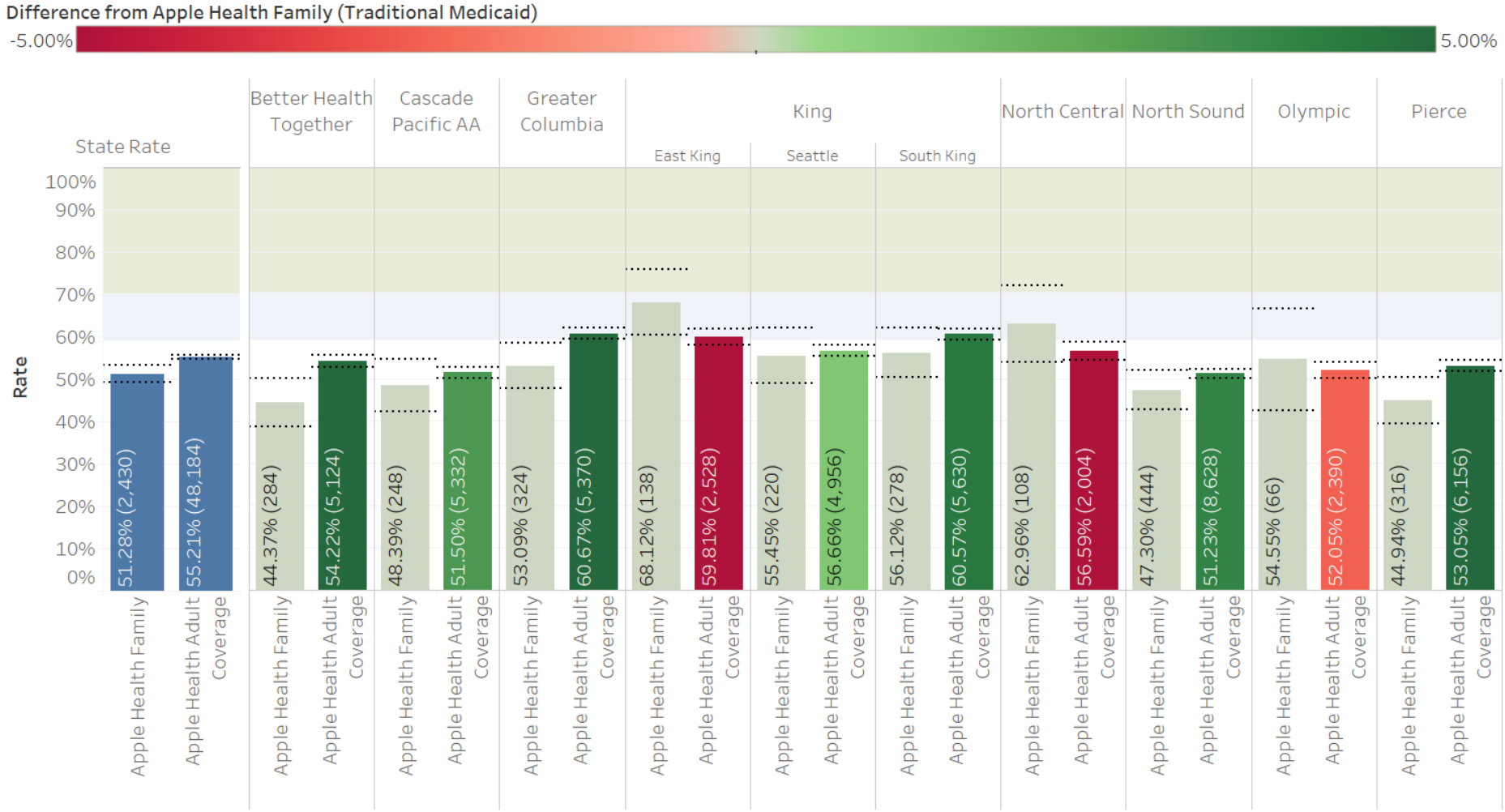
Performance on this measure also showed substantial variations by race. In all regions, white women were shown to be less likely to complete a breast cancer screening than all other groups, with a difference of more than 10 percent statewide. In North Central the variation is more than 15 percent.

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

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

In contrast to the access measures, performance rates were better statewide for the Apple Health Adult Coverage (Medicaid expansion) population than for Apple Health Family (traditional Medicaid). Significantly different rates can be seen in Better Health Together, Pierce, and Greater Columbia.

Table 44: Breast Cancer Screening Performance Variation by Region and Program



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 percent)

In this section, the following key applies:

50th to 90th national percentile

90th+ national percentile

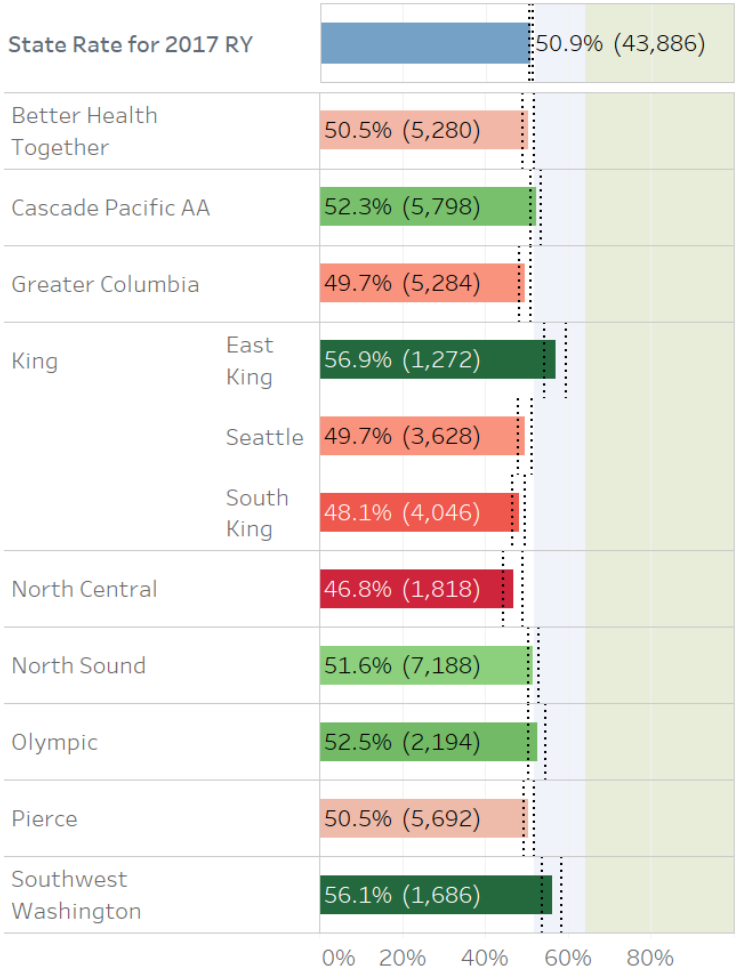
confidence interval around measure outcome

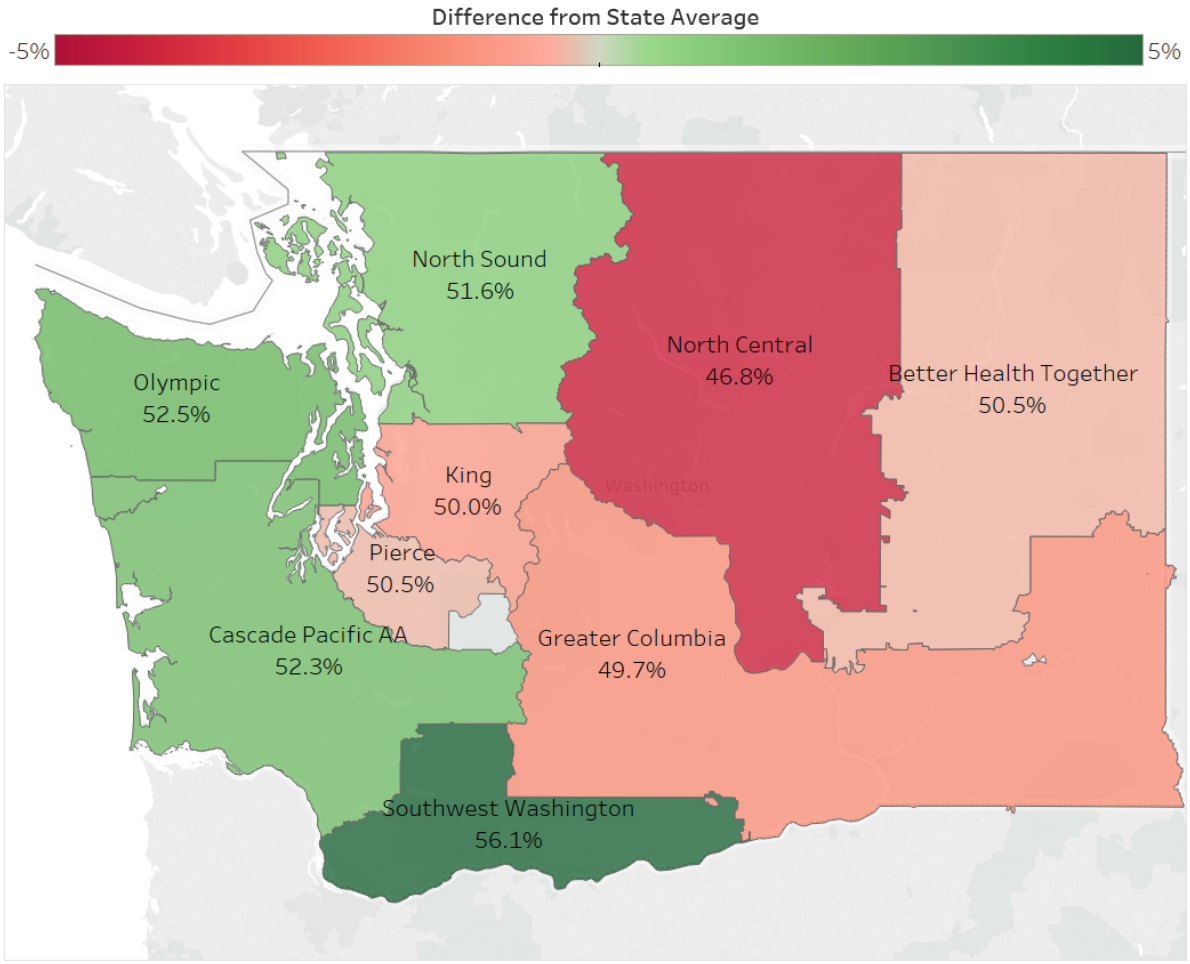
Antidepressant Medication Management—Acute Treatment Phase

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, with Southwest Washington having the highest rate of 56.1 percent. The rate was lowest in North Central at 46.8 percent, more than 4 percent below the state average. Note that the rate in East King was also a high outlier for this measure, whereas the other two King subdivisions were significantly lower.

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

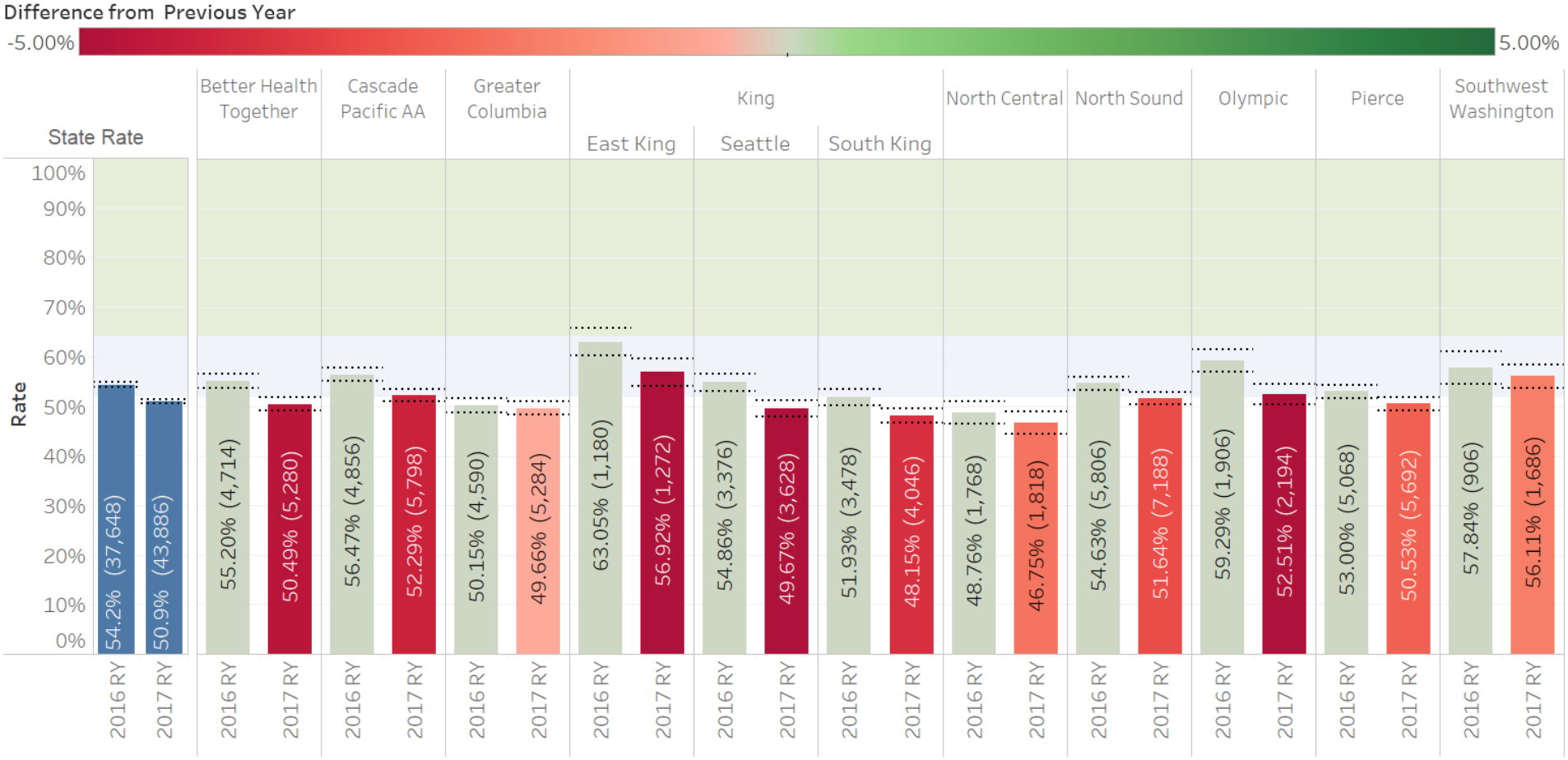




Year-to-Year Performance

Performance on this measure has dropped over time. Since 2016 RY, rates have decreased in every region, with significant drops in Better Health Together, Cascade Pacific AA, East King, Seattle, South King, North Sound, and Olympic.

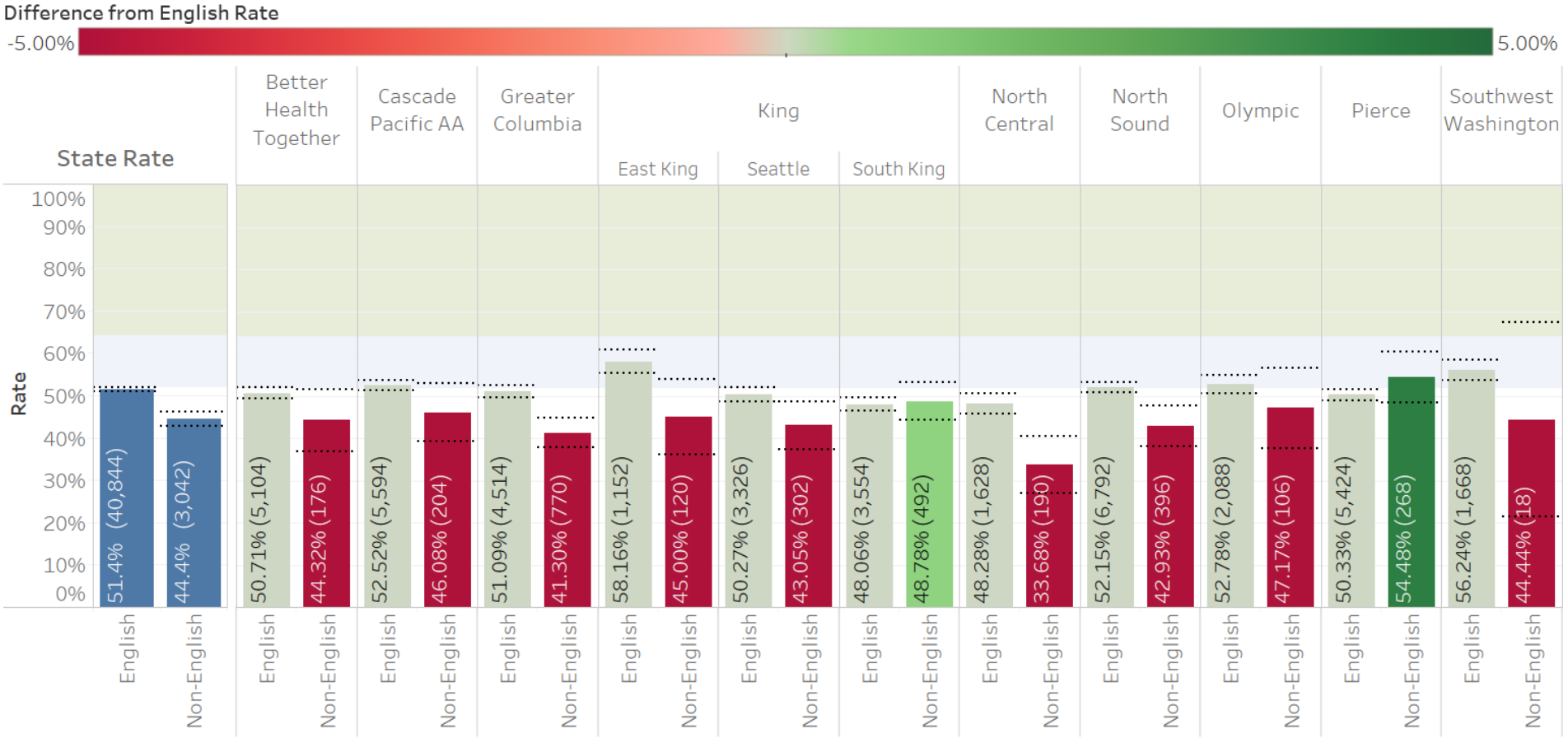
Table 46: AMM–Acute Treatment Phase, Performance Statewide and by Region, 2016 RY to 2017 RY



Variation by Language

Analysis of this measure by language showed that rates for enrollees with a non-English-language preference were considerably lower than for rates for English-speaking enrollees. The margin between the two groups is significant in Greater Columbia, North Central, North Sound, and Southwest Washington.

Table 47: AMM–Acute Treatment Phase, Variation by Region and Language

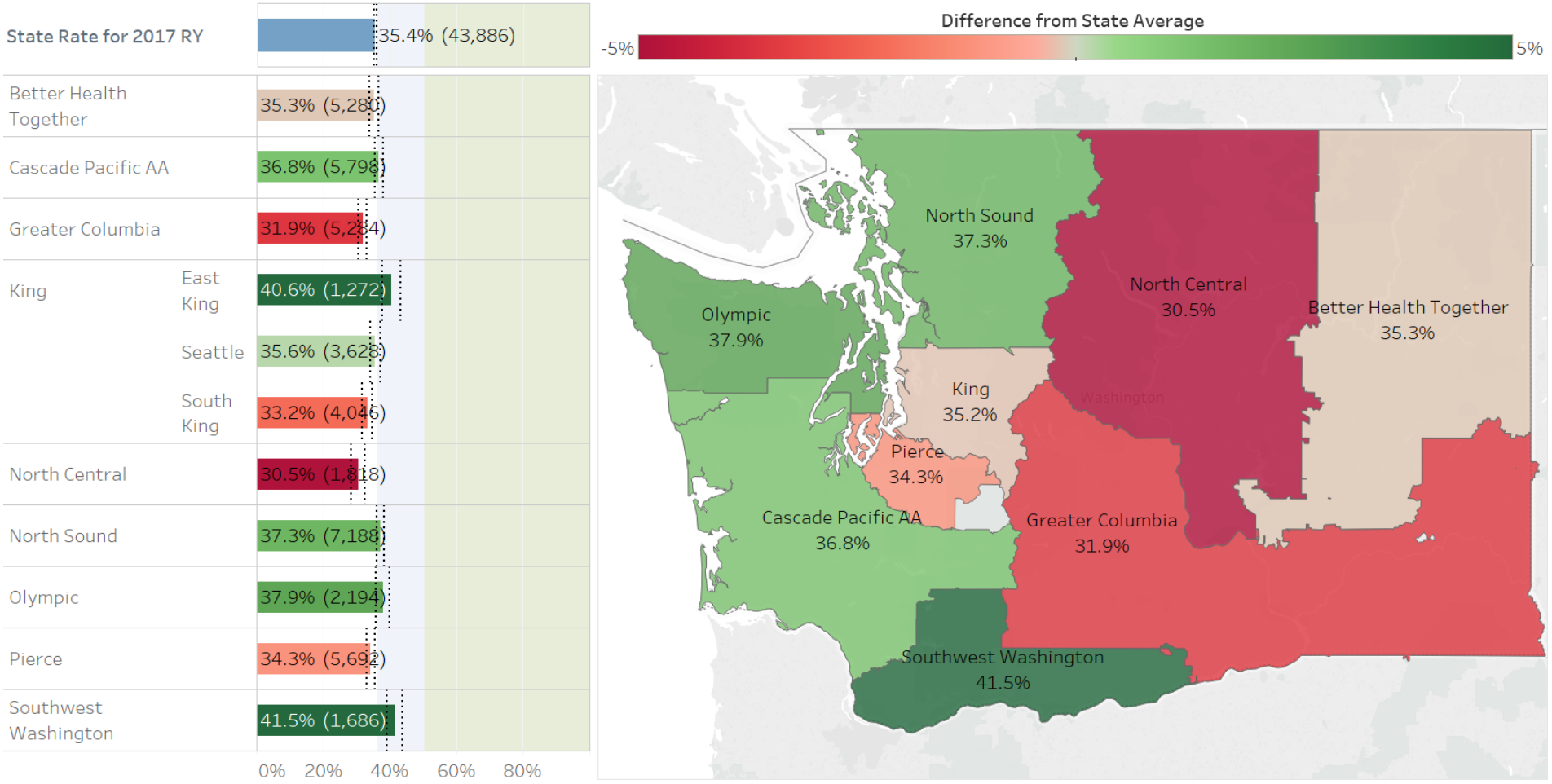


Antidepressant Medication Management—Continuation Treatment Phase

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 Southwest Washington and North Central at high and low ends of the spectrum, respectively. Notice that the rate in East King was also a high outlier, whereas the rate in South King was significantly lower.

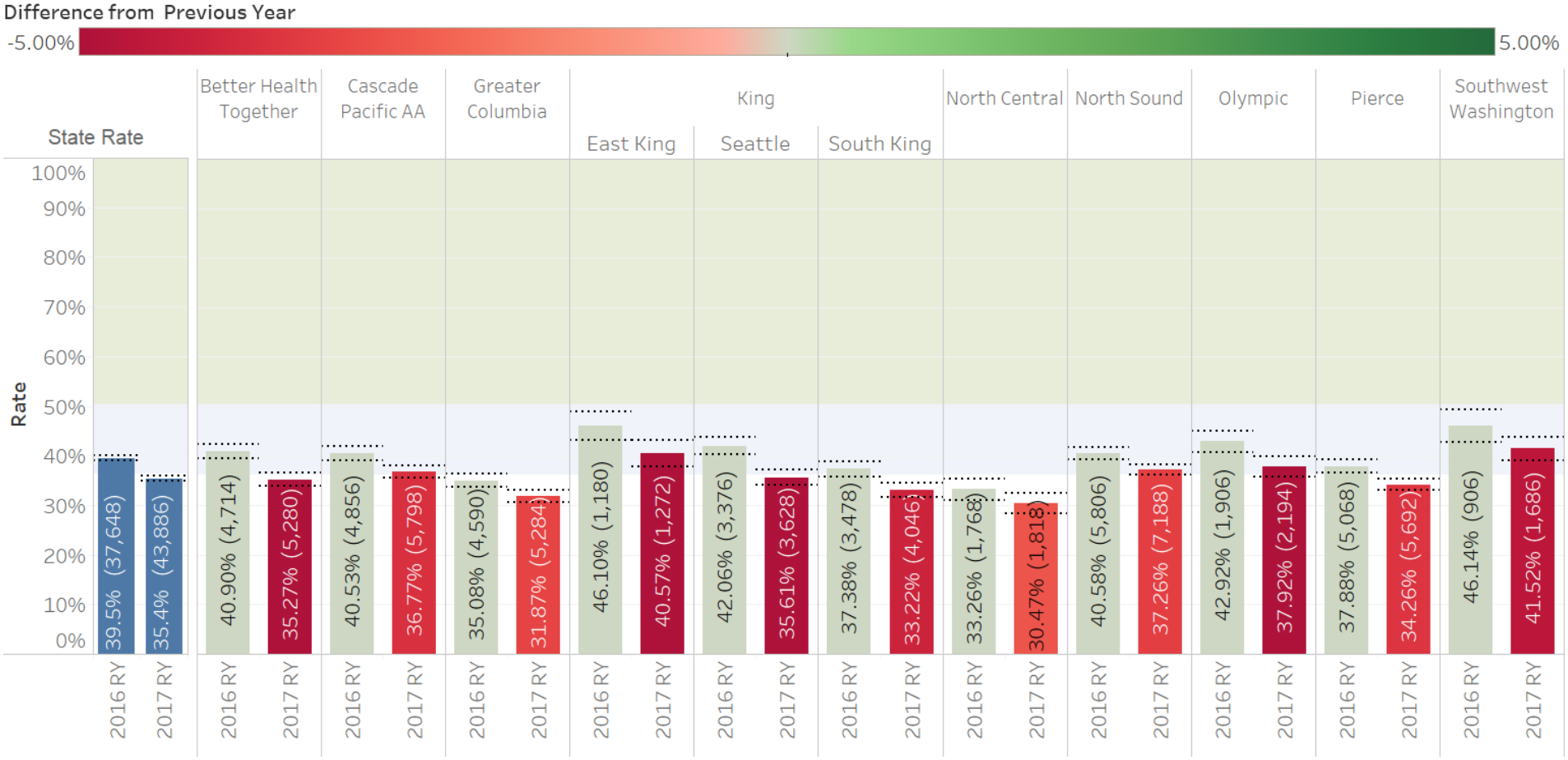
Table 48: Antidepressant Medication Management, Continuation Treatment Phase, Performance by Region



Year-to-Year Performance

As for the acute treatment phase measure, performance on this measure has dropped over time in every region. Significant drops can be seen in Better Health Together, Cascade Pacific AA, Greater Columbia, Seattle, South King, North Sound, Olympic, and Pierce.

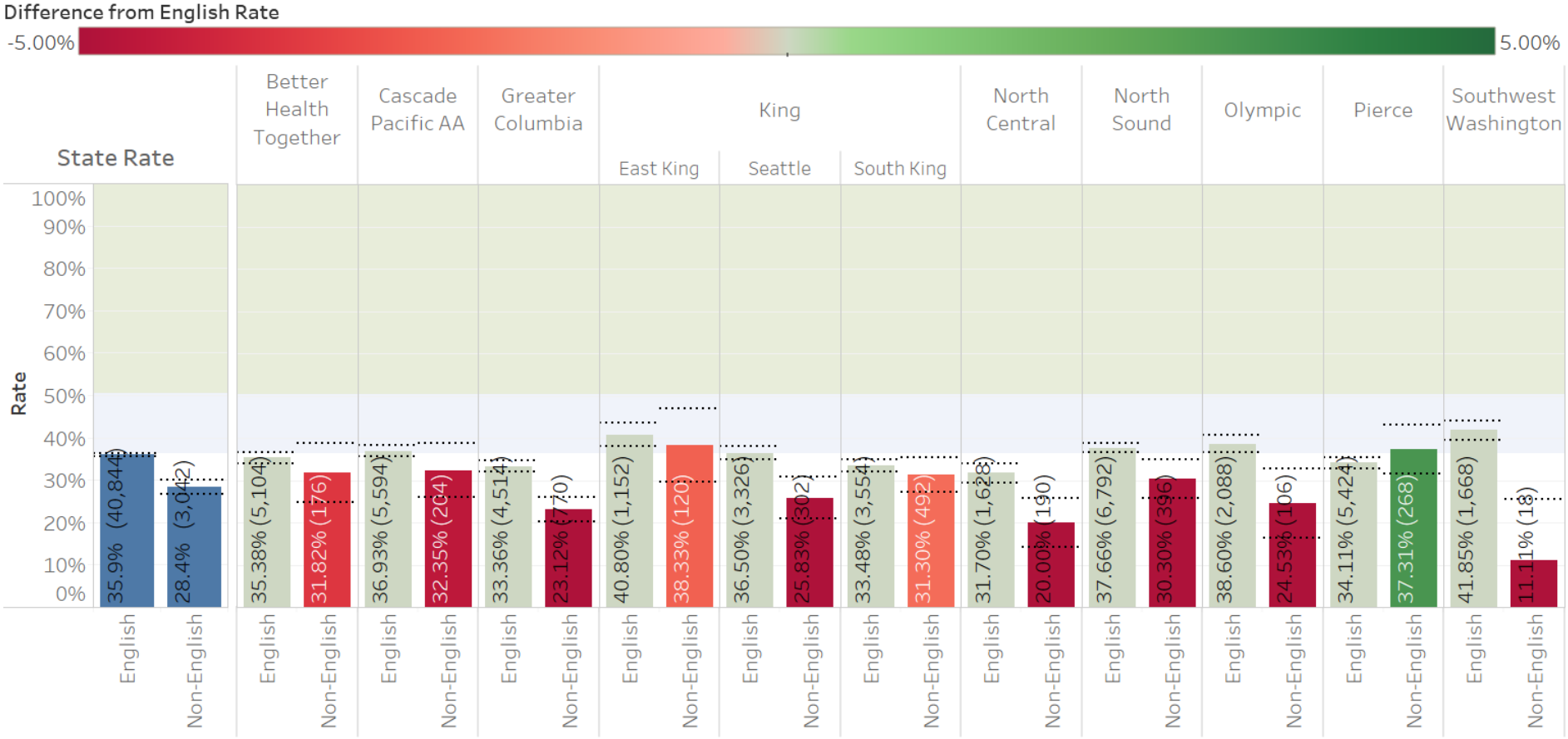
Table 49: AMM–Continuation Treatment Phase, Performance Statewide and by Region, 2016 RY to 2017 RY



Variation by Language

Again, rates for non-English-speaking enrollees were lower than for English speakers, with significant margins in Greater Columbia, Seattle, North Central, North Sound, Olympic, and Southwest Washington.

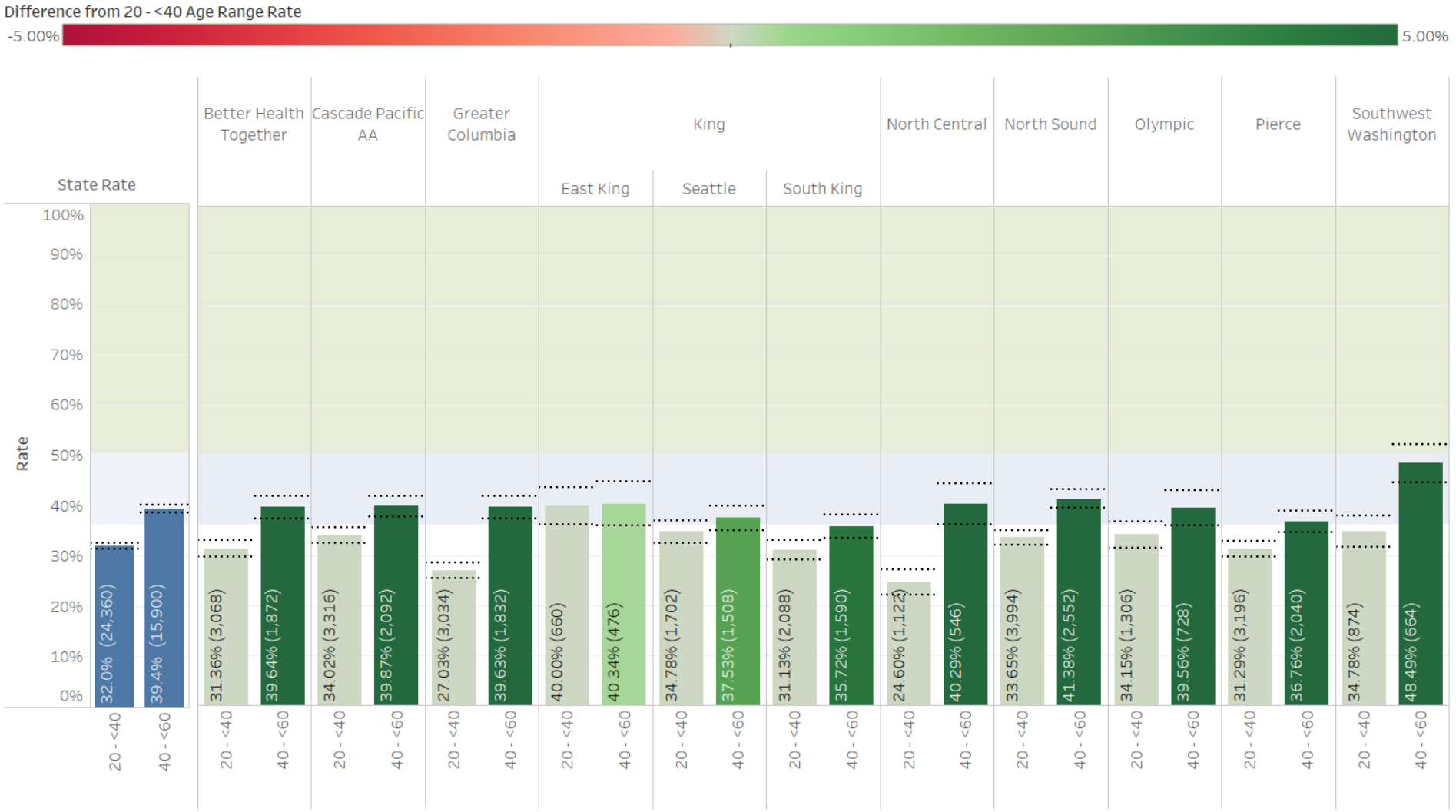
Table 50: AMM–Continuation Treatment Phase, Variation by Region and Language



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 considerably lower than for those enrollees ages 40–60. The difference is most substantial in Greater Columbia, North Central, and Southwest Washington.

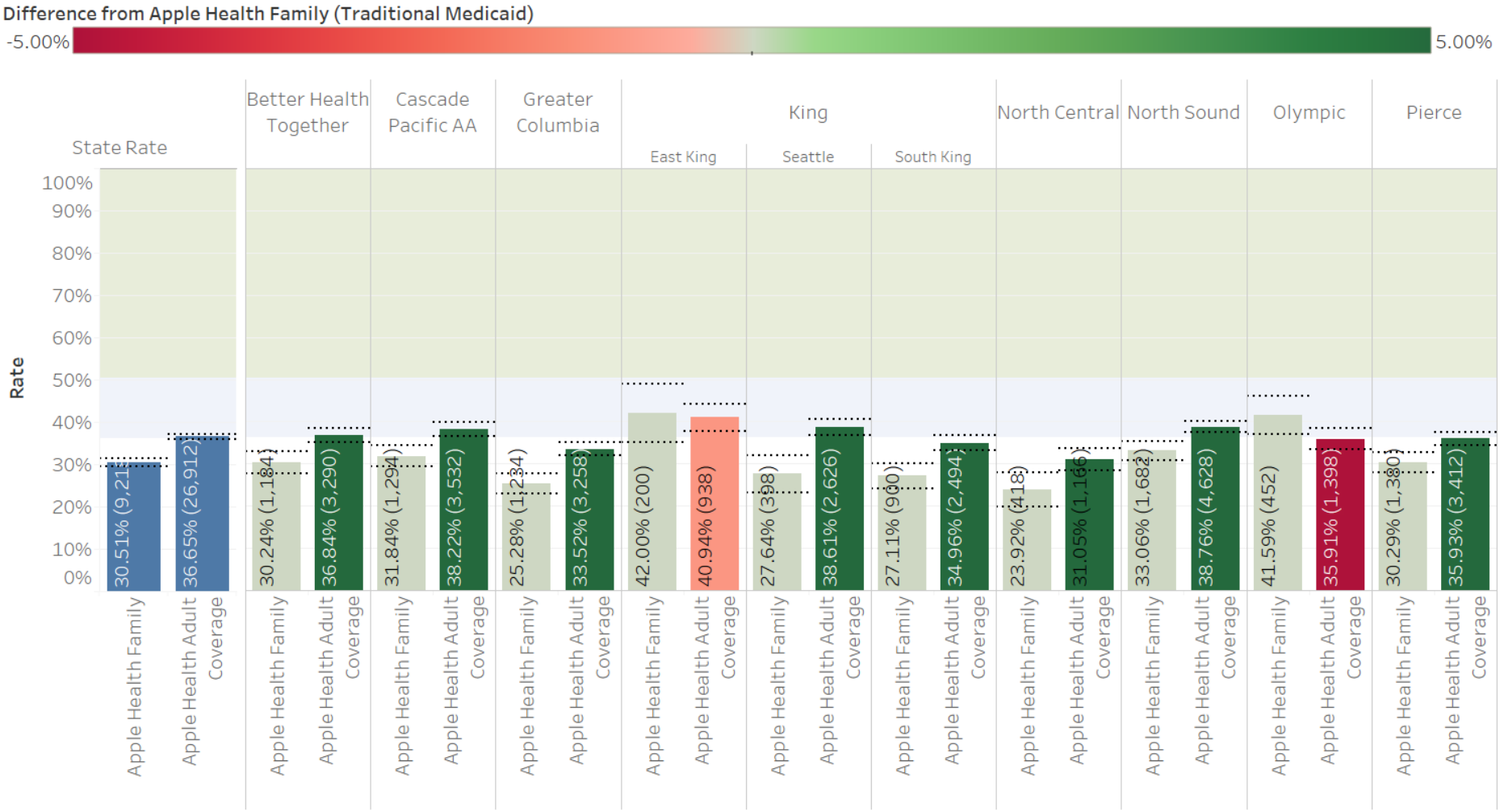
Table 51: AMM–Continuation Treatment Phase, Variation by Region and Age



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

Rates are also better on this measure for Apple Health Adult Coverage enrollees overall, with significant leads over the Apple Health Family population in Better Health Together, Cascade Pacific AA, Seattle, South King, North Central, and Olympic.

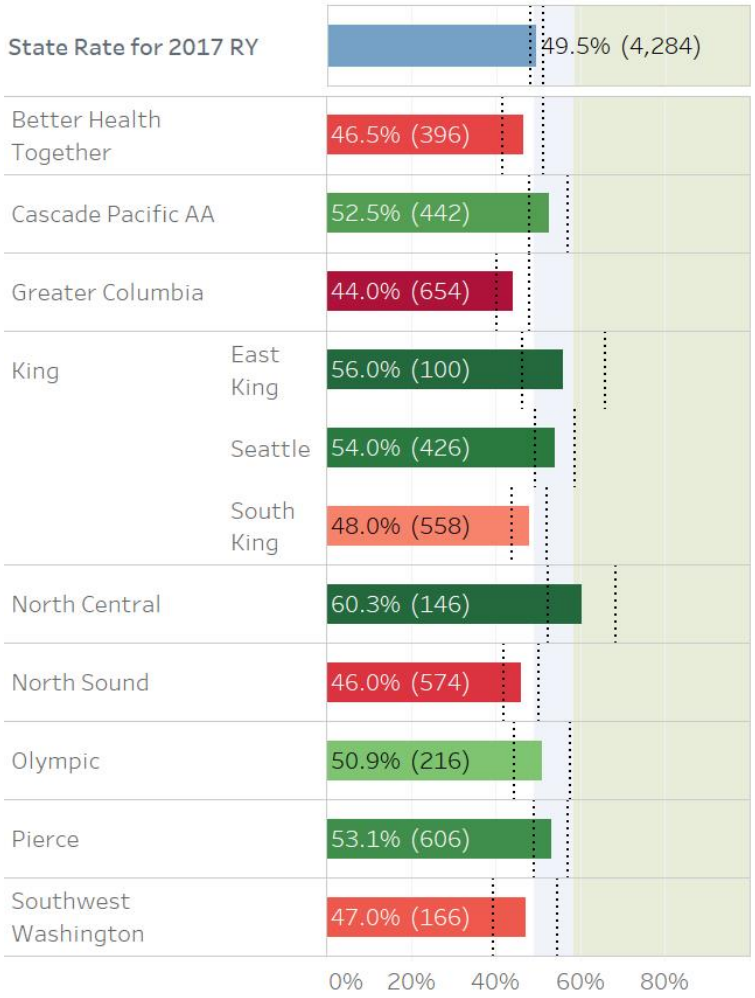
Table 52: AMM–Continuation Treatment Phase, Variation by Region and Program

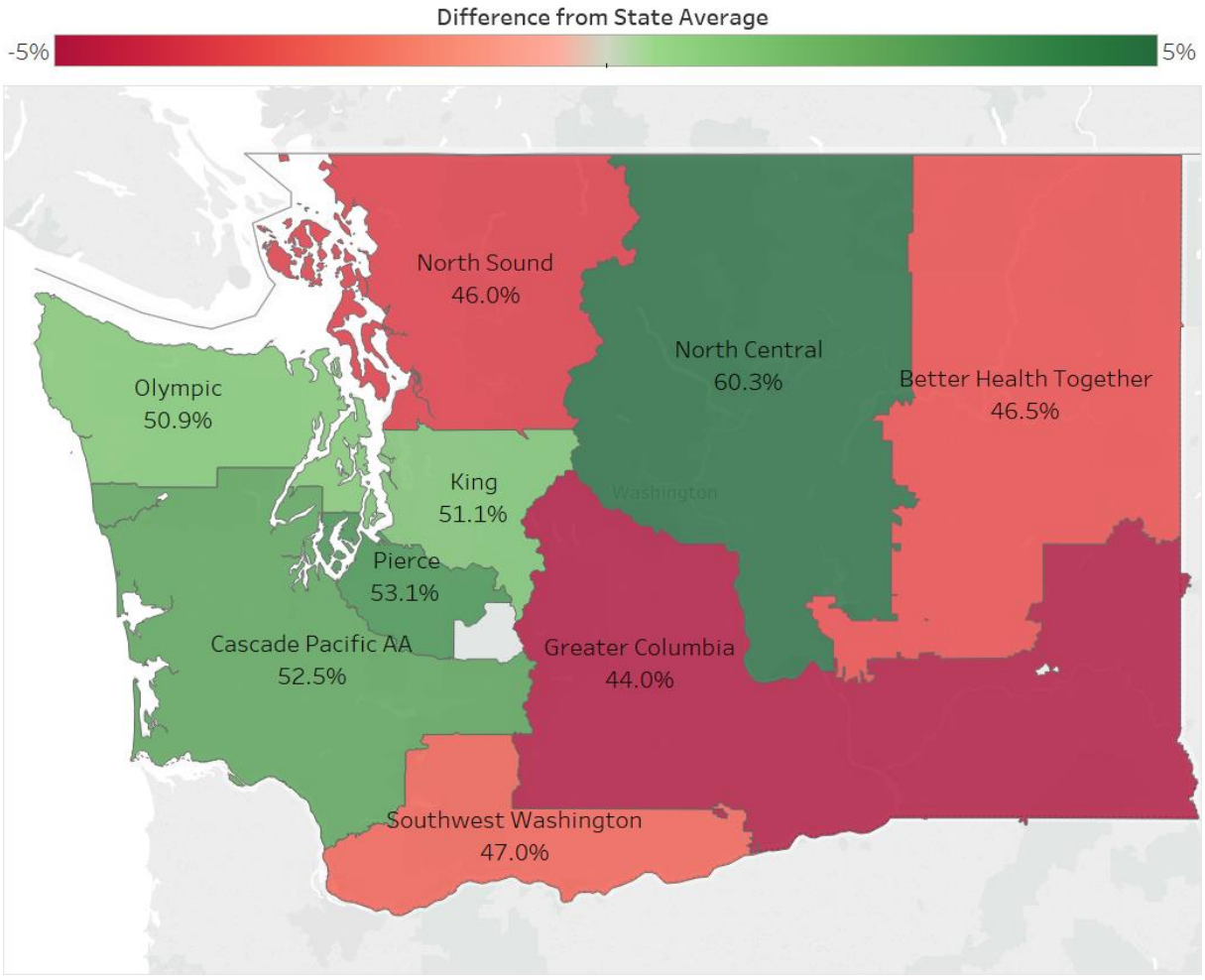


Comprehensive Diabetes Care—HbA1c Control (< 8 Percent)

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 percent (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 substantial variation on this measure, with more than 16 percentage points separating the highest (North Central) and lowest (Greater Columbia) regional rates.

Table 53: Comprehensive Diabetes Care—HbA1c Control (< 8 Percent), Performance by Region

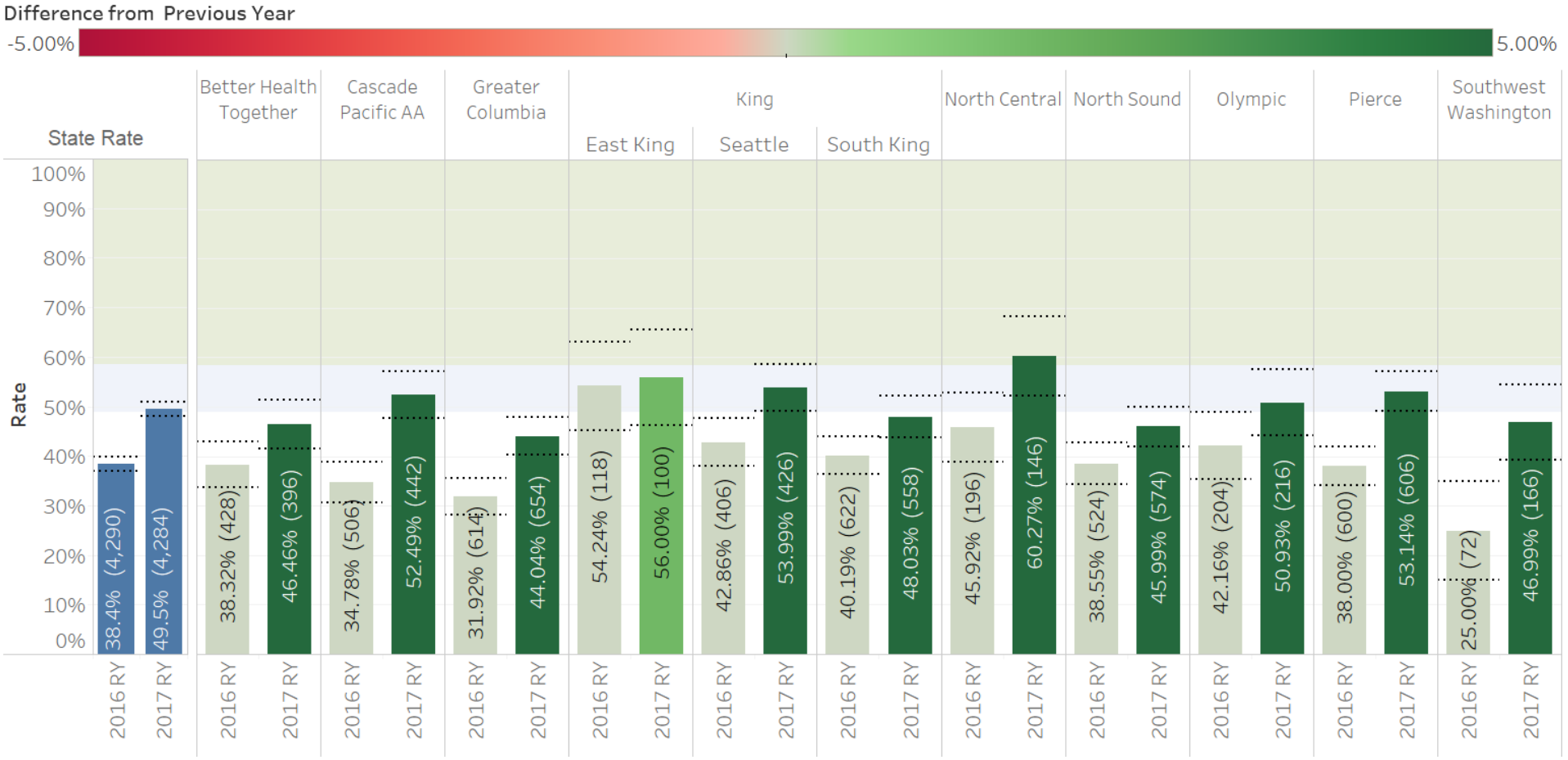




Year-to-Year Performance

At a state level, performance rates for this measure have shifted up significantly. Rates in Cascade Pacific, Greater Columbia, Seattle, Pierce, and Southwest Washington all showed significant increases since 2016 RY.

Table 54: Comprehensive Diabetes Care—HbA1c Control (< 8 Percent), Performance Statewide and by Region, 2016 RY to 2017 RY



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 2016 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, as noted on page six, this information was not included in the PLD 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* 2017 Comparative Analysis Report*.*

In this section, the following key applies:

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

90^{th}+ national percentile

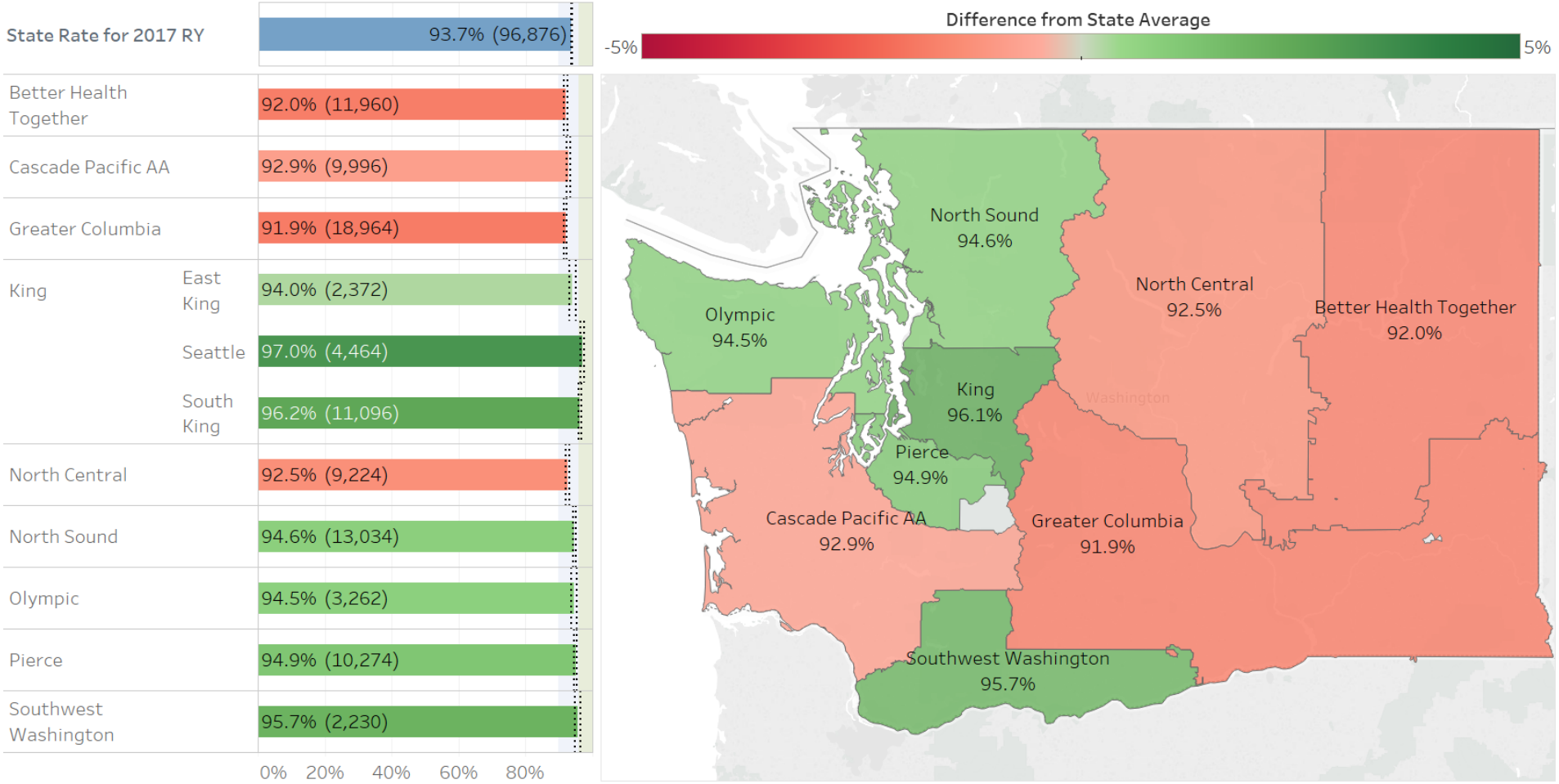
confidence interval around measure outcome

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 and South King.

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



Year-to-Year Performance

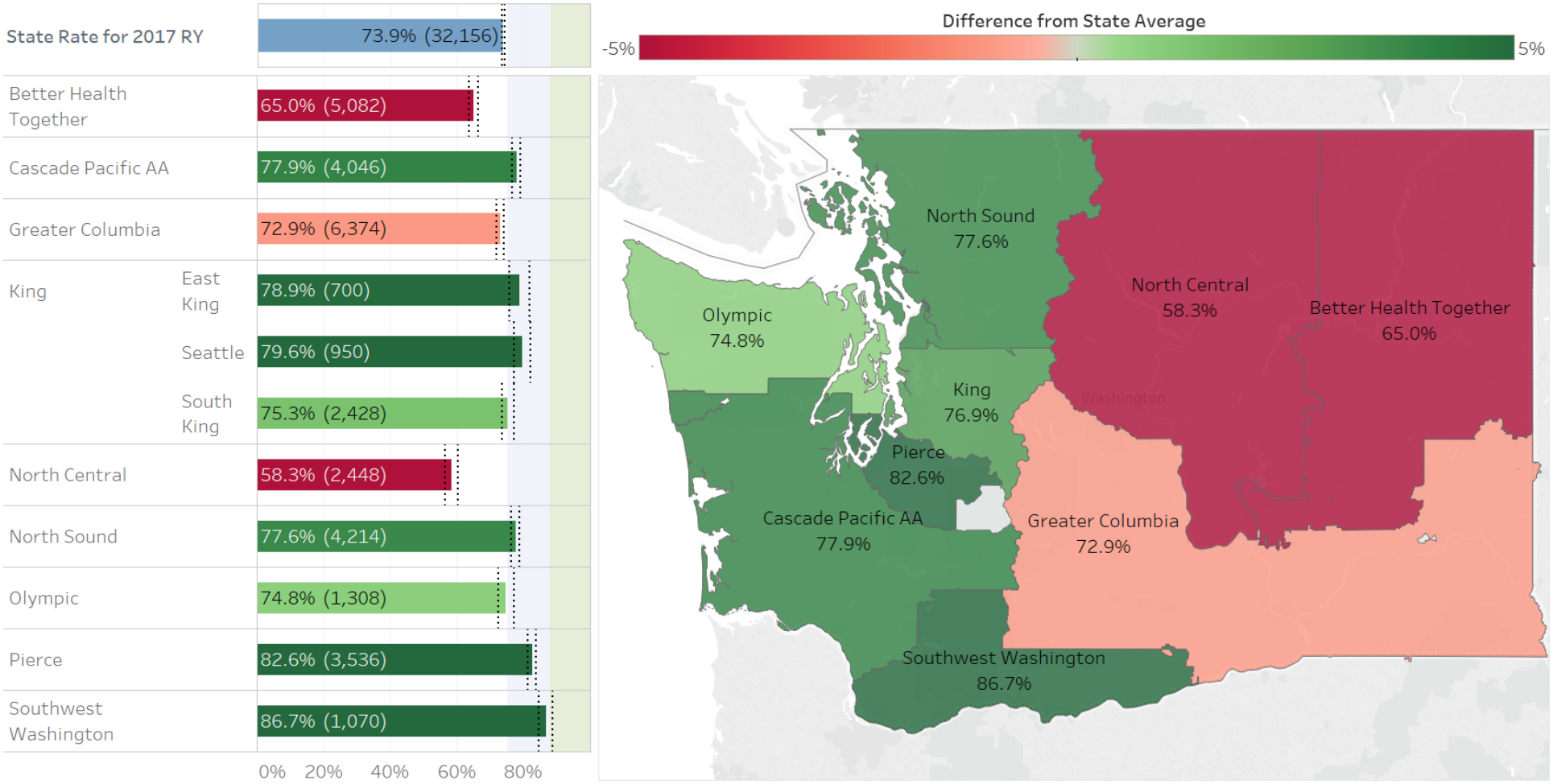
Statewide performance on this measure has remained steady since 2016 RY, without any significant rate change by region.

Table 56: Appropriate Treatment for Children with Upper Respiratory Infection, Performance Statewide and by Region, 2016 RY to 2017 RY

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. Note that North Central and Better Health Together are low outliers, while Pierce, Southwest Washington, East King, and Seattle are high outliers. Variation for this measure is more than 28 percent, which is a huge swing in behavior.

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



Variation by Language

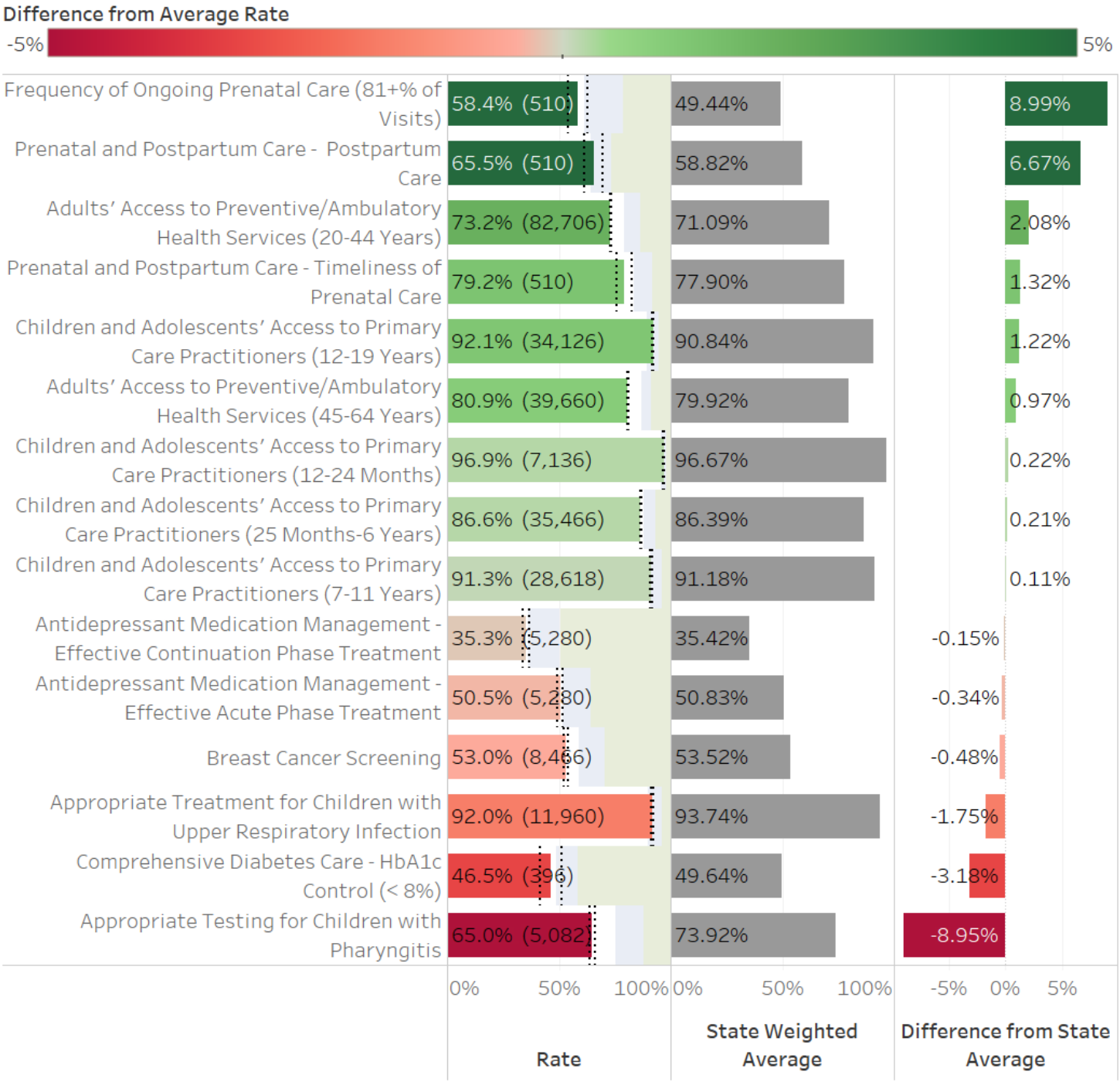
Notice the larger differences between rates for English and non-English speakers for Better Health Together, North Central, and North Sound.

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

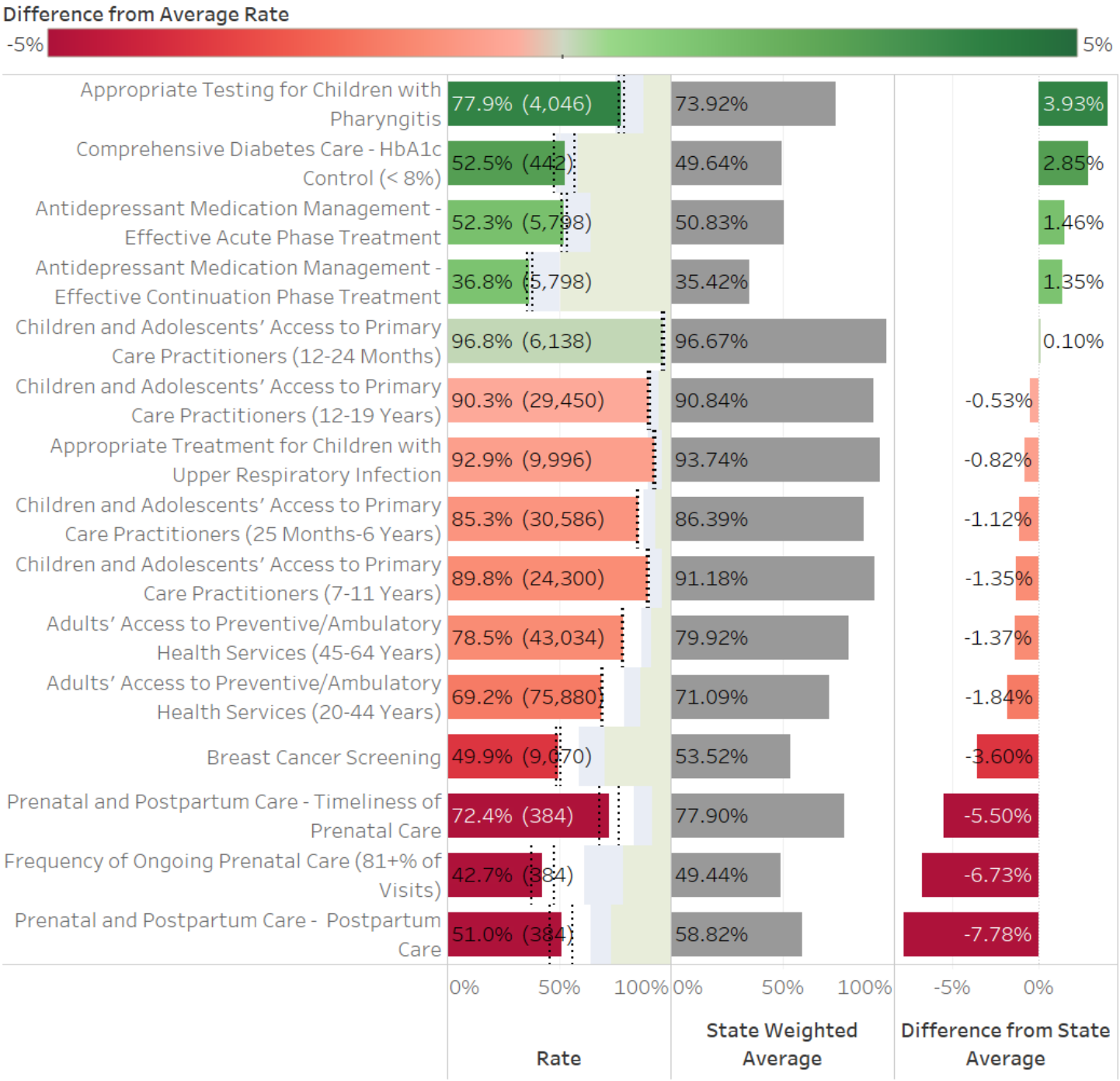
Appendix A: Regional Scorecards

Better Health Together	A-2
Cascade Pacific Action Alliance	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

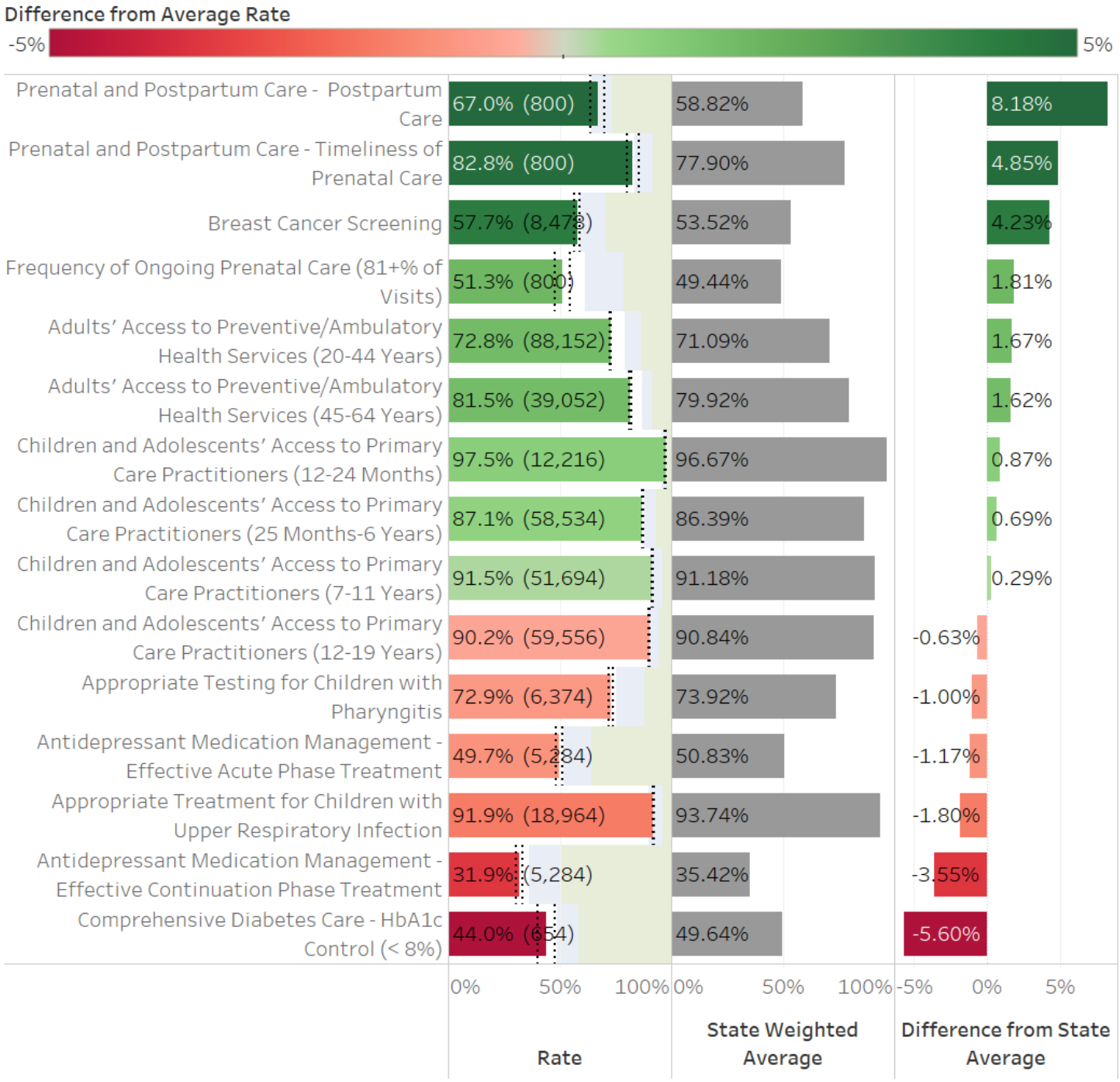
Regional Scorecard: Better Health Together



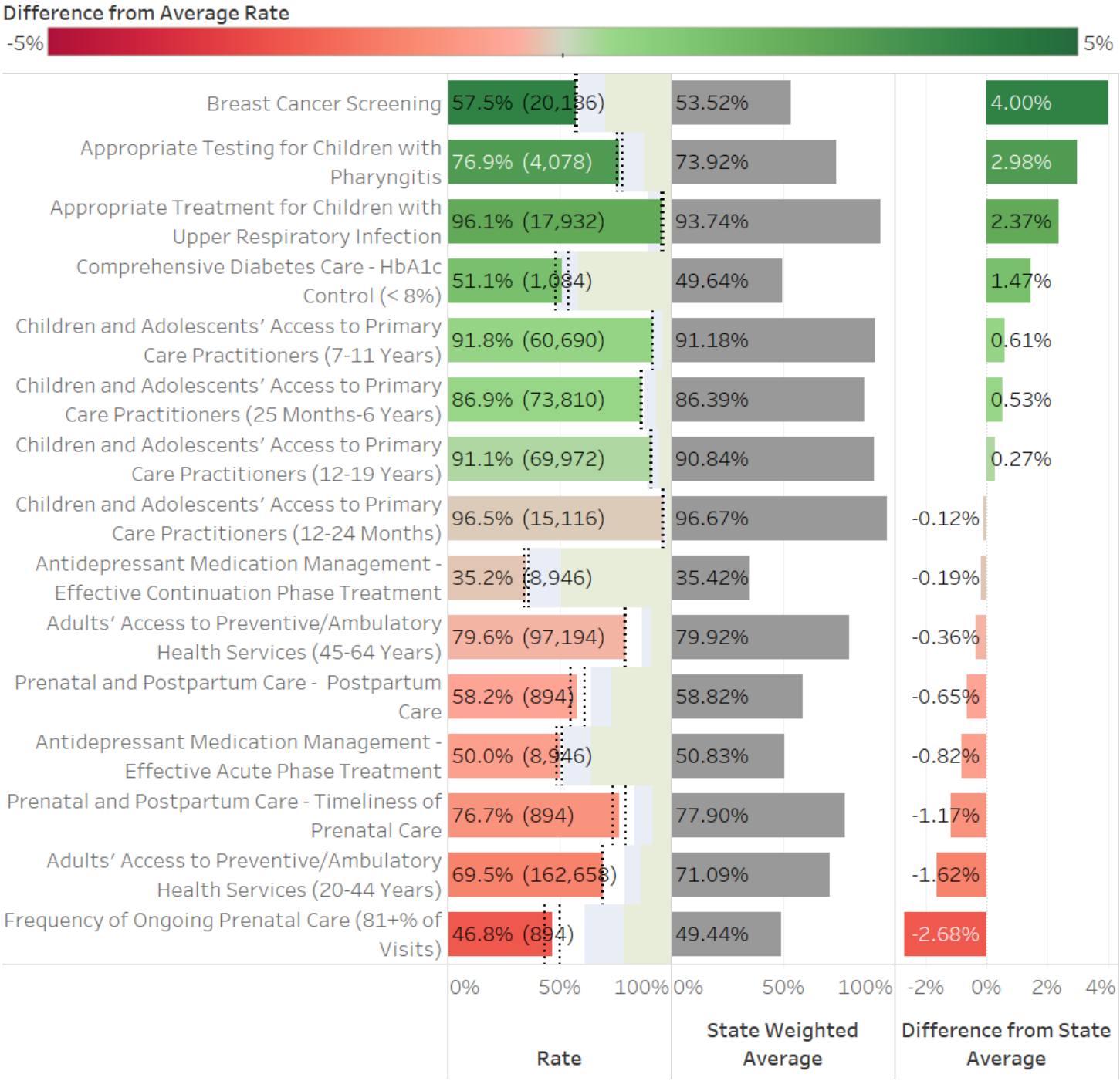
Regional Scorecard: Cascade Pacific Action Alliance



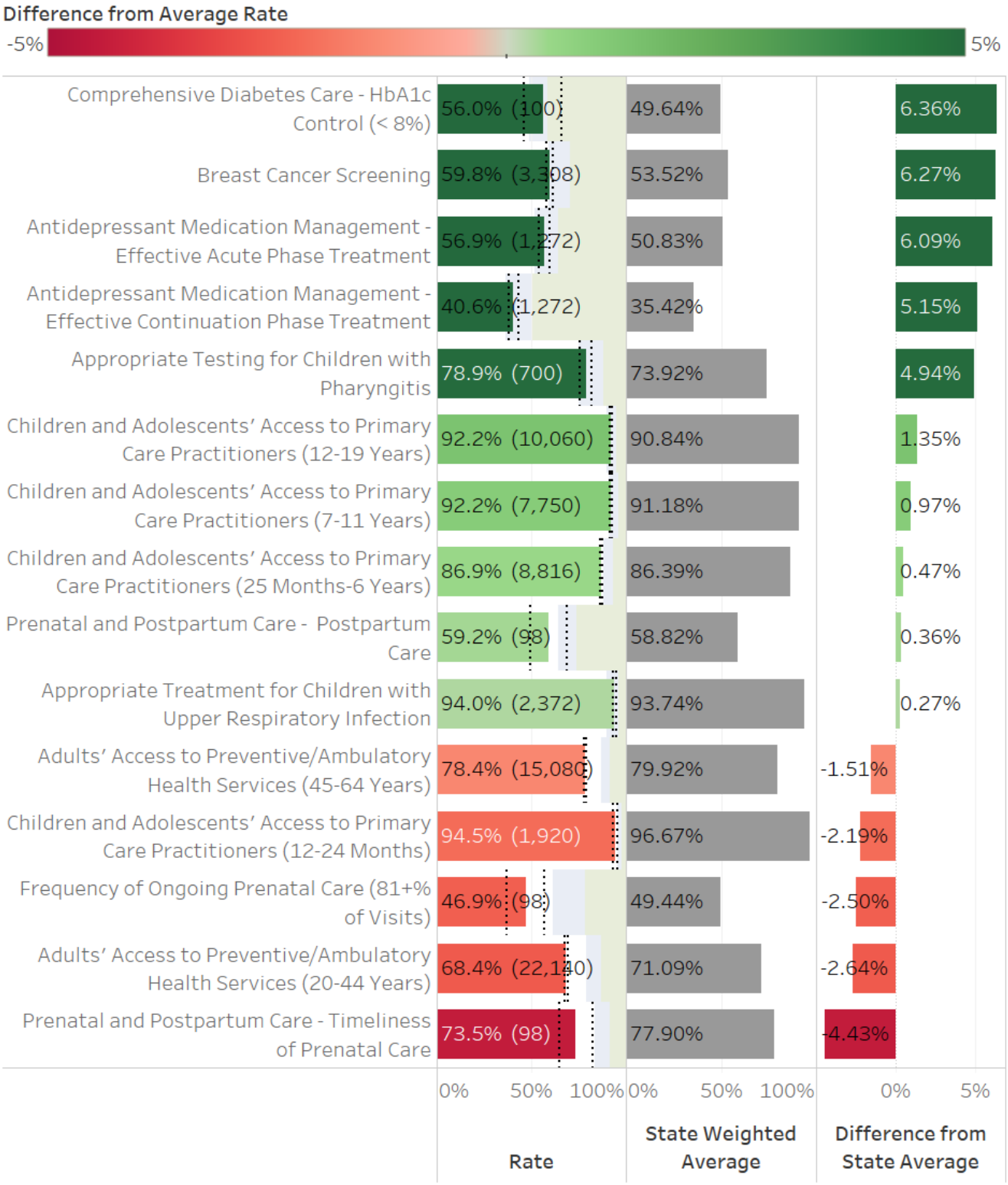
Regional Scorecard: Greater Columbia



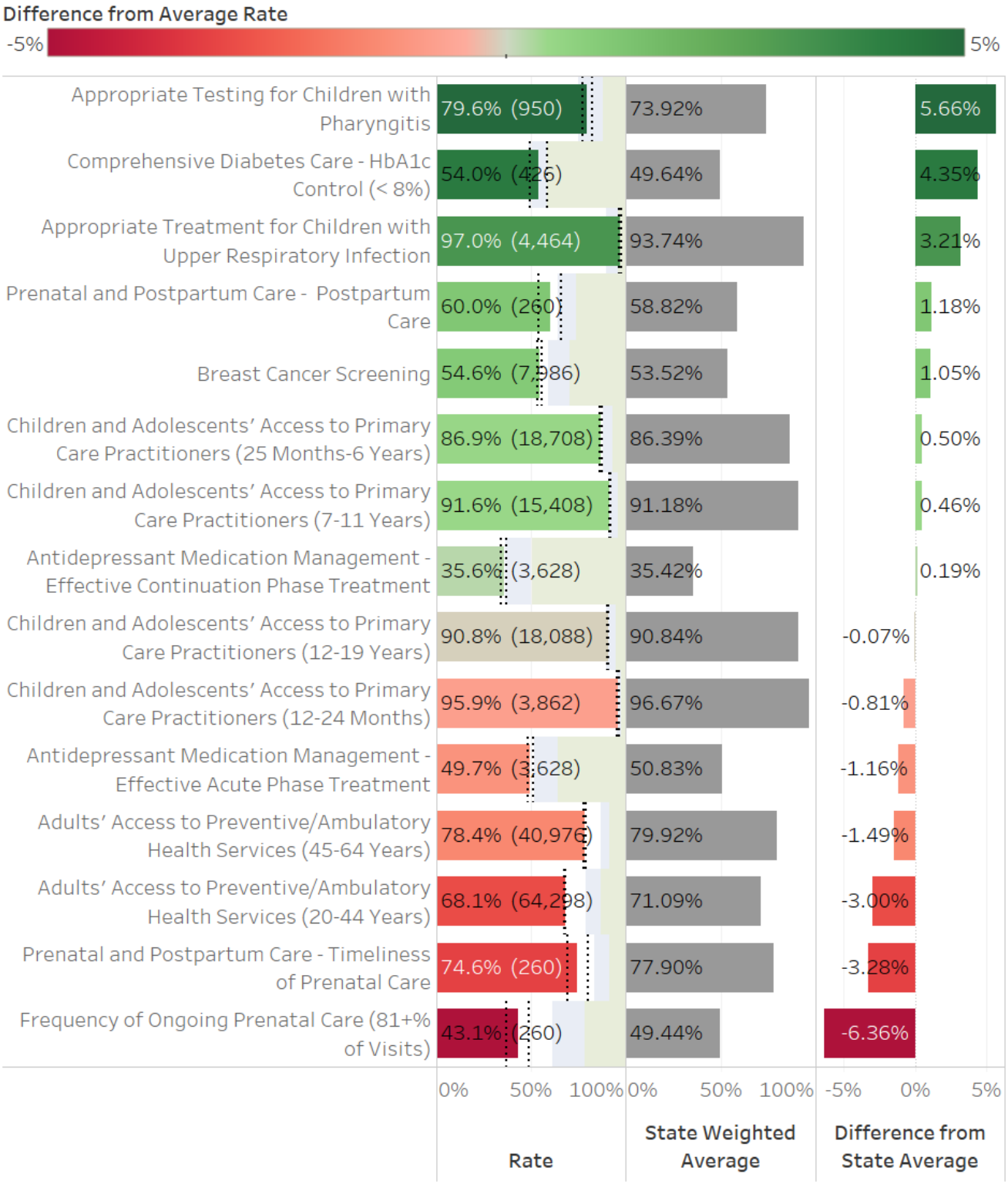
Regional Scorecard: King



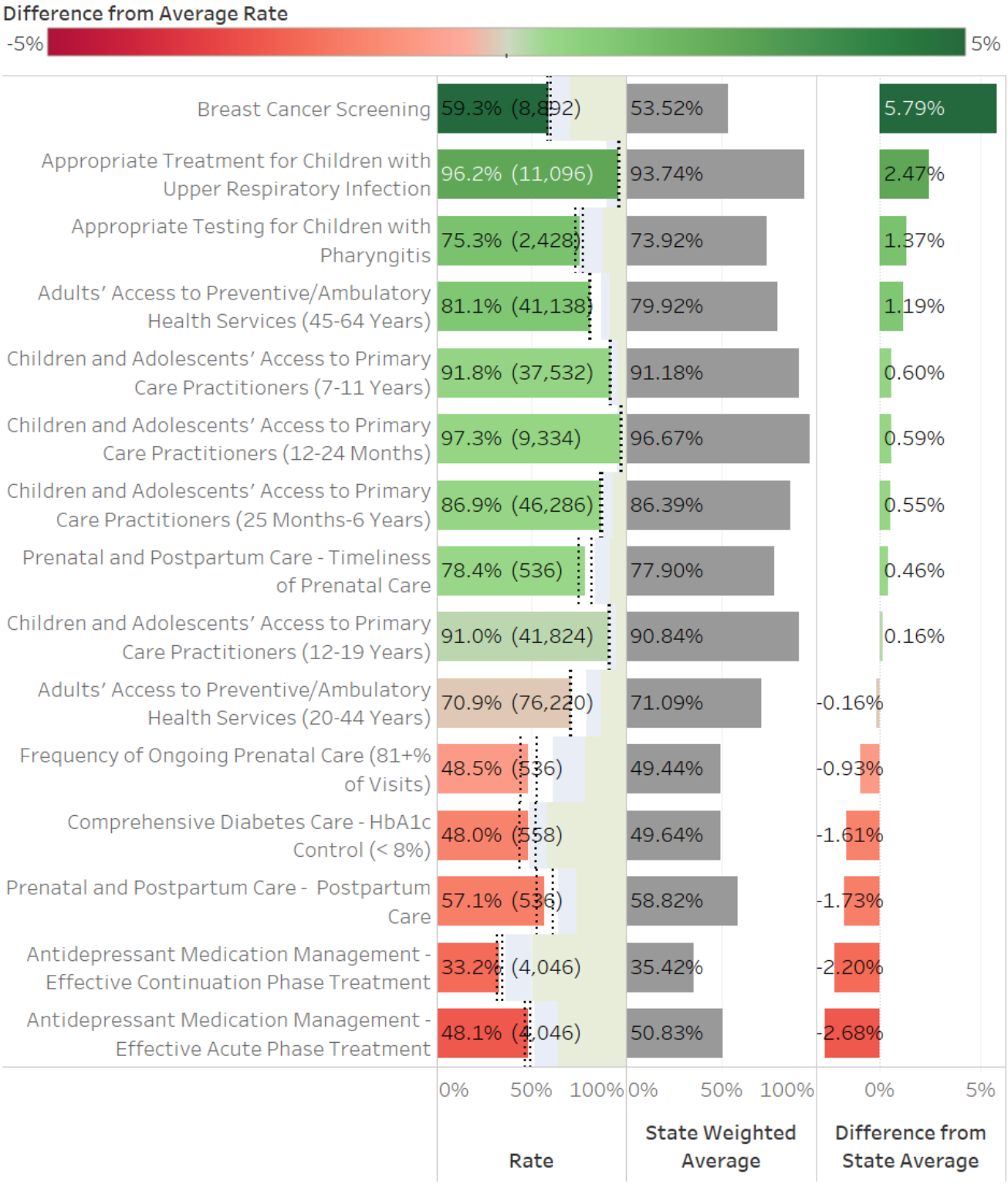
Regional Scorecard: East King



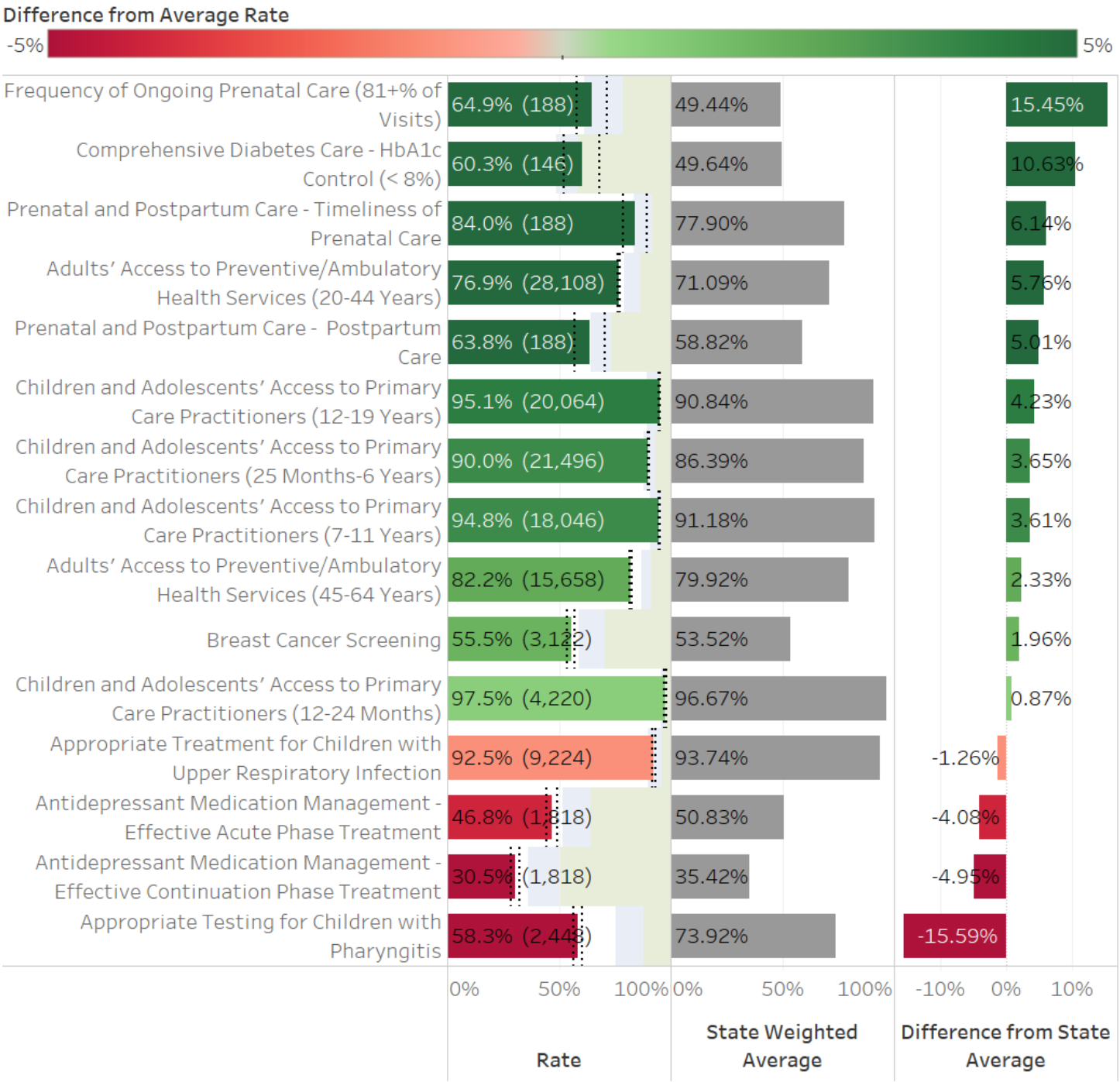
Regional Scorecard: Seattle



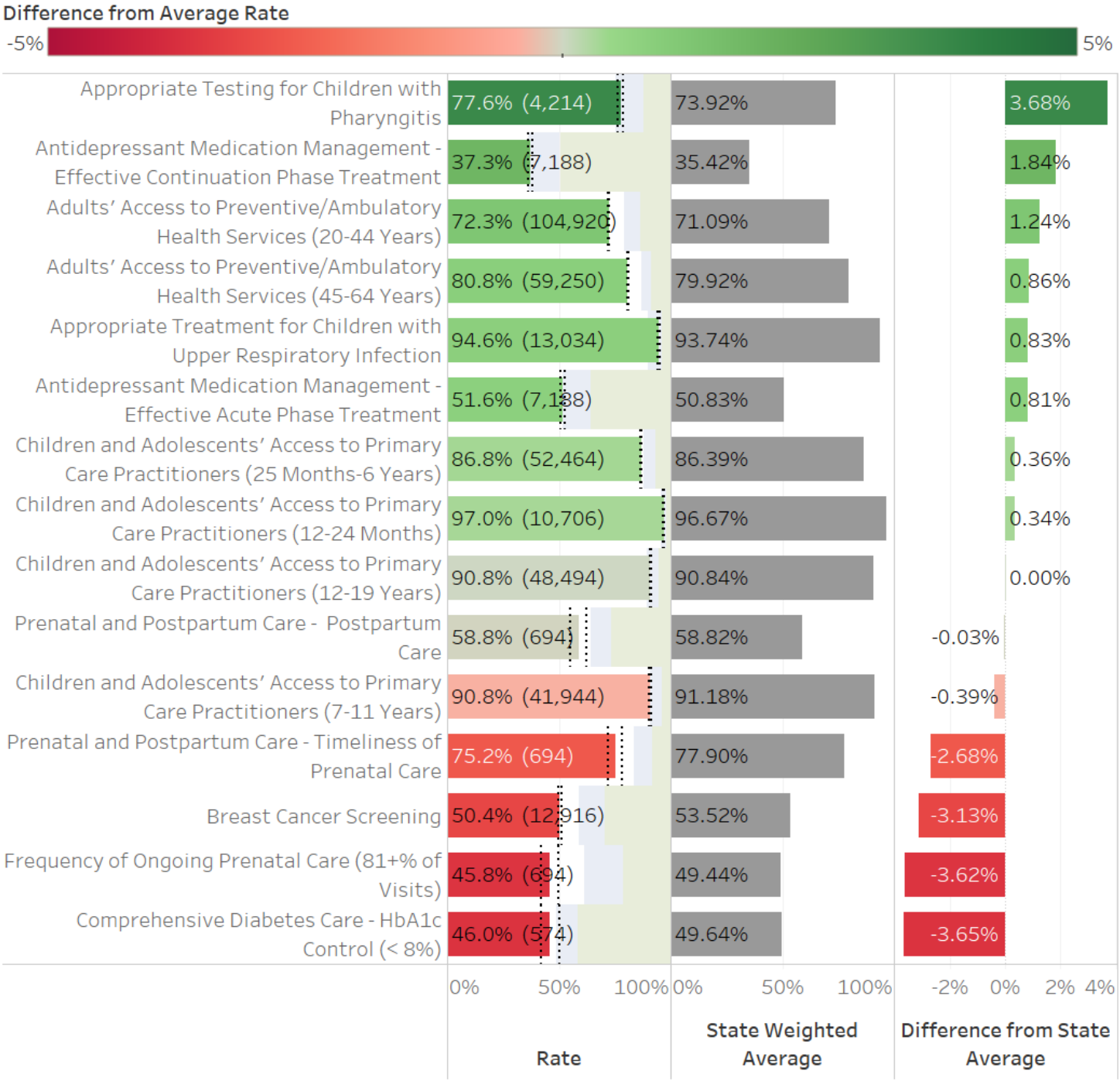
Regional Scorecard: South King



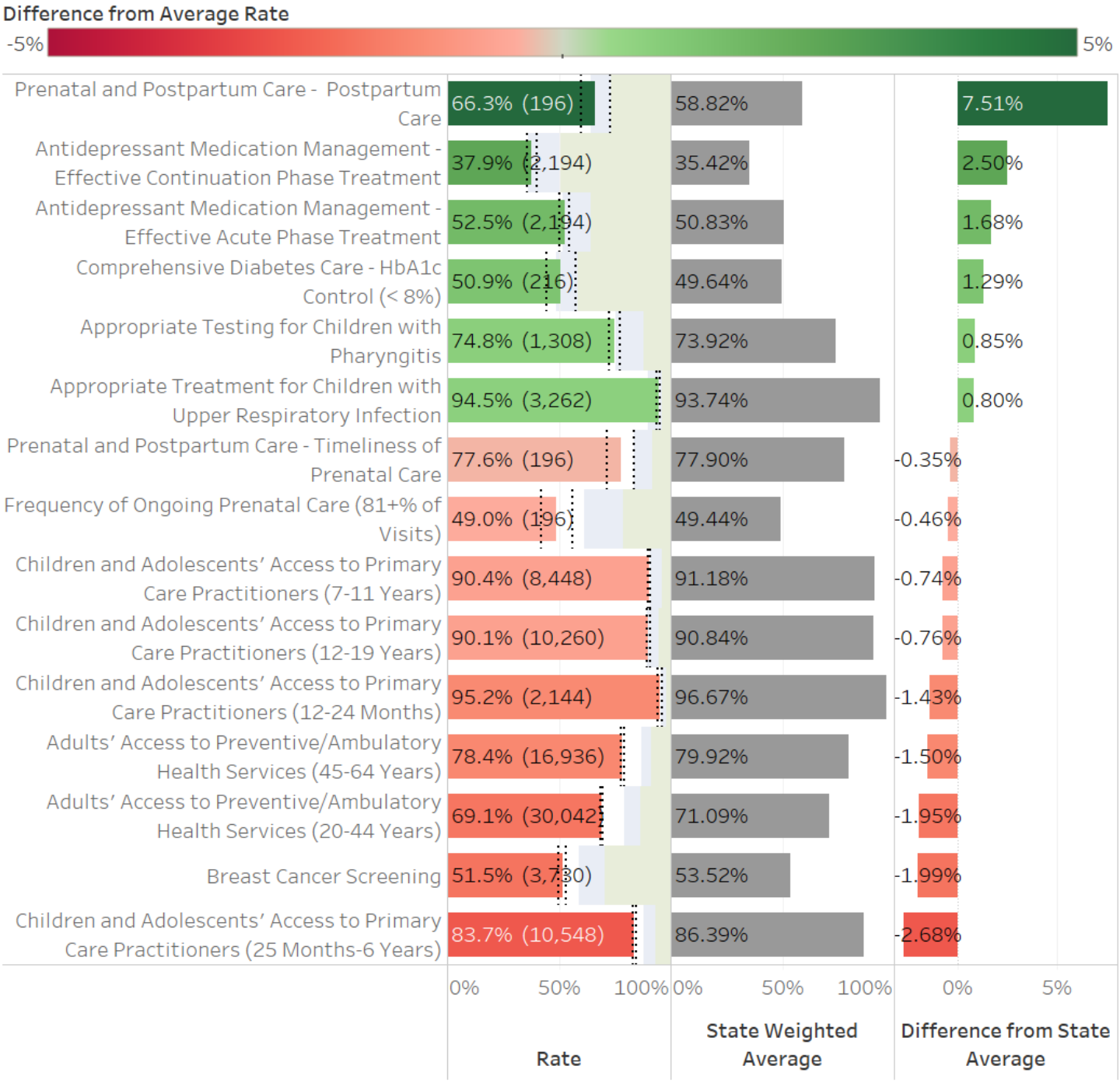
Regional Scorecard: North Central



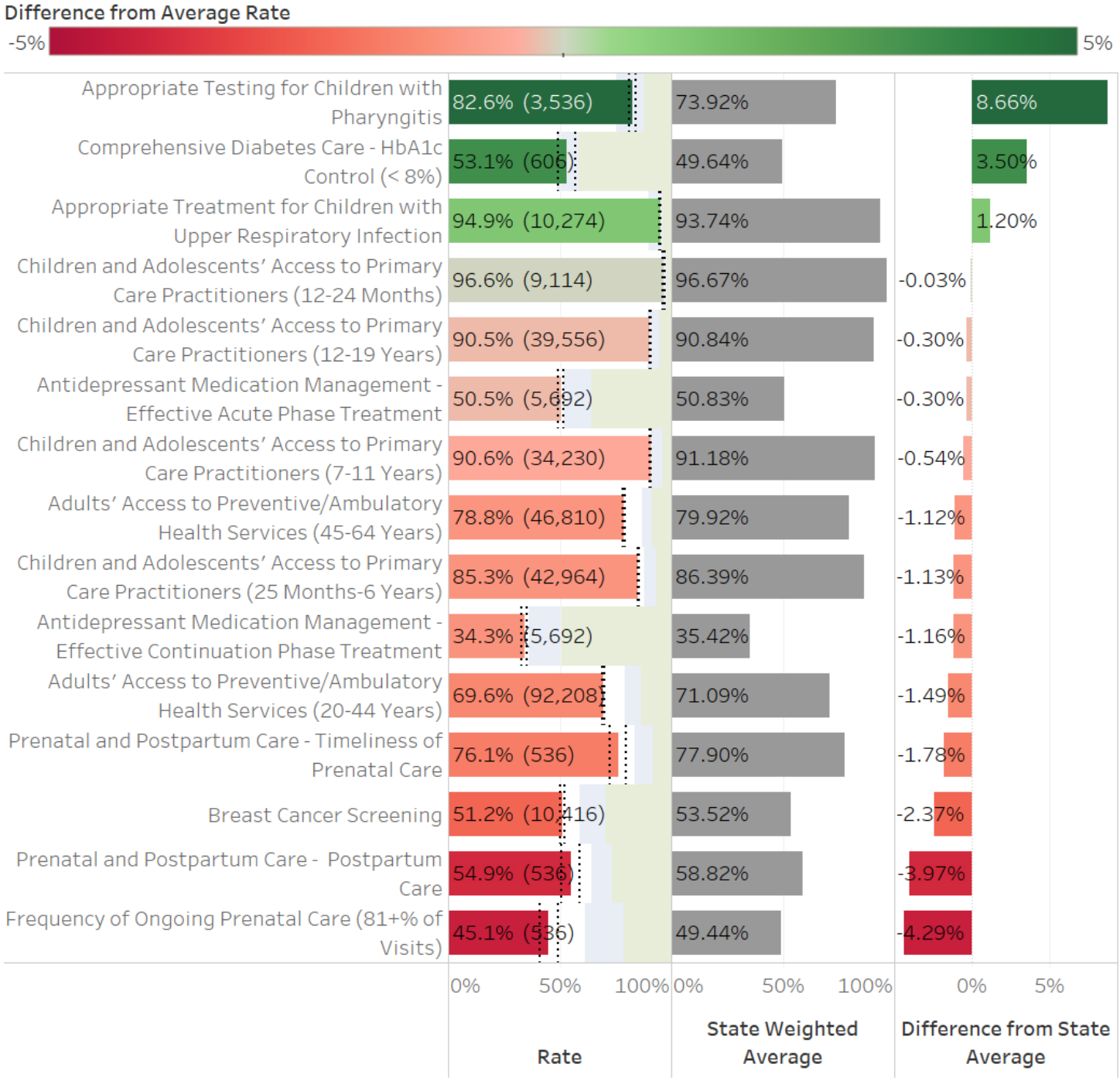
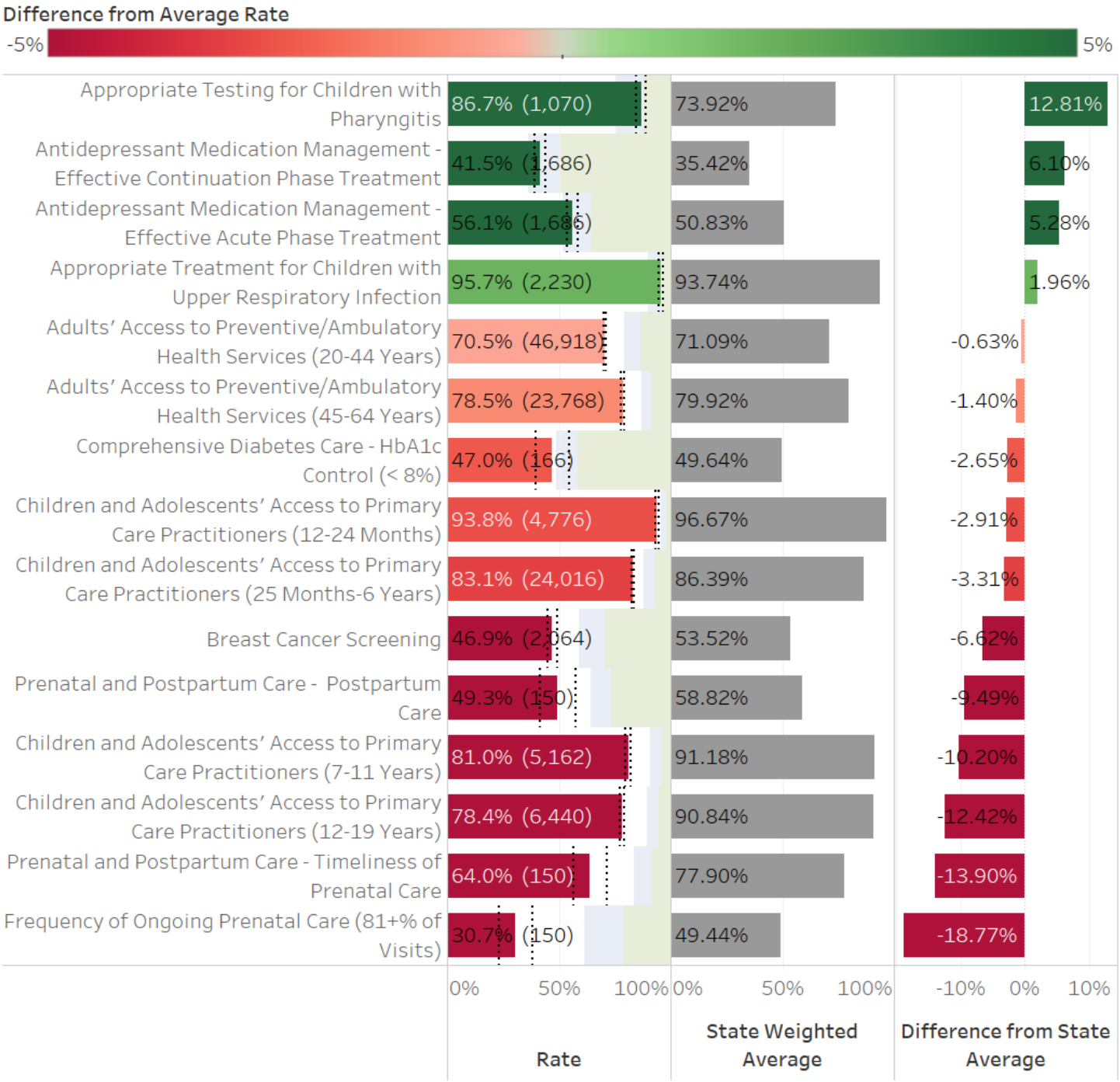
Regional Scorecard: North Sound



Regional Scorecard: Olympic



Regional Scorecard: Pierce



Regional Scorecard: Southwest Washington