Insights About King County's Medicaid Population: Focus On Children and Adults 18-64 Years Old

King County Accountable Community of Health
2017 Regional Health Needs Inventory

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EXECUTIVE SUMMARY

Exploring the characteristics and needs for health care and social services of King County's low-income population

Why a Regional Health Needs Inventory?

The Washington State Health Care Authority mandated that *"ACHs conduct an assessment to identify regional health needs, disparities in care, and significant gaps in care, health, and social outcomes."* This Regional Health Needs Inventory is the King County ACH's attempt to answer these basic questions. Before we can transform the Medicaid delivery system, we need to understand the system as it currently exists. To do so, we sought answers to the following questions:

Who are King County's Medicaid members?

Compared to King County residents without Medicaid coverage (excluding those with Medicare coverage), Medicaid members are disproportionately represented by children, women of reproductive age, adults with disabilities, and adults age 65 and older (dual eligibles). Medicaid members reside primarily in South Seattle, 8 South King County cities near the I-5 corridor, and part of Shoreline adjacent to State Route 99/Aurora.

- Compared to King County adults without Medicaid coverage (excluding those with Medicare coverage), adult Medicaid members are more likely to:
  - Live in a very low-income household, receive food assistance (SNAP), rent rather than own a home, and live in unaffordable housing.
  - Be female; live in a family household headed by a female; have given birth to a child in the past year and have a child in the household.
  - Be American Indian/Alaska Native, Black, or multiple race
  - Speak English less than very well; live in a household where no one older than 14 speaks English very well.
  - Be a naturalized citizen.
  - Be unemployed or not in the labor force.
  - Have low educational attainment.
  - Report a disability or difficulty with self-care, hearing, vision, independent living, ambulation, or cognitive functioning.
- Children on Medicaid, when compared to King County children without Medicaid coverage (excluding those with Medicare coverage), are more likely to:
  - Live in a very low- or moderately low-income household, receive food assistance (SNAP), and live in unaffordable housing.
  - Be Black or Latino; less likely to be Asian or white.
  - Live in a household where no one older than 14 speaks English very well; speak English less than very well
  - Be foreign born.
  - Live in a single-parent household.
  - Have moved in the past year.

What are the health and social services needs of King County Medicaid members?

- Within the Medicaid population, members most likely to be over-represented among those with negative health care and social outcomes …
  - … had mental health needs and/or needed treatment for substance use disorder.
  - … were American Indian/Alaska Native or Black.
- Place-based disparities were substantial, and in many cases exceeded differences by race, ethnicity, and language. For example, 15 King County ZIP codes accounted for half of all emergency department visits among Medicaid members.
- Adult Medicaid members, compared to commercially insured residents of King County, were more likely to report:
  - Chronic respiratory disease
  - Arthritis
  - Frequent mental distress and serious psychological distress
  - Obesity
  - Current use of cigarettes, electronic cigarettes, and marijuana
- For most of the top-10 causes of hospitalization, Medicaid-insured children were more likely than expected (by their percentage of the population) to end up in the hospital.
  - Although only 37% of King County children were covered by Medicaid in 2016, these same children accounted for 40% to 51% of hospitalizations in all but one of the overlapping top-10 causes.
  - The percentages of total hospitalizations and rank orders of causes of hospitalization were similar among Medicaid- and non-Medicaid-insured children, with mental illness topping both lists.
  - Hospitalizations related to pregnancy and childbirth accounted for 4% of total hospitalizations among Medicaid-insured children but were not among the top-10 for children not covered by Medicaid.
- Mental illness accounted for 16% of all hospitalizations among Medicaid adults, but only 5% among commercially-insured adults.
- Medicaid members, compared to the overall King County population, were …
  - More than 3 times as likely to die from unintentional injuries.
  - More than twice as likely to die from suicide.
  - More than 7 times as likely to die from homicide.
  - More than 4 times as likely to die from chronic liver disease.

Who are the primary providers of health care, mental health care, and social services for Medicaid members?

- Active providers physically located in King County and serving King County Medicaid members include:
  - 17 emergency departments
  - 19 hospitals
  - 83 outpatient facilities
  - 310 dental providers

    - 1,272 non-institutional providers (i.e. individual providers who bill for professional services)
- In 2016, almost 5 million claims were paid for professional and outpatient services delivered to King County Medicaid members. These included 233,880 visits to emergency departments. Looking at claims among Medicaid members in 2016,
    - 25 dental providers account for more than half of all dental claims (56%).
    - Harborview Medical Center accounts for 19% of all outpatient facility claims.
    - Three hospitals (Swedish Medical Center, Valley Medical Center, Harborview) account for 42% of all hospitalizations.
    - Four emergency departments (Valley Medical Center, Highline Medical Center, Harborview, Swedish Medical Center) account for 45% of all ED visits.
    - Six organizations (Sound Mental Health, Therapeutic Health Services Rainier, Evergreen Treatment Services, Navos, Community Psychiatric Clinic, and Valley Cities Counseling) account for 60% of the more than 2 million claims for outpatient and professional services primarily related to behavioral health.
- 41% of Medicaid claims paid for outpatient and professional services to King County residents in 2016 were for services primarily related to a behavioral health concern. The six behavioral health organizations listed above:
    - Provided services to more than 36,000 unique individuals.
    - Were paid for 1.2 million behavioral-health-related claims, for an average of 34 claims per person per year. This contrasts with an average of 5.9 claims per person per year for the provider with the highest volume of professional-claims billing in 2016 (UW Physicians); 91% of these claims were not related to behavioral health.
    - To better understand health care needs by provider type and service provided, the King County Accountable Community of Health (KCACH) Performance Measurement & Data Committee (PMD) has requested more detailed data from the state.

What are the gaps between Medicaid members' needs and the health care and social services provided?

- Health care service gaps
    - Compared to commercially-insured adult residents of King County, adult Mediciad members were:
        - Less likely to have had a dental visit in the past year.
        - Less likely to receive a flu shot in the past year.
        - Less likely to meet mammography recommendations.
        - More likely to have unmet medical needs due to cost in the past year.
    - Claims-based comparisons of Medicaid- and commercially-insured residents revealed, for Medicaid members:
        - Less screening for cancer (breast, cervical, colon).
        - Lower proportion of children age 3-6 getting well-child visits.
        - Less access to primary care across the life span.
        - Higher rate of potentially avoidable ED visits.
        - For those with an identified need, higher likelihood of receiving a mental health service in the past year.

- Disparities in access to care and use of preventive services: Results from a state-wide report on disparities in health care were confirmed by over-representation of people of color at the annual Seattle/King County Clinic. The top 3 reasons given for seeking this free medical care were:
    - Lack of health insurance
    - Having health insurance but being unable to afford medical procedures
    - Dissatisfaction with the timeliness of health care

- Lack of social services integration**:** Fragmentation of services and information pervades every level of our social service delivery systems.
    - To initiate and strengthen cross-sector relationships for sharing information, the Performance Measurement & Data Committee is developing a data sharing agreement with the **Crisis Clinic** (King County 2-1-1), which we hope will be used to assess sub-county availability of, use of, and gaps in social services for the Medicaid population.
    - A King County location filter reveals 6,207 services available to King County residents.

- Summary: We identified critical gaps between Medicaid members' needs and available health and social services in three key areas:
    - Access-to-care (barriers included finding providers, finding transportation, and paying for services)
    - Integration of physical, behavioral, and social services.
    - The quality of health care and social services (use of evidence-based practices, cultural relevance of services). A "performance gap analysis" comparing current performance in King County Medicaid- and commercially-insured populations with national benchmarks offers a local perspective on what may be achievable in our community.

INTRODUCTION

Why a Regional Health Needs Inventory?

Before we can transform the Medicaid delivery system, we need to understand the system as it currently exists. To do so, we sought answers to the following questions:

- Who are King County's Medicaid members?
- What are their health and social service needs?
- Who are the primary providers of health care, mental health care, and social services for Medicaid members?
- What are the gaps between Medicaid members' needs and the health care and social services currently provided?

The answers to these questions will lay the groundwork for transformation. The Washington State Health Care Authority mandated that "*ACHs conduct an assessment to identify regional health needs, disparities in care, and significant gaps in care, health, and social outcomes.*" This Regional Health Needs Inventory is the King County ACH's attempt to answer these basic questions. Eventually, demonstration projects intended to transform the Medicaid delivery system will rely on the information in this report as they "focus on health systems capacity building, care delivery redesign, prevention and health promotion, and increased use of value-based payment (VBP) models that reward providers for quality of care rather than the volume of services and procedures provided."

Who are we? King County Accountable Community of Health (KCACH) Performance Measurement & Data Committee (PMD)

The Performance Measurement & Data Committee (PMD, formerly the Performance Measurement Work Group), a committee of the King County Accountable Community of Health (KCACH), was created in 2015 to support the evolving data and information needs of the KCACH; and to advance data integration overall as part of health and social services transformation.

The PMD focused much of its early work on building a cross-sector and cross-disciplinary understanding of the mutual benefits of sharing and linking our data. We also clarified our understanding of common barriers to data sharing and linkage, and developed strong relationships across health and social service sectors. Specifically, we:

- Mapped our local and state data landscape
- Identified opportunities for cross-sector data sharing
- Identified opportunities for cross-sector relationships

When the Regional Health Needs Inventory (RHNI) became a required component of the Medicaid demonstration, the PMD was prepared to leverage its early work to more fully describe our local Medicaid members, their health care and social service needs, their providers, and existing gaps between needs and health care / social services provided under the Medicaid demonstration.

A data-driven approach to planning

The PMD has used three data-driven approaches to inform ACH planning:

1) We joined other ACHs (a) to identify cross-cutting data needs and (b) to communicate these data needs to the state. Our efforts yielded a wealth of data from our state partners at the Health Care Authority (HCA) and Department of Social and Health Services (DSHS).
2) The PMD developed an online, interactive, dynamically updated RHNI[1] that includes:
    - Health, social, and demographic information about the Medicaid and overall populations
    - Care/client volume data by service type, provider, and diagnostic categories
    - Information about *pay-for-performance* (P4P) measures to improve health care quality
    - An ACH performance gap analysis
3) To meet targeted data needs during the planning process, the PMD assigned data-support staff to project design teams.

In all three approaches, the PMD adopted a "reverse engineering" method, based on the assumption that the success of any project is influenced by at least three factors:

- The effectiveness of the transformation strategies
- The reach, both in terms of Medicaid members (particularly members with the greatest room for improvement) and providers
- Historical trends in the pay-for-performance measures

For instance, with project reach in mind, the PMD identified for each project and/or P4P measure:

- The subsets of the King County Medicaid population with the greatest room for improvement by demographic characteristics (e.g. age, sub-county location, etc.) and health characteristics (e.g. diabetes diagnosis).
- The health and human service providers that serve the largest number of these Medicaid members.

Analysts from the state's Department of Social and Health Services (DSHS) have observed differences between the new expansion and classic Medicaid adult populations in both health care needs and utilization. These population differences are important since 59% of adult King County Medicaid members are covered under Medicaid expansion (February 2017 enrollment counts, HCA correspondence).[2]

The King County Performance Gap Analysis has supported the planning process by visualizing the magnitude of improvement needed to hit initial improvement targets for specific projects and P4P measures. This tool has been used in project-design-team and Demonstration-Project-Committee meetings to compare the "number needed to treat" across projects and measures. The tool has also helped ACH stakeholders understand what is expected, what may be within reach, and how certain improvement targets will be shared across multiple project areas (e.g. Emergency Department utilization).

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[1] Online data will not always be consistent with data in this report. In an effort to promote alignment and cooperation among all ACHs in the state, the PMD also produced RHNI products for all ACH regions and counties where data were available.

[2] To better understand our past performance, as well as recent fluctuations in pay-for-performance measures, DSHS and AIM (Analytics, Interoperability, and Measurement) team partners are producing historical trends for select pay-for-performance measures by Medicaid coverage group.

Data sources

To guide initial thinking about planning, the PMD looked to a variety of federal, state, and local sources for administrative data (e.g. Medicaid claims), vital statistics, population-based surveys, and program data. Data sources include:

- Official population estimates (state Office of Financial Management)
- Demographic and social determinants of health data (US Bureau of Labor Statistics, American Community Survey, Office of Superintendent of Public Instruction, DSHS Community Risk Profiles),
- Behavioral Risk Factor Surveillance System (Washington State Department of Health)
- Birth and death records (vital statistics)
- Pregnancy Risk Assessment Monitoring System (Washington State Department of Health)
- Title X trends
- All-payer hospitalization data (CHARS)
- Medicaid eligibility and claims data
- First Steps Database
- Community Checkup
- Jail health data
- Emergency medical services data
- Dental service utilization data from the Arcora Foundation (formerly the Washington Dental Service Foundation)

These data sources have either been provided by the state (RHNI "Starter Kit", 1519/5372 measures from RDA, Healthier Washington Dashboard, ad hoc data products) or derived from locally available data.

Managed care organizations (MCOs) have participated in the PMD since its inception. Under the demonstration they have provided valuable input about data resources and project planning. For example, they showed us how their 1%-premium-withhold-value-based-payment (VBP) measures were aligned with the demonstration pay-for-performance (P4P) measures. MCOs collectively asked that requests for claims data be centralized at the Health Care Authority. In deference to this preference, we refrained from making specific data requests of MCOs under demonstration planning. Even without new data from MCOs, we were able to use data that had been shared previously as well as newly shared provider data. These include:

- Data from jail, jail health services, and Harborview ED for the Familiar Faces initiative (for high jail utilizers with behavioral health concerns)
- Data on health characteristics of inmates of South Correctional Entity (SCORE) in King County

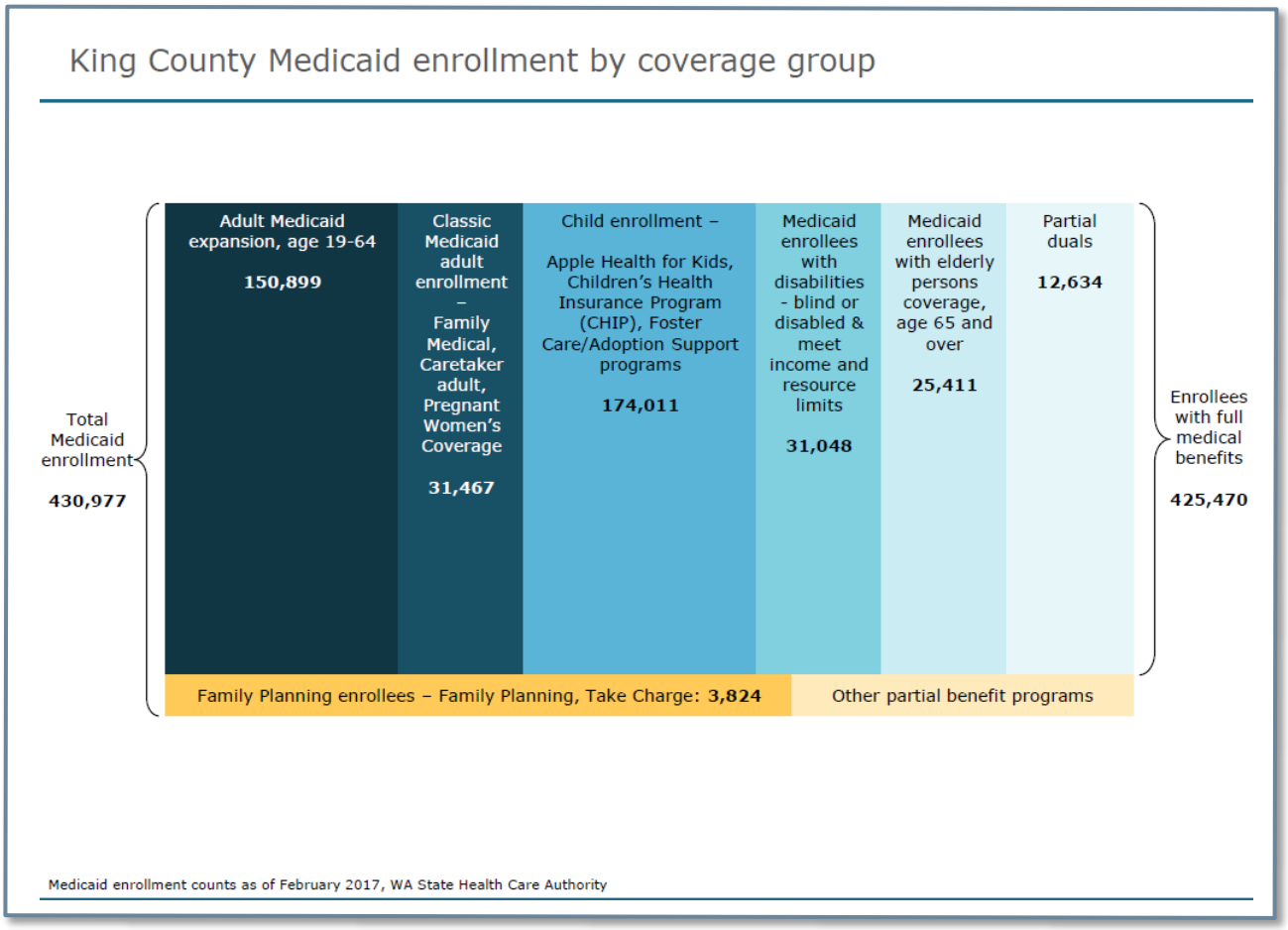
The PMD also reviewed recent trends in Uniform Data System (UDS) measures of clinical quality and health outcome that Federally Qualified Health Centers (FQHCs) submit to the federal government. With social services data in mind, the PMD is exploring a data-sharing agreement with the Crisis Clinic (i.e. King County 2-1-1). This agreement would allow us to access comprehensive data on social service providers and call-level data on social service referrals (including demographic characteristics such as Medicaid coverage and residence ZIP code), and might be used to assess sub-county availability of, utilization of, and gaps in social services for the Medicaid population.

As expected when consulting multiple data sources, we found some inconsistencies across sources. Some (for example, differences between survey self-reports and claims-based reports), may reflect sampling bias or other shortcomings of surveys. Having multiple data sources enabled us to validate our findings and flag data that seemed questionable.

WHO ARE KING COUNTY'S MEDICAID MEMBERS?

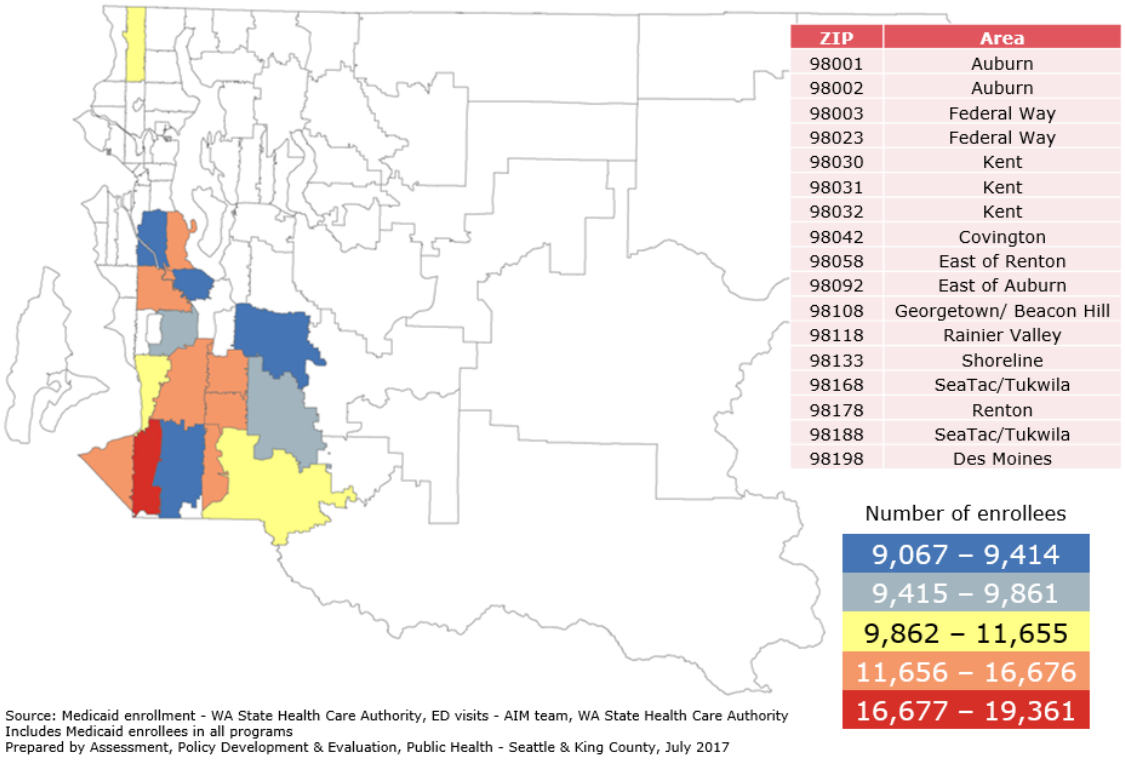
A Demographic And Socioeconomic Analysis Of Our Medicaid Population

As of February 2017, total Medicaid enrollment in King County was 430,977 (HCA enrollment totals, HCA correspondence). Of these, 425,470 (98.7%) had coverage offering full medical benefits. Excluding 12,634 "partial duals," (Medicare beneficiaries who qualify to have Medicaid pay some of the expenses they incur under Medicare), who will not be included in demonstration pay-for-performance measures, King County Medicaid enrollment for this analysis drops to 412,836 (95.8% of total enrollment).



Where do Medicaid members live?

To assess the geographic distribution of Medicaid enrollee residence, the PMD generated a series of ZIP code-level maps, including maps of Emergency Department (ED) visits (broad definition) and avoidable ED visits. *Half of the King County Medicaid population resides in 17 ZIP codes in South Seattle neighborhoods (Georgetown, Beacon Hill, Rainier Valley), South Region cities (Auburn, Covington, Des Moines, Federal Way, Kent, Renton, and SeaTac/Tukwila), and the North End (Shoreline and the Aurora Avenue/State Route 99 corridor).*



What are the demographic characteristics of Medicaid members?

Because Medicaid eligibility is linked to income and characteristics such as disability, pregnancy, and age, the demographic and socioeconomic characteristics of residents with and without Medicaid coverage differ substantially. Using American Community Survey data (2015 Public Use Microdata Sample), the PMD conducted a demographic and socioeconomic analysis of the Medicaid and non-Medicaid populations in King County. As described above, the total Medicaid population is disproportionately represented by children, women of reproductive age, adults with disabilities, and adults age 65 and older (dual eligibles) (age distribution shown in Table 1 below).

Table 1. Age distribution by Medicaid status, King County (2015)		
Age group	**Medicaid**	**Non-Medicaid**
Under 18*	40.0%	19.5%
18-34	21.3%	30.3%
35-49	14.8%	26.9%
50-64	13.5%	22.4%
65 and above*	10.4%	0.8%

Notes:

1. *Data source: US Census Bureau, American Community Survey, Public Use Microdata Sample, 2015*
2. *To make the comparison between Medicaid and non-Medicaid populations as similar as possible with respect to age, individuals with Medicare coverage not on Medicaid are excluded from the non-Medicaid group.*
3. **Characteristic statistically significantly over-represented among Medicaid members, compared to King County residents without Medicaid coverage (p-value < 0.05)*

Because 40% of Medicaid members are children, demographic comparisons are presented separately for children and adults in Table 2 below.

Table 2. Demographic and socioeconomic characteristics by Medicaid status of adults ages 18-64 and children, King County (2015)				
	Adults		**Children**	
	Medicaid	**Non-Medicaid**	**Medicaid**	**Non-Medicaid**
Age group				
18-34	43.0%*	38.1%		
35-49	29.8%	33.8%*		
50-64	27.3%	28.1%		
Sex				
Female	54.3%*	48.6%	51.0%	48.2%
Race/ethnicity				
American Indian/Alaska Native alone or in combination	4.8%*	1.5%	4.3%	1.7%
Asian	15.7%	17.9%	10.6%	16.0%*
Black	16.8%*	4.7%	18.5%*	3.3%
Latino	9.4%	8.9%	32.3%*	7.9%
Multiple race	7.6%*	3.9%	13.5%	13.7%
Native Hawaiian/Pacific Islander alone or in combination	0.3%	0.3%	0.3%	0.4%
White	52.3%	68.8%*	40.1%	63.5%*
Language				
Speaks English less than very well	16.5%*	10.5%	6.6%*	2.0%
Lives in a linguistically isolated household	7.2%	4.6%	17.2%*	2.6%
Citizenship status				
Born in US	70.9%	73.8%	89.8%	94.7%*
Naturalized	16.5%*	11.7%	2.3%`	1.0%
Non-citizen	12.6%	14.5%	7.9%	4.3%

Table 2. Demographic and socioeconomic characteristics by Medicaid status of adults ages 18-64 and children, King County (2015)				
	Adults		Children	
	Medicaid	Non-Medicaid	Medicaid	Non-Medicaid
Household income as a percent of federal poverty level				
< 138% of FPL	49.0%*	8.1%	42.5%*	3.8%
138 – 399% of FPL	38.1%*	28.5%	47.7%*	26.3%
400% of FPL and greater	12.9%	63.3%*	9.9%	69.9%*
Housing: owning vs. renting				
Owns home with mortgage	29.3%	50.2%*		
Owns home free and clear	9.8%	11.1%		
Rents home for cost	59.7%*	37.9%		
Rents home for no cost	1.2%	0.8%		
Housing costs and food assistance (household)				
Housing costs 30% or more of income	58.8%*	25.1%	60.4%*	21.0%
Housing costs 50% of more of income	33.8%*	8.2%	30.1%*	4.8%
Received food assistance (SNAP) in past year	50.0%*	6.3%	47.0%*	4.1%
Household type (4 levels)				
Married	42.5%	59.7%*		
Family, male head of household	6.1%	4.6%		
Family, female head of household	22.3%*	7.5%		
Nonfamily	29.1%	28.1%		
Employment status				
Employed	43.2%	82.5%*	9.8%	19.0%
Unemployed	10.5%*	2.8%	4.3%	3.1%
Not in labor force	46.3%*	14.7%	85.9%	80.0%
Children only --2 parents, both in labor force			23.2%	53.7%*
Children only --2 parents, 1 in labor force			29.7%	30.4%
Children only --single parent, in labor force			35.6%*	14.2%
Children only --2 parents, neither in labor force			1.3%	0.6%
Children only --single parent, not in labor force			10.2%*	1.1%
Educational attainment				
Less than high school	16.8%*	5.7%	99.8%	99.2%
High school diploma or equivalent	30.2%*	14.3%	0.2%	0.4%
Some college	33.9%*	28.0%	---	0.4%
Bachelor degree	14.4%	33.2%*	---	---
Graduate/professional degree	4.8%	18.8%*	---	---
Mobility, fertility, children in household				
Moved in past year	25.0%	21.6%	21.7%*	13.3%
Gave birth to a child in the past year	8.9%*	4.6%	2.5%	0.5%
Child present in household	66.6%*	50.0%		
Disability/difficulty				
Self-care difficulty*	4.9%*	0.3%		
Hearing difficulty *	3.1%*	1.0%		

Table 2. Demographic and socioeconomic characteristics by Medicaid status of adults ages 18-64 and children, King County (2015)				
	Adults		Children	
	Medicaid	Non-Medicaid	Medicaid	Non-Medicaid
Vision difficulty*	5.0%*	0.9%		
Independent living difficulty*	10.8%*	0.9%		
Ambulatory difficulty*	12.0%*	1.6%		
Cognitive difficulty*	16.9%*	1.5%		

Notes:

1. *Data source: US Census Bureau, American Community Survey, Public Use Microdata Sample, 2015*
2. *To make the comparison between Medicaid and non-Medicaid populations as similar as possible with respect to age, individuals with Medicare coverage not on Medicaid are excluded from the non-Medicaid group.*
3. ** = characteristic significantly over-represented among Medicaid members or King County residents without Medicaid coverage (p-value < 0.05)*

Compared to King County adults without Medicaid coverage (excluding those with Medicare coverage), adult Medicaid members are more likely to:

- Live in a very low-income household, receive food assistance (SNAP), rent rather than own a home, and live in unaffordable housing.
- Be female; live in a family household headed by a female; have given birth to a child in the past year and have a child in the household.
- Be American Indian/Alaska Native, Black, or multiple race
- Speak English less than very well; live in a household where no one older than 14 speaks English very well.
- Be a naturalized citizen.
- Be unemployed or not in the labor force.
- Have low educational attainment.
- Report a disability or difficulty with self-care, hearing, vision, independent living, ambulation, or cognitive functioning.

Children on Medicaid, when compared to King County children without Medicaid coverage (excluding those with Medicare coverage), are more likely to:

- Live in a very low- or moderately low-income household, receive food assistance (SNAP), and live in unaffordable housing.
- Be Black or Latino; less likely to be Asian or white.
- Live in a household where no one older than 14 speaks English very well; speak English less than very well
- Be foreign born.
- Live in a single-parent household.
- Have moved in the past year.

Just as it's important to highlight differences between the adult and child Medicaid populations, it's also important to acknowledge that broad demographic categories, such as the racial/ethnic groups shown in Table 2, can mask disparities within groups. For example, the distributions of Asians in the Medicaid and non-Medicaid populations shown in the tables above *do not accurately describe any sub-group of Asians*.

Table 3 compares the ethnic composition of King County Medicaid and non-Medicaid residents who identified as Asian on the American Community Survey. After Chinese ancestry (the most common ancestry for both Medicaid and non-Medicaid Asian residents), King County Asian residents with Medicaid coverage are most likely to identify as Vietnamese, while Asian residents with non-Medicaid coverage are most likely to identify as Asian Indian. It is important to keep these differences in mind when reporting on any diverse group.[3]

Table 3. Comparing reported ancestry between Asian Medicaid and Non-Medicaid King County residents (2015)

Ancestry, first reported	Medicaid	Non-Medicaid
Asian Indian	7%	18%
Cambodian	5%	1%
Chinese	19%	25%
Filipino	9%	12%
Japanese	4%	6%
Korean	6%	9%
Laotian	5%	1%
Taiwanese	1%	2%
Vietnamese	17%	9%

Notes:

1. *Data source: US Census Bureau, American Community Survey, Public Use Microdata Sample, 2015*
2. *To make the comparison between Medicaid and non-Medicaid populations as similar as possible with respect to age, individuals with Medicare coverage not on Medicaid are excluded from the non-Medicaid group.*

WHAT ARE THE HEALTH AND SOCIAL SERVICES NEEDS OF KING COUNTY MEDICAID MEMBERS?

A comparative analysis of health status, risk factors, and access to care

From its inception, the King County ACH has worked within a framework that:

- Emphasizes equity and social justice
- Recognizes that where we live, work, learn and play strongly shape our health and social well-being

Keeping these priorities in mind throughout the planning process, the PMD explored data on service utilization, health, and social well-being by race/ethnicity, language, place, and income.

In this section, we assess disparities in King County both (a) within the Medicaid population (e.g. by race/ethnicity, place) and (b) in comparisons of the Medicaid population with the overall[4] and commercially-insured populations.

[3] The pattern of above-average health outcomes often reported among Asian residents in the overall King County population is not seen in Medicaid members (not shown here).

[4] Because the "overall" King County population includes Medicaid members, the magnitudes of differences revealed by these comparisons are by definition conservative.

Disparities in negative outcomes

Although many disparities in King County are linked to differences in income, health disparities are also common within the county's low-income Medicaid population. The PMD used state agency-provided summary data on Medicaid adults to identify substantial disparities in outcomes by behavioral health needs; age, race/ethnicity, gender; and Medicaid coverage group. Disparities are highlighted here if a subgroup is over-represented by 1.5 or more times among those with negative outcomes on measures of (a) multiple ED visits or hospital admissions; (b) absence of appropriate health screenings or follow-up actions; and (c) homelessness, lack of employment, and arrests. For example, the "negative" outcome for the "percent arrested" pay-for-performance measure is being arrested. A summary of this analysis is presented in Table 4. Across the range of measures presented here, Medicaid members most likely to be over-represented among those with negative outcomes were American Indians/Alaska Natives, Blacks, and those who needed treatment for mental health and/or substance use disorder.

Table 4. Disparities analysis of pay-for-performance and related measures among Medicaid adults age 18-64, King County (2015)

This subgroup…	…is over-represented in the negative-outcome group by…	…for these "negative outcome" metrics
Co-occurring MI/SUD	5.6 times	3 or more ED visits per year
Serious Mental Illness	2.7 times	
Any mental health need	2.2 times	
SUD treatment need	4.5 times	
Co-occurring MI/SUD	1.5 times	Plan all-cause 30-day readmission
Co-occurring MI/SUD	1.8 times	Diabetes – no blood sugar testing
SUD treatment need	1.9 times	
Co-occurring MI/SUD	2.1 times	Percent unemployed
Serious Mental Illness	1.7 times	
Any mental health need	1.5 times	
SUD treatment need	1.8 times	
Co-occurring MI/SUD	4.2 times	Percent homeless
Serious Mental Illness	1.9 times	
Any mental health need	1.5 times	
SUD treatment need	4.3 times	
Co-occurring MI/SUD	4.9 times	Percent arrested
Serious Mental Illness	1.8 times	
SUD treatment need	5.4 times	
Age 18-24	1.9 times	No follow-up within 7 days after ED visit for alcohol or drug dependence
Age 18-24	1.8 times	No follow-up within 30 days after ED visit for alcohol or drug dependence
Age 18-24	1.9 times	Diabetes – no blood sugar testing
Age 25-34	2.0 times	
American Indian/Alaska Native	2.3 times	3 or more ED visits per year
Black	1.6 times	
American Indian/Alaska Native	1.6 times	No breast cancer screening
American Indian/Alaska Native	1.9 times	Diabetes – no blood sugar testing
Latino	1.5 times	No follow-up within 7 days after hospitalization for MI

Table 4. Disparities analysis of pay-for-performance and related measures among Medicaid adults age 18-64, King County (2015)		
This subgroup…	**…is over-represented in the negative-outcome group by…**	**…for these "negative outcome" metrics**
American Indian/Alaska Native	1.8 times	No follow-up within 7 days after ED visit for alcohol or drug dependence
Black	1.5 times	
American Indian/Alaska Native	1.8 times	No follow-up within 30 days after ED visit for alcohol or drug dependence
Black	1.5 times	
American Indian/Alaska Native	2.6 times	Percent homeless
Black	1.7 times	
American Indian/Alaska Native	2.6 times	Percent arrested
Black	1.6 times	
Male	1.5 times	Percent homeless
Male	1.5 times	Percent arrested
Disabled	2.1 times	3 or more ED visits per year
Disabled	5.8 times	Percent unemployed

Notes:

1. *Source: Measure Decomposition Data, Released July 7, 2017, WA State Department of Social & Health Services, Research & Data Analysis Division*
2. *Data represents adults (age 18-64, with exception of breast cancer screening – 50-64) with full-benefit Medicaid coverage, with exclusion of persons with third-party coverage from most metrics. Most metrics require 11 of 12 months with Medicaid coverage to qualify for measurement and 11 of 12 months with residence in the region to qualify for ACH attribution. Employment, arrest, and homelessness measures are less restrictive, requiring 7 of 12 months of Medicaid enrollment and residence in the region.*
3. *ED = emergency department; SUD= substance use disorder; MI = mental illness*

Patterns of over-representation among those with negative outcomes varied by subgroup. For example, young adults were over-represented among Medicaid members who didn't follow up after visiting the emergency department or didn't get regular blood tests if they had diabetes, but they were not over-represented among Medicaid members who visited the ED 3 or more times in a year. Adult Medicaid members who were homeless, visited the ED 3 or more times per year, or were unemployed/unable to work were over-represented in all four behavioral health need subgroups.

Place-based disparities among Medicaid members

The King County neighborhoods where Medicaid members live also strongly predict health care utilization and health outcomes. Using ZIP-code data extracted from the state's Healthier Washington Dashboard, the PMD ranked King County's ZIP codes by median performance among Medicaid-member residents on 18 measures of health care use and outcomes.

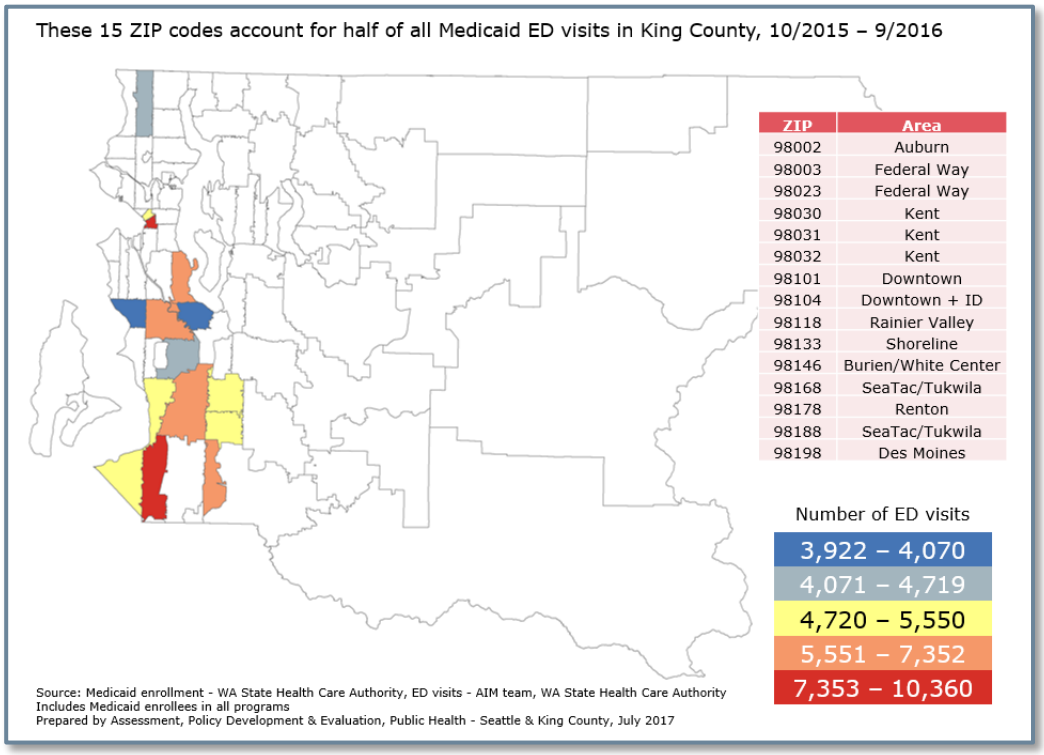
Place-based disparities among Medicaid members were substantial, and in many cases they exceeded differences by race, ethnicity, and language. For example, appropriate medication management for asthma ranged from 19% in the lowest-performing ZIP code to 46% in the highest-performing ZIP code (Table 5).

Table 5. Median performance levels among Medicaid members living in ZIP codes with highest and lowest median performances, King County (2015-2016)		
Measure	**Lowest-performing ZIP code**	**Highest-performing ZIP code**
Child PCP access	75%	100%
Adult PCP access (20+)	63%	84%
Adult PCP access (20-44)	61%	83%
Adult PCP access (45-64)	67%	90%
Adult PCP access (65+)	76%	100%
Well-child visits (3-6)	44%	74%
Asthma med management	19%	46%
Diabetes eye exam	17%	49%
Diabetes HbA1c test	63%	100%
Diabetes kidney test	71%	100%
ED broad (0-17)	52 per 1000 mm	10 per 1000 mm
ED broad (18+)	194 per 1000 mm	21 per 1000 mm
Avoidable ED (1-17)	29%	10%
Avoidable ED (18+)	17%	8%
Plan all cause readmission	41%	10%
Asthma diagnosis	6%	1%
Diabetes diagnosis	7%	2%
Depression diagnosis	24%	6%

Notes:

1. *Data source: HW Dashboard, Medicaid claims data 10/2015 – 9/2016*
2. *PCP=primary care provider; mm=member months; ED=emergency department*

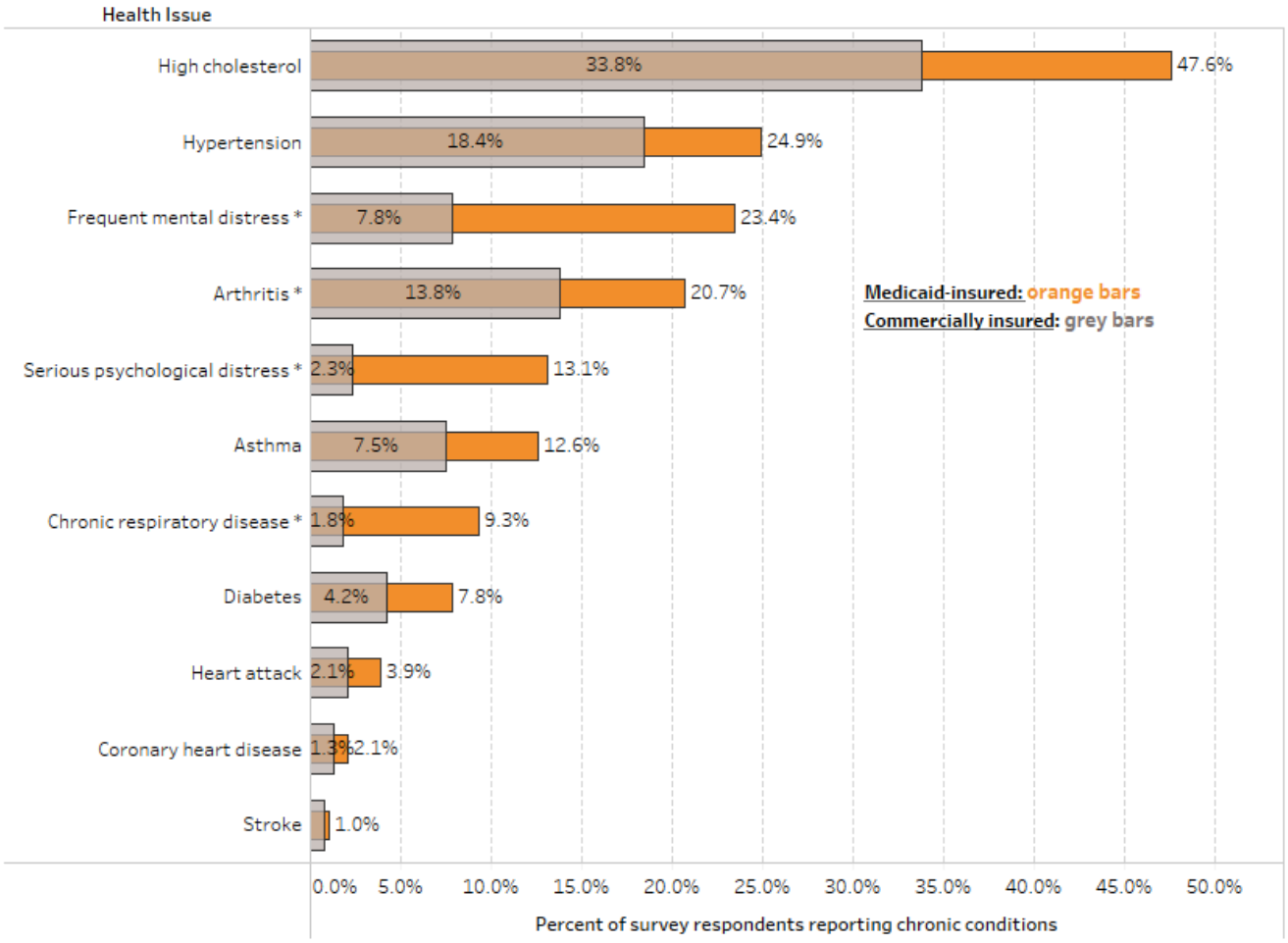
Given these large place-based disparities and the clustering of the Medicaid member population noted in the section above ("Where do Medicaid members live?"), we can identify locations where customized efforts to improve Medicaid demonstration's pay-for-performance metrics may have the greatest impact on our ACH region's overall performance. For example, the PMD found that 15 King County ZIP codes accounted for half of all ED visits among Medicaid members (see map on right); 14 of these 15 ZIP codes (all except 98101, Downtown Seattle) accounted for half of all *avoidable ED visits* among Medicaid members (map not shown).



Health differences between Medicaid and commercially-insured adults

The PMD has also assessed health disparities by comparing Medicaid members to the overall King County or commercially-insured population. Using locally available data from the Behavioral Risk Factor Surveillance System,[5] Charts 1 and 2 (and Table 6 in Appendix) show selected differences in health status comparing the Medicaid and commercially-insured adult populations in King County.

Chart 1. Chronic disease prevalence among Medicaid-insured and commercially insured adults ages 18-64, King County (2014-2015)



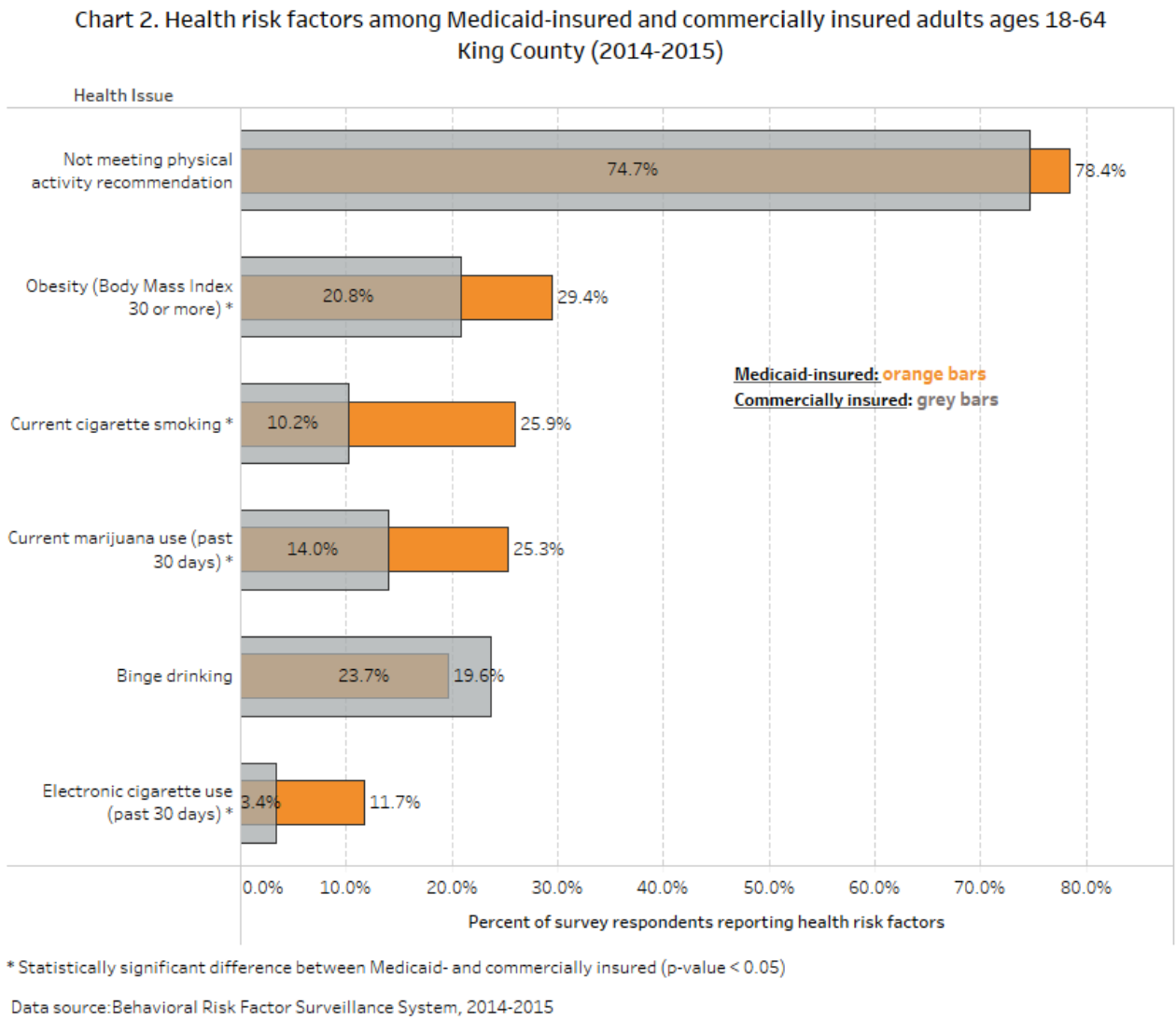
* Statistically significant difference between Medicaid- and commercially insured (p-value < 0.05)

Data source: Behavioral Risk Factor Surveillance System, 2014-2015

[5] A question about type of health insurance coverage was asked on the Behavioral Risk Factor Surveillance System survey beginning in 2014.

Dual eligibles, Medicare members, and uninsured individuals were excluded from this analysis. The median age of Medicaid and commercially-insured individuals was 44 and 48 years, respectively. Compared to commercially-insured residents of King County, Medicaid members were more likely to report:

- Chronic respiratory disease
- Arthritis
- Frequent mental distress (≥14 poor mental health days in past 30 days)
- Serious psychological distress (determined by responses to questions about the frequency, over the past 30 days, of feeling nervous, hopeless, restless, worthless, that everything was an effort, and so depressed that nothing could cheer them up)
- Obesity
- Current use of cigarettes, electronic cigarettes, and marijuana



Leading causes of hospitalization and death

In addition to chronic disease prevalence and risk factors, the PMD conducted a comparative analysis of leading causes of hospitalization and death.

Table 7, compares the top 10 causes of hospitalization for Medicaid vs. Non-Medicaid children in King County in 2016. Although only 37% (153,907) of King County children age 1-17 were covered by Medicaid in 2016, these same children accounted for 40% to 51% of hospitalizations in all but one (epilepsy/convulsions) of the overlapping top-10 causes.

Two of the top-10 causes of hospitalization for Medicaid children (#7, pregnancy/childbirth-related and #10, urinary system disease) were not among the top-10 for children not covered by Medicaid. Similarly, skin infections and respiratory failure (#9 and #10, respectively) did not show up among the top-10 causes for children covered by Medicaid. Nevertheless, the *percentages of total hospitalizations* of the leading causes of hospitalization were similar among Medicaid- and non-Medicaid-insured children. Mental illness topped both lists.

Table 7. Top 10 causes of hospitalization among Medicaid and Non-Medicaid children, ages 1-17, King County (2016)

Rank	Medicaid (% of total hospitalizations; count of hospitalizations)	Non-Medicaid (% of total hospitalizations; count of hospitalizations)
1	Mental Illness (17%; 509)	Mental illness (20%; 679)
2	Respiratory Infection (9%; 259)	Respiratory infection (8%; 269)
3	Asthma (7%; 194)	Cancer & benign tumors (6%; 217)
4	Cancer & benign tumors (6%; 185)	Lower GI disorders (6%; 210)
5	Unintentional Injuries (5%; 159)	Asthma (6%; 196)
6	Lower GI Disorders (5%; 140)	Epilepsy; convulsions (5%; 174)
7	Pregnancy/childbirth-related (4%; 107)	Unintentional injuries (5%; 166)
8	Epilepsy; convulsions (3%; 93)	Diabetes with complications (3%; 86)
9	Diabetes with complications (3%; 89)	Skin infections (2%; 69)
10	Urinary System Disease (3%; 84)	Respiratory failure (2%; 67)

Notes:

1) *Data sources: Comprehensive Hospital Abstract Reporting System (Hospital discharge data), 2016; 2016 population estimates from Washington State Office of Financial Management.*
2) *Insurance coverage type drawn from all 3 "payer" fields in CHARS data set; "non-Medicaid" group includes children covered by HMOs, commercial insurance, and health care service contractors; this payer information may differ from information on health insurance claims.*
3) *Provisional count of unintentional injuries based on proposed ICD-10-CM External Cause Matrix for Reporting Injury Morbidity, available at http://c.ymcdn.com/sites/www.safestates.org/resource/resmgr/isw9/ISW9_FINAL_Report.pdf*

Leading causes of hospitalization among adults show a different picture (Table 8), with mental illness accounting for 16% of all hospitalizations among Medicaid adults, but only 5% among commercially-insured adults. This finding supports the greater burden of self-reported mental illness among Medicaid adults from the Behavioral Risk Factor Surveillance System.

Table 8. Top 10 causes of hospitalization among King County Medicaid and Non-Medicaid adults, age 18 and older (2016)		
Rank	**Medicaid** (% of total hospitalizations; count of hospitalizations)	**Non-Medicaid** (% of total hospitalizations; count of hospitalizations)
1	Pregnancy/childbirth-related (20%; 7,889)	Pregnancy/childbirth-related (24%; 19,027)
2	Mental illness (16%; 6,150)	Heart disease (9%; 7,081)
3	Septicemia (9%; 3,548)	Osteoarthritis (6%; 5,078)
4	Heart disease (7%; 2,642)	Cancer & benign tumors (6%; 4,798)
5	Unintentional injuries (4%; 1,567)	Septicemia (6%; 4,764)
6	Cancer & benign tumors (3%; 1,206)	Mental illness (5%; 4,055)
7	Urinary system disease (3%; 1,078)	Unintentional injuries (4%; 3,368)
8	Stroke (2%, 963)	Lower GI disorders (4%; 2,864)
9	Skin infections (2%, 919)	Stroke (3%; 2,811)
10	Lower GI disorders (2%; 745)	Urinary system disease (3%; 2,456)

Notes:

1) *Data source: Comprehensive Hospital Abstract Reporting System (Hospital discharge data), 2016*
2) *Insurance coverage type drawn from all 3 "payer" fields in CHARS data set; "non-Medicaid" group includes adults covered by HMOs, commercial insurance, and health care service contractors; this payer information may differ from information on health insurance claims.*
3) *Provisional count of unintentional injuries based on proposed ICD-10-CM External Cause Matrix for Reporting Injury Morbidity, available at http://c.ymcdn.com/sites/www.safestates.org/resource/resmgr/isw9/ISW9_FINAL_Report.pdf*

Table 9 (on the next page) compares the top 10 causes of death among Medicaid members to leading causes of death in the overall King County population. This comparison reveals striking differences in both the ranks (shown in Table 9) and percentages of total deaths attributed to each leading cause (not shown in table). Among the leading causes of death,

- Unintentional injuries accounted for 18.6% of total deaths among Medicaid members versus 5.3% in the overall population – more than a 3-fold difference.
- Suicide and homicide accounted for 5.6% and 2.9% of total deaths among Medicaid members, respectively, versus only 2.1% and 0.4% of total deaths in the overall population – more than 2-fold and 7-fold differences, respectively.
- Chronic liver disease accounted for 7.6% of deaths among Medicaid members and only 1.7% of deaths in the overall population – more than a 4-fold difference.
- Medicaid members were *less likely* than members of the overall population to die of Alzheimer's disease, stroke, and influenza or pneumonia – all causes of death associated with old age.

Table 9. Leading causes of death among King County Medicaid members versus the overall population		
Rank	**Medicaid, 2015** (Count of deaths)	**Overall population, 2011-2015 average** (Average count of deaths per year)
1	Cancer (255)	Cancer (2,941)
2	Unintentional injury (208)	Heart disease (2,534)
3	Heart disease (169)	Alzheimer's (832)
4	Chronic liver disease & cirrhosis (85)	Unintentional injury (654)
5	Suicide (62)	Stroke (605)
6	Homicide (32)	Chronic lower respiratory disease (571)
7	Chronic lower respiratory disease (29)	Diabetes (370)
8	Diabetes (28)	Suicide (255)
9	Viral hepatitis (15)	Chronic liver disease & cirrhosis (210)
10	Septicemia (13)	Influenza & pneumonia (183)

Data sources: RHNI "Starter Kit" (Medicaid), Death certificate data, WA State Department of Health (Overall)

Although children make up 40% of King County's Medicaid population (see Table 1) we do not have the kinds of data on children that we have on adults. Thanks to the Behavioral Risk Factor Surveillance System, this RHNI includes comparative data on health and social risk factors by Medicaid enrollment status for adults. Because a similar, locally available data source does not exist for children, it is important that we leverage cross-sector partnerships to use claims, electronic health records, and social service data resources to better understand the needs and opportunities for the 37% of King County children who are enrolled in Medicaid.

WHO ARE THE PRIMARY PROVIDERS OF HEALTH CARE, MENTAL HEALTH CARE, AND SOCIAL SERVICES FOR MEDICAID MEMBERS?

To assess how the current health care delivery system is meeting the needs of the King County Medicaid population, the PMD has looked at both availability (supply of providers and services) and gaps (i.e. unmet need for services). To understand availability of health care providers and services and to identify high-volume providers by service type (e.g. inpatient vs. outpatient), the PMD assessed:

- The number of health care delivery providers, by type, serving the King County Medicaid population.
- The volumes of claims paid and unique clients served.

Active health care providers

Using information provided by the Washington State Health Care Authority on *active* providers serving Medicaid members (drawn from provider registry information in the Health Care Authority's ProviderOne resource) and physically located within King County, the PMD identified:[6]

- 17 emergency departments
- 19 hospitals
- 83 outpatient facilities
- 310 dental providers
- 1,272 non-institutional providers (i.e. individual providers who bill for professional services)

Claims by service type and providers

In 2016, almost 5 million claims were paid for professional and outpatient services delivered to King County Medicaid members.[7] King County Medicaid members visited an emergency department 233,880 times (enough to fill Safeco field almost 5 times). To explore Medicaid-paid claims in depth, the PMD developed an interactive website to display the volume of health care service utilization (claims and unique members), by:

- ACH region
- Service type
- Primary diagnosis

This database includes fee-for-service claims and managed-care encounters for both physical and behavioral health services, and has been used primarily to identify the highest-volume providers for given service types. This resource allows us to easily identify the organizations and providers that deliver the most services to the Medicaid population.[8] For example, looking at claims among King County Medicaid members in 2016,

- 25 dental providers account for more than half of all dental claims (56%).
- Harborview Medical Center accounts for 19% of all outpatient facility claims.
- Three hospitals (Swedish Medical Center, Valley Medical Center, Harborview) account for 42% of all hospitalizations.

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[6] Although the PMD de-duplicated provider counts by National Provider Identifier (NPI) and provider/organization name, the outpatient, dental, and non-institutional provider counts may be slightly inflated due to multiple NPIs used within organizations and different spellings/typographical errors for provider/organization names.

[7] Not surprisingly, some services were delivered by providers outside Medicaid members' ACH.

[8] The ACH has also used information about highest volume providers for provider engagement, such as efforts to assess Health Information Technology (HIT) capacity of providers through the ACH's recent provider engagement survey.

- Four emergency departments (Valley Medical Center, Highline Medical Center, Harborview, Swedish Medical Center) account for 45% of all ED visits.
- Six organizations (Sound Mental Health, Therapeutic Health Services Rainier, Evergreen Treatment Services, Navos, Community Psychiatric Clinic, and Valley Cities Counseling) account for 60% of the more than 2 million claims for outpatient and professional services primarily related to behavioral health.

The last of these, behavioral health, merits additional scrutiny because 41% of total claims paid for outpatient and professional services on behalf of King County Medicaid members in 2016 were for services primarily related to a behavioral health concern (Medicaid Provider Report Volume 2, HCA). In just one year, the six organizations listed above provided services to more than 36,000 unique individuals and were paid for 1.2 million behavioral-health-related claims, for an average of 34 claims per person per year. In contrast, for the provider with the highest volume of professional-claims billing in 2016 (UW Physicians), 91% of claims were *not* related to behavioral health concerns, and their clients averaged 5.9 claims per person per year.

To better understand underlying health care needs by provider type and service provided, the PMD has asked the state for more detailed data on care volume. Starting in March, these data are being generated by Clinical Classification Software (CCS), which uses more precise diagnostic categories developed by the Healthcare Cost & Utilization Project.

WHAT ARE THE GAPS BETWEEN MEDICAID MEMBERS' NEEDS AND THE HEALTH CARE AND SOCIAL SERVICES PROVIDED?

Health care service gaps

To understand service gaps, the PMD reviewed both self-reported and claims-based measures of access to care and use of preventive care (Table 10). Compared to commercially-insured adult residents of King County, Medicaid adults responding to surveys were:

- Less likely to report a dental visit in the past year
- Less likely to report receiving a flu shot in the past year
- Less likely to meet mammography recommendations
- More likely to have medical needs that were unmet due to cost in the past year

Claims-based measures of use of preventive services align well with these self-reported barriers, including:

- Lower levels of screening for cancer (breast, cervical, colon)
- Lower proportion of children age 3-6 getting well-child visits
- Higher rate of potentially avoidable ED visits

Although survey responses to "has a usual primary care provider" did not reveal a significant difference between Medicaid- and commercially insured adults, claims-based data showed a lower proportion of

claims on behalf of Medicaid members – especially for well-child visits for 3- to 6-year olds and visits for adults of all ages.

In contrast, compared to commercially-insured individuals, Medicaid members were more likely to have received a mental health service in the past year if they had an identified need, though it was not possible to compare whether the acuity of mental health needs or the efficacy of treatments differed across the two populations (see Table 6 in Appendix for self-reported mental health measures).

Table 10. Access to care and use of preventive care: Medicaid and commercially-insured individuals (2014-2015 and 2015)

	Medicaid	Commercial
Self-reported measures, adults (2014-2015)[1]		
Access to care		
Dental visit in past year*	46.1%	78.2%
Has a usual primary care provider	73.3%	76.7%
Unmet medical need due to cost in past year*	17.0%	8.0%
Prevention and screening		
Meets cervical cancer screening recommendations (Pap)	77.1%	85.2%
Meets mammography recommendations*	59.8%	80.4%
Received flu shot in past year*	34.4%	44.3%
Claims-based measures (2015)[2]		
Access to primary care		
Age 12-24 months	94%	98%
Age 2-6 years	86%	89%
Age 7-11 years	91%	90%
Age 12-19 years	90%	90%
Age 20-44 years	71%	92%
Age 45-64 years	75%	96%
Age 65 and above	84%	98%
Prevention		
Well-child visits (age 3-6 years)	65%	73%
Adolescent well-care visits	41%	44%
Potentially avoidable emergency department visits	19%	10%
Mental health: Among those with identified mental health service need, % who received ≥1 services in a given year		
Adults age 18-64	51%	30%
Children age 6-17	65%	33%
Disease screening		
Breast cancer	27%	75%
Cervical cancer	55%	75%
Chlamydia	55%	39%
Colon cancer	43%	63%

Notes:

1) *Data sources: [1]Behavioral Risk Factor Surveillance System (BRFSS), 2014-2015, [2]WA Health Alliance Community Checkup, 2016*
2) ** Statistically significant difference (p-value < 0.05); differences were only tested for BRFSS data*

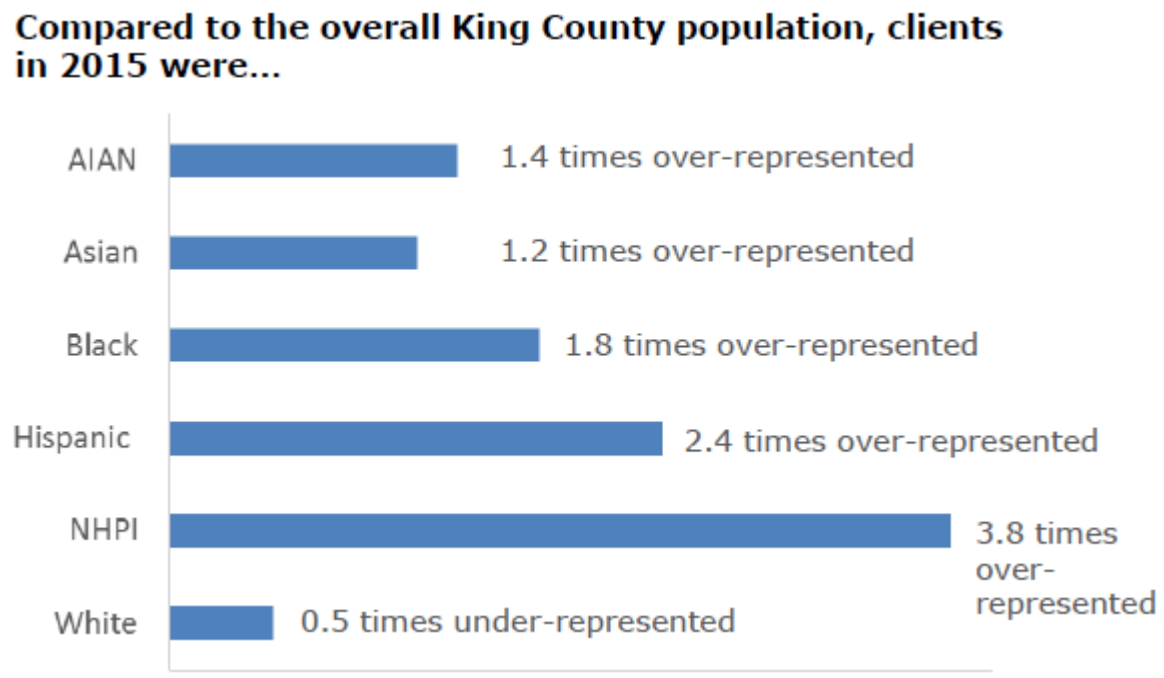
Disparities in access to care and use of preventive services

The PMD also reviewed disparities in access to care and use of preventive services by race/ethnicity and language, as presented in the WA Health Alliance's 2016 Disparities in Care report (hereafter referred to as "Alliance report"). Although this report presents only statewide data, it provides a valuable context for understanding disparities consistently found across multiple domains of access to care and preventive services in our state's Medicaid population. Specifically, the report notes:

- Lower rates of primary care visits across the lifespan among Asian, Black, and Native Hawaiian/Pacific Islander members (Alliance report, Figure 2),
- Lower rates of adherence to antidepressant medication among Black and Latino members (Alliance report, Figure 8)
- Higher rates of potentially avoidable ER visits among Black, Latino, and Native Hawaiian/Pacific Islander members (Alliance report, Figure 16)
- Lower rates of primary care visits across most of the lifespan among Medicaid members who speak a language other than English or Spanish (Alliance report, Figure 18).

The Seattle/King County Clinic, a "giant free health clinic" held annually at Seattle Center since 2014, offers another window into access-to-care barriers. Data from these annual events reveal health care access disparities similar to those identified in the *Disparities in Care* report. For example, compared to the overall King County population, clients of the Seattle/King County Clinic in 2015 were almost 4 times as likely to be Native Hawaiian/Pacific Islander, almost 2 and a half times more likely to be Hispanic, and about half as likely to be white (see Chart 3 below).

Chart 3. Skewed representation of race/ethnicity groups among attendees at Seattle/King County Clinic (2015)



These clinics have also offered insights into the reasons why individuals seek this free medical care despite living in a region that has implemented Medicaid expansion and a state health insurance marketplace. The top three reasons reported by clients were:

- Lack of health insurance
- Having health insurance but being unable to afford medical procedures
- Dissatisfaction with the timeliness of health care

For more context, patient stories from the 2017 clinic were depicted in comic-book form by volunteer artists.

Lack of social services integration

The theme of integration surfaces frequently, both in the Medicaid demonstration and in discussions of health and human services transformation overall. Why? Because fragmentation of services and information pervades every level of our health care and social service delivery systems. While a great deal of information is available on use of health care services (see above), the same has not historically been true for information about social or community-based services.

In many instances, the solution is not to collect more data, but to initiate and strengthen cross-sector relationships for sharing information. With this in mind, the PMD is developing a data sharing agreement with the Crisis Clinic (i.e. King County 2-1-1) that will cover comprehensive data on social service providers as well as call-level data on social service referrals (by demographic characteristics including insurance coverage, ethnicity, and ZIP code of residence). These data assets can be used to assess sub-county availability of, utilization of, and gaps in social services for the Medicaid population.

The types of social services available to the Medicaid population are described in detail on the Washington Information Network 211's website. A King County location filter reveals 6,207 services available to King County residents, including services for:

- Basic needs (e.g. food, housing, transportation)
- Consumer services (e.g. tax services)
- Criminal justice and legal services (e.g. ex-offender re-entry programs)
- Education (e.g. educational support programs)
- Health care (e.g. medical expense assistance)
- Income (e.g. temporary financial assistance)
- Individual and family life (e.g. spiritual enrichment)
- Mental health and substance use disorder services (e.g. transitional mental health services)
- Target population services (e.g. immigration services)

The database also includes health care services already described above (e.g. hospitals).

SUMMARY: CRITICAL GAPS BETWEEN MEDICAID MEMBER NEEDS AND AVAILABLE HEALTH AND SOCIAL SERVICES

When considering unmet health and social needs of the King County Medicaid population, we identified critical gaps in three key areas:

- Access-to-care (barriers include finding providers, finding transportation, and paying for services)
- Integration of physical, behavioral, and social services
- The quality of health care and social services (e.g. use of evidence-based practices, cultural relevance of services).

Access-to-care barriers

For individual Medicaid members, access-to-care barriers include difficulties in finding a provider, getting to a provider, and paying for services:

- Finding a provider – often linked to workforce capacity and/or reimbursement rates.
  - Federally Qualified Health Centers engaged in planning Medicaid demonstration projects report long-standing challenges in finding specialty providers who will accept referrals of their primary-care Medicaid patients.
  - The percentage of dentists accepting Medicaid members is also low, so low dental service utilization rates among Medicaid members is not surprising. A 10-year study of the gap between Medicaid and commercial dental insurance reimbursement rates found that in 2013-2014, pediatric and adult Medicaid reimbursement rates in Washington State were just 41% and 29% of commercial dental insurance charges, respectively -- gaps that have widened over the past decade.[9]
  - Shortages of behavioral health providers impede access to care in King County. This challenge is being addressed in part through the implementation plan of King County's Mental Illness & Drug Dependency (MIDD) sales tax, which includes a goal to "increase culturally appropriate, trauma-informed behavioral health services." A local workforce survey of 29 behavioral health agencies funded by the MIDD sales tax found that most agencies report difficulty hiring and retaining the staff they need to meet demand for services.
    - 79% of agencies reported having at least one open job (total of 168 open positions).
    - More than 80% of agencies reported that they had lost employees due to high caseloads or insufficient pay or benefits.
    - These workforce recruitment and retention challenges were even more severe for bi-lingual and bi-cultural staff.

[9] A 10-year, state-by-state, analysis of Medicaid fee-for-service reimbursement rates for dental care services, Health Policy Institute, October 2014

- Getting to a provider: More than 1 in 4 King County Medicaid adults (26%) who delayed getting medical care in 2014-15 did so because they did not have transportation, compared to 1 in 12 (8%) commercially-insured adults (Behavioral Risk Factor Surveillance System, 2014-15).
- Paying for services: Lower-income individuals and families often find it challenging to pay for basic needs such as food and housing, so costs associated with health care services can be burdensome even with Medicaid coverage. In 2014, about 1 in 5 King County Medicaid adults (19%) reported having health care bills that they were paying off over time (BRFSS, 2014). And 17% of Medicaid adults reporting not seeking care in the past year because of cost, compared to 8% of commercially-insured adults (BRFSS, 2014-15). Improved access to social services could help Medicaid members deal with these competing demands.

Fragmentation of health and social services

Given the high percentage of members with needs that span the physical health care, behavioral health care, and social service systems, fragmentation of health and social services is particularly challenging for the Medicaid population. Compared to commercially-insured individuals, Medicaid members have:

- Higher rates of chronic disease, behavioral health concerns, and risk factors (Table 6 in Appendix).
- Lower use of clinical preventive services (Table 10).

The Medicaid population's need for behavioral health care and support services is intense.

- Mental illness is the #1 cause of hospitalization among Medicaid children (Table 7) and #2 (after pregnancy/childbirth) among adults (Table 8).
- Individuals with behavioral health needs – especially those needing treatment for co-occurring mental health and substance use disorder – are over-represented in subsets of the Medicaid population struggling to meet clinical quality metrics (e.g. chronic disease screening, chronic disease management) and avoid social crises (unemployment, arrest, homelessness) (Table 4).
- Among the 92,463 King County Medicaid members with a mental health diagnosis or a need for treatment of substance use disorder, 2 out of 3 (67%) have 1 or more chronic physical diseases (Behavioral Health and Chronic Conditions data product, HCA AIM team, September 2017).

All of these findings point to the critical need for integration of physical, behavioral, and social services to support Medicaid members (and all individuals) to receive the right service at the right time regardless of which door they walk through.

Quality of health care and social services

One approach for considering gaps in the quality of health care and social services provided to Medicaid members is to compare local performance to national standards. While such an analysis of "gap-to-goal" pay-for-performance measures for the Medicaid demonstration helps us understand the greatest opportunities for improvement for health care metrics, it offers little for social service utilization/quality measures.

As shown in Table 11, the King County Performance Gap Analysis enables us to compare current performance in King County Medicaid- and commercially-insured populations with national 90th percentile benchmarks for managed Medicaid plans. For those "gap-to-goal" measures where the King County Medicaid rate is far below the national benchmark (well-child visits, diabetes eye exams, and medication management for asthma and depression) the performance for King County commercially-insured individuals is typically much closer to or even surpasses the national Medicaid plan benchmark, providing a local perspective on what may be achievable in our community.

Table 11. King County ACH gap analysis of Medicaid demonstration pay-for-performance "gap-to-goal" measures

Measure	King County Medicaid rate	90th percentile national benchmark for Medicaid plans	King County commercially-insured rate
Adolescent access to PCP, 12-19 years	90%	94.9%	90%
Antidepressant med management, acute	51%	62.6%	72%
Antidepressant med management, chronic	32%	48.5%	56%
Asthma med management	25%	44.1%	67%
Child access to PCP, 2-6 years	86%	92.9%	89%
Child access to PCP, 7-11 years	91%	95.9%	90%
Child access to PCP, 12-24 months	94%	98.2%	98%
Chlamydia screening in women	55%	68.6%	39%
Diabetes care: blood sugar test	85%	91.9%	90%
Diabetes care: eye exam	29%	67.9%	75%
Diabetes care: kidney screening	86%	87.7%	86%
Well-child visits, age 3-6	65%	83.8%	73%

Data sources: King County Performance Gap Analysis (King County Medicaid rates, 90th percentile benchmarks), WA Health Alliance Community Checkup (King County commercial rates)

Another approach to understanding the quality of health and social services provided to Medicaid members is to consider the cultural representativeness of providers and cultural relevance of services. How likely is it that King County Medicaid members see themselves represented in their care providers or receive services in a preferred language?

- While 40% of King County Medicaid members identified as white in 2015 (Medicaid enrollee health profile, PMD), 79% of primary care physicians working in King County in 2012 identified as white (WA State Primary Care Provider Survey, 2011-2012: Summary of Findings, Table 3, Center for Health Workforce Studies).
- Similarly, 16% of King County Medicaid members identified as Latino while only 2.1% of primary care nurse practitioners identified as Latino.

We have only identified the tip of the iceberg, however. More current information is needed to identify key areas of opportunity for improving cultural relevance of health and social services provided to Medicaid members.

The social and cultural contexts of health

The persistent place, race and income disparities in King County tell a deep story about the social determinants of health. In particular, people and communities of color are more likely to experience multiple complex barriers to health that significantly impact their ability to access health and social services that work for them and to act on the guidance of their providers. It is important to measure these disparities at the population level when considering how the Medicaid demonstration can be leveraged to address social inequities in our community.

At the provider/client level, we must keep these disparities in mind as we try to improve the cultural competence and cultural relevance of providers and the services they offer. Individuals and families are often hesitant to discuss their health and social needs or their ability to access and/or pay for needed services. The degree to which services are used effectively can be influenced by cultural factors such as

- The degree to which individuals can see themselves represented in their providers
- Whether services are available that meet client preferences for language, privacy, setting, and other factors.

Routinely available, representative, cross-sector information on client experience of services is not used sufficiently at either the population or point-of-care levels for improving the quality of health and social policies, programs, and services.

It is critical to understand the societal context in which the Medicaid demonstration will be implemented. In a presentation to a local Federally Qualified Health Center (FQHC), the PMD highlighted the local trends that will likely interact with health and human services transformation efforts, as well as local opportunities for advancing health equity. For example, we know that the interrelated forces of gentrification and Puget Sound's hot real estate market are pushing lower income families farther from urban cores and their proximity to employment, education, and health and social services opportunities. This ongoing displacement highlights the vital roles that affordable housing and transportation access play in shaping health and well-being. With this in mind, we view the Medicaid demonstration as an important opportunity in the broad milieu of threats and opportunities that affect population and individual health and well-being.

At the same time that we work to prevent and/or mitigate threats at the federal, state, and local levels, we must also work across sectors to align the Medicaid demonstration efforts with synergistic initiatives such as Best Starts for Kids and Communities of Opportunity. Since the Medicaid demonstration is largely aimed at transformation within the health care delivery system, maximal impact will in part depend on parallel investments in the social determinants of health, including affordable housing, quality child care, and access to public transportation.

APPENDIX

Table 6, below, shows source data for Charts 1 and 2.

Table 6. Adult health status: Medicaid versus commercial health insurance coverage (2014-2015)		
	Medicaid	**Commercial**
Chronic disease prevalence		
High cholesterol	47.6%	33.8%
Hypertension	24.9%	18.4%
Frequent mental distress (14 or more days per month)*	23.4%	7.8%
Arthritis*	20.7%	13.8%
Serious psychological distress*	13.1%	2.3%
Asthma	12.6%	7.5%
Chronic respiratory disease*	9.3%	1.8%
Diabetes	7.8%	4.2%
Heart attack	3.9%	2.1%
Coronary heart disease	2.1%	1.3%
Stroke	1.0%	0.8%
Prevalence of health and social risk factors		
Not meeting physical activity recommendation	78.4%	74.7%
Obesity (Body Mass Index 30 or more)*	29.4%	20.8%
Current cigarette smoking*	25.9%	10.2%
Current marijuana use (past 30 days)*	25.3%	14.0%
Binge drinking	19.6%	23.7%
Electronic cigarette use (past 30 days)*	11.7%	3.4%

Notes:

1) *Data source: Behavioral Risk Factor Surveillance System, 2014-2015*
2) **Statistically significant difference comparing Medicaid to Commercial (p-value < 0.05)*