Washington State Health Care Authority

REPORT TO THE LEGISLATURE

Medicaid Managed Care Preventive Services and Vaccinations

Engrossed Substitute Senate Bill 6032; Section 213 (1)(t); Chapter 299; Laws of 2018

September 15, 2018

Washington State Health Care Authority

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Legislative Reference

The Washington State Health Care Authority (HCA) is submitting this report to the Legislature as required by Engrossed Substitute Senate Bill 6032 (2017):

> "The authority shall submit reports to the governor and the legislature by September 15, 2018, and no later than September 15, 2019, that delineate the number of individuals in medicaid managed care, by carrier, age, gender, and eligibility category, receiving preventative services and vaccinations. The reports should include baseline and benchmark information from the previous two fiscal years and should be inclusive of, but not limited to, services recommended under the United States preventative services task force, advisory committee on immunization practices, early and periodic screening, diagnostic, and treatment (EPSDT) guidelines, and other relevant preventative and vaccination Medicaid guidelines and requirements."

We will submit a second report in 2019.

Summary

To ensure the Legislature has the information it requested regarding Apple Health (Medicaid) managed care enrollees, we have included the *2017 Comparative Analysis Report* by Qualis Health, our state's Medicaid external quality review organization.

The report details Qualis Health's analysis and findings[1] on the following:

- Preventive care — including vaccinations — service delivery
- Enrollee numbers by program/plan
- Enrollee demographics (race, language, age, and gender)

The report includes reporting and trending for three calendar years (2015, 2016, and 2017) rather than the two previous fiscal years requested in the legislation. This is in keeping with the national standard for reporting this information based on calendar years.

In response to poor performance on any measure — including when performance improved but still failed to meet the national benchmark — HCA required plans to prepare a targeted quality improvement project plan for each affected measure. HCA staff will review these proposed plans and monitor each plan's implementation through team monitoring activities. We expect to include our results in our 2019 legislative report.

[1] HCA concurs with Qualis Health's analysis and findings.

Report Highlights

- The "Executive Summary" (pages 5–10) includes recommendations to HCA for improving plan performance. This section also provides an overview of statewide plan performance on these preventive and vaccination measures:
    - Access to primary care
    - Well-child visits
    - Maternal health visits
    - Child and adolescent immunizations
    - Weight assessment and counseling
    - Women's health screenings

- The "Introduction" (pages 11–27) describes the methods Qualis Health used to conduct the analysis. This section also provides an overview of the enrolled population, including assigned eligibility program, race, language, age, and gender.

  The "Introduction" also provides an overview of the performance variation across plans, including a(n):
    - Overview of performance measure variations (page 23).
    - Table summarizing each plan's performance for each prevention and vaccination measure in calendar year (CY) 2017 (page 25).
    - Series of tables on performance variation, by plan, on each preventive and vaccination measure (for CYs 2015, 2016, and 2017) (pages 26–32).
    - Explanation of each measure and a comparison between statewide and plan-level performance (for CYs 2015, 2016, and 2017) (pages 33–45).
    - Table reporting the statewide and by-plan CY 2017 performance for lead screening (new to this year's report) (page 44).

- "Appendix A" summarizes, by plan, CY 2017 performance by measure. This section also indicates the significance of the change from the prior year.

2017 Comparative Analysis Report

Washington Apple Health

Washington State Health Care Authority

December 2017

QUALIS HEALTH™

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

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

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.

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Executive Summary

As part of its work as the external quality review organization (EQRO) for the Washington State Health Care Authority (HCA), Qualis Health reviewed Apple Health managed care organization (MCO) performance for the calendar year (CY) 2016. The MCOs were required to report results for 46 Healthcare Effectiveness Data and Information Set (HEDIS®)[1] measures representing 168 submeasures that reflect the levels of quality, timeliness, and accessibility of healthcare services MCOs furnished to the state's Medicaid enrollees. HEDIS measures are developed and maintained by the National Committee for Quality Assurance (NCQA), whose database of HEDIS results for health plans, the Quality Compass[2], enables benchmarking against other Medicaid managed care health plans nationwide.

During 2016 CY, five MCOs provided care for Apple Health enrollees:

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

To be consistent with NCQA methodology, the 2016 calendar or measurement year is referred to as the 2017 reporting year (RY) in this report.

Performance Highlights

Overall performance for Washington Apple Health plans is summarized below. The following symbols are used throughout this report to provide context for measure performance:

Symbol	Meaning
▼	overall state rate significantly lower than national 50th percentile
◄►	overall state rate similar to national 50th percentile
▲	overall state rate significantly higher than national 50th percentile
±	mixed performance on measures included in the domain, meaning there is significant variation between included measures

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

[2] Quality Compass® 2017 is used in accordance with a Data License Agreement with the NCQA.

Access to Care

Managed care organizations are required to ensure their members have access to primary care. MCOs can accomplish this by developing a robust provider network, providing good customer service and guidance, and educating members on the importance of engaging with providers for routine healthcare.

Access to care measures are evaluated by measuring the percentage of unduplicated enrollees with documented primary, well-child, and maternal health visits.

- **Primary care visits:**

  Adults' access to ambulatory/preventive health services (AAP) (▼): In 2017 RY, statewide performance on each AAP measure (also referred to as adult access to primary care in this report) was below the respective national 50th percentile. Three of the five MCOs showed a statistically significant drop on adult access to primary care measures between 2016 RY and 2017 RY, leading to a statewide 0.6 percent drop in the rate of adults having a primary care appointment. Statewide trending for adult access to primary care has been downward for the past two years. The strongest driver of this trend is the significant demographic shift in the eligible population due to Medicaid expansion. The AAP outcomes for the Apple Health Adult Coverage (Medicaid expansion) population are well below those for Apple Health Family (traditional Medicaid). The rate differences are most evident in the 20–44 age range, with a gap of over 14 percent between traditional Medicaid and Medicaid expansion populations for the past two years. The denominator (eligible population) for this age range alone doubled in size between 2015 RY and 2017 RY, from around 175,000 to 354,000.

  Rates for 2017 RY performance on adult access to primary care measures are shown in Tables 1 and 2 below. Note that the rate for enrollees in the 20–44 age range was also lower in the Integrated Managed Care (IMC) program, with only 20,000 enrollees.

Table 1: Adults' Access to Preventive/Ambulatory Health Services, Eligible Enrollees by Program, All MCOs Statewide, 2017 RY*

2017 RY Total enrollees eligible for any AAP measure: 545,033	**Apple Health Adult Coverage**	**Apple Health Family**	**Apple Health Blind/Disabled**	**Apple Health Integrated Managed Care**
AGE 20–44 Denominator	239,884	70,545	22,806	20,439
AGE 20–44 Rate	**67.16%**	81.93%	78.59%	**70.38%**
AGE 45–64 Denominator	129,776	11,891	35,471	10,380
AGE 45–64 Rate	77.53%	82.59%	87.11%	78.15%

*Rates significantly below the state average are denoted in red.

Table 2: Adults' Access to Preventive/Ambulatory Health Services, Eligible Enrollees by Program, All MCOs Statewide, 2016 RY*

2016 RY Total enrollees eligible for any AAP measure: 461,661	**Apple Health Adult Coverage**	**Apple Health Family**	**Apple Health Blind/Disabled**
AGE 20–44 Denominator	205,030	68,528	22,596
AGE 20–44 Rate	**67.6%**	81.9%	78.1%
AGE 45–64 Denominator	115,438	12,378	35,080
AGE 45–64 Rate	78.3%	81.8%	86.7%

*Rates significantly below the state average are denoted in red.

Symbol	**Meaning**
▼	overall state rate significantly lower than national 50th percentile
◄►	overall state rate similar to national 50th percentile
▲	overall state rate significantly higher than national 50th percentile

- **Children/adolescents' access to primary care practitioners (▲ for all submeasures, except 25 months–6yrs, which was ▼):** Rates for this measure (also referred to as child/adolescent access to primary care in this report) increased for every age group at the state level. This increase is mostly due to CHPW's correction of a data collection and reporting issue it experienced in 2016 RY. Performance for each measure was similar to national rates, except for enrollees between 25 months and 6 years of age, which was slightly lower than the 50th percentile.

- **Well-child visits:**
  - **Adolescent well-care visits** and **well-child visits in third, fourth, fifth, and sixth years of life (▼):** Rates for adolescent well-care visits and well-child visits for children ages 3–6 remained flat between 2016 RY and 2017 RY. When comparing to national rates, however, the measure for children ages 3–6 is below the 50th percentile.
  - **Well-child visits in the first 15 months of life (▲):** The state rate of children receiving six or more well-child visits prior to age 15 months rose by 6.3 percent from 2016 RY to 2017 RY. Note that this increase is mostly due to CHPW's resolved data issue. One MCO (CCW) dropped on this measure by 10.7 percent. Compared with national rates, statewide performance on this measure is well over the national 50th percentile.

- **Maternal health visits:**
  - **Frequency of ongoing prenatal care (▼):** For the percentage of women receiving at least 81 percent of recommended prenatal visits, three out of five MCOs saw significant performance increases of over 10 percent between 2016 RY and 2017 RY. The overall state rate increased by 9.1 percent. However, rates are still below the national 50th percentile.
  - **Timeliness of prenatal care (▼):** The statewide rate for prenatal care timeliness increased by 9.7 percent between 2016 RY and 2017 RY, with two MCOs having a statistically significant increase: AMG (13.9 percent increase) and CHPW (22.1 percent increase). Performance on this measure is in the bottom third nationally (still below the national 33rd percentile); however, it is trending in a positive direction.
  - **Postpartum care (▼):** The state rate of postpartum visits increased by 6.6 percent from 2016 RY to 2017 RY, mostly due to a statistically significant increase for CHPW of 13.3 percent. Performance on this measure is in the bottom third nationally (still below the national 33rd percentile); however, it is trending in a positive direction.

Preventive Care

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

- **Child and adolescent immunizations:**
  - **Childhood immunizations status —Combination 2 (▼)**: Performance on this measure, a reported combination of immunizations, dropped only slightly—by 0.9 percent—in 2017 RY, but it is also below the 33rd national percentile.

Symbol	Meaning
▼	overall state rate significantly lower than national 50th percentile
◄►	overall state rate similar to national 50th percentile
▲	overall state rate significantly higher than national 50th percentile

- **Childhood immunization status—Combination 10 (▲):** Statewide performance on this measure dropped by four percent; however, it is above the 66th percentile nationally.
- **Immunizations for adolescents—Combination 1 (◄►):** Performance on this measure increased slightly between 2016 RY and 2017 RY, and is on par with the national 50th percentile.

- **Weight assessment and counseling:**
  - **Adult BMI (body mass index) assessment (▲):** The rate for adult BMI assessments rose from 85 to 90.2 percent, with only one MCO showing a significant increase (AMG). Washington is above the 70th national percentile for this measure.
  - **Weight assessment and counseling for children/adolescents (▼):** Performance on most measures relating to weight assessment and counseling (BMI percentile, counseling for nutrition, and counseling for physical activity, with submeasures for child age) improved between 2016 RY and 2017 RY. Only the submeasure for physical activity counseling for 3–11-year-olds showed a slight drop, leading the overall physical activity counseling measure to drop slightly. However, the state rates remain at or below the national 33rd percentiles for all measures.

- **Women's health screenings:**
  - **Breast cancer screening** and **cervical cancer screening (▼)**: Several plans made statistically significant improvements in breast cancer screening performance from 2016 RY to 2017 RY, but rates for this measure are still below the national 33rd percentile. Performance on the cervical cancer screening measure remained steady, and continues to be below the national 50th percentile.

Chronic Care Management

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

- **Comprehensive diabetes care:**
  - **Good HbA1c control (▲):** Statewide rates for 2017 RY showed a significant increase (10.6 percent) in the number of individuals with diabetes whose hemoglobin A1c (HbA1c) was under control (HbA1c < 8.0 percent). Compared nationally, state rates are above the national 50th percentile.
  - **Eye exam** and **blood pressure control (▲):** Rates for these measures improved at the state level and are above the national 50th percentile.
  - **Medical attention for nephropathy (◄►):** Rates for this measure improved at the state level and are on par with the national 50th percentile.

- **Other chronic care management:**
  - **Antidepressant medication management (▼):** Performance on this measure, which includes submeasures for initiation phase and continuation phase medication management, trended downward in 2017 RY. Nationally, both measures rank around the 45th percentile.
  - **Controlling high blood pressure (▼):** The results for this measure remained steady in 2017 RY. Statewide performance ranks within the national 45th percentile.

Symbol	Meaning
▼	overall state rate significantly lower than national 50th percentile
◄►	overall state rate similar to national 50th percentile
▲	overall state rate significantly higher than national 50th percentile

- **Adherence to antipsychotic medications for individuals with schizophrenia (◄►):** This measure has trended down significantly but is on par with the national 50th percentile.
- **Follow-up care for children prescribed ADHD medication (◄►):** Statewide performance on the continuation phase submeasure remained steady in 2017 RY with results on par with the national 50th percentile. The initiation phase submeasure increased significantly from 2016 RY to 2017 RY.

Medical Care Utilization

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

- **Appropriateness of treatments:**
  - **Avoidance of antibiotics for adults with acute bronchitis (▲):** This measure improved statewide by almost 6 percent in 2017 RY and is above the 50th national percentile.
  - **Appropriate testing for children with pharyngitis (▼):** This measure improved statewide by almost 6 percent in 2017 RY; results were slightly below the 50th national percentile.
  - **Use of imaging for low back pain (▲):** This measure trended down slightly but is above the national average.
  - **Appropriate treatment for children with upper respiratory infection (▲):** The results for this measure remained steady in 2017 RY with results above the national average.

- **Avoidance of emergent and inpatient care:**
  - **Ambulatory care** and **inpatient utilization (▲)**: Apple Health enrollees had slightly fewer per capita ED visits and inpatient stays in 2017 RY as compared to 2016 RY. Apple Health enrollee ED visits and inpatient days per capita were lower than the national averages.

MCO-Level Variation

Significant variation between MCOs indicates quality improvement opportunities. Statistically significant variation was observed across a number of HEDIS measures. This variation was observed for both administrative and hybrid HEDIS measures (administrative measures are based solely on administrative data such as claims, and hybrid measures use a sample of administrative data combined with medical record reviews). Investigation is therefore needed to isolate and identify potential drivers of this variation. Enrollee demographics by MCO also vary; hence, it is imperative to account for these differences before comparisons are made.

- Adult access to primary care performance was variable, with three low performers (AMG, CCW, and UHC) and two high performers (CHPW and MHW).
- Wide variation was noted on the BMI percentile measure for children and adolescents. CHPW was a leader on this measure at 70.3 percent, and CCW had the lowest performance at 48.1 percent. The other MCOs had outcomes in the 50–60 percent range.
- Breast cancer screening showed a 10 percent swing from the highest to lowest performers, with CHPW and MHW as leaders.
- While all MCOs performed around the 50th percentile for well-child visits in the first 15 months of life, CCW performed particularly poorly on this measure.

Symbol	Meaning
▼	overall state rate significantly lower than national 50th percentile
◄►	overall state rate similar to national 50th percentile
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Recommendations

Based on 2017 RY MCO performance, Qualis Health recommends HCA consider the following options:

- Monitor rates of adult access to primary care, which have shown improvement but are still considerably lower than national rates. Specifically, HCA should seek root causes for low access rates for 20–44-year-olds in Apple Health Adult Coverage and Integrated Managed Care, which are much lower than rates for other members of the Medicaid population, and determine whether action is needed. HCA should consider requiring underperforming MCOs to have a plan in place, ideally with timelines and deliverables, to improve performance.

- Examine barriers to well-child visits for children ages 3–6, and determine whether statewide action is necessary. This measure did not show improvement in 2017 RY and is still below the national 50th percentile. HCA should consider requiring underperforming MCOs to have a plan in place, ideally with timelines and deliverables, to improve performance.

- To sustain improvements demonstrated by plans in 2017 RY, HCA should continue to monitor and emphasize maternal health measures, weight assessment and counseling for children measures, women's health screenings, and antidepressant medication management. While performance on many of these measures improved from 2016 RY to 2017 RY, rates are all considerably below national averages. To bring statewide performance in line with national standards, HCA should consider setting statewide performance goals for MCOs.

Introduction

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 on select Healthcare Effectiveness Data and Information Set (HEDIS) measures for the calendar year (CY) 2016. To enable a reliable measurement of performance, the HCA required MCOs to report on 46 HEDIS measures. HEDIS measures were developed and are maintained by the National Committee for Quality Assurance (NCQA), whose database of HEDIS results for health plans—the Quality Compass—enables benchmarking against other Medicaid managed care health plans nationwide. To be consistent with NCQA methodology, the 2016 calendar year is referred to as the 2017 reporting year (RY) in this report.

During 2017 RY, five MCOs provided managed healthcare services for Apple Health enrollees:

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

HEDIS Performance Measures

HEDIS is a widely used set of healthcare performance measures reported by health plans. HEDIS results can be used by the public to compare plan performance over eight domains of care; they also allow plans to determine where quality improvement efforts may be needed. In the first half of 2017, Qualis Health, through a subcontract with NCQA-certified auditor Healthy People, conducted an NCQA HEDIS Compliance Audit™ of each Apple Health MCO to ensure that MCOs were accurately collecting, calculating, and reporting HEDIS measures.

Using the NCQA-standardized audit methodology, auditors assessed each MCO's information system capabilities and compliance with HEDIS specifications. HCA and each MCO were provided with an onsite report and a final report outlining findings and results.

Methods

Performance Measures

Qualis Health assessed audited MCO-level HEDIS data for the 2017 reporting year (measuring enrollee experience during calendar year 2016), including 46 measures comprising 168 specific indicators. Many measures include more than one indicator, usually for specific age groups or other defined population groups.

The HEDIS effectiveness of care measures are considered to be unambiguous performance indicators, whereas the utilization measures can be helpful for identifying patterns and disparities in enrollees' access to care. It should be noted that the HEDIS measures are not risk adjusted and may vary from

MCO to MCO because of factors that are out of a health plan's control, such as medical acuity, demographic characteristics, and other factors that may impact enrollees' interaction with healthcare providers and systems. NCQA has not developed methods for risk adjustment of these measures; however, with the enrollment increase that occurred with Medicaid expansion, performance impacts that may be attributable to differences in enrollee mix are likely to diminish over time as MCOs' population growth continues to slow.

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

Administrative Versus Hybrid Data Collection

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

For example, Table 3 outlines the difference between state rates for select measures comparing the administrative rate (before chart reviews) versus the hybrid rate (after chart reviews).

Table 3: Administrative versus Hybrid Rates for Select Measures, 2017 RY

Measure	Administrative Rate	Hybrid Rate	Difference
Childhood Immunizations—Combination 2	61.9%	68.4%	+6%
Comprehensive Diabetes Care—HbA1c Control (<8.0%)	3.5%	49.6%	+ 46%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	34.9%	77.6%	+ 43%
Prenatal and Postpartum Care—Postpartum Care	31.5%	60.1%	+ 29%

Supplemental Data

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

Potential Sources of Variation in Performance

The adoption, accuracy, and completeness of electronic health records (EHRs) have improved over recent years as new standards and systems have been introduced and enhanced. However, HEDIS performance measures are specifically defined; occasionally, patient records may not include the specific notes or values required for a visit or action to count as a numerator event. It is therefore important to keep in mind that a low performance score can be the result of an actual need for quality improvement, or it may reflect a need to improve electronic documentation and diligence in recording notes. For example, in order for an outpatient visit to be counted as counseling for nutrition, a note with evidence of the counseling must be attached to the medical record, with demonstration of one of several specific examples from a list of possible types of counseling, such as discussion of behaviors, a checklist, distribution of educational materials, etc. Even if such discussion did take place during the visit, if it was not noted in the patient record, it cannot be counted as a numerator event for weight assessment and counseling for nutrition and physical activity for children/adolescents. For low observed scores, health plans and other stakeholders should examine (and strive to improve) both of these potential sources of low measure performance.

Member-Level Data

HCA required MCOs to submit member-level data for all administrative and hybrid measures. Member-level data enable HCA and Qualis Health to conduct analyses relating to racial and geographic disparities to identify quality improvement opportunities. Analyses based on member-level data are included in this report. The companion *2017 Regional Analysis Report* draws more heavily from the member-level data to summarize regional differences in access and quality.

Calculation of the Washington Apple Health Average

This report provides estimates of the average performance among the five Apple Health MCOs for the three most recent reporting years: 2015 RY, 2016 RY, and 2017 RY. The state average for a given measure is calculated as the weighted average among the MCOs that reported the measure (usually five MCOs), with MCOs' shares of the total eligible population used as the weighting factors.

Statistical Significance

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

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

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

Comparison to National Benchmarks

This report provides national benchmarks for select measures from NCQA's Quality Compass. These benchmarks represent the national average and 90th percentile performance among all Medicaid plans nationwide. Rates for all NCQA-accredited Medicaid plans are included in the Quality Compass, regardless of whether the state expanded Medicaid coverage. States such as Washington, with Medicaid expansion, may observe different performance rates than in the past because the addition of expansion enrollees changes the overall risk profile of the total population.

The license agreement with NCQA for publishing HEDIS benchmarks in this report limited the number of individual indicators to 30, with no more than two benchmarks reported for each selected indicator. Therefore, a number of charts and tables do not include a direct comparison with national benchmarks, but may instead include a narrative comparison with national benchmarks, for example, noting that a specific indicator or the state average is lower or higher than the national average.

Interpreting Performance

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

Overview of Apple Health Enrollment

While the primary purpose of the *Comparative Analysis Report* is to summarize MCO performance for selected HEDIS measures, it is important to note that MCOs' members are not homogenous. MCOs serve different populations with a varying mix of demographics and program enrollment. Depending upon the HEDIS measure, the impact of members enrolled in Apple Health Adult Coverage (Medicaid expansion) or Integrated Managed Care (IMC) on measure performance will vary.

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

Another population to monitor is the IMC program population. While this program is relatively new in the Southwest region of the state, affecting only CHPW and MHW, eventually all plans and populations will transition to the IMC model, which incorporates administration of physical healthcare, mental health services, and substance use disorder treatment under one health plan. Currently, the IMC population

accounts for 4.7 percent of all Medicaid enrollees in Washington, and the age distribution for this population is relatively evenly distributed, with a higher concentration only for enrollees under the age of 10 (26 percent).

Tables 4, 5, and 6 show the distribution of Apple Health enrollees by program, age, and both program and age. Note that these data are sourced from the member-level data submitted by MCOs and are based on the total number of enrollees.

Table 4: 2017 RY Enrollee Population by Apple Health Program
1,318,385 Enrollees in Total

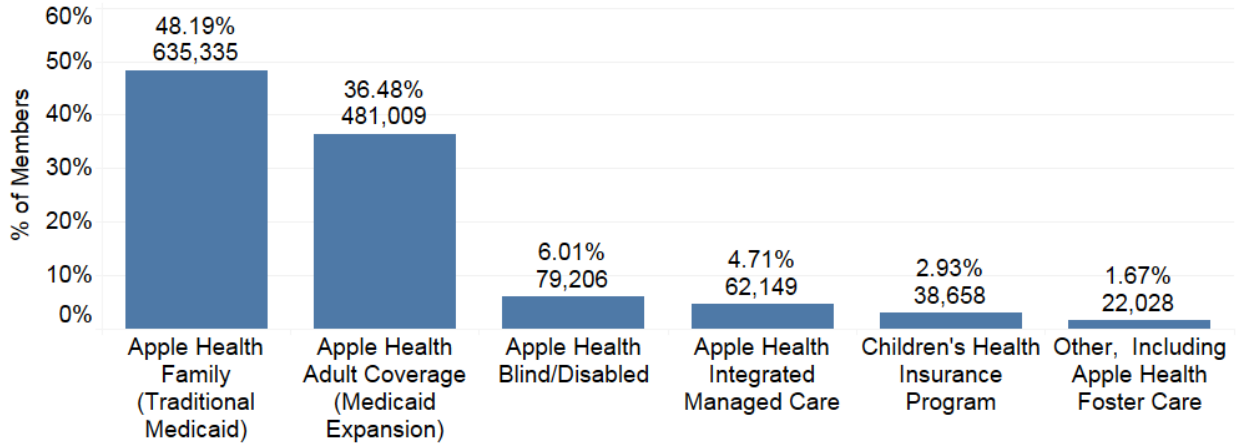


Table 5: 2017 RY Enrollee Population by Age

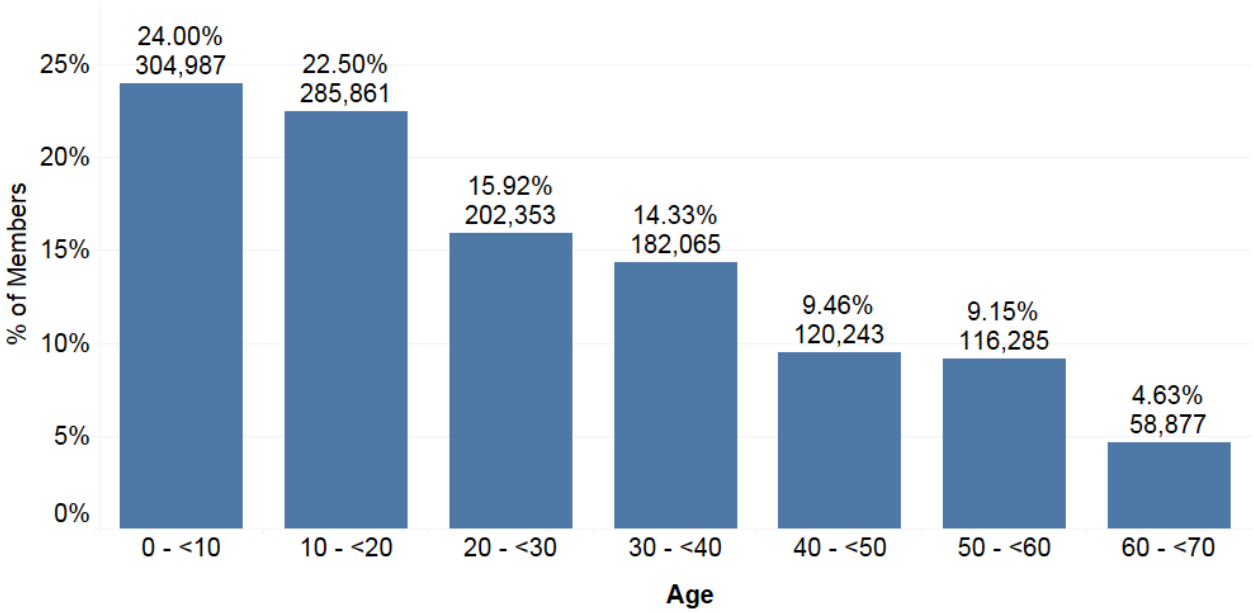
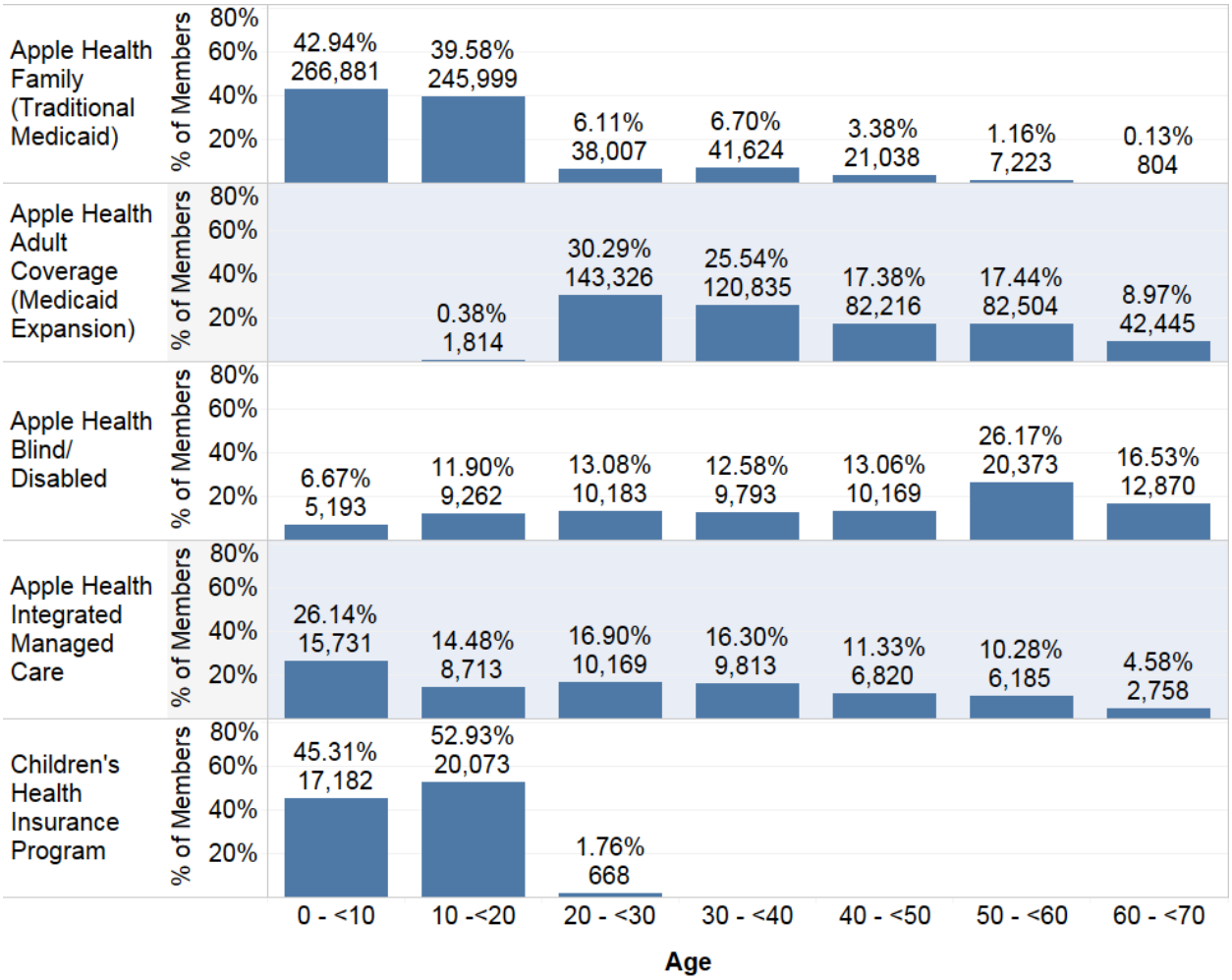
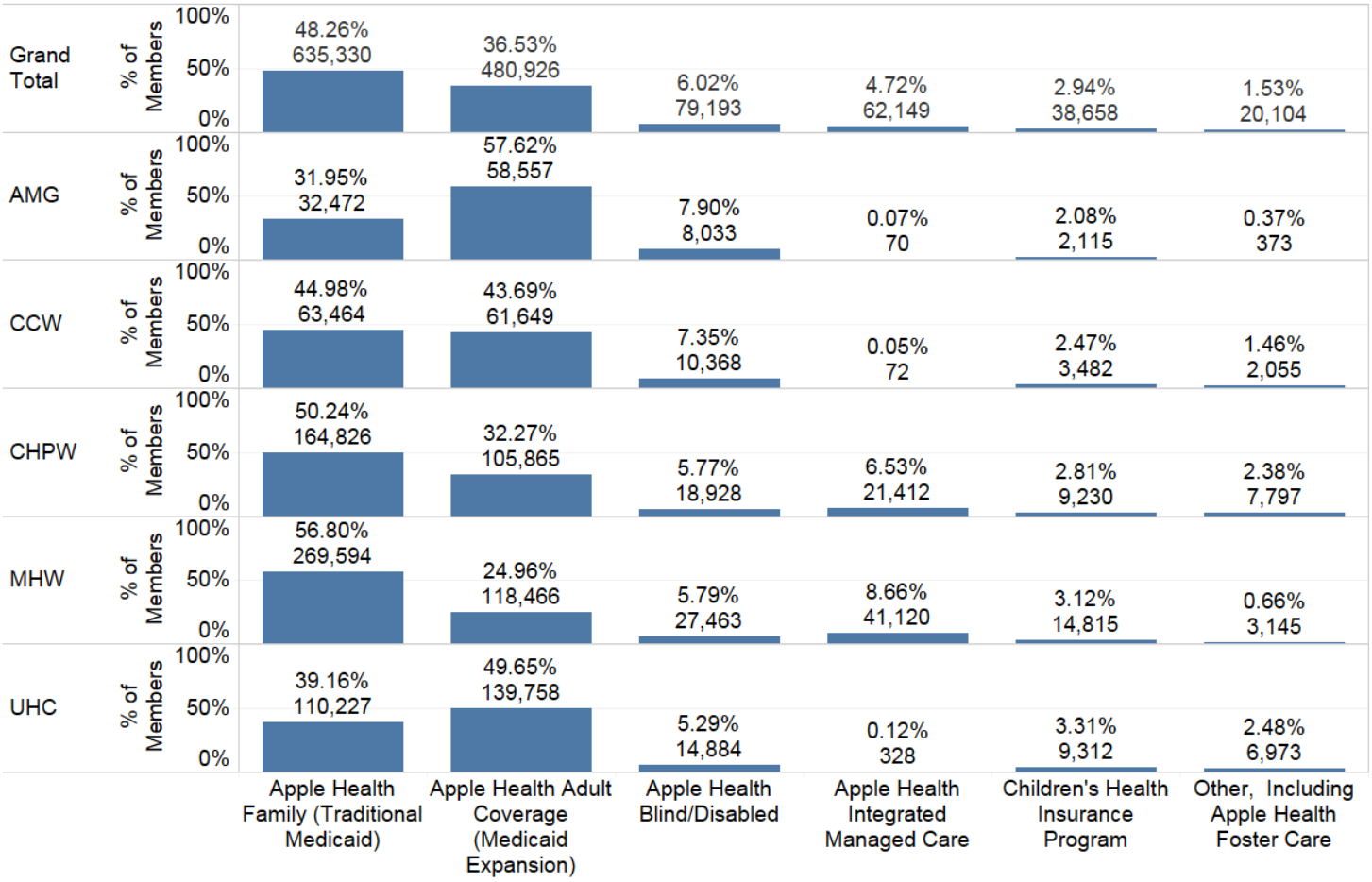


Table 6: 2017 RY Enrollee Population by Apple Health Program and Age



It is important to note that the relative distribution of these members is not uniform across MCOs. For example, 57.6 percent of AMG's members are enrolled in Apple Health Adult Coverage (Medicaid expansion), while only 24.96 percent of MHW members are enrolled in that program. Additionally, only CHPW and MHW administered FIMC in 2016. (Note that while Table 7 reflects some IMC enrollment in other plans, this likely reflects enrollees who relocated to different regions during the data pull.) This variation in Medicaid program mix by MCO can affect HEDIS performance outcomes, so it is important to monitor performance at both the plan level and at the plan and program level. Table 7 shows Apple Health enrollee population distribution by program and plan.

Table 7: 2017 RY Member Population by Apple Health Program and Plan



Overall, Apple Health MCOs experienced a total growth rate of 8.35 percent from December 2015 to December 2016 CY. The largest MCO, MHW, grew by over 18 percent during this time. CCW's enrollee population also grew by more than 10 percent. Note that MHW (the largest MCO) is over four times the size of the smallest MCO (AMG), and MHW is more than double the size of the second-largest MCO (CHPW). Table 8 shows Apple Health enrollment by plan for the 2014, 2015, and 2016 calendar years.

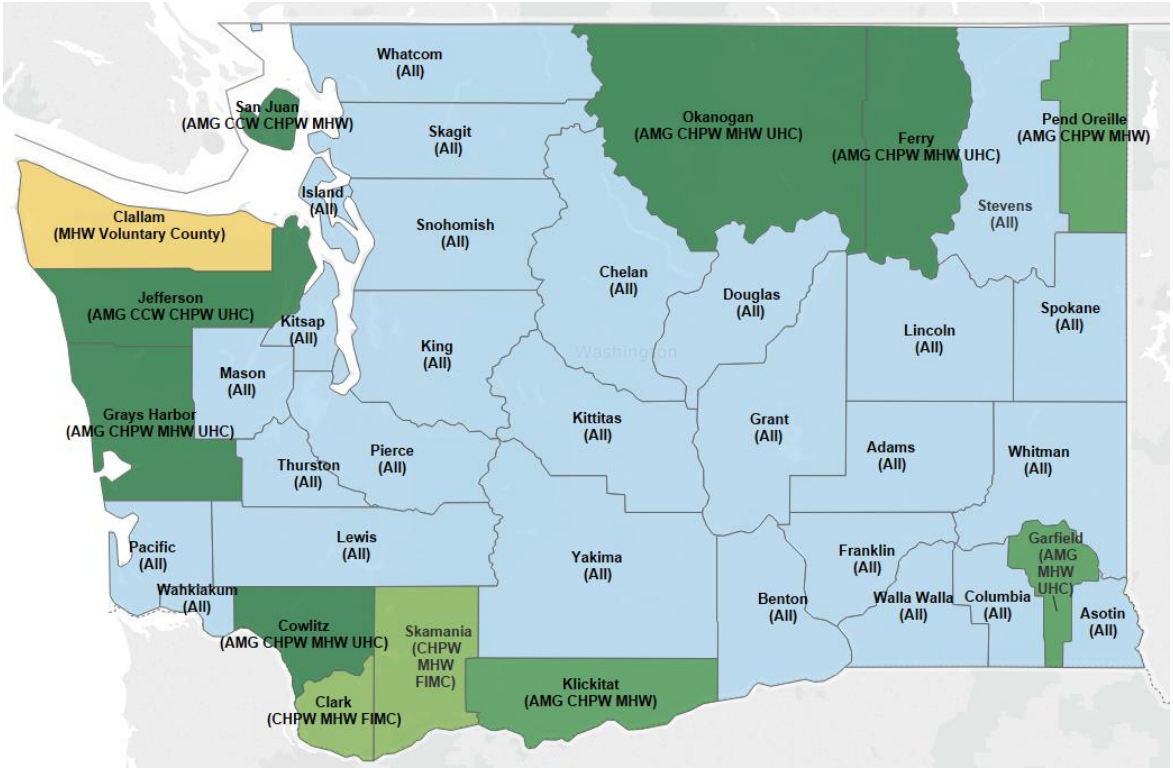
Table 8: Apple Health Enrollment, December 2014, December 2015, December 2016 CY[3]

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

[3] www.hca.wa.gov/about-hca/apple-health-medicaid-reports

MCOs are also represented to varying degrees in the regions around Washington. While the bulk of enrollees reside in the densely populated areas of Seattle, Tacoma, and Spokane, MCOs have varying degrees of representation in predominantly rural areas that include Yakima, Skagit, and Thurston counties. The map in Figure 1 shows MCO representation by county. For more detail, please refer to the *2017 Regional Analysis Report.*

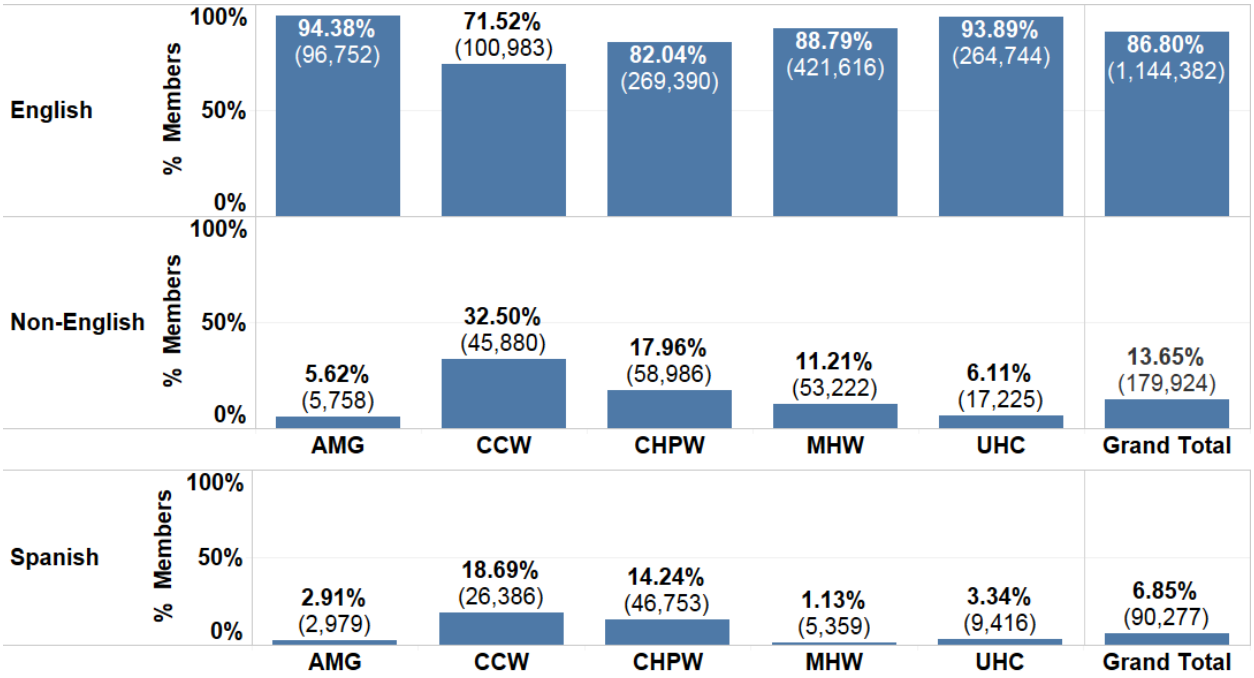
Figure 1: Apple Health Managed Care Service Areas As of December 2016



Primary Language by MCO

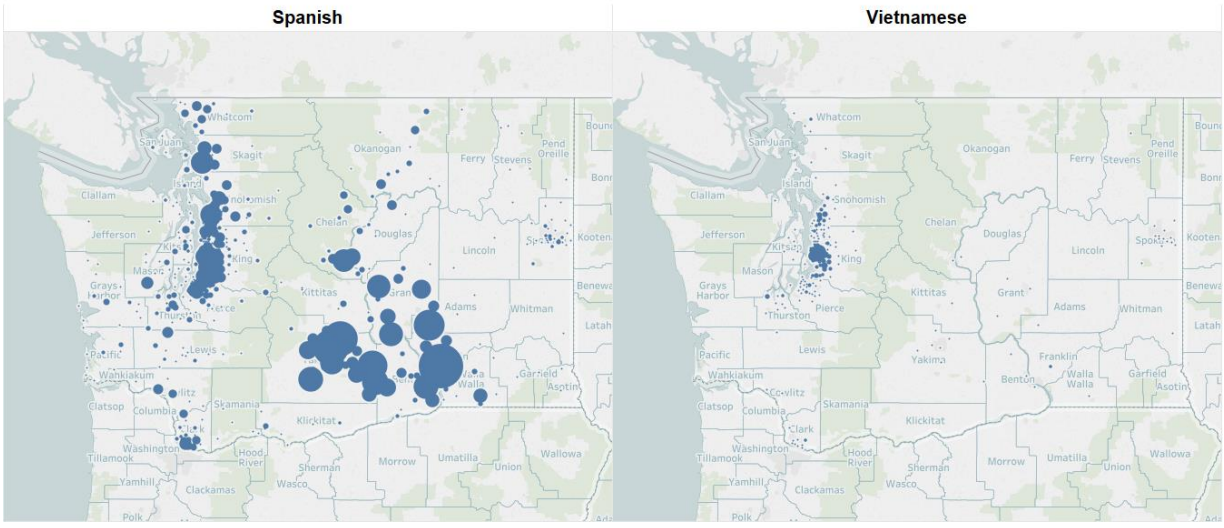
Overall, 86.8 percent of Apple Health members speak English as their preferred language; however, the composition of enrollee preferred languages varies by MCO, as indicated in Table 9. Over 94 percent of AMG enrollees, for example, cite English as their preferred language, compared to less than 72 percent of CCW enrollees. Table 9, next page, shows the distribution of enrollee preferred languages by each plan.

Table 9: Apple Health Enrollment by Language and MCO, 2017 RY
1,318,385 Enrollees in Total



The most prevalent identified non-English language cited by Apple Health enrollees is Spanish, and it accounts for 18.69 percent of CCW enrollees and 14.24 percent of CHPW enrollees. It is noteworthy that enrollees who cite a non-English preferred language are concentrated geographically. The maps in Figure 2 show concentrations of enrollees who prefer Spanish and Vietnamese, another prevalent non-English language among Apple Health enrollees. Note that the size of the circles is relative to population size. One possibility the State might consider would be to collect detailed data on preferred languages among enrollee populations to identify areas of concentration and more efficiently allocate resources, such as interpretive services.

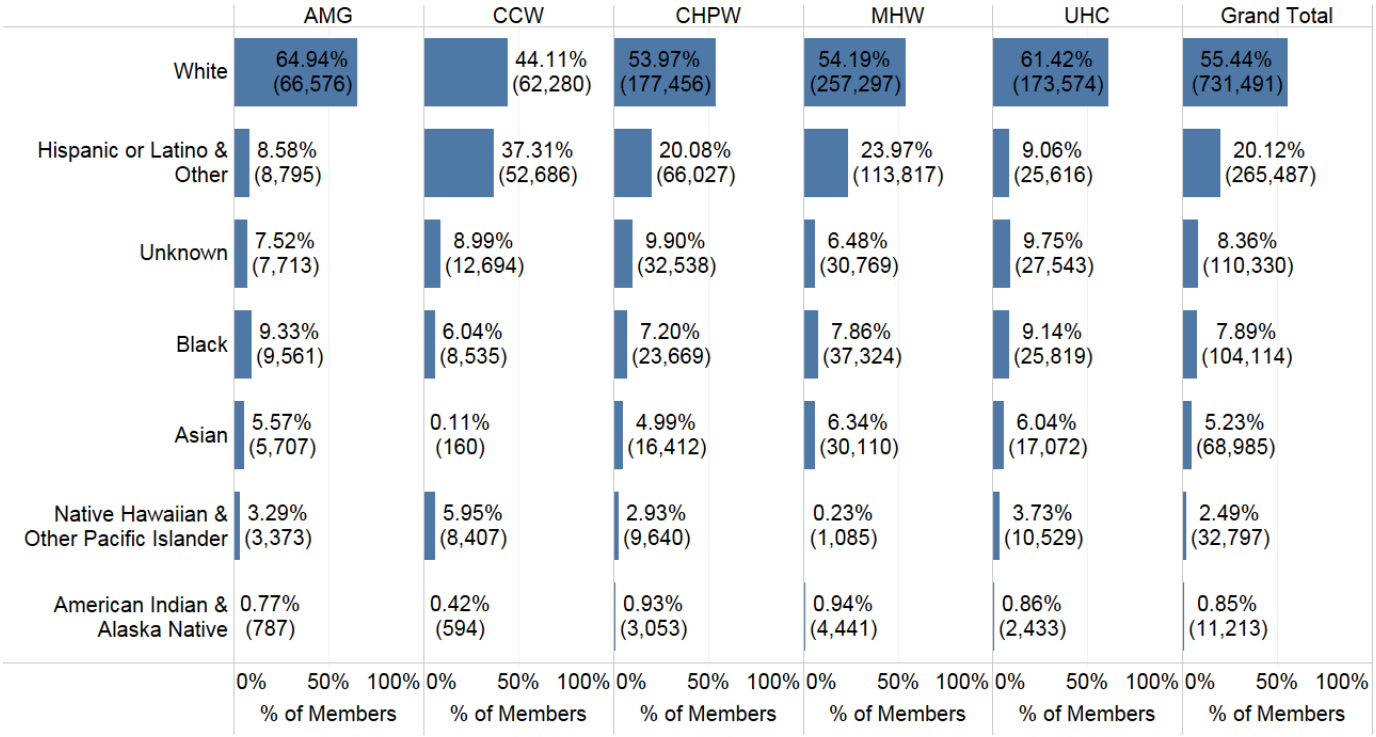
Figure 2: Geographic Distribution of Apple Health Enrollee Language Preference, 2017 RY



Race by MCO

Overall, 55.44 percent of Apple Health enrollees identify as white; however, composition of enrollee race also varies by MCO, as indicated in Table 10. Over 64.94 percent of enrollees in AMG, for example, identify as white, while only 44.11 percent of CCW enrollees identify as white. Please refer to the *2017 Regional Analysis Report* for more exploration of the relationship between race and measure performance.

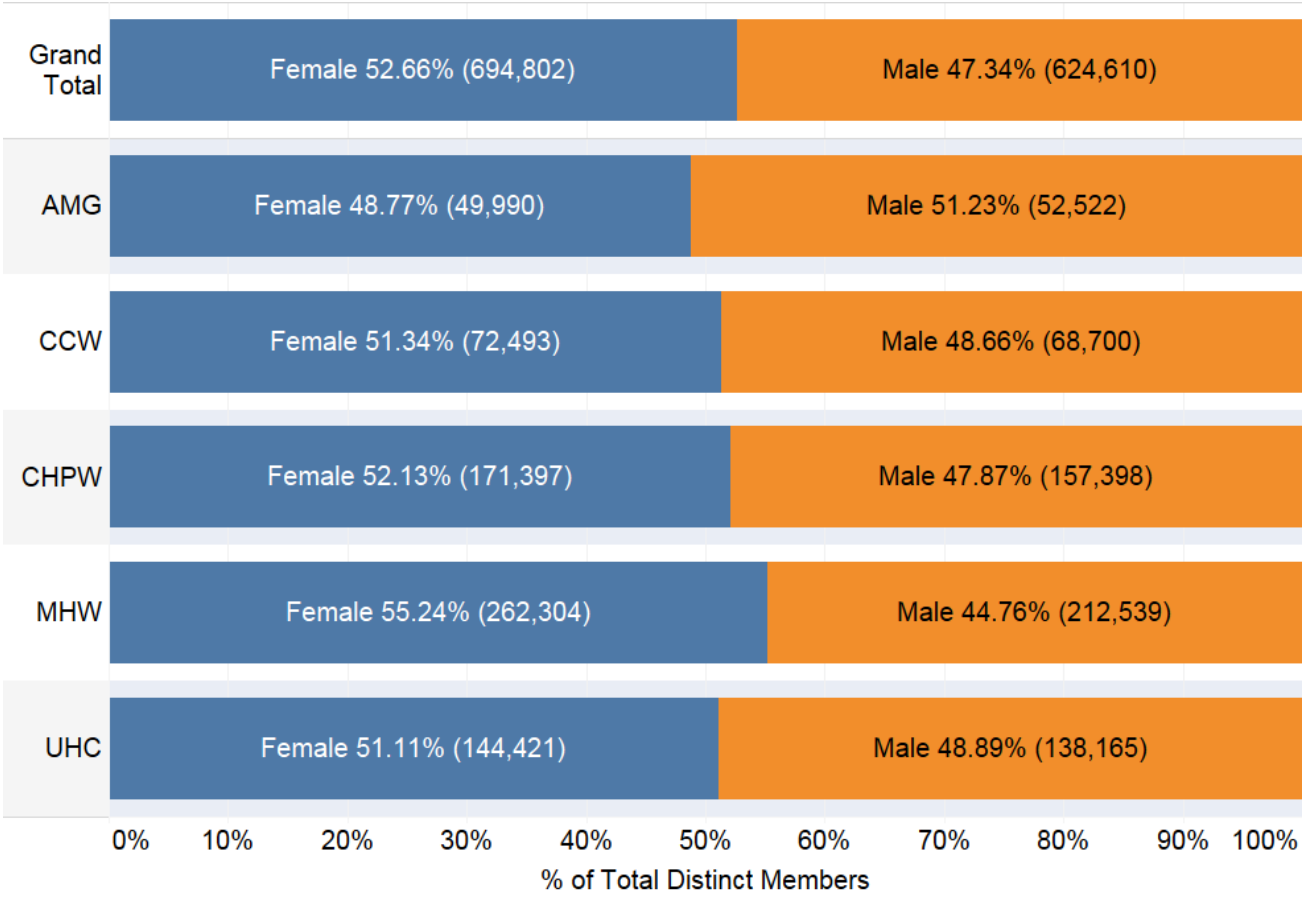
Table 10: Apple Health Enrollee Race Distribution by MCO, 2017 RY



Sex by MCO

Overall, 52.66 percent of Apple Health members identify as female. AMG has the lowest proportion of female members, with only 48.77 percent, while MHW has the largest, with 55.24 percent. Historically, females have been shown to seek care more regularly than males. Table 11 shows distribution of enrollees by sex among Apple Health plans.

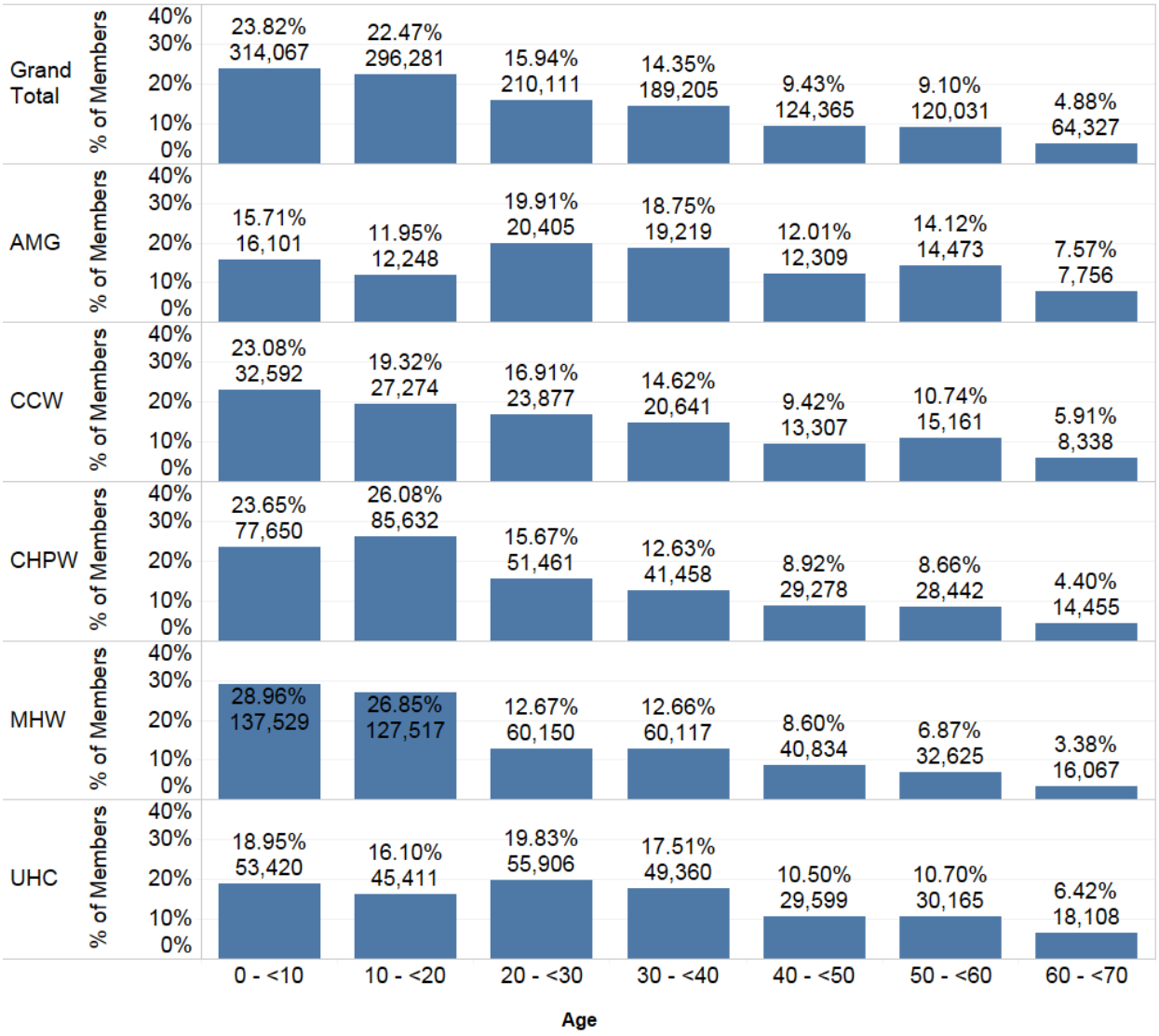
Table 11: Enrollee Distribution Among Apple Health Plans by Sex, 2017 RY



Age by MCO

As discussed earlier, Apple Health Family (traditional Medicaid) and Apple Health Adult Coverage (Medicaid expansion) programs serve members of different ages; additionally, MCOs vary in their respective proportions of traditional Medicaid and Medicaid expansion enrollees. As a result, we see variations in age distribution by MCO. While CCW, CHPW, and MHW all have a high concentration of members under 20, AMG's and UHC's members shift older, to the 20-plus age ranges. Table 12 shows the distribution of enrollees among Apple Health plans by age.

Table 12: Distribution of Enrollees Among Apple Health Plans by Age, 2017 RY



Overview of Performance Measure Variation

While subsequent sections of this report present performance by detailed measure, this section is intended to summarize two key forms of variation:

- Variation among MCOs
- Variation over time by individual MCO and at a state level

Note: In this section, the following keys apply:

Change Over Time

- Trending down: Statistically significant decrease from 2016 RY to 2017 RY ($p<0.05$)
- No change: No statistically significant change from 2016 RY to 2017 RY ($p<0.05$)
- Trending up: Statistically significant increase from 2016 RY to 2017 RY ($p<0.05$)

Difference From Other MCOs

- Below other MCOs: MCO is statistically significantly below other MCOs in 2017 RY ($p<0.05$)
- Same as other MCOs: No statistically significant difference from other MCOs in 2017 RY ($p<0.05$)
- Above other MCOs: MCO is statistically significantly above other MCOs in 2017 RY ($p<0.05$)

Variation among MCOs in 2017 RY

Several measures showed significant variation among MCOs during the 2017 reporting year, indicated in Table 13. Wide variation among MCOs implies that there are MCO-specific differences that may present opportunities for improvement. Among the general trends for this set of highly variable measures, CHPW is frequently the top performer and never is statistically below the other MCOs.

Access to Care

- Adult access to primary care performance was variable, with three low performers (AMG, CCW, and UHC) and two high performers (CHPW and MHW).
- Well-child visits in the first 15 months of life showed AMG as a high performer and CCW as a low performer. With a rate of only 58.2 percent, this is a potential area of improvement for CCW.

Prevention and Screening

- The most variable measure in this category was the BMI percentile measure for children and adolescents. CHPW was a leader on this measure at 70.3 percent, and CCW had the lowest performance at 48.1 percent. The other MCOs had outcomes in the 50–60 percent range. While performance has improved on this measure overall, there is still need for statewide improvement.
- The other highly variable prevention and screening measure was physical activity counseling for children and adolescents, on which CHPW was a high performer at 63.7 percent; the other MCOs showed rates ranging from the high 40s to the mid 50s.
- Breast cancer screening showed a 10 percent swing from the highest to lowest performers, with CHPW and MHW as leaders.

Diabetes Care

For the comprehensive diabetes care measure, three submeasures stood out as variable:

- Blood pressure control: CCW was a low performer.

- Eye exams: Both AMG and UHC were low performers.
- Poor HbA1C control (* Note that a lower rate is better for this measure): AMG was a leader on this measure, at a rate 10 percent better than the low performers CCW and UHC.

Other Chronic Care Management

- CHPW was the highest performer for the controlling high blood pressure measure, while UHC showed the lowest performance.
- Most plans performed relatively poorly for the medication management for people with asthma measure.

Avoidance of Inappropriate Care

- For appropriate testing for children with pharyngitis, CCW was a low performer at 62 percent.

Table 13, next page, shows variation among MCO performance on select measures.

Table 13: Select Measures Displaying Sizable Performance Variation among MCOs, 2017 RY

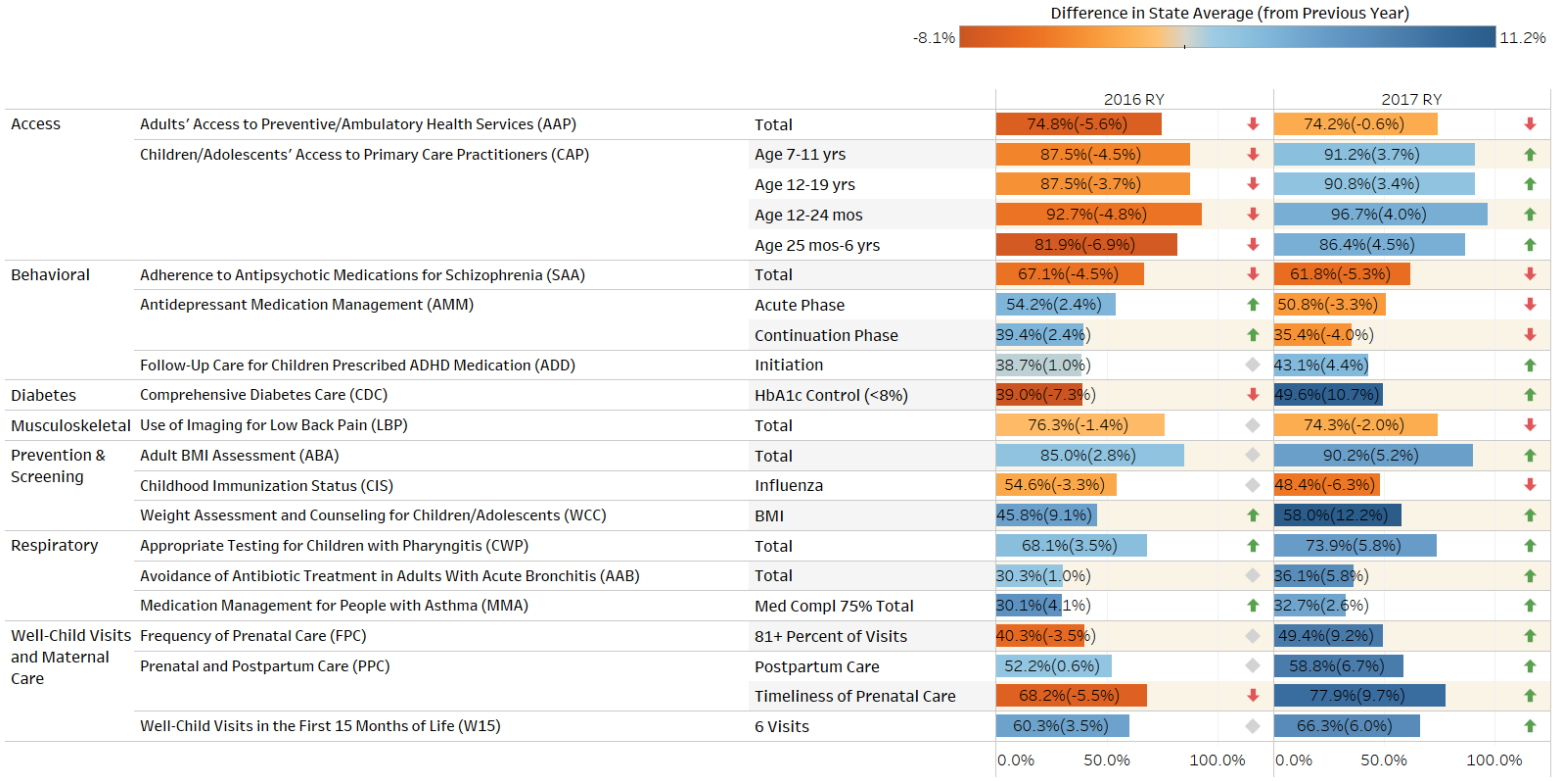
			Difference in Performance from Highest to Lowest MCO	AMG	CCW	CHPW	MHW	UHC
Prevention & Screening	Weight Assessment and Counseling for Children/Adolescents (WCC)	BMI	22.2%	59.7%	48.1%	70.3%	56.3%	50.6%
Cardiovascular	Controlling High Blood Pressure (CBP)	Total	18.9%	55.1%	53.1%	65.1%	56.9%	46.2%
Respiratory	Appropriate Testing for Children with Pharyngitis (CWP)	Total	16.9%	74.8%	62.0%	75.3%	75.0%	78.9%
Prevention & Screening	Weight Assessment and Counseling for Children/Adolescents (WCC)	Phys Activ Counseling	16.8%	56.3%	54.6%	63.7%	49.7%	47.0%
Behavioral	Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	Total	16.7%	56.8%	69.2%	73.5%	73.4%	66.9%
Respiratory	Medication Management for People with Asthma (MMA)	Med Compl 75% Total	15.3%	32.7%	32.6%	32.2%	30.0%	45.3%
Diabetes	Comprehensive Diabetes Care (CDC)	Blood Pressure Control	15.2%	63.7%	58.5%	73.7%	66.7%	62.5%
Well-Child Visits	Well-Child Visits in the First 15 Months of Life (W15)	6 Visits	13.8%	72.0%	58.2%	70.1%	65.6%	68.9%
Diabetes	Comprehensive Diabetes Care (CDC)	Eye Exam	12.4%	54.2%	66.6%	63.5%	57.2%	54.5%
Access	Adults' Access to Preventive/Ambulatory Health Services (AAP)	Total	10.9%	68.2%	69.6%	74.8%	79.2%	71.2%
Diabetes	Comprehensive Diabetes Care (CDC)	Poor HbA1c Control	10.7%	33.8%	43.4%	37.2%	37.3%	44.5%
Prevention & Screening	Breast Cancer Screening (BCS)	Total	10.4%	48.0%	53.1%	58.4%	56.1%	48.7%

Variation in State Performance between 2016 RY and 2017 RY

Performance on several measures varied significantly at the state level between 2016 RY and 2017 RY, as indicated in Table 14.

Note that the rate changes for the children's access measures were driven primarily by CHPW's correction of a data collection and reporting issues it experienced in 2016 RY. Most of the overall state rates are improving; notably, the maternal health measures, as well as the measure for well-child visits in the first 15 months of life, showed major improvement. However, there are a number of measures for which performance declined significantly, including several in the Washington State Common Measure Set on Health Care Quality and Cost—2017.[4] **Note**: In the following table, the numbers in columns 2016 and 2017 RY display both the rate for that year and the percent increase or decrease from the previous year.

Table 14: Select Measures Displaying Sizable Performance Variation at the State Level, 2016 to 2017 RY



			2016 RY	2017 RY
Access	Adults' Access to Preventive/Ambulatory Health Services (AAP)	Total	74.8%(-5.6%)	74.2%(-0.6%)
	Children/Adolescents' Access to Primary Care Practitioners (CAP)	Age 7-11 yrs	87.5%(-4.5%)	91.2%(3.7%)
		Age 12-19 yrs	87.5%(-3.7%)	90.8%(3.4%)
		Age 12-24 mos	92.7%(-4.8%)	96.7%(4.0%)
		Age 25 mos-6 yrs	81.9%(-6.9%)	86.4%(4.5%)
Behavioral	Adherence to Antipsychotic Medications for Schizophrenia (SAA)	Total	67.1%(-4.5%)	61.8%(-5.3%)
	Antidepressant Medication Management (AMM)	Acute Phase	54.2%(2.4%)	50.8%(-3.3%)
		Continuation Phase	39.4%(2.4%)	35.4%(-4.0%)
	Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Initiation	38.7%(1.0%)	43.1%(4.4%)
Diabetes	Comprehensive Diabetes Care (CDC)	HbA1c Control (<8%)	39.0%(-7.3%)	49.6%(10.7%)
Musculoskeletal	Use of Imaging for Low Back Pain (LBP)	Total	76.3%(-1.4%)	74.3%(-2.0%)
Prevention & Screening	Adult BMI Assessment (ABA)	Total	85.0%(2.8%)	90.2%(5.2%)
	Childhood Immunization Status (CIS)	Influenza	54.6%(-3.3%)	48.4%(-6.3%)
	Weight Assessment and Counseling for Children/Adolescents (WCC)	BMI	45.8%(9.1%)	58.0%(12.2%)
Respiratory	Appropriate Testing for Children with Pharyngitis (CWP)	Total	68.1%(3.5%)	73.9%(5.8%)
	Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)	Total	30.3%(1.0%)	36.1%(5.8%)
	Medication Management for People with Asthma (MMA)	Med Compl 75% Total	30.1%(4.1%)	32.7%(2.6%)
Well-Child Visits and Maternal Care	Frequency of Prenatal Care (FPC)	81+ Percent of Visits	40.3%(-3.5%)	49.4%(9.2%)
	Prenatal and Postpartum Care (PPC)	Postpartum Care	52.2%(0.6%)	58.8%(6.7%)
		Timeliness of Prenatal Care	68.2%(-5.5%)	77.9%(9.7%)
	Well-Child Visits in the First 15 Months of Life (W15)	6 Visits	60.3%(3.5%)	66.3%(6.0%)

[4] https://www.hca.wa.gov/assets/program/2016.12.20.Common-Measure-Set-Health-Care-Quality-Cost-Approved.pdf

Variation in MCO Performance between 2016 RY and 2017 RY

At an MCO level, MCOs have shown performance variation year to year. The following pages detail the primary performance shifts that occurred from 2016 RY to 2017 RY, by MCO.

Amerigroup

Key performance highlights

- **Largest declines:** Antidepressant medication management (acute and continuation phases), childhood immunization status for influenza
- **Largest increases:** Timeliness of prenatal care, BMI percentile for children and adolescents, HbA1c control, avoidance of antibiotics for adults with acute bronchitis
    - Smaller but significant increase due to population size for children's access to primary care practitioners, 25 months–6 years

Table 15: Variation in AMG Performance, 2016 RY to 2017 RY

Difference in Rate: -12.0% to 28.0%

		2015 RY	2016 RY	2017 RY	Change from 2016RY to 2017RY
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)	Total	37.4%	32.7%	39.9%	7.3%
Adults' Access to Preventive/Ambulatory Health Services (AAP)	Total	73.3%	68.8%	68.2%	-0.6%
Adult BMI Assessment (ABA)	Total	81.4%	84.9%	91.4%	6.5%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Initiation	36.4%	39.6%	37.1%	-2.4%
Antidepressant Medication Management (AMM)	Acute Phase	58.0%	60.5%	50.7%	-9.8%
Antidepressant Medication Management (AMM)	Continuation Phase	44.4%	46.4%	36.9%	-9.4%
Children/Adolescents' Access to Primary Care Practitioners (CAP)	Age 12-24 mos	96.2%	95.9%	95.4%	-0.6%
Children/Adolescents' Access to Primary Care Practitioners (CAP)	Age 25 mos-6 yrs	83.5%	80.9%	82.7%	1.8%
Children/Adolescents' Access to Primary Care Practitioners (CAP)	Age 7-11 yrs	88.6%	86.9%	85.9%	-1.0%
Children/Adolescents' Access to Primary Care Practitioners (CAP)	Age 12-19 yrs	85.5%	87.3%	86.2%	-1.1%
Comprehensive Diabetes Care (CDC)	HbA1c Control (<8%)	43.9%	41.3%	54.6%	13.3%
Childhood Immunization Status (CIS)	Influenza	52.4%	54.5%	48.6%	-5.9%
Appropriate Testing for Children with Pharyngitis (CWP)	Total	71.5%	70.9%	74.8%	3.9%
Frequency of Prenatal Care (FPC)	81+ Percent of Visits	45.8%	42.6%	49.8%	7.2%
Use of Imaging for Low Back Pain (LBP)	Total	71.3%	76.0%	75.5%	-0.5%
Medication Management for People with Asthma (MMA)	Med Compl 75% Total	34.2%	32.3%	32.7%	0.4%
Prenatal and Postpartum Care (PPC)	Timeliness of Prenatal Care	68.6%	67.1%	81.0%	14.0%
Prenatal and Postpartum Care (PPC)	Postpartum Care	56.3%	56.7%	62.3%	5.6%
Adherence to Antipsychotic Medications for Schizophrenia (SAA)	Total	71.3%	59.8%	58.3%	-1.5%
Well-Child Visits in the First 15 Months of Life (W15)	6 Visits	58.1%	68.4%	72.0%	3.5%
Weight Assessment and Counseling for Children/Adolescents (WCC)	BMI	42.6%	45.8%	59.7%	13.9%

Community Health Plan of Washington

Key performance highlights

- **Largest declines:** Antidepressant medication management—continuation phase, use of imaging for low back pain
- **Largest increases**: Major upward shifts due to resolution of data issues for child-related measures, as well as increases for timeliness of prenatal care, postpartum care, and HbA1c control

NOTE: Last year, when reporting 2016 RY rates, CHPW experienced data reporting and collection issues that significantly impacted its individual as well as statewide rates on a number of measures, particularly those related to child and adolescent access and maternal care. CHPW remedied the situation; as a result, this year's reported statewide rates for these measures are more aligned with statewide averages reported in prior years.

Table 16: Variation in CHPW Performance, 2016 RY to 2017 RY

Difference in Rate: -12.0% to 28.0%

		2015 RY	2016 RY	2017 RY	Change from 2016RY to 2017RY
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)	Total	32.5%	31.2%	38.2%	7.0%
Adults' Access to Preventive/Ambulatory Health Services (AAP)	Total	83.9%	75.5%	74.8%	-0.7%
Adult BMI Assessment (ABA)	Total	86.0%	78.7%	88.2%	9.5%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Initiation	30.5%	30.5%	42.3%	11.8%
Antidepressant Medication Management (AMM)	Acute Phase	52.3%	53.1%	49.1%	-4.0%
Antidepressant Medication Management (AMM)	Continuation Phase	38.0%	38.7%	33.2%	-5.5%
Children/Adolescents' Access to Primary Care Practitioners (CAP)	Age 12-24 mos	97.4%	74.7%	96.2%	21.5%
Children/Adolescents' Access to Primary Care Practitioners (CAP)	Age 25 mos-6 yrs	87.9%	62.3%	85.0%	22.8%
Children/Adolescents' Access to Primary Care Practitioners (CAP)	Age 7-11 yrs	91.1%	73.7%	90.8%	17.1%
Children/Adolescents' Access to Primary Care Practitioners (CAP)	Age 12-19 yrs	89.5%	75.7%	89.8%	14.1%
Comprehensive Diabetes Care (CDC)	HbA1c Control (<8%)	52.3%	27.6%	51.8%	24.3%
Childhood Immunization Status (CIS)	Influenza	57.4%	54.0%	49.6%	-4.4%
Appropriate Testing for Children with Pharyngitis (CWP)	Total	65.8%	68.4%	75.3%	6.9%
Frequency of Prenatal Care (FPC)	81+ Percent of Visits	46.7%	23.1%	45.3%	22.1%
Use of Imaging for Low Back Pain (LBP)	Total	78.0%	76.4%	71.6%	-4.8%
Medication Management for People with Asthma (MMA)	Med Compl 75% Total	27.7%	29.0%	32.2%	3.1%
Prenatal and Postpartum Care (PPC)	Timeliness of Prenatal Care	77.9%	54.5%	76.6%	22.1%
Prenatal and Postpartum Care (PPC)	Postpartum Care	52.6%	47.0%	60.3%	13.4%
Adherence to Antipsychotic Medications for Schizophrenia (SAA)	Total	64.4%	69.0%	64.0%	-5.0%
Well-Child Visits in the First 15 Months of Life (W15)	6 Visits	57.7%	42.4%	70.1%	27.6%
Weight Assessment and Counseling for Children/Adolescents (WCC)	BMI	37.2%	51.8%	70.3%	18.5%

Coordinated Care Washington

Key performance highlights

- **Largest declines:** Childhood immunization status for influenza, well-child visits in the first 15 months of life
- **Largest increases:** Frequency of prenatal care, BMI percentile for children and adolescents, appropriate testing for children with pharyngitis

Table 17: Variation in CCW Performance, 2016 RY to 2017 RY

Difference in Rate: -12.0% to 28.0%

		2015 RY	2016 RY	2017 RY	Change from 2016RY to 2017RY
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)	Total	26.9%	33.6%	39.1%	5.6%
Adults' Access to Preventive/Ambulatory Health Services (AAP)	Total	75.2%	69.4%	69.6%	0.3%
Adult BMI Assessment (ABA)	Total	70.5%	86.4%	90.1%	3.7%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Initiation	42.4%	33.3%	41.8%	8.5%
Antidepressant Medication Management (AMM)	Acute Phase	52.6%	52.3%	49.6%	-2.8%
Antidepressant Medication Management (AMM)	Continuation Phase	38.5%	37.7%	33.5%	-4.2%
Children/Adolescents' Access to Primary Care Practitioners (CAP)	Age 12-24 mos	97.7%	96.4%	96.9%	0.5%
Children/Adolescents' Access to Primary Care Practitioners (CAP)	Age 25 mos-6 yrs	89.2%	86.7%	86.2%	-0.5%
Children/Adolescents' Access to Primary Care Practitioners (CAP)	Age 7-11 yrs	91.6%	92.0%	90.0%	-2.0%
Children/Adolescents' Access to Primary Care Practitioners (CAP)	Age 12-19 yrs	90.9%	90.1%	89.3%	-0.8%
Comprehensive Diabetes Care (CDC)	HbA1c Control (<8%)	39.4%	36.9%	45.7%	8.9%
Childhood Immunization Status (CIS)	Influenza	66.9%	62.1%	53.4%	-8.8%
Appropriate Testing for Children with Pharyngitis (CWP)	Total	46.4%	55.9%	62.0%	6.1%
Frequency of Prenatal Care (FPC)	81+ Percent of Visits	48.4%	36.4%	49.6%	13.3%
Use of Imaging for Low Back Pain (LBP)	Total	79.3%	78.5%	75.7%	-2.8%
Medication Management for People with Asthma (MMA)	Med Compl 75% Total	30.7%	31.3%	32.6%	1.3%
Prenatal and Postpartum Care (PPC)	Timeliness of Prenatal Care	74.1%	70.2%	76.3%	6.1%
Prenatal and Postpartum Care (PPC)	Postpartum Care	49.3%	55.2%	60.4%	5.2%
Adherence to Antipsychotic Medications for Schizophrenia (SAA)	Total	72.4%	65.1%	60.1%	-5.1%
Well-Child Visits in the First 15 Months of Life (W15)	6 Visits	60.6%	68.9%	58.2%	-10.7%
Weight Assessment and Counseling for Children/Adolescents (WCC)	BMI	24.5%	21.0%	48.1%	27.1%

Molina Healthcare of Washington

Key performance highlights

- **Largest declines:** Childhood immunization status for influenza, adherence to antipsychotic medications for individuals with schizophrenia
  - Smaller but significant decline for antidepressant medication management—continuation phase
- **Largest increases:** Moderate improvement in most measures

Table 18: Variation in MHW Performance, 2016 RY to 2017 RY

Difference in Rate: -12.0% to 28.0%

		2015 RY	2016 RY	2017 RY	Change from 2016RY to 2017RY
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)	Total	27.7%	28.7%	34.4%	5.6%
Adults' Access to Preventive/Ambulatory Health Services (AAP)	Total	85.3%	81.3%	79.2%	-2.1%
Adult BMI Assessment (ABA)	Total	84.5%	90.1%	92.6%	2.5%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Initiation	41.3%	42.6%	44.1%	1.5%
Antidepressant Medication Management (AMM)	Acute Phase	48.4%	52.2%	50.7%	-1.5%
Antidepressant Medication Management (AMM)	Continuation Phase	32.8%	37.2%	34.5%	-2.6%
Children/Adolescents' Access to Primary Care Practitioners (CAP)	Age 12-24 mos	97.9%	97.5%	97.1%	-0.5%
Children/Adolescents' Access to Primary Care Practitioners (CAP)	Age 25 mos-6 yrs	89.5%	88.8%	87.5%	-1.3%
Children/Adolescents' Access to Primary Care Practitioners (CAP)	Age 7-11 yrs	92.6%	92.8%	92.2%	-0.7%
Children/Adolescents' Access to Primary Care Practitioners (CAP)	Age 12-19 yrs	92.6%	92.6%	92.3%	-0.3%
Comprehensive Diabetes Care (CDC)	HbA1c Control (<8%)	45.9%	49.0%	50.3%	1.3%
Childhood Immunization Status (CIS)	Influenza	56.7%	52.8%	45.7%	-7.1%
Appropriate Testing for Children with Pharyngitis (CWP)	Total	67.9%	70.7%	75.0%	4.3%
Frequency of Prenatal Care (FPC)	81+ Percent of Visits	40.2%	51.7%	52.1%	0.4%
Use of Imaging for Low Back Pain (LBP)	Total	79.1%	76.3%	75.8%	-0.5%
Medication Management for People with Asthma (MMA)	Med Compl 75% Total	23.4%	28.3%	30.0%	1.7%
Prenatal and Postpartum Care (PPC)	Timeliness of Prenatal Care	74.7%	75.2%	79.1%	3.9%
Prenatal and Postpartum Care (PPC)	Postpartum Care	52.0%	51.3%	56.4%	5.2%
Adherence to Antipsychotic Medications for Schizophrenia (SAA)	Total	76.8%	70.5%	62.3%	-8.2%
Well-Child Visits in the First 15 Months of Life (W15)	6 Visits	55.2%	62.7%	65.6%	2.9%
Weight Assessment and Counseling for Children/Adolescents (WCC)	BMI	39.1%	50.3%	56.3%	6.0%

United Healthcare Community Plan

Key performance highlights

- **Largest declines:** Adherence to antipsychotic medications for individuals with schizophrenia (although not a significant shift statistically)
    - Smaller but significant decreases due to population size: child and adolescent access to primary care practitioners (ages 25 months–6 years, 7–11 years, 12–19 years)
- **Largest increases:** Frequency of prenatal care, BMI percentile for children and adolescents

Table 19: Variation in UHC Performance, 2016 RY to 2017 RY

Difference in Rate: -12.0% … 28.0%

		2015 RY	2016 RY	2017 RY	Change from 2016RY to 2017RY
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)	Total	26.5%	28.9%	33.0%	4.0%
Adults' Access to Preventive/Ambulatory Health Services (AAP)	Total	75.7%	72.5%	71.2%	-1.3%
Adult BMI Assessment (ABA)	Total	68.1%	80.8%	86.7%	5.8%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Initiation	29.6%	44.8%	42.6%	-2.2%
Antidepressant Medication Management (AMM)	Acute Phase	57.2%	56.4%	54.5%	-1.9%
Antidepressant Medication Management (AMM)	Continuation Phase	43.0%	41.2%	40.7%	-0.4%
Children/Adolescents' Access to Primary Care Practitioners (CAP)	Age 12-24 mos	96.2%	96.2%	96.2%	0.0%
Children/Adolescents' Access to Primary Care Practitioners (CAP)	Age 25 mos-6 yrs	88.3%	87.5%	85.8%	-1.6%
Children/Adolescents' Access to Primary Care Practitioners (CAP)	Age 7-11 yrs	91.2%	92.5%	90.3%	-2.2%
Children/Adolescents' Access to Primary Care Practitioners (CAP)	Age 12-19 yrs	88.9%	91.5%	89.8%	-1.7%
Comprehensive Diabetes Care (CDC)	HbA1c Control (<8%)	43.6%	36.3%	45.3%	9.0%
Childhood Immunization Status (CIS)	Influenza	59.6%	54.0%	50.4%	-3.6%
Appropriate Testing for Children with Pharyngitis (CWP)	Total	65.8%	69.7%	78.9%	9.2%
Frequency of Prenatal Care (FPC)	81+ Percent of Visits	43.1%	34.5%	45.3%	10.7%
Use of Imaging for Low Back Pain (LBP)	Total	74.8%	74.4%	72.0%	-2.4%
Medication Management for People with Asthma (MMA)	Med Compl 75% Total	35.8%	39.8%	45.3%	5.5%
Prenatal and Postpartum Care (PPC)	Timeliness of Prenatal Care	65.2%	67.9%	74.7%	6.8%
Prenatal and Postpartum Care (PPC)	Postpartum Care	48.2%	56.7%	61.3%	4.6%
Adherence to Antipsychotic Medications for Schizophrenia (SAA)	Total	73.5%	66.5%	61.9%	-4.6%
Well-Child Visits in the First 15 Months of Life (W15)	6 Visits	57.4%	64.5%	68.9%	4.4%
Weight Assessment and Counseling for Children/Adolescents (WCC)	BMI	30.4%	38.2%	50.6%	12.4%

Access to Care

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

NOTE: Last year, when reporting 2016 RY rates, Community Health Plan of Washington (CHPW) experienced data reporting and collection issues that significantly impacted its individual as well as statewide rates on a number of measures, particularly those related to child and adolescent access and maternal care. CHPW remedied the situation; as a result, this year's reported statewide rates for these measures are more aligned with statewide averages reported in prior years.

Reported Measures

The access-related measures in this section include:

- Adults' access to preventive/ambulatory health services (also referred to as adult access to primary care in this report): the percentage of adult enrollees with an ambulatory or preventive care visit during the MCO reporting year, not including inpatient stays or ED visits
- Children and adolescents' access to primary care practitioners (also referred to as child and adolescent access to primary care in this report): the percentage of children and adolescents who had an outpatient visit during the MCO reporting year (or the year prior for age groups 7–11 and 12–19) with a primary care physician
- Well-child visits: the percentage of enrollees of the specified age groups receiving the specified number of well-care visits
  - Ages 0–15 months: six or more visits (State-contracted minimum threshold: 75 percent)
  - Ages 3–6 years: one or more visits (State-contracted minimum threshold: 75 percent)
  - Ages 12–21 years: one or more visits (State-contracted minimum threshold: 75 percent)
- Timeliness of prenatal care: the percentage of women delivering a live baby who received prenatal care in the first trimester (or within 42 days of enrolling with the MCO) *[Note: Does not require one year of continuous enrollment]*
- Frequency of ongoing prenatal care: the percentage of women delivering a live baby who received 81 percent or more of the recommended prenatal visits (the recommended number of visits for the measure depends on the member's stage of pregnancy at the time of enrollment) *[Note: Does not require one year of continuous enrollment]*
- Postpartum care: the percentage of women delivering a live baby who received at least one postpartum visit between 21 and 56 days following delivery *[Note: Does not require one year of continuous enrollment]*

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

Measure Performance

Adults' Access to Preventive/Ambulatory Health Services

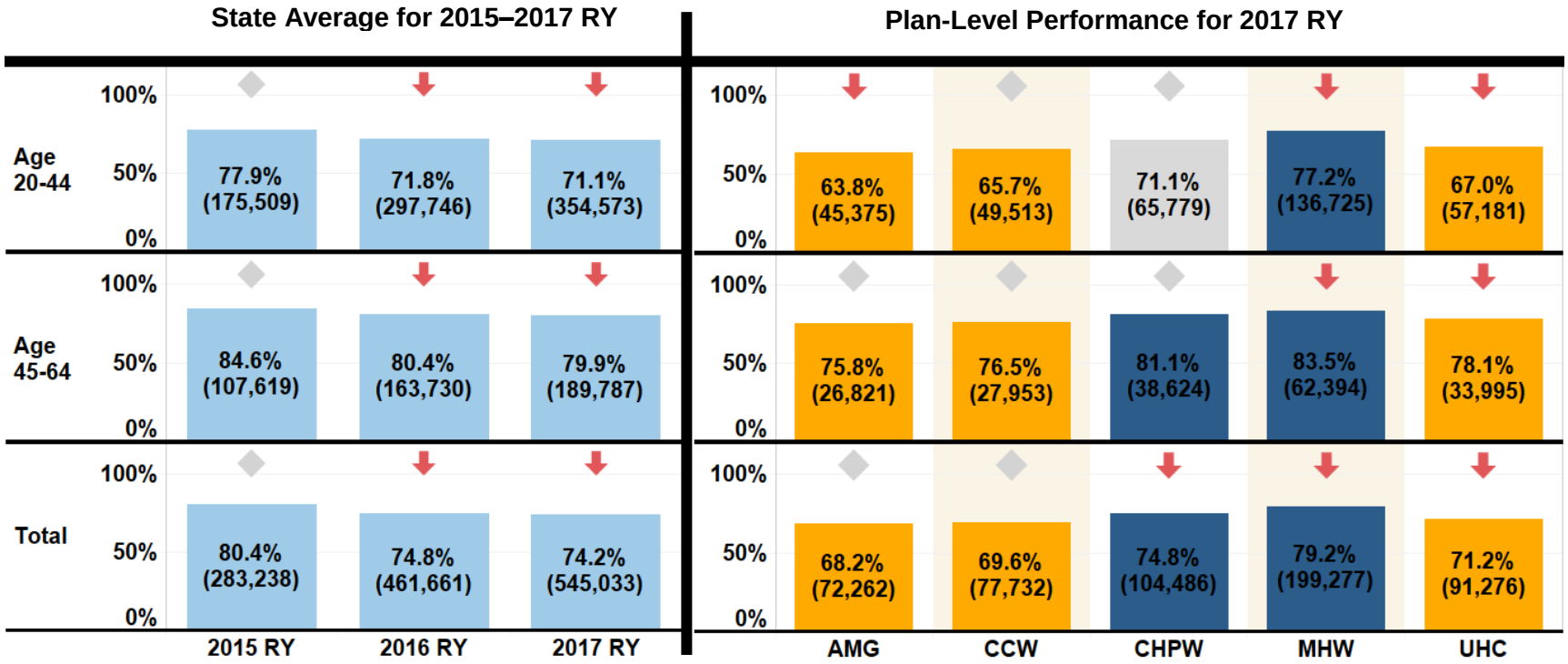
Adults' access to preventive/ambulatory health services is part of the Washington State Common Measure Set on Health Care Quality and Cost—2017.

Key Points:

At a state level, all measures trended down, which may be expected given the increase in the Medicaid expansion population.

- **AMG** was a statistically low performer for all measures but only trended down for the age range of 20–44.
- **MHW** was a statistically high performer for all measures but trended slightly down for each measure.
- **UHC** was a statistically low performer for all measures and trended slightly down for each measure.

Table 20: Adults' Access to Preventive/Ambulatory Health Services, Statewide and by MCO*



Children and Adolescents' Access to Primary Care Practitioners

Children and adolescents' access to primary care practitioners is subdivided into four age categories: 12–24 months, 25 months–6 years, 7–11 years, and 12–19 years. Children and adolescents' access to primary care practitioners is part of the Washington State Common Measure Set on Health Care Quality and Cost—2017.

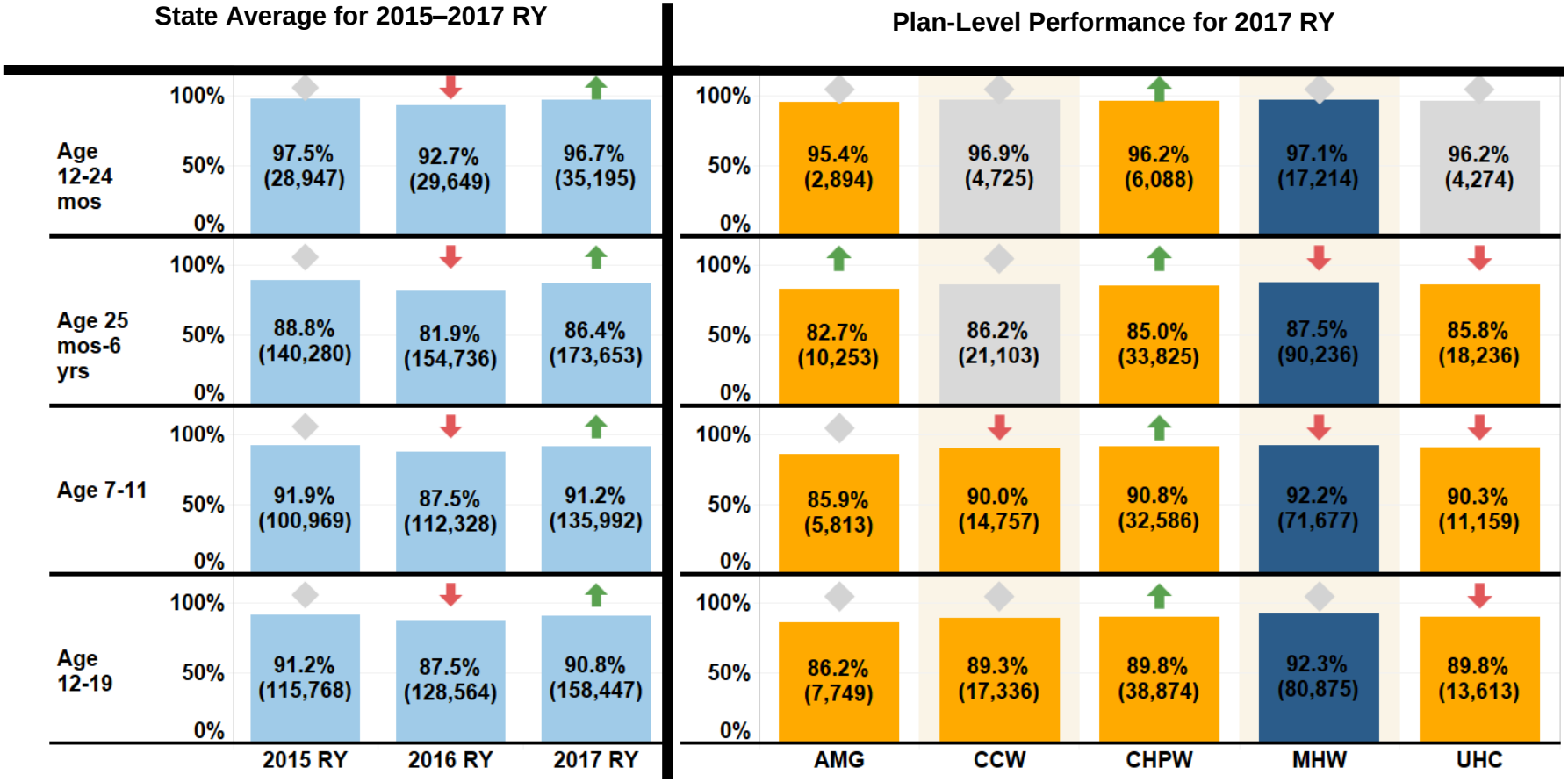
Key Points:

At a state level, all measures trended up; this trend was expected as a result of CHPW's correction of the data collection and reporting issues it experienced in 2016 RY.

- **AMG** was a statistically low performer for all measures and only trended up for the 25 months–6 years age range.
- **CHPW** was a statistically low performer for all measures but was responsible for the overall upward trend because of its corrected data issue.
- **CCW** was a statistically low performer for two measures and trended down for 7–11-year-olds.
- **MHW** was a statistically high performer for all measures but trended slightly down for two age ranges (25 months–6 years and 7–11 years).
- **UHC** was a statistically low performer for most measures and trended slightly down for most measures.

Table 21, next page, displays plan and statewide performance for these measures.

Table 21: Children and Adolescents' Access to Primary Care Practitioners, Statewide and by MCO*



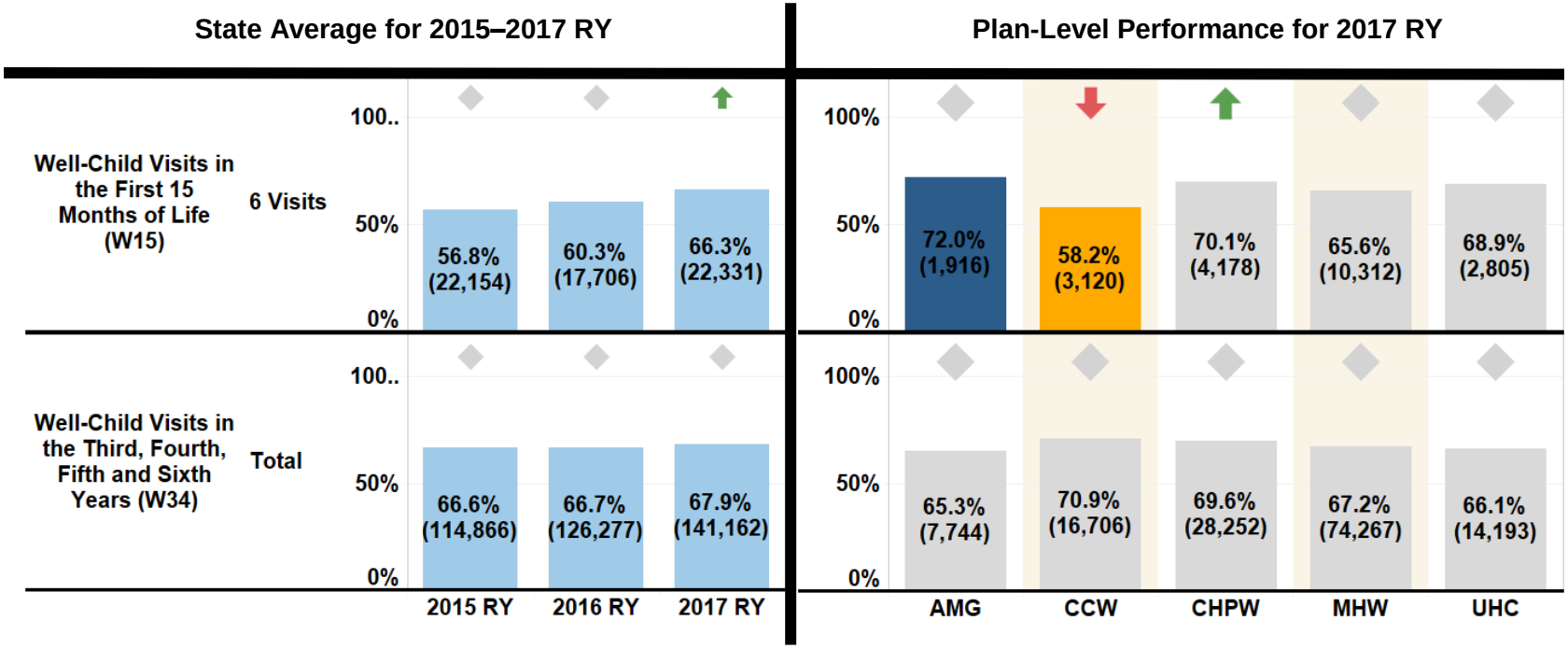
Well-Child Measures

The well-child visit measures are part of the Washington State Common Measure Set on Health Care Quality and Cost—2017.

Key Points:

At a state level, well-child visits in the first 15 months of life trended up, resulting from CHPW's substantial increase after resolution of its data collection and reporting issue experienced in 2016 RY. MHW was a high performer on this measure. The low performer (CCW) for this measure trended down. Well-child visits for 3–6-year-olds did not show significant change.

Table 22: Well-Child Visits, Statewide and by MCO*



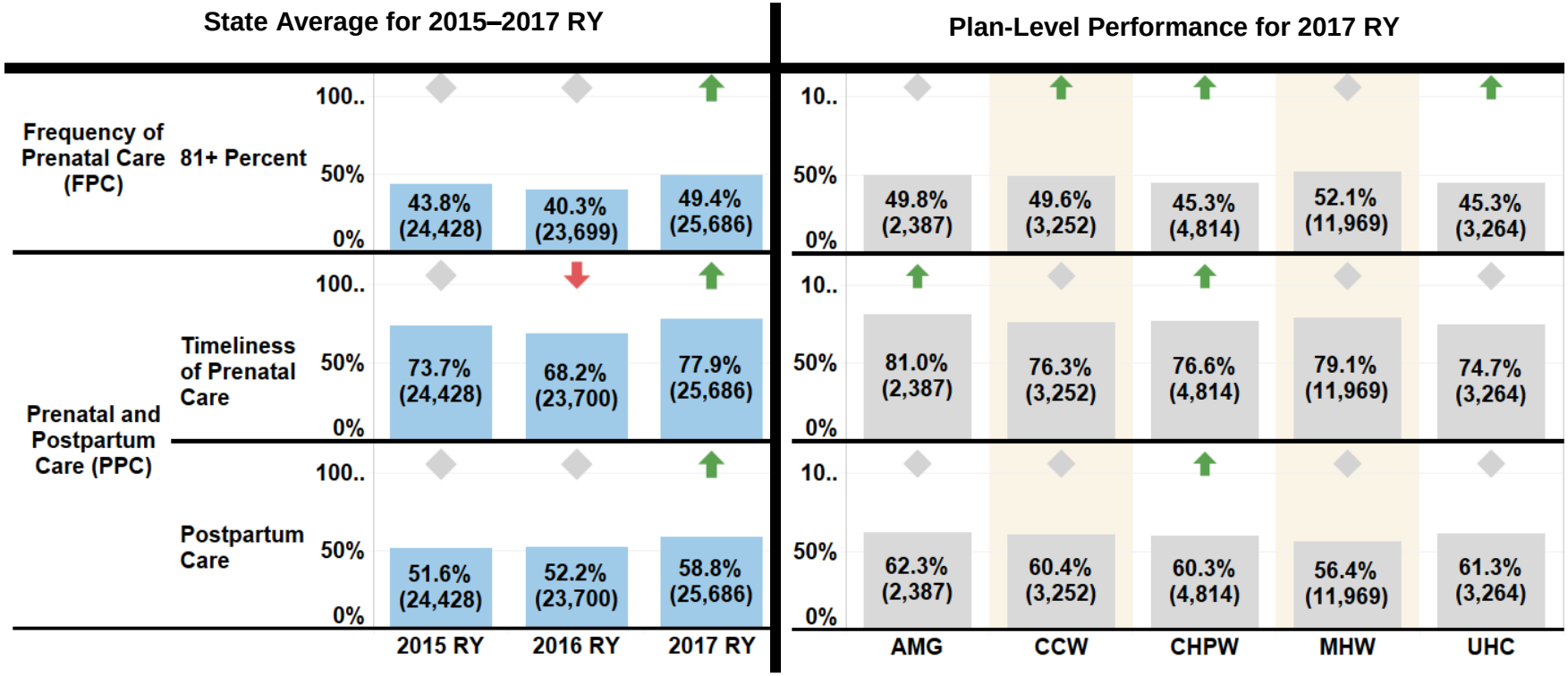
Maternal Health Measures

All Apple Health MCOs performed lower than the national average for women entering prenatal care in the first trimester, as shown in Table 23 below. Note that the number of recommended prenatal visits varies for each enrollee, as it depends on the stage of the enrollee's pregnancy at the time of enrollment.

Key Points:

At a state level, all measures trended up: three MCOs increased performance for frequency of prenatal care, and two MCOs increased performance for timeliness of prenatal care. Only CHPW showed a statistical increase in postpartum care.

Table 23: Prenatal and Postpartum Care, Statewide and by MCO*



Preventive Care

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

Reported Measures

Measures in this section include:

- Weight management: the percentage of enrollees with an outpatient visit to a primary care provider (PCP) who had evidence of:
  - Adult BMI assessment (ages 18–74)
  - Children's BMI percentile screening (ages 3–17)
  - Children's nutritional counseling (ages 3–17)
  - Children's physical activity counseling (ages 3–17)
- Immunizations before age 2: For children age 2, the State required MCOs to report 10 separate vaccine antigens and 9 combinations of vaccines, shown in Table 24. The HEDIS immunization measure follows the CDC guidelines for immunizations, and is updated when those guidelines change. The definitions of these measures are noted below.
  - Diphtheria, tetanus, and acellular pertussis (DTaP): four doses
  - Haemophilus influenzae type B (HiB): three doses
  - Hepatitis A (HepA): one dose
  - Hepatitis B (HepB): three doses
  - Influenza (Flu): two doses
  - Measles, mumps, and rubella (MMR): one dose
  - Pneumococcal conjugate (PCV): four doses
  - Polio (IPV): three doses
  - Rotavirus (RV): two or three doses
  - Varicella-Zoster virus (VZV): one dose
  - Combination 2 (refer to Table 24) (HCA-contracted goal: 75 percent)
  - Combination 3 (refer to Table 24)

Table 24: Childhood Immunization Combinations

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

- Immunizations for adolescents
  - Meningococcal vaccine: one dose, on or between the enrollee's 10th and 13th birthdays
  - Tetanus, diphtheria toxoids, and acellular pertussis (TDaP)
  - Combination 1: both of the above vaccines
  - HPV: At least two HPV vaccines, with different dates of service on or between the enrollee's 9th and 13th birthdays
  - Combination 2: All three of the above vaccines
- Lead screening in children: The percentage of children two years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday
- Women's health screenings
  - Breast cancer screening: the percentage of women ages 50–74 who had at least one mammogram in the reporting year or the prior year
  - Cervical cancer screening: the percentage of women ages 21–64 receiving a PAP test during the reporting year or prior two years, and co-testing of PAP and human papilloma virus (HPV) for women ages 30–64 in the reporting year or the four prior years
  - Chlamydia screening: the percentage of women ages 16–24 years and identified as sexually active having at least one test for chlamydia during the reporting year

Measure Performance

Adult Body Mass Index (BMI) Assessment

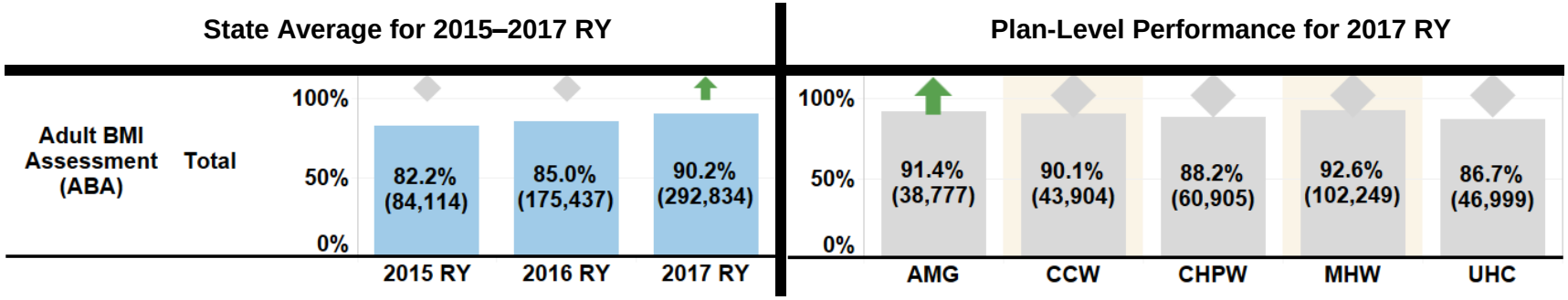
The Apple Health average for this measure surpassed the national average in 2017 RY.

Adult BMI assessment is part of the Washington State Common Measure Set on Health Care Quality and Cost—2017.

Key Points:

At a state level, this measure trended up, although AMG was the only MCO with a statistical increase.

Table 25: Adult BMI Assessment, Statewide and by MCO*



Child and Adolescent Prevention Measures

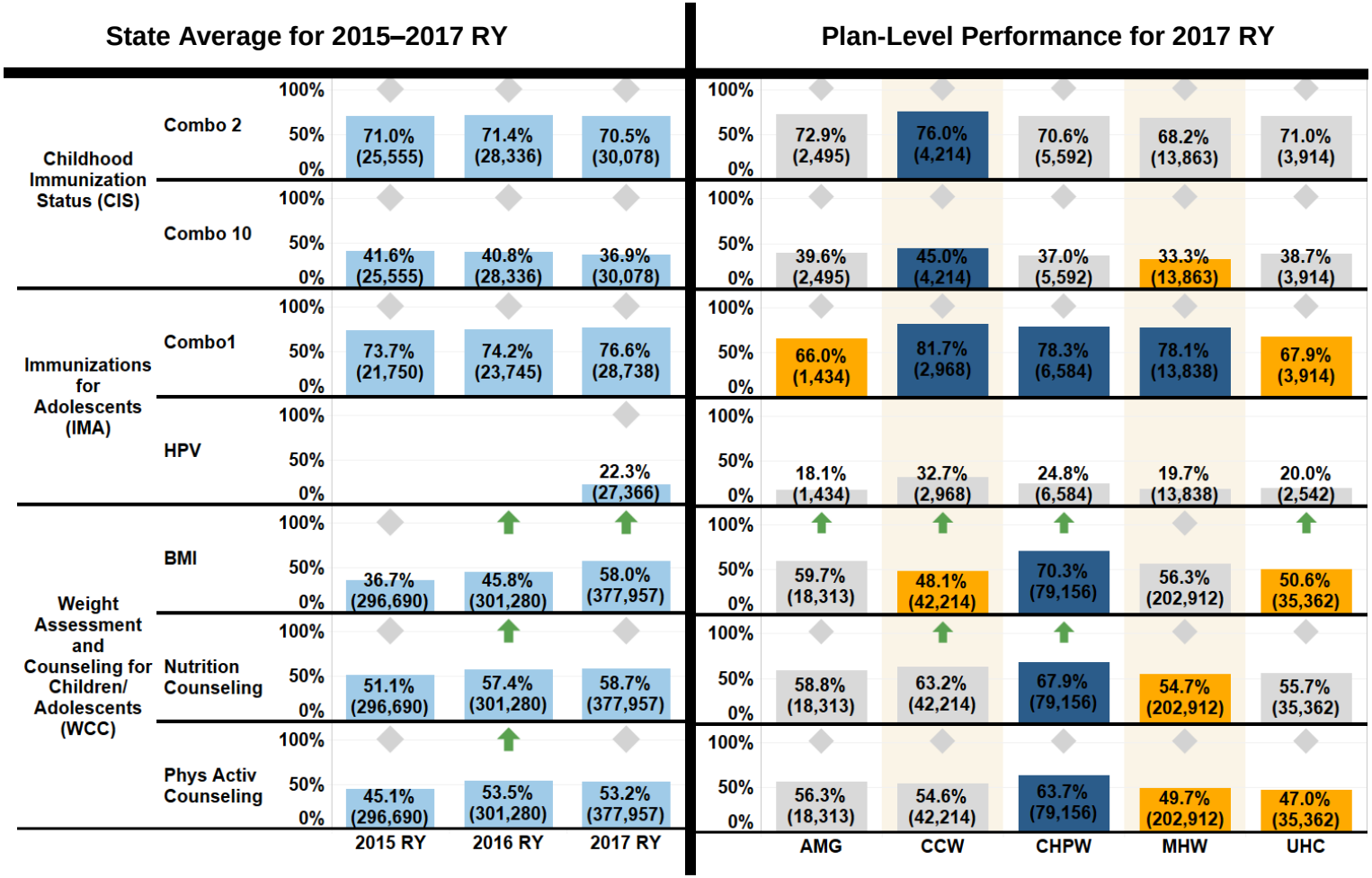
Childhood immunization status—combination 10, immunizations for adolescents, and weight assessment and counseling for nutrition and physical activity for children/adolescents are all part of the Washington State Common Measure Set on Health Care Quality and Cost—2017.

Key Points:

Immunizations: State-level performance for both child and adolescent measures showed very little change from 2016 RY. However, CCW was a high performer for all immunization measures. Note that the measure specifications for HPV vaccinations have changed, so there are no prior-year comparisons for this measure; performance ranged from 18 percent (AMG) to 32 percent (CCW).

Weight Assessment and Counseling: Performance for BMI percentile continued to shift upward statewide, with four of the MCOs trending up. Statewide performance for nutrition counseling and physical activity counseling did not change. Table 26, next page, displays the results for these measures.

Table 26: Child and Adolescent Prevention Measures, Statewide and by MCO*



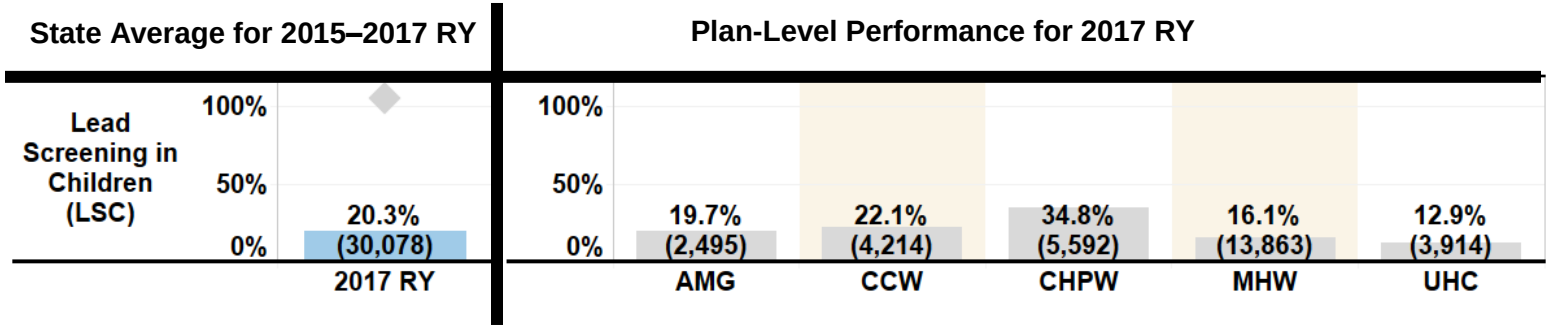
Lead Screening in Children

Reporting of the lead screening measure is new for Apple Health MCOs in 2017 RY and should be watched closely for trending next year, when comparison data are available.

Key Points:

In this baseline year, statewide performance is just over 20 percent, with MCOs varying in performance from 12.9 percent (UHC) to 34.8 (CHPW).

Table 27: Lead Screening in Children, Statewide and by MCO*



Women's Health Screenings

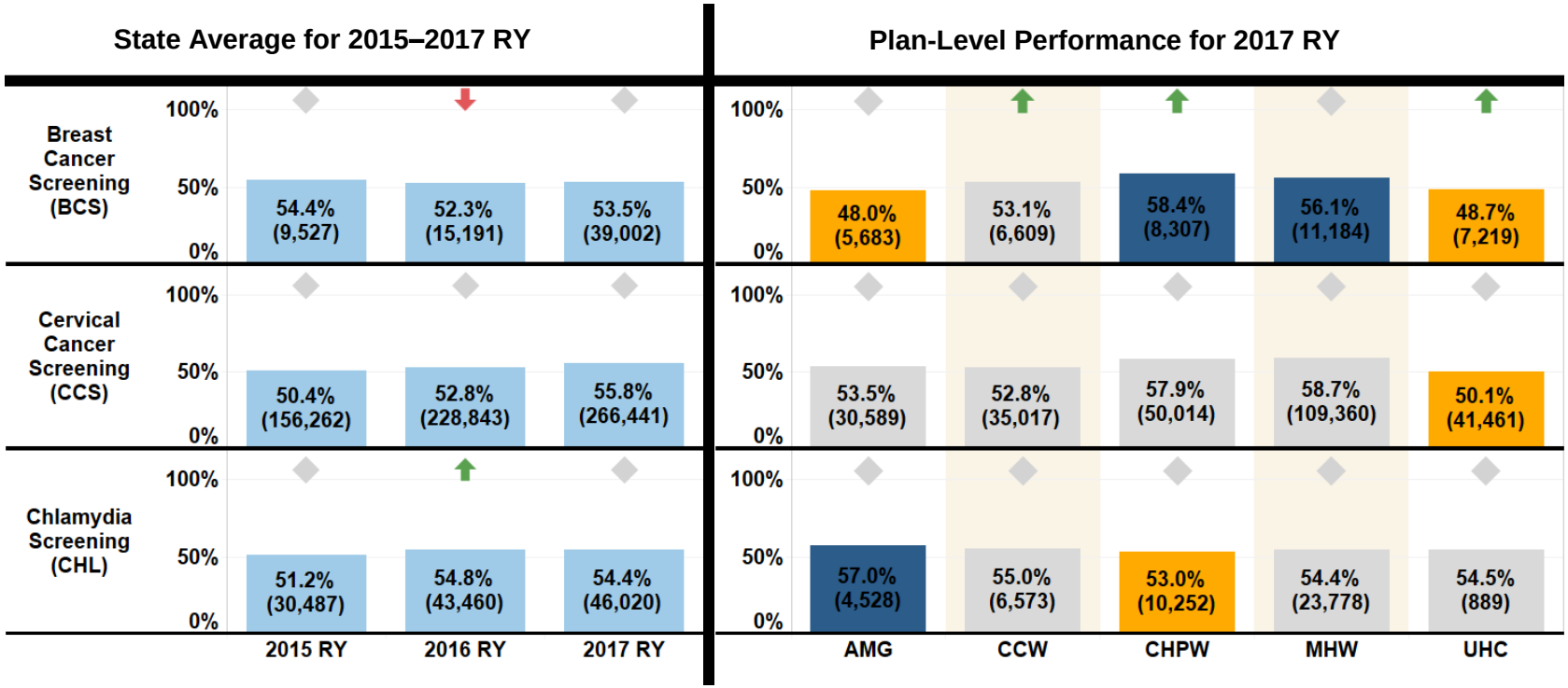
Overall Apple Health performance on women's health screenings fell considerably below national averages (below the 33rd percentile) for three measures (breast cancer screening, cervical cancer screening, and chlamydia screening), as shown in Table 28. Significant improvement is needed on all three screening measures to ensure the health and well-being of women enrolled in Apple Health.

Breast cancer screening, cervical cancer screening, and chlamydia screening are all part of the Washington State Common Measure Set on Health Care Quality and Cost—2017.

Key Points:

At a state level, all measures showed no significant change for 2017 RY; at the MCO level, CCW, CHPW, and UHC showed upward shifts for breast cancer screening.

Table 28: Women's Health Screenings, Statewide and by MCO*



Chronic Care Management

Adequate management of chronic conditions can delay morbidity and mortality and improve enrollee quality of life. It may also prevent more costly emergency department (ED) visits and inpatient stays. Diabetes is a condition that, if poorly managed, can lead to significant complications. Proactive testing and management of diabetes and other conditions should be important wellness goals for the State.

Reported Measures

Measures included in this section include:

- Diabetes process measures
  - HbA1c testing: presence of at least one HbA1c test during the reporting year, regardless of result
  - Eye exams: presence of at least one eye exam during the reporting year (or year prior if previous eye exam showed no evidence of diabetic retinopathy)
  - Medical attention for nephropathy: presence of at least one nephropathy test or evidence of the presence of nephropathy during the reporting year
- Diabetes outcome measures
  - Blood pressure control (less than 140/90)
  - HbA1c control (less than 8.0 percent)
  - Poor HbA1c control (more than 9.0 percent): Note that individuals not receiving an HbA1c test during the reporting year are included in this category and that for this measure, a lower score is better
- Other chronic care management
  - Controlling high blood pressure: the percentage of adults ages 18–85 diagnosed with hypertension with blood pressure reading indicating adequate control according to their age group
  - Antidepressant medication management: the percentage of adults age 18 or over having diagnosis of major depression who were treated with antidepressant medication and remained on antidepressant medication treatment for six months
  - Medication management for people with asthma: the percentage of enrollees ages 5–11 and 12–17 identified as having persistent asthma who were treated with medication and remained on medication for at least 75 percent of their treatment period
  - Follow-up care for children prescribed ADHD medication, initiation phase: the percentage of members 6–12 years of age with an ambulatory prescription for an ADHD medication who had at least one follow-up visit with a provider during the 30-day initiation phase

Measure Performance

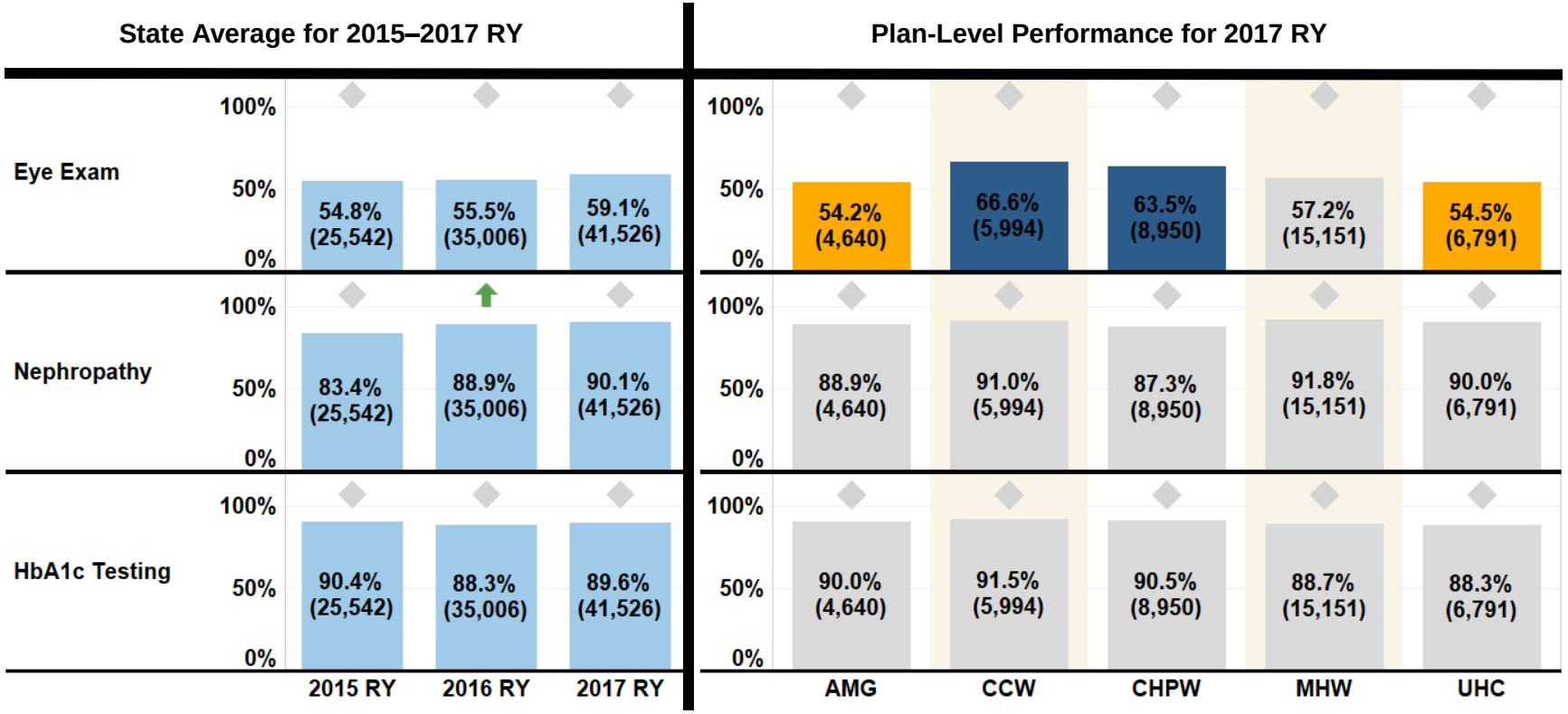
Diabetes Process Measures

There are three process measures included in the comprehensive diabetes care measure (HbA1c testing, eye exam, and medical attention for nephropathy). They are all included in the Washington State Common Measure Set on Health Care Quality and Cost—2017.

Key Points:

All measures remained steady this year at the state level. The most variation seen on a plan level was for the eye exam measure, from 54.2 percent (AMG) to 66.6 percent (CCW).

Table 29: Diabetes Process Measures, Statewide and by MCO*



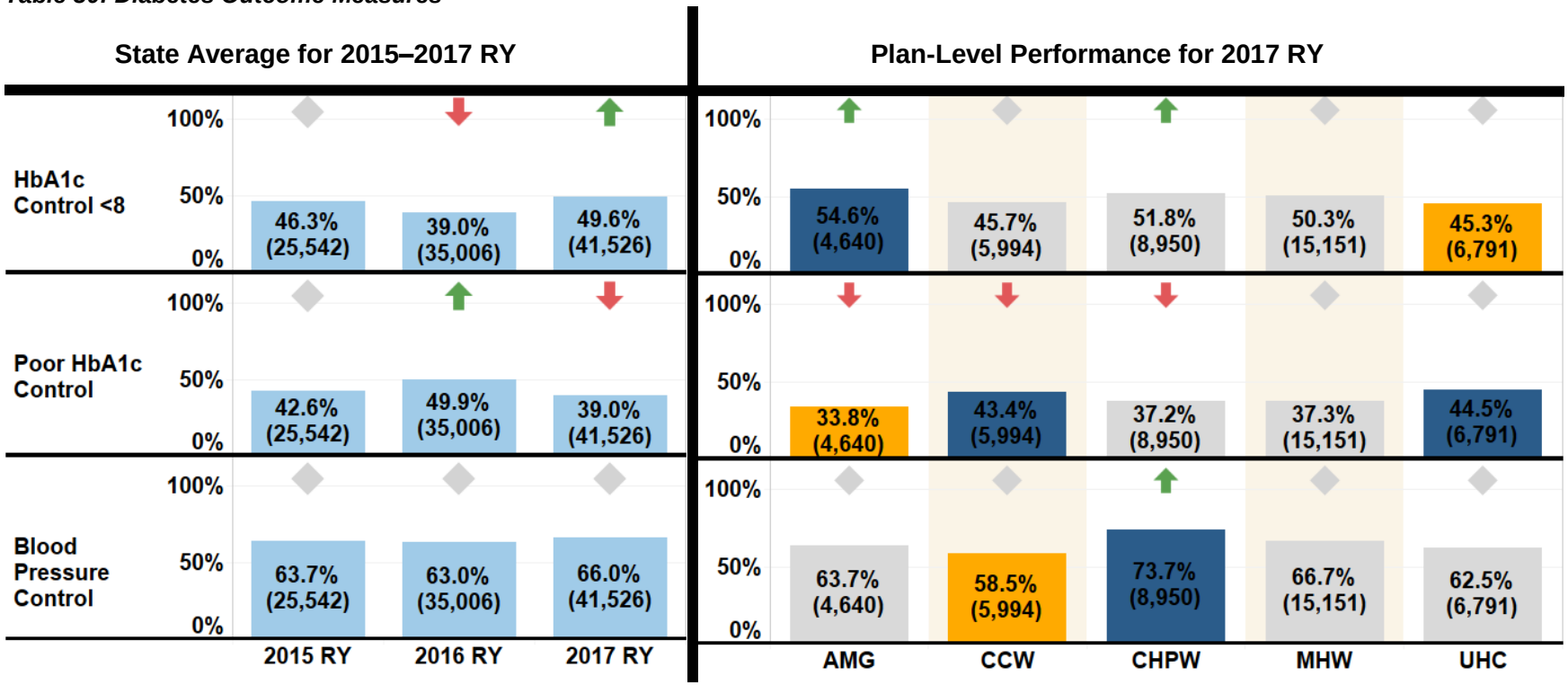
Diabetes Outcome Measures

Three diabetes outcome measures include HbA1c control, poor HbA1c control, and blood pressure control. Poor HbA1c control and blood pressure control are both included in the Washington State Common Measure Set on Health Care Quality and Cost—2017.

Key Points:

At a state level, blood pressure control remained steady. While HbA1c control trended up, its inverse measure, poor HbA1c, trended down. The upward shift in HbA1c control was led by AMG and CCW. The decline in poor HbA1c was due to performance by AMG, CCW, and CHPW, which all trended down. Note that for poor HbA1c control, a lower score is better.

Table 30: Diabetes Outcome Measures*



Note: For poor HbA1c control, a lower score is better.

Other Chronic Care Management

Controlling high blood pressure, follow-up care for children prescribed ADHD medication, and antidepressant medication management are all included in the Washington State Common Measure Set on Health Care Quality and Cost—2017.

Key Points:

Controlling high blood pressure: At a state level, the rate for this measure remained unchanged. However, at a plan level, performance varies significantly between MCOs, with almost 20 points separating the highest performer (CHPW) and the lowest performer (UHC). These raw rates may not be fully due to differences in quality of care, as MCOs serve different enrollee populations that may have different risk rates for uncontrolled high blood pressure. For example, individuals who are older or obese are more likely to have non-controlled high blood pressure. These factors may be outside the direct control of the MCO. However, blood pressure management is important for continued good health, particularly for vulnerable populations.

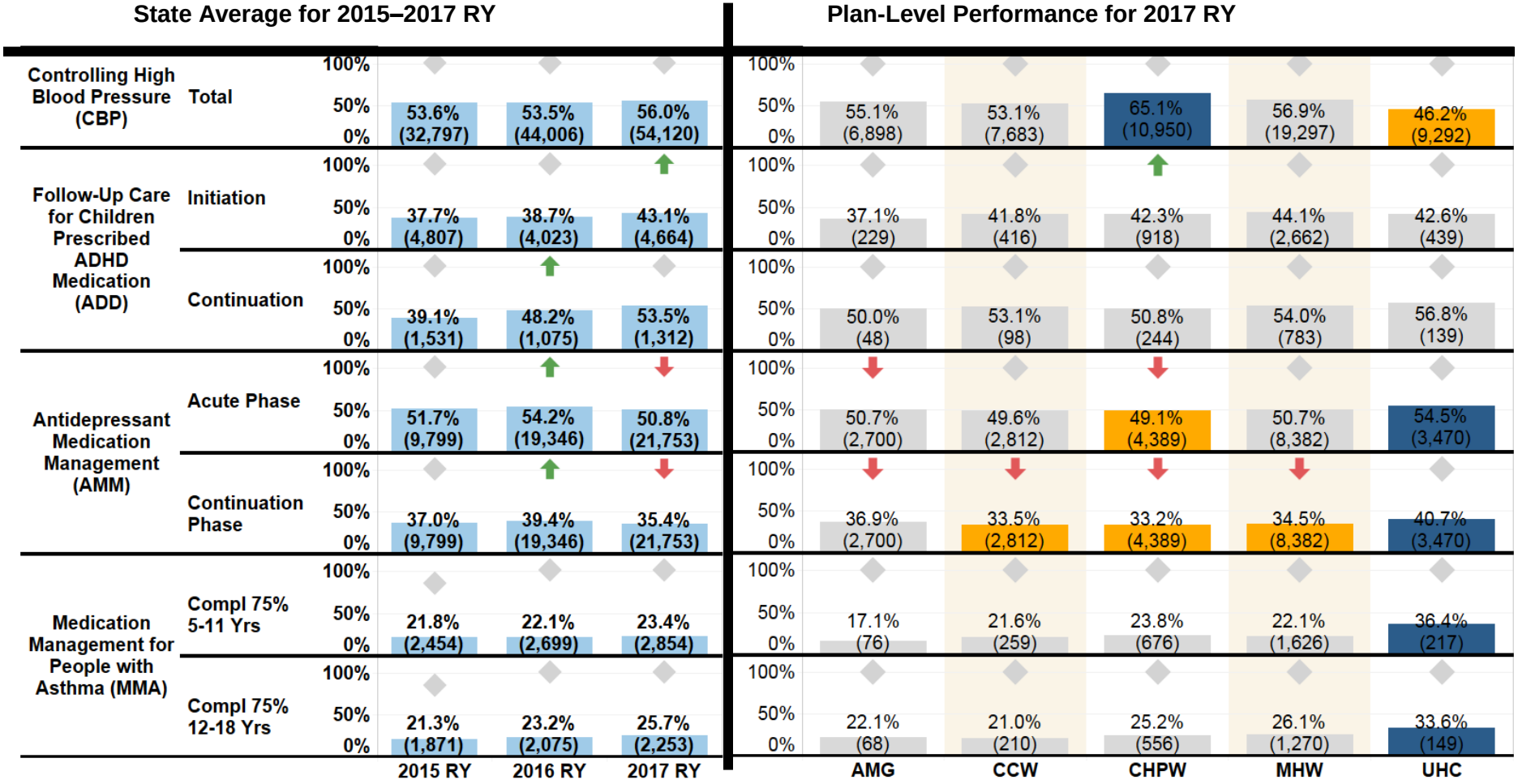
Follow-up care for children prescribed ADHD medication: Statewide performance increased significantly for the initiation phase and remained steady for the continuation phase. This lift was driven by CHPW.

Antidepressant medication management: Performance on both the acute and continuation phase measures are in line with national averages. However, performance on both measures also shifted down at a state level. Lower acute phase performance was driven by AMG and CHPW; for the continuation phase measure, every MCO except UHC trended down in 2017 RY. UHC was also the highest performer for both measures.

Medication management for people with asthma: This measure did not change at the state or plan level in 2017 RY.

Table 31, next page, displays the results of these measures.

Table 31: Chronic Care Management Measures, Statewide and by MCO*



Medical Care Utilization

Limiting cost growth while maximizing health coverage is essential for the Medicaid program to be sustainable. There are two important components of controlling costs: preventing waste and reducing hospital utilization.

Reported Measures

Measures in this domain include:

- Avoidance of inappropriate care
  - Imaging for low-back pain: the percentage of individuals diagnosed with lower back pain who did not receive an imaging study within 28 days of the initial diagnosis
  - Antibiotics for acute bronchitis: the percentage of adults with a diagnosis of acute bronchitis who were not dispensed an antibiotic
  - Antibiotics for upper respiratory infection: the percentage of children with a diagnosis of upper respiratory infection who were not dispensed an antibiotic
- Ambulatory care utilization
  - Outpatient visits per 1,000 member months
  - Emergency department (ED) visits per 1,000 member months
- Inpatient utilization
  - Inpatient discharges per 1,000 member months

Measure Performance

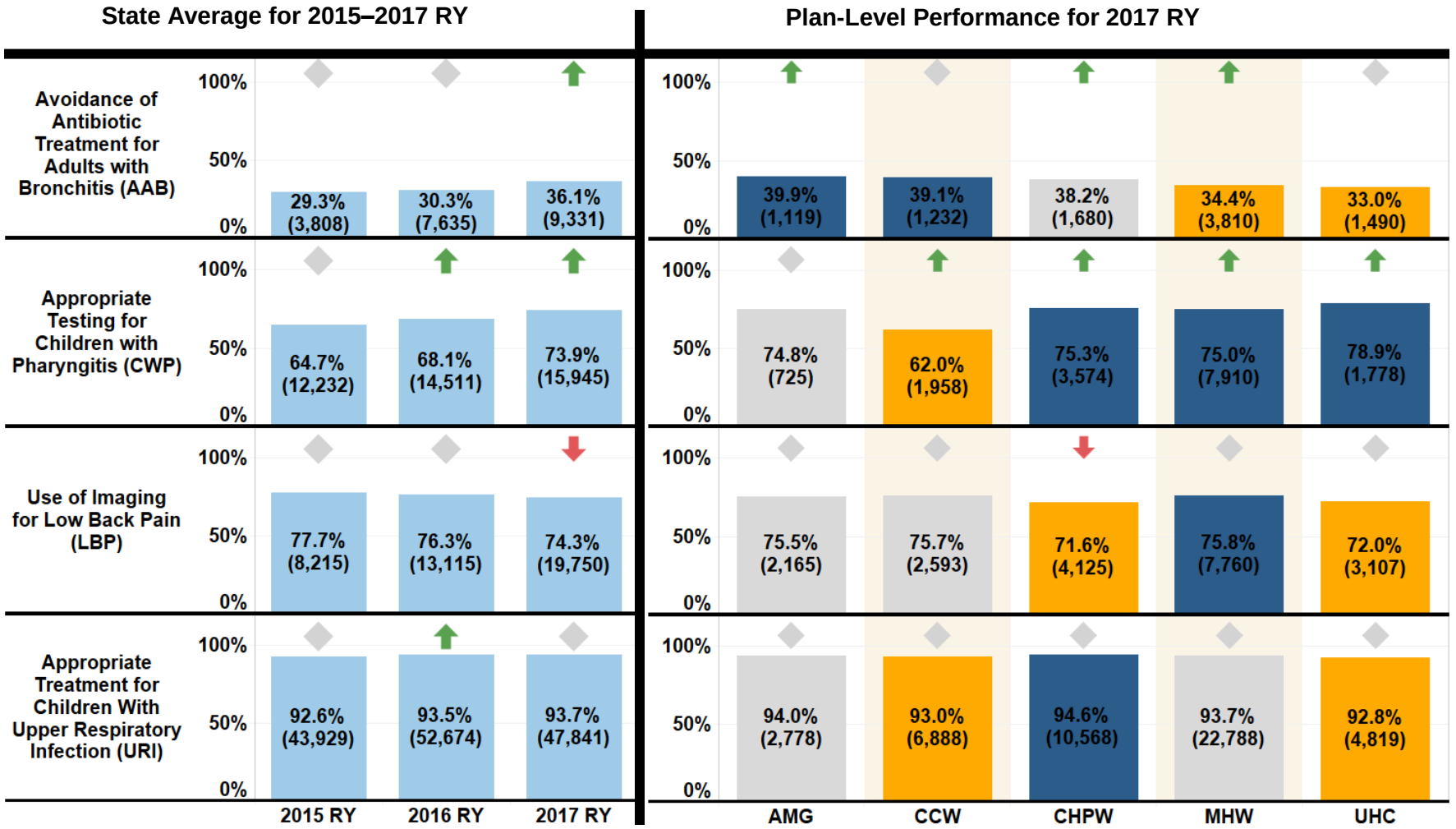
Avoidance of Inappropriate Care

Overall Apple Health rates were higher than national averages for all three measures of appropriate utilization (meaning MCOs did a *better* job of ensuring individuals did *not* receive inappropriate care). Avoidance of antibiotic use in adults with acute bronchitis, appropriate testing for children with pharyngitis, and use of imaging for low back pain are all included in the Washington State Common Measure Set on Health Care Quality and Cost—2017.

Key Points:

The overall state rate for avoidance of antibiotic use in adults with acute bronchitis trended up as a result of upward shifts for AMG, CHPW, and MHW. Appropriate testing for children with pharyngitis also trended up at a state level, as a result of upward shifts for all but one of the MCOs. Use of imaging for low back pain declined at the state level as a result of a downward shift for CHPW. Performance for appropriate treatment for children with upper respiratory infection was unchanged. Table 32, next page, shows the results for these measures.

Table 32: Avoidance of Inappropriate Care Measures, Statewide and by MCO*



Ambulatory Care and Inpatient Utilization

Ambulatory care measures are part of the Washington State Common Measure Set on Health Care Quality and Cost—2017.

Key Points:

At a state level, emergency room (ER) visits, outpatient visits, and total discharges all declined in 2017 RY; most other utilization metrics did not change.

Variation between MCOs may be due to differing demographics, network sizes, specialist referral policies, or care management services offered by MCOs.

Emergency room visit rates are difficult to interpret without additional analyses of enrollee demographics. It is possible that an MCO may have high ER visit rates because of significant enrollee acuity, but it is also possible that high ER rates can be attributed to lack of access to primary or specialty providers. Overall, Apple Health enrollees had significantly fewer ER visits per 1,000 member months than the national average, as shown in Table 33. (Per 1,000 member months is a method used routinely in hospital utilization measures; it is a simple way to equate the overall usage of hospital services while accounting for the overall number of members. If an enrollee is in a plan for one full year, they will account for 12 member months. Calculating the number of overall ED visits per 1,000 member months enables identification of any significant changes to hospital utilization by controlling for the overall number of members, which can shift and grow over time.)

Total inpatient utilization is significantly below the national average, reflecting good performance by Apple Health MCOs for reducing unnecessary hospitalization. Again, it is difficult to compare inpatient utilization rates between MCOs because each MCO serves a distinct enrollee population; enrollees in different MCOs do not necessarily have the same risk profiles.

Table 33, next page, displays the statewide results for these measures.

Table 33: Ambulatory Care and Utilization Measures, Statewide Performance, 2015–2017 RY

		2015 RY	2016 RY	2017 RY
Ambulatory Care (AMB)	Total ER Visits Per 1,000 MM	52.1	53.3	51.3
	Total OP Visits Per 1,000 MM	330.0	328.4	310.5
Inpatient Utilization—General Hospital/Acute Care (IPU)	Total ALOS	3.9	4.1	4.6
	Total Days Per 1,000 MM	21.3	21.2	21.2
	Total Discharges Per 1,000 MM	5.4	5.1	4.9
	Total Maternity ALOS	2.3	2.3	2.4
	Total Maternity Days Per 1,000 MM	7.0	5.8	5.6
	Total Maternity Discharges Per 1,000 MM	3.1	2.5	2.4
	Total Medicine ALOS	3.7	3.7	4.0
	Total Medicine Days Per 1,000 MM	7.3	7.5	7.7
	Total Medicine Discharges Per 1,000 MM	2.0	2.0	1.9
	Total Surgery ALOS	7.0	7.2	7.4
	Total Surgery Days Per 1,000 MM	9.2	9.6	9.6
	Total Surgery Discharges Per 1,000 MM	1.3	1.3	1.3

Appendix A: MCO Performance Summaries

Amerigroup Washington (AMG)

Access to Care

Primary care visits

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

Maternal health visits

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

Well-child visits

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

Preventive Care

Women's health screenings

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

Weight assessment and counseling

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

Children's immunizations

Combination 2	67.5%	
Combination 10	37.8%	

Adolescents' immunizations

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

Chronic Care Management

Diabetes care

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

Other chronic care management

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

Appropriateness of Care

Appropriateness of treatments

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

▼▲Plan score increased or decreased significantly from the prior year

* Lower rate is better performance

Coordinated Care of Washington (CCW)

Access to Care

Primary care visits

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

Maternal health visits

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

Well-child visits

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

Preventive Care

Women's health screenings

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

Weight assessment and counseling

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

Children's immunizations

Combo 2	75.5%	▲
Combo 10	47.1%	▲

Adolescents' immunizations

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

Chronic Care Management

Diabetes care

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

Other chronic care management

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

Appropriateness of Care

Appropriateness of treatments

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

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

* Lower rate is better performance

Community Health Plan of Washington (CHPW)

Access to Care

Primary care visits

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

Maternal health visits

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

Well-child visits

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

Preventive Care

Women's health screenings

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

Weight assessment and counseling

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

Children's immunizations

Combo 2	71.0%	
Combo 10	41.4%	

Adolescents' immunizations

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

Chronic Care Management

Diabetes care

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

Other chronic care management

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

Appropriateness of Care

Appropriateness of treatments

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

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

* Lower rate is better performance

Molina Healthcare of Washington (MHW)

Access to Care

Primary care visits

Adults' access (20-44 yrs)	79.4%	▲
Adults' access (45-64 yrs)	85.4%	
Adults' access (total)	81.3%	▲

Maternal health visits

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

Children's access (12-24 mths)	97.5%	
Children's access (25 mths-6 yrs)	88.8%	▲
Children's access (7-11 yrs)	92.8%	▲
Children's access (12-19 yrs)	92.6%	▲

Well-child visits

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

Preventive Care

Women's health screenings

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

Weight assessment and counseling

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

Children's immunizations

Combo 2	72.0%	
Combo 10	39.7%	

Adolescents' immunizations

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

Chronic Care Management

Diabetes care

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

Other chronic care management

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

Appropriateness of Care

Appropriateness of treatments

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

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

* Lower rate is better performance

United Healthcare Community Plan (UHC)

Access to Care

Primary care visits

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

Maternal health visits

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

Well-child visits

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

Preventive Care

Women's health screenings

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

Weight assessment and counseling

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

Children's immunizations

Combo 2	66.9%	
Combo 10	37.5%	

Adolescents' immunizations

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

Chronic Care Management

Diabetes care

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

Other chronic care management

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

Appropriateness of Care

Appropriateness of treatments

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

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

* Lower rate is better performance

Appendix B: HEDIS Performance Measure Tables

Please see separate attached document for Appendix B.

Appendix C: Apple Health MCO Performance on Selected Benchmarking Measures

Please see separate attached document for Appendix C.