2022 Comparative and Regional Analysis Report

Washington Apple Health
Washington Health Care Authority

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

Comagine Health prepared this report under contract K3866 with the Washington State Health Care Authority to conduct external quality review and quality improvement activities to meet 42 CFR §462 and 42 CFR §438, Managed Care, Subpart E, External Quality Review.

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

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Acronym List

Table 1. List of Acronyms with Definitions.

Acronym	Definition
ACA	Affordable Care Act
AHAC	Apple Health Adult Coverage (Medicaid Expansion)
AH-BD	Apple Health Blind/Disabled
AH-IFC	Apple Health Integrated Foster Care
AH-IMC	Apple Health Integrated Managed Care
AMG	Amerigroup Washington, Inc.
BHSO	Behavioral Health Services Only
CCW	Coordinated Care of Washington
CHIP	Children's Health Insurance Program
CHPW	Community Health Plan of Washington
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CY	Calendar Year
DSHS	Department of Social and Health Services
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 Rate (Broad version) [MH-B]: formally Mental Health Service Penetration – Broad Definition (MH-B)
MHW	Molina Healthcare of Washington
MLD	Member-Level Data
MY	Measurement Year
NCQA	National Committee for Quality Assurance
RDA	Research and Data Analysis Division of the Washington Department of Social and Health Services
RSA	Regional Service Area
RUCA	Rural-Urban Commuting Area
RY	Reporting Year
SUD	Substance Use Disorder (SUD) Treatment Rate: formally Substance Use Disorder Treatment Penetration (SUD)
TANF	Temporary Assistance to Needy Families
UHC	UnitedHealthcare Community Plan
VBP	Value-Based Payment

Executive Summary

In 2021, over 2 million Washingtonians were enrolled in Apple Health, with more than 85% enrolled in managed care.[1] This managed care population is served by five managed care organizations (MCOs):

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

These MCOs are required to annually report results of their performance on measures reflecting the levels of quality, timeliness and accessibility of health care services furnished to the state's Medicaid enrollees. As part of its work as the external quality review organization (EQRO) for the Washington State Health Care Authority (HCA), Comagine Health reviewed MCO performance on Healthcare Effectiveness Data and Information Set (HEDIS®)[2] measures for the calendar year (CY) 2021. In addition to the HEDIS measures, this report also includes data on two behavioral health measures developed by the state of Washington.

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

HEDIS Measures

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

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

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

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

[1] Apple Health Client Eligibility Dashboard. Washington State Health Care Authority. Available at: https://hca-tableau.watech.wa.gov/t/51/views/ClientDashboard-Externalversion/AppleHealthClientDashboard?:isGuestRedirectFromVizportal=y&:embed=y.
[2] The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.
[3] Quality Compass® is a registered trademark of NCQA.
[4] Healthier Washington. About the Washington Statewide Common Measure Set for Health Care Quality and Cost. Available at: https://www.hca.wa.gov/assets/program/washington-state-common-measures.pdf.

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

Washington State Behavioral Health Measure Overview

At HCA's instruction, Comagine Health also assessed statewide performance on two non-HEDIS behavioral health measures that are calculated by the Department of Social and Health Services (DSHS) 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 Rate, Broad Definition (MH-B)
- Substance Use Disorder (SUD) Treatment Rate

Note the names of these measures have changed. These two measures were formerly known as the Mental Health Service Penetration, Broad Definition (MH-B) and the Substance Use Disorder Treatment Penetration (SUD) measures. The specifications for these measures were also updated, but the changes will not affect the ability to make year-over-year comparisons.

Alignment with Value-Based Purchasing Efforts

In 2022, the Washington Legislature updated budget proviso, ESSB 5693 Sec.211 (37)(2022) requiring Washington State's HCA to select value-based purchasing (VBP) metrics to be included in the contractual agreements with the Apple Health MCOs providing services to Medicaid enrollees.[5]

As the EQRO for the State of Washington, Comagine Health is contracted to assess MCO performance on measures reported by each plan and, in August 2022, recommended 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 VBP performance measure set.

In addition, in October 2022, Comagine Health evaluated MCO performance of the VBP measures as selected by HCA for both AH-IMC and IFC contracts. The result of this evaluation has a direct effect on the reimbursement to MCOs. MCOs achieved VBP reimbursement if they demonstrated year-over-year improvement or scored in the top national Medicaid quartile of the performance measure.

Comparative Analysis in this Report

Comagine Health thoroughly reviewed each MCO's rates for selected HEDIS measures and associated submeasures and the RDA measures. With HCA's approval, Comagine Health focused on the 42 highest priority measures for analysis in this report. These 42 measures, which include HEDIS measures and the two Washington behavioral health measures, reflect current HCA priorities and are part of the Statewide Common Measure Set. They also represent a broad population base or population of specific or prioritized interest.

[5] Engrossed Substitute Senate Bill (ESSB) 5693 Sec.211 (37)(2022), State of Washington, 67th Legislature, 2022 Regular Season. Available at: https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/Senate/5693-S.SL.pdf.

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

- Apple Health statewide weighted rates
- Individual Apple Health MCOs
- Apple Health service regions

The 2021 calendar year is referred to as the measurement year 2021 (MY2021) in this report to be consistent with NCQA methodology.

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

Key Observations

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

Statewide Statistically Significant Improvements

Many access measures show a strong shift of improvement, as well as a few of the behavioral health measures. These statistically significant improvements are notable, especially in the context of COVID-19.

Please click here to view MY2021 MCO Statewide Weighted Average for 42 Measures (Figure 4).

There were two years of statistically significant improvement (between MY2019 and MY2020 and between MY2020 and MY2021) for the following measures:

- Asthma Medication Ratio (AMR), Total
- Antidepressant Medication Management (AMM) Acute and Continuation Phase measures
- Use of Opioids at High Dosage (HDO)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET), Total: Initiation of AOD Treatment: 13-17 Years

The Asthma Medication Ratio (AMR) and Antidepressant Medication Management (AMM) measures also had a statistically significant improvement between MY2018 and MY2019. This information is not captured in Figure 4, but is shown in Appendix B.

There was a statistically significant improvement between MY2020 and MY2021 for the following measures:

- Controlling High Blood Pressure (CBP)

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

- Prenatal and Postpartum Care (PPC), Postpartum Care
- Child and Adolescent Well-Care Visits (WCV), all age bands

Statistically Significant Declines

While there were measures that showed improvements, there were also measures that demonstrated statistically significant declines. The following measures have declined for the last two years:

- Breast Cancer Screening (BCS) measure
- Immunizations for Adolescents (IMA), Combo 2
- Mental Health Service Rate, Broad Definition (MH-B), 6-64 Years
- Pharmacotherapy for Opioid Use Disorder (POD): 16-64 Years
- Use of Opioids at High Dosage (HDO) (note that a lower rate is better for this measure)
- Adults' Access to Preventive/Ambulatory Health Services (AAP), Total
- Well-Child Visits in the First 30 Months of Life (W30), 15-30 Months

There were measures that showed improvements between MY2019 and MY2020, but then demonstrated a statistically significant decline between MY2020 and MY2021:

- Follow-Up after Hospitalization for Mental Illness (FUH), 7-Day Follow-Up, Total
- Follow-Up after Hospitalization for Mental Illness (FUH), 30-Day Follow-Up, 18-64 Years
- Follow-Up after Hospitalization for Mental Illness (FUH), 30-Day Follow-Up, Total
- Substance Use Disorder (SUD) Treatment Rate, 12-64 Years
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET), Total: Engagement of AOD Treatment: Total

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

There was a statistically significant decline between both MY2019 and MY2020, and MY2020 and MY2021 time periods for the Breast Cancer Screening (BCS) measure. Note the Breast Cancer Screening ECDS measure has been adopted as a VBP plan-specific measure for the MCO contract year 2023.

MCO Variation

There is considerable variation among the five MCOs both in terms of year-over-year improvements and comparisons to benchmarks. This variation often exists even for those measures that show strong statewide improvement. Figure 40 provides information on how the MCOs compare to each other and to benchmarks.

Please click here to view MCO Variation from MY2020 to MY2021 (Figure 40).

Prevention and Screening – There was very little variation seem for the Breast Cancer Screening (BCS) measure. The statewide weighted average and the five MCOs were all below the national 50th percentile. With the exception of AMG, all of the MCOs also declined in the year-over-year comparison.

There was some variation seen with other preventive measures.

Chronic Care – There was notable variation in the comparison to benchmarks for the Asthma Medication Ratio (AMR) measure. On a statewide basis, there were statistically significant improvements from MY2020 to 2021. These improvements were also seen for AMG, CCW and MHW. CHPW showed a statistically significant decline in performance, while there was no statistically significant change detected for UHC.

There was some variation noted for the Controlling High Blood Pressure (CBP) and the diabetes measures.

Behavioral Health – In general, there is a lot of variation in performance for the behavioral health measures. Here are some observations about a few of the measures:

- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependencies (FUA), 30-day and 7-day, Total – The statewide average and all plans compare well to the national benchmarks.
- Follow-Up after Hospitalization for Mental Illness (FUH) – Many of the plans are below the national 50th percentile. Many of the plans also experienced a year-over-year decline.
- Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation – The results for this measure are consistently below the national 50th percentile. There has been no year-over-year improvement.
- Mental Health Service Rate, Broad Definition (MH-B), 6-64 Years – The statewide weighted rate had a statistically significant decline. The results for the individual MCOs were mixed. MHW performed the best when compared to the benchmark.
- Substance Use Disorder (SUD) Treatment Rate, 12-64 Years – The statewide weighted rate had a statistically significant decline. The results for the individual MCOs were mixed. CHPW and UHC performed the best when compared to the benchmark.

Access/Availability of Care – There is some variation for the other Access/Availability of Care measures, especially in terms of comparisons to benchmarks. There is a lot of variation in performance across the MCOs in terms of comparisons to benchmarks for the Prenatal and Postpartum Care (PPC) measures.

Utilization – This category comprises the well-child visits. For the Well-Child Visits in the First 30 Months of Life (W30), there is variation among the MCOs across the MCOs when compared to the national benchmarks for both the First 15 Months and 15-30 Month measure indicators. The results for the Child and Adolescent Well-Care Visit (WCV) measures were more consistent. For all age bands, this measure is consistently below the national 50th percentile for both the statewide weighted average and the MCOs. The exception was CCW, whose rates are at the national 50th percentile for the Age 3-11 age band.

Health Equity

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

The two primary views of the health equity data are the Statewide Measure Results by Race/Ethnicity and the Statewide Measure Results by Language.

- Please click here to view Statewide Variation in Rates by Race/Ethnicity (Figure 15).
- Please click here to view Statewide Variation in Rates by Spoken Language (Figure 20).

Also new to the report this year is three-year trend information for both race/ethnicity and spoken language. Note that Figure 20 only reports English, Spanish/Castilian, and all other languages. The three-year trend charts include the 15 languages where HCA provides written materials and an all-other language category.

- Please click here to view Variation in Rates by Race/Ethnicity, Three-Year Trend (Figure 16).
- Please click here to view Variation in Rates by Spoken Language, Three-Year Trend (Figure 21).

The results of the health equity analysis are very similar to the results reported in the 2021 Comparative Analysis report.

Prenatal and Postpartum Care (PPC): The Postpartum Care measure was statistically significant below the statewide weighted average for enrollees who identified themselves as Hawaiian/Pacific Islander. This year's report included an analysis of this data for a three-year trend (MY2019 through MY2021); Hawaiian/Pacific Islanders were consistently below the other race/ethnicity categories for all three years. As reported in the 2021 Comparative Analysis report, measure performance was significantly lower for Hawaiian/Pacific Islanders than other race/ethnicity categories for MY2020, but there were no statistically significant differences detected for MY2019 or MY2021.

It is also worth noting that measure performance was significantly better for Hispanic members than other race/ethnicity groups for MY2020 and MY2021. When this data was analyzed by language, Spanish-speaking members performed significantly better than other languages for both the Timeliness of Prenatal Care and Postpartum Care measures. It is assumed there is a large overlap between members who identify as Hispanic and Spanish speakers.

Behavioral health: Although there have been improvements in the behavioral health measures at the statewide level, there are still disparities in measure performance by race/ethnicity. In general, members who identify as white have significantly higher performance for the behavioral health measures than other races/ethnicities.

In contrast, for members identifying as Black, the results were the opposite with a consistently worse performance across the board for the same metrics. The performance was also worse for other measures for other races/ethnicities.

For the two RDA measures, performance was significantly better for Native Americans/Alaskan Natives than others.

There is not as much contrast in this data when analyzed by language. Performance was significantly better among English speakers for the Antidepressant Medication Management (AMM) and Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependencies (FUA), Total for the 30-Day and 7-Day Follow-Up measures, while performance was significantly worse among Spanish speakers. There was no statistically significant difference detected for the other behavioral health measures.

Preventive care: For preventive measures, performance was consistently significantly better among Hispanic members than members who identify as white. Performance was worse among Black members for Breast Cancer Screening (BCS) and Childhood Immunization Status (CIS), Combo 10, but significantly

better than other race/ethnicities for Chlamydia Screenings (CHL). The results for Asian members are the reverse with significantly better performance for Breast Cancer Screening (BCS) and Childhood Immunization Status (CIS), Combo 10 but significantly worse for Chlamydia Screenings (CHL). Breast Cancer Screening (BCS) performance was significantly worse among Native Americans/Alaskan Natives.

Analysis by language shows a similar result for Spanish-speaking members as Hispanics, with better performance on preventive care measures that English speakers.

Chronic disease: There was significant variation in performance by race and language for the Kidney Health Evaluation for Patients with Diabetes (KED), 18-64 Years. This variation was not seen in the other diabetes measures that were analyzed for this report. The KED measure was adopted in MY2020. Comagine Health recommends continuing to monitor the performance of this measure since it is fairly new.

Additional Observations

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

MCO and Regional Variation

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

With that caveat in mind, there have been some intriguing statistically significant improvements that can be seen across the MCOs. Comparisons are made using the state simple average to mitigate the impact of plan size when comparing a particular plan's performance. For more details on the calculation of the state simple average, please refer to the section titled "Calculation of the Washington Apple Health Average" on page 18.

There was variation in performance of the MCOs, particularly for behavioral health measures. The exceptions to this were the Child and Adolescent Well-Care Visit (WCV) measures, which saw year-over-year significant improvement across all MCOs, and the Breast Cancer Screening (BCS) measure, which saw a significant year-over-year decline for all MCOs except AMG.

AMG

AMG performed below the state simple average for the majority of the measures. The measures that were notably below the state simple average were the Cervical Cancer Screening (CCS) measure and the Follow-Up after ED Visit for Mental Illness (FUM) measures. Note AMG performance is very similar to

what was reported in the 2021 Comparative Analysis Report, with the same behavioral health measures above the state simple average and similar measures notably below the state simple average. See Figure 42 for MCO measure performance.

CCW

CCW has several pediatric measures with rates above the state simple average. In addition, CCW performed better than the state simple average for the Asthma Medication Ratio (AMR) measure. Many of the behavioral health measures were below the state simple average for CCW. Other measures where their rates were markedly below the state simple average included Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care and Postpartum Care; Comprehensive Diabetes Care (CDC), Poor HbA1c Control; and Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0%. (Note that a lower score is better for the Comprehensive Diabetes Care (CDC), Poor HbA1c Control measure.)

One notable change for CCW is performance on the Asthma Medication Ratio (AMR) measure. CCW performed 6% higher than the state simple average in MY2021, compared to being no different than the state simple average in MY2020. Performance on the remaining measures was very similar to what was reported in the 2021 Comparative Analysis report. See Figure 43 for MCO measure performance.

CHPW

CHPW performs above the state simple average for many of the measures, including several pediatric and behavioral health measures. CHPW was also well above the state simple average for the Prenatal and Postpartum (PPC) measures for both the Timeliness of Prenatal Care and Postpartum Care components. CHPW was notably below the state simple average for the Asthma Medication Ratio (AMR) measure. The MCO was also below the state simple average for a small number of behavioral health measures.

Overall, CHPW has more measures above the state simple average for MY2021 than were reported in the 2021 Comparative Analysis report. However, there was also a change in the mix of measures where CHPW performs well and where they perform notably below the other MCOs. Most notable was a drop in their rate for the Asthma Medication Ratio (AMR) measure, which is now 7% below the state simple average for MY2021 compared to being 3% above the state simple average for MY2020. See Figure 44 for MCO measure performance.

MHW

MHW performed markedly above the state simple average for the Follow-Up after Hospitalization for Mental Illness (FUH), Follow-Up After Emergency Department Visit for Mental Illness (FUM) and Asthma Medication Ratio (AMR) measures. The MCO was above the state simple average for several other measures. MHW was markedly below the state simple average for the Childhood Immunization Status (CIS), Combo 10 and Immunizations for Adolescents (IMA), Combo 2 measures. As a reminder, comparisons are made using the state simple average to mitigate the impact of plan size when comparing a particular plan's performance. Even after mitigating the impact its large size would have on the state average, MHW still performed well.

Overall, MHW showed improvement when compared to results from the 2021 Comparative Analysis Report. There are more measures notably above the state simple average this year. It is also worth noting that although the same immunization measures are below the state simple average this year,

MHW has closed the gap. For MY2021, none of the measures are much below the state simple average. See Figure 45 for MCO measure performance.

UHC

UHC performed close to the state simple average for the majority of the measures. UHC performed markedly above the state average for the Comprehensive Diabetes Care (CDC), Antidepressant Medication Management (AMM), Controlling High Blood Pressure (CBP), and Prenatal and Postpartum Care (PPC) measures. UHC was markedly below the average for the following measures: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependencies (FUA), 30-Day Follow-Up, 13-17 Years; Follow-Up after Hospitalization for Mental Illness (FUH); Lead Screening in Children (LSC); Well-Child Visits in the First 30 Months of Life (W30), First 15 Months; and Asthma Medication Ratio. UHC performance was very similar to what was reported in the 2021 Comparative Analysis Report. See Figure 46 for MCO measure performance.

Regions

When measures are split by MCO and region, it appears the MCO is a bigger driver in differences in performance than region. There is not a lot of variation in a specific MCO's performance across regions; in other words, if an MCO performed well in one region, it tended to perform well in others. MHW had strong performance in several regions. Conversely, AMG had weaker performance across several regions. There was some variation in performance by measure, but no other compelling themes emerged from the regional analysis.

Recommendations

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

- Sustain Improvement in Clinically Meaningful Areas
- Continue to leverage Value Based Payment incentives
- Address Behavioral Health Declines
- Focus on Access and Preventive Care
- Continue to prioritize Health Equity

We suggest caution in interpreting statistically significant improvements as a trend when only one year of improvement is noted. Because of the size of the population for many measures, particularly those that are collected with the hybrid methodology, there may be statistically significant changes in the measure results that simply reflect normal variation. A trend that has continued for three to five years has a much higher probability of demonstrating meaningful improvement.

Sustain Improvement in Clinically Meaningful Areas

Comagine Health recommends continuing the current work on behavioral health integration and the continuous quality improvement efforts associated with these measures. The Antidepressant Medication Management (AMM) measures have seen significant improvement for the last two reporting periods, with AMG and UHC improving significantly from MY2020 to MY2021. Continue to monitor these

measures to ensure performance in these areas does not decline and identify opportunities to incorporate this new data to address program needs.

On a statewide basis, the Asthma Medication Ratio (AMR) improved from a rate of 53% in MY2018 to 65% in MY2020. This 12% improvement can yield large population-based benefits, including a reduction of emergency department visits and inpatient stays for patients with asthma.[7,8,9] Three of five MCOs demonstrated statistically significant improvement for the Asthma Medication Ratio (AMR), Total measure between MY2020 and MY2021. CHPW saw significant improvement between MY2019 and MY2020, followed by a statistically significant decline between MY2020 and MY2021. It should be noted that although there has been considerable statewide improvement on this measure, statewide performance is still below the national 50th percentile which indicates there is still opportunity for significant improvement on this measure. We recommend continued emphasis on this important measure to avoid the slippage in performance as experienced by CHPW.

Statewide, Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care, demonstrated statistically significant improvement between MY2020 and MY2021. Over the past few years, several of the MCOs have implemented PIPs to improve prenatal and postpartum care, although only CCW had a PIP in this area for MY2021. The MCOs have also made efforts to identify pregnant members early in order to better coordinate care. Continued focus on prenatal and postpartum Care by all MCOs is recommended.

There is still substantial variation in the performance of the five MCOs for many of the key measures. For example, for the Asthma Medication Ratio (AMR) measure, CCW had the best performance in MY2021 with a rate of 70%, while CHPW and UHC had the lowest rates of 57%. Overall, collaboration among the MCOs with the higher performing plans sharing successful strategies that have led to improved measure performance may help improve all of the MCOs performance on these measures.

Continue to Leverage Value-Based Payment Incentives

There are early indications that the VBP incentive program has led to improvements in MCO performance. On a statewide basis, the Antidepressant Medication Management (AMM) and Asthma Medication Ratio (AMR) measures have both seen statistically significant improvements over the last two measurement periods. In addition, the Child and Adolescent Well-Care Visit (WCV) measure significantly improved between MY2020 and MY2021. There have also been improvements in the Prenatal and Postpartum Care (PPC) measures. These measures have been included in the VBP contracts for the MCOs since the program was first implemented in 2020.

Comagine Health recommends continued focus on the VBP incentive program, with an emphasis on selecting measures the MCOs can impact through care coordination or data sharing. In addition, we recommend continuing statewide collaboratives that allow the entire health care community to focus on quality improvement efforts that minimize administrative burden for providers. Monitoring the

[7] Andrews AL, Simpson AN, Basco WT Jr, Teufel RJ 2nd. Asthma medication ratio predicts emergency department visits and hospitalizations in children with asthma. *Medicare Medicaid Res Rev*. 2013. Available at: https://pubmed.ncbi.nlm.nih.gov/24834366/.

[8] Hasegawa K, Brenner BE, Clark S, Camargo CA. Emergency department visits for acute asthma by adults who ran out of their inhaled medications. *Allergy Asthma Proc*. 2014 May-Jun;35(3):42-50. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4012130/.

[9] Healthy People 2030. Reduce emergency department visits for people aged 5 years and over with asthma — RD-03. Available at: https://health.gov/healthypeople/objectives-and-data/browse-objectives/respiratory-disease/reduce-emergency-department-visits-people-aged-5-years-and-over-asthma-rd-03.

development of value-based purchasing efforts in other states such as those of Covered California[10] can inform the continued development of Washington's value-based purchasing program.

Address Behavioral Health Declines

Several behavioral health measures saw significant improvement between MY2019 and MY2020; however, between MY2020 and MY2021 most of these measures either saw no significant change or performance declined significantly. In addition, the statewide Mental Health Service Rate Broad version (MH-B) and the Pharmacotherapy for Opioid Use Disorder (POD) measures have declined significantly for the last two years (MY2019 to MY2020 and MY2020 to MY2021). The decline in statewide rates may be due to restrictions put in place at the beginning of the COVID-19 pandemic that limited in-person visits.

Behavioral health metrics show the most variation between the MCOs, both in terms of year-over-year improvements and when compared to benchmarks. This suggests there is the potential for MCOs to improve performance through coordination of care efforts and through adopting best practices. MCOs can also work with providers to leverage telehealth appointments where clinically appropriate. Focused efforts to ensure individuals receive mental health treatment must be a priority for all MCOs.

Focus on Access and Preventive Care

There have been significant declines in Breast Cancer Screenings (BCS) for several years. All MCOs except AMG demonstrated a significant decrease between MY2020 and MY2021. In addition, the Adult Access to Preventive Care (AAP) measure has seen a significant decline over the past two measurement years. There was also a significant decline in the Immunizations for Adolescents (IMA) – Combo 2 measure between MY2020 and MY2021. All MCOs need to focus on these important preventive and access measures.

It is worth noting that breast cancer screenings have been selected as a VBP plan-specific measure for the 2023 contract period. We are optimistic the payment incentive will lead to MCO focus and improvements on this measure as incentives have been associated with improvement in other metrics.

The COVID-19 pandemic continues to impact preventive care.

- Outreach to individuals to ensure preventive care is obtained should be prioritized. MCOs need to include strategies to support practitioners in catching up on preventive care that was delayed so declines do not continue.
- HCA should continue work to improve quality care in primary care settings, including leveraging the work of the Washington Multi-payer Primary Care Transformation Model.[11]
- HCA should continue to focus on bidirectional integration to sustain the behavioral health integration work. Just as primary care screens for behavioral health needs, build in screening

[10] California's Marketplace Innovations: Driving Health Plan Accountability For Quality And Equity. Available at: https://www.healthaffairs.org/content/forefront/california-s-marketplace-innovations-driving-health-plan-accountability-quality-and.

[11] Washington State Health Care Authority. Multi-payer Primary Care Transformation Model. Available at: https://www.hca.wa.gov/about-hca/programs-and-initiatives/value-based-purchasing/multi-payer-primary-care-transformation-model.

and coordination of preventive care should be built into behavioral health visits. (Certified Community Behavioral Health Clinic – CCBHC – model of care).[12]

Continue to Prioritize Health Equity

There is sufficient evidence of health disparities in these data to warrant further research and focused effort to better understand details of this disparity and to develop effective ways to meet the unique needs of communities.

The severity of the COVID-19 impact has been greater in the non-white populations. Although there have been improvements in several measures at the statewide level, that improvement does not translate into improvements for all race/ethnicity categories.

There are marked disparities for the behavioral health measures, especially for the Black community. Increased attention needs to be directed by the MCOs at communities of color.

Additional areas of focus to address health equity needs include:

- Prenatal and Postpartum Care (PPC), Postpartum measures for Hawaiian/Pacific Islander members
- Prevention and screening measures for most races/ethnicities
- Well-Child Visits in the First 30 Months of Life (W30) and child and Adolescent Well-Care Visit (WCV) for most races/ethnicities, including white members

Hispanics and Spanish speakers performed statistically better than other groups on many of the preventive and well-child visit measures. Potential reasons for this may shed light on effective strategies for other minorities suffering from health disparities. There are two large federally qualified health centers in the State of Washington that provide culturally sensitive care to the Hispanic population. There is also a statewide network of community health workers comprised of individuals from this community that emphasizes preventive care education across a range of clinical topics that are closely aligned with these measures. HCA is encouraged to determine the best pathway forward for supporting additional racial and ethnic communities in the development of similar systems. It is important for people from minority communities to receive culturally competent health care and information from members of their own communities.

Comagine Health recommends that HCA continue to coordinate efforts to support equity-centered managed care accountability through the value-based payment (VBP) program as well as quality and performance strategies to address disparities. With a growing national interest in adopting a standardized approach to health equity measurement, NCQA has developed a health equity measurement framework.[13] This schema is specifically aimed at aligning quality and performance strategies with equity-centered approaches to address disparities and close gaps in health care and outcomes for Medicaid managed care health members. This may be a useful tool/resource in moving forward with health equity in Washington.

[12] Washington State Health Care Authority. Certified Community Behavioral Health Clinic (CCBHC) Expansion Grants. Fact Sheet. Available at: cchbc-grant-fact-sheet_0.pdf (wa.gov).
[13] National Committee for Quality Assurance. Advancing Standardized Health Equity Quality Measurement. Available at: https://www.ncqa.org/health-equity/measure-accountability/.

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

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 State, Comagine Health reviewed Apple Health MCO performance on HEDIS measures for the calendar year 2021. Each Apple Health MCO is required to report results for HEDIS measures reflecting the levels of quality, timeliness and accessibility of health care services furnished to the state's Medicaid enrollees. HCA requires MCOs to report on these measures and their specific indicators (for example, rates for specific age groups).

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

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

The 2021 calendar year is referred to as the measurement year 2021 (MY2021) in this report to be consistent with NCQA methodology.

Overview of Apple Health Enrollment

During MY2021, five MCOs provided managed health care services for Apple Health enrollees:

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

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

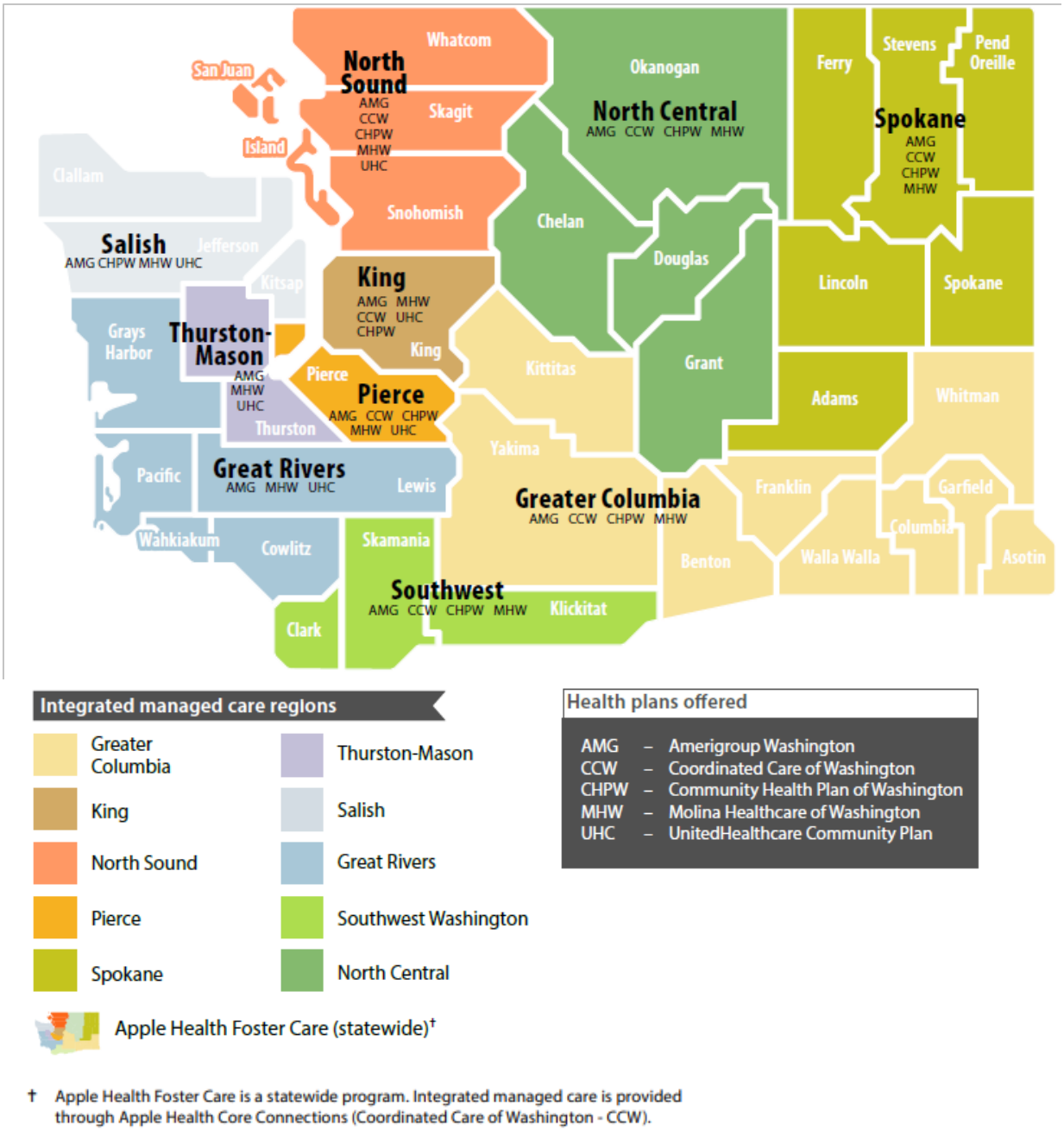
- Apple Health Integrated Managed Care (AH-IMC)
- Apple Health Integrated Foster Care (AH-IFC)
- Apple Health Behavioral Health Services Only (BHSO) (PIHP-contracted services)

Within Washington's AH-IMC program, Medicaid enrollees may qualify under the following eligibility categories:

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

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

Figure 1. Apple Health Regional Service Areas by County in 2021.[14,15]



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

The regional service areas are defined as follows:

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

[15] On July 1, 2021, CHPW was added to the North Sound and Pierce service areas and CCW was added to the Southwest service area. Note that effective January 1, 2022, CCW was added to Great Rivers, Salish and Thurston-Mason; CHPW was added to Great Rivers and Thurston-Mason.

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

Methodology for Comparing Performance Measures

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

Interpreting Performance

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

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

Impact of COVID-19 on Performance Measurement

In March 2020, the State of Washington implemented a "Stay Home, Stay Healthy" order in response to the threat of COVID-19. This order included limiting health care facilities to emergency services for the months of March and April 2020 and delaying elective procedures and other non-urgent treatment until later in the year. Effects of the "Stay Home, Stay Healthy" order along with other changes due to the pandemic lingered into 2021 are still being felt. The performance for many of the MY2021 HEDIS measures may have been impacted as a result. This is particularly true for many of the preventive care and access measures. Other health care utilization may have decreased due to a lower incidence of flu and other respiratory illnesses due to the adherence to masking and social distancing.

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 2022, Apple Health plans reported measures and their specific indicators (for example, rates for specific age groups). Comagine Health thoroughly reviewed each MCO's rates for all reported HEDIS measures, with associated submeasures and the RDA measures. These results are presented in Appendix B and Appendix C.

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

Washington State Behavioral Health Measures

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

- Mental Health Service Rate, Broad Definition (MH-B)
- Substance Use Disorder (SUD) Treatment Rate (SUD)

Note the names of these measures have changed. These two measures were formerly known as the Mental Health Service Penetration, Broad Definition (MH-B) and the Substance Use Disorder Treatment Penetration (SUD) measures. The specifications of these measures were also updated, but the changes will not affect the ability to make year-over-year comparisons.

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 on these measures. Data is collected via the administrative method, using claims, encounters and eligibility data and assessed on a quarterly basis.

Calculation of the Washington Apple Health Average

This report provides estimates of the average performance among the five Apple Health MCOs for the three most recent measurement years: MY2019, MY2020 and MY2021. The majority of the analyses presented in this report use the state weighted average. The state weighted average for a given measure is calculated as the weighted average among the MCOs that reported the measure (usually five), where the MCOs' share of the total eligible population is used as the weighting factor.

However, the MCO scorecards compare the individual MCO rates to the state simple average, or unweighted average. The state simple average for a given measure is calculated as the average of the measure rate for the MCOs that reported that measure. The potential disadvantage of comparing an

individual MCO to a weighted state average is that significantly larger plans could have undue influence on the state rate. A simple average of the plans' performance (rather than a weighted average) mitigates those concerns. Comagine Health chose to use the simple average for the MCO scorecards because the Apple Health MCOs vary in size. The state simple average for a given measure is calculated as the average of the measure rate for the MCOs that reported that measure.

Comparison to National Benchmarks

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

The licensing agreement with NCQA limits the number of benchmarks that can be published each year. The current agreement limits publication to two benchmarks for 40 measures. HCA selected the 40 measures to be reported with benchmarks in Appendix B. The two benchmarks selected are the national 50th percentile and the national 75th percentile. In other areas of the report, Comagine Health provides information on comparison of performance to national benchmarks without providing the actual benchmark rates, in accordance with NCQA licensing terms.

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

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

Interpreting Percentages versus Percentiles

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

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

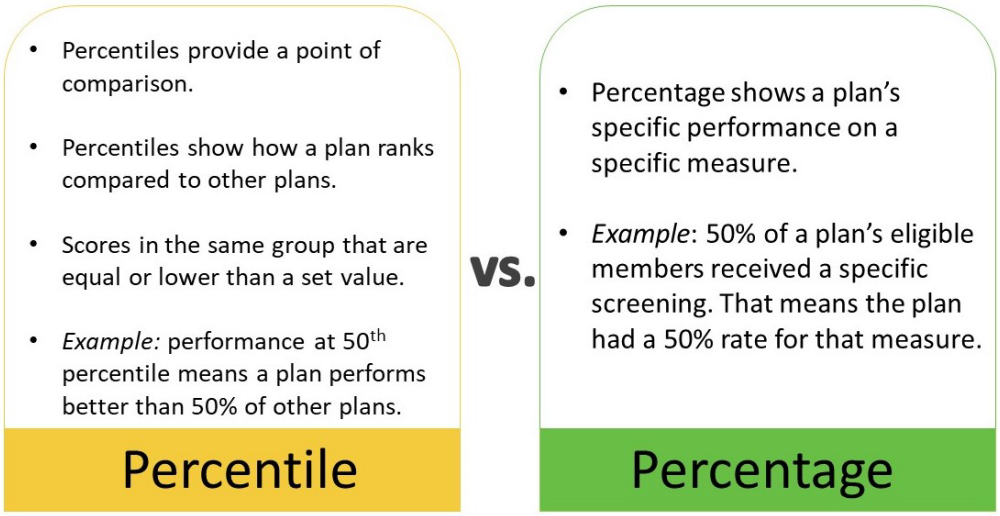
- If a plan's Breast Cancer Screening rate is at the national 50th percentile, it means that approximately 50% of the plans in the nation reported Breast Cancer Screening rates that were equal to or below Plan A; approximately 50% of the plans in the nation had rates that were above.

- If Plan A is above the 75th percentile, that means that at most 25% of the plans in the nation reported rates above Plan A, and at least 75% of the plans reported rates below Plan A.

The national percentiles give a benchmark, or point of comparison, to assess how Plan A's performance compares to other plans. This is especially important in identifying high priority areas for quality improvement. For example, if Plan A performs below the 50th percentile, we can conclude there is considerable room for improvement given the number of similar plans that performed better than Plan A. However, if Plan A performs above the 75th percentile, we can conclude that performance on that particular measure already exceeds the performance of most other plans and that improving the actual rate for that measure may not be the highest priority for this plan.

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

Figure 2. Percentile Versus Percentage.



Confidence Intervals, Statistical Significance and Denominator Size

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

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

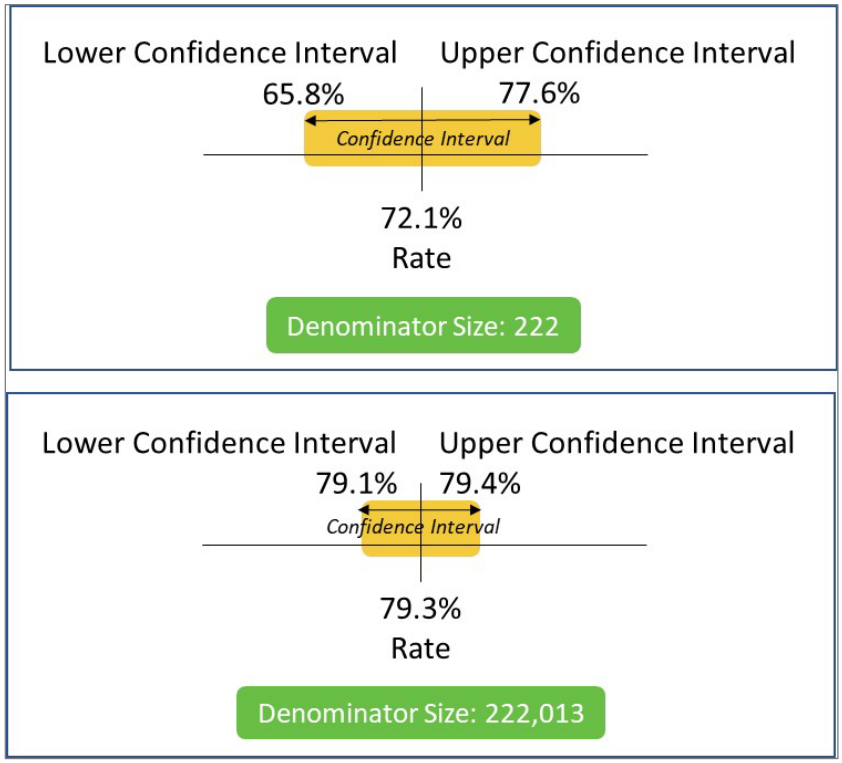
Significant and Significantly

Throughout this report, comparisons are frequently made between specific measurements (e.g., for an individual MCO) and a benchmark. Unless otherwise indicated, the terms "significant" or "significantly" are used when describing a statistically significant difference at the 95 percent confidence level. A Wilson Score Interval test was applied to calculate the 95 percent confidence intervals. This means that the reader can be 95% confident there is a real difference between two numbers, and that the differences are not due to chance.

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

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

Figure 3. Illustration of How Denominator Affects Confidence Intervals.



Limitations

Below are limitations to consider when reviewing this report.

- **Fee-for-service population:** The fee-for-service population is not included in these measures. Fee-for-service individuals include those eligible for both Medicare and Medicaid services. In addition, American Indian/Alaskan Natives are exempt from mandatory managed care enrollment.
- **Lack of risk adjustment**: HEDIS measures are not risk adjusted. Risk adjustment is a method of using characteristics of a patient population to estimate the population's illness burden. Diagnoses, age and gender are characteristics that are often used. Because HEDIS measures are not risk adjusted, the variation between MCOs is partially due to factors that are out of a plan's control, such as enrollees' medical acuity, demographic characteristics and other factors that may impact interaction with health care providers and systems.
- **COVID-19 impact and rotated measures**: In response to COVID-19, NCQA allowed Medicaid plans participating in HEDIS the option of submitting MY2018 rates for their MY2019 hybrid measures – "rotating" the measures they reported. Hybrid measures combine administrative claims data and data obtained from clinical charts. Under NCQA guidelines, MCOs could decide which hybrid measures, and how many, to report as rotated measures (i.e., submit MY2018 rates).
  The NCQA's decision was made to avoid placing a burden on clinics while they were dealing with the COVID-19 crisis. As a result of this decision, Comagine Health did not have access to updated rates for certain measures from the plans for MY2019. See Appendix A, Table A-2, for the rotated measures by MCO.
  Note that there were no rotated measures submitted for MY2020. The impact of the rotated measures will be seen in the year-over-year comparisons.
- **State behavioral health measures:** There are no national benchmarks available for the Washington Behavioral Health measures as these measures are Washington-specific measures developed by the state. Note there are several HEDIS measures related to behavioral health which are reported within this report which do include national benchmarks.
  For further discussion on HEDIS measures and the methodology utilized to report MCO performance, please see Appendix A.

Apple Health Statewide Performance

Comagine Health combined MCO performance to show how plans performed from MY2020 to MY2021 statewide. With HCA's approval, Comagine Health focused on the 42 highest priority measures for analysis in this report rather than the full list of HEDIS measures. These 42 measures, which include the two Washington behavioral health measures, reflect current HCA priorities and are part of the Statewide Common Measure Set. They also represent a broad population base or population of specific or prioritized interest.

Figure 4 shows the MY2020 statewide weighted average compared to the MY2021 statewide weighted average for the 42 measures. Below are the highlights of this statewide comparison:

- There were two years of statistically significant improvement (between MY2019 and MY2020, and between MY2020 and MY2021) for the following measures:
    - Asthma Medication Ratio (AMR), Total
    - Antidepressant Medication Management (AMM) Acute and Continuation Phase measures
    - Use of Opioids at High Dosage (HDO)
    - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET), Total: Initiation of AOD Treatment: 13-17 Years
- There was a statistically significant improvement between MY2020 and MY2021 for the following measures:
    - Controlling High Blood Pressure (CBP)
    - Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care
    - Child and Adolescent Well-Care Visits (WCV), all age bands
- There was a statistically significant improvement between MY2019 and MY2020 followed by a statistically significant decline between MY2020 and MY2021 for the following measures:
    - Follow-Up after Hospitalization for Mental Illness (FUH), 7-Day Follow-Up, Total
    - Follow-Up after Hospitalization for Mental Illness (FUH), 30-Day Follow-Up, 18-64 Years
    - Follow-Up after Hospitalization for Mental Illness (FUH), 30-Day Follow-Up, Total
    - Substance Use Disorder (SUD) Treatment Rate, 12-64 Years
    - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET), Total: Engagement of AOD Treatment: Total
- There was a statistically significant decline between both MY2019 and MY2020, and MY2020 and MY2021 time periods for the following measures:
    - Breast Cancer Screening (BCS) measure.
    - Immunizations for Adolescents (IMA), Combo 2
    - Mental Health Service Rate, Broad Definition (MH-B), 6-64 Years
    - Pharmacotherapy for Opioid Use Disorder (POD): 16-64 Years
    - Use of Opioids at High Dosages (HDO) (Note that lower is better for this measure)

- Adults' Access to Preventive/Ambulatory Health Services (AAP), Total
- Well-Child Visits in the First 30 Months of Life (W30), 15-30 Months

Note there were several measures that showed a statistically significant improvement between MY2019 and MY2020, but no change between MY2020 and MY2021.

The Asthma Medication Ratio (AMR) and Antidepressant Medication Management (AMM) measures also had a statistically significant improvement between MY2018 and MY2019. This information is not captured in Figure 4, but it is captured in Appendix B.

In a similar fashion, the Breast Cancer Screening (BCS) measure also had a statistically significant decline between MY2018 and MY2019. This information is not captured in Figure 4, but it is captured in Appendix B.

Note about the following 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 MY2021. Arrows pointing down represent a statistically significant decrease; arrows pointing up represent a statistically significant increase.

Figure 4. MY2021 MCO Statewide Weighted Average for 42 Measures.

Click here to return to key observations.

Apple Health Programs

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

- **Apple Health Integrated Managed Care (AH-IMC)** – Integration of physical health, mental health and substance use disorder treatment services under one contract.
- **Apple Health Integrated Foster Care (AH-IFC**) – Statewide program for eligible children and youth, including:
  - < 21 Years old in the foster care program
  - < 21 Years old and receiving adoption support
  - Those 18–26 years of age who have aged out of the foster care program
- **Apple Health Behavioral Health Services Only (BHSO)** – Program for members who are eligible for Apple Health but not eligible to be on an integrated managed care program, including the below:
  - Dual-eligible for Medicare and Medicaid
  - Medically Needy program
  - Individuals who have met their Medicaid spenddown

The AH-IMC program is further broken down into the following four Medicaid eligibility categories:

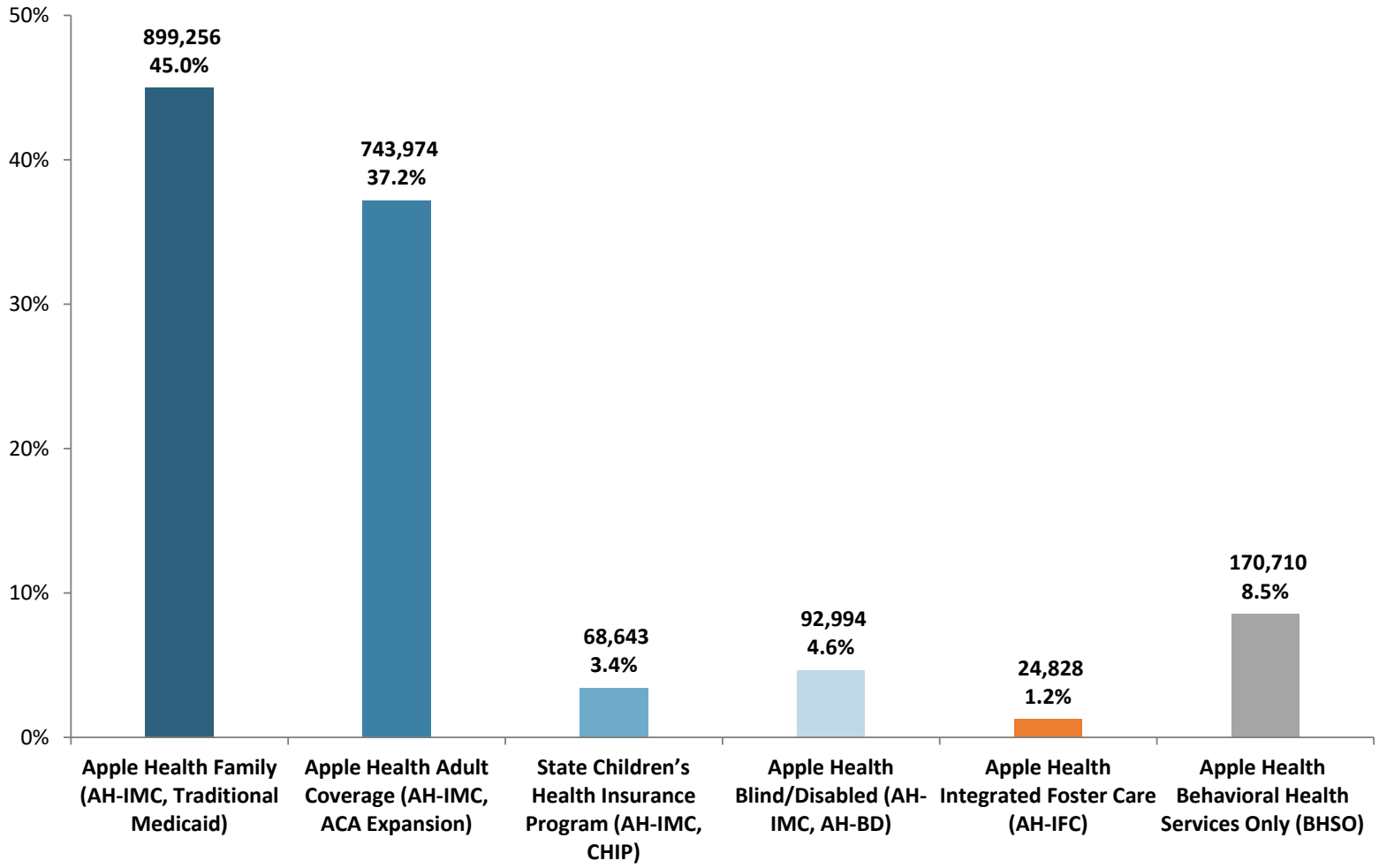
- **Apple Health Family** – Low-income programs for families, pregnant women and Temporary Assistance to Needy Families (TANF).
- **Apple Health Adult Coverage (AHAC)** – Low-income program for adults between 19 and 65 years old who are at or below the 138% federal poverty level (FPL). This expansion of coverage was introduced as part of the Affordable Care Act (ACA) in 2014.
- **Apple Health for Kids** – State Children's Health Insurance Program (CHIP)
  - Provides coverage for eligible children in households that are up to 250% FPL
  - The state also utilizes Medicaid CHIP funding to provide coverage with a monthly premium for children in households up to 312% FPL
- **Apple Health Blind/Disabled (AH-BD)** – Program for Supplemental Security Income (SSI)-related eligible members, including those who are currently receiving SSI.

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

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

Figure 5 shows enrollment by Apple Health Program. Note that the first four blue columns represent AH-IMC program with various eligibility categories. The majority of members were enrolled in the AH-IMC program, with 45.0% enrolled as Apple Health Family (traditional Medicaid) and 37.2% enrolled as Apple Health Adult (Medicaid expansion).

Figure 5. MY2021 Percent Enrollment by Apple Health Program and Eligibility Category.

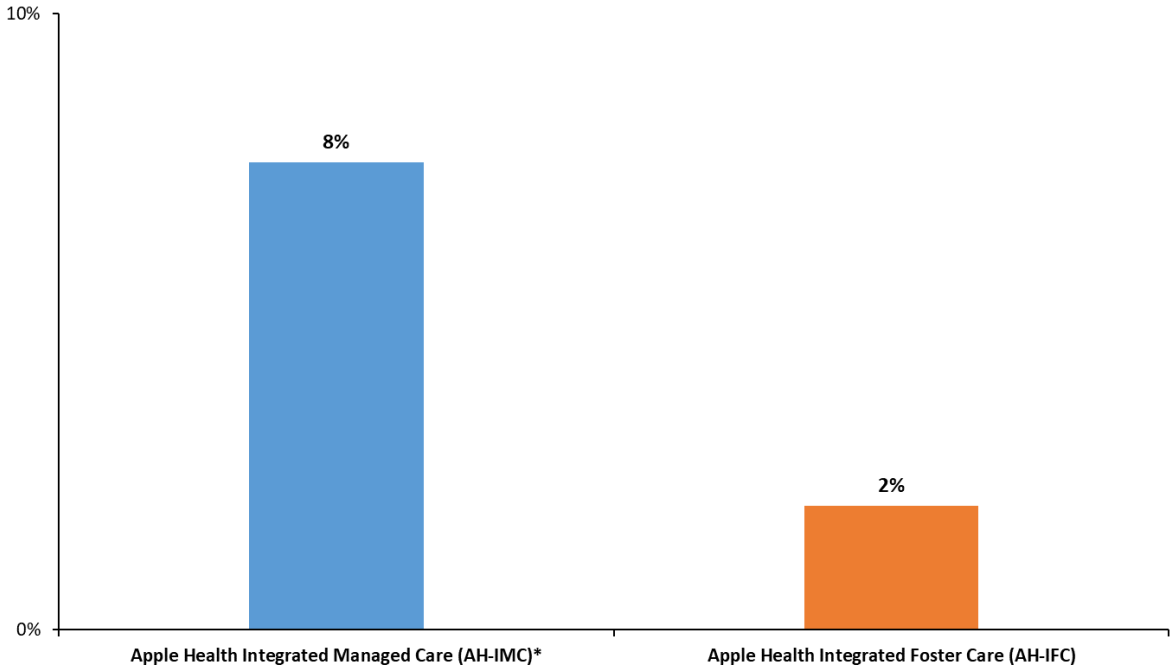


Note: The first four columns (the IMC programs) are shown in shades of blue.

There was an increase in Apple Health enrollment in calendar year 2021. Large increases in enrollment can impact measure results as there may be an underlying shift in the demographics of the population and delays in receiving care for new members.

Figure 6 shows the growth in Apple Health enrollment by program. The overall growth between MY2020 and MY2021 was 8%. The AH-IMC and AH-IFC populations grew 8% and 2%, respectively, between MY2020 and MY2021.

Figure 6. Enrollment Growth by Program, MY2020 vs. MY2021.



Demographics by Program

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

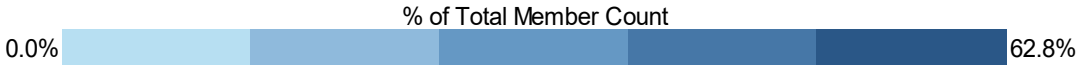
While this section of the report summarizes and compares MCO performance for certain HEDIS measures, it is crucial to recognize that the differences between the MCOs' member populations may impact MCO performance on different measures. Because of this variation, monitoring performance at both the plan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

Age Range

Figure 7 shows the percentages of enrollment by age group and Apple Health program. In this chart and the following, the darker blue signifies a higher percentage, while lighter blue signifies lower, with a medium gradient for those values in between. Blank, unshaded cells indicate the age group is not served by that program; for example, the State CHIP program covers only children and youth up to age 19.

Figure 7. Enrollee Population by Apple Health Program and Age Range, MY2021.

Age Range	Apple Health Adult Coverage (AH-IMC, ACA Expansion)	Apple Health Blind/Disabled (AH-IMC, AH-BD)	Apple Health Family (AH-IMC, Traditional Medicaid)	Apple Health Integrated Foster Care (AH-IFC)	State Children's Health Insurance Program (AH-IMC, CHIP)
Age 0 to 5	0.0%	3.3%	26.2%	24.5%	22.9%
Age 6 to 12	0.0%	8.8%	31.0%	34.5%	39.9%
Age 13 to 20	6.1%	11.4%	26.7%	36.3%	37.2%
Age 21 to 44	62.8%	31.1%	13.8%	4.7%	NR
Age 45 to 64	30.9%	41.3%	2.3%	NR	NR
Age 65+	0.2%	4.1%	0.0%	NR	NR



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

- **Apple Health Adult (AH-IMC, ACA expansion)**: 62.8% of enrollees are between the ages of 21 and 44
- **Apple Health Family (AH-IMC, Traditional Medicaid)**: 83.9% of the enrollees are below the age of 21; 13.8% of enrollees are between the ages of 21 and 44, and 2.3% of the enrollees are between the ages of 45 and 64
- **State Children's Health Insurance Program (AH-IMC, CHIP):** 39.9% are children ages 6 to 12
- **Apple Health Blind/Disabled (AH-IMC, AH-BD)**: most are adults between the ages of 21 and 64
- **Apple Health Foster Care (IFC)**: most enrollees are youth and children under the age of 21; 4.7% are Foster Care alumni between the age of 21 to 44

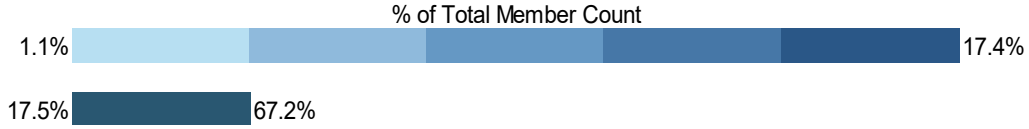
Race and Ethnicity

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

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

Figure 8. Statewide Apple Health Enrollees by Program and Race, MY2021.

Race	Apple Health Adult Coverage (AH-IMC, ACA Expansion)	Apple Health Blind/Disabled (AH-IMC, AH-BD)	Apple Health Family (AH-IMC, Traditional Medicaid)	Apple Health Integrated Foster Care (AH-IFC)	State Children's Health Insurance Program (AH-IMC, CHIP)
White	65.1%	67.2%	52.9%	62.6%	53.0%
Other	10.6%	8.7%	17.0%	7.0%	13.7%
Not Provided	4.3%	5.2%	10.0%	11.0%	17.4%
Black	8.4%	11.2%	9.5%	11.2%	4.8%
Asian	6.1%	3.6%	4.0%	1.1%	6.1%
American Indian/Alaska Native	2.0%	1.8%	2.0%	5.0%	1.5%
Hawaiian/Pacific Islander	3.5%	2.3%	4.6%	2.1%	3.5%

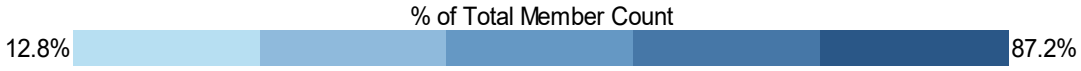


Note: These are the categories that HCA provided in Medicaid eligibility data files. The "Other" category indicates "client identified as a race other than those listed," and the "Not Provided" category is defined as "client chose not to provide."

Figure 9 shows that most Apple Health Program enrollees are not Hispanic. The Apple Health Family (Traditional Medicaid) program has the largest percentage of Hispanic enrollees at 29.9%.

Figure 9. Statewide Apple Health Enrollees by Program and Hispanic Indicator, MY2021.

Hispanic	Apple Health Adult Coverage (AH-IMC, ACA Expansion)	Apple Health Blind/Disabled (AH-IMC, AH-BD)	Apple Health Family (AH-IMC, Traditional Medicaid)	Apple Health Integrated Foster Care (AH-IFC)	State Children's Health Insurance Program (AH-IMC, CHIP)
No	83.5%	87.2%	70.1%	82.6%	75.8%
Yes	16.5%	12.8%	29.9%	17.4%	24.2%



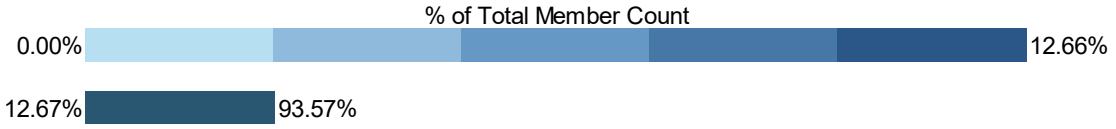
Language

Upon application for Medicaid eligibility, clients also provide information on primary spoken language. According to Apple Health eligibility data, there are 85 separate spoken languages among 2 million members. Many of these languages have very small numbers of speakers in the Apple Health population. The top 15 most common non-English languages are listed in this report (HCA provides Apple Health-related written materials in these same 15 languages).

Figure 10 shows the variation in primary spoken language by Apple Health enrollees, reflecting the 15 most common languages. Similar to the race chart, the shading in Figure 10 is different from similar charts in this report to better differentiate languages other than English. After English, Spanish/Castilian is the most common language across programs. Russian and Vietnamese are the third and fourth most common languages, depending on the program, but are still spoken by less than 1.0% of enrollees.

Figure 10. Statewide Apple Health Enrollees by Program and Spoken Language, MY2021.

Spoken Language	Apple Health Adult Coverage (AH-IMC, ACA Expansion)	Apple Health Blind/Disabled (AH-IMC, AH-BD)	Apple Health Family (AH-IMC, Traditional Medicaid)	Apple Health Integrated Foster Care (AH-IFC)	State Children's Health Insurance Program (AH-IMC, CHIP)
English	93.57%	89.14%	83.66%	90.65%	86.25%
Spanish; Castilian	3.45%	2.92%	12.66%	1.45%	10.89%
Russian	0.57%	0.49%	0.80%	0.01%	0.69%
Vietnamese	0.54%	0.33%	0.43%	0.02%	0.85%
Chinese	0.44%	0.13%	0.33%	0.01%	0.47%
Arabic	0.16%	0.45%	0.28%	0.01%	0.04%
Ukrainian	0.17%	0.13%	0.25%	0.00%	0.12%
Somali	0.14%	0.17%	0.23%	0.01%	0.00%
Korean	0.14%	0.08%	0.07%	NR	0.17%
Amharic	0.07%	0.07%	0.12%	NR	0.07%
Tigrinya	0.06%	0.07%	0.09%	0.02%	0.00%
Panjabi; Punjabi	0.07%	0.08%	0.06%	NR	0.07%
Burmese	0.05%	0.03%	0.07%	NR	0.02%
Farsi	0.06%	0.07%	0.05%	NR	0.02%
Cambodian; Khmer	0.04%	0.08%	0.04%	0.02%	0.05%
Other Language*	0.45%	5.76%	0.87%	7.80%	0.29%



**Other Language is the sum of the 70 languages not specifically reported in this table and represents approximately 1% of enrollees.*

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

Measure Performance by Apple Health Program and Eligibility Categories

Comagine Health stratified the 40 of the 42 measures reported in Figure 4 by Apple Health program and eligibility category to determine if there are statistically significant differences in measure results between them. The two RDA measures were excluded because of lack of data availability by program.

Because the different programs and eligibility categories serve different populations, this analysis can serve as a proxy for determining if there are health disparities that can be addressed.

Figure 11 lists the statewide measure results by the Apple Health programs that serve adults. Note the Apple Health Integrated Foster Care program also serves adults between ages 18 and 26, but they are not displayed in this table because the number of eligible members is too small. Measures that are specific to the pediatric population have been removed from this view. This chart reports the statewide weighted average for each measure, along with the MY2021 result for each Apple Health program. Upward arrows indicate a particular program or eligibility category performs better than the other eligibility categories. A downward arrow indicates a particular program or eligibility category performs worse than the other programs or eligibility categories. Note that the comparison is done across all programs including both children and adults.

Figure 11. Statewide Measure Results by Apple Health Program Group, MY2021.

Measures where higher is better: Statistically significant higher rate than other programs ▲; Statistically significant lower rate than other programs ▼

Measures where lower is better: Statistically significant higher rate than other programs ▲; Statistically significant lower rate than other programs ▼

			Adult Programs			Child Programs			
		Statewide Weighted Average	Apple Health Adult Coverage (ACA Expansion)	Apple Health Blind Disabled Adult (BD Adult)	Apple Health Family (Adults)	Apple Health Blind Disabled Child (BD Child)	Apple Health Family (Children)	Apple Health Foster Care (IFC)	State Children's Health Insurance Program (CHIP)
Prevention and Screening	Childhood Immunization Status (CIS), Combo 10	39%	NR	NR	NR	***	38% ▼	54% ▲	54% ▲
	Immunizations for Adolescents (IMA), Combo 2	33%	NR	NR	NR	30%	33%	31%	31%
	Lead Screening in Children (LSC)	34%	NR	NR	NR	***	34%	31%	36%
	Breast Cancer Screening (BCS)	45%	46% ▲	39% ▼	41% ▼	NR	NR	***	NR
	Cervical Cancer Screening (CCS)	54%	51% ▼	44% ▼	60% ▲	NR	NR	***	NR
	Chlamydia Screening (CHL), Ttl	50%	54% ▲	34% ▼	61% ▲	21% ▼	40% ▼	53% ▲	34% ▼
Respiratory Conditions	Asthma Medication Ratio (AMR), Ttl	65%	61% ▼	61% ▼	59% ▼	77% ▲	71% ▲	80% ▲	80% ▲
Cardiovascular Conditions	Controlling High Blood Pressure (CBP)	65%	63%	66%	61%	NR	***	***	NR
Diabetes	Comprehensive Diabetes Care (CDC), Poor HbA1c Control (Lower score is better)	37%	37%	35%	44%	NR	***	***	***
	Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0%	51%	50%	52%	45%	NR	***	***	***
	Kidney Health Eval for Patients with Diabetes (KED), 18-64 Yrs	43%	45% ▲	40% ▼	40% ▼	NR	25% ▼	25% ▼	27% ▼
Behavioral Health	Antidepressant Medication Mgmt (AMM), Effective Acute Phase	61%	62% ▲	58% ▼	59% ▼	NR	54% ▼	57%	62%
	Antidepressant Medication Mgmt (AMM), Continuation Phase	44%	45% ▲	44%	40% ▼	NR	31% ▼	35% ▼	39%
	Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	43%	NR	NR	NR	43%	42% ▼	46%	46%
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, 6-17 Yrs	72%	NR	***	NR	73%	72%	65% ▼	79% ▲
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, 18-64 Yrs	50%	48% ▼	56% ▲	48%	NR	58%	35% ▼	***
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, Ttl	54%	48% ▼	56%	48% ▼	73% ▲	70% ▲	57%	79% ▲
	Follow-Up after Hosp for Mental Illness (FUH), 7-Day FU, Ttl	36%	30% ▼	38%	29% ▼	60% ▲	48% ▲	38%	59% ▲
	Follow-Up After ED Visit for Mental Illness (FUM), 30-Day FU, Ttl	59%	52% ▼	63% ▲	52% ▼	73% ▲	71% ▲	70% ▲	76% ▲
	Follow-Up After ED Visit for Mental Illness (FUM), 7-Day FU, Ttl	46%	40% ▼	48% ▲	40% ▼	61% ▲	58% ▲	49%	63% ▲

In Figure 11, the Apple Health Blind/Disabled eligibility category was statistically significantly below the other program and eligibility categories for many of the measures, particularly those related to prevention and screening.

There are several measures reported for both the adult and child Apple Health programs where performance was statistically worse for adults and statistically better for children. You can see this with the following measures:

- Follow-Up after Hospitalization for Mental Illness (FUH), 30-Day Follow-Up, Total
- Follow-Up after Hospitalization for Mental Illness (FUH), 7-Day Follow-Up, Total
- Asthma Medicare Ratio (AMR), Total

The Statewide Children's Health Insurance Program (CHIP) and Apple Health Foster Care (IFC) enrollees perform better than the Apple Health Family (Children) category for the Child and Adolescent Well-Visit (WCV) measures. The exception is the 18-21 age band for the Apple Health Foster Care (IFC), which performs worse than the other categories. Note that this age band includes enrollees who have aged out of the foster care program.

Value-Based Purchasing (VBP) Quality Measure Performance

In 2022, the Washington Legislature updated the budget proviso, ESSB 5693 Sec.211 (37)(2022), requiring Washington HCA's contracted EQRO to annually analyze the performance of Apple Health MCOs providing services to Medicaid enrollees. Specifically, MCOs will be assessed on a set of seven performance measures, including four shared measures reported by all plans and three specific to each of the five MCOs. The following year, HCA will evaluate the MCOs on their performance on these assigned measures and reimburse them according to their achievement level. Additionally, HCA uses the VBP performance measure evaluation as part of the evaluation of effectiveness for the Washington State Medicaid Quality Strategy.

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

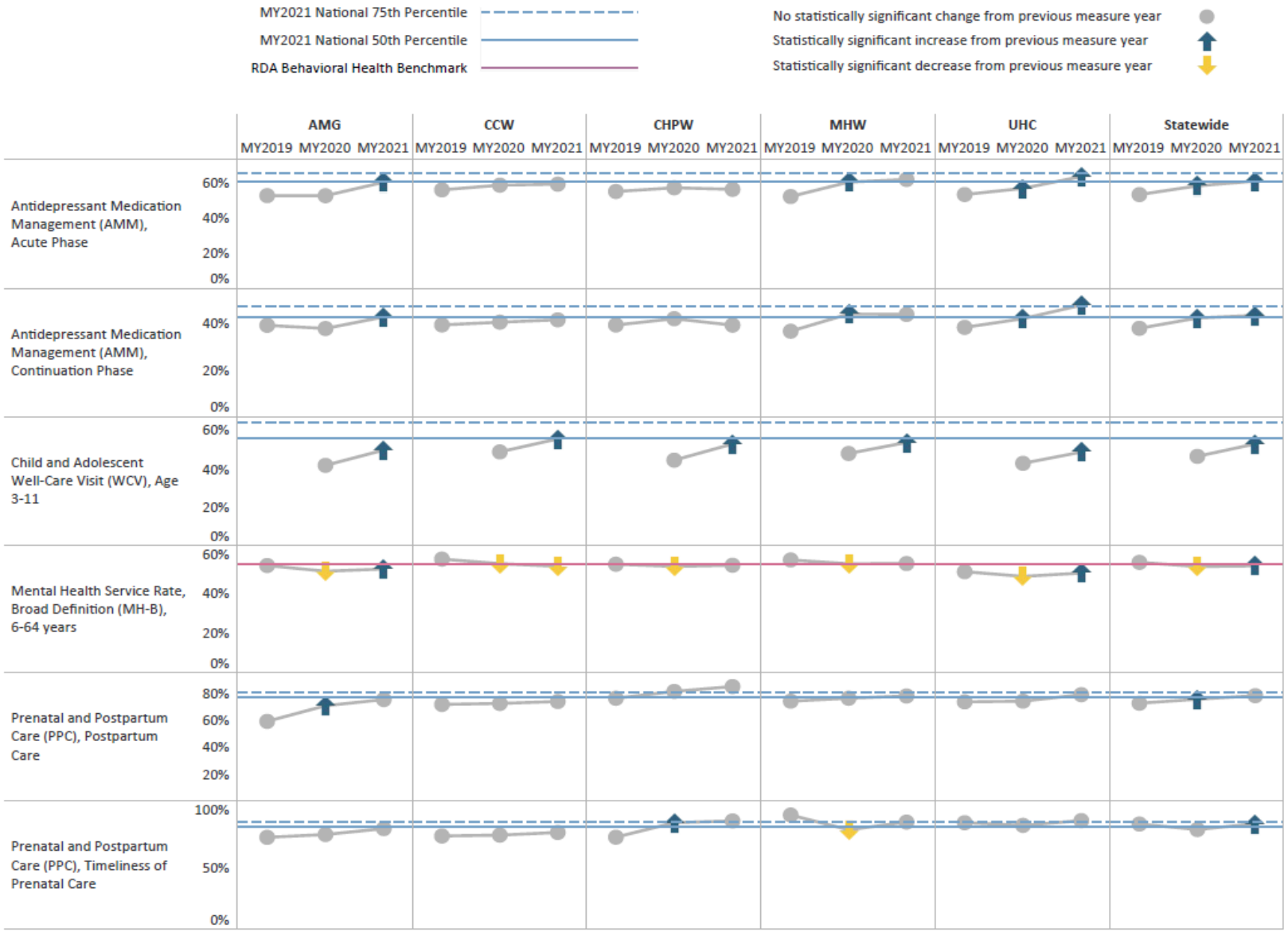
HCA contracted with Comagine Health to assess MCO performance on the measures reported by each plan and to recommend a set of priority measures that meets the bill's specific criteria and best reflects the state's quality and value priorities — balancing cost and utilization — while ensuring quality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

The measures included in this section of the report are the VBP performance measures included in the contracts for the 2021 performance period. In addition, the AH-IFC contract includes seven VBP measures that are included in this report. HCA has also contracted with Comagine Health for the evaluation of measure performance; this was submitted to HCA as a separate deliverable in October 2022.

The following charts (Figures 12–14) show the three-year trend (MY2019 through MY2021) in performance for these measures by MCO and for the statewide weighted average for each measure. In these charts:

- The blue dashed line shows the MY2021 national 75th percentile for HEDIS measures; the solid blue line shows the MY2021 national 50th percentile.
- The solid red line shows the benchmark for the RDA measures, which is the second highest performing MCO in MY2020.
- The arrows indicate statistically significant changes in the year-over-year performance of the measures (blue arrows indicate increases while yellow indicate decreases; see keys with each chart for more).
- Gray circles indicate there was no statistically significant change for that measure year.

Figure 12. VBP Performance for MY2019 through MY2021; IMC Shared Measures.



VBP Performance – IMC Shared Measures

Figure 12 reports the VPB performance for the four AH-IMC shared measures. Note the Antidepressant Medication Management (AMM) and Prenatal and Postpartum Care (PPC) measures have two measure indicators that are reported separately in the chart.

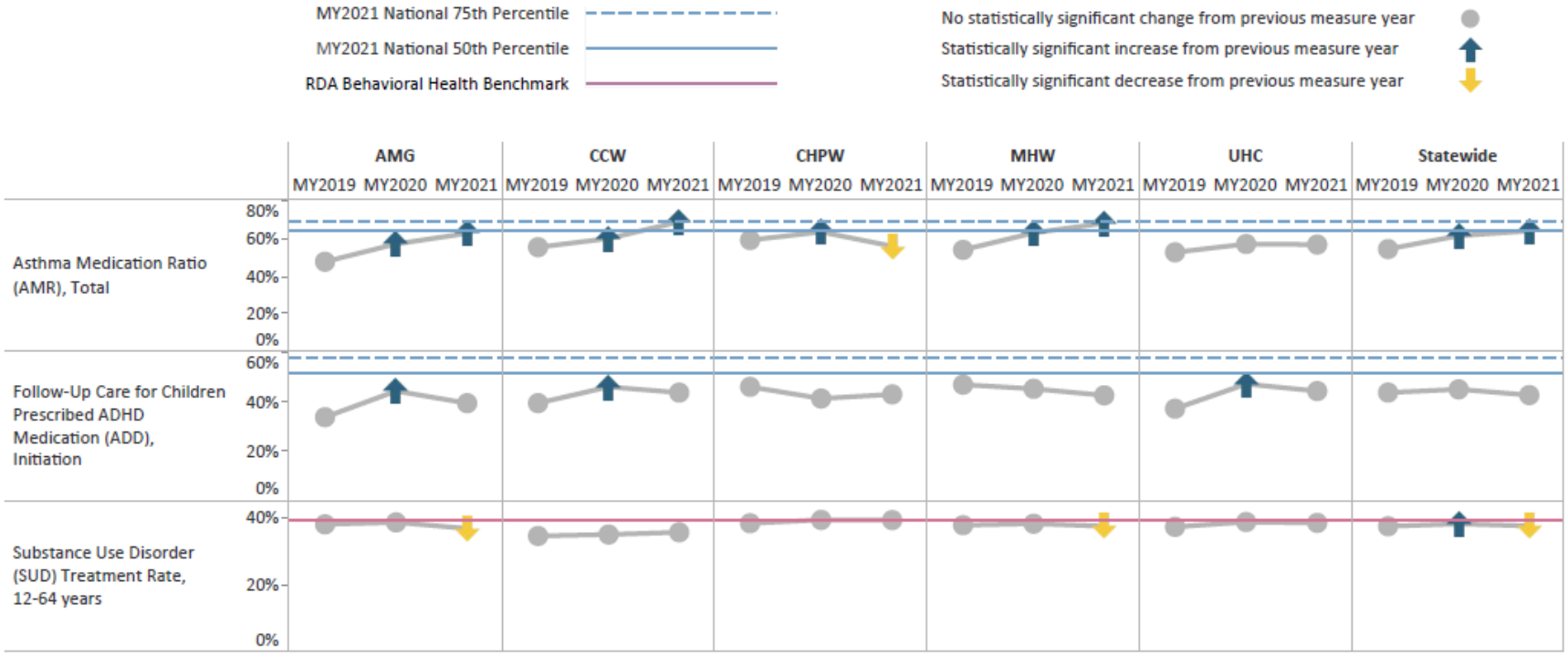
Here are the results by measure:

- **Antidepressant Medication Management (AMM), Acute Phase:** On a statewide basis, this measure has significantly improved for the last two years. (MY2019–MY2020 and MY2020–MY2021). The statewide rate is above the national 50th percentile, but still below the national 75th percentile. UHC has significantly improved for the last two years. UHC also has the best performance for MY2021 and is above the national 75th percentile. AMG significantly improved between MY2020 and MY2021, but is still below the national 50th percentile for MY2021.
- **Antidepressant Medication Management (AMM), Continuation Phase:** The results for the Continuation Phase are the same as the Acute Phase.
- **Child and Adolescent Well-Care Visit (WCV), Age 3-11:** There was a statistically significant improvement for the measure across all MCOs and statewide between MY2020 and MY2021. CCW is at the national 50th percentile; all other MCOs and the statewide weighted rate are below the national 50th percentile.
- **Mental Health Service Rate, Broad Definition (MH-B), 6-64 Years:** All of the MCOs and the statewide weighted average for the measure significantly declined between MY2019 and MY2020, likely due to the impact of the COVID-19 pandemic. There was a statistically significant improvement for the statewide weighted rate, AMG and UHC between MY2020 and MY2021. There was a statistically significant decrease for CCW for the same time period. Note that although MY2021 rates improved over MY2020 for most MCOs, they are still below MY2019 rates. The MY2021 rates are below the benchmark for the statewide weighted rate in all of the MCOs except MHW; MHW is at the benchmark.
- **Prenatal and Postpartum Care (PPC), Postpartum Care**: There was no statistically significant change between MY2020 and MY2021 for the measure for either the statewide weighted rate or the MCOs. The statewide weighted rate is above the national 50th percentile but below the national 75th percentile. CHPW has the best performance of all of the MCOs for MY2021, performing above the national 75th percentile for the Postpartum Care measure.
- **Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care:** The statewide rate for the Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care measure significantly improved between MY2020 and MY2021. There was no change in performance for an individual MCO for Timeliness of Prenatal Care. The statewide weighted rate is at the national 50th percentile for Timeliness of Prenatal Care. CHPW has the best performance of all of the MCOs for MY2021, performing at the national 75th percentile. CCW has the lowest performance for MY2021, performing below the national 50th percentile for the Timeliness of Prenatal Care.

VBP Performance – IMC Plan-Specific Measures

Figure 13 reports the VPB performance for the three AH-IMC plan-specific measures.

Figure 13. VBP Performance for MY2019 through MY2021; IMC Plan-Specific Measures.



Here are the results by measure:

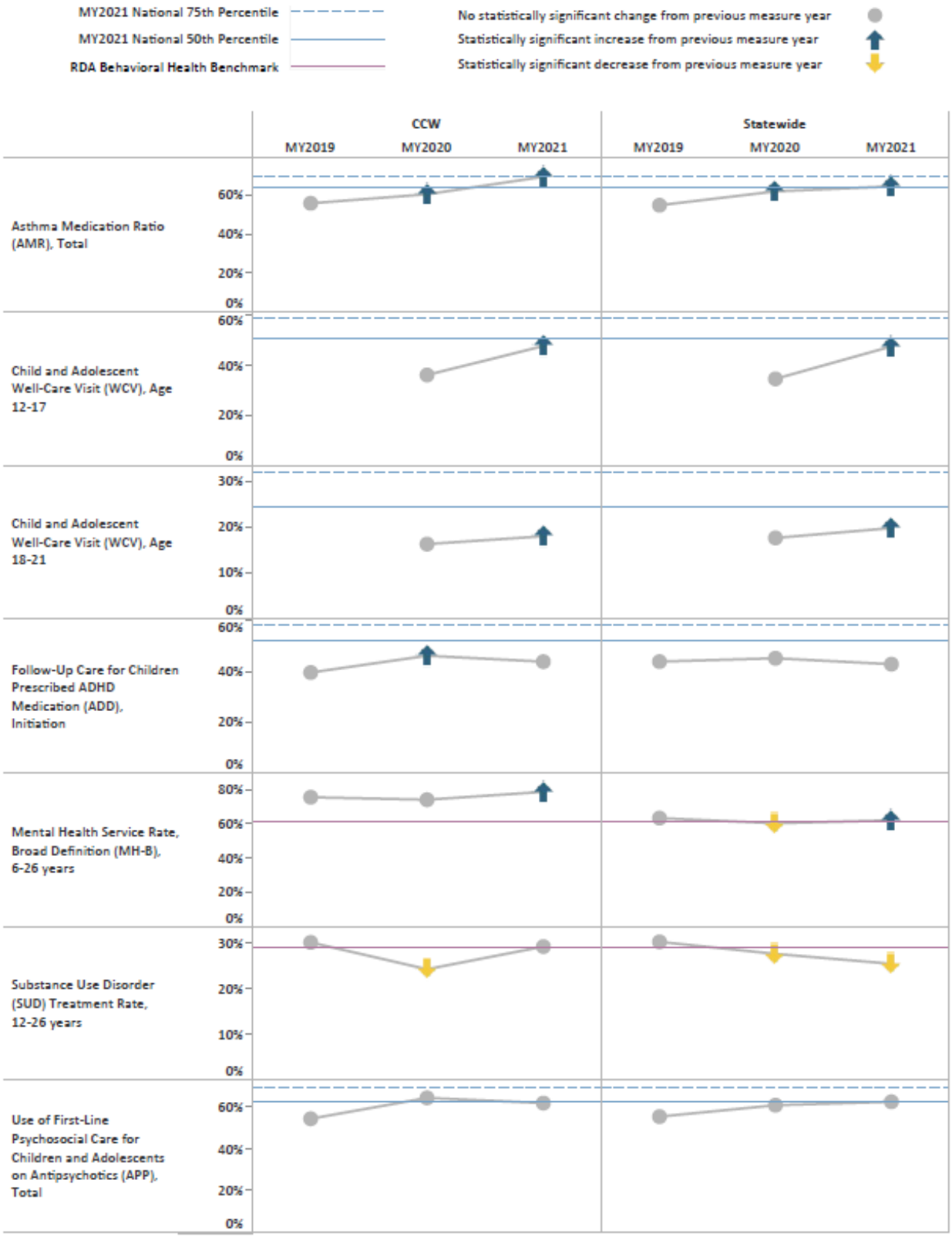
- **Asthma Medication Ratio (AMR)**: On a statewide basis, this measure has significantly improved for the last two years (MY2019-MY2020 and MY2020-MY2021). AMG, CCW and MHW have also significantly improved for the last two years. CHPW had a statistically significant improvement between MY2019 and MY2020, and then had a significantly significant decrease in performance between MY2020 and MY2021. There has been no statistically significant change for UHC. The MY2021 performance for the statewide weighted rate and AMG is at the national 50th percentile. For MY2021, CCW and MHW are both at the national 75th percentile; CHPW and UHC are below the national 50th percentile.

- **Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation:** There has been no significant change to the statewide weighted rate. There was a statistically significant improvement in performance for AMG, CCW and UHC between MY2019 and MY2020, but no significant change for any of the five MCOs between MY2020 and MY2021. The statewide weighted rate and all MCOs are below the national 50th percentile for MY2021.
- **Substance Use Disorder (SUD) Treatment Rate, 12-64 Years:** The statewide weighted rate for the measure improved significantly between MY2019 and MY2020, but then had a statistically significant decline between MY2020 and MY2021. AMG and MHW also had a statistically significant decline between MY2020 and MY2021. The statewide weighted rate and AMG, CCW and MHW are below the benchmark for MY2021; CHPW and UHC are at the benchmark.

VBP Performance – IFC Measures

Figure 14 reports the VPB performance for the AH-IFC measures. Note that CCW is contracted to provide services for the foster care population therefore the other MCOs are not included in this chart. For the HEDIS measures, CCW is evaluated using the measures they report for their overall population. The CCW rates for the two RDA measures (MH-B and SUD) are specific to their AH-AFC population.

Figure 14. VBP Performance for MY2019 through MY2021; IFC Measures.



Here are the results by measure:

- **Asthma Medication Ratio (AMR):** This measure is also a plan-specific VBP performance measure for the AH-IMC contract. On a statewide basis, this measure has significantly improved for the last two years (MY2019–MY2020 and MY2020–MY2021). CCW has also significantly improved for the last two years. The MY2021 performance for the statewide weighted rate is at the national 50th percentile; CCW is at the national 75th percentile.
- **Child and Adolescent Well-Care Visit (WCV), Age 12-17:** For both the statewide weighted rate and CCW, there was a statistically significant improvement for this measure. For MY2021, both the statewide rated rate and CCW's rate are below the national 50th percentile.
- **Child and Adolescent Well-Care Visit (WCV), Age 18-21:** The results for the Age 18-21 are the similar to Age 12-17. There was statistically significant improvement for the statewide rate and CCW, and both are below the national 50th percentile.
- **Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation:** There has been no significant change to the statewide weighted rate for this measure. There was a statistically significant improvement in performance for CCW, but no significant change between MY2020 and MY2021. The MY2021 performance for the statewide weighted rate and CCW's rate is below the national 50th percentile for MY2021.
- **Mental Health Service Rate, Broad Definition (MH-B), 6-26 Years:** The statewide weighted average for the measure significantly declined between MY2019 and MY2020, likely due to the impact of the COVID-19 pandemic. There was a statistically significant improvement for the statewide weighted rate between MY2020 and MY2021. There was no statistically significant change for CCW's foster care population between MY2019 and MY2020, followed by a statistically significant improvement between MY2020 and MY2021. The MY2021 rates are above the benchmark for the statewide weighted rate and the CCW foster care population.
- **Substance Use Disorder (SUD) Treatment Rate, 12-26 Years:** The statewide weighted rate for the measure has significantly decreased for the last two years (MY2019–MY2020 and MY2020–MY2021). There was a statistically significant decrease for CCW's foster care population between MY2019 and MY2020, followed by no statistically significant change between MY2020 and MY2021. The MY2021 rates are below the benchmark for the statewide weighted rate and at the benchmark for the CCW foster care population.
- **Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), Total:** There has been no statistically significant changes for the measure for either the statewide weighted rate or for CCW. Both the statewide weighted rate and CCW's rate are at the national 50th percentile.

Health Equity Analysis

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

These are some basic concepts of health equity:

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

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

Challenges of Small Numbers with Health Equity Data

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

The issue with small denominators is particularly problematic for the hybrid measures. Hybrid measure results are based on a sampling, which is typically around 400 members for each MCO. Once that data is stratified by the various demographic categories included in this analysis, the denominators often are too small for a reasonable analysis.

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

Table 2. Denominator Size by Spoken Language for Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care.

Spoken Language	Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care	
	Denominator †	Rate‡
Amharic	5	***
Arabic	0	*NR*
Burmese	2	***
Cambodian; Khmer	0	*NR*
Chinese	3	***
English	1,855	*86%*
Farsi	0	*NR*
Korean	0	*NR*
Laotian	0	*NR*
Panjabi; Punjabi	0	*NR*
Russian	4	***
Somali	4	***
Spanish; Castilian	87	*95%*
Tigrinya	7	***
Ukrainian	4	***
Vietnamese	6	***
Other Language*	79	*89%*

**Other Language is the sum of the 70 languages not specifically reported in this table and represents approximately 1% of enrollees.*

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

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

Comagine Health approached the health equity analysis by including as many categories as possible in comparison to detect statistically significant differences among groups. The statewide view of selected measures by race/ethnicity was fairly robust, allowing comparisons across most categories. Comagine Health provided two separate analyses by language. The first compares English, Spanish; Castilian and all other languages for the 40 key HEDIS measures. The second compares across the 16 language categories listed in Table 1 for the measures that had at least 10 languages that had sufficient denominators for analysis.

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

Analysis by Race/Ethnicity

This section focuses on measure results stratified by race and ethnicity. Figure 15 displays the results of this analysis. The first column displays the statewide average; the results by race are to the right. Downward arrows indicate the measure results for a particular race are statistically significantly lower than the statewide average; upward pointing arrows indicate the measure results are statistically significantly higher than the statewide average. This chart illustrates the variation that can be seen by race. However, due to the small number of measures presented, caution should be taken to not over-interpret these results as a reflection on all health care received by members of each racial group.

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

Figure 15. Statewide Variation in Rates by Race/Ethnicity, MY2021.*

Measures where higher is better:
- Statistically significant higher rate than other races/ethnicities ▲
- Statistically significant lower rate than other races/ethniciities ▼

Measures where lower is better:
- Statistically significant higher rate than other races/ethnicities ▲
- Statistically significant lower rate than other races/ethnicities ▼

		American Indian/ Alaska Native	Asian	Black	Hawaiian/ Pacific Islander	Hispanic	White	Not Provided/ Other	MY2021 Statewide Weighted Average
Prevention and Screening	Breast Cancer Screening (BCS)	38% ▼	55% ▲	40% ▼	47%	55% ▲	42% ▼	46%	45%
	Cervical Cancer Screening (CCS)	57%	58%	56%	45%	61% ▲	51% ▼	44%	54%
	Childhood Immunization Status (CIS), Combo 10	* * *	62% ▲	26% ▼	35%	44% ▲	35% ▼	47% ▲	39%
	Chlamydia Screening (CHL), Ttl	52%	48% ▼	59% ▲	52%	54% ▲	47% ▼	49% ▼	50%
	Lead Screening in Children (LSC)	* * *	42%	33%	35%	38% ▲	29% ▼	36%	30%
Respiratory Conditions	Asthma Medication Ratio (AMR), Ttl	63%	72% ▲	61% ▼	70%	67% ▲	64% ▼	70% ▲	55%
Cardiovascular Conditions	Controlling High Blood Pressure (CBP)	* * *	71%	60%	68%	67%	63%	61%	59%
Diabetes	Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0%	50%	56%	57%	51%	50%	49%	46%	51%
	Comprehensive Diabetes Care (CDC), Poor HbA1c Control (Lower score is better)	37%	26% ▼	35%	41%	38%	39%	43%	35%
	Kidney Health Eval for Patients with Diabetes (KED), 18-64 Yrs	40% ▼	52% ▲	43%	46% ▲	48% ▲	41% ▼	47% ▲	43%
Behavioral Health	Antidepressant Medication Mgmt (AMM), Continuation Phase	42%	44%	35% ▼	45%	37% ▼	46% ▲	47% ▲	38%
	Antidepressant Medication Mgmt (AMM), Effective Acute Phase	58%	60%	51% ▼	61%	56% ▼	64% ▲	63%	54%
	Follow-Up After ED Visit for Alcohol & Other Drug Abuse Dependencies (FUA), 7-Day FU, Ttl	19%	14% ▼	12% ▼	11% ▼	18% ▼	21% ▲	17%	17%
	Follow-Up After ED Visit for Alcohol & Other Drug Abuse Dependencies (FUA), 30-Day FU, 13-17 Yrs	* * *	* * *	* * *	* * *	26% ▲	17%	* * *	15%
	Follow-Up After ED Visit for Alcohol & Other Drug Abuse Dependencies (FUA), 30-Day FU, Ttl	29%	21% ▼	18% ▼	20% ▼	27%	31% ▲	26%	26%
	Follow-Up After ED Visit for Mental Illness (FUM), 7-Day FU, Ttl	47%	38% ▼	40% ▼	41%	45%	48% ▲	44%	38%
	Follow-Up After ED Visit for Mental Illness (FUM), 30-Day FU, Ttl	57%	56%	50% ▼	54%	58%	61% ▲	59%	51%
	Follow-Up After High Intensity Care for SUD (FUI): 7-Day FU, Ttl	38%	35%	33% ▼	44%	36%	38% ▲	33%	37%
	Follow-Up After High Intensity Care for SUD (FUI): 30-Day FU, Ttl	60%	52%	51% ▼	62%	54% ▼	59% ▲	51% ▼	56%
	Follow-Up after Hosp for Mental Illness (FUH), 7-Day FU, Ttl	33%	40%	30% ▼	33%	36%	38% ▲	32% ▼	32%
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, 6-17 Yrs	79%	72%	67%	* * *	69%	74% ▲	65%	63%

Measures where higher is better:
Statistically significant higher rate than other races/ethnicities ▲
Statistically significant lower rate than other races/ethniciities ▼

Measures where lower is better:
Statistically significant higher rate than other races/ethnicities ▲
Statistically significant lower rate than other races/ethnicities ▼

		American Indian/ Alaska Native	Asian	Black	Hawaiian/ Pacific Islander	Hispanic	White	Not Provided/ Other	MY2021 Statewide Weighted Average
Behavioral Health	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, 18-64 Yrs	49%	51%	44% ▼	48%	50%	53% ▲	46% ▼	45%
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, Ttl	56%	55%	47% ▼	51%	56%	57% ▲	50% ▼	48%
	Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	44%	41%	40%	36%	41%	44% ▲	42%	43%
	Mental Health Svc Rate, Broad (MH-B), 6-64 Yrs	57% ▲	52% ▼	53% ▼	51% ▼	54%	55% ▲	54%	54%
	Pharmacotherapy for Opioid Use Disorder (POD), 16-64 Yrs	11%	15%	10% ▼	16%	10% ▼	14% ▲	13%	13%
	Substance Use Disorder (SUD) Treat Rate, 12-64 Yrs	45% ▲	31% ▼	31% ▼	31% ▼	34% ▼	40% ▲	30% ▼	38%
Overuse/App..	Use of Opioids at High Dosage (HDO) (Lower score is better)	4%	3% ▼	5%	5%	3% ▼	6% ▲	7%	5%
Access/ Availability of Care	Adults' Access to Preventive/Ambulatory Health Services (AAP), Ttl	75% ▲	70% ▼	70% ▼	64% ▼	74% ▲	72% ▲	69% ▼	72%
	I&E of Alcohol & Other Drug Dependence Treat (IET), Ttl: Engagement of AOD Treat: Ttl	17%	13%	12% ▼	12% ▼	14% ▼	16% ▲	13% ▼	15%
	I&E of Alcohol & Other Drug Dependence Treat (IET), Ttl: Initiation of AOD Treat: 13-17 Yrs	42%	* * *	33%	* * *	34% ▼	46% ▲	40%	31%
	I&E of Alcohol & Other Drug Dependence Treat (IET), Ttl: Initiation of AOD Treat: Ttl	47%	40% ▼	43% ▼	45%	41% ▼	47% ▲	45%	42%
	Prenatal & Postpartum Care (PPC), Postpartum Care	75%	88%	80%	64% ▼	82% ▲	78%	81%	74%
	Prenatal & Postpartum Care (PPC), Timeliness of Prenatal Care	84%	90%	86%	81%	88%	85%	89%	83%
	Use of First-Line Psychosocial Care for Children & Adolescents on Antipsychotics (APP), Ttl	76%	* * *	70%	* * *	59%	64%	52% ▼	56%
Utilization	Child & Adolescent Well-Care Visit (WCV), Age 3-11	50% ▼	56% ▲	51% ▼	45% ▼	59%	50% ▼	54% ▲	47%
	Child & Adolescent Well-Care Visit (WCV), Age 12-17	44% ▼	50% ▲	48%	42% ▼	53%	43%	48%	35%
	Child & Adolescent Well-Care Visit (WCV), Age 18-21	17% ▼	26% ▲	20%	18% ▼	22% ▲	18% ▼	20%	18%
	Child & Adolescent Well-Care Visit (WCV), Ttl	43% ▼	49% ▲	45% ▼	40% ▼	51%	42%	49% ▲	39%
	Well-Child Visits in the First 30 Mnths of Life (W30), 15-30 Mnths	58% ▼	72% ▲	57% ▼	53% ▼	69% ▲	63% ▼	65%	64%
	Well-Child Visits in the First 30 Mnths of Life (W30), First 15 Mnths	54%	66% ▲	46% ▼	49% ▼	57% ▲	53% ▼	54%	54%

**The "Not Provided" category means a member's race was not provided by the member at the time of enrollment. The "Other" category means that a member selected "Other" as their race at the time of enrollment. The two categories were combined in this report to be consistent with RDA reporting. This group comprises approximately 20% of Apple Health enrollment.*

Click here to return to key observations.

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

Prevention and Screening – The results for the Prevention and Screening domain are similar to the results from the 2021 Comparative Analysis Report. There was notable variation in performance by race/ethnicity category:

- Members who identify as white members were consistently below the other race/ethnicity categories for all of the preventive screening measures presented in Figure 15.
- Members who identify as Black perform below the other race/ethnicity categories on several of the prevention and screening measures. The exception is Chlamydia Screenings (CHL), where they are significantly above the other race/ethnicity categories.
- Hispanic members were statistically significantly above the other race/ethnicity categories for the prevention and screening measures that are included in this report.

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

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

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

- The improvement in mental health and substance use disorders was due primarily to improvement in members identifying as white.
- Measure performance for members who identify as Black was statistically significantly below the other race/ethnicity categories.

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

Prenatal and Postpartum Care (PPC) – In the MY2020 analysis completed last year for the 2021 Comparative Report, it was noted that Hawaiian/Pacific Islanders were statistically significantly below the other race/ethnicity categories for the Timeliness of Prenatal Care measure. For MY2021, there are no longer any statistically significant disparities noted for any of the race/ethnicity categories.

The MY2020 analysis also showed the Hawaiian/Pacific Islanders were statistically significantly below the other race/ethnicity categories for the Postpartum Care measure. This result is the same for MY2021. In addition, Hispanic members are statistically above the other race/ethnicity categories for this measure.

Well-Child Visits in the First 30 Months of Life (W30) and Child and Adolescent Well-Care Visit (WCV) – Asian members were significantly above other race/ethnicity categories across all age bands. Hispanic members were statistically above the other race/ethnicity categories for the W30 measure, and for the

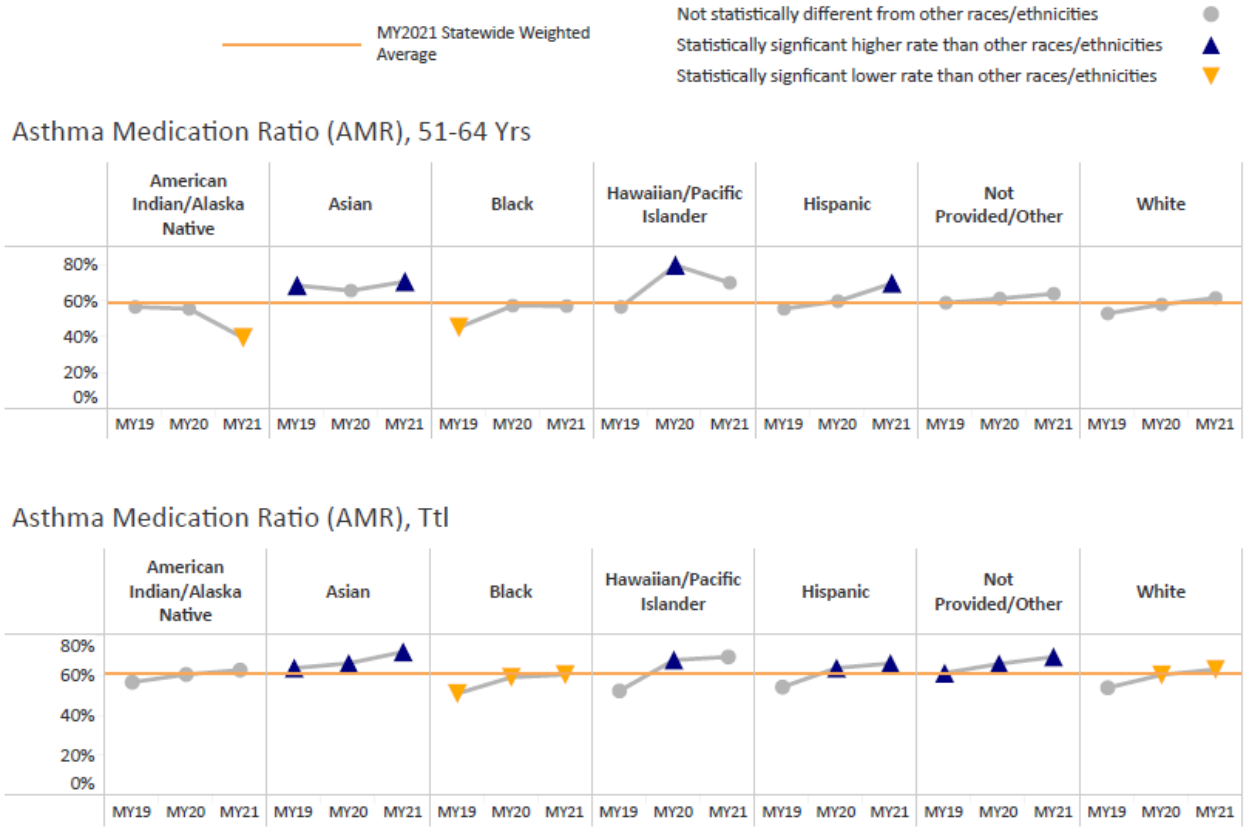
WCV measure for Age 18-21. The remaining race/ethnicity categories were statistically below Asian and Hispanic members for many of the age bands included in these measures.

Analysis by Race/Ethnicity, Three-Year Trend

The last section focused on differences among the race/ethnicity categories using data for MY2021. There was interest in knowing if these disparities have been persistent for previous years. This section of the report shows the three-year trend for selected measures stratified by race/ethnicity. Appendix E includes this information for all measures.

Figure 16 displays the results for two of the Asthma Medication Ratio (AMR) indicators. The orange horizontal line represents the MY2021 statewide weighted average.

Figure 16. Asthma Medication Ratio (AMR), Variation in Rates by Race/Ethnicity, Three-Year Trend.*



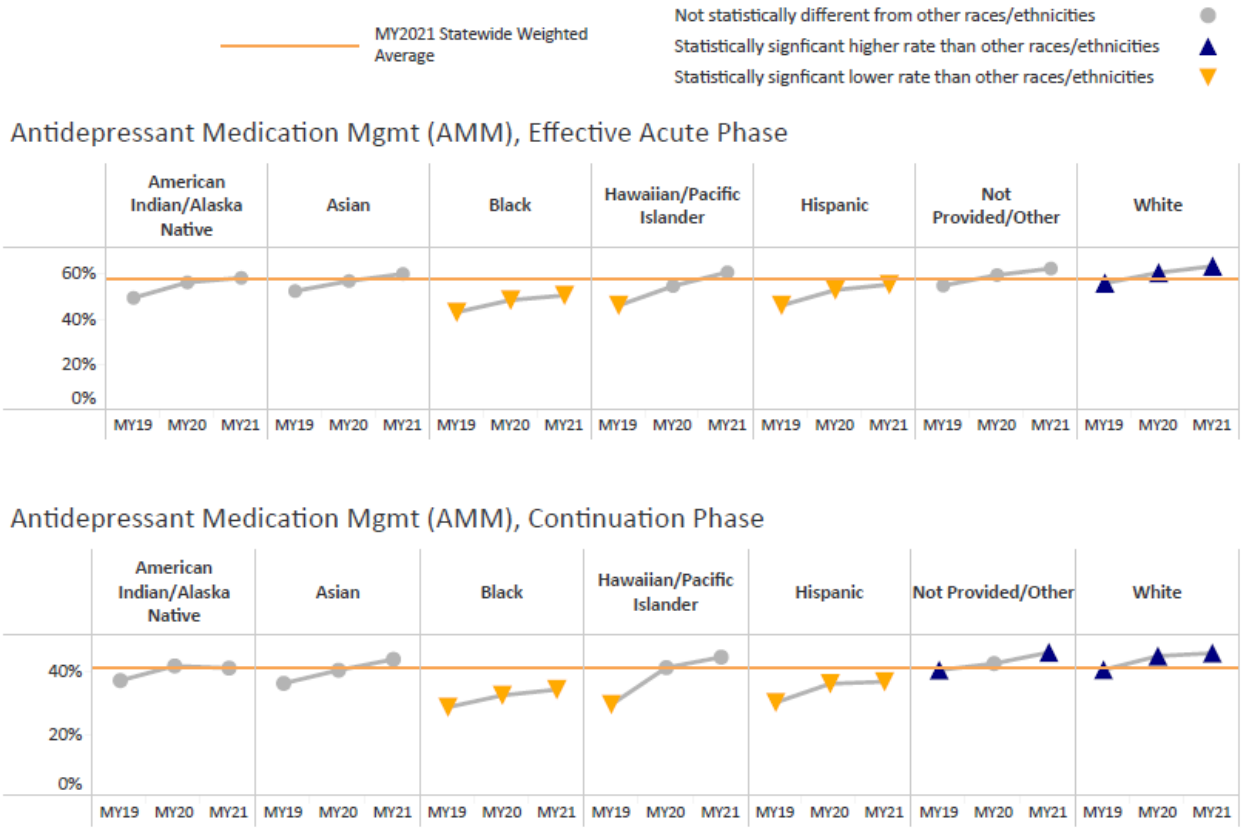
**The "Not Provided" category means a member's race was not provided by the member at the time of enrollment. The "Other" category means that a member selected "Other" as their race at the time of enrollment. The two categories were combined in this report to be consistent with RDA reporting. This group comprises approximately 20% of Apple Health enrollment.*

The total measure indicator performance was better for Asian members and worse for Black members for all three years reported. Hispanics were not statistically different than the other race/ethnicity groups in MY2019, but had better measure performance than the other groups in MY2020 and MY2021.

Measure performance for white members was not statistically significantly different than other groups in MY2019, but was worse than other groups in MY2020 and MY2021.

Figure 17 displays the results for two of the Antidepressant Medication Management (AMM) measure indicators.

Figure 17. Antidepressant Medication Management (AMM), Variation in Rates by Race/Ethnicity, Three-Year Trend.

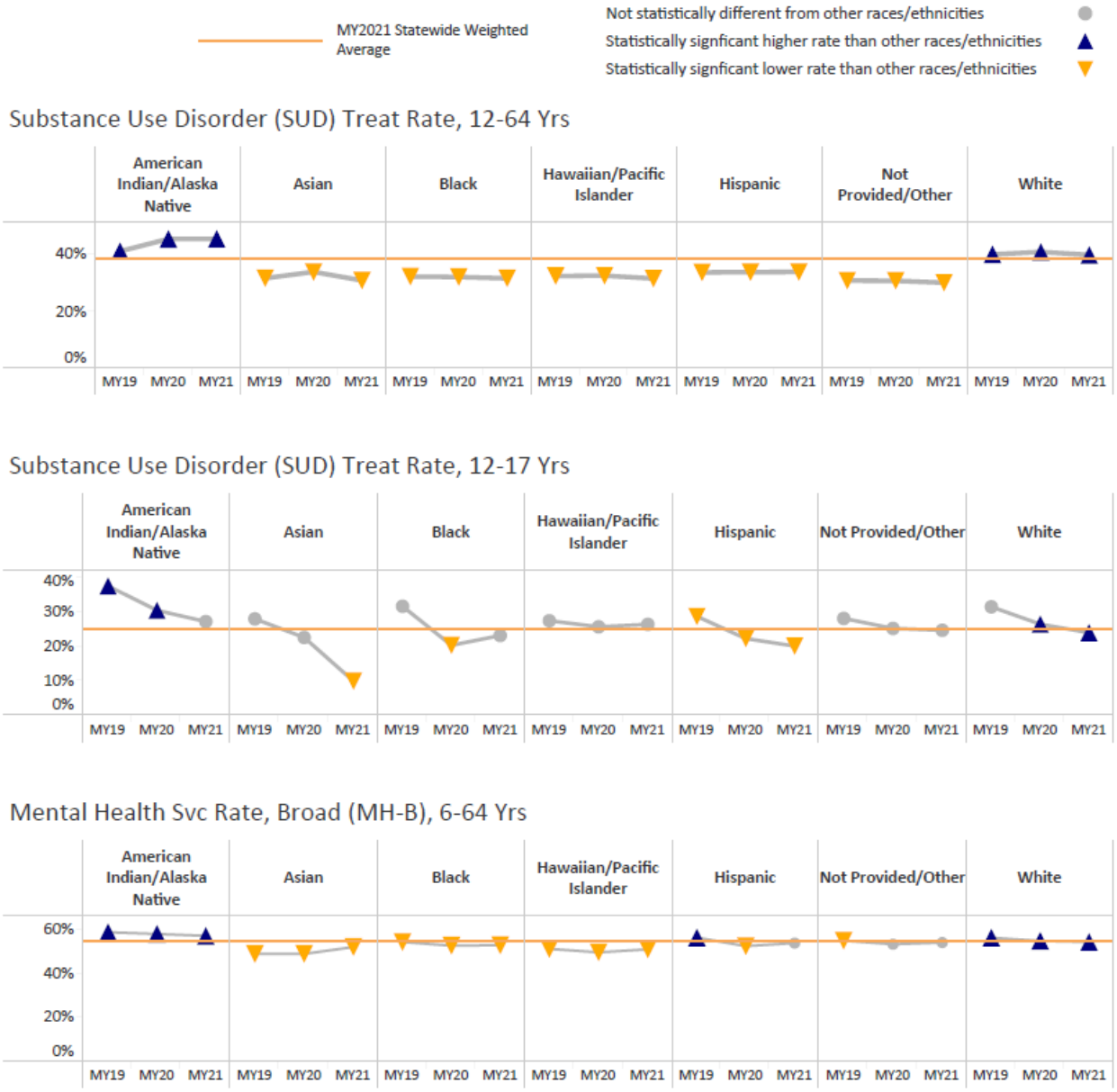


**The "Not Provided" category means a member's race was not provided by the member at the time of enrollment. The "Other" category means that a member selected "Other" as their race at the time of enrollment. The two categories were combined in this report to be consistent with RDA reporting. This group comprises approximately 20% of Apple Health enrollment.*

For both the Effective Acute and Continuation Phase measures, performance was statistically significantly lower for Black and Hispanic members than for other race/ethnicity categories for all three years. Performance was statistically significantly higher for white members than other race/ethnicity categories for the same time period.

Figure 18 displays the results for two of the Substance Use Disorder (SUD) Treatment Rate measure indicators and one indicator for the Mental Health Service Rate, Broad Definition (MH-B) measure.

Figure 18. Substance Use Disorder (SUD) Treatment Rate and Mental Health Service Rate, Broad Definition (MH-B), Variation in Rates by Race/Ethnicity, Three-Year Trend.*



**The "Not Provided" category means a member's race was not provided by the member at the time of enrollment. The "Other" category means that a member selected "Other" as their race at the time of enrollment. The two categories were combined in this report to be consistent with RDA reporting. This group comprises approximately 20% of Apple Health enrollment.*

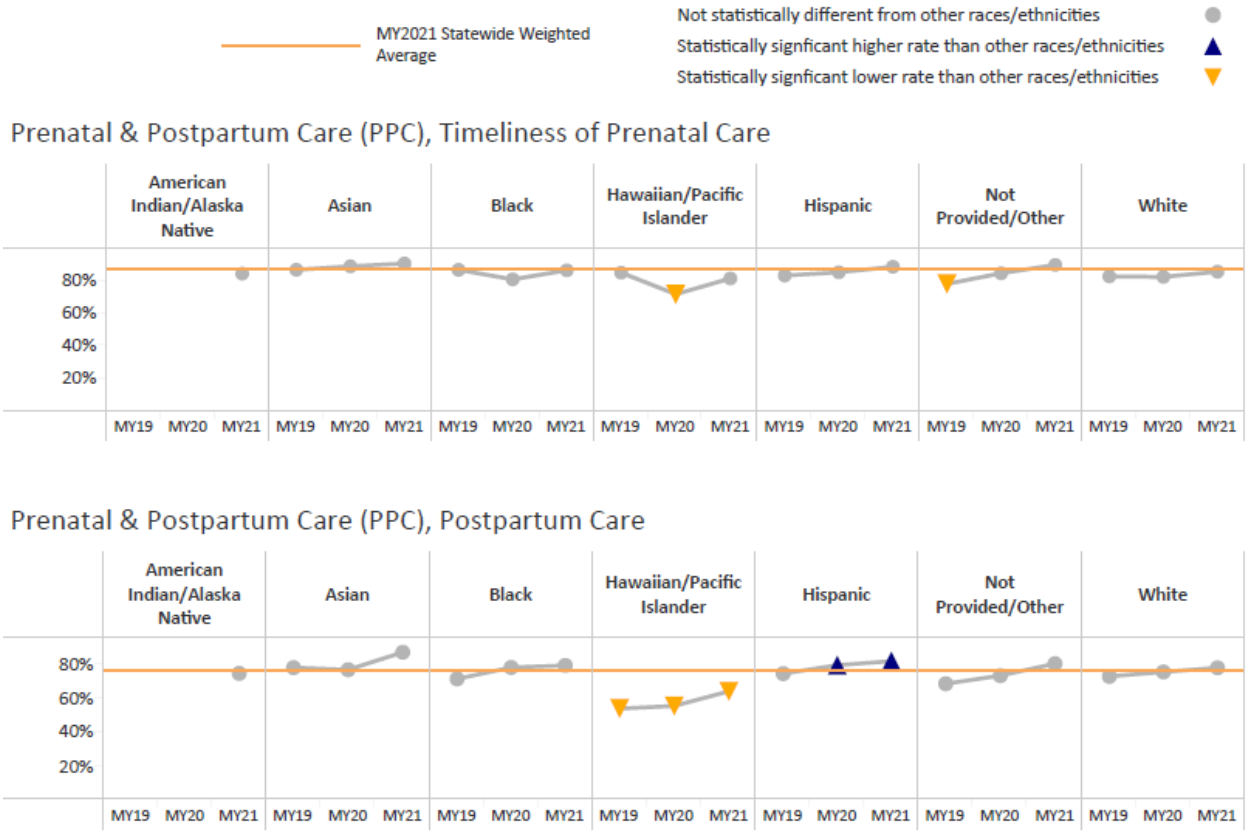
Statistically significant differences between the race/ethnicity groups were consistent across all three years for the Substance Use Disorder (SUD) Treatment Rate, 12-64 Years and the Mental Health Service Rate, Broad Definition (MH-B), 6-64 Years measures.

It is interesting to note that racial disparities are not as prevalent for the adolescent age band for the Substance Use Disorder (SUD) Treatment Rate measure. Hispanic members are statistically significantly below the other race/ethnicity groups for all three years, while white members were statistically

significantly above for the same time periods. Differences are less noticeable and not consistent across the three-year trend for other race/ethnicity categories. This observation comes with the caveat that this may be a function of smaller numbers reported for this measure with the adolescent age bands.

Figure 19 displays the results for the Prenatal and Postpartum Care (PPC) measure for both the Timeliness of Prenatal Care and Postpartum Care measures.

Figure 19. Prenatal and Postpartum Care (PPC), Variation in Rates by Race/Ethnicity, Three-Year Trend.*



**The "Not Provided" category means a member's race was not provided by the member at the time of enrollment. The "Other" category means that a member selected "Other" as their race at the time of enrollment. The two categories were combined in this report to be consistent with RDA reporting. This group comprises approximately 20% of Apple Health enrollment.*

Click here to return to key observations.

Postpartum Care measure performance was statistically significantly lower for Hawaiian/Pacific Islander members than the other race/ethnicity groups for all three years. However, their results are trending upwards. Measure performance was statistically significantly higher for Hispanic members than the other race/ethnicity categories for MY2020 and MY2021.

Analysis by Spoken Language

As noted in the introduction to the health equity section of this report, analysis of measure results by spoken language can be limited due to small denominators that must be suppressed. Comagine Health and our partners at the Washington HCA have discussed various approaches for overcoming this obstacle.

For this year's report, we are taking two different approaches to analyzing measures by spoken language. The first approach recognizes that there are typically sufficient denominators for English and Spanish speakers. HCA tracks 85 separate spoken languages in their enrollment data. The non-English, non-Spanish-speaking members account for approximately 4% of all enrollees. The first section of the language analysis is a comparison of English, Spanish and the remaining languages grouped into an Other Language category.

The second approach is to analyze selected measures across a broader list of spoken languages. Currently, HCA provides written materials in 15 languages to Apple Health enrollees. This second analysis provides measure results for all 15 of these languages. The 70 remaining languages are grouped into an Other Language category and account for approximately 1% of all enrollees.

For future reports, we are exploring the possibility of grouping similar languages into broader categories in order to have more robust data for reporting. This approach must be considered carefully to prevent obscuring the experience of unique population groups when they are aggregated with others.

Figure 20 reports the MY2021 results of the key measures for English, Spanish and Other Languages.

Figure 20. Statewide Variation in Rates by Spoken Language, MY2021.*

Measures where higher is better:
Statistically significant higher rate than other spoken languages ▲
Statistically significant lower rate than other spoken languages ▼

Measures where lower is better:
Statistically significant higher rate than other spoken languages ▲
Statistically significant lower rate than other spoken languages ▼

		English	Spanish; Castilian	Other Language	Statewide Weighted Average
Prevention and Screening	Breast Cancer Screening (BCS)	44% ▼	62% ▲	48% ▲	45%
	Cervical Cancer Screening (CCS)	52% ▼	73% ▲	61%	54%
	Childhood Immunization Status (CIS), Combo 10	37% ▼	58% ▲	44%	39%
	Chlamydia Screening (CHL), Ttl	51% ▲	48% ▼	50%	50%
	Immunizations for Adolescents (IMA), Combo 2	28% ▼	51% ▲	25%	33%
	Lead Screening in Children (LSC)	30% ▼	56% ▲	41%	34%
Respiratory Conditions	Asthma Medication Ratio (AMR), Ttl	64% ▼	71% ▲	68%	65%
Cardiovascular Conditions	Controlling High Blood Pressure (CBP)	64%	68%	64%	65%
Diabetes	Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0%	50%	50%	61%	51%
	Comprehensive Diabetes Care (CDC), Poor HbA1c Control (Lower score is better)	38% ▲	33%	30%	37%
	Kidney Health Eval for Patients with Diabetes (KED), 18-64 Yrs	42% ▼	56% ▲	52% ▲	43%
Behavioral Health	Antidepressant Medication Mgmt (AMM), Continuation Phase	44% ▲	34% ▼	42%	44%
	Antidepressant Medication Mgmt (AMM), Effective Acute Phase	61% ▲	53% ▼	59%	61%
	Follow-Up After ED Visit for Alcohol & Other Drug Abuse Dependencies (FUA), 7-Day FU, Ttl	20% ▲	8% ▼	17%	19%
	Follow-Up After ED Visit for Alcohol & Other Drug Abuse Dependencies (FUA), 30-Day FU, 13-17 Yrs	19%	19%	* * *	20%
	Follow-Up After ED Visit for Alcohol & Other Drug Abuse Dependencies (FUA), 30-Day FU, Ttl	29% ▲	14% ▼	27%	29%
	Follow-Up After ED Visit for Mental Illness (FUM), 7-Day FU, Ttl	46%	49%	44%	46%
	Follow-Up After ED Visit for Mental Illness (FUM), 30-Day FU, Ttl	59%	61%	61%	59%
	Follow-Up After High Intensity Care for SUD (FUI): 7-Day FU, Ttl	37%	26%	43%	37%
	Follow-Up After High Intensity Care for SUD (FUI): 30-Day FU, Ttl	57%	47%	61%	57%
	Follow-Up after Hosp for Mental Illness (FUH), 7-Day FU, Ttl	36%	47% ▲	35%	36%
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, 6-17 Yrs	72%	71%	67%	72%
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, 18-64 Yrs	51%	58%	46%	50%
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, Ttl	55%	66% ▲	50%	54%
	Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	43%	45%	49%	43%
	Pharmacotherapy for Opioid Use Disorder (POD), 16-64 Yrs	13%	* * *	17%	13%
Overuse/Appropriateness	Use of Opioids at High Dosage (HDO) (Lower score is better)	6% ▲	NR	2% ▼	5%
Access/Availability of Care	Adults' Access to Preventive/Ambulatory Health Services (AAP), Ttl	72% ▼	77% ▲	74% ▲	72%
	I&E of Alcohol & Other Drug Dependence Treat (IET), Ttl: Engagement of AOD Treat: Ttl	15% ▲	10% ▼	10% ▼	15%
	I&E of Alcohol & Other Drug Dependence Treat (IET), Ttl: Initiation of AOD Treat: 13-17 Yrs	42% ▲	27% ▼	* * *	40%
	I&E of Alcohol & Other Drug Dependence Treat (IET), Ttl: Initiation of AOD Treat: Ttl	46% ▲	33% ▼	44%	46%
	Prenatal & Postpartum Care (PPC), Postpartum Care	78% ▼	93% ▲	82%	79%
	Prenatal & Postpartum Care (PPC), Timeliness of Prenatal Care	86%	95% ▲	87%	87%
	Use of First-Line Psychosocial Care for Children & Adolescents on Antipsychotics (APP), Ttl	64% ▲	48% ▼	* * *	63%
Utilization	Child & Adolescent Well-Care Visit (WCV), Age 3-11	52% ▼	65% ▲	52% ▼	53%
	Child & Adolescent Well-Care Visit (WCV), Age 12-17	45% ▼	58% ▲	44% ▼	48%
	Child & Adolescent Well-Care Visit (WCV), Age 18-21	19% ▼	25% ▲	24% ▲	20%
	Child & Adolescent Well-Care Visit (WCV), Ttl	44% ▼	56% ▲	45% ▼	46%
	Well-Child Visits in the First 30 Mnths of Life (W30), 15-30 Mnths	63% ▼	75% ▲	62%	64%
	Well-Child Visits in the First 30 Mnths of Life (W30), First 15 Mnths	53% ▼	60% ▲	54%	54%

**Other Language is the sum of the 83 languages not specifically reported in this table and represents approximately 4% of enrollees.*

Click here to return to key observations.

Here are some noteworthy observations of the statewide results by spoken language categories.

Prevention and Screening – With the exception of the Chlamydia Screening (CHL) measure, measure performance for Spanish-speaking members was significantly higher than members who speak English or other languages for all the prevention and screening measures included in Figure 20. Measure performance among English-speaking members was significantly below the other two groups. The results for the Chlamydia Screening (CHL) measure are reversed, with statistically higher performance for English speakers than the other two groups, and significantly lower for Spanish speakers.

Note this result is consistent with the findings in the analysis by race/ethnicity, where Hispanic members performed better than other race/ethnicity categories for prevention and screening measures.

Diabetes Care – Performance on the Comprehensive Diabetes Care (CDC), Poor HbA1c Control measure was significantly higher among English-speaking members than the other categories. For the Kidney Health Evaluation for Patients with Diabetes (KED), 18-64 Years measure, measure performance was significantly higher for non-English (both Spanish and Other Languages) speakers than English.

Behavioral Health – For many of the measures, there were no statistically significant differences detected. There were a few behavioral health measures with significantly better performance among English speakers than the other two language categories, and significantly worse performance among Spanish speakers:

- Antidepressant Medication Management (AMM), Effective Acute and Continuation Phase
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependencies (FUA), Total, both the 7-Day and 30-Day Follow-up

Performance on the Follow-Up after Hospitalization for Mental Illness (FUH), Total, was significantly higher for both the 7-Day and 30-Day follow-up among Spanish-speaking members than the other two groups.

Access to Care – There are a few measures related to access to care with statistically significantly better performance among English speakers and significantly worse performance among Spanish-speaking members:

- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET), for Total Initiation, Initiation for Age 13-17 years, and Engagement Total
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), Total

Performance of the following measures was statistically significantly worse among English-speaking members, while significantly better among non-English speaking members (Spanish and Other):

- Adults' Access to Preventive/Ambulatory Health Services (AAP), Total

Prenatal and Postpartum Care (PPC) – Among Spanish-speaking members, performance was statistically significantly higher than the other two language categories for both the Timeliness of Prenatal Care and Post-Partum care measures. For the Postpartum Care measure, performance was statistically significantly lower for English speakers than the other two language categories.

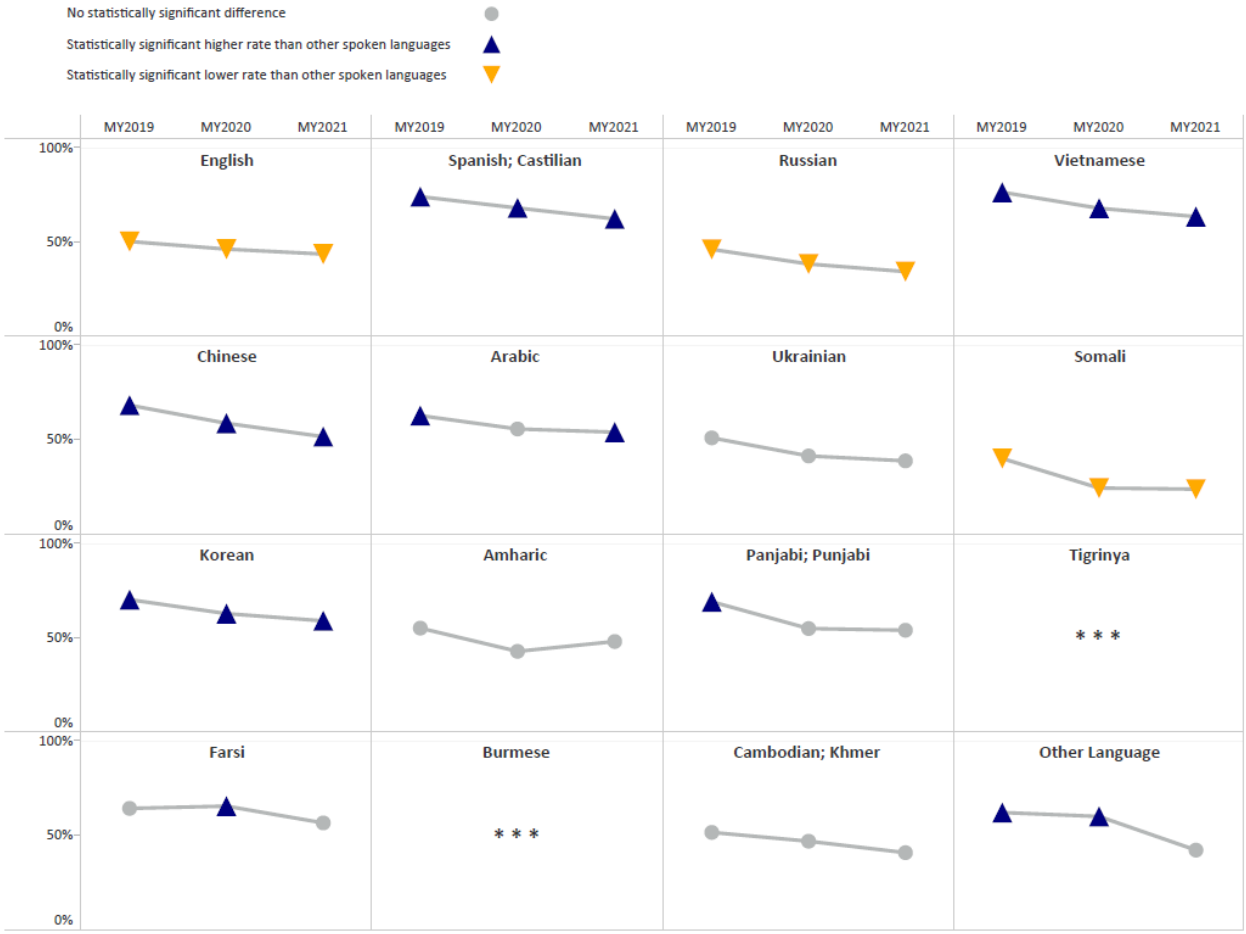
Well-Child Visits in the First 30 Months of Life (W30) and Child and Adolescent Well-Care Visit (WCV) – Measure performance for members who speak Spanish was statistically significantly above the other two categories for all measures related to well-child visits, while significantly lower for English speakers for the same measures. Performance was significantly above English and Spanish speakers for the Child

and Adolescent Well-Care Visit (WCV) measure for ages 18-21 years for members who speak other languages.

Similar to the findings for prevention and screening, this result is consistent with the findings in the analysis by race/ethnicity, where performance was better for Hispanic members than other race/ethnicity categories for well-child visit measures.

Figures 21 through 24 show the results for selected measures for the 15 languages for which Washington HCA provides written materials. These are measures with denominator populations that are sufficient to report across all measures.

Figure 21. Breast Cancer Screenings (BCS), Variation in Rates by Spoken Language, MY2021.*



**Other Language is the sum of the 70 languages not specifically reported in this table and represents approximately 1% of enrollees.*

There was interesting variation in the results by spoken language for breast cancer screenings. Among Spanish/Castilian, Vietnamese, Chinese and Korean speakers, rates were statistically significantly above the other language groups for MY2019, MY2020 and MY2021.

Speakers of English, Russian and Somali had rates that were statistically significantly below the other language groups for the same time period.

There was isolated variation for the remaining language categories.

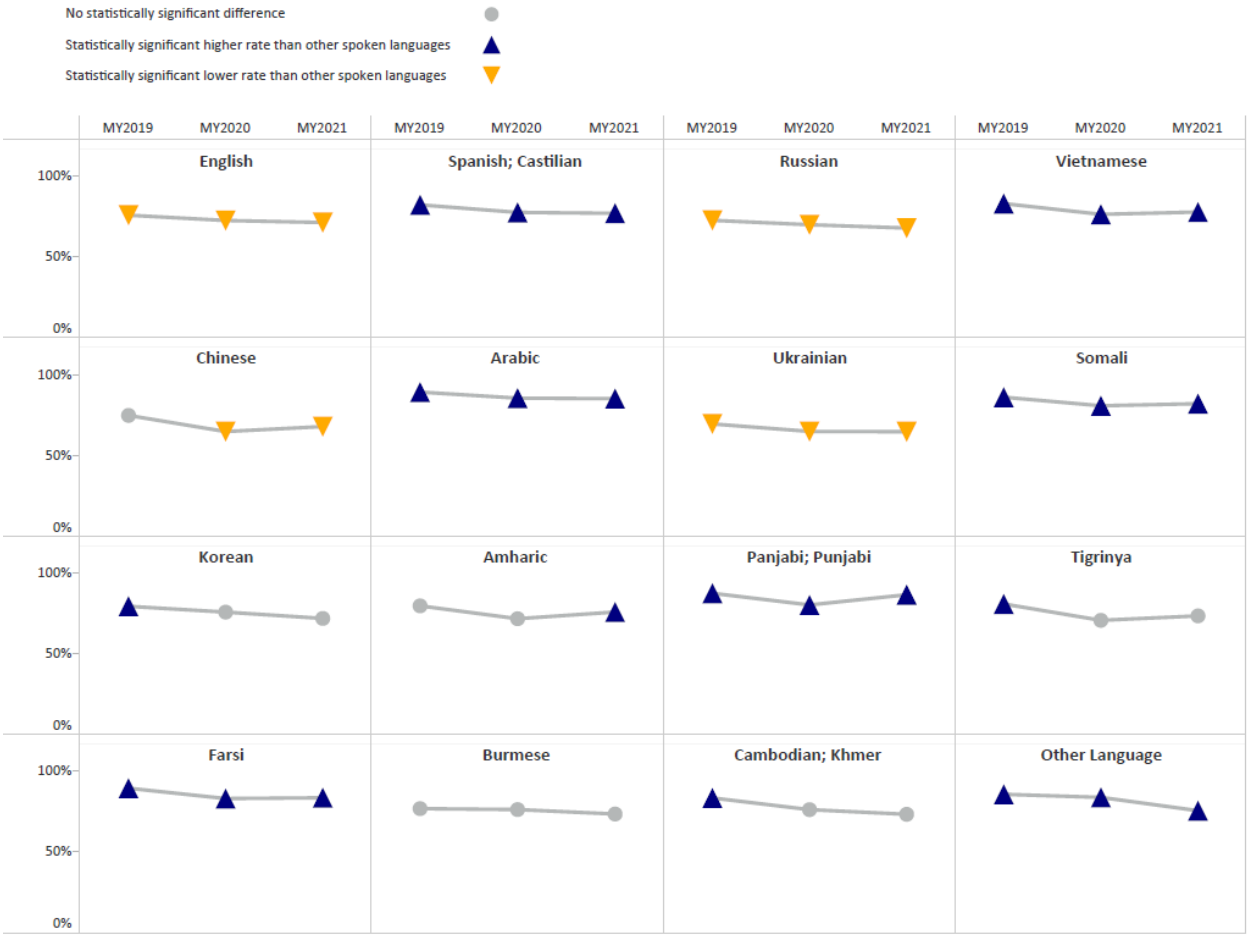
Figure 22. Kidney Health Evaluation for Patients with Diabetes (KED), 65-74 Years, Variation in Rates by Spoken Language, MY2021.*

**Other Language is the sum of the 70 languages not specifically reported in this table and represents approximately 1% of enrollees.*

The Kidney Health Evaluation for Patients with Diabetes (KED) was adopted in MY2020, so Figure 22 only reports two data periods. There are several language categories where performance was statistically significantly better than the other languages. Performance was better among Spanish, Vietnamese, Arabic, Amharic and Panjabi; Punjabi speakers than other language categories for both MY2020 and MY2021. Measure performance was better among Farsi speakers for MY2021.

For both years, performance was statistically significantly worse for English speakers than the other language categories.

Figure 23. Adults' Access to Preventive/Ambulatory Health Services (AAP), Total, Variation in Rates by Spoken Language, MY2021.*



**Other Language is the sum of the 70 languages not specifically reported in this table and represents approximately 1% of enrollees.*

Performance was statistically significantly better among Spanish, Vietnamese, Arabic, Somali, Panjabi; Punjabi and Farsi speakers than other languages for all three years reported; Amharic was better in MY2021 (Figure 23).

Performance was statistically significantly lower for English, Russian and Ukrainian speakers than the other language categories for all three years reported. Performance was significantly below the other language categories for Chinese speakers in MY2020 and MY2021.

Figure 24. Child and Adolescent Well-Care Visit (WCV), Total, Variation in Rates by Spoken Language, MY2021.*

**Other Language is the sum of the 70 languages not specifically reported in this table and represents approximately 1% of enrollees.*

Click here to return to key observations.

Note that this measure was new in MY2020 so there is no data for MY2019.

Performance was statistically significantly better among Spanish, Vietnamese, Chinese and Burmese speakers than the other language categories in MY2020 and MY2021 (Figure 24). Performance was better among Amharic speakers in MY2021 and Panjabi; Punjabi speakers performed better in MY2020.

Performance was statistically significantly worse for English, Russian, Ukrainian and Somali speakers in MY2020 and MY2021; performance was significantly worse among Tigrinya speakers in MY2020.

Gender Comparison

This section of the report analyzes the key performance measures by gender for a three-year trend. (MY2019 through MY2021.)

Note the analysis is limited to reporting by female and male. While HCA, the Department of Social and Health Services, and the Health Benefit Exchange are working together with other state agencies to incorporate gender identity into their applications and other processes,[16,17] we want to acknowledge the current binary nature of data collection and reporting and the limitations that presents in this kind of analysis.

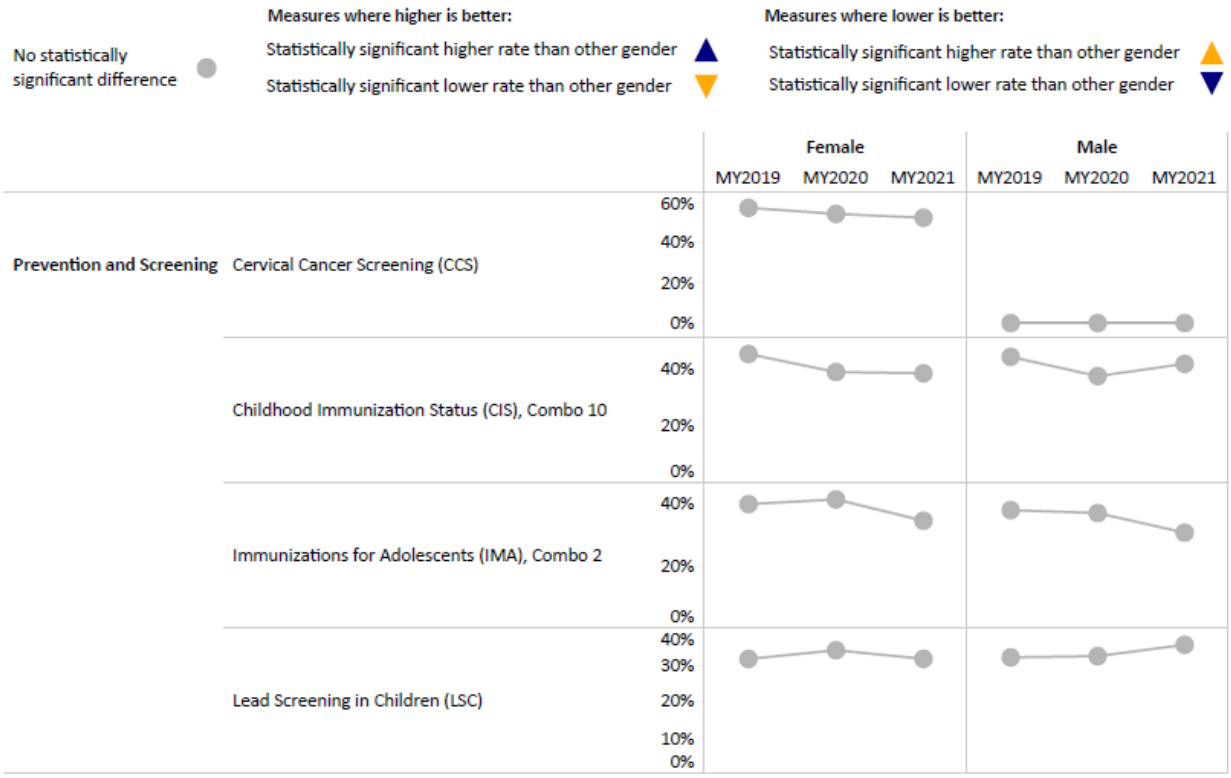
The results of this analysis are very interesting. Although the impact on school closing and service industry jobs during the first year of the pandemic impacted women particularly heavily, there are several measures where females perform statistically higher than males. This may be due to the focus within Washington on maternal/child health and the well-established historic cultural tendency for adult women to engage with the medical system more than men.

Figure 25 displays the results of this analysis for Prevention and Screening measures. Note that gender-specific measures such as breast cancer screenings have been removed from this chart. The blue triangles pointing upward indicate a gender performs statistically better than the other gender; the downward yellow triangles indicate they perform statistically worse.

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

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

Figure 25. Gender Comparison by Measure,* Prevention and Screening, Three-Year Trend (MY2019-MY2021).



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

There were no statistically significant differences for the prevention and screening measures included in Figure 25. The domains that are related to chronic conditions are displayed in Figure 26.

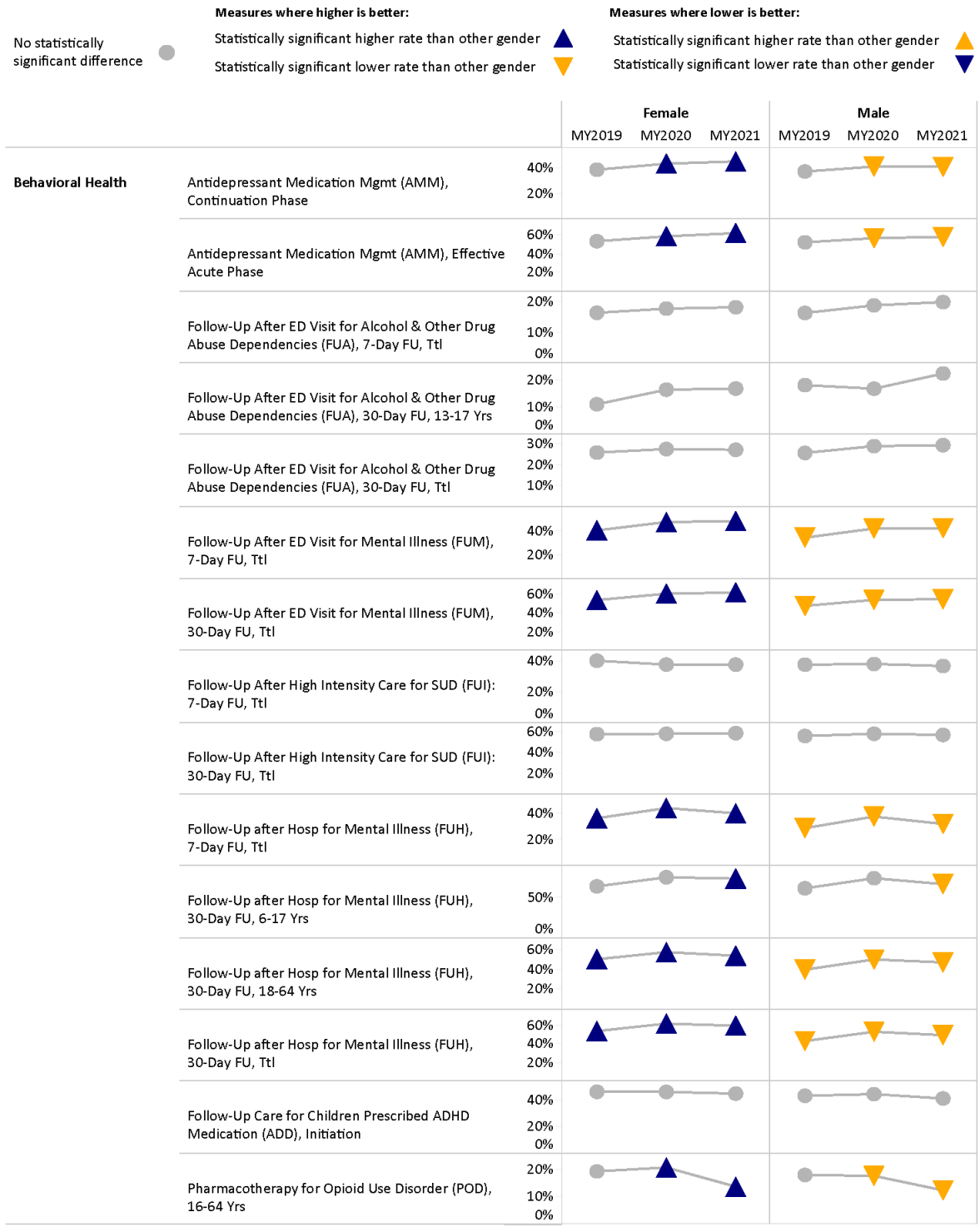
Figure 26. Gender Comparison by Measure,* Chronic Care Domains, Three-Year Trend (MY2019-MY2021).

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

There were no statistically significant differences for found for the majority of the measures related to asthma, heart disease or diabetes. The only statistically significant difference was found for the Controlling High Blood Pressure (CBP) measure, which had statistically significantly higher performance among females than males in MY2019. However, there were no statistically significant differences found for this measure in either MY2020 or MY2021.

Figure 27 displays the results for the behavioral health measures.

Figure 27. Gender Comparison by Measure*, Behavioral Health, Three-Year Trend (MY2019-MY2021).



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

There are several behavioral health measures where females perform statistically significantly higher than males:

- **Antidepressant Medication Management (AMM), Acute and Continuation Phase** – There was no statistically significant difference in measure performance between female and male members for MY2019. However, performance was better among females than males in MY2020 and MY2021.
- **Follow-Up After Emergency Department Visit for Mental Illness (FUM)** – For all of the measure indicators, performance was better among females than males for all three years reported.
- **Follow-Up after Hospitalization for Mental Illness (FUH)** – For the adult and total indicators, performance was better among females than males for all three years. It is interesting to note that for the Age 6-17 measure, there were no statistically significant differences for MY2019 or MY2020, but there was a difference for MY2021.
- **Pharmacotherapy for Opioid Use Disorder (POD), 16-64 Years** – There was no statistically significant difference in performance between females and males in MY2019. Performance was better among females than males in MY2020 and MY2021.

Overuse/appropriateness and access/availability of care measures are included in Figure 28.

Figure 28. Gender Comparison by Measure,* Overuse/Appropriateness and Access/Availability of Care, Three-Year Trend (MY2019-MY2021).

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

Overuse/Appropriateness – Performance on the Use of Opioids at High Dosage (HDO) measure was better among females than males for all three performance years. Note that a lower score is better for this measure.

Access/Availability of Care – For the Adults' Access to Preventive/Ambulatory Health Services (AAP), Total measure, performance was statistically significantly better for females than males for all three performance years. For the Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), Total measure, there was no statistical difference in measure performance

between females and males in MY2019 or MY2020; performance was significantly better for females in MY2021.

Figure 29 includes the measures in the utilization domain.

Figure 29. Gender Comparison by Measure*, Utilization, Two-Year Trend (MY2019-MY2021).

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

This category comprises the well-child visits.

- **Well-Child Visits in the First 30 Months of Life (W30)** – There were no statistically significant difference found between females and males for either age band.

- **Child and Adolescent Well-Care Visit (WCV)** – The Age 3-11 measure indicator is the only age band for this measure where performance was better among males than females. There was a statistically significant difference for MY2021, although there was no statistically significant difference for MY2020. For the remaining age bands, performance among females was significantly better than males for both the MY2020 and MY2021 performance.

Urban Versus Rural Comparison

This section compares measure results for members who live in urban settings versus rural settings. To define urban versus rural geographies, Comagine Health relied on the CMS rural-urban commuting area (RUCA) codes. RUCA codes classify United States census tracts using measures of population density, urbanization and daily commuting.[18]

Note that for MY2019, the enrollment data that Comagine Health uses to identify demographic categories did not include ZIP code information, which is necessary for assigning RUCA codes. As a result, MY2019 data was dropped from this particular analysis, and only MY2020 and MY2021 data was included.

Figure 30 below shows measures by urban versus rural designation for the Prevention and Screening domain. There were a few measures with statistically significant differences between the urban population and the rural population.

[18] 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 30. Urban and Rural Comparison by Measure, Prevention and Screening, Two-Year Trend (MY2020 and MY2021).

There were two measures reported in the prevention and screening domain where there were statistically significant differences between the rural and urban populations:

- **Childhood Immunization Status (CIS), Combo 10** – This measure was significantly lower for members in rural areas than urban members for MY2020. There was no statistically significant difference between the two categories for MY2021.
- **Chlamydia Screening (CHL), Total** – This measure performed statistically significantly higher for urban area members compared to rural members for MY2021.

The domains that are related to chronic conditions are displayed in Figure 31.

Figure 31. Urban and Rural Comparison by Measure, Chronic Condition Domains, Two-Year Trend (MY2020 and MY2021).

Performance on the Asthma Medication Ratio (AMR) measure was statistically significantly lower for rural areas than urban for both years. There were no statistically significant differences for found for the Controlling High Blood Pressure (CBP) measure or measures related to diabetes.

Figure 32 displays the results for the behavioral health measures.

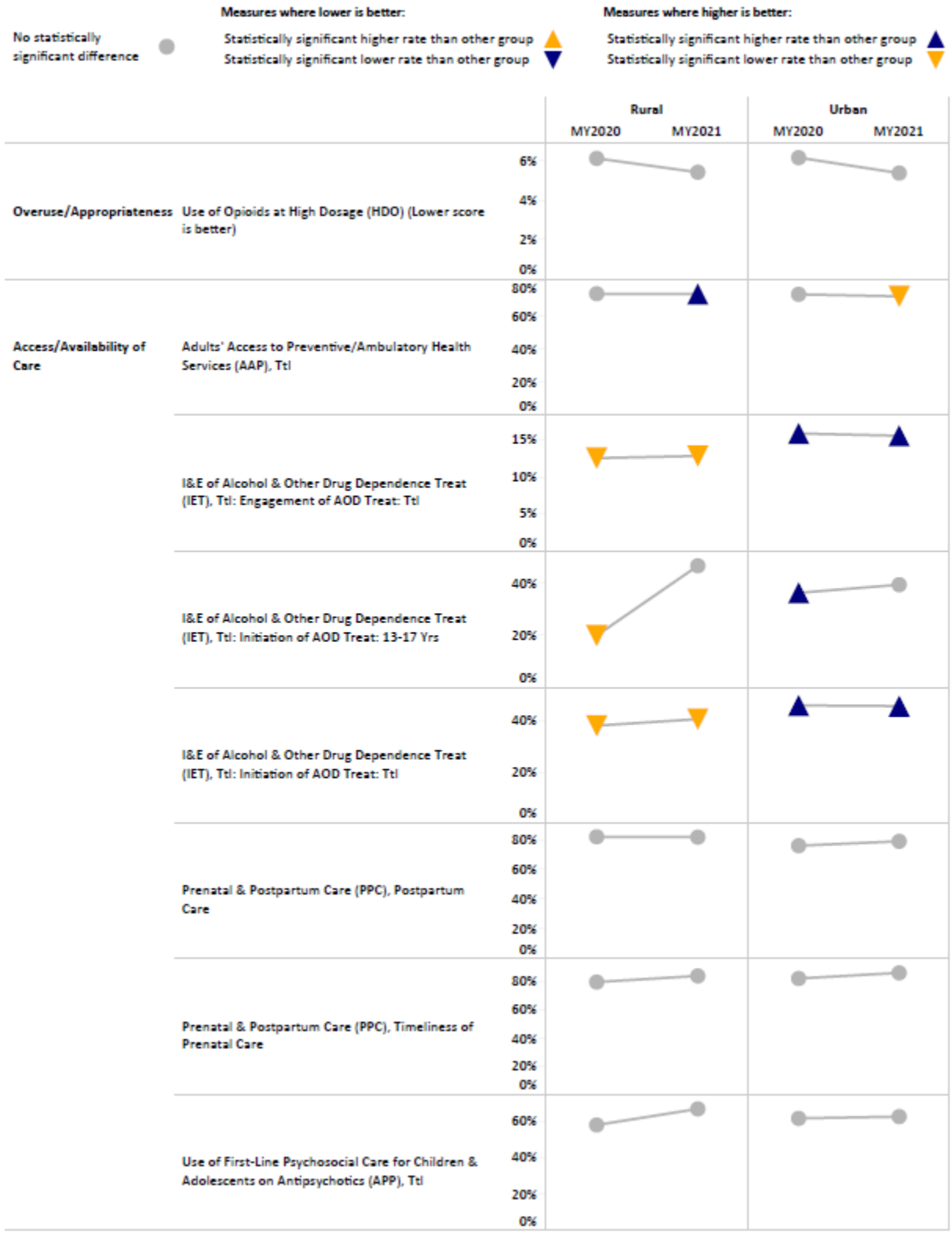
Figure 32. Urban and Rural Comparison by Measure, Behavioral Health, Two-Year Trend (MY2020 and MY2021).

For most of the behavioral health measures, there was no statistically significant difference between the measures. However, there were a few exceptions:

- **Follow-Up After Emergency Department Visit for Mental Illness (FUM), 30-day and 7-day** – The rates for rural areas are statistically significantly higher than the rates for urban areas for both MY2020 and MY2021.
- **Follow-Up after Hospitalization for Mental Illness (FUH)** – For the 30-day adult and total indicators, rural performed better than urban for both MY2020 and MY2021. For the 7-day total indicator, there was no statistically significant difference for MY2020. Performance was significantly better among rural areas than urban in MY2021. There was no statistically significant difference between rural and urban for the Age 6-17 age band indicator.
- **Pharmacotherapy for Opioid Use Disorder (POD), 16-64 Years** – Rural was statistically significantly higher than urban for MY2020. There was no statistically significant difference between rural and urban in MY2021.

Overuse/appropriateness and access/availability of care measures are included in Figure 33.

Figure 33. Urban and Rural Comparison by Measure, Overuse/Appropriateness and Access/Availability of Care Domains, Two-Year Trend (MY2020 and MY2021).

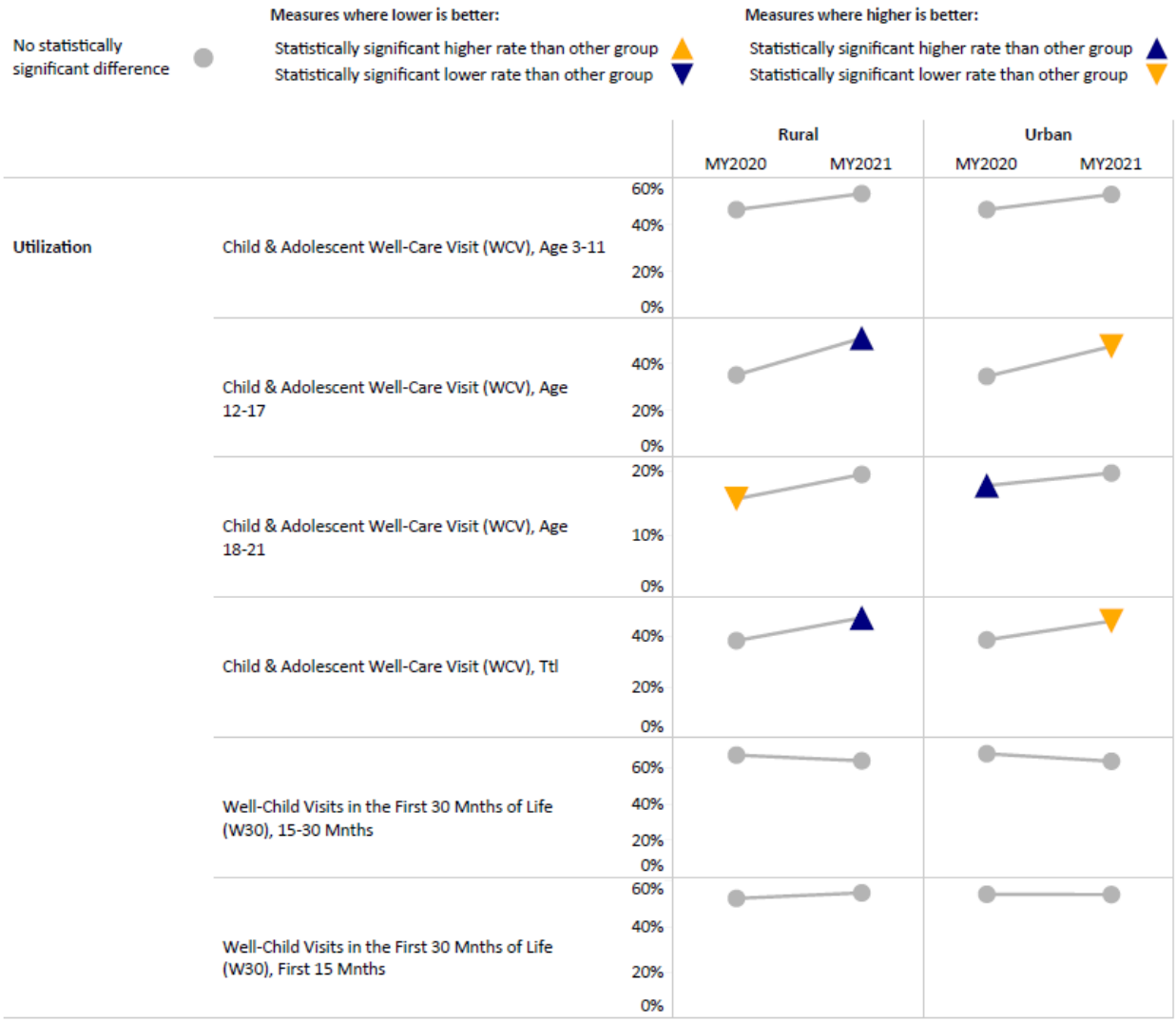


There were several measures where there were statistically significant differences between the urban and rural populations.

- **Adults' Access to Preventive/Ambulatory Health Services (AAP), Total** – Performance was statistically significantly better in urban areas than rural in MY2021. There was no statistically significant difference between the two populations for MY2020.
- **Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)** – For the Initiation Age 13-17 Years measure indicator, performance was statistically significantly higher in urban populations than rural population in MY2020. There was no statistically significant difference for MY2021. The Initiation, Total and the Engagement, Total measure indicators had statistically significantly higher performance in the urban population over the rural population for both years reported.

Figure 34 includes the measures in the utilization domain.

Figure 34. Urban and Rural Comparison by Measure, Utilization, Two-Year Trend (MY2020 and MY2021).



This category comprises the well-child visits.

- **Well-Child Visits in the First 30 Months of Life (W30)** - There were no statistically significant differences found between rural and urban for either age band.
- **Child and Adolescent Well-Care Visit (WCV)** – The total measure indicator had statistically significantly higher performance in rural areas than urban in MY2021. There was some variation in results by age band.

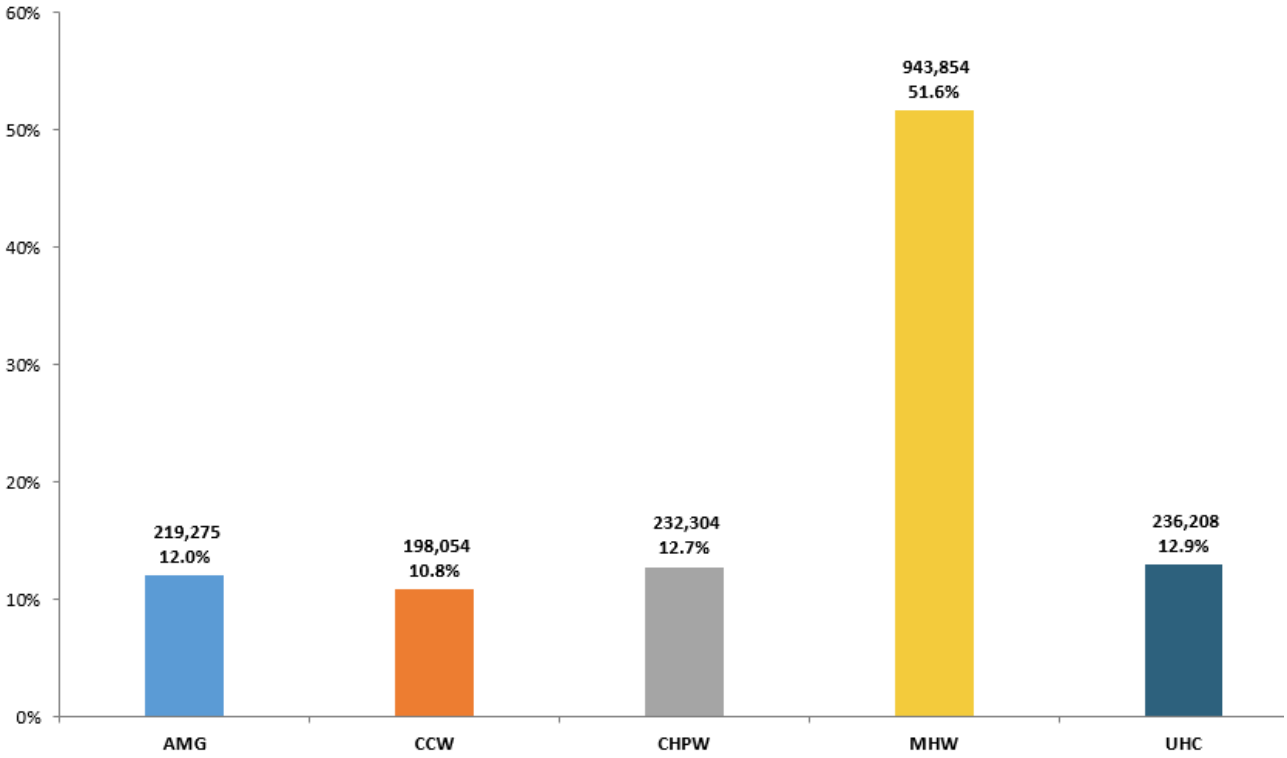
MCO-Specific Results

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 35 shows Medicaid enrollment by MCO. MHW enrolls about half of the Medicaid members in Washington. The rest of the member population is distributed across the remaining four plans, with 10.8% in CCW and about 12% in AMG, CPHW and UHC, respectively.

Figure 35. Percent of Total Statewide Medicaid Enrollment, According to MCO, MY2021.



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.

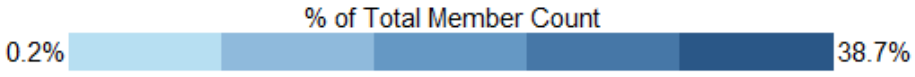
Age

Figure 36 shows the percentages of enrollment by age group and MCO. The darker blue signifies a higher percentage, while lighter blue signifies lower, with a medium gradient for those values in between.

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

Figure 36. Enrollee Population by MCO and Age Range, MY2021.

Age Range	AMG	CCW	CHPW	MHW	UHC
Age 0 to 5	13.0%	16.1%	12.9%	14.9%	12.3%
Age 6 to 12	14.2%	19.7%	17.6%	18.9%	14.6%
Age 13 to 20	13.9%	19.7%	20.2%	19.1%	14.4%
Age 21 to 44	38.7%	29.7%	32.2%	33.3%	37.4%
Age 45 to 64	19.8%	14.4%	16.6%	13.7%	20.9%
Age 65+	0.5%	0.4%	0.4%	0.2%	0.4%



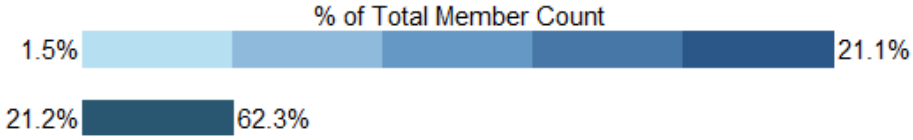
Race and Ethnicity by MCO

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

As shown in Figure 37, approximately half of CCW and CHPW's enrollment is white; the other three MCOs have approximately 60% of their enrollment is white. The "Other" race category was the second most common for most MCOs. Note that "Other" race is selected by the enrollee when they identify themselves as a race other than those listed; CCW and CHPW have the most enrollment in this category with approximately 20% of their members selecting other. Black members make up 11.4% of UHC's enrollee population and 9.4% of AMG's population, which were higher percentages than other MCOs.

Figure 37. Statewide Apple Health Enrollees by MCO and Race,* MY2021.

Race	AMG	CCW	CHPW	MHW	UHC
White	62.3%	52.8%	51.9%	61.0%	57.8%
Other	10.4%	21.1%	20.6%	12.6%	8.3%
Not Provided	7.2%	8.6%	8.0%	7.5%	8.0%
Black	9.4%	8.2%	8.4%	8.6%	11.4%
Asian	4.3%	4.1%	6.0%	4.4%	7.0%
American Indian/Alaska Native	2.0%	1.9%	1.5%	2.2%	2.0%
Hawaiian/Pacific Islander	4.3%	3.3%	3.5%	3.8%	5.4%

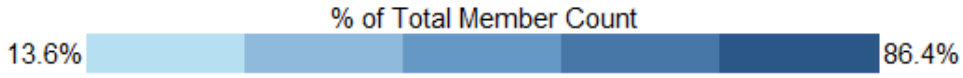


**These are the categories MCOs provide to HCA in eligibility data files. The "Other" category is defined as "client identified as a race other than those listed." And the "Not Provided" category is defined as "client chose not to provide."*

Figure 38 shows the percentage of MCO members who identified as Hispanic. CCW and CHPW have the largest percentages of Hispanic members at 35.6% and 33.3%, respectively. Please note that within this report, Hispanic is used to identify an ethnicity and does not indicate race.

Figure 38. Statewide Apple Health Enrollees by MCO and Hispanic Indicator, MY2021.

Hispanic	AMG	CCW	CHPW	MHW	UHC
Yes	19.2%	35.6%	33.3%	21.4%	13.6%
No	80.8%	64.4%	66.7%	78.6%	86.4%



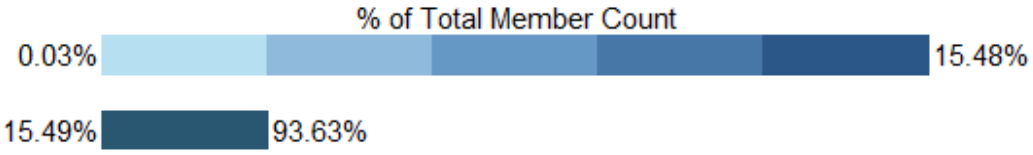
Primary Spoken Language by MCO

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

Figure 39 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 39. Statewide Apple Health Enrollees by MCO and Spoken Language, MY2021.

Spoken Language	AMG	CCW	CHPW	MHW	UHC
English	90.07%	83.09%	79.22%	89.61%	93.63%
Spanish; Castilian	6.69%	13.07%	15.48%	7.05%	2.97%
Russian	0.33%	0.19%	0.56%	0.96%	0.37%
Vietnamese	0.35%	0.53%	0.78%	0.39%	0.60%
Chinese	0.38%	0.35%	1.04%	0.20%	0.37%
Arabic	0.20%	0.18%	0.34%	0.20%	0.27%
Ukrainian	0.15%	0.11%	0.11%	0.28%	0.14%
Somali	0.14%	0.11%	0.36%	0.16%	0.16%
Korean	0.07%	0.07%	0.06%	0.08%	0.27%
Amharic	0.12%	0.06%	0.17%	0.08%	0.10%
Tigrinya	0.10%	0.04%	0.12%	0.06%	0.06%
Panjabi; Punjabi	0.05%	0.06%	0.06%	0.07%	0.05%
Burmese	0.06%	0.05%	0.13%	0.04%	0.05%
Farsi	0.06%	0.05%	0.09%	0.05%	0.05%
Cambodian; Khmer	0.05%	0.03%	0.05%	0.04%	0.05%
Other Language*	1.19%	2.01%	1.44%	0.72%	0.84%



**Other Language is the sum of the 70 languages not specifically reported in this table and represents less than 1% of enrollees.*

MCO-Specific Performance for MY2020

This section of the report presents MCO-specific results for selected measures. These 42 measures, which include 40 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 40 shows the MY2021 statewide weighted average results that were displayed in Figure 4 with the addition of the results for each of the five MCOs. The triangles represent statistically significant changes in measure results between MY2020 and MY2021 for that MCO; triangles pointing down represent a statistically significant decrease and triangles pointing up indicate a statistically significant increase in performance for that MCO between years. The shading indicates performance compared to national benchmarks for the HEDIS measures, and a state-assigned benchmark for the two RDA measures. Darker colors indicate higher performance in terms of benchmarks.

Figure 40. MCO Variation from MY2020 to MY2021.

Benchmark Comparison: Below 50th; At 50th; Above 50th, Below 75th; At or Above 75th; Below Benchmark; At Benchmark; No Benchmark

▲ Statistically significant increase from previous measurement year

▼ Statistically significant decrease from previous measurement year

		AMG	CCW	CHPW	MHW	UHC	Statewide
Prevention and Screening	Breast Cancer Screening (BCS)	41%	45% ▼	42% ▼	47% ▼	45% ▼	45% ▼
	Cervical Cancer Screening (CCS)	45%	54%	56%	57%	53%	53%
	Childhood Immunization Status (CIS), Combo 10	36%	43%	42%	37%	43%	40%
	Chlamydia Screening (CHL), Ttl	49%	52%	49%	51%	49%	50%
	Immunizations for Adolescents (IMA), Combo 2	28%	34%	39%	31%	31%	33% ▼
	Lead Screening in Children (LSC)	36%	31%	41%	35%	27%	34%
Respiratory Conditions	Asthma Medication Ratio (AMR), Ttl	63% ▲	70% ▲	57% ▼	69% ▲	57%	65% ▲
Cardiovascular Conditions	Controlling High Blood Pressure (CBP)	61%	60%	65%	65% ▲	68%	64% ▲
Diabetes	Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0%	51%	42%	51%	52%	58%	51%
	Comprehensive Diabetes Care (CDC), Poor HbA1c Control (Lower score is better)	38%	45%	38%	36%	32%	38%
	Kidney Health Eval for Patients with Diabetes (KED), 18-64 Yrs	42%	45%	46%	43%	43%	43%
Behavioral Health	Antidepressant Medication Mgmt (AMM), Continuation Phase	43% ▲	42%	40%	44%	48% ▲	44% ▲
	Antidepressant Medication Mgmt (AMM), Effective Acute Phase	61% ▲	59%	57%	62%	64% ▲	61% ▲
	Follow-Up After ED Visit for Alcohol & Other Drug Abuse Dependencies (FUA), 7-Day FU, Ttl	15%	14%	23%	22%	16%	19%
	Follow-Up After ED Visit for Alcohol & Other Drug Abuse Dependencies (FUA), 30-Day FU, 13-17 Yrs	31%	23%	14%	18%	10%	20%
	Follow-Up After ED Visit for Alcohol & Other Drug Abuse Dependencies (FUA), 30-Day FU, Ttl	23%	24%	34%	31%	25%	29%
	Follow-Up After ED Visit for Mental Illness (FUM), 7-Day FU, Ttl	33%	36%	48%	53%	43%	46%
	Follow-Up After ED Visit for Mental Illness (FUM), 30-Day FU, Ttl	45%	50%	62%	66%	56%	59%
	Follow-Up After High Intensity Care for SUD (FUI): 7-Day FU, Ttl	35%	35%	41%	38%	36%	37%
	Follow-Up After High Intensity Care for SUD (FUI): 30-Day FU, Ttl	55%	55%	61%	58%	56%	57%
	Follow-Up after Hosp for Mental Illness (FUH), 7-Day FU, Ttl	28%	27% ▼	36%	43% ▼	29%	36% ▼
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, 6-17 Yrs	65%	66%	67%	79%	60%	72%
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, 18-64 Yrs	41%	28% ▼	54% ▼	60%	41%	50% ▼
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, Ttl	45%	41% ▼	56%	65%	44%	54% ▼
	Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	40%	44%	43%	43%	45%	43%
	Mental Health Treat Rate, Broad (MH-B), 6-64 Yrs	53% ▲	54% ▼	55%	55%	51% ▲	54% ▼
	Pharmacotherapy for Opioid Use Disorder (POD), 16-64 Yrs	13% ▼	12% ▼	11% ▼	13% ▼	14% ▼	13% ▼
	Substance Use Disorder (SUD) Treat Rate, 12-64 Yrs	37% ▼	36%	40%	38% ▼	39%	38% ▼
Overuse / Appropriateness	Use of Opioids at High Dosage (HDO) (Lower score is better)	5%	6%	5%	5% ▲	7%	5% ▲
Access / Availability of Care	Adults' Access to Preventive/Ambulatory Health Services (AAP), Ttl	67% ▼	70% ▼	72% ▼	75% ▼	70% ▼	72% ▼
	I&E of Alcohol & Other Drug Dependence Treat (IET), Ttl: Engagement of AOD Treat: Ttl	14% ▼	13%	16%	16% ▼	15%	15% ▼
	I&E of Alcohol & Other Drug Dependence Treat (IET), Ttl: Initiation of AOD Treat: 13-17 Yrs	47%	41%	36%	41%	37%	40% ▲
	I&E of Alcohol & Other Drug Dependence Treat (IET), Ttl: Initiation of AOD Treat: Ttl	49%	42%	42%	47%	44%	46%
	Prenatal & Postpartum Care (PPC), Postpartum Care	76%	75%	86%	79%	80%	79%
	Prenatal & Postpartum Care (PPC), Timeliness of Prenatal Care	83%	80%	90%	89%	90%	86% ▲
	Use of First-Line Psychosocial Care for Children & Adolescents on Antipsychotics (APP), Ttl	59%	62%	66%	64%	62%	63%
Utilization	Child & Adolescent Well-Care Visit (WCV), Age 3-11	50% ▲	56% ▲	53% ▲	54% ▲	49% ▲	53% ▲
	Child & Adolescent Well-Care Visit (WCV), Age 12-17	44% ▲	48% ▲	49% ▲	49% ▲	44% ▲	48% ▲
	Child & Adolescent Well-Care Visit (WCV), Age 18-21	16% ▲	18% ▲	20% ▲	21% ▲	19% ▲	20% ▲
	Child & Adolescent Well-Care Visit (WCV), Ttl	43% ▲	47% ▲	46% ▲	47% ▲	43% ▲	46% ▲
	Well-Child Visits in the First 30 Mnths of Life (W30), 0-15 Mnths	51%	52% ▼	61%	55%	48%	54%
	Well-Child Visits in the First 30 Mnths of Life (W30), 16-30 Mnths	61% ▼	66% ▼	65%	64% ▼	64% ▼	64% ▼

Click here to return to key observations.

Below are the notable findings.

Prevention and Screening – There was very little variation seem for the Breast Cancer Screening (BCS) measure. The statewide weighted average and the five MCOs were all below the national 50th percentile. With the exception of AMG, all of the MCOs also declined in the year-over-year comparison.

There was some variation seen with other preventive measures.

Chronic Care – There was notable variation in the comparison to benchmarks for the Asthma Medication Ratio (AMR) measure. On a statewide basis, there were statistically significant improvements from MY2020 to 2021. These improvements were also seen for AMG, CCW and MHW. CHPW showed a statistically significant decline in performance, while there was no statistically significant change detected for UHC.

There was some variation noted for the Controlling High Blood Pressure (CBP) and the diabetes measures.

Behavioral Health – In general, there is a lot of variation in performance for the behavioral health measures. Here are some observations about a few of the measures:

- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependencies (FUA), 30-day and 7-day, Total – The statewide average and all plans compare well to the national benchmarks.
- Follow-Up after Hospitalization for Mental Illness (FUH) – Many of the plans are below the national 50th percentile. Many of the plans also experienced a year-over-year decline.
- Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation – The results for this measure are consistently below the national 50th percentile. There has been no year-over-year improvement.
- Mental Health Service Rate, Broad Definition (MH-B), 6-64 Years – The statewide weighted rate had a statistically significant decline; the results for the individual MCOs were mixed. MHW performed the best when compared to the benchmark.
- Substance Use Disorder (SUD) Treatment Rate, 12-64 Years – The statewide weighted rate had a statistically significant decline, while the results for the individual MCOs were mixed. CHPW and UHC performed the best when compared to the benchmark.

Access/Availability of Care – There is some variation for the other Access/Availability of Care measures, especially in terms of comparisons to benchmarks.

- Adults' Access to Preventive/Ambulatory Health Services (AAP), Total – The statewide weighted average had a statistically significant decline between MY2020 and MY2021; this decline was also experienced by all five MCOs. Note that there was no national benchmark available for this measure.
- Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care and Postpartum Care – There is a lot of variation in performance across the MCOs in terms of comparisons to benchmarks. There was a statistically significant improvement in the statewide weighted rate for Timeliness of Prenatal Care.

Utilization – This category comprises the well-child visits.

- Well-Child Visits in the First 30 Months of Life (W30) – There is variation among the MCOs across the MCOs when compared to the national benchmarks for both the First 15 Months and 15-30

Month measure indicators. There was a statistically significant decrease for the 15-30 Month measure for the statewide weighted average; this decline was experienced by all MCOs except CHPW.

- Child and Adolescent Well-Care Visit (WCV) – For all age bands, this measure is consistently below the national 50th percentile for both the statewide weighted average and the MCOs. The exception was CCW, whose rates are at the national 50th percentile for the Age 3-11 age band. The statewide weighted average and all five MCOs had rates that showed a statistically significant improvement between MY2020 and MY2021.

MCO Scorecards

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

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

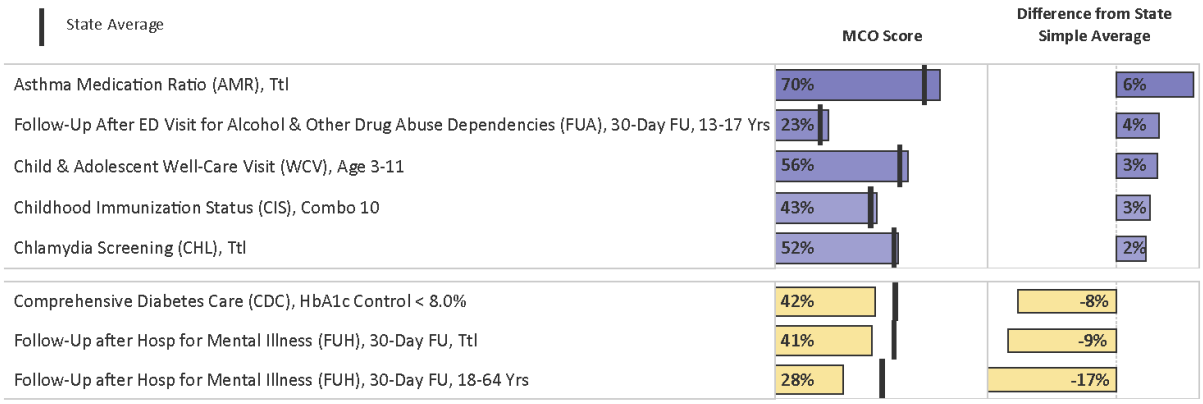
- **AMG** performed below the state simple average for many of the measures. A few of the behavioral health measures were above the state simple average. Note: AMG performance is very similar to what was reported in the 2021 Comparative Analysis Report, with the same behavioral health measures above the state simple average and similar measures notably below the state simple average.
- **CCW** had more of a mixed performance, with performance well above the state simple average on several measures, but performance well below the state simple average on others. Although CCW has several pediatric measures where the rates were above the state simple average, it performed below the state simple average on many measures related to maternity and pediatric care. Many of the behavioral health measures were below the state simple average for CCW. One notable change for CCW is performance on the Asthma Medication Ratio (AMR) measure. CCW performed 6% higher than the state simple average in MY2021, compared to being no different than the state simple average in MY2020. Performance on the remaining measures was very similar to what was reported in the 2021 Comparative Analysis report.
- **CHPW** performed above the state simple average for the majority of the measures, including several pediatric and behavioral health measures. Overall, CHPW has more measures above the state simple average for MY2021 than were reported in the 2021 Comparative Analysis report. However, there were also a change in the mix of measures where CHPW performs well and where they perform notably below the other MCOs. Most notable was a drop in their rate for the Asthma Medication Ratio (AMR) measure, which is now 7% below the state simple average for MY2021 compared to being 3% above the state simple average for MY2020.
- **MHW** performed above the state simple average for several measures and close to the state average for others. Overall, MHW showed improvement when compared to results from the 2021 Comparative Analysis Report. There are more measures notably above the state simple average this year. It is also worth noting that although the same immunization measures are below the state simple average this year, MHW has closed the gap. For MY2021, none of the measures are much below the state simple average.
- **UHC** had a very mixed performance, performing well above the state simple average for some measures and well below the state simple average for others. UHC performance is very similar to what was reported in the 2021 Comparative Analysis Report.

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

Figure 41 shows a snapshot of the scorecard to illustrate how to read the MCO scorecards. The measures are listed in the left column with MCO performance listed in the shaded column in the middle. The bold vertical bar illustrates the Statewide Simple Average.

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

Figure 41. Example of MCO Scorecard.



The MCO performance scorecards on the following pages (Figures 42–46) 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.

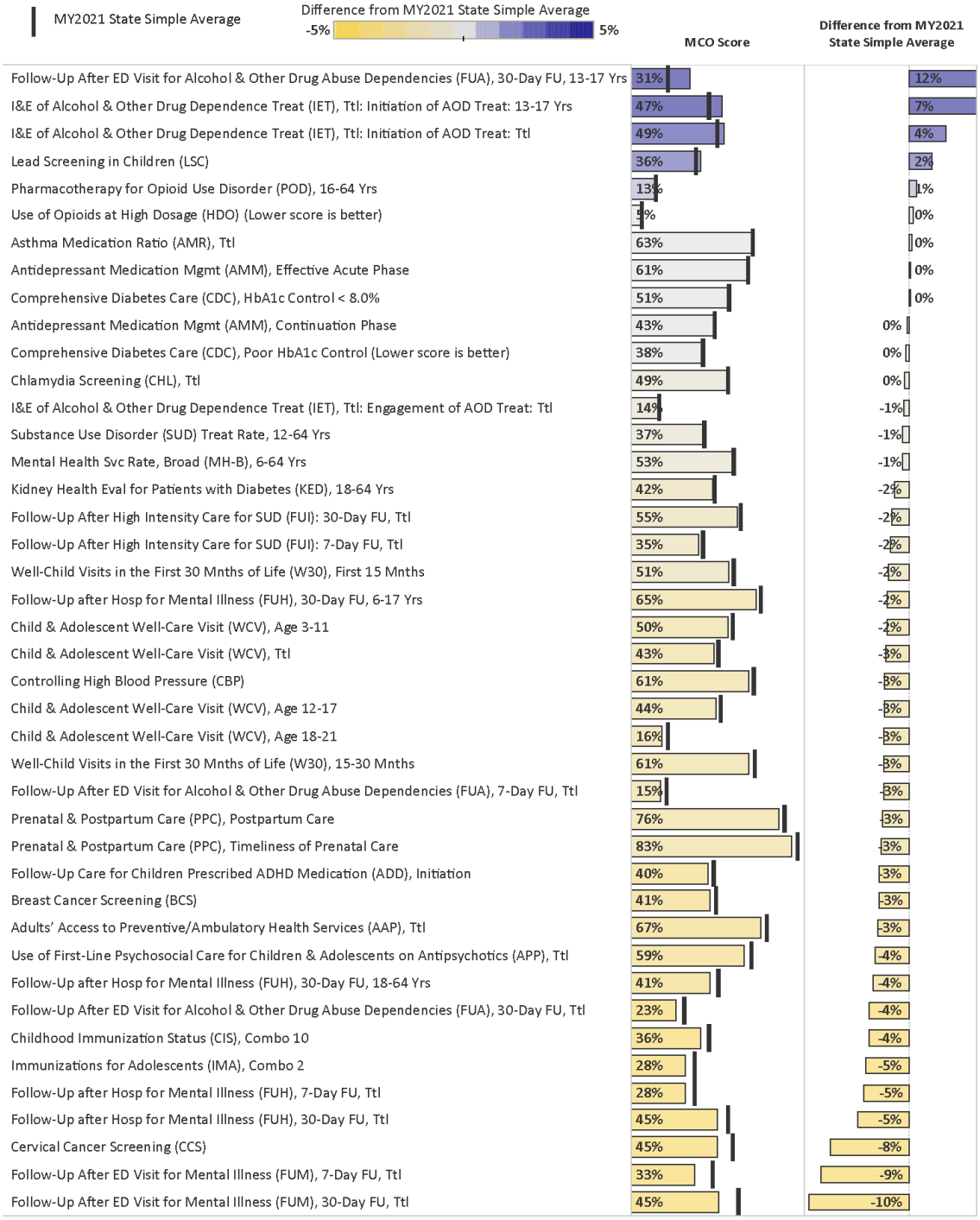
Please note that the simple state average is different than the weighted state average used in other sections of the report. The potential disadvantage of comparing an individual MCO to a weighted state average is that significantly larger plans could have undue influence on the state rate. A simple average of the plans (rather than a weighted average) mitigates those concerns.

Please refer to the methodology section of this report for more information on how the simple state average is calculated.

Amerigroup Washington (AMG)

Most of the measures for AMG were below the state simple average. (The state simple average for a measure is calculated as the average of the measure rate for the MCOs that reported the measure.) The measures that were notably below the state simple average were the Cervical Cancer Screening (CCS) measure and the Follow-Up after ED Visit for Mental Illness (FUM) measures. Note that these results are very similar to what was reported in the MY2021 Comparative Analysis Report.

Figure 42. AMG Scorecard, MY2021.

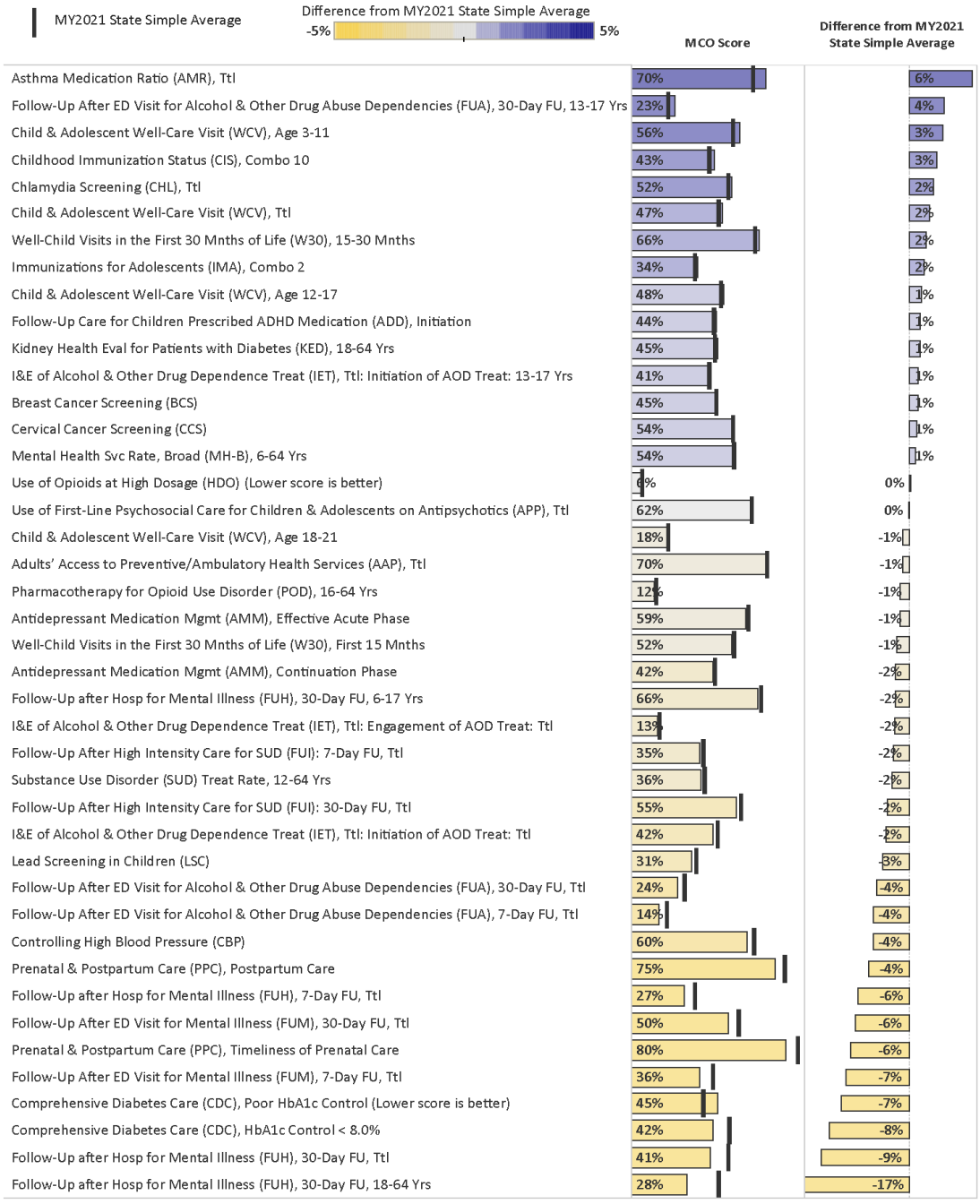


Click here to return to key observations.

Coordinated Care of Washington (CCW)

CCW has several pediatric measures where the rates were above the state simple average. In addition, CCW performed better than the state simple average for the Asthma Medication Ratio (AMR) measure. Many of the behavioral health measures are below the state simple average for CCW. Other measures where their rates were markedly below the state simple average included Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care and Postpartum Care; Comprehensive Diabetes Care (CDC), Poor HbA1c Control; and Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0%. (Note that a lower score is better for the Comprehensive Diabetes Care (CDC), Poor HbA1c Control measure.)

Figure 43. CCW Scorecard, MY2021.

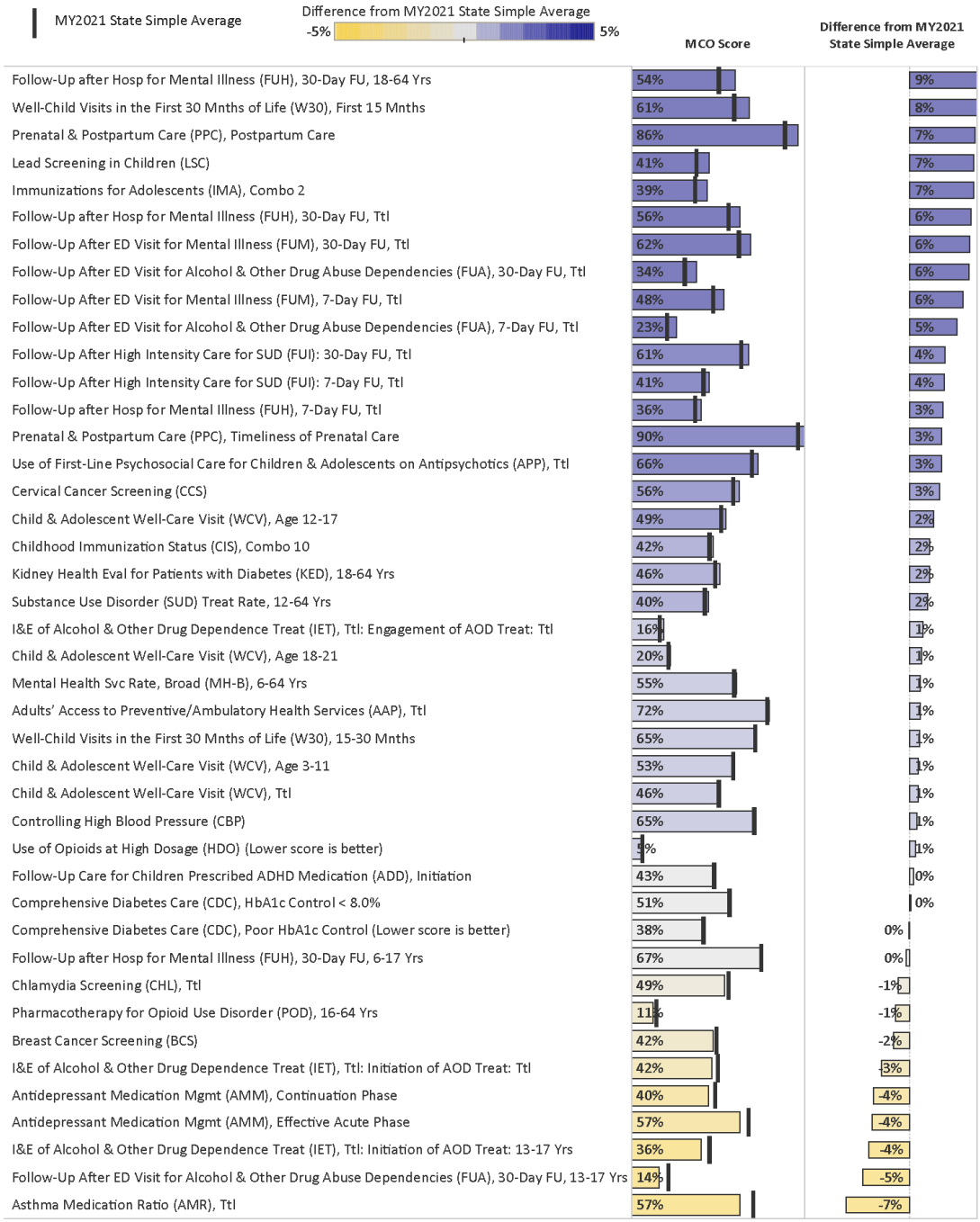


Click here to return to key observations.

Community Health Plan of Washington (CHPW)

CHPW performed above the state simple average for many of the measures, including several pediatric and behavioral health measures. CHPW was also well above the state simple average for the Prenatal and Postpartum (PPC) measures for both the Timeliness of Prenatal Care and Postpartum Care components. CHPW was notably below the state simple average for the Asthma Medication Ratio (AMR) measure. The MCO was also below the state simple average for a small number of behavioral health measures.

Figure 44. CHPW Scorecard, MY2021.

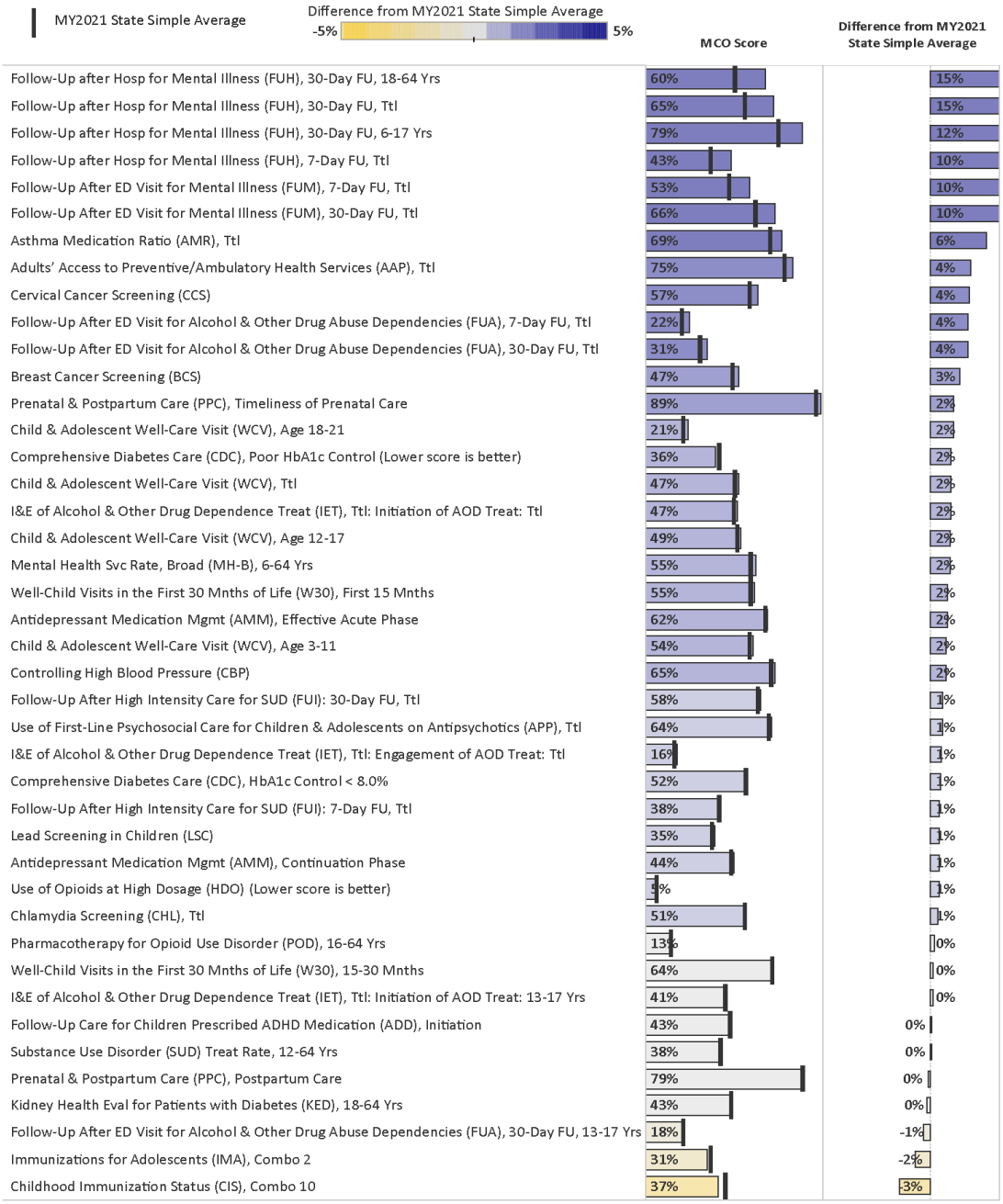


Click here to return to key observations.

Molina Healthcare of Washington (MHW)

MHW performed markedly above the state simple average for the Follow-Up after Hospitalization for Mental Illness (FUH), Follow-Up After Emergency Department Visit for Mental Illness (FUM) and Asthma Medication Ratio (AMR) measures. They were above the state simple average for several other measures. MHW was markedly below the state simple average for the Childhood Immunization Status (CIS), Combo 10 and Immunizations for Adolescents (IMA), Combo 2 measures. As a reminder, comparisons are made using the state simple average to mitigate the impact of plan size when comparing a particular plan's performance. MHW, in fact, performs well after mitigating the impact its size would have on the state average.

Figure 45. MHW Scorecard, MY2021.

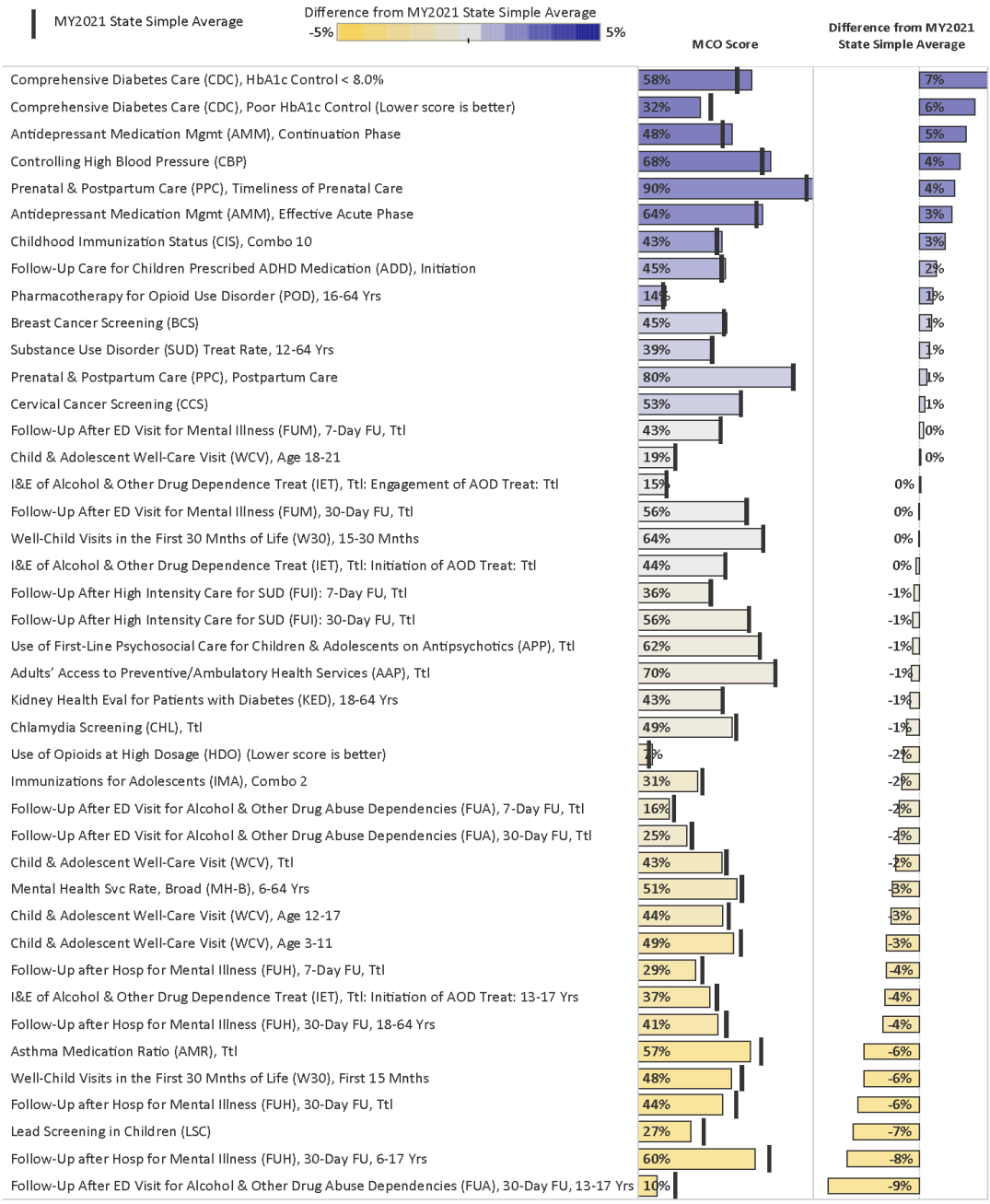


Click here to return to key observations.

UnitedHealthcare Community Plan (UHC)

For many of the measures, UHC performed close to the state simple average. UHC performed markedly above the state average for the Comprehensive Diabetes Care (CDC), Antidepressant Medication Management (AMM), Controlling High Blood Pressure (CBP), and Prenatal and Postpartum Care (PPC) measures. UHC was markedly below the average for the Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependencies (FUA), 30-Day Follow-Up, 13-17 Years, Follow-Up after Hospitalization for Mental Illness (FUH), Lead Screening in Children (LSC), Well-Child Visits in the First 30 Months of Life (W30), First 15 Months and Asthma Medication Ratio measures.

Figure 46. UHC Scorecard, MY2021.



Click here to return to key observations.

Regional Comparison

This section compares the selected measures by region. The regional comparison is imperative because it provides contextual information on the potential unique population needs and health inequities within each region. The regional comparison provides additional depth and understanding of the health and well-being of Medicaid enrollees. As shown in Table 3 below, MCO coverage varies by region, with only two MCOs that are present in all 10 Regional Service Areas as of July 1, 2021.

On July 1, 2021, CHPW was added to the North Sound and Pierce service areas and CCW was added to the Southwest service area. Measure results for these MCOs in these service areas will only contain six months of data as a result and should be interpreted with caution.

Table 3. MCO Coverage by Region (AH-IMC and AH-BHSO only).[19]

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

✓ Indicates the MCO covers that region.
– Indicates the MCO does not cover that region.

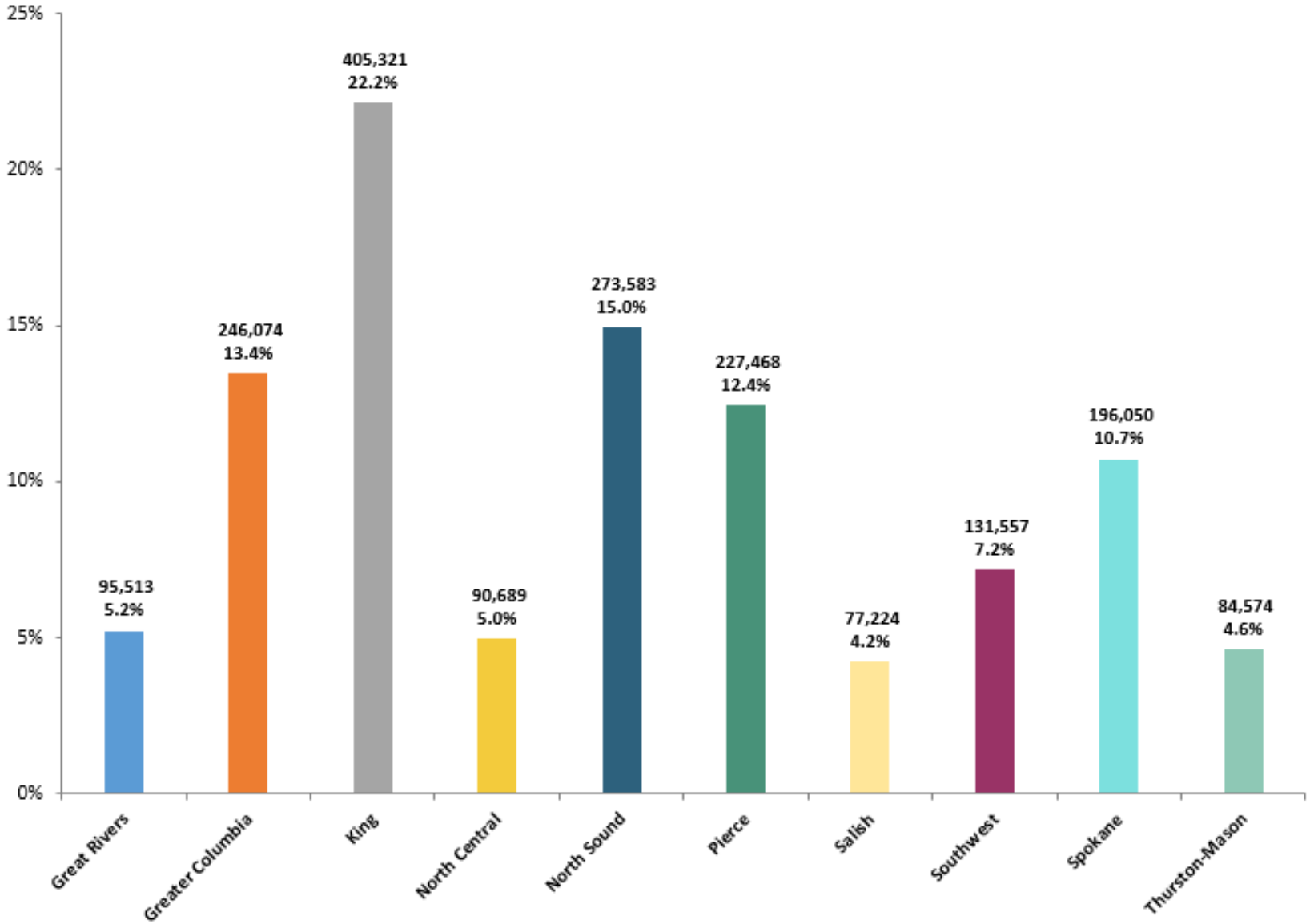
[19] On July 1, 2021, CHPW was added to the North Sound and Pierce service areas and CCW was added to the Southwest service area. Note that effective January 1, 2022, CCW was added to Great Rivers, Salish and Thurston-Mason; CHPW was added to Great Rivers and Thurston-Mason.

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

Figure 47. Percent Enrollment of Total Apple Health Enrollment Statewide by Region, MY2021.

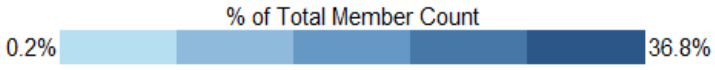


Age Range

Across regions, the largest percentage of enrollees are ages 21 to 44 (Figure 48). All regions have enrollees across all age 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 48. Percent Enrollment by Region and Age Range, MY2021.

Age Range	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	Southwest	Spokane	Thurston - Mason
Age 0 to 5	13.7%	16.1%	13.2%	16.0%	14.3%	14.5%	12.4%	14.5%	13.8%	13.7%
Age 6 to 12	17.4%	20.5%	15.9%	20.9%	17.6%	17.9%	15.3%	18.4%	17.2%	16.9%
Age 13 to 20	17.6%	21.7%	16.5%	21.9%	17.6%	17.7%	15.8%	19.0%	17.2%	16.2%
Age 21 to 44	33.0%	30.0%	36.1%	27.8%	33.8%	34.3%	36.8%	32.9%	36.0%	36.5%
Age 45 to 64	18.3%	11.6%	17.8%	13.1%	16.3%	15.3%	19.5%	14.9%	15.7%	16.5%
Age 65+	0.2%	0.2%	0.5%	0.2%	0.3%	0.2%	0.2%	0.3%	0.2%	0.2%



Race and Ethnicity

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

Figure 49 shows that the member population for most regions is at least 50% white. The exception is the King region, which is 38.7% white, 20.0% Black, 11.7% Asian and 6.2% Hawaiian/Pacific Islander. All regions have at least a 1% American Indian/Alaskan Native membership, with the highest percentages in the Great Rivers, Spokane and Thurston-Mason regions.

Figure 49. Statewide Apple Health Enrollees by Region and Race, MY2021

Race	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	Southwest	Spokane	Thurston - Mason
White	79.5%	55.5%	38.7%	63.4%	62.1%	52.8%	73.5%	68.6%	76.5%	69.6%
Other	7.5%	31.0%	12.6%	23.8%	12.9%	10.4%	5.9%	9.7%	6.3%	8.2%
Not Provided	5.7%	7.3%	9.3%	8.4%	8.7%	7.3%	6.8%	8.3%	5.3%	6.1%
Black	2.0%	2.3%	20.0%	1.3%	5.8%	15.0%	4.9%	4.8%	4.8%	6.0%
Asian	1.1%	1.2%	11.7%	0.6%	5.2%	5.2%	1.8%	2.8%	1.6%	3.6%
American Indian/Alaska Native	2.8%	1.7%	1.5%	1.9%	2.3%	2.0%	2.3%	1.8%	2.7%	2.7%
Hawaiian/Pacific Islander	1.3%	1.1%	6.2%	0.6%	3.2%	7.4%	4.7%	4.1%	2.8%	3.8%

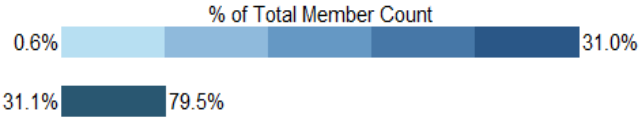
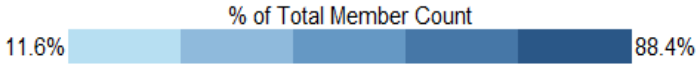


Figure 50 shows the breakdown of the Apple Health enrollment by Hispanic indicator. Most of the regions are at least 80% non-Hispanic. The exceptions are the Greater Columbia and North Central regions. Hispanics are the majority population for Apple Health members who reside in the Greater Columbia region, with 53.9% of members flagged as Hispanic. Hispanics represent 48.2% of the Apple Health population in the North Central region.

Figure 50. Statewide Apple Health Enrollees by Region and Hispanic Indicator, MY2021.

Hispanic	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	Southwest	Spokane	Thurston - Mason
No	84.0%	46.1%	82.7%	51.8%	79.8%	83.0%	88.4%	82.6%	87.9%	84.4%
Yes	16.0%	53.9%	17.3%	48.2%	20.2%	17.0%	11.6%	17.4%	12.1%	15.6%

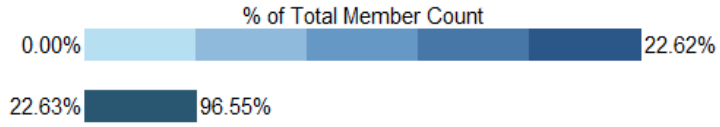


Primary Spoken Language by Region

Figure 51 shows the variation in primary spoken language by region. Spanish/Castilian is the second most commonly spoken language across regions, with Greater Columbia and North Central having the highest percentages. After that, Russian is the most common language with North Sound and Southwest having the highest percentages.

Figure 51. Statewide Apple Health Enrollees by Region and Spoken Language, MY2021.

Spoken Language	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	Southwest	Spokane	Thurston - Mason
English	94.2%	79.5%	84.5%	76.7%	89.2%	92.8%	96.6%	89.7%	95.1%	94.5%
Spanish; Castilian	4.90%	19.39%	7.14%	22.62%	7.21%	4.49%	2.51%	5.89%	2.53%	4.26%
Russian	0.05%	0.17%	0.67%	0.16%	0.99%	0.60%	0.01%	2.80%	0.63%	0.03%
Vietnamese	0.05%	0.08%	1.27%	0.04%	0.44%	0.51%	0.07%	0.23%	0.13%	0.37%
Chinese	0.06%	0.05%	1.29%	0.05%	0.24%	0.10%	0.12%	0.11%	0.04%	0.09%
Arabic	NR	0.15%	0.45%	NR	0.34%	0.10%	0.02%	0.10%	0.31%	0.01%
Ukrainian	0.00%	0.08%	0.43%	0.11%	0.34%	0.21%	NR	0.13%	0.05%	0.00%
Somali	0.01%	0.04%	0.75%	NR	0.01%	0.01%	NR	NR	0.01%	0.01%
Korean	0.01%	0.01%	0.17%	NR	0.19%	0.21%	0.02%	0.03%	0.00%	0.10%
Amharic	NR	0.00%	0.36%	NR	0.08%	0.00%	NR	0.01%	0.01%	0.00%
Tigrinya	NR	0.00%	0.27%	0.00%	0.05%	0.01%	NR	0.01%	0.02%	0.00%
Panjabi; Punjabi	0.00%	0.01%	0.16%	0.01%	0.13%	0.05%	0.00%	0.02%	0.00%	0.02%
Burmese	NR	0.07%	0.17%	0.00%	0.01%	0.00%	NR	0.02%	0.07%	0.00%
Farsi	NR	0.00%	0.17%	0.00%	0.06%	0.02%	0.01%	0.01%	0.04%	NR
Cambodian; Khmer	0.05%	NR	0.08%	NR	0.04%	0.12%	NR	0.02%	0.01%	0.05%
Other Language*	0.66%	0.45%	2.13%	0.30%	0.69%	0.78%	0.66%	0.96%	1.08%	0.58%



Note: NR in a cell means that those languages were not reported for that region.

Region-Specific Performance

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

MCO Performance by Region

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

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

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

Figures 52 through 61 include the results of this analysis. The yellow downward arrows indicate MCOs that perform statistically below other MCOs that operate in the region; the blue upward arrows indicate MCOs that perform statistically above other MCOs that operate in the region. If an MCO does not operate in that region, its column is grayed out. The regional simple average is provided for comparison. Note this simple average is calculated using the rates that are reported for each region; if the MCO does not operate in that region or if there is insufficient data for an MCO, their rate is excluded.

Here are the findings from the regional analysis:

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

Great Rivers Region

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

Figure 52. Comparison of MCOs by Measure within Great Rivers Region, MY2021.

Measures where higher is better:
Statistically significant higher rate than other MCOs ▲
Statistically significant lower rate than other MCOs ▼

Measures where lower is better:
Statistically significant higher rate than other MCOs ▲
Statistically significant lower rate than other MCOs ▼

		AMG	CCW	CHPW	MHW	UHC	Regional Simple Average
Prevention and Screening	Breast Cancer Screening (BCS)	40%			42%	44%	42%
	Cervical Cancer Screening (CCS)	39%			***	***	39%
	Childhood Immunization Status (CIS), Combo 10	40%			***	***	40%
	Chlamydia Screening (CHL), Ttl	41% ▼			49% ▲	46%	45%
	Immunizations for Adolescents (IMA), Combo 2	***			***	***	***
	Lead Screening in Children (LSC)	47%			***	***	47%
Respiratory Conditions	Asthma Medication Ratio (AMR), Ttl	59%			66% ▲	51% ▼	59%
Cardiovascular Conditions	Controlling High Blood Pressure (CBP)	73%			64%	67%	68%
Diabetes	Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0%	57%			***	49%	53%
	Comprehensive Diabetes Care (CDC), Poor HbA1c Control (Lower score is better)	33%			***	30%	31%
	Kidney Health Eval for Patients with Diabetes (KED), 18-64 Yrs	37%			33% ▼	37%	36%
Behavioral Health	Antidepressant Medication Mgmt (AMM), Continuation Phase	39%			40%	48% ▲	42%
	Antidepressant Medication Mgmt (AMM), Effective Acute Phase	53% ▼			61%	63%	59%
	Follow-Up After ED Visit for Alcohol & Other Drug Abuse Dependencies (FUA), 7-Day FU, Ttl	11%			17%	10%	13%
	Follow-Up After ED Visit for Alcohol & Other Drug Abuse Dependencies (FUA), 30-Day FU, 13-17 Yrs	***			***	***	***
	Follow-Up After ED Visit for Alcohol & Other Drug Abuse Dependencies (FUA), 30-Day FU, Ttl	24%			28%	25%	26%
	Follow-Up After ED Visit for Mental Illness (FUM), 7-Day FU, Ttl	34% ▼			60% ▲	61%	52%
	Follow-Up After ED Visit for Mental Illness (FUM), 30-Day FU, Ttl	43% ▼			73% ▲	77%	64%
	Follow-Up After High Intensity Care for SUD (FUI): 7-Day FU, Ttl	37%			43%	40%	40%
	Follow-Up After High Intensity Care for SUD (FUI): 30-Day FU, Ttl	53%			58%	61%	57%
	Follow-Up after Hosp for Mental Illness (FUH), 7-Day FU, Ttl	46%			59% ▲	40% ▼	48%
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, 6-17 Yrs	***			91%	***	91%
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, 18-64 Yrs	57%			70% ▲	54%	60%
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, Ttl	61% ▼			76% ▲	60%	66%
	Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	45%			45%	***	45%
	Pharmacotherapy for Opioid Use Disorder (POD), 16-64 Yrs	14%			17%	13%	14%
Overuse/Appropriateness	Use of Opioids at High Dosage (HDO) (Lower score is better)	5%			5%	7%	6%
Access/Availability of Care	Adults' Access to Preventive/Ambulatory Health Services (AAP), Ttl	66% ▼			74% ▲	69% ▼	70%
	I&E of Alcohol & Other Drug Dependence Treat (IET), Ttl: Engagement of AOD Treat: Ttl	19%			18%	18%	19%
	I&E of Alcohol & Other Drug Dependence Treat (IET), Ttl: Initiation of AOD Treat: 13-17 Yrs	***			42%	***	42%
	I&E of Alcohol & Other Drug Dependence Treat (IET), Ttl: Initiation of AOD Treat: Ttl	51%			51%	51%	51%
	Prenatal & Postpartum Care (PPC), Postpartum Care	***			***	***	***
	Prenatal & Postpartum Care (PPC), Timeliness of Prenatal Care	***			***	***	***
	Use of First-Line Psychosocial Care for Children & Adolescents on Antipsychotics (APP), Ttl	***			75%	***	75%
Utilization	Child & Adolescent Well-Care Visit (WCV), Age 3-11	45% ▼			53% ▲	44% ▼	47%
	Child & Adolescent Well-Care Visit (WCV), Age 12-17	43% ▼			47% ▲	37% ▼	42%
	Child & Adolescent Well-Care Visit (WCV), Age 18-21	14% ▼			20% ▲	12% ▼	15%
	Child & Adolescent Well-Care Visit (WCV), Ttl	38% ▼			47% ▲	35% ▼	40%
	Well-Child Visits in the First 30 Mnths of Life (W30), 15-30 Mnths	58% ▼			70% ▲	56% ▼	61%
	Well-Child Visits in the First 30 Mnths of Life (W30), First 15 Mnths	49%			55% ▲	50%	52%

Greater Columbia Region

Many measures did not show significantly differences by plan. However, CHPW performed significantly above the other MCOs for the Well-Child Visits in the First 30 Months of Life (W30), First 15 Months and Child and Adolescent Well-Care Visit (WCV) measures. AMG performed below the regional average for these same measures. There were a handful of other measures where an individual MCO did better or worse than the other MCOs.

Figure 53. Comparison of MCOs by Measure within Greater Columbia Region, MY2021.

Measures where higher is better:
Statistically significant higher rate than other MCOs ▲
Statistically significant lower rate than other MCOs ▼

Measures where lower is better:
Statistically significant higher rate than other MCOs ▲
Statistically significant lower rate than other MCOs ▼

		AMG	CCW	CHPW	MHW	UHC	Regional Simple Average
Prevention and Screening	Breast Cancer Screening (BCS)	44% ▼	49%	51%	50%		48%
	Cervical Cancer Screening (CCS)	41% ▼	58%	71% ▲	48%		54%
	Childhood Immunization Status (CIS), Combo 10	40%	39%	47%	45%		43%
	Chlamydia Screening (CHL), Ttl	50%	55% ▲	55%	52% ▼		53%
	Immunizations for Adolescents (IMA), Combo 2	27%	35%	45%	50%		39%
	Lead Screening in Children (LSC)	31%	33%	36%	26%		31%
Respiratory Conditions	Asthma Medication Ratio (AMR), Ttl	65%	71% ▲	57% ▼	67%		65%
Cardiovascular Conditions	Controlling High Blood Pressure (CBP)	***	62%	63%	59%		61%
Diabetes	Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0%	***	35% ▼	56% ▲	55%		49%
	Comprehensive Diabetes Care (CDC), Poor HbA1c Control (Lower score is better)	***	51% ▲	38%	35%		42%
	Kidney Health Eval for Patients with Diabetes (KED), 18-64 Yrs	42%	47%	49% ▲	42% ▼		45%
Behavioral Health	Antidepressant Medication Mgmt (AMM), Continuation Phase	47%	41%	38% ▼	44% ▲		43%
	Antidepressant Medication Mgmt (AMM), Effective Acute Phase	65%	58%	56% ▼	63% ▲		61%
	Follow-Up After ED Visit for Alcohol & Other Drug Abuse Dependencies (FUA), 7-Day FU, Ttl	10% ▼	16%	17%	23% ▲		16%
	Follow-Up After ED Visit for Alcohol & Other Drug Abuse Dependencies (FUA), 30-Day FU, 13-17 Yrs	***	***	***	***		***
	Follow-Up After ED Visit for Alcohol & Other Drug Abuse Dependencies (FUA), 30-Day FU, Ttl	21%	23%	29%	32% ▲		26%
	Follow-Up After ED Visit for Mental Illness (FUM), 7-Day FU, Ttl	44%	39%	34%	42%		40%
	Follow-Up After ED Visit for Mental Illness (FUM), 30-Day FU, Ttl	60%	52%	56%	59%		57%
	Follow-Up After High Intensity Care for SUD (FUI): 7-Day FU, Ttl	38%	40%	36%	45%		40%
	Follow-Up After High Intensity Care for SUD (FUI): 30-Day FU, Ttl	62%	54%	59%	61%		59%
	Follow-Up after Hosp for Mental Illness (FUH), 7-Day FU, Ttl	31%	44%	40%	42%		39%
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, 6-17 Yrs	***	75%	74%	74%		74%
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, 18-64 Yrs	56%	63%	65%	65%		62%
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, Ttl	57%	67%	67%	67%		65%
	Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	43%	41%	37%	40%		40%
	Pharmacotherapy for Opioid Use Disorder (POD), 16-64 Yrs	11%	15%	9% ▼	13%		12%
Overuse/Appropriateness	Use of Opioids at High Dosage (HDO) (Lower score is better)	4%	5%	4%	5%		4%
Access/Availability of Care	Adults' Access to Preventive/Ambulatory Health Services (AAP), Ttl	67% ▼	75% ▲	75%	76% ▲		73%
	I&E of Alcohol & Other Drug Dependence Treat (IET), Ttl: Engagement of AOD Treat: Ttl	14%	15%	17%	17%		15%
	I&E of Alcohol & Other Drug Dependence Treat (IET), Ttl: Initiation of AOD Treat: 13-17 Yrs	***	24%	34%	32%		30%
	I&E of Alcohol & Other Drug Dependence Treat (IET), Ttl: Initiation of AOD Treat: Ttl	44% ▲	40%	37% ▼	41%		40%
	Prenatal & Postpartum Care (PPC), Postpartum Care	***	75% ▼	89% ▲	72%		78%
	Prenatal & Postpartum Care (PPC), Timeliness of Prenatal Care	***	83%	91%	91%		88%
	Use of First-Line Psychosocial Care for Children & Adolescents on Antipsychotics (APP), Ttl	***	54%	***	41% ▼		47%
Utilization	Child & Adolescent Well-Care Visit (WCV), Age 3-11	51% ▼	57%	57% ▲	56%		55%
	Child & Adolescent Well-Care Visit (WCV), Age 12-17	41% ▼	49%	52% ▲	47% ▼		47%
	Child & Adolescent Well-Care Visit (WCV), Age 18-21	18% ▼	20% ▼	23% ▲	21%		20%
	Child & Adolescent Well-Care Visit (WCV), Ttl	42% ▼	48%	50% ▲	47% ▼		47%
	Well-Child Visits in the First 30 Mnths of Life (W30), 15-30 Mnths	69%	61% ▼	68%	70% ▲		67%
	Well-Child Visits in the First 30 Mnths of Life (W30), First 15 Mnths	55% ▼	55% ▼	70% ▲	61%		60%

King Region

There was notable variation for several of the behavioral health measures, with CHPW and MHW performing significantly better than other MCOs in the King region; AMG and CCW performed significantly worse on many of these same measures. MHW also performed significantly better than the other MCOs on the Well-Child Visits in the First 30 Months of Life (W30) and Child and Adolescent Well-Care Visit (WCV) measures; the exception was the Well-Child Visits in the First 30 Months of Life (W30), Ages 15-30 months measure. AMG performed significantly below the other MCOs for the well-child visit measures. There were a handful of other measures where an individual MCO did better or worse than the other MCOs.

Figure 54. Comparison of MCOs by Measure within King Region, MY2021.

Measures where higher is better:
Statistically significant higher rate than other MCOs ▲
Statistically significant lower rate than other MCOs ▼

Measures where lower is better:
Statistically significant higher rate than other MCOs ▲
Statistically significant lower rate than other MCOs ▼

		AMG	CCW	CHPW	MHW	UHC	Regional Simple Average
Prevention and Screening	Breast Cancer Screening (BCS)	38% ▼	41%	40% ▼	47% ▲	44%	42%
	Cervical Cancer Screening (CCS)	54%	45%	51%	57%	56%	52%
	Childhood Immunization Status (CIS), Combo 10	34%	42%	48%	36%	41%	40%
	Chlamydia Screening (CHL), Ttl	54%	54%	50% ▼	56% ▲	54%	54%
	Immunizations for Adolescents (IMA), Combo 2	37%	27%	38%	24% ▼	33%	32%
	Lead Screening in Children (LSC)	39%	19% ▼	59% ▲	46%	35%	40%
Respiratory Conditions	Asthma Medication Ratio (AMR), Ttl	61%	66%	55% ▼	69% ▲	57% ▼	62%
Cardiovascular Conditions	Controlling High Blood Pressure (CBP)	47% ▼	56%	65%	66%	64%	59%
Diabetes	Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0%	51%	43%	48%	48%	55%	49%
	Comprehensive Diabetes Care (CDC), Poor HbA1c Control (Lower score is better)	35%	38%	36%	38%	37%	36%
	Kidney Health Eval for Patients with Diabetes (KED), 18-64 Yrs	45% ▼	48% ▼	56% ▲	51% ▲	48% ▼	50%
Behavioral Health	Antidepressant Medication Mgmt (AMM), Continuation Phase	39% ▼	44%	40% ▼	45%	47% ▲	43%
	Antidepressant Medication Mgmt (AMM), Effective Acute Phase	58%	61%	55% ▼	61%	62%	60%
	Follow-Up After ED Visit for Alcohol & Other Drug Abuse Dependencies (FUA), 7-Day FU, Ttl	11%	9%	16% ▲	13%	11%	12%
	Follow-Up After ED Visit for Alcohol & Other Drug Abuse Dependencies (FUA), 30-Day FU, 13-17 Yrs	***	***	***	***	***	***
	Follow-Up After ED Visit for Alcohol & Other Drug Abuse Dependencies (FUA), 30-Day FU, Ttl	15% ▼	14% ▼	27% ▲	23% ▲	19%	20%
	Follow-Up After ED Visit for Mental Illness (FUM), 7-Day FU, Ttl	15% ▼	18% ▼	47% ▲	46% ▲	35%	32%
	Follow-Up After ED Visit for Mental Illness (FUM), 30-Day FU, Ttl	22% ▼	27% ▼	59% ▲	60% ▲	47%	43%
	Follow-Up After High Intensity Care for SUD (FUI): 7-Day FU, Ttl	23%	23%	26%	31% ▲	25%	26%
	Follow-Up After High Intensity Care for SUD (FUI): 30-Day FU, Ttl	46%	41%	51%	54% ▲	47%	48%
	Follow-Up after Hosp for Mental Illness (FUH), 7-Day FU, Ttl	7% ▼	7% ▼	36% ▲	41% ▲	10% ▼	20%
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, 6-17 Yrs	***	43% ▼	76% ▲	73% ▲	38% ▼	57%
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, 18-64 Yrs	15% ▼	9% ▼	51% ▲	60% ▲	18% ▼	31%
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, Ttl	15% ▼	14% ▼	53% ▲	62% ▲	20% ▼	33%
	Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	30%	34% ▼	56%	44%	57% ▲	44%
	Pharmacotherapy for Opioid Use Disorder (POD), 16-64 Yrs	8% ▼	18% ▲	9%	10%	12%	11%
Overuse/Appropriateness	Use of Opioids at High Dosage (HDO) (Lower score is better)	4%	7%	3% ▼	5%	7% ▲	5%
Access/Availability of Care	Adults' Access to Preventive/Ambulatory Health Services (AAP), Ttl	65% ▼	66% ▼	70%	73% ▲	69% ▼	69%
	I&E of Alcohol & Other Drug Dependence Treat (IET), Ttl: Engagement of AOD Treat: Ttl	12%	10% ▼	13%	15% ▲	13%	13%
	I&E of Alcohol & Other Drug Dependence Treat (IET), Ttl: Initiation of AOD Treat: 13-17 Yrs	***	36%	26%	41%	***	34%
	I&E of Alcohol & Other Drug Dependence Treat (IET), Ttl: Initiation of AOD Treat: Ttl	50% ▲	40% ▼	41% ▼	47% ▲	41% ▼	44%
	Prenatal & Postpartum Care (PPC), Postpartum Care	75%	69%	74%	82%	81%	76%
	Prenatal & Postpartum Care (PPC), Timeliness of Prenatal Care	86%	69% ▼	91%	87%	91% ▲	85%
	Use of First-Line Psychosocial Care for Children & Adolescents on Antipsychotics (APP), Ttl	***	39%	***	62% ▲	***	50%
Utilization	Child & Adolescent Well-Care Visit (WCV), Age 3-11	50% ▼	53%	53%	54% ▲	52% ▼	52%
	Child & Adolescent Well-Care Visit (WCV), Age 12-17	43% ▼	44% ▼	51% ▲	50% ▲	48%	47%
	Child & Adolescent Well-Care Visit (WCV), Age 18-21	17% ▼	18% ▼	21% ▼	24% ▲	23%	21%
	Child & Adolescent Well-Care Visit (WCV), Ttl	43% ▼	44% ▼	46%	48% ▲	47%	46%
	Well-Child Visits in the First 30 Mnths of Life (W30), 15-30 Mnths	55% ▼	64% ▲	62%	60%	61%	60%
	Well-Child Visits in the First 30 Mnths of Life (W30), First 15 Mnths	47% ▼	45% ▼	57% ▲	52% ▲	44% ▼	49%

North Central Region

Many of the measures reported for the North Central region had denominators too small to report. There was isolated variation between the plans for the measures with sufficient data but, overall, there was no discernible statistical differences. This may also be due to small denominators leading to difficulties in detecting statistical differences.

Figure 55. Comparison of MCOs by Measure within North Central Region, MY2021.

Measures where higher is better:
Statistically significant higher rate than other MCOs ▲
Statistically significant lower rate than other MCOs ▼

Measures where lower is better:
Statistically significant higher rate than other MCOs ▲
Statistically significant lower rate than other MCOs ▼

		AMG	CCW	CHPW	MHW	UHC	Regional Simple Average
Prevention and Screening	Breast Cancer Screening (BCS)	44%	52%	***	48%		48%
	Cervical Cancer Screening (CCS)	***	67%	***	***		67%
	Childhood Immunization Status (CIS), Combo 10	***	61%	***	55%		58%
	Chlamydia Screening (CHL), Ttl	45%	43%	47%	45%		45%
	Immunizations for Adolescents (IMA), Combo 2	***	39%	***	34%		37%
	Lead Screening in Children (LSC)	***	55% ▲	***	29%		42%
Respiratory Conditions	Asthma Medication Ratio (AMR), Ttl	69%	65%	***	62%		65%
Cardiovascular Conditions	Controlling High Blood Pressure (CBP)	***	66%	***	***		66%
Diabetes	Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0%	***	57%	***	***		57%
	Comprehensive Diabetes Care (CDC), Poor HbA1c Control (Lower score is better)	***	37%	***	***		37%
	Kidney Health Eval for Patients with Diabetes (KED), 18-64 Yrs	52%	48% ▼	***	57% ▲		52%
Behavioral Health	Antidepressant Medication Mgmt (AMM), Continuation Phase	44%	39%	***	42%		42%
	Antidepressant Medication Mgmt (AMM), Effective Acute Phase	64%	57%	***	62%		61%
	Follow-Up After ED Visit for Alcohol & Other Drug Abuse Dependencies (FUA), 7-Day FU, Ttl	24%	14% ▼	***	29%		22%
	Follow-Up After ED Visit for Alcohol & Other Drug Abuse Dependencies (FUA), 30-Day FU, 13-17 Yrs	***	***	***	***		***
	Follow-Up After ED Visit for Alcohol & Other Drug Abuse Dependencies (FUA), 30-Day FU, Ttl	35%	24% ▼	***	38%		32%
	Follow-Up After ED Visit for Mental Illness (FUM), 7-Day FU, Ttl	28% ▼	53%	***	68% ▲		50%
	Follow-Up After ED Visit for Mental Illness (FUM), 30-Day FU, Ttl	41% ▼	71%	***	79% ▲		64%
	Follow-Up After High Intensity Care for SUD (FUI): 7-Day FU, Ttl	39%	***	***	36%		37%
	Follow-Up After High Intensity Care for SUD (FUI): 30-Day FU, Ttl	68%	***	***	62%		65%
	Follow-Up after Hosp for Mental Illness (FUH), 7-Day FU, Ttl	***	53%	***	53%		53%
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, 6-17 Yrs	***	***	***	85%		85%
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, 18-64 Yrs	***	***	***	62% ▲		62%
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, Ttl	***	76%	***	72%		74%
	Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	***	51%	***	42%		47%
	Pharmacotherapy for Opioid Use Disorder (POD), 16-64 Yrs	13%	23%	***	13%		16%
Overuse/Appropriateness	Use of Opioids at High Dosage (HDO) (Lower score is better)	6%	6%	***	6%		6%
Access/Availability of Care	Adults' Access to Preventive/Ambulatory Health Services (AAP), Ttl	72% ▼	73% ▼	80%	78% ▲		76%
	I&E of Alcohol & Other Drug Dependence Treat (IET), Ttl: Engagement of AOD Treat: Ttl	14%	11%	15%	14%		14%
	I&E of Alcohol & Other Drug Dependence Treat (IET), Ttl: Initiation of AOD Treat: 13-17 Yrs	***	***	***	30%		30%
	I&E of Alcohol & Other Drug Dependence Treat (IET), Ttl: Initiation of AOD Treat: Ttl	48% ▲	36% ▼	35%	42%		40%
	Prenatal & Postpartum Care (PPC), Postpartum Care	***	91%	***	93%		92%
	Prenatal & Postpartum Care (PPC), Timeliness of Prenatal Care	***	95%	***	93%		94%
	Use of First-Line Psychosocial Care for Children & Adolescents on Antipsychotics (APP), Ttl	***	***	***	67%		67%
Utilization	Child & Adolescent Well-Care Visit (WCV), Age 3-11	64%	69% ▲	53% ▼	61% ▼		62%
	Child & Adolescent Well-Care Visit (WCV), Age 12-17	59%	58%	49%	57%		56%
	Child & Adolescent Well-Care Visit (WCV), Age 18-21	23%	21%	17%	23%		21%
	Child & Adolescent Well-Care Visit (WCV), Ttl	56%	58% ▲	44% ▼	54% ▼		53%
	Well-Child Visits in the First 30 Mnths of Life (W30), 15-30 Mnths	71%	77% ▲	***	70% ▼		73%
	Well-Child Visits in the First 30 Mnths of Life (W30), First 15 Mnths	66% ▲	53% ▼	***	57%		59%

North Sound Region

MHW performed significantly better than other MCOs operating in the North Sound region. AMG and CCW performed significantly worse. MHW and UHC both performed better than the other MCOS on the Well-Child Visits in the First 30 Months of Life (W30) and Child and Adolescent Well-Care Visit (WCV) measures; AMG, CCW and CHPW performed worse on these measures. Note that CHPW was added to the North Sound region as of July 1, 2021, and members may not have been enrolled long enough to meet the inclusion criteria for many of these measures.

Figure 56. Comparison of MCOs by Measure within North Sound Region.

Measures where higher is better:
Statistically significant higher rate than other MCOs ▲
Statistically significant lower rate than other MCOs ▼

Measures where lower is better:
Statistically significant higher rate than other MCOs ▲
Statistically significant lower rate than other MCOs ▼

		AMG	CCW	CHPW	MHW	UHC	Regional Simple Average
Prevention and Screening	Breast Cancer Screening (BCS)	39% ▼	45%	40% ▼	46%	49% ▲	44%
	Cervical Cancer Screening (CCS)	33% ▼	49%	48%	67% ▲	61%	52%
	Childhood Immunization Status (CIS), Combo 10	42%	33%	48%	46%	45%	43%
	Chlamydia Screening (CHL), Ttl	50% ▲	47%	43% ▼	47%	44%	46%
	Immunizations for Adolescents (IMA), Combo 2	22%	37%	46% ▲	38%	29%	34%
	Lead Screening in Children (LSC)	29%	9% ▼	33% ▲	29%	23%	25%
Respiratory Conditions	Asthma Medication Ratio (AMR), Ttl	55%	65%	57% ▼	69% ▲	55% ▼	60%
Cardiovascular Conditions	Controlling High Blood Pressure (CBP)	***	63%	60%	67%	73%	66%
Diabetes	Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0%	41%	33% ▼	45%	48%	65% ▲	46%
	Comprehensive Diabetes Care (CDC), Poor HbA1c Control (Lower score is better)	38%	55% ▲	40%	33%	24% ▼	38%
	Kidney Health Eval for Patients with Diabetes (KED), 18-64 Yrs	36% ▼	39%	37% ▼	44% ▲	46% ▲	40%
Behavioral Health	Antidepressant Medication Mgmt (AMM), Continuation Phase	48%	43%	38% ▼	45%	49% ▲	45%
	Antidepressant Medication Mgmt (AMM), Effective Acute Phase	64%	61%	58% ▼	63%	66% ▲	62%
	Follow-Up After ED Visit for Alcohol & Other Drug Abuse Dependencies (FUA), 7-Day FU, Ttl	10% ▼	18%	19%	20%	21%	18%
	Follow-Up After ED Visit for Alcohol & Other Drug Abuse Dependencies (FUA), 30-Day FU, 13-17 Yrs	***	***	***	***	***	***
	Follow-Up After ED Visit for Alcohol & Other Drug Abuse Dependencies (FUA), 30-Day FU, Ttl	20% ▼	32%	29%	31%	30%	29%
	Follow-Up After ED Visit for Mental Illness (FUM), 7-Day FU, Ttl	34% ▼	33% ▼	49%	50% ▲	39%	41%
	Follow-Up After ED Visit for Mental Illness (FUM), 30-Day FU, Ttl	49% ▼	46% ▼	63%	64% ▲	53%	55%
	Follow-Up After High Intensity Care for SUD (FUI): 7-Day FU, Ttl	37% ▼	48%	42%	48% ▲	44%	44%
	Follow-Up After High Intensity Care for SUD (FUI): 30-Day FU, Ttl	58%	65%	60%	67% ▲	62%	62%
	Follow-Up after Hosp for Mental Illness (FUH), 7-Day FU, Ttl	29%	23% ▼	34%	41% ▲	36%	33%
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, 6-17 Yrs	***	54%	55%	73% ▲	63%	61%
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, 18-64 Yrs	47%	28% ▼	53%	56% ▲	50%	47%
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, Ttl	51%	37% ▼	53%	60% ▲	52%	51%
	Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	46%	45%	42%	44%	43%	44%
	Pharmacotherapy for Opioid Use Disorder (POD), 16-64 Yrs	15%	23% ▲	10% ▼	12%	15%	15%
Overuse/Appropriateness	Use of Opioids at High Dosage (HDO) (Lower score is better)	8%	7%	6%	6%	7%	7%
Access/Availability of Care	Adults' Access to Preventive/Ambulatory Health Services (AAP), Ttl	65% ▼	69% ▼	72% ▼	75% ▲	74% ▲	71%
	I&E of Alcohol & Other Drug Dependence Treat (IET), Ttl: Engagement of AOD Treat: Ttl	13% ▼	16%	16%	17%	17%	16%
	I&E of Alcohol & Other Drug Dependence Treat (IET), Ttl: Initiation of AOD Treat: 13-17 Yrs	***	54% ▲	23%	26%	26%	32%
	I&E of Alcohol & Other Drug Dependence Treat (IET), Ttl: Initiation of AOD Treat: Ttl	45%	47%	44%	46%	44%	45%
	Prenatal & Postpartum Care (PPC), Postpartum Care	80%	77%	89%	77%	86%	82%
	Prenatal & Postpartum Care (PPC), Timeliness of Prenatal Care	89%	73% ▼	89%	80%	94% ▲	85%
	Use of First-Line Psychosocial Care for Children & Adolescents on Antipsychotics (APP), Ttl	***	***	***	59%	***	59%
Utilization	Child & Adolescent Well-Care Visit (WCV), Age 3-11	49% ▼	54%	52% ▼	52%	55% ▲	52%
	Child & Adolescent Well-Care Visit (WCV), Age 12-17	39% ▼	44% ▼	47%	48% ▲	50% ▲	45%
	Child & Adolescent Well-Care Visit (WCV), Age 18-21	14% ▼	17% ▼	18% ▼	21% ▲	24% ▲	19%
	Child & Adolescent Well-Care Visit (WCV), Ttl	41% ▼	45% ▼	44% ▼	46% ▲	49% ▲	45%
	Well-Child Visits in the First 30 Mnths of Life (W30), 15-30 Mnths	66%	67%	64%	65% ▼	72% ▲	67%
	Well-Child Visits in the First 30 Mnths of Life (W30), First 15 Mnths	54%	51%	59% ▲	54%	53%	54%

Pierce Region

Many measures did not show significantly differences by plan. However, MHW does better than the other MCOs on several of the measures, most notably for the Well-Child Visits in the First 30 Months of Life (W30) and Child and Adolescent Well-Care Visit (WCV) measures. AMG, CCW and UHC performed significantly worse for the well-child visit measures. There were a handful of other measures where an individual MCO did better or worse than the other MCOs. Note that CHPW was added to the Pierce region as of July 1, 2021, and members may not have been enrolled long enough to meet the inclusion criteria for many of these measures.

Figure 57. Comparison of MCOs by Measure within Pierce Region, MY2021.

Measures where higher is better:
Statistically significant higher rate than other MCOs ▲
Statistically significant lower rate than other MCOs ▼

Measures where lower is better:
Statistically significant higher rate than other MCOs ▲
Statistically significant lower rate than other MCOs ▼

		AMG	CCW	CHPW	MHW	UHC	Regional Simple Average
Prevention and Screening	Breast Cancer Screening (BCS)	37% ▼	40%	***	42%	43%	40%
	Cervical Cancer Screening (CCS)	36%	53%	***	46%	46%	45%
	Childhood Immunization Status (CIS), Combo 10	37%	44%	***	25%	37%	36%
	Chlamydia Screening (CHL), Ttl	55%	52%	54%	53%	50%	53%
	Immunizations for Adolescents (IMA), Combo 2	33%	28%	***	32%	35%	32%
	Lead Screening in Children (LSC)	42%	33%	***	25%	25%	31%
Respiratory Conditions	Asthma Medication Ratio (AMR), Ttl	59% ▼	74% ▲	***	70% ▲	59% ▼	66%
Cardiovascular Conditions	Controlling High Blood Pressure (CBP)	58%	59%	***	70%	68%	64%
Diabetes	Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0%	51%	55%	***	58%	57%	55%
	Comprehensive Diabetes Care (CDC), Poor HbA1c Control (Lower score is better)	45%	36%	***	38%	35%	39%
	Kidney Health Eval for Patients with Diabetes (KED), 18-64 Yrs	41%	39%	49%	42% ▲	38% ▼	42%
Behavioral Health	Antidepressant Medication Mgmt (AMM), Continuation Phase	44%	41%	***	43%	47%	44%
	Antidepressant Medication Mgmt (AMM), Effective Acute Phase	61%	59%	***	60%	62%	60%
	Follow-Up After ED Visit for Alcohol & Other Drug Abuse Dependencies (FUA), 7-Day FU, Ttl	13%	12%	8%	15%	13%	12%
	Follow-Up After ED Visit for Alcohol & Other Drug Abuse Dependencies (FUA), 30-Day FU, 13-17 Yrs	***	***	***	17%	***	17%
	Follow-Up After ED Visit for Alcohol & Other Drug Abuse Dependencies (FUA), 30-Day FU, Ttl	21%	19%	25%	23%	23%	22%
	Follow-Up After ED Visit for Mental Illness (FUM), 7-Day FU, Ttl	36% ▼	46%	***	54% ▲	44%	45%
	Follow-Up After ED Visit for Mental Illness (FUM), 30-Day FU, Ttl	50% ▼	63%	***	67% ▲	60%	60%
	Follow-Up After High Intensity Care for SUD (FUI): 7-Day FU, Ttl	38%	37%	32%	35%	37%	36%
	Follow-Up After High Intensity Care for SUD (FUI): 30-Day FU, Ttl	54%	49%	54%	56%	55%	54%
	Follow-Up after Hosp for Mental Illness (FUH), 7-Day FU, Ttl	35%	31%	30%	42%	42%	36%
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, 6-17 Yrs	***	***	***	85% ▲	***	85%
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, 18-64 Yrs	50%	43% ▼	***	57% ▲	57%	52%
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, Ttl	51%	47% ▼	30% ▼	62% ▲	57%	49%
	Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	46%	45%	***	42%	38%	43%
	Pharmacotherapy for Opioid Use Disorder (POD), 16-64 Yrs	12%	19% ▲	18%	12%	15%	15%
Overuse/Appropriateness	Use of Opioids at High Dosage (HDO) (Lower score is better)	4%	5%	***	4%	7% ▲	5%
Access/Availability of Care	Adults' Access to Preventive/Ambulatory Health Services (AAP), Ttl	64% ▼	65% ▼	69%	72% ▲	64% ▼	67%
	I&E of Alcohol & Other Drug Dependence Treat (IET), Ttl: Engagement of AOD Treat: Ttl	15%	12% ▼	17%	16% ▲	14%	15%
	I&E of Alcohol & Other Drug Dependence Treat (IET), Ttl: Initiation of AOD Treat: 13-17 Yrs	***	***	***	37%	***	37%
	I&E of Alcohol & Other Drug Dependence Treat (IET), Ttl: Initiation of AOD Treat: Ttl	51%	49%	51%	50%	47% ▼	50%
	Prenatal & Postpartum Care (PPC), Postpartum Care	78%	73%	***	83%	76%	77%
	Prenatal & Postpartum Care (PPC), Timeliness of Prenatal Care	83%	83%	***	91%	84%	85%
	Use of First-Line Psychosocial Care for Children & Adolescents on Antipsychotics (APP), Ttl	***	***	***	77% ▲	***	77%
Utilization	Child & Adolescent Well-Care Visit (WCV), Age 3-11	46% ▼	49%	46%	53% ▲	40% ▼	47%
	Child & Adolescent Well-Care Visit (WCV), Age 12-17	40% ▼	41% ▼	37%	49% ▲	34% ▼	40%
	Child & Adolescent Well-Care Visit (WCV), Age 18-21	13% ▼	12% ▼	13%	21% ▲	13% ▼	14%
	Child & Adolescent Well-Care Visit (WCV), Ttl	39% ▼	41% ▼	36% ▼	47% ▲	34% ▼	39%
	Well-Child Visits in the First 30 Mnths of Life (W30), 15-30 Mnths	60%	67% ▲	***	63%	57% ▼	62%
	Well-Child Visits in the First 30 Mnths of Life (W30), First 15 Mnths	49% ▼	49% ▼	***	58% ▲	46% ▼	51%

Salish Region

Many measures did not show significantly differences by plan. However, MHW performed better than the other MCOs on several measures. AMG performed lower than the other MCOs for several measures; UHC performed lower than the regional average for the Child and Adolescent Well-Visit (WCV) measures. There were a handful of other measures where an individual MCO did better or worse than the other MCOs.

Figure 58. Comparison of MCOs by Measure within Salish Region, MY2021.

Measures where higher is better:
Statistically significant higher rate than other MCOs ▲
Statistically significant lower rate than other MCOs ▼

Measures where lower is better:
Statistically significant higher rate than other MCOs ▲
Statistically significant lower rate than other MCOs ▼

		AMG	CCW	CHPW	MHW	UHC	Regional Simple Average
Prevention and Screening	Breast Cancer Screening (BCS)	44% ▼			50%	52%	48%
	Cervical Cancer Screening (CCS)	34% ▼			***	49%	41%
	Childhood Immunization Status (CIS), Combo 10	***			***	60%	60%
	Chlamydia Screening (CHL), Ttl	46%			46%	44%	45%
	Immunizations for Adolescents (IMA), Combo 2	26%			***	16%	21%
	Lead Screening in Children (LSC)	***			***	19%	19%
Respiratory Conditions	Asthma Medication Ratio (AMR), Ttl	66%			69%	63%	66%
Cardiovascular Conditions	Controlling High Blood Pressure (CBP)	73%			***	71%	72%
Diabetes	Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0%	***			***	66%	66%
	Comprehensive Diabetes Care (CDC), Poor HbA1c Control (Lower score is better)	***			***	24%	24%
	Kidney Health Eval for Patients with Diabetes (KED), 18-64 Yrs	44%			48% ▲	42%	45%
Behavioral Health	Antidepressant Medication Mgmt (AMM), Continuation Phase	47%			49%	50%	49%
	Antidepressant Medication Mgmt (AMM), Effective Acute Phase	59% ▼			66%	67%	64%
	Follow-Up After ED Visit for Alcohol & Other Drug Abuse Dependencies (FUA), 7-Day FU, Ttl	12% ▼			33% ▲	32%	26%
	Follow-Up After ED Visit for Alcohol & Other Drug Abuse Dependencies (FUA), 30-Day FU, 13-17 Yrs	***			***	***	***
	Follow-Up After ED Visit for Alcohol & Other Drug Abuse Dependencies (FUA), 30-Day FU, Ttl	17% ▼			43% ▲	43% ▲	34%
	Follow-Up After ED Visit for Mental Illness (FUM), 7-Day FU, Ttl	49% ▼			63%	62%	58%
	Follow-Up After ED Visit for Mental Illness (FUM), 30-Day FU, Ttl	65%			72%	70%	69%
	Follow-Up After High Intensity Care for SUD (FUI): 7-Day FU, Ttl	35%			37%	41%	38%
	Follow-Up After High Intensity Care for SUD (FUI): 30-Day FU, Ttl	58%			58%	60%	59%
	Follow-Up after Hosp for Mental Illness (FUH), 7-Day FU, Ttl	41%			56% ▲	48%	48%
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, 6-17 Yrs	***			90% ▲	***	90%
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, 18-64 Yrs	66%			66%	65%	66%
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, Ttl	64%			75%	66%	69%
	Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	41%			42%	46%	43%
	Pharmacotherapy for Opioid Use Disorder (POD), 16-64 Yrs	17% ▲			7% ▼	14%	13%
Overuse/Appropriateness	Use of Opioids at High Dosage (HDO) (Lower score is better)	6%			3% ▼	13% ▲	7%
Access/Availability of Care	Adults' Access to Preventive/Ambulatory Health Services (AAP), Ttl	69% ▼			74% ▲	72%	72%
	I&E of Alcohol & Other Drug Dependence Treat (IET), Ttl: Engagement of AOD Treat: Ttl	16%			18% ▲	13% ▼	16%
	I&E of Alcohol & Other Drug Dependence Treat (IET), Ttl: Initiation of AOD Treat: 13-17 Yrs	***			59%	***	59%
	I&E of Alcohol & Other Drug Dependence Treat (IET), Ttl: Initiation of AOD Treat: Ttl	53%			56% ▲	41% ▼	50%
	Prenatal & Postpartum Care (PPC), Postpartum Care	***			***	***	***
	Prenatal & Postpartum Care (PPC), Timeliness of Prenatal Care	***			***	***	***
	Use of First-Line Psychosocial Care for Children & Adolescents on Antipsychotics (APP), Ttl	***			67%	***	67%
Utilization	Child & Adolescent Well-Care Visit (WCV), Age 3-11	43% ▼			52% ▲	46% ▼	47%
	Child & Adolescent Well-Care Visit (WCV), Age 12-17	41%			43% ▲	39% ▼	41%
	Child & Adolescent Well-Care Visit (WCV), Age 18-21	14%			17% ▲	13% ▼	15%
	Child & Adolescent Well-Care Visit (WCV), Ttl	37% ▼			44% ▲	38% ▼	40%
	Well-Child Visits in the First 30 Mnths of Life (W30), 15-30 Mnths	63%			64%	70%	65%
	Well-Child Visits in the First 30 Mnths of Life (W30), First 15 Mnths	51%			57%	49%	52%

Southwest Region

Again, MHW performed significantly better than other MCOs in this region on the Well-Child Visits in the First 30 Months of Life (W30) and Child and Adolescent Well-Care Visit (WCV) measures; CCW also performed better on several of these measures. AMG performed significantly worse on all of the well-child measures; CHPW performed worse on the Child and Adolescent Well-Care Visit (WCV) measures. There were a handful of other measures where an individual MCO did better or worse than the other MCOs. Note that CCW was added to the Southwest region on July 1, 2021, and members may not have been enrolled long enough to meet the inclusion criteria for many of these measures.

Figure 59. Comparison of MCOs by Measure within Southwest Region, MY2021.

Measures where higher is better:
Statistically significant higher rate than other MCOs ▲
Statistically significant lower rate than other MCOs ▼

Measures where lower is better:
Statistically significant higher rate than other MCOs ▲
Statistically significant lower rate than other MCOs ▼

		AMG	CCW	CHPW	MHW	UHC	Regional Simple Average
Prevention and Screening	Breast Cancer Screening (BCS)	43%	***	37% ▼	47% ▲		42%
	Cervical Cancer Screening (CCS)	***	***	***	51%		51%
	Childhood Immunization Status (CIS), Combo 10	***	***	***	27%		27%
	Chlamydia Screening (CHL), Ttl	46%	50%	45% ▼	49%		48%
	Immunizations for Adolescents (IMA), Combo 2	***	***	19%	19%		19%
	Lead Screening in Children (LSC)	***	***	***	23% ▼		23%
Respiratory Conditions	Asthma Medication Ratio (AMR), Ttl	66%	***	58% ▼	75% ▲		66%
Cardiovascular Conditions	Controlling High Blood Pressure (CBP)	***	***	75%	52% ▼		63%
Diabetes	Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0%	***	***	54%	47%		51%
	Comprehensive Diabetes Care (CDC), Poor HbA1c Control (Lower score is better)	***	***	35%	42%		38%
	Kidney Health Eval for Patients with Diabetes (KED), 18-64 Yrs	20% ▼	***	29%	27%		25%
Behavioral Health	Antidepressant Medication Mgmt (AMM), Continuation Phase	52%	***	42% ▼	49%		48%
	Antidepressant Medication Mgmt (AMM), Effective Acute Phase	71%	***	60% ▼	65%		66%
	Follow-Up After ED Visit for Alcohol & Other Drug Abuse Dependencies (FUA), 7-Day FU, Ttl	22%	***	26% ▲	16% ▼		21%
	Follow-Up After ED Visit for Alcohol & Other Drug Abuse Dependencies (FUA), 30-Day FU, 13-17 Yrs	***	***	***	***		***
	Follow-Up After ED Visit for Alcohol & Other Drug Abuse Dependencies (FUA), 30-Day FU, Ttl	28%	***	34% ▲	24% ▼		28%
	Follow-Up After ED Visit for Mental Illness (FUM), 7-Day FU, Ttl	33%	59%	40%	48%		45%
	Follow-Up After ED Visit for Mental Illness (FUM), 30-Day FU, Ttl	44% ▼	68%	55%	61%		57%
	Follow-Up After High Intensity Care for SUD (FUI): 7-Day FU, Ttl	33%	***	41% ▲	33%		35%
	Follow-Up After High Intensity Care for SUD (FUI): 30-Day FU, Ttl	47%	***	58%	54%		53%
	Follow-Up after Hosp for Mental Illness (FUH), 7-Day FU, Ttl	30%	***	35%	38%		34%
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, 6-17 Yrs	***	***	***	76%		76%
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, 18-64 Yrs	47% ▼	***	52% ▼	65% ▲		54%
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, Ttl	46% ▼	***	54% ▼	66% ▲		55%
	Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	***	***	50%	44%		47%
	Pharmacotherapy for Opioid Use Disorder (POD), 16-64 Yrs	11%	***	18%	20%		16%
Overuse/Appropriateness	Use of Opioids at High Dosage (HDO) (Lower score is better)	6%	***	8%	5%		6%
Access/Availability of Care	Adults' Access to Preventive/Ambulatory Health Services (AAP), Ttl	61% ▼	65% ▼	64% ▼	73% ▲		66%
	I&E of Alcohol & Other Drug Dependence Treat (IET), Ttl: Engagement of AOD Treat: Ttl	14%	21%	18% ▲	13% ▼		16%
	I&E of Alcohol & Other Drug Dependence Treat (IET), Ttl: Initiation of AOD Treat: 13-17 Yrs	***	***	***	40%		40%
	I&E of Alcohol & Other Drug Dependence Treat (IET), Ttl: Initiation of AOD Treat: Ttl	49%	42%	45%	44%		45%
	Prenatal & Postpartum Care (PPC), Postpartum Care	***	***	***	72%		72%
	Prenatal & Postpartum Care (PPC), Timeliness of Prenatal Care	***	***	***	83%		83%
	Use of First-Line Psychosocial Care for Children & Adolescents on Antipsychotics (APP), Ttl	***	***	***	76%		76%
Utilization	Child & Adolescent Well-Care Visit (WCV), Age 3-11	36% ▼	58% ▲	45% ▼	53% ▲		48%
	Child & Adolescent Well-Care Visit (WCV), Age 12-17	36% ▼	53% ▲	39% ▼	48% ▲		44%
	Child & Adolescent Well-Care Visit (WCV), Age 18-21	9% ▼	13%	12% ▼	19% ▲		13%
	Child & Adolescent Well-Care Visit (WCV), Ttl	30% ▼	49% ▲	37% ▼	46% ▲		41%
	Well-Child Visits in the First 30 Mnths of Life (W30), 15-30 Mnths	39% ▼	77% ▲	61%	59%		59%
	Well-Child Visits in the First 30 Mnths of Life (W30), First 15 Mnths	25% ▼	45%	38%	44% ▲		38%

Spokane Region

MHW performed significantly better than the other MCOs in the region for many of the measures. AMG performed significantly worse than the other MCOs on many of the measures. The exceptions were the Kidney Health Evaluation for Patients with Diabetes (KED), 18-64 Years and two of the Child and Adolescent Well-Care Visit (WCV) measures, where AMG performed significantly better than the other MCOs. The performance of CHPW was more mixed, with several of their measures significantly above the other MCOs, and several significantly below.

Figure 60. Comparison of MCOs by Measure within Spokane Region, MY2021.

Measures where higher is better:
Statistically significant higher rate than other MCOs ▲
Statistically significant lower rate than other MCOs ▼

Measures where lower is better:
Statistically significant higher rate than other MCOs ▲
Statistically significant lower rate than other MCOs ▼

		AMG	CCW	CHPW	MHW	UHC	Regional Simple Average
Prevention and Screening	Breast Cancer Screening (BCS)	47%		43% ▼	52% ▲		47%
	Cervical Cancer Screening (CCS)	61%		60%	48%		56%
	Childhood Immunization Status (CIS), Combo 10	30%		24%	23%		25%
	Chlamydia Screening (CHL), Ttl	49%		42% ▼	50% ▲		47%
	Immunizations for Adolescents (IMA), Combo 2	26%		28%	28%		27%
	Lead Screening in Children (LSC)	41%		32%	38%		37%
Respiratory Conditions	Asthma Medication Ratio (AMR), Ttl	67%		56% ▼	68% ▲		64%
Cardiovascular Conditions	Controlling High Blood Pressure (CBP)	64%		68%	64%		65%
Diabetes	Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0%	50%		49%	55%		51%
	Comprehensive Diabetes Care (CDC), Poor HbA1c Control (Lower score is better)	36%		40%	30%		35%
	Kidney Health Eval for Patients with Diabetes (KED), 18-64 Yrs	48% ▲		42% ▼	45%		45%
Behavioral Health	Antidepressant Medication Mgmt (AMM), Continuation Phase	40%		40%	43%		41%
	Antidepressant Medication Mgmt (AMM), Effective Acute Phase	58%		54% ▼	61% ▲		58%
	Follow-Up After ED Visit for Alcohol & Other Drug Abuse Dependencies (FUA), 7-Day FU, Ttl	27% ▼		35%	34%		32%
	Follow-Up After ED Visit for Alcohol & Other Drug Abuse Dependencies (FUA), 30-Day FU, 13-17 Yrs	***		***	***		***
	Follow-Up After ED Visit for Alcohol & Other Drug Abuse Dependencies (FUA), 30-Day FU, Ttl	37% ▼		46%	43%		42%
	Follow-Up After ED Visit for Mental Illness (FUM), 7-Day FU, Ttl	48% ▼		60%	59% ▲		56%
	Follow-Up After ED Visit for Mental Illness (FUM), 30-Day FU, Ttl	60% ▼		72%	72%		68%
	Follow-Up After High Intensity Care for SUD (FUI): 7-Day FU, Ttl	39% ▼		54% ▲	43%		45%
	Follow-Up After High Intensity Care for SUD (FUI): 30-Day FU, Ttl	59% ▼		73% ▲	63%		65%
	Follow-Up after Hosp for Mental Illness (FUH), 7-Day FU, Ttl	36%		40%	43%		40%
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, 6-17 Yrs	71%		76%	80% ▲		76%
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, 18-64 Yrs	51%		62%	58%		57%
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, Ttl	56% ▼		65%	66% ▲		63%
	Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	37%		44%	44%		42%
	Pharmacotherapy for Opioid Use Disorder (POD), 16-64 Yrs	15%		13%	12%		14%
Overuse/Appropriateness	Use of Opioids at High Dosage (HDO) (Lower score is better)	6%		6%	4% ▼		5%
Access/Availability of Care	Adults' Access to Preventive/Ambulatory Health Services (AAP), Ttl	74% ▼		74% ▼	78% ▲		75%
	I&E of Alcohol & Other Drug Dependence Treat (IET), Ttl: Engagement of AOD Treat: Ttl	15% ▼		18%	18%		17%
	I&E of Alcohol & Other Drug Dependence Treat (IET), Ttl: Initiation of AOD Treat: 13-17 Yrs	***		56%	54%		55%
	I&E of Alcohol & Other Drug Dependence Treat (IET), Ttl: Initiation of AOD Treat: Ttl	46%		43% ▼	48% ▲		46%
	Prenatal & Postpartum Care (PPC), Postpartum Care	78%		90%	76%		81%
	Prenatal & Postpartum Care (PPC), Timeliness of Prenatal Care	83% ▼		93%	93%		89%
	Use of First-Line Psychosocial Care for Children & Adolescents on Antipsychotics (APP), Ttl	68%		***	65%		67%
Utilization	Child & Adolescent Well-Care Visit (WCV), Age 3-11	56%		53% ▼	56%		55%
	Child & Adolescent Well-Care Visit (WCV), Age 12-17	52% ▲		47% ▼	49%		49%
	Child & Adolescent Well-Care Visit (WCV), Age 18-21	20%		20%	22% ▲		21%
	Child & Adolescent Well-Care Visit (WCV), Ttl	49% ▲		45% ▼	48%		48%
	Well-Child Visits in the First 30 Mnths of Life (W30), 15-30 Mnths	64% ▼		66%	67%		66%
	Well-Child Visits in the First 30 Mnths of Life (W30), First 15 Mnths	53% ▼		54%	61% ▲		56%

Thurston-Mason Region

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

Figure 61. Comparison of MCOs by Measure within Thurston-Mason Region, MY2021.

Measures where higher is better:
Statistically significant higher rate than other MCOs ▲
Statistically significant lower rate than other MCOs ▼

Measures where lower is better:
Statistically significant higher rate than other MCOs ▲
Statistically significant lower rate than other MCOs ▼

		AMG	CCW	CHPW	MHW	UHC	Regional Simple Average
Prevention and Screening	Breast Cancer Screening (BCS)	40%			42%	39%	40%
	Cervical Cancer Screening (CCS)	42%			***	51%	47%
	Childhood Immunization Status (CIS), Combo 10	***			***	***	***
	Chlamydia Screening (CHL), Ttl	48%			48%	48%	48%
	Immunizations for Adolescents (IMA), Combo 2	15%			***	29%	22%
	Lead Screening in Children (LSC)	***			***	***	***
Respiratory Conditions	Asthma Medication Ratio (AMR), Ttl	71%			70%	64% ▼	68%
Cardiovascular Conditions	Controlling High Blood Pressure (CBP)	65%			***	***	65%
Diabetes	Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0%	***			***	***	***
	Comprehensive Diabetes Care (CDC), Poor HbA1c Control (Lower score is better)	***			***	***	***
	Kidney Health Eval for Patients with Diabetes (KED), 18-64 Yrs	35%			38% ▲	31% ▼	35%
Behavioral Health	Antidepressant Medication Mgmt (AMM), Continuation Phase	46%			45% ▼	53% ▲	48%
	Antidepressant Medication Mgmt (AMM), Effective Acute Phase	67%			63%	65%	65%
	Follow-Up After ED Visit for Alcohol & Other Drug Abuse Dependencies (FUA), 7-Day FU, Ttl	11% ▼			25% ▲	17%	17%
	Follow-Up After ED Visit for Alcohol & Other Drug Abuse Dependencies (FUA), 30-Day FU, 13-17 Yrs	***			***	***	***
	Follow-Up After ED Visit for Alcohol & Other Drug Abuse Dependencies (FUA), 30-Day FU, Ttl	18%			32% ▲	23%	24%
	Follow-Up After ED Visit for Mental Illness (FUM), 7-Day FU, Ttl	28% ▼			51% ▲	45%	42%
	Follow-Up After ED Visit for Mental Illness (FUM), 30-Day FU, Ttl	47% ▼			63% ▲	59%	56%
	Follow-Up After High Intensity Care for SUD (FUI): 7-Day FU, Ttl	37%			38%	43%	39%
	Follow-Up After High Intensity Care for SUD (FUI): 30-Day FU, Ttl	56%			60%	62%	59%
	Follow-Up after Hosp for Mental Illness (FUH), 7-Day FU, Ttl	37%			46%	42%	42%
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, 6-17 Yrs	***			80%	***	80%
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, 18-64 Yrs	57%			61%	57%	58%
	Follow-Up after Hosp for Mental Illness (FUH), 30-Day FU, Ttl	60%			66%	58%	62%
	Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	13% ▼			40%	40%	31%
	Pharmacotherapy for Opioid Use Disorder (POD), 16-64 Yrs	21%			20%	18%	20%
Overuse/Appropriateness	Use of Opioids at High Dosage (HDO) (Lower score is better)	3%			3%	5%	4%
Access/Availability of Care	Adults' Access to Preventive/Ambulatory Health Services (AAP), Ttl	66% ▼			73% ▲	69% ▼	69%
	I&E of Alcohol & Other Drug Dependence Treat (IET), Ttl: Engagement of AOD Treat: Ttl	14%			14%	16%	15%
	I&E of Alcohol & Other Drug Dependence Treat (IET), Ttl: Initiation of AOD Treat: 13-17 Yrs	***			52%	***	52%
	I&E of Alcohol & Other Drug Dependence Treat (IET), Ttl: Initiation of AOD Treat: Ttl	50%			45%	47%	47%
	Prenatal & Postpartum Care (PPC), Postpartum Care	***			***	66%	66%
	Prenatal & Postpartum Care (PPC), Timeliness of Prenatal Care	***			***	89%	89%
	Use of First-Line Psychosocial Care for Children & Adolescents on Antipsychotics (APP), Ttl	***			44%	***	44%
Utilization	Child & Adolescent Well-Care Visit (WCV), Age 3-11	43% ▼			51% ▲	49%	48%
	Child & Adolescent Well-Care Visit (WCV), Age 12-17	34% ▼			43% ▲	39% ▼	39%
	Child & Adolescent Well-Care Visit (WCV), Age 18-21	11% ▼			16% ▲	15%	14%
	Child & Adolescent Well-Care Visit (WCV), Ttl	34% ▼			43% ▲	40% ▼	39%
	Well-Child Visits in the First 30 Mnths of Life (W30), 15-30 Mnths	59% ▼			67%	67%	65%
	Well-Child Visits in the First 30 Mnths of Life (W30), First 15 Mnths	51%			54% ▲	43% ▼	49%

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 2021 measurement year. The measures include Healthcare Effectiveness Data and Information Set (HEDIS®) performance measure rates collected in 2022, reflecting performance in calendar year 2021. It also includes behavioral health measures that were developed by the Washington State Health Care Authority. To be consistent with NCQA methodology, the 2021 calendar year (CY) is referred to as the Measure Year 2021 (MY2021) 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 Rate, Broad Definition (MH-B)
- Substance Use Disorder (SUD) Treatment Rate

Note the names of these measures have changed. These two measures were formerly known as the Mental Health Service Penetration, Broad Definition (MH-B) and the Substance Use Disorder Treatment Penetration (SUD) measures. The specifications of these measures were also updated, but the changes will not affect the ability to make year-over-year comparisons.

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.[20]

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).

Table A-1. Administrative Versus Hybrid Rates for Select Measures, MY2021.

Measure	Administrative Rate	Hybrid Rate	Difference
Controlling High Blood Pressure (CBP)	38.0%	63.9%	+ 25.9%
Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care	56.7%	86.5%	+ 29.8%
Prenatal and Postpartum Care (PPC), Postpartum Care	57.5%	79.3%	+ 21.8%

Supplemental Data

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

Rotated Measures

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

Table A-2. MY2019 Rotated Measures by MCOs.

Measure Name	AMG	CCW	CHPW	MHW	UHC
Adolescent Well-Care Visits (AWC)	—	—	—	—	Y
Adult BMI Assessment (ABA)	Y	Y	—	—	—
Cervical Cancer Screening (CCS)	Y	—	—	—	—
Childhood Immunization Status (CIS), All Components	—	—	—	Y	Y
Controlling High Blood Pressure (CBP)	Y	Y	—	—	—

[20] 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.

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. These data sets were then provided to Comagine Health for analysis. In addition to the MLD files, HCA also provided Comagine Health with an eligibility file that included enrollee demographic information (age, gender, race/ethnicity, language, county of residence and specific Apple Health program and eligibility category). 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, 2021, and December 31, 2021. Of note: Only individuals who are in the denominator of at least one HEDIS measure are included in the member-level data. As a result, individuals with short tenures in their plans or individuals with little to no healthcare utilization may not be included in the measure analysis. The HEDIS measures were not risk-adjusted for any differences in enrollee demographic characteristics. Prior to performing analysis, member-level data were aggregated to the MCO level and validated against the reported HEDIS measures.

Definitions Used to Stratify Member-Level Data

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

- **Apple Health Program and Eligibility Category** – HCA included the Apple Health program information on the eligibility file, (Apple Health Integrated Managed Care, Apple Health Integrated Foster Care and Apple Health Behavioral Health Services Only). The data was first stratified by Apple Health Program. The AH-IMC program was then further broken down into eligibility groups using recipient aid category (RAC) codes on the enrollment file and a mapping of RAC codes to eligibility category.

- **Race/Ethnicity Data** – The HCA eligibility data included both a race field and a Hispanic indicator field. Enrollment data is reported separately by race and Hispanic ethnicity. For measure reporting, the race and ethnicity information is combined into one category; an individual who indicated they are Hispanic are reported as Hispanic, otherwise they are reported by race.
- **Spoken Language** – The HCA eligibility data also captures approximately 85 different spoken languages. In addition to English, Comagine Health reported on the 15 languages where HCA currently had written materials available. The remaining languages were reported in the "Other languages" category; they represent less than 1% of the total enrollees.
- **Urban versus Rural** – To define urban versus rural geographies, Comagine Health relied on the CMS rural-urban commuting area (RUCA) codes. RUCA codes classify United States census tracts using measures of population density, urbanization and daily commuting.

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

Sufficient Denominator Size

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

Note that stratification of the measure results for the various of the member level data analyses often resulted in measures with denominators too small to report. This was particularly true for the hybrid measures, which tend to have smaller denominators because of the sampling methodology used to collect the data. The measures selected for reporting varied 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 four most recent reporting years: MY2018, MY2019, MY2020 and MY2021. 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 MY2021 NCQA Quality Compass. These benchmarks represent the national average and selected percentile performance among all NCQA-accredited Medicaid HMO plans and non-accredited Medicaid HMO plans that opted to publicly report their HEDIS rates. These plans represent states both with and without Medicaid expansion. The number of plans reporting on each measure varies, depending on each state's requirement (not all states require reporting; they also vary on the number of measures they require their plans to report).

The license agreement with NCQA for publishing HEDIS benchmarks in this report limits the number of individual indicators to 40, with no more than two benchmarks reported for each selected indicator. Therefore, a number of charts and tables do not include a direct comparison with national benchmarks but may instead include a narrative comparison with national benchmarks; for example, noting that a specific indicator or the state average is lower or higher than the national average.

Note there are no national benchmarks for the Washington State Behavioral Health measures. As an alternative approach, HCA leadership chose to consider the plan with the second highest performance in 2020 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 comparisons of performance scores between categories such as MCO or race/ethnicity, a chi-square test was used to compare each category against the remaining categories as a group (i.e., an individual MCO would be compared to the average of the other four MCOs). Occasionally, a test may be significant even when the confidence interval crosses the state average line shown in the bar charts, because the state averages on the charts reflect the weighted average of all MCOs, not the average excluding the MCO being tested.

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

Denominator Size Considerations and Confidence Intervals

When measures have values required for a visit or action to count as a numerator event. Therefore, it is important to keep in mind that a low performance score can be the result of an actual need for quality improvement, or it may reflect a need to improve electronic documentation and diligence in recording notes. For example, in order for an outpatient visit to be counted as counseling for nutrition, a note with evidence of the counseling must be attached to the medical record, with demonstration of one of several specific examples from a list of possible types of counseling, such as discussion of behaviors, a checklist, distribution of educational materials, etc. Even if such discussion did occur during the visit, if it was not noted in the patient record, it cannot be counted as a numerator event for weight assessment and counseling for nutrition and physical activity for children/adolescents. For low observed scores, health plans and other stakeholders should examine (and strive to improve) both of these potential sources of low measure performance.

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

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

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

For example, if a plan had a performance rate in the previous year of 286/432 (66.20%), the Wilson Score Interval would provide a 95% confidence interval of 61.62% (lower confidence interval value) to 70.50% (upper confidence interval value). The plan's current rate for the measure is then compared to the confidence interval to determine if there is a statistically significant change. If the plan is currently

performing at a 72% rate, the new rate is above the upper confidence interval value and would represent a statistically significant improvement. However, if the plan is currently performing at a 63% rate, the new rate is within the confidence interval range and is statistically the same as the previous rate. If the current performance rate is 55%, the new rate is below the lower confidence interval value and would represent a statistically significant decrease in performance.

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

Additional Notes Regarding Interpretation

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

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

Limitations

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

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

Interpreting Performance

Potential Sources of Variation in Performance

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

Additional Notes Regarding Interpretation

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

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

Appendix B: 2022 Performance Measure Tables

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

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

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Appendix C: MCO Comparison Results

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

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Appendix D: Regional Comparison Results

Appendix D contains state maps comparing regional performance.

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Appendix E: Measure Comparison by Race/Ethnicity, Three-Year Trend

Appendix E contains measure comparisons by race/ethnicity with three-year trends.