2021 Comparative and Regional Analysis Report

Washington Apple Health
Washington Health Care Authority

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As Washington's Medicaid external quality review organization (EQRO), Comagine Health provides external quality review and supports quality improvement for enrollees of Washington Apple Health managed care programs and managed behavioral health care services.

Comagine Health prepared this report under contract K3866 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.

Comagine Health is a national, nonprofit, health care consulting firm. We work collaboratively with patients, providers, payers and other stakeholders to reimagine, redesign and implement sustainable improvements in the health care system.

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Acronym List

Acronym	Definition
ACA	Affordable Care Act
AHAC	Apple Health Adult Coverage (Medicaid Expansion)
AH-BD	Apple Health Blind/Disabled
AH-IFC	Apple Health Integrated Foster Care
AH-IMC	Apple Health Integrated Managed Care
AMG	Amerigroup Washington, Inc.
BHSO	Behavioral Health Services Only
CCW	Coordinated Care of Washington
CHIP	Children's Health Insurance Program
CHPW	Community Health Plan of Washington
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CY	Calendar Year
EQR	External Quality Review
EQRO	External Quality Review Organization
ESHB	Washington State Engrossed Substitute House Bill
HCA	Health Care Authority
HEDIS	Healthcare Effectiveness Data and Information Set
MCO	Managed Care Organization
MH-B	Mental Health Service Penetration – Broad Definition measure
MHW	Molina Healthcare of Washington
MLD	Member-Level Data
MY	Measurement Year
NCQA	National Committee for Quality Assurance
RDA	Research and Data Analysis Division of the Washington Department of Social and Health Services
RSA	Regional Service Area
RUCA	Rural-Urban Commuting Area
RY	Reporting Year
SUD	Substance Use Disorder
TANF	Temporary Assistance to Needy Families
UHC	UnitedHealthcare Community Plan

Executive Summary

In 2020, over 1.9 million Washingtonians were enrolled in Apple Health, with more than 85% enrolled in managed care.[1] This managed care population is served by five managed care organizations (MCOs):

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

These MCOs are required to annually report results of their performance on measures reflecting the levels of quality, timeliness and accessibility of health care services furnished to the state's Medicaid enrollees. As part of its work as the external quality review organization (EQRO) for the Washington State Health Care Authority (HCA), Comagine Health reviewed MCO performance on Healthcare Effectiveness Data and Information Set (HEDIS®)[2] measures for the calendar year (CY) 2019. In addition to the HEDIS measures, this report also includes data on two behavioral health measures developed by the state of Washington.

This report illustrates trends in managed care performance across the performance measure set, focusing on performance against benchmarks and year-over-year trends. This report is intended as a description of year-over-year performance at the state, regional and MCO levels.

HEDIS Measures

HEDIS measures are developed and maintained by the National Committee for Quality Assurance (NCQA) and they are reflective of the levels of quality, timeliness and accessibility of health care services MCOs furnished to the state's Medicaid enrollees. The NCQA's database of HEDIS results, the Quality Compass,®[3] enables benchmarking against other Medicaid managed care health plans nationwide.

Many of the HEDIS measures included in this report are also included in the Washington State Common Measure Set on Health Care Quality and Cost,[4] a set of measures that enables a common way of tracking important elements of health and health care performance intended to inform public and private health care purchasing.

Comagine Health assessed each MCO's most recently reported HEDIS rates. In addition, this report also provides the following levels of analysis:

- Statewide performance compared to national benchmarks (when available)
- Individual MCO performance compared to national benchmarks (when available)

[1] About Washington Apple Health (Medicaid). Available at: https://www.hca.wa.gov/assets/free-or-low-cost/about-Apple-Health.pdf.
[2] The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.
[3] Quality Compass® is a registered trademark of NCQA.
[4] Healthier Washington. About the Washington Statewide Common Measure Set for Health Care Quality and Cost. Available at: https://www.hca.wa.gov/assets/program/washington-state-common-measures.pdf.

- Regional performance on select measures (not all measures provide a sufficient volume of data for regional analyses)

Washington State Behavioral Health Measure Overview

At HCA's instruction, Comagine Health also assessed statewide performance on two non-HEDIS behavioral health measures that are calculated by the Department of Social and Health Services Research and Data Analysis Division (RDA). The state monitors and self-validates the following two measures, both reflecting behavioral health care services delivered to Apple Health enrollees:

- Mental Health Service Penetration – Broad Definition (MH-B)
- Substance Use Disorder Treatment Penetration (SUD)

Alignment with Value-Based Purchasing Efforts

In 2019, the Washington Legislature passed the Washington State Engrossed Substitute House Bill (ESHB) 1109 requiring HCA's contracted EQRO to annually analyze the performance of Apple Health MCOs providing services to Medicaid enrollees.[5]

As the EQRO for the State of Washington, Comagine Health is contracted to assess MCO performance on measures reported by each plan and to recommend a set of priority measures that meets the bill's specific criteria and best reflects the state's quality and value priorities — balancing cost and utilization — while ensuring quality care to enrollees. This recommendation process supports HCA's determination of the statewide Value-Based Purchasing (VBP) performance measure set.

In 2021, Comagine Health analyzed and reported on MCO performance on the VBP measures as selected by HCA for both AH-IMC and IFC contracts. The result of this analysis has a direct effect on the reimbursement to MCOs. MCOs achieved VBP reimbursement if the demonstrated year-over-year improvement or scored in the top national Medicaid quartile of the performance measure.

In addition, in 2021, Comagine Health analyzed the performance of AH-IMC and IFC managed care organizations providing services to clients and made recommendations for 2022 required under the Washington State Budget Proviso 2019 (211)(50) to support HCA decision-making in selecting performance measures required by the Proviso.

Comparative Analysis in this Report

Comagine Health thoroughly reviewed each MCO's rates for selected HEDIS measures and associated submeasures and the RDA measures. With HCA's approval, Comagine Health focused on the 41 highest priority measures for analysis in this report. These 41 measures, which include HEDIS measures and the two Washington behavioral health measures, reflect current HCA priorities and are part of the Statewide Common Measure Set. They also represent a broad population base or population of specific or prioritized interest.

We present measure performance and comparison to national benchmarks (NCQA),[6] by the following:

[5] State of Washington. 66th Legislature. Engrossed Substitute House Bill 1109. Chapter 14, Laws of 2019. Available at https://legiscan.com/WA/text/HB1109/id/2028380/Washington-2019-HB1109-Chaptered.pdf.
[6] Note: NCQA licensing agreement does not allow display of national performance benchmarks for all measures.

- Apple Health programs
- Individual Apple Health MCOs
- Apple Health service regions

The 2020 calendar year is referred to as the measurement year 2020 (MY2020) in this report to be consistent with NCQA methodology.

Appendix B contains a full report of all performance measures and was submitted separately to HCA. Since Appendix B contains confidential information, including measure results with small denominators and NCQA Quality Compass benchmarks, it is not available publicly. For this reason, we have included Appendix C, which contains a subset of the information included in Appendix B for all the performance measures by MCO and by region.

Key Observations

This report represents the first analysis of performance measures following completion of the integration of behavioral health benefits into the Apple Health managed care program, providing Medicaid enrollees with access to both physical and behavioral health services through a single managed care program. As of January 1, 2020, the majority of services for Apple Health clients were provided through the MCOs.

Statistically Significant Improvements

Many behavioral health measures show a strong shift of improvement, as do the access measures. (See Figure 4.) These statistically significant improvements are notable, especially in the context of COVID-19.

There were two years of statistically significant improvement (between MY2018 and MY2019 and between MY2019 and MY2020) for the following measures:

- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET), Total: Initiation of AOD Treatment: Total
- Antidepressant Medication Management (AMM) Acute and Continuation Phase measures
- Follow-Up After Emergency Department Visit for Mental Illness (FUM), Total for both the 7-Day and 30-Day Follow-Up
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependencies (FUA), Total for both the 7-Day and 30-Day Follow-Up
- Substance Use Disorder Treatment Penetration (SUD), 12–64 Years
- Asthma Medication Ratio (AMR), Total

There was a statistically significant improvement between MY2019 and MY2020 for the following measures:

- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET), Total: Initiation of AOD Treatment: Age 13-17
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET), Total: Engagement of AOD Treatment: Total

- Prenatal and Postpartum Care (PPC), Postpartum Care
- Follow-Up after Hospitalization for Mental Illness (FUH), Total for both the 7-Day and 30-Day Follow-Up
- Use of Opioids at High Dosage (HDO)

Statistically Significant Declines

While there were measures that showed improvements there were also measures that demonstrated statistically significant decline.

There was a statistically significant decline between MY2019 and MY2020 for the following measures:

- Adults' Access to Preventive/Ambulatory Health Services (AAP), Total
- Mental Health Treatment Penetration (MH-B), 6-64 years
- Childhood Immunization Status (CIS), Combo 2
- Childhood Immunization Status (CIS), Combo 10
- Chlamydia Screening (CHL), Total

Preventive Care: Rates of adult preventive services, immunizations and preventive screening for breast cancer all showed significant declines. It was assumed that the COVID-19 pandemic would have a negative effect on preventive care. Steps required to reduce transmission, including requirements of the *Stay Home, Stay Healthy* orders instituted in the early days of the public health emergency, resulted in steep declines of in-person care. In fact, this was the observed pattern overall. (Refer to Figure 4.)

There was a statistically significant decline between both MY2018 and MY2019, and MY2019 and MY2020 time periods for the Breast Cancer Screening (BCS) measure.

There are a few consistent statistically significant declines in performance across all MCOs. The Adults' Access to Preventive/Ambulatory Health Services (AAP), Total; Breast Cancer Screening (BSC); and Chlamydia Screening (CHL) measures declined for all MCOs between MY2019 and MY2020.

Health Equity

The stress of COVID-19 pandemic on the Medicaid system has revealed several important patterns in health disparities, which suggest areas for further investigation and offer insights into potential strategies for addressing health disparities. The impact has been worse on communities heavily represented by non-white minority groups.

Prenatal and Postpartum Care (PPC) – Both the Timeliness of Prenatal Care and Postpartum measures were significantly below (statistically significant) the statewide weighted average for enrollees who identified themselves as Hawaiian/Pacific Islander. There were no disparities noted for the other race/ethnicity categories.

Behavioral health: Although there have been improvements in the behavioral health measures at the statewide level, that improvement does not translate into improvements for all race/ethnicity categories.

The improvement in mental health and substance use disorder measures was due primarily to improvement in members identifying as white.

- In contrast, for members identifying as Black the results were exactly the opposite with a consistent worsening across the board in the same metrics.
- For Hispanic members, the results were similar as to Black members except for a significant improvement in follow up after hospitalization and Emergency Department use measure.

Preventive care: During the past year, declines have been seen in preventive services for white, Black and Hawaiian/Pacific Islander members, while Hispanic members showed significant improvements in preventive care visits across nearly all age groups for child and adolescent immunizations and screenings for cancer, lead in children, and chlamydia in young women. The pattern for Asian members was similar to that of Hispanic members.

Chronic disease: Diabetes measures were significantly worse only in Hispanic members. The prevalence of COVID-19 was particularly high in that ethnic group during much of 2020 when the Hispanic population included 21% of the confirmed cases but were only 13% of Washington's total population.[7] Asthma measures showed significant improvement in the medication ratio that was driven largely by the Hispanic population, and to a lesser degree by the Asian and Hawaiian/Pacific Islander populations. There was a significant decrease in this metric among white members.

Additional Observations

Two major impacts on Medicaid in 2020 were the COVID-19 pandemic and a 12% increase in Medicaid enrollment in the Apple Health Integrated Managed Care (AH-IMC) program. COVID-19 severely stressed primary care delivery systems due to workflow changes required to protect the workforce and patients, re-ordering of clinical priorities and unstable delivery system revenue. The stress on the member population through anxiety, isolation and job loss increased the burden on mental health and substance use conditions. In addition, there was a significant influx of new Medicaid members, for which additional time and effort is usually required. Depending on prior insurance or lack of insurance, these new members may have a greater burden of unmet care needs than established members. Due to COVID-19 and the increase in managed care enrollment, year-over-year comparison should be viewed with caution.

MCO and Regional Variation

Plan performance rates must be interpreted carefully. There are several potential sources of variation with the measures that must be considered, including a lack of risk adjustment, data availability and small denominators. A full discussion of these issues and the limitations of the data in this report can be found in Appendix A.

With that caveat in mind, there have been some intriguing statistically significant improvements that can be seen across the MCOs. Comparisons are made using the state simple average to mitigate the impact of plan size when comparing a particular plan's performance. For more details on the calculation of the state simple average, please refer to the section titled "Calculation of the Washington Health Average" on page 14. Several of the behavioral health measures have improved between MY2019 and MY2020. In addition, all MCOs except UHC have seen statistically significant improvement for the Asthma Medication Ratio (AMR), Total measure.

[7] Washington State Department of Health. COVID-19 Data Dashboard. Available at: https://www.doh.wa.gov/Emergencies/COVID19/DataDashboard#tables.

There were minor differences in performance on mental health and substance use disorder metrics across MCOs. CHPW and MHW tended to perform better than the other MCOs in this clinical domain.

AMG performed below the state simple average for the majority of the measures. A few of the behavioral health measures were above the state simple average, most notably Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependencies (FUA), 30-Day Follow-Up, 13-17 Years and Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET), Total: Initiation of AOD Treatment: 13-17 Years measures. However, the remaining behavioral health measures were below the state simple average, including the Follow-Up after Hospitalization for Mental Illness (FUH) and the Follow-Up after ED Visit for Mental Illness (FUM) measures. *Refer to Figure 61 for MCO measure performance.*

CCW had more of a mixed performance, with performance well above the state simple average on several measures, but performance well below the state simple average on others. Although CCW has several pediatric measures with rates were above the state simple average, it performed below the state simple average on many measures related to maternity and pediatric care. Many of the behavioral health measures were below the state simple average for CCW. Other measures where the MCO's rates were markedly below the state simple average include Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care and Postpartum Care, and Cervical Cancer Screening (CCS). *Refer to Figure 62 for MCO measure performance.*

CHPW performed above the state simple average for the majority of the measures, including several pediatric and behavioral health measures. CHPW was also well above the state simple average for the Prenatal and Postpartum (PPC) measures for both the Timeliness of Prenatal Care and Postpartum Care components. The only measure where CHPW was notably below the state simple average was the Follow-Up Care for Children Prescribed ADHD Medication (ADD), for both the Initiation and Continuation phase. *Refer to Figure 63 for MCO measure performance.*

MHW performed above the state simple average for several measures and close to the state average for others. MHW was markedly below the state simple average for the Childhood Immunization Status (CIS), Combo 2 and Combo 10 measures. As a reminder, comparisons are made using the state simple average to mitigate the impact of plan size when comparing a particular plan's performance. MHW, in fact, performs well on many of the measures after mitigating the impact its size would have on the state average. *Refer to Figure 64 for MCO measure performance.*

UHC performed close to the state simple average for the majority of the measures. UHC performed markedly above the state average for the Comprehensive Diabetes Care (CDC), Poor HbA1c Control and Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0% measure. UHC was markedly below the average for the Well-Child Visits in the First 30 Months of Life (W30), 0-15 Months, Lead Screening in Children (LSC), Follow-Up after Hospitalization for Mental Illness (FUH), 30-Day Follow-Up, Total, Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), Total, Childhood Immunization Status (CIS), Combo 2, and Immunizations for Adolescents (IMA), Combo 2 measures. *Refer to Figure 65 for MCO measure performance.*

When measures are split by MCO and race/ethnicity, it appears the MCO is a bigger driver in differences in performance than race/ethnicity.

There was a similar finding with the regional analysis. There is not a lot of variation in a specific MCOs performance across regions; in other words, if an MCO performed well in one region, it tended to perform well in others. MHW had strong performance in several regions. Conversely, AMG had weaker performance across several regions. There was some variation in performance by measure, but no other compelling themes emerged from the regional analysis.

Recommendations

In the following recommendations, we highlight areas of distinct improvement in Washington State, measures to proactively monitor in the light of the ongoing COVID-19 pandemic and opportunities to augment the current dataset to allow deeper future analysis related to health equity. Recommendations are in four areas:

- Sustain Improvement in Clinically Meaningful Areas
- Address Behavioral Health Declines
- Focus on Preventive Care
- Continue to prioritize Health Equity

Sustain Improvement in Clinically Meaningful Areas

Comagine Health recommends continuing the current work on behavioral health integration and continuous quality improvement with these measures. Improvement in behavioral health metrics continued from last year with new significant improvement in initiation/engagement of alcohol, substance use and other drug dependence, and for follow up after mental health hospitalization. Continue to monitor these measures to ensure performance in these areas does not decline and look for opportunities to incorporate this new data to address program needs.

All MCOs, except UHC, saw statistically significant improvement for the Asthma Medication Ratio (AMR), Total measure between MY2019 and MY2020. We recommend continued emphasis on this important measure.

Statewide, Prenatal and Postpartum Care (PPC) - Postpartum Care, demonstrated statistically significant improvement between MY2019 and MY2020. AMG demonstrated statistically significant improvement during this same timeframe, where the other four MCOs had no notable year-over-year improvement in rates. Continued focus on Postpartum Care by all MCOs is recommended.

Overall, collaboration among the MCOs, with the higher performing plans sharing successful strategies that have led to improved measure performance may help improve all of the MCOs performance on these measures.

Address Behavioral Health Declines

The decline in statewide Mental Health Treatment Penetration (MH-B), for 6-64 years rates may be due to restrictions put in place at the beginning of the COVID-19 pandemic that limited in-person visits. CCW, CHPW and MHW demonstrated a statistically significant increase from MY2019 to MY2020. AMG and UHC had significant decreases in mental health treatment penetration during this timeframe. Focused efforts to ensure individuals receive mental health treatment need to be a priority for all MCOs.

Although there have been improvements in the behavioral health measures at the statewide level, that improvement does not translate into improvements for all race/ethnicity categories. See the “Continue to Prioritize Health Equity” section for additional information.

Focus on Preventive Care

Although there were statistically significant declines from MY2019 to MY2020 in multiple preventive care measures (CIS Combo 2 & Combo 10, CHL, AAP and BCS), Breast Cancer Screenings (BCS) have

declined over the past two measurement years. All MCOs demonstrated a significant decrease in BCS this past measurement year. In addition, the urban population received statistically significant higher rates of breast cancer screenings over the rural population. All MCOs need to focus on this important preventive measure.

The COVID-19 pandemic continues to impact preventive care.

- It is recommended that the use of telehealth be maximized to the greatest degree possible for preventive (and acute) care needs.
- Outreach to individuals to ensure preventive care is obtained should be prioritized. Plans need to include strategies to support practitioners in catching up on preventive care that was delayed so declines do not continue.
- HCA should continue to focus on bidirectional integration to sustain the behavioral health integration work. Just as primary care screens for behavioral health needs, build in screening and coordination of preventive care should be built into behavioral health visits. (Certified Community Behavioral Health Clinic – CCBHC – model of care).[8]

Continue to Prioritize Health Equity

There is sufficient evidence of health disparities in these data to warrant further research and focused effort to better understand details on effectiveness and needs of communities.

The severity of COVID-19 impact has been greater in the non-white populations. Although there have been improvements in the behavioral health measures at the statewide level, that improvement does not translate into improvements for all race/ethnicity categories. As noted above in the "Statistically Significant Improvements" section, the behavioral health program in its present form is working and the positive impact is measurable when looking at the statewide measures. However, increased attention needs to be directed at communities of color, particularly Black and Hispanic communities.

Additional areas of focus to address health equity needs include:

- Prenatal and Postpartum Care (PPC) both timeliness of Prenatal Care and Postpartum measures for Hawaiian/Pacific Islanders
- Prevention and Screening measures for most races/ethnicities
- Well-Child Visits in the First 30 Months of Life (W30) and child and Adolescent Well-Care Visit (WCV) for most races/ethnicities

Continued collaboration with partners in Washington around health equity data, including the collection, analysis, reporting and community participation in validating and interpreting those data will continue to benefit HCA in driving health equity work in Washington.

HCA may consider incorporating equity-focused payment and contracting models in their value-based payment (VBP) program as an approach to improving health equity. According to a report by the Institute for Medicaid Innovation, "The development of equity-focused VBP approaches to support care

[8] Washington State Health Care Authority. Certified Community Behavioral Health Clinic (CCBHC) Expansion Grants. Fact Sheet. Available at: cchbc-grant-fact-sheet_0.pdf (wa.gov).

delivery transformation is an important lever that can help payers advance health equity and eliminate disparities in health care with their provider organizations and members."[9]

The report outlines six strategies to guide the development of equity-focused VBP approaches to mitigate health disparities:

1. Articulating an equity goal
2. Assessing the payment and care delivery environment
3. Selecting performance measures
4. Setting performance targets
5. Designing the payment approach
6. Addressing operational challenges

[9] Institute for Medicaid Innovation and Center for Health Care Strategies. Leveraging Value-Based Payment Approaches to Advance Health Equity: Key Strategies for Health Care Payers. January 2021. Available at: IMI-2021-Leveraging_Value-Based_Payment_Approaches_to_Promote_Health_Equity-Report.pdf (medicaidinnovation.org).

Introduction

The purpose of this report is to identify strengths and opportunities for improvement in the delivery of Medicaid services in Washington by examining variation in MCO performance across geographic, Medicaid program and demographic categories.

As part of its work as the EQRO for Washington HCA, Comagine Health reviewed Apple Health MCO performance on HEDIS measures for the calendar year 2020. Each Apple Health MCO is required to report results for HEDIS measures reflecting the levels of quality, timeliness and accessibility of health care services furnished to the state's Medicaid enrollees. HCA requires MCOs to report on these measures and their specific indicators (for example, rates for specific age groups).

HEDIS measures are developed and maintained by the NCQA, whose database of HEDIS results for health plans — the Quality Compass — enables benchmarking against other Medicaid managed care health plans nationwide (see Methodology section for more about HEDIS measures).

Many of these selected measures are also part of the Washington Statewide Common Measure Set on Health Care Quality and Cost, a set of measures that enables a common way of tracking important elements of health and health care performance intended to inform public and private health care purchasing. In addition to the HEDIS measures, two behavioral health measures developed by HCA are also included in this report.

The 2020 calendar year is referred to as the measurement year 2020 (MY2020) in this report to be consistent with NCQA methodology.

Overview of Apple Health Enrollment

During MY2020, five MCOs provided managed health care services for Apple Health enrollees:

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

Medicaid enrollees are covered by the five MCOs through the following programs:

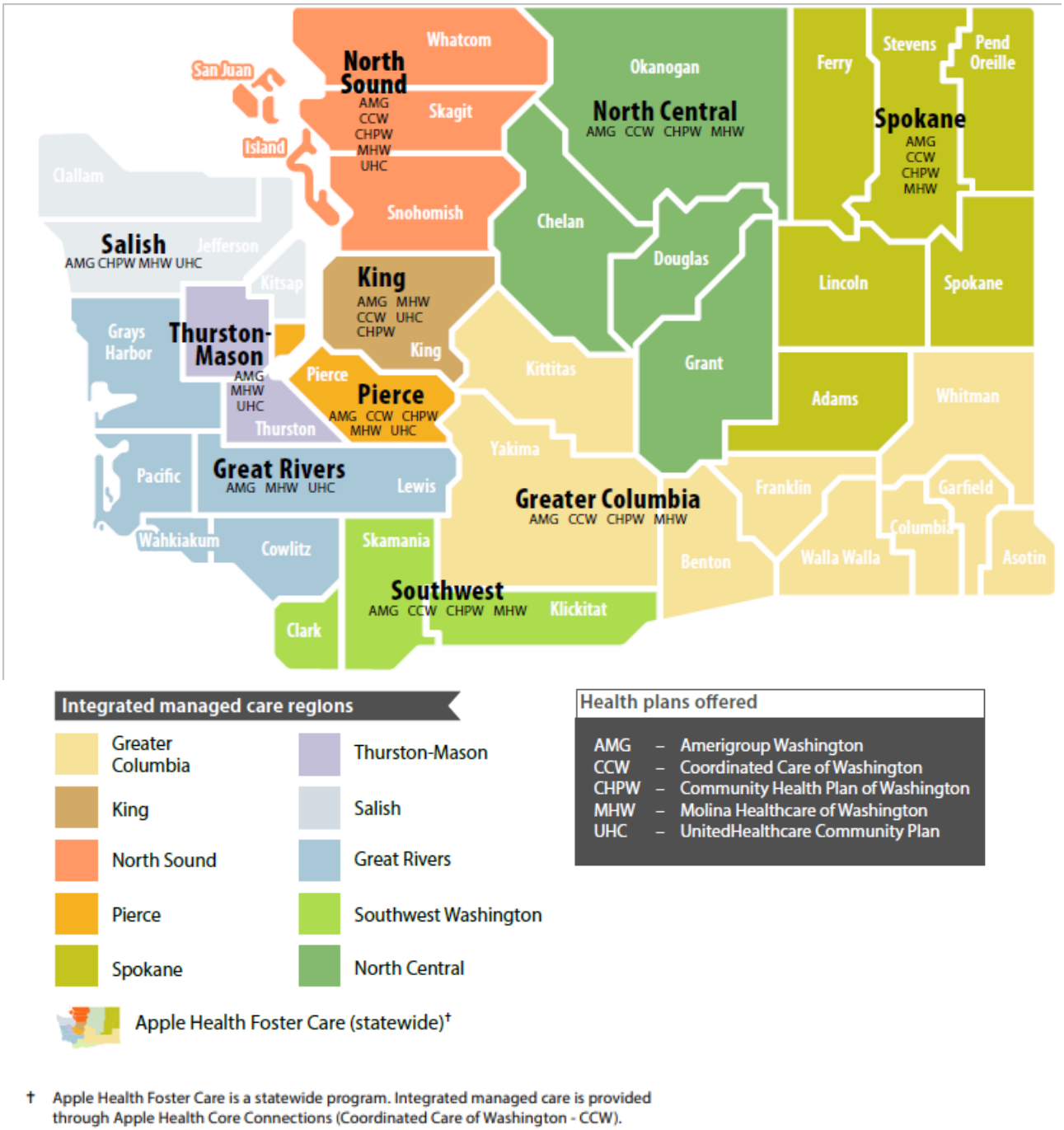
- Apple Health Integrated Managed Care (AH-IMC)
- Apple Health Integrated Foster Care (AH-IFC)
- Apple Health Behavioral Health Services Only (BHSO) (PIHP-contracted services)

Within Washington's Apple Health Integrated Managed Care program, Medicaid enrollees may qualify under the following eligibility categories:

- Apple Health Family (traditional Medicaid)
- Apple Health Adult Coverage (Medicaid expansion)
- Apple Health Blind/Disabled (AH-BD)
- State Children's Health Insurance Program (CHIP)

Figure 1 shows enrollment by Apple Health regional service areas (RSA) by county.

Figure 1. Apple Health Regional Service Areas by County in 2021.[10]



† Apple Health Foster Care is a statewide program. Integrated managed care is provided through Apple Health Core Connections (Coordinated Care of Washington - CCW).

[10] Apple Health Managed Care Service Area Map (July 2021). Provided by Washington Health Care Authority. Available here: https://www.hca.wa.gov/assets/free-or-low-cost/service_area_map.pdf.

The regional service areas are defined as follows:

- **Great Rivers** includes Cowlitz, Grays Harbor, Lewis, Pacific and Wahkiakum counties
- **Greater Columbia** includes Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Whitman and Yakima counties
- **King** includes King County
- **North Central** includes Chelan, Douglas, Grant and Okanogan counties
- **North Sound** includes Island, San Juan, Skagit, Snohomish and Whatcom counties
- **Pierce** includes Pierce County
- **Salish** includes Clallam, Jefferson and Kitsap counties
- **Southwest** includes Clark, Klickitat and Skamania counties
- **Spokane** includes Adams, Ferry, Lincoln, Pend Oreille, Spokane and Stevens counties
- **Thurston-Mason** includes Mason and Thurston counties

Methodology for Comparing Performance Measures

This report provides a summary of MCO performance at the plan, region and state levels, and compared to national benchmarks of Medicaid plans across the country. Performance on select measures is also presented by Apple Health program, member-selected race, member-spoken language, urban versus rural geography and regional service area.

Interpreting Performance

Plan performance rates must be interpreted carefully. There are several potential sources of variation with the measures.

- **Performance measures are specifically defined.** It is 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. Occasionally, member records may not include the specific notes or values required for a visit or action to count the member as having received the service.
- **Measures are not risk adjusted.** Risk adjustment is a method of using characteristics of a member population to estimate the population's illness burden. Diagnoses, age and gender are characteristics that are often used. Because HEDIS measures are not risk adjusted, the variation between MCOs is partially due to factors that are out of a plan's control, such as enrollees' medical acuity, demographic characteristics and other factors that may impact interaction with health care providers and systems.
- **Some measures have very large, or very small, denominators.** There are populations with large denominator sizes, making it more likely statistical significance for differences of small magnitude is detected. There are also many HEDIS measures that are based on a small sample or are focused on a narrow eligible member population; these have small denominators, making it less likely to detect statistical differences. For measures with small denominators, it may be useful to look at patterns among associated measures to interpret overall performance.

Impact of COVID-19 on Performance Measurement

In March 2020, the State of Washington implemented a "Stay Home, Stay Healthy" order in response to the threat of the COVID-19 virus. This order included limiting health care facilities to emergency services for the months of March and April 2020 and delaying elective procedures and other non-urgent treatment until later in the year. This impacted the performance of many MY2020 HEDIS measures, particularly many of the preventive care and access measures. Other utilization may have decreased due to a lower incidence of flu and other respiratory illnesses due to the adherence to masking and social distancing.

In addition, it is worth noting there were increases in Apple Health enrollment likely due to widespread layoffs during the pandemic closures. Large increases in enrollment can impact measure results as there may be an underlying shift in the demographics of the population and delays in receiving care for new members.

HEDIS Performance Measures

HEDIS is a widely used set of health care performance measures reported by health plans. HEDIS rates are derived from provider administrative (such as claims) and clinical data. They can be used by the public to compare plan performance over six domains of care, and also allow plans to determine where quality improvement efforts may be needed.

In June 2020, Apple Health plans reported measures and their specific indicators (for example, rates for specific age groups). Comagine Health thoroughly reviewed each MCO's rates for all reported HEDIS measures, with associated submeasures and the RDA measures. These results are presented in Appendix B and Appendix C.

Since Appendix B contains information that is confidential, including measure results with small denominators and NCQA Quality Compass benchmarks, it is not available publicly and was submitted to HCA separately. Appendix C contains a subset of the information included in Appendix B for all the performance measures by MCO and by region and is available publicly.

Washington State Behavioral Health Measures

In addition to several HEDIS behavioral health measures the state monitors, the state also monitors and self-validates the following two measures, both reflecting behavioral health care services delivered to Apple Health enrollees:

- Mental Health Service Penetration – Broad Definition (MH-B)
- Substance Use Disorder Treatment Penetration (SUD)

The MH-B metric is a state-developed measure of access to mental health services (among persons with an indication of need for mental health services). The SUD metric is a state-developed measure of access to SUD treatment services (among persons with an indication of need for SUD treatment services).

HCA partners with the Department of Social and Health Services Research and Data Analysis Division (RDA) to measure performance on these measures. Data is collected via the administrative method, using claims, encounters and eligibility data and assessed on a quarterly basis.

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 measurement years: MY2018, MY2019 and MY2020. The majority of the analyses presented in this report use the state weighted average. The state weighted average for a given measure is calculated as the weighted average among the MCOs that reported the measure (usually five), where the MCOs' share of the total eligible population is used as the weighting factor.

However, the MCO scorecards compare the individual MCO rates to the state simple average, or unweighted average. The state simple average for a given measure is calculated as the average of the measure rate for the MCOs that reported that measure. The potential disadvantage of comparing an individual MCO to a weighted state average is that significantly larger plans could have undue influence on the state rate. A simple average of the plans' performance (rather than a weighted average) mitigates those concerns. Comagine Health chose to use the simple average for the MCO scorecards

because the Apple Health MCOs vary in size. The state simple average for a given measure is calculated as the average of the measure rate for the MCOs that reported that measure.

Comparison to National Benchmarks

We compare MCO performance on national HEDIS measures with national benchmarks, which are published annually by NCQA in the *Quality Compass* report and are used with the permission of NCQA. These benchmarks represent performance of NCQA-accredited Medicaid HMO plans and Medicaid HMO plans that are either required to report HEDIS measures by the state agency responsible for monitoring managed Medicaid performance or opt to publicly report their HEDIS rates. The HEDIS measures reported to NCQA vary by plan. These national benchmarks reflect the average of the plans that reported the benchmark and are not a true national average of all managed Medicaid plans. Also, note these plans represent states with and without Medicaid expansion coverage.

The licensing agreement with NCQA limits the number of benchmarks that can be published each year. The current agreement limits publication to two benchmarks for 40 measures. HCA selected the 40 measures to be reported with benchmarks in Appendix B. The two benchmarks selected are the national average and the national 75th percentile. In other areas of the report, Comagine Health provides information on comparison of performance to national benchmarks without providing the actual benchmark rates, in accordance with NCQA licensing terms.

In addition to the national average for measures, Quality Compass provides benchmarks that are measured as percentiles. Percentiles show how a plan ranks compared to a proportion of other plans that reported performance on a particular measure to NCQA. For example, if a plan performs at the 75th percentile, that means it performed better than 75% of plans nationwide on that particular measure.

The Washington State Behavioral Health measures were developed by the State. As there are no national benchmarks for these measures, HCA leadership chose to consider the plan with the second highest performance in MY2019 as the benchmark.

Interpreting Percentages versus Percentiles

The majority of the measure results in this report are expressed as percentages. The actual percentage shows a plan's specific performance on a measure. For example, if Plan A reports a Breast Cancer Screening rate of 69%, that means that 69% of the eligible women enrolled in Plan A have received the screening. Ideally, 100% of the eligible woman should receive breast cancer screenings. The actual rate indicates there is still a gap in care that can be improved.

The national benchmarks included in this report are often displayed as percentiles. The percentile shows how Plan A ranks among all other plans who have reported Breast Cancer Screening rates. For example:

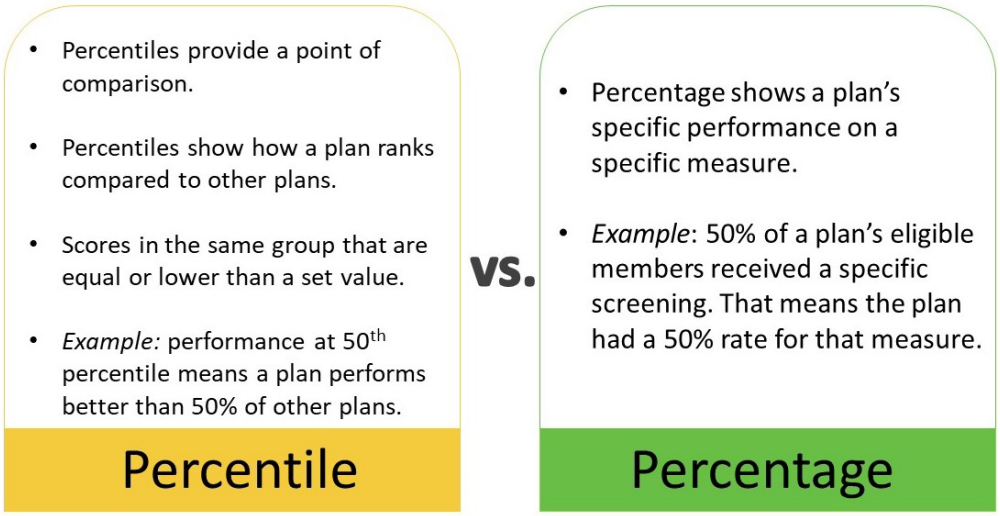
- If a plan's Breast Cancer Screening rate is at the national 50th percentile, it means that approximately 50% of the plans in the nation reported Breast Cancer Screening rates that were equal to or below Plan A; approximately 50% of the plans in the nation had rates that were above.
- If Plan A is above the 75th percentile, that means that at most 25% of the plans in the nation reported rates above Plan A, and at least 75% of the plans reported rates below Plan A.

The national percentiles give a benchmark, or point of comparison, to assess how Plan A's performance compares to other plans. This is especially important in identifying high priority areas for quality

improvement. For example, if Plan A performs below the 50th percentile, we can conclude there is a considerable room for improvement given the number of similar plans that performed better than Plan A. However, if Plan A performs above the 75th percentile, we can conclude that performance on that particular measure already exceeds the performance of most other plans and that improving the actual rate for that measure may not be the highest priority for this plan.

Figure 2 shows the differences between percentiles and percentages in the context of this report.

Figure 2. Percentile Versus Percentage.



Confidence Intervals, Statistical Significance and Denominator Size

The statistical tests in this report include calculations of the 95% confidence intervals. In layman's terms, this indicates the reader can be 95% confident there is a real difference between two numbers, and that the differences are not just due to random chance. The calculation of confidence intervals is dependent on denominator sizes.

The confidence interval is expressed as a range from the lower confidence interval value to the upper confidence interval value. A statistically significant improvement is identified if the current performance rate is above the upper confidence interval for the previous year.

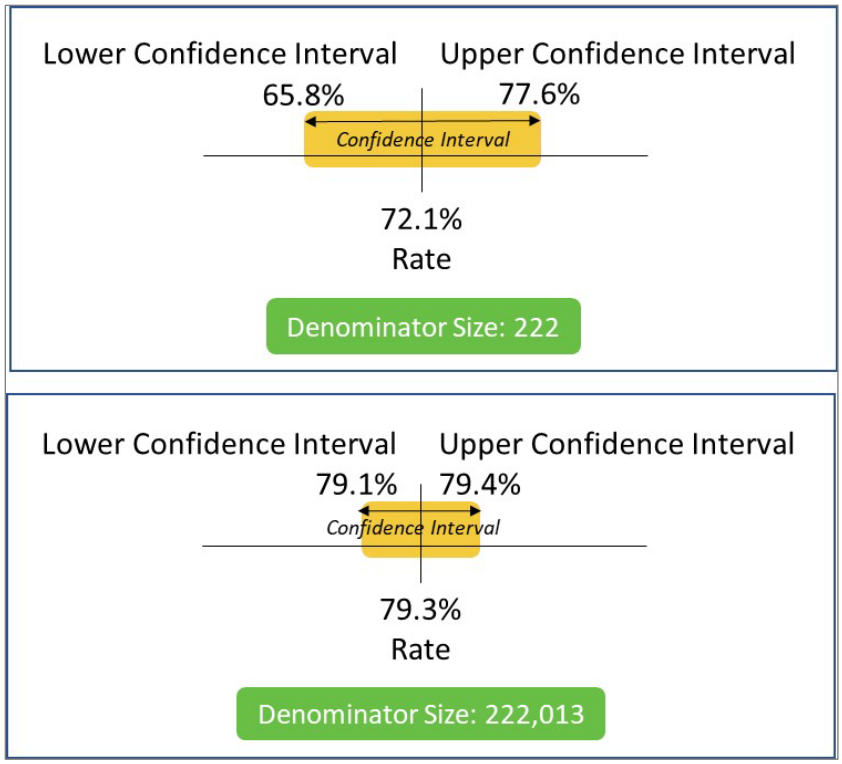
Significant and Significantly

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. A Wilson Score Interval test was applied to calculate the 95 percent confidence intervals. This means that the reader can be 95% confident there is a real difference between two numbers, and that the differences are not due to chance.

Denominator size is important when comparing measure performance between MCOs. Some MCOs have larger populations than others, such as MHW. When measures have very large denominators (populations of sample sizes), it is more likely to detect significant differences even when the size of the difference between two rates is very small. Also, the member populations, or sample sizes, for particular measures vary widely. This means sometimes it appears there are large differences between two numbers, but the confidence interval is too wide to be 95% confident that there is a true difference.

Figure 3 shows two examples of how rates and their corresponding confidence intervals are affected by denominator size. The first example has a denominator of 222, and the second example has a much larger denominator of 222,013. Notice how the confidence interval is much wider for the first example, while the second is narrower. That is because with a small denominator, we are less confident in the result and the confidence interval range will be much larger. With a large denominator, we can be more confident in the result; therefore, the confidence range is smaller.

Figure 3. Illustration of How Denominator Affects Confidence Intervals.



Limitations

Below are limitations to consider when reviewing this report.

- **Fee-for-service population:** The fee-for-service population is not included in these measures. Fee-for-service individuals include those eligible for both Medicare and Medicaid services. In addition, American Indian/Alaskan Natives are exempt from mandatory managed care enrollment.
- **Lack of risk adjustment**: HEDIS measures are not risk adjusted. Risk adjustment is a method of using characteristics of a patient population to estimate the population's illness burden. Diagnoses, age and gender are characteristics that are often used. Because HEDIS measures are

not risk adjusted, the variation between MCOs is partially due to factors that are out of a plan's control, such as enrollees' medical acuity, demographic characteristics and other factors that may impact interaction with health care providers and systems.

- **COVID-19 impact and rotated measures**: In response to COVID-19, NCQA allowed Medicaid plans participating in HEDIS the option of submitting MY2018 rates for their MY2019 hybrid measures – "rotating" the measures they reported. Hybrid measures combine administrative claims data and data obtained from clinical charts. Under NCQA guidelines, MCOs could decide which hybrid measures, and how many, to report as rotated measures (i.e., submit MY2018 rates).

  The NCQA's decision was made to avoid placing a burden on clinics while they were dealing with the COVID-19 crisis. As a result of this decision, Comagine Health did not have access to updated rates for certain measures from the plans for MY2019. See Appendix A, Table A-2, for the rotated measures by MCO.

  Note that there were no rotated measures submitted for MY2020. The impact of the rotated measures will be seen in the year-over-year comparisons.

- **State behavioral health measures:** There are no national benchmarks available for the Washington Behavioral Health measures as the measures are Washington-specific measures developed by the state. Note there are several HEDIS measures related to behavioral health which are reported within this report which do include national benchmarks.

For further discussion on HEDIS measures and the methodology utilized to report MCO performance, please see Appendix A.

Apple Health Statewide Performance

Comagine Health combined MCO performance to show how plans performed from MY2019 to MY2020 statewide. With HCA's approval, Comagine Health focused on the 41 highest priority measures for analysis in this report rather than the full list of HEDIS measures. These 41 measures, which include the two Washington behavioral health measures, reflect current HCA priorities and are part of the Statewide Common Measure Set. They also represent a broad population base or population of specific or prioritized interest.

Figure 4 shows the MY2020 statewide weighted average compared to the MY2019 statewide weighted average for the 41 measures. Below are the highlights of this statewide comparison:

- There were two years of statistically significant improvement (between MY2018 and MY2019, and between MY2019 and MY2020) for the following measures:
    - Asthma Medication Ration (AMR), Total
    - Antidepressant Medication Management (AMM) Acute and Continuation Phase measures
    - Substance Use Disorder Treatment Penetration, 12–64 Years
    - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET), Total: Initiation of AOD Treatment: Total
    - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependencies (FUA), Total for both the 7-Day and 30-Day Follow-Up
    - Follow-Up After Emergency Department Visit for Mental Illness (FUM), Total for both the 7-Day and 30-Day Follow-Up
- There was a statistically significant improvement between MY2019 and MY2020 for the following measures:
    - Prenatal and Postpartum Care (PPC), Postpartum Care
    - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET), Total: Initiation of AOD Treatment: 13-17 Years
    - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET), Total: Engagement of AOD Treatment: Total
    - Follow-Up after Hospitalization for Mental Illness (FUH), Total for both the 7-Day and 30-Day Follow-Up
    - Use of Opioids at High Dosage (HDO)
- There was a statistically significant decline between both MY2018 and MY2019, and MY2019 and MY2020 time periods for the Breast Cancer Screening (BCS) measure.
- There was a statistically significant decline between MY2019 and MY2020 for the following measures:
    - Mental Health Treatment Penetration (MH-B), 6-64 years
    - Adults' Access to Preventive/Ambulatory Health Services (AAP), Total
    - Childhood Immunization Status (CIS), Combo 2
    - Childhood Immunization Status (CIS), Combo 10
    - Chlamydia Screening (CHL), Total

Note about chart: The arrows in the right columns show statistically significant changes in year-over-year performance for these measures. The middle column with the gray bars shows the statewide rates for MY2020. Arrows pointing down represent a statistically significant decrease; arrows pointing up represent a statistically significant increase.

Figure 4. MY2020 MCO Statewide Weighted Average for 41 Measures.

Statistically Significant Change:
↑ Higher than previous year
↓ Lower than previous year

		MY 2020 Statewide Weighted Average	2018 to 2019	2019 to 2020
Access / Availability of Care	Adults' Access to Preventive/Ambulatory Health Services (AAP), Total	73%	↑	↓
	I&E of AOD Dependence Treatment (IET): Total Initiation of Treatment: 13-17 yrs	36%		↑
	I&E of AOD Dependence Treatment (IET): Total Initiation of Treatment: Total	45%	↑	↑
	I&E of AOD Dependence Treatment (IET): Total Engagement in Treatment: Total	16%		↑
	Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care	83%		
	Prenatal and Postpartum Care (PPC), Postpartum Care	77%		↑
	Use of First-Line Psychosocial Care for Children and Adolsecents (APP), Total	61%	↑	
Behavioral Health	Antidepressant Medication Management (AMM), Effective Acute Phase	58%	↑	↑
	Antidepressant Medication Management (AMM), Continuation Phase	43%	↑	↑
	Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	45%		
	Follow-Up Care for Children Prescribed ADHD Medication (ADD), Continuation	52%		
	Follow-Up after Hospitalization for Mental Illness (FUH), 30-Day Follow-Up, Total	57%		↑
	Follow-Up after Hospitalization for Mental Illness (FUH), 7-Day Follow-Up, Total	40%		↑
	Follow-Up After ED Visit for Mental Illness (FUM), 30-day, Total	58%	↑	↑
	Follow-Up After ED Visit for Mental Illness (FUM), 7-day, Total	45%	↑	↑
	Follow-Up After ED Visit for AOD Dependency (FUA), 30-day, 13-17 years	17%		
	Follow-Up After ED Visit for AOD Dependency (FUA), 30-day, Total	29%	↑	↑
	Follow-Up After ED Visit for AOD Dependency (FUA), 7-day, Total	19%	↑	↑
	Follow-Up After High Intensity Care for SUD (FUI), 30-day, Total	58%		
	Follow-Up After High Intensity Care for SUD (FUI), 7-day, Total	38%		
	Pharmacotherapy for Opioid Use Disorder (POD): Total	19%		
	Substance Use Disorder Treatment Penetration (SUD), 12-64 years	38%	↑	↑
	Mental Health Treatment Penetration (MH-B), 6-64 years	54%		↓
Cardiovascular Conditions	Controlling High Blood Pressure (CBP)	59%		
Diabetes	Comprehensive Diabetes Care (CDC), Poor HbA1c Control (lower is better)	37%		
	Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0%	52%		
Overuse / Appropriateness	Use of Opioids at High Dosage (HDO) (lower is better)	6%		↑
Prevention and Screening	Childhood Immunization Status (CIS), Combo 2	68%		↓
	Childhood Immunization Status (CIS), Combo 10	42%		↓
	Immunizations for Adolescents (IMA), Combo 2	40%		
	Lead Screening in Children (LSC)	34%		
	Breast Cancer Screening (BCS)	48%	↓	↓
	Cervical Cancer Screening (CCS)	59%		
	Chlamydia Screening (CHL), Total	50%		↓
Respiratory Conditions	Asthma Medication Ratio (AMR), Total	62%	↑	↑
Utilization	Well-Child Visits in the First 30 Months of Life (W30), 0-15 Months	54%		
	Well-Child Visits in the First 30 Months of Life (W30), 16-30 Months	68%		
	Child and Adolescent Well-Care Visit (WCV), Age 3-11	47%		
	Child and Adolescent Well-Care Visit (WCV), Age 12-17	35%		
	Child and Adolescent Well-Care Visit (WCV), Age 18-21	18%		
	Child and Adolescent Well-Care Visit (WCV), Total	39%		

Apple Health Programs

In Washington, Medicaid enrollees are covered by five MCOs through the following managed care programs:

Apple Health Integrated Managed Care (AH-IMC) – Integration of physical health, mental health and substance use disorder treatment services under one contract.

Apple Health Integrated Foster Care (AH-IFC) – Statewide program for eligible children and youth, including:

- < 21 Years old in the foster care program
- < 21 Years old and receiving adoption support
- Those 18–26 years of age who have aged out of the foster care program

Apple Health Behavioral Health Services Only (BHSO) – Program for members who are eligible for Apple Health but not eligible to be on an integrated managed care program, including the below:

- Dual-eligible for Medicare and Medicaid
- Medically Needy program
- Individuals who have met their Medicaid Spenddown

The Apple Health integrated managed care program are further broken down into the following four Medicaid eligibility categories:

Apple Health Family – Low-income programs for families, pregnant women and Temporary Assistance to Needy Families (TANF).

Apple Health Adult Coverage (AHAC) – Low-income program for adults between 19 and 65 years old who are at or below the 138% federal poverty level (FPL). This expansion of coverage was introduced as part of the Affordable Care Act (ACA) in 2014.

Apple Health for Kids – State Children's Health Insurance Program (CHIP)

- Provides coverage for eligible children in households that are up to 250% FPL
- The state also utilizes Medicaid CHIP funding to provide coverage with a monthly premium for children in households up to 312% FPL

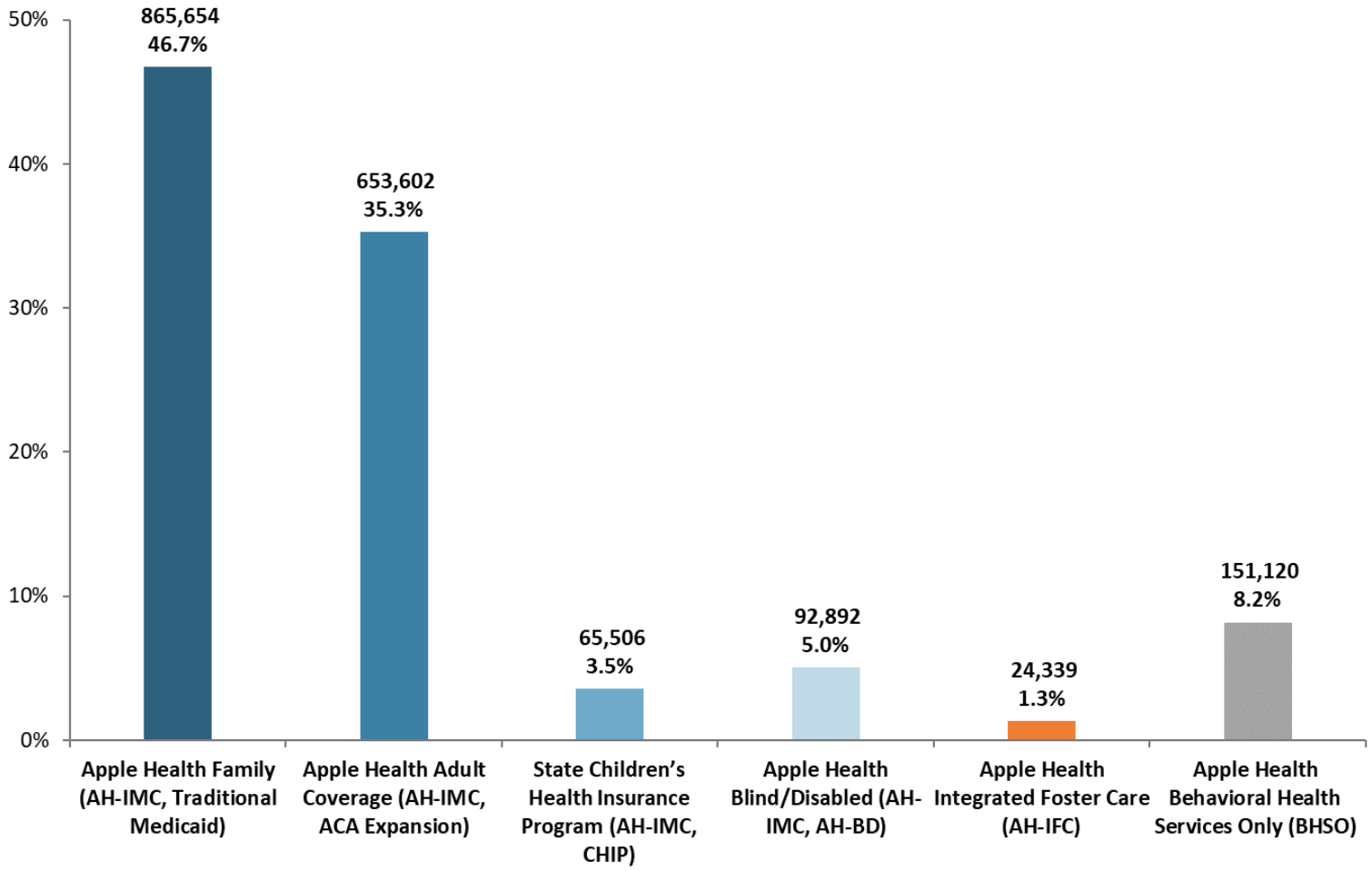
Apple Health Blind/Disabled (AH-BD) – Program for Supplemental Security Income (SSI)-related eligible members, including those who are currently receiving SSI.

The different Medicaid programs and eligibility categories may impact the performance of the MCOs since the mix of enrollees will vary by each MCO. For instance, CCW is the sole MCO contracted for AH-IFC throughout the entire state. Additionally, MCO coverage varied by RSAs, which would also impact the mix of enrollees and the performance of each MCO as reported in this report.

Comparison year over year must be taken with caution due to the changing status of RSAs with integrated MCO structure. In 2019, not all RSAs had yet implemented AH-IMC, leaving three of the RSAs with administering segregated payment for physical health and behavioral health services. As part of the transition to IMC, the number of MCOs varied in each region; this would impact the potential baseline/denominator of enrollees for a given performance measure.

Figure 5 shows enrollment by Apple Health Program. Note that the first four blue columns represent Apple Health Integrated Managed Care (AH-IMC) program with various eligibility categories. The majority of members were enrolled in the AH-IMC program, with 46.7% enrolled as Apple Health Family (traditional Medicaid) and 35.3% enrolled as Apple Health Adult (Medicaid expansion).

Figure 5. MY2020 Percent Enrollment by Apple Health Program and Eligibility Category.

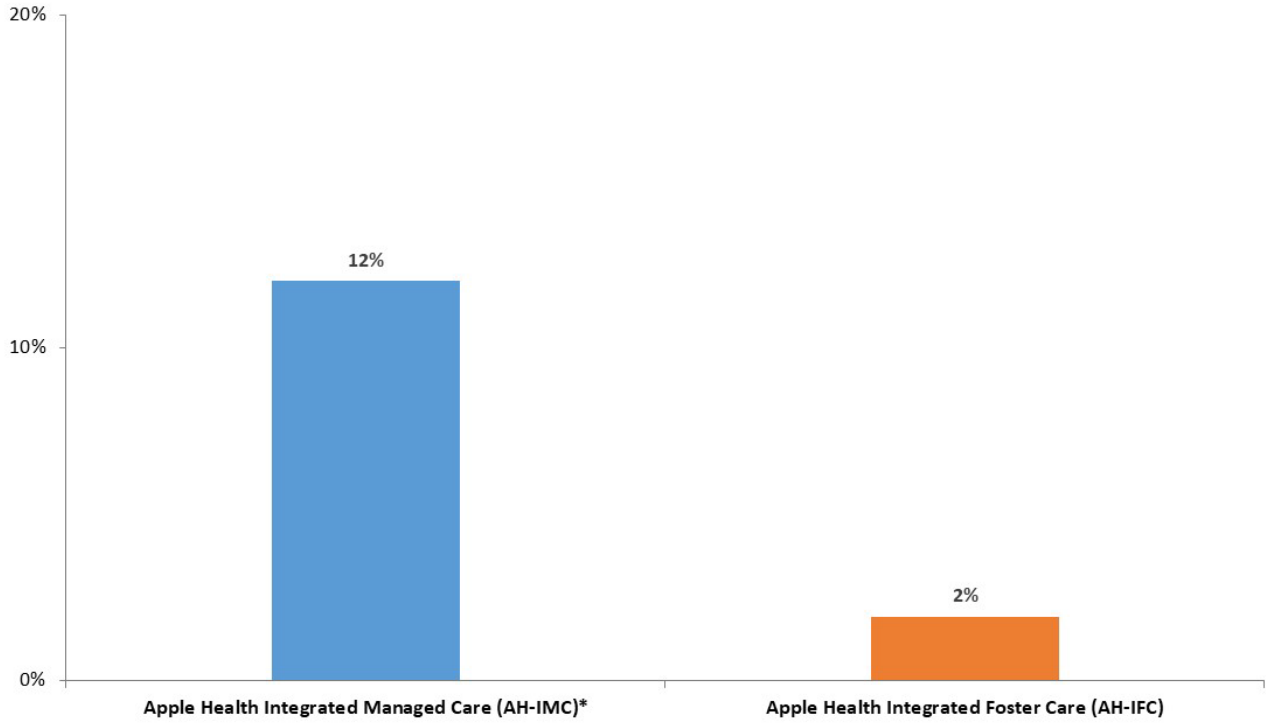


Note: The first four columns - the IMC programs - are shown in shades of blue.

There was an increase in Apple Health enrollment in calendar year 2020 (e.g., primarily due to the public health emergency). Large increases in enrollment can impact measure results as there may be an underlying shift in the demographics of the population and delays in receiving care for new members.

Figure 6 shows the growth in Apple Health enrollment by program. The overall growth between MY2019 and MY2020 was 14%. The AH-IMC and AH-IFC populations grew 12% and 2%, respectively, between MY2019 and MY2020.

Figure 6. Enrollment Growth by Program.



Demographics by Program

Medicaid enrollment demographics vary between programs and eligibility categories. This variation can affect the overall demographic mix of each MCO. It is important to consider this when comparing MCO performance by measure.

While this section of the report summarizes and compares MCO performance for certain HEDIS measures, it is crucial to recognize that the differences between the MCOs' member populations may impact MCO performance on different measures. Because of this variation, monitoring performance at both the plan level, and at the plan and program level, is important.

Age Range

Figure 7 shows the percentages of enrollment by age group and Apple Health program.

In this chart and the following, the darker blue signifies a higher percentage, while lighter blue signifies lower, with a medium gradient for those values in between. Blank, unshaded cells indicate the age group is not served by that program; for example, the State CHIP program covers only children and youth up to age 19.

Figure 7. Enrollee Population by Apple Health Program and Age Range, MY2020.

Age Range	Apple Health Adult Coverage (AH-IMC, ACA Expansion)	Apple Health Blind/Disabled (AH-IMC, AH-BD)	Apple Health Family (AH-IMC, Traditional Medicaid)	Apple Health Integrated Foster Care (AH-IFC)	State Children's Health Insurance Program (AH-IMC, CHIP)
Age 0 to 5	0.0%	3.4%	27.2%	25.8%	24.4%
Age 6 to 12		9.1%	31.5%	35.8%	40.4%
Age 13 to 20	6.3%	11.3%	25.5%	33.8%	35.2%
Age 21 to 44	61.9%	31.0%	13.6%	4.6%	
Age 45 to 64	31.6%	42.3%	2.2%		
Age 65+	0.2%	2.8%	0.0%		

% of Total Member Count

0.0% 61.9%

The average age of enrollees varies across programs and eligibility categories. Below are the age groups with greatest percentages of enrollees as seen in Figure 7:

- **Apple Health Adult (AH-IMC, Medicaid expansion)**: 61.9% of enrollees are between the ages of 21 and 44
- **Apple Health Family (AH-IMC, Traditional Medicaid)**: 84.2% of the enrollees are below the age of 21; 13.6% of enrollees are between the ages of 21 and 44, and 2.2% of the enrollees are between the ages of 45 and 64
- **State Children's Health Insurance Program (AH-IMC, CHIP):** 40.4% are children ages 6 to 12
- **Apple Health Blind/Disabled (AH-IMC, AH-BD)**: most are adults between the ages of 21 and 64
- **Apple Health Foster Care (IFC)**: most enrollees are youth and children under the age of 21; 4.6% are Foster Care alumni between the age of 21 to 44

Race and Ethnicity

The race and ethnicity data presented here was provided by the members upon their enrollment in Apple Health. The members may choose "Other" if their race is not on the list defined in Medicaid eligibility application. The member may decline to provide the information, marked as "not provided".

The shading in Figure 8 is different from similar charts in this report to better differentiate race/ethnicities other than white, which is highlighted in the darkest blue and represents the majority of individuals. Overall, the "other" and "not provided" categories were the next most common. Blacks and Asians showed the most variation in enrollment by program.

Figure 8. Statewide Apple Health Enrollees by Program and Race, MY2020.

Race	Apple Health Adult Coverage (AH-IMC, ACA Expansion)	Apple Health Blind/Disabled (AH-IMC, AH-BD)	Apple Health Family (AH-IMC, Traditional Medicaid)	Apple Health Integrated Foster Care (AH-IFC)	State Children's Health Insurance Program (AH-IMC, CHIP)
White	66.1%	68.1%	53.0%	62.4%	52.6%
Other	10.2%	8.6%	17.4%	7.1%	15.1%
Not Provided	4.5%	5.3%	10.3%	11.8%	17.4%
Black	8.3%	11.1%	9.3%	11.2%	4.5%
Asian	6.1%	3.4%	4.0%	1.1%	5.7%
American Indian/Alaska Native	1.8%	1.6%	1.8%	4.3%	1.4%
Hawaiian/Pacific Islander	3.1%	1.9%	4.2%	2.1%	3.3%

Note: These are the categories that HCA provided in Medicaid eligibility data files. The "Other" category indicates "client identified as a race other than those listed," and the "Not Provided" category is defined as "client chose not to provide."

Figure 9 shows that most Apple Health Program enrollees are not Hispanic. The Apple Health Family (Traditional Medicaid) program has the largest percentage of Hispanic enrollees at 29.6%.

Figure 9. Statewide Apple Health Enrollees by Program and Hispanic Indicator, MY2020.

Hispanic	Apple Health Adult Coverage (AH-IMC, ACA Expansion)	Apple Health Blind/Disabled (AH-IMC, AH-BD)	Apple Health Family (AH-IMC, Traditional Medicaid)	Apple Health Integrated Foster Care (AH-IFC)	State Children's Health Insurance Program (AH-IMC, CHIP)
N	84.4%	87.7%	70.4%	83.0%	74.5%
Y	15.6%	12.3%	29.6%	17.0%	25.5%

Language

Upon application for Medicaid eligibility, clients also provide information on primary spoken language. According to Apple Health eligibility data, there are approximately 85 separate spoken languages among 1.6 million members. Many of these languages have very small numbers of speakers in the Apple Health population. The top 15 most common non-English languages are listed in this report (HCA provides Apple Health-related written materials in these same 15 languages).

Figure 10 shows the variation in primary spoken language by Apple Health enrollees, reflecting the 15 most common languages. After English, Spanish/Castilian is the most common language across programs. Russian and Vietnamese are the third and fourth most common languages, depending on the program, but are still spoken by less than 1.0% of enrollees.

Figure 10. Statewide Apple Health Enrollees by Program and Spoken Language, MY2020.

Spoken Language	Apple Health Adult Coverage (AH-IMC, ACA Expansion)	Apple Health Blind/Disabled (AH-IMC, AH-BD)	Apple Health Family (AH-IMC, Traditional Medicaid)	Apple Health Integrated Foster Care (AH-IFC)	State Children's Health Insurance Program (AH-IMC, CHIP)
English	94.00%	89.74%	83.60%	91.81%	84.87%
Spanish; Castilian	3.13%	2.85%	12.83%	1.45%	12.50%
Russian	0.57%	0.51%	0.85%	0.01%	0.72%
Vietnamese	0.56%	0.30%	0.45%	0.02%	0.79%
Chinese	0.45%	0.10%	0.33%	0.02%	0.42%
Arabic	0.16%	0.46%	0.29%	0.02%	0.03%
Ukrainian	0.16%	0.13%	0.27%	0.00%	0.10%
Somali	0.14%	0.18%	0.24%	0.01%	0.01%
Korean	0.15%	0.07%	0.06%		0.15%
Amharic	0.07%	0.05%	0.11%		0.04%
Panjabi; Punjabi	0.07%	0.06%	0.06%		0.06%
Burmese	0.06%	0.03%	0.08%		0.03%
Tigrinya	0.05%	0.07%	0.09%	0.01%	0.01%
Farsi	0.06%	0.06%	0.04%		0.02%
Cambodian; Khmer	0.04%	0.07%	0.04%	0.01%	0.05%
Other Language*	0.32%	5.32%	0.67%	6.64%	0.21%

**Other Language is the sum of the 67 languages not specifically reported in this table and represents less than 1% of enrollees.*

Note: blank, unshaded cells mean that those languages were not reported by clients enrolled in that program. A 0.00% indicates that there were a small number of enrollees in that category, but the percentage is too small to report.

Measure Performance by Apple Health Program and Eligibility Categories

Comagine Health stratified the 41 measures reported in Figure 4 by Apple Health program and eligibility category to determine if there are statistically significant differences in measure results between them. Because the different programs and eligibility categories serve different populations, this analysis can serve as a proxy for determining if there are health disparities that can be addressed.

Figure 11 lists the statewide measure result by the Apple Health programs that serve adults. Note the Apple Health Integrated Foster Care program also serves adults between the ages of 18 and 26, but they are not displayed in this table because the number of eligibles is too small. Measures that are specific to the pediatric population have been removed from this view. This table reports the statewide weighted average for each measure, along with the MY2020 result for each Apple Health program. Upward arrows indicate a particular program or eligibility category performs better than the other eligibility categories. A downward arrow indicates a particular program or eligibility category performs worse than the other programs or eligibility categories.

Figure 11. Statewide Measure Results by Apple Health Program Group, Programs that Serve Adults.

↓ ↑ Statistically significant difference from other programs.

		Statewide Weighted Rate	Apple Health Adult Coverage (ACA Expansion)	Apple Health Blind Disabled Adult (BD Adult)	Apple Health Family (Adults)
Access/Availability of Care	Adults' Access to Preventive/Ambulatory Health Services (AAP), Total	73%	70% ↓	82%	78%
	I&E of AOD Dependence Treatment (IET): Total Engagement in Treatment: Total	16%	16% ↑	10% ↓	18% ↑
	I&E of AOD Dependence Treatment (IET): Total Initiation of Treatment: Total	45%	46% ↑	44% ↓	48% ↑
	Prenatal and Postpartum Care (PPC), Postpartum Care	77%	80% ↑	***	73% ↓
	Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care	83%	84%	***	80% ↓
Behavioral Health	Antidepressant Medication Management (AMM), Continuation Phase	43%	43% ↑	42%	40% ↓
	Antidepressant Medication Management (AMM), Effective Acute Phase	58%	59% ↑	56% ↓	57% ↓
	Follow-Up After ED Visit for AOD Dependency (FUA), 30-day, Total	29%	29% ↑	25% ↓	34% ↑
	Follow-Up After ED Visit for AOD Dependency (FUA), 7-day, Total	19%	19% ↑	16% ↓	22% ↑
	Follow-Up After ED Visit for Mental Illness (FUM), 30-day, Total	58%	51% ↓	60% ↑	51% ↓
	Follow-Up After ED Visit for Mental Illness (FUM), 7-day, Total	45%	39% ↓	46%	40% ↓
	Follow-Up After High Intensity Care for SUD (FUI), 30-day, Total	58%	57%	55%	61% ↑
	Follow-Up After High Intensity Care for SUD (FUI), 7-day, Total	38%	38%	33% ↓	42% ↑
	Follow-Up after Hospitalization for Mental Illness (FUH), 30-Day Follow-Up, Total	57%	51% ↓	59% ↑	56%
	Follow-Up after Hospitalization for Mental Illness (FUH), 7-Day Follow-Up, Total	40%	35% ↓	42% ↑	39%
	Pharmacotherapy for Opioid Use Disorder (POD): Total	19%	18% ↓	24% ↑	23% ↑
Cardiovascular Conditions	Controlling High Blood Pressure (CBP)	59%	57% ↓	64% ↑	59%
Diabetes	Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0%	52%	50%	49%	50%
	Comprehensive Diabetes Care (CDC), Poor HbA1c Control (lower is better)	37%	38%	39%	40%
Overuse/Appropriateness	Use of Opioids at High Dosage (HDO) (lower is better)	6%	5% ↑	9% ↓	4% ↑
Prevention and Screening	Breast Cancer Screening (BCS)	48%	49% ↑	43% ↓	45% ↓
	Cervical Cancer Screening (CCS)	59%	53%	44% ↓	62% ↑
	Chlamydia Screening (CHL), Total	50%	53% ↑	33% ↓	59% ↑
Respiratory Conditions	Asthma Medication Ratio (AMR), Total	62%	59% ↓	54% ↓	54% ↓

Figure 11 shows there was a lot of variation between the program groups for the various measures, although no real discernible pattern emerged. The results for the Apple Health Blind/Disabled eligibility category was statistically significantly below the other program and eligibility categories.

Figure 12 lists the statewide measure result by the Apple Health programs that serve children. The Apple Health Integrated Foster Care program does include adults age 18 to 26, but the small numbers of these enrollees does not materially skew these results. Measures that are specific to the adult population have been removed from this view.

Similar to the results displayed for the program groups that serve adults, there is a lot of variation between the programs and eligibility categories for the various measures, although no discernible pattern emerges.

Figure 12. Statewide Measure Results by Apple Health Program Group, Programs that Serve Children.

↓ ↑ Statistically significant difference from other programs.

		Statewide Weighted Rate	Apple Health Blind Disabled Child (BD Child)	Apple Health Family (Children)	Apple Health Family (SCHIP)	Apple Health Foster Care (IFC)
Access/Availability of Care	I&E of AOD Dependence Treatment (IET): Total Initiation of Treatment: 13-17 yrs	36%	36%	34%	36%	41%
	I&E of AOD Dependence Treatment (IET): Total Initiation of Treatment: Total	45%	36%	33%	37%	36% ↓
	I&E of AOD Dependence Treatment (IET): Total Engagement in Treatment: Total	16%	9%	9%	16%	14%
	Use of First-Line Psychosocial Care for Children and Adolsecents (APP), Total	61%	51% ↓	61%	65%	67%
Behavioral Health	Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	45%	43%	44%	49%	49%
	Follow-Up Care for Children Prescribed ADHD Medication (ADD), Continuation	52%	44% ↓	53%	52%	52%
	Follow-Up after Hospitalization for Mental Illness (FUH), 30-Day Follow-Up, Total	57%	78% ↑	74%	76% ↑	70% ↑
	Follow-Up after Hospitalization for Mental Illness (FUH), 7-Day Follow-Up, Total	40%	61% ↑	54%	62% ↑	50% ↑
	Follow-Up After ED Visit for Mental Illness (FUM), 30-day, Total	58%	75% ↑	71%	78% ↑	73% ↑
	Follow-Up After ED Visit for Mental Illness (FUM), 7-day, Total	45%	55% ↑	57%	60% ↑	58% ↑
	Follow-Up After ED Visit for AOD Dependency (FUA), 30-day, 13-17 years	17%	***	16%	18%	15%
	Follow-Up After ED Visit for AOD Dependency (FUA), 30-day, Total	29%	***	14%	15%	13% ↓
	Follow-Up After ED Visit for AOD Dependency (FUA), 7-day, Total	19%	***	9%	7%	9% ↓
	Follow-Up After High Intensity Care for SUD (FUI), 30-day, Total	58%	***	35%	***	***
	Follow-Up After High Intensity Care for SUD (FUI), 7-day, Total	38%	***	26%	***	***
	Pharmacotherapy for Opioid Use Disorder (POD): Total	19%	NR	***	***	***
Prevention and Screening	Childhood Immunization Status (CIS), Combo 2	68%	73% ↑	64%	70% ↑	82% ↑
	Childhood Immunization Status (CIS), Combo 10	42%	39%	37%	46% ↑	52% ↑
	Immunizations for Adolescents (IMA), Combo 2	40%	35%	40%	37%	34%
	Lead Screening in Children (LSC)	34%	***	33%	34%	31%
	Chlamydia Screening (CHL), Total	50%	28% ↓	41%	33% ↓	52%
Respiratory Conditions	Asthma Medication Ratio (AMR), Total	62%	75% ↑	68%	80% ↑	73% ↑
Utilization	Well-Child Visits in the First 30 Months of Life (W30), 0-15 Months	54%	23% ↓	54%	50% ↓	67% ↑
	Well-Child Visits in the First 30 Months of Life (W30), 16-30 Months	68%	74% ↑	67%	79% ↑	85% ↑
	Child and Adolescent Well-Care Visit (WCV), Age 3-11	47%	48% ↑	46%	53% ↑	56% ↑
	Child and Adolescent Well-Care Visit (WCV), Age 12-17	35%	36% ↑	33%	40% ↑	41% ↑
	Child and Adolescent Well-Care Visit (WCV), Age 18-21	18%	NR	21%	25% ↑	17%
	Child and Adolescent Well-Care Visit (WCV), Total	39%	42% ↑	40%	46% ↑	46% ↑

Value-Based Purchasing (VBP) Quality Measure Performance

Starting in May 2019, Washington State ESHB 1109 required the Washington HCA's contracted EQRO to analyze annually the performance of Apple Health MCOs providing services to Medicaid clients. Specifically, MCOs will be assessed on a set of seven performance measures, including four shared measures reported by all plans and three specific to each of the five MCOs. The following year, HCA will evaluate the MCOs on their performance on these assigned measures and reimburse them according to their achievement level. Additionally, HCA uses the VBP performance measure evaluation as part of the evaluation of effectiveness for the Washington State Medicaid Quality Strategy.

The shared measures must be weighted toward having the potential to impact managed care costs and population health. Plan-specific measures must be chosen from the Washington Statewide Common Measure Set, reflect areas where a managed care organization has shown poor performance, and be substantive and clinically meaningful in promoting health status.

HCA contracted with Comagine Health to assess MCO performance on the measures reported by each plan and to recommend a set of priority measures that meets the bill's specific criteria and best reflects the state's quality and value priorities — balancing cost and utilization — while ensuring quality care to clients. HCA then selected the final measure set and included the measures as VBP performance measures in the MCO contracts.

The measures included in this section of the report are the VBP performance measures included in the contracts for the 2020 performance period. HCA has also contracted with Comagine Health for the evaluation of measure performance; this was submitted to HCA as a separate deliverable in October 2021. Note that there are no charts for measures that were retired by NCQA in MY2020:

- **Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34):** This was a plan-specific measure for all IMC contracts. This measure was replaced with the Child and Adolescent Well-Care Visit (WCV), Age 3-11.
- **Comprehensive Diabetes Care (CDC), Medical Attention for Nephropathy:** This was a plan-specific VBP measure for AMG.
- **Children's Access to Primary Care Practitioners (CAP), 7-11 Years**: This was a VBP measure for the IFC contract.

The following charts (Figures 13–27) show the three-year trend (MY2018 through MY2020) in performance for these measures by MCO, compared to the statewide average for each measure. In these charts:

- The thick vertical gray line shows the statewide average for each measure.
- The arrows indicate statistically significant changes in the year-over-year performance of the measures (blue arrows indicate increases while red and yellow indicate decreases; see keys with each chart for more).
- Light gray circles show the MY2018 rate for each MCO, dark gray circles show the MY2019 rate, and green circles indicate the MY2020 RY.
- Additional information on measure performance is bulleted to the left of the charts.

Note that while comparisons to national benchmarks are mentioned in the text, these benchmarks are not included on the charts due to NCQA licensing terms regarding displaying national benchmarks (see Methodology section for further explanation).

Antidepressant Medication Management (AMM), Effective Acute Phase

- AMM is a shared VBP measure for the IMC contracts.
- The MY2020 statewide average is above the national 50th percentile benchmark but below the 75th percentile. There have been two years of statistically significant statewide improvement between MY2018 and MY2019, and MY2019 and MY2020.
- AMG's MY2020 rate is above the national 50th percentile benchmark but below the 75th percentile. There has been no notable year-over-year improvement in rates.
- CCW's MY2020 rate is above the national 50th percentile benchmark but below the 75th percentile. There were no notable year-over-year improvements.
- CHPW's MY2020 rate is at the national 50th percentile. There was a statistically significant improvement between MY2018 and MY2019, but no notable improvement between MY2019 and MY2020.
- MHW's MY2020 rate is above the national 50th percentile benchmark, but below the 75th percentile. There have been two years of statistically significant improvement between MY2018 and MY2019, and MY2019 and MY2020.
- UHC's MY2020 rate is at the national 50th percentile. There was a statistically significant improvement between MY2019 and MY2020.

Figure 13. AMM, Effective Acute Phase.

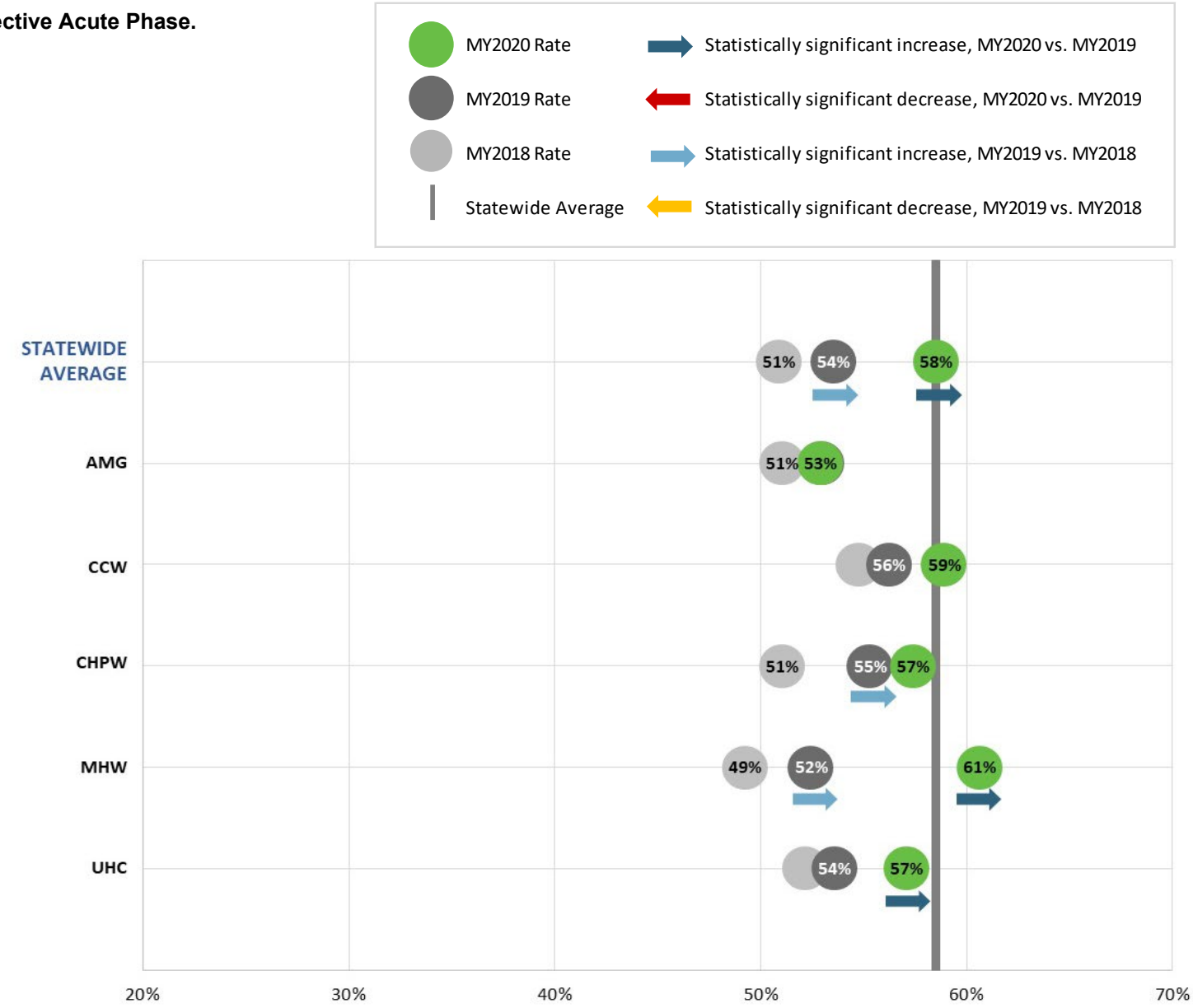


Figure 14. Antidepressant Medication Management (AMM), Continuation Phase.

- AMM is a shared VBP measure for the IMC contracts.
- The MY2020 statewide average is above the national 50th percentile benchmark but below the 75th percentile. There have been two years of statistically significant statewide improvement, between both MY2018 and MY2019, and MY2019 and MY2020.
- AMG's MY2020 rate is below the national 50th percentile. There was a statistically significant improvement between MY2018 and MY2019, but no notable improvement between MY2019 and MY2020.
- The following MCOs' MY2020 rates were above the 50th percentile, but below the 75th percentile: CCW, CHPW, MHW and UHC.
- CHPW had a statistically significant improvement between MY2018 and MY2019.
- MHW had two years of statistically significant statewide improvement.
- UHC had a statistically significant improvement between MY2019 and MY2020.

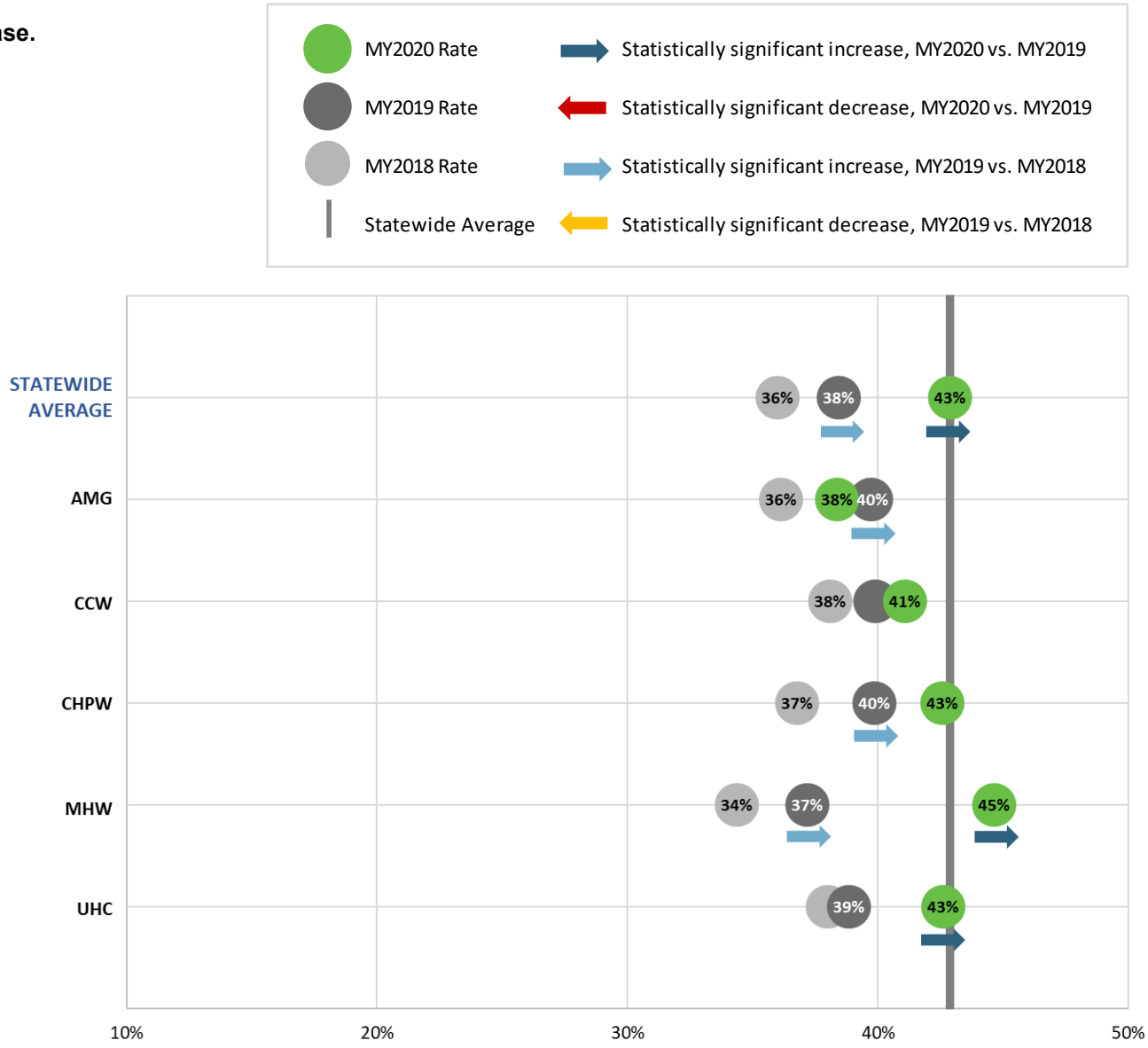


Figure 15. Asthma Medication Ratio (AMR), Total.

- AMR Total (all ages) is a shared VBP measure for the IMC program.
- The MY2020 statewide average is below the national 50th percentile benchmark. This is also true for all of the MCOs except CHPW, where the MY2020 rate is at the national 50th percentile benchmark.
- There have been two years of statistically significant statewide improvement, both between MY2018 and MY2019, and MY2019 and MY2020.
- There was a statistically significant improvement for MY2019 and MY2020 rates for all of the MCOs except UHC.
- The MY2020 rate for CHPW improved by a statistically significant amount between MY2018 and MY2019.

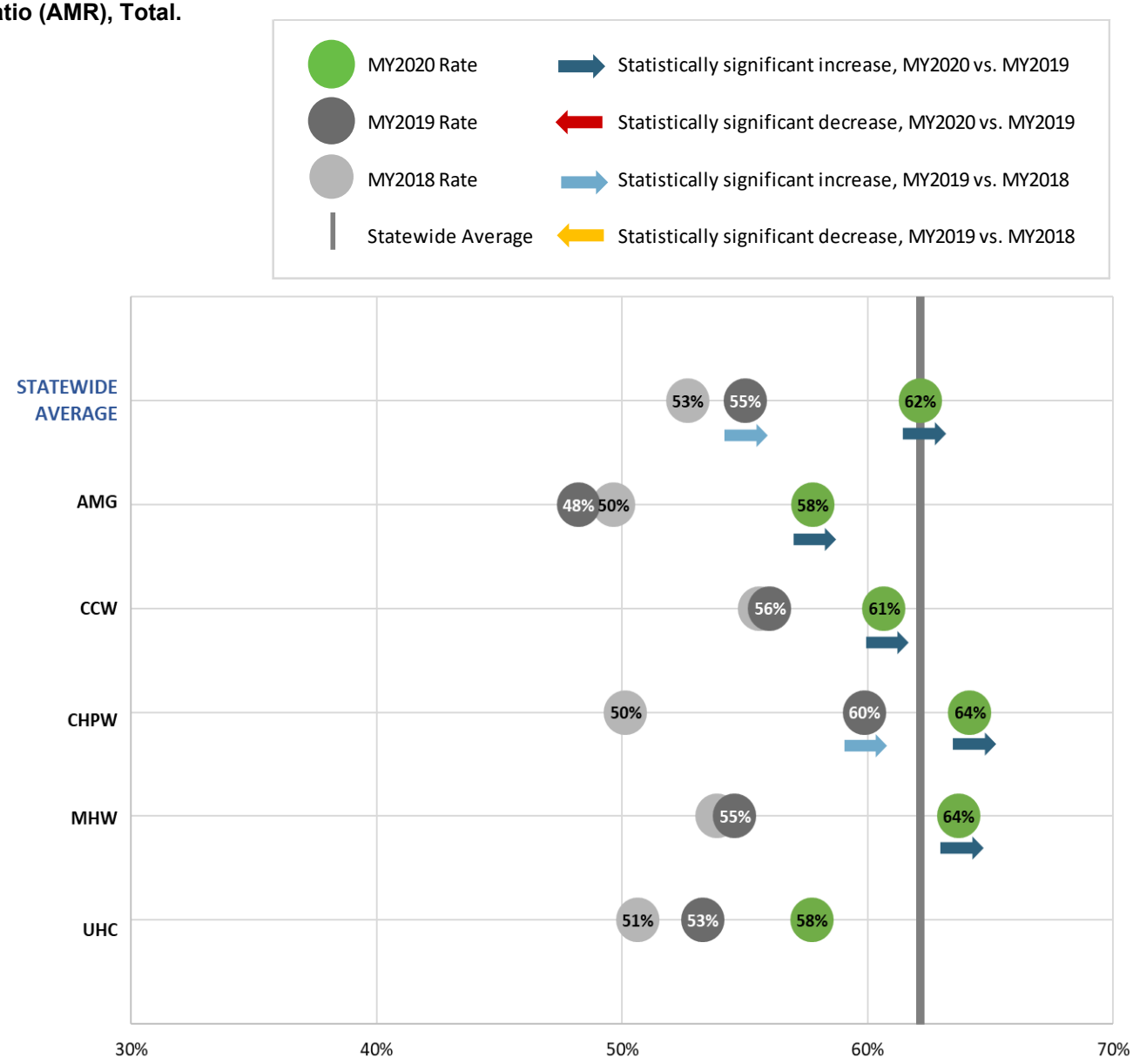


Figure 16. Mental Health Treatment Penetration (MH-B), Ages 6 to 64 Years.

- MH-B for ages 6 to 64 years is a shared VBP measure for the IMC contracts.
- There are no national benchmarks for the state-created measures. For the purposes of the IMC contract, HCA has established a benchmark that is the rate for the second-highest performing MCO in MY2019.
- The MY2020 statewide average is below the benchmark. This is also true for all of the MCOs except CCW, which had a MY2020 rate at the 50th benchmark.
- The statewide average had a statistically significant decline between MY2019 and MY2020.
- AMG had a statistically significant decline between MY2018 and MY2019, and between MY2019 and MY2020.
- CCW had a statistically significant improvement between MY2018 and MY2019.
- CHPW and MHW had statistically significant increases in their rates between MY2018 and MY2019, and between MY2019 and MY2020.

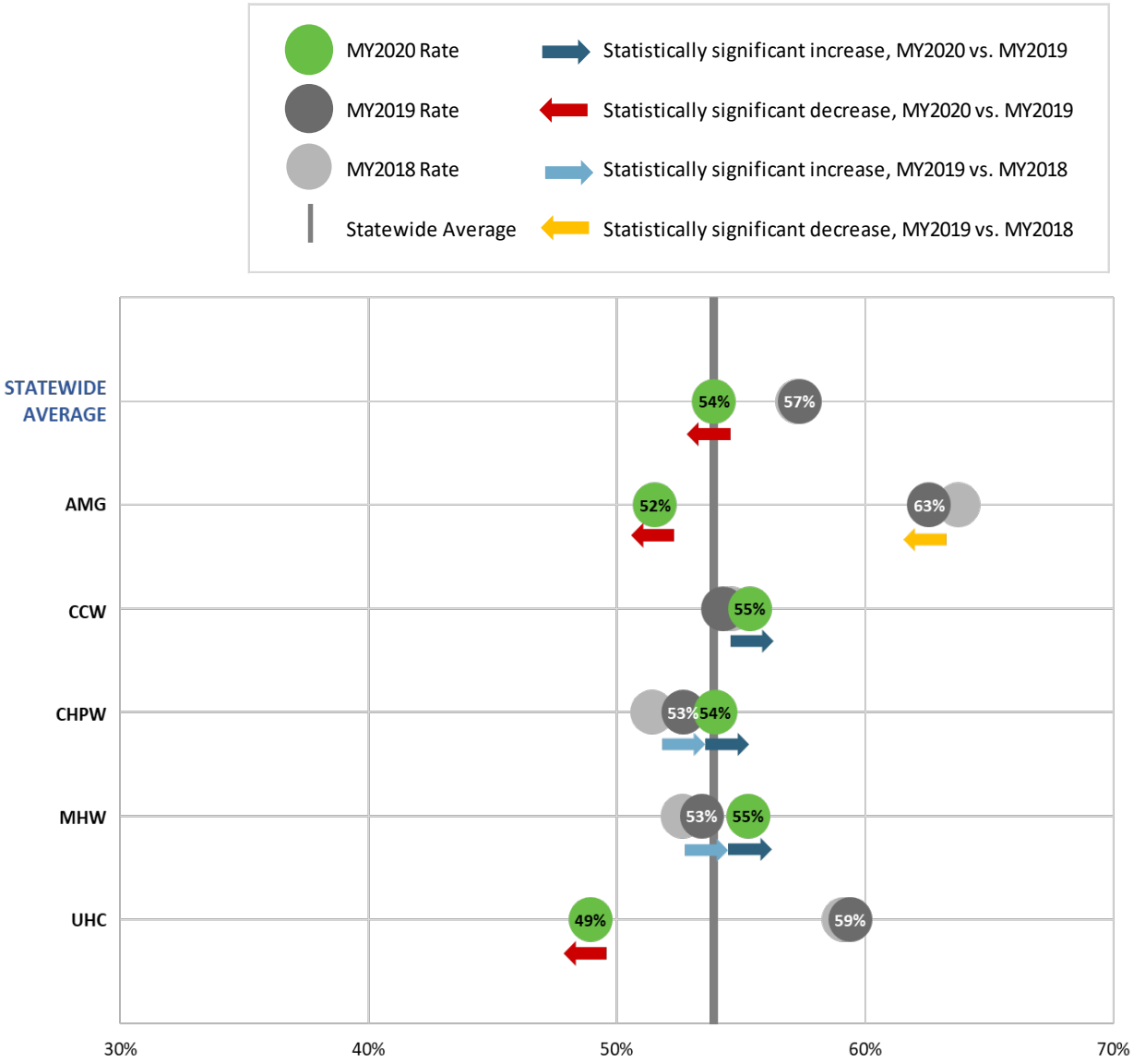


Figure 17. Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care.

- PPC is a shared VBP measure for the IMC contracts.
- The MY2020 statewide average is below the national 50th percentile benchmark. There has been no notable year-over-year improvement in rates.
- AMG's MY2020 rate is below the national 50th percentile benchmark. There has been no notable year-over-year improvement in rates.
- CCW's MY2020 rate is below the national 50th percentile. There has been no notable year-over-year improvement in rates.
- CHPW's MY2020 rate is at the national 50th percentile. There was a statistically significant improvement between MY2019 and MY2020.
- MHW's MY2020 rate is below the national 50th percentile. There was a statistically significant decline between MY2019 and MY2020.
- UHC's MY2020 rate is at the national 50th percentile. There has been no notable year-over-year improvement in rates.

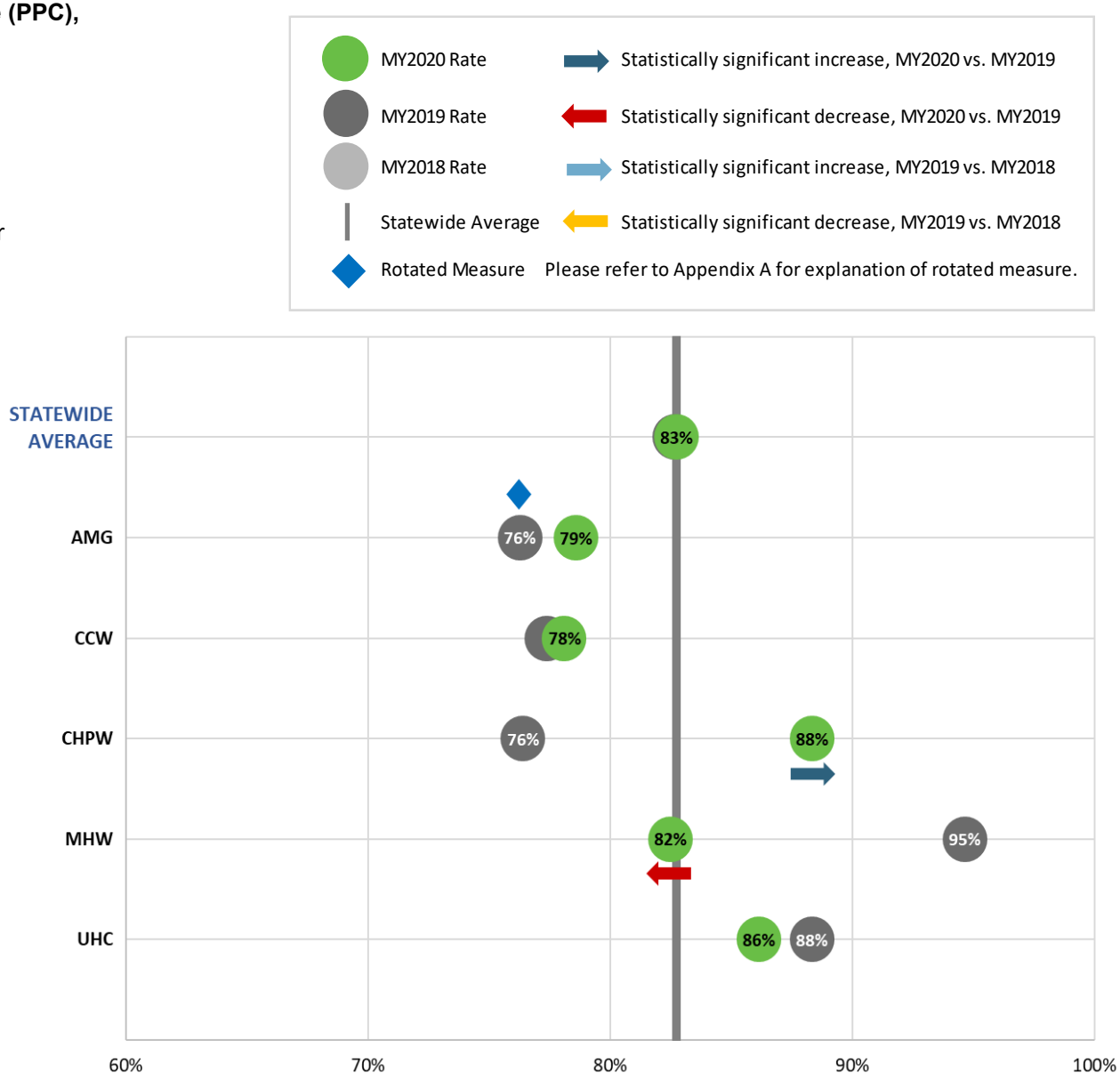


Figure 18. Prenatal and Postpartum Care (PPC), Postpartum Care.

- PPC is a shared VBP measure for the IMC contracts.
- The MY2020 statewide average is at the national 50th percentile benchmark. There was a statistically significant improvement between MY2019 and MY2020.
- AMG's MY2020 rate is below the national 50th percentile benchmark. There was a statistically significant improvement between MY2019 and MY2020.
- CCW's MY2020 rate is at the national 50th percentile benchmark. There has been no notable year-over-year improvement in rates.
- CHPW's MY2020 rate is at the national 75th percentile. There has been no notable year-over-year improvement in rates.
- MHW's MY2020 rate is at the national 50th percentile. There has been no notable year-over-year improvement in rates.
- UHC's MY2020 rate is at the national 50th percentile. There has been no notable year-over-year improvement in rates.

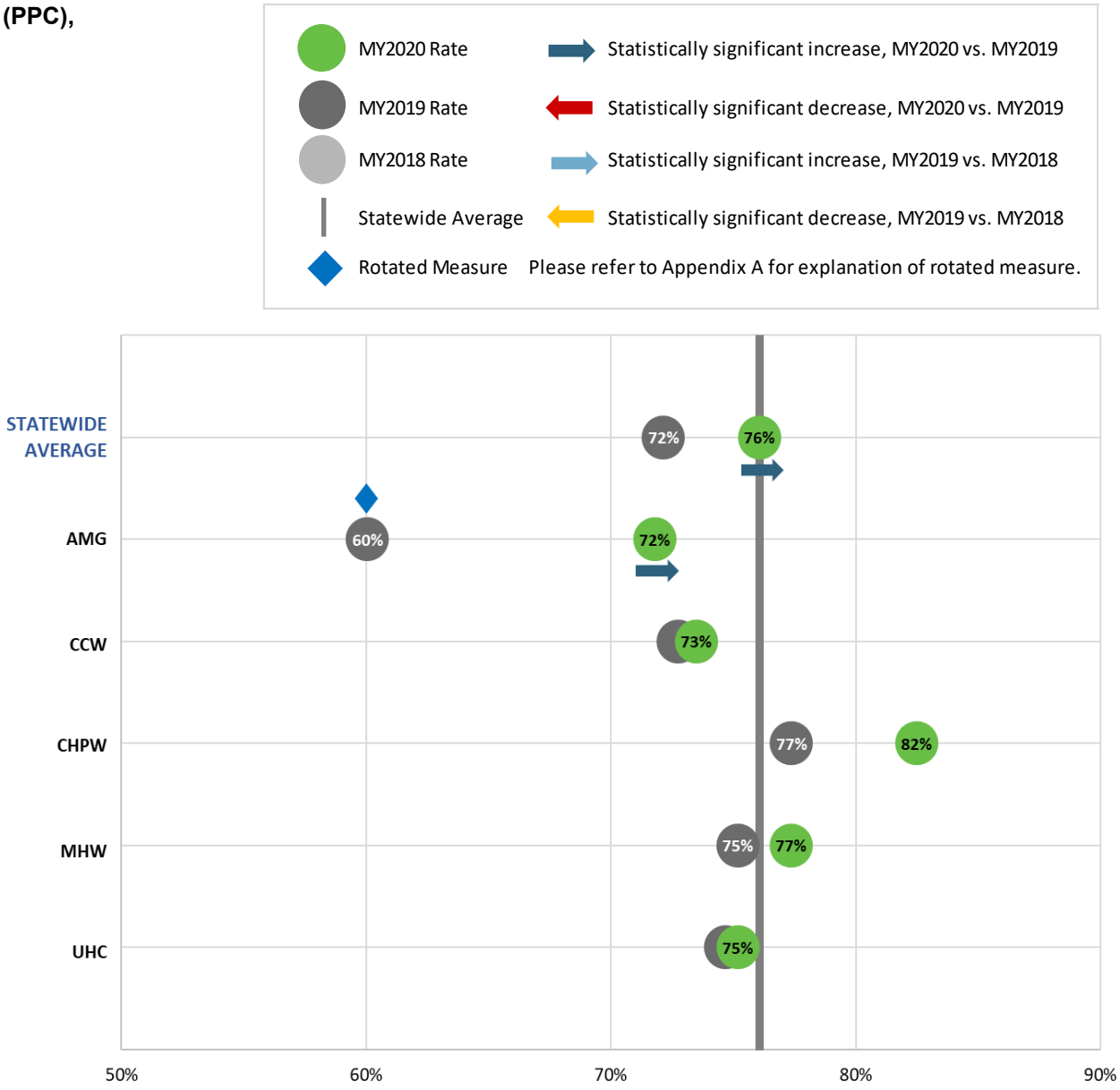
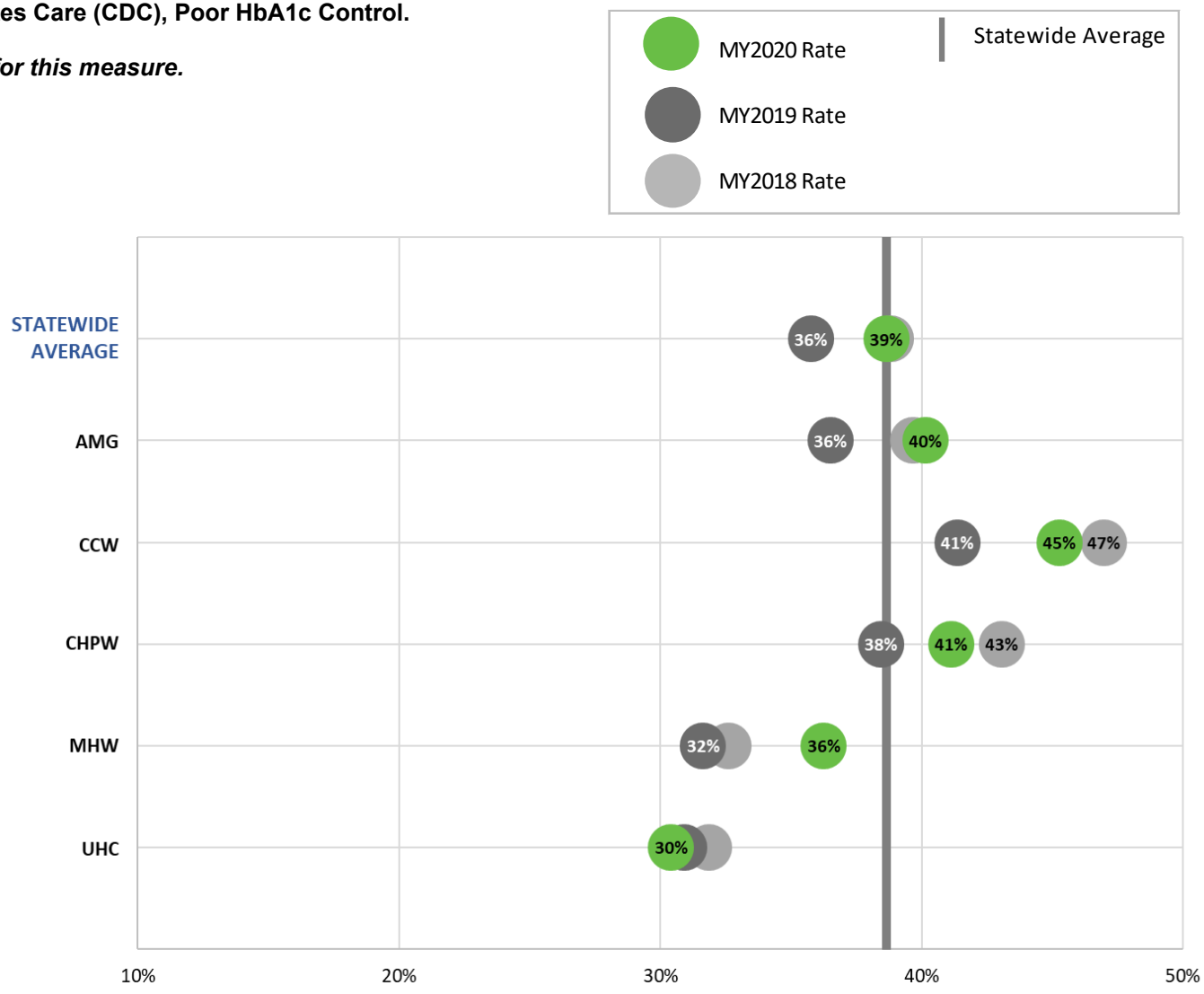


Figure 19. Comprehensive Diabetes Care (CDC), Poor HbA1c Control.

Note that a lower score is better for this measure.

- This is a plan-specific VBP measure for MHW and UHC.
- The MY2020 statewide average is above the national 75th percentile benchmark. This is true of the MY2020 rates for all of the MCOs except CCW, where the MY2020 rate was above the national 50th percentile benchmark but below the 75th percentile.
- There has been no notable year-over-year improvement in rates.



** Note a lower rate is better for this measure.*

Figure 20. Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation.

- This is a plan-specific VBP measure for CCW and CHPW.
- The statewide average is below the national 50th percentile benchmark. This is true of the MY2020 rates for all of the MCOs.
- There was a statistically significant improvement betwee MY2019 and MY2020 for AMG, CCW and UHC.
- There was no notable year-over year improvement in the statewide average.
- There was no notable improvement in the rates for CHPW and MHW.

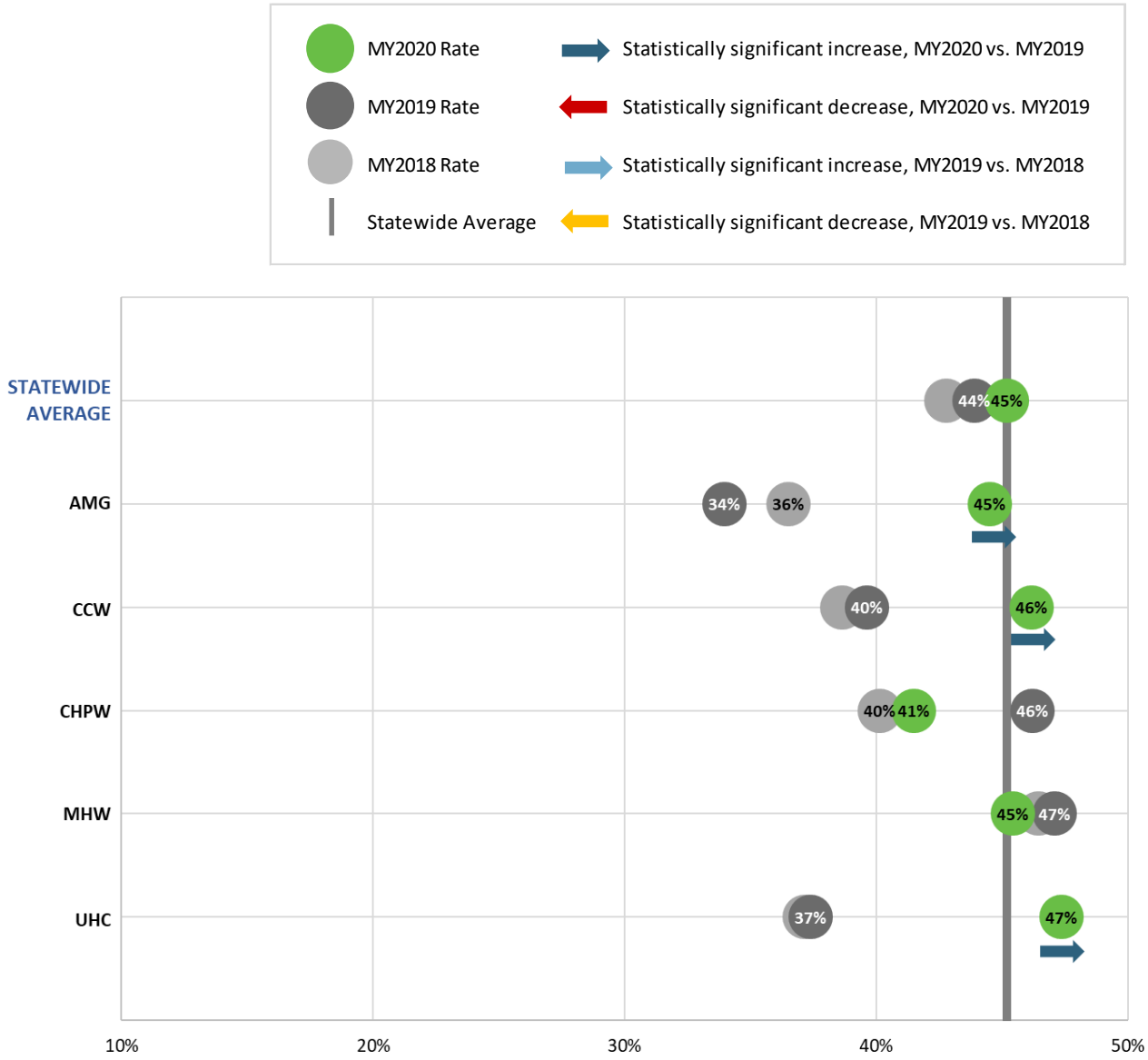


Figure 21. Substance Use Disorder Treatment Penetration (SUD), 12-64 Years.

- This is a plan-specific VBP measure for all IMC contracts
- There are no national benchmarks for state-created measures. For the purposes of the IMC contract, HCA has established a benchmark that is the rate for the second-highest performing MCO in MY2019.
- The MY2020 statewide average is at the benchmark. There have been two years of statistically significant statewide improvement, both between MY2018 and MY2019, and MY2019 and MY2020.
- AMG's MY2020 rate is at the benchmark. AMG had two years of statistically significant statewide improvement, both between MY2018 and MY2019, and MY2019 and MY2020.
- CCW's MY2020 rate is below the benchmark. There was a statistically significant improvement between MY2018 and MY2019, but not between MY2019 and MY2020.
- CHPW, MHW and UHC had MY2020 rates above the benchmark. CHPW and MHW had statistically significant changes between MY2018 and 2019; UHC had statistically significant improvement between MY2019 and MY2020.

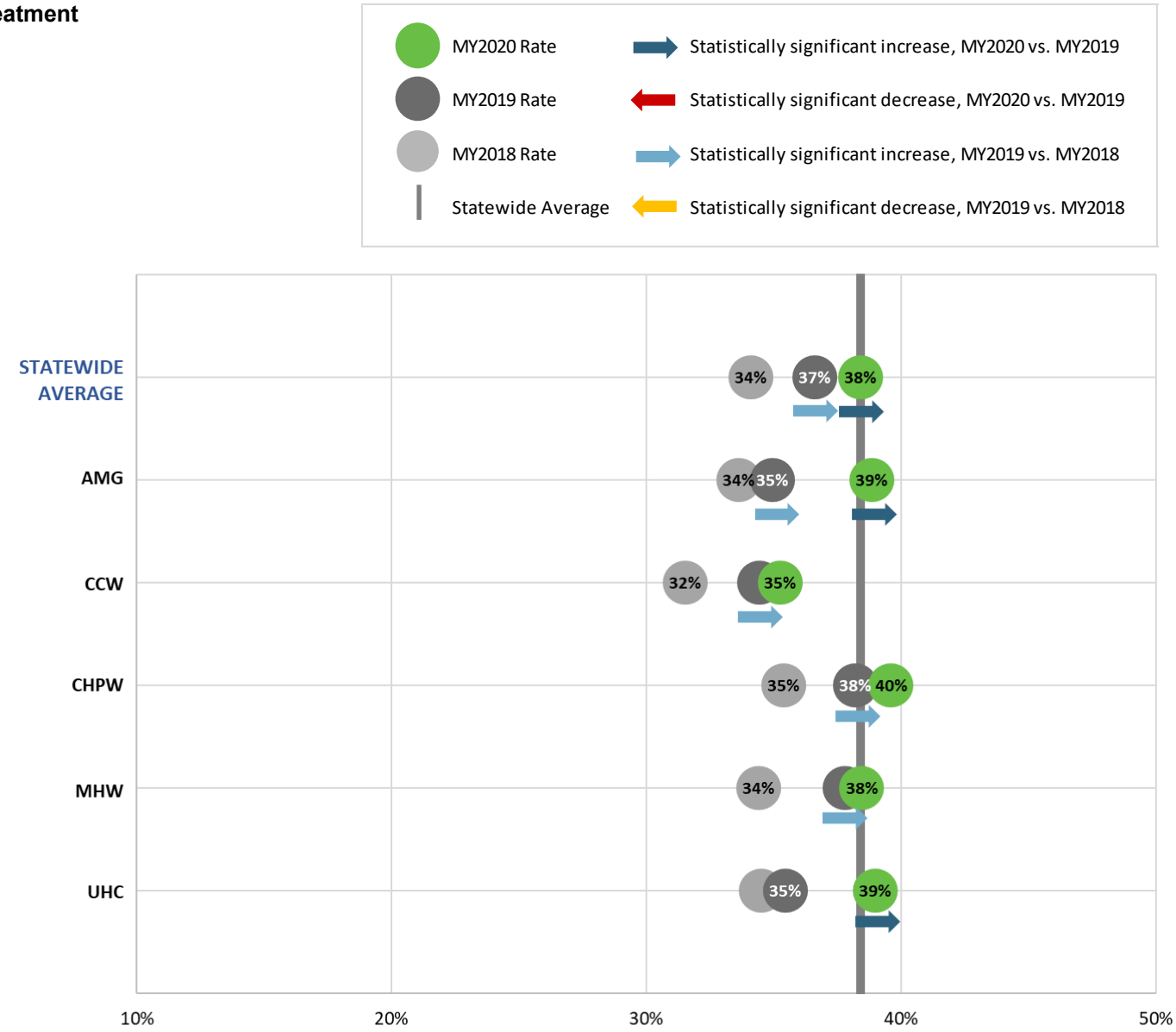


Figure 22. Child and Adolescent Well-Care Visit (WCV), Age 3-11.

- This is a plan-specific VBP measure for all IMC contracts.
- The MY2020 statewide average is below the national 50th percentile benchmark. This is true of the MY2020 rates for all of the MCOs.
- This is a new measure replacing Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34), retired by NCQA in MY2020. There were significant changes in the measure specifications which does not allow for year-over-year comparison.

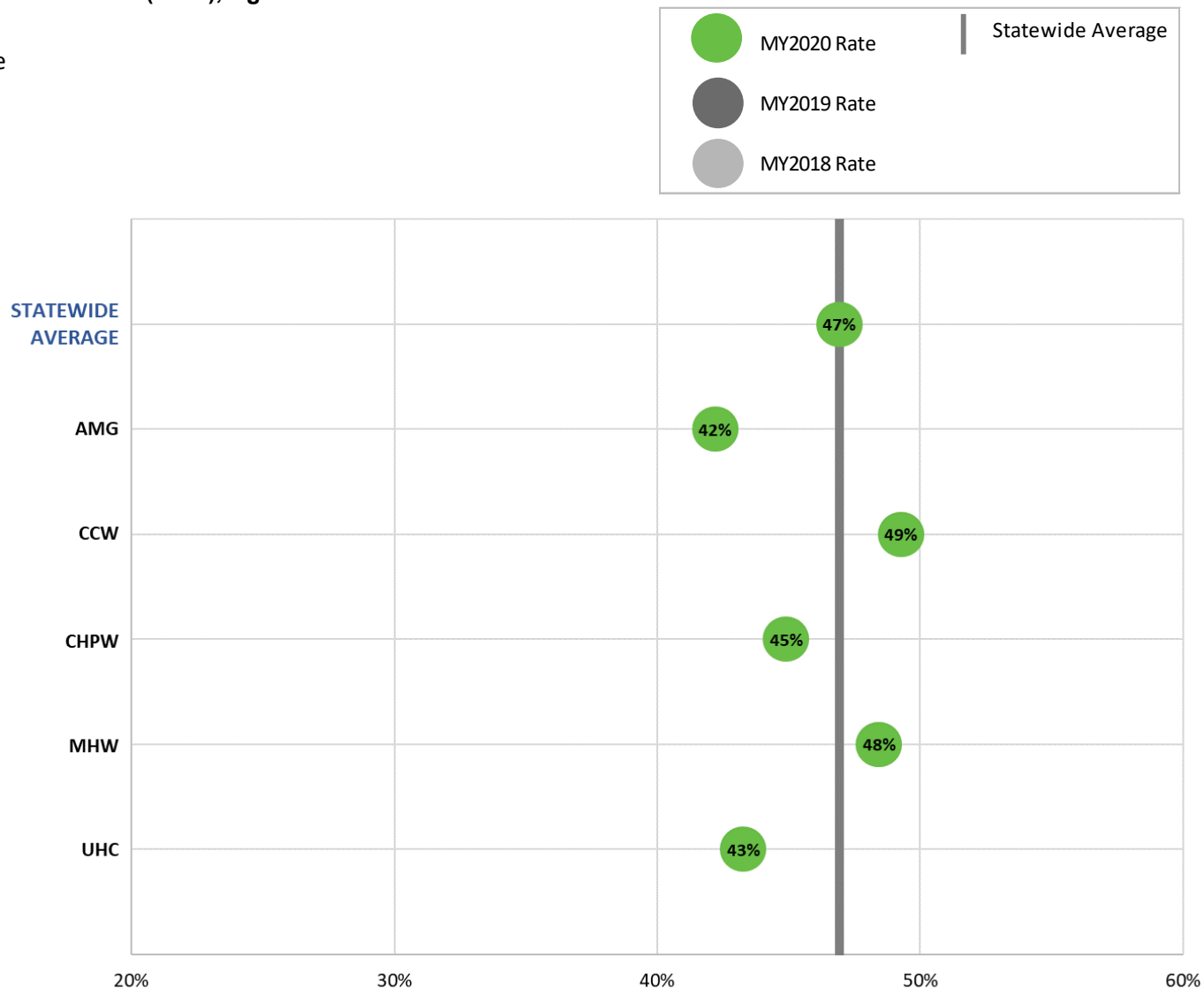


Figure 23. Mental Health Treatment Penetration (MH-B), 6-26 Years.

- This is a VBP measure for the IFC contract.
- There are no national benchmarks for state-created measures. For the purposes of the IMC contract, HCA has established a benchmark that is the rate for the second-highest performing MCO in MY2019.
- The statewide average for this chart is the total population for Apple Health enrollees who are between 6 and 26 years of age. The rates displayed for CCW are specific to the IFC enrollees; CCW is contracted to manage the foster care population.
- The MY2020 statewide average is below the benchmark. There has been a statistically significant decline between both MY2018 and MY2019, and MY2019 and MY2020.
- The rates for the CCW Foster Care population are well above the statewide average, and the MY2020 rate exceeds the benchmark. There was a statistically significant decline between MY2018 and MY2019.

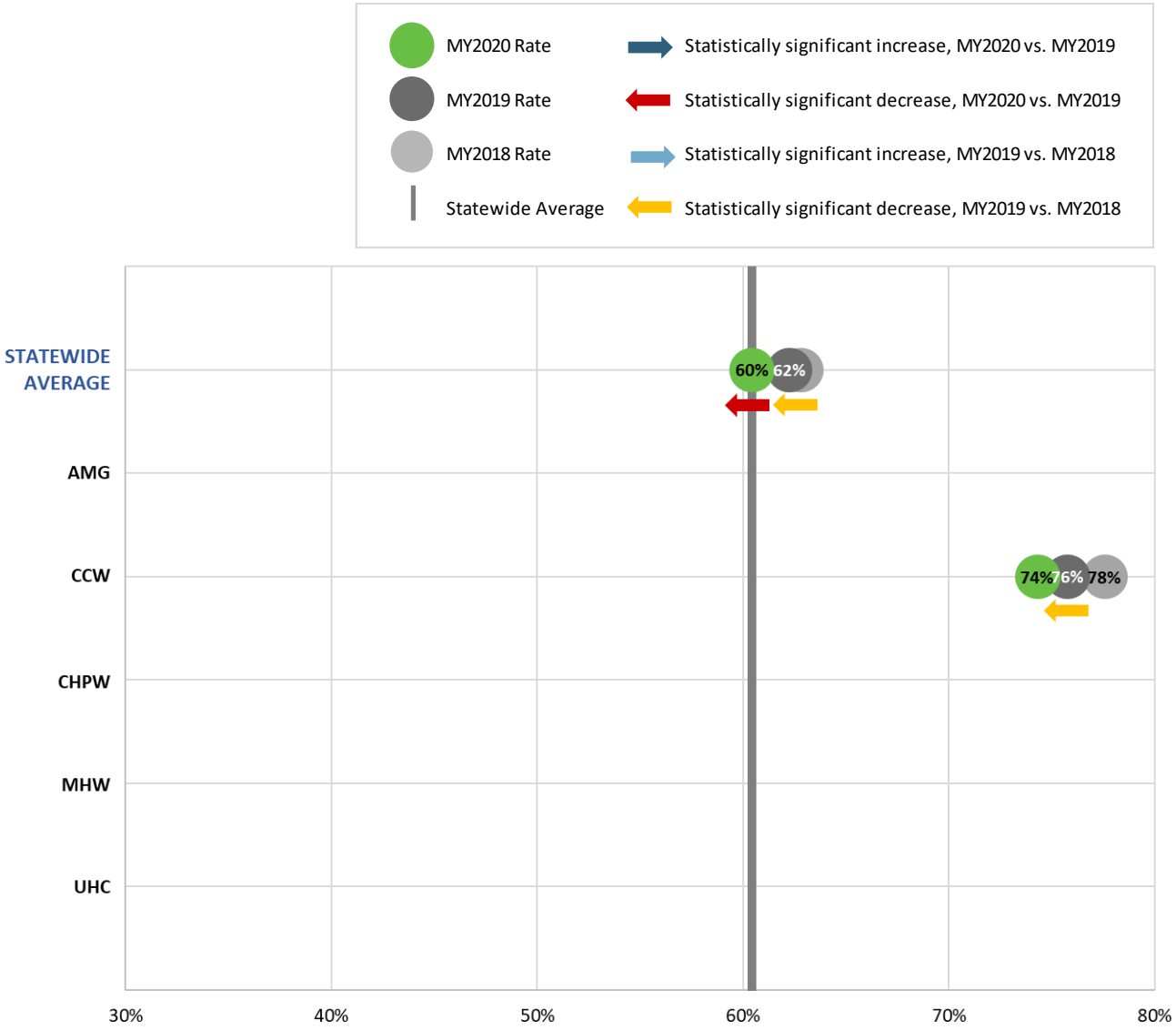


Figure 24. Substance Use Disorder Treatment Penetration (SUD), 12-26 Years.

- This is a VBP measure for the IFC contract. This chart includes data specific to the Foster Care program.
- There are no national benchmarks for state-created measures For the purposes of the IMC contract, HCA has established a benchmark that is the rate for the second-highest performing MCO in MY2019.
- The statewide average for this chart is the total population for Apple Health enrollees who are between 12 and 26 years of age. The rates displayed for CCW are specific to the IFC enrollees; CCW is contracted to manage the foster care population.
- The MY2020 statewide average is below the benchmark. There has been a statistically significant decline between MY2019 and MY2020.
- The MY2020 rate for the CCW Foster Care population is below the benchmark. There was a statistically significant decline between MY2019 and MY2020.

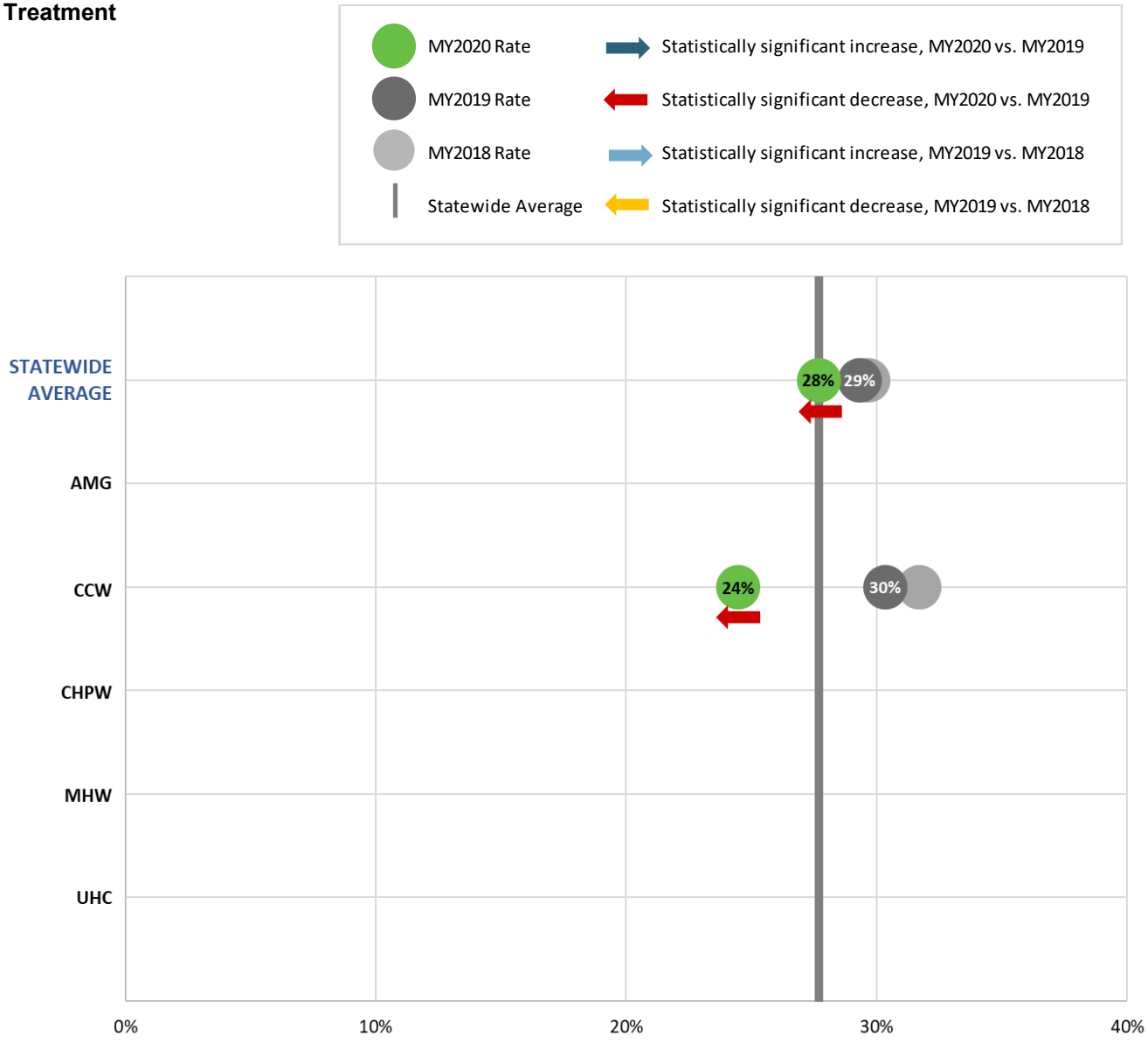


Figure 25. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), Total.

- This is a VBP measure for the IFC contracts.
- The MY2020 statewide average is at the national 50th percentile benchmark. There was a statistically significant improvement between MY2018 and MY2019.
- AMG's MY2020 rate is below the national 50th percentile. It had statistically significant improvement between MY2018 and MY2019, but not between MY2019 and MY2020.
- CCW and CHPW had MY2020 rates at the national 50th percentile. Both had statistically significant improvement between MY2018 and MY2019, but not between MY2019 and MY2020.
- MHW's MY2020 rate is at the national 50th percentile.
- UHC's MY2020 rate is below the national 50th percentile. It had a statistically significant improvement between MY2018 and MY2019, but not between MY2019 and MY2020.

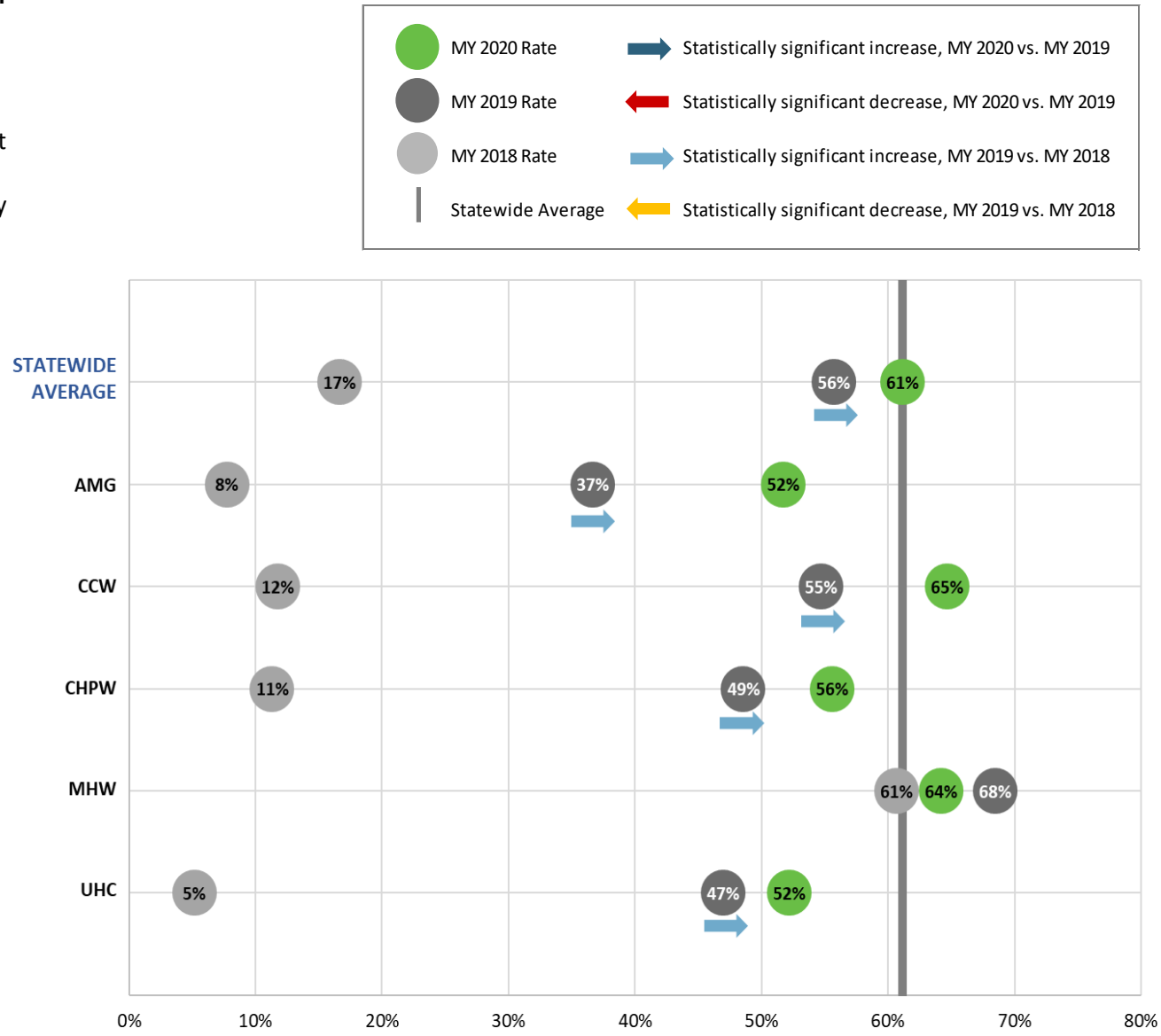


Figure 26. Child and Adolescent Well-Care Visit (WCV), Age 12-17.

- This is a VBP measure for the IFC contracts.
- The MY2020 statewide average is below the national 50th percentile benchmark. This is true of the MY2020 rates for all of the MCOs.
- This measure was new in MY2020, so there are no year-over-year comparisons.

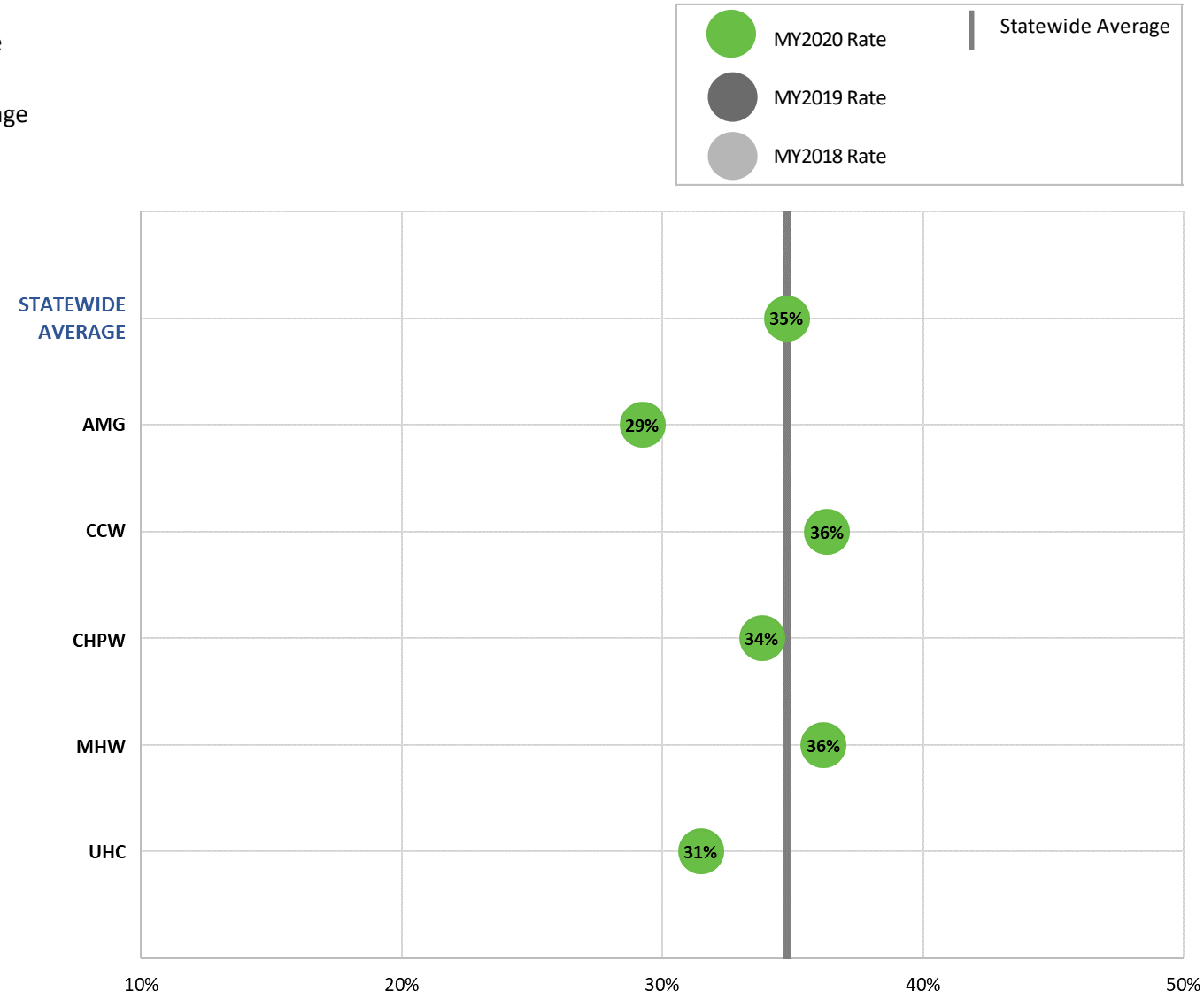
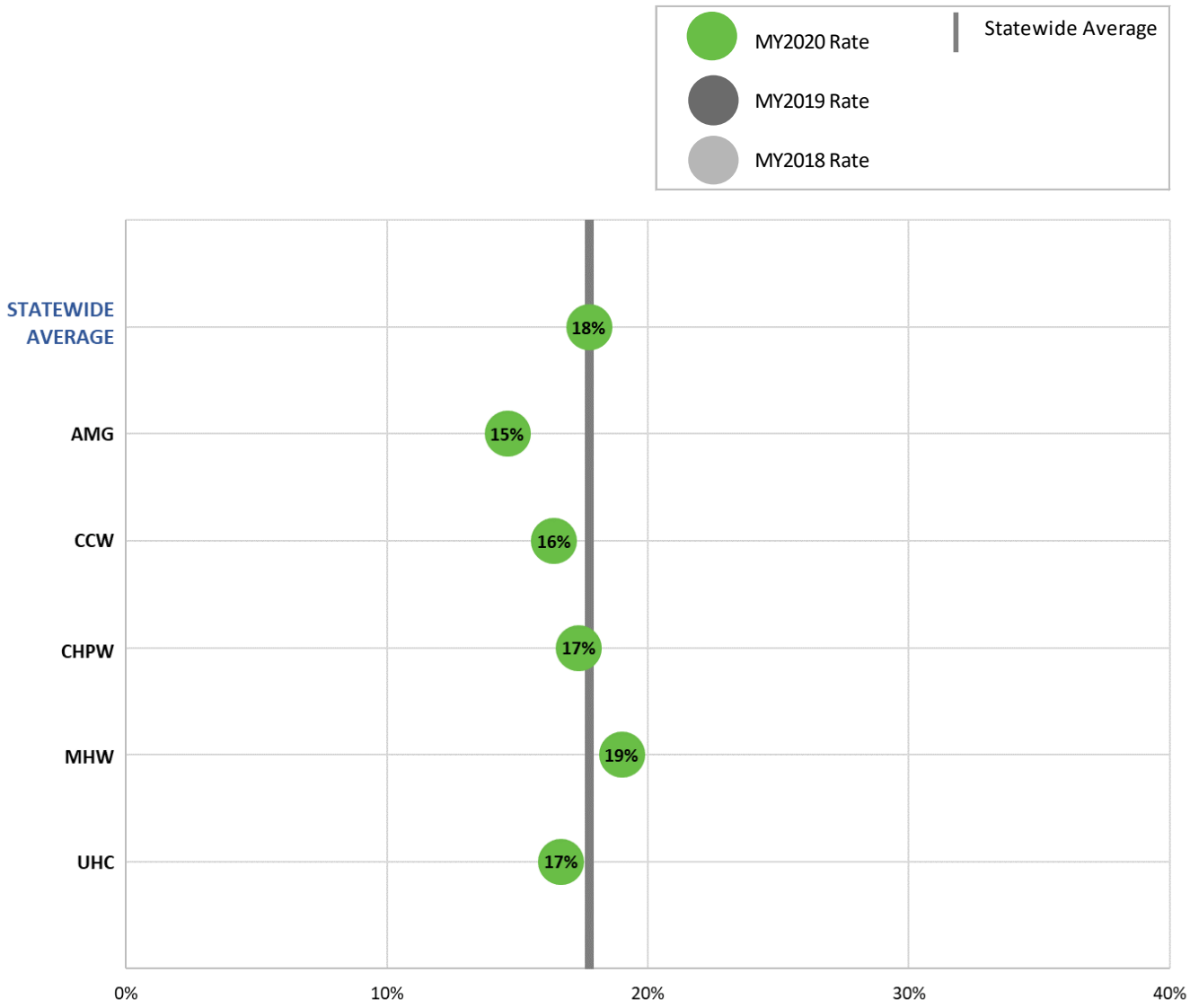


Figure 27. Child and Adolescent Well-Care Visit (WCV), Age 18-21.

- This is a VBP measure for the IFC contracts.
- The MY2020 statewide average is below the national 50th percentile benchmark. This is true of the MY2020 rates for all of the MCOs.
- This measure was new in MY2020, so there are no year-over-year comparisons.



Health Equity Analysis

Monitoring health equity is essential and of increasing importance. Since the majority of Medicaid enrollees are associated with a vulnerable population, HCA values and continues to prioritize the identification and comprehension of health disparities to proactively address these gaps. The COVID-19 pandemic has added stress to the Medicaid system and revealed several important patterns in health disparities.

These are some basic concepts of health equity:

- High quality health care is equitable. Care cannot be considered high quality if it is not equitable.
- A community includes ALL members. A healthy community is one that allows all members to grow to their full potential.
- Health equity is complex. Good health depends on many factors beyond just health care, such as environmental, social and economic factors.
- Health equity means treating the root causes, not just the symptoms.
- Health disparities lead to unhealthy communities which have far reaching and often unseen or overlooked ramifications.

Since performance measures are used to approximate population health and well-being, this section will further illuminate differences in measure results to identify potential health disparities. This section includes an analysis of statewide performance on all HEDIS measures by race, language and urban versus rural geographic location.

Challenges of Small Numbers with Health Equity Data

A major challenge with this analysis is that denominators for some measures are very small once the data is stratified by various demographic categories and MCO. NCQA guidelines state that measure results should not be reported when the denominator includes fewer than 30 individuals. This ensures that individual identity is protected, and that measure results are more stable. Note that 30 is still small for most statistical tests, and it is difficult to identify true statistical differences.

The issue with small denominators is particularly problematic for the hybrid measures. Hybrid measure results are based on a sampling, which is typically around 400 members for each MCO. Once that data is stratified by the 10 RSAs, the denominators often are too small for a reasonable analysis, particularly in the rural regions of the state.

As an example, Table 1 illustrates the denominator size for the Prenatal and Postpartum Care (PPC), Timeless of Prenatal Care measure when stratified by Spoken Language. There are several languages with a denominator of zero because there were no individuals who met the criteria for the measure who spoke that language (indicated by an NR) or where the denominator is less than 30 (indicated by “***”). English, Spanish; Castilian, and Other Language are the only spoken languages with sufficient denominators to be included in an analysis by spoken language for this particular measure.

Table 1. Denominator Size by Spoken Language for Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care.

Spoken Language	Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care	
	Denominator †	Rate‡
Amharic	3	***
Arabic	6	***
Burmese	2	***
Cambodian; Khmer	0	*NR*
Chinese	6	***
English	1725	*83%*
Farsi	0	*NR*
Korean	1	***
Laotian	0	*NR*
Panjabi; Punjabi	1	***
Russian	8	***
Somali	7	***
Spanish; Castilian	86	*84%*
Tigrinya	2	***
Ukrainian	8	***
Vietnamese	5	***
Other Language*	195	*85%*

**Other Language is the sum of the 67 languages not specifically reported in this table and represents less than 1% of enrollees.*

† Denominators of "0" indicate there were no individuals who met the criteria for that language and indicated by "NR"

*‡ Denominator with less than 30 indicated by "***"*

Comagine Health approached the health equity analysis by including as many categories as possible in comparison to detect statistically significant differences among groups. The statewide view of selected measures by race/ethnicity was fairly robust, allowing comparisons across most categories. However, comparisons became more limited when the race/ethnicity data was further stratified by MCO. The analysis by spoken language and MCO was even more problematic due to the large number of languages captured in the HCA data.

Understanding these inequities and being able to identify other more subtle disparities will require new approaches and additional data sources. This is a topic of national interest and, as such, there is a growing body of experience from which to learn. Comagine Health will continue to explore innovative ways to analyze this data to address the important topic of health equity.

Analysis by Race/Ethnicity

This section focuses on measure results stratified by race and ethnicity. Figure 28 displays the results of this analysis. The first column displays the statewide average; the results by race are to the right.

Downward arrows indicate the measure results for a particular race are statistically significantly lower than the statewide average; upward pointing arrows indicate the measure results are statistically significantly higher than the statewide average. This chart illustrates the variation that can be seen by race. However, due to the small number of measures presented, caution should be taken to not over-interpret these results as a reflection on all health care received by members of each racial group.

It is worth noting the American Indian/Alaska Native population is allowed to choose whether to enroll in an MCO or to be served by the FFS delivery systems. As a result, the data for this population is split and therefore, the denominators for this population tend to also be small as a result.

Figure 28. Statewide Variation in Rates by Race/Ethnicity, MY2020.*

Statistically significant difference from **Statewide Weighted Average**

		American Indian/Alaska Native	Asian	Black	Hawaiian/ Pacific Islander	Hispanic	Not Provided	White	Statewide Weighted Average
Access / Availability of Care	Adults' Access to Preventive/Ambulatory Health Services (AAP), Total	76% ↑	69% ↓	71% ↓	66% ↓	75% ↑	65% ↓	73% ↑	73%
	I&E of AOD Dependence Treatment (IET): Total Initiation of Treatment: 13-17 yrs	40%	***	39%	31%	32%	33%	36%	36%
	I&E of AOD Dependence Treatment (IET): Total Initiation of Treatment: Total	48%	41% ↓	43% ↓	45%	39% ↓	48% ↑	47% ↑	45%
	I&E of AOD Dependence Treatment (IET): Total Engagement in Treatment: Total	16%	11% ↓	12% ↓	13%	13% ↓	17% ↑	16% ↑	16%
	Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care	***	87%	80%	71% ↓	85%	85%	82%	83%
	Prenatal and Postpartum Care (PPC), Postpartum Care	***	77%	78%	55% ↓	79% ↑	73%	75%	77%
	Use of First-Line Psychosocial Care for Children and Adolsecents (APP), Total	***	***	65%	***	57%	54%	62%	61%
Behavioral Health	Antidepressant Medication Management (AMM), Effective Acute Phase	56%	58%	49% ↓	55%	53% ↓	58%	60% ↑	58%
	Antidepressant Medication Management (AMM), Continuation Phase	42%	42%	32% ↓	41%	36% ↓	41%	45% ↑	43%
	Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	59% ↑	60% ↑	40% ↓	46%	42% ↓	44%	46% ↑	45%
	Follow-Up Care for Children Prescribed ADHD Medication (ADD), Continuation	***	***	49%	***	54%	51%	52%	52%
	Follow-Up after Hospitalization for Mental Illness (FUH), 30-Day Follow-Up, Total	62%	61%	47% ↓	57%	60% ↑	47% ↓	59% ↑	57%
	Follow-Up after Hospitalization for Mental Illness (FUH), 7-Day Follow-Up, Total	40%	43%	33% ↓	42%	43% ↑	31% ↓	41% ↑	40%
	Follow-Up After ED Visit for Mental Illness (FUM), 30-day, Total	57%	63%	45% ↓	53%	60% ↑	55%	59% ↑	58%
	Follow-Up After ED Visit for Mental Illness (FUM), 7-day, Total	42%	48%	34% ↓	41%	46%	44%	46% ↑	45%
	Follow-Up After ED Visit for AOD Dependency (FUA), 30-day, 13-17 years	***	***	10%	***	15%	***	17%	17%
	Follow-Up After ED Visit for AOD Dependency (FUA), 30-day, Total	29%	26%	16% ↓	19% ↓	24% ↓	29%	31% ↑	29%
	Follow-Up After ED Visit for AOD Dependency (FUA), 7-day, Total	19%	16%	10% ↓	12% ↓	15% ↓	19%	21% ↑	19%
	Follow-Up After High Intensity Care for SUD (FUI), 30-day, Total	58%	56%	49% ↓	61%	56%	55%	59% ↑	58%
	Follow-Up After High Intensity Care for SUD (FUI), 7-day, Total	37%	34%	29% ↓	33%	36%	35%	39% ↑	38%
	Pharmacotherapy for Opioid Use Disorder (POD): Total	17%	14% ↓	12% ↓	20%	14% ↓	20%	20% ↑	19%
Cardiovascular Conditions	Controlling High Blood Pressure (CBP)	***	60%	54%	60%	57%	59%	60%	59%
Diabetes	Comprehensive Diabetes Care (CDC), Poor HbA1c Control (lower is better)	47%	21% ↑	36%	39%	43% ↓	34%	39%	37%
	Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0%	47%	68% ↑	57%	47%	43% ↓	51%	50%	52%
Overuse / Appropriateness	Use of Opioids at High Dosage (HDO) (lower is better)	6%	2% ↑	6%	4%	3% ↑	9% ↓	6% ↓	6%
Prevention and Screening	Childhood Immunization Status (CIS), Combo 2	67%	75% ↑	58% ↓	63%	74% ↑	65%	58% ↓	68%
	Childhood Immunization Status (CIS), Combo 10	39%	56% ↑	31% ↓	40%	44% ↑	41% ↑	32% ↓	42%
	Immunizations for Adolescents (IMA), Combo 2	***	46%	32%	23% ↓	52% ↑	32%	30% ↓	40%
	Lead Screening in Children (LSC)	***	34%	36%	27%	40% ↑	28% ↓	29% ↓	34%
	Breast Cancer Screening (BCS)	38% ↓	60% ↑	43% ↓	49%	57% ↑	47%	45% ↓	48%
	Cervical Cancer Screening (CCS)	36%	56%	58%	57%	63% ↑	57%	51% ↓	59%
	Chlamydia Screening (CHL), Total	50%	46% ↓	60% ↑	50%	52% ↑	40% ↓	47% ↓	50%
Respiratory Conditions	Asthma Medication Ratio (AMR), Total	61%	66% ↑	59% ↓	68% ↑	64% ↑	69% ↑	60% ↓	62%
Utilization	Well-Child Visits in the First 30 Months of Life (W30), 0-15 Months	45% ↓	60% ↑	49% ↓	48% ↓	57% ↑	53%	52% ↓	54%
	Well-Child Visits in the First 30 Months of Life (W30), 16-30 Months	67%	78% ↑	60% ↓	60% ↓	71% ↑	71% ↑	66% ↓	68%
	Child and Adolescent Well-Care Visit (WCV), Age 3-11	43% ↓	49% ↑	40% ↓	40% ↓	51%	50% ↑	44% ↓	47%
	Child and Adolescent Well-Care Visit (WCV), Age 12-17	31% ↓	38% ↑	30% ↓	28% ↓	39% ↑	34%	31% ↓	35%
	Child and Adolescent Well-Care Visit (WCV), Age 18-21	14% ↓	23% ↑	15% ↓	14% ↓	19% ↑	18%	16% ↓	18%
	Child and Adolescent Well-Care Visit (WCV), Total	34% ↓	40% ↑	33% ↓	33% ↓	43%	44% ↑	36%	39%

**The "Not Provided" category means a member's race was not provided by the member at the time of enrollment. This group comprises approximately 9% of Apple Health enrollment.*

Here are some noteworthy observations of the statewide results by race/ethnicity categories.

Prenatal and Postpartum Care (PPC) – Both the Timeliness of Prenatal Care and Postpartum measures were significantly below (statistically significant) the statewide weighted average for enrollees who identified themselves as Hawaiian/Pacific Islander. There were no disparities noted for the other race/ethnicity categories.

The situation of the Hawaiian Pacific Islander population bears calling out. This is a relatively small, isolated community in South King County that, unlike the Hispanic, Asian and Native American communities, has no clinic system designed to meet its needs and has few providers from that community in any delivery system in Washington State.

Behavioral Health – There have been improvements in the behavioral health measures at the statewide level, but that improvement does not translate into improvements for all race/ethnicity categories:

- The improvement in mental health and substance use disorders was due primarily to improvement in members identifying as white.
- Measure performance for members who identify as Black was statistically significantly below the statewide average.
- For members who identify as Hispanic, the results were similar as Black members except for the Follow-Up after Hospitalization for Mental Illness (FUH) for both the 30-day and 7-day Follow-Up, and the Follow-Up After Emergency Department Visit for Mental Illness (FUM), 30-Day Follow-Up, Total which were statistically above the statewide weighted average.

All indications from external data point to a marked increase in the need for treatment of mental health and substance use disorders during the COVID-19 pandemic. The severity of COVID-19 impact has been worse for disadvantaged communities heavily represented by non-white minority groups.

Prevention and Screening – At a statewide level, there were statistically significant declines for several preventive measures between MY2019 and MY2020 (see Figure 4). There was notable variation in performance by race/ethnicity category:

- Members who identify as white members were consistently below the statewide average for many of the preventive care measures.
- Members who identify as Black perform below the statewide average on several of the prevention and screening measures. The exception is Chlamydia Screenings (CHL), where they are significantly above the statewide average.
- Hispanic members were statistically significantly above the statewide average for the prevention and screening measures that are included in this report.

It is worth noting that Washington State has two large federally qualified health centers run by and for the Hispanic community. It would be helpful to understand the degree to which these delivery systems are driving the observed favorable outcomes and strategies they are using to achieve these outcomes.

In Washington State, there is an emerging cadre of community health workers. One of the largest of these is devoted entirely to hiring, training and supporting Latin American immigrant health workers through grant-funded initiatives providing educational outreach to the migrant and refugee population focusing their efforts on preventive care, immunizations and cancer screening. It would be helpful to better understand the impact of such programs on engagement of their target communities in addressing health disparities.

Well-Child Visits in the First 30 Months of Life (W30) and Child and Adolescent Well-Care Visit (WCV) – Asian and Hispanic members were significantly above the statewide average. All other race/ethnicity categories were significantly below the statewide average.

Analysis by MCO and Race/Ethnicity

The following section further stratifies the race/ethnicity data by MCO to determine if there is variation in the MCOs for any given race/ethnicity. This section focuses on the 11 HEDIS measures that are also VBP performance measures.

Figures 29–39 include the MY2020 statewide weighted average and the rates for the individual MCOs by race/ethnicity. The upward arrows indicate the measure result is statistically significantly above the other MCOs in the group; the downward arrows indicate the measure result is significantly below the other MCOs in the group.

Further stratifying the data did cause the suppression of data due to small numbers. A good example of this is seen with Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation measure. In the statewide view by race/ethnicity category (Figure 28), there is notable variation in this measure by race/ethnicity category. However, when reviewing the data further broken down by MCO in Figure 35, several cells are suppressed due to small denominators, and not as much variation can be reported.

Given the small numbers, there isn't as much variation seen in this view. However, this is a summary of the notable findings found in the charts below:

- For the Antidepressant Medication Management (AMM), Acute Phase measure in Figure 29, there was variation across the MCOs but not much variation within an MCO when stratified by race/ethnicity. In other words, if an individual MCO tended to perform better or worse than the other MCOs, it tended to perform better or worse across all race/ethnicity categories. With the exception of the Hawaiian/Pacific Islander category, MHW performed above the other MCOs for most of the race/ethnicity categories; the other MCOs were below.
- The Well Child Visit (WCV) measure in Figures 36, 38 and 39 had similar results to the AMM measure. MHW performed better than the other MCOs on this measure across most of the race/ethnicity categories, while AMG and CHPW performed worse across most of the race/ethnicity categories. Note there was very little variation for the 18-21 age band.

The key take-away from this section is that when measures are stratified by MCO and race/ethnicity, it appears that most of the variation is due to the MCO rather than the race/ethnicity category.

Figure 29. Antidepressant Medication Management (AMM), Effective Acute Phase, Variation in Rates by MCO and Race/Ethnicity, MY2020.

⬇⬆ Statistically significant difference from **other MCOs in race/ethnicity category**

		AMG	CCW	CHPW	MHW	UHC	Statewide Weighted Average
Antidepressant Medication Management (AMM), Effective Acute Phase	American Indian/Alaska Native	55%	50%	51%	59%	54%	58.5%
	Asian	51%	62%	49% ⬇	61%	58%	
	Black	43%	45%	50%	52% ⬆	43% ⬇	
	Hawaiian/Pacific Islander	56%	57%	65%	50% ⬇	60%	
	Hispanic	45% ⬇	53%	50%	55% ⬆	56%	
	Not Provided*	55%	58%	59%	58%	58%	
	Other	39% ⬇	61%	48%	60% ⬆	51%	
	White	54% ⬇	63%	60%	62% ⬆	58% ⬇	

**The "Not Provided" category means a member's race was not provided by the member at the time of enrollment. This group comprises approximately 9% of Apple Health enrollment.*

- AMM is a shared VBP measure for the Integrated Managed Care (IMC) contracts.
- There was variation across the MCOs when this measure is stratified by race. MHW performed above the other MCOs for several race/ethnicity categories; the other MCOs were below.

Figure 30. Antidepressant Medication Management (AMM), Continuation Phase, Variation in Rates by MCO and Race/Ethnicity, MY2020.

⬇⬆ Statistically significant difference from **other MCOs in race/ethnicity category**

		AMG	CCW	CHPW	MHW	UHC	Statewide Weighted Average
Antidepressant Medication Management (AMM), Continuation Phase	American Indian/Alaska Native	37%	37%	40%	44%	43%	42.9%
	Asian	42%	48%	38%	43%	38%	
	Black	25% ⬇	26%	35%	35% ⬆	32%	
	Hawaiian/Pacific Islander	34%	52%	55% ⬆	39%	39%	
	Hispanic	35%	34%	33%	38%	41%	
	Not Provided*	40%	38%	44%	42%	40%	
	Other	24% ⬇	40%	33%	40%	39%	
	White	40% ⬇	45%	45%	47% ⬆	45%	

**The "Not Provided" category means a member's race was not provided by the member at the time of enrollment. This group comprises approximately 9% of Apple Health enrollment.*

- AMM is a shared VBP measure for the IMC contracts.
- There was less variation among the MCOs' AMM Continuation Phase measure when stratified by race.

Figure 31. Asthma Medication Ratio (AMR), Total, Variation in Rates by MCO and Race/Ethnicity, MY2020.

↓ ↑ Statistically significant difference from **other MCOs in race/ethnicity category**

		AMG	CCW	CHPW	MHW	UHC	Statewide Weighted Average
Asthma Medication Ratio (AMR), Total	American Indian/Alaska Native	***	67%	***	62%	52%	62.1%
	Asian	69%	73%	64%	69%	55% ↓	
	Black	52%	63%	62%	60%	55%	
	Hawaiian/Pacific Islander	***	66%	64%	68%	71%	
	Hispanic	65%	59% ↓	62%	67% ↑	57%	
	Not Provided*	68%	66%	62%	71%	71%	
	Other	***	67%	72%	65%	47% ↓	
	White	54% ↓	58%	65% ↑	62% ↑	57% ↓	

**The "Not Provided" category means a member's race was not provided by the member at the time of enrollment. This group comprises approximately 9% of Apple Health enrollment.*

- AMR Total (all ages) is a shared VBP measure for the IMC program.
- Most of the variation for this measure is in the white race/ethnicity category.

Figure 32. Prenatal and Postpartum Care, Timeliness of Prenatal Care, Variation in Rates by MCO and Race/Ethnicity, MY2020.

↓ ↑ Statistically significant difference from **other MCOs in race/ethnicity category**

		AMG	CCW	CHPW	MHW	UHC	Statewide Weighted Average
Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care	American Indian/Alaska Native	***	***	***	***	***	82.7%
	Asian	***	***	***	***	***	
	Black	73%	70%	***	84%	83%	
	Hawaiian/Pacific Islander	***	***	***	***	***	
	Hispanic	86%	80% ↓	91% ↑	79%	89%	
	Not Provided*	75% ↓	***	93%	***	86%	
	Other	***	***	***	***	***	
	White	77%	76%	84%	81%	89% ↑	

**The "Not Provided" category means a member's race was not provided by the member at the time of enrollment. This group comprises approximately 9% of Apple Health enrollment.*

- PPC is a shared VBP measure for the IMC contracts.
- There was very little variation among the MCOs for the Timeliness of Prenatal Care measure when stratified by race.

Figure 33. Prenatal and Postpartum Care, Timeliness of Postpartum Care, Variation in Rates by MCO and Race/Ethnicity, MY2020.

↓ ↑ Statistically significant difference from **other MCOs in race/ethnicity category**

		AMG	CCW	CHPW	MHW	UHC	Statewide Weighted Average
Prenatal and Postpartum Care (PPC), Postpartum Care	American Indian/Alaska Native	***	***	***	***	***	76.7%
	Asian	***	***	***	***	***	
	Black	76%	73%	***	82%	77%	
	Hawaiian/Pacific Islander	***	***	***	***	***	
	Hispanic	78%	80%	81%	81%	68%	
	Not Provided*	64%	***	83% ↑	***	71%	
	Other	***	***	***	***	***	
	White	70% ↓	69%	85% ↑	73%	82% ↑	

**The "Not Provided" category means a member's race was not provided by the member at the time of enrollment. This group comprises approximately 9% of Apple Health enrollment.*

- PPC is a shared VBP measure for the IMC contracts.
- Similar to the Timeliness of Prenatal Care measure, there was very little variation among the MCOs for the Postpartum Care measure when stratified by race/ethnicity.

Figure 34. Comprehensive Diabetes Care (CDC), Poor HbA1c Control, Variation in Rates by MCO and Race/Ethnicity, MY2020.

Note that a lower score is better for this measure. The blue arrows indicate an MCO performed statistically better than its peers for a particular race/ethnicity category. For example, MHW has the lowest (best) rate for the Hispanic category and performs statistically better than the other MCOs.

Statistically significant difference from **other MCOs in race/ethnicity category**

		AMG	CCW	CHPW	MHW	UHC	Statewide Weighted Average
Comprehensive Diabetes Care (CDC), Poor HbA1c Control (Note that a lower score is better for this measure)	American Indian/Alaska Native	***	***	***	***	***	37.5%
	Asian	***	***	***	***	10% ↑	
	Black	***	33%	23%	***	38%	
	Hawaiian/Pacific Islander	***	***	***	***	33%	
	Hispanic	35%	48%	50%	30% ↑	40%	
	Not Provided*	***	***	***	***	***	
	Other	***	***	***	***	***	
	White	40%	45%	42%	38%	31% ↑	

**The "Not Provided" category means a member's race was not provided by the member at the time of enrollment. This group comprises approximately 9% of Apple Health enrollment.*

- CDC, Poor HbA1c Control is a plan-specific VBP measure for MHW and UHC.
- There is very little variation among the MCOs for this measure when stratified by race.

Figure 35. Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation, Variation in Rates by MCO and Race/Ethnicity, MY2020.

↓ ↑ Statistically significant difference from **other MCOs in race/ethnicity category**

		AMG	CCW	CHPW	MHW	UHC	Statewide Weighted Average
Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	American Indian/Alaska Native	***	***	***	47%	***	45.2%
	Asian	***	***	***	65%	***	
	Black	***	45%	***	38%	46%	
	Hawaiian/Pacific Islander	***	***	***	58%	***	
	Hispanic	36%	40%	47%	42%	48%	
	Not Provided*	50%	45%	36% ↓	49%	43%	
	Other	***	***	***	41%	***	
	White	46%	49%	43%	46%	48%	

**The "Not Provided" category means a member's race was not provided by the member at the time of enrollment. This group comprises approximately 9% of Apple Health enrollment.*

- ADD, Initiation is a plan-specific VBP measure for CCW and CHPW.
- There was very little variation among the MCOs for this measure when stratified by race/ethnicity.

Figure 36. Child and Adolescent Well-Care Visit (WCV), Age 3-11, Variation in Rates by MCO and Race/Ethnicity, MY2020.

↓ ↑ Statistically significant difference from **other MCOs in race/ethnicity category**

		AMG	CCW	CHPW	MHW	UHC	Statewide Weighted Average
Child and Adolescent Well-Care Visit (WCV), Age 3-11	American Indian/Alaska Native	37% ↓	52% ↑	36% ↓	43%	41%	46.9%
	Asian	45% ↓	47%	47%	51% ↑	47%	
	Black	37% ↓	46% ↑	35% ↓	41% ↑	41%	
	Hawaiian/Pacific Islander	35% ↓	38%	35% ↓	42% ↑	40%	
	Hispanic	50% ↓	52%	50% ↓	53% ↑	47% ↓	
	Not Provided*	45% ↓	49%	47% ↓	53% ↑	47% ↓	
	Other	37% ↓	42%	37% ↓	45% ↑	44%	
	White	38% ↓	47% ↑	39% ↓	46% ↑	41% ↓	

**The "Not Provided" category means a member's race was not provided by the member at the time of enrollment. This group comprises approximately 9% of Apple Health enrollment.*

- WCV for ages 3-11 is a plan-specific VBP measure for all IMC contracts.
- MHW performed better than other MCOs across race/ethnicity categories, while AMG and CHPW performed below the other MCOs.
- When this measure is stratified by MCO and race/ethnicity, it appears that most of the variation is due to the MCO rather than the race/ethnicity category.

Figure 37. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), Total, Variation in Rates by MCO and Race/Ethnicity, MY2020.

⬇ ⬆ Statistically significant difference from **other MCOs in race/ethnicity category**

		AMG	CCW	CHPW	MHW	UHC	Statewide Weighted Average
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), Total	American Indian/Alaska Native	***	***	***	***	***	61.2%
	Asian	***	***	***	***	***	
	Black	***	***	***	61%	***	
	Hawaiian/Pacific Islander	***	***	***	***	***	
	Hispanic	***	63%	***	55%	***	
	Not Provided*	***	***	***	***	***	
	Other	***	***	***	***	***	
	White	53%	69%	54%	66%	48% ⬇	

**The "Not Provided" category means a member's race was not provided by the member at the time of enrollment. This group comprises approximately 9% of Apple Health enrollment.*

- APP, Total is a VBP measure for the IFC contracts.
- White was the only race/ethnicity category that had sufficient denominators to report data across all five MCOs for this measure. There was very little variation among the MCOs for this category.

Figure 38. Child and Adolescent Well-Care Visit (WCV), Age 12-17, Variation in Rates by MCO and Race/Ethnicity, MY2020.

Statistically significant difference from **other MCOs in race/ethnicity category**

		AMG	CCW	CHPW	MHW	UHC	Statewide Weighted Average
Child and Adolescent Well-Care Visit (WCV), Age 12-17	American Indian/Alaska Native	24% ↓	43% ↑	23% ↓	32%	26% ↓	34.8%
	Asian	33% ↓	33% ↓	39%	38%	39%	
	Black	25% ↓	32% ↑	22% ↓	31% ↑	32% ↑	
	Hawaiian/Pacific Islander	25% ↓	29%	24% ↓	30% ↑	29%	
	Hispanic	35% ↓	39%	39%	40% ↑	34% ↓	
	Not Provided*	28% ↓	30% ↓	29% ↓	38% ↑	33%	
	Other	25% ↓	33%	32%	36% ↑	35%	
	White	25% ↓	33% ↑	27% ↓	33% ↑	28% ↓	

**The "Not Provided" category means a member's race was not provided by the member at the time of enrollment. This group comprises approximately 9% of Apple Health enrollment.*

- WCV for ages 12-17 is a VBP measure for the IFC contracts.
- Similar to the WCV for the 3-11 year age band, there is variation between MCOs, but most MCOs perform consistently across all race/ethnicity categories. There is variation between race/ethnicity categories for CCW and UHC.
- When this measure is stratified by MCO and race/ethnicity, it appears that most of the variation is due to the MCO rather than the race/ethnicity category.

Figure 39. Child and Adolescent Well-Care Visit (WCV), Age 18-21, Variation in Rates by MCO and Race/Ethnicity, MY2020.

↓ ↑ Statistically significant difference from **other MCOs in race/ethnicity category**

		AMG	CCW	CHPW	MHW	UHC	Statewide Weighted Average
Child and Adolescent Well-Care Visit (WCV), Age 18-21	American Indian/Alaska Native	12%	18%	21%	14%	9%	17.7%
	Asian	20%	21%	23%	24%	22%	
	Black	12%	16%	12% ↓	16% ↑	14%	
	Hawaiian/Pacific Islander	10% ↓	13%	11%	16% ↑	15%	
	Hispanic	18%	17% ↓	19%	20% ↑	17% ↓	
	Not Provided*	18%	15%	15%	19%	18%	
	Other	14%	12% ↓	17%	20% ↑	17%	
	White	12% ↓	14% ↓	14% ↓	18% ↑	16%	

**The "Not Provided" category means a member's race was not provided by the member at the time of enrollment. This group comprises approximately 9% of Apple Health enrollment.*

- WCV for ages 18-21 is a VBP measure for the IFC contracts.
- There is very little variation among the MCOs for this measure when stratified by race/ethnicity.
- When this measure is stratified by MCO and race/ethnicity, it appears that most of the variation is due to the MCO rather than the race/ethnicity category.

Analysis by Spoken Language

Currently, HCA provides written materials in 15 non-English languages to Apple Health enrollees. This analysis provides measure results for all 15 of these languages plus English. The data is further stratified by MCO to determine if there is variation in the MCOs for any spoken language. This section focuses on the 11 HEDIS measures that are also VBP performance measures.

Figures 40–50 include the MY2020 statewide weighted average and the rates for the individual MCOs by spoken language. The upward arrows indicate the measure result is statistically significantly above the other MCOs in the group for that language; the downward arrows indicate the measure result is significantly below the other MCOs in the group for that language.

This is a summary of the key findings from the analysis by MCO and Spoken Language:

- The large denominators for the Well Child Visit (WCV) measure yield more usable results than many of the other VBP measures. There was sufficient data to report spoken language performance across the MCOs, with a lot of variation. However, there were no real patterns when viewing the individual MCOs.
- For the remaining measures, the only spoken language categories with sufficient data to report are English, Spanish; Castilian, and Other Language. There was very little variation reported for the other measures.

Figure 40. Antidepressant Medication Management (AMM), Effective Acute Phase, Variation in Rates by MCO and Spoken Language, MY2020.

Statistically significant difference from other MCOs in language category

Measure Description	Statewide Weighted Rate	Language	AMG	CCW	CHPW	MHW	UHC
Antidepressant Medication Management (AMM), Effective Acute Phase	58%	Amharic	***	NR	***	***	NR
		Arabic	***	***	***	55%	***
		Burmese	NR	***	***	***	NR
		Cambodian; Khmer	NR	NR	***	***	***
		Chinese	***	***	***	***	***
		English	53% ↓	59%	57%	60% ↑	57% ↓
		Farsi	***	***	***	***	***
		Korean	***	NR	***	***	***
		Other Language*	52%	55%	58%	56%	56%
		Panjabi; Punjabi	***	***	NR	***	***
		Russian	***	***	***	***	***
		Somali	***	***	***	***	***
		Spanish; Castilian	31% ↓	58% ↑	49%	49%	44%
		Tigrinya	***	NR	***	***	NR
		Ukrainian	***	NR	NR	***	***
		Vietnamese	***	***	***	***	***

**Other Language is the sum of the 67 languages not specifically reported in this table and represents less than 1% of enrollees.*

- AMM is a shared VBP measure for the IMC contracts.
- The only spoken language categories with sufficient data to report are English, Spanish; Castilian, and Other Language. There was very little variation among the MCOs for this measure when stratified by language.

Figure 41. Antidepressant Medication Management (AMM), Continuation Phase, Variation in Rates by MCO and Spoken Language, MY2020.

Measure Description	Statewide Weighted Rate	Language	AMG	CCW	CHPW	MHW	UHC
			↓ ↑ Statistically significant difference from other MCOs in language category				
Antidepressant Medication Management (AMM), Continuation Phase	43%	Amharic	***	NR	***	***	NR
		Arabic	***	***	***	48%	***
		Burmese	NR	***	***	***	NR
		Cambodian; Khmer	NR	NR	***	***	***
		Chinese	***	***	***	***	***
		English	38% ↓	41%	42%	45% ↑	43%
		Farsi	***	***	***	***	***
		Korean	***	NR	***	***	***
		Other Language*	38%	31%	44% ↑	38%	38%
		Panjabi; Punjabi	***	***	NR	***	***
		Russian	***	***	***	***	***
		Somali	***	***	***	***	***
		Spanish; Castilian	18%	34%	35%	29%	32%
		Tigrinya	***	NR	***	***	NR
		Ukrainian	***	NR	NR	***	***
		Vietnamese	***	***	***	***	***

**Other Language is the sum of the 67 languages not specifically reported in this table and represents less than 1% of enrollees.*

- AMM is a shared VBP measure for the IMC contracts.
- The only spoken language categories with sufficient data to report are English, Spanish; Castilian, and Other Language. There was very little variation among the MCOs for this measure when stratified by language.

Figure 42. Asthma Medication Ratio (AMR), Total, Variation in Rates by MCO and Spoken Language, MY2020.

Statistically significant difference from other MCOs in language category

Measure Description	Statewide Weighted Rate	Language	AMG	CCW	CHPW	MHW	UHC
Asthma Medication Ratio (AMR), Total	62%	Amharic	NR	***	NR	***	***
		Arabic	***	***	***	***	***
		Burmese	***	NR	***	***	NR
		Cambodian; Khmer	NR	NR	***	***	NR
		Chinese	***	***	***	***	***
		English	56% ↓	60%	64% ↑	62% ↑	57% ↓
		Farsi	NR	NR	NR	***	***
		Korean	NR	NR	***	***	***
		Other Language*	***	***	***	72%	***
		Panjabi; Punjabi	***	***	NR	***	NR
		Russian	NR	***	***	***	***
		Somali	***	***	***	***	***
		Spanish; Castilian	71%	60% ↓	61% ↓	73% ↑	***
		Tigrinya	NR	NR	***	***	***
		Ukrainian	NR	***	NR	***	NR
		Vietnamese	***	***	***	81%	***

**Other Language is the sum of the 67 languages not specifically reported in this table and represents less than 1% of enrollees.*

- AMR Total (all ages) is a shared VBP measure for the IMC program.
- The only spoken language categories with sufficient data to report are English and Spanish; Castilian. There was some variation among the MCOs for this measure when stratified by language.

Figure 43. Prenatal and Postpartum Care, Timeliness of Prenatal Care, Variation in Rates by MCO and Spoken Language, MY2020.

Statistically significant difference from other MCOs in language category

Measure Description	Statewide Weighted Rate	Language	AMG	CCW	CHPW	MHW	UHC
Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care	83%	Amharic	***	NR	NR	NR	***
		Arabic	NR	***	***	***	***
		Burmese	***	NR	***	NR	NR
		Cambodian; Khmer	NR	NR	NR	NR	NR
		Chinese	NR	NR	***	***	***
		English	78%	78% ↓	86% ↑	83%	86%
		Farsi	NR	NR	NR	NR	NR
		Korean	NR	NR	***	NR	NR
		Other Language*	76%	***	90%	***	89%
		Panjabi; Punjabi	NR	NR	***	NR	NR
		Russian	***	NR	NR	***	***
		Somali	***	NR	***	NR	***
		Spanish; Castilian	***	78%	***	***	***
		Tigrinya	NR	NR	***	NR	NR
		Ukrainian	***	***	NR	***	NR
		Vietnamese	NR	NR	***	NR	***

**Other Language is the sum of the 67 languages not specifically reported in this table and represents less than 1% of enrollees.*

- PPC is a shared VBP measure for the IMC contracts.
- The only spoken language categories with sufficient data to report is English. There was very little variation among the MCOs for this measure when stratified by language.

Figure 44. Prenatal and Postpartum Care, Postpartum Care, Variation in Rates by MCO and Spoken Language, MY2020.

Statistically significant difference from other MCOs in language category

Measure Description	Statewide Weighted Rate	Language	AMG	CCW	CHPW	MHW	UHC
Prenatal and Postpartum Care (PPC), Postpartum Care	77%	Amharic	***	NR	NR	NR	***
		Arabic	NR	***	***	***	***
		Burmese	***	NR	***	NR	NR
		Cambodian; Khmer	NR	NR	NR	NR	NR
		Chinese	NR	NR	***	***	***
		English	72%	73%	81% ↑	76%	76%
		Farsi	NR	NR	NR	NR	NR
		Korean	NR	NR	***	NR	NR
		Other Language*	63%	***	84% ↑	***	68%
		Panjabi; Punjabi	NR	NR	***	NR	NR
		Russian	***	NR	NR	***	***
		Somali	***	NR	***	NR	***
		Spanish; Castilian	***	87%	***	***	***
		Tigrinya	NR	NR	***	NR	NR
		Ukrainian	***	***	NR	***	NR
		Vietnamese	NR	NR	***	NR	***

**Other Language is the sum of the 67 languages not specifically reported in this table and represents less than 1% of enrollees.*

- PPC is a shared VBP measure for the IMC contracts.
- The only spoken language categories with sufficient data to report is English. There was very little variation among the MCOs for this measure when stratified by language.

Figure 45. Comprehensive Diabetes Care (CDC), Poor HbA1c Control, Variation in Rates by MCO and Spoken Language, MY2020.

Note that a lower score is better for this measure.

Statistically significant difference from other MCOs in language category

Measure Description	Statewide Weighted Rate	Language	AMG	CCW	CHPW	MHW	UHC
Comprehensive Diabetes Care (CDC), Poor HbA1c Control (Note that a lower score is better for this measure)	37%	Amharic	NR	NR	NR	***	***
		Arabic	***	***	***	***	***
		Burmese	NR	NR	***	NR	NR
		Cambodian; Khmer	NR	NR	NR	NR	NR
		Chinese	***	***	***	***	***
		English	40%	47% ↓	40%	37%	30% ↑
		Farsi	NR	NR	NR	NR	***
		Korean	***	***	***	***	***
		Other Language*	***	***	***	***	***
		Panjabi; Punjabi	NR	NR	NR	***	***
		Russian	***	NR	***	***	***
		Somali	***	NR	NR	***	***
		Spanish; Castilian	***	35%	48%	***	***
		Tigrinya	***	***	NR	NR	***
		Ukrainian	NR	NR	NR	NR	***
		Vietnamese	***	***	***	***	***

**Other Language is the sum of the 67 languages not specifically reported in this table and represents less than 1% of enrollees.*

- CDC, Poor HbA1c Control is a plan-specific VBP measure for MHW and UHC.
- The only spoken language categories with sufficient data to report is English. There was very little variation among the MCOs for this measure when stratified by language.

Figure 46. Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation, Variation in Rates by MCO and Spoken Language, MY2020.

Statistically significant difference from other MCOs in language category

Measure Description	Statewide Weighted Rate	Language	AMG	CCW	CHPW	MHW	UHC
Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	45%	Amharic	NR	NR	NR	NR	NR
		Arabic	***	***	***	***	***
		Burmese	NR	NR	***	NR	NR
		Cambodian; Khmer	NR	NR	NR	NR	NR
		Chinese	NR	NR	NR	***	NR
		English	43%	47%	42%	45%	47%
		Farsi	NR	NR	NR	NR	NR
		Korean	***	NR	NR	***	NR
		Other Language*	50%	42%	36% ↓	50%	45%
		Panjabi; Punjabi	NR	NR	***	NR	NR
		Russian	NR	NR	NR	***	NR
		Somali	NR	NR	NR	***	***
		Spanish; Castilian	43%	48%	49%	44%	***
		Tigrinya	NR	NR	NR	NR	NR
		Ukrainian	NR	NR	NR	NR	NR
		Vietnamese	NR	***	NR	***	NR

**Other Language is the sum of the 67 languages not specifically reported in this table and represents less than 1% of enrollees.*

- ADD, Initiation is a plan-specific VBP measure for CCW and CHPW.
- The only spoken language categories with sufficient data to report were English, Spanish; Castilian, and Other Language. There was very little variation among the MCOs for this measure when stratified by language.

Figure 47. Child and Adolescent Well-Care Visit (WCV), Age 3-11, Variation in Rates by MCO and Spoken Language, MY2020.

Statistically significant difference from other MCOs in language category

Measure Description	Statewide Weighted Rate	Language	AMG	CCW	CHPW	MHW	UHC
Child and Adolescent Well-Care Visit (WCV), Age 3-11	47%	Amharic	48%	***	41%	49%	49%
		Arabic	45%	36%	41%	44%	43%
		Burmese	***	38% ↓	48%	54%	72% ↑
		Cambodian; Khmer	***	***	***	45%	***
		Chinese	38% ↓	42%	54% ↑	48%	37% ↓
		English	39% ↓	48% ↑	41% ↓	47% ↑	42% ↓
		Farsi	***	***	48%	35%	***
		Korean	***	***	***	52%	50%
		Other Language*	39% ↓	48% ↑	44%	46%	41%
		Panjabi; Punjabi	***	***	***	67%	***
		Russian	41%	30%	31% ↓	39% ↑	38%
		Somali	27%	44%	32%	35%	30%
		Spanish; Castilian	59% ↑	55% ↓	54% ↓	58% ↑	55%
		Tigrinya	61% ↑	***	33%	41%	***
		Ukrainian	46%	33%	32%	41%	38%
		Vietnamese	46%	37% ↓	51%	51%	45%

**Other Language is the sum of the 67 languages not specifically reported in this table and represents less than 1% of enrollees.*

- WCV for ages 3-11 is a plan-specific VBP measure for all IMC contracts.
- The large denominators for this measure yield more usable results than many of the other VBP measures. There was sufficient data to report spoken language performance across the MCOs, with a lot of variation. However, there were no real patterns when viewing the individual MCOs.

Figure 48. Child and Adolescent Well-Care Visit (WCV), Age 12-17, Variation in Rates by MCO and Spoken Language, MY2020.

↓ ↑ Statistically significant difference from other MCOs in language category

Measure Description	Statewide Weighted Rate	Language	AMG	CCW	CHPW	MHW	UHC
Child and Adolescent Well-Care Visit (WCV), Age 12-17	35%	Amharic	***	***	24%	36%	***
		Arabic	20% ↓	34%	35%	29%	38%
		Burmese	***	***	22% ↓	35%	***
		Cambodian; Khmer	***	***	***	31%	***
		Chinese	41%	43%	45% ↑	30% ↓	30%
		English	26% ↓	34% ↑	29% ↓	34% ↑	30% ↓
		Farsi	***	***	***	26%	***
		Korean	***	***	***	32% ↓	54% ↑
		Other Language*	26%	30%	31%	35% ↑	28%
		Panjabi; Punjabi	***	***	***	41%	***
		Russian	27%	***	18% ↓	26%	26%
		Somali	22%	***	17%	21%	31%
		Spanish; Castilian	41% ↓	42%	41% ↓	45% ↑	43%
		Tigrinya	20%	***	21%	27%	***
		Ukrainian	37%	***	16%	25%	50% ↑
		Vietnamese	37%	26% ↓	47% ↑	40%	46%

**Other Language is the sum of the 67 languages not specifically reported in this table and represents less than 1% of enrollees.*

- WCV for ages 12-17 is a VBP measure for the IFC contracts.
- The large denominators for this measure yield more usable results than many of the other VBP measures. There is sufficient data to report spoken language performance across the MCOs, with a lot of variation. However, there were no real patterns when viewing the individual MCOs.

Figure 49. Child and Adolescent Well-Care Visit (WCV), Age 18-21, Variation in Rates by MCO and Spoken Language, MY2020.

Statistically significant difference from other MCOs in language category

Measure Description	Statewide Weighted Rate	Language	AMG	CCW	CHPW	MHW	UHC
Child and Adolescent Well-Care Visit (WCV), Age 18-21	18%	Amharic	***	***	***	***	***
		Arabic	***	***	22%	20%	21%
		Burmese	***	***	***	***	***
		Cambodian; Khmer	***	***	***	***	***
		Chinese	30%	***	39% ↑	26%	23%
		English	13% ↓	15% ↓	15% ↓	18% ↑	16%
		Farsi	***	***	***	***	***
		Korean	***	***	***	13% ↓	41% ↑
		Other Language*	11%	17%	14%	17%	14%
		Panjabi; Punjabi	***	***	***	***	NR
		Russian	***	***	7% ↓	16%	12%
		Somali	***	***	8%	7%	***
		Spanish; Castilian	24%	20% ↓	23%	25% ↑	21%
		Tigrinya	***	***	***	***	***
		Ukrainian	***	***	***	15%	***
		Vietnamese	25%	26%	26%	28%	35%

**Other Language is the sum of the 67 languages not specifically reported in this table and represents less than 1% of enrollees.*

- WCV for ages 18-21 is a VBP measure for the IFC contracts.
- The large denominators for this measure yield more usable results than many of the other VBP measures. There is sufficient data to report spoken language performance across the MCOs, with a lot of variation. However, there were no real patterns when viewing the individual MCOs.

Figure 50. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), Total, Variation in Rates by MCO and Spoken Language, MY2020.

Statistically significant difference from other MCOs in language category

Measure Description	Statewide Weighted Rate	Language	AMG	CCW	CHPW	MHW	UHC
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), Total	61%	Amharic	NR	NR	NR	NR	NR
		Arabic	NR	***	NR	***	NR
		Burmese	NR	NR	NR	NR	NR
		Cambodian; Khmer	NR	NR	NR	NR	NR
		Chinese	NR	NR	NR	NR	NR
		English	54%	63%	56%	65% ↑	49% ↓
		Farsi	NR	NR	NR	NR	NR
		Korean	NR	NR	NR	NR	NR
		Other Language*	***	***	***	***	***
		Panjabi; Punjabi	NR	NR	NR	NR	NR
		Russian	NR	NR	NR	***	NR
		Somali	NR	NR	NR	***	***
		Spanish; Castilian	***	***	***	***	***
		Tigrinya	NR	NR	NR	NR	NR
		Ukrainian	NR	NR	NR	NR	NR
		Vietnamese	NR	NR	NR	***	NR

**Other Language is the sum of the 67 languages not specifically reported in this table and represents less than 1% of enrollees.*

- APP, Total is a VBP measure for the IFC contracts.
- The only spoken language categories with sufficient data to report is English. There was very little variation among the MCOs for this measure when stratified by language.

Urban Versus Rural Comparison

This section compares measure results for members who live in urban settings versus rural settings. To define urban versus rural geographies, Comagine Health relied on the CMS rural-urban commuting area (RUCA) codes. RUCA codes classify United States census tracts using measures of population density, urbanization and daily commuting.[11]

Figure 51 below shows measures by urban versus rural designation. There were a few measures with statistically significant differences between the urban population and the rural population.

[11] Whole numbers (1-10) delineate metropolitan, micropolitan, small town and rural commuting areas based on the size and direction of the primary (largest) commuting flows. For the purposes of this analysis, RUCA codes 8, 9, and 10 were classified as rural; this effectively defines rural areas as towns with populations of 10,000 or smaller.

Figure 51. Urban and Rural Comparison by Measure.

↓ Urban is statistically significantly **Lower** than Rural
↑ Urban is statistically significantly **Higher** than Rural

		Rural	Urban	
Access / Availability of Care	Adults' Access to Preventive/Ambulatory Health Services (AAP), Total	73%	73%	
	I&E of AOD Dependence Treatment (IET): Total Initiation of Treatment: 13-17 yrs	20%	37%	↑
	I&E of AOD Dependence Treatment (IET): Total Initiation of Treatment: Total	38%	46%	↑
	I&E of AOD Dependence Treatment (IET): Total Engagement in Treatment: Total	13%	16%	↑
	Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care	80%	83%	
	Prenatal and Postpartum Care (PPC), Postpartum Care	81%	76%	
	Use of First-Line Psychosocial Care for Children and Adolsecents (APP), Total	58%	61%	
Behavioral Health	Antidepressant Medication Management (AMM), Effective Acute Phase	56%	59%	
	Antidepressant Medication Management (AMM), Continuation Phase	41%	43%	
	Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	48%	45%	
	Follow-Up Care for Children Prescribed ADHD Medication (ADD), Continuation	51%	52%	
	Follow-up after Hospitalization for Mental Illness (FUH), 30-Day Follow-Up, Total	68%	58%	↓
	Follow-up after Hospitalization for Mental Illness (FUH), 7-Day Follow-Up, Total	45%	41%	
	Follow-Up After ED Visit for Mental Illness (FUM), 30-day, Total	72%	57%	↓
	Follow-Up After ED Visit for Mental Illness (FUM), 7-day, Total	60%	45%	↓
	Follow-Up After ED Visit for AOD Dependency (FUA), 30-day, 13-17 years	15%	17%	
	Follow-Up After ED Visit for AOD Dependency (FUA), 30-day, Total	33%	28%	
	Follow-Up After ED Visit for AOD Dependency (FUA), 7-day, Total	21%	19%	
	Follow-Up After High Intensity Care for SUD (FUI), 30-day, Total	60%	58%	
	Follow-Up After High Intensity Care for SUD (FUI), 7-day, Total	38%	38%	
	Pharmacotherapy for Opioid Use Disorder (POD): Total	24%	19%	↓
Cardiovascular Conditions	Controlling High Blood Pressure (CBP)	56%	60%	
Diabetes	Comprehensive Diabetes Care (CDC), Poor HbA1c Control (lower is better)	30%	39%	
	Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0%	54%	50%	
Overuse / Appropriateness	Use of Opioids at High Dosage (HDO) (lower is better)	6%	6%	
Prevention and Screening	Childhood Immunization Status (CIS), Combo 2	66%	64%	
	Childhood Immunization Status (CIS), Combo 10	34%	39%	↑
	Immunizations for Adolescents (IMA), Combo 2	32%	40%	
	Lead Screening in Children (LSC)	31%	34%	
	Breast Cancer Screening (BCS)	46%	48%	↑
	Cervical Cancer Screening (CCS)	48%	55%	
	Chlamydia Screening (CHL), Total	42%	50%	↑
Respiratory Conditions	Asthma Medication Ratio (AMR), Total	55%	63%	↑
Utilization	Well-Child Visits in the First 30 Months of Life (W30), 0-15 Months	52%	54%	
	Well-Child Visits in the First 30 Months of Life (W30), 16-30 Months	68%	68%	
	Child and Adolescent Well-Care Visit (WCV), Age 3-11	47%	47%	
	Child and Adolescent Well-Care Visit (WCV), Age 12-17	35%	35%	
	Child and Adolescent Well-Care Visit (WCV), Age 18-21	16%	18%	↑
	Child and Adolescent Well-Care Visit (WCV), Total	38%	39%	

- In the Access/Availability of Care section, the urban population was statistically significantly higher for the Initiation and Engagement of AOD Dependence (IET) measures.

- The urban population was statistically significantly higher for several of the Prevention Screening measures, including Breast Cancer Screening (BSC), Childhood Immunization Status (CIS), Combo 10 and Chlamydia Screening (CHL), Total.
- The Asthma Medication Ratio (AMR) measure was also statistically significantly higher for the urban population.
- The rural population performed statistically significantly higher for the Follow-Up after Hospitalization for Mental Illness (FUH), Follow-Up after ED Visit for Mental Illness (FUM), and Pharmacotherapy for Opioid Use Disorder (POD) measures.
- It is interesting to see higher performance in rural areas on these measures given the historical barriers to access to behavioral health services in rural areas

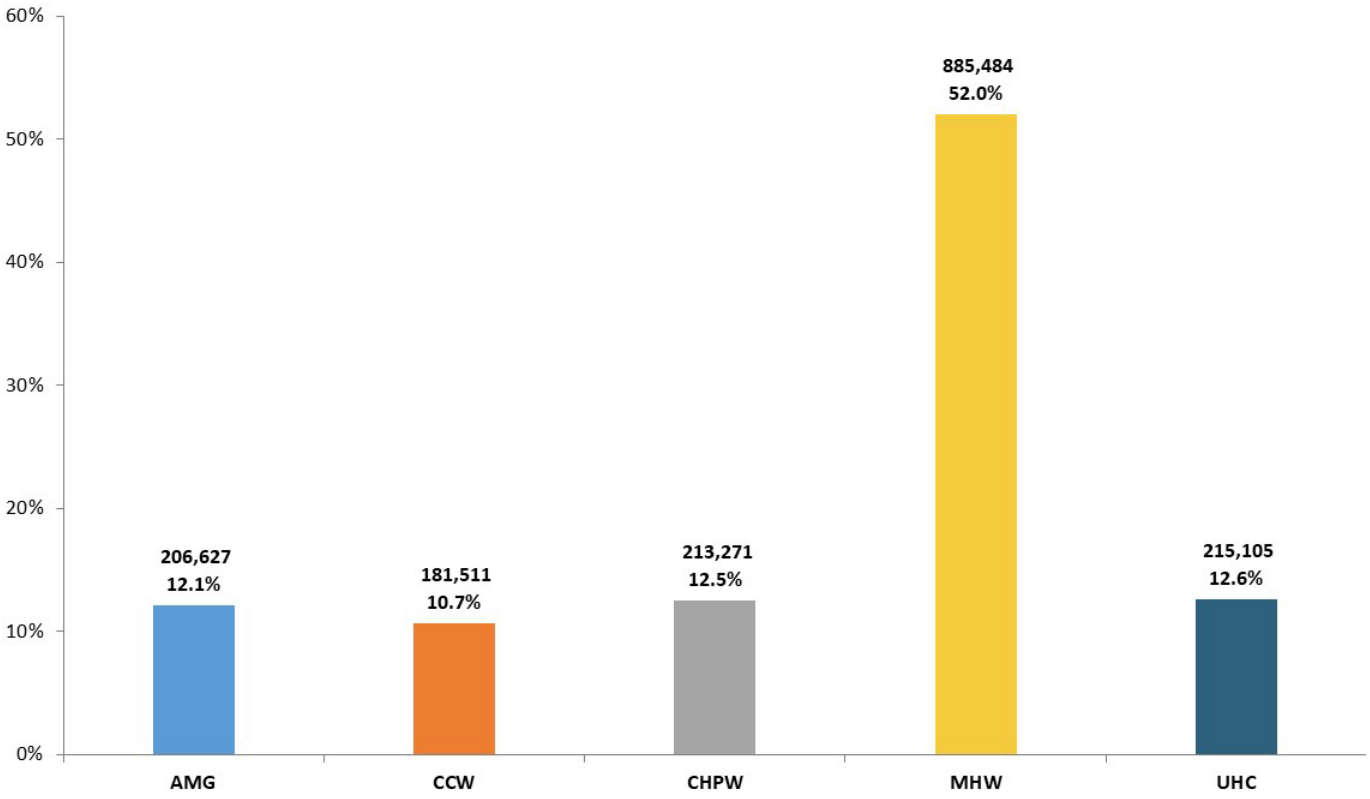
MCO-Specific Results

This section of the report presents MCO-specific demographic data and results on performance measures for each MCO. Washington MCOs have different member populations, and these differences may impact MCO performance on different measures. Because of this variation, it is important to monitor performance at both the plan and program levels.

MCO Enrollment

Figure 52 shows Medicaid enrollment by MCO. MHW enrolls about half of the Medicaid members in Washington. The rest of the member population is distributed across the remaining four plans, with 10.7% in CCW and about 12% in AMG, CPHW and UHC, respectively.

Figure 52. Percent of Total Statewide Medicaid Enrollment, According to MCO.



Demographics by MCO

Variation between MCOs' demographic profiles is a reflection of the difference in plan mix for each MCO and should be taken into account when assessing HEDIS measurement results.

Age

Figure 53 shows the percentages of enrollment by age group and MCO. The darker blue signifies a higher percentage, while lighter blue signifies lower, with a medium gradient for those values in between.

Though the average age of members varies across plans, the highest proportion of members across MCOs was in the 21–44 age group.

Figure 53. Enrollee Population by MCO and Age Range, MY2020.

Age Range	AMG	CCW	CHPW	MHW	UHC
Age 0 to 5	13.9%	17.3%	14.0%	16.1%	13.3%
Age 6 to 12	14.4%	20.6%	19.0%	19.9%	15.0%
Age 13 to 20	13.8%	19.4%	20.0%	18.9%	14.2%
Age 21 to 44	37.6%	28.1%	30.3%	31.7%	36.4%
Age 45 to 64	20.0%	14.4%	16.4%	13.3%	20.8%
Age 65+	0.3%	0.3%	0.3%	0.1%	0.3%

% of Total Member Count

0.1% 37.6%

Race and Ethnicity by MCO

The data on race and ethnicity presented in this report was provided by members to their MCO upon their enrollment. Race is another demographic category where there is variation between the MCOs.

As shown in Figure 54, more than half of each MCO's members are white. The Other race category was the second most common for most MCOs. Note the Other race is selected by the enrollee when they identify themselves as a race other than those listed. Black members make up 11.2% of UHC's enrollee population and 9.1% of AMG's population, which were higher percentages than other MCOs.

Figure 54. Statewide Apple Health Enrollees by MCO and Race,* MY2020.

Race	AMG	CCW	CHPW	MHW	UHC
White	63.3%	52.1%	51.5%	61.3%	58.6%
Other	10.4%	21.9%	21.1%	12.7%	8.3%
Not Provided	7.4%	9.1%	8.5%	7.8%	8.3%
Black	9.1%	8.0%	8.4%	8.5%	11.2%
Asian	4.2%	4.0%	6.2%	4.3%	6.8%
American Indian/Alaska Native	1.8%	1.8%	1.4%	1.9%	1.9%
Hawaiian/Pacific Islander	3.8%	3.0%	3.0%	3.5%	5.0%

**These are the categories MCOs provide to HCA in eligibility data files. The "Other" category is defined as "client identified as a race other than those listed." And the "Not Provided" category is defined as "client chose not to provide."*

Figure 55 shows the percentage of MCO members who identified as Hispanic. CCW and CHPW have the largest percentages of Hispanic members at 35.8% and 33.0%, respectively. Please note that within this report, Hispanic is used to identify an ethnicity and does not indicate race.

Figure 55. Statewide Apple Health Enrollees by MCO and Hispanic Indicator, MY2020.

Hispanic	AMG	CCW	CHPW	MHW	UHC
N	81.1%	64.2%	67.0%	78.8%	86.8%
Y	18.9%	35.8%	33.0%	21.2%	13.2%

Primary Spoken Language by MCO

According to Apple Health eligibility data, there are approximately 85 separate spoken languages among members. Many of these languages have very small numbers of speakers in the Apple Health population. Therefore, only the most common non-English languages are listed in this report (HCA provides Apple Health-related written materials in these same 15 languages).

Figure 56 shows the variation in the most common primary spoken languages. Across MCOs, Spanish; Castilian is the second most common language after English. Among other languages, such as Russian and Vietnamese, the percentages are much smaller and vary by MCO.

Figure 56. Statewide Apple Health Enrollees by MCO and Spoken Language, MY2020.

Spoken Language	AMG	CCW	CHPW	MHW	UHC
English	90.23%	82.91%	78.88%	89.49%	93.81%
Spanish; Castilian	6.72%	13.67%	15.80%	7.22%	2.95%
Russian	0.34%	0.17%	0.64%	1.00%	0.37%
Vietnamese	0.36%	0.54%	0.88%	0.39%	0.62%
Chinese	0.38%	0.34%	1.08%	0.18%	0.38%
Arabic	0.20%	0.18%	0.36%	0.21%	0.29%
Ukrainian	0.15%	0.11%	0.10%	0.28%	0.15%
Somali	0.16%	0.11%	0.38%	0.17%	0.17%
Korean	0.08%	0.07%	0.07%	0.08%	0.26%
Amharic	0.11%	0.06%	0.17%	0.07%	0.09%
Panjabi; Punjabi	0.04%	0.06%	0.07%	0.07%	0.05%
Burmese	0.06%	0.07%	0.14%	0.05%	0.05%
Tigrinya	0.09%	0.04%	0.13%	0.06%	0.06%
Farsi	0.05%	0.04%	0.08%	0.04%	0.04%
Cambodian; Khmer	0.05%	0.03%	0.05%	0.04%	0.06%
Other Language*	0.98%	1.61%	1.17%	0.65%	0.66%

**Other Language is the sum of the 67 languages not specifically reported in this table and represents less than 1% of enrollees.*

MCO-Specific Performance for MY2020

This section of the report presents MCO-specific results for selected measures. These 41 measures, which include 39 HEDIS measures and two Washington behavioral health measures, reflect current HCA priorities and are part of the Statewide Common Measure Set. They also represent a broad population base or population of specific or prioritized interest.

MCO Performance Variation for Selected Measures

This section includes two different perspectives on assessing MCO performance. The first is to look at year-over-year performance to determine if rates are improving. The second perspective for assessing performance is to compare measure results to benchmarks.

Figures 57 and 58 show the MY2020 statewide weighted average results that were displayed in Figure 4 with the addition of the results for each of the five MCOs. The arrows represent statistically significant changes in measure results between MY2019 and MY2020 for that MCO; arrows pointing down represent a statistically significant decrease and arrows pointing up indicate a statistically significant increase in performance for that MCO between years.

Figure 57. MCO Variation from MY2019 to MY2020.

↓ ↑ Statistically significant difference from **previous measurement year**

		AMG	CCW	CHPW	MHW	UHC	Statewide Weighted Avg
Access / Availability of Care	Adults' Access to Preventive/Ambulatory Health Services (AAP), Total	68%↓	71%↓	73%↓	76%↓	72%↓	73%↓
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET), Total: Initiation of AOD Treatment: 13-17 Years	42%	36%	34%	34%	36%	36%↑
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET), Total: Initiation of AOD Treatment: Total	48%	41%	43%↑	46%↑	45%	45%↑
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET), Total: Engagement of AOD Treatment: Total	16%	14%	16%↑	17%↑	16%↑	16%↑
	Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care	79%	78%	88%↑	82%↓	86%	83%
	Prenatal and Postpartum Care (PPC), Postpartum Care	72%↑	73%	82%	77%	75%	77%↑
	Use of First-Line Psychosocial Care for Children and Adolsecents (APP), Total	52%	65%	56%	64%	52%	61%
Behavioral Health	Antidepressant Medication Management (AMM), Effective Acute Phase	53%	59%	57%	61%↑	57%↑	58%↑
	Antidepressant Medication Management (AMM), Continuation Phase	38%	41%	43%	45%↑	43%↑	43%↑
	Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	45%↑	46%↑	41%	45%	47%↑	45%
	Follow-Up Care for Children Prescribed ADHD Medication (ADD), Continuation	53%	54%	45%	53%	54%	52%
	Follow-Up after Hospitalization for Mental Illness (FUH), 30-Day Follow-Up, Total	47%↑	47%↑	61%↑	67%↑	47%↑	57%↑
	Follow-Up after Hospitalization for Mental Illness (FUH), 7-Day Follow-Up, Total	31%↑	34%↑	41%↑	48%↑	33%↑	40%↑
	Follow-Up After Emergency Department Visit for Mental Illness (FUM), 30-Day Follow-Up, Total	45%↑	50%	61%	64%↑	56%	58%↑
	Follow-Up After Emergency Department Visit for Mental Illness (FUM), 7-Day Follow-Up, Total	32%↑	37%	48%	51%↑	43%↑	45%↑
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependencies (FUA), 30-Day Follow-Up, 13-17 Years	24%	16%	21%	16%	15%	17%
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependencies (FUA), 30-Day Follow-Up, Total	27%	21%	34%	31%↑	26%↑	29%↑
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependencies (FUA), 7-Day Follow-Up, Total	18%	13%	22%	20%↑	16%↑	19%↑
	Follow-Up After High Intensity Care for Substance Use Disorder (FUI): 30-Day Follow-Up, Total	56%	56%	60%	59%	56%	58%
	Follow-Up After High Intensity Care for Substance Use Disorder (FUI): 7-Day Follow-Up, Total	38%	36%	41%	39%	36%	38%
	Pharmacotherapy for Opioid Use Disorder (POD): Total	21%	18%	16%	20%↑	22%	19%
	Substance Use Disorder Treatment Penetration (SUD), 12-64 years	39%↑	35%	40%	38%	39%↑	38%↑
	Mental Health Treatment Penetration (MH-B), 6-64 years	52%↓	55%↑	54%↑	55%↑	49%↓	54%↓

Figure 58. MCO Variation from MY2019 to MY2020 (continued).

Statistically significant difference from **previous measurement year**

		AMG	CCW	CHPW	MHW	UHC	Statewide Weighted Avg.
Cardiovascular Conditions	Controlling High Blood Pressure (CBP)	57%	58%	63%	56%	62%	59%
Diabetes	Comprehensive Diabetes Care (CDC), Poor HbA1c Control (lower is better)	40%	45%	41%	36%	30%	37%
	Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0%	48%	45%	49%	54%	58%	52%
Overuse / Appropriateness	Use of Opioids at High Dosage (HDO) (lower is better)	6%	7%	6% ↑	6%	8%	6% ↑
Prevention and Screening	Childhood Immunization Status (CIS), Combo 2	72%	78%	77%	63% ↓	67%	68% ↓
	Childhood Immunization Status (CIS), Combo 10	40%	52%	48%	37%	44%	42% ↓
	Immunizations for Adolescents (IMA), Combo 2	36%	43%	44%	39%	34%	40%
	Lead Screening in Children (LSC)	31%	34%	41%	34%	26%	34%
	Breast Cancer Screening (BCS)	42% ↓	49% ↓	46% ↓	50% ↓	49% ↓	48% ↓
	Cervical Cancer Screening (CCS)	48%	51%	55%	66%	53%	59%
	Chlamydia Screening (CHL), Total	49% ↓	52% ↓	49% ↓	50% ↓	48% ↓	50% ↓
Respiratory Conditions	Asthma Medication Ratio (AMR), Total	58% ↑	61% ↑	64% ↑	64% ↑	58%	62% ↑
Utilization	Well-Child Visits in the First 30 Months of Life (W30), 0-15 Months	50%	56%	62%	54%	45%	54%
	Well-Child Visits in the First 30 Months of Life (W30), 16-30 Months	67%	72%	67%	68%	67%	68%
	Child and Adolescent Well-Care Visit (WCV), Age 3-11	42%	49%	45%	48%	43%	47%
	Child and Adolescent Well-Care Visit (WCV), Age 12-17	29%	36%	34%	36%	31%	35%
	Child and Adolescent Well-Care Visit (WCV), Age 18-21	15%	16%	17%	19%	17%	18%
	Child and Adolescent Well-Care Visit (WCV), Total	34%	40%	37%	40%	36%	39%

There have been some intriguing statistically significant improvements that can be seen across all MCOs. Several of the behavioral health measures have improved between MY2019 and MY2020. In addition, all of the MCOs except UHC have seen statistically significant improvement for the Asthma Medication Ratio (AMR), Total measure.

There are also a few consistent statistically significant declines in performance across all MCOs. The Adults' Access to Preventive/Ambulatory Health Services (AAP), Total, Breast Cancer Screening (BSC), and Chlamydia Screening (CHL) measures declined for all MCOs between MY2019 and MY2020.

The second perspective for assessing performance is to compare measure results to benchmarks.

Figure 59 shows how the statewide average and the individual MCOs compare to the national HEDIS 50th and 75th percentiles. Note, this table excludes the two Washington Health behavioral health measures that do not have national benchmarks.

Figure 59. Statewide and MCO Variation from Benchmarks, by National Percentile.

Percentiles: Below 50th | At 50th | Between 50th & 75th | At or Above 75th

		AMG	CCW	CHPW	MHW	UHC	Statewide Weighted Average
Access / Availability of Care	Adults' Access to Preventive/Ambulatory Health Services (AAP), Total	68%	71%	73%	76%	72%	73%
	I&E of AOD Dependence Treatment (IET): Total Initiation of Treatment: 13-17 yrs	42%	36%	34%	34%	36%	36%
	I&E of AOD Dependence Treatment (IET): Total Initiation of Treatment: Total	48%	41%	43%	46%	45%	45%
	I&E of AOD Dependence Treatment (IET): Total Engagement in Treatment: Total	16%	14%	16%	17%	16%	16%
	Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care	79%	78%	88%	82%	86%	83%
	Prenatal and Postpartum Care (PPC), Postpartum Care	72%	73%	82%	77%	75%	77%
	Use of First-Line Psychosocial Care for Children and Adolsecents (APP), Total	52%	65%	56%	64%	52%	61%
Behavioral Health	Antidepressant Medication Management (AMM), Effective Acute Phase	53%	59%	57%	61%	57%	58%
	Antidepressant Medication Management (AMM), Continuation Phase	38%	41%	43%	45%	43%	43%
	Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	45%	46%	41%	45%	47%	45%
	Follow-Up Care for Children Prescribed ADHD Medication (ADD), Continuation	53%	54%	45%	53%	54%	52%
	Follow-Up after Hospitalization for Mental Illness (FUH), 30-Day Follow-Up, Total	47%	47%	61%	67%	47%	57%
	Follow-Up after Hospitalization for Mental Illness (FUH), 7-Day Follow-Up, Total	31%	34%	41%	48%	33%	40%
	Follow-Up After ED Visit for Mental Illness (FUM), 30-day, Total	45%	50%	61%	64%	56%	58%
	Follow-Up After ED Visit for Mental Illness (FUM), 7-day, Total	32%	37%	48%	51%	43%	45%
	Follow-Up After ED Visit for AOD Dependency (FUA), 30-day, 13-17 years	24%	16%	21%	16%	15%	17%
	Follow-Up After ED Visit for AOD Dependency (FUA), 30-day, Total	27%	21%	34%	31%	26%	29%
	Follow-Up After ED Visit for AOD Dependency (FUA), 7-day, Total	18%	13%	22%	20%	16%	19%
	Follow-Up After High Intensity Care for SUD (FUI), 30-day, Total	56%	56%	60%	59%	56%	58%
	Follow-Up After High Intensity Care for SUD (FUI), 7-day, Total	38%	36%	41%	39%	36%	38%
	Pharmacotherapy for Opioid Use Disorder (POD): Total	21%	18%	16%	20%	22%	19%
Cardiovascular..	Controlling High Blood Pressure (CBP)	57%	58%	63%	56%	62%	59%
Diabetes	Comprehensive Diabetes Care (CDC), Poor HbA1c Control (lower is better)	40%	45%	41%	36%	30%	37%
	Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0%	48%	45%	49%	54%	58%	52%
Overuse / App..	Use of Opioids at High Dosage (HDO) (lower is better)	6%	7%	6%	6%	8%	6%
Prevention and Screening	Childhood Immunization Status (CIS), Combo 2	72%	78%	77%	63%	67%	68%
	Childhood Immunization Status (CIS), Combo 10	40%	52%	48%	37%	44%	42%
	Immunizations for Adolescents (IMA), Combo 2	36%	43%	44%	39%	34%	40%
	Lead Screening in Children (LSC)	31%	34%	41%	34%	26%	34%
	Breast Cancer Screening (BCS)	42%	49%	46%	50%	49%	48%
	Cervical Cancer Screening (CCS)	48%	51%	55%	66%	53%	59%
	Chlamydia Screening (CHL), Total	49%	52%	49%	50%	48%	50%
Respiratory Co..	Asthma Medication Ratio (AMR), Total	58%	61%	64%	64%	58%	62%
Utilization	Well-Child Visits in the First 30 Months of Life (W30), 0-15 Months	50%	56%	62%	54%	45%	54%
	Well-Child Visits in the First 30 Months of Life (W30), 16-30 Months	67%	72%	67%	68%	67%	68%
	Child and Adolescent Well-Care Visit (WCV), Age 3-11	42%	49%	45%	48%	43%	47%
	Child and Adolescent Well-Care Visit (WCV), Age 12-17	29%	36%	34%	36%	31%	35%
	Child and Adolescent Well-Care Visit (WCV), Age 18-21	15%	16%	17%	19%	17%	18%
	Child and Adolescent Well-Care Visit (WCV), Total	34%	40%	37%	40%	36%	39%

It is worth noting that although there can be statistically significant year-over-year improvement on a given measure, the overall measure performance can still be below the national benchmarks. For example, there was a statistically significant increase for the Asthma Medication Ration (AMR), Total measure, but the statewide average and four of the five of the MCOs are performing below the national 50th percentile.

Also notable is the variation by individual measures. There are measures where there is no variation in the comparison to benchmarks for the statewide average or the individual MCOs; an example of this is the Breast Cancer Screening (BCS) measure, which is below the national 50th percentile across the board. Other measures show variation in the comparison to national benchmarks. For example, the statewide average for the Well-Child Visits in the First 30 Months of Life (W30), 0-15 Months is below the national 50th percentile, as are the rates for AMG and UHC. However, the rates for CCW and MHW are between the national 50th percentile and the 75th percentile, and the rate for CHPW is above the national 75th percentile.

MCO Scorecards

Comagine Health compared MCO performance on each measure to the statewide simple average for that measure and created a "scorecard" chart for each MCO. Comagine Health chose to use the simple average for the MCO scorecards because the Apple Health MCOs are of such different sizes. The state simple average for a given measure is calculated as the average of the measure rate for the MCOs that reported that measure. The potential disadvantage of comparing an individual MCO to a weighted state average is that significantly larger plans could have undue influence on the state rate. A simple average of the plans (rather than a weighted average) mitigates those concerns.

Here is a summary of the key findings from the MCO scorecards:

- **AMG** performed below the state simple average for the majority of the measures. A few of the behavioral health measures were above the state simple average.
- **CCW** had more of a mixed performance, with performance well above the state simple average on several measures, but performance well below the state simple average on others. Although CCW has several pediatric measures where the rates were above the state simple average, it performed below the state simple average on many measures related to maternity and pediatric care. Many of the behavioral health measures were below the state simple average for CCW.
- **CHPW** performed above the state simple average for the majority of the measures, including several pediatric and behavioral health measures.
- **MHW** performed above the state simple average for several measures and close to the state average for others.
- **UHC** performed close to the state simple average for the majority of the measures.

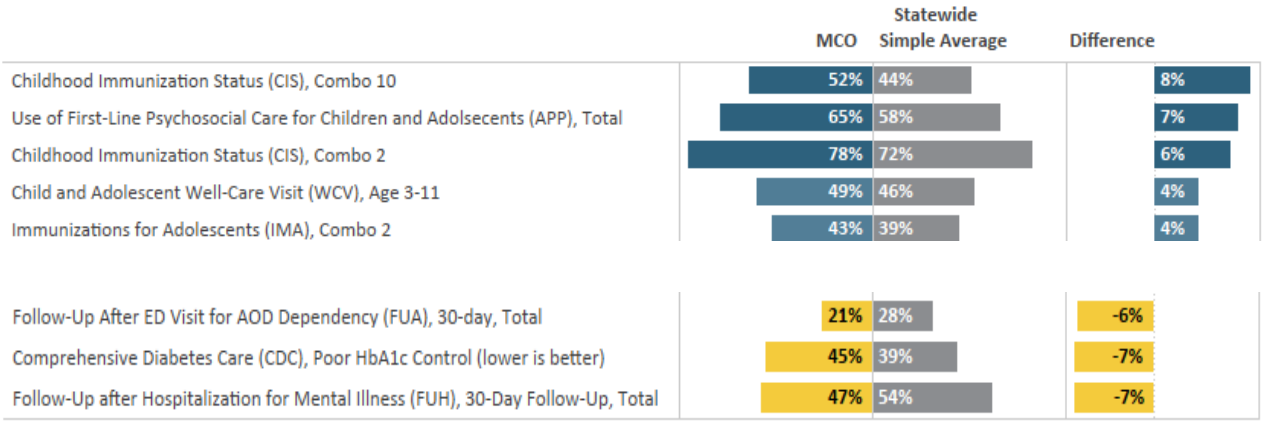
More detail on the specific measures where the MCOs performed well can be found on the following pages.

Figure 60 shows a snapshot of the scorecard to illustrate how to read these.

The measures are listed in the left column with MCO performance and the statewide simple average listed in the middle columns. The difference column, on the right, shows the difference in percentage points between the MCO's rate and the statewide average.

Color coding: blue shading indicates a positive difference from the statewide average; that is, the MCO performed better/higher on that measure. Yellow shading indicates lower performances than the statewide average.

Figure 60. Example of MCO Scorecard.



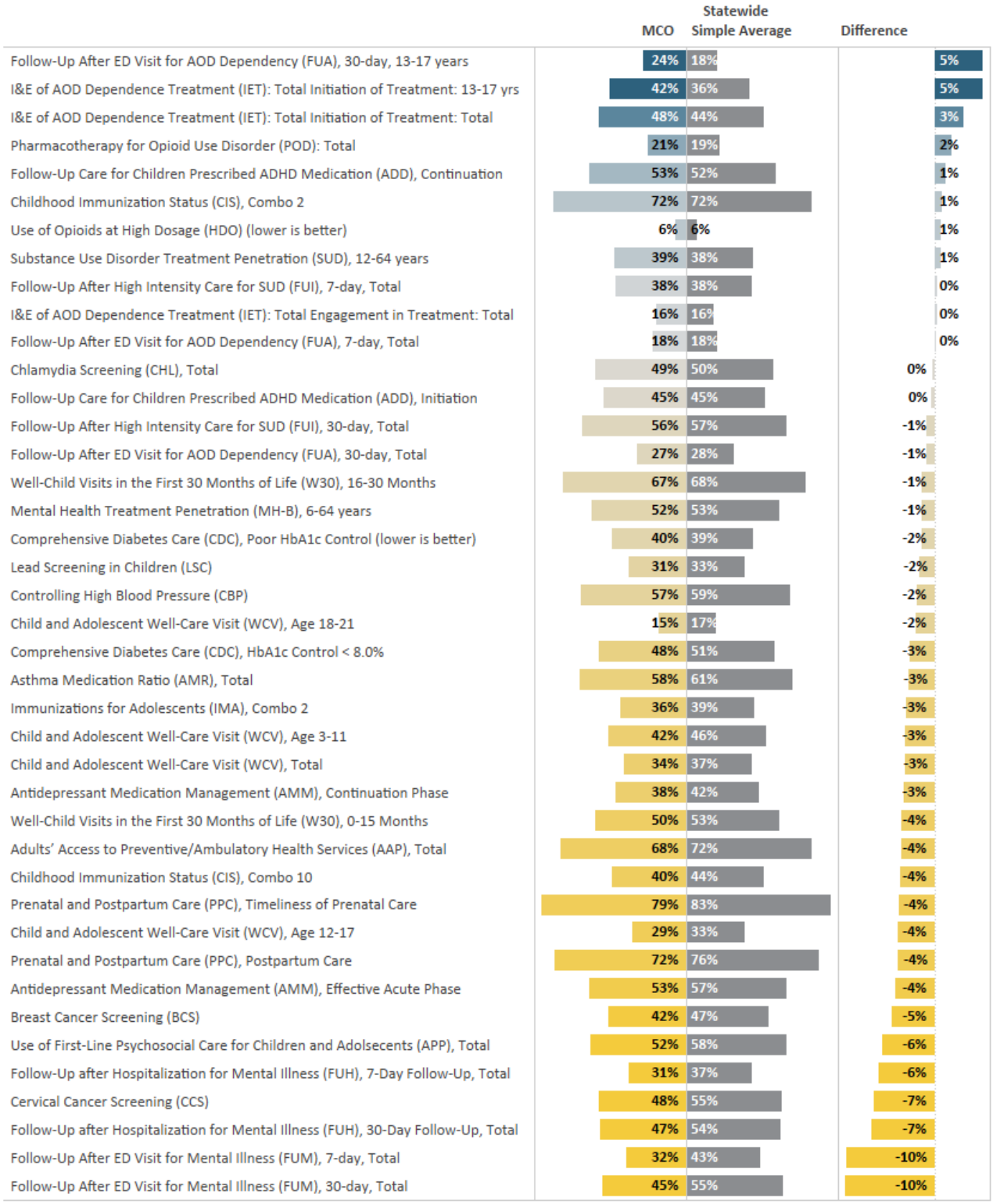
The MCO performance scorecards on the following pages (Figures 61–65) highlight the variance of measures from the simple state average.

Comagine Health chose to use the simple average for the MCO scorecards as the Apple Health MCOs are of such different sizes; note that the simple state average is different than the weighted state average used in other sections of the report. The potential disadvantage of comparing an individual MCO to a weighted state average is that significantly larger plans could have undue influence on the state rate. A simple average of the plans (rather than a weighted average) mitigates those concerns. Please refer to the methodology section of this report for more information on how the simple state average is calculated.

Amerigroup Washington (AMG)

A few of the behavioral health measures were above the state simple average, most notably Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependencies (FUA), 30-Day Follow-Up, 13-17 Years and Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET), Total: Initiation of AOD Treatment: 13-17 Years measures. (The state simple average for a measure is calculated as the average of the measure rate for the MCOs that reported the measure.) However, the remaining behavioral health measures were below the state simple average, including the Follow-Up after Hospitalization for Mental Illness (FUH) and the Follow-Up after ED Visit for Mental Illness (FUM) measures. The Breast Cancer Screening (BCS) and Cervical Cancer Screening (CCS) measures are also below the state simple average.

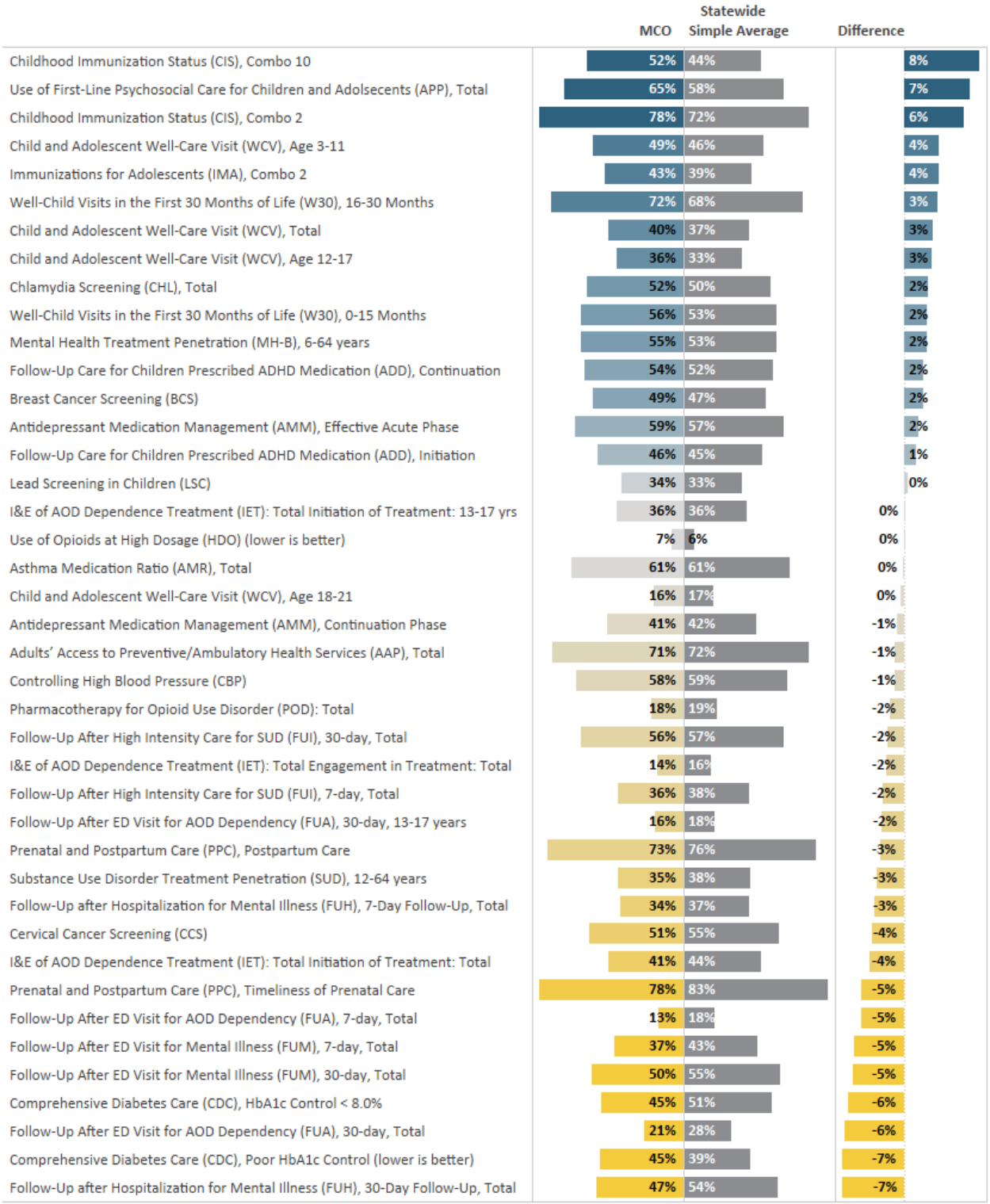
Figure 61. AMG Scorecard.



Coordinated Care of Washington (CCW)

CCW has several pediatric measures where the rates were above the state simple average. In addition, CCW performs better than the state simple average for the Comprehensive Diabetes Care (CDC), Poor HbA1c Control measure. Many of the behavioral health measures are below the state simple average for CCW. Other measures where their rates were markedly below the state simple average include Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care and Postpartum Care; Cervical Cancer Screening (CCS), and Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0%.

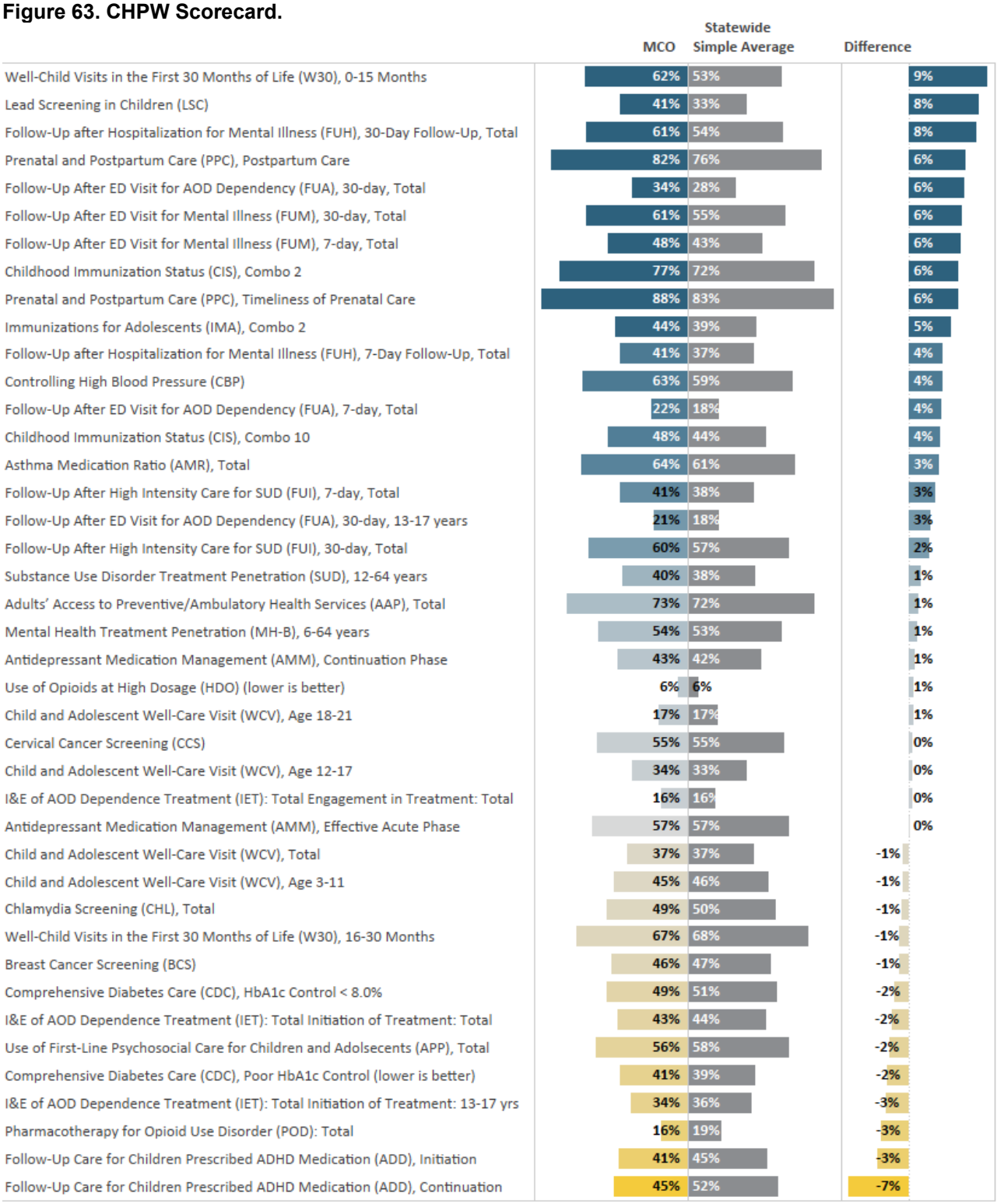
Figure 62. CCW Scorecard.



Community Health Plan of Washington (CHPW)

CHPW performs above the state simple average for many of the measures, including several pediatric and behavioral health measures. CHPW was also well above the state simple average for the Prenatal and Postpartum (PPC) measures for both the Timeliness of Prenatal Care and Postpartum Care components. The only measure where CHPW is notably below the state simple average were the Follow-Up Care for Children Prescribed ADHD Medication (ADD), for both the Initiation and Continuation phase.

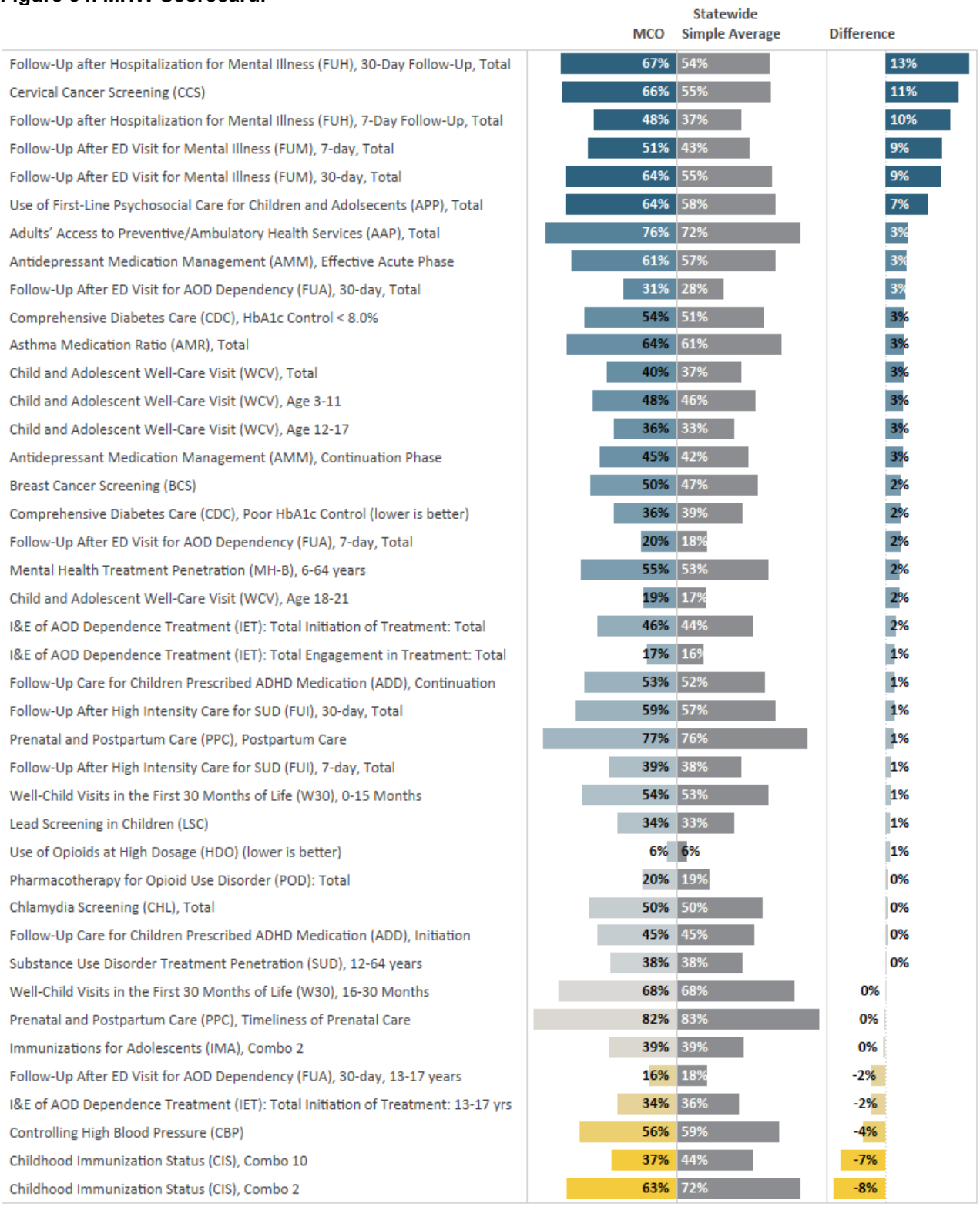
Figure 63. CHPW Scorecard.



Molina Healthcare of Washington (MHW)

MHW performed markedly above the state simple average for the Follow-Up after Hospitalization for Mental Illness (FUH), Follow-Up After Emergency Department Visit for Mental Illness (FUM), Cervical Cancer Screening (CCS), and Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), Total measures. They were above the state simple average for several other measures. MHW was markedly below the state simple average for the Childhood Immunization Status (CIS), Combo 2 and Combo 10 measures. As a reminder, comparisons are made using the state simple average to mitigate the impact of plan size when comparing a particular plan's performance. MHW, in fact, performs well after mitigating the impact its size would have on the state average.

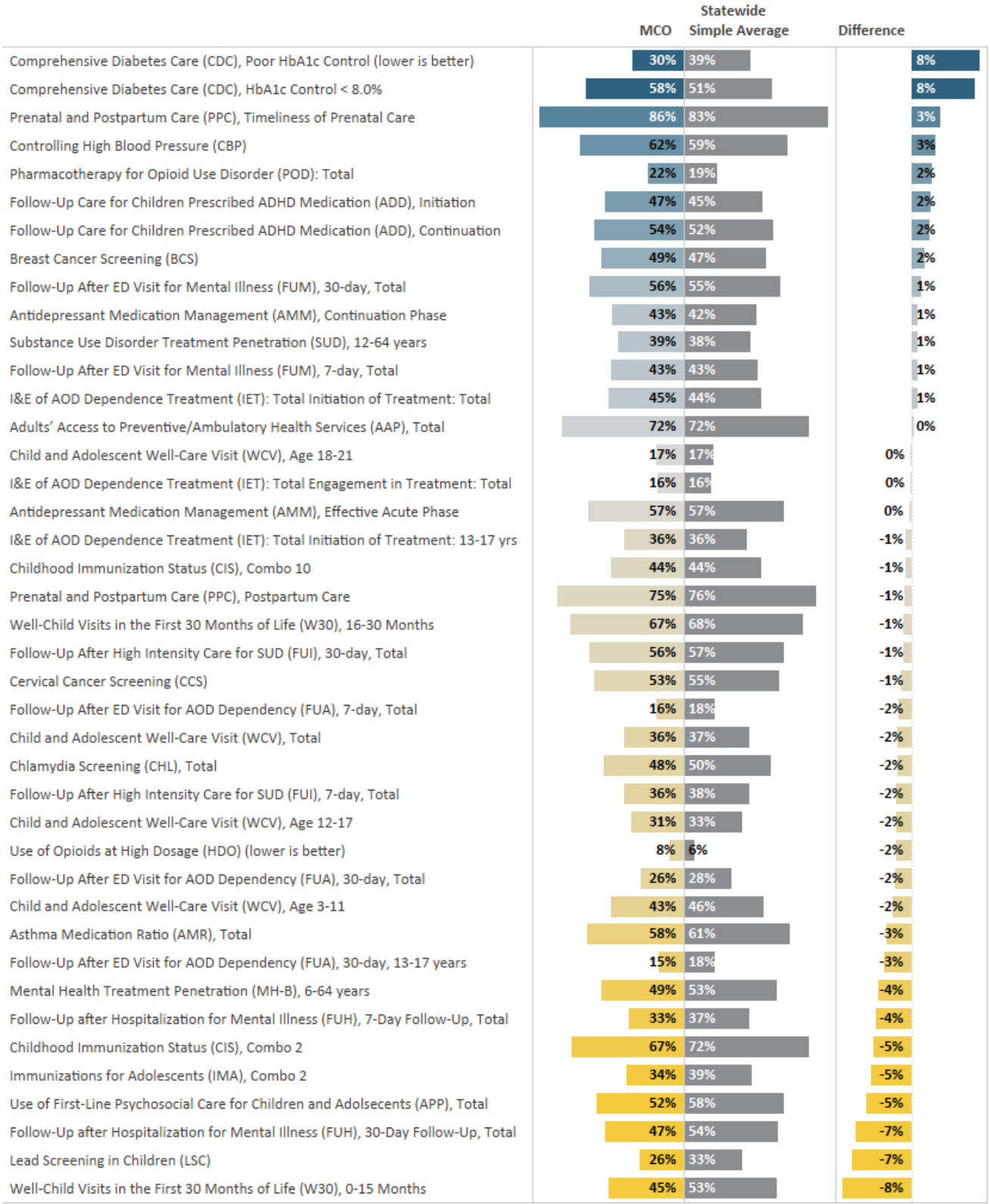
Figure 64. MHW Scorecard.



UnitedHealthcare Community Plan (UHC)

For many of the measures, UHC performed close to the state simple average. UHC performed markedly above the state average for the Comprehensive Diabetes Care (CDC), Poor HbA1c Control and Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0% measure. UHC was markedly below the average for the Well-Child Visits in the First 30 Months of Life (W30), 0-15 Months, Lead Screening in Children (LSC), Follow-Up after Hospitalization for Mental Illness (FUH), 30-Day Follow-Up, Total, Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), Total, Childhood Immunization Status (CIS), Combo 2, and Immunizations for Adolescents (IMA), Combo 2 measures.

Figure 65. UHC Scorecard.



Regional Comparison

This section compares the selected measures by region. The regional comparison is imperative because it provides contextual information on the potential unique population needs and health inequities within each region. The regional comparison provides additional depth and understanding of the health and well-being of Medicaid enrollees.

As shown in Table 2 below, MCO coverage varies by region, with only two MCOs that are present in all 10 Regional Service Areas as of July 1, 2021.

Table 2. MCO Coverage by Region (AH-IMC and AH-BHSO only).

Regions	Managed Care Organizations				
Regional Service Areas with their counties	**AMG**	**CCW**	**CHPW**	**MHW**	**UHC**
Great Rivers *Cowlitz, Grays Harbor, Lewis, Pacific and Wahkiakum counties*	✓	–	–	✓	✓
Greater Columbia *Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Whitman and Yakima counties*	✓	✓	✓	✓	–
King *King County*	✓	✓	✓	✓	✓
North Central *Chelan, Douglas, Grant and Okanogan counties*	✓	✓	✓	✓	–
North Sound *Island, San Juan, Skagit, Snohomish and Whatcom counties*	✓	✓	✓	✓	✓
Pierce *Pierce County*	✓	✓	✓	✓	✓
Salish *Clallam, Jefferson and Kitsap counties*	✓	–	✓	✓	✓
Southwest *Clark, Klickitat and Skamania counties*	✓	✓	✓	✓	–
Spokane *Adams, Ferry, Lincoln, Pend Oreille, Spokane and Stevens counties*	✓	✓	✓	✓	–
Thurston-Mason *Mason and Thurston counties*	✓	–	–	✓	✓

✓ *Indicates the MCO covers that region.*

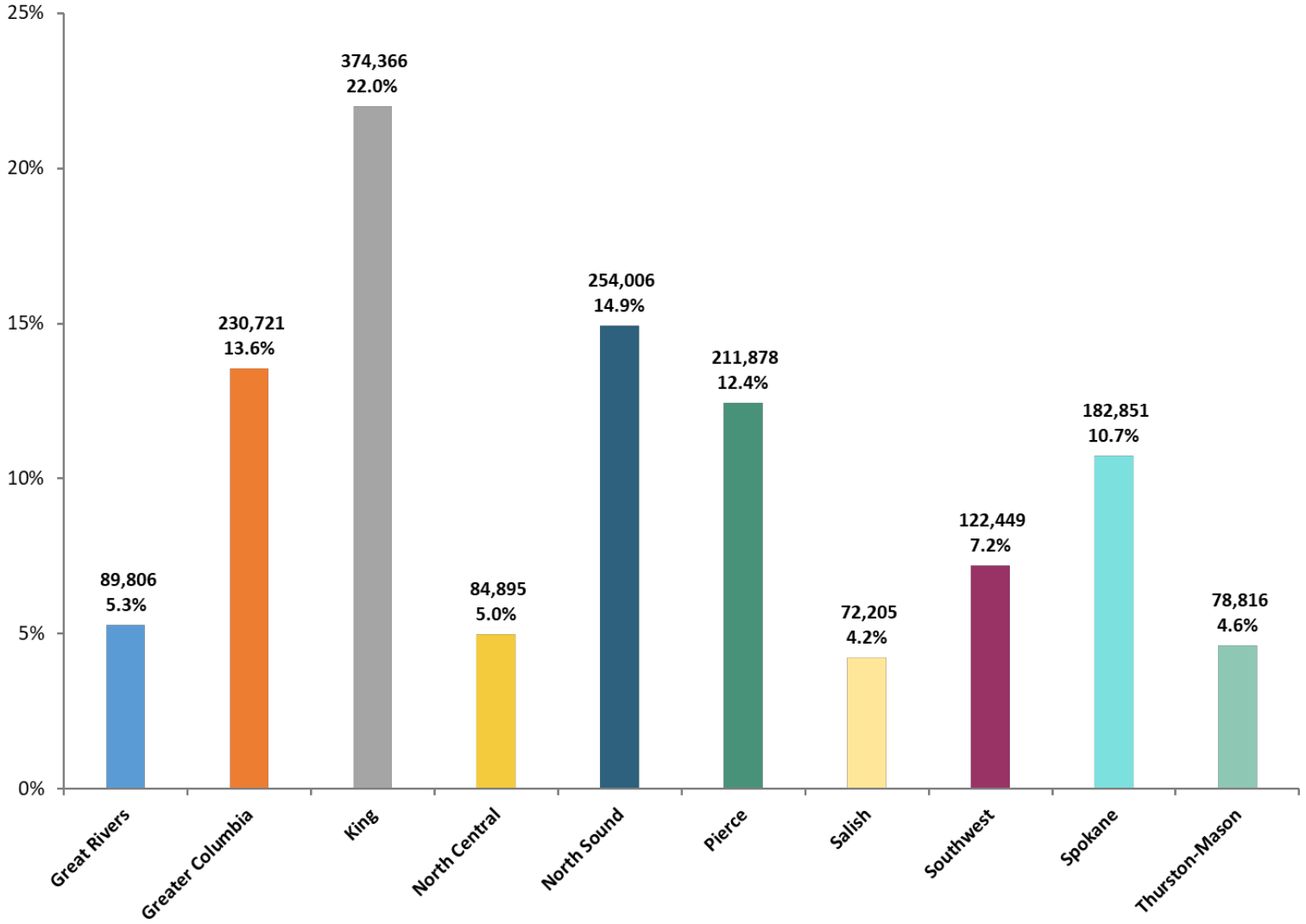
– *Indicates the MCO does not cover that region.*

Demographics by Region

As with MCO performance compared in previous sections, differences between the member populations of each region may impact regional performance on different measures.

Figure 66 shows Medicaid enrollment by region. Not surprisingly, the regions that include the Seattle metropolitan area have the largest enrollment, while the more sparsely populated Salish and Thurston-Mason regions have the smallest Medicaid enrollments.

Figure 66. Percent Enrollment of Total Apple Health Enrollment Statewide by Region, 2021.



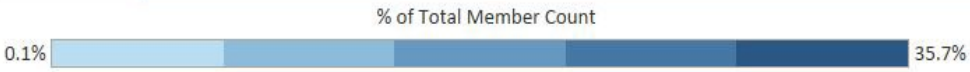
Age Range

Across regions, the largest percentage of enrollees are ages 21 to 44 (Figure 67). All regions have enrollees across all age groups, with Greater Columbia and North Central having higher percentages in the youth and children ages 6 to 12 groups.

In this chart and those that follow, the darker blue signifies a higher percentage, while lighter blue signifies lower, with a medium gradient for those values in between.

Figure 67. Percent Enrollment by Region and Age Range, MY2020.

Age Range	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	Southwest	Spokane	Thurston - Mason
Age 0 to 5	14.7%	17.4%	14.2%	17.3%	15.5%	15.7%	13.3%	15.6%	14.8%	14.6%
Age 6 to 12	17.9%	21.5%	17.0%	22.1%	18.4%	18.6%	15.9%	19.3%	17.9%	17.5%
Age 13 to 20	17.2%	21.3%	16.4%	21.6%	17.4%	17.4%	15.6%	18.8%	17.2%	16.1%
Age 21 to 44	31.9%	28.3%	34.3%	26.1%	32.3%	33.0%	35.7%	31.5%	34.6%	35.3%
Age 45 to 64	18.1%	11.3%	17.7%	12.8%	16.1%	15.1%	19.4%	14.6%	15.4%	16.4%
Age 65+	0.1%	0.1%	0.4%	0.2%	0.2%	0.2%	0.2%	0.2%	0.1%	0.2%



Race and Ethnicity

This data is reported in categories to align eligibility data collected and provided by DSHS when a client enrolls in Apple Health. Note that in addition to a specific race, members could select “other,” meaning, “client identified as a race other than those listed.” The “not provided” category is defined as, “client chose not to provide”; in other words, the member did not select any of the race categories.

Figure 68 shows that the member population for most regions is at least 50% white. The exception is the King region, which is 39.02% white, 19.78% Black, 11.68% Asian and 5.73% Hawaiian/Pacific Islander. All regions have at least a 1% American Indian/Alaskan Native membership, with the highest percentages in the Great Rivers, Spokane and Thurston-Mason regions.

Figure 68. Statewide Apple Health Enrollees by Region and Race, MY2020.

Race	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	Southwest	Spokane	Thurston - Mason
White	79.8%	54.4%	39.0%	63.4%	62.5%	53.4%	74.0%	69.2%	77.2%	70.2%
Other	7.5%	31.7%	12.6%	24.0%	13.0%	10.4%	5.8%	9.7%	6.3%	8.2%
Not Provided	5.9%	8.0%	9.8%	8.5%	8.9%	7.5%	7.0%	8.7%	5.5%	6.5%
Black	2.0%	2.2%	19.8%	1.2%	5.6%	14.8%	4.9%	4.6%	4.8%	5.8%
Asian	1.1%	1.2%	11.7%	0.6%	5.1%	5.1%	1.7%	2.7%	1.6%	3.4%
American Indian/Alaska Native	2.5%	1.5%	1.3%	1.7%	2.0%	1.8%	2.0%	1.6%	2.5%	2.4%
Hawaiian/Pacific Islander	1.2%	1.0%	5.7%	0.6%	2.8%	7.0%	4.5%	3.4%	2.2%	3.4%

Figure 69. Statewide Apple Health Enrollees by Region and Hispanic Indicator, MY2020.

Hispanic	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	Southwest	Spokane	Thurston - Mason
N	84.2%	46.4%	83.0%	51.8%	80.1%	83.4%	88.8%	83.0%	88.1%	84.9%
Y	15.8%	53.6%	17.0%	48.2%	19.9%	16.6%	11.2%	17.0%	11.9%	15.1%

Primary Spoken Language by Region

Figure 70 shows the variation in primary spoken language by region. Spanish; Castilian is the second most commonly spoken language across regions, with Greater Columbia and North Central having the highest percentages. After that, Russian is the most common language with King and Southwest having the highest percentages.

Figure 70. Statewide Apple Health Enrollees by Region and Spoken Language, MY2020.

Spoken Language	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	Southwest	Spokane	Thurston - Mason
English	94.16%	79.04%	84.61%	76.17%	89.15%	92.86%	96.71%	89.46%	95.15%	94.50%
Spanish; Castilian	5.01%	19.90%	7.24%	23.22%	7.27%	4.54%	2.43%	6.10%	2.60%	4.27%
Russian	0.06%	0.18%	0.70%	0.16%	1.04%	0.62%	0.01%	2.98%	0.64%	0.02%
Vietnamese	0.05%	0.08%	1.32%	0.04%	0.46%	0.52%	0.07%	0.24%	0.13%	0.38%
Chinese	0.05%	0.06%	1.29%	0.04%	0.22%	0.09%	0.12%	0.09%	0.03%	0.07%
Arabic		0.16%	0.47%		0.36%	0.09%	0.02%	0.11%	0.32%	0.00%
Ukrainian	0.00%	0.08%	0.44%	0.12%	0.35%	0.20%		0.14%	0.06%	0.00%
Somali	0.01%	0.04%	0.79%		0.01%	0.01%			0.01%	0.01%
Korean	0.01%	0.01%	0.17%		0.20%	0.20%	0.02%	0.03%	0.00%	0.09%
Other Language	0.61%	0.36%	1.77%	0.24%	0.58%	0.68%	0.60%	0.76%	0.90%	0.58%
Amharic		0.00%	0.34%		0.07%		0.00%	0.01%	0.01%	
Panjabi; Punjabi	0.00%	0.01%	0.16%	0.01%	0.13%	0.04%	0.00%	0.02%	0.00%	0.02%
Burmese		0.08%	0.19%		0.01%	0.00%		0.02%	0.07%	0.01%
Tigrinya		0.00%	0.27%		0.05%	0.01%		0.01%	0.03%	
Farsi		0.00%	0.16%	0.00%	0.05%	0.01%	0.01%	0.01%	0.04%	
Cambodian; Khmer	0.04%		0.07%		0.04%	0.13%		0.03%	0.00%	0.04%

% of Total Member Count

0.00% 96.71%

Note: the blank cells mean that those languages were not reported for that region.

Region-Specific Performance

This section presents performance on the selected measures by region. Appendix D contains state maps showing regional performance.

MCO Performance by Region

This analysis compares MCO performance within each RSA. The key question explored in this section is whether a particular MCO is performing differently within a region than the region as a whole. Each MCO's performance within the region will be compared to the regional weighted average.

HCA provided the definitions of RSAs, which are defined by county. Note the RSAs reflect the regional footprint for the Integrated Managed Care plans. The HCA enrollment file includes the county of residence for each measure. This was used to stratify the measure results by RSA and MCO.

Similar to data presented in the Health Equity section of this report, denominators for some measures get very small once the data is stratified by RSA and MCO. Rates where the denominators are less than 30 have been suppressed and are indicated with "***". Note that an "NR" will be used to indicate when there is no data reported for a particular cell. There may be regional variation in measure performance that cannot be identified with this analysis due to small denominators.

Figures 71 through 80 include the results of this analysis. The regional average is shown on the left, with the rates for the MCOs that operate in a particular region on the right. The yellow downward arrows indicate MCOs that perform statistically below the regional average; the blue upward arrows indicate MCOs that perform statistically above the regional average. If an MCO does not operate in that region, its column is grayed out.

Here are the findings from the regional analysis:

- There is not a lot of variation in a specific MCOs performance across regions; in other words, if an MCO performed well in one region, it tended to perform well in others.
- MHW had strong performance in several regions. Conversely, AMG had weaker performance across several regions.
- There was some variation in performance by measure, but no other compelling themes emerged from the regional analysis.

Great Rivers Region

Many measures did not show significantly differences by plan. However, MHW performed above the regional average for the Adults' Access to Preventive/Ambulatory Health Services (AAP), Well-Child Visits in the First 30 Months of Life (W30) and Child and Adolescent Well-Care Visit (WCV) measures; AMG and UHC performed below the regional average. MHW also performed above the regional average for the Antidepressant Medication Management (AMM) measures while AMG performed below the regional average. There were a handful of other measures where an individual MCO did better or worse than the regional average.

Figure 71. Comparison of MCOs by Measure within Great Rivers Region.

↓ ↑ Statistically significant difference from other MCOs in **Region**

	AMG	CCW	CHPW	MHW	UHC	Regional Weighted Rate
Adults' Access to Preventive/Ambulatory Health Services (AAP), Total	68% ↓			74% ↑	71% ↓	73%
I&E of AOD Dependence Treatment (IET): Total Initiation of Treatment: 13-17 yrs	***			38%	***	38%
I&E of AOD Dependence Treatment (IET): Total Initiation of Treatment: Total	49%			51% ↓	79% ↑	53%
I&E of AOD Dependence Treatment (IET): Total Engagement in Treatment: Total	16%			21% ↑	2% ↓	18%
Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care	***			***	***	72%
Prenatal and Postpartum Care (PPC), Postpartum Care	***			***	***	74%
Use of First-Line Psychosocial Care for Children and Adolsecents (APP), Total	***			75%	***	68%
Antidepressant Medication Management (AMM), Effective Acute Phase	49% ↓			62% ↑	55%	58%
Antidepressant Medication Management (AMM), Continuation Phase	34% ↓			44% ↑	40%	41%
Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	48%			46%	***	46%
Follow-Up Care for Children Prescribed ADHD Medication (ADD), Continuation	***			48%	***	48%
Follow-Up after Hospitalization for Mental Illness (FUH), 30-Day Follow-Up, Total	69%			70%	68%	70%
Follow-Up after Hospitalization for Mental Illness (FUH), 7-Day Follow-Up, Total	56%			52%	53%	53%
Follow-Up After ED Visit for Mental Illness (FUM), 30-day, Total	46% ↓			66% ↑	66%	62%
Follow-Up After ED Visit for Mental Illness (FUM), 7-day, Total	40% ↓			59%	61%	56%
Follow-Up After ED Visit for AOD Dependency (FUA), 30-day, 13-17 years	***			***	***	24%
Follow-Up After ED Visit for AOD Dependency (FUA), 30-day, Total	31%			26%	28%	28%
Follow-Up After ED Visit for AOD Dependency (FUA), 7-day, Total	20%			15%	21%	18%
Follow-Up After High Intensity Care for SUD (FUI), 30-day, Total	58%			62%	61%	61%
Follow-Up After High Intensity Care for SUD (FUI), 7-day, Total	45%			39%	43%	42%
Pharmacotherapy for Opioid Use Disorder (POD): Total	38% ↑			32%	27% ↓	32%
Controlling High Blood Pressure (CBP)	67%			***	***	51%
Comprehensive Diabetes Care (CDC), Poor HbA1c Control (lower is better)	33%			32%	17%	29%
Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0%	48%			64%	70%	62%
Use of Opioids at High Dosage (HDO) (lower is better)	5%			6%	5%	6%
Childhood Immunization Status (CIS), Combo 2	***			71%	***	72%
Childhood Immunization Status (CIS), Combo 10	***			41%	***	42%
Immunizations for Adolescents (IMA), Combo 2	***			***	***	37%
Lead Screening in Children (LSC)	***			***	***	67%
Breast Cancer Screening (BCS)	39% ↓			46%	47%	46%
Cervical Cancer Screening (CCS)	37%			61%	45%	52%
Chlamydia Screening (CHL), Total	43%			47%	42%	46%
Asthma Medication Ratio (AMR), Total	48% ↓			62% ↑	55%	59%
Well-Child Visits in the First 30 Months of Life (W30), 0-15 Months	43% ↓			56% ↑	25% ↓	53%
Well-Child Visits in the First 30 Months of Life (W30), 16-30 Months	61% ↓			76% ↑	51% ↓	72%
Child and Adolescent Well-Care Visit (WCV), Age 3-11	38% ↓			53% ↑	33% ↓	49%
Child and Adolescent Well-Care Visit (WCV), Age 12-17	30% ↓			42% ↑	19% ↓	37%
Child and Adolescent Well-Care Visit (WCV), Age 18-21	13% ↓			23% ↑	7% ↓	19%
Child and Adolescent Well-Care Visit (WCV), Total	31% ↓			46% ↑	24% ↓	41%

Greater Columbia Region

Many measures did not show significantly differences by plan. However, CHPW performed above the regional average for the Childhood Immunization Status (CIS), Well-Child Visits in the First 30 Months of Life (W30) and Child and Adolescent Well-Care Visit (WCV) measures. CCW also performed above the regional average for the Childhood Immunization Status (CIS) measures. MHW performed above the regional average for the Antidepressant Medication Management (AMM) measures. AMG performed below the regional average for the Well-Child Visits in the First 30 Months of Life (W30) and Child and Adolescent Well-Care Visit (WCV) measures. There were a handful of other measures where an individual MCO did better or worse than the regional average.

Figure 72. Comparison of MCOs by Measure within Greater Columbia Region.

↓ ↑ Statistically significant difference from other MCOs in **Region**

	AMG	CCW	CHPW	MHW	UHC	Regional Weighted Rate
Adults' Access to Preventive/Ambulatory Health Services (AAP), Total	67% ↓	76% ↑	75%	77% ↑		76%
I&E of AOD Dependence Treatment (IET): Total Initiation of Treatment: 13-17 yrs	***	34%	31%	29%		33%
I&E of AOD Dependence Treatment (IET): Total Initiation of Treatment: Total	44% ↑	37% ↓	39%	40%		40%
I&E of AOD Dependence Treatment (IET): Total Engagement in Treatment: Total	16%	13% ↓	16%	16%		16%
Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care	***	77% ↓	88% ↑	80%		82%
Prenatal and Postpartum Care (PPC), Postpartum Care	***	83%	87%	72% ↓		80%
Use of First-Line Psychosocial Care for Children and Adolsecents (APP), Total	***	63%	62%	44%		54%
Antidepressant Medication Management (AMM), Effective Acute Phase	54%	59%	57%	61% ↑		60%
Antidepressant Medication Management (AMM), Continuation Phase	36% ↓	41%	40%	44% ↑		42%
Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	***	48%	46%	45%		47%
Follow-Up Care for Children Prescribed ADHD Medication (ADD), Continuation	***	64%	57%	65%		63%
Follow-Up after Hospitalization for Mental Illness (FUH), 30-Day Follow-Up, Total	73%	70%	80% ↑	67%		72%
Follow-Up after Hospitalization for Mental Illness (FUH), 7-Day Follow-Up, Total	53%	55% ↑	55%	40% ↓		49%
Follow-Up After ED Visit for Mental Illness (FUM), 30-day, Total	60%	59%	61%	65%		62%
Follow-Up After ED Visit for Mental Illness (FUM), 7-day, Total	43%	42%	46%	48%		46%
Follow-Up After ED Visit for AOD Dependency (FUA), 30-day, 13-17 years	***	13%	***	7%		12%
Follow-Up After ED Visit for AOD Dependency (FUA), 30-day, Total	26%	27%	27%	31%		29%
Follow-Up After ED Visit for AOD Dependency (FUA), 7-day, Total	15%	17%	17%	20%		18%
Follow-Up After High Intensity Care for SUD (FUI), 30-day, Total	55%	65%	55%	63%		61%
Follow-Up After High Intensity Care for SUD (FUI), 7-day, Total	37%	42%	40%	42%		41%
Pharmacotherapy for Opioid Use Disorder (POD): Total	9%	9% ↓	12%	15% ↑		13%
Controlling High Blood Pressure (CBP)	***	57%	58%	56%		58%
Comprehensive Diabetes Care (CDC), Poor HbA1c Control (lower is better)	***	52%	49%	38%		47%
Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0%	***	37%	42%	48%		42%
Use of Opioids at High Dosage (HDO) (lower is better)	4%	4%	4%	5%		5%
Childhood Immunization Status (CIS), Combo 2	75%	82% ↑	82% ↑	67% ↓		71%
Childhood Immunization Status (CIS), Combo 10	28%	54% ↑	56% ↑	35% ↓		40%
Immunizations for Adolescents (IMA), Combo 2	24% ↓	49%	50%	38%		46%
Lead Screening in Children (LSC)	21%	42%	40%	25%		29%
Breast Cancer Screening (BCS)	42% ↓	54% ↑	51%	53%		52%
Cervical Cancer Screening (CCS)	***	60%	54%	81% ↑		64%
Chlamydia Screening (CHL), Total	45% ↓	52%	51%	49%		51%
Asthma Medication Ratio (AMR), Total	56%	58%	57%	60%		59%
Well-Child Visits in the First 30 Months of Life (W30), 0-15 Months	55% ↓	57% ↓	70% ↑	62%		63%
Well-Child Visits in the First 30 Months of Life (W30), 16-30 Months	69%	68%	68%	71% ↑		70%
Child and Adolescent Well-Care Visit (WCV), Age 3-11	40% ↓	48%	49% ↑	48%		48%
Child and Adolescent Well-Care Visit (WCV), Age 12-17	26% ↓	35%	38% ↑	35%		36%
Child and Adolescent Well-Care Visit (WCV), Age 18-21	16%	16% ↓	20% ↑	18%		18%
Child and Adolescent Well-Care Visit (WCV), Total	32% ↓	39%	40% ↑	39%		40%

King Region

Many measures did not show significantly differences by plan. However, CHPW and MHW performed better than the regional average on many measures, with only a small number of measures where these two MCOs performed worse than the regional average. AMG and CCW performed worse than the regional average on many of the measures, with only a small number of measures where they performed better than the regional average. The performance of UHC was more mixed in this region.

Figure 73. Comparison of MCOs by Measure within King Region.

↓ ↑ Statistically significant difference from other MCOs in **Region**

	AMG	CCW	CHPW	MHW	UHC	Regional Weighted Rate
Adults' Access to Preventive/Ambulatory Health Services (AAP), Total	66% ↓	66% ↓	72% ↑	74% ↑	71%	71%
I&E of AOD Dependence Treatment (IET): Total Initiation of Treatment: 13-17 yrs	***	***	37%	35%	***	36%
I&E of AOD Dependence Treatment (IET): Total Initiation of Treatment: Total	46%	40% ↓	39% ↓	46%	57% ↑	45%
I&E of AOD Dependence Treatment (IET): Total Engagement in Treatment: Total	11%	10% ↓	12%	16% ↑	0% ↓	12%
Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care	74%	71%	89% ↑	82%	84%	82%
Prenatal and Postpartum Care (PPC), Postpartum Care	69%	62% ↓	82%	77%	76%	75%
Use of First-Line Psychosocial Care for Children and Adolsecents (APP), Total	***	***	***	58% ↑	***	48%
Antidepressant Medication Management (AMM), Effective Acute Phase	49% ↓	59%	57%	56%	55%	56%
Antidepressant Medication Management (AMM), Continuation Phase	34% ↓	40%	42%	41%	41%	41%
Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	35%	38%	51%	45%	48%	45%
Follow-Up Care for Children Prescribed ADHD Medication (ADD), Continuation	***	32% ↓	***	51%	***	47%
Follow-Up after Hospitalization for Mental Illness (FUH), 30-Day Follow-Up, Total	10% ↓	13% ↓	62% ↑	63% ↑	19% ↓	38%
Follow-Up after Hospitalization for Mental Illness (FUH), 7-Day Follow-Up, Total	3% ↓	10% ↓	38% ↑	47% ↑	11% ↓	26%
Follow-Up After ED Visit for Mental Illness (FUM), 30-day, Total	23% ↓	22% ↓	58% ↑	54% ↑	53% ↑	45%
Follow-Up After ED Visit for Mental Illness (FUM), 7-day, Total	14% ↓	13% ↓	43% ↑	40% ↑	38% ↑	32%
Follow-Up After ED Visit for AOD Dependency (FUA), 30-day, 13-17 years	***	***	***	11%	***	13%
Follow-Up After ED Visit for AOD Dependency (FUA), 30-day, Total	13% ↓	13% ↓	23% ↑	23% ↑	16%	19%
Follow-Up After ED Visit for AOD Dependency (FUA), 7-day, Total	6% ↓	8%	12% ↑	12% ↑	8%	10%
Follow-Up After High Intensity Care for SUD (FUI), 30-day, Total	39% ↓	32% ↓	46%	56% ↑	46%	49%
Follow-Up After High Intensity Care for SUD (FUI), 7-day, Total	22%	15% ↓	22%	33% ↑	23%	27%
Pharmacotherapy for Opioid Use Disorder (POD): Total	10% ↓	14%	12%	15% ↑	12%	13%
Controlling High Blood Pressure (CBP)	62%	52%	66%	53%	61%	58%
Comprehensive Diabetes Care (CDC), Poor HbA1c Control (lower is better)	38%	39%	38%	37%	31%	37%
Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0%	53%	48%	50%	50%	55%	52%
Use of Opioids at High Dosage (HDO) (lower is better)	3% ↑	8% ↓	3% ↑	5%	7% ↓	6%
Childhood Immunization Status (CIS), Combo 2	77% ↑	70%	72% ↑	61% ↓	66%	63%
Childhood Immunization Status (CIS), Combo 10	46%	49%	49%	40% ↓	45%	41%
Immunizations for Adolescents (IMA), Combo 2	40%	39%	46%	42%	38%	42%
Lead Screening in Children (LSC)	43%	27%	54% ↑	37%	26% ↓	38%
Breast Cancer Screening (BCS)	40% ↓	44% ↓	47%	50% ↑	49%	48%
Cervical Cancer Screening (CCS)	45%	47%	58%	69% ↑	55%	59%
Chlamydia Screening (CHL), Total	53%	55%	49% ↓	54% ↑	53%	53%
Asthma Medication Ratio (AMR), Total	58%	59%	64%	65% ↑	55% ↓	62%
Well-Child Visits in the First 30 Months of Life (W30), 0-15 Months	43% ↓	48%	61% ↑	49%	39% ↓	49%
Well-Child Visits in the First 30 Months of Life (W30), 16-30 Months	64%	69% ↑	66%	64%	64%	65%
Child and Adolescent Well-Care Visit (WCV), Age 3-11	40% ↓	45% ↑	39% ↓	45% ↑	45% ↑	44%
Child and Adolescent Well-Care Visit (WCV), Age 12-17	27% ↓	31%	27% ↓	34% ↑	34% ↑	32%
Child and Adolescent Well-Care Visit (WCV), Age 18-21	15% ↓	15% ↓	15% ↓	20% ↑	18%	18%
Child and Adolescent Well-Care Visit (WCV), Total	33% ↓	36%	31% ↓	38% ↑	38% ↑	36%

North Central Region

Many measures did not show significantly differences by plan. However, The most variation between the three MCOs operating in this region is seen with the Well-Child Visits in the First 30 Months of Life (W30) and Child and Adolescent Well-Care Visit (WCV) measures. CCW performs better than the regional average on many of these measures, while AMG and MHW are below the regional average. There were a handful of other measures where an individual MCO did better or worse than the regional average.

Figure 74. Comparison of MCOs by Measure within North Central Region.

↓ ↑ Statistically significant difference from other MCOs in **Region**

	AMG	CCW	CHPW	MHW	UHC	Regional Weighted Rate
Adults' Access to Preventive/Ambulatory Health Services (AAP), Total	72% ↓	74% ↓		78% ↑		77%
I&E of AOD Dependence Treatment (IET): Total Initiation of Treatment: 13-17 yrs	***	***		29%		32%
I&E of AOD Dependence Treatment (IET): Total Initiation of Treatment: Total	50% ↑	37%		36% ↓		39%
I&E of AOD Dependence Treatment (IET): Total Engagement in Treatment: Total	17%	15%		14%		15%
Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care	***	86%		83%		83%
Prenatal and Postpartum Care (PPC), Postpartum Care	***	83%		90%		87%
Use of First-Line Psychosocial Care for Children and Adolsecents (APP), Total	***	***		70%		68%
Antidepressant Medication Management (AMM), Effective Acute Phase	50%	56%		58%		57%
Antidepressant Medication Management (AMM), Continuation Phase	36%	38%		41%		41%
Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	***	52%		42%		46%
Follow-Up Care for Children Prescribed ADHD Medication (ADD), Continuation	***	***		49%		54%
Follow-Up after Hospitalization for Mental Illness (FUH), 30-Day Follow-Up, Total	***	***		76%		75%
Follow-Up after Hospitalization for Mental Illness (FUH), 7-Day Follow-Up, Total	***	***		64%		59%
Follow-Up After ED Visit for Mental Illness (FUM), 30-day, Total	64%	77%		77%		76%
Follow-Up After ED Visit for Mental Illness (FUM), 7-day, Total	52%	60%		69% ↑		66%
Follow-Up After ED Visit for AOD Dependency (FUA), 30-day, 13-17 years	***	***		9%		13%
Follow-Up After ED Visit for AOD Dependency (FUA), 30-day, Total	33%	20%		28%		27%
Follow-Up After ED Visit for AOD Dependency (FUA), 7-day, Total	26%	10% ↓		20%		19%
Follow-Up After High Intensity Care for SUD (FUI), 30-day, Total	60%	67%		49% ↓		55%
Follow-Up After High Intensity Care for SUD (FUI), 7-day, Total	47%	47%		29% ↓		36%
Pharmacotherapy for Opioid Use Disorder (POD): Total	11%	15%		17%		16%
Controlling High Blood Pressure (CBP)	***	66%		48%		52%
Comprehensive Diabetes Care (CDC), Poor HbA1c Control (lower is better)	***	33%		20%		26%
Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0%	***	56%		60%		57%
Use of Opioids at High Dosage (HDO) (lower is better)	4%	6%		5%		5%
Childhood Immunization Status (CIS), Combo 2	68%	80%		73%		73%
Childhood Immunization Status (CIS), Combo 10	34%	42%		39%		39%
Immunizations for Adolescents (IMA), Combo 2	***	47%		37%		41%
Lead Screening in Children (LSC)	40%	32%		***		42%
Breast Cancer Screening (BCS)	46%	58% ↑		52%		53%
Cervical Cancer Screening (CCS)	***	52%		***		62%
Chlamydia Screening (CHL), Total	47%	44%		44%		45%
Asthma Medication Ratio (AMR), Total	62%	62%		55%		57%
Well-Child Visits in the First 30 Months of Life (W30), 0-15 Months	52%	51%		56%		55%
Well-Child Visits in the First 30 Months of Life (W30), 16-30 Months	70%	82% ↑		73% ↓		75%
Child and Adolescent Well-Care Visit (WCV), Age 3-11	51% ↓	58% ↑		54% ↓		55%
Child and Adolescent Well-Care Visit (WCV), Age 12-17	37% ↓	46% ↑		40% ↓		41%
Child and Adolescent Well-Care Visit (WCV), Age 18-21	15% ↓	18%		18%		18%
Child and Adolescent Well-Care Visit (WCV), Total	40% ↓	48% ↑		44% ↓		45%

North Sound Region

Many measures did not show significantly differences by plan. However, MHW performs above the regional average on several measures. There were a handful of other measures where an individual MCO did better or worse than the regional average.

Figure 75. Comparison of MCOs by Measure within North Sound Region.

Statistically significant difference from other MCOs in **Region**

	AMG	CCW	CHPW	MHW	UHC	Regional Weighted Rate
Adults' Access to Preventive/Ambulatory Health Services (AAP), Total	67% ↓	69% ↓	73%	76% ↑	75% ↑	74%
I&E of AOD Dependence Treatment (IET): Total Initiation of Treatment: 13-17 yrs	***	31%	27%	34%	***	32%
I&E of AOD Dependence Treatment (IET): Total Initiation of Treatment: Total	50%	47%	45% ↓	46% ↓	61% ↑	48%
I&E of AOD Dependence Treatment (IET): Total Engagement in Treatment: Total	19%	19% ↑	16%	18% ↑	1% ↓	17%
Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care	74%	71% ↓	83%	91%	87%	86%
Prenatal and Postpartum Care (PPC), Postpartum Care	64%	63%	72%	77%	73%	73%
Use of First-Line Psychosocial Care for Children and Adolsecents (APP), Total	***	***	***	64%	53%	57%
Antidepressant Medication Management (AMM), Effective Acute Phase	54% ↓	60%	58%	61% ↑	56%	59%
Antidepressant Medication Management (AMM), Continuation Phase	39%	44%	42%	43%	43%	43%
Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	41%	38%	38%	44%	55% ↑	45%
Follow-Up Care for Children Prescribed ADHD Medication (ADD), Continuation	***	46%	43%	53%	67% ↑	53%
Follow-Up after Hospitalization for Mental Illness (FUH), 30-Day Follow-Up, Total	60%	57%	59%	70% ↑	60%	64%
Follow-Up after Hospitalization for Mental Illness (FUH), 7-Day Follow-Up, Total	40%	42%	41%	49% ↑	45%	45%
Follow-Up After ED Visit for Mental Illness (FUM), 30-day, Total	46% ↓	51% ↓	61%	64% ↑	56%	59%
Follow-Up After ED Visit for Mental Illness (FUM), 7-day, Total	32% ↓	37% ↓	47%	49% ↑	43%	45%
Follow-Up After ED Visit for AOD Dependency (FUA), 30-day, 13-17 years	***	***	***	***	***	16%
Follow-Up After ED Visit for AOD Dependency (FUA), 30-day, Total	28%	31%	36%	33%	34%	34%
Follow-Up After ED Visit for AOD Dependency (FUA), 7-day, Total	21%	21%	23%	19% ↓	24%	21%
Follow-Up After High Intensity Care for SUD (FUI), 30-day, Total	60%	59%	62%	64%	63%	63%
Follow-Up After High Intensity Care for SUD (FUI), 7-day, Total	40%	37%	46%	44%	42%	43%
Pharmacotherapy for Opioid Use Disorder (POD): Total	24%	26%	22% ↓	24%	27% ↑	25%
Controlling High Blood Pressure (CBP)	47%	66%	64%	53%	60%	58%
Comprehensive Diabetes Care (CDC), Poor HbA1c Control (lower is better)	42%	40%	45%	41%	25% ↑	39%
Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0%	42%	49%	44%	47%	58%	49%
Use of Opioids at High Dosage (HDO) (lower is better)	6%	8%	6%	6%	7%	7%
Childhood Immunization Status (CIS), Combo 2	70%	76%	81% ↑	62% ↓	69%	65%
Childhood Immunization Status (CIS), Combo 10	46%	51%	48%	38% ↓	43%	40%
Immunizations for Adolescents (IMA), Combo 2	45%	17% ↓	43%	37%	30%	36%
Lead Screening in Children (LSC)	22%	18%	32%	21%	25%	22%
Breast Cancer Screening (BCS)	40% ↓	47%	43% ↓	47%	51% ↑	47%
Cervical Cancer Screening (CCS)	56%	38% ↓	57%	70% ↑	59%	61%
Chlamydia Screening (CHL), Total	49%	49%	47%	46%	42% ↓	47%
Asthma Medication Ratio (AMR), Total	56%	58%	67% ↑	63%	56% ↓	62%
Well-Child Visits in the First 30 Months of Life (W30), 0-15 Months	52%	47% ↓	58% ↑	52%	50%	53%
Well-Child Visits in the First 30 Months of Life (W30), 16-30 Months	64% ↓	71%	69%	66% ↓	76% ↑	69%
Child and Adolescent Well-Care Visit (WCV), Age 3-11	44% ↓	49% ↑	47%	48% ↑	47%	48%
Child and Adolescent Well-Care Visit (WCV), Age 12-17	27% ↓	35%	35%	36% ↑	34%	35%
Child and Adolescent Well-Care Visit (WCV), Age 18-21	14% ↓	14% ↓	15% ↓	21% ↑	20% ↑	19%
Child and Adolescent Well-Care Visit (WCV), Total	35% ↓	40%	38% ↓	41% ↑	39%	40%

Pierce Region

Many measures did not show significantly differences by plan. However, MHW does better than the regional average on several of the measures. There were a handful of other measures where an individual MCO did better or worse than the regional average.

Figure 76. Comparison of MCOs by Measure within Pierce Region.

↓ ↑ Statistically significant difference from other MCOs in **Region**

	AMG	CCW	CHPW	MHW	UHC	Regional Weighted Rate
Adults' Access to Preventive/Ambulatory Health Services (AAP), Total	66% ↓	66% ↓		73% ↑	72% ↑	71%
I&E of AOD Dependence Treatment (IET): Total Initiation of Treatment: 13-17 yrs	***	28%		26%	***	31%
I&E of AOD Dependence Treatment (IET): Total Initiation of Treatment: Total	46%	44% ↓		47%	61% ↑	48%
I&E of AOD Dependence Treatment (IET): Total Engagement in Treatment: Total	14%	12%		17% ↑	1% ↓	14%
Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care	76%	83%		82%	85%	83%
Prenatal and Postpartum Care (PPC), Postpartum Care	68%	59% ↓		81%	77%	76%
Use of First-Line Psychosocial Care for Children and Adolsecents (APP), Total	***	***		43%	***	44%
Antidepressant Medication Management (AMM), Effective Acute Phase	53% ↓	58%		61% ↑	57%	59%
Antidepressant Medication Management (AMM), Continuation Phase	39%	41%		44%	43%	44%
Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	48%	47%		41%	43%	43%
Follow-Up Care for Children Prescribed ADHD Medication (ADD), Continuation	***	53%		56%	43%	54%
Follow-Up after Hospitalization for Mental Illness (FUH), 30-Day Follow-Up, Total	59%	48% ↓		67% ↑	60%	61%
Follow-Up after Hospitalization for Mental Illness (FUH), 7-Day Follow-Up, Total	42%	32% ↓		48% ↑	44%	44%
Follow-Up After ED Visit for Mental Illness (FUM), 30-day, Total	54%	54%		55%	50%	54%
Follow-Up After ED Visit for Mental Illness (FUM), 7-day, Total	38%	40%		46% ↑	36% ↓	42%
Follow-Up After ED Visit for AOD Dependency (FUA), 30-day, 13-17 years	***	***		***	***	4%
Follow-Up After ED Visit for AOD Dependency (FUA), 30-day, Total	27%	19%		26%	20%	24%
Follow-Up After ED Visit for AOD Dependency (FUA), 7-day, Total	16%	9% ↓		16%	13%	15%
Follow-Up After High Intensity Care for SUD (FUI), 30-day, Total	57%	48%		55%	56%	56%
Follow-Up After High Intensity Care for SUD (FUI), 7-day, Total	35%	31%		37%	36%	36%
Pharmacotherapy for Opioid Use Disorder (POD): Total	15%	21%		19%	18%	19%
Controlling High Blood Pressure (CBP)	62%	59%		60%	61%	61%
Comprehensive Diabetes Care (CDC), Poor HbA1c Control (lower is better)	36%	41%		33%	36%	36%
Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0%	51%	50%		56%	54%	54%
Use of Opioids at High Dosage (HDO) (lower is better)	7%	6%		5% ↑	9% ↓	7%
Childhood Immunization Status (CIS), Combo 2	72%	71%		65%	59%	66%
Childhood Immunization Status (CIS), Combo 10	44%	54%		41%	41%	42%
Immunizations for Adolescents (IMA), Combo 2	34%	31%		54% ↑	36%	44%
Lead Screening in Children (LSC)	33%	20%		30%	16% ↓	30%
Breast Cancer Screening (BCS)	36% ↓	44%		45%	47% ↑	45%
Cervical Cancer Screening (CCS)	41%	46%		60%	54%	55%
Chlamydia Screening (CHL), Total	53%	56%		55% ↑	50% ↓	55%
Asthma Medication Ratio (AMR), Total	58%	64%		64%	60%	63%
Well-Child Visits in the First 30 Months of Life (W30), 0-15 Months	54%	60%		60% ↑	47% ↓	57%
Well-Child Visits in the First 30 Months of Life (W30), 16-30 Months	62% ↓	69%		67%	65%	67%
Child and Adolescent Well-Care Visit (WCV), Age 3-11	36% ↓	44%		46% ↑	39% ↓	44%
Child and Adolescent Well-Care Visit (WCV), Age 12-17	25% ↓	30% ↓		35% ↑	28% ↓	33%
Child and Adolescent Well-Care Visit (WCV), Age 18-21	10% ↓	15%		17% ↑	14%	16%
Child and Adolescent Well-Care Visit (WCV), Total	29% ↓	36%		38% ↑	32% ↓	36%

Salish Region

Many measures did not show significantly differences by plan. However, MHW performed better than the regional average for several of the measures. AMG performed lower than the regional average for several measures, while performing higher than the regional average for Pharmacotherapy for Opioid Use Disorder (POD): Total. There were a handful of other measures where an individual MCO did better or worse than the regional average.

Figure 77. Comparison of MCOs by Measure within Salish Region.

↓ ↑ Statistically significant difference from other MCOs in **Region**

	AMG	CCW	CHPW	MHW	UHC	Regional Weighted Rate
Adults' Access to Preventive/Ambulatory Health Services (AAP), Total	67% ↓			74% ↑	73%	73%
I&E of AOD Dependence Treatment (IET): Total Initiation of Treatment: 13-17 yrs	***			***	***	39%
I&E of AOD Dependence Treatment (IET): Total Initiation of Treatment: Total	52%			53%	61%	54%
I&E of AOD Dependence Treatment (IET): Total Engagement in Treatment: Total	18%			18% ↑	0% ↓	17%
Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care	***			***	***	75%
Prenatal and Postpartum Care (PPC), Postpartum Care	***			***	***	70%
Use of First-Line Psychosocial Care for Children and Adolsecents (APP), Total	***			***	***	73%
Antidepressant Medication Management (AMM), Effective Acute Phase	58%			63%	66%	63%
Antidepressant Medication Management (AMM), Continuation Phase	43%			46%	51%	47%
Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	***			50%	***	46%
Follow-Up Care for Children Prescribed ADHD Medication (ADD), Continuation	***			51%	***	48%
Follow-Up after Hospitalization for Mental Illness (FUH), 30-Day Follow-Up, Total	60%			70%	72%	69%
Follow-Up after Hospitalization for Mental Illness (FUH), 7-Day Follow-Up, Total	41%			56%	51%	52%
Follow-Up After ED Visit for Mental Illness (FUM), 30-day, Total	59% ↓			71%	68%	68%
Follow-Up After ED Visit for Mental Illness (FUM), 7-day, Total	39% ↓			57%	55%	53%
Follow-Up After ED Visit for AOD Dependency (FUA), 30-day, 13-17 years	***			***	***	0%
Follow-Up After ED Visit for AOD Dependency (FUA), 30-day, Total	32% ↓			42%	42%	40%
Follow-Up After ED Visit for AOD Dependency (FUA), 7-day, Total	22% ↓			32% ↑	27%	29%
Follow-Up After High Intensity Care for SUD (FUI), 30-day, Total	64%			63%	53% ↓	61%
Follow-Up After High Intensity Care for SUD (FUI), 7-day, Total	44%			43%	36%	42%
Pharmacotherapy for Opioid Use Disorder (POD): Total	25% ↑			16% ↓	22%	20%
Controlling High Blood Pressure (CBP)	36% ↓			***	54%	58%
Comprehensive Diabetes Care (CDC), Poor HbA1c Control (lower is better)	36%			***	***	34%
Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0%	50%			***	***	62%
Use of Opioids at High Dosage (HDO) (lower is better)	8%			4% ↑	12% ↓	9%
Childhood Immunization Status (CIS), Combo 2	***			66%	***	67%
Childhood Immunization Status (CIS), Combo 10	***			37%	***	38%
Immunizations for Adolescents (IMA), Combo 2	***			***	***	27%
Lead Screening in Children (LSC)	***			***	***	9%
Breast Cancer Screening (BCS)	46%			50%	52%	50%
Cervical Cancer Screening (CCS)	54%			***	43%	57%
Chlamydia Screening (CHL), Total	50%			50%	44% ↓	49%
Asthma Medication Ratio (AMR), Total	56%			69%	67%	67%
Well-Child Visits in the First 30 Months of Life (W30), 0-15 Months	56%			53%	50%	53%
Well-Child Visits in the First 30 Months of Life (W30), 16-30 Months	67%			70%	64%	69%
Child and Adolescent Well-Care Visit (WCV), Age 3-11	38% ↓			47% ↑	39% ↓	44%
Child and Adolescent Well-Care Visit (WCV), Age 12-17	26% ↓			31% ↑	27% ↓	30%
Child and Adolescent Well-Care Visit (WCV), Age 18-21	12%			15% ↑	13%	14%
Child and Adolescent Well-Care Visit (WCV), Total	30% ↓			37% ↑	31% ↓	35%

Southwest Region

Many measures did not show significantly differences by plan. However, MHW performs higher than the regional average for several of the measures. AMG and CHPW performed worse than the regional average for several of the measures. CHPW performed better than the regional average for the Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependencies (FUA) measure.

Figure 78. Comparison of MCOs by Measure within Southwest Region.

↓ ↑ Statistically significant difference from other MCOs in **Region**

	AMG	CCW	CHPW	MHW	UHC	Regional Weighted Rate
Adults' Access to Preventive/Ambulatory Health Services (AAP), Total	65% ↓		65% ↓	74% ↑		72%
I&E of AOD Dependence Treatment (IET): Total Initiation of Treatment: 13-17 yrs	***		***	39%		40%
I&E of AOD Dependence Treatment (IET): Total Initiation of Treatment: Total	42%		49%	45%		46%
I&E of AOD Dependence Treatment (IET): Total Engagement in Treatment: Total	14%		19%	15%		16%
Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care	***		***	70%		73%
Prenatal and Postpartum Care (PPC), Postpartum Care	***		***	64%		68%
Use of First-Line Psychosocial Care for Children and Adolsecents (APP), Total	***		***	74%		76%
Antidepressant Medication Management (AMM), Effective Acute Phase	47% ↓		60%	65% ↑		64%
Antidepressant Medication Management (AMM), Continuation Phase	43%		46%	50%		49%
Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	***		25% ↓	48%		47%
Follow-Up Care for Children Prescribed ADHD Medication (ADD), Continuation	***		***	48%		48%
Follow-Up after Hospitalization for Mental Illness (FUH), 30-Day Follow-Up, Total	34% ↓		51% ↓	63% ↑		59%
Follow-Up after Hospitalization for Mental Illness (FUH), 7-Day Follow-Up, Total	14% ↓		34%	38%		36%
Follow-Up After ED Visit for Mental Illness (FUM), 30-day, Total	40% ↓		48% ↓	63% ↑		59%
Follow-Up After ED Visit for Mental Illness (FUM), 7-day, Total	23% ↓		40%	48%		45%
Follow-Up After ED Visit for AOD Dependency (FUA), 30-day, 13-17 years	***		***	29%		28%
Follow-Up After ED Visit for AOD Dependency (FUA), 30-day, Total	29%		36% ↑	23% ↓		27%
Follow-Up After ED Visit for AOD Dependency (FUA), 7-day, Total	22%		21% ↑	14% ↓		17%
Follow-Up After High Intensity Care for SUD (FUI), 30-day, Total	55%		59%	55%		56%
Follow-Up After High Intensity Care for SUD (FUI), 7-day, Total	37%		41%	35%		37%
Pharmacotherapy for Opioid Use Disorder (POD): Total	22%		20%	23%		22%
Controlling High Blood Pressure (CBP)	***		64%	59%		60%
Comprehensive Diabetes Care (CDC), Poor HbA1c Control (lower is better)	***		37%	47%		47%
Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0%	***		54%	41%		43%
Use of Opioids at High Dosage (HDO) (lower is better)	4%		7%	6%		7%
Childhood Immunization Status (CIS), Combo 2	***		***	56%		56%
Childhood Immunization Status (CIS), Combo 10	***		***	30%		30%
Immunizations for Adolescents (IMA), Combo 2	***		***	28%		28%
Lead Screening in Children (LSC)	***		***	44%		44%
Breast Cancer Screening (BCS)	51%		41% ↓	51% ↑		49%
Cervical Cancer Screening (CCS)	***		47%	58%		57%
Chlamydia Screening (CHL), Total	45%		43% ↓	49%		48%
Asthma Medication Ratio (AMR), Total	42% ↓		66%	72% ↑		71%
Well-Child Visits in the First 30 Months of Life (W30), 0-15 Months	45%		43%	44%		45%
Well-Child Visits in the First 30 Months of Life (W30), 16-30 Months	40% ↓		61%	63%		63%
Child and Adolescent Well-Care Visit (WCV), Age 3-11	30% ↓		37% ↓	48% ↑		46%
Child and Adolescent Well-Care Visit (WCV), Age 12-17	22% ↓		26% ↓	34% ↑		33%
Child and Adolescent Well-Care Visit (WCV), Age 18-21	9% ↓		10% ↓	17% ↑		16%
Child and Adolescent Well-Care Visit (WCV), Total	24% ↓		29% ↓	39% ↑		38%

Spokane Region

Many measures did not show significantly differences by plan. However, AMG performed lower than the regional average for several of the measures. There were a handful of other measures where an individual MCO did better or worse than the regional average.

Figure 79. Comparison of MCOs by Measure within Spokane Region.

↓ ↑ Statistically significant difference from other MCOs in **Region**

	AMG	CCW	CHPW	MHW	UHC	Regional Weighted Rate
Adults' Access to Preventive/Ambulatory Health Services (AAP), Total	72% ↓		74% ↓	78% ↑		76%
I&E of AOD Dependence Treatment (IET): Total Initiation of Treatment: 13-17 yrs	43%		***	38%		40%
I&E of AOD Dependence Treatment (IET): Total Initiation of Treatment: Total	43%		42%	46% ↑		45%
I&E of AOD Dependence Treatment (IET): Total Engagement in Treatment: Total	16%		17%	18%		18%
Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care	86%		90%	87%		88%
Prenatal and Postpartum Care (PPC), Postpartum Care	79%		85%	82%		83%
Use of First-Line Psychosocial Care for Children and Adolsecents (APP), Total	66%		***	64%		66%
Antidepressant Medication Management (AMM), Effective Acute Phase	53% ↓		54%	58% ↑		56%
Antidepressant Medication Management (AMM), Continuation Phase	39% ↓		42%	43%		42%
Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	38%		47%	47%		46%
Follow-Up Care for Children Prescribed ADHD Medication (ADD), Continuation	45%		36%	52%		49%
Follow-Up after Hospitalization for Mental Illness (FUH), 30-Day Follow-Up, Total	60% ↓		67%	68%		66%
Follow-Up after Hospitalization for Mental Illness (FUH), 7-Day Follow-Up, Total	41% ↓		48%	49%		48%
Follow-Up After ED Visit for Mental Illness (FUM), 30-day, Total	57% ↓		71%	73% ↑		69%
Follow-Up After ED Visit for Mental Illness (FUM), 7-day, Total	44% ↓		59%	61% ↑		57%
Follow-Up After ED Visit for AOD Dependency (FUA), 30-day, 13-17 years	***		***	24%		28%
Follow-Up After ED Visit for AOD Dependency (FUA), 30-day, Total	38%		45% ↑	41%		42%
Follow-Up After ED Visit for AOD Dependency (FUA), 7-day, Total	29%		32%	33%		32%
Follow-Up After High Intensity Care for SUD (FUI), 30-day, Total	57%		67% ↑	61%		62%
Follow-Up After High Intensity Care for SUD (FUI), 7-day, Total	39%		44%	41%		42%
Pharmacotherapy for Opioid Use Disorder (POD): Total	15%		13%	16%		16%
Controlling High Blood Pressure (CBP)	57%		64%	51%		56%
Comprehensive Diabetes Care (CDC), Poor HbA1c Control (lower is better)	42%		28%	33%		34%
Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0%	42% ↓		59%	56%		53%
Use of Opioids at High Dosage (HDO) (lower is better)	6%		6%	5%		6%
Childhood Immunization Status (CIS), Combo 2	68%		72%	58% ↓		59%
Childhood Immunization Status (CIS), Combo 10	39%		37%	32%		33%
Immunizations for Adolescents (IMA), Combo 2	37%		23%	32%		32%
Lead Screening in Children (LSC)	23%		27%	29%		29%
Breast Cancer Screening (BCS)	50%		46% ↓	52% ↑		50%
Cervical Cancer Screening (CCS)	51%		52%	62%		58%
Chlamydia Screening (CHL), Total	49%		46%	48%		48%
Asthma Medication Ratio (AMR), Total	60%		66% ↑	60%		62%
Well-Child Visits in the First 30 Months of Life (W30), 0-15 Months	52% ↓		54%	57%		56%
Well-Child Visits in the First 30 Months of Life (W30), 16-30 Months	73%		64% ↓	71%		71%
Child and Adolescent Well-Care Visit (WCV), Age 3-11	49%		45% ↓	50% ↑		50%
Child and Adolescent Well-Care Visit (WCV), Age 12-17	36% ↓		35% ↓	38%		37%
Child and Adolescent Well-Care Visit (WCV), Age 18-21	18%		19%	20%		20%
Child and Adolescent Well-Care Visit (WCV), Total	41%		38% ↓	42% ↑		41%

Thurston-Mason Region

Many measures did not show significantly differences by plan. However, the most variation between the three MCOs operating in this region was in the Well-Child Visits in the First 30 Months of Life (W30), 0-15 Months and Child and Adolescent Well-Care Visit (WCV) measures. A handful of other measures had individual MCOs that did better or worse than the regional average.

Figure 80. Comparison of MCOs by Measure within Thurston-Mason Region.

Statistically significant difference from other MCOs in **Region**

	AMG	CCW	CHPW	MHW	UHC	Regional Weighted Rate
Adults' Access to Preventive/Ambulatory Health Services (AAP), Total	67% ↓			73% ↑	70%	72%
I&E of AOD Dependence Treatment (IET): Total Initiation of Treatment: 13-17 yrs	***			37%	***	42%
I&E of AOD Dependence Treatment (IET): Total Initiation of Treatment: Total	52%			46% ↓	67% ↑	50%
I&E of AOD Dependence Treatment (IET): Total Engagement in Treatment: Total	15%			16% ↑	0% ↓	15%
Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care	***			***	90%	84%
Prenatal and Postpartum Care (PPC), Postpartum Care	***			***	78%	78%
Use of First-Line Psychosocial Care for Children and Adolsecents (APP), Total	***			***	***	73%
Antidepressant Medication Management (AMM), Effective Acute Phase	61%			64%	61%	63%
Antidepressant Medication Management (AMM), Continuation Phase	44%			49%	44%	48%
Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	***			39%	41%	41%
Follow-Up Care for Children Prescribed ADHD Medication (ADD), Continuation	***			49%	***	48%
Follow-Up after Hospitalization for Mental Illness (FUH), 30-Day Follow-Up, Total	53%			63%	59%	60%
Follow-Up after Hospitalization for Mental Illness (FUH), 7-Day Follow-Up, Total	31% ↓			46%	40%	41%
Follow-Up After ED Visit for Mental Illness (FUM), 30-day, Total	40% ↓			63%	63%	59%
Follow-Up After ED Visit for Mental Illness (FUM), 7-day, Total	30% ↓			56% ↑	53%	50%
Follow-Up After ED Visit for AOD Dependency (FUA), 30-day, 13-17 years	***			***	***	32%
Follow-Up After ED Visit for AOD Dependency (FUA), 30-day, Total	25%			27%	32%	28%
Follow-Up After ED Visit for AOD Dependency (FUA), 7-day, Total	16%			17%	21%	18%
Follow-Up After High Intensity Care for SUD (FUI), 30-day, Total	57%			58%	66%	60%
Follow-Up After High Intensity Care for SUD (FUI), 7-day, Total	39%			42%	50%	43%
Pharmacotherapy for Opioid Use Disorder (POD): Total	29% ↑			11% ↓	35% ↑	21%
Controlling High Blood Pressure (CBP)	***			***	66%	71%
Comprehensive Diabetes Care (CDC), Poor HbA1c Control (lower is better)	***			***	***	39%
Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0%	***			***	***	57%
Use of Opioids at High Dosage (HDO) (lower is better)	4%			4%	7% ↓	5%
Childhood Immunization Status (CIS), Combo 2	***			67%	***	68%
Childhood Immunization Status (CIS), Combo 10	***			40%	***	41%
Immunizations for Adolescents (IMA), Combo 2	***			***	***	38%
Lead Screening in Children (LSC)	***			***	***	38%
Breast Cancer Screening (BCS)	43%			46%	44%	45%
Cervical Cancer Screening (CCS)	***			***	50%	53%
Chlamydia Screening (CHL), Total	51%			50%	49%	51%
Asthma Medication Ratio (AMR), Total	58%			63%	58%	62%
Well-Child Visits in the First 30 Months of Life (W30), 0-15 Months	44%			56% ↑	42% ↓	52%
Well-Child Visits in the First 30 Months of Life (W30), 16-30 Months	63%			68%	64%	67%
Child and Adolescent Well-Care Visit (WCV), Age 3-11	34% ↓			47% ↑	41% ↓	44%
Child and Adolescent Well-Care Visit (WCV), Age 12-17	24% ↓			36% ↑	28% ↓	33%
Child and Adolescent Well-Care Visit (WCV), Age 18-21	11% ↓			16% ↑	12% ↓	14%
Child and Adolescent Well-Care Visit (WCV), Total	27% ↓			39% ↑	33% ↓	36%

Appendix A: Methodology

Methodology

This appendix contains additional information about the methodology used for the analysis presented in this report.

HEDIS

Comagine Health assessed Apple Health MCO-level performance data for the 2020 measurement year. The measures include Healthcare Effectiveness Data and Information Set (HEDIS®) performance measure rates collected in 2021, reflecting performance in calendar year 2020. It also includes behavioral health measures that were developed by the Washington State Health Care Authority. To be consistent with NCQA methodology, the 2020 calendar year (CY) is referred to as the Measure Year 2020 (MY2020) in this report. The measures also include their indicators (for example, rates for specific age groups or specific populations).

Washington State Behavioral Health Measures

The state monitors and self-validates the following two measures, both reflecting behavioral health care services delivered to Apple Health enrollees:

- Mental Health Service Penetration – Broad Definition (MH-B)
- Substance Use Disorder Treatment Penetration (SUD)

The MH-B metric is a state-developed measure of access to mental health services (among persons with an indication of need for mental health services). The SUD metric is a state-developed measure of access to SUD treatment services (among persons with an indication of need for SUD treatment services). HCA partners with the Department of Social and Health Services RDA to measure performance. Data is collected via the administrative method, using claims, encounters and enrollment data and assessed on a quarterly basis.

Administrative Versus Hybrid Data Collection

HEDIS measures draw from clinical data sources, utilizing either a fully "administrative" or a "hybrid" collection method, explained below:

- The administrative collection method relies solely on clinical information collected from electronic records generated through claims, registration systems or encounters, among others.
- The hybrid collection method supplements administrative data with a valid sample of carefully reviewed chart data.

Because hybrid measures are supplemented with sample-based data, scores for these measures will always be the same or better than scores based solely on the administrative data for these measures.[12]

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

[12] Tang et al. HEDIS measures vary in how completely the corresponding data are captured in course of clinical encounters and the degree to which administrative data correspond to the actual quality parameter they are designed to measure.

Table A-1. Administrative Versus Hybrid Rates for Select Measures, MY2020.

Measure	Administrative Rate	Hybrid Rate	Difference
Childhood Immunization Status (CIS), Combo 2	65.6%	72.3%	+ 6.7%
Comprehensive Diabetes Care (CDC), Blood Pressure Control < 140/90 mm Hg	48.2%	70.1%	+ 21.9%
Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care	54.6%	82.5%	+ 27.9%
Prenatal and Postpartum Care (PPC), Postpartum Care	54.5%	77.4%	+ 22.9%

Supplemental Data

In calculating HEDIS rates, the Apple Health MCOs used auditor-approved supplemental data, which is generated outside of a health plan's claims or encounter data system. This supplemental information includes historical medical records, lab data, immunization registry data and FFS data on early and periodic screening, diagnosis and treatment provided to MCOs by HCA. Supplemental data were 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 plans were not required to review charts for individuals who, according to HCA's supplemental data, had already received the service.

Rotated Measures

In the following table shows all the rotated measures and which MCO chose to report as rotated. MCO specific charts in the report will include footnotes to indicate where rotated measures are reported.

Table A-2. MY2019 Rotated Measures by MCOs.

Measure Name	AMG	CCW	CHPW	MHW	UHC
Adolescent Well-Care Visits (AWC)	—	—	—	—	Y
Adult BMI Assessment (ABA)	Y	Y	—	—	—
Cervical Cancer Screening (CCS)	Y	—	—	—	—
Childhood Immunization Status (CIS), All Components	—	—	—	Y	Y
Controlling High Blood Pressure (CBP)	Y	Y	—	—	—
Lead Screening in Children (LSC)	Y	—	—	—	—
Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care	Y	—	—	—	—
Prenatal and Postpartum Care (PPC), Postpartum Care	Y	—	—	—	—

Measure Name	AMG	CCW	CHPW	MHW	UHC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC), All Components and Age Bands	Y	—	—	—	—
Well-Child Visits in the First 15 Months of Life (W15), 0, 1, 2, 3, 4, 5 and 6 or More Visits	Y	Y	—	—	—
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)	—	—	—	—	Y

Y = indicates yes; the MCO reported on that measure.

— Indicates the MCO did not report that measure.

Member-Level Data Analysis

For this report, HCA required MCOs to submit member-level data (MLD) files for analyses relating to demographic and geographic disparities. These files provide member-level information for each HEDIS quality measure. These data sets were then provided to Comagine Health for analysis. In addition to the MLD files, HCA also provided Comagine with an eligibility file that included enrollee demographic information (age, gender, race/ethnicity, language, county of residence and specific Apple Health program). Note the MLD files do not contain data for the Washington State behavioral health measures.

The populations underlying each measure in this report represent Apple Health members enrolled with an MCO in Washington State between January 1, 2020, and December 31, 2020. Of note: Only individuals who are in the denominator of at least one HEDIS measure are included in the member-level data. As a result, individuals with short tenures in their plans or individuals with little to no healthcare utilization may not be included in the measure analysis. The HEDIS measures were not risk-adjusted for any differences in enrollee demographic characteristics. Prior to performing analysis, member-level data were aggregated to the MCO level and validated against the reported HEDIS measures.

Definitions Used to Stratify Member-Level Data

Comagine Health needed to develop methods for stratifying the member level data for the various analyses presented in this report.

- **Apple Health Program and Eligibility Category** – HCA included the Apple Health program information on the eligibility file, (Apple Health Integrated Managed Care, Apple Health Integrated Foster Care and Apple Health Behavioral Health Services Only). The data was first stratified by Apple Health Program. The Apple Health Integrated Managed Care program was then further broken down into eligibility groups using recipient aid category (RAC) codes on the enrollment file and a mapping of RAC codes to eligibility category.
- **Race/Ethnicity Data** – The HCA eligibility data included both a race field and a Hispanic indicator field. Enrollment data is reported separately by race and Hispanic ethnicity. For measure reporting, the race and ethnicity information is combined into one category; an individual who indicated they are Hispanic are reported as Hispanic, otherwise they are reported by race.
- **Spoken Language** – The HCA eligibility data also captures approximately 85 different spoken languages. In addition to English, Comagine Health reported on the 15 languages where HCA

currently had written materials available. The remaining languages were reported in the "Other languages" category; they represent less than 1% of the total enrollees.

- **Urban versus Rural** – To define urban versus rural geographies, Comagine Health relied on the CMS rural-urban commuting area (RUCA) codes. RUCA codes classify United States census tracts using measures of population density, urbanization and daily commuting.

  Whole numbers (1-10) delineate metropolitan, micropolitan, small-town and rural commuting areas based on the size and direction of the primary (largest) commuting flows. The member ZIP code included in the MLD files was used to map each member to the appropriate RUCA codes. For the purposes of this analysis, RUCA codes 8, 9 and 10 were classified as rural; this effectively defines rural areas as towns of ten thousand or smaller.

- **Regional** – The member county from the HCA enrollment data was used to map the member to region.

Sufficient Denominator Size

In order to report measure results, there needs to be a sufficient denominator, or number of enrollees who meet the criteria for inclusion in the measure. Comagine Health follows NCQA guidelines to suppress the reporting of measure results if there are fewer than 30 enrollees in a measure. This ensures that patient identity is protected for HIPAA purposes, and that measure results are not volatile. Note that 30 is still small for most statistical tests, and it is difficult to identify true statistical differences.

Note that stratification of the measure results for the various of the member level data analyses often resulted in measures with denominators too small to report. This was particularly true for the hybrid measures, which tend to have smaller denominators because of the sampling methodology used to collect the data. The measures selected for reporting varied by for each analysis as a result.

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: MY2018, MY2019 and MY2020. The majority of the analyses presented in this report use the state weighted average. The state weighted average for a given measure is calculated as the weighted average among the MCOs that reported the measure (usually five), with the MCOs' shares of the total eligible population used as the weighting factors.

However, the MCO scorecards compare the individual MCO rates to the state simple average. The state simple average for a given measure is calculated as the average of the measure rate for the MCOs that reported that measure. The potential disadvantage of comparing an individual MCO to a weighted state average is that significantly larger plans could have undue influence on the state rate. A simple average of the plans (rather than a weighted average) mitigates those concerns. Comagine Health chose to use the simple average for the MCO scorecards because the Apple Health MCOs are of such different sizes. The state simple average for a given measure is calculated as the average of the measure rate for the MCOs that reported that measure.

Comparison to Benchmarks

This report provides national benchmarks for select HEDIS measures from the MY2020 NCQA Quality Compass. These benchmarks represent the national average and selected percentile performance among all NCQA-accredited Medicaid HMO plans and non-accredited Medicaid HMO plans that opted to

publicly report their HEDIS rates. These plans represent states both with and without Medicaid expansion. The number of plans reporting on each measure varies, depending on each state's requirement (not all states require reporting; they also vary on the number of measures they require their plans to report).

The license agreement with NCQA for publishing HEDIS benchmarks in this report limits the number of individual indicators to 40, 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.

Note there are no national benchmarks for the Washington State Behavioral Health measures. As an alternative approach, HCA leadership chose to consider the plan with the second highest performance in 2019 as the benchmark.

Interpreting Percentages Versus Percentiles

The majority of the measure results in this report are expressed as a percentage. The actual percentage shows a plan's specific performance on a measure. For example, if Plan A reports a Breast Cancer Screening rate of 69%, that means that 69% of the eligible women enrolled in Plan A have received the screening. Ideally, 100% of the eligible woman should receive breast cancer screenings. The actual rate indicates there is still a gap in care that can be improved.

The national benchmarks included in this report are often displayed as percentiles. The percentile shows how Plan A ranks among all other plans who have reported Breast Cancer Screening rates. For example, if we say the plan's Breast Cancer Screening rate is at the national 50th percentile, it means that approximately 50% of the plans in the nation reported Breast Cancer Screening rates that were equal to or below Plan A; approximately 50% of the plans in the nation had rates that were above. If Plan A is above the 90th percentile, that means that at least 90% of the plans reported rates below Plan A.

The national percentiles give a benchmark, or point of comparison, to assess how Plan A's performance compares to other plans. This is especially important for identifying high priority areas for quality improvement. For example, if Plan A performs below the 50th percentile, we can conclude there is a lot of room for improvement given the number of similar plans who perform better than Plan A. However, if Plan A performs above the 90th percentile, we can conclude that performance on that particular measure already exceeds the performance of most other plans and improving the actual rate for that measure may not be the highest priority.

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. A Wilson Score Interval test was applied to calculate the 95 percent confidence intervals.

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 Appendix B tables for all measures, when applicable. 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 calculated using a Wilson Score Interval test, 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 table notes.

Denominator Size Considerations and Confidence Intervals

When measures have values required for a visit or action to count as a numerator event. Therefore, it is 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 occur 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.

Confidence interval ranges are narrow when there are very large denominators (populations of sample sizes), it is more likely to detect significant differences even when the apparent difference between two numbers is very small. Conversely, many HEDIS measures are focused on a small segment of the patient population, which means sometimes it appears there are large differences between two numbers, but the confidence interval is too wide to be 95% confident that there is a true difference between two numbers. In such instances, it may be useful to look at patterns among associated measures to interpret overall performance. In this report, we attempt to identify true statistical differences between populations as much as the data allows. This is done through the comparison of 95 percent confidence interval ranges calculated using a Wilson Score Interval. In layman's terms, this indicates the reader can be 95 percent confident there is a real difference between two numbers, and that the differences are not just due to random chance. The calculation of confidence intervals is dependent on denominator sizes.

Confidence interval ranges are narrow when there is a large denominator because we can be more confident in the result with a large sample. When there is a small sample, we are less confident in the result, and the confidence interval range will be much larger.

The confidence interval is expressed as a range from the lower confidence interval value to the upper confidence interval value. A statistically significant improvement is identified if the current performance rate is above the upper confidence interval for the previous year.

For example, if a plan had a performance rate in the previous year of 286/432 (66.20%), the Wilson Score Interval would provide a 95% confidence interval of 61.62% (lower confidence interval value) to 70.50% (upper confidence interval value). The plan's current rate for the measure is then compared to the confidence interval to determine if there is a statistically significant change. If the plan is currently performing at a 72% rate, the new rate is above the upper confidence interval value and would represent a statistically significant improvement. However, if the plan is currently performing at a 63% rate, the new rate is within the confidence interval range and is statistically the same as the previous rate. If the current performance rate is 55%, the new rate is below the lower confidence interval value and would represent a statistically significant decrease in performance.

Note that for measures where a lower score indicates better performance, the current performance rate must be below the lower confidence interval value to show statistically significant improvement.

Additional Notes Regarding Interpretation

Plan performance rates must be interpreted carefully. HEDIS measures are not risk adjusted. Risk adjustment is a method of using characteristics of a patient population to estimate the population's illness burden. Diagnoses, age and gender are characteristics that are often used. Because HEDIS measures are not risk adjusted, the variation between MCOs is partially due to factors that are out of a plan's control, such as enrollees' medical acuity, demographic characteristics and other factors that may impact interaction with health care providers and systems.

Some measures have very large denominators (populations of sample sizes), making it more likely to detect significant differences even for very small differences. Conversely, many HEDIS measures are focused on a narrow eligible patient population and in the final calculation, can differ markedly from a benchmark due to a relatively wide confidence interval. In such instances, it may be useful to look at patterns among associated measures to interpret overall performance.

Limitations

- **Fee-for-service population:** The fee-for-service population is not included in these measures. Fee-for-service individuals include those eligible for both Medicare and Medicaid services. In addition, American Indian/Alaskan Natives are exempt from mandatory managed care enrollment.
- **Lack of risk adjustment**: HEDIS measures are not risk adjusted. Risk adjustment is a method of using characteristics of a patient population to estimate the population's illness burden. Diagnoses, age and gender are characteristics that are often used. Because HEDIS measures are not risk adjusted, the variation between MCOs is partially due to factors that are out of a plan's control, such as enrollees' medical acuity, demographic characteristics and other factors that may impact interaction with health care providers and systems.
- **COVID-19 impact**: In response to COVID-19, NCQA allowed Medicaid plans participating in HEDIS reporting the option of submitting 2019 rates for their 2020 hybrid measures (rotated measures). Hybrid measures combine administrative claims data and data obtained from clinical charts. Under NCQA guidelines, the MCOs could decide which hybrid measures, and how many, to rotate.

  The NCQA's decision was made to avoid placing a burden on clinics while they were dealing with the COVID-19 crisis. As a result of this decision, Comagine Health did not have access to updated rates for certain measures from the plans.
- **State behavioral health measures**: There are no national benchmarks available for the Washington Behavioral Health measures as the measures are Washington-specific measures developed by the State.

Interpreting Performance

Potential Sources of Variation in Performance

The adoption, accuracy and completeness of electronic health records 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. Therefore, it is 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 occur 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.

Additional Notes Regarding Interpretation

Plan performance rates must be interpreted carefully. HEDIS measures are not risk adjusted. Risk adjustment is a method of using characteristics of a patient population to estimate the population's illness burden. Diagnoses, age and gender are characteristics that are often used. Because HEDIS measures are not risk adjusted, the variation between MCOs is partially due to factors that are out of a plan's control, such as enrollees' medical acuity, demographic characteristics and other factors that may impact interaction with health care providers and systems.

Some measures have very large denominators (populations of sample sizes), making it more likely to detect significant differences even for very small differences. Conversely, many HEDIS measures are focused on a narrow eligible patient population and in the final calculation, can differ markedly from a benchmark due to a relatively wide confidence interval. In such instances, it may be useful to look at patterns among associated measures to interpret overall performance.

Appendix B: 2021 Performance Measure Tables

The data included in Appendix B includes specific NCQA benchmarks which, due to licensing agreement limitations, are available to HCA staff for internal use only.

For a full set of performance measure overall results, please see Appendix C.

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Appendix C: MCO Comparison Results

Appendix C contains a subset of the information included in Appendix B for all the performance measures by MCO and by region and is available publicly.

Appendix D: Regional Comparison Results

Appendix D contains state maps comparing regional performance.

Appendix E: Measure Comparison by Gender

In October of 2021, to support a long-standing legislative reporting requirement, HCA requested that Comagine Health provide an additional analysis of measure results by gender. At that point, Comagine Health was in the process of completing the first draft of the Comparative Report, and it was not feasible to incorporate the additional information into the body of the report. However, Comagine Health agreed to provide the additional information as an Appendix to the Comparative Report.

While the Health Care Authority, Department of Social and Health Services, and the Health Benefit Exchange are working together with other state agencies to incorporate gender identity into their applications and other processes,[13][14] we want to acknowledge the current binary nature of data collection and reporting and the limitations that presents in this kind of analysis.

Figure E-1 shows the results of this analysis. Note that Comagine Health is reporting females versus males as reported in the eligibility data provided by HCA.

The results of this analysis are very interesting. Although the impact on school closing and service industry jobs during the first year of the pandemic impacted women particularly heavily, there are several measures where females perform statistically higher than males. This may be due to the focus within the Washington state on maternal/child health and the well-established historic cultural tendency for adult women to engage with the medical system more than men. Note that for the Adults' Access to Preventive/Ambulatory Health Services (AAP), Total measure there is a gap of 16%.

Females also perform statistically higher than males for the Child and Adolescent Well-Care Visit (WCV), Age 12-17 and Age 18-21. There is a 7% gap between females and males for the ages 18-21 category. These differences for adolescents and young adults may be due to females seeking services for reproductive health.

There are a few areas such as the differences in behavioral health measures that would be worth exploring in future reports. While beyond the scope of this analysis, the state might consider the comparison of the prevalence of behavioral health issues in men versus women if data is available.

The data below reflects services provided in MY2020; it would be interesting to know if this pattern existed in a pre-COVID time period.

[13] For more information on the Health Care Authority's work to collect accurate gender identity information: https://www.hca.wa.gov/about-hca/gender-identity-information.

[14] For more information on the Apple Health Transhealth program: https://www.hca.wa.gov/health-care-services-and-supports/apple-health-medicaid-coverage/transhealth-program.

Figure E-1. Measure Comparison by Gender.*

Female is statistically significantly **Lower** than Male
Female is statistically significantly **Higher** than Male

		Female	Male	
Access / Availability of Care	Adults' Access to Preventive/Ambulatory Health Services (AAP), Total	80%	64%	↑
	I&E of AOD Dependence Treatment (IET): Total Initiation of Treatment: 13-17 yrs	37%	34%	
	I&E of AOD Dependence Treatment (IET): Total Initiation of Treatment: Total	45%	46%	
	I&E of AOD Dependence Treatment (IET): Total Engagement in Treatment: Total	15%	16%	
	Use of First-Line Psychosocial Care for Children and Adolsecents (APP), Total	65%	57%	↑
Behavioral Health	Antidepressant Medication Management (AMM), Effective Acute Phase	59%	57%	↑
	Antidepressant Medication Management (AMM), Continuation Phase	44%	41%	↑
	Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	47%	45%	
	Follow-Up Care for Children Prescribed ADHD Medication (ADD), Continuation	55%	51%	
	Follow-Up after Hospitalization for Mental Illness (FUH), 30-Day Follow-Up, Total	62%	53%	↑
	Follow-Up after Hospitalization for Mental Illness (FUH), 7-Day Follow-Up, Total	44%	37%	↑
	Follow-Up After ED Visit for Mental Illness (FUM), 30-day, Total	61%	55%	↑
	Follow-Up After ED Visit for Mental Illness (FUM), 7-day, Total	48%	43%	↑
	Follow-Up After ED Visit for AOD Dependency (FUA), 30-day, 13-17 years	16%	17%	
	Follow-Up After ED Visit for AOD Dependency (FUA), 30-day, Total	28%	29%	
	Follow-Up After ED Visit for AOD Dependency (FUA), 7-day, Total	18%	19%	
	Follow-Up After High Intensity Care for SUD (FUI), 30-day, Total	58%	58%	
	Follow-Up After High Intensity Care for SUD (FUI), 7-day, Total	38%	38%	
	Pharmacotherapy for Opioid Use Disorder (POD): Total	21%	18%	↑
Cardiovascular Conditions	Controlling High Blood Pressure (CBP)	62%	57%	
Diabetes	Comprehensive Diabetes Care (CDC), Poor HbA1c Control (lower is better)	38%	40%	
	Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0%	51%	50%	
Overuse / Appropriateness	Use of Opioids at High Dosage (HDO) (lower is better)	6%	7%	↑
Prevention and Screening	Childhood Immunization Status (CIS), Combo 2	65%	64%	
	Childhood Immunization Status (CIS), Combo 10	39%	38%	
	Immunizations for Adolescents (IMA), Combo 2	42%	37%	
	Lead Screening in Children (LSC)	34%	33%	
Respiratory Conditions	Asthma Medication Ratio (AMR), Total	62%	63%	
Utilization	Well-Child Visits in the First 30 Months of Life (W30), 0-15 Months	54%	54%	
	Well-Child Visits in the First 30 Months of Life (W30), 16-30 Months	68%	69%	
	Child and Adolescent Well-Care Visit (WCV), Age 3-11	47%	47%	
	Child and Adolescent Well-Care Visit (WCV), Age 12-17	36%	34%	↑
	Child and Adolescent Well-Care Visit (WCV), Age 18-21	21%	14%	↑
	Child and Adolescent Well-Care Visit (WCV), Total	39%	38%	↑

**While the Health Care Authority, Department of Social and Health Services, and the Health Benefit Exchange are working together with other state agencies to incorporate gender identity into their applications and other processes, we want to acknowledge the current binary nature of data collection and reporting and the limitations that presents in this kind of analysis.*