2016 Regional Analysis Report

Washington Apple Health

Washington Health Care Authority

December 2016

QUALIS HEALTH™

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

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

Qualis Health is one of the nation's leading population health management organizations, and a leader in improving care delivery and patient outcomes, working with clients throughout the public and private sectors to advance the quality, efficiency and value of healthcare for millions of Americans every day. We deliver solutions to ensure that our partners transform the care they provide, with a focus on process improvement, care management and effective use of health information technology.

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

Table of Contents

Executive Summary

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 2015. The MCOs were required to report on 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 they furnished to the state's Medicaid enrollees. HEDIS measures are developed and maintained by the National Committee for Quality Assurance (NCQA).

During 2015, 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 year (CY) is referred to as the 2016 reporting year (RY) in this report.

Report Overview

The primary purpose of this report is to summarize variation in Washington Apple Health MCO performance across regions and multiple demographic factors on selected HEDIS measures. It is a companion report to the *Comparative Analysis Report*, which provides overall HEDIS measure performance by Apple Health MCOs.

The populations in this report represent Apple Health members enrolled with an MCO in Washington State between January 1, 2015, and December 31, 2015. The HEDIS measures were not risk-adjusted for differences in enrollee demographic characteristics. The regions delineated in this report are the Regional Service Area (RSA) boundaries for 2016 defined by the HCA as of June 2015.[2] Enrollees were assigned to RSAs based on their residence ZIP code and not where the care was provided.

---

[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] HCA memo titled "Joint HCA-DSHS Revised Regional Service Area Boundaries for 2015 Medicaid Purchasing." June 30, 2105.

This report is structured to present two dimensions of variation:

- Variation **across** regions, MCOs, or other demographic groups, to identify areas where performance was below or above the overall state average
- Variation **within** regions, MCOs, or demographic groups, to identify which MCOs performed well or poorly within each area

A review of each type of variation for each measure may provide insight as to whether performance improvement may be most effectively addressed at a regional level or an MCO level.

Performance Highlights

The sections below outline performance across four domains: Access to Care, Preventive Care, Chronic Care Management, and Medical Utilization. Multiple environmental factors may influence performance, including continued Medicaid expansion growth and changing demographic patterns within MCO-covered populations.

Access to Care

Health plans are responsible for ensuring care is available for their members. This is achieved by establishing an adequate provider network, providing good customer service and guidance, and educating members on the importance of engaging with providers for their routine care. In this report, the primary access measures presented are adult access to primary care and child and adolescent access to primary care. Additionally, select demographic analyses are offered for prenatal and postpartum care measures.

- **Adults' primary care visits:** Adult access to primary care declined by more than 5 percent statewide from 2015 RY to 2016 RY. All plans had lower performance, but declines were not uniform statewide; Wahkiakum County had an increase of 0.7 percent while Clark County had a decline of 19.9 percent. Most plans had significant variation among regions: there were over 22 percentage points in difference between the highest- and lowest-performance regions for CHPW. The expansion populations have lower access rates than the overall population, and rates of access for the expansion population dropped from 2015 RY to 2016 RY. While this may reflect that the expansion population is healthier overall than the adult Apple Health traditional Medicaid population and thus less in need of regular physician visits, it could also indicate that adults struggled to schedule appointments with providers because of lack of access and potentially stretched provider networks.
- **Children's primary care visits:** Child and adolescent access to primary care declined statewide across all age groups and is significantly lower than the national averages. However, that decline was primarily driven by CHPW, which had decreases ranging from 13 to 25 points for each age group. CHPW was the lowest-performing MCO in every region in every age group. There is also evidence of racial disparities in access. For instance, children who are Native Hawaiian/Pacific Islander were statistically significantly less likely to have had a primary care visit during the reporting year.
- **Prenatal and postpartum care:** Aggregate Apple Health rates of timeliness of prenatal care, frequency of prenatal care, and receipt of postpartum care were significantly lower than national Medicaid averages. Select analyses did not reveal racial disparities in these measures but did indicate that all MCOs need to improve performance. It is possible that there are barriers to adequate care in place at the state level that need to be addressed by HCA.

Preventive Care

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

- **Breast cancer screenings:** A higher level of variation across plan-region scores was seen for breast cancer screening rates; however, this could have been due to the smaller sizes of the populations from which this measure was derived. Individuals enrolled in the Healthy Options Blind/Disabled program were less likely to have received appropriate screening, indicating that these individuals may have additional barriers to mammogram screening not seen in the broader Apple Health population.
- **Chlamydia screenings:** Regional performance patterns varied widely for chlamydia screening rates; however, MCO aggregate rates did not vary significantly. Notably, individuals enrolled through the Healthy Options Blind/Disabled program and the State Children's Health Insurance Program were statistically significantly less likely to have received adequate chlamydia screening compared to individuals enrolled in other programs.

Chronic Care Management

Health plans can enhance quality of care and outcomes by helping providers coordinate care so that chronic illness is effectively managed and unnecessary care is avoided. This report includes measures relating to antidepressant medication management and disparities in blood pressure management for individuals with hypertension.

- **Antidepressant medication management:** Performance on this measure revealed regional variation in both acute and continuing antidepressant medication management. Some of this variation may be attributed to MCO regional performance, but variation may also be due to the relative availability of adequate behavioral healthcare in select regions and coordination between the regional Behavioral Health Organizations (BHOs) and the MCOs. Additionally, individuals whose primary language is Spanish had lower rates of appropriate antidepressant medication management, potentially revealing difficulties accessing mental healthcare for individuals who do not speak English as a primary language.
- **Blood pressure management:** The aggregate Apple Health rate of blood pressure management for individuals with hypertension is similar to the US average of Medicaid plans; however, there is evidence of racial disparities in Washington for this measure. Individuals who are black and individuals enrolled through the Healthy Options (traditional Medicaid) program are statistically less likely to have controlled blood pressure.

Medical Utilization

One important method of controlling costs is to limit the provision of inappropriate and wasteful care. This report assesses appropriate antibiotics use for children with upper respiratory infections.

- **Antibiotics for upper respiratory infections:** Data for 2016 showed good performance statewide in avoiding inappropriate antibiotics use for children with upper respiratory infections. Some regional variation is evident, however, which may indicate opportunities for provider education regarding appropriate prescribing practices and antimicrobial stewardship.

Recommendations

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

- Require plans with poor performance on select hybrid HEDIS measures to conduct a mandatory oversample the following reporting year to identify potential root causes of poor performance. Oversamples will assist in identifying potential disparities in care.
- Continue to establish and enforce firm performance standards, and require that MCOs conduct performance improvement projects (PIPs) when performance falls below those standards. HCA may also consider adding contract clauses requiring PIPs for plans when any performance rate drops by more than 10 percent on a priority measure.
- Continue to closely monitor performance on healthcare access and utilization measures to ensure that enrollees, including newly insured individuals, are able to receive high-quality care.
- Take steps to identify root causes of primary care access difficulties in the Southwest RSA to better ensure care quality in that region.
- Continue to require submission of the HEDIS patient-level data (PLD) file to enable future analyses of regional and racial disparities in care.

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 2015 (reporting year 2016). To enable a reliable measurement of performance, the MCOs were required to report on more than 30 Healthcare Effectiveness Data and Information Set (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®[3]—enables benchmarking against other Medicaid managed care health plans nationwide.

The purpose of this report is to summarize the performance of Washington Apple Health MCOs in furnishing quality, timely, accessible care to Medicaid enrollees across plans, regions, and demographic areas. It draws from MCO performance on seven selected HEDIS measures Apple Health MCOs reported on in 2015 RY and 2016 RY. It is a companion report to the *Comparative Analysis Report*, which provides overall HEDIS measure performance with comparisons to state and national benchmarks.

HEDIS Performance Measures

HEDIS measures are widely used performance measures reported by health plans. HEDIS results can be used by the public to compare plan performance over eight domains of care; they also allow plans to determine where quality improvement efforts may be needed.[4] In the first half of 2016, Qualis Health, through subcontractor 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.

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

Administrative Versus Hybrid Data Collection

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

---

[3] Quality Compass® 2016 is used in accordance with a Data License Agreement with the NCQA.
[4] K. Krishnamoorthy and Jie Peng. “Some Properties of the Exact and Score Methods for Binomial Proportion and Sample Size Calculation.” Communications in Statistics – Simulation and Computation, 36: pp 1171-1186, 2007.

In order to determine regional differences in the quality of care provided to enrollees, selected measures needed to have sufficient volumes in each region to be included in the analyses. No hybrid measure had sufficient volumes in each region to be analyzed at the regional level. As a result, this report focuses on variation in measures collected using the administrative methodology.

Patient-Level Data

As part of the HEDIS audit process, each MCO was required to produce a patient-level data (PLD) file that conformed to NCQA specifications. These files provide patient-level information for all HEDIS quality measures to assist in the validation process. Only measures that are considered "quality of care" measures, such as whether an individual received all appropriate immunizations, are included in this PLD file. These measures all have unambiguous interpretations: higher performance indicates better performance. That is in contrast to HEDIS utilization measures, which may be more indicative of the overall risk pool of the population rather than quality modifiable by the health plan. Since the available data in the PLD file only included HEDIS quality measures, select utilization measures, such as inpatient utilization, are not included in this report.

HCA requested that each MCO's PLD file be submitted to the State for mapping to enrollee demographic information (race/ethnicity, language, and ZIP code of residence). The PLD files, linked with State data, were provided to Qualis Health for analysis and are the principal data source for this report.

The populations underlying each measure in this report represent Apple Health members enrolled with an MCO in Washington State between January 1, 2015, and December 31, 2015. Of note: Only individuals who are in the denominator of at least one HEDIS measure are included in the PLD file. As a result, individuals with short tenures in their plans or individuals with little to no healthcare utilization may not be included in this report. The HEDIS measures were not risk-adjusted for any differences in enrollee demographic characteristics. Prior to performing regional analysis, patient-level data were aggregated to the MCO level and validated against the reported HEDIS measures.

Measure Selection

As noted above, this report focuses on variation in measures collected using the administrative methodology. It does not include administrative measures with small denominators, such as follow-up care for children prescribed attention-deficit hyperactivity disorder (ADHD) medication–initiation and continuation phases, which were included in the *2015 Regional Analysis Report* but were determined this year to be inconclusive because of small volumes.

The HEDIS performance measures included in this report were selected by the HCA and are listed in Table 1. Abbreviations for the measure names are included in the table and used throughout the text.

Table 1: Select HEDIS Administrative Measures and Abbreviations Included in Report

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

While the focus of this report is on administrative measures, it does include limited references to select measures collected through the hybrid methodology. It is not possible to conduct regional analyses on hybrid measures without sacrificing precision due to small numbers; however, select analyses relating to racial disparities are included in this report as sample sizes allow. These analyses are called out in special "Spotlight" sections throughout the report. Selected measures can be found in Table 2 below.

Table 2: Select HEDIS Hybrid Measures and Abbreviations Included in Report

Abbreviation	HEDIS Measure
Access to Care	
PPC	Prenatal and Postpartum Care
FPC	Frequency of Ongoing Prenatal Care
Chronic Care Management	
CBP	Controlling High Blood Pressure

More information on MCO comparative performance on hybrid measures can be found in the *2016 Comparative Analysis Report.*

Analysis of Variation

This report is structured to present two dimensions of variation in MCO performance:

- Variation **across** regions, MCOs, or other demographic groups, to identify areas where performance was below or above the overall state average
- Variation **within** regions, MCOs, or demographic groups, to identify which MCOs performed well or poorly within each area

A review of each type of variation for each measure may provide insight as to whether performance improvement may be most effectively addressed at a regional level or at the MCO level.

Statistical Significance

In this report, the words "significant" or "significantly" refer to measure performance in each region or demographic group compared to the overall state-level rate. A Wilson Score Interval Test, with a 95 percent confidence interval, is used. The Wilson Score Interval Test yields confidence intervals that have

been shown to be accurate for most values (e.g., performance measure scores) and small samples (e.g., numbers of eligible enrollees).

Demographic and Geographic Analyses

Enrollee demographic information, such as race, gender, ZIP code of residence, and primary language, is derived from data submitted by MCOs as part of the PLD submission. Where MCO-supplied demographic information was missing, demographic data supplied by HCA were used.

For each measure, a map depicts statistically significant variation for each region compared to the state average. Each region is colored green (statistically above average), red (statistically below average), or yellow (no statistical difference from the average). All regions had at least 30 eligible enrollees for each measure.

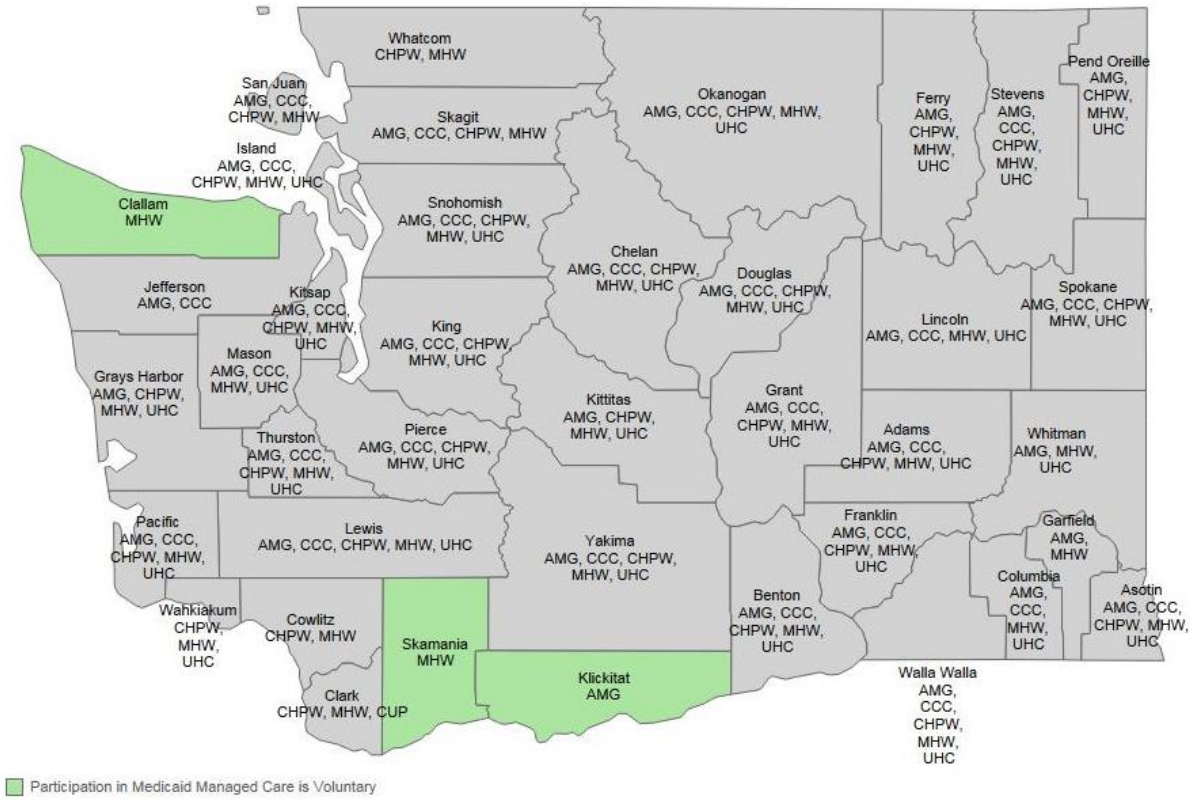
The regions delineated in this report are the Regional Service Area (RSA) boundaries for 2016 defined by the HCA as of June 2015 (Figure 1).[5] Enrollees were assigned to RSAs based on their residence ZIP code and not where the care was provided. Individuals with missing or out-of-state ZIP codes were excluded (less than 0.25 percent of the total).

Figure 1: Apple Health Regional Service Areas As of December 2015

[5] HCA memo titled "Joint HCA-DSHS Revised Regional Service Area Boundaries for 2015 Medicaid Purchasing," June 30, 2015.

Most Washington counties are served by multiple Apple Health MCOs (Figure 2). Throughout this report, Qualis Health will attempt to identify where plan-specific factors influence overall region rates.

Figure 2: Apple Health MCO Service Areas As of December 2015



Performance Summary

Overview of Apple Health Enrollment

Apple Health offers multiple enrollment programs based on enrollee age, income, health status, and other factors. Each population has distinct characteristics and risk factors that may influence overall performance.

In Washington State, Medicaid expansion took effect on January 1, 2014, and by December 2015, over 520,000 individuals were enrolled in the new Apple Health Adult Coverage program. The Apple Health MCOs, which differ in size and composition, 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 enrollees. 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. Table 3 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 3: 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 2013 CY, when the majority of individuals enrolled through HOBD were covered by only two MCOs. With the population spread out more evenly among MCOs, no MCO's performance on quality measures is likely to be unduly influenced by a disproportionate share of individuals enrolled in HOBD. Table 4 shows MCO Apple Health enrollment by program type.

Table 4: Apple Health Enrollment by Program Type and MCO, December 2015[6]

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

Each plan other than CHPW experienced growth across the course of calendar year 2015, as shown in Table 5. Many individuals who were part of this growth are not included in performance measure data in 2016 RY because most HEDIS measures require a minimum of 10 months of continuous enrollment for inclusion.

Table 5: Apple Health Enrollment, December 2014 vs December 2015[7]

	December 2014 Enrollment	December 2015 Enrollment	Percent Change
AMG	128,369	141,571	9.3%
CUP	N/A	57,301	N/A
CCW	175,353	181,801	3.6%
CHPW	332,456	294,141	-13.0%
MHW	486,524	566,201	14.1%
UHC	180,225	204,078	11.7%
Total	1,302,927	1,445,093	9.8%

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

Variation in Race by MCO

Each MCO has a different racial composition, as shown in Table 6. This reflects the different outreach and enrollment strategies of each MCO. Limited data are available relating to how these differences may impact overall measure performance.

[6] Source: http://www.hca.wa.gov/about-hca/apple-health-medicaid-reports
[7] Source: http://www.hca.wa.gov/about-hca/apple-health-medicaid-reports

Table 6: Apple Health Enrollment by Race and MCO, 2016 RY

Race	AMG	CCW	CHPW	MHW	UHC	Total
Asian	5.8%	3.4%	4.8%	6.2%	10.3%	6.2%
Black (Non-Hispanic)	9.0%	6.2%	6.6%	8.0%	9.9%	7.8%
Hispanic	11.6%	30.4%	28.4%	20.9%	14.1%	22.2%
Native American/Alaska Native	0.4%	0.3%	0.7%	0.9%	0.7%	0.7%
Native Hawaiian/Pacific Islander	2.8%	2.8%	2.5%	0.2%	0.3%	1.4%
White (Non-Hispanic)	61.7%	48.1%	46.7%	52.6%	62.7%	52.9%
Other race	3.1%	3.3%	3.7%	4.0%	0.8%	3.2%
Unknown race	5.7%	5.5%	6.7%	7.2%	1.3%	5.7%

Note: This data include all individuals enrolled in these plans for any part of 2015 CY. Information by race and plan for enrollees eligible for each measure is detailed in later sections of the report.

Variation in Primary Language by MCO

The composition of enrollee primary languages also varies by MCO, as shown in Table 7. Over 94 percent of enrollees in AMG, for example, cite English as a primary language, compared to less than 78 percent of CHPW enrollees.

Table 7: Apple Health Enrollment by Primary Language and MCO, 2016 RY

Language	AMG	CCW	CHPW	MHW	UHC	Total
English	94.9%	80.0%	77.7%	89.3%	93.5%	86.1%
Spanish	3.0%	15.7%	14.7%	8.4%	3.8%	9.8%
Other language	1.8%	1.6%	3.5%	2.0%	2.4%	2.5%
Unknown language	0.3%	2.7%	4.2%	0.3%	0.3%	1.69%

Additionally, 84 percent of individuals whose primary language is Spanish are enrolled in the Healthy Options (traditional Medicaid) program as compared to 12.8 percent who are enrolled in Apple Health Adult Coverage (Medicaid expansion). In comparison, 51.2 percent of individuals whose primary language is English are enrolled in Healthy Options and 40.2 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.

Note: Individuals enrolled in the Healthy Options Blind/Disabled program constitute over 90 percent of the individuals with unknown language data when combining MCO and state demographic data (meaning enrollee language is missing from both databases). There may be opportunities to improve the collection of language data for those individuals or to otherwise note individual communication preferences.

Overview of Geographic Variation

Performance in a number of regions varied significantly from the state average for the selected set of performance measures. Table 8 presents highest- and lowest-performance regions for each of the seven measures. For some measures, the range between the highest- and lowest-performance regions was substantial. Smaller regions were often seen at the extremes. For example, North Central and Southwest, the regions with the fewest eligible enrollees, were each the highest-performance regions for three measures and the lowest-performance regions for three measures. The highest- and lowest-performance regions for each measure were statistically different than the aggregate state level with the exception of breast cancer screenings, where volumes were too small to be statistically distinguishable.

Table 8: Highest- and Lowest-Performance Regions for Each Performance Measure

Measure	2015 RY Average	2016 RY Average	2015 RY to 2016 RY Difference	Highest-Performance Region 2016 RY	Lowest-Performance Region 2016 RY
AAP	80.4%	74.2%	-6.2%	North Central (80.0%)	Southwest (59.9%)
AMMa	51.7%	54.2%	2.5%	Peninsula (59.3%)	North Central (47.9%)
AMMb	37.0%	39.4%	2.4%	Southwest (46.0%)	North Central (33.0%)
BCS	54.4%	52.3%	-2.1%	North Central (57.7%)	Southwest (47.8%)
CAP	91.0%	85.8%	-5.2%	North Central (93.2%)	Southwest (67.3%)
CHL	51.2%	54.8%	3.6%	Southwest (60.0%)	North Central (46.9%)
URI	92.6%	93.5%	0.9%	Southwest (97.3%)	Timberlands (90.2%)

For information on the measure abbreviations used in this report, please refer to Table 1 on page 7.

Access to Care

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

- Adults' access to preventive/ambulatory health services (also referred to as adult access to primary care in this report)
- Children and adolescents' access to primary care practitioners (also referred to as child and adolescent access to primary care in this report)
- Prenatal and postpartum care
- Frequency of ongoing prenatal care

Adults' Access to Preventive/Ambulatory Health Services

Adults' access to preventive/ambulatory health services is defined as the percentage of enrollees ages 20 years and older who had an ambulatory or preventive care visit in the last year. This measure excludes acute inpatient encounters and emergency department (ED) visits. A higher score indicates better performance.

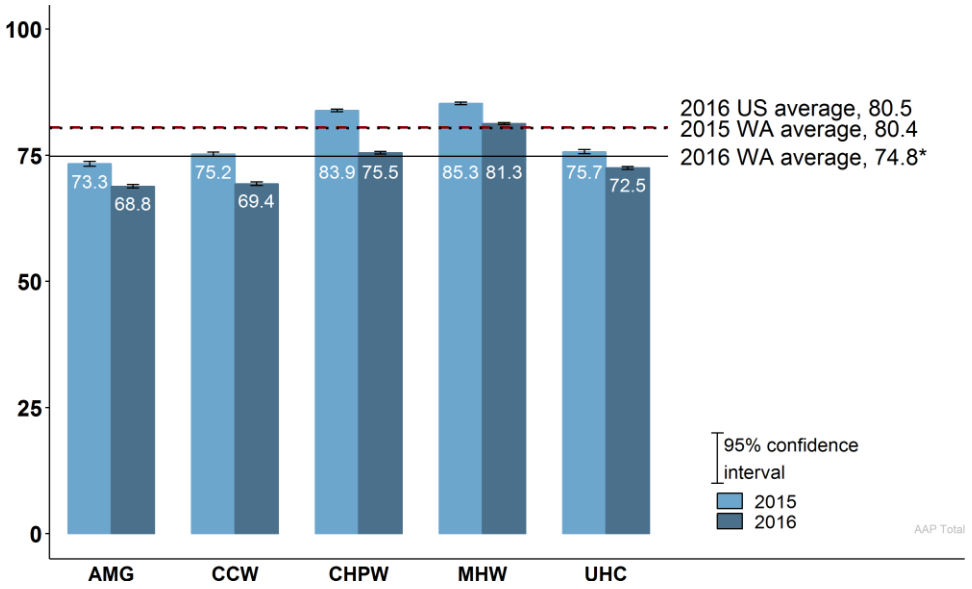
Variation by MCO and Region

There were 459,514 adult enrollees eligible for this measure during the 2016 reporting year. A total of 74.8 percent of eligible adult enrollees had an ambulatory or preventive care visit over the last year. MHW was the highest-performing MCO (81.3 percent), while AMG was the lowest (68.8 percent). All MCOs showed decreases in adult access from 2015 RY to 2016 RY, and the state rate is now more than 5 percent lower than the national average of Medicaid plans.

Lower rates suggest one of two access problems: enrollees cannot access care (potentially due to stretched provider networks), or they do not understand the importance of routine care and therefore do not seek it. In both cases, the MCO can make a difference by increasing access or by developing systems to identify and reach out to persons needing care. However, an MCO or region with a younger, healthier population may naturally have lower access rates, as healthy individuals generally have less incentive to seek primary care.

Figure 3 shows MCO performance variation in adult access to primary care over the 2015 to 2016 reporting years.

Figure 3: Adult Access to Primary Care by MCO, 2015 RY and 2016 RY



CHPW had the largest difference between its highest- and lowest-performance regions (22.4 percent), while AMG had the smallest difference (6.0 percent). Notably, AMG's performance was below the state average in all regions, as shown in Table 9.

Table 9: Range of Regional Variation by MCO, Adult Access to Primary Care, 2016 RY

MCO	MCO Average	Highest-Performance Region	Lowest-Performance Region	Difference
AMG	68.8%	Spokane (72.4%)	Greater Columbia (66.4%)	6.0%
CCW	69.3%	North Central (76.4%)	Thurston-Mason (64.3%)	12.1%
CHPW	75.5%	Peninsula (78.9%)	Southwest (56.5%)	22.4%
MHW	81.2%	North Central (84.2%)	Southwest (64.7%)	19.5%
UHC	72.4%	North Sound (79.2%)	Thurston-Mason (68.1%)	11.1%
All MCOs	**74.8%**	**North Central (80.0%)**	**Southwest (59.9%)**	**20.1%**

Figure 4 displays the region-level results. Performance in all of Eastern Washington and the North Sound region is statistically above the state average; performance in the remaining regions is either at or below the state average. Performance in Southwest (59.9 percent) is significantly lower than in all other regions, followed by Thurston-Mason (73.0 percent).

Figure 4: Map of Regional Variation, Adult Access to Primary Care, 2016 RY

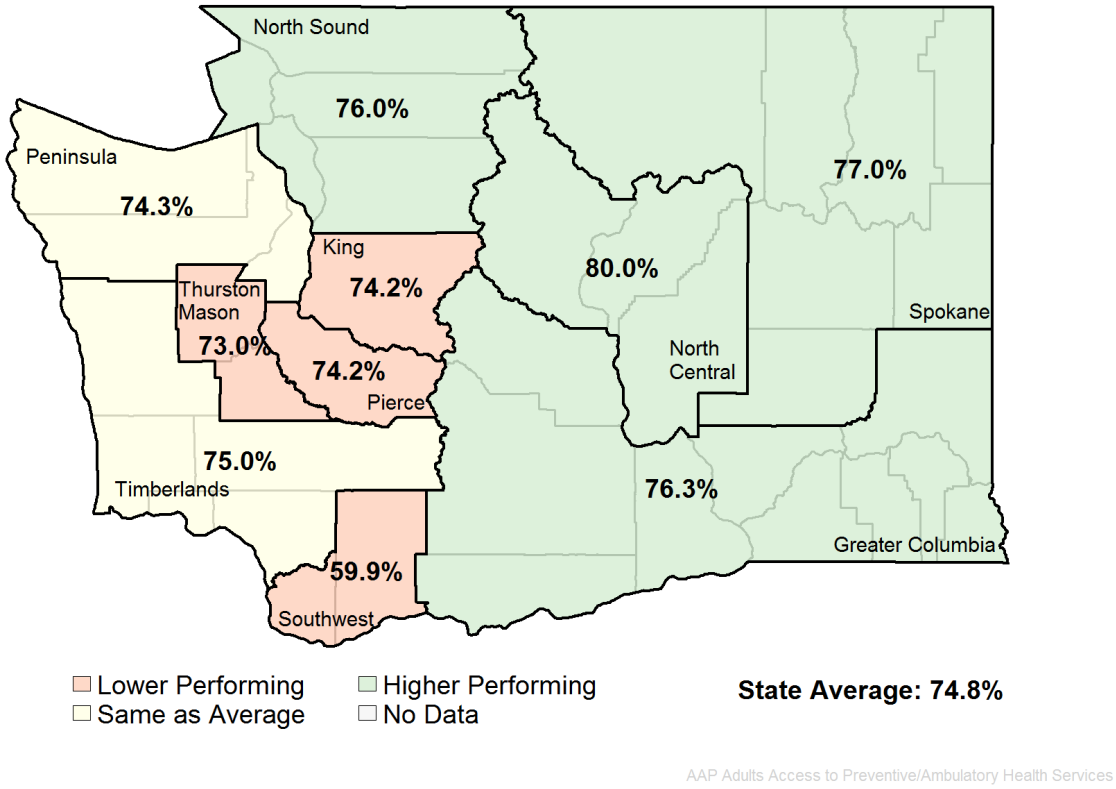


Table 10 shows the highest- and lowest-performing MCOs in each region. MHW was the highest-performing MCO in each region. CCW was the lowest performer in six of the ten regions, but AMG was the lowest performer overall.

Table 10: MCO Performance Range by Region, Adult Access to Primary Care, 2016 RY

Region	Region Average	Highest-Performing MCO	Lowest-Performing MCO	Difference
Greater Columbia	76.3%	MHW (82.2%)	AMG (66.4%)	15.8%
King	74.2%	MHW (82.1%)	CCW (67.2%)	14.9%
North Central	80.0%	MHW (84.2%)	UHC (69.0%)	15.2%
North Sound	76.0%	MHW (81.3%)	CCW (67.2%)	14.1%
Peninsula	74.3%	MHW (79.9%)	AMG (69.4%)	10.5%
Pierce	74.2%	MHW (81.5%)	CCW (67.4%)	14.1%
Southwest	59.9%	MHW (64.7%)	CHPW (56.5%)	8.2%
Spokane	77.0%	MHW (83.0%)	CCW (67.1%)	15.9%
Thurston-Mason	73.0%	MHW (81.5%)	CCW (64.3%)	17.2%
Timberlands	75.0%	MHW (80.8%)	CCW (66.1%)	14.7%
All Regions	**74.8%**	**MHW (81.2%)**	**AMG (68.8%)**	**12.4%**

Variation by Age and Gender

NCQA divides adult access to primary care into three age groups (20–44, 45–64, and 65+); however, very few individuals in Washington have Medicaid as a primary payer after age 65. As a result, this analysis primarily reports individuals in the 20–44 and 45–64 age groups.

There were statistically significant differences in MCO performance between age groups. MCO performance for individuals ages 20–44 was considerably lower than for individuals ages 45–64. This disparity most likely owes to the younger age group's healthier cohort, who are less likely to seek regular preventive care unless prompted to do so.

Table 11 below shows access rates by age and gender. Men were less likely to have received a primary care visit during the year compared to women. Males between the ages of 20 and 44 had the lowest rate of access (59.1 percent) and were the only group statistically significantly below the overall state average (74.8 percent).

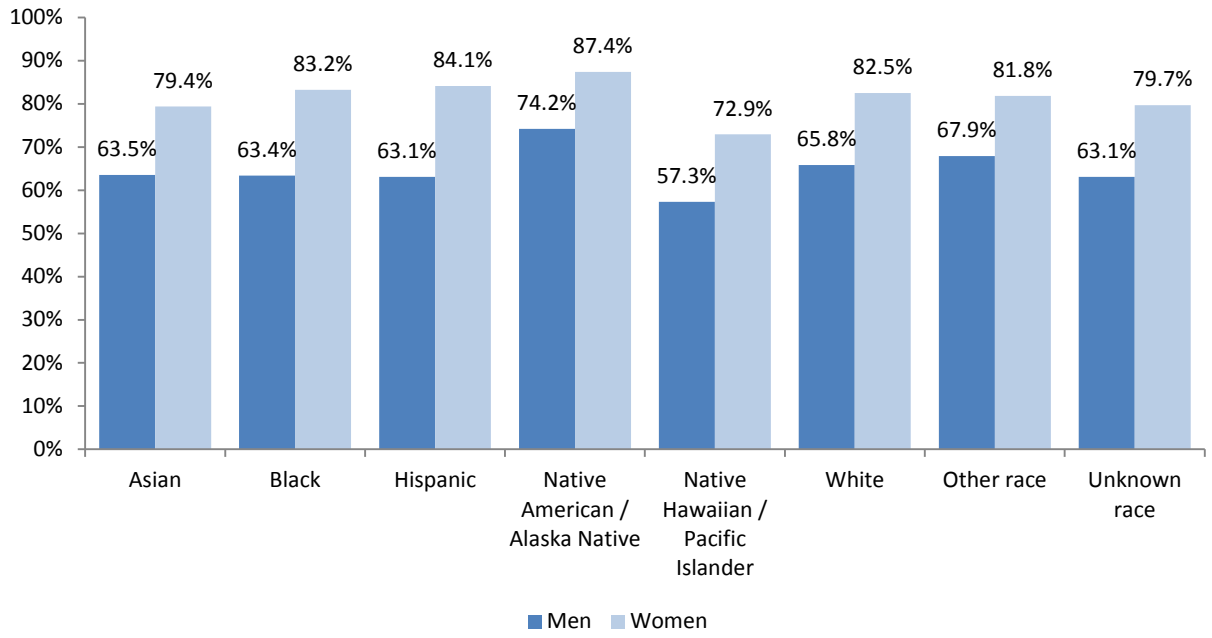
Table 11: Statewide Performance by Age and Gender, Adult Access to Primary Care, 2016 RY

	Age 20–44	Age 45–64	Total
Men	59.1%	74.7%	65.1%
Women	80.8%	85.4%	82.3%
Total	71.7%	80.4%	74.8%

Variation by Race and Language

MCO performance on access measures indicated racial disparities, as shown in Figure 5. For example, individuals who are Native Hawaiian or Pacific Islander were indicated to be less likely to have access to preventive services (69.3 percent) than individuals of other races, and individuals who are Native American or Alaska Native were more likely to have access (83.1 percent) than others.

Figure 5: Statewide Performance by Race and Gender, Adult Access to Primary Care, 2016 RY



Language does not generally appear to be a strong factor in adult access to primary care, with the exception of those enrollees for whom language was coded as unknown. These enrollees, as shown in Table 12, have slightly higher rates of access than those speaking English, Spanish, or another identified language.

Table 12: Statewide Performance by Language, Adult Access to Primary Care, 2016 RY

Language	Rate	Number of Enrollees
English	74.3%	423,278
Spanish	79.5%	12,804
Other language	78.7%	9,809
Unknown language	82.4%	13,623

The higher rate of access for individuals with language unknown is likely related to program enrollment. Most individuals who are enrolled in the Healthy Options Blind/Disabled program have language coded as unknown, and these individuals are also more likely to have received a primary care visit, as discussed in the section below.

Variation by Enrollment Program

There is also evidence of variation in adult access among primary enrollment programs, as shown in Table 13. Individuals enrolled through Apple Health Adult Coverage (Medicaid expansion, approximately 70 percent of eligible enrollees) had lower access to primary care compared to individuals enrolled through Healthy Options (traditional Medicaid) and Healthy Options Blind/Disabled, as well as to the state average.

Table 13: Statewide Performance by Enrollment Program, Adult Access to Primary Care, 2016 RY

Enrollment Program	Rate	Enrollees
Apple Health Adult Coverage	71.4%	320,584
Healthy Options	81.9%	80,918
Healthy Options Blind/Disabled	83.4%	57,732

Spotlight: County Variation in Adult Access to Primary Care

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

Adults' access to preventive/ambulatory health services is a key measure to monitor as Medicaid expansion efforts progress. As shown in the previous section, the statewide rate for adult access to primary care dropped by over 5 percent from 2015 RY to 2016 RY. That decrease was not uniform across the state. Figures 6 and 7 below show county rates of adult access to primary care during 2015 RY and 2016 RY.

Figure 6: Map of County Variation, Adult Access to Primary Care, 2015 RY

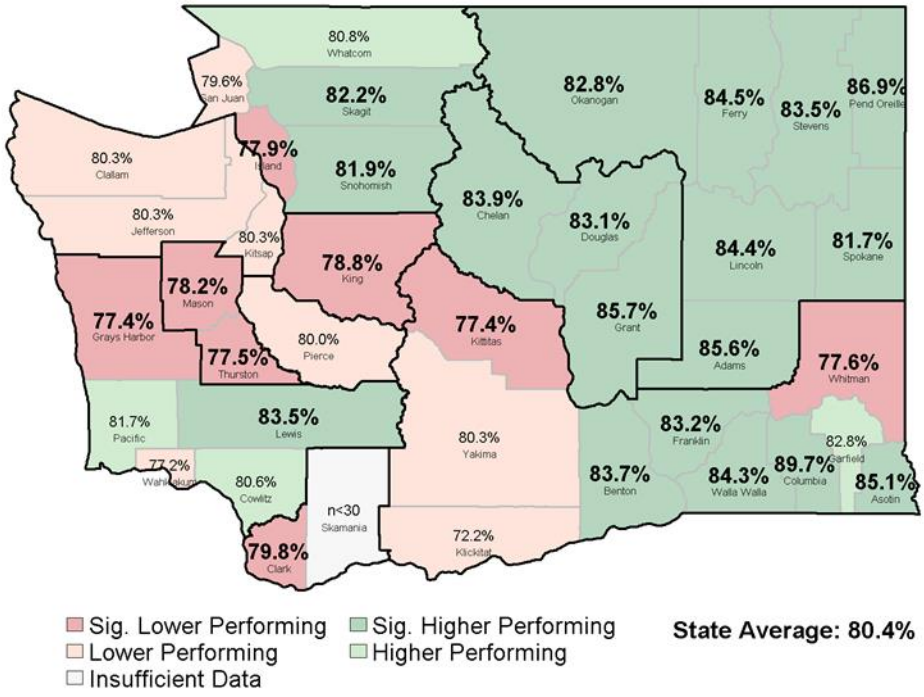


Figure 7: Map of County Variation, Adult Access to Primary Care, 2016 RY

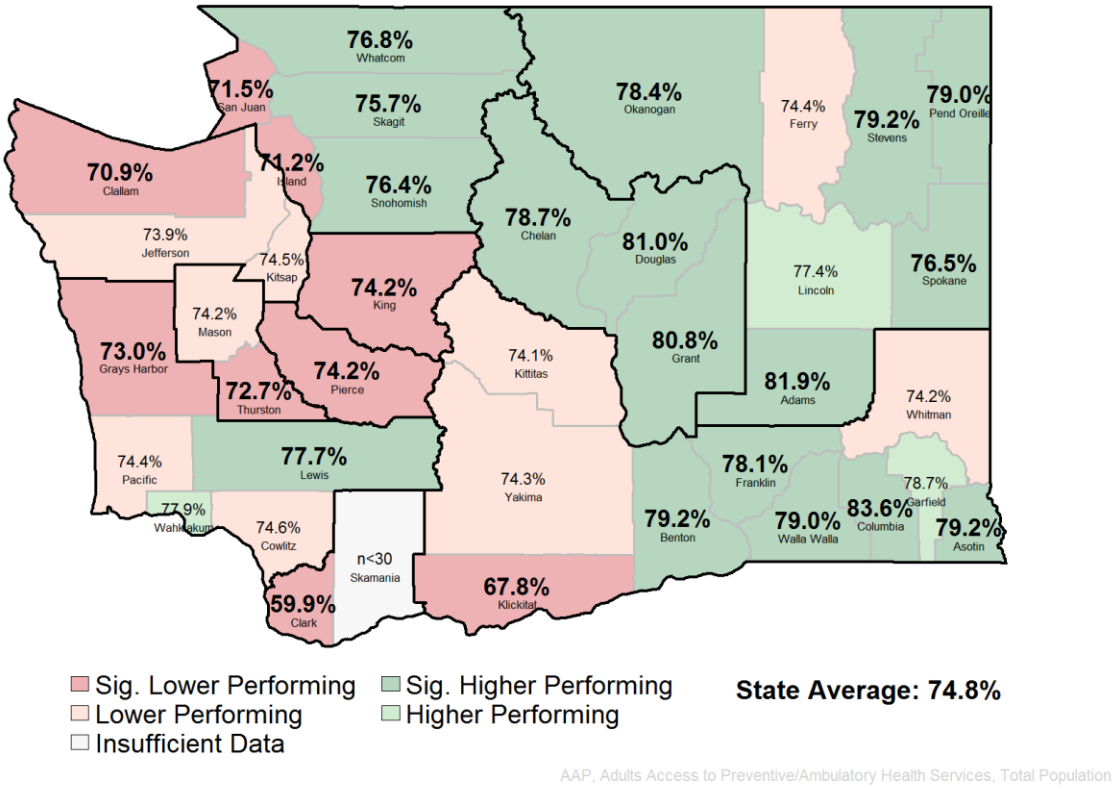


Table 14 shows the change in rates of access to care for each county between the two years. All counties except Wahkiakum saw a decrease in rate; Clark and Ferry counties had decreases of more than 10 percent.

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%
Grant	85.7%	80.8%	-4.9%

County	2015 RY	2016 RY	Difference
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— Expansion Population

In examining adult access to care, special attention should be paid to the expansion population. These individuals differ demographically from the traditional Medicaid population, and as such may face unique barriers to care (see Table 3 on p. 10 for more detail on enrollee demographic differences by enrollment program). Figures 8 and 9 show county variation in adult access to primary care for the Apple Health Adult Coverage program (Medicaid expansion) population for 2015 RY and 2016 RY.

Figure 8: Map of County Variation, Adult Access to Primary Care among Adults in Medicaid Expansion Population, 2015 RY

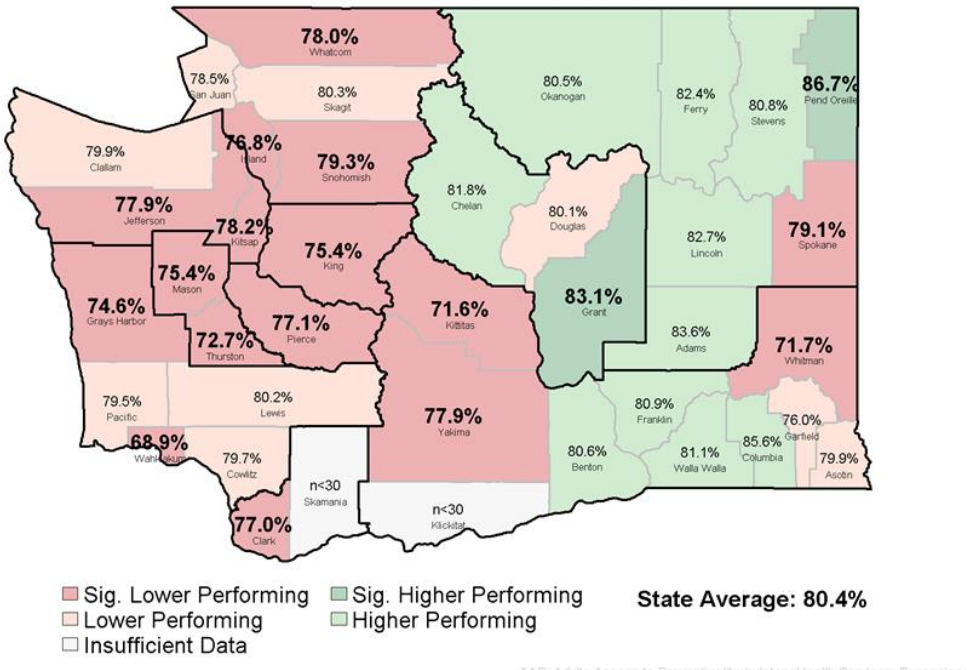
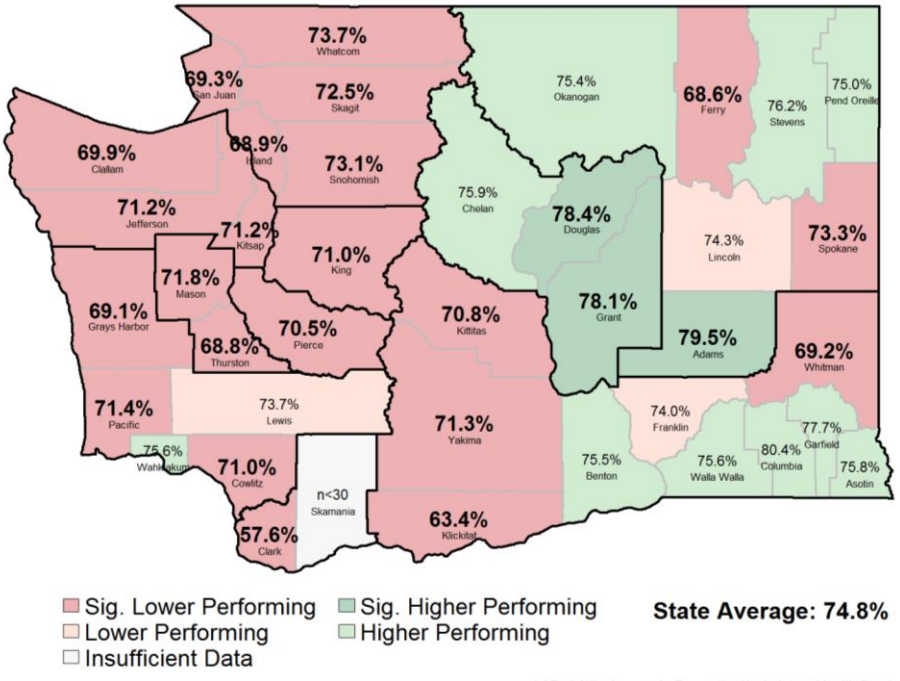


Figure 9: Map of County Variation, Adult Access to Primary Care among Adults in Medicaid Expansion Population, 2016 RY



Access for the Apple Health Adult Coverage program also dropped in 2016 RY from 2015 RY. Four counties had higher access in 2016 RY, with Wahkiakum having 9 percent higher rates in 2016 RY

compared to 2015 RY. Clark, whose performance was already statistically significantly below the state average in 2015 RY, saw its access rate drop by more than 17 percent in 2016 RY. Table 15 shows the change in rates of access to care for each county between the two years.

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

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%
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%

County	2015 RY	2016 RY	Difference
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 defined as the percentage of children ages 12 months–19 years who had a visit with a primary care practitioner in the last year (or the year prior for 7–19 year olds). A higher score indicates better performance.

Variation by MCO and Age

In the 2016 reporting year there were 423,962 Apple Health enrollees ages 12 months–19 years eligible for this measure. A total of 85.8 percent of those enrollees had a visit with a primary care practitioner. MHW was the highest-performing MCO (91.6 percent), while CHPW was the lowest (70.6 percent). Children's access to care should not have been overly impacted by Medicaid expansion, because expansion efforts primarily impacted adults without children who were not otherwise eligible for Medicaid. However, overall state rates fell several percentage points from 2015 RY for all children's access age groups, as shown in Table 16.

In general, lower rates suggest that either children cannot access care, or parents do not understand the importance of routine care and therefore do not seek it. In either case, health plans can make a difference by increasing access or by developing systems to identify and reach out to persons needing care.

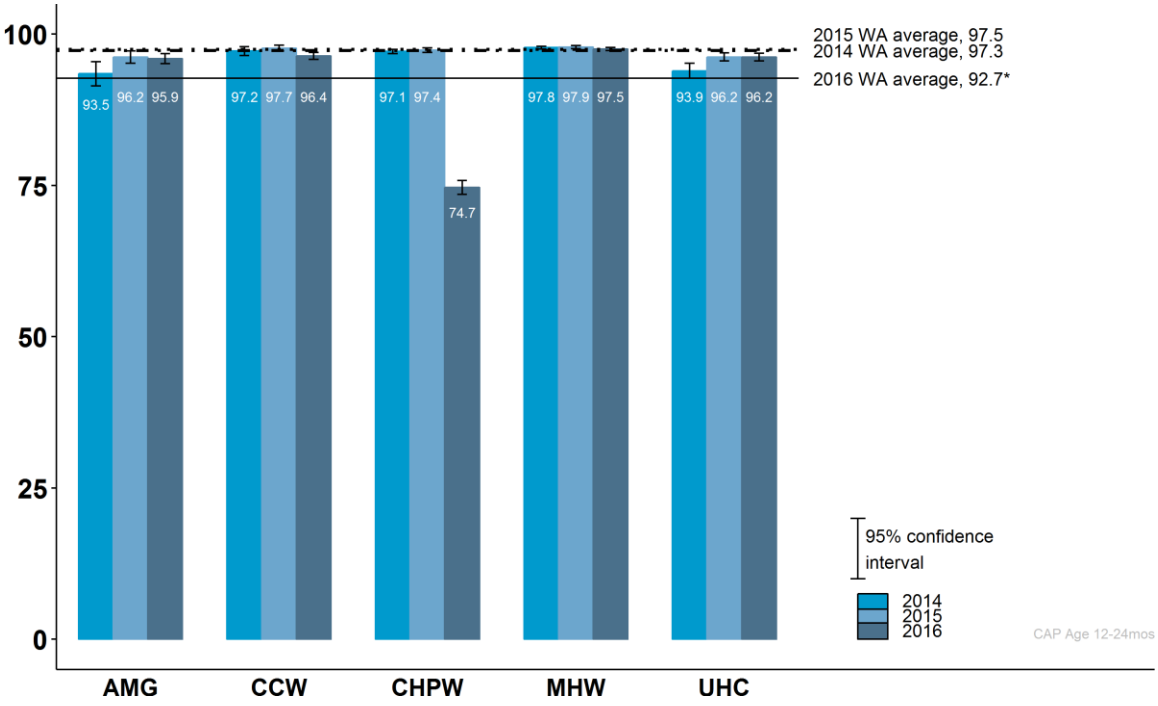
Children and adolescents' access to primary care practitioners is part of the Washington State Common Measure Set on Health Care Quality and Cost—2016.

Table 16: Child and Adolescent Access to Primary Care, 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%

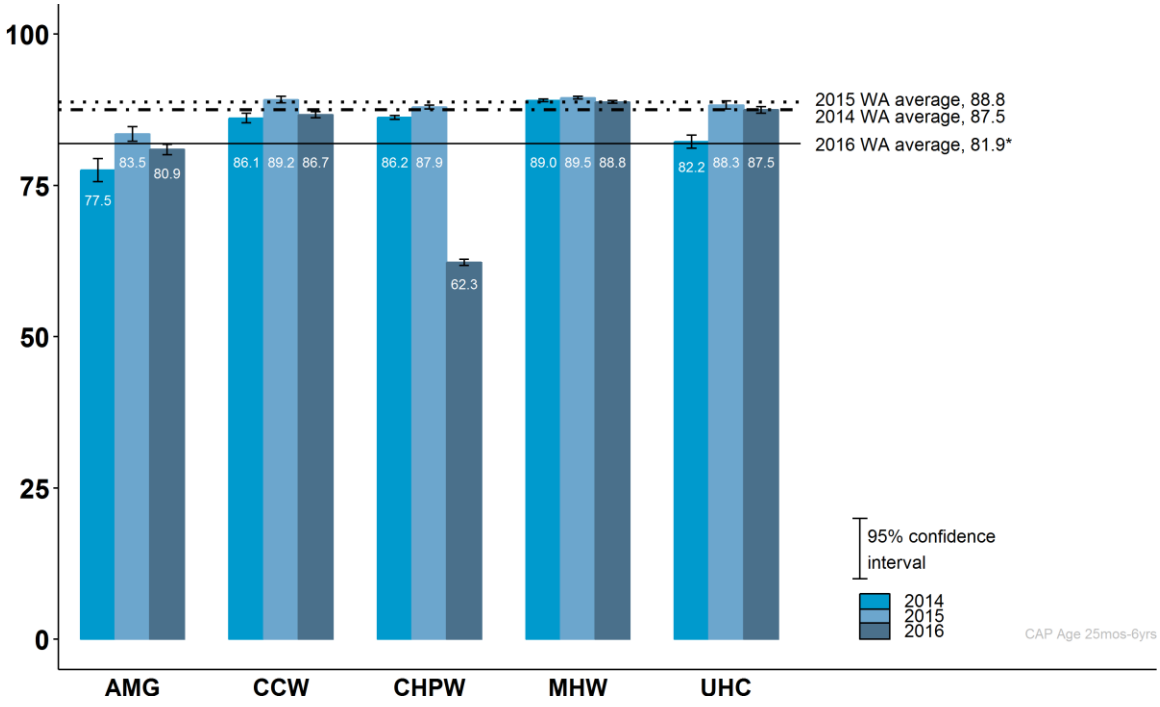
As shown in the following figures, much of this rate decrease was driven by one MCO's performance.

Figure 10: Child and Adolescent Access to Primary Care, Ages 12–24 Months, 2015 RY and 2016 RY



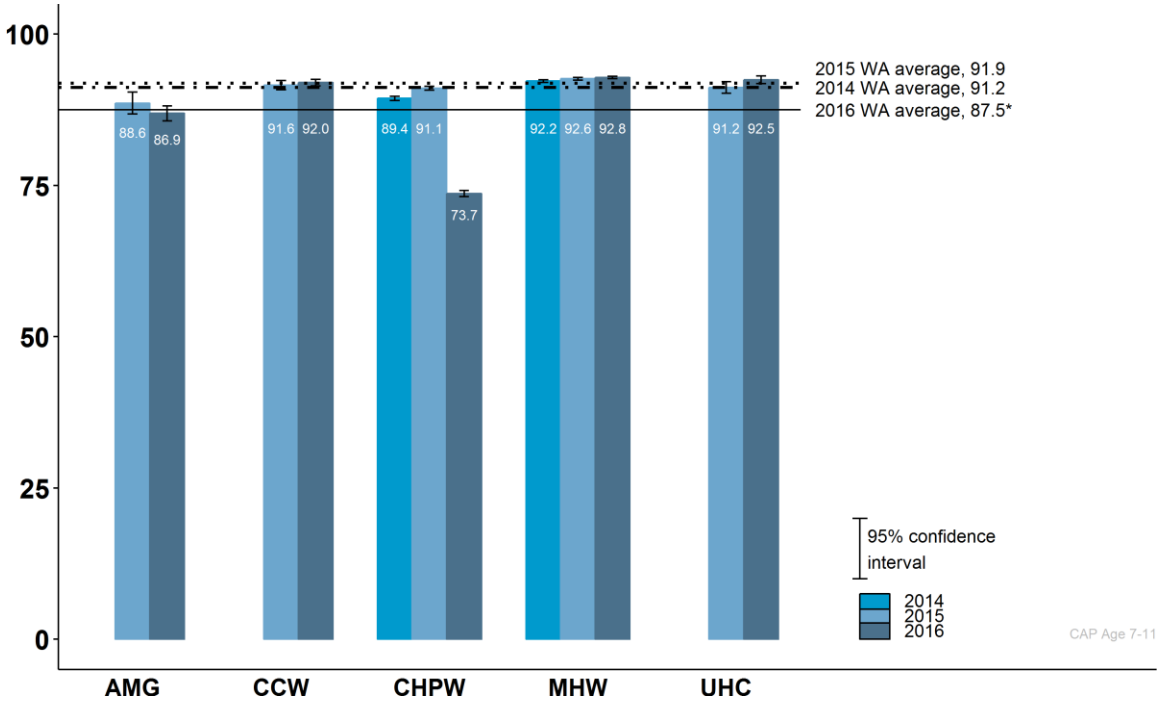
For this measure (Figure 10), CHPW had the lowest performance of any Medicaid plan in the nation based on benchmarks from the Quality Compass. All other MCOs are performing above the national average. MHW performed in the top 25 percent of plans nationwide on this measure.

Figure 11: Child and Adolescent Access to Primary Care, Ages 25 Months–6 Years, 2015 RY and 2016 RY



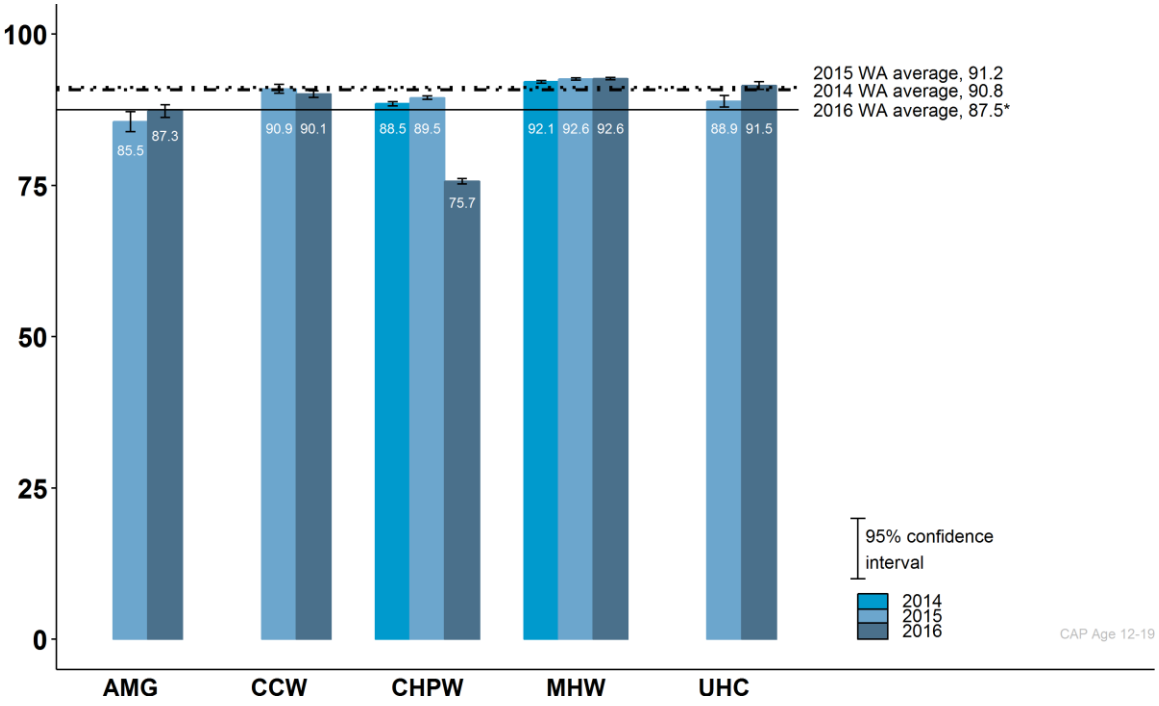
For this age group (Figure 11), CHPW had the lowest performance of any Medicaid plan in the nation. Only one MCO (MHW) performed above the national average on this measure.

Figure 12: Child and Adolescent Access to Primary Care, Ages 7–11 Years, 2015 RY and 2016 RY



For this measure (Figure 12), CHPW's performance put the MCO in the lowest 10 percent of Medicaid plans nationwide. CCW, MHW, and UHC performed above the national average on this measure.

Figure 13: Child and Adolescent Access to Primary Care, Ages 12–19 Years, 2015 RY and 2016 RY



CHPW's performance in the adolescent age group (Figure 13) also put 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.

Variation by Region

Table 17 shows performance variation within each MCO by region. CHPW had the highest variation in child and adolescent access to care by region (43.4 percent), while AMG had the lowest (6.3 percent).

Table 17: Range of Regional Variation by MCO, Child and Adolescent Access to Primary Care, 2016 RY

MCO	MCO Average	Highest-Performance Region	Lowest-Performance Region	Difference
AMG	85.5%	North Sound (87.9%)	Greater Columbia (81.6%)	6.3%
CCW	89.8%	North Central (95.7%)	Timberlands (73.8%)	21.9%
CHPW	70.6%	North Central (88.6%)	Thurston-Mason (45.2%)	43.4%
MHW	91.6%	North Central (94.9%)	Southwest (82.5%)	12.4%
UHC	90.5%	North Sound (93.3%)	Timberlands (82.9%)	10.4%
All MCOs	85.8%	North Central (93.2%)	Southwest (67.3%)	25.9%

The map in Figure 14 below shows aggregate performance by region. North Central (93.2 percent) and Spokane (88.9 percent) had the highest rates of access, while Southwest (67.3 percent) and Timberlands (76.6 percent) had the lowest rates of access.

Figure 14: Map of Regional Variation, Child and Adolescent Access to Primary Care, 2016 RY

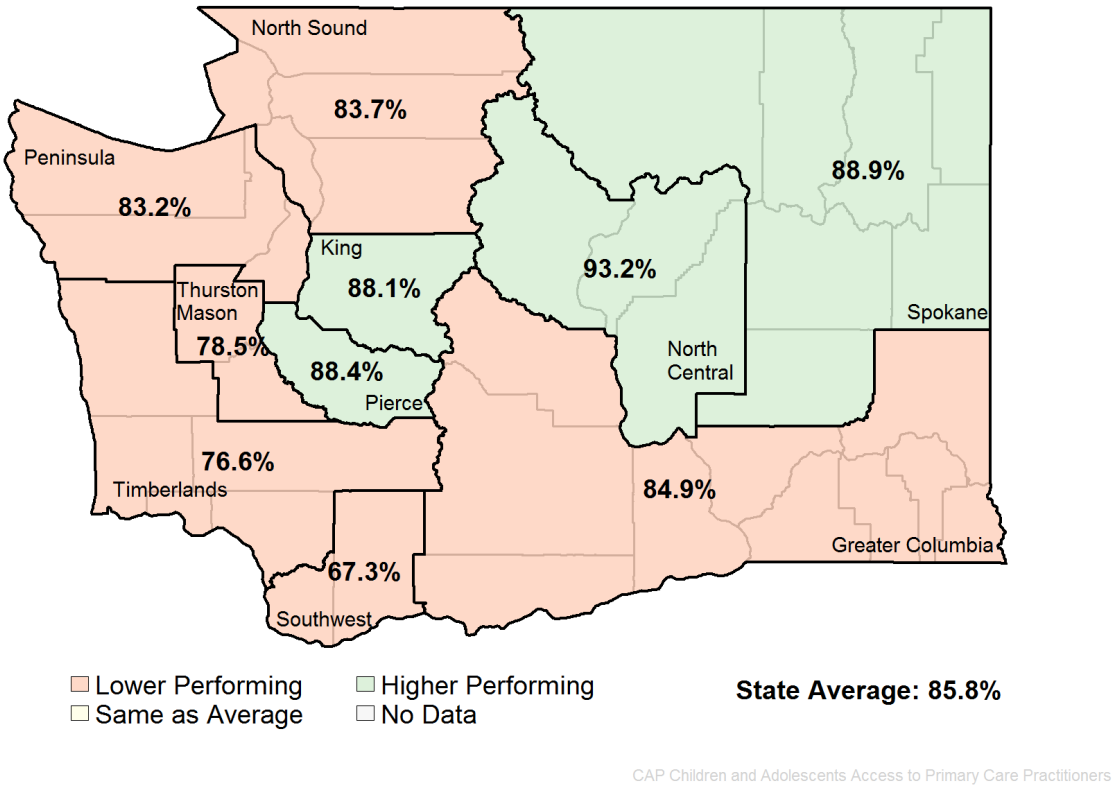


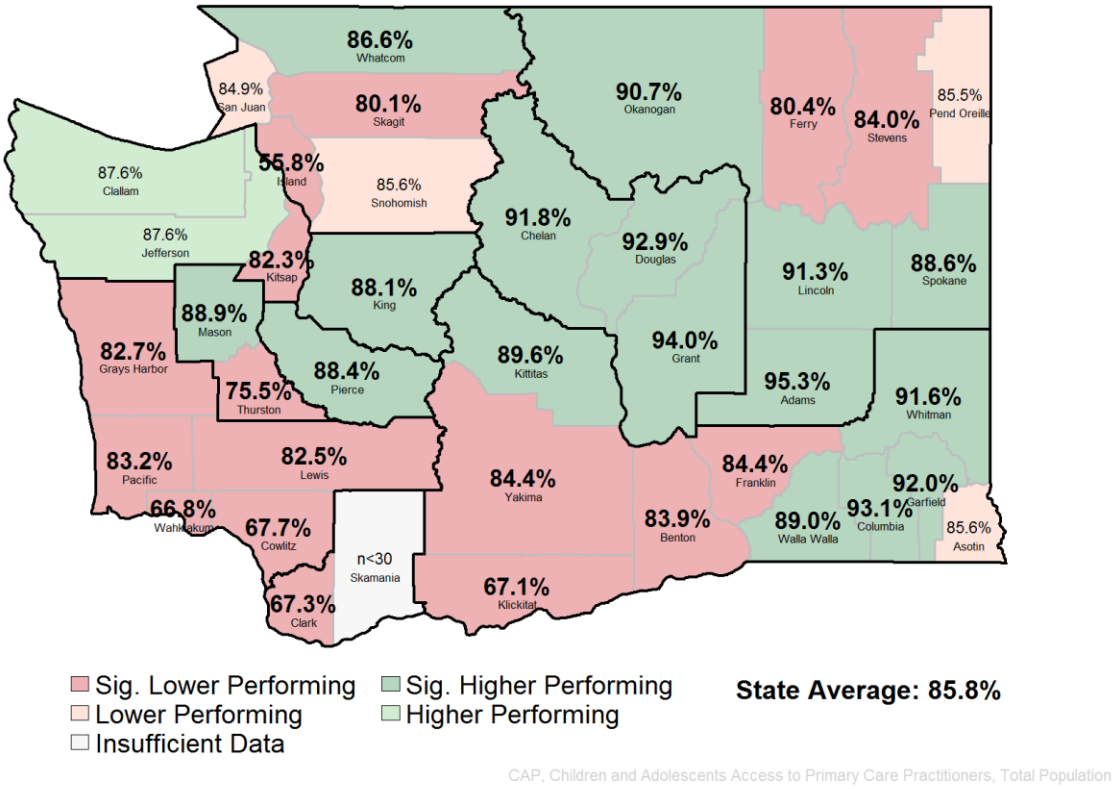
Table 18 shows MCO variation within each region. North Central had the lowest variation between MCOs (7.1 percent), while Thurston-Mason had the highest variation between MCOs (46.3 percent). CHPW was the lowest-performing MCO in each region.

Table 18: MCO Performance Range by Region, Child and Adolescent Access to Primary Care, 2016 RY

Region	Region Average	Highest-Performing MCO	Lowest-Performing MCO	Difference
Greater Columbia	84.9%	MHW (92.0%)	CHPW (70.0%)	22.0%
King	88.1%	MHW (91.9%)	CHPW (79.5%)	12.4%
North Central	93.2%	CCW (95.7%)	CHPW (88.6%)	7.1%
North Sound	83.7%	UHC (93.3%)	CHPW (66.8%)	26.5%
Peninsula	83.2%	MHW (91.2%)	CHPW (66.2%)	25.0%
Pierce	88.4%	MHW (91.7%)	CHPW (67.9%)	23.8%
Southwest	67.3%	MHW (82.5%)	CHPW (46.2%)	36.3%
Spokane	88.9%	CCW (92.0%)	CHPW (77.3%)	14.7%
Thurston-Mason	78.5%	MHW (91.5%)	CHPW (45.2%)	46.3%
Timberlands	76.6%	MHW (89.7%)	CHPW (59.2%)	30.5%
Statewide	**85.8%**	**MHW (91.6%)**	**CHPW (70.6%)**	**21.1%**

Regional aggregation can mask county-level variation. For example, as shown in Figure 15, child and adolescent access in Whatcom County is statistically significantly above the state average, even though the North Sound region as a whole falls below the state average. Five counties fell below the 70 percent rate for access: Island (55.8 percent), Wahkiakum (66.8 percent), Kittitas (67.1 percent), Clark (67.3 percent), and Cowlitz (67.7 percent). Island County is served by all five MCOs (see Figure 2 on page 9), but the other listed counties were served by one to three MCOs.

Figure 15: Map of County Variation, Child and Adolescent Access to Primary Care, 2016 RY



Variation by Gender

Rates of child and adolescent access to primary care did not vary substantially by gender except for the 12–19 years group, for which females were more likely to have had a primary care visit. The gender disparity among individuals ages 12–19 is consistent with what is seen in adult access to primary care.

Variation by Race and Language

The rate of child and adolescent access to primary care showed variation by race. Children who are Pacific Islander/Hawaiian were less likely to have received a primary care visit during the reporting year (74.2 percent), while children who are Asian and black were more likely to have had a primary care visit (87.9 percent and 86.4 percent, respectively). Rates of access, by race, are shown in Table 19.

Table 19: Statewide Performance by Race, Child and Adolescent Access to Primary Care, 2016 RY

Race	Rate	Number of Enrollees
Asian	87.9%	23,737
Black	86.4%	30,933
Hispanic	86.5%	137,270
Native American/Alaska Native	82.6%	3,458
Native Hawaiian/Pacific Islander	74.2%	4,647
White	85.5%	167,957
Other race	85.3%	18,446
Unknown race	84.7%	37,514

As shown in Table 20, child and adolescent access to primary care did not show substantial variation by primary language of the enrollee. Only the rate for individuals with language coded as unknown was statistically lower than the aggregate state average. This is in contrast to adult access to primary care, where individuals with language unknown (many of whom are enrolled through the Healthy Options Blind/Disabled program) had higher rates of access.

Table 20: Statewide Performance by Language, Child and Adolescent Access to Primary Care, 2016 RY

Language	Performance	Number of Enrollees
English	85.6%	334,679
Spanish	86.8%	76,835
Other language	85.0%	10,922
Unknown language	77.4%	1,526

Variation by Enrollment Program

The state rate for child and adolescent access to primary care is driven by individuals enrolled in the Healthy Options (traditional Medicaid) program, in which almost 92 percent of eligible individuals are enrolled (Table 21).

Table 21: Statewide Performance by Enrollment Program, Child and Adolescent Access to Primary Care, 2016 RY

Program	Performance	Number of Enrollees
Apple Health Adult Coverage (Medicaid Expansion)	89.0%	3,333
Healthy Options (Traditional Medicaid)	85.5%	389,302
Healthy Options Blind/Disabled	89.6%	12,629
State Children's Health Insurance Program	89.0%	16,964

Spotlight: Racial Variation in Prenatal and Postpartum Care

Prenatal and postpartum care measures are collected using the "hybrid" methodology. Each plan sampled 411 to 439 records from eligible enrollees to determine performance rates. Because of sample sizes, it is not feasible to conduct regional analyses for hybrid measures. However, sample sizes permit limited analyses by race or other demographic factors. Qualis Health selected these measures for additional analysis because of the low overall state rate, alignment with Healthier Washington goals, and HCA interest in reducing disparities in birth outcomes.

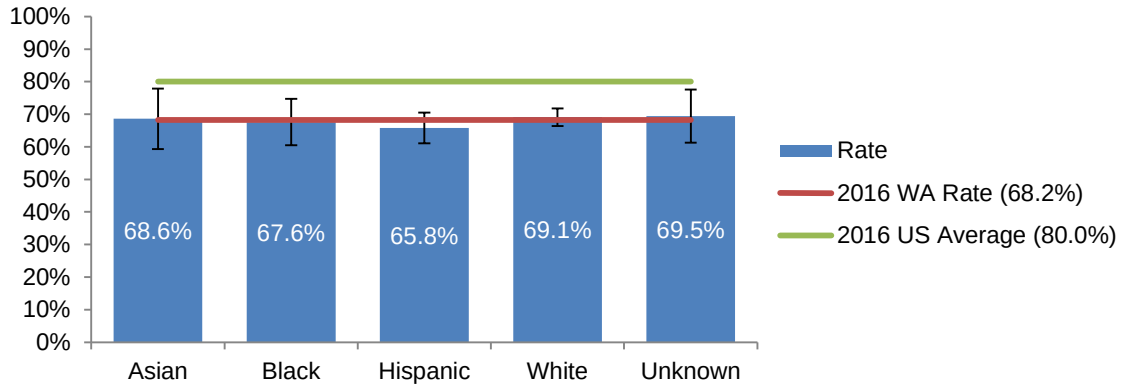
The analyses below were conducted to attempt to identify whether racial disparities exist in the provision of prenatal and postpartum care to Apple Health enrollees. A minimum of 100 eligible enrollees are included in the entire sample for each reported rate below.

Note: Because of the small sample sizes of select groups, the confidence intervals on performance rates can be wide; it is important to identify statistically significant differences rather than simply rely on large differences in rates as evidence of disparities given the sizable potential impact of random variation.

Prenatal and Postpartum Care—Timeliness of Prenatal Care

This measure determines whether enrollees received their first prenatal visit during the first trimester or within 45 days of enrollment in Apple Health. Overall Apple Health performance (68.2 percent) fell significantly below the US average of national Medicaid plans (80.0 percent). There were no statistically significant differences in MCO performance for this measure by race, as shown in Figure 16, and all racial groups in Apple Health performed statistically significantly lower than the national average.

Figure 16: Statewide Performance by Race, Timeliness of Prenatal Care, 2016 RY

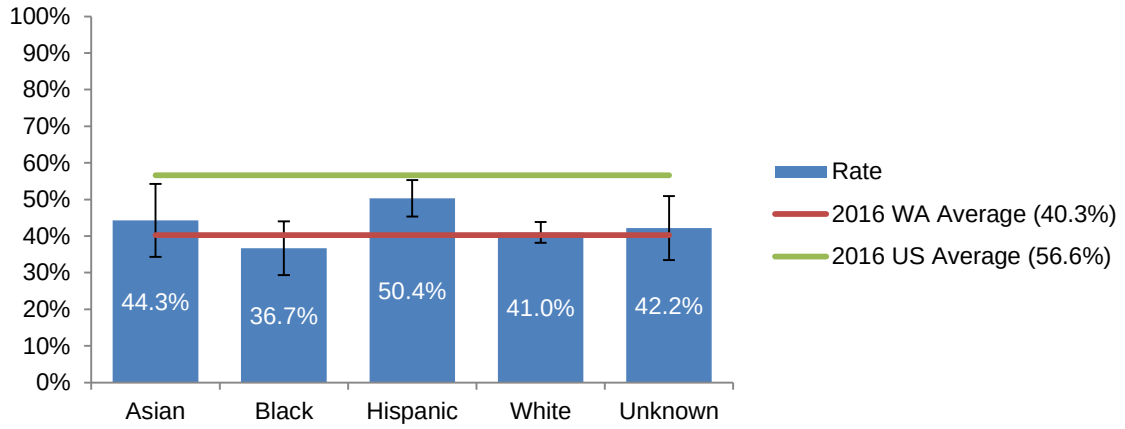


Frequency of Ongoing Prenatal Care—Receipt of At Least 81% of Recommended Visits

This measure determines the percentage of Apple Health enrollees who received at least 81 percent of recommended prenatal care visits during their pregnancies. (Note that the number of recommended prenatal visits varies for each enrollee, depending on the enrollee's state of pregnancy at the time of enrollment). The statewide Apple Health rate (40.3 percent) was significantly lower than the national average of Medicaid plans (56.6 percent) for enrollees receiving at least 81 percent of recommended prenatal visits. Individuals who are Hispanic were statistically significantly more likely to receive at least

81 percent of recommended prenatal visits compared to the state rate. However, all racial groups had statistically significantly lower performance rates than the 2016 US Medicaid national average, as shown in Figure 17.

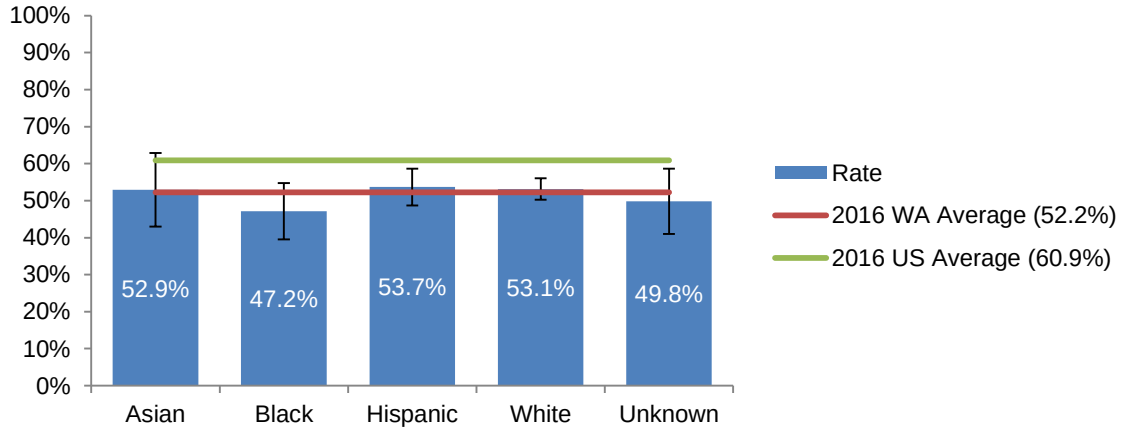
Figure 17: Statewide Performance by Race, Frequency of Ongoing Prenatal Care, 2016 RY



Prenatal and Postpartum Care—Postpartum Visit

This measure determines whether women received at least one visit during the postpartum period. Postpartum visits can be important visits for mother and baby well care as well as for future family planning. The Apple Health average (52.2 percent) was significantly lower than the 2016 US average of Medicaid plans (60.9 percent), as shown in Figure 18. Qualis Health's analysis did not provide evidence of racial disparities in the receipt of adequate postpartum care; however, it is important to continue monitoring this measure in light of disparities in birth outcomes and infant mortality in Washington State, as well as the low overall performance on this measure.

Figure 18: Statewide Performance by Race, Postpartum Visit, 2016 RY



Preventive Care

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

- Breast cancer screening
- Chlamydia screening

Breast Cancer Screening

The breast cancer screening measure is defined as the percentage of women ages 50–74 years who had a mammogram within the last two years. A higher score indicates better performance.

Variation by MCO and Region

There were 15,145 women ages 50–74 years who were eligible for this measure during the 2016 reporting year. A total of 52.3 percent of those women had a mammogram within the last two years. MHW was the highest-performing MCO on this measure (56.7 percent), while AMG was the lowest (43.9 percent). Figure 19 shows how all MCOs performed on this measure in 2015 RY and 2016 RY. Mammography rates may be low because some women are unaware of the importance of routine mammograms, are apprehensive about the procedure, or face barriers to accessing mammogram services. MCOs may improve mammography rates by raising patient awareness and using computerized tracking and reminder systems to support patient outreach.

Figure 19: Breast Cancer Screening by MCO, 2015 RY and 2016 RY

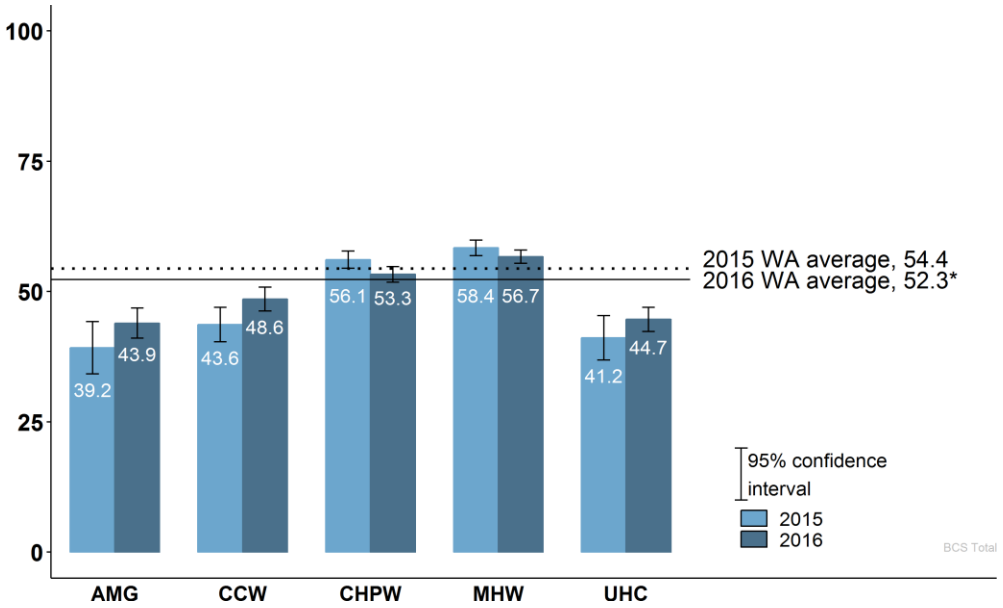


Table 22 shows regional performance variation by MCO. MHW had the highest variation between regions (21.7 percent), while AMG had the lowest (7.6 percent).

Table 22: Range of Regional Variation by MCO, Breast Cancer Screening, 2016 RY

MCO	MCO Average	Highest-Performance Region	Lowest-Performance Region	Difference
AMG	43.9%	Spokane (47.2%)	Pierce (39.6%)	7.6%
CCW	48.6%	Spokane (58.0%)	North Sound (42.4%)	15.6%
CHPW	53.3%	North Central (60.3%)	Spokane (43.8%)	16.5%
MHW	56.7%	Spokane (63.3%)	Southwest (41.6%)	21.7%
UHC	44.7%	Greater Columbia (48.8%)	Peninsula (37.9%)	10.9%
All MCOs	**52.3%**	**North Central (57.7%)**	**Southwest (47.8%)**	**9.9%**

Figure 20 shows the region-level results for this measure. King and North Central were statistically above the state average, and Pierce and Timberlands were statistically below. Although Southwest had the lowest performance among regions (47.8 percent), there were relatively few eligible enrollees in this area, and the difference from the state rate is not statistically significant. Regions with lower rates may have barriers to accessing other preventive care services or a shortage of mammography options.

Figure 20: Map of Regional Variation, Breast Cancer Screening, 2016 RY

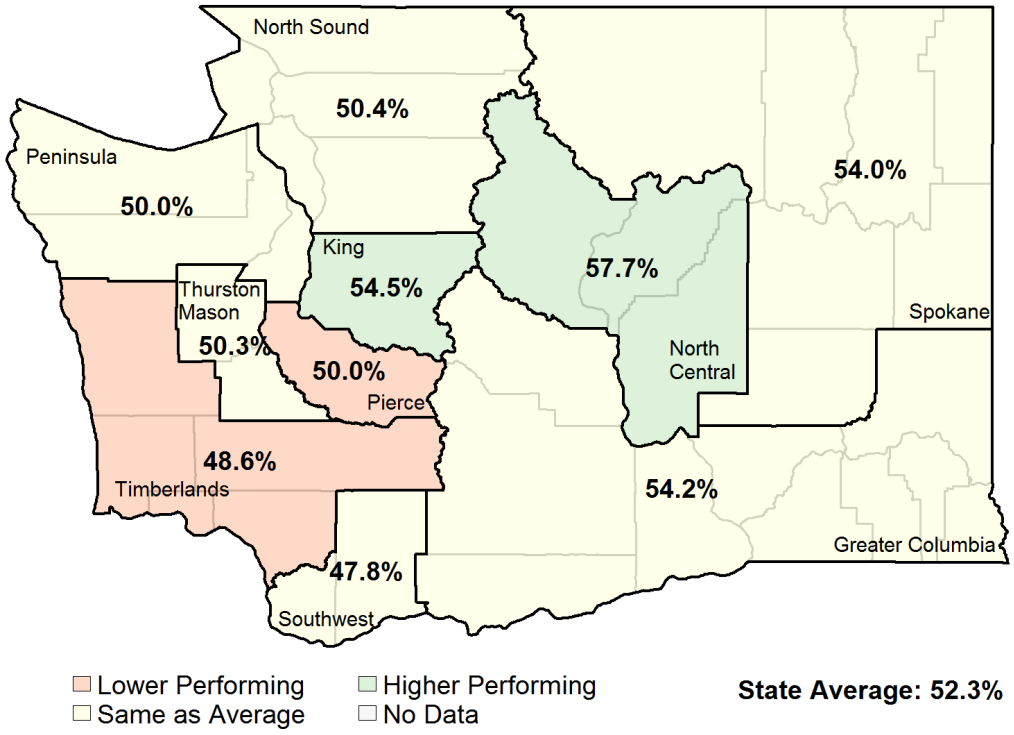


Table 23 displays MCO variation within regions. Greater Columbia had the least variation between MCOs (9.1 percent), while Spokane had the highest variation between MCOs (20.1 percent).

Table 23: MCO Performance Range by Region, Breast Cancer Screening, 2016 RY

Region	Region Average	Highest-Performing MCO	Lowest-Performing MCO	Difference
Greater Columbia	54.2%	CHPW (57.9%)	UHC (48.8%)	9.1%
King	54.5%	MHW (60.5%)	AMG (44.6%)	15.9%
North Central	57.7%	MHW (60.3%)	CCW (49.1%)	11.2%
North Sound	50.4%	CHPW (52.9%)	AMG (41.5%)	11.4%
Peninsula	50.0%	CHPW (54.6%)	UHC (37.9%)	16.7%
Pierce	50.0%	MHW (55.9%)	AMG (39.6%)	16.3%
Southwest	47.8%	CHPW (59.0%)	MHW (41.6%)	17.4%
Spokane	54.0%	MHW (63.3%)	UHC (43.2%)	20.1%
Thurston-Mason	50.3%	MHW (55.8%)	CCW (43.7%)	12.1%
Timberlands	48.6%	MHW (53.4%)	UHC (39.2%)	14.2%
Statewide	**52.3%**	**MHW (56.7%)**	**AMG (43.9%)**	**12.8%**

Variation by Age

Rates of breast cancer screening varied only slightly by age group. Individuals ages 45–54 were slightly less likely to have received mammograms than individuals 55–64 (50.8 percent vs. 52.8 percent).

Variation by Race and Language

Member-level analyses indicate that women who are Asian had the highest breast cancer screening rates (67.5 percent), while women who are Native American/Alaska Native were least likely to be screened (43.6 percent). Rates of other racial groups were statistically similar to the statewide rate.

Individuals whose primary language is not English, interestingly, were statistically significantly more likely to have received adequate breast cancer screening than individuals whose primary language is English, as shown in Table 24.

Table 24: Statewide Performance Rate by Language, Breast Cancer Screening, 2016 RY

Language	Rate	Number of Enrollees
English	52.3%	11,355
Spanish	75.0%	180
Other language	68.1%	429
Unknown language	48.7%	3,181

Variation by Enrollment Program

Most enrollees eligible for the breast cancer screening measure were enrolled in the Healthy Options Blind/Disabled program. Individuals enrolled in that program were also less likely to have received adequate screening, as shown in Table 25. It is possible that there are structural barriers limiting access for these individuals that can be addressed at the state level.

Table 25: Statewide Performance Rate by Enrollment Program, Breast Cancer Screening, 2016 RY

Primary Enrollment Program	Rate	Number of Enrollees
Apple Health Adult Coverage (Medicaid Expansion)	62.7%	3,585
Healthy Options (Traditional Medicaid)	53.2%	620
Healthy Options Blind/Disabled	48.8%	10,940

Chlamydia Screening

Chlamydia screening is defined as the percentage of sexually active women ages 16–24 years who have had at least one test for chlamydia. A higher score indicates better performance.

Variation by MCO and Region

There were 43,190 women ages 16–24 years eligible for chlamydia screening in the 2016 reporting year. A total of 54.8 percent had at least one chlamydia test. AMG was the highest-performing MCO (56.6 percent), while CHPW was the lowest (53.5 percent). Figure 21 displays the 2015 RY and 2016 RY results of the chlamydia screening measure by MCO.

Figure 21: Performance on Chlamydia Screening by MCO, 2015 RY and 2016 RY

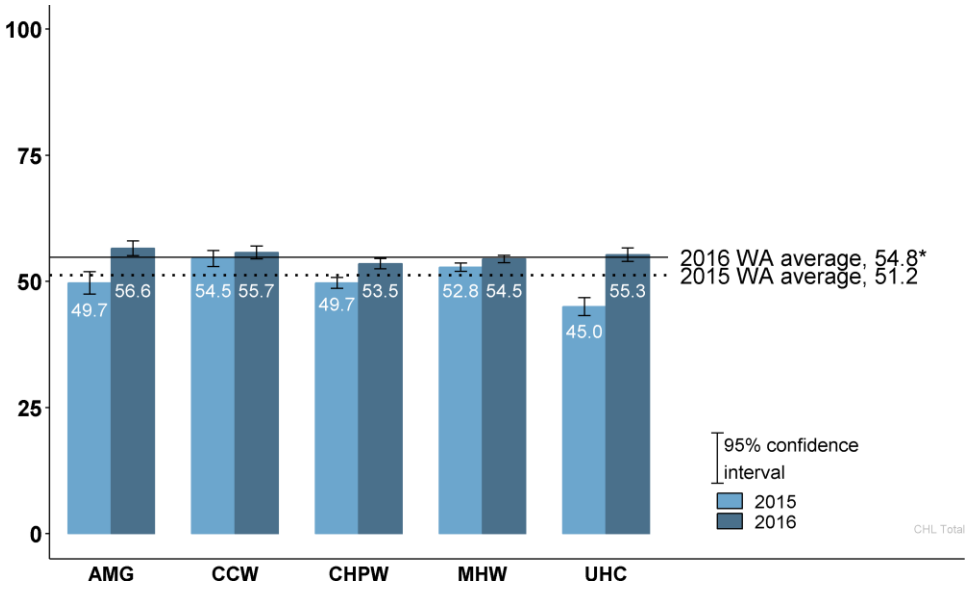


Table 26 shows the regional variation on this measure for each MCO. UHC had the lowest variation between regions (8.9 percent) while MHW had the highest variation between regions (19.9 percent).

Table 26: Range of Regional Variation by MCO, Chlamydia Screening, 2016 RY

MCO	MCO Average	Highest-Performance Region	Lowest-Performance Region	Difference
AMG	56.6%	Greater Columbia (60.5%)	North Sound (47.4%)	13.1%
CCW	55.7%	Thurston-Mason (60.4%)	North Central (43.7%)	16.7%
CHPW	53.5%	Pierce (58.1%)	Peninsula (47.4%)	10.7%
MHW	54.5%	Southwest (65.0%)	North Central (45.1%)	19.9%
UHC	55.3%	Thurston-Mason (59.0%)	North Sound (50.1%)	8.9%
All MCOs	**54.8%**	**Southwest (60.0%)**	**North Central (46.9%)**	**13.1%**

Figure 22 shows the region-level results. Performance in Southwest, Pierce, Thurston-Mason, and King was statistically above the state average; performance in North Sound, Peninsula, and North Central was statistically below the state average. MCOs were highest performing in Southwest (60.0 percent) and lowest performing in North Central (46.9 percent).

Figure 22: Map of Regional Variation, Chlamydia Screening, 2016 RY

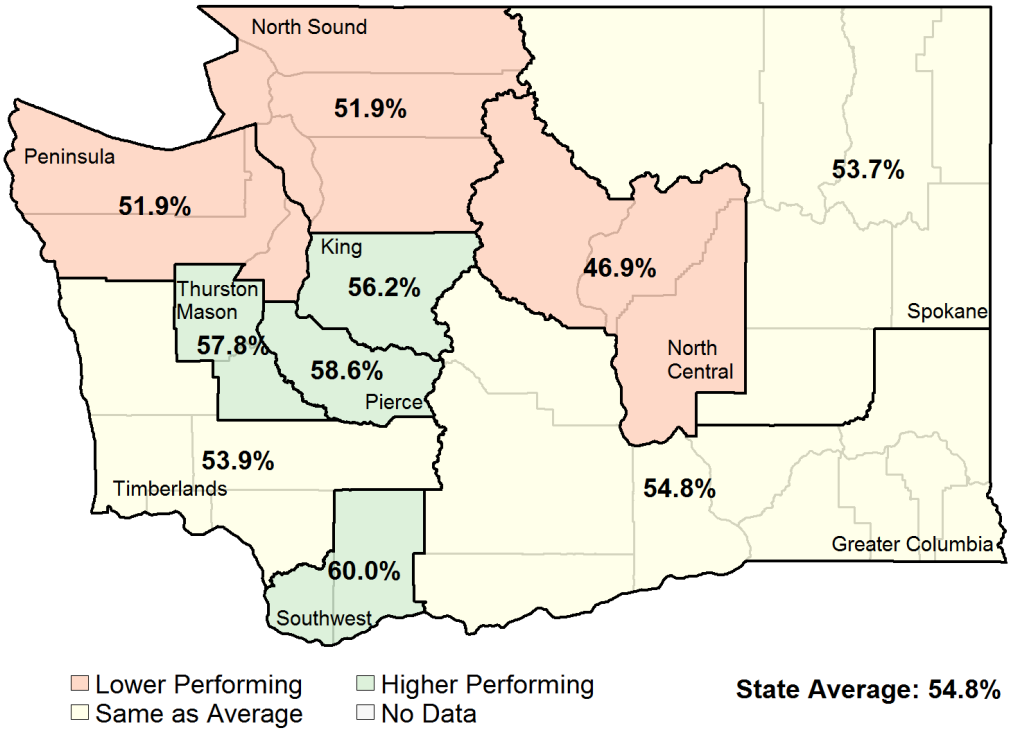


Table 27 shows MCO performance variation within regions. King had the lowest variation between MCOs (1.9 percent) while Timberlands had the highest (11.9 percent). There was little overall performance difference between MCOs on this measure statewide (3.1 percent).

Table 27: MCO Performance Range by Region, Chlamydia Screening, 2016 RY

Region	Region Average	Highest-Performing MCO	Lowest-Performing MCO	Difference
Greater Columbia	54.8%	AMG (60.5%)	MHW (51.8%)	8.7%
King	56.2%	CCW (57.1%)	CHPW (55.2%)	1.9%
North Central	46.9%	UHC (54.5%)	CCW (43.7%)	10.8%
North Sound	51.9%	CHPW (54.1%)	AMG (47.4%)	6.7%
Peninsula	51.9%	AMG (57.9%)	CHPW (47.4%)	10.5%
Pierce	58.6%	CCW (60.2%)	MHW (57.9%)	2.3%
Southwest	60.0%	MHW (65.0%)	CHPW (54.5%)	10.5%
Spokane	53.7%	CCW (59.1%)	CHPW (49.6%)	9.5%
Thurston-Mason	57.8%	AMG (60.5%)	MHW (56.3%)	4.2%
Timberlands	53.9%	AMG (58.6%)	CCW (46.7%)	11.9%
Statewide	54.8%	AMG (56.6%)	CHPW (53.5%)	3.1%

Variation by Age

Table 28 shows MCO performance by age group: 16–20 years and 21–24 years. Individuals in the 16–20 age group were less likely to have been screened for chlamydia (49.7 percent) compared to women ages 21–24 (59.7 percent).

Table 28: Statewide Performance Rate by Age Group, Chlamydia Screening, 2016 RY

Age Group	Performance	Number of Enrollees
16–20	49.7%	21,388
21–24	59.7%	21,802

Variation by Race and Language

Analysis of 2016 RY data revealed some variation in statewide performance according to race, as shown in Table 29. For example, individuals who are black were more likely to have received chlamydia screening compared to the overall state rate (64.3 percent and 54.8 percent, respectively).

Table 29: Statewide Performance Rate by Race, Chlamydia Screening, 2016 RY

Race	Rate	Number of Enrollees
Asian	52.6%	1,873
Black	64.3%	3,578
Hispanic	55.9%	10,604
Native American/Alaska Native	53.0%	319
Native Hawaiian/Pacific Islander	55.6%	592
White	53.3%	24,205
Other race	51.7%	1,194
Unknown race	49.5%	825

Performance also varied by enrollee language. Enrollees speaking Spanish and languages other than English, and those for whom primary language was unknown, received screenings at lower rates (45.9 percent, 36.7 percent, and 48.8 percent, respectively) than English speakers, who received screenings at a rate of 55.3 percent. Table 30 shows the statewide performance rates for chlamydia screenings by language.

Table 30: Statewide Performance Rate by Language, Chlamydia Screening, 2016 RY

Language	Rate	Number of Enrollees
English	55.3%	40,369
Spanish	48.8%	2,271
Other language	36.7%	308
Unknown language	45.9%	242

Variation by Enrollment Program

Individuals enrolled in Healthy Options (traditional Medicaid) were slightly less likely to have received chlamydia screening compared to the state average, while individuals enrolled in Apple Health Adult Coverage (Medicaid expansion) were more likely to have been screened. Table 31 and Table 32 show statewide performance rates for 2016 RY by enrollment program and age.

Table 31: Statewide Performance Rate by Enrollment Program, Chlamydia Screening, Ages 16–20, 2016 RY

Program	Rate	Number of Enrollees
Apple Health Adult Coverage (Medicaid Expansion)	55.7%	5,294
Healthy Options (Traditional Medicaid)	48.9%	14,655
Healthy Options Blind/Disabled	37.5%	624
State Children's Health Insurance Program	34.4%	736

*There are additional programs included in this population for which volumes are too small to report.

Table 32: Statewide Performance Rate by Enrollment Program, Chlamydia Screening, Ages 21–24, 2016 RY

Program	Rate	Number of Enrollees
Apple Health Adult Coverage (Medicaid Expansion)	59.7%	13,829
Healthy Options (Traditional Medicaid)	61.2%	7,028
Healthy Options Blind/Disabled	46.6%	877

*There are additional programs included in this population for which volumes are too small to report.

Chronic Care Management

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

- Antidepressant medication management, acute treatment phase
- Antidepressant medication management, continuation treatment phase
- Controlling high blood pressure

Antidepressant Medication Management, Acute Treatment Phase

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

Variation by MCO and Region

There were 18,824 enrollees ages 18 years or older who had a new episode of major depression and were treated with an antidepressant medication during the 2016 reporting year. A total of 54.3 percent of eligible enrollees remained on the medication for the entire 84-day acute treatment phase. AMG was the highest-performing MCO (60.5 percent), while MHW was the lowest (52.2 percent). Figure 23 shows performance by all MCOs on this measure for 2015 RY and 2016 RY.

Figure 23: Performance by MCO, Acute Antidepressant Management, 2015 RY and 2016 RY

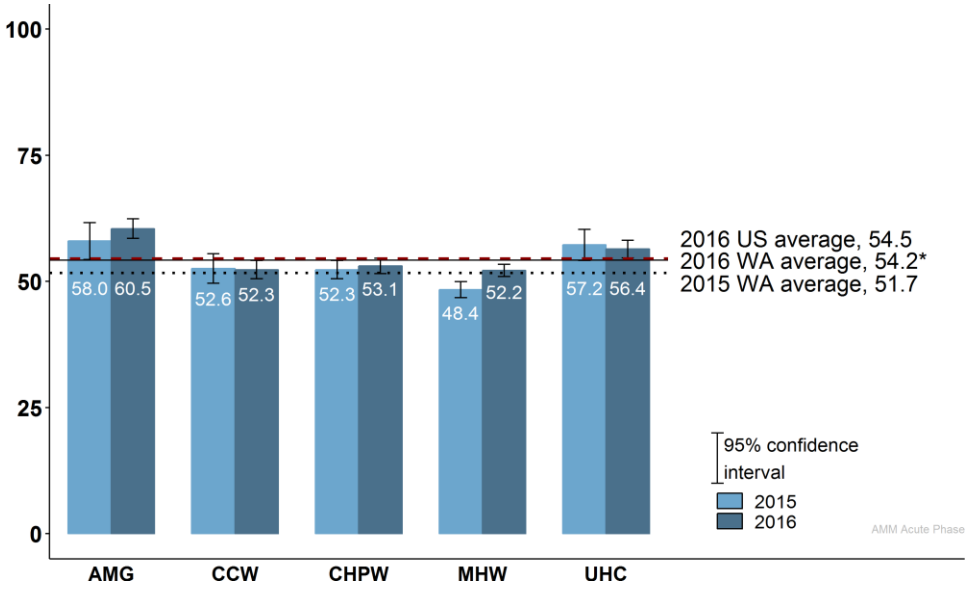


Table 33 displays the variation in performance among MCOs by region. UHC had the lowest level of variation between regions (7.3 percent), while CHPW had the highest (23.1 percent).

Table 33: Range of Regional Variation by MCO, Acute Antidepressant Management, 2016 RY

MCO	MCO Average	Highest-Performance Region	Lowest-Performance Region	Difference
AMG	60.5%	Thurston-Mason (70.8%)	Spokane (57.0%)	13.8%
CCW	52.3%	Thurston-Mason (55.6%)	Greater Columbia (46.6%)	9.0%
CHPW	53.1%	Peninsula (67.2%)	North Central (44.1%)	23.1%
MHW	52.2%	Thurston-Mason (58.6%)	Greater Columbia (48.7%)	9.9%
UHC	56.4%	Peninsula (60.7%)	Timberlands (53.4%)	7.3%
All MCOs	**54.2%**	**Peninsula (59.3%)**	**North Central (47.9%)**	**11.4%**

Figure 24 below shows statewide performance by region. MCOs performed significantly above the state average in Peninsula (59.3 percent) and Thurston-Mason (58.6 percent), while in North Central (47.9 percent) and Greater Columbia (50.2 percent) they performed below the state average.

Figure 24: Map of Regional Variation, Acute Antidepressant Management, 2016 RY

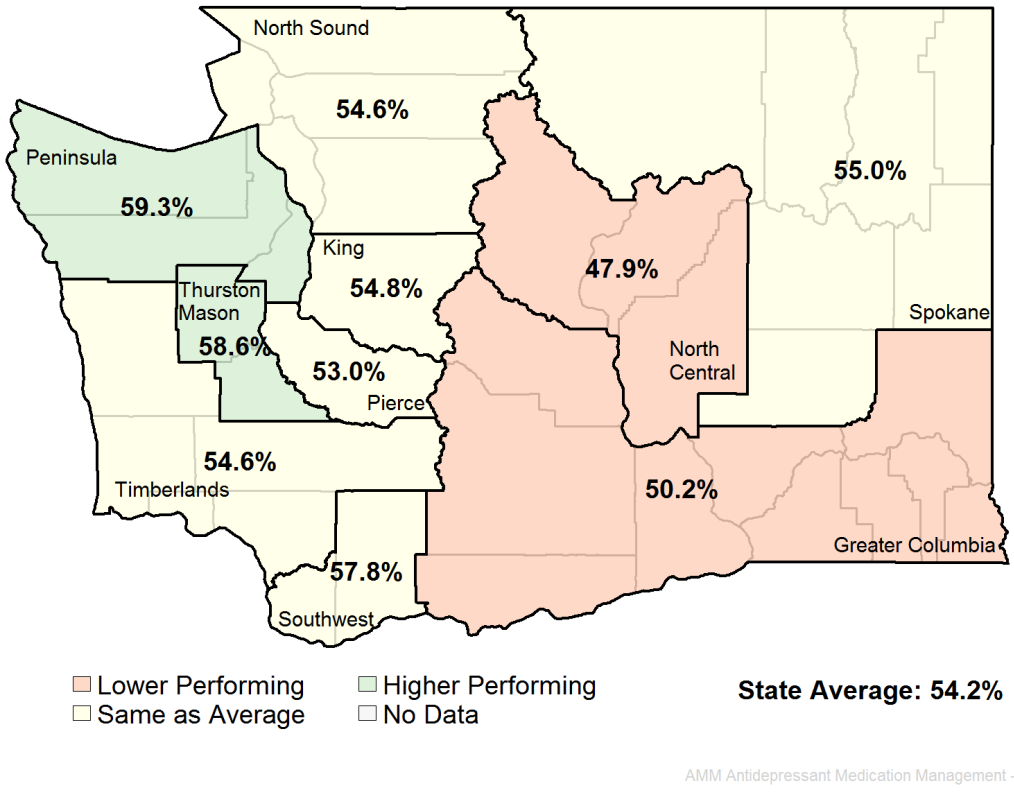


Table 34 shows variation in MCO performance within regions. Southwest had the lowest variation between MCOs (0.3 percent), while Thurston-Mason had the highest (20.8 percent).

Table 34: MCO Performance Range by Region, Acute Antidepressant Management, 2016 RY

Region	Region Average	Highest-Performing MCO	Lowest-Performing MCO	Difference
Greater Columbia	50.2%	AMG (65.6%)	CCW (46.6%)	19.0%
King	54.8%	AMG (59.3%)	CHPW (48.9%)	10.4%
North Central	47.9%	CCW (49.5%)	CHPW (44.1%)	5.4%
North Sound	54.6%	AMG (57.5%)	CCW (53.2%)	4.3%
Peninsula	59.3%	CHPW (67.2%)	CCW (50.6%)	16.6%
Pierce	53.0%	AMG (61.0%)	MHW (49.7%)	11.3%
Southwest	57.8%	CHPW (57.6%)*	MHW (57.3%)	0.3%
Spokane	55.0%	UHC (58.5%)	CHPW (52.3%)	6.2%
Thurston-Mason	58.6%	AMG (70.8%)	CHPW (50.0%)	20.8%
Timberlands	54.6%	CHPW (57.3%)	MHW (50.0%)	7.3%
Statewide	54.2%	AMG (60.5%)	MHW (52.2%)	8.3%

*Highest MCO with a minimum of 30 eligible enrollees.

Variation by Age and Gender

More than twice as many women had episodes of acute depression during RY 2016 compared to men (12,924 vs. 5,900), but there were no significant differences in rates of acute phase antidepressant medication management by gender (53.9 percent vs. 55.0 percent, respectively). Table 35 shows the rate for each gender broken down by age.

Table 35: Statewide Performance Rate by Age and Gender, Acute Antidepressant Management, 2016 RY

	Ages 18–24	Ages 25–44	Ages 45–64	Total
Men	42.3%	55.6%	57.4%	55.0%
Women	45.1%	53.4%	58.8%	53.9%
Total	44.4%	54.1%	58.3%	54.2%

Note: There are also a nominal number of individuals who are 65 and older included in the total number; volumes are too small to report individually for that age group.

Variation by Race and Language

Performance indicated that individuals who are racial minorities were less likely to have received adequate antidepressant medication management during the acute phase compared to individuals who are white, as shown in Table 36.

Table 36: Statewide Performance by Race, Acute Antidepressant Management, 2016 RY

Race	Rate	Number of Enrollees
Asian	50.9%	585
Black	42.0%	1,282
Hispanic	44.4%	2,286
Native American/Alaska Native	54.8%	126
Native Hawaiian/Pacific Islander	48.8%	164
White	57.4%	13,487
Other race	46.6%	408
Unknown race	57.2%	486

Additionally, individuals whose primary language is Spanish were less likely to have received adequate acute phase antidepressant medication management compared to individuals whose primary language is English (35.3 percent vs. 54.9 percent, respectively), as shown in Table 37.

Table 37: Statewide Performance by Language, Acute Antidepressant Management, 2016 RY

Language	Rate	Number of Enrollees
English	54.9%	17,676
Spanish	35.3%	417
Other language	49.2%	191
Unknown language	50.2%	540

Variation by Enrollment Program

Data for 2016 indicated that MCO performance varied significantly by enrollment program, as shown in Table 38. Individuals enrolled as part of the Healthy Options Blind/Disabled program were less likely than other adults to have adequate medication management of antidepressants during the acute phase, despite having overall higher access to adult and adolescent primary care, as shown in previous sections. It could be that there are structural barriers in place for individuals enrolled in the Healthy Options Blind/Disabled program when seeking mental healthcare services that do not exist for physical healthcare services.

Table 38: Statewide Performance by Enrollment Program, Acute Antidepressant Management, 2016 RY

Primary Enrollment Program	Rate	Number of Enrollees
Apple Health Adult Coverage (Medicaid Expansion)	57.1%	11,766
Healthy Options (Traditional Medicaid)	50.0%	4,592
Healthy Options Blind/Disabled	48.3%	2,437

Antidepressant Medication Management, Continuation Phase

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

Variation by MCO and Region

There were 18,824 enrollees ages 18 years or older who had a new episode of major depression and were treated with an antidepressant medication during the 2016 reporting year. A total of 39.4 percent of those enrollees remained on the medication for the entire 180-day continuation phase. AMG was the highest-performing MCO (46.4 percent) on this measure, while MHW was the lowest (37.2 percent). Figure 25 presents performance measure results for this measure by MCO.

Figure 25: Performance by MCO, Continuation Antidepressant Management, 2015 RY and 2016 RY

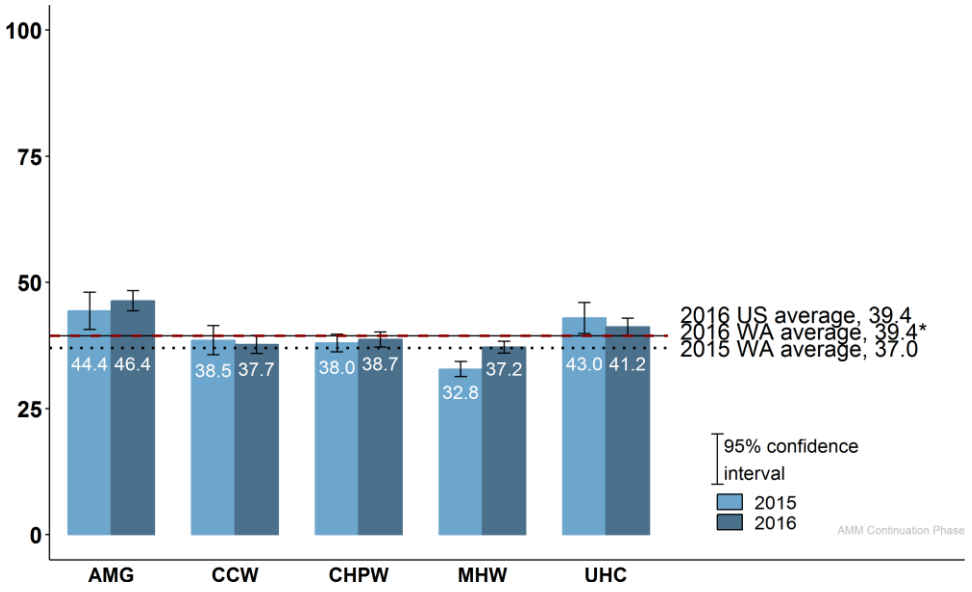


Table 39 shows regional performance variation within each MCO. UHC and CCW had the lowest level of variation (9.9 percent), while AMG had the highest (23.4 percent).

Table 39: Range of Regional Variation by MCO, Continuation Antidepressant Management, 2016 RY

MCO	MCO Average	Highest-Performance Region	Lowest-Performance Region	Difference
AMG	46.4%	Thurston-Mason (57.9%)	Timberlands (34.5%)	23.4%
CCW	37.7%	King (41.3%)	Greater Columbia (31.4%)	9.9%
CHPW	38.7%	Peninsula (47.5%)	North Central (29.4%)	18.1%
MHW	37.2%	Southwest (44.7%)	Greater Columbia (33.7%)	11.0%
UHC	41.2%	Peninsula (45.7%)	Timberlands (35.8%)	9.9%
All MCOs	**39.4%**	**Southwest (46.0%)**	**North Central (33.0%)**	**13.0%**

Figure 26 shows MCO performance by region. MCOs obtained the highest performance in Southwest (46.2 percent), Thurston-Mason (45.0 percent), and Peninsula (43.1 percent), and the lowest in North Central (33.7 percent) and Greater Columbia (35.2 percent). The relatively high rate in Southwest is noteworthy given it was an early adopter of fully integrated managed care during 2016 CY.

Figure 26: Map of Regional Variation, Continuation Antidepressant Management, 2016 RY

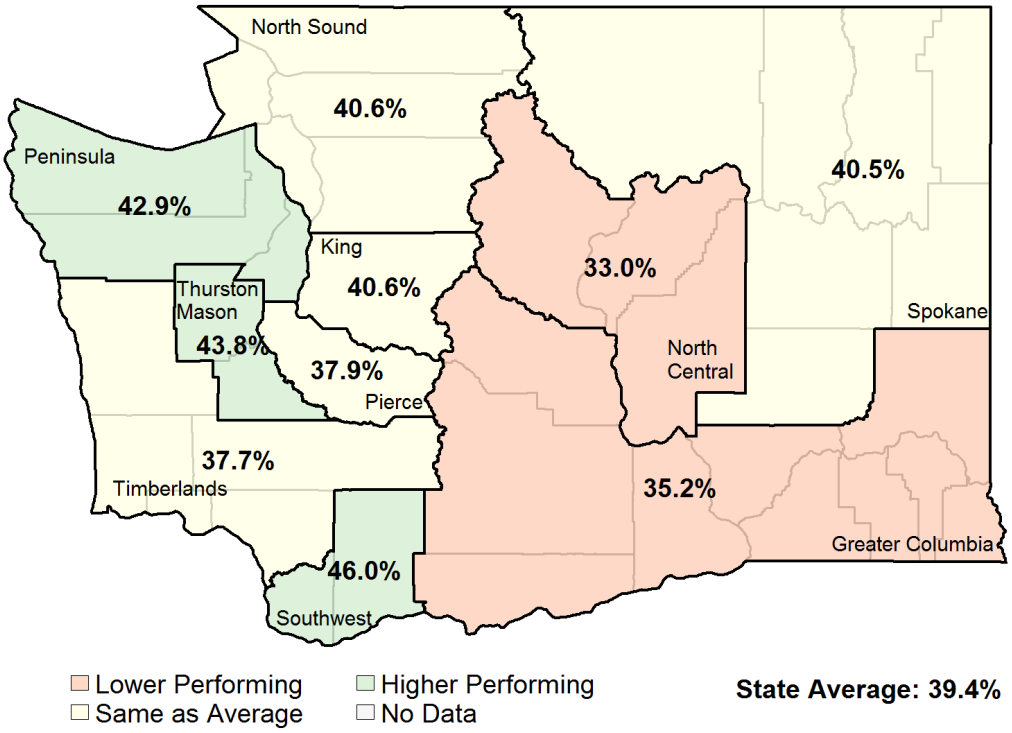


Table 40 shows MCO performance variation within regions. Southwest had the lowest level of variation (2.2 percent) and Greater Columbia had the highest (19.4 percent).

Table 40: MCO Performance Range by Region, Continuation Antidepressant Management, 2016 RY

Region	Region Average	Highest-Performing MCO	Lowest-Performing MCO	Difference
Greater Columbia	35.2%	AMG (50.8%)	CCW (31.4%)	19.4%
King	40.6%	AMG (47.0%)	CHPW (37.3%)	9.7%
North Central	33.0%	MHW (34.8%)	CHPW (29.4%)	5.4%
North Sound	40.6%	AMG (44.3%)	MHW (38.6%)	5.7%
Peninsula	42.9%	CHPW (47.5%)	CCW (38.5%)	9.0%
Pierce	37.9%	AMG (45.5%)	MHW (34.5%)	11.0%
Southwest	46.0%	CHPW (46.9%)	MHW (44.7%)	2.2%
Spokane	40.5%	UHC (42.6%)	CCW (37.6%)	5.0%
Thurston-Mason	43.8%	AMG (57.9%)	MHW (39.9%)	18.0%
Timberlands	37.7%	CHPW (40.3%)	AMG and MHW (34.5%)	5.8%
Statewide	39.4%	AMG (46.4%)	MHW (37.2%)	9.2%

Variation by Age and Gender

As with acute antidepressant medication management, the continuing antidepressant medication management measure shows a distinct trend by age, with individuals who are older being more likely to receive adequate follow-up care (Table 41). There was no significant performance variation by gender.

Table 41: Statewide Performance Rate by Age, Continuation Antidepressant Management, 2016 RY

Age Group	Rate	Number of Enrollees
18–24	26.5%	2,463
25–44	38.4%	9,939
45–64	46.1%	6,333
65+	47.2%	89

Variation by Race and Language

As with acute antidepressant medication management, performance on the continuing antidepressant medication management measure indicated that individuals who are white were more likely to have adequate continued monitoring, as shown in Table 42. There may be structural barriers to care for individuals who are not white; this may be worth further investigation as fully integrated managed care progresses in Washington State.

Table 42: Statewide Performance Rate by Race, Continuation Antidepressant Management, 2016 RY

Race	Rate	Number of Enrollees
Asian	38.6%	585
Black	27.5%	1,282
Hispanic	29.0%	2,286
Native American/Alaska Native	39.7%	126
Native Hawaiian/Pacific Islander	30.5%	164
White	42.7%	13,487
Other race	31.4%	408
Unknown race	42.2%	486

Additionally, individuals whose primary language is English are more likely to have adequate continuing antidepressant medication management. As shown in Table 43, individuals whose primary language is Spanish were approximately half as likely as individuals whose primary language is English to receive continued antidepressant medication management.

Table 43: Statewide Performance Rate by Language, Continuation Antidepressant Management, 2016 RY

Language	Rate	Number of Enrollees
English	40.1%	17,676
Spanish	19.9%	417
Other language	34.6%	191
Unknown language	36.7%	540

Variation by Enrollment Program

As with acute antidepressant medication monitoring, the continuation antidepressant medication monitoring measure shows that performance rates were better for individuals who were a part of the Apple Health Adult Coverage (Medicaid expansion) program (Table 44). This is a measure that should continue to be monitored as physical and behavioral health integration efforts move forward in Washington State.

Table 44: Statewide Performance Rate by Enrollment Program, Continuation Antidepressant Management, 2016 RY

Primary Enrollment Program	Rate	Number of Enrollees
Apple Health Adult Coverage (Medicaid Expansion)	42.8%	11,766
Healthy Options (Traditional Medicaid)	33.5%	4,592
Healthy Options Blind/Disabled	35.2%	2,437

Spotlight: Racial and Program Variation in Blood Pressure Control

The controlling high blood pressure measure is collected using the "hybrid" methodology. Each plan sampled 380 to 459 records from eligible enrollees to determine performance rates. Because of low sample sizes, it was not feasible to conduct regional analyses for this measure. However, it was possible to conduct limited analyses by race or other demographic factors. Qualis Health selected this measure for additional analysis because of known national disparities in performance and for alignment with Healthier Washington goals.

The analyses below were performed to attempt to identify whether racial disparities exist in blood pressure control for Apple Health enrollees. A minimum of 100 eligible enrollees are included in the entire sample for each reported rate below.

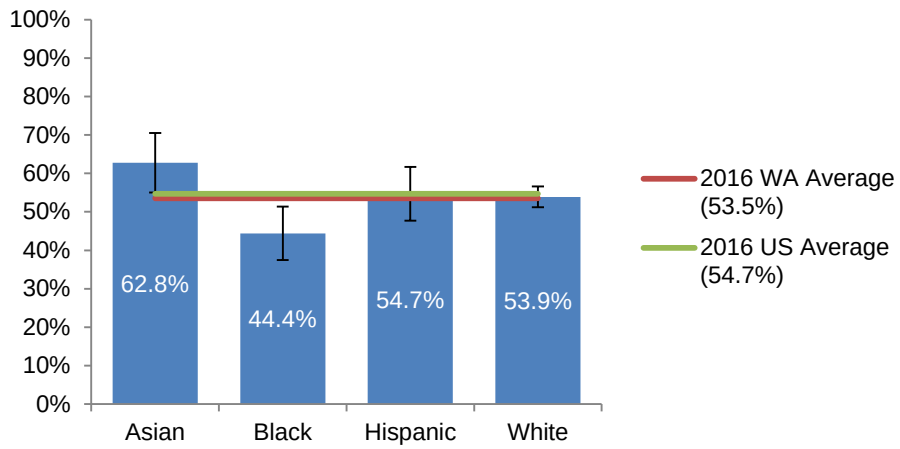
Note: Because of the small sample sizes of select groups, the confidence intervals on performance rates can be wide; it is important to identify statistically significant differences rather than simply rely on large differences in rates as evidence of disparities given the sizable potential impact of random variation.

Controlling High Blood Pressure

This measure is defined as the percentage of enrollees with diagnosed hypertension whose most recent blood pressure reading was under 140/90. The 2016 RY Apple Health average of controlling high blood pressure (53.5 percent) was statistically similar to the 2016 RY US average of Medicaid plans (54.7 percent). However, 2016 RY data also indicated evidence of racial disparities in blood pressure control.

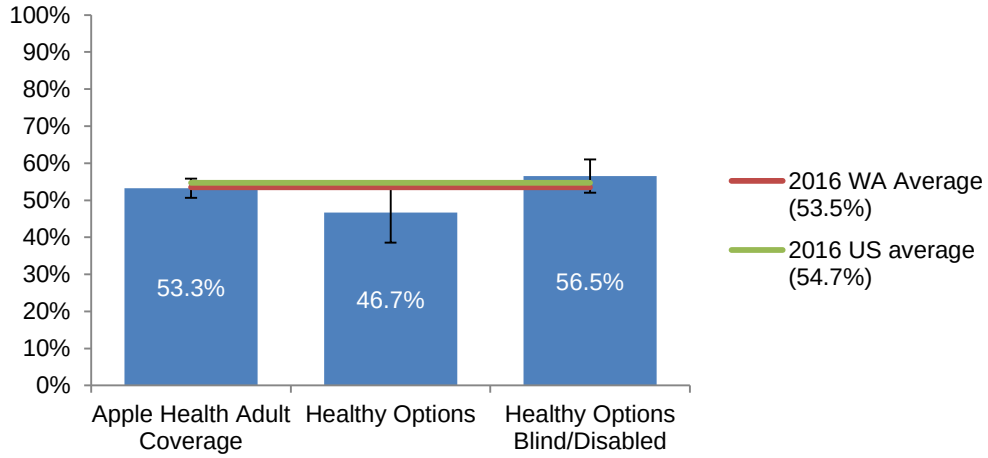
As shown in Figure 27, individuals with hypertension who are Asian were statistically significantly more likely to have their blood pressure under control compared to the state rate, and individuals with hypertension who are black were statistically significantly less likely to have their blood pressure under control. These values align with national data that indicate widespread disparities and present a clear quality improvement opportunity for providers working largely with black patients. Further work should be done at the state level to determine statewide opportunities for decreasing this disparity in blood pressure control.

Figure 27: Statewide Performance Rate by Race, Controlling High Blood Pressure, 2015 RY and 2016 RY



There is also statistically significant variation in performance based on program enrollment, as shown in Figure 28. Individuals enrolled in Healthy Options (traditional Medicaid) are statistically significantly less likely to have controlled high blood pressure compared to the state rate. There may be opportunities to improve overall management of blood pressure for individuals who are part of Healthy Options and other individuals living in poverty.

Figure 28: Statewide Performance Rate by Enrollment Program, Controlling High Blood Pressure, 2016 RY



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. One method of doing so is to limit waste and unnecessary care provided in the healthcare system. The measure reported in this section is appropriate treatment for children with upper respiratory infection.

Note: In the 2015 Regional Analysis Report*, data for utilization measures related to ambulatory utilization [outpatient and emergency department visits], inpatient utilization, and readmissions were gathered independently and included in this section. However, as noted on page six, this information was not included in the PLD submitted by the MCOs and therefore was not available for regional analysis. MCO and overall statewide performance on these measures may be viewed in the* 2016 Comparative Analysis Report*.*

Appropriate Treatment for Children with Upper Respiratory Infection

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

Variation by MCO and Region

There were 51,176 eligible children ages 3 months–18 years who were diagnosed with an upper respiratory infection during the 2016 reporting year. A total of 93.5 percent of eligible children were not prescribed an antibiotic within three days. (Note: For this measure, higher rates indicate better performance. It can be interpreted as a higher percentage of children *not* receiving inappropriate care.) Performance, shown in Figure 29, ranged from 94.0 percent (CHPW) to 92.3 percent (UHC).

Figure 29: Performance by MCO, Appropriate Treatment for Upper Respiratory Infection, 2015 RY and 2016 RY

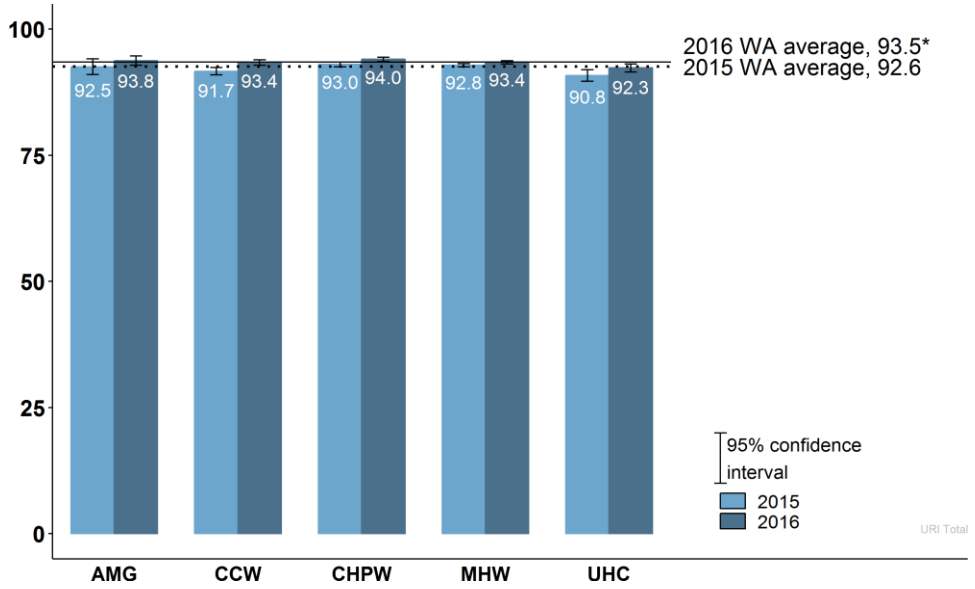


Table 45 shows regional variation within MCOs. CHPW had the lowest level of variation (6.6 percent) while UHC had the highest (13.4 percent).

Table 45: Range of Regional Variation by MCO, Appropriate Treatment for Upper Respiratory Infection, 2016 RY

MCO	MCO Average	Highest-Performance Region	Lowest-Performance Region	Difference
AMG	93.8%	King (96.5%)	Timberlands (83.9%)	12.6%
CCW	93.4%	Pierce (96.5%)	Spokane (88.5%)	8.0%
CHPW	94.0%	King (97.6%)	Spokane (91.0%)	6.6%
MHW	93.4%	Southwest (97.2%)	Greater Columbia (86.9%)	10.3%
UHC	92.3%	North Sound (95.7%)	Timberlands (82.3%)	13.4%
All MCOs	93.5%	Southwest (97.3%)	Timberlands (90.2%)	7.1%

Figure 30 below shows aggregate rates by region. Southwest had the highest rate (97.3 percent) while Timberlands had the lowest (90.2 percent). Regions with lower performance may be ripe for state-led provider education efforts relating to antibiotic stewardship.

Figure 30: Map of Regional Variation, Appropriate Treatment for Upper Respiratory Infection, 2016 RY

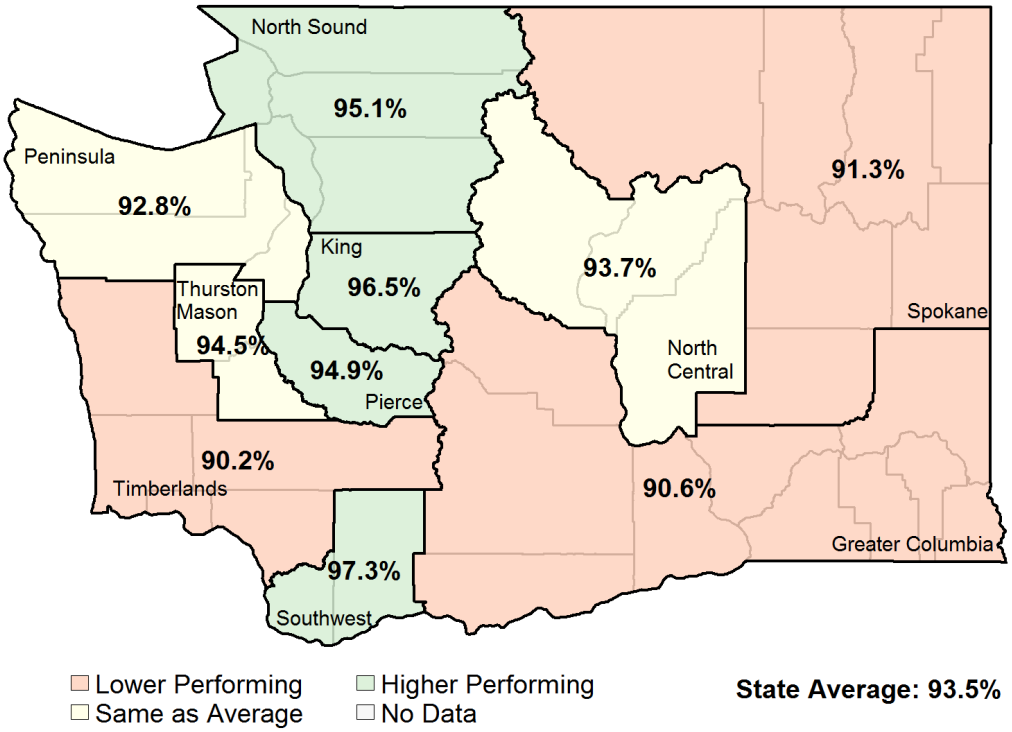


Table 46 shows MCO variation within regions. Southwest had the lowest variation (0.2 percent) while Greater Columbia had the highest (11.8 percent).

Table 46: MCO Performance Range by Region, Appropriate Treatment for Upper Respiratory Infection, 2016 RY

Region	Region Average	Highest-Performing MCO	Lowest-Performing MCO	Difference
Greater Columbia	90.6%	CCW (95.5%)	UHC (83.7%)	11.8%
King	96.5%	CHPW (97.6%)	UHC (93.7%)	3.9%
North Central	93.7%	CHPW (94.8%)	CCW (89.7%)	5.7%
North Sound	95.1%	UHC (95.7%)	CCW and CHPW (94.6%)	1.1%
Peninsula	92.8%	MHW (94.2%)	AMG (90.4%)	3.8%
Pierce	94.9%	CCW (96.5%)	UHC (91.4%)	5.1%
Southwest	97.3%	CHPW (97.4%)	MHW (97.2%)	0.2%
Spokane	91.3%	AMG (95.8%)	CCW (88.5%)	7.3%
Thurston-Mason	94.5%	MHW (95.1%)	AMG (92.9%)	2.2%
Timberlands	90.2%	CHPW (93.9%)	UHC (82.3%)	11.6%
Statewide	93.5%	CHPW (94.0%)	UHC (92.3%)	1.7%

Variation by Age and Gender

As shown in Table 47, performance rates for this measure decrease with increasing enrollee age. Performance rates are identical for each gender.

Table 47: Statewide Performance Rate by Age, Appropriate Treatment for Upper Respiratory Infection, 2016 RY

Age Group	Rate	Number of Enrollees
Ages 3–24 months	95.1%	11,028
Ages 25 months–6 years	93.7%	19,429
Ages 7–11	93.2%	12,091
Ages 12–19	91.2%	8,628

Variation by Race and Language

Data for 2016 did not indicate significant racial disparities in performance rates for this measure, as shown in Table 48. Performance for all racial groups, except for individuals who are white, were at or above the state rate.

Table 48: Statewide Performance Rate by Race, Appropriate Treatment for Upper Respiratory Infection, 2016 RY

Race	Rate	Number of Enrollees
Asian	94.8%	2,840
Black	96.2%	3,253
Hispanic	93.4%	17,792
Native American/Alaska Native	94.3%	508
Native Hawaiian/Pacific Islander	95.6%	517
White	92.6%	19,191
Other race	93.9%	2,187
Unknown race	94.5%	4,888

There were also no statistical differences in performance by primary language spoken, as shown in 49.

Table 49: Statewide Performance Rate by Language, Appropriate Treatment for Upper Respiratory Infection, 2016 RY

Language	Rate	Number of Enrollees
English	93.4%	39,938
Spanish	93.7%	9,704
Other language	93.6%	1,364
Unknown language	94.7%	170

Variation by Enrollment Program

Over 93 percent of eligible enrollees were part of the Healthy Options enrollment program; for this group, statewide performance was 93.5 percent. As a result, performance rates for other enrollment programs had wide confidence intervals and were not statistically significantly different from the state rate.