Comparative Analysis Report

Washington Apple Health

Washington Health Care Authority

December 2015

QUALIS HEALTH™

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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Overview

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 organizations (MCOs) and the managed mental healthcare services.

This *Comparative Analysis Report* documents performance among Apple Health MCOs during the 2014 measurement year (2015 reporting year). The report comes during a time of transformation in Washington's Medicaid program. As a result of the expansion of Medicaid coverage under the Affordable Care Act, Apple Health enrollments grew by over 40 percent during 2014, covering over 1.3 million people by the end of the year. Washington is on a path to transform the way healthcare is furnished in the state through initiatives such as Healthier Washington, behavioral and physical health integration, introduction of value-based payments, greater community and consumer empowerment through Accountable Communities of Health and primary practice transformation.

Most of the performance measures found in this report come from NCQA's HEDIS® and AHRQ's CAHPS® measure sets. For some measures, the State has contractually defined goals that MCOs must meet. In an ongoing effort to improve the quality of care for enrollees, the report aims to:

- Contribute to the Centers for Medicare & Medicaid Services (CMS) requirements for an external quality review of managed care organization performance in Washington
- Provide transparency allowing stakeholders and consumers to have visibility to health plan performance information
- Encourage ongoing quality improvement by all stakeholders in Washington's Apple Health program

A companion *Regional Analysis Report* provides regional comparisons of selected performance measures. Our aim is that these reports inspire better alignment between MCO performance and State healthcare initiatives. Qualis Health welcomes your questions and comments regarding these reports.

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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 2014 calendar year (CY). The MCOs were required to report more than 30 Healthcare Effectiveness Data and Information Set (HEDIS) measure items in order to assess the levels of quality, timeliness and access to healthcare services that they furnished to Apple Health Medicaid enrollees. HEDIS measures were developed and are maintained by the National Committee for Quality Assurance (NCQA). NCQA's database of HEDIS results for health plans enables benchmarking against other Medicaid managed care health plans nationwide.

During 2014, five MCOs provided care for Apple Health enrollees:

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

An additional Medicaid MCO, Columbia United Providers (CUP), began operations in Washington in 2015. As CUP was not operating in Washington in 2014, its performance is not reviewed in this report.

To be consistent with NCQA methodology, the 2014 measurement year (MY) is referred to as the 2015 reporting year (RY) in this report.

Background Trends

The primary purpose of this report is to summarize MCO performance drawing from selected HEDIS measures. Multiple environmental factors may influence performance, including:

- **Medicaid Expansion:** Between January and December 2014, total Apple Health enrollment grew by over 40 percent. Medicaid expansion impacted each MCO differently. MCOs with rapid growth may have experienced strain among provider networks. It is important to note that for most measures included in this report, one year of continuous enrollment is required for inclusion. As a result, many newly insured individuals are not directly reflected. This report more accurately measures the impact of Medicaid expansion on members who were insured prior to and through 2014.

- **Blind or Disabled Individuals in Managed Care:** Most individuals eligible for Apple Health now receive care from one of the MCOs; only about 10 percent of eligible individuals are still covered by traditional fee-for-service models. The transition toward managed care includes thousands of individuals who are eligible for Apple Health because of their blind/disabled status. In early 2014, these individuals were not evenly distributed across MCOs, which may have influenced the observed overall performance for some measures. With the rapid enrollment growth during 2014, differences among the MCOs in the percent of blind or disabled members were greatly reduced. By the end of the year, the shares of blind and disabled members in each MCO ranged from 6 to 7 percent across the five MCOs.

Performance Highlights

Washington Apple Health overall performance is summarized below. As an aid for quickly reviewing performance, the following symbols are used to summarize each group of measures: ▼(poor performance), ◄►(average performance), ▲(good performance), ±(mixed performance).

Access

Health plans are responsible for ensuring care is convenient and 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 routine healthcare. Access is measured by the frequency of primary care, well-child and maternal health visits.

- **Primary care visits (◄►):** The rapid growth in enrollments during 2014 makes it difficult to generalize performance on access to primary care, but overall access measures were reasonably adequate for Apple Health members. The percentage of adults who had at least one primary care visit was slightly below the national average, while the percentage for children was slightly above. Overall, the outpatient visit rate per 1,000 member months declined slightly in the 2015 reporting year from the previous year, and was about 93 percent of the national average rate. MCOs with rates below the state average tended to be both newer MCOs in Washington and more strongly impacted by Medicaid expansion, and are likely working to expand their provider networks.

- **Well-child visits (▼):** The percentage of well-child visits for Apple Health children and adolescents registered a relatively poor performance, remaining below the national average and declining between the 2014 and 2015 reporting years. The State has set goals for these measures as contract provisions for MCOs; all MCOs fell below at least one goal level and will be required to implement performance improvement projects. It is unclear whether these measures were low because of incomplete medical coding or an actual deficiency in the number of well-care visits, given that the percentage of children with primary care visits was above the national average.

- **Maternal health visits (▼):** Apple Health was well below the national average on three key maternal health visit rates: timeliness of prenatal visits (in the first trimester), the percentage of pregnant women with 81 percent or more of their recommended prenatal visits (the recommended number for this measure depends on the member's stage of pregnancy at time of enrollment), and the percentage of new mothers with postpartum visits. Improvement on these measures will be key to achieving Healthier Washington goals relating to decreases in disparities in adverse birth outcomes.

Preventive Care

Effective preventive care is delivered proactively, before the onset of disease. Perhaps the best example of primary preventive care is immunization from disease, which must be administered at the right ages for highest effectiveness. Other types of preventive care and screenings also should be delivered at the right time to be effective, such as cancer screenings, and weight and nutrition counseling.

- **Child and adolescent immunizations (▲):** Two commonly reported combinations of vaccines (2 and 3) for children under the age of two improved over the previous year, with one now surpassing the national average. Adolescent immunizations (Combination 1) also improved and surpassed the national average.

- **Weight assessment and counseling (±):** The percentage of Body Mass Index (BMI) assessments was very low for Apple Health children (20 points lower than the nation). Counseling for nutrition and

physical activity were also below the national average, although physical activity counseling rose significantly in 2015. BMI assessments for adults were nominally above the national average.

- **Women's health screenings (▼):** All three measures of women's health screenings were significantly below national averages, including breast cancer, cervical cancer and chlamydia. The percentage of girls receiving human papillomavirus (HPV) vaccinations before the age of 13 was above the national average.

Quality of Care

Health plans can greatly enhance quality of care and outcomes by helping providers coordinate care so that chronic illness is effectively managed and unnecessary or inappropriate care is avoided.

- **Diabetes management (▲):** Process measures for the detection of diabetes, including hemoglobin A1c (HbA1c) (blood sugar) testing, eye exams and checking for kidney damage, were all above national averages. Outcome measures like controlling high blood pressure and keeping blood sugar levels in control were near the national average for Apple Health members with diabetes. Diabetes screening and monitoring measures for individuals with schizophrenia were both above the national average.

- **Other chronic care management (±):** Management of asthma medication was nominally below the national average, very good for chronic obstructive pulmonary disease (COPD) medications and average for antidepressant medications. Follow-up care for children prescribed attention deficit hyperactivity disorder (ADHD) medication was below the national average, and adherence to medications for individuals with schizophrenia was well above the national average. Control of high blood pressure for members at risk was lower than the national average.

- **Appropriateness of treatments (±):** Use of antibiotics for children and adults with respiratory infections was generally appropriate, above the national averages, except for children with pharyngitis, which was significantly below the national average. The appropriate use of imaging for lower back pain was higher than the national average.

- **Avoidance of emergent and inpatient care (±):** Hospital all-cause readmissions were significantly higher in 2015 than in the previous year. Emergency department (ED) visits were slightly higher than the previous year, but still well below the national average. Hospitalization rates and lengths of stay were slightly higher in 2015, but were below national average rates.

MCO-Level Variation

- **Significant variation between MCOs indicates quality improvement opportunities.**
  Statistically significant variation was observed across a number of HEDIS measures. This variation was observed for both administrative and hybrid HEDIS measures. (Administrative measures are based solely administrative data like claims, and hybrid measures use a sample of administrative data combined with medical record reviews.) Table 2 on page 13 displays measures for which at least four MCOs performed significantly above or below the state rate.

- **All MCOs underperformed compared to national rates in well-care visits, weight management, women's health and maternal healthcare.**
  There are several measures on which most Apple Health MCOs performed below the national average (shown in Table 3 on page 14). Uniformly poor performance may be driven by provider behavior and may be difficult to influence by individual MCOs; as a result, the State may opt to

encourage cross-MCO collaboration on these measures so as to drive better performance and share costs of provider education and technical assistance.

At least four MCOs performed below the national average on four measures, and at least three MCOs were below the national average on another ten measures. These measures can be grouped into six domains: adults' access to care, well-care visits for children and adolescents, immunizations for children and adolescents, weight management for children and adolescents, women's health and pregnancy care. Measures in several of these domains should not have been unduly impacted by coverage expansion, as children, adolescents and pregnant women were previously eligible for coverage. For three of these measures (well-care visits for children 3–6 years, well-care visits for adolescents and childhood immunizations with Combo 2), the State has specified a requirement to implement performance improvement projects (PIPs). HCA may consider adopting some or all of the other low-performing measures as priority measures in future contracts to ensure adequate performance.

- **All MCOs showed strong performance on inpatient and ED utilization measures; there may be opportunities to further decrease hospital utilization (and costs) through maximizing outpatient utilization.**
  All MCOs registered lower than national averages for inpatient and ED utilization. The two measures suggest a positive level of overall health and quality of care received by enrollees. MHW had the lowest rates of both inpatient utilization and ED visits in 2015 while also providing the highest rate of outpatient utilization. There may be opportunities for other MCOs to gain insight from the MHW model to minimize hospital utilization through maximizing outpatient access and utilization.

Recommendations

Based on 2015 MCO performance, Qualis Health recommends that HCA:

- Attempt to align MCO reporting requirements with other State programs such as Healthier Washington. For example, the Common Measure Set for Healthier Washington includes multiple reported HEDIS measures, including adult and child access to primary care, well-child visits, youth obesity, comprehensive diabetes care, childhood and adolescent immunizations and avoidance of low-value health services.[i] Making these measures priority measures for MCOs may encourage improved performance on State goals. Additionally, there are several Healthier Washington goals that align with HEDIS measures that are currently not required reporting measures for MCOs, such as tobacco screening and cessation counseling, follow-up after hospitalization for mental illness and annual monitoring for patients on persistent medications. Requiring MCOs to report these measures in the future may enable improvement on Healthier Washington goals.

- Require MCOs to submit member-level HEDIS data in a standard format to HCA. When aggregated, the data should match audited and reported values submitted to NCQA (e.g., via the Interactive Data Submission System [IDSS]). These data would provide a common basis for analysis of performance by the State and the EQRO. The usefulness of such a dataset would be enhanced if it included a masked, unique member identifier so that member records could be linked across HEDIS measures.

- Move forward with requiring MCOs to complete performance improvement projects (PIPs) if they did not meet the contracted goals for 2015 for well-child visits (0–15 months, 3–6 years, and 12–21 years) and childhood immunizations (Combination 2).

- Establish additional performance standards for low performance measures in 2015, including maternal health visit measures, children's weight assessment and counseling measures and women's health screening measures. HCA should require that MCOs conduct performance improvement projects (PIPs) when performance falls below those standards.

- Require MCOs to submit member-level data relating to enrollee receipt of prenatal care (in terms of both timeliness and frequency) in order to conduct analyses to identify particular subgroups or patterns common to all MCOs that could form a foundation for improvement. This would assist in achieving the State's goals of decreasing disparities in adverse birth outcomes.

- Take steps to help MCOs address common challenges and share best practices through a group learning forum. For example, MHW's performance in 2015 RY indicates a successful pattern of low emergent and inpatient utilization coupled with high ambulatory access and utilization, suggesting a successful service model design, elements of which could be shared with other MCOs.

Qualis Health recommends that MCOs:

- Provide assistance to providers to improve the collection and accuracy of clinical data supporting HEDIS and other performance measures.

- Consider incentivizing providers to improve collection of clinical data, with the goal of leveraging administrative data for real-time reporting and dashboards for providers.

- Partner with the State in implementing elements of the Healthier Washington plan and the State Healthcare Innovation Plan. For example, MCOs could identify specific performance measure targets that align with Healthier Washington and make formal commitments to achieve them.

Introduction

As part of its work as the external quality review organization (EQRO) for the Health Care Authority (HCA), Qualis Health reviewed managed care organization (MCO) performance for the measurement year (MY) 2014 (reporting year 2015). The performance measures included Healthcare Effectiveness Data and Information Set (HEDIS) measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data collected during early 2015 for the Medicaid child population. The purpose of this report is to summarize the performance of Washington Apple Health MCOs in furnishing accessible, timely and quality care to Medicaid recipients. To enable a reliable measurement of performance, the MCOs were required to report more than 30 HEDIS measures. HEDIS measures were developed and are maintained by the National Committee for Quality Assurance (NCQA). NCQA's database of HEDIS results for health plans enables benchmarking against other Medicaid managed care health plans nationwide.

During 2014, five MCOs managed healthcare for Apple Health enrollees:

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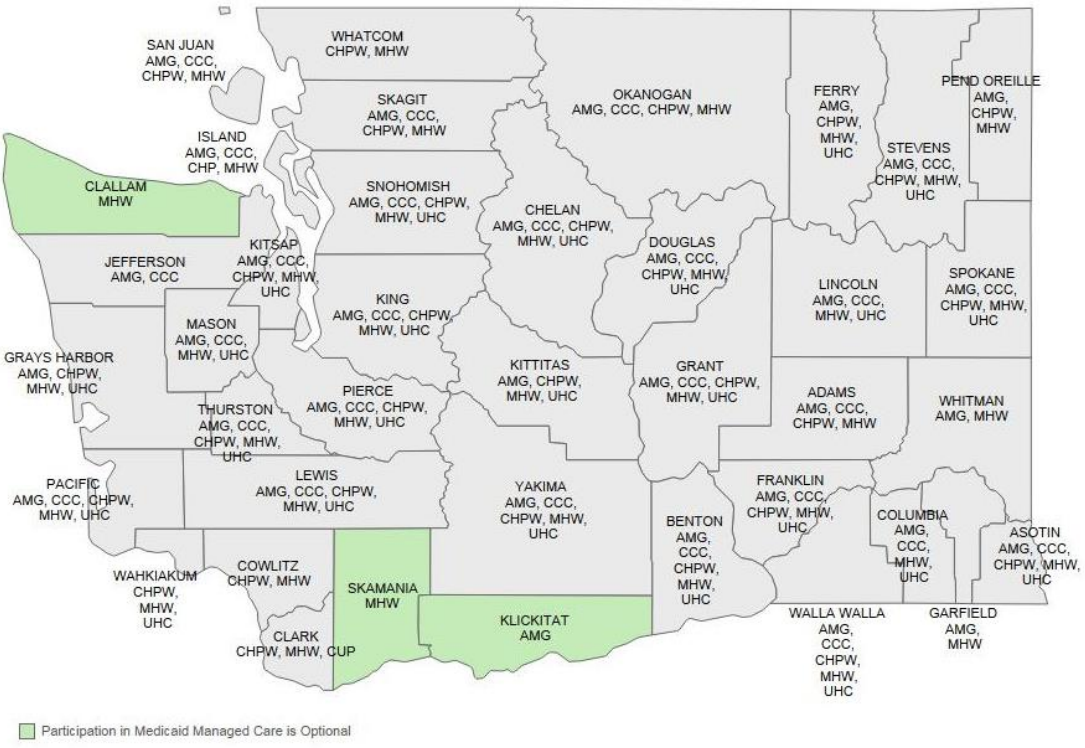
Most Washington counties are served by multiple Apple Health MCOs (Figure 1).

Figure 1: Apple Health Managed Care Service Areas as of January 2015



HEDIS Performance Measures

The NCQA Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of healthcare performance measures reported by health plans. HEDIS results can be used by the public to compare MCO performance over eight domains of care; they also allow MCOs to determine where quality improvement efforts may be needed[1]. In the first half of 2015, Qualis Health conducted an NCQA HEDIS Compliance Audit™ of each Apple Health Medicaid managed care plan to ensure that MCOs are accurately collecting, calculating and reporting HEDIS measures.

Using the NCQA-standardized audit methodology, NCQA-certified auditors assessed each MCO's information system capabilities and compliance with HEDIS specifications. HCA and each MCO were provided with an onsite report and a final report that included an Audited Measures List, Summary of Audit Activity, Information Systems Standards Validation, HEDIS Source Code Validation, Survey Sample Frame Validation, HEDIS Supplemental Database Validation, Medical Record Review Validation, Final Audit Statement and Audit Measure Designations.

Methods

Performance Measures

Qualis Health assessed audited MCO-level HEDIS data for the 2015 reporting year (2015 RY, measuring enrollee experience during 2014), including 31 measures comprising 106 specific indicators. Many measures include more than one indicator, usually for specific age groups or other defined population

groups[i]. Of the 31 measures, 28 relate to effectiveness of care and three relate to utilization (ambulatory and inpatient physical care and mental health). These measure groups (care and utilization) account for 91 and 15 indicators, respectively.

The HEDIS measures are considered to be unambiguous performance indicators, whereas the utilization indicators can be helpful for identifying patterns and disparities in members' access to care. It should be noted that the HEDIS measures are not risk adjusted, and so may vary from MCO to MCO due partly to factors that are out of an MCO's control, such as medical acuity, demographic characteristics and other factors that may impact members' interaction with healthcare providers and systems. NCQA has not developed methods for risk adjustment of these measures; however, with the rapid growth of Apple Health enrollments during 2014, performance impacts that may be attributable to differences in member mix are likely diminishing. Many of the HEDIS measures are focused on a narrow eligible patient population where the measured action is almost always appropriate, regardless of disease severity or underlying health condition.

An additional performance measure, Plan All-Cause Readmissions, was audited but not submitted to NCQA and is included in this report. The readmissions measure follows a similar methodology and definition as the audited readmissions measure defined for Medicare and commercial populations, but has not been formally adopted for the Medicaid population by NCQA.

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, healthcare providers may not have an incentive to report all patient encounters, such as under-capitated models, 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 health plans 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.

Potential Sources of Variation in Performance

The adoption, accuracy and completeness of electronic health records (EHRs) have slowly improved over recent years as new standards and systems have been introduced and enhanced. Still, many providers do not use a comprehensive EHR system.[2] HEDIS performance measures are often very specifically defined and may result in health records not including the required notes or values in order to meet the criteria for a visit or action to count as a numerator event. It is therefore important to keep in mind that a low performance score can be the result of either an actual need for quality improvement, or the need to improve electronic documentation and diligence in recording of notes. For example, in order for an outpatient visit to be counted as having counseling for nutrition taken place, a note with evidence of the counseling must be attached to the medical record, with evidence being one of several specific examples from a list of possible types of counseling, such as discussion of behaviors, a checklist, distribution of educational materials, etc. Even if such discussion did take place during the visit, if it was not noted in the

[i] While MCOs where audited for 34 HEDIS measures, only 31 were actually available because three measures relating to mental health services were excluded, as mental health services for Medicaid enrollees in Washington were provided by Regional Support Networks.

medical record, it cannot be counted as a numerator event for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents. For low observed scores, health plans and other stakeholders should examine (and strive to improve) both of these potential sources of low measured performance.

Member-Level Data

HCA required MCOs to submit de-identified member-level data (i.e., for each individual member) for all administrative and hybrid measures. The member-level data enabled HCA and Qualis Health to conduct analyses relating to racial and geographic disparities to identify quality improvement opportunities. Analyses based on member-level data are included in this report. A companion *Regional Analysis Report* draws more heavily from the member-level data to summarize regional differences in access and quality.

Calculation of the Washington Apple Health Average

This report provides estimates of the average performance among the five Apple Health MCOs for the two most recent reporting years, 2014 and 2015. In the 2015 reporting year, HCA required that MCOs provide a larger number of measures than in 2014, so for some measures only a 2015 RY average is reported. The state average for a given measure is calculated as the weighted average among the MCOs that reported the measure (usually five MCOs), with MCOs' shares of the total eligible population used as the weighting factors. For most measures, the reported average for the 2014 measurement year is different from those reported in the previous year's comparative analysis report. The previous report appears to have used a weighted average; however, for measures using a hybrid measurement method, the average was calculated using MCOs' shares of the sample population as the weighting factors, rather than shares of total eligible population. In this report, all state averages use the shares of total eligible population as the weighting factors.

Statistical Significance

Throughout this report, comparisons are frequently made between specific measurements (e.g., for an individual MCO) and a benchmark. Unless otherwise indicated, the terms "significant" or "significantly" are used when describing a statistically significant difference at the 95 percent confidence level.

For individual MCO performance scores, a chi-square test is used to compare the MCO against the remaining MCOs as a group (i.e., the state average not including the MCO score being tested). The results of this test are included in the Appendix B tables for all measures, when applicable. For this reason, occasionally a test may be significant even when the confidence interval crosses the state average line shown in the bar charts, because the state averages on the charts reflect the weighted average of all MCOs, not the average excluding the MCO being tested.

Other tests of statistical significance are generally made by comparing confidence interval boundaries, for example, comparing the MCO performance scores or state averages from year to year. These results are indicated in Appendix B tables by upward and downward arrows and explained in table notes.

Comparison to National Benchmarks

This report provides national benchmarks for select measures from NCQA's Quality Compass. These benchmarks represent the national average and 90th percentile performance among Medicaid managed care organizations nationwide. All NCQA-accredited Medicaid MCOs are included, regardless of whether the state expanded Medicaid coverage. It is unknown at this time how Medicaid expansion may be impacting these benchmarks. The license agreement required by NCQA for publishing HEDIS benchmarks in this report limited the number of individual indicators to 30, with no more than two benchmarks reported for each selected indicator. Therefore, a number of charts and tables do not include a direct comparison with national benchmarks, but may instead include a narrative comparison with

national benchmarks, for example, noting that a specific indicator or the state average is lower or higher than the national average.

Interpreting Performance

As described above, the performance measures in this report must be interpreted carefully. At best, they serve as a guide for further investigation and potential improvement. Two factors should be considered when interpreting any measure. First, the source of measurement should be considered, and whether a score could potentially be a reflection of variations in medical record completeness. Both administrative and hybrid measures can be susceptible to this variation. Second, what is the practical significance in the difference between an MCO score and a state or national benchmark (e.g., average)? Some measures have very large denominators (populations or sample sizes), making it more likely to detect significant differences even for very small differences. Conversely, a measure may be markedly different from a benchmark, but because of a small denominator may have a relatively wide confidence interval. In such instances, it may be useful to look at patterns among associated measures, if available, in interpreting overall performance.

Overview of Apple Health Enrollment Trends

A review of enrollment trends provides a background to help better understand how the Medicaid expansion may have impacted performance in the 2014 MY. A number of HEDIS quality measures require continuous enrollment over one year or more for members to be eligible for the measure. With the current environment of rapid Medicaid enrollment growth, the experience of a large number of new members may not be directly reflected; however, the experience of eligible longstanding members could have been affected in many instances by the influx of new members in the 2014 CY, especially with respect to access to care.

Enrollment Growth During 2014

The Medicaid expansion provision of the Affordable Care Act was implemented in January 2014. As a result, Medicaid MCOs in Washington State grew rapidly during 2014 (Table 1). Overall, the Apple Health-covered population grew by nearly 42 percent during the year. The member populations for two MCOs, AMG and UHC, more than doubled.

Table 1: MCO Enrollment Growth During Calendar Year 2014

Medicaid Managed Care Plan	January 2014	December 2014	% Change
Amerigroup Washington (AMG)	55,459	128,369	131.4%
Coordinated Care of Washington (CCW)	105,914	175,353	65.6%
Community Health Plan of Washington (CHW)	267,634	332,456	24.2%
Molina Healthcare of Washington (MHW)	402,942	486,524	20.7%
United Health Care Community Plan (UHC)	88,199	180,225	104.3%
Total	**920,158**	**1,302,927**	**41.6%**

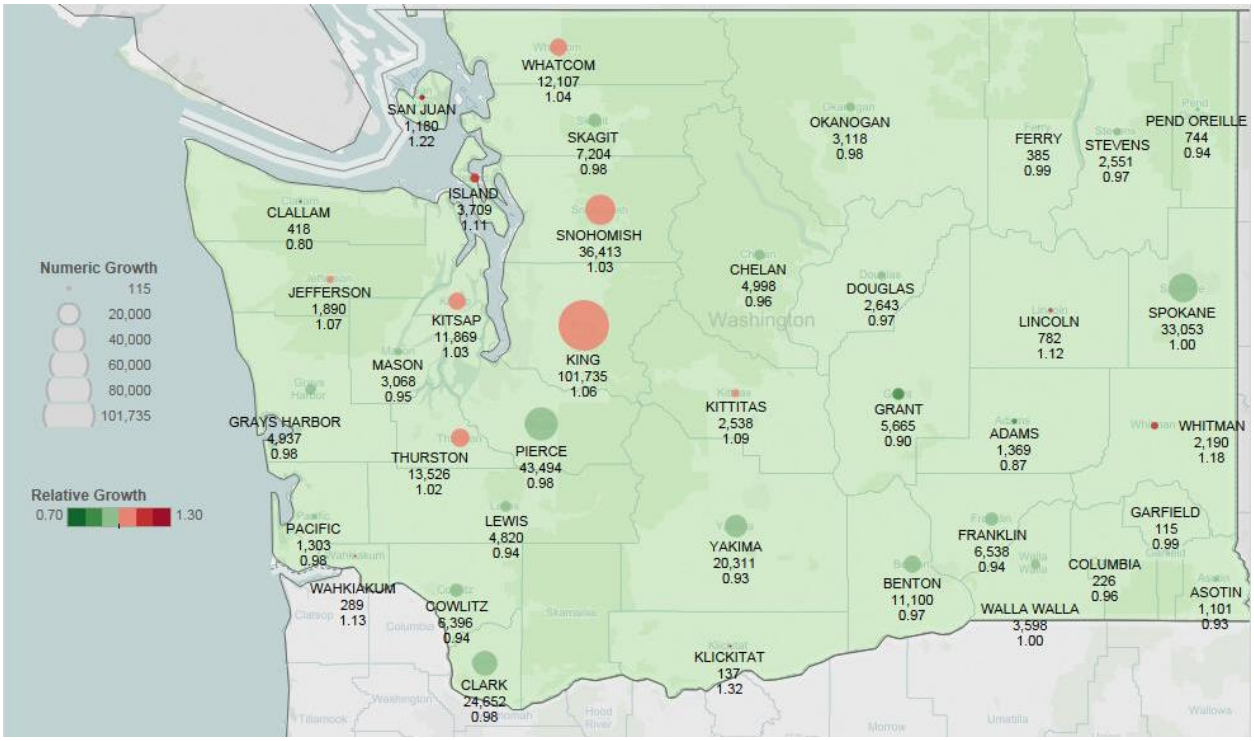
Source: Enrollment data provided by Washington State Health Care Authority

Growth was not uniform across the state. The map in Figure 2 depicts the number of additional enrollees by county between January and December 2014, as well as each county's "location factor," the share of the county's growth relative to its share of enrollees at the beginning of 2014 (in January). King County, for example, had over 100,000 new enrollees during the year. As a share of the statewide new enrollments, those 100,000 enrollees represented a greater share than King County's share of enrollment

in January, by a factor of 1.06, or 6 percent. That is, King County's Medicaid population grew 6 percent faster than the state average. Yakima County, by contrast, had over 20,000 new enrollees; however, its share of new enrollments lagged behind its share of enrollees at the beginning of the year, by a factor of .93, or about –7 percent. That is, Yakima County enrollments grew 7 percent slower than the state average.

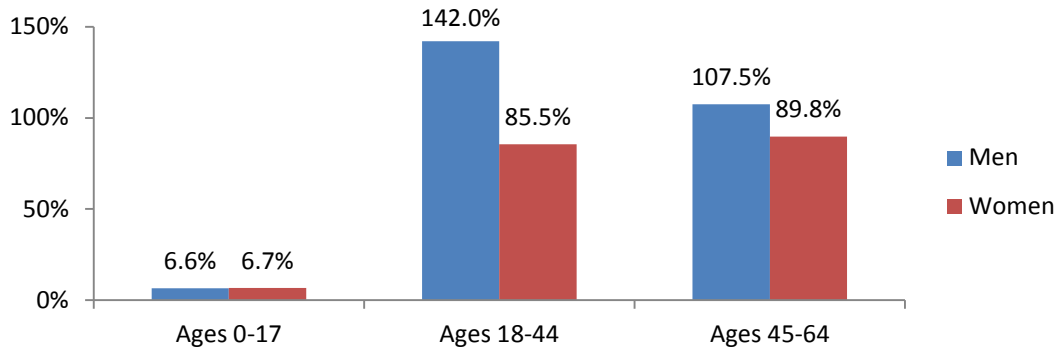
While nearly all counties saw growth in the Medicaid-covered population, the growth fueled by the Medicaid expansion was relatively concentrated in western Washington counties. San Juan and Island counties saw the greatest relative increase in Medicaid enrollees, growing 22 percent and 11 percent faster than the state average, respectively. Both counties, however, began 2014 with small Medicaid populations. Skamania was the only county to have lost Medicaid enrollees during 2014.

Figure 2: Medicaid Enrollment Growth By County, Calendar Year 2014



A majority of the new enrollees in 2014 were men, and many new enrollees were older than traditional (pre-expansion) new enrollees, over the age of 45 (Figure 3). This demographic shift was not likely reflected in many of the performance measures reviewed in this report; however, it may become more apparent in the performance measures collected in 2015 and reported in next year's (2016) edition of this comparative analysis report. An older population will have different healthcare needs and utilization patterns than a traditionally younger population.

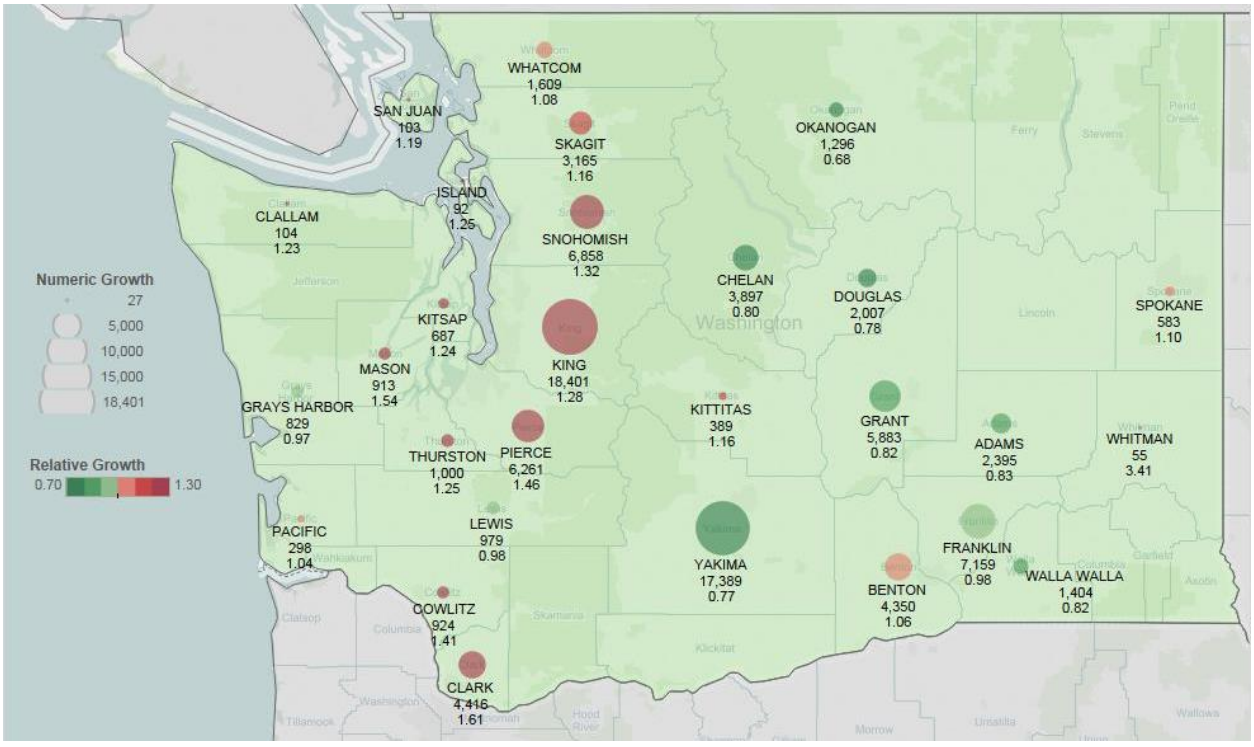
Figure 3: Medicaid Enrollment Growth By Age and Gender, January to December 2014



Language Data

There was an 87 percent decline in the number of individuals with primary language coded as "unknown" in 2014 MY, a significant victory in efforts to enhance collection of REaL (Race, Ethnicity and Language) data. All MCOs improved on reducing missing language data by at least 70 percent. As a result of both Medicaid expansion and improved reporting, there was an increase of over 300 percent (over 93,000) of enrollees with Spanish as a primary language, as well as over 1,000 more enrollees with primary languages of Russian, Vietnamese, Chinese, Somali, Arabic and Korean in December 2014, compared to January 2014. As shown in Figure 4, several counties registered a 500 percent increase in the number of enrollees whose primary language is Spanish, and both King County and Yakima County registered an increase of over 15,000 enrollees whose primary language is Spanish.

Figure 4: Medicaid Enrollment Growth of Individuals Whose Primary Language Is Spanish By County, January to December 2014



Overview of Performance Measure Variation

This report presents MCO performance on select HEDIS measures as compared to peers as well as to state and national benchmarks. Subsequent sections will present performance by detailed measure, but there are several summary observations that can be made.

Measures Displaying High Performance Variation Among MCOs

There are several measures for which at least four MCOs perform statistically significantly above or below the other MCOs taken as a group. Wide variation among MCOs can point to opportunities for improvement. Some of these measures have large denominators and thus very narrow confidence intervals; the State and stakeholders will need to consider whether these rates are meaningfully different.

Table 2: Measures for Which Four or More Apple Health MCOs Performed Significantly Above or Below State Peers, 2015 RY

Measure Description	Sub Measure	Applicable Member Population	State Average	Number of MCOs Sig Below Others	Number of MCOs Sig Above Others
Breast Cancer Screening (BCS)		9,527	54.4	3	2
Cervical Cancer Screening (CCS)		156,262	50.4	2	2
Children's Access to Primary Care Practitioners (CAP)	12-19 Years	115,768	91.2	3	1
Chlamydia Screening (CHL)	Total	30,487	51.2	2	2
Medication Management for People With Asthma (MMA)	Medication Compliance 75% - All Ages	6,774	26.1	1	4
Adult BMI Assessment (ABA)		84,114	82.2	2	3
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	BMI Percentile, Total	296,690	36.7	2	2
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	Physical Activity Counseling, Total	296,690	45.1	2	2
Adult Access to Preventive/Ambulatory Health Services (AAP)	45-64 Years	107,619	84.6	3	2

Measures Displaying Low Performance Among All MCOs

Four of five MCOs performed below the national average rate on four measures, and for another 10 measures, at least three of five MCOs were below the national average. These measures can be grouped into six domains: adults' access to care, well-care visits for children and adolescents, immunizations for children and adolescents, weight management for children and adolescents, women's health and

pregnancy care. Measures in three of the four domains should not have been highly impacted by coverage expansion, as many of the children, adolescents and pregnant women enrolled in 2014 could have been previously eligible for coverage. For three of these measures (well-care visits for children 3–6 years, well-care visits for adolescents and childhood immunizations with Combo 2), the State has specified a requirement for MCOs to implement performance improvement projects (PIPs) if their measures fall below the contract goal. The State may consider adopting some or all of the other low-performing measures as priority measures in future contracts to encourage adequate performance.

Table 3: Selected Measures for Which Three or More Apple Health MCOs Perform Lower Than the National Average, 2015 RY

Measure	State Rate	National Average	Highest MCO	Lowest MCO
Adults' Access to Care				
Adults' Access to Preventive/Ambulatory Health Services (Total)	80,4	*	85.3	73.3
Well-Care Visits for Children and Adolescents				
Six or More Well-Care Visits Before Age 15 Months	56.8	58.9	60.6	55.2
Well-Care Visits for Individuals Ages 3-6 Years	66.6	71.9	68.3	65.0
Adolescent Well-Care Visits	42.6	50.0	45.7	38.0
Children and Adolescent Immunizations				
Childhood Immunizations (Combo 2)	70.9	73.8	79.5	66.1
Immunizations for Adolescents (Combo 1)	73.7	71.4	75.5	61.3
Weight Management for Children and Adolescents				
BMI Screening for Children and Adolescents (Total)	36.7	64.0	42.6	24.5
Nutrition Counseling for Children and Adolescents (Total)	51.1	60.5	56.9	39.2
Physical Activity Counseling for Children and Adolescents (Total)	45.1	53.5	52.4	37.7
Women's Health				
Chlamydia Screening (Total)	51.2	54.6	54.5	45.0
Breast Cancer Screening	54.4	*	58.4	39.2
Cervical Cancer Screening	50.4	*	58.7	35.5
Pregnancy Care				
Timeliness of Prenatal Care	73.7	*	77.9	65.2
Receipt of at least 81% of Recommended Prenatal Care	43.8	*	48.4	40.2
Post-Partum Care	51.6	61.8	56.3	48.2

* National average could not be publicly reported under NCQA Quality Compass use license.

Impact of Apple Health Blind and Disabled Population on Measure Performance

Some stakeholders expressed concern to Qualis Health that certain MCOs may perform poorly in a comparative analysis because of disproportionately large numbers of Apple Health enrollees who are blind and/or disabled (AHBD). In response, Qualis Health conducted additional analyses to determine the potential impact of this population on select measures.

HEDIS measures are normally not risk adjusted, and NCQA has not developed risk adjustment methodologies for HEDIS measures. The implications of case-mix adjustment have been debated in different contexts, and viewpoints around the need for it often depend on the perspectives and interests of stakeholders. While adjustment is often needed to make valid apple-to-apple comparisons, such as adjusting for the acuity of patients when comparing hospital performance, it may also mask important disparities that some argue should not be adjusted away.

During 2014, the shares of AHBD population for each of the five Apple Health MCOs became more consistent. In January, the shares of AHBD ranged from 6.8 percent to 15.6 percent. By December, the shares ranged from 6.0 percent to 7.1 percent. This change in composition was fueled by the rapid growth of new members under the Medicaid expansion, and so probably did not directly influence the impact that AHBD enrollees may have had on the performance of specific MCOs. Given that the share of AHBD members in each MCO became more uniform by the end of 2014, it is much less likely that AHBD member mix will impact performance in future years.

Table 4: Percentage of Enrollees Who Are Blind or Disabled By MCO, 2014 MY

	Blind or Disabled Members		Total Members		Share of Blind or Disabled Members	
MCO	**Jan 2014**	**Dec 2014**	**Jan 2014**	**Dec 2014**	**Jan 2014**	**Dec 2014**
AMG	8,659	8,694	55,469	128,369	15.6%	6.8%
CCW	20,813	21,212	267,634	332,456	7.8%	6.4%
CHPW	13,494	12,532	105,914	175,353	12.7%	7.1%
MHW	27,302	29,296	402,942	486,524	6.8%	6.0%
UHC	12,418	12,686	88,199	180,225	14.1%	7.0%

The proportion of AHBD members eligible for each performance measure varies. For some measures, there may be a greater association between the share of AHBD population and performance, and for others, less so. This factor should be taken into consideration when considering specific causes for lower performance for a measure.

Access to Care

Overview

Access to primary care depends on the ability of consumers to locate healthcare providers and receive services. Following the implementation of the Medicaid expansion under the Affordable Care Act (ACA) in January 2014, enrollments in Apple Health grew to over 1.3 million by December 2014, representing a 40 percent increase. As intended, this expansion significantly improved the ability of many people to afford care; however, the rapid influx of new enrollees may also be overtaxing provider networks, limiting the ability of Apple Health members to receive care where and when they need it.

Surveys of Apple Health enrollees have shown that finding care and making appointments have been difficult in recent years. Survey scores for two key composites, "Getting Needed Care" and "Getting Care Quickly," were below the national average in surveys reflecting the experiences of adults in 2014 and of children in 2015, as measured by the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.[ii]

Well-care visits provide an important opportunity to monitor health and development as well as for screening, immunizations and counseling. Behaviors established during childhood can extend into adulthood, so experiencing well-care visits during childhood and adolescence can provide the foundation for good lifelong health practices. Additionally, research indicates that high-quality primary care may reduce the rate of non-urgent emergency department (ED) visits.[3]

One of the most important areas where well-care visits may promote healthy behaviors is in weight management, including counseling on nutrition and physical activity. According to the Centers for Disease Control and Prevention (CDC), childhood obesity has doubled and adolescent obesity has quadrupled in the past 30 years.[4] Washington State has not been immune to that trend, as over one quarter of the state's children and teens are overweight or obese.[5]

As part of the 2015 Apple Health contract with Washington's managed care organizations, the State has set goals for the proportion of children receiving well-care visits, as noted in the following sections. MCOs that do not meet these goals in the 2015 reporting year are required to conduct a performance improvement project designed to increase the rates.

Similar to well-child visits, prenatal and postpartum visits represent important opportunities to promote health and wellness for mothers and babies through preventive care and education. These visits also represent opportunities to inflect key State performance measures such as C-section rates, unintended pregnancy rates and disparities in adverse birth outcomes.

[ii] For the 2014 adult survey results, see *2014 Washington State Health Care Authority Adult Medicaid Health Plan CAHPS® Report*, Health Services Advisory Group, December 2014, http://www.hca.wa.gov/medicaid/healthyoptions/documents/2014_cahps.pdf

For the 2015 child survey results, see *Apple Health Managed Care: CAHPS® 5.0H Child Medicaid with Chronic Conditions,* Qualis Health, August 2015, http://www.hca.wa.gov/medicaid/healthyoptions/Documents/AHMC_CAHPS_2015.pdf

Reported Measures

The access-related measures in this section include:

- Adults' Access to Preventive Health Services: the percentage of adult enrollees with an ambulatory or preventive care visit during the measurement year, not including inpatient stays or ED visits
- Children and Adolescents' Access to Primary Care Practitioners: the percentage of children and adolescents who had an outpatient visit during the measurement year (or the year prior for age groups 7–11 and 12–19) with a primary care physician
- Well-Care Visits: the percentage of enrollees of the specified age groups receiving the specified number of well-care visits:
    - Ages 0–15 months: 6 or more visits (State-contracted goal: 60 percent)
    - Ages 3–6 years: 1 or more visits (State-contracted goal: 68 percent)
    - Ages 12–21: 1 or more visits (State-contracted goal: 43 percent)
- Prenatal Care: the percentage of women delivering a live baby who received prenatal care in the first trimester (or within 42 days of enrolling in the MCO) *[Note: Does not require one year of continuous enrollment]*
- Frequency of Prenatal Care: the percentage of women delivering a live baby who received 81 percent or more of the recommended prenatal visits. The recommended number of visits for this measure depends on the member's stage of pregnancy at time of enrollment. *[Note: Does not require one year of continuous enrollment]*
- Postpartum Care: the percentage of women delivering a live baby who received at least one postpartum visit between 21 and 56 days following giving birth *[Note: Does not require one year of continuous enrollment]*

For data tables on these measures, please refer to Appendix B.

Measure Performance

Adults' Access to Preventive Health Services

Adult access to preventive health services is subdivided into two age categories: individuals aged 20–44 and individuals aged 45–64. Only one MCO, CHPW, reported rates for individuals 65 and older. Historical data for Washington are not available on this measure.

Overall Apple Health rates were slightly lower than national averages for individuals aged 20–44 and individuals aged 45–64. Within Washington, this measure varied significantly across MCOs for both age groups. AMG, CCW and UHC all performed significantly lower than the state average in the 45-to-64 age group. Some of this variation may have been exacerbated by Medicaid expansion; AMG, CCW and UHC all experienced over 50 percent growth in enrollment during 2014, compared to less than 25 percent growth for CHPW and MHW, which are both larger MCOs that have been established in Washington for a longer period of time. While the measure is only applicable to individuals with 12 months of continuous enrollment (meaning it is not applicable in this report to most of the expansion population), expansion may have stretched capacity of existing provider networks. Adult access should continue to be monitored closely in future years.

Figure 5: Percent of Adults <u>Aged 20–44 Years</u> With At Least One Ambulatory or Preventive Care Visit, 2015 RY

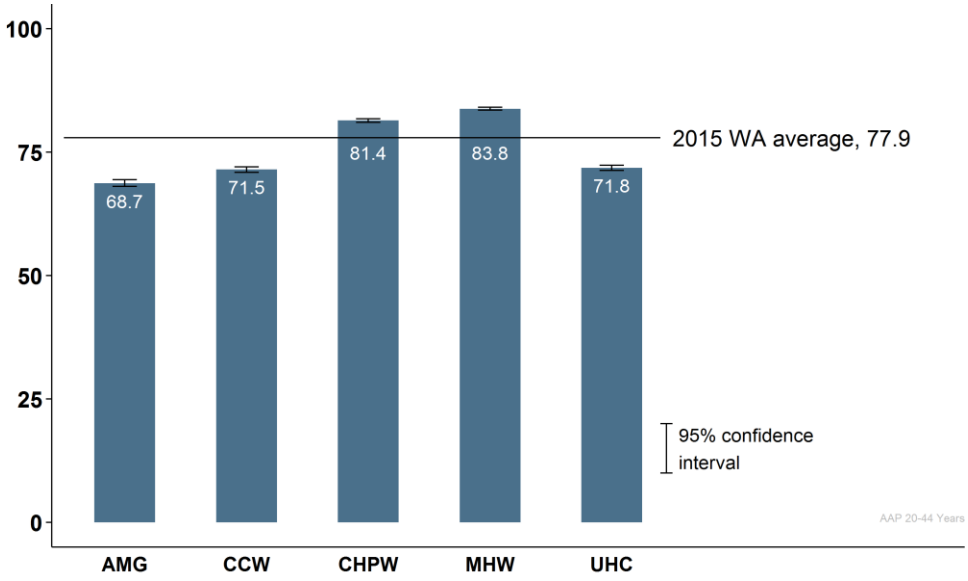
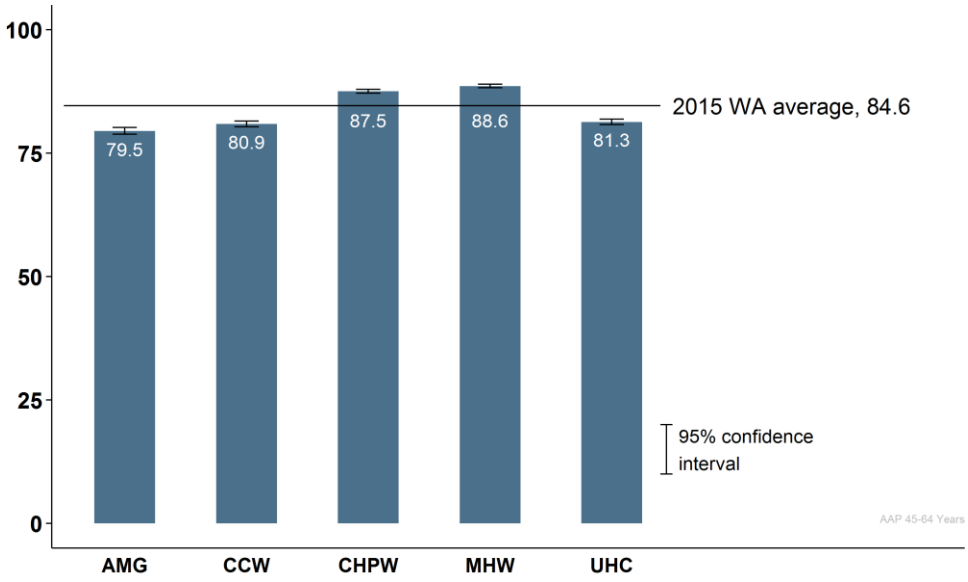


Figure 6: Percent of Adults <u>Aged 45–64 Years</u> With At Least One Ambulatory or Preventive Care Visit, 2015 RY



Spotlight: Geographic Variation in Adult Access to Primary Care

Access to care varies geographically as well as by MCO and, as previously noted, may be heavily influenced by Medicaid expansion. The following maps display adult access to primary care during the 2015 reporting year; only individuals with 12 months of continuous coverage are included in this population. This will be an important measure to track in coming years to ensure that all Apple Health enrollees have adequate access to care.

Access to primary care was significantly below the state average in several counties, including Mason, Grays Harbor, Thurston and Kittitas, as shown in the following figures. Aggregate rates by county may mask potential access problems among minority populations. For example, while Whatcom County had higher access for the overall population, enrollees whose primary language is not English had fewer appointments, suggesting improvement opportunities. In contrast, enrollees whose primary language is not English were more likely to have access to care than the broader population in Kittitas, Kitsap and King counties. Additionally, individuals in the Medicaid expansion population generally had lower access rates than the non-expansion population, though those differences may be due in part to demographic differences between the populations. More information on regional differences in MCO performance for this and other measures can be found in the companion *Regional Report.*

Figure 7: Percent of Adults With At Least One Ambulatory or Preventive Care Visit By County, 2015 RY

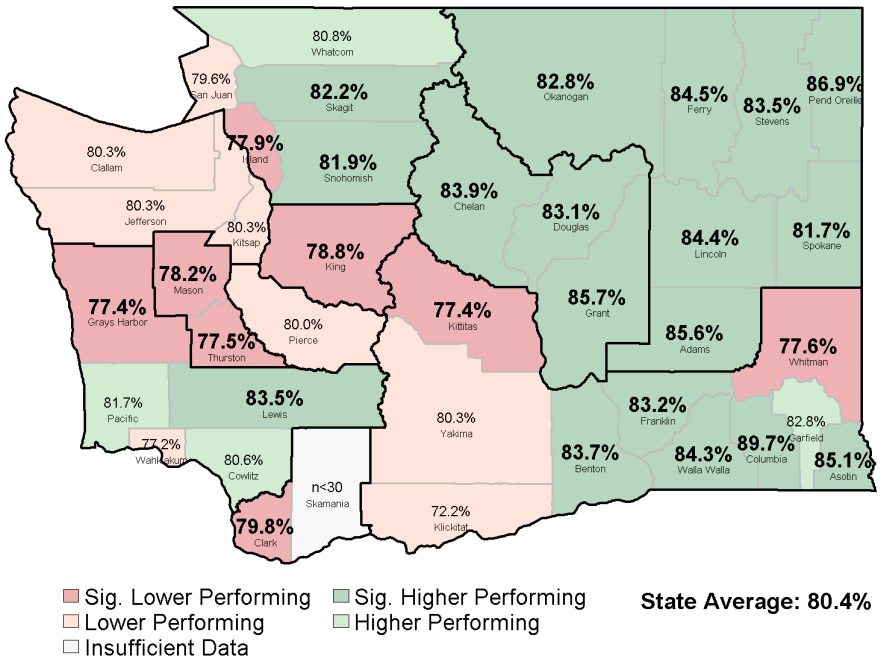


Figure 8: Percent of Adults Whose Primary Language Is Not English With At Least One Ambulatory or Preventive Care Visit By County, 2015 RY

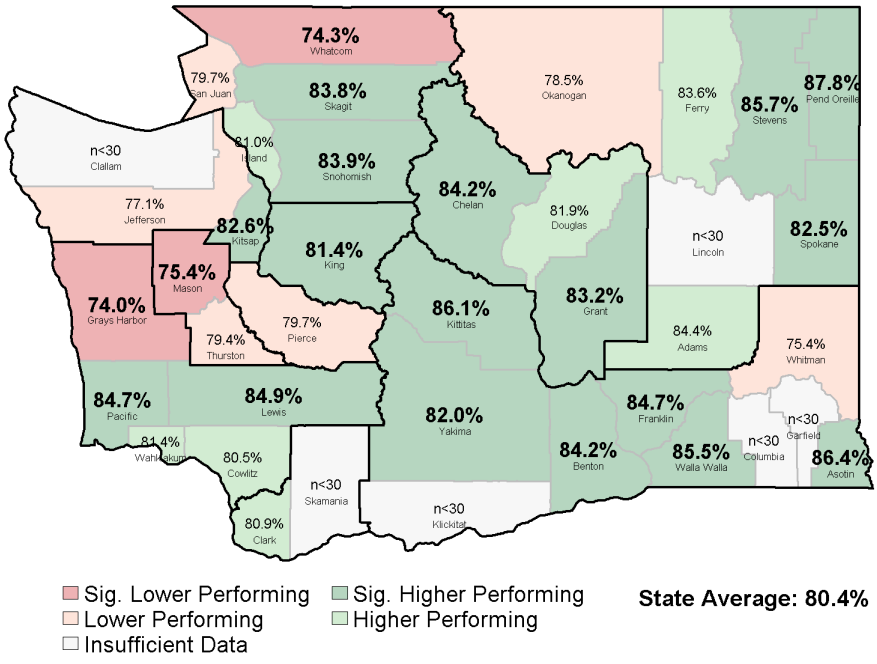
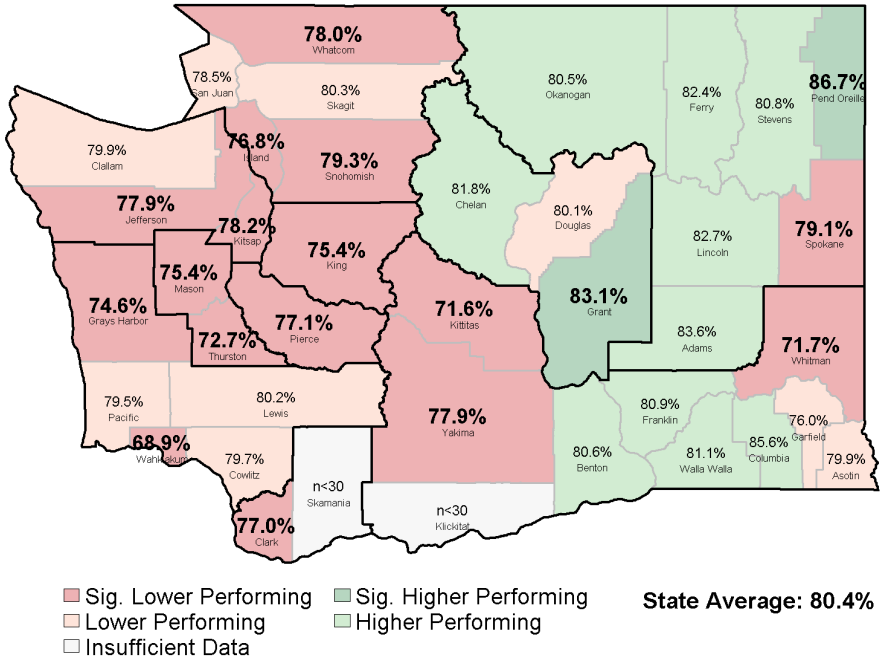


Figure 9: Percent of Adults in Medicaid Expansion Population With At Least One Ambulatory or Preventive Care Visit By County, 2015 RY



Children and Adolescents' Access to Primary Care Practitioners

Children and adolescents' access to primary care physicians is subdivided into four age categories: 12–24 months, 25 months–6 years, 7–11 years and 12–19 years. Overall Apple Health rates were higher for all of the age groups compared to the national average.

There was less variation between MCOs for child and adolescent access to primary care practitioners than was observed for adult access. However, the five MCOs followed similar patterns of access for both children and adults. For example:

- MHW had significantly higher access rates than the other MCOs in the state for all age groups, for both children and adults
- AMG had significantly lower access rates than the other MCOs in the state for all age groups, for both children and adults

Table 5: Percent of Children and Adolescents With At Least One Primary Care Visit, 2015 RY

	AMG	CCW	CHPW	MHW	UHC	State
12–24 months	96.2▼	97.7	97.4	97.9▲	96.2▼	97.5
25 months–6 years	83.5▼	89.2	87.9▼	89.5▲	88.3	88.8
7–11 years	88.6▼	91.6	91.0▼	92.6▲	91.2	91.9
12–19 years	85.5▼	91.0	89.5▼	92.6▲	88.9▼	91.2

▼▲ Performance score is significantly higher or lower than other MCOs combined

Most MCOs improved in access for all age groups compared to the previous year (2014 reporting year). The highest rates were observed for children between one and two, which is an important period for receiving needed immunizations. State rates in 2014 RY and 2015 RY for these age groups are shown in Table 6. The state rate was slightly higher in 2015 RY for all age groups. While the differences were significant for several groups, the significance was more due to the large population sizes than to the magnitude of differences in rates. Detailed information on MCO-specific improvements can be found in Appendix B.

Table 6: Percent of Children and Adolescents With At Least One Primary Care Visit, State Performance in 2014 RY and 2015 RY

	2014 RY State Average	2015 RY State Average
12–24 months	97.3	97.5
25 months–6 years	87.5	88.8↑
7–11 years	91.2	91.9↑
12–19 years	90.8	91.2↑

↑↓ 2015 RY state score significantly higher or lower than the 2014 RY state score

Well-Care Visits

All MCOs performed below the national average in ensuring adequate well-care visit rates for all three age groups (0–15 months, 3–6 years and 12–21 years) in the 2015 reporting year. The state overall performed statistically significantly lower in 2015 RY than in 2014 RY in ensuring that all Apple Health infants had at least six well-care visits (Figure 10). The 2015 RY state rate for that measure was 56.8 percent, significantly lower than the 2014 RY rate of 64.0 percent. All MCOs except CCW failed to meet the goal of 60 percent for infants receiving six or more visits.

The state's average percent of children aged 3 to 6 having one well-care visit rose slightly in 2015 RY, but remained below the national average (Figure 11). The average percent of adolescents aged 12 to 21 having one well-care visit in 2015 RY was practically unchanged from 2014 RY (Figure 12). In both measures, a number of MCOs were below the State-contracted goal of 68 percent and 43 percent, respectively.

These low rates are surprising in light of the strong performance on measures such as child and adolescent access to primary care physicians (shown in Table 5 on page 21). It is possible that providers need additional education or technical assistance on what constitutes a well-care visit to meet the requirements for these measures. Alternatively, it is possible that because of access constraints, children are only able to see primary care providers when they are ill and are not receiving appropriate wellness checks.

Figure 10: Percent of Infants Aged 0–15 Months With At Least Six Well-Care Visits, 2015 RY

State-contracted goal: 60%

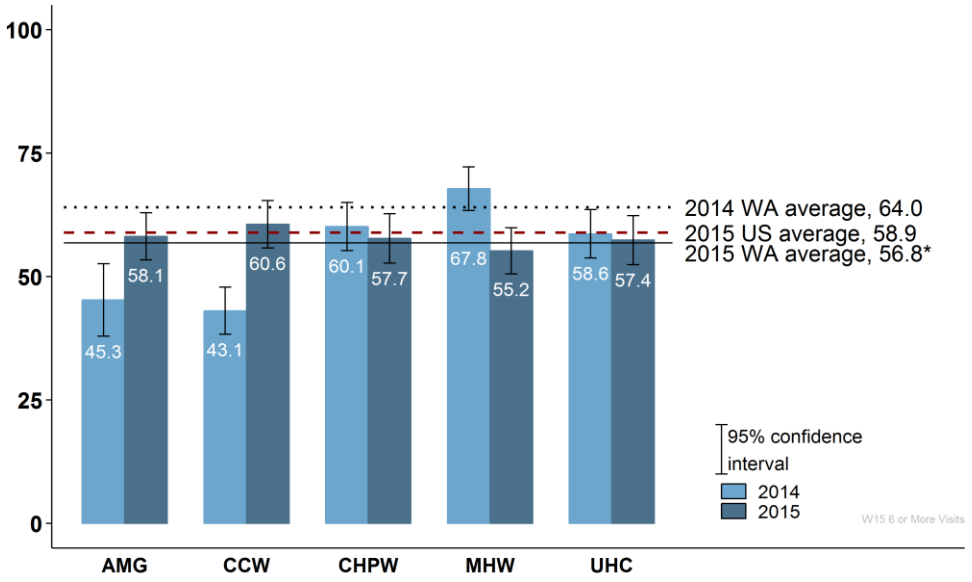


Figure 11: Percent of Children <u>Aged 3–6 Years</u> With At Least One Well-Care Visit, 2015 RY

State-contracted goal: 68%

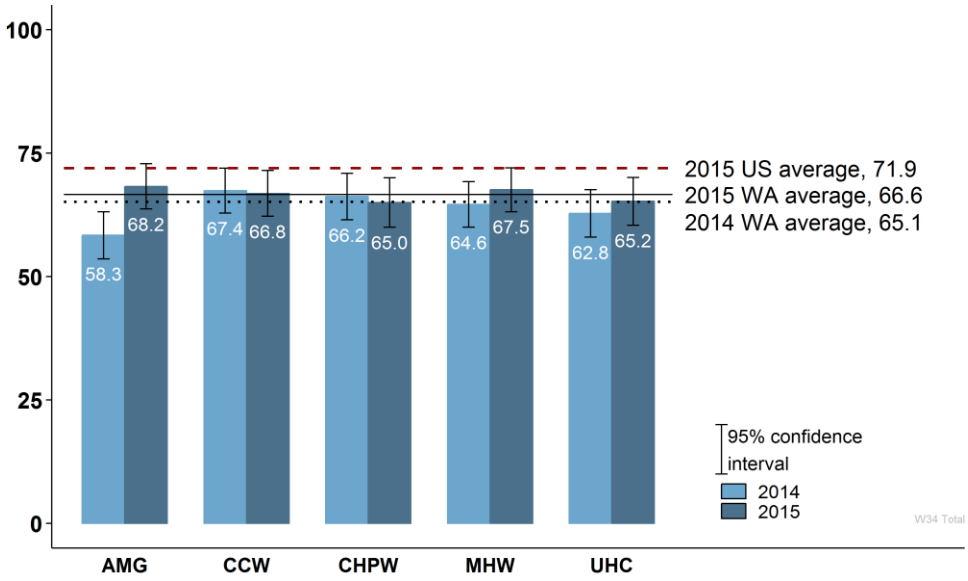
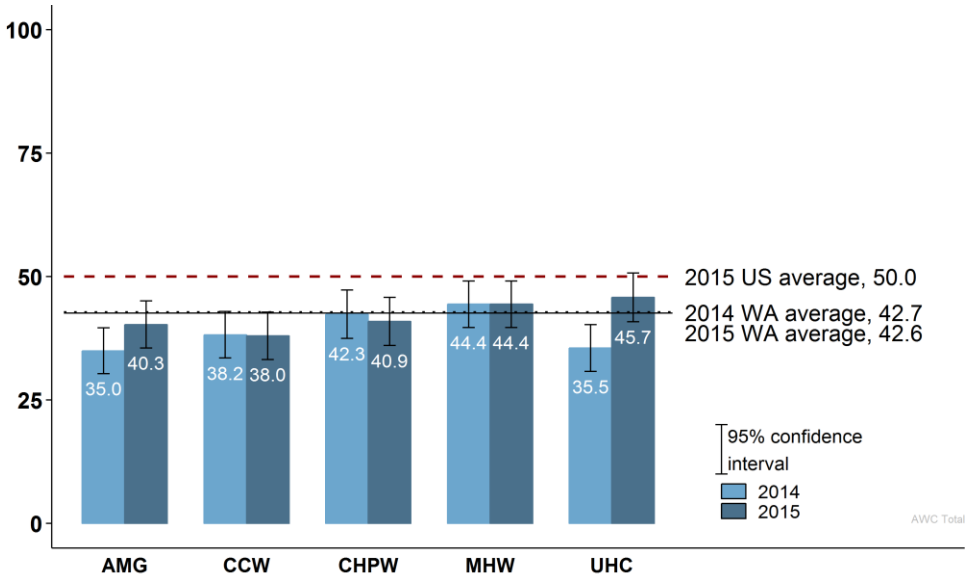


Figure 12: Percent of Adolescents <u>Aged 12–21 Years</u> With At Least One Well-Care Visit, 2015 RY

State-contracted goal: 43%



Maternal Health: Prenatal Care

All Apple Health MCOs performed lower than the national average of women entering prenatal care in the first trimester, as shown in Figure 13 below. There is room for improvement in the adequacy of prenatal care, as evidenced by all MCOs performing significantly lower than the national average for women receiving at least 81 percent of their recommended prenatal visits, shown in Figure 14. (Note that the number of recommended prenatal visits varies for each member, as it is dependent on the state of pregnancy of the member at the time of enrollment.)

Figure 13: Percent of Pregnant Women Receiving Prenatal Care During First Trimester, 2015 RY

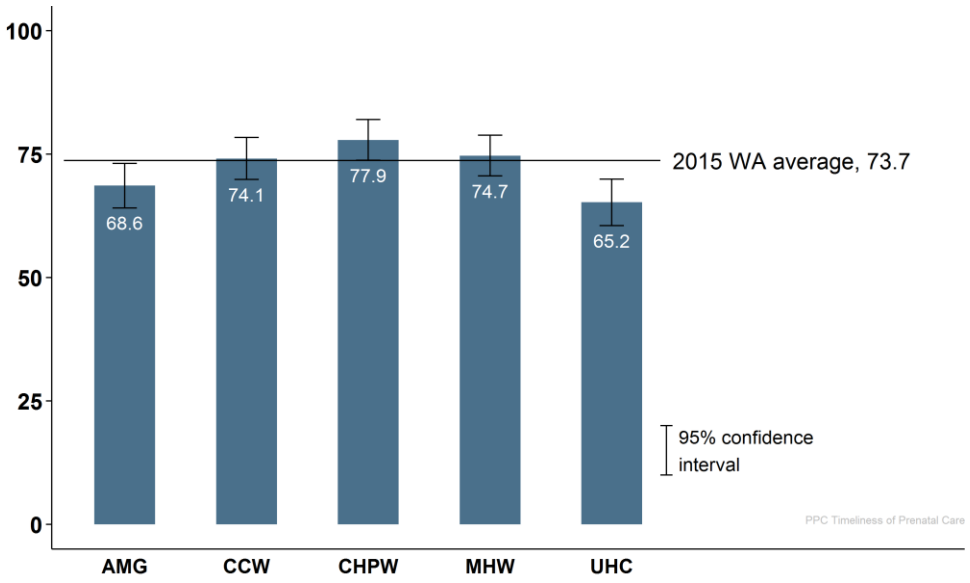
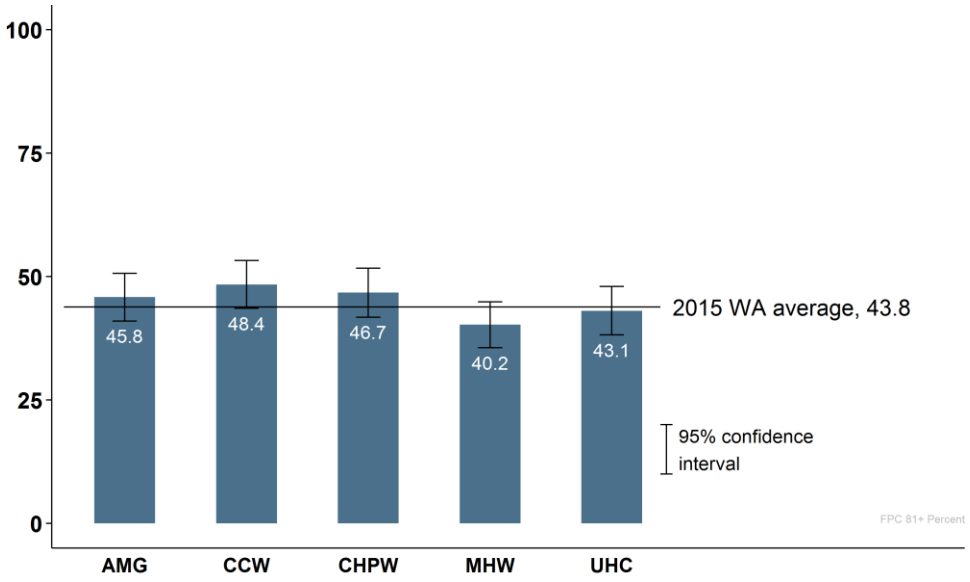


Figure 14: Percent of Pregnant Women Receiving At Least 81 Percent of Recommended Prenatal Visits, 2015 RY

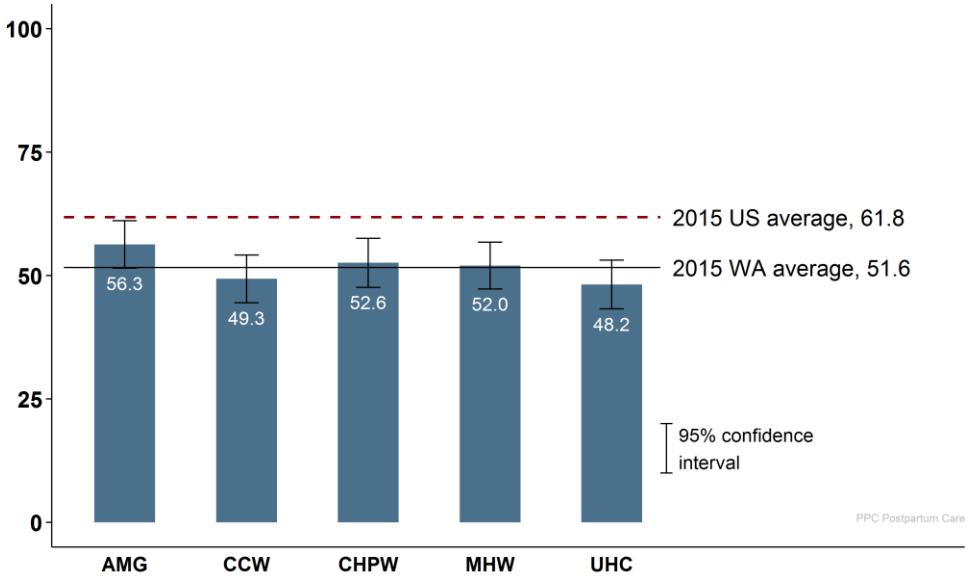


Maternal Health: Postpartum Care

The weeks following birth are an important period of physical, emotional and social adjustment for new mothers. The American College of Obstetricians and Gynecologists recommends that new mothers see their healthcare provider for a postpartum visit between four and six weeks following delivery. Postpartum visits provide opportunities for answering parents' questions and providing family planning guidance and important nutritional and developmental counseling.

As with prenatal access to care, Apple Health MCOs performed about evenly in the percentage of women with a postpartum visit between 21 and 56 days of giving birth. The state average, however, is significantly below the national average.

Figure 15: Percent of Mothers With a Postpartum Visit, 2015 RY



Performance Summary

- There was significant variation in adult access to preventive services, with AMG, CCW and UHC performing below the state and national averages for both age groups. All three of these MCOs grew over 50 percent in enrollment during 2014, which may have stretched capacity of provider networks and impacted existing enrollees. This measure should continue to be monitored closely during the next several years.
- For children and adolescents, access to primary care practitioners improved for all age groups, and the state average was higher than the national average.
- All MCOs lag behind the national averages for well-care visits for all three applicable age groups; a number of MCOs fell below the State's contract goals for the three well-care visit measures.
- Given the strong performance observed for measures relating to child and adolescent access to primary care physicians, it is possible that some of this poor performance is due to the technical specifications of what constitutes a well-care visit for this measure as opposed to lack of provided care.

- Aside from potential measurement issues, the divergence between well-care visits and overall children's access to primary care suggests that many children may be only seeing a physician when they are ill. This may be a reflection of limited provider capacity, parents having difficulty finding a convenient provider for well-care checkups or parents' lack of awareness of the need for regular well-child visits.
- The state performed below the nation at getting women into prenatal care during the first trimester and in ensuring that women receive all of the recommended visits during the entirety of their pregnancy. The State may encourage MCOs to analyze whether there are gaps in care or racial disparities in the timeliness and frequency of prenatal care provided to their Apple Health members.
- The state also performed below the nation in getting women into healthcare providers for postpartum visits.

Preventive Care

Overview

One of the most important areas where well-care visits may promote healthy behaviors is in weight management, including counseling on nutrition and physical activity. According to the CDC, childhood obesity has doubled and adolescent obesity has quadrupled in the past 30 years.[6] Washington State has not been immune to that trend, as over one quarter of the state's children and teens are overweight or obese.[7]

Immunization is perhaps the best example of effective primary prevention in medicine. The CDC estimates that immunization rates for kindergarteners during the 2013–2014 school year in Washington State were 89.7 percent and 90.3 percent for Measles, Mumps and Rubella (MMR) and Diphtheria, tetanus and acellular pertussis (DTaP), respectively, both rates that are below the average among states.[8] For measles in particular, the immunization rate falls below the 95–97 percent rate necessary for herd immunity, leading to greater risk for outbreaks.

Adequate adult access to preventive care can also improve management of chronic conditions, important for both patient quality of life and keeping costs low.

Reported Measures

Measures in this section include:

- **Weight Management:** the percentage of enrollees with an outpatient visit to a primary care provider (PCP) who had evidence of:
    - BMI Assessment (Adults ages 18–74)
    - BMI Percentile Screening (Ages 3–11 and 12–17)
    - Nutritional Counseling (Ages 3–11 and 12–17)
    - Physical Activity Counseling (Ages 3–11 and 12–17)

For children aged 2, the State required MCOs to report 10 separate vaccine antigens and 9 combinations of vaccines (see Table 7). The MCOs are contracted to meet a goal of 68 percent for Combination 2 and conduct a performance improvement project they do not meet the goal in reporting year 2015. For adolescents aged 13, MCOs reported three vaccines separately and one combination of vaccines. The HEDIS immunization measure follows the Centers for Disease Control and Prevention (CDC) guidelines for immunizations, and is updated when those guidelines change. The definitions of these measures are noted below.

- **Immunizations Before Age 2**
    - Diphtheria, tetanus and acellular pertussis (DTaP): four doses
    - Haemophilus influenzae type B (HiB): three doses
    - Hepatitis A (HepA): one dose
    - Hepatitis B (HepB): three doses
    - Influenza (Flu): two doses
    - Measles, Mumps and Rubella (MMR): one dose

- Pneumococcal Conjugate (PCV): four doses
- Polio (IPV): three doses
- Rotavirus (RV): two or three doses
- Varicella-Zoster virus (VZV): one dose
- Combination 2 (refer to Table 7) (HCA-contracted goal: 68 percent)
- Combination 3 (refer to Table 7)

- **Immunizations Before Age 13**
  - Meningococcal vaccine (MNG): one dose
  - Tetanus, diphtheria toxoids and acellular pertussis (TDaP) or Tetanus and diphtheria toxoids (Td): one dose
  - Combination 1: Both of the above vaccines (refer to Table 7)

Table 7: Adolescent and Childhood Immunization Combinations

Antigen	Combination number									
	1*	2	3	4	5	6	7	8	9	10
DTaP		√	√	√	√	√	√	√	√	√
HiB		√	√	√	√	√	√	√	√	√
HepA				√			√	√		√
HepB		√	√	√	√	√	√	√	√	√
Flu						√		√	√	√
MMR		√	√	√	√	√	√	√	√	√
PCV			√	√	√	√	√	√	√	√
IPV		√	√	√	√	√	√	√	√	√
RV					√		√		√	√
VZV		√	√	√	√	√	√	√	√	√
MNG	√									
TDaP	√									

* Adolescent combination

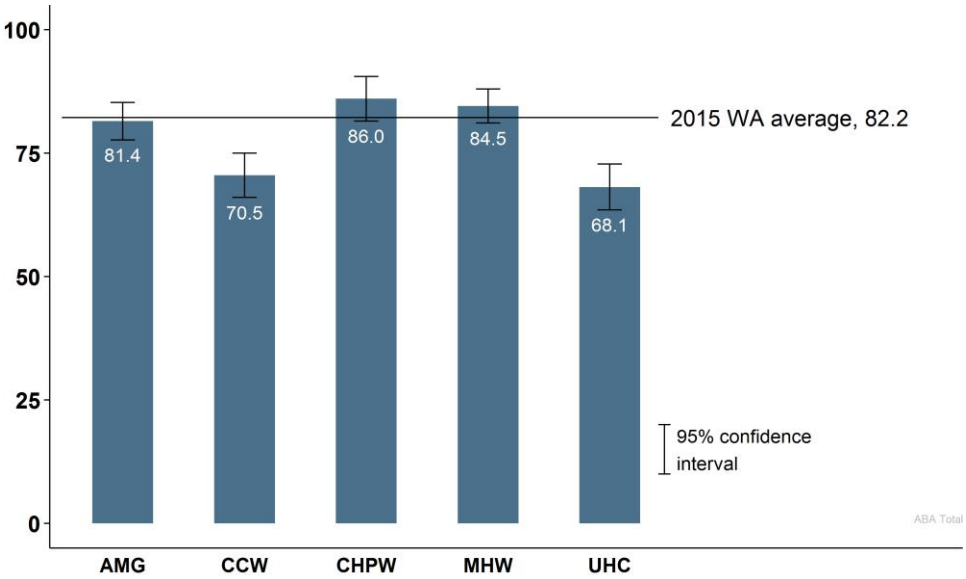
- **Women's Health Screenings**
  - Breast Cancer Screening: the percentage of women aged 50–74 who had at least one mammogram in the measurement year or the prior year
  - Cervical Cancer Screening: the percent of women aged 21–64 receiving a PAP test during the measurement year or prior two years, and co-testing of PAP and HPV for women aged 30–64 in the measurement year or the four prior years
  - Chlamydia Screening: the percentage of women aged 16–24 and identified as sexually active having at least one test for chlamydia during the measurement year
  - Human Papillomavirus Vaccine for Female Adolescents: the percentage of children who turn 13 and had three doses of HPV vaccine between their 9th and 13th birthdays

Measure Performance

Adult Body Mass Index (BMI) Assessment

The Apple Health average in 2015 RY surpassed the national average, but there was wide variation among the MCOs, and three MCOs, AMG, CCW and UHC, were significantly below their peers.

Figure 16: Percent of Adults Receiving BMI Assessment, 2015 RY



Children's Weight Assessment and Counseling for Nutrition and Physical Activity

Only 36.7 percent of members aged 3–17 who had an outpatient visit during the year had evidence that their BMI percentile was recorded, over 20 points lower than the national average and over 40 points lower than the national 90th percentile. Similarly, Apple Health overall rates lag significantly behind the national average rates for nutritional and physical activity counseling.

Figure 17: Percent of Children and Adolescents Receiving BMI Assessment, 2015 RY

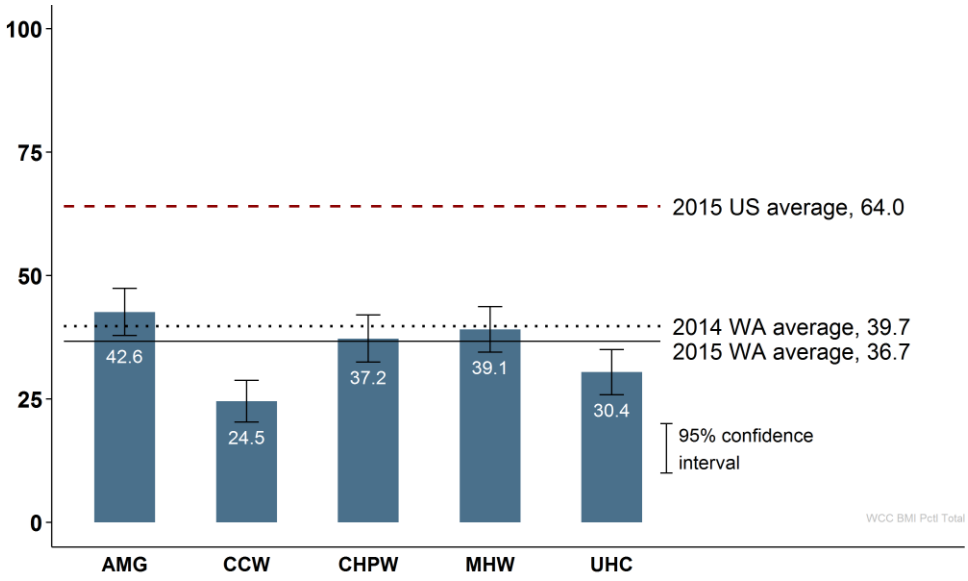


Figure 18: Percent of Children and Adolescents Receiving Nutritional Counseling, 2015 RY

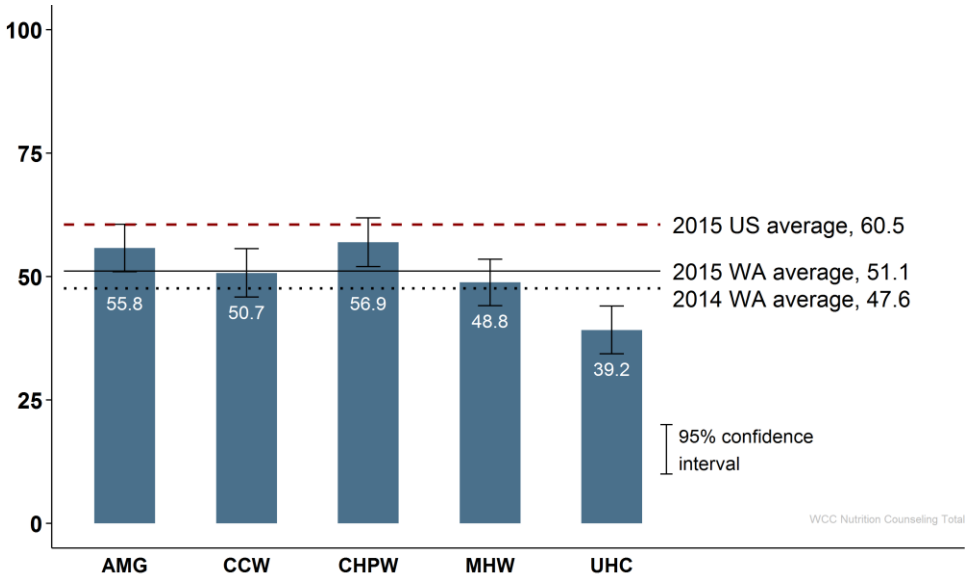
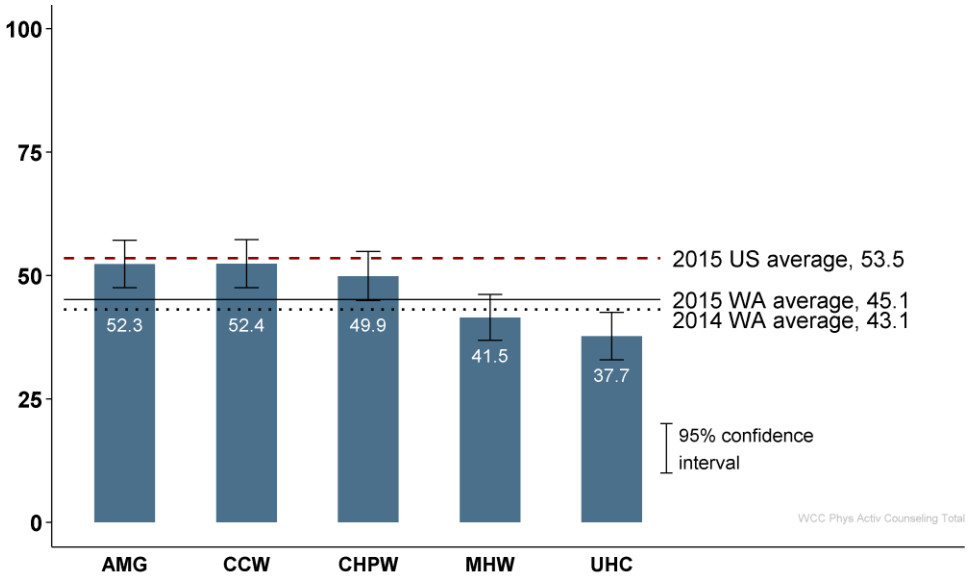


Figure 19: Percent of Children and Adolescents Receiving Physical Activity Counseling, 2015 RY



Childhood Immunizations (Before Age 2)

Performance on immunization measures rebounded in 2015 RY after a dip in 2014 RY, with the result that Washington Apple Health's rate became more comparable to the national average than in 2014 RY. Every childhood immunization rate improved, including bumps of six points for Pneumococcal Conjugate (PCV) and Hepatitis B (HepB). AMG's rates lag behind the rates for other MCOs for most immunizations, while CCW performed statistically significantly better than other MCOs on all childhood immunization measures. For more information on comparative rates for individual vaccinations, please refer to Appendix B.

Table 8: Childhood Immunization Performance, 2015 RY

Antigen	AMG	CCW	CHPW	MHW	UHC	State
DTaP	72.4▼	82.4 ▲	77.1	74.8	73.7	76.1
HiB	86.3 ▼	94.1 ▲	89.8	90.5	86.4 ▼	90.3
HepA	77.0 ▼	89.1 ▲	82.7	79.3	80.1	81.2
HepB	83.8 ▼	93.8 ▲	90.5	89.6	88.8	90.1
Flu	52.4 ▼	66.9 ▲	57.4	56.7	59.6	58.0
MMR	86.5	92.6 ▲	89.3	87.6	85.9	88.5
PCV	71.9 ▼	86.2 ▲	80.8	79.3	79.6	80.2
IPV	84.7 ▼	93.3 ▲	90.0	90.3	86.9	90.2
RV	60.6 ▼	77.6 ▲	69.1	69.8	66.2	69.9
VZV	83.5 ▼	91.4 ▲	88.6	86.5	86.6	87.5

▼▲ Performance score is significantly higher or lower than peers

Vaccination combinations are used to determine whether children are receiving all recommended vaccines. The contracted goal for Combo 2 is 68 percent. Four of the five MCOs improved on Combo 2 from 2014 RY, including AMG, which improved by over 12 points, and CCW, which improved by over 15 points. AMG remains below the State-contracted goal of 68 percent.

Combo 3 is a widely cited measure, and differs from Combo 2 by including pneumococcal vaccines (PCV). The state continues to perform below the national average rate for Combo 3, but performance improved slightly from 2014 RY. For rates of all other childhood vaccination combinations, please see Appendix B.

Figure 20: Percent of Children Immunized With Combination 2, 2015 RY

(See page 28 for definition of Combination 2)

State-contracted goal: 68%

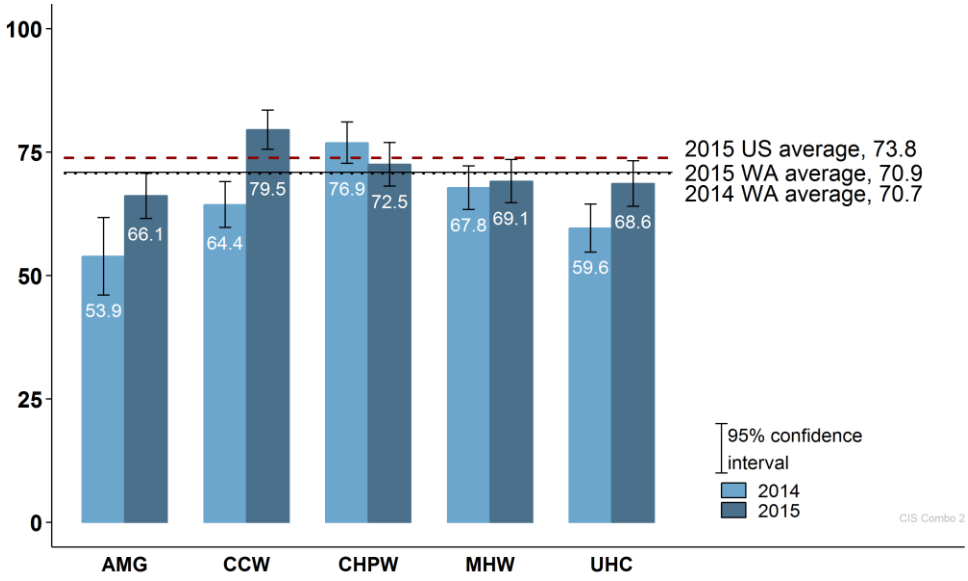
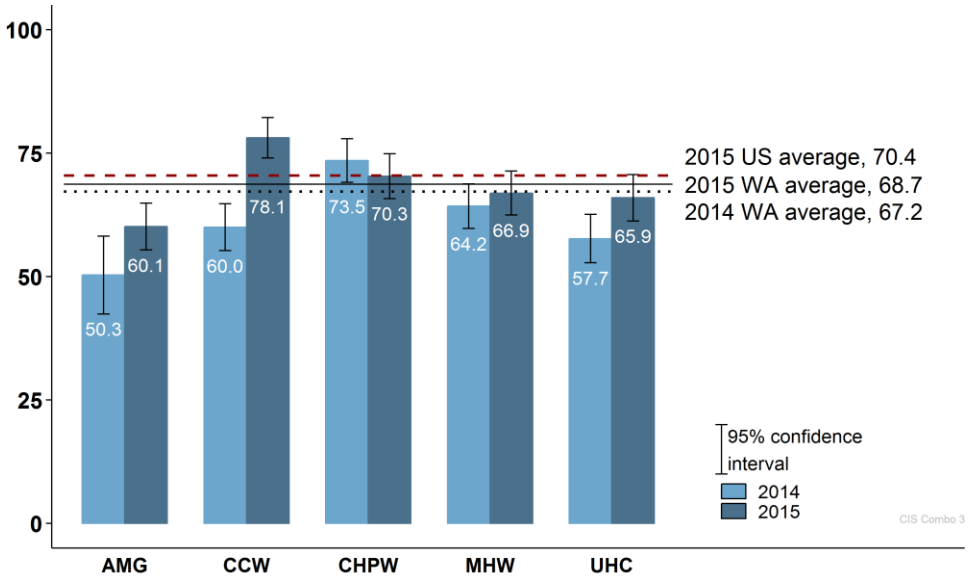


Figure 21: Percent of Children Immunized With Combination 3, 2015 RY

(See page 28 for definition of Combination 3)



Adolescent Immunizations (Before Age 13)

Adolescent immunization rates also experienced large increases in 2015 RY over 2014 RY across several MCOs. Meningococcal immunization rates rose over seven points for the state, led by AMG, which had a 10-point improvement above 2014 RY.

CCW registered a significant drop in TDaP immunization rates, from 88.7 percent in 2014 RY to 76.4 percent in 2015 RY. For more information on historical rates, please see Appendix B.

Table 9: Adolescent Immunization Performance, 2015 RY

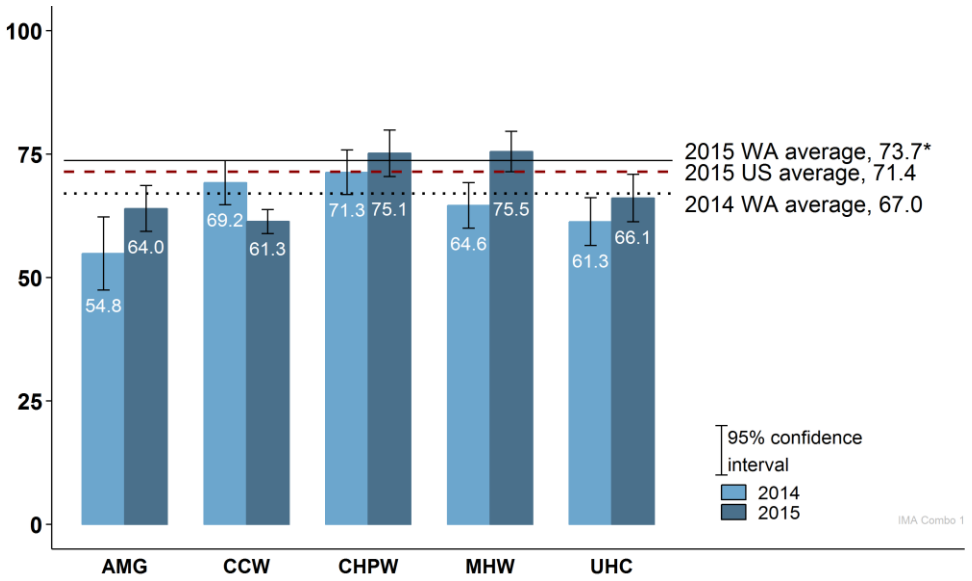
Antigen	AMG	CCW	CHPW	MHW	UHC	State
Meningococcal	66.1▼	74.0	75.7	75.9	68.6	75.2
TDaP or Td	81.6	76.4▼	91.8▲	92.5▲	80.6	90.4

▼▲ Performance score is significantly higher or lower than peers

Combo 1 (p. 28) indicates whether adolescents received both meningococcal and TDaP (or Td) vaccinations by age 13. The state rate improved by over six points from 2014 RY and is currently above the national average rate. All MCOs showed improvement except for CCW, which was hampered by the drop in TDaP immunizations. For all other MCOs, the Combo 1 rate closely mirrored the meningococcal rates, indicating that increases in meningococcal immunizations also had a strong impact on the Combo 1 rates.

Figure 22: Percent of Adolescents Immunized With Combination 1, 2015 RY

(See page 28 for definition of Combination 2)



Women's Health Screenings

Overall Apple Health performance on women's health screenings fell below national averages for three measures of interest (breast cancer screening, cervical cancer screening and chlamydia screening), but was above the national average for HPV vaccinations. There was wide variation in performance for

women's health screenings, as all MCOs were significantly different when compared to their peers, and four MCOs were significantly different from peers for cervical cancer and chlamydia screens. Only one MCO performed higher than the national average on any of the measures (MHW for breast cancer screenings); all other MCOs performed below the national average for all three measures. AMG and UHC, for example, both performed more than 24 points lower than the national average rate for cervical cancer screenings. These two MCOs also had the lowest rates of HPV vaccination for adolescents in WA (see Figure 26 on page 36). Significant improvement is needed on all three measures to ensure the health and well-being of women enrolled in Apple Health. Beyond Apple Health, there have been statistically significant declines in both Washington State and the nation in the percentage of women reporting having received a Pap test in the previous three years, and Washington State is currently below the Healthy People 2020 goal for cervical cancer screening.[9]

Figure 23: Percent of Women <u>Aged 50–74 Years</u> Receiving Breast Cancer Screening, 2015 RY

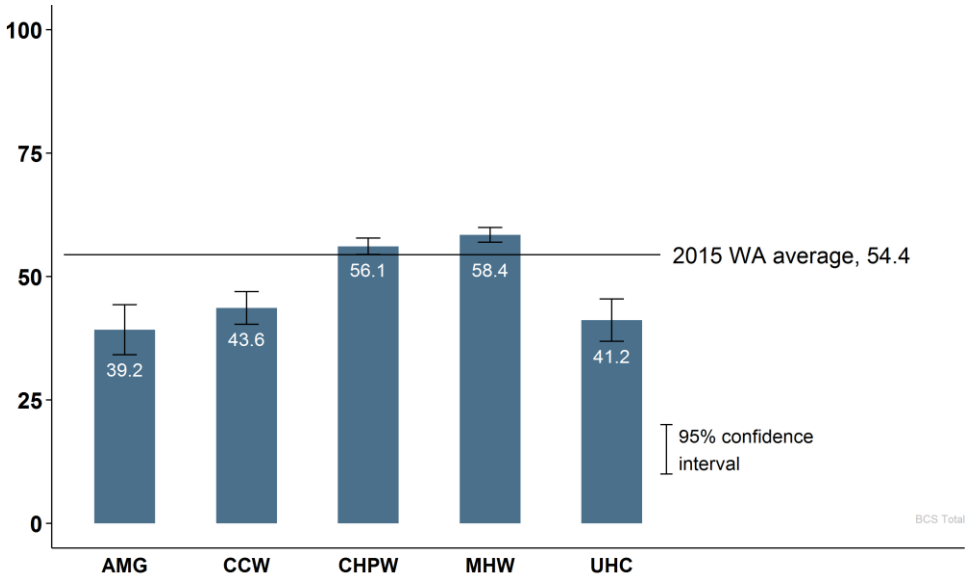


Figure 24: Percent of Women <u>Aged 21–64 Years</u> Receiving Cervical Cancer Screening, 2015 RY

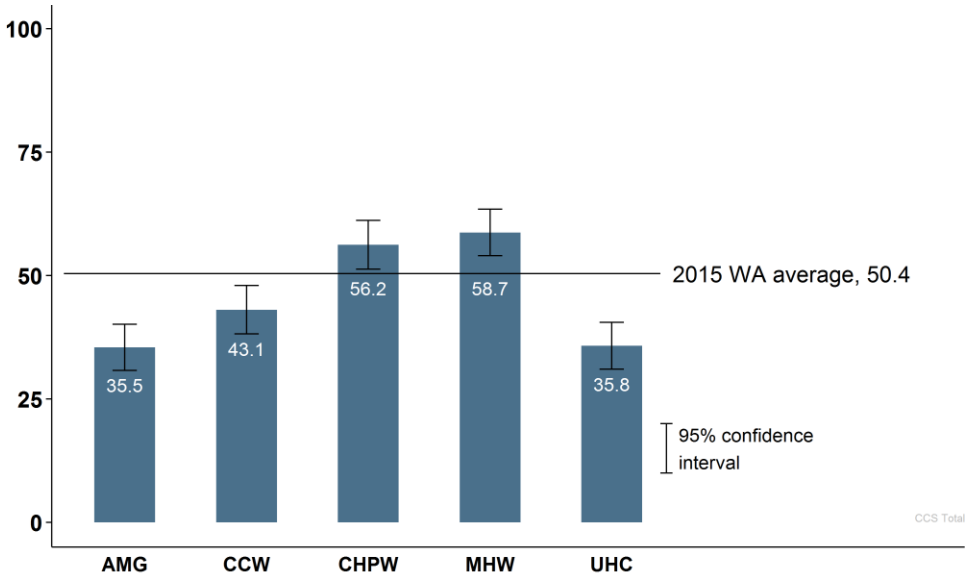


Figure 25: Percent of Women <u>Aged 16–24 Years</u> Receiving Chlamydia Screening, 2015 RY

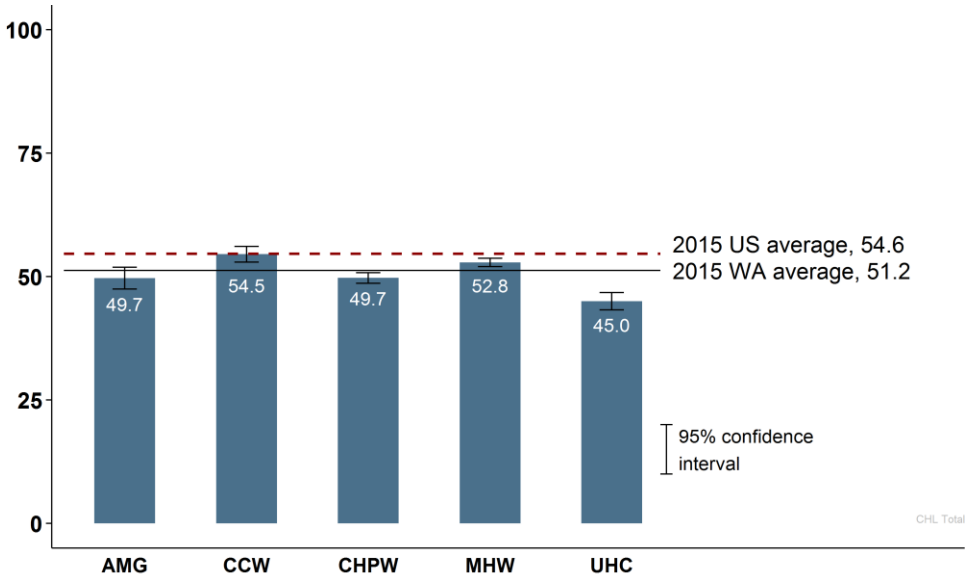
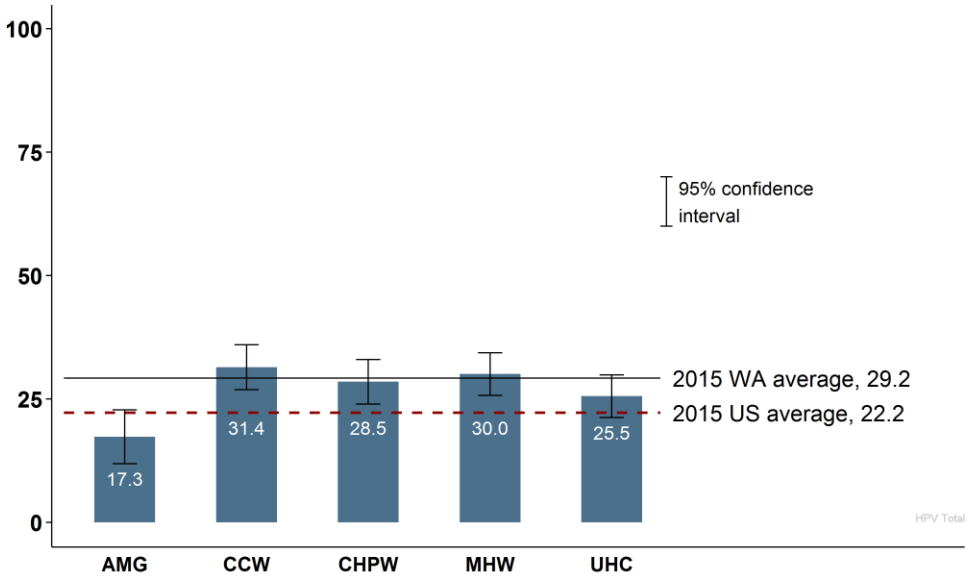


Figure 26: Percent of Girls Turning 13 Receiving Human Papillomavirus Vaccine, 2015 RY



Performance Summary

- Corrective action may be needed to increase the very low percentage of children with recorded BMI percentiles and the percentage of children who receive nutritional and physical activity counseling, both of which are important for reinforcing good health habits and avoiding future health problems.
- With such systematic underperformance in children's BMI assessments, it is likely that community providers need additional assistance in electronic health record (EHR) configuration or education on the importance of BMI measurement for children. The State may consider encouraging MCOs to work together to share costs of the required technical assistance and education to increase rates of BMI assessment and well-being counseling.
- Childhood vaccination rates rebounded in 2015 RY after a poor performance in 2014 RY. Additional work is still needed to ensure all children have appropriate coverage before age 2.
- Statewide adolescent immunization rates rose, and the statewide rates are now higher than the national average rate for these measures.
    - In contrast to prevailing trends, CCW experienced a large drop in TDaP immunization rates for adolescents from 2014 RY; it may be appropriate to conduct a root cause analysis to determine the causes of that drop.
- Aggregate performance on all women's health screening measures (breast cancer screenings, cervical cancer screenings and chlamydia screenings) was low, and all but one MCO performed lower than the national average on all three measures. Apple Health's performance ensuring female adolescents receive HPV vaccinations was better than the national average.

Chronic Care Management

Overview

Preventive services can promote healthy behaviors, facilitate early diagnosis of select health conditions, and slow the progression of chronic diseases. These services are of particular importance for Medicaid enrollees, who are more likely than individuals in the commercial insurance market to experience socioeconomic risk factors that may make them more susceptible to developing serious chronic conditions. Additionally, good screening and control of chronic conditions may reduce costs associated with caring for individuals with advanced disease.

Diabetes is one chronic condition that, if left untreated, can cause significant morbidity, mortality and healthcare costs. According to the Washington State Diabetes Epidemic and Action Report, over 640,000 individuals in Washington have diabetes, over one-fourth of whom are undiagnosed.[10] Additionally, the report estimates the annual cost of direct medical expenditures to be $3.75 billion in 2012.

There is evidence that Medicaid expansion has led to an increase in diabetes diagnoses as newly insured individuals receive preventive care for the first time.[11] Average hemoglobin A1c (HbA1c, an indicator for blood glucose or "sugar") levels in individuals newly diagnosed in Medicaid expansion states is statistically significantly lower than individuals newly diagnosed in non-Medicaid expansion states, implying that individuals in Medicaid expansion states are now being diagnosed earlier in their disease. Early diagnosis presents opportunities to slow the progression of the disease through routine testing and improved HbA1c control.

These preventive care measures may be sensitive to the impacts from the Medicaid expansion in 2014 calendar year (CY) and 2015 CY, and so should be monitored closely. Continued monitoring of these measures will determine whether newly insured enrollees receive adequate care or whether additional volumes are stressing an overburdened provider system.

Reported Measures

Measures included in this section include:

- **Diabetes Monitoring Measures:**
    - HbA1c Testing: presence of at least one HbA1c test during measurement year, regardless of result
    - Eye Exams: presence of at least one eye exam during measurement year (or year prior if previous eye exam showed no evidence of diabetic retinopathy)
    - Medical Attention for Nephropathy: presence of at least one nephropathy test or evidence of the presence of nephropathy during the measurement year
    - Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication: percentage of people aged 18 to 64 diagnosed with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year
    - Diabetes Monitoring for People With Diabetes and Schizophrenia: percentage of people aged 18 to 64 who were diagnosed with schizophrenia and diabetes, who had both an

low-density lipoprotein cholesterol (LDL-C) test and an HbA1c test during the measurement year

- **Diabetes Control Measures:**
    - Blood Pressure Control (less than 140/90)
    - Good HbA1c Control (less than 8.0 percent)
    - Poor HbA1c Control (more than 9.0 percent): Note that individuals not receiving an HbA1c test during the measurement year are included in this category.
- **Other Chronic Care Management**
    - Controlling High Blood Pressure: the percentage of adults aged 18 to 85 diagnosed with hypertension with blood pressure reading indicating adequate control according to their age group
    - Antidepressant Medication Management: the percentage of adults aged 18 or over having diagnosis of major depression who were treated with antidepressant medication and remained on antidepressant medication treatment for six months
    - Medication Management for People with Asthma: the percent of members aged 5 to 85 identified as having persistent asthma who were treated with medication and remained on medication for at least 75 percent of their treatment period
    - Follow-Up Care for Children Prescribed ADHD Medication, Initiation Phase: the percentage of members aged 6 to 12 with an ambulatory prescription for an ADHD medication who had at least one follow-up visit with a provider during the 30-day initiation phase

Measure Performance

Diabetes Monitoring Measures

There are three monitoring measures included in the Comprehensive Diabetes Care measure (HbA1c testing, annual eye exams and medical attention for nephropathy). Performance on all three measures increased from 2014 RY and all three show performance above the national average rate. While performance on HbA1c testing and medical attention for nephropathy are uniformly high and display little variation, eye exam rates vary by more than 15 points between MCOs. There may be opportunities for sharing best practices on establishing referral networks between MCOs.

There are also two measures that relate to schizophrenia and diabetes, namely screening for and monitoring diabetes. All MCOs performed higher than the national average on screening individuals with schizophrenia for diabetes. UHC performed higher than the national average on ensuring individuals with schizophrenia and diabetes received both an LDL-C test and an HbA1c test; all other MCOs performed statistically the same as the national average. This measure is not directly correlated with the Comprehensive Diabetes Care measure, which only includes HbA1c testing, but the rate is significantly lower. Monitoring for individuals with schizophrenia and diabetes could serve as an important measure for monitoring, particularly as the State moves forward with behavioral health integration.

Figure 27: Percent of Diabetic Individuals With At Least One HbA1c Test, 2015 RY

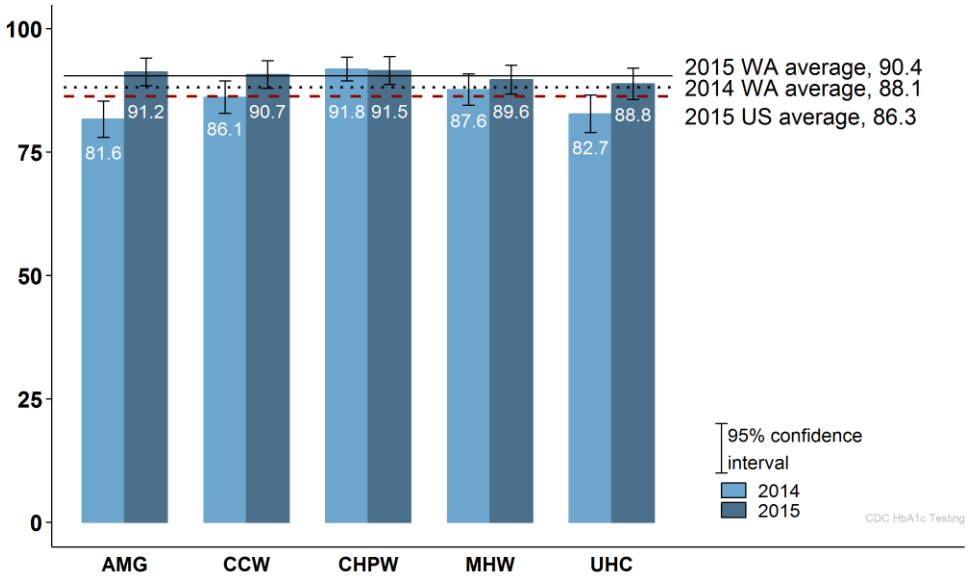


Figure 28: Percent of Diabetic Individuals With At Least One Eye Exam, 2015 RY

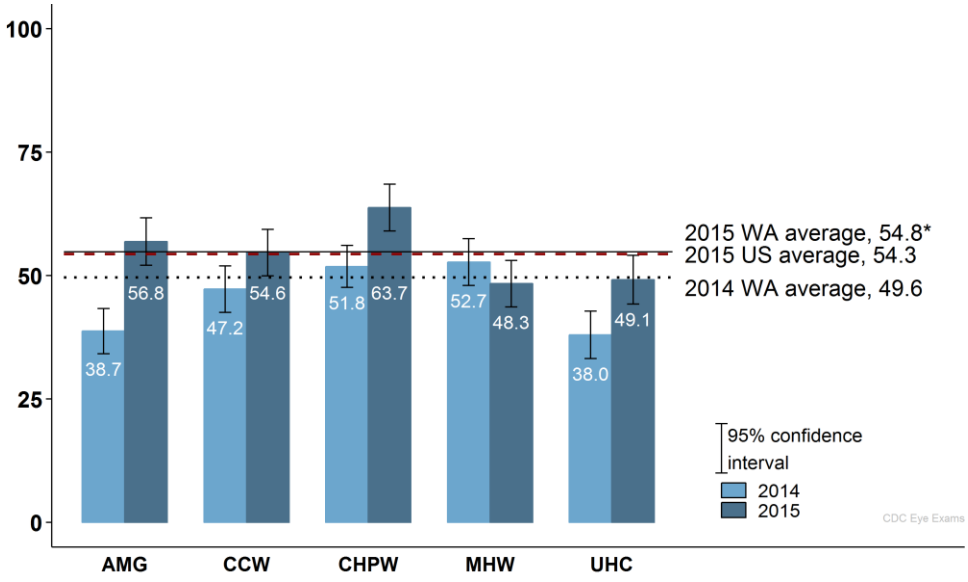


Figure 29: Percent of Diabetic Individuals Who Received Medical Attention For Nephropathy, 2015 RY

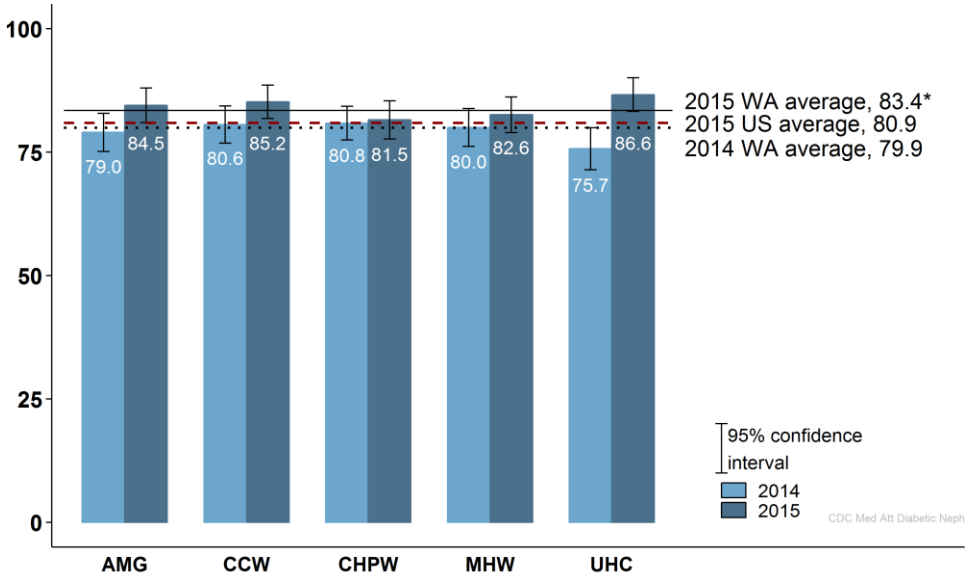


Figure 30: Percent of Individuals With Schizophrenia or Bipolar Disorder Using Antipsychotic Medications Who Were Screened for Diabetes, 2015 RY

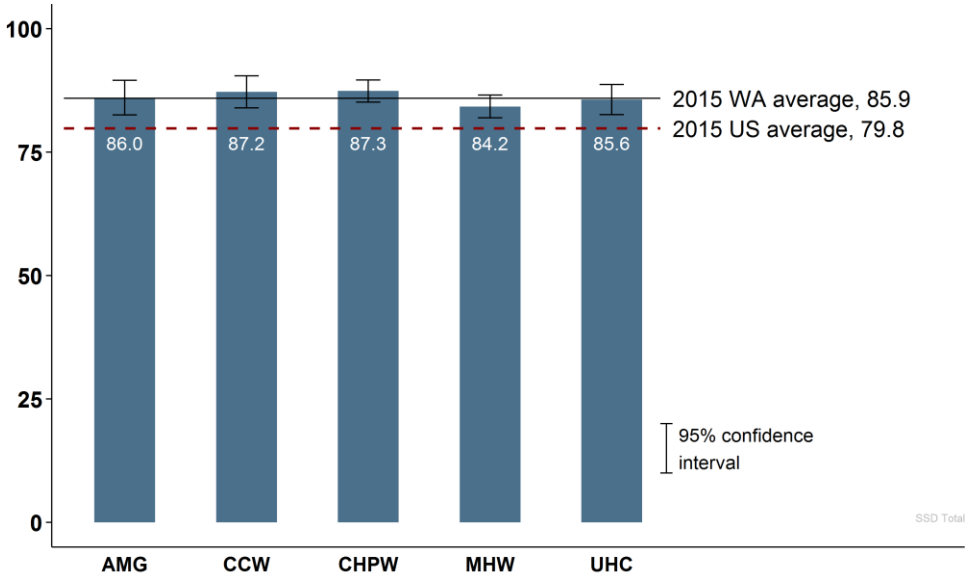
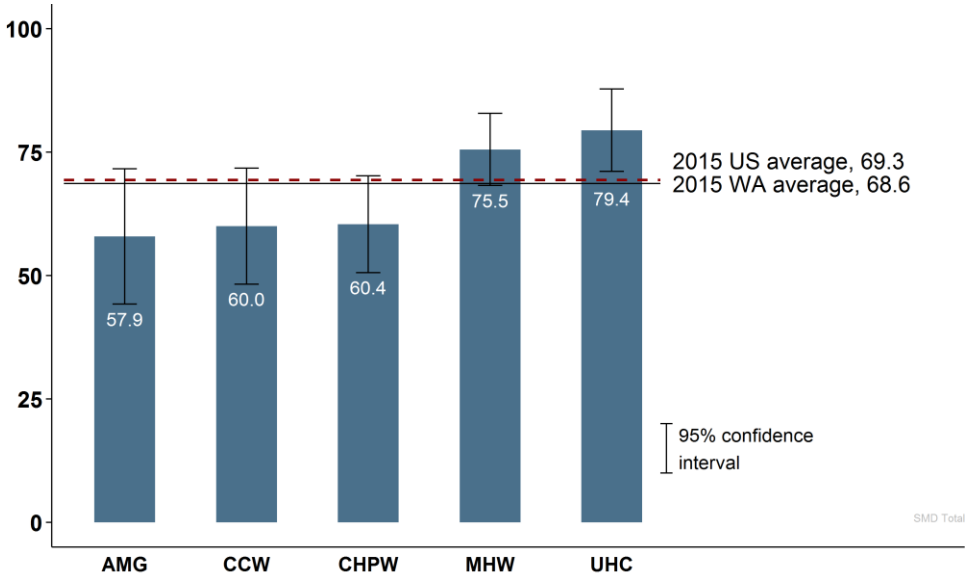


Figure 31: Percent of Individuals With Diabetes and Schizophrenia Who Received Both an LDL-C Test and an HbA1c Test, 2015 RY



Diabetes Control Measures

Three diabetes control measures include enrollee's good HbA1c control, poor HbA1c control and blood pressure control. For the poor HbA1c control measure, a lower score is better. Unlike the process measures above, the performance on these measures may be more influenced by the demographic characteristics of the MCO (for example, the average age of enrollees or the percentage of enrollees who are disabled). As a result, strong or weak performance on these measures may partially reflect factors outside the direct control of the plan. In future years, the large demographic changes as a result of Medicaid expansion will make it more difficult to compare performance on outcomes measures across years.

Apple Health's rates for good HbA1c control rose in 2015 RY, and rates for poor HbA1c declined. CHPW led the way with the highest rates of good control and the lowest rates of poor control in 2015 RY, and UHC's rates were vastly improved from 2014 RY. The state's rate of poor control improved enough to fall below the national average in 2015 RY from its position above the nation in 2014 RY.

Rates of blood pressure control for diabetics also improved for each MCO and by four points statewide from 2014 RY. It is unclear how much of this improvement is due to MCO improvement efforts or demographic shifts that occurred in Medicaid during 2014 CY.

Figure 32: Percent of Diabetic Adults With Good HbA1c Control (<8.0 percent), 2015 RY

Note that a higher score is better for this measure.

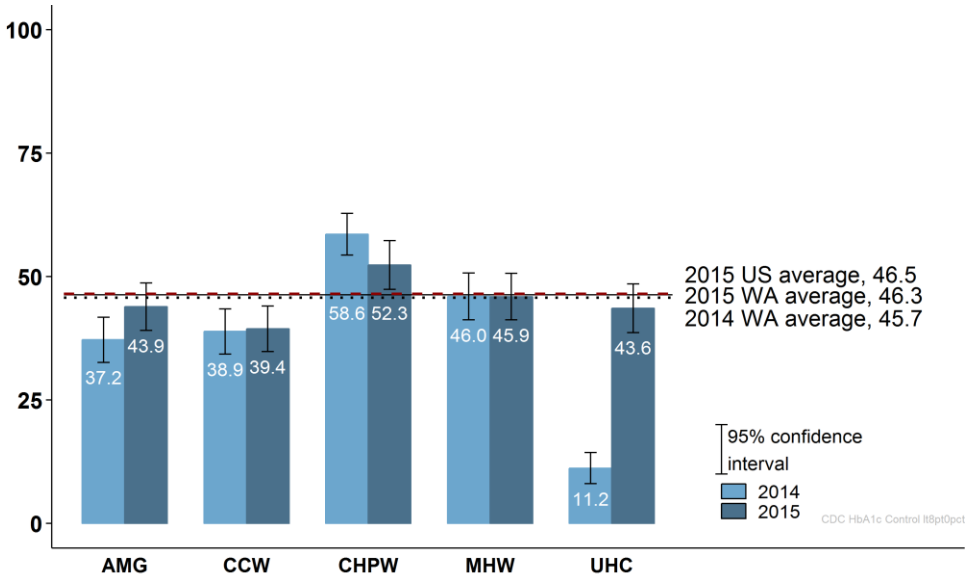


Figure 33: Percent of Diabetic Adults With Poor HbA1c Control (>9.0 percent), 2015 RY

Note that a lower score is better for this measure.

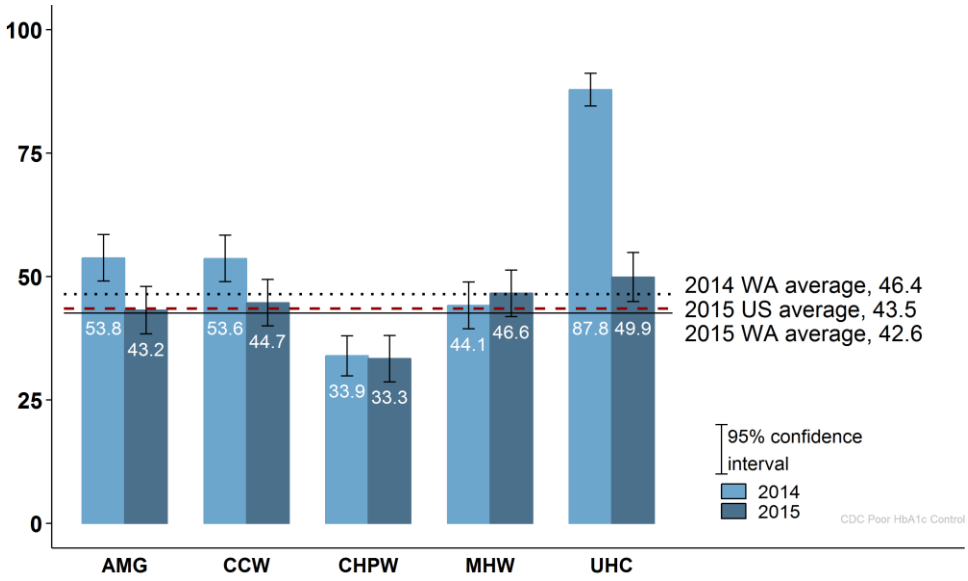
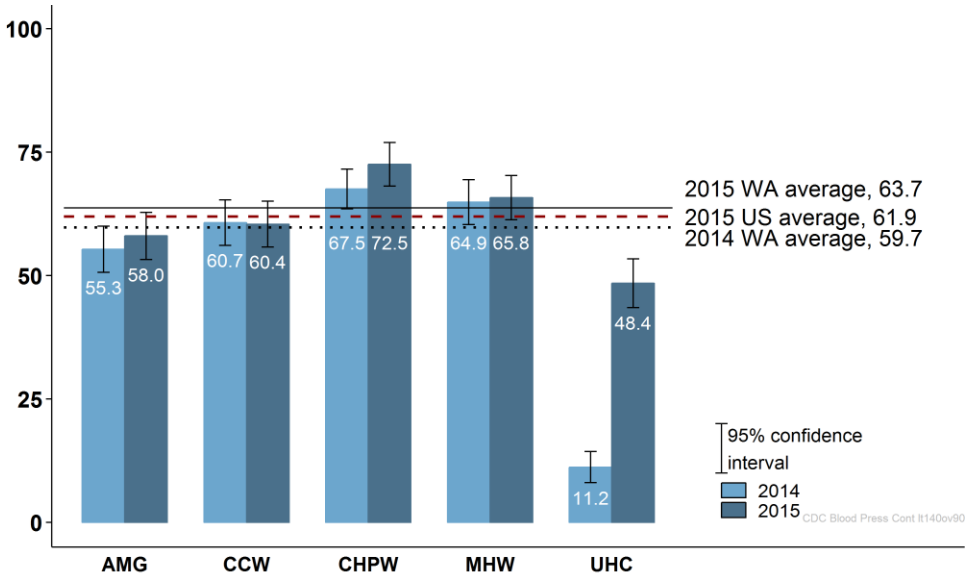


Figure 34: Percent of Diabetic Adults With Blood Pressure Under Control (<140/90), 2015 RY



Other Chronic Care Management

Blood pressure control varies significantly between MCOs, with almost 30 points separating the highest performer (CHPW) and the lowest performer (UHC). These raw rates may not be fully due to differences in quality of care, as MCOs serve different enrollee populations that may have different risk rates for uncontrolled high blood pressure. For example, individuals who are older, obese or otherwise disabled are also more likely to have non-controlled high blood pressure. These factors may be outside the direct control of the MCO. However, blood pressure management is important for continued good health, particularly for vulnerable populations. Comparisons between MCOs may be improved with adjustments for prevalence of risk factors among members, but aggregate state rates clearly present a quality improvement opportunity.

Less variation among MCOs is observed for medication adherence measures (antidepressant medication compliance, asthma medication compliance and ADHD medication monitoring). Antidepressant and asthma medication measures show similar patterns, with AMG and UHC showing the highest performance and MHW showing the lowest performance. For ADHD medication monitoring, MHW performed better than the aggregate of the other MCOs, and CHPW and UHC performed worse. Apple Health aggregate rates were even with the national average rate for antidepressant continuation and lower than the national average rate for high compliance with asthma medications and ADHD monitoring during treatment initiation. Antidepressant initiation and continuation will be important measures to monitor as the State moves forward with the integration of physical and behavioral healthcare programs.

Figure 35: Percent of Adults <u>Aged 18–85 Years</u> With High Blood Pressure In Control, 2015 RY

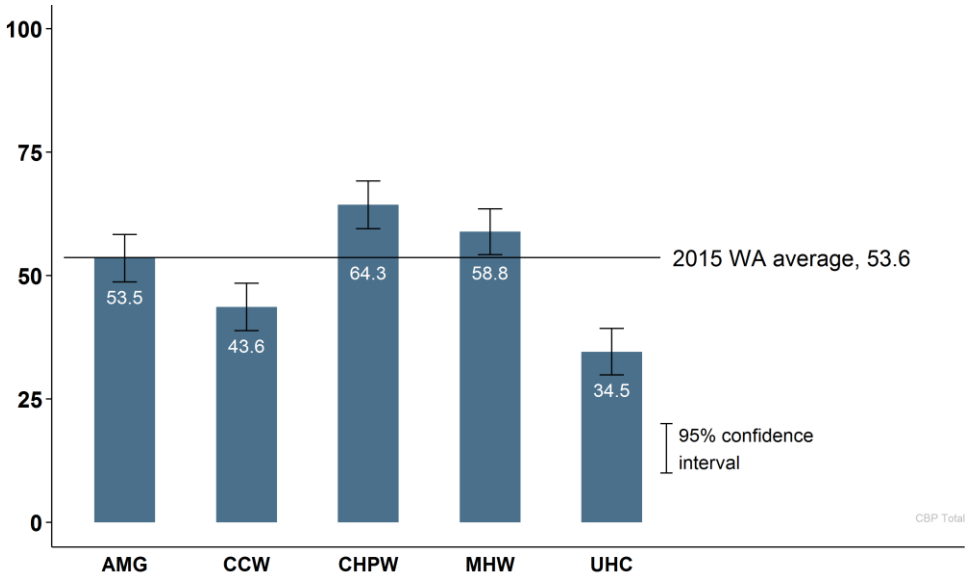


Figure 36: Percent of Patients <u>18 Years and Over</u> Continuing Antidepressant Medication, 2015 RY

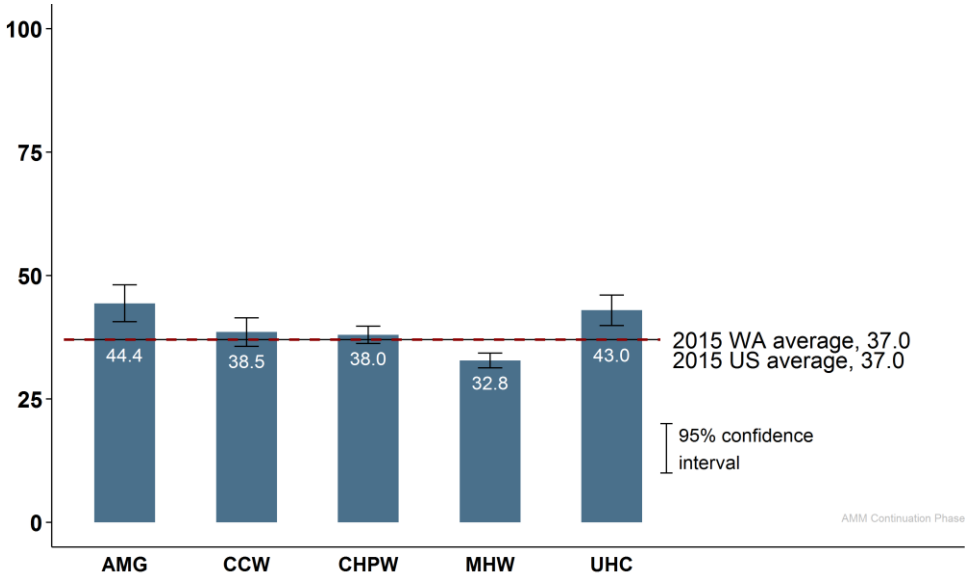


Figure 37: Percent of Asthma Patients <u>Aged 5–85 Years</u> Continuing Medication At Least 75 Percent of Treatment Period, 2015 RY

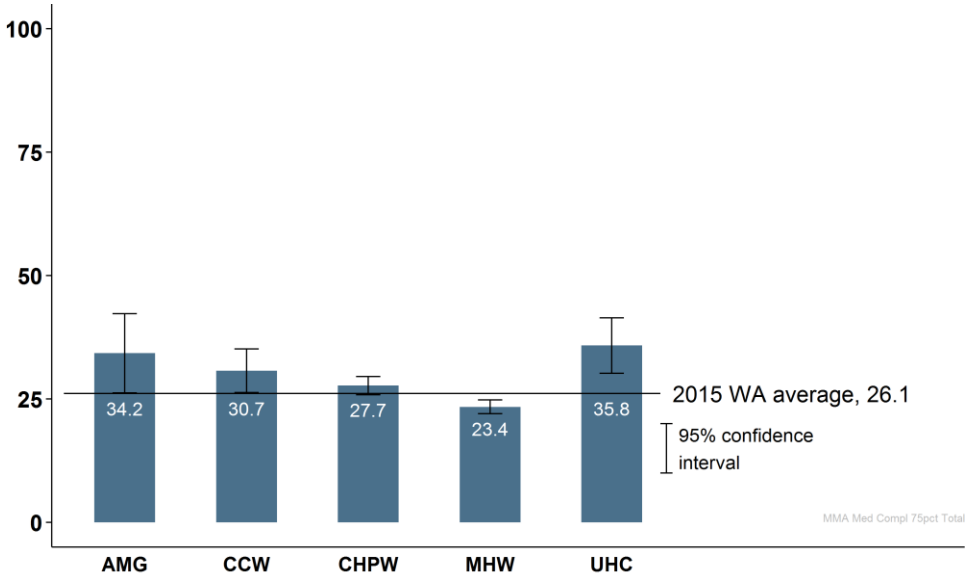
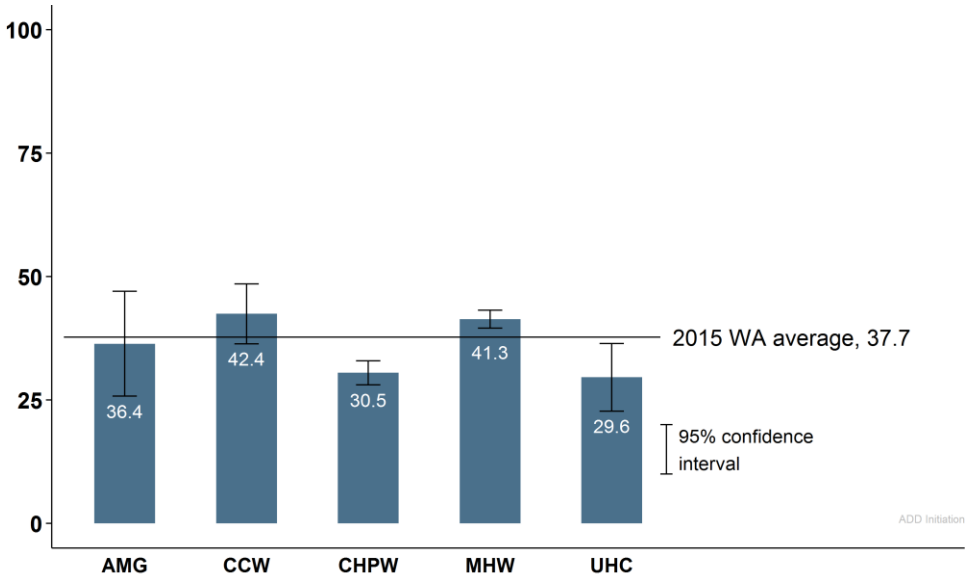


Figure 38: Percent of ADHD Patients With At Least One Visit During Treatment Initiation Phase, 2015 RY



Performance Summary

- Apple Health diabetes process measures were generally good in the 2015 reporting year. The state average was better than the national average for testing, eye exams and attention to nephropathy, with significant gains made compared to 2014 RY for the latter two measures.
    - MHW and UHC performed below the state and national averages for eye examinations, although UHC significantly improved compared to the prior year.
- Outcomes measures also generally improved compared to 2014 RY (but none significantly), and were all better than the national average.
    - UHC remained below the state average for controlling blood pressure, but improved dramatically from the prior year.
- CHPW led the state for all diabetes outcomes performance measures in the 2015 reporting year.
- Caution should be used in comparing MCO rates of blood pressure control due to differing patient populations; however, the state overall rate still lags behind the national average rate, so there are quality improvement opportunities on the measure as a whole.
- Overall antidepressant medication continuation performance is lower than the national average rate; this will be an important measure to monitor as the State moves forward with behavioral and physical health integration.
- Overall asthma medication compliance is lower than the nation, with the two largest MCOs showing the lowest rates. Better asthma medication compliance may be achieved as an outcome of increasing well-care visit rates, as noted previously.
- Overall ADHD medication monitoring during the initiation of treatment phase is lower than the national average rate, indicating an opportunity for all MCOs to improve care.

Medical Care Utilization

Overview

The cost of healthcare is growing at an unsustainable rate. Health spending per capita grew by 5 percent in 2014 CY after five years of slowed growth in the wake of the economic downturn.[12] While the costs of insuring the Medicaid expansion population are currently covered in full by the Federal government, Washington State will begin assuming more of these costs in future years, beginning with 10 percent of costs in 2017. Limiting cost growth while maximizing health coverage is essential for the program to be sustainable. There are two important methods of controlling costs: preventing waste and reducing unnecessary inpatient admissions.

Preventing Waste

The Institute of Medicine estimated that in 2010, approximately one-third of medical spending in the United States ($750 billion) was spent on services that did not improve health.[13] This includes $210 billion in unnecessary services. Seventy-two percent of physicians say they believe the average medical doctor prescribes an unnecessary test or procedure at least once per week.[14] The American Board of Internal Medicine (ABIM) has developed the Choosing Wisely campaign to identify and educate providers on tests or procedures that may be of little value. The Washington Health Alliance publishes an annual report on geographic and provider trends on several of these measures.[15] In this report we include MCO performance on three of the Choosing Wisely measures (use of imaging for low back pain, antibiotics use for bronchitis, and antibiotics use for upper respiratory infections).

Reducing Inpatient Admissions

Nearly one-third of all healthcare spending in the United States is spent on inpatient care.[16] Research suggests that nearly 10 percent of all inpatient stays are potentially avoidable with better outpatient patient monitoring of chronic conditions or better outpatient access to after-hours care for acute conditions.[17] There may be opportunities to lower costs and improve the care provided to Apple Health enrollees through enhanced outpatient access and reduced rehospitalizations within 30 days.

Reported Measures

Measures in this domain include:

- **Avoidance of Inappropriate Care:**
    - Imaging for Low Back Pain: the percentage of individuals diagnosed with lower back pain who did not receive an imaging study within 28 days of the initial diagnosis
    - Antibiotics for Acute Bronchitis: the percentage of adults with a diagnosis of acute bronchitis who were not dispensed an antibiotic
    - Antibiotics for Upper Respiratory Infection: the percentage of children with a diagnosis of upper respiratory infection who were not dispensed an antibiotic
- **Ambulatory Care Utilization**
    - Outpatient Visits per 1,000 Member Months
    - Emergency Department Visits per 1,000 Member Months

- **Inpatient Utilization**
    - Inpatient Discharges per 1,000 Member Months
    - Percentage of Discharges Readmitted Within 30 Days

For more information on historical performance on these measures, as well as performance on additional measures such as length of stay by service line, please refer to Appendix B.

Measure Performance

Avoidance of Inappropriate Care

Overall Apple Health rates are higher than national averages for all three measures of appropriate utilization (meaning MCOs did a *better* job at ensuring individuals did *not* receive inappropriate care). There remain high rates of prescribing antibiotics for acute bronchitis, a surprising contrast to the low rate of inappropriate antibiotic prescribing for upper respiratory infections. Additional provider education efforts may be necessary.

There is some variation between MCOs in all three measures. More information on the geographic variation in these measures can be found in the Washington Health Alliance Community Checkup Reports available at www.wacommunitycheckup.org.

Note: For the measures below, higher scores indicate better performance (i.e., a higher percentage of individuals who did not receive inappropriate care).

Table 10: Performance on Inappropriate Care Measures, 2015 RY

Measure	AMG	CCW	CHPW	MHW	UHC	State
Imaging for Low Back Pain	71.3▼	79.3	78.0	79.1▲	74.8▼	77.7
Antibiotics for Acute Bronchitis	37.4▲	26.9	32.5▲	27.7	26.5	29.3
Antibiotics for Upper Respiratory Infection	92.5	91.7▼	93.0	92.8	90.8▼	92.6

▼▲ Performance score is significantly higher or lower than the state score

Ambulatory Care Utilization

Ambulatory care utilization (visits) ranged from 311.5 (AMG) to 345.8 (MHW) per 1,000 member months. All MCOs had lower ambulatory utilization than the national average rate. Ambulatory visit rates declined slightly for most MCOs in 2015 RY and for the state overall.

It is difficult to determine optimal ambulatory utilization rates by MCO because each MCO serves different patient populations. One measure of the appropriateness of ambulatory utilization is ED visit rates; MCOs with adequate outpatient access should expect to see reduced ED visits. That pattern is observed in Apple Health: MHW, which has the highest ambulatory visit rate, also has the lowest ED visit rate. Similarly, CCW, which has one of the lowest ambulatory visit rates, also has the highest ED visit rate. This data suggest that there may be opportunities to minimize ED visits by improving ambulatory utilization for select MCOs. AMG and CCW both reduced ED visits substantially in 2015 RY. (We do not calculate confidence intervals for utilization measures because they reflect full populations; because the populations are large, the confidence intervals would not be meaningful.)

Figure 39: Total Ambulatory Visits per 1,000 Member Months, 2015 RY

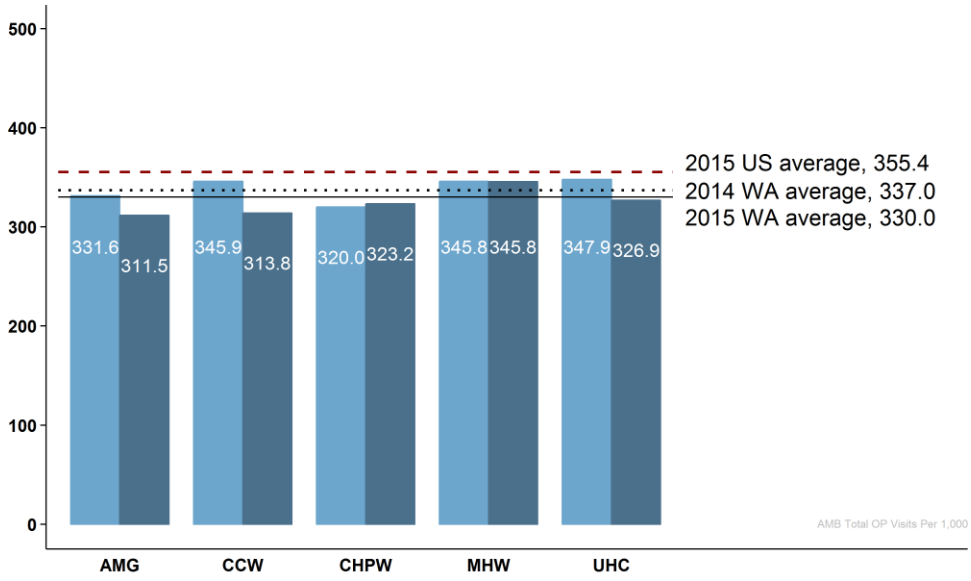
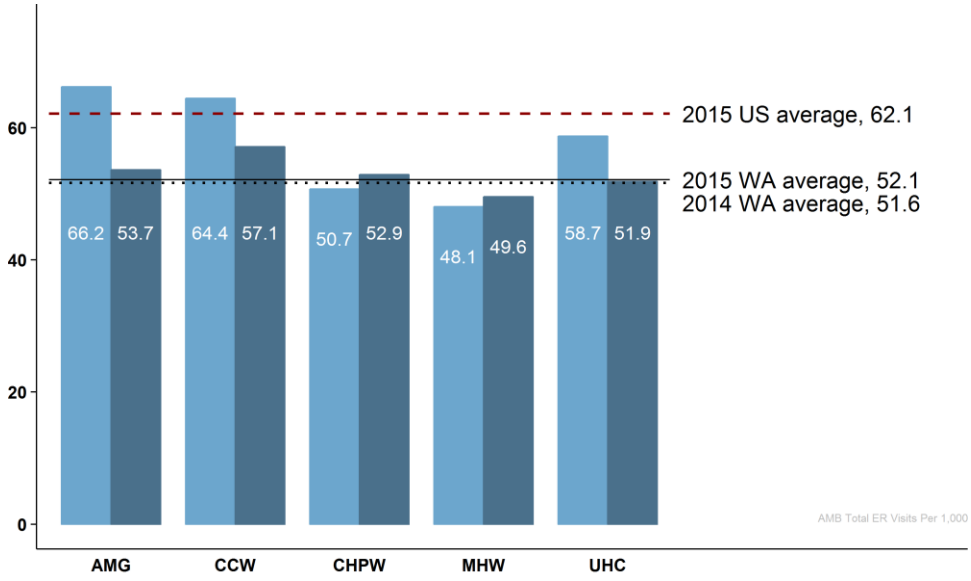


Figure 40: Total Emergency Department Visits per 1,000 Member Months, 2015 RY

Note: For this measure, a lower score is interpreted as better performance.



Inpatient Utilization

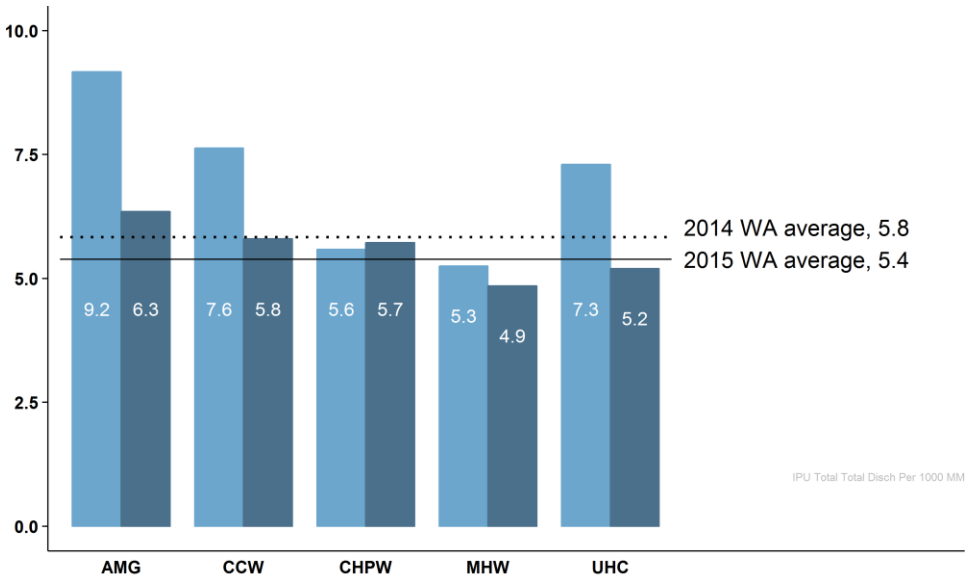
Total inpatient utilization is significantly below the national average, reflecting good performance by Apple Health plans at keeping enrollees out of the hospital.

It is difficult to compare inpatient utilization rates between MCOs because each one serves a distinct patient population; enrollees in different MCOs do not necessarily have the same risk profiles. However, when comparing inpatient utilization to total outpatient utilization (Figure 39, above), similar patterns emerge. MHW has the highest outpatient utilization rate and the lowest inpatient utilization rate. AMG has

the lowest outpatient utilization rate and the highest inpatient utilization rate. This data suggest there may be opportunities to further decrease inpatient utilization rates by optimizing outpatient utilization. Inpatient utilization was lower than the nation for the state overall.

Figure 41: Total Inpatient Discharges per 1,000 Member Months, 2015 RY

Note: For this measure, a lower score is interpreted as better performance.



Inpatient utilization is reflected in two measures: the rate at which individuals are initially admitted to the hospital, and the rate at which individuals are rehospitalized within 30 days after an initial hospitalization. The following charts reflect the 30-day rehospitalization rates by MCO for individuals aged 18–44, 45–54 and 55–64. There is currently no widely accepted Medicaid risk-adjustment methodology for rehospitalizations, so differences in MCO performance may reflect different risk profiles of enrollees.

Figure 42: Percent of Discharges Readmitted Within 30 Days, <u>All Ages</u>, 2015 RY

Note: For this measure, a lower score is interpreted as better performance.

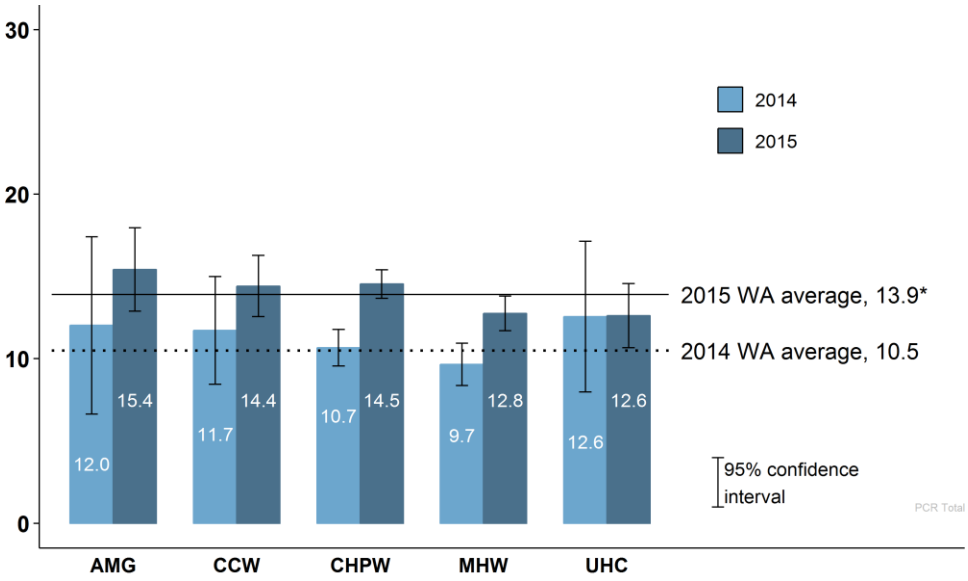


Figure 43: Percent of Discharges Readmitted Within 30 Days, <u>Ages 18–44</u>, 2015 RY

Note: For this measure, a lower score is interpreted as better performance.

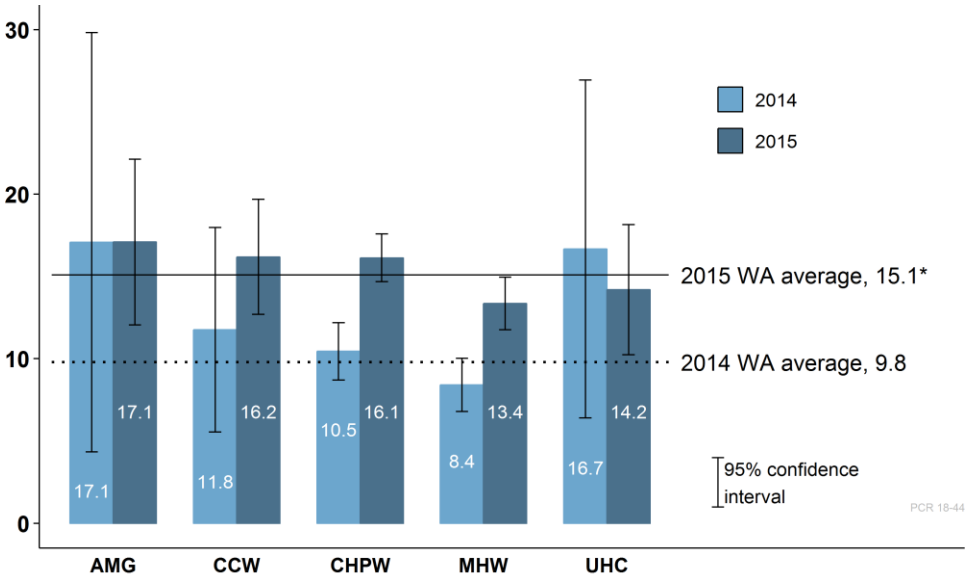


Figure 44: Percent of Discharges Readmitted Within 30 Days, Ages 45–54, 2015 RY

Note: For this measure, a lower score is interpreted as better performance.

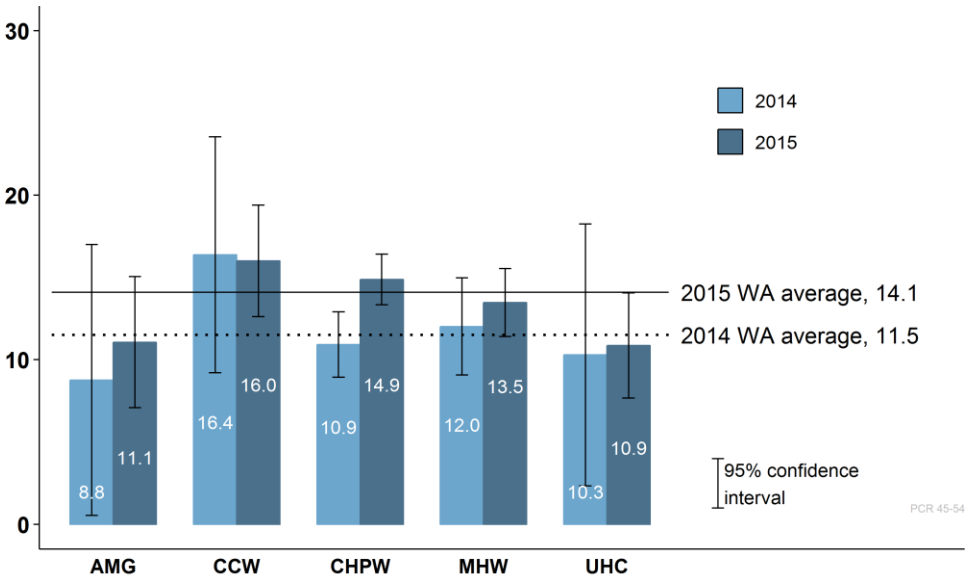
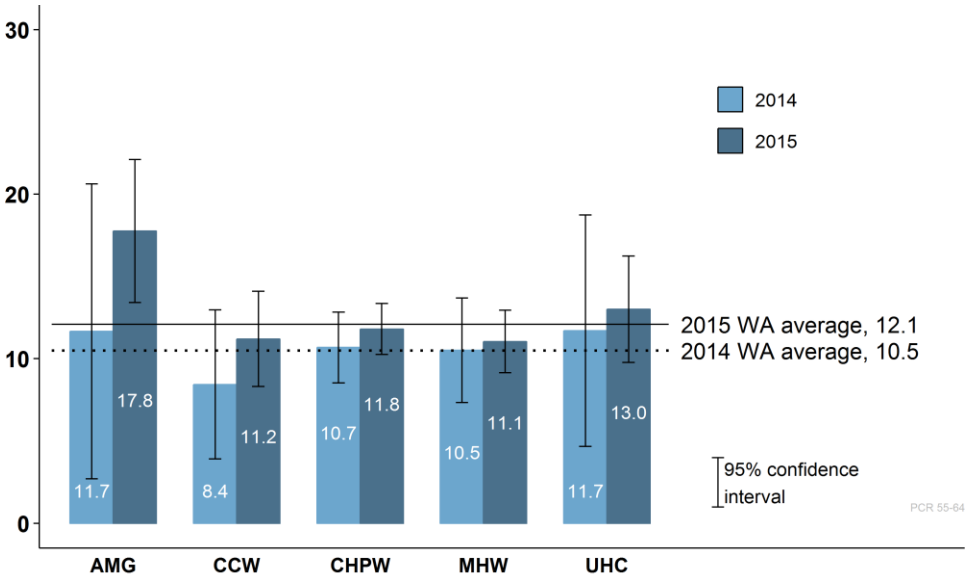


Figure 45: Percent of Discharges Readmitted Within 30 Days, Ages 55–64, 2015 RY

Note: For this measure, a lower score is interpreted as better performance.



Spotlight: Geographic Variation in Rehospitalization Rates

There is significant county-level variation in rehospitalization rates, which may be influenced by population trends, provider quality and provider availability. The Seattle metropolitan area has rehospitalization rates slightly above the state average, while more rural portions of the state have lower rehospitalization rates. This trend is particularly pertinent for the Medicaid expansion population, which had high rehospitalization rates in King and Pierce counties as compared with the rest of the state.

Individuals in the blind or disabled population are, unsurprisingly, more likely to be rehospitalized than the Medicaid population at large, but there are particular regions, such as Clark County, where enrollees may benefit from additional MCO-led case management.

Figure 46: Percent of Discharges Readmitted Within 30 Days, 2015 RY, By Region and County

Note: For this measure, a lower score is interpreted as better performance.

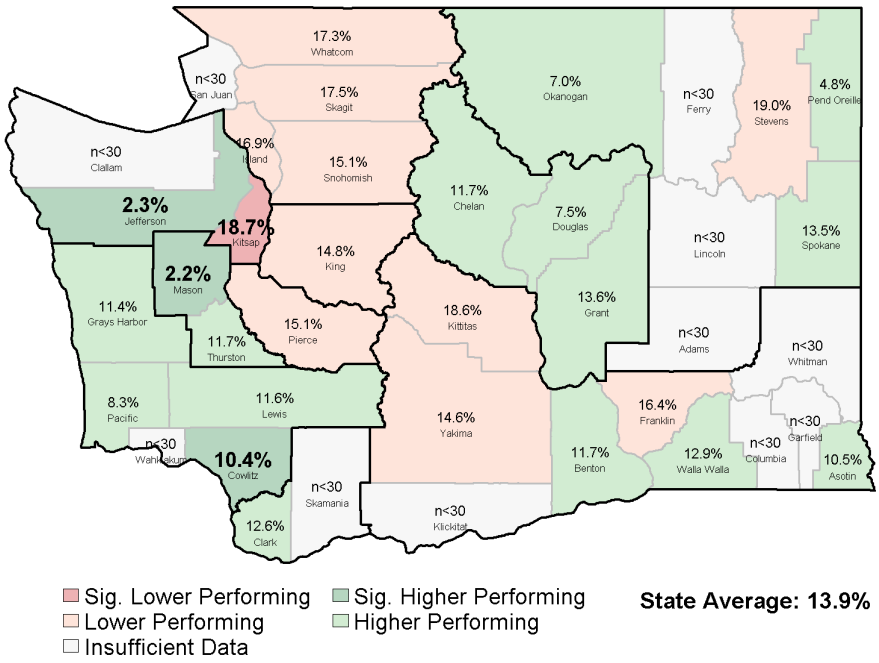


Figure 47: Percent of Discharges Readmitted Within 30 Days Among Blind or Disabled Populations, 2015 RY, By Region and County

Note: For this measure, a lower score is interpreted as better performance.

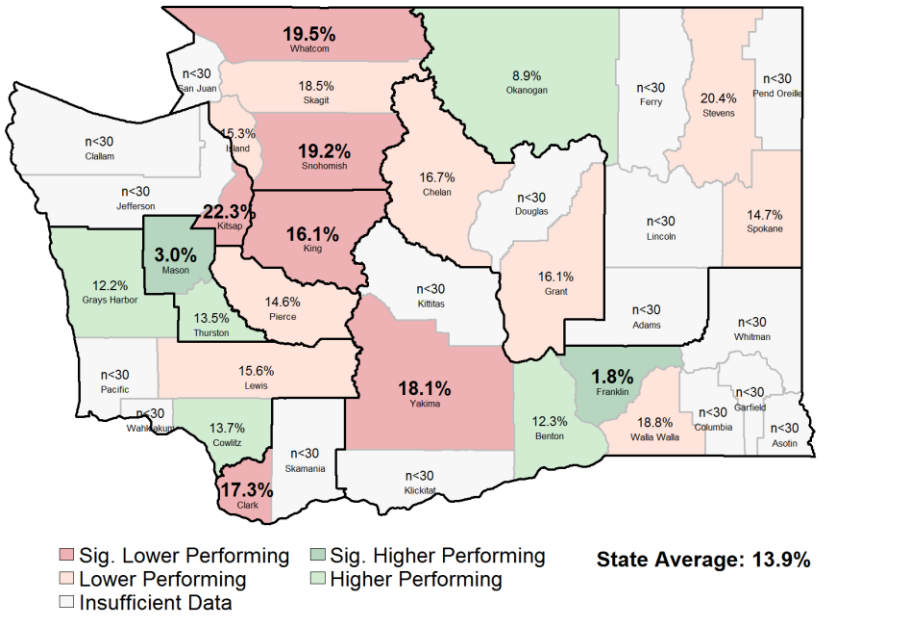
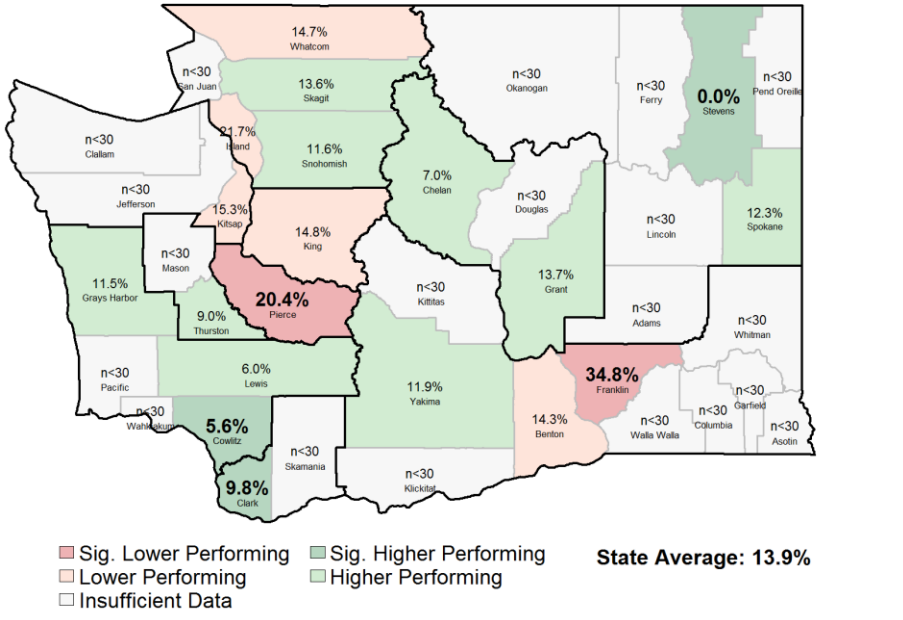


Figure 48: Percent of Discharges Readmitted Within 30 Days Among Medicaid Expansion Populations, 2015 RY, By Region and County

Note: For this measure, a lower score is interpreted as better performance.



Performance Summary

- MHW has the highest outpatient utilization, lowest ED visit rate and lowest inpatient utilization rate. There may be best practices that MHW can offer to other MCOs for optimizing outpatient utilization rates to minimize the utilization of more costly services.

Appendix A: MCO Performance Summaries

The next several pages include performance summaries for each of the individual MCOs.

Amerigroup Washington (AMG)

Access to Care

Primary care visits

Adult access (20-44 yrs)	68.7%
Adult access (45-64 yrs)	79.5% ▼
Adult access (total)	73.3%

Children's access (12-24 mths)	96.2% ▼
Children's access (25 mths - 6 yrs)	83.5% ▼
Children's access (7-11 yrs)	88.6% ▼
Children's access (12-19 yrs)	85.5% ▼

Maternal health visits

Prenatal timeliness	68.6%
Frequency of prenatal care	45.8%
Postpartum care	56.3% ▲

Well child visits

6+ visits in the first 15 months	58.1%
Annual visit, 3-5 yrs	68.2%
Annual visit, adolescent	40.3%

Preventive Care

Womens health screenings

Breast cancer	39.2% ▼
Cervical cancer	35.5% ▼
Chlamydia	49.7%
HPV vaccination before 13 yrs	17.3% ▼

Weight assessment and counseling

BMI percentile	42.6% ▲
Nutrition counseling	55.8% ▲
Physical activity counseling	52.3% ▲
Adult BMI assessments	81.4% ▲

Children's immunizations

Combo 2	66.1% ▼
Combo 3	60.1% ▼

Adolescents' immunizations

Combo 1	64.0%
Meningococcal	66.0% ▼
Tdap	81.6%

Quality of Medical Care

Diabetes management

HbA1c testing	91.2%
Eye exam	56.8%
Attention to nephropathy	84.5%
Good HbA1c control	43.9%
Poor HbA1c control *	43.2%
Bood pressure < 140/90 mm Hg	58.0%
Screening - Schiz/Bipolar	86.0%
Monitoring - Schiz/Bipolar	57.9%

Other chronic care management

Asthma medication - 75% compliance	34.2% ▲
COPD medication - systemic corticosteroid	75.1%
COPD medication - bronchodialator	89.0%
Antidepressant medication - acute	58.0% ▲
Antidepressant medication - continuation	44.4% ▲
ADHD medication follow up - initial	36.4%
ADHD medication follow up - continuing	35.5%
Medication adherence - schizophrenia	71.3%
Control of high blood pressure	53.5%

Ambulatory, emergent, and inpatient care

Outpatient visits per 1,000 MM	311.54
Hospital all cause readmisssions *	15.4%
ED visits per 1,000/MM *	53.65
Hosp. rate - medical, disch./1,000 MM*	2.45
Hosp. ALOS - medical *	3.89
Hosp. rate - surgical, disch./1,000 MM *	1.74
Hosp. ALOS - surgical *	7.92

Appropriateness of treatments

Antibiotics for children with colds (URI)	92.5%
Antibiotics for adults with bronchitis	37.4% ▲
Children pharyngitis	71.5% ▲
Use of imaging for lower back pain	71.3% ▼

▼▲Plan score significantly different from peers (p<.05)
* Lower rate is better performance

Hosp.: Hospitalization disch.: discharges
MM: member months
ALOS: average length of stay (days)

Coordinated Care Washington (CCW)

Access to Care

Primary care visits

Adult access (20-44 yrs)	71.5%
Adult access (45-64 yrs)	80.9% ▼
Adult access (total)	75.2%

Children's access (12-24 mths)	97.7%
Children's access (25 mths - 6 yrs)	89.2%
Children's access (7-11 yrs)	91.6%
Children's access (12-19 yrs)	90.9%

Maternal health visits

Prenatal timeliness	74.1%
Frequency of prenatal care	48.4%
Postpartum care	49.3%

Well child visits

6+ visits in the first 15 months	60.6%
Annual visit, 3-5 yrs	66.8%
Annual visit, adolescent	38.0%

Preventive Care

Womens health screenings

Breast cancer	43.6% ▼
Cervical cancer	43.1%
Chlamydia	54.5% ▲
HPV vaccination before 13 yrs	31.4%

Weight assessment and counseling

BMI percentile	24.5% ▼
Nutrition counseling	50.7%
Physical activity counseling	52.4% ▲
Adult BMI assessments	70.5% ▼

Children's immunizations

Combo 2	79.5% ▲
Combo 3	78.1% ▲

Adolescents' immunizations

Combo 1	61.3% ▼
Meningococcal	74.0%
Tdap	76.4% ▼

Quality of Medical Care

Diabetes management

HbA1c testing	90.7%
Eye exam	54.6%
Attention to nephropathy	85.2%
Good HbA1c control	39.4% ▼
Poor HbA1c control *	44.7%
Bood pressure < 140/90 mm Hg	60.4%
Screening - Schiz/Bipolar	87.2%
Monitoring - Schiz/Bipolar	60.0%

Other chronic care management

Asthma medication - 75% compliance	30.7% ▲
COPD medication - systemic corticosteroid	75.5%
COPD medication - bronchodialator	86.1%
Antidepressant medication - acute	52.6%
Antidepressant medication - continuation	38.5%
ADHD medication follow up - initial	42.4%
ADHD medication follow up - continuing	40.6%
Medication adherence - schizophrenia	72.4%
Control of high blood pressure	43.6% ▼

Ambulatory, emergent, and inpatient care

Outpatient visits per 1,000 MM	313.83
Hospital all cause readmisssions *	14.4%
ED visits per 1,000/MM *	57.12
Hosp. rate - medical, disch./1,000 MM*	2.24
Hosp. ALOS - medical *	3.71
Hosp. rate - surgical, disch./1,000 MM *	1.52
Hosp. ALOS - surgical *	7.21

Appropriateness of treatments

Antibiotics for children with colds (URI)	91.7% ▼
Antibiotics for adults with bronchitis	26.9%
Children pharyngitis	46.4% ▼
Use of imaging for lower back pain	79.3%

▼▲Plan score significantly different from peers (p<.05)
* Lower rate is better performance

Hosp.: Hospitalization disch.: discharges
MM: member months
ALOS: average length of stay (days)

Community Health Plan of Washington (CHPW)

Access to Care

Primary care visits

Adult access (20-44 yrs)	81.4%	▲
Adult access (45-64 yrs)	87.5%	▲
Adult access (total)	83.9%	

Maternal health visits

Prenatal timeliness	77.9%	▲
Frequency of prenatal care	46.7%	
Postpartum care	52.6%	

Children's access (12-24 mths)	97.4%	
Children's access (25 mths - 6 yrs)	87.9%	▼
Children's access (7-11 yrs)	91.1%	▼
Children's access (12-19 yrs)	89.5%	▼

Well child visits

6+ visits in the first 15 months	57.7%	
Annual visit, 3-5 yrs	65.0%	
Annual visit, adolescent	40.9%	

Preventive Care

Womens health screenings

Breast cancer	56.1%	▲
Cervical cancer	56.2%	▲
Chlamydia	49.7%	▼
HPV vaccination before 13 yrs	28.5%	

Children's immunizations

Combo 2	72.5%	
Combo 3	70.3%	

Weight assessment and counseling

BMI percentile	37.2%	
Nutrition counseling	56.9%	▲
Physical activity counseling	49.9%	
Adult BMI assessments	86.0%	▲

Adolescents' immunizations

Combo 1	75.1%	▲
Meningococcal	75.7%	
Tdap	91.8%	▲

Quality of Medical Care

Diabetes management

HbA1c testing	91.5%	
Eye exam	63.7%	▲
Attention to nephropathy	81.5%	
Good HbA1c control	52.3%	▲
Poor HbA1c control *	33.3%	▼
Bood pressure < 140/90 mm Hg	72.5%	▲
Screening - Schiz/Bipolar	87.3%	
Monitoring - Schiz/Bipolar	60.4%	▼

Ambulatory, emergent, and inpatient care

Outpatient visits per 1,000 MM	323.20	
Hospital all cause readmisssions *	14.5%	▲
ED visits per 1,000/MM *	52.91	
Hosp. rate - medical, disch./1,000 MM*	2.30	
Hosp. ALOS - medical *	3.52	
Hosp. rate - surgical, disch./1,000 MM *	1.41	
Hosp. ALOS - surgical *	6.50	

Other chronic care management

Asthma medication - 75% compliance	27.7%	▲
COPD medication - systemic corticosteroid	75.2%	
COPD medication - bronchodialator	87.2%	
Antidepressant medication - acute	52.3%	
Antidepressant medication - continuation	38.0%	
ADHD medication follow up - initial	30.5%	▼
ADHD medication follow up - continuing	30.0%	▼
Medication adherence - schizophrenia	64.4%	▼
Control of high blood pressure	64.3%	▲

Appropriateness of treatments

Antibiotics for children with colds (URI)	93.0%	
Antibiotics for adults with bronchitis	32.5%	▲
Children pharyngitis	65.8%	
Use of imaging for lower back pain	78.0%	

▼▲Plan score significantly different from peers (p<.05)
* Lower rate is better performance

Hosp.: Hospitalization disch.: discharges
MM: member months
ALOS: average length of stay (days)

Molina Healthcare of Washington (MHW)

Access to Care

Primary care visits

Adult access (20-44 yrs)	83.8% ▲	Children's access (12-24 mths)	97.9% ▲
Adult access (45-64 yrs)	88.6% ▲	Children's access (25 mths - 6 yrs)	89.5% ▲
Adult access (total)	85.3% ▲	Children's access (7-11 yrs)	92.6% ▲
		Children's access (12-19 yrs)	92.6% ▲

Maternal health visits

Prenatal timeliness	74.7%
Frequency of prenatal care	40.2% ▼
Postpartum care	52.0%

Well child visits

6+ visits in the first 15 months	55.2%
Annual visit, 3-5 yrs	67.5%
Annual visit, adolescent	44.4%

Preventive Care

Womens health screenings

Breast cancer	58.4% ▲
Cervical cancer	58.7% ▲
Chlamydia	52.8% ▲
HPV vaccination before 13 yrs	30.0%

Weight assessment and counseling

BMI percentile	39.1% ▲
Nutrition counseling	48.8%
Physical activity counseling	41.5% ▼
Adult BMI assessments	84.5% ▲

Children's immunizations

Combo 2	69.1%
Combo 3	66.9%

Adolescents' immunizations

Combo 1	75.5% ▲
Meningococcal	75.9%
Tdap	92.5% ▲

Quality of Medical Care

Diabetes management

HbA1c testing	89.6%
Eye exam	48.3% ▼
Attention to nephropathy	82.6%
Good HbA1c control	45.9%
Poor HbA1c control *	46.6%
Bood pressure < 140/90 mm Hg	65.8% ▲
Screening - Schiz/Bipolar	84.2%
Monitoring - Schiz/Bipolar	75.5% ▲

Other chronic care management

Asthma medication - 75% compliance	23.4% ▼
COPD medication - systemic corticosteroid	77.0%
COPD medication - bronchodialator	87.1%
Antidepressant medication - acute	48.4% ▼
Antidepressant medication - continuation	32.8% ▼
ADHD medication follow up - initial	41.3% ▲
ADHD medication follow up - continuing	44.0% ▲
Medication adherence - schizophrenia	76.8% ▲
Control of high blood pressure	58.8% ▲

Ambulatory, emergent, and inpatient care

Outpatient visits per 1,000 MM	345.81
Hospital all cause readmisssions *	12.8% ▼
ED visits per 1,000/MM *	49.55
Hosp. rate - medical, disch./1,000 MM*	1.56
Hosp. ALOS - medical *	3.64
Hosp. rate - surgical, disch./1,000 MM *	1.07
Hosp. ALOS - surgical *	6.95

Appropriateness of treatments

Antibiotics for children with colds (URI)	92.8%
Antibiotics for adults with bronchitis	27.7% ▼
Children pharyngitis	67.9% ▲
Use of imaging for lower back pain	79.1% ▲

▼▲Plan score significantly different from peers (p<.05)
* Lower rate is better performance

Hosp.: Hospitalization disch.: discharges
MM: member months
ALOS: average length of stay (days)

United Healthcare Community Plan (UHC)

Access to Care

Primary care visits

Adult access (20-44 yrs)	71.8%	Children's access (12-24 mths)	96.2% ▼
Adult access (45-64 yrs)	81.3% ▼	Children's access (25 mths - 6 yrs)	88.3%
Adult access (total)	75.7%	Children's access (7-11 yrs)	91.2%
		Children's access (12-19 yrs)	88.9% ▼

Maternal health visits

Prenatal timeliness	65.2% ▼
Frequency of prenatal care	43.1%
Postpartum care	48.2%

Well child visits

6+ visits in the first 15 months	57.4%
Annual visit, 3-5 yrs	65.2%
Annual visit, adolescent	45.7%

Preventive Care

Womens health screenings

Breast cancer	41.2% ▼
Cervical cancer	35.8% ▼
Chlamydia	45.0% ▼
HPV vaccination before 13 yrs	25.5%

Weight assessment and counseling

BMI percentile	30.4% ▼
Nutrition counseling	39.2% ▼
Physical activity counseling	37.7% ▼
Adult BMI assessments	68.1% ▼

Children's immunizations

Combo 2	68.6%
Combo 3	65.9%

Adolescents' immunizations

Combo 1	66.1%
Meningococcal	68.6%
Tdap	80.6%

Quality of Medical Care

Diabetes management

HbA1c testing	88.8%
Eye exam	49.1% ▼
Attention to nephropathy	86.6%
Good HbA1c control	43.6%
Poor HbA1c control *	49.9% ▲
Bood pressure < 140/90 mm Hg	48.4% ▼
Screening - Schiz/Bipolar	85.6%
Monitoring - Schiz/Bipolar	79.4% ▲

Other chronic care management

Asthma medication - 75% compliance	35.8% ▲
COPD medication - systemic corticosteroid	75.8%
COPD medication - bronchodialator	85.5%
Antidepressant medication - acute	57.2% ▲
Antidepressant medication - continuation	43.0% ▲
ADHD medication follow up - initial	29.6% ▼
ADHD medication follow up - continuing	32.8%
Medication adherence - schizophrenia	73.5%
Control of high blood pressure	34.5% ▼

Ambulatory, emergent, and inpatient care

Outpatient visits per 1,000 MM	326.91
Hospital all cause readmisssions *	12.6%
ED visits per 1,000/MM *	51.89
Hosp. rate - medical, disch./1,000 MM*	1.99
Hosp. ALOS - medical *	3.95
Hosp. rate - surgical, disch./1,000 MM *	1.42
Hosp. ALOS - surgical *	7.04

Appropriateness of treatments

Antibiotics for children with colds (URI)	90.8% ▼
Antibiotics for adults with bronchitis	26.5%
Children pharyngitis	65.8%
Use of imaging for lower back pain	74.8% ▼

▼▲Plan score significantly different from peers (p<.05)

* Lower rate is better performance

Hosp.: Hospitalization disch.: discharges

MM: member months

ALOS: average length of stay (days)

Appendix B: HEDIS Performance Measure Tables

Please see separate attached document for Appendix B.

References

[i] Washington State Common Measure Set for Health Care Quality and Cost. Approved December 2014. Available at: www.hca.wa.gov/hw/Documents/pmcc_final_core_measure_set_approved_121714.pdf

[2] DesRoches CM, Campbell EG, Rao SR, et al. Electronic health records in ambulatory care -- a national survey of physicians. *New England Journal of Medicine* 2008 Jul 3;359(1):50-60.

[3] Bloom, B, et al. "Summary health statistics for U.S. children: National Health Interview Survey, 2011." National Center for Health Statistics. Vital Health Statistics 10(254). 2012. http://www.cdc.gov/nchs/data/series/sr_10/sr10_254.pdf.

[4] CDC. Childhood Obesity Facts. Available at: www.cdc.gov/healthyschools/obesity/facts.htm (Accessed Oct 8 2015)

[5] Kaiser Family Foundation (KFF). State Health Facts. Available at: http://kff.org/other/state-indicator/overweightobese-children/ (Accessed Oct 8 2015).

[6] CDC. Childhood Obesity Facts. Available at: www.cdc.gov/healthyschools/obesity/facts.htm (Accessed Oct 8 2015)

[7] Kaiser Family Foundation (KFF). State Health Facts. Available at: http://kff.org/other/state-indicator/overweightobese-children/ (Accessed Oct 8 2015).

[8] Seither, R, et al. "Vaccination Coverage Among Children in Kindergarten – United States, 2013-14 School Year." *MMWR.* 63(41):913-920. October 17, 2014.

[9] Washington State Department of Health. Invasive Cervical Cancer. Aug 22, 2013. Available at: http://www.doh.wa.gov/Portals/1/Documents/5500/CD-CVCN2013.pdf (Accessed Oct 12 2015).

[10] Washington State Diabetes Epidemic and Action Report. December 2014. Available at: http://www.doh.wa.gov/Portals/1/Documents/Pubs/345-342-DiabetesEpidemicActionReport.pdf (Accessed Oct 9 2015)

[11] Kaufman, HW, et al. "Surge in Newly Identified Diabetes Among Medicaid Patients in 2014 Within Medicaid Expansion States Under the Affordable Care Act." *Diabetes Care.* 38(5): 833-7. May 2015.

[12] Tozzi, J. "U.S. Health-Care Spending is On the Rise Again." *Bloomberg Business.* February 18, 2015. Available at: http://www.bloomberg.com/news/articles/2015-02-18/u-s-health-care-spending-is-on-the-rise-again (Accessed Oct 12 2015).

[13] Institute of Medicine (IOM). "Best Care at Lower Cost: The Path to Continuously Learning Health Care in America." September 6, 2012. Available at: http://iom.nationalacademies.org/Reports/2012/Best-Care-at-Lower-Cost-The-Path-to-Continuously-Learning-Health-Care-in-America.aspx (Accessed Oct 12 2015).

[14] "Unnecessary Tests and Procedures in the Health Care System: What Physicians Say About the Problem, the Causes, and the Solutions." PerryUndem Research for the American Board of Internal Medicine. May 1, 2014. Available at: http://www.choosingwisely.org/wp-content/uploads/2015/04/Final-Choosing-Wisely-Survey-Report.pdf (Accessed Oct 9 2015).

[15] "Less Waste. Less Harm. Choosing Wisely® in Washington State." Washington Health Alliance. September 2014. Available at: http://wahealthalliance.org/wp-content/uploads/2014/09/Choosing-Wisely-in-Washington-state.pdf (Accessed Oct 12 2015).

[16] Weiss, AJ, et al. “Trends and Projections in Inpatient Hospital Costs and Utilization, 2003-2013.” HCUP Statistical Brief #175. July 2014. Available at: http://www.hcup-us.ahrq.gov/reports/statbriefs/sb175-Hospital-Cost-Utilization-Projections-2013.pdf (Accessed Oct 12 2015).

[17] Stranges, E, et al. “Potentially Preventable Hospitalizations for Acute and Chronic Conditions, 2008.” HCUP Statistical Brief # 99. November 2010. Available at: https://www.hcup-us.ahrq.gov/reports/statbriefs/sb99.pdf (Accessed Oct 12 2015).