2023 EQR Annual Technical Report

January 2024

Washington Apple Health

Washington Health Care Authority

Presented by:
Comagine Health
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.

Table of Contents

Index of Tables and Figures

Acronym List

Table 1. Acronyms Used Frequently in this Report.

Acronym	Definition
AH-BD	Apple Health Blind/Disabled
AH-IFC	Apple Health Integrated Foster Care
AH-IMC	Apple Health Integrated Managed Care
AMG	Amerigroup Washington, Inc.
BHA	Behavioral Health Agency
BHSO	Behavioral Health Services Only – *a PIHP plan*
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CANS	Child and Adolescent Needs and Strengths
CAP	Corrective Action Plan
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
DSHS	Department of Social and Health Services
EQR	External Quality Review
EQRO	External Quality Review Organization
FAR	Final Audit Report
HCA	Health Care Authority
HCBS	Home and Community-Based Long-Term Services and Supports Use
HEDIS	Healthcare Effectiveness Data and Information Set
HOME-B	Percent Homeless – Broad Version
HOME-N	Percent Homeless – Narrow Version
IMC	Integrated Managed Care
ISCA	Information Systems Capabilities Assessment
LTSS	Long-Term Services and Support
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 Rate – Broad Definition
MHW	Molina Healthcare of Washington
MLD	Member-Level Detail
MY	Measurement Year
NCQA	National Committee for Quality Assurance

[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.

Acronym	Definition
PAHP	Prepaid Ambulatory Health Plans[2]
PCCM	Primary Care Case Management
PDSA	Plan-Do-Study-Act
PIHP	Prepaid Inpatient Health Plan *HCA contracted with PIHPs (BHSO) in the year reported within the Medicaid IMC contract.*
PIP	Performance Improvement Project
PMV	Performance Measure Validation
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
VBP	Value-Based Purchasing
WISe	Wraparound with Intensive Services

[2] HCA did not contract with any PAHPs in the year reported.

Executive Summary

In 2022, over 2.3 million Washingtonians were enrolled in Apple Health,[3] with more than 85% enrolled in an integrated managed care program. The Washington State Health Care Authority (HCA) administered services for care delivery through contracts with five managed care plans (MCPs):

- Amerigroup Washington (AMG)[4]
- Community Health Plan of Washington (CHPW)
- Coordinated Care of Washington (CCW)
- Molina Healthcare of Washington (MHW)
- UnitedHealthcare Community Plan (UHC)

The MCPs in Washington State include both a managed care organization (MCO) and a Behavioral Health Services Only (BHSO) program--a Prepaid Inpatient Health Plan (PIHP)[5] – within each entity. In this report, the plans will be referred as MCPs **except** for the following sections where the MCO/BHSO descriptors will be used to differentiate the plans.

- Compliance: MCP will be used in this section when not specifically referring to MCO or BHSO results.
- Performance measure review – performance measure comparative analysis: MCP will be used in this section when not specifically referring to MCO or BHSO population data and/or results.

Federal requirements mandate that every state Medicaid agency that contracts with managed care plans 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 2023 review as Washington's Medicaid external quality review organization (EQRO). This technical report describes the results of this evaluation. No MCPs in Washington are exempt from the EQR.

In 2023, TEAMonitor, at HCA, which provides formal oversight and monitoring activities on their compliance with federal and state regulatory and contractual standards, reviewed both MCOs and BHSOs for compliance and performance improvement projects (PIPs). 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. TEAMonitor provided the MCP-specific reports relating these activities to the EQRO.

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.

[3]Apple Health Client Eligibility Dashboard. Washington State Health Care Authority. Available at: https://hca-tableau.watech.wa.gov/t/51/views/ClientDashboard-Externalversion/AppleHealthClientDashboard?:isGuestRedirectFromVizportal=y&:embed=y.

[4] Effective 1/1/24, AMG will become Wellpoint of WA (WLP).

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

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 (AH-BD)
- State Children's Health Insurance Program (CHIP)

Apple Health Managed Care Program and Initiatives

The Apple Health managed care program has been providing Medicaid and CHIP enrollees with access to both physical and behavioral health services through a single managed care program since January 2020. Most services for Apple Health clients are provided through managed care organizations through the following programs AH-IMC, AH-IFC and BHSO. The AH-IMC program provides Apple Health clients both physical and behavioral health (mental health and substance use disorder treatment benefits) and crisis services while the AH-IFC program provides these benefits and services to clients in foster care, receiving adoption support, and alumni of foster care. 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 have access to 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, such as dental services for all enrollees.

To support recovery from the COVID-19 public health emergency, HCA has continued strategies implemented during the public health emergency to respond to access to care challenges, support workforce and system stability, as well as quality improvement activities. For example, HCA continues to work in collaboration with all five MCPs to free up hospital resources and create capacity by coordinating efforts to move clients experiencing a complex discharge out of acute care hospital settings.

Health equity has also been a focus for Washington's Apple Health program. To strengthen the health equity lens of Apple Health quality oversight, HCA continues to explore ways to embed health equity concepts into all program areas. Examples include expanding the available data set to allow for deeper analysis to identify health inequity, as well as encouraging and publicly recognizing the contracted MCPs holding a National Committee for Quality Assurance (NCQA) Distinction in Multicultural Health Care and/or Health Equity Accreditation.

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

Through assessment of the EQR activities, 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 in Figure 1 and the following text.

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.

Key Observations

Two major impacts on MCP performance between 2020 and 2022 were the COVID-19 pandemic and an increase in Medicaid enrollment in the Apple Health Integrated Managed Care (AH-IMC) program. COVID-19 severely stressed primary care delivery systems due to workflow changes required to protect the workforce and patients, re-ordering of clinical priorities and unstable delivery system revenue. In addition, there was a significant influx of new Medicaid members, for which additional time and effort is usually required. Depending on prior insurance or lack of insurance, these new members may have a greater burden of unmet care needs than established members. In addition, as part of the federal Public Health Emergency, Medicaid qualifications were not updated between 2020 and 2023.

It should be noted there has been an overall decline in MCP performance across many of the EQR activities as described in this report. For instance:

- While Compliance performance has remained relatively stable, availability of services and coordination and continuity of care requirements were partially met by the MCPs, indicating access issues.
- Success rates for the PIP interventions were low. A few factors impacted the success of PIP interventions, including balancing the return to in-person care with telehealth interventions as the public health emergency continued, and staff turnover at the MCPs.
- Delivery system performance measure outcomes have shown a significant decrease due to impacts affecting the health care system.
- Achievement of VBP incentive measure benchmarks have declined over the past couple of years.
- Performance on many of the summary CAHPS rate scores have declined over the reporting period (2019-2023). This decline is evident across all three populations: Adult Medicaid, Child Medicaid and the Foster Care population. It does not appear the decline is isolated to a specific population but is instead an overall statewide decline.

In response, HCA and the MCPs have met to review and develop plans to address access issues identified across the EQR activities in 2022 and 2023. Throughout these sessions, the MCPs consistently shared how the pandemic affected access over time during the 2020-2022 period, which continues to the present day.

Summary of EQR Activities and Recommendations

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.[6] The 2023 EQR in Washington included the following activities which are in alignment with the CMS protocols. In addition, the resulting recommendations from the 2023 EQR are listed.

Please see the full recommendations in their respective sections of this report for more detail. EQRO Recommendations will specify whether HCA or the MCPs are responsible for addressing any recommendations issued by Comagine Health and follow-up will be included in the 2024 EQR Annual Technical Report.

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

Quality Strategy Effectiveness Analysis

To fulfill the requirement established by federal regulation 42 CFR Part 438 Subpart E §438.340, the Washington State Managed Care Quality Strategy[7] 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 CFR §§ 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. Comagine Health's analysis includes 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.

Quality Strategy Effectiveness Analysis Recommendation

After review of the Quality Strategy and MCP performance, the EQRO recommends the following to HCA to improve the effectiveness of the Quality Strategy and MCP performance:

- Tie evaluation of state directed payments to the Managed Care Quality Strategy
- Updates to reflect changes to the VBP process, including no current legislative proviso and addition of state directed payments
- Update the Network Adequacy Validation portion of the Quality Strategy to reflect updated processes and the new EQR Protocol 4
- Re-evaluate the focused quality study of the Wraparound with Intensive Services (WISe) service delivery model to ensure the study is providing information to guide continuous quality improvement of this important initiative
- Maintain focus on clinically meaningful areas
- Continue to leverage value-based payment incentives
- Focus on access, preventive care and utilization
- Continue to prioritize health equity

Compliance Review

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.

[7] 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.

Compliance Recommendations

Compliance – Program Level

In reviewing the 2023 MCP aggregate compliance scores provided by TEAMonitor, the Apple Health Plan MCPs[8] did not meet all elements for the following standards and associated elements. The MCPs will benefit from technical assistance by HCA to ensure they meet those requirements.

- Availability of services (90%)
  - Four of five MCPs did not meet the following elements:
    - 438.206 (b)(1)(i-v) & (c) Delivery network; 438.10 (h) Information for all enrollees – Provider directory
    - 438.207 Assurances of adequate capacity and services (b)(c)
- Practice guidelines standards (91%)
  - Four of five MCPs did not meet the following element:
    - 438.236(c) Dissemination of practice guidelines
- Coordination and Continuity of Care (83%)
  - Two of five MCPs did not meet the following element:
    - 438.208 Coordination and Continuity of Care (b) Care and coordination of services for all MCO, PIHP, and PAHP enrollees; §438.224 Confidentiality
  - No MCP (MCO and BHSO combined) met the following elements:
    - 438.208 Continuity of care (a) Basic requirement
    - 438.208 Additional services for enrollees with special heath care needs (2) Assessment and (3) Treatment plans
- QAPI (83%)
  - Three of five MCPs did not meet the following element:
    - 438. 330 (e)(2) QAPI Program evaluation

For comprehensive aggregate plan level scores see the compliance section of the report (page 28).

Compliance – Plan Level

EQRO recommendations are based on the TEAMonitor corrective action plans (CAPs) supplied to the MCPs. MCPs were reviewed in the first half of the calendar year. Because MCPs may have implemented CAPs since that time to address specific issues, these recommendations may not be indicative of current performance. An update of the current year's EQRO recommendations will be reflected in the 2024 Annual Technical Report.

Please refer to the MCP profiles in Appendix A for each MCP's EQRO Recommendations.

Performance Improvement Project (PIP) Validation

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

[8] *Please note both the MCO and BHSO are referred to as the Apple Health Plan MCP (i.e., AMG MCP is AMG MCO **and** AMG BHSO, etc.).*

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.

PIP Recommendation

The five MCPs did not receive a TEAMonitor Corrective Action Plan (CAP) as part of the 2023 PIP validation activity. Therefore, in reviewing the 2023 MCP PIP submissions, the five MCPs were not issued EQRO recommendations.

Performance Measure Review

Performance measures are used to monitor the performance of the individual MCPs at a point in time, to track performance over time, to compare performance among MCPs, and to inform the selection and evaluation of quality improvement activities. States specify standard performance measures which the MCPs must include in their QAPI program.

This section contains results of the following areas of performance measure validation and comparative analysis that was completed in 2023.

Performance Measure Validation

Performance measure validation is a required EQR activity described in 42 CFR §438.358(b)(2). Aqurate Health Data Management, Inc., is an NCQA-Licensed HEDIS Compliance Organization, which conducted the 2022 MCP HEDIS®[9] audits according to the standards and methods described in the NCQA HEDIS® Compliance Audit™ Standards, Policies and Procedures, provided Comagine Health with the MCP's Final Audit Report (FAR).

Performance Measure Validation Recommendation

All MCPs were in full compliance with the MY2022 audits. Comagine Health did not identify any EQRO recommendations, strengths or weaknesses for any MCP during the 2023 PMV. However, when reviewing the MCPs' FARs, Comagine Health identified suggested opportunities for improvement within the FARs based on the audit team recommendations. HCA plans to follow-up via the TEAMonitor process and will be requiring a response from the MCPs to HCA. If the MCP's response does not sufficiently address the issue in the upcoming year, an EQRO Recommendation will be issued as part of the 2024 performance measure review.

For additional information see the Performance Measure Validation section of this report (page 46).

Washington State Developed Performance Measure Validation

The state monitors and self-validates the following state-developed measures reflecting services delivered to Apple Health enrollees:

[9] The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

- Mental Health Service Rate (Broad version) [MH-B]* – Measure of access to mental health services (among persons with an indication of need for mental health services)
- Substance Use Disorder Treatment Rate (SUD)* – Measure of access to SUD treatment services (among persons with an indication of need for SUD treatment services)
- Home and Community-Based Long-Term Services and Supports Use (HCBS) – Measure of receipt of home and community-based services (among those who need LTSS)
- Percent Homeless (Broad version) [HOME-B] – The percentage of Medicaid enrollees who were homeless or unstably housed in at least one month in the measurement year
- Percent Homeless (Narrow version) [HOME-N] – The percentage of Medicaid enrollees who were homeless in at least one month in the measurement year

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

Validated performance rates for this program are included in this report.

Washington State Developed Performance Measure Validation Recommendation

Based on the validation process completed for each performance measure, the measures meet audit specifications and are reportable by the state. Comagine Health did not identify any strengths or opportunities for improvement/weaknesses during the 2022 performance measure validation.

It would be beneficial for RDA to develop cross-validation activities in partnership with HCA's Analytics, Research, and Measurement team. However, given staff turnover and workload demands on state agency analytic teams supporting other agency operations, this was not a feasible undertaking in the 2023 Measurement Year.

Cross-agency work has begun to review mental illness and substance use disorder diagnosis code sets that underlie current measurement specifications. RDA anticipates 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.

Performance Measure Comparative Analysis

Performance measures are used to monitor the performance of individual MCPs at a point in time, track performance over time, compare performance among MCPs, and inform the selection and evaluation of quality improvement activities. Comagine Health conducted an analysis of the MCPs' Healthcare Effectiveness Data and Information Set (HEDIS®) measures. HEDIS is a widely used set of health care performance measures reported by health plans.

In addition, five non--HEDIS measures, calculated by the Department of Social and Health Services Research and Data Analysis Division (RDA), were analyzed:

- Mental Health Service Rate, Broad Definition (MH-B)
- Substance Use Disorder Treatment Rate (SUD)
- Home and Community-Based Long-Term Services and Supports Use (HCBS)
- Percent Homeless - Narrow Definition (HOME-N)
- Percent Homeless - Broad Definition (HOME-B)

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

Performance Measure Comparative Analysis Recommendation

For additional information see the Performance Measure Comparative Analysis section of this report (page 54). Refer to the *2023 Comparative and Regional Analysis Report* for comprehensive recommendations.

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 MCPs 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 2023, the Apple Health MCPs conducted the CAHPS 5.1H Adult Medicaid survey of individuals enrolled in Apple Health. The full report summarizing the findings is Comagine Health's *2023 CAHPS® 5.1H Member Survey: Medicaid Adult Washington All Plan Report*[10] produced by Press Ganey, an NCQA-certified survey vendor and subcontractor of Comagine Health.

In 2023, the Apple Health MCPs also conducted the CAHPS 5.1H Child with Chronic Conditions Medicaid survey of individuals enrolled in Apple Health. The full report summarizing the findings is in Comagine Health's *2023 CAHPS® 5.1H Member Survey: Medicaid Child Washington All Plan Report* [11] produced by Press Ganey.

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 CCW's *MY2022 CAHPS® Medicaid Child with CCC 5.1 Survey: Coordinated Care- Foster Care Report* produced by Press Ganey.

CAHPS Recommendations

Recommendations for CAHPS are provided to all MCPs for the Apple Health Integrated Managed Care – Medicaid Adult and Medicaid Child with Chronic Conditions surveys and include:

[10] 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/2023-apple-health-cahps-adult-report.pdf.

[11] 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/2023-apple-health-cahps-child-report.pdf.

- Utilizing telehealth and other technologies may help combat access issues, which continued to be an issue in Washington as evidenced by the Getting Needed Care Scores. The size of the state and the rural eastern part of the state are drivers of the access issues.
- Targeting high-risk members with a care coordination outreach program. Collaborating with providers and sharing tools, resources and best practices to support, or reinforce, a complete and effective information exchange with all patients.
- Recommended improvement strategies for CCW for the Apple Health Foster Care – Child Medicaid with Chronic Conditions Survey are referenced in the CAHPS section of this report.

For comprehensive recommendations see the CAHPS section of this report (page 63).

Wraparound with Intensive Services (WISe) Program Review (Focus Study)

Washington HCA chose to conduct a statewide study on quality with focus on the WISe service delivery model in 2022. Comagine Health is contracted to review agencies 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 Washington Apple Health Integrated Foster Care (AH-IFC), Washington Apple Health-Integrated Managed Care (AH-IMC), Behavioral Health Services Only (BHSO) programs, and State Children's Health Insurance Program (CHIP).[12] It is a team-based approach that provides services to youth and their families in home and community settings rather than at a Behavioral Health Agency (BHA) and is intended as a treatment model to defer from and limit the need for institutional care.

The reviews consisted of clinical record reviews chosen from a state-wide sample provided by HCA. Records were chosen for two types of reviews: "Enrollment," spanning the first 90 days of WISe services and "Transition," reviews spanning the last 90 days of WISe services based on the criteria of the Washington Quality Improvement Review Tool (QIRT). These records reflect a combination of both rural and urban agencies providing WISe services throughout the state of Washington during the period from July 2021 through June 2022.

WISe Recommendations

We recommend MCPs work with their agencies by using the findings in this study to drive improvement efforts. In addition, HCA should work with the MCPs to assist agencies in conducting a root cause analysis to identify the barriers to success in meeting WISe requirements. As interventions are identified, agencies should use Plan-Do-Study-Act (PDSA) cycles of improvement to measure the effectiveness of each intervention. Agencies should:

- Ensure WISe team is utilizing training resources for WISe and Crisis Planning and reviewing WISe Manual for Crisis Plan template
- Ensure WISe team is participating in coaching through the WISe Workforce Collaborative
- Conduct collaborative and timely initial full CANs assessments
- Continue utilizing MCPs' support of agency-level QIRT review
- Ensure collaboration in the development of crisis plans

[12] WISe Policy and Procedure Manual. Available at: https://www.hca.wa.gov/assets/billers-and-providers/wise-wraparound-intensive-services-manual.pdf

- Conduct CFT meetings at least every 30 days, with the youth 100% of the time
- Develop formal transition plans and ensure the plans contain collaboration and input from youth, family, formal service providers, and natural supports
- Conduct collaborative initial full CANs assessments
- Ensure documentation of progress and celebration of success is identified in all records

Due to similar results in prior years, we also recommend HCA work with the MCPs to investigate underlying causes of these results such as workforce issues and WISe program processes to drive improvement efforts and reduce barriers to success.

Additional EQR Activities

In addition to the above activities, the following activities were included in the 2023 Washington EQR.

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

Since 2019, Comagine Health has been contracted to assess both Washington Apple Health Integrated Managed Care (AH-IMC) and Apple Health Integrated Foster Care (IFC) MCP 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.

The following year, the MCPs' data are collected and analyzed to evaluate their performance on these assigned measures according to their achievement level. 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 MCP on their achievement of the state's quality initiative within the VBP strategy.

In 2023, the governor of Washington vetoed a section of the proposed budget proviso requiring HCA's contracted EQRO to annually analyze the performance of Apple Health MCPs providing services to Medicaid enrollees. Although proviso language was vetoed, much of the process remains the same. This is the fifth year that HCA will be using this annual process to review and select VBP performance measures for the five MCPs.

Enrollee Quality Report

The purpose of the 2023 Enrollee Quality Report "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. The Plan Report Card provides information to eligible Apple Health clients regarding MCP quality in serving Medicaid and CHIP clients and is posted annually to the Washington Healthplanfinder website.[13]

[13] Washington Healthplanfinder. Available at: https://www.wahealthplanfinder.org/

Overview of Apple Health MCP Enrollment

In Washington, Medicaid enrollees are covered by the five MCPs 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)

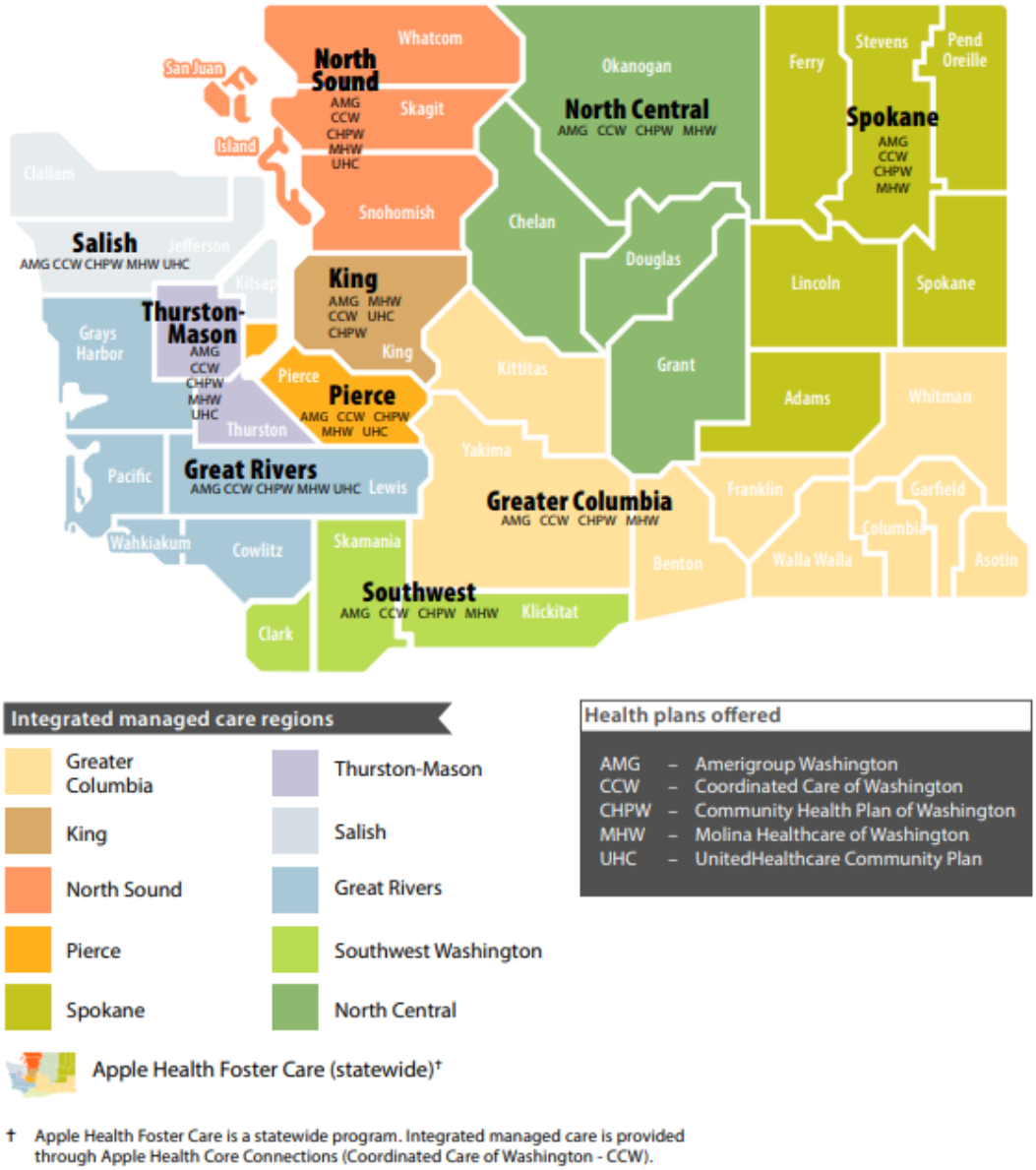
Within Washington's Apple Health Integrated Managed Care program, Medicaid enrollees may qualify under the following eligibility categories:

- 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 MCP for the Apple Health Regional Service Areas by County in 2023 which are defined as follows:

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

Figure 2. Apple Health Regional Service Areas by County in 2023.[14]



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

Apple Health MCP Enrollment

In 2023, the five MCPs provided managed health care services for Apple Health enrollees who meet the eligibility requirements. The following figures show MCP enrollment data covering physical and behavioral health services, including mental health and substance use disorder treatment services.

[14] Apple Health Managed Care Service Area Map. Provided by Washington Health Care Authority. Latest map available at: https://www.hca.wa.gov/assets/free-or-low-cost/service_area_map.pdf.

Figure 3 shows MCO Medicaid enrollment by MCP. MHW enrolls about half of the Medicaid members in Washington. The rest of the member population is distributed across the remaining four plans, ranging from 11.2% to 13.5%.

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

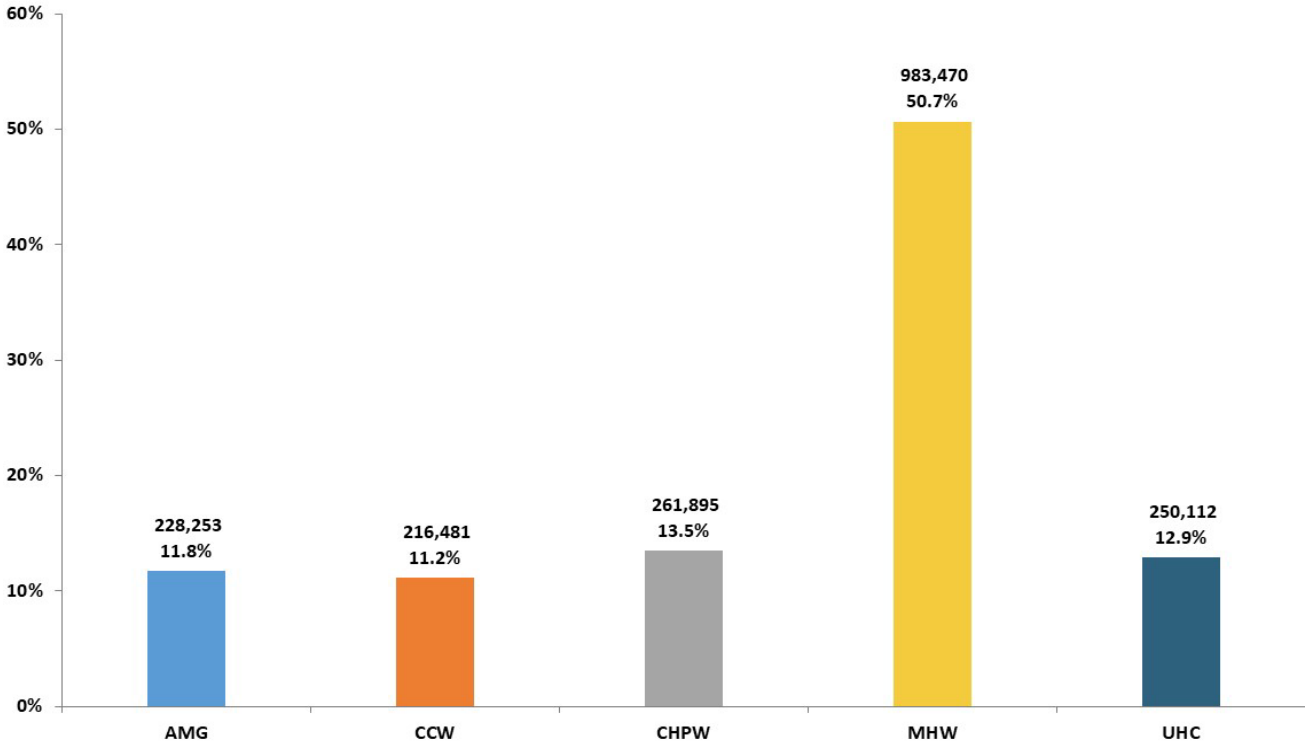
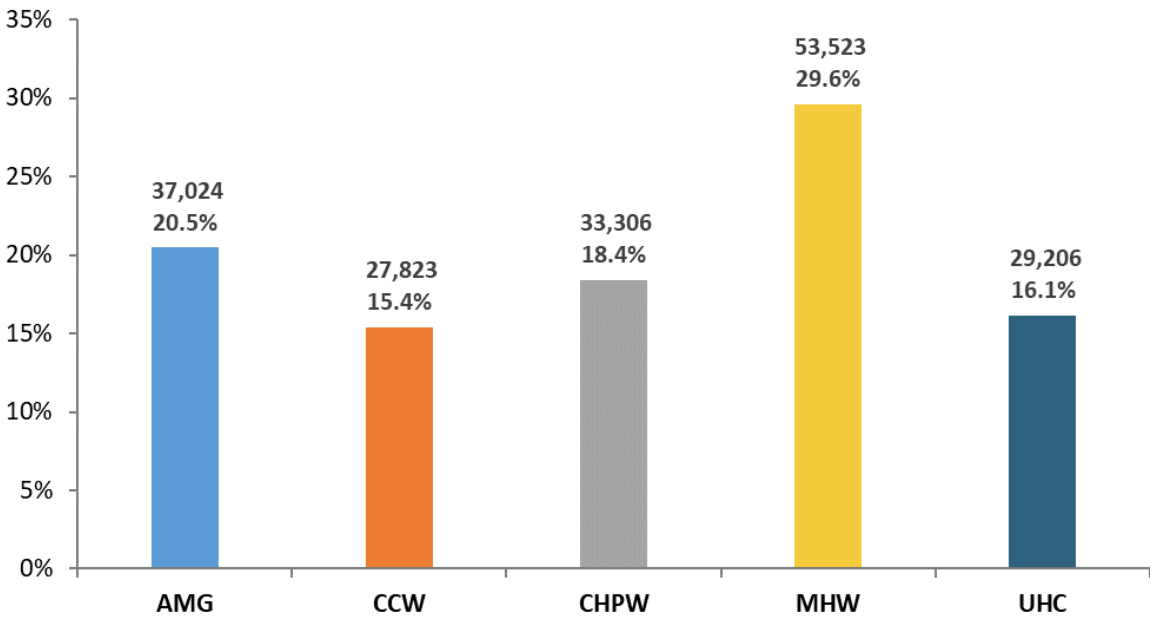


Figure 4 shows BHSO enrollment by MCP. The BHSO enrollment is distributed a bit differently than the MCO Medicaid enrollment. MHW still has the largest share of the enrollment, but only has 29.6% of BHSO enrollees. AMG is the second largest with 20.5% of the BHSO enrollees. The remaining enrollment is distributed fairly evenly among CCW, CHPW and UHC.

Figure 4. Percent of BHSO Enrollment, According to MCP.



Demographics by MCP

Variation between the MCPs' demographic profiles reflects the difference in plan mix for each MCP, which includes MCOs and BHSOs, and should be considered when assessing HEDIS measurement results.

Age

The 2022 calendar year is referred to as the measurement year 2022 (MY2022) 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 MCPs was in the 21–44 age group.

Figure 5. MCO Enrollee Population by MCP and Age Range, MY2022 (Excluding BHSO).

Age Range	AMG	CCW	CHPW	MHW	UHC
Age 0 to 5	12.4%	15.0%	12.4%	14.0%	11.5%
Age 6 to 12	14.1%	18.8%	16.5%	18.2%	14.2%
Age 13 to 20	13.9%	19.3%	19.7%	19.2%	14.3%
Age 21 to 44	39.4%	31.8%	34.2%	34.4%	38.7%
Age 45 to 64	19.5%	14.4%	16.7%	13.9%	20.7%
Age 65+	0.6%	0.6%	0.6%	0.2%	0.6%

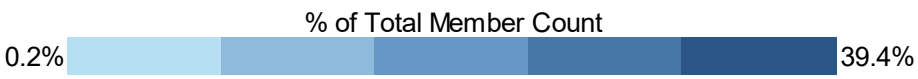
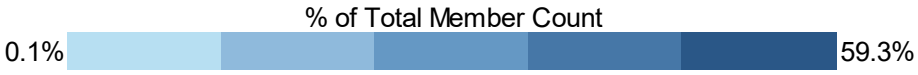


Figure 6 shows the percentages of enrollment by age group and BHSO. The darker blue signifies a higher percentage, while lighter blue signifies lower, with a medium gradient for those values in between. Though the average age of members varies across plans, the highest proportion of members across BHSOs was in the 65+ age group.

Figure 6. BHSO Enrollee Population by MCP and Age Range, MY2022.

Age Range	AMG	CCW	CHPW	MHW	UHC
Age 0 to 5	0.1%	0.5%	0.2%	0.2%	0.1%
Age 6 to 12	1.1%	2.3%	0.9%	1.4%	1.0%
Age 13 to 20	2.3%	3.3%	1.8%	2.5%	2.0%
Age 21 to 44	18.8%	18.5%	18.5%	19.2%	17.0%
Age 45 to 64	21.8%	18.4%	19.6%	22.4%	20.6%
Age 65+	55.9%	57.0%	59.0%	54.3%	59.3%



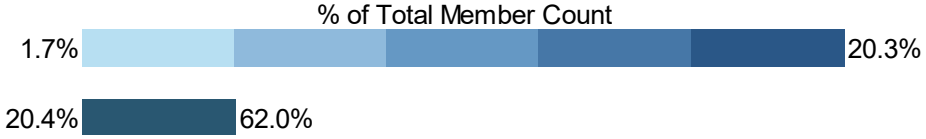
Race and Ethnicity by MCP

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.

As shown in Figure 7, approximately half of CCW and CHPW’s enrollment is white; the other three MCPs have approximately 60% of their enrollment is white. The “Other” race category was the second most common for most MCPs. Note that “Other” race is selected by the enrollee when they identify themselves as a race other than those listed; CCW and CHPW have the most enrollment in this category with approximately 20% of their members selecting other. Black members make up 11.6% of UHC’s enrollee population and 9.4% of AMG’s population, which were higher percentages than other MCPs.

Figure 7. Statewide MCO Apple Health Enrollees by MCP and Race,* MY2022 (Excluding BHSO).

Race/Ethnicity	AMG	CCW	CHPW	MHW	UHC
White	62.0%	53.8%	52.2%	60.6%	57.2%
Other	10.5%	20.1%	20.3%	12.6%	8.5%
Not Provided	6.9%	8.2%	7.7%	7.2%	7.9%
Black	9.4%	8.2%	8.3%	8.7%	11.6%
Asian	4.3%	4.2%	5.9%	4.5%	7.0%
American Indian/Alaska Native	2.2%	2.0%	1.7%	2.3%	2.2%
Hawaiian/Pacific Islander	4.6%	3.5%	3.9%	4.0%	5.7%

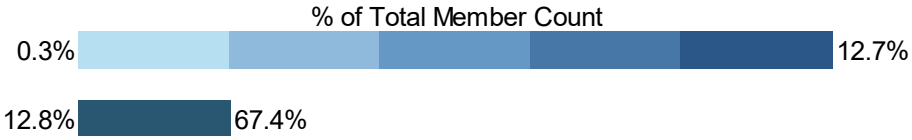


**These are the categories MCOs provide to HCA in eligibility data files. The “Other” category is defined as “client identified as a race other than those listed.” And the “Not Provided” category is defined as “client chose not to provide.”*

Figure 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. The "Other" race category was the second most common for three of the five BHSOs. Note that "Other" race is selected by the enrollee when they identify themselves as a race other than those listed; CCW and CHPW have the most enrollment in this category with approximately 12.3% and 12.2% of their members selecting other, respectively.

Figure 8. Statewide BHSO Apple Health Enrollees by MCP and Race,* MY2022.

Race/Ethnicity	AMG	CCW	CHPW	MHW	UHC
White	65.7%	57.3%	61.9%	67.4%	62.0%
Other	9.2%	12.3%	12.2%	8.7%	7.1%
Not Provided	6.1%	6.9%	6.5%	5.8%	6.1%
Black	6.2%	7.5%	5.9%	5.9%	7.8%
Asian	9.4%	11.8%	10.5%	8.5%	12.7%
American Indian/Alaska Native	0.5%	0.9%	0.3%	0.9%	0.5%
Hawaiian/Pacific Islander	2.9%	3.2%	2.7%	2.8%	3.7%



**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 9 shows the percentage of MCO members who identified as Hispanic. CCW and CHPW have the largest percentages of Hispanic members at 34.4% and 33.3%, respectively. Please note that within this report, Hispanic is used to identify an ethnicity and does not indicate race.

Figure 9. Statewide MCO Apple Health Enrollees by MCP and Hispanic Indicator (Excluding BHSO), MY2022.

Hispanic	AMG	CCW	CHPW	MHW	UHC
No	80.4%	65.6%	66.7%	78.3%	85.9%
Yes	19.6%	34.4%	33.3%	21.7%	14.1%

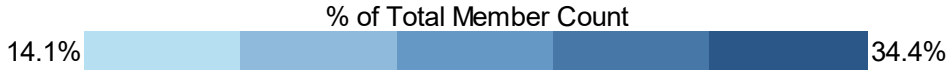
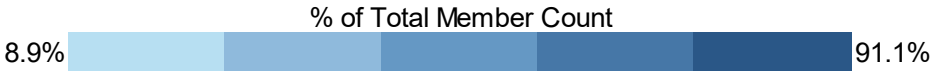


Figure 10 shows the percentage of BHSO enrollees who identified as Hispanic. CCW and CHPW have the largest percentages of Hispanic members at 17.5% and 17.3%, respectively. Please note that within this report, Hispanic is used to identify an ethnicity and does not indicate race.

Figure 10. Statewide BHSO Apple Health Enrollees by MCP and Hispanic Indicator, MY2022.

Hispanic	AMG	CCW	CHPW	MHW	UHC
No	87.0%	82.5%	82.7%	87.5%	91.1%
Yes	13.0%	17.5%	17.3%	12.5%	8.9%



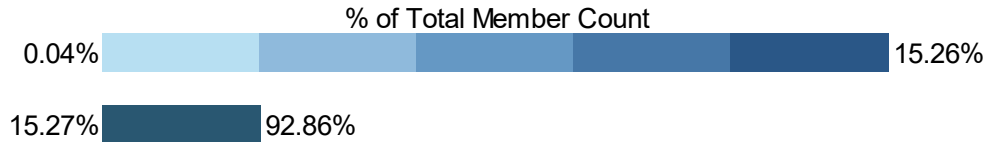
Primary Spoken Language by MCP

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

Figure 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, MY2022 (Excluding BHSO).

Spoken Language	AMG	CCW	CHPW	MHW	UHC
English	89.03%	82.82%	78.28%	89.04%	92.86%
Spanish; Castilian	6.83%	12.25%	15.26%	6.90%	3.11%
Russian	0.67%	0.56%	1.08%	1.16%	0.63%
Vietnamese	0.36%	0.53%	0.72%	0.39%	0.57%
Chinese	0.39%	0.36%	1.04%	0.22%	0.33%
Arabic	0.20%	0.18%	0.33%	0.20%	0.25%
Ukrainian	0.47%	0.52%	0.51%	0.53%	0.54%
Somali	0.14%	0.11%	0.30%	0.16%	0.17%
Korean	0.06%	0.07%	0.05%	0.08%	0.28%
Amharic	0.13%	0.08%	0.16%	0.08%	0.10%
Tigrinya	0.10%	0.04%	0.11%	0.07%	0.06%
Panjabi; Punjabi	0.05%	0.06%	0.06%	0.08%	0.06%
Burmese	0.06%	0.04%	0.12%	0.04%	0.04%
Farsi	0.07%	0.05%	0.09%	0.05%	0.06%
Cambodian; Khmer	0.04%	0.04%	0.05%	0.04%	0.06%
Other Language*	1.39%	2.31%	1.84%	0.94%	0.88%

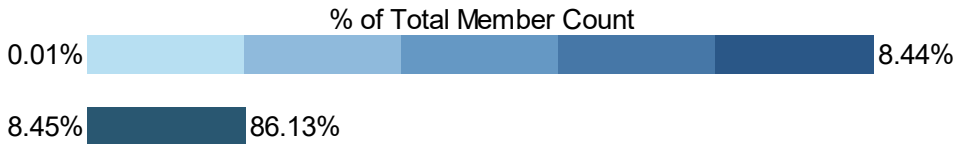


**Other Language is the sum of the 85 languages not specifically reported in this figure and represents less than 1% of enrollees.*

Figure 12 shows the most common primary spoken languages for BHSO enrollees. Similar to the 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 MCP.

Figure 12. Statewide BHSO Apple Health Enrollees by MCP and Language, MY2022.

Spoken Language	AMG	CCW	CHPW	MHW	UHC
English	84.7%	80.4%	80.4%	86.1%	86.0%
Spanish; Castilian	5.66%	7.95%	8.14%	4.98%	3.67%
Russian	0.44%	0.48%	0.69%	0.99%	0.52%
Vietnamese	0.65%	0.81%	0.84%	0.73%	1.03%
Chinese	0.67%	0.78%	0.99%	0.61%	0.79%
Arabic	0.07%	0.06%	0.10%	0.08%	0.10%
Ukrainian	0.04%	0.09%	0.08%	0.09%	0.06%
Somali	0.05%	0.08%	0.12%	0.05%	0.10%
Korean	0.30%	0.41%	0.29%	0.33%	0.63%
Amharic	0.05%	0.09%	0.08%	0.07%	0.09%
Tigrinya	0.06%	0.04%	0.07%	0.04%	0.05%
Panjabi; Punjabi	0.12%	0.15%	0.20%	0.15%	0.18%
Burmese	0.02%	0.02%	0.03%	0.01%	0.03%
Farsi	0.05%	0.03%	0.05%	0.05%	0.04%
Cambodian; Khmer	0.19%	0.21%	0.14%	0.18%	0.21%
Other Language*	6.95%	8.44%	7.82%	5.52%	6.49%



**Other Language is the sum of the 85 languages not specifically reported in this figure and represents approximately 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[15] 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 CFR §§ 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 Assurance 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

Washington 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 the 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, Washington State Division of Behavioral Health and Recovery 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. In 2020, the update 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. At that time, Quality Strategy updates were also reviewed and approved by several committees including Washington's Title XIX Committee. Changes made were 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

[15] Washington State Health Care Authority. Washington State Managed Care Quality Strategy. October 2022. 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 and Provider Payment Initiatives
- Expanded description of 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 of the Quality Strategy (conducted in 2022) by HCA, incorporated feedback from the EQRO Annual Technical Reports occurring during the period of review. HCA works continually to update the Quality Strategy for its next iteration.

Per the update submitted to CMS on 12/8/2022, "*The 2022 Washington State Managed Care Quality Strategy does not represent significant change, therefore modifications to the Quality Strategy were made in response to internal stakeholder and partner feedback (including a review by CMS's contracted Quality Strategy reviewer), and any applicable Apple Health contract amendments. Any/all updates to the Managed Care Quality Strategy take into account the results of HCA review of effectiveness of previous Quality Strategy, recommendations from HCA's contracted EQRO, as well as an internal review of the most current CMS Quality Strategy Toolkit and CMS EQR protocols. Since its last Quality Strategy submission, submitted to CMS in October of 2020, the Apple Health program has not undergone significant change. Agency response to the COVID-19 pandemic and associated public health emergency was carried out via existing relationships and quality monitoring/improvement structures and although impactful, did not result in significant change as defined by the Quality Strategy.*"

Quality Strategy Populations and Programs

The Quality Strategy is applicable to the following 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 provide 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 on the next page (Table 2), 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 six Quality Strategy aims are shown below in Table 2.

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.

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

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

CMS National Quality Strategy Goals*	WA State Medicaid: Apple Health Value-Based Purchasing Principles**	WA Medicaid Managed Care: Managed Care Aims for Quality Oversight±
Promote Aligned and Improved Health Outcomes Advance Equity and Engagement for All Individuals Ensure Safe and Resilient Health Care Systems Accelerate Interoperability and Scientific Innovation	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)*
	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)*
	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)*

**CMS National Quality Strategy—2022[16].*

***Paying for Health and Value – Health Care Authority's Long-term Value-Based Purchasing Roadmap 2023-2027.*

±February 2023 Washington State Managed Care Quality Strategy – October 2022.[17]

[16] CMS National Quality Strategy. Available at: https://www.cms.gov/medicare/quality/meaningful-measures-initiative/cms-quality-strategy

[17] Washington HCA. Value-Based Purchasing Roadmap. Available at: https://www.hca.wa.gov/assets/program/vbp-roadmap.pdf.

Information and Documentation Reviewed

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:

- 2023 Washington State Managed Care Quality Strategy
- All EQRO activities, including:
    - HCA follow-up on 2022 EQRO Technical Report recommendations
    - Compliance review
    - Performance Improvement Project validation
    - Enrollee Quality Report "Washington Apple Health Plan Report Card" (Quality Rating System)
    - WISe Program review (focus study)
    - CAHPS surveys
    - Value-based purchasing strategy within the Quality Strategy
    - VBP report card
    - Performance measure comparative analysis

2023 Recommendations

Comagine Health acknowledges the significant effort put forth by HCA to make the Quality Strategy an effective, value-added and living document. After review of the Quality Strategy and MCP performance, the following recommendations are being made to HCA to improve the effectiveness of the Quality Strategy (Table 3).

Table 3. Recommendations Related to Quality Strategy.

Recommendations	Linked to Aim(s)*
To help the state achieve their overall objectives for delivery system and payment reform and performance improvement, tie evaluation of state directed payments to the Managed Care Quality Strategy as required by CMS. Include clarification of the measure selection process and enhanced program integrity in the use of state directed payments.	Aims 1, 2, 4, 6
Updates to reflect changes to the VBP process, including no current legislative proviso and addition of state directed payments.	Aims 1 and 4
Update the Network Adequacy Validation portion of the Quality Strategy to reflect updated processes and the new EQR Protocol 4 Validation of Network Adequacy.	Aim 2, 3, 5
Re-evaluate the focused quality study of the WISe service delivery model to ensure the study is providing information to guide continuous quality improvement of this important initiative.	Aim 1, 2, 3, 4
Recommendations from Performance Measure Comparative Analysis**	
Maintain focus on clinically meaningful areas	Aim 1

Recommendations	Linked to Aim(s)*
Continue to leverage value-based payment incentives	Aim 1
Focus on access, and preventive care and utilization	Aims 1, 2, 3
Continue to prioritize health equity	Aims 1, 2, 4, 5

**Aims from Washington State Managed Care Quality Strategy – October 2022.*
***See the Performance Measure Comparative Analysis section of this report for additional information and the 2023 Comparative and Regional Analysis Report for comprehensive recommendations.*

Please see additional recommendations made to the MCPs to improve MCP performance in the following sections of this Annual Technical Report. (The recommendations to the MCPs align with the existing Quality Strategy Aims.)

- Compliance Review (Aims 1, 2, 3, 4, 5, 6)
- Performance Measure Comparative Analysis (Aims 1, 2, 4)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) (Aim 4)
- Wraparound with Intensive Services (WISe) Program Review (Aims 1, 2, 3, 4)

Follow-Up on Recommendations from the Previous Year (2022)

Table 4 outlines HCA's follow-up on recommendations made in the 2022 EQR technical report to assist with targeting goals and objectives in the Quality Strategy to better support the quality, timeliness and access to health care services.

Table 4. 2022 EQRO Recommendations, HCA Response and EQRO Response.

EQRO Recommendation	HCA Response	EQRO Response
Ensure transparency of MCP quality concerns by public reporting of corrective action plans and sanctions related to quality. • The EQRO Technical Report provides information on corrective action plans for EQR activities. Possible sanctions are defined in the MCP contracts with HCA. Since these sanctions may highlight significant quality issues, they should be readily available/easy to find and tied to quality reports (Managed Care Report card, EQR Technical Report, etc.).	Regarding transparency of MCP quality concerns, development of processes for public reporting of sanction information within the annual EQR Technical report is being evaluated and options are being discussed with HCA leadership. Current State: 1) Corrective action plans (CAP) associated with TEAMonitor processes are already reported in annual EQR Technical Report in compliance with managed care regulations; however, CAPs identified and issued outside the TEAMonitor process are not publicly reported. 2) Not all sanctions and liquidated damages are publicly reported. Those that are required by 42 CFR 438.602(g)(4) can be found here: https://www.hca.wa.gov/about-hca/other-administrative-activities/audits-and-reporting 3) Sanctions are reported to CMS according to 42 CFR 438.724. 4) The process for CAPs and sanctions is described publicly in the WA Medicaid Managed Care Quality Strategy.	HCA response to EQRO recommendations accepted as written.
Tie the status of network adequacy to overall MCP performance of quality, access and timeliness. Analyze and ensure transparency in reporting of the relationship between network adequacy and quality performance. • Network adequacy is a driver of quality. As an example, if an MCP does not have an adequate primary care network, then it may have challenges meeting performance metrics targets. • MCPs should continue to address and improve their networks as defined in contract (provider numbers, types, ratios, geographic accessibility, travel distance and	HCA agrees that network adequacy is a driver of quality and has developed a comprehensive review process. MCP provider network validations are done on an ongoing basis during the first month of every quarter. The MCP provides all documentation to determine network adequacy including a self-analysis to demonstrate understanding of where their network is, but the actual determinations are done by HCA. The HCA created a framework based on the MCPs ability to serve a percentage of a given county and base participation in the region on that capacity threshold. MCPs are expected to maintain a capacity threshold of 80% or better in all CMS-designated critical provider types to have full participation in a region and would be removed from that region if the capacity	HCA response to EQRO recommendations accepted as written.

EQRO Recommendation	HCA Response	EQRO Response
meet compliance standards). In addition, analysis should tie this information to quality performance measurement. (This may be included in the annual EQR Technical Report. Compliance with access and availability standards is reported once every three years in the Technical Report. Network adequacy validation is currently being conducted by HCA on an ongoing basis. Network adequacy validation is not yet a mandated EQR protocol).	threshold falls below 60% in any of the critical provider types. We are able to see the full picture of what the adequacy looks like as determined by CMS designated critical provider types. This approach allows the HCA to work directly with MCPs to ensure identified gaps and challenges are addressed and resolved in a timely manner. To complete this work MCPs are required to use templates, proximity files, and geolocation software designated by HCA to ensure consistency per the Integrated Managed Care Contract. If there is a discrepancy or noted gap that is not identified in the self-assessment or accompanying narrative explanation of findings, HCA would send a formal notice to the MCP of our findings and expectation for resolution by a given date. The MCP has two quarters to correct the issue before we look at corrective action and potential removal from participation in a region. Additionally, non-performance penalties are built into our provider network program which allows HCA to impose penalties for non-compliance. HCA is also working toward implementing CMS EQR Protocol 4 within our network validation structure and implementing CMS required updates now that the new regulations are released.	
2022 Performance Measure Comparative and Regional Analysis Recommendations within the Quality Strategy Analysis: • Sustain Improvement in Clinically Meaningful Areas • Continue to Leverage Value Based Payment Incentives • Address Behavioral Health Declines • Focus on Access and Preventive Care • Continue to prioritize Health Equity	HCA seeks to sustain improvement and address behavioral health declines through multiple quality improvement efforts that continue the HCA/MCP collaboration fostered through the Behavioral Health integration implementation. Examples include the MCP Well-Child Collaborative Performance Improvement Project (PIP), Child Behavioral Health Equity Collaborative PIP, Administrative Simplification workgroup, Skilled Nursing Facility (SNF) Collaborative workgroup, and selection process for Value Based Purchasing (VBP) measures. In January 2020, all 10 regions of the state completed the transition to an integrated system for physical health, mental	HCA response to EQRO recommendations accepted as written.

EQRO Recommendation	HCA Response	EQRO Response
	health, and substance use disorder treatment services within the Apple Health program. HCA has had projects underway to support ongoing bi-directional clinical integration of physical and behavioral health through care transformation in each of the regions, specific to the identified needs of those areas. HCA annually selects VBP performance measures after an analysis by the contracted EQRO. Comagine Health, WA State's currently contracted EQRO, presented recommendations to HCA leadership in August and measures were selected in alignment with Quality Measuring Monitoring and Improvement (QMMI) guiding principles, WA State Common Measure Set, and WA State Medicaid Quality Strategy. HCA priorities for measure selection include access to preventive care, behavioral health care, and maternity care. HCA leadership is also committed to moving towards more outcomes-based measures to support better health outcomes in Washington. Last year HCA requested the EQRO VBP recommendation analysis include additional reflection of the impact of health disparities to inform HCA in its selection process. HCA continues to explore how to incorporate equity-focused payment and contracting models into the VBP program as an approach to improving health equity.	

Compliance Review

Objective

The purpose of the compliance review is to determine whether Medicaid managed care plans are following federal standards. The Centers for Medicare & Medicaid Services (CMS) developed mandatory standards for MCPs which are codified at 42 CFR 438[18] and 42 CFR 457[19], as revised by the Medicaid and CHIP managed care final rule issued in 2016.

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 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 2023, Year 2 of the current review cycle, TEAMonitor reviewed the following principal standards (Table 5) for the MCPs. These fall under the domains of access, quality and timeliness.

Please note that TEAMonitor may review standards in conjunction with standards falling under other subparts. Please see Appendix E for a detailed summary of the standards reviewed in the current cycle.

Table 5. Compliance Principal Standards Reviewed in Year 2 of the Current Cycle.

Principle Standard
§438.100 - Enrollee rights
§438.206 - Availability of services
§438.208 - Coordination and continuity of care
§438.236 - Practice guidelines
§438.242 - Health information systems
§438.330 - Quality assessment and performance improvement program (QAPI)
§438.400 - Grievance System

Note: these standards fall under the domains of access, quality and timeliness, and apply to the following Quality Strategy Aims: 1, 2, 3, 4, 5, 6.

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

[19] 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 types of files reviewed include authorizations, 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 in the MCP profiles for each MCP.

After review, HCA staff share results with the MCPs through phone calls and virtual visits. 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 element 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:

- 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 compliance standard section reported below are denoted by 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% reported for the standard section. In addition, plans are reviewed on standard 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.

Summary of Aggregate MCP Compliance Results

Table 6 provides a summary of the aggregate results for the MCPs within Apple Health by compliance standard in Year 2 of the current three-year cycle.

Table 6. Aggregate Compliance Results of the Apple Health MCPs.

Standard	Score*
§438.100 - Enrollee rights	99%
§438.206 - Availability of services	90%
§438.208 - Coordination and continuity of care	85%

Standard	Score*
§438.236 - Practice guidelines	91%
§438.242 - Health information systems	100%
§438.330 - QAPI	83%
§438.400 - Grievance System	99%

**Aggregate MCP point values were totaled and the sum was divided by the aggregate number of applicable elements in the standard to derive percentage scores.*

Compliance Program Level EQRO Recommendation for HCA

The Apple Health Plan MCPs* did not meet all elements for the following standards and associated elements and will benefit from technical assistance by HCA to ensure the plans meet those requirements.

- Availability of services (90%)
  - Four of five MCPs did not meet the following elements
    - 438.206 (b)(1)(i-v) & (c) Delivery network; 438.10 (h) Information for all enrollees – Provider directory
    - 438.207 Assurances of adequate capacity and services (b)(c)
- Practice guidelines standards (91%)
  - Four of five MCPs did not meet the following element
    - 438.236(c) Dissemination of practice guidelines
- Coordination and Continuity of Care (83%)
  - Two of five MCPs did not meet the following element
    - 438.208 (b) Care and coordination of services for all MCO, PIHP, and PAHP enrollees; §438.224 Confidentiality
  - No MCP* (MCO and BHSO combined) met the following elements
    - 438.208 (a) Basic rules
    - 438.208 (c) Additional services for enrollees with special health care needs; (2) Assessment and (3) Treatment plans
- QAPI (83%)
  - Three of five MCPs did not meet the following element
    - 438. 330 (e)(2) QAPI Program evaluation

Please note both the MCO and BHSO are referred to as the Apple Health Plan MCP (i.e., AMG MCP is AMG MCO **and AMG BHSO, etc.).*

Review of Previous Year (2022) Compliance Program Level EQRO Recommendations

Comagine Health provided recommendations to HCA in 2022. Table 7 shows the program-level compliance recommendations made, HCA's responses and the EQRO response to HCA.

Table 7. EQRO Responses to 2022 EQR Recommendations to HCA.

EQRO Recommendation	HCA Response	EQRO Response
Four of the five MCOs/BHSOs did not meet all standards for Quality Assessment and Performance Improvement Program (QAPI) and will benefit from technical assistance by HCA to ensure the plans meet those requirements. These elements include: • General rules • QAPI program evaluation • Monitoring Procedures - Claims payment monitoring	The plans identified with deficiencies in general rules, QAPI program evaluation, and claims payment monitoring through compliance review were required to respond to the state with corrective action. • General rules monitoring has been addressed. The Corrective Action issued was met. • QAPI program evaluations are reviewed later in the compliance review cycle. HCA routinely reviews for follow through with previous year CAPs and issues new CAPs in current year cycle if issues are not fully addressed to achieve compliance. Current year MCP CAPs are under review at the time of this response. Technical Assistance regarding QAPI requirements has been provided to plans as requested. • Claims payment monitoring has been addressed. The Corrective Action issued was met. Technical assistance has been offered to all MCO/BHSOs. HCA will continue to follow compliance through TEAMonitor's compliance review processes.	The EQRO acknowledges that HCA has provided technical assistance to the MCPs. However, three of the five MCPs (MCO/BHSO) did not meet the QAPI program evaluation element in 2023. The QAPI program evaluation portion of this recommendation stands while the responses to General rules and Monitoring procedures – Claims payment monitoring are accepted as written.

EQRO Recommendation	HCA Response	EQRO Response
Four of the five MCOs/BHSOs did not meet all elements for the Coverage and Authorization standards. The MCPs will benefit from technical assistance by HCA to ensure the plans meet those requirements. These elements include: • Authorization of services • Notice of adverse benefit determination • Timeframe for decisions	The plans identified with deficiencies in authorization of services, notice of adverse benefit determination, and timeframe for decisions through compliance review were required to respond to the state with corrective action. All five MCO/BHSOs met the elements for the Coverage and Authorization standards related to: • Timeframe for decisions Four of the five MCO/BHSOs made improvements in the elements for the Coverage and Authorization standards related to: • Authorization of services • Notice of adverse benefit determination Technical assistance has been offered to all MCO/BHSOs. HCA will continue to follow compliance through TEAMonitor's compliance review processes.	HCA response to EQRO recommendations accepted as written.

Summary of MCP Plan Level Compliance Results/Conclusions

Table 8 shows the scoring key for compliance strengths and weaknesses/opportunities for improvement.

Table 9 provides a summary of all MCP scores by compliance standard in Year 1 of the current three-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.

Detailed scores for each element within the CFR standards reported below are available in the MCP's individual profile (Appendix A).

Table 8. Strengths and Weaknesses/Opportunities for Improvement Key.

Strengths	Weaknesses/Opportunities for Improvement		
Met all elements within this standard ●	Partially met the elements within this standard	◑	Did not meet any elements within this standard ○

Table 9. Compliance Review Results by MCP.

CFR Standard	AMG		CCW		CHPW		MHW		UHC	
	MCO	BHSO	MCO	BHSO	MCO	BHSO	MCO	BHSO	MCO	BHSO
§438.100 - Enrollee rights	97%	97%	97%	97%	100%	100%	100%	100%	100%	100%
	◑	◑	◑	◑	●	●	●	●	●	●
§438.206 - Availability of services	83%	81%	92%	90%	92%	90%	96%	95%	92%	90%
	◑	◑	◑	◑	◑	◑	◑	◑	◑	◑
§438.208 - Coordination and continuity of care	80%	87%	87%	93%	80%	93%	73%	87%	80%	87%
	◑	◑	◑	◑	◑	◑	◑	◑	◑	◑
§438.236 - Practice guidelines	89%	89%	89%	89%	89%	89%	89%	89%	100%	100%
	◑	◑	◑	◑	◑	◑	◑	◑	●	●
§438.242- Health Information Systems	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	●	●	●	●	●	●	●	●	●	●
§438.330 - QAPI	50%	50%	83%	83%	100%	100%	100%	100%	83%	83%
	◑	◑	◑	◑	●	●	●	●	◑	◑
§438.400 - Grievance System	95%	100%	100%	100%	100%	100%	98%	100%	100%	100%
	◑	●	●	●	●	●	◑	●	●	●

2023 EQRO Compliance Recommendations Based on TEAMonitor CAPs

EQRO recommendations are based on the TEAMonitor CAPs supplied to the MCPs. MCPs were reviewed in the first half of the calendar year. Because MCPs may have implemented CAPs since that time to address specific issues, these recommendations may not be indicative of current performance. An update of the current year's EQRO recommendations will be reflected in the 2024 Annual Technical Report. Please refer to the MCP profiles (Appendix A) for each MCP's EQRO recommendations.

Review of Previous Year (2022) EQRO Compliance Recommendations Based on TEAMonitor CAPs

Table 10 provides a summary of the results of previous year (2022) EQRO Compliance Recommendations Based on TEAMonitor CAPs follow-up review. For a detailed description of the elements subject to follow-up for the MCPs' please refer to the applicable MCP profile in Appendix A.

Degree to which plans have addressed the previous year's EQRO recommendations key:

- Low – No CAPs met
- Medium – Less than all CAPs met
- High – All CAPs met
- NA – No CAPs received

Table 10. Results of Previous Year (2022) EQRO Compliance Recommendations – Count.

Score	AMG		CCW		CHPW		MHW		UHC	
	MCO	BHSO	MCO	BHSO	MCO	BHSO	MCO	BHSO	MCO	BHSO
Met	11	11	6	6	2	2	15	15	2	2
Partially Met*	1	0	0	0	0	0	0	0	0	0
Not Met*	6	6	0	0	0	0	0	0	0	0
Degree Addressed	Medium		High		High		High		High	

**Future follow-up required.*

Performance Improvement Project (PIP) Validation

Objectives

States must require their Medicaid and CHIP MCPs to conduct PIPs that focus on both clinical and nonclinical areas each year as a part of the plan's QAPI program, per 42 CFR §§ 438.330 and 457.1240(b).

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.

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

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 1 Validation of Performance Improvement Projects (PIPs)*, TEAMonitor determined whether PIP validation criteria were Met, Partially Met or Not Met. In addition, TEAMonitor utilizes validation ratings in reporting the results of the MCPs' PIPs.

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

Summary of PIP Validation Results/Conclusions

The following tables provide an overview of each MCP's PIPs, including applicable domains, score, strengths, weaknesses/opportunities for improvement, validation status*, validation rating** and performance measure results, if applicable. Please refer to Appendix A for additional details of the MCP PIPs.

Note: PIP weaknesses/opportunities for improvement in the referenced tables are provided when the MCP did not meet the scoring element. This language is a synopsis from TEAMonitor PIP Validation Worksheets completed for each PIP.

**"Validation status" means that TEAMonitor reviewed all relevant parts of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.*

***"Validation rating" refers to TEAMonitor's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.*

2023 Statewide Collaborative PIPs Summary: AMG, CCW, CHPW, MHW and UHC

The following PIP was submitted collaboratively by the five MCPs for validation (Table 11).

Table 11. Statewide Well-Child Collaborative: AMG, CCW, CHPW, MHW and UHC.

PIP Title: Collaborative MCO Well-Child Visit Rate PIP						
Domain	**Score**	**Validation Status**	**Validation Rating**	**Strengths**	**Weaknesses/ Opportunities for Improvement**	**Performance Measure and Results**
Access, Quality, Timeliness	Met	Yes	Moderate confidence in reported results	• Workgroup considered multiple quality resources and use indicators from the HEDIS utilization measures which align with, and are incorporated into, the 2022 CMS Child Core Set • Nice work thinking about and planning for assessment of race and ethnicity specifics for WCV to address health equity gaps	• Statistical significance is only demonstrated in the WCV measure 12-17 for 2020 – 2021 and 2020–2022 • Clinics do show improvement, but statistical significance was never achieved, and the rate increases decline over time	HEDIS measures: • W30, 0-15 months: Demonstrated performance improvement; no statistically significant change; p-value <.05 • W30, 15-30 months: Demonstrated performance improvement; no statistically significant change; p-value <.05 • WCV, 3-11 years: No demonstrated performance improvement; no statistically significant change; p-value <.05 • WCV, 12-17 years: No demonstrated performance improvement; no statistically significant change; p-value <.05 • WCV, 18-21 years: No demonstrated performance improvement; no statistically significant change; p-value <.05

2023 PIP Summary by MCP: AMG

The following PIPs were submitted by AMG for validation (Tables 12-13).

Table 12. AMG: Diabetes Screening for Adult Members on Antipsychotic Medication PIP.

PIP Title: Diabetes Screening for Adult Members on Antipsychotic Medication						
Domain	**Score**	**Validation Status**	**Validation Rating**	**Strengths**	**Weaknesses/Opportunities for Improvement**	**Performance Measure and Results**
Access, Quality, Timeliness	Met	Yes	Moderate confidence in reported results	• Successful in choosing an important PIP topic and implementing interventions tailored toward the member, provider and the MCP • Utilized the PDSA cycle and recognized the challenges of connecting with enrollees and developed creative outreach solutions	• Some interventions outlined do not seem to differ from AMG's typical care coordination activities. • Many interventions seemed to only bring about potential short-term change • Most of the interventions were not implemented until Q3 or later	Increase the percentage of diabetes screenings for adult members 18-64 years of age diagnosed with schizophrenia, schizoaffective disorder or bipolar disorder who are using antipsychotic medications from 79.90% in 2021 to 85.53%: No demonstrated performance improvement; no statistically significant change; p-value 0.61

Table 13. AMG: Improving 7-day Follow-Up After Hospitalizations for BHSO Members with Mental Illness and Emergency Department Visits for BHSO Members with Mental Illness and/or Alcohol and Other Drug Abuse or Dependence PIP.

PIP Title: Improving 7-day Follow-Up After Hospitalizations for BHSO Members with Mental Illness and Emergency Department Visits for BHSO Members with Mental Illness and/or Alcohol and Other Drug Abuse or Dependence						
Domain	**Score**	**Validation Status**	**Validation Rating**	**Strengths**	**Weaknesses/Opportunities for Improvement**	**Performance Measure and Results**
Access, Timeliness	Met	Yes	Moderate confidence in reported results	• Learning for the PIP informed AMG substantially on the needs of their population and helpful interventions moving forward	• BHSO-only PIPs experience difficulties regarding data completion without physical health claims • While there was a minimal increase in FUA, there was decrease in FUH and FUM measures which were attributed to a change in measure specifications,	Achieve a 10% aggregate increase from the 2021 baseline aggregate rate of 39.57% in BHSO members' FUH, FUM and FUA HEDIS measure rates: No demonstrated performance improvement; no statistically significant change; p-value 0.062

PIP Title: Improving 7-day Follow-Up After Hospitalizations for BHSO Members with Mental Illness and Emergency Department Visits for BHSO Members with Mental Illness and/or Alcohol and Other Drug Abuse or Dependence						
Domain	**Score**	**Validation Status**	**Validation Rating**	**Strengths**	**Weaknesses/Opportunities for Improvement**	**Performance Measure and Results**
					decrease in utilization, members experiencing homelessness and on the Do Not Call list, as well as a large change in MCO population/enrollment	

2023 PIP Summary by MCP: CCW

The following PIPs were submitted by CCW for validation (Tables 14-16).

Table 14. CCW: Improving the Timeliness of Postpartum Visits Following Live Births Within 7-84 Days PIP.

PIP Title: Improving the Timeliness of Postpartum Visits Following Live Births Within 7-84 Days						
Domain	**Score**	**Validation Status**	**Validation Rating**	**Strengths**	**Weaknesses/Opportunities for Improvement**	**Performance Measure and Results**
Access, Timeliness	Met	Yes	Moderate confidence in reported results	• Through the PDSA cycle, PIP was able to identify lessons learned and plan for potential follow up activities	• Interventions were not effective in increasing PPC rates	HEDIS measure: • PPC: No demonstrated performance improvement; no statistically significant change

Table 15. CCW: Increasing the Rate of Follow-up after Hospitalization for Behavioral Health (FUH) for Members Enrolled in BHSO PIP.

PIP Title: Increasing the Rate of Follow-up after Hospitalization for Behavioral Health (FUH) for Members Enrolled in BHSO						
Domain	**Score**	**Validation Status**	**Validation Rating**	**Strengths**	**Weaknesses/Opportunities for Improvement**	**Performance Measure and Results**
Access, Timeliness	Met	Yes	Moderate confidence in reported results	• Improvement within the IMC population was considerable (10% points)	• Low BHSO population and difficulty with King County data	HEDIS measures: • FUH (BHSO): Demonstrated performance improvement; no statistically significant change

PIP Title: Increasing the Rate of Follow-up after Hospitalization for Behavioral Health (FUH) for Members Enrolled in BHSO						
Domain	**Score**	**Validation Status**	**Validation Rating**	**Strengths**	**Weaknesses/Opportunities for Improvement**	**Performance Measure and Results**
						• FUH (IMC with BHSO): Demonstrated performance improvement; statistically significant change; p-value <.01

Table 16. CCW: Increasing the RDA MH-B Penetration Rates for Members 6 to 26 Years Old Enrolled in Foster Care PIP.

PIP Title: Increasing the RDA MH-B Penetration Rates for Members 6 to 26 Years Old Enrolled in Foster Care						
Domain	**Score**	**Validation Status**	**Validation Rating**	**Strengths**	**Weaknesses/Opportunities for Improvement**	**Performance Measure and Results**
Access, Quality, Timeliness	Met	Yes	Moderate confidence in reported results	• Interventions seem to be effective and have created a path for effective treatment in the future for children in the IFC system	• PIP writing has substantially improved, but is still need for proofreading • Data regarding raw numerators and denominators is confusing • Unclear why there isn't mention of MY 2021 data	RDA measure: • MH-B: Demonstrated performance improvement; statistically significant change; p-value <.05

2023 PIP Summary by MCP: CHPW

The following PIPs were submitted by CHPW for validation (Tables 17-18).

Table 17. CHPW: Implementation of Community-Based Interventions to Address Disparities in Breast Cancer Screening Rates PIP.

PIP Title: Implementation of Community-Based Interventions to Address Disparities in Breast Cancer Screening Rates						
Domain	**Score**	**Validation Status**	**Validation Rating**	**Strengths**	**Weaknesses/ Opportunities for Improvement**	**Performance Measure and Results**
Access, Timeliness	Met	Yes	High confidence in reported results	• CHPW chose an important PIP topic and chose to focus their efforts on a variety of	• Goal of a 2.5% rate increase was not met for all targeted populations, nor was it met for	HEDIS BCS measure – MCO and CHC • CHPW: Demonstrated performance improvement;

PIP Title: Implementation of Community-Based Interventions to Address Disparities in Breast Cancer Screening Rates						
Domain	**Score**	**Validation Status**	**Validation Rating**	**Strengths**	**Weaknesses/ Opportunities for Improvement**	**Performance Measure and Results**
				groups most affected by a low BCS rate • Thorough research was done to choose appropriate interventions • CHPW utilized the PDSA cycle to adjust interventions • CHPW developed the framework to continue and improve this PIP for 2023	the participating community health center (CHC) • One of the main interventions of providing mobile mammography services was not able to be implemented • Aim statement was not clearly outlined	statistically significant change; p-value <.05 • CHC: Demonstrated performance improvement; no statistically significant change; p-value <.05 HEDIS BCS measure – Language • Spanish: Demonstrated performance improvement; statistically significant change; p-value <.05 • Russian: Demonstrated performance improvement; no statistically significant change; p-value <.05 • Somali: No demonstrated performance improvement; no statistically significant change; p-value <.05 HEDIS BCS measure – Race/Ethnicity • Hispanic or Latino: Demonstrated performance improvement; statistically significant change; p-value <.05 • Black/African American: No demonstrated performance improvement; no statistically significant change; P-value <.05 • American Indian/Alaska Native: Demonstrated performance

PIP Title: Implementation of Community-Based Interventions to Address Disparities in Breast Cancer Screening Rates						
Domain	**Score**	**Validation Status**	**Validation Rating**	**Strengths**	**Weaknesses/ Opportunities for Improvement**	**Performance Measure and Results**
						improvement; no statistically significant change; p-value <.05 HEDIS BCS measure – Region • King: Demonstrated performance improvement; statistically significant change; p-value <.05 • Greater Columbia: Demonstrated performance improvement; statistically significant change; p-value <.05

Table 18. CHPW: Expanding Access to Peer Support and High Value Reward Incentives for BHSO Members with Substance Use Disorders PIP.

PIP Title: Expanding Access to Peer Support and High Value Reward Incentives for BHSO Members with Substance Use Disorders						
Domain	**Score**	**Validation Status**	**Validation Rating**	**Strengths**	**Weaknesses/ Opportunities for Improvement**	**Performance Measure and Results**
Access	Met	Yes	Low confidence in reported results	• CHPW addressed how members could access phones if they did not already have access to one • Members who speak Spanish can access the WEconnect in their primary language • Increase in member use	• It is unclear whether the intervention offered to members will increase utilization and further and will transfer to a higher utilization of outpatient services	Statistically increase outpatient SUD treatment utilization for BHSO members that engage with the digital peer support platform: No demonstrated performance improvement; statistically significant change; p-value <.01

2022 PIP Summary by MCP: MHW

The following PIPs were submitted by MHW for validation (Tables 19-20).

Table 19. MHW Increasing Breast Cancer Screening (BCS) for Female Medicaid Members Aged 50 - 74 Years PIP.

PIP Title: Increasing Breast Cancer Screening for Female Medicaid Members Aged 50 - 74 Years						
Domain	**Score**	**Validation Status**	**Validation Rating**	**Strengths**	**Weaknesses/Opportunities for Improvement**	**Performance Measure and Results**
Access, Timeliness	Met	Yes	High confidence in reported results	• Statistically significant increase in BCS rates for the second measurement year	• Only one mention in the PIP regarding the possible impact of COVID on BCS rates	HEDIS measure • BCS: Demonstrated performance improvement; statistically significant change p-value <.01

Table 20. MHW: Increase Utilization of Telehealth Services for BHSO Adult Members PIP.

PIP Title: Increase Utilization of Telehealth Services for BHSO Adult Members						
Domain	**Score**	**Validation Status**	**Validation Rating**	**Strengths**	**Weaknesses/Opportunities for Improvement**	**Performance Measure and Results**
Access, Quality	Met	Yes	Moderate confidence in reported results	• None identified	• Interventions/measure more appropriate for 2020/2021 due to the increase usage of vaccines and return to in-person care • There was an overall decline of BH utilization for this population as more things opened up in after the pandemic	HEDIS measure • MPT: No demonstrated performance improvement; statistically significant change; p-value <.01

2022 PIP Summary by MCP: UHC

The following PIPs were submitted by UHC for validation (Tables 21-22).

Table 21. UHC: Increasing the ADHD Medication Adherence (ADD) Initiation Phase HEDIS Measure Rate PIP.

PIP Title: Increasing the ADD Initiation Phase HEDIS Measure Rate						
Domain	**Score**	**Validation Status**	**Validation Rating**	**Strengths**	**Weaknesses/Opportunities for Improvement**	**Performance Measure and Results**
Access, Timeliness	Met	Yes	Moderate confidence in reported results	• UHC was successful in choosing an important PIP topic and implementing interventions tailored towards the member and providers • UHC utilized the PDSA cycle, recognized the importance of connecting members with clinicians to answer questions during outreach calls, and developed a solution to address this need	• Aim statement remains wordy and does not include baseline data • Data did not show sustained year-over-year improvement • UHC did not implement any MCO/system-focused interventions	HEDIS measure • ADD, Initiation Phase: Demonstrated performance improvement; statistically significant change; p-value <.05

Table 22. UHC: Follow-Up After Hospitalization for Mental Illness (FUH) PIP.

PIP Title: Follow-Up After Hospitalization for Mental Illness (FUH)						
Domain	**Score**	**Validation Status**	**Validation Rating**	**Strengths**	**Weaknesses/Opportunities for Improvement**	**Performance Measure and Results**
Access, Timeliness	Met	Yes	High confidence in reported results	• UHC increased FUH rate by over 7 points through a multi-faceted intervention strategy • Combined efforts of engaging in contracting and payment mechanisms with telehealth were successful	• The PIP did not discuss all the data limitations sufficiently in appropriate sections.	HEDIS measure • FUH: Demonstrated performance improvement; statistically significant change; p-value <.05

Summary of 2023 MCP PIP Scores

In this review cycle, TEAMonitor noted the MCP scores improved in areas such as the design, description, interventions and analysis of PIPs. However, the success rates for the interventions were low. A few factors impacted the success of PIP interventions included low numbers within the intervention groups, particularly the BHSO PIPs, the challenge of balancing the return to in-person care with ongoing telehealth interventions during the public health emergency, and staff turnover at the MCPs.

Below is the summary of the scores the MCPs received:

- **Collaborative: AMG, CCW, CHPW, MHW and UHC** – PIPs: 1 Met (Included in individual MCP count below)
- **AMG** – PIPs: 3 Met
- **CCW** – PIPs: 4 Met
- **CHPW** – PIPs: 3 Met
- **MHW** – PIPs: 3 Met
- **UHC** – PIPs: 3 Met

2023 EQRO PIP Recommendations Based on TEAMonitor CAPs

TEAMonitor CAPs are reflective of the §438.330 (d) Performance Improvement Projects review and may include issues for more than one of the MCP's PIPs. MCPs were reviewed in the first half of the calendar year. Because MCPs may have implemented CAPs since that time to address specific issues, the following recommendations may not be indicative of current performance. A follow-up of the current year's EQRO recommendations will be reflected in the 2024 Annual Technical Report.

The five MCPs did not receive TEAMonitor Corrective Action Plans (CAPs) as part of the 2023 PIP validation activity. Therefore, in reviewing the 2023 MCP PIP submissions, the five MCPs were not issued EQRO recommendations.

Summary of Previous Year (2022) PIP EQRO Recommendations Based on TEAMonitor CAPs

The following table shows the results of the previous year's EQR recommendations and the degree which the plans addressed the recommendations. The responses submitted by the MCPs to the 2022 PIP EQRO Recommendations based on TEAMonitor CAPs were reviewed and accepted with the responses in Table 23.

Below is the key showing the degree to which plans have addressed the previous year's EQR recommendations:

- Low – CAP Not Met
- Medium – CAP Partially Met
- High – CAP Met
- NA – No CAP Received

Table 23. Previous Year (2022) EQRO PIP Recommendation Based on TEAMonitor CAP Follow-Up.

MCP	EQRO Response	Degree Addressed
AMG	Partially Met – The response provided by AMG did not address the findings related to: • Identification of internal/external threats to validity, and • A feasible data collection process. However, current ongoing monthly technical assistance meetings between HCA and AMG has demonstrated that AMG has created infrastructure to attend to the above improvements. To address how AMG will make constructive improvements in the current active (2022) PIPs, AMG stated that they will: • Participate in technical assistance meetings with HCA • Will follow the CMS EQR Protocols, October 2019, Protocol 8 – Implementation of Additional Performance Improvement Projects • Use HCA's Conducting a PIP Worksheet, and AMG's internal Study Selection, Design, Implementation and Evaluation: Quality Improvement Projects (QIPs)	Medium
CCW	Met – Corrective action is completed. No further action required. CCW provided the required documentation to address the finding as part of the 2022 Corrective Action review process.	High
CHPW	CHPW did not receive an EQRO recommendation based on a TEAMonitor CAP in 2022.	NA
MHW	Met – Corrective action is completed. No further action required. MHW provided the required documentation to address the finding as part of the 2022 Corrective Action review process.	High
UHC	Met – Corrective action is completed. No further action required. UHC provided the required documentation to address the finding as part of the 2022 Corrective Action review process.	High

For a detailed summary, please see the individual PIP summary section of the applicable MCP profile in Appendix A.

Performance Measure Review

Objective

Performance measures are used to monitor the performance of the individual MCPs at a point in time, to track performance over time, to compare performance among MCPs, and to inform the selection and evaluation of quality improvement activities. States specify standard performance measures which the MCPs must include in their QAPI program.

It should be noted that two major impacts on Medicaid between 2020 and 2022 were the COVID-19 pandemic and an increase in Medicaid enrollment in the Apple Health Integrated Managed Care (AH-IMC) program. COVID-19 severely stressed primary care delivery systems due to workflow changes required to protect the workforce and patients, re-ordering of clinical priorities and unstable delivery system revenue. The stress on the member population through anxiety, isolation and job loss increased the burden on mental health and substance use conditions. In addition, there was a significant influx of new Medicaid members, for which additional time and effort is usually required. Depending on prior insurance or lack of insurance, these new members may have a greater burden of unmet care needs than established members. Due to COVID-19 and the increase in managed care enrollment, year-over-year comparison should be viewed with caution.

In addition, as part of the federal Public Health Emergency, Medicaid qualifications were not updated between 2020 and 2023. This resulted in an artificially inflated Medicaid population that might have an impact on the data for the relevant measure years.

This section contains results of the following areas of performance measure validation and comparative analysis that was completed in 2023.

Performance Measure Validation

Overview

Performance measure validation is a required EQR activity described at 42 CFR §438.358(b)(2). Aqurate Health Data Management, Inc., the private accreditation firm which conducted the 2022 MCP HEDIS audits according to the standards and methods described in the NCQA HEDIS® Compliance Audit™ Standards, Policies and Procedures, provided Comagine Health with each MCP's Final Audit Report (FAR).

Methodology

Performance measure validation is conducted through the HEDIS Compliance Audit by Aqurate Health Data Management, Inc.

Technical Methods of Data Collection/Description of Data Obtained

HEDIS Compliance Audit Process

The MY2022 HEDIS compliance audit process was conducted according to the standards and methods described in the NCQA *HEDIS® Compliance Audit™ Standards, Policies and Procedures.* The audit had the following components:

- An overall assessment of the capability of information systems to capture and process the information required for reporting (also referred to as ISCA)
- An evaluation of the processes that were used to prepare individual measures
- An assessment of the accuracy of rates reported

Comagine Health received the MCP FARs from Aqurate Health Data Management, Inc., an independent organization providing performance measure validation review and HEDIS compliance audits, which conducted the MY2022 MCP HEDIS audits. Comagine Health then assessed the FARs to determine and develop EQR findings and recommendations.

Summary of MCP MY2022 HEDIS FARs

All MCPs were in full compliance with the MY2022 audits. Comagine Health did not identify any EQRO recommendations, strengths or weaknesses for any MCP during the 2023 PMV. However, when reviewing the MCPs' FARs, Comagine Health identified suggested opportunities for improvement within the FARs based on the audit team recommendations. HCA plans to follow-up via the TEAMonitor process and will be requiring a response from the MCPs to HCA. If the MCP's response does not sufficiently address the issue in the upcoming year, an EQRO Recommendation will be issued as part of the 2024 performance measure review.

Table 24 shows the MCP results for each standard addressed in the individual MCP's FAR.

Table Legend: Met = Met PM = Partially Met NM = Not Met NA = Not Applicable

Table 24. Summary of MCP MY2022 HEDIS Final Audit Reports.

Information System Standard	MCP				
	AMG	CCW	CHPW	MHW	UHC
IS 1.0 Medical Services Data	Met	Met	Met	Met	Met
IS 1.A Behavioral Health Services	NA	NA	NA	NA	Met
IS 1.B Vision Services	Met	Met	Met	Met	Met
IS 1.C Pharmacy Services	Met	Met	Met	Met	Met
IS 1.D Dental Services	NA	NA	NA	NA	NA
IS 1.E Laboratory Services	NA	NA	NA	NA	NA
IS 2.0 Enrollment Data	Met	Met	Met	Met	Met
IS 3.0 Practitioner Data	Met	Met	Met	Met	Met
IS 4.0 Medical Record Review Process	Met	Met	Met	Met	Met
IS 5.0 Supplemental Data	Met	Met	Met	Met	Met
IS 6.0 Data Preproduction Processing	Met	Met	Met	Met	Met
IS 7.0 Data Integration and Reporting	Met	Met	Met	Met	Met
IS 8.0 Case Management Data: Long-Term Services & Support (LTSS)	NA	NA	NA	NA	NA
IS AD 1.0 General Information	Met	Met	Met	Met	Met
IS HD 5.0 Outsourced or Delegated Reporting Function	NA	NA	Met	Met	Met

Washington State-Developed Performance Measure Validation

Objectives

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

Overview

The state monitors and self-validates the following state-developed measures reflecting services delivered to Apple Health enrollees:

- Mental Health Service Rate (Broad version) [MH-B]* – Measure of access to mental health services (among persons with an indication of need for mental health services)
- Substance Use Disorder Treatment Rate (SUD)* – Measure of access to SUD treatment services (among persons with an indication of need for SUD treatment services)
- Home and Community-Based Long-Term Services and Supports Use (HCBS) – Measure of receipt of home and community-based services (among those who need LTSS)
- Percent Homeless (Broad version) [HOME-B] – The percentage of Medicaid enrollees who were homeless or unstably housed in at least one month in the measurement year
- Percent Homeless (Narrow version) [HOME-N] – The percentage of Medicaid enrollees who were homeless in at least one month in the measurement year

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

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.

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 three 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."*

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 performance is done for these measures with interim monitoring on a quarterly basis, reviewing the performance of these measures for IMC and BHSO populations.

Tables 25-26 show the population and age bands reported for the MY2022 RDA measures reported.

Table Legend: ✓ = Population/Age Band Reported – = Population/Age Band Not Reported

Table 25. RDA MH-B, SUD and HCBS Measures Population and Age Bands, MY2022.

Measure	IMC Only (6-64)	IMC Only (12-64)	IMC Only (18-64)	IMC & BHSO (6-64)	IMC & BHSO (12-64)	IMC & BHSO (18+)	BSHO Only (6-17)	BSHO Only (12-17)	BHSO Only (18+)
MH-B	✓	–	–	✓	–	–	✓	–	✓
SUD	–	✓	–	–	✓	–	–	✓	✓
HCBS	–	–	✓	–	–	✓	–	–	✓

Table 26. RDA HOME Measures Population and Age Bands, MY2022.

Measure	IMC Only (0-17)	IMC Only (18+)	IMC & BHSO (0-17)	IMC & BHSO (18+)	BSHO Only (6-17)	BSHO Only (0-17)	BHSO Only (18+)
HOME-B	✓	✓	✓	✓	✓	✓	✓
HOME-N	✓	✓	✓	✓	✓	✓	✓

The RDA division produces and validates the quarterly and annual measures. 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 Department of Social and Health Services RDA Division to measure performance for the Apple Health 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 HCA Performance Measure Validation Rates and Results

HCA Performance Validation Rates

Tables 27-31 show the rates for the MH-B, SUD, HCBS, HOME-B and HOME-N measures in MY2020–MY2022.

Table 27. Statewide Performance Measures Results: MH-B.

Statewide Performance Measure	MY2020 Rate				MY2021 Rate				MY2022 Rate			
	IMC Only (6-64)	IMC & BHSO (6-64)	BSHO Only (6-17)	BHSO Only (18+)	IMC Only (6-64)	IMC & BHSO (6-64)	BHSO Only (6-17)	BSHO Only (18+)	IMC Only (6-64)	IMC & BHSO (6-64)	BHSO Only (6-17)	BHSO Only (18+)
Numerator	226,591	239,850	1,011	18,193	254,848	267,846	929	18,091	272,310	283,667	16,502	922
Denominator (N)	420,257	443,719	1,510	39,155	469,702	492,954	1,401	38,558	506,467	527,164	36,571	1,310
Rate	**53.9%**	**54.1%**	**67.0%**	**46.5%**	**54.3%**	**54.3%**	**66.3%**	**46.9%**	**53.8%**	**53.8%**	**45.1%**	**70.4%**

Table 28. Statewide Performance Measures Results: SUD.

Statewide Performance Measure	MY2020 Rate				MY2021 Rate				MY2022 Rate			
	IMC Only (12-64)	IMC & BHSO (12-64)	BSHO Only (12-17)	BHSO Only (18+)	IMC Only (12-64)	IMC & BHSO (12-64)	BSHO Only (12-17)	BHSO Only (18+)	IMC Only (12-64)	IMC & BHSO (12-64)	BSHO Only (12-17)	BHSO Only (18+)
Numerator	51,103	52,973	30	2,154	53,823	55,708	31	2,171	53,694	55,317	2,080	31
Denominator (N)	133,042	140,055	131	10,217	142,428	149,502	126	10,221	148,111	154,190	9,711	117
Rate	**38.4%**	**37.8%**	**22.9%**	**21.1%**	**37.8%**	**37.3%**	**24.6%**	**21.2%**	**36.3%**	**35.9%**	**21.4%**	**26.5%**

Table 29. Statewide Performance Measures Results: HCBS.

Statewide Performance Measure	MY2021 Rate			MY2022 Rate		
	IMC Only (18-64)	IMC & BHSO* (18+)	BHSO Only (18+)	IMC Only (Age 18-64)	IMC & BHSO (Age 18+)	BHSO Only (Age 18+)
Numerator	140,694	661,769	521,075	131,910	664,764	527,329
Denominator (N)	146,674	744,413	597,739	137,471	744,890	601,572
Rate	**95.9%**	**88.9%**	**87.2%**	**96.0%**	**89.2%**	**87.7%**

**Excluding small proportion of IMC LTSS clients age 65+*

Table 30. Statewide Performance Measures Results: HOME-B* (MY2022 is the first year of RDA self-validation for this measure).

Statewide Performance Measure	MY2022 Rate					
	IMC Only (Age 0-17)	IMC Only (Age 18+)	BHSO Only (Age 0-17)	BHSO Only (Age 18+)	IMC & BHSO (Age 0-17)	IMC & BHSO (Age 18+)
Numerator	32,300	126,345	71	9,445	32,371	135,790
Denominator (N)	774,191	1,032,346	5,236	150,718	779,427	1,183,064
Rate	**4.2%**	**12.2%**	**1.4%**	**6.3%**	**4.2%**	**11.5%**

**Note lower performance is better for this measure*

Table 31. Statewide Performance Measures Results: HOME-N* (MY2022 is the first year of RDA self-validation for this measure).

Statewide Performance Measure	MY2022 Rate					
	IMC Only (Age 0-17)	IMC Only (Age 18+)	BHSO Only (Age 0-17)	BHSO Only (Age 18+)	IMC & BHSO (Age 0-17)	IMC & BHSO (Age 18+)
Numerator	24,487	107,480	41	5,220	24,528	112,700
Denominator (N)	774,191	1,032,346	5,236	150,718	779,427	1,183,064
Rate	**3.2%**	**10.4%**	**0.8%**	**3.5%**	**3.1%**	**9.5%**

**Note lower performance is better for this measure*

HCA Performance Validation Results

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 32 shows results of the validation of the MH, SUD, HCBS and HOME (Broad and Narrow) measures in MY2022.

Table 32. Results of Washington State Developed Performance Measure Validation Requirements, MY2022.

Component	Validation Element	MH-B	SUD	HCBS	HOME-B	HOME-N
Documentation	Did appropriate and complete measurement plans and programming specifications exist, including data sources, programming logic, and computer source code?	Yes	Yes	Yes	Yes	Yes
	Were internally developed codes used?	Yes	Yes	Yes	Yes	Yes
Denominator	Were all the data sources used to calculate the denominator complete and accurate?	Yes	Yes	Yes	Yes	Yes
	Did the calculation of the performance measure adhere to the specifications for all components of the denominator?	Yes	Yes	Yes	Yes	Yes
Numerator	Were the data sources used to calculate the numerator complete and accurate?	Yes	Yes	Yes	Yes	Yes
	Did the calculation of the performance measure adhere to the specifications for all components of the numerator?	Yes	Yes	Yes	Yes	Yes
	If medical record abstraction was used, were the abstraction tools adequate?	N/A	N/A	N/A	N/A	N/A
	If the hybrid method was used, was the integration of administrative and medical record data adequate?	N/A	N/A	N/A	N/A	N/A
	If the hybrid method or medical record review was used, did the results of the medical record review validation substantiate the reported numerator?	N/A	N/A	N/A	N/A	N/A
Sampling	Was the sample unbiased? Did the sample treat all measures independently? Did the sample size and replacement methodologies meet specifications?	N/A	N/A	N/A	N/A	N/A
Reporting	Were the state specifications for reporting performance measures followed?	Yes	Yes	Yes	Yes	Yes
Validation Rating – EQRO's overall confidence that the calculation of the performance measure adhered to acceptable methodology.		High Confidence	High Confidence	High Confidence	High Confidence	High Confidence

Analyses and Conclusions

Based on the validation process completed for each performance measure, the measures meet audit specifications and are reportable by the state. Comagine Health did not identify any strengths or weaknesses during the 2023 PMV.

2023 EQRO Recommendations Based on RDA Self-Validation

It would be beneficial for RDA to develop cross-validation activities in partnership with HCA's Analytics, Research, and Measurement team. However, given staff turnover and workload demands on state agency analytic teams supporting other agency operations, this was not a feasible undertaking in the 2023 Measurement Year.

Cross-agency work has begun to review mental illness and substance use disorder diagnosis code sets that underlie current measurement specifications. RDA anticipates 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.

Summary of Previous Year (2022) EQRO Recommendations Based on RDA Self-Validation

Last year RDA anticipated that this year's validation report might 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, staff turnover and workload demands on state agency analytic teams rendered this to be an unrealistic goal over the past year.

Significant work has been done to identify enhancements to code sets used for the MH and SUD Treatment Rate measures, and RDA anticipates that those coding enhancements will be implemented in the 2023 Measurement Year.

RDA response to EQRO recommendations accepted as written.

Performance Measure Comparative Analysis

Objectives

Federal regulations at 42 CFR § 438.330(c) require states to specify standard performance measures for MCPs to include in their comprehensive QAPI programs. Each year, the MCPs must:

- Measure and report to the state the standard performance measures specified by the state;
- Submit specified data to the state which enables the state to calculate the standard performance measures; or
- A combination of these approaches

Overview

This section contains results of the following areas of performance measure comparative analysis related to the EQR in Washington in 2022:

- **Healthcare Effectiveness Data and Information Set (HEDIS) measures:**

  MCPs 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 MCP performance on HEDIS measures for the calendar year (CY) 2022 (see more about HEDIS measures in the section, HEDIS and RDA Performance Measure Analysis, which follows).

- **Statewide Non-HEDIS Measures:**

  At HCA's instruction, Comagine Health also assessed statewide performance by the MCPs on five non-HEDIS measures that are calculated by the DSHS RDA. The state also monitors and self-validates those five measures reflecting services delivered to Apple Health enrollees:

  - Mental Health Service Rate, Broad Definition (MH-B)
  - Substance Use Disorder Treatment Rate (SUD)
  - Home and Community-Based Long-Term Services and Supports Use (HCBS)
  - Percent Homeless - Narrow Definition (HOME-N)
  - Percent Homeless - Broad Definition (HOME-B)

  Note the Home and Community-Based Long-Term Services and Supports Use (HCBS) and Percent Homeless measures (HOME-N and HOME-B) are new to the Performance Measure Comparative Analysis section.

  In addition, the state monitors and self-validates these five measures delivered to Apple Health enrollees. RDA reviewed and validated performance rates for the five measures to determine impact and need for this program's population. Validated performance rates for these five measures are included in this section, starting on page 61.

HEDIS and RDA Measure Analysis

HEDIS is a widely used set of health care performance measures reported by health plans. HEDIS rates are derived from provider administrative (such as claims) and clinical data. They can be used by the

public to compare plan performance over six domains of care, and also allow plans to determine where quality improvement efforts may be needed. [20]

It is worth noting the HEDIS measures now contain several measures that use electronic clinical data systems (ECDS) as the source for quality measures. NCQA has developed ECDS standards and specifications to leverage the health care information contained in electronic data systems, and to ease the burden of quality reporting. Note that several of these ECDS measures will replace measures that currently are being reported through other methods.

With HCA's approval, Comagine Health focused on the 42 highest priority measures for analysis in this report rather than the full list of HEDIS measures. These 42 measures, which include the two Washington behavioral health measures related to behavioral health, 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 2022 calendar is referred to as measure year 2022 (MY2022) in this report. The results from these analyses can be found in the *2023 EQR Performance Measure Comparative Analysis Report*.

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

Interpreting Percentages versus Percentiles

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

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

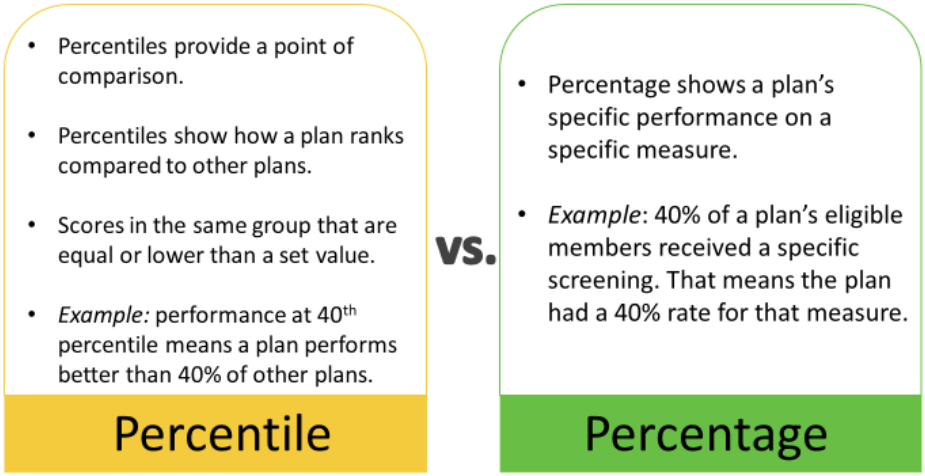
- If a plan's Breast Cancer Screening rate is at the national 50th percentile, it means that approximately 50% of the plans in the nation reported Breast Cancer Screening rates that were equal to or below Plan A; approximately 50% of the plans in the nation had rates that were above.
- If Plan A is above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

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

Figure 13 shows the differences between percentiles and percentages in the context of this report.

[20] 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 MCPs 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/Availability of Care HEDIS Measures

HEDIS access/availability of 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.

Access for adults has been steadily declining for the years included in this report (MY2019 through MY2022). The state remains below the national 40th percentile for both adult age bands.

Note the former well-child visit measures were retired and replaced with new measures in MY2020 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 for MY2019 and therefore those results are not reported. There was an improvement for children ages 0-15 months between MY2021 and MY2022; there was also improvements for the age 3-11 age bands for the years reported (MY2020 through MY2022). These two age categories do the best when compared to national benchmarks; they are both between the 40th and 59th national percentile. The other age categories are below the national 40th percentile with the 18-21 age band falling below the national 20th percentile.

Performance in the maternal health category is between the 60th and 79th percentile for both the Timeliness of Prenatal Care and Postpartum Care measures. The state also saw improvement for both measures between MY2020 and MY2021 with a slight decrease in Timeliness of Prenatal Care measure between MY2021 and MY2022.

Table 33 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.

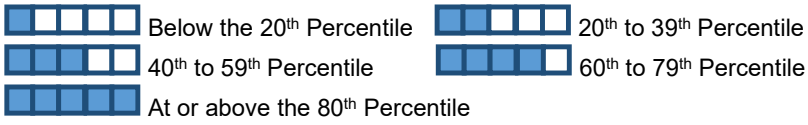


Table 33. Access/Availability of Care HEDIS Measures, MY2019–MY2022.

Measures	MY2019 State Rate	MY2020 State Rate	MY2021 State Rate	MY2022 State Rate	MY2022 National Quintile*
Adults' Access to Preventive/Ambulatory Health Services					
20–44 years	74.1	70.9	69.5	65.5	
45–64 years	80.5	77.2	76.8	74.6	
Well-Child Visits**					
First 15 months	NR	54.0	54.1	56.3	
15-30 months	NR	68.4	64.3	64.8	
3–11 years	NR	46.9	53.4	53.8	
12–17 years	NR	34.8	47.8	44.6	
18-21 years	NR	17.7	19.9	18.7	
Maternal Health					
Timeliness of Prenatal Care	87.2	82.7	87.5	86.7	
Postpartum Care	73.6	76.7	79.3	79.6	

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.*

Prevention and Screening HEDIS Measures

Prevention and screening 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. Table 34 shows the results for these measures.

The performance of the weight assessment and counseling measures has been varied over the time periods reported. This is likely due to the relatively small denominators for these hybrid measures. These measures are all below the 40th percentile for MY2022.

Two children's immunization rates were reported: Combination 3 and Combination 10. There are also two adolescent immunization rates reported: Combination 1 and Combination 2. Performance on these measures has been declining since MY2019. The children's Combination 3 measure is between the 20th and 39th percentile in MY2022; Combination 10 is above the 60th percentile but below the 80th.

Combination 1 for the adolescent rate is below the 20th percentile and Combination 2 is below the 40th percentile.

The lead screening in children measure is below the 20th percentile for MY2022 and has declined between MY2022 and MY2023, after an increase from MY2019 to MY2021.

Both the Breast Cancer Screening and Cervical Cancer Screening measures declined between MY2019 and MY2021, and then saw an improvement between MY2021 and MY2022. Chlamydia screenings declined between MY2019 and MY2021, and then saw no change between MY2021 and MY2022. All three of the women's health measures were below the 40th percentile in MY2021.

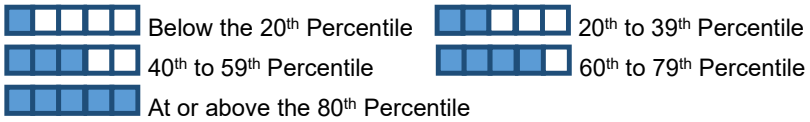


Table 34. Prevention and Screening HEDIS Measures, MY2019–MY2022.

Measure	MY2019 State Rate	MY2020 State Rate	MY2021 State Rate	MY2022 State Rate	MY2022 National Quintile*
Weight Assessment and Counseling					
Children's BMI Percentile	73.1	69.6	75.7	75.6	
Children's Nutrition Counseling	62.8	59.7	63.6	65.9	
Children's Physical Activity Counseling	58.6	56.3	61.8	62.5	
Immunizations					
Children's Combination 3	70.7	64.8	62.2	60.6	
Children's Combination 10	42.1	41.7	38.8	35.0	
Adolescents' Combination 1	77.4	75.0	73.0	70.4	
Adolescents' Combination 2	41.4	39.6	32.5	32.2	
Pediatric Screenings					
Lead Screening in Children	29.8	33.7	34.5	31.9	
Women's Health Screenings					
Breast Cancer Screening	52.0	48.0	44.9	46.3	
Cervical Cancer Screening	60.5	58.6	54.1	55.0	
Chlamydia Screening	53.6	49.9	50.3	50.3	

**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 HEDIS Measures

Chronic care management measures relate to whether enrollees with chronic conditions can receive adequate outpatient management services to prevent worsening of chronic conditions and more costly inpatient services. These measures reflect access and quality. Table 35 shows these results.

Statewide performance on the diabetes care measures has been mostly volatile, most likely due to small denominators related to using the hybrid measure. The rates for diabetic eye exams have declined between MY2019 and MY2022; this measure is below the national 40th percentile for MY2022. The HBA1c measures are between the national 40th and 59th percentile. The blood pressure control and kidney health evaluation measures are between the 60th and 79th percentile for MY2022 although there is still room for improvement in terms of actual performance. Statewide performance improved for the Controlling High Blood Pressure (<140/90) measure between MY2020 and MY2021 but then declined in MY2022, again likely due to variation due to small number. Performance was above the 40th percentile but below the 60th for this measure in MY2022.

Performance has been steadily improving for the Asthma Medication Ratio measure. The statewide performance was above the 80th percentile for MY2022.

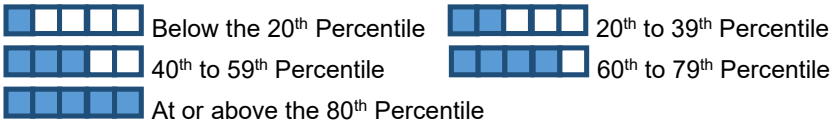


Table 35. Chronic Care Management HEDIS Measures, MY2019–MY2022.

Measure	MY2019 State Rate	MY2020 State Rate	MY2021 State Rate	MY2022 State Rate	MY2022 National Quintile*
Diabetes Care					
Eye Exam	59.1	51.6	50.7	48.7	
Blood Pressure Control (<140/90)***	NR	68.4	71.1	69.6	
HbA1c Control (<8.0%)	51.9	51.9	51.1	52.5	
Poor HbA1c Control (>9.0%)**	34.5	37.5	36.7	36.5	
Kidney Health Evaluation****	NR	43.0	43.5	41.5	
Other Chronic Care Management					
Controlling High Blood Pressure (<140/90)***	NR	58.6	64.6	60.1	
Asthma Medication Ratio, Total	55.0	62.1	64.7	72.4	

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.*
***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.*
***** New measure for MY2020.*

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.

As shown in Table 36, the state saw improvements with several behavioral health measures between MY2019 and MY2022.

The state does perform well when compared to the national benchmarks. The Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependencies (FUA), 7-Day Follow-Up measures are above the national 80th percentile for MY2022. The Antidepressant Medication Management (AMM) measures have shown improvement between MY2019 and MY2022 and are above the 60th percentile. Follow-Up after Hospitalization for Mental Illness (FUH), 7-Day Follow-Up; Follow-Up After Emergency Department Visit for Substance Use (FUA), 30-Day Follow-Up; and Follow-Up After Emergency Department Visit for Mental Illness (FUM), 7-Day Follow-Up measures are above the 60th percentile.

The Follow-Up Care for Children Prescribed ADHD Medication (ADD), Follow-Up after Hospitalization for Mental Illness (FUH), 30-Day Follow-Up and Follow-Up After Emergency Department Visit for Mental Illness (FUM), 30-Day Follow-Up measures are between the national 40th and 59th percentile for MY2022.

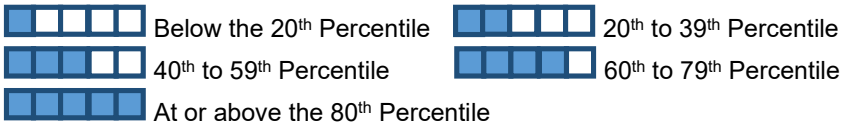


Table 36. Behavioral Health HEDIS Measures, MY2019–MY2022.

Measure	MY2019 State Rate	MY2020 State Rate	MY2021 State Rate	MY2022 State Rate	MY2022 National Quintile*
Antidepressant Medication Management (Effective Acute Phase)	53.5	58.5	61.2	63.5	
Antidepressant Medication Management (Continuation Phase)	38.4	42.9	44.0	45.4	
Follow-Up Care for Children Prescribed ADHD Medication (Initiation Phase)	43.9	45.2	42.9	44.9	
Follow-Up Care for Children Prescribed ADHD Medication (Continuation Phase)	53.6	52.4	54.8	53.1	
Follow-Up after Hospitalization for Mental Illness (FUH), 7-Day Follow-Up, Total	32.0	40.2	35.9	39.4	
Follow-Up after Hospitalization for Mental Illness (FUH), 30-Day Follow-Up, Total	48.3	57.2	54.5	58.5	

Measure	MY2019 State Rate	MY2020 State Rate	MY2021 State Rate	MY2022 State Rate	MY2022 National Quintile*
Follow-Up After Emergency Department Visit for Substance Use (FUA), 7-Day Follow-Up, Total **	NR	NR	NR	31.4	
Follow-Up After Emergency Department Visit for Substance Use (FUA), 30-Day Follow-Up, Total **	NR	NR	NR	43.8	
Follow-Up After Emergency Department Visit for Mental Illness (FUM), 7-Day Follow-Up, Total	37.5	45.1	45.6	44.8	
Follow-Up After Emergency Department Visit for Mental Illness (FUM), 30-Day Follow-Up, Total	51.0	57.8	58.9	58.1	

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.*
*** Due to significant changes in the measure specifications for MY2022, historical data is not displayed for this measure.*

Washington State (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 MCPs 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.

This year, HCA requested Comagine Health add three additional measures that have been developed by the state:

- HCBS – Measure of receipt of home and community-based services (among those who need LTSS)
- Percent Homeless (Broad version) [HOME-B] – The percentage of Medicaid enrollees who were homeless or unstably housed in at least one month in the measurement year
- Percent Homeless (Narrow version) [HOME-N] – The percentage of Medicaid enrollees who were homeless in at least one month in the measurement year

Table 37 shows the results of these three measures from MY2019 through MY2022. There was a significant increase in the SUD Treatment Rate measure between MY2019 and MY2020, followed by a statistically significant decline between MY2020 and MY2021, and between MY2021 and MY2022. The Mental Health Service Rate measure has declined between MY2019 and MY2020 with an improvement between MY2020 and MY2021 and then declined again between MY2021 and MY2022. There were statistically significant declines for the two Percent Homeless measures between MY2020 and MY2021, and between MY2021 and MY2022.

Table 37. Washington State (RDA) Measures, MY2019–MY2022.

Measures	MY2019 State Rate	MY2020 State Rate	MY2021 State Rate	MY2022 State Rate
Mental Health Service Rate, Broad Definition (MH-B), 6-64 Years*	54.9	53.9	54.3	53.8
Substance Use Disorder (SUD) Treatment Rate, 12-64 Years*	37.0	38.4	37.8	36.2
Home and Community-Based Long Term Services and Supports Use (HCBS), 18-64 Years	NR	95.9	95.9	96.0
Percent Homeless - Narrow Definition (HOME-N), 18-64 Years (Note that a lower score is better for this measure)	NR	12.1	10.8	10.2
Percent Homeless - Broad Definition (HOME-B), 18-64 Years (Note that a lower score is better for this measure)	NR	14.8	13.1	12.1

**These two measures are also as part of the Washington State Developed Performance Measure Validation.*

Summary of MCP Performance Measure Comparative Analysis

For details of each MCP's strengths and weaknesses/opportunities for improvement regarding the performance measure comparative analysis, please see Appendix A.

Performance Measure Comparative Analysis State Recommendations

With the following recommendations, we highlight areas of focus for Washington State MCO performance measures. The COVID-19 Public Health Emergency ended in April 2023. As we emerge from the COVID-19 pandemic, a close eye will be kept on its impacts on measurement and care. The ability to monitor the current measure set over time allows deeper analysis, including a focus on health equity. Recommendations are in four areas:

- Maintain Focus on Clinically Meaningful Areas
- Continue to Leverage Value Based Payment Incentives
- Focus on Access, Preventive Care and Utilization
- Continue to Prioritize Health Equity

Please refer to the *2023 Comparative and Regional Analysis* for additional details and comprehensive recommendations.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Objectives

As required by HCA, the MCPs contract with NCQA-certified HEDIS survey vendors to conduct annual CAHPS Health Plan Surveys. In 2023, the Apple Health MCPs conducted the CAHPS 5.1H Adult Medicaid and the CAHPS 5.1H Child Medicaid with Chronic Conditions survey of their members enrolled in Apple Health. CCW conducted the CAHPS 5.1 Child Medicaid and Children with Chronic Conditions survey of the Apple Health Foster Care program.

Overview

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 MCPs 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.

Apple Health Integrated Managed Care – Adult Medicaid Survey

In 2023, the Apple Health MCPs conducted the CAHPS® 5.1H Adult Medicaid 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, 2022, with no more than one enrollment gap of 45 days or less.

Data Aggregation and Analysis

Each MCP's survey data was provided to NCQA-certified survey vendor Press Ganey, 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. Press Ganey produced a report that summarized survey responses and identified key strengths and opportunities for improvement, as well as recommendations based on survey questions most highly correlated to enrollees' satisfaction with their health plan.

The SatisAction™ key driver statistical model was used to identify the key drivers of the health plan rating and provide actionable direction for satisfaction improvement programs. This proprietary statistical methodology identifies which items are important in driving the rating of the health plan by measuring the relative importance of each survey item to members and comparing them with plan performance. Both individual questions and composite scores were evaluated using this method and reported as summary rate scores.

Summary of Findings/Conclusions

The following results present the Apple Health MCP average rating as compared to national benchmarks derived from the NCQA Quality Compass. The full summary of findings is available in the *2023 CAHPS® 5.1H Member Survey: Medicaid Adult Washington All Plan Report*. The report is designed to identify key opportunities for improving members' experiences. Member responses to survey questions are summarized as summary rate scores. Summary rate scores are computed and reported for all pertinent survey items. The lower the summary rate score, the greater the need for the program to improve. In addition, composite scores are built from summary rate scores 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.

Included below are results from the 2020, 2022 and 2023 CAHPS® 5.1H Adult Medicaid survey years. While the differences in summary rate scores are not statistically significant in year-over-year trends, many of the scores have declined over this period.

Table 38 reports 2020, 2022 and 2023 reporting year (RY) performance.

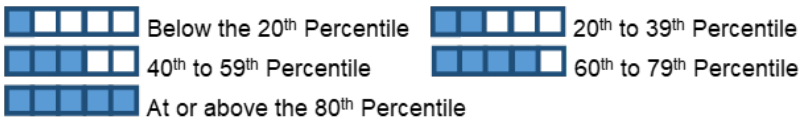


Table 38. Adult CAHPS Ratings Results, 2020, 2022 and 2023 RY.

Results	2020 Rating	2022 Rating	2023 Rating	2023 National Quintile*
Rating of All Health Care (Scored 8, 9 or 10 out of 10)	76.2	68.7	67.6	
Rating of Personal Doctor (Scored 8, 9 or 10 out of 10)	80.1	79.2	87.9	
Rating of Specialist Seen Most Often Scored 8, 9 or 10 out of 10)	83.8	77.6	77.7	
Rating of Plan (Scored 8, 9 or 10 out of 10)	73.3	68.4	72.2	
Getting Needed Care (composite score)	82.1	74.6	72.8	
Getting Care Quickly (composite score)	80.3	73.9	71.2	
How Well Doctors Communicate composite score)	93.0	91.4	91.1	
Customer Service (composite score)	87.3	87.3	85.2	

**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/Power

Questions with high summary rate score that also have a high correlation with the Apple Health plans members' satisfaction with the health plan are indicated as key strengths/power in the SatisAction™ key driver statistical model. These are items that have a relatively large impact on the rating of the health plan and performance is above average. In 2023, no questions met these criteria. Plans can focus on increasing the scores for items listed as opportunities for improvement into key strengths/power.

Note that the global rating questions for personal doctors, specialists and overall health care have been excluded from the listed recommendations. 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. These global ratings are available in the CAHPS reports.

Weaknesses/Opportunities for Improvement

The five questions with the lowest summary rate scores that also are highly correlated with the Apple Health plans members' satisfaction with the health plan are presented below as weaknesses/ opportunities for improvement in the SatisAction™ key driver statistical model. These are items that have a relatively large impact on the rating of the health plan but performance is below average (Table 39). Plans should prioritize improving these items.

Note that the global rating questions for personal doctors, specialists and overall health care have been excluded from the listed recommendations. 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. These global ratings are available in the CAHPS reports.

Table 39. Adult CAHPS Survey Questions: Weaknesses/Opportunities for Improvement.

Question	Summary Rate Score
Q20. In the last 6 months, how often did you get an appointment with a specialist as soon as you needed?	69.2
Q04. In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?	74.6
Q09. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?	76.4
Q6. In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as you needed?	67.9
Q25. In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?	92.2

Supplemental Questions

Supplemental questions were included in the Adult CAHPS survey by HCA and were associated with members experiences with their child's mental health care and treatment (Table 40). These questions are not part of the CAHPS percentile scores, composites or benchmarked against other programs.

Table 40. Adult CAHPS Survey - Supplemental Questions.

Question	Summary Rate Score
Rating of Treatment or Counseling (9 or 10 out of 10)	39.9
In the last 6 months, did your personal doctor or anyone from that office ask you about your mental or emotional health?	45.7
Did you receive mental health care or counseling in the last 6 months?	21.0
Did you receive all the mental health care or counseling that you needed?	74.5
If you received mental health care or counseling in the last 6 months, how often were you involved as much as you wanted in your mental health care or counseling?	63.7
In the last 12 months, did you need any treatment or counseling for a personal or family problem?	24.9
In the last 12 months, how often was it easy to get the treatment or counseling you needed through your health plan?	58.3

Recommendations

Comagine Health offers the following recommendations to assist MCPs in focusing their efforts on the identified improvement opportunities. While the CAHPS survey helps identify priorities across Washington State, the MCPs 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. MCPs may look at member grievances to see what issues show up frequently for their members.

Access to Care

As seen in Table 38, access to care continues to be an area where Apple Health MCPs should focus improvement. Getting Needed Care (72.8%) and Getting Care Quickly (71.2%) have been key measures where members have had lower satisfaction ratings in both 2022 and 2023 CAHPS surveys, although there has not been a statistically significant change between these two years. Getting a check-up or routine appointment (67.9%) is the lowest scoring question in this segment. Access to care is a key measure in members' satisfaction with their MCP and an important area of focus for improvement efforts.

Washington state is a large state with a sizable rural area, and MCPs should assess why Apple Health members are reporting difficulty accessing care. Some improvements may be:

- Increased utilization of telemedicine and other technologies
- Targeting high-risk members with a care coordination outreach programs
- Collaborate with providers and share tools, resources, and best practices to support, or reinforce, a complete and effective information exchange with all patients

Please see the *2023 CAHPS® 5.1H Member Survey: Medicaid Adult Washington All Plan Report* for the full survey results and description of recommendations.

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

In 2023, the Apple Health MCPs 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 parents/caregivers of children 17 years and younger continuously enrolled in Apple Health for at least six months as of December 31, 2022, with no more than one enrollment gap of 45 days or less.

Data Aggregation and Analysis

Each MCP's survey data was provided to NCQA-certified survey vendor Press Ganey 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. Press Ganey produced a report that summarized survey responses and identified key strengths and opportunities for improvement, as well as recommendations based on survey questions most highly correlated to enrollees' satisfaction with their health plan.

The SatisAction™ key driver statistical model was used to identify the key drivers of the health plan rating and provide actionable direction for satisfaction improvement programs. This proprietary statistical methodology identifies which items are important in driving the rating of the health plan by measuring the relative importance of each survey item to members and comparing them with plan performance. Both individual questions and composite scores were evaluated using this method and reported as summary rate scores.

Summary of Findings/Conclusions

The following results present the Apple Health MCP average rating as compared to national benchmarks derived from the NCQA Quality Compass. The full summary of findings is available in the *2023 CAHPS® 5.1H Member Survey: Medicaid Child Washington All Plan Report*. The report is designed to identify key opportunities for improving members' experiences. Member responses to survey questions are summarized as summary rate scores. Summary rate scores are computed and reported for all pertinent survey items. The lower the summary rate score, the greater the need for the program to improve. In addition, composite scores are built from summary rate scores 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.

Included below are results from the 2019, 2021, and 2023 CAHPS® 5.1H Child Medicaid with Chronic Conditions survey years. As seen in Table 41, many of the summary rate scores have declined during this time period.

Table 41 reports 2019, 2021 and 2023 RY performance.

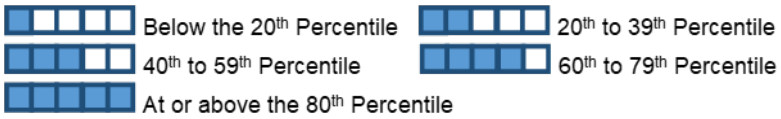


Table 41. Child CAHPS Ratings Results, 2019, 2021 and 2023 RY.

Results	2019 Rating	2021 Rating	2023 Rating	2023 National Quintile*
Rating of All Health Care (Scored 8, 9 or 10 out of 10)	87.7	87.5	82.5	
Rating of Personal Doctor (Scored 8, 9 or 10 out of 10)	90.4	88.6	87.5	
Rating of Specialist Seen Most Often (Scored 8, 9 or 10 out of 10)	86.0	85.2	84.9	
Rating of Plan (Scored 8, 9 or 10 out of 10)	85.2	82.8	84.3	
Getting Needed Care (composite score)	82.6	82.8	76.1	
Getting Care Quickly (composite score)	86.8	84.1	78.8	
How Well Doctors Communicate (composite score)	93.7	93.0	91.0	
Customer Service (composite score)	87.8	85.5	88.1	

**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.*

Key Strengths/Power

Questions with high summary rate score that also have a high correlation with the Apple Health plan members' satisfaction with the health plan are indicated as key strengths/power in the SatisAction™ key driver statistical model. These are items that have a relatively large impact on the rating of the health plan and performance is above average. In 2023, no questions met these criteria. Plans can focus on increasing the scores for items listed as opportunities for improvement into key strengths.

Note that the global rating questions for personal doctors, specialists and overall health care have been excluded from the listed recommendations. 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. These global ratings are available in the CAHPS reports.

Weaknesses/Opportunities for Improvement

The five questions with the lowest summary rate scores that also are highly correlated with the Apple Health plans members' satisfaction with the health plan are presented below as weaknesses/ opportunities for improvement (Table 42). These are items that have a relatively large impact on the rating of the health plan, but performance is below average. Plans should prioritize improving these items.

Note that the global rating questions for personal doctors, specialists and overall health care have been excluded from the listed recommendations. 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. These global ratings are available in the CAHPS reports.

Table 42. Child CAHPS Survey Questions: Weaknesses/Opportunities for Improvement.

Question	Summary Rate Score
Q29. In the last 6 months, how often did your child's personal doctor show respect for what you had to say?	94.3
Q28. In the last 6 months, how often did your child's personal doctor listen carefully to you?	92.2
Q27. Child's personal doctor explain things about your child's health in a way that was easy to understand?	91.2
Q31. In the last 6 months, how often did your child's personal doctor explain things in a way that was easy for your child to understand?	92.4
Q32. In the last 6 months, how often did your child's personal doctor spend enough time with your child?	86.3

Supplemental Questions

Supplemental questions were included in the Child CAHPS survey by HCA and were associated with members experiences with their child's mental health care and treatment (Table 43). These questions are not part of the CAHPS percentile scores, composites, or benchmarked against other programs.

Table 43. Child CAHPS Survey: Supplemental Questions.

Question	Summary Rate Score
Rating of Treatment or Counseling (9 or 10 out of 10)	46.1
In the last 6 months, did your child's personal doctor or anyone from that office ask you about your child's mental or emotional health?	33.1
Did your child receive mental health care or counseling in the last 6 months?	10.1
Did your child receive all the mental health care or counseling that he or she needed?	57.5
In the last 12 months, did your child need any treatment or counseling for a personal or family problem?	11.3
In the last 12 months, how often was it easy to get the treatment or counseling your child needed through your child's health plan?	67.0
If your child received mental health care or counseling in the last 6 months, how often were you involved as much as you wanted in your child's mental health care or counseling?	51.5

Recommendations

Comagine Health offers the following recommendations to assist MCPs in focusing their efforts on the identified improvement opportunities. While the CAHPS survey helps identify priorities across Washington State, the MCPs 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. MCPs may look at member grievances to see what issues show up frequently for their members. Recommendations for the adult and child populations are similar in this report and highlight the importance of addressing access to care concerns.

Access to Care

As seen in Table 41, Getting Care Quickly is an important part of the patient experience and continues to be an area of focus for Apple Health MCPs. Members had statistically significant lower satisfaction for this segment than in the 2021 CAHPS (78.8% vs. 84.1%). Getting a check-up or routine appointment (73.0%) is the lowest scoring question in this segment. Access to care is a key measure in members satisfaction with their MCP.

Getting Needed Care (76.1%) is also a key measure for member satisfaction. Got an appointment with specialist as soon as needed (69.3%) remains the key measure question with the lowest level of member satisfaction for the general population. Ease of getting care, tests or treatment, showed a statistically significant decrease when compared to 2021 scores (82.8% vs. 87.1%).

Washington state is a large state with a sizable rural area, and MCPs should assess why Apple Health members are reporting difficulty accessing care. Some improvements may be:

- Increased utilization of telemedicine and other technologies
- Targeting high-risk members with a care coordination outreach program can be impactful
- Collaborate with providers and share tools, resources, and best practices to support, or reinforce, a complete and effective information exchange with all patients

Please see the *2023 CAHPS® 5.1H Member Survey: Medicaid Child Washington All Plan Report* for full survey results description of recommendations.

Apple Health Foster Care – Child Medicaid with Chronic Conditions Survey

In 2023, CCW, the Apple Health Foster Care plan, conducted the CAHPS 5.1 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, 2022, 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 produced a summary report, including comparison of the Apple Health Foster Care scores to Child Medicaid 2022 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 44 shows the results for the Integrated Foster Care CAHPS survey in 2021, 2022 and 2023 RY performance for the general population. Note there are no national benchmarks available for the foster care population. For the full report, please see *MY2022 CAHPS® Medicaid Child with CCC 5.1 Survey: Coordinated Care- Foster Care Report*. Produced by Press Ganey. 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 44. Foster Care CAHPS Ratings Results, General Population, 2021–2023 RY.

Results	2021 Rating	2022 Rating	2023 Rating
Rating of All Health Care (Scored 8, 9 or 10 out of 10)	89.8	82.9	82.8
Rating of Personal Doctor (Scored 8, 9 or 10 out of 10)	92.3	92.3	86.4
Rating of Specialist Seen Most Often (Scored 8, 9 or 10 out of 10)	***	***	***
Rating of Plan (Scored 8, 9 or 10 out of 10)	77.6	75.6	74.6
Getting Needed Care (composite score)	***	***	75.9
Getting Care Quickly (composite score)	***	***	88.9
How Well Doctors Communicate (composite score)	97.5	96.8	96.2
Customer Service (composite score)	***	***	***

**** Denominator < 100; insufficient for reporting.*

Key Strengths and Weaknesses/Opportunities for Improvement

The SatisAction™ key driver statistical model was used to identify the key drivers of the rating of the health plan and identified items that are important in driving of the rating of the health plan. Questions with a high correlation to member satisfaction are included below as either key strengths/power or weaknesses/opportunities for improvement.

Note that the global rating questions for personal doctors, specialists and overall health care have been excluded from the listed recommendations. 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. These global ratings are available in the CAHPS reports.

Key Strengths/Power

Questions with high summary rate score that also have a high correlation with members' satisfaction with the health plan are indicated as key strengths/power in the SatisAction™ key driver statistical model. These are items that have a relatively large impact on the rating of the health, plan and performance is above average. Plans should continue to promote and leverage these items as they are key strengths.

The following measures shown in Table 45 are key drivers/strengths of the plan.

Table 45. Key Strengths/Power.

Question	Summary Rate Score
Q27. In the last 6 months, how often did your child's personal doctor explain things about your child's health in a way that was easy to understand	96.4
Q29. In the last 6 months, how often did your child's personal doctor show respect for what you had to say	97.6
Q32. In the last 6 months, how often did your child's personal doctor spend enough time with your child?	95.7
Q06. In the last 6 months, how often did you get an appointment for a check-up or routine care for your child as soon as your child needed?	88.7
Q45. In the last 6 months, how often did customer service at your child's health plan give you the information or help you needed?	84.2

Weaknesses/Opportunities for Improvement

Questions with low summary rate scores that also are highly correlated with members' satisfaction with the health plan are presented below as weaknesses/opportunities for improvement. These are items that have a relatively large impact on the rating of the health plan, but performance is below average. Plans should prioritize improving these items.

The following measures in Table 46 present opportunities for improvement.

Table 46. Weaknesses/Opportunities for Improvement.

Question	Summary Rate Score
Q10. In the last 6 months, how often was it easy to get the care, tests, or treatment your child needed?	86.9
Q4. In the last 6 months, when your child needed care right away, how often did your child get care as soon as he or she needed?	89.0
Q28. In the last 6 months, how often did your child's personal doctor listen carefully to you?	95.2

Recommendations

Please refer to the *MY2022 CAHPS® Medicaid Child with CCC 5.1 Survey: Coordinated Care-Foster Care Report* for full survey results and recommended improvement strategies.

Wraparound with Intensive Services (WISe) Program Review (Focus Study)

Objectives

The State of Washington HCA chose to conduct a statewide study on quality with focus on the WISe service delivery model in 2022. Comagine Health is contracted to review agencies throughout the state that have implemented the WISe service delivery model. Comagine Health contracted with MetaStar, Inc., to conduct the WISe record reviews. WISe implementation began in Washington in 2014, with a statewide goal establishing WISe treatment throughout the state by 2018. 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 Washington Apple Health Integrated Foster Care (AH-IFC), Washington Apple Health-Integrated Managed Care (AH-IMC), Behavioral Health Services Only (BHSO) programs, and State Children's Health Insurance Program (CHIP).[21] It is a team-based approach that provides services to youth and their families in home and community settings rather than at a Behavioral Health Agency (BHA) and is 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 chosen from a statewide sample provided by HCA. Records were chosen for two types of reviews, "Enrollment" spanning the first 90 days of WISe services, and "Transition" reviews spanning the last 90 days of WISe services. These records 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).[22]

The key areas evaluated during the Enrollment review include:

- Care Coordination
- Child and Family Team (CFT) Processes
- Crisis Prevention and Response

[21] WISe Policy and Procedure Manual. Available at: https://www.hca.wa.gov/assets/billers-and-providers/wise-wraparound-intensive-services-manual.pdf.
[22] WISe QIRT Manual. Available at: https://www.hca.wa.gov/assets/program/qirt-manual-v1.6.pdf.

- Treatment Characteristics
- Parent and Youth Peer Support

The key areas evaluated during the Transition review include:

- Care Coordination
- CFT Processes and Transition Planning
- Crisis Prevention and Response
- Treatment Characteristics
- Parent and Youth Peer Support

In order to determine the significance of year-to-year results, a Pearson's chi-squared test[23] was used to evaluate the statistical significance for both increased and decreased results (see Table 47 for key). The results of the test identified which changes were statistically significant and likely due to actions taken by the WISe agencies as well as the level of significance or whether changes were due to normal variation.

Table 47. Levels of Statistical Significance.

Level Statistical Significance Legend		
Level of Significance	***p*-value**	**Designation of Significance**
Not Significant	$p > .05$	NS
Significant	$p \leq .05$	*
Very Significant	$p \leq .01$	**
Highly Significant	$p \leq .001$	***

Description of Data Obtained

HCA provided Comagine Health with a list of randomly selected charts from a list of randomly selected agencies. The initial review process included 191 enrollment records and 113 transition records; however, seven of enrollment and three of transition records reviewed were excluded from the analysis and dashboard due to technical limitations of the data cleaning process. The review included examining PDF records of the clinical charts covering services provided during the period from September 2022 through April 2023. Review data was collected using the Research Electronic Data Capture (REDCap) system. REDCap is a secure web-based data collection application supported by the Center for Clinical and Translational Science at the University of Kentucky. Aggregate level results are provided in a dashboard report pulled from REDCap.[24]

[23] *Pearson's chi-squared test is a statistical test used to compare categorical variables. This test evaluates how likely it is that any observed difference between data sets occurred by normal variation or chance. A p-value, or probability value, that is less than or equal to the .05 significance level indicates that the observed values are different than the expected values.*

[24] WISe dashboard reports. Available at: https://www.hca.wa.gov/about-hca/behavioral-health-recovery/wraparound-intensive-services-wise-0

Data Aggregation and Analysis

This summary review is based on what was documented within the enrollment records during this review compared to the results from last year's review. The results from the prior year's review were collected from August 2021–April 2022. This is the first year for the transition reviews, therefore, data does not exist for comparison. In addition, each chart review was performed on documentation from individual WISe provider agencies and may not reflect care provided outside the reviewed agencies, if not coordinated and documented by the agencies reviewed. Once the reviews of all charts were completed, HCA provided an aggregate dashboard of the data generated from the QIRT reviews for this report to Comagine Health. WISe agencies should compare the results from this review to the findings from internal QIRT reviews.

Summary of Findings – Enrollment Reviews

The results reported in this section consisted of clinical record reviews spanning the first 90 days of WISe services.

Care Coordination Elements

Initial Engagement and Assessment

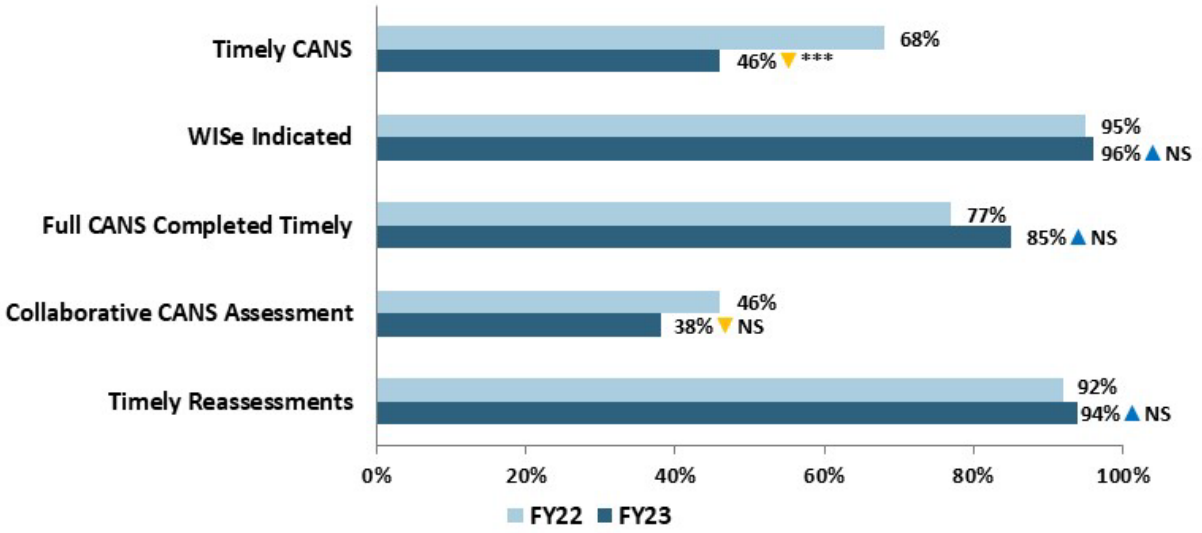
A Child and Adolescent Needs and Strengths (CANS) screening is required to be offered within 10 business days of a WISe referral and an initial full CANS assessment completed within the first 30 days of enrollment. Documentation should include evidence of youth and family inclusion in the CANS process.

Of the 184 charts reviewed this year, five received the 0-4 version compared to the prior review where four received the 0-4 version. Of the 184 records reviewed, 179 received the 5+ version of the CANS, compared to 173 during the prior review. Please note that due to the low number of records in the sample that utilized the 0-4 CANS version, the results of the review are not representative of the population utilizing this assessment.

Figure 14 below identifies the CANS assessment findings.

Rate Change Legend	
Increased	▲
Decreased	▼
No change	○

Figure 14. CANS-related Findings.†



†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.

**Significant (p ≤ .05)*

**** Highly Significant (p ≤ .001)*

NS = Not Significant

Statistical Analysis of CANS-Related Findings

The requirement of Timely CANS evaluates if the initial CANS assessments were conducted within 30 days of enrollment.

- Results decreased from the prior review. Analysis indicated the year-to-year difference in the rates is statistically significant. Factors contributing to the reduction in results should be evaluated by the agencies.

All youth enrolled in the WISe must meet the program eligibility requirements evaluated under the requirement WISe Indicated.

- Results improved from the prior year. Analysis indicated the year-to-year difference in the rates is likely attributable to normal variation or chance.

A full CANS Assessment must be completed no later than 30 days following enrollment.

- Results for Full CANS Completed Timely improved since the prior year's review. Analysis indicated the year-to-year difference in the rates is likely attributable to normal variation or chance.

The CANS Assessments must be completed collaboratively including members of the child's team in the completion of the assessment.

- Results for Collaborative CANS Assessment decreased from the prior review. Analysis indicated the year-to-year difference in the rates is statistically significant. Factors contributing to the reduction in results should be evaluated by the agencies.

All reassessments must be completed within the required timeframe.

- Results for Timely Reassessments have improved since the prior review. Analysis indicated the year-to-year difference in the rates is likely attributable to normal variation or chance.

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 8.3 hours compared to 7.1 hours from the prior review, an increase of 1.2 hours.
- Almost 10% of the youth in the sample had fewer than one CFT during the first 90 days of enrollment compared to 8% from prior review, a 2% decrease.

During the first 90 days of enrollment:

- Thirty-six percent (36%) of youth had zero to one CFT meetings compared to 23% from the prior review, a 13% increase.
- Sixty-four percent (64%) of youth had two or more CFT meetings compared to 77% from the prior review, a 13% decrease.

Participation

Members of the child's team are required to participate in CFTs. Please note that due to the small number of children in the 0-4 age group, results may not be representative of the entire population. Figures 15 and 16 below identify the percentage of attendees by category who participated in CFT processes.

Rate Change Legend	
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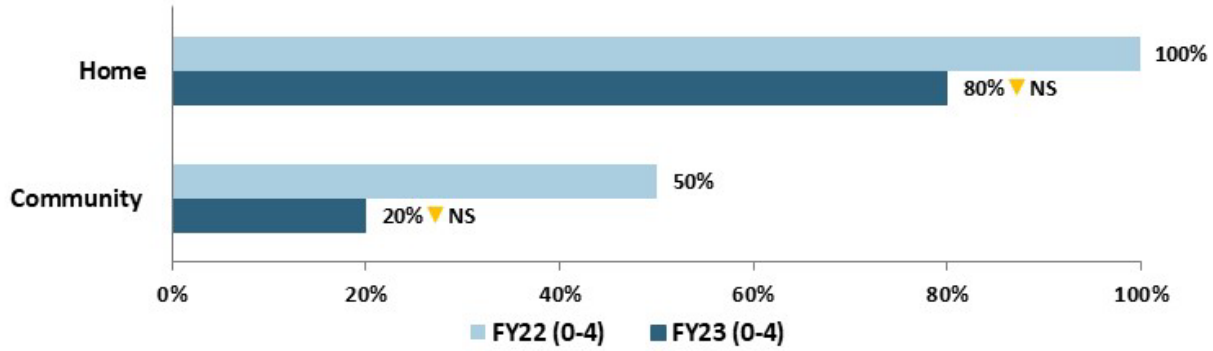
Decreased	▼
No change	○

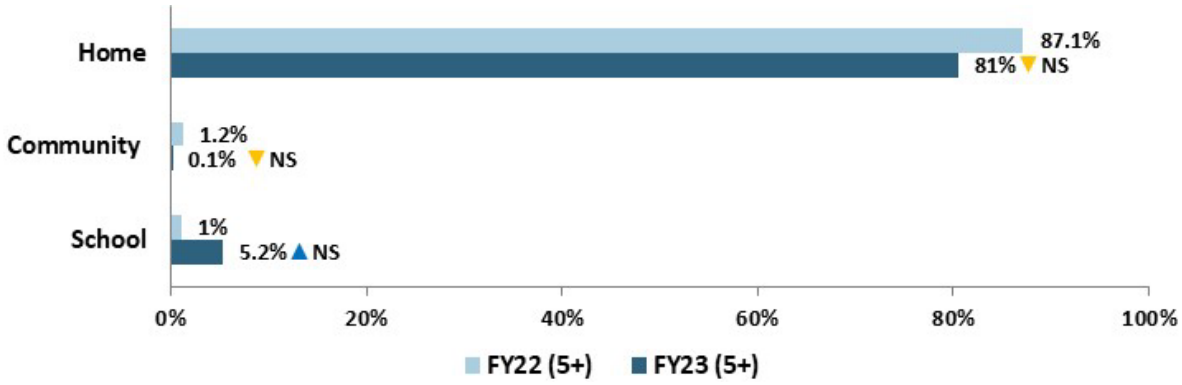
Figure 15. CFT Meeting Participants Year-to-Year Comparison (0-4 Version).



NS = Not significant

Rate Change Legend	
Increased	▲
Decreased	▼
No change	○

Figure 16. CFT Meetings Year-to-Year Comparison (5+ Version).



NS = Not significant

Statistical Analysis of CFT Processes Findings

During the first 90 days of enrollment, CFT Meeting Participation for youth receiving the 0-4 version showed no statistical significance in the year-to-year rates and included:

- A home representative attended 80% of sessions during the current year compared to 100% in the prior year, a 20% decrease. Analysis indicated the year-to-year difference in the rates is likely attributable to normal variation or chance.
- A community representative attended 20% of sessions during the current year compared to 50% in the prior year, a 30% decrease. Analysis indicated the year-to-year difference in the rates is likely attributable to normal variation or chance.

During the first 90 days of enrollment, CFT Meeting Participation for youth receiving the 5+ version showed no statistical significance in the year-to-year rates included:

- A home representative attended 81% of sessions during the current year compared to 87.1% in the prior year, a 6.1% decrease. Analysis indicated the year-to-year difference in the rates is likely attributable to normal variation or chance.
- Of sessions attended by community representative, 0.1% were attended during the current year compared to 1.2% in the prior year, a 1.1% decrease.
- During the current year, 5.2% of sessions were attended by a school representative compared to 1% in the prior year, a 4.2% increase. Analysis indicated the year-to-year difference in the rates is likely attributable to normal variation or chance.

Crisis Prevention and Response

Each Cross-System Care Plan (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

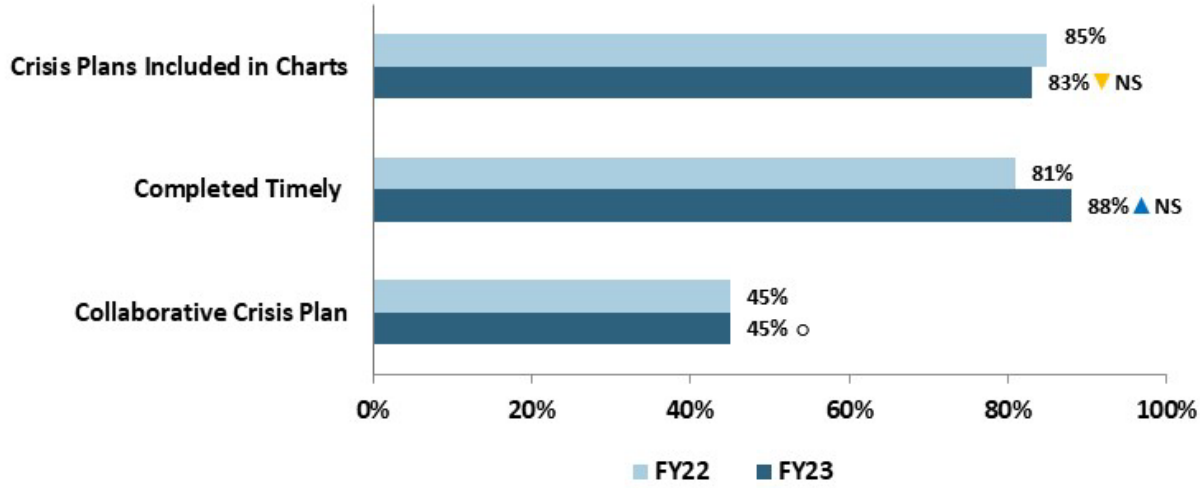
A crisis plan must be completed for each child enrolled in the program no later than 45 days following enrollment. The number of charts containing crisis plans increased from the prior review. Of the charts containing crisis plans the number completed timely improved from the prior year's review. Analysis indicated the year-to-year difference in the rates for both requirements is likely attributable to normal variation or chance.

Crisis plans should be collaboratively involving members of the child's team. Results remained consistent for Collaborative Crisis Plan this year compared to the prior review.

Figure 17 identifies the year-to-year comparison of crisis plans.

Rate Change Legend	
Increased	▲
Decreased	▼
No change	○

Figure 17. Crisis Plans (Year-to-Year Comparison) – Crisis Plan, Timely, Collaborative.



NS = Not significant

Statistical Analysis of Crisis Prevention and Response Findings

- Of the 184 charts reviewed, 83% contained crisis plans, compared to 85% from the previous review. Results decreased from the previous review. Analysis indicated the year-to-year difference in the rates is likely attributable to normal variation or chance.
- Of the 153 charts containing crisis plans, 88% were completed in a timely manner, within 45 days of enrollment, compared to 81% from the previous review. Results improved from the previous year. Analysis indicated the year-to-year difference in the rates is likely attributable to normal variation or chance.
- For the 153 charts that contained crisis plans reviewed, 45% were created collaboratively. Results stayed the same from the previous year's review.

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. Statistical testing on Treatment Characteristics was not conducted as this data is for informational purposes only.

- Therapist involvement in the WISe service model was evidenced by participation in 71.9% of all CFT meetings and an average of three treatment sessions monthly, compared to 74.5% of all CFT meetings and an average of 3.3 treatment sessions monthly during the prior review.
- The review indicated 53% of treatment sessions were attended by the youth alone compared to 51% identified during the prior review.
- The youth and caregiver participated in 34% of sessions compared to 33% in the previous review.
- Only the caregiver attended 13% of the treatment sessions compared to 16% identified during the previous review.
- Persistence in problem-solving was evidenced by documentation of the same treatment focus from session to session in 87% of the sessions, compared to 95% of the sessions identified during the prior review.
- The most frequently treatment content documented were Skill Development and Enlisting Treatment Support at 18.3% and 11.5%, respectively, compared to 18.6% and 9.5% identified during the previous review.
- Documentation of progress reviewed was identified in 13% of records, while 3% of records included celebrating success, compared to 7% of records documenting progress and 3% of records including celebrating success identified during the prior review.

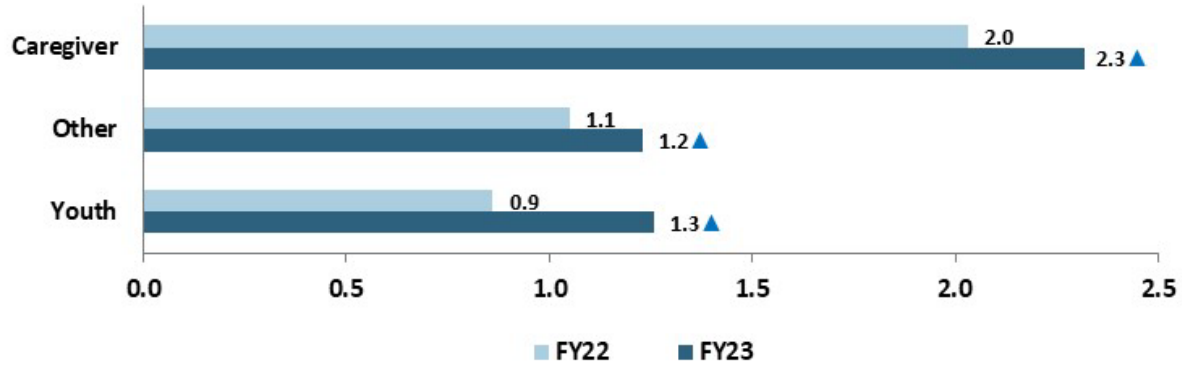
Parent and Youth Peer Support Elements

Each youth and family must be offered a youth peer or parent peer 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.

Figures 18 (parent) and 19 (youth) identify the average hours of Peer Support by Type for FY2022 and FY2023.

Rate Change Legend	
Increased	▲
Decreased	▼
No change	○

Figure 18. Parent Peer Support Elements: Average Hours of Peer Support by Type* (Year-to-Year Comparison).**

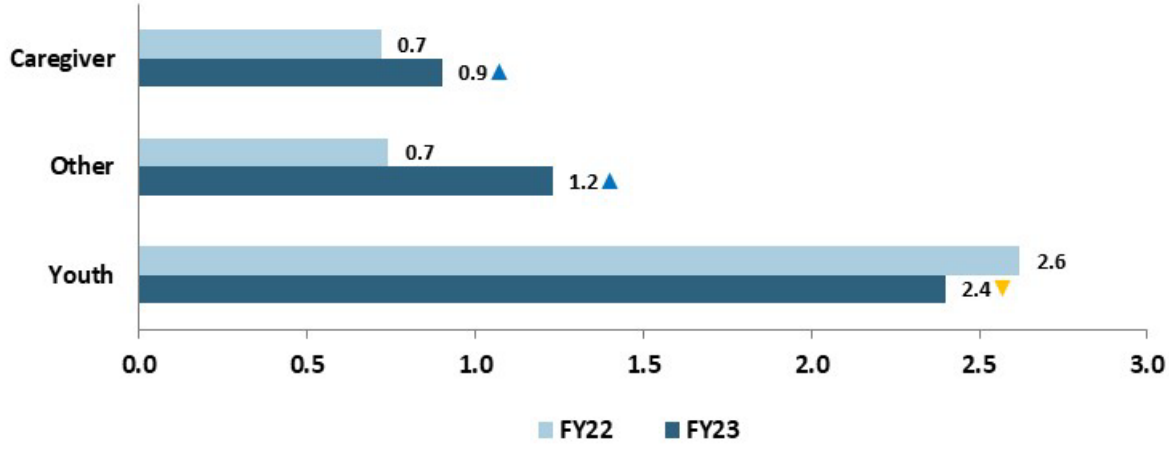


Since children under age 5 are not eligible for youth peers, these cases are not included in youth peer metrics of any kind.

***Statistical testing was not conducted on Parent Peer Support Elements as this data is for informational purposes only.*

Rate Change Legend	
Increased	▲
Decreased	▼
No change	○

Figure 19. Youth Peer Support Elements: Average Hours of Peer Support by Type* (Year-to-Year Comparison).**



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

***Statistical testing was not conducted on Youth Peer Support Elements as this data is for informational purposes only.*

During the first 90 days of enrollment, the parent peer support partner:

- Spent an average of 2.3 hours with caregiver(s), compared to 2.0 hours from the previous review
- Spent an average of 1.2 hours with other(s), compared to 1.1 hours from the previous review
- Spent an average of 1.3 hours with the youth, compared to 0.9 hours from the previous review

During the first 90 days of enrollment, the youth peer support partner:

- Spent an average of 0.9 hours with caregiver(s), compared to 0.7 hours from the previous review
- Spent an average of 1.2 hours with other(s), compared to 0.7 hours from the previous review
- Spent an average of 2.4 hours with the youth, compared to 2.6 hours from the previous review

Summary of Findings – Transition Reviews

The results reported in this section consisted of clinical record reviews spanning the last 90 days of WISe services.

Care Coordination Elements

CFT Processes

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.

- Almost 8% of the youth in the sample had fewer than one CFT during the last 90 days of care.

During the last 90 days of care:

- Twenty-nine percent (29%) of youth had zero to one CFT meetings.
- Seventy-one percent (71%) of youth had two or more CFT meetings.

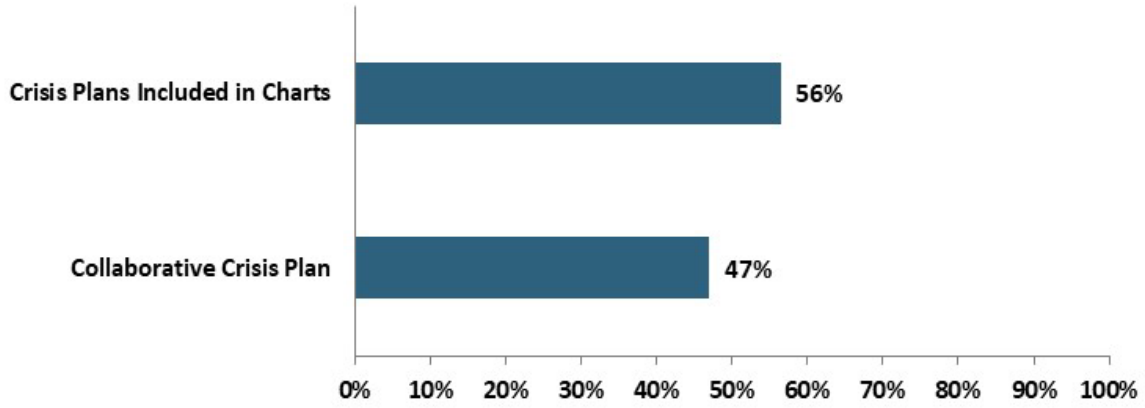
Crisis Prevention and Response

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

Figure 20 identifies the percentage of compliance with crisis plan requirements for the last 90 days of care.

Figure 20. Crisis Plans - Crisis Plan and Collaborative for FY2023.



Of 110 charts reviewed, 56% contained crisis plans. Of the 62 charts containing crisis plans, 47% were created collaboratively.

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.

- The average number of treatment sessions attended per month was 2.52 sessions.
- Therapist involvement in the WISe service model was evidenced by participation in 68% of all CFT meetings.
- The review indicated 60% of treatment sessions were attended by the youth alone.
- The youth and caregiver participated in 26% of sessions.
- Only the caregiver attended 14% of the treatment sessions.

Persistence in problem-solving was evidenced by documentation of the same treatment focus from session to session in 82% of the sessions. Most frequently treatment content documented were Skill Development and Transition Planning at 21% and 15.4%, respectively. Documentation of progress reviewed was identified in 21% of records, while 7% 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.

Figures 21 (parent) and 22 (youth) identify the average hours of Peer Support by Type for FY2023.

Figure 21. Parent Peer Support Elements: Average Hours of Peer Support by Type.

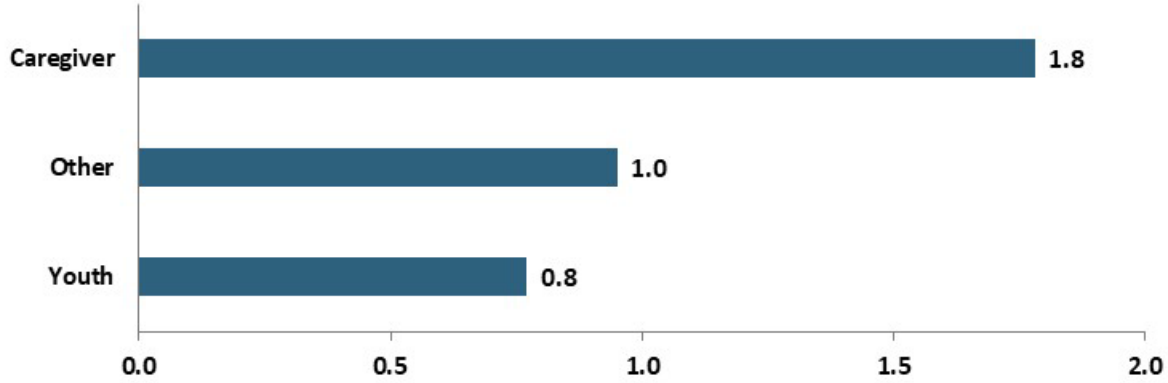
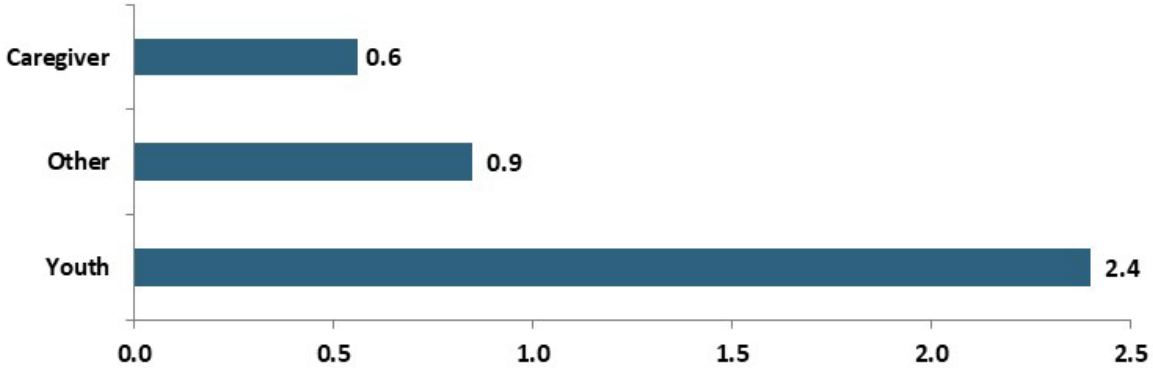


Figure 22. Youth Peer Support Elements: Average Hours of Peer Support by Type.



During the last 90 days of enrollment, the parent peer support partner:

- Spent an average of 1.8 hours with caregiver(s)
- Spent an average of 1.0 hours with other(s)
- Spent an average of 0.8 hours with the youth

During the last 90 days of enrollment, the youth peer support partner:

- Spent an average of 0.6 hours with caregiver(s)
- Spent an average of 0.9 hours with other(s)
- Spent an average of 2.4 hours with the youth

Transition Planning

Prior to transitioning from the WISe Program, all youth must have a formal transition plan developed to plan for a successful transition from the program. The plan must contain specific steps to be taken during the transition as well as the supports available to make the transition successful. The plan must be created in collaboration with input from the youth, family, formal service providers, and natural supports.

- A formal transition plan was present in 50 of cases out of 110 (45%) of records reviewed.

- Of the 50 cases with transition plans, 68% contained evidence of collaboration and input from the youth, family, formal service providers, and natural supports.

Strengths

The agencies reviewed exhibited strengths in both enrollment and transition practices in the following areas of the WISe service delivery model:

- Persistence in problem-solving remained the same focus from session to session in 87% of enrollment records and 82% of transition records.

Enrollment

The agencies reviewed exhibited strengths for enrollment practices in the following areas of the WISe service delivery model:

- Ninety-six percent of records confirmed indication for the WISe Program.
- The initial full Child and Adolescent Needs and Strengths (CANS) assessment was completed within the required timeframe 85% of the time.
- A home representative attended CFT sessions 80% of the time for the 0-4 age and 80.5% of the time for the 5+ age group.
- Crisis plans were evidenced in the chart in 83% of records reviewed.
- Crisis plans were completed in a timely manner 88% of the time.

Progress

Progress is defined as an area of practice the agencies made improvements to from the prior review. Progress only applies to practices identified in the enrollment reviews as data for transition reviews was not collected in the prior review. The following progress was identified for the enrollment reviews:

- The agencies improved practices to ensure youth enrolled in the WISe met the program eligibility requirements evaluated under the requirement WISe indicated.
- The agencies implemented processes to ensure a full CANS assessment was completed no later than 30 days following enrollment.
- The agencies demonstrated improvement in ensuring reassessment was completed within the required timeframe.
- The agencies improved crisis planning practices and ensured a crisis plan was completed for each child enrolled in the program no later than 45 days following enrollment.

Weaknesses/Opportunities for Improvement

The agencies reviewed exhibited the following opportunities for improvement for both enrollment and transition practices of the WISe service delivery model:

- Crisis plans were created collaboratively 45% of the time for enrollment reviews and 47% of the time in transition reviews.

Enrollment

The agencies reviewed exhibited the following opportunities for improvement for enrollment practices of the WISe service delivery model:

- Collaboration when completing the initial full CANS assessment was evident in 38% of the records.
- Of the youth, 10% did not have CFT meetings during the first 90 days of enrollment.

Transition

The agencies reviewed exhibited the following opportunities for improvement for transition practices of the WISe service delivery model:

- Forty-four percent of the youth did not have crisis plans.
- A formal transition plan was not found in 55% of the charts reviewed.
- Of the charts containing formal transition plans, 32% did not contain collaboration and input from youth, family, formal service providers and natural supports.

Recommendations

We recommend MCPs work with their agencies by using the findings in this study to drive improvement efforts.

In addition, HCA should work with the MCPs to assist agencies in conducting a root cause analysis to identify the barriers to success in meeting WISe requirements. As interventions are identified, agencies should use PDSA cycles of improvement to measure the effectiveness of each intervention. Agencies should:

- Ensure WISe team is utilizing training resources for WISe and Crisis Planning and reviewing WISe Manual for Crisis Plan template
- Ensure WISe team is participating in coaching through the WISe Workforce Collaborative
- Conduct collaborative and timely initial full CANs assessments
- Continue utilizing MCPs' support of agency-level QIRT reviews
- Ensure collaboration in the development of crisis plans
- Conduct CFT meetings at least every 30 days, with the youth 100% of the time
- Develop formal transition plans and ensure the plans contain collaboration and input from youth, family, formal service providers, and natural supports
- Conduct collaborative initial full CANs assessments
- Ensure documentation of progress and celebration of success is identified in all records

Due to similar results in prior years, we also recommend HCA work with the MCPs to investigate underlying causes of these results such as workforce issues and WISe program processes to drive improvement efforts and reduce barriers to success.

Enrollment Summary Trend Data

Table 48 provides a summary of the Enrollment Summary Trend Data reported within this section.

In order to determine the significance of year-to-year results, a Pearson's chi-squared test was used to evaluate the statistical significance for both increased and decreased results. The results of the test identified which changes were statistically significant and likely due to actions taken by the WISe agencies as well as the level of significance or whether changes were due to normal variation.

Rate Change Legend	
Increased	▲
Decreased	▼
No change	○

Table 48. Enrollment Summary Trend Data.

Enrollment Summary Data			
Criteria	**FY2022 Result**	**FY2023 Result**	**Alpha Level**
CANS-Related Findings			
Timely CANS	68%	46% ▼	$p \leq .001$
WISe Indicated	95%	96% ▲	NS
Full CANS Completed Timely	77%	85% ▲	NS
Collaborative CANS Assessment	46%	38% ▼	NS
Timely Reassessments	92%	94% ▲	NS
CFT Meeting Participants (0-4 Version)			
Home	100%	80% ▼	NS
Community	50%	20% ▼	NS
CFT Meeting Participants (5+ Version)			
Home	87.1%	81% ▼	NS
Community	1.2%	0.1% ▼	NS
School	1%	5.2% ▲	NS
Crisis Plans			
Crisis Plans Included in Charts	85%	83% ▼	NS
Completed Timely	81%	88% ▲	NS
Collaborative Crisis Plan	45%	45% ○	NS
Parent Peer Support Elements: Average Hours			
Caregiver	2.0	2.3 ▲	NA*
Other	1.1	1.2 ▲	NA*
Youth	0.9	1.3 ▲	NA*
Youth Peer Support Elements: Average Hours			
Caregiver	0.7	0.9 ▲	NA*
Other	0.7	1.2 ▲	NA*
Youth	2.6	2.4 ▼	NA*

**Informational purposes only.*

NS = not significant.

Review of Previous Year (2022) WISe EQRO Recommendations

Table 49 shows the 2022 WISe recommendation with HCA's responses and the EQRO's response to HCA.

Table 49. EQRO Responses to 2022 EQR Recommendations to HCA.

EQRO Recommendations	HCA's Response	EQRO's Response

We recommend the MCPs work with their agencies to conduct a root cause analysis to identify the barriers to success in meeting WISe requirements. As interventions are identified, use PDSA cycles of improvement to measure the effectiveness of each intervention.
Recommended focus areas for improvement include:
• 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
• Conduct CFT meetings at least every 30 days, ensuring each CFT includes educators and/or community partners when identified as areas of need
• Ensure CFT meetings are conducted with youth included 100% of the time
• Ensure all youth in WISe have an active crisis plan
• Ensure collaboration in the development of crisis plans. Documentation of collaboration may include:
  ○ Specific action steps
  ○ Post-crisis follow-up activities
  ○ Identification of all CFT members' roles in crisis response
	HCA meets with the MCPs monthly to partner and provide technical assistance and clarity with WISe requirements. HCA also attends regional WISe collaboratives with MCPs and contracted WISe agencies to provide assistance, clarity and support for any issues voiced by the provider agencies or MCPs. In collaboration with the WISe Workforce Collaborative and the MCPs, HCA has increased training and support for WISe providers around both quality improvement and other WISe skills for providers. MCPs continue to engage in focused work with agencies to address their individual quality improvement needs, as does the WISe Workforce collaborative. The ongoing additional required crisis-focused trainings are an example of how the WISe training curriculum has been updated to address issues identified in the external QIRT review of WISe.
	
	The regional WISe collaborative meetings provide a forum for HCA to address these issues with MCPs and agencies. In addition, the required internal QIRT review process is used to identify and address quality improvement issues on an agency-level basis. Internal QIRT reviews are conducted by agencies, monitored by the MCPs, and reviewed by HCA via an MCP-produced deliverable. Feedback is also gathered from participants at required WISe trainings and technical assistance sessions. This provides a sustainable framework to support ongoing quality improvement work at WISe agencies.
		The EQRO acknowledges that HCA has worked closely with the MCPs by meeting monthly and providing technical assistance to the MCPs and recommends HCA continue with this approach. HCA's response to the EQRO recommendation is accepted as written.
		
		It should be noted that, due to similar results in the current 2023 EQR, we have also recommended HCA work with the MCPs to investigate underlying causes of these results such as workforce issues and WISe program processes to drive improvement efforts and reduce barriers to success which will be followed up during the 2024 EQR.

EQRO Recommendations	HCA's Response	EQRO's Response

• Ensure documentation is identified in all records including 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		

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

Objectives

Since 2019, Comagine Health has been contracted to assess both AH-IMC and IFC MCP 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.

The following year, the MCPs' data are collected and analyzed to evaluate their performance on these assigned measures according to their achievement level. 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 MCP on their achievement of the state's quality initiative within the VBP strategy.

Overview

In 2023, the governor of Washington vetoed a section of the proposed budget proviso requiring HCA's contracted EQRO to annually analyze the performance of Apple Health MCPs providing services to Medicaid enrollees. Although proviso language was vetoed, much of the process remains the same. This is the fifth year that HCA will be using this annual process to review and select VBP performance measures for the five MCPs.

In August 2023, Comagine Health clinicians, analysts and program staff completed a rigorous review process using HCA's specific criteria and guidance to identify, review and select the recommended measures submitted in the *2023 EQR Value-Based Purchasing Measures Analysis Report* to be evaluated in 2024.

In October 2023, Comagine Health delivered the *2023 EQR VBP Evaluation Spreadsheet* to HCA that included detail by contract and a separate *2023 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.

In addition, in 2022, HCA updated its Quality Strategy to include expanded VBP across Washington State, supporting Washington State Medicaid Apple Health VBP principles and aims related to quality, access and timeliness of care.[25] VBP performance by MCP is directly tied to the Quality Strategy.

Methodology

Please see the Comagine Health *2023 EQR Value-Based Purchasing Measures Analysis Report* and the *2023 EQR Value-Based Purchasing Evaluation Methodology Report* for the methodology used in this report.

[25] Washington State Quality Strategy. Washington State Health Care Authority. October 2022. Available at: Washington State Managed Care Quality Strategy.

Summary of Conclusions

As previously noted, two major impacts on MCP performance between 2020 and 2022 were the COVID-19 pandemic and an increase in Medicaid enrollment in the Apple Health Integrated Managed Care (AH-IMC) program.

While achievement of VBP incentive measure benchmarks have declined over the past couple of years, there are early indications that the VBP incentive program has led to improvements in MCP performance in some areas. As noted below, and on a statewide basis, the Antidepressant Medication Management (AMM) and Asthma Medication Ratio (AMR) measures have both seen statistically significant improvements over the last three measurement periods. These measures have been included in the VBP contracts for the MCPs since the program was first implemented in 2020. Other measures, including SUD and MH-B, 6-64 Years, have declined or remained stable.

VBP Performance – IMC Shared Measures

The Antidepressant Medication Management (AMM) measure has improved substantially on a statewide basis. There have been statistically significant increases in measure performance for the last three years. For CY2022, the state average was still slightly below the national 75th percentile.

The Child and Adolescent Well-Care Visit (WCV), 3-11 Years measure has improved significantly for the last two years. This improvement appears to be driven by the performance of MHW. The state average is still below the national 50th percentile.

The Prenatal and Postpartum Care (PPC) measures have not shown consistent improvement. These measures will continue to be a priority for quality improvement strategies.

The Substance Use Disorder Treatment Rate (SUD) measure has decreased by a statistically significant amount over the last two years. The larger population of MHW enrollees reflects this same pattern.

VBP Performance – IMC Plan-Specific Measures

The Asthma Medication Ratio (AMR) measure has shown substantial improvement. With the exception of UHC, all of the MCOs are now above the national 50th percentile; AMG and MHW are performing above the national 75th percentile.

There have been no changes in the performance of the Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation Phase measure.

The Mental Health Treatment Rate (MH-B), 6-64 Years decreased by a statistically significant amount between MY2021 and MY2022.

VBP Performance – IFC Measures

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

None of the seven measures included in the IFC contract showed statistically significant increases between MY2021 and MY2022.

The Child and Adolescent Well-Care Visit (WCV), 12-17 Years had a statistically significant decrease between MY2021 and MY2022.

The Asthma Medication Ratio (AMR) and the Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), Total performance is statistically at the national 75th percentile; the Mental Health Treatment Rate (MH-B), 6-64 Years measure is below the RDA benchmark.

All other HEDIS measures perform statistically at or below the national 50th percentile; the Substance Use Disorder Treatment Rate (SUD), 12-64 Years measure is also below the RDA benchmark.

The following tables (“report cards”) show how Washington Apple Health Plans performed in Performance Year 2022 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.

2023 Value-Based Payment (VBP) Report Card

Washington Apple Health

This report card shows how Washington Apple Health Plans performed in Performance Year 2022 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**

Value-Based Payment Measure		Amerigroup Washington	Coordinated Care	Community Health Plan of Washington	Molina Healthcare of Washington	UnitedHealthcare Community Plan
Total Percent Achieved for VBP Quality Performance Measures		**64.3%**	**57.1%**	**35.7%**	**85.7%**	**42.9%**
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	✓	✓	✓	✓	✓
	Effective Continuation Phase Treatment	✓	✓	✓	✓	✓
Child and Adolescent Well-Care Visits (WCV), Age 3-11		✓	No	No	✓	✓
Prenatal and Postpartum Care (PPC)	Timeliness of Prenatal Care	✓	No	No	✓	No
	Postpartum Care	No	No	✓	✓	No
Substance Use Disorder (SUD)Treatment Rate, Age12–64, all MCO excluding BHSO		No	No	No	No	No
Washington Apple Health Integrated Managed Care (AH-IMC) Plan-Specific Measures - *Three quality focus performance measures specific to each MCO*						
Asthma Medication Ratio (AMR), Total		✓	✓	✓	✓	✓
Follow Up Care for Children Prescribed ADHD Medication (ADD), Initiation Phase		✓	✓	No	✓	No
Mental Health Service Rate, Broad Definition (MH-B), Age 6-64, All MCO excluding BHSO		No	✓	No	✓	No

HCA 19-0072 (11/23)

Washington State Health Care Authority

2023 Value-Based Payment (VBP) Report Card

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 2022 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**

Apple Health Integrated Foster Care VBP Measure		Coordinated Care
Total Percent Achieved for VBP Quality Performance Measures		**75%**
Apple Health Integrated Foster Care (AH-IFC) Shared Measures -*Seven performance measures specific to the IFC contract.*		
Asthma Medication Ratio (AMR), Total		✓
Child and Adolescent Well-Care Visit (WCV)	Age 12-17	No
	Age 18-21	✓
Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation Phase		✓
Mental Health Service Rate, Broad Definition (MH-B), Age 6–26, IFC Only		✓
Substance Use Disorder Treatment Penetration, Age 12-26, IFC Only		✓
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), Total		No

Enrollee Quality Report

Objectives

The purpose of the 2023 Enrollee Quality Report "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. The Plan Report Card provides information to eligible Apple Health clients regarding MCP quality in serving Medicaid and CHIP clients.

In April 2016, CMS issued a final rule that requires states to implement a Medicaid and State CHIP quality rating system (QRS) (42 CFR § 438.334). States are not yet required to use a QRS until CMS finalizes and releases specific guidance. HCA and Comagine Health are monitoring the development of the CMS QRS to ensure the Enrollee Quality Report aligns with CMS methodology.

Overview

The Apple Health Plan Report Card provides information to eligible Apple Health clients regarding MCP quality in serving Medicaid and CHIP clients. The Apple Health Plan Report Card is posted annually to the Washington Healthplanfinder website[26] and is included in the Welcome to Washington Apple Health Managed Care handbook. [27]

Methodology

For more information on the methodology used to derive this report's star rating system and detailed results, refer to Comagine Health's *2023 Enrollee Quality Report Methodology.*

Summary of Conclusions

Comagine Health produced the 2023 Enrollee Quality Report Card, 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.

The following tables ("report cards") show how Washington Apple Health Plans compared to each other in key performance areas in English and Spanish. Results reflect scores for all 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).

[26] Washington State Health Care Authority. Washington Healthplanfinder. Available at: https://www.wahealthplanfinder.org/.
[27] 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.

2023 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	Coordinated Care of Washington	Community Health Plan of Washington	Molina Healthcare of Washington	United Healthcare Community Plan	Wellpoint (previously Amerigroup)
Getting care	★★½	★½★	★★½	★★½	★½★
Keeping kids healthy	★★½	★★½	★★½	★½★	★½★
Keeping women and mothers healthy	★★½	★★½	★★★	★½★	★½★
Preventing and managing illness	★½★	★½★	★★½	★★½	★½★
Ensuring appropriate care	★★★	★★★	★★½	★½★	★½★
Satisfaction of care provided to adults	★★½	★★½	★★½	★★½	★★½
Satisfaction with plan for adults	★★½	★★½	★★½	★★½	★½★

KEY: Performance compared to all Apple Health plans	
Above average	★★★
Average	★★½
Below average	★½★

These ratings were based on information collected from health plans and surveys of health plan members in 2022. (some of the data used in the Getting Care category is from 2021).

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

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HCA 19-057 (9/23)

Informe sobre los planes de Washington Apple Health para el año 2023

Este informe muestra una comparativa entre los planes de Washington Apple Health según los resultados en diversas áreas. Puede utilizar este informe como ayuda para elegir el plan que mejor se adapte a sus necesidades.

Valoración por áreas	Coordinated Care of Washington	Community Health Plan of Washington	Molina Healthcare of Washington	United Healthcare Community Plan	Wellpoint (antes eran Amerigroup)
Obtención de atención	★★★	★★★	★★★	★★★	★★★
Mantenimiento de niños sanos	★★★	★★★	★★★	★★★	★★★
Mantenimiento de mujeres y madres sanas	★★★	★★★	★★★★	★★★	★★★
Prevención y tratamiento de enfermedades	★★★	★★★	★★★	★★★	★★★
Garantía de atención adecuada	★★★	★★★	★★★	★★★	★★★
Satisfacción con la atención brindada a los adultos	★★★	★★★	★★★	★★★	★★★
Satisfacción con el plan para adultos	★★★	★★★	★★★	★★★	★★★

LEYENDA: Resultados de la comparación de todos los planes de Apple Health	
Superior al promedio	★★★
Promedio	★★★
Inferior al promedio	★★★

Estas calificaciones se basaron en la información recaudados de los planes de salud y las encuestas de los miembros del plan de salud en 2022 (algunos de los datos utilizados en la categoría Obtención de Atención son de 2021).

Varios auditores independientes revisaron estos datos para comprobar que fueran exactos.

No se ajustaron los resultados de los planes de salud por las diferencias demográficas entre sus afiliados o las regiones de servicio.

Definiciones de las áreas evaluadas

Obtención de atención
- Los afiliados tienen acceso a un médico.
- Los afiliados informan que reciben la atención que necesitan cuando la necesitan.

Mantenimiento de niños sanos
- Los niños incluidos en el plan se someten a chequeos habituales.
- Los niños reciben vacunaciones importantes.
- Los niños reciben el nivel adecuado de atención cuando están enfermos.

Mantenimiento de mujeres y madres sanas
- Las mujeres se someten a exámenes médicos importantes, como exámenes de detección de cáncer de cuello uterino
- Las madres primerizas y embarazadas reciben la atención que necesitan.

Prevención y tratamiento de enfermedades
- El plan ayuda a sus afiliados a tener bajo control las enfermedades crónicas como el asma, la tensión arterial alta o la diabetes.
- El plan contribuye a prevenir enfermedades gracias a exámenes médicos y una atención adecuada.

Garantía de atención adecuada
- Los afiliados reciben la atención y el tratamiento más adecuados para su condición.

Satisfacción con la atención brindada a los adultos
- Los afiliados valoran positivamente a los doctores, especialistas y la atención médica en general.

Satisfacción con el plan para adultos
- Los afiliados valoran positivamente el servicio de atención de cliente del plan, así como el plan en general.

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HCA 19-057 SP (9/23) Spanish

Appendix A: MCP Profiles

About the MCP Profiles

The MCP profiles are presented for the five MCOs and five BHSOs that served the Apple Health enrollees in 2023. These profiles briefly describe each MCP's performance in the review areas covered by the 2023 EQR:

- Review of compliance with regulatory and contractual standards
- Statewide and MCP-specific PIPs
- Validation of performance measures based on the MCP's Final Audit Report (FAR) from Aqurate Health Data Management, Inc., which conducted the 2021 MCP HEDIS audits
- Analysis of performance measures including a "scorecard" for each MCP, showing its performance on statewide performance measures

Results are extracted from the reports of individual health plan reviews for the following activities and presented in this appendix.

Compliance

- Compliance weaknesses/opportunities for improvement and EQRO recommendations are included 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 and EQRO recommendations in the referenced tables are included when the MCP did not meet the scoring element.
- The language is a synopsis from TEAMonitor PIP Validation Worksheets completed for each PIP.

Performance Measure Comparative Analysis

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

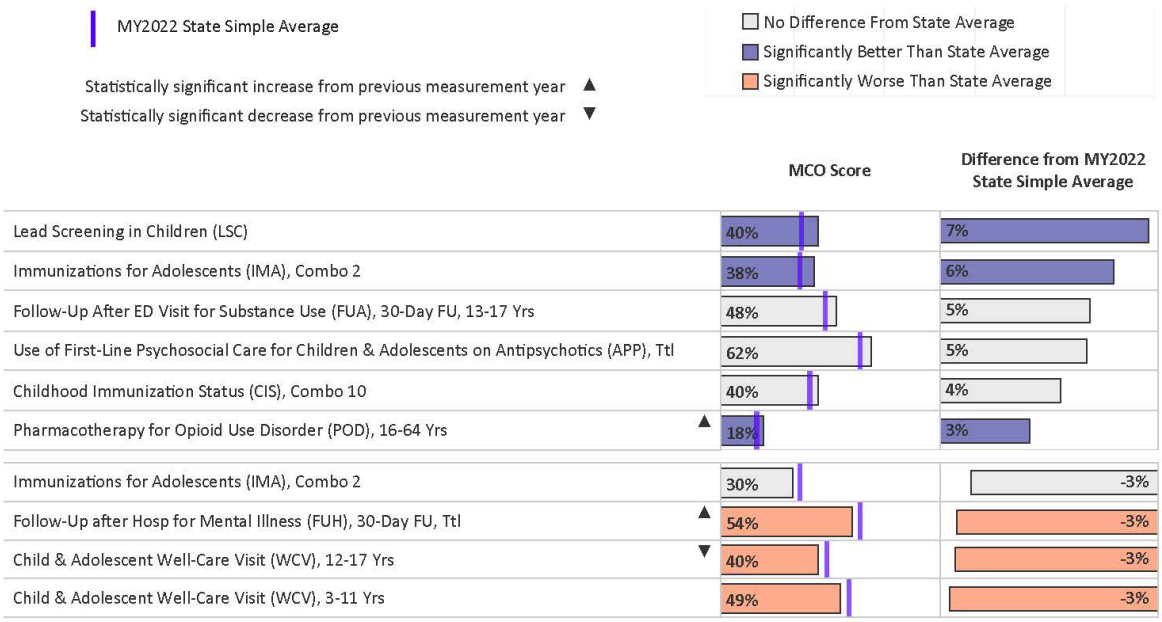
MCP Performance Measure Comparative Analysis Scorecards

Comagine Health compared MCP performance on each measure to the statewide simple average for that measure and created a "scorecard" chart for each MCP. Comagine Health chose to use the simple average for the MCP scorecards because the Apple Health MCPs are of such different sizes. The state simple average for a given measure is calculated as the average of the measure rate for the MCPs that reported that measure. The potential disadvantage of comparing an individual MCP 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.

Figure A-1 shows a snapshot of the scorecard to illustrate how to read the MCP scorecards. The measures are listed in the left column with MCP performance listed in the shaded column in the middle. The bold vertical bar illustrates the Statewide Simple Average.

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

Figure A-1. Example of MCP Scorecard.



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

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

Amerigroup Washington (AMG) Profile

AMG Overall Perspective

While AMG has demonstrated strengths, the plan continues to struggle in multiple areas regarding quality, access and timeliness. AMG will need to address the following compliance standards where they did not fully meet the requirements and received CAPs:

- Enrollee Rights
- Availability of Services
- Coordination and Continuity of Care – (repeat finding)
- Practice Guidelines
- QAPI – (repeat findings)
- Grievance System
- Coverage and Authorization of Services – (repeat findings)

AMG fully met all elements in the compliance standard of Health Information Systems.

TEAMonitor identified a best practice by AMG during the QAPI section of the compliance review. The MCPs were to provide a written narrative that describes the actions the MCO/BHSO has taken to encourage and support the use of the clinical data repository (CDR) with their eligible providers. AMG promoted access to provider types who do not currently have access. In addition, AMG participated in a joint provider training in 2022 that included CDR in the "important reminders" section.

AMG met the criteria for validation of their PIPs with strengths including the choice of important PIP topics and implementation of interventions. While the confidence in the reported results were moderate due to low success rates during the current review, things such as low numbers within the intervention groups, balancing the return to in-person care with telehealth interventions as the public health emergency continued, and staff turnover have impacted the low success rates at all the MCPs. AMG partially met their EQRO recommendation from the previous year due to not addressing the findings related to the identification of internal/external threats to validity and a feasibility data collection process.

The performance measure comparative analysis conducted this year demonstrated that AMG was below the state simple average for 29 of the 42 measures and significantly worse than the statewide average on 20 measures.

Several measures were significantly below the statewide simple average, including many behavioral health measures such as Follow-Up after ED Visit for Mental Illness (FUM) and Follow-Up after Hospitalization for Mental Illness (FUH) measures.

AMG performed above the statewide simple average on a few measures. They demonstrated statistically significant improvement over their previous performance year for Asthma Medication Ratio (AMR) Total and scored significantly better than the statewide average on this measure as well. In addition, AMG scored significantly above the statewide simple average for measures, including Initiation and Engagement of Substance Use Disorder Treatment (IET), and Use of Opioids from Multiple Prescribers and Multiple Pharmacies (UOP).

AMG achieved 64.3% of the VBP quality performance measures for 2022, which reflects decrease from the previous year in performance areas identified by HCA, based on the legislative proviso (ESSB 5693 Sec.211 (37)(2022)), as important in having potential to impact costs, affect population health, target

areas of poor performance or be clinically meaningful in promoting health status. AMG MCO did not meet the VBP performance targets for:

- Prenatal and Postpartum Care (PPC) Postpartum Care
- Substance Use Disorder Treatment Rate (SUD) Age 12-64

In the Enrollee Quality Report (2023 Washington Apple Health Plan Report Card), AMG received an average rating for "Satisfaction of care provided to adults." They received below average ratings in the remaining performance areas:

- Getting care
- Keeping kids healthy
- Keeping women and mothers healthy
- Preventing and managing illness
- Ensuring appropriate care
- Satisfaction with plan for adults

Overall, AMG is encouraged to ensure its QAPI program is effective, monitored, objectively evaluated and updated to provide overall continuous improvement related to quality, access and timeliness of services provided by the MCP. Please see the following profile for additional detail.

Summary of Results: Compliance Review

TEAMonitor's review assessed activities for the previous calendar year and evaluated AMG's compliance with the standards set forth in 42 CFR Part 438, as well as those established in the MCP contract with HCA for all Apple Health Managed Care programs. 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.

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. A follow-up of the current year's EQRO recommendations will be reflected in the 2024 Annual Technical Report.

The compliance review section, starting on page 28 of the 2023 Annual Technical Report, outlines weaknesses and opportunities for improvement. These weaknesses and areas for improvement are the elements identified by TEAMonitor as "not met" or "partially met," requiring a corrective action plan. Comagine Health's recommendations to the AMG MCPs reflect the CAPs provided by TEAMonitor. Please note both the MCO and BHSO received the same EQRO recommendations. This language is a synopsis from TEAMonitor Compliance Summary report completed for each standard reviewed in 2023.

Tables A-1 through A-9 show the results of the AMG MCPs' 2023 TEAMonitor compliance review.

Table A-1. AMG 2023 TEAMonitor Compliance Review Results: Enrollee Rights.

§438.100 – Enrollee rights	MCO	BHSO
438.100 (a) - General rule	3	3
438.100 (b)(2)(i) Specific rights - 438.10 (c) Language and format	3	3
438.100 (b)(2)(i) Specific rights - 438.10 (d) Language and format (3) Notification	3	3
438.100 (b)(2)(i) Specific rights - 438.10 (d) Language and format (4)(5) Language – Oral interpretation/written information	3	3

§438.100 – Enrollee rights	MCO	BHSO
438.100 (b)(2)(i) Specific rights - 438.10 (d)(6) Format, easily understood	3	3
438.100 (b)(2)(i) Specific rights - 438.10 (d)(6)(iii)	3	3
438.100 (b)(2)(i) Specific rights - 438.10 (f)(2) General requirements	2	2
438.100 (b)(2)(i) Specific rights - 438.10 (g)(1-4) Information for Enrollees – Enrollee Handbook	3	3
438.100 (b)(2)(i) Specific rights - 438.10 (i) Information for Enrollees – Formulary	3	NA
438.100 (b)(2)(ii - iv) and (3) Specific rights	3	3
438.100 (d) Compliance with other Federal and State laws	3	3
438.106 - Liability for payment	3	3
Total Score	**35/36**	**32/33**
Total Score (%)	**97%**	**97%**

EQRO Recommendations based on TEAMonitor CAPs – 1

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

1. To address the Partially Met score, the AMG will provide HCA documentation for each applicable provider on the list of terminated providers.

Table A-2. AMG 2023 TEAMonitor Compliance Review Results: Availability of Services.

§438.206 – Availability of services	MCO	BHSO
438.206 (b)(1)(i-v) & (c) Delivery network, 438.10 (h) Information for all enrollees – Provider directory	2	2
438.206 (b)(2) Direct access to a women's health specialist	3	NA
438.206 (b)(3) Provides for a second opinion	3	3
438.206 (b)(4) Services out of network	3	3
438.206 (b)(5) Out-of-network payment	2	2
438.206 (c) Furnishing of services (1)(i) through (vi) Timely access	2	2
438.206 (c)(2) Cultural considerations	3	3
438.207 (b)(c) Assurances of adequate capacity and services	2	2
Total Score	**20/24**	**17/21**
Total Score (%)	**83%**	**81%**

EQRO Recommendations based on TEAMonitor CAPs – 6

To address the Partially Met score, AMG will provide HCA:

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

1. An updated narrative report with an analysis on the impact closed panels have on their network including availability of services with supporting data
2. Policies or evidence of a tracking mechanism to show that there is a process in place for the contracting and monitoring activities
3. Evidence of a link to behavioral health services including information on how enrollees can access behavioral health services on the front page of their website as required by contract

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

4. Updated information that addresses:
    a. The expectation the providers must coordinate with the MCO/PIHP, with respect to payment and ensured cost to the enrollee was no greater than it would be if the services were furnished within the network; and
    b. Apple Health enrollees served by the contracts under review cannot be billed for a covered service

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

5. Documentation that clearly outlines the emergency fill policy including the provision that these are covered without authorization and evidence that the policy is visibly posted in an easily accessible location on their website

438.207 (b)(c) Assurances of adequate capacity and services

6. Provide evidence of a tracking mechanism for HCA-identified issues

Table A-3. AMG 2023 TEAMonitor Compliance Review Results: Coordination and Continuity of Care.

§438.208 – Coordination and continuity of care	MCO	BHSO
438.208 (a) General requirement	2	3
438.208 (b) Care coordination of services for all MCO, PIHP, and PAHP enrollees - 438.224 Confidentiality	3	3
438.208 (c)(1) Additional services for enrollees with special health care needs or who need LTSS - Identification	3	3
438.208 (c)(2)(3) Assessment and treatment/service plans	2	2
438.208 (c)(4) Direct access to specialists	2	2
Total Score	**12/15**	**13/15**
Total Score (%)	**80%**	**87%**

EQRO Recommendations based on TEAMonitor CAPs – 7

438.208 (a) General requirement

To address the Partially Met score, AMG will attend an HCA pharmacy presentation that will be provided to obtain a better understanding of HCA's expectations around the contract requirement. AMG will then update their policy and procedure documents and submit them to HCA for review and approval based on the following:

1. AMG's policy and procedure related to continuity of care and prior authorization did not include the steps AMG has in place to approve the one-month approval and initiate the prior authorization process with the prescribing provider.
2. The documentation did not detail how AMG identifies when a continuation fill is needed for a new enrollee, and how AMG determines that a requested medication is an established medication for the enrollee. The document lists medication exceptions to the transition fills and is incorrect.
3. The documents did not include procedures for approving the payment of the dispensing of a refill for an antipsychotic, antidepressant or antiepileptic medication.

438.208 (c)(2)(3) Assessment and treatment/service plans

To address the Partially Met score, AMG will provide HCA documentation of:

4. The assessment of the identified files to determine the cause of findings and identify and follow up on actions for improvements to prevent future issues. Additionally, AMG will provide evidence of the implementation of training of current and new staff on the use of criteria and Predictive Risk Intelligence SysteM scores for identification of individual with special health care needs clients, specifically as it applies to clients with behavioral health and developmental disabilities. (Repeat finding.)
5. The update of the policy and procedure to include facilitating re-testing, facilitating follow up referrals and current processes for notification from HCA.
6. The process that will be put in place to ensure future case files will contain full information, including follow-up care coordination, retesting and efforts to make appropriate referrals.

438.208 (c)(4) Direct access to specialists

The file review identified concerns related to the lack of evidence that AMG coordinated and assisted in accessing needed services when a need was identified or reported, including behavioral health, physical health, comprehensive medication therapy management, oral health, non-contracted services, and other community resources such.

7. To address the Partially Met score, AMG will provide HCA documentation of the assessment of the identified files to determine the cause of findings and identify and follow up on actions for improvements to prevent future issues.

Table A-4. AMG 2023 TEAMonitor Compliance Review Results: Practice Guidelines.

§438.236 – Practice Guidelines	MCO	BHSO
438.236 (a)(b)(1-4) Adoption of [practice] guidelines	3	3
438.236(c) Dissemination of [practice] guidelines	2	2
438.236(d) Application of [practice] guidelines	3	3
Total Score	8/9	8/9
Total Score (%)	89%	89%

EQRO Recommendations based on TEAMonitor CAPs – 1

438.236(c) Dissemination of [practice] guidelines

1. To address the Partially Met score, AMG should provide documentation outlining the exact date and method of distribution of updated clinical practice guidelines to affected providers. Additionally, the exact dates of when practice guidelines were adopted or revised must be provided to ensure that the notification to providers was within 60 days of adoption or revision.

Table A-5. AMG 2023 TEAMonitor Compliance Review Results: Health Information Systems.

§438.242 – Health information systems	MCO	BHSO
438.242 (a) General rule	3	3
438.242 (b)(1)(2) Basic elements	3	3
438.242 (b)(3) Basic element - Accuracy	3	3
Total Score	**9/9**	**9/9**
Total Score (%)	**100%**	**100%**

AMG met all elements within this standard. As a result, no recommendations are being made.

Table A-6. AMG 2023 TEAMonitor Compliance Review Results: QAPI.

§438.330 – QAPI	MCO	BHSO
438.330 (b)(2) and (c), Performance measurement, and 438.330(e)(2) QAPI Program Evaluation - Desk Review	3	3
438.330 (e)(2) QAPI Program evaluation	0	0
Total Score	**3/6**	**3/6**
Total Score (%)	**50%**	**50%**

EQRO Recommendations based on TEAMonitor CAPs – 1

438.330 (e)(2) QAPI Program evaluation

1. To address the Not Met score, AMG should provide documentation that will identify how they will ensure future submissions:
    a. Address and respond to the EQRO recommendations found within the annual EQR Technical Report. The grid provided addressed TEAMonitor recommendations, inaccurately labeled as HCA/EQRO recommendations. EQRO recommendations should be pulled from the annual EQR Technical Report. Recommendations were made in four areas:
        i. Sustain Improvement in Clinically Meaningful areas
        ii. Address Behavioral Health Declines
        iii. Focus on Preventive Care
        iv. Continue to Prioritize Health Equity
    b. Some components were found throughout evaluation but not all were addressed and not all were housed within the table meant to address EQRO recommendations. (Repeat finding.)
    c. Include the full scope (all subsections) of an evaluation of the overall efficacy of the QAPI program. The assessment of the overall effectiveness of the QI program was brief and very high-level—it did not cover the full scope of the QAPI program. A roll-up of all the subsections should be included in the evaluation of overall efficacy. Some of the areas missing were objective assessment criteria, a list of program accomplishments, and the results of the objective assessment. AMG should request technical assistance for additional clarification and guidance through the HCA MC Programs mailbox. (Repeat finding.)

d. The inclusion of objective assessment criteria, a list of program accomplishments and results of the objective assessment as part of overall efficacy of the quality improvement program. See the "Partially Met" scored 2022 recommendation.

Table A-7. AMG 2023 TEAMonitor Compliance Review Results: Grievance System.

§438.400 – Grievance System	MCO	BHSO
438.400 (b) Statutory basis and definitions – file review	3	3
438.402 (c)(1) Filing requirements - Authority to file – file review	3	3
438.402 (c)(2) Filing requirements - Timing – file review	3	3
438.402 (c)(3) Filing requirements - Procedures – file review	3	3
438.404 (a) Notice of adverse benefit determination - language and format – file review	3	3
438.404 (b) Notice of action - Content of notice – file review	3	3
438.406 (a) Handling of grievances and appeals - General requirements – file review	3	3
438.406 (b) Special requirements for appeals – file review	3	3
438.408 (a) Resolution and notification: Grievances and appeals - Basic rule – file review	2	3
438.408 (b)(c) Specific timeframes and extension of timeframes – file review	3	3
438.408 (d)(e) Format of notice and content of notice of appeal resolution – file review	2	3
438.410 Expedited resolution of appeals – file review	3	3
438.420 Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State fair hearing are pending – file review	3	3
438.424 Effectuation of reversed appeal resolutions – file review	3	3
Total Score	**40/42**	**42/42**
Total Score (%)	**95%**	**100%**

EQRO Recommendations based on TEAMonitor CAPs – 2

To address the Partially Met Score, AMG will review the files to determine the cause of findings and identify and follow up on actions for improvements to prevent future issues. This must include, at minimum, documentation of staff training, and monitoring for the following:

438.408 (a) Resolution and notification: Grievances and appeals - Basic rule – file review

1. The file review identified concerns related to the lack of evidence AMG medical necessity determinations followed the requirements, and the coverage determination conformed to the contract, including Washington Administrative Code, Early and Periodic Screening, Diagnosis, and Treatment coverage requirements.

438.408 (d)(e) Format of notice and content of notice of appeal resolution – file review

2. The file review identified concerns related to the lack of evidence that the documentation of the appeal resolution including the resolution process and the date it was completed.

Summary of AMG 2022 EQRO Recommendations Based on TEAMonitor Compliance CAPs Follow-Up

Table A-8 shows the number of MCO/BHSO EQRO recommendations that were followed up during the current review.

Degree to which plans have addressed the previous year's EQRO recommendations key:

- **Low** – No CAPs met
- **Medium** – Less than all CAPs met
- **High** – All CAPs met
- **NA** – No CAPs received

Table A-8. AMG Results of Previous Year (2022) EQRO Compliance Recommendations Based on TEAMonitor CAPs – Count.

Met	Partially Met*	Not Met*	Degree to which plans addressed all EQRO recommendation(s):
11	1	6	Medium

**Future follow-up required.*

Table A-9 shows the results of the previous year EQRO compliance recommendations based on TEAMonitor CAPs follow-up.

Table A-9. AMG Results of Previous Year (2022) EQRO Compliance Recommendations Based on TEAMonitor CAPs – Follow-up.

42 CFR Part 438	MCO and BHSO		
Subpart D – MCO, PIHP and PAHP Standards	**Met**	**Partially Met**	**Not Met**
438.208(c)(2)(3) Additional services for enrollees with special health care needs – Assessment and treatment plans – Care Coordination or Individuals with Special Health Care Needs (Repeat Finding) – 4 CAPs	3	0	1
438.210 (b) Authorization of services – File review (Repeat finding) – 6 CAPs	2	0	4*
438.210 (c) Notice of adverse benefit determination – File review (Repeat finding) – 1 CAP	0	0	1
438.210 (d) Timeframe for decisions – File review (Repeat finding) – 1 CAP	1	0	0
438.214(a) General Rules and 438.214(b) Credentialing and recredentialing requirements – 1 CAP	1	0	0
Subpart E – Quality Measurement and Improvement (Quality Assessment and Performance Improvement Program (QAPI))	**Met**	**Partially Met**	**Not Met**
438.330 (e)(2) QAPI Program evaluation – 2 CAPs	1	1	0
Subpart F – Grievance System	**Met**	**Partially Met**	**Not Met**
438.406(a) Handling of grievances and appeals – General requirements – File review – 1 CAP	1	0	0

42 CFR Part 438	MCO and BHSO		
438.408(b) and (c) Resolution and notification: Grievances and appeals – specific timeframes and extension of timeframes – File review – 1 CAP	1	0	0
438.410 Expedited resolution of appeals – File review – 1 CAP	1	0	0

**Includes a repeat finding – plans are reviewed on elements that received Partially Met or Not Met scores in previous reviews until the finding is satisfied.*

Summary of Results: PIP Validation

PIPs: 3 Met; 0 Partially Met; 0 Not Met

The PIP validation section, starting on page 35 of the 2023 Annual Technical Report, outlines strengths, weaknesses and opportunities for improvement. These weaknesses and areas for improvement are the elements identified by TEAMonitor as "not met" or "partially met," requiring a corrective action plan. This language is a synopsis from TEAMonitor PIP Validation Worksheets completed for each PIP.

Tables A-10 through A-12 show the results of the MCP's PIP validation.

PIP Title: Collaborative MCO Well-Child Visit Rate PIP

PIP Type: AH-IMC, AH-IFC **Domain:** Access, Quality, Timeliness

Improvement Strategies/Interventions

- Member-focused: Social media postings, well-care visit flyers
- Provider-focused: Two MCO-provider group partnerships, named Spring and Fall Project 2022, that aim to engage over-due or unestablished members through efforts that include empanelment clean-up, patient outreach and provider incentives
- MCP-focused: Continued use of standardized empanelment data format; incentive reference list for clinics

Table A-10. AMG: Collaborative MCO Well-Child Visit Rate PIP.

Score	Validation Status	Validation Rating	Performance Measure and Results
Met	Yes	Moderate confidence in reported results	HEDIS Measures: • W30, 0-15 months: Demonstrated performance improvement; no statistically significant change; p-value <.05 • W30, 15-30 months: Demonstrated performance improvement; no statistically significant change; p-value <.05 • WCV, 3-11 years: No demonstrated performance improvement; no statistically significant change; p-value <.05 • WCV, 12-17 years: No demonstrated performance improvement; no statistically significant change; p-value <.05 • WCV, 18-21 years: No demonstrated performance improvement; no statistically significant change; p-value <.05

PIP Title: Diabetes Screening for Adult Members on Antipsychotic Medication PIP

PIP Type: AH-IMC, AH-IFC **Domain:** Access, Quality, Timeliness

Improvement Strategies/Interventions

- **Member-focused:** Reminder text messages to members who are due for monitoring; member education campaign outlining the potential risks associated with antipsychotic medication and the importance of diabetes screening; assist members with scheduling an appointment with the member's primary care provider (PCP) to obtain lab services at the PCP's office and arrange medical appointment transportation; provide and distribute A1c at-home test kits to applicable members; encourage and endorse use of telehealth.
- **Provider-focused:** Develop and distribute provider newsletter article in July 2022 newsletter; provider education focus on HEDIS measures, including BH measure schizophrenia, schizoaffective disorder (SSD); AMG's Quality Management and Care Delivery Transformation teams established regular meetings with providers to reinforce the SSD measure and technical specifications; outreach to providers prescribing antipsychotics to remind them to conduct diabetes screening; pharmacy outreach; partner with providers who have high numbers of non-compliant members for the SSD measure to help facilitate member outreach and education to enhance understanding of preventive care; and partner with providers to leverage the use of A1c at-home test kits.
- **MCP-focused:** Mail member flyers educating them on the importance of diabetes screenings as another form of outreach to members designated as "Do Not Call."

Table A-11. AMG: Diabetes Screening for Adult Members on Antipsychotic Medication PIP.

Score	Validation Status	Validation Rating	Performance Measure and Results
Met	Yes	Moderate confidence in reported results	Increase the percentage of diabetes screenings for adult members 18-64 years of age diagnosed with schizophrenia, schizoaffective disorder or bipolar disorder who are using antipsychotic medications from 79.90% in 2021 to 85.53%: no demonstrated performance improvement; no statistically significant change; p-value 0.61.

PIP Title: Improving 7-day Follow-Up After Hospitalizations for BHSO Members with Mental Illness and Emergency Department Visits for BHSO Members with Mental Illness and/or Alcohol and Other Drug Abuse or Dependence

PIP Type: BHSO **Domain:** Access, Timeliness

Improvement Strategies/Interventions

- **Member-focused:** A 7-day follow-up to assist members understand the benefits and options associated with behavioral health (BH)/SUD treatment; collaborate with BH providers to engage members and destigmatize MH and/or SUD diagnosis, treatment, and services; assist members arrange transportation for in-person appointments; promote telehealth to minimize barriers to treatment access; outreach to members who do not have an AMG SafeLink cell phone to obtain a cell phone; member incentives; quality management monitoring daily pharmacy reports for members newly prescribed antipsychotic medications and outreach to prescribers to timely follow-up with members regarding adherence; BH case managers work with hospital staff to

schedule 7-day follow-up appointment post discharge and reinforce members receive discharge plans, including details of the 7-day follow-up appointment; social workers and case managers can assist members meet basic social determinants of health needs such as transportation, cell phone, housing, food insecurity, etc.

- **Provider-focused**: Quality management (QM) promoting telehealth as an accepted mechanism for 7-day follow-up and more convenient access for members; QM monitoring daily Emergency Department Information Exchange (EDIE) reports to submit to specific BH providers who agreed to contact the PIP's study populations for follow-up within 7 days after MH hospitalizations and MH/SUD emergency (MHSUD) visits; engaged specific BH providers who agreed to contact the PIP's study populations for follow-up within 7 days after MHSUD visits; produce daily EDIE reports to providers who can outreach to members for timely 7-day follow-up after MHSUD visits; providers will reinforce member incentives among the BHSO population; during provider engagement meetings, as well as specific provider training sessions, QM will increase awareness that telephone follow-up visits are allowed; promote telehealth among provider networks to improve timely 7-day follow-up appointments; remind providers that members are eligible to obtain an AMG SafeLink cell phone; during regularly scheduled provider engagement meetings, as well as specific provider training sessions, QM reinforced NCQA technical specifications associated with 7-day follow-up for FUA, FUH, and FUM; providers were reminded members are eligible to obtain an AMG SafeLink cellphone during provider engagement meetings.

Table A-12. AMG: Improving 7-day Follow-Up After Hospitalizations for BHSO Members with Mental Illness and Emergency Department Visits for BHSO Members with Mental Illness and/or Alcohol and Other Drug Abuse or Dependence PIP.

Score	Validation Status	Validation Rating	Performance Measure and Results
Met	Yes	Moderate confidence in reported results	Achieve a 10% aggregate increase from the 2021 baseline aggregate rate of 39.57% in BHSO members' FUH, FUM and FUA HEDIS measure rates: no demonstrated performance improvement; no statistically significant change; p-value 0.062

Summary of AMG 2023 EQRO PIP Recommendation Based on TEAMonitor CAPs

AMG did not receive an EQRO recommendation based on a TEAMonitor CAP in 2023.

Summary of Previous Year (2022) EQRO PIP Recommendation Based on TEAMonitor CAP Follow-Up

Degree to which plans have addressed the previous year's EQRO recommendations key:

- **Low** – CAP Not Met
- **Medium** – CAP Partially Met
- **High** – CAP Met
- **NA** – No CAP Received

Degree to which plan addressed EQRO recommendation: Medium

2022 TEAMonitor CAP

AMG must submit a narrative and any supporting documents describing the actions they will take to address the findings related to:

- Identification of internal/external threats to validity
- A feasible data collection process

In addition to the elements above the narrative should address actions that can be taken to improve the current active (2022) PIPs and describe how the deficiencies in this year's PIP report and feedback from HCA will be used to make constructive changes in the (2022) PIPs.

TEAMonitor Response/MCP Response – Action Taken

Partially Met – The response provided by AMG did not address the findings related to:

- Identification of internal/external threats to validity and
- A feasible data collection process

However, current ongoing monthly technical assistance meetings between HCA and AMG has demonstrated that AMG has created infrastructure to attend to the above improvements. To address how AMG will make constructive improvements in the current active (2022) PIPs, AMG stated that they will:

- Participate in technical assistance meetings with HCA
- Will follow the CMS External Quality Review (EQR) Protocols, October 2019, Protocol 8 – Implementation of Additional Performance Improvement Projects
- Use HCA's "Conducting a PIP Worksheet" and AMG's internal "Study Selection, Design, Implementation and Evaluation: Quality Improvement Projects (QIPs)"

Summary of Results: Performance Measure Validation

Comagine Health received the AMG's FAR from Aqurate Health Data Management, Inc., an independent organization providing performance measure validation review and HEDIS compliance audits, which conducted the 2023 MCP HEDIS audits. Comagine Health then assessed the FAR to determine and develop EQR findings and recommendations. AMG was in full compliance with the MY2022 audits. Comagine Health did not identify any EQRO recommendations, strengths or weaknesses during the 2023 PMV.

However, when reviewing the MCP's FAR, Comagine Health identified suggested opportunities for improvement within the FAR based on the audit team recommendations. HCA plans to follow-up via the TEAMonitor process and will be requiring a response from AMG to HCA. If the AMG's response does not sufficiently address the issue in the upcoming year, an EQRO Recommendation will be issued as part of the 2024 performance measure review.

Table A-13 shows AMG's results for each standard addressed in the FAR.

Table A-13. Summary of AMG 2023 HEDIS FAR.

Information Standard	Score
IS 1.0 Medical Services Data	Met
IS 1.A Behavioral Health Services	NA

Information Standard	Score
IS 1.B Vision Services	Met
IS 1.C Pharmacy Services	Met
IS 1.D Dental Services	NA
IS 1.E Laboratory Services	NA
IS 2.0 Enrollment Data	Met
IS 3.0 Practitioner Data	Met
IS 4.0 Medical Record Review Process	Met
IS 5.0 Supplemental Data	Met
IS 6.0 Data Preproduction Processing	Met
IS 7.0 Data Integration and Reporting	Met
IS 8.0 Case Management Data: LTSS	NA
IS AD 1.0 General Information	Met
IS HD 5.0 Outsourced or Delegated Reporting Function	NA

Summary of Results: Performance Measure Comparative Analysis

AMG has several pediatric measures where the rates were above the state simple average. In addition, AMG performed better than the state simple average for the Asthma Medication Ratio (AMR) measure. Many of the behavioral health measures are below the state simple average for AMG. Other measures where AMG's rates were markedly below the state simple average include Prenatal and Postpartum Care (PPC), both the Timeliness of Prenatal Care and Postpartum Care measures, several Comprehensive Diabetes Care (CDC) measures, and several behavioral health measures.

VBP Measure Performance

AMG's performance on the Asthma Medication Ratio (AMR) has been outstanding. There have been statistically significant increases for the last three years (MY2020 through MY2022). This MY2022 result for this measure is now above the national 75th percentile. Performance for the remaining VBP measures was mostly flat. There have been scattered historical improvements for other VBP measures but those may be due to random statistical variation.

Table A-14 shows AMG's performance measure comparative analysis strengths and weaknesses/opportunities for improvement.

Table A-14. AMG's Performance Measure Comparative Analysis Strengths and Weaknesses/ Opportunities for Improvement.

Performance Measures	
Strengths	**Weaknesses/Opportunities for Improvement**
Respiratory Conditions: • Asthma Medication Ratio (AMR)* Access/Availability of Care:	Prevention and Screening: • Breast Cancer Screening (BCS-E) • Immunizations for Adolescents (IMA), Combo 2 • Cervical Cancer Screenings (CCS)

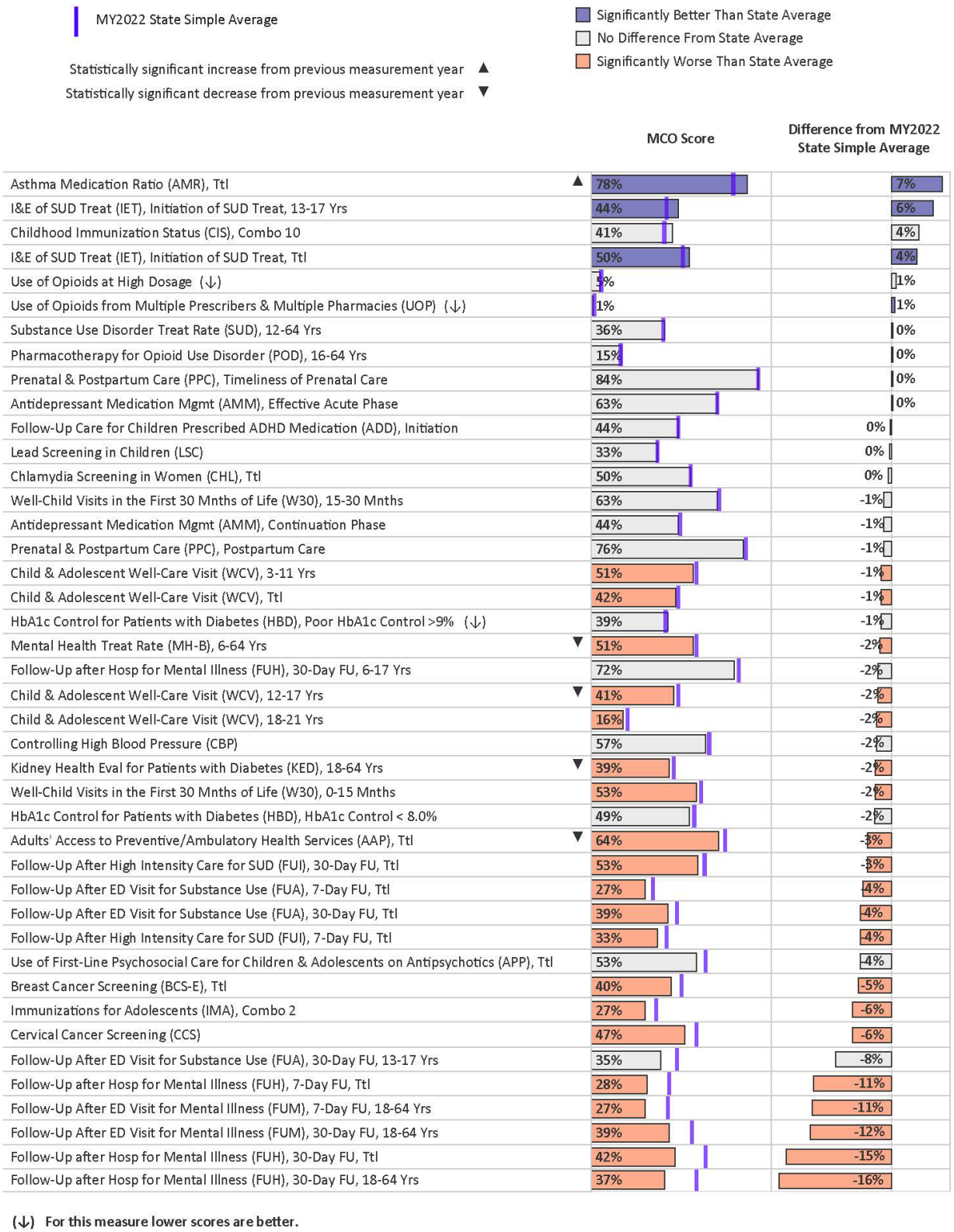
Performance Measures	
Strengths	**Weaknesses/Opportunities for Improvement**
• Initiation and Engagement of Substance Use Disorder Treatment (IET), Initiation of SUD Treatment, 13-17 years • Initiation and Engagement of Substance Use Disorder Treatment (IET), Initiation of SUD Treatment, Total Overuse/Appropriateness: • Use of Opioids from Multiple Prescribers and Multiple Pharmacies (UOP)	Behavioral Health: • Follow-Up After Emergency Department Visit for Substance Use (FUA) • Follow-Up After Emergency Department Visit for Mental Illness (FUM) • Follow-Up after Hospitalization for Mental Illness (FUH) • Follow-Up After High Intensity Care for Substance Use Disorder (FUI)

**These measures are also required VBP measures.*

AMG Performance Measure Comparative Analysis Scorecard

Figure A-2, on the next page, represents the variance of measures from the simple state average for AMG.

Figure A-2. AMG Scorecard, MY2022.



Coordinated Care of Washington (CCW) Profile

CCW Overall Perspective

CCW demonstrated strengths in compliance by demonstrating a best practice within their QAPI program by providing a description of the action CCW has taken to encourage and support the use of the Clinical Data Repository (CDR) with their eligible providers. CCW provided:

- The inclusion of the regional provider training in expansion area
- The inclusion of contract requirements in provider manual/provider agreement including contact information for OneHealthPort
- The inclusion of CDR "important reminder" within joint MCO provider training
- Monthly outreach calls using "Provider Active Engagement Report"

CCW will need to address the following compliance standards where they did not fully meet the requirements and received CAPs:

- Enrollee Rights
- Availability of Services
- Coordination and Continuity of Care
- Practice Guidelines
- QAPI

CCW fully met all elements in the compliance standards of Health Information Systems and Grievance Systems. CCW met all compliance CAPs provided in 2022, demonstrating a high degree of compliance with their follow-up.

CCW met the criteria for validation of their PIPs with strengths including implementation of interventions allowing the MCP to identify lessons learned and plan for potential follow up activities. While the confidence in the reported results were moderate due to low success rates during the current review, things such as low numbers within the intervention groups, balancing the return to in-person care with telehealth interventions as the public health emergency continued, and staff turnover have impacted the low success rates at all the MCPs. CCW fully met their EQRO recommendation from the previous year by providing the required documentation to address the finding as part of the 2022 TEAMonitor Corrective Action review process.

The performance measure comparative analysis conducted this year demonstrated that CCW is at or above the MY2023 State Simple Average for 25 of the 42 performance measures reviewed. Seventeen of the performance measures reviewed fell significantly below the state simple average when compared to the other MCOs.

CCW achieved 57.1% of the VBP Quality Performance Measures for 2022, which reflects decrease from the previous year in performance areas identified by HCA, based on the legislative proviso (ESSB 5693 Sec.211 (37)(2022)), as important in having potential to impact costs, effect population health, target areas of poor performance or be clinically meaningful in promoting health status. CCW did not meet the VBP performance targets for:

- Child and Adolescent Well-Care Visits (WCV), Age 3-11
- Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care and Postpartum Care
- Substance Use Disorder Treatment Rate (SUD), Age 12-64, all MCO excluding BHSO

CCW is the single MCP providing Apple Health Integrated Foster Care services (AH-IFC). CCW achieved 75.0% of the VBP Quality Performance Measures for AH-IFC, which demonstrated improvement over the previous year. They did not meet the VBP criteria for this population for:

- Child and Adolescent Well-Care Visit (WCV) Age 12-17
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), Total

In the Enrollee Quality Report (2023 Washington Apple Health Plan Report Card), CCW received an above average rating for "Ensuring appropriate care." They received average ratings for:

- Getting Care
- Keeping kids healthy
- Keeping women and mothers' health
- Satisfaction with plan for adults
- Satisfaction of care provided to adults

CCW received below average ratings for preventing and managing illness.

Overall, CCW is encouraged to ensure the QAPI program is effective, monitored, objectively evaluated and updated to provide overall continuous improvement related to quality, access and timeliness of services provided by the MCP.

Please see the following profile for additional detail.

Summary of Results: Compliance Review

TEAMonitor's review assessed activities for the previous calendar year and evaluated CCW's compliance with the standards set forth in 42 CFR Part 438, as well as those established in the MCP contract with HCA for all Apple Health Managed Care programs. 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.

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. A follow-up of the current year's EQRO recommendations will be reflected in the 2024 Annual Technical Report.

The compliance review section, starting on page 28 of the 2023 Annual Technical Report, outlines weaknesses and opportunities for improvement. These weaknesses and areas for improvement are the elements identified by TEAMonitor as "not met" or "partially met," requiring a corrective action plan. Comagine Health's recommendations to the CCW MCPs reflect the CAPs provided by TEAMonitor. Please note both the MCO and BHSO received the same EQRO recommendations. This language is a synopsis from TEAMonitor's Compliance Summary report completed for each standard reviewed in 2023.

Tables A-15 through A-23 show the results of CCW MCPs' 2023 TEAMonitor Compliance Review.

Table A-15. CCW 2023 TEAMonitor Compliance Review Results: Enrollee Rights.

§438.100 – Enrollee rights	MCO	BHSO
438.100 (a) - General rule	3	3
438.100 (b)(2)(i) Specific rights - 438.10 (c) Language and format	3	3
438.100 (b)(2)(i) Specific rights - 438.10 (d) Language and format (3) Notification	3	3

§438.100 – Enrollee rights	MCO	BHSO
438.100 (b)(2)(i) Specific rights - 438.10 (d) Language and format (4)(5) Language – Oral interpretation/written information	2	2
438.100 (b)(2)(i) Specific rights - 438.10 (d)(6) Format, easily understood	3	3
438.100 (b)(2)(i) Specific rights - 438.10 (d)(6)(iii)	3	3
438.100 (b)(2)(i) Specific rights - 438.10 (f)(2) General requirements	3	3
438.100 (b)(2)(i) Specific rights - 438.10 (g)(1- 4) Information for Enrollees – Enrollee Handbook	3	3
438.100 (b)(2)(i) Specific rights - 438.10 (i) Information for Enrollees – Formulary	3	NA
438.100 (b)(2)(ii - iv) and (3) Specific rights	3	3
438.100 (d) Compliance with other Federal and State laws	3	3
438.106 - Liability for payment	3	3
Total Score	**35/36**	**32/33**
Total Score (%)	**97%**	**97%**

EQRO Recommendations based on TEAMonitor CAPs - 1

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

1. To address the Partially Met score, CCW will provide an updated policy and procedure that addresses:
    a. How CCW will internally monitor, and address issues directly related to the oral interpretation availability of information as required under 438.10(c)(4) and (5) Language – Oral interpretation.
    b. Provide the process or policies used to monitor available provider requests including ensuring providers are within the requesting enrollee's area of residence.

Table A-16. CCW 2023 TEAMonitor Compliance Review Results: Availability of Services.

§438.206 – Availability of services	MCO	BHSO
438.206 (b)(1)(i-v) & (c) Delivery network, 438.10 (h) Information for all enrollees – Provider directory	2	2
438.206 (b)(2) Direct access to a women's health specialist	3	NA
438.206 (b)(3) Provides for a second opinion	3	3
438.206 (b)(4) Services out of network	3	3
438.206 (b)(5) Out-of-network payment	3	3
438.206 (c) Furnishing of services (1)(i) through (vi) Timely access	3	3
438.206 (c)(2) Cultural considerations	3	3
438.207 (b)(c) Assurances of adequate capacity and services	2	2
Total Score	**22/24**	**19/21**
Total Score (%)	**92%**	**90%**

EQRO Recommendations based on TEAMonitor CAPs - 6

To address the Partially Met scores, CCW will:

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

1. Provide the process or policies used to monitor available provider requests including ensuring providers are within the requesting enrollee's area of residence
2. Provide the process or policies used to monitor unavailable providers specific to an enrollee's area of residence
3. Update the provider manual, including all critical provider types. At the time of review, pediatricians and outpatient services were not included in the list

438.207 (b)(c) Assurances of adequate capacity and services

4. Include Mental Health Outpatient (BHA) and SUD Outpatient providers in their analysis of critical providers (04-08-1_Comprehensive_Access_Report) as both were added in the contract prior to 2022.
5. Update policies and procedures to be inclusive of additional critical provider types and account for chances that happen outside of the licensing/credentialing cycle (i.e., providers moving, etc.).
6. Provide a policy or process used to address issues that are received prior to being elevated to a CAP. This can include but is not limited to emails from HCA staff noting a data issue or network discrepancy, and/or notices from contract managers of access issues with contracted providers.

Table A-17. CCW 2023 TEAMonitor Compliance Review Results: Coordination and Continuity of Care.

§438.208 – Coordination and continuity of care	MCO	BHSO
438.208 (a) General requirement	2	2
438.208 (b) Care and coordination of services for all MCO, PIHP, and PAHP enrollees - 438.224 Confidentiality	3	3
438.208 (c)(1) Additional services for enrollees with special health care needs or who need LTSS - Identification	3	3
438.208 (c)(2)(3) Assessment and treatment/service plans	2	3
438.208 (c)(4) Direct access to specialists	3	3
Total Score	**13/15**	**14/15**
Total Score (%)	**87%**	**93%**

EQRO Recommendations based on TEAMonitor CAPs - 4

To address the Partially Met scores, CCW will:

438.208 (a) General requirement

Provide documentation based on the following:

1. The IFC file review findings were not self-identified by CCW. The file review identified concerns with the CCW's process for developing transition plans for transitional aged youth (TAY) and was substantially different from the CCW's previous response. CCW will provide:
    a. Documentation of an assessment of the originally reviewed files to determine the cause of findings and identify and follow up on actions for improvements to prevent future

issues. This must include, at minimum, implementation and evidence of additional staff training and monitoring.

b. An updated policy and procedure with information regarding the CCW's process in place for developing transitional plans for TAY.

CCW will attend an HCA pharmacy presentation that will be provided to obtain a better understanding of HCA's expectations around the contract requirement. CCW will then update their policy and procedure documents and submit them to HCA for review and approval for the following issues:

2. The MCO's policy and procedure related to continuity of care and prior authorization process had incorrect information related to exclusions to the continuation fill or transition fill policy. The final CAP score will be determined as part of the 2024 TEAMonitor review process.
3. The documentation related to identification and provision of continuity of care (transition fill) and continuation of therapy for prescriptions for new enrollees did not address all requirements. The final CAP score will be determined as part of the 2024 TEAMonitor review process.

438.208 (c)(2)(3) Assessment and treatment/service plans

The policy and procedure did not include CCW's lead match procedures.

4. CCW will update the policy and procedure to include the MCO lead match procedures (i.e., how the HCA provided reports are reviewed, and how the MCO determines which clinic to follow up with etc.).

Table A-18. CCW 2023 TEAMonitor Compliance Review Results: Practice Guidelines.

§438.236 – Practice Guidelines	MCO	BHSO
438.236 (a)(b)(1-4) Adoption of [practice] guidelines	3	3
438.236(c) Dissemination of [practice] guidelines	2	2
438.236(d) Application of [practice] guidelines	3	3
Total Score	**8/9**	**8/9**
Total Score (%)	**89%**	**89%**

EQRO Recommendations based on TEAMonitor CAPs - 1

438.236(c) Dissemination of [practice] guidelines

5. To address the Partially Met score, CCW should:
    a. Provide documentation outlining the exact dates of when practice guidelines were distributed to affected providers to ensure that the notification to providers was within 60 days of adoption or revision of guidelines
    b. An updated policy and procedure that addresses how CCW will internally monitor, and address issues directly related to the oral interpretation availability of information as required under 438.10(c)(4) and (5) Language – oral interpretation
    c. Provide the process or policies used to monitor available provider requests including ensuring providers are within the requesting enrollee's area of residence

Table A-19. CCW 2023 TEAMonitor Compliance Review Results: Health information Systems.

§438.242 – Health information systems	MCO	BHSO
438.242 (a) General rule	3	3
438.242 (b)(1)(2) Basic elements	3	3
438.242 (b)(3) Basic element - Accuracy	3	3
Total Score	**9/9**	**9/9**
Total Score (%)	**100%**	**100%**

CCW MCPs met all elements within this standard. As a result, no recommendations are being made.

Table A-20. CCW 2023 TEAMonitor Compliance Review Results: QAPI.

§438.242 – Health information systems	MCO	BHSO
438.330 (b)(2) and (c), Performance measurement, and 438.330(e)(2) QAPI Program Evaluation - Desk Review	3	3
438.330 (e)(2) QAPI Program evaluation	2	2
Total Score	**5/6**	**5/6**
Total Score (%)	**83%**	**83%**

EQRO Recommendations based on TEAMonitor CAPs - 1

438.330 (e)(2) QAPI Program evaluation

1. To address the Partially Met score CCW should provide documentation that will identify how they will ensure future submissions include the assessment of overall effectiveness includes an evaluation of the Quality Improvement program in its entirety. A roll-up of all the subsections should be included in the evaluation of overall efficacy.

Table A-21. CCW 2023 TEAMonitor Compliance Review Results: Grievance System.

§438.400 – Grievance system	MCO	BHSO
438.400 (b) Statutory basis and definitions – file review	3	3
438.402 (c)(1) Filing requirements - Authority to file – file review	3	3
438.402 (c)(2) Filing requirements - Timing – file review	3	3
438.402 (c)(3) Filing requirements - Procedures – file review	3	3
438.404 (a) Notice of adverse benefit determination - language and format – file review	3	3
438.404 (b) Notice of action - Content of notice – file review	3	3
438.406 (a) Handling of grievances and appeals - General requirements – file review	3	3
438.406 (b) Special requirements for appeals – file review	3	3
438.408 (a) Resolution and notification: Grievances and appeals - Basic rule – file review	3	3
438.408 (b)(c) Specific timeframes and extension of timeframes – file review	3	3
438.408 (d)(e) Format of notice and content of notice of appeal resolution – file review	3	3
438.410 Expedited resolution of appeals – file review	3	3
438.420 Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State fair hearing are pending – file review	3	3
438.424 Effectuation of reversed appeal resolutions – file review	3	3

§438.400 – Grievance system	MCO	BHSO
Total Score	42/42	42/42
Total Score (%)	100%	100%

CCW MCPs met all elements within this standard. As a result, no recommendations are being made.

Summary of CCW 2022 EQRO Recommendations Based on TEAMonitor Compliance CAPs Follow-Up

Table A-22 shows the number of MCO/BHSO EQRO recommendations that were followed up during the current review.

Degree to which plans have addressed the previous year's EQRO recommendations key:

- **Low** – No CAPs met
- **Medium** – Less than all CAPs met
- **High** – All CAPs met
- **NA** – No CAPs received

Table A-22. CCW Results of Previous Year (2022) EQRO Compliance Recommendations Based on TEAMonitor CAPs – Count.

Met	Partially Met*	Not Met*	Degree to which plans addressed all EQRO recommendation(s):
6	0	0	High

**Future follow-up required.*

Table A-23 shows the results of the previous year EQRO compliance recommendations based on TEAMonitor CAPs follow-up.

Table A-23. CCW Results of Previous Year (2022) EQRO Compliance Recommendations Based on TEAMonitor CAPs – Follow-up.

42 CFR Part 438	MCO and BHSO		
Subpart D – MCO, PIHP and PAHP Standards	**Met**	**Partially Met**	**Not Met**
438.210 (b) Authorization of services – 1 CAP	1	0	0
438.210 (d) Timeframe for decisions – 1 CAP	1	0	0
Subpart E – Quality Measurement and Improvement (Quality Assessment and Performance Improvement Program (QAPI))	**Met**	**Partially Met**	**Not Met**
438.330 (a) General rules – 2 CAPs	2	0	0
438.66 (c)(3) Monitoring Procedures - Claims payment monitoring – 1 CAP	1	0	0
Subpart F – Grievance System	**Met**	**Partially Met**	**Not Met**
438.408 (b)(c) Specific timeframes and extension of timeframes – 1 CAP	1	0	0

Summary of Results: PIP Validation

PIPs: 4 Met; 0 Partially Met; 0 Not Met

The PIP validation section, starting on page 35 of the 2023 Annual Technical Report, outlines strengths, weaknesses and opportunities for improvement. These weaknesses and areas for improvement are the elements identified by TEAMonitor as "not met" or "partially met," requiring a corrective action plan. This language is a synopsis from TEAMonitor PIP Validation Worksheets completed for each PIP.

Tables A-24 through A-27 show the results of the CCW's PIP validation.

PIP Title: Collaborative MCO Well-Child Visit Rate PIP

PIP Type: AH-IMC, AH-IFC

Domain: Access, Timeliness

Improvement Strategies/Interventions

- Member-focused: Social media postings, well-care visit flyers
- Provider-focused: Two MCO-provider group partnerships, named Spring and Fall Project 2022, that aim to engage over-due or unestablished members through efforts that include empanelment clean-up, patient outreach and provider incentives
- MCP-focused: Continued use of standardized empanelment data format, incentive reference list for clinics

Table A-24. CCW: Collaborative MCO Well-Child Visit Rate PIP.

Score	Validation Status	Validation Rating	Performance Measure and Results
Met	Yes	Moderate confidence in reported results	HEDIS Measures: • W30, 0-15 months: Demonstrated performance improvement; no statistically significant change; p-value <.05 • W30, 15-30 months: Demonstrated performance improvement; no statistically significant change; p-value <.05 • WCV, 3-11 years: No demonstrated performance improvement; no statistically significant change; p-value <.05 • WCV, 12-17 years: No demonstrated performance improvement; no statistically significant change; p-value <.05 • WCV, 18-21 years: No demonstrated performance improvement; no statistically significant change; p-value <.05

PIP Title: Improving the Timeliness of Postpartum Visits Following Live Births Within 7-84 Days

PIP Type: AH-IMC

Domain: Access, Timeliness

Improvement Strategies/Interventions

- **Member-focused:** Doula and Lactation Consultants offered through the PACIFY app; behavioral health care management (CM) support services and WA Behavioral Health Resources for postpartum moms with signs and symptoms of postpartum depression, loss of fetus, etc.; Start Smart for Babies CM can continue after delivery up to one year if mom and/or baby have issues

indicating extra support is needed; After Pregnancy Coverage is available to WA residents and member guidance on how to apply for it; 1:1 follow-up dialogue encouraging member to make and attend a postpartum follow-up appointment; and new member health incentive for prenatal and postpartum visits pending approval from HCA and anticipate launch in third quarter of 2023.

- **Provider-focused**: Provide clinics, and thus members, with enhanced education and information regarding the importance of postpartum care during the prenatal period. CCW conducted data analysis during fourth quarter on provider CPT2 coding and identified clinics who are not submitting CPT2 codes.
- **MCP-focused**: Launch of formal Prenatal Postpartum workgroup with cross-departmental key stakeholders including health equity, case management, network and community outreach teams; formal PDSA process including PDSA template and PDSA standard operating procedures.

Table A-25. CCW: Improving the Timeliness of Postpartum Visits Following Live Births Within 7-84 Days PIP.

Score	Validation Status	Validation Rating	Performance Measure and Results
Met	Yes	Moderate confidence level in reported results	HEDIS measure: • PPC: No demonstrated performance improvement; No statistically significant change

PIP Title: Increasing the Rate of Follow-up after Hospitalization for Behavioral Health (FUH) for Members Enrolled in BHSO

PIP Type: BHSO

Domain: Access, Timeliness

Improvement Strategies/Interventions

- **Member-focused:** Personalized member outreach; creation of member incentive option for follow up visit completion; review capitated arrangements and confirm encounters are being processed into HEDIS engine, if not develop process to ensure future claims are ingested; Provider care gap lists created by CCW:
  - Behavioral health inpatient facilities outreach and collaboration – emphasis on importance of follow-up care
  - Behavioral health provider outreach and collaboration – support use of audio/video calls and resources for support
  - Education to emphasize critical importance of outpatient follow-up; what to do if member misses appointment; alternate service resources, e.g., telemedicine providers or telemedicine-video/audio-with current behavioral health providers

Table A-26. CCW: Increasing the Rate of Follow-up after Hospitalization for Behavioral Health (FUH) for Members Enrolled in BHSO PIP.

Score	Validation Status	Validation Rating	Performance Measure and Results
Met	Yes	Moderate confidence in reported results	HEDIS measures • FUH (BHSO): Demonstrated performance improvement; No statistically significant change • FUH (IMC with BHSO): Demonstrated performance improvement; Statistically significant change; p-value <.01

PIP Title: Increasing the RDA MH-B Penetration Rates for Members 6 to 26 Years Old Enrolled in Foster Care

PIP Type: AH-IFC

Domain: Access, Quality, Timeliness

Improvement Strategies/Interventions

- **Member-focused:** Provide outreach and referral support to members in foster care who have mental health needs that require follow-up care; Increase initial health screening rate for new IFC enrollments to identify new members with mental health needs and provide referral support to behavior health and Department of Children Youth and Family services; and support existing opportunities for foster care providers/relative care providers to add to their knowledge base regarding identifying the need for behavioral health services for children and youth in their care.
- **Provider-focused:** Implement a program to increase mental health/behavioral health screening and coding at the primary care level and referring for appropriate care; support to providers for closing MH-B gaps in care without a referral, this including gap in care lists, member outreach support, and assistance with member referrals for high-risk cases; connect member with Center of Excellence providers provide case consultation and warm transfer of care to limit disruption caused by placement changes; provide training for therapists to become certified in Trauma-Focused-Cognitive Behavioral Therapy; and enhance the MH-B workgroup to include additional key stakeholders.

Table A-27. CCW: Increasing the RDA MH-B Penetration Rates for Members 6 to 26 Years Old Enrolled in Foster Care PIP.

Score	Validation Status	Validation Rating	Performance Measure and Results
Met	Yes	Moderate confidence in reported results	RDA measure: • MHB: Demonstrated performance improvement; Statistically significant change; p-value <.05

Summary of CCW 2023 EQRO PIP Recommendation Based on TEAMonitor CAPs

CCW did not receive an EQRO recommendation based on a TEAMonitor CAP in 2023.

Summary of Previous Year (2022) EQRO PIP Recommendation Based on TEAMonitor CAP Follow-Up

Degree to which plans have addressed the previous year's EQRO recommendations key:

- **Low** – No CAPs met
- **Medium** – Less than all CAPs met
- **High** – All CAPs met
- **NA** – No CAPs received

Degree to which plan addressed EQRO recommendation: High

2022 TEAMonitor CAP

The MCP must submit a narrative and any supporting documents describing the actions they will take to address the findings related to:

- Adherence to HCA standards regarding:
  - Unclear AIM statements
  - Addressing the project population in section 3.1
  - Addressing PDSA in section 8.3
  - Lack of symmetry between variables, data collection and analysis plan

In addition to the elements above the narrative should address actions that can be taken to improve the current active (2022) PIPs and describe how the deficiencies in this year's PIP report and feedback from HCA will be used to make constructive changes in the (2022) PIPs.

TEAMonitor Response/MCP Response-Action Taken

Met – Corrective action is completed. No further action required. The MCP provided the required documentation to address the finding as part of the 2022 Corrective Action review process.

Summary of Results: Performance Measure Validation

Comagine Health received the MCP's FAR from Aqurate Health Data Management, Inc., an independent organization providing performance measure validation review and HEDIS compliance audits, which conducted the 2023 MCP HEDIS audits. Comagine Health then assessed the FAR to determine and develop EQR findings and recommendations. CCW was in full compliance with the MY2022 audits. Comagine Health did not identify any EQRO recommendations, strengths or weaknesses during the 2023 PMV.

However, when reviewing the MCP's FAR, Comagine Health identified suggested opportunities for improvement within the FAR based on the audit team recommendations. HCA plans to follow-up via the TEAMonitor process and will be requiring a response from CCW to HCA. If the CCW's response does not sufficiently address the issue in the upcoming year, an EQRO Recommendation will be issued as part of the 2024 performance measure review.

Table A-28 shows the CCW's results for each standard addressed in the FAR.

Table A-28. Summary of CCW 2023 HEDIS FAR.

Information Standard	Score
IS 1.0 Medical Services Data	Met
IS 1.A Behavioral Health Services	NA
IS 1.B Vision Services	Met
IS 1.C Pharmacy Services	Met
IS 1.D Dental Services	NA
IS 1.E Laboratory Services	NA
IS 2.0 Enrollment Data	Met
IS 3.0 Practitioner Data	Met
IS 4.0 Medical Record Review Process	Met
IS 5.0 Supplemental Data	Met
IS 6.0 Data Preproduction Processing	Met
IS 7.0 Data Integration and Reporting	Met
IS 8.0 Case Management Data: Long-Term Services & Support (LTSS)	NA
IS AD 1.0 General Information	Met
IS HD 5.0 Outsourced or Delegated Reporting Function	NA

Summary of Results: Performance Measure Comparative Analysis

CCW performed significantly better than the state simple average for many of the pediatric measures; a couple of notable examples are the Lead Screening in Children (LSC) and Immunizations for Adolescents (IMA), Combo 2 measures. They performed significantly worse than the state simple average for several behavioral health measures, as well as Controlling High Blood Pressure (CBP), HbA1c Control for Patients with Diabetes (HBD), and Prenatal and Postpartum Care (PPC), both the Timeliness of Prenatal Care and Postpartum Care measures. Although CCW performed significantly below the statewide average for all measures for Follow-Up After ED Visit and Hospitalization for Mental Illness (FUH), they made statistically significant improvements in their own performance over last year. This result is very similar to what was reported in the 2022 Comparative Report.

VBP Measure Performance

CCW had statistically significant improvement on the Asthma Medication Ratio (AMR) between MY2019 and MY2020, and then again between MY2020 and MY2021. There was no statistically significant improvement between MY2021 and MY2022. This MY2022 result for this measure is now at the national 75th percentile.

Performance for the remaining VBP measures was mostly flat. There have been scattered historical improvements for other VBP measures but those may be due to random statistical variation.

Table A-29 shows the CCW's performance measure comparative analysis strengths and weaknesses/opportunities for improvement.

Table A-29. CCW's Performance Measure Comparative Analysis Strengths and Weaknesses/ Opportunities for Improvement.

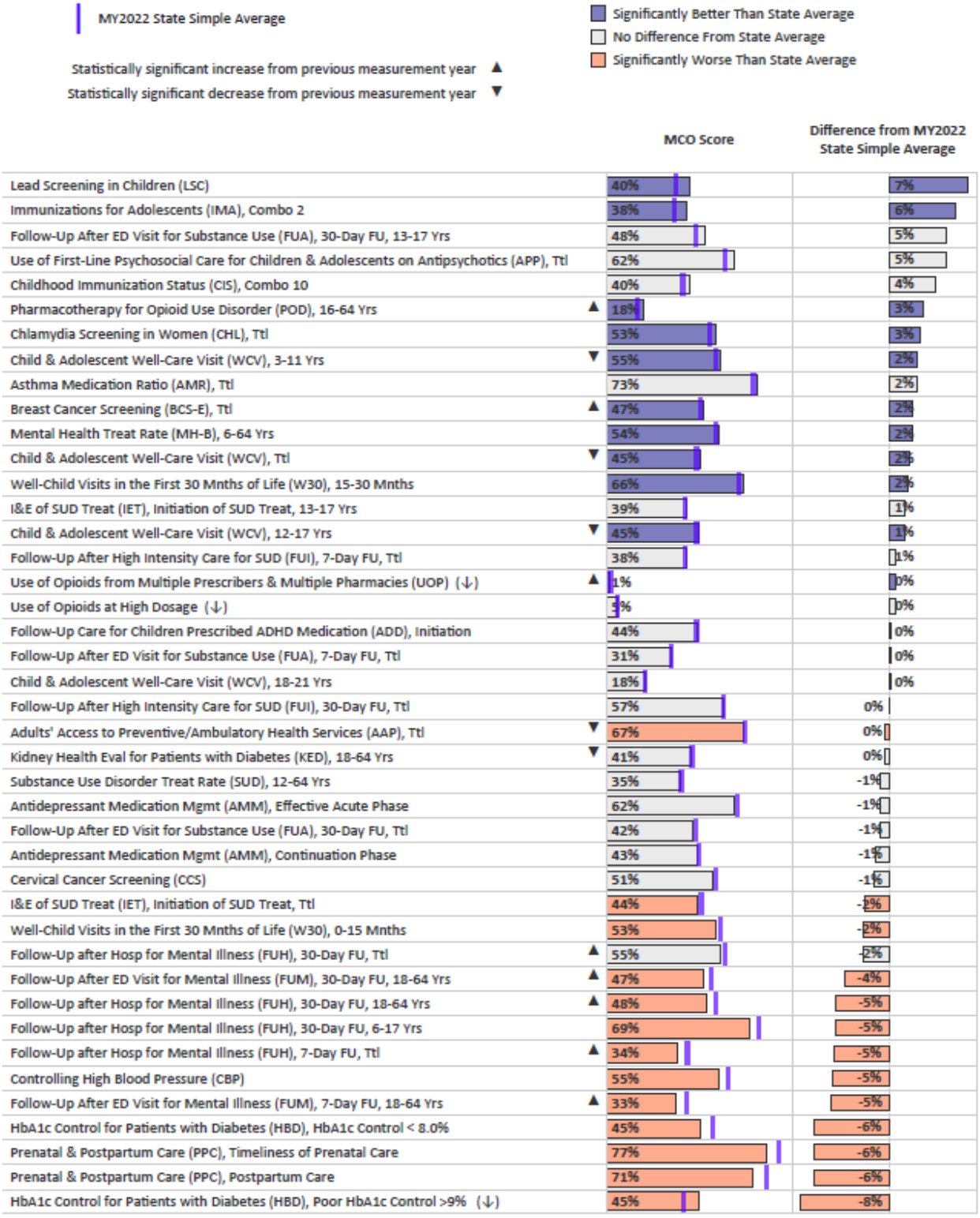
Performance Measures	
Strengths	**Weaknesses/Opportunities for Improvement**
Prevention and Screening • Lead Screening in Children (LSC) • Immunizations for Adolescents (IMA-E), Combo 2	Cardiovascular Conditions • Controlling High Blood Pressure (CBP) Diabetes • Hemoglobin A1c Control for Patients with Diabetes (HBD) Behavioral Health • Follow-Up after Hospitalization for Mental Illness (FUH) • Follow-Up After Emergency Department Visit for Mental Illness (FUM) Access/Availability of Care • Prenatal and Postpartum Care (PPC)*

**These measures are also required VBP measures.*

CCW Performance Measure Comparative Analysis Scorecard

Figure A-3, on the next page, represents the variance of measures from the simple state average for CCW.

Figure A-3. CCW Scorecard, MY2022.



(↓) For this measure lower scores are better.

Community Health Plan of Washington (CHPW) Profile

CHPW Overall Perspective

CHPW demonstrated strengths in compliance by demonstrating a best practice within their QAPI program by providing a description of the action CHPW has taken to encourage and support the use of the Clinical Data Repository (CDR) with their eligible providers. CHPW provided:

- Inclusion of contract requirements in provider manual/provider agreements
- Inclusion of CDR in provider training and onboarding materials as well as joint 2022 MCO provider training where CDR was included as an "important reminder."

CHPW will need to address the following compliance standards where they did not fully meet the requirements and received CAPs:

- Availability of Services
- Coordination and Continuity of Care
- Practice Guidelines

CHPW fully met all elements in the compliance standards of Enrollee Rights, QAPI, Health Information Systems and Grievance Systems.

CHPW met all compliance CAPs provided in 2022, demonstrating a high degree of compliance with their follow-up.

Overall, CHPW met the criteria for validation of their PIPs with strengths including the choice of an important PIP topic, focusing their efforts on a variety of population groups affected and utilizing PDSA cycles to adjust interventions. While the confidence in the reported results were mixed due to low success rates during the current review, things such as low numbers within the intervention groups, balancing the return to in-person care with telehealth interventions as the public health emergency continued, and staff turnover have impacted the low success rates at all the MCPs. CHPW did not receive an EQRO recommendation in 2022; therefore, no follow up was required.

CHPW is at or above the MY2022 State Simple Average for 25 of the 42 performance measures reviewed. They performed significantly above the state simple average for 13 measures and significantly below the state simple average for 11 measures. All FUH measures demonstrated a statistically significant improvement over the previous year. Several access measures demonstrated declines over last year. All WCV measures demonstrated a statistically significant decline over the previous year, as did the SUD and APP.

CHPW achieved 35.7% of the VBP Quality Performance Measures for 2022, which reflects a significant decline in performance areas identified by HCA, based on the legislative proviso (ESSB 5693 Sec.211 (37)(2022)), as important in having potential to impact costs, effect population health, target areas of poor performance or be clinically meaningful in promoting health status. CHPW did not meet the VBP performance targets for:

- Child and Adolescent Well-Care Visits (WCV), Age 3-11
- Prenatal and Postpartum Care - Timeliness of Prenatal Care (PPC)
- Substance Use Disorder Treatment Rate (SUD), Age 12-64,
- Follow Up Care for Children Prescribed ADHD Medication (ADD), Initiation Phase
- Mental Health Service Rate, Broad Definition (MH-B), Age 6-64, all MCO excluding BHSO

In the Enrollee Quality Report (2023 Washington Apple Health Plan Report Card), CHPW received an above average rating for "Ensuring appropriate care." They received average ratings for:

- Keeping kids healthy
- Keeping women and mothers' health
- Satisfaction of care provide to adults
- Satisfaction with plans for adults

CHPW received below average ratings for:

- Getting Care
- Preventing and managing illness

Overall, CHPW is encouraged to ensure the QAPI program is effective, monitored, objectively evaluated and updated to provide overall continuous improvement related to quality, access and timeliness of services provided by the MCP. Please see the following profile for additional detail.

Summary of Results: Compliance Review

TEAMonitor's review assessed activities for the previous calendar year and evaluated CHPW's compliance with the standards set forth in 42 CFR Part 438, as well as those established in the MCP contract with HCA for all Apple Health Managed Care programs. 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.

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. A follow-up of the current year's EQRO recommendations will be reflected in the 2024 Annual Technical Report.

The compliance review section, starting on page 28 of the 2023 Annual Technical Report, outlines weaknesses and opportunities for improvement. These weaknesses and areas for improvement are the elements identified by TEAMonitor as "not met" or "partially met," requiring a corrective action plan. Comagine Health's recommendations to the CHPW MCPs reflect the CAPs provided by TEAMonitor. Please note both the MCO and BHSO received the same EQRO recommendations. This language is a synopsis from TEAMonitor Compliance Summary report completed for each standard reviewed in 2023.

Tables A-30 through A-38 show the results of the CHPW MCPs' 2023 TEAMonitor Compliance Review.

Table A-30. CHPW 2023 TEAMonitor Compliance Review Results: Enrollee Rights.

§438.100 – Enrollee rights	MCO	BHSO
438.100 (a) - General rule	3	3
438.100 (b)(2)(i) Specific rights - 438.10 (c) Language and format	3	3
438.100 (b)(2)(i) Specific rights - 438.10 (d) Language and format (3) Notification	3	3
438.100 (b)(2)(i) Specific rights - 438.10 (d) Language and format (4)(5) Language – Oral interpretation/written information	3	3
438.100 (b)(2)(i) Specific rights - 438.10 (d)(6) Format, easily understood	3	3
438.100 (b)(2)(i) Specific rights - 438.10 (d)(6)(iii)	3	3
438.100 (b)(2)(i) Specific rights - 438.10 (f)(2) General requirements	3	3

§438.100 – Enrollee rights	MCO	BHSO
438.100 (b)(2)(i) Specific rights - 438.10 (g)(1-4) Information for Enrollees – Enrollee Handbook	3	3
438.100 (b)(2)(i) Specific rights - 438.10 (i) Information for Enrollees – Formulary	3	NA
438.100 (b)(2)(ii - iv) and (3) Specific rights	3	3
438.100 (d) Compliance with other Federal and State laws	3	3
438.106 - Liability for payment	3	3
Total Score	**36/36**	**33/33**
Total Score (%)	**100%**	**100%**

CHPW met all elements within this standard. As a result, no recommendations are being made.

Table A-31. CHPW 2023 TEAMonitor Compliance Review Results: Availability of Services.

§438.206 – Availability of services	MCO	BHSO
438.206 (b)(1)(i-v) & (c) Delivery network, 438.10 (h) Information for all enrollees – Provider directory	2	2
438.206 (b)(2) Direct access to a women's health specialist	3	NA
438.206 (b)(3) Provides for a second opinion	3	3
438.206 (b)(4) Services out of network	3	3
438.206 (b)(5) Out-of-network payment	3	3
438.206 (c) Furnishing of services (1)(i) through (vi) Timely access	3	3
438.206 (c)(2) Cultural considerations	3	3
438.207 (b)(c) Assurances of adequate capacity and services	2	2
Total Score	**22/24**	**19/21**
Total Score (%)	**92%**	**90%**

EQRO Recommendations based on TEAMonitor CAPs - 4

To address the Partially Met scores, the MCO/BHSO will address the following issues:

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

1. CHPW provided a narrative with documentation showing ongoing monitoring activities. This documentation was not inclusive of all critical provider types and several distance standards are not compliant with the contract (e.g., pediatricians listed in the policy as having a 30-mile distance standard, but contractually must be 2 in 10 for urban or 1 in 25 for non-urban). CHPW will update policies and procedures to include all critical provider types and correct distance standards to ensure compliance with the contract (e.g., pediatricians listed in the policy as having a 30-mile distance standard, but contractually must be 2 in 10 for urban or 1 in 25 for non-urban).
2. CHPW will update their website to provide a link to HCA's WISe webpage.

438.207 (b)(c) Assurances of adequate capacity and services

3. CHPW provided a detailed narrative with support documentation showing compliance with elements a (ii)-(v), b (i)-(iii), and c. The policies provided for element a (i) are not inclusive of all critical provider types during the review year. CHPW will update policies and procedures to be

inclusive of and apply to all critical provider types as named in the contract. If "Primary Care Practitioner" and "Non-prescribing Behavioral Health Provider" are intended to cover the missing critical providers, this needs to be clearly defined in the policy or the additional provider types need to be broken out.

4. CHPW provided a narrative and policy outlining contract requirements for provider network submissions. There was no policy or procedure specific to HCA-identified issues or resolution of issues within the submissions. CHPW will provide policies and/or procedures directly related to HCA identified issues in the provider submission received.

Table A-32. CHPW 2023 TEAMonitor Compliance Review Results: Coordination and Continuity of Care.

§438.208 – Coordination and continuity of care	MCO	BHSO
438.208 (a) General requirement	2	3
438.208 (b) Care and coordination of services for all MCO, PIHP, and PAHP enrollees - 438.224 Confidentiality	2	2
438.208 (c)(1) Additional services for enrollees with special health care needs or who need LTSS - Identification	3	3
438.208 (c)(2)(3) Assessment and treatment/service plans	2	3
438.208 (c)(4) Direct access to specialists	3	3
Total Score	**12/15**	**14/15**
Total Score (%)	**80%**	**93%**

EQRO Recommendations based on TEAMonitor CAPs - 5

To address the Partially Met scores:

438.208 (a) General requirement

CHPW will attend an HCA pharmacy presentation that will be provided to obtain a better understanding of HCA's expectations around the contract requirement. CHPW will then update their policy and procedure documents and submit them to HCA for review and approval for the following issues:

1. CHPW's policy and procedure did not address the requirement to initiate the prior authorization process with the provider for opioids for newly enrolled members. CHPW will then update their policy and procedure documents and submit them to HCA for review and approval. The final CAP score will be determined as part of the 2024 TEAMonitor review process.
2. The documentation provided did not sufficiently address the requirements related to continuity for strength/dose fills for new enrollees. CHPW will then update their policy and procedure documents and submit them to HCA for review and approval. The final CAP score will be determined as part of the 2024 TEAMonitor review process.
3. The documents detail the transition policy and the emergency fill policy, but do not provide the policy and procedures for approving payment for antipsychotic, antidepressant, or antiepileptic medication. This contractual requirement is in addition to the transition fill policy and the emergency fill policy and should be a separate policy. CHPW will then update their policy and procedure documents and submit them to HCA for review and approval. The final CAP score will be determined as part of the 2024 TEAMonitor review process.

438.208 (b) Care and coordination of services for all MCO, PIHP, and PAHP enrollees - 438.224 Confidentiality

4. CHPW will submit care coordination policies and procedures that:
    a. Ensure the coordination of MCO services furnished to the enrollee with services the enrollee receives from any other MCO, Behavioral Health Organization, or other entity specified in contract subsection 14.5, including coordination of assessments and evaluations with mental health, SUD and other providers.
    b. Includes language that the MCO/BHSO will share the results of its identification and assessment of the enrollee's needs with other entities to prevent the duplication of services.

438.208 (c)(2)(3) Assessment and treatment/service plans

The CHPW policy is incorrect as it indicated that the process is done quarterly instead of monthly. CHPW's policy and procedure should have reflected this update.

5. CHPW will update the policy and procedure to reflect the current processes for notification from HCA. Additionally, it did not include expectations to facilitate re-testing and follow-up referrals.

Table A-33. CHPW 2023 TEAMonitor Compliance Review Results: Practice Guidelines.

§438.236 – Practice guidelines	MCO	BHSO
438.236 (a)(b)(1-4) Adoption of [practice] guidelines	3	3
438.236(c) Dissemination of [practice] guidelines	2	2
438.236(d) Application of [practice] guidelines	3	3
Total Score	**8/9**	**8/9**
Total Score (%)	**89%**	**89%**

EQRO Recommendations based on TEAMonitor CAPs - 1

438.236(c) Dissemination of [practice] guidelines

Supporting screenshot of the e-mail from 2/18/2022 outlines which clinical practice guidelines (CPGs) were uploaded to CHPW's website, the date of last revision, and the date that revised practice guidelines were uploaded on CHPW's website. However, the screenshot of the e-mail from 5/20/2022 does not clearly outline which CPGs were uploaded to CHPW's website.

1. To address the Partially Met score, the MCO/BHSO must submit documentation verifying the exact date that the notification of new or revised practice guidelines was disseminated to providers to ensure that the notification to providers was within 60 days of adoption or revision of guidelines.

Table A-34. CHPW 2023 TEAMonitor Compliance Review Results: QAPI.

§438.242 – QAPI	MCO	BHSO
438.330 (b)(2) and (c), Performance measurement, and 438.330(e)(2) QAPI Program Evaluation - Desk Review	3	3
438.330 (e)(2) QAPI Program evaluation	3	3
Total Score	**6/6**	**6/6**
Total Score (%)	**100%**	**100%**

CHPW met all elements within this standard. As a result, no recommendations are being made.

Table A-35. CHPW 2023 TEAMonitor Compliance Review Results: Health information Systems.

§438.242 – Health information systems	MCO	BHSO
438.242 (a) General rule	3	3
438.242 (b)(1)(2) Basic elements	3	3
438.242 (b)(3) Basic element - Accuracy	3	3
Total Score	**9/9**	**9/9**
Total Score (%)	**100%**	**100%**

CHPW met all elements within this standard. As a result, no recommendations are being made.

Table A-36. CHPW 2023 TEAMonitor Compliance Review Results: Grievance System.

§438.400 – Grievance system	MCO	BHSO
438.400 (b) Statutory basis and definitions – file review	3	3
438.402 (c)(1) Filing requirements - Authority to file – file review	3	3
438.402 (c)(2) Filing requirements - Timing – file review	3	3
438.402 (c)(3) Filing requirements - Procedures – file review	3	3
438.404 (a) Notice of adverse benefit determination - language and format – file review	3	3
438.404 (b) Notice of action - Content of notice – file review	3	3
438.406 (a) Handling of grievances and appeals - General requirements – file review	3	3
438.406 (b) Special requirements for appeals – file review	3	3
438.408 (a) Resolution and notification: Grievances and appeals - Basic rule – file review	3	3
438.408 (b)(c) Specific timeframes and extension of timeframes – file review	3	3
438.408 (d)(e) Format of notice and content of notice of appeal resolution – file review	3	3
438.410 Expedited resolution of appeals – file review	3	3
438.420 Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State fair hearing are pending – file review	3	3
438.424 Effectuation of reversed appeal resolutions – file review	3	3
Total Score	**42/42**	**42/42**
Total Score (%)	**100%**	**100%**

CHPW met all elements within this standard. As a result, no recommendations are being made.

Summary of CHPW 2022 EQRO Recommendations Based on TEAMonitor Compliance CAPs Follow-Up

Table A-37 shows the number of MCO/BHSO EQRO recommendations that were followed up during the current review.

Degree to which plans have addressed the previous year's EQRO recommendations key:

- **Low** – No CAPs met
- **Medium** – Less than all CAPs met
- **High** – All CAPs met
- **NA** – No CAPs received

Table A-37. CHPW 2022 EQRO Recommendations Based on TEAMonitor CAPs Follow-Up – Count.

Met	Partially Met*	Not Met*	Degree to which plans addressed all EQRO recommendation(s):
2	0	0	High

**Future follow-up required.*

Table A-38 shows the results of the previous year EQRO compliance recommendations based on TEAMonitor CAPs follow-up.

Table A-38. CHPW Results of Previous Year (2022) EQRO Compliance Recommendations Based on TEAMonitor CAPs – Follow-up.

42 CFR Part 438	MCO and BHSO		
Subpart D – MCO, PIHP and PAHP Standards	**Met**	**Partially Met**	**Not Met**
438.210 (b) Authorization of services – 1 CAP	1	0	0
438.210 (c) Notice of adverse benefit determination – 1 CAP	1	0	0

Summary of Results: PIP Validation

PIPs: 3 Met; 0 Partially Met; 0 Not Met

The PIP validation section, starting on page 35 of the 2023 Annual Technical Report, outlines strengths, weaknesses and opportunities for improvement. These weaknesses and areas for improvement are the elements identified by TEAMonitor as "not met" or "partially met," requiring a corrective action plan. This language is a synopsis from TEAMonitor PIP Validation Worksheets completed for each PIP.

Tables A-39 through A-41 show the results of CHPW's PIP validation.

PIP Title: Collaborative MCO Well-Child Visit Rate PIP

PIP Type: AH-IMC, AH-IFC **Domain:** Access, Quality, Timeliness

Improvement Strategies/Interventions

- Member-focused: Social media postings, well-care visit flyers

- Provider-focused: Two MCO-provider group partnerships, named Spring and Fall Project 2022, that aim to engage over-due or unestablished members through efforts that include empanelment clean-up, patient outreach and provider incentives
- MCP-focused: Continued use of standardized empanelment data format, incentive reference list for clinics

Table A-39. CHPW: Collaborative MCO Well-Child Visit Rate PIP.

Score	Validation Status	Validation Rating	Performance Measure and Results
Met	Yes	Moderate confidence in reported results	HEDIS Measures: • W30, 0-15 months: Demonstrated performance improvement; No statistically significant change; p-value <.05 • W30, 15-30 months: Demonstrated performance improvement; No statistically significant change; p-value <.05 • WCV, 3-11 years: No demonstrated performance improvement; No statistically significant change; p-value <.05 • WCV, 12-17 years: No demonstrated performance improvement; No statistically significant change; p-value <.05 • WCV, 18-21 years: No demonstrated performance improvement; No statistically significant change; p-value <.05

PIP Title: Implementation of Community-Based Interventions to Address Disparities in Breast Cancer Screening Rates

PIP Type: AH-IMC **Domain:** Access, Timeliness

Improvement Strategies/Interventions

- **Member-focused:** Targeted, linguistically tailored education text campaign to encourage Breast cancer screening (BCS) for members with an identified gap-in-care; adding BCS to CHPW's customer service gap-in-care list to remind and encourage members to seek screening mammography when they call customer service and have an identified gap-in-care; translate materials into targeted enrollee languages; and understand what enrollees' cultural beliefs and attitudes are around BCS.
- **Provider-focused**: Establish partnership with community health center (CHC) to pilot mobile mammography intervention with Rezolut (vendor)
- **MCP-focused**: Conduct root cause analysis to understand barriers and facilitators to accessing BCS services for enrollees in populations with greater disparity and established contract with mobile mammography vendor, Rezolut, to help increase access to BCS in communities with known barriers or limited access.

Table A-40. CHPW: Implementation of Community-Based Interventions to Address Disparities in Breast Cancer Screening Rates PIP.

Score	Validation Status	Validation Rating	Performance Measure and Results
Met	Yes	High confidence in reported results	HEDIS BCS measure – MCO and CHC • CHPW: Demonstrated performance improvement; Statistically significant change; p-value <.05 • CHC: Demonstrated performance improvement; No statistically significant change; p-value <.05 HEDIS BCS measure – Language • Spanish: Demonstrated performance improvement; Statistically significant change; p-value <.05 • Russian: Demonstrated performance improvement; No statistically significant change; p-value <.05 • Somali: No demonstrated performance improvement; No statistically significant change; p-value <.05 HEDIS BCS measure – Race/Ethnicity • Hispanic or Latino: Demonstrated performance improvement; Statistically significant change; p-value <.05 • Black/African American: No demonstrated performance improvement; No statistically significant change; P-value <.05 • American Indian/Alaska Native: Demonstrated performance improvement; No statistically significant change; p-value <.05 HEDIS BCS measure – Region • King: Demonstrated performance improvement; Statistically significant change; p-value <.05 • Greater Columbia: Demonstrated performance improvement; Statistically significant change; p-value <.05

PIP Title: Expanding Access to Peer Support and High Value Reward Incentives for Behavioral Health Services Only (BHSO) Members with Substance Use Disorders

PIP Type: BHSO **Domain:** Access

Improvement Strategies/Interventions

- **Member-focused:** Outreach via phone and letter, inviting members to download the WEconnect application; for members of the application: access to 1:1 peer support services, goal setting and habit tracking technology, incentives for completing recovery challenges, group support sessions available at multiples times of day.
- **MCP-focused:** Continue to fund and offer a virtual peer offering and high-value rewards to bridge the gap in recovery support services and support members diagnosed with SUD.

Table A-41. CHPW: Expanding Access to Peer Support and High Value Reward Incentives for Behavioral Health Services Only (BHSO) Members with Substance Use Disorders PIP.

Score	Validation Status	Validation Rating	Performance Measure and Results
Met	Yes	Low confidence in reported results	Statistically increase outpatient SUD treatment utilization for BHSO members that engage with the digital peer support platform: No demonstrated performance improvement; Statistically significant change; p-value <.01

Summary of CHPW 2023 EQRO PIP Recommendation Based on TEAMonitor CAPs

CHPW did not receive an EQRO recommendation based on a TEAMonitor CAP in 2023.

Summary of Previous Year (2022) EQRO PIP Recommendation Based on TEAMonitor CAP Follow-Up

CHPW did not receive an EQRO recommendation based on a TEAMonitor CAP in 2022.

Summary of Results: Performance Measure Validation

Comagine Health received CHPW's FAR from Aqurate Health Data Management, Inc., an independent organization providing performance measure validation review and HEDIS compliance audits, which conducted the 2023 MCP HEDIS audits. Comagine Health then assessed the FAR to determine and develop EQR findings and recommendations. CHPW was in full compliance with the 2023 audit. Comagine Health did not identify any EQRO recommendations, strengths or weaknesses during the 2023 PMV. Table A-42 shows the CHPW's results for each standard addressed in the FAR.

Table A-42. Summary of CHPW 2023 HEDIS FAR.

Information Standard	Score
IS 1.0 Medical Services Data	Met
IS 1.A Behavioral Health Services	NA
IS 1.B Vision Services	Met
IS 1.C Pharmacy Services	Met
IS 1.D Dental Services	NA
IS 1.E Laboratory Services	NA
IS 2.0 Enrollment Data	Met
IS 3.0 Practitioner Data	Met
IS 4.0 Medical Record Review Process	Met
IS 5.0 Supplemental Data	Met
IS 6.0 Data Preproduction Processing	Met
IS 7.0 Data Integration and Reporting	Met
IS 8.0 Case Management Data: Long-Term Services & Support (LTSS)	NA
IS AD 1.0 General Information	Met
IS HD 5.0 Outsourced or Delegated Reporting Function	NA

Summary of Results: Performance Measure Comparative Analysis

CHPW demonstrated a statistically significant increase in performance over last year and significantly better than the statewide average this year for all Follow-Up after Hospitalization for Mental Illness (FUH) measures. In addition, they performed significantly above the state simple average for the Lead Screening in Children (LSC), Prenatal and Postpartum Care (PPC), and Immunizations for Adolescents (IMA). They performed significantly below the state simple average for the Asthma Medication Ratio (AMR) and many of the behavioral health measures. Although CHPW performed at or above the statewide simple average this year for many of their measures, they demonstrated a decrease in the overall number of measures at or above the statewide average when compared to last year's performance (reflected in the 2022 Comparative Analysis Report).

Where last year, CHPW was above the statewide average for Child & Adolescent Well-Care Visit (WCV), 3-11 Years, and Total, they performed significantly worse than the statewide average this year with a statistically significant decrease in their own performance.

VBP Measure Performance

CHPW had statistically significant improvement on the Asthma Medication Ratio (AMR) between MY2019 and MY2020, and then again between MY2021 and MY2022. The MY2022 result for this measure is now at the national 50th percentile.

Performance for the remaining VBP measures was mostly flat. There have been scattered historical improvements for other VBP measures but those may be due to random statistical variation.

Table A-43 shows the CHPW's Performance Measure Comparative Analysis Strengths and Weaknesses/ Opportunities for Improvement.

Table A-43. CHPW's Performance Measure Comparative Analysis Strengths and Weaknesses/ Opportunities for Improvement.

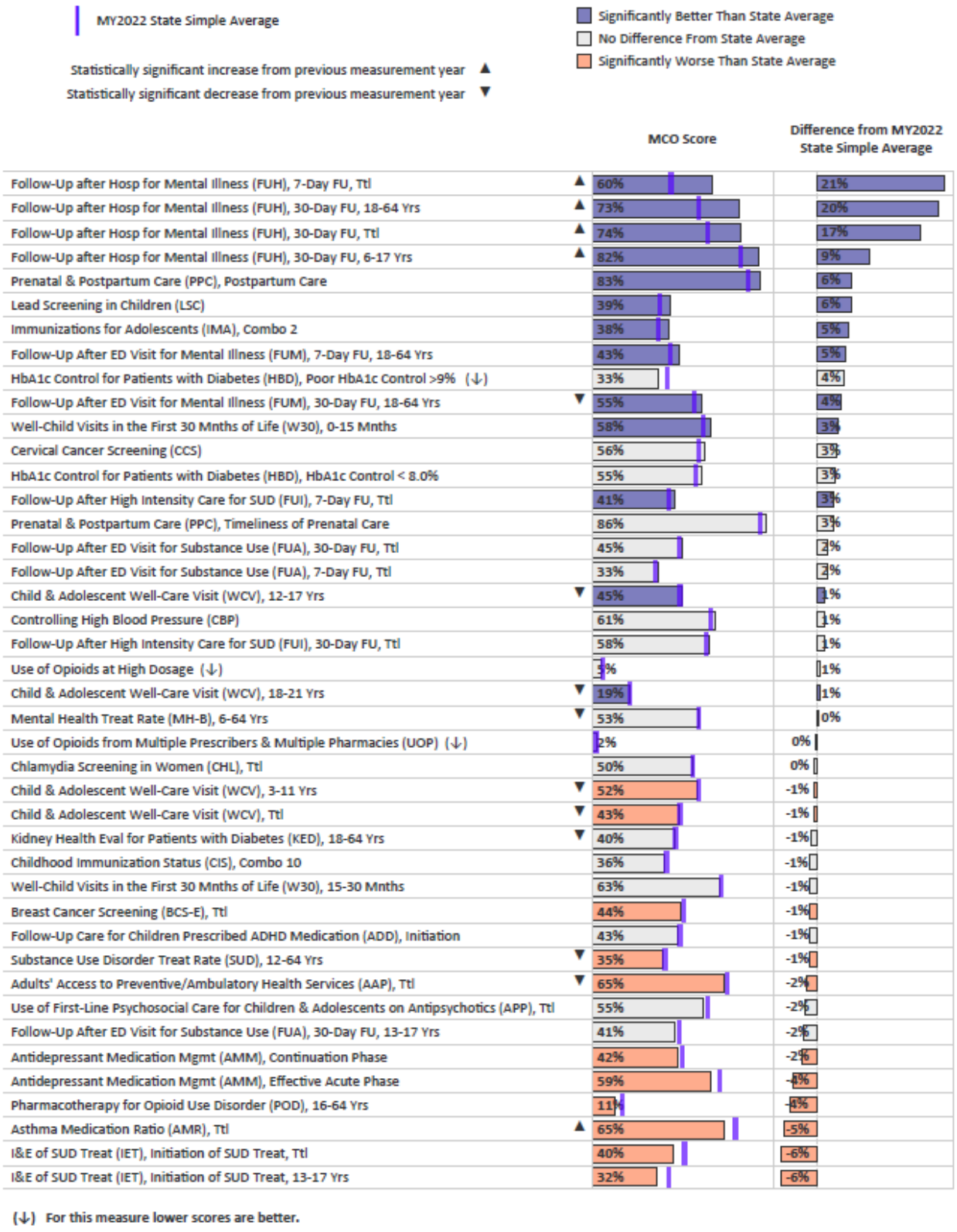
Performance Measures	
Strengths	**Weaknesses/Opportunities for Improvement**
Prevention and Screening • Lead Screening in Children (LSC) • Immunizations for Adolescents (IMA-E), Combo 2 Behavioral Health • Follow-Up after Hospitalization for Mental Illness (FUH) • Follow-Up After Emergency Department Visit for Mental Illness (FUM) Access/Availability of Care • Prenatal and Postpartum Care (PPC)*	Respiratory Conditions • Asthma Medication Ratio (AMR)* Behavioral Health • Antidepressant Medication Management (AMM)* • Pharmacotherapy for Opioid Use Disorder (POD), 16-64 Years Access/Availability of Care • Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)

**These measures are also required VBP measures.*

CHPW Performance Measure Comparative Analysis Scorecard

Figure A-4 represents the variance of measures from the simple state average for CHPW.

Figure A-4. CHPW Scorecard, MY2022.



Molina Healthcare of Washington (MHW) Profile

MHW Overall Perspective

MHW demonstrated a best practice within the QAPI program evaluation by including the WISe program summary.

MHW will need to address the following compliance standards where they did not fully meet the requirements and received CAPs:

- Availability of Services
- Coordination and Continuity of Care
- Practice Guidelines
- Grievance System

MHW fully met all elements in the standards of Enrollee Rights, Health Information Systems and QAPI.

MHW met all compliance CAPs provided in 2022, demonstrating a high degree of compliance with their follow-up.

Overall, MHW met the criteria for validation of their PIPs with strengths including statistically significant increase in BCS rates for the second measurement year. While the confidence in the reported results were mixed due to low success rates during the current review, things such as low numbers within the intervention groups, balancing the return to in-person care with telehealth interventions as the public health emergency continued, and staff turnover have impacted the low success rates at all the MCPs. MHW fully met their EQRO recommendation from the previous year by providing the required documentation to address the finding as part of the 2022 TEAMonitor Corrective Action review process.

MHW is at or above the MY2022 State Simple Average for 35 of the 42 performance measures reviewed. The majority of the performance measures reviewed (25 of 42) performed above the state simple average when compared to the other MCOs.

MHW achieved 85.7% of the VBP Quality Performance Measures for 2022, which reflects improvement in performance areas identified by HCA, based on the legislative proviso (ESSB 5693 Sec.211 (37)(2022)), as important in having potential to impact costs, effect population health, target areas of poor performance or be clinically meaningful in promoting health status. MHW did not meet the VBP performance target for Substance Use Disorder Treatment Rate (SUD), age 12-64, all MCO excluding BHSO.

In the Enrollee Quality Report (2023 Washington Apple Health Plan Report Card), MHW received an above average rating for “Keeping women and mothers healthy.” They received average ratings for:

- Getting Care
- Keeping kids healthy
- Preventing and managing illness
- Ensuring appropriate care
- Satisfaction with care provided to adults
- Satisfaction with plan for adults

Overall, MHW is encouraged to ensure the QAPI program is effective, monitored, objectively evaluated and updated to provide overall continuous improvement related to quality, access and timeliness of services provided by the MCP.

Please see the following profile for additional detail.

Summary of Results: Compliance Review

TEAMonitor's review assessed activities for the previous calendar year and evaluated MHW's compliance with the standards set forth in 42 CFR Part 438, as well as those established in the MCP contract with HCA for all Apple Health Managed Care programs. 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.

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. A follow-up of the current year's EQRO recommendations will be reflected in the 2024 Annual Technical Report.

The compliance review section, starting on page 28 of the 2023 Annual Technical Report, outlines weaknesses and opportunities for improvement. These weaknesses and areas for improvement are the elements identified by TEAMonitor as "not met" or "partially met," requiring a corrective action plan. Comagine Health's recommendations to the MHW MCPs reflect the CAPs provided by TEAMonitor. Please note both the MCO and BHSO received the same EQRO recommendations. This language is a synopsis from TEAMonitor Compliance Summary report completed for each standard reviewed in 2023.

Tables A-44 through A-53 show the results of MHW's 2023 TEAMonitor Compliance Review. Please note both the MCO and BHSO received the same EQRO recommendations.

Table A-44. MHW 2023 TEAMonitor Compliance Review Results: Enrollee Rights.

§438.100 – Enrollee rights	MCO	BHSO
438.100 (a) - General rule	3	3
438.100 (b)(2)(i) Specific rights - 438.10 (c) Language and format	3	3
438.100 (b)(2)(i) Specific rights - 438.10 (d) Language and format (3) Notification	3	3
438.100 (b)(2)(i) Specific rights - 438.10 (d) Language and format (4)(5) Language – Oral interpretation/written information	3	3
438.100 (b)(2)(i) Specific rights - 438.10 (d)(6) Format, easily understood	3	3
438.100 (b)(2)(i) Specific rights - 438.10 (d)(6)(iii)	3	3
438.100 (b)(2)(i) Specific rights - 438.10 (f)(2) General requirements	3	3
438.100 (b)(2)(i) Specific rights - 438.10 (g)(1-4) Information for Enrollees – Enrollee Handbook	3	3
438.100 (b)(2)(i) Specific rights - 438.10 (i) Information for Enrollees – Formulary	3	NA
438.100 (b)(2)(ii - iv) and (3) Specific rights	3	3
438.100 (d) Compliance with other Federal and State laws	3	3
438.106 - Liability for payment	3	3
Total Score	**36/36**	**33/33**
Total Score (%)	**100%**	**100%**

MHW met all elements within this standard. As a result, no recommendations are being made.

Table A-45. MHW 2023 TEAMonitor Compliance Review Results: Availability of Services.

§438.206 – Availability of services	MCO	BHSO
438.206 (b)(1)(i-v) & (c) Delivery network, 438.10 (h) Information for all enrollees – Provider directory	2	2
438.206 (b)(2) Direct access to a women's health specialist	3	NA
438.206 (b)(3) Provides for a second opinion	3	3
438.206 (b)(4) Services out of network	3	3
438.206 (b)(5) Out-of-network payment	3	3
438.206 (c) Furnishing of services (1)(i) through (vi) Timely access	3	3
438.206 (c)(2) Cultural considerations	3	3
438.207 Assurances of adequate capacity and services (b)(c)	3	3
Total Score	**23/24**	**20/21**
Total Score (%)	**96%**	**95%**

EQRO Recommendations based on TEAMonitor CAPs - 1

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

1. To address the Partially Met score, MHW will update their webpage to include a link to the HCA WISe webpage or if the link already exists, ensure it is clearly labeled.

Table A-46. MHW 2023 TEAMonitor Compliance Review Results: Coordination and Continuity of Care.

§438.208 – Coordination and continuity of care	MCO	BHSO
438.208 (a) General requirement	2	3
438.208 (b) Care and coordination of services for all MCO, PIHP, and PAHP enrollees - 438.224 Confidentiality	3	3
438.208 (c)(1) Additional services for enrollees with special health care needs or who need LTSS - Identification	1	1
438.208 (c)(2)(3) Assessment and treatment/service plans	2	3
438.208 (c)(4) Direct access to specialists	3	3
Total Score	**11/15**	**13/15**
Total Score (%)	**73%**	**87%**

EQRO Recommendations based on TEAMonitor CAPs - 5

To address the Partially Met scores:

438.208 (a) General requirement

MHW will attend an HCA Pharmacy presentation that will be provided to obtain a better understanding of HCA's expectations around the contract requirement. MHW will then update their policy and procedure documents and submit them to HCA for review and approval for the following issues:

1. MHW's policy and procedure did not address the continuity of care period for opioids. The MCO will then update their policy and procedure documents and submit them to HCA for review and approval. The final CAP score will be determined as part of the 2024 TEAMonitor review process.

2. The documentation provided did not address exclusions to the continuation of care/transition of care requirement and ensure the requirements in the policy and procedure align with IMC Contract section 14.1.
3. MHW's policy and procedure did not address how the MCO approves payment for the dispensing of a refill of an antipsychotic, antidepressant, or antiepileptic medication.

438.208 (c)(2)(3) Assessment and treatment/service plans

4. MHW will update the policy and procedure to include:
    a. The current process for the release of the HCA report
    b. Providing educations education regarding elevated blood lead levels to families; and
    c. Facilitating re-testing and referrals

To address the Not Met score:

438.208 (c)(1) Additional services for enrollees with special health care needs or who need LTSS - Identification

5. MHW will submit supporting policies and procedures that outline the process to identify ISCHN for both new and existing MCO/BHSO enrollees, including a list of data sources, descriptions, flowcharts, etc. The supporting policies and procedures must address all contracts under review.

Table A-47. MHW 2023 TEAMonitor Compliance Review Results: Practice Guidelines.

§438.236 – Practice guidelines	MCO	BHSO
438.236 (a)(b)(1-4) Adoption of [practice] guidelines	3	3
438.236(c) Dissemination of [practice] guidelines	2	2
438.236(d) Application of [practice] guidelines	3	3
Total Score	**8/9**	**8/9**
Total Score (%)	**89%**	**89%**

EQRO Recommendations based on TEAMonitor CAPs - 1

438.236(c) Dissemination of [practice] guidelines

1. To address the Partially Met score, MHW will submit documentation outlining the exact dates of when practice guidelines were distributed to affected providers to ensure that the notification to providers was within 60 days of adoption or revision of guidelines.

Table A-48. MHW 2023 TEAMonitor Compliance Review Results: Health Information Systems.

§438.242 – Health information systems	MCO	BHSO
438.242 (a) General rule	3	3
438.242 (b)(1)(2) Basic elements	3	3
438.242 (b)(3) Basic element - Accuracy	3	3
Total Score	**9/9**	**9/9**
Total Score (%)	**100%**	**100%**

MHW met all elements within this standard. As a result, no recommendations are being made.

Table A-49. MHW 2023 TEAMonitor Compliance Review Results: QAPI.

§438.242 – QAPI	MCO	BHSO
438.330 (b)(2) and (c), Performance measurement, and 438.330(e)(2) QAPI Program Evaluation - Desk Review	3	3
438.330 (e)(2) QAPI Program evaluation	3	3
Total Score	**6/6**	**6/6**
Total Score (%)	**100%**	**100%**

MHW met all elements within this standard. As a result, no recommendations are being made.

Table A-50. MHW 2023 TEAMonitor Compliance Review Results: Grievance System.

§438.400 – Grievance system	MCO	BHSO
438.228 (a)(b) Grievance and appeal systems	3	3
438.400 (b) Statutory basis and definitions – file review	3	3
438.402 (c)(1) Filing requirements - Authority to file – file review	3	3
438.402 (c)(2) Filing requirements - Timing – file review	3	3
438.402 (c)(3) Filing requirements - Procedures – file review	3	3
438.404 (a) Notice of adverse benefit determination - language and format – file review	3	3
438.404 (b) Notice of action - Content of notice – file review	3	3
438.406 (a) Handling of grievances and appeals - General requirements – file review	2	3
438.406 (b) Special requirements for appeals – file review	3	3
438.408 (a) Resolution and notification: Grievances and appeals - Basic rule – file review	3	3
438.408 (b)(c) Specific timeframes and extension of timeframes – file review	3	3
438.408 (d)(e) Format of notice and content of notice of appeal resolution – file review	3	3
438.410 Expedited resolution of appeals – file review	3	3
438.420 Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State fair hearing are pending – file review	3	3
438.424 Effectuation of reversed appeal resolutions – file review	3	3
Total Score	**44/45**	**45/45**
Total Score (%)	**98%**	**100%**

EQRO Recommendations based on TEAMonitor CAPs - 1

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

1. To address the Partially Met Score, the MCP will review the files to determine the cause of findings and identify and follow up on actions for improvements to prevent future issues. This must include, at minimum, documentation of staff training and monitoring.

Summary of MHW 2022 EQRO Recommendations Based on TEAMonitor Compliance CAPs Follow-Up

Table A-51 shows the number of MCO/BHSO EQRO recommendations that were followed up during the current review.

Degree to which plans have addressed the previous year's EQRO recommendations key:

- **Low** – No CAPs met
- **Medium** – Less than all CAPs met
- **High** – All CAPs met
- **NA** – No CAPs received

Table A-51. MHW Results of Previous Year (2022) EQRO Compliance Recommendations Based on TEAMonitor CAPs – Count.

Met	Partially Met*	Not Met*	Degree to which plans addressed all EQRO recommendation(s):
15	0	0	High

**Future follow-up required.*

Table A-52 shows the results of the previous year EQRO compliance recommendations based on TEAMonitor CAPs follow-up.

Table A-53. MHW Results of Previous Year (2022) EQRO Compliance Recommendations Based on TEAMonitor CAPs – Follow-up.

42 CFR Part 438	MCO and BHSO		
Subpart D – MCO, PIHP and PAHP Standards	**Met**	**Partially Met**	**Not Met**
438.210 (b) Authorization of services – 4 CAPs	4	0	0
438.210 (c) Notice of adverse benefit determination – 1 CAP	1	0	0
438.210 (d) Timeframe for decisions (Repeat finding) – 1 CAP	1	0	0
438.214 (a) General rules and (b) Credentialing and recredentialing requirements – 1 CAP	1	0	0
Subpart E – Quality Measurement and Improvement (Quality Assessment and Performance Improvement Program (QAPI))	**Met**	**Partially Met**	**Not Met**
438.66(c)(3) Provider Complaints and Appeals – 1 CAP	1	0	0
438.330 (a) General rules – 1 CAP	1	0	0
438.330 (e)(2) QAPI Program Evaluation (Repeat finding) – 1 CAP	1	0	0
Subpart F – Grievance System	**Met**	**Partially Met**	**Not Met**
438.228 (a)(b) Grievance and appeal systems – 2 CAPs	2	0	0
438.408 (a) Basic rule – 1 CAP	1	0	0
438.408 (b)(c) Specific timeframes and extension of timeframes – 1 CAP	1	0	0
438.424 Effectuation of reversed appeal resolutions – 1 CAP	1	0	0

Summary of Results: PIP Validation

PIPs: 3 Met; 0 Partially Met; 0 Not Met

The PIP validation section, starting on page 35 of the 2023 Annual Technical Report, outlines strengths, weaknesses and opportunities for improvement. These weaknesses and areas for improvement are the elements identified by TEAMonitor as "not met" or "partially met," requiring a corrective action plan. This language is a synopsis from TEAMonitor PIP Validation Worksheets completed for each PIP. Tables A-54 through A-56 show the results of the MHW's PIP validation.

PIP Title: Collaborative MCO Well-Child Visit Rate PIP

PIP Type: AH-IMC, AH-IFC **Domain:** Access, Quality, Timeliness

Improvement Strategies/Interventions

- Member-focused: Social media postings, well-care visit flyers
- Provider-focused: Two MCO-provider group partnerships, named Spring and Fall Project 2022, that aim to engage over-due or unestablished members through efforts that include empanelment clean-up, patient outreach and provider incentives
- MCP-focused: Continued use of standardized empanelment data format, incentive reference list for clinics

Table A-54. MHW: Collaborative MCO Well-Child Visit Rate PIP.

Score	Validation Status	Validation Rating	Performance Measure and Results
Met	Yes	Moderate confidence in reported results	HEDIS Measures: • W30, 0-15 months: Demonstrated performance improvement; no statistically significant change; p-value <.05 • W30, 15-30 months: Demonstrated performance improvement; no statistically significant change; p-value <.05 • WCV, 3-11 years: No demonstrated performance improvement; no statistically significant change; p-value <.05 • WCV, 12-17 years: No demonstrated performance improvement; no statistically significant change; p-value <.05 • WCV, 18-21 years: No demonstrated performance improvement; no statistically significant change; p-value <.05

PIP Title: Increasing Breast Cancer Screening (BCS) for Female Medicaid Members Aged 50 through 74 Years

PIP Type: AH-IMC **Domain:** Access, Timeliness

Improvement Strategies/Interventions

- **Member-focused:** Telephonic outreach; BCS letters; reminder e-mails; reminder text messages; member education on MHW website; Breast Cancer Postcard; allow members easy access and guidance on imaging services available near them.
- **Provider-focused**: Value-Based Contracting (VBC) Tracking measures: add BCS measure to all VBC groups tracking measures and VBC scorecards that have BCS members; large health system:

reach out to established VBC groups and inquire what current interventions and or resources are currently in place for BCS for CY22.

- **MCP-focused:** Mobile mammography – partner with a mobile mammography van to offer breast cancer screening to members who are experiencing access issues.

Table A-55. MHW: Increasing Breast Cancer Screening (BCS) for Female Medicaid Members Aged 50 through 74 Years PIP.

Score	Validation Status	Validation Rating	Performance Measure and Results
Met	Yes	High confidence in reported results	HEDIS measure • BCS: Demonstrated performance improvement; Statistically significant change p <.01

PIP Title: Increase Utilization of Telehealth Services for Behavioral Health Services Only (BHSO) Adult Members

PIP Type: BHSO **Domain:** Access, Quality

Improvement Strategies/Interventions

- **Member-focused:** Review and update the following BHSO materials: member handbook, public website, quick start guide and welcome letter.
- **Provider-focused:** Communications via blast fax and provider portal alerts; promote cultural competency training with behavioral health providers; provider newsletter; blast fax and provider portal alerts.

Table A-56. MHW: Increase Utilization of Telehealth Services for Behavioral Health Services Only (BHSO) Adult Members PIP.

Score	Validation Status	Validation Rating	Performance Measure and Results
Met	Yes	Moderate confidence in reported results	HEDIS measure MPT: No demonstrated performance improvement; Statistically significant change; p <.01

Summary of MHW 2023 EQRO PIP Recommendation Based on TEAMonitor CAPs

MHW did not receive an EQRO recommendation based on a TEAMonitor CAP in 2023.

Summary of Previous Year (2022) EQRO PIP Recommendation Based on TEAMonitor CAP Follow-Up

Degree to which plans have addressed the previous year's EQRO recommendations key:

- **Low** – No CAPs met
- **Medium** – Less than all CAPs met
- **High** – All CAPs met
- **NA** – No CAPs received

Degree to which plan addressed EQRO recommendation: High

2022 TEAMonitor CAP

To address the finding the MCP will participate in a quarterly technical assistance (TA) meeting with HCA. The TA meeting will be used to review and discuss any potential barriers and work towards ensuring successful outcomes.

The MCP must submit a narrative and any supporting documents describing the actions they will take to address the findings related to:

- Inconsistent data reporting and data interpretation
- Incomplete data results - no statistical significance test comparing results of MY2021 to MY2020
- PDSA was not completed per HCA standards

In addition to the elements above the narrative should address actions that can be taken to improve the current active (2022) PIPs and describe how the deficiencies in this year's PIP report and feedback from HCA will be used to make constructive changes in the (2022) PIPs.

TEAMonitor Response/MCP Response-Action Taken

Met – Corrective action is completed. No further action required. MHW provided the required documentation to address the finding as part of the 2022 Corrective Action review process.

Summary of Results: Performance Measure Validation

Comagine Health received the MHW's FAR from Aqurate Health Data Management, Inc., an independent organization providing performance measure validation review and HEDIS compliance audits, which conducted the 2023 MCP HEDIS audits. Comagine Health then assessed the FAR to determine and develop EQR findings and recommendations. MHW was in full compliance with the MY2022 audits. Comagine Health did not identify any EQRO recommendations, strengths or weaknesses during the 2023 PMV.

However, when reviewing the MCP's FAR, Comagine Health identified suggested opportunities for improvement within the FAR based on the audit team recommendations. HCA plans to follow-up via the TEAMonitor process and will be requiring a response from MHW to HCA. If the MHW's response does not sufficiently address the issue in the upcoming year, an EQRO Recommendation will be issued as part of the 2024 performance measure review.

Table A-57 shows MHW's results for each standard addressed in the FAR.

Table A-57. Summary of MHW 2023 HEDIS FAR.

Information Standard	Score
IS 1.0 Medical Services Data	Met
IS 1.A Behavioral Health Services	NA
IS 1.B Vision Services	Met
IS 1.C Pharmacy Services	Met

Information Standard	Score
IS 1.D Dental Services	NA
IS 1.E Laboratory Services	NA
IS 2.0 Enrollment Data	Met
IS 3.0 Practitioner Data	Met
IS 4.0 Medical Record Review Process	Met
IS 5.0 Supplemental Data	Met
IS 6.0 Data Preproduction Processing	Met
IS 7.0 Data Integration and Reporting	Met
IS 8.0 Case Management Data: Long-Term Services & Support (LTSS)	NA
IS AD 1.0 General Information	Met
IS HD 5.0 Outsourced or Delegated Reporting Function	NA

Summary of Results: Performance Measure Comparative Analysis

MHW performed at or above the statewide simple average for 35 of 42 measures and significantly better than the state average on 25 measures. Notable measures include Follow-Up After Emergency Department Visit for Mental Illness (FUM), Asthma Medication Ratio (AMR), Cervical Cancer Screening (CCS), and Prenatal and Postpartum Care (PPC) measures. Among additional improvements, MHW demonstrated significant improvements over last year's performance with Asthma Medication Ratio (AMR)-Total, Breast Cancer Screening (BCS-E)-Total, and Child & Adolescent Well-Care Visit (WCV)-3-11 years.

MHW performed significantly below the state simple average for two measures: Pharmacotherapy for Opioid Use Disorder (POD), 16-64 Years, and Use of Opioids from Multiple Prescribers and Multiple Pharmacies (UOP). 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.

VBP Measure Performance

MHW has seen statistically significant improvement on several VBP measures. The Asthma Medication Ratio (AMR) has seen statistically significant improvement over the last three years (MY2020 through MY2022) and is now well above the national 75th percentile. The Antidepressant Medication Management (AMM) measure for both the Effective Acute and Continuation phase saw statistically significant improvement between MY2019 and MY2020, and then again between MY2021 and MY2022. The MY2022 result for this measure is now above the national 50th percentile, although still below the national 75th percentile. MHW also saw statistically significant improvement for the Child and Adolescent Well-Care Visit (WCV), 3-11 Years measure for the last two years reported. Measure performance is still below the national 50th percentile, however, so there are still opportunities for improvement for this measure.

Performance for the remaining VBP measures was mostly flat. There have been scattered historical improvements for other VBP measures but those may be due to random statistical variation.

Table A-58 shows the MHW's performance measure comparative analysis strengths and weaknesses/opportunities for improvement.

Table A-58. MHW's Performance Measure Comparative Analysis Strengths and Weaknesses/ Opportunities for Improvement.

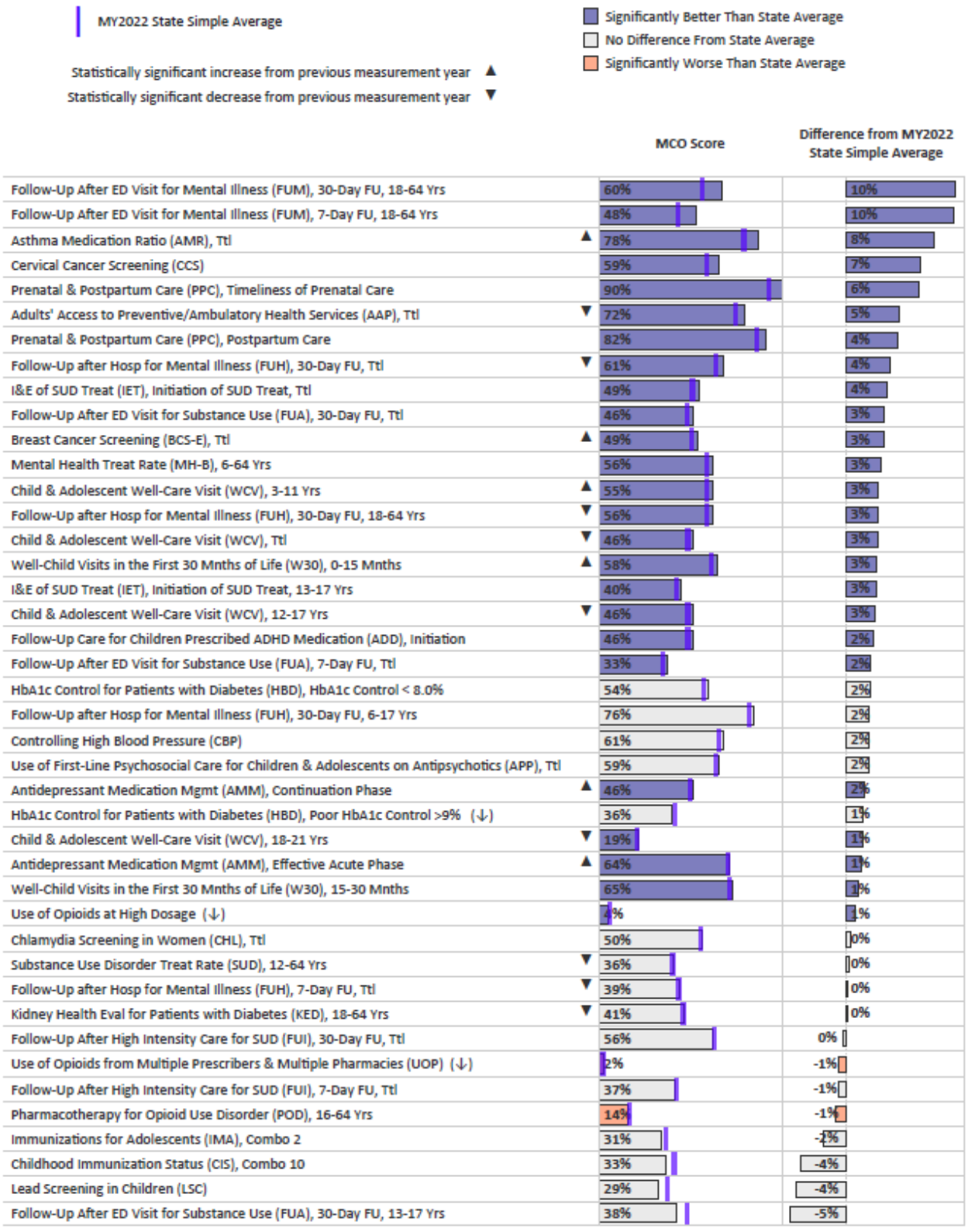
Performance Measures	
Strengths	**Weaknesses/Opportunities for Improvement**
Prevention and Screening • Breast Cancer Screening (BCS-E) • Cervical Cancer Screening (CCS) Respiratory Conditions • Asthma Medication Ratio (AMR)* Behavioral Health • Follow-Up after Hospitalization for Mental Illness (FUH) • Follow-Up After Emergency Department Visit for Mental Illness (FUM) • Follow-Up After Emergency Department Visit for Substance Use (FUA) • Mental Health Treatment Rate (MH-B)* Access/Availability of Care • Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) • Prenatal and Postpartum Care (PPC)* Utilization • Well-Child Visits in the First 30 Months of Life (W30), 0-15 Months • Child and Adolescent Well-Care Visit (WCV)**	Behavioral Health • Pharmacotherapy for Opioid Use Disorder (POD), 16-64 Years Overuse/Appropriateness • Use of Opioids from Multiple Prescribers and Multiple Pharmacies (UOP)

**These measures are also required VBP measures.*
***The Child and Adolescent Well-Care Visit (WCV), Age 3-11 measure is also a required VBP measure*

MHW Performance Measure Comparative Analysis Scorecard

Figure A-5, on the next page, represents the variance of measures from the simple state average for MHW.

Figure A-5. MHW Scorecard, MY2022.



(↓) For this measure lower scores are better.

UnitedHealthcare Community Plan (UHC) Profile

UHC Overall Perspective

UHC demonstrated strengths in compliance within the QAPI program, by including clinical data repository (CDR) one-pager, inclusion of contract requirements and OneHealthPort contract information in the provider manual as an addendum to the provider agreement, and an article in the provider newsletter. Further, UHC tracks the participation of CORE/Strategic Provider groups for CDR participation and implementation of strategies to improve participation year over year.

UHC will need to address the following compliance standards where they did not fully meet the requirements and received CAPs:

- Availability of Services
- Coordination and Continuity of Care
- QAPI

UHC fully meeting all elements in the compliance standards of:

- Enrollee Rights
- Practice Guidelines
- Health Information Systems
- Grievance Systems

UHC met all compliance CAPs provided in 2022, demonstrating a high degree of compliance with their follow-up.

Overall, UHC met the criteria for validation of their PIPs with strengths the choice of important PIP topic, implementing interventions tailored towards the member and providers, increase of the FUH rate by over seven points through a multi-faceted intervention strategy. While the confidence in the reported results were Mixed due to low success rates during the current review, things such as low numbers within the intervention groups, balancing the return to in-person care with telehealth interventions as the public health emergency continued, and staff turnover have impacted the low success rates at all the MCPs. UHC fully met their EQRO recommendation from the previous year by providing the required documentation to address the finding as part of the 2022 TEAMonitor Corrective Action review process.

UHC is at or above the MY2022 State Simple Average for 21 of the 42 performance measures reviewed. They demonstrated mixed results with performance significantly above the simple statewide average on seven measures, and significantly below the simple statewide average on 10 measures.

UHC achieved 42.9% of the VBP Quality Performance Measures for 2022, which reflects decrease in performance areas identified by HCA, based on the legislative proviso (ESSB 5693 Sec.211 (37)(2022)), as important in having potential to impact costs, effect population health, target areas of poor performance or be clinically meaningful in promoting health status. UHC did not meet the VBP performance targets for:

- Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care and Postpartum Care
- Follow Up Care for Children Prescribed ADHD Medication (ADD), Initiation Phase
- Mental Health Service Rate, Broad Definition (MH-B), Age 6-64, all MCOs, excluding BHSOs

In the Enrollee Quality Report (2023 Washington Apple Health Plan Report Card), UHC received average ratings for:

- Getting Care
- Preventing and managing illness
- Satisfaction of care provided to adults
- Satisfaction with plan for adults

UHC received below average ratings for:

- Keeping kids healthy
- Keeping women and mothers healthy
- Ensuring appropriate care

Overall, UHC is encouraged to ensure the QAPI program is effective, monitored, objectively evaluated and updated to provide overall continuous improvement related to quality, access and timeliness of services provided by the MCP.

Please see the following profile for additional detail.

Summary of Results: Compliance Review

TEAMonitor's review assessed activities for the previous calendar year and evaluated UHC's compliance with the standards set forth in 42 CFR Part 438, as well as those established in the MCP contract with HCA for all Apple Health Managed Care programs. 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.

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. A follow-up of the current year's EQRO recommendations will be reflected in the 2024 Annual Technical Report.

The compliance review section, starting on page 28 of the 2023 Annual Technical Report, outlines weaknesses and opportunities for improvement. These weaknesses and areas for improvement are the elements identified by TEAMonitor as "not met" or "partially met," requiring a corrective action plan. Comagine Health's recommendations to the UHC MCPs reflect the CAPs provided by TEAMonitor. Please note both the MCO and BHSO received the same EQRO recommendations. This language is a synopsis from TEAMonitor Compliance Summary report completed for each standard reviewed in 2023.

Tables A-59 through A-67 show the results of the UHC's 2023 TEAMonitor Compliance Review. Please note both the MCO and BHSO received the same EQRO recommendations.

Table A-59. UHC 2023 TEAMonitor Compliance Review Results: Enrollee Rights

§438.100 – Enrollee rights	MCO	BHSO
438.100 (a) - General rule	3	3
438.100 (b)(2)(i) Specific rights - 438.10 (c) Language and format	3	3
438.100 (b)(2)(i) Specific rights - 438.10 (d) Language and format (3) Notification	3	3
438.100 (b)(2)(i) Specific rights - 438.10 (d) Language and format (4)(5) Language – Oral interpretation/written information	3	3

§438.100 – Enrollee rights	MCO	BHSO
438.100 (b)(2)(i) Specific rights - 438.10 (d)(6) Format, easily understood	3	3
438.100 (b)(2)(i) Specific rights - 438.10 (d)(6)(iii)	3	3
438.100 (b)(2)(i) Specific rights - 438.10 (f)(2) General requirements	3	3
438.100 (b)(2)(i) Specific rights - 438.10 (g)(1-4) Information for Enrollees – Enrollee Handbook	3	3
438.100 (b)(2)(i) Specific rights - 438.10 (i) Information for Enrollees – Formulary	3	NA
438.100 (b)(2)(ii - iv) and (3) Specific rights	3	3
438.100 (d) Compliance with other Federal and State laws	3	3
438.106 - Liability for payment	3	3
Total Score	**36/36**	**33/33**
Total Score (%)	**100%**	**100%**

UHC met all elements within this standard. As a result, no recommendations are being made.

Table A-60. UHC 2023 TEAMonitor Compliance Review Results: Availability of Services.

§438.206 – Availability of services	MCO	BHSO
438.206 (b)(1)(i-v) & (c) Delivery network, 438.10 (h) Information for all enrollees – Provider directory	3	3
438.206 (b)(2) Direct access to a women's health specialist	3	NA
438.206 (b)(3) Provides for a second opinion	3	3
438.206 (b)(4) Services out of network	3	3
438.206 (b)(5) Out-of-network payment	3	3
438.206 (c) Furnishing of services (1)(i) through (vi) Timely access	3	3
438.206 (c)(2) Cultural considerations	2	2
438.207 (b)(c) Assurances of adequate capacity and services	2	2
Total Score	**22/24**	**19/21**
Total Score (%)	**92%**	**90%**

EQRO Recommendations based on TEAMonitor CAPs - 3

To address the Partially Met scores, UHC will provide:

438.206 (c)(2) Cultural considerations

1. Documentation that addresses how UHC uses the data to monitor and evaluate the impact of CLAS on health equity and outcomes to inform service delivery.

438.207 (b)(c) Assurances of adequate capacity and services

2. Updated policies and procedures. The updated policy and procedure should describe the steps that will be taken to prevent the re-occurrence of (HCA) identified issues in MCO/PIHPs quarterly provider network submissions.
3. A plan as to how they will include evidence of quality assurance oversite and implementation of any changes needed to prevent reoccurrence in future submissions.

Table A-61. UHC 2023 TEAMonitor Compliance Review Results: Coordination and Continuity of Care.

§438.208 – Coordination and continuity of care	MCO	BHSO
438.208 (a) General requirement	2	2
438.208 (b) Care and coordination of services for all MCO, PIHP, and PAHP enrollees - 438.224 Confidentiality	2	2
438.208 (c)(1) Additional services for enrollees with special health care needs or who need LTSS - Identification	3	3
438.208 (c)(2)(3) Assessment and treatment/service plans	2	3
438.208 (c)(4) Direct access to specialists	3	3
Total Score	**11/15**	**12/15**
Total Score (%)	**73%**	**80%**

EQRO Recommendations based on TEAMonitor CAPs - 6

To address the Partially Met scores:

438.208 (a) General requirement

UHC's response did not address the process for developing transition plans for Transition Age Youth Services (TAY) and is substantially different from UHC's response to HCA Issue #27050.

1. UHC will provide an updated policy and procedure with information regarding TAY.

UHC will attend an HCA Pharmacy presentation that will be provided to obtain a better understanding of HCA's expectations around the contract requirement. UHC will then update their policy and procedure documents and submit them to HCA for review and approval for the following issues:

2. The documentation did not include how the MCP initiates the prior authorization process for opioids with the provider for newly enrolled members.
3. The documentation did not appear to address a procedure for how an enrollee receives a 90-day continuation of care approval for medications they were established on prior to enrollment.
4. The documents provided refer to the emergency fill policy, which only provides a single fill up to 30 days for enrollees. There does not appear to be a procedure specific to this scenario, which is not an emergency fill.

438.208 (b) Care and coordination of services for all MCO, PIHP, and PAHP enrollees - 438.224 Confidentiality

The ICS CC 003 policy outlines these expectations, specific to enrollees with special health care needs only. It is unclear if this extends to all enrollees. UHC will provide:

5. Updated care coordination policies and procedures that clearly outline the following requirements as they apply to all enrollees not just enrollees with special health care needs:
    a. 2(b) - Coordination of MCO/PIHP services furnished to the enrollee with services the enrollee receives from any other MCO/PIHP, behavioral health organization, or other entity specified in contract subsection 14.5, including coordination of assessments and evaluations with mental health, SUD, and other providers; and
    b. 2(c)- Prevention of duplication of services through the sharing of the results of its identification and assessment of the enrollee's needs with other entity specified in Contract subsection 14.6.

438.208 (c)(2)(3) Assessment and treatment/service plans

6. UHC will update the policy and procedure to include the MCO lead match procedures (i.e., how the HCA provided reports are reviewed, and how UHC determines which clinic to follow up with etc.).

Table A-62. UHC 2023 TEAMonitor Compliance Review Results: Practice Guidelines.

§438.236 – Practice guidelines	MCO	BHSO
438.236 (a)(b)(1-4) Adoption of [practice] guidelines	3	3
438.236(c) Dissemination of [practice] guidelines	3	3
438.236(d) Application of [practice] guidelines	3	3
Total Score	**9/9**	**9/9**
Total Score (%)	**100%**	**100%**

UHC met all elements within this standard. As a result, no recommendations are being made.

Table A-63. UHC 2023 TEAMonitor Compliance Review Results: Health Information Systems.

§438.242 – Health information systems	MCO	BHSO
438.242 (a) General rule	3	3
438.242 (b)(1)(2) Basic elements	3	3
438.242 (b)(3) Basic element - Accuracy	3	3
Total Score	**9/9**	**9/9**
Total Score (%)	**100%**	**100%**

UHC met all elements within this standard. As a result, no recommendations are being made.

Table A-64. UHC 2023 TEAMonitor Compliance Review Results: QAPI.

§438.242 – QAPI	MCO	BHSO
438.330 (b)(2) and (c), Performance measurement, and 438.330(e)(2) QAPI Program Evaluation - Desk Review	3	3
438.330 (e)(2) QAPI Program evaluation	2	2
Total Score	**5/6**	**5/6**
Total Score (%)	**83%**	**83%**

EQRO Recommendations based on TEAMonitor CAPs - 1

438.330 (e)(2) QAPI Program evaluation

1. To address the Partially Met score, UHC will provide a narrative document detailing the steps they will take to ensure future submissions include:
    a. WISe quality indicators in the QI workplan and QAPI evaluations, and
    b. Objective assessment criteria, a list of program accomplishments, and results of objective assessment as part of future assessments – based on the 2022 partially met recommendation.

Table A-65. UHC 2023 TEAMonitor Compliance Review Results: Grievance System.

§438.400 – Grievance system	MCO	BHSO
438.400 (b) Statutory basis and definitions – file review	3	3
438.402 (c)(1) Filing requirements - Authority to file – file review	3	3
438.402 (c)(2) Filing requirements - Timing – file review	3	3
438.402 (c)(3) Filing requirements - Procedures – file review	3	3
438.404 (a) Notice of adverse benefit determination - language and format – file review	3	3
438.404 (b) Notice of action - Content of notice – file review	3	3
438.406 (a) Handling of grievances and appeals - General requirements – file review	3	3
438.406 (b) Special requirements for appeals – file review	3	3
438.408 (a) Resolution and notification: Grievances and appeals - Basic rule – file review	3	3
438.408 (b)(c) Specific timeframes and extension of timeframes – file review	3	3
438.408 (d)(e) Format of notice and content of notice of appeal resolution – file review	3	3
438.410 Expedited resolution of appeals – file review	3	3
438.420 Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State fair hearing are pending – file review	3	3
438.424 Effectuation of reversed appeal resolutions – file review	3	3
Total Score	**42/42**	**42/42**
Total Score (%)	**100%**	**100%**

UHC met all elements within this standard. As a result, no recommendations are being made.

Summary of UHC 2022 EQRO Recommendations Based on TEAMonitor Compliance CAPs Follow-Up

Table A-66 shows the number of MCO/BHSO EQRO recommendations that were followed up during the current review.

Degree to which plans have addressed the previous year's EQRO recommendations key:

- **Low** – No CAPs met
- **Medium** – Less than all CAPs met
- **High** – All CAPs met
- **NA** – No CAPs received

Table A-66. UHC Results of Previous Year (2022) EQRO Compliance Recommendations Based on TEAMonitor CAPs – Count.

Met	Partially Met*	Not Met*	Degree to which plans addressed all EQRO recommendation(s):
2	0	0	High

**Future follow-up required.*

Table A-67 shows the results of the previous year EQRO compliance recommendations based on TEAMonitor CAPs follow-up.

Table A-67. UHC Results of Previous Year (2022) EQRO Compliance Recommendations Based on TEAMonitor CAPs – Follow-up.

42 CFR Part 438	MCO and BHSO		
Subpart E – Quality Measurement and Improvement (Quality Assessment and Performance Improvement Program (QAPI))	Met	Partially Met	Not Met
438.330 (e)(2) QAPI Program evaluation – 1 CAP	1	0	0
438.66(c)(3) Provider Complaints and Appeals – 1 CAP	1	0	0

Summary of Results: PIP Validation

PIPs: 3 Met; 0 Partially Met; 0 Not Met

The PIP validation section, starting on page 35 of the 2023 Annual Technical Report, outlines strengths, weaknesses and opportunities for improvement. These weaknesses and areas for improvement are the elements identified by TEAMonitor as "not met" or "partially met," requiring a corrective action plan. This language is a synopsis from TEAMonitor PIP Validation Worksheets completed for each PIP.

Tables A-68 through A-70 show the results of the UHC's PIP validation.

PIP Title: Collaborative MCO Well-Child Visit Rate PIP

PIP Type: AH-IMC, AH-IFC **Domain:** Access, Quality, Timeliness

Improvement Strategies/Interventions

- Member-focused: Social media postings, well-care visit flyers
- Provider-focused: Two MCO-provider group partnerships, named Spring and Fall Project 2022, that aim to engage over-due or unestablished members through efforts that include empanelment clean-up, patient outreach and provider incentives
- MCP-focused: Continued use of standardized empanelment data format, incentive reference list for clinics

Table A-68. UHC: Collaborative MCO Well-Child Visit Rate PIP.

Score	Validation Status	Validation Rating	Performance Measure and Results
Met	Yes	Moderate confidence in reported results	HEDIS Measures: • W30, 0-15 months: Demonstrated performance improvement; No statistically significant change; p-value <.05 • W30, 15-30 months: Demonstrated performance improvement; No statistically significant change; p-value <.05 • WCV, 3-11 years: No demonstrated performance improvement; No statistically significant change; p-value <.05 • WCV, 12-17 years: No demonstrated performance improvement; No statistically significant change; p-value <.05 • WCV, 18-21 years: No demonstrated performance improvement; No statistically significant change; p-value <.05

PIP Title: Increasing the ADHD Medication Adherence (ADD) Initiation Phase HEDIS Measure Rate

PIP Type: AH-IMC **Domain:** Access, Timeliness

Improvement Strategies/Interventions

- **Member-focused:** The Health Promotion Specialist (HPS) informs members they need a 30-day follow-up visit for the newly prescribed ADHD medication(s). If a visit had not yet been scheduled, the HPS assists the member in contacting the prescribing provider to set their 30-day follow-up visit scheduled; Genoa pharmacists provide short-term outreach and support for parents of children ages 6-12 who have been newly prescribed ADHD medication to provide education, support, and ensure a follow-up appointment is completed within 30 days of initial fill.
- **Provider-focused:** Clinical Practice Consultants (CPCs) routinely meet with provider groups to share best practices based on clinical practice guidelines for the HEDIS ADD IP measure based on recommendations from the America Association of Pediatrics; CPCs provide member level detail to close care gaps; flyer was shared during meetings which outlines recommendations for follow-up after a newly prescribed ADHD medication and includes a spot to write a set appointment for follow-up, a list of signs and symptoms for parents to review and resources for parents if they want more information.

Table A-69. UHC: Increasing the ADHD Medication Adherence (ADD) Initiation Phase HEDIS Measure Rate PIP.

Score	Validation Status	Validation Rating	Performance Measure and Results
Met	Yes	Moderate confidence in reported results	HEDIS measure: • ADD, Initiation Phase: Demonstrated performance improvement; Statistically significant change; p-value <.05

PIP Title: Follow-Up After Hospitalization for Mental Illness (FUH)

PIP Type: BHSO **Domain:** Access, Timeliness

Improvement Strategies/Interventions

- **Member-focused:** Promote use of telehealth services – email to enrollees to promote virtual visits including link to find virtual providers; provide peer service to support completion of follow-up care; post videos on member website, encourage hospital discharge and aftercare.
- **Provider-focused**: Email blast - sent 4/5/23 and 8/3/2022 to BH providers including coordination/continuity of care info; outreach to network providers to educate on appointment access standards and afterhours availability expectations; practitioner performance available in patient care opportunity report and reinforced by clinical practice consultants; on-demand webcasts with continuing education units for medical providers on substance-use disorders in primary care and depression follow up after higher levels of care provide care management staff a method for instant access to comprehensive, localized program listings.
- **MCP-focused**: Value-Based Purchasing (VBP) contracts with King County, expanding VBP and shared savings; expanded community and state telehealth provider network by 49.3% (15,841) nationally in 2022; expanded the Express Access program by 26% (7,256) nationally in 2022.

Table A-70. UHC: Follow-Up After Hospitalization for Mental Illness (FUH) PIP.

Score	Validation Status	Validation Rating	Performance Measure and Results
Met	Yes	High confidence in reported results	HEDIS measure: • FUH: Demonstrated performance improvement; Statistically significant change; p-value <.05

Summary of UHC 2023 EQRO PIP Recommendation Based on TEAMonitor CAPs

UHC did not receive an EQRO recommendation based on a TEAMonitor CAP in 2023.

Summary of Previous Year (2022) EQRO PIP Recommendation Based on TEAMonitor CAP Follow-Up

Degree to which plans have addressed the previous year's EQRO recommendations key:

- **Low** – No CAPs met
- **Medium** – Less than all CAPs met
- **High** – All CAPs met
- **NA** – No CAPs received

Degree to which plan addressed EQRO recommendation: High

2022 TEAMonitor CAP

UHC must submit a narrative and any supporting documents describing the actions they will take to address the findings related to:

- Adherence to HCA standards regarding:
- Aim statement did not include population or time-period
- Addressing the project population in section 3.1
- Addressing PDSA in section 8.3
- Unclear numerical and graphic presentation of results. (Repeat finding)
- Lack of documentation of threats to internal and external validity. (Repeat finding)

In addition to the elements above, the narrative should address actions that can be taken to improve the current active (2022) PIPs and describe how the deficiencies in this year's PIP report and feedback from HCA will be used to make constructive changes in the (2022) PIPs.

To address the repeat findings UHC will participate in a quarterly Technical Assistance (TA) meeting with HCA. The TA meeting will be used to review and discuss any potential barriers and work towards ensuring successful outcomes. UHC should contact HCA to set up the first meeting in October 2022.

TEAMonitor Response/MCP Response-Action Taken

Met – Corrective action is completed. No further action required. UHC provided the required documentation to address the finding as part of the 2022 Corrective Action review process.

Summary of Results: Performance Measure Validation

Comagine Health received the UHC's FAR from Aqurate Health Data Management, Inc., an independent organization providing performance measure validation review and HEDIS compliance audits, which conducted the 2023 MCP HEDIS audits. Comagine Health then assessed the FAR to determine and develop EQR findings and recommendations. UHC was in full compliance with the MY2022 audits. Comagine Health did not identify any EQRO recommendations, strengths or weaknesses during the 2023 PMV.

Table A-71 shows the UHC's results for each standard addressed in the FAR.

Table A-71. Summary of UHC 2023 HEDIS FAR.

Information Standard	Score
IS 1.0 Medical Services Data	Met
IS 1.A Behavioral Health Services	NA
IS 1.B Vision Services	Met
IS 1.C Pharmacy Services	Met
IS 1.D Dental Services	NA
IS 1.E Laboratory Services	NA
IS 2.0 Enrollment Data	Met
IS 3.0 Practitioner Data	Met
IS 4.0 Medical Record Review Process	Met
IS 5.0 Supplemental Data	Met
IS 6.0 Data Preproduction Processing	Met
IS 7.0 Data Integration and Reporting	Met
IS 8.0 Case Management Data: Long-Term Services & Support (LTSS)	NA
IS AD 1.0 General Information	Met
IS HD 5.0 Outsourced or Delegated Reporting Function	NA

Summary of Results: Performance Measure Comparative Analysis

UHC performed at or above the statewide simple average for half of their measures. They performed significantly better than the statewide average and demonstrated statistically significant increases over last year's performance for Kidney Health Evaluation for Patients with Diabetes (KED)-18-64, and Pharmacotherapy for Opioid Use Disorder (POD)-16-64 Years. Additionally, UHC performed significantly above the statewide simple average for the two Antidepressant Medication Management (AMM) measures. Among additional measures, UHC performed significantly below the state simple average for the Asthma Medication Ratio (AMR), Lead Screening in Children (LSC), and Follow-Up after Hospitalization for Mental Illness (FUH), 7-Day Follow-Up, Total measures. The overall results are very similar to what was reported in the 2022 Comparative Analysis Report.

VBP Measure Performance

UHC has seen statistically significant improvement on the Antidepressant Medication Management (AMM) measure for both the Effective Acute and Continuation phase saw statistically significant improvement between MY2019 and MY2020, and then again between MY2020 and MY2021. There was no statistically significant improvement between MY2021 and MY2022. The measure is at the national 75 percentile for both components.

Performance for the remaining VBP measures was mostly flat. There have been scattered historical improvements for other VBP measures but those may be due to random statistical variation.

Table A-72 shows UHC's Performance Measure Comparative Analysis Strengths and Weaknesses/ Opportunities for Improvement.

Table A-72. UHC's Performance Measure Comparative Analysis Strengths and Weaknesses/ Opportunities for Improvement.

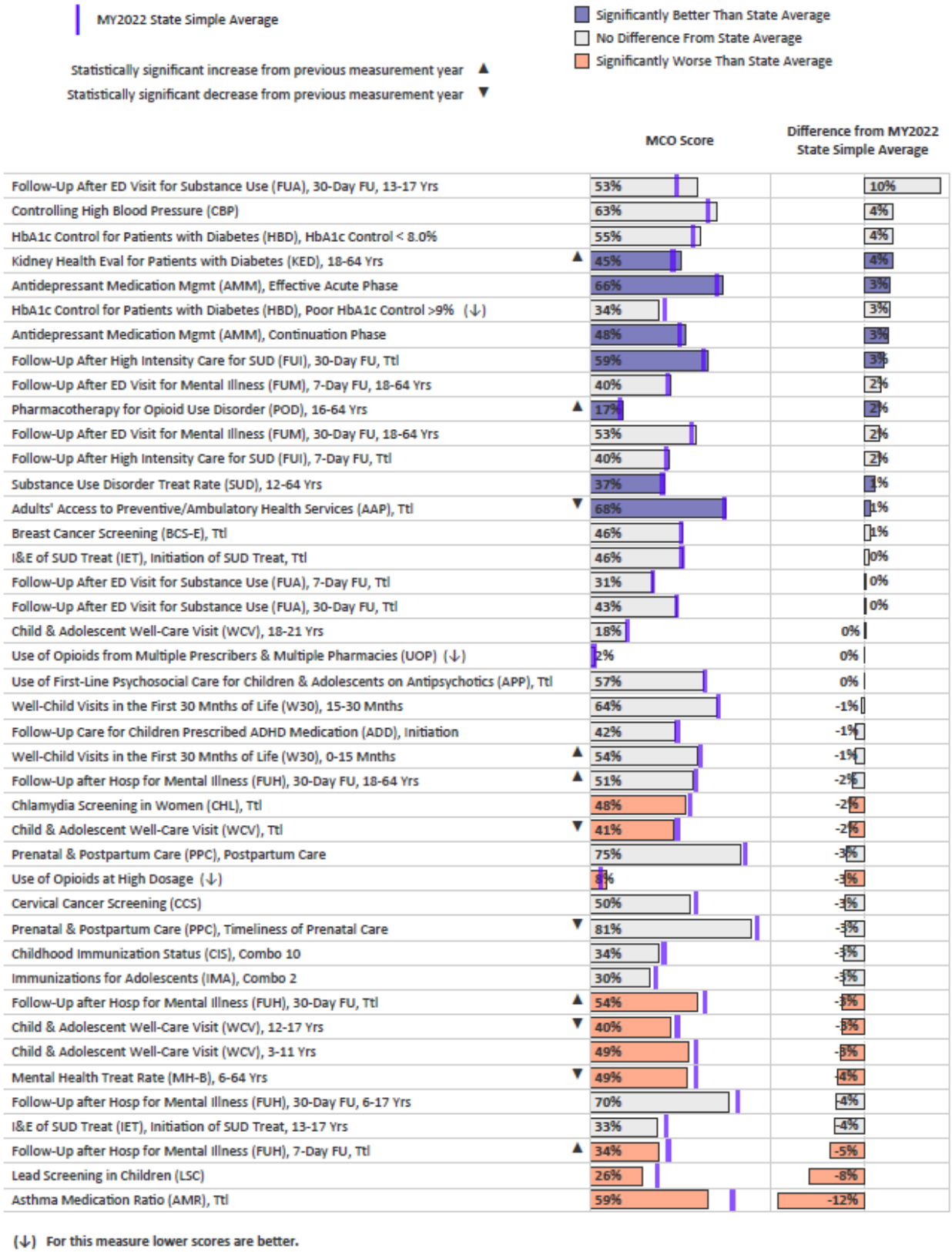
Performance Measures	
Strengths	**Weaknesses/Opportunities for Improvement**
Diabetes • Kidney Health Evaluation for Patients with Diabetes (KED), 18-64 Years Behavioral Health • Antidepressant Medication Management (AMM)* • Pharmacotherapy for Opioid Use Disorder (POD), 16-64 Years	Prevention and Screening • Lead Screening in Children (LSC) Respiratory Conditions • Asthma Medication Ratio (AMR)* Behavioral Health • Follow-Up after Hospitalization for Mental Illness (FUH)

**These measures are also required VBP measures.*

UHC Performance Measure Comparative Analysis Scorecard

Figure A-6, on the next page, represents the variance of measures from the simple state average for UHC.

Figure A-6. UHC Scorecard, MY2022.



Appendix B: Compliance Regulatory and Contractual Requirements

Compliance Review and Manner of Reporting

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. 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.[28,29]

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:

[28] 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

[29] 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 conduct a virtual visit with each MCP, and/or may 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.

Contractual and Regulatory 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, PAHP, PCCM or PCCM entity

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

**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.*

438.100(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) 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*

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

**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.*

438.228 - 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

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 (QAPI)

438.66(c)(3) Monitoring Procedures - Claims payment monitoring

438.330(a) General rules

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

**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.*

438.330(b)(2) Collection and submission of performance measurement data in accordance with paragraph (c) of this section*

438.330(c) Performance measurement*

438.330(e)(2) Program review by the State of an MCO, PAHP, or PCCM entity evaluation of the impact and effectiveness of its own QAPI program*

438.330(d) Performance improvement projects*

438.608 - Program integrity requirements under the contract

438.608(a)(b) Program integrity requirements

§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

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

**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 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 RY2022, TEAMonitor completed full 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.

Technical Methods of Data Collection

The TEAMonitor evaluations are based on *Worksheets for Protocol 1. PIP Validation Tools and Reporting Framework*, a set of worksheets used to guide and record answers for the validation of PIPs and reporting of summary PIP information, developed by CMS to determine whether a PIP was designed, conducted and reported in a methodologically sound manner.

Protocol 1 specifies procedures in assessing the validity and reliability of a PIP and how to conduct the following three activities:

- Activity 1: Assess the PIP methodology
- Activity 2: Perform overall validation and reporting of PIP results
- Activity 3: Verify PIP findings (optional)

Activity 1: Assess the PIP Methodology

1. Review the selected PIP topic to assess the appropriateness of the selected topic
2. Review the PIP Aim Statement to assess the appropriateness and adequacy of the aim statement
3. Review the identified PIP population
4. Review the sampling method
5. Review the selected PIP variables and performance measures
6. Review the data collection procedures
7. Review data analysis and interpretation of PIP results
8. Assess the improvement strategies
9. Assess the likelihood that significant and sustained improvement occurred

Activity 2: Perform Overall Validation and Reporting of PIP Results

Following the completion of Activity 1 and Activity 2, the EQRO will provide an overall validation rating of the PIP results. The "validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced evidence of significant improvement.

TEAMonitor utilizes one of the following validation ratings in reporting the results of the MCPs' PIPs:

- High confidence in reported results
- Moderate confidence in reported results
- Low confidence in reported results
- No confidence in reported results
- Enough time has not elapsed to assess meaningful change

Activity 3: Verify PIP Findings (Optional)

A state may request that the EQRO verify the data produced by the MCP to determine if the baseline and repeated measurements are accurate. Comagine Health does not verify the data produced by the MCPs.

Description of Data Obtained

TEAMonitor validates each PIP using data gathered and submitted by the MCP using *Worksheets for Protocol 1. PIP Validation Tools and Reporting Framework*.

Data Aggregation and Analysis

As the MCPs submit their PIP data directly within the protocol worksheets, 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 MCPs' 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 the following 12 elements:

- A problem or need for Medicaid enrollees reflected in the topic of the PIP
- The aim statement is stated in writing
- Relevant quantitative or qualitative measurable indicators documented
- Descriptions of the eligible population to whom the aim statements 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, aim statements, selected clinical or nonclinical measures or indicators, results

To achieve a score of Partially Met, the PIP must demonstrate all 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 aim statements 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 Comparative Analysis Methodology

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

Technical Methods of Data Collection

HEDIS

Comagine Health assessed Apple Health MCO-level performance data for the 2022 measurement year. The measures include Healthcare Effectiveness Data and Information Set (HEDIS®) performance measure rates collected in 2023, reflecting performance in calendar year 2022. It also includes behavioral health measures that were developed by the Washington State Health Care Authority. To be consistent with NCQA methodology, the 2022 calendar year (CY) is referred to as the Measure Year 2022 (MY2022) in this report. The measures also include their indicators (for example, rates for specific age groups or specific populations).

It is worth noting the HEDIS measures now contain several measures that use electronic clinical data systems (ECDS) as the source for quality measures. NCQA has developed ECDS standards and specifications to leverage the health care information contained in electronic data systems, and to ease the burden of quality reporting. Note that several of these ECDS measures will replace measures that currently are being reported through other methods.

For more information on ECDS measure development, please visit https://www.ncqa.org/hedis/the-future-of-hedis/hedis-electronic-clinical-data-system-ecds-reporting/.

Washington State Behavioral Health Measures

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

- Mental Health Treatment Rate, Broad Definition (MH-B)
- Substance Use Disorder Treatment Rate (SUD)
- Home and Community-Based Long-Term Services and Supports Use (HCBS)
- Percent Homeless - Narrow Definition (HOME-N)
- Percent Homeless - Broad Definition (HOME-B)

Note the Home and Community-Based Long-Term Services and Supports Use (HCBS) and Percent Homeless (HOME-N and HOME-B) measures are new to this report.

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.[30] 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, MY2021.

Measure	Administrative Rate	Hybrid Rate	Difference
Controlling High Blood Pressure (CBP)	42.0%	61.3%	+ 19.3%
Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care	66.0%	90.3%	+ 24.3%
Prenatal and Postpartum Care (PPC), Postpartum Care	63.7%	82.0%	+ 18.3%

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

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

Table D-2. MY2019 Rotated Measures by MCPs.

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	—	—	—	—

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

Measure Name	AMG	CCW	CHPW	MHW	UHC
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 MCP reported on that measure.

— Indicates the MCP 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 Health with an eligibility file that included enrollee demographic information (age, gender, race/ethnicity, language, county of residence and specific Apple Health program and eligibility category). Note the MLD files do not contain data for the Washington State behavioral health measures.

The populations underlying each measure in this report represent Apple Health members enrolled with an MCO in Washington State between January 1, 2022, and December 31, 2022. Of note: Only individuals who are in the denominator of at least one HEDIS measure are included in the member-level data. As a result, individuals with short tenures in their plans or individuals with little to no healthcare utilization may not be included in the measure analysis. The HEDIS measures were not risk-adjusted for any differences in enrollee demographic characteristics. Prior to performing analysis, member-level data were aggregated to the MCO level and validated against the reported HEDIS measures.

Definitions Used to Stratify Member-Level Data

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

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

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

- **Urban versus Rural** – To define urban versus rural geographies, Comagine Health relied on the CMS rural-urban commuting area (RUCA) codes. RUCA codes classify United States census tracts using measures of population density, urbanization and daily commuting.
  Whole numbers (1-10) delineate metropolitan, micropolitan, small-town and rural commuting areas based on the size and direction of the primary (largest) commuting flows. The member ZIP code included in the MLD files was used to map each member to the appropriate RUCA codes. For the purposes of this analysis, RUCA codes 8, 9 and 10 were classified as rural; this effectively defines rural areas as towns of ten thousand or smaller.
- **Regional** – The member county from the HCA enrollment data was used to map the member to region.

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 for each analysis as a result.

Calculation of the Washington Apple Health Average

This report provides estimates of the average performance among the five Apple Health MCOs for the four most recent reporting years: MY2019, MY2020, MY2021 and MY2022. 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 MY2022 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 MY2021 as the benchmark.

Interpreting Percentages versus Percentiles

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

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

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

Statistical Significance

Throughout this report, comparisons are frequently made between specific measurements (e.g., for an individual MCO) and a benchmark. Unless otherwise indicated, the terms "significant" or "significantly" are used when describing a statistically significant difference at the 95 percent confidence level. A Wilson Score Interval test was applied to calculate the 95 percent confidence intervals.

For comparisons of performance scores between categories such as MCO or race/ethnicity, a chi-square test was used to compare each category against the remaining categories as a group (i.e., an individual MCO would be compared to the average of the other four MCOs). Occasionally, a test may be significant even when the confidence interval crosses the state average line shown in the bar charts, because the

state averages on the charts reflect the weighted average of all MCOs, not the average excluding the MCO being tested.

Other tests of statistical significance are generally made by comparing confidence interval boundaries calculated using a Wilson Score Interval test, for example, comparing the MCO performance scores or state averages from year to year.

Denominator Size Considerations and Confidence Intervals

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

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

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

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

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

rate. If the current performance rate is 55%, the new rate is below the lower confidence interval value and would represent a statistically significant decrease in performance.

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

Additional Notes Regarding Interpretation

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

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

Limitations

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

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

Interpreting Performance

Potential Sources of Variation in Performance

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

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 2022, TEAMonitor began a new three-year review cycle.

Current Review Cycle Schedule and Scores

HCA has incorporated the use of nonduplication regulations outlined in 42 CFR §438.360 within the Washington State Managed Care Quality Strategy. This implementation specifically pertains to Apple Health MCPs, which include PIHPs (BHSO programs), which serve Medicaid and CHIP enrollees in the state of Washington. The Quality Strategy outlines the accreditation standards that either fully met the non-duplication regulations and are deemed (in place of compliance review) or partially met, requiring some review within scheduled EQR activities.

Deemed standards will rely on NCQA accreditation compliance and will not be reviewed in scheduled EQR activities. To be eligible for deeming, MCPs must adhere to NCQA accreditation standards. As part of Apple Health contracts, they are required to submit all relevant accreditation materials to HCA for thorough review. See the Washington State Managed Care Quality Strategy for details.
During the current review cycle (2022-2024), TEAMonitor will review the following standards (Table E-1). Please note that TEAMonitor may review standards in conjunction with standards falling under other subparts.

Table Legend: ● = Desk and File (if applicable) ◑ = File Review Only

Table E-1. Current Review Cycle Standards.

Current Review Cycle Standards		2022	2023	2024
42 CFR Part 438 Subpart C – Enrollee Rights and Protections				
§438.10	Information requirements		●	
§438.100	Enrollee rights		●	
42 CFR Part 438 Subpart D – MCO, PHIP and PAHP Standards				
§447.46	Timely claims payment by MCOs			●
§438.56	Disenrollment: Requirements and limitation			●
§438.206	Availability of services*		●	
§438.207	Assurances of adequate capacity and services		●	
§438.208	Coordination and continuity of care	◑	●	◑
§438.210	Coverage and authorization of services	◑	◑	●
§438.214	Provider Selection (Credentialing)*	●		
$438.224	Confidentiality	●		
§438.230	Subcontractual relationships and delegation			●
§438.236	Practice guidelines*		●	
§438.242	Health Information Systems*	●	●	●
42 CFR Part 438 Subpart E – Quality Measurement and Improvement; External Review				
§438.66	Monitoring Procedures - Claims payment monitoring	●		
§438.330	Quality Assessment and Performance Improvement Program (QAPI)	●		
§438.330	Quality Assessment and Performance Improvement Program (QAPI) (b)(2)(c) Performance measurement	●	●	●
§438.330	Quality Assessment and Performance Improvement Program (QAPI) (b)(2)(c)(e)(2) Program review	●	●	●
42 CFR Part 438 Subpart F – Grievance and Appeal Systems				
§438.228	Grievance and Appeals Systems	●	◑	◑

Current Review Cycle Standards		2022	2023	2024
§438.400	Statutory basis, definitions, and applicability (b)	●	◑	◑
§438.402	Filing requirements (c)(1-3)	●	◑	◑
§438.404	Timely and adequate notice of adverse benefit determination (a-c)	●	◑	◑
§438.406	Handling of grievances and appeals (a)(b)	●	◑	◑
§438.408	Resolution and notification: Grievances and appeals (a-e)	●	◑	◑
§438.410	Expedited resolution of appeals	●	◑	◑
§438.414	Information about the grievance and appeal system to providers and subcontractors	●	◑	◑
§438.416	Recordkeeping and reporting requirement	●	◑	◑
§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	●	◑	◑
42 CFR Part 438 Subpart H – Additional Program Integrity Safeguards				
§455.104	Disclosure by Medicaid providers and fiscal agents: Information on ownership and control			●
§438.608	Program integrity requirements under the contract			●

** Accreditation standard that either fully met the non-duplication regulations and is deemed (in place of compliance review) or partially met, requiring some review within scheduled EQR activities.*

Scoring

Final scores for each section are denoted 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 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.

Table E-2 provides a summary of the aggregate results for the MCPs within Apple Health by compliance standard in Years 1 and 2 of the current three-year cycle.

Table E-2. Summary of the Aggregate Review Cycle Compliance Scores.

Compliance Standards Reviewed	Score*
Standard – Year 1 (2022)	
§438.208 - Coordination and continuity of care	95%
§438.210 - Coverage and authorization of services	53%
§438.214 - Provider selection (Credentialing)	96%
§438.228 - Grievance and appeals systems	97%
§438.242 - Health information systems	100%
§438.330 - QAPI	83%
Standard – Year 2 (2023)	
§438.100 - Enrollee rights	99%
§438.206 - Availability of services	90%
§438.208 - Coordination and continuity of care	85%

Compliance Standards Reviewed	Score*
§438.236 - Practice guidelines	91%
§438.242 - Health information systems	100%
§438.330 - QAPI	83%
§438.400 - Grievance System	99%

**Aggregate MCP point values were totaled and the sum was divided by the aggregate number of applicable elements in the standard to derive percentage scores.*

Tables E-3 and E-4 summarize the Years 1 and 2 scores of the current review cycle (2022–2024).

Table E-3. Summary of the Current Review Cycle Compliance Scores (Year 1 – 2022).

Compliance Area and CFR Citation	Year 1 (2022)									
	AMG		CCW		CHPW		MHW		UHC	
	MCO	BHSO	MCO	BHSO	MCO	BHSO	MCO	BHSO	MCO	BHSO
§438.208 - Coordination and continuity of care	75%	75%	100%	100%	100%	100%	100%	100%	100%	100%
§438.210 - Coverage and authorization of services	0%	0%	78%	78%	78%	78%	11%	11%	100%	100%
§438.214 - Provider Selection (Credentialing)	89%	89%	100%	100%	100%	100%	89%	89%	100%	100%
§438.228 - Grievance and Appeals Systems	94%	94%	98%	98%	100%	100%	91%	91%	100%	100%
§438.242 - Health Information Systems	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
§438.330 - QAPI	93%	93%	80%	80%	100%	100%	67%	67%	73%	73%

Table E-4. Summary of the Current Review Cycle Compliance Scores (Year 2 – 2023).

Compliance Area and CFR Citation	Year 2 (2023)									
	AMG		CCW		CHPW		MHW		UHC	
	MCO	BHSO	MCO	BHSO	MCO	BHSO	MCO	BHSO	MCO	BHSO
§438.100 - Enrollee rights	97%	97%	97%	97%	100%	100%	100%	100%	100%	100%
§438.206 - Availability of services	83%	81%	92%	90%	92%	90%	96%	95%	92%	90%
§438.208 - Coordination and continuity of care	80%	87%	87%	93%	80%	93%	73%	87%	80%	87%
§438.236 - Practice guidelines	89%	89%	89%	89%	89%	89%	89%	89%	100%	100%
§438.242 - Health Information Systems	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
§438.330 - QAPI	50%	50%	83%	83%	100%	100%	100%	100%	83%	83%
§438.400 Grievance System	95%	100%	100%	100%	100%	100%	98%	100%	100%	100%