Comagine Health

2020 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.

For more information, visit us online at www.comagine.org.

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Acronym List

Acronym	Definition
AHAC	Apple Health Adult Coverage (Medicaid Expansion)
AH-BD	Apple Health Blind/Disabled
AH-IFC	Apple Health Integrated Foster Care
AHMC	Apple Health Managed 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
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 2019, over 1.7 million Washingtonians were enrolled in Apple Health,[1,2] with more than 84% enrolled in managed care.[3] 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 56 Healthcare Effectiveness Data and Information Set (HEDIS®)[4] 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,®[5] enables benchmarking against other Medicaid managed care health plans nationwide.

Comparative tables shown in this report identify the HEDIS measures that are also included in the Washington State Common Measure Set on Health Care Quality and Cost,[6] 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:

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[1] About Washington Apple Health (Medicaid). Available at: https://www.hca.wa.gov/assets/free-or-low-cost/about-Apple-Health.pdf.
[2] Quick Facts – Washington. United States Census Bureau. Available at: https://www.census.gov/quickfacts/WA
[3] Healthier Washington. About the Washington Statewide Common Measure Set for Health Care Quality and Cost. https://www.hca.wa.gov/assets/measures-fact-sheet.pdf.
[4] The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.
[5] Quality Compass® is a registered trademark of NCQA.
[6] Healthier Washington. About the Washington Statewide Common Measure Set for Health Care Quality and Cost. Available at: https://www.hca.wa.gov/assets/measures-fact-sheet.pdf.

- Statewide performance compared to national benchmarks (when available)
- Individual MCO performance compared to national benchmarks (when available)
- 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.[7]

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 2020, Comagine Health assessed MCO performance on HEDIS measures reported by each plan according to ESHB 1109's specific criteria and those that best reflect the state's quality and value priorities — balancing cost and utilization — while ensuring quality care to enrollees. Comagine Health assessed each MCO's most recently reported HEDIS rates as well as performance rates for the select non-HEDIS measures related to penetration rates for behavioral health treatment and substance use disorder treatment (the MH-B and SUD measures).

Comparative Analysis in this Report

Comagine Health thoroughly reviewed each MCO's rates for all 56 HEDIS measures and associated submeasures and the RDA measures. Appendix B, presented separately to HCA, contains a full report of all performance measures

With HCA's approval, we focused on 31 of the 56 measures for the majority of the comparative analyses in this report. These 31 measures, which included 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.

[7] 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.

We present measure performance and comparison to national benchmarks (NCQA),[8] by the following:

- Apple Health Programs
- Individual Apple Health MCOs
- Apple Health service regions

To be consistent with NCQA methodology, the 2019 calendar or measurement year (January 1, 2019 – December 31, 2019) is referred to as the 2020 reporting year (RY) in this report.

Since Appendix B contains information that is confidential, 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

- **Significant improvement in several measures statewide**

  Several measures showed statistically significant improvement from 2019 to 2020, most notably measures related to diabetes and those that focus on improved monitoring for proper medication use.

  Whether these statistically significant improvements are clinically significant will depend on whether these trends can be sustained over several years.

- **Impact of COVID-19 and hybrid measures for certain MCOs**

  In response to COVID-19, NCQA allowed Medicaid plans participating in HEDIS reporting the option of submitting 2019 rates for their 2020 hybrid measures, referred to as "rotating" measures. Hybrid measures combine administrative claims data and data obtained from clinical charts. Under NCQA guidelines, the MCOs were allowed to 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 (also discussed under Limitations in the Methodology section and in Appendix A).

- **One MCO performed above the regional average for the four access/availability of care measures.**

  As the largest MCO in Washington, MHW's rates tend to drive statewide results. MHW had improved performance from 2019 to 2020 RY in the following access/availability of care measures:

  - Adults' Access to Preventive/Ambulatory Health Services (AAP), Total
  - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (AAP), Total

- **Fully integrated managed care**

  In 2016, physical health, mental health and substance use disorder treatment services were integrated under one contract. In 2019, all but three Regional Service Areas (RSAs: Great Rivers,

[8] Note: NCQA licensing agreement does not allow display of national performance benchmarks for all measures.

Salish and Thurston-Mason) had implemented Apple Health Integrated Managed Care (AH-IMC). The majority of members (79.1%) were enrolled in the fully integrated managed care program.

- **Enrollee Demographics**
    - Variation between MCOs' demographic profiles are a reflection of the difference in plan mix for each MCO and should be taken into account when assessing HEDIS measurement results.
    - Differences were found when comparing demographic characteristics of enrollees by region. King and Pierce regions, which are more urban, were the most racially diverse.
    - The Greater Columbia region had the highest percentage of enrollees who identified as Hispanic.
    - Several measures had statistically significant differences in performance between English and Spanish/Castilian speakers.
- **Regional Comparisons**

  New to the comparative report this year is an analysis of MCO performance within each regional service area.
    - There were a few measures in the Prevention and Screening category with statistically significant differences between the urban population and rural populations.
        - The urban population was statistically significantly higher for
            - Breast Cancer Screening (BSC)
            - Childhood Immunization Status (CIS)**,** Combo 10
            - Chlamydia Screening (CHL), Total measure.
        - The rural population was significantly higher for the Weight Counseling for Children and Adolescents, Nutrition Counseling, Total measure.

Measures Showing Improvements Statewide

Table 1 shows the following measures had statistically significant improvement[9] statewide.

Table 1. Measures with Statistically Significant Improvement from 2019 to 2020 RY.

Measure with Statistically Significant Improvement
Adults' Access to Preventive/Ambulatory Health Services (AAP), Total
Children's Access to Primary Care Practitioners (CAP), 7–11 Years*
Antidepressant Medication Management (AMM), Acute Phase
Antidepressant Medication Management (AMM), Continuation Phase
Substance Use Disorder Treatment Penetration, 12–64 Years
Comprehensive Diabetes Care (CDC), Blood Pressure Control < 140/90 mm Hg
Asthma Medication Ratio (AMR), Total
Medication Management for People With Asthma (MMA), Medication Compliance 75%, 12–18 Years

**Note that this measure had a significant decline between the 2018 RY and 2019.*

There was also a significant increase in the Use of First Line Psychosocial Care for Children and Antipsychotics (APP), Total measure. However, NCQA issued guidance advising caution when comparing measure results to prior reporting periods due to changes in measure specifications.

Measures with Declining Performance Statewide

The following measures had declining performance statewide.

Table 2. Measure with Declining Performance Statewide from 2019 to 2020 RY.

Measure with Statistically Significant Decline in Performance
Breast Cancer Screening (BCS)

[9] Statistically significant is based on statistical test that establishes the 95% confidence level. This means there is 95% confidence that there is a real difference between two numbers, and that the differences are not due to chance. For more explanation about this definition, please see the Methodology section.

Recommendations

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

Sustain Clinically Meaningful Areas of Improvement

This comparative report identifies many statistically significant improvements in quality measures across MCOs this year. Several measure categories had improvement across all or most MCOs or spanned more than one year. We consider year-over-year improvement in particular to be clinically meaningful in that it is clear that the standard of practice is showing sustained improvement. We recommend that the MCOs sustain momentum in these key areas, identifying the best practices contributing to this performance and, where possible, standardizing approaches to encourage sustainability.

Key areas include:

- **Behavioral Health Integration**. There was year-over-year improvement across all or nearly all MCOs in several behavioral health medication management metrics (Antidepressant Medication Management, Acute and Continuation phase and Follow-Up Care for Children Provided ADHD Medication, Initiation and Continuation phases). We recommend continued emphasis on this important topic with additional focus on the behavioral health issues for which there has not been sustained improvement, including Mental Health Service Penetration – Broad Definition (MH-B).
- **Substance Use Disorder.** There was improvement across all MCOs in Substance Use Disorder Treatment Penetration (SUD) for all enrollees (ages 12–64) for the last two years. This improvement was not seen for adolescents (ages 12–18) or the foster care population (ages 12–26). SUD has impacted all clinicians serving Medicaid patients and has been a high priority in the state and nationally. We recommend that improvement efforts be continued with additional focus on patients under the age of 26.

Anticipate Impacts due to the COVID-19 Pandemic

The data for this analysis was collected through December 2019 and, therefore, does not reflect impacts of the COVID-19 pandemic. Maintaining quality improvement momentum in 2020 will be a challenge because of the disruption to care delivery across all sectors because of the pandemic.

We recommend that MCOs do not wait for 2020 data to address anticipated effects, but rather work to proactively address these domains. We anticipate that the impact of the pandemic will be measurable in several particularly vulnerable clinical areas.

- **Access to care.** As providers have increased access via telemedicine and limited in-person services, it will be important to pay attention to equitable access to care and particularly care for children. Given that some patients from disadvantaged communities will have limited access to the technology, privacy or internet access needed for telehealth, we recommend that MCOs focus on ensuring that in-person services are prioritized for those unable to participate in virtual visits. With early reports of reduced childhood immunization during the pandemic, consideration should be given to an early convening of MCOs to design innovative strategies for immunizing children rather than waiting for a full year of data.

- **Behavioral health**. As the pandemic's impact on personal isolation continues, we anticipate that depression, anxiety and other behavioral health needs among the population will increase. We recommend that the MCOs continue efforts that strengthen the integration of behavioral health and primary care, as well as initiatives to identify and meet behavioral health needs.
- **Chronic conditions (cardiovascular conditions, diabetes and respiratory conditions)**. Monitoring physiologic control and end organ damage, as well as medication adherence, are foundational components of chronic disease management. All three are threatened by the COVID-19 pandemic. MCOs will need to work to ensure patients with chronic cardiovascular and respiratory conditions continue to receive evidence-based monitoring and interventions through the use of alternative methods of care delivery including telehealth, collaboration with community health worker programs and optimal use of community-based organizations.
- **Prevention and screening**. We anticipate a reduction in screening and preventive services caused by the pandemic that will lead to delayed, late-stage diagnoses and an increase in preventable conditions. We recommend focused efforts to develop standardized plans across all MCOs to increase incentives and remove barriers to preventive care during the pandemic.
- **Utilization**. If our assumptions about limited access to preventive and maintenance services are correct, we are concerned about a potential increase in the utilization of critical care and emergency services above and beyond conditions directly related to COVID-19 infection. We recommend a coordinated effort across MCOs to give clinical providers a unified framework for addressing these threats.

Standardize Approaches Across MCOs When Possible to Reduce Burnout

Given the significant degree of burnout in the provider community and stress on the overall health care system as documented in the medical literature, we recommend that MCOs coordinate on standardized approaches to minimize burden wherever possible.[10]

As noted in last year's report, Comagine Health sees a particular opportunity for MCOs to impact quality in areas where providers have a limited view of data related to the patient's overall care journey (such as in pre- and postnatal care). This creates an opportunity for the MCO to add valuable information to the quality improvement process that would otherwise not exist in the system. In the context of a pandemic where care patterns have been dramatically disrupted, we encourage MCOs to proactively coordinate on approaches to identify data and unified approaches in domains of potential pandemic impact.

Changes in Data Availability Will be Required to Improve Analysis of Equity

There is agreement that monitoring health equity is essential, and of increasing importance given disruption of health services due to COVID-19.

Where possible we have conducted initial analysis, but also underscore here the limitations of the current data set and opportunity to source additional data for future analyses. The analysis in this comparative report is based off enrollment data and member-level measure results, augmented with race, ethnicity and language. One meaningful limitation is that the percentage of Washington residents who report being members of a minority are small, so analyses at the measure level by race and language often lead to very small denominators, limiting the ability to detect meaningful differences.

[10] See "Burnout and Health Care Workforce Turnover." Grace-Willard et al. *Ann Fam Med*. 2019. 17(1):36-41.

Further, race and preferred language are imperfect metrics for the concepts they are intended to measure (ethnicity/cultural heritage and ability to communicate with the health care team, respectively). Missing are measures pertaining to food insecurity, housing stability, socioeconomic status, education and numerous other important factors.

Despite these limitations, one notable finding in the current data underscores the importance of improving the ability to detect and address inequity. As noted elsewhere in this report there was improvement across all MCOs in medication management for depression and for ADHD in children. However, this improvement was entirely driven by improvement in patients identifying as "white," whereas those identifying as either "Black" or "Hispanic" showed statistically significant deterioration for these measures.

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. In this spirit, we recommend the following actions to lay the foundation for more robust health equity reporting in the Medicaid population.

- Conduct an environmental scan to identify experience, tools and findings pertaining to measurement of social determinants of health and their impact on equity in Medicaid programs nationally, with a particular focus on Western States with similar demographics. While this represents a large-scale effort to capture such information, there's widespread consensus that social determinants of health play a significant role in health outcomes and disparities.
- Create an inventory of other data sets already available to HCA that if combined with the current EQR data sets would allow additional analysis in the interim. Efforts to capture new social determinants of health information require time, resources and planning, and reusing existing data sets could provide additional insight into disparities in Medicaid population outcomes. An example would include MCO Medicaid claims files that would make possible analysis of who is getting care and who is not with relatively precise geographic granularity.
- With the understanding that additional analytics requires additional resources, we would suggest a review the current analysis underway to determine which parts provide information of lesser value and might be swapped for higher-value analysis of health equity.

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 (CY) 2019. To enable a reliable measurement of performance, the HCA required MCOs to report on 56 HEDIS 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).

The 2019 calendar year is referred to as the 2020 reporting year (RY) in this report to be consistent with NCQA methodology.

Background

Each Apple Health MCO is required to report results for 56 HEDIS measures reflecting the levels of quality, timeliness and accessibility of health care services furnished to the state's Medicaid enrollees. 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 56 HEDIS measures, two behavioral health measures developed by HCA are also included in this report.

Overview of Apple Health Enrollment

In 2019, over 1.7 million Washington residents were enrolled in Apple Health, with more than 84% enrolled in managed care.

During 2019 CY, 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:

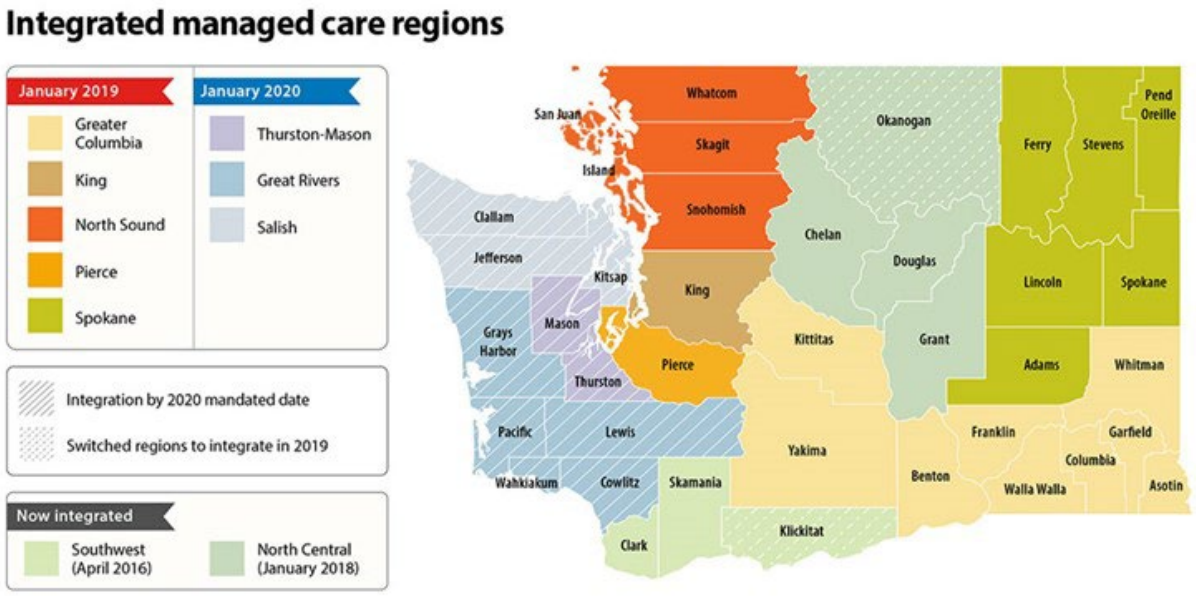
- **Apple Health Family (traditional Medicaid)**
    - Note in 2019, Apple Health Family was only available in the Great Rivers, Salish and Thurston-Mason regions.

- **Apple Health Adult Coverage (Medicaid expansion)**
    - Note in 2019, Apple Health Adult Coverage was only available in the Great Rivers, Salish and Thurston-Mason regions.
- **Apple Health Integrated Managed Care (IMC)**
    - Note in 2019, Apple Health Integrated Managed Care was not available in the Great Rivers, Salish or Thurston-Mason regions. Those regions were integrated beginning January 1, 2020.
- **Apple Health Blind/Disabled (AH-BD)**
    - Note in 2019, AH-BD was only available in regions that were not integrated. Those regions were integrated beginning January 1, 2020.
- **Apple Health Integrated Foster Care (AH-IFC)**
- **State Children's Health Insurance Program (CHIP)**
    - Note in 2019, CHIP was only available in regions that were not integrated. Those regions were integrated beginning January 1, 2020.
- **Apple Health Behavioral Health Services Only[11] (BHSO)**
    - Only available for IMC regions, which included all regions except Great Rivers, Salish and Thurston-Mason. Those regions were integrated beginning January 1, 2020.

Figure 1 shows enrollment by Apple Health Program.

[11] BHSO enrollees are not represented in this report's performance rates. HEDIS measures, based on NCQA requirements, are designed to include enrollees with medical coverage, which is not included in the BHSO program.

Figure 1. Apple Health Regional Service Areas by County in 2019.[12]



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, 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 and Stevens counties
- **Thurston-Mason** includes Mason and Thurston counties

[12] Enrollment map and chart provided by Washington Health Care Authority. Available here: https://www.hca.wa.gov/about-hca/hca-announces-managed-care-plans-offering-integrated-care-starting-2019-and-2020.

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 region, member-selected race and member-preferred language.

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 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, 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 patient 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.

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 2019, Apple Health plans reported 56 measures and their specific indicators (for example, rates for specific age groups). Comagine Health thoroughly reviewed each MCO's rates for all 56 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

The state monitors and 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 enrollment 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 reporting years: 2018 RY, 2019 RY and 2020 RY. 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 30 measures. HCA selected the 30 measures to be reported with benchmarks in Appendix B. The two benchmarks selected are the National Average and the National 90th 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, which are Washington-specific 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 2017 as the benchmark.

Interpreting Percentages versus Percentiles

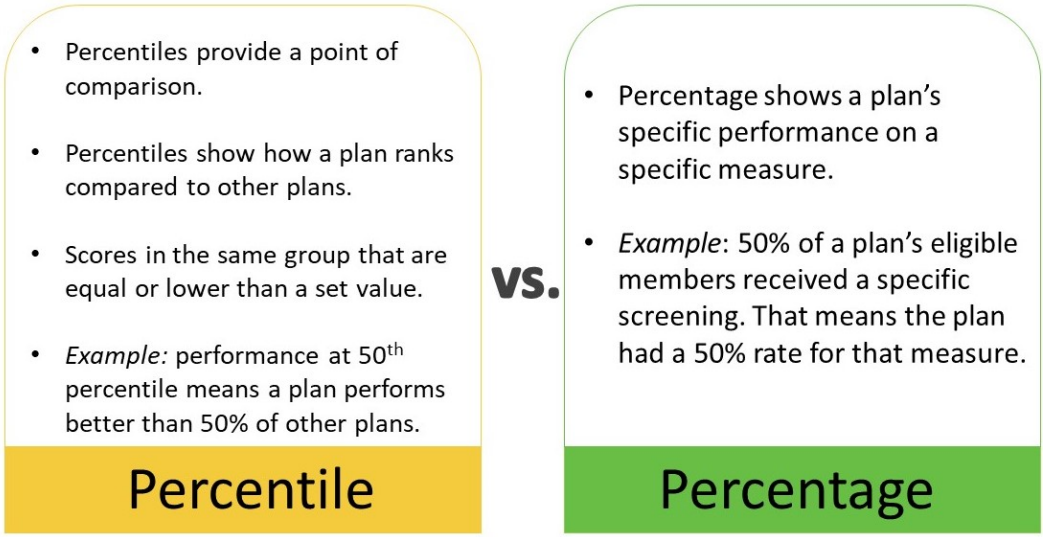
The majority of the measure results in this report are expressed as percentages. The actual percentage shows a plan's specific performance on a measure. For example, if Plan A reports a Breast Cancer Screening rate of 69%, that means that 69% of the eligible women enrolled in Plan A have received the 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 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 10% of the plans in the nation reported rates above Plan A and 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 considerable room for improvement given the number of similar plans that performed 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 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.



Statistical Significance

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.

Confidence Intervals 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.

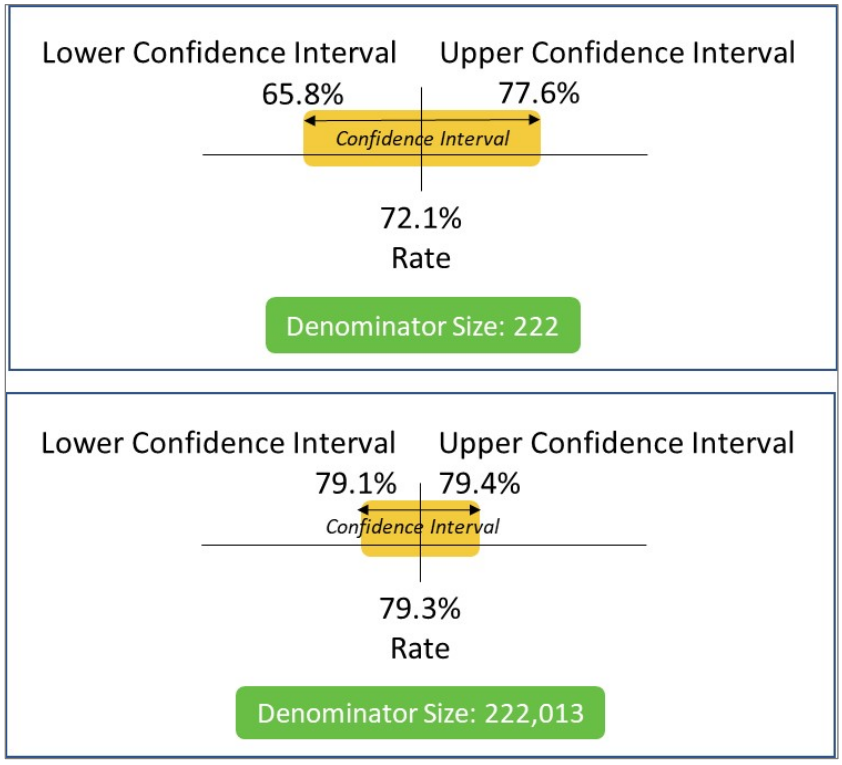
The confidence interval is expressed as a range from the lower confidence interval value to the upper confidence interval value. A statistically significant improvement is identified if the current performance rate is above the upper confidence interval for the previous year.

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 measure vary widely, 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.

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

- **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 2019 rates for their 2020 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 2019 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. See Appendix A, Table A-2, for the rotated measures by MCO.

- **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.

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

Apple Health Programs

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

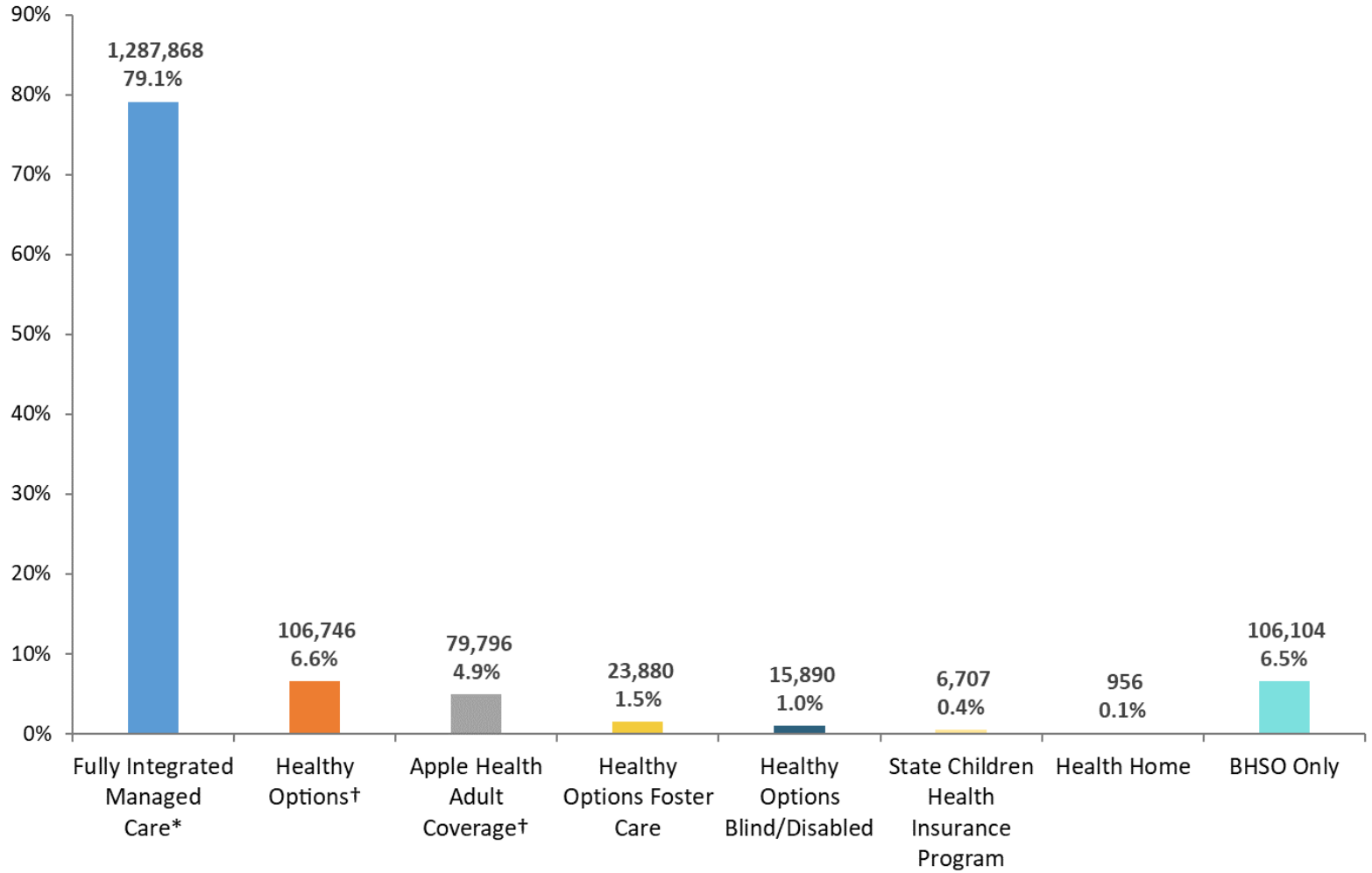
- **Modified Adjusted Gross Income Programs**, which are offered to individuals based on income eligibility. Note that in 2019, these programs were only available in the Great Rivers, Salish and Thurston-Mason regions. These include:
    - **Apple Health Family** – Low-income programs for families, pregnant 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 was introduced as part of the Medicaid expansion in 2014.
    - **Apple Health for Kids** – Washington's 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. Note that in 2019, Apple Health Blind/Disabled was only available in the Great Rivers, Salish and Thurston-Mason regions.
- **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 Integrated Managed Care (AH-IMC)** – Integration of physical health, mental health, and substance use disorder treatment services under one contract. This program serves Medicaid-eligible adults, pregnant women, people with disabilities, CHIP-eligible children and low-income families. In 2019, all but three Regional Service Areas (RSAs; Great Rivers, Salish, and Thurston-Mason) had implemented AH-IMC.
- **Apple Health Behavioral Health Services Only (BHSO)** – Program offered in IMC regions for members who are eligible for Apple Health but not eligible to be on a managed care plan, including the below:
    - Dual-eligible for Medicare and Medicaid
    - Medically Needy program
    - Individuals who have met their Medicaid Spenddown

The different Medicaid programs offered 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.

In 2019, not all RSAs 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 five MCOs were active in only two of the RSAs, while the number of MCOs varied in the other regions; this would impact the potential baseline/denominator of enrollees for a given performance measure.

Figure 4 shows enrollment by Apple Health Program. The majority of members (79.1%) were enrolled in the fully integrated managed care program.

Figure 4. 2020 Percent Enrollment by Apple Health Program.*†



** Fully Integrated Managed Care was not available in the Great Rivers, Salish or Thurston-Mason regions in 2019. Those regions were integrated beginning January 1, 2020.*

† Healthy Options and Apple Health Adult Coverage were only available in the three regions where Fully Integrated Managed Care was not available.

Demographics by Program

Medicaid enrollment demographics vary between programs. 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 (see previous Overview of Enrollment section). Because of this variation, monitoring performance at both the plan level, and at the plan and program level, is important.

Age Range

The average age of enrollees varies across programs. Below are the age groups with greatest percentages of enrollees by program:

- **Apple Health Adult**: 59.9% of enrollees are between the ages of 21 and 44
- **Fully integrated managed care enrollees:** 30.8% of enrollees are between the ages of 21 and 44
- **Health Home**: 52.2% of enrollees are 65 and over
- **Healthy Options**: most enrollees are youth and children under the age of 20
- **Healthy Options Blind/Disabled**: most are adults between the ages of 21 and 64
- **Healthy Options Foster Care**: most are enrollees are youth and children under the age of 20
- **State CHIP:** 41% are children ages 6 to 12

Figure 5 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 5. 2020 RY Enrollee Population by Apple Health Program and Age Range.*

Age Range	Apple Health Adult Coverage†	Fully Integrated Managed Care*	Health Home†	Healthy Options	Healthy Options Blind/Disabled	Healthy Options Foster Care	State Children Health Insurance Program
Age 0 to 5		16.82%	0.21%	28.08%	2.54%	27.67%	26.55%
Age 6 to 12		20.06%	0.10%	31.16%	8.38%	36.43%	41.09%
Age 13 to 20	5.47%	17.75%	0.42%	23.55%	10.22%	31.62%	32.35%
Age 21 to 44	59.90%	30.17%	12.87%	15.10%	30.98%	4.28%	
Age 45 to 64	34.53%	15.01%	34.21%	2.10%	47.17%		
Age 65+	0.10%	0.18%	52.20%	0.00%	0.72%		

% of Total Member Count

0.00% 59.90%

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†Healthy Options and Apple Health Adult Coverage were only available in the three regions where Fully Integrated Managed Care was not available.

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 the Provider One application. The member may also choose "not provided" if they decline to provide the information.

As shown in Figure 6, the majority of Apple Health members across all programs are white. Overall, the "other" and "not provided" categories were the next most common.

Figure 6. Statewide Apple Health Enrollees by Program and Race, 2020 RY.

Race	Apple Health Adult Coverage†	Fully Integrated Managed Care*	Health Home†	Healthy Options	Healthy Options Blind/Disabled	Healthy Options Foster Care	State Children Health Insurance Program
White	81.05%	56.16%	62.13%	69.09%	82.91%	61.77%	66.99%
Other	4.90%	15.51%	7.95%	9.71%	3.80%	7.50%	7.04%
Not Provided	3.68%	8.75%	6.28%	8.38%	4.45%	12.92%	14.82%
Black	3.33%	9.48%	8.26%	4.65%	3.96%	11.14%	3.24%
Asian	2.27%	5.08%	7.74%	1.92%	1.55%	1.07%	2.70%
American Indian / Alaskan Native	2.31%	1.45%	0.73%	2.83%	2.12%	3.63%	2.21%
Hawaiian / Pacific Islander	2.45%	3.57%	6.90%	3.41%	1.21%	1.97%	3.01%

% of Total Member Count

0.73% 82.91%

Note: These are the categories that MCOs provide to HCA in enrollment 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."

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†Healthy Options and Apple Health Adult Coverage were only available in the three regions where Fully Integrated Managed Care was not available.

Figure 7 shows that most Apple Health Program enrollees are not Hispanic. The Fully Integrated Managed Care program has the largest percentage of Hispanic enrollees at 24.6%.

Figure 7. Statewide Apple Health Enrollees by Program and Hispanic Indicator, 2020 RY.

Hispanic	Apple Health Adult Coverage†	Fully Integrated Managed Care*	Health Home†	Healthy Options	Healthy Options Blind/Disabled	Healthy Options Foster Care	State Children Health Insurance Program
N	90.86%	75.40%	93.72%	80.98%	93.03%	83.51%	85.42%
Y	9.14%	24.60%	6.28%	19.02%	6.97%	16.49%	14.58%

% of Total Member Count

0.00% 63.80%

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Language

Upon enrollment, members also provide information on primary spoken language. According to Apple Health enrollment data, there are 81 separate spoken languages among 1.6 million 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 8 shows the variation in primary spoken language by Apple Health Program, reflecting the 15 most common languages. After English, Spanish/Castilian is the most common language across programs. Russian and Vietnamese are the third most common languages, depending on the program, but are still spoken by less than 1.0% of enrollees.

Figure 8. Statewide Apple Health Enrollees by Program and Language, 2020 RY.

Spoken Language	Apple Health Adult Coverage†	Fully Integrated Managed Care*	Health Home†	Healthy Options	Healthy Options Blind/Disabled	Healthy Options Foster Care	State Children Health Insurance Program
English	98.48%	86.40%	96.55%	92.57%	94.08%	92.62%	93.95%
Spanish; Castilian	1.08%	9.63%	0.94%	6.88%	0.90%	1.49%	5.32%
Russian	0.03%	0.87%	0.10%	0.04%	0.03%	0.01%	0.10%
Vietnamese	0.15%	0.54%	0.10%	0.14%	0.04%	0.02%	0.34%
Chinese	0.08%	0.39%	0.10%	0.06%	0.01%	0.01%	0.19%
Arabic	0.00%	0.30%	0.10%	0.01%	0.01%	0.01%	
Ukrainian	0.00%	0.25%		0.01%	0.03%	0.00%	
Somali	0.01%	0.23%		0.01%		0.01%	
Korean	0.07%	0.12%	0.10%	0.03%	0.03%		0.03%
Amharic	0.00%	0.10%	0.10%				
Panjabi; Punjabi	0.01%	0.07%		0.01%			
Burmese	0.00%	0.08%		0.00%		0.00%	
Tigrinya		0.08%	0.10%			0.02%	
Farsi	0.00%	0.06%		0.00%	0.01%		
Cambodian; Khmer	0.04%	0.05%	0.10%	0.03%	0.04%	0.01%	0.03%
Laotian	0.01%	0.01%		0.00%	0.01%	0.01%	
Other Languages	0.05%	0.83%	1.67%	0.19%	4.82%	5.77%	0.03%

% of Total Member Count

0.00% 98.48%

Note: blank, unshaded cells mean that those languages were not reported for 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.

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†Healthy Options and Apple Health Adult Coverage were only available in the three regions where Fully Integrated Managed Care was not available.

Apple Health Statewide Performance

Comagine Health combined MCO performance to show how plans performed from 2019 to 2020 (comparison years) statewide. With HCA's approval, we focused on the 31 highest priority measures for analysis in this report rather than the full list of 56 HEDIS measures. These 31 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 9 shows the 2020 RY statewide weighted average for the 31 measures. Below are the highlights of this statewide comparison:

- There was a statistically significant improvement between 2019 RY and 2020 RY for the following measures:
    - Adults' Access to Preventive/Ambulatory Health Services (AAP) Total
    - Children's Access to Primary Care Practitioners (CAP), 7–11 Years measures. (Note that the children's measure showed a significant decline between the 2018 RY and 2019.)
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), Total measure
    - Antidepressant Medication Management (AMM) Acute and Continuation Phase measures
    - Substance Use Disorder Treatment Penetration, 12–64 Years measure (for both years)
    - Comprehensive Diabetes Care (CDC), Blood Pressure Control < 140/90 mm Hg measure
    - Two of the asthma measures: Asthma Medication Ratio (AMR), Total and Medication Management for People With Asthma (MMA), Medication Compliance 75%, 12–18 Years
- There was a statistically significant decline between the 2019 RY and 2020 RY for the Breast Cancer Screening (BCS) measure.

Note: The fee-for-service program 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.

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 2020. Arrows pointing down represent a statistically significant decrease; arrows pointing up represent a statistically significant increase.

Figure 9. 2020 RY Statewide Weighted Average for 31 Measures.

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

		2020 Statewide Rate	2018 to 2019	2019 to 2020
Access / Availability of Care	Adults' Access to Preventive/Ambulatory Health Services (AAP), Total	76.5%		↑
	Children's Access to Primary Care Practitioners (CAP), 7-11 Years	90.8%	↓	↑
	Prenatal and Postpartum Care (PPC), Postpartum Care	72.1%		
	Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care	82.7%		
	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), Total	55.7%		↑
Behavioral Health	Antidepressant Medication Management (AMM), Acute Phase	53.5%		↑
	Antidepressant Medication Management (AMM), Continuation Phase	38.4%		↑
	Follow-Up Care for Children Prescribed ADHD Medication (ADD), Continuation	53.6%		
	Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	43.9%		
	Mental Health Treatment Penetration, 6-64 Years	57.4%	↑	
	Substance Use Disorder Treatment Penetration, 12-64 Years	36.6%	↑	↑
Cardiovascular Conditions	Controlling High Blood Pressure (CBP)	63.1%		
Diabetes	Comprehensive Diabetes Care (CDC), Blood Pressure Control < 140/90 mm Hg	69.8%		↑
	Comprehensive Diabetes Care (CDC), Eye Exam	58.0%		
	Comprehensive Diabetes Care (CDC), Medical Attention for Nephropathy	88.0%		
	Comprehensive Diabetes Care (CDC), Poor HbA1c Control (Note that a lower score is better for this measure)	35.8%		
Overuse / Appropriateness	Use of Opioids at High Dosage (HDO) (Note that a lower score is better for this measure)	7.1%		
Prevention and Screening	Breast Cancer Screening (BCS)	52.0%		↓
	Cervical Cancer Screening (CCS)	57.6%		
	Childhood Immunization Status (CIS), Combo 2	75.0%	↑	
	Childhood Immunization Status (CIS), Combo 10	44.9%	↑	
	Chlamydia Screening (CHL), Total	53.6%	↓	
	Lead Screening in Children (LSC)	32.1%	↑	
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC), BMI Percentile, Total	70.7%		
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC), Nutrition Counseling, Total	63.0%		
Respiratory Conditions	Asthma Medication Ratio (AMR), Total	55.0%		↑
	Medication Management for People With Asthma (MMA), Medication Compliance 75%, 5-11 Years	30.4%		
	Medication Management for People With Asthma (MMA), Medication Compliance 75%, 12-18 Years	30.1%		↑
Utilization	Adolescent Well-Care Visits (AWC)	51.2%		
	Well-Child Visits in the First 15 Months of Life (W15), 6 or More Visits	70.7%		
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)	70.4%		

Value-Based Quality Measures 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.

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.

In 2019 and 2020, 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 in September 2020 and will assign measures to the MCOs.

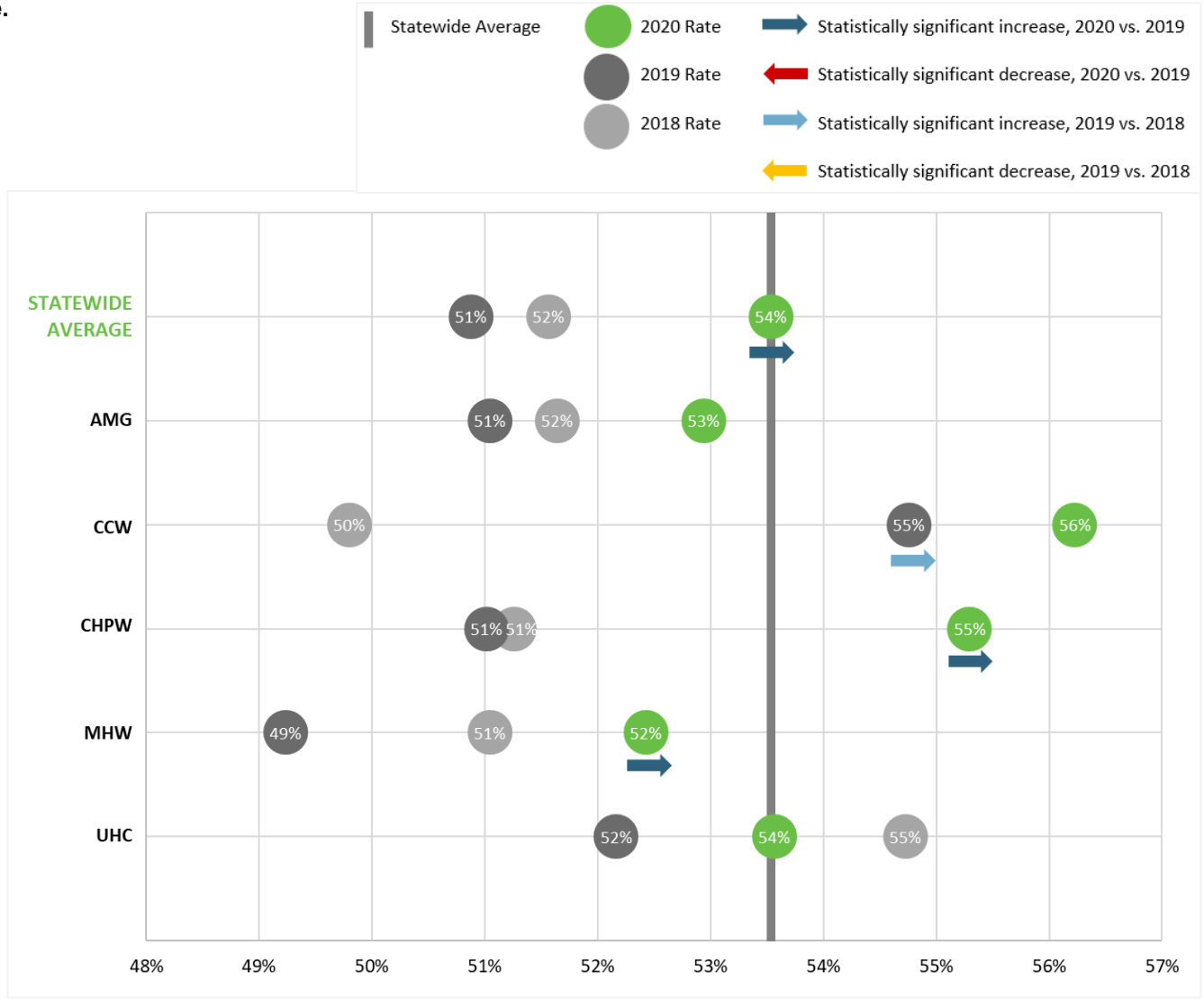
The 2020 RY represents the baseline year for the Value-Based Quality Measures Performance program; the performance evaluation for these measures will be completed in 2021. While it is too soon to assess performance for VBP purposes, Comagine Health thought it was important to provide detailed information on these measures in this report.

The following charts (Figures 10–25) show the three-year trend (2018 RY through 2020 RY) 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 2018 rate for each MCO, dark gray circles show the 2019 rate, and green circles indicate the 2020 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, page 12, for further explanation).

Figure 10. Antidepressant Medication Management (AMM), Acute Phase.



- AMM is a shared measure for the VBP program.
- The 2020 RY statewide average was at the national 50th percentile benchmark. Between 2019 and 2020 RYs, there was a statistically significant statewide improvement.
- The 2020 RY rates for AMG and UHC were also at the national 50th percentile benchmark (note: national benchmarks are not shown in this chart).
- The 2020 RY rate for CCW was above the national 50th percentile, but below the 75th.
- There was statistically significant improvement for CHPW and MHW between the 2019 and 2020 RYs.
- The 2020 RY rate for CHPW was above the 50th but below the 75th percentile.
- MHW was below the 50th percentile.

Figure 11. Antidepressant Medication Management (AMM), Continuation Phase.

- This is a shared measure for the VBP program.
- The 2020 RY statewide average was at the national 50th percentile benchmark. There was a statistically significant improvement between 2019 and 2020 RYs.
- The 2020 RY rates for AMG, CCW and UHC were also at the national 50th percentile benchmark (note: the national benchmark is not shown on this chart).
- AMG had statistically significant improvement between 2019 and 2020 RY. CHPW and MHW had statistically significant improvement between 2019 RY and 2020 RY.
- The 2020 RY rate for CHPW was above the 50th percentile but below the 75th; MHW was below the 75th percentile.

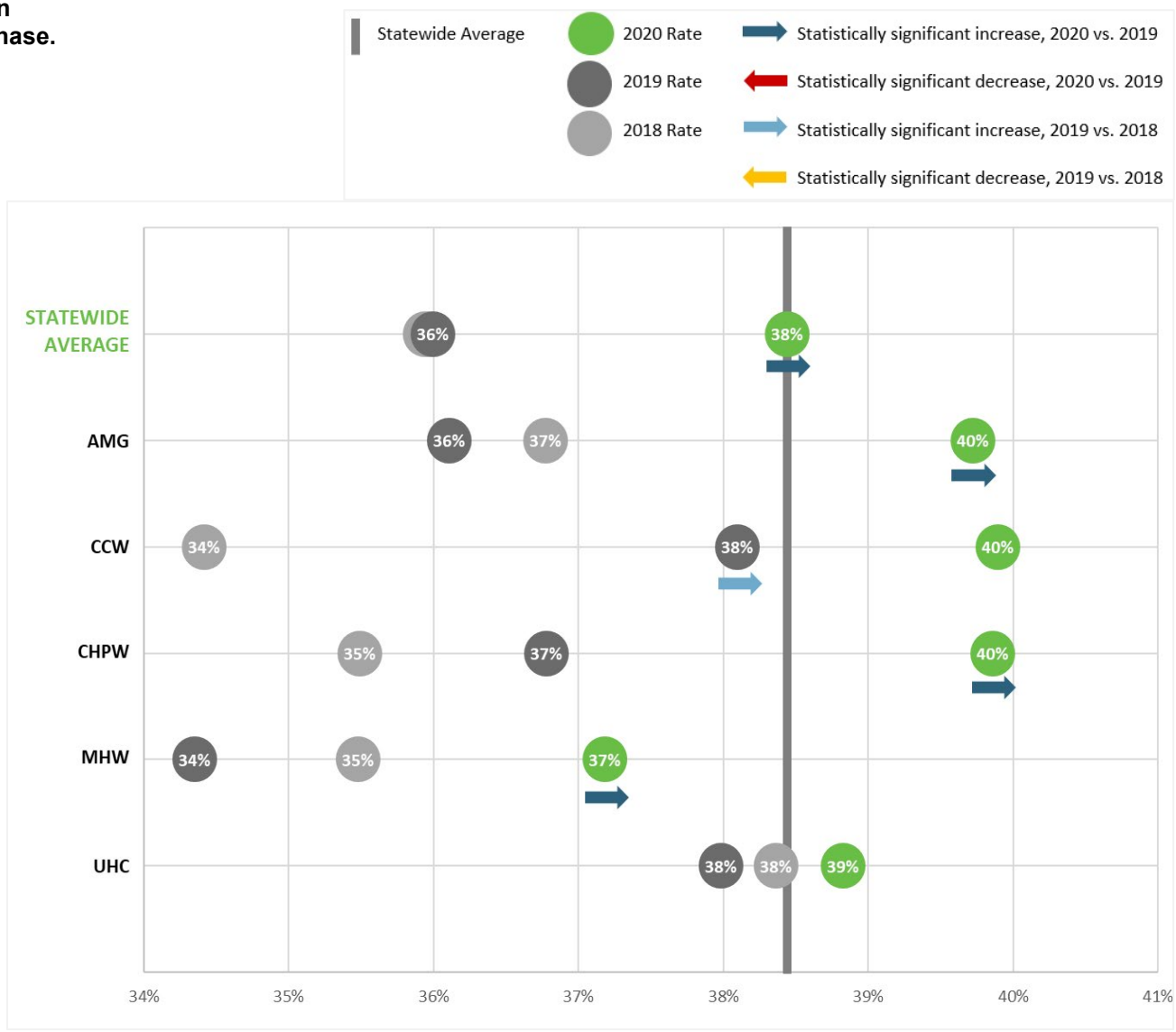
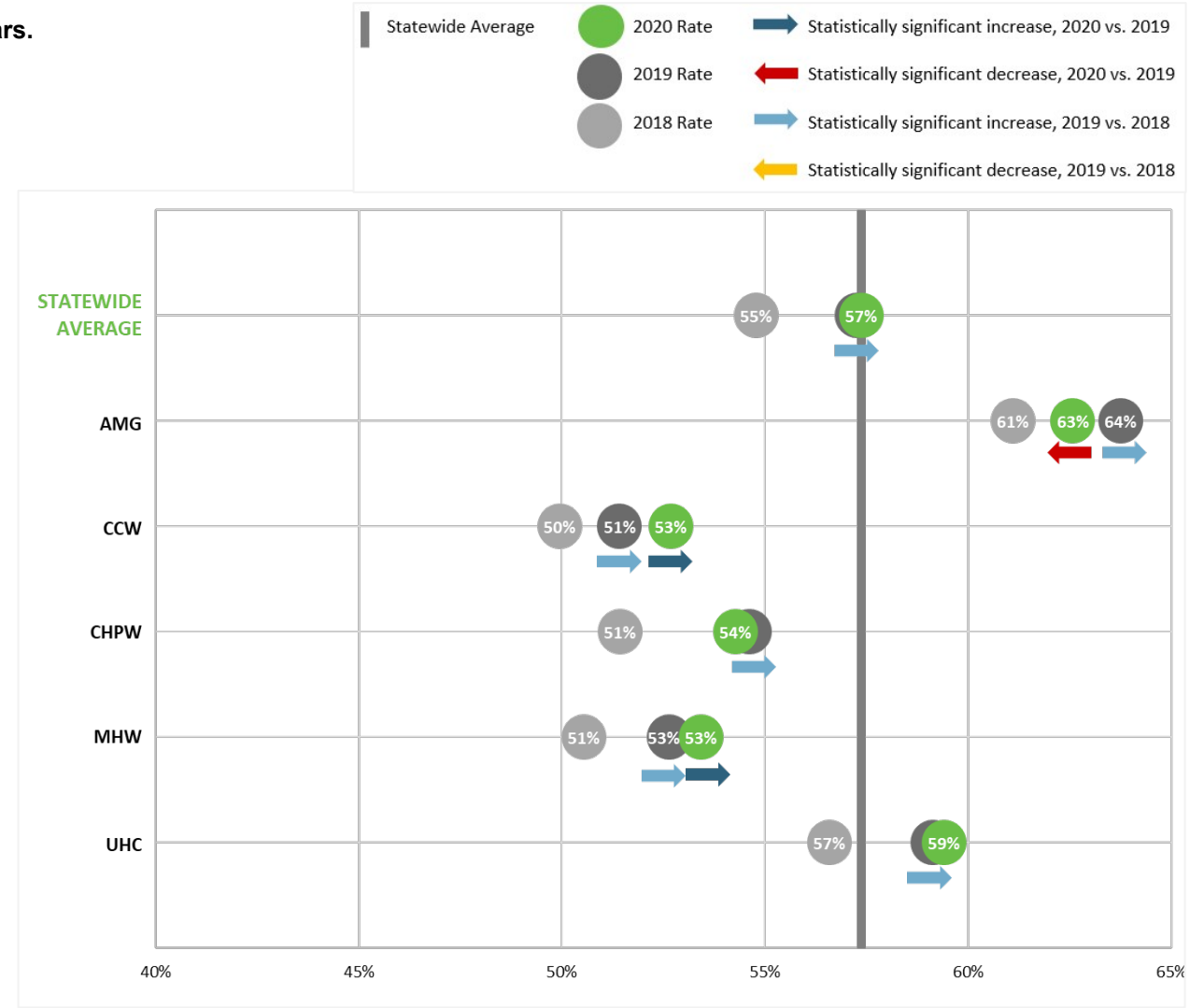


Figure 12. Mental Health Treatment Penetration (MH-B), Ages 6 to 64 Years.



- MH-B is a shared measure for the VBP program (2018 to 2020).
- The benchmark for this measure was the second highest performing MCO for the period ending in 2017 Q4.
- The statewide average was higher than the benchmark, as were the rates for AMG and UHC. The other MCOs were below the benchmark.
- There was a statistically significant increase in the statewide rate between the 2018 and 2019 RY, but the rate did not improve between 2019 and 2020.
- AMG had a statistically significant decrease between 2019 RY and 2020 RY.
- CCW and MHW had statistically significant increases in their rates two years in a row.
- CHPW and UHC had statistically significant increases between 2018 and 2019 RY, but the rates did not significantly change between 2019 and 2020.

Figure 13. Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care.

- This is a shared measure for the VBP program, from 2018 to 2020.
- Due to significant changes in the measure specifications for 2020 RY, historical data is not displayed for this measure.
- The 2020 RY statewide average was below the national 50th percentile, as were the rates for AMG, CCW and CHPW (the national benchmark is not shown on this chart).
- The 2020 RY statewide average for MHW was at the national 75th percentile.
- The 2020 RY rate for UHC was at the national 50th percentile.

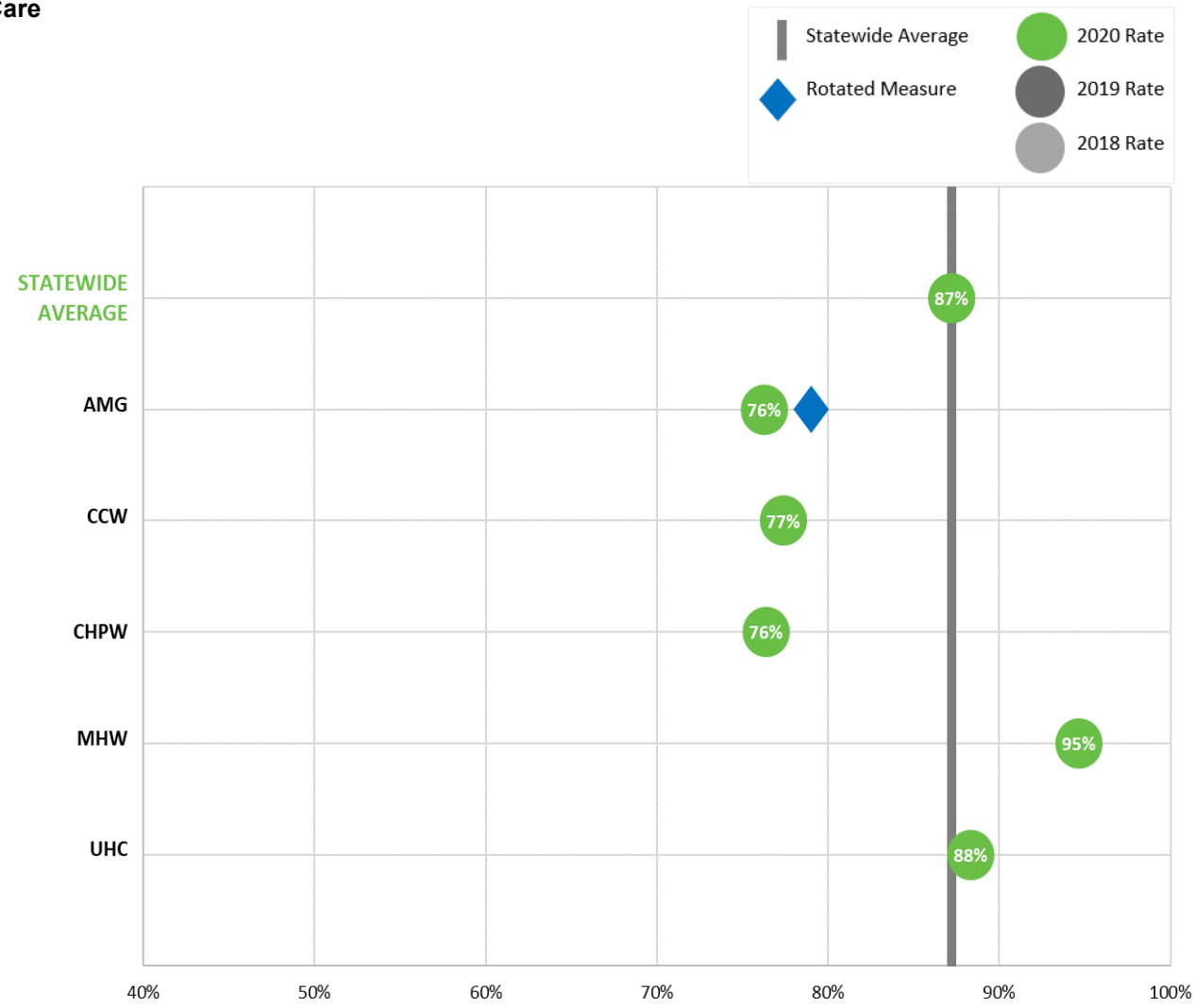


Figure 14. Prenatal and Postpartum Care (PPC), Postpartum Care.

- This is a shared measure for the VBP program.
- Due to significant changes in the measure specifications for 2020 RY, historical data is not displayed for this measure.
- The 2020 RY statewide average was below the national 50th percentile, as was AMG's rate.
- The 2020 RY rates for CCW, CHPW, MHW and UHC were at the national 50th percentile.

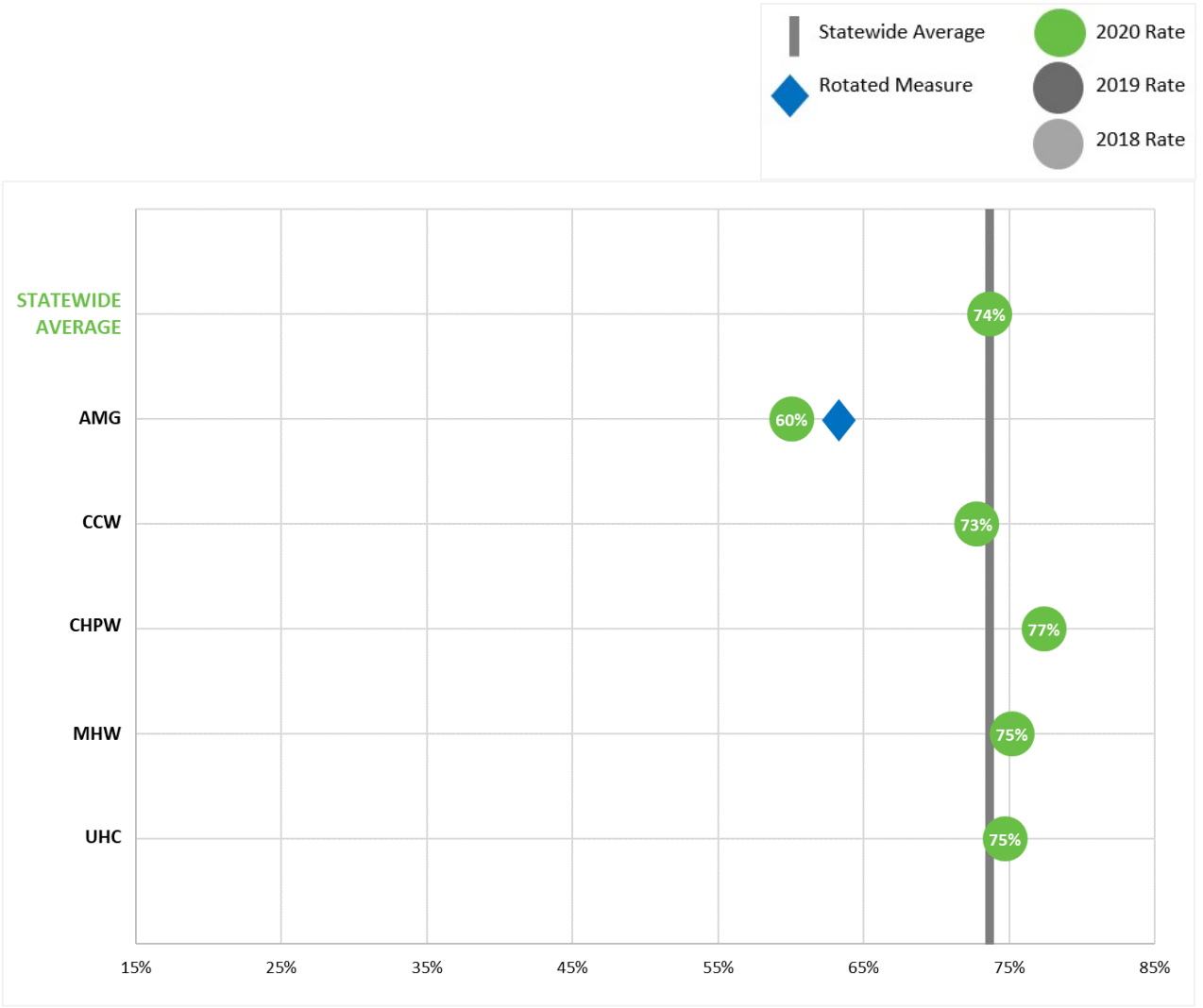


Figure 15. Asthma Medicare Ratio (AMR), Total.

- The 2020 RY statewide average and the rates for all five MCOs were below the national 50th percentile (the national benchmark is not shown in this chart).
- There was a statistically significant increase in the statewide average between 2019 and 2020 RY.
- CCW had a statistically significant increase between 2018 and 2019 RY; there was no significant increase between 2019 and 2020 RY.
- There was a statistically significant increase in CHPW's rate between 2019 and 2020 RY.
- There was a statistically significant decrease in the rate for MHW between the 2018 and 2019 RY, and no significant increase between 2019 and 2020 RY.

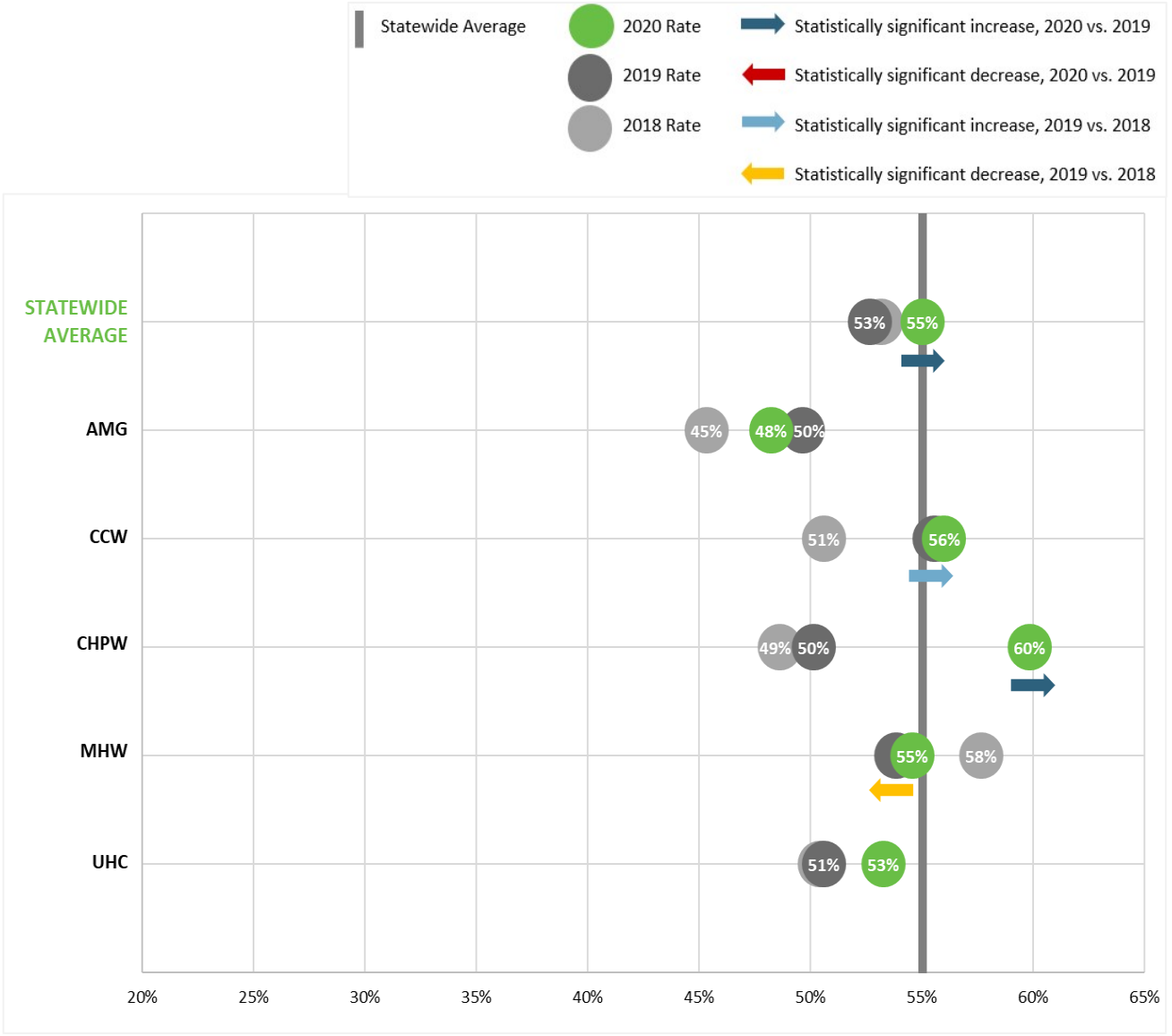


Figure 16. Substance Abuse Disorder Treatment Penetration (SUD), Age 12 to 64.

- This is a plan-specific VBP measure for all five MCOs.
- The benchmark for this measure is the second highest performing MCO for the period ending in 2017 Q4. The statewide rate was higher than the benchmark, as are the rates for all five MCOs.
- There was a statistically significant improvement in the statewide average between the 2018 RY and 2019 RY; as well, all MCOs had a statistically significant improvement during this time period.
- There was a statistically significant improvement in the statewide average between 2019 RY and 2020 RY; all MCOs except UHC also had a statistically significant improvement during this time period.

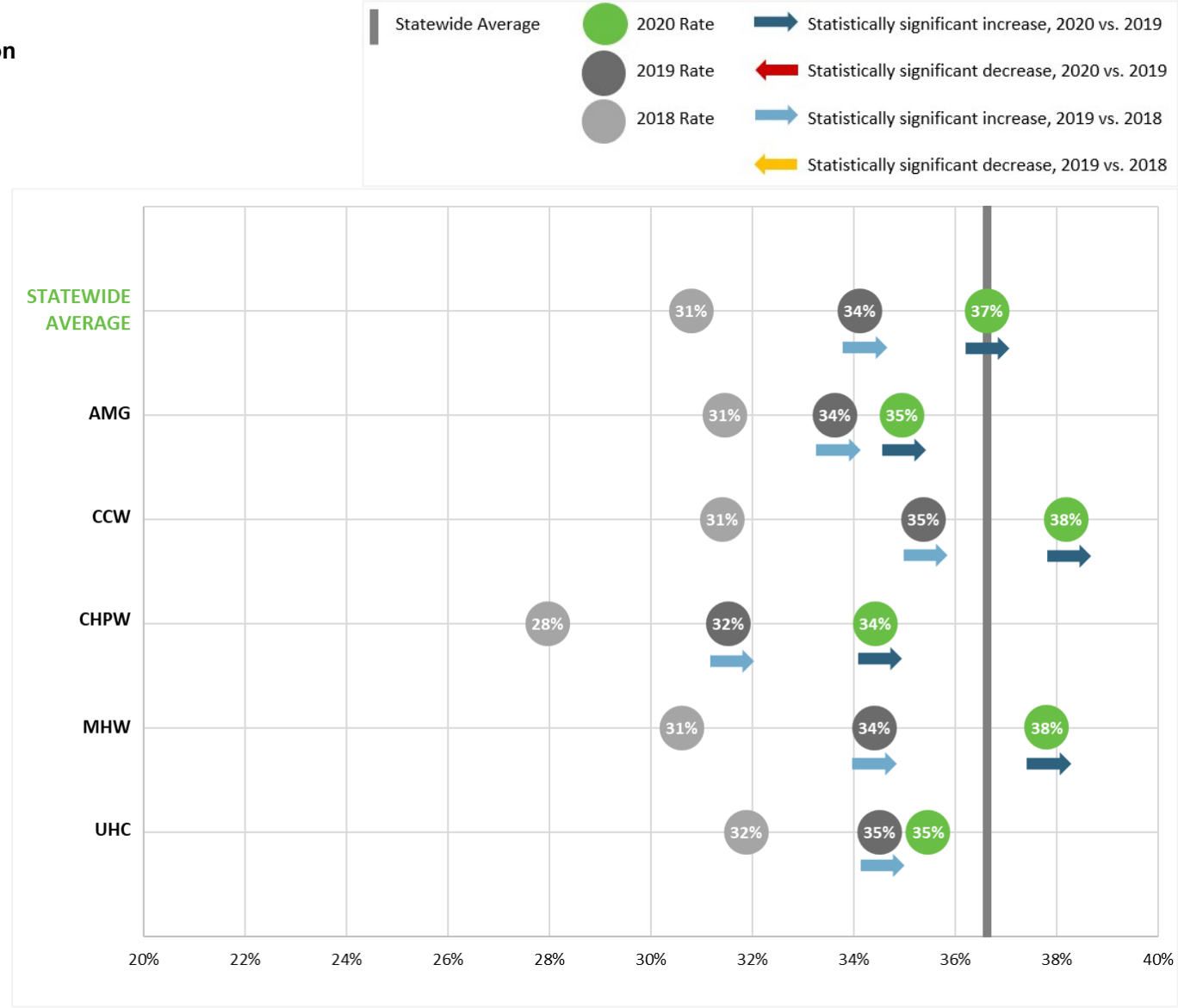


Figure 17. Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34).

- This is a plan-specific VBP measure for all five MCOs.
- The 2020 RY statewide average was below the national 50th percentile for this measure, as were the rates for AMG, MHW and UHC (the national benchmark is not shown in this chart).
- The 2020 RY rates for CCW and CHPW were at the national 50th percentile.
- There were no statistically significant changes in the year-over-year performance.

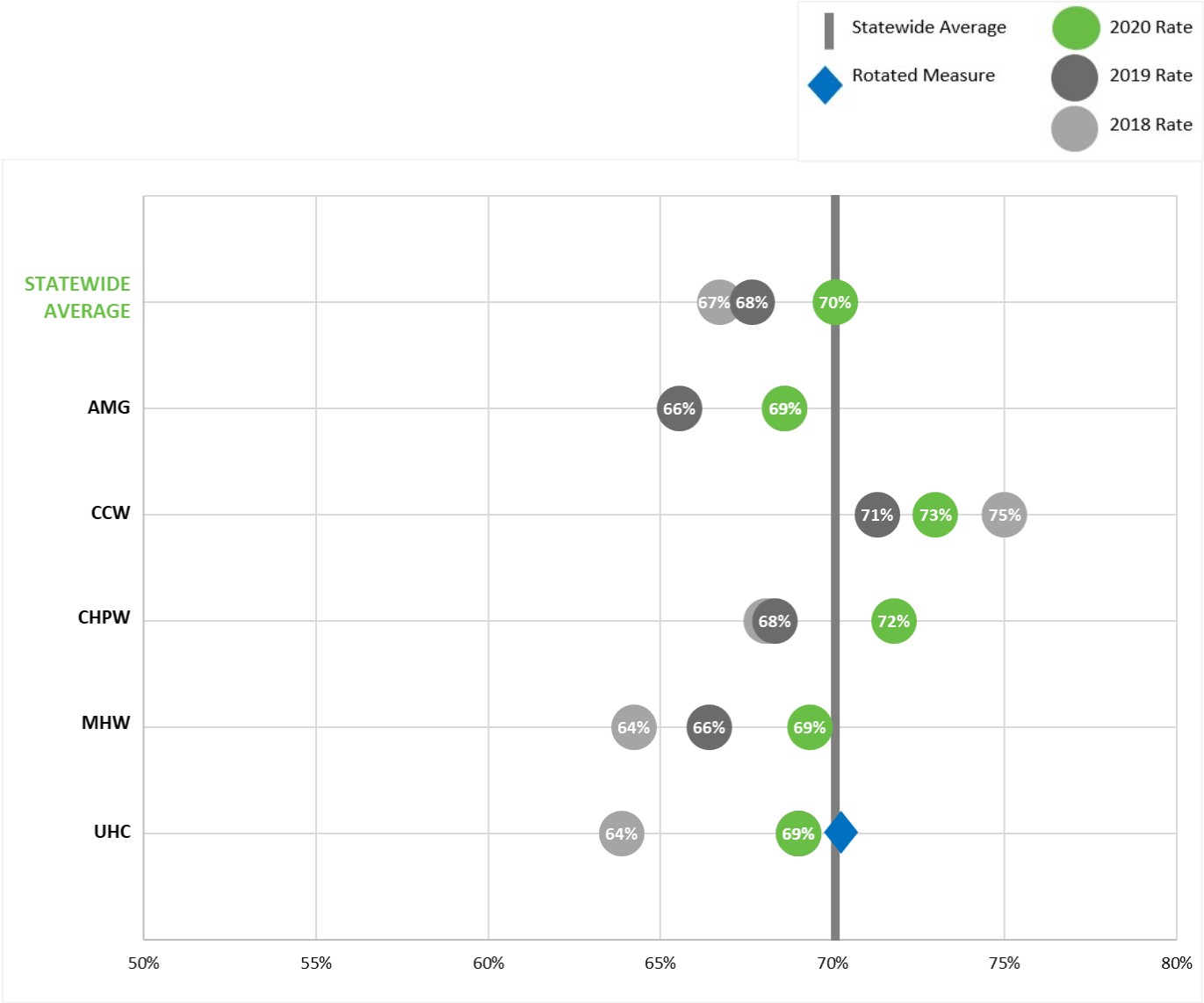


Figure 18. Follow-up Care for Children Prescribed ADHD Medication (ADD), Initiation Phase.

- This is a plan-specific VBP measure for CCW and CHPW. It is also a VBP measure for the foster care contract.
- The 2020 RY statewide average was at the national 50th percentile for this measure (the national benchmark is not shown in this chart).
- The 2020 RY rates for AMG, CCW and UHC were below the national 50th percentile.
- The 2020 RY rate for CHPW was at the national 50th percentile.
- The 2020 RY rate for MHW was at the national 75th percentile.
- There were no statistically significant changes in the year-over-year performance.

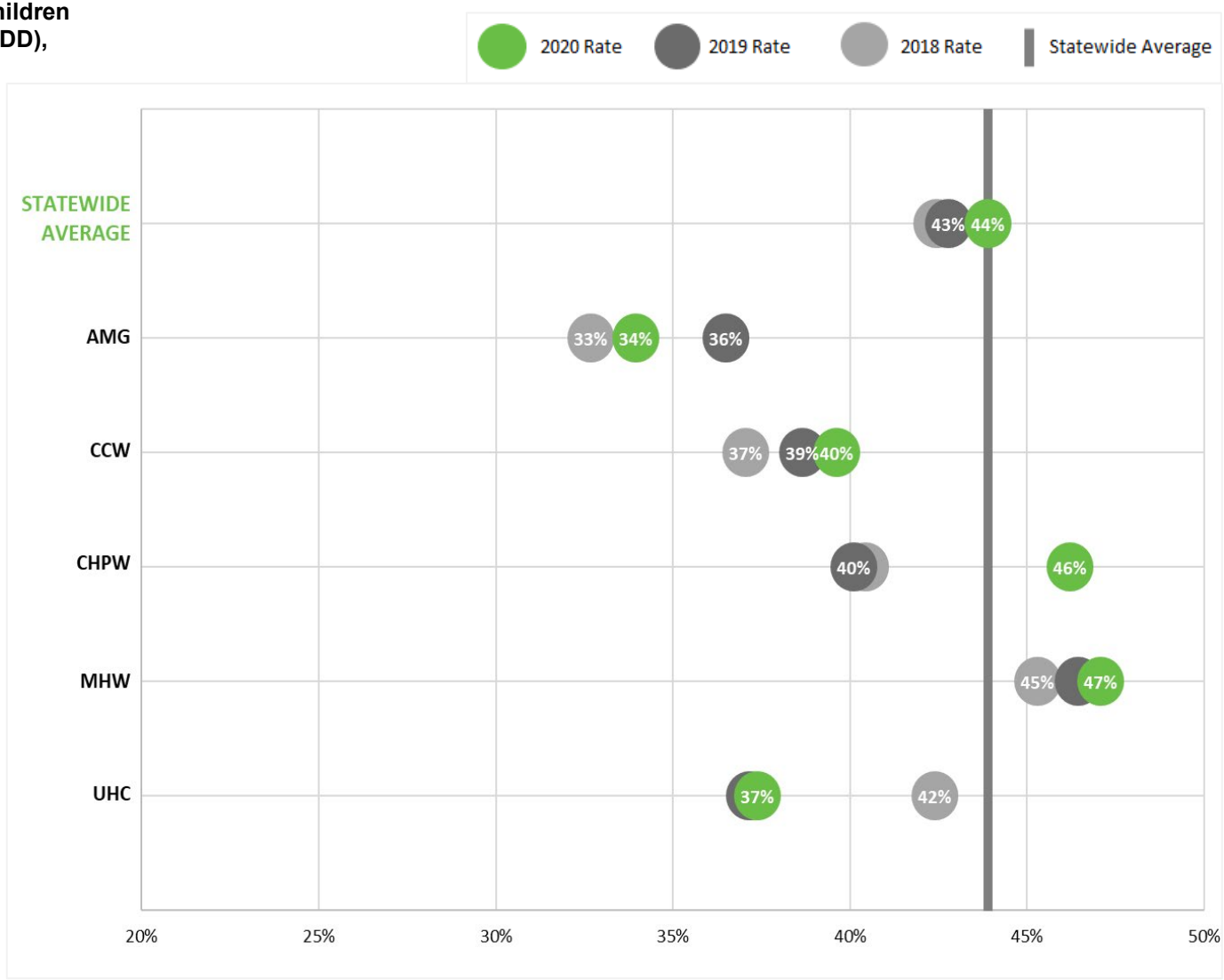


Figure 19. Comprehensive Diabetes Care (CDC), Poor HbA1c Control*

- This is a plan-specific VBP measure for MHW and UHC.
- The 2020 RY statewide average was above the national 50th percentile, but below the 75th (the national benchmark is not shown in this chart).
- The 2020 RY rates for CCW and CHPW were above the national 50th percentile but below the 75th percentile.
- The 2020 RY rates for AMG, MHW and UHC were at the national 50th percentile.
- There were no statistically significant changes in the year-over-year performance.

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

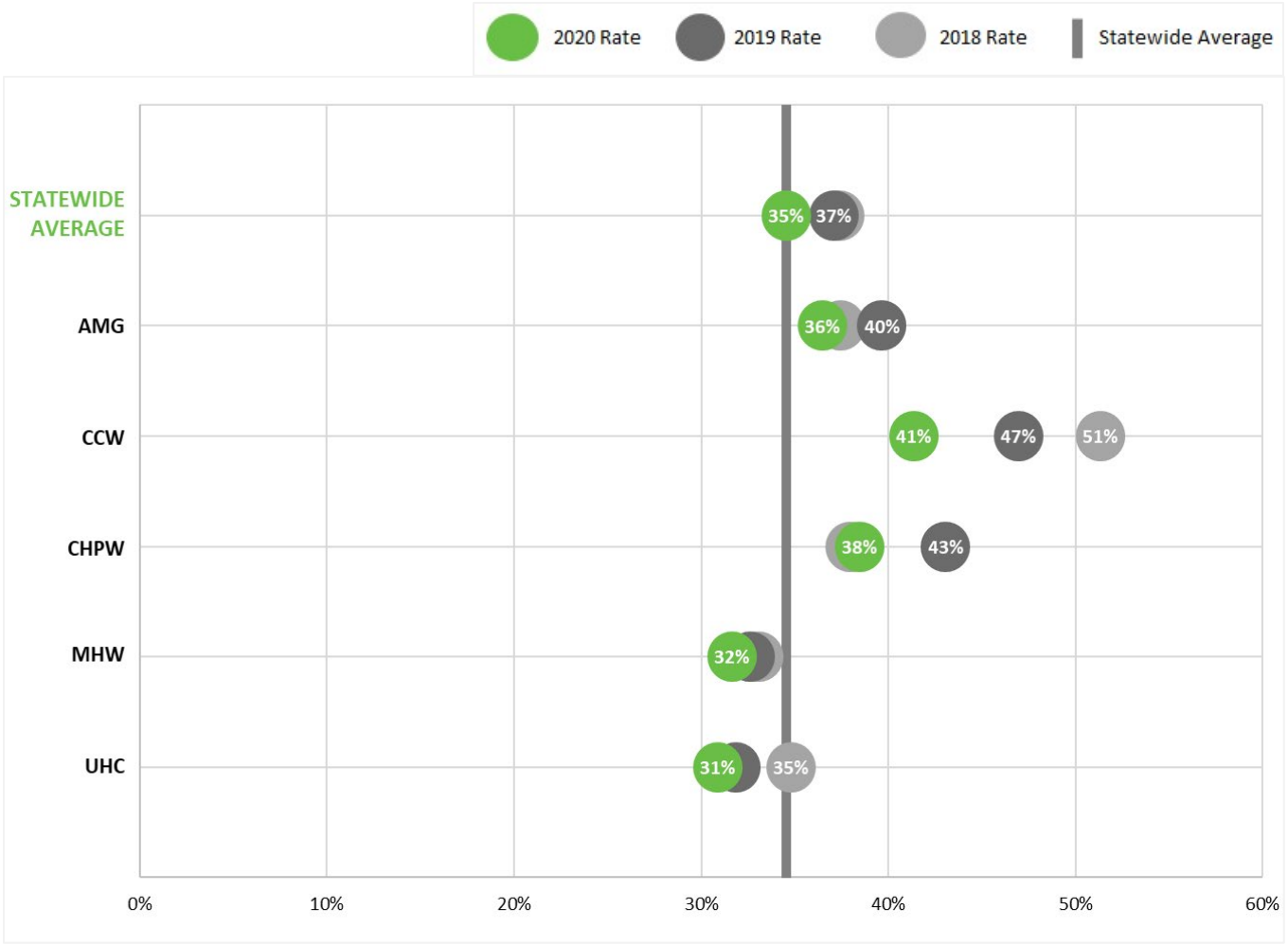


Figure 20. Comprehensive Diabetes Care (CDC), Treatment for Nephropathy.

- This is a plan-specific VBP measure for AMG.
- The 2020 RY statewide average was below the national 50th percentile (the national benchmark is not shown in this chart). The rate for CHPW was also below the national 50th percentile.
- The 2020 RY rates for AMG, CCW, MHW and UHC were at the national 50th percentile.
- Note, the actual statewide average of 88% is higher than CCW's rate of 87%, yet the statewide average is below the national 50th percentile, while CCW was at the national 50th percentile. This is a function of the confidence intervals — the statewide average has a larger denominator and, therefore, a narrower confidence interval.
- There were no statistically significant changes in the year-to-year performance for this measure.

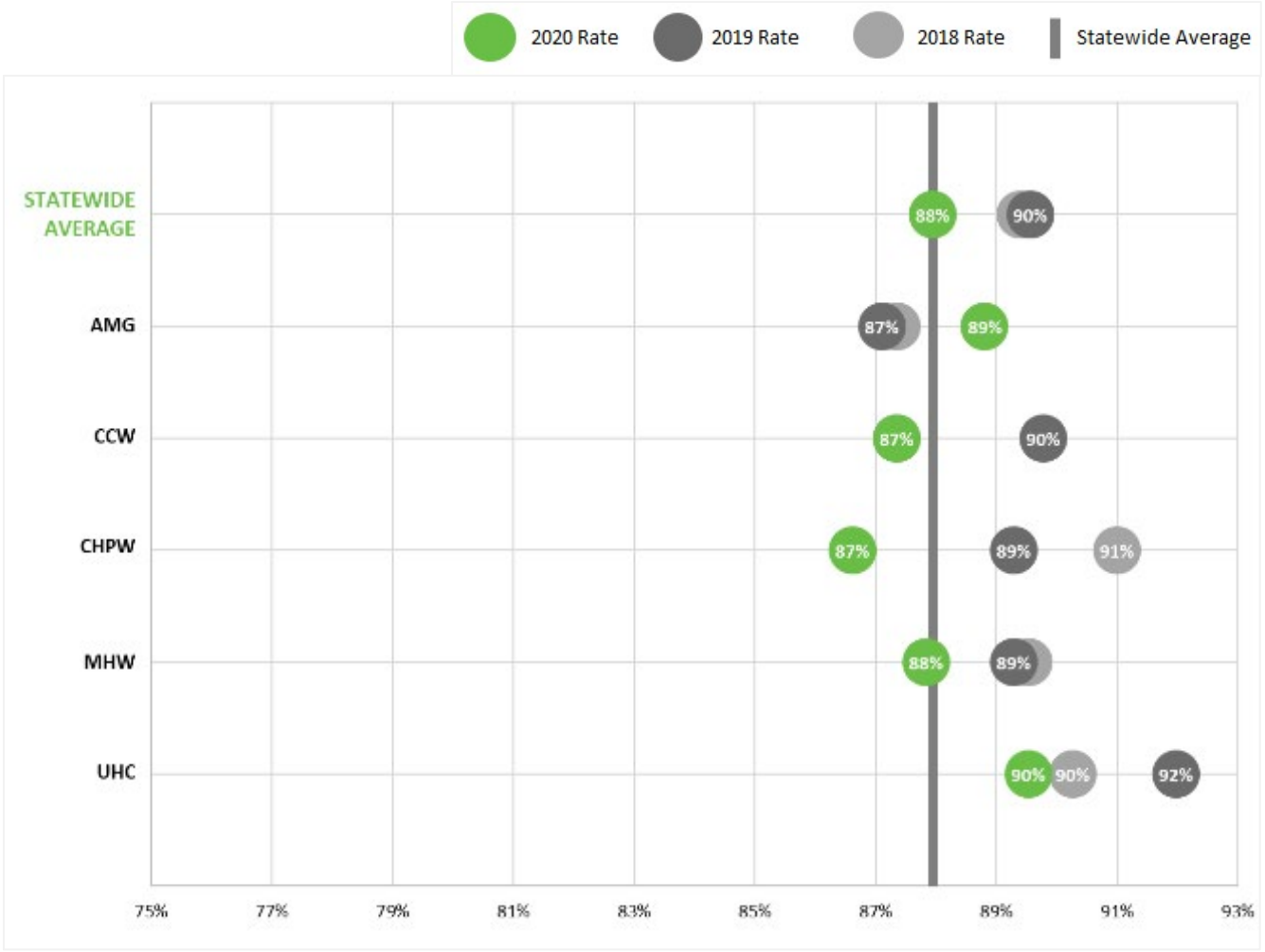


Figure 21. Adolescent Well-Care Visits (AWC).

- This is a VBP measure for the foster care contract.
- The 2020 RY statewide average was below the national 50th percentile.
- The 2020 RY rates for all MCOs were at the national 50th percentile.
- There were no statistically significant changes in the year-to-year performance.

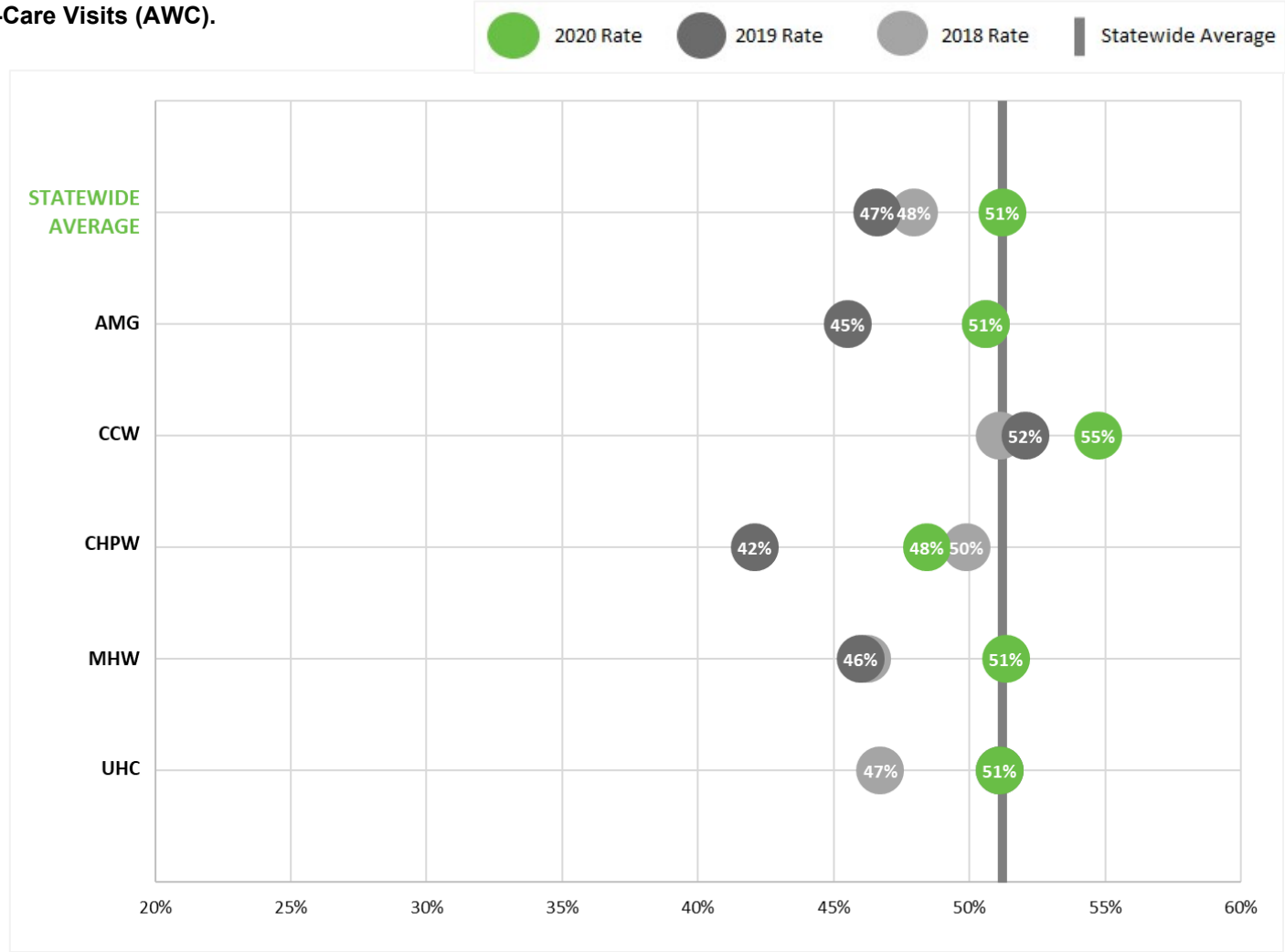


Figure 22. Mental Health Treatment Penetration (MH-B), Age 6 to 26.

- This is a VBP measure for the foster care contract.
- The benchmark for this measure is the second highest performing MCO for the period ending in 2017 Q4. The statewide average is higher than the benchmark, as were the rates for CHPW and MHW. AMG and CCW are at the benchmark; UHC is below the benchmark.
- There was a statistically significant increase in the statewide average between 2018 and 2019 RY. This was followed by a statistically significant decrease between 2019 and 2020 RY.
- All MCOs had a statistically significant increase between 2018 and 2019 RY.
- AMG's rate had a statistically significant increase between 2019 and 2020 RY (two years in a row).
- Between 2019 RY and 2020, the rates for CCW and MHW had a statistically significant decrease.

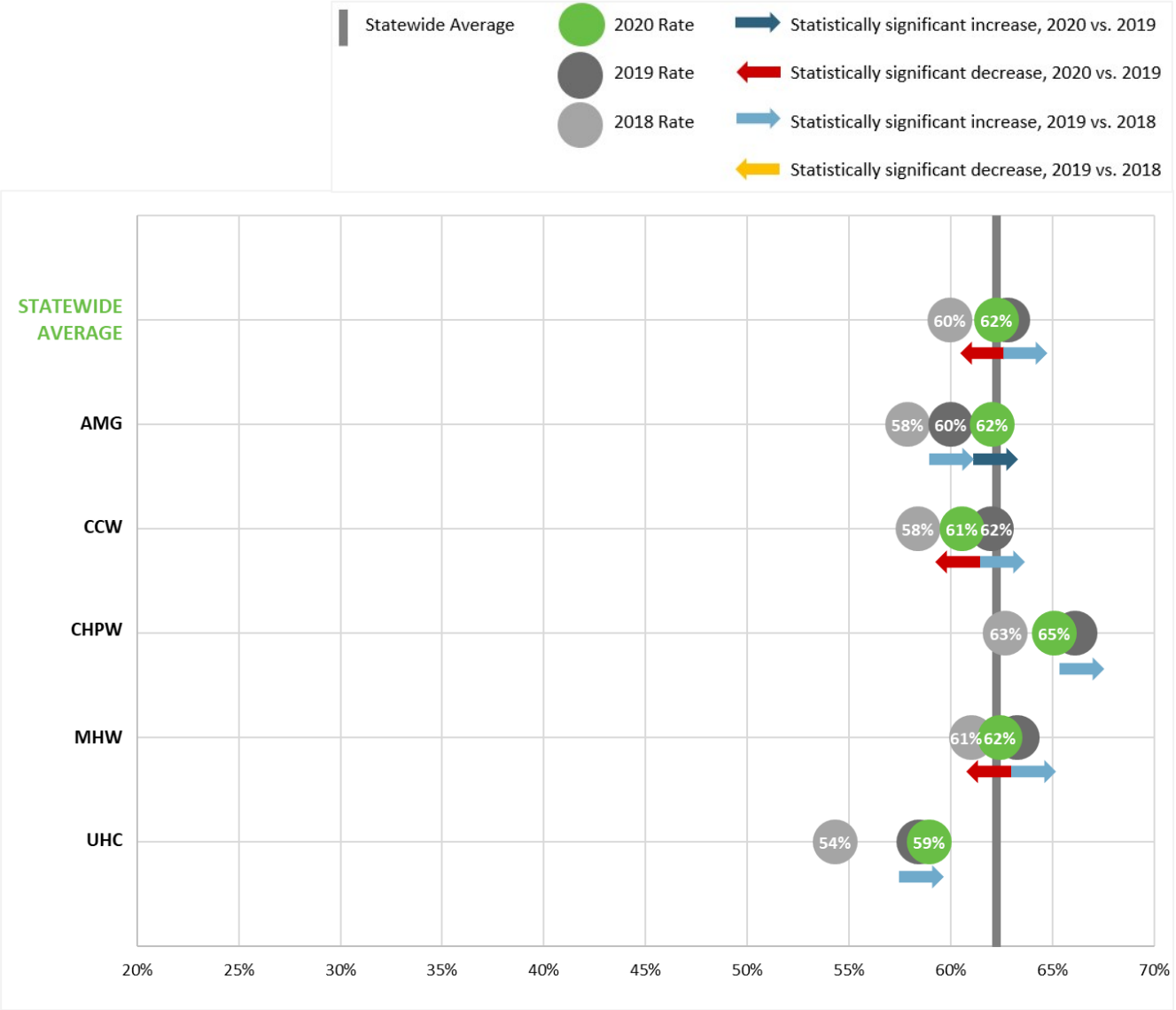


Figure 23. Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), Total.*

- This is a VBP measure for the foster care contract.
- The 2020 RY statewide average is below the national 50th percentile for this measure.
- There was a statistically significant increase in the statewide average between 2019 and 2020 RY for this measure.
- The 2020 RY rates for AMG, CCW, CHPW and UHC were below the national 50th percentile.
- The 2020 RY rate for MHW was at the national 50th percentile.
- There was a statistically significant increase between 2019 and 2020 RY for all MCOs except MHW.

**NCQA issued guidance advising caution when comparing measure results to prior reporting periods due to changes in measure specifications.*

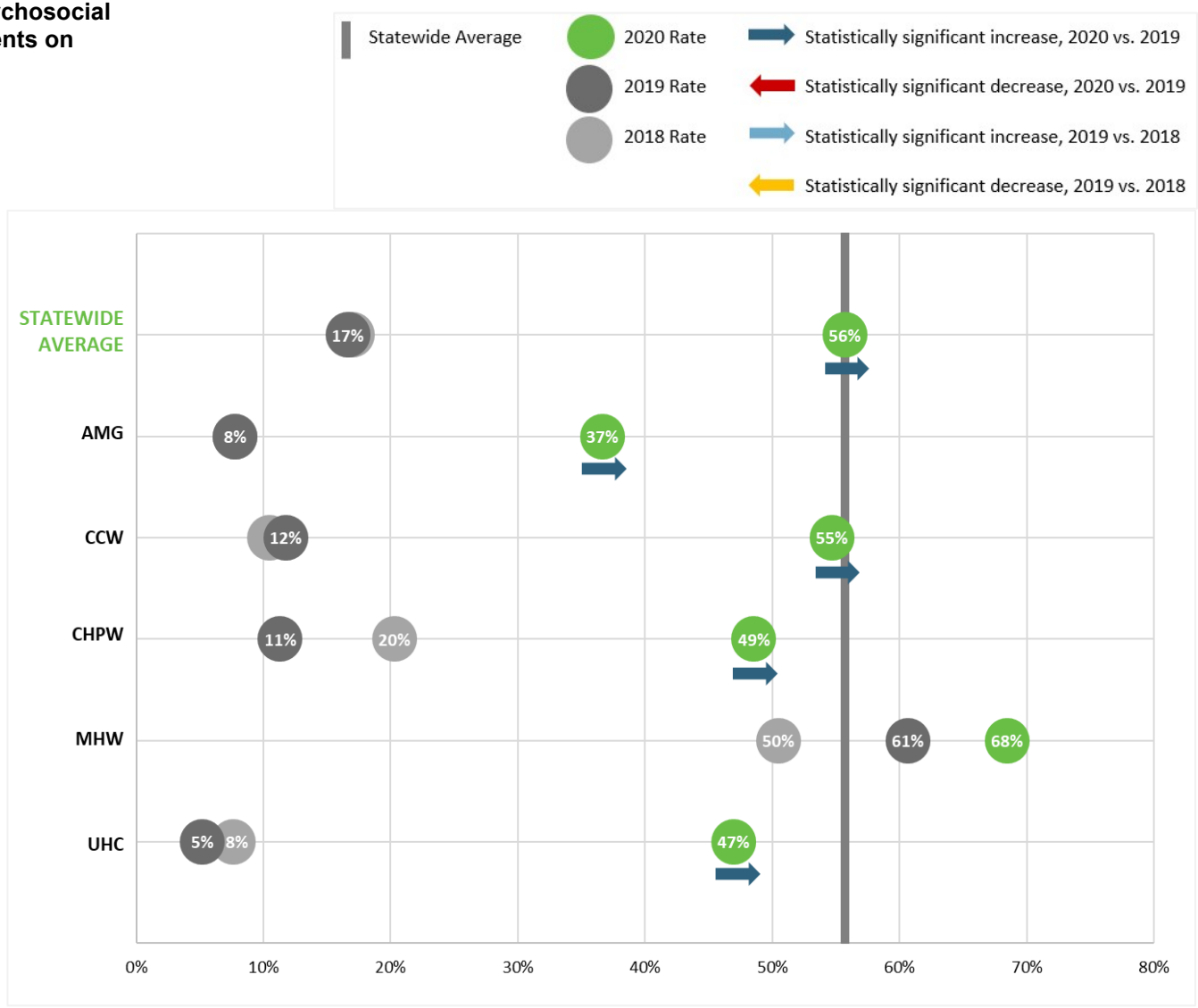


Figure 24. Substance Use Disorder Treatment Penetration (SUD), Age 12 to 26.

- This is a VBP measure for the foster care contract.
- The benchmark for this measure is the second highest performing MCO for the period ending in 2017 Q4. The statewide rate is not statistically different than the benchmark; neither are the rates for the individual MCOs.
- There was a statistically significant increase in the statewide average between 2018 and 2019 RY, and no statistically significant change between 2019 and 2020 RY.
- There was a statistically significant increase in CHPW's rate between 2018 and 2019 RY. There was not a statistically significant change between 2019 and 2020 RY.

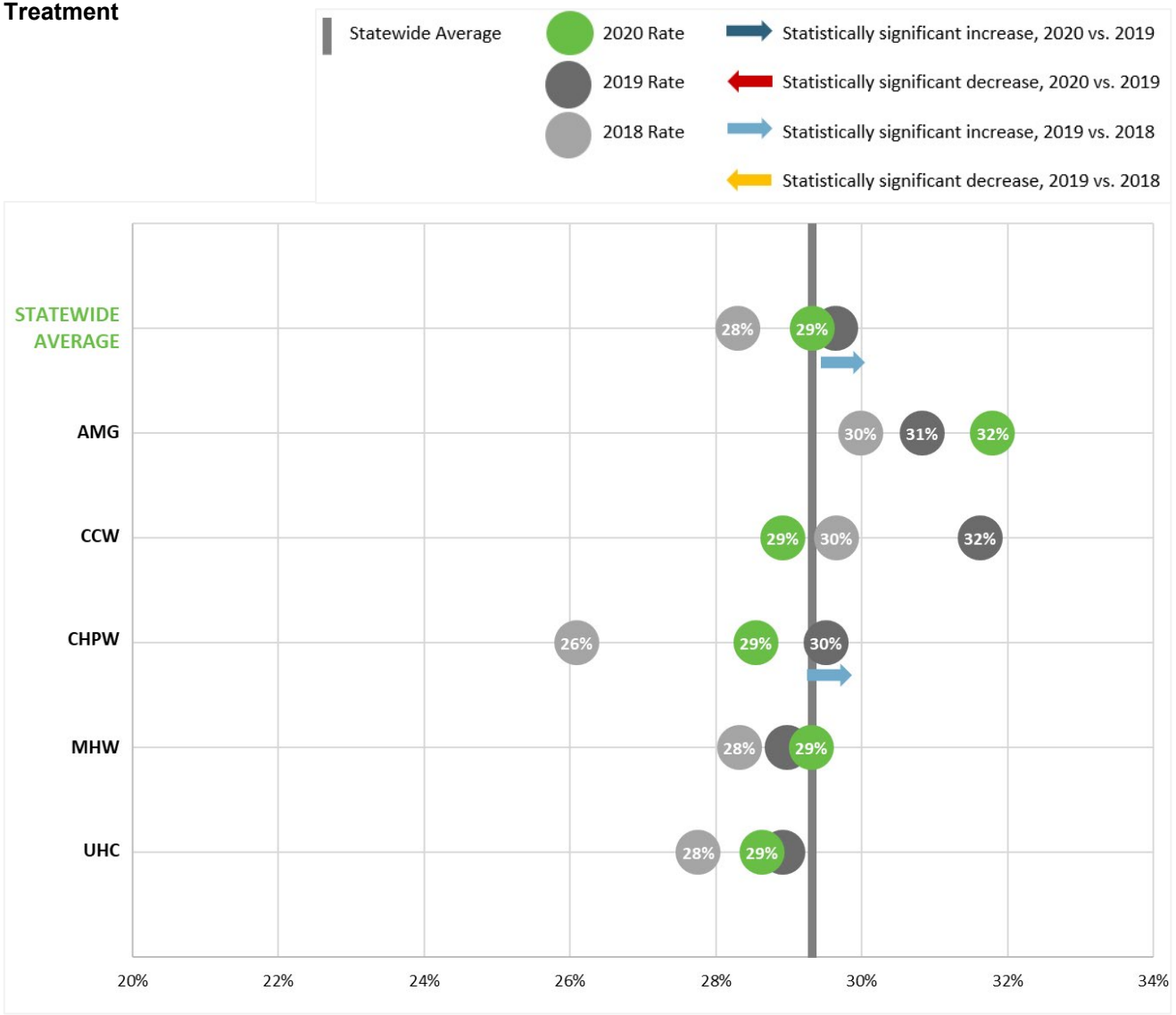


Figure 25. Children's Access to Primary Care Practitioners (CAP), Age 7 to 11.

- This is a VBP measure for the foster care contract.
- The 2020 RY statewide average is below the national 50th percentile for this measure. There was a statistically significant increase in the measure results between 2019 and 2020 RY.
- The 2020 RY rates for AMG, CCW, CHPW and UHC were below the national 50th percentile. The 2020 RY rate for MHW was above the national 50th percentile, but below the 75th percentile.
- AMG, CCW and MHW had statistically significant increases in their rates between 2019 and 2020 RY.

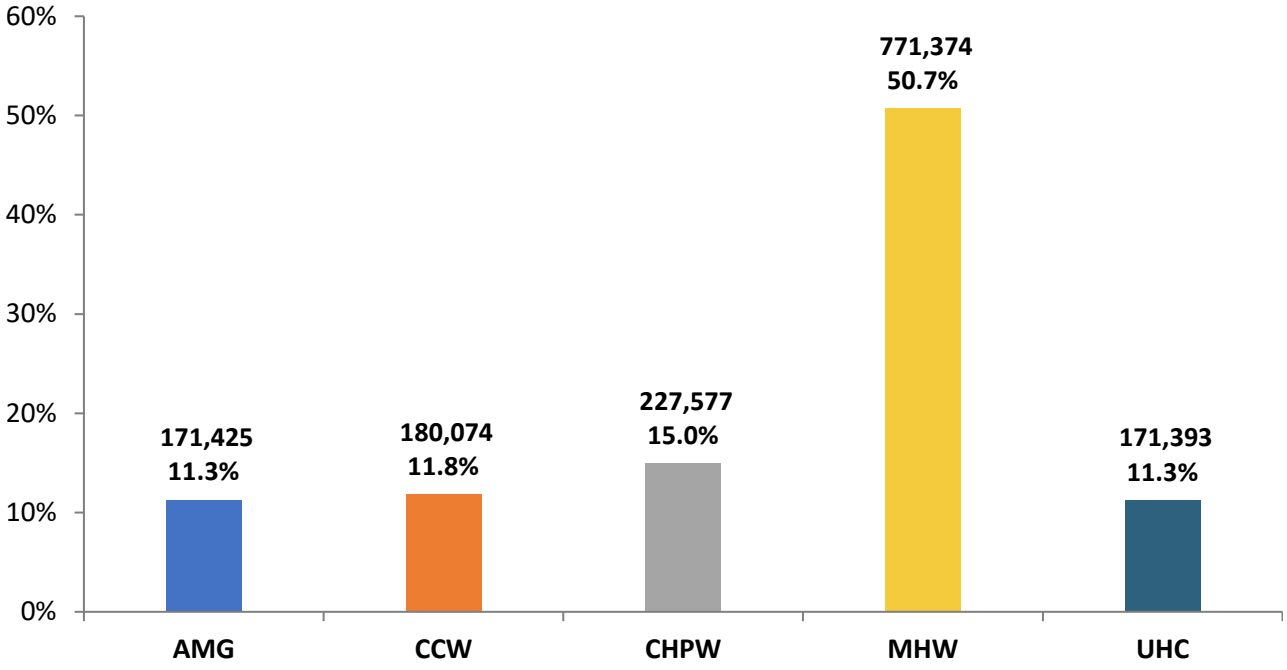
MCO-Specific Results

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 26 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 15% in CHPW and about 11% in AMG, CCW and UHC, each.

Figure 26. 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 27 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 are in the 21–44 age group.

Figure 27. Enrollee Population by MCO and Age Range, 2020 RY.

Age Range	AMG	CCW	CHPW	MHW	UHC
Age 0 to 5	15.47%	18.58%	15.04%	17.61%	14.82%
Age 6 to 12	14.81%	21.14%	20.52%	21.67%	15.78%
Age 13 to 20	13.34%	18.62%	19.16%	18.88%	13.89%
Age 21 to 44	35.88%	26.74%	28.72%	29.09%	34.50%
Age 45 to 64	20.25%	14.71%	16.35%	12.62%	20.53%
Age 65+	0.24%	0.21%	0.21%	0.13%	0.47%

% of Total Member Count

0.13% 35.88%

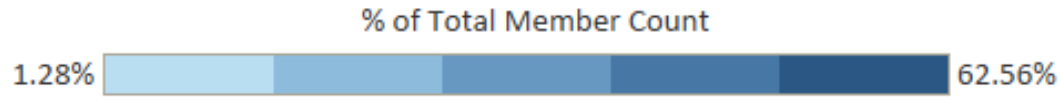
Race and Ethnicity by MCO

The data on race 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 28, more than half of each MCO's members are white. The "other race" category was the second most common for most MCOs. Black members make up 11.68% of UHC's enrollee population and 9.36% of AMG's population, which were higher percentages than other MCOs.

Figure 28. Statewide Apple Health Enrollees by MCO and Race,* 2020 RY.

Race	AMG	CCW	CHPW	MHW	UHC
White	62.56%	53.34%	54.50%	60.81%	57.36%
Other	10.64%	21.30%	19.55%	13.13%	8.50%
Not Provided	7.78%	9.64%	8.58%	8.32%	8.75%
Black	9.36%	7.58%	7.68%	8.57%	11.68%
Asian	4.26%	3.66%	5.52%	4.08%	7.06%
American Indian / Alaskan Native	1.69%	1.61%	1.28%	1.74%	1.65%
Hawaiian / Pacific Islander	3.72%	2.85%	2.89%	3.35%	5.00%



**These are the categories MCOs provide to HCA in enrollment 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 29 shows the percentage of MCO members who identified as Hispanic. CCW and CHPW have the largest percentages of Hispanic members at 34.53% and 30.35%, respectively.

Figure 29. Statewide Apple Health Enrollees by MCO and Hispanic Indicator, 2020 RY.

Hispanic	AMG	CCW	CHPW	MHW	UHC
N	81.13%	65.47%	69.65%	78.68%	86.87%
Y	18.87%	34.53%	30.35%	21.32%	13.13%

Primary Spoken Language by MCO

According to Apple Health enrollment data, there are 81 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 30 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 30. Statewide Apple Health Enrollees by MCO and Language, 2020 RY.

Spoken Language	AMG	CCW	CHPW	MHW	UHC
English	90.03%	83.11%	80.75%	88.94%	93.64%
Spanish; Castilian	6.77%	13.74%	14.57%	7.58%	2.96%
Russian	0.33%	0.16%	0.57%	1.10%	0.39%
Vietnamese	0.39%	0.49%	0.79%	0.38%	0.60%
Chinese	0.40%	0.31%	0.85%	0.17%	0.40%
Arabic	0.24%	0.20%	0.33%	0.23%	0.35%
Ukrainian	0.17%	0.09%	0.09%	0.31%	0.15%
Somali	0.18%	0.10%	0.36%	0.18%	0.19%
Korean	0.09%	0.07%	0.07%	0.09%	0.28%
Amharic	0.09%	0.06%	0.13%	0.07%	0.09%
Panjabi; Punjabi	0.05%	0.05%	0.06%	0.07%	0.05%
Burmese	0.07%	0.07%	0.13%	0.05%	0.06%
Tigrinya	0.10%	0.03%	0.11%	0.06%	0.06%
Farsi	0.05%	0.04%	0.07%	0.04%	0.05%
Cambodian; Khmer	0.05%	0.03%	0.05%	0.04%	0.06%
Laotian	0.01%	0.01%	0.01%	0.01%	0.01%
Other Languages	1.02%	1.43%	1.06%	0.68%	0.67%

MCO-Specific Performance for 2020 RY

This section of the report presents MCO-specific results for selected measures. These 31 measures, which include 29 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.

Figure 31 includes the 2020 RY Statewide Weighted Average results that were displayed in Figure 9 with the addition of the results for each of the five MCOs. The arrows represent statistically significant changes in measure results between 2019 RY and 2020 RY for that MCO; arrows pointing down represent a statistically significant decrease and arrows pointing up indicate a statistically significant decrease in performance for that MCO between years.

Figure 31. MCO Variation from 2019 RY to 2020 RY.

Rotated Measures Reported in RY2020
* AMG † UHC
** AMG & CCW †† MHW & UHC

		Statewide	AMG	CCW	CHPW	MHW	UHC
Access / Availability of Care	Adults' Access to Preventive/Ambulatory Health Services (AAP), Total	76% ↑	72% ↑	73% ↑	76% ↑	79%	75% ↑
	Children's Access to Primary Care Practitioners (CAP), 7-11 Years	91% ↑	87% ↑	91% ↑	90%	92% ↑	87%
	Prenatal and Postpartum Care (PPC), Postpartum Care*	72%	60%	73%	77%	75%	75%
	Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care*	83%	76%	77%	76%	95%	88%
	Use of First-Line Psychosocial Care for Children and Adolsecents (APP), Total	56% ↑	37% ↑	55% ↑	49% ↑	68%	47% ↑
Behavioral Health	Antidepressant Medication Management (AMM), Acute Phase	54% ↑	53%	56%	55% ↑	52% ↑	54%
	Antidepressant Medication Management (AMM), Continuation Phase	38% ↑	40% ↑	40%	40% ↑	37% ↑	39%
	Follow-Up Care for Children Prescribed ADHD Medication (ADD), Continuation	54%	47%	49%	57%	58%	38%
	Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	44%	34%	40%	46%	47%	37%
	Mental Health Treatment Penetration, 6-64 Years	57%	63% ↓	53% ↑	54%	53% ↑	59%
	Substance Use Disorder Treatment Penetration, 12-64 Years	37% ↑	35% ↑	38% ↑	34% ↑	38% ↑	35%
Cardiovascular Conditions	Controlling High Blood Pressure (CBP)**	63%	64%	54%	62%	69%	67%
Diabetes	Comprehensive Diabetes Care (CDC), Blood Pressure Control < 140/90 mm Hg	70% ↑	70%	62%	68%	77%	72% ↑
	Comprehensive Diabetes Care (CDC), Eye Exam	58%	50%	61%	58%	62%	59%
	Comprehensive Diabetes Care (CDC), Medical Attention for Nephropathy	88%	89%	87%	87%	88%	90%
	Comprehensive Diabetes Care (CDC), Poor HbA1c Control (lower is better)	36%	36%	41%	38%	32%	31%
Overuse / Appropriateness	Use of Opioids at High Dosage (HDO) (lower is better)	7%	6%	7%	8%	6%	9%
Prevention and Screening	Breast Cancer Screening (BCS)	52% ↓	46%	52%	52% ↓	54%	53% ↑
	Cervical Cancer Screening (CCS)*	58%	54%	56%	54%	66%	58%
	Childhood Immunization Status (CIS), Combo 2††	75%	72%	82%	75%	72%	74%
	Childhood Immunization Status (CIS), Combo 10††	45%	45%	54%	43%	38%	44%
	Chlamydia Screening (CHL), Total	54%	53%	55%	52%	54%	52%
	Lead Screening in Children (LSC)*	32%	32%	37%	40%	26%	26%
	Weight Counseling for Children / Adolescents (WCC), BMI Percentile, Total*	71%	73%	64%	77%	76%	64%
	Weight Counseling for Children / Adolescents (WCC), Nutrition, Total*	63%	61%	70%	63%	62%	60%
Respiratory Conditions	Asthma Medication Ratio (AMR), Total	55% ↑	48%	56%	60% ↑	55%	53%
	Medication Management for Asthma (MMA), Compliance 75%, 5-11 Yrs	30%	41% ↑	32%	32%	29%	31%
	Medication Management for Asthma (MMA), Compliance 75%, 12-18 Yrs	30% ↑	25%	33%	35% ↑	29%	23%
Utilization	Adolescent Well-Care Visits (AWC)†	51%	51%	55%	48%	51%	51%
	Well-Child Visits in the First 15 Months of Life (W15), 6 or More Visits**	71%	70%	68%	73%	73%	71%
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)†	70%	69%	73%	72%	69%	69%

It is interesting to note is that different MCOs drive significant changes in the statewide results for different measures. For the Adults' Access to Preventive/Ambulatory Health Services (AAP), Total measure, all of the MCOs except MHW demonstrated a statistically significant year-over-year increase. For the two Antidepressant Medication Management (AMM) measures, CHPW and MHW appear to be driving the change in the statewide average. For Breast Cancer Screening (BSC), there was a significant decrease in the statewide average. This was mirrored in the year-over-year performance for CHPW, but there was a statistically significant increase for UHC.

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

Figure 32 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 32. Statewide and MCO Variation from Benchmarks, by National Percentile.

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

Rotated Measures Reported in RY2020
* AMG † UHC
** AMG & CCW †† MHW & UHC

		Statewide	AMG	CCW	CHPW	MHW	UHC
Access / Availability of Care	Adults' Access to Preventive/Ambulatory Health Services (AAP), Total	76.48%	72.49%	73.12%	75.89%	79.27%	75.25%
	Children's Access to Primary Care Practitioners (CAP), 7-11 Years	90.78%	87.06%	90.59%	90.43%	91.94%	86.52%
	Prenatal and Postpartum Care (PPC), Postpartum Care*	72.15%	60.05%	72.75%	77.37%	75.18%	74.70%
	Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care*	82.68%	76.29%	77.37%	76.40%	94.65%	88.32%
	Use of First-Line Psychosocial Care for Children and Adolsecents (APP), Total	55.71%	36.67%	54.70%	48.55%	68.49%	46.99%
Behavioral Health	Antidepressant Medication Management (AMM), Acute Phase	53.53%	52.94%	56.22%	55.29%	52.43%	53.57%
	Antidepressant Medication Management (AMM), Continuation Phase	38.44%	39.72%	39.90%	39.86%	37.18%	38.83%
	Follow-Up Care for Children Prescribed ADHD Medication (ADD), Continuation	53.62%	47.25%	48.89%	56.73%	58.30%	37.50%
	Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	43.89%	33.95%	39.62%	46.20%	47.08%	37.38%
Cardiovascular Conditions	Controlling High Blood Pressure (CBP)**	63.07%	64.48%	53.77%	61.80%	68.61%	66.67%
Diabetes	Comprehensive Diabetes Care (CDC), Blood Pressure Control < 140/90 mm Hg	69.78%	69.59%	62.04%	68.37%	77.37%	71.53%
	Comprehensive Diabetes Care (CDC), Eye Exam	58.00%	50.12%	61.07%	58.15%	61.56%	59.12%
	Comprehensive Diabetes Care (CDC), Medical Attention for Nephropathy	88.03%	88.81%	87.35%	86.62%	87.83%	89.54%
	Comprehensive Diabetes Care (CDC), Poor HbA1c Control (lower is better)	35.77%	36.50%	41.36%	38.44%	31.63%	30.90%
Overuse / Appropriateness	Use of Opioids at High Dosage (HDO) (lower is better)	7.10%	6.21%	7.08%	7.77%	6.43%	9.41%
Prevention and Screening	Breast Cancer Screening (BCS)	51.96%	45.91%	51.97%	51.51%	53.83%	52.85%
	Cervical Cancer Screening (CCS)*	57.58%	54.05%	55.96%	54.01%	66.18%	57.66%
	Childhood Immunization Status (CIS), Combo 2††	74.99%	71.53%	82.24%	74.70%	72.02%	74.45%
	Childhood Immunization Status (CIS), Combo 10††	44.87%	45.26%	54.01%	42.82%	37.96%	44.28%
	Chlamydia Screening (CHL), Total	53.61%	53.41%	55.35%	52.16%	53.97%	51.63%
	Lead Screening in Children (LSC)*	32.07%	32.12%	37.47%	39.66%	25.55%	25.55%
	Weight Counseling for Children / Adolescents (WCC), BMI Percentile, Total*	70.70%	72.75%	63.99%	77.11%	75.67%	64.48%
	Weight Counseling for Children / Adolescents (WCC), Nutrition, Total*	62.99%	60.58%	70.32%	62.89%	61.56%	59.61%
Respiratory Conditions	Asthma Medication Ratio (AMR), Total	55.02%	48.23%	56.01%	59.85%	54.58%	53.27%
	Medication Management for Asthma (MMA), Compliance 75%, 5-11 Yrs	30.44%	41.13%	31.55%	31.64%	28.80%	31.49%
	Medication Management for Asthma (MMA), Compliance 75%, 12-18 Yrs	30.08%	25.23%	33.12%	34.62%	29.26%	22.53%
Utilization	Adolescent Well-Care Visits (AWC)†	51.24%	50.61%	54.74%	48.42%	51.34%	51.09%
	Well-Child Visits in the First 15 Months of Life (W15), 6 or More Visits**	70.67%	69.55%	67.88%	72.70%	72.51%	70.80%
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)†	70.40%	68.62%	72.99%	71.78%	69.34%	69.01%

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 Adults' Access to Preventive/Ambulatory Health Services (AAP), Total measure, but the statewide average and all five of the MCOs are performing below the national 50th percentile.

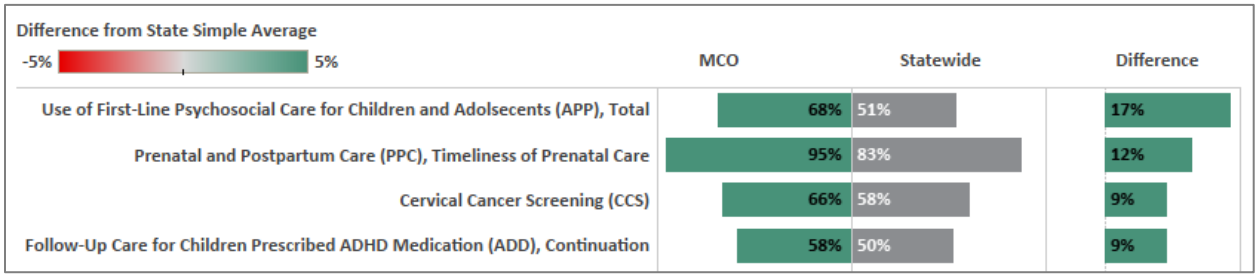
Also notable is the variation by individual measures. There are measures where there is no variation in the comparison to benchmarks for the statewide average or the individual MCOs; an example of this is the Breast Cancer Screening (BCS) measure, which is below the national 50th percentile across the board. Other measures show variation in the comparison to national benchmarks. For example, the statewide average for the Controlling High Blood Pressure (CBP) is at the national 50th percentile, as are the rates for AMG and CHPW. However, the rate for CCW is below the national 50th percentile, and the rates for MHW and UHC are at the 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. Figure 33 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: green shading indicates a positive difference from the statewide average; that is, the MCO performed better/higher on that measure. Red shading indicates lower performances than the statewide average.

Figure 33. Snapshot of MCO Scorecards.



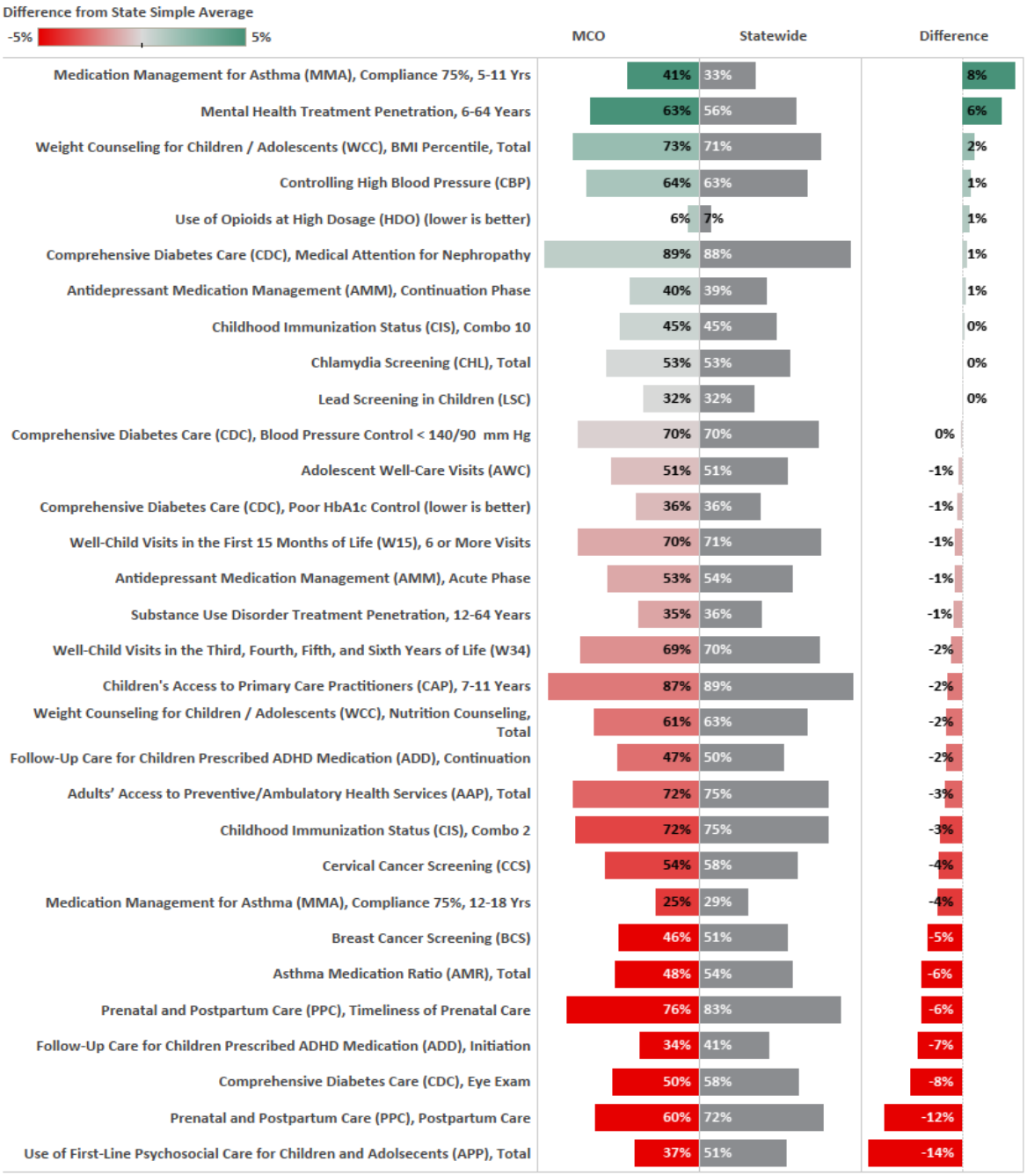
The MCO performance scorecards on the following pages (Figures 34–38) highlight the variance of measures from the simple state average.

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 for more information on how the simple state average is calculated.

Amerigroup Washington (AMG)

AMG was 8% above the state simple average for the Medication Management for People With Asthma (MMA), Medication Compliance 75%, 5-11 Years measure. (The state simple average for a measure is calculated as the average of the measure rate for the MCOs that reported the measure.) Although AMG was above the state simple average for the younger age group, it was 4% below the state simple average for the Management for People With Asthma (MMA), Medication Compliance 75%, 12-18 Years measure, and 6% below for the Asthma Medication Ratio (AMR), Total measure. Both of the measures for Prenatal and Postpartum Care (PPC) were below the state simple average; the Timeliness of Prenatal Care measure was 6% below, and the Postpartum Care measure was 12% below.

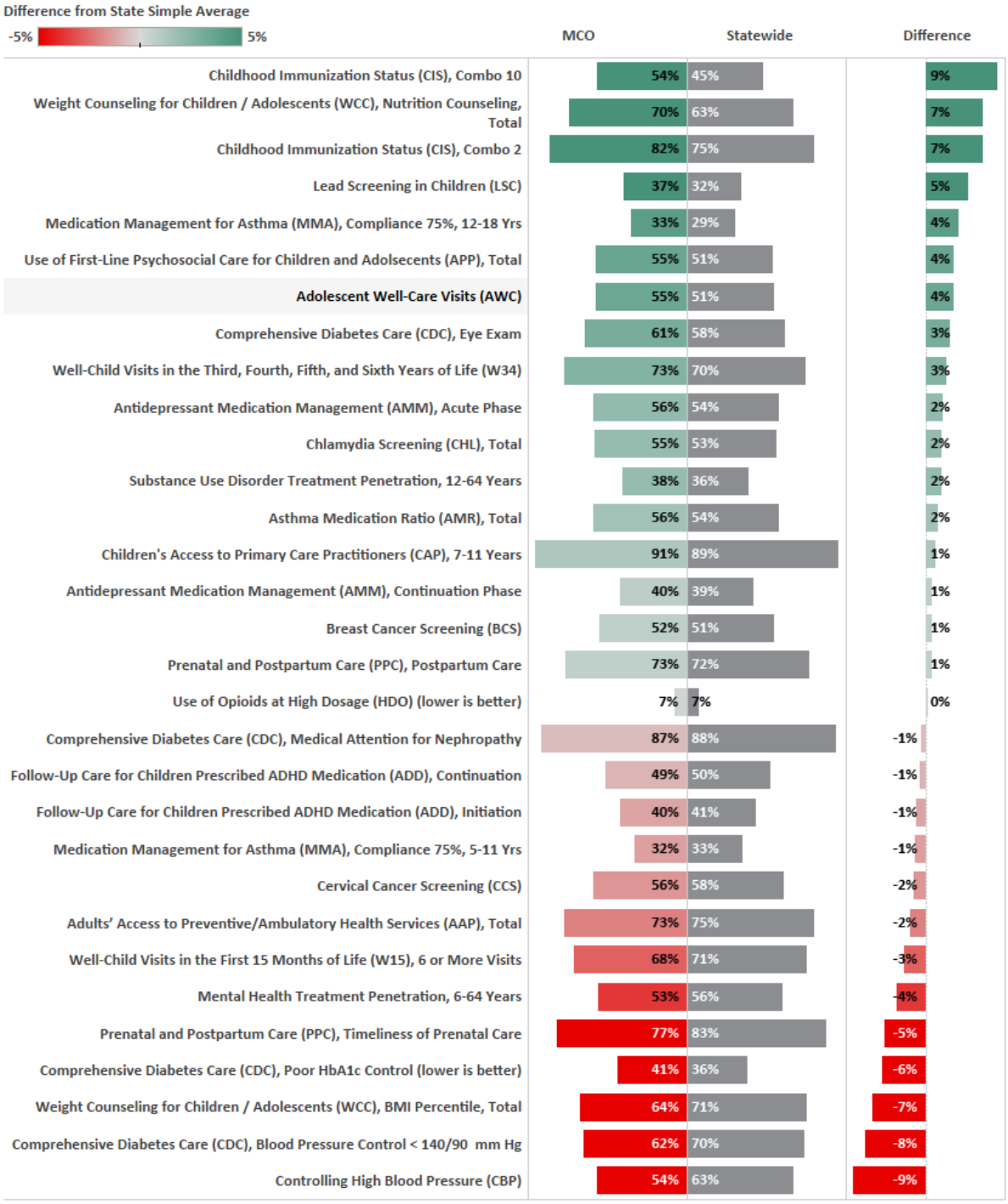
Figure 34. AMG Scorecard.



Coordinated Care of Washington

CCW has several pediatric measures where the rates were above the state simple average. The measures where their rates were markedly below the state simple average include Timeliness of Prenatal Care; two of the Comprehensive Diabetes Care (CDC) measures; Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC); BMI Percentile, Total; and Controlling High Blood Pressure (CBP).

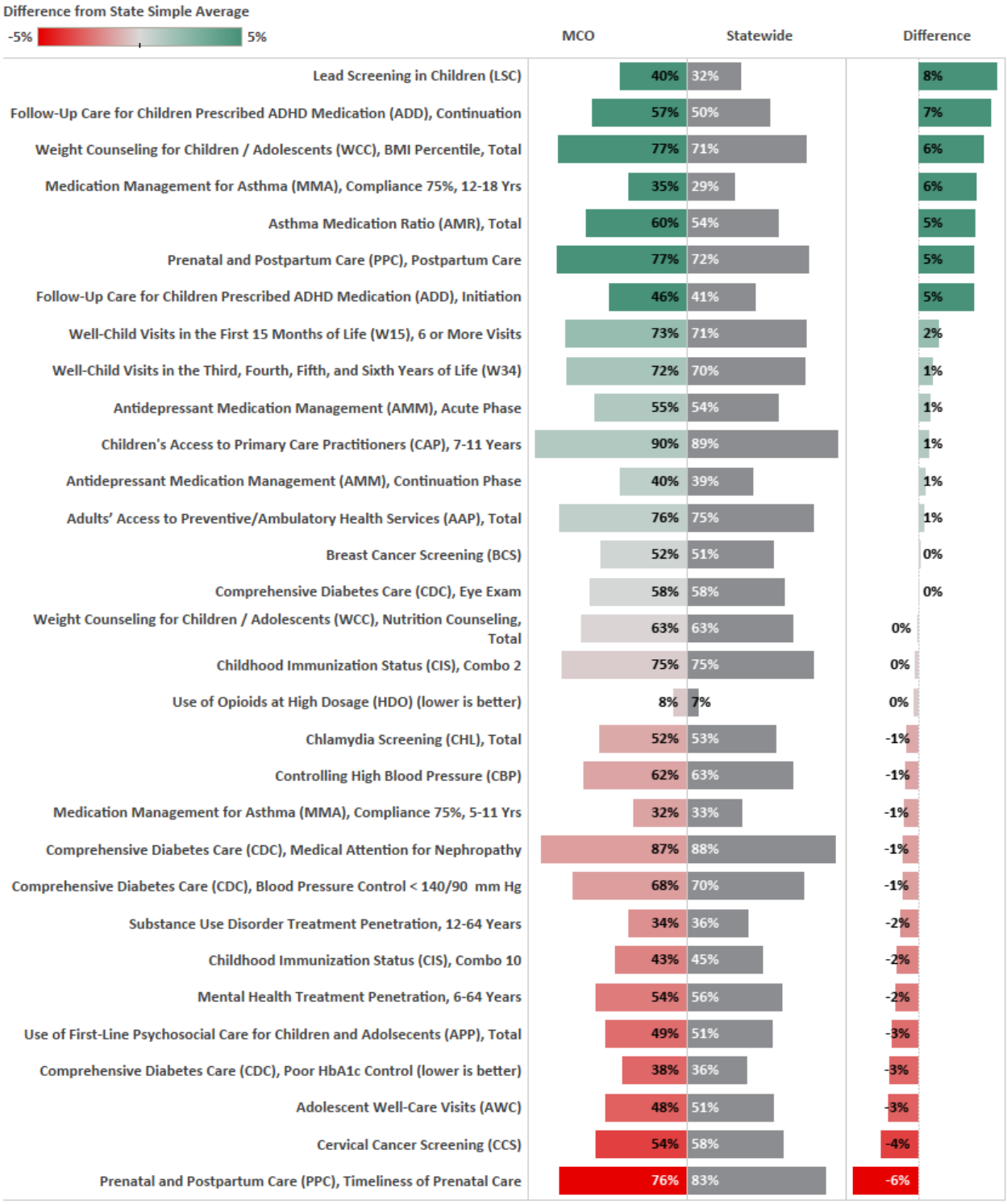
Figure 35. CCW Scorecard.



Community Health Plan of Washington (CHPW)

CHPW has a small handful of pediatric measures where the rates were above the state simple average. CHPW was above the state simple average for the Asthma Medication Ratio (AMR) measure and markedly below the state simple average for the Timeliness of Prenatal Care measure.

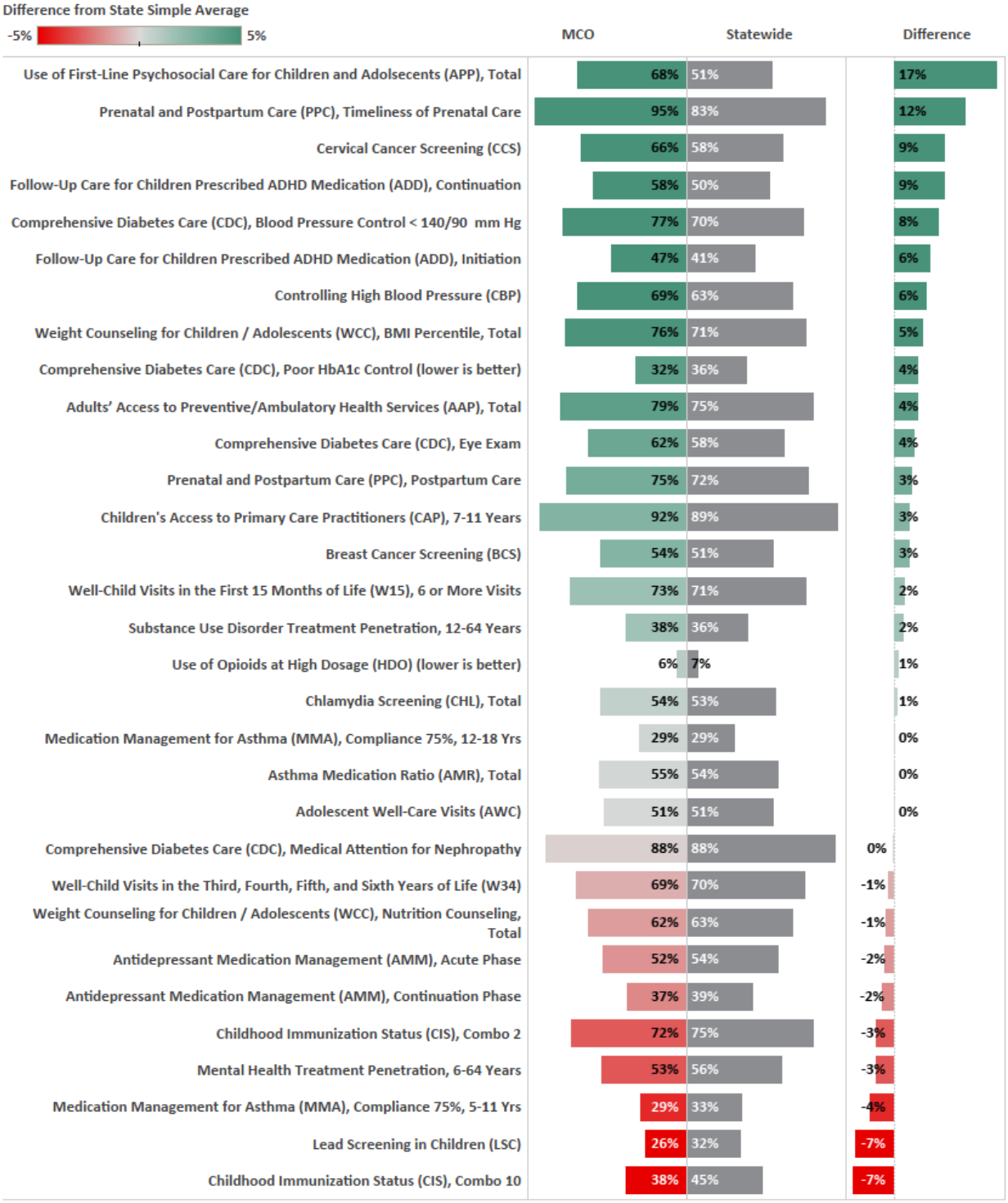
Figure 36. CHPW Scorecard.



Molina Healthcare of Washington (MHW)

MHW performed above the state simple average for several measures and markedly below the state simple average for the Lead Screening in Children (LSC) and Childhood Immunization Status (CIS), Combo 10 measures.

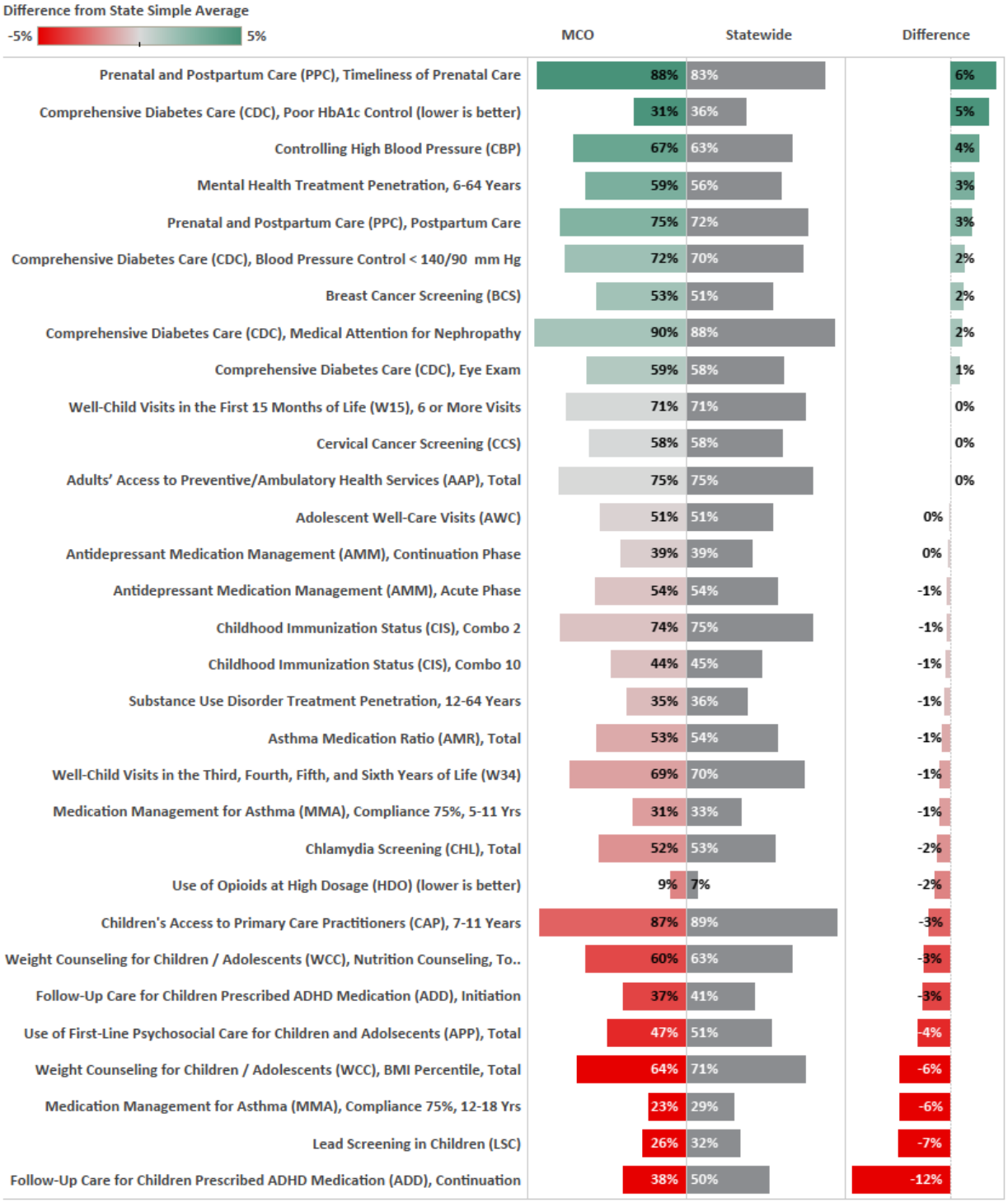
Figure 37. MHW Scorecard.



United Healthcare Community Plan (UHC)

For many of the measures, UHC performed close to the state simple average. UHC was markedly below the average for the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC), Total; Medication Management for People With Asthma (MMA), Medication Compliance 75%, 12–18 Years; Lead Screening in Children (LSC); and Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), Total measures.

Figure 38. 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 to the accompanying MCO comparison section.

As shown in Table 3 below, MCO coverage varies by region, with only two MCOs that are present in all 10 Regional Service Areas.

Table 3. MCO Coverage by Region.

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, 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 and Stevens counties*	✓	–	✓	✓	–
Thurston-Mason *Mason and Thurston counties*	✓	–	–	✓	✓

✓ *Indicates the MCO covers that region.*

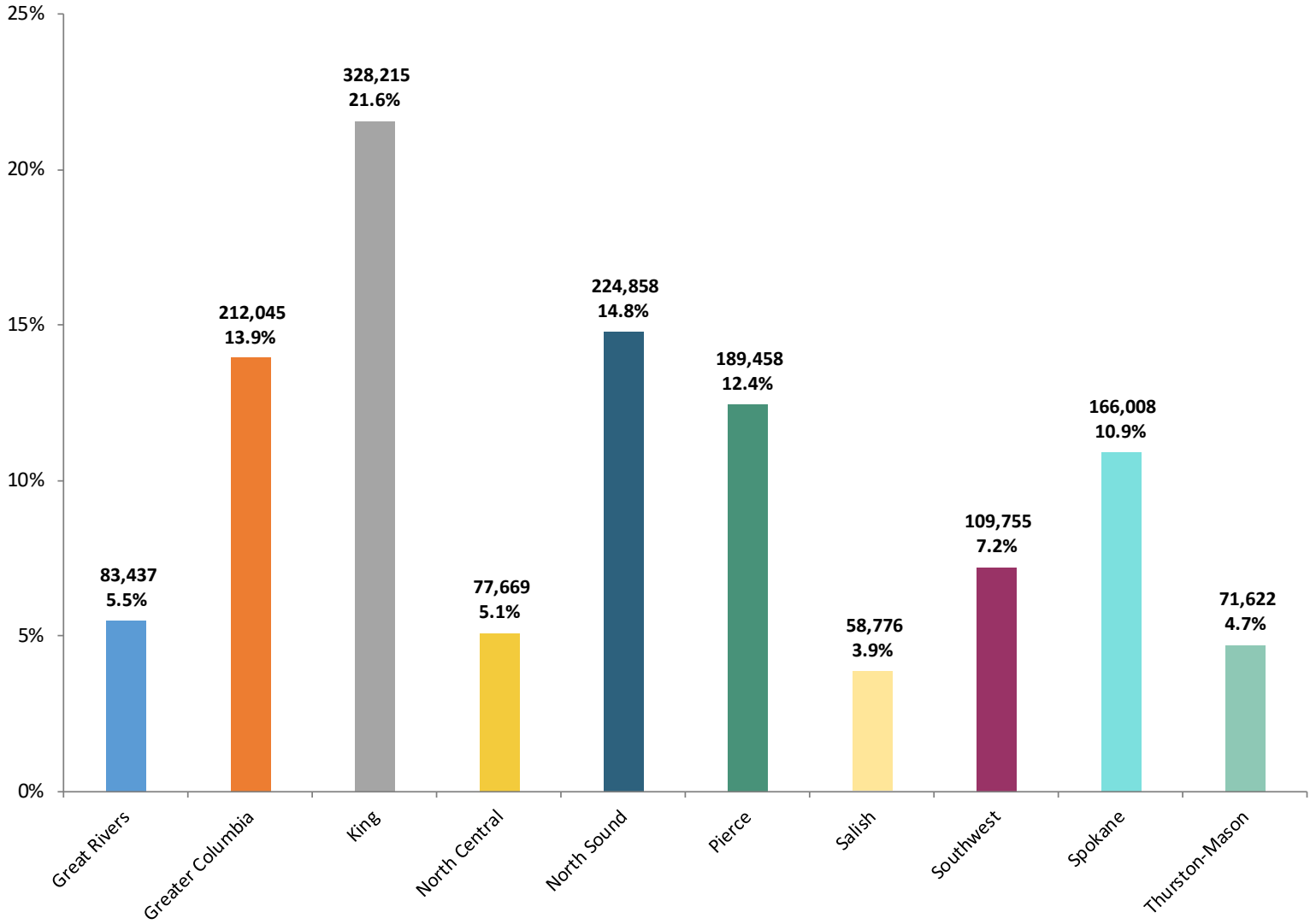
– *Indicates the MCO does not cover that region.*

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 39 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 North Central regions have the smallest Medicaid enrollments.

Figure 39. Percent Enrollment of Total Apple Health Enrollment Statewide by Region, 2020.



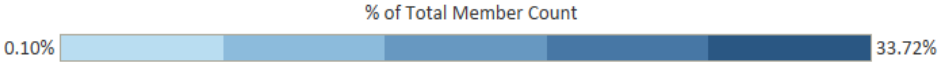
Age Range

Across regions, the largest percentage of enrollees are ages 21 to 44 (Figure 40). 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 40. Percent Enrollment by Region and Age Range, 2020 RY.

Age Range	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	Southwest	Spokane	Thurston - Mason
Age 0 to 5	15.76%	18.76%	15.78%	18.68%	17.00%	17.01%	15.09%	17.12%	16.09%	15.94%
Age 6 to 12	18.69%	23.04%	18.66%	23.76%	19.86%	19.89%	17.19%	20.90%	19.01%	18.51%
Age 13 to 20	16.85%	20.86%	16.44%	21.12%	17.27%	17.09%	15.70%	18.64%	17.15%	15.93%
Age 21 to 44	30.48%	26.37%	31.45%	23.85%	29.83%	31.01%	33.72%	29.09%	32.54%	33.32%
Age 45 to 64	18.11%	10.85%	17.29%	12.45%	15.80%	14.84%	18.19%	14.04%	15.10%	16.18%
Age 65+	0.11%	0.11%	0.38%	0.14%	0.24%	0.17%	0.11%	0.20%	0.10%	0.13%



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 rate, 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 41 shows that the member population for most regions is at least 60% white. In the King region, 20.01% of the member population is Black, 11.29% Asian and 5.57% Hawaiian/Pacific Islander. All regions have at least a 1% American Indian/Alaskan Native membership, with the highest percentages in the Great Rivers and Thurston-Mason regions.

Figure 41. Statewide Apple Health Enrollees by Race, 2020 RY.

Race	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	Southwest	Spokane	Thurston - Mason
White	79.23%	53.37%	38.61%	63.13%	62.51%	53.49%	72.87%	69.09%	77.56%	70.34%
Other	7.54%	32.27%	12.82%	24.37%	13.49%	10.46%	5.95%	10.07%	6.43%	8.17%
Not Provided	6.38%	8.75%	10.60%	8.57%	9.34%	7.91%	6.92%	9.09%	5.61%	6.57%
Black	1.98%	2.20%	20.01%	1.23%	5.44%	14.93%	5.27%	4.48%	4.66%	5.70%
Asian	1.07%	1.14%	11.29%	0.62%	4.87%	5.01%	1.76%	2.60%	1.49%	3.37%
American Indian / Alaskan Native	2.66%	1.31%	1.11%	1.56%	1.64%	1.54%	2.44%	1.42%	2.15%	2.64%
Hawaiian / Pacific Islander	1.13%	0.97%	5.57%	0.51%	2.70%	6.66%	4.79%	3.25%	2.10%	3.21%

% of Total Member Count

0.51% 79.23%

Figure 42. Statewide Apple Health Enrollees by Region and Hispanic Indicator, 2020 RY.

Hispanic	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	Southwest	Spokane	Thurston - Mason
N	84.44%	46.60%	83.07%	51.53%	79.99%	83.72%	88.74%	83.10%	88.31%	85.07%
Y	15.56%	53.40%	16.93%	48.47%	20.01%	16.28%	11.26%	16.90%	11.69%	14.93%

% of Total Member Count

11.26% 88.74%

Primary Spoken Language

According to Apple Health enrollment data, there are 81 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 43 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 and Vietnamese are the most common languages, with King and Southwest having the highest percentages of those, respectively.

Figure 43. Statewide Apple Health Enrollees by Region and Spoken Language, 2020 RY.*

Spoken Language	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	Southwest	Spokane	Thurston - Mason
English	94.06%	78.42%	84.08%	75.21%	88.78%	92.74%	96.71%	89.03%	94.93%	94.55%
Spanish; Castilian	5.07%	20.46%	7.57%	24.13%	7.59%	4.66%	2.44%	6.40%	2.67%	4.28%
Russian	0.07%	0.19%	0.75%	0.17%	1.10%	0.67%	0.01%	3.07%	0.67%	0.02%
Vietnamese	0.04%	0.07%	1.35%	0.04%	0.42%	0.50%	0.07%	0.24%	0.14%	0.33%
Chinese	0.04%	0.05%	1.24%	0.03%	0.22%	0.07%	0.11%	0.08%	0.03%	0.07%
Arabic		0.18%	0.52%		0.39%	0.10%	0.03%	0.10%	0.37%	0.01%
Ukrainian	0.00%	0.07%	0.49%	0.14%	0.36%	0.18%		0.15%	0.06%	0.02%
Somali	0.00%	0.06%	0.85%	0.00%	0.02%	0.00%			0.01%	0.01%
Korean	0.02%	0.02%	0.18%	0.00%	0.21%	0.22%	0.02%	0.02%	0.00%	0.09%
Amharic			0.33%		0.07%	0.00%	0.00%	0.01%	0.01%	
Panjabi; Punjabi	0.00%	0.01%	0.15%	0.01%	0.12%	0.04%	0.00%	0.02%	0.01%	0.02%
Burmese		0.08%	0.21%	0.00%	0.01%	0.00%		0.02%	0.07%	0.00%
Tigrinya			0.27%		0.04%	0.00%		0.01%	0.03%	
Farsi		0.00%	0.17%	0.00%	0.04%	0.01%	0.01%	0.01%	0.04%	
Cambodian; Khmer	0.04%		0.07%		0.05%	0.12%		0.03%	0.00%	0.04%
Laotian	0.02%	0.01%	0.02%		0.00%	0.01%		0.00%		
Other Languages	0.63%	0.39%	1.74%	0.27%	0.58%	0.68%	0.60%	0.80%	0.97%	0.55%

% 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 for each of the 31 measures.

MCO Performance by Region

New to the comparative report this year is an analysis of MCO performance within each Regional Service Area (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. The member ZIP code was used to map the member to the county. Note that when a ZIP code spans more than one county, Comagine Health chose the county with the larger population. Once the county was assigned, the member was then assigned to the appropriate region.

One issue that needed to be addressed with this new analysis is that denominators for some measures get very small once the data is stratified by RSA and MCO. NCQA guidelines state that measure results should not be reported when the denominator includes fewer than 30 patients. This ensures that patient 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 close to 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, Tables 4 and 5 illustrates the denominator size for two measures of high interest; the denominators are less than 30 for many regions. There are several cells where the denominator is less than 30 patients and a statistical analysis could not be completed that would accurately identify where performance was better or worse for a particular MCO for these two measures. Cells shaded gray with dashes indicate regions where MCOs are not contracted to operate for a particular region.

Table 4. Denominator Size by Region and MCO, Childhood Immunization Status (CIS), Combo 10.

Region	Denominator					Rates				
	AMG	CCW	CHPW	MHW	UHC	AMG	CCW	CHPW	MHW	UHC
Great Rivers	25	--	--	27	5	Denom <30	--	--	Denom <30	Denom <30
Greater Columbia	24	159	116	49	--	Denom <30	57%	43%	43%	--
King	109	65	100	66	112	56%	52%	51%	47%	46%
North Central	10	42	--	34	--	Denom <30	62%	--	32%	--
North Sound	54	44	77	60	106	48%	48%	47%	50%	54%
Pierce	63	46	--	55	69	52%	37%	--	44%	46%
Salish	14	--	--	18	10	Denom <30	--	--	Denom <30	Denom <30
Southwest	8	--	17	51	--	Denom <30	--	Denom <30	31%	--
Spokane	81	--	25	33	--	32%	--	Denom <30	27%	--
Thurston-Mason	23	--	--	17	16	Denom <30	--	--	Denom <30	Denom <30

-- Indicates that the MCO had no members in a particular region.

Table 5. Denominator Size by Region and MCO, Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care.

Region	Denominator					Rates				
	AMG	CCW	CHPW	MHW	UHC	AMG	CCW	CHPW	MHW	UHC
Great Rivers	36	--	--	14	9	81%	--	--	Denom <30	Denom <30
Greater Columbia	30	175	115	42	--	90%	78%	84%	95%	--
King	80	73	69	70	121	74%	74%	87%	100%	87%
North Central	11	32	--	33	--	Denom <30	78%	--	94%	--
North Sound	60	32	73	53	120	62%	66%	71%	94%	91%
Pierce	62	46	--	51	101	81%	89%	--	90%	91%
Salish	14	--	--	11	17	Denom <30	--	--	Denom <30	Denom <30
Southwest	6	--	19	61	--	Denom <30	--	Denom <30	95%	--
Spokane	72	--	56	53	--	92%	--	79%	96%	--
Thurston-Mason	17	--	--	22	32	Denom <30	--	--	Denom <30	78%

-- Indicates that the MCO had no members in a particular region.

In order to perform the comparative analysis, it was important to identify the measures that had sufficient data across all regions and MCOs. Comagine Health identified the measures that met these criteria; HCA selected the 19 measures from that list that are reported in this section. Note that the measures that met the criteria that have not been reported are subsets of the selected measures.

Figures 44 through 53 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 downward triangles indicate MCOs that perform statistically below the regional average; the upward triangles indicate MCOs that perform statistically above the regional average. If an MCO does not operate in that region, its column is grayed out.

Great Rivers Region

MHW performed above the regional average for the four Access/Availability of Care measures. AMG and UHC perform below the regional average for a few of these measures. MCO performance varied on measures in the Overuse/Appropriateness section, with no discernable pattern. CCW and CHPW do not serve Apple Health members in this region.

Figure 44. Comparison of MCOs by Measure within Great Rivers Region.

Statistically significant difference from **Region**

		Region	AMG	CCW	CHPW	MHW	UHC
Access / Availability of Care	Adults' Access to Preventive/Ambulatory Health Services (AAP), 20-44 Years	72.6%	69.0% ↓			75.3% ↑	67.0% ↓
	Adults' Access to Preventive/Ambulatory Health Services (AAP), 45-64 Years	77.5%	76.1%			78.6% ↑	77.2%
	Adults' Access to Preventive/Ambulatory Health Services (AAP), Total	74.5%	72.0% ↓			76.4% ↑	71.9% ↓
	Children's Access to Primary Care Practitioners (CAP), 7-11 Years	90.8%	90.9%			92.7% ↑	78.8% ↓
Behavioral Health	Antidepressant Medication Management (AMM), Acute Phase	54.9%	53.8%			53.6%	56.3%
	Antidepressant Medication Management (AMM), Continuation Phase	38.4%	39.5%			36.5%	37.4%
Diabetes	Statin Therapy for Patients With Diabetes (SPD), Received Statin Therapy	63.9%	53.8% ↓			63.6%	64.3%
	Statin Therapy for Patients With Diabetes (SPD), Statin Adherence 80%	66.9%	66.2%			67.0%	68.1%
Overuse / Appropriateness	Appropriate Treatment for Upper Respiratory Infection (URI), Total	92.5%	91.5%			93.3% ↑	88.1% ↓
	Avoidance of Antibiotics for Bronchitis (AAB), Total	52.7%	68.5% ↑			45.9% ↓	62.2%
	Risk of Continued Opioid Use (COU), At least 30 days, Total	3.0%	4.4% ↑			2.7%	4.2%
	Use of Imaging Studies for Low Back Pain (LBP)	70.7%	73.6%			70.4%	70.7%
	Use of Opioids at High Dosage (HDO) (lower is better)	7.0%	3.9% ↑			6.3%	8.1%
	Use of Opioids from Multiple Pharmacies (lower is better)	3.8%	1.6% ↑			4.2%	6.5% ↓
	Use of Opioids from Multiple Prescribers (lower is better)	24.0%	14.0% ↑			31.1% ↓	17.8% ↑
	Use of Opioids from Multiple Prescribers and Pharmacies (lower is better)	2.6%	0.6% ↑			3.4%	3.2%
Prevention and Screening	Breast Cancer Screening (BCS)	47.5%	48.0%			47.6%	46.9%
	Chlamydia Screening (CHL), Total	54.2%	53.8%			55.7%	45.0% ↓
Respiratory Conditions	Appropriate Testing for Pharyngitis (CWP), Total	78.8%	77.6%			78.5%	71.6% ↓

Greater Columbia Region

MHW performed above the regional average for the adult Access/Availability of Care measures. AMG performed below the regional average for the Access/Availability of Care measures. There was some variation in performance on Overuse/Appropriateness measures, with some MCOs performing above the regional average and some performing below. AMG performed below the regional average for the two measures in the Prevention and Screening section, while CCW performed above the regional average. UHC does not serve Apple Health enrollees in this region.

Figure 45. Comparison of MCOs by Measure within Greater Columbia Region.

↓ ↑ Statistically significant difference from **Region**

		Region	AMG	CCW	CHPW	MHW	UHC
Access / Availability of Care	Adults' Access to Preventive/Ambulatory Health Services (AAP), 20-44 Years	76.2%	67.6% ↓	76.0%	75.8%	78.8% ↑	
	Adults' Access to Preventive/Ambulatory Health Services (AAP), 45-64 Years	82.8%	76.1% ↓	83.6%	83.2%	84.1% ↑	
	Adults' Access to Preventive/Ambulatory Health Services (AAP), Total	78.2%	70.4% ↓	78.3%	78.2%	80.2% ↑	
	Children's Access to Primary Care Practitioners (CAP), 7-11 Years	92.6%	88.1% ↓	93.2% ↑	92.7%	92.2%	
Behavioral Health	Antidepressant Medication Management (AMM), Acute Phase	53.2%	55.1%	53.1%	51.5%	54.0%	
	Antidepressant Medication Management (AMM), Continuation Phase	36.7%	41.6%	37.9%	32.5% ↓	37.3%	
Diabetes	Statin Therapy for Patients With Diabetes (SPD), Received Statin Therapy	66.2%	61.9%	66.3%	67.3%	65.5%	
	Statin Therapy for Patients With Diabetes (SPD), Statin Adherence 80%	69.6%	72.9%	69.7%	72.0%	65.9%	
Overuse / Appropriateness	Appropriate Treatment for Upper Respiratory Infection (URI), Total	93.6%	91.9% ↓	95.4% ↑	93.9%	92.1% ↓	
	Avoidance of Antibiotics for Bronchitis (AAB), Total	62.3%	57.3%	75.0% ↑	64.8%	53.5% ↓	
	Risk of Continued Opioid Use (COU), At least 30 days, Total	3.2%	4.7% ↑	2.5% ↓	3.3%	3.7%	
	Use of Imaging Studies for Low Back Pain (LBP)	77.4%	73.2%	81.6% ↑	73.2% ↓	77.3%	
	Use of Opioids at High Dosage (HDO) (lower is better)	4.9%	5.3%	4.8%	5.2%	4.7%	
	Use of Opioids from Multiple Pharmacies (lower is better)	3.6%	3.3%	4.2%	3.6%	3.4%	
	Use of Opioids from Multiple Prescribers (lower is better)	21.3%	21.3%	20.9%	22.6%	21.0%	
	Use of Opioids from Multiple Prescribers and Pharmacies (lower is better)	2.1%	2.2%	2.3%	2.5%	1.7%	
Prevention and Screening	Breast Cancer Screening (BCS)	55.7%	43.9% ↓	58.3% ↑	55.4%	56.3%	
	Chlamydia Screening (CHL), Total	55.8%	51.4% ↓	57.7% ↑	56.8%	53.9% ↓	
Respiratory Conditions	Appropriate Testing for Pharyngitis (CWP), Total	74.1%	70.4%	81.3% ↑	75.7%	69.2% ↓	

King Region

MHW performed above the regional average for the four Access/Availability of Care measures displayed below. AMG, CCW and UHC performed below the regional average for these measures. MCO performance varied for many of the other measures, especially in the Overuse/Appropriateness section.

Figure 46. Comparison of MCOs by Measure within King Region.

↓ ↑ Statistically significant difference from **Region**

		Region	AMG	CCW	CHPW	MHW	UHC
Access / Availability of Care	Adults' Access to Preventive/Ambulatory Health Services (AAP), 20-44 Years	72.3%	68.1% ↓	67.2% ↓	72.5%	77.2% ↑	69.3% ↓
	Adults' Access to Preventive/Ambulatory Health Services (AAP), 45-64 Years	80.3%	75.9% ↓	75.4% ↓	82.8% ↑	83.8% ↑	79.3% ↓
	Adults' Access to Preventive/Ambulatory Health Services (AAP), Total	75.6%	71.3% ↓	70.5% ↓	76.8% ↑	79.5% ↑	74.5% ↓
	Children's Access to Primary Care Practitioners (CAP), 7-11 Years	90.6%	86.8% ↓	87.0% ↓	91.3%	92.4% ↑	87.4% ↓
Behavioral Health	Antidepressant Medication Management (AMM), Acute Phase	51.9%	47.6% ↓	54.7%	53.7%	52.4%	50.9%
	Antidepressant Medication Management (AMM), Continuation Phase	37.8%	35.5%	40.7%	38.4%	36.9%	38.6%
Diabetes	Statin Therapy for Patients With Diabetes (SPD), Received Statin Therapy	67.6%	68.2%	65.6%	69.6%	67.9%	65.7%
	Statin Therapy for Patients With Diabetes (SPD), Statin Adherence 80%	66.0%	66.5%	69.5%	71.6% ↑	61.8% ↓	63.9%
Overuse / Appropriateness	Appropriate Treatment for Upper Respiratory Infection (URI), Total	95.5%	95.2%	95.0%	96.9% ↑	95.9% ↑	93.7% ↓
	Avoidance of Antibiotics for Bronchitis (AAB), Total	68.5%	70.4%	70.6%	73.3% ↑	68.7%	62.7% ↓
	Risk of Continued Opioid Use (COU), At least 30 days, Total	1.9%	2.1%	2.0%	1.7%	1.7%	2.0%
	Use of Imaging Studies for Low Back Pain (LBP)	80.7%	81.0%	81.4%	81.4%	80.2%	80.8%
	Use of Opioids at High Dosage (HDO) (lower is better)	8.5%	6.1% ↑	8.9%	11.2% ↓	7.1% ↑	10.0% ↓
	Use of Opioids from Multiple Pharmacies (lower is better)	7.6%	3.7% ↑	7.8%	8.3%	7.6%	8.8% ↓
	Use of Opioids from Multiple Prescribers (lower is better)	25.7%	24.1%	22.6%	26.5%	26.3%	26.7%
	Use of Opioids from Multiple Prescribers and Pharmacies (lower is better)	4.4%	1.5% ↑	4.0%	5.3%	4.5%	5.4% ↓
Prevention and Screening	Breast Cancer Screening (BCS)	53.2%	46.5% ↓	50.5% ↓	55.8% ↑	55.2% ↑	54.1%
	Chlamydia Screening (CHL), Total	57.1%	57.7%	58.0%	53.2% ↓	58.3% ↑	56.8%
Respiratory Conditions	Appropriate Testing for Pharyngitis (CWP), Total	80.7%	77.8%	81.0%	82.4%	80.8%	80.5%

North Central Region

MHW performed above the regional average for the adult Access/Availability of Care measures. AMG performed below the regional average for all four measures in this section, while CCW also performed below the regional average for some of these. MHW performed below the regional average for both of the AMM measures. Performance varied among MCOs for some of the other measures, though it was difficult to discern a pattern.

Figure 47. Comparison of MCOs by Measure within North Central Region.

↓ ↑ Statistically significant difference from **Region**

		Region	AMG	CCW	CHPW	MHW	UHC
Access / Availability of Care	Adults' Access to Preventive/Ambulatory Health Services (AAP), 20-44 Years	79.0%	74.4% ↓	75.8% ↓		80.6% ↑	
	Adults' Access to Preventive/Ambulatory Health Services (AAP), 45-64 Years	83.6%	79.9% ↓	82.1%		84.9% ↑	
	Adults' Access to Preventive/Ambulatory Health Services (AAP), Total	80.7%	76.6% ↓	78.2% ↓		82.1% ↑	
	Children's Access to Primary Care Practitioners (CAP), 7-11 Years	94.1%	87.8% ↓	95.5% ↑		93.9%	
Behavioral Health	Antidepressant Medication Management (AMM), Acute Phase	51.0%	58.5%	55.2%		48.9% ↓	
	Antidepressant Medication Management (AMM), Continuation Phase	33.9%	41.5%	35.7%		32.2% ↓	
Diabetes	Statin Therapy for Patients With Diabetes (SPD), Received Statin Therapy	68.2%	83.3% ↑	66.3%		67.6%	
	Statin Therapy for Patients With Diabetes (SPD), Statin Adherence 80%	60.5%	55.0%	63.3%		60.4%	
Overuse / Appropriateness	Appropriate Treatment for Upper Respiratory Infection (URI), Total	94.4%	94.0%	91.7% ↓		95.5% ↑	
	Avoidance of Antibiotics for Bronchitis (AAB), Total	63.6%	72.6% ↑	74.0% ↑		58.5% ↓	
	Risk of Continued Opioid Use (COU), At least 30 days, Total	3.1%	2.3%	3.8%		3.0%	
	Use of Imaging Studies for Low Back Pain (LBP)	73.7%	76.7%	82.3% ↑		71.1% ↓	
	Use of Opioids at High Dosage (HDO) (lower is better)	6.4%	4.2%	5.7%		6.8%	
	Use of Opioids from Multiple Pharmacies (lower is better)	3.8%	3.0%	5.7%		3.3%	
	Use of Opioids from Multiple Prescribers (lower is better)	16.8%	17.8%	19.4%		16.1%	
	Use of Opioids from Multiple Prescribers and Pharmacies (lower is better)	2.0%	0.7%	3.1%		1.9%	
Prevention and Screening	Breast Cancer Screening (BCS)	56.3%	42.0% ↓	62.4% ↑		55.6%	
	Chlamydia Screening (CHL), Total	47.9%	47.7%	49.0%		47.6%	
Respiratory Conditions	Appropriate Testing for Pharyngitis (CWP), Total	71.0%	62.2% ↓	43.0% ↓		81.4% ↑	

North Sound Region

MHW performed above the regional average for the four Access/Availability of Care measures. AMG and CCW performed below the regional average for these measures. UHC performed above the regional average for the adult Access/Availability of Care measures, but below the regional average for the children's measure. MHW performed below the regional average for both of the AMM measures. Performance varied among MCOs for the other measures, though it was difficult to discern a pattern.

Figure 48. Comparison of MCOs by Measure within North Sound Region.

Statistically significant difference from **Region**

		Region	AMG	CCW	CHPW	MHW	UHC
Access / Availability of Care	Adults' Access to Preventive/Ambulatory Health Services (AAP), 20-44 Years	75.1%	67.7% ↓	67.8% ↓	74.6%	78.4% ↑	76.1% ↑
	Adults' Access to Preventive/Ambulatory Health Services (AAP), 45-64 Years	81.7%	76.9% ↓	77.6% ↓	81.5%	84.1% ↑	82.7% ↑
	Adults' Access to Preventive/Ambulatory Health Services (AAP), Total	77.6%	71.3% ↓	71.6% ↓	77.3%	80.4% ↑	79.1% ↑
	Children's Access to Primary Care Practitioners (CAP), 7-11 Years	90.5%	87.0% ↓	87.9% ↓	89.6% ↓	92.3% ↑	89.5% ↓
Behavioral Health	Antidepressant Medication Management (AMM), Acute Phase	53.7%	54.3%	60.3% ↑	55.4%	51.4% ↓	53.4%
	Antidepressant Medication Management (AMM), Continuation Phase	39.3%	41.7%	43.1%	42.6% ↑	37.0% ↓	37.7%
Diabetes	Statin Therapy for Patients With Diabetes (SPD), Received Statin Therapy	66.6%	59.4% ↓	63.6%	69.8% ↑	65.4%	70.2% ↑
	Statin Therapy for Patients With Diabetes (SPD), Statin Adherence 80%	68.9%	63.0%	67.4%	70.9%	67.4%	72.2%
Overuse / Appropriateness	Appropriate Treatment for Upper Respiratory Infection (URI), Total	93.6%	94.8% ↑	93.2%	94.4% ↑	93.2% ↓	93.4%
	Avoidance of Antibiotics for Bronchitis (AAB), Total	57.2%	61.5%	65.4% ↑	58.4%	53.2% ↓	59.2%
	Risk of Continued Opioid Use (COU), At least 30 days, Total	3.0%	4.0%	2.7%	4.2% ↑	2.9%	2.1% ↓
	Use of Imaging Studies for Low Back Pain (LBP)	76.3%	77.3%	73.5%	79.4%	75.2%	76.3%
	Use of Opioids at High Dosage (HDO) (lower is better)	8.2%	7.8%	8.8%	8.7%	8.3%	7.2%
	Use of Opioids from Multiple Pharmacies (lower is better)	5.1%	3.8%	4.1%	3.7% ↑	6.0% ↓	5.7%
	Use of Opioids from Multiple Prescribers (lower is better)	22.8%	21.5%	20.4%	22.9%	22.4%	24.9%
	Use of Opioids from Multiple Prescribers and Pharmacies (lower is better)	3.1%	1.7%	2.3%	2.8%	3.4%	3.9%
Prevention and Screening	Breast Cancer Screening (BCS)	50.4%	43.5% ↓	47.4%	48.3%	50.6%	57.6% ↑
	Chlamydia Screening (CHL), Total	48.3%	50.4%	47.7%	46.9%	49.6%	46.8%
Respiratory Conditions	Appropriate Testing for Pharyngitis (CWP), Total	80.7%	81.3%	78.0%	83.0% ↑	79.5%	82.0%

Pierce Region

MHW performed above the regional average for the four Access/Availability of Care measures. AMG and CCW performed below the regional average for these measures. MCO performance varies for many other measures. CHPW does not serve Apple Health enrollees in this region.

Figure 49. Comparison of MCOs by Measure within Pierce Region.

Statistically significant difference from **Region**

		Region	AMG	CCW	CHPW	MHW	UHC
Access / Availability of Care	Adults' Access to Preventive/Ambulatory Health Services (AAP), 20-44 Years	71.9%	67.4% ↓	65.7% ↓		75.5% ↑	71.0% ↓
	Adults' Access to Preventive/Ambulatory Health Services (AAP), 45-64 Years	79.2%	75.5% ↓	74.1% ↓		82.7% ↑	79.5%
	Adults' Access to Preventive/Ambulatory Health Services (AAP), Total	74.7%	70.5% ↓	68.9% ↓		77.7% ↑	75.1%
	Children's Access to Primary Care Practitioners (CAP), 7-11 Years	89.2%	84.8% ↓	87.0% ↓		91.4% ↑	82.4% ↓
Behavioral Health	Antidepressant Medication Management (AMM), Acute Phase	53.4%	53.2%	60.3% ↑		51.1% ↓	55.3%
	Antidepressant Medication Management (AMM), Continuation Phase	38.1%	41.1%	40.8%		36.4%	39.7%
Diabetes	Statin Therapy for Patients With Diabetes (SPD), Received Statin Therapy	66.2%	69.2%	63.0%		66.4%	65.7%
	Statin Therapy for Patients With Diabetes (SPD), Statin Adherence 80%	63.5%	64.6%	71.8% ↑		62.4%	60.0%
Overuse / Appropriateness	Appropriate Treatment for Upper Respiratory Infection (URI), Total	94.1%	94.0%	94.4%		94.2%	93.3% ↓
	Avoidance of Antibiotics for Bronchitis (AAB), Total	66.6%	66.9%	65.6%		66.3%	66.9%
	Risk of Continued Opioid Use (COU), At least 30 days, Total	2.4%	2.8%	1.8%		2.3%	2.6%
	Use of Imaging Studies for Low Back Pain (LBP)	74.7%	77.0%	78.3%		71.4% ↓	78.9% ↑
	Use of Opioids at High Dosage (HDO) (lower is better)	7.4%	6.4%	6.8%		5.6% ↑	11.0% ↓
	Use of Opioids from Multiple Pharmacies (lower is better)	6.9%	4.9%	7.9%		7.4%	6.6%
	Use of Opioids from Multiple Prescribers (lower is better)	23.7%	23.8%	23.0%		25.8% ↓	20.6% ↑
	Use of Opioids from Multiple Prescribers and Pharmacies (lower is better)	4.5%	3.8%	5.8%		5.1%	3.3% ↑
Prevention and Screening	Breast Cancer Screening (BCS)	48.2%	41.5% ↓	47.9%		49.7%	49.8%
	Chlamydia Screening (CHL), Total	57.3%	57.3%	57.7%		58.6% ↑	52.7% ↓
Respiratory Conditions	Appropriate Testing for Pharyngitis (CWP), Total	83.3%	77.8% ↓	84.9%		84.5% ↑	80.6% ↓

Salish Region

MHW performed above the regional average for the four Access/Availability of Care measures. AMG and UHC performed below the regional average for many of these measures. MCO performance varies for many other measures. CCW and CHPW do not serve Apple Health enrollees in this region.

Figure 50. Comparison of MCOs by Measure within Salish Region.

↓ ↑ Statistically significant difference from **Region**

		Region	AMG	CCW	CHPW	MHW	UHC
Access / Availability of Care	Adults' Access to Preventive/Ambulatory Health Services (AAP), 20-44 Years	71.8%	69.9% ↓			76.1% ↑	68.4% ↓
	Adults' Access to Preventive/Ambulatory Health Services (AAP), 45-64 Years	78.3%	76.5%			81.2% ↑	78.1%
	Adults' Access to Preventive/Ambulatory Health Services (AAP), Total	74.2%	72.7% ↓			77.8% ↑	72.3% ↓
	Children's Access to Primary Care Practitioners (CAP), 7-11 Years	87.9%	80.8% ↓			90.2% ↑	84.0% ↓
Behavioral Health	Antidepressant Medication Management (AMM), Acute Phase	53.3%	55.0%			51.9%	51.1%
	Antidepressant Medication Management (AMM), Continuation Phase	40.3%	43.1%			39.8%	40.3%
Diabetes	Statin Therapy for Patients With Diabetes (SPD), Received Statin Therapy	61.2%	65.1%			61.5%	63.3%
	Statin Therapy for Patients With Diabetes (SPD), Statin Adherence 80%	67.4%	67.4%			67.5%	59.0% ↓
Overuse / Appropriateness	Appropriate Treatment for Upper Respiratory Infection (URI), Total	93.0%	91.9%			93.6%	90.8% ↓
	Avoidance of Antibiotics for Bronchitis (AAB), Total	48.6%	50.4%			50.7%	50.7%
	Risk of Continued Opioid Use (COU), At least 30 days, Total	3.0%	5.1% ↑			2.5%	2.8%
	Use of Imaging Studies for Low Back Pain (LBP)	76.8%	84.7%			71.4% ↓	82.5%
	Use of Opioids at High Dosage (HDO) (lower is better)	9.3%	8.8%			5.1% ↑	13.5% ↓
	Use of Opioids from Multiple Pharmacies (lower is better)	2.3%	1.0%			2.5%	3.1%
	Use of Opioids from Multiple Prescribers (lower is better)	20.4%	17.4%			25.7% ↓	17.5%
	Use of Opioids from Multiple Prescribers and Pharmacies (lower is better)	1.4%	0.5%			1.8%	1.3%
Prevention and Screening	Breast Cancer Screening (BCS)	50.3%	48.0%			51.5%	51.5%
	Chlamydia Screening (CHL), Total	50.5%	55.8%			50.1%	50.0%
Respiratory Conditions	Appropriate Testing for Pharyngitis (CWP), Total	81.5%	76.4%			80.9%	83.8%

Southwest Region

MHW performed above the regional average for the four Access/Availability of Care measures. CHPW performed below the regional average for these measures. MCO performance varies for many other measures. CCW and UHC do not serve Apple Health enrollees in this region.

Figure 51. Comparison of MCOs by Measure within Southwest Region.

↓ ↑ Statistically significant difference from **Region**

		Region	AMG	CCW	CHPW	MHW	UHC
Access / Availability of Care	Adults' Access to Preventive/Ambulatory Health Services (AAP), 20-44 Years	72.6%	67.8% ↓		64.3% ↓	74.9% ↑	
	Adults' Access to Preventive/Ambulatory Health Services (AAP), 45-64 Years	78.3%	77.3%		72.7% ↓	80.2% ↑	
	Adults' Access to Preventive/Ambulatory Health Services (AAP), Total	74.6%	71.6% ↓		67.8% ↓	76.7% ↑	
	Children's Access to Primary Care Practitioners (CAP), 7-11 Years	88.1%	88.8%		81.0% ↓	89.3% ↑	
Behavioral Health	Antidepressant Medication Management (AMM), Acute Phase	56.2%	57.4%		59.3%	55.6%	
	Antidepressant Medication Management (AMM), Continuation Phase	40.7%	48.1%		44.9%	39.5%	
Diabetes	Statin Therapy for Patients With Diabetes (SPD), Received Statin Therapy	64.3%	58.8%		62.6%	65.0%	
	Statin Therapy for Patients With Diabetes (SPD), Statin Adherence 80%	66.8%	66.7%		71.7%	65.5%	
Overuse / Appropriateness	Appropriate Treatment for Upper Respiratory Infection (URI), Total	95.6%	94.9%		94.2% ↓	95.8%	
	Avoidance of Antibiotics for Bronchitis (AAB), Total	67.7%	72.7%		68.1%	67.3%	
	Risk of Continued Opioid Use (COU), At least 30 days, Total	3.0%	9.3% ↑		3.8%	2.7% ↓	
	Use of Imaging Studies for Low Back Pain (LBP)	80.1%	78.8%		85.4%	79.1%	
	Use of Opioids at High Dosage (HDO) (lower is better)	7.1%	6.3%		6.8%	7.2%	
	Use of Opioids from Multiple Pharmacies (lower is better)	5.5%	0.0% ↑		6.2%	5.7%	
	Use of Opioids from Multiple Prescribers (lower is better)	27.0%	16.2% ↑		25.9%	28.0%	
	Use of Opioids from Multiple Prescribers and Pharmacies (lower is better)	3.7%	0.0% ↑		3.9%	3.9%	
Prevention and Screening	Breast Cancer Screening (BCS)	55.7%	45.9% ↓		52.7%	57.2% ↑	
	Chlamydia Screening (CHL), Total	51.5%	49.4%		53.3%	50.9%	
Respiratory Conditions	Appropriate Testing for Pharyngitis (CWP), Total	86.2%	91.6%		79.9% ↓	87.0% ↑	

Spokane Region

MHW performed above the regional average for the four Access/Availability of Care measures. AMG and CHPW performed below the regional average for these measures. MCO performance varied for many of the other measures. CCW and UHC do not serve Apple Health enrollees in this region.

Figure 52. Comparison of MCOs by Measure within Spokane Region.

↓ ↑ Statistically significant difference from **Region**

		Region	AMG	CCW	CHPW	MHW	UHC
Access / Availability of Care	Adults' Access to Preventive/Ambulatory Health Services (AAP), 20-44 Years	78.0%	75.6% ↓		74.8% ↓	80.1% ↑	
	Adults' Access to Preventive/Ambulatory Health Services (AAP), 45-64 Years	82.4%	79.5% ↓		81.3% ↓	84.2% ↑	
	Adults' Access to Preventive/Ambulatory Health Services (AAP), Total	79.4%	77.0% ↓		77.1% ↓	81.4% ↑	
	Children's Access to Primary Care Practitioners (CAP), 7-11 Years	91.6%	88.1% ↓		90.0% ↓	92.6% ↑	
Behavioral Health	Antidepressant Medication Management (AMM), Acute Phase	53.6%	55.5%		57.8% ↑	51.0% ↓	
	Antidepressant Medication Management (AMM), Continuation Phase	38.2%	40.4%		40.9%	36.9%	
Diabetes	Statin Therapy for Patients With Diabetes (SPD), Received Statin Therapy	65.5%	70.6% ↑		65.5%	63.8%	
	Statin Therapy for Patients With Diabetes (SPD), Statin Adherence 80%	68.1%	71.5%		72.1%	65.3% ↓	
Overuse / Appropriateness	Appropriate Treatment for Upper Respiratory Infection (URI), Total	91.1%	92.0% ↑		89.5% ↓	91.5% ↑	
	Avoidance of Antibiotics for Bronchitis (AAB), Total	57.0%	58.3%		53.9%	57.3%	
	Risk of Continued Opioid Use (COU), At least 30 days, Total	3.8%	3.8%		4.1%	3.7%	
	Use of Imaging Studies for Low Back Pain (LBP)	75.4%	77.5%		72.4%	75.7%	
	Use of Opioids at High Dosage (HDO) (lower is better)	6.3%	6.7%		6.1%	6.2%	
	Use of Opioids from Multiple Pharmacies (lower is better)	4.5%	4.2%		5.5%	4.3%	
	Use of Opioids from Multiple Prescribers (lower is better)	27.8%	28.5%		26.3%	28.1%	
	Use of Opioids from Multiple Prescribers and Pharmacies (lower is better)	3.3%	3.2%		3.6%	3.3%	
Prevention and Screening	Breast Cancer Screening (BCS)	54.5%	50.4% ↓		50.3% ↓	57.8% ↑	
	Chlamydia Screening (CHL), Total	52.6%	51.3%		49.8%	54.0% ↑	
Respiratory Conditions	Appropriate Testing for Pharyngitis (CWP), Total	76.0%	70.4% ↓		75.6%	78.6% ↑	

Thurston-Mason Region

MHW performed above the regional average for the four Access/Availability of Care measures. AMG performed below the regional average for these measures. MCO performance varied for several other measures. CCW and CHPW do not serve Apple Health enrollees in this region.

Figure 53. Comparison of MCOs by Measure within Thurston-Mason Region.

↓ ↑ Statistically significant difference from **Region**

		Region	AMG	CCW	CHPW	MHW	UHC
Access / Availability of Care	Adults' Access to Preventive/Ambulatory Health Services (AAP), 20-44 Years	72.1%	67.0% ↓			76.4% ↑	69.9% ↓
	Adults' Access to Preventive/Ambulatory Health Services (AAP), 45-64 Years	77.5%	74.9% ↓			82.7% ↑	76.7%
	Adults' Access to Preventive/Ambulatory Health Services (AAP), Total	74.0%	70.1% ↓			78.4% ↑	72.4% ↓
	Children's Access to Primary Care Practitioners (CAP), 7-11 Years	89.9%	86.9% ↓			92.2% ↑	86.8% ↓
Behavioral Health	Antidepressant Medication Management (AMM), Acute Phase	57.3%	52.3%			56.7%	61.3%
	Antidepressant Medication Management (AMM), Continuation Phase	42.8%	38.6%			41.7%	42.8%
Diabetes	Statin Therapy for Patients With Diabetes (SPD), Received Statin Therapy	63.2%	58.5%			62.8%	64.6%
	Statin Therapy for Patients With Diabetes (SPD), Statin Adherence 80%	68.3%	69.9%			69.1%	61.1%
Overuse / Appropriateness	Appropriate Treatment for Upper Respiratory Infection (URI), Total	93.6%	93.3%			93.9%	93.5%
	Avoidance of Antibiotics for Bronchitis (AAB), Total	65.0%	68.2%			63.2%	60.0%
	Risk of Continued Opioid Use (COU), At least 30 days, Total	3.0%	4.0%			3.3%	3.1%
	Use of Imaging Studies for Low Back Pain (LBP)	72.8%	74.3%			69.2%	75.0%
	Use of Opioids at High Dosage (HDO) (lower is better)	5.4%	4.6%			5.6%	6.0%
	Use of Opioids from Multiple Pharmacies (lower is better)	4.3%	2.0%			5.9% ↓	3.7%
	Use of Opioids from Multiple Prescribers (lower is better)	21.4%	20.2%			25.1% ↓	16.3% ↑
	Use of Opioids from Multiple Prescribers and Pharmacies (lower is better)	2.3%	1.5%			3.6% ↓	1.4%
Prevention and Screening	Breast Cancer Screening (BCS)	49.6%	47.3%			54.5% ↑	48.7%
	Chlamydia Screening (CHL), Total	52.8%	54.2%			54.6%	52.8%
Respiratory Conditions	Appropriate Testing for Pharyngitis (CWP), Total	79.5%	77.1%			81.1%	78.7%

Additional Analysis

This new section of the Comparative Report provides an analysis of statewide performance on all HEDIS measures by race, language and urban versus rural geographic location. Since the majority of Medicaid enrollees are associated with a vulnerable population, HCA values and prioritizes the identification and comprehension of health disparities to proactively address these gaps. 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.

Analysis by Race/Ethnicity

The issue with small denominators is also present when the data is stratified by race/ethnicity, although not to the same extent as in the analysis of MCOs within each region.

Table 6 shows the denominators for the Childhood Immunization Status (CIS), Combo 10 and the Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care measures.

Table 6. Denominator Size by Race/Ethnicity for Selected Measures.

Race*	Childhood Immunization Status (CIS), Combo 10		Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care	
	Denominator	Rate	Denominator	Rate
White	717	38%	948	81%
Hispanic	541	48%	514	83%
Black	156	40%	187	87%
Asian	93	58%	91	88%
Hawaiian/Pacific Islander	62	53%	71	85%
American Indian/Alaskan Native	23	***Denom <30***	26	***Denom <30***
Not provided	326	52%	134	78%
Other	137	42%	61	82%

**These are the categories that MCOs provide to HCA in enrollment 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."*

Comagine Health was able to identify 10 high priority measures with sufficient data to compare performance by race. Figure 54 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 medical care received by members of each racial group.

Figure 54. Variation in Rates by Race/Ethnicity, RY 2020.*

↓ ↑ Statistically significant difference from **Statewide**

		Statewide	American Indian/Alaska Native	Asian	Black	Hawaiian/Pacific Islander	Hispanic	Not Provided	White
Access / Availability of Care	Adults' Access to Preventive/Ambulatory Health Services (AAP), Total	76.5%	79.2% ↑	74.5% ↓	75.0% ↓	68.7% ↓	79.0% ↑	71.7% ↓	76.7% ↑
	Children's Access to Primary Care Practitioners (CAP), 7-11 Years	90.8%	90.9%	88.8% ↓	88.4% ↓	80.9% ↓	93.2% ↑	88.1% ↓	90.2% ↓
Behavioral Health	Antidepressant Medication Management (AMM), Acute Phase	53.5%	49.7%	50.6%	43.2% ↓	47.8%	46.4% ↓	58.6% ↑	56.1% ↑
	Antidepressant Medication Management (AMM), Continuation Phase	38.4%	36.3%	35.6%	28.5% ↓	28.8% ↓	30.5% ↓	43.5% ↑	41.1% ↑
	Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	43.9%	40.9%	39.1%	36.4% ↓	31.3%	41.1% ↓	36.7% ↓	47.4% ↑
Overuse / Appropriateness	Use of Opioids at High Dosage (HDO) (lower is better)	7.1%	6.2%	4.8%	8.8% ↓	7.3%	4.2% ↑	9.1% ↓	7.3% ↓
Prevention and Screening	Breast Cancer Screening (BCS)	52.0%	45.5% ↓	65.3% ↑	48.4% ↓	52.1%	62.3% ↑	53.2%	48.8% ↓
	Chlamydia Screening (CHL), Total	53.6%	56.1%	53.0%	62.6% ↑	55.5%	56.1% ↑	49.3% ↓	51.1% ↓
Respiratory Conditions	Asthma Medication Ratio (AMR), Total	55.0%	57.8%	60.3% ↑	51.9% ↓	59.7%	55.1%	60.5% ↑	54.3% ↓
	Medication Management for Asthma (MMA), Compliance 75%, 5-11 Yrs	30.4%	38.7%	27.1%	22.4% ↓	47.4% ↑	26.8% ↓	23.8%	35.7% ↑

**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.*

Analysis by Preferred Language

Currently HCA provides written materials in 15 non-English languages to Apple Health enrollees. Comagine Health intended to provide analysis of measure performance for all 15 of these languages plus English. However, the small denominator issue is highly problematic when the data is stratified by language. NCQA guidelines state that measure results should not be reported when the denominator includes fewer than 30 patients. This ensures that patient 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 close to 400 members for each MCO.

Table 7 shows two measures as examples for languages and denominator size: the Childhood Immunization Status (CIS), Combo 10 and Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care measures.

Table 7. Denominator Size by Preferred Language for Selected Measures.

Preferred Language	Childhood Immunization Status (CIS), Combo 10		Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care	
	Denominator	Rate	Denominator	Rate
Amharic	4	***Denom <30***	3	***Denom <30***
Arabic	4	***Denom <30***	7	***Denom <30***
Burmese	2	***Denom <30***	3	***Denom <30***
Cambodian; Khmer	NR	***NR***	NR	***NR***
Chinese	10	***Denom <30***	4	***Denom <30***
English	1,429	42%	1,499	84%
Farsi	2	***Denom <30***	NR	***NR***
Korean	2	***Denom <30***	NR	***NR***
Laotian	NR	***NR***	NR	***NR***
Panjabi; Punjabi	1	***Denom <30***	NR	***NR***
Russian	9	***Denom <30***	8	***Denom <30***
Somali	2	***Denom <30***	8	***Denom <30***
Spanish; Castilian	255	64%	132	85%
Tigrinya	NR	***NR***	2	***Denom <30***
Ukrainian	1	***Denom <30***	3	***Denom <30***
Vietnamese	11	***Denom <30***	8	***Denom <30***
Other Language	323	38%	355	75%

NR indicates that language was not reported for that measure.

There were only two measures with sufficient data to provide a comparative analysis across all languages. After discussing this issue with HCA, Comagine Health explored the possibility of analyzing the most prevalent languages. There is sufficient data for the majority of the measures for the Spanish-speaking population. Figure 55 below compares 30 measures by the most prevalent languages within Apple Health enrollees: English and Spanish/Castilian.

Note that there were several measures with statistically significant differences in performance between English and Spanish/Castilian speakers.

- Measure performance was notably higher for Spanish/Castilian speakers for 14 measures.
- Measure performance was notably higher for English speakers for 3 measures.

Figure 55. English and Spanish/Castilian Language Comparison by Measure.

◆ English is statistically significantly **Lower** than Spanish
◆ English is statistically significantly **Higher** than Spanish

		English	Spanish; Castilian	
Access / Availability of Care	Adults' Access to Preventive/Ambulatory Health Services (AAP), Total	76%	81%	◆
	Children's Access to Primary Care Practitioners (CAP), 7-11 Years	90%	95%	◆
	Prenatal and Postpartum Care (PPC), Postpartum Care	71%	82%	◆
	Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care	84%	85%	
	Use of First-Line Psychosocial Care for Children and Adolsecents (APP), Total	57%	67%	
Behavioral Health	Antidepressant Medication Management (AMM), Acute Phase	53%	42%	◆
	Antidepressant Medication Management (AMM), Continuation Phase	38%	25%	◆
	Follow-Up Care for Children Prescribed ADHD Medication (ADD), Continuation	53%	57%	
	Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	44%	44%	
Cardiovascular Conditions	Controlling High Blood Pressure (CBP)	63%	60%	
Diabetes	Comprehensive Diabetes Care (CDC), Blood Pressure Control < 140/90 mm Hg	70%	80%	◆
	Comprehensive Diabetes Care (CDC), Eye Exam	56%	81%	◆
	Comprehensive Diabetes Care (CDC), Medical Attention for Nephropathy	88%	90%	
	Comprehensive Diabetes Care (CDC), Poor HbA1c Control (lower is better)	35%	29%	
Overuse / Appropriateness	Use of Opioids at High Dosage (HDO) (lower is better)	7%	1%	◆
Prevention and Screening	Breast Cancer Screening (BCS)	51%	73%	◆
	Cervical Cancer Screening (CCS)	58%	69%	
	Childhood Immunization Status (CIS), Combo 2	72%	88%	◆
	Childhood Immunization Status (CIS), Combo 10	42%	64%	◆
	Chlamydia Screening (CHL), Total	54%	52%	
	Lead Screening in Children (LSC)	27%	53%	◆
	Weight Counseling for Children / Adolescents (WCC), BMI Percentile, Total	68%	78%	◆
	Weight Counseling for Children / Adolescents (WCC), Nutrition Counseling, Total	61%	75%	◆
Respiratory Conditions	Asthma Medication Ratio (AMR), Total	54%	58%	
	Medication Management for Asthma (MMA), Compliance 75%, 5-11 Yrs	32%	20%	◆
	Medication Management for Asthma (MMA), Compliance 75%, 12-18 Yrs	30%	27%	
Utilization	Adolescent Well-Care Visits (AWC)	50%	62%	◆
	Well-Child Visits in the First 15 Months of Life (W15), 6 or More Visits	70%	73%	
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)	68%	82%	◆

Urban versus Rural Comparison

New to the comparative report this year is a comparison of 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.[13]

Figure 56 below shows measures by urban versus rural designation.

[13] 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 56. 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	77%	76%	
	Children's Access to Primary Care Practitioners (CAP), 7-11 Years	91%	91%	
	Prenatal and Postpartum Care (PPC), Postpartum Care	76%	72%	
	Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care	76%	83%	
	Use of First-Line Psychosocial Care for Children and Adolsecents (APP), Total	66%	55%	
Behavioral Health	Antidepressant Medication Management (AMM), Acute Phase	54%	54%	
	Antidepressant Medication Management (AMM), Continuation Phase	37%	39%	
	Follow-Up Care for Children Prescribed ADHD Medication (ADD), Continuation	45%	54%	
	Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	43%	44%	
Cardiovascular Conditions	Controlling High Blood Pressure (CBP)	58%	63%	
Diabetes	Comprehensive Diabetes Care (CDC), Blood Pressure Control < 140/90 mm Hg	71%	70%	
	Comprehensive Diabetes Care (CDC), Eye Exam	52%	58%	
	Comprehensive Diabetes Care (CDC), Medical Attention for Nephropathy	88%	88%	
	Comprehensive Diabetes Care (CDC), Poor HbA1c Control (lower is better)	45%	35%	
Overuse / Appropriateness	Use of Opioids at High Dosage (HDO) (lower is better)	7%	7%	
Prevention and Screening	Breast Cancer Screening (BCS)	47%	52%	◆
	Cervical Cancer Screening (CCS)	52%	58%	
	Childhood Immunization Status (CIS), Combo 2	70%	74%	
	Childhood Immunization Status (CIS), Combo 10	33%	45%	◆
	Chlamydia Screening (CHL), Total	45%	54%	◆
	Lead Screening in Children (LSC)	26%	32%	
	Weight Counseling for Children / Adolescents (WCC), BMI Percentile, Total	66%	71%	
	Weight Counseling for Children / Adolescents (WCC), Nutrition Counseling, Total	73%	62%	◆
Respiratory Conditions	Asthma Medication Ratio (AMR), Total	51%	55%	◆
	Medication Management for Asthma (MMA), Compliance 75%, 5-11 Yrs	25%	31%	
	Medication Management for Asthma (MMA), Compliance 75%, 12-18 Yrs	27%	30%	
Utilization	Adolescent Well-Care Visits (AWC)	58%	51%	
	Well-Child Visits in the First 15 Months of Life (W15), 6 or More Visits	69%	71%	
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)	73%	70%	

There were a few measures in the Prevention and Screening category where there were statistically significant differences between the urban population and the rural population. The urban population was statistically significantly higher for the Breast Cancer Screening (BSC), Childhood Immunization Status (CIS), Combo 10 and Chlamydia Screening (CHL), Total.

The rural population performed statistically significantly higher for the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC), Nutrition Counseling Total measure.

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 reporting year (calendar year 2019). The measures include 56 Healthcare Effectiveness Data and Information Set (HEDIS®) performance measure rates collected in 2020, reflecting performance in calendar year 2019. It also includes behavioral health measures that were developed by the Washington State Health Care Authority. To be consistent with NCQA methodology, the 2019 calendar year (CY) is referred to as the 2020 reporting year (RY) 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.[14]

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).

[14] 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, 2020 RY.

Measure	Administrative Rate	Hybrid Rate	Difference
Childhood Immunizations—Combination 2	68.2%	75.0%	+ 6.8%
Comprehensive Diabetes Care— Blood Pressure Controlled (< 140/90 mm Hg)	31.8%	69.8%	+ 38.0%
Prenatal and Postpartum Care— Timeliness of Prenatal Care	59.9%	82.7%	+ 22.8%
Prenatal and Postpartum Care— Postpartum Care	49.0%	72.1%	+ 23.1%

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 fee-for-service 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 March 2020, NCQA recognized that COVID-19 would likely impact plans' ability to collect medical record data due to travel bans, quarantines, and efforts to minimize risk to staff. Therefore, NCQA allowed Medicaid plans participating in HEDIS reporting the option of submitting 2019 rates for their hybrid measures, referred to as "rotated measures." Hybrid measures are calculated by combining administrative claims data with data obtained from medical records.

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

Table A-2. 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	—	—	—

Measure Name	AMG	CCW	CHPW	MHW	UHC
Lead Screening in Children (LSC)	Y	—	—	—	—
Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care	Y	—	—	—	—
Prenatal and Postpartum Care (PPC), Postpartum Care	Y	—	—	—	—
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. Each plan's MLD file was submitted to HCA for mapping to enrollee demographic information (race/ethnicity, language, ZIP code of residence). These collective data sets were then provided to Comagine Health for analysis. Because the statewide rates for the regional analysis are derived from this member-level data, statewide results for some measures may differ slightly from those presented in the Performance Measure section of the report, which are derived from HEDIS data. 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, 2019, and December 31, 2019. 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 regional assessment. The HEDIS measures were not risk-adjusted for any differences in enrollee demographic characteristics. Prior to performing regional 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.

- **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 ZIP code was used to map the member to the county. Note that when a ZIP code spans more than one county, Comagine Health chose the county with the larger population. Once the county was assigned, the member was then assigned to the appropriate region.
- **Race Data** – There was variation in how each MCO submitted race data, including spelling differences and the granularity of the descriptions. Comagine Health standardized the descriptions to match the categories that HCA uses to report enrollment.
- **Preferred Language** – Similar to the race data, there was variation in how the MCOs submitted preferred language data. The data also included approximately 85 different 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.

Calculations and Comparisons

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: 2018 RY, 2019 RY and 2020 RY. 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 2020 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 30, with no more than two benchmarks reported for each selected indicator. Therefore, a number of charts and tables do not include a direct comparison with national benchmarks but may instead include a narrative comparison with national benchmarks; for example, noting that a specific indicator or the state average is lower or higher than the national average.

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 2017 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 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.

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.

Limitations

- **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.

Appendix B: 2020 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.

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.