Washington State Health Care Authority

REPORT TO THE LEGISLATURE

Service Coordination Organizations

Accountability Measures Implementation Status

RCW 70.320.050: SSB 5147, C 209 L 2015 § 3; and ESHB 1519, C 320 L 2013 § 5
RCW 43.20A.895: 2SSB 5732, C 338 L 2013 § 2
RCW 41.05.690: E2SHB 2572, C 223 L 2014 PV § 6
2SSB 6312, C 225, L 2014

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Washington State Department of Social & Health Services

Transforming lives

Service Coordination Organizations

Accountability Measures Implementation Status

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Executive Summary

Over the past three legislative sessions (2013 to 2015), the Health Care Authority (HCA) and Department of Social and Health Services (DSHS) have been charged with identifying common performance measures for reporting by contracted service organizations. In 2015, Substitute Senate Bill (SSB) 5147 was enacted, requiring an annual report on the agencies' progress on those measures. This report presents the initial results for measure sets that were created to respond to previous legislation, and a new measurement of health risk assessments. In addition, recommendations for improving the health of Medicaid enrollees based on these initial results are presented.

Measure Sets in this Report

This report, fulfilling a requirement under SSB 5147, provides three separate sets of performance measures that are used to monitor service coordination organizations under contract with HCA and DSHS. The measure sets are developed according to different rules for data collection and reporting. Two different groups of stakeholders were involved in their creation. Together, they begin to describe the success of contracted organizations to reach clients eligible for Medicaid services, identify those who need services, and provide high quality services to help them achieve their health-related goals.

The measure sets include:

1. ESHB 1519 and 2SSB 5732 Performance Measures

The following measures were adopted or developed in response to Engrossed Substitute House Bill (ESHB) 1519 and Second Substitute Senate Bill (2SSB) 5732. They are reported at the regional level with trends over three years:

- Adults' Access to Preventative/Ambulatory Care
- Alcohol/Drug Treatment Penetration
- Mental Health Service Penetration (Behavioral Health Organization Service Only)
- Mental Health Service Penetration (Broad)
- Psychiatric Hospital Readmission Rate
- Plan All-Cause Readmission Rate
- Homelessness (Narrow)
- Employment Rate
- Criminal Justice Involvement
- Emergency Department (ED) Visits per 1000 Member Months

2. Statewide Common Measure Set

The measures in the Statewide Common Set developed by the Performance Measure Coordinating Committee include measures in the following categories, which are reported for the Medicaid population as statewide measures for State Fiscal Year (SFY) 2015, and with national Medicaid managed care benchmarks where relevant:

- Access to Care
  - Adult and Child access to preventive/ambulatory care
- Asthma and COPD
  - Use of appropriate medication
  - Hospitalization for COPD or asthma (per 100,000)
- Cardiovascular Disease
  - Controlling high blood pressure
- Diabetes
  - Eye exam; Blood sugar (HBA1c) test; and Kidney disease screening
  - Blood pressure and Blood sugar (HbA1c) control
- Health Screenings
  - Child and Adolescent well-care visits
  - Screening for breast cancer, cervical cancer, and chlamydia
- Generic Prescription Drugs
- Medication Adherence and Safety
- Behavioral Health
  - Antidepressant medication (at 12 weeks and 6 months)
- Obesity Prevention
  - Weight assessment (BMI percentile) for children and adults
  - Counseling for nutrition and physical activity for children/adolescents
- Oral Health
- Potentially Avoidable Care
  - Avoidance of antibiotic treatment in adults with acute bronchitis
  - Potentially avoidable Emergency Room (ER) visits
  - Appropriate testing for children with pharyngitis
  - Avoidance of x-ray, Magnetic resonance imaging (MRI) and computerized tomography (CT) scan for low back pain
  - Avoidance of antibiotics for common cold

3. Other Measures and Reports on Performance

In this report, HCA includes a new reported measure: the percent of clients by health plan with completed health risk assessments.

HCA also submitted two other performance measure reports this year as requested by the Legislature. These reports are "Child Health Services: Provider Performance" responsive to ESHB 2128, Laws of 2009, and "Medicaid Managed Care Preventive Services and Vaccinations" responsive to Second Engrossed Substitute House Bill (2ESHB) 2376, Laws of 2016. They differ from this report because they track different measures, use data from different sources or time frames, or

track different subject populations (e.g., all Medicaid enrollees, in both managed care and fee-for-service, instead of only Medicaid managed care enrollees).

In last year's Comparative Analysis Report the External Quality Review Organization, Qualis, made some recommendations, including:

- Align and prioritize measures with the Healthier Washington Common Measure Set,
- Require MCOs to complete performance improvement projects for areas of low performance (e.g. well-child and adolescent visits and childhood immunizations),
- Establish new performance standards for low performance indicators, and
- Create a forum for MCOs to share common challenges and best practices.

With the core measures reported for service coordination organizations by DSHS' Research and Data Analysis (RDA), HCA and DSHS have begun reporting out by new contracting regions and subpopulations in 2016. A sample snapshot of a few of these measures is provided below.

Statewide	CY 2013	CY 2014	CY 2015
	1/13-12/13	1/14-12/14	1/15-12/15
Medicaid - Substance Use Disorder Treatment Penetration	25.5%	27.4%	25.6%
Medicaid - Mental Health Treatment Penetration (Broad Definition)	45.8%	44.1%	41.2%
Medicaid - Plan All Cause 30 Day Readmission	18.6%	18.4%	17.5%
Medicaid - Percent Homeless	12.2%	12.8%	13.5%
Medicaid - Percent Employed	18.6%	33.7%	38.8%
Medicaid - Percent Arrested	7.1%	7.4%	7.7%

Many factors make it difficult to interpret trends: the new Regional Service Areas, new contracting responsibilities for Behavioral Health Organizations, and the rapid growth of the Medicaid population since 2014. Despite the difficulties, HCA and DSHS are moving forward with recommendations and are committed to improving data quality and transparency, for example, aligning measure inclusion criteria across reporting processes, and using contracts to improve areas of poor performance, including adding core measures to contracts with service coordination organizations. The new roadmap for value-based purchasing points to an aggressive timeline for increasing the proportion of dollars tied to performance for HCA's managed care contractors; key measures will be tied to a premium withhold in 2017.

Introduction

This report is submitted pursuant to RCW 70.320.050 which directs:

(1) By December 1, 2014, the department and the authority shall report jointly to the legislature on the expected outcomes and the performance measures. The report must identify the performance measures and the expected outcomes established for each program, the relationship between the performance measures and expected improvements in client outcomes, mechanisms for reporting outcomes and measuring performance, and options for applying the performance measures and expected outcomes development process to other health and social service programs.

(2) By December 1, 2016, and annually thereafter, the department and the authority shall report to the legislature on the incorporation of the performance measures into contracts with service coordination organizations and progress toward achieving the identified outcomes. The report shall include:

(a) The number of medicaid clients enrolled over the previous year;

(b) The number of enrollees who received a baseline health assessment over the previous year;

*(c) An analysis of trends in health improvement for medicaid enrollees in accordance with the measure set established under *RCW 41.05.065; and*

(d) Recommendations for improving the health of medicaid enrollees.

***Reviser's note:** The reference to RCW 41.05.065 appears to be erroneous. A reference to RCW 41.05.690 was apparently intended.

This report describes the progress to date and initial results of two performance measure sets required by legislation enacted since 2013: (1) ESHB 1519 and 2SSB 5732, and (2) E2SHB 2572. These two measure sets fulfill different purposes set by the Legislature. ESHB 1519 and 2SSB 5732 measures were developed specifically for monitoring HCA and DSHS contracted Medicaid service coordination organizations, and E2SHB 2572 statewide common measures were selected for comparing provider and health plan performance for both the commercial and public sectors.

ESHB 1519 and 2SSB 5732 measures were chosen to reflect the performance of providers and managed care organization (MCO) health plans in the areas of access and effectiveness, utilization, care coordination and wellness, employment, criminal justice, housing, and quality of life. A minority of the measures, including those related to quality of life, would require new funding sources to collect and report results. A small number do not have finalized technical specifications.

HCA and DSHS agreed on a subset of measures to include in contracts beginning in 2016. On April 1, 2016, HCA and DSHS began contracting for medical and behavioral health services in the same Regional Service Areas (RSAs), and measures at the RSA level are included in this report. In addition, the measures are reported for clients of the Area Agencies on Aging (AAAs). The Home and Community Services Division of Aging and Long Term Services Administration is developing contract language for the AAAs that will ensure that the AAAs take reported performance measures outcomes into account when planning and delivering services.

In 2014, E2SHB 2572 directed HCA to establish the Governor-appointed Performance Measures Coordinating Committee (PMCC) for the purpose of identifying and recommending standard

statewide measures of health performance and set benchmarks for both the public and private sectors through the development of a Statewide Common measure set to inform health care purchasing. The measures cover access to care for adults and children; preventive, acute and chronic care; the cost of care and overuse of services; and behavioral health. Most measures can already be calculated using data that is required for reporting, or that is provided voluntarily to the Washington Health Alliance. In compliance with the objectives of SSB 5147, this report includes results of these performance measures, as well as data on health assessments conducted with new health plan enrollees. It also describes the progress on the use of these standard performance measures for Medicaid's Apple Health population. Specific data is provided for:

- The number of Medicaid clients enrolled over the previous year,
- The number of enrollees who received a baseline health assessment over the previous year, and
- An analysis of the trends in health improvement for Medicaid enrollees in accordance with the established measure sets.

Implications of 2SSB 6312 on Performance Measurement

The passage of 2SSB 6312, Laws of 2014, brought new direction to the implementation of ESHB 1519 and 2SSB 5732. DSHS and HCA are now responding to new guidance for reforming and integrating the behavioral healthcare system. Provisions within 2SSB 6312 include:

- Establish common Regional Service Areas for the purposes of purchasing behavioral and medical health care services;
- Direct the formation of Behavioral Health Organizations (BHOs), an organization within each common RSA, responsible for the provision of both mental health and substance use disorder (SUD) services in a managed care structure, and allow the adoption of fully integrated managed care in certain regions; and
- Authorize HCA and DSHS to incentivize outcome-based performance and "integration of behavioral health services in the primary care setting, promoting care that is integrated, collaborative, co-located, and preventive.[1]"

Performance Measures by Legislative Action

Implementation of SSB 5147

SSB 5147, Section 3 (enacted as Chapter 209, Laws of 2015) requires that contracts with service coordination organizations include the standard statewide measures of health performance developed by the Performance Measures Coordinating Committee, as well as an initial health screen for new enrollees.

[1] Second Substitute Bill 6312, Section 55, 2, e. (i) H

According to the June 2016 Value-Based Roadmap, "as a key strategy under Healthier Washington, HCA has pledged that 80 percent of HCA provider payments under State-financed health care programs—Apple Health (Medicaid) and the Public Employees Benefits Board (PEBB) program—will be linked to quality and value by 2019."[2] Paying for value is key to achieving the triple aim and—most importantly—ensuring that systems contribute to the health of the whole person. Meeting this goal will require shifting reimbursement and delivery system strategies away from a system that rewards volume of service to one that rewards quality and outcomes as measured by the common measure set. Washington State will utilize its position in the marketplace to drive transformation as both a "first mover" and "market convener."

Washington State now purchases health care coverage for more than 2 million people through Medicaid and PEBB. Recognizing opportunities to more effectively manage care and cost, Washington brought purchasing for Medicaid and public employees into the same agency and reinforced the State's commitment to managed care in 2011.

In addition to the adoption of E2SHB 2572 in 2014 directing HCA to facilitate the Performance Measures Coordinating Committee, recent statutory Medicaid managed care requirements include: performance-based managed care for the integrated delivery of medical and behavioral health services; compliance with network adequacy standards; incentives for chronic care management within health homes; comprehensive medication management; assessment of evidence-based practices utilization in children's services; outcome and performance measures to assess and improve medical care, mental health, long-term care, and chemical dependency services; outcome and performance measures developed by the PMCC; and integrated managed health and behavioral health care for foster children.

ESHB 1519 and 2SSB 5732

Implementation of ESHB 1519 and 2SSB 5732 required HCA and DSHS to include cross-system performance measures in contracts with service contracting entities, starting in July of 2015. See the 2014 report to the Legislature for details on the measure selection process. Beginning in 2016, a core set of performance measures are included as contractual terms in Medicaid managed care contracts for medical and behavioral health contractors statewide. Performance measures for contracted long-term supports and services with the AAAs also align with the 2016 implementation date in order to be consistent with the goal of shared performance measures. See the 2014 report to the Legislature for operational and technical details on the measure selection process, including the principles used to select measures, which are intended to include Medicaid individuals across the lifespan. See Appendix 1 for a list of all measures chosen for eventual reporting.

With the April 1, 2016 implementation of BHOs and Fully Integrated Managed Care (FIMC) in Clark and Skamania counties (Southwest Washington), DSHS and HCA have continued to include the

[2] Link to VBP Roadmap: http://www.hca.wa.gov/assets/program/vbp_roadmap.pdf

ESHB 1519 prioritized performance measures in Medicaid managed care contracts statewide. The following measures were selected for MCO and BHO contracts:

- Mental health service penetration rate
    - BHO contracts use a numerator definition measuring receipt of BHO services only.
    - MCO contracts use a broader numerator that includes services paid by the MCO.
- Substance use disorder treatment penetration rate
- Psychiatric hospitalization 30-day readmission rate
- Substance use disorder treatment initiation and engagement (Washington Circle adaptation)

Home and Community Services (HCS), a division of DSHS' Aging and Long Term Supports Administration (ALTSA), through its work within the ESHB 1519 Interagency Workgroup, selected a draft set of measures utilizing the criteria established by the workgroup. The six measures are shared by one, or both, of the other contracting agencies and will require, and can be leveraged, to drive strategies that cut across health sectors. HCS, in a collaborative process with the AAAs, agreed on contract language. The language is directed to ensure AAAs take reported performance measures outcomes into account when planning and delivering services.

Division of Behavioral Health & Recovery Contracts with Behavioral Health Organizations

The Division of Behavioral Health & Recovery (DBHR) contracts with nine BHOs to deliver all SUD treatment and complex mental health services to Medicaid enrollees in their geographical region through a managed care service system. These contracts were initiated on April 1, 2016 and include the following cross-system performance measures:

- Mental Health Treatment Penetration
- Substance Use Disorder Treatment Penetration
- 30-Day Psychiatric Hospitalization Readmission Rate
- Substance Use Disorder Treatment Initiation and Engagement (Washington Circle adaptation)

DBHR has taken a phased approach to inclusion of performance measures in BHO contracts. The above measures were selected based upon their relevance to the dramatic changes taking place within the public behavioral health delivery system through the creation of the BHOs and the movement of SUD services from fee-for-service (FFS) to managed care. DBHR will track performance on these measures in order to evaluate how well the BHOs are providing access to behavioral health services, delivering quality services, and preventing avoidable re-hospitalizations. DBHR will select additional performance measures for future BHO contracts and intends to address additional outcome areas such as housing, employment, and reducing criminal justice involvement.

Baselines are being established for performance measures in the current BHO contracts, and these could be used for value-based payment in the future. However, in doing so, the rates paid to BHOs must remain actuarially sound, and BHOs must have a reasonable ability to earn back the withheld incentive.

Home and Community Services Division Contracts with Area Agencies on Aging

The Home and Community Services Division contracts with 13 AAAs statewide and selected a set of performance measures utilizing criteria established through a workgroup. The selected performances measures are:

- Adults' Access to Preventative/Ambulatory Care
- Alcohol/Drug treatment Penetration
- Mental Health Treatment Penetration
- Home and Community-Based Long term Services and Supports Use
- Emergency Department (ED) Visits
- Plan All-Cause Readmission Rate

The potential outcomes are: client health and wellness, quality of life and reduction in avoidable hospitalizations.

Health Care Authority Contracts with Managed Care Organizations

HCA contracts for Apple Health Medicaid managed care statewide include both broad and specific requirements related to quality of care and service delivery. At a broad level, MCOs are required to create and maintain a Quality Assessment and Performance Improvement program which is evaluated by both HCA and the National Committee for Quality Assurance (NCQA). In addition, both MCOs and BHOs report on Performance Improvement Projects and their use of evidence-based practices, and are evaluated by an External Quality Review Organization. MCOs report Healthcare Effectiveness Data and Information (HEDIS) measures and are required to make these reports available to the public via the NCQA Quality Compass. HCA has used HEDIS results for incentives in the past (such as assignment of new members), and is incorporating new financial incentives tied to results in 2017 through a premium withhold of 1%. Where measures are included in both the ESHB 1519 core set and the measures in Community Checkup, the overlap helps to reinforce these strategies for service coordination organizations and providers.

From the 51 performance measures accepted by the ESHB 1519 Steering Committee on April 18, 2014, 15 proposed performance measures were chosen by HCA for inclusion in 2016 Apple Health Medicaid managed care contracts statewide:

- Adult's Access to Preventative/ Ambulatory Care
- Well Child Visits
- Comprehensive Diabetes Care

- Medical Assistance with Smoking and Tobacco Use Cessation
- Body Mass Assessment
- Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia
- Ambulatory Care Sensitive Conditions – Hospital Admissions
- Emergency Department (ED) Visits
- Plan All-Cause Readmission Rate
- Inpatient Utilization
- Substance Use Disorder Treatment Penetration
- Substance Use Disorder Treatment Initiation and Engagement (Washington Circle adaptation)
- Mental Health Service Penetration
- Psychiatric Hospital Readmission Rate
- Proportion of people receiving long-term services and supports (LTSS) associated with receipt of in-home and community-based settings

In 2016, the Apple Health Medicaid managed care plans included questions from the World Health Organization Quality of Life survey in the annual client survey. Managed care plans and BHOs also use evidence-based interventions that are recognized by the Washington State Institute for Public Policy.[3] In 2017, HCA will withhold 1% of MCO premiums which can be earned back based on performance against a subset of the measures, using appropriate baselines and benchmarks.

Results and Trends for Measures under ESHB 1519 and 2SSB 5732

Among the performance measures DSHS and HCA are tracking for Washington Medicaid Service Coordination Organizations, the emergency department usage and "all-cause" hospital readmission rate measures show the improvement we are seeking for people with mental health and/or substance use needs, and clients of the AAAs, for the period of 2011-2015. In addition, the alcohol and drug treatment penetration measure showed improvement for people with mental health needs and/or substance use disorders, as well as the managed care enrollee population. However, for most key measures, apparent changes in 2015 results cannot be attributed to changes in performance. The impact of the expansion of Medicaid eligibility was monumental, and analysis over the coming years will use 2015 as the new baseline for the 1.9illion Medicaid enrollees. See Appendix 2 for growth in enrollment broken down by eligibility group.

Why Trends Should Be Interpreted with Caution

Medicaid expansion under the Affordable Care Act (ACA) has significantly changed the composition of the adult Medicaid caseload. Reporting information by major coverage group allows for more valid comparisons of adult Medicaid enrollee experiences over time. For example, the overall employment rate for Medicaid-enrolled adults with mental illness roughly doubled from SFY 2013 to SFY 2015, but almost all of this increase is accounted for by the relatively high employment rate in the New Adult population.

[3] Washington State Institute for Public Policy: http://www.wsipp.wa.gov/Reports/588

Medicaid expansion has had complex effects on the composition of the adult Medicaid caseload, beyond simply expanding coverage to new populations. For example, the "classic non-disabled adult" coverage group experienced a "welcome mat" caseload increase that tended to be associated with healthier new enrollees. Also, some pre-existing high-risk coverage groups (Presumptive SSI, Disability Lifeline and ADATSA coverage groups) transitioned into New Adult coverage upon implementation of the ACA, creating an initial New Adult population in Calendar Year (CY) 2014 with a relatively high prevalence of physical and behavioral health risk factors, compared to the composition of the New Adult population in CY 215 and future years.

Detailed results for the measures responsive to ESHB 1519 and 2SSB 5732 are in Appendix 3. Technical specifications for these measures will be kept up-to-date at RDA's website, https://www.dshs.wa.gov/sesa/research-and-data-analysis/dashboards.

Initial Health Screen and Assessment of Managed Care Enrollees

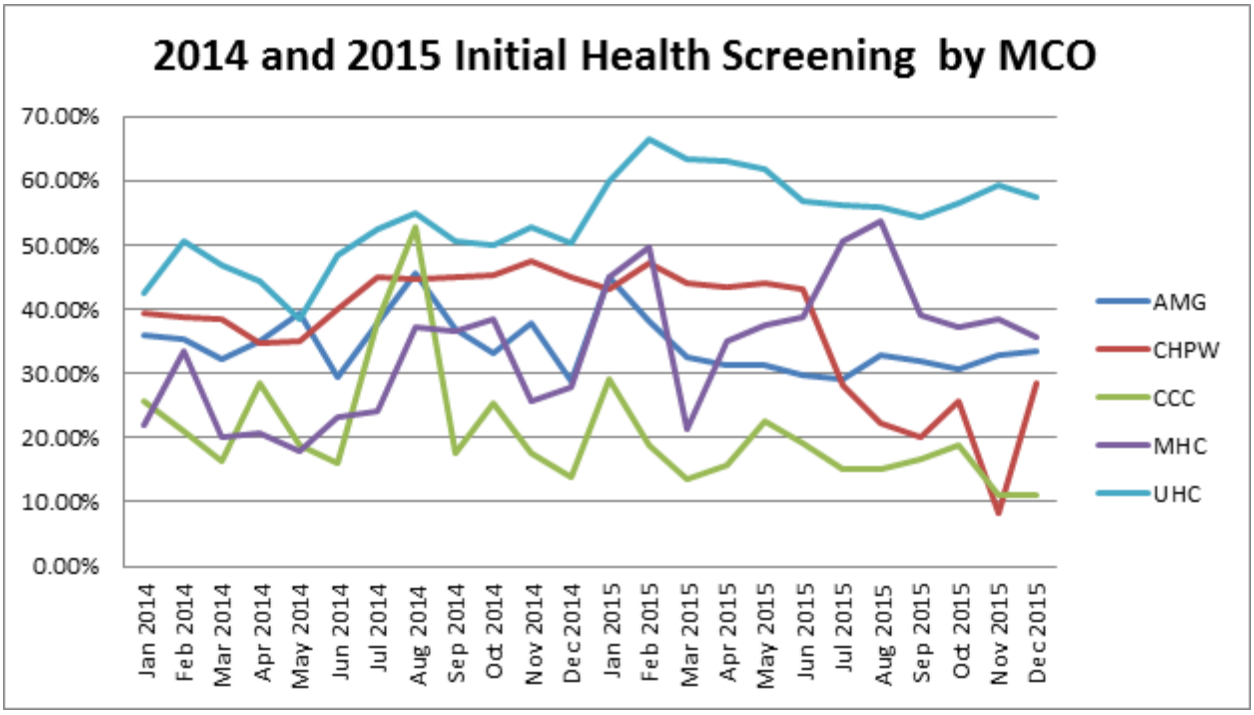
HCA requires the managed care plans to conduct a brief Initial Health Screen (IHS) within sixty calendar days of enrollment for all new enrollees. The managed care plans are expected to make at least three reasonable attempts on different days and times of day to contact an enrollee to complete the IHS and document these attempts. The screen evaluates the enrollee's physical; behavioral; and oral health status; health services history, including receipt of preventive care services; current medications, and identification of special needs. The screener evaluates the need for care coordination, or the need for clinical and non-clinical services, including referrals to specialists and community resources. As a result of the screening the managed care plan works with the enrollee's primary care provider and care coordinator to ensure that arrangements are made for the enrollee to receive follow-up services that reflect the findings in the IHA, such as consultations with mental health and/or substance use disorder providers or referral to community-based social services. The screener will develop a care coordination plan for any enrollee identified with special health care needs.

This plan will address:

- Enrollee self-management goals.
- Short- and long-term treatment goals, identification of barriers to meeting goals.
- Identification of barriers to achieving self-management goals and how these were addressed.
- Time schedule for follow-up treatment and communication with the enrollee.
- Clinical and non-clinical services accessed by the enrollee or recommended by the primary care provider or care manager.
- Referrals and, as appropriate, funding of community-based self-help programs, such as the Chronic Disease Self-Management Education program. The Contractor may choose to fund such programs.

- Integration and coordination of clinical and non-clinical services, including follow-up to ensure services are accessed.
- Comprehensive medication therapy management services.
- Modifications as needed to address emerging needs of the enrollee.
- Progress or reason for lack of progress on self-management goals.
- Communication with primary and specialty care providers including mental health and substance use disorder providers.
- A clear description of actions the enrollee's care manager shall take to support the enrollee in meeting the goals of the plan.

In 2015 the number of Medicaid-covered clients increased to 1,771,679; 655,586 of these individuals were new managed care enrollees. In total, the managed care plans conducted 256,952 initial health screens for new enrollees. New enrollees who are placed in a health home do not receive this screening. See the graph on the following page for each plan's performance conducting initial health screens for the years 2014 and 2015.



Implementation of E2SHB 2572

E2SHB 2572, Section 6 (enacted as Chapter 223, Laws of 2014), directed HCA to establish the Governor-appointed Performance Measures Coordinating Committee (PMCC)[4] for the purpose of identifying and recommending standard statewide measures of health performance and setting benchmarks for both the public and private sectors through the development of a Statewide Common measure set to inform health care purchasing. The PMCC submitted measures in the following categories to HCA:

- Access to primary care and prevention for children and adolescents;
- Access to primary care and prevention for adults;
- Behavioral health;
- Effective management of chronic illness in the outpatient setting;
- Ensuring appropriate care: avoiding overuse;
- Effective hospital-based care; and
- Cost of care.

The PMCC established a public process to periodically evaluate the measure set and to make additions or changes to the measure set, as needed. The following principles, some of which are included in the guiding legislation and others proposed by HCA and Alliance staff, further define this work and form the "guard rails" that determine the scope of this effort.

The measure set:

- Is of manageable size;
- Is based on *readily available* health care insurance claims and/or clinical data;
- Gives preference to nationally vetted measures, particularly measures endorsed by the National Quality Forum; and
- Taken as a whole, the measures will help to identify the lowest cost, highest quality care for preventive care and acute and chronic conditions.

Results from the recommended measure set may be used to assess performance at the county, health plan, medical group and/or hospital level. Results are publicly reported when numerators and denominators are sufficient to produce results that are statistically valid and reliable. The goal is ultimately to promote voluntary measure alignment among state and private payers. Efforts will continue to support a measure set that can be used by multiple payers, clinicians, hospitals, purchasers, and counties for health improvement, care improvement, provider payment system design, benefit design, and administrative simplification efforts, as appropriate.

With the 2014 adoption of a "starter" set of 52 measures across the domains of prevention, chronic illness and acute care, the PMCC continues to evolve with state priorities and will be consistent with other measure sets to reduce provider burden. For example, two behavioral health measures were

[4] http://www.hca.wa.gov/about-hca/healthier-washington/performance-measures

added to the common measure set in January 2016, and they will be reported by DSHS using existing data.

Washington State's goal for the Statewide Common Measures Set is to evolve the set over time, as the science of measurement matures. This goal was recognized during the development of the Statewide Common Measures Set in the creation of the "High Priority Development List": a list of 28 topics that did not meet the criteria for inclusion in the "starter" set of measures, but were identified as important to consider in the future (e.g., health outcomes that require clinical data abstraction). It is not the intent to dramatically increase the number of measures over time, but to carefully consider the addition, replacement, or retirement of measures in order to keep the total number of measures in the set to a reasonable number.

To support this goal, the process for the evaluation and evolution of the Statewide Common Measures Set will occur in two separate, yet integrated processes that are summarized here.

- Topic-focused workgroups will research and recommend measures for topic areas, as identified by HCA and the Committee, using the High Priority Development List. Each of these workgroups will submit recommendations to the Committee to consider as new measures to include in the Common Measures Set that address the topic(s) of interest.
- After each year of reporting results for the Statewide Common Measures Set, the Health Care Authority and the PMCC will review annual reported performance outcomes and replace or retire measures, if necessary.

By implementing each of these processes, the Statewide Common Measures Set will remain current, including a set of measures that keeps pace with state priorities to improve health outcomes and quality of health care, reduce cost and waste in the system, and increase transparency for purchasers, consumers, providers and health plans.

Performance Measures for E2SHB 2572

The Washington Health Alliance (WHA) reports the performance of the Medicaid managed care plans for Common Measures established by the Performance Measure Coordinating Committee in its 2015 Community Checkup Report, "Measuring Health Care in Washington State." The report is based on SFY 2015 data, dates of service July 1, 2013 through June 30, 2014. It provides summary level information of the state performance rate across Medicaid's five managed care plans and the fee for service program, compared to the National Commission of Quality Assurance's reported National 90th Percentile. The data provides insight to the variation in care by medical groups and counties. (Selected results for 2015 are in Appendix 4.) An accompanying WHA report, "Performance Results for Health Insurance Plans," ranks each Medicaid managed care plan's performance for each measure reported.

2015's "Measuring Health Care in Washington State" is the first report produced by WHA that includes the common measure set established under RCW 41.05.690; therefore, it is not conducive for conducting a trend analysis, as requested by the Legislature, regarding the health improvement

of Medicaid enrollees reflected in these measures. The key findings from the 2015 analysis are not specific to Medicaid, however, it is important to note:

- Washington has a long way to go to consistently be in the top 10 percent of performance nationally in the delivery of high-quality health care.
- Variation by county, medical group and clinic is a persistent problem in the delivery of health care.
- Too many patients are not receiving the evidence-based care they need to remain healthy and manage their conditions.
- Local successes prove that delivering high-quality health care is an achievable goal.
- The common measure set and transparency help us to collectively understand current performance and target areas for improvement.

These key findings are important because they lend themselves to at least one recommendation for improving the health of Medicaid enrollees: continue capturing the data and reporting the results. Only through data can the performance of the managed care plans be evaluated, allowing the identification of opportunities for improving the delivery of care to improve the health status of Medicaid enrollees.

Of note, the Community Checkup report includes this caveat about Medicaid results:

> *Medicaid results in this report should be interpreted with caution, especially with respect to year over year changes. Specifically, because of the Medicaid expansion, the denominator of Medicaid beneficiaries has been significantly altered through the addition of more than 550,000 new adult enrollees. This significant change took place within the 2014 reporting year which is July 1, 2013 through June 30, 2014. This change in Medicaid caseload characteristics could distort 2014 results when compared with 2013 results. In addition, because data in 2013 and 2014 does not include claims information from four contracted managed care plans, a significant portion of the managed Medicaid population was filtered from the results for this report. Cumulatively, these factors can substantially impact reporting of results within and between reported years. Notwithstanding these apparent issues, this report balances concerns around incomplete Medicaid data with the need to report on performance across all payer groups, i.e., commercial and Medicaid payers.*

The development of the measures in the Statewide Common Measure Set was due to the efforts of numerous stakeholders, including representation from the purchasing, payer, and health provider communities. A subset of the measures in the current set have been identified to go into HCA's Medicaid and PEBB contracts and will be tied to payment in 2017. Furthermore, HCA continues to align measures from the common measure set with the Healthier Washington initiatives to measure the impact of the community-based work and to drive alternative payment models that support better quality of care.

Conclusion and Recommendations

While there are areas of high performance among Washington Medicaid health plans and BHOs, several measures point to a need for improvement in performance or in reporting. (See notes on measures in appendices.)

In other reports to the Legislature, HCA has reported on measures for children's health and preventive services.[5] Among measures of quality of care delivered to Medicaid managed care enrolled adults for both prevention and chronic conditions, the below measures can be tracked for 2014 and 2015 experience.

Medicaid MCO HEDIS Measures in Statewide Common Set	2014 WA Average	2015 WA Average	2015 US Average
Percent Diabetic Individuals with at least one HbA1c Test	88.1	90.4	86.3
Percent Diabetic Individuals with at least one Eye Exam	49.6	54.8	54.3
Percent Diabetic Individuals with Attention to Nephropathy	79.9	83.4	80.9
Percent Diabetic Individuals with Poor HbA1c Control	46.4	42.6	43.5
Percent Diabetic Individuals with Blood Pressure Under Control	59.7	63.7	61.9
Total Ambulatory Visits per 1000 Member Months	337	330	355

Data source: December 2015 HEDIS report: http://www.hca.wa.gov/assets/free-or-low-cost/ComparativeAnalysis_20151215.pdf

Qualis made the following recommendations to HCA in last year's annual Comparative Analysis Report,[6] based on the 2015 performance of health plans:

- Align and prioritize measures with the Healthier Washington Common Measure Set;
- Require submission of member-level HEDIS data in a standard format with a unique member identifier to allow analysis across measures;
- Require MCOs to complete performance improvement projects for areas of low performance (e.g. well-child and adolescent visits and childhood immunizations);
- Establish new performance standards for low performance indicators;
- Require submission of member-level data for prenatal care timeliness and frequency to allow additional analysis of disparities and outcomes; and
- Create a forum for MCOs to share common challenges and best practices.

HCA and DSHS have restructured Medicaid procurement of health care services and agreements with managed care systems on a phased basis to better support integrated physical health, mental

[5] September 2016 Child Health Services: Provider Performance report: http://hca.wa.gov/assets/program/eshb-2128-child-health-svcs.pdf
September 2016 Medicaid Managed Care Preventive Services and Vaccinations report: http://hca.wa.gov/assets/program/2eshb-2376-med-prev-vacc_0.pdf

[6] December 2015 HEDIS report: http://www.hca.wa.gov/assets/free-or-low-cost/ComparativeAnalysis_20151215.pdf
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health and SUD service, consistent with 2SSB 6312 and the recommendations of the Behavioral Health System Task Force. HCA has incorporated the following principles into Medicaid procurement efforts aimed at integrating the delivery of physical and behavioral health services:

- Medicaid purchasing that supports the delivery of integrated, person-centered care that addresses the spectrum of individuals' health needs in the context of the communities in which they live and with the availability of care continuity as their health needs change;
- Accountability for client outcomes and performance measures linked to those outcomes;
- Medicaid benefit design that recognizes that adequate preventive care, crisis intervention, and support services promote a recovery-focused approach;
- Evidence-based care interventions and continuous quality improvement that are enforced through contract specifications and performance measures that provide meaningful integration at the patient care level with broadly distributed accountability for results;
- Active purchasing and oversight of Medicaid managed care contracts responsibility; and
- Deliberate and flexible systems change plans with identified benchmarks to promote system stability, provide continuity of treatment for patients, and protect essential existing behavioral health system infrastructure and capacity.

New for 2017 managed care contracts, HCA is tying a 1% withhold of the monthly premium to performance on key indicators from the Common Measure Set. Included in this strategy is an incentive for meeting the requirement that at least 30% of provider payments are paid to network providers in the form of value-based payments. HCA also monitors performance on the use of care coordination via the Health Home program to improve chronic disease management, and is considering penalties tied to low engagement rates for Health Home eligible.

Under the direction provided in E2SHB 2572, HCA has incorporated, in purchasing and contracting efforts, improvements in:

- Prevention and early detection of disease;
- Integration of behavioral health;
- Linkages between the health care delivery system and community; and
- New regional collaboratives to improve health care quality and lower costs.

Work to incorporate these measures into value-based contracting by HCA and DSHS will continue through Healthier Washington efforts first initiated under the State Health Care Innovation Plan in 2013, directed by E2SHB 2572 the year following and supported through the four-year State Innovation Models Grant which began in February 2015.

In addition, the State recently secured an agreement in principle from the Centers for Medicare and Medicaid Services (CMS) for a five-year Medicaid Transformation Demonstration which will provide critical support for providers and community partners as they implement new, innovative care models and make the transition to payment based on outcomes. The demonstration will utilize the framework and common measures from ESHB 1519, 2SSB 5732 and E2SHB 2572 as

accountability metrics for regionally deployed projects and as key performance indicators on a statewide level.

The aims of Healthier Washington—to ensure better health and care for Washington's citizens and communities, and to keep the cost of health care manageable—are more critical than ever. Significant progress has been made in achieving these aims and our state is well-poised to make even greater strides as the work of Medicaid transformation moves forward.

Appendix 1: ESHB 1519 and 2SSB 5732 Performance Measures

Health/Wellness, Utilization and Disparities

Access/effectiveness	1	Adults' Access to Preventive/Ambulatory Care	Contract
	2	Well-Child Visits	Contract
	3	Comprehensive Diabetes Care: Hemoglobin A1c Testing	Contract
	4	Alcohol/Drug Treatment Penetration	Contract
	5	Mental Health Treatment Penetration	Contract
	6	SBIRT Service Penetration	Contract
	7	Home- and Community-Based Long Term Services and Supports Use	Contract
	8	Suicide and drug overdose mortality rates	System Monitoring
Utilization	9	Psychiatric Hospitalization Readmission Rate	Contract
	10*	Emergency Department (ED) Visits	Contract
	11	Inpatient Utilization	Contract
	12	Plan All-Cause Readmission Rate	Contract
	13	Hospital Admissions for diabetes complications	Contract
	14	Hospital Admissions for Chronic Obstructive Pulmonary Disease	Contract
	15	Hospital Admissions for Congestive Heart Failure	Contract
	16	Hospital Admissions for asthma	Contract
Care coordination	17	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	Contract
Wellness	18	Medical Assistance with Smoking and Tobacco Use Cessation	System Monitoring
	19	Body Mass Assessment	Contract
	20	Tobacco Use Assessment	Contract

Health Disparities

To support measurement of disparities and performance differences across service contracting entities, where feasible and appropriate, metrics will be reported by:

- Race/ethnicity or primary language
- Age group and gender
- Geographic region
- Service-contracting entities
- Delivery system participation (for example, measuring mental health service penetration for clients receiving long-term services and supports, relative to its own benchmark or the experiences of other disabled clients not served in the long-term services and supports delivery system)
- Medicaid coverage type (for example, persons with disabilities, newly eligible adults)
- Chronic physical and behavioral health conditions
- History of criminal justice involvement
- Housing stability

Housing, Employment, Education and Meaningful Activities

Housing	21*	Homelessness/housing instability (broad)	System Monitoring
	22	HMIS-recorded housing assistance penetration	Contract
	23	Homelessness (narrow)	Contract
	24	Residential instability	Aspirational
Employment	25*	Employment rate	Contract
	26*	Earnings	Contract
	27*	Hours worked	Contract
Education	28	School-age children enrolled in school	Contract
	29	On time and late graduation from high school	Contract
	30	Adult enrollment in post-secondary education or training	Contract
Meaningful Activities	31*	Survey item: "To what extent do you do things that are meaningful to you?"	System Monitoring

Criminal Justice and Forensic Patients

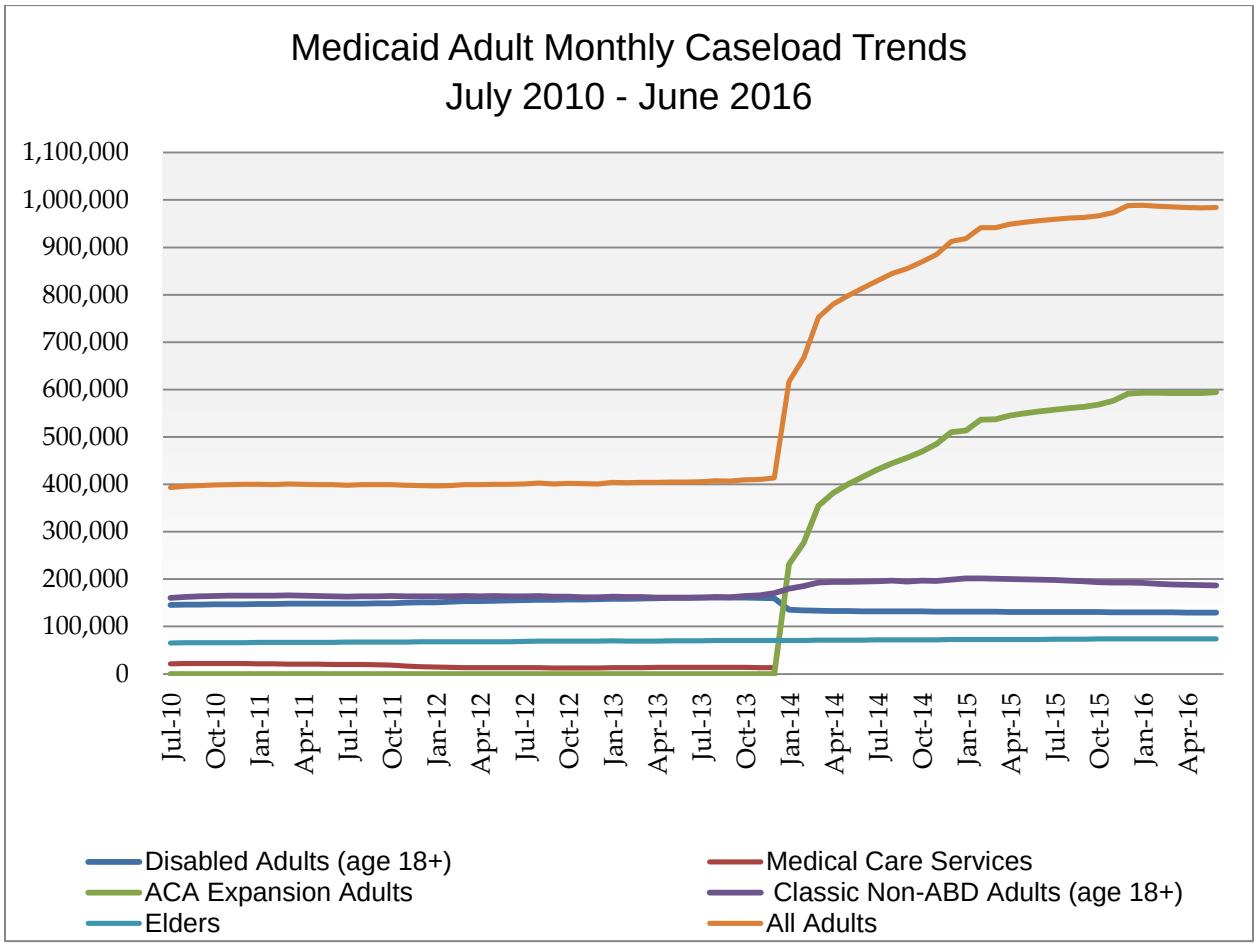
Criminal Justice Involvement	32	Criminal Justice Involvement	Contract
	33	Jail Admissions	Contract
	34	Days in Jail	Contract
	35	Referrals for Competency Evaluation	Contract
	36	Persons in Prison with Serious Mental Illness	Contract
Access to Treatment for Forensic Patients	37	Mental Health Treatment after Release from Incarceration	Contract
	38	Serving Previously Un-served Offenders	System Monitoring
	39	Alcohol or Drug Treatment after Release from Incarceration	Contract
	40	Alcohol or Drug Treatment Retention	Contract
	41	Mental Health Treatment Engagement	Contract
	42	New Medicaid Enrollments after Release from Criminal Justice Facilities	System Monitoring

Quality of Life

Physical Health	43	WHOQOL-BREF Physical Health Scale	System Monitoring
Emotional Health	44	WHOQOL-BREF Emotional Health Scale	System Monitoring
Social Health	45	WHOQOL-BREF Social Health Scale	System Monitoring
Autonomy/Safety	46	WHOQOL-BREF Autonomy/Safety Scale	System Monitoring
Overall Quality	47	WHOQOL-BREF Overall Quality of Life Scale	System Monitoring
Hope	48	WHOQOL Item: "How positive do you feel about the future?"	System Monitoring
Respect	49	New survey item: "To what extent are you respected and treated fairly?"	System Monitoring
Choice	50	New survey item: "To what extent do you make your own choices?"	System Monitoring
Cultural Connectedness	51	New survey item: to be defined	System Monitoring

Measures 10 under Health/Wellness, Utilization, and Disparities and 21, 25, 26, 27, and 31 under Housing, Employment, Education and Meaningful Activities are shared with Quality of Life

Appendix 2: Trends in Medicaid Enrollment by Population



Notes:

1. Disabled Adults, age 18+ : CN Bind/Disabled, MN Blind/Disabled, CN Health Care for Workers w/ Disabilities, CN Breast & Cervical Cancer. Note that some number of the CN Blind/Disabled, MN Blind/Disabled, and CN BCCT populations transitioned to the ACA Expansion Adult coverage group effective 1/1/2014.
2. Medical Care Services: Federally qualified GA/DL-U and GA/DL-ADTASA. Program ended 12/31/2013 with the population transitioning to ACA Expansion Adult coverage.
3. ACA Expansion Adults: New coverage group effective 1/1/2014
4. 'Classic' Non-ABD Adults, age 18+: CN Adult Caretaker/Relatives, CN Pregnant Women, CN Children (some CN Children over age 18 are captured, including clients who age out of Foster Care with Medicaid coverage up to age 26).
5. Elders: CN Aged, MN Aged

Appendix 3: ESHB 1519 and 2SSB 5732 Measure Results

Note about interpretation of data since Calendar Year (CY) 2014:

- Medicaid expansion under the ACA has significantly changed the composition of the adult Medicaid caseload. For example, New Adults are more likely to be employed, and New Adults with substance use disorders are more likely to be unstably housed or arrested, compared to their peers in other Medicaid coverage groups. Reporting information by major coverage group allows for more valid comparisons of adult Medicaid enrollee experiences over time.
- Medicaid expansion has had complex effects on the composition of the adult Medicaid caseload, beyond simply expanding coverage to new populations. For example, the "classic non-disabled adult" coverage group experienced a "welcome mat" caseload increase that tended to be associated with healthier new enrollees. Also, some pre-existing high-risk coverage groups (Presumptive SSI, Disability Lifeline and ADATSA coverage groups) transitioned into New Adult coverage upon implementation of the ACA, creating an initial New Adult population in CY 2014 with a relatively high prevalence of physical and behavioral health risk factors, compared to the composition of the New Adult population in CY 2015 and future years.

Medicaid Enrollees with Mental Health Needs

11+ Months on Medicaid for Annual-Experience Metrics
6 Continuous Months on Medicaid for Utilization Metrics

MEASURE	Dual Eligibles Included?	TPL Included?	Age Group	SFY 2011 7/10-6/11	SFY 2012 7/11-6/12	SFY 2013 7/12-6/13	SFY 2014 7/13-6/14	SFY 2015 7/14-6/15
Adults' Access to Preventative/Ambulatory Care	Yes	No	20-64	94.0%	93.1%	94.3%	94.4%	93.2%
Alcohol/Drug Treatment Penetration	Yes	No	18-64	30.2%	29.3%	27.5%	27.0%	26.8%
Mental Health Service Penetration (RSN Service Only)	Yes	No	18-64	34.1%	33.6%	34.0%	32.9%	25.5%
Mental Health Service Penetration (Broad)	Yes	No	18-64	51.1%	50.6%	52.1%	50.4%	46.3%
Psychiatric Hospital Readmission Rate	Yes	No	18-64	12.8%	12.7%	12.1%	13.1%	13.5%
Plan All-Cause Readmission Rate	Yes	No	18-64	20.8%	19.7%	19.3%	19.3%	17.6%
Homelessness (Narrow)	Yes	Yes	18-64	5.6%	5.0%	4.6%	4.3%	5.5%
Employment Rate	Yes	Yes	18-64	19.4%	19.3%	19.6%	23.3%	38.8%
Criminal Justice Involvement	Yes	Yes	18-64	8.5%	7.9%	7.5%	7.3%	7.6%
UTILIZATION MEASURES	Dual Eligibles Included?	TPL Included?	Age Group	SFY 2011 7/10-6/11	SFY 2012 7/11-6/12	SFY 2013 7/12-6/13	SFY 2014 7/13-6/14	SFY 2015 7/14-6/15
Emergency Department (ED) Visits per 1000 Member Months	Yes	No	18-64	159.1	138.9	131.9	132.6	119.4
Home and Community-Based Long Term Services and Supports Use per 1000 Member Months	Yes	Yes	18-64	891.9	901.5	906.8	911.3	915.0

Medicaid Enrollees with Substance Use Disorders

11+ Months on Medicaid for Annual-Experience Metrics
6 Continuous Months and on Medicaid for Utilization Metrics

MEASURE	Dual Eligibles Included?	TPL Included?	Age Group	SFY 2011 7/10-6/11	SFY 2012 7/11-6/12	SFY 2013 7/12-6/13	SFY 2014 7/13-6/14	SFY 2015 7/14-6/15
Adults' Access to Preventative/Ambulatory Care	Yes	No	20-64	91.6%	90.9%	92.0%	91.6%	87.0%[7]
Alcohol/Drug Treatment Penetration	Yes	No	18-64	30.4%	29.3%	27.4%	27.4%	27.0%
Mental Health Service Penetration (RSN Service Only)	Yes	No	18-64	47.6%	45.4%	45.2%	43.9%	38.0%
Mental Health Service Penetration (Broad)	Yes	No	18-64	63.8%	61.7%	62.8%	60.9%	57.8%
Psychiatric Hospital Readmission Rate	Yes	No	18-64	13.8%	14.2%	13.1%	14.3%	14.6%
Plan All-Cause Readmission Rate	Yes	No	18-64	24.1%	22.5%	21.6%	21.9%	19.8%
Homelessness (Narrow)	Yes	Yes	18-64	10.6%	9.4%	8.8%	8.0%	12.0%
Employment Rate	Yes	Yes	18-64	16.0%	16.2%	17.2%	21.0%	35.2%
Criminal Justice Involvement	Yes	Yes	18-64	18.9%	17.6%	16.6%	16.3%	19.4%
UTILIZATION MEASURES	Dual Eligibles Included?	TPL Included?	Age Group	**SFY 2011 7/10-6/11**	**SFY 2012 7/11-6/12**	**SFY 2013 7/12-6/13**	**SFY 2014 7/13-6/14**	**SFY 2015 7/14-6/15**
Emergency Department (ED) Visits per 1000 Member Months	Yes	No	18-64	236.2	208.4	195.0	192.6	176.5
Home and Community-Based Long Term Services and Supports Use per 1000 Member Months	Yes	Yes	18-64	897.6	906.0	907.3	912.7	914.9

[7] See note at beginning of Appendix about impact of Medicaid Expansion.

All Washington State AAAs – Medicaid Enrollees with Long-term Services and Supports (LTSS) Home and Community Based Services (HCBS) Service Use

11+ Months in AAA and on Medicaid, Including Index Month, for Annual Experience Metrics
6 Continuous Months in AAA and on Medicaid for Utilization Metrics

MEASURE	Dual Eligibles Included?	TPL Included?	Age Group	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015
				7/10-6/11	7/11-6/12	7/12-6/13	7/13-6/14	7/14-6/15
Adults' Access to Preventive/ Ambulatory Care	Yes	No	20-64	97.0%	96.9%	97.2%	97.2%	97.6%
			65+	97.0%	97.6%	97.6%	97.8%	97.9%
			Total	97.0%	97.3%	97.4%	97.5%	97.8%
Alcohol/Drug Treatment Penetration	Yes	No	18-64	12.2%	11.6%	10.5%	8.2%	9.0%
			65+	6.6%	7.8%	6.0%	4.9%	5.3%
			Total	10.7%	10.6%	9.3%	7.3%	7.9%
Mental Health Service Penetration (Broad)	Yes	No	18-64	46.1%	46.3%	47.0%	47.6%	47.7%
			65+	28.6%	28.7%	28.8%	28.2%	28.2%
			Total	36.4%	36.6%	37.2%	37.2%	37.5%
Plan All-Cause Readmission Rate	Yes	No	18-64	21.6%	21.3%	21.2%	20.4%	19.1%
			65+	16.0%	14.3%	15.9%	15.5%	16.0%
			Total	18.7%	17.8%	18.5%	17.8%	17.5%
UTILIZATION MEASURES	Dual Eligibles Included?	TPL Included?	Age Group	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015
				7/10-6/11	7/11-6/12	7/12-6/13	7/13-6/14	7/14-6/15
Emergency Department (ED) Visits per 1000 Member Months	Yes	No	18-64	123.8	119.6	118.7	116.9	120.9
			65+	58.2	65.3	75.5	70.1	70.7
			Total	84.4	87.6	93.7	89.9	92.4
Home and Community-Based Long Term Services and Supports Use	Yes	Yes	18-64	91.0%	91.9%	92.1%	92.4%	92.6%
			65+	76.6%	77.4%	77.8%	78.0%	78.6%
			Total	81.6%	82.4%	82.9%	83.1%	83.6%

All Qualifying Washington State Managed Care Enrollees

11+ Months Enrolled with MCO for Annual-Experience Metrics
6 Continuous Months Enrolled with MCO for Utilization Metrics

MEASURE	TPL Included ?	Age Group	SFY 2013 7/12-6/13	SFY 2014 7/13-6/14	SFY 2015 7/14-6/15
Adults' Access to Preventative/Ambulatory Care	No	20-64	86.2%	85.6%	78.9%[8]
Alcohol/Drug Treatment Penetration	No	18-64	27.8%	26.1%	26.8%
Mental Health Service Penetration (RSN Service Only)	No	18-64	28.8%	33.0%	25.1%
Mental Health Service Penetration (Broad)	No	18-64	51.6%	51.0%	46.1%
Psychiatric Hospital Readmission Rate	No	18-64	7.4%	14.5%	15.1%
Plan All-Cause Readmission Rate	No	18-64	11.1%	16.5%	14.9%
Homelessness (Narrow)	Yes	18-64	3.2%	4.0%	4.6%
Employment Rate	Yes	18-64	37.0%	32.9%	48.8%
Criminal Justice Involvement	Yes	18-64	6.1%	6.3%	5.8%
UTILIZATION MEASURES	TPL Included ?	Age Group	**SFY 2013 7/12-6/13**	**SFY 2014 7/13-6/14**	**SFY 2015 7/14-6/15**
Emergency Department (ED) Visits per 1000 Member Months	No	18-64	84.4	93.6	67.8

[8] See note at beginning of Appendix about impact of Medicaid Expansion.

Appendix 4: E2SHB 2572 Selected Measure Results

Selected Medicaid Performance Measures from 2015 Community Checkup Report, "Measuring Health Care in Washington State"

Measure Name	State Medicaid Rate (Managed Care and Fee-For-Service)[9]
Access to Care	
Adult access to preventive/ambulatory care - ages 20-44	83%
Adult access to preventive/ambulatory care - ages 45-64	85%
Child and adolescent access to primary care (reported in separate age groups)	81-94%
Asthma and COPD	
Use of appropriate medication	82%
Hospitalization for COPD or asthma (per 100,000)	601
Use of spirometry testing in the assessment and diagnosis of COPD	23%
Cardiovascular Disease	
Controlling high blood pressure	51%
Diabetes	
Eye exam	61%
Kidney disease screening	53%
Blood pressure control	61%
Blood sugar (HbA1c) poor control	44%

[9] Community Checkup measure includes Medicare-eligible clients and clients with third party insurance coverage in the denominator; these clients are not enrolled in Apple Health Managed Care.

Measure Name	State Rate
Health Screenings	
Adolescent well-care visits	39%
Screening for breast cancer	25%[10]
Screening for cervical cancer	69%
Screening for chlamydia	51%
Well-child visits - ages 3 - 6 years	57%
Generic Prescription Drugs	
Includes medications for attention deficit hyperactivity disorder and high blood pressure; Antacid medication; Antidepressants; and Cholesterol-lowering drugs (statins)	Range 71% - 97%
Medication Adherence and Safety	
Medication safety - monitoring patients on hypertension medications	73%
Mental Health and Depression	
Antidepressant medication (12 weeks)	47%
Antidepressant medication (6 months)	33%
Obesity Prevention	
Weight assessment (BMI percentile) for adults	78%
Weight assessment for children/adolescents (BMI percentile) - ages 3-17	35%
Counseling for nutrition for children/adolescents - ages 3-17	50%
Measure Name	**State Rate**

[10] Average HEDIS result for Washington Medicaid MCOs is 54%; Community Checkup measure includes Medicare eligible clients in denominator but does not include Medicare utilization data in numerator.

Potentially Avoidable Care	
Avoidance of antibiotic treatment in adults with acute bronchitis	27%
Potentially avoidable ER visits	13%
Appropriate testing for children with pharyngitis	66%
Avoidance of x-ray, MRI and CT scan for low back pain	79%
Avoidance of antibiotics for common cold	92%