



2016 Comparative Analysis Report

Washington Apple Health
Washington Health Care Authority

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

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Executive Summary

As part of its work as the external quality review organization (EQRO) for the Washington State Health Care Authority (HCA), Qualis Health reviewed Apple Health managed care organization (MCO) performance for the calendar year (CY) 2015. The MCOs were required to report results for 31 Healthcare Effectiveness Data and Information Set (HEDIS[®])¹ measure items representing 102 submeasures, reflecting the levels of quality, timeliness, and accessibility of healthcare services MCOs furnished to the state's Medicaid recipients. HEDIS measures are developed and maintained by the National Committee for Quality Assurance (NCQA), whose database of HEDIS results for health plans, the Quality Compass², enables benchmarking against other Medicaid managed care health plans nationwide.

During 2015 CY, six MCOs provided care for Apple Health enrollees:

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

Columbia United Providers (CUP) served over 55,000 Clark County enrollees during 2015. In November, Molina Healthcare of Washington acquired CUP's network and members, effective January 1, 2016. Given this change, performance measure data were not available for CUP for the 2016 reporting year and are therefore not included in this report.

To be consistent with NCQA methodology, the 2015 calendar or measurement year is referred to as the 2016 reporting year (RY) in this report.

Impact of Medicaid Expansion

The primary purpose of this report is to summarize MCO performance by drawing from selected HEDIS measures. One environmental factor that may have influenced performance includes Medicaid expansion.

The initial impact of Medicaid expansion, which took effect January 2014, was measured during the 2015 reporting year (representing calendar year 2014). However, for many measures, a minimum of 11 months

¹ The HEDIS[®] measures and specifications were developed and are owned by the National Committee for Quality Assurance (NCQA). The HEDIS measures and specifications are not clinical guidelines and do not establish standards of medical care. NCQA makes no representations, warranties, or endorsement about the quality of any organization or physician that uses or reports performance measures or any data or rates calculated using the HEDIS measures and specifications and NCQA has no liability to anyone who relies on such measures or specifications. ©2015 National Committee for Quality Assurance, all rights reserved.

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

of continuous enrollment is required for an enrollee to be included in the measure denominators. Individuals who enrolled in Apple Health as part of Medicaid expansion in March 2014 or later would not have been represented in much of the 2015 RY data. As a result, calendar year 2015 (2016 RY) would be the first time many of these individuals would be included in performance measures for Apple Health plans.

Performance Highlights

Washington Apple Health overall performance is summarized below. Emphasized measures include those that are also components of the Washington State Common Measure Set on Health Care Quality and Cost—2016.³ As an aid for quickly reviewing performance, the following symbols are used to summarize each group of measures: ▼ (overall state rate significantly lower than national average), ◀▶ (overall state rate similar to national average), ▲ (overall state rate significantly higher than national average), ± (mixed performance on measures included in the domain, meaning there is significant variation between included measures).

Access to Care

Health plans are responsible for ensuring that care is convenient and available to 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 (▼):**
 - Adult access to primary care dropped for all MCOs between 2015 RY and 2016 RY, leading to a statewide 5.6 percent drop in the rate of adults having a primary care appointment. The expansion population has lower rates of access than the overall population. This may reflect that the expansion population is healthier overall than previous adult Apple Health enrollees and thus less in need of regular physician visits, but it could also indicate that adults struggled to schedule appointments with providers because of lack of access and potentially stretched provider networks.
 - Child and adolescent access to primary care rates dropped for every age group at the state level; however, the decreases in statewide performance levels were mostly driven by performance declines by CHPW.
- **Well-child visits (◀▶):**
 - Rates for adolescent well-care visits and well-care visits for children ages 3–6 remained flat between 2015 RY and 2016 RY.
 - The state rate of children receiving six or more well-child visits prior to age 15 months rose by 3.5 percent from 2015 RY to 2016 RY; four of the five MCOs increased performance on this measure by at least 7 percent, but one MCO (CHPW) dropped by more than 15 percent. It is unclear whether CHPW had low performance because of incomplete medical coding or because of an actual deficiency in the number of well-care visits.

³ http://www.hca.wa.gov/sites/default/files/measures_list.pdf

- **Maternal health visits (▼):**
 - The statewide rate of prenatal care timeliness dropped by 5.5 percent between 2015 RY and 2016 RY, and all plans performed at least 4 percent lower than the national average. This measure remains important to watch both at a statewide level and among the MCOs, as it indicates ongoing issues with the receipt of prenatal care.
 - For the percentage of women receiving at least 81 percent of recommended prenatal visits, four out of five MCOs saw performance decreases between 2015 RY and 2016 RY, with CHPW decreasing by 23.6 percent. However, the overall state rate decreased by only 3.5 percent because MHW improved performance by 11.5 percent. The state rate remains significantly below the national average.
 - The state rate of postpartum visits held steady between 2015 RY and 2016 RY, remaining well below the national average.

Preventive Care

Effective preventive care is delivered proactively, before the onset of illness. 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, such as cancer screenings, and weight and nutrition counseling, should also be delivered at the right time to be effective.

- **Child and adolescent immunizations (◀▶):**
 - The rate for combination 2, a commonly reported combination of children's immunizations, increased again in 2016 RY, and is on par with the national average.
 - Statewide adolescent immunizations remained steady between 2015 RY and 2016 RY, on par with the national average.
- **Weight assessment and counseling for children (▼):**
 - Performance on all measures relating to weight assessment and counseling (body mass index [BMI] assessment, counseling for nutrition, and counseling for physical activity, with subdivisions for child age) improved between 2015 RY and 2016 RY. At least one MCO included these measures as part of its provider pay-for-performance program, and results indicate improvement for that MCO. However, the state rates remain below the national averages for BMI screening.
- **Women's health screenings (▼):**
 - Rates for all three measures of women's health screenings (breast cancer, cervical cancer, and chlamydia screenings) were below national averages, but several plans made significant improvements in 2016 RY from 2015 RY.

Chronic Care Management

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 (▼):**
 - There was a significant increase in the number of individuals with diabetes whose hemoglobin A1c (HbA1c) was not under control (HbA1c>9.0 percent). While some of those individuals may be part of the expansion population and receiving care for their diabetes for the first time, it is important to improve on this measure to prevent additional long-term complications.

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

Medical Care Utilization

Effective preventive care and chronic care management are important for reducing emergency department (ED) visits and hospital stays. Lower hospital utilization generally indicates lower overall costs and higher overall quality of life for enrollees, but these measures may be subject to external forces outside the direct control of health plans.

- **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 low-back pain was higher than the national average (meaning fewer individuals received inappropriate care).
- **Avoidance of emergent and inpatient care (▲):**
 - Apple Health enrollees had slightly fewer per capita ED visits and inpatient stays in 2016 RY as compared to 2015 RY. Apple Health enrollee ED visits and inpatient days per capita were lower than the national averages.

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 on administrative data such as claims, and hybrid measures use a sample of administrative data combined with medical record reviews). Large variation between MCOs indicates that rather than statewide barriers to care, there are likely structural barriers within poorly performing MCOs that need to be addressed.
- **All MCOs underperformed compared to national averages in women's health and maternal healthcare.**
There were several measures on which most Apple Health MCOs performed below the national average. Uniformly poor performance may be driven by 1) provider behavior or 2) structural barriers at the state level. Measures on which all MCOs under-performed compared to national averages may require HCA action to determine whether there are barriers preventing optimal performance. These measures may also be appropriate for statewide performance improvement projects (PIPs) with cross-MCO collaboration to drive better performance and spread the costs of provider education and technical assistance.
- **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.

Recommendations

Based on 2016 RY MCO performance, Qualis Health recommends HCA consider the following options:

- Continue to require that MCOs conduct PIPs when measure performance falls below HCA-designated standards. Additionally, HCA should consider requiring MCOs to conduct thorough root cause analyses and/or PIPs for performance measures that drop by more than 10 percentage points between reporting years.
- Monitor performance on healthcare access and utilization measures to ensure that enrollees are able to receive high-quality care.
- Monitor performance on key outcome measures such as diabetes HbA1c control and blood pressure control to ensure that enrollees achieve optimal outcomes.
- Require MCOs to identify barriers relating to receipt of prenatal care (both timeliness and frequency) to determine if statewide action is necessary.
- Continue to provide supplemental quality data to MCOs to reduce the burden of chart reviews and improve the integrity of statewide performance data.
- Maintain focus on improving the health of children: even with improvement, rates for well-child visits (3–6 years and adolescents) and weight assessment (BMI) for children and adolescents fell below the national averages.

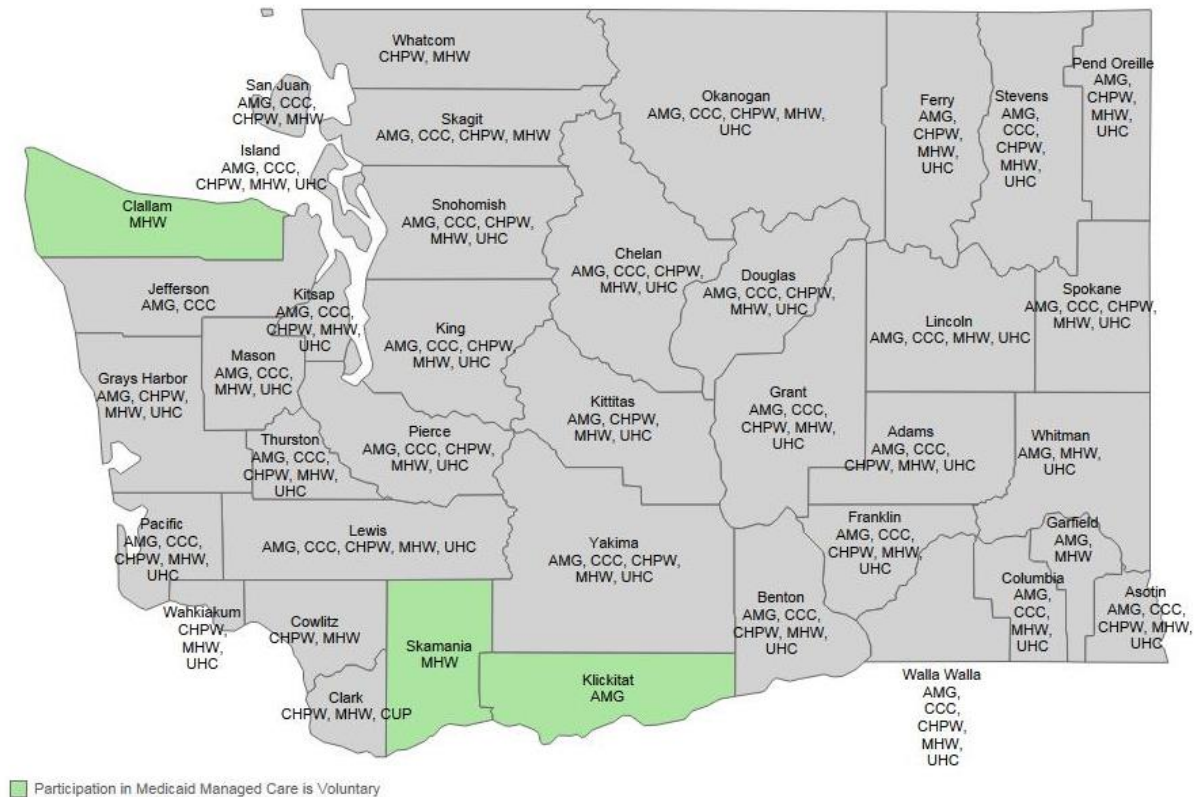
Introduction

As part of its work as the external quality review organization (EQRO) for the Washington State Health Care Authority (HCA), Qualis Health and its subcontractor Healthy People reviewed managed care organization (MCO) performance for the calendar year (CY) 2015 by reviewing MCO performance on select Healthcare Effectiveness and Data Information Set (HEDIS) measures. To enable a reliable measurement of performance, the MCOs were required to report on 31 HEDIS measures. HEDIS measures were developed and are maintained by the National Committee for Quality Assurance (NCQA), whose database of HEDIS results for health plans—the Quality Compass—enables benchmarking against other Medicaid managed care health plans nationwide. Healthy People conducted the NCQA HEDIS audits. To be consistent with NCQA methodology, the 2015 calendar year is referred to as the 2016 reporting year (RY) in this report.

During 2015 CY, six MCOs provided managed healthcare services for Apple Health enrollees:

- Amerigroup Washington (AMG)
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Figure 1: Apple Health Managed Care Service Areas As of December 2015

HEDIS Performance Measures

The HEDIS measure set is a widely used set of healthcare performance measures reported by health plans. HEDIS results can be used by the public to compare plan performance over eight domains of care; they also allow plans to determine where quality improvement efforts may be needed. In the first half of 2016, Qualis Health, through a subcontract with NCQA-certified auditor Healthy People, conducted an NCQA HEDIS Compliance Audit™ of each Apple Health MCO to ensure that MCOs were accurately collecting, calculating, and reporting HEDIS measures.

Using the NCQA-standardized audit methodology, 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 outlining findings and results.

Methods

Performance Measures

Qualis Health assessed audited MCO-level HEDIS data for the 2016 reporting year (measuring enrollee experience during calendar year 2015), including 31 measures comprising 102 specific indicators. Many measures include more than one indicator, usually for specific age groups or other defined population groups. (While MCOs were audited for 34 HEDIS measures, only 31 were actually available because 3

measures relating to mental health services were excluded, as mental health services for Medicaid enrollees in Washington were provided by Behavioral Health Organizations.) Of the 31 measures, 29 relate to effectiveness of care, and two relate to utilization (ambulatory and inpatient physical care). These measure groups (care and utilization) account for 88 and 14 submeasures, respectively.

The HEDIS effectiveness of care measures are considered to be unambiguous performance indicators, whereas the utilization measures can be helpful for identifying patterns and disparities in enrollees' access to care. It should be noted that the HEDIS measures are not risk adjusted and may vary from MCO to MCO because of factors that are out of a health plan's control, such as medical acuity, demographic characteristics, and other factors that may impact enrollees' interaction with healthcare providers and systems. NCQA has not developed methods for risk adjustment of these measures; however, with the enrollment increase that occurred with Medicaid expansion, performance impacts that may be attributable to differences in enrollee mix are likely diminishing.

Many of the HEDIS measures are focused on a narrow eligible patient population for which the measured action is almost always appropriate, regardless of disease severity or underlying health condition.

Administrative Versus Hybrid Data Collection

HEDIS measures draw from clinical data sources, utilizing either a fully "administrative" collection method or a "hybrid" collection method. The administrative collection method relies solely on clinical information that is collected from the electronic records generated in the normal course of business, such as claims, registration systems, or encounters, among others. In some delivery models, such as capitated models, healthcare providers may not have an incentive to report all patient encounters, so rates based solely on administrative data may be artificially low. For measures that are particularly sensitive to this gap in data availability, the hybrid collection method supplements administrative data with a valid sample of carefully reviewed chart data, allowing health plans 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 always be the same or better than scores based solely on administrative data.

For example, the table below outlines the difference between state rates for select measures comparing the administrative rate (before chart reviews) versus the hybrid rate (after chart reviews).

Table 1: Administrative versus Hybrid Rates for Select Measures, 2016 RY

Measure	Administrative Rate	Hybrid Rate	Difference
Children's Immunizations—Combo 2	47.8	71.4	+23.6
Comprehensive Diabetes Care—Good HbA1c Control (<8.0%)	4.9	39.0	+34.1
Controlling High Blood Pressure	0.0	53.5	+53.5
Prenatal and Postpartum Care—Timeliness of Prenatal Care	34.1	68.2	+34.1

Supplemental Data

In calculating HEDIS rates, the Apple Health MCOs used auditor-approved supplemental data, which is information generated outside of a health plan's claims or encounter data system. This supplemental information included historical medical records, lab data, immunization registry data, and fee-for-service data on Early and Periodic Screening, Diagnosis and Treatment (EPSDT) provided to MCOs by HCA. Supplemental data was used in determining performance rates for both administrative and hybrid measures. For hybrid measures, supplemental data provided by the State reduced the number of necessary chart reviews for MCOs, as MCOs were not required to review charts for individuals who, per HCA's supplemental data, had already received the service.

Potential Sources of Variation in Performance

The adoption, accuracy, and completeness of electronic health records (EHRs) have improved over recent years as new standards and systems have been introduced and enhanced. However, HEDIS performance measures are specifically defined; occasionally patient records may not include the specific notes or values required 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 either of an actual need for quality improvement, or may reflect a need to improve electronic documentation and diligence in recording notes. For example, in order for an outpatient visit to be counted for counseling for nutrition, a note with evidence of the counseling must be attached to the medical record, with demonstration of 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 patient 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 measure performance.

Member-Level Data

HCA required MCOs to submit de-identified member-level data for all administrative and hybrid measures. Member-level data enable 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. The companion *2016 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, 2015 RY and 2016 RY. 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.

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 reflects 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 all Medicaid plans nationwide. Rates for all NCQA-accredited Medicaid plans are included in the Quality Compass, regardless of whether the state expanded Medicaid coverage. States such as Washington, with Medicaid expansion, may observe different performance rates than in the past because the addition of expansion enrollees changes the overall risk profile of the total population. For more information on how Apple Health Adult Coverage enrollees differ demographically from individuals enrolled in other Apple Health programs, please see Table 2 on page 17.

The license agreement with 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 to consider 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, an MCO's performance may differ markedly from a benchmark, but because of the measure's 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

Medicaid expansion took effect on January 1, 2014, and over 520,000 individuals were enrolled in the Apple Health Adult Coverage program in December 2015. MCOs differ in size and composition and have been impacted by expansion efforts differently. For example, 55.8 percent of individuals enrolled in AMG were part of the Apple Health Adult Coverage program (Medicaid expansion), compared to 26.9 percent of MHW. This difference is important because there is some evidence that individuals enrolled in Medicaid expansion programs nationwide differ demographically from individuals enrolled in traditional Medicaid. The table below shows how individuals enrolled in Apple Health Adult Coverage may differ

from individuals who are enrolled in Healthy Options (traditional Medicaid) and Healthy Options Blind/Disabled programs.

Table 2: Select Demographic Characteristics of Apple Health Enrollees by Enrollment Program, 2016 RY

	Apple Health Adult Coverage (Medicaid Expansion)	Healthy Options (Traditional Medicaid)	Healthy Options Blind/Disabled	Total Apple Health
Median Age	36	10	44	21
Percent Female	50.8%	54.8%	48.5%	52.7%
Percent English as Primary Language	94.1%	81.9%	74.5%**	86.1%
Percent Rural*	21.1%	23.8%	21.9%	22.6%

*Based on Census Bureau classification of enrollee ZIP code of residence.

**22.4 percent of individuals enrolled in the Healthy Options Blind/Disabled program have missing language data in the state database, representing over 90 percent of all individuals with unknown language data.

As Medicaid expansion is still fairly new nationwide, more study is needed to understand how the different health characteristics of the expansion population may impact measure performance.

Individuals enrolled in the Healthy Options Blind/Disabled (HOBD) program constitute between 5.5 percent (MHW) and 6.4 percent (AMG) of each MCO, representing a significant shift from calendar year 2013, when the majority of individuals enrolled through HOBD were covered by only two MCOs. With the population spread out more evenly among plans, no MCO's performance on quality measures is likely unduly influenced by a disproportionate share of individuals enrolled in HOBD. The distribution of enrollment programs among the MCOs is outlined in Table 3.

Table 3: Apple Health Enrollment by Program Type and MCO, December 2015⁴

MC Program Code	AMG	CUP	CHPW	CCW	MHW	UHC	Total
Apple Health Adult Coverage (Medicaid Expansion)	79,055	14,639	99,635	79,145	152,181	98,919	523,574
Healthy Options (Traditional Medicaid)	51,098	38,507	169,971	87,662	366,039	87,003	800,280
Healthy Options Blind/Disabled	9,026	2,487	18,034	11,516	31,183	12,709	84,955
Healthy Options Foster Care	111	126	453	198	1,630	337	2,855
State Children's Health Insurance Program	2,281	1,542	5,462	3,280	15,168	4,534	32,267
Other/Unknown	0	0	586	0	0	576	1,162
Total	141,571	57,301	294,141	181,801	566,201	204,078	1,445,093

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

CUP's network and members were acquired by Molina Healthcare in November 2015; CUP ceased to operate as of December 2015. As a result, HEDIS performance data for its enrollees are not available for this report.

Most plans continued to see significant enrollment growth across 2015 CY, as seen in Table 4. While not as significant as in 2014 CY, the increases may have stretched existing provider networks.

Table 4: Apple Health Enrollment, December 2014 vs December 2015⁵

	December 2014 Enrollment	December 2015 Enrollment	Percent Change
AMG	128,369	141,571	+9.33%
CUP	N/A	57,301	N/A
CCW	175,353	181,801	+3.55%
CHPW	332,456	294,141	-13.03%
MHW	486,524	566,201	+14.07%
UHC	180,225	204,078	+11.69%
Total	1,302,927	1,445,093	+9.84%

The decline in enrollment for CHPW may be attributable at least in part to the creation of CUP in 2015; the sharpest declines in enrollment for CHPW were evident in Clark County, the CUP coverage area.

Variation in Primary Language by MCO

The composition of enrollee primary languages also varies by MCO, as indicated in Table 5. Over 88 percent of enrollees in AMG, for example, have English as a primary language, compared to less than 76 percent of CHPW enrollees.

Table 5: Apple Health Enrollment by Primary Language and MCO, 2016 RY

Language	AMG	CCW	CHPW	MHW	UHC	Total
English	88.5%	76.3%	75.9%	83.8%	87.7%	81.8%
Spanish	2.5%	15.5%	15.8%	8.7%	4.0%	10.1%
Other	2.1%	1.6%	3.5%	2.5%	2.7%	2.7%
Unknown	6.9%	6.6%	4.8%	5.0%	5.6%	5.4%

Additionally, 85.2 percent of individuals whose primary language is Spanish are enrolled in the Healthy Options (traditional Medicaid) program as compared to 11.7 percent who are enrolled in Apple Health Adult Coverage (Medicaid expansion). In comparison, 53.7 percent of individuals whose primary language is English are enrolled in Healthy Options, and 41.5 percent are enrolled in Apple Health Adult Coverage. This differential may indicate that additional outreach is needed to enroll qualified adults whose primary language is Spanish into Medicaid expansion plans.

Note: 70.5 percent of individuals enrolled in the Healthy Options Blind/Disabled program have no listed language ("unknown"). They constitute over 95 percent of the individuals with unknown language data in the State database. There is a clear need to improve language collection for individuals who are part of the HOBD program.

⁵ www.hca.wa.gov/about-hca/apple-health-medicaid-reports

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 several summary observations can be made.

Measures Displaying High Performance Variation among MCOs for 2016 RY

Several measures show significant variation among MCOs during reporting year 2016, indicated in Table 6. Wide variation among MCOs implies that there are MCO-specific differences that may present opportunities for improvement.

Table 6: Select Measures Displaying Sizable Variation among MCOs, 2016 RY

Measure Description	Submeasure	State Average	Highest MCO Rate	Lowest MCO Rate	Difference Between Highest and Lowest MCO Rates
Adults' Access to Preventive/Ambulatory Health Services (AAP)	Total	74.8%	81.3% (MHW)	68.8% (AMG)	12.5%
Children and Adolescents' Access to Primary Care Practitioners (CAP)	25 Months–6 Years	81.9%	88.8% (MHW)	62.3% (CHPW)	26.5%
Comprehensive Diabetes Control (CDC)	Poor HbA1c Control (>9.0)*	49.9%	35.8% (MHW)	64.6% (CHPW)	28.8%
Controlling High Blood Pressure (CBP)	Total	53.5%	58.9% (CHPW)	44.7% (CCW)	14.2%
Frequency of Ongoing Prenatal Care (FPC)	At Least 81% of Recommended Visits	40.3%	51.7% (MHW)	23.1% (CHPW)	28.6%
Prenatal and Postpartum Care (PPC)	Timeliness of Prenatal Care	68.2%	75.2% (MHW)	54.5% (CHPW)	20.7%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	BMI Percentile, Total	45.8%	51.8% (CHPW)	21.0% (CCW)	30.8%
Well-Child Visits in First 15 Months of Life (W15)	6+ Visits	60.3%	68.9% (CCW)	42.4% (CHPW)	26.5%

*Lower scores on this measure indicate better performance.

With the exception of the adult and child/adolescent access to primary care measures, all measures in the table above are hybrid measures. Because hybrid measures are based on samples rather than the entire eligible population, the confidence intervals of performance are typically slightly larger (generally roughly +/- 5 percent). As a result, it is possible that for those hybrid measures, the true difference between high- and low-performing plans may be roughly 10 percent lower or 10 percent higher than reported here.

MCO Performance Variation Between 2015 RY and 2016 RY

Several measures showed change of more than 5 percent between 2015 RY and 2016 RY. For each MCO, performance change of more than 5 percent, either positive or negative, must be justified to HEDIS auditors as part of the quality control process. It is interesting to note that many of these changes were localized to relatively few measures. Table 7 shows quality measures with at least four of five MCOs showing at least 5 percent change between 2015 RY and 2016 RY.

Table 7: Select Measures in Which at Least Four of Five MCOs Had at Least 5% Change Between 2015 and 2016 Reporting Years

Measure	Submeasure	MCOs with Better Rates by at Least 5% Between 2015 RY and 2016 RY	MCOs with Worse Rates by at Least 5% Between 2015 RY and 2016 RY
Adult BMI Assessment (ABA)	Total	3	1
Follow-up Care for Children Prescribed ADHD Medication (ADD)	Continuation	4	0
Comprehensive Diabetes Care (CDC)	Poor HbA1c Control (>9.0%)*	1	3
Frequency of Ongoing Prenatal Care (FPC)	Receiving at Least 81% of Recommended Visits	1	3
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	Total	0	4
Well-Child Visits in the First 15 Months of Life (W15)	6+ Visits	4	1
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)	Physical Activity Counseling, Total	3	1

*Lower scores on this measure indicate better performance.

Variation in State Performance between 2015 RY and 2016 RY

Several measures saw significant changes between 2015 RY and 2016 RY at the state level, both positive and negative, as indicated in Table 8. Rate changes may have been driven by large changes by an individual MCO or small changes by most MCOs. Many of the measures that saw statistically significant declines are included in the Common Measure Set on Health Care Quality and Cost—2016.

Table 8: Select Measures With Declining State Performance by More Than 5% Between 2015 and 2016 Reporting Years

Measure	Submeasure	2015 RY State Rate	2016 RY State Rate	Difference
Comprehensive Diabetes Care (CDC)	HbA1c Control (<8.0%)	46.3%	39.0%	-7.3%
Children and Adolescents' Access to Primary Care Practitioners (CAP)	Ages 25 Months–6 Years	88.8%	81.9%	-6.9%
Adults' Access to Preventive/ Ambulatory Health Services (AAP)	Ages 20–44	77.9%	71.8%	-6.1%
Prenatal and Postpartum Care (PPC)	Timeliness of Prenatal Care	73.7%	68.2%	-5.5%
Comprehensive Diabetes Care (CDC)	Poor HbA1c Control*	42.6%	49.9%	+7.3%

*Lower scores on this measure indicate better performance.

Measures that improved at the state level between 2015 RY and 2016 RY are below in Table 9. Of note, at least one MCO included each of these measures in its provider pay-for-performance programs.

Table 9: Select Measures With Improving State Performance by More Than 5% Between 2015 and 2016 Reporting Years

Measure	Submeasure	2015 RY State Rate	2016 RY State Rate	Difference
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	BMI Percentile Total	36.7%	45.8%	+9.1%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)	Physical Activity Counseling Total	45.1%	53.5%	+8.3%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)	Nutrition Counseling Total	51.1%	57.4%	+6.3%
Comprehensive Diabetes Care (CDC)	Medical Attention for Diabetic Nephropathy	83.4%	88.9%	+5.5%

Performance on HCA-Selected Benchmarking Measures

HCA selected 30 measures for which to display national benchmarks based on current strategic priorities. For many of those measures identified by HCA, the statewide performance rate is below the national 50th percentile, and there is significant variation in performance between MCOs. The tables below show statewide performance as compared to the national average from the NCQA Quality Compass. Please note that the national benchmarks are based on Medicaid plans nationwide, including for states that chose not to expand Medicaid. It is possible that benchmarking is not appropriate in all instances given the different demographics of enrollees in the Medicaid expansion population.

The measures described in Table 10 and Table 11 are divided into quality measures and utilization measures. For quality measures, higher performance is considered better (except where noted). These quality measures represent care measures that are appropriate for nearly all individuals.

Table 10: Performance on HCA-Selected Benchmarking Quality Measures, 2016 RY

Measure	State Rate	National Average	Highest MCO	Lowest MCO
Adult Access to Primary Care				
Adults' Access to Preventive/Ambulatory Health Services (AAP Total)	74.8	80.6	81.3 (MHW)	68.8 (AMG)
Well-Care Visits for Children and Adolescents				
Six or More Well-Care Visits Before Age 15 Months (W15)	60.3	59.4	68.9 (CCW)	42.4 (CHPW)
Well-Care Visits for Individuals Ages 3–6 Years (W34)	66.7	71.3	69.7 (MHW)	61.9 (AMG)
Adolescent Well-Care Visits (AWC)	43.3	48.9	44.5 (UHC)	38.9 (CCW)
Child and Adolescent Immunizations				
Childhood Immunizations (CIS Combination 2)	71.4	72.5	75.5 (CCW)	66.9 (UHC)
Childhood Immunizations (CIS Combination 10)	40.8	33.2	47.1 (CCW)	37.5 (UHC)
Immunizations for Adolescents (IMA Combination 1)	74.2	72.7	76.4 (CHPW)	65.0 (AMG)
Weight Management for Children and Adolescents				
BMI Screening for Children and Adolescents (WCC Total)	45.8	64.4	51.8 (CHPW)	21.0 (CCW)
Nutrition Counseling for Children and Adolescents (WCC Total)	57.4	60.2	64.2 (UHC)	51.6 (AMG)
Physical Activity Counseling for Children and Adolescents (WCC Total)	53.5	53.4	57.7 (CHPW)	47.0 (AMG)
Pregnancy Care				
Timeliness of Prenatal Care (PPC)	68.2	80.0	75.2 (MHW)	54.5 (CHPW)
Receipt of at Least 81% of Recommended Prenatal Visits (FPC)	40.3	56.6	51.7 (MHW)	23.1 (CHPW)
Postpartum Care (PPC)	52.2	60.9	56.7 (AMG/UHC)	47.0 (CHPW)
Diabetes Management				
Annual HbA1c Testing (CDC)	88.3	86.0	89.0 (CHPW)	86.8 (AMG)
Poor HbA1c Control (CDC >9.0%)*	49.9*	45.4*	64.6* (CHPW)	35.8* (MHW)
Good HbA1c Control (CDC <8.0%)	39.0	45.5	49.0 (MHW)	27.6 (CHPW)
Medical Attention for Diabetic Nephropathy (CDC)	88.9	90.0	91.0 (CHPW)	85.4 (CCW)
Eye Exams (CDC)	55.5	52.8	58.5 (MHW)	49.0 (AMG)
Blood Pressure Control (CDC <140/90)	63.0	59.0	68.2 (MHW)	58.6 (UHC)
Management of Other Chronic Conditions				
Medication Management for People with Asthma (MMA 75% Compliance, Ages 5–11)	22.1	28.3	24.4 (UHC)	15.4 (AMG)
Medication Management for People with Asthma (MMA 75% Compliance, Ages 12–18)	23.2	26.3	25.9 (UHC)	19.0 (AMG)
Controlling High Blood Pressure (CBP)	53.5	54.7	58.9 (CHPW)	44.7 (CCW)
Antidepressant Medication Management—Acute Phase Treatment (AMM)	54.2	54.5	60.5 (AMG)	52.2 (MHW)
Antidepressant Medication Management—Continuation Phase Treatment (AMM)	39.4	39.5	46.4 (AMG)	37.2 (MHW)
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	67.1	58.0	70.5 (MHW)	59.8 (AMG)

* Lower scores indicate better performance.

For utilization measures, shown in Table 11, lower performance generally reflects a healthier population. It is important to note that the health of the populations may be driven by factors other than MCO performance (for example, the age and health of enrollees).

Table 11: Performance on HCA-Selected Benchmarking Utilization Measures, 2016 RY

Lower scores indicate lower utilization on these measures; while lower scores may indicate better care management and access to preventive care for enrollees, they may also indicate that a given MCO has an overall healthier cohort of enrollees, irrespective of other factors.

Measure	State Rate	National Average	Highest MCO	Lowest MCO
Total ED Visits per 1,000 Member Months (AMB-b)	53.2	64.4	55.9 (CCW)	50.3 (MHW)
Inpatient Days per 1,000 Member Months (All Service Lines) (IPU)	21.2	38.9	25.1 (AMG)	18.3 (MHW)
Inpatient Days per 1,000 Member Months (IPU Maternity)	5.8	9.9	6.3 (MHW)	4.9 (UHC)
Inpatient Days per 1,000 Member Months (IPU Medicine)	7.5	18.5	8.7 (AMG)	6.2 (MHW)
Inpatient Days per 1,000 Member Months (IPU Surgery)	9.6	14.2	12.1 (AMG)	7.9 (MHW)

These data do not indicate whether all utilization is appropriate (i.e., whether there was potential overuse of the ED) or whether enrollees were unable to access care because of lack of availability. Other data sources, such as HEDIS quality measures or patient-reported CAHPS survey data, may be more indicative of the overall quality of care provided by plans.

Impact of HCA-Supplied Supplemental Data on Measure Performance

There is limited evidence that the EPSDT data, included as a supplemental database when calculating some HEDIS rates, impacted reported statewide performance. Table 10 below outlines statewide averages on two administrative measures with and without State-supplied supplemental data.

Table 12: Performance on Two Administrative Measures With and Without State-Supplied Supplemental Data, 2016 RY

Measure	State Rate With State-Supplied Supplemental Data	State Rate Without State-Supplied Supplemental Data	Difference
Breast Cancer Screening (BCS)	52.27	52.26	0.01
Chlamydia Screening (CHL)	54.75	54.64	0.11

The true value of the State-supplied supplemental data is that it decreases the number of chart reviews necessary for hybrid measures. (When calculating rates for hybrid measures, MCOs take a random sample of applicable enrollees, and then evaluate the number of numerator events through administrative and supplemental data. All individuals in the sample who do not have numerator events located through administrative or supplemental data then require a thorough chart review. For more details on the differences between administrative and hybrid measures, please see the Administrative Versus Hybrid Data Collection section of this report on page 14. Chart reviews during the audit process can be timely

and costly. Table 13 below shows the number of fewer chart reviews necessary for select hybrid measures incorporating supplemental data.

Table 13: Number of Supplemental Data Records Used in Final Samples of Select Hybrid Measures That Prevented Necessary Chart Reviews, 2016 RY

Measure	AMG	CCW	CHPW	MHW	UHC	Total
Childhood Immunizations Combination 2	216	159	207	116	191	889
Adolescent Immunizations Combination 1	117	119	52	21	108	417
Well-Child Visits—6 or more visits by Age 15 Months	61	75	26	87	63	312
Adolescent Well Care Visits	5	5	0	12	10	32
Well-Child Visits—Ages 3–6	1	1	1	13	3	19

It is unknown whether this supplemental data supplied information that otherwise would not have been located during a chart review. As a result, it is not possible to determine whether the supplemental data had any impact overall on the statewide rates. However, some MCOs indicated that inclusion of this database added value and contributed to rate increases.

The following sections provide more depth on statewide and MCO performance in the following key domains of care:

- Access to Care
- Preventive Care
- Chronic Care Management
- Medical Care Utilization

Appendix B contains detailed performance for each MCO on each of the 102 HEDIS measures and submeasures.

Access to Care

Access to primary care depends on the ability of consumers to locate healthcare providers and receive services. Primary care visits are important for preventing or improving the management of chronic conditions. As Medicaid expansion progresses, it is important that MCOs establish sufficient provider networks to ensure adequate access to care.

Reported Measures

The access-related measures in this section include:

- Adults' access to preventive/ambulatory health services (also referred to as adult access to primary care in this report): the percentage of adult enrollees with an ambulatory or preventive care visit during the MCO year, not including inpatient stays or ED visits
- Children and adolescents' access to primary care practitioners (also referred to as child and adolescent access to primary care in this report): the percentage of children and adolescents who had an outpatient visit during the MCO 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: six or more visits (State-contracted minimum threshold: 75 percent)
 - Ages 3–6 years: one or more visits (State-contracted minimum threshold: 75 percent)
 - Ages 12–21 years: one or more visits (State-contracted minimum threshold: 75 percent)
- Timeliness of prenatal care: the percentage of women delivering a live baby who received prenatal care in the first trimester (or within 42 days of enrolling with the MCO) *[Note: Does not require one year of continuous enrollment]*
- Frequency of ongoing 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 the measure depends on the member's stage of pregnancy at the 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 delivery *[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/Ambulatory Health Services

Adults' access to preventive/ambulatory health services is subdivided into two age categories: individuals ages 20–44 and individuals ages 45–64. As seen in Figures 2 and 3 below, all MCOs showed decreases in adult access for both age groups between 2015 RY and 2016 RY. This decrease may have been due to Medicaid expansion: because these measures require a minimum of 11 months of enrollment for inclusion, 2016 RY is the first year that many individuals in the expansion population were largely included. The decreases may have been driven by 1) stretched provider networks unable to

accommodate the increase in volume and/or 2) a healthier expansion population that is less likely to need or proactively seek care. Adult access should continue to be monitored closely in future years.

Adults' access to preventive/ambulatory health services is part of the Washington State Common Measure Set on Health Care Quality and Cost—2016.

Figure 2: Percentage of Adults Ages 20–44 Years With at Least One Ambulatory or Preventive Care Visit, 2015 RY and 2016 RY

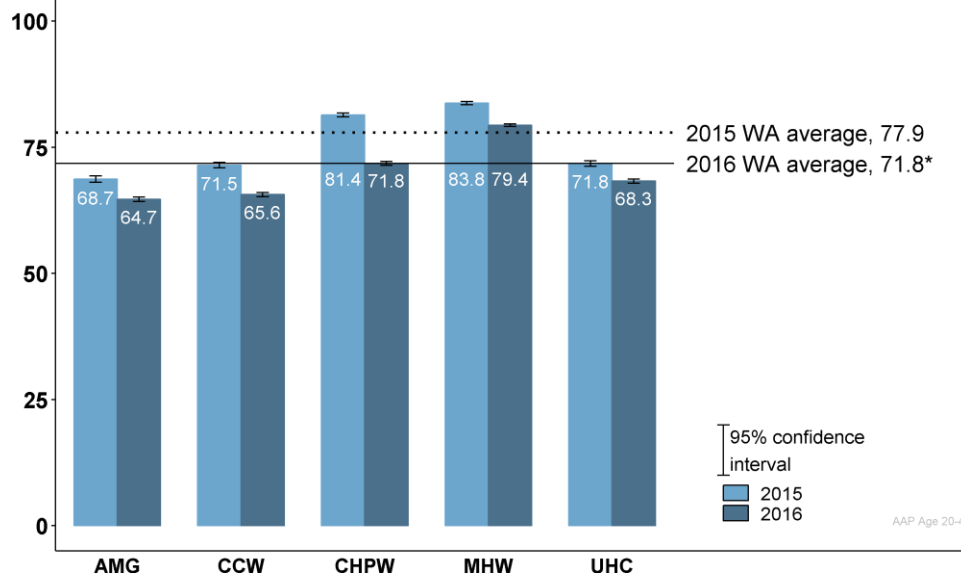
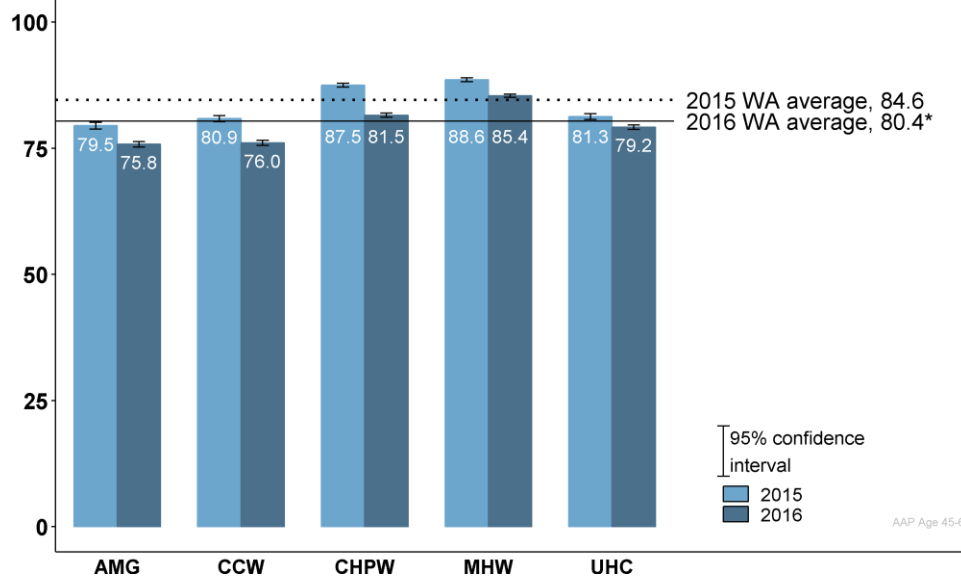
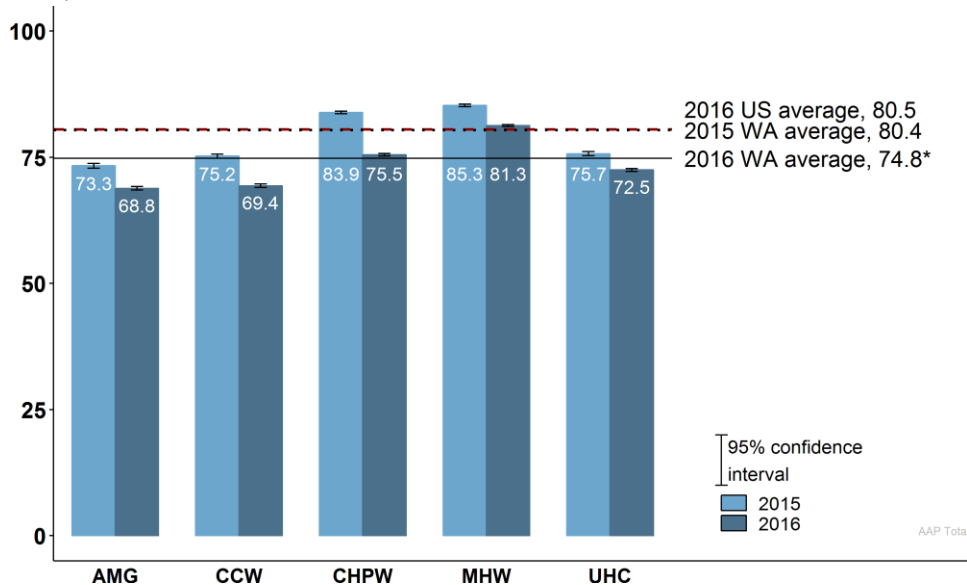


Figure 3: Percentage of Adults Ages 45–64 Years With at Least One Ambulatory or Preventive Care Visit, 2015 RY and 2016 RY



The rollup measure shown in Figure 4 includes populations from each of the charts above as well as the nominal number of individuals enrolled in Apple Health MCOs who are 65 and older. (Most individuals who are 65 and older have Medicare as a primary payer.) The total rollup represents how well MCOs are getting all of their adult enrollees into primary care. As a whole, there was a statistically significant drop in adult access to primary care in 2016 RY, and the state rate is now more than five points lower than the national average.

Figure 4: Percentage of Adults Ages 20+ Years With at Least One Ambulatory or Preventive Care Visit, 2015 RY and 2016 RY



Spotlight: Geographic Variation in Adult Access to Primary Care

Adults' Access to Preventive/Ambulatory Health Services —Total Population

Access to primary 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. Figure 5 and Figure 6 below show county rates of adult access to primary care during 2015 RY and 2016 RY.

Figure 5: Map of County Variation, Adult Access to Primary Care, 2015 RY

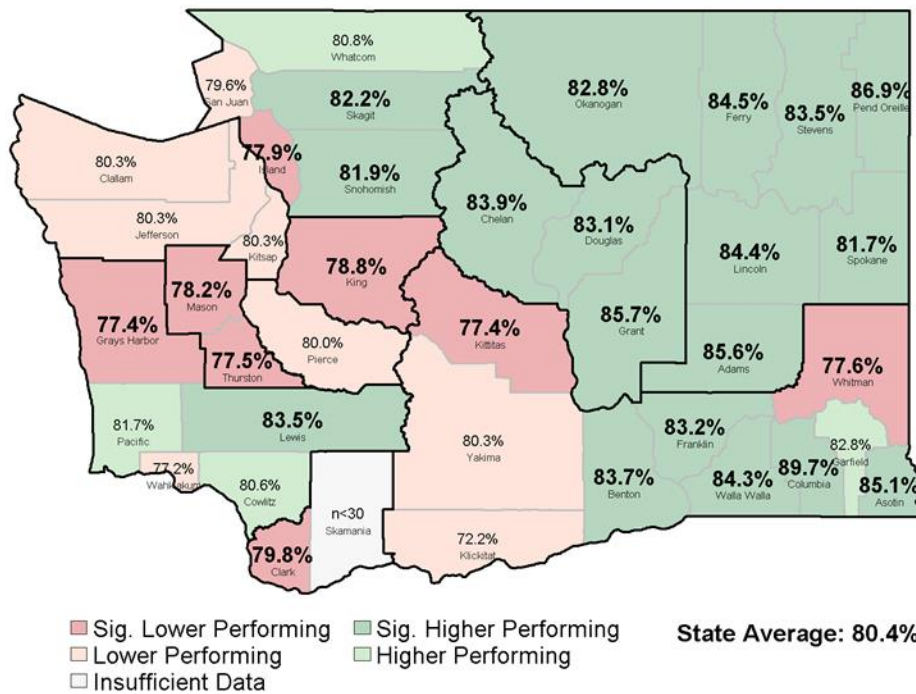
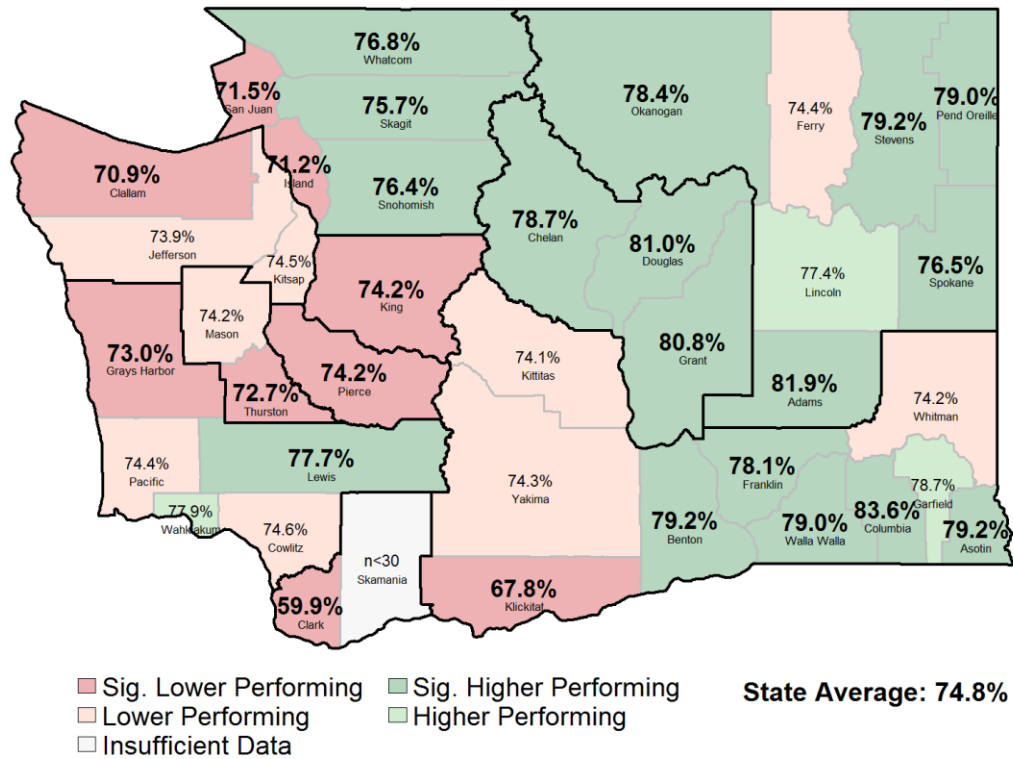


Figure 6: Map of County Variation, Adult Access to Primary Care, 2016 RY



AAP, Adults Access to Preventive/Ambulatory Health Services, Total Population

Table 14 shows the change in rates of access to care for each county between the two years. All counties except Wahkiakum saw a decrease in rates; Clark and Ferry counties had decreases of more than 10 percent.

Table 14: Performance by County, Adult Access to Primary Care, 2015 RY to 2016 RY

County	2015 RY	2016 RY	Difference
Adams	85.6%	81.9%	-3.7%
Asotin	85.1%	79.2%	-5.9%
Benton	83.7%	79.2%	-4.5%
Chelan	83.9%	78.7%	-5.2%
Clallam	80.3%	70.9%	-9.4%
Clark	79.8%	59.9%	-19.9%
Columbia	89.7%	83.6%	-6.1%
Cowlitz	80.6%	74.6%	-6.0%
Douglas	83.1%	81.0%	-2.1%
Ferry	84.5%	74.4%	-10.1%
Franklin	83.2%	78.1%	-5.1%
Garfield	82.8%	78.7%	-4.1%

County	2015 RY	2016 RY	Difference
Grant	85.7%	80.8%	-4.9%
Grays Harbor	77.4%	73.0%	-4.4%
Island	77.9%	71.2%	-6.7%
Jefferson	80.3%	73.9%	-6.4%
King	78.8%	74.2%	-4.6%
Kitsap	80.3%	74.5%	-5.8%
Kittitas	77.4%	74.1%	-3.3%
Klickitat	72.2%	67.8%	-4.4%
Lewis	83.5%	77.7%	-5.8%
Lincoln	84.4%	77.4%	-7.0%
Mason	78.2%	74.2%	-4.0%
Okanogan	82.8%	78.4%	-4.4%
Pacific	81.7%	74.4%	-7.3%
Pend Oreille	86.9%	79.0%	-7.9%
Pierce	80.0%	74.2%	-5.8%
San Juan	79.6%	71.5%	-8.1%
Skagit	82.2%	75.7%	-6.5%
Skamania	N<30	N<30	N/A
Snohomish	81.9%	76.4%	-5.5%
Spokane	81.7%	76.5%	-5.2%
Stevens	83.5%	79.2%	-4.3%
Thurston	77.5%	72.7%	-4.8%
Wahkiakum	77.2%	77.9%	0.7%
Walla Walla	84.3%	79.0%	-5.3%
Whatcom	80.8%	76.8%	-4.0%
Whitman	77.6%	74.2%	-3.4%
Yakima	80.3%	74.3%	-6.0%
Overall	80.4%	74.8%	-5.6%

Adults' Access to Preventive/Ambulatory Health Services — Medicaid Expansion Population

In examining adult access to primary care, special attention should be paid to the Apple Health Adult Coverage (Medicaid expansion) population. These individuals differ demographically from the traditional Medicaid population (for example, see Table 2 on page 17), and as such may face unique barriers to care. Three generally accepted reasons for lower access rates for individuals who are part of Medicaid expansion efforts across the country include: 1) These individuals may have gone significant lengths of time without health insurance and thus may not have had usual sources of care; 2) These individuals are likely healthier than individuals enrolled through the Healthy Options Blind/Disabled program and thus are less likely to proactively seek care; and 3) Provider networks may be stretched by the large-scale addition of insured individuals and may not have sufficient capacity to handle new demand.

In 2016 RY, adults enrolled in Apple Health Adult Coverage (Medicaid expansion) had lower rates of access than other adults. Additionally, the rates of access for those individuals dropped significantly in virtually every county between 2015 RY and 2016 RY. Figures 7 and 8 show county variation in adult access to primary care for the Apple Health Adult Coverage program population for 2015 RY and 2016 RY.

Figure 7: Map of County Variation, Adult Access to Primary Care among Adults in Medicaid Expansion Population, 2015 RY

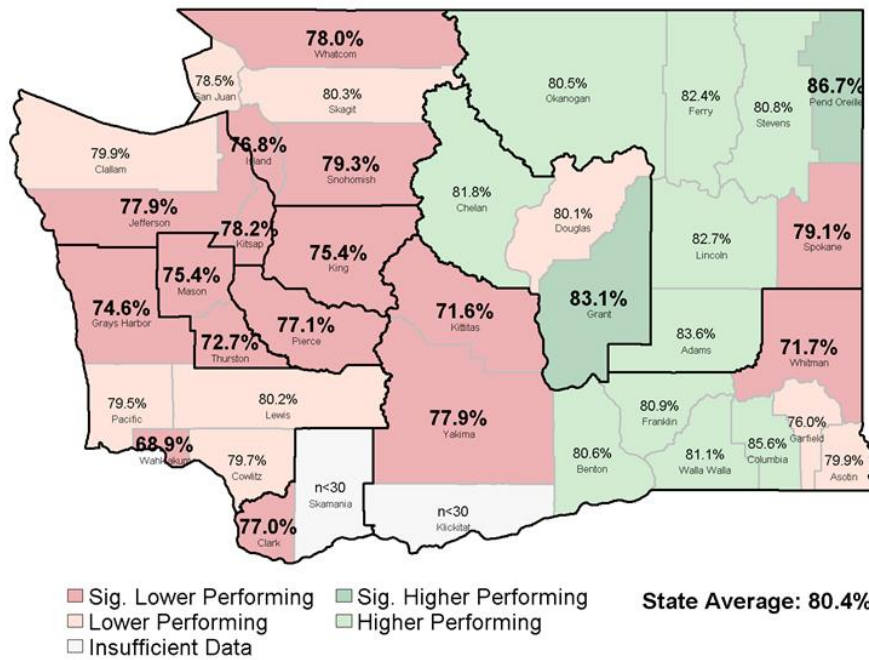


Figure 8: Map of County Variation, Adult Access to Primary Care among Adults in Medicaid Expansion Population, 2016 RY

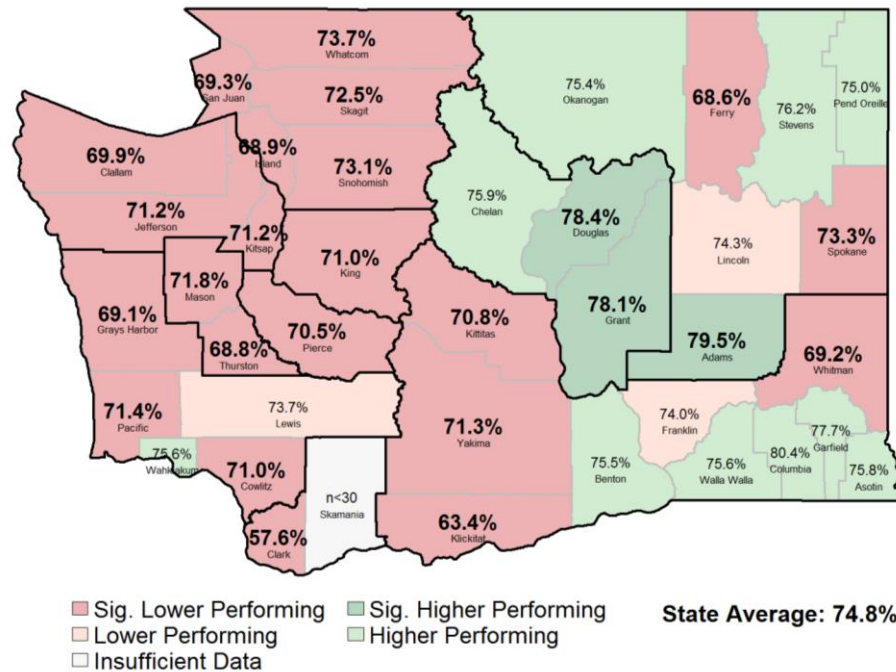


Table 15 below shows how the rates of access changed for individuals enrolled in Apple Health Adult Coverage (Medicaid expansion) between 2015 RY and 2016 RY. Four counties had higher access in 2016 RY, with Wahkiakum having 9 percent higher rates in 2016 RY compared to 2015 RY. Clark County, whose performance was already statistically significantly below the state average in 2015 RY, saw its access rate drop by more than 19 percent in 2016 RY.

Table 15: Performance by County, Adult Access to Primary Care for Medicaid Expansion Population, RY 2015 vs. RY 2016

County	2015 RY	2016 RY	Difference
Adams	83.6%	79.5%	-4.1%
Asotin	79.9%	75.8%	-4.1%
Benton	80.6%	75.5%	-5.1%
Chelan	81.8%	75.9%	-5.9%
Clallam	79.9%	69.9%	-10.0%
Clark	77.0%	57.6%	-19.4%
Columbia	85.6%	80.4%	-5.2%
Cowlitz	79.7%	71.0%	-8.7%
Douglas	80.1%	78.4%	-1.7%
Ferry	82.4%	68.6%	-13.8%
Franklin	80.9%	74.0%	-6.9%

County	2015 RY	2016 RY	Difference
Garfield	76.0%	77.7%	1.7%
Grant	83.1%	78.1%	-5.0%
Grays Harbor	74.6%	69.1%	-5.5%
Island	76.8%	68.9%	-7.9%
Jefferson	77.9%	71.2%	-6.7%
King	75.4%	71.0%	-4.4%
Kitsap	78.2%	71.2%	-7.0%
Kittitas	71.6%	70.8%	-0.8%
Klickitat	N<30	63.4%	NA
Lewis	80.2%	73.7%	-6.5%
Lincoln	82.7%	74.3%	-8.4%
Mason	75.4%	71.8%	-3.6%
Okanogan	80.5%	75.4%	-5.1%
Pacific	79.5%	71.4%	-8.1%
Pend Oreille	86.7%	75.0%	-11.7%
Pierce	77.1%	70.5%	-6.6%
San Juan	78.5%	69.3%	-9.2%
Skagit	80.3%	72.5%	-7.8%
Skamania	N<30	N<30	N<30
Snohomish	79.3%	73.1%	-6.2%
Spokane	79.1%	73.3%	-5.8%
Stevens	80.8%	76.2%	-4.6%
Thurston	72.7%	68.8%	-3.9%
Wahkiakum	68.9%	75.6%	6.7%
Walla Walla	81.1%	75.6%	-5.5%
Whatcom	78.0%	73.7%	-4.3%
Whitman	71.7%	69.2%	-2.5%
Yakima	77.9%	71.3%	-6.6%

Children and Adolescents' Access to Primary Care Practitioners

Children and adolescents' access to primary care practitioners is subdivided into four age categories: 12–24 months, 25 months–6 years, 7–11 years, and 12–19 years. These measures should not have experienced significant changes as a result of Medicaid expansion, as a majority of children eligible for Medicaid were already enrolled through the state Children's Health Insurance Program (CHIP). However, as shown in Table 16 below, statewide rates dropped roughly 4–7 percent between 2015 RY and 2016 RY for each age group. As a result of this decrease, Apple Health statewide performance rates are lower on all of these measures than the national average.

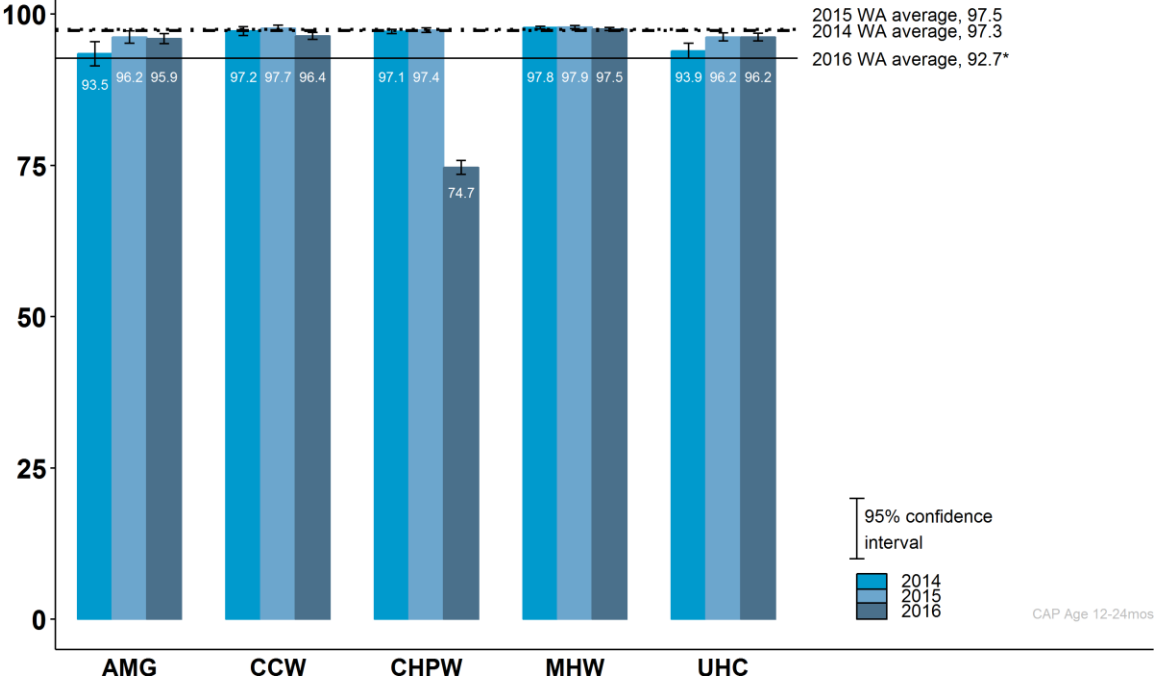
Children and adolescents' access to primary care practitioners is part of the Washington State Common Measure Set on Health Care Quality and Cost—2016.

Table 16: Percentage of Children and Adolescents With at Least One Primary Care Visit, Statewide Performance in 2014 RY, 2015 RY, and 2016 RY

	2014 RY State Rate	2015 RY State Rate	2016 RY State Rate	2015 RY to 2016 RY Change
12–24 months	97.3%	97.5%	92.7%	-4.8%
25 months–6 years	87.5%	88.8%	81.9%	-6.9%
7–11 years	91.2%	91.9%	87.5%	-4.4%
12–19 years	90.8%	91.2%	87.5%	-3.7%

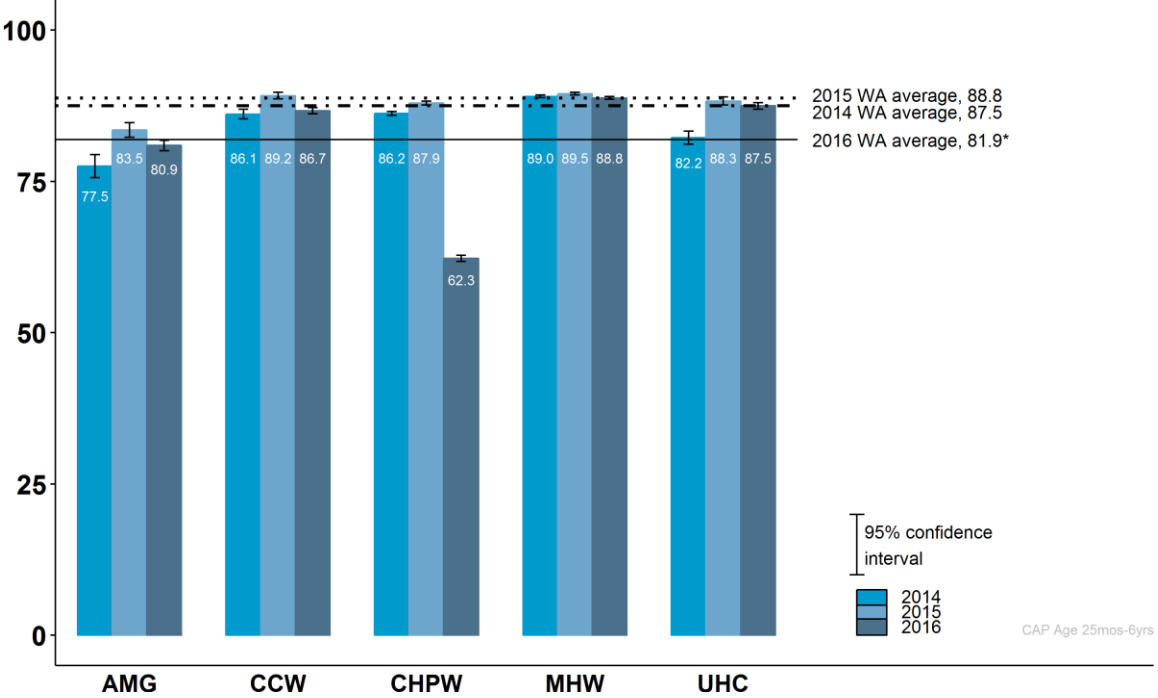
As shown in Figures 9–12, much of this rate decrease was driven by one MCO’s performance.

Figure 9: Percentage of Children Ages 12–24 Months With at Least One Primary Care Physician Visit, 2015 RY and 2016 RY



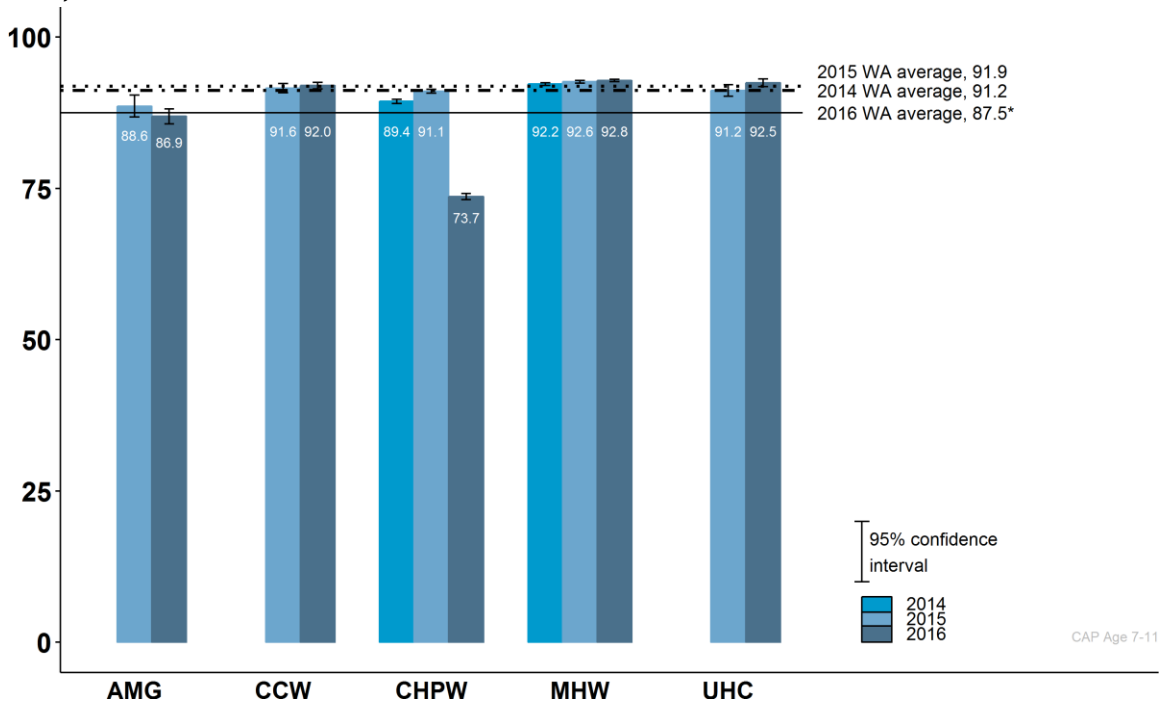
For this measure, CHPW had the lowest performance of any Medicaid plan in the nation based on benchmarks from Quality Compass. All other MCOs are performing above the national average. MHW performed in the top 75 percent of plans nationwide on this measure.

Figure 10: Percentage of Children Ages 25 Months–6 Years With at Least One Primary Care Physician Visit, 2015 RY and 2016 RY



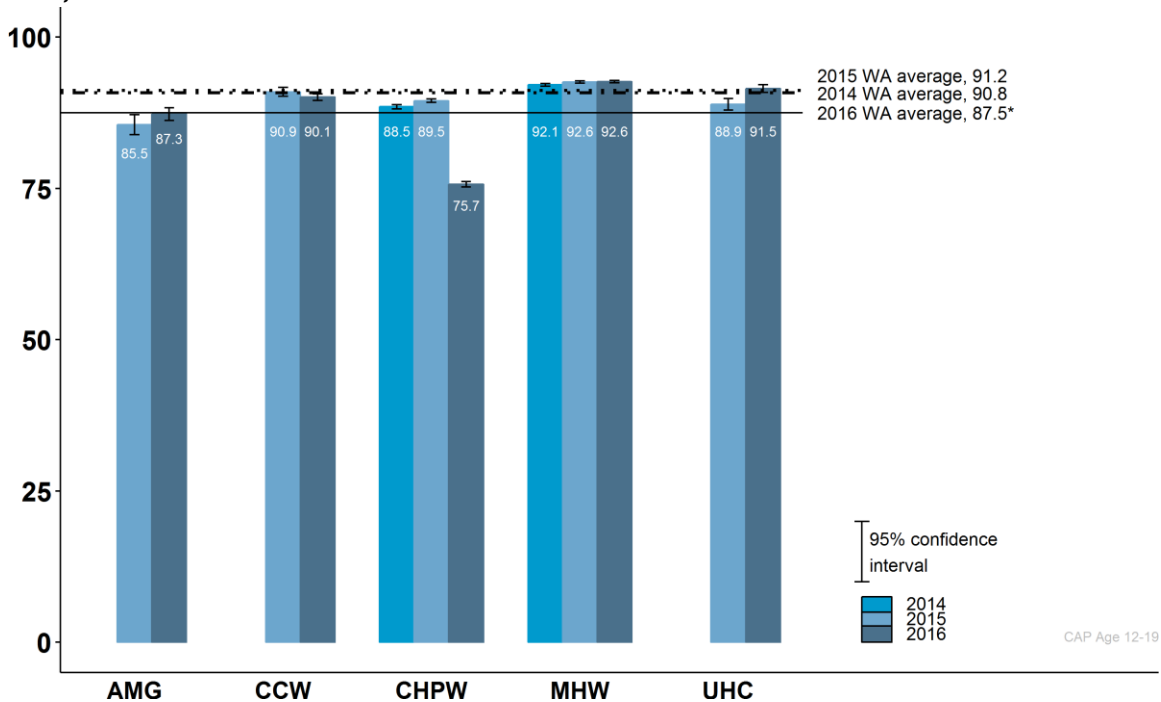
Again, CHPW had the lowest performance of any Medicaid plan in the nation for this measure based on benchmarks from Quality Compass. Only one MCO (MHW) performed above the national average on this measure.

Figure 11: Percentage of Children Ages 7–11 Years With at Least One Primary Care Physician Visit, 2015 RY and 2016 RY



For this measure, CHPW’s performance puts the MCO in the lowest 10 percent of Medicaid plans nationwide. CCW, MHW, and UHC performed above the national average on this measure.

Figure 12: Percentage of Children Ages 12–19 Years With at Least One Primary Care Physician Visit, 2015 RY and 2016 RY



For the measure shown in Figure 12, CHPW’s performance puts the MCO in the lowest 10 percent of Medicaid plans nationwide. CCW, MHW, and UHC performed above the national average on this measure. MHW’s performance is in the top 25 percent of Medicaid plans nationwide.

Well-Care Visits

Statewide performance on infants receiving six or more visits prior to age 15 months rebounded in 2016 RY from a sharp decline during 2015 RY, as shown in Table 17. Four of the five MCOs increased performance on this measure by at least 7 percent; however, CHPW dropped by more than 15 percent. Performance on well-care visits for the other two age groups (ages 3–6 and ages 12–21), however, remained flat, with performance on each almost five percentage points lower than the national average. Well-child visits (ages 3–6 years) is part of the Washington State Common Measure Set on Health Care Quality and Cost—2016.

Table 17: Percentage of Children and Adolescents With Minimum Recommended Primary Care Visits, State Performance in RY 2014, 2015 RY, and 2016 RY

	RY 2014 State Rate	2015 RY State Rate	2016 RY State Rate	2016 National Average
Six or more visits by 15 months (W15)	64.0%	56.8%	60.3%	59.6%
One or more visit for children ages 3–6 (W34)	65.1%	66.6%	66.7%	71.4%
One or more visit for adolescents ages 12–21 (AWC)	42.7%	42.6%	43.3%	48.4%

Figures 13–15 illustrate child well-child visits by MCO, segmented by age groups.

Figure 13: Percentage of Infants Ages 0–15 Months With at Least Six Well-Care Visits, 2015 RY and 2016 RY

State-contracted minimum threshold: 75%

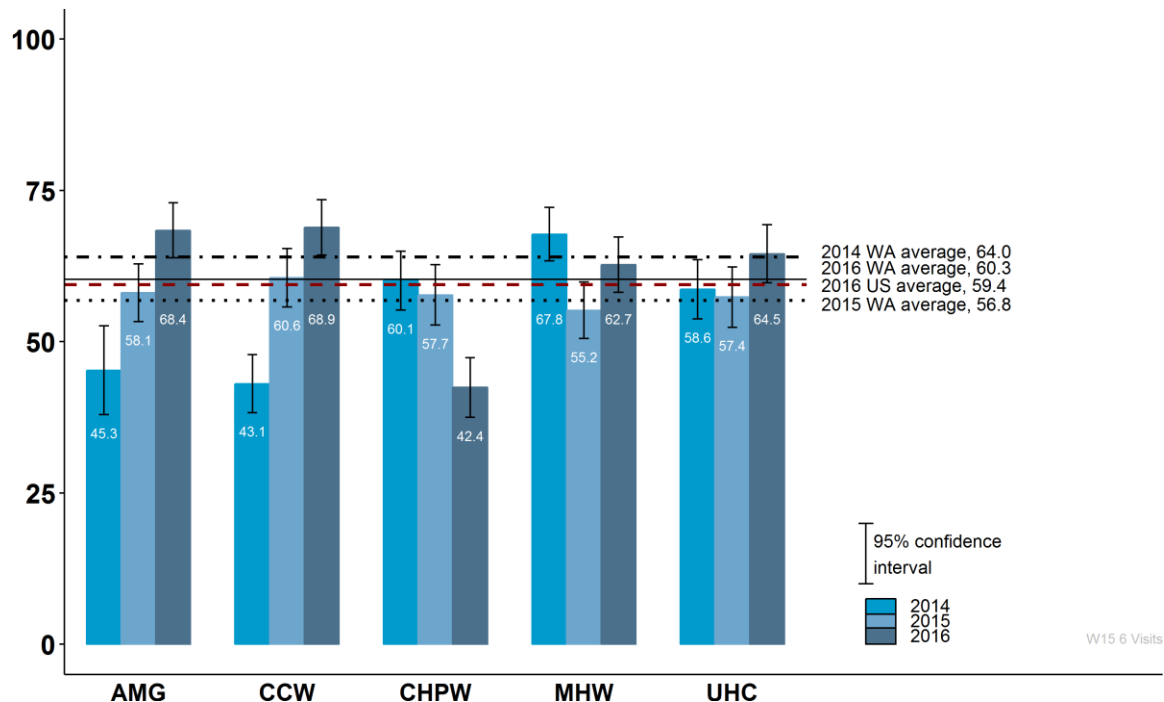


Figure 14: Percentage of Children Ages 3–6 Years With at Least One Well-Care Visit, 2015 RY and 2016 RY

State-contracted minimum threshold: 75%

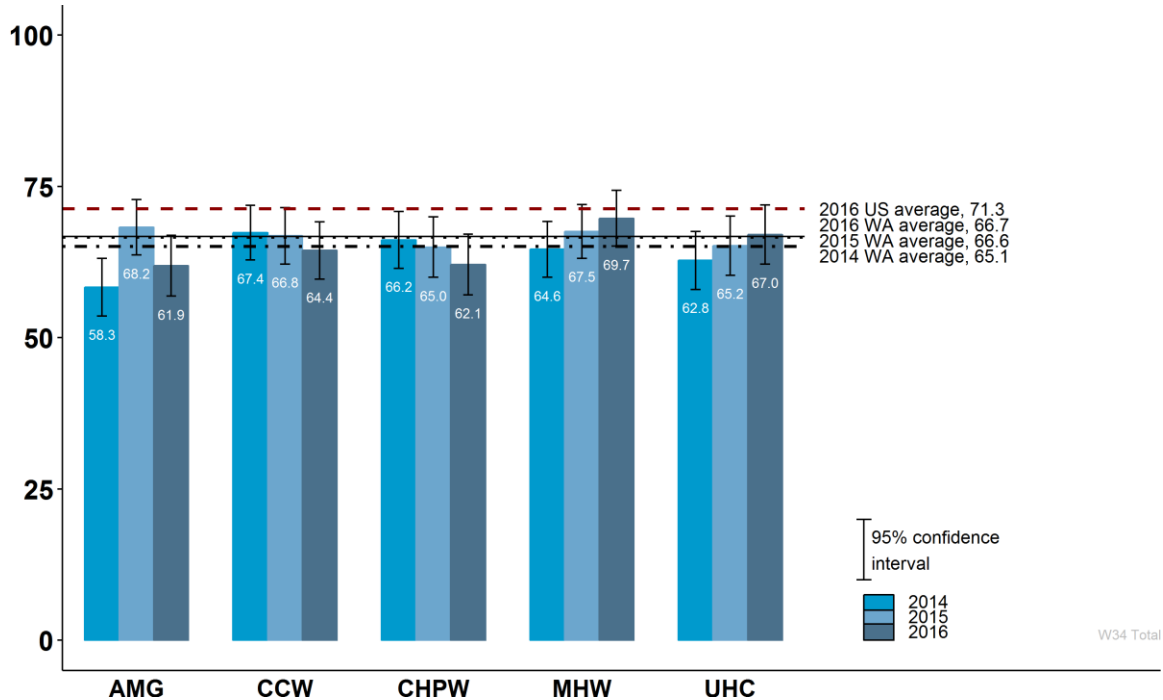
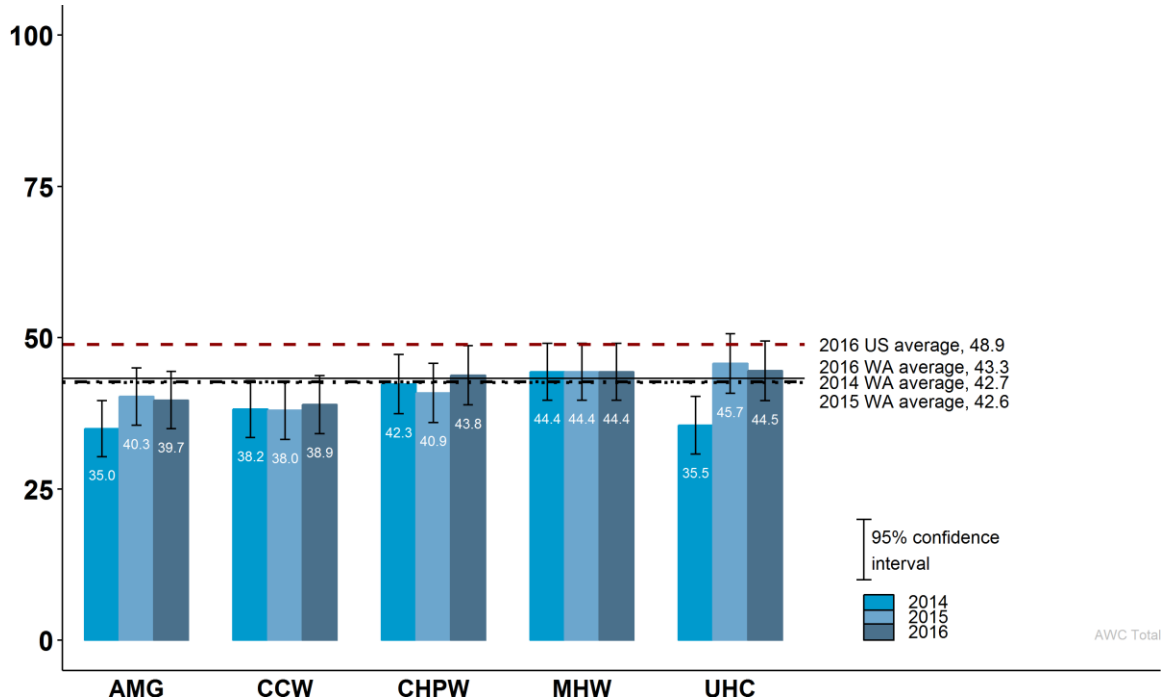


Figure 15: Percentage of Adolescents Ages 12–21 Years With at Least One Well-Care Visit, 2015 RY and 2016 RY

State-contracted minimum threshold: 75%

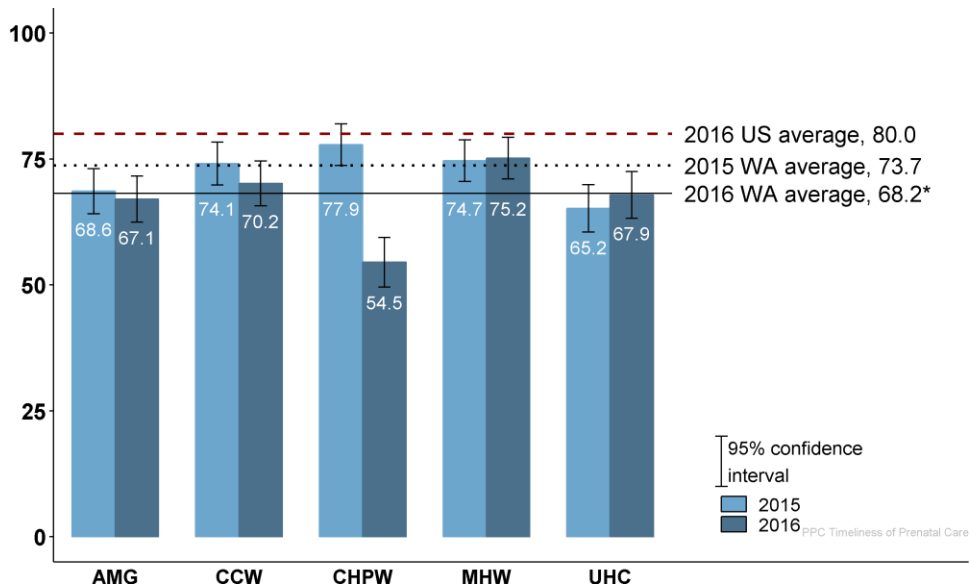


Maternal Health: Prenatal Care

All Apple Health MCOs performed lower than the national average for women entering prenatal care in the first trimester, as shown in Figure 16 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 recommended prenatal visits, shown in Figure 17. Note that the number of recommended prenatal visits varies for each enrollee, as it depends on the stage of the enrollee’s pregnancy at the time of enrollment.

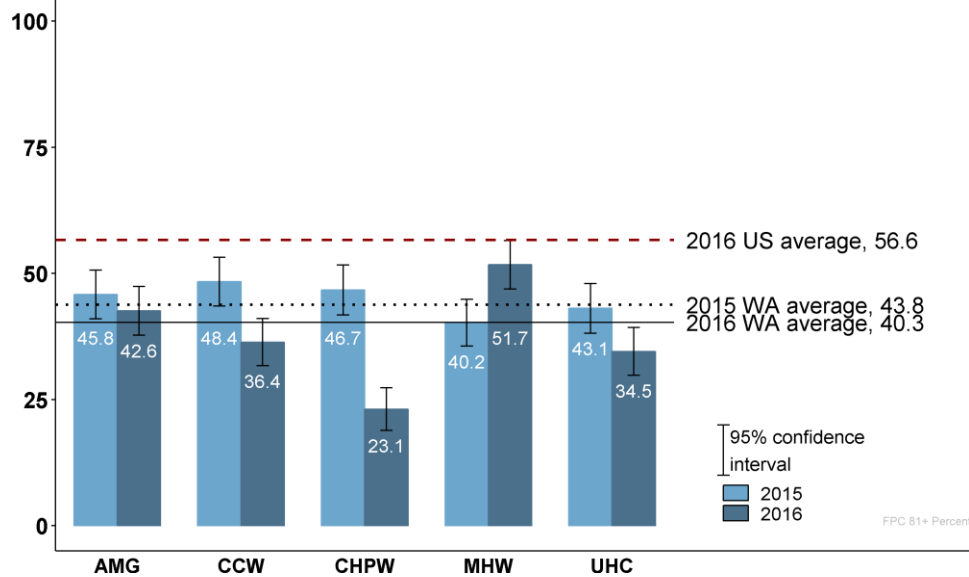
Given continued overall Apple Health performance below national averages on these maternal health measures, HCA may consider implementing statewide performance improvement efforts for these measures. There may be MCO-specific or statewide barriers to receiving care for existing enrollees and enrollees newly eligible due to pregnancy.

Figure 16: Percentage of Pregnant Women Receiving Prenatal Care During First Trimester, 2015 RY and 2016 RY



CHPW’s performance on this measure is in the lowest 10 percent of Medicaid plans nationwide. No MCO performed above the national average.

Figure 17: Percentage of Pregnant Women Receiving at Least 81% of Recommended Prenatal Visits, 2015 RY and 2016 RY (Recommended number of visits depends on the member’s state of pregnancy at the time of enrollment.)

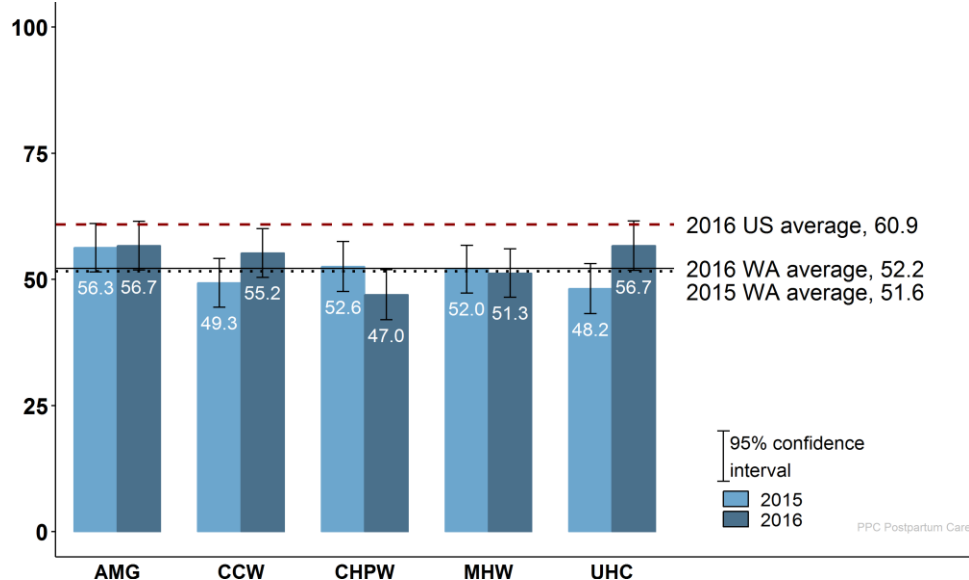


CHPW’s performance on this measure is in the lowest 10 percent of Medicaid plans nationwide. All MCOs except MHW performed in the lowest 25 percent of Medicaid plans nationwide on this measure.

Maternal Health: Postpartum Care

As with prenatal access to care, access to postpartum care lags significantly behind the national average, as shown in Figure 18. There may be state barriers to care that are limiting performance by all MCOs on this measure.

Figure 18: Percentage of Mothers With a Postpartum Visit, 2015 RY and 2016 RY



No MCO performed better than the national average for this measure. Three of the MCOs (CCW, CHPW, and MHW) performed in the lowest 25 percent of Medicaid plans nationwide.

Performance Summary

- All MCOs experienced decreases in overall adult access to primary care in 2016 RY compared to 2015 RY. That result is not surprising, as 2016 RY is the first full year that includes data for many individuals part of the Medicaid expansion population.
- The statewide rate for child and adolescent access to care dropped statewide across all age groups between 2015 RY and 2016 RY; however, that drop was primarily driven by CHPW and is likely not attributable to Medicaid expansion efforts.
- Although four of the five MCOs increased performance by at least 7 percent for the rate of infants receiving six or more visits prior to age 15 months, CHPW dropped by more than 15 percent.
- Well-care visit rates for children ages 3–6 and adolescents 12–21 are roughly five points below national averages, presenting a missed opportunity for establishing healthy habits in children and adolescents.
- MCO-specific rates for well-care visits do not correlate well to MCO-specific rates for overall access to care for those age groups. This divergence 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 significantly below the nation for getting women into prenatal care during the first trimester, ensuring they receive all of the recommended visits during the entirety of their pregnancy, and providing appropriate postpartum care.

Preventive Care

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

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:
 - Adult BMI assessment (ages 18–74)
 - Children’s BMI percentile screening (ages 3–17)
 - Children’s nutritional counseling (ages 3–17)
 - Children’s physical activity counseling (ages 3–17)
- Immunizations before age 2: For children age 2, the State required MCOs to report 10 separate vaccine antigens and 9 combinations of vaccines, shown in Table 18. The HEDIS immunization measure follows the CDC guidelines for immunizations, and is updated when those guidelines change. The definitions of these measures are noted below.
 - 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 18) (HCA-contracted goal: 75 percent)
 - Combination 3 (refer to Table 18)

Table 18: Childhood Immunization Combinations

Antigen	Combination Number								
	2	3	4	5	6	7	8	9	10
DTaP	√	√	√	√	√	√	√	√	√
HiB	√	√	√	√	√	√	√	√	√
HepA			√			√	√		√
HepB	√	√	√	√	√	√	√	√	√
Flu					√		√	√	√
MMR	√	√	√	√	√	√	√	√	√
PCV		√	√	√	√	√	√	√	√
IPV	√	√	√	√	√	√	√	√	√
RV				√		√		√	√
VZV	√	√	√	√	√	√	√	√	√

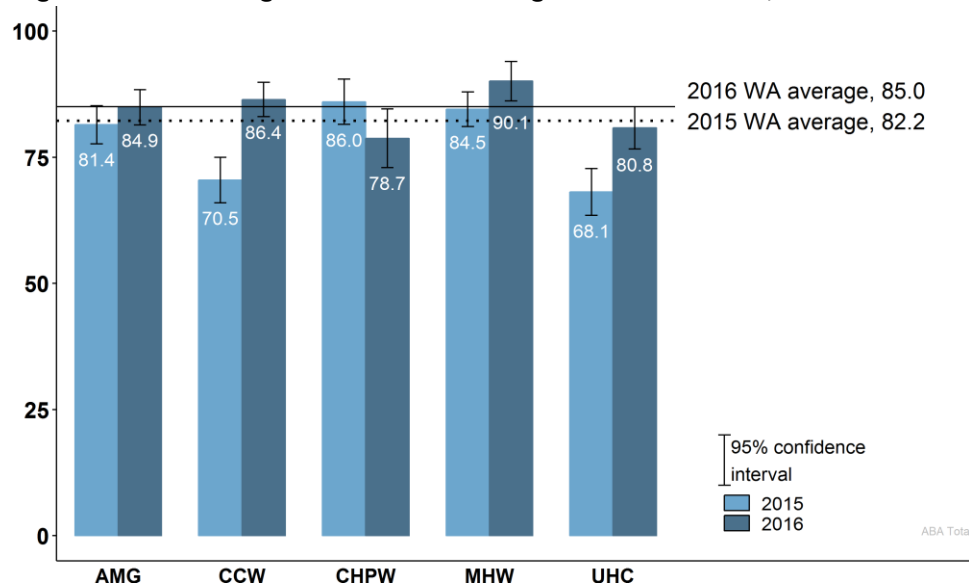
- Immunizations before age 13
 - Meningococcal vaccine: one dose
 - Tetanus, diphtheria toxoids, and acellular pertussis (TDaP) or tetanus and diphtheria toxoids (Td): one dose
 - Combination 1: both of the above vaccines
- Women's health screenings
 - Breast cancer screening: the percentage of women ages 50–74 who had at least one mammogram in the reporting year or the prior year
 - Cervical cancer screening: the percentage of women ages 21–64 receiving a PAP test during the reporting year or prior two years, and co-testing of PAP and human papilloma virus (HPV) for women ages 30–64 in the reporting year or the four prior years
 - Chlamydia screening: the percentage of women ages 16–24 years and identified as sexually active having at least one test for chlamydia during the reporting 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 for this measure in 2016 RY surpassed the national average, but there were over 10 points of variation among the MCOs, as shown in Figure 19.

Adult BMI assessment is part of the Washington State Common Measure Set on Health Care Quality and Cost—2016.

Figure 19: Percentage of Adults Receiving BMI Assessment, 2015 RY and 2016 RY

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents

Only 45.8 percent of members ages 3–17 who had an outpatient visit during the year had evidence that their BMI percentile was recorded, almost 20 points lower than the national average, shown in Figure 20. While the state rate did rise by 9.1 percent from 2015 RY to 2016 RY, there is still room for improvement. CCW performed in the lowest 10 percent of Medicaid plans nationwide.

State performance on nutritional counseling and physical activity counseling was comparable to the national averages because of significant improvement from 2015 RY to 2016 RY, shown in Figure 21. UHC, in particular, improved its performance on nutritional counseling by 25 percent.

Weight assessment and counseling for nutrition and physical activity for children and adolescents is part of the Washington State Common Measure Set on Health Care Quality and Cost—2016.

Figure 20: Percentage of Children and Adolescents Receiving BMI Assessment, 2015 RY and 2016 RY

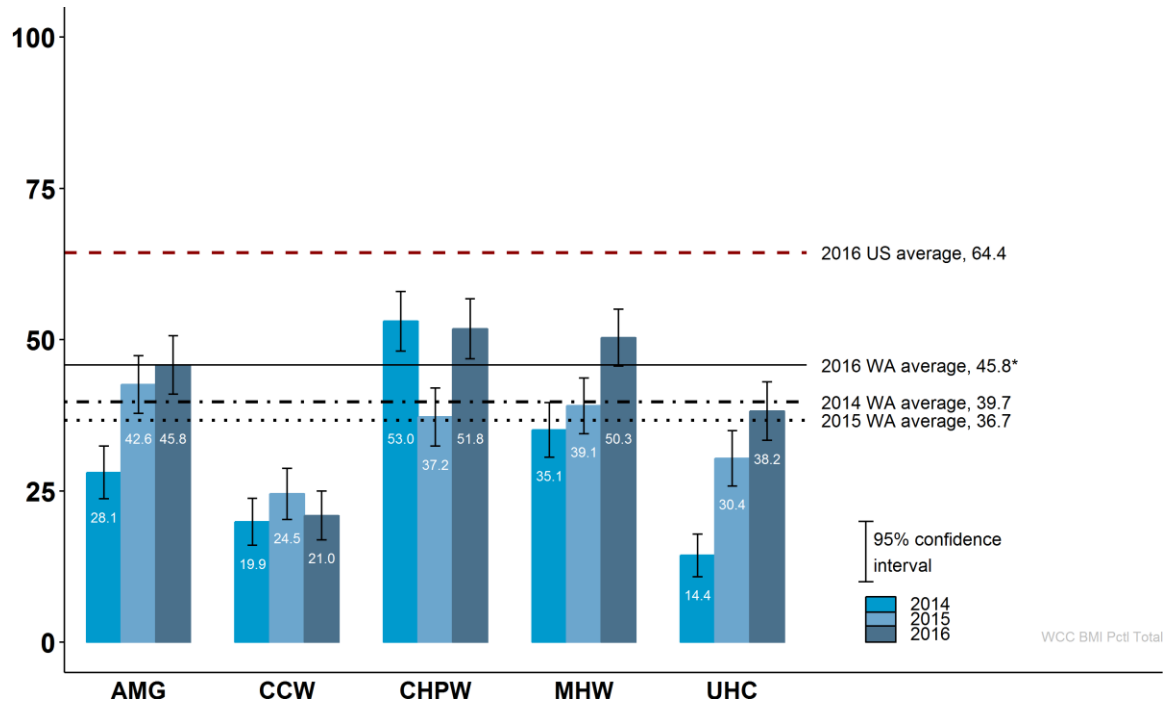


Figure 21: Percentage of Children and Adolescents Receiving Nutritional Counseling, 2015 RY and 2016 RY

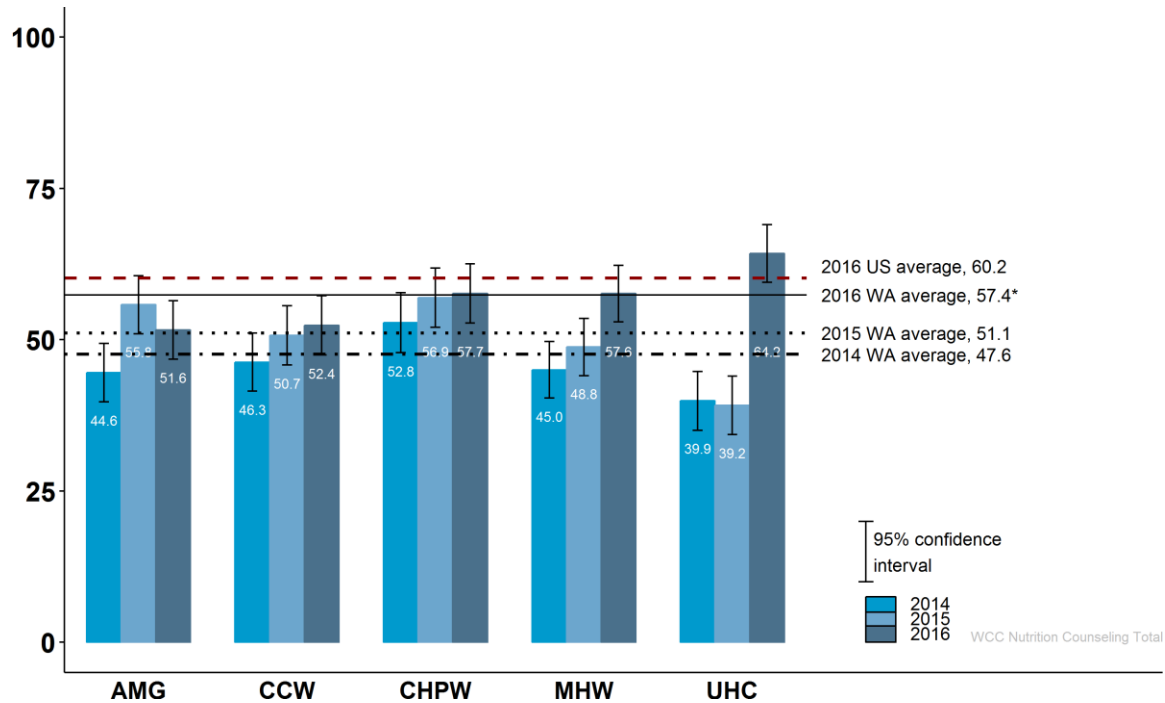
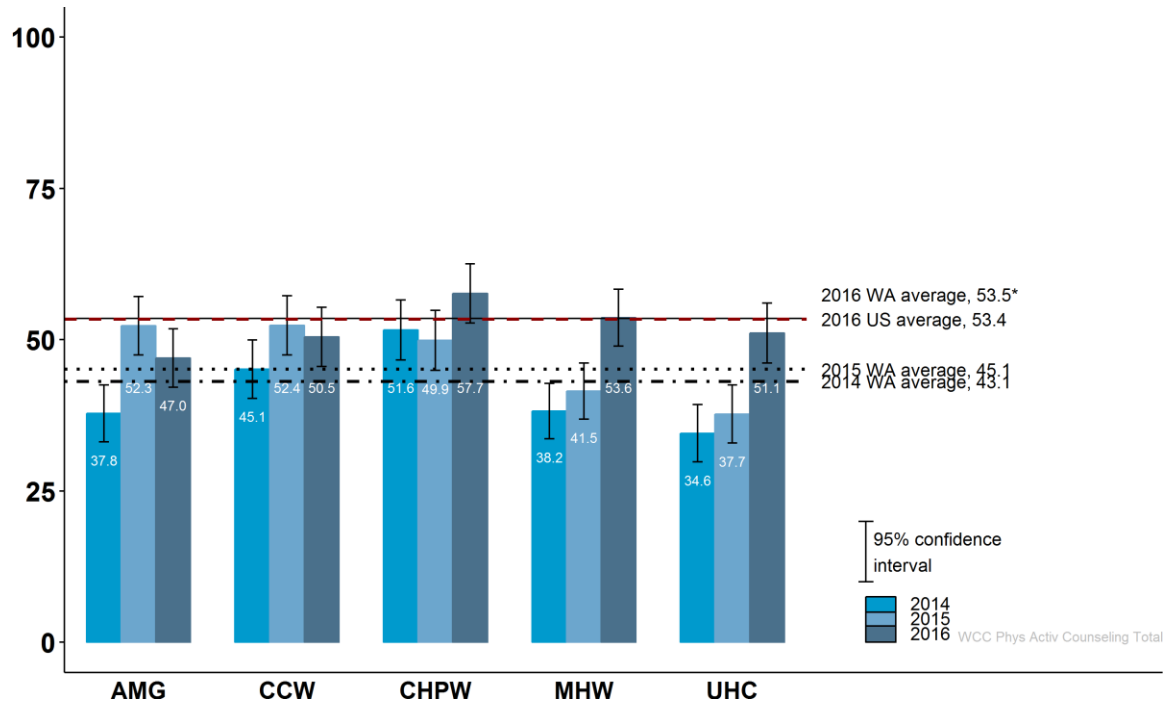


Figure 22: Percentage of Children and Adolescents Receiving Physical Activity Counseling, 2015 RY and 2016 RY



Childhood Immunizations (Before Age 2)

Performance on immunization measures dipped slightly in 2016 RY compared to 2015 RY, shown in Tables 19 and 20. The state rates for each of the individual immunizations are similar to the national averages.

Table 19: Childhood Immunization Performance, 2016 RY

Antigen	AMG	CCW	CHPW	MHW	UHC	State
DTaP	72.4%	80.0%▲	74.0%	76.2%	70.3%▼	75.4%
HiB	86.5%	91.7%▲	88.6%	89.6%	83.7%▼	88.8%
HepA	78.0%	85.7%▲	82.7%	79.7%	75.7%▼	80.6%
HepB	87.7%	91.2%▲	89.3%	89.2%	83.7%▼	88.8%
Flu	54.5%	62.1%▲	54.0%	52.8%	54.0%	54.6%
MMR	83.8%▼	89.5%	87.8%	89.0%	83.0%▼	87.8%
PCV	74.0%	83.1%▲	78.6%	78.8%	73.0%▼	78.4%
IPV	83.1%▼	91.7%▲	89.1%	90.1%	83.5%▼	88.0%
RV	67.7%	76.2%▲	68.1%	72.2%	66.9%	71.0%
VZV	83.3%	88.3%	86.4%	87.2%	83.7%	86.5%

▼▲ Performance score is significantly lower or higher than peers

Table 20: State Childhood Immunization Performance, 2014 to 2016 Reporting Years

Antigen	RY 2014 State Rate	2015 RY State Rate	2016 RY State Rate	Change 2015 RY to 2016 RY State Rate
DTaP	75.9%	76.1%	75.4%	-0.7%
IPV	89.5%	90.2%	88.0%	-2.2%
MMR	89.3%	88.4%	87.8%	-0.6%
HiB	89.8%	90.3%	88.8%	-1.5%
HepB	88.1%	90.1%	88.8%	-1.3%
VZV	88.0%	87.5%	86.5%	-1.0%
Pneumococcal	76.5%	80.2%	78.4%	-1.8%
HepA	78.3%	81.2%	80.6%	-0.5%
Rotavirus	69.0%	69.9%	71.0%	+1.2%
Influenza	55.4%	58.0%	54.6%	-3.3%

Vaccination combinations are used to determine whether all children are receiving all recommended vaccines. See the introduction to this section for more information on which vaccines are included in which combination measures.

State performance on combination 2, shown in Figure 23, increased slightly from 2015 RY to 2016 RY and is on par with the national average. State performance on combination 10 (all of the individual vaccinations included in the table above) shown in Figure 24, is above the US average driven by strong performance by CCW.

Figure 23: Percentage of Children Immunized With Combination 2, 2015 RY and 2016 RY

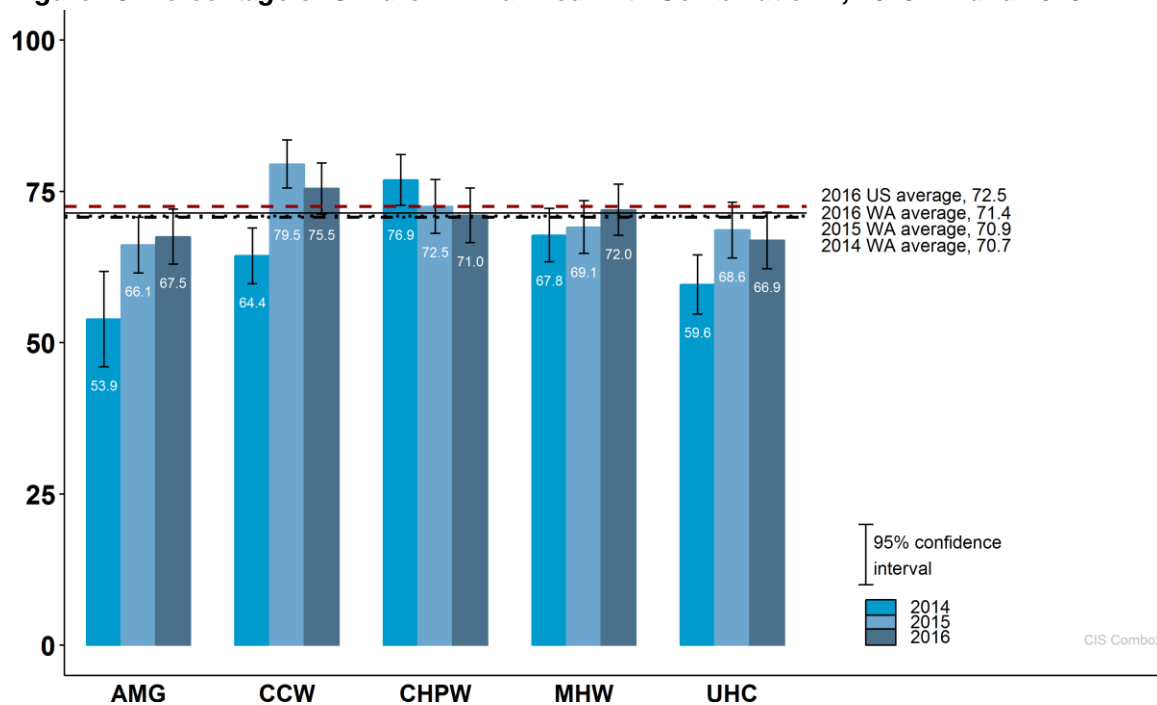
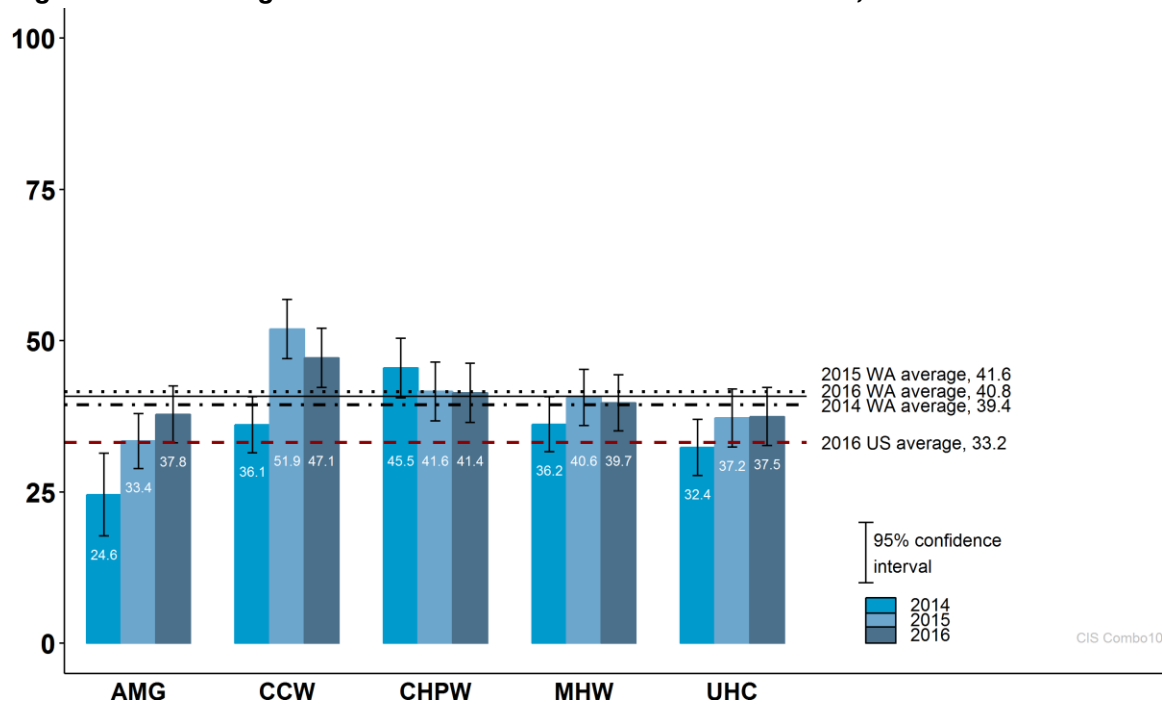


Figure 24: Percentage of Children Immunized With Combination 10, 2015 RY and 2016 RY



Adolescent Immunizations (Before Age 13)

Adolescent immunization rates remained generally constant in 2016 RY, largely maintaining the gains made in 2015 RY, as shown in Tables 20 and 21.

Adolescent immunization status is part of the Washington State Common Measure Set on Health Care Quality and Cost—2016.

Table 21: Statewide Adolescent Immunization Performance, 2014 to 2016 Reporting Years

Antigen	RY 2014 State Rate	2015 RY State Rate	2016 RY State Rate	Change 2015 RY to 2016 RY State Rate
Meningococcal	68.7	75.2	75.7	+0.5
TDap or Td	87.7	90.3	90.1	-0.2
Combination 1 (both of the above)	67.0	73.7	74.2	+0.5

Table 22: Adolescent Immunization Performance, 2016 RY

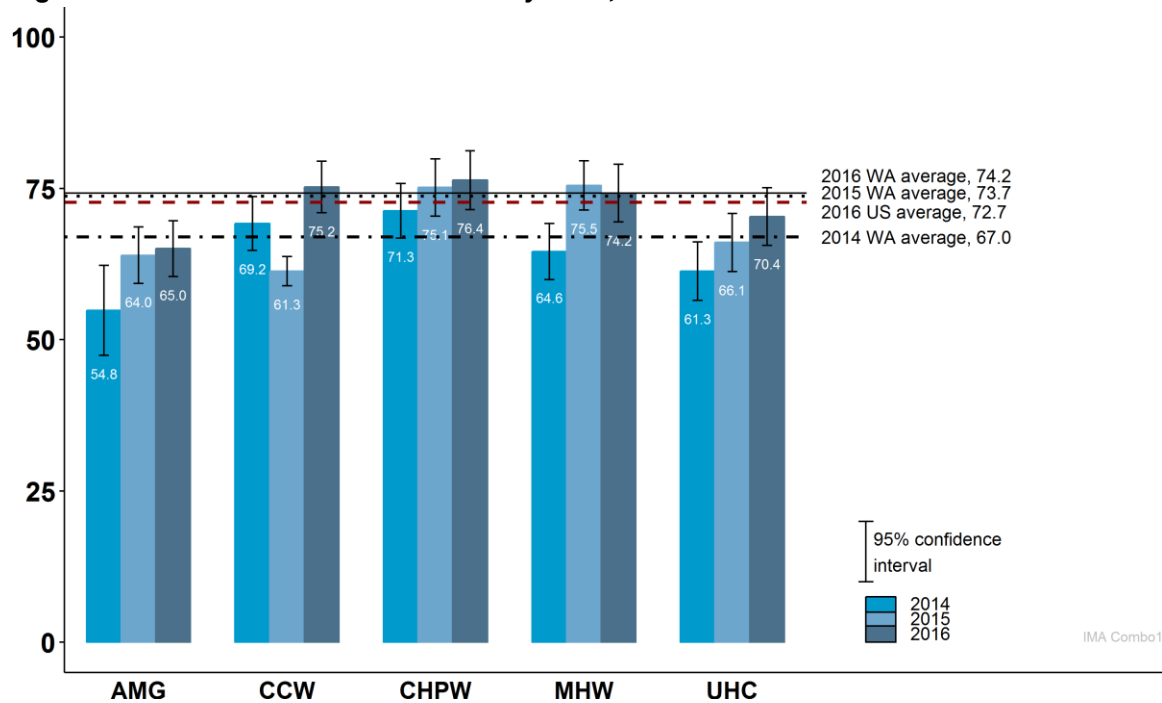
Antigen	AMG	CCW	CHPW	MHW	UHC	State
Meningococcal	▼ 66.7%	77.2%	77.6%	75.7%	72.0%	75.7%
TDaP or Td	86.8%	90.4%	91.1%	90.7%	▼ 84.4%	90.1%

▼ ▲ Performance score is significantly higher or lower than peers.

*National percentiles cannot be shown based on contract with NCQA Quality Compass.

Combination 1 indicates whether adolescents received both meningococcal and TDaP (or Td) vaccinations by age 13. The combination 1 rate, shown in Figure 25, closely mirrors the meningococcal rates, indicating that for most MCOs, improvements in combination 1 in the future might be driven by improvements in meningococcal rates.

Figure 25: Combination 1 Performance by MCO, 2015 RY and 2016 RY



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), as shown in Figures 26–28. Significant improvement is needed on all three screening measures to ensure the health and well-being of women enrolled in Apple Health.

Breast cancer screening, cervical cancer screening, and chlamydia screening are all part of the Washington State Common Measure Set on Health Care Quality and Cost—2016.

Figure 26: Percentage of Women Ages 50–74 Years Receiving Breast Cancer Screening, 2015 RY and 2016 RY

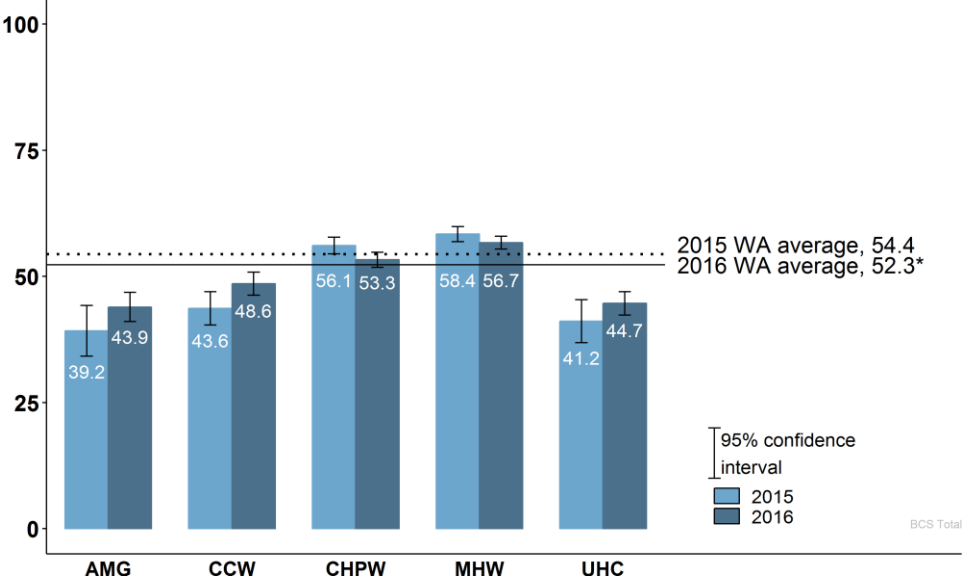


Figure 27: Percentage of Women Ages 21–64 Years Receiving Cervical Cancer Screening, 2015 RY and 2016 RY

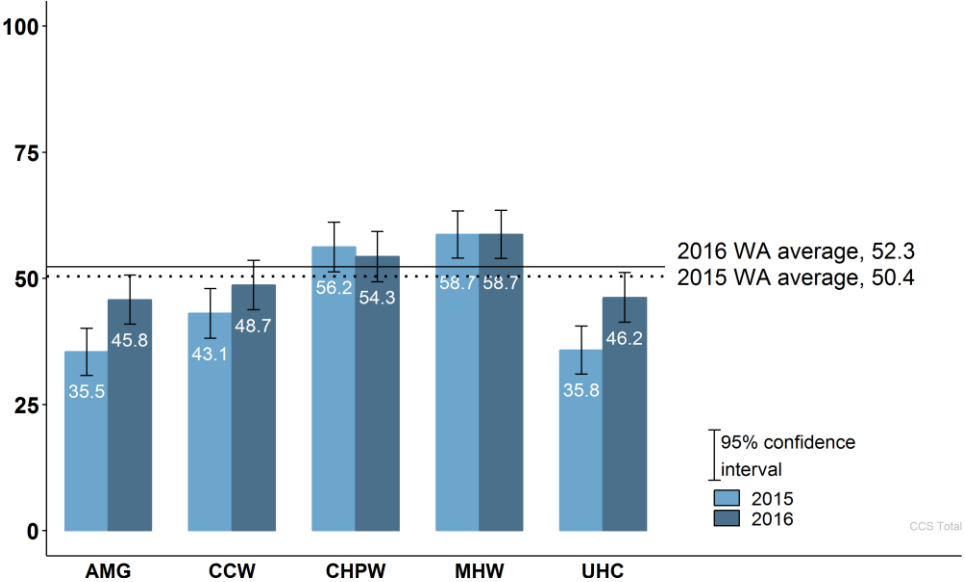
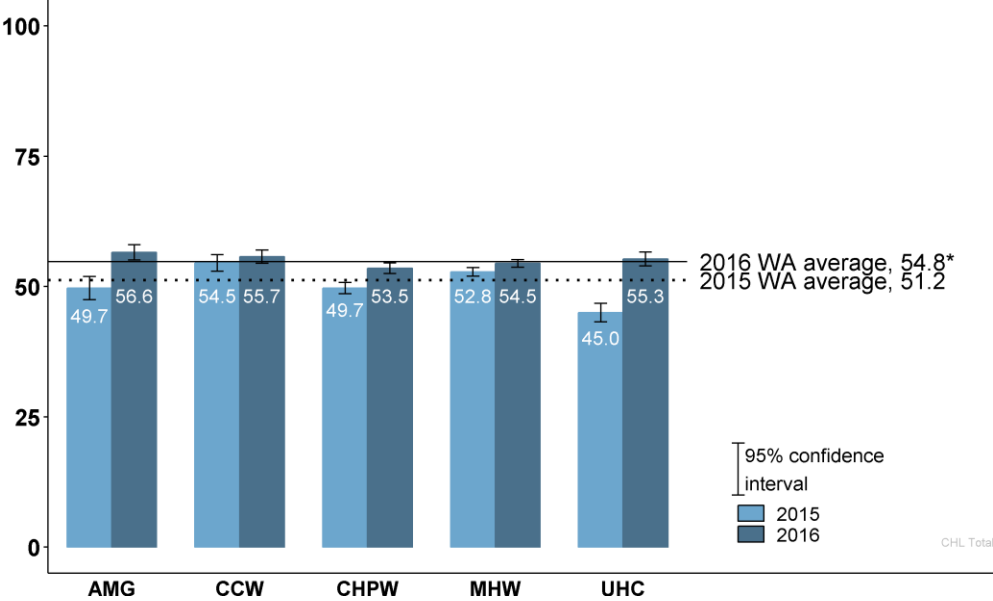
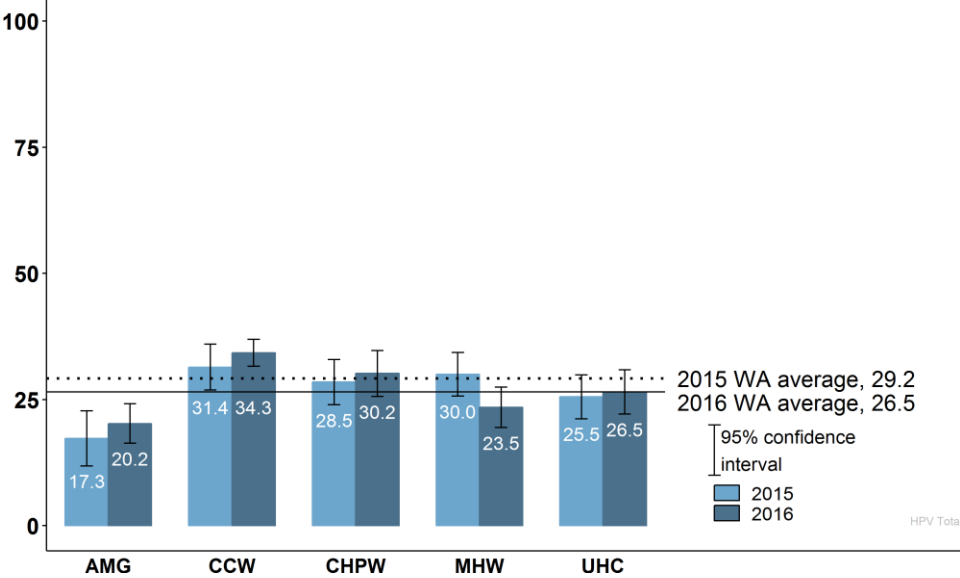


Figure 28: Percentage of Women Ages 16–24 Years Receiving Chlamydia Screening, 2015 RY and 2016 RY



Percentage of girls turning 13 receiving HPV vaccine (results shown in Figure 29) is part of the Washington State Common Measure Set on Health Care Quality and Cost—2016. However, the Common Measure Set also includes boys, who are not currently included in HEDIS data. NCQA is modifying this measure in future years to include boys. Current performance declined in 2016 RY slightly from 2015 RY, but statewide performance remains above the national average.

Figure 29: Percentage of Girls Turning 13 Receiving HPV Vaccine, 2015 RY and 2016 RY



Performance Summary

- Despite considerable progress, the state rate of the percentage of children with recorded BMI percentiles remains well below the national average.
- Performance improved significantly on physical activity and nutritional counseling for children and adolescents, putting the state rate on par with the national averages.
- Childhood vaccination rates remained constant in 2016 RY.
- Aggregate performance on all women's health screening measures (breast cancer screenings, cervical cancer screenings, and chlamydia screenings) was low.
- Apple Health MCOs' performance ensuring female adolescents receive HPV vaccinations was better than the national average.

Chronic Care Management

Adequate management of chronic conditions can delay morbidity and mortality and improve enrollee quality of life. It may also prevent more costly emergency department (ED) visits and inpatient stays.

Diabetes, in particular, is a condition that, if poorly managed, can lead to significant complications. 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.⁶ Proactive testing and management of diabetes and other conditions are important wellness goals for the state.

Reported Measures

Measures included in this section include:

- Diabetes process measures
 - HbA1c testing: presence of at least one HbA1c test during the reporting year, regardless of result
 - Eye exams: presence of at least one eye exam during the reporting 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 reporting year
- Diabetes outcome 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 reporting year are included in this category.
- Other chronic care management
 - Controlling high blood pressure: the percentage of adults ages 18–85 diagnosed with hypertension with blood pressure reading indicating adequate control according to their age group
 - Antidepressant medication management: the percentage of adults age 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 percentage of enrollees ages 5–11 and 12–17 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 6–12 years of age 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

⁶ 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 2016)

Measure Performance

Diabetes Process Measures

There are three process measures included in the comprehensive diabetes care measure (HbA1c testing, annual eye exams, and medical attention for nephropathy), shown in Figures 30–32. In 2016 RY, performance on HbA1c testing and eye exams exceeded the US average. Performance on the third measure, monitoring diabetic nephropathy, improved more than six points in 2016 RY from 2015 RY, and has almost reached the national average.

Figure 30: Percentage of Diabetic Individuals With at Least One HbA1c Test During Reporting Year, 2015 RY and 2016 RY

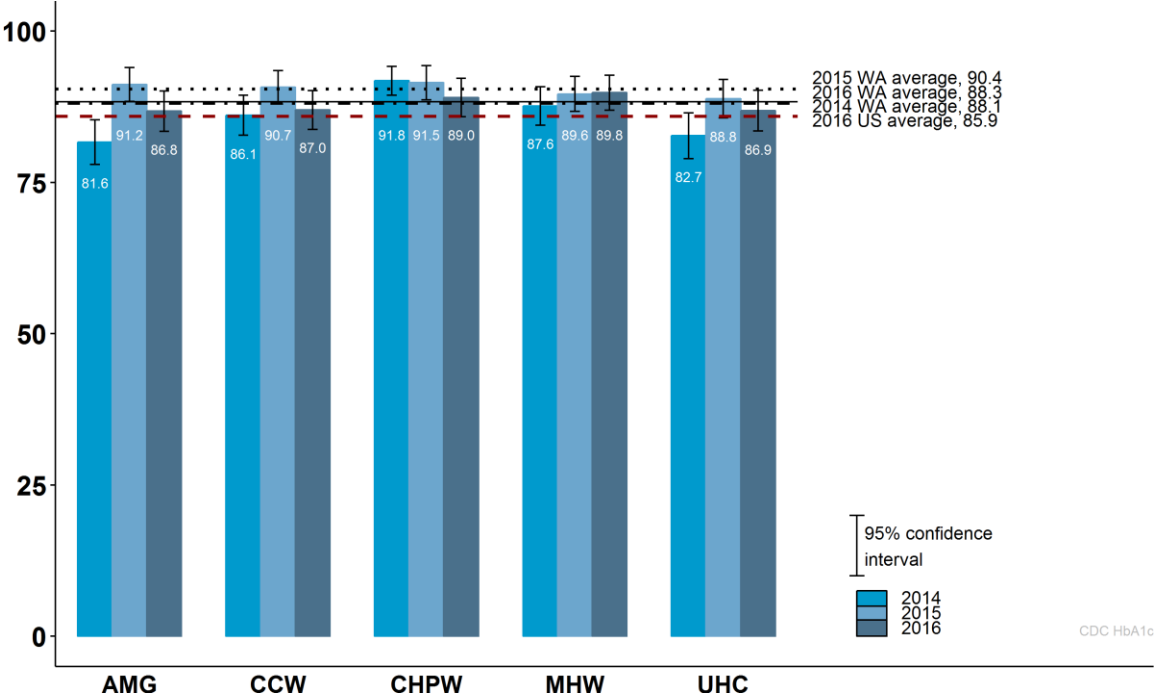


Figure 31: Percentage of Diabetic Individuals With at Least One Eye Exam During Reporting Year or Year Prior, 2015 RY and 2016 RY

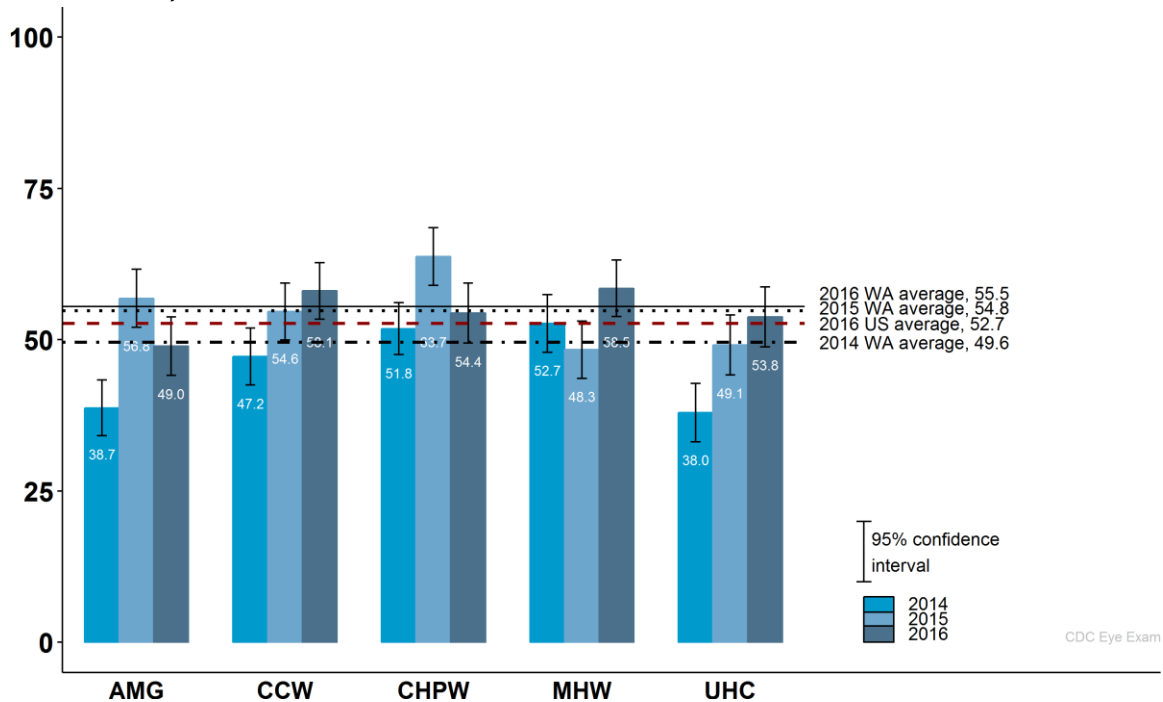
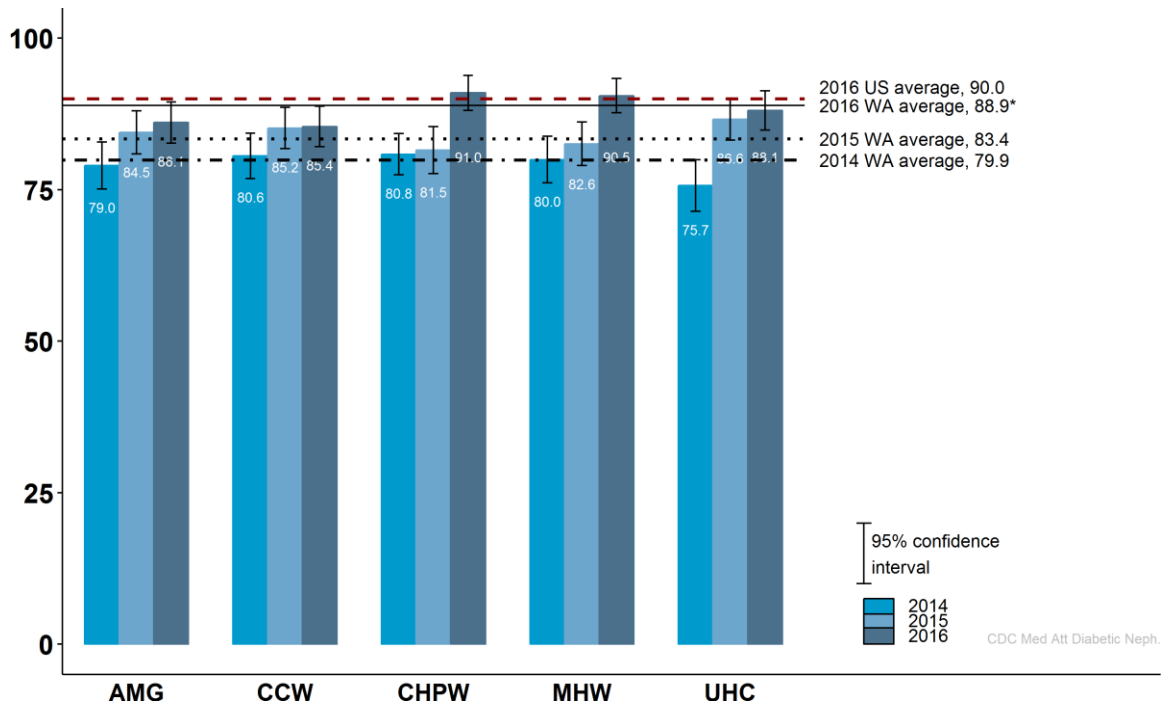


Figure 32: Percentage of Diabetic Individuals Who Received Medical Attention for Nephropathy, 2015 RY and 2016 RY



Diabetes Outcomes Measures

Three diabetes outcomes measures include 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 individuals randomly selected into the sample for each MCO (for example, the average age of enrollees or the percentage of enrollees who are disabled who are selected for review). As a result, strong or weak performance on these measures may partially reflect factors outside the direct control of the MCO. 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.

Rates of blood pressure control for diabetics remained steady at the state level, but several MCOs saw significant variation from 2015 RY performance, as shown in Figure 33. Apple Health’s rates for good HbA1c control fell in 2016 RY, and rates for poor HbA1c rose, shown in Figure 34 and Figure 35.

Figure 33: Diabetic Blood Pressure Control (<140/90), 2015 RY and 2016 RY

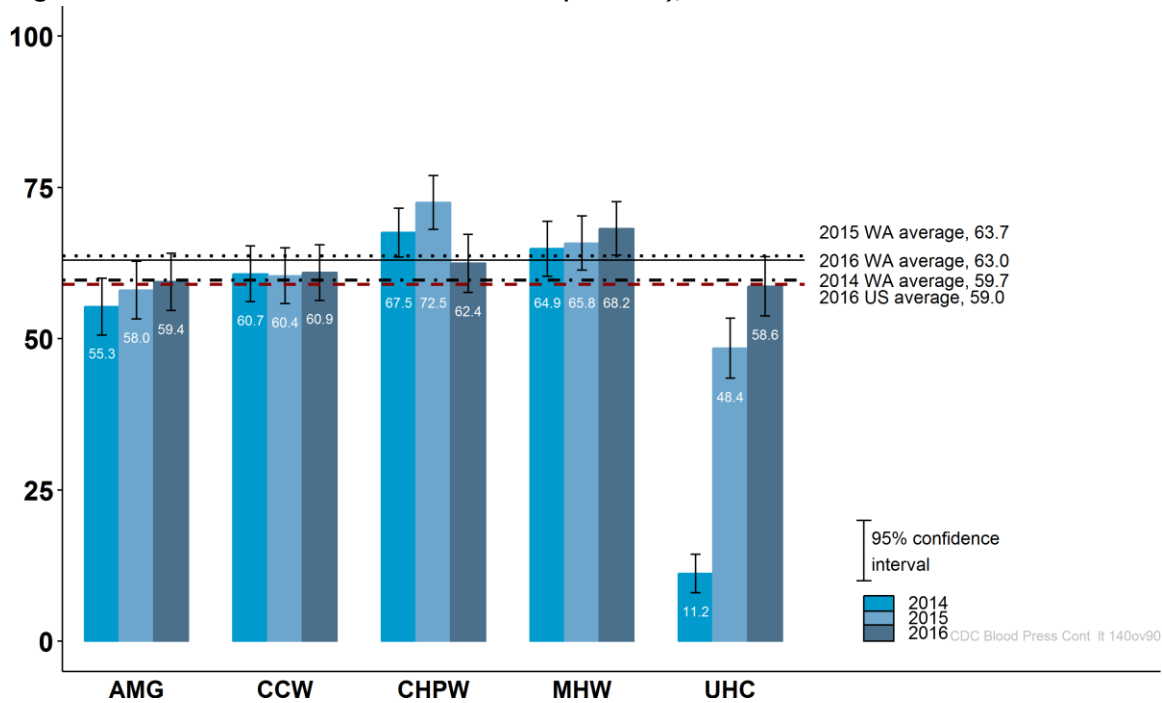


Figure 34: Percentage of Diabetic Adults With Good HbA1c Control (<8.0%), 2015 RY and 2016 RY

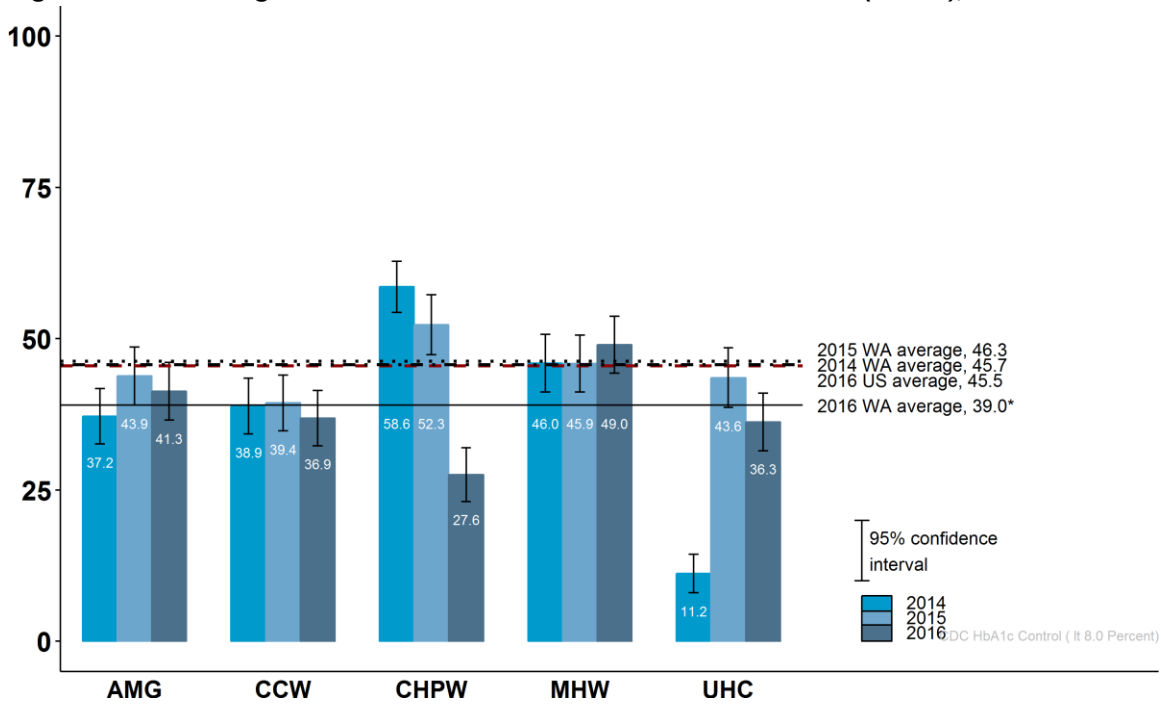
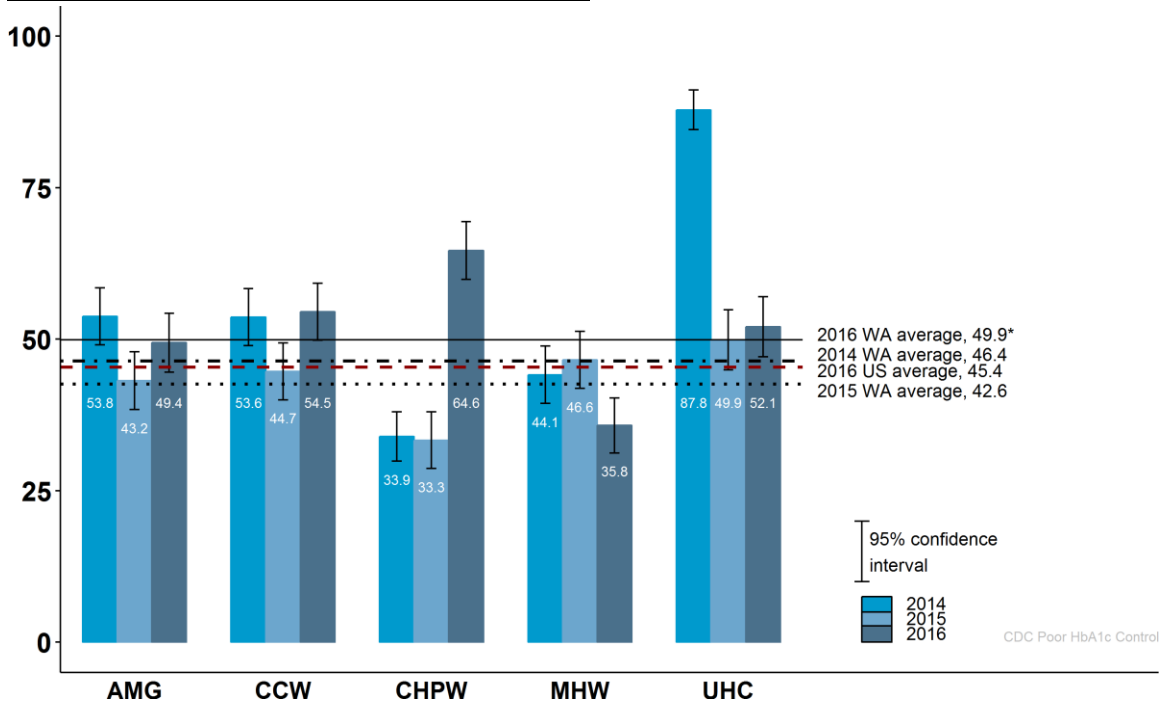


Figure 35: Percentage of Diabetic Adults With Poor HbA1c Control (>9.0%), 2015 RY and 2016 RY

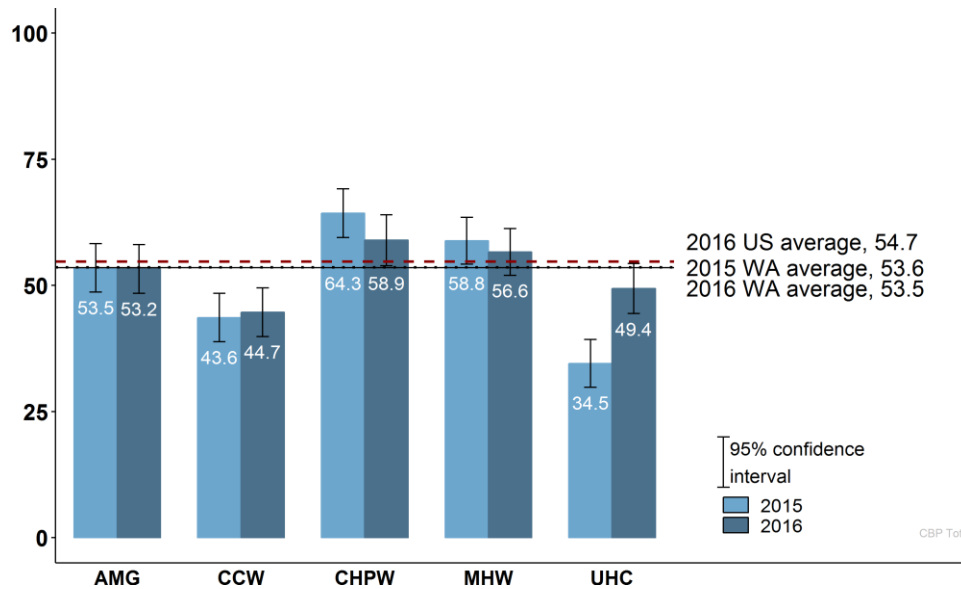
Note that a lower score is better for this measure.



Other Chronic Care Management

Blood pressure control varies significantly between MCOs, with almost 15 points separating the highest performer (CHPW) and the lowest performer (CCW), shown in Figure 36 below. 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 or obese 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.

Figure 36: Percentage of Adults Ages 18–85 Years With High Blood Pressure in Control, 2015 RY and 2016 RY



Antidepressant medication management measures are in line with national averages and show improvement from 2015 RY, shown in Figures 37 and 38. Antidepressant initiation and continuation will be important measures to monitor as the State moves forward with the integration of physical and behavioral healthcare programs.

Antidepressant medication management measures are part of the Washington State Common Measure Set on Health Care Quality and Cost—2016.

Figure 37: Percentage of Patients Ages 18 Years and Over Starting Antidepressant Medication Remaining in Treatment 12 Weeks Later, 2015 RY and 2016 RY

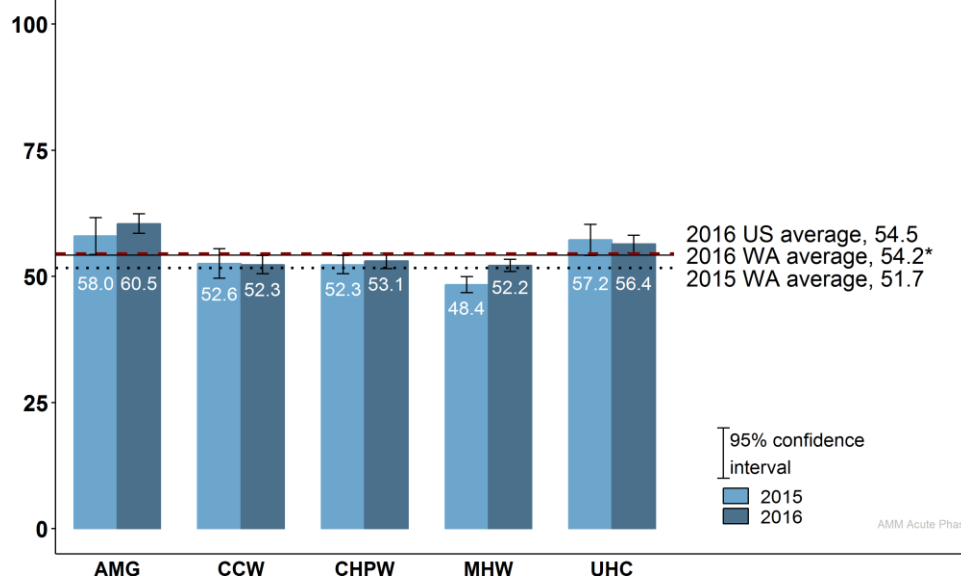
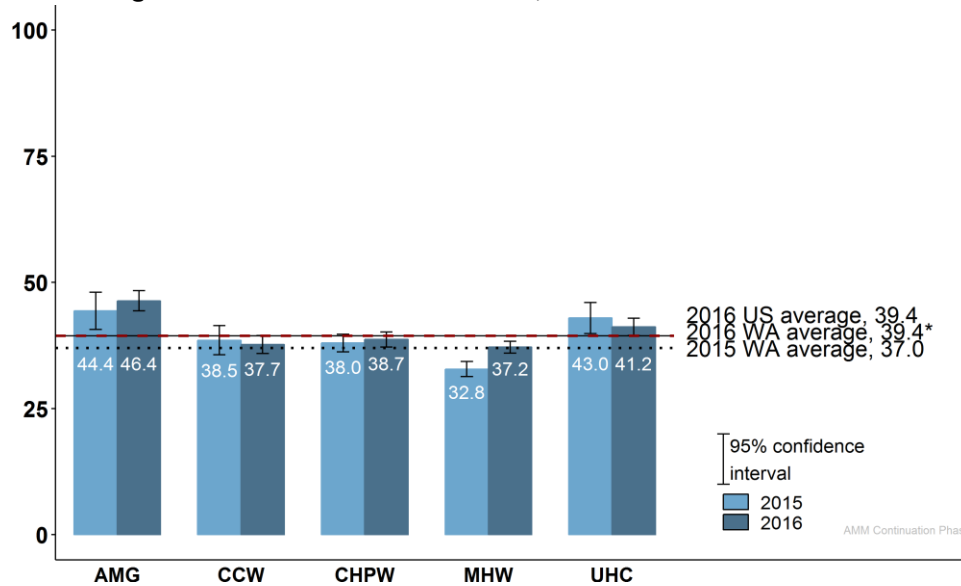


Figure 38: Percentage of Patients Ages 18 Years and Over Starting Antidepressant Medication Remaining in Treatment Six Months Later, 2015 RY and 2016 RY



Asthma medication management measures are also aligned with national averages but are qualitatively low, as shown in Figures 39 and 40. Less than a quarter of children with asthma have 75 percent compliance rates with asthma medications. Despite being in line with national benchmarks, these may be measures that present opportunities for improvement because childhood asthma attacks are leading causes of preventable emergency department use and other costs.

Asthma medication management measures are part of the Washington State Common Measure Set on Health Care Quality and Cost—2016.

Figure 39: Percentage of Asthma Patients Ages 5–11 Years Continuing Medication at Least 75% of Treatment Period, 2015 RY and 2016 RY

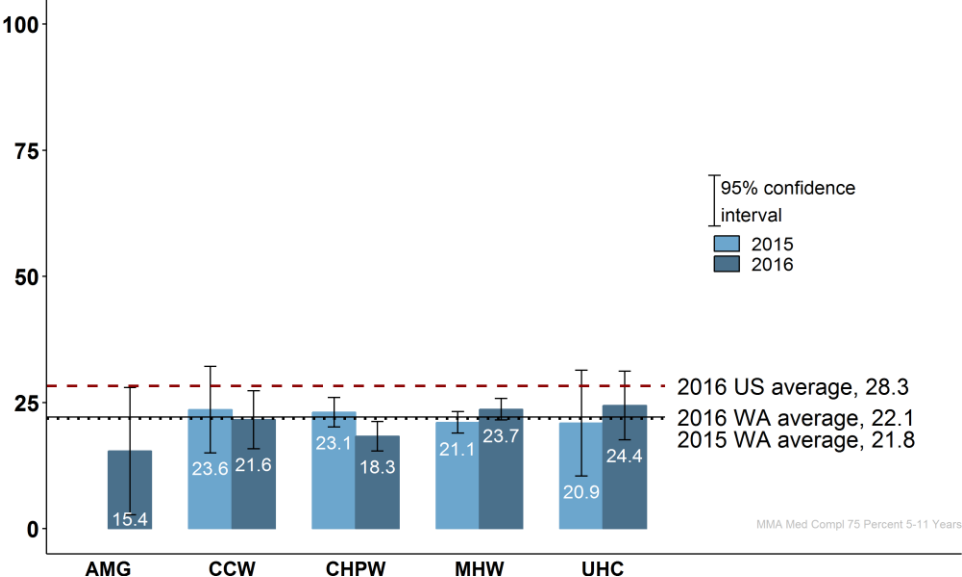
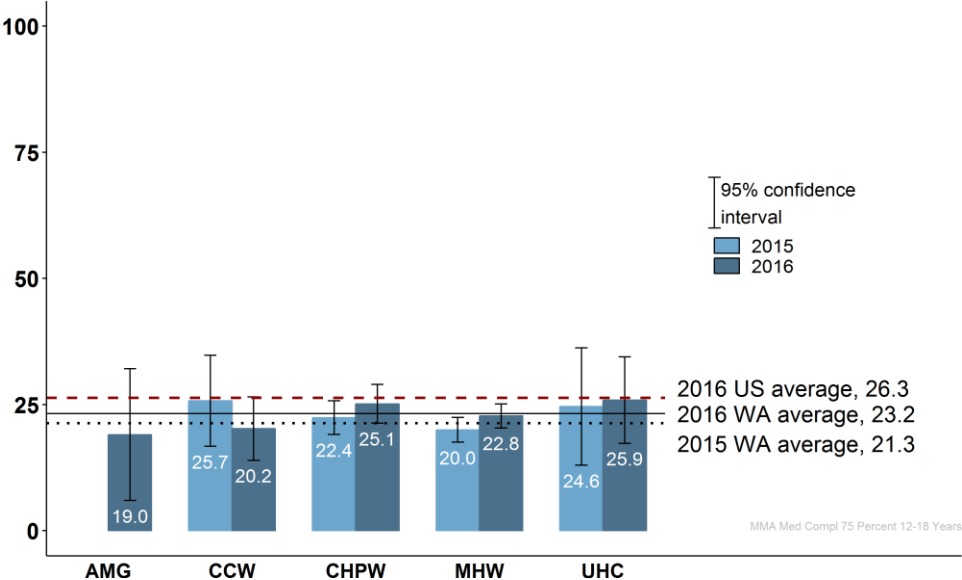
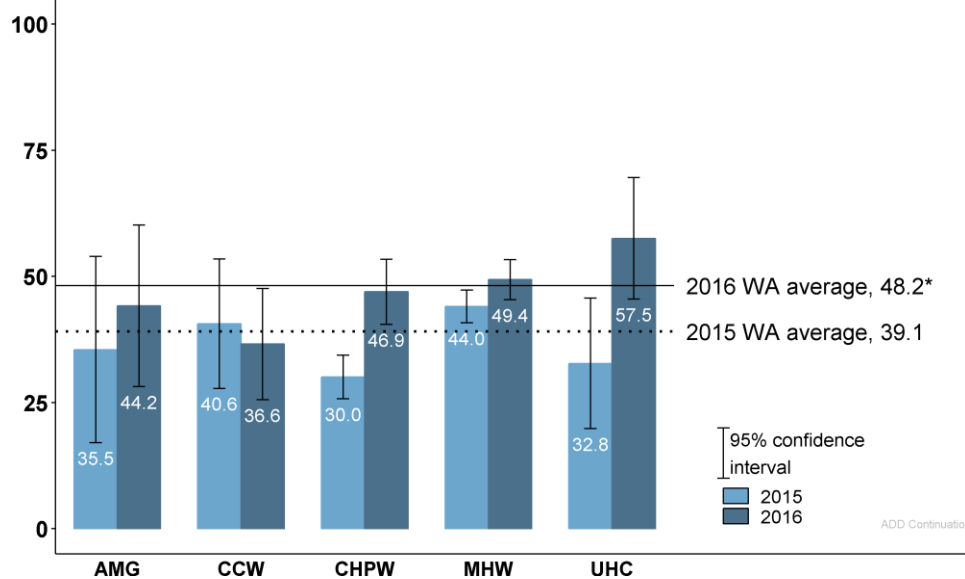


Figure 40: Percentage of Asthma Patients Ages 12–18 Years Continuing Medication at Least 75% of Treatment Period, 2015 RY and 2016 RY



The state saw significant increases in the rate of appropriate ADHD monitoring in 2016 RY driven by increases by four of the five MCOs. However, state performance still falls several points below the national average, shown in Figure 41.

Figure 41: Percentage of ADHD Patients With at Least One Visit During Treatment Continuation Phase, 2015 RY and 2016 RY



Performance Summary

- Apple Health diabetes process measures were generally strong in 2016 RY.
- Diabetes outcomes measures declined compared to 2015 RY, which may have been a result of the inclusion of the Medicaid expansion population, many of whom may not previously have had access to adequate care. These will be important measures to continue to monitor in future years.
- The state rate of blood pressure control is comparable to the national average.
- Antidepressant medication performance is aligned with the national average; this will be an important measure to monitor as the State moves forward with behavioral and physical health integration.
- Overall asthma medication compliance is in line with the national average but still may present an opportunity for improvement given compliance rates are less than 25 percent and asthma is a key driver of avoidable emergency department use.
- ADHD medication monitoring is lower than the national average, indicating an opportunity for all MCOs to improve care.

Medical Care Utilization

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 expenses 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 components of controlling costs:

Preventing Waste

Seventy-two percent of physicians say they believe the average medical doctor prescribes an unnecessary test or procedure at least once per week.⁷ 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.⁸ In this report we include MCO performance on three of the Choosing Wisely measures. *[Note: The Washington Health Alliance reports as one combined measure the two HEDIS measures on antibiotics for acute bronchitis and antibiotics for upper respiratory infection.]*

Reducing Hospital Utilization

Nearly one-third of all healthcare spending in the United States is spent on inpatient care.⁹ Research suggests that nearly 10 percent of all inpatient stays are potentially avoidable with better outpatient monitoring of chronic conditions or better outpatient access to after-hours care for acute conditions.¹⁰

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

⁷ “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 www.choosingwisely.org/wp-content/uploads/2015/04/Final-Choosing-Wisely-Survey-Report.pdf (Accessed Oct 9 2016).

⁸ “Less Waste. Less Harm. Choosing Wisely[®] in Washington State.” Washington Health Alliance. August 2016. Available at <http://wahealthalliance.org/wp-content/uploads.php?link-year=2016&link-month=08&link=2016-choosing-wisely-washington-state-report.pdf> (Accessed Oct 12 2016).

⁹ Weiss, AJ, et al. “Trends and Projections in Inpatient Hospital Costs and Utilization, 2003-2013.” HCUP Statistical Brief #175. July 2014. Available at www.hcup-us.ahrq.gov/reports/statbriefs/sb175-Hospital-Cost-Utilization-Projections-2013.pdf (Accessed Oct 12 2016).

¹⁰ Stranges, E, et al. “Potentially Preventable Hospitalizations for Acute and Chronic Conditions, 2008.” HCUP Statistical Brief # 99. November 2010. Available at www.hcup-us.ahrq.gov/reports/statbriefs/sb99.pdf (Accessed Oct 12 2016).

- Ambulatory care utilization
 - Outpatient visits per 1,000 member months
 - Emergency department (ED) visits per 1,000 member months
- Inpatient utilization
 - Inpatient discharges per 1,000 member months

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 were higher than national averages for all three measures of appropriate utilization (meaning MCOs did a *better* job of ensuring individuals did *not* receive inappropriate care). There remain high rates of inappropriate antibiotic prescribing for acute bronchitis, a surprising contrast to the low rate of inappropriate antibiotic prescribing for upper respiratory infections. Additional provider and enrollee 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 in Tables 23 and 24, higher scores indicate better performance (i.e., a higher percentage of individuals did not receive inappropriate care).

Table 23: MCO Performance on Inappropriate Care Measures, 2016 RY

Measure	AMG	CCW	CHPW	MHW	UHC	State
Imaging for Low-Back Pain	76.0%	78.5%▲	76.4%	76.3%	74.4%▼	76.3%
Antibiotics for Acute Bronchitis	32.7%	33.6%▲	31.2%	28.7%▼	28.9%	30.3%
Antibiotics for Upper Respiratory Infection	93.8%	93.4%	94.0%▲	93.4%	92.3%▼	93.5%
Appropriate Testing for Children with Pharyngitis	70.9%	55.9%▼	68.4%	70.7%▲	69.7%	68.1%

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

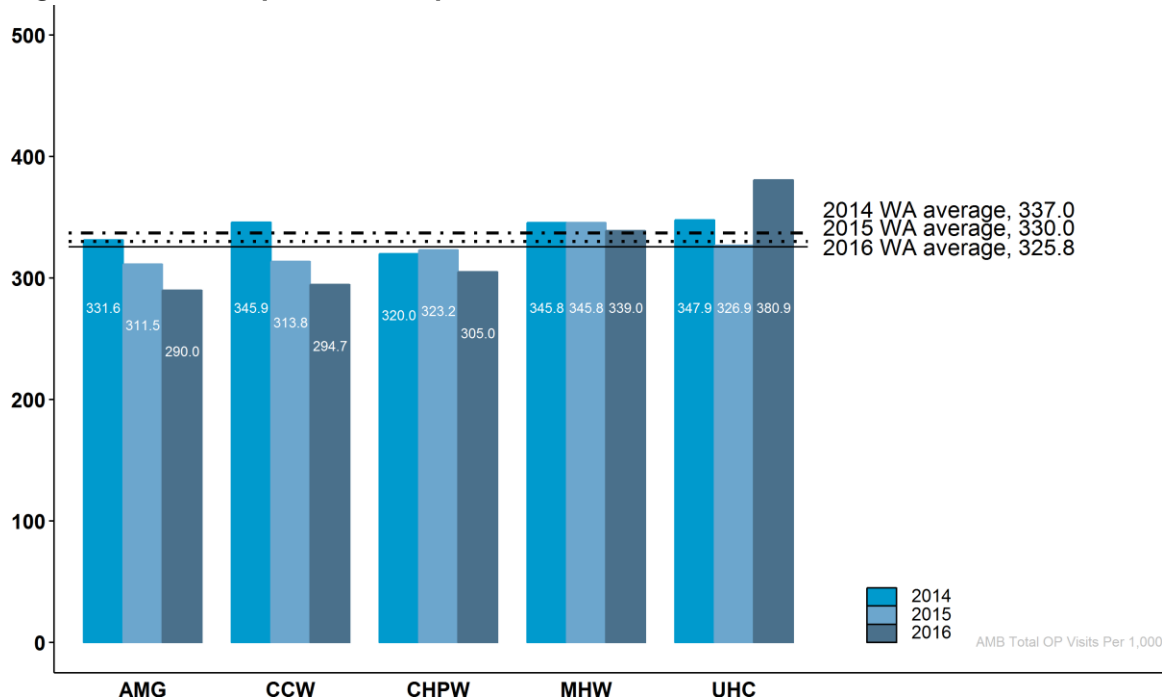
Table 24: State Performance on Inappropriate Care Measures, 2015 RY and 2016 RY

Measure	2015 RY State Rate	2016 RY State Rate	Change between 2015 RY and 2016 RY
Appropriate Testing for Children with Pharyngitis	64.7%	68.1%	+3.5%
Antibiotics for Upper Respiratory Infection	92.6%	93.5%	+0.9%
Antibiotics for Acute Bronchitis	29.3%	30.3%	+1.0%
Imaging for Low-Back Pain	77.7%	76.3%	-1.4%

Ambulatory Care Utilization

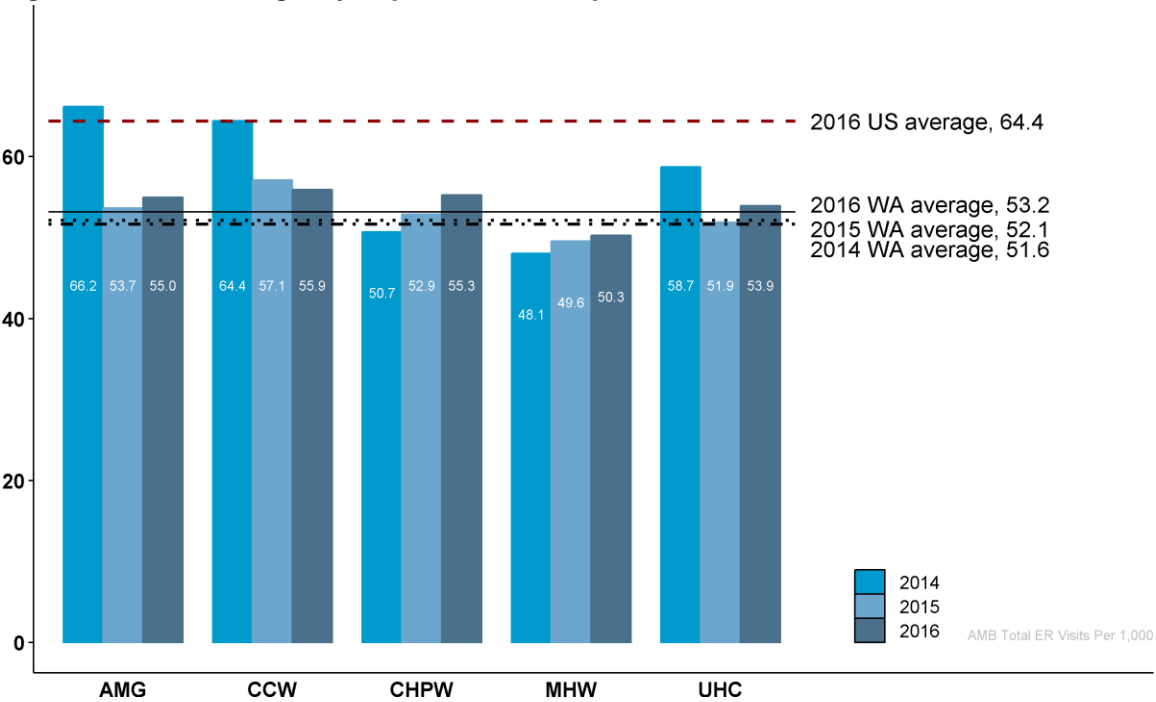
Ambulatory care utilization (visits) ranged from 290.0 (AMG) to 380.9 (UHC) per 1,000 member months. (For an individual enrolled with a plan for the entire year, this would translate to approximately 3.48 to 4.57 visits per year on average.) Outpatient visits declined for each MCO except UHC, which experienced a significant increase. Variations between MCOs may be due to differing demographics, network sizes, specialist referral policies, or care management services offered by MCOs. UHC’s significant increase may indicate the need for a root cause analysis to determine factors driving that change. Results for this measure are shown in Figure 42.

Figure 42: Total Outpatient Visits per 1,000 Member Months, 2015 RY and 2016 RY



ED visit rates are difficult to interpret without additional analyses of enrollee demographics. It is possible that an MCO may have high ED visit rates because of significant enrollee acuity, but it is also possible that high ED rates can be attributed to lack of access to primary or specialty providers. Overall, Apple Health enrollees had significantly fewer ED visits per 1,000 member months than the national average, as shown in Figure 43. MCOs ranged from 50.3 to 55.9 ED visits per 1,000 member months. (For an individual enrolled all year in a plan, that would translate into 0.60 to 0.67 ED visits per year.)

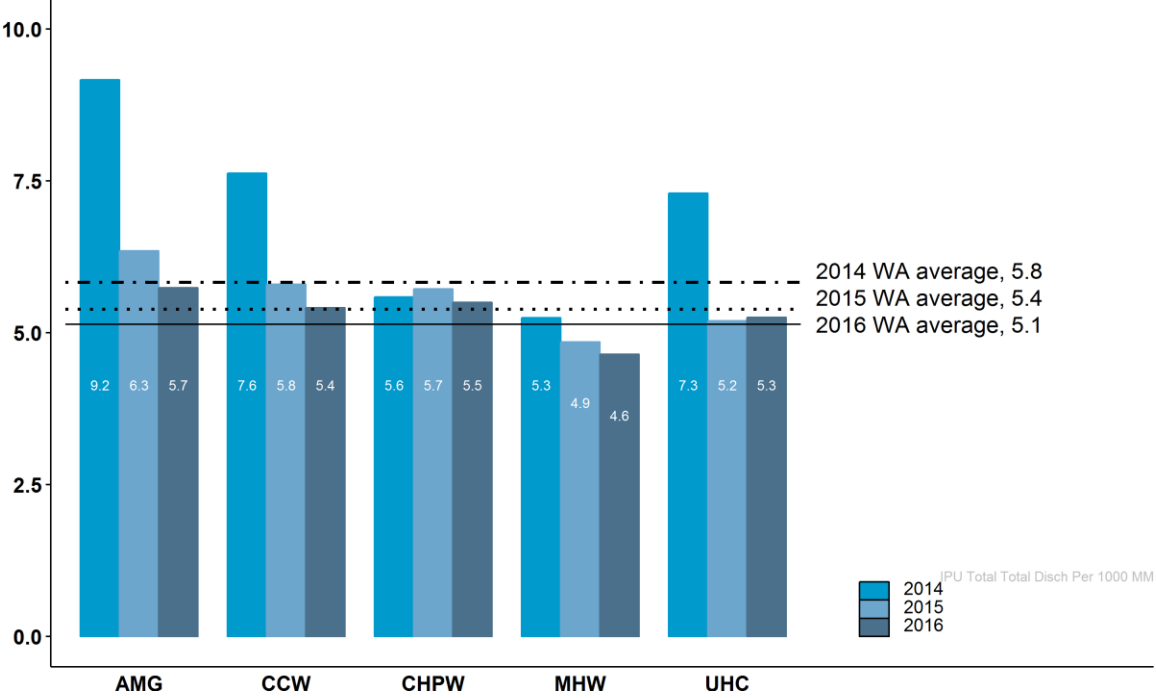
Figure 43: Total Emergency Department Visits per 1,000 Member Months, 2015 RY and 2016 RY



Inpatient Utilization

Total inpatient utilization is significantly below the national average, reflecting good performance by Apple Health MCOs for reducing unnecessary hospitalization (Figure 44). It is difficult to compare inpatient utilization rates between MCOs because each MCO serves a distinct patient population; enrollees in different MCOs do not necessarily have the same risk profiles. It is notable, however, that MHW has the highest rates of adult and child and adolescent access to primary care and the lowest rates of inpatient utilization and ED visits.

Figure 44: Total Inpatient Discharges per 1,000 Member Months, 2015 RY and 2016 RY



Performance Summary

- Inpatient and ED use among Apple Health enrollees is lower than the national averages, which is important for limiting future cost growth. However, there may still be room to further decrease these rates with optimal primary care utilization.

Appendix A: MCO Performance Summaries

Amerigroup Washington (AMG)	A-1
Coordinated Care Washington (CCW)	A-2
Community Health Plan of Washington (CHPW)	A-3
Molina Healthcare of Washington (MHW)	A-4
United Healthcare Community Plan (UHC)	A-5

Amerigroup Washington (AMG)

Access to Care

Primary care visits

Adults' access (20-44 yrs)	64.7%		Children's access (12-24 mths)	95.9%	▲
Adults' access (45-64 yrs)	75.8%	▼	Children's access (25 mths-6 yrs)	80.9%	▼
Adults' access (total)	68.8%	▼	Children's access (7-11 yrs)	86.9%	
			Children's access (12-19 yrs)	87.3%	

Maternal health visits

Timeliness of prenatal care	67.1%	
Frequency of prenatal care	42.6%	▲
Postpartum care	56.7%	

Well-child visits

0-15 months, 6+ visits	68.4%	▲
3-6 yrs, annual visit	61.9%	
12-21 yrs, semi-annual visit	39.7%	

Preventive Care

Women's health screenings

Breast cancer screening	43.9%	▼
Cervical cancer screening	45.8%	▼
Chlamydia screening	56.6%	▲

Weight assessment and counseling

Children's BMI percentile assessment	45.8%	▲
Children's nutritional counseling	51.6%	▼
Children's physical activity counseling	47.0%	▼
Adult BMI percentile assessment	84.9%	

Children's immunizations

Combo 2	67.5%	
Combo 10	37.8%	

Adolescents' immunizations

Adolescent Combo 1	65.0%	▼
HPV vaccination before 13 years	20.2%	▼

Chronic Care Management

Diabetes care

HbA1c testing	86.8%	
Eye examinations	49.0%	▼
Medical attention for nephropathy	86.1%	
Good HbA1c control	41.3%	
Poor HbA1c control *	49.4%	
Blood pressure control	59.4%	
Diabetes screening - schizophrenia/bipol	85.6%	
Diabetes monitoring - schizophrenia/bipo	61.0%	

Other chronic care management

Asthma medication 5-11 yrs - 75% complianc	32.3%	
Asthma medication 12-18 yrs - 75% compliar	72.4%	
COPD medication - bronchodialator	83.3%	
Antidepressant medication - acute	60.5%	▲
Antidepressant medication - continuation	46.4%	▲
ADHD medication follow-up - initial	39.6%	
ADHD medication follow-up - continuing	44.2%	
Medication adherence - schizophrenia	59.8%	▼
Controlling high blood pressure	53.2%	

Appropriateness of Care

Appropriateness of treatments

Antibiotics for URI infections (children)	92.5%	
Antibiotics for acute bronchitis (adults)	37.4%	▲
Children pharyngitis	71.5%	▲
Imaging for lower back pain	71.3%	▼

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

* Lower rate is better performance

Coordinated Care Washington (CCW)

Access to Care

Primary care visits

Adults' access (20-44 yrs)	65.6%	Children's access (12-24 mths)	96.4% ▲
Adults' access (45-64 yrs)	76.0% ▼	Children's access (25 mths-6 yrs)	86.7% ▲
Adults' access (total)	69.4%	Children's access (7-11 yrs)	92.0% ▲
		Children's access (12-19 yrs)	90.1% ▲

Maternal health visits

Timeliness of prenatal care	70.2%
Frequency of prenatal care	36.4%
Postpartum care	55.2%

Well-child visits

0-15 months, 6+ visits	68.9% ▲
3-6 yrs, annual visit	64.4%
12-21 yrs, semi-annual visit	38.9%

Preventive Care

Women's health screenings

Breast cancer screening	48.6% ▼
Cervical cancer screening	48.7%
Chlamydia screening	55.7%

Weight assessment and counseling

Children's BMI percentile assessment	21.0% ▼
Children's nutritional counseling	52.4% ▼
Children's physical activity counseling	50.5%
Adult BMI percentile assessment	86.4%

Children's immunizations

Combo 2	75.5% ▲
Combo 10	47.1% ▲

Adolescents' immunizations

Adolescent Combo 1	75.2%
HPV vaccination before 13 years	34.3% ▲

Chronic Care Management

Diabetes care

HbA1c testing	87.0%
Eye examinations	58.1%
Medical attention for nephropathy	85.4% ▼
Good HbA1c control	36.9%
Poor HbA1c control *	54.5%
Blood pressure control	60.9%
Diabetes screening - schizophrenia/bipol	83.8%
Diabetes monitoring - schizophrenia/bipo	66.7%

Other chronic care management

Asthma medication 5-11 yrs - 75% complianc	31.3%
Asthma medication 12-18 yrs - 75% compliar	73.9%
COPD medication - bronchodialator	86.5%
Antidepressant medication - acute	52.3% ▼
Antidepressant medication - continuation	37.7% ▼
ADHD medication follow-up - initial	33.3% ▼
ADHD medication follow-up - continuing	36.6% ▼
Medication adherence - schizophrenia	65.1%
Controlling high blood pressure	44.7% ▼

Appropriateness of Care

Appropriateness of treatments

Antibiotics for URI infections (children)	91.7% ▼
Antibiotics for acute bronchitis (adults)	26.9%
Children pharyngitis	46.4% ▼
Imaging for lower back pain	79.3%

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

* Lower rate is better performance

Community Health Plan of Washington (CHPW)

Access to Care

Primary care visits

Adults' access (20-44 yrs)	71.8%	Children's access (12-24 mths)	74.7% ▼
Adults' access (45-64 yrs)	81.5% ▲	Children's access (25 mths-6 yrs)	62.3% ▼
Adults' access (total)	75.5% ▲	Children's access (7-11 yrs)	73.7% ▼
		Children's access (12-19 yrs)	75.7% ▼

Maternal health visits

Timeliness of prenatal care	54.5% ▼
Frequency of prenatal care	23.1% ▼
Postpartum care	47.0% ▼

Well-child visits

0-15 months, 6+ visits	42.4% ▼
3-6 yrs, annual visit	62.1%
12-21 yrs, semi-annual visit	43.8%

Preventive Care

Women's health screenings

Breast cancer screening	53.3%
Cervical cancer screening	54.3%
Chlamydia screening	53.5% ▼

Weight assessment and counseling

Children's BMI percentile assessment	51.8% ▲
Children's nutritional counseling	57.7%
Children's physical activity counseling	57.7% ▲
Adult BMI percentile assessment	78.7% ▼

Children's immunizations

Combo 2	71.0%
Combo 10	41.4%

Adolescents' immunizations

Adolescent Combo 1	76.4%
HPV vaccination before 13 years	30.2%

Chronic Care Management

Diabetes care

HbA1c testing	89.0%
Eye examinations	54.4%
Medical attention for nephropathy	91.0%
Good HbA1c control	27.6% ▼
Poor HbA1c control *	64.6% ▲
Blood pressure control	62.4%
Diabetes screening - schizophrenia/bipol	86.6%
Diabetes monitoring - schizophrenia/bipo	74.5%

Other chronic care management

Asthma medication 5-11 yrs - 75% complianc	29.0%
Asthma medication 12-18 yrs - 75% compliar	75.3%
COPD medication - bronchodialator	85.5%
Antidepressant medication - acute	53.1%
Antidepressant medication - continuation	38.7%
ADHD medication follow-up - initial	30.5% ▼
ADHD medication follow-up - continuing	46.9%
Medication adherence - schizophrenia	69.0%
Controlling high blood pressure	58.9% ▲

Appropriateness of Care

Appropriateness of treatments

Antibiotics for URI infections (children)	93.0%
Antibiotics for acute bronchitis (adults)	32.5% ▲
Children pharyngitis	65.8%
Imaging for lower back pain	78.0%

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

* Lower rate is better performance

Molina Healthcare of Washington (MHW)

Access to Care

Primary care visits

Adults' access (20-44 yrs)	79.4%	▲	Children's access (12-24 mths)	97.5%
Adults' access (45-64 yrs)	85.4%		Children's access (25 mths-6 yrs)	88.8% ▲
Adults' access (total)	81.3%	▲	Children's access (7-11 yrs)	92.8% ▲
			Children's access (12-19 yrs)	92.6% ▲

Maternal health visits

Timeliness of prenatal care	75.2%	▲
Frequency of prenatal care	51.7%	▲
Postpartum care	51.3%	

Well-child visits

0-15 months, 6+ visits	62.7%
3-6 yrs, annual visit	69.7% ▲
12-21 yrs, semi-annual visit	44.4%

Preventive Care

Women's health screenings

Breast cancer screening	56.7%	▲
Cervical cancer screening	58.7%	▲
Chlamydia screening	54.5%	

Weight assessment and counseling

Children's BMI percentile assessment	50.3%	▲
Children's nutritional counseling	57.6%	
Children's physical activity counseling	53.6%	
Adult BMI percentile assessment	90.1%	▲

Children's immunizations

Combo 2	72.0%	
Combo 10	39.7%	

Adolescents' immunizations

Adolescent Combo 1	74.2%	
HPV vaccination before 13 years	23.5%	▼

Chronic Care Management

Diabetes care

HbA1c testing	89.8%	
Eye examinations	58.5%	
Medical attention for nephropathy	90.5%	
Good HbA1c control	49.0%	▲
Poor HbA1c control *	35.8%	▼
Blood pressure control	68.2%	▲
Diabetes screening - schizophrenia/bipol	85.6%	
Diabetes monitoring - schizophrenia/bipo	66.7%	

Other chronic care management

Asthma medication 5-11 yrs - 75% complianc	28.3%	▼
Asthma medication 12-18 yrs - 75% compliar	74.0%	
COPD medication - bronchodialator	85.5%	
Antidepressant medication - acute	52.2%	▼
Antidepressant medication - continuation	37.2%	▼
ADHD medication follow-up - initial	42.6%	▲
ADHD medication follow-up - continuing	49.4%	
Medication adherence - schizophrenia	70.5%	▲
Controlling high blood pressure	56.6%	▲

Appropriateness of Care

Appropriateness of treatments

Antibiotics for URI infections (children)	92.8%	
Antibiotics for acute bronchitis (adults)	27.7%	▼
Children pharyngitis	67.9%	▲
Imaging for lower back pain	79.1%	▲

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

* Lower rate is better performance

United Healthcare Community Plan (UHC)

Access to Care

Primary care visits

Adults' access (20-44 yrs)	68.3%	▼	Children's access (12-24 mths)	96.2%	▲
Adults' access (45-64 yrs)	79.2%	▼	Children's access (25 mths-6 yrs)	87.5%	▲
Adults' access (total)	72.5%	▼	Children's access (7-11 yrs)	92.5%	▲
			Children's access (12-19 yrs)	91.5%	▲

Maternal health visits

Timeliness of prenatal care	67.9%
Frequency of prenatal care	34.5%
Postpartum care	56.7%

Well-child visits

0-15 months, 6+ visits	64.5%
3-6 yrs, annual visit	67.0%
12-21 yrs, semi-annual visit	44.5%

Preventive Care

Women's health screenings

Breast cancer screening	44.7%	▼
Cervical cancer screening	46.2%	▼
Chlamydia screening	55.3%	

Weight assessment and counseling

Children's BMI percentile assessment	38.2%	
Children's nutritional counseling	64.2%	▲
Children's physical activity counseling	51.1%	
Adult BMI percentile assessment	80.8%	▼

Children's immunizations

Combo 2	66.9%
Combo 10	37.5%

Adolescents' immunizations

Adolescent Combo 1	70.4%
HPV vaccination before 13 years	26.5%

Chronic Care Management

Diabetes care

HbA1c testing	86.9%	
Eye examinations	53.8%	
Medical attention for nephropathy	88.1%	
Good HbA1c control	36.3%	
Poor HbA1c control *	52.1%	
Blood pressure control	58.6%	
Diabetes screening - schizophrenia/bipol	85.8%	
Diabetes monitoring - schizophrenia/bipo	78.2%	▲

Other chronic care management

Asthma medication 5-11 yrs - 75% complianc	39.8%	▲
Asthma medication 12-18 yrs - 75% compliar	77.0%	
COPD medication - bronchodialator	83.2%	
Antidepressant medication - acute	56.4%	▲
Antidepressant medication - continuation	41.2%	▲
ADHD medication follow-up - initial	44.8%	▲
ADHD medication follow-up - continuing	57.5%	
Medication adherence - schizophrenia	66.5%	
Controlling high blood pressure	49.4%	

Appropriateness of Care

Appropriateness of treatments

Antibiotics for URI infections (children)	92.3%	▼
Antibiotics for acute bronchitis (adults)	28.9%	
Children pharyngitis	69.7%	
Imaging for lower back pain	74.4%	▼

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

* Lower rate is better performance

Appendix B: HEDIS Performance Measure Tables

Please see separate attached document for Appendix B.