Annual Technical Report

Washington Apple Health
Washington Health Care Authority

January 2020

Table of Contents

Index of Tables and Figures

Acronym List

ACH	Accountable Community of Health
AHAC	Apple Health Adult Coverage (Medicaid Expansion)
AHFC	Apple Health Foster Care
AHMC	Apple Health Managed Care
AH-IMC	Apple Health Integrated Managed Care
AHRQ	Agency for Healthcare Research and Quality
AMG	Amerigroup Washington, Inc.
ASAM	American Society of Addiction Medicine
ASO	Administrative Service Organization
BHA	Behavioral Health Agency
BH-ASO	Behavioral Health Administrative Service Organization
BHDS	Behavioral Health Data System
BHO	Behavioral Health Organization
BHSO	Behavioral Health Services Only
CANS	Child and Adolescent Needs and Strengths
CAHPS	Consumer Assessment of Healthcare Providers and Systems
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
CMS	Centers for Medicare & Medicaid Services
CY	Calendar Year
DOH	Department of Health
DBHR	Division of Behavioral Health and Recovery
DSHS	Department of Social and Health Services
EDI	Electronic Data Interchange
EDMA	(HCA) Enterprise Data Management and Analytics
EDV	Encounter Data Validation
EQR	External Quality Review
EQRO	External Quality Review Organization
FIMC	Fully Integrated Managed Care (term used in 2018 for AH-IMC)
GRBHO	Great Rivers Behavioral Health Organization
HCA	Health Care Authority
HEDIS	Healthcare Effectiveness Data and Information Set
ISCA	Information Systems Capabilities Assessment
MCO	Managed Care Organization
MHW	Molina Healthcare of Washington
NCQA	National Committee for Quality Assurance
NOABD	Notice of Adverse Benefit Determination
PACT	Program for Assertive Community Treatment
PAHP	Prepaid Ambulatory Health Plans
PCP	Primary Care Provider

PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
QAPI	Quality Assessment and Performance Improvement
QIRT	Quality Improvement Review Tool
QRT	Quality Review Team
RY	Reporting Year
SBHO	Salish Behavioral Health Organization
SERI	Service Encounter Reporting Instructions
SUD	Substance Use Disorder
TANF	Temporary Assistance for Needy Families
TMBHO	Thurston-Mason Behavioral Health Organization
UHC	UnitedHealthcare Community Plan
UM	Utilization Management
WISe	Wraparound with Intensive Services
WSIPP	Washington State Institute for Public Policy

Executive Summary

Apple Health, Washington's Medicaid program, serves over 1.8 million of the state's residents. Nearly 85% of Apple Health clients are enrolled in managed care. In 2019, the Washington State Health Care Authority (HCA) administered services for care delivery through contracts with managed care organizations (MCOs). The MCOs facilitate delivery of physical health care services and, in some regions, behavioral health services. The behavioral health organizations (BHOs), which are ceasing operation at the end of 2019, administered mental health care and substance use disorder (SUD) treatment in select regions. By 2020, the remaining regions will transition to the integrated managed care model.

Federal requirements mandate that every state Medicaid agency that contracts with managed care organizations provide for an external quality review (EQR) of health care services to assess the accessibility, timeliness and quality of care furnished to Medicaid enrollees. Comagine Health (formerly Qualis Health) conducted this 2019 review as Washington's Medicaid external quality review organization (EQRO). This technical report describes the results of this evaluation.

Information in this report was collected from MCOs and BHOs through review activities based on Centers for Medicare & Medicaid Services (CMS) protocols. Additional activities may be included as specified by contract, including Wraparound with Intensive Services (WISe) program review.

Washington's Medicaid Program

Under the direction of Senate Bill E2SSB 6312, behavioral health benefits will be fully integrated into the Apple Health managed care program, providing Medicaid enrollees with access to both physical and behavioral health services through a single managed care program no later than 2020. The transition to an integrated system began in 2016, with behavioral health services previously purchased and administered by regional BHOs being transferred to Apple Health MCOs. In 2019, Apple Health Integrated Managed Care, which combines physical health services with behavioral health and SUD treatment under one health plan, expanded to the Greater Columbia, King, Pierce, Spokane and North Sound regions.

The three remaining BHOs reviewed by Comagine Health in 2019 — Great Rivers BHO (GRBHO), Salish BHO (SBHO) and Thurston-Mason BHO (TMBHO) — will cease operations by January 1, 2020.

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

- Apple Health Family (traditional Medicaid)
- Apple Health Adult Coverage (AHAC) (Medicaid expansion)
- Apple Health Integrated Managed Care (AH-IMC)
- Apple Health Blind/Disabled
- Apple Health Foster Care (AHFC)
- State Children's Health Insurance Program (CHIP)
- Apple Health Behavioral Health Services Only (BHSO)

Description of EQR Activities

EQR federal regulations under 42 CFR Part 438 specify the mandatory and optional activities that the EQRO must address in a manner consistent with CMS protocols. The 2019 report includes strengths, opportunities for improvement and recommendations reflecting the results of the following:

- **MCOs**
  - Validation of performance measures, including Healthcare Effectiveness Data and Information Set (HEDIS®[1]) measures
  - Compliance monitoring, including follow-up of the previous year's corrective action plans
  - Validation of performance improvement projects (PIPs)
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS®[2]) consumer surveys

Note: the BHSO program is federally defined as a Prepaid Inpatient Health Program (PIHP) and as such requires EQR review. BHSO enrollees are served by the five MCOs and are included in the term "MCO" unless stated otherwise.

- **BHOs**
  - Compliance monitoring
  - Follow-up of the previous year's corrective action plans
  - Validation of PIPs
  - Validation of statewide performance measures

Description of Access, Timeliness, and Quality

Through assessment of the review activities described above, this report demonstrates how MCOs and BHOs are performing with regard to the delivery of quality, timely and accessible care. These concepts are summarized here.

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.

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[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[2] CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

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 thus 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.

Physical Health

Comagine Health's review of physical health care services delivered by Apple Health MCOs included an assessment of the compliance review and PIP validation conducted by the state interagency TEAMonitor and HCA, respectively; a validation and analysis of performance measures reported by the MCOs, which included HEDIS data and CAHPS survey results; and a review of prior-year EQR recommendations. Appendix A contains profiles of each MCO with summary results of their compliance reviews, PIP validation and performance measure validation.

TEAMonitor and HCA's review addressed services delivered by Apple Health MCOs, including physical health services and low to moderate level mental health services; integrated services provided by AH-IMC plans located in regions that were integrated in 2018, and services provided as part of the Behavioral Health Services Only (BSHO) program. Through BHSO, clients who are not eligible for medical managed care plans (such as those with Medicare as primary insurance) receive coverage for specialty behavioral health services; for example, SUD treatment.

Compliance Review

Washington's MCOs are evaluated by TEAMonitor, the interagency unit of the Health Care Authority and the Department of Social and Health Services (DSHS), on their compliance with federal and state regulatory and contractual standards. TEAMonitor's review assesses activities for the previous calendar year and evaluates MCOs' compliance with the standards set forth in 42 CFR Part 438, as well as those established in the MCOs' contracts with HCA for all programs, including Apple Health, Apple Health Integrated Managed Care, Apple Health Foster Care and Behavioral Health Services Only.

Performance Improvement Project Validation

MCOs are required to have an ongoing program of clinical and non-clinical PIPs that are designed to improve processes, health outcomes and enrollee satisfaction for all Apple health programs, including Apple Health, Apple Health Integrated Managed Care, Apple Health Foster Care and Behavioral Health Services Only. HCA assesses and validates the MCOs' PIPs to ensure they meet state and federal guidelines, include all Apple Health enrollees, and are designed, conducted and reported in a methodologically sound manner.

Performance Measure Validation

HEDIS is a widely used set of health care performance measures reported by health plans. HEDIS results can be used by the public to compare plan performance over five domains of care; they also allow MCOs to determine where quality improvement efforts may be needed. For the 2019 reporting year (RY, measuring 2018 data), MCOs submitted data on 53 specific measures. Comagine Health used these data to perform comparisons among MCOs and against national benchmarks, as well as to identify variations in measure performance across regions, Apple Health programs and demographic groups. Summary results from these analyses can be found in the *2019 Comparative and Regional Analysis Report*.

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

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The CAHPS survey assesses consumers' experiences with health care services and support. Developed by the U.S. Agency for Healthcare Research and Quality (AHRQ), the 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.

In 2019, the Apple Health MCOs conducted the CAHPS 5.0H Child Medicaid with Chronic Conditions survey of parents/caregivers of children enrolled in Apple Health. The full analysis is available in the *2019 Apple Health CAHPS® 5.0H Child Medicaid with Chronic Conditions Report*.[3]

Behavioral Health

Comagine Health's EQR of the state's three BHOs consisted of an abbreviated compliance review assessing the BHOs' adherence to state and federal regulatory and contractual requirements, an evaluation of the BHOs' PIPs, validation of two statewide performance measures and a review of prior-year EQR recommendations. The three remaining BHOs reviewed by Comagine Health in 2019 — Great Rivers BHO (GRBHO), Salish BHO (SBHO) and Thurston-Mason BHO (TMBHO) — will cease operations by January 1, 2020.

Compliance Review

Comagine Health's compliance review assessed each BHO's compliance with federal Medicaid managed care regulations and applicable elements of the BHOs' contract with the state in key areas, related, but not limited, to availability of services, coordination and continuity of services, coverage and authorization of services, subcontractual relationships and delegation of services, provider selection, health care information systems, practice guidelines, and quality assessment and program improvement. Additionally, for each BHO, Comagine Health interviewed one mental health agency, one SUD treatment agency and one dual (mental health/SUD) agency as well as performed onsite reviews at two behavioral health agencies (BHAs) to evaluate care coordination and credentialing standards. A

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[3] Washington State Health Care Authority and Comagine Health. *2019 Apple Health CAHPS® 5.0H Child Medicaid with Chronic Conditions Report.* August 2019. Available at: https://www.hca.wa.gov/assets/billers-and-providers/AHMC_CAHPS_2019.pdf

walk-through was also conducted to assess ADA compliance. Finally, Comagine Health reviewed the BHO's previous-year recommendations.

Each section of the compliance review protocol contains elements corresponding to relevant sections of 42 CFR Part 438, the state's contract with the BHOs, the Washington Administrative Code (WAC) and other state regulations where applicable.

PIP Validation

BHOs are required to have an ongoing program of performance improvement projects that are designed to assess and improve the processes and outcomes of the health care the BHOs provide. In 2019, BHOs were required to implement or maintain two PIPs, one clinical and one non-clinical; one of these focused on a SUD treatment area and one focused on children. PIPs are evaluated and validated each year to ensure they meet state and federal standards.

Performance Measure Validation

42 CFR §438.358 requires the annual validation of performance measures for managed care entities that serve Medicaid enrollees. In 2019, Comagine Health validated statewide performance data submitted by the state for two measures assessing access to and engagement with the state's mental health and SUD treatment services.

Summary of Recommendations

In its assessment of the degree to which MCOs and BHOs provided Medicaid enrollees with accessible, timely, quality care, this *2019 Annual Technical Report* explains to what extent the state's managed care plans are meeting federal and state regulations, contract requirements, and statewide goals, and where they need to improve. Comagine Health's recommendations to the state are intended to help improve Washington's overall Medicaid system of care. Subsequent sections offer further discussion.

Physical Health Recommendations and Opportunities for Improvement

Compliance Review – Opportunity for Improvement

In this year's review, MCO scores indicated that complying with the grievance system standard was difficult for some plans. Coverage and authorization, historically problematic, showed some improvement but remains a challenge.

- As the Apple Health program moves closer to a fully integrated managed care model, the state should maintain its focus on the areas of coverage and authorization, continuing to provide technical assistance to MCOs; supporting collaborative efforts between physical and behavioral health services; and implementing initiatives that will help ensure quality care for enrollees.

PIPs – Opportunities for Improvement

MCOs demonstrated need for improvement on PIP performance in 2019 RY, achieving more Not Met scores and fewer Met scores than in 2018 RY.

- To enhance the MCOs' ability to design a sound PIP, HCA should continue to provide MCOs with both ongoing training, specifically on the overall study design, and ongoing technical assistance with a focus on defining, streamlining and simplifying study questions.

- HCA should encourage MCOs to utilize rapid-cycle process improvement where feasible to accelerate change and results.

Performance Measure Validation – Recommendations

The following measures continue to fall under the 50th percentile nationally. These measures address prevention and access and are widely considered central to population health.

- Children's Access to Primary Care Providers (CAP) (7–11 and 12–19 year age groups)
- Prenatal and Postpartum Care (PPC)
- Adolescent Well-Care Visits (AWC)
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)
- Adults' Access to Ambulatory/Preventive Health Services (AAP)
- Breast Cancer Screening (BCS)

See the Summary of HEDIS Performance Measure Results section for more information on current and prior year rates.

As the MCOs focus on outcomes improvement efforts over the coming year, Comagine Health encourages the Washington State MCOs to continue to align quality improvement efforts and design initiatives with a concurrent goal of reducing provider burden and unintended variation at the practice level.

- In designing initiatives, the MCOs should find ways to minimize the need for providers to navigate variation in MCO processes. The behavioral health integration initiative has necessitated alignments of MCO programs; we recommend using lessons from behavioral health integration as a starting point for a similar initiative to improve outcomes on a limited number of high-priority HEDIS measures by aligning MCO quality efforts.

- We recommend the MCOs collectively identify a small number of closely related high-priority HEDIS measures around which to align improvement efforts, with the goal of reducing provider burden and care delivery variation.

Behavioral Health Recommendations

Compliance Review

The BHOs have reported that the BHAs have been affected by workforce shortages in their respective regions due to the increased enrollee capacity and their need for services.

- We recommend the state ensures the BHOs are analyzing network providers and specialties to show their networks are sufficient in number, mix and geographic distribution to meet the needs of the current and anticipated number of enrollees in the service area until the BHOs cease operations.

All three BHOs have policies, procedures and contract language regarding the coordination of care and services provided by the BHAs. However, the review of the BHOs' randomly chosen clinical records indicated that care coordination within all three BHO networks is poorly documented. In addition, there was little to no evidence of progress notes documenting correspondence, exchanges of information and plans for collaboration between clinical staff and other relevant treatment supporters.

- We recommend the state ensures the BHOs are monitoring the BHAs on adherence to care coordination contract requirements, which includes but is not limited to

- o   providing and documenting coordination of care for all enrollees with their clinical providers, specialty and allied providers, and PCPs

- o   documenting correspondence, exchanges of information, and a plan for collaboration between clinical staff and other relevant treatment supporters

For all three BHOs, the use and identification of needed practice guidelines varied. Variation included the collection and assessment of utilization data pertaining to prevalence of diagnoses as well as the identification of the types of services utilized within populations with intensive or specialized needs. Ongoing training to providers on implementation and usefulness of the clinical practice guidelines was limited or non-existent.

Additionally, one BHO did not submit evidence of annual monitoring on the effective use of the practice guidelines adopted by the BHO or evidence of interface between the QAPI program and the practice guidelines adoption process.

- • We recommend the state ensures the identification and adoption of practice guidelines are based on analysis of utilization data pertaining to prevalence of diagnoses as well as the identification of types of services used by populations with intensive or specialized needs.

- • Additionally, we recommend the state ensures training on the implementation of guidelines and monitoring for adherence to the guidelines continues for the behavioral health providers.

BHOs are required to submit a yearly evaluation to the state on the impact and effectiveness of the care and services provided to Medicaid enrollees. Although all three BHOs submitted a 2018 program evaluation, one BHO's report significantly lacked the key elements of an effective program review. The year-end evaluation included the aggregated results for the agencies without including the methodology or the criteria used to score the records, and listed only one item in the evaluation: measuring the interval between the request for service and the first offered intake.

- • If the BHOs were to continue operating, we would recommend the state develop a formal method for ensuring the BHOs evaluate, on a yearly basis, the impact and effectiveness of the care and services provided to Medicaid enrollees by the BHAs. The evaluation should include the results of administrative and clinical reviews performed by the BHOs. Additionally, the evaluation should include review criteria, methodologies, outcomes, committee descriptions/priorities and an executive summary outlining the individual BHO's priorities for the upcoming year based on analysis and evaluation of the previous year's data.

PIP Validation

If the BHOs were to continue operating, we would recommend the State ensure the BHOs develop PIPs that are designed, conducted and reported in a methodologically effective manner. The BHOs should consider the following:

- • During the PIP selection process, a thorough review and analysis of data should be conducted. Furthermore, when developing a data analysis plan, the methodology must be appropriate to the study question and adhere to a statistical analysis technique that indicates the statistical significance of any differences between the baseline and remeasurement periods.

- • When assessing the statistical significance, the confidence level needs to be stated.

- • To produce successful PIP outcomes, it is important to identify and implement robust interventions. Also, to aid in removing barriers to successfully achieving improvement for the PIP interventions, consider utilizing a range of quality tools and techniques, such as root-cause

analyses, driver diagrams, process mapping, failure modes and effects analysis (FMEA) and find, organize, clarify, uncover and start (FOCUS).

- Various committee meetings with stakeholders should be used as opportunities to identify and address regional barriers to the PIP interventions, which may be impacting the ability to achieve meaningful improvement.

Some of the BHOs struggled with determining next steps after data analysis revealed unintended outcomes or absence of statistically significant change.

- If the BHOs were to continue operating, we would recommend the State ensure the BHOs develop robust, system-level interventions responsive to barriers/challenges that may arise during the PIP process, which may include changes in guidelines, employing additional resources and/or establishing collaborative external partnerships with key stakeholders.

- Consideration should be given to testing changes on a small scale:

  o Rapid-cycle learning principles should be utilized where appropriate over the course of the PIP.

  o Undertaking shorter remeasurement periods allows adequate time for modifications to be made until the desired outcome is achieved and sustained.

  o Steps should be taken to identify improvement opportunities including, but not limited to, conducting barrier analyses to derive the improvement strategies to be implemented.

  o Adjusting intervention strategies early on leads to improvement occurring more efficiently, which can have longer term sustainability.

  o Data, both qualitative and quantitative, should be reviewed at least quarterly to ensure the PIP is moving in a successful direction.

Quality Strategy Status and Summary

State Medicaid agencies that contract with managed care organizations are required under federal regulations to have a quality strategy in place to assess and improve the quality of managed health care services.

Since its last quality strategy submission, reviewed by CMS in October 2017, the Washington Medicaid program has undergone significant changes. HCA has completed the statewide implementation of physical and behavioral health managed care, expanded value-based payment strategies, and realigned internally to support increased managed care oversight. Given these changes, it was determined by HCA that a major revision to the strategy was necessary.

Prior to updating the quality strategy, HCA staff conducted extensive document research and review, addressing both regulatory requirements and Washington initiatives. The revised strategy will focus attention on managed care oversight initiatives and activities, not just agency-wide initiatives, and demonstrate clearly defined goals and objectives for managed care oversight.

At the time of this report, HCA is thoroughly reviewing the updated strategy to ensure it reflects behavioral and physical health managed care integration, alignment and compliance with the CFR. After finalizing, the quality strategy will be submitted to CMS, distributed to all MCOs and posted on the state's website. HCA intends to ensure the plan is evaluated for effectiveness yearly.

Physical Health Care and Integrated Managed Care Provided by Apple Health Managed Care Organizations

Introduction

Throughout calendar year (CY) 2018, five managed care organizations (MCOs) delivered physical health care services to Apple Health managed care (Medicaid) enrollees across the State of Washington:

- Amerigroup Washington, Inc. (AMG)

- Community Health Plan of Washington (CHPW)

- Coordinated Care of Washington (CCW)

- Molina Healthcare of Washington (MHW)

- UnitedHealthcare Community Plan (UHC)

For Medicaid enrollees in the Southwest Washington region (Clark and Skamania counties) in 2018, integrated managed care — physical health, mental health and SUD treatment services — was coordinated through CHPW and MHW. In the North Central region (Chelan, Douglas and Grant counties), enrollees received integrated managed care through AMG, CCW and MHW.

Figure 1, provided by HCA, identifies the MCOs and the counties they served throughout 2018. In Clallam County, enrollment was voluntary because only one MCO was providing services in the county due to having a sufficient network for enrollees.

Figure 1. Washington Apple Health MCO Coverage by County.
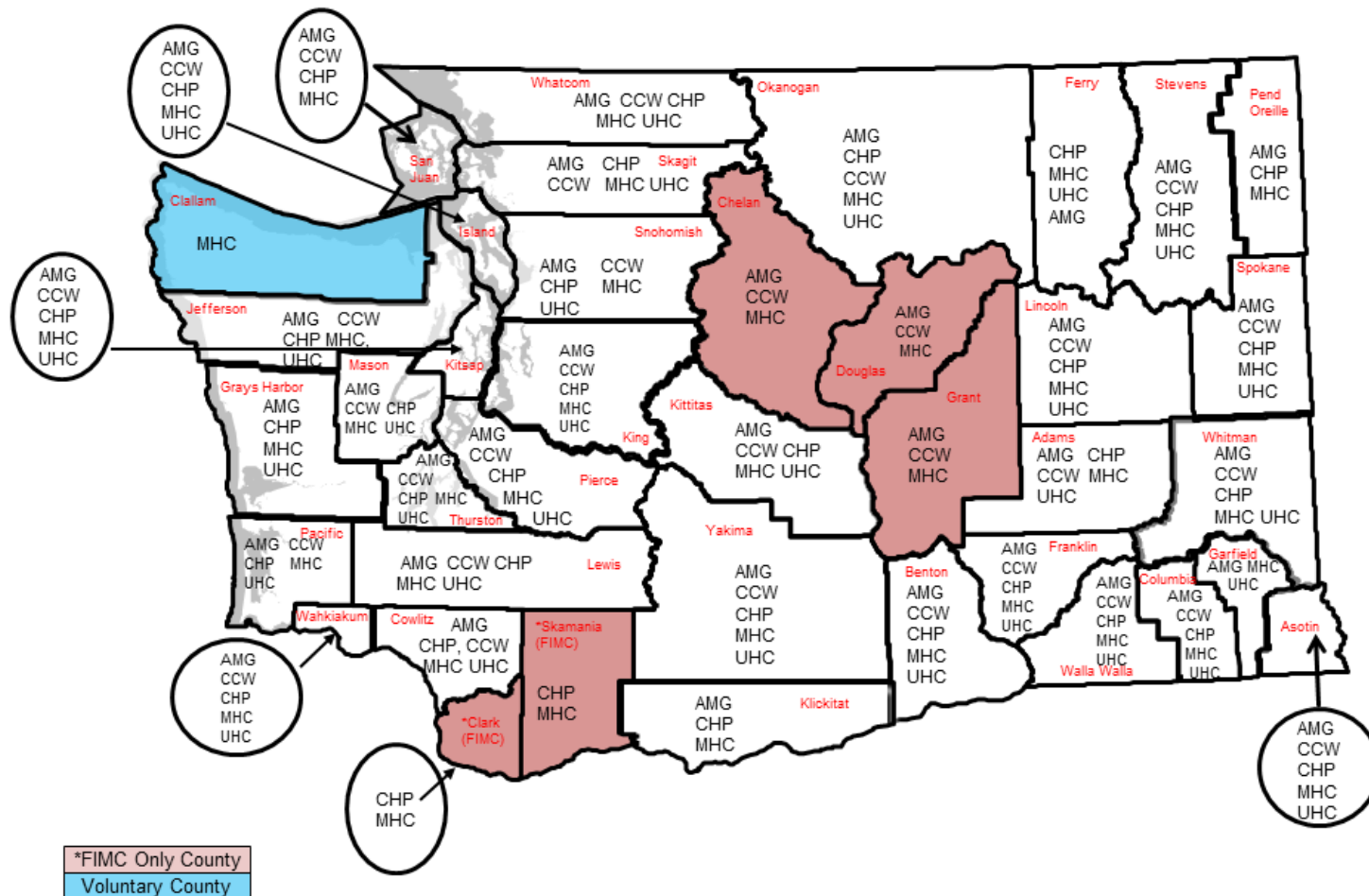
Overview of Apple Health Enrollment Trends

In Washington, Medicaid enrollees are covered by five MCOs through the following programs: Apple Health Family (traditional Medicaid), Apple Health Adult Coverage (Medicaid expansion), Apple Health Blind/Disabled, Integrated Managed Care, State Children's Health Insurance Program CHIP, AHFC AND Behavioral Health Services Only (BHSO).

As of December 2018, the majority of Medicaid enrollees were enrolled in Apple Health Family (traditional Medicaid; 47%) or Apple Health Adult Coverage (Medicaid expansion; 32%). The remaining membership was enrolled in Apple Health Integrated Managed Care (11%), Apple Health Blind/Disabled (5%), Apple Health Foster Care (2%), or State Children's Health Insurance Program (4%).

Coordinated Care of Washington serves as the managed care health plan for Apple Health Foster Care, the statewide foster care program. Members covered include 23,930 children and youth in foster care and adoption support, young adults (18–21 years) in extended foster care and young adults (18–26 years) who have aged out of foster care.

Medicaid enrollment demographics vary across programs. Most members of the Apple Health Family program (traditional Medicaid) are under the age of 20 (85%), while the majority of members in the Apple Health Adult Coverage program (Medicaid expansion) are between the ages of 21 and 44 (61%), and 33% of members in that program are between the ages of 45 and 64.

It is important to note that the relative distribution of these members is not uniform across MCOs. For example, 45% of AMG's members are enrolled in Apple Health Adult Coverage (Medicaid expansion), while only 26% of MHW's members are enrolled in that program. Because this variation in Medicaid program mix by MCO can affect HEDIS performance outcomes, it is important to monitor performance at the plan level and at the plan and program level. As MCOs continue to transition to the AH-IMC model, plan and program enrollment will continue to change.

Figures 2–4 show the distribution of Apple Health enrollees by program, age and both program and age. Note that these data are sourced from the member-level data submitted by MCOs and are based on the total number of enrollees.

Figure 2. 2019 RY Enrollee Population by Apple Health Program.

Legend:
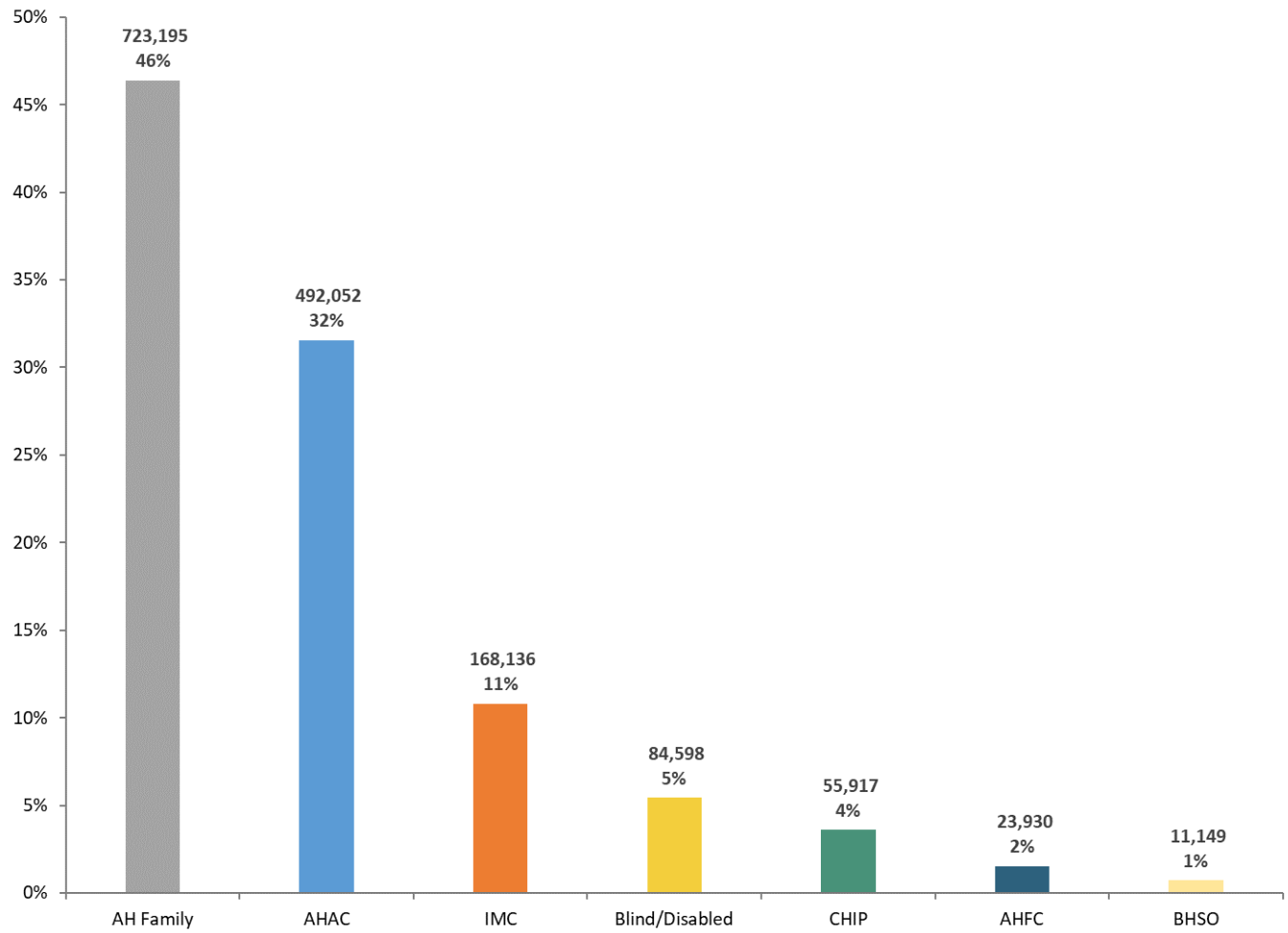
- **Apple Health (AH) Family (Traditional Medicaid)**
- **Apple Health Adult Coverage (AHAC) (Medicaid Expansion)**
- **Apple Health Integrated Managed Care (AH-IMC)**
- **Apple Health Blind/Disabled**
- **Statewide Children's Health Insurance Program (CHIP)**
- **Apple Health Foster Care (AHFC)**
- **Behavioral Health Services Only (BHSO)**

Figure 3. 2019 RY Enrollee Population by Apple Health Program and Age Range.
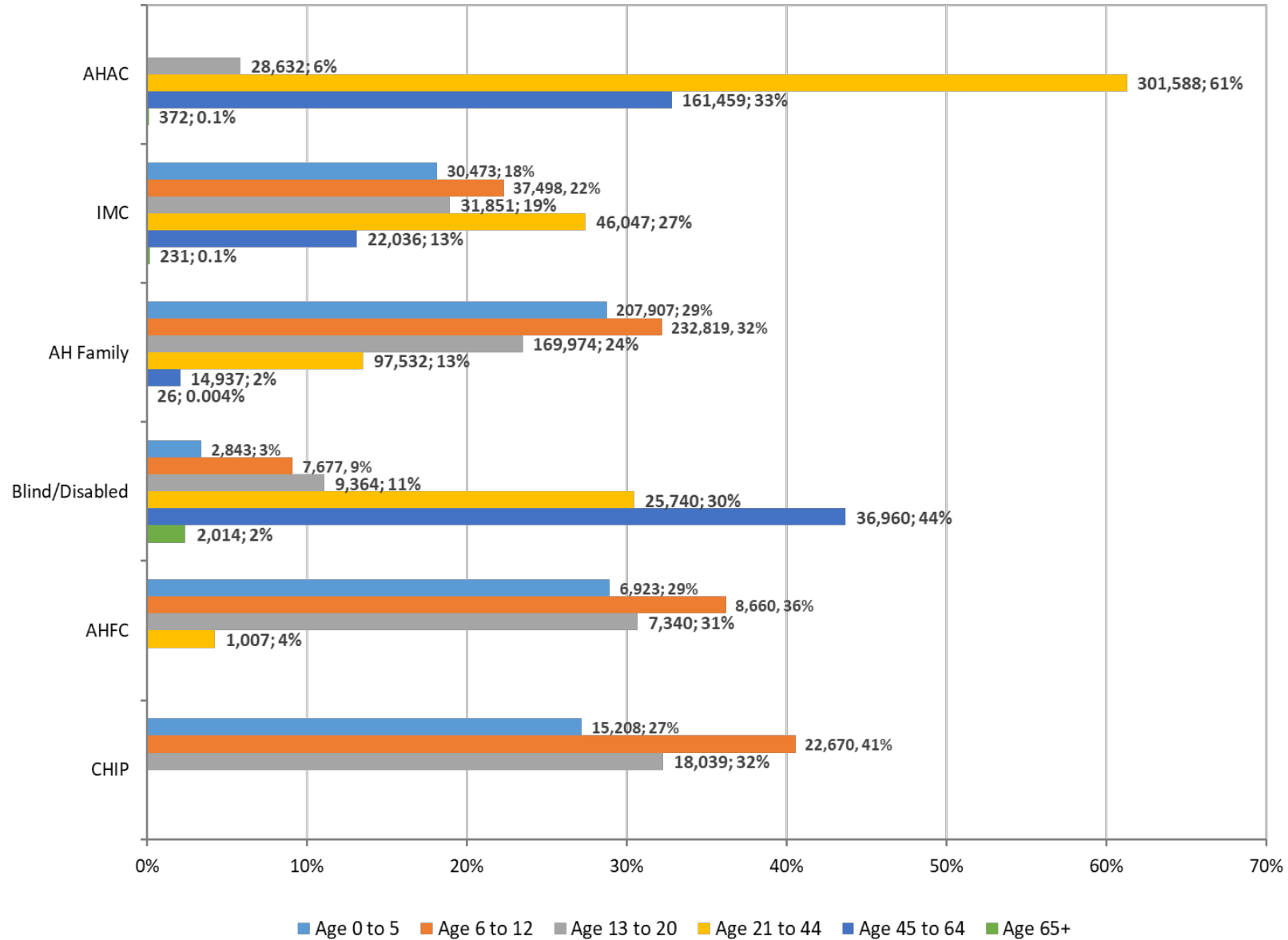
Figure 4. 2019 RY Enrollee Population by Apple Health Program and MCO.

Legend: AHAC | IMC | AH Family | Blind/Disabled | AHFC | CHIP

AMG:
- AHAC: 68,977; 45%
- IMC: 4,768; 3%
- AH Family: 63,323; 42%
- Blind/Disabled: 10,612; 7%
- CHIP: 4,040; 3%

CCW:
- AHAC: 58,962; 31%
- IMC: 13,498; 7%
- AH Family: 76,747; 40%
- Blind/Disabled: 11,282; 6%
- AHFC: 23,930; 13%
- CHIP: 5,160; 3%

CHPW:
- AHAC: 80,421; 32%
- IMC: 16,645; 7%
- AH Family: 129,882; 51%
- Blind/Disabled: 15,979; 6%
- CHIP: 9,585; 4%

MHW:
- AHAC: 190,940; 26%
- IMC: 133,225; 18%
- AH Family: 358,819; 48%
- Blind/Disabled: 32,969; 4%
- CHIP: 28,957; 4%

UHC:
- AHAC: 92,752; 44%
- AH Family: 94,424; 45%
- Blind/Disabled: 13,756; 7%
- CHIP: 8,175; 4%

Summary of Results: Compliance Review

The state interagency TEAMonitor annually evaluates Washington's MCOs on their compliance with federal and state regulatory and contractual standards, including those set forth in 42 CFR Part 438, as well as those established in the MCOs' contracts with HCA. Compliance with these standards reflects accessibility, timeliness and quality of care. TEAMonitor's review includes assessment of each Medicaid managed care program, including Apple Health, Apple Health Foster Care, Apple Health Integrated Managed Care and Behavioral Health Services Only.

HCA evaluated the efficiency and effectiveness of the TEAMonitor process and determined to continue annual compliance review with CFR-required elements on a three-year rotating schedule for full review. This process allowed the monitoring team to have additional focus on elements in the managed care program that were changing or newly implemented. It also allowed TEAMonitor to devote resources to individual enrollee and provider file review to monitor key aspects of managed care, which focus on complex or changing aspects of the program, such as utilization management.

In 2019, TEAMonitor fully reviewed the following protocol sections:

- 438.228 – Grievance Systems

- 438.214 – Provider Selection/Credentialing

- 438.240 – Quality Assessment and Performance Improvement Programs (QAPI)

In addition, plans were reviewed on elements that received Partially Met or Not Met scores in 2018 RY to validate improvement or need for further corrective action.

For a listing of regulatory standards by which MCOs are evaluated, see Appendix C.

Methodology

The TEAMonitor review process is a combined effort by clinical and non-clinical staff and subject matter experts. Desk review includes assessment of MCO policies and procedures, program descriptions, evaluations and reports. TEAMonitor also reviews individual enrollee files and denials, appeals, grievances, health home services, care coordination and more. Also assessed are prior-year corrective action plans (CAPs) implemented by the MCOs. After review, HCA staff share results with the MCOs through phone calls and onsite visits. Each MCO then receives a final report that includes compliance scores, notification of CAPs for standards not fully 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 MCOs on each compliance standard according to a metric of Met, Partially Met, and Not Met, each of which corresponds to a value on a point system of 0–3.

- Scores of 0 and 1 indicate Not Met

- Score of 2 indicates Partially Met

- Score of 3 indicates Met

Final scores for each section are denoted by a fraction indicating the points obtained (the numerator) relative to all possible points (the denominator). For example, in a section consisting of four elements in

which the MCO 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 MCO's total points would be 10, yielding a score of 10 out of 12.

TEAMonitor's file review scoring is based on the following: "Met" is 100–90%; "Partially Met" is 89–60%, and "Not Met" is 59% and below.

Summary of Compliance Results

Overall, MCO compliance varied by standards. Below are a few notable areas:

- Most MCOs fully or nearly fully met standards for provider selection and for quality assessment and performance improvement programs (QAPI).

- UHC received recognition for following a best practice for including excerpts of its PIP and CAHPs reports in its QI program evaluation.

- Two plans, MHW and UHC, fully met or nearly fully met all elements within the three main areas reviewed in 2019 (grievance systems, provider selection, and quality assessment and performance improvement).

- Most MCOs adequately addressed prior-year findings and received verification and full recognition of CAPs completion. However, 2018 CAPs related to coverage and authorizations saw little improvement this year, with no plans fully meeting criteria for all elements.

The following tables provide a summary of all MCO scores by compliance standard. MCOs with elements scored as Partially Met or Not Met were required to submit CAPs to HCA. MCOs were scored on these elements in the first half of the calendar year. Because MCOs may have implemented CAPs since that time to address specific issues, scores may not be indicative of current performance.

Grievance system

Figure 5 shows the 2019 grievance system scores by MCO.

- CCW and MHW improved to fully meet the criteria from previous years except for a grievance system standard. Two plans fully met all of the standards for the Grievance System.

- Elements not met by three plans included proper classification of appeals, resolution and notification of grievances and appeals, and expedited resolution of appeals.

Figure 5. 2019 Grievance System Compliance Scores* by MCO.
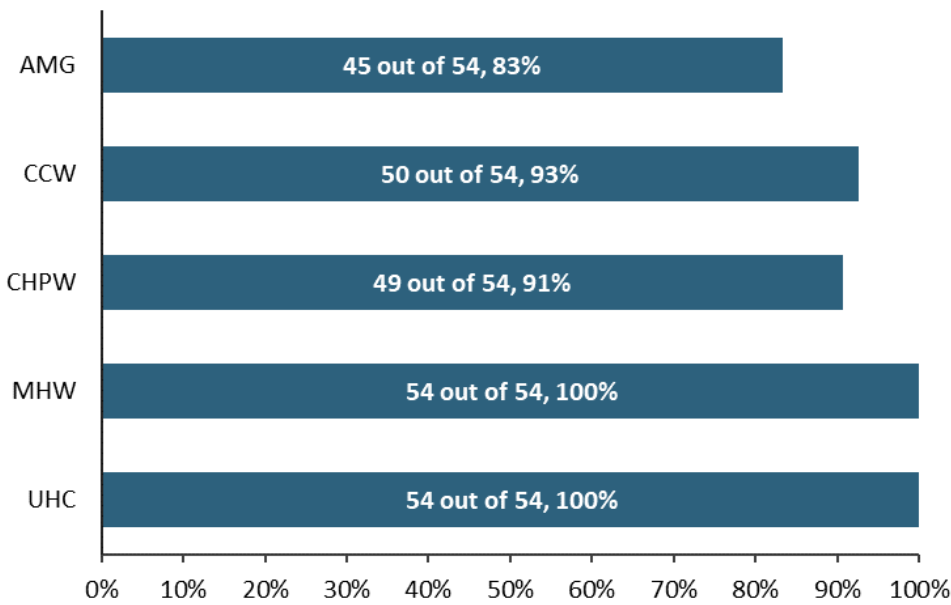
*Out of a total possible score of 54.

Provider selection (credentialing)

Figure 6 shows the 2019 provider selection scores by MCO. Four of five plans fully met standards for this section.

- One plan did not meet one of the elements (regarding a process and operationalizing high categorical risk enrollment verification of providers) and only partially met another.

Figure 6. 2019 Provider Selection (Credentialing) Scores* by MCO.
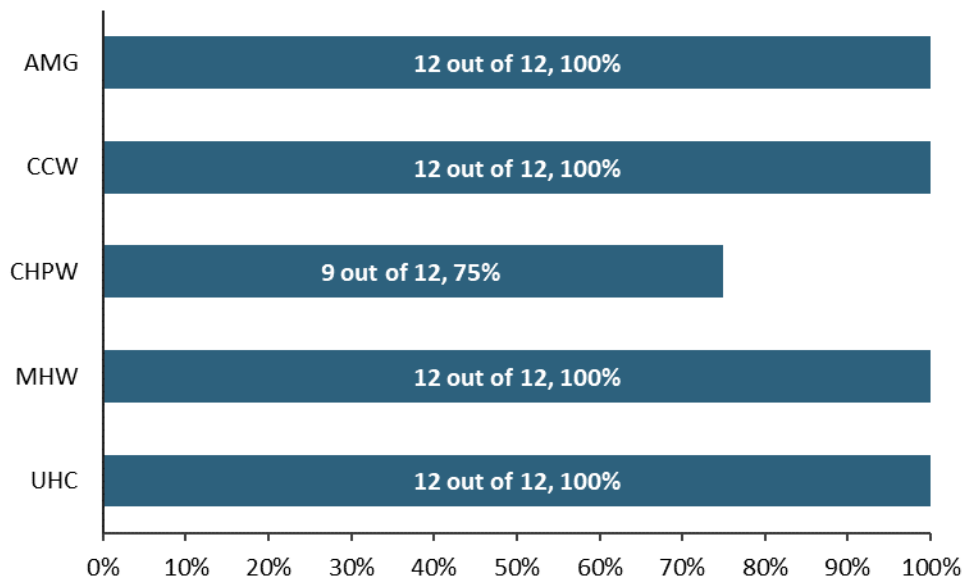
*Out of a total possible score of 12.

Quality assessment and performance improvement program (QAPI)

Figure 7 shows the 2019 QAPI scores by MCO. All plans fully met four of the five QAPI elements.

- One plan did not meet the element for provider complaints and appeals. Two plans only partially met this element. Those that did not fully meet the element received CAPs to address adequate policy and procedure to process, track and record all provider complaints and appeals, including a quality improvement structure and the ability for the MCO to accept and process provider complaints.

Figure 7. 2019 QAPI Scores* by MCO.
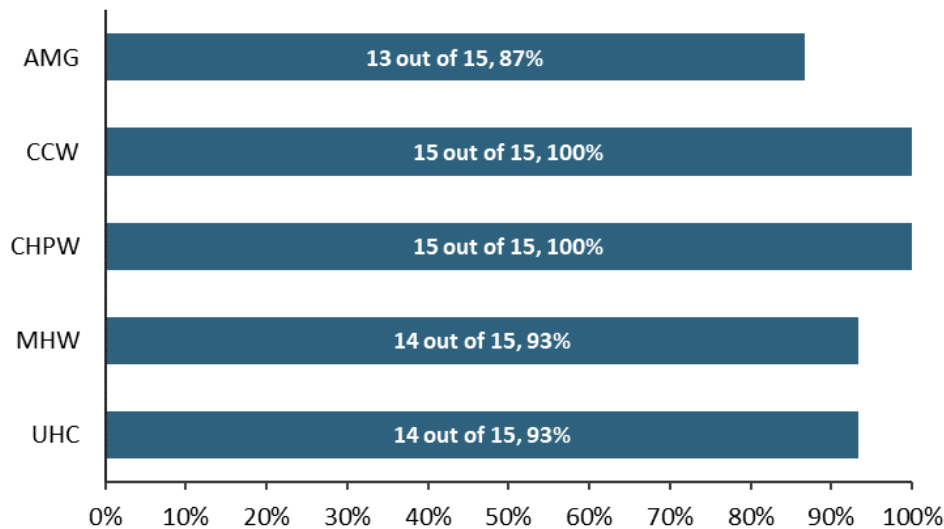
*Out of a total possible score of 15.

TEAMonitor reviewed and scored corrective action plans from 2018 for the following standards:

Availability of services

After review, the two plans that partially met elements within this standard in 2018 fully met all elements in 2019.

Program integrity

Four of five plans fully met the criteria for all elements after partially meeting or not meeting criteria in 2018. These plans provided documentation evidencing the use of the provider appeal process for program integrity activities, the process in place for the whistleblower program and the process for reporting overpayment. HCA issued corrective action to the plan not fully meeting the elements, to ensure completion.

Coordination and continuity of care

The care coordination standard related to assessment and treatment plans was somewhat improved for the MCOs, with two plans fully meeting and two plans not meeting this standard.

- One plan did not meet the standard for coordination between contractors and external entities, a repeat finding. The criteria were not met due to continued findings within file review regarding lack of the case manager checking internal systems prior to enrollee contact. Issues centered on lack of documentation for activities, including follow-up on issues identified, clinically appropriate care and informed interventions.

Coverage and authorization

After re-review, MCO performance in this area, which has historically been a problem, showed little improvement, with all plans receiving findings for the authorization of services standard. Findings, among others, were related to elements missing from plans' utilization management (UM) program description and/or UM program evaluation, incomplete or outdated lists of clinical and non-clinical staff involved in UM activities, and insufficient inter-rater reliability reports.

- None of the five plans fully met the criteria regarding authorization of services.

- Only MHW fully met the standard for notice of adverse benefit determination. Plans were cited for sending letters to enrollees that did not meet HCA criteria for readability and clarity, not including information in the notifications explaining why the requests were denied, and using outdated grievance and appeal inserts, among other reasons.

- Three plans did not meet criteria regarding timeframes for decisions.

- Two plans (MHW and UHC) fully met the criteria for the element regarding emergency and post-stabilization services (after being required to provide a corrective action plan in 2018).

Enrollee rights

All plans fully met the criteria for all elements of enrollee rights.

Practice guidelines

Only one plan did not meet all criteria in a follow-up review of this standard, receiving a repeat finding for the application of practice guidelines element. The plan did not demonstrate steps taken to ensure decision-making in the areas of utilization management or coverage determinations and other functional areas is consistent with adopted practice guidelines.

Subcontractual relationships and delegation

Only one plan (AMG) required a re-review in 2019 and fully met the element regarding monitoring performance of subcontractors.

Table 1 shows a summary of TEAMonitor's 2019 compliance reviews and number plans with findings for each review area.

Table 1. TEAMonitor Compliance Review: Summary of Issues.

Compliance Area 42 CFR and Apple Health Contract Citation	Number of Plans with Findings
Grievance Systems	
438.228 Grievance systems	1
438.402(a) The grievance system	2
438.402(b)(1) Filing requirements – Authority to file	1
438.406(a) Handling of grievances and appeals – General requirements, 13.1	2
438.408(a) Resolution and notification: Grievances and appeals – Basic rule, 11.4.5 and 13.3.10	2
438.408(b) and (c) Resolution and notification: Grievances and appeals – specific timeframes and extension of timeframes, 13.3.10 and 13.4.3	3
438.408(d) and (e) Resolution and notification: Grievances and appeals – Format of notice and content of notice of appeal resolution, 13.3.11	1
438.410 Expedited resolution of appeals, 13.4.5	1
Provider Credentialing	
438.214(a) General Rules and 438.214(b) Credentialing and re-credentialing requirements	1
438.214 Provider selection (e) State requirements	1
Quality Assessment and Performance Improvement Program (QAPI)	
438.66(c)(3) - Provider Complaints and Appeals	3
Program Integrity Requirements	
438.608(a)(b) Program integrity requirements, 12.6	1
Coordination & Continuity of Care	
438.208(c)(2) Assessment and (3) Treatment plans, 14.3	2
438.240(b)(4) Care Coordination Oversight, 14.10	1
Coordination & Continuity of Care - Apple Health Contract	
Transitional Care	1
Coordination Between the Contractor and External Entities	1
Coordination Between the Contractor and External Entities - AHFC	1
Coverage and Authorization	
438.210(b) (1) (2) (3) Authorization of services	5
438.210(c) Notice of adverse action	4
438.210(d) Timeframe for decisions	3
Outpatient Mental Health, 17.1	2
Emergency Contraceptives 17.1.16.1.7	1
Practice Guidelines	
438.236(d) Application of practice guidelines, 7.8.1.6	1

Opportunity for Improvement

In this year's review, MCO scores indicated that complying with the grievance system standard was difficult for some plans. Coverage and authorization, historically problematic, showed some improvement but remains a challenge.

As the Apple Health Program moves closer to a fully integrated managed care model, the state should maintain its focus on the areas of coverage and authorization, continuing to provide technical assistance to MCOs; supporting collaborative efforts between physical and behavioral health services; and implementing initiatives that will help ensure quality care for enrollees.

Performance Improvement Project Validation

Medicaid MCOs are federally required to design and implement a series of PIPs intended to effect sustainable improvements in care delivery.

Apple Health MCOs were required to conduct the following PIPs in CY 2018:

- one clinical PIP (not age-specific) piloting a behavioral health intervention that is evidence-based, research-based, or a promising practice, including but not restricted to those recognized by the Washington State Institute for Public Policy (WSIPP)

- one collaborative clinical statewide PIP, conducted in partnership with the Department of Health (DOH), focused on improving well-child visit rates in infants, young children and adolescents

- one non-clinical PIP of the MCO's choosing

In addition to the PIPs referenced above, the Apple Health Foster Care plan, CCW was required to complete the following PIPs related to that program's population:

- one additional PIP of the MCO's choosing

- one non-clinical PIP developed in partnership with DSHS and HCA

In addition to the PIPs required of all Apple Health MCOs, Integrated Managed Care plans were required to complete the following PIP:

- one clinical PIP piloting a behavioral health intervention for children including, for example, those found in the current WSIPP report

Integrated Managed Care PIPs were required to include both AH-IMC and BHSO enrollees. Table 2 shows the PIP requirements.

Table 2. PIPS required of Apple Health Managed Care Plans in 2018.

PIP Type	Apple Health Managed Care (AHMC)	Apple Health Integrated Care, including both AH-IMC and BHSO enrollees	Apple Health Foster Care (AHFC)
One clinical, WSIPP, adult		X	
One clinical, WSIPP, child		X	
One clinical, WSIPP, not age-specific	X		X
One clinical, in partnership with DOH statewide (collaborative)	X	X	X
One non-clinical of MCO's choosing	X	X	
One additional of the MCO's choosing			X
One non-clinical, in partnership with HCA and DSHS			X

Please note that MCO PIPs may fulfill more than one contract requirement (for example, a plan could combine its Apple Health and Integrated Managed Care PIP if it met both PIP and population needs and requirements).

As a component of its review, HCA conducted a validation of the MCOs' PIPs. Table 3 displays the MCOs' PIP study topics. TEAMonitor scored the MCOs' PIPs as Met, Partially Met or Not Met, according to how well they performed against a checklist of elements designed to measure success in meeting the standards specified by CMS. For a full description of HCA's methodology and scoring for PIP validation, as well as the elements associated with the respective scores, please see Appendix B.

Table 3. PIP Study Topics by MCO.

MCO	Study Topic		Result
Amerigroup (AMG)	Clinical PIP: Washington State Institute for Public Policy Adult (AHMC, FIMC)	Clinical Mental Health Intervention Adult (PIP) – WSIPP evidence based collaborative effort for depression, anxiety comorbid depression and chronic health treatment	Not Met
	Clinical PIP: Washington State Institute for Public Policy Children (AHMC, FIMC)	Clinical Mental Health Intervention Adolescent (PIP) – WSIPP evidence-based collaborative effort for depression, anxiety comorbid depression and chronic health treatment	Not Met
	Clinical PIP: Collaborative Well-Child Visits (AHMC)	Collaborative MCO Well-Child Visit Rate PIP	Partially Met
	Non-Clinical PIP (AHMC)	Improving Member Engagement and Satisfaction	Not Met
Coordinated Care of Washington (CCW)	Clinical PIP: Washington State Institute for Public Policy Adult (FIMC)	Improving Antidepressant Medication Adherence in Adult Members (18 to 64 Years Old), who are eligible for enrollment with Medicaid through CCW.	Not Met
	Clinical PIP: Washington State Institute for Public Policy Children (FIMC)	Improving Adherence with ADHD Follow-up Visits and Medications in Children with ADD Ages 6-12 Years Old	Not Met
	Clinical PIP: Washington State Institute for Public Policy (AHMC, AHFC, FIMC)	Decreasing Overutilization of Multiple Physicians and Pharmacies to Access Opioids in Members 18-64	Not Met
	Clinical PIP: Collaborative Well-Child Visits (AHMC, AHFC, FIMC)	Collaborative MCO Well-Child Visit Rate PIP	Partially Met
	Non-Clinical PIP (AHMC, FIMC)	Improving Adult Male Access to Preventative/Ambulatory Health Services in Members Aged 20-64 Years (AAP)	Not Met
	Non-Clinical PIP: Clinical or Non-Clinical (AHFC, FIMC)	Improving asthma medication adherence in children aged 5-18	Partially Met
	Additional PIP: Clinical or Non-Clinical (AHFC)	Improving Well-Visit Claims at School-Based Clinics (SBHC) for	Not Met

MCO	Study Topic		Result
		Members in Foster Care Ages 6 to 18	
	Non-Clinical PIP in Partnership with MCO, DSHS & HCA (AHFC)	Improving Access to Assigned Primary Care Provider for Apple Health Foster Care Members Ages 12 Months to 19 Years Old	Not Met
Community Health Plan (CPHW)	Clinical PIP: Washington State Institute for Public Policy Adult (FIMC)	Outpatient Engagement Post Psychiatric Inpatient Hospitalization	Partially Met
	Clinical PIP: Washington State Institute for Public Policy Children (FIMC)	Caregiver Attachment in Young Children Exposed to Trauma	Partially Met
	Clinical PIP: Washington State Institute for Public Policy (AHMC)	Improving Antidepressant Medication Management through Brief Pharmacist Interventions	Partially Met
	Clinical PIP: Collaborative Well-Child Visits (AHMC)	Collaborative MCO Well-Child Visit Rate PIP	Partially Met
	Non-Clinical PIP (AHMC)	Improving Utilization for High-Risk Members through Community Care Coordination	Not Met
Molina Healthcare of Washington (MHW)	Clinical PIP: Washington State Institute for Public Policy Adult (AHMC, BHSO, FIMC)	Collaborative Primary Care for Depression	Partially Met
	Clinical PIP: Washington State Institute for Public Policy Children (BHSO, FIMC)	Effective Provider Collaboration: Enhancing Behavioral Parent Training (BPT) for Parents of Children with Attention Deficit Hyperactivity Disorder (ADHD)	Not Met
	Clinical PIP: Collaborative Well-Child Visits (AHMC, FIMC)	Collaborative MCO Well-Child Visit Rate PIP	Partially Met
	Non-Clinical PIP (AHMC, FIMC)	Bridging the Gap: Level of Provider Engagement and Quality Improvement	Partially Met
UnitedHealthcare Community (UHC)	Clinical PIP: Washington State Institute for Public Policy (AHMC)	Increase Antidepressant Treatment Plan Compliance for Adult, Female, TANF members diagnosed with depression (antidepressant medication management)	Partially Met
	Clinical PIP: Collaborative Well-Child Visits (AHMC)	Collaborative MCO Well-Child Visit Rate PIP	Partially Met
	Non-Clinical PIP (AHMC)	Increasing The Rate of Members Receiving Diabetic Education Services	Met

Summary of PIP Validation Results

Outlined below are summaries of each MCO's PIPs and the scores awarded to each following review. MCOs demonstrated need for improvement on PIP performance in 2019 RY, achieving more Not Met scores and fewer Met scores than in 2018 RY. Findings were related to, among other issues, PIPs having ambiguous study designs with overly broad study questions, documentation deficiencies, and insufficient data analysis and monitoring. Two plans were issued significant corrective action to address poor performance in the PIP program, including developing a plan for addressing the findings and participating in monthly technical assistance meetings with HCA.

Amerigroup Washington, Inc. (AMG)

Summary/Interventions

Clinical PIP: Washington State Institute for Public Policy Adult (AHMC, FIMC) – Not Met

Mental Health Intervention, Adult – "WSIPP evidence-based collaborative effort for depression, anxiety comorbid depression and chronic health treatment"

The intent of this PIP was to pilot an evidence- and research-based (or promising practice) mental health intervention, focused on the adult population, that is recognized by the Washington State Institute for Public Policy WSIPP Reports.

AMG submitted incorrect PIP validation documentation that was not previously approved by HCA. These documents were also submitted past the submission deadline. AMG received a score of Not Met.

Clinical PIP: Washington State Institute for Public Policy Children (AHMC, FIMC) – Not Met

Mental Health Intervention, Adolescent – "WSIPP evidence-based collaborative effort for depression, anxiety comorbid depression and chronic health treatment"

The intent of this PIP was to implement an adolescent-focused mental health intervention that is evidence- and research-based (or promising practice) as recognized by the Washington State Institute for Public Policy WSIPP Reports. AMG submitted incorrect PIP validation documentation that was not previously approved by HCA. These documents were also submitted past the submission deadline. AMG received a score of Not Met.

Clinical PIP: Collaborative Well-Child Visits (AHMC) – Partially Met

"Collaborative MCO Well-Child Visit Rate PIP"

This PIP was initiated in mid-2016 through an MCO peer collaborative with the aim of improving statewide well-child visit rates in infants (0–15 months), children (3–6 years), and adolescents (12–21 years). During CY 2018, the intervention grew to 35 clinics targeting the 3- to 6-year-old population (W34 HEDIS measure).

Although an empanelment process geared toward outreach and educational activities took place, this PIP received a Partially Met score for incongruencies relative to the PIP study design and how the project was actually executed in 2018. For example, the pilot clinics reported additional data measures that were not clearly identified, and the MCO did not explain how these measures would be integrated into the study design. There was misalignment between data analysis and the prospective data analysis plan, and the interventions focused on only one of the three populations identified in the PIP.

Non-Clinical PIP (AHMC) – Not Met

"Improving Member Engagement and Satisfaction"

This PIP was in its second year during CY 2018. Though the purpose is intended to achieve better outcomes relative to member engagement and satisfaction, it was unclear how these are defined.

The study question is, "Will increased culturally appropriate phone calls, mailings, emails, texts and incentives to members combined with increased communication, education and partnership to promote the relative HEDIS measures with providers, result in effectively increasing member engagement and satisfaction in their own health care?" However, it was not written in a clear and easily understandable format.

This PIP was scored Not Met because 2018 data were not provided, sections of the PIP validation worksheet were not updated, and 2018 RY feedback from HCA was not incorporated into the PIP responses.

TEAMonitor-Identified Opportunities for Improvement

- Before implementing a PIP, review baseline data to ensure a problem or need truly does exist.

- Develop unambiguous study questions that are easily understood and answerable.

- Establish well-defined, objective measure indicators to track performance over time.

- Define the PIP measurement periods to ensure data collection timelines are fulfilled and reporting timeframe requirements are met.

Coordinated Care of Washington (CCW)

Summary/Interventions

Clinical PIP: Washington State Institute for Public Policy Adult (FIMC) – Not Met

"Improving Antidepressant Medication Adherence in Adult Members (18 to 64 Years Old), who are eligible for enrollment with Medicaid through CCW"

The purpose of this PIP was to improve overall quality of life and well-being of adults ages 18 to 64 years with a diagnosis of major depressive disorder who were receiving treatment and to increase HEDIS AMM rates. During CY 2018, this PIP was in its second year, yet new interventions were not carried out.

This PIP received a Not Met score for various reasons, including

- the lack of a WSIPP strategy

- the study question was not written in a simple and answerable format

- an insufficient data analysis plan; include improvement strategies as a result of the data analysis

- an approach to monitor the PIP progress

Clinical PIP: Washington State Institute for Public Policy Children (FIMC) – Not Met

"Improving Adherence with ADHD Follow-up Visits and Medications in Children with ADD Ages 6-12 Years Old"

This PIP was in its second year during CY 2018. Utilizing NCQA definitions of medication adherence and visit follow-up, CCW sought to improve abidance with ADHD follow-up visits and medications as a means to reduce ADHD symptomology, prevent substandard social and emotional development, and decrease the risk of worsening ADHD symptoms.

This PIP received a Not Met score for various reasons, including the lack of a WSIPP strategy, the study question not being written in a simple and answerable format, insufficient data analysis plan, lack of improvement strategies as a result of the outlined data analysis, and lack of a defined approach to monitor the PIP progress. The MCO identified the study design as unsound, with no change attributable to the interventions.

Clinical PIP: Washington State Institute for Public Policy (AHMC, AHFC, FIMC) – Not Met

"Decreasing Overutilization of Multiple Physicians and Pharmacies to Access Opioids in Members 18-64"

CCW was seeking to pilot educational interventions for members identified as having opioid prescriptions from more than four physicians or as obtaining opioid prescriptions from more than four pharmacies. The MCO began monitoring data in CY 2019 as it relates to the new 2018 HEDIS measure Use of Opioids from Multiple Providers. The members who met the outlined criteria were enrolled in the Patient Review and Coordination (PRC) Program, with access restricted to only one physician, one pharmacy, and one emergency system. The identified interventions included opioid overutilization education, PRC Program enrollment, and SUD care management.

A score of Not Met was received, as the PIP did not include key aspects such as complete demographics and epidemiology of members' health needs, care or services; the study question was broad-based with a focus on HEDIS data to determine the measurable impact on the study population, although this data is unable to answer the study question; insufficient measurable indicators; the overall study design lacked clarity; an intervention recognized by WSIPP was not utilized; and the PIP did not have a detailed description of what the implemented interventions entailed including timeframes.

Clinical PIP: Collaborative Well-Child Visits (AHMC, AHFC, FIMC) – Partially Met

"Collaborative MCO Well-Child Visit Rate PIP"

This PIP was initiated in mid-2016 through an MCO peer collaborative with the aim of improving statewide well-child visit rates in infants (0–15 months), children (3–6 years), and adolescents (12–21 years). During CY 2018, the intervention grew to intervene with 35 clinics targeting the 3–6 years population (W34 HEDIS measure).

Although an empanelment process geared toward outreach and educational activities took place, this PIP received a Partially Met score for incongruencies relative to the PIP study design and how the project was actually executed in 2018. For example, the pilot clinics reported additional data measures that were not clearly identified, and the MCO did not explain how these measures would be integrated into the study design. There was misalignment between data analysis and prospective data analysis plan, and the interventions focused on only one of the three populations identified in the PIP.

Non-Clinical PIP (AHMC, FIMC) – Not Met

"Improving Adult Male Access to Preventative/Ambulatory Health Services in Members Aged 20-64 Years (AAP)"

The purpose of this PIP was to improve preventative well visits for men ages 20–64 years as a preemptive means to reduce potential health risks. Although this PIP was in its second year during CY 2018, a Not Met score was received as the PIP suffered from substantial challenges such as lack of a detailed description indicating how the topic was relevant to the study population; the one study question was non-specific and did not provide support for analysis of the identified interventions; incomplete explanation of PIP interventions implemented as well as the barrier analysis utilized; data and interventions for CY 2018 were not submitted; insufficient documentation outlining the way in which improvement strategies were developed as a result of the data analysis; and how the ongoing project was actively monitored.

CCW identified the study design as unreliable.

Non-Clinical PIP: Clinical or Non-Clinical (AHMC, FIMC) – Partially Met

"Improving asthma medication adherence in children aged 5-18"

Utilizing the HEDIS measure of asthma medication adherence in children ages 5–18 years (MMA), this PIP aims to improve rates of follow-up visits and prescription adherence. The interventions encompassed general information on medication adherence, disease management and access to care. These were implemented via general provider outreach, text messaging via SafeLink phones to reach members without addresses and updating a "Healthy Kids Club" newsletter.

During CY 2018, this PIP was in its second year and these interventions were continued from the previous year. The target audience for the interventions included members, parents and providers. The rates decreased somewhat for the 5–11 age group and marginally increased for the 12–18 age group; however, CCW indicated potential inaccuracies with the results due to use of an unreliable study design. The MCO did not specifically indicate what was erroneous with the design or the outcomes. Nonetheless, a Partially Met score was received, as many areas of the PIP submission contained outdated, insufficient or unclear information.

Additional PIP: Clinical or Non-Clinical (AHFC) – Not Met

"Improving Well-Visit Claims at School Based Clinics (SBHC) for Members in Foster Care Members Ages 6 to 18"

The focus of this PIP was to increase well-visit rates of the 6–18 years age group in Chelan, Grant and Douglas counties. CY 2018 was the PIP's first year, but it was unclear whether any interventions were implemented. The PIP submission mentioned the opening of a school-based clinic; however, this is not something operated by the MCO. Posters were positioned throughout the school, but it was unclear whether the MCO did this.

The PIP received a Not Met score because no interventions were implemented, some of the data was incongruent with the PIP, submitted documentation lacked clarity as to the relevance, and the PIP lacked a data analysis plan, among other elements.

Non-Clinical PIP in Partnership with MCO, DSHS & HCA (AHFC) – Not Met

"Improving Access to Assigned Primary Care Provider for Apple Health Foster Care Members Ages 12 Months to 19 Years Old"

The purpose of this PIP was to increase the rate of primary care visits for the foster care population ages 12 months to 19 years. The HEDIS measure of Child and Adolescent Access to Primary Care was being used.

This PIP received a score of Not Met as there were many interventions included within the PIP submission, but none were tailored specifically to the foster care population nor was there any indication interventions were implemented in CY 2018. Many interventions had the appearance of usual operations instead of direct linkage to the PIP, and many were done as part of the DOH Well-Child Collaborative PIP. The submission did not follow the CMS format for a PIP; irrelevant and incomplete information was included and the documentation lacked cohesiveness overall.

TEAMonitor-Identified Opportunities for Improvement

- Review the CMS "Conducting a Performance Improvement Project Worksheet" document to ensure the study is well-designed.

- Develop clear and measurable study questions.

- Identify sufficient indicators to track performance over a specified timeframe.

- Ensure interventions are linked to the PIP and are designed to make an impact in this important area.

- Focus on improving the linkage between the PIP design, interventions, indicators and desired outcomes.

Community Health Plan of Washington (CHPW)

Summary/Interventions

Clinical PIP: Washington State Institute for Public Policy Adult (FIMC) – Partially Met

"Outpatient Engagement Post Psychiatric Inpatient Hospitalization"

This PIP was in its third year for CY 2018 and has been seeking to increase the rate of follow-up care for all Fully Integrated Managed Care (FIMC) adult members ages 18 and older, beginning the date of discharge from a community psychiatric hospital/unit, or Evaluation and Treatment Center (E&T), regardless of diagnosis. The HEDIS measure of seven-days follow-up after hospitalization for mental illness for this population was used. The study question indicated two evidence-based practices/services (EBPs) — modified Peer Bridger Program[4] and Program for Assertive Community Treatment (PACT)[5] — would be used to carry out the intervention of referral and engagement.

A score of Partially Met was attributed to the fluctuating results and the interventions being inadequately defined with no substantiating information relevant to the EBPs. Although this PIP demonstrated improvement in its second year, there was a considerable decrease in the third year.

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[4] Peer Bridger Program: https://riinternational.com/our-services/washington/peer-bridger-program/
[5] PACT. https://depts.washington.edu/ebpa/projects/pact

Clinical PIP: Washington State Institute for Public Policy Children (FIMC) – Partially Met

"Caregiver Attachment in Young Children Exposed to Trauma"

The aim for this PIP was to decrease parent and child stress from the time of enrollment to the completion of the therapeutic program by employing Child-Parent Psychotherapy (CPP); a minimum of 12 sessions was set, with the intervention geared toward 12–52 sessions being completed with the child, parent and a licensed professional within CHPWs first Integrated Managed Care region, Southwest Washington (Clark and Skamania counties). This intervention, which is recognized by the Washington State Institute for Public Policy WSIPP, is intended to strengthen the relationship between the parent and the child, and in so doing creating or increasing a sense of safety and security for the child.

CY 2018 was the third year for this PIP; however, the sample size was small and only four pre-and-post assessments were completed. A Partially Met score was received because the results were not submitted; therefore, the data could not be analyzed.

Clinical PIP: Washington State Institute for Public Policy (AHMC) – Partially Met

"Improving Antidepressant Medication Management through Brief Pharmacist Interventions"

Using AMM-Effective Acute Phase Treatment and AMM-Effective Continuation Phase Treatment for adults 18 years of age and older in selected pilot sites, pharmacists played an integral role in assisting members with antidepressant medication adherence. The intervention consisted of pharmacists making phone calls to members to discuss and address barriers to medication continuation and make referrals to primary care providers when necessary. This PIP was in its second year during CY 2018 and met all elements for 2019 RY.

A score of Partially Met was received because the overall rate of improvement from year to year was not statistically significant, although the rate was significantly higher in the subgroup that had the intervention than in the group that did not have the intervention.

Clinical PIP: Collaborative Well-Child Visits (AHMC) – Partially Met

"Collaborative MCO Well-Child Visit Rate PIP"

This PIP was initiated in mid-2016 through an MCO peer collaborative with the aim of improving statewide well-child visit rates in infants (0–15 months), children (3–6 years), and adolescents (12–21 years). During CY 2018, the intervention grew to intervene with 35 clinics targeting the 3–6 years population (W34 HEDIS measure).

Although an empanelment process geared toward outreach and educational activities took place, this PIP received a Partially Met score for incongruencies relative to the PIP study design and how the project was actually executed in 2018. For example, the pilot clinics reported additional data measures that were not clearly identified, and the MCO did not explain how these measures would be integrated into the study design. There was misalignment between data analysis and prospective data analysis plan, and the interventions focused on only one of the three populations identified in the PIP.

Non-Clinical PIP (AHMC) – Not Met

"Improving Utilization for High-Risk Members through Community Care Coordination"

During CY 2018, this PIP was in its third year. The aim is to use Community Health Worker interventions to address social barriers that may prevent high-risk members from engaging in appropriate care. The

Community Health Workers focus on addressing needs relative to the health, logistical and social (CHPW has identified these care coordination elements as C3) aspects of care as a means to remove the barriers faced by the enrollees. Some of the interventions include, but are not limited to, assisting members with transportation to medical appointments, connecting members with culturally appropriate primary care and mental health providers, assisting with employment search and application processes, assisting with housing resources, and encouraging members to seek health care services when indicated.

This PIP received a Not Met score, as the submission contained data inconsistencies (the documentation related to the data analysis plan and the measures to be used as indicators was not consistent throughout the report), which made the true impacts of the program difficult to ascertain; also other areas of the report were unclear.

TEAMonitor-Identified Strengths

- Interventions were chosen that met criteria of being evidence-based, research-based or promising practices.

- Interventions could reasonably be expected to effect change.

- The submissions clearly addressed all required elements.

TEAMonitor-Identified Opportunities for Improvement

- Thoroughly review information provided by HCA in response to PIP submissions and incorporate feedback into PIP processes and reporting in following years.

- When interventions are evidence-based, the MCO should examine whether the interventions were implemented with fidelity to fully understand the analysis of the results.

- AH-IMC PIPs must clearly identify the BHSO population, impact and involvement. The MCO must design PIPs for the BHSO population for a clinical and non-clinical PIP, at minimum.

Molina Healthcare of Washington (MHW)

Summary/Interventions

Clinical PIP: Washington State Institute for Public Policy Adult (AHMC, BHSO, FIMC) – Partially Met

"Collaborative Primary Care for Depression"

This PIP is aiming to influence change in the HEDIS measure of Antidepressant Medication Management (AMM)-Continuation phase. The study population included adults age 18 and older. The MCO mentioned eight interventions, seven of them aimed at providers. MHW attempted to educate providers on HEDIS measures overall, and to make them aware of their patients who were prescribed but not taking their antidepressant medications. This PIP was in its third year during CY 2018.

The project received a score of Partially Met; although it was well-organized, it appeared to be identical to the previous year's submission. The goal and the interventions did not align. The IMPACT model mentioned in the introduction was not referenced elsewhere and did not appear to have been implemented. There was not any improvement seen and it is recommended the PIP not be continued in its current state.

Clinical PIP: Washington State Institute for Public Policy Children (BHSO, FIMC) – Not Met

"Effective Provider Collaboration: Enhancing Behavioral Parent Training (BPT) for Parents of Children with Attention Deficit Hyperactivity Disorder (ADHD)"

In CY 2018, this third-year PIP was seeking to increase ADHD medication adherence and to provide treatment opportunities for families that have children diagnosed with ADHD. The study question for this PIP does not mention the use of BPT, which is the evidence-based intervention recognized by WSIPP. MHW used the HEDIS ADD measure to track the PIP's performance, yet the quality indicators used mostly measured whether newly diagnosed children with ADHD received an initial prescription, and whether they had follow-up visits with a practitioner who had prescribing authority, remained on their medication for 210 days, and followed-up with their practitioner over specified timeframes (as defined by HEDIS).

This PIP received a Not Met score due to numerous variables, including, but not limited to:

- no indicators measuring effectiveness or use of BPT, and access to therapy
- no criteria measuring effectiveness of activities implemented to address identified barriers through a barrier analysis to connect the PIP activities
- the study design only addressed collection of HEDIS data elements for the ADD measure
- the design did not address how specific provider engagement activities and impact on medication adherence rates would be evaluated

The MCO intends to conduct a behavioral health provider survey to gather a better understanding of the barriers contracted providers are facing when recommending behavioral therapy; however, the PIP submission did not include any details about when the survey would be initiated, the number of providers to be queried, who would be responsible for developing a follow-up action plan, etc.

Clinical PIP: Collaborative Well-Child Visits (AHMC, FIMC) – Partially Met

"Collaborative MCO Well-Child Visit Rate PIP"

This PIP was initiated in mid-2016 through an MCO peer collaborative with the aim of improving statewide well-child visit rates in infants (0–15 months), children (3–6 years), and adolescents (12–21 years). During CY 2018, the intervention grew to intervene with 35 clinics targeting the 3–6 years population (W34 HEDIS measure).

Although an empanelment process geared towards outreach and educational activities took place, this PIP received a Partially Met score for incongruencies relative to the PIP study design and how the project was actually executed in 2018. For example, the pilot clinics reported additional data measures that were not clearly identified, and the MCO did not explain how these measures would be integrated into the study design. There was misalignment between data analysis and prospective data analysis plan, and the interventions focused on only one of the three populations identified in the PIP.

Non-Clinical PIP (AHMC, FIMC) – Partially Met

"Bridging the Gap: Level of Provider Engagement and Quality Improvement"

This second-year PIP aims to improve five HEDIS measures (asthma medication adherence for ages 5–11, asthma medication adherence for ages 12–18, well-child visits for ages 3–6, Childhood Immunization Status Combo 10 (CIS) for 2-year-olds, and percent of diabetic members with hemoglobin A1c testing). MHW is seeking to improve these rates from year to year, yet the project is comparing one group to

another: patients in a value-based purchasing group against the rest of the MCO population, and patients in the Pediatric – Transforming Clinical Practice Initiative grant against the rest of the MCO population.

This PIP received a score of Partially Met, as the presentation of the results did not match the study questions and stated aim of the PIP; interventions were targeted to providers, with reminders and incentives; and there was a lack of clear linkages throughout.

TEAMonitor-Identified Opportunities for Improvement

- The MCO should evaluate each PIP that is Partially or Not Met to determine what actions can be taken to improve the currently active PIP.

- The MCP should summarize the evaluation of their PIPs as well as any planned steps to improve individual PIPs and the overall PIP program.

- AH-IMC PIPs must clearly identify the BHSO population, impact, and involvement. BHSO enrollees must be addressed in a clinical and non-clinical PIP, at minimum.

UnitedHealthcare Community (UHC)

Summary/Interventions

Clinical PIP: Washington State Institute for Public Policy (AHMC) – Partially Met

"Increase Anti-Depressant Treatment Plan Compliance for Adult, Female, TANF (Temporary Assistance for Needy Families) members diagnosed with depression (anti-depressant medication management)"

This PIP was in its fourth year during CY 2018. The purpose was to improve the HEDIS measure of Antidepressant Medication Management (AMM) among a sub-population of female TANF-eligible members. The intervention was mailing a "depression packet" to select providers, specifically OB/GYNs, who could possibly function as primary care providers for some women and may be inexperienced in discussing depression and its treatment.

This PIP received a score of Partially Met. Although there was statistically significant improvement in the indicator from 2107 to 2018, the performance in previous years had been decreasing and there is little confidence the improvement was the direct result of the intervention. The analysis of the PIP did not include follow-up information with the providers to ascertain the effectiveness of the mailings, no analysis was conducted to determine whether the intervention was what led to the improvement, and potential threats to validity of the measure were not documented.

Clinical PIP: Collaborative Well-Child Visits (AHMC) – Partially Met

"Collaborative MCO Well-Child Visit Rate PIP"

This PIP was initiated in mid-2016 through an MCO peer collaborative with the aim of improving statewide well-child visit rates in infants (0–15 months), children (3–6 years), and adolescents (12–21 years). During CY 2018, the intervention grew to intervene with 35 clinics targeting members ages 3–6 (W34 HEDIS measure).

Although an empanelment process geared towards outreach and educational activities took place, this PIP received a Partially Met score for incongruencies relative to the PIP study design and how the project was actually executed in 2018. For example, the pilot clinics reported additional data measures that were not clearly identified, and the MCO did not explain how these measures would be integrated into the study

design. There was misalignment between data analysis and prospective data analysis plan, and the interventions focused on only one of the three populations identified in the PIP.

Non-Clinical PIP (AHMC) – Met

"Increasing the Rate of Members Receiving Diabetic Education Services"

The aim of this PIP was to increase the rate of diabetic education services received by members ages 18 to 74 diagnosed with Type I and Type II diabetes. The MCO measures monthly and annual rates of members seeing a diabetes educator as well as the HEDIS rate of members having Dilated Retinal Eye Exam. The intervention for this year was emails sent to members informing and encouraging them regarding diabetic education, with a small monetary incentive for completing either a visit or an online diabetes education course. There were interventions carried over from previous years, which included education to providers, enhancing case management and participating in two local Accountable Community of Health groups on diabetes care.

Although the rate of members receiving diabetic education services did not change, there was improvement in the rate of members receiving eye exams. Additionally, an analysis was not done on what influences an individual to get an eye exam versus what influences them to take a class or visit a professional.

TEAMonitor-Identified Strengths

- PIP reports are logically organized and easy to follow, with clear linkages and alignment between the data analysis documenting the need for improvement, the study question, selected indicators, interventions, and results.

TEAMonitor-Identified Opportunities for Improvement

- The MCO should evaluate each PIP that is Partially or Not Met to determine what actions can be taken to improve the currently active PIP.
- The MCO should summarize the evaluation of its PIPs as well as any planned steps to improve individual PIPs and the overall PIP program.
- Strengthen the analysis of evaluation results demonstrating how the interventions did or did not influence the results, and what other interventions might be possible.
- If an intervention is not effective, the MCO should examine both its processes in implementing it, and the validity of the intervention as it can be expected to effect improvement.
- AH-IMC PIPs must clearly identify the BHSO population, impact, and involvement. The MCO must design PIPs for the BHSO population for a clinical and non-clinical PIP, at minimum.

Overall Opportunities for Improvement

MCOs demonstrated need for improvement on PIP performance in 2019 RY, achieving more Not Met scores and fewer Met scores than in 2018 RY. To enhance the MCOs' ability to design a sound PIP, HCA should continue to:

- Provide ongoing training specifically focused on the overall study design.
  - Establishing a framework for sustainable improvement stems from well-defined and well-scoped study designs

- o   As MCOs move forward with PIPs and also adjust their interventions, all elements of the PIP study design should be considered to ensure all aspects of the projects are realistic and obtainable
- Provide technical assistance to the MCOs with a focus on defining, streamlining and simplifying study questions.
  - o   Questions should be written in an easily understandable format that supports the MCOs' ability to determine whether the chosen intervention has a measurable impact for the study population
- Encourage MCOs to utilize rapid-cycle process improvement where feasible to accelerate change and results.
  - o   Utilizing this process allows for early revised interventions and course correction when original interventions are not successful.

Performance Measure Review

Healthcare Effectiveness Data and Information Set (HEDIS)

The performance of Apple Health MCOs in delivering accessible, timely, quality care and services to enrollees can be measured quantitatively through the Healthcare Effectiveness Data and Information Set (HEDIS), a widely used set of health care performance measures reported by health plans and developed by the National Committee for Quality Assurance (NCQA). HEDIS results can be used by the public to compare plan performance over five domains of care; they also allow plans to determine where quality improvement efforts may be needed.[6] The HEDIS data are derived from provider administrative and clinical data.

Comagine Health assessed audited MCO-level HEDIS data for the 2019 reporting year (RY) (measuring enrollee experience during calendar year 2018). MCOs submitted 53 measures, many of which included one or more submeasures, usually for specific age groups or other defined population groups.

It should be noted that the HEDIS measures are not risk adjusted and may vary from MCO to MCO because of factors that are out of a health plan's control, such as medical acuity, demographic characteristics, and other factors that may impact enrollees' interaction with health care providers and systems. Many of the HEDIS measures are focused on a narrow eligible patient population for which the measured action is almost always appropriate, regardless of disease severity or underlying health condition.

Data Collection and Validation

In the first half of 2019, each MCO participated in an NCQA HEDIS Compliance Audit™ to validate accurate collection, calculation and reporting of HEDIS measures for the member populations. This audit does not analyze HEDIS results; rather, it ensures the integrity of the HEDIS measurements.

Using the NCQA-standardized audit methodology, NCQA-certified auditors assessed each MCO's information systems capabilities and compliance with HEDIS specifications. HCA and each MCO received an onsite report and final report of all audit activity; all Apple Health MCOs were in compliance with HEDIS specifications.

Administrative Versus Hybrid Data Collection

HEDIS measures draw from clinical data sources, utilizing either a fully "administrative" collection method or a "hybrid" collection method. The administrative collection method relies solely on clinical information that is collected from the electronic records generated in the normal course of business, such as claims, registration systems or encounters, among others. In some delivery models, such as undercapitated models, health care providers may not have an incentive to report all patient encounters, so rates based solely on administrative data may be artificially low. For measures that are particularly sensitive to this gap in data availability, the hybrid collection method supplements administrative data with a valid sample of carefully reviewed chart data, allowing health plans to correct for biases inherent in administrative data gaps. Hybrid measures therefore allow health plans to overcome missing or erroneous administrative data by using sample-based adjustments. As a result, hybrid performance scores will nearly always be the same or better than scores based solely on administrative data.

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[6] http://www.ncqa.org/HEDISQualityMeasurement/WhatisHEDIS.aspx

Supplemental Data

In calculating HEDIS rates, the Apple Health MCOs used auditor-approved supplemental data, which is information generated outside of a health plan's claims or encounter data system. This supplemental information included historical medical records, lab data, immunization registry data and fee-for-service data on Early and Periodic Screening, Diagnosis and Treatment provided to MCOs by HCA. Supplemental data was used in determining performance rates for both administrative and hybrid measures.

Member-level Data

Additionally, HCA required MCOs to submit de-identified member-level data for all administrative and hybrid measures. Member-level data enable analyses related to geographic and demographic performance variation to identify quality improvement opportunities.

Calculation of the Washington Apple Health Average

The state average for a given measure is calculated as the weighted average among the MCOs that reported the measure (usually five MCOs), with MCOs' shares of the total eligible population used as the weighting factors.

Summary of HEDIS Performance Measure Results

The following results present the Apple Health average (the state rate) compared to national benchmarks, derived from the Quality Compass[7], the NCQA's database of HEDIS results for health plans. It also includes select results of regional and demographic analyses conducted using member-level data (described above). Further analyses based on member-level data are included in the *2019 Comparative Analysis Report* as well as comparative plan performance.

Access to Care

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

Statewide access measures for younger children have improved between the 2018 and 2019 RY. The state also performs relatively well compared to national benchmarks for the youngest age bands; the well-child visits for ages 0 to 15 months and the children's access to primary care measures for children age 12 to 24 months are above the 50th percentile. However, children's access for children 7 to 11 years and children 12 to 19 years declined significantly between the 2018 and 2019 RY; this is the second year of a significant decline.

Performance in this category was poorest in the area of maternal health. Between the 2017 and 2018 RY the statewide rate for timeliness of prenatal care declined by more than 5 percentage points. That decline did not repeat itself between the 2018 and 2019 RY; there was no significant change in the rate for either the timeliness of prenatal care or the postpartum care measure. Both rates fall below the national 20th percentile for performance.

Regionally, rates for adult and child access measures were stronger in the eastern regions of the state. Analysis by identified language preference showed higher rates for non-English-speaking enrollees than for English-speaking enrollees.

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[7] Quality Compass® 2019 is used in accordance with a Data License Agreement with the NCQA.

Table 4 displays the statewide results of these measures for the last four reporting years.

Table 4. Access to Care HEDIS Measures, 2016–2019 RY.

	2016 State Rate	2017 State Rate	2018 State Rate	2019 State Rate	2019 National Quintile*
Adults' Access to Preventive/Ambulatory Health Services					
20–44 years	71.8	71.1	72.6	73.1	
45–64 years	80.4	79.9	80.6	80.2	
Children and Adolescents' Access to Primary Care Practitioners					
12–24 months	92.7	96.7	96.7	96.8	
25 months–6 years	81.9	86.4	85.8	86.6	
7–11 years	87.5	91.2	90.4	89.9	
12–19 years	87.5	90.8	90.6	89.8	
Well-Child Visits					
0–15 months, 6 or more visits	60.3	66.4	67.7	67.4	
3–6 years	66.7	67.9	66.7	67.7	
12–21 years	43.3	45.8	48.0	46.6	
Maternal Health					
Timeliness of Prenatal Care	68.2	77.9	72.6	74.8	
Postpartum Care	52.2	58.8	58.8	58.6	

*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 percent of results.

Below the 20th Percentile

20th to 39th Percentile

40th to 59th Percentile

60th to 79th Percentile

At or above the 80th Percentile
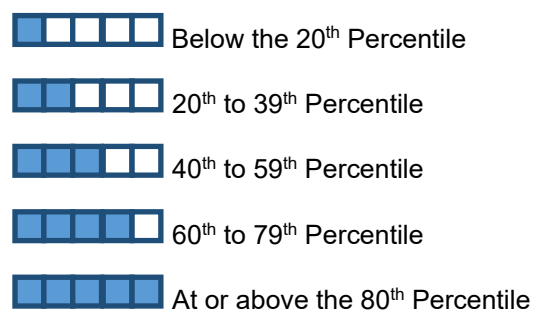
Preventive Care

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

Performance on many preventive care measures improved or remained steady between 2018 and 2019 RY. However, there was a significant decline in the chlamydia screening rate in the same time period. Many of the rates remain below the 40th percentile of national performance.

Demographic analyses showed lower breast cancer screening rates for white, English-speaking women than for all other groups.

Table 5 displays results for preventive care measures.

Table 5. Preventive Care HEDIS Measures, 2016–2019 RY.

	2015 State Rate	2017 State Rate	2018 State Rate	2019 State Rate	2019 National Quintile*
Weight Assessment and Counseling					
Children's BMI Percentile	45.8	58.0	70.9	72.2	
Children's Nutrition Counseling	57.4	58.7	62.9	61.8	
Children's Physical Activity Counseling	53.5	53.2	57.8	57.5	
Adult BMI Assessment	85.0	90.2	89.0	90.9	
Immunizations					
Children's Combination 2	71.4	70.5	70.5	73.2	
Children's Combination 10	40.8	36.9	38.1	41.6	
Adolescents' Combination 1	74.2	77.0	76.0	76.0	
Women's Health Screenings					
Breast Cancer Screening	52.3	53.5	55.3	54.5	
Cervical Cancer Screening	52.3	55.8	56.9	57.7	
Chlamydia Screening	54.8	54.4	55.1	54.2	

*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 percent of results.

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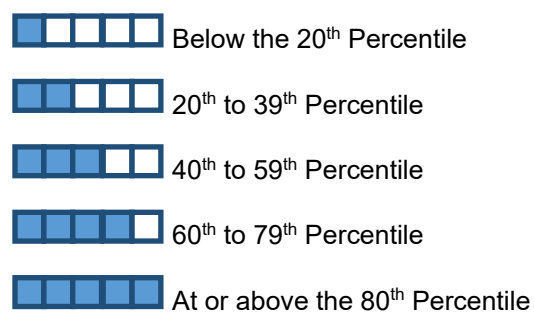
Chronic Care Management

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

Statewide performance on all chronic care management measures remained steady in 2019 RY, as shown in Table 6. Many of the rates remain below the 40th percentile of national performance; the asthma medication ratio rate is below the 20th percentile of national performance.

Regional analysis showed particular variation on the asthma medication ratio measures. The variation differed by age band, with some regions performing better for the younger age bands and performing worse for the older age bands.

Table 6. Chronic Care Management HEDIS Measures, 2016–2019 RY.

	2016 State Rate	2017 State Rate	2018 State Rate	2019 State Rate	2019 National Quintile*
Diabetes Care					
HbA1c Testing	88.3	89.6	89.3	89.5	40th to 59th Percentile
Eye Exam	55.5	59.1	59.7	58.5	20th to 39th Percentile
Medical Attention for Diabetic Nephropathy	88.9	90.1	89.4	89.6	20th to 39th Percentile
Blood Pressure Control (<140/90)	63.0	66.0	67.8	67.8	40th to 59th Percentile
HbA1c Control (<8.0%)	39.0	49.6	50.0	50.3	20th to 39th Percentile
Other Chronic Care Management					
Controlling High Blood Pressure (<140/90)	53.5	56.0	59.9	62.9	40th to 59th Percentile
Asthma Medication Ratio, Total	50.8	50.8	53.2	52.7	Below the 20th Percentile

*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 percent of results.

Below the 20th Percentile

20th to 39th Percentile

40th to 59th Percentile

60th to 79th Percentile

At or above the 80th Percentile
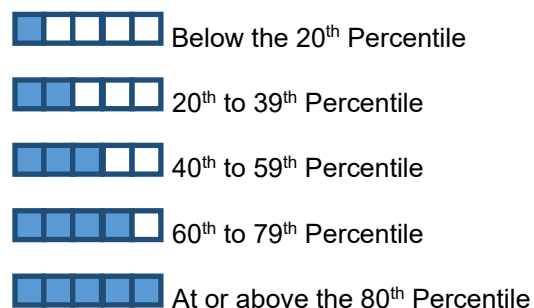
Behavioral Health Medication Management

Effective medication treatment of major depression can improve well-being in adults. For children, medication for attention-deficit/hyperactivity disorder (ADHD) can control symptoms when monitored carefully by the prescribing clinician.

Statewide performance on behavioral health measures remained steady in 2019 RY, as shown in Table 7.

Regional analysis showed particular variation on the antidepressant medication management measures. Rates for both submeasures were generally higher in the western regions of the state, continuing a trend identified in 2018 RY.

Table 7. Behavioral Health Medication Management HEDIS Measures, 2016–2019 RY.

	2016 State Rate	2017 State Rate	2018 State Rate	2019 State Rate	2019 National Quintile*
Antidepressant Medication Management (Acute Phase)	54.2	50.8	51.6	50.9	▣▣▢▢▢
Antidepressant Medication Management (Continuation Phase)	39.4	35.4	35.9	36.0	▣▣▣▢▢
Follow-Up Care for Children Prescribed ADHD Medication (Initiation Phase)	38.7	43.1	42.4	42.8	▣▣▣▢▢
Follow-Up Care for Children Prescribed ADHD Medication (Continuation Phase)	48.2	53.5	49.1	50.9	▣▣▣▢▢

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

▣▢▢▢▢ Below the 20th Percentile

▣▣▢▢▢ 20th to 39th Percentile

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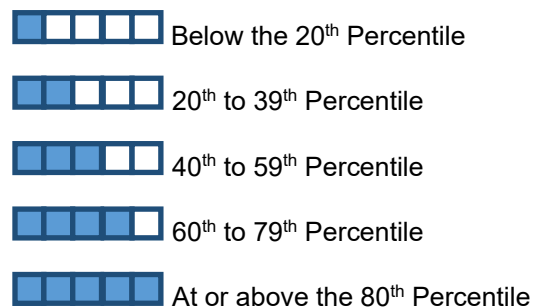
Performance Measure Recommendations

As shown in the previous tables, the following measures continue to fall under the 50th percentile nationally, and have either remained stable or had a negative trend. These measures address prevention and access and are widely considered central to population health.

- Children's Access to Primary Care Providers (CAP) (7–11 and 12–19 year age groups)
- Prenatal and Postpartum Care (PPC)
- Adolescent Well-Care Visits (AWC)
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)
- Adults' Access to Ambulatory/Preventive Health Services (AAP)
- Breast Cancer Screening (BCS)

As the MCOs focus on outcomes improvement efforts over the coming year, Comagine Health encourages the Washington State MCOs to continue to design initiatives with a concurrent goal to reduce provider burden and unintended variation at the practice level.

- **Managed Care Alignment on Quality Improvement Efforts**: In designing initiatives, the managed care organizations should find ways to minimize the need for providers to navigate variation in MCO processes. The behavioral health integration initiative has necessitated alignments of MCO programs; we recommend using lessons learned from behavioral health integration as a starting point for a similar initiative to improve outcomes on a limited number of high-priority HEDIS measures by aligning MCO quality efforts.

- **Choose a Subset of Measures for Impacting the Quality of Care**: We recommend the MCOs collectively identify a small number of closely related high-priority HEDIS measures around which to align improvement efforts, with the goal of reducing provider burden and care delivery variation.

  Specifically, Comagine Health sees an opportunity for MCOs to impact quality in areas where providers have a limited view of their performance, for example with the Adult Access to Ambulatory/Preventive Health Services (AAP) measure. A provider seeking to improve quality on this measure may only see a segment of the patient's care journey, while the MCOs have the opportunity to see the full journey. This creates an opportunity for the MCO to add valuable information to the quality improvement process that would otherwise not exist in the system.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

CAHPS surveys assess consumers' experiences with health care services and support. Developed by the U.S. Agency for Healthcare Research and Quality (AHRQ), the surveys address such areas as the timeliness of getting care, how well doctors communicate, global ratings of healthcare, access to specialized services, and coordination of care.

In 2019, the Apple Health MCOs conducted the CAHPS 5.0H Child Medicaid with Chronic Conditions survey via individually contracted NCQA-certified survey vendors. Survey respondents included parents/caretakers of children under the age of 18 continuously enrolled in Apple Health for at least six months as of December 31, 2018, with no more than one enrollment gap of 45 days or less. The survey included the general Apple Health population as well as children with chronic conditions. NCQA-certified survey vendor DataStat, under a subcontract with Comagine Health, produced a report that summarized survey responses and identified key strengths and opportunities for improvement, based on survey questions most highly correlated to enrollees' satisfaction with their health plan.

The following results present the Apple Health MCO average rating as compared to national benchmarks derived from the NCQA Quality Compass. Full comparative results of the Apple Health CAHPS 5.0H Child Medicaid with Chronic Conditions summary report may be viewed here: https://www.hca.wa.gov/assets/billers-and-providers/AHMC_CAHPS_2019.pdf

Table 8 compares 2019 RY performance with 2017 RY performance, the last time the child population was surveyed. There was a statistically significant improvement in the rating of personal doctor between the 2017 and 2019 RY; the other CAHPS rates remained steady. The rating of personal doctor, getting needed care, and how well doctors communicate were below the 40th percentile for national performance; the other rates were below the 20th percentile for national performance.

Table 8. CAHPS Ratings Results, 2017 and 2019 RY.

	2017 Rating	2019 Rating	2019 National Quintile*
Rating of Overall Health Care (Scored 9 or 10 out of 10)	64.6	67.3	
Rating of Personal Doctor (Scored 9 or 10 out of 10)	73.3	76.4	
Rating of Specialist Seen Most Often (Scored 9 or 10 out of 10)	71.0	71.4	
Rating of Plan (Scored 9 or 10 out of 10)	65.2	67.7	
Getting Needed Care	81.5	82.6	
Getting Care Quickly	86.7	86.8	
How Well Doctors Communicate	93.9	93.7	
Customer Service	87.9	87.8	

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

Below the 20th Percentile

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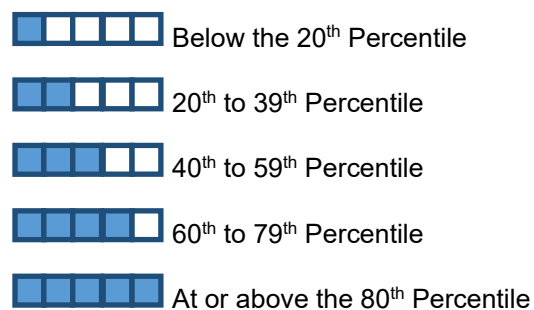
Apple Health Foster Care – 2019 Consumer Assessment of Healthcare Providers and Systems (CAHPS)

In 2019, Coordinated Care of Washington, the Apple Health Foster Care plan, conducted the CAHPS 5.0H Child Medicaid with Chronic Conditions via an independently contracted NCQA-certified survey vendor. Respondents included parents/caregivers of children under the age of 18 enrolled in the in foster care and adoption support components of the Apple Health Foster Care program. The survey included children enrolled as part of the general foster care population as well as children with chronic conditions.

CCW's survey vendor produced a summary report, including comparison of the Apple Health Foster Care scores to Child Medicaid 2018 Quality Compass rates. Prior year data was not available to demonstrate improvement over time. The reported included 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. While results of the key driver assessment differed between the two populations, for the Overall Rating of Health Plan, the report identified Question 50: Got Information or Help Needed, as an area of action for both.

For the full assessment, please see *2019 CAHPS Child Medicaid with CCC 5.0H Summary Report. Centene-WA (Coordinated Care) – Foster Care*. Produced by SPH Analytics, July 2019.

BHSO Performance Measure Validation

Behavioral Health Services Only (BHSO) enrollment is for Apple Health clients who are not eligible for medical managed care plans (such as those with Medicare as primary insurance). BHSO enrollment ensures everyone who is eligible has access to behavioral health benefits. Through BHSO, clients get coverage for their specialty behavioral health care (behavioral health and SUD treatment). More information on the program can be found at https://www.hca.wa.gov/assets/program/bhso-fact-sheet.pdf.

In 2018, four plans operated BHSO programs in 2018, Amerigroup (AMG), Community Health Plan of Washington (CHPW), Coordinated Care (CCW) and Molina Healthcare (MHW).

For this program, the state monitors and self-validates the following two measures, both reflecting care delivered to Apple Health BHSO enrollees:

- Mental Health Service Penetration – Broad Definition (MH-B)

- Substance Use Disorder Treatment Penetration (SUD)

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

The validation of performance measures is used to determine the accuracy of the reported performance measures and the extent to which performance measures follow state specifications and reporting requirements. These measures have been used over time by the state to monitor the Medicaid population; however, BHSO is relatively new and benchmarking data specific to this population is not yet available. Outlined below are the findings of HCA's validation of these two measures.

Methodology

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

HCA partners with DSHS' Research and Data Analysis Division (RDA) to measure performance for the BHSO population. Data is collected via the administrative method only, using claims, encounters and enrollment data. All payers' integrated data is utilized, which includes ProviderOne Medicaid claims and enrollment data, RSN/BHO encounter data and DBHR-paid behavioral health services for non-integrated managed care regions, and Medicare Parts A and B claims and Medicare Part D encounters for dual-eligible members. The RDA division measures and self-validates this data due to the availability of Medicare data and prevalence of dual-eligible members in the BHSO population. No sampling is conducted as all eligible enrollees are included in the measures. The measures track statewide performance for the BHSO population. In 2018, only two regions were integrated and had BHSO members: Southwest Washington and North Central.

Annual review of BHSO-specific performance is done for these measures with interim monitoring on a quarterly basis reviewing the performance of these measure for the entire Medicaid population. The RDA division produces and validates the quarterly and annual measures. Then a cross-agency workgroup reviews the metrics to monitor performance, identify unusual variation, and determine if any contractor follow-up is needed. The cross-agency workgroup consists of RDA and HCA staff focused on performance measures, quality improvement, and managed care oversight. Once the cross-agency workgroup has reviewed the metrics, the data is shared with the appropriate MCOs.

Validation

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

Validation Key

Yes ●	No ◉	Not Applicable ○

Yes means the state's measurement and reporting process was fully compliant with requirements.

No means the state's measurement and reporting process was not compliant with requirements.

N/A means the element was not applicable to the state's measurement and reporting process.

Summary of BHSO Performance Measure Validation Results: Mental Health Service Penetration – Broad Definition (MH-B)

Table 9. Performance Measure: Mental Health Treatment Penetration.

Broad Definition: The percentage of members with a mental health service need who received mental health services in the measurement year, including RSN/BHO services, MCO services and Medicare-paid services for dual eligibles.			
BHSO	**CY 2018**	**Numerator**	**Denominator**
Statewide	41.9%	1,953	4,663
Amerigroup Washington	24.8%	149	601
Community Health Plan of WA	51.4%	658	1,281
Coordinated Care of WA	30.9%	194	628
Molina Health Care of WA	44.2%	952	2,153
UnitedHealthcare Community Plan	N/A	0	0

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) that parallels measures like AAP that proxy access to primary care services. It was developed as a result of state legislation passed in 2013 requiring the Washington State DSHS and HCA to develop cross-system performance measures for Medicaid delivery systems. Results are reported for delivery system monitoring purposes by the DSHS RDA Division. 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.

Table 10. Results for Review of Mental Health Service Penetration – Broad Definition Measure.

Validation Component	Audit Element	Meets Validation Requirements
Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic and computer source code.	● Yes
Denominator	Data sources used to calculate the denominator were complete and accurate.	● Yes
	Calculation of the performance measure adhered to the specifications for all components of the denominator.	● Yes
Numerator	Data sources used to calculate the numerator were complete and accurate. Calculation of the performance measure adhered to the specifications for all components of the numerator.	● Yes
Sampling	Sampling was unbiased. Sampling treated all measures independently. Sample size and replacement methodologies met specifications.	N/A
Reporting	State specifications for reporting performance measures were followed.	● Yes

Documentation

The documentation used for the MH-B measure fully met validation requirements. Appropriate and complete measurement plans and programming specifications exist, including documentation of data sources, programming logic, and computer source code.

Strengths

- State-defined metric specification mirrors NCQA-HEDIS specification structures; measure production is aligned with the division's global master reference data management and performance measure production processes; a comprehensive repository of documented code is maintained.

Weaknesses

- There may be longer-term challenges to adequately resource measure-stewardship processes for this state-defined metric; dependency on HCA or its contractors to validate completeness and accuracy of source data.

Opportunities for Improvement

- Though not specific to "documentation" per se, we note that metric production processes are not funded at a level supporting internal validation, leaving a single (staff) point of failure for measure production; lack of resources to validate underlying encounter data, an activity outside the expected scope of work of the metric production team.

Denominator

Data sources used to calculate the denominator (e.g., eligibility files, claims files, provider files, pharmacy records) fully met validation requirements.

The metric is produced using service encounter and eligibility extracts from the ProviderOne Operational Data Store (P1 ODS) and the Behavioral Health Data Store (BHDS) maintained by the Health Care Authority, and Medicare Parts A, B, and D data received from CMS contractors. We report validation requirements as "Met" under the assumption that no further P1 ODS, BHDS, and Medicare source data validation is required in this measure production context, beyond what may have already been performed by HCA, CMS and/or their contractors.

Calculation of the performance measure adhered to the specifications for all components of the denominator of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9 or ICD-10, CPT-4, DRGs, UB-92, member month's calculation, member year's calculation, and adherence to specified time parameters).

Strengths

- Metric uses an admin-only specification amenable to measurement for the statewide population of qualifying discharges; data is integrated across payers and IT systems (P1 ODS, BHDS, Medicare).

Weaknesses

- Dependency on HCA, CMS and/or their contractors to validate completeness and accuracy of source data.

Opportunities for Improvement

- Exploration of value of restricting qualifying psychotropic medications identifying mental health treatment need to a minimum number of days supplied. This would address concerns that persons receiving relatively small duration scripts of antianxiety medications prior to surgery may be inappropriately included in the definition of persons with a mental health service need.

Numerator

Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO's network) fully met validation requirements.

The metric is produced using service encounter and eligibility extracts from the P1 ODS and the BHDS maintained by the Health Care Authority, and Medicare Parts A, B, and D data received from CMS contractors. We report validation requirements as "Met" under the assumption that no further P1 ODS, BHDS, and Medicare source data validation is required in this measure production context, beyond what may have already been performed by HCA, CMS, and/or their contractors.

Calculation of the performance measure adhered to the specifications for all components of the numerator of the performance measure (e.g., clinical codes such as ICD-9 or ICD-10, CPT-4, LOINC, DRGs, pharmacy data, relevant time parameters such as admission/discharge dates or treatment start and stop dates, adherence to specified time parameters, number or type of provider).

Strengths

- Metric uses an admin-only specification amenable to measurement for the statewide population of qualifying discharges and associated readmissions; data is integrated across payers and IT systems (P1 ODS, BHDS, Medicare).

Weaknesses

- Dependency on HCA, CMS, and/or its contractors to validate completeness and accuracy of source data.

Opportunities for Improvement

- None identified.

Sampling

Admin-only specification; survey sampling was not used.

Reporting

State specifications for reporting performance measures were followed.

Strengths

- An expert incumbent conducted metric production during this production and validation cycle; production occurs as part of an integrated suite of metrics, ensuring alignment of attribution for companion metric production (outside of the scope of this validation process); expert review of results is conducted on a quarterly basis; metric production is aligned with global master reference data management and performance measure production processes.

Weaknesses

- May be longer-term challenges to adequately resource measure stewardship for this state-defined metric.

Opportunities for improvement

- Metric production processes are not funded at a level allowing for internal validation, leaving a single (staff) point of failure for measure production; lack of resources to validate underlying encounter data, an activity outside the expected scope of work of the metric production team.

Summary of BHSO Performance Measure Validation Results: Substance Use Disorder Treatment Penetration (SUD) Measure

Table 11. Performance Measure: Substance Use Disorder Treatment Penetration.

The percentage of members with a substance use disorder (SUD) treatment need who received SUD treatment in the measurement year.			
BHSO	**CY 2018**	**Numerator**	**Denominator**
Statewide	14.9%	187	1,259
Amerigroup Washington	11.8%	20	169
Community Health Plan of WA	15.9%	50	314
Coordinated Care of WA	11.0%	20	181
Molina Health Care of WA	16.3%	97	595
UnitedHealthcare Community Plan	N/A	0	0

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) that parallels measures like AAP that proxy access to primary care services. It was developed as a result of state legislation passed in 2013 requiring the Washington State DSHS and HCA to develop cross-system performance measures for Medicaid delivery systems. The measure has not been implemented in a value-based purchasing or performance-based contracting context. Results are reported for delivery-system monitoring purposes by the DSHS RDA Division.

The measure production process includes the quarterly monitoring of multi-year trends in numerators, denominators, and rates at the regional scale, 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.

Table 12. Results for Review of Substance Use Disorder Treatment Penetration Measure.

Validation Component	Audit Element	Meets Validation Requirements
Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic and computer source code.	● Yes
Denominator	Data sources used to calculate the denominator were complete and accurate.	● Yes
	Calculation of the performance measure adhered to the specifications for all components of the denominator.	● Yes
Numerator	Data sources used to calculate the numerator were complete and accurate. Calculation of the performance measure adhered to the specifications for all components of the numerator.	● Yes

Validation Component	Audit Element	Meets Validation Requirements
Sampling	Sampling was unbiased. Sampling treated all measures independently. Sample size and replacement methodologies met specifications.	N/A
Reporting	State specifications for reporting performance measures were followed.	● Yes

Documentation

The documentation used for the SUD measure fully met validation requirements. Appropriate and complete measurement plans and programming specifications exist, including documentation of data sources, programming logic, and computer source code.

Strengths

- State-defined metric specification mirrors NCQA-HEDIS specification structures; measure production is aligned with the division's global master reference data management and performance measure production processes; a comprehensive repository of documented code is maintained.

Weaknesses

- May be longer-term challenges to adequately resource measure-stewardship processes for this state-defined metric; dependency on HCA or its contractors to validate completeness and accuracy of source data.

Opportunities for Improvement

- Though not specific to "documentation" per se, we note that metric production processes are not funded at a level supporting internal validation, leaving a single (staff) point of failure for measure production; lack of resources to validate underlying encounter data, an activity outside the expected scope of work of the metric production team.

Denominator

Data sources used to calculate the denominator (e.g., eligibility files, claims files, provider files, pharmacy records) fully met validation requirements.

The metric is produced using service encounter and eligibility extracts from the P1 ODS and the BHDS maintained by Washington HCA, and Medicare Parts A, B, and D data received from CMS contractors. We report validation requirements as "met" under the assumption that no further P1 ODS, BHDS, and Medicare source data validation is required in this measure production context, beyond what may have already been performed by HCA, CMS, and/or their contractors.

Calculation of the performance measure adhered to the specifications for all components of the denominator of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9 or ICD-10, CPT-4, DRGs, UB-92, member month's calculation, member year's calculation, and adherence to specified time parameters).

Strengths

- Metric uses an admin-only specification amenable to measurement for the statewide population of qualifying discharges; data is integrated across payers and IT systems (P1 ODS, BHDS, Medicare).

Weaknesses

- Dependency on HCA, CMS, and/or their contractors to validate completeness and accuracy of source data.

Opportunities for Improvement

- None identified.

Numerator

Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO's network) fully met validation requirements.

The metric is produced using service encounter and eligibility extracts from the P1 ODS)and the BHDS maintained by HCA, and Medicare Parts A, B, and D data received from CMS contractors. We report validation requirements as "Met" under the assumption that no further P1 ODS, BHDS, and Medicare source data validation is required in this measure production context, beyond what may have already been performed by HCA, CMS, and/or their contractors.

Calculation of the performance measure adhered to the specifications for all components of the numerator of the performance measure (e.g., clinical codes such as ICD-9 or ICD-10, CPT-4, LOINC, DRGs, pharmacy data, relevant time parameters such as admission/discharge dates or treatment start and stop dates, adherence to specified time parameters, number or type of provider).

Strengths

- Metric uses an admin-only specification amenable to measurement for the statewide population of qualifying discharges and associated readmissions; data is integrated across payers and IT systems (P1 ODS, BHDS, Medicare).

Weaknesses
- Dependency on HCA, CMS, and/or its contractors to validate completeness and accuracy of source data.

Opportunities for Improvement

- None identified.

Sampling

Admin-only specification; survey sampling was not used.

Reporting

State specifications for reporting performance measures were followed.

Strengths

- An expert incumbent conducted metric production during this production and validation cycle; production occurs as part of an integrated suite of metrics, ensuring alignment of attribution for companion metric production (outside of the scope of this validation process); expert review of results is conducted on a quarterly basis; metric production is aligned with global master reference data management and performance measure production processes.

Weaknesses

- May be longer-term challenges to adequately resource measure stewardship for this state-defined metric.

Opportunities for improvement

- Metric production processes are not funded at a level allowing for internal validation, leaving a single (staff) point of failure for measure production; lack of resources to validate underlying encounter data, an activity outside the expected scope of work of the metric production team.

Review of Previous-Year EQR Recommendations

Required EQR activities include a review of the applicable state organization's response to previously issued EQR recommendations. Table 13 below displays Comagine Health's 2018 recommendations and suggested opportunities for improvement, HCA's responses to those recommendations, and the EQRO's subsequent response.

Table 13. Review of HCA Responses to 2018 EQR Recommendations.

Prior-Year Recommendation	HCA Response	EQRO Response
Performance Measure Review Statewide rates for maternal care measures, including timeliness of prenatal care and postpartum care, dropped or remained flat in 2018 RY, and remain below the 40th percentile of national performance.		
HCA needs to examine root causes for poor performance on these measures and determine what action is needed. The State should consider requiring MCOs to have a plan in place, including timelines and deliverables, to improve performance.	In response to the Technical Report recommendations, the Health Care Authority (HCA) carefully reviewed and analyzed the Managed Care Organization (MCO) performance with attention to areas in need of improvement across MCOs and for each MCO specifically. In November 2018, HCA sent each MCO a letter requiring a quality improvement plan addressing specified performance measures with concerning performance. Maternal care measures were included for all MCOs requiring they conduct a self-assessment, perform a root-cause analysis and identification of barriers, and development of a quality improvement plan integrated within the MCO's overall Quality Assessment and Performance Improvement (QAPI) program work. Most of the MCOs have identified specific goals in their QAPI plans for timeliness of prenatal care and postpartum care measures. They all offer members incentives and specialized interventions, and most have made recent modifications, such as changing or increasing the value of incentives. One MCO is working to increase involvement of pregnant enrollees in case management. One MCO is doing a 2019 performance improvement project on increasing access to reproductive care. There is also one PIP on increasing connection to the Nurse-Family Partnership, and another on increasing the use of WIC services. Both of these programs are evidence-based, and can help increase the use of prenatal and postpartum care. HCA continues to monitor these performance measures. After reviewing HEDIS 2019 data, HCA selected both timeliness of prenatal care and postpartum	Response accepted

Prior-Year Recommendation	HCA Response	EQRO Response
	care as value-based purchasing (VBP) measures for all plans for the upcoming contract year. They will be included as VBP measures starting in January 2020.	
Performance Measure Review Statewide rates for numerous measures, including child and adolescent access to care, adolescent well-care and well-child visits, immunizations for adolescents, women's health screenings, HbA1c control, antidepressant medication management, and follow-up care for children prescribed ADHD medication, have either dropped or remained flat since 2017 RY, yet are still below the 60th national percentile.		
To continue to improve care delivery to all Apple Health enrollees, HCA should continue to monitor these measures. To bring statewide performance above national standards, HCA should consider setting higher statewide performance goals for MCOs.	HCA has responded to this recommendation by both continuing to monitor this performance and including these measures within the letters requiring a Quality Improvement Plan (QIP) sent to each MCO in November 2018. Each plan with poor performance in these measures were required to evaluate these measures, perform a root cause analysis, identify barriers, and develop a QIP. When new HEDIS results were available in summer 2019, HCA evaluated the performance of these measures for consideration in the value-based purchasing strategy. New value-based purchasing measures, which will start in 2020, address many of these measures: Antidepressant Medication Management for all Plans, Well-Child visits ages 3-6 for all Plans, Follow-up for ADHD Medication for two plans, HbA1c control for two Plans, Child and Adolescent Access to Primary Care for one Plan, and Adolescent Well-Visits for one Plan. Additionally, multiple MCOs are addressing these measures through Performance Improvement Projects including: Improving Access to Assigned Primary Care Provider for members in foster care, Increasing Access to Reproductive Care, Antidepressant Medication Management, Improving Follow-Up for ADHD Medications, using behavioral-parent training for families of children with ADHD, and increasing the use of diabetes education services.	Response accepted

Prior-Year Recommendation	HCA Response	EQRO Response
Performance Measure Review Statewide rates for adult access to care improved slightly in 2018 RY; those for child/adolescent access decreased. Overall, access rates in the eastern regions of the state continued to surpass those in the western regions of the state.		
The State should consider examining root causes of low performance rates on access measures in the western regions of the state. Performance on access to primary care for both adults and children/adolescents were all particularly low in these regions of the state compared to the state average and should be a focus of improvement. HCA should consider requiring underperforming MCOs to have a plan in place, ideally with timelines and deliverables, to improve performance.	In November 2018, HCA included access to care as part of the quality improvement plan requirement from MCOs. One MCO is performing two PIPs that pertain to access to care: one on increasing access to care for children in foster care, and one on improving access to care for reproductive-age women. MCOs continually assess and make changes to provider networks as needed to reach goals for care access.	Response accepted
Performance Measure Review Although performance on the antidepressant medication management measures improved slightly in the eastern regions of the state in 2018 RY, rates here still lag behind those in the western areas of the state.		
The State should consider examining root causes of low performance on these behavioral health measures in the eastern part of the state and determine whether focused improvement efforts may be necessary, including examining the number and types of behavioral health practitioners and provider organizations available in the underperforming regions. Success for some of the measures may require sophisticated and specialized care potentially not readily available in rural areas.	HCA is working to maximize collaboration with behavioral health integration efforts and an increased emphasis on behavioral health-related performance measures. Behavioral health measures are a priority for the state, as demonstrated by the choice of both AMM measures as continuing value-based purchasing measures for all MCOs in 2019 and 2020. Also, Mental Health Treatment Penetration and Substance Use Disorder Treatment Penetration continue to be value-based purchasing measures for 2019 and 2020 to support access to behavioral health across the state. To address reduce health disparities in the AMM measure, HCA contracts with DOH to facilitate an MCO collaborative workgroup. This group is concentrating on antidepressant medication adherence in people who speak primarily Spanish,	Response accepted.

Prior-Year Recommendation	HCA Response	EQRO Response
Depending on the results of these analyses, HCA should consider maximizing collaboration with the behavioral health integration efforts, priorities, and resources of Healthier Washington to better facilitate behavioral health integration across the state, particularly in the eastern regions.	many of whom are located in the eastern part of the state. The workgroup has been successful in bringing support groups and presentations from the National Association for Mental Illness to areas around Yakima. They are working with pharmacies to educate patients in making informed decisions about antidepressant medications. They are working to increase access to and use of interpretation and translation at pharmacies, not only in Spanish but other languages as well. The workgroup is also looking into increased opportunities for tele-health especially in mental health. Two MCOs are focusing on depression management in PIPs using the Collaborative Care model for people with depression.	
Performance Measure Review Numerous measures, including most access measures and the breast cancer screening measure, showed lower performance rates for English-speaking enrollees; on other measures, performance was lower for those enrollees with a non-English-language preference.		
Language preference plays a critical role in healthcare delivery, yet currently, methods for collecting enrollees' preferred language data vary among the plans and do not collect optimally detailed data. To further understand the specific language challenges present in delivering equitable care and to ensure enrollees are obtaining care and information in language they understand, HCA should consider the following options: asking MCOs to expand options for capturing enrollees' preferred language data beyond "other" to include a variety of languages, standardizing collection of this information among the plans, and evaluating whether the language capture is accurate. Obtaining an enhanced level	HCA agrees language preference plays a critical role in healthcare delivery. Collecting language data is challenging for many reasons. Language preference is self-reported when clients apply for Medicaid eligibility. HCA and the MCOs recognize that this self-reported data does not always correspond to the way clients actually prefer to communicate. MCOs try to verify language and cultural information during contacts with members, such as the Initial Health Screen. The MCOs are researching ways to improve the collection of data. One way is to offer a greater selection of languages to choose from on written requests; another way is to ask people "live" or on the phone, which sometimes has better responses than written requests. One MCO is doing a PIP increasing depression screening in preferred languages. Two of the WA Medicaid MCOs have received National Committee on Quality Assurance's (NCQA) Distinction in Multicultural Health Care, and all MCOs are committed to providing culturally appropriate care.	Response accepted

Prior-Year Recommendation	HCA Response	EQRO Response
of enrollee data may assist in identifying regions where additional or specialized outreach may be concentrated.		
Opportunity for Improvement: Compliance In this year's review, MCO scores indicated that complying with the standards for coordination and continuity of care, specifically assessment and treatment plans, and coverage and authorization continues to be a challenge. HCA has prioritized these areas, providing frequent technical assistance to the plans and collaborating with the MCOs on multiple efforts to improve care coordination and transitions, especially with regard to services that span the physical and behavioral health realms.		
As the Apple Health program moves closer to a fully integrated managed care model, the state should remain focused on the areas of coordination and continuity of care and coverage and authorization, continuing to provide guidance to MCOs, supporting collaborative efforts between physical and behavioral health services, and implementing initiatives that will help ensure quality care for enrollees.	HCA agrees with the focus on the areas of coordination and continuity of care and coverage and authorization given the implementation of integration statewide. HCA has prioritized these areas this year and will continue to do so to ensure quality of care for enrollees. The state has continued to provide guidance to and worked with the MCOs on specific aspects of this work, especially focusing on enrollees with high behavioral health needs. All MCOs participated in the Knowledge Transfer Webinars hosted by HCA, which addressed topics on integration of the behavioral health system, such as crisis system coordination, state hospital coordination, substance use disorder medical necessity determinations, and behavioral health inpatient authorization.	Response accepted
Opportunity for Improvement: Performance Improvement Projects MCOs showed improvement on PIP performance in 2018 RY, achieving more Met scores and fewer Not Met scores than in 2017 RY. However, numerous PIPs continued to suffer from lack of clarity and specificity in documentation, and data and results analysis was often insufficient.		
HCA's continued work with the MCOs to improve PIP design and documentation appears to be affecting a positive shift in PIP execution and outcomes; to further improve performance, particularly among MCOs that have demonstrated less improvement, the State should continue to provide trainings and technical assistance to the MCOs and their staff on PIP	HCA continued to provide a focused effort in supporting MCO PIP programs by providing technical assistance and requiring PIP study design approval early in the year through a PIP Proposal process. HCA implemented meetings for verbal feedback on PIP reports and scores, in a format similar to TEAMonitor to support the written report messaging. This allows for more individualized discussion regarding the plan's performance on PIPs. MCO response to these meetings was positive. Strong corrective actions were issued where needed, and extensive technical assistance has been offered to all MCOs. HCA and MCOs will	Response accepted

Prior-Year Recommendation	HCA Response	EQRO Response
study design and implementation.	have more frequent meetings this year, to update on PIP progress and areas in need of assistance. The DOH/MCO Collaborative PIP on well-child care also got detailed feedback from HCA and this mechanism will be used to provide technical assistance sessions throughout the year to connect the PIP expectations with the real example of the collaborative work with the intention of using this to inform all MCO PIP work. Additionally, HCA made some changes in the PIP proposal and submission processes that will allow for more timely feedback to MCOs, and a more structured timeline for the completion of the PIP work.	

Behavioral Health Care Review

Introduction

The Washington State Health Care Authority (HCA), Division of Medicaid Program Operations and Integrity, currently contracts with the three BHOs to provide comprehensive and culturally appropriate mental health and SUD treatment services for adults, children and their families. BHOs administer services by contracting with BHAs — community mental health agencies, SUD treatment providers and private nonprofit agencies — to provide mental health and SUD services and treatment. The BHOs are accountable for ensuring that services are delivered in an integrated manner that complies with legal, contractual and regulatory standards for effective care.

Under the direction of Senate Bill E2SSB 6312, behavioral health benefits will be fully integrated into the Apple Health managed care program, providing Medicaid enrollees with access to both physical and behavioral health services through a single managed care program no later than 2020. Many regions have completed this transition, in which behavioral health services purchased and administered by regional BHOs have been transferred to Apple Health MCOs through the AH-IMC contracts administered by Washington HCA. The three remaining BHOs reviewed by Comagine Health in 2019 — Great Rivers BHO (GRBHO), Salish BHO (SBHO) and Thurston-Mason BHO (TMBHO) — will cease operations by January 1, 2020.

Table 14 displays the BHOs facilitating services in 2019 and their service areas, and Figure 8, next page, displays the behavioral health service areas as delivered by BHOs and AH-IMC.

Table 14. BHO Service Areas.

BHO	Counties Served
Great Rivers BHO (GRBHO)	Lewis, Pacific, Wahkiakum, Cowlitz, Grays Harbor
Salish BHO (SBHO)	Clallam, Jefferson, Kitsap
Thurston-Mason BHO (TMBHO)	Mason, Thurston

Figure 8. Behavioral Health Service Areas, by Region.
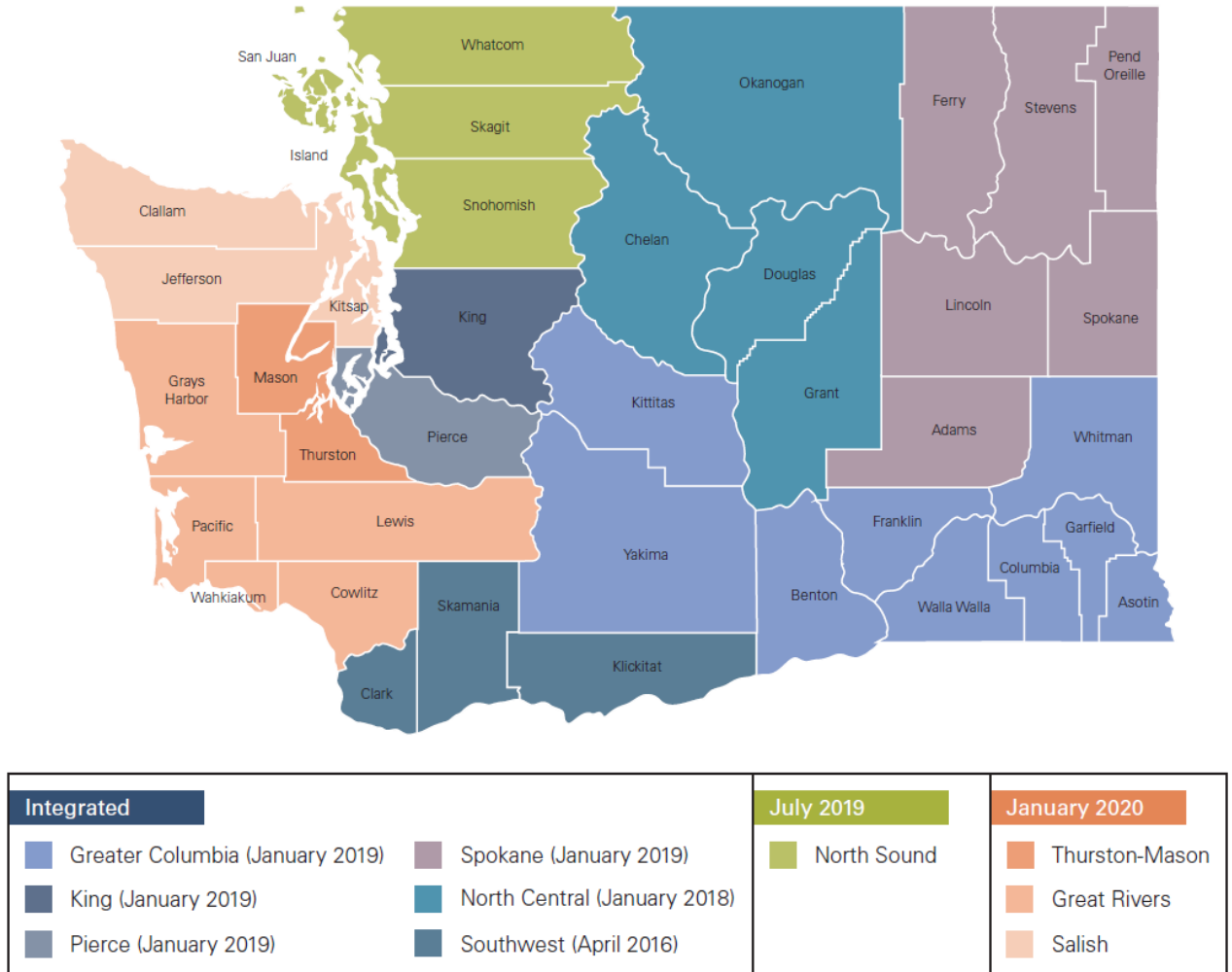
Comagine Health's 2019 EQR of the BHOs consisted of an abbreviated compliance review assessing the BHO's overall performance as well as identifying strengths and recommendations for improvement regarding the BHO's compliance with state and federal requirements for access, timeliness and quality measures. This included assessing compliance with standards related, but not limited, to quality assessment and program improvement, certifications and program integrity; validating the BHO's PIPs; and performing a follow-up review of the Information Systems Capabilities Assessment (ISCA). Additionally, for each BHO, Comagine Health interviewed one mental health agency, one SUD treatment agency and one dual (mental health/SUD) agency as well as performed onsite reviews at two BHAs to assess care coordination and credentialing standards and to perform a walk-through to assess ADA compliance. Finally, Comagine Health reviewed the BHO's previous-year recommendations.

The following sections describe the results of these assessments.

Compliance Review

The compliance portion of Comagine Health's EQR of the BHOs assesses overall performance, identifies strengths, and notes opportunities for improvement in areas where BHOs did not clearly or comprehensively meet federal and/or state requirements. Because the BHOs will cease operations by December 31, 2019, scores were not assigned. Recommendations are intended to aid the state in ensuring BHOs, as appropriate, address compliance deficiencies during their remaining time in operation.

Methodology

Comagine Health evaluated the BHOs' performance on each element of the protocol by reviewing and performing desk audits on documentation submitted by the BHOs, conducting telephone interviews with the BHOs' contracted provider agencies and conducting onsite interviews with the BHO staff.

The procedures for conducting the review included the following:

- Performing desk audits on documentation submitted by the BHO

- Conducting telephone interviews with one SUD treatment agency and one dual mental health/SUD treatment agency on standards related to enrollee rights and protections, the grievance system and program integrity

- Conducting onsite walk-throughs and interviews at two BHAs to evaluate adherence to Americans with Disabilities Act accommodations, care coordination and credentialing standards

- Conducting onsite interviews with BHO staff on standards related to:

  - Quality assessment and program improvement (QAPI)

  - Follow up with ISCA and program integrity

  - Performance improvement projects (PIPs)

  - Following up on the prior year's corrective action plans (CAPs)

After the onsite interview process, the BHO had two weeks to submit additional information and/or documentation. Comagine Health then compiled and submitted to the state a draft report for the BHO, which includes strengths, opportunities for improvement and recommendations for criteria not fully met. To improve accessibility, timeliness and quality of care for Medicaid enrollees, Comagine Health is available throughout the year and during the review process to provide technical assistance to the BHO.

Summary of Results

Table 15. Great Rivers BHO.

Compliance with Contractual and Regulatory Standards
Comagine Health recognizes GRBHO will cease operations on December 31, 2019; therefore, we have noted recommendations, as appropriate, during the final operational period. These assessments are not scored.

Section 1: Availability of Services	
Protocol Section	**CFR Citation**
Delivery Network / Network Adequacy Standards	**438.206 (a)(b)(1), 438.68 (a-c)**

Strengths

- GRBHO's policy and procedure *Availability and Sufficiency of Services* details how the BHO establishes and maintains a network sufficient to provide its enrollees with adequate access to all behavioral health services, the criteria the BHO uses in determining that the network is adequate and how the BHO will monitor its network to ensure adequate staffing is available.

- GRBHO has several formal procedures in place to monitor and evaluate its BHA network for network adequacy, including:

    – reviewing monthly the service hours provided to enrollees by each provider

    – monitoring monthly providers' staffing mix and number of mental health specialist staff

    – monitoring the use of mental health specialists and certified chemical dependency professionals (CDPs) through clinical and utilization data reviews

    – analyzing the actual travel times and distances to BHAs for enrollees in rural and urban areas

Second Opinion	**438.206 (b)(3)**

Strengths

- GRBHO's policy 8007.01, *Right to a Second Opinion*, outlines the steps to take when an enrollee makes a request for a second opinion.

- The BHO's staff were knowledgeable about State and federal requirements regarding second opinions and were able to articulate the internal policies and procedures on second opinions.

- Although GRBHO stated it had not had a formal request for a second opinion, the BHO still requires the BHAs to submit logs of requests for second opinions and has provided the BHAs training/education on second opinions.

Access and Cultural Considerations	**438.206 (c)(2-3), 438.68 (a)(c)**

Strengths

- GRBHO's policy *Culturally Competent Services* includes the requirement that providers consult with an ethnic minority mental health specialist when a culturally related issue is identified and prioritized by the enrollee. The BHAs also use the intake assessment to identify an enrollee's culture, the impact of cultural considerations on treatment and relevant issues of concern as identified and prioritized by the enrollee (or parent/legal guardian, if applicable).

- GRBHO monitors compliance with this requirement through its annual quality management clinical reviews, which include examination of how treatment has addressed identified cultural issues and needs, and whether specialist recommendations have been incorporated and followed in the course of treatment.

- GRBHO requires its staff to complete a training module on cultural competency on an annual basis using the Relias Learning platform. The platform tracks completion of coursework and post-training testing on content.

Assurance of Adequate Capacity and Services	438.207

Strengths

- To ensure there is adequate staffing to provide contracted covered services, including 24/7 response to urgent or emergent requests, GRBHO conducts:
  - monthly monitoring of providers' staffing mix, certifications and specialties and the number of mental health specialist staff, including child, geriatric, developmental disabilities and ethnic minority specialists
  - periodic review to ensure staffing levels are sufficient to assess and provide services to Medicaid enrollees within mandated timeframes

Section 2: Coordination and Continuity of Care	
Protocol Section	**CFR Citation**
Primary Care and Coordination of Healthcare Services	**438.208 (b)(1–5)**

Strengths	**Opportunities for Improvement**
GRBHO's *Coordination of Care* policy and the BHAs' contract state when an enrollee is assessed for services, a behavioral health professional will do the following:	Although the results of Comagine Health's clinical record review for care coordination at two BHAs showed there were a number of charts that contained some evidence of care coordination such as records from other treatment supporters, ISP goals/objectives pertaining to care coordination and completed releases of information, there was little evidence of progress notes that documented correspondence, exchanges of information and collaboration between clinical staff and other relevant treatment supporters.

- GRBHO's *Coordination of Care* policy and the BHAs' contract state when an enrollee is assessed for services, a behavioral health professional will do the following:
  - ask about other systems or providers the individual may also be receiving services from or has received services from in the recent past
  - attempt to obtain releases of information in order to coordinate care
  - ask the enrollee if they need a primary care physician, provide a referral, and help them obtain an appointment
  - track and coordinate care with an assigned primary care provider through the treatment plan and progress notes
- GRBHO has several processes in place to monitor care coordination and health care services furnished to its enrollees by its BHAs. GRBHO monitors care coordination at least annually using a comprehensive clinical record audit tool.
- Additionally, the clinical record audit includes reviewing treatment plans and progress notes for coordination of care and services between the BHA, the

- We recommend the State ensures the BHO:
  - is regularly monitoring the BHAs for care coordination to ensure that clinicians are coordinating with all relevant treatment supporters.
  - continues to provide training on treatment planning and documentation to the BHAs so that care coordination is easily identified in the clinical record.
  - is monitoring the BHAs on adherence to care coordination contract requirements.

	primary care provider and other health care entities.
•	Great Rivers has implemented an incentive measure to increase care coordination services. Data are reviewed quarterly and shared with the Great Rivers Board of Directors, Great Rivers Advisory Board and Quality Management Committee members.

Enrollee Privacy and HIPAA Compliance	**438.224, 45 CFR 164.104, 164.502, 160.316**

Strengths

- GRBHO has a robust monitoring program with many policies in place addressing confidentiality and to ensure compliance with HIPAA regulations.

- GRBHO has several mechanisms in place to ensure its framework for maintaining confidentiality is appropriate:

  – In the event of a breach of unsecured PHI or disclosure that compromises the privacy or security of PHI obtained from any GRBHO data system, the contractor must comply with all requirements of the HIPAA Security and Privacy rules and breach notification rules.

  – The BHO completes a risk assessment and evaluation of its quality program to determine areas for quality improvement, as well as an annual review to evaluate performance.

  – GRBHO requires all contracted providers to maintain an incident reporting structure that includes reporting breaches and incidents involving patient privacy.

  – GRBHO also encourages the reporting of suspected compliance violations and inquiries related to other ethical and compliance issues.

  – The BHO's business associate agreement includes duties of business associates relative to PHI.

- GRBHO's policy *Oversight of Protected Health Information* indicates that the compliance and privacy officers are responsible for a number of activities for ensuring the BHO is HIPAA compliant, including:

  – implementing all HIPAA and confidentiality policies and procedures

  – performing monitoring and auditing for HIPAA compliance

  – providing annual HIPAA and compliance training

  – receiving and investigating reports of HIPAA violation incidents

  – submitting reports of violation of HIPAA and compliance to federal and State authorities

  – coordinating the BHO's HIPAA team to ensure individual rights and confidentiality are maintained by federal and State regulations

Additional Services for Enrollees with Special Health Care Needs	**438.208 (c)(2)**

Strengths

- GRBHO has developed reports to evaluate the number of individuals with identified special health care needs during the initial assessment.

- GRBHO reviews clinical records annually to ensure enrollees with special health care needs received an assessment that is age and culturally relevant, contains developmental history,

identifies any medical concerns, and any other age, cultural or disability concern to determine special health care needs. These record reviews ensure appropriately credentialed staff complete assessments or an appropriately credentialed consultant is utilized

Treatment/Service Plans	438.208 (c)(3)

Strengths

- GRBHO completes annual clinical record reviews, contract monitoring and other clinical reviews conducted by BHO care coordinators, such as Golden Thread review, to ensure that all specialized needs are addressed on the individual service plan.

- GRBHO has provided a number of trainings within their region regarding how to appropriately document assessments, develop individual service plans and document and record progress notes to ensure all needs are being identified and addressed in treatment.

Direct Access to Specialists	438.208 (c)(4)

Section 3: Coverage and Authorization of Services	
Protocol Section	**CFR Citation**
Coverage	**438.210 (a)**

Strengths

- GRBHO has a robust process in place to monitor amount, duration, scope and medical necessity at reauthorization, as well as during other clinical reviews. This process ensures, not only that the enrollee is receiving the right level of care and services but also that the BHA is not arbitrarily denying or reducing services based on diagnosis, type of illness or condition.

- Great Rivers authorization staff work to be consistent in their processing of authorizations. One way they do this is to ensure inter-rater reliability by daily and weekly staff meetings regarding questions of authorizations to make sure staff have the same understanding of how to process them over a variety of situations. The team works together to review clinical information to ensure that there is no arbitrary denial of authorizations.

Authorization of Services	438.210 (b)

Strengths

- GRBHO has developed and implemented a plan to comply with parity and began informing and training providers on parity rules in October 2018. This information was disseminated at Clinical Leadership Meetings, and a Basecamp FAQ document was created to be a comprehensive guide on how to request parity authorizations for complex situations.

- GRBHO has a robust policy and procedure in place ensuring consistent application of continuing stay criteria for enrollees, including a process for consulting with the BHA requesting the authorization when information submitted is incomplete or needs correcting or updated.

- GRBHO is able to verify that all outpatient services that do not require prior authorization are medically necessary by a retro-review process and identifying trends and patterns of problems. Ongoing trends and patterns are analyzed to determine if further in-depth record review is indicated per agency.

- GRBHO ensures inter-rater reliability with daily and weekly staff meetings regarding questions of authorizations to ensure that staff have the same understanding of how to process a variety of situations that may arise when reviewing authorization criteria.

- BHAs are consulted when clarification is needed regarding a specific element needed to determine medical necessity or to determine if the proposed plan of care provides the amount,

duration and scope of services sufficient to meet the individual's needs for continuing care or if information is incomplete or missing. For example:

- If the guarantor does not match the insurance listed in ProviderOne.
- When a mismatch level of care is being requested and clinical rationale not documented in request
- When the individual may be appropriate for WISe services or Program for Assertive Community Treatment (PACT) services, but Level 4 services have been requested
- If it appears the individual needs more/less service than the re-authorization request is documenting
- If lack of progress on treatment goals are documented without a plan to address them

- The BHO includes both the inpatient and outpatient process and criteria for authorizations, including contacting the medical director for special populations and complex cases. GRBHO policy states only a medical director can deny an authorization request for medical necessity.

- WISe authorization requests are authorized by a Mental Health Professional (MHP) who is also a Child Mental Health Specialist (CMHS) or under the supervision of a CMHS. Utilization Management (UM) Coordinators are also able to consult with the UM Management supervisor who is a CMHS regarding any authorization requests that are questionable or complex. The Chief Clinical Officer and medical directors are also available for consultation.

Notice and Timeliness of Adverse Benefit Determination	438.210 (c), 438.404

Strengths

- Great Rivers will issue the enrollee and the requesting agency a written Notice of Adverse Benefit Determination (NOABD) when a decision is made by the BHO to deny, limit, reduce, suspend or terminate authorization for a requested service or service payment.

Timeframe for Decisions, Standard and Expedited	438.210 (d)(1–2)

Compensation for Utilization Management Activities	438.210 (e)

Strengths

- GRBHO's policy *Monitoring of Contractors* ensures compensation to individuals or entities who conduct utilization activities is not structured to provide incentives for the individual or entity to deny, limit or discontinue medically necessary services to any enrollee.

- The safeguards the BHO has in place include contract monitoring, clinical service reviews, continuous real-time data reports, QRT surveys and Ombuds reports.

Section 4: Provider Selection	
Protocol Section	**CFR Citation**
Credentialing and Recredentialing	**438.214 (a-b)**

Strengths

- In March 2019, the BHO updated its credentialing/re-credentialing process which incorporates: Information submission from providers, verification of licensure, verification of Office of Inspector General (OIG), System for Award Management (SAM) and Washington Health Care Authority (WHCA) exclusion for agency, disclosure of ownership, key staff, audit and grievance review; Medical Director review; and Credentialing Committee determination.

- GRBHO ensures the BHAs have in place and follow credentialing and recredentialing processes by sharing credentialing updates at the Clinical Leadership Committee Meetings.

Nondiscrimination of Providers	438.214 (c), 438.12

Strengths

- GRBHO's policy *Provider Selection and Management* states the BHO shall not discriminate against provider network applicants that serve high-risk populations or specialize in conditions that require costly treatment, nor against applicants that practice within the scope of their license or certification under applicable State law, solely based on that license or certification.

- Great Rivers' contracts with the BHAs requires the providers to serve populations based on medical necessity and not to limit services to enrollees who are high risk or need costly specialized treatment.

Excluded Providers	438.214 (d)

Strengths

- Great Rivers conducts monthly exclusion screening which include OIG, SAM and WHCA reviews for all GRBHO and BHAs' staff and Governing Board members, and any person with an employment, consulting or other arrangement with the BHO for the provision of items and services that are significant and material to the BHO's obligations under its contract with the State.

- Great Rivers' BHA contracts clearly specify expected standards of performance for ensuring exclusion screenings and the indicators and methods used to monitor the providers' performances. If a Great Rivers network provider fails to meet its contractual obligations, Great Rivers requires immediate corrective action as specified by contract.

Section 5: Subcontractual Relationships and Delegation

Subcontractual Relationships and Delegation	438.230 (a–c)

Strengths

- GRBHO's policy *Delegation Functions* outlines the BHAs' delegated activities, the required organizational and clinical capacity requirements of the BHAs and how the BHO will monitor the BHAs to ensure compliance with the policy.

- GRBHO conducts ongoing monitoring, concurrent clinical reviews, clinical utilization reviews and formal annual contract monitoring to ensure the quality of delegated services. The BHO has given corrective action to BHAs that have not met the minimum standard, including termination of contracts when necessary.

- Prior to contracting with new providers, GRBHO completes a pre-delegation assessment which includes ensuring the BHAs have met all the required organization and clinical capacity components.

Section 6: Practice Guidelines

Adoption of Practice Guidelines	438.236 (a–b)

Strengths

- GRBHO has several policies and procedures related to the adoption of their practice guidelines. These include the collaborative process utilized by its Quality Management and Utilization/Care Management teams' analysis of utilization data pertaining to prevalence of diagnoses and types of services utilized in Great Rivers region. The BHO involves their Medical Director and Advisory Board throughout the process.

- In consultation with the BHAs, the BHO's guidelines are based on identification of populations with intensive or specialized needs that cut across diagnoses and take into consideration current regional needs of GRBHO's enrollees.
- GRBHO's three practice guidelines include PTSD in children and youth, major depressive disorder in adults and treating adults diagnosed with opioid use disorder.

Dissemination of Guidelines	438.236 (c)

Strengths

- The BHO includes in its *Practice Guidelines* policy a process to disseminate guidelines to all BHAs. They are also available upon request to enrollees and potential enrollees, as well as published on GRBHO's website.
- Practice guidelines are reviewed and disseminated during GRBHO's Clinical Leadership Committee Meetings. The BHO encourages BHAs to take practice guideline information back to their agencies to incorporate the materials into their trainings and provider team meetings.
- When new practice guidelines are adopted, GRBHO provides implementation and ongoing (by request) trainings to BHAs.

Application of Guidelines	438.236 (d)

Strengths

- GRBHO states its practice guidelines are re-evaluated annually or more often as needed with the BHO Clinical Team and Medical Directors and the BHAs are consulted when reviewing guidelines and appropriateness through the Clinical Leadership Meetings.

Section 7: Health Information Systems	
Protocol Section	**CFR Citation**
General Rule, Utilization, Claims, Grievances and Appeals and Disenrollments	**438.242(a)**

Strengths

- GRBHO works with a network and security operation center that provides IT security to ensure HIPAA compliance and information security.
- The BHO utilizes data collected and analyzes it to identify trends in areas. Trends and identified areas of concerns are then shared and discussed at Quality Management Committee meetings and clinical leadership meetings. Trends and concerns are also addressed in the Quality Assessment and Performance Improvement (QAPI) process and workplan.

Basic Elements and Enrollee Encounter Data	438.242 (b-c)

Strengths

- GRBHO has multiple levels of verification of accuracy and completeness of the data including a variety of logic checks, automated weekly reports on invalid demographics and encounters, validation process as the data passes through the EDI, rejections from the state, as well as encounter data validations which are performed annually.
- The BHO reports experiencing challenges operationalizing the data requirements to meet provider business needs as the BHAs struggle with implementing workflows that effectively and efficiently capture the data requirements.
- To mitigate and/or resolve the challenges with collecting accurate data, the BHO implemented a support structure composed of a core team within the BHO as well as functional teams that communicate to multiple levels within the BHAs, including an information systems committee where data and systems are the focus.

- The information systems committee meets monthly to discuss reporting requirements and data quality. The BHO has formed a helpdesk and a FAQ team for responding to questions and data and systems issues.
- Great Rivers has also implemented scheduled trainings, developed training videos and data entry guides. The BHO has contracted additional assistance for systems support, development and implementation, along with enhancements, including reporting assistance as well as developing rigorous error reporting tools to help ensure the data are following the reporting requirements.
- GRBHO requires BHAs to correct identified data errors prior to submitting to the state. If an error cannot be corrected such as an encounter error, then the BHO requires the encounter to be removed from the Information System. If Great Rivers identifies a pattern of error submissions from a BHA, the BHO will contact the BHA and work to resolve the issue.
- The BHO requires BHAs to certify all data submissions within 10 working days after the end of the previous month.

Section 8: Quality Assessment and Performance Improvement Program	
Protocol Section	**CFR Citation**
General Rules	**438.330 (a)**

Strengths

- GRBHO's quality assessment and performance improvement program ensures the on-going practice of evaluating, monitoring, and improving the services delivered to its enrollees.

- GRBHO monitors the quality and appropriateness of care by:

    - conducting PIPs

    - collecting and analyzing performance measurement data,

    - having policies and procedures in place to detect both underutilization and overutilization of services

    - reviewing all grievance data

    - performing ongoing concurrent and retrospective reviews of intakes, authorization of services, and hospitalizations

- GRBHO's Quality Management Committee meets monthly and includes agendas, attendees and minutes. The committee reviews performance measure data and discusses ideas for improvement. Performance measures reviewed include readmission rates, penetration rates, over-/under-utilization, access data, phone accessibility, follow-up services post hospitalization, care coordination and deployment of telemedicine technology.

- The Great Rivers' Quality and Utilization teams conduct ongoing concurrent and retrospective reviews of intakes, re-authorization of services, treatment plans, crisis plans and hospitalizations to monitor the quality of services provided to enrollees and provide feedback to the BHAs for quality improvement.

- Great Rivers' quality management process is responsive to trends and problems through its ongoing monitoring of data, through issues identified by the Quality Review Team (QRT) and Ombuds and by contract monitoring.

- Great Rivers solicits enrollee input/voice in their overall QAPI process through:

    - The work performed by its QRT. The QRT includes individuals enrolled in services of the behavioral health system, past enrollees, and/or family members of enrollees. The QRT independently reviews the performance of Great Rivers and BHAs to evaluate through its enrollee surveys; and through meeting with interested individuals who are enrolled in services, family members and allied service providers as appropriate to

> determine if services are accessible and designed to address the needs of the individuals in services.
>
> – The GRBHO's Behavioral Health Advisory Board which is representative of the geographic and demographic mix of Great Rivers' service population and includes at least 51% consumer membership, which also solicits and uses enrollee voice and input to improve services.
>
> – The results of its own annual client satisfaction/member experience survey that was recently conducted at provider agencies May 20, 2019 – June 3, 2019.
>
> – Attending regional Family Youth System Partner Round Table (FYSPRT) meetings and a WISe Community Collaborative meeting to gather both stakeholder and enrollee input.

- This information is reviewed and integrated into the quality management plan as appropriate and shared with the relevant BHAs for program improvement and development process.

Basic Elements	438.330 (b)(1–4)

Strengths

- GRBHO reviews all grievances and incident reports and identifies trends and areas of improvement through Great Rivers' Critical Incident and Grievance Committee and QMC.

- An example of a trend identified through the grievance reporting system was enrollees were reporting that telemedicine prescribers were not treating them with dignity and respect. GRBHO initiated a Great Rivers' provider network team member to contact the telemedicine provider and discuss the concerns and ideas for improvement.

- The Great Rivers' Quality and Utilization teams conduct ongoing concurrent and retrospective reviews of intakes, re-authorization of services, treatment plans, over and underutilization of services, crisis plans and hospitalizations. These reviews help Great Rivers to monitor the quality of services and provide feedback to providers for quality improvement.

- Additionally, all BHAs have quality management plans and work plans. Great Rivers reviews them annually during contract compliance audits. As we move closer to 2020, BHAs have become more focused on individual agencywide efforts to prepare for the transition to MCOs. Great Rivers has been reinforcing the importance of data analysis by increased data sharing both in meetings and through individual reports provided on SFTP sites. During meetings, Great Rivers asks each provider to share during discussions so their feedback and experiences can be considered for QI activities.

Performance Measurement	438.330 (c)

Strengths

- The Great Rivers Behavioral Health Quality Work Plan Indicators for 2018-2019 were developed to include the performance measures defined by the State as well as expectations outlined in the BHO contract.

- GRBHO takes into consideration best practice, audit results, recommendations from the utilization management team and network analysis done by the BHO's Provider Network team. The BHO's performance indicators are objective, measurable, based on current knowledge, best practice or both, and include at least those measures defined by contract with the State.

Performance Improvement Projects	438.330 (d)(1–3)

Opportunities for Improvement

- GRBHO did not pursue EQR 2018 recommendations nor new study topics in 2019. The children focused, clinical and substance use disorder focused and non-clinical PIPs which were in process in 2018 were retired as incomplete due to unforeseen outcomes.

• It is recommended the BHO regroup and develop revised, robust interventions intended to produce successful outcomes. GRBHO should utilize a range of quality tools and techniques such as root cause analyses (RCA), driver diagrams, process mapping, failure modes and effects analysis (FMEA) as well as find, organize, clarify, uncover and start (FOCUS), to aid in removing barriers to successfully achieving improvement for the PIP interventions. • GRBHO may want to use the various committee meetings with stakeholders as opportunities to identify and address regionwide barriers to the PIP interventions, which may be impacting the ability to achieve meaningful improvement.	

Program Review by the State	438.330 (e)

Strengths

- GRBHO's Executive Management Team is responsible for ensuring the implementation of all aspects of the Quality Improvement Program. GRBHO's Behavioral Health Advisory Board also provides input into the annual QM Plan and Work Plan. Ultimately Great Rivers Governing Board has final accountability for the management and improvement of the quality of clinical care and services provided to individuals.

- On an annual basis, the Governing Board reviews the Quality Management Plan and Work Plan. Great Rivers' Medical Director approves the plans. QM updates are presented monthly to the BHO Executive Management Team. The BHO Executive Management Team makes recommendations that are operationalized by the Quality Management Committee.

- GRBHO submitted its year-end evaluation to both the State and Comagine Health. GRBHO's 2018-2019 *Quality Management, Utilization Management and Care Management Program Evaluation* is an excellent example of what should be included in a program evaluation. This report which presents the evaluation of Great Rivers Quality Management Plan and the entire Quality Program, as well as the Utilization Management and Care Management programs gives the reader a clear understanding of the goals and outcomes of the BHO as it moves to improve the overall well-being of enrollees in their regions.

- The BHO is commended for its successes in helping to improve the quality of care, as well as the timeliness and access to services for its enrollees as well as those in the community.

Performance Improvement Projects
Children's Clinical PIP: Improved Outcomes for Children and Youth with Intensive Behavioral Health Needs
SUD Non-Clinical PIP: Grievance Process for Behavioral Health Agencies Providing Substance Use Disorder Treatment Services

Previous-Year Corrective Action Plans (2018)		
Section	**Number of CAPs**	**Number Resolved**
Enrollee Rights and Protections	0	N/A
Grievance System	0	N/A
Certifications and Program Integrity	0	N/A

Table 16. Salish BHO.

Compliance with Contractual and Regulatory Standards
Comagine Health recognizes SBHO will cease operations on December 31, 2019; therefore, we have noted recommendations, as appropriate, during the final operational period. These assessments are not scored.

Section 1: Availability of Services	
Protocol Section	**CFR Citation**
Delivery Network / Network Adequacy Standards	**438.206 (a)(b)(1), 438.68 (a-c)**

Strengths

- SBHO's policy *Service Provider Selection* indicates that the BHO establishes and maintains a sufficient network of contracted providers, including outpatient behavioral centers and evaluation and treatment facilities, to ensure sufficient access and capacity to serve the BHO's expected number of enrollees. The BHO monitors for this policy by conducting annual provider and subcontractor administrative reviews, reviewing annual network provider staffing directories and analyzing annual Medicaid enrollment projections.

- To establish and maintain network sufficiency, SBHO analyzes data from several sources — including its customer service call log, grievance and appeal logs, Quality Review Team (QRT) satisfaction surveys, Utilization Management (UM) reports and information discussed at the BHA clinical directors' meetings.

- SBHO requires all BHAs to accept new Medicaid clients. To ensure BHAs are not denying services to clients, SBHO regularly monitors the BHAs by reviewing grievances and conducting a 100% review of denied services to ensure appropriateness.

Second Opinion	**438.206 (b)(3)**

Strengths

- SBHO's policy *Second Opinions* states that Medicaid enrollees within the BHO's network have the right to free access to a second opinion from another clinician within the network. If a qualified clinician is not available in the network, the BHA must refer the enrollee to a provider outside the network for a second opinion at no cost to the enrollee.

- Enrollees receive information related to their right to receive a second opinion from a qualified health care professional at no cost in accordance with 42 CFR 438.206(b)(3) via the SBHO *PIHP Member Handbook* which contains the SBHO client rights. The handbook is mailed out to all authorized enrollees at the time of authorization and is listed on the BHO's website.

- SBHO monitors BHA compliance to the *Seconds Opinions* policy by reviewing monthly and quarterly grievance reports, monthly Ombuds reports, reporting from the Quality Improvement Committee (QUIC) meetings and results from the annual provider chart reviews.

- SBHO requires the BHAs to track and monitor requests for second opinions and make the logs available to the BHO at the time of the administrative review.

Access and Cultural Considerations	**438.206 (c)(2-3), 438.68 (a)(c)**

Strengths

- SBHO's policy *Culturally Competent Services* states that the BHO maintains a directory of in-network cultural consultants, bilingual staff and evidence-based trained staff. The BHO makes this information available to its BHAs, and updates and distributes it annually.

- SBHO monitors adherence to the Culturally Competent Services policy by:
  - Conducting administrative and clinical chart reviews

– Reviewing grievance reports, results of quarterly onsite reviews	
– Performing licensing and certification reviews	
– SBHO provides cultural diversity training; the curriculum includes:	

- Awareness of the lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI) community
- Gender, gender identity and gender dysphoria
- Difference between sexual orientation and gender identity
- Risk factors and health disparities that exist for the members of the transgender community
- How to create inclusive and culturally competent services
- Community resources for the LGBTQI community, family members and friends

Assurance of Adequate Capacity and Services   438.207

Strengths

- SBHO requires the BHAs to seek, on behalf of enrollees, services from external, out-of-network providers, as medically necessary whenever they do not have the needed services available. Authorizations follow the current authorization processes based on the level of care for the service. The BHO monitors referred services through the annual provider fiscal review, tracking of single-case agreements, review of authorization tracking logs, grievance tracking logs and administrative reviews.

Section 2: Coordination and Continuity of Care	
Protocol Section	**CFR Citation**
Primary Care and Coordination of Healthcare Services	438.208 (b)(1–5)

Strengths

- SBHO has several policies that address coordination of care to ensure that medically necessary services are provided, and care coordination occurs between the enrollee's BHA and primary medical care providers.

- SBHO requires its provider agencies to assign a mental healthcare professional (MHP) to coordinate care with each enrollee's primary care provider (PCP). If the enrollee does not have a PCP, the MHP assists the enrollee in acquiring a PCP.

- SBHO monitors care coordination through several methods, including assigning a BHO staff member to:

  - Attend weekly Youth Inpatient Evaluation & Treatment facility team meetings
  - Attend the weekly Child & Family Resource Management meetings
  - Facilitate Wraparound with Intensive Services (WISe) clinical manager meetings
  - Conduct clinical chart reviews to audit for evidence of care coordination in the enrollee's treatment plan and progress notes, for the presence of release of information documents, and for documentation of correspondence between providers

Recommendations to the State

The BHO has policies, procedures and contract language regarding the coordination of care and services provided by the BHAs and SBHO. However, Comagine Health's review of 20 randomly chosen clinical records indicated that care coordination within the BHO network is poorly documented. There was little to no evidence that care coordination occurred.

Although treatment supporters were identified in many of the assessments, the charts lacked a plan to coordinate care with relevant treatment supporters.

- We recommend the State ensures the BHO is monitoring the BHAs on adherence to care coordination contract requirements until the BHO ceases operations.

Enrollee Privacy and HIPAA Compliance	**438.224, 45 CFR 164.104, 164.502, 160.316**

Strengths

- SBHO has several policies on confidentiality and privacy that specifically outline how the BHO and each of its providers and other subcontractors will comply with all federal and state privacy regulations, including HIPAA and 42 CFR Part 2.

- SBHO trains BHA staff and its own staff at least annually on the requirements of the privacy and security regulations of HIPAA and 42 CFR Part 2.

- The training curriculum, which is annually reviewed and modified as required, includes an overview of the law, privacy regulations, security regulations, and breach notification regulations.

- When documents containing PHI are transported to and from the BHO or the BHAs, SBHO ensures confidentiality is maintained by requiring that:

  - The approval of a supervisor is obtained

  - Only the minimum necessary amount of PHI is transported

  - PHI (including in portable media devices) is never left unattended, including inside a vehicle

  - All PHI is transported in a dedicated, locked container within a locked vehicle, preferably out of sight, such as in the trunk

  - BHA staff maintain a log of files or documents that are being transported from the BHA site

Additional Services for Enrollees with Special Health Care Needs	**438.208 (c)(2)**

Strengths

- The BHO uses the following to describe enrollees with special health care needs:

  - "Special healthcare needs include any physical, developmental, mental, sensory, behavioral, cognitive or emotional impairment or limiting condition that requires medical management, healthcare intervention and/or use of specialized services or programs. The condition may be congenital or developmental, or acquired through disease, trauma or environmental cause and may impose limitations in performing daily self-maintenance activities or substantial limitations in a major life activity."

- The BHO states that because they adhere to the above definition, all BHO's enrollees have special healthcare needs and will receive services that meet all federal and state requirements.

- Per contract requirements and SBHO's *Individuals with Special Health Care Needs Policy*, the BHO monitors through annual administrative reviews and annual clinical chart reviews to ensure enrollees are assessed by appropriate credentialed professionals.

Treatment/Service Plans	**438.208 (c)(3)**

Strengths

- SBHO ensures that treatment plans for enrollees are developed with the enrollee's participation, and in consultation with any specialists caring for the enrollee.

- The BHO monitors progress notes, clinical chart reviews and the grievance system to determine whether treatment plans provide necessary services and include client voice. The

results of the clinical chart reviews are submitted to the Quality Assurance (QA) Department for analysis and review at the QUIC meetings and for incorporation into the Quality Management Plan (QMP) and work plans as needed. Corrective action plans may also be utilized if results indicate a significant deviation from expected performance.

Direct Access to Specialists	438.208 (c)(4)

Strengths

- SBHO requires, when the BHAs determine that an individual has a medically necessary need for specialized behavioral health care services not provided at their agency, that they are responsible for purchasing out of network services in accordance with the BHO's Policy 11.16 – Provider Purchasing Out of Network Services.

Section 3: Coverage and Authorization of Services	
Protocol Section	**CFR Citation**
Coverage	**438.210 (a)**

Strengths

- The duration, amount and scope of services offered are outlined in the SBHO Behavioral Health Level of Care Guidelines (SBHO Policy 7.03) which states the services rendered must meet medical necessity and adhere to all applicable System for Award Management (SAM) and WAC requirements. The BHO refers this determination to BHAs.

- All enrollee services are monitored by SBHO through clinical chart reviews and reviews of utilization management information at the regional provider meetings with all network BHAs. SBHO provides ongoing technical assistance to all BHAs should they need additional guidance for current or new services.

- When the SBHO identifies challenges pertaining to services not being provided to achieve the intended purpose, the SBHO Clinical Care Managers and/or Quality Assurance Manager will coordinate services in conjunction with network BHAs as well as offer ongoing technical support.

Authorization of Services	438.210 (b)

Strengths

- The BHO's policy *Authorization of Services Independent from Financial Incentives* states that compensation to CommCare, its Administrative Services Organization (ASO), is not structured to provide incentives for denying, limiting or discontinuing medically necessary services to any enrollee. CommCare, per its contract with the BHO, receives a flat monthly sum for all Medicaid enrollees in the SBHO catchment area, regardless of authorization decision.

- SBHO's ASO, CommCare, and SBHO staff apply consistent criteria when making authorization decisions that adhere to the SBHO level of care standards, access to care and medical necessity. Regardless of service authorization type (initial or continuing), CommCare and SBHO staff must ensure the requested services are clinically and fiscally sound.

- Additionally, CommCare conducts inter-rater reliability testing between CommCare's clinical staff to determine how consistent staff members are in authorizing the same level of care given the same clinical information.

- The SBHO monitors the BHAs to ensure they have written policies and procedures in place for providing services in an amount, duration and scope sufficient to achieve the purpose for which they are provided and for requesting authorizations for extensions of services this through routine administrative review of the network BHAs.

- Mental health residential service authorization requests are conducted by SBHO clinical staff. BHAs submit initial and continuing authorization requests via HIPAA secure online forms. BHO clinical staff with the appropriate credentials review the request for medical necessity, access

> to care standards, functional impairment and diagnosis. BHAs are notified of the authorization or denial via peer-to-peer phone calls, documenting this notification in the request form.
>
> - For individuals who require continued stays after the initial authorization period, continuing stay criteria are reviewed every 180 days. These components include that admission criteria for residential services continues to be met and the individual must have a treatment plan that identifies need and measurable goals for residential services. The individual must be making progress toward treatment goals.

Notice and Timeliness of Adverse Benefit Determination	**438.210 (c), 438.404**

Strengths

- With parity, the SBHO does not authorize routine outpatient (OP) level services, and only sends Notice of Adverse Benefit Determination (NOABD) notifications upon request from BHAs. Should SBHO disagree with the denial request based on the BHO reviewer's determination that services should be provided based on medical necessity, then peer-to-peer discussions will occur with the requesting agency.

- If the SBHO denies a mental health residential authorization request, the BHO has a process for creating a denial request that will then follow the existing procedures for denials. In accordance with SBHO utilization management policies, if the BHO ASO, CommCare, decides to deny or limit a service authorization request, they will first request additional information from the network provider and conduct a peer-to-peer review. If the denial decision is finalized, mental health providers are notified via their electronic medical record or secure email by CommCare staff. SUD providers are notified by CommCare returning the authorization form via HIPAA compliant secure encrypted email/fax with the authorization decision.

- In accordance with parity rules, CFR and SBHO policies, when BHAs deny a request for outpatient services due to not meeting medical necessity, they submit a denial request via a HIPAA secure on-line form to SBHO. Appropriately credentialed SBHO clinical staff review the request and, if approved, the SBHO issues a NOABD letter to the enrollees.

- For mental health and SUD residential services, if SBHO determines that the authorization request is denied or limited, the SBHO issues a NOABD letter to the enrollee.

- In all cases denial letters are issued in the enrollee's native language, explaining what action was taken, the reason behind the action and how to request an appeal of such a decision. Fair Hearing options are also explained. These letters are issued within 14 days of the request for services, unless an extension is requested. For non-Medicaid eligible authorization denials, a Letter of Determination is issued to the individual.

Timeframe for Decisions, Standard and Expedited	**438.210 (d)(1–2)**

- Standard authorization decisions are made as expeditiously as the enrollee's condition requires and within the state's established timeline, within 14 days of the date of the request for services, unless an authorization extension of up to 14 days is requested. Standard authorization decisions for psychiatric inpatient and secure detox authorization requests are made within 12 hours of the request.

- Expedited authorization decisions are made when following the standard time frame could seriously jeopardize the enrollee's life, health or ability to attain, maintain or regain maximum function.

Compensation for Utilization Management Activities	**438.210 (e)**

Strengths

- SBHO delegates authorization for inpatient mental health services, secure detox and residential SUD services as well utilization management to its ASO, CommCare. CommCare is required by contract to adhere to Utilization Review Accreditation Commission (URAC) standards. Payments are not dependent on services provided. CommCare is paid a flat monthly sum for all Medicaid enrollees in the SBHO catchment area, regardless of the authorization decisions.

Section 4: Provider Selection	
Protocol Section	**CFR Citation**
Credentialing and Recredentialing	**438.214 (a-b)**

Strengths

- SBHO's credentialing/re-credentialing process includes reviewing information submitted from network providers, verification of licensures, verification of Office of Inspector General (OIG), System for Award Management (SAM) and Washington Health Care Authority (WHCA) exclusion for agency, debarment certification, governing board/board of trustees, disclosure of ownership and staff roster.

- The BHO makes sure BHAs comply with credentialing and re-credentialing processes through annual administrative reviews and monthly tracking of the BHAs written attestations of verification.

Nondiscrimination of Providers	**438.214 (c), 438.12**

Strengths

- SBHO's *Service Provider Selection Policy* states the BHO will not discriminate against any network provider that is acting within the scope of their license or certification solely based upon the basis of that status.

- The BHO's contracts with the BHAs require the providers to serve enrollees based on medical necessity and not to limit services to enrollees who are high-risk, high-cost or need specialized treatment.

- SBHO has policies in place that ensure BHAs providing the same type of services are reimbursed in the same manner. Mental health providers receive payment based on a sub capitation basis and SUD providers receive payment based on a case rate.

- The BHO has a process of notifying providers when they are not chosen for participation in the network. In March 2019, an outpatient SUD/MH provider demonstrated interest in contracting with SBHO. The BHO deemed the provider did not meet the requirements set forth in its *Service Provider Selection Policy*. The provider was located in Kitsap County which already had sufficient network capacity. The provider was notified of the decision in writing.

Excluded Providers	**438.214 (d)**

Strengths

- SBHO has policies and processes in place requiring BHAs to disclose the name and address of any person with an ownership or controlling interest in the BHA. If a change in ownership occurs, the BHA must notify the BHO within 35 days.

Section 5: Subcontractual Relationships and Delegation	
Subcontractual Relationships and Delegation	**438.230 (a–c)**

Strengths

- SBHO delegates many aspects of the authorization and utilization management functions to the BHO's ASO, CommCare. This Contractor performs all authorization functions for SUD residential and inpatient behavioral health services, conducts service denial notifications and

- appeal requests on behalf of the SBHO for these services. CommCare is required to maintain URAC and/or NCQA accreditation.

- SBHO evaluated any prospective subcontractor's ability to perform activities before any new subcontracting delegation decision was finalized. Areas of delegation included: organizational capacity, clinical/staffing capacity, quality improvement processes, HIPAA and Medicaid compliance, data security requirements and authorization for services and utilization management.

- SBHO monitors the quality of delegated services on an ongoing basis through contract monitoring and clinical services review, as well as ongoing concurrent reviews. Additionally, SBHO utilizes its *Subcontractor Delegation and Assessment Tool* to conduct performance reviews.

- When SBHO identifies delegation deficiencies or areas for improvement, the BHO takes corrective action. The delegated subcontractor is required to respond to specified areas of non-compliance with a Corrective Action Plan (CAP). The CAP is required to be submitted to SBHO no later than 30 days after the receipt of the audit results for approval.

Section 6: Practice Guidelines

Adoption of Practice Guidelines	438.236 (a–b)

Strengths

- SBHO has a number of policies and processes related to the adoption of practice guidelines. Processes include collaboration with the BHA's clinical directors and discussions with the BHAs held at both the SBHO QUIC and Utilization Management Committee (UMC) meetings.

- The BHO's Clinical Practice Guidelines Workgroup recommended the use of the American Psychiatric Association (APA), the American Academy of Child & Adolescent Psychiatry (AACAP) and Substance Abuse and Mental Health Services Administration (SAMHSA) practice guidelines after analysis of the current service needs of enrollees with the most prevalent behavioral health diagnoses within SBHO's region.

- SBHO's five practice guidelines include: trauma disorders in children and youth, treating adults diagnosed with schizophrenia, bipolar disorder in adults, PTSD in adults and substance use disorder assessment and coordination of alcohol and other drugs (AOD) treatment.

Dissemination of Guidelines	438.236 (c)

Strengths

- The BHO disseminates practice guidelines to all BHAs and upon requests by enrollees as well as publishing the practice guidelines on SBHO's website.

Application of Guidelines	438.236 (d)

Strengths

- SBHO consults with its BHAs' clinical directors to identify which elements to monitor within each adopted practice guideline.

- The BHO reviews, at least yearly, a sample of charts for adherence to the appropriate guidelines. and presents the results to the QUIC. The BHO also provides summary results of these chart reviews to its BHAs.

- SBHO incorporates its practice guidelines into the BHO's utilization management (UM) protocols.

Section 7: Health Information Systems

Protocol Section	CFR Citation
General Rule, Utilization, Claims, Grievances and Appeals and Disenrollments	**438.242(a)**

Strengths

- SBHO requires all providers to submit their data based on the requirements listed in the Service Encounter Reporting Instructions (SERI), the SBHO Data Dictionary, and the 837 Encounter Guides listed on the HCA website. Providers upload the data to the SBHO SFTP where it is imported into the SBHO clearinghouse which is run every day. Providers receive a batch summary and an error report in return. The culmination of the data contained within these transactions is stored in the Clearinghouse SQL database with the ability of the BHO to query the results. The BHO uses the reports generated from these queries to assist in identifying utilization trends and needs.

Basic Elements and Enrollee Encounter Data	438.242 (b-c)

Strengths	Opportunities for Improvement
- SBHO has monthly provider meetings to keep all the BHAs informed of their current accuracy, completeness, integrity and timeliness of their data. - As several agencies have recently or are still planning to transition to a new EMR, the BHO has implemented significant efforts to ensure data are being submitted properly and timely. This includes data submission processes, testing of new systems and monitoring via QUIC for specific timeliness and accuracy measures. - SBHO ensures there is sufficient notice of new SERI changes to the BHAs and that BHAs have needed contact information should they have questions or need technical assistance until the BHO ceases operations.	The BHO's last EDV review was the first year incorporating all SUD providers into the EDV. The BHO's findings indicated that there remain many differences between the performance of the mental health agencies and the SUD agencies. SBHO issued CAPs for all agencies that did not meet minimum standards of the encounter data validation. SBHO conducted follow up to ensure implementation of the CAPs was also conducted by the BHAs. Several agencies have recently or are still planning to transition to a new EMR. - The BHO should continue to monitor the BHAs and provide any necessary technical assistance to ensure data transmitted to the BHO are accurate and timely until the BHO ceases operations.

Recommendations to the State

We recommend the State ensure the BHO monitors BHAs and provide any necessary technical assistance to ensure data transmitted to the BHO are accurate and timely until the BHO ceases operations.

Section 8: Quality Assessment and Performance Improvement Program

Protocol Section	CFR Citation
General Rules	**438.330 (a)**

Strengths

- The BHO assesses the quality and appropriateness of care furnished to enrollees through a variety of methods. SBHO monitors quality performance in four primary areas: quality of services, satisfaction, administrative practices and compliance.

- SBHO analyzes information gathered through quality assurance tools and activities developed to improve strategies to enhance quality of care and services. Activities to support these assessments include but are not limited to:
  - Developing, reviewing and updating the quality management plan
  - Developing, tracking and monitoring of regional performance measures (including the core performance measures specified in the PIHP contract)
  - Continued monitoring and review of all grievances (provider and SBHO)
  - Providing oversight to other components by including clinical chart reviews, targeted ad hoc reviews, utilization management reporting, critical incident reporting, the new parity processes and performance improvement projects
- At the end of each year, SBHO submits the annual *QA Program Evaluation Summary* to HCA as a contract deliverable with the work plan and self-assessment.
- SBHO's BHAs are involved in the ongoing efforts to have a quality improvement program. Each BHA is reviewed at least annually via the administrative review process to monitor their own quality program.
- The BHAs' quality management plan is reviewed along with the BHAs' participation in the QUIC, grievance reporting system, critical incident reporting, and other aspects that contribute to a healthy and active overall quality program such as regular internal supervision and chart reviews.
- When BHAs have any need for assistance in developing or improving aspects of their quality program, the SBHO is available to provide technical assistance.

Basic Elements	438.330 (b)(1–4)

Strengths

- SBHO reviews significant deviation from what is considered optimal utilization levels based on medical necessity and level of care. For underutilization, criteria include clients not receiving the level and quantity of services that are medically necessary. This includes not being authorized for services when their actual need indicates services are medically necessary.

- Overutilization is reviewed by the SBHO for clients who are accessing levels/types or quantities of services that are in excess of medically necessity. SBHO also defines overutilization as an individual who has more than one inpatient psychiatric hospitalization within a 30-day time period.

Performance Measurement	438.330 (c)

Strengths

- While the contractually required performance measures are officially monitored and tracked by the State, SBHO also tracks, monitors and assesses the performance measures using its own data sources for the purposes of comparison, internal awareness and to provide opportunities to be proactive should concerning trends be observed.

- SBHO also continually assesses, discusses and updates, as necessary, its regional performance measures created by the QA Department with QUIC oversight and input. These regional performance measures are reviewed during work plan development and as a part of the annual QA program evaluation.

Performance Improvement Projects	438.330 (d)(1–3)

Please review the PIP section of this report.

Program Review by the State	438.330 (e)

Strengths

- Annually, SBHO's QA Department completes the QA program evaluation summary per contract requirements. This is a detailed process whereby all aspects of the Quality Program are examined and evaluated; goals for the coming year are also planned. The report is disseminated to the BHO's boards and QUIC for review and feedback which is considered for inclusion in future planning and evaluation.

- SBHO states it plans to submit its annual program evaluation, risk assessment and work plans by January 15, 2020, unless directed by the State to do otherwise. Because of the transition, the BHO states some content may be different although the same focus on providing the highest quality services will remain.

- SBHO's QUIC meets every other month, after the regional provider meetings. The QUIC is fully integrated and now includes members from both mental health and SUD QUICs.

Performance Improvement Projects

Children's Non-Clinical PIP: Increasing Child and Family Team Meetings Among High-Risk, High-Cost and High-Need Children Served by the Mental Health System

SUD Non-Clinical PIP: Improving Implementation of the Grievance System Among SUD Treatment Providers

Previous-Year Corrective Action Plans (2018)		
Section	**Number of CAPs**	**Number Resolved**
Enrollee Rights and Protections	3	3
Grievance System	0	N/A
Certifications and Program Integrity	1	1

Table 17. Thurston Mason BHO.

Compliance with Contractual and Regulatory Standards
Comagine Health recognizes TMBHO will cease operations on December 31, 2019; therefore, we have noted recommendations, as appropriate, during the final operational period. These assessments are not scored.

Section 1: Availability of Services	
Protocol Section	**CFR Citation**
Delivery Network / Network Adequacy Standards	**438.206 (a)(b)(1), 438.68 (a-c)**

Strengths	**Opportunities for Improvement**
• TMBHO's provider contract states that any time it is determined a provider is at capacity and cannot accept any new enrollees, the provider must report it to the BHO. • TMBHO collaborates on a regular basis with providers, especially children's services such as Wrap-Around Intensive Services (WISe), to stay apprised of any staffing circumstances that impact the providers' ability to deliver services. • TMBHO utilizes Language Link for interpreter services, which includes ASL requests. In addition, TMBHO purchased a braille machine over five years ago to ensure all alternative formats are made available upon request by any Medicaid enrollee. This includes any information about the network, as well as other written or verbal information shared and/or provided by TMBHO and its network providers.	TMBHO submitted its 2019 Managed Care Accessibility Report which includes the list of BHAs, enrollees served by ZIP code, ethnicity, languages spoken and distance to providers; it does not include an analysis of network providers and specialties to show the network is sufficient in number, mix and geographic distribution to meet the needs of the current and anticipated number of enrollees in the service area. • If the BHO were to continue operations, the BHO would need to ensure an analysis of network providers and specialties within its report.

Recommendations to the State
We recommend the State ensure the BHO is analyzing its network providers and specialties to show the network is sufficient in number, mix and geographic distribution to meet the needs of the current and anticipated number of enrollees in the service area.

Second Opinion	**438.206 (b)(3)**
Strengths	**Opportunities for Improvement**
• Upon intake, TMBHO makes copies of the DSHS Handbook, Enrollees Rights and Ombuds Brochure available to all enrollees. • Second opinions have primarily taken place for continued stays at inpatient facilities. The facilities provide the BHO with the clinical records which is then submitted to the BHO's second opinion physician. If medical necessity has been met, the request is granted.	Although TMBHO stated it requires the BHAs to submit second opinion logs, the submitted logs were blank as enrollees have not sought second opinions for outpatient services. • TMBHO should require BHAs to submit a statement indicating its enrollees did not seek second opinions during the reporting period if no requests were received.

Access and Cultural Considerations	438.206 (c)(2-3), 438.68 (a)(c)

Recommendations to the State

TMBHO did not submit documentation indicating the BHO provided any trainings to the BHAs on cultural competencies. Additionally, TMBHO did not submit documentation showing any monitoring or tracking of the delivery of services to enrollees with limited English or diverse cultural and ethnic backgrounds.

TMBHO's administrative monitoring tool includes reviewing BHAs for compliance with ADA standards. Although the state licensing division reviews the BHAs for ADA compliance, Comagine Health has found that there continue to be inadequacies with the BHAs in complying with ADA requirements.

- We recommend the State ensure the BHO continue to:
  - monitor the BHAs for compliance to ADA requirements and address any issues
  - provide trainings to the BHAs on culturally competent health care service delivery
  - monitor and track the BHAs' delivery of services to enrollees with limited English or diverse cultural and ethnic backgrounds

Assurance of Adequate Capacity and Services	438.207

Strengths

- TMBHO reported it has few "out-of-network requests" as it has continued to expand its provider network through its "open network" policy and contracting with out-of-region providers including multiple SUD providers throughout the state. These specialized services are covered under their access to care standards and are contracted through Single Case Agreements

Recommendations to the State

Although TMBHO reported it has significantly increased capacity over the past two years, BHAs are affected by workforce shortages within this region.

- We recommend the State partner with the BHO to recruit qualified clinical staff to meet the needs of enrollees in high intensity behavioral health programs.

Section 2: Coordination and Continuity of Care	
Protocol Section	**CFR Citation**
Primary Care and Coordination of Healthcare Services	438.208 (b)(1–5)

Recommendations to the State

The BHO has policies, procedures and contract language regarding the coordination of care and services provided by the BHAs and TMBHO. However, the review of 20 randomly chosen clinical records indicated that care coordination within the BHO network is very poorly documented. Despite the fact most of the charts contained releases of information, there was little to no evidence that care coordination occurred.

Although treatment supporters were identified in the assessment, most of the charts lacked a plan to coordinate care with relevant treatment supporters.

- We recommend the State ensures the BHO is monitoring the BHAs on adherence to care coordination contract requirements.

Enrollee Privacy and HIPAA Compliance	438.224, 45 CFR 164.104, 164.502, 160.316

Strengths

- TMBHO abides by its policy, *Use and Disclosure of PHI*, which requires BHO staff comply with HIPAA regulations and reporting requirements.
- TMBHO has a policy and procedure to ensure a covered entity or business associate may not threaten, intimidate, coerce, harass, discriminate against or take any other retaliatory action

against any individual or other person for filing a complaint with CMS or the State regarding HIPAA compliance.	

Additional Services for Enrollees with Special Health Care Needs	**438.208 (c)(2)**

Strengths

- TMBHO's policy, Management of High-Risk Consumers, describes the BHO's procedure for identifying any special conditions for high risk and/or special needs enrollees. The procedure is designed to specifically address high risk enrollees' unique treatment engagement needs. Activities include initial and ongoing identification of enrollees with special health care needs, high-risk care plan staffing, staff training, hospital discharge planning and utilization/care management tracking.
- TMBHO reported that as of March 2019, 14.7% of enrollees (10,721 of 72,942 total) in the TMBHO network met the special health care needs criteria, as follows:
  - 6,386 Disabled adults
  - 2,843 Adults aged 65 or older
  - 1,492 Early and Periodic Screening, Diagnostic, and Treatment children with multiple needs (disabled)

Recommendations to the State

Although both the policy on high-risk enrollees and the BHO's utilization program description states the BHO will track over- and underutilization of services, the BHO was unable to produce any related reports.

- We recommend the State ensure the BHO has mechanisms in place to detect both over- and underutilization of services for enrollees with special health care needs and for assessing the quality and appropriateness of care furnished to enrollees with special health care needs.

Treatment/Service Plans	**438.208 (c)(3)**

Strengths	**Opportunities for Improvement**
- TMBHO's care management team conducted treatment planning training for the BHAs on March 20, March 28 and November 14, 2018.	TMBHO stated it reviews treatment plans for enrollees with special health care needs to ensure the treatment plans are developed with the enrollee's participation and in consultation with any specialists caring for the enrollee; however, the BHO was unable to substantiate this statement as it did not submit any results of these reviews. - The BHO should ensure documentation of treatment plans includes development with the enrollee's participation and in consultation with any specialists.

Recommendations to the State

The review of 20 randomly selected clinical records indicated that enrollees' special health care needs were not incorporated into the individual service plans.

- We recommend the State ensure the BHO is identifying enrollees with special health care needs and the BHAs' treatment plans for enrollees with special health care needs are developed with the enrollee's participation and in consultation with any specialists caring for the enrollee.

Direct Access to Specialists	438.208 (c)(4)

Strengths

- TMBHO does not require referral/authorization of enrollees identified as having special health care needs. The BHO's provider contract requires the providers to accommodate this population's special health care needs when identified. However, TMBHO does have some specialized programs that require referral and/or authorization, and many of these programs serve/overlap with the population that has identified special health care needs such as Wraparound with Intensive Services (WISe and PACT).

Section 3: Coverage and Authorization of Services	
Protocol Section	**CFR Citation**
Coverage	**438.210 (a)**

Strengths

- TMBHO monitors medical necessity though retrospective clinical chart audits and encounter validations to ensure authorized services are
    - clinically justified
    - provided in a sufficient amount, duration and scope to achieve the purpose for which they are provided, appropriate to the enrollee's needs
    - supported by appropriate clinical documentation

Authorization of Services	438.210 (b)

Strengths

- In accordance with federal parity requirements, TMBHO has developed and implemented a plan to ensure prior authorization requirements for routine outpatient behavioral health services have been eliminated. The BHO has stated it monitors the consistent application of medical necessity through random retrospective chart reviews to ensure services are clinically justified, appropriate to the enrollee's needs, and are supported by the appropriate clinical documentation. TMBHO has asserted it has not had concerns or findings to date in making sure enrollees meet continued stay criteria.

Recommendations to the State

TMBHO was unable to describe a process for performing inter-rater reliability between authorization staff.

- If the BHO were to continue operations, the State should ensure the BHO is reviewing authorization criteria and performing inter-rater reliability testing at least annually.

Notice and Timeliness of Adverse Benefit Determination	438.210 (c), 438.404

Strengths

- TMBHO's policy for notifying enrollees on denying service requests requires the BHA, when determining ongoing services are not medically necessary, to submit an authorization request with a note to TMBHO describing the reason why services are not medically necessary. TMBHO reviews the request and, if the BHO concurs, initiates the Notice of Adverse Benefit Determination (NOABD) process.
- TMBHO logs and tracks all Medicaid denials, NOABDs issued, appeals requested and any fair hearing requests.
- Additionally, TMBHO's notice includes all the required information.

Timeframe for Decisions, Standard and Expedited	438.210 (d)(1–2)

Strengths

- TMBHO's policy on decision timelines includes the procedure for standard authorizations as well as expedited authorization decisions.
- TMBHO tracks, monitors and reports all authorization requests and decisions (including expedited authorizations) through its "tracking performance measures log," which includes:
    - time from request for services to intake
    - time from intake to first routine service
    - time from provider request for authorization to TMBHO authorization decision and notification
    - requests for second opinions
    - requests for appeals and/or grievances regarding BHO decisions

Compensation for Utilization Management Activities	438.210 (e)

Strengths

- TMBHO has a policy and procedure specifying that compensation to individuals or entities that conduct utilization management activities is not structured to provide incentives for the individual or entity to deny, limit or discontinue medically necessary services to any enrollee.

Section 4: Provider Selection	
Protocol Section	**CFR Citation**
Credentialing and Recredentialing	**438.214 (a-b)**

Strengths

- TMBHO's policy on credentialing indicates network providers are responsible for ensuring that all subcontractors are qualified to perform behavioral health care services per the contract between the network provider and TMBHO. This includes review of licenses, credentials, certifications, insurance and any other requirement to meet the standards of a TMBHO contract. The contractor must submit copies of all subcontracts to TMBHO for review.
- TMBHO's policy regarding network credentialing indicates the BHO will, at any given time, perform monitoring of a contractor's subcontract for the purpose of ensuring contract and Medicaid compliance, service delivery and quality.

Recommendations to the State

Although credentialing and recredentialing should occur every year, TMBHO's Network Credentialing policy indicates credentialing and recredentialing is conducted at a minimum of every two years.

- We recommend the State confirm the BHO is monitoring the BHAs to ensure credentialing and recredentialing processes are occurring in accordance with all regulations.

Nondiscrimination of Providers	438.214 (c), 438.12

Strengths

- TMBHO has only denied one out-of-network SUD provider from participating in its program. It was determined by the BHO that there was more than sufficient capacity for the outpatient SUD services. The provider was notified in writing regarding the decision.
- TMBHO maintains an open network which allows for the addition of newly licensed network providers to the existing network provider pool as needed to provide capacity and quality behavioral health and professional services to maintain a necessary continuum of care and sufficient size network.

- TMBHO's policy on subcontractual relationships and delegation indicates the BHO does not discriminate in the participation, reimbursement or indemnification of providers who are acting within the scope of their license or certification.

Excluded Providers	438.214 (d)

Strengths

- Prior to employing or contracting with providers, TMBHO requires potential providers or subcontractors to meet specific requirements regarding disclosure of ownership, controlling interest, debarment, excluded provider requirements and credentialing.

- TMBHO, through the credentialing process, requires all providers sign a debarment certification, as well as submit a *Disclosure and Ownership Form*. In addition, once under contract with TMBHO, each provider must submit a monthly staffing roster for TMBHO to check against the List of Excluded Individuals/Entities (LEIE) or the provider can submit an attestation stating they have completed monthly checks. TMBHO monitors this through the Administrative Review process, where all employee files are reviewed for LEIE exclusions.

- TMBHO gives providers the option to run their own Office of Inspector General (OIG)/LEIE checks and submit a monthly attestation. The BHO then conducts random checks utilizing the staff rosters submitted by the BHAs.

- BHAs who opt into the BHO conducting their monthly OIG/LEIE screenings are still required to conduct an annual OIG check which must be maintained in personnel files.

- TMBHO revoked one BHA's ability to participate in submitting attestations because of a provider review that determined the BHA had a current employee on the excluded providers list. The BHO conducted a formal investigation, required immediate termination of the employee, recouped all funding paid to the provider towards that employees' salary, and required the BHA to refund the monies paid for the services rendered by that employee. HCA was notified once the investigation was completed.

Section 5: Subcontractual Relationships and Delegation

Subcontractual Relationships and Delegation	438.230 (a–c)

Strengths

- Prior to contracting with providers, TMBHO performs a pre-delegation assessment to determine the provider's ability and capacity to perform the delegated services.

- The BHAs' contracts include the specifics of what is delegated, the BHAs' responsibilities for performing delegated services, monitoring of the delegated services, and the assignment of performance improvement/corrective action plans for lack of compliance in adhering to the delegation agreements.

- The BHA's continued ability to perform delegation agreements is assessed through TMBHO's administrative review, which includes auditing the BHA policies and procedures; tracking and monitoring logs; grievances and survey results. If the subcontractor/BHA's performance does not meet requirements outlined in the contract, the BHO initiates a PIP. If the BHA does not comply with the PIP, the BHO assigns a corrective action plan. Last resort could include reassigning delegation activities, remuneration of contract dollars and/or discontinuing the BHA's contract.

Section 6: Practice Guidelines

Adoption of Practice Guidelines	438.236 (a–b)

Strengths

- TMBHO has policies and procedures related to the adoption of their practice guidelines, including the involvement of contracted BHAs and professionals within Washington.

- The BHO's guidelines are based on diagnostic studies and online information/libraries available through professional organizations, including APA and AACAP; however, they have not identified key practice guidelines specific to their enrollee population.
- TMBHO's 25 practice guidelines include 13 adult categories (12 diagnostic plus suicidal behaviors) and 12 children/youth categories (11 diagnostic plus suicidal behaviors).
- The BHO reports its new Medical Director will assist TMBHO and the provider network during the fall of 2019 in reviewing existing guidelines and paring down the number that actually address the most prevalent and current needs of their enrollees.

Recommendations to the State

The BHO did not submit evidence of trainings made available to providers aimed at improving the quality and appropriateness of care or serving as educational guidance tools to inform clinical decision making.

We recommend the State ensure the BHO

- collectively assess utilization data pertaining to prevalence of diagnoses and types of services utilized within the Thurston-Mason region, identification of populations with intensive or specialized needs that cut across diagnoses and consideration of available and current (updated within the past seven years) practice guidelines
- provide implementation and ongoing (by request) training to providers on implementation and usefulness of the clinical practice guidelines

Dissemination of Guidelines	**438.236 (c)**

Strengths

- The BHO's practice guidelines are published on its website and are easily accessible to enrollees.
- TMBHO has a policy and procedure on how to disseminate practice guidelines to its BHAs. However, one of the three BHAs interviewed indicated the BHO had not communicated or consulted with them regarding any decision-making processes or updates on relevant clinical practice guidelines.

Application of Guidelines	**438.236 (d)**

Recommendations to the State

The BHO did not submit evidence of annual monitoring on the effective use of the practice guidelines adopted by the BHO.

TMBHO did not submit evidence of interface between the QAPI program and the practice guidelines adoption process.

- If the BHO were to continue operations, the QAPI programs should outline how practice guidelines are incorporated into its administration and monitoring of services at the BHAs.

Section 7: Health Information Systems	
Protocol Section	**CFR Citation**
General Rule, Utilization, Claims, Grievances and Appeals and Disenrollments	**438.242(a)**

Strengths	**Opportunities for Improvement**
- TMBHO has policies and processes in place to reasonably and appropriately protect the confidentiality, integrity and availability of all electronic protected health information that it creates, receives, maintains or transmits.	TMBHO collects information on grievances, appeals, disenrollment, provider changes and service intensity, yet the BHO care management staff reported the inability to identify trends in utilization, grievances, appeals, disenrollment and requests to change providers attributed to

• The BHO has administrative, physical and technical safeguards in place in accordance with HIPAA's security provisions.	inaccessible reports, In addition, the BHO reports data are analyzed to assist in identifying health care needs of its enrollees; yet, there was a lack of supporting documentation to confirm this statement. • The BHO should ensure the collected information is made available prior to December 31 in order to assist BHAs in their operations.

Recommendations to the State

We recommend the State ensure the BHO makes information collected, but not limited to, grievances, appeals, disenrollment, provider changes and service intensity be made available to BHAs prior to December 31 in order to assist in their operations.

Basic Elements and Enrollee Encounter Data	**438.242 (b-c)**
Strengths	**Opportunities for Improvement**
• At the end of each month, TMBHO's Chief Executive Officer (CEO) or other TMBHO authorized signing authority certifies the accuracy, completeness and truthfulness of TMBHO electronic data and encounter submissions to HCA. TMBHO submits and maintains data certification emails and documents according to HCA requirements as stated in the *WA Health Care Authority Encounter Data Reporting Guide for Managed Care Organizations, Qualified Health Homes Lead Entities and Behavioral Health Organizations.* • When BHAs submit encounter data to the BHO's Management Information System (MIS), errors are identified by the IT administrator and returned to the BHAs for corrections. The BHO submits the data to DSHS upon re-submission and reconciliation (within the contract identified time limits).	TMBHO expressed concern about the BHAs effectively managing data submissions to meet all future requirements. • The BHO should monitor the BHAs and provide any necessary technical assistance to ensure data transmitted to the BHO are accurate and timely until the BHO ceases operations.

Recommendations to the State

We recommend the State ensure the BHO monitors BHAs and provide any necessary technical assistance to ensure data transmitted to the BHO are accurate and timely until the BHO ceases operations.

Section 8: Quality Assessment and Performance Improvement Program	
Protocol Section	**CFR Citation**
General Rules	**438.330 (a)**
Strengths	**Opportunities for Improvement**
• TMBHO has a well-written, comprehensive Quality Management Program description developed in 2017 and updated in 2019.	Although TMBHO has a plan for ongoing QAPI for the services it furnishes to its enrollee population, the BHO has not been adhering to the plan as a means to continuously improve the quality of care

	• The BHO does have two PIPs which are summarized in the PIP section of this report.	and services provided to the enrollees within the BHO's delivery network. • The BHO should adhere to its Quality Management plan for the services it furnishes to its enrollee population.

Recommendations to the State

TMBHO's quality management committee does not meet on a regular basis and does not generate any meaningful meeting minutes to identify what actions and discussions took place during these meetings and what follow-up tasks were assigned. Meeting minutes also did not indicate if key performance indicators were reviewed, discussed and analyzed to identify enrollee needs.

Although TMBHO stated it has a combined quality management and compliance committee, documentation was not submitted outlining discussions on compliance issues and only submitted agendas and not the meeting minutes for its Children's System of Care meetings. Meeting agendas/minutes were requested for all standing network provider meetings, but none were submitted.

- If the BHO were to continue operations, it would need to hold regularly scheduled management meetings with minutes capturing actions, discussions, follow-up tasks, and the performance indicators reviewed, discussed and analyzed to identify enrollee needs.

Basic Elements	**438.330 (b)(1–4)**

Opportunities for Improvement

Although TMBHO stated it has several methods for monitoring under- and overutilization (including analyzing encounter and claims data for frequency of services, tracking and analyzing enrollees' grievances, reviewing inpatient tracking reports for inappropriate stays and auditing clinical records), the BHO did not submit any evidence these activities occurred.

TMBHO's care manager stated the BHO tracks and monitors utilization of evaluation and treatment services, emergency department services and inpatient admissions; however, monitoring evidence or results were not submitted for this review.

- The BHO should share continue monitoring for under- and overutilization and make that information available prior to December 31 in order to assist BHAs in their operations.

Recommendations to the State

TMBHO transitioned to a new information system over two years ago and is still unable to build and develop reports to detect under- and overutilization of services in all its programs.

- If the BHO were to continue operations, it would need to expand its capacity to build and develop reports to detect under- and overutilization in all of its programs.

Performance Measurement	**438.330 (c)**

Strengths

- TMBHO has a review tool to assess performance measures, WAC and CFR requirements.
- TMBHO has processes to submit data, which enables the State to calculate the BHO's performance using standard measures.

Performance Improvement Projects	**438.330 (d)(1–3)**

Please review the Behavioral Health PIP section of this report.

Program Review by the State	**438.330 (e)**

Recommendations to the State

Although TMBHO indicated it has a process in place to evaluate the impact and effectiveness of its own QAPI program, there was little evidence this occurs at the BHO. The BHO did submit its 2018 year-end program evaluation but the report lacked key elements of an effective program review.

The BHO performed clinical record reviews for 16 agencies during 2018. The year-end evaluation only included the aggregated results for the agencies without including the methodology or the criteria used to score the records. The items reviewed were the intake, service plan, service delivery, medication management, utilization management and crisis.

TMBHO only listed one other item in the evaluation, measuring the interval between the request for service and the first offered intake.

- If the BHO were to continue, it would need to develop a formal process for evaluating the impact and effectiveness of its QAPI program and include all results in its year-end evaluation, including results of all reviews including administrative, credentialing, care coordination, golden thread, parity, encounter data validation, under- and overutilization, geomapping, second opinions, compliance, risk assessments, grievances and appeals, surveys, Ombuds and WISe. Additionally, the evaluation would need to include review criteria, methodologies, outcomes, committee descriptions/priorities and an executive summary outlining the BHO's priority for the upcoming year based on the analysis and evaluation of the previous year's data.

Performance Improvement Projects

Children's Clinical PIP: Implementing CANS at BHR to Improve Treatment Planning and Clinical Outcomes

Strengths

- TMBHO's plan for implementation appears well thought out and appropriate. The full scope of the project is still in the nascent stages however the BHO did take EQR 2018 recommendations under review to refine their study topic and demonstrate a current issue existed reflecting an area truly in need of improvement. TMBHO has partnered with Behavioral Health Resources (BHR), their largest provider of children's mental health services, to develop meaningful treatment plans, address prioritized needs, build upon strengths, and track progress to improve successful treatment outcomes through the implementation of the CANS.

SUD Non-Clinical PIP: Increasing Concurrent and Co-occurring Mental Health and Substance Use Disorder Service Participation for Adult Enrollees

Opportunity for Improvement

- TMBHO is encouraged to thoroughly review the data analysis plan. When developing a data analysis plan, the methodology must be appropriate to the study question and adhere to a statistical analysis technique that indicates the statistical significance of any differences between the baseline and remeasurement periods. In the case of this PIP, the statistical analysis that would be most appropriate is a t-test as TMBHO had a sufficiently large study population and was seeking the statistical difference between two time points.
- Further, the BHO needs to state the confidence level used to assess statistical significance.

Previous-Year Corrective Action Plans (2018)		
Section	**Number of CAPs**	**Number Resolved**
Enrollee Rights and Protections	8	8
Grievance System	5	3
Certifications and Program Integrity	4	3

Performance Improvement Project Validation

PIPs are designed to assess and improve the processes and outcomes of the health care system. They represent a focused effort to address a particular problem identified by an organization. As prepaid inpatient health plans (PIHPs), BHOs are required to have an ongoing program of PIPs.

For 2019, BHOs were required to maintain two PIPs: one clinical and one non-clinical; one of these PIPs was to focus on children's mental health and the other to focus on a SUD issue. The PIPs must involve:

1. Measurement of performance using objective quality indicators

2. Implementation of systems interventions to achieve improvement in quality

3. Evaluation of the effectiveness of the interventions

4. Planning and initiation of activities for increasing or sustaining improvement

Methodology

Comagine Health evaluates the BHOs' PIPs to determine whether they are designed, conducted, and reported in a methodologically sound manner. The PIPs must be designed to achieve, through ongoing measurements and intervention, significant improvement sustained over time that is expected to have a favorable effect on health outcomes and enrollee satisfaction. In evaluating PIPs, the EQRO determines whether:

- The study topic was appropriately selected

- The study question is clear, simple, and answerable

- The study population is appropriate and clearly defined

- The study indicator is clearly defined and is adequate to answer the study question

- The PIP's sampling methods are appropriate and valid

- The procedures the BHO used to collect the data to be analyzed for the PIP measurement(s) are valid

- The BHO's plan for analyzing and interpreting PIP results is accurate

- The BHO's strategy for achieving real, sustained improvement(s) is appropriate

- It is likely that the results of the PIP are accurate and that improvement is "real"

- Improvement is sustained over time

A full description of Comagine Health's PIP evaluation methodology is included in Appendix B.

PIP Evaluation

Comagine Health assessed BHOs' PIPs using the current CMS EQR protocol, available at https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html

Components may be "Not Applicable" if the PIP is at an early stage of implementation. Components determined to be "Not Applicable" are not reviewed and are not included in the overall evaluation.

Assessment is based on the answers BHOs provide in the completion of a response form (which addresses questions listed under each standard component) and follows a review of written documentation and in-person interviews.

Summary of PIP Validation Results

Comagine Health's review of the BHOs' PIPs revealed many areas of strength as well as some opportunities for improvement. Themes within the BHOs' chosen topics this year continued from RY 2018, including increasing mental health clinical outcomes for the intensive youth population, improving the grievance process among SUD treatment providers, and increasing co-occurring processes and care for enrollees with both a mental health need and a SUD treatment need.

The PIPs were in varying stages and some had not progressed to the second remeasurement of the identified study indicator. In these cases, sufficient data were not yet available to conduct thorough analysis of the study topics and Comagine Health was unable to assess for success related to real or sustained improvement. Table 18 displays the BHOs' PIP topics.

Table 18. Results of BHO PIP Validation.

BHO	PIP Type	Study Topic
Great Rivers (GRBHO)	Children's Clinical PIP	Improved Outcomes for Children and Youth with Intensive Behavioral Health Needs
	SUD Non-clinical PIP	Grievance Process for Behavioral Health Agencies Providing SUD Services
Salish (SBHO)	Children's Non-clinical PIP	Increasing Child and Family Team Meetings among High-risk, High-cost, and High-need Children Served by the Mental Health System
	SUD Non-clinical PIP	Improving Implementation of the Grievance System among SUD Treatment Providers
Thurston-Mason (TMBHO)	Children's Clinical PIP	Implementing the CANS Tool at BHR to Improve Treatment Planning and Clinical Outcomes
	SUD Non-clinical PIP	Increasing Concurrent and Co-occurring Mental Health and SUD Service Participation for Adult Enrollees

Strengths

- Over the course of 2019, the majority of PIPs were able to use qualitative and quantitative data to inform assessments of their projects' effectiveness and, if needed, implement modifications to improve outcomes.

- Several BHOs were able to identify and assess change ideas that might help solve complex quality issues in behavioral health care.

- PIPs demonstrated an overall commitment to improving the processes and outcomes of behavioral health care for all enrollees.

- All of the BHOs have staff who are familiar with the PIP process and CMS protocol for conducting PIPs.

Recommendations

Some of the BHOs struggled with determining next steps after data analysis revealed unintended outcomes or absence of statistically significant change.

- If the BHOs were to continue operating, we would recommend the State ensure the BHOs develop robust, system-level interventions responsive to barriers/challenges that may arise during the PIP process, which may include changes in guidelines, employing additional resources and/or establishing collaborative external partnerships with key stakeholders.

- Consideration should be given to testing changes on a small scale:
  - Rapid-cycle learning principles should be utilized where appropriate over the course of the PIP.
  - Undertaking shorter remeasurement periods allows adequate time for modifications to be made until the desired outcome is achieved and sustained.
  - Steps should be taken to identify improvement opportunities including, but not limited to, conducting barrier analyses to derive the improvement strategies to be implemented.
  - Adjusting intervention strategies early on leads to improvement occurring more efficiently, which can have longer term sustainability.
  - Data, both qualitative and quantitative, should be reviewed at least quarterly to ensure the PIP is moving in a successful direction.

Greater Rivers (GRBHO)

Children's Clinical: Improved Outcomes for Children and Youth with Intensive Behavioral Health Needs

*This remains unchanged from the 2018 EQR report as GRBHO did not pursue Comagine Health (formerly Qualis Health) recommendations nor new study topics in 2019; this PIP was retired.

GRBHO selected this PIP study topic in order to improve outcomes for children and youth with intensive behavioral health needs. These youth are involved with more systems, utilize more services and are at higher risk for severely negative outcomes than the majority of child and adolescent enrollees. The PIP's primary focus is improving Child and Adolescent Needs and Strengths (CANS) assessment scores over time, specifically the 2s and 3s in five key domains: Behavioral/Emotional Needs, Functioning, Risk Factors, Youth Strengths and Caregiver/Family Needs and Strengths, to ultimately improve overall outcomes in service delivery. Although the BHO found some positive outcomes of care at both remeasurement points, it was not to the desired degree.

GRBHO should look at BHAs' internal processes in terms of CANS administration and data collection, entry of these data into the Behavioral Health Assessment System, and the tracking of CANS re-assessment due dates. All of these processes are key components in understanding variances in the captured data.

SUD Non-clinical: Grievance Process for Behavioral Health Agencies Providing Substance Use Disorder Treatment Services

*This remains unchanged from the 2018 EQR report as GRBHO did not pursue Comagine Health's (formerly Qualis Health) recommendations or new study topics in 2019; this PIP was retired.

GRBHO developed this PIP after it began contracting with SUD treatment providers on April 1, 2016. At that time, many of the providers were new to managed care regulations and, therefore, were in the process of building or refining policies and procedures to meet their new contractual obligations, one of which was to implement a formal grievance system. Thus, the BHO sought to increase the number of reported grievances submitted to the BHO by the BHAs. The grievance process was new for many of the SUD treatment agencies. GRBHO recognized this gap and saw the need for improvement to ensure individual grievances were identified, reviewed and responded to within the grievance system. In 2017, the BHO provided targeted training for each of its SUD treatment BHAs in order to increase understanding and knowledge of grievance system requirements. This training outlined clear processes to investigate, resolve and follow up on grievances within specified time periods and demonstrated how to document grievance information for analysis and utilization in quality improvement.

Although this PIP is still in the infancy stages of implementation, GRBHO has made great strides to effect change, including providing training, testing BHA knowledge around grievance processes and policies, following up with BHAs and monitoring grievance reporting (which includes ensuring that all grievances are properly documented and resolved) on an ongoing basis.

Salish (SBHO)

Salish Behavioral Health Organization had two non-clinical PIPs. These projects were well underway prior to the Division of Behavioral Health and Recovery contract amendment that outlined the new PIP requirements.

Children's Non-clinical: Increasing Child and Family Team Meetings Among High-Risk, High-Cost and High-Need Children Served by the Mental Health System

SBHO initiated this multi-phase PIP in 2015 with the first focus on ensuring high-risk, high-cost and high-need children were accurately identified for receiving more intensive services including child and family team (CFT) meetings and cross-system planning. The second focus of the PIP was on improving the frequency of CFT meetings for these children (those who met criteria for SBHO's Children's Intensive Services (CIS) Program or WISe).

Since the inception of this PIP, SBHO has made great strides in collecting data, continually adjusting the interventions (including additional updated training for the BHAs) and implementing appropriate improvement strategies throughout to ensure the interventions were meaningful and ultimately achieved the overall aim.

SUD Non-clinical: Improving Implementation of the Grievance System Among SUD Treatment Providers

SBHO's selection of this PIP topic was the result of its review of preliminary SUD data indicating low numbers of reported grievances among its BHAs. The intervention involved training the SUD treatment BHAs on the grievance system (including reporting requirements) then measuring the increase in reported grievances, assuming it would increase as BHA staff knowledge increased. Thus, the aim of this PIP was to improve the implementation of the grievance system among SUD treatment BHAs, and then

measuring the number of grievances per 1,000 enrollees who received at least one service from a SUD BHA. The BHO had completed and achieved all validation criteria, and when faced with challenges, SBHO realigned their interventions to keep the theory for improvement at the forefront.

Thurston-Mason (TMBHO)

Children's Clinical: Implementing the CANS Tool at BHR to Improve Treatment Planning and Clinical Outcomes

TMBHO sought to improve clinical outcomes for youth and adolescent enrollees receiving traditional outpatient treatment services at Behavioral Health Resources (BHR), a BHA in the TMBHO network. The BHO partnership with BHR stemmed from the fact the BHA was the largest child-serving provider in TMBHO's region yet had the lowest level of treatment completion rates. Through the implementation of the Washington State Child and Adolescent Needs and Strengths (CANS) assessment at intake and at 90-day intervals, the aim was to guide treatment planning and in turn to impact overall outcomes of care with an increase in successful treatment completion rates. TMBHO incorporated EQR 2018 recommendations into its preliminary data analysis and demonstrated the great disparity of treatment completion rates between BHR and the other BHAs in the BHO's region. Since the implementation of the CANS, improvements have been seen with treatment planning and overall clinical outcomes. The study has been well thought out and is showing some preliminary positive impacts thus far.

SUD Non-clinical: Increasing Co-occurring Mental Health and Substance Use Disorder Service Participation for Adult Enrollees

TMBHO sought to increase availability of co-occurring mental health and SUD treatment services for adult enrollees who met the medical necessity criteria for both mental health and SUD services. Through extensive data analysis the BHO observed a disparity within its network between the number of individuals who meet the criteria for having both a mental health diagnosis and a SUD diagnosis and those who actually received co-occurring services or standalone services for both of their diagnoses. The BHO laid the foundation and provided the framework, which suggests there is evidence of the intervention (a BHO Protocol delivered to all TMBHO contracted providers requiring referral of enrollees for an ASAM assessment or co-occurring MH-SUD services for adults meeting mental health medical necessity and who score 3 or higher on the GAIN-SS SUD subscale at intake) being sufficient to improve outcomes in a meaningful way.

Performance Measure Validation

As part of its 2019 EQR of behavioral health services, Comagine Health validated two performance measures, reflecting care BHOs provided to enrollees in 2018. For validation, the state chose the following two measures for EQR, both reflecting care delivered across BHOs on a statewide level:

- Behavioral Health Access Monitoring (BHAM)

- Substance Use Disorder Treatment Initiation and Engagement (SUD IET)

Methodology

Comagine Health conducted performance measure validation for these measures based on the CMS protocol for this activity, adapted as necessary to validate performance measures at the state level.

The validation involves assessing the accuracy of performance measures reported by the state and determining the extent to which performance measures calculated follow State specifications and reporting requirements.

In validating the performance measures, Comagine Health conducted the following activities:

- requested all relevant documents from the state regarding the processes used in calculating the required performance measures

- reviewed the relevant materials and identified questions for further review

- met with relevant state staff to review the preliminary findings and ask any additional questions required to complete the review

- assigned compliance ratings for each performance measure based on the information provided by the state, summarizing areas of strength and weakness, and identifying opportunities for improvement

Documentation requested from the state included the following:

- measurement plans and programming specifications, including specifications of data sources, programming logic, and computer source codes

- calculation specifications for all components of the denominator and numerator of the performance measures (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9 or ICD-10, CPT-4, DRGs, member months calculation, member years calculation, and specified time parameters)

- documentation showing that sampling was unbiased, treated all measures independently, and size and replacement methodologies met specifications

- the frozen data set used for the performance measure calculation

Comagine Health used the following logic model to perform validation checks for the two performance measures:

- integrity checks for encounter data files (data completeness and timeliness of data received)

- validation of data received: consistency checks and verification that critical fields contained values in the correct format and were consistent across fields, erroneous or missing values of data fields, out-of-range values, etc.

- analysis and interpretation of data on submitted fields, including the volume and consistency of encounter data utilization rates

- validation of attribution methodology

- review and analysis of the appropriateness of reporting tools

Scoring

Comagine Health used CMS' three-point scoring system in validating the performance measures. The three-point scale allows for credit when a requirement is partially met, and the level of performance is determined to be acceptable.

Scoring Key

| Fully Met (pass) ● | Partially Met (pass) ◉ | Not Met ○ |

Met means the state's measurement and reporting process was fully compliant with specifications.

Partially Met means the state's measurement and reporting process was partially compliant with specifications.

Not Met means the state's measurement and reporting process was not compliant with specifications.

N/A means the element was not applicable to the state's measurement and reporting process.

Summary of Performance Measure Validation Results: Behavioral Health Access Monitoring (BHAM) Measure

This measure reflects all members (adults and youth) in the BHO catchment area who received mental health or SUD treatment services in the reporting period, regardless of the funding source, coverage or benefit package (Table 19).

Table 19. Results for Review of Behavioral Health Access Monitoring Measure.

Standard	Description	Result
Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic and computer source code.	● Fully Met (pass)
Denominator	Data sources used to calculate the denominator were complete and accurate. Calculation of the performance measure adhered to the specifications for all components of the denominator.	N/A
Numerator	Data sources used to calculate the numerator were complete and accurate. Calculation of the performance measure adhered to the specifications for all components of the numerator.	◉ Partially Met (pass)
Sampling	Sampling was unbiased. Sampling treated all measures independently. Sample size and replacement methodologies met specifications.	N/A
Reporting	state specifications for reporting performance measures were followed.	● Fully Met (pass)

Documentation

The documentation used for the BHAM measure fully met requirements.

The state provided a description of the behavioral health access monitoring measure, as well as technical specifications, computer source codes, Behavioral Health Data System (BHDS) Behavioral Health Supplemental Transaction Data Guide and programmer logic for the calculation of the measure.

Data sources for this measure included encounters for Medicaid-funded mental health and substance use disorder treatment services. The state utilizes two systems to collect data from the BHOs and for reporting: native transaction data from BHDS and encounter data from ProviderOne. BHDS is the primary data repository for reporting behavioral healthcare activity and monitoring the BHOs. Encounter and eligibility data are received from ProviderOne, the primary source for encounter data.

ProviderOne is owned by HCA and supported and maintained by Client Network Services, Inc. The BHOs submit their encounter data directly to ProviderOne via HIPAA-standard electronic data interchange. ProviderOne performs a series of pre-adjudication file-level edits and adjudication edits that reflect industry standards. Data format and validity checks are performed on standard coded fields found in the 837-transaction set (837I and 837P). Data format and validity checks also happen for pharmacy encounters as well, using the NCPDP D.0 format.

For submission encounters in 2018, BHOs used Encounter Data reporting guide v.1 and v.2, released by HCA in August 2018. This guide includes all current edits and disposition for all submitting entities. This guide specified encounter data processing and described the HIPAA-level edits on integrity and

requirements editing and included a list of encounter error codes. The state monitors the quality and completeness of the BHOs' submitted data through multiple mechanisms. The BHOs received an 835-HIPAA-compliant response file that is generated weekly. All encounter-submitting entities were transitioned to the 835 report last year except for BHOs. BHOs have continued to receive the ETRR (Encounter Transaction Results Report), the HCA weekly response file. The purpose of either response file is to let the submitting entity know what transactions were accepted or rejected and reasons for rejection. An extract of accepted encounters is sent weekly to each BHO to compare to its own systems. Since the BHOs will ultimately cease operations by January 1, 2020, they were not transitioned to the HIPAA response file. All other entities, including BH-ASOs, receive 835s. The BHOs receive data quality and completeness reports from the state biweekly and ProviderOne returns 835 reports weekly.

BHOs are contractually required to conduct annual encounter data validation (EDV) reviews for each of their contracted BHAs. The overall limitations of the EDV audits are related to their random sampling methodology for the smaller agencies. Significant deficiencies were identified during the EDV audits related to substantial attribution errors, with a match of only 71% for mental health service data. For one of the BHOs, the SUD services match was only for 46.4% of submitted results, which is below the allowable threshold of 95%. The other concerning areas related to validating the sample of encounters included the use of modifiers (only a 90% match) and service codes aligned with the treatment provided (with only a 53% match). Corrective actions plans were issued by the BHO to its BHAs to address these deficiencies. Only one of the BHOs was able to meet 95% accuracy threshold required by Medicaid regulations.

To address these deficiencies, the state provided training sessions for contractors and providers on implementation of the revised Service Encounter Reporting Instructions (SERI) guide to encourage behavioral health data accuracy and completeness. Significant education and technical assistance efforts on SERI and encounter reporting are continuing, to ensure consistency across all providers. For 2020, HCA focused on assessing both medical and behavioral health services' data accuracy and completeness during the EDV audits for the new managed integrated system (all BHOs will cease operation by January 1, 2020).

The state-level ISCA Comagine Health (formerly Qualis Health) conducted as part of the 2017 EQR indicated that the state did not have any controls in place to ensure all behavioral health encounter data entered into the system were fully accounted for (e.g., batch control sheets, data validation or data completeness studies, reconciliation procedures). Comagine Health also identified in the 2017 ISCA that a comprehensive penetration test of the network had not been completed since 2012. It should be noted that during this timeframe, Behavioral Health was part of DSHS. All penetration testing and audit results were associated with DSHS and its IT environment. As of the 2017 ISCA, HCA was continuing to work on issues discovered during the last penetration test. These include obtaining tools to routinely scan applications for vulnerabilities, which is required by the state Office of the Chief Information Officer in published standards. Those tools are Tenable and Burp Suite. However, HCA has not performed a penetration test since BHDS was moved to HCA on July 1, 2018. With the merger, data for BHDS, which had been subject to penetration testing in the past, has been moved to HCA. HCA is currently working with WaTech to initiate the implementation of penetration testing in the HCA IT environment.

Procedures for submitting data to BHDS and ProviderOne are well documented. In August 2019, HCA released the Behavioral Health Data System Behavioral Health Supplemental Transaction Data Guide to address reporting requirements to meet the HCA Division of Behavioral Health and Recovery's (DBHR) state and federal reporting requirements related to funding. BHOs used the Behavioral Health Data System Data Guide for supplemental data. This data guide enumerates and explains each of the supplemental transaction fields in each of the transactions that are submitted directly to HCA. However,

2019 Annual Technical Report

for ProviderOne 2018 submissions, BHOs used the Washington Apple Health Encounter Data Reporting Guide version 2, which describes the encounter data reporting process and the required reporting elements.

In addition, for ProviderOne encounter data submission, HCA updated the SERI guide, which specifies eligibility requirements for public health services, types of services, Medicaid and non-Medicaid eligibility criteria, updates to Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes, encounter reporting requirements, coding instructions, clinical documentation and mental health service modalities for the BHOs. BHOs are also required to submit both service encounters through the ProviderOne Medicaid billing system and the behavioral health supplemental transaction.

Strengths

- The state provided the technical specifications, computer source codes, BHDS Behavioral Health Supplemental Transaction Data Guide and programmer logic used for calculating this measure.

- Procedures for submitting data to BHDS and ProviderOne are well documented.

- HCA had established processes to oversee integrity of encounter data submitted by BHOs and performed annual EDV audits and shared EDV findings reports for the BHOs performed in 2018.

- The state monitors the quality and completeness of the BHOs' submitted data through multiple mechanisms. HCA provides the BHOs with data quality and completeness reports biweekly.

Opportunities for Improvement

ProviderOne does apply program-specific edits to behavioral health encounters as defined by program and policy directives. Specifically, ProviderOne edits behavioral health encounters at multiple levels. Prior to acceptance, every encounter file received is validated against HIPAA transaction standards to ensure that files are constructed in a compliant manner and adhere to the use of standard code sets. Once files are accepted, all behavioral health encounters are then adjudicated against the edits defined by program and policy staff. Per HCA response, this scenario is applicable to the regions where behavioral health services have been integrated into the Apple Health contract. This transition will be completed by January 1, 2020. However, not all adjudicative edits available in ProviderOne are applied to behavioral health encounters. Data quality could be improved if appropriate oversight processes were applied by the state.

- To ensure the appropriateness and accuracy of behavioral health encounter data, HCA should develop and implement additional data integrity and completeness adjudicative edits in ProviderOne.

The state-level ISCA Comagine Health conducted as part of the 2017 EQR indicated that the state did not have any controls in place to ensure all behavioral health encounter data entered into the system were fully accounted for.

- The state should heighten its control to ensure behavioral health encounter data entered into the system are fully accounted for (e.g., data validation or data completeness studies, reconciliation procedures). These edits can help with encounter validation checking, as well as for controlling quality of fee-for-service claims. It should not be used as a catch-all for data quality. However, any new editing would require change requests in ProviderOne — which

means long turnaround times for implementation and substantial budgetary asks. HCA will need to estimate cost and return on investment with these changes.

HCA had established processes to oversee integrity of encounter data submitted by BHOs and performed annual EDV audits utilizing random sampling methodology.

- The state should re-evaluate sampling methodology for the EDV audits performed to eliminate the skewness of the methodology while selecting a sample size for the smaller agencies.

Denominator

Per measure specifications, there is no denominator for this measure.

Numerator

The data sources used to calculate the numerator for the BHAM measure partially met requirements.

Data are extracted from ProviderOne/BHDS using a comprehensive SAS program called Qualis Access Monitoring that includes programmatic logic and computer source code for creating the analytic extract for the access monitoring measure. The SAS program is used to develop an integrated table called Behavioral Health Service Summary (BHSS), which includes data from multiple sources: mental health (MH) outpatient (OP) encounters, MH community hospital encounters from contracted providers, MH evaluation and treatment encounters, and all SUD encounters. The BHSS is created through the consolidation of multiple data feeds into the BHDS. The primary data source is identified by Research and Data Analysis (RDA). Previously all BHSD data were in premises hosted by DSHS. Since November 13, 2018, HCA has contracted with Amazon Web Services (AWS) cloud vendor to host these data. Data collection and validation processes did not change in a new environment. AWS is a FEDRAMP-certified vendor and allows its customers to carry out security assessments or penetration tests against their AWS infrastructure without prior approval for services

The state shared its SAS program with Comagine Health, enabling the EQRO to verify that critical fields and values were in the correct format and that consistency existed across fields. The program features edit checks to catch erroneous, missing or out-of-range values. state Hospital and Children's Long-term Inpatient Program encounters were excluded from the original source per the final version of the measure specifications. SUD treatment includes all modalities except detoxification, housing support services and inactivated modalities. The SAS program provided mapping of all encounter data and limited encounter events and hearing events to the three BHOs that are a subject of this validation contract.

Review of EDV findings reports for selected BHOs demonstrated that two of three BHOs did not meet allowable thresholds for matching mental health services data (around 72.3% match) and for one of the BHOs, the SUD services match was only for 46.4% of submitted results. The other areas of concern were related to the use of modifiers (only a 90% match) and service codes aligned with the treatment provided (only a 53% match). Corrective action plans were issued to address these deficiencies. Note that some BHOs have not reliably reported admissions (especially residential and detoxification encounters) or submitted native transactions as required. Only one of three BHOs was compliant with Medicaid-established thresholds for capturing appropriate encounter data.

Calculation of the BHAM measure adhered to the specifications for all components of the numerator (e.g., clinical codes to include inpatient and outpatient modalities per BHAM technical specifications,

Involuntary Treatment Act hearings, dates services were provided, adherence to specified time parameters, eligible population, number or type of providers).

The state shared two datasets that were used to calculate this measure. Comagine Health found these datasets reasonable and well documented and did not find any inconsistences in their structure or values. Comagine Health validated the programmatic logic used to calculate these datasets and did not find any deficiencies.

Strengths

- Data are extracted from ProviderOne/BHDS using a comprehensive SAS program called Qualis Access Monitoring, which includes programmatic logic and computer source code for creating the analytic extract for the access monitoring measure.

- The state shared its SAS program with Comagine Health, enabling the EQRO to verify that critical fields and values were in the correct format and that consistency existed across fields. The program featured edit checks to catch erroneous, missing or out-of-range values.

- The state shared two datasets that were used to calculate this measure. Comagine Health found these datasets reasonable and did not find any inconsistences in their structure or values.

- The datasets were well documented and followed the BHDS Behavioral Health Supplemental Transaction Data Guide provided by the state. Comagine Health validated the programmatic logic used to calculate these datasets and did not find any deficiencies

- Calculation of the BHAM measure adhered to the specifications for all components of the numerator (e.g., clinical codes to include inpatient and outpatient modalities per BHAM technical specifications, dates services were provided, adherence to specified time parameters, number or type of provider).

Opportunities for Improvement

The SUD treatment component of the state's SAS program submitted to Comagine Health did not include all modalities identified in the technical specifications referenced in the BHAM measure definition. The primary areas of concern with this sample of encounters were with service provider, modifiers, and service code agreement with treatment provided. The following includes a list of findings.

- **Service Provider:** Including the known attribution error, the "Match" rate for this data element is 71%. This is below the allowable threshold of 95%.

- **Modifiers:** Some of the BHOs have not properly used procedure code modifiers. BHO EDV findings report identified serious deficiencies in matching modifiers, as low as 46% and also low for some of their behavioral health agencies. This was the primary area SUD agencies struggled with.

- **Procedure Codes:** Some of the agencies were not able to meet any regulatory standards for matching procedure codes (with 45% of invalid codes observed by one of the BHOs). In addition, agencies used appropriate service codes that were misaligned with the treatment provided (only a 53% match).

The state should ensure that all treatment modalities are included in the SAS program.

- If the BHOs were to continue operations, the state would need to continue to improve the quality of submitted data from BHOs. In 2018, two out of three BHOs were below the allowable threshold of 95% for matching mental health and SUD services data.

To ensure the accuracy and completeness of the performance measure queries and reports, HCA should initiate the following reconciliation and validation processes:

- comparison of results against historical trend

- subject matter expert review of results

- comparison of data samples in the repository to transaction files to verify completeness of data elements captured

Sampling

Per measure specifications, no sampling was used.

Reporting

The reporting processes used for the BHAM measure fully met requirements.

Former Decision Support and Evaluation (DSE) staff moved to the HCA Enterprise Data Management and Analytics (EDMA) division. This department is responsible only for administrative reporting related to all HCA programs and services, including DBHR. This includes block grant application data and reporting, data and reports for rate setting and other reports to support monitoring and compliance functions. EDMA's primary sources of data are BHDS and ProviderOne's Operational Data Store. The EDMA team produces several reports for DBHR's internal use, which include but are not limited to Operation Dashboard reports, reports on Involuntary Treatment Act (ITA) and Summary of Benefits and Coverage (SBC), and the No Bed Report. With all the changes in the state behavioral health infrastructure, EDMA/DAPS was not charged to perform any oversight or control of data completeness and accuracy, validation of transfers or quality of data received from BHOs. These responsibilities were previously completed by IT and (subsequently) Decision Support and Evaluation staff within DSHS/DBHR.

However, per the state, higher-level leadership discussions were being initiated to identify departments responsible for this work oversight.

The state requires the BHOs to monitor two performance measures but has not set performance goals or targets. The state generates and monitors other measures but has not shared the data with the BHOs. However, it shares the measures, in aggregate, with the public via its website.

Strengths

- The HCA EDMA division analyzes data and provides administrative reports to meet the state's needs.

- The EDMA team produces several reports for DBHR internal use including, but not limited to, Operation Dashboard reports, reports on ITA and SBC, and the No Bed Report.

Opportunities for Improvement

The state requires the BHOs to monitor two performance measures but has not set performance goals or targets, which could be used to improve client outcomes.

- HCA should set benchmarks and targets for each of the required performance measures and use these benchmarks to measure the BHOs' outcomes. With the BHOs closing out by Dec. 31, 2019, HCA is evaluating the data collected and how to standardize and improve data submission processes for providers, Administrative Service Organizations (ASOs), and MCOs. Performance measures and data quality are a part of this discussion. The new data guide and processes as a result of this project will help standardize data collection and help facilitate development of benchmarks and performance goals for the measures.

- HCA needs to develop reports for the monitoring of data completeness and accuracy and the validation of transfers and quality of data received from the BHOs. New quality processes and measures are being discussed by HCA to monitor and review incoming data; these should be established and transitioned over by late 2020.

Previously, IT and (subsequently) Decision Support and Evaluation staff within DSHS/DBHR ran biweekly reports for each of the BHOs, which summarized data, timeliness and completeness and discussed them at the monthly data workgroup meetings.

BH services have been integrated into the Apple Health contracts starting April 1, 2016, and the final BHO regions will be integrated effective Jan. 1, 2020. OMSD/MCOIU staff perform quarterly reconciliation analysis on Medical and BH services but do not share findings with the agencies. The quarterly encounter data reconciliation is managed care plan- and contract-specific. Results are shared with each MCO according to contract specifications. There is currently no provision for sharing this information with entities not covered by the contract.

- The state needs to work on data governance in order to share performance dashboards as a public-facing reporting vehicle. This would include sharing the operational data with the agencies and BHOs. However, it shares the aggregate measures with the public via its website.

Summary of Performance Measure Validation Results: Substance Use Disorder Treatment Initiation and Engagement (SUD IET) Measure

This measure describes SUD treatment initiation and engagement, with initiation of SUD treatment defined as the percentage of adult and youth SUD OP service episodes in which the client received at least one face-to-face treatment encounter or one medication-assisted treatment (MAT) dispensing event within the 14 days following the start of an SUD OP service episode. The state adapted the definition of the measure as defined by the Washington Circle, a group focused on developing and disseminating performance measures for substance abuse services.

Table 20 shows the results.

Table 20. Results for Review of Substance Use Disorder Treatment Initiation and Engagement (SUD IET) Measure.

Standard	Description	Result
Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic and computer source code.	● Fully Met (pass)
Denominator	Data sources used to calculate the denominator were complete and accurate. Calculation of the performance measure adhered to the specifications for all components of the denominator of the performance measure.	● Fully Met (pass)
Numerator	Data sources used to calculate the numerator were complete and accurate. Calculation of the performance measure adhered to the specifications for all components of the numerator of the performance measure.	◉ Partially Met (pass)
Sampling	Sampling was unbiased. Sampling treated all measures independently. Sample size and replacement methodologies met specifications.	N/A
Reporting	state specifications for reporting performance measures were followed.	● Fully Met (pass)

Documentation

The documentation used for the SUD IET measure fully met requirements. The state provided a detailed description of this measure.

Data sources for this measure included encounters for mental health and substance use disorder treatment services funded through HCA. HCA utilizes two systems to collect data from the BHOs and for reporting: BHDS and ProviderOne. BHDS is the primary data repository for reporting behavioral health care activity and monitoring the BHOs. Encounter and eligibility data are received from ProviderOne, the primary source for encounter data. ProviderOne is owned by the HCA and supported and maintained by Client Network Services, Inc. The BHOs submit their encounter data directly to ProviderOne via HIPAA-standard electronic data interchange. ProviderOne performs a series of pre-adjudication file-level edits and adjudication edits that reflect industry standards. Data format and validity checks are performed on standard coded fields found in the 837-transaction set (837I and 837P). For submission encounters in

2018 BHOs used Encounter Data reporting guide v.1 and v.2 that was released by HCA in August 2018. This guide includes all current edits and disposition for all submitting entities. This guide specified encounter data processing and described the HIPAA-level edits on integrity and requirements editing and includes a list of encounter error codes. The state monitors the quality and completeness of the BHOs' submitted data through multiple mechanisms. The BHOs receive an ETRR report of transactions and errors for their submissions. An extract of accepted encounters is sent weekly to each BHO to compare to its own systems.

The state monitors the quality and completeness of the BHOs' submitted data through multiple mechanisms. The BHOs receive data quality and completeness reports from the state biweekly and ProviderOne returns encounter transaction results reports weekly. BHOs are contractually required to conduct EDV reviews for each of their contracted BHAs annually.

The state-level ISCA Comagine Health (formerly Qualis Health) conducted as part of the 2017 EQR indicated that the state did not have any controls in place to ensure all behavioral health encounter data entered into the system were fully accounted for (e.g., batch control sheets, data validation or data completeness studies, reconciliation procedures). Comagine Health also identified in this assessment that a comprehensive penetration test of the network had not been completed since 2012. It should be noted that during this timeframe, Behavioral Health was part of the DSHS. All penetration testing and audit results are associated with DSHS and its IT environment. As of the 2017 ISCA, HCA was continuing to work on issues discovered during the last penetration test. These include obtaining tools to routinely scan applications for vulnerabilities, which is required by the state Office of the Chief Information Officer in published standards. Those tools are Tenable and Burp Suite. However, HCA has not performed a penetration test since BHDS was moved to HCA on July 1, 2018. With the merger, data for BHDS, which had been subject to penetration testing in the past, has been moved to HCA. HCA is currently working with WaTech to initiate the implementation of penetration testing in the HCA IT environment.

Procedures for submitting data to BHDS and ProviderOne are well documented. HCA publishes the SERI, which specifies eligibility requirements for public health services, types of services, Medicaid and non-Medicaid eligibility criteria, updates to CPT and HCPCS codes, encounter reporting requirements, coding instructions, clinical documentation and mental health service modalities for the BHOs. HCA also publishes the Washington Apple Health Encounter Data Reporting Guide, which describes the encounter data reporting process and the required reporting elements.

HCA established EDV audits to monitor quality and completeness of SUD data on annual basis. The overall limitation of the EDV audits is related to the methodology used to draw a sample while selecting encounters from a single chart for the smaller agencies. Significant deficiencies were identified in matching submitted encounter data for SUD services (in one BHO, the SUD services match was only for 46.4% of submitted results based on the audit report findings of June 6, 2018). Only one BHO was in a full compliance with established thresholds for processing encounter data.

Currently, HCA's Program Integrity Department is working on a new EDV process to ensure data completeness and accuracy issues are addressed. In 2018, the state provided training sessions for contractors and providers on implementation and revised the SERI guide to encourage behavioral health data accuracy and completeness. Significant education and technical assistance efforts on SERI and encounter reporting continue to ensure consistency across all providers. In addition, the program integrity department focused on assessing both medical and behavioral health services data accuracy and completeness during the EDV audits for the new integrated system in 2020 (all BHOs will be closed by January 1, 2020).

Strengths

- The state provided the technical specifications, computer source codes, BHDS Behavioral Health Supplemental Transaction Data Guide and programmer logic for calculating this measure.

- Procedures for submitting data to BHDS and ProviderOne are well documented.

- The state monitors the quality and completeness of the BHOs' submitted data through multiple mechanisms. HCA provides the BHOs with data quality and completeness reports biweekly. ProviderOne returns encounter transaction results reports weekly.

Opportunities for Improvement

There are data edits in place for encounter data in order to maximize the amount of data collected. Data quality could be improved if appropriate oversight processes were applied by the state.

- To ensure the appropriateness and accuracy of behavioral health encounter data, HCA should develop and implement additional data quality edits in ProviderOne.

- The EDV audits' random sampling methodology used for selecting a small sample size for the validation was not appropriate to evaluate overall BHOs' performance, drawing fewer encounters for the smaller agencies and sometimes pulling more than 10 encounters from a single chart.

Per the state-level ISCA Comagine Health conducted as part of the 2017 EQR, the state did not have any controls in place to ensure all behavioral health encounter data entered into the system were fully accounted for. During 2018 reporting year, oversight of Behavioral Health data was part of the DSHS responsibilities. All penetration testing and audit results are associated with DSHS and its IT environment. HCA does have a few tools to scan for vulnerability in systems and software. Those tools are Tenable and Burp Suite. However, HCA has not performed a penetration test since BHDS was moved to HCA. The state is currently working with WaTech to initiate a penetration test for the HCA IT environment.

- The state should install controls to ensure behavioral health encounter data entered into the ProviderOne and flow of the encounter data into BHDS are fully accounted for (e.g., data validation or data completeness studies, reconciliation procedures).

Denominator

The data sources used to calculate the denominator for the SUD IET measure fully met requirements.

The state has well-established processes to collect all needed data. Data are extracted from ProviderOne/BHDS using a SAS program called Qualis Init_Engage v.2. The state shared its SAS program with Comagine Health, enabling the EQRO to verify that critical fields and values were in the correct format and that consistency existed across fields.

The SAS program contains the source code for the production of the SUD IET measure and describes a logic model for how this measure is calculated. Encounters are extracted for the Integrated Managed Care regions using a dataset maintained by RDA, for clients in the BHO service areas using BHDS's "outpatient encounter" table, for recipients of MAT using ProviderOne and ProviderOne eligibility history (client-by-month).

The full SAS code was provided for the review. The process extracts data from various data sources including RDA's Client Outcomes Database, ProviderOne and BHDS. However, because of the size of the data and limited access to various data sources, a full extract of all data sources was not available. In addition, data sources not owned by HCA were not available to Comagine Health, as that would require data sharing agreements to be created between Comagine Health and the other agencies that owned those sources. Instead, the state provided an event-level dataset and the detailed code used to produce the measure. Two reference files and an eligibility months table the state provided enabled Comagine Health to re-run a portion of the SAS code and calculate denominators and initiation and engagement rates by BHO and statewide.

The SAS program used for the calculation of this measure has all necessary logic checks in place to ensure the integrity of the data. Critical data fields contain values in the correct format and are consistent across fields. Program edit checks are in place to catch erroneous, missing or out-of-range values. The program defined the eligible population for this measure and includes steps to meet continuous enrollment criteria for the denominator calculation. Source codes use appropriate state-developed clinical codes and SUD service modalities: HCPCS and CPT modifiers.

The state shared two datasets that were used to calculate this measure and provided reference tables for Recovery Audit Contractors and eligibility. Comagine Health analyzed these datasets and did not find any inconsistences in their structure or values. The datasets were well documented. Comagine Health validated the programmatic logic used to calculate these datasets and did not find any deficiencies.

Calculation of the SUD IET measure adhered to the specifications for all components of the denominator (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9 or ICD-10, CPT-4, member months calculation, member years calculation and adherence to specified time parameters).

Strengths

- The state has well-established processes to collect all needed data.

- Data are extracted from ProviderOne/BHDS using a SAS program to calculate performance measures based on approved measure definitions.

- HCA provided the SAS program that contains the source code for the production of the SUD IET measure and describes a logic model for how this measure was calculated.

- The SAS program used for the calculation of this measure features all necessary logic to ensure the integrity of the data used to calculate the measure.

- Calculation of the SUD IET measure adhered to the specifications for all components of the denominator (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9 or ICD-10, CPT-4, member months calculation, member years calculation and adherence to specified time parameters).

Weakness

The full SAS code was provided for the review. The process extracts data from various data sources including RDA's Client Outcomes Database, ProviderOne and BHDS. However, because of the size of the data and limited access to various data sources, a full extract of all data sources was not available. In addition, data sources not owned by HCA were not available to Comagine Health as it would require data sharing agreements to be created between Comagine Health and the other agencies that owned

those sources. Instead, the state provided an event-level dataset and a detailed code used to produce it. Two reference files and an eligibility months table the state provided enabled Comagine Health to re-run a portion of the SAS code and calculate denominators and initiation and engagement rates by BHO and statewide.

Numerator

The data sources used to calculate the numerator for the SUD IET measure partially met requirements due to the deficiencies identified in the encounter data validation audits related to accuracy and completeness of SUD mapping of service providers, modifiers and appropriate attribution of the service codes with treatment provided.

Comagine Health identified that the SUD IET partially met the requirements. Per state direction, the data submitted for calculation of the SUD IET measure for episodes starting on January 1, 2018, through Dec. 31, 2018, includes all qualifying events within 44 days of the episode begin date (14+30=44)*; up to 47 days for MAT claims (14+33=47).

Calculation of the SUD IET measure adhered to the specifications for all components of the numerator (e.g., clinical codes such as ICD-9 or ICD-10, CPT-4, relevant time parameters such as initiation or start episode dates and treatment start and stop dates, adherence to specified time parameters, number or type of provider).

Strength

- Calculation of the SUD performance measure adhered to the specifications for all components of the numerator (e.g., clinical codes such as ICD-9 or ICD-10, CPT-4, relevant time parameters such as initiation or start episode dates and treatment start and stop dates, adherence to specified time parameters, number or type of provider).

Opportunities for Improvement

The state needs to continue to improve the quality of submitted data from BHOs. In 2018, two out of three BHOs were below the allowable threshold of 95% for matching mental health and SUD services date. The primary areas of concern with SUD encounters were with service provider, modifiers, and service code agreement with treatment provided. The following includes a list of finding.

- **Service Provider:** Including the known attribution error, the "Match" rate for this data element is 71%. This is below the allowable threshold of 95%.

- **Modifiers:** Some of the BHOs have not properly used procedure code modifiers. BHO EDV findings reports identified serious deficiencies in matching modifiers as low as 46% and low for some of their behavioral agencies. This was the primary area SUD agencies struggled with.

- **Procedure Codes:** Some of the agencies were not able to meet any regulatory standards for matching procedure codes (with 45% of invalid codes observed by one of the BHOs). In addition, agencies used appropriate service codes that were misaligned with the treatment provided (only a 53% match).

Sampling

Per measure specifications, no sampling was used.

Reporting

The reporting processes used for the SUD IET measure fully met requirements.

The state provided a dashboard for this measure at the state and BHO levels, featuring clear classification of reporting categories and rates. The SUD dashboard includes the following categories:

- SUD: Treatment Initiation — Adults
- SUD: Treatment Initiation — Youth ^
- SUD: Treatment Engagement — Adults
- SUD: Treatment Engagement — Youth ^
- SUD: Adults Receiving Treatment Services (Access Monitoring)
- SUD: Youth Receiving Treatment Services (Access Monitoring)
- MH: Adults Receiving Treatment Services (Access Monitoring)
- MH: Youth Receiving Treatment Services (Access Monitoring)

^ Youth includes individuals age 17 and younger at the date of admission to SUD treatment.
% Change = (most recent data point [numerator]/baseline data point [denominator]) -1

Comagine Health reviewed the dashboard and determined that it would be beneficial for the state to add denominators to the dashboard as a reference to estimate the impact of initiation and engagement services provided.

Former DSE staff have been absorbed into HCA's EDMA section under the Division of ProviderOne Operations and Services (P1OS). This section is responsible for administrative reporting related to HCA programs and services, with DBHR being one of its many customers. Reporting generated for DBHR programs includes block grant application data and reporting, data and reports for rate setting, and other reports to support monitoring and compliance functions. EDMA's primary sources of data are BHDS and ProviderOne's Operational Data Store. EDMA runs biweekly reports for each of the BHOs, which summarize data quality, timeliness and completeness. The EDMA team produces several reports for DBHR internal use, which include but are not limited to Operation Dashboard reports, reports on ITA and SBC, and the No Bed Report. With all changes in the state behavioral health infrastructure, EDMA/DAPS was not charged to perform any oversight or control of data completeness and accuracy, validation of transfers or quality of data received from BHOs. These responsibilities were previously completed by the DSHS DSE reporting group. However, per the state, higher-level leadership discussions were being initiated to identify departments for this oversight.

The state requires the BHOs to monitor two performance measures but has not set performance goals or targets. The state generates and monitors other measures but has not shared the data with the BHOs. However, it shares the measures, in aggregate, with the public via its website.

Strengths

- HCA's EDMA division analyzes data and provides administrative reports to meet the state's needs.
- The EDMA team produces several reports for DBHR internal use, which include but are not limited to Operation Dashboard reports, reports on ITA and SBC, and the No Bed Report.

Opportunities for Improvement

The state provided a dashboard for the SUD IET measure at the state and BHO levels with clear classification of reporting categories and rates.

- The state should add denominators to the dashboard as a reference in order to estimate the impact of initiation and engagement services provided.

- HCA needs to develop reports for the monitoring of data completeness and accuracy and the validation of transfers and quality of data received from the BHOs. New quality processes and measures are being discussed by HCA to monitor and review incoming data and should be established and transitioned over by late 2020.

The state requires the BHOs to monitor two performance measures but has not set performance goals or targets, which could be used to improve client outcomes.

- HCA should set benchmarks and targets for each of the required performance measures and use these benchmarks to measure the BHOs' outcomes.

- With the BHOs closing out by Jan. 1, 2020, HCA is evaluating the data collected and how to standardize and improve data submission processes for providers, ASOs, and MCOs. Performance measures and data quality are a part of this discussion.

- The new data guide and processes as a result of this project will help standardize data collection and help facilitate initiation of benchmarks and establishment of performance goals for the measures.

Wraparound with Intensive Services (WISe) Quality Improvement Review Tool (QIRT) Findings Summary & Recommendations

As the EQRO for Washington, Comagine Health (formerly Qualis Health) was contracted to review BHAs throughout the state that have implemented the WISe program.

WISe is designed for Medicaid-eligible children with complex behavioral health needs. It is a team-based approach that provides services to youth in their homes and communities rather than institutions. The quality improvement review for 2019 consisted of two days of onsite record reviews at each of the 15 BHA offices selected by HCA. These locations reflect a combination of both rural and urban agencies providing WISe services throughout the state of Washington.

Please see Appendix D for the complete QIRT Summary and Recommendations report.

Review of Previous Year (2018) EQR Recommendations

Integrated Managed Care was implemented in the Greater Columbia, King, Pierce and Spokane regions in January 2019, and in the North Sound region in July 2019. The following recommendations were based upon review of these five BHOs in addition to the three BHOs reviewed for the 2019 EQR period. As of January 1, 2020, Integrated Managed Care expands to the remaining three regions and Washington State will have converted completely to an integrated model of care.

Compliance: Enrollee Rights and Protections

Not all BHAs, including both SUD treatment and Behavioral Health, are complying with informing and training their staff on enrollee rights policies and procedures at the time of hire and as rights are updated and revised.

- Ensure that BHOs are informing and training BHA staff on enrollee rights policies and procedures at the time of hire and as rights are updated or revised. The BHOs could create a PowerPoint training on client rights and require the BHAs to submit attestations that staff have reviewed the PowerPoint training. The BHOs could also review staff personnel files for evidence of the training completion during their administrative review.

Not all BHOs have a policy and mechanism in place to provide their staff and BHA staff with information on where to refer enrollees who are having difficulty understanding written materials or information posted on the BHO's website.

- Ensure that all BHOs have implemented a policy and mechanism for informing enrollees of whom to contact when they are experiencing difficulties understanding benefit and client rights materials. This may include, but is not limited to, publishing this information on the BHO's website.

Not all BHOs include in their online provider directory the types of clinical specialties and languages spoken at the BHAs or whether each BHA meets ADA accessibility requirements.

- Ensure that all BHO provider directories include the specialties, languages spoken, and whether each BHA meets ADA accessibility requirements.

Compliance: Grievance System

Not all BHOs have mechanisms in place for tracking the grievances the BHO or BHAs receive.

- Ensure that all BHOs develop a standardized form or spreadsheet for tracking the grievances they receive and those the BHAs receive. This form or spreadsheet should be distributed to the BHAs to ensure they are capturing all the elements the BHO needs to trend and monitor.

Not all BHOs have updated the grievance system policies to reflect current CFR language and requirements regarding notice of adverse benefit determinations and grievance timelines.

- Ensure that all BHOs' grievance policies are up to date with current language and requirements.

Although most BHOs monitor compliance with grievance system standards and requirements through an onsite process or administrative review and through the submission of quarterly grievance reports and acknowledgment and resolutions letters, one BHO has not conducted a complete review of BHA compliance with grievance system standards.

- Ensure that the BHOs maintain compliance with current grievance system standards at least annually or upon any change in standards and requirements

Although most BHOs indicated that they monitor the BHAs for grievance record retention during annual administrative reviews, one BHO indicated that it has not completed monitoring for all its BHAs for several years.

- Ensure that the BHOs routinely monitor BHAs for compliance with grievance system standards and requirements, including where and how grievance records are stored

One BHO's notice of adverse benefit determination does not describe the process for requesting that benefits continue while an appeal or state fair hearing is pending or notify enrollees of their financial responsibility for services received while an appeal is pending if the final resolution of the appeal is adverse to the enrollee. Additionally, the BHO did not provide information indicating that it notifies enrollees of these elements through a different medium.

- The state provided a template for the notice of adverse benefit determination for the BHOs to adopt or incorporate. Ensure that the BHOs' notice of adverse benefit determination contains all of the required elements, including the process for requesting that benefits continue while an appeal or state fair hearing is pending, and notification that enrollees may be financially responsible for services received while an appeal is pending if the final resolution of the appeal is adverse to the enrollee.

Compliance: Certifications and Program Integrity

One BHO's policy on conflict of interest and the BHO's administrative tool do not include how often the conflict of interest disclosure form needs to be reviewed and attested to by BHO staff and volunteers, BHA staff, and the BHO's governing board. Conflict of interest disclosure forms should be reviewed and attested to annually.

- Ensure that the BHOs include both in their policies on conflict of interest and in administrative tools the timeframes in which all BHO and BHA staff and volunteers and BHO governing board members need to review and attest to the conflict of interest disclosure forms.

One BHO has not performed a risk assessment to identify its top three vulnerable areas and outlined action plans for mitigating risks in each of those areas since 2016. The compliance officer stated that the BHO has been actively working to address the vulnerable areas identified during the 2016 risk assessment.

- Ensure that all BHOs are performing current risk assessments in order to identify and evaluate the most current vulnerable areas and implement action plans for mitigating risks in those areas.

Not all BHOs have an active compliance committee to review the compliance program for effectiveness. Additionally, one of the BHOs' Quality Management Committees is inactive and last met in March 2017. The compliance officer stated that difficulty coordinating meeting times for BHO leadership staff has been the cause of inactivity.

- To be in compliance with both the CFR and HCA contracts, ensure that all BHOs convene their compliance and quality management committees to monitor the effectiveness of the compliance programs, as well as the accessibility, timeliness, and quality of care enrollees are receiving.

Performance Improvement Projects

Some of the BHOs struggled with determining next steps after failing to achieve statistically significant improvement.

Ensure that when PIP interventions need course correction, the BHOs:

- take steps to identify improvement opportunities, including but not limited to conducting barrier analyses to derive the improvement strategies to be implemented

- undertake shorter remeasurement periods to allow adequate time for modifications to be made until the desired outcome is achieved and sustained

- review data at least on a quarterly basis to ensure the PIP is moving in a successful direction

Continue to provide technical support to ensure BHOs understand how to utilize core improvement concepts and tools when implementing PIPs.

HCA Response

The following box contains HCA's response to the prior year's recommendations.

> At this time, BHOs will no longer be contracted to provide Medicaid services and behavioral health care will be provided, along with physical health care, through the MCOs. MCOs have been providing integrated managed care throughout most of the state and have been successfully implementing these practices in integrated regions. With the changes across the state bringing integrated care to our health care system, Health Care Authority has endeavored to find a way to incorporate the EQRO recommendations into impactful action items for overall system improvement while also addressing the need for quality services to continue through existing contractors.
>
> To meet this goal HCA took the following steps: The recommendations identified in the Technical Report have been shared with the three remaining BHOs to inform them of opportunities to improve and support them in the remaining time before the BHO contracts end as well as help inform their future systems of care. Additionally, HCA convened a workgroup of subject matter experts to discuss statewide trends and specific areas of concern within the behavioral health system and to review the EQRO recommendations to determine what requires increased oversight with the new integrated delivery system. Follow-up is occurring in many different mechanisms, through technical assistance and Knowledge Transfer sessions, TEAMonitor compliance review, deliverable monitoring, and contract revisions.

Appendices

Appendix A: MCO Profiles

About the MCO Profiles

The first page reflects HEDIS measures selected for benchmarking against national performance rates. In the table, reported measures are sorted — from top to bottom — in order from those above the state average to those measures that are below the state average. Dark red indicates the lowest difference from the state average, while the darker green indicates the highest difference. The lighter shades of red, pink, and green indicates smaller differences from the state average.

Note: the charts display the raw differences from the state average, which may not be statistically different.

Amerigroup Washington (AMG) Profile

Figure A-1. AMG Scorecard.

Measure	Rate	State Weighted 2019	Difference from State Weighted Average
Well-Child Visits in the First 15 Months of Life (W15), 6 or More Visits	70%	67%	2%
Controlling High Blood Pressure (CBP)	64%	63%	2%
Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care	76%	75%	2%
Prenatal and Postpartum Care (PPC), Postpartum Care	60%	59%	1%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC), BMI Percentile, Total	73%	72%	1%
Lead Screening in Children (LSC)	32%	32%	0%
Antidepressant Medication Management (AMM), Acute Phase	51%	51%	0%
Antidepressant Medication Management (AMM), Continuation Phase	36%	36%	0%
Adolescent Well-Care Visits (AWC)	45%	47%	-1%
Chlamydia Screening (CHL), Total	53%	54%	-2%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)	66%	68%	-2%
Comprehensive Diabetes Care (CDC), Medical Attention for Nephropathy	87%	90%	-2%
Comprehensive Diabetes Care (CDC), Poor HbA1c Control (Note that a lower score is better for this measure)	40%	37%	-3%
Comprehensive Diabetes Care (CDC), HbA1c Testing	87%	90%	-3%
Asthma Medication Ratio (AMR), Total	50%	53%	-3%
Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0%	47%	50%	-3%
Childhood Immunization Status (CIS), Combo 10	38%	42%	-3%
Childhood Immunization Status (CIS), Combo 2	70%	73%	-3%
Cervical Cancer Screening (CCS)	54%	58%	-4%
Medication Management for People With Asthma (MMA), Medication Compliance 75%, 5-11 Years	22%	27%	-5%
Comprehensive Diabetes Care (CDC), Blood Pressure Control < 140/90 mm Hg	63%	68%	-5%
Follow-Up Care for Children Prescribed ADHD Medication (ADD), Continuation	45%	51%	-5%
Children's Access to Primary Care Practitioners (CAP), 7-11 Years	84%	90%	-6%
Adults' Access to Preventive/Ambulatory Health Services (AAP), Total	70%	76%	-6%
Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	36%	43%	-6%
Comprehensive Diabetes Care (CDC), Eye Exam	52%	58%	-7%
Breast Cancer Screening (BCS)	47%	55%	-7%
Medication Management for People With Asthma (MMA), Medication Compliance 75%, 12-18 Years	17%	26%	-9%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), Total	8%	17%	-9%

Table A-1. AMG's Performance Measure Strengths and Opportunities for Improvement.

Performance Measures	
Strengths	**Opportunities for Improvement**
Well-Child Visits, 0 to 15 Months, 6 or more visits (W15): • This measure is above the state average of 67%.	Women's health measures (CCS, CHL, BCS) fell below the state average, with Breast Cancer Screening (BCS) being particularly low
	Access to primary care for both adults (AAP) and children ages 7-11 (CAP) are below the state average.
	Asthma measures are below the state average: • Medication Management for People with Asthma (MMA), Compliance 75%, for age bands of 5-11 and 12-18 years • Asthma Medication Ratio (AMR), Total

Table A-2. Summary of AMG's PIPs.

Performance Improvement Projects (PIPs)		
Type	**Study Topic**	**Score**
Clinical: Washington State Institute for Public Policy Adult (AHMC, FIMC)	WSIPP evidence based collaborative effort for depression, anxiety comorbid depression and chronic health treatment	Not Met
Clinical: Washington State Institute for Public Policy Children (AHMC, FIMC)	WSIPP evidence based collaborative effort for depression, anxiety comorbid depression and chronic health treatment	Not Met
Clinical: Collaborative Well-Child Visits (AHMC)	Collaborative MCO Well-Child Visit Rate	Partially Met
Non-clinical: (AHMC)	Improving Member Engagement and Satisfaction	Not Met
Opportunities for Improvement • Before implementing a PIP, review baseline data to ensure a problem or need truly does exist • Develop unambiguous study questions that are easily understood and answerable • Establish well-defined, objective measured indicators to track performance over time • Define the PIP measurement periods to ensure data collection timelines are fulfilled and reporting timeframe requirements are met		

Table A-3.Summary of AMG's Compliance Review Results.

Compliance with Regulatory and Contractual Standards		
Standard	**Score**	**Possible**
Grievance	45	54
Provider Selection	12	12
Quality Assessment and Performance Improvement	13	15
Review of Previous-Year (2018) Corrective Action Plans		
Standard	**Score**	
Availability of Services – six elements reviewed	Met	
Coverage and Authorization – three elements reviewed	Not Met, one repeat finding	
Enrollee Rights – four elements reviewed	Met	
Practice Guidelines – two elements reviewed	Met	
Program Integrity Requirements – two elements reviewed	Met	
Provider Selection – four elements reviewed	Met	
Quality Assessment and Performance Improvement Program – one element reviewed	Met	
Subcontractual Relationships and Delegation – one element reviewed	Partially Met	

Coordinated Care of Washington (CCW) Profile

Figure A-2. CCW Scorecard.

Measure	Rate	State Weighted 2019	Difference from State Weighted Average
Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care	81%	75%	6%
Adolescent Well-Care Visits (AWC)	52%	47%	5%
Childhood Immunization Status (CIS), Combo 10	47%	42%	5%
Lead Screening in Children (LSC)	37%	32%	5%
Childhood Immunization Status (CIS), Combo 2	77%	73%	4%
Antidepressant Medication Management (AMM), Acute Phase	55%	51%	4%
Medication Management for People With Asthma (MMA), Medication Compliance 75%, 12-18 Years	30%	26%	4%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)	71%	68%	4%
Asthma Medication Ratio (AMR), Total	56%	53%	3%
Antidepressant Medication Management (AMM), Continuation Phase	38%	36%	2%
Chlamydia Screening (CHL), Total	56%	54%	1%
Well-Child Visits in the First 15 Months of Life (W15), 6 or More Visits	68%	67%	1%
Comprehensive Diabetes Care (CDC), Medical Attention for Nephropathy	90%	90%	0%
Medication Management for People With Asthma (MMA), Medication Compliance 75%, 5-11 Years	27%	27%	0%
Children's Access to Primary Care Practitioners (CAP), 7-11 Years	89%	90%	-1%
Comprehensive Diabetes Care (CDC), HbA1c Testing	89%	90%	-1%
Comprehensive Diabetes Care (CDC), Eye Exam	56%	58%	-2%
Breast Cancer Screening (BCS)	52%	55%	-3%
Adults' Access to Preventive/Ambulatory Health Services (AAP), Total	72%	76%	-4%
Prenatal and Postpartum Care (PPC), Postpartum Care	55%	59%	-4%
Follow-Up Care for Children Prescribed ADHD Medication (ADD), Initiation	39%	43%	-4%
Cervical Cancer Screening (CCS)	53%	58%	-4%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), Total	12%	17%	-5%
Follow-Up Care for Children Prescribed ADHD Medication (ADD), Continuation	44%	51%	-7%
Comprehensive Diabetes Care (CDC), HbA1c Control < 8.0%	42%	50%	-8%
Controlling High Blood Pressure (CBP)	54%	63%	-9%
Comprehensive Diabetes Care (CDC), Blood Pressure Control < 140/90 mm Hg	58%	68%	-9%
Comprehensive Diabetes Care (CDC), Poor HbA1c Control (Note that a lower score is better for this measure)	47%	37%	-10%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC), BMI Percentile, Total	60%	72%	-12%

Table A-4. CCW's Performance Measure Strengths and Opportunities for Improvement.

Performance Measures	
Strengths	**Opportunities for Improvement**
Prenatal and Postpartum Care (PPC) • CCW's timeliness of prenatal care measure is above the state average of 75%.	The Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC), BMI measure is 12% points below the state average.
Adolescent Well-Care Visits (AWC) • This measure is above the state average of 47%.	Many of the Comprehensive Diabetes Care (CDC) measures are below the state average, including HbA1c testing, eye exams, blood pressure control, and HbA1c control.
Childhood Immunization Status (CIS) • The Combo 10 measure is above the state average of 42%. • The Combo 2 measure is above the state average of 73%.	The Controlling High Blood Pressure (CBP) measure is below the state average.
	The Follow-Up Care for Children Prescribed ADHD Medication (ADD) measure is below the state average for both the initiation and the continuation phase.

Table A-5. Summary of CCW's PIPs.

Performance Improvement Projects (PIPs)		
Type	**Study Topic**	**Score**
Clinical: Washington State Institute for Public Policy Adult (FIMC)	Improving Antidepressant Medication Adherence in Adults Members (18 to 64 Years Old), who are eligible for enrollment with Medicaid through CCW	Not Met
Clinical: Washington State Institute for Public Policy Children (FIMC)	Improving Adherence with ADHD Follow-up Visits and Medications in Children with ADD Ages 6-12 Years Old	Not Met
Clinical: Washington State Institute for Public Policy (AHMC, AHFC, FIMC)	Decreasing Overutilization of Multiple Physicians and Pharmacies to Access Opioids in Members 18-64	Not Met
Clinical: Collaborative Well-Child Visits (AHMC, AHFC, FIMC)	Collaborative MCO Well-Child Visit Rate PIP	Partially Met
Non-Clinical: (AHMC, FIMC)	Improving Adult Male Access to Preventative/Ambulatory Health Services in Members Aged 20-64 Years (AAP)	Not Met
Non-Clinical: Clinical or Non-Clinical (AHMC, FIMC)	Improving asthma medication adherence in children aged 5-18	Partially Met
Additional: Clinical or Non-Clinical (AHFC)	Improving Well-Visit Claims at School Based Clinics (SBHC) for Members in Foster Care Members Ages 6 to 18	Not Met

Performance Improvement Projects (PIPs)		
Type	**Study Topic**	**Score**
Non-Clinical: in Partnership with MCO, DSHS & HCA (AHFC)	Improving Access to Assigned Primary Care Provider for Apple Health Foster Care Members Ages 12 Months to 19 Years Old	Not Met
Opportunities for Improvement		

- Review the CMS "Conducting a Performance Improvement Project Worksheet" document to ensure the study is well-designed.
- Develop clear and measurable study questions.
- Identify sufficient indicators to track performance over a specified timeframe.
- Ensure interventions are linked to the PIP and are designed to make an impact in this important area.
- Focus on improving the linkage between the PIP design, interventions, indicators, and desired outcomes.

Table A-6. Summary of CCW's Compliance Results.

Compliance with Regulatory and Contractual Standards		
Standard	**Score**	**Possible**
Grievance	50	54
Provider selection	12	12
Quality Assessment and Performance Improvement	15	15
Review of Previous-Year (2018) Corrective Action Plans		
Standard	**Score**	
Enrollee Rights – two elements reviewed	Met	
Coverage and Authorization – three elements reviewed	One Partially Met, Two Not Met, One repeat finding	
Program Integrity Requirements – one element reviewed	Met	

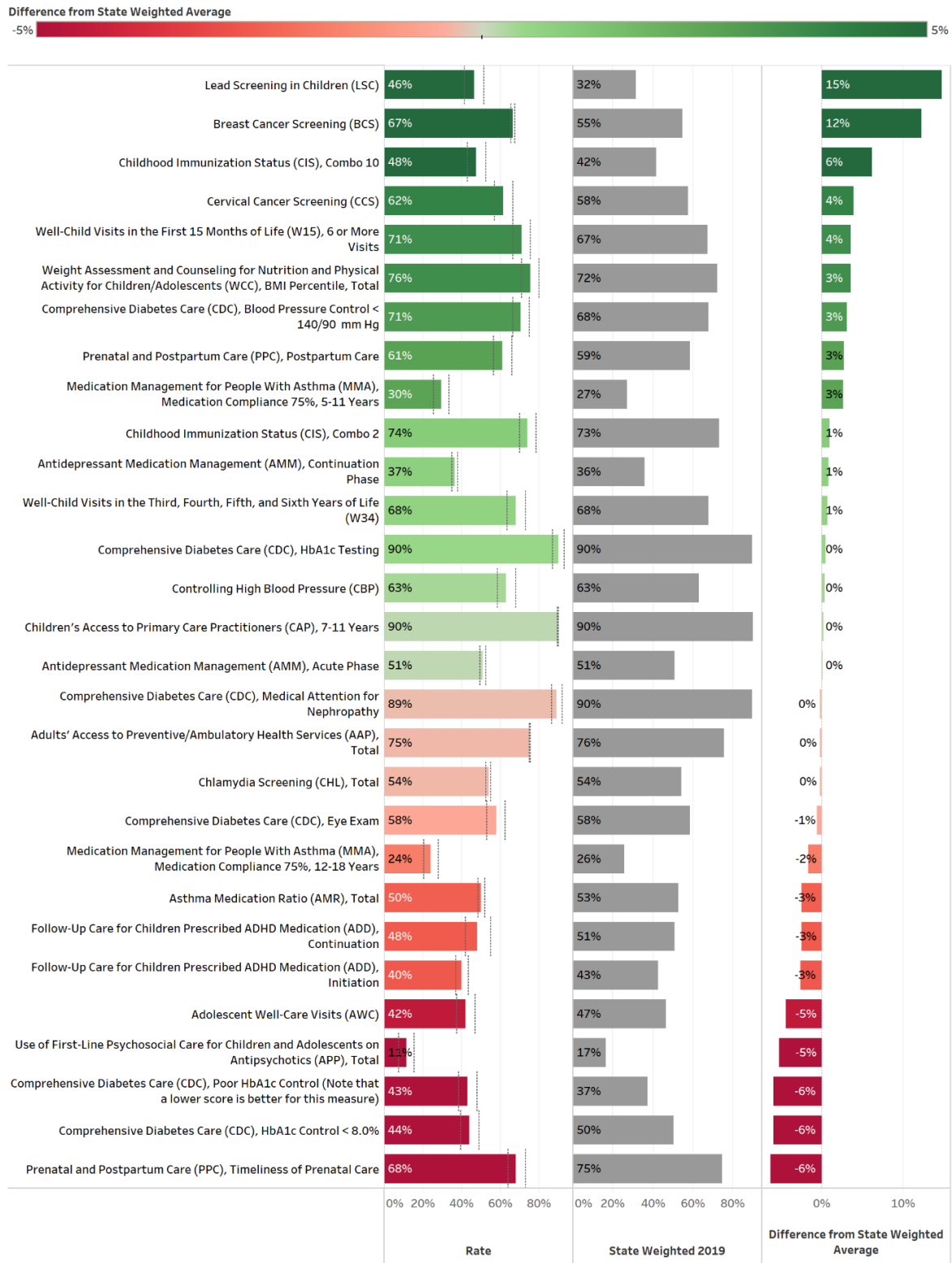# Community Health Plan of Washington (CHPW)

Figure A-3. CHPW Scorecard.

Table A-7. CHPW's Performance Measure Strengths and Opportunities for Improvement.

Performance Measures	
Strengths	**Opportunities for Improvement**
Lead Screening in Children (LSC) • This measure is above the state average of 32%.	The Timeliness of Prenatal Care (PPC) measure is below the state average.
Breast Cancer Screening (BCS) • This measure is above the state average of 55%.	Many of the Comprehensive Diabetes Care (CDC) measures are below the state average, including medical attention for nephropathy, eye exams, and HbA1c control.
Cervical Cancer Screening (CCS) • This measure is above the state average of 58%.	The Adolescent Well-Care Visits (AWC) measure is below the state average.
Childhood Immunization Status (CIS), Combo 10 • This measure is above the state average of 42%.	

Table A-8. Summary of CHPW's PIPs.

Performance Improvement Projects (PIPs)		
Type	**Study Topic**	**Score**
Clinical: Washington State Institute for Public Policy Adult (FIMC)	Outpatient Engagement Post Psychiatric Inpatient Hospitalization	Partially Met
Clinical: Washington State Institute for Public Policy Children (FIMC)	Caregiver Attachment in Young Children Exposed to Trauma	Partially Met
Clinical: Washington State Institute for Public Policy (AHMC)	Improving Antidepressant Medication Management through Brief Pharmacist Interventions	Partially Met
Clinical: Collaborative Well-Child Visits (AHMC)	Collaborative MCO Well-Child Visit Rate PIP	Partially Met
Non-Clinical: AHMC	Improving Utilization for High-Risk Members through Community Care Coordination"	Not Met

Strengths

- Interventions were chosen that met criteria of being evidence-based, research-based or promising practices.

- Interventions could reasonably be expected to affect change.

- The submissions clearly addressed all required elements.

Opportunities for Improvement

- Thoroughly review information provided by HCA in response PIP submissions and incorporate feedback into PIP processes and reporting in following years.

- When interventions are evidence-based, the MCO should examine whether it was implemented with fidelity to fully understand the analysis of the results.

- IMC PIPs must clearly identify the BHSO population, impact and involvement. The MCO must design PIPs for the BHSO population for a clinical and non-clinical PIP, at minimum.

Table A-9. Summary of CHPW's Compliance Review Results.

Compliance with Regulatory and Contractual Standards		
Standard	**Score**	**Possible**
Grievance	49	54
Provider selection	9	12
Quality Assessment and Performance Improvement	15	15
Review of Previous-Year (2018) Corrective Action Plans		
Standard	**Score**	
Availability of Services – two elements reviewed	Met	
Certifications & Program Integrity – one element reviewed	Met	
Coverage & Authorization of Services – three elements reviewed	Not Met	
Grievance Systems – two elements reviewed	One Met, One Partially Met	
Provider Selection – three elements reviewed	One Met, One Partially Met, One Not Met	

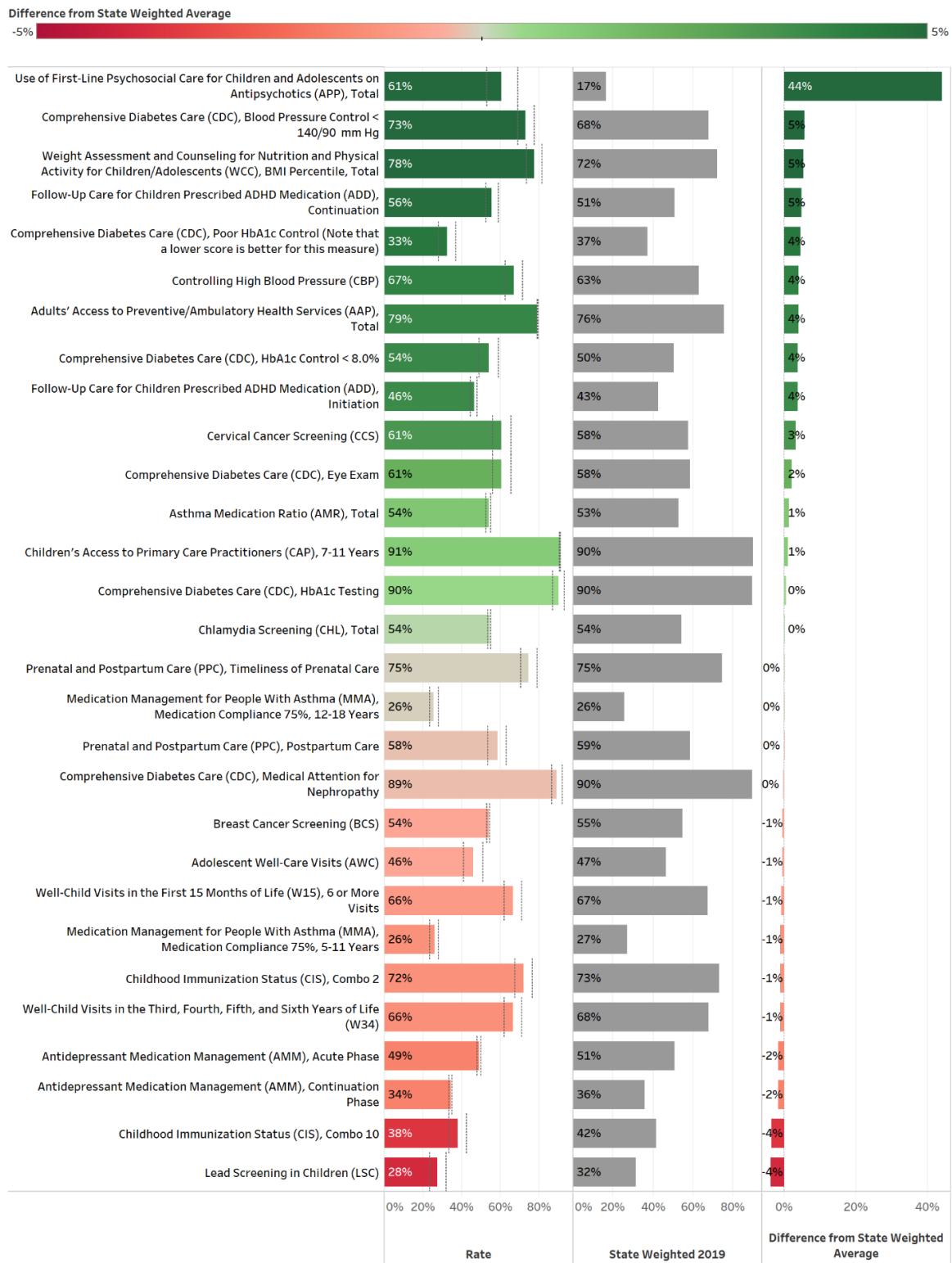# Molina Healthcare of Washington (MHW)

Figure A-4. MHW's Scorecard.

Table A-10. MHW's Performance Measure Strengths and Opportunities for Improvement.

Performance Measures	
Strengths	**Opportunities for Improvement**
Comprehensive Diabetes Care (CDC) • The blood pressure control measure is above the state average of 68%. • The poor HbA1c control measure is below the state average of 37% (note that lower is better for this measure). • The HbA1c control measure (< 8%) is above the state average of 50%. • The eye exam measure is above the state average of 58%.	The Childhood Immunization Status (CIS) Combo 2 and Combo 10 measures are below the state average.
Controlling High Blood Pressure (CBP) • This measure is above the state average of 63%.	The Lead Screening in Children (LSC) measure is below the state average.
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC), BMI • This measure is above the state average of 72%.	
Follow-Up Care for Children Prescribed ADHD Medication (ADD) • The initiation measure is above the state average of 43%. • The continuation measure is above the state average of 51%.	

Table A-11. Summary of MHW's PIPs.

Performance Improvement Projects (PIPs)		
Type	**Study Topic**	**Score**
Clinical: Washington State Institute for Public Policy Adult (AHMC, BHSO, FIMC)	Collaborative Primary Care for Depression	Partially Met
Clinical: Washington State Institute for Public Policy Children (BHSO, FIMC)	Effective Provider Collaboration: Enhancing Behavioral Parent Training (BPT) for Parents of Children with Attention Deficit Hyperactivity Disorder (ADHD)	Not Met
Clinical: Collaborative Well-Child Visits (AHMC, FIMC)	Collaborative MCO Well-Child Visit Rate PIP	Partially Met
Non-Clinical: (AHMC, FIMC)	Bridging the Gap: Level of Provider Engagement and Quality Improvement	Partially Met

Performance Improvement Projects (PIPs)		
Type	**Study Topic**	**Score**

Opportunities for Improvement

- The MCO should evaluate each PIP that is Partially or Not Met to determine what actions can be taken to improve the currently active PIP.

- The MCO should summarize the evaluation of their PIPs as well as any planned steps to improve individual PIPs and the overall PIP program.

- IMC PIPs must clearly identify the BHSO population, impact, and involvement. BHSO enrollees must be addressed in a clinical and non-clinical PIP, at minimum.

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

Compliance with Regulatory and Contractual Standards		
Standard	**Score**	**Possible**
Grievance	54	54
Provider selection	12	12
Quality Assessment and Performance Improvement	14	15
Review of Previous-Year (2018) Corrective Action Plans (2018)		
Standard	**Score**	
Availability of Services – one element reviewed	Met	
Coverage and Authorization of Services – two elements reviewed	One Met, One Not Met	
Enrollee Rights and Protections – one element reviewed	Met	
Grievance Systems – four elements reviewed	Met	
Program Integrity Requirements – one element reviewed	Not Met	
Provider Selection – one element reviewed	Met	

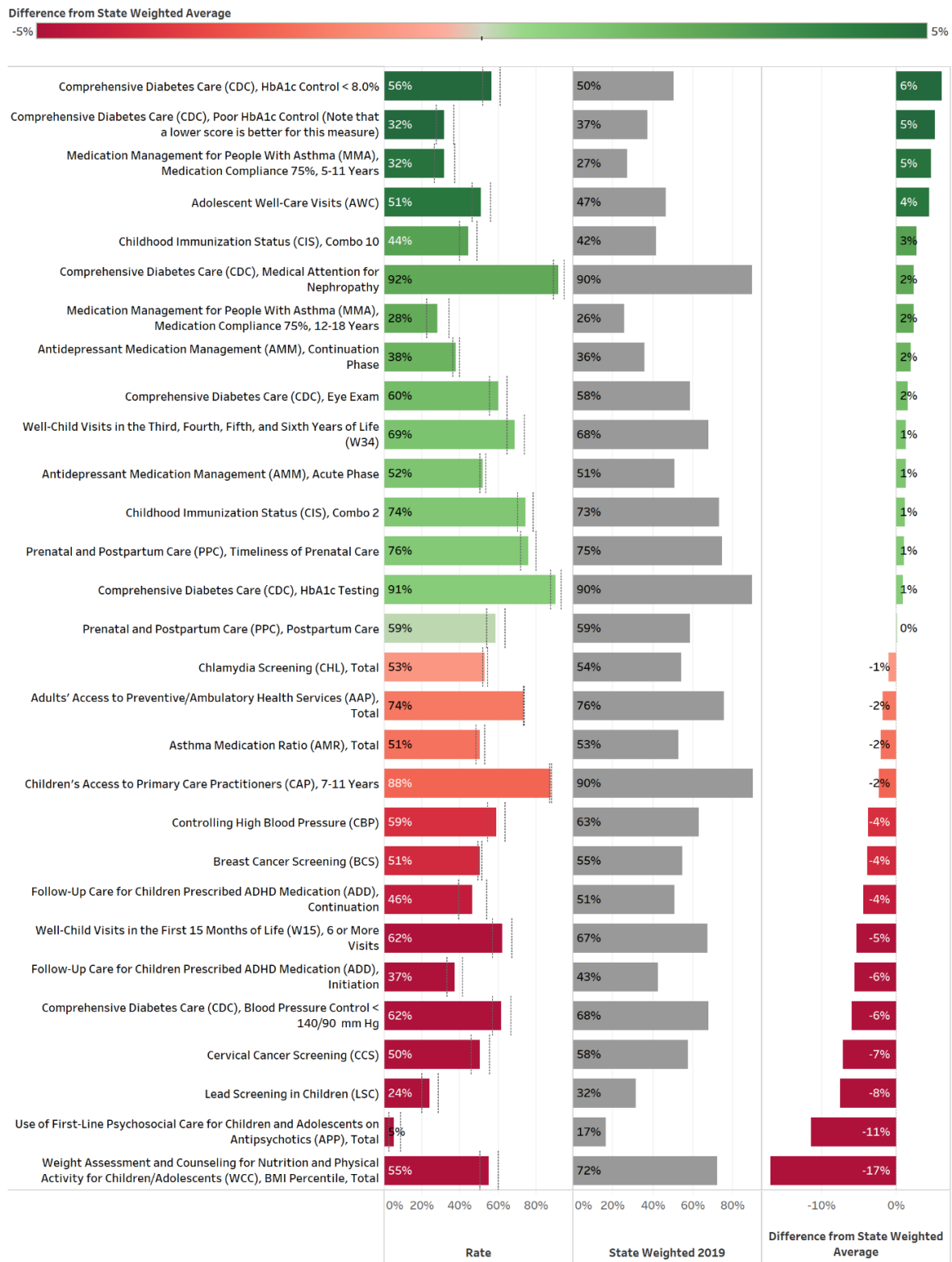# UnitedHealthcare Community Plan (UHC)

Figure A-5. UHC's Scorecard.

Table A-13. UHC's Performance Measure Strengths and Opportunities for Improvement.

Performance Measures	
Strengths	**Opportunities for Improvement**
Comprehensive Diabetes Care (CDC) • The poor HbA1c control measure is below the state average of 37% (note that lower is better for this measure. • The HbA1c control measure (< 8%) is above the state average of 50%.	Women's health measures (CCS, CHL, BCS) fell below the state average, with Cervical Cancer Screening (CCS) being particularly low.
Adolescent Well-Care Visits (AWC) • This measure is above the state average of 47%.	The Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC), BMI measure is 17% points below the state average.
	The Follow-Up Care for Children Prescribed ADHD Medication (ADD) measure is below the state average for both the initiation and the continuation phase.

Table A-14. Summary of UHC's PIPs.

Performance Improvement Projects (PIPs)		
Type	**Study Topic**	**Score**
Clinical: Washington State Institute for Public Policy (AHMC)	Increase Anti-Depressant Treatment Plan Compliance for Adult, Female, TANF members diagnosed with depression (anti-depressant medication management)	Partially Met
Clinical: Collaborative Well-Child Visits (AHMC)	Collaborative MCO Well-Child Visit Rate PIP	Partially Met
Non-Clinical: (AHMC)	Increasing The Rate of Members Receiving Diabetic Education Services	Met

Strengths

- PIP reports are logically organized and easy to follow, with clear linkages and alignment between the data analysis documenting the need for improvement, the study question, selected indicators, interventions, and results.

Opportunities for Improvement

- The MCO should evaluate each PIP that is Partially or Not Met to determine what actions can be taken to improve the currently active PIP.

- The MCO should summarize the evaluation of their PIPs as well as any planned steps to improve individual PIPs and the overall PIP program.

- Strengthen the analysis of evaluation results demonstrating how the interventions did or did not influence the results, and what other interventions might be possible.

- If an intervention is not effective, the MCO should examine both their processes in implementing it, and the validity of the intervention as it can be expected to affect improvement.

Performance Improvement Projects (PIPs)		
Type	**Study Topic**	**Score**
• IMC PIPs must clearly identify the BHSO population, impact, and involvement. The MCO must design PIPs for the BHSO population for a clinical and non-clinical PIP, at minimum.		

Table A-15. Summary of UHC's Compliance Review Results.

Compliance with Regulatory and Contractual Standards		
Standard	**Score**	**Possible**
Grievance	54	54
Provider selection	12	12
Quality Assessment and Performance Improvement	14	15
Review of Previous-Year (2018) Corrective Action Plans		
Standard	**Score**	
Certifications & Program Integrity – one element reviewed	Met	
Coverage and Authorization of Services – three elements reviewed	One Met, Two Not Met	
Enrollee Rights and Protections – one element reviewed	Met	
Practice guidelines – three elements reviewed	Two Met, One Not Met	
Subcontractual Relationships and Delegation – one element reviewed	Met	

Appendix B: PIP Review Procedures

PIP Review Procedure

As part of their overall compliance review of Apple Health MCOs and BHOs, HCA (TEAMonitor) and Comagine Health, respectively, conduct a review of performance improvement projects (PIPs). The evaluations are based on Attachment A of *EQR Protocol 3: Validating Performance Improvement Projects, Version 2.0*[8] developed by the Centers for Medicare & Medicaid Services (CMS) to determine whether a PIP was designed, conducted and reported in a methodologically sound manner.

The review process and scoring methods (BHO PIPs were not scored) for evaluating PIPs are outlined below.

* Indicates MCO only review process component   ** Indicates BHO only review process component

Part A: Assessing the Study Methodology

1: Review the Selected Study Topic(s)
   a) Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care and services?
   b) Is the PIP consistent with the demographics and epidemiology of the enrollees?
   c) Did the PIP consider input from enrollees with special health needs, especially those with mental health and substance abuse problems?
   d) Did the PIP, over time, address a broad spectrum of key aspects of enrollee care and services (e.g., preventive, chronic, acute, coordination of care, inpatient, etc.)?
   e) Did the PIP, over time, include all enrolled populations (i.e., special healthcare needs)? *

2: Review the Study Question(s)
   a) Was/were the study question(s) stated clearly in writing?
   b) Does the study question set the framework for goals, data collection, analysis and interpretation? **
   c) Does the study question include the intervention, the study population (denominator), what is being measured (numerator), a metric (percentage or average) and a desired outcome? **

3: Review Selected Study Indicator(s)
   a) Did the study use objective, clearly defined, measurable indicators?
   b) Did the indicators track performance over a specified period of time?
      i.   Are the baseline and first and second re-measurement periods unambiguously stated and appropriate in length? **

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[8] https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3-attachment-a.pdf

    c)   Are the number of indicators adequate to answer the study question, appropriate for the level of complexity of applicable medical practice guidelines, and appropriate to the availability of resources to collect necessary data?
        i.   Are there mitigation strategies in case sufficient data is not able to be collected? **

    d)   Is there an explanation of how the indicators are appropriate and adequate to answer the study question? Does it describe how the indicator objectively measures change to impact the enrollee? **

4: Review the Identified Study Population

    a)   Were the enrollees to whom the study question and indicators are relevant clearly defined?
        i.   If there is an inclusion or exclusion criterion, is it clearly defined? **

    b)   Is the study population reflective of the entire Medicaid enrollee population to which the study indicator applies? Or is a sample used? **

    c)   If the entire population was studied, did its data collection approach capture all enrollees to whom the study question applied?

5: Review Sampling Methods

    a)   Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the acceptable margin of error?

    b)   Were valid sampling techniques employed that protected against bias (specifying the type of sampling or census used)?

    c)   Did the sample contain a sufficient number of enrollees?

    d)   Is the sampling technique specified? Is it specified whether the sample is a probability or non-probability sample? **

6: Review Data Collection Procedures

    a)   Did the study design clearly specify the data to be collected?

    b)   Did the study design clearly specify the sources of the data?

    c)   Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?

    d)   Did the instruments for data collection provide for consistent and accurate data collection over the time periods studied?
        i.   Was any additional documentation that was requested provided and appropriate? **

    e)   Did the study design prospectively specify a data analysis plan?

    f)   Were qualified staff and personnel used to collect the data?
        i.   If so, are their qualifications included? **

    g)   Is there a description of how inter-rater reliability is ensured? **

7: Assess Improvement Strategies

    a)   Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes?

    b)   Are the interventions sufficient to be expected to improve processes or outcomes?

    c)   Are the interventions culturally and linguistically appropriate?

    d)   Were steps taken to identify improvement opportunities during the PIP process (e.g., root cause analysis, data analysis and other quality improvement [QI] activities)? **

8: Review Data Analysis and Interpretation of Study Results

    a)   Was an analysis of the findings performed according to the data analysis plan?

    b)   Were numerical PIP results and findings accurately and clearly presented?

    c)   Did the analysis identify initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?

    d)   Did the analysis of study data include an interpretation of the extent to which its PIP was successful and follow-up activities?

    e)   Is the data analysis methodology appropriate to the study question and data types? **

    f)   Does the analysis include an interpretation of the PIP's success, statistically significant or otherwise? Is there a description of any follow-up activities as a result? **

9: Assess Whether Improvement is "Real" Improvement

    a)   Was the same methodology as the baseline measurement used when measurement was repeated?

    b)   Was there any documented, quantitative improvement in processes or outcomes of care?

    c)   Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)?

         i.   Or an analysis related to why there was not improvement? **

    d)   Is there any statistical evidence that any observed performance improvement is true improvement?

    e)   Was statistical analysis performed thoroughly and accurately? **

10: Assess Sustained Improvement

    a)   Was sustained improvement demonstrated through repeated measurements over comparable time periods?

    b)   If improvement was not sustained, was there an explanation? Is there a plan for next steps? **

Part B: Verifying Study Findings (optional)

Were the initial study findings verified upon repeat measurement? *

Part C: Evaluate Overall Validity and Reliability of Study Results

Indicate one of the following regarding the results of the MCO's PIP.

- High confidence in reported results
- Confidence in reported results

- Low confidence in reported results
- Reported results not credible
- Enough time has not elapsed to assess meaningful change

PIP Scoring (MCO only, BHO PIPs were not scored)

TEAMonitor scored the MCOs' PIPs as Met, Partially Met or Not Met according to how well they performed against a checklist of elements designed to measure success in meeting the standards specified by CMS. The elements associated with the respective scores follow.

To achieve a score of Met, the PIP must demonstrate all of the following 12 elements:
- A problem or need for Medicaid enrollees reflected in the topic of the PIP.
- The study question(s) stated in writing.
- Relevant quantitative or qualitative measurable indicators documented.
- Descriptions of the eligible population to whom the study questions and identified indicators apply
- A sampling method documented and determined prior to data collection
- The study design and data analysis plan proactively defined
- Specific interventions undertaken to address causes/barriers identified through data analysis and QI processes (e.g., barrier analysis, focus groups, etc.)
- Numerical results reported (e.g., numerator and denominator data)
- Interpretation and analysis of the reported results
- Consistent measurement methods used over time or, if changed, documentation of the rationale for the change
- Sustained improvement demonstrated through repeat measurements over time (baseline and at least two follow-up measurements required)
- Linkage or alignment between the following: data analysis documenting need for improvement, study questions, selected clinical or nonclinical measures or indicators, results

To achieve a score of Partially Met, the PIP must demonstrate all of the following seven elements. If the PIP fails to demonstrate any one of the elements, the PIP will receive a score of Not Met.
- A problem or need for Medicaid enrollees reflected in the topic of the PIP.
- The study question(s) stated in writing.
- Relevant quantitative or qualitative measurable indicators documented.
- A sampling method documented and determined prior to data collection
- The study design and data analysis plan proactively defined
- Numerical results reported (e.g., numerator and denominator data)
- Consistent measurement methods used over time or, if changed, documentation of the rationale for the change

Appendix C: Regulatory and Contractual Requirements

The following is a list of the access, quality and timeliness elements cited in the Code of Federal Regulations (CFR), Title 42 Chapter IV Subchapter C Part 438, that managed care organizations (MCOs) and behavioral health organizations (BHOs) are required to meet. These standards, along with state contractual requirements specific to physical or behavioral health care, were assessed during 2019 compliance reviews of Apple Health MCOs and BHOs.

As part of this year's audit, TEAMonitor fully reviewed MCO compliance with the following protocols:
- 438.228 – Grievance Systems
- 438.214 – Provider Selection/Credentialing
- 438.240 – Quality Assessment and Performance Improvement Programs (QAPI)

In addition, plans were reviewed on elements that received Partially Met or Not Met scores in 2018 RY.

Comagine Health fully reviewed BHO compliance with standards below noted with an asterisk (*).

438.100 Enrollee Rights

438.100 (a) *General rule*

438.100 (b) *Specific rights*

438.100 (c) *Free exercise of rights*

438.100 (d) *Compliance with other Federal and State laws*

438.206 Availability of Services (a) – Delivery Network

438.206 (a) *Basic rule**

Additional under this section:

438.68   Network adequacy standards*

438.206 Availability of Services (b) – Delivery Network

438.206 (b)(1) *Maintenance and monitoring of appropriate providers**

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 Availability of Services (c) – Furnishing of Services

438.206(c)(1) *Timely access**

438.206(c)(2) *Cultural considerations**

438.206(c)(3) *Accessibility considerations**

438.207 Assurances of Adequate Capacity and Services

438.207 (a) *Basic rule**

438.207 (b) *Nature of supporting documentation**

438.207 (c) *Timing of documentation**

438.208 Coordination & Continuity of Care (b) - Care and coordination of services for all MCO, PIHP, and PAHP enrollees

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

 Additional under this section:

438.224   Confidentiality*

164.502   Uses and disclosures of protected health information: General rules (b) *Standard: Minimum necessary— Minimum necessary applies**

438.208 Coordination & Continuity of Care (c) - Additional Services for Enrollees with Special Healthcare Needs

438.208 (c)(1) *Identification**

438.208 (c)(2) *Assessment**

438.208 (c)(3) *Treatment/service plans**

438.208 (c)(4) *Direct access to specialists**

438.210 Coverage and Authorization of Services

438.210 (a) *Coverage**

438.210 (b) *Authorization of services**

438.210 (c) *Notice of adverse benefit determination**

438.210 (d) *Timeframe for decisions**

438.210 (e) *Compensation for utilization management activities**

438.214 Provider Selection (Credentialing)

438.214 (a) *General rules**

438.214 (b) *Credentialing and recredentialing requirements**

438.214 (c) *Nondiscrimination**

438.214 (d) *Excluded providers**

438.214 (e) *State requirements**

Additional under this section:

438.12   Provider discrimination prohibited*

438.230 Subcontractual Relationships and Delegation

438.230 (a) *Applicability**

438.230 (b) *General rule**

438.230 (c) Written agreement with subcontractors*

438.236 Practice Guidelines

438.236 (a) *Basic rule**

438.236 (b) *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 (a) *General rule**
438.242 (b) *Basic elements of a health information system**
438.242 (c) *Enrollee encounter data**

438.330 Quality Assessment and Performance Improvement Program

438.330 (a) *General rules**
438.330 (b) *Basic elements of quality assessment and performance improvement programs**
438.330 (c) *Performance measurement**
438.330 (d) *Performance improvement projects**
438.330 (e) *Program review by the State**
438.66 State monitoring requirements (c)(3)

438.402 General Requirements (Subpart F—Grievance And Appeal System)

438.402 (a) *The grievance and appeal system*
438.402 (b) *Level of appeals*
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 Timely And Adequate Notice of Adverse Benefit Determination

438.404 (a) *Notice*
438.404 (b) *Content of notice*
438.404 (c) *Timing of notice*

438.406 Handling of grievances and appeals

438.406(a) *General requirements*
438.406 (b) *Special requirements*

438.408 Resolution and Notification: Grievances and Appeals

438.408 (a) *Basic rule*
438.408 (b) *Specific timeframes*
438.408 (c) *Extension of timeframes*
438.408 (d) *Format of notice*
438.408 (e) *Content of notice of appeal resolution.*

Subpart F—Grievance And Appeal System

438.228 Grievance and appeal systems
438.410 Expedited resolution of appeals

438.414 Information about the grievance system to providers and subcontractors

438.416 Recordkeeping requirements

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

438.424 Effectuation of reversed appeal resolutions

438.608 Program Integrity Requirements Under the Contract

438.608 (a) *Administrative and management arrangements or procedures to detect and prevent fraud, waste and abuse*

438.608 (b) *Provider screening and enrollment requirements*

438.602 (c)(2) *Disclosures*

Appendix D: 2019 QIRT Summary Report

Wraparound with Intensive Services (WISe)
Quality Improvement Review Tool (QIRT)
Findings Summary & Recommendations

Wraparound with Intensive Services (WISe) is designed for Medicaid-eligible children with complex behavioral health needs. It is a team-based approach that provides services to youth in their homes and communities rather than institutions.

Components of this program include:

- Comprehensive care coordination
- Intensive services provided in the home and in the community
- Mobile crisis intervention and stabilization services

Because of its comprehensive nature, potential for crisis intervention, and the number of professionals and peers partnering in support of the client, all the components must be documented carefully—both to assist the providers in fulfilling program requirements and monitoring client progress, but also to allow a means by which to assess the quality of the WISe program.

Number of Agencies Reviewed:
15
Number of Files Reviewed:
146
Review Period:
January – September 2019

WISe implementation began in Washington in 2014, with a statewide goal establishing WISe treatment throughout the state by 2018. Per the T.R. v. Birch and Strange settlement agreement (https://www.disabilityrightswa.org/cases/tr-v-quigley/) 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 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

As the external quality review organization (EQRO) for Washington, Comagine Health (formerly Qualis Health) was contracted to review behavioral health agencies (BHAs) throughout the state that have implemented the WISe program.

Comagine Health prepared this report under contract with the Washington State Health Care Authority (Contract No. 1534-28375).

Introduction

The Quality Improvement Review for 2019 consisted of two days of onsite record reviews at each of the 15 behavioral healthcare agency (BHA) offices selected by HCA. These locations reflect a combination of both rural and urban agencies providing WISe services throughout the state of Washington. Record reviews consisted of examining paper records, electronic records or a combination of both against review criteria. The information gleaned from the records was then entered into the online Quality Improvement Review Tool (QIRT). The reviews began in January and concluded in September. Following each agency review, the WISe team presented the state with a summary and recommendations report. Those reports were sent out to the individual agencies in November, after the completion of the final review in September.

The Quality Improvement Review was performed by the Comagine Health WISe clinical review team which consisted of three reviewers with extensive training and years of experience performing External Quality Review (EQR) activities. Additionally, the reviewers:

- Completed a four-day Washington WISe training and are certified in the WISe program
- Participated in the Quality Service Review (QSR) pilot study conducted in previous years and provided feedback on additions and improvements of the QIRT
- Achieved certification on the final QIRT prior to conducting any reviews

A component of the T.R. Settlement Agreement is to develop and refine a review process for future quality assurance. The QIRT is used to assess the quality of care of the WISe program. This review assessed care elements provided by the WISe agency and did not assess other elements such as documentation from other care providers involved in the client's treatment or billing information. Therefore, the scope of the review is likely to underestimate the actual volume of care provided.

Limitations of the QIRT include:

- Limited ability to capture activities such as care coordination completed by the therapist, youth or parent peer because the tool is role defined
- Limited opportunities in the treatment characteristics section as it does not incorporate whether the sessions address the needs identified in the CANS (The Child and Adolescent Needs and Strengths), CFTs, the intake assessment, ISP (individual service plan) or goals and items within the CSCP (Cross System Care Plan)
- Underutilization of the Notes section, which may be a result of limited field space to enter documentation including detailing of activities such as
    - communication between the care coordinator and the therapist and how they can best assist the youth/family
    - documenting difficulties in contacting the youth/family to schedule appointments thereby providing insight as to extended timeframes for services
    - documentation of multiple staff providing the same service at the same time
    - capturing the overall outcome of the youth's success in treatment including what worked well and areas for improvement

As stated in the HCA WISe manual, the Washington State Children's Behavioral Health Principles outlined below guide the implementation of WISe. These principles provide the foundation for the practice model and clinical delivery of intensive services in which the QIRT was used to assess WISe services and assist in identifying needed system changes, educational opportunities for providers and other quality improvement strategies. The Behavioral Health Principles used in reviewing WISe include:

- The use of family and youth voice and choice during all phases of the process, including the first contact with or about the family as well as during the planning, delivery, transition and evaluation of services
- The use of a team-based approach for services and supports to develop and implement a plan to address unmet needs and work toward the youth's and family's vision
- The use of natural supports from the youth's and family members' networks of interpersonal and community relationships
- The use of collaboration and care coordination to respond effectively to the behavioral health needs of multi-system involved youth and their caregivers
- Maintaining or returning youth safely to their own homes or to the least restrictive setting possible
- Providing services that are culturally relevant and provided with respect for the values, preferences, beliefs, culture and identity of the participant/youth and family and their community
- Services, strategies and supports that are individualized and tailored to the unique strengths and needs of the youth and family
- The development of goals and strategies—based on the youth/family's needs and vision—which are tied to observable indicators of success and tracked for use in revising the treatment plan over time
- Working with the family toward their goals until the family indicates that a formal process is no longer required

Key areas of review focused on:
- Care Coordination Elements
- CFT Processes and Transition Planning
- Crisis Prevention and Response
- Treatment Characteristics
- Parent and Youth Support

This report summarizes the trends and results of the QIRT review of the 15 BHAs (146 enrollee records) following the above principles. Each BHA review was performed at one individual provider location and may not reflect the practices throughout the BHAs' office network.

Summary of Findings

Care Coordination Elements

Initial Engagement & Care Planning

Documentation noting inclusion of youth/family in the CANS process is a critical element of WISe and aligns with the principles of the model. To be effective, initial engagement should be a collaborative process and include youth/family voice and choice. To be a collaborative process, the initial full CANS (Child and Adolescent Needs and Strengths) should be reviewed by the caregiver and youth and their feedback solicited and incorporated into the final CANS version. Use of CANS data can inform decision making at many stages during the treatment process.

Per the WISe Program policy and procedure manual, CANS screenings must be offered within 10 business days of receiving a WISe referral and initial full CANS within 30 days of enrollment. Timeliness standards were met for 71% of CANS screening and 55% of initial full CANS. The trend at most BHAs was inconsistency in documentation. For example, documentation on the CANS and what was documented elsewhere in the clinical record were not always consistent. There was not consistent documentation of discussion and review of the

initial full CANS or incorporating youth voice and any suggested changes. The summary results of the reviews indicated this was a collaborative process 22% of the time. We encourage processes and documentation that reflect the voice of the youth and family which support achieving collaborative treatment outcomes.

Overall, there was a lack of consistent documentation of discussions regarding the content of WISe services taking place, literature being provided, or questions elicited and answered. Often, it was unclear how or when collaboration or acceptance of services occurred. Barriers to treatment were not consistently identified nor processes offered to resolve identified barriers. We recommend assisting the family and youth in understanding the WISe objectives, identifying potential barriers and finding solutions to mitigate obstacles to full participation and engagement in WISe services.

The QIRT review criteria states that all needs identified by the initial full CANS are to be addressed in the Cross System Care Plan (CSCP). This includes prioritization of needs and goals by the youth and family, which should be discussed and integrated into the development of the CSCP. The establishment of prioritized needs, goals and the expected outcomes were integrated with input from the youth and family in 17% of the CSCPs. CSCPs did not consistently include or address all the needs and strengths identified on the initial full CANS nor document the decision to defer addressing low priority needs (as allowed in the QIRT criteria). In most records, needs were identified relevant to school and other environments but attempts to contact potential treatment supporters were minimal, and there was not consistent documentation indicating school staff were invited to participate in WISe efforts. We encourage expanded and consistent outreach to treatment supporters when needs are identified in the home, school or community and the inclusion of these supporters in the child and family team meetings. Although 45% of the CSCPs were completed in a timely manner, meaningful strategies to meet the identified needs were not consistently documented in the plans.

If CSCPs did include goals and objectives, the majority were not specific, measurable, attainable, realistic and timely (SMART goals). Moreover, the goals appeared to be written entirely from the perspective of the professional/clinical staff. Goals and objectives captured within the CSCP or Individual Service Plan (ISP) must meet the criteria of being both SMART as well as being written in the youth and family's own words to support actionable, youth-centered work. Additionally, goals need to be specific to the youth and family and include exactly what needs to be accomplished, the timeframe by which the goals need to be completed, and how the team will know when goals are successfully met.

There is an opportunity to incorporate more meaningful discussions of strengths, needs, barriers and culture with family members and integrate these conversations into the formulation of the youth's support needs and strengths in the CSCP. Culture plays an important moral, spiritual and religious role in the youth's life. It is important to include these elements when administering the CANS and collaboratively creating the CSCP as it encourages individuality and respect of other's personal differences and builds an environment of trust and openness in information sharing. The ability of the child and family team to assess and manage family dynamics and behaviors is related to their knowledge, understanding and appreciation of the strengths, needs, barriers and cultural context within which the youth and family function.

Care coordinators play a key role by focusing on early engagement and strategies to expand the child and family team. Documentation indicated the overall average face-to-face time between the care coordinator and caregiver/youth combined was just under an hour a month. Although there is no prescribed duration of time for the care coordinator to meet with the child and family team, a low average of face-to-face time limits the ability to connect with the family. We recommend care coordinators for all BHAs concentrate on early engagement and on outreach to potential treatment supporters and coordination/collaboration with external system stakeholders.

CFT Processes and Transition Planning

The CFT includes the youth, parent/caregiver/ family member, care coordinator, therapist, peer supports, and formal and natural supports. The aim of the CFT meetings is to develop and update the CSCP, address unmet needs and work towards the family's vision and mission. Progress towards meeting goals should be monitored regularly and used to revise the comprehensive care plan. These meetings should take place at least every 30 days once a youth is enrolled in WISe. During the first 90 days in WISe, 52% of the youth had at least one CFT meeting, 14% of youth did not have any meetings occur, while 28% of the youth reviewed had three or more CFT meetings. We recommend that all youth have at least one CFT meeting every 30 days in order to update the CSCPs, address any unmet needs, provide constructive feedback regarding group accountability and continue to work on the family's vison and mission for WISe.

Although discussion of participant roles and the exchange of contact information may be occurring during CFT meetings, the documentation did not reflect that this was regularly occurring. The CFT meetings were attended primarily by family, the care coordinators and therapists. Documentation indicated there were needs in environments other than the home, but did not indicate that these needs were addressed, and potential treatment supporters were contacted and invited to participate in the CFTs.

At the CFT meetings, it was not always clear if the CSCP was collaboratively reviewed. When tasks or action steps were identified in the CSCPs, it was often not evident to whom the items were assigned or when the actions needed to be completed. Documentation did not consistently reflect follow-up with CFT members on previously assigned goals and/or tasks. This step is important as it ensures forward movement towards achieving the treatment goals for successful transition out of WISe.

All team members should receive a copy of the initial CSCP and all updates in order to be an effective CFT member/supporter to the youth and family, however, documentation did not consistently reflect that CFT members received a copy of CSCPs.

Improving engagement of external system partners and natural supports are clear areas for improvement of fidelity to the WISe model. We also recommend documentation reflect partnering with potential treatment supporters and external system stakeholders.

Overall, documentation showed little evidence of any discussions regarding transition goals or discharge criteria. The conversation of transition planning should occur at the very onset of the start of care. We recommend following best practice which includes discussing transition planning and goals as well as discharge goals throughout treatment, beginning with the initial engagement. Additionally, documentation should include outreach to potential treatment supporters or coordination and collaboration with other system supporters.

Crisis Prevention and Response

A critical component of a CSCP is an effective crisis plan that includes:

- Crisis identification and prevention steps

- CFT members' roles in proactive interventions to minimize the occurrence and severity of crises

- Crisis response actions, using a tiered approach to address the severity level of the crisis

- Re-evaluating the youth's behavioral health status to reflect any progress or changes in the youth/family's expectations

- A post-crisis plan for evaluating the management of the crisis and overall effectiveness of the plan

Although documentation showed that 61% of crisis plans were completed timely, many were completed prior to the youths entering the WISe program and had not been updated to reflect the youth's current risk factors. Crisis plans consistently lacked the above key elements. Additionally, related collaboration with CFT members on roles and interventions occurred in only 13% of records. When a crisis did occur, there was a lack of any follow up by the CFT members for evaluating the management of the crisis and overall effectiveness of the plan. Per the WISe manual, the team reviews and expands the crisis plan to reflect proactive and graduated strategies to prevent crises, or to respond to them in the most effective and least restrictive manner.

To ensure safety and stability, we encourage incorporating and addressing all elements (including all risk factors identified and addressed in the CANS), creating crisis plans collaboratively with the team and youth, and updating/distributing the crisis plans as outlined in the WISe manual.

Treatment Characteristics

Individual clinical treatment sessions are available to the youth/family in the amount, duration and scope appropriate to address the medically necessary identified needs and are provided by a qualified clinician. Typically, therapists provided two treatment sessions per month, primarily targeted to the youth. A caregiver attended the therapy sessions 44% of the time. There is an opportunity to improve clarity regarding what actions and strategies the therapist used and include any therapeutic treatment interventions. Therapy documentation was not always clear regarding what actions and strategies the therapist used, and sessions lacked evidence of any therapeutic treatment interventions. Progress notes generally included the problem of the day, status updates, youth reported check-ins and updates to the Individual Service Plan (ISP).

Progress note documentation did not always reflect items identified on the CSCP or indicate how the therapeutic intervention benefited the youth's functioning or symptoms, nor did they indicate how the services impacted the youth at home, school or in the community. We recommend clear and consistent documentation describing how the therapy sessions and interventions were beneficial to the youth's functioning or symptoms and how the services impacted the youth at home, school and in the community.

Evidence-Based Practice (EBP) technical language was often used but did not regularly describe what specific strategies of the EBP were put into practice, how they were utilized or the individual's response to the intervention. Therapists would benefit from additional training on how to use consistent session structures focused on skill development and review, success celebration and recruitment of additional practice supporters.

Treatment practice continuity has the potential to significantly improve overall treatment outcomes as it allows the therapist to determine the youth's treatment stage, monitor whether the youth is progressing or regressing and recognize successful practices that could be applied to other goals. Monitoring of progress and success is a means to ensure overall treatment quality. Treatment sessions broadly focused on similar goals. Notes related to reviewing progress or celebrating success were documented 15% and 2% of the time, respectively. The same item or concern was addressed in 52% of consecutive sessions and 42% had a different focus than that of a previous session.

Potential opportunities for improvement include following up on the previous therapy session's focus, reviewing progress towards the overall goals, celebrating successes and using CFT meetings to address the needs and relevant treatment topics discussed in therapy as well as identifying and mitigating barriers to attending treatment sessions.

We recommend clear and focused documentation that describes the youth's progress towards goals, including responses from the family and youth on the effectiveness of the therapeutic intervention, success celebration,

enlistment of added treatment supporters and indication of how the services impacted the youth's overall functioning.

Parent and Youth Support

Offering family and/or youth peer support is a required component of WISe and can be highly effective. Parent and youth partners are formal members of the WISe team whose roles are to partner with the youth/parents and enable them to drive the WISe process through active engagement and informed decision-making.

Parent partners and youth partners both averaged three face-to-face hours per month with the caregiver and youth. Documentation was not consistently clear about what the youth and parent partners' roles were or what tasks/goals the youth, family and partners were focused on completing. For the CFTs that did not have a family or youth peer support, it wasn't clear the peer had been offered to the families as a potential treatment supporter. Our recommendation is to encourage BHAs to increase the use of parent and youth peers for the purpose of promoting the youth/parent's active participation and contributions to the team thereby creating an opportunity for them to drive the WISe process.

Recommendations to the State

Based on the reviews at the 15 BHAs, our top recommendation is to ensure WISe services are clearly and fully documented. In addition, we recommend providing training to all BHAs on the areas/elements listed below to ensure all components are consistent with the goals and principles of the T.R. v. Birch and Strange settlement agreement.

Structured training and guidance should include the following:

- Increased documentation training for providers on how to document and encounter/code for services that are team based or when one or more siblings are simultaneously enrolled in WISe services.

- Developing and implementing individually tailored crisis plans—to include prevention strategies, crisis severity, tiered action steps, crisis response and roles of CFT members

- Establishing a process to ensure crisis plans are created at the onset of treatment, reviewed/updated and properly implemented throughout the course of treatment

- Documenting and communicating what is entailed in various therapeutic interventions (psychoeducation, EBP, etc.) and how the components are linked to the youth's mental health symptoms, needs, goals and objectives as outlined in the ISP or CSCP

- Consistently collaborating with the youth and family on the identification, development and agreement of goals, tasks, preferences and potential treatment supporters

- Establishing documentation standards and the Golden Thread, which ensures the needs identified in the assessment are also identified in the individual service plan and are addressed in each treatment session provided. Each service should indicate medical necessity.

- Ensuring peer supports are offered to all clients and the resulting acceptance/refusal documented

- Clarifying peer roles and responsibilities to reflect the needs of the youth and family

- Defining SMART (specific, measurable, attainable, realistic and timely) goals

- Developing methods to encourage youth and family input in the identification of barriers to service

- Implementing strategies to help youth build skills and apply them outside of the treatment session

One goal of the T.R. v. Birch and Strange settlement agreement is to provide effective care coordination and behavioral health management. When examining the records, the reviewers observed rapid staff turnover often disrupting the continuity of care. Youth would build rapport with one therapist, then have to start over with a new one—delaying therapeutic progress for weeks. We recommend the state work with a consultant to identify barriers and strategies for recruiting the behavioral health workforce as well as adopting ongoing retention strategies to ensure continuity of care.

Services provided should be tied back to a treatment goal on the ISP or CSCP. BHAs were providing services deviating from what was on the ISP or CSCP such as locating funding for the mother to purchase a car, transporting the youth back and forth from school and spending up to four or more hours going to the zoo or YMCA without documenting the connection to the overall goal. Careful documentation allows all treatment providers to see the goals of treatment and the accommodations that have been made to meet them including those non-traditional interventions as stated above.

During the review, we found documentation indicating underutilization of services. Reviewers observed that for many youth, there was an extended length of time between the CANS screening to the initial full CANS until WISe services began. While waiting for services, records did not show documentation that they had received any other intervention such as outpatient, group or inpatient services. For many of the youth, when subsequently enrolled in WISe, either they no longer met the medical necessity criteria (resulting in overutilization of services), or their behavioral conditions had worsened. We recommend the state work with BHAs to make sure certain mitigation strategies are implemented while youth and families are waiting to receive WISe services. Strategies could include:

- Connecting families with another provider
- Providing education to families regarding management of signs/symptoms of behaviors
- Using group interventions where feasible
- Routinely auditing the length of time between the CANS screening to the initial full CANS to determine whether youths awaiting WISe enrollment continue to require services
- Routinely monitor timeframes from referral to enrollment in order to assess network adequacy and utilization of services

Appendix E: 2019 Enrollee Quality Report

As a component of its EQR work for HCA, Comagine Health produced the *2019 Enrollee Quality Report,* designed to provide Apple Health applicants and enrollees with simple, straightforward comparative health plan performance information that may assist them in selecting a plan that best meets their needs.

Data sources for this report include the Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measure sets. The rating method is in alignment with the star rating systems used by other states and reflects the data sources available for the Apple Health population in Washington. For more information on the methodology used to derive this report's star rating system, see the *2019 Enrollee Quality Report Methodology.*

2019 Washington Apple Health Plan Report Card

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.

KEY: Performance compared to all Apple Health plans   ABOVE AVERAGE ★★★   AVERAGE ★★☆   BELOW AVERAGE ★☆☆

Performance Areas	Amerigroup Washington	Coordinated Care of Washington	Community Health Plan of Washington	Molina Healthcare of Washington	UnitedHealthcare Community Plan
Getting Care	★☆☆	★★☆	★★☆	★★★	★☆☆
Keeping Kids Healthy	★☆☆	★★☆	★★☆	★★☆	★☆☆
Keeping Women and Mothers Healthy	★☆☆	★★☆	★★☆	★★☆	★☆☆
Preventing and Managing Illness	★★☆	★☆☆	★★☆	★★☆	★★☆
Ensuring Appropriate Care	★★☆	★☆☆	★★☆	★★☆	★★☆
Satisfaction with Care Provided to Children	★★☆	★★☆	★★☆	★★☆	★★☆
Satisfaction with Plan for Children	★★☆	★★☆	★★☆	★★☆	★★☆

These ratings were based on information collected from health plans and surveys of health plan members in 2018. 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
- 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 most appropriate care and treatment for their condition

Satisfaction with Care Provided to Children
- Members report high ratings for:
  - ° Doctors   ° Specialists   ° Overall healthcare

Satisfaction with Plan for Children
- Members report high ratings for:
  - ° The plan's customer service   ° The plan overall