Comagine Health

Annual Technical Report

Washington Apple Health

Washington Health Care Authority

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Seattle, WA

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.

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 improvement in the health care system.

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

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Acronym List

Table 1. Acronyms Used Frequently in this Report.

Acronym	Definition
ACH	Accountable Community of Health
AH-BD	Apple Health Blind/Disabled
AH-IFC	Apple Health Integrated Foster Care
AH-IMC	Apple Health Integrated Managed Care
AHRQ	Agency for Healthcare Research and Quality
AMG	Amerigroup Washington, Inc.
BHSO	Behavioral Health Services Only – *a PIHP plan*
CANS	Child and Adolescent Needs and Strengths
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CANS	Child and Adolescent Needs and Strengths
CCW	Coordinated Care of Washington
CHIP	Children's Health Insurance Program
CHPW	Community Health Plan of Washington
CFR	Code of Federal Regulations
CFT	Child and Family Team
CMS	Centers for Medicare & Medicaid Services
CSCP	Cross System Care Plan
CY	Calendar Year
DCYF	Department of Children, Youth and Families
DOH	Department of Health
DSHS	Department of Social and Health Services
EQR	External Quality Review
EQRO	External Quality Review Organization
HCA	Health Care Authority
HEDIS	Healthcare Effectiveness Data and Information Set
IMC	Integrated Managed Care
MCO	Managed Care Organization
MCP	Managed Care Plan *Includes MCOs, prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), and primary care case management (PCCM) entities described in 42 CFR 438.310(c)(2).*[1]
MH-B	Mental Health Service Penetration – Broad Definition
MHW	Molina Healthcare of Washington
MY	Measurement Year
NCQA	National Committee for Quality Assurance
PAHP	Prepaid Ambulatory Health Plans[2]

[1] HCA's PCCM contracts do not include shared savings, incentive payments, or other financial reward for the PCCM entity for improved quality outcomes, thus are not included in the state's EQR work.
[2] HCA did not contract with any PAHPs in the year reported.

Acronym	Definition
PCP	Primary Care Provider
PHE	Public Health Emergency
PIHP	Prepaid Inpatient Health Plan *HCA contracted with PIHPs (BHSO) in the year reported within the Medicaid IMC contract.*
PIP	Performance Improvement Project
QAPI	Quality Assessment and Performance Improvement
QIRT	Quality Improvement Review Tool
RDA	Department of Social and Health Services Research and Data Analysis Division
RY	Reporting Year
SUD	Substance Use Disorder
UHC	UnitedHealthcare Community Plan
UM	Utilization Management
VBP	Value-Based Purchasing
WISe	Wraparound with Intensive Services
WSIPP	Washington State Institute for Public Policy

Executive Summary

In 2020, over 1.9 million Washingtonians were enrolled in Apple Health with more than 84% enrolled in managed care. The Washington State Health Care Authority (HCA) administered services for care delivery through contracts with 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)

Federal requirements mandate that every state Medicaid agency that contracts with managed care organizations provide for an external quality review (EQR) of health care services to assess the accessibility, timeliness and quality of care furnished to Medicaid enrollees. Comagine Health conducted this 2021 review as Washington's Medicaid external quality review organization (EQRO). This technical report describes the results of this evaluation. No MCOs in Washington are exempt from external quality review.

In 2021, TEAMonitor also reviewed and reported on the Behavioral Health Services Only (BHSO) program, a Prepaid Inpatient Health Plan (PIHP).[3] Although TEAMonitor completed both MCO and BHSO reviews in one session of the onsite visit, the programs were reviewed as separate entities, with their own scores.

Managed care plans (MCPs) include the MCOs and BHSOs. TEAMonitor reviewed both MCOs and BHSOs for compliance, performance measure validation and performance improvement projects (PIPs).

Information in this report was collected from MCPs through review activities based on Centers for Medicare & Medicaid Services (CMS) protocols. Additional activities may be included as specified by contract.

Washington's Medicaid Program Overview

In Washington, Medicaid enrollees are covered by five health plans through the following managed care 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 Medicaid managed care programs, Medicaid enrollees may qualify under the following categories:

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

[3] Washington HCA. Behavioral Health Services Only Enrollment. Available at: https://www.hca.wa.gov/assets/program/bhso-fact-sheet.pdf

Medicaid Managed Care Program Structure and Initiatives

Under the direction of Senate Bill E2SSB 6312, behavioral health benefits were integrated 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 by January 1, 2020. The transition to an integrated system began in 2016. As of January 2020, all 10 regions of the state completed the transition to an integrated system for physical health, mental health, and substance use disorder services within the Apple Health program. Most services for Apple Health clients are provided through managed care organizations.

Behavioral Health Services Only (BHSO) enrollment is for clients with behavioral health benefits in their Apple Health eligibility package who are not eligible for AH-IMC (such as those with Medicare as primary insurance) or who have opted out of an integrated program (e.g., adoption support and alumni of foster care). BHSO enrollment ensures everyone who is eligible has access to behavioral health benefits. BHSO enrollees receive physical health benefits through the fee-for-service delivery system (referred to as Apple Health coverage without a managed care plan) and/or other primary health insurance.

Additionally, some services continue to be available through the fee-for-service delivery system (also referred to as coverage without a managed care plan), such as dental services.

To respond to the continuing COVID-19 public health emergency, HCA took a proactive approach to both anticipate and respond to access to care challenges at the beginning of the pandemic and throughout the year, supporting workforce and system stability as well as continued quality improvement activities. HCA worked in collaboration with all five MCPs to free up hospital resources and create surge capacity to address higher demand for health care by coordinating increased efforts to move difficult to discharge clients out of acute care hospital settings during the public health emergency.

As an example, HCA has had projects underway to support ongoing bi-directional integration of physical and behavioral health through care transformation in each of the regions, specific to the identified needs of those areas. In 2020, as well as 2021, much of the work inside of these projects pivoted to address the needs emerging because of the COVID-19 public health emergency, such as investments in broadband and equipment necessary for providing telehealth services (e.g., smart phones, laptops and Zoom licenses). Resources diverted to COVID-19 response supported sustaining service capacity for clients with behavioral health care needs. Response to COVID-19 continues to be discussed at monthly meetings with the MCOs to address and reduce barriers to services.

Health equity has also been a focus for Washington's Medicaid program. HCA hired an experienced clinician as the Health Equity Social Justice and Strategy Manager. HCA has partnered with Comagine Health as the contracted EQRO to explore ways to expand the available data set to allow for deeper analysis related to health equity. Additionally, HCA recognizes three of the five contracted MCPs currently hold an NCQA Multicultural Healthcare Distinction:

- Amerigroup Washington (AMG)
- Community Health Plan of Washington (CHPW)
- Molina Healthcare of Washington (MHW)

Please see the health equity section of this report for some of the results of this collaborative work.

For more about enrollment and the different service programs and regions see page 13, Introduction.

Summary of EQR Activities

EQR federal regulations under 42 CFR Part 438 specify the mandatory and optional activities that the EQRO must address in a manner consistent with CMS protocols.[4]

Washington's MCPs are evaluated by TEAMonitor, at HCA, which provides formal oversight and monitoring activities on their compliance with federal and state regulatory and contractual standards.

The 2021 EQR in Washington included the following activities which are in alignment with the CMS protocols:

- **Quality Strategy Effectiveness Analysis**
- **Compliance Review**
    - Including follow-up of the previous year's corrective action plans (CAPs)
- **Performance Improvement Project (PIP) Validation**
- **Performance Measure Validation, including:**
    - Healthcare Effectiveness Data and Information Set (HEDIS®[5]) measures
    - Two non-HEDIS measures that are calculated by the Department of Social and Health Services Research and Data Analysis Division (RDA)
        - Mental Health Service Penetration – Broad Definition (MH-B)
        - Substance Use Disorder Treatment Penetration (SUD)
- **Value-Based Purchasing (VBP) Performance Measure Recommendation and Evaluation**
- **Consumer Assessment of Healthcare Providers and Systems (CAHPS)**
- **Wraparound with Intensive Services (WISe) Program Review (Focus Study)**
- **Behavioral Health Performance Measure Focus Study**
- **Evaluation of Quality, Access and Timeliness of Health Care and Services**

Quality Strategy Effectiveness Analysis

Comagine Health has recommended improvements to the quality of health care services furnished by each MCP, including how the state can target goals and objectives in the quality strategy to better support improvement in the quality, timeliness and access to health care services furnished to Medicaid beneficiaries

[4] Electronic Code of Federal Regulations. Available at: https://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr438_main_02.tpl

[5] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Compliance Review

TEAMonitor's review assesses activities for the previous calendar year and evaluates MCP compliance with the standards set forth in 42 CFR Part 438, as well as those established in HCA's contracts with the MCPs for all Apple Health managed care including AH-IMC, AH-IFC, BHSO and CHIP.

Performance Improvement Project (PIP) Validation

MCPs are required to have an ongoing program of clinical and non-clinical PIPs that are designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction for all Apple Health programs, including AH-IMC, AH-IFC and BHSO. HCA assesses and validates the MCPs' PIPs to ensure they meet state and federal guidelines, include Apple Health enrollees as required, and are designed, implemented, analyzed and reported in a methodologically sound manner.

Performance Measure Validation

Performance measures are used to monitor the performance of individual MCOs at a point in time, track performance over time, compare performance among MCOs, and inform the selection and evaluation of quality improvement activities. HEDIS is a widely used set of health care performance measures reported by health plans. HEDIS results can be used by the public to compare plan performance over six domains of care:

- Effectiveness of Care
- Access/Availability of Care
- Experience of Care
- Utilization and Risk Adjusted Utilization
- Health Plan Descriptive Information
- Measures Collected Using Electronic Clinical Data Systems

These measures also allow MCOs to determine where quality improvement efforts may be needed.

Comagine Health thoroughly reviewed each MCO's rates for all 56 HEDIS measures and associated sub-measures and the RDA measures. With HCA's approval, Comagine Health focused on 31 measures for the majority of analysis and comparison rather than the full list of HEDIS measures. These 31 measures also included the two RDA measures since they 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.

As part of its monitoring of the BHSO, a PIHP-contracted services program, TEAMonitor validated performance rates related to behavioral health services, including measures for SUD Treatment Penetration and MH-B Treatment Penetration to determine impact and need for this program's population. Validated performance rates for this program are included in this report.

Value-Based Purchasing (VBP) Performance Measure Recommendation and Evaluation

In 2019, the Washington Legislature passed the Washington State Engrossed Substitute House Bill (ESHB) 1109 requiring HCA's contracted EQRO to annually analyze the performance of Apple Health MCOs providing services to Medicaid enrollees.[6]

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

In addition, Comagine Health is contracted to evaluate both AH-IMC and AH-IFC MCO performance on the VBP measures specific to each contract. Comagine Health identifies where plans have met the criteria for the return of withhold dollars, either by demonstrating year-over-year improvement in measure performance or by exceeding the contracted benchmarks for each measure. This evaluation provides feedback to each MCO on their achievement of the state's quality initiative within the VBP strategy.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The CAHPS survey is a tool used to assess consumers' experiences with their health plans. CAHPS surveys address such areas as the timeliness of getting care, how well doctors communicate, global ratings of health care, access to specialized services and coordination of care. The survey aims to measure how well MCOs are meeting their members' expectations and goals, determine which areas of service have the greatest effect on members' overall satisfaction and identify opportunities for improvement.

In 2021, the Apple Health MCOs conducted the CAHPS 5.1H Child Medicaid with Chronic Conditions survey of parents/caregivers of children enrolled in Apple Health. The full report summarizing the findings is Comagine Health's *2021 Apple Health CAHPS® 5.1H Child Medicaid with Chronic Conditions Report*.[7]

As required by HCA, CCW conducted the CAHPS 5.1H Child Medicaid and Children with Chronic Conditions survey of the Apple Health Foster Care program. The full summary of findings is available in the *2021 Apple Health IFC CAHPS® Medicaid Child with CCC 5.1 Report* produced by SPH Analytics, July 2021.

Focus Quality Study: Wraparound with Intensive Services (WISe) Service Delivery Model Review

In 2021, HCA chose to continue a study on quality with focus on the WISe service delivery model. As the EQRO for Washington, Comagine Health is contracted to review behavioral health agencies (BHAs)

[6] State of Washington. 66th Legislature. Engrossed Substitute House Bill 1109. Chapter 14, Laws of 2019. Available at: https://legiscan.com/WA/text/HB1109/id/2028380/Washington-2019-HB1109-Chaptered.pdf.

[7] Produced by Comagine Health. The Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS® 5.1H) Report. Available at: https://www.hca.wa.gov/assets/billers-and-providers/2021AH-IMCCAHPS5.1HChildMedicaidwithCC.PDF.

throughout the state that have implemented the WISe service delivery model. WISe is a service delivery model that offers intensive services to Medicaid-eligible youth with complex behavioral health needs within the AH-IFC, AH-IMC and BHSO programs.

The reviews consisted of clinical record reviews for each of the 10 BHA provider locations selected by HCA. These locations reflect a combination of both rural and urban agencies providing WISe services throughout the state of Washington.

This summary includes overall results for the 10 WISe reviews conducted during the review period of January to May 2021 and aggregated in two quarterly reports.

Focus Quality Study: Behavioral Health Performance Measure Study

In March 2021, HCA contracted with Comagine Health to conduct a study analyzing performance measure variation across the state's MCOs, Accountable Communities of Health (ACHs) and regional system partners. The study followed *Protocol 9 – Conducting Focus Studies of Health Care Quality* – from the October 2019 CMS External Quality Review (EQR) Protocols. The study focused on establishing a baseline understanding why certain performance measures are performing better or worse and understand why performance has changed over time. The measures described within the report have been and will continue to be utilized on an ongoing basis to monitor performance and inform HCA's work.

HCA's ultimate goal for the study is to help inform and target quality improvement activities across regions and payors, including measures related to high-profile care coordination needs between physical health and behavioral health providers.

Evaluation of Quality, Access and Timeliness of Health Care and Services

Through assessment of the review activities described above, this report demonstrates how MCPs are performing in delivering quality, accessible and timely care. Under 42 CFR §438.364, the EQRO provides analysis and evaluation of aggregated information on the quality and timeliness of and access to health services provided by a managed care plan, or its contractors, to Medicaid beneficiaries. These concepts are summarized below.

Figure 1. Illustration of Quality, Access and Timeliness of Care.

Quality

Quality of care encompasses access and timeliness as well as the process of care delivery and the experience of receiving care. Although enrollee outcomes can also serve as an indicator of quality of care, outcomes depend on numerous variables that may fall outside the provider's control, such as patients' adherence to treatment. CMS describes quality as the degree to which a managed care organization increases the likelihood of desired health outcomes for its enrollees through its structural and operational characteristics as well as through the provision of health services that are consistent with current professional knowledge.

Access

Access to care encompasses the steps taken for obtaining needed health care and reflects the patient's experience before care is delivered. Access to care affects a patient's experience as well as outcomes and, therefore, the quality of care received. Adequate access depends on many factors, including availability of appointments, the patient's ability to see a specialist, adequacy of the health care network, and availability of transportation and translation services.

Timeliness

Timeliness of care reflects the readiness with which enrollees are able to access care, a factor that ultimately influences quality of care and patient outcomes. It also reflects the health plan's adherence to timelines related to authorization of services, payment of claims, and processing of grievances and appeals.

Summary of Recommendations

Below are the recommendations for each of the major EQR activities this year. Please see the full recommendations in their respective section of this report for more detail.

Quality Strategy Effectiveness Analysis

- Sustain Improvement in clinically meaningful areas (including behavioral health integration) through collaboration among MCOs, with higher performing plans sharing successful strategies that have led to improved measure performance and may help improve all the MCOs performance on these measures.
- Address behavioral health declines to ensure individuals receive necessary treatment and improvements are reflected across all race/ethnicity categories.
- Focus on Preventive Care by maximizing the use of telehealth, providing outreach to ensure preventive care is obtained and focusing on bidirectional integration.
- Prioritize Health Equity by continuing to collaborate with partners around health equity data, including the collection, analysis, reporting and community participation in validating and interpretation to drive health equity work.
- Continue to refine/focus on Value Based Purchasing as a strategy to move improvements forward.
- Refine language for required non-duplication of EQR-Related Activities.
- Continue to focus on collaboration and standardization across MCPs and HCA.
- Focus on strategies to assist MCPs in development and monitoring of their QAPI programs to address necessary improvements and move quality care forward.
- MCPs need to have an effective QAPI program that moves quality care forward with a focus on strategies to assist MCPs in development and monitoring of their QAPI programs to address necessary improvements.

Compliance Review

Overall, the MCPs continue to work to meet the requirements for each of the elements reviewed. The following are recommendations for the MCPs.

Coverage and Authorization of Service

It is recommended that HCA continue to monitor and provide technical assistance to the MCPs for compliance with the coverage and authorization of service elements. HCA has provided intensive technical assistance to support needed improvements in this standard.

Subcontractual Relationships and Delegation

Four of the five MCPs (AMG/MCO, AMG/BHSO, CCW/MCO, CCW/BHSO, CHP/MCO, CHP/BHSO, UHC/MCO, UHC/BHSO) will benefit from technical assistance by HCA to ensure the plans meet the requirements for the subcontractual relationships and delegation standard. These elements include:

- Subcontractual relationships and delegation
- Written agreements
- Monitoring of sub-contractor performance
- Identifying deficiencies and ensuring corrective action is taken

Program Integrity Requirements

HCA should provide technical assistance to all plans regarding program integrity requirements. Four MCOs (CCW, CHPW, MHW, UHC) and four BHSOs (CCW, CHPW, MHW, UHC) did not meet at least one element under this standard.

Performance Improvement Project (PIP) Validation

The challenges of the 2020 COVID-19 pandemic affected the implementation and improvement of the PIPs during the RY2021 period which led to a majority of the PIPs being scored as Partially Met. Thus, the recommendations from the previous year remain, for the most part, the same.

To enhance the MCPs' ability to design a sound PIP, HCA should continue the following activities to engage and guide the MCPs in providing desired quality health outcomes for its enrollees.

- HCA should continue to provide ongoing training specifically focused on the overall study design by establishing a framework for sustainable improvement that stems from well-defined and well-scoped study designs. This would include continuing to work with the MCPs' incorporation of the rapid-cycle process improvement process introduced by HCA in 2021.
- As the 2020 COVID-19 pandemic has shown, it is important the MCPs to be flexible and persistent in trying to work within any disruptions that may be encountered. HCA should work closely with the MCPs when unexpected disruptions occur to determine appropriate pivots of the interventions through evaluation of the study design and the analysis plan to ensure improved outcomes.
- A concise study question will improve the MCP's ability to align the entire PIP study design. HCA should continue to provide technical assistance to the MCPs with a focus on defining, streamlining and simplifying study questions.
- In RY2021, TEAMonitor began implementation of *Protocol 1 Validation of Performance Improvement Projects* updated by CMS in 2019 in its validation of PIPs. HCA should continue to work with the MCPs to help familiarize them with the additional measurements of success within this protocol.

For comprehensive recommendations see the PIP Validation section of this report (page 38).

Performance Measure Validation

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

- Sustain improvements in clinically meaningful areas, including:
  - Behavioral health integration
  - Asthma Medication Ratio
  - Prenatal and Postpartum Care
- Address behavioral health declines, including:
  - Mental Health Treatment Penetration for 6-64 years
  - Behavioral health measures for all race/ethnicity categories that have declined
- Focus on Preventive Care
  - Although there were statistically significant declines from MY2019 to MY2020 in multiple preventive care measures (CIS Combo 2 & Combo 10, CHL, AAP and BCS), Breast Cancer Screenings (BCS) have declined over the past two measurement years.
  - As the COVID-19 pandemic continues to impact preventive care,
    - It is recommended that the use of telehealth be maximized to the greatest degree possible for preventive (and acute) care needs.
    - Outreach to individuals to ensure preventive care is obtained, should be prioritized. Plans need to include strategies to support practitioners in catching up on preventive care that was delayed so declines do not continue.
    - Continue to focus on bidirectional integration to sustain the behavioral health integration work.
- Continue to Prioritize Health Equity
  - Increased attention needs to be directed at communities of color, particularly Black and Hispanic communities.
  - Additional areas of focus to address health equity needs include:
    - Prenatal and Postpartum Care (PPC) both timeliness of Prenatal Care and Postpartum measures for Hawaiian/Pacific Islanders
    - Prevention and Screening measures for most races/ethnicities
    - Well-Child Visits in the First 30 Months of Life (W30) and Child and Adolescent Well-Care Visit (WCV) for most races/ethnicities
  - Continued collaboration with partners in Washington around health equity data, including the collection, analysis, reporting and community participation in validating and interpreting those data will continue to benefit HCA in driving health equity work in Washington.
  - HCA may consider incorporating equity-focused payment and contracting models in the VBP program as an approach to improving health equity.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

CAHPS is the most comprehensive tool available for assessing consumers' experiences with their health plans. Results of the survey provide consumers, purchasers, health plans and state Medicaid programs with information about a broad range of key consumer issues. While the CAHPS survey helps identify priorities, the MCOs should identify actionable areas for their own quality improvement activities, then conduct a root cause analysis to identify underlying causes and build quality improvement plans. MCOs may look at patient grievances to see what issues show up frequently.

The two sources of information, CAHPS data and grievances, complement each other in attempts to understand the issues and get a complete picture. MCOs should evaluate improvement methods and

implement those most relevant to their improvement goals. MCOs should follow a process similar to the Plan-Do-Study-Act (PDSA) model to target low performing measures.

The following questions have the lowest achievement scores and are presented as opportunities for improvement.

- Q15. Usually or always easy to get special medical equipment or devices for child
- Q18. Usually or always easy to get therapy for child
- Q19. Someone from doctor's office helped get therapy for child
- Q21. Usually or always easy to get treatment or counseling for child
- Q45. Customer service usually or always gave help you needed

For comprehensive recommendations see the CAHPS section of this report (page 84) as well as the *2021 Apple Health CAHPS® 5.1H Child Medicaid with Chronic Conditions Report*.

Wraparound with Intensive Services (WISe) Program Review

In this year's review, some of the agencies provided services during the early days of the COVID-19 PHE, including the *Stay Home, Stay Healthy* orders which may be contributing factors in the agencies' results.

- As the PHE continues, HCA should continue working closely with the MCPs to review the organizations' response to the COVID-19 PHE to address gaps in their emergency or disaster plans to:
    - Identify alternate methods for providing services and supports in the event of a PHE
    - Ensure adaptation of the identified alternative methods for a rapid return to provision of the full range of services

The reviewed agencies experienced difficulties in meeting WISe requirements in regard to the delivery of quality, accessible and timely care.

- HCA should continue providing technical assistance through its WISe Workforce Collaborative to agencies delivering WISe services which includes:
    - Working with the MCPs in providing support for their subcontracted providers
    - Communicating with contracted trainers to ensure alignment with technical assistance and support

Agencies experienced difficulties in meeting WISe requirements including conducting collaborative full CANS, CSCPs, CFTs and crisis plans in a timely manner, in addition to providing clear documentation.

- We recommend the agencies conduct a root-cause analysis to identify the barriers to success in meeting WISe requirements. As interventions are identified, use Plan-Do-Study-Act (PDSA) cycles of improvement to measure the effectiveness of each intervention. Recommended focus areas for improvement include:
    - Complete timely and collaborative crisis plans.
    - Conduct collaborative initial full CANS assessments.
    - Complete collaborative CSCPs within the required timeframe.
    - Conduct CFT meetings at least every 30 days, ensuring each CFT includes educators and/or community partners when identified as areas of need

- Record therapy notes that clearly reflect the following:
  - Interventions used in therapy sessions
  - Youth and/or caregiver responses to the intervention
  - Progress reviewed and successes celebrated
  - Document the specific content of treatment sessions such as psychoeducation, skill development or evidence-based practice components

For comprehensive recommendations see the WISe section of this report (page 92).

Behavioral Health Performance Measure Focus Study

Based on the survey and interview results, Comagine Health identified the following areas for improvement and recommendations for HCA. These are meant to be starting points for further development and discussion toward the ultimate goal of improving behavioral health care and integration statewide. The recommendations are focused on the following areas:

- Workforce shortage
- Health information technology
- Patient health information sharing
- Limited access to data
- Access to services
- Challenges for children and youth in behavioral health treatment

For comprehensive recommendations see the Behavioral Health Performance Measure Study section of this report (page 98).

Introduction

Overview of Apple Health Managed Care

In 2020, over 1.9 million Washingtonians were enrolled in Apple Health, with more than 84% enrolled in managed care.[8]

During 2020, five MCOs provided managed health care services for Apple Health enrollees:

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

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

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

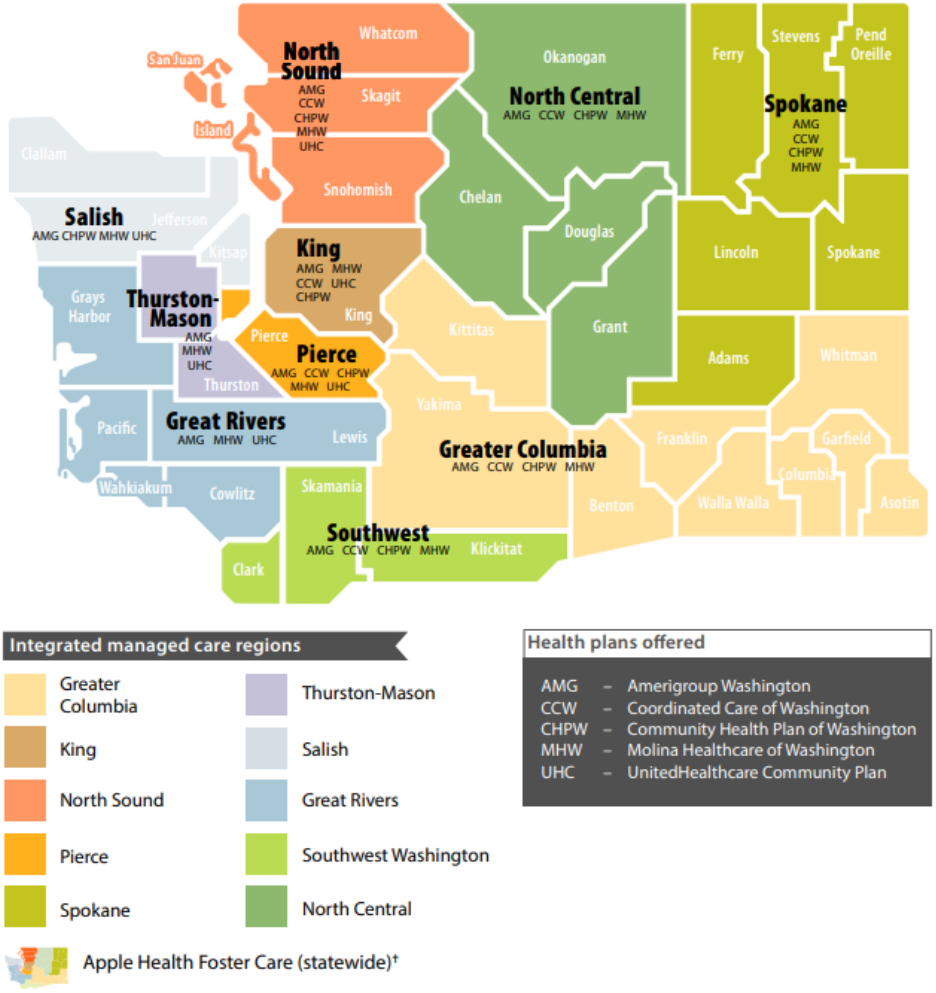
Within Washington's Apple Health Integrated Managed Care program, Medicaid enrollees may qualify under the following eligibility categories:

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

Figure 2 shows enrollment by Apple Health Program reflecting the transition to an integrated system for physical health, mental health and substance use disorder services within the Apple Health program.

[8] Washington HCA. About Washington Apple Health (Medicaid). Available at: https://www.hca.wa.gov/assets/free-or-low-cost/about-Apple-Health.pdf.

Figure 2. Apple Health Regional Service Areas by County in 2021.[9]



† 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:

- **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

[9] 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.

- **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

Overview of Apple Health MCP Enrollment

Five MCOs provide 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)

Figure 3 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 12.5% in CHPW, about 12% in AMG and UHC, and close to 11% in CCW.

Figure 4. shows BHSO enrollment by plan. About 8% of Apple Health enrollees (151,120) are in a BHSO program.

Figure 3. Percent of Total Statewide Medicaid Enrollment, According to MCO.

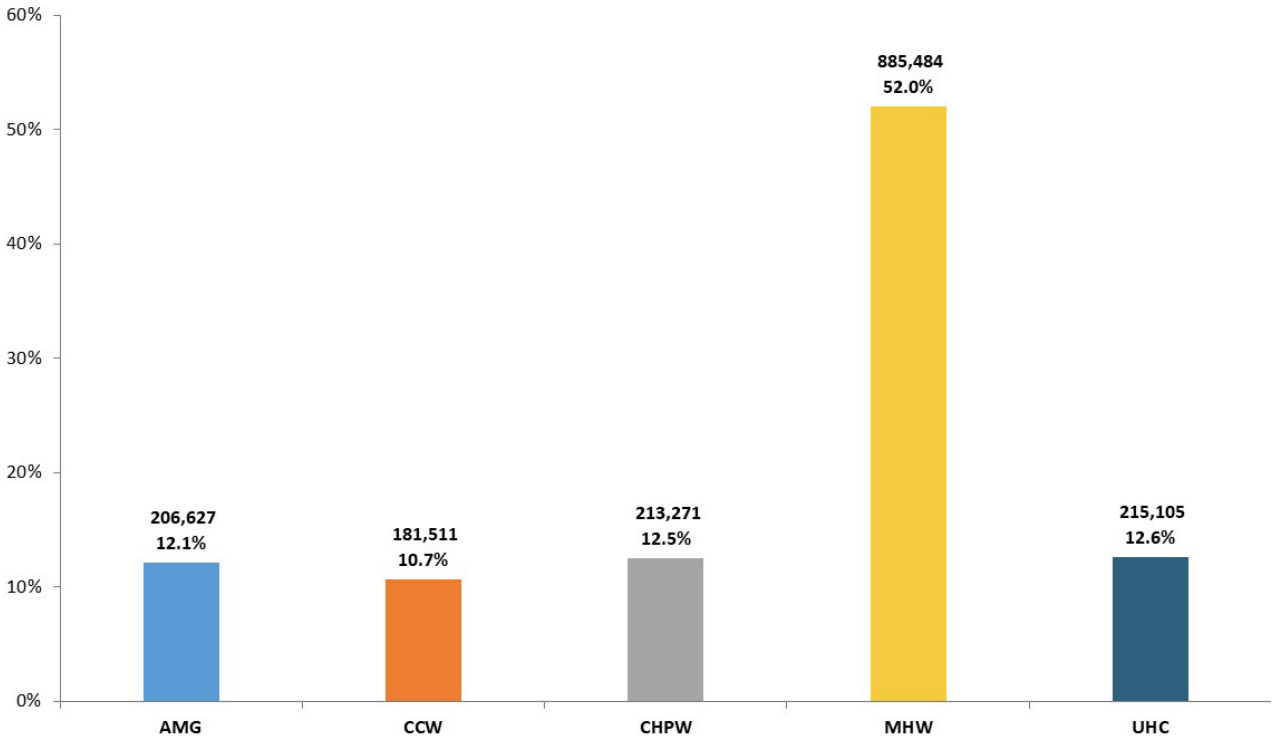
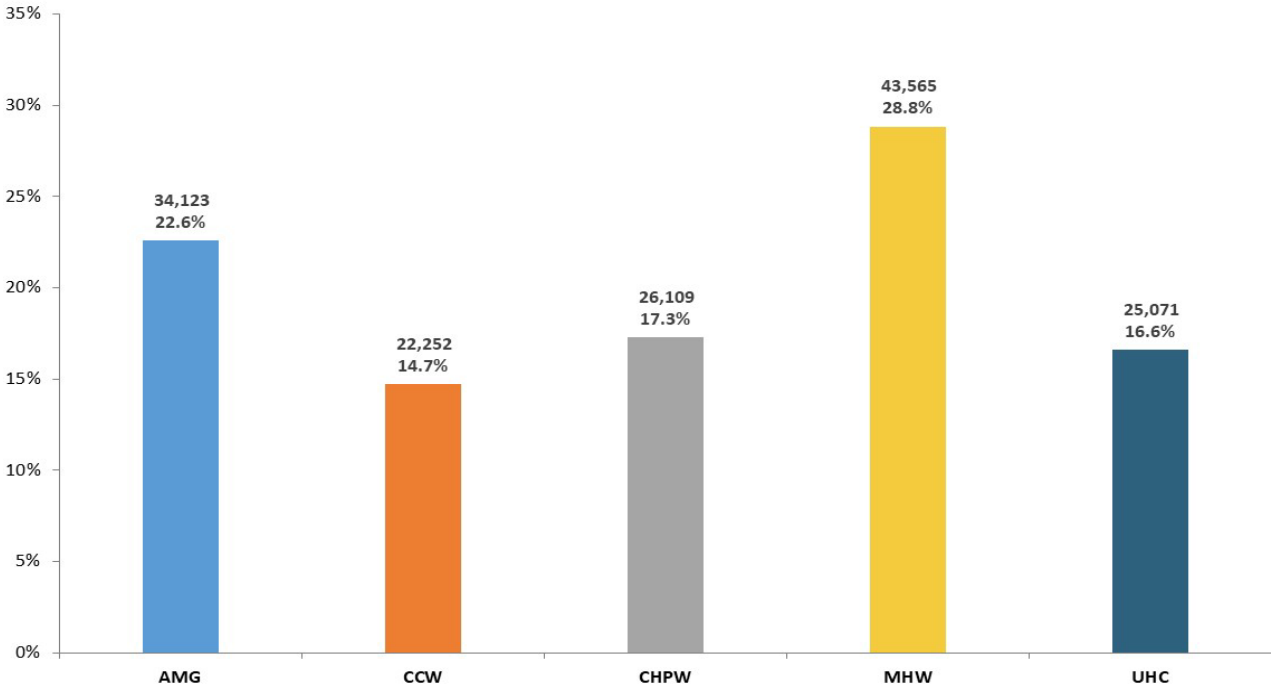


Figure 4. Percent of BHSO Enrollment by MCP.



Demographics by MCP

Variation between MCOs' demographic profiles is a reflection of the difference in plan mix for each Managed Care Plan (MCP) which includes MCOs and BHSOs and should be taken into account when assessing HEDIS measurement results.

Age

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

Figure 5 shows the percentages of enrollment by age group and MCP. The darker blue signifies a higher percentage, while lighter blue signifies lower, with a medium gradient for those values in between. Though the average age of members varies across plans, the highest proportion of members across MCOs are in the 21–44 age group.

Figure 5. MCO Enrollee Population by MCP and Age Range, MY2020 (Excluding BHSO).

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

As shown in Figure 6, Age 65+ has over 50% of the enrollment.

Figure 6. BHSO Enrollee Population by MCP and Age Range, MY2020.

Age Range	AMG	CCW	CHPW	MHW	UHC
Age 0 to 5	0.3%	0.7%	0.3%	0.5%	0.2%
Age 6 to 12	1.8%	2.8%	1.6%	2.3%	1.7%
Age 13 to 20	2.9%	4.1%	2.4%	3.3%	2.7%
Age 21 to 44	17.7%	16.5%	16.5%	18.4%	16.4%
Age 45 to 64	23.0%	19.4%	20.7%	22.6%	21.8%
Age 65+	54.3%	56.4%	58.4%	52.8%	57.2%

Race and Ethnicity by MCP

The race and ethnicity data presented here was provided by the members upon their enrollment in Apple Health. The members may choose "other" if their race is not on the list defined in the Provider One application. The member may also choose "not provided" if they decline to provide the information.

The shading in Figure 7 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.

The "other race" category was the second most common for most MCOs. Black members make up 11.2% of UHC's enrollee population and 9.1% of AMG's population, which were higher percentages than other MCOs.

Figure 7. Statewide MCO Apple Health Enrollees by MCP and Race,* MY2020 (Excluding BHSO).

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

**These are the categories MCPs 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 8 shows the statewide BHSO enrollment by race. The shading in Figure 8 is the same as Figure 7 to better differentiate race/ethnicities other than white. Similar to the population enrolled in MCOs, over half the BHSO enrollees are white.

Figure 8. Statewide BHSO Apple Health Enrollees by MCP and Race,* MY2020.

Race	AMG	CCW	CHPW	MHW	UHC
White	66.0%	55.5%	62.2%	67.2%	62.0%
Other	8.7%	12.1%	11.5%	8.5%	6.9%
Not Provided	6.8%	7.3%	6.9%	6.5%	6.4%
Black	6.0%	7.8%	5.6%	5.8%	7.6%
Asian	9.3%	12.9%	10.9%	8.5%	12.8%
American Indian/Alaska Native	0.5%	1.0%	0.4%	0.9%	0.6%
Hawaiian/Pacific Islander	2.6%	3.4%	2.4%	2.6%	3.7%

**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 9 shows the percentage of MCO members who identified as Hispanic. CCW and CHPW have the largest percentages of Hispanic members at 35.8% and 33.0%, respectively.

Figure 9. Statewide MCO Apple Health Enrollees by MCP and Hispanic Indicator (Excluding BHSO), MY2020.

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

Figure 10 shows the percentage of BHSO enrollees who identified as Hispanic. Approximately 12% of the BHSO enrollees identified as Hispanic.

Figure 10. Statewide BHSO Apple Health Enrollees by MCP and Hispanic Indicator, MY2020.

Hispanic	AMG	CCW	CHPW	MHW	UHC
N	88.6%	84.9%	86.1%	89.0%	92.4%
Y	11.4%	15.1%	13.9%	11.0%	7.6%

Primary Spoken Language by MCP

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

Figure 11 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 11. Statewide MCO Apple Health Enrollees by MCP and Language, MY2020 (Excluding BHSO).

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

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

Figure 12 shows the most common primary spoken languages for BHSO enrollees. The results are similar to the MCO enrollees.

Figure 12. Statewide BHSO Apple Health Enrollees by MCP and Language, MY2020.

Spoken Language	AMG	CCW	CHPW	MHW	UHC
English	87.35%	84.82%	85.59%	88.01%	88.28%
Spanish; Castilian	4.06%	5.56%	4.83%	3.51%	2.48%
Russian	0.35%	0.36%	0.67%	0.76%	0.37%
Vietnamese	0.52%	0.65%	0.69%	0.60%	0.77%
Chinese	0.47%	0.59%	0.74%	0.46%	0.60%
Arabic	0.04%	0.04%	0.07%	0.05%	0.05%
Ukrainian	0.02%	0.06%	0.07%	0.05%	0.04%
Somali	0.06%	0.09%	0.09%	0.04%	0.08%
Korean	0.22%	0.35%	0.24%	0.27%	0.43%
Amharic	0.04%	0.08%	0.05%	0.05%	0.07%
Panjabi; Punjabi	0.09%	0.12%	0.17%	0.12%	0.18%
Burmese	0.01%	0.02%	0.02%	0.01%	0.02%
Tigrinya	0.05%	0.04%	0.05%	0.03%	0.04%
Farsi	0.04%	0.03%	0.04%	0.03%	0.05%
Cambodian; Khmer	0.16%	0.20%	0.11%	0.15%	0.16%
Other Language*	6.52%	7.01%	6.56%	5.86%	6.37%

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

Washington State Managed Care Quality Strategy Effectiveness Analysis

Objective

To fulfill the requirement established by federal regulation 42 CFR Part 438 Subpart E §438.340, the Washington State Managed Care Quality Strategy[10] created a comprehensive strategy to assess, monitor, coordinate the quality of the managed care services and develop measurable goals and targets for continuous quality improvement.

The EQR is one part of an interrelated set of quality requirements that apply to Medicaid managed care. Feedback provided by the EQRO is reviewed when HCA updates the Quality Strategy. Per 42 C.F.R. §§ 438.364(a)(4) and 457.1250, the feedback obtained from the state's EQRO should be used by states when they examine and update their quality strategy. The Quality Strategy is implemented through the ongoing comprehensive quality assessment and performance improvement (QAPI) program that each MCP is required to establish for the services provided to members. The PIPs and performance measures included in the QAPIs are validated through the annual EQR.

Overview

The HCA utilizes the Quality Strategy to communicate its mission, vision and guiding principles for assessing and improving the quality of health care and services furnished by MCPs. Since its last revision in 2017, Washington State and the HCA experienced several changes that required the Quality Strategy to be updated in order to align more closely with the current health care landscape. The changes that have occurred within Washington are listed below.

- Statewide transition of financial integration of physical health, mental health and substance use disorder services within the Apple Health managed care program concluded in January 2020.
- VBP was expanded across Washington State.
- As part of the transition to integrated managed care, DBHR staff who were originally under DSHS were realigned and integrated under HCA.

Within the Quality Strategy, HCA has identified goals, aims and objectives to support improvement in the quality, timeliness and access to health care services furnished to managed care members. The Quality Strategy is updated no less than triennially and when there is a significant change to Washington's Apple Health Program. The most recent HCA review and updating of the Quality Strategy was completed by a multidisciplinary team that conducted an evaluation of effectiveness and solicited feedback from a variety of stakeholders as well as tribal partners. Quality Strategy updates were also reviewed and approved by several committees including Washington's Title XIX Committee. Changes made based on most review of effectiveness include but are not limited to:

- Development of aims and objectives
- Descriptions of HCA quality and performance measure review teams and processes that help ensure transparency and alignment with agency-wide, statewide and national quality initiatives

[10] Washington State Health Care Authority. Washington State Managed Care Quality Strategy. October 2020. Available at: https://www.hca.wa.gov/assets/program/13-0053-washington-state-managed-care-quality-strategy.pdf.

- Address agency payment reform initiatives to incentivize quality care, such as Delivery System & Provider Payment Initiatives (DSRIP)
- Expanded description of Performance Improvement Projects (PIPs), state required collaborative topics and their role in driving quality of care statewide
- Identification of roles assigned for ongoing EQR activities to provide more clarity about who ensures oversight of managed care quality functions

Additionally, review and updating of the Quality Strategy takes into account recommendations from the EQRO for improving the quality of health care services furnished by each MCP, including how HCA can target goals and objectives in the quality strategy to better support improvement in the quality, timeliness and access to health care services furnished to MCP members. The most recent review incorporated feedback from the EQRO Annual Technical Reports occurring during the period of review. HCA is actively working to update the Quality Strategy for the next iteration to be published in October of 2023.

Quality Strategy Populations and Programs

The Quality Strategy is applicable to the below programs:

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

The Quality Strategy is not applicable to Medicaid Fee-For-Service.

Quality Strategy Mission and Vision

HCA's goals, Vision and Mission Statement, and Core Values for Apple Health align with the three aims of the National Quality Strategy: better care, healthy people/healthy communities and affordable care. The Mission and Vision provides the overall framework that informs HCA's strategy to assess, monitor, coordinate and engage in continuous process improvement. HCA's VBP principles are a primary strategy and guide for achieving these goals.

The CMS, Apple Health and Washington managed care oversight goal crosswalk, included at the end of this section, further illustrates how all the goals are aligned.

The primary goals include:

- Rewarding the delivery of person- and family-centered high value care
- Driving standardization and care transformation based on evidence
- Striving for smarter spending and better outcomes, and better consumer and provider experience

Washington Managed Care Program Aims and Objectives

At a high level, the Quality Strategy aims relate to quality, access and timeliness of care. The Quality Strategy provides six aims that ensure Apple Health enrollees receive the appropriate, responsive and evidence-based health care.

The Quality Strategy objectives further expand on the approach that HCA will take to provide oversight to ensure that the managed care program is accountable to achieving each aim. In addition to usual monitoring activities defined in the Quality Strategy objectives, it provides an expectation to evaluate strategies to address health inequities.

The six Quality Strategy aims are shown below in Table 2.

Table 2. CMS, Apple Health, and WA Managed Care Oversight Goal Crosswalk.

Federal: CMS Quality Strategy Aims (1)	WA State Medicaid: Apple Health Value-Based Purchasing Principles (2)	WA Medicaid Managed Care: Managed Care Aims for Quality Oversight
Healthier People, Healthier Communities	Drive standardization and care transformation based on evidence	**Aim 1:** Assure the quality and appropriateness of care for Apple Health managed care enrollees *(Quality)* **Aim 2:** Assure enrollees have timely access to care *(Access and Timeliness)*
Better Care	Reward the delivery of person-and family-centered, high-value care	**Aim 3:** Assure medically necessary services are provided to enrollees as contracted *(Quality, Access and Timeliness)* **Aim 4:** Demonstrate continuous performance improvement *(Quality, Access and Timeliness)*
Smarter spending	Strive for smarter spending, better outcomes, and better consumer and provider experience	**Aim 5:** Assure that MCOs are contractually compliant *(Quality, Access and Timeliness)* **Aim 6:** Eliminate fraud, waste and abuse in Apple Health managed care programs *(Quality)*

1. *CMS Quality Strategy—2016.*
2. *HCA Value-Based Purchasing Roadmap 2019-2021 and Beyond; October 2019.*

Information and Documentation Reviewed

As the EQRO, Comagine Health has reviewed the following information and activities to assist with targeting goals and objectives in the Quality Strategy to better support the quality, timeliness and access to health care services provided to MCP enrollees:

- As outlined in the "Summary of Results: Performance Measure Validation" section of this report, Comagine Health used HEDIS data to perform comparisons among MCOs and against national benchmarks, as well as to identify variations in measure performance across regions, Apple Health programs and demographic groups, including age (for certain measures), race, ethnicity, sex, primary language and disability status (to target disparities and health equity). RDA measure review and analysis were completed for two behavioral health measures. The comparative analysis is also used to assess the implementation of the Quality Strategy.

  Performance measure validation and review were completed for:

  - Healthcare Effectiveness Data and Information Set (HEDIS) measures
  - Statewide Behavioral Health Measures
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys
- Performance Improvement Projects (PIP)

- Focused Quality Studies – WISe and Behavioral Health Performance Measure Study
- Value-based purchasing strategy within the Quality Strategy
- Enrollee Quality Report "Washington Apple Health Plan Report Card"

Recommendations

The following table provides recommendations offered to assist HCA as they prepare to update the Quality Strategy in identifying goals and objectives to support quality, timeliness and access.

Table 3. Recommendations Related to Quality Strategy.

Recommendations	Linked to Aim(s)
Sustain Improvement in clinically meaningful areas (including behavioral health integration) through collaboration among MCOs, with higher performing plans sharing successful strategies that have led to improved measure performance and may help improve all the MCOs performance on these measures.	Sustaining improvements in clinically meaningful areas addresses Quality Strategy Aims: Aims 1, 2, 3 and 4
Address Behavioral Health Declines to ensure individuals receive necessary treatment and improvements are reflected across all race/ethnicity categories.	Addressing behavioral health declines addresses Quality Strategy Aims: Aims 1, 2, 3 and 4
Focus on Preventive Care • Maximize use of telehealth • Outreach to ensure preventive care is obtained • Focus on bidirectional integration	Focusing on preventive care addresses Quality Strategy Aims: Aims 1, 2, 3 and 4
Continue to Prioritize Health Equity Continue to collaborate with partners around health equity data, including the collection, analysis, reporting and community participation in validating and interpretation to drive health equity work.	Prioritizing health equity addresses Quality Strategy Aims: Aims 1, 2, 3, 4 and 5
Continue to refine/focus on Value Based Purchasing as a strategy to move improvements forward by:	Focusing on VBP addresses all Quality Strategy Aims: Aims 1, 2, 3, 4, 5 and 6

Recommendations	Linked to Aim(s)
• Incorporating equity-focused payment and contracting models into the VBP program as an approach to improving health equity.[11] • Broadening payment reform to more settings, including primary care. The more VBP is standardized across settings, the better able to improve on shared goals. This VBP process has proven to support improvements and is supported by the Washington legislature. • Focusing VBP measures on those that will drive change and improve care in the primary care arena.	
Refine language for required non-duplication of EQR-Related Activities: • Include details explaining which arrangements assist with non-duplication, including deeming processes such as the Information Systems Capability Assessment (ISCA) completed during the HEDIS PMV process and NCQA Accreditation of all plans.	Non-duplication of EQR-related activities addresses the following Quality Strategy Aims: Aims 4 and 5
Continue to focus on collaboration and standardization across MCPs and HCA: • Working together on identified areas of improvement has proven effective in driving state-wide change. Recent collaborations include the Health Equity workgroup which has turned into a collaborative PIP and the VBP workgroup.	Standardization of approaches across MCPs addresses the following Quality Strategy Aims: Aims 1, 2, 4 and 5
MCPs need to have an effective QAPI program that moves quality care forward with a focus on strategies to assist MCPs in development and monitoring of their QAPI programs to address necessary improvements including: • QAPI program evaluations should address the summative evaluation of the QI program and address recommendations above and beyond HEDIS performance measures. • QAPI program reports should include trend data to demonstrate performance related to quality and safety of clinical care and non-clinical/service-related care for the disability population in the Social Determinants of Health/Health Equity section of the MCP QI program evaluation.	Individual MCP improvements address Quality Strategy Aims: Aims 1, 2, 3, 4 and 5

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

Compliance Review

Objective

The purpose of the compliance review is to determine whether Medicaid managed care plans are in compliance with federal standards. The U.S. Department of Health & Human Services (HHS) developed standards for managed care plans, including 42 CFR §438 and 42 CFR §457.[12,13]

Overview

Federal regulations require MCPs to undergo a review at least once every three years to determine MCP compliance with federal standards as implemented by the state. Washington's MCPs (which include the MCOs and BHSOs) are evaluated by TEAMonitor, at HCA, which provides formal oversight and monitoring activities on their compliance with federal and state regulatory and contractual standards. TEAMonitor has chosen to spread the review over a three-year cycle.

TEAMonitor's review assesses activities for the previous calendar year and evaluates MCPs' compliance with the standards set forth in 42 CFR Part 438, as well as those established in the MCPs' contracts with HCA for all Apple Health Managed Care programs including AH-IMC, AH-IFC, CHIP and the BHSO. Although TEAMonitor completed both MCO and BHSO reviews in one session of the virtual visit, the programs were reviewed as separate entities, with their own scores.

In 2021, Year 3 of the current review cycle, TEAMonitor reviewed the following standards (Table 4) for the MCPs.

Table 4. Compliance Standards.

Standards	Elements	Quality Strategy Aim(s)
§438.56 - Disenrollment: Requirements and limitations	Quality, Access and Timeliness	Aims 3 and 5
§438.210 - Coverage and authorization of service*	Quality, Access and Timeliness	Aims 1, 2, 3, 5 and 6
§438.230 - Subcontractual relationships and delegation	Quality, Access and Timeliness	Aims 1, 2, 3, 5 and 6
§438.242 - Health information systems	Quality and Timeliness	Aims 5 and 6
§438.608 - Program integrity requirements†	Quality	Aims 5 and 6

* TEAMonitor reviews §438.114 - Emergency and post-stabilization services in conjunction with this standard.

† TEAMonitor reviews Social Security Act (SSA) section 1903(i)(2) of the Act; §455.104 - Disclosure of ownership and control; §455.106 - Disclosure by providers: Information on persons convicted of crimes; §455.23 - Provider Payment Suspension; and §1001.1901(b) - Scope and effect of exclusion in conjunction with this standard.

[12] Electronic Code of Federal Regulations. Title 42, part 438 – Managed Care. Available at: https://www.ecfr.gov/current/title-42/part-438.

[13] Electronic Code of Federal Regulations. Title 42, part 457 Allotments and Grants to States. Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=60f9f0f14136be95a1cee250074ae00d&mc=true&node=pt42.4.457&rgn=div5.

Methodology

Technical Methods of Data Collection

The TEAMonitor review process is a combined effort by clinical and non-clinical staff and subject matter experts. Desk review includes assessment of MCP policies and procedures, program descriptions, evaluations and reports. TEAMonitor also reviews individual enrollee files during the applicable review cycle. The type of files reviewed include denials, appeals, grievances, health home services, care coordination and other applicable file types according to the review period. Also assessed are prior-year corrective action plans (CAPs) implemented by the MCPs which can be viewed in Appendix A, MCP Profiles for each MCP.

After review, HCA staff share results with the MCPs through phone calls and onsite visits. The onsite visits were conducted virtually due to the COVID-19 public health emergency (PHE) this year. Each MCP then receives a final report that includes compliance scores, notification of CAPs for standards not met and recommendations. Throughout the year, HCA offers plans technical assistance to develop and refine processes that will improve accessibility, timeliness and quality of care for Medicaid enrollees.

Scoring

TEAMonitor scores the MCPs on each compliance standard according to a metric of Met, Partially Met and Not Met, each of which corresponds to a value on a point system of 0–3.
Scoring key:

- Score of 0 indicates previous year CAP Not Met
- Score of 1 indicates Not Met
- Score of 2 indicates Partially Met
- Score of 3 indicates Met
- Score of NA indicates Not Applicable

Final scores for each section are denoted by a fraction indicating the points obtained (the numerator) relative to all possible points (the denominator) and the corresponding percentage. For example, in a section consisting of four elements in which the MCP scored a 3, or Met, in three categories and a 1, or Not Met, in one category, the total number of possible points would be 12, and the MCP's total points would be 10, yielding a score of 10 out of 12 with a corresponding 83%.

In addition, plans are reviewed on elements that received Partially Met or Not Met scores in previous reviews until the finding is satisfied.

See Appendix B for more information on methodology, including technical methods of data collection, description of data obtained, and how TEAMonitor and Comagine Health aggregated and analyzed the data.

MCP Compliance Review Results

The following tables (Tables 5–9) provide a summary of all MCP scores by compliance standard in Year 3 of the current 3-year cycle. Plans with elements scored as Partially Met or Not Met were required to submit CAPs to HCA. Plans were scored on these elements in the first half of the calendar year. Because MCPs may have implemented CAPs since that time to address specific issues, scores may not be indicative of current performance.

Table 5. Compliance Review Results by MCP: Disenrollment: Requirements and Limitations.

§438.56 - Disenrollment: Requirements and limitations	AMG MCO	AMG BHSO	CCW MCO	CCW BHSO	CHPW MCO	CHPW BHSO	MHW MCO	MHW BHSO	UHC MCO	UHC BHSO
438.56(b)(1) - (3) Disenrollment requested by the MCO, PIHP Involuntary	3	3	3	3	3	3	3	3	3	3
Total Score	3	3	3	3	3	3	3	3	3	3
Total Score - %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Table 6. Compliance Review Results by MCP: Coverage and Authorization of Service.

§438.210 - Coverage and authorization of service	AMG MCO	AMG BHSO	CCW MCO	CCW BHSO	CHPW MCO	CHPW BHSO	MHW MCO	MHW BHSO	UHC MCO	UHC BHSO
438.114 Emergency and post-stabilization services	3	3	3	3	3	3	3	3	3	3
438.210 Coverage and authorization of services (b) Authorization of services – File review	0	0	1	1	2	2	0	1	2	2
438.210 Coverage and authorization of services (c) Notice of adverse benefit determination – File review	0	0	1	1	1	1	1	1	1	1
438.210 Coverage and authorization of services (d) Timeframe for decisions – File review	0	0	3	3	3	3	0	1	3	3
438.210 Coverage and authorization of services (e) Compensation for utilization management decisions	3	3	3	3	3	3	3	3	3	3
Total Score	6	6	11	11	12	12	7	9	12	12
Total Score - %	40%	40%	73%	73%	80%	80%	47%	60%	80%	80%

Table 7. Compliance Review Results by MCP: Subcontractual Relationships and Delegation.

§438.230 - Subcontractual Relationships and Delegation	AMG MCO	AMG BHSO	CCW MCO	CCW BHSO	CHPW MCO	CHPW BHSO	MHW MCO	MHW BHSO	UHC MCO	UHC BHSO
438.230 Subcontractual relationships and delegation (a) and (b)(1) and (2) Subcontractual relationships and delegation	1	1	2	2	3	3	3	3	2	2
438.230 Subcontractual relationships and delegation (b)(2) Subcontractual relationships and delegation – written agreement	3	3	3	3	1	1	3	3	3	3

§438.230 - Subcontractual Relationships and Delegation	AMG MCO	AMG BHSO	CCW MCO	CCW BHSO	CHPW MCO	CHPW BHSO	MHW MCO	MHW BHSO	UHC MCO	UHC BHSO
438.230 Subcontractual relationships and delegation (b)(3) MCO monitors subcontractors performance	3	3	2	2	3	3	3	3	1	1
438.230 Subcontractual relationships and delegation (b)(4) MCO identifies deficiencies and ensures corrective action is taken	3	3	2	2	3	3	3	3	1	1
Total Score	10	10	9	9	10	10	12	12	7	7
Total Score - %	83%	83%	75%	75%	83%	83%	100%	100%	58%	58%

Table 8. Compliance Review Results by MCP: Health Information Systems.

§438.242 - Health Information Systems	AMG MCO	AMG BHSO	CCW MCO	CCW BHSO	CHPW MCO	CHPW BHSO	MHW MCO	MHW BHSO	UHC MCO	UHC BHSO
438.242 Health information systems (a) General rule	3	3	3	3	3	3	3	3	3	3
438.242 Health information systems (b)(1)(2) Basic elements	3	3	3	3	3	3	3	3	3	3
438.242 Health information systems (b)(3) Basic element	3	3	3	3	3	3	3	3	3	3
Total Score	9	9	9	9	9	9	9	9	9	9
Total Score - %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Table 9. Compliance Review Results by MCP: Program Integrity Requirements.

§438.608 - Program integrity requirements	AMG MCO	AMG BHSO	CCW MCO	CCW BHSO	CHPW MCO	CHPW BHSO	MHW MCO	MHW BHSO	UHC MCO	UHC BHSO
438.608 Program integrity requirements (a)(b)	2	2	1	1	3	3	1	1	1	1
455.104 Disclosure of ownership and control	3	3	3	3	3	3	3	3	1	1
455.23 Provider Payment Suspension	3	3	2	2	3	3	1	1	2	2
Social Security Act (SSA) section 1903(i)(2) of the Act; 42 CFR 455.104, 42 CFR 455.106, and 42 CFR 1001.1901(b) - Excluded Individuals and Entities	3	3	2	2	1	1	3	3	3	3
Total Score	11	11	8	8	10	10	8	8	7	7
Total Score - %	92%	92%	67%	67%	83%	83%	67%	67%	58%	58%

Conclusions

Disenrollment: Requirements and Limitations

Strengths

- All MCPs met the element for this standard.

Coverage and Authorization of Service

Strengths

- All MCPs met the elements for emergency and post-stabilization services and compensation for utilization management decisions.
- After file review, three MCOs and three BHSOs met the element for timeframe for decisions (CCW/MCO, CCW/BHSO, CHPW/MCO, CHPW/BHSO, UHC/MCO and UHC/BHSO).

Weaknesses/Opportunities for Improvement

- Coverage and authorization of services has historically been a problem for the MCPs.
- After file review, CHPW/MCO, CHPW/BHSO, UHC/MCO and UHC BHSO partially met the element for coverage and authorization of services. CAPs were not accepted for AMG/MCO, AMG/BHSO and MHW/MCO. CCW/MCO, CCW/BHSO and MHW/BHSO did not meet the element.
- After file review, no MCPs partially met or met the element for notice of adverse benefit determination. The CAP was not accepted for AMG/MCO and AMG/BHSO for this element.
- After file review, CAPs were not accepted for AMG/MCO, AMG/BHSO and MHW/MCO for the element for timeframe for decisions.

Subcontractual Relationships and Delegation

Strengths

- MHW met all elements for this standard.
- Four MCOs (AMG, CCW, MHW and UHC) and four BHSOs (AMG, CCW, MHW and UHC) met the element for written agreements for subcontractual relationships and delegation.
- Three MCOs (AMG, CHPW and MHW) and three BHSOs (AMG, CHPW and MHW) met the element for monitoring subcontractors' performance.
- Three MCOs (AMG, CHPW and MHW) and three BHSOs (AMG, CHPW and MHW) met the element for identifying deficiencies and ensuring corrective action is taken.

Weaknesses/Opportunities for Improvement

- AMG/MCO and AMG/BHSO did not meet the element for subcontractual relationships and delegation. UHC/MCO and UHC/BHSO partially met the elements for subcontractual relationships and delegation.
- CHPW/MCO and CHPW/BHSO did not meet the element for subcontractual relationships and delegation – written agreement

- CCW/MCO and CCW/BHSO partially met the elements for subcontractual relationships and delegation, monitoring subcontractors' performance, and identifying deficiencies and ensuring corrective action is taken.
- UHC/MCO and UHC/BHSO did not meet the elements for monitoring subcontractor performance or identifying deficiencies and ensuring corrective action is taken.

Health Information Systems

Strengths

- All MCPs met all elements for this standard.

Program Integrity Requirements

Strengths

- CHPW/MCO and CHPW/BHSO met the element of program integrity requirements.
- Four MCOs (AMG, CCW, CHPW and MHW) and four BHSOs (AMG, CCW, CHPW and MHW) met the element for disclosure of ownership and control.
- Two MCOs (AMG and CHPW) and two BHSOs (AMG and CHPW) met the element for provider payment suspension.
- Three MCOs (AMG, MHW and UHC) and three BHSOs (AMG, MHW and UHC) met the element for excluded individuals and entities.

Weaknesses/Opportunities for Improvement

- AMG/MCO and AMG/BHSO partially met the element for program integrity requirements. Three MCOs (CCW, MHW and UHC) and three BHSOs (CCW, MHW and UHC) did not meet the element for program integrity requirements.
- UHC/MCO and UHC/BHSO did not meet the element for disclosure of ownership and control.
- Two MCOs (CCW and UHC) and two BHSOs (CCW and UHC) partially met the element for provider payment suspension. MHW/MCO and MHW/BHSO did not meet the element for provider payment suspension.
- CCW/MCO and CCW/BHSO partially met the element for excluded individuals and entities. CHPW/MCO and CHPW/BHSO did not meet the element for excluded individuals and entities.

Review of Previous Year (2020) Corrective Action Plans (CAPs)

The MCPs adequately addressed prior year findings and received verification and full recognition of completion of their CAPS, except for coverage and authorization of services, where no MCP successfully met the corrective action plan requirements for all elements in this standard.

Availability of Services

All CAPS were met by all MCPs for elements within this standard.

- All five MCOs and BHSOs met their correction action plans for availability of services for their delivery network, provider directory information for all enrollees, and assurances of adequate capacity and services.
- UHC/MCO and UHC/BHSO met their CAP for out-of-network payment.
- CCW/MCO, CHPW/MCO and CHPW/BHSO met the CAP for providing direct access to women's health specialists.
- Two MCOs (CHPW and MHW) and two BHSOs (CHPW and MHW) met their CAP for providing a second opinion.
- CCW/MCO and CCW/BHSO met their CAPs for both services out of network and out-of-network payment.
- Three MCOs (CHPW, MHW and UHC) and three BHSOs (CHPW, MHW and UHC) met their CAP for furnishing of services – timely access.
- Four MCOs (AMG, CCW, CHPW, MHW) and four BHSOs (AMG, CCW, CHPW and MHW) successfully completed their CAPS for cultural considerations.

Coordination and Continuity of Care

All CAPS were met by all MCPs for elements within this standard.

- Four MCOs (AMG, CCW, CHPW, MHW) and four BHSOs (AMG, CCW, CHPW and MHW) met their CAPS for primary care and coordination of health care services for all enrollees, and confidentiality.
- UHC/MCO and UHC/BHSO met their CAP for care coordination for enrollees with special health care needs, assessment and treatment plans.

Coverage and Authorization of Services

Due to the timing of the TEAMonitor review process from the previous year it was expected that there would still be some findings. The MCO's were able to provide evidence of improvement as part of their Corrective Action response. It is expected to see additional improvement as part of the 2022 review.

- CCW/MCO and CCW/BHSO met the CAP for authorization of services. Two MCOs (AMG and MHW) and AMG/BHSO did not meet the CAP for this element. This is a repeat finding for MHW/MCO.
- Two MCOs (CCW, MHW) and two BHSOs (CCW and MHW) met the CAP for notice of adverse benefit determinations. Two MCOs (CHPW and UHC) and two BHSOs (CHPW and UHC) partially met their CAP for this element. AMG did not meet the CAP for this element, which is also a repeat finding.
- AMG/MCO and AMG/BHSO partially met the CAP for coverage and authorization of services, timeframe for decisions. MHW/MCO did not meet the CAP for this element, which is also a repeat finding.

Enrollee Rights and Protections

All CAPS were met by all MCPs for elements within this standard.

- Two MCOs (AMG and UHC) and two BHSOs (AMG and UHC) met the CAP for enrollee rights – general rule.

- Two MCOs (AMG and CHPW) and two BHSOs (AMG and CHPW) met the CAP for specific rights; format, easily understood.
- AMG/MCO met their CAP for formulary information for enrollees.
- CHPW/MCO and CHPW/BHSO met their CAP for specific rights - language and format, as well as their CAP for additional specific rights.
- CCW/MCO and CCW/BHSO met their CAP for specific rights.
- Three MCOs (CHPW, MHW and UHC) and three BHSOs (CHPW, MHW and UHC) met their CAPs for specific rights – general requirements.
- Two MCOs (CCW and CHPW) and two BHSOs (CCW and CHPW) met the CAP for enrollee rights and compliance with other federal and state laws.
- Two MCOs (CHPW and MHW) and two BHSOs (CHPW and MHW) met the cap for liability for payment.

Grievance System

All CAPS were met by all MCPs for elements within this standard.

- AMG/MCO and AMG/BHSO met the CAP for filing requirements – authority to file, as well as expedited resolution of appeals.
- CHPW/MCO and CHPW/BHSO met the CAP for filing requirements – timing.
- Two MCOs (AMG and MHW) and two BHSOs (AMG and MHW) met the CAP for general requirements for handling of grievances and appeals.
- Two MCOs (AMG and UHC) and two BHSOs (AMG and UHC) met the CAP for the basic rule, resolution and notification of grievances and appeals.
- Three MCOs (AMG, MHW and UHC) and three BHSOs (AMG, MHW and UHC) met the CAP for specific timeframes and extension of timeframes in the resolution and notification of grievances and appeals.
- Three MCOs (AMG, CCW and MHW) and three BHSOs (AMG, CHW and MHW) met the CAP for format of notice and content of notice of appeal resolution.

Practice Guidelines

- AMG/MCO (AMG) and AMG/BHSO met the CAP regarding application of practice guidelines upon re-review.

Recommendations

Overall, the MCPs continue to work to meet the requirements for each of the elements reviewed. The following are recommendations for the MCPs.

Coverage and Authorization of Service

HCA has provided intensive technical assistance to support needed improvements in this standard. It is recommended that HCA continue to monitor and provide technical assistance to the MCPs for compliance with the coverage and authorization of service elements.

Subcontractual Relationships and Delegation

Four of the five MCPs (AMG/MCO, AMG/BHSO, CCW/MCO, CCW/BHSO, CHP/MCO, CHP/BHSO, UHC/MCO and UHC/BHSO) will benefit from technical assistance by HCA to ensure the plans meet the requirements for the subcontractual relationships and delegation standard. These elements include:

- Subcontractual relationships and delegation
- Written agreements
- Monitoring of sub-contractor performance
- Identifying deficiencies and ensuring corrective action is taken.

Program Integrity Requirements

HCA should provide technical assistance to all plans regarding program integrity requirements. Four MCOs (CCW, CHPW, MHW and UHC) and four BHSOs (CCW, CHPW, MHW and UHC) did not meet at least one element under this standard.

Performance Improvement Project (PIP) Validation

Objectives

Medicaid MCPs are federally required to design and implement PIPs that focus on both clinical and non-clinical areas as part of a comprehensive quality assessment and performance improvement (QAPI program).[14] The PIPs should aim to achieve significant improvement related to health outcomes and member satisfaction over a sustained period of time.[15] These PIP interventions may be designed to change the behaviors at the member level, behaviors at the provider level or influence change at the MCP and/or systems level.

PIPs are outlined in the Washington State Managed Care Quality Strategy and are aligned with Washington Quality Aim #4 – "Demonstrate continuous performance improvement."

Overview

Washington's MCPs (which include the MCOs and BHSOs) are contractually required to have an ongoing program of clinical and non-clinical PIPs that are designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction for all Apple Health programs, including AH-IMC, AH-IFC and BHSO.

As a component of its EQR review, TEAMonitor conducted an assessment and validation of the MCPs' PIPs to ensure they met state and federal guidelines; included all Apple Health enrollees; and were designed, implemented, analyzed and reported in a methodologically sound manner.

Methodology

The intent of the PIP validation process is to ensure the PIPs contain sound methodology in its design, implementation, analysis and reporting of its results. It is crucial that it has a comprehensive and logical thread that ties each aspect (e.g., aim statement, sampling methodology and data collection) together.

As required under *CMS Protocol 3 Validation of Performance Improvement Projects (PIPs)*, TEAMonitor determined whether PIP validation criteria were Met, Partially Met or Not Met. In addition, TEAMonitor utilizes confidence indicators in reporting the results of the MCPs' PIPs.

Note: In RY2021, TEAMonitor begun implementation of *Protocol 1 Validation of Performance Improvement Projects* [16]updated by CMS in 2019 in its validation of PIPs. The updated protocol includes additional measurements of success and will be fully implemented for RY2022.

For a full description of HCA's methodology and scoring for PIP validation, please see Appendix C.

[14] Federal regulations: 42 C.F.R. § 438.330(b)(1) and 457.1240(b).
[15] CMS. EQR Protocol 3 – Attachment A. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3-attachment-a.pdf.
[16] CMS. EQR Protocol 1. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf.

Summary of PIP Validation Results/Conclusions

Tables 10–15 provide an overview of each MCP's PIPs, including applicable elements, aims/study topics, Quality Strategy aims, interventions, strengths, weaknesses/opportunities for improvement, confidence in MCO PIP results, scores and statistical significance.

Table 10. 2021 Collaborative PIP Summary: AMG, CCW, CHPW, MHW and UHC.

Statewide Collaborative PIP		
PIP Type: Clinical (AH-IMC/AH-IFC) **PIP Name:** Collaborative MCO Well-Child Visit Rate PIP **Aim/Study Question:** Will partnering with providers and community organizations serving early learning populations increase the effect of efforts to get unestablished and overdue patients in for a well visit and increase the percentage of Washington State Medicaid managed care enrolled children who receive appropriate well visits for children/adolescents as measured by the following: • Official PIP Measures • HEDIS child/adolescent well visit measures rates for the populations for W15, W34, and AWC in Washington State and/or Proxy Measurement HEDIS-like administrative rates for the populations for W15, W34, and AWC in the focused county		
Score: Partially Met **Confidence:** Confidence in reported MCO PIP results **Statistical Significance Indicating Improvement:** No Statistically Significant Change • Statewide improvement not seen. • It is well understood that the COVID-19 pandemic is a likely factor in the lack of sustained improvement across the state.		
PIP Summary	**Strengths**	**Weaknesses**
• **Element:** Access, Quality, Timeliness • **History**: This PIP was initiated in mid-2016 through an MCO peer collaborative; it was in its fifth year during CY2020. • **Intervention**: **Provider-focused** During CY2020, performed culturally focused data analysis to examine cultural and linguistic variation on well-care visits and utilized HEDIS-like subpopulation reporting to develop flyers in the highest reported language requests throughout the MCOs.	• Interventions were culturally and linguistically appropriate. • Good pivoting to meet challenges posed by the retirement of HEDIS measures used for this PIP. • Interventions would have been expected to move the measure if not for circumstances outside of the control of the collaborative.	• The pandemic changed how many members were receiving care. A focused intervention change involving telemedicine would have been advisable.

Table 11. 2021 PIP Summary by MCP: AMG.

<table>
<tr><th colspan="3">Amerigroup Washington</th></tr>
<tr><td colspan="3">PIP Type: Clinical - Washington State Institute for Public Policy (AH-IMC/BHSO) – Adult
PIP Name: Using SBIRT (Screening, Brief Intervention, and Referral to Treatment) for Identification and Intervention of Substance Use Disorders by Physical Health Practitioners
Aim/Study Question: Will an educational campaign about SBIRT services, including information on training, certification, reimbursement processes, and incentivizing certification in SBIRT services for physical health providers in the North Central region increase practitioner certification in, and use of, SBIRT services for adult enrollees as measured by count of certified practitioners in the region and count of reimbursable claims submissions and analyzed by rate of change from 2019 to 2020?

Will an increase in SBIRT services, as known by an increase in the number of certified SBIRT providers in the North Central region and an increase in reporting of SBIRT services in the North Central region, decrease the total count of visits in the ED for substance use disorder, and therefore increase HEDIS-like performance measure scores for Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) and Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) in the North Central Region?</td></tr>
<tr><td colspan="3">Score: Partially Met
Confidence: Confidence in reported MCO PIP results
Statistical Significance Indicating Improvement: No Statistically Significant Change
• Although not statistically significant, there was an increase in the number of providers trained and a small improvement in one of the HEDIS measures for one county.</td></tr>
<tr><th>PIP Summary</th><th>Strengths</th><th>Weaknesses</th></tr>
<tr><td>• Element: Access, Quality
• History: This PIP was initiated in CY2019; it was in its second year in CY2020.
• Intervention: Provider-focused
Train new providers on how to use and bill for SBIRT and educate and support providers who are already trained.</td><td>• Well-planned with clear problem, barriers and interventions.
• Interventions were mostly carried out in spite of the difficulties of 2020.
• Five new providers were trained in SBIRT, although those providers had not yet submitted SBIRT claims by the end of the PIP.</td><td>• Addresses ethnicity and language, but not substance use as culture.
• Good description of barriers and interventions but could use more detail on “educational interventions,” i.e., what specific materials were used.</td></tr>
<tr><td colspan="3">PIP Type: Clinical - Washington State Institute for Public Policy (AH-IMC/BHSO) – Child
PIP Name: Using the Alcohol Literacy Challenge in Washington State School-Based Settings to Reduce Youth Drinking Rates Through Changed Alcohol Effect Beliefs
Aim/Study Question: Will implementation of the Alcohol Literacy Challenge in school-based or community settings show a 20%-30% increase in attendees’ understanding, and beliefs of alcohol effects as measured by the pre- and post-Alcohol Literacy Challenge questionnaire?

Will implementation of the Alcohol Literacy Challenge in school-based or community settings show a 20%-30% positive change in attendees’ beliefs and understanding of the effects of media and alcohol as measured by the pre- and post-Media Ready survey questions 7, 9, 13, 15, 17, and 19?</td></tr>
</table>

Amerigroup Washington

Score: Partially Met
Confidence: Confidence in reported MCO PIP results
Statistical Significance Indicating Improvement: Statistically Significant Change

- The MCO saw statistically significant improvement in the two study questions.

PIP Summary	Strengths	Weaknesses
• **Element:** Quality • **History**: This PIP was initiated in CY2019; it was in its second year in CY2020. • **Intervention**: **Member-focused** Train trainers and have them give the ALC curriculum in schools or community settings. The intervention was altered due to being unable to access schools due to the COVID-19 pandemic and resulting restrictions.	• Community was engaged regarding alcohol use. • MCO had a good plan to implement the program with fidelity. • MCO is to be commended for its persistence and flexibility in still partly implementing the project, by changing the people it was planning to work with, and by switching the training to a virtual format.	• PIP was not fully implemented as intended, however that is due to factors largely out of control of the MCO. • While the interventions were linguistically appropriate, no discussion of relevant cultures (i.e., within geographic areas, schools or community centers) were included. • Strength of the study design would benefit with more information on assuring anonymity to the students and school staff. • No sustained improvement has been shown over multiple measurement periods.

PIP Type: Non-Clinical (AH-IMC/BHSO)
PIP Name: Improving WIC Participation
Aim/Study Question: Does outreach to IMC and BHSO WIC eligible members and outreach to pediatric and obstetric providers show a decrease in the percentage of unmatched Amerigroup WIC participation rate in 2020 as compared to 2019?

Score: Partially Met
Confidence: Reported MCO PIP results not credible – Per the MCO/BHSO, this PIP will not be continued
Statistical Significance Indicating Improvement: No Statistically Significant Change

PIP Summary	Strengths	Weaknesses
• **Element:** Access, Quality • **History**: This PIP was initiated in CY2019; it was in its second year in CY2020. • **Intervention**: **Member-focused** Interventions included: – Mailings to all identified WIC eligible, non-enrolled members – Sponsored baby shower – WIC social media posts	• Strong PIP design and interventions.	• Enrollees with special health care needs are not excluded, but input was not directly sought from this population. • Validity of the data provided by DOH used over the course of the PIP strongly affected the credibility of the results.

Amerigroup Washington		
– Public Charge Rule education for members – Text campaign to Spokane Regional Health District (SRHD) members		

Table 12. 2021 PIP Summary by MCP: CCW.

Coordinated Care of Washington		
PIP Type: Clinical - Washington State Institute for Public Policy (AH-IMC/BHSO) – Adult **PIP Name:** Improving Continuity of Cognitive Behavioral Therapy Services for Medicaid/BHSO members ages 19-64 **Aim/Study Question:** Will assisting Medicaid youth members to access outpatient Cognitive Behavioral Therapy (CBT) services following inpatient psychiatric treatment for depression and anxiety result in: • Increased completed behavioral health follow up visits for CBT? • Decreased length of time between discharge and follow up outpatient CBT appointment?		
Score: Partially Met **Confidence:** Confidence in reported MCO PIP results **Statistical Significance Indicating Improvement:** No Statistically Significant Change • The MCO saw increases in follow-up BH visits after discharge. The change was not statistically significant, and not valid due to the pandemic and due to the change in specifications for the FUH measures.		
PIP Summary	**Strengths**	**Weaknesses**
• **Element:** Access, Quality, Timeliness • **History**: This PIP was initiated in CY2020. • **Intervention**: **Member-focused** Partnering with specific hospitals to have staff link discharging members to follow-up care.	• Well-planned and evaluated; the write-up is thorough. • The MCO was flexible and persistent in trying to work within the disruptions caused by the pandemic.	• Study design was weak. • Not implemented completely according to plan due to factors outside the MCO's control. • While the interventions were linguistically appropriate, no discussion of cultures was addressed.
PIP Type: Clinical - Washington State Institute for Public Policy (AH-IMC/BHSO) – Child **PIP Name:** Improving Continuity of Cognitive Behavioral Therapy Services for Medicaid/BHSO members ages 12-18 **Aim/Study Question:** Will assisting Medicaid youth members to access outpatient Cognitive Behavioral Therapy (CBT) services following inpatient psychiatric treatment for depression and anxiety result in: • Increase in completed behavioral health follow up visits for CBT? • Decrease in average length of time between discharge and follow up outpatient CBT appointment?		
Score: Partially Met **Confidence:** Confidence in reported MCO PIP results **Statistical Significance Indicating Improvement:** No Statistically Significant Change		

<table>
<tr><th colspan="3">Coordinated Care of Washington</th></tr>
<tr><td colspan="3">• The MCO saw a positive increase in the indicators, but this cannot be considered valid for many reasons: small sample size, change in NCQA measure specifications and the problems posed by the global pandemic.</td></tr>
<tr><th>PIP Summary</th><th>Strengths</th><th>Weaknesses</th></tr>
<tr><td>• Element: Access, Quality, Timeliness
• History: This PIP was initiated in CY2020.
• Intervention: Member-focused
Partnering with clinics</td><td>• The PIP was well-planned and evaluated and the write-up is thorough.
• The MCO was flexible and persistent in trying to work within the disruptions caused by the pandemic.</td><td>• Not implemented completely according to plan due to factors outside the MCO’s control.
• Study appears to have been conducted with fidelity, although results are not valid.
• While the interventions were linguistically appropriate, no discussion of cultures was addressed.</td></tr>
<tr><td colspan="3">PIP Type: Non-Clinical (AH-IMC)
PIP Name: Improving the Timeliness of Postpartum Visits Following Live Births – Within 7-84 Days
Aim/Study Question: Will collaborating with clinics with low postpartum visit rates result in an increase in overall postpartum rates? Will collaborating with the internal maternity program, Start Smart for Baby (SSFB), result in an increase in postpartum rates? (Low-risk pregnancy assessment) Will providing postpartum education during the prenatal period result in an increase in postpartum visits?</td></tr>
<tr><td colspan="3">Score: Met
Confidence: High confidence in reported MCO PIP results
Statistical Significance Indicating Improvement: Statistically Significant Change
• The PPC Postpartum rate rose from 72.75 to 73.48 demonstrating a solid improvement.
• During the height of the pandemic overall member utilization decreased, however the ability to maintain and exceed the MY2019 PPC postpartum rate speaks to a concerted successful intervention.</td></tr>
<tr><th>PIP Summary</th><th>Strengths</th><th>Weaknesses</th></tr>
<tr><td>• Element: Access, Quality, Timeliness
• History: This PIP was initiated in CY 2020.
• Intervention: Member-focused
– Partnering clinics to schedule member’s postpartum visit before live birth, with reminder calls to member. Visit to be scheduled at last prenatal visit. Clinics to report prescheduled postpartum visit dates to CCW monthly.
– Clinics to educate members of state maternal program availability. CCW to provide information on types of services</td><td>• Good linkage of problem, indicators, interventions and results.
• Great interventions that produced results even in the setting of a global pandemic.</td><td>• Data analysis plan very vague.
• Special health needs populations were not excluded from the study; however, their input was not directly sought.</td></tr>
</table>

Coordinated Care of Washington		
from the statewide programs for new mothers. – Clinics to receive monitoring reports based on CCW outcome measure monitoring. – Members to report, by survey, of their awareness of the need for postpartum follow-up. – Team with internal maternal services (SSFB) to stress the importance of postpartum follow-up. – 1:1 reminder calls to focus population: IMC members (16-44) having recently given live birth and assessed as low-risk by SSFB) to make and keep their postpartum follow-up appointments.		
PIP Type: Non-Clinical (AH-IMC/BHSO) **PIP Name:** Improving Reporting Of EBP Codes for Integrated Managed Care and Behavioral Health Services Only Members Receiving Mental Health Evidence-Based Practices Services **Aim/Study Question:** Will educating mental health providers/facilities regarding Evidence Based Practice Codes (EBP) improve reporting of Mental Health EBP codes?		
Score: Partially Met **Confidence:** Confidence in reported MCO PIP results **Statistical Significance Indicating Improvement:** Statistically Significant Change • IMC/BHSO Adult increase in SERI/EBP coding - statistically significant at p<0.0346 • IMC Adult increase in SERI/EBP coding - statistically significant at p<0.039 • BHSO Adult increase in use of SERI/EBP coding - statistically significant at p<0.0078 • Sustained improvement cannot be determined based on the circumstances of the 2020 pandemic		
PIP Summary	**Strengths**	**Weaknesses**
• **Element:** Quality • **History:** This PIP was initiated in CY2020. • **Intervention: Provider-focused** – Provider "tip sheet" to educate providers/facilities regarding contractually mandated standards for coding EBP.	• Analysis of data and threats to validity were included. • Enrollees were clearly defined as members eligible for IMC/BHSO benefits, and with an inpatient admission or outpatient encounter for a behavioral health diagnosis.	• Interventions could be more robust.

Coordinated Care of Washington		
– Provider Relations to develop provider face-to-face mini-training(s) regarding the importance of appropriate EBP billing. – Monitoring behavioral health providers and facilities EBP coding trends to inform them of their ongoing compliance status. – Select and work with community partners to pilot interventions.		
PIP Type: Non-Clinical (AH-IFC) **PIP Name:** Improve Asthma Medication Adherence **Aim/Study Question:** 1) Will increasing 90-day prescription refills: a. Increase medication adherence (members refill prescriptions) b. Improve medication compliance (members take medication as prescribed) c. Decrease hospital visits (inpatient/emergency department) 2) Will involving Foster Care members and their families in outreach interventions improve member/family health literacy? 3) Will involving Foster Care members in structured asthma pilots result in a reduction of patient admission and emergency department visits?		
Score: Partially Met **Confidence:** Confidence in reported MCO PIP results **Statistical Significance Indicating Improvement:** Statistically Significant Change • Shows statistically significant improvement, but the MCO is correct in not attributing that to their interventions.		
PIP Summary	**Strengths**	**Weaknesses**
• **Element:** Access, Quality, Timeliness • **History:** This PIP was initiated in CY2020. • **Intervention: Member-focused** Contacting members to educate on the importance of 90-day prescriptions and medication adherence.	• Good plan and important topic. • MCO shows good insight into the reasons for the PIP not going as planned.	• Study question: first part is clear and measurable. Questions 2 and 3 are vague as "involve" is not defined, nor is health literacy. Some of the interventions are not clearly described. • Interventions were not culturally and linguistically appropriate • Study design was weak
PIP Type: Non-Clinical (Tribal IFC) **PIP Name:** Improving Administrative Coordination/Collaboration of Care Services for American Indian/Alaska Native Children and Youth in Foster Care Between Coordinated Care of Washington, Inc., Department of Children, Youth, and Families, and the Health Care Authority		

<table>
<tr><th colspan="3">Coordinated Care of Washington</th></tr>
<tr><td colspan="3">Aim/Study Question: Will collaborating with the Health Care Authority, Tribal Authorities, Department of Children, Youth, and Families, and Coordinated Care of Washington, Inc. as well analyzing CCW processes and systems, better serve American Indian/Alaska Native children and youth in Foster Care result in:
Approved written communication / standards protocol between CCW/Department of Children, Youth and Families (DCYF)/HCA and Tribal service staff and care managers?
Establishment of an approved written standard pathway for coordination of physical health/behavioral health services between CCW and Tribal care and service managers?
Approved written processes that increases the provision of Tribal/CCW services to American Indian/Alaska Native children and youth in Foster Care?
Increased and on-going sharing of Tribal services eligibility information?</td></tr>
<tr><td colspan="3">Score: Partially Met
Confidence: Enough time has not elapsed to assess meaningful change
Statistical Significance Indicating Improvement: No Statistically Significant Change</td></tr>
<tr><th>PIP Summary</th><th>Strengths</th><th>Weaknesses</th></tr>
<tr>
<td>Element: Access, Quality
History: This PIP was initiated in Spring CY2020
Intervention: Provider-focused
Interventions included:
Obtaining tribal affiliations
Establishing protocols
Providing education regarding standards for CMS, Indian Health Service (IHS), HCA, DOH, DCYF and NCQA
Displaying cultural humility
Showing respect for the cultural norms of all Tribes
Recognition and understanding of Tribal hierarchies
Listening. Listening some more. Listening before speaking
Transparent and open relationship building
Acknowledging historical trauma</td>
<td>Knowledge gain related to barriers and interventions:
Obtaining and recording self-reported Tribal affiliation is less important than originally believed.
Care in the use of words used in the provision of services between Tribes and CCW (or other MCOs) must be totally understood, e.g., care management and/or care coordination.
Each party, the Tribes and CCW (and other MCOs) must consider that each may adhere to different quality standards of standards of care, i.e., Government Performance and Results Act (GPRA), Public Health Management Corporation (PHMC), Meaningful Use (MU), HEDIS, NCQA.</td>
<td>This PIP is significantly qualitative in nature and as such is difficult to evaluate success. The indicators (other than number of recorded tribal affiliations) are not measurable.
Challenges brought on by the pandemic, as well as changes in understanding of the cultural and language differences between the MCO and the tribes affected the outcomes of this PIP.</td>
</tr>
</table>

Table 13. 2021 PIP Summary by MCP: CHPW.

Community Health Plan of Washington		
PIP Type: Clinical - Washington State Institute for Public Policy (AH-IMC/BHSO) – Adult **PIP Name:** Promoting Wellness and Recovery with Peer Specialists **Aim/Study Question:** Does participation in peer specialist led Wellness Recovery Action Plan (WRAP®) improve the sense of confidence and hope, as measured by RAS-DS, in members?		
Score: Partially Met **Confidence:** Confidence in reported MCO PIP results **Statistical Significance Indicating Improvement:** No Statistically Significant Change • The MCO was unable to implement the interventions or gather any data likely due to restrictions imposed by the global pandemic, however it is not possible to assess if it would have been successful without that barrier.		
PIP Summary	**Strengths**	**Weaknesses**
• **Element:** Access, Quality • **History**: This PIP was initiated in CY2019; It was in its second year in CY2020. • **Intervention**: **Member-focused** Referring members to WRAP program and increasing capacity of WRAP program.	• The PIP was well-planned but did not show results.	• Not implemented, no improvement seen. • MCO does not explain how it ensured reliability and validity. • Study design did not include the detail of exactly how the MCO would receive the scores from the local health agencies where they are administered.
PIP Type: Clinical - Washington State Institute for Public Policy (AH-IMC) – Child **PIP Name:** Implementation of the Collaborative Care Model in Pediatric Primary Care **Aim/Study Question:** Can the Collaborative Care Model be adapted and implemented in pediatric primary care to improve access to behavioral health services for children and adolescents?		
Score: Not Met **Confidence:** Reported MCO PIP results not credible **Statistical Significance Indicating Improvement:** No Statistically Significant Change		
PIP Summary	**Strengths**	**Weaknesses**
• **Element:** Access, Quality, Timeliness • **History:** This PIP was initiated in CY2020. • **Intervention: Provider-focused** Implement the Collaborative Care Model in certain clinics.	• MCO used multiple sources of information, including a family advocate.	• Study question is not clear and measurable. • The primary indicator is an “operationalized workflow”, which is not defined or measurable. The Collaborative Care Patient Registry is not explained. • Overall, the PIP was not designed to be successful.

Community Health Plan of Washington

PIP Type: Non-Clinical (AH-IMC)
PIP Name: Depression Screening and Follow-up in Preferred Languages
Aim/Study Question:

1. Will the engagement of translated, validated PHQ-9 depression screening tools with foreign language speaking enrollees increase the detection of depression in primary care?
2. Will providing a limited set of culturally appropriate follow-up recommendations for depression treatment in primary care increase the performance rate of appropriate follow-up for positive screens?

Score: Partially Met
Confidence: Low confidence in reported MCO PIP results
Statistical Significance Indicating Improvement: No Statistically Significant Change

- The COVID-19 pandemic greatly impacted the ability to fully implement this PIP and to make an accurate comparison between the data from 2019 and 2020.

PIP Summary	Strengths	Weaknesses
• **Element:** Access, Quality • **History:** This PIP was initiated in CY2019; it was in its second year in CY2020. • **Intervention: Member-focused** Interventions included: – Inclusion of HEDIS-like Depression Screening and Follow up for Adults and Adolescents (DSF) ¬measures into Pay for Performance (P4P) incentive program. – Use of the University of Washington's AIMS Center best practices for universal depression screening in primary care. – Translation of PHQ-9 depression screening tools into preferred languages. – Identification and Promotion of culturally appropriate depression follow-up care for clinic partners.	• Important topic with good interventions planned. • Ability to implement workflow changes despite pandemic challenges.	• MCO was unable to fully implement all interventions.

Table 14. 2021 PIP Summary by MCP: MHW.

Molina Healthcare of Washington		
PIP Type: Clinical - Washington State Institute for Public Policy (AH-IMC/BHSO) – Adult **PIP Name:** Increasing the number of members on Medication Assisted Treatment, who have a diagnosis of Opioid Use Disorder **Aim/Study Question:** By utilizing Molina's Medication Assisted Treatment (MAT) Model of Care, which is the use of medications in combination with counselling and behavioral therapies, can Molina Healthcare of Washington (MHW), increase the number of adult members 18 years of age and older, in the Integrated Managed Care (IMC) and Behavioral Health Services Only (BHSO) populations, who are enrolled in the Medication Assisted Treatment Program for the management of Opioid Use Disorder (OUD)?		
Score: Met **Confidence:** High confidence in reported MCO PIP results **Statistical Significance Indicating Improvement:** Statistically Significant Change • Statistical analysis supports a true improvement that was very likely due to the interventions: p-value<0.000.		
PIP Summary	**Strengths**	**Weaknesses**
• **Element:** Access, Quality • **History**: This PIP was initiated in CY2020. • **Intervention**: **Member-focused** Implement the MAT Model of Care in order to get more eligible members using MAT.	• PIP was well-planned and executed. • MCO/BHSO was able to work with restrictions posed by the pandemic. • Excellent analysis of results, including threats to internal and external validity.	• Concentrates on ethnicity/language. Suggest including "cultures" of drug using, if relevant. • The reviewer is not left with a clear understanding of what the interventions were—to make up a model of care—and these could have been explained more precisely.
PIP Type: Clinical - Washington State Institute for Public Policy (AH-IMC) – Child **PIP Name:** Increasing the Number of Pediatric Members Receiving Evidence Based Behavioral Health Services **Aim/Study Question:** Aims to increase the use of evidence-based practices - as evidenced by claims, tracking data, and working with providers		
Score: Partially Met **Confidence:** Confidence in reported MCO PIP results **Statistical Significance Indicating Improvement:** No Statistically Significant Change		
PIP Summary	**Strengths**	**Weaknesses**
• **Element:** Quality • **History**: This PIP was initiated in CY2020. • **Intervention: Provider-focused** Partnered with clinics to train and support providers in using evidence-based practices and coding and billing appropriately.	• MCO included a complete qualitative analysis of the project, in which problems were recognized including data integrity, continued lack of motivation among providers to code correctly, and the effects of the COVID-19 pandemic, which changed priorities for providers and members. • MCO has plans for continual improvement in this area.	• Overall write-up was not as clear as in other PIPs from this MCO. • Study question is not concisely stated.

Molina Healthcare of Washington		
PIP Type: Non-Clinical (AH-IMC) **PIP Name:** Improving Timely Access to Care **Aim/Study Question:** *No study question presented – This section is currently under review by HCA/TEAMonitor*		
Score: Not Met **Confidence:** Confidence in reported MCO PIP results **Statistical Significance Indicating Improvement:** No Statistically Significant Change • First year PIP. There are not 3 or more data points available for comparison.		
PIP Summary	**Strengths**	**Weaknesses**
• **Element:** Access, Quality, Timeliness • **History**: This PIP was initiated in CY2020. • **Intervention**: **Member-focused** Interventions included a one-time mailing on telehealth, CAHPS provider Tool Kit educational information, and restructuring Molina's mobile app.	• Data collection accuracy of CAHPS scores. • Resources provided in Spanish, as well as English. The interventions are not culturally specific; however, the information is presented in multiple mediums for greatest reach despite cultural differences in healthcare seeking behavior.	• No study question was presented. • The interventions are mostly informational and limited to one-time educational mailings. It is unlikely these interventions alone will be enough to move the measure. • Annual nature of CAHPS scores does not allow for effective monitoring of the PIP and course correction throughout the measurement year.
PIP Type: Non-Clinical (AH-IMC/BHSO) **PIP Name:** Improving Member Experience for BHSO Adult Members **Aim/Study Question:** *No Study question presented – This section is currently under review by HCA/TEAMonitor*		
Score: Not Met **Confidence:** Enough time has not elapsed to assess meaningful change **Statistical Significance Indicating Improvement:** No Statistically Significant Change		
PIP Summary	**Strengths**	**Weaknesses**
• **Element:** Quality • **History**: This PIP was initiated in CY 2020. • **Intervention**: **Provider-focused** Survey to create baseline	• Implementation of survey for BHSO clients. • Interventions were culturally and linguistically appropriate.	• No study question was presented. • PIP is meant as a baseline measurement and has no data to make a comparison of statistical significance. • Each year's PIP should be able to stand alone. The baseline measurement nature of this PIP does not allow for this.

Table 15. 2021 PIP Summary by MCP: UHC.

UnitedHealthcare Community Plan		
PIP Type: Clinical - Washington State Institute for Public Policy (AH-IMC) – Adult **PIP Name:** Increase Anti-Depressant Treatment Plan Compliance for IMC members diagnosed with depression (anti-depressant medication management, AMM) **Aim/Study Question:** Does educating Primary Care Practices and OB/GYN providers about appropriate depression diagnostic tools such as the PHQ-9 or GAD-7 increase the WA Health Plan's rate of members who are compliant with their antidepressant medication regime for 84 days and 180 days respectively?		
Score: Partially Met **Confidence:** Low confidence in reported MCO PIP results **Statistical Significance Indicating Improvement:** The MCO did not supply results of the statistical tests.		
PIP Summary	**Strengths**	**Weaknesses**
• **Element:** Access, Timeliness • **History**: This PIP was initiated in CY2019; it is in its second year in CY2020. • **Intervention**: **Provider-focused** The MCO set out to encourage providers to use standard screening tools for depression, to decrease the number of members who did not stay on their antidepressants (AMM acute and continuation phase).	• A year-over-year improvement in the measures.	• The interventions are never clearly defined, and throughout the rest of the PIP there is no report on whether and how the interventions were done. • There were serious threats to validity which the MCO did not sufficiently acknowledge, e.g., the COVID pandemic, and the fact that other interventions were ongoing such as the collaborative health equity workgroup to try to increase AMM measures. • While the interventions were linguistically appropriate, no discussion of cultures was addressed.
PIP Type: Clinical - Washington State Institute for Public Policy (AH-IMC/BHSO) – Adult **PIP Name:** BHSO Clinical - Jail Transition and Assertive Community Treatment (JTACT) **Aim/Study Question:** Will the contact from the UHC Jail Transition coordinator to the UHC incarcerated enrollee pre discharge from jail increase the engagement of the enrollees in the PIP and increase the enrollee's behavioral health treatment penetration and transition into the community?		
Score: Not Met **Confidence:** Reported MCO PIP results not credible **Statistical Significance Indicating Improvement:** No Statistically Significant Change • The small sample size nullifies any validity of the PIP.		
PIP Summary	**Strengths**	**Weaknesses**
• **Element:** Access, Timeliness • **History**: This PIP was initiated in CY2020.	• Supporting incarcerated members is a good practice that should be continued.	• Small sample size of four not sufficient for any analysis.

UnitedHealthcare Community Plan		
• **Intervention**: **Member-focused** Specially trained jail transition coordinators collaborated with the jail and met with enrollee before and after release to help enrollee get and continue with needed behavioral health treatment.	• Good description of interventions by care coordinators.	• While the interventions were linguistically appropriate, no discussion of cultures was addressed (such as incarceration).
PIP Type: Clinical - Washington State Institute for Public Policy (AH-IMC) – Child **PIP Name:** Increasing the ADD (ADHD Medication Adherence) Initiation Phase HEDIS Measure Rate **Aim/Study Question:** Will utilizing a Community Health Worker (CHW) and Health Promotion Specialist to assist with the review and monitoring of a one-page Important Information sheet which includes the date and time of the 30-day follow-up appointment improve the HEDIS ADD (ADHD) Initiation Phase measure?		
Score: Met **Confidence:** Low confidence in reported MCO PIP results **Statistical Significance Indicating Improvement:** The MCO claims statistically significant improvement but does not show the test or the *p*-value.		
PIP Summary	**Strengths**	**Weaknesses**
• **Element:** Access, Timeliness • **History**: This PIP was initiated in CY2019; It is in its second year in CY2020. • **Intervention**: **Member-focused** CHWs met with parents/guardians (virtually) to explain the importance of follow-up visits after being prescribed medications. They also assisted in making appointments if needed.	• This seems to be a reasonable way to increase the rates of follow-up appointments, as evidenced by parents/guardians stating they were not aware of the importance, as well as seeing that providers sometimes did not schedule the appointments.	• MCO did not describe how the CHWs were trained to do this intervention, or how inter-rater reliability was assured. • Results were presented without clear labeling as to the numerator and denominator. • Statistical significance was claimed without reporting the *p*-value. • The MCO only mentions interpreter services, not other aspects of culture.
PIP Type: Non-Clinical (AH-IMC) **PIP Name:** Non-Clinical PIP -- Increasing The Rate of Members Receiving Diabetic Education Services **Aim/Study Question:** Will the rate of diabetic education, by a certified diabetic educator or licensed clinicians, for members diagnosed with Type 1 and Type 2 diabetes, increase after we educate the King County Integrated Care Network behavioral health providers about the need for ongoing management of their clients adherence to their diabetic treatment plan as well as their behavioral needs? Also, does this consequently positively affect HEDIS® CDC diabetes in good control, or A1c < 8, rates?		
Score: Partially Met **Confidence:** Enough time has not elapsed to assess meaningful change **Statistical Significance Indicating Improvement:** No Statistically Significant Change • The PIP has been active in some form for four years, but this is the first year of focusing on the King County Integrated Care network, and therefore sustained improvement could not be seen in this group.		

UnitedHealthcare Community Plan		
PIP Summary	**Strengths**	**Weaknesses**
• **Element:** Access, Quality • **History**: This PIP was initiated in CY2017; it is in its fourth year in CY2020. • **Intervention**: **Member-focused** Direct outreach to high-risk members, education and care gap reports supplied to KCICN BH providers	• Intervention planned may have been sufficient to improve the desired measures.	• Unable to assess true change as no baseline is available for the selected population. • Provider selection within KCICN does not address the cultural appropriateness of the interventions undertaken by the MCO.
PIP Type: Non-Clinical (AH-IMC/BHSO) **PIP Name:** BHSO Coordination of Care Between Behavioral Health and Referring Providers (BHSO non-clinical) **Aim/Study Question:** Will providing coordination of care templates and forms, to our behavioral health practitioners during the behavioral health network performance improvement site visits and on the network website positively impact behavioral health practitioners' coordination of care practices with the referring provider?		
Score: Partially Met **Confidence:** Confidence in reported MCO PIP results **Statistical Significance Indicating Improvement:** No Statistically Significant Change		
PIP Summary	**Strengths**	**Weaknesses**
• **Element:** Access, Quality • **History**: This PIP was initiated in CY2019; it is in its second year in CY2020. • **Intervention**: **Provider-focused** MCO staff did site visits with behavioral health providers to assess coordination of care practices and educate on how to improve.	• Good topic for the BHSO population.	• Unclear numerical and graphic presentation of results. • The MCO did not address threats to internal and external validity. • No improvement seen.

Summary of Previous Year (2020) MCP PIP CAPs

The responses submitted by the MCPs to the 2020 CAPs were reviewed and accepted with the following responses by HCA:

- **AMG: Met** – The MCP shows improvement in all PIPs this year, although unfortunately the pandemic prevented full implementation as planned and influenced performance measure results, most notably in the well-child PIP. The MCP initiated multiple technical assistance sessions with the HCA, and it is apparent that the information was helpful.
- **CCW and MHW**: **Met** – Corrective action is completed.
- **CHPW: Met** – Corrective action is completed. The MCP fulfilled the requirement to attend a one-hour technical assistance meeting and demonstrated planned changes to their program.
- **UHC: Met** – Corrective action is completed. There is a slight improvement in overall PIP scores this year.

Summary of 2021 MCP PIP Scores and CAPs

MCPs, overall, achieved Partially Met scores during RY2021, but there were still several PIPs that scored Not Met. For the most part, the challenges of the 2020 COVID pandemic affected the implementation and improvement of the PIPs during the RY2021 period; thus, the MCPs were not required to submit CAPs for several PIPs scored as Partially Met.

Below is the summary of the scores and CAPs the MCPs received:

- **Collaborative: AMG, CCW, CHPW, MHW and UHC** – *PIPS: 1 Partially Met*
    - The MCPs will not be required to provide a corrective action plan for the partially met PIP.
- **AMG** – *PIPS: 3 Partially Met*
    - 2020 PIPs did not show improvement due to impact of the COVID-19 pandemic and other data issues. The MCP will not be required to provide a corrective action plan for the partially met PIPs.
- **CCW** – *PIPs: 1 met; 5 Partially Met (2 of 5 were not required to submit a CAP)*
    - By September 20, 2021, the MCP must submit a narrative and any supporting documents describing the actions they will take to address the findings related to:
        - Interventions and the lack of documentation of threats to internal and external validity.
        - The evaluation of each PIP (not exempted from required corrective action) that is Partially Met to determine what actions can be taken to improve the currently active PIPs. The evaluation should address a summary of the status of currently active PIPs to determine if any additional efforts would improve the metrics. Describe how the deficiencies in this year's PIP report and feedback from HCA will be used to make constructive changes in the PIPs.
- **CHPW** – PIPs: *1 Not Met; 2 Partially Met (Both were not required to submit a CAP)*
    - By September 20, 2021, the MCP must submit a narrative and any supporting documents describing the actions they will take to address the findings related to:
        - Study questions.

        - The evaluation of each PIP (not exempted from required corrective action) that is Partially or Not Met to determine what actions can be taken to improve the currently active PIPs. The evaluation should address a summary of the status of currently active PIPs to determine if any additional efforts would improve the metrics. Describe how the deficiencies in this year's PIP report and feedback from HCA will be used to make constructive changes in the PIPs.
- **MHW** – PIPs: *1 met; 2 Partially Met (1 of 2 were not required to submit a CAP); 2 Not Met*
    - By September 20, 2021, the MCP must submit a narrative and any supporting documents describing the actions they will take to address the findings related to:
        - Lack of study questions.
        - The evaluation of each PIP (not exempted from required corrective action) that is Partially or Not Met to determine what actions can be taken to improve the currently active PIPs. The evaluation should address a summary of the status of currently active PIPs to determine if any additional efforts would improve the metrics. Describe how the deficiencies in this year's PIP report and feedback from HCA will be used to make constructive changes in the PIPs.
- **UHC** – PIPs: *1 met; 3 Partially Met (1 of 3 were not required to submit a CAP)*
    - By September 20, 2021, the MCP must submit a narrative and any supporting documents describing the actions they will take to address the findings related to:
        - Unclear numerical and graphic presentation of results.
        - Lack of documentation of threats to internal and external validity.
        - The evaluation of each PIP (not exempted from required corrective action) that is Partially Met or Not Met to determine what actions can be taken to improve the currently active PIPs. The evaluation should address a summary of the status of currently active PIPs to determine if any additional efforts would improve the metrics. Describe how the deficiencies in this year's PIP report and feedback from HCA will be used to make constructive changes in the PIPs.

Recommendations

As stated previously, the challenges of the 2020 COVID-19 pandemic affected the implementation and improvement of the PIPs during the RY2021 period which led to a majority of the PIPs being scored as Partially Met. Thus, the recommendations from the previous year remain, for the most part, the same.

To enhance the MCPs' ability to design a sound PIP, HCA should continue the following activities to engage and guide the MCPs in providing desired quality health outcomes for its enrollees.

The MCPs had PIPs with weaknesses in their study designs, including the inclusion of cultural and/or linguistic diversity and needs, details on data analysis, and input from populations with special health care needs. (Access and quality of care)

While acknowledging 2020 was an unprecedented year of the pandemic, the MCPs had PIPs with weaknesses in achieving sustained improvement through repeated measurements over comparable time periods. (Quality and timeliness of care)

- HCA should continue to provide ongoing training specifically focused on the overall study design by establishing a framework for sustainable improvement that stems from well-defined and

well-scoped study designs. This would include continuing to work with the MCPs' incorporation of the rapid-cycle process improvement process introduced by HCA in 2021.

    - All MCPs had issues with addressing threats to validity such as the 2020 pandemic.
    - One UHC PIP–Clinical WSIPP-Adult (AH-IMC)–did not include results of the statistical tests.
    - One AMG PIP–Clinical WSIPP-Child (AH-IMC/BHSO)–would benefit with inclusion of more information on how they assured anonymity to the students and school staff within the study design.

- As the 2020 COVID-19 pandemic has shown, it is important the MCPs to be flexible and persistent in trying to work within any disruptions that may be encountered. HCA should work closely with MCPs when unexpected disruptions occur to determine appropriate pivots of the interventions through evaluation of the study design and the analysis plan to ensure improved outcomes.

The MCPs had PIPs with weaknesses reflecting broad, unclear study questions resulting in generalized interventions being weakly or not linked to the study questions. It should be noted these PIPs are under further review by HCA/TEAMonitor via the Corrective Action Plan (CAP) process. (Quality of care)

- A concise study question will improve the MCP's ability to align the entire PIP study design. HCA should continue to provide technical assistance to the MCOs with a focus on defining, streamlining and simplifying study questions.
    - MHW submitted two Non-Clinical PIPs (AH-IMC and AH-IMC/BHSO) without study questions.
    - CHPW submitted a PIP–Clinical WSSIP-Child (AH-IMC)– with both an unclear and unmeasurable study question.
    - CCW submitted a PIP–Non-Clinical (AH-IFC)–with two of the three study questions being vague.

In RY2021, TEAMonitor began implementation of *Protocol 1 Validation of Performance Improvement Projects* updated by CMS in 2019 in its validation of PIPs.

- HCA should continue to work with the MCPs to help familiarize them with the additional measurements of success within the protocol.

Performance Measure Validation

Objectives

Performance measures are used to monitor the performance of the individual MCOs at a point in time, to track performance over time, to compare performance among MCOs, and to inform the selection and evaluation of quality improvement activities. Validation is a required EQR activity. This section contains results of the following areas of performance measure validation and review that was completed in 2020.

Overview

Performance measure validation is a required EQR activity described at 42 CFR 438.358(b)(2). This section contains results of the following areas of performance measure validation and review related to the EQR in Washington in 2021:

- **Healthcare Effectiveness Data and Information Set (HEDIS) measures**:
    - 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. Comagine Health analyzed MCO performance on HEDIS measures for the calendar year (CY) 2020 (see more about HEDIS measures below).
- **Statewide Behavioral Health Measures**:
    - At HCA's instruction, Comagine Health also assessed statewide performance on the two non-HEDIS behavioral health measures that are calculated by the Department of Social and Health Services Research and Data Analysis Division (RDA): MH-B and SUD.
    - In addition, the state monitors and self-validates these two measures, both reflecting behavioral health care services delivered to Apple Health enrollees. TEAMonitor reviewed and validated performance rates for the two measures to determine impact and need for this program's population. Validated performance rates for this program are included in this section, starting on page 66.

Methodology

For a full description of Comagine Health's methodology, please see Appendix D.

HEDIS and RDA Measure Analysis and Validation

The performance of Apple Health MCOs in delivering accessible, timely, quality care and services to enrollees can be measured quantitatively through HEDIS, a widely used set of health care performance measures reported by health plans and developed by the National Committee for Quality Assurance (NCQA). HEDIS results can be used by the public to compare plan performance over six domains of care:

- Effectiveness of Care
- Access/Availability of Care
- Experience of Care
- Utilization and Risk Adjusted Utilization
- Health Plan Descriptive Information
- Measures Collected Using Electronic Clinical Data Systems

They also allow MCOs to determine where quality improvement efforts may be needed.[17] The HEDIS data are derived from provider administrative and clinical data.

With HCA's approval, Comagine Health focused on 41 measures for the majority of analysis and comparison rather than the full list of HEDIS measures reported by the MCOs. These 41 measures also included the two Washington behavioral health measures (also referred to as RDA measures) as they 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.

To be consistent with NCQA methodology, the 2020 calendar is referred to as measurement year 2020 reporting year (MY2020) in this report. Historical measure results are also reported by the measurement year; for example, results for calendar year 2019 are reported as MY2019. The results from these analyses can be found in the *2021 EQR Performance Measure Comparative Analysis Report*.

For a full description of the performance measure validation methodology, please see Appendix D.

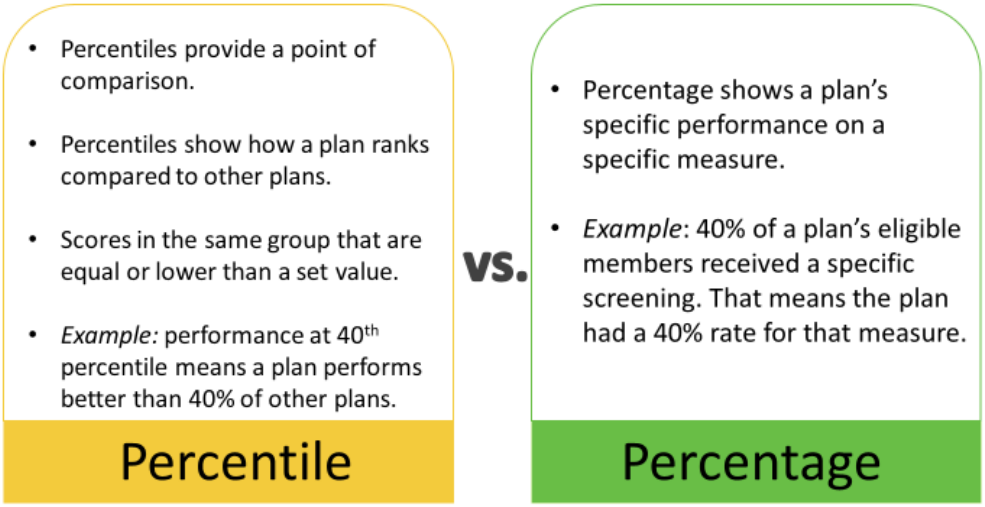
National Quintiles

The national benchmarks included in this report are displayed as quintiles, which divide performance by the 20th, 40th, 60th and 80th national percentiles. 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 40th percentile, we can conclude there is a lot of room for improvement given the number of similar plans that performed better than Plan A. However, if Plan A performs above the 80th 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 13 shows the differences between percentiles and percentages in the context of this report.

[17] NCQA. HEDIS and Performance Measurement. Available at: http://www.ncqa.org/HEDISQualityMeasurement/WhatisHEDIS.aspx.

Figure 13. Percentile vs. Percentage.



Summary of Performance Measure Results/Conclusions

Comagine Health used HEDIS data to perform comparisons among MCOs and against national benchmarks, as well as to identify variations in measure performance across regions, Apple Health programs and demographic groups.

The RDA measure analysis was limited due to a lack of national benchmarks and detailed data that would allow Comagine Health to stratify the data by region, Apple Health programs or demographic groups.

Access to Care Measures

HEDIS access to care measures relate to whether enrollees are able to access primary care providers at least annually, whether children are able to access appropriate well-child and well-care services, and whether pregnant women are able to access adequate prenatal and postpartum care. These measures reflect the accessibility and timeliness of care provided.

Note the Children and Adolescent's Access to Primary Care Practitioners measure was retired with MY2020 and is no longer included in this report. Similarly, the well-child visit measures were retired, and replaced with new measures that cover the entire age span for children from birth to 21 years of age. The specifications for the new well-child visit measures changed substantially, and do not allow comparisons to historical measure results so only MY2020 is reported. Statewide access measures for children and adolescents are below the 40th percentile when compared to national benchmarks.

Access for adults improved between MY2018 and MY2019; however, results declined between MY2019 and MY2020. The state remains below the national 40th percentile for adults ages 20 to 44, and below the national 20th percentile for adults ages 45 to 64.

Note that there were significant changes in the measure specifications for the maternal health measure between MY2018 and MY2019 that did not allow Comagine Health to report historical data for MY2017 or MY2018. Performance in this category remained below the national 40th percentile for the Timeliness

of Prenatal Care measure but was above the national 40th percentile for the Postpartum Care measure. The state also saw improvement for the Postpartum Care measure between MY2019 and MY2020.

Table 16 displays the statewide results of these measures for the last four reporting years. The national benchmarks included in this report are displayed as quintiles, which divide performance by the 20th, 40th, 60th and 80th national percentiles. Note that the small blue squares reflect quintiles and their corresponding national percentile ranges.

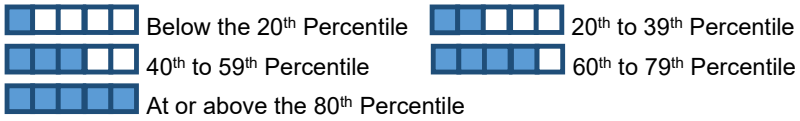


Table 16. Access to Care HEDIS Measures, MY2017–MY2020.

Measures	MY2017 State Rate	MY2018 State Rate	MY2019 State Rate	MY2020 State Rate	MY2020 National Quintile*
Adults' Access to Preventive/Ambulatory Health Services					
20–44 years (AAP)	72.6	73.1	74.1	70.9	
45–64 years (AAP)	80.6	80.2	80.5	77.2	
Well-Child Visits**					
0-15 months (W30)	NR	NR	NR	53.3	
16-30 months (W30)	NR	NR	NR	68.3	
3–11 years (WCV)	NR	NR	NR	45.6	
12–17 years (WCV)	NR	NR	NR	33.4	
18-21 years (WCV)	NR	NR	NR	16.8	
Maternal Health (PPC)					
Timeliness of Prenatal Care (PPC)***	NR	NR	87.2	82.7	
Postpartum Care (PPC)***	NR	NR	73.6	76.7	

NR indicates not reported.

**Apple Health performance as compared to Medicaid plans nationwide, in which the lowest quintile indicates performance in the lowest 20% of results and the highest quintile indicates performance in the top 20% of results.*

*** New measures for MY2020.*

**** Due to significant changes in the measure specifications for MY2019, historical data is not displayed for this measure.*

Preventive Care

Preventive care measures relate to whether enrollees receive adequate preventive care needed to prevent chronic conditions or other acute health problems. These measures reflect access and quality.

Two children's immunization rates were reported: Combination 2 and Combination 10. There was a decline in performance on these measures between MY2019 and MY2020. There was also a decline in performance for the Breast Cancer Screening measure between MY2018 and MY2019, and from MY2019 to MY2020.

As shown in Table 17, the state performed below the national 40th percentile for several of the measures. The exceptions were for the Children's Combination 10 and Adolescents' Combination 2 immunization measures which were above the 60th percentile, and the Cervical Cancer Screening measure which was above the national 40th percentile. It is also worth noting the Lead Screening in Children measure is below the 20th percentile.

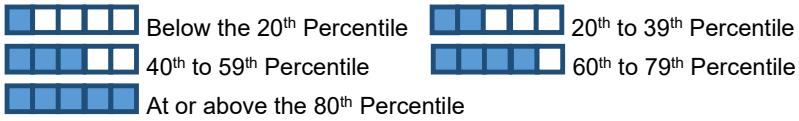


Table 17. Preventive Care HEDIS Measures, MY2017–MY2020 RY.

Measure	MY2017 State Rate	MY2018 State Rate	MY2019 State Rate	MY2020 State Rate	MY2020 National Quintile*
Weight Assessment and Counseling					
Children's BMI Percentile (WCC)	70.8	72.2	73.1	69.6	
Children's Nutrition Counseling (WCC)	62.9	61.8	62.8	59.7	
Children's Physical Activity Counseling (WCC)	57.8	57.5	58.6	56.3	
Immunizations					
Children's Combination 2 (CIS)	70.5	73.2	74.0	68.3	
Children's Combination 10 (CIS)	38.1	41.5	42.1	41.7	
Adolescents' Combination 1 (IMA)	75.9	76.0	77.4	75.0	
Adolescents' Combination 2 (IMA)	37.7	36.7	41.4	39.6	
Pediatric Screenings					
Lead Screening in Children (LSC)	24.2	31.7	29.8	33.7	
Women's Health Screenings					
Breast Cancer Screening (BCS)	55.3	54.5	52.0	48.0	
Cervical Cancer Screening (CCS)	56.9	57.7	60.5	58.6	
Chlamydia Screening (CHL)	55.1	54.2	53.6	49.9	

**Apple Health performance as compared to Medicaid plans nationwide, in which the lowest quintile indicates performance in the lowest 20% of results and the highest quintile indicates performance in the top 20% of results.*

Chronic Care Management

Chronic care management measures relate to whether enrollees with chronic conditions are able to receive adequate outpatient management services to prevent worsening of chronic conditions and more costly inpatient services. These measures reflect access and quality.

Statewide performance on many of chronic care management measures remained steady in MY2020, as shown in Table 18. The notable exception was the Asthma Medication Ratio measure, which saw significant improvement between MY2018 and MY2019, and between MY2019 and MY2020. The Diabetes Care Eye Exam measure, which saw a significant decline between MY2019 and MY2020.

When compared to national benchmarks, the state performed very well on many of the Comprehensive Diabetes Care (CDC) Measures, with several above the 60th percentile. The Diabetes Care Blood Pressure Control and Diabetes Care Poor HbA1c control measures were both above the national 80th percentile. The state was also above the national 60th percentile on the Controlling High Blood Pressure measure.

The Asthma Medication Ratio rate was below the 40th percentile of national performance.

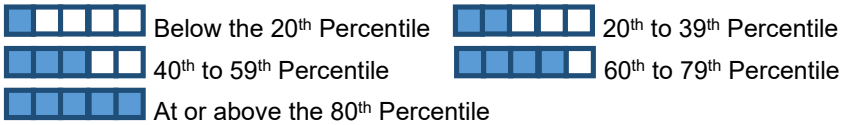


Table 18. Chronic Care Management HEDIS Measures, MY2017–MY2020.

Measure	MY2017 State Rate	MY2018 State Rate	MY2019 State Rate	MY2020 State Rate	MY2020 National Quintile*
Diabetes Care					
HbA1c Testing (CDC)	89.2	89.5	89.5	84.7	
Eye Exam (CDC)	59.7	58.5	59.1	51.6	
Blood Pressure Control (<140/90)*** (CDC)	NR	NR	NR	68.4	
HbA1c Control (<8.0%) (CDC)	49.9	50.3	51.9	51.9	
Poor HbA1c Control (>9.0%)** (CDC)	37.4	37.1	34.5	37.5	
Other Chronic Care Management					
Controlling High Blood Pressure (<140/90)*** (CBP)	NR	NR	NR	58.6	
Asthma Medication Ratio, Total (AMR)	53.2	52.7	55.0	62.1	

**Apple Health performance as compared to Medicaid plans nationwide, in which the lowest quintile indicates performance in the lowest 20% of results and the highest quintile indicates performance in the top 20% of results.*

***Note that a lower score is better for this measure.*

**** Due to significant changes in the measure specifications for MY2020, historical data is not displayed for this measure.*

Behavioral Health

Behavioral health measures relate to whether enrollees with mental health conditions or substance use disorders receive adequate outpatient management services to improve their condition. Positive behavioral health allows people to cope better with everyday stress, and engage in healthy eating, sleeping and exercise habits that can improve their overall health status. These measures reflect access and quality.

The state has performed well on several behavioral health measures as shown in Table 19. There have been statistically significant improvements in the performance of the Antidepressant Medication Management, Follow-Up After Hospitalization for Mental Illness, Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependencies, and Follow-Up After Emergency Department Visit for Mental Illness for the last two years (MY2018 to MY2019, and MY2019 to MY2020). The state also performs well when compared to the national benchmarks. There are several measures that are above the national 60th percentile, and the Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependencies (FUA), 30-Day Follow-Up, Total measure is above the national 80th percentile.

Note there are two behavioral health measures where the state performs below the national 40th percentile: Follow-Up Care for Children Prescribed ADHD Medication (Continuation Phase) and Follow-Up after Hospitalization for Mental Illness (FUH), 30-Day Follow-Up.

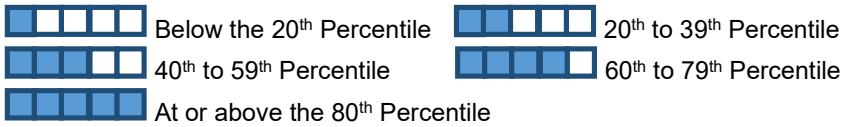


Table 19. Behavioral Health HEDIS Measures, MY2017–MY2020 RY.

Measure	MY2017 State Rate	MY2018 State Rate	MY2019 State Rate	MY2020 State Rate	MY2020 National Quintile*
Antidepressant Medication Management (AMM), Acute Phase	51.6	50.9	53.5	58.5	
Antidepressant Medication Management (AMM), Continuation Phase	35.9	36.0	38.4	42.9	
Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation Phase	42.4	42.8	43.9	45.2	
Follow-Up Care for Children Prescribed ADHD Medication (Continuation Phase) (ADD)	49.1	50.8	53.6	52.4	
Follow-Up after Hospitalization for Mental Illness (FUH), 7-Day Follow-Up, Total	34.9	35.1	32.0	40.2	

Measure	MY2017 State Rate	MY2018 State Rate	MY2019 State Rate	MY2020 State Rate	MY2020 National Quintile*
Follow-Up after Hospitalization for Mental Illness (FUH), 30-Day Follow-Up, Total	51.0	52.1	48.3	57.2	
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependencies (FUA), 7-Day Follow-Up, Total	7.4	8.6	16.6	18.8	
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependencies (FUA), 30-Day Follow-Up, Total	12.7	15.0	26.1	28.7	
Follow-Up After Emergency Department Visit for Mental Illness (FUM), 7-Day Follow-Up, Total	14.7	19.6	37.5	45.1	
Follow-Up After Emergency Department Visit for Mental Illness (FUM), 30-Day Follow-Up, Total	26.1	31.9	51.0	57.8	

**Apple Health performance as compared to Medicaid plans nationwide, in which the lowest quintile indicates performance in the lowest 20% of results and the highest quintile indicates performance in the top 20% of results.*

Behavioral Health RDA Measures

In 2020, HCA requested that Comagine Health include the state behavioral health measures as part of the VBP measure recommendation process. Developed by RDA, these behavioral health measures (MH-B and SUD) were initially designed to capture how enrollees were being served across multiple systems. These measures have been utilized for many years to monitor access to care and utilization of services. Since financial integration has been fully implemented, it is important for HCA and the MCOs to continue to monitor these measures to ensure access and service goals are being met. Therefore, these behavioral health measures have been included as either a shared measure or plan-specific measure.

Table 20 shows the results of these two measures from MY2017 through MY2020. There have been statistically significant increases in the SUD Treatment Penetration measure for the last two years. There was a statistically significant decline in the Mental Health Treatment Penetration measure between MY2019 and MY2020.

Table 20. Washington State Behavioral Health (RDA) Measures, MY2017–MY2020.

Measures	MY2017 State Rate	MY2018 State Rate	MY2019 State Rate	MY2020 State Rate
Mental Health Treatment Penetration, 6-64 Years	54.8	57.3	57.4	53.9

Measures	MY2017 State Rate	MY2018 State Rate	MY2019 State Rate	MY2020 State Rate
SUD Treatment Penetration, 12-64 Years	30.8	34.1	36.6	38.4

These measures are also covered in the following section, pages 73–76, as part of the state's self-validation of these measures for BHSO, a PIHP-contracted services program.

Summary of MCO Performance Measure Validation

Table 21 provides an overview of each MCO's strengths and weaknesses/opportunities for improvement in regard to performance measure validation.

- **Access to Care:** These measures reflect the accessibility and timeliness of care provided.
- **Behavioral Health:** These measures reflect the accessibility and timeliness of care provided.
- **Chronic Care Management:** These measures reflect access and quality.
- **Preventive Care:** These measures reflect access and quality.

Table 21. Summary of MCO Performance Measure Validation.

MCO	Strengths	Weaknesses/ Opportunities for Improvement
AMG	**Access to Care** • Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET), Total: Initiation of AOD Treatment: 13-17 Years is 5% above the state average. • Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET), Total: Initiation of AOD Treatment: Total was above the state average. **Behavioral Health** • Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependencies (FUA), 30-Day Follow-Up, 13-17 Years is 5% above the state average.	**Access to Care** • Prenatal and Postpartum Care (PPC) measures are both 4% below the state average. **Behavioral Health Medication Management** • Follow-Up After Emergency Department Visit for Mental Illness (FUM), Total is 10% below the state average for both the 7-Day and 30-Day Follow-Up components. • Follow-Up after Hospitalization for Mental Illness (FUH), Total is below the state average for both the 7-Day and 30-Day Follow-Up components. • Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), Total is below the state average. • Antidepressant Medication Management (AMM) is below the state average for both the Effective Acute Phase and Continuation Phase components. **Preventive Care**

MCO	Strengths	Weaknesses/ Opportunities for Improvement
		• Breast Cancer Screening (BCS) and Cervical Cancer Screenings (CCS) fell below the state average.
CCW	**Access to Care** • Child and Adolescent Well-Care Visit (WCV) are above the state average for both the 3-11 and 12-17 years age bands. • Well-Child Visits in the First 30 Months of Life (W30) is above the state average for both the 0-15 month and 16-30 month age bands. **Preventive Care** • Childhood Immunization Status (CIS) is above the state average for both Combo 2 and Combo 10. Combo 10 is especially high at 8% above the state average. • Immunizations for Adolescents (IMA), Combo 2 is above the state average. **Behavioral Health** • Use of First-Line Psychosocial Care for Children and Adolescents (APP), Total measure is 7% above the state average.	**Access to Care** • Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care measure is well below the state average. • Prenatal and Postpartum Care (PPC), Postpartum Care measure is well below the state average. **Behavioral Health** • Follow-Up after Hospitalization for Mental Illness (FUH), Total is below the state average for both the 7-Day and 30-Day Follow-Up components. The 30-Day Follow-Up component is especially low at 7% below the state average. • Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependencies (FUA), Total is below the state average for both the 7-Day and 30-Day Follow-Up components. • Follow-Up After Emergency Department Visit for Mental Illness (FUM), Total is below the state average for both the 7-Day and 30-Day Follow-Up components. **Chronic Care Management** • Comprehensive Diabetes Care (CDC), Poor HbA1c Control is 7% below the state average • Similar to the Poor HbA1c Control measure, Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0% is 6% below the state average.
CHPW	**Access to Care** • Prenatal and Postpartum Care (PPC) is above the state average for both the Timeliness of Prenatal Care and Postpartum Care components. • Well-Child Visits in the First 30 Months of Life (W30), 0-15 Months is 9% above the state average.	**Behavioral Health** • Follow-Up Care for Children Prescribed ADHD Medication (ADD) is above the state average for both the Initiation and Continuation Components. The Initiation component is especially low at 7% below the state average. • Pharmacotherapy for Opioid Use Disorder (POD) is below the state average.

MCO	Strengths	Weaknesses/ Opportunities for Improvement
	Behavioral Health • Follow-Up after Hospitalization for Mental Illness (FUH), Total is above the state average for both the 7-Day and 30-Day Follow-Up components. The 30-Day Follow-Up component is especially high at 8% above the state average. • Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependencies (FUA), Total is above the state average for both the 7-Day and 30-Day Follow-Up components. • Follow-Up After Emergency Department Visit for Mental Illness (FUM), Total is above the state average for both the 7-Day and 30-Day Follow-Up components. **Chronic Care Management** • Controlling High Blood Pressure (CBP) is above the state average. **Preventive Care** • Lead Screening in Children (LSC) measure is 8% above the state average. • Childhood Immunization Status (CIS), Combo 2 and Combo 10 are above the state average. • Immunization for Adolescents (IMA), Combo 2 is above the state average.	
MHW	**Behavioral Health** • Follow-Up after Hospitalization for Mental Illness (FUH), Total is above the state average for both the 7-Day and 30-Day Follow-Up components. The 7-Day Follow-Up component is 10% above the state average; the 30-Day Follow-Up component is 13% above the state average. • Follow-Up After Emergency Department Visit for Mental Illness (FUM), Total for both the 7-Day and 30-Day Follow-Up	**Chronic Care Management** • Controlling High Blood Pressure (CBP) is 4% below the state average. **Preventive Care** • Childhood Immunization Status (CIS), Combo 2 measure is 8% below the state average. • Childhood Immunization Status (CIS), Combo 10 measure is 7% below the state average.

MCO	Strengths	Weaknesses/ Opportunities for Improvement
	components. Both components are 9% above the state average. • Use of First-Line Psychosocial Care for Children and Adolescents (APP), Total measure is 7% above the state average. **Preventive Care** • Cervical Cancer Screening (CCS) measure is 11% above the state average.	
UHC	**Access to Care** • Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care measure is above the state average. **Chronic Care Management** • Comprehensive Diabetes Care (CDC), Poor HbA1c Control is especially strong at 8% above the state average. • Similar to the Poor HbA1c Control measure, Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0% is also 8% above the state average. • Controlling High Blood Pressure (CBP) is above the state average.	**Access to Care** • Well-Child Visits in the First 30 Months of Life (W30), 0-15 Months is below the state average. **Behavioral Health** • Follow-Up after Hospitalization for Mental Illness (FUH), Total is below the state average for both the 7-Day and 30-Day components. The 30-Day component is especially low at 7% below the state average. • Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), Total is below the state average. • Mental Health Treatment Penetration (MH-B), 6-64 years is below the state average. **Preventive Care** • Lead Screening in Children (LSC) measure is below the state average. • Childhood Immunization Status (CIS), Combo 2 and Combo 10 are below the state average. • Immunization for Adolescents (IMA), Combo 2 is below the state average.

Performance Measure Validation Recommendations

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

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

Sustain Improvement in Clinically Meaningful Areas

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

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

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

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

Address Behavioral Health Declines

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

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

Focus on Preventive Care

Although there were statistically significant declines from MY2019 to MY2020 in multiple preventive care measures (CIS Combo 2 and Combo 10, CHL, AAP and BCS), Breast Cancer Screenings (BCS) have declined over the past two measurement years. All MCOs demonstrated a significant decrease in BCS this past measurement year. In addition, the urban population received statistically significant higher rates of breast cancer screenings over the rural population. All MCOs need to focus on this important preventive measure.

The COVID-19 pandemic continues to impact preventive care.

- It is recommended that the use of telehealth be maximized to the greatest degree possible for preventive (and acute) care needs.
- Outreach to individuals to ensure preventive care is obtained should be prioritized. Plans need to include strategies to support practitioners in catching up on preventive care that was delayed so declines do not continue.
- HCA should continue to focus on bidirectional integration to sustain the behavioral health integration work. Just as primary care screens for behavioral health needs, build in screening and coordination of preventive care should be built into behavioral health visits. (Certified Community Behavioral Health Clinic – CCBHC – model of care)[18]

Continue to Prioritize Health Equity

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

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

Additional areas of focus to address health equity needs include:

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

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

[18] 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).

HCA may consider incorporating equity-focused payment and contracting models in their VBP program as an approach to improving health equity. According to a report by the Institute for Medicaid Innovation, "The development of equity-focused VBP approaches to support care delivery transformation is an important lever that can help payers advance health equity and eliminate disparities in health care with their provider organizations and members."[19]

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

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

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

Behavioral Health Services Only (BHSO) Performance Measure Validation

Objectives

Performance measures are used to monitor the performance of the BHSO programs at a point in time, to track performance over time, to compare performance among BHSOs, and to inform the selection and evaluation of quality improvement activities. Validation is required per 42 CFR §438.330(c).

Overview

Enrollment in BHSO, a PIHP-contracted services program, is for Apple Health clients who are not eligible for medical managed care plans (such as those with Medicare as primary insurance). BHSO enrollment ensures that all who are eligible have access to behavioral health benefits. Through BHSO, clients get coverage for their specialty behavioral health care needs (e.g., behavioral health and SUD treatment). More information on the program is available on HCA's website.[20]

In 2020, the five MCO plans operated BHSO programs. For this program, the state monitors and self-validates the following two state-developed measures, both reflecting statewide care delivered to Apple Health BHSO enrollees:

- **Mental Health Service Penetration – Broad Definition (MH-B)** – measure of access to mental health services (among persons with an indication of need for mental health services).
- **Substance Use Disorder (SUD) Treatment Penetration** – measure of access to SUD treatment services (among persons with an indication of need for SUD treatment services).

These measures are also required VBP measures and are monitored for the Integrated Managed Care and Foster Care programs.

Performance measure validation is used to determine the accuracy of the reported performance measures and the extent to which performance measures follow state specifications and reporting requirements. Outlined below are the findings of HCA's validation of these two measures.

Technical Methods of Data Collection

HCA conducted the performance measure validation for these measures based on the CMS EQR Protocol 2, *"Validation of Performance Measures Reported by the MCO."*

Description of Data Obtained

All payers' integrated data is utilized, which includes a ProviderOne Medicaid Management Information System (MMIS) data repository and a Medicare data repository for persons dually eligible for Medicare and Medicaid. Annual review of BHSO-specific performance is done for these measures with interim monitoring on a quarterly basis, reviewing the performance of these measures for the entire Medicaid population. The RDA division produces and validates the quarterly and annual measures.

[20] Healthier Washington. Understanding Behavioral Health Services Only Enrollment: Fact Sheet. Available at: https://www.hca.wa.gov/assets/program/bhso-fact-sheet.pdf.

The measure production process includes the monitoring of multi-year trends in numerators, denominators and rates, which helps inform regular assessment of data completeness and data quality before information is released. However, the RDA team that produces this measure is not responsible for (or resourced for) validating the accuracy and completeness of the underlying service encounter and Medicaid enrollment data.

Data Aggregation and Analysis

HCA partners with DSHS' RDA Division to measure performance for the BHSO population. Within the 1915b waiver (November 2019), HCA has been approved to self-validate measures produced by RDA. No sampling is conducted, as all eligible enrollees are included in the measures. Data is collected via the administrative method only, using claims, encounters and enrollment data.

Summary of BHSO Performance Measure Validation Results

Table 22 shows the penetration rates for the MH-B and SUD measures in MY2020.

Table 22. Performance Measures: MH-B and SUD Penetration.

Performance Measure	MY2019 Rate	MY2020 Rate	MY2020 Numerator	MY2020 Denominator
Mental Health Service Penetration – Broad Definition (MH-B) Statewide (Ages 18+)	47%	46.5%	18,193	39,155
Substance Use Disorder Treatment Penetration (SUD) Statewide (Ages 18+)	19.2%	21.1%	2,154	10,217

HCA's tool, based on CMS EQR Protocol 2, "*Validation of Performance Measures,"* Worksheet 2.2, was used to determine if validation requirements were met.

Validation Key

- **Yes**: The RDA's measurement and reporting process was fully compliant with state specifications.
- **No**: The RDA's measurement and reporting process was not fully compliant with state specifications.
- **N/A**: The validation component was not applicable.

Table 23 shows results of the validation of the MH-B and SUD measures.

Table 23. Results for Review of RDA BHSO Performance Measures.

Component	Validation Element	Meets Validation Requirements MH-B	Meets Validation Requirements SUD
Documentation	Did appropriate and complete measurement plans and programming specifications exist, including data sources, programming logic, and computer source code?	Yes	Yes
	Were internally developed codes used?	Yes	Yes
Denominator	Were all the data sources used to calculate the denominator complete and accurate?	Yes	Yes
	Did the calculation of the performance measure adhere to the specifications for all components of the denominator?	Yes	Yes
Numerator	Were the data sources used to calculate the numerator complete and accurate?	Yes	Yes
	Did the calculation of the performance measure adhere to the specifications for all components of the numerator?	Yes	Yes
	If medical record abstraction was used, were the abstraction tools adequate?	NA	NA
	If the hybrid method was used, was the integration of administrative and medical record data adequate?	NA	NA
	If the hybrid method or medical record review was used, did the results of the medical record review validation substantiate the reported numerator?	NA	NA
Sampling	Was the sample unbiased? Did the sample treat all measures independently? Did the sample size and replacement methodologies meet specifications?	NA	NA
Reporting	Were the state specifications for reporting performance measures followed?	Yes	Yes

Analyses and Conclusions

Based on the validation process completed for each performance measure, the measures meet audit specifications and are reportable by the state.

Recommendations for Improvement

It would be desirable to develop cross-validation activities in partnership with HCA's Analytics, Research and Measurement team. However, given the workload demands on state agency analytic teams

associated with the COVID-19 pandemic and supporting other agency operations, this may not be a feasible undertaking in the 2021 Measurement Year.

Cross-agency work has begun to review mental illness and substance use disorder diagnosis code sets that underly current measurement specs, and we anticipate future modifications such as addition of selected eating disorders (e.g., anorexia/bulimia) and personality disorders (e.g., borderline personality disorder) to the mental illness diagnosis code set. These changes are not expected to have a significant impact on measure results.

Progress Made from Prior Year's Recommendations

Last year RDA anticipated that this year's validation report would explore opportunities for measurement process improvement in greater detail, including the potential to leverage cross-validation opportunities presented by working in partnership with HCA's Analytics, Research and Measurement team. However, workload demands on state agency analytic teams associated with the COVID-19 pandemic and other agency analytic priorities rendered this to be an unrealistic goal over the past year. It remains to be seen whether this will be a feasible undertaking in the 2021 Measurement Year.

Value-Based Purchasing (VBP) Performance Measure Recommendation and Evaluation

Objectives

As the EQRO for the State of Washington, Comagine Health is contracted to assess both Washington Apple Health Integrated Managed Care (AH-IMC) and Apple Health Integrated Foster Care (IFC) MCO performance on measures reported by each plan and to recommend a set of priority measures that meets the bill's specific criteria and best reflects the state's quality and value priorities—balancing cost and utilization—while ensuring quality care to enrollees. This recommendation process supports HCA's determination of the statewide VBP performance measure set. HCA uses the VBP performance measure evaluation as part of the evaluation of effectiveness for the Washington State Medicaid Quality Strategy.

In addition, Comagine Health is contracted to evaluate both AH-IMC and AH-IFC MCO performance on the VBP measures specific to each contract. Comagine Health identifies where plans have met the criteria for the return of withhold dollars, either by demonstrating year-over-year improvement in measure performance or by exceeding the contracted benchmarks for each measure.

Overview

In 2019, the Washington Legislature passed the Washington State Engrossed Substitute House Bill (ESHB) 1109 requiring Washington HCA's contracted external quality review organization (EQRO) to annually analyze the performance of Apple Health managed care organizations (MCOs) providing services to Medicaid enrollees.[21]

In October 2021, Comagine Health delivered the 2021 EQR VBP Evaluation Spreadsheet to HCA that included detail by contract and a separate 2021 Value-Based Payment Report Card that presented the overall results of its evaluation. Comagine Health evaluated the VBP performance measures selected for the five AH-IMC contracted plans: AMG, CHPW, CCW, MHW and UHC. In addition, Comagine Health evaluated the performance for the IFC contract that is currently held by CCW.

Methodology

Technical Methods for Data Collection

Measure Selection

Apple Health MCOs are required to report results for certain HEDIS® measures reflecting the levels of quality, timeliness and accessibility of health care services furnished to the state's Medicaid enrollees. Many of these selected measures are also part of the Washington Statewide Common Measure Set on Health Care Quality and Cost, a set of measures that enables a common way of tracking important elements of health and health care performance intended to inform public and private health care purchasing.

In addition, the Department of Social and Health Services – Research and Data Analysis (RDA) tracks several Washington State Behavioral Health measures for the Apple Health population that are reported by MCO.

[21] State of Washington. 66th Legislature. Engrossed Substitute House Bill 1109. Chapter 14, Laws of 2019. Available at https://legiscan.com/WA/text/HB1109/id/2028380/Washington-2019-HB1109-Chaptered.pdf.

In response to ESHB 1109's specific criteria, HCA selected seven recommended measures to be included in the MCO contracts for the 2020 performance year as VBP measures in fall 2019. These measures best reflect the state's quality and value priorities—balancing cost and utilization—while ensuring quality care to enrollees. The measures also are substantive (i.e., tied to a strong evidence base and, where possible, focused on prevention) as well as clinically meaningful (i.e., the available data meaningfully approximates clinical care). More specifically, the measures were selected by applying the criteria included in ESHB 1109, Section 211 (50). There are four shared measures reported by all plans[22]:

- At least one shared measure must be weighted toward having the potential to impact managed care costs
- At least one shared measure must be weighted toward population health management

Three additional quality focus performance measures were selected to be specific to each MCO. The MCO specific measures must[23]:

- Be chosen from the Washington Statewide Common Measure Set
- Reflect specific measures where an MCO has poor performance
- Be substantive and clinically meaningful in promoting health status

In addition to the VBP performance measures selected for the five IMC contracts, HCA also selected seven VBP performance measures for the IFC contract. These measures were also evaluated for this deliverable.

For more detail on the measure selection process, please refer to the *2019 EQRO VBP Measures Analysis Report*.

HEDIS Overview

HEDIS is one of health care's most widely used performance improvement tools among health care plans. The HEDIS data are derived from provider administrative and clinical data. 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.[24]

In June 2021, Apple Health plans reported 55 measures across five domains of care. Submitted measure rates reflect performance for calendar year 2020.

[22] *Note: ESHB 1109, Section 211 (50)(i), refers to "four common measures across each managed care organization." For the purpose of this analysis, we are referring to these four measures as* ***shared*** *rather than* ***common*** *to avoid confusion with the Washington Statewide Common Measure Set.*

[23] Engrossed Substitute House Bill (ESHB) 1109, Section 211 (50), State of Washington, 66th Legislature, 2019 Regular Season. Available at: http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/House%20Passed%20Legislature/1109-S.PL.pdf.

[24] Tang PC, et al. Comparison of Methodologies for Calculating Quality Measures Based on Administrative Data versus Clinical Data from an Electronic Health Record System: Implications for Performance Measures. 2007. *JAMIA* 14(1):10-15.

Washington State Behavioral Health Measure Overview

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

- **Mental Health Service Penetration** – **Broad Definition (MH-B)** – measure of access to mental health services (among persons with an indication of need for mental health services).
- **Substance Use Disorder (SUD) Treatment Penetration** – measure of access to SUD treatment services (among persons with an indication of need for SUD treatment services).

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 DSHS RDA to measure performance. Data is collected via the administrative method, using claims, encounters and enrollment data and assessed on a quarterly basis.

Measure Weighting and Replacement

In addition to selecting the measures, HCA has included measure weighting in the contractual VBP methodology. There are various reasons for the weighting.

For the IMC contract, there are two share measures that include multiple components or submeasures. The Antidepressant Medication Management (AMM) measure reports both an Effective Acute Phase Treatment and an Effective Continuation Phase Treatment component. The Prenatal and Postpartum Care (PPC) measure reports both the Timeliness of Prenatal Care and Postpartum Care component. Each of these components was given a half weight.

NCQA also made changes to the HEDIS measure set after the IMC and IFC contracts were in place that resulted in data not being available to complete the VBP evaluation. In these cases, HCA amended the contracts to give impacted measures a zero weight. Three measures were given a zero weight:

- NCQA replaced the Well-Child Visits in the 3rd, 4th, 5th and 6th Year of Life (W34) measure with the new Well-Child Visit (WCV) measure. The WCV measure includes several age bands, but does not include an age band for 3- to 6-year-olds. HCA amended the contracts to include the WCV measure for the 3- to 11-year-old age band but gave the measure a zero weight for the 2020 performance year since there was no equivalent measure for comparison in 2019.
- NCQA retired the Comprehensive Diabetes Care (CDC), Medical Attention for Nephropathy measure, so this data was not available for performance year 2020. This measure was selected as a plan-specific VBP measure for AMG. Because there was no performance year 2020 data, this measure was given a zero weight.
- NCQA retired the Children's Access to Primary Care Practitioners (CAP) measure, so this data was not available for performance year 2020. The age 7-11 component of this measure was selected as an IFC measure. Because there was no performance year 2020 data, this measure was given a zero weight.

NCQA also replaced the Adolescent Well-Care Visits (AWC) measure with the new WCV measure. The AWC measure included members ages 12-21; the new WCV measure includes the age bands 3-11, 12-17 and 18-21. HCA amended the IFC contract to allow for the comparison of the AWC results for performance year 2019 to the combined WCV results for the 12-17 and 18-21 age bands for performance year 2020.

It is important to note that changes to measure sets and specifications will be an ongoing consideration for administering the Apple Health VBP program. HCA will need to continue to monitor the impact of NCQA changes and make adjustments to the weighting and measures to ensure that reimbursement to the contracted plans is not negatively affected by changes to measures that are made during routine NCQA processes, but outside of the control of HCA or the plans themselves.

Description of Data Obtained

The VBP analysis used the measure results from the Interactive Data Submission System files (HEDIS measures reported by plans) and the RDA measures.

Data Aggregation and Analysis

Performance Baseline Year and Benchmarking

Under the budget proviso, MCOs can earn back their withheld dollars if they are able to achieve either of the following:

- Demonstrate a statistically significant improvement over their previous year's performance on the plan specific measure(s)
- Achieve performance in the top national quartile (75th percentile) for the plan-specific performance measures

Note that for the purposes of the IMC and IFC contracts and VBP, HCA has defined statistically significant improvement as an improvement over the prior year's performance.

For the HEDIS measures, the previous year's performance is defined as the measure results from RY2020 (MY2019). The performance evaluation year is the measure results from MY2020.

For the Washington State Performance Measures, the previous year's performance is the 2019 Q4 measure results that were reported in July 2020. The performance evaluation year are the 2020 Q4 measure results that were reported in July 2021.

The HEDIS national 75th percentile benchmark was obtained from the NCQA Quality Compass® report published in September 2020. There are no national benchmarks for the Washington State Performance Measures. Instead, HCA has established that the benchmarks for these measures would be the second-highest performing MCO from the previous performance period (i.e., performance year 2019).

Note that CCW is the single MCO that is contracted to manage the IFC population. The HEDIS measure results for the general CCW population were used for the evaluation of the IFC contract. The RDA measures are specific to the foster care population.

External Evaluation

HCA created an internal VBP performance tracking tool for budgeting and actuarial purposes which was shared with Comagine Health to facilitate the validation of performance periods and benchmarks used for the evaluation. This was an additional step included in Comagine Health's standard quality control processes.

Limitations

There were a few limitations that impacted the analysis as follows:

- COVID-19 impact: In March 2020, the State of Washington implemented a "*Stay Home, Stay Healthy*" order in response to the threat of the COVID-19 virus. This order included limiting health care facilities to emergency services for the months of March and April 2020 and delaying elective procedures and other non-urgent treatment until later in the year. This impacted the performance of many MY2020 HEDIS measures, particularly many of the preventive care and access measures. Other utilization may have decreased due to a lower incidence of flu and other respiratory illnesses due to the adherence to masking and social distancing.
- Rotated measures: In March 2020, the NCQA recognized that COVID-19 would likely impact plans' ability to collect medical record data due to travel bans, quarantines and efforts to minimize risk to staff.[25] Therefore, NCQA allowed Medicaid plans participating in HEDIS reporting the option of submitting 2019 rates for their hybrid measures in 2020, referred to by NCQA as "rotated measures." Hybrid measures (those eligible to be rotated in 2020) are calculated by combining administrative claims data with data obtained from medical records. There were two instances where rotated measures had the potential to affect the VBP evaluation:
    - The Prenatal and Postpartum Care (PPC) measure was selected as a shared measure for the VBP 2020 performance year. AMG reported a rotated measure for the MY2019 reporting period, which was the baseline year used for identifying if there was a year-over-year improvement in measure performance. The effect of this was that AMG's 2020 performance was compared to their performance for the MY2018 period.
    - UHC reported a rotated measure for the Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) measure. This was selected as a plan-specific VBP measure for all plans for the 2020 performance year. However, this measure was replaced by the new Well-Child Visits (WCV) measure in MY2020, so this measure was given a zero weight. The reporting of a rotated measure by UHC had no impact on their VBP evaluation.
- State behavioral health measures: There are no national benchmarks available for the Washington behavioral health measures.

Although NCQA publishes national benchmarks for Medicaid managed care plans, it should be noted that states do not submit data for every HEDIS measure. In the 2020 Quality Compass, the most recent set of benchmarks available, the number of states included in the national benchmarks varied from 4 to 20.

Summary of Conclusions

The following tables ("report cards") show how Washington Apple Health Plans performed in Performance Year 2020 which identifies where plans have met the criteria for the return of withhold dollars for the quality performance measure part of the value-based purchasing strategy. Criteria can be met either by demonstrating year-over-year improvement in measure performance or by exceeding the contracted benchmarks for each measure.

[25] NCQA. Coronavirus and NCQA. Available at: https://www.ncqa.org/covid/.

2021 Value-Based Payment (VBP) Quality Report Card

Washington Apple Health

This report card shows how Washington Apple Health Plans performed in Performance Year 2020 which identifies where plans have met the criteria for the return of withhold dollars for the quality performance measure part of the value-based purchasing strategy. Criteria can be met either by demonstrating year-over-year improvement in measure performance or by exceeding the contracted benchmarks for each measure.

Key: ✓ Criteria Met No **Criteria Not Met** NA **Not applicable/Not contracted**

Value-Based Payment Measure		Amerigroup Washington	Coordinated Care of Washington	Community Health Plan of Washington	Molina Healthcare of Washington	UnitedHealthcare Community Plan
Total Percent Achieved		60%	83%	83%	58%	75%
Washington Apple Health Integrated Managed Care (AH-IMC) Shared Measures - *Four shared measures reported by all MCOs*						
Antidepressant Medication Management (AMM)	Effective Acute Phase Treatment	No	✓	✓	✓	✓
	Effective Continuation Phase Treatment	No	✓	✓	✓	✓
Mental Health Treatment (Service) Penetration, Age 6-64, all MCO, excluding BHSO		No	No	✓	No	No
Prenatal and Postpartum Care (PPC)	Timeliness of Prenatal Care	✓	✓	✓	No	No
	Postpartum Care	✓	✓	✓	✓	✓
Asthma Medication Ratio (AMR), Total		✓	✓	✓	✓	✓
Washington Apple Health Integrated Managed Care (AH-IMC) Plan-Specific Measures - Three quality focus performance measures specific to each MCO						
Substance Use Disorder Treatment Penetration, Age 12-64, all MCO, excluding BHSO		✓	✓	✓	✓	✓
Well Child Visits (WCV), Age 3-11		Data not available				
Follow Up Care for Children Prescribed ADHD Medication (ADD), Initiation Phase		NA	✓	No	NA	NA
Comprehensive Diabetes Care (CDC), Poor HbA1c Control (>9%)		NA	NA	NA	No	✓
Comprehensive Diabetes Care (CDC), Medical Attention for Nephropathy		Data not available	NA	NA	NA	NA

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Washington State Health Care Authority

2021 Value-Based Payment (VBP) Quality Report Card - Integrated Foster Care

This report card shows how Coordinated Care of Washington, as the single MCO providing Apple Health Integrated Foster Care (AH-IFC) services, performed in Performance Year 2020 and identifies where the plan has met the criteria for the return of withhold dollars for the quality performance measure part of the value-based purchasing strategy. Criteria can be met either by demonstrating year-over-year improvement in measure performance or by exceeding the contracted benchmarks for each measure.

Key: ✓ **Criteria Met** No **Criteria Not Met** NA **Not applicable/Not contracted**

Apple Health Integrated Foster Care VBP Measure	Coordinated Care of Washington
Total Percent Achieved=66.7%	
Apple Health Integrated Foster Care (AH-IFC) Shared Measures -*Seven performance measures specific to the IFC contract.*	
Child and Adolescent Well-Care Visit (WCV), Age 12–17 and Age 18–21 (Evaluation comparison to AWC measure)	No
Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation Phase	✓
Mental Health Treatment (Service) Penetration, Age 6–26, IFC only	✓
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), Total	✓
Asthma Medication Ratio (AMR), Total	✓
Substance Use Disorder Treatment Penetration, Age 12-26, IFC Only	No
Children's Access to Primary Care Practitioners (CAP), Age 7–11	Data not available

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Objectives

The CAHPS survey is a tool used to assess consumers' experiences with their health plans. CAHPS surveys address such areas as the timeliness of getting care, how well doctors communicate, global ratings of health care, access to specialized services and coordination of care. The survey aims to measure how well MCOs are meeting their members' expectations and goals; determine which areas of service have the greatest effect on members' overall satisfaction; and identify areas of opportunity for improvement.

Overview

In 2021, HCA required the Apple Health MCOs to conduct the CAHPS 5.1H Child Medicaid with Chronic Conditions survey of their members enrolled in Apple Health, and CCW, the Apple Health Foster Care plan, to conduct the same survey of the Apple Health Foster Care program members. The MCOs contracted with NCQA-certified survey vendors to conduct these CAHPS surveys.

Technical Methods for Data Collection

Member responses to the standardized CAHPS surveys were collected via NCQA-approved protocol for survey administration. Responses to the survey questions measure patient experience and overall rating, achievement scores, composite measures (a combination of two or more related survey items), and single-item measures. The CAHPS surveys use a 0–10 rating for assessing overall experience with health plans, providers, specialists and health care.

The survey instrument administered in 2021 was the CAHPS 5.1H Child Medicaid with Chronic Conditions survey, a revised version of the CAHPS 5.0H Child Medicaid with Chronic Conditions survey utilized in prior years. The modified CAHPS survey includes minor changes to some of the instructions and survey items to reflect the different ways in which patients may be receiving care including in person visits or via telehealth.

There are no new questions on the 5.1H version, but existing questions have been modified so that respondents know they should include telehealth visits as an appointment type as they respond to the survey.

More information on data collection and detailed descriptions of the methodology including sampling frame and selection of cases for analysis are provided in the CAHPS reports referenced under each survey below.

Apple Health Integrated Managed Care – Child Medicaid with Chronic Conditions Survey

In 2021, the Apple Health MCOs conducted the CAHPS® 5.1H Child Medicaid with Chronic Conditions survey via individually contracted NCQA-certified survey vendors.

Description of Data Obtained

Survey respondents included members 18 years and older continuously enrolled in Apple Health for at least six months as of December 31, 2020, with no more than one enrollment gap of 45 days or less.

Data Aggregation and Analysis

Each MCO's survey data was provided to NCQA-certified survey vendor DataStat, who under a subcontract with Comagine Health, aggregated and assessed the survey response sets utilizing current CAHPS analytic routines for calculating composites and rating questions. DataStat produced a report that summarized survey responses and identified key strengths and weaknesses/opportunities for improvement, as well as recommendations based on survey questions most highly correlated to enrollees' satisfaction with their health plan. Included were priority matrices to help focus improvement activities by graphically displaying two kinds of information: the magnitude of the health plan's achievement scores and their correlation with overall plan satisfaction. For ratings questions, composites and the questions on which composites are based, achievement scores are plotted against their correlation with overall health plan satisfaction.

Summary of Findings/Conclusions

The following results present the Apple Health MCO average rating as compared to national benchmarks derived from the NCQA Quality Compass. The full summary of findings is available in the *2021 Apple Health CAHPS® 5.1H Child Medicaid with Chronic Conditions Report*. The report is designed to identify key opportunities for improving members' experiences. Member responses to survey questions are summarized as achievement scores. Achievement scores are computed and reported for all pertinent survey items. Responses indicating a positive experience are labeled as achievements, and an achievement score is computed equal to the proportion of responses qualifying as achievements. The lower the achievement score, the greater the need for the program to improve. In addition, composite scores are built from achievements for groups of survey items that make up broad domains of members' experience: getting needed care, getting care quickly, how well doctors communicate and customer service.

Table 24 reports 2017, 2019 and 2021 RY performance. Most of the 2021 RY CAHPS measures included in the table were below above the 20th percentile but below the 40th percentile for national performance. The exceptions were Rating of Plan and Customer Service, which were both below the 20th percentile.

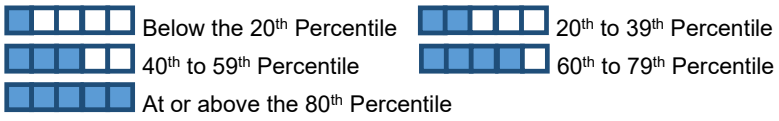


Table 24. Children's CAHPS Ratings Results, 2017, 2019 and 2021 RY.

Results	2017 Rating	2019 Rating	2021 Rating	2021 National Quintile*
Rating of Overall Health Care (Scored 8, 9 or 10 out of 10)	85.4	87.7	87.5	
Rating of Personal Doctor (Scored 8, 9 or 10 out of 10)	88.4	90.4	88.6	
Rating of Specialist Seen Most Often (Scored 8, 9 or 10 out of 10)	85.9	86.0	85.2	
Rating of Plan (Scored 8, 9 or 10 out of 10)	83.1	85.2	82.8	
Getting Needed Care (composite score)	81.5	82.6	82.8	
Getting Care Quickly (composite score)	86.7	86.8	84.1	
How Well Doctors Communicate (composite score)	93.9	93.7	93.0	
Customer Service (composite score)	87.9	87.8	85.5	

**Apple Health performance as compared to Medicaid plans nationwide, in which the lowest quintile indicates performance in the lowest 20% of results and the highest quintile indicates performance in the top 20% of results.*

Key Strengths and Weaknesses/Opportunities for Improvement

The five questions most highly correlated with the Apple Health plans members' satisfaction with the health plan are presented as key strengths below. These are areas that appeared to matter most to members, and where the health plan was doing well.

Key Strengths

Questions Most Strongly Correlated with Member Satisfaction:

- Q28. Personal doctor usually or always listened carefully to you
- Q46. Customer service usually or always treated you with courtesy and respect
- Q51. Usually or always easy to get prescription medicines for child through health plan
- Q10. Usually or always easy to get the care, tests or treatment child needed

- Q35. Personal doctor usually or always seemed informed about care child got from other providers

Weaknesses/Opportunities for Improvement

The five questions with the lowest achievement scores are presented below as weaknesses/ opportunities for improvement. These are areas that appear to matter the most to members, but where the health plan is not doing as well and could focus quality improvement efforts.

Note that the global rating questions for personal doctors, specialists and overall health care have been excluded from this analysis. By their nature, global ratings tend to be more highly correlated with overall satisfaction with a health plan and are typically not specific enough to provide clear pathways to action for improvement.

Questions with Lowest Achievement Scores:

- Q15. Usually or always easy to get special medical equipment or devices for child
- Q21. Usually or always easy to get treatment or counseling for child
- Q18. Usually or always easy to get therapy for child
- Q19. Someone from doctor's office helped get therapy for child
- Q45. Customer service usually or always gave help you needed

Recommendations

While the CAHPS survey helps identify priorities, the MCOs should identify actionable areas for their own quality improvement activities, then conduct a root cause analysis to identify underlying causes and build quality improvement plans. MCOs may look at patient grievances to see what issues show up frequently. The two sources of information, CAHPS data and grievances, complement each other in attempts to understand the issues and get a complete picture.

MCOs should evaluate improvement methods and implement those most relevant to their improvement goals. MCOs should follow a process similar to the Plan-Do-Study-Act (PDSA) model to target low performing measures.

In addition, MCOs should be clear about providers' realm of control and what providers can realistically influence and improve upon. MCOs may use process mapping to improve understanding of the details of care processes to know exactly, step by step, what happens within that process, and what each entity (MCOs/providers) is responsible for and can impact.

By working collaboratively to understand these processes, the MCOs will be able to see where improvements can be made and how to make them. The five MCOs could collectively select a single process that providers are required to follow (i.e., authorizations) and work together to simplify and standardize that process across all MCOs so that there is no difference to providers and patients.

The following recommendations are offered to assist MCOs in focusing their efforts on the identified opportunities for improvement.

- MCOs should look at their current processes and workflow to identify target areas.

- MCOs may also want to convene focus groups with office staff, providers and/or patients (families) to gather information on the barriers or challenges to accessing specialized services.
- MCOs may focus their efforts on ensuring closed loop referrals are in place to ensure a child receives the recommended treatment. MCOs may monitor referral patterns to ensure availability of needed providers.
- MCOs should ensure that members and providers are aware of appropriate therapy/treatment opportunities.
- MCOs may work with providers to ensure they have the necessary information to provide appropriate referrals to patients (families) and ensure that providers and members have access to up to-date provider directories.
- Ensure providers and members have access to appropriate referrals options by including information in provider directories, using push notifications through provider and/or patient portals, sending mailers, providing ready links, etc.
- MCOs should improve the ability of their customer service representatives to provide members with necessary information or help when requested.
- Overall, having clear, step-by-step directions in provider and member benefits manuals, that are supported by knowledgeable customer service teams, may result in a positive impact on the five opportunities of improvement.
- Once new workflows and processes are identified and implemented, the MCOs should reassess whether these have resulted in improvements. This may include talking with and/or sending a short questionnaire to providers, patients and/or families asking if they are experiencing easier access to these services.

Please see the *2021 Apple Health CAHPS® 5.1H Child Medicaid with Chronic Conditions Report* for the full description of recommendations.

Apple Health Integrated Foster Care – Child Medicaid with Chronic Conditions Survey

In 2021, CCW, the Apple Health Foster Care plan, conducted the CAHPS 5.1H Child Medicaid with Chronic Conditions survey via an independently contracted NCQA-certified survey vendor.

Description of Data Obtained

Respondents included parents/caregivers of children 17 years and younger as of December 31, 2020, continuously enrolled in the in foster care and adoption support components of the Apple Health Foster Care program for at least five of the last six months of the measurement year. The survey included children enrolled as part of the general foster care population as well as children with chronic conditions.

Data Aggregation and Analysis

CCW's survey vendor assessed the data and produced a summary report, including comparison of the Apple Health Foster Care scores to Child Medicaid 2020 Quality Compass® rates. The SatisAction™ key driver statistical model was used to identify the key drivers of the rating of the health plan. This model is a powerful, proprietary statistical methodology used to identify the key drivers of the rating of the health plan and provide actionable direction for satisfaction improvement programs.

Summary of Findings/Conclusions

Table 25 shows the results for the Integrated Foster Care CAHPS survey in 2019 through 2021. Note there are no national benchmarks available for the foster care population. For the full report, please see *2021 Apple Health IFC CAHPS® Medicaid Child with CCC 5.1 Report, Coordinated Care – Foster Care (Centene WA)*. Produced by SPH Analytics, July 2021. This report includes a key driver summary, conducted to understand the impact different aspects of service and care have on members' overall satisfaction with their health plan, physicians and health care.

Table 25. Foster Care CAHPS Ratings Results, 2019-2021 RY.

Results	2019 Rating	2020 Rating	2021 Rating
Rating of Overall Health Care (Scored 8, 9 or 10 out of 10)	83.7	86.9	89.8
Rating of Personal Doctor (Scored 8, 9 or 10 out of 10)	90.2	92.3	92.3
Rating of Specialist Seen Most Often (Scored 8, 9 or 10 out of 10)	78.1	79.3	80.0
Rating of Plan (Scored 8, 9 or 10 out of 10)	72.6	79.3	77.6
Getting Needed Care (composite score)	83.6	85.1	85.1
Getting Care Quickly (composite score)	91.6	90.8	93.6

Results	2019 Rating	2020 Rating	2021 Rating
How Well Doctors Communicate (composite score)	94.6	97.9	97.5
Customer Service (composite score)	82.5	86.8	81.0

Key Strengths and Weaknesses/Opportunities for Improvement

There were no key measures that had significantly lower scores than last year. One question, "Q33. Doctor talked about how child is feeling, growing, and behaving," showed significant improvement over last year.

Key Strengths

The following measures are Key Drivers/Strengths of the plan:

- Q4: Got urgent care
- Q6: Got routine care
- Q48: Easy to fill out forms

Weaknesses/Opportunities for Improvement

The following measure are opportunities for improvement:

- Q10: Got care/tests/treatment
- Q28: Dr. listened carefully
- Q35: Dr. informed about care
- Q41: Got specialist appointment
- Q43: Specialist overall

Recommendations

Please refer to the *2021 Apple Health IFC CAHPS® Medicaid Child with CCC 5.1 Report, Coordinated Care – Foster Care (Centene WA)* for recommended improvement strategies.

Quality Studies

States may direct their EQROs to conduct focus studies for quality improvement (QI), administrative, legislative or other purposes. A focus study is a study of a particular aspect of clinical care or nonclinical services provided by an MCP at a point in time.

Based on *EQR Protocol 9: Conducting Focus Studies Of Health Care Quality* developed by the Centers for Medicare & Medicaid Services (CMS), Comagine Health conducted the following two focus studies in 2021:

- A study on quality with focus on the WISe service delivery model
- A study analyzing behavioral health performance measure variation across the state's MCOs, Accountable Communities of Health (ACHs) and regional system partners

Wraparound with Intensive Services (WISe)

Objectives

In 2021, HCA chose to conduct a study on quality with focus on the WISe service delivery model. As the EQRO for Washington, Comagine Health is contracted to review behavioral health agencies (BHAs) throughout the state that have implemented the WISe service delivery model. WISe implementation began in Washington in 2014, with a statewide goal establishing WISe treatment throughout the state by 2018. According to the *T.R. v. Birch and Strange* settlement agreement,[26] the goals of this review summary are to:

- Assess WISe performance at both the individual child and system level
- Gauge fidelity to the WISe program
- Present program data and identify weaknesses/opportunities for improvement
- Develop and refine a review process for future quality assurance use
- Identify practices associated with high-quality, effective care coordination and behavioral health treatment

Overview

WISe is a service delivery model that offers intensive services to Medicaid-eligible youth with complex behavioral health needs within the AH-IFC, AH-IMC and BHSO programs. It is a team-based approach that provides services to youth and their families in home and community settings rather than at a BHA and intended as a treatment model to defer from and limit the need for institutional care.

Review Methodology and Scope of Review

Technical Methods of Data Collection

The reviews consisted of clinical record reviews for each of the 10 BHA provider locations selected by HCA. These locations reflect a combination of both rural and urban agencies providing WISe services throughout the state of Washington. The review criteria are identified in the Washington Quality Improvement Review Tool (QIRT). The key areas evaluated during the review include:

- Care Coordination
- Child and Family Team (CFT) Processes and Transition Planning
- Crisis Prevention and Response
- Treatment Characteristics
- Parent and Youth Peer Support

Description of Data Obtained

HCA provided the review team with a list of randomly selected charts for review for each provider location. The review included examining paper records, electronic records and/or a combination of

[26]Disability Rights Washington. *T.R. v. Birch and Strange*. Available at: https://www.hca.wa.gov/about-hca/behavioral-health-recovery/childrens-mental-health-lawsuit-and-agreement.

both. The clinical charts reviewed cover services provided during the period from June 2018 through January 2021.

Data Aggregation and Analysis

The review is based on what was documented within the records. In addition, each review was performed for one individual provider agency and may not reflect care provided outside the reviewed agencies, if not coordinated and documented by the agencies reviewed. The review period included the early days of the COVID-19 PHE, including the *Stay Home, Stay Healthy* orders. The requirements of the *Stay Home, Stay Healthy* orders may be a contributing factor in the agencies' results.

Summary of Findings/Conclusions

This summary includes overall results for the 10 WISe reviews conducted during the review period of January to May 2021 and previously aggregated in two quarterly reports.[27]

Care Coordination Elements

Initial Engagement & Assessment

A Child and Adolescent Needs and Strengths (CANS) screening is required to be offered within 10 business days of a WISe referral and an initial full CANS assessment completed within the first 30 days of enrollment. Documentation should include evidence of youth and family inclusion in the CANS process.

Of the 116 charts in this review, 21 received the 0-4 version while 95 received the 5+ version of the CANS, respectively.

- Timely CANS were identified in 78% of the records reviewed and 93% met the criteria for WISe indicated. Note, there is not an algorithm for the 0-4 version of the CANS screening; therefore, these cases were not included in the calculation of WISe indicated youth.
- The initial full CANS assessment was completed within the required timeframe in 64% of the records of which 45% were collaborative.
- The documentation identified 66% of the reassessments occurred as required.

Care Planning

All needs identified by the initial full CANS are to be included in the youth's Cross System Care Plan (CSCP). Needs may be "deferred" on the CSCP if not currently being addressed.

- Aggregately, 32% of CSCPs were completed within the required timeframe and 49% showed a collaborative review with youth and families.
- Caregiver engagement in the care planning process was evidenced by participation in CFT meetings in the
    - 0-4 age group: 98%
    - 5+ age group: 78%
- Non-CFT Face-to-Face Contact for caregivers averaged 1.2 hours per month.

[27]The individual WISe QIRT quarterly summary reports are available at https://www.hca.wa.gov/about-hca/behavioral-health-recovery/wraparound-intensive-services-wise-0#Quarterly-cumulative-reports.

CFT Processes and Transition Planning

Each youth has a CFT that develops and implements the youth and family's plan, addresses unmet needs and works toward the family's vision and monitors progress regularly. CFT meetings should take place every 30 days, with documentation reflecting ongoing discussions for transition planning and discharge criteria.

- During the first 30 days, the average contact between CFT members and youth/family was 6.4 hours.
- During the first 90 days of enrollment,
    - 10% of youth had zero (0) CFT meetings
    - 29% of youth had one (1) CFT meeting
    - 29% of youth had two (2) CFT meetings
    - 31% of youth had three or more (3+) CFT meetings

Table 26. WISe Care Coordination Elements: CFT Processes and Transition Planning – CFT Meetings Participation.

CFT Participation (0-4)	CFT Participation (5+)
Home: 98%	Home: 78%
Community: 40%	Community: 1%
School: 0%	School: 7%

Crisis Prevention and Response

Each CSCP must include a crisis plan that addresses potential crises that could occur for the youth and family to ensure safety. An effective crisis plan includes:

- Crisis identification and prevention steps, with CFT members' roles
- Crisis response actions based on the severity level of a crisis
- Post-crisis evaluation of the youth's behavioral health status and the effectiveness of the crisis plan

Aggregately, 75% of crisis plans were completed in a timely manner with 41% reflecting collaborative development. Crisis plans were included in 68% of the charts reviewed.

Treatment Characteristics

Qualified clinicians provide individual clinical treatment sessions to the youth/family in the amount, duration and scope appropriate to address the identified medically necessary needs. Documentation should reflect needs identified in the CSCP, indicate how the therapeutic intervention benefitted the youth's functioning or symptoms, and the impact of the services for the youth at home, school and/or in the community.

- Therapist involvement in the WISe service model was evidenced by participation in 75% of all CFT meetings and an average of 3.12 treatment sessions monthly.
- The review indicated 50.5% of treatment sessions were attended by the youth alone.
- The youth and caregiver participated in 28.2% of sessions.
- Only the caregiver attended 21.3% of the treatment sessions.

Persistence in problem-solving was evidenced by documentation of the same treatment focus from session to session in 88% of the sessions. Specific treatment content was not consistently documented. Most frequently documented were skill development and enlisting treatment support at 13.5% and 13.3%, respectively. Documentation of progress reviewed was identified in 12% of records, while 4% of records included celebrating success.

Parent and Youth Peer Support Elements

Each youth and family must be offered a youth peer or parent support partner. These partners are formal members of the CFT who support the parent/youth in the WISe process through active engagement and informed decision making.

Table 27. Parent and Youth Peer Support Elements: Average Hours of Peer Support by Type.

Average Hours of Contact		
	Youth Peer*	Parent Peer
Youth	1.78	1.06
Caregiver	0.96	1.4
Other	0.48	0.83

**Since children under age 5 are not eligible for youth peers, these cases are not included in Youth Peer metrics of any kind.*

Strengths

Overall, the agencies reviewed exhibited strengths in the following areas of the WISe service delivery model:

- Timely CANS were identified in 78% of the records reviewed.
- Home/Caregiver engagement in both the care and transition planning processes, was evidenced by:
    - 98% participation of the 0-4 age group in CFT meetings across all agencies
    - 78% participation of the 5+ age group in CFT meetings across all agencies
- Persistence in problem solving was evidenced during 88% of therapy sessions identified.
- Average Contact Between CFT members and youth/family within the first 30 days was 6.4 hours.

Weaknesses/Opportunities for Improvement

As a result of this review, the following weaknesses/opportunities for improvement were identified to support improvements in the quality of care and services provided to youth in the WISe service delivery model.

- The initial full CANS assessment was completed within the required timeframe in 64% of the records of which 45% were collaborative.
- Aggregately, 32% of CSCPs were completed within the required timeframe and 49% showed a collaborative review with youth and families.
- 68% of charts had crisis plans of which 75% of crisis plans were completed in a timely manner.
- The documentation identified 66% of the reassessments occurred as required.
- During the first 90 days of enrollment, 10% of youth had no (0) CFT meetings, 29% of youth had one (1) CFT meeting and 29% of youth had two (2) CFT meetings.
- Specific treatment content was not consistently documented from session to session. Documentation of progress reviewed was identified in 12% of records, while 4% of records included celebrating success.

Recommendations

In this year's review, some of the agencies provided services during the early days of the COVID-19 PHE, including the *Stay Home, Stay Healthy* orders which may be contributing factors in the agencies' results.

- As the PHE continues, HCA should continue working closely with the MCPs to review the organizations' response to the COVID-19 PHE to address gaps in their emergency or disaster plans to:
    - Identify alternate methods for providing services and supports in the event of a PHE
    - Ensure adaptation of the identified alternative methods for a rapid return to provision of the full range of services

The reviewed agencies experienced difficulties in meeting WISe requirements in regard to the delivery of quality, accessible and timely care.

- HCA should continue providing technical assistance through its WISe Workforce Collaborative to agencies delivering WISe services which includes:
    - Working with the MCPs in providing support for their subcontracted providers
    - Communicating with contracted trainers to ensure alignment with technical assistance and support

Agencies experienced difficulties in meeting WISe requirements including conducting collaborative full CANS, CSCPs, CFTs and crisis plans in a timely manner, in addition to providing clear documentation.

- We recommend the agencies conduct a root-cause analysis to identify the barriers to success in meeting WISe requirements. As interventions are identified, use Plan-Do-Study-Act (PDSA) cycles of improvement to measure the effectiveness of each intervention. Recommended focus areas for improvement include:

- Complete timely and collaborative crisis plans. Documentation of collaboration may include:
  - Specific action steps
  - Post-crisis follow-up activities
  - Identification of all CFT members' roles in crisis response
- Conduct collaborative initial full CANS assessments. The CANS assessments indicate collaboration when:
  - Areas of the youth and caregiver feedback are addressed
  - Documentation reflects the changes that are incorporated
  - Consensus is clearly identified
  - Both strengths and culture are discussed
- Complete collaborative CSCPs within the required timeframe. Documentation that reflects collaboration may include:
  - Attendees and their titles
  - CFT members' contact information
  - Youth or family agreement with the CSCP
  - Documenting a copy of the CSCP was provided to all CFT participants
- Conduct CFT meetings at least every 30 days, ensuring each CFT includes educators and/or community partners when identified as areas of need.
- Record therapy notes that clearly reflect the following:
  - Interventions used in therapy sessions
  - Youth and/or caregiver responses to the intervention
  - Progress reviewed and successes celebrated
  - Document the specific content of treatment sessions such as psychoeducation, skill development or evidence-based practice components

Behavioral Health Performance Measure Study

Objective

In March 2021, Washington HCA contracted with Comagine Health to conduct a study analyzing performance measure variation across the state's MCOs, ACHs and regional system partners. The study focused on establishing a baseline understanding why certain performance measures are performing better or worse and understand why performance has changed over time. The measures described in the full report will be utilized on an ongoing basis to monitor performance and inform HCA's work.

HCA's ultimate goal for the study is to help inform and target quality improvement activities across regions and payors, including measures related to high-profile care coordination needs between physical health and behavioral health providers.

Overview

There are five MCOs in Washington state that contract with HCA to provide integrated managed care. Integrated managed care (IMC) responsibilities include coordinating physical health, mental health and SUD treatment services to help provide whole-person care under one health plan.

ACHs are independent, regional organizations that work with communities on projects and activities related to specific health and social needs. They focus on integrating physical and behavioral health care and coordinating care between providers and organizations. There are nine ACHs covering the state, each serving a specific region. Although each ACH is unique, they share a common approach to improving the health of their communities and changing health care delivery. To understand the variation in behavioral health measure performance among ACHs and MCOs and over time, Comagine Health analyzed performance measure data, surveyed providers from each region, and interviewed ACH, MCO and King County Integrated Care Network (KCICN) staff.

HCA identified 12 behavioral health measures to focus on for this study. The Department of Social and Health Services RDA and HCA provided Comagine Health with three years' worth of performance data for these measures.

Of note, Q1 2020 was the beginning of the COVID-19 pandemic and its impact on the performance as measured by the identified performance measures may begin to be visible in Q1 2020 and Q2 2020. Of the 12 quarters of performance measurement data provided for this study, 10 quarters were "pre-COVID-19."

Initial baseline measurement and data analysis included reviewing the data to identify specific areas with the greatest variation in performance between MCOs, ACHs and across time. The areas of focus were prioritized for study and data collection via surveys and interviews.

Review Methodology and Scope of Review

Technical Methods of Data Collection

Performance Measures

HCA identified 12 measures for this study based on the initial RDA measure data from three years' worth of performance data from Q3 2017 to Q2 2020. Six of these measures had worsening statewide trends and four measures were stable or improving statewide during the timeframe of the data supplied to Comagine Health. These measures are listed in Table 28.

Table 28. Statewide Trends of Performance Measure.

Abbreviation	Measure	Age Group	HCA Assessment
HEDIS-FUH-7D	Adults With Serious Mental Illness (SMI): Follow-Up After Hospitalization for Mental Illness – Within 7 Days	18+	Worse
HEDIS-FUH-30D	Adults With SMI: Follow-Up After Hospitalization for Mental Illness – Within 30 Days	18+	Worse
HEDIS-FUM-7D	Adults With SMI: Follow-Up After ED Visit for Mental Illness – Within 7 Days	18+	Worse
HEDIS-FUM-7D	Children/Adolescents (6-17) With Mental Health Needs: Follow-Up After ED Visit for Mental Illness – Within 7 Days	6–17	Worse
SUPPL-MH-B	Children/Adolescents (6-17) With Mental Health Needs: Mental Health Service Penetration (Broad)	6–17	Worse
SUPPL-SUD	Children/Adolescents (10-17) With SUD Treatment Needs: Substance Use Disorder Treatment Penetration	10–17	Worse
SUPPL-HOME-N	Adult Medicaid, Homeless, Narrow Definition	18–64	Stable or Improving
SUPPL-EMP	Adult Medicaid: Percent Employed	18–64	Stable or Improving
SUPPL-SUD	Adults With SUD Treatment Needs: Substance Use Disorder Treatment Penetration	18+	Stable or Improving
HEDIS-FUA-7D	Adult SUD: Follow-Up After ED Department Visit for Alcohol/Other Drug – 7 Day	18+	Stable or Improving
HEDIS-PCR-P	Psychiatric Inpatient 30-Day Readmission	18+	For future study
HEDIS-PCR-P	Psychiatric Inpatient 30-Day Readmission	6–17	For future study

Surveys

In collaboration with HCA, Comagine Health developed a 16-question survey guided by the analysis of the behavioral health performance measures. Comagine Health administered the survey via SurveyMonkey during nine regional provider meetings conducted over the month of April 2021.

During each regional provider meeting, HCA provided data on the performance measures for the state and for that region prior to conducting the survey. Following the survey, HCA led an informal discussion to help understand some of the data for the region. Recordings of the meetings were provided to HCA.

Interviews

In collaboration with HCA, Comagine Health developed an interview tool guided by the analysis of the behavioral health performance measures. Comagine Health conducted interviews via Zoom with eight

ACHs, five MCOs and KCICN during April and May 2021, recording and later transcribing interviews for analysis.

Description of Data Obtained

In early March 2021, HCA and RDA provided Comagine Health with information related to the performance measures broken down by ACH and MCO.

In order to inform this study and outline survey and interview questions, Comagine Health analyzed aggregated statewide measure data for three one-year periods starting Q3 2017 and ending in Q2 2020. This assessment visually compared real rates in line charts and visual matrices based on the comprehensive aggregate of numerators and denominators across the entire state.

SurveyMonkey data files were imported into SAS® Enterprise Guide (SAS Corporation, Carey, NC). All the separate regional files were appended together, transformed and characterized in SAS®. The data was aggregated into frequency counts and exported from SAS to Microsoft Excel. All interviews were recorded and transcribed.

Data Aggregation and Analysis

The Comagine Health team used the qualitative software NVivo to organize and analyze interview data. After coding, the team grouped interview information into themes through a consensus process.

The distribution of survey responses was analyzed but no statistical tests were performed. The survey data were analyzed descriptively. Additional frequency counts were generated to allow comparison of specific groupings for selected questions.

Summary of Findings/Conclusions

After compiling, reviewing and analyzing the results of the 195 surveys and 14 interviews, Comagine Health identified seven main themes listed below.

1. Workforce shortages
2. Health information technology
3. Challenges sharing patient information/data
4. Limited access to data to assess progress on performance measures
5. Limited access to services
6. Challenges with integration of behavioral and physical health
7. Challenges for children and youth in behavioral health treatment

These themes may be considered baseline information from which efforts to improve performance may begin.

The full report presents survey and interview results for each theme, including strengths and areas for improvement. Comagine Health also identified strengths related to performance measures, such as what the ACHs and MCOs are doing well.

Strengths

The following are strengths/progress noted by participants regarding the process of integration.

- **Integration:**
    - The state has made enormous strides implementing payment reform for integration through the MCOs.
    - Several primary care settings have integrated or co-located behavioral health providers within their clinics, leading to greater coordination of care and follow-up on referrals to specialty care.
- **Data and information sharing:** Providers, ACHs and MCOs see Collective Medical's tools as significant care management tools for all Washingtonians. Adoption of Collective Medical technologies was particularly strong in one area of Washington state (see survey data, King County).
    - Some MCOs work closely with providers regarding their performance on specific metrics.
- **Adoption of EHR:** Penetration of EHRs and analytic systems has been successful in all primary care, and the vast majority of behavioral health. PCPs have been successful in adopting bi-directional referrals to various provider types. ACHs have provided significant technical assistance to support behavioral health providers in the process of choosing and implementing EHRs.
- **Workforce:** The workforce providing Medication for Opioid Use Disorder (MOUD) is increasing.
- **Data:** Providers, ACHs and MCOs all recognize the need for accurate and timely exchange of data.
- **Improvement Mindset:** Most providers consider their practices to be highly focused on improving care coordination and service delivery. This could be through a combination of their own work, collaboration with ACHs and others.
    - A majority of survey respondents (87%) reported their clinics engage in improvement efforts for coordination and service delivery.
- **Access:**
    - Telehealth has improved access for many individuals.
    - Many primary care settings are integrating or co-locating behavioral health providers within their clinics.
    - More primary care providers are providing MOUD services.

Opportunities for Improvement and Recommendations

Based on the survey and interview results, Comagine Health identified areas for improvement and recommendations for HCA. These are meant to be starting points for further development and discussion toward the ultimate goal of improving behavioral health care and integration statewide.

- **Workforce Shortage:** The behavioral health provider workforce challenge is a multi-sector and multi-agency challenge. A statewide effort is needed to pull stakeholders together to address

the issue and increase workforce capacity (access) and support clinical supervision and workforce development. Professionals and non-clinical workers (e.g., certified peer counselors, recovery coaches, other peer support workers, patient navigators and community health workers) are needed. A big picture approach to workforce shortages will help resolve many of these issues. These could include:

- Focused efforts to recruit behavioral health professionals while they are in college.
- Loan forgiveness for individuals with professional behavioral health degrees.
- Supports to include adequate professional staff to provide training and clinical supervision for clinicians and non-clinical staff, including clinical supervision toward licensure.
- Increased focus on statewide efforts to recruit, train, certify and support non-clinical workers throughout the state (Oregon offers a comprehensive model utilizing traditional health workers that is built into the State Plan Amendment[28]).
- Support increased pay for behavioral health providers and offer more funding for increased reimbursement as well as expanded payment for non-clinical workers.
- Increased recruitment, hiring, training, credentialing and supervision of SUD workforce.
- Continue efforts to increase MOUD by primary care providers.
- Workforce development should include education, training and certification to increase the number of behavioral health providers for children and youth.
- Continue support for remote services, while providing multiple treatment modalities so patients can use the one that works best for them.

Of note: To address the shortage of behavioral health professionals and expand and diversify the workforce, in May 2021, the Washington state legislature earmarked funds for a training hospital; more behavioral health programs at 12 Washington state universities; and using dollars for scholarships, grants and loan forgiveness for this workforce. In addition to this legislation, the Ballmer Group provided $38 million to support a broad, collaborative response to the state's behavioral health crisis.

- **Health Information Technology:**
  - Support EMR improvements to improve clinical integration which may include increased funding for innovation and technology enabling bidirectional referrals between physical health and behavioral health.
  - Work with providers and MCOs to address privacy concerns related to telehealth.

- **Patient Health Information Sharing:**
  - HCA, ACHs and the MCOs (and their delegates) should connect all providers with Collective Medical regarding emergency department (ED) and hospitals in order to share patient information with providers. They should standardize implementation, training, support and learning collaboratives related to Collective Medical across MCOs and regions.

[28] State of Oregon. Oregon Administrative Rules: Medical Assistance Programs – Chapter 410. Traditional Health Workers. Available at: https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1741.

  - HCA should implement a statewide effort to support providers and ensure consistent application and succinct processes, in compliance with 42 CFR Part 2, in order to increase the effectiveness of care coordination, improve health outcomes, decrease costs and to truly integrate care for those experiencing SUD.
  - HCA, ACHs and the MCOs (and their delegates) should share best practices, incentives, technical assistance and more across all regions of the state to encourage timely follow-ups after ED visits for behavioral health issues.

- **Limited Access to Data:** The availability of complete, consistent, accurate and timely data is critical for performance measure and quality improvement efforts. Providers have limited capacity to staff this work (working with MCOs to identify how they can receive the data transfer) and have capacity and systems to support value-based purchasing to incentivize outcomes. MCOs need to work closely with providers (of all sizes) and providers need to be willing to work closely with MCOs.
  - HCA should assist MCOs, ACHs and providers in identifying and addressing operational and administrative barriers to timely sharing of data.
  - Standardization of data gathering and information sharing by all MCOs would assist providers in streamlining processes.
- **Access to Services**: In order to improve access to behavioral health services, it is recommended that the state:
  - Address workforce issues as outlined above.
  - Continue to provide telehealth services when appropriate and desired.
  - Extra attention should be paid to additional issues affecting access, including social determinants of health, such as transportation, housing and economic stability. The State should explore options to help ensure members have resources to access transportation for Medicaid-covered services.
- **Challenges for Children and Youth in Behavioral Health Treatment**: In addition to the workforce issues identified for children and youth, recommendations include:
  - Providing choices regarding virtual vs. in-person treatment may help youth engage in treatment in a manner that works best for them.
  - Schools are the primary referral source for behavioral health services for children and youth. While schools were closed to in-person learning during the pandemic, referrals suffered. When schools are not open, ACHs and MCOs should increase regular well-child check-ups, screenings and connections with pediatricians and primary care providers. Further outreach may include identifying culturally effective solutions and reaching out to community-based organizations or partners who may serve as a support for families in need of resources.
  - Changes in school discipline policy implemented by the State Office of Superintendent of Public Instruction has impacted the ability of schools to mandate substance use screenings and assessments to avoid suspension/expulsion.

Enrollee Quality Report

Objectives

The purpose of the *2021 Enrollee Quality Report "*Washington Apple Health Plan Report Card*"* is to provide Washington State Apple Health applicants and enrollees with simple, comparative information about health plan performance that may assist them in selecting a plan that best meets their needs.

Overview

The Apple Health Plan Report Card provides information to eligible Apple Health clients regarding MCO quality in serving Medicaid and Children's Health Insurance Program (CHIP) clients. The Apple Health Plan Report Card is posted annually to the Washington Healthplanfinder website[29] and is included in the Welcome to Washington Apple Health Managed Care handbook. [30]

Technical Methods for Data Collection

Description of Data Obtained

Data sources for this report include the HEDIS and CAHPS measure sets. Use of this data is in alignment with the star rating systems used by other states and reflects the data sources available for the Apple Health population in Washington. Star rating systems assess how well plans perform. Plans are scored in several categories, including quality of care and consumer satisfaction.

The measures selected for inclusion in this report were based on a review of existing star rating systems for Medicaid programs in other states and on internal priorities set by HCA including the Washington Statewide Common Measure Set and other statewide initiatives.

HEDIS Measures

Washington State Apple Health MCOs submitted data for measurement year 2020 (calendar year 2020) for selected HEDIS measures and associated submeasures and the RDA measures. With HCA's approval, Comagine Health focused on selected, prioritized measures.

The measure data submitted by Apple Health MCOs cover three performance areas: effectiveness of care, access/availability of care and utilization.

- The effectiveness of care category includes measures that are broadly applicable to nearly all enrollees in the specified populations and should not vary by enrollee acuity or age.
- The access category includes measures that reflect how many members use basic plan services, such as ambulatory and preventive services, and are therefore roughly indicative of the ability of members to get care. Measure results in this domain may vary from population to population even when the terms and promotion of access provided by the health plan are identical across the populations (for example, individuals with a chronic disability may be more likely than others to see a doctor during a calendar year).

[29] Washington State Health Care Authority. Washington Healthplanfinder: https://www.wahealthplanfinder.org/.
[30] Washington State Health Care Authority. Apple Health Managed Care Handbook. Available at: https://www.hca.wa.gov/assets/free-or-low-cost/19-046.pdf.

- The utilization category includes measures of resource use. Some measures of utilization, such as hospital inpatient use, may reflect acute or emergent care availability but can also reveal a gap in providing preventive or ambulatory care. Therefore, not every measure in this area has an unambiguous "performance" interpretation.

CAHPS Measures

The CAHPS data in this report include results of the CAHPS 5.0H Adult Medicaid Survey conducted by Apple Health MCOs in spring of 2020. This report also includes the results of the CAHPS 5.0H Child Medicaid with Chronic Conditions Survey conducted by Apple Health MCOs in spring of 2019. (While the Apple Health plans conducted the CAHPS 5.0H Child with Chronic Conditions Medicaid survey in spring 2021, final results were not available in time for inclusion in the 2021 report). As with the HEDIS measures included in the star rating, the CAHPS measures selected for inclusion in this report were based on a review of existing star rating systems for other state Medicaid programs and on internal priorities set by HCA.

Technical Overview of Rating Systems

In 2015, as part of the initial star rating report development process, Comagine Health reviewed multiple rating systems implemented by other state EQROs at the time, as well as NCQA and the Centers for Medicare & Medicaid Services (CMS). Through that review, Comagine Health found that health plan rating systems are frequently based on the differences between individual health plan performance measure results and a benchmark, such as a national or state average score.

The two national-level systems, from the NCQA and CMS, provide ratings of health plans within a national scope and use national percentile rankings or percentile cut points (such as the national 25th, 50th and 75th percentiles) as benchmarks. The state-level rating systems use state averages as benchmarks.

Given that average health plan performance can vary significantly across national regions or states, a more localized benchmark, rather than a national benchmark, is often more suitable. Because Apple Health enrollees do not have access to plans nationwide, it is not helpful to compare Apple Health plans to plans in which they cannot enroll. As such, most states opt to compare plan performance to state rates rather than to a national rate.

The potential disadvantage of selecting a weighted state average as the comparison of interest is that significantly larger plans could have undue influence on the state rate, thus large plans are less likely to be statistically significantly above or below the state rate. A simple average of the plans, rather than a weighted average, would mitigate those concerns. Other states use either the weighted or simple average as the comparison point, but Comagine Health chose to use the simple average because the Apple Health MCOs are of such different sizes.

Assessment of Individual Measures

The primary goals in assessing individual measures are to preserve measure variation and account for the level of confidence in the measure's accuracy or precision. Denominator sizes for individual measures can be small; this is especially true for hybrid measures. With these smaller sample sizes, a

greater proportion of the observed differences in performance measure rates can be due to measurement error rather than true variation.

Given that the measures are estimates that are subject to a degree of uncertainty, we characterize performance by focusing attention on the significance and direction of each measure with respect to its comparison benchmark, rather than using the differences between measure point estimates and the state benchmark.

Aggregation of Measure Results to Domains

Individual measures are grouped into categories known as domains that represent different areas of patient care. For example, measures related to women's health are often grouped into the same domain. The performance of the individual measures is then aggregated into an overall result for that domain.

The method for aggregation of individual performance measure scores into domain scores or an overall score varies among the reviewed rating systems mentioned in the previous section. The two national rating systems assign points based on quantiles (NCQA) or averages of percentile ranks (CMS) to aggregate individual measures. The state rating systems tend to use a variance-based approach, such as assigning points based on how far the individual measures are from the state average.

Given that the measures are estimates subject to a degree of uncertainty, we characterize performance by focusing attention on the significance and direction of each measure with respect to its comparison benchmark, rather than using the differences between measure point estimates and the state benchmark. Measures that are significantly below the benchmark are given a score of 0, measures at the benchmark are given a score of 1, and measures that are significantly above the benchmark are given a score of 2.

The overall score for the domain is calculated as a weighted average of the measures included in the domain.

Selection of Measures

In order to define a set of domains, it is necessary to distill a subset of performance measures from the full list of HEDIS measures. Below are several criteria considered when selecting measures for the rating system:

- **Degree of variation**: There is enough variation in the measure across plans that it will help differentiate plan performance and add value to the star rating comparison.
- **Population impact**: The measure reflects a broad population base, or a population of specific or prioritized interest, ensuring its meaningfulness or importance to consumers.
- **Precedent:** The measure is used in other similar rating systems, suggesting a degree of consensus regarding its importance.
- **Compatibility:** The population represented by the measure is broadly present across the plans.
- **HCA priority:** The measure reflects current HCA priorities and measures included in the Healthier Washington Common Measure Set.

Represented Population

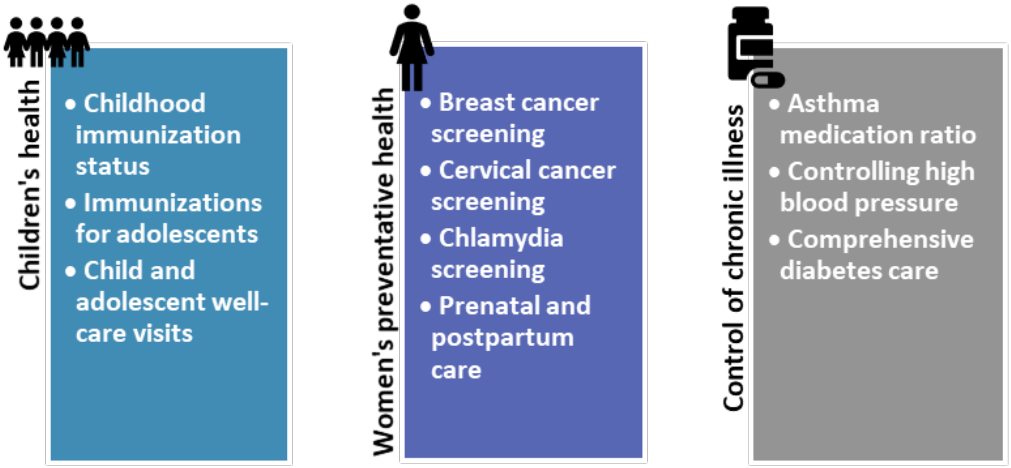
Each HEDIS measure is reflective of a specific population, defined by age, sex or health condition, or a combination of these attributes. The result is that some measures are representative of relatively large populations, and others of very small populations.

The represented population as a consideration of inclusion in the star rating scheme must be balanced with other factors, but—all else equal—a measure that represents a small, limited population should be included only if it aligns with a particular meaning or importance to consumers.

Precedence of Performance Measures Used in Rating Systems

In order to develop a sense of the level of agreement or consensus among the rating systems regarding the applicability of individual measures to a consumer-facing rating system, we checked how often each measure was included in each of the rating systems that we reviewed (see Overview). Relatively, more measures were included in the NCQA system and CMS Quality Rating System. Several HEDIS measures appear frequently among rating systems. These include the following groups of measures below (Figure 14).

Figure 14. Performance Measure Groups.



While precedence is not the only criterion for measure selection, it is important for supporting the face validity of the rating system.

Data Aggregation and Analysis

Analysis of Performance Measure Variation

NCQA recommends that for comparative performance, the state's simple average be used as the benchmark rather than the weighted average, especially in situations where enrollees have equal opportunity to choose among plans, regardless of plan size. Using a weighted mean (e.g., using enrolled population as the weight) as the comparison benchmark unduly favors (or penalizes) larger plans, with the tendency for their scores to fall closer to the average.

In reviewing data for previous *Enrollee Quality Reports*, we observed slightly more significant variation using the simple average for HEDIS measures, confirming our expectation that a weighted mean would dampen the divergence from the mean for larger health plans. We also observed greater differentiation in performance, noting a larger imbalance between the numbers of measures with negatively and positively varying MCOs. As a result, Comagine Health has continued to use the simple average methodology for this and previous editions (2016–2020) of the *Enrollee Quality Report*.

Selection of Domains

The Comagine Health methodology relies on qualitative judgment to determine the number and composition of rating system domains. Statistical methods for establishing domains (such as factor analysis) are not applicable because of the small number of plans (five) included.

Generally, the literature suggests it is best to limit the number of domains and to compose them in such a way that they are most likely to be relevant and actionable for Medicaid plan consumers. Below are several criteria we considered when selecting star rating domains:

- **Precedent**: It is helpful to consider domains used in other star rating systems, especially where empirical analysis and/or consumer focus groups were used to determine domains. For example, the fact that access to care was used in all rating systems we reviewed suggests a consensus that this is an important domain.
- **Coverage/Importance**: All potentially important rating areas should be covered by the final selection of domains to the extent possible based on the availability of measures.
- **Final number of domains**: The number of domains presented to consumers for comparison should be limited to avoid overloading them with information, but still provide adequate diversity to allow specificity in areas of interest. Most star rating systems include six or fewer domains.

Precedence of Performance Domains Used in Rating Systems

As part of our initial scan of selected rating systems in 2015, we observed a variety of rating system domains. The rating systems fell more or less naturally into two groups. The first group, consisting of the two national-level systems and a state rating system, tend to define performance domains more in terms of clinical groupings and include differentiation among domains and subdomains.

These three rating systems also use a larger number of HEDIS measures than the other state rating methodologies that were reviewed. Part of this may be driven by these rating systems having a larger number of measures with adequate eligible populations for reliable reporting.

Definition of Domains

Based on our findings in reviews of relevant literature and examples of existing star rating systems, as well as our observations of the characteristics of performance measures observed in Washington, Comagine Health defined domains and assigned measures to them. To maximize the usefulness of the rating system to a Medicaid audience, we included the following in our approach:

- Levels of measure performance variation in Washington
- Available data

- Impacted populations
- Precedence
- Topical coverage
- HCA feedback
- Internal consistency of domain definitions

Scoring Method and Analysis

Scoring is the process of aggregating performance measure results to the summary level of a star rating for each performance domain.

The scoring approach used in this report is referred to as the "points-based method." It begins with the determination of statistical significance for each individual HEDIS and CAHPS measure, compared with the state average for that measure as the benchmark. Measure significance is determined using confidence intervals calculated using Wilson Score intervals.

Points are assigned based on the measure's statistical significance and on direction. A plan's performance was considered to be statistically higher or lower than the state average for that measure if the state average was higher than the upper confidence limit or lower than the lower confidence limit. Zero points were assigned for performance significantly below the state average, one point for performance statistically the same as the state average, and two points for performance that is significantly above the average. These points are aggregated for each domain and divided by the total points possible for the domain, to obtain a score that represents the percentage of total possible points.

We believe a points-based method more accurately accounts for the degree of confidence in each individual measure score, by way of using the confidence interval around each measure score to determine whether the MCO is statistically lower, the same as, or above the benchmark (simple state average). Because CAHPS measures and hybrid HEDIS measures are based on samples rather than entire populations, using statistical significance is an appropriate method to account for the potential variation from the selected samples. Scoring methods based on plan percentile performance (as used in some other states) do not account for the variable degrees of confidence we have in individual scores, even though they give the appearance of a precise measurement.

Another benefit of the points-based method is that it is relatively easy to calculate and explain, using a straightforward process for assigning points and basic arithmetic.

Measure Weighting

The NCQA's rating system applies a weight to each measure to emphasize the measure's relative importance to consumers; a higher weight indicates the measure is more important to consumers. That system uses a weight equal to three for "outcome" measures (such as keeping blood pressure under control or HbA1C less than 8.0), a weight equal to 1.5 for consumer experience scores (CAHPS measures), and a weight of one for the remaining measures, which reflect processes or utilization/access. We adopted the NCQA's weighting approach, as it appears to reflect a reasonable

balance of priorities and was determined through a consensus process of measurement experts.[31] Two measures were given a zero weighting for this year's scorecard. Two measures were given a zero weighting because statewide behavioral health integration occurred recently, and MCO processes to manage behavioral health are still being developed. One measure was given a zero weight because it is a new measure.

Rating Levels and Stars

Rating systems vary with regard to how and how many "stars" are assigned. The national-level systems, which are based on rankings, assign between one and five stars (or points, for NCQA) based on quantile cut points. The state-level rating systems tend to assign between one and three stars based on significance of the final score in comparison to the benchmark. The state-level rating systems we reviewed use the three-star rating system, which depicts performance below the average with one star, equal to the average with two stars, and above the average with three stars. We chose to use a three-star rating system. Three stars allows for enough range for a comparison without risking a false sense of precision that five stars might give by suggesting differences when substantively there are done.

The 2021 Enrollee Quality Report in Appendix x shows how the Washington Apple Health plans: Amerigroup Washington (AMG), Coordinated Care of Washington (CCW), Community Health Plan of Washington (CHPW), Molina Healthcare of Washington (MHW), and UnitedHealthcare Community Plan (UHC) compare to each other in key performance areas.

The scores refer to the percentage of possible points received by plans in each domain; the stars refer to the corresponding number of stars earned by the respective scores:

- Scores under 50 earn one star
- Scores between 50 to 74 earn two stars
- Scores 75 and higher earn three stars (the highest rating possible)

Conclusions

Please refer to Appendix F of this report for the 2021 Enrollee Quality Report ("Washington Apple Health Plan Report Card").

[31] NCQA. NCQA's Health Insurance Plan Ratings 2019–2020. Available at: https://www.ncqa.org/hedis/reports-and-research/ratings-2019/.

Review of Previous Year's EQR Recommendations

Required EQR activities include a review of the applicable state organization's response to previously issued EQR recommendations. Additionally, HCA uses the annual response to EQR recommendations as part of the evaluation of effectiveness for the Washington State Managed Care Quality Strategy.

Table 29 shows the recommendations from the 2020 EQR report, with HCA's response and the EQRO's response.

Table 29. Responses to 2020 EQR Recommendations.

Quality Strategy - Based on our comparative analysis, Comagine Health recommends the following to assist HCA in targeting the goals, aims and objectives in the quality strategy.
• We recommend that the MCOs sustain momentum in key areas (Behavioral Health Integration and Substance Use Disorder Treatment Penetration) where statistically significant and clinical meaningful improvements have been noted. Identifying the best practices contributing to this performance and, where possible, standardizing approaches to encourage sustainability will also lead to continued improvements. (Aim 1 and Aim 4) • Proactively monitor measures in the light of the COVID-19 pandemic with a focus on access to care, behavioral health, chronic conditions, prevention and screening and utilization. (Aims 1-5) • Continue to work on a strategy and plan to expand the available data set to allow deeper future analysis related to health equity. (Aims 1-4) • Standardize approaches across MCOs when possible, to reduce provider burnout. (Aim 4) • Continue to evaluate recommendations on measure trends to guide selection of VBP measures. (Aims 5-6)
HCA Response: In January 2020, all 10 regions of the state completed the transition to an integrated system for physical health, mental health, and substance use disorder treatment services within the Apple Health program. HCA has had projects underway to support ongoing bi-directional integration of physical and behavioral health through care transformation in each of the regions, specific to the identified needs of those areas. In 2020, much of the work inside of these projects pivoted to address the needs emerging because of the COVID-19 public health emergency, such as investments in broadband and equipment necessary for providing telehealth services (e.g., smart phones, laptops, and Zoom licenses). Resources diverted to COVID-19 response supported sustaining service capacity for BH clients. In March of 2020, HCA contracted with our EQRO, Comagine Health, to take a deeper dive into BH performance measures, surveying providers and interviewing MCOs in an effort to understand current outcomes and how to support improvement of BH performance measures, including but not limited to, HCA selected IMC/IFC VBP measures: Mental Health treatment penetration (MH-B) and substance use disorder (SUD). 4 of 5 MCOs dropped in performance for MH-B while all plans saw improvement in SUD measures, only one of 5 performing below the benchmark. This work is ongoing with an emphasis on children's measures. As an example, HCA worked with CCW, who currently holds the IFC contract, regarding more intense/robust care coordination - to be sure to connect these kids. As a result, CCW is doing some specific outreach (BH, SUD, suicide) in addition to standard communications.

HCA has encouraged MCPs to proactively monitor measures considering the CV-19 pandemic. Details regarding strategies implemented and the extent to which MCPs were able to implement this EQRO recommendation can be found further down in HCA response.

HCA is working internally in alignment with recently hired Health Equity Social Justice and Strategy Manager and our contracted EQRO to explore ways to expand the available data set to allow for deeper future analysis related to health equity. HCA recognizes three of our five contracted MCPs currently hold an NCQA Multicultural Healthcare Distinction: Amerigroup of WA, Community Health Plan of WA, and Molina Healthcare of WA. Additionally, HCA plans to encourage MCP participation in the national focus on Health Equity by implementing NCQA HEDIS stratification of measure requirements into future IMC/IFC contracts.

HCA seeks alignment through multiple quality improvement efforts to continue the collaboration fostered through the BH integration implementation. Examples include the MCO Well-Child Collaborative, AMM health disparity workgroup, Administrative Simplification workgroup, SNF Collaborative workgroup, selection process for VBP measures, and the Asthma Affinity Group.

The Administrative Simplification workgroup, convened in 2020, meets quarterly, and is a collaboration between the Office of the Insurance Commissioner (OIC), HCA, provider groups, and insurance plans (including Medicaid MCPs). The SNF Collaborative workgroup, also convened in 2020 is a collaboration between HCA and MCPs. Goals of these groups include standardization of processes and templates across plans to ease administrative burden for providers. All 5 MCPs are contractually required to participate in these workgroups and abide by best practice recommendations for standardization. Participation in these workgroups and achievements therein represent implementation of this EQRO recommendation.

Section 211(50)(a) of Engrossed Substitute House Bill 1109 (2019 session) and Section 211(31)(a) of Engrossed Substitute Senate Bill 5092 (2021 session) requires HCA to annually select performance measures after an analysis by the contracted External Quality Improvement Organization (EQRO). Comagine Health, WA State's currently contract EQRO, presented recommendations to HCA leadership in August and measures were selected in alignment with WA State Common Measure Set, WA State Medicaid Quality Strategy, and the above-mentioned Proviso language requirements. Plan performance on the selected VBP measures is used to evaluate the effectiveness of our WA State Medicaid Quality Strategy. All 5 MCPs are contractually required to participate in VBP program. Participation and achievements therein represent implementation of this EQRO recommendation. For information regarding individual plan performance see VBP results section of EQR technical report.

EQRO Response: Comagine Health accepts the responses to the recommendations and acknowledges all of the efforts made. As the Quality Strategy is updated, applicable priorities and goals can be included.

Compliance - Overall, the MCPs continue to work to meet the requirements for each of the elements reviewed. The following are recommendations for the MCPs.

Enrollee Rights
HCA should continue technical assistance to support the MCPs in meeting the following enrollee rights elements:

- MCOs (AMG, CHPW, MHW and UHC) and BHSOs (AMG, CHPW, MHW and UHC) need to ensure enrollees are provided the necessary information if providers are terminated.
- MCOs (CHPW and MHW) and BHSOs (CHPW and MHW) need to follow up on processes to ensure that liability for payment issues are resolved.
- Two MCOs (AMG and CHPW) and two BHSOs (AMG and CHPW) need to ensure they have required processes in place to monitor and address issues related to the provision of written materials.

HCA Response:
The plans identified with deficiencies through Compliance Review as outlined above were required to respond to the state with corrective action. These responses were reviewed, and all were accepted as completed by HCA.

EQRO Response: Response accepted.

Availability of Services

- All MCPs require attention, support and continued technical assistance from HCA to meet the elements. All plans need to focus on comprehensive documentation that includes required provider directory information for enrollees, direct access to women's health specialists, providing for second opinions, addressing out-of-network services and payment for out-of-network services.

HCA Response: All MCPs were required to respond to the state with corrective action. These responses were reviewed, and all were accepted as completed by HCA.

EQRO Response: Response accepted.

Care Coordination
Overall, the plans demonstrated care coordination as a strength. HCA should continue technical assistance to support the MCPs in meeting the following elements:

- Three MCOs (AMG, CCW and MHW) and three BHSOs (AMG, CCW and MHW) should focus improvement efforts on general primary care and coordination of health care services for all enrollees.
- AMG-MCO and AMG-BHSO need to ensure appropriate care coordination oversight is documented and in place.

HCA Response: The plans identified with deficiencies through Compliance Review as outlined above were required to respond to the state with corrective action. These responses were reviewed, and all were accepted as completed by HCA.

EQRO Response: Response accepted.

Practice Guidelines

- HCA should continue technical assistance to AMG-MCO and AMG-BHSO to ensure they are demonstrating that their UM decisions and criteria align with adopted practice guidelines and that providers across the MCO/BHSO networks receive consistent messages to guide their documentation and decisions.

HCA Response: HCA provided detailed technical assistance on reviewing and comparing practice guidelines and UM criteria to AMG. AMG demonstrated understanding and met this requirement in 2021. Technical assistance continues to be available as needed.

EQRO Response: Response accepted.
Corrective Action Plans • CAPs regarding coverage and authorization standards from 2019 continue to indicate little improvement. HCA is requiring MCOs to create detailed CAPs to meet coverage and authorization requirements. In addition, HCA mandates monthly technical assistance meetings to support the MCOs in UM decision-making processes and/or Notice of Adverse Benefit Determination. These meetings include visual review and feedback, discussion of processes followed for the reviewed documentation, and demonstration that processes are appropriate and meet contract requirements. It is recommended that continued technical assistance addressing coverage and authorization issues be provided for the MCOs.
***HCA Response*:** All MCPs were required to participate in technical assistance meetings during the 4th quarter of 2020 and the first quarter of 2021. Progress during these technical assistance meetings was sufficient to close the corrective action from 2020 for all 5 plans. Due to the timing of technical assistance and files pulled for the 2021 TM review process, continued issues were identified occurring prior to the technical assistance, however, processes had already been put into place by each MCP to mitigate future deficiencies. New adverse benefit determination letter templates were submitted by each MCP and approved by HCA. Due to the overlapping timeframes for TM 2020 and 2021, full resolution of the corrective action will not be complete until the 2022 TM review process is completed. Technical assistance continues to be available as needed.
EQRO Response: Comagine Health recognizes the efforts of HCA and MCPs to make improvements in meeting the elements for this standard. It is further noted that the overlapping review schedules impact full resolution of the corrective actions. Corrective action stands through 2022.
Performance Improvement Projects - Some of the recommendations from 2019 RY remain the same. To enhance the MCOs' ability to design a sound PIP, HCA should continue the following activities to engage and guide the five MCOs in providing desired quality health outcomes for its enrollees.

The five MCOs had PIPs with weaknesses in their study designs, including a lack of clear alignment and linkage throughout the PIP, inclusion of cultural and/or linguistic diversity and needs, and details on data analysis and input from populations with special health care needs. The PIPs also did not emphasize confidentiality and safe handling of sensitive information or quality improvement processes. *(Access and quality of care)*
• HCA should continue to provide ongoing training specifically focused on the overall study design by establishing a framework for sustainable improvement that stems from well-defined and well-scoped study designs.
  ○ Establishing well-defined, objectively measured indicators allows for the tracking of performance over time.
  ○ Addressing identified barriers and challenges in PIP interventions in a delineated approach contributes to sustainable improvement.

The five MCOs had PIPs with weaknesses reflecting broad, unclear study questions resulting in generalized interventions being weakly or not linked to the study questions. *(Quality of care)*
• HCA should provide technical assistance to the MCOs with a focus on defining, streamlining and simplifying study questions.
  ○ Questions should be written in an easily understandable format that supports the MCOs' ability to determine whether the chosen intervention has a measurable impact on the study population.
  ○ A concise study question will improve the MCO's ability to align the entire PIP study design.

HCA Response: Each MCO improved its average PIP score from 2019 to 2020. Two MCOs (AMG and CCW) had monthly Technical Assistance meetings with HCA between January and June 2020 to discuss individual PIPs in detail and make corrections to meet requirements. Some of the MCOs changed their PIP topics in 2020, and the change in topics generally resulted in improved PIP scores. HCA presented a PIP training to all MCOs in January 2021. Individual MCOs continued to receive technical assistance on PIPs into 2021. Technical assistance continues to be available as needed.

EQRO Response: The EQRO acknowledges the work HCA has done in providing technical assistance to the MCOs. However, several PIPs initiated in 2020 continue to reflect weak study design, including two PIPS with no study question. The recommendations, with modifications within the *2021 Annual Technical Report*, stand.

The five MCOs had PIPs with weaknesses in achieving sustained improvement through repeated measurements over comparable time periods. *(Quality and timeliness of care)*

- HCA should encourage the MCOs to utilize rapid-cycle process improvement where feasible to accelerate change and results.
  - Utilizing this process allows for the opportunity to revise interventions sooner and correct course when original interventions are not successful.
  - For PIPs with multiple interventions, utilizing this process also provides more accurate identification of which specific intervention actually had a measurable impact for the study population.

HCA Response: HCA introduced the concept of rapid-cycle improvement process to the MCOs in January 2021 training and found they had a significant pre-existing knowledge of the process and were eager to use it in their PIPs going forward. The well-child collaborative PIP is using the rapid cycle improvement (PDSA) process with its participating medical practices, and all PIPs will be using the process in 2021.

EQRO Response: The EQRO acknowledges the work HCA has done in providing training to the MCOs. The response is accepted.

Performance Measure Validation

Sustain Clinically Meaningful Areas of Improvement

Several measure categories had improvement across all or most MCOs or spanned more than one year. We consider year-over-year improvement in particular to be "clinically meaningful" in that it is clear that the standard of practice is showing sustained improvement.

- We recommend that HCA work with the MCOs to sustain momentum in these key areas, identifying the best practices contributing to this performance and, where possible, standardizing approaches to encourage sustainability. Key areas include:
  - **Behavioral Health Integration** *(Access and timeliness of care).* There was year-over-year improvement across all or nearly all MCOs in several behavioral health medication management metrics (Antidepressant Medication Management, Acute and Continuation phase and Follow Up Care for Children Provided ADHD Medication, Initiation and Continuation phase). We recommend continued emphasis on this important topic with additional focus on the behavioral health issues for which there has not been sustained improvement, including Mental Health treatment penetration (MH-B).

- **Substance Use Disorder** *(Access and timeliness of care).* There was improvement across all MCOs in SUD for all enrollees (ages 12–64) for the last two years. This improvement was not seen for adolescents (ages 12–18) or the foster care population (ages 12–26). SUD has impacted all clinicians serving Medicaid patients and has been a high priority in the state and nationally. We recommend that improvement efforts be continued with additional focus on patients under the age of 26.

HCA Response: See HCA response in Quality Strategy section specific to Behavioral Health Integration (Aim 1 and Aim 4).

EQRO Response: Response accepted.

Anticipate Impacts due to the COVID-19 Pandemic

The data for the measures was collected through December 2019 and, therefore, does not reflect impacts of the COVID-19 pandemic. Maintaining quality improvement momentum in 2021 will be a challenge because of the disruption to care delivery across all sectors because of the pandemic.

- We recommend that HCA encourage MCOs to not wait for 2020 data to address anticipated effects, but rather work to proactively address these domains. We anticipate that the impact of the pandemic will be measurable in several particularly vulnerable clinical areas.
  - **Access to care**. As providers have increased access via telemedicine and limited in-person services, it will be important to pay attention to equitable access to care and particularly care for children. Given that some patients from disadvantaged communities will have limited access to the technology, privacy or internet access needed for telehealth, we recommend that MCOs focus on ensuring that in-person services are prioritized for those unable to participate in virtual visits. With early reports of reduced childhood immunization during the pandemic, consideration should be given to an early convening of MCOs to design innovative strategies for immunizing children rather than waiting for a full year of data.
  - **Behavioral health.** As the pandemic's impact on personal isolation continues, we anticipate that depression, anxiety and other behavioral health needs among the population will increase. We recommend that the MCOs continue efforts that strengthen the integration of behavioral health and primary care, as well as initiatives to identify and meet behavioral health needs.
  - **Chronic conditions (cardiovascular conditions, diabetes and respiratory conditions).** Monitoring physiologic control and end organ damage, as well as medication adherence, are foundational components of chronic disease management. All three are threatened by the COVID-19 pandemic. MCOs will need to work to ensure patients with chronic cardiovascular and respiratory conditions continue to receive evidence-based monitoring and interventions through the use of alternative methods of care delivery including telehealth, collaboration with community health worker programs, and optimal use of community-based organizations.
  - **Prevention and screening.** We anticipate a reduction in screening and preventive services caused by the pandemic that will lead to delayed, late-stage diagnoses and an increase in preventable conditions. We recommend focused efforts to develop standardized plans across all MCOs to increase incentives and remove barriers to preventive care during the pandemic.
  - **Utilization.** If our assumptions about limited access to preventive and maintenance services are correct, we are concerned about a potential increase in the utilization of critical care and emergency services above and beyond conditions directly related to COVID-19 infection. We recommend a coordinated effort across MCOs to give clinical providers a unified framework for addressing these threats.

HCA Response: HCA took a proactive approach to both anticipate and respond to access to care challenges at the beginning of the pandemic and throughout the year. HCA requested and MCOs provided their plans to maintain and improve rates of well-child visits and immunizations during the pandemic. At least one MCO added a member incentive for getting the COVID-19 vaccine. MCOs participated in the extra vaccine clinics along with providers and clinics, and they encouraged adding days or hours dedicated to vaccine catch-up. MCOs also collaborated with schools to do immunization reminders at back-to-school events and parent meetings. Additionally, HCA/MCOs leveraged the Collaborative well-child PIP to support implementation of interventions with pilot groups to provide in-person care within COVID-19 restrictions (e.g. utilization of hybrid visits).

There has been a tremendous amount of work that has been implemented or is in the planning stages of implementation to address the COVID surge of behavioral health needs in youth and families. These have included a regional hub to manage the utilization of youth inpatient beds, developed training under the directive of Emergency Proclamation of the Governor 21-05 and in partnership with DOH to respond to youth BH emergencies associated with the impacts of COVID-19, as well as developing a robust referrals and resource collection for youth and families such as blogs, BH toolbox for families, reference guides and a parent and teen referral line. Additionally, increased support for telemedicine and telehealth usage was implemented to facilitate and strengthen the ability of clients to access behavioral health resources. Strategies outlined above represents implementation of this EQRO recommendation by all 5 plans.

HCA lifted restrictions on audio only telehealth modalities to ensure continued access to care during the early stages of the CV-19 public health emergency. Smart phones were distributed to some AH clients to facilitate continued access to care. Additionally, HCA provided Zoom licenses and laptops to providers to assist with standing up telehealth services for both physical health and behavioral health providers that lacked the capability. HCA collaborated with MCOs to reach out to providers to assess needs and provide resources to ensure continued evidence-based monitoring and interventions were provided to patients with chronic cardiovascular and respiratory conditions. All 5 plans included in their annual QAPI evaluations details regarding resources provided directly to AH enrollees and providers as evidence of implementation of this EQRO recommendation.

HCA worked in collaboration with all 5 MCPs to free up hospital resources and create surge capacity by coordinating increased efforts to move difficult to discharge clients out of acute care hospital settings during the public health emergency. Meetings were conducted up to twice weekly to discuss individual clients, offer ideas for difficult placements, and encourage creative use of incentives. This work initially began with clients escalated to the HCA by individual hospitals and has now been expanded across the state to include all AH clients that are medically ready for discharge from an acute setting.

EQRO Response: Response accepted. It is acknowledged that we are still in this public health emergency, and HCA and the MCPs are focused on efforts to decrease impacts while maintaining quality improvement efforts.

CAHPS
HCA should utilize the CAHPS data, analysis and reports to identify specific areas of focus for the MCOs. These areas may be targeted and focused on survey items that fall below the national comparative data when this data is available. If national comparative data is not available, then looking at trends over time can provide valuable information to use when identifying areas of focus. In addition, we recommend looking at areas of improvement to identify successful strategies that can be shared and spread across all MCOs.
HCA Response: CAHPS data is compiled into a state-wide report on an annual basis by our contracted EQRO, the topic of the report (adult/child/CHIP) varies year over year based on contractual requirements. Additionally, MCPs are required to submit CAHPS vendor reports to HCA and include their CAHPS quality improvement plans within their QAPI workplans and evaluations submitted to the HCA as part of TM review process. All 5 MCPs met the requirements for QAPI section in 2020. For 2021, HCA shared resources provided to them from CMS/AHRQ partners with the MCPs with encouragement to review/utilize them in their future QAPI CAHPS quality improvement plans. Additionally, Comagine Health will be including recommendations within the 2021 statewide CAHPS report provided to the plans.
EQRO Response: Response accepted.
WISe

In this year's review, some of the agencies provided services during the early days of the COVID-19 PHE, including the Stay Home, Stay Healthy orders which may be contributing factors in the agencies' results.
• As the PHE continues, HCA should work closely with the MCOs to review the organizations' response to the COVID-19 PHE to address gaps in the emergency or disaster plans to:
  ○ Identify alternate methods for providing services and supports in the event of a PHE
  ○ Ensure adaptation of the identified alternative methods for a rapid return to provision of the full range of services

HCA Response: Response to COVID-19 continues to be discussed at monthly meetings with the MCOs. The MCOs also provide monthly action plans that list the identified barriers per region, and methods that are being implemented to provide service and supports to both providers and clients to reduce these barriers. One identified barrier was reduced through telehealth services, supported by HCA and the MCOs, to ensure HIPAA compliant methods were implemented by the providers in order to continue to provide services to clients.
EQRO Response: The EQRO acknowledges the work HCA has done to address this recommendation. However, due to the review period of the focus study (January through May of 2021) covering services provided during the period from June 2018 through January 2021, the recommendation stands. In addition, the EQRO is aware the next review will be of services covered in the first part of 2021 which will provide a more accurate picture of HCA's work.
The reviewed agencies experienced difficulties in meeting WISe requirements in regard to the delivery of quality, accessible and timely care. • HCA should continue providing technical assistance to the agencies delivering WISe services including encouraging the agencies to conduct a root-cause analysis to identify the barriers to success in meeting WISe requirements.

HCA Response: Technical assistance continues to be provided through regional meetings with the MCOs. Root cause analysis is a suggested strategy to identify barriers in the WISe Quality Plan. The WISe Quality Plan also contains additional information about how to identify strategies to address quality improvement needs. Technical assistance continues to be available as needed.
EQRO Response: The EQRO acknowledges the work HCA has done in providing technical assistance to the MCOs. However, due to the review period of the focus study (January through May of 2021) covering services provided during the period from June 2018 through January 2021, the recommendation stands. In addition, the EQRO is aware the next review will be of services covered in the first part of 2021 which will provide a more accurate picture of HCA's work.

Appendix A: MCP Profiles

About the MCP Profiles

The profiles include a summary of review results for the compliance of MCPs (includes MCOs and BHSOs), and PIP and performance measure reviews for each MCO. They also include a "scorecard" for each MCO, showing its performance on statewide performance measures.

Noted Strengths and Weaknesses/Opportunities for Improvement

Compliance:

- Compliance strengths are noted when the MCP met a standard or all elements within the standard.
- Compliance weaknesses/opportunities for improvement are provided when the MCP did not meet an element within a standard. The language provided is a synopsis from TEAMonitor reports to the MCPs.

PIPs:

- PIP weaknesses/opportunities for improvement in the referenced tables are provided when the MCO did not meet the scoring element.
- The language for both strengths and weaknesses/opportunities is a synopsis from TEAMonitor PIP Validation Worksheets completed for each PIP.

Performance Measures:

- Strengths and weaknesses/opportunities for Improvement are noted when an MCO scores above or below the state average, respectively.

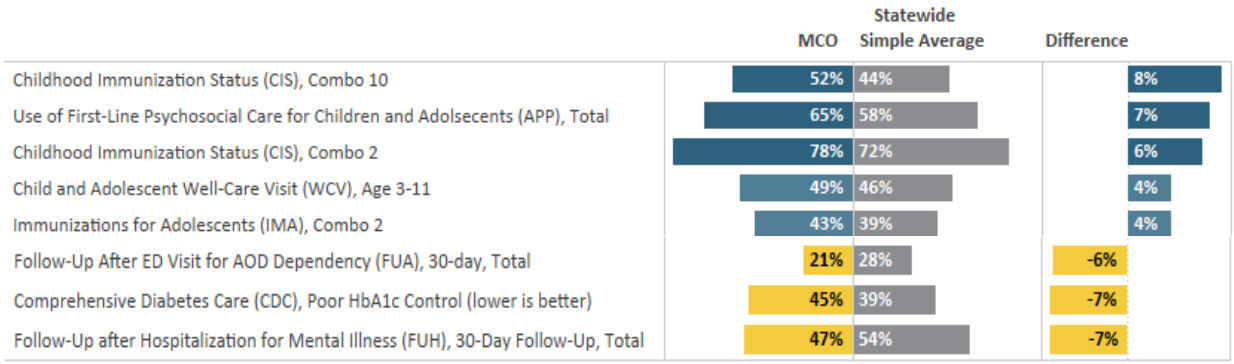
MCO Scorecards

Comagine Health compared MCO performance on each measure to the statewide simple average for that measure and created a "scorecard" chart for each MCO. Figure A-1 shows a snapshot of the scorecard to illustrate how to read these.

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

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

Figure A-1. Snapshot of MCO Scorecards.

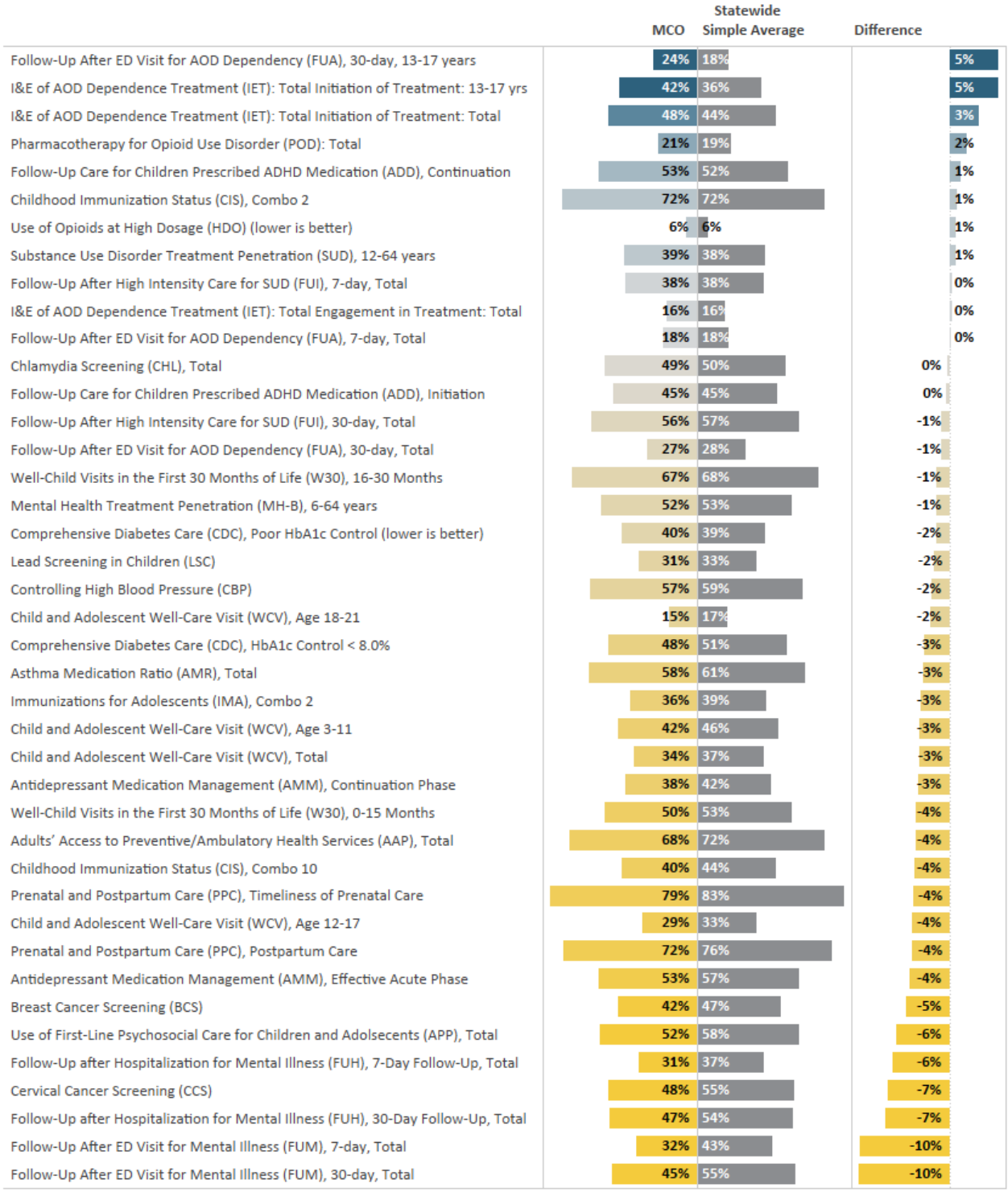


The MCO performance scorecards on the following pages highlight the variance of measures from the simple state average. Comagine Health chose to use the simple average for the MCO scorecards as the Apple Health MCOs are of such different sizes; note that the simple state average is different than the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

Amerigroup Washington (AMG) Profile

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

Figure A-2. AMG Scorecard.



Summary of Results for the Compliance, PIP and Performance Measure Reviews: AMG

Table A-1. Summary of AMG's MCP 2021 Compliance Review Results.

Compliance with Regulatory and Contractual Standards				
Standard	**MCO Score/Possible**	**%**	**BHSO Score/Possible**	**%**
Element: Quality, Access and Timeliness **§438.56 - Disenrollment: Requirements and limitations**	3/3	100%	3/3	100%
Weaknesses/Opportunities for Improvement • No improvements needed. Continue to demonstrate compliance.				
Element: Quality, Access and Timeliness **§438.210 - Coverage and authorization of service**	6/15	40%	6/15	40%

Weaknesses/Opportunities for Improvement
AMG-MCO and AMG-BHSO should focus improvement efforts on:
• Authorization of services
  ○ Ensure that consultation with the requesting provider is completed for adverse benefit determinations concerning medical necessity or other clinical issues, prior to denying or modifying services, is documented
  ○ Ensure MDs and other determining reviewers look at and perform a complete review of submitted medical records when making a final determination decision
  ○ Document that the medical necessity determination followed the requirements, and the coverage determination was appropriate in regard to what was covered under the contract
  ○ Identify clients with unmet care needs or other indicators of special health care needs that would benefit from care coordination and refer these clients to care coordination services as appropriate
  ○ Provide additional staff training as needed
  ○ Provide ongoing monitoring
• Notice of adverse benefit determination
  ○ Include notification requirements within the Notice of Adverse Benefit Determination that include the required elements in the CFR and contract
  ○ Ensure that documents are easily understood and including all requirement elements
• Timeframe for decisions
  ○ Ensure that the timeframes for authorization are appropriate to the enrollee's health condition (standard or expedited), per Contractual requirements, and if the timeframe was extended, it is documented and appropriate
  ○ Provide additional staff training as needed
  ○ Provide ongoing monitoring				

Element: Quality, Access and Timeliness **§438.230 - Subcontractual Relationships and Delegation**	10/12	83%	10/12	83%
Weaknesses/Opportunities for Improvement AMG-MCO and AMG-BHSO should focus improvement efforts on: • Subcontractual relationships and delegation ○ Include delegation entity contractor information in annual Report of Delegated Entities				

Compliance with Regulatory and Contractual Standards				
Standard	**MCO Score/Possible**	**%**	**BHSO Score/Possible**	**%**
○ Improve documentation in pre-delegation and annual audit to include reviewer names, dates and review scores to ensure they are correct				
Element: Quality and Timeliness **§438.242 - Health Information Systems**	9/9	100%	9/9	100%
Weakness/Opportunities for Improvement • No improvements needed. Continue to demonstrate compliance.				
Element: Quality **§438.608 - Program integrity requirements**	11/12	92%	11/12	92%
Weakness/Opportunities for Improvement AMG-MCO and AMG-BHSO should focus improvement efforts on: • Program integrity requirements ○ Training documents should include reference to CFR requirement ○ Utilize the Payment Assistance Request Form (PARF) as required in the contract				

Table A-2. Summary of AMG's MCP 2020 Corrective Action Plans.

Review of 2020 MCP Corrective Action Plans	Not Met	Partially Met	Met
Element: Access **Standard: Availability of services**	–	–	2
Two elements reviewed for CAPs: • 438.206 Availability of Services (b)(1)(i-v) & (c) Delivery network, 438.10 (h) Information for all enrollees – Provider directory - 438.207 Assurances of adequate capacity and services – Met • 438.206 Availability of Services (c)(2) Cultural considerations – Met			
Element: Quality and Access **Standard: Coordination and Continuity of Care**	–	–	1
One element reviewed for a CAP: • 438.208 Coordination and Continuity of Care (b) Primary care and coordination of health care services for all MCO/PIHP enrollees and §438.224 Confidentiality - Met			
Element: Quality, Access and Timeliness **Standard: Coverage and Authorization of Services**	2	1	–
Three elements reviewed for CAPs: • 438.210 Coverage and Authorization of Services (b) Authorization of services – Not Met* • 438.210 Coverage and Authorization of Services (c) Notice of adverse benefit determination – Not Met* *(Repeat Finding)* • 438.210 Coverage and Authorization of Services (d) Timeframe for decisions – Partially Met*			
Element: Quality **Standard: Enrollee Rights and Protections**	–	–	4
Four elements reviewed for CAPs: • 438.100 Enrollee Rights (a) - General rule – Met • 438.100 Enrollee Rights (b)(2)(i) Specific rights - 438.10(d)(6) Format, easily understood – Met • 438.100 Enrollee Rights (b)(2)(i) Specific rights - 438.10(f) (2) General requirements – Met			

Review of 2020 MCP Corrective Action Plans	Not Met	Partially Met	Met
• 438.100 Enrollee Rights (b)(2)(i) Specific rights - 438.10(i) Information for Enrollees *(CAP for MCO Only)* – Met			
Element: Quality and Timeliness **Standard: Grievance System**	–	–	6
Six elements reviewed for CAPs: • 438.402 General requirements (c)(1) Filing requirements - authority to file - Met • 438.406 Handling of grievances and appeals (a) General requirements - Met • 438.408 Resolution and notification: Grievances and appeals (a) basic rule - Met • 438.408 Resolution and notification: Grievances and appeals (b) and (c) Specific timeframes and extension of timeframes - Met • 438.408 Resolution and notification: Grievances and appeals (d) and (e) Format of notice and content of notice of appeal resolution - Met • 438.410 Expedited resolution of appeals - Met			
Element: Quality **Practice Guidelines**	–	–	1
One element reviewed for a CAP: • 438.236 Practice Guidelines (d) Application of [practice] guidelines - Met			

**Future follow-up required.*

Table A-3. Summary of AMG's 2021 PIPs.

Performance Improvement Projects (PIPs)*			
Type	**PIP Name**	**Score/ Confidence**	**Statistical Significance**
Element: Access, Quality, Timeliness **Clinical:** AH-IMC/AH-IFC	Collaborative MCO Well-Child Visit Rate PIP	Partially Met Confidence in reported MCO PIP results	No Statistically Significant Change
Element: Access, Quality **Clinical:** Washington State Institute for Public Policy (AH-IMC/BHSO) – Adult	Using SBIRT (Screening, Brief Intervention, and Referral to Treatment) for Identification and Intervention of Substance Use Disorders by Physical Health Practitioners	Partially Met Confidence in reported MCO PIP results	No Statistically Significant Change
Element: Quality **Clinical:** Washington State Institute for Public Policy (AH-IMC/BHSO) – Child	Using the Alcohol Literacy Challenge in Washington State School-Based Settings to Reduce Youth Drinking Rates Through Changed Alcohol Effect Beliefs	Partially Met Confidence in reported MCO PIP results	Statistically Significant Change
Element: Access, Quality **Non-Clinical:** AH-IMC/ BHSO	Improving WIC Participation	Partially Met	No Statistically Significant Change

Performance Improvement Projects (PIPs)*			
Type	**PIP Name**	**Score/ Confidence**	**Statistical Significance**
		Reported MCO PIP results not credible	

**Please refer to Tables 10 and 11 for strengths and weaknesses/opportunities for improvement.*

Summary of Previous Year (2020) MCP PIP CAP

The response submitted by the MCP to the 2020 CAP was reviewed and accepted with the following response by HCA:

- **AMG**: Met – The MCP shows improvement in all PIPs this year, although unfortunately the pandemic prevented full implementation as planned and influenced performance measure results, most notably in the well-child PIP. The MCP initiated multiple technical assistance sessions with the HCA, and it is apparent that the information was helpful.

Summary of 2021 MCP PIP CAP

Please refer to pages 55-57 for the summary of the MCP's CAP.

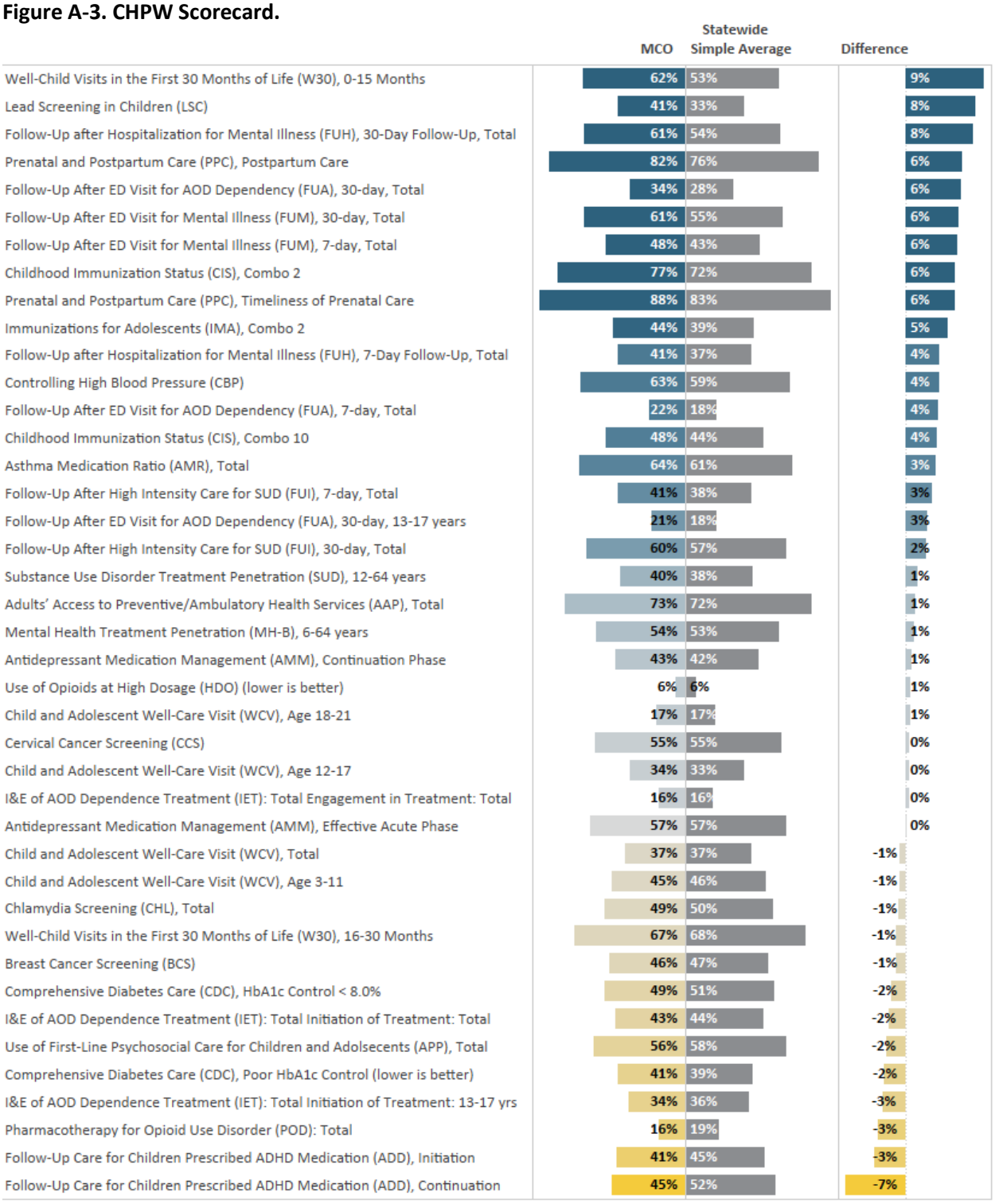
Table A-4. AMG's Performance Measure Strengths and Weaknesses/Opportunities for Improvement.

Performance Measures	
Strengths	**Weaknesses/Opportunities for Improvement**
Access to Care • Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET), Total: Initiation of AOD Treatment: 13-17 Years is 5% above the state average. • Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET), Total: Initiation of AOD Treatment: Total was above the state average. **Behavioral Health** • Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependencies (FUA), 30-Day Follow-Up, 13-17 Years is 5% above the state average.	**Access to Care** • Prenatal and Postpartum Care (PPC) measures are both 4% below the state average. **Behavioral Health Medication Management** • Follow-Up After Emergency Department Visit for Mental Illness (FUM), Total is 10% below the state average for both the 7-Day and 30-Day Follow-Up components. • Follow-Up after Hospitalization for Mental Illness (FUH), Total is below the state average for both the 7-Day and 30-Day Follow-Up components. • Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), Total is below the state average. • Antidepressant Medication Management (AMM) is below the state average for both the Effective Acute Phase and Continuation Phase components. **Preventive Care** • Breast Cancer Screening (BCS) and Cervical Cancer Screenings (CCS) fell below the state average.

Community Health Plan of Washington (CHPW) Profile

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

Figure A-3. CHPW Scorecard.



Summary of Results for the Compliance, PIP and Performance Measure Reviews: CHPW

Table A-5. Summary of CHPW's MCP 2021 Compliance Review Results.

Compliance with Regulatory and Contractual Standards				
Standard	**MCO Score/Possible**	**%**	**BHSO Score/Possible**	**%**
Element: Quality, Access and Timeliness **§438.56 - Disenrollment: Requirements and limitations**	3/3	100	3/3	100
Weaknesses/Opportunities for Improvement • No improvements needed. Continue to demonstrate compliance.				
Element: Quality, Access and Timeliness **§438.210 - Coverage and authorization of service**	12/15	80	12/15	80

Weaknesses/Opportunities for Improvement
CHPW-MCO and CHPW-BHSO should focus improvement efforts on:
• Authorization of services
  ○ Ensure that consultation with the requesting provider is completed for adverse benefit determinations concerning medical necessity or other clinical issues, prior to denying or modifying services, is documented
  ○ Ensure MDs and other determining reviewers look at and perform a complete review of submitted medical records when making a final determination decision
  ○ Provide additional staff training as needed
  ○ Provide ongoing monitoring
• Notice of adverse benefit determination
  ○ Include notification requirements within the Notice of Adverse Benefit Determination that include the required elements in the CFR and contract
  ○ Ensure that documents are easily understood and including all requirement elements				

Element: Quality, Access and Timeliness **§438.230 - Subcontractual Relationships and Delegation**	10/12	83	10/12	83

Weaknesses/Opportunities for Improvement
CHPW-MCO and CHPW-BHSO should focus improvement efforts on:
• Subcontractual relationships and delegation – written agreement
  ○ Provide delegation activity details to HCA
  ○ Ensure that delegation agreements are provided to HCA for review and approval				

Element: Quality and Timeliness **§438.242 - Health Information Systems**	9/9	100	9/9	100
Weakness/Opportunities for Improvement • No improvements needed. Continue to demonstrate compliance.				
Element: Quality **§438.608 - Program integrity requirements**	10/12	83	10/12	83
Weakness/Opportunities for Improvement CHPW-MCO and CHPW-BHSO should focus improvement efforts on: • Document submissions shall include Medicaid enrollment numbers as part of the justification of adequate staffing resources.				

Compliance with Regulatory and Contractual Standards				
Standard	**MCO Score/Possible**	**%**	**BHSO Score/Possible**	**%**
• Evidence of monthly screening for MCO/PIHP employees, owners, persons with a controlling interest and subcontractors for individual and entities excluded from federal financial participation for the year under review.				

Table A-6. Summary of CHPW's MCP 2020 Corrective Action Plans.

Review of 2020 MCP Corrective Action Plans	Not Met	Partially Met	Met
Element: Access **Standard: Availability of services**	–	–	5
Five elements reviewed for CAPs: • 438.206 Availability of Services (b)(1)(i-v) & (c) Delivery network, 438.10 (h) Information for all enrollees – Provider directory - 438.207 Assurances of adequate capacity and services – Met • 438.206 Availability of Services (b)(2) Direct access to a women's health specialist – Met • 438.206 Availability of Services (b)(3) Provides for a second opinion – Met • 438.206 Availability of Services (c) Furnishing of services (1)(i) through (vi) Timely access – Met • 438.206 Availability of Services (c)(2) Cultural considerations – Met			
Element: Quality and Access **Standard: Coordination and Continuity of Care**	–	–	1
One element reviewed for a CAP: • 438.208 Coordination and Continuity of Care (b) Primary care and coordination of health care services for all MCO/PIHP, PIHP enrollees and §438.224 Confidentiality – Met			
Element: Quality, Access and Timeliness **Standard: Coverage and Authorization of Services**	–	1	–
One element reviewed for a CAP: • 438.210 Coverage and Authorization of Services (c) Notice of adverse benefit determination – Partially Met*			
Element: Quality **Standard: Enrollee Rights and Protections**	–	–	6
Six elements reviewed for CAPs: • 438.100 Enrollee Rights (b)(2)(i) Specific rights - 438.10 (d) Language and format (3) – Met • 438.100 Enrollee Rights (b)(2)(i) Specific rights - 438.10(d)(6) Format, easily understood – Met • 438.100 Enrollee Rights (b)(2)(i) Specific rights - 438.10(d)(6)(iii) – Met • 438.100 Enrollee Rights (b)(2)(i) Specific rights - 438.10(f) (2) General requirements – Met • 438.100 Enrollee Rights (b)(2)(ii - iv) and (3) Specific rights – Met • 438.106 Liability for payment – Met			
Element: Quality and Timeliness **Standard: Grievance System**	–	–	1
One element reviewed for a CAP: • 438.402 General requirements (c)(2) Filing requirements – timing – Met			

**Future follow up required.*

Table A-7. Summary of CHPW's 2021 PIPs.

Performance Improvement Projects (PIPs)*			
Type	**PIP Name**	**Score/ Confidence**	**Statistical Significance**
Element: Access, Quality, Timeliness **Clinical:** AH-IMC/AH-IFC	Collaborative MCO Well-Child Visit Rate PIP	Partially Met Confidence in reported MCO PIP results	No Statistically Significant Change
Element: Access, Quality **Clinical:** Washington State Institute for Public Policy (AH-IMC/BHSO) – Adult	Promoting Wellness and Recovery with Peer Specialists	Partially Met Confidence in reported MCO PIP results	No Statistically Significant Change
Element: Access, Quality, Timeliness **Clinical:** Washington State Institute for Public Policy (AH-IMC) – Child	Implementation of the Collaborative Care Model in Pediatric Primary Care	Not Met Reported MCO PIP results not credible	No Statistically Significant Change
Element: Access, Quality **Non-Clinical:** AH-IMC/ BHSO	Depression Screening and Follow-up in Preferred Languages	Partially Met Low confidence in reported MCO PIP results	No Statistically Significant Change

**Please refer to Tables 10 and 12 for strengths and weaknesses/opportunities for improvement.*

Summary of Previous Year (2020) MCP PIP CAP

The response submitted by the MCP to the 2020 CAP was reviewed and accepted with the following response by HCA:

- **CHPW:** Met – Corrective action is completed. The MCP fulfilled the requirement to attend a one-hour technical assistance meeting had the meetings as required and demonstrated planned changes to their program (please refer to page 55 for the MCP's 2020 CAP).

Summary of 2021 MCP PIP CAP

Please refer to pages 55-57 for the summary of the MCP's CAP.

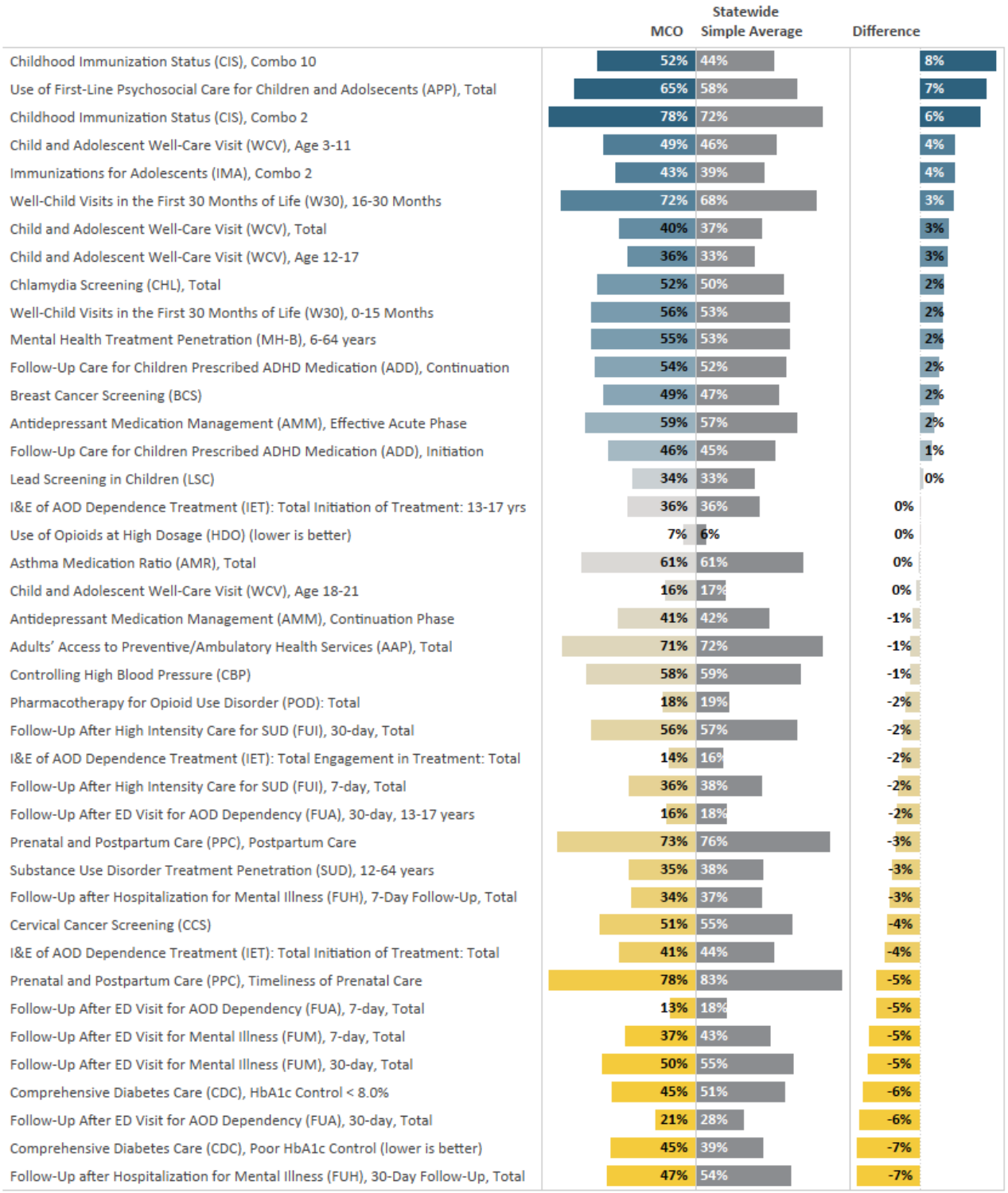
Table A-8. CHPW's Performance Measure Strengths and Weaknesses/Opportunities for Improvement.

Performance Measures	
Strengths	**Weaknesses/Opportunities for Improvement**
Access to Care • Prenatal and Postpartum Care (PPC) is above the state average for both the Timeliness of Prenatal Care and Postpartum Care components. • Well-Child Visits in the First 30 Months of Life (W30), 0-15 Months is 9% above the state average. **Behavioral Health** • Follow-Up after Hospitalization for Mental Illness (FUH), Total is above the state average for both the 7-Day and 30-Day Follow-Up components. The 30-Day Follow-Up component is especially high at 8% above the state average. • Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependencies (FUA), Total is above the state average for both the 7-Day and 30-Day Follow-Up components. • Follow-Up After Emergency Department Visit for Mental Illness (FUM), Total is above the state average for both the 7-Day and 30-Day Follow-Up components. **Chronic Care Management** • Controlling High Blood Pressure (CBP) is above the state average. **Preventive Care** • Lead Screening in Children (LSC) measure is 8% above the state average. • Childhood Immunization Status (CIS), Combo 2 and Combo 10 are above the state average. • Immunization for Adolescents (IMA), Combo 2 is above the state average.	**Behavioral Health** • Follow-Up Care for Children Prescribed ADHD Medication (ADD) is above the state average for both the Initiation and Continuation Components. The Initiation component is especially low at 7% below the state average. • Pharmacotherapy for Opioid Use Disorder (POD) is below the state average.

Coordinated Care of Washington (CCW) Profile

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

Figure A-4. CCW Scorecard.



Summary of Results for the Compliance, PIP and Performance Measure Reviews: CCW

Table A-8. Summary of CCW's MCP 2021 Compliance Review Results.

Compliance with Regulatory and Contractual Standards				
Standard	**MCO Score/Possible**	**%**	**BHSO Score/Possible**	**%**
Element: Quality, Access and Timeliness **§438.56 - Disenrollment: Requirements and limitations**	3/3	100	3/3	100
Weaknesses/Opportunities for Improvement • No improvements needed. Continue to demonstrate compliance.				
Element: Quality, Access and Timeliness **§438.210 - Coverage and authorization of service**	11/15	73	11/15	73

Weaknesses/Opportunities for Improvement
CCW-MCO and CCW-BHSO should focus improvement efforts on:
• Authorization of services
  ○ Ensure that consultation with the requesting provider is completed for adverse benefit determinations concerning medical necessity or other clinical issues, prior to denying or modifying services, is documented
  ○ All adverse benefit determinations will include documented evidence that the medical necessity determination followed the requirements and the coverage determination in regard to what was covered under the contract
  ○ Utilize appropriate practice guidelines or utilization management decision-making criteria for adverse benefit determinations
  ○ Provide additional staff training as needed
  ○ Provide ongoing monitoring
• Notice of adverse benefit determination
  ○ Notice of Adverse Benefit Determination will include all the required elements in the CFR and contract and be approved by HCA
  ○ Ensure that documents are easily understood and including all requirement elements				

Element: Quality, Access and Timeliness **§438.230 - Subcontractual Relationships and Delegation**	9/12	75	9/12	75

Weaknesses/Opportunities for Improvement
CCW-MCO and CCW-BHSO should focus improvement efforts on:
• Subcontractual relationships and delegation
  ○ Ensure all delegated entities are correctly identified and included in the Report of Delegated Entities
  ○ Develop and document a review process to ensure information is correct prior to submission
• MCO monitors subcontractors' performance
  ○ Include all acronyms and definitions in documentation
  ○ Ensure information provided is clear and understandable by the reviewer
  ○ Include the full name of their delegated entities as well as acronyms
• MCO identifies deficiencies and ensures corrective action is taken
  ○ Develop and document a review process to ensure information is correct prior to submission				

Compliance with Regulatory and Contractual Standards				
Standard	**MCO Score/Possible**	**%**	**BHSO Score/Possible**	**%**
Element: Quality and Timeliness **§438.242 - Health Information Systems**	9/9	100	9/9	100
Weakness/Opportunities for Improvement • No improvements needed. Continue to demonstrate compliance.				
Element: Quality **§438.608 - Program integrity requirements**	8/12	67	8/12	67

Weakness/Opportunities for Improvement
CCW-MCO and CCW-BHSO should focus improvement efforts on:
• Program integrity requirements
  ○ Training documents should include reference to CFR requirement
  ○ Utilize the Payment Assistance Request Form (PARF) as required in the contract
  ○ Ensure verification of submitted claims and provide documentation of the quantity and frequency
• Provider Payment Suspension
  ○ Ensure the provider payment suspension letter includes all the required elements
• Social Security Act (SSA) section 1903(i)(2) of the Act; 42 CFR 455.104, 42 CFR 455.106, and 42 CFR 1001.1901(b) - Excluded Individuals and Entities
  ○ Include subcontractor(s) in evidence of monthly screening for MCO/PIHP employees, owners, persons with a controlling interest, and subcontractors for individual and entities excluded from federal financial participation for the year under review.				

Table A-9. Summary of CCW's MCP 2020 Corrective Action Plans.

Review of 2020 MCP Corrective Action Plans	Not Met	Partially Met	Met
Element: Access **Standard: Availability of services**	–	–	5
Five elements reviewed for CAPs: • 438.206 Availability of Services (b)(1)(i-v) & (c) Delivery network, 438.10 (h) Information for all enrollees – Provider directory - 438.207 Assurances of adequate capacity and services – Met • 438.206 Availability of Services (b)(2) Direct access to a women's health specialist – Met • 438.206 Availability of Services (b)(4) Services out of network – Met • 438.206 Availability of Services (b)(5) Out-of-network payment – Met • 438.206 Availability of Services (c)(2) Cultural considerations – Met			
Element: Quality and Access **Standard: Coordination and Continuity of Care**	–	–	1
One element reviewed for a CAP: • 438.208 Coordination and Continuity of Care (b) Primary care and coordination of health care services for all MCO/PIHP, PIHP enrollees and §438.224 Confidentiality – Met			
Element: Quality, Access and Timeliness **Standard: Coverage and Authorization of Services**	–	–	3

Review of 2020 MCP Corrective Action Plans	Not Met	Partially Met	Met
Three elements reviewed for CAPs: • 438.210 Coverage and Authorization of Services (b) Authorization of services – Met • 438.210 Coverage and Authorization of Services (c) Notice of adverse benefit determination – Met • 438.210 Coverage and Authorization of Services (d) Timeframe for decisions – Met			
Element: Quality **Standard: Enrollee Rights and Protections**	–	–	2
Two elements reviewed for CAPs: • 438.100 Enrollee Rights (b)(2)(ii - iv) and (3) Specific rights – Met • 438.100 Enrollee Rights (d) Compliance with other Federal and State laws – Met			
Element: Quality and Timeliness **Standard: Grievance System**	–	–	1
One element reviewed for a CAP: • 438.408 Resolution and notification: Grievances and appeals (d) and (e) Format of notice and content of notice of appeal resolution – Met			
Element: Quality **Standard: Quality Assessment and Performance Improvement Program (QAPI)**	–	–	1
One element reviewed for a CAP: • 438. 330 (e)(2) QAPI Program evaluation – Met			

Table A-10. Summary of CCW's 2021 PIPs.

Performance Improvement Projects (PIPs)*			
Type	**PIP Name**	**Score/ Confidence**	**Statistical Significance**
Element: Access, Quality, Timeliness **Clinical:** AH-IMC/AH-IFC	Collaborative MCO Well-Child Visit Rate PIP	Partially Met Confidence in reported MCO PIP results	No Statistically Significant Change
Element: Access, Quality, Timeliness **Clinical:** Washington State Institute for Public Policy (AH-IMC/BHSO) – Adult	Improving Continuity of Cognitive Behavioral Therapy Services for Medicaid/BHSO members ages 19-64	Partially Met Confidence in reported MCO PIP results	No Statistically Significant Change
Element: Access, Quality, Timeliness **Clinical:** Washington State Institute for Public Policy (AH-IMC/BHSO) – Child	Improving Continuity of Cognitive Behavioral Therapy Services for Medicaid/BHSO members ages 12-18	Partially Met Confidence in reported MCO PIP results	No Statistically Significant Change

Performance Improvement Projects (PIPs)*			
Type	**PIP Name**	**Score/ Confidence**	**Statistical Significance**
Element: Access, Quality **Non-Clinical:** AH-IMC	Improving the Timeliness of Postpartum Visits Following Live Births – Within 7-84 Days	Met High confidence in reported MCO PIP results	Statistically Significant Change
Element: Quality **Non-Clinical:** AH-IMC	Improving Reporting Of EBP Codes for Integrated Managed Care and Behavioral Health Services Only Members Receiving Mental Health Evidence-Based Practices Services	Partially Met Confidence in reported MCO PIP results	Statistically Significant Change
Element: Access, Quality, Timeliness **Non-Clinical:** AH-IFC	Improve Asthma Medication Adherence	Partially Met Confidence in reported MCO PIP results	Statistically Significant Change
Element: Access, Quality **Non-Clinical:** Tribal IFC	Improving Administrative Coordination/Collaboration of Care Services for American Indian/Alaska Native Children and Youth in Foster Care Between Coordinated Care of Washington, Inc., Department of Children, Youth, and Families, and the Health Care Authority	Partially Met Enough time has not elapsed to assess meaningful change	No Statistically Significant Change

**Please refer to Tables 10 and 12 for strengths and weaknesses/opportunities for improvement.*

Summary of Previous Year (2020) MCP PIP CAP

The response submitted by the MCP to the 2020 CAP was reviewed and accepted with the following response by HCA:

- **MHW**: Met. Corrective action is completed (please refer to page 55 for the MCP's 2020 CAP).

Summary of 2021 MCP PIP CAP

Please refer to pages 55-57 for the summary of the MCP's CAP.

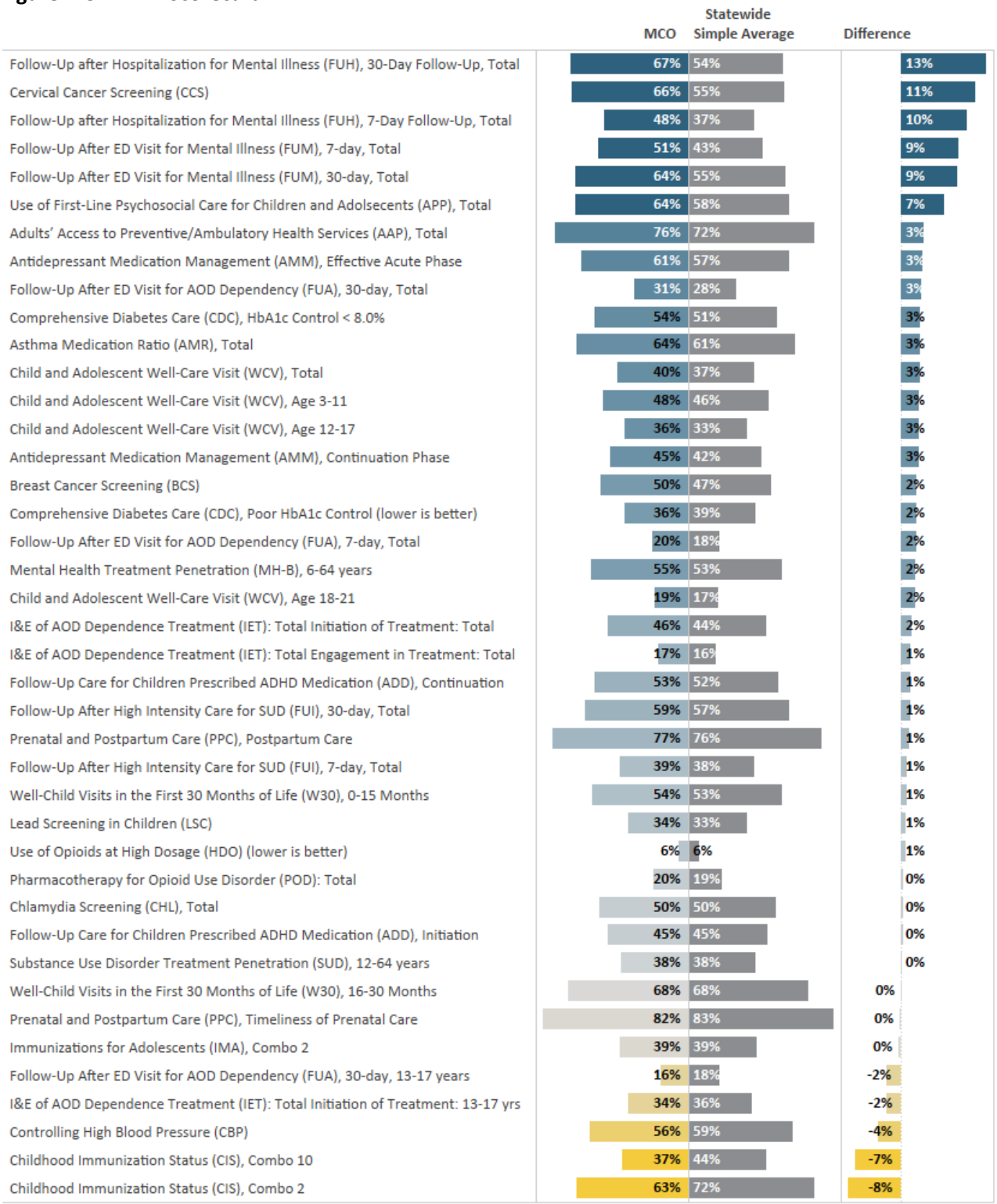
Table A-11. CCW's Performance Measure Strengths and Weaknesses/Opportunities for Improvement.

Performance Measures	
Strengths	**Weaknesses/Opportunities for Improvement**
Access to Care • Child and Adolescent Well-Care Visit (WCV) are above the state average for both the 3-11 and 12-17 years age bands. • Well-Child Visits in the First 30 Months of Life (W30) is above the state average for both the 0-15 month and 16-30 month age bands. **Preventive Care** • Childhood Immunization Status (CIS) is above the state average for both Combo 2 and Combo 10. Combo 10 is especially high at 8% above the state average. • Immunizations for Adolescents (IMA), Combo 2 is above the state average. **Behavioral Health** • Use of First-Line Psychosocial Care for Children and Adolescents (APP), Total measure is 7% above the state average.	**Access to Care** • Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care measure is well below the state average. • Prenatal and Postpartum Care (PPC), Postpartum Care measure is well below the state average. **Behavioral Health** • Follow-Up after Hospitalization for Mental Illness (FUH), Total is below the state average for both the 7-Day and 30-Day Follow-Up components. The 30-Day Follow-Up component is especially low at 7% below the state average. • Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependencies (FUA), Total is below the state average for both the 7-Day and 30-Day Follow-Up components. • Follow-Up After Emergency Department Visit for Mental Illness (FUM), Total is below the state average for both the 7-Day and 30-Day Follow-Up components. **Chronic Care Management** • Comprehensive Diabetes Care (CDC), Poor HbA1c Control is 7% below the state average • Similar to the Poor HbA1c Control measure, Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0% is 6% below the state average.

Molina Healthcare of Washington (MHW) Profile

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

Figure A-5. MHW Scorecard.



Summary of Results for the Compliance, PIP and Performance Measure Reviews: MHW

Table A-12. Summary of MHW's MCP 2021 Compliance Review Results.

Compliance with Regulatory and Contractual Standards				
Standard	**MCO Score/Possible**	**%**	**BHSO Score/Possible**	**%**
Element: Quality, Access and Timeliness **§438.56 - Disenrollment: Requirements and limitations**	3/3	100	3/3	100
Weaknesses/Opportunities for Improvement • No improvements needed. Continue to demonstrate compliance.				
Element: Quality, Access and Timeliness **§438.210 - Coverage and authorization of service**	7/15	47	9/15	60

Weaknesses/Opportunities for Improvement
MHW-MCO and MHW-BHSO should focus improvement efforts on:
• Authorization of services
  ○ Ensure that consultation with the requesting provider is completed for adverse benefit determinations concerning medical necessity or other clinical issues, prior to denying or modifying services, is documented
  ○ Ensure denials are appropriate and include the medical necessity determination followed the requirements and the coverage determination was appropriate in regard to what was covered under the contract, including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) coverage requirements
  ○ Provide additional staff training as needed
  ○ Provide ongoing monitoring
• Notice of adverse benefit determination
  ○ Include notification requirements within the Notice of Adverse Benefit Determination that include the required elements in the CFR and contract
  ○ Ensure that documents are easily understood and including all requirement elements
• Timeframe for decisions
  ○ Ensure that the timeframes for authorization are appropriate to the enrollee's health condition (standard or expedited), per Contractual requirements, and if the timeframe was extended, it is documented and appropriate
  ○ Provide additional staff training as needed
  ○ Provide ongoing monitoring				

Element: Quality, Access and Timeliness **§438.230 - Subcontractual Relationships and Delegation**	12/12	100	12/12	100
Weaknesses/Opportunities for Improvement • No improvements needed. Continue to demonstrate compliance.				
Element: Quality and Timeliness **§438.242 - Health Information Systems**	9/9	100	9/9	100
Weakness/Opportunities for Improvement • No improvements needed. Continue to demonstrate compliance.				

Compliance with Regulatory and Contractual Standards				
Standard	**MCO Score/Possible**	**%**	**BHSO Score/Possible**	**%**
Element: Quality **§438.608 - Program integrity requirements**	8/12	67	8/12	67

Weakness/Opportunities for Improvement
MHW-MCO and MHW-BHSO should focus improvement efforts on:
• Program integrity requirements
  ○ Provide an updated policy to clarify the requirements of contract Section 12.9 are met regarding submission of program integrity activity correspondence to HCA. The policy should include the process to ensure courtesy copies of MCO/BHSO Fraud, Waste and Abuse correspondence sent to providers and subcontractors are submitted to HCA through MC-Track as required.
  ○ Training documents should include reference to CFR requirement
  ○ Utilize the Payment Assistance Request Form (PARF) as required in the contract
  ○ Ensure verification of submitted claims and provide documentation of the quantity and frequency
• Provider Payment Suspension
  ○ Summary reports of provider payment suspension actions during the contract period under review should include all relevant elements.
  ○ Provider payment suspension letters will include information of the provider's right to submit written evidence for consideration by the state Medicaid agency.
  ○ Ensure policy and procedure (MHI-SIU-101 Administrative Actions) are in alignment with the Washington State IMC contract and states that HCA determines if there is good cause to not suspend payments, not the MCOs.				

Table A-13. Summary of MHW's MCP 2020 Corrective Action Plans.

Review of 2020 MCP Corrective Action Plans	Not Met	Partially Met	Met
Element: Access **Standard: Availability of services**	–	–	4
Four elements reviewed for CAPs: • 438.206 Availability of Services (b)(1)(i-v) & (c) Delivery network, 438.10 (h) Information for all enrollees – Provider directory - 438.207 Assurances of adequate capacity and services – Met • 438.206 Availability of Services (b)(3) Provides for a second opinion – Met • 438.206 Availability of Services (c) Furnishing of services (1)(i) through (vi) Timely access – Met • 438.206 Availability of Services (c)(2) Cultural considerations – Met			
Element: Quality and Access **Standard: Coordination and Continuity of Care**	–	–	1
One element reviewed for a CAP: • 438.208 Coordination and Continuity of Care (b) Primary care and coordination of health care services for all MCO/PIHP, PIHP, and enrollees and §438.224 Confidentiality – Met			
Element: Quality, Access and Timeliness **Standard: Coverage and Authorization of Services**	2	–	1

Review of 2020 MCP Corrective Action Plans	Not Met	Partially Met	Met
Three elements reviewed for CAPs: • 438.210 Coverage and Authorization of Services (b) Authorization of services – Not Met* *(Repeat Finding)* • 438.210 Coverage and Authorization of Services (c) Notice of adverse benefit determination – Met • 438.210 Coverage and Authorization of Services (d) Timeframe for decisions – Not Met* *(Repeat Finding)*			
Element: Quality **Standard: Enrollee Rights and Protections**	–	–	2
Two elements reviewed for CAPs: • 438.100 Enrollee Rights (b)(2)(i) Specific rights - 438.10(f) (2) General requirements – Met • 438.106 Liability for payment – Met			
Element: Quality and Timeliness **Standard: Grievance System**	–	–	3
Three elements reviewed for CAPs: • 438.406 Handling of grievances and appeals (a) General requirements – Met • 438.408 Resolution and notification: Grievances and appeals (b) and (c) Specific timeframes and extension of timeframes – Met • 438.408 Resolution and notification: Grievances and appeals (d) and (e) Format of notice and content of notice of appeal resolution – Met			

**Future follow up required.*

Table A-14. Summary of MHW's 2021 PIPs.

Performance Improvement Projects (PIPs)*			
Type	**PIP Name**	**Score/ Confidence**	**Statistical Significance**
Element: Access, Quality, Timeliness **Clinical:** AH-IMC/AH-IFC	Collaborative MCO Well-Child Visit Rate PIP	Partially Met Confidence in reported MCO PIP results	No Statistically Significant Change
Element: Access, Quality, **Clinical:** Washington State Institute for Public Policy (AH-IMC/BHSO) – Adult	Increasing the number of members on Medication Assisted Treatment, who have a diagnosis of Opioid Use Disorder	Met High confidence in reported MCO PIP results	Statistically Significant Change
Element: Quality **Clinical:** Washington State Institute for Public Policy (AH-IMC) – Child	Increasing the Number of Pediatric Members Receiving Evidence Based Behavioral Health Services	Partially Met Confidence in reported MCO PIP results	No Statistically Significant Change
Element: Access, Quality, Timeliness **Non-Clinical:** AH-IMC	Improving Timely Access to Care	Not Met	No Statistically Significant Change

Performance Improvement Projects (PIPs)*			
Type	**PIP Name**	**Score/ Confidence**	**Statistical Significance**
		Confidence in reported MCO PIP results	
Element: Quality **Non-Clinical:** AH-IMC/ BHSO	Improving Member Experience for BHSO Adult Members	Not Met Enough time has not elapsed to assess meaningful change	No Statistically Significant Change

**Please refer to Tables 10 and 13 for strengths and weaknesses/opportunities for improvement.*

Summary of Previous Year (2020) MCP PIP CAP

The response submitted by the MCP to the 2020 CAP was reviewed and accepted with the following response by HCA:

- **MHW**: Met. Corrective action is completed (please refer to page 55 for the MCP's 2020 CAP).

Summary of 2021 MCP PIP CAP

Please refer to pages 55-57 for the summary of the MCP's CAP.

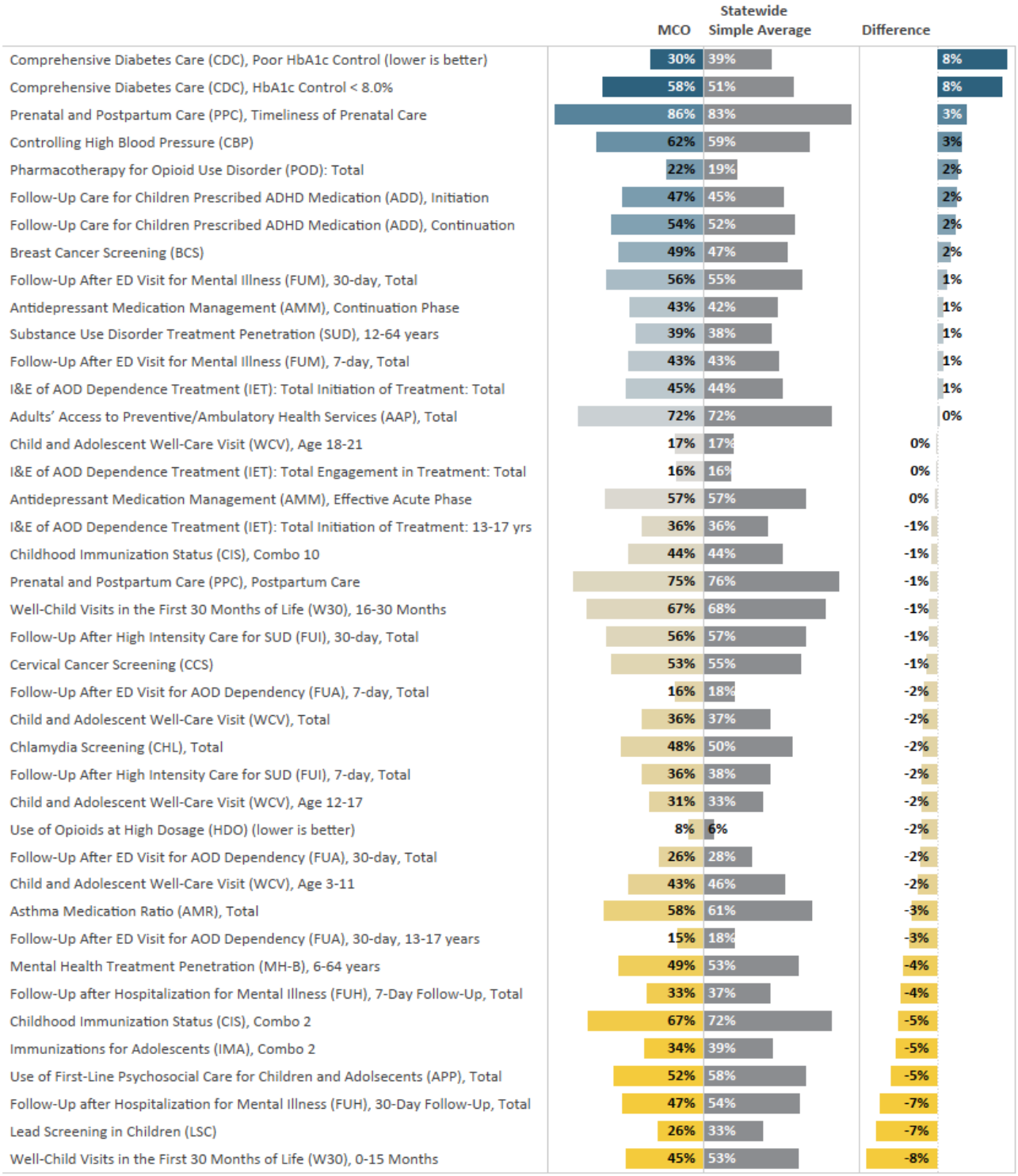
Table A-15. MHW's Performance Measure Strengths and Weaknesses/Opportunities for Improvement.

Performance Measures	
Strengths	**Weaknesses/Opportunities for Improvement**
Behavioral Health • Follow-Up after Hospitalization for Mental Illness (FUH), Total is above the state average for both the 7-Day and 30-Day Follow-Up components. The 7-Day Follow-Up component is 10% above the state average; the 30-Day Follow-Up component is 13% above the state average. • Follow-Up After Emergency Department Visit for Mental Illness (FUM), Total for both the 7-Day and 30-Day Follow-Up components. Both components are 9% above the state average. • Use of First-Line Psychosocial Care for Children and Adolescents (APP), Total measure is 7% above the state average. **Preventive Care** • Cervical Cancer Screening (CCS) measure is 11% above the state average.	**Chronic Care Management** • Controlling High Blood Pressure (CBP) is 4% below the state average. **Preventive Care** • Childhood Immunization Status (CIS), Combo 2 measure is 8% below the state average. • Childhood Immunization Status (CIS), Combo 10 measure is 7% below the state average.

UnitedHealthcare Community Plan (UHC) Profile

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

Figure A-6. UHC Scorecard.



Summary of Results for the Compliance, PIP and Performance Measure Reviews: UHC

Table A-16. Summary of UHC's MCP 2021 Compliance Review Results.

Compliance with Regulatory and Contractual Standards				
Standard	**MCO Score/Possible**	**%**	**BHSO Score/Possible**	**%**
Element: Quality, Access and Timeliness **§438.56 - Disenrollment: Requirements and limitations**	3/3	100	3/3	100
Weaknesses/Opportunities for Improvement • No improvements needed. Continue to demonstrate compliance.				
Element: Quality, Access and Timeliness **§438.210 - Coverage and authorization of service**	12/15	80	12/15	80

Weaknesses/Opportunities for Improvement
UHC-MCO and UHC-BHSO should focus improvement efforts on:
• Authorization of services
  ○ Ensure denials are appropriate and include the medical necessity determination followed the requirements and the coverage determination was appropriate in regard to what was covered under the contract, including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) coverage requirements
  ○ Provide evidence that referral to care coordination services to address unmet care needs or other indicators of special health care needs (as appropriate) are offered to enrollees
  ○ Document that transitional care services are provided to enrollees transitioning from one care setting to another.
  ○ Provide additional staff training as needed
  ○ Provide ongoing monitoring
• Notice of adverse benefit determination
  ○ Notice of Adverse Benefit Determination will include all the required elements in the CFR and contract and be approved by HCA
  ○ Ensure that documents are easily understood and including all requirement elements				

Element: Quality, Access and Timeliness **§438.230 - Subcontractual Relationships and Delegation**	7/12	58	7/12	58

Weaknesses/Opportunities for Improvement
UHC-MCO and UHC-BHSO should focus improvement efforts on:
• Subcontractual relationships and delegation
  ○ Develop and policy and procedure used to evaluate potential subcontractor's ability to perform delegated activities
• MCO monitors subcontractors' performance
  ○ Provide complete and final meeting minutes and/or other documents that show evidence of the monitoring of delegated entities
  ○ Policy and procedure will describe the process used to monitor delegated entities to include how often monitoring occurs
  ○ Develop and provide the most recent finalized reports that clearly documents the questions and answers for the monitoring of the entities delegated for the required activities
• MCO identifies deficiencies and ensures corrective action is taken				

Compliance with Regulatory and Contractual Standards				
Standard	**MCO Score/Possible**	**%**	**BHSO Score/Possible**	**%**
○ Provide documentation that describes the expectation of the responsibility of the committee(s) responsible for overseeing corrective action of delegated functions ○ Include a standing agenda item for the committee meetings related to monitor and oversight corrective action of delegated functions ○ Policy and procedure will describe the process used to address the implementation of corrective actions identified from the monitoring process of delegated and/or full risk contracts or agreements				
Element: Quality and Timeliness **§438.242 - Health Information Systems**	9/9	100	9/9	100
Weakness/Opportunities for Improvement • No improvements needed. Continue to demonstrate compliance.				
Element: Quality **§438.608 - Program integrity requirements**	7/12	58	7/12	58
Weakness/Opportunities for Improvement UHC-MCO and UHC-BHSO should focus improvement efforts on: • Program integrity requirements ○ Documentation will include staff names and FTE levels assigned in the PI and SIU departments who are dedicated to identifying fraud, waste, and abuse ○ Training documents should include reference to CFR requirement ○ Utilize the Payment Assistance Request Form (PARF) as required in the contract • Disclosure of ownership and control ○ Document process for collection ownership or control interest disclosures forms from all subcontractors including which department is responsible for the oversight of the process • Provider Payment Suspension ○ Ensure documentation references which HCA letter is included with the letter				

Table A-17. Summary of UHC's MCP 2020 Corrective Action Plans.

Review of 2020 MCP Corrective Action Plans	Not Met	Partially Met	Met
Element: Access **Standard: Availability of services**	–	–	3
Three elements reviewed for CAPs: • 438.206 Availability of Services (b)(1)(i-v) & (c) Delivery network, 438.10 (h) Information for all enrollees – Provider directory - 438.207 Assurances of adequate capacity and services – Met • 438.206 Availability of Services (b)(5) Out-of-network payment – Met • 438.206 Availability of Services (c) Furnishing of services (1)(i) through (vi) Timely access – Met			
Element: Quality, Access and Timeliness **Standard: Coverage and Authorization of Services**	–	1	–
One element reviewed for a CAP: • 438.210 Coverage and Authorization of Services (c) Notice of adverse benefit determination – Partially Met*			
Element: Quality **Standard: Enrollee Rights and Protections**	–	–	2

Review of 2020 MCP Corrective Action Plans	Not Met	Partially Met	Met
Two elements reviewed for CAPs: • 438.100 Enrollee Rights (a) - General rule – Met • 438.100 Enrollee Rights (b)(2)(i) Specific rights - 438.10(f) (2) General requirements – Met			
Element: Quality and Timeliness **Standard: Grievance System**	–	–	4
Two elements reviewed for CAPs: • 438.404 Timely and adequate notice of adverse benefit determination (b) Notice of action - content of notice – Met • 438.406 Handling of grievances and appeals (a) General requirements – Met • 438.408 Resolution and notification: Grievances and appeals (a) basic rule – Met • 438.408 Resolution and notification: Grievances and appeals (b) and (c) Specific timeframes and extension of timeframes – Met			

**Future follow-up required.*

Table A-18. Summary of UHC's 2021 PIPs.

Performance Improvement Projects (PIPs)*			
Type	**PIP Name**	**Score/ Confidence**	**Statistical Significance**
Element: Access, Timeliness **Clinical:** AH-IMC/AH-IFC	Collaborative MCO Well-Child Visit Rate PIP	Partially Met Confidence in reported MCO PIP results	No Statistically Significant Change
Element: Access, Timeliness **Clinical:** Washington State Institute for Public Policy (AH-IMC) – Adult	Increase Anti-Depressant Treatment Plan Compliance for IMC members diagnosed with depression (anti-depressant medication management, AMM)	Partially Met Low confidence in reported MCO PIP results	The MCO did not supply results of the statistical tests
Element: Access, Timeliness **Clinical:** Washington State Institute for Public Policy (AH-IMC/BHSO) – Adult	BHSO Clinical - Jail Transition and Assertive Community Treatment (JTACT)	Not Met Reported MCO PIP results not credible	No Statistically Significant Change
Element: Access, Timeliness **Non-Clinical:** Washington State Institute for Public Policy (AH-IMC) – Child	Increasing the ADD (ADHD Medication Adherence) Initiation Phase HEDIS Measure Rate	Met Low confidence in reported MCO PIP results	No Statistically Significant Change
Element: Quality **Non-Clinical:** AH-IMC/ BHSO	Improving Member Experience for BHSO Adult Members	Not Met	The MCO claims statistically significant improvement

Performance Improvement Projects (PIPs)*			
Type	**PIP Name**	**Score/ Confidence**	**Statistical Significance**
		Enough time has not elapsed to assess meaningful change	but does not show the test or the p-value.
Element: Access, Quality **Non-Clinical:** AH-IMC/ BHSO	Increasing The Rate of Members Receiving Diabetic Education Services	Partially Met Enough time has not elapsed to assess meaningful change	No Statistically Significant Change
Element: Access, Quality **Non-Clinical:** AH-IMC/ BHSO	BHSO Coordination of Care Between Behavioral Health and Referring Providers (BHSO non-clinical)	Partially Met Confidence in reported MCO PIP results	No Statistically Significant Change

**Please refer to Tables 10 and 14 for strengths and weaknesses/opportunities for improvement.*

Summary of Previous Year (2020) MCP PIP CAP

The response submitted by the MCP to the 2020 CAP was reviewed and accepted with the following response by HCA:

- **UHC**: Met. Corrective action is completed (please refer to page 55 for the MCP's 2020 CAP). There is a slight improvement in overall PIP scores this year.

Summary of 2021 MCP PIP CAP

Please refer to pages 55-57 for the summary of the MCP's CAP.

Table A-19. UHC's Performance Measure Strengths and Weaknesses/Opportunities for Improvement.

Performance Measures	
Strengths	**Weaknesses/Opportunities for Improvement**
Access to Care • Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care measure is above the state average. **Chronic Care Management** • Comprehensive Diabetes Care (CDC), Poor HbA1c Control is especially strong at 8% above the state average • Similar to the Poor HbA1c Control measure, Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0% is also 8% above the state average. • Controlling High Blood Pressure (CBP) is above the state average	**Access to Care** • Well-Child Visits in the First 30 Months of Life (W30), 0-15 Months is below the state average. **Behavioral Health** • Follow-Up after Hospitalization for Mental Illness (FUH), Total is below the state average for both the 7-Day and 30-Day components. The 30-Day component is especially low at 7% below the state average. • Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), Total is below the state average. • Mental Health Treatment Penetration (MH-B), 6-64 years is below the state average. **Preventive Care** • Lead Screening in Children (LSC) measure is below the state average. • Childhood Immunization Status (CIS), Combo 2 and Combo 10 are below the state average. • Immunization for Adolescents (IMA), Combo 2 is below the state average.

Appendix B: Compliance Regulatory and Contractual Requirements

Compliance Review and Manner of Reporting

Federal regulations require managed care plans (MCPs) to undergo a review at least once every three years to determine MCP compliance with federal standards as implemented by the state. States may choose to review all applicable standards at once or may spread the review over a three-year cycle in any manner they choose (for example, fully reviewing a third of plans each year or conducting a third of the review on all plans each year). In Washington, the MCPs are reviewed on a three-year cycle where HCA rotates different areas of the review to ensure all areas are reviewed within this time.

Objectives

The purpose of the compliance review is to determine whether Medicaid managed care plans are in compliance with federal standards. The U.S. Department of Health & Human Services (HHS) developed standards for managed care plans, including 42 CFR §438 and 42 CFR §457.[32,33]

Technical Methods of Data Collection

TEAMonitor provides detailed instructions to MCPs regarding the document submission and review process. These instructions include the electronic submission process, file review submission/ instructions, and timelines. Required documentation is submitted to TEAMonitor for review.

Description of Data Obtained

Documents obtained and reviewed include those for monitoring of a wide variety of programmatic documents depending on the area of focus, such as program descriptions, program evaluations, policies and procedures, meeting minutes, desk manuals, data submissions, narrative reflection on progress, reports, MCP internal tracking tools or other MCP records.

The File review documentation for EQR purposes includes, the categories listed below, as appropriate:

- Denials-Adverse Benefit Determinations/Actions
- Appeals, including the denial portion of the file
- Grievances
- Care Coordination
- Provider Credentialing

Data Aggregation and Analysis

Washington's MCPs are evaluated by TEAMonitor, an interagency team, which provides formal oversight and monitoring activities on their compliance with federal and state regulatory and contractual standards. The TEAMonitor reviews consist of a document review, file review and an onsite/virtual visit. The TEAMonitor process includes:

[32] Electronic Code of Federal Regulations. Title 42, part 438 – Managed Care. Available here: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438?toc=1

[33] Electronic Code of Federal Regulations. Title 42, part 457 Allotments and Grants to States. Available here: https://www.ecfr.gov/cgi-bin/text-idx?SID=60f9f0f14136be95a1cee250074ae00d&mc=true&node=pt42.4.457&rgn=div5

- Document Request/Document Submission
- Desk Review/File Review
    - The desk review includes review of documentation provided (see Description of Data Obtained, above).
    - The file review is incorporated into the relevant area of review. Each category has a checklist with 12-40 questions for each file reviewed. Five to ten files are reviewed per category per MCP. Files are reviewed in-depth to ensure key elements are handled appropriately, required timeframes were met, and identify whether there are opportunities the MCP can improve upon.
- Any findings are supported by evidence and provided to MCPs to prepare a response
- Onsite/Virtual visit - TEAMonitor staff visit each MCP's in-state headquarters (when appropriate). The agenda is to verbally report on the findings from the document and file review, provide feedback on trends or changes in MCP performance from the previous year, discuss any themes within the findings, and listen to MCP responses to HCA interview questions. The interview questions are developed to obtain information on emerging issues, key areas of interest, or MCP activities not included in the document review.
- Formal written reports and scores are provided to the MCP after completion of the document review, file review and onsite visit. This report provides detail on findings and sets written expectations on what corrective action is required. Each section within each area of focus is scored and tracked from year to year. Also, HCA identifies MCP best practices to be shared with permission to improve performance of other MCPs.

Regulations Subject to Compliance Review

The standards that are the subject to compliance review are contained in the Code of Federal Regulations (CFR), Title 42 Part 438, Subparts D and E. The scope of those sections includes:

- Availability of services §438.206
- Assurances of adequate capacity and services §438.207
    - TEAMonitor reviews this standard in conjunction with §438.206(b)(1)(i-v) & (c) Delivery network and §438.10 (h) Information for all enrollees – Provider directory
- Coordination and continuity of care §438.208
- Coverage and authorization of services §438.210
- Provider selection §438.214
- Confidentiality §438.224
    - TEAMonitor reviews this standard in conjunction within the review of §438.208(b)
- Grievance and appeal systems §438.228
- Subcontractual relationships and delegation §438.230
- Practice guidelines §438.236
- Health information systems §438.242
    - Using the NCQA-standardized HEDIS audit methodology, NCQA-certified HEDIS auditors assessed each MCO's information systems capabilities and compliance with HEDIS specifications. HCA and each MCO received onsite and final reports of all HEDIS audit activity.
- Quality assessment and performance improvement program (QAPI) §438.330

Regulatory and Contractual Requirements

The following is a list of the access, quality and timeliness elements cited in 42 CFR Chapter IV Subchapter C Part 438, that comprise the three-year review cycle of Apple Health MCPs.

In addition, plans are reviewed on elements that received Partially Met or Not Met scores in previous reviews until the finding is satisfied.

438.56 - Disenrollment: Requirements and limitations*

438.56(b)(1- 3) Disenrollment requested by the MCO, PIHP. Involuntary Termination Initiated by the Contractor

438.100 - Enrollee rights

438.100(a) - General rule

438.100(b)(2)(i) Specific rights - 438.10(c) Basic rules

438.100(b)(2)(i) Specific rights - 438.10(d)(3) Language and format

438.100(b)(2)(i) Specific rights - 438.10(d)(4) Language and format and (5) Language – oral interpretation/written information

438.100(b)(2)(i) Specific rights - 438.10(d)(6) Format, easily understood

438.100(b)(2)(i) Specific rights - 438.10(d)(6)(iii)

438.100(b)(2)(i) Specific rights - 438.10(f)(2) General requirements

438.100(b)(2)(i) Specific rights - 438.10(g)(1 - 4) Information for enrollees – Enrollee Handbook

438.100(b)(2)(i) Specific rights - 438.10(i) Information for enrollees – Formulary

438.100(b)(2)(ii - iv)(3) Specific rights

438.100(d) Compliance with other federal and state laws

438.106 Liability for payment

438.114 Emergency and post stabilization services*

(TEAMonitor reviews this standard in conjunction with §438.210 Coverage and authorization of services)

438.206 - Availability of services

438.206(b)(1)(i-v)(c) Delivery network - 438.10(h) Information for all enrollees - Provider directory

438.206 (b)(2) Direct access to a women's health specialist

438.206(b)(3) Provides for a second opinion

438.206(b)(4) Services out of network

438.206(b)(5) Out-of-network payment

438.206(c) Furnishing of services (1)(i)(vi) Timely access

438.206(c)(2) Cultural considerations

438.207 - Assurances of adequate capacity and services

(TEAMonitor reviews this standard in conjunction with §438.206(b)(1)(i-v) & (c) Delivery network and §438.10 (h) Information for all enrollees – Provider directory)

**Standards subject to the current review period by TEAMonitor. Appendix E lists the schedule for review of the remaining standards and a summary of findings from all previous reviews within the current review cycle.*

438.207(a) General rule

438.207(b) Nature of supporting documents

438.207(c) Timing of documentation

438.208 Coordination and continuity of care

438.208 Continuity of Care - File review

438.208(b) Primary care and coordination of health care services for all MCO/PIHP, PIHP enrollees

438.208(c)(1) Identification - Identification of individuals with special health care needs

438.208(c)(2) Assessment and (3) Treatment plans - Care coordination for individuals with special health care needs

438.240(b)(4) Care coordination oversight

438.208(c)(4) Direct access for individuals with special health care needs

438.210 - Coverage and authorization of services*

438.210(b) Authorization of services

438.210(c) Notice of adverse action

438.210(d) Timeframe for decisions

438.210(e) Compensation for utilization management decisions,

438.114 Emergency and post-stabilization services

438.214 - Provider selection

438.214(a) General rules

438.214(b) Credentialing and recredentialing requirements

438.214(c) and 438.12 Nondiscrimination and provider discrimination prohibited

438.214(d) Excluded providers

438.214(e) State requirements

438.224 - Confidentiality

438.224 Confidentiality

438.228 - Grievance and appeal systems

438.228(a)(b) Grievance and appeal systems

438.400(b) Statutory basis and definitions

438.402(c)(1) Filing requirements - authority to file

438.402(c)(2) Filing requirements - timing

438.402(c)(3) Filing requirements - procedures

438.404(a) Notice of adverse benefit determination - language and format

438.404(b) Notice of action - content of notice

438.404(c) Timely and adequate notice of adverse benefit determination - timing of notice

438.406(a) Handling of grievances and appeals - General requirements

438.406(b) Handling of grievances and appeals - special requirements for appeals

**Standards subject to the current review period by TEAMonitor. Appendix E lists the schedule for review of the remaining standards and a summary of findings from all previous reviews within the current review cycle.*

438.408(a) Resolution and notification: Grievances and appeals - basic rule

438.408(b)(c) Resolution and notification: Grievances and appeals - specific timeframes and extension of timeframes

438.408 (d)(e) Resolution and notification: Grievances and appeals - format of notice and content of notice of appeal resolution

438.410 Expedited resolution of appeals

438.414 Information about the grievance and appeal system to providers and subcontractors

438.416 Recordkeeping and reporting requirements

438.420 Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State fair hearing are pending

438.424 Effectuation of reversed appeal resolutions

438.230 - Subcontractual relationships and delegation*

438.230(a)(b) Subcontractual relationships and delegation

438.230(c)(2) Subcontractual relationships and delegation

438.230(c)(1)(ii) Subcontractual relationships and delegation

438.230(c)(1)(iii) Subcontractual relationships and delegation

438.236 - Practice guidelines

438.236(a)(b)(1-4) Adoption of practice guidelines

438.236(c) Dissemination of [practice] guidelines

438.236(d) Application of [practice] guidelines

438.242 - Health information systems*

438.242 Health information systems - General rule

438.242(b)(1)(2) Basic elements

438.242(b)(3) Basic elements

438.330 - Quality assessment and performance improvement program

438.330(a) General rules

438.330(b)(1) Basic elements of MCO and PIHP quality assessment and performance improvement programs

438.330(d) Performance improvement projects

438.608 - Program integrity requirements under the contract*

438.608(a)(b) Program integrity requirements

Social Security Act (SSA) section 1903(i)(2) of the Act

§455.104 - Disclosure of ownership and control;

§455.106 - Disclosure by providers: Information on persons convicted of crimes

§455.23 - Provider Payment Suspension

§1001.1901(b) - Scope and effect of exclusion

**Standards subject to the current review period by TEAMonitor. Appendix E lists the schedule for review of the remaining standards and a summary of findings from all previous reviews within the current review cycle.*

Appendix C: PIP Validation Procedures

PIP Validation Procedure

Objectives

Washington's MCPs (which include the MCOs and BHSOs) are contractually required to have an ongoing program of clinical and non-clinical PIPs that are designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction for all Apple Health programs, including AH-IMC, AH-IFC and BHSO.

As a component of its EQR review, TEAMonitor conducted an assessment and validation of the MCPs' PIPs to ensure they met state and federal guidelines; included all Apple Health enrollees; and were designed, implemented, analyzed and reported in a methodologically sound manner.

Note: In RY2021, TEAMonitor begun implementation of *Protocol 1 Validation of Performance Improvement Projects* updated by CMS in 2019 in its validation of PIPs. The updated protocol includes additional measurements of success and will be fully implemented for RY2022.

Technical Methods of Data Collection

The TEAMonitor evaluations are based on Attachment A of *EQR Protocol 3: Validating Performance Improvement Projects, Version 2.0*[34] developed by the Centers for Medicare & Medicaid Services (CMS) to determine whether a PIP was designed, conducted and reported in a methodologically sound manner.

Protocol 3 specifies procedures in assessing the validity and reliability of a PIP. Protocol 3 specifies how to conduct the following three activities:

A. Assess the study methodology

B. Verify PIP study findings

C. Evaluate overall validity and reliability of study results

Part A: Assessing the Study Methodology

1. Review the selected study topic(s) for the appropriateness of the selected study topic(s) in addressing the overarching goal of a PIP to improve processes and outcomes of health care provided by the MCO.
2. Review the study question(s) for the appropriateness and adequacy of the study question(s) in identifying the focus and establishing the framework for data collection, analysis and interpretation.
3. Review the identified study population to determine whether the PIP population was clearly identified.
4. Review the selected study indicators to determine if appropriate measures are used.
5. Review the sampling methods for appropriateness and validity of the PIP's sampling method.

[34] EQR PROTOCOL 3 – Validation of Performance Improvement Projects (PIPs). Attachment A: PIP Review Worksheet. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3-attachment-a.pdf

6. Review the data collection procedures to determine the validity of the procedures the MCO uses to collect the data that inform the PIP measurements.
7. Review the data analysis and interpretation of study results to determine the accuracy of the MCO's plan for analyzing and interpreting the PIP's results.
8. Assess the MCO's improvement strategies for the appropriateness of the strategy for achieving true improvements.
9. Access the likelihood that reported improvement is "Real" improvement.
10. Assess sustainability of the documented improvement.

Part B: Verifying Study Findings (optional)

States may request the EQRO verify the actual data produced to determine if the initial and repeated measurements of the quality indicators are accurate.

Part C: Evaluate Overall Validity and Reliability of Study Results

Following the completion of Activity 1 and Activity 2, the EQRO will assess the validity and reliability of all findings to determine whether or not the State has confidence in the MCO's reported PIP findings.

TEAMonitor utilizes one of the following confidence indicators in reporting the results of the MCOs' PIPs:

- High confidence in reported results
- Confidence in reported results
- Low confidence in reported results
- Reported results not credible
- Enough time has not elapsed to assess meaningful change

Description of Data Obtained

TEAMonitor validates each PIP using data gathered and submitted by the MCO using Attachment A of *EQR Protocol 3: Validating Performance Improvement Projects, Version 2.0.*

Data Aggregation and Analysis

As the MCOs submit their PIP data directly within the protocol attachment, all elements necessary for the validation of the PIP is submitted and readily available for TEAMonitor to validate.

The TEAMonitor scoring method for evaluating PIPs is outlined below.

PIP Scoring

TEAMonitor scored the MCOs' PIPs as Met, Partially Met or Not Met according to how well they performed against a checklist of elements designed to measure success in meeting the standards specified by CMS. The elements associated with the respective scores follow.

To achieve a score of Met, the PIP must demonstrate all of the following 12 elements:

- A problem or need for Medicaid enrollees reflected in the topic of the PIP.
- The study question(s) stated in writing.
- Relevant quantitative or qualitative measurable indicators documented.
- Descriptions of the eligible population to whom the study questions and identified indicators apply
- A sampling method documented and determined prior to data collection
- The study design and data analysis plan proactively defined
- Specific interventions undertaken to address causes/barriers identified through data analysis and QI processes (e.g., barrier analysis, focus groups, etc.)
- Numerical results reported (e.g., numerator and denominator data)
- Interpretation and analysis of the reported results
- Consistent measurement methods used over time or, if changed, documentation of the rationale for the change
- Sustained improvement demonstrated through repeat measurements over time (baseline and at least two follow-up measurements required)
- Linkage or alignment between the following: data analysis documenting need for improvement, study questions, selected clinical or nonclinical measures or indicators, results

To achieve a score of Partially Met, the PIP must demonstrate all of the following seven elements. If the PIP fails to demonstrate any one of the elements, the PIP will receive a score of Not Met.

- A problem or need for Medicaid enrollees reflected in the topic of the PIP
- The study question(s) stated in writing
- Relevant quantitative or qualitative measurable indicators documented
- A sampling method documented and determined prior to data collection
- The study design and data analysis plan proactively defined
- Numerical results reported (e.g., numerator and denominator data)
- Consistent measurement methods used over time or, if changed, documentation of the rationale for the change

Appendix D: Performance Measure Validation Methodology

Methodology

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

Technical Methods of Data Collection

HEDIS

In the first half of 2020, each MCO participated in an NCQA HEDIS Compliance Audit™ to validate accurate collection, calculation and reporting of HEDIS measures for the member populations. This audit does not analyze HEDIS results; rather, it ensures the integrity of the HEDIS measurements.

Using the NCQA-standardized audit methodology, NCQA-certified auditors assessed each MCO's information systems capabilities and compliance with HEDIS specifications. HCA and each MCO received an onsite report and final report of all audit activity; all Apple Health MCOs were in compliance with HEDIS specifications.

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

Washington State Behavioral Health Measures

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

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

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

Administrative Versus Hybrid Data Collection

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

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

Because hybrid measures are supplemented with sample-based data, scores for these measures will always be the same or better than scores based solely on the administrative data for these measures.[35]

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 D-1. Administrative versus Hybrid Rates for Select Measures, MY2020.

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

Description of Data Obtained

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 March 2020, NCQA recognized that COVID-19 would likely impact plans' ability to collect medical record data due to travel bans, quarantines and efforts to minimize risk to staff. Therefore, NCQA allowed Medicaid plans participating in HEDIS reporting the option of submitting MY2018 rates in MY2019 for their hybrid measures, referred to as "rotated measures." Hybrid measures are calculated by combining administrative claims data with data obtained from medical records. Rotated measures were not applicable in MY2020 but may have impacted analysis of year over year performance.

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.

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

Table D-2. MY2019 Rotated Measures by MCOs.

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

Data Aggregation and Analysis

Member-Level Data Analysis

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

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

Definitions Used to Stratify Member-Level Data

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

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

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

Calculations and Comparisons

Sufficient Denominator Size

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

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

Calculation of the Washington Apple Health Average

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

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

Comparison to Benchmarks

This report provides national benchmarks for select HEDIS measures from the MY2020 NCQA Quality Compass. These benchmarks represent the national average and selected percentile performance among all NCQA-accredited Medicaid HMO plans and non-accredited Medicaid HMO plans that opted to publicly report their HEDIS rates. These plans represent states both with and without Medicaid expansion. The number of plans reporting on each measure varies, depending on each state's requirement (not all states require reporting; they also vary on the number of measures they require their plans to report).

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

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

Interpreting Percentages versus Percentiles

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

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

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

Statistical Significance

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

For individual MCO performance scores, a chi-square test was used to compare the MCO against the remaining MCOs as a group (i.e., the state average not including the MCO score being tested). 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.

Denominator Size Considerations and Confidence Intervals

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

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

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

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

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

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

Interpreting Performance

Potential Sources of Variation in Performance

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

Additional Notes Regarding Interpretation

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

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

Limitations

- **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.

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Appendix E: TEAMonitor Review Schedule

Federal regulations require MCPs to undergo a review at least once every three years to determine MCP compliance with federal standards as implemented by the state. Washington's MCPs are evaluated by TEAMonitor, at HCA, which provides formal oversight and monitoring activities on their compliance with federal and state regulatory, and contractual standards. TEAMonitor has chosen to spread the review over a three-year cycle.

In 2021, TEAMonitor completed the current review three-year review cycle of the MCPs. In 2022, a new three-year cycle will begin.

Summary of Findings Within the Current Review Cycle

During the current review cycle (2019-2021), TEAMonitor reviewed the following standards.

Table E-1. Standards Reviewed During the Current Review Cycle.

Year	Standards
Year 1 (2019)	• §438.214 - Provider Selection (Credentialing) • §438.228 - Grievance and Appeals Systems • §438.330 - Quality Assessment and Performance Improvement Program (QAPI)*
Year 2 (2020)	• §438.100 - Enrollee rights • §438.206 - Availability of services • §438.207 - Assurances of adequate capacity and service† • §438.208 - Coordination and continuity of care • §438.236 - Practice guidelines
Year 3 (2021)	• §438.56 - Disenrollment: Requirements and limitations • §438.210 - Coverage and authorization of service‡ • §438.230 - Subcontractual Relationships and Delegation • §438.608 - Program integrity requirements‖

* TEAMonitor reviews §438.66 (c)(3) Monitoring Procedures - Claims payment monitoring in conjunction with the QAPI standard

† TEAMonitor reviews this standard in conjunction with §438.206(b)(1)(i-v) & (c) Delivery network and §438.10 (h) Information for all enrollees – Provider directory

‡ TEAMonitor reviews §438.114 Emergency and post stabilization services in conjunction with this standard

‖ TEAMonitor reviews Social Security Act (SSA) section 1903(i)(2) of the Act; §455.104 - Disclosure of ownership and control; §455.106 - Disclosure by providers: Information on persons convicted of crimes; §455.23 - Provider Payment Suspension; and §1001.1901(b) - Scope and effect of exclusion in conjunction with this standard.

Scoring

TEAMonitor scores the MCPs on each compliance standard according to a metric of Met, Partially Met, and Not Met, each of which corresponds to a value on a point system of 0–3.

Scoring Key:

- Score of 0 indicates previous year CAP Not Met
- Score of 1 indicates Not Met
- Score of 2 indicates Partially Met
- Score of 3 indicates Met
- Score of NA indicates Not Applicable

Final scores for each section are denoted by a fraction indicating the points obtained (the numerator) relative to all possible points (the denominator) and the corresponding percentage. For example, in a section consisting of four elements in which the MCP scored a 3, or Met, in three categories and a 1, or Not Met, in one category, the total number of possible points would be 12, and the MCP's total points would be 10, yielding a score of 10 out of 12 with a corresponding 83%.

Table E-2 summarizes the scores of Years 1-3 (2019-2021) of the current review cycle.

The MCO/BHSO deficiencies identified within the 2019 TEAMonitor Compliance Review required a response with corrective action to the state. The state reviewed the responses and were accepted as completed by HCA.

Table E-2. Summary of the Current Review Cycle Compliance Scores.

Compliance Area and CFR Citation	Year 1 (2019)								
	AMG		CCW		CHPW		MHW		UHC*
	MCO	BHSO	MCO	BHSO	MCO	BHSO	MCO	BHSO	MCO
§438.214 - Provider Selection (Credentialing)	12/12 100%	12/12 100%	12/12 100%	12/12 100%	9/12 75%	9/12 75%	12/12 100%	12/12 100%	12/12 100%
§438.228 - Grievance and Appeals Systems	45/54 83%	45/54 83%	50/54 93%	50/54 93%	49/54 91%	49/54 91%	54/54 100%	54/54 100%	54/54 100%
§438.242 - Health Information Systems	3/3 100%	3/3 100%	3/3 100%	3/3 100%	3/3 100%	3/3 100%	3/3 100%	3/3 100%	3/3 100%
§438.330 - Quality Assessment and Performance Improvement Program (QAPI)	12/15 87%	12/15 87%	15/15 100%	15/15 100%	15/15 100%	15/15 100%	14/15 93%	14/15 93%	14/15 93%
Compliance Area and CFR Citation	**Year 2 (2020) Note: Year 2 of the cycle was the first year of the BHSO program was reviewed separately**									
	AMG		CCW		CHPW		MHW		UHC	
	MCO	BHSO	MCO	BHSO	MCO	BHSO	MCO	BHSO	MCO	BHSO
§438.100 Enrollee Rights	31/36 86%	28/33 85%	34/36 94 %	31/33 94%	28/36 78%	25/33 85%	33/36 92%	30/33 91%	34/36 94%	31/33 94%
§438.206 Availability of Services	17/21 81%	14/18 78%	16/21 76%	14/18 78%	16/21 76%	14/18 78%	16/21 76%	13/18 72%	17/21 81%	14/18 78%
§438.208 Coordination and Continuity of Care	14/18 78%	15/18 83%	16/18 89%	16/18 89%	18/18 100%	18/18 100%	16/18 89%	16/18 89%	17/18 94%	18/18 100%
§438.236 Practice Guidelines	7/9 78%	8/9 89%	9/9 100%	9/9 100%	9/9 100%	9/9 100%	9/9 100%	9/9 100%	9/9 100%	9/9 100%
§438.242 - Health Information Systems	3/3 100%	3/3 100%	3/3 100%	3/3 100%	3/3 100%	3/3 100%	3/3 100%	3/3 100%	3/3 100%	3/3 100%
Compliance Area and CFR Citation	**Year 3 (2021)**									
	AMG		CCW		CHPW		MHW		UHC	
	MCO	BHSO	MCO	BHSO	MCO	BHSO	MCO	BHSO	MCO	BHSO
§438.56 - Disenrollment: Requirements and limitations	3/3 100%	3/3 100%	3/3 100%	3/3 100%	3/3 100%	3/3 100%	3/3 100%	3/3 100%	3/3 100%	3/3 100%
§438.210 - Coverage and authorization of service	6/15 40%	6/15 40%	11/15 73%	11/15 73%	12/15 80%	12/15 80%	7/15 47%	9/15 60%	12/15 80%	11/15 73%
§438.230 - Subcontractual	10/12 83%	10/12 83%	9/12 75%	9/12 75%	10/12 83%	10/12 83%	12/12 100%	12/12 100%	7/12 58%	7/12 58%

Relationships and Delegation										
§438.242 - Health Information Systems	3/3 100%	3/3 100%	3/3 100%	3/3 100%	3/3 100%	3/3 100%	3/3 100%	3/3 100%	3/3 100%	3/3 100%
§438.608 - Program integrity requirements	11/12 92%	11/12 92%	8/12 67%	8/12 67%	10/12 83%	10/12 83%	8/12 67%	8/12 67%	7/12 58%	7/12 58%

*In 2019 all MCO's except for UHC were contracted with the state for BHSO.

In addition, plans were reviewed on elements that received Partially Met or Not Met scores to validate improvement or need for further corrective action. If an MCP receives a corrective action plan or recommendations based on an element, that element will be re-reviewed the following year or until the finding is satisfied. In 2021, TEAMonitor reviewed and scored corrective action plans from 2020 for the following standards. Table E-3 summarizes the previous year CAPs of the current review cycle.

Table E-3. Summary of Previous Year (2020) Corrective Action Plans (CAPs)

Standard	CAPs
Availability of Services	All CAPS were met by all MCPs for elements within this standard. • All five MCOs and BHSOs met the CAPs for availability of services for the delivery network, provider directory information for all enrollees and assurances of adequate capacity and services. • UHC/MCO and UHC/BHSO met the CAP for out-of-network payment. • CCW/MCO, CHPW/MCO and CHPW/BHSO met the CAP for providing direct access to women's health specialists. • Two MCOs (CHPW, MHW) and two BHSOs (CHPW, MHW) met the CAP for providing a second opinion. • CCW/MCO and CCW/BHSO met the CAPs for both Services Out of network and Out-of-network payment. • Three MCOs (CHPW, MHW, UHC) and three BHSOs (CHPW, MHW, UHC) met the CAP for furnishing of services – timely access. • Four MCOs (AMG, CCW, CHPW, MHW) and four BHSOs (AMG, CCW, CHPW, MHW) successfully completed the CAP for cultural considerations.
Coordination and Continuity of Care	All CAPS were met by all MCPs for elements within this standard. • Four MCOs (AMG, CCW, CHPW, MHW) and four BHSOs (AMG, CCW, CHPW, MHW) met the CAP for primary care and coordination of health care services for all enrollees, and confidentiality. • UHC MCO and UHC BHSO met the CAP for care coordination for enrollees with special health care needs, assessment and treatment plans.
Coverage and Authorization of Services	• CCW/MCO and CCW/BHSO met the CAP for authorization of services. Two MCOs (AMG, MHW) and one BHSO

Standard	CAPs
	(AMG) did not meet the CAP for this element. This is a repeat finding for MHW/MCO. • Two MCOs (CCW, MHW) and two BHSOs (CCW, MHW) met the CAP for notice of adverse benefit determinations. Two MCOs (CHPW, UHC) and two BHSOs (CHPW, UHC) partially met the CAP for this element. AMG did not meet the CAP for this element. • AMG/MCO and AMG/BHSO partially met the CAP for coverage and authorization of services, timeframe for decisions. MHW/MCO did not meet the CAP for this element, which is also a repeat finding.
Enrollee Rights and Protections	All CAPS were met by all MCPs for elements within this standard. • Two MCOs (AMG, UHC) and two BHSOs (AMG, UHC) met the CAP for enrollee rights – general rule. • Two MCOs (AMG, CHPW) and two BHSOs (AMG, CHPW) met the CAP for specific rights; format, easily understood. • AMG/MCO met the CAP for formulary information for enrollees. • CHPW/MCO and CHPW/BHSO met the CAP for specific rights - language and format, as well as the CAP for additional specific rights. • CCW/MCO and CCW/BHSO met the CAP for specific rights. • Three MCOs (CHPW, MHW, UHC) and three BHSOs (CHPW, MHW, UHC) met the CAP for specific rights – general requirements. • Two MCOs (CCW, CHPW) and two BHSOs (CCW, CHPW met the CAP for enrollee rights and compliance with other federal and state laws. • Two MCOs (CHPW, MHW) and two BHSOs (CHPW, MHW) met the CAP for liability for payment.
Grievance System	All CAPS were met by all MCPs for elements within this standard. • AMG/MCO and AMG/BHSO met the CAPs for filing requirements – authority to file, as well as expedited resolution of appeals. • CHPW/MCO and CHPW/BHSO met the CAP for filing requirements – timing. • Two MCOs (AMG, MHW) and two BHSOs (AMG, MHW) met the CAP for general requirements for handling of grievances and appeals. • Two MCOs (AMG, UHC) and two BHSOs (AMG, UHC) met the CAPs for the basic rule, resolution and notification of grievances and appeals. • Three MCOs (AMG, MHW, UHC) and three BHSOs (AMG, MHW, UHC) met the CAPs for specific timeframes and

Standard	CAPs
	extension of timeframes in the resolution and notification of grievances and appeals. • Three MCOs (AMG, CCW, MHW) and three BHSOs (AMG, CHW, MHW) met the CAPs for format of notice and content of notice of appeal resolution.
Practice Guidelines	• The one MCO (AMG) and BHSO (AMG) that had a CAP regarding application of practice guidelines met the requirements upon re-review.

Schedule of the Next Review Cycle (2022–2024)

In 2022, TEAMonitor will begin a new three-year review cycle. Table E-4 lists the schedule of the next review cycle.

Table E-4. Schedule of the Next Review Cycle.

Year	Standards
Year 1 (2022)	• §438.228 - Grievance and Appeals Systems • §438.214 - Provider Selection (Credentialing) • §438.242 - Health Information Systems • §438.330 - Quality Assessment and Performance Improvement Program (QAPI) ○ TEAMonitor reviews §438.66 (c)(3) Monitoring Procedures - Claims payment monitoring in conjunction with the QAPI standard
Year 2 (2023)	• §438.100 Enrollee rights • §438.206 Availability of services • §438.207 - Assurances of adequate capacity and services ○ TEAMonitor reviews this standard in conjunction with §438.206(b)(1)(i-v) & (c) Delivery network and §438.10 (h) Information for all enrollees – Provider directory • §438.208 Coordination and continuity of care • §438.236 Practice guidelines • §438.242 - Health Information Systems
Year 3 (2024)	• §438.56 - Disenrollment: Requirements and limitations • §438.100 - Coverage and authorization of service • §438.230 - Subcontractual Relationships and Delegation • §438.242 - Health Information Systems • §438.608 - Program integrity requirements

Appendix F: 2021 Enrollee Quality Report

"Washington Apple Health Plan Report Card"

Comagine Health produced the *2021 Enrollee Quality Report,* designed to provide Apple Health applicants and enrollees with simple, straightforward comparative health plan performance information that may assist them in selecting a plan that best meets their needs.

Data sources for this report include the Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measure sets. The rating method is in alignment with the star rating systems used by other states and reflects the data sources available for the Apple Health population in Washington. For more information on the methodology used to derive this report's star rating system, refer to Comagine Health's *2021 Enrollee Quality Report Methodology.*

2021 Washington Apple Health Plan Report Card

Washington Apple Health

This report card shows how Washington Apple Health plans compare to each other in key performance areas. You can use this report card to help guide your selection of a plan that works best for you.

Performance areas	Amerigroup Washington	Coordinated Care of Washington	Community Health Plan of Washington	Molina Healthcare of Washington	United Healthcare Community Plan
Getting care	★☆☆	★☆☆	★☆☆	★★☆	★★☆
Keeping kids healthy	★☆☆	★★☆	★★☆	★★☆	★☆☆
Keeping women and mothers healthy	★☆☆	★☆☆	★☆☆	★☆☆	★☆☆
Preventing and managing illness	★☆☆	★☆☆	★☆☆	★☆☆	★☆☆
Ensuring appropriate care	★☆☆	★★☆	★★☆	★☆☆	★☆☆
Satisfaction of care provided to adults	★★☆	★★☆	★★☆	★★☆	★★☆
Satisfaction with plan for adults	★★☆	★★☆	★★☆	★★☆	★★☆

KEY: Performance compared to all Apple Health plans	
Above average	★★★
Average	★★☆
Below average	★☆☆

These ratings were based on information collected from health plans in 2019 - 2020.

The information was reviewed for accuracy by independent auditors.

Health plan performance scores were not adjusted for differences in their member populations or service regions.

Performance area definitions

Getting care
- Members have access to a doctor
- Members report they get the care they need, when they need it

Keeping kids healthy
- Children in the plan get regular checkups
- Children get important immunizations
- Children get the appropriate level of care when they are sick

Keeping women and mothers healthy
- Women get important health screenings, such as cervical cancer screenings
- New and expecting mothers get the care they need

Preventing and managing illness
- The plan helps its members keep long-lasting illness under control, such as asthma, high blood pressure or diabetes
- The plan helps prevent illnesses with screenings and appropriate care

Ensuring appropriate care
- Members receive the most appropriate care and treatment for their condition

Satisfaction with care provided to adults
- Members report high ratings for doctors, specialists and overall health care

Satisfaction with plan for adults
- Members report high ratings for the plan's customer service and the plan overall

Washington State Health Care Authority

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