Comagine Health
Formerly Qualis Health and HealthInsight

Annual Technical Report

Washington Apple Health

Washington Health Care Authority

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

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

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

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

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Acronym List

Table 1. Acronyms Used Frequently in this Report.

Acronym	Definition
AH-BD	Apple Health Blind/Disabled
AH-IFC	Apple Health Integrated Foster Care
AH-IMC	Apple Health Integrated Managed Care
AHMC	Apple Health Managed Care
AHRQ	Agency for Healthcare Research and Quality
AMG	Amerigroup Washington, Inc.
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
DBHR	Division of Behavioral Health and Recovery
DOH	Department of Health
DSHS	Department of Social and Health Services
EQR	External Quality Review
EQRO	External Quality Review Organization
FPL	Federal Poverty Level
HCA	Health Care Authority
HEDIS	Healthcare Effectiveness Data and Information Set
IMC	Integrated Managed Care
MCO	Managed Care Organization
MCRA	Medicaid Compliance Review and Analytics
MCP	Managed Care Plan *Includes MCOs, prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), and primary care case management (PCCM) entities described in 42 CFR 438.310(c)(2).*[1]
MH-B	Mental Health Service Penetration – Broad Definition
MHW	Molina Healthcare of Washington
NCQA	National Committee for Quality Assurance
PAHP	Prepaid Ambulatory Health Plans
PCP	Primary Care Provider
PHE	Public Health Emergency

[1] HCA's PCCM contracts do not include shared savings, incentive payments, or other financial reward for the PCCM entity for improved quality outcomes, thus are not included in the state's EQR work

Acronym	Definition
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
QAPI	Quality Assessment and Performance Improvement
QIRT	Quality Improvement Review Tool
RDA	Department of Social and Health Services Research and Data Analysis Division
RY	Reporting Year
SHCN	Special Health Care Needs
SUD	Substance Use Disorder
TANF	Temporary Assistance for Needy Families
UHC	UnitedHealthcare Community Plan
UM	Utilization Management
VBP	Value-Based Purchasing
WISe	Wraparound with Intensive Services
WSIPP	Washington State Institute for Public Policy

Executive Summary

In 2020, over 1.7 million Washingtonians were enrolled in Apple Health,[2,3] with more than 84% enrolled in managed care.[4] The Washington State Health Care Authority (HCA) administered services for care delivery through contracts with five managed care organizations (MCOs):

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

Federal requirements mandate that every state Medicaid agency that contracts with managed care organizations provide for an external quality review (EQR) of health care services to assess the accessibility, timeliness and quality of care furnished to Medicaid enrollees. Comagine Health conducted this 2020 review as Washington's Medicaid external quality review organization (EQRO). This technical report describes the results of this evaluation. No MCOs in Washington are exempt from external quality review.

This year, TEAMonitor reviewed and reported on the Behavioral Health Services Only (BHSO) program . Although TEAMonitor completed both MCO and BHSO reviews in one session of the onsite visit, the programs were reviewed as separate entities, with their own scores.

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

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

Washington's Medicaid Program Overview

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

- Apple Health Family (traditional Medicaid)
- Apple Health Adult Coverage (Medicaid expansion)
- Apple Health Integrated Managed Care (AH-IMC)
- Apple Health Blind/Disabled (AH-BD)
- Apple Health Integrated Foster Care (AH-IFC)
- State Children's Health Insurance Program (CHIP)

[2] About Washington Apple Health (Medicaid). Available at: https://www.hca.wa.gov/assets/free-or-low-cost/about-Apple-Health.pdf.
[3] Quick Facts – Washington. United States Census Bureau. Available at: https://www.census.gov/quickfacts/WA.
[4] Healthier Washington. About the Washington Statewide Common Measure Set for Health Care Quality and Cost. Available at: https://www.hca.wa.gov/assets/measures-fact-sheet.pdf.

- Apple Health Behavioral Health Services Only (BHSO) (prepaid inpatient health plan [PIHP]–contracted services)

Under the direction of Senate Bill E2SSB 6312, behavioral health benefits were integrated into the Apple Health managed care program, providing Medicaid enrollees with access to both physical and behavioral health services through a single managed care program by January 1, 2020. The transition to an integrated system began in 2016, with behavioral health services previously purchased and administered by regional behavioral health organizations (BHOs) being transferred to Apple Health MCOs via a two-step process.

As of January 2020, all 10 regions of the state completed the transition to an integrated system for physical health, mental health and substance use disorder services within the Apple Health program. In this program, the majority of services for Apple Health clients are provided through managed care organizations. However, some services continue to be available through the fee-for-service delivery system (also referred to as coverage without a managed care plan), such as dental services.

For more about enrollment and the different service programs and regions see page 9, Introduction.

Summary of EQR Activities

EQR federal regulations under 42 CFR Part 438 specify the mandatory and optional activities that the EQRO must address in a manner consistent with CMS protocols.[5]

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

The 2020 EQR in Washington included the following activities which are in alignment with the CMS protocols:

- **Compliance review**
    - Including follow-up of the previous year's corrective action plans (CAPs)
- **Performance improvement project (PIP) validation**
- **Validation of performance measures, including:**
    - Healthcare Effectiveness Data and Information Set (HEDIS®[6]) measures
    - Two non-HEDIS measures that are calculated by the Department of Social and Health Services Research and Data Analysis Division (RDA)
        - Mental Health Service Penetration – Broad Definition (MH-B)
        - Substance Use Disorder Treatment Penetration (SUD)
- **Consumer Assessment of Healthcare Providers and Systems (CAHPS®[7]) consumer surveys**
- **Wraparound with Intensive Services (WISe) program review**

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

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

[7] CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Compliance Review

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

Performance Improvement Project (PIP) Validation

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

Performance Measure Validation

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

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

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

Comagine Health thoroughly reviewed each MCO's rates for all 56 HEDIS measures and associated sub-measures and the RDA measures. With HCA's approval, Comagine Health focused on 31 measures for the majority of analysis and comparison rather than the full list HEDIS measures. These 31 measures also included the two RDA measures since they reflect current HCA priorities and are part of the Statewide Common Measure Set. They also represent a broad population base or population of specific or prioritized interest.

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

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The CAHPS survey is a tool used to assess consumers' experiences with their health plans. CAHPS surveys address such areas as the timeliness of getting care, how well doctors communicate, global ratings of health care, access to specialized services and coordination of care. The survey aims to

measure how well MCOs are meeting their members' expectations and goals, determine which areas of service have the greatest effect on members' overall satisfaction and identify opportunities for improvement.

In 2020, the Apple Health MCOs conducted the CAHPS 5.0H Adult Medicaid survey of their members enrolled in Apple Health. The full report summarizing the findings is available in the *2020 Apple Health CAHPS® 5.0H Adult Medicaid Report*.

As required by HCA, CCW conducted the CAHPS 5.0H Child Medicaid and Children with Chronic Conditions survey of the Apple Health Foster Care program. The full summary of findings is available in the *2020 Apple Health IFC CAHPS® Medicaid Child with CCC 5.0 Report.*

Additionally, NCQA-certified CAHPS survey vendor DataStat, under a subcontract with Comagine Health, administered the 5.0H Child Medicaid survey of the member households of children enrolled in the state's CHIP. The full summary is available in the *2020 Washington Apple Health Children's Health Insurance Program CAHPS® 5.0H Report*.

Wraparound with Intensive Services (WISe) Program Review

In 2019, HCA chose to conduct a study on quality with focus on the WISe service delivery model. As the EQRO for Washington, Comagine Health is contracted to review behavioral health agencies (BHAs) throughout the state that have implemented the WISe service delivery model. WISe is a service delivery model that offers intensive services to Medicaid-eligible youth with complex behavioral health needs within the AH-IFC, AH-IMC and BHSO programs.

The reviews consisted of clinical record reviews for each of the 16 BHA provider locations selected by HCA. These locations reflect a combination of both rural and urban agencies providing WISe services throughout the State of Washington.

This summary includes overall results for the first 16 WISe reviews conducted during the review period of May to September 2020 and aggregated in three quarterly reports.

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

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

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

Quality

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

Access

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

Timeliness

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

Summary of Recommendations

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

Quality Strategy

Based on our comparative analysis, Comagine Health recommends the following to assist HCA in targeting the goals, aims and objectives in the quality strategy.

- We recommend that the MCOs sustain momentum in key areas (Behavioral Health Integration and Substance Use Disorder Treatment Penetration) where statistically significant and clinical meaningful improvements have been noted. Identifying the best practices contributing to this performance and, where possible, standardizing approaches to encourage sustainability will also lead to continued improvements. (Aim 1 and Aim 4)
- Proactively monitor measures in the light of the COVID-19 pandemic with a focus on access to care, behavioral health, chronic conditions, prevention and screening and utilization. (Aims 1-5)
- Continue to work on a strategy and plan to expand the available data set to allow deeper future analysis related to health equity. (Aims 1-4)
- Standardize approaches across MCOs when possible to reduce provider burnout. (Aim 4)
- Continue to evaluate recommendations on measure trends to guide selection of VBP measures. (Aims 5-6)

Compliance Review

In this year's review, MCP scores indicated that overall, the plans were compliant with Enrollee Rights, Availability of Services, Coordination and Continuity of Care, and Practice Guidelines.

Enrollee Rights

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

- enrollees are provided the necessary information if providers are terminated
- liability for payment issues are resolved
- required processes in place to monitor and address issues related to the provision of written materials

Availability of Services

- All MCPs require attention, support and continued technical assistance from HCA to meet these access elements. Areas requiring attention include:
    - provider directory information for enrollees
    - direct access to women's health specialists
    - providing for second opinions
    - addressing of and payment for out-of-network services
- HCA should continue to provide targeted technical assistance to MHW-BHSO regarding the §438.206 Availability of services standard as they scored below 75%.

Care Coordination

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

- general primary care and coordination of health care services for all enrollees
- ensure appropriate care coordination oversight is documented and in place

Practice Guidelines

- HCA should continue to provide direction and technical assistance to AMG-MCO and AMG-BHSO regarding their application of practice guidelines.

Corrective Action Plans

Please refer to Appendix A, MCP Profiles, for the individual CAP results.

- CAPs regarding coverage and authorization standards from 2019 continue to indicate little improvement. HCA is requiring MCOs to create detailed CAPs to meet coverage and authorization requirements. In addition, HCA mandates monthly technical assistance meetings to support the MCOs in utilization management (UM) decision-making processes and/or Notice of Adverse Benefit Determination. These meetings include visual review and feedback; discussion of processes followed for the reviewed documentation and demonstration that processes are appropriate and meet contract requirements. It is recommended that continued technical assistance to address coverage and authorization issues be provided for the MCOs.

PIP Review

Some of the recommendations from 2019 RY remain the same. To enhance the MCOs' ability to design a sound PIP, HCA should continue the following activities to engage and guide the five MCOs in providing desired quality health outcomes for its enrollees.

The five MCOs had PIPs with weaknesses in their study designs, including a lack of clear alignment and linkage throughout the PIP, inclusion of cultural and/or linguistic diversity and needs, and details on data analysis and input from populations with special health care needs. The PIPs also did not emphasize confidentiality and safe handling of sensitive information or quality improvement processes. (Access and quality of care)

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

The five MCOs had PIPs with weaknesses reflecting broad, unclear study questions resulting in interventions that were weakly or not linked to the study questions.

- HCA should provide technical assistance to the MCOs with a focus on defining, streamlining and simplifying study questions.

The five MCOs had PIPs with weaknesses in achieving sustained improvement through repeated measurements over comparable time periods.

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

Performance Measure Validation

Sustain Clinically Meaningful Areas of Improvement

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

- We recommend that HCA work with the MCOs to sustain momentum in these key areas, identifying the best practices contributing to this performance and, where possible, standardizing approaches to encourage sustainability. Key areas include:
    - Behavioral Health Integration
    - Substance Use Disorder

Anticipate Impacts due to the COVID-19 Pandemic

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

- We recommend that HCA encourage the MCOs not to wait for 2020 data to address anticipated effects, but rather work to proactively address these domains.

We anticipate that the impact of the pandemic will be measurable in several particularly vulnerable clinical areas, including:

- Access to care
- Behavioral health
- Chronic conditions (cardiovascular conditions, diabetes and respiratory conditions)
- Prevention and screening
- Utilization

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

HCA should utilize the CAHPS data, analysis and reports to identify specific areas of focus for the MCOs. These areas may be targeted and focused on survey items that fall below the national comparative data when this data is available. If national comparative data is not available, then looking at trends over time can provide valuable information to use when identifying areas of focus. In addition, we recommend looking at the survey items that showed improvement to identify successful strategies that can be shared and spread across all MCOs.

Introduction

Medicaid Managed Care in Washington

Medicaid managed care has a long history in Washington State. As the health care delivery system most widely used by Apple Health, it is organized to manage cost, utilization and quality. Beginning in 1985, CMS allowed the state to mandatorily enroll the Medicaid Temporary Assistance for Needy Families (TANF) population into a single plan. At that time, Medicaid also had a contract with an HMO (Group Health Cooperative) so that individuals could voluntarily enroll within a small number of counties. Based upon the successes of these early efforts, Medicaid managed care was later expanded and is currently operated statewide.

HCA now contracts with five managed care organizations (MCOs) to deliver multiple managed care programs for Apple Health clients throughout the state. HCA administers both Medicaid and the Children's Health Insurance Plan (CHIP) within the same managed care delivery system. Apple Health managed care is a mandatory program for the majority of Apple Health clients. These MCOs serve the majority of Apple Health clients, including low income and blind/disabled Medicaid populations and CHIP.

The Patient Protection and Affordable Care Act (ACA), enacted by Congress in 2010, created an unrivaled opportunity for increasing health coverage and provided states with the option of expanding eligibility for Medicaid. Under the opportunity presented by the ACA, Washington State chose to expand Apple Health as part of its Medicaid Transformation work. Before Medicaid expansion, coverage was essentially limited to low-income children, people with disabilities or devastating illnesses, and those whose incomes were far below the federal poverty level. After Medicaid expansion, for the first time, many low-income adults suffering from chronic conditions, such as diabetes, high blood pressure, asthma and other diseases now had better options than waiting until they were sick enough to go to the emergency room. People who were used to going without medical care were able to get regular doctor visits, including preventive care.

The number of people eligible for Apple Health increased significantly with the higher income limits that were part of Medicaid expansion. Others who had previously qualified but were not enrolled also obtained coverage. By 2020, nearly 600,000 newly enrolled individuals were receiving Apple Health for Adults coverage, with most of these adults enrolled in managed care.

Historically, Apple Health clients with co-occurring disorders had to navigate separate systems in order to access the physical and behavioral health services they needed to stay healthy. The physical health, mental health and substance use disorder delivery systems were disconnected, which led to poorly coordinated care, worse health outcomes, and a frustrating experience for Washington's Apple Health clients and the providers who served them. In 2014, the Washington State Legislature required HCA to transform how it delivers behavioral health services by integrating the financing and delivery of behavioral (public mental health and substance use disorder services) and physical health care for Apple Health. HCA began this integration in April 2016.

By January 1, 2020, all 10 regions of the state completed the transition to an integrated system for physical health, mental health and substance use disorder services within the Apple Health program. In this program, most services for Apple Health clients are provided through managed care organizations. However, some services continue to be available through the fee-for-service delivery system (also referred to as coverage without a managed care plan), such as dental services.

In prior years, two separate state agencies sponsored and monitored the Washington Medicaid Managed Care Quality Strategy:

- Washington State HCA, Medicaid Program Operations and Integrity Division
- Department of Social and Health Services (DSHS), Behavioral Health Administration (BHA), Division of Behavioral Health and Recovery (DBHR)

In July 2018, behavioral health services and employees transferred from DSHS to HCA. The purpose for this transfer from DSHS was to align the state's resources to better support the integration of physical and behavioral health. The move also supported the state's shift to integrated physical and behavioral health care purchasing for Apple Health Medicaid clients.

Many HCA divisions and staff administer health care coverage for Apple Health clients, including low-income adults, families, pregnant women, children, the elderly and individuals with disabilities. Apple Health covers nearly 50% of all Washington children and more than 50% of all births in Washington. Nearly 1.8 million Washingtonians currently receive managed health care through Apple Health in all of Washington's 39 counties.

Overview of Apple Health Managed Care

In 2020, over 1.7 million Washingtonians were enrolled in Apple Health,[8,9] with more than 84% enrolled in managed care.[10]

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

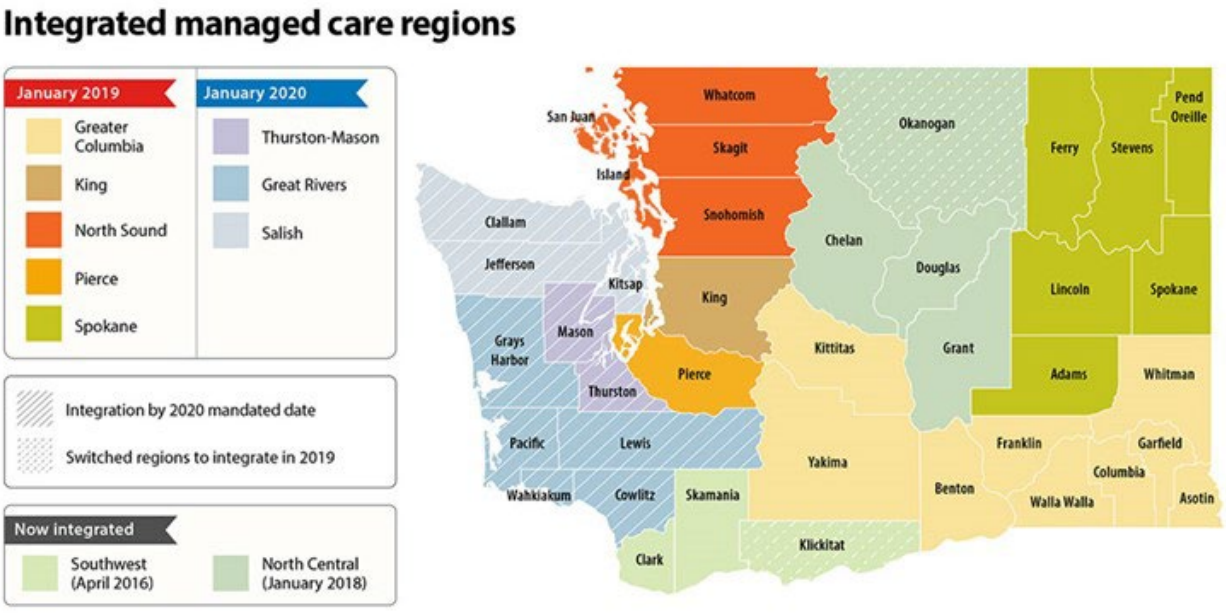
- **Apple Health Family (traditional Medicaid)** – Low-income programs for families, pregnant women and TANF.
- **Apple Health Adult Coverage (Medicaid expansion)** – Low-income program for adults between 19 and 65 years old who are at or below the 138% federal poverty level (FPL). This was introduced as part of the Medicaid expansion in 2014.
- **Apple Health Integrated Managed Care (AH-IMC)** – This program serves Medicaid-eligible adults, pregnant women, people with disabilities, CHIP-eligible children and low-income families.
    - Integration of physical health, mental health and substance use disorder treatment services under one contract.
- **Apple Health Blind/Disabled (AH-BD)** – Program for Supplemental Security Income (SSI)-related eligible members, including those who are currently receiving SSI.
- **Apple Health Integrated Foster Care (AH-IFC)** – Statewide program for eligible children and youth, including:
    - < 21 years old in the foster care program
    - < 21 years old and receiving adoption support
    - those 18–26 years old who have aged out of the foster care program

[8] About Washington Apple Health (Medicaid). Available at: https://www.hca.wa.gov/assets/free-or-low-cost/about-Apple-Health.pdf.
[9] Quick Facts – Washington. United States Census Bureau. Available at: https://www.census.gov/quickfacts/WA
[10] Healthier Washington. About the Washington Statewide Common Measure Set for Health Care Quality and Cost. https://www.hca.wa.gov/assets/measures-fact-sheet.pdf.

- **Apple Health for Kids – State CHIP**
    - Provides coverage for eligible children in households who are up to 250% FPL.
    - The state also uses Medicaid CHIP funding to provide coverage with a monthly premium for children in households up to 312% FPL.
- **Apple Health Behavioral Health Services Only[11] (BHSO)** – Program offered in IMC regions for members who are eligible for Apple Health, but not eligible to be on a managed care plan, including:
    - Dual-eligible for Medicare and Medicaid
    - Medically Needy program
    - Individuals who have met their Medicaid spend-down
    - Only available for IMC regions, which included all regions except Great Rivers, Salish and Thurston-Mason

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

Figure 2. Apple Health Regional Service Areas by County in 2020.[12]



[11] BHSO enrollees are not represented in this report's performance rates. HEDIS measures are designed to include enrollees with medical coverage, which is not included in the BHSO program.
[12] Enrollment map and chart provided by Washington Health Care Authority. Available at: https://stateofreform.com/featured/2018/08/hca-announces-managed-care-plans-offering-integrated-care-starting-in-2019-and-2020/.

The regional service areas are defined as follows:

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

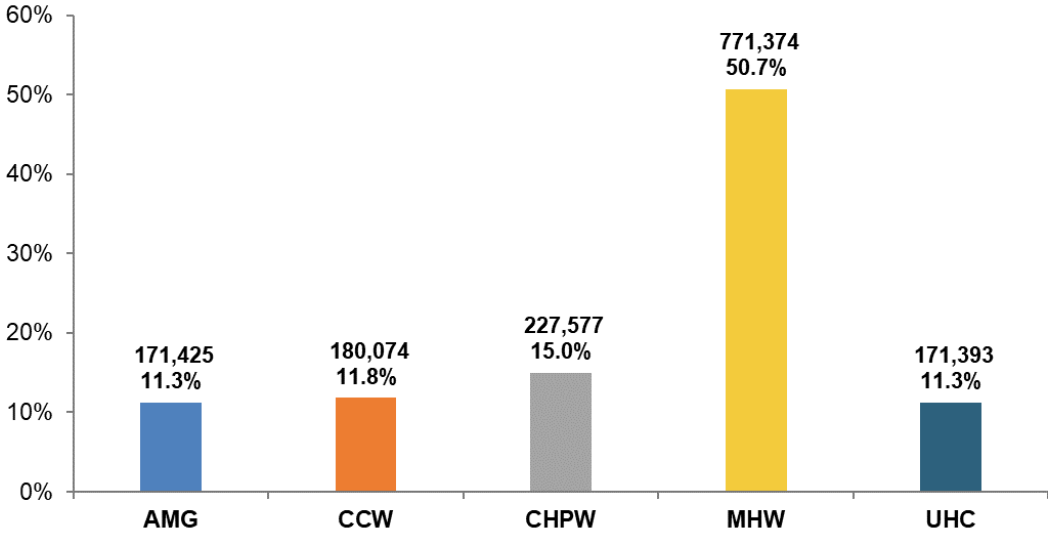
Overview of Apple Health MCO Enrollment

Five MCOs provide managed health care services for Apple Health enrollees:

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

Figure 3 shows Medicaid enrollment by MCO. MHW enrolls about half of the Medicaid members in Washington. The rest of the member population is distributed across the remaining four plans, with 15% in CHPW, about 11% in AMG and UHC, and close to 12% in CCW.

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



Demographics by MCO

Variation between MCOs' demographic profiles is a reflection of the difference in plan mix for each MCO and should be taken into account when assessing HEDIS measurement results.

Age

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

Figure 4 shows the percentages of enrollment by age group and MCO. The darker blue signifies a higher percentage, while lighter blue signifies lower, with a medium gradient for those values in between.

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

Figure 4. Enrollee Population by MCO and Age Range, 2020 RY.

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

% of Total Member Count

0.13% 35.88%

Race and Ethnicity by MCO

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

As shown in Figure 5, more than half of each MCO's members are white. The "other race" category was the second most common for most MCOs. Black members make up 11.68% of UHC's enrollee population and 9.36% of AMG's population, which were higher percentages than for other MCOs.

Figure 5. Statewide Apple Health Enrollees by MCO and Race,* 2020 RY.

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

% of Total Member Count

1.28% 62.56%

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

Figure 6 shows the percentage of MCO members who identified as Hispanic. CCW and CHPW have the largest percentages of Hispanic members at 34.53% and 30.35%, respectively.

Figure 6. Statewide Apple Health Enrollees by MCO and Hispanic Indicator, 2020 RY.

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

Primary Spoken Language by MCO

According to Apple Health enrollment data, there are 81 separate spoken languages among members. Many of these languages have very small numbers of speakers in the Apple Health population. Therefore, only the most common non-English languages are listed in this report (HCA provides Apple Health-related written materials in these same 15 languages).

Figure 7 shows the variation in the most common primary spoken languages. Across MCOs, Spanish/Castilian is the second most common language after English. Among other languages, such as Russian and Vietnamese, the percentages are much smaller and vary by MCO.

Figure 7. Statewide Apple Health Enrollees by MCO and Language, 2020 RY.

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

Washington State Managed Care Quality Strategy

Objective

To fulfill the requirement established by federal regulation 42 CFR Part 438 Subpart E §438.340, the Washington State Managed Care Quality Strategy[13] created a comprehensive strategy to assess, monitor, coordinate the quality of the managed care services and develop measurable goals and targets for continuous quality improvement.

Overview

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

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

Within the Quality Strategy, HCA has identified goals, aims and objectives to support improvement in the quality, timeliness and access to health care services furnished to managed care members. The Quality Strategy is updated triennially and when there is a significant change to Washington's Apple Health Program.

Primary Changes within the 2020 Quality Strategy

- As a result of the realignment of DBHR within HCA, the 2020 Quality Strategy is now updated solely by HCA.
- The 2020 Quality Strategy contains a new section that delineates the Quality Strategy Mission and Vision and alignment with HCA's mission and vision.
- HCA has expanded the Quality Strategy framework to align with the National Quality Strategy aims and Washington Medicaid's VBP principles.
- HCA comprehensively defines the programs and populations included in managed care.
- In the 2020 Quality Strategy, HCA clearly explains the processes for identifying opportunities for improvement and providing managed care oversight; assigning clear roles and responsibilities; and defining monitoring activities related to oversight of integrated managed care.

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

Quality Strategy Populations and Programs

The Quality Strategy is applicable to the below programs:

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

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

Quality Strategy Mission and Vision

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

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

The primary goals include:

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

Washington Managed Care Program Aims and Objectives

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

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

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

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

Federal: CMS Quality Strategy Aims (1)	WA State Medicaid: Apple Health Value-Based Purchasing Principles (2)	WA Medicaid Managed Care: Managed Care Aims for Quality Oversight
Healthier People, Healthier Communities	Drive standardization and care transformation based on evidence	**Aim 1:** Assure the quality and appropriateness of care for Apple Health managed care enrollees *(Quality)* **Aim 2:** Assure enrollees have timely access to care *(Access and Timeliness)*

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

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

Summary of Stakeholder Feedback

HCA solicited extensive stakeholder feedback period prior to finalizing its 2020 Quality Strategy, including from MCOs, tribal partners and the public to ensure that the Quality Strategy will continue to serve as a meaningful roadmap for the future.

MCO Feedback

All five MCOs were given the opportunity to review the 2020 Quality Strategy and provide comments through email feedback. None of the MCOs provided significant additional comments or questions related to the 2020 Quality Strategy during this period.

Tribal Partners Feedback

Tribal partners were engaged to review and provide feedback on the 2020 Quality Strategy utilizing tribal roundtables and consultation. Tribal partners offered some suggestions to clarify language within the document, which HCA addressed and changed. No additional significant comments or questions related to the 2020 Quality Strategy were provided during this time.

Public Feedback

In the spirit of ensuring that the Quality Strategy is given the widest audience for public comment and feedback, the final Quality Strategy was posted in the Washington State Register in November 2020 to solicit public comment. No public feedback was received during the public comment period.

HCA is also committed to ensuring that the final document complies with the Americans with Disabilities Act (ADA) requirements and is accessible to all audiences before being posted online for the public. The HCA Communications Department has worked to ensure that the final document is compliant with accessibility guidelines.

Both ADA compliance and posting in the Washington State Register are new activities introduced with the 2020 update.

Description of Data Obtained and Analysis

As outlined in the "Summary of Results: Performance Measure Validation" section of this report, Comagine Health used HEDIS data to perform comparisons among MCOs and against national benchmarks, as well as to identify variations in measure performance across regions, Apple Health programs, and demographic groups. RDA measure review and analysis were completed for two behavioral health measures. The comparative analysis is also used to assess the implementation of the Quality Strategy.

Performance measure validation and review were completed for:

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

Recommendations

Based on our comparative analysis, Comagine Health recommends the following (Table 3) to assist HCA in targeting the goals, aims and objectives in the quality strategy.

Table 3. Recommendations for HCA.

Recommendations	Linked to Aim(s)
We recommend that the MCOs sustain momentum in key areas (Behavioral Health Integration and Substance Use Disorder Treatment Penetration) where statistically significant and clinical meaningful improvements have been noted. Identifying the best practices contributing to this performance and, where possible, standardizing approaches to encourage sustainability will also lead to continued improvements.	Aim 1 and Aim 4
Proactively monitor measures in the light of the COVID-19 pandemic with a focus on access to care, behavioral health, chronic conditions, prevention and screening and utilization.	Aim 1, Aim 2, Aim 3, Aim 4, and Aim 5
Continue to work on a strategy and plan to expand the available data set to allow deeper future analysis related to health equity.	Aim 1, Aim 2, Aim 3, and Aim 4
Standardize approaches across MCOs when possible to reduce provider burnout.	Aim 4
Continue to evaluate recommendations on measure trends to guide selection of VBP measures.	Aim 5 and Aim 6

For a comprehensive explanation of these recommendations, please see Comagine Health's review, comparative analysis, and recommendations of the complete set of HEDIS measures and RDA Statewide Behavioral Health Measures in the "2020 Comparative and Regional Analysis Report."

Compliance Review

Objectives

The purpose of the compliance review is to determine whether Medicaid managed care plans are in compliance with federal standards. The U.S. Department of Health & Human Services (HHS) developed standards for managed care plans, including 42 CFR §438 and 42 CFR §457.[14,15]

Overview

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

TEAMonitor's review assesses activities for the previous calendar year and evaluates MCOs' compliance with the standards set forth in 42 CFR Part 438,[16] as well as those established in the MCOs' contracts with HCA for all Apple Health Managed Care programs including Apple Health Integrated Managed Care (AH-IMC), Apple Health Integrated Foster Care (AH-IFC), CHIP and the Behavioral Health Services Only (BHSO) Prepaid Inpatient Health Plan (PIHP).

This year, TEAMonitor reviewed and reported on the BHSO PIHP program for first time. Although TEAMonitor completed both MCO and BHSO reviews in one session of the onsite visit, the programs were reviewed as separate entities, with their own scores.

In 2020, Year 2 of the current review cycle, TEAMonitor reviewed the following standards (Table 4) for the MCPs.

Table 4. Compliance Standards.

Standards	Elements
§438.100 Enrollee rights	Quality
§438.206 Availability of services	Access
§438.208 Coordination and continuity of care	Quality and Access
§438.236 Practice guidelines	Quality

In addition, plans were reviewed on elements that received Partially Met or Not Met scores in 2019 RY to validate improvement or need for further corrective action. If an MCP receives a corrective action

[14] Electronic Code of Federal Regulations. Title 42, part 438 – Managed Care. Available at: https://www.ecfr.gov/cgi-bin/text-idx?rgn=div5&node=42:4.0.1.1.8.
[15] Electronic Code of Federal Regulations. Title 42, part 457 Allotments and Grants to States. Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=60f9f0f14136be95a1cee250074ae00d&mc=true&node=pt42.4.457&rgn=div5.
[16] Electronic Code of Federal Regulations. Available at: https://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr438_main_02.tpl.

plan or recommendations based on an element, that element will be re-reviewed the following year or until the finding is satisfied.

In 2021, TEAMonitor will complete the current review three-year review cycle of the MCPs. In 2022, a new three-year cycle will begin.

Appendix E contains summary of findings from all previous reviews within the current review cycle and TEAMonitor review schedule. See Appendix A for individual MCP compliance summaries and Appendix B for regulations subject to compliance review.

Methodology

Technical Methods of Data Collection

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

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

Scoring

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

Scoring key:

- Score of 0 or 1 indicates Not Met
- Score of 2 indicates Partially Met
- Score of 3 indicates Met
- Score of NA indicates Not Applicable

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

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

MCP Compliance Review Results/Conclusions

The following tables (Tables 5–8) provide a summary of all MCP scores by compliance standard in Year 2 of the current 3-year cycle. Plans with elements scored as Partially Met or Not Met were required to submit CAPs to HCA. Plans were scored on these elements in the first half of the calendar year. Because MCPs may have implemented CAPs since that time to address specific issues, scores may not be indicative of current performance.

Table 5. Compliance Review Results by MCP: Enrollee Rights.

§438.100 Enrollee rights	AMG MCO	AMG BHSO	CCW MCO	CCW BHSO	CHPW MCO	CHPW BHSO	MHW MCO	MHW BHSO	UHC MCO	UHC BHSO
	31/36 86%	28/33 85%	34/36 94 %	31/33 94%	28/36 78%	25/33 85%	33/36 92%	30/33 91%	34/36 94%	31/33 94%
438.100(a) General rule	2	2	3	3	3	3	3	3	2	2
438.100(b)(2)(i) Specific rights - 438.10 (c) Language and format	3	3	3	3	3	3	3	3	3	3
438.100(b)(2)(i) Specific rights - 438.10 (d) Language and format (3)	3	3	3	3	2	2	3	3	3	3
438.100(b)(2)(i) Specific rights - 438.10(d) Language and format (4) and (5) Language – oral interpretation/ written information	3	3	3	3	3	3	3	3	3	3
438.100(b)(2)(i) Specific rights - 438.10(d)(6) Format, easily understood	1	1	3	3	1	1	3	3	3	3
438.100(b)(2)(i) Specific rights - 438.10(d)(6)(iii)	3	3	3	3	2	2	3	3	3	3
438.100(b)(2)(i) Specific rights - 438.10(f) (2) General requirements	1	1	3	3	2	2	2	2	2	2
438.100(b)(2)(i) Specific rights - 438.10(g) (1 - 4) Information for Enrollees – Enrollee Handbook	3	3	3	3	3	3	3	3	3	3
438.100(b)(2)(i) Specific rights - 438.10(i) Information for Enrollees – Formulary	3	NA	3	NA	3	NA	3	NA	3	NA
438.100(b)(2)(ii - iv) and (3) Specific rights	3	3	2	2	2	2	3	3	3	3
438.100(d) Compliance with other Federal and State laws	3	3	2	2	3	3	3	3	3	3
438.106 Liability for payment	3	3	3	3	1	1	1	1	3	3

Table 6. Compliance Review Results by MCP: Availability of Services.

§438.206 Availability of services	AMG MCO	AMG BHSO	CCW MCO	CCW BHSO	CHPW MCO	CHPW BHSO	MHW MCO	MHW BHSO	UHC MCO	UHC BHSO
	17/21 81%	14/18 78%	16/21 76%	14/18 78%	16/21 76%	14/18 78%	16/21 76%	13/18 72%	17/21 81%	14/18 78%
438.206(b)(1)(i-v) & (c) Delivery network, 438.10 (h) Information for all enrollees – Provider directory	1	1	2	2	2	2	2	2	1	1
438.206 (b)(2) Direct access to a women's health specialist	3	NA	2	NA	2	NA	3	NA	3	NA
438.206(b)(3) Provides for a second opinion	3	3	3	3	2	2	2	2	3	3
438.206(b)(4) Services out of network	3	3	2	2	3	3	3	3	3	3
438.206(b)(5) Out-of-network payment	3	3	2	2	3	3	3	3	2	2
438.206(c) Furnishing of services (1)(i) through (vi) Timely access	3	3	3	3	2	2	2	2	2	2
438.206(c)(2) Cultural considerations	1	1	2	2	2	2	1	1	3	3

Table 7. Compliance Review Results by MCP: Coordination and Continuity of Care.

§438.208 Coordination and continuity of care	AMG MCO	AMG BHSO	CCW MCO	CCW BHSO	CHPW MCO	CHPW BHSO	MHW MCO	MHW BHSO	UHC MCO	UHC BHSO
	14/18 78%	15/18 83%	16/18 89%	16/18 89%	18/18 100%	18/18 100%	16/18 89%	16/18 89%	17/18 94%	18/18 100%
438.208 Continuity of Care - File review	3	3	3	3	3	3	3	3	3	3
438.208(b) Primary care and coordination of health care services for all MCO/PIHP, PIHP enrollees	2	2	1	1	3	3	1	1	3	3
438.208(c)(1) Identification - Identification of individuals with special health care needs	3	3	3	3	3	3	3	3	3	3

§438.208 Coordination and continuity of care	AMG MCO	AMG BHSO	CCW MCO	CCW BHSO	CHPW MCO	CHPW BHSO	MHW MCO	MHW BHSO	UHC MCO	UHC BHSO
	14/18 78%	15/18 83%	16/18 89%	16/18 89%	18/18 100%	18/18 100%	16/18 89%	16/18 89%	17/18 94%	18/18 100%
438.208(c)(2) Assessment and (3) Treatment plans - Care coordination for individuals with special health care needs	3	3	3	3	3	3	3	3	2	3
438.240(b)(4) Care coordination oversight	0	1	3	3	3	3	3	3	3	3
438.208(c)(4) Direct access for individuals with special health care needs	3	3	3	3	3	3	3	3	3	3

Table 8. Compliance Review Results by MCP: Practice Guidelines.

§438.236 Practice guidelines	AMG MCO	AMG BHSO	CCW MCO	CCW BHSO	CHPW MCO	CHPW BHSO	MHW MCO	MHW BHSO	UHC MCO	UHC BHSO
	7/9 78%	8/9 89%	9/9 100%	9/9 100%	9/9 100%	9/9 100%	9/9 100%	9/9 100%	9/9 100%	9/9 100%
438.236(a)(b)(1-4) Adoption of practice guidelines	3	3	3	3	3	3	3	3	3	3
438.236(c) Dissemination of [practice] guidelines	3	3	3	3	3	3	3	3	3	3
438.236(d) Application of [practice] guidelines	1	1	3	3	3	3	3	3	3	3

Summary of Compliance Results/Conclusions

Overall, the MCPs' compliance varied across the standards. With minor exceptions, the MCOs and BHSOs in each organization received the same scores on the reviewed standards. Below are a few notable areas.

Enrollee Rights

Strengths:

- For the most part, the required information regarding enrollee rights is provided.
- Scoring the highest among the MCPs, two MCOs (CCW and UHC) and two BHSOs (CCW and UHC) scored 94% on standards regarding enrollee rights.
- One MCO (CCW) and one BHSO (CCW) met the element for specific rights — general requirements around notification of members regarding terminated providers.
- Three MCOs (AMG, CCW and UHC) and three BHSOs (AMG, CCW and UHC) met the element for liability for payment.
- All MCPs met the element for information for enrollees in the enrollee handbooks.
- The five MCOs all met the element for information regarding the plans' formularies for members. BHSOs were not reviewed for this element.
- All MCPs met the elements regarding language and format for easily understood marketing materials, and processes used to monitor and address issues related to oral interpretation.

Weaknesses/Opportunities for Improvement:

- Two MCOs (AMG and CHPW) and two BHSOs (AMG and CHPW) did not meet the elements regarding specific rights and processes to monitor and address issues related to the provision of written materials.
- Three MCOs (CHPW, MHW and UHC) and three BHSOs (CHPW, MHW and UHC) partially met the element for specific rights — general requirements around notification of members regarding terminated providers, and one MCO (AMG) and one BHSO (AMG) did not meet this element.
- Two MCOs (CHPW and MHW) and two BHSOs (CHPW and MHW) did not meet the element regarding liability of payment.

Availability of Services

Strengths:

- Four MCOs (AMG, CHPW, MHW and UHC) and four BHSOs (AMG, CHPW, MHW and UHC) met the element regarding access to out-of-network services.

Weaknesses/Opportunities for Improvement:

- No MCPs met all elements for availability of services. All MCPs require attention to meet the elements of this standard.
- Three MCOs (CCW, CHPW and MHW) and three BHSOs (CCW, CHPW and MHW) partially met, and two MCOS (AMG and UHC) and two BHSOs (AMG and UHC) did not meet the element regarding complete provider directory information.

- Two MCOs (CCW, CHPW) and two BHSOs (CCW, CHPW) partially met, and two MCOs (AMG, MHW) and two BHSOs (AMG, MHW) did not meet the element regarding cultural considerations.

Coordination and Continuity of Care

Strengths:

- Most MCPs met the requirements for care coordination.
- MCPs demonstrated strength in their coordination of services for individuals with special health care needs (SHCNs).
- One MCO (CHPW) and two BHSOs (CHPW and UHC) met the standard for coordination and continuity of care. One MCO (UHC) scored 94% for the standard for coordination and continuity of care.
- All MCPs met the element for continuity of care (file review).
- All MCPs met the element for individuals with SHCNs, including identification of individuals with SHCNs; assessment and treatment plans demonstrating care coordination (except one, UHC, which partially met); and direct access for individuals with SHCNs.
- Four MCOs (CCW, CHPW, MHW and UHC) and four BHSOs (CCW, CHPW, MHW and UHC) met the care coordination oversight element.

Weaknesses/Opportunities for Improvement:

- Two MCOs (CCW and MHW) and two BHSOs (CCW and MHW) did not meet the element regarding primary care and coordination of health care services for all enrollees. AMG partially met this element.
- One BHSO (AMG) did not meet the element for care coordination oversight. One MCO (AMG) did not meet the CAP for a repeat finding of this standard.

Practice Guidelines

Strengths:

- With minor exceptions, all MCPs met the requirements for adoption, dissemination and application of practice guidelines.
- Four MCOs (CCW, CHPW, MHW and UHC) and four BHSOs (CCW, CHPW, MHW and UHC) met standard for practice guidelines.

Weaknesses/Opportunities for Improvement:

- AMG-MCO and AMG-BHSO did not meet the element for application of practice guidelines.

Review of Previous Year (2019) Corrective Action Plans (CAPs)

Most MCOs adequately addressed prior year findings and received verification and full recognition of completion of their CAPs. However, CAPs related to coverage and authorizations continued to see little improvement. The MCOs will receive a full review of the coverage and authorization standard during the 2020 review year.

TEAMonitor reviewed and scored CAPs from 2019 for the standards below.

Coverage and Authorization of Services

- After re-review, MCO performance in this area, which has historically been a problem, showed little improvement.
- Only two MCOs (CHPW and UHC) met CAPs for previous findings.
- Four MCOs (AMG, CCW, CHPW and UHC), re-reviewed for CAPs, had repeat findings and did not meet their CAPs.
- After file reviews, CAPs were not accepted for two MCOs (AMG and CCW) regarding authorization of services, three MCOs (CCW, CHPW and UHC) regarding notice of adverse action, and one MCO (AMG) for timeframe decisions.

Practice Guidelines

- The one MCO (UHC) that had a CAP regarding practice guidelines met the requirements upon re-review.

Coordination and Continuity of Care

- After re-review, three plans (AMG, CHPW and MHW) met their CAPs that had been required for assessment and treatment plans – care coordination for individuals with SHCNs.
- One MCO (AMG) received a repeat finding and did not meet their CAP due to lack of narrative describing care coordination oversight.

Grievance Systems

- Two MCOs (CCW and CHPW) that had required CAPs regarding grievance systems met the requirements upon re-review.
- One plan (AMG) met the CAP regarding statutory basis and definitions, partially met CAPs for two elements of grievance systems (handling of grievances and appeals, and expedited resolution of appeals), did not meet CAPs for resolution and notification; specific timeframes and extension of timeframes (repeat finding); and format of notice and content of notice of appeal resolution (“partially accepted”).

Recommendations

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

Enrollee Rights

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

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

Availability of Services

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

Care Coordination

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

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

Practice Guidelines

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

Corrective Action Plans

- CAPs regarding coverage and authorization standards from 2019 continue to indicate little improvement. HCA is requiring MCOs to create detailed CAPs to meet coverage and authorization requirements. In addition, HCA mandates monthly technical assistance meetings to support the MCOs in UM decision-making processes and/or Notice of Adverse Benefit Determination. These meetings include visual review and feedback, discussion of processes followed for the reviewed documentation, and demonstration that processes are appropriate and meet contract requirements. It is recommended that continued technical assistance addressing coverage and authorization issues be provided for the MCOs.

Performance Improvement Project (PIP) Validation

Objectives

Medicaid MCOs are federally required to design and implement PIPs that focus on both clinical and non-clinical areas as part of a comprehensive quality assessment and performance improvement.[17] The PIPs should aim to achieve significant improvement related to health outcomes and member satisfaction over a sustained period of time.[18] These PIP interventions may be designed to change the behaviors at the member level, behaviors at the provider level, or influence change at the MCO and/or systems level.

Overview

MCOs are required to have an ongoing program of clinical and non-clinical PIPs that are designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction for all Apple Health programs, including AH-IMC, AH-IFC and BHSO.

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

Methodology

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

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

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 C.

Beginning in 2021 RY, TEAMonitor will be implement *Protocol 1 Validation of Performance Improvement Projects* updated by CMS in 2019 in its validation of PIPs.

Summary of PIP Validation Results/Conclusions

Tables 9–13 provides an overview of each MCO's PIPs, including applicable elements, aims, interventions, strengths, weaknesses/opportunities for improvement, confidence in MCO PIP results, scores and statistical significance. Note: The updated protocol to be used in 2021 RY includes additional measurements of success.

[17] Federal regulations at 42 C.F.R. § 438.330(b)(1) and 457.1240(b).
[18] CMS EQR Protocol. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3-attachment-a.pdf.

Table 9. 2020 PIP Summary by MCO: AMG.

Amerigroup				
PIP Summary	**Strengths**	**Weaknesses/ Opportunities for Improvement**	**Confidence/Score**	**Statistical Significance Indicating Improvement**
Clinical PIP: Washington State Institute for Public Policy (AHMC/AHFC) – Adult *Evidence-based Collaborative Effort for Depression, Anxiety, Comorbid Depression and Chronic Health*				
• **Element:** Quality • **History**: This PIP was initiated in CY 2017; it was in its third year during CY 2019. • **Aim**: Improve clinical outcomes in 2019 compared to 2018 through collaborative care between behavioral health professionals working with the primary care medical team. • **Intervention: Provider-focused** Providers screen patients utilizing the Patient Health Questionnaire 9 (PHQ-9) and General Anxiety Disorder 7 (GAD-7) screening tools for depression and anxiety, respectively.	• Although this PIP scored "not met," it is a solid idea and has some very good areas of implementation. Most notably, there was improvement in the measures each year. • Screening was implemented and resulted in some improvement. • The data were presented clearly.	• The study question is too vague to be measurable and should define how collaborative care is realized, and what specific member clinical outcomes they will be looking at • There was not alignment and linkage throughout the PIP. It is unclear how the proposed intervention (i.e., screening) coincides with "collaborative care" and linked to desired outcomes • The documentation does not explain how screening was encouraged and implemented at the provider level.	**Confidence in reported MCO PIP Results** **Not Met**	**No Statistically Significant Change**
Clinical PIP: Washington State Institute for Public Policy (FIMC) – Children *Evidence-based Collaborative Effort for Depression, Anxiety, Comorbid Depression and Chronic Health*				
• **Element:** Quality • **History:** This PIP was initiated in CY 2017; it was in its third year during CY 2019. • **Aim:** Improve clinical outcomes for children and adolescents in 2019 compared to 2018 through collaborative care between behavioral	• Although this PIP scored "not met", it is a solid idea and has some very good areas of implementation. Screening was implemented and resulted in some	• The study question is too vague to be measurable and should define how collaborative care is realized, and what specific member clinical outcomes they will be looking at.	**Confidence in reported MCO PIP Results** **Not Met**	**No Statistically Significant Change**

Amerigroup				
PIP Summary	**Strengths**	**Weaknesses/ Opportunities for Improvement**	**Confidence/Score**	**Statistical Significance Indicating Improvement**
health professionals working with the primary care medical team. • **Intervention: Provider-focused** Providers screen patients utilizing the Patient Health Questionnaire 9 (PHQ-9) and General Anxiety Disorder 7 (GAD-7) screening tools for depression and anxiety, respectively.	improvement. The data were presented clearly.	• There was not alignment and linkage throughout the PIP. It is unclear how the proposed intervention (i.e., screening) coincides with "collaborative care" and linked to desired outcomes. • The documentation does not explain how screening was encouraged and implemented at the provider level.		
Mandatory Clinical PIP: Collaborative (AHMC) *Collaborative MCO Well-Child Visit Rate PIP*				
• **Element:** Access, Quality, Timeliness • **History**: This PIP was initiated in mid-2016 through an MCO peer collaborative; it was in its fourth year during CY 2019. • **Aim**: Improve statewide well-child visit rates in infants (0–15 months), children (3–6 years), and adolescents (12–21 years). • **Intervention: Provider-focused** During CY 2019, focused on provider and clinic staff education on engaging parents and providing reminders for missed well child visits and a peer sharing of identified best practices and successes.	• Statistically significant increase in HEDIS Well-Child visit rates was found across all 3 measures.	• There is no indication that enrollees with special health needs or their families participated in the focus groups, or otherwise provided input. It is not evident how the MCO ensured that input from enrollees/families whose circumstances prevented them from having the time or resources to participate in a focus group had an opportunity to provide input.	**Confidence in reported MCO PIP Results** • Confidence in results of the PIP is lowered by the use of aggregate data from MY2018 and 2019 **Met**	**Statistically Significant Change** • W15 - Well-Child Visits in the First 15 Months of Life HEDIS measure • W34 - Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life HEDIS measure • AWC – Adolescent Well-Care Visits HEDIS measure

Amerigroup				
PIP Summary	**Strengths**	**Weaknesses/ Opportunities for Improvement**	**Confidence/Score**	**Statistical Significance Indicating Improvement**
Clinical PIP: Washington State Institute for Public Policy (BHSO/FIMC) – Adult *Using SBIRT (Screening, Brief, Intervention, and Referral to Treatment) for Identification and Intervention of Substance Use Disorders by Physical Health Practitioners*				
• **Element:** Access, Quality • **History:** This PIP was initiated in CY 2019; it was in its first year during CY 2019. • **Aim**: Increase the screening and identification of substance use disorders within medical or physical health services. • **Intervention**: **Provider-focused** Focused on providers making referrals for substance use disorder treatment and ease of billing.	• The study question for Phase I was comprehensive and stated clearly • Led a behavioral health advisory council that consisted of providers, members from the community, and behavioral health member representatives to discuss interventions and barriers members experience when seeking treatment. • Intervention led to increased number of certified SBIRT providers.	• All interventions are aimed at providers making referrals and ease of billing, yet root-cause analysis activities identify legitimate issues that may impact enrollee follow-through with referral and/or seeking of treatment. • The study question for Phase 2 was very complex and does not support the ability to determine whether the intervention has a measurable impact for a clearly defined population.	**Enough time has not elapsed to assess meaningful change** **Not Met**	**No Statistically Significant Change**
Non-Clinical PIP (AHMC/FIMC/BHSO) *Improving WIC Participation*				
• **Element:** Access, Quality • **History**: This PIP was initiated in CY 2019; it was in its first year during CY 2019.	• The aim of the project and the interventions are clearly stated. • The data is presented in an appropriate way.	• The study question should better define the intervention in a way that it can be measured.	**Confidence in reported MCO PIP Results** **Met**	**No Statistically Significant Change** • Statistical significance was not included in this PIP.

Amerigroup				
PIP Summary	**Strengths**	**Weaknesses/ Opportunities for Improvement**	**Confidence/Score**	**Statistical Significance Indicating Improvement**
• **Aim**: Increase the use of federal WIC services among enrollees who were eligible. • **Intervention**: **Member-focused** Obtained list of adult and children enrollees eligible for but not enrolled in WIC. Sent mailers, faxes, and website notices for providers and members. Raised awareness of the WIC program by participating in community events.	• There is alignment throughout the PIP between study questions, interventions, data and analysis. • Interventions such as mailers and websites are often not enough to change an indicator; but in this case, it appears they were sufficient to involve more people in WIC.	• The PIP does not state how often the indicators will be monitored.		
Clinical PIP: Washington State Institute for Public Policy (IMC/BHSO) – Children *Using the Alcohol Literacy Challenge in Washington State School-Based settings to reduce youth drinking rates through changed alcohol affect beliefs*				
• **Element:** Quality • **History**: This PIP was initiated in 2019; it was in its first year during CY 2019. • **Aim**: Increase understanding and beliefs of alcohol effects by 20-30% for school-aged youth. • **Intervention**: **Member-focused** Implement the Alcohol Literacy Challenge program in schools. This intervention was not implemented during CY 2019.	• Community engagement planned as part of intervention. • Solid evidence was cited for the program	• Did not identify how long/how many times the intervention will be done • The barrier analysis only contained process barriers pertaining to the PIP itself; nothing about members and their barriers to lowering alcohol use.	**Reported MCO PIP results not credible** **Not Met** • This PIP is scored not met because it was not fully implemented.	**No Statistically Significant Change** • No results were available for this PIP.

Table 10. 2020 PIP Summary by MCO: CCW.

Coordinated Care of Washington				
PIP Summary	**Strengths**	**Weaknesses/ Opportunities for Improvement**	**Confidence/Score**	**Statistical Significance Indicating Improvement**
Clinical PIP: Washington State Institute for Public Policy (AHMC/AHFC/FIMC) *Improving Psychotherapeutic Claims Through Provider and Member Education for 19-64-Year-Old Members with Depression*				
• **Element:** Quality • **History**: This PIP was initiated in CY 2019; it was in its first year during CY 2019. • **Aim**: Increase the utilization of psychotherapy services (e.g., Cognitive Behavioral Therapy, Dialectical Behavioral Therapy) within an integrated primary care setting for adult Medicaid members with depression. • **Intervention**: **Provider-focused** Supply provider and member education on psychotherapy services (e.g., Cognitive Behavioral Therapy) in integrated primary care settings.	**None Identified**	• Barriers and outcomes not linked to interventions • Tools not reviewed or tested for cultural and/or linguistic appropriateness • No enrollee input was obtained or represented	**Reported MCO PIP results not credible** **Not Met**	**No Statistically Significant Change**
Mandatory Clinical PIP: Collaborative Well-Child Visits (AHMC) *Collaborative MCO Well-Child Visit Rate PIP*				
• **Element: Access,** Quality, Timeliness • **History**: This PIP was initiated in mid-2016 through an MCO peer collaborative; it was in its fourth year during CY 2019. • **Aim**: Improve statewide well-child visit rates in infants (0–15 months), children (3–6 years), and adolescents (12–21 years). • **Intervention**: **Provider-focused**	• Statistically significant increase in HEDIS Well-Child visit rates was found across all 3 measures.	• There is no indication that enrollees with special health needs or their families participated in the focus groups, or otherwise provided input. It is not evident how the MCO ensured that input from enrollees/families whose circumstances prevented them from having the time or resources to participate in a	**Confidence in reported MCO PIP Results** • Confidence in results of the PIP is lowered by the use of aggregate data from MY2018 and 2019	**Statistically Significant Change** • W15 - Well-Child Visits in the First 15 Months of Life HEDIS measure • W34 - Well-Child Visits in the Third, Fourth, Fifth, and

Coordinated Care of Washington				
PIP Summary	**Strengths**	**Weaknesses/ Opportunities for Improvement**	**Confidence/Score**	**Statistical Significance Indicating Improvement**
During CY 2019, focused on provider and clinic staff education on engaging parents and providing reminders for missed well child visits and a peer sharing of identified best practices and successes.		focus group had an opportunity to provide input.	**Met**	Sixth Years of Life HEDIS measure • AWC – Adolescent Well-Care Visits HEDIS measure
Clinical PIP: Washington State Institute for Public Policy – Child (IFC) *Improving Psychotherapeutic Claims Through Provider and Member Education for 12-18-Year-Old Members with Depression*				
• **Element:** Access, Quality • **History**: This PIP was initiated in CY 2019; it was in its first year during CY 2019. • **Aim**: Increase utilization of psychotherapy services (e.g., Cognitive Behavioral Therapy, Dialectical Behavioral Therapy) within an integrated primary care setting for adolescent Medicaid members with depression, anxiety, PTSD, and ADHD. • **Intervention**: **Provider-focused** Supply provider and member education on psychotherapy services (e.g., Cognitive Behavioral Therapy) in integrated primary care settings.	**None Identified**	• Tools not reviewed or tested for cultural and/or linguistic appropriateness • No enrollee input was obtained or represented • The study question was broad, resulting in generalized interventions and that outcome measures were weakly associated with intervention and study question or not linked to the intervention or study question.	**Reported MCO PIP results not credible** **Not Met**	**No Statistically Significant Change**
Non-Clinical PIP (AHMC/FIMC/BHSO/AHFC) *Improving Timely and Appropriate Access to Care for Reproductive-Age Women*				
• **Element:** Quality, Timeliness • **History**: This PIP was initiated in CY 2019; it was in its first year during CY 2019.	**None Identified**	**As self-identified by the MCO:** • "Selected indicators were not linked to the Study Question or the selected interventions.	**Reported MCO PIP results not credible**	**No Statistically Significant Change**

Coordinated Care of Washington				
PIP Summary	**Strengths**	**Weaknesses/ Opportunities for Improvement**	**Confidence/Score**	**Statistical Significance Indicating Improvement**
• **Aim**: Improve timely utilization of prenatal care, improve health outcomes, and reduce healthcare expenditures. • **Intervention**: **Member-focused** Intentional outreach and educational campaign to Medicaid-eligible women ages 18-44 and their healthcare providers.		Indicators, Barriers, interventions, and outcome measures not well linked…" • "The named interventions were insufficient to improve the stated goals (outcomes)." • "Tools were neither reviewed nor tested for cultural and/or linguistic appropriateness." **TEAMonitor:** • There is no evidence presented that input from populations with special health care needs has been sought out or incorporated.	• This PIP is not met due to significant flaws in PIP design including relevant indicators, interventions, and data analysis. **Not Met**	• The analysis did not use any measures of statistical significance or investigate factors that influence comparability of initial and repeat measurements or factors that threaten internal and external validity.
Non-Clinical PIP (AHFC) *Improving Access to Assigned Primary Care Provider for Apple Health Foster Care Members Ages 12 Months to 19 Years Old*				
• **Element:** Access, Quality • **History**: This PIP was initiated in CY 2017; it was in its third year during CY 2019. • **Aim**: Improve rate of primary care visits for children and adolescents in foster care. • **Intervention**: **Member-focused** Call members about primary care provider reassignments.	**None Identified**	• Lack of cohesion throughout PIP – the aim, study question, outcome indicators and intervention were not clearly linked.	**Reported MCO PIP results not credible** **Not Met**	**No Statistically Significant Change** • No results were available for this PIP.

Table 11. 2020 PIP Summary by MCO: CHPW.

Community Health Plan of Washington				
PIP Summary	**Strengths**	**Weaknesses/ Opportunities for Improvement**	**Confidence/Score**	**Statistical Significance Indicating Improvement**
Clinical PIP: Washington State Institute for Public Policy (AHMC/FIMC/BHSO) *Promoting Wellness and Recovery with Peer Specialists*				
• **Element:** Quality • **History**: This PIP was initiated in CY 2019; it was in its first year during CY 2019. • **Aim**: Improve members' sense of confidence and hope through support from peer specialists. • **Intervention**: **Member-focused** Peer specialists lead members through Wellness Recovery Action Plan (WRAP), which teaches self-management tools to identify actions to take when triggers, symptoms, and crises occur.	• Use of an evidence-based practice (i.e., WRAP). • Hosted a Member Engagement Workgroup to gather enrollee input. Although small, the workgroup appeared to have some diversity. • Inclusion of peer specialist as core of intervention.	• No enrollment data such as age, gender, race, language, disability or functional status or utilization data was included; no under or over-utilization data, encounters, critical incidents or other adverse incidents were addressed; no epidemiology was documented. • Narrative did not provide detail related to how they performed the barrier analysis, nor how enrollee and provider feedback was used to inform the analysis. It did not appear that a root-cause analysis was completed.	**Enough time has not elapsed to assess meaningful change** **Not Met**	**No Statistically Significant Change** • No data or PIP analysis were available for Year 1 of this PIP.
Mandatory Clinical PIP: Collaborative Well-Child Visits (AHMC) *Collaborative MCO Well-Child Visit Rate PIP*				
• **Element:** Access, Quality, Timeliness • **History**: This PIP was initiated in mid-2016 through an MCO peer collaborative; it was in its fourth year during CY 2019. • **Aim**: improve statewide well-child visit rates in infants (0–15 months), children (3–6 years), and adolescents (12–21 years).	• Statistically significant increase in HEDIS Well-Child visit rates was found across all 3 measures.	• There is no indication that enrollees with special health needs or their families participated in the focus groups, or otherwise provided input. It is not evident how the MCO ensured that input from enrollees/families whose circumstances prevented	**Confidence in reported MCO PIP Results** • Confidence in results of the PIP is lowered by the use of aggregate data.	**Statistically Significant Change** • W15 - Well-Child Visits in the First 15 Months of Life HEDIS measure • W34 - Well-Child Visits in the Third,

Community Health Plan of Washington				
PIP Summary	**Strengths**	**Weaknesses/ Opportunities for Improvement**	**Confidence/Score**	**Statistical Significance Indicating Improvement**
• **Intervention**: **Provider-focused** During CY 2019, focused on provider and clinic staff education on engaging parents and providing reminders for missed well child visits and a peer sharing of identified best practices and successes.		them from having the time or resources to participate in a focus group had an opportunity to provide input.	.from MY2018 and 2019 **Met**	Fourth, Fifth, and Sixth Years of Life HEDIS measure • AWC – Adolescent Well-Care Visits HEDIS measure
Non-Clinical PIP (AHMC/FIMC/BHSO) *Depression Screening and Follow-Up in Preferred Languages*				
• **Element:** Access, Quality • **History:** This PIP was initiated in CY 2019 • **Aim**: Improve depression screening and follow-up by utilizing screening tools translated in preferred languages. • **Intervention**: **Provider-focused** Use of translated and validated PHQ-9 depression screening tools with foreign language-speaking enrollees and providing limited set of culturally appropriate follow-up recommendations for depression treatment in primary care settings. This intervention was partially implemented in CY 2019.	• Address health equity gaps by focusing on improving depression screening and follow-up that is more linguistically and culturally appropriate. • Provided thorough citation and justification for conducting this PIP.	**None Identified**	**Confidence in reported MCO PIP results** **Partially Met**	**No Statistically Significant Change**
Clinical PIP: Washington State Institute for Public Policy – Child (FIMC) *Improving Child Health Outcomes Through Connecting Mothers to the Nurse Family Partnership*				
• **Element:** Access, Quality • **History**: This PIP was initiated in CY 2019 (that was its first year).	• Use of an evidence-based prenatal support program	• Study design does not involve matching on an individual basis—whether a mother who had NFP had decreased	**Low confidence in reported MCO PIP results**	**No Statistically Significant Change**

Community Health Plan of Washington				
PIP Summary	**Strengths**	**Weaknesses/ Opportunities for Improvement**	**Confidence/Score**	**Statistical Significance Indicating Improvement**
• **Aim**: Connect more pregnant members to the Nurse-Family Partnership to reduce number of infants born with maternal substance use-related conditions. • **Intervention**: **MCO/System-focused** Referrals to the Nurse-Family Partnership program	• Inclusion of a community resource as primary intervention	substance use and healthier babies • Interventions of this PIP were not sufficiently underway that they can be believed to have any effect on this change	**Partially Met** • The MCO decided not to continue this PIP in the coming year.	

Table 12. 2020 PIP Summary by MCO: MHW.

Molina Healthcare				
PIP Summary	**Strengths**	**Weaknesses/ Opportunities for Improvement**	**Confidence/Score**	**Statistical Significance Indicating Improvement**
Clinical PIP: Washington State Institute for Public Policy (AHMC/FIMC/BHSO) *Collaborative Primary Care for Depression*				
• **Element:** Access, Quality, Timeliness • **History**: This PIP was initiated in CY 2016 (that was its first year). • **Aim**: Improve antidepressant medication adherence in members 18 years and older with a diagnosis of Major depression. • **Intervention: Provider-focused** Address barriers to care for members, collaborating with case managers and providers. Also educated members on need for medication adherence. MHW also implemented 90-day refill model to help address inconsistencies often associated with medication refill process.	• Interventions showed improvement in HEDIS measure of Antidepressant Medication Management (AMM) Continuation phase • Implementation of multimodal interventions	• The study question is very broad, and it would not be possible to determine which interventions resulted in the outcome of improving the measure. • Enrollees to whom the study question and indicators are relevant were not clearly defined.	**Confidence in reported MCO PIP results** **Not Met** • This PIP is being retired by MHW.	**No Statistically Significant Change** • AMM Acute Phase HEDIS measure **Statistically Significant Change** • AMM Continuation Phase HEDIS measure

Molina Healthcare				
PIP Summary	**Strengths**	**Weaknesses/ Opportunities for Improvement**	**Confidence/Score**	**Statistical Significance Indicating Improvement**
Mandatory Clinical PIP: Collaborative Well-Child Visits (AHMC) *Collaborative MCO Well-Child Visit Rate PIP*				
• **Element:** Access, Quality, Timeliness • **History**: This PIP was initiated in mid-2016 through an MCO peer collaborative; it was in its fourth year during CY 2019. • **Aim**: improve statewide well-child visit rates in infants (0–15 months), children (3–6 years), and adolescents (12–21 years). • **Intervention**: **Provider-focused** During CY 2019, focused on provider and clinic staff education on engaging parents and providing reminders for missed well child visits and a peer sharing of identified best practices and successes.	• Statistically significant increase in HEDIS Well-Child visit rates was found across all 3 measures.	• There is no indication that enrollees with special health needs or their families participated in the focus groups, or otherwise provided input. • It is not evident how the MCO ensured that input from enrollees/families whose circumstances prevented them from having the time or resources to participate in a focus group had an opportunity to provide input.	**Confidence in reported MCO PIP Results** • Confidence in results of the PIP is lowered by the use of aggregate data from MY2018 and 2019. **Met**	**Statistically Significant Change**
Non-Clinical PIP (AHMC/FIMC) *Bridging the Gap: Level of Provider Engagement and Quality Improvement*				
• **Element:** Quality • **History:** This PIP was initiated in CY 2016; it was in its fourth year during CY 2019. • **Aim**: Improve providers' efforts in improving quality care and health outcomes. • **Intervention: Provider-focused** Use of Molina Health's Quality Improvement Provider engagement strategies to provide education and	• All five study questions were clearly written.	• PIP identified BHSO enrollees were to be included in this study, the selected indicators are not relevant to the BHSO population, and as such did not address the needs of the BHSO population. • No clear connection between listed barriers, interventions, and the identified study indicators.	**Low confidence in reported MCO PIP results** **Partially Met**	**No Statistically Significant Change**

Molina Healthcare				
PIP Summary	**Strengths**	**Weaknesses/ Opportunities for Improvement**	**Confidence/Score**	**Statistical Significance Indicating Improvement**
improvement of administrative workflows.		• Threats to validity of the study results were not documented. • No culturally and linguistically appropriate interventions were addressed.		
Clinical PIP: Washington State Institute for Public Policy – Child (FIMC/BHSO) *Enhancing Behavioral Parent Training for Parents of Children with ADHD*				
• **Element:** Quality • **History**: This PIP was initiated in CY 2016; it was in its fourth year during CY 2019. • **Aim**: Increase ADHD medication adherence rates in pediatric members. • **Intervention**: **Provider-focused** Distribution of letters, posting items on websites, and telephone surveys that provide resources/information on Behavioral Parent Training.	**None Identified**	• Identified intervention of "Behavioral Parent Training" was not included in the actual implementation of interventions. • Interventions did not directly correlate with PIP aim and measurement indicators.	**Low confidence in reported MCO PIP results** **Not Met**	**No Statistically Significant Change** • The *p* values are very difficult to read and are not presented in the generally accepted way of reporting results.

Table 13. 2020 PIP Summary by MCO: UHC.

UnitedHealthCare				
PIP Summary	**Strengths**	**Weaknesses/ Opportunities for Improvement**	**Confidence/Score**	**Statistical Significance Indicating Improvement**
Clinical PIP: Washington State Institute for Public Policy (AHMC) *Increase Anti-Depressant Treatment Plan Compliance for Adult, Female, TANF (Temporary Assistance for Needy Families) members diagnosed with depression (anti-depressant medication management)*				
• **Element:** Quality • **History**: This PIP was initiated in CY 2016; it was in its fourth year during CY 2019. • **Aim**: Improve HEDIS measure of Antidepressant Medication Management (AMM) among a sub-population of female TANF-eligible members. • **Intervention**: **Provider-focused** Mailing a "depression packet" to select providers, specifically OB/GYNs, who could possibly function as PCPs for some women, and may be inexperienced in discussing depression and its treatment.	• Barriers that were identified appear to be relevant to the focus of the PIP.	• Limited documentation was provided regarding the support and need for this topic. • No details regarding data analysis and quality improvement processes that informed the identified barriers for members, providers, and the plan was provided. • Minimal information about how the recommendations for improvement were developed. • No plan-specific demographic information provided that was relevant to the population served under the contract requiring this PIP.	**Confidence in reported MCO PIP results** **Not Met**	**No Statistically Significant Change**
Clinical PIP: Washington State Institute for Public Policy (FIMC) *Increase Anti-Depressant Treatment Plan Compliance for Members Diagnosed with Depression (anti-depressant medication management)*				
• **Element:** Quality • **History**: This PIP was initiated in CY 2016; it was in its fourth year during CY 2019. • **Aim**: Improve HEDIS measure of Antidepressant Medication	• Barriers that were identified appear to be relevant to the focus of the PIP	• Minimal information about how the recommendations for improvement were developed. • No details regarding data analysis and quality improvement processes that	**Confidence in reported MCO PIP results** **Not Met**	**No Statistically Significant Change**

UnitedHealthCare				
PIP Summary	**Strengths**	**Weaknesses/ Opportunities for Improvement**	**Confidence/Score**	**Statistical Significance Indicating Improvement**
Management (AMM) among general adult population. • **Intervention**: **Provider-focused** Mailing a "depression packet" to select providers to educate on using depression diagnostic tools.		informed the identified barriers for members, providers, and the plan was provided. • Limited documentation was provided regarding the support and need for this topic.		
Clinical PIP (BHSO) *Jail Transition and Assertive Community Treatment*				
• **Element:** Access, Quality • **History:** This PIP was initiated in 10/2019; it was in its first year in CY 2019. • **Aim**: Increase behavioral health treatment plan compliance for BHSO members transition from jail to the community with the Jail Transition Team Program. • **Intervention: Member-focused** Use of Jail Transition Team Program and Assertive Community Treatment interventions with a local correctional facility to follow-up and coordinate care for members transitioning from jail to the community. The intervention was not implemented in CY 2019.	• Engagement of community resource (i.e., correctional facility) as part of intervention	• Vague definition of intervention plans. • Lack of thorough analysis as to the discrepancy in projected members who would qualify for intervention.	**Reported MCO PIP results not credible** **Not Met** • Recommended that this PIP not continue unless major changes are made	**No Statistically Significant Change**

UnitedHealthCare				
PIP Summary	**Strengths**	**Weaknesses/ Opportunities for Improvement**	**Confidence/Score**	**Statistical Significance Indicating Improvement**
Non-Clinical PIP (AHMC/FIMC) *Increasing the Rate of Members Receiving Diabetic Education Services*				
• **Element:** Access, Quality, Timeliness • **History**: This PIP was in its fourth year during CY 2019. • **Aim**: Increase the rate of diabetic education services received by members ages 18 to 74 diagnosed with Type I and Type II diabetes. • **Intervention**: **Member-focused** Sending 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.	• Provides some linguistic consideration with e-mails sent in Spanish. • Although the rate of members receiving diabetic education services did not change, there was improvement in the rate of members receiving eye exams.	• Barriers and interventions were not sufficiently explained.	**Confidence in reported MCO PIP results** **Partially Met**	**No Statistically Significant Change**
Clinical PIP Child (FIMC) *Increasing the ADD (ADHD Medication Adherence) Initiation Phase HEDIS Measure*				
• **Element:** Quality, Timeliness • **History**: This PIP was initiated in 2019; it was in its first year in CY 2019. • **Aim**: Improve the HEDIS ADD Initiation Phase measure by increasing rates of adherence to ADD medication. • **Intervention**: **Member-focused** Community health workers reaching out to members to assist the review and monitoring of provider-distributed one-page information	**None Identified**	• Linkage unclear throughout the PIP • Demographics and epidemiology of the plan's enrollees is not included • Web-based survey is not available in other languages, and there is no indication that other documents such as the exchange of information form to be signed by patients is available in other languages	**Low confidence in reported MCO PIP results** • The MCO reported an improvement due to the intervention. This is not possible to verify from	**No Statistically Significant Change**

UnitedHealthCare				
PIP Summary	**Strengths**	**Weaknesses/ Opportunities for Improvement**	**Confidence/Score**	**Statistical Significance Indicating Improvement**
sheets that includes date and time of 30-day follow-up appointment.			looking at the data presented. **Partially Met**	
Non-Clinical PIP (BHSO) *Coordination of Care Between Behavioral Health and Medical Providers*				
• **Element:** Quality • **History:** This PIP was initiated in CY 2016; it was in its first year during CY 2019. • **Aim**: Increase behavioral health practitioners' coordination of care practices. • **Intervention**: **Provider-focused** Provide templates and forms to practitioners and acute care facilities during behavioral health network improvement site visits and on network website. The intervention was not implemented during CY 2019.	**None Identified**	• Coordination to be done as the intervention was not well-defined • Barriers and outcomes not linked to interventions	**Reported MCO PIP results not credible** **Not Met**	**No Statistically Significant Change**

Summary of Previous Year (2019) MCO PIP CAPs

The responses submitted by the five MCOs to the 2019 CAPs were reviewed and accepted with the following response by HCA:

- **AMG, CCW and CHPW:** Met. Corrective action is completed.
- **MHW:** Not Met. Immediate correction of CAP required. The final part of this CAP is not met:
  - The BHSO population was not identified and addressed in clinical and non-clinical PIPs.
  - Individual PIP scores did not improve from last year.
- **UHC:** Not Met. Immediate correction of CAP required. The final part of the CAP is not met, as the PIP scores this year were not improved from last year.
  - The AMM PIP (IMC, Adult WSIPP) that was a continuation from 2019, scored "partially met" last year and "not met" this year.
  - The non-clinical PIP on diabetic education services that was a continuation from 2019, scored "met" last year and "not met" this year.
  - Three other plan-specific PIPs were new topics this year. Of those, one is "partially met" and two are "not met."

Summary of 2020 MCO PIP Corrective Action

Overall, the MCOs achieved more Met scores during 2020 RY than 2019 RY, but there were still several PIPs that scored Not Met resulting in the five MCOs receiving the following CAP.

The MCO/BHSO must submit a narrative and any supporting documents describing the plan to address this repeat finding, including at minimum:

- Demonstrated improvement in individual PIP scoring as noted within each individual PIP Validation Worksheet as part of the 2021 review.
- The evaluation of each PIP that is Partially or Not Met to determine what actions can be taken to improve the currently active PIPs. Summarize the MCO's evaluation and any planned steps to improve individual PIPs and the overall PIP program. The corrective action should address a brief summary of the status of currently active PIPs to determine if any additional efforts would improve the metrics. Describe how the deficiencies in this year's PIP report and feedback from HCA have been used to make constructive changes in the PIPs.
- How PIP requirements apply to the BHSO populations within the section 12 documentation as applicable.
  - In addition, **CCW** received a repeat finding. The MCO must design PIPs for the BHSO population for a clinical and non-clinical PIP, at minimum. Clearly identify the BHSO population, impact and involvement.
- **MHW and UHC:** Monthly 30-minute technical assistance meetings with HCA Medicaid Compliance Review and Analytics (MCRA) staff, scheduled by the MCO. The meetings shall continue through to the completion of the 2021 PIP proposals, and thereafter with frequency to be determined by the HCA. The meetings will include MCO/BHSO written and verbal updates regarding:
  - Overall PIP program progress.
  - The status of the completion and write-up of CY 2020 PIPs.
  - The progress of the implementation and write-up of the 2021 PIPs. Include activities and interventions performed in the preceding month, with results if applicable. Discussion

regarding any process or program activities or changes to the PIP program and information demonstrating the plan to tie PIPs to overall quality of care, and not focusing solely on HEDIS outcomes.

- **AMG, CCW and CHPW:** A one-hour technical assistance meeting with HCA MCRA staff, by no later than February 15, 2021. The meeting will be used to support any technical assistance the MCO requires for continued PIP improvement and provide HCA with the following:
  - Overall PIP program progress.
  - The status of the completion and write-up of CY 2020 PIPs.
  - The progress of the implementation and write-up of the 2021 PIPs.

Recommendations

Some of the recommendations from 2019 RY remain the same. To enhance the MCOs' ability to design a sound PIP, HCA should continue the following activities to engage and guide the five MCOs in providing desired quality health outcomes for its enrollees.

The five MCOs had PIPs with weaknesses in their study designs, including a lack of clear alignment and linkage throughout the PIP, inclusion of cultural and/or linguistic diversity and needs, and details on data analysis and input from populations with special health care needs. The PIPs also did not emphasize confidentiality and safe handling of sensitive information or quality improvement processes. (Access and quality of care)

- HCA should continue to provide ongoing training specifically focused on the overall study design by establishing a framework for sustainable improvement that stems from well-defined and well-scoped study designs.
  - Establishing well-defined, objectively measured indicators allows for the tracking of performance over time.
  - Addressing identified barriers and challenges in PIP interventions in a delineated approach contributes to sustainable improvement.

The five MCOs had PIPs with weaknesses reflecting broad, unclear study questions resulting in generalized interventions being weakly or not linked to the study questions. (Quality of care)

- HCA should provide technical assistance to the MCOs with a focus on defining, streamlining and simplifying study questions.
  - Questions should be written in an easily understandable format that supports the MCOs' ability to determine whether the chosen intervention has a measurable impact on the study population.
  - A concise study question will improve the MCO's ability to align the entire PIP study design.

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

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

Performance Measure Validation

Objectives

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

Overview

Performance measure validation is a required EQR activity described at 42 CFR 438.358(b)(2). This section contains results of the following areas of performance measure validation and review related to the EQR in Washington in 2020:

- **Healthcare Effectiveness Data and Information Set (HEDIS) measures**:
    - MCOs are required to annually report results of their performance on measures reflecting the levels of quality, timeliness and accessibility of health care services furnished to the state's Medicaid enrollees. Comagine Health analyzed MCO performance on 56 HEDIS measures for the calendar year (CY) 2019 (see more about HEDIS measures below).
- **Statewide Behavioral Health Measures**:
    - At HCA's instruction, Comagine Health also assessed statewide performance on the two non-HEDIS behavioral health measures that are calculated by the Department of Social and Health Services Research and Data Analysis Division (RDA): MH-B and SUD.
    - In addition, the state monitors and self-validates these two measures, both reflecting behavioral health care services delivered to Apple Health enrollees. TEAMonitor reviewed and validated performance rates for the two measures to determine impact and need for this program's population. Validated performance rates for this program are included in this section, starting on page 62.

HEDIS and RDA Measure Analysis and Validation

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

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

They also allow MCOs to determine where quality improvement efforts may be needed.[19] The HEDIS data are derived from provider administrative and clinical data.

With HCA's approval, Comagine Health focused on 31 measures for the majority of analysis and comparison rather than the full list of 56 HEDIS measures. These 31 measures also included the two Washington behavioral health measures (also referred to as RDA measures) as they reflect current HCA priorities and are part of the Statewide Common Measure Set. They also represent a broad population base or population of specific or prioritized interest.

To be consistent with NCQA methodology, the 2019 calendar or measurement year is referred to as the 2020 reporting year (RY) in this report. The results from these analyses can be found in the *2020 EQR Performance Measure Comparative Analysis Report*.

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

Summary of Performance Measure Results/Conclusions

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

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

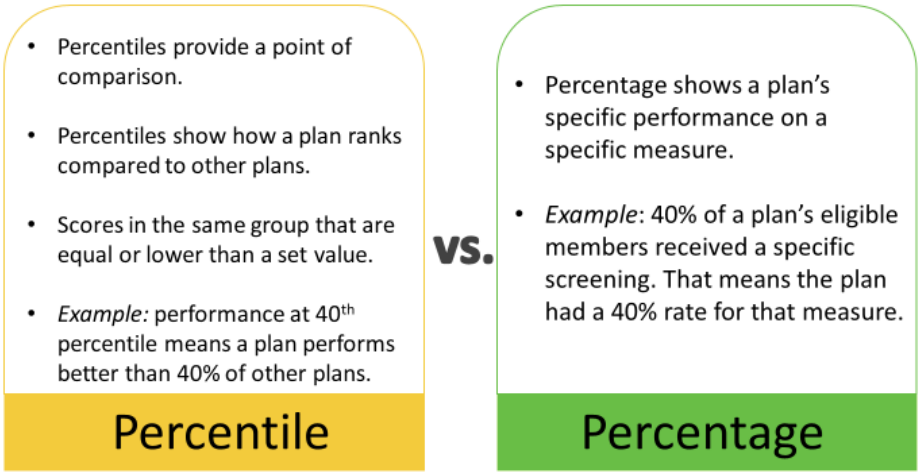
National Quintiles

The national benchmarks included in this report are displayed as quintiles, which divide performance by the 20th, 40th, 60th and 80th national percentiles. The national percentiles give a benchmark, or point of comparison, to assess how Plan A's performance compares to other plans. This is especially important for identifying high priority areas for quality improvement. For example, if Plan A performs below the 40th percentile, we can conclude there is a lot of room for improvement given the number of similar plans that performed better than Plan A. However, if Plan A performs above the 80th percentile, we can conclude that performance on that particular measure already exceeds the performance of most other plans and that improving the actual rate for that measure may not be the highest priority for this plan.

Figure 8 shows the differences between percentiles and percentages in the context of this report.

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

Figure 8. Percentile vs. Percentage.



Access to Care Measures

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

Statewide access measures for children and adolescents have stayed relatively steady between the 2019 and 2020 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 80th percentile.

Access for adults improved between the 2019 and 2020 RY. However, the state remains below the national 40th percentile for these measures.

Note that there were significant changes in the measure specifications for the maternal health measure that did not allow Comagine Health to report historical data for these measures. Performance in this category remained below the national 40th percentile.

An analysis that compared enrollees with an identified language preference of English to Spanish/Castilian revealed that Spanish speakers showed higher rates than English speakers for many of the access to care measures.

Table 14 displays the statewide results of these measures for the last four reporting years. The national benchmarks included in this report are displayed as quintiles, which divide performance by the 20th, 40th, 60th and 80th national percentiles. Note that the small blue squares reflect quintiles and their corresponding national percentile ranges.

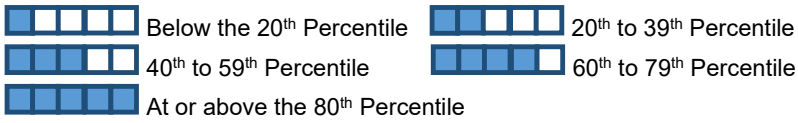


Table 14. Access to Care HEDIS Measures, 2017–2020 RY.

Measures	2017 State Rate	2018 State Rate	2019 State Rate	2020 State Rate	2020 National Quintile*
Adults' Access to Preventive/Ambulatory Health Services					
20–44 years	71.1	72.6	73.1	74.1	
45–64 years	79.9	80.6	80.2	80.5	
Children and Adolescents' Access to Primary Care Practitioners					
12–24 months	96.7	96.7	96.8	96.8	
25 months–6 years	86.4	85.8	86.6	87.0	
7–11 years	91.2	90.4	89.9	90.8	
12–19 years	90.8	90.6	89.7	90.2	
Well-Child Visits					
0–15 months, 6 or more visits	66.4	67.7	67.0	71.4	
3–6 years	67.9	66.7	67.7	70.1	
12–21 years	45.7	48.0	46.6	51.2	
Maternal Health					
Timeliness of Prenatal Care**	NR	NR	NR	87.2	
Postpartum Care**	NR	NR	NR	73.6	

NR indicates not reported.

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

*** Due to significant changes in the measure specifications for 2020 RY, historical data is not displayed for this measure.*

Preventive Care

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

Performance on preventive care measures remained steady between 2019 and 2020 RY. However, there was a significant decline in the breast screening rate in the same time period. Many of the rates remain below the 40th percentile of national performance. Notable exceptions are the Adult BMI Assessment, Cervical Cancer Screenings and many of the immunization measures.

Two children's immunization rates were reported: Combination 2 and Combination 10. As shown in Table 15, the state performed above the 60th percentile on Combination 10 and above the 40th percentile for Combination 2 when compared to national benchmarks.

For the adolescent immunization measures, the state performed below the 40th percentile for Combination 1 and performing above the 60th percentile for Combination 2.

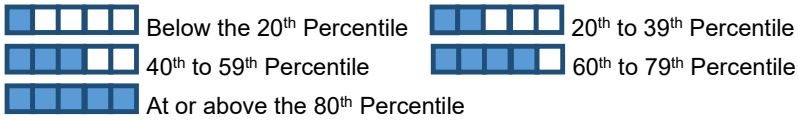


Table 15. Preventive Care HEDIS Measures, 2017–2020 RY.

Measure	2017 State Rate	2018 State Rate	2019 State Rate	2020 State Rate	2020 National Quintile*
Weight Assessment and Counseling					
Children's BMI Percentile	57.9	70.8	72.2	73.1	
Children's Nutrition Counseling	58.7	62.9	61.8	62.8	
Children's Physical Activity Counseling	53.2	57.8	57.5	58.6	
Adult BMI Assessment	90.2	89.0	90.9	91.5	
Immunizations					
Children's Combination 2	70.5	70.5	73.2	74.0	
Children's Combination 10	36.9	38.1	41.5	42.1	
Adolescents' Combination 1	77.0	75.9	76.0	77.4	
Adolescents' Combination 2	20.9	37.7	36.7	41.4	
Pediatric Screenings					
Lead Screening in Children	20.3	24.2	31.7	29.8	
Women's Health Screenings					
Breast Cancer Screening	53.5	55.3	54.5	52.0	
Cervical Cancer Screening	55.8	56.9	57.7	60.5	
Chlamydia Screening	54.4	55.1	54.2	53.6	

**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% of results.*

Chronic Care Management

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

Statewide performance on many of chronic care management measures remained steady in 2020 RY, as shown in Table 16. The exception was the Diabetes Care Blood Pressure Control measure, which saw a significant improvement between 2019 and 2020 RY.

When compared to national benchmarks, the state performed very well on many of the Diabetes Care Measures, with several above the 60th percentile. The state was also above the national 60th percentile on the Controlling High Blood Pressure measure.

The Asthma Medication Ratio rate was below the 20th percentile of national performance.

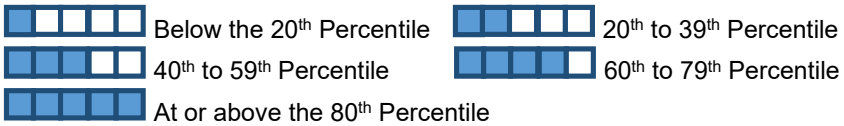


Table 16. Chronic Care Management HEDIS Measures, 2017–2020 RY.

Measure	2017 State Rate	2018 State Rate	2019 State Rate	2020 State Rate	2020 National Quintile*
Diabetes Care					
HbA1c Testing	89.6	89.2	89.5	89.5	
Eye Exam	59.1	59.7	58.5	59.1	
Medical Attention for Diabetic Nephropathy	90.1	89.4	89.6	88.0	
Blood Pressure Control (<140/90)	66.0	67.8	67.8	72.0	
HbA1c Control (<8.0%)	49.6	49.9	50.3	51.9	
Poor HbA1c Control (>9.0%)**	39.0	37.4	37.1	34.5	
Other Chronic Care Management					
Controlling High Blood Pressure (<140/90)	56.0	59.9	62.9	64.7	
Asthma Medication Ratio, Total	50.8	53.2	52.7	55.0	

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

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

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. These measures reflect the accessibility and timeliness of care provided.

Statewide performance on behavioral health measures remained steady in 2020 RY, as shown in Table 17.

An analysis that compared enrollees with an identified language preference of English to Spanish/Castilian revealed that English speakers showed higher rates than Spanish speakers for the Antidepressant Medication Management Initiation and Continuation Phase measures.

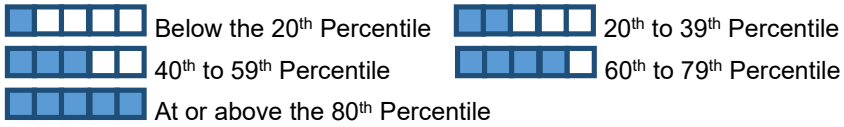


Table 17. Behavioral Health Medication Management HEDIS Measures, 2017–2020 RY.

Measure	2017 State Rate	2018 State Rate	2019 State Rate	2020 State Rate	2020 National Quintile*
Antidepressant Medication Management (Acute Phase)	50.8	51.6	50.9	53.5	
Antidepressant Medication Management (Continuation Phase)	35.4	35.9	36.0	38.4	
Follow-Up Care for Children Prescribed ADHD Medication (Initiation Phase)	43.1	42.4	42.8	43.9	
Follow-Up Care for Children Prescribed ADHD Medication (Continuation Phase)	53.5	49.1	50.8	53.6	

**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% of results.*

Behavioral Health RDA Measures

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

Table 18 shows the results of these two measures from 2018 through 2020 RY. There have been statistically significant increases in the SUD Treatment Penetration measure for the last two years.

Table 18. Washington State Behavioral Health (RDA) Measures, 2018–2020 RY.

Measures	2018 State Rate	2019 State Rate	2020 State Rate
MH-B, 6-64 Years	54.8	57.3	57.4
SUD Treatment Penetration, 12-64 Years	30.8	34.1	36.6

These measures are also covered in the following section, pages 62–64, as part of the state's self-validation of these measures for BHSO, a PIHP-contracted services program.

Summary of MCO Performance Measure Validation

Table 19 provides an overview of each MCO's strengths and weaknesses/opportunities for improvement in regard to performance measure validation.

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

Table 19. Summary of MCO Performance Measure Validation.

MCO	Strengths	Weaknesses/ Opportunities for Improvement

AMG	**Access to Care measures**
	• Mental Health Treatment Penetration
	• (MH-B) measure was above the state average.
	
	Chronic Care Management
	• Medication Management for People with Asthma (MMA), Compliance at 75%, was above the state average for children age 5-11 Years.
		Access to Care Measures
		• Prenatal and Postpartum Care (PPC) measures are below the state average. The Postpartum Care measure is particularly low.
		
		Behavioral Health Medication Management
		• Behavioral health medication management measures for the pediatric population are below the state average:
		  ○ Follow Up Care for Children Prescribed ADHD Medication, for both the Initiation and Continuation measures.
		  ○ The Use of First Line Psychosocial Care for Children and Adolescents was particularly low at 12% below the state average.

MCO	Strengths	Weaknesses/ Opportunities for Improvement
		Preventive Care • Breast Cancer Screening (BCS) and Cervical Cancer Screenings (CCS) fell below the state average.
CCW	**Preventive Care** • Childhood Immunization Status (CIS) measure is above the state average for both Combo 2 and Combo 10. • Weight Counseling for Children and Adolescent (WCC), Nutrition, Total measure is above the state average. • Lead Screening in Children (LSC) measure is above the state average.	**Chronic Care Management** • Controlling High Blood Pressure (CBP) measure is well below the state average. • Comprehensive Diabetes Care (CDC) measure is below the state average for the following components: ○ Poor HbA1c Control ○ Blood Pressure Control < 140/90 mm Hg
CHPW	**Access to Care Measures** • Prenatal and Postpartum Care (PPC), Postpartum Care measure is above the state average. **Preventive Care** • Lead Screening in Children (LSC) measure is above the state average. **Chronic Care Management** • Two asthma medication measures above the state average: ○ Asthma Medication Ratio (AMR), Total ○ Medication Management for Asthma (MMA), 12-18 years • Follow-Up Care for Children Prescribed ADHD Medication (ADD) is above the state average for both the Initiation and Continuation components.	**Access to Care Measures** • Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care measure is below the state average. **Preventive Care** • Cervical Cancer Screening (CCS) measure is below the state average.
MHW	**Access to Care Measures** • Prenatal and Postpartum Care (PPC) is above the state average for both the Timeliness of Prenatal Care and Postpartum Care measures. **Behavioral Health Medication Management** • Use of First-Line Psychosocial Care for Children and Adolescents (APP), Total measure is 17% above the state average.	**Preventive Care** • Lead Screening in Children (LSC) measure is below the state average. • Childhood Immunization Status (CIS), Combo 10 measure is below the state average.

MCO	Strengths	Weaknesses/ Opportunities for Improvement

	• Follow-Up Care for Children Prescribed ADHD Medication (ADD) is above the state average for both the Initiation and Continuation components.
	
	Chronic Care Management
	• All of the components of the Comprehensive Diabetes Care (CDC) measure are above the state average. Performance was particularly good on the following components:
	  ○ Poor HbA1c Control
	  ○ Blood Pressure Control < 140/90 mm Hg
	• Controlling High Blood Pressure (CBP) measure is above the state average.
	
	Preventive Care
	• Cervical Cancer Screening (CCS) measure is above the state average.	

UHC	**Access to Care Measures** • Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care measure is above the state average. **Preventive Care** • Comprehensive Diabetes Care (CDC), Poor HbA1c Control is above the state average.	**Chronic Care Management** • Medication Management for Asthma (MMA) measure is 6% below the state average for the 12-18 years age group. **Behavioral Health Medication Management** • Follow-Up Care for Children Prescribed ADHD Medication (ADD) is below the state average for both the Initiation and Continuation components. The continuation component is especially low at 12% below the state average. **Preventive Care** • Lead Screening in Children (LSC) measure is below the state average. • Weight Counseling for Children and Adolescent (WCC), BMI Percentile, Total measure is below the state average.

Performance Measure Recommendations

Sustain Clinically Meaningful Areas of Improvement

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

- We recommend that HCA work with the MCOs to sustain momentum in these key areas, identifying the best practices contributing to this performance and, where possible, standardizing approaches to encourage sustainability. Key areas include:
    - **Behavioral Health Integration** (Access and timeliness of care). There was year-over-year improvement across all or nearly all MCOs in several behavioral health medication management metrics (Antidepressant Medication Management, Acute and Continuation phase and Follow Up Care for Children Provided ADHD Medication, Initiation and Continuation phase). We recommend continued emphasis on this important topic with additional focus on the behavioral health issues for which there has not been sustained improvement, including Mental Health treatment penetration (MH-B).
    - **Substance Use Disorder** (Access and timeliness of care)**.** There was improvement across all MCOs in Substance Use Disorder Treatment Penetration (SUD) for all enrollees (ages 12–64) for the last two years. This improvement was not seen for adolescents (ages 12–18) or the foster care population (ages 12–26). SUD has impacted all clinicians serving Medicaid patients and has been a high priority in the state and nationally. We recommend that improvement efforts be continued with additional focus on patients under the age of 26.

Anticipate Impacts due to the COVID-19 Pandemic

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

- We recommend that HCA encourage MCOs to not wait for 2020 data to address anticipated effects, but rather work to proactively address these domains. We anticipate that the impact of the pandemic will be measurable in several particularly vulnerable clinical areas.
    - **Access to care**. As providers have increased access via telemedicine and limited in-person services, it will be important to pay attention to equitable access to care and particularly care for children. Given that some patients from disadvantaged communities will have limited access to the technology, privacy or internet access needed for telehealth, we recommend that MCOs focus on ensuring that in-person services are prioritized for those unable to participate in virtual visits. With early reports of reduced childhood immunization during the pandemic, consideration should be given to an early convening of MCOs to design innovative strategies for immunizing children rather than waiting for a full year of data.
    - **Behavioral health.** As the pandemic's impact on personal isolation continues, we anticipate that depression, anxiety and other behavioral health needs among the population will increase. We recommend that the MCOs continue efforts that strengthen the integration of behavioral health and primary care, as well as initiatives to identify and meet behavioral health needs.

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

Behavioral Health Services Only (BHSO) Performance Measure Validation

Objectives

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

Overview

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

In 2019, the five MCO plans operated BHSO programs. For this program, the state monitors and self-validates the following two state-developed measures, both reflecting statewide care delivered to Apple Health BHSO enrollees:

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

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

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

Technical Methods of Data Collection

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

Description of Data Obtained

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

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

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

before information is released. However, the RDA team that produces this measure is not responsible for (or resourced for) validating the accuracy and completeness of the underlying service encounter and Medicaid enrollment data.

Data Aggregation and Analysis

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

Summary of BHSO Performance Measure Validation Results/Conclusions

Table 20 shows the penetration rates for the MH-B and SUD measures in CY 2019.

Table 20. Performance Measures: MH-B and SUD Penetration.

Performance Measure	CY 2019	Numerator	Denominator
Mental Health Service Penetration – Broad Definition (MH-B) Statewide (Ages 6-64)	54.9%	209,428	381,810
Substance Use Disorder Treatment Penetration (SUD) Statewide (Ages 12-64)	37%	44,066	118,938

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

Validation Key

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

Table 21 shows results of the validation of the MH-B and SUD measures.

Table 21. Results for Review of RDA BHSO Performance Measures.

Validation Component	Validation Element	Meets Validation Requirements MH-B	Meets Validation Requirements SUD
Documentation	Did appropriate and complete measurement plans and programming specifications exist, including data sources, programming logic, and computer source code?	Yes	Yes
	Were internally developed codes used?	Yes	Yes
Denominator	Were all the data sources used to calculate the denominator complete and accurate?	Yes	Yes
	Did the calculation of the performance measure adhere to the specifications for all components of the denominator?	Yes	Yes
Numerator	Were the data sources used to calculate the numerator complete and accurate?	Yes	Yes
	Did the calculation of the performance measure adhere to the specifications for all components of the numerator?	Yes	Yes
Sampling	Was the sample unbiased? Did the sample treat all measures independently? Did the sample size and replacement methodologies meet specifications?	N/A	N/A
Reporting	Were the state specifications for reporting performance measures followed?	Yes	Yes

Analyses and Conclusions

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

Recommendations for Improvement

RDA anticipates that next year's validation report will explore weaknesses/opportunities for improvement in greater detail, including the potential to leverage cross-validation opportunities presented by working in partnership with HCA's Analytics, Research and Measurement team.

Progress Made from Prior Year's Recommendations

Not applicable. This is the first self-validation report in the current format.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Objectives

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

Overview

As required by HCA, the MCOs contract with NCQA-certified HEDIS survey vendors to conduct annual CAHPS Health Plan Surveys. In 2020, the Apple Health MCOs conducted the CAHPS 5.0H Adult Medicaid survey of their members enrolled in Apple Health. CCW conducted the CAHPS 5.0H Child Medicaid and Children with Chronic Conditions survey of the Apple Health Foster Care program. Additionally, NCQA-certified CAHPS survey vendor DataStat, under a subcontract with Comagine Health, administered the 5.0H Child Medicaid survey of the member households of children enrolled in the state's CHIP.

Technical Methods for Data Collection

Standardized CAHPS surveys were used to produce several measures of patient experience and overall rating, achievement scores, composite measures (a combination of two or more related survey items), and single-item measures. The CAHPS surveys use a 0–10 rating for assessing overall experience with health plans, providers, specialists and health care. The survey instruments administered in 2020 included:

- CAHPS 5.0H Adult Medicaid survey
- CAHPS 5.0H Child Medicaid with Chronic Conditions survey
- CAHPS 5.0H Child Medicaid survey

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

Apple Health Integrated Managed Care, Adult Medicaid Survey

In 2020, the Apple Health MCOs conducted the CAHPS® 5.0H Adult Medicaid survey via individually contracted NCQA-certified survey vendors.

Description of Data Obtained

Survey respondents included members 18 years and older continuously enrolled in Apple Health for at least six months as of December 31, 2019, with no more than one enrollment gap of 45 days or less.

Data Aggregation and Analysis

The survey data was provided to NCQA-certified survey vendor DataStat, who under a subcontract with Comagine Health, produced a report that summarized survey responses and identified key strengths and weaknesses/opportunities for improvement, based on survey questions most highly correlated to enrollees' satisfaction with their health plan. Priority matrices help focus improvement activities by graphically displaying two kinds of information: the magnitude of the health plan's achievement scores and their correlation with overall plan satisfaction. For ratings questions, composites and the questions on which composites are based, achievement scores are plotted against their correlation with overall health plan satisfaction.

Summary of Findings/Conclusions

The following results present the Apple Health MCO average rating as compared to national benchmarks derived from the NCQA Quality Compass. The full summary of findings is available in the *2020 Apple Health CAHPS® 5.0H Adult Medicaid Report*. The report is designed to identify key opportunities for improving members' experiences. Member responses to survey questions are summarized as achievement scores. Achievement scores are computed and reported for all pertinent survey items. Responses indicating a positive experience are labeled as achievements, and an achievement score is computed equal to the proportion of responses qualifying as achievements. The lower the achievement score, the greater the need for the program to improve. In addition, composite scores are built from achievements for groups of survey items that make up broad domains of members' experience: getting needed care, getting care quickly, how well doctors communicate and customer service.

Key Strengths and Weaknesses/Opportunities for Improvement

The five questions most highly correlated with the Apple Health plans members' satisfaction with the health plan, along with their corresponding achievement scores, are presented as key strengths in Table 22. These are areas that appeared to matter most to members, and where the health plan was doing well. Achievement scores are considered "high" when the score is 80% or higher. A correlation coefficient of 0.40 or greater indicates a relatively high correlation with health plan satisfaction.

Key Strengths

Table 22. Questions Most Strongly Correlated with Member Satisfaction.

Question	Apple Health Achievement Score	Correlation with Satisfaction
Q14. Personal doctor usually or always showed respect for what you had to say	96.3	0.30
Q25. Health plan's customer service staff usually or always treated you with courtesy and respect	93.4	0.28
Q13. Personal doctor usually or always listened carefully to you	92.5	0.29
Q12. Personal doctor usually or always explained things in way that was easy to understand	92.3	0.33
Q15. Personal doctor usually or always spent enough time with you	91.0	0.34

Weaknesses/Opportunities for Improvement

The five questions with the lowest achievement scores are presented in Table 23 as weaknesses/opportunities for improvement. These are areas that appear to matter the most to members, but where the health plan is not doing as well and could focus quality improvement efforts.

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

Table 23. Questions with Lowest Achievement Scores.

Question	Apple Health Achievement Score	Correlation with Satisfaction
Q6. Usually or always got an appt. for check-up or routine care as soon as you needed	77.2	0.19
Q20. Usually or always got an appointment to see a specialist as soon as you needed	79.0	0.32
Q24. Health plan's customer service usually or always gave needed information or help	81.3	0.37
Q4. Usually or always got urgent care as soon as you needed.	83.4	0.23
Q9. Usually or always easy to get care, tests, or treatment you	85.1	0.41

Table 24 reports 2020 RY performance. The Rating of Overall Health Care was below the national 40th percentile; the remaining adult CAHPS rates were below the 20th percentile for national performance.

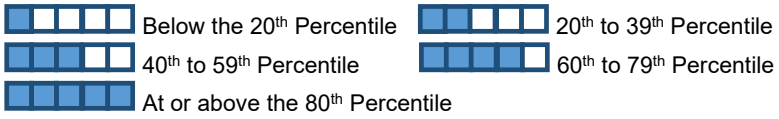


Table 24. Adult CAHPS Ratings Results, 2020 RY.

Results	2020 Rating	2020 National Quintile*
Rating of Overall Health Care (Scored 8, 9 or 10 out of 10)	76.2	
Rating of Personal Doctor (Scored 8, 9 or 10 out of 10)	80.1	
Rating of Specialist Seen Most Often (Scored 8, 9 or 10 out of 10)	83.8	
Rating of Plan (Scored 8, 9 or 10 out of 10)	73.3	
Getting Needed Care (composite score)	82.1	
Getting Care Quickly (composite score)	80.3	
How Well Doctors Communicate (composite score)	93.0	
Customer Service (composite score)	87.3	

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

Apple Health Foster Care – Child Medicaid with Chronic Conditions Survey

In 2020, CCW, the Apple Health Foster Care plan, conducted the CAHPS 5.0H Child Medicaid with Chronic Conditions survey via an independently contracted NCQA-certified survey vendor.

Description of Data Obtained

Respondents included parents/caregivers of children 17 years and younger as of December 31, 2019, continuously enrolled in the in foster care and adoption support components of the Apple Health Foster Care program for at least five of the last six months of the measurement year. The survey included children enrolled as part of the general foster care population as well as children with chronic conditions.

Data Aggregation and Analysis

CCW's survey vendor produced a summary report, including comparison of the Apple Health Foster Care scores to Child Medicaid 2019 Quality Compass® rates. The SatisAction™ key driver statistical model was used to identify the key drivers of the rating of the health plan. This model is a powerful, proprietary statistical methodology used to identify the key drivers of the rating of the health plan and provide actionable direction for satisfaction improvement programs.

Summary of Findings/Conclusions

Table 25 shows the results for the Integrated Foster Care CAHPS survey in 2019 and 2020. Note there are no national benchmarks available for the foster care population. For the full report, please see *2020 Apple Health IFC CAHPS® Medicaid Child with CCC 5.0 Report. Coordinated Care – Foster Care (Centene WA)*. Produced by SPH Analytics, July 2020. This report includes a key driver summary, conducted to understand the impact different aspects of service and care have on members' overall satisfaction with their health plan, physicians and health care.

Key Strengths and Weaknesses/Opportunities for Improvement

The key measures that had significant improvements from last year include:

- Q27: Doctor explained things
- Q29: Doctor showed respect
- Q35: Doctor informed about care

There were no key measures that had significantly lower scores than last year.

Table 25. Integrated Foster Care CAHPS Ratings Results, 2019 and 2020 RY.

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

Results	2019 Rating	2020 Rating
Getting Care Quickly (composite score)	91.6	90.8
How Well Doctors Communicate (composite score)	94.6	97.9
Customer Service (composite score)	82.5	86.8

Apple Health Children's Health Insurance Program (CHIP) – Child Medicaid Survey

In 2020 NCQA-certified survey vendor DataStat, under a subcontract with Comagine Health, administered the 5.0H Child Medicaid survey of the member households of children enrolled in CHIP.

Description of Data Obtained

Respondents included parents/caregivers of children 17 years and younger as of December 31, 2019, who were continuously enrolled in CHIP for at least five of the last six months of the measurement year.

Data Aggregation and Analysis

NCQA-certified survey vendor DataStat, under a subcontract with Comagine Health, produced a report that summarized survey responses and identified key strengths and weaknesses/opportunities for improvement, based on survey questions most highly correlated to enrollees' satisfaction with their health plan.

Summary of Findings/Conclusions

The following results present the Apple Health MCO average rating as compared to national benchmarks derived from the NCQA Quality Compass. For the full report, please see the *2020 Washington Apple Health Children's Health Insurance Program CAHPS 5.0H Summary Report.* Assessing consumers' experience in this report is accomplished with the use of achievement scores and composite scores. Member responses to survey questions are summarized as achievement scores. Responses indicating a positive experience are labeled as achievements, and an achievement score is computed equal to the proportion of responses qualifying as achievements. The lower the achievement score, the greater the need for the program to improve. In addition, composite scores are built from achievements for groups of survey items that make up broad domains of members' experience: getting needed care, getting care quickly, how well doctors communicate and customer service.

Key Strengths and Weaknesses/Opportunities for Improvement

Table 26 shows the results for the CHIP CAHPS survey in 2018 and 2020. Getting Needed Care was below the national 40th percentile, and the remaining CHIP CAHPS rates were below the 20th percentile for national performance. The improvement in the Rating of Plan measure from 80.2 to 86.3 was a statistically significant increase, although the measure is still below the 20th percentile for national performance.

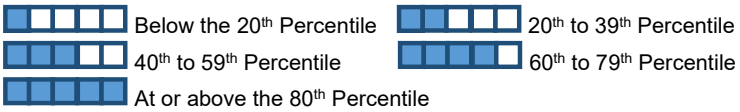


Table 26. Child CAHPS Ratings Results, 2018 and 2020 RY.

Results	2018 Rating	2020 Rating	2020 National Quintile*
Rating of Overall Health Care (Scored 8, 9 or 10 out of 10)	85.2	88.3	
Rating of Personal Doctor (Scored 8, 9 or 10 out of 10)	88.9	90.5	
Rating of Specialist Seen Most Often (Scored 8, 9 or 10 out of 10)	89.4	92.4	
Rating of Plan (Scored 8, 9 or 10 out of 10)	80.2	86.3	
Getting Needed Care (composite score)	84.1	87.8	
Getting Care Quickly (composite score)	89.0	90.7	
How Well Doctors Communicate (composite score)	94.6	96.6	
Customer Service (composite score)	88.1	87.3	

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

Recommendations

HCA should utilize the CAHPS data, analysis and reports to identify specific areas of focus for the MCOs. These areas may be targeted and focused on survey items that fall below the national comparative data when this data is available. If national comparative data is not available, then looking at trends over time can provide valuable information to use when identifying areas of focus. In addition, we recommend looking at areas of improvement to identify successful strategies that can be shared and spread across all MCOs.

Wraparound with Intensive Services (WISe)

Objective

In 2019, HCA chose to conduct a study on quality with focus on the WISe service delivery model. As the EQRO for Washington, Comagine Health is contracted to review behavioral health agencies (BHAs) throughout the state that have implemented the WISe service delivery model. WISe implementation began in Washington in 2014, with a statewide goal establishing WISe treatment throughout the state by 2018. According to the *T.R. v. Birch and Strange* settlement agreement,[21] the goals of this review summary are to:

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

Overview

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

Review Methodology and Scope of Review

Technical Methods of Data Collection

The reviews consisted of clinical record reviews for each of the 16 BHA provider locations selected by HCA. These locations reflect a combination of both rural and urban agencies providing WISe services throughout the State of Washington. The review criteria are identified in the Washington Quality Improvement Review Tool (QIRT). The key areas evaluated during the review include:

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

Description of Data Obtained

HCA provided the review team with a list of randomly selected charts for review for each provider location. Six records, at a minimum, were reviewed per BHA and the review included examining paper

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

records, electronic records and/or a combination of both. The clinical charts reviewed cover services provided during the period from February 2017 through June 2020.

Data Aggregation and Analysis

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

Summary of Findings/Conclusions

This summary includes overall results for the first 16 WISe reviews conducted during the review period of May to September 2020 and aggregated in three quarterly reports.[22]

Care Coordination Elements

Initial Engagement & Assessment

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

Table 27. WISe Care Coordination Elements: Initial Engagement & Assessment.

Screening	Initial	Reassessment
Timely: 64%	Timely: 70%	Timely: 68%
WISe Indicated: 92%	Collaborative: 49%	—

Care Planning

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

Table 28. WISe Care Coordination Elements: Care Planning.

Care Planning	Caregiver Engagement
Timely: 62%	Participation: 80.2%
Collaborative: 56%	—

CFT Processes and Transition Planning

Each youth has a CFT that develops and implements the youth and family's plan, addresses unmet needs, and works toward the family's vision and monitors progress regularly.

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

Table 29. WISe Care Coordination Elements: CFT Processes and Transition Planning.

Average Contact Between CFT Members and Youth/Family Within the First 30 days
7.02 hours

CFT meetings should take place every 30 days, with documentation reflecting ongoing discussions for transition planning and discharge criteria.

Table 30. WISe Care Coordination Elements: CFT Processes and Transition Planning – CFT Meetings.

CFT Meetings	CFT Participation
No CFTs: 16%	Home: 80.2%
One CFT: 27%	Community: 1.5%
Two CFTs: 29%	School: 8.7%
Three or More CFTs: 28%	—

Crisis Prevention and Response

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

Table 31. WISe Care Coordination Elements: Crisis Prevention and Response.

Crisis Planning	Percentage with Crisis Plans
Timely: 77%	69.5%
Collaborative: 55%	—

Treatment Characteristics

Qualified clinicians provide individual clinical treatment sessions to the youth/family in the amount, duration and scope appropriate to address the identified medically necessary needs.

Table 32. Treatment Characteristics: Individual Clinical Treatment Sessions.

CFT Attendance/Participants	Interaction Content	Treatment Interactions
Therapist: 62%	Same Treatment Focus: 79%	Avg. Sessions Per Month: 2.33
Youth Only: 61%	Skill Development: 15%	—
Youth and Caregiver: 32%	Evidence-Based Practice Curriculum Used: 7.5%	—
Caregiver Only: 7%	Enlisting Treatment Support: 7.1%	—

Parent and Youth Peer Support Elements

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

Table 33. Parent and Youth Peer Support Elements: Average Hours of Peer Support by Type.

Average Hours of Contact					
Youth Peer with Youth	1.9	Parent Peer with Youth	1.1	CFT Members and Youth/Family	7.02
Youth Peer with Caregiver/Others	1.6	Parent Peer with Caregiver/Others	3.2	—	—

Strengths

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

- The need for the WISe service delivery model was indicated in 92% of the records reviewed.
- The initial full CANS screening was completed within the required timeframe in 70% of the records with documentation identified in 68% of the reassessments occurring as required.
- Caregiver engagement in the care planning process was evidenced by 80.2% participation in CFT meetings across all agencies.
- Overall, 77% of crisis plans were completed timely manner.
- Persistence in problem solving was evidenced during 79% of therapy sessions identified.

Weaknesses/Opportunities for Improvement

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

The review period included the early days of the COVID-19 PHE, including the *Stay Home, Stay Healthy* orders. The requirements of the *Stay Home, Stay Healthy* orders may be a contributing factor in the agencies' results.

- We recommend the agencies review the organization's response to the COVID-19 PHE to address gaps in the emergency or disaster plans to:
    - Identify alternate methods for providing services and supports in the event of a PHE
    - Ensure adaptation of the identified alternative methods for a rapid return to provision of the full range of services

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

- We recommend the agencies conduct a root-cause analysis to identify the barriers to success in meeting WISe requirements. As interventions are identified, use Plan-Do-Study-Act (PDSA)

cycles of improvement to measure the effectiveness of each intervention. Recommended focus areas for improvement include:

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

Recommendations

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

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

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

- HCA should continue providing technical assistance to the agencies delivering WISe services including encouraging the agencies to conduct a root-cause analysis to identify the barriers to success in meeting WISe requirements.

Review of Previous Year's EQR Recommendations

Required EQR activities include a review of the applicable state organization's response to previously issued EQR recommendations.

As of January 2020, behavioral health benefits were 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. 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. As part of the 2019 EQR, Comagine Health reviewed the last three BHOs: Great Rivers BHO, Salish BHO and Thurston-Mason BHO. These BHOs ceased operations by January 1, 2020, but because they were included in the 2019 EQR, recommendations related to those BHOs are included below.

Table 34 shows the physical health-related recommendations from the 2019 EQR report, with HCA's response and the EQRO's response.

Table 35 shows the BHO-related recommendations from the 2019 EQR report, with HCA's response and the EQRO's response.

Table 34. HCA Responses to 2019 Physical Health EQR Recommendations.

Prior-Year Opportunity for Improvement or Recommendation	HCA Response	EQRO Response
Opportunity for Improvement: Compliance		
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.	Coverage and authorization processes are ever-changing and inherently complex. To support MCOs and Medicaid clients, and address the challenges, HCA has been providing extensive general guidance. Examples include the provision of significant technical assistance throughout the year by HCA. With a focus on identifying barriers as well as addressing case-specific reviews and supports such as State Administrative hearings with our contracted MCOs throughout the year. 2020 TEAMonitor reviews demonstrated ongoing need for support in this area. Virtual onsite visits were used to highlight specific areas needing improvement and provide further technical assistance. 2020 TEAMonitor reviews demonstrated ongoing need for support in this area. Virtual onsite visits were used to highlight specific areas needing improvement and provide further technical assistance.	**Response accepted**
Recommendation: Performance Measure Review		
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	HCA seeks alignment through multiple quality improvement efforts to continue the collaboration fostered through the BH integration implementation. Examples include the MCO Well-Child Collaborative, AMM health disparity workgroup, selection process for VBP measures, and the Asthma Affinity Group. As of June 2019, HCA requested plans participate in the Asthma Affinity Group to improve outcomes related to the AMR HEDIS measure. HCA is in the early stages of this work. MCO contracts have been fully integrated as of January 1, 2020.	**Response accepted**

Prior-Year Opportunity for Improvement or Recommendation	HCA Response	EQRO Response
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.		
Opportunity for Improvement: Performance Improvement Project		
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.	EQRO recommendations have been incorporated into overall PIP program redesign, including a phased submission process intended to support MCOs with improving both study design and outcomes. Since September of 2019, HCA staff have met monthly to provide technical assistance to MCOs who required corrective action on their PIP program. These meetings have included examination of both completed projects and first-year PIPs (e.g., lessons learned from previous PIPs that may not have met standards and preparing the proposals for first-year PIPs). HCA also provided education/assistance in understanding HCA/CMS expectations of PIPs to recently-hired MCO quality staff assigned to this work. HCA collaborated with the Department of Health within the bi-weekly MCO Collaborative PIP workgroup to present on PIP design, emphasizing the importance of good study questions, overall PIP design, and appropriate write up. MCO quality staff in attendance were instructed to apply the learnings from these sessions to all active PIPs. Regarding rapid-cycle process improvement, HCA has taken note that this strategy is imbedded within the CMS EQR protocol update currently being reviewed by HCA staff. MCO contracts already require compliance with CMS protocols. Process changes may be required with the planning and implementation of Protocol 1 updates; implementation is currently planned for 2021.	**Response accepted**

Table 35. HCA Responses to 2019 Behavioral Health EQR Recommendations.

Prior-Year Recommendation	HCA Response	EQRO Response
Compliance		
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.	At this time, BHOs are no longer in operation. 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 changes finalized across the state, bringing integrated care to all regions of our health care system, HCA 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. 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. HCA will continue to review for system opportunities as described above. The BHO program has closed and the contract was terminated effective December 31, 2019.	**Response accepted**
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.	**Addressed above**	**Response accepted**

Prior-Year Recommendation	HCA Response	EQRO Response
• 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 ○ providing and documenting coordination of care for all enrollees with their clinical providers, specialty and allied providers, and PCPs ○ 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.	**Addressed above**	**Response accepted**
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	**Addressed above**	**Response accepted**

Prior-Year Recommendation	HCA Response	EQRO Response
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.		
Performance Improvement Projects		
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	**Addressed above**	**Response accepted**

Prior-Year Recommendation	HCA Response	EQRO Response
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: ○ 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.	**Addressed above**	**Response accepted**

Appendix A: MCP Profiles

About the MCP Profiles

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

Noted Strengths and Weaknesses/Opportunities for Improvement

Compliance:

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

PIPs:

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

Performance Measures:

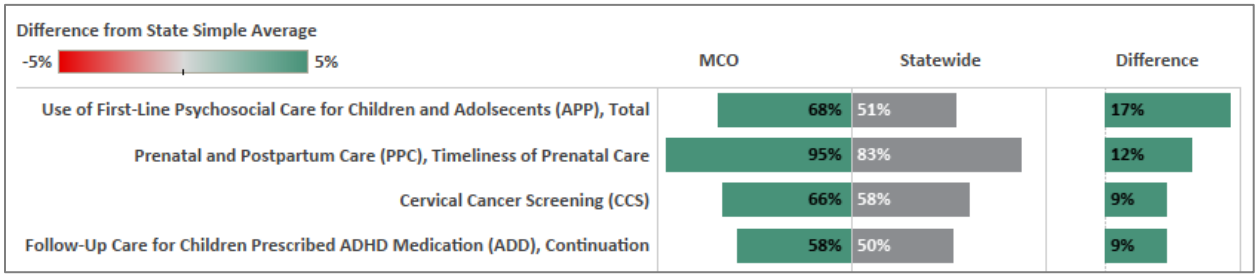
- Strengths and weaknesses/opportunities for Improvement are noted when an MCO scores above or below the state average, respectively.

MCO Scorecards

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

- The measures are listed in the left column with MCO performance and the statewide simple average listed in the middle columns. The differences between the MCO and statewide percentages are listed in the right column.
- Color coding: green shading indicates a positive difference from the statewide average; meaning the MCO performed better/higher on that measure. Red shading indicates lower performances than the statewide average, meaning the MCO performed worse/lower on that measure.

Figure A-1. Snapshot of MCO Scorecards.

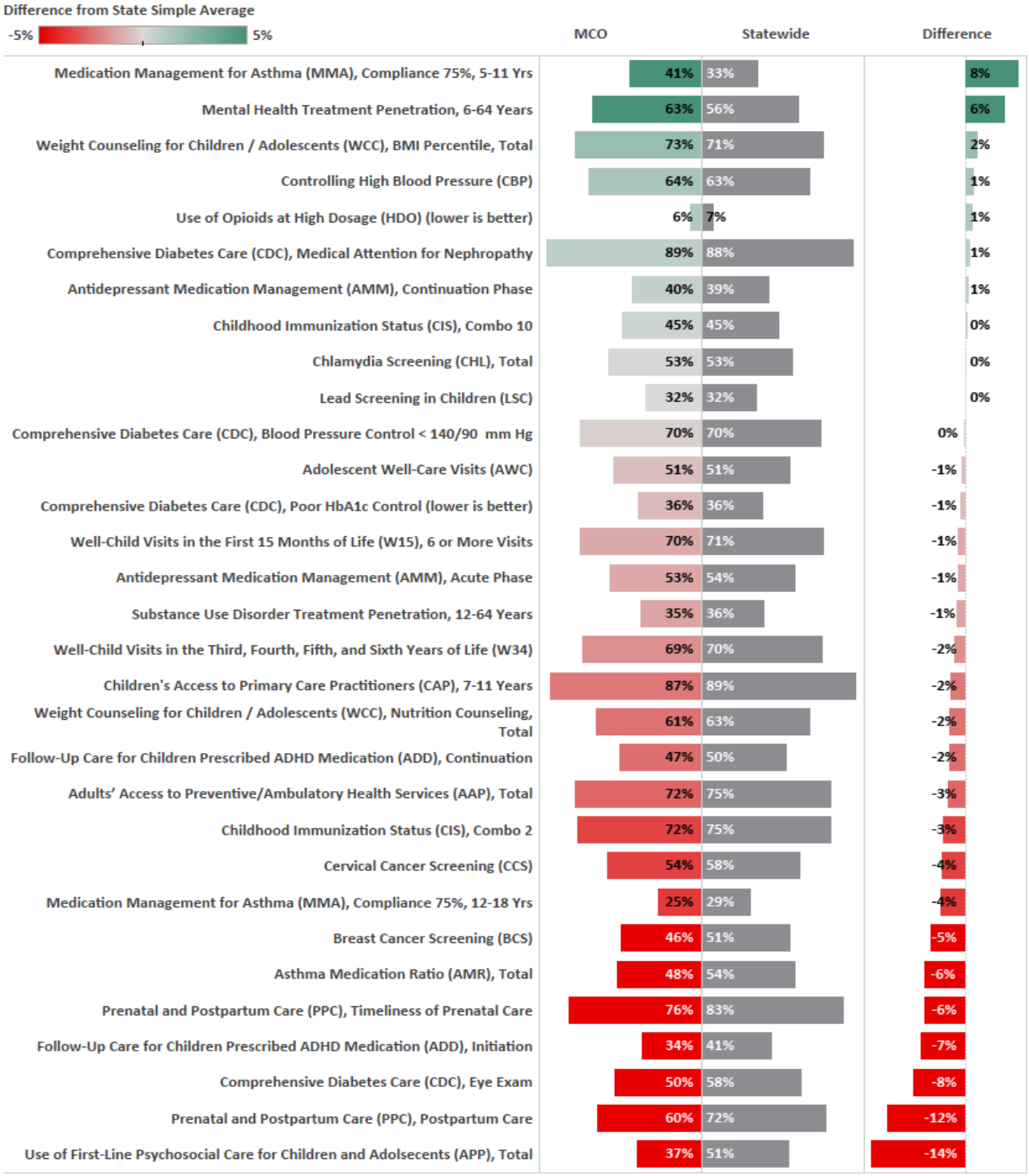


The MCO performance scorecards in the following profiles highlight the variance of measures from the simple state average.

Comagine Health chose to use the simple average for the MCO scorecards as the Apple Health MCOs are of such different sizes; note that the simple state average is different than the weighted state average used in other sections of the report. The potential disadvantage of comparing an individual MCO to a weighted state average is that significantly larger plans could have undue influence on the state rate. A simple average of the plans (rather than a weighted average) mitigates those concerns.

Amerigroup Washington (AMG) Profile

Figure A-2. AMG Scorecard.



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

Table A-1. Summary of AMG's 2020 Compliance Review Results.

Compliance with Regulatory and Contractual Standards				
Standard	**MCO Score/Possible**	**%**	**BHSO Score/Possible**	**%**
Element: Quality **Enrollee Rights**	31/36	83%	28/33	85%
Weaknesses/Opportunities for Improvement AMG-MCO and AMG-BHSO should focus improvement efforts on: • Evidence of monitoring for provision of alternate materials • Enrollee notification of termination of providers				
Element: Access, Timeliness **Availability of Services**	17/21	81%	14/18	78%
Weaknesses/Opportunities for Improvement AMG-MCO and AMG-BHSO should focus improvement efforts on: • Network adequacy - GeoAccess reporting and top six utilized specialists • Process to monitor information about available providers • Policy to address HCA identified issues in their network • Documentation on how the plans use language race and ethnicity data to inform system decision making related to network decisions, quality assurance, or improvement in utilization • Description of specific needs/characteristics when establishing, maintaining and monitoring behavioral health provider network				
Element: Quality, Access **Coordination and Continuity of Care**	14/18	78%	15/18	83%
Weaknesses/Opportunities for Improvement AMG-MCO and AMG-BHSO should focus improvement efforts on: • Policy specifying that each enrollee has an ongoing source of primary care and an entity designated for care coordination, prevention of duplication of services and protection of enrollee privacy • A single written narrative report describing care coordination oversight that meets all requirements				
Element: Quality **Practice Guidelines**	7/9	78%	8/9	89%
Weakness/Opportunities for Improvement AMG-MCO and AMG-BHSO should focus improvement efforts on: • Ensuring UM decisions and criteria are aligned with MCO/BHSO practice guidelines, and ensuring messaging to the MCO/BHSO network is consistent across the MCO/BHSO documentation and decisions				

Table A-2. Summary of AMG's 2019 Corrective Action Plans.

Review of 2019 MCO Corrective Action Plans	Not Met	Partially Met	Met
Element: Quality and Access **Standard: Care Coordination and Continuity of Care**	1	–	1
Two elements reviewed for CAPs: • 438.240(b)(4) Care Coordination Oversight – Repeat Finding* • 438.208(c) (2) Assessment and (3) Treatment plans – Care Coordination for Individuals with Special Health Care Needs – Met			
Element: Access **Standard: Coverage and Authorization**	2	–	1
Three elements reviewed for CAPs: • 438.210(b)(1)(2)(3) Authorization of services – Repeat Finding* • 438.210(c) Notice of adverse benefit determination – Met • 438.210(d) Timeframe for decisions (1)(2) – Not Met			
Element: Timeliness **Standard: Grievance systems**	3	2	1
Six elements reviewed for CAPs: • 438.408(b)(c) Resolution and notification: Grievances and appeals - specific timeframes and extension of timeframes – Repeat Finding* • 438.408(a) Resolution and notification: Grievances and appeals - Basic rule – Not Met • 438.408 (d)(e) Resolution and notification: Grievances and appeals - Format of notice and Content of notice of appeal resolution – Not Met • 438.406(a) General requirements - Handling of grievances and appeals – Partially Met • 438.410 Expedited resolution of appeals – Partially Met • §438.400 Statutory basis and definitions – Met			

**Repeat finding is also scored as not met.*

Table A-3. Summary of AMG's 2020 PIPs.

Performance Improvement Projects (PIPs)*			
Type	**Study Topic**	**Confidence**	**Score**
Element: Quality **Clinical:** Washington State Institute for Public Policy Adult (AHMC, AHFC)	WSIPP evidence-based collaborative effort for depression, anxiety comorbid depression and chronic health treatment	Confidence in reported MCO PIP Results	Not Met
Element: Quality **Clinical:** Washington State Institute for Public Policy Children (FIMC)	WSIPP evidence-based collaborative effort for depression, anxiety, comorbid depression and chronic health treatment	Confidence in reported MCO PIP Results	Not Met
Element: Access, Quality	Using of SBIRT (Screening, Brief, Intervention, and Referral to Treatment) for identification and	Enough time has not elapsed to	Not Met

Performance Improvement Projects (PIPs)*			
Type	**Study Topic**	**Confidence**	**Score**
Clinical: Washington State Institute for Public Policy Adult (BHSO, FIMHC)	intervention of substance use disorders by physical health practitioners	assess meaningful change	
Element: Quality **Clinical:** Washington State Institute for Public Policy Children (IMC, BHSO)	Using the Alcohol Literacy Challenge in Washington State school-based settings to reduce youth drinking rates through changed alcohol effect beliefs	Reported MCO PIP results not credible	Not Met
Element: Access, Quality, Timeliness **Clinical:** Collaborative Well-Child Visits (AHMC)	Collaborative MCO Well-Child Visit Rate	Confidence in reported MCO PIP Results	Met
Element: Access, Quality **Non-clinical:** (AHMC, FIMC, BHSO)	Improving WIC Participation	Confidence in reported MCO PIP Results	Met

**Please refer to Table 9 for strengths and weaknesses/opportunities for improvement.*

Summary of Previous Year (2019) MCO PIP CAP

The response submitted by the MCO to the 2019 CAP was reviewed and accepted with the following response by HCA:

- **AMG**: Met. Corrective action is completed.

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

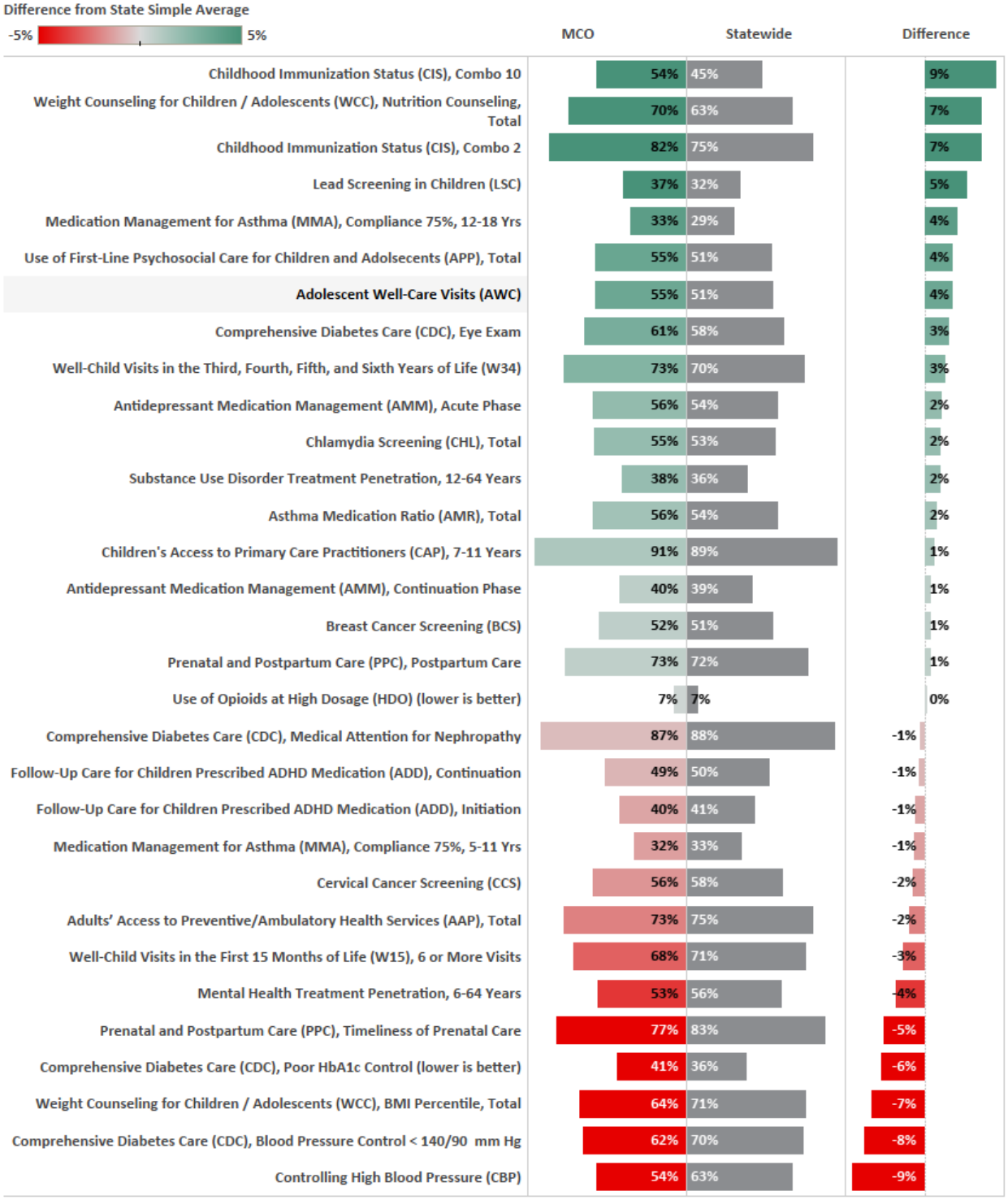
Performance Measures	
Strengths	**Weaknesses/ Opportunities for Improvement**
Access to Care Measures • Mental Health Treatment Penetration (MH-B) measure was above the state average.	**Access to Care Measures** • Prenatal and Postpartum Care (PPC) measures are below the state average. The Postpartum Care measure is particularly low.
Chronic Care Management • Medication Management for People with Asthma (MMA), Compliance at 75%, was above the state average for children age 5-11 Years.	**Preventive Care** • Breast Cancer Screening (BCS) and Cervical Cancer Screenings (CCS) fell below the state average.

Performance Measures	
Strengths	**Weaknesses/ Opportunities for Improvement**

—	**Behavioral Health Medication Management**
	• Behavioral health medication management measures for the pediatric population are below the state average:
	  ○ Follow Up Care for Children Prescribed ADHD Medication, for both the Initiation and Continuation measures.
	  ○ The Use of First Line Psychosocial Care for Children and Adolescents was particularly low at 12% below the state average.

Coordinated Care of Washington (CCW) Profile

Figure A-3. CCW Scorecard.



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

Table A-5. Summary of CCW's 2020 Compliance Review Results.

Compliance with Regulatory and Contractual Standards				
Standard	**MCO Score/Possible**	**%**	**BHSO Score/Possible**	**%**
Element: Quality **Enrollee Rights**	34/36	94%	31/33	94%
Weakness/Opportunities for Improvement CCW-MCO and CCW-BHSO should focus improvement efforts on: • Training and evidence of training on physician orders for life-sustaining treatment (POLST)/ advance directives, including mental health advance directives				
Element: Access, Timeliness **Availability of Services**	16/21	76%	14/18	78%
Weaknesses/Opportunities for Improvement CCW-MCO and CCW-BHSO should focus improvement efforts on: • Evidence of processes used to monitor the provision of information about available providers specific to the requesting enrollee's area of residence and physical or behavioral health needs in hard copy/pdf format when requested. Include evidence of how your MCO/PIHP addresses any issues related to delivering the information to the requesting enrollee. • Policy specifically referencing direct access to a women's health specialist and how the MCO identifies/monitors issues outside of an enrollee filing a grievance or appeal. • Ensure enrollees receive appropriate access to out-of-network care and claims for out-of-network services are processed appropriately. • Provider manual with clearly identified information that the cost to the enrollee is no greater for services from non-participating providers than services provided by participating providers. • Evidence of the implementation of a training program for MCO/PIHP governance, leadership and staff about the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care. • Narrative or policy/procedure describing how the MCO/BHSO considers the required when establishing, maintaining, monitoring and reporting of its behavioral health provider network.				
Element: Quality, Access **Coordination and Continuity of Care**	16/18	89%	16/18	89%
Weakness/Opportunities for Improvement CCW-MCO and CCW-BHSO should focus improvement efforts on: • General care coordination policy addressing primary care and protection of enrollee privacy				
Element: Quality **Practice Guidelines**	9/9	100%	9/9	100%
Strengths CCW-MCO and CCW-BHSO met all elements for this practice guidelines standard.				

Table A-6. Summary of CCW's 2019 Corrective Action Plans.

Review of 2019 MCO Corrective Action Plans	Not Met	Partially Met	Met
Element: Access **Standard: Coverage and Authorization**	2	–	1
Three elements reviewed for CAPs: • 438.210(b)(1)(2)(3) Authorization of services – Repeat Finding* • 438.210(c) Notice of adverse benefit determination – Repeat Finding* • 438.210(d) Timeframe for decisions (1)(2)			
Element: Timeliness **Standard: Grievance systems**	–	–	3
Three elements reviewed for CAPs: • §438.400 Statutory basis and definitions – Met • 438.406(a) General requirements - Handling of grievances and appeals – Met • 438.408(b)(c) Resolution and notification: Grievances and appeals - specific timeframes and extension of timeframes			

**Repeat finding is also scored as not met.*

Table A-7. Summary of CCW's 2020 PIPs.

Performance Improvement Projects (PIPs)*			
Type	**Study Topic**	**Confidence**	**Score**
Element: Quality **Clinical:** Washington State Institute for Public Policy Adult (AHMC, AHFC, FIMC)	Improving psychotherapeutic claims through provider and member education for 19- to 64-year-old members with depression	Reported MCO PIP results not credible	Not Met
Element: Access, Quality **Clinical:** Washington State Institute for Public Policy Children (IFC)	Improving psychotherapeutic claims through provider and member education for 12- to 18-year-old members with depression	Reported MCO PIP results not credible	Not Met
Element: Access, Quality, Timeliness **Clinical:** Collaborative Well-Child Visits (AHMC)	Collaborative MCO Well-Child Visit Rate	Confidence in reported MCO PIP Results	Met
Element: Quality, Timeliness **Non-clinical:** AHMC, FIMC, BHSO, AHFC	Improving timely and appropriate access to care for reproductive-age women	Reported MCO PIP results not credible	Not Met
Element: Access, Quality **Nonclinical:** AHFC	Improving access to assigned primary care provider for Apple Health Foster Care members ages 12 months to 19 years old	Reported MCO PIP results not credible	Not Met

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

Summary of Previous Year (2019) MCO PIP CAP

The response submitted by the MCO to the 2019 CAP was reviewed and accepted with the following response by HCA:

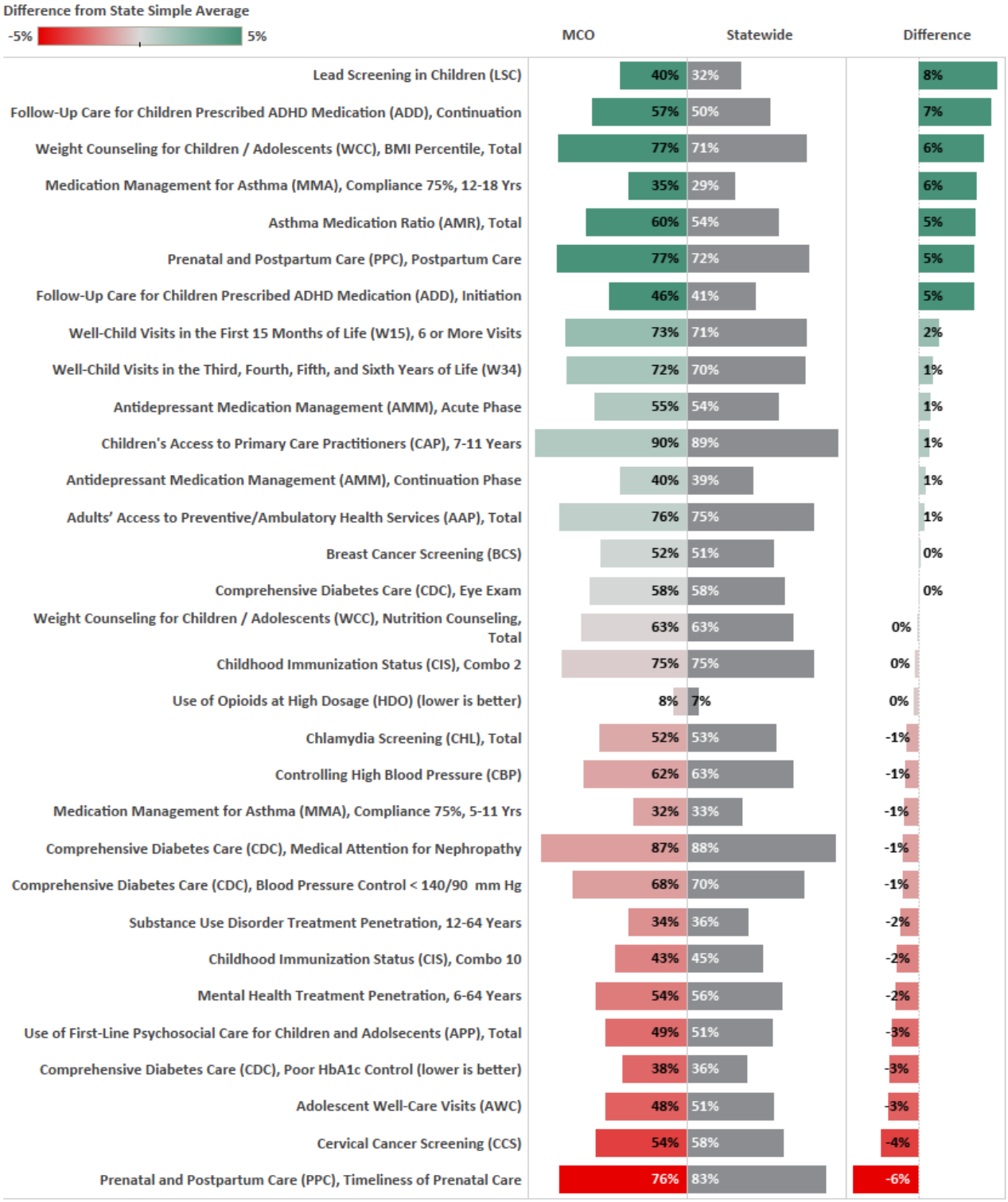
- **CCW:** Met. Corrective action is completed.

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

Performance Measures	
Strengths	**Weaknesses/Opportunities for Improvement**
Preventive Care • Childhood Immunization Status (CIS) measure is above the state average for both Combo 2 and Combo 10. • Weight Counseling for Children and Adolescent (WCC), Nutrition, Total measure is above the state average. • Lead Screening in Children (LSC) measure is above the state average.	**Access to Care Measures** Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care measure is below the state average.
—	**Chronic Care Management** • Controlling High Blood Pressure (CBP) measure is well below the state average. • Comprehensive Diabetes Care (CDC) measure is below the state average for the following components: ○ Poor HbA1c Control ○ Blood Pressure Control < 140/90 mm Hg

Community Health Plan of Washington (CHPW) Profile

Figure A-4. CHPW Scorecard.



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

Table A-9. Summary of CHPW's 2020 Compliance Review Results.

Compliance with Regulatory and Contractual Standards				
Standard	**MCO Score/Possible**	**%**	**BHSO Score/Possible**	**%**
Element: Quality **Enrollee Rights**	28/36	78%	25/33	85%
Weaknesses/Opportunities for Improvement CHPW-MCO and CHPW-BHSO should focus improvement efforts on: • Policy to reflect language threshold requirement to ensure no barriers in the provision of written languages • Process to monitor and address issues related to written materials • Policy to reflect provision of auxiliary aids and alternative formats • Notification of provider termination to enrollees • Update provider/employee training and community education efforts to include POLST • Ensure all liability for payment issues are addressed				
Element: Access, Timeliness **Availability of Services**	16/21	76%	14/18	78%
Weaknesses/Opportunities for Improvement CHPW-MCO and CHPW-BHSO should focus improvement efforts on: • Include in policy how the MCO/BHSO verifies that providers listed in directory are practicing in the state or an allowed border state • MCO should ensure women's health care services are defined in policy • Ensure internal claims processes include required information related to second opinions from in and out-of-network providers • Ensure policy on access and availability standards includes all requirements • Ensure provider manual includes provider responsibility to consider cultural considerations (in addition to interpreter services)				
Element: Quality, Access **Coordination and Continuity of Care**	18/18	100%	18/18	100%
Strengths CHPW-MHO and CHPW-BHSO met all elements for the Coordination and Continuity of Care standard.				
Element: Quality **Practice Guidelines**	9/9	100%	9/9	100%
Strengths CHPW-MHO and CHPW-BHSO met all elements for the practice guidelines standard.				

Table A-10. Summary of CHPW's 2019 Corrective Action Plans.

Review of 2019 MCO Corrective Action Plans	Not Met	Partially Met	Met
Element: Quality and Access **Standard: Care Coordination and Continuity of Care**	–	–	1
One element reviewed for CAPs: • 438.208(c) (2) Assessment and (3) Treatment plans - Care Coordination for Individuals with Special Health Care Needs – Met			
Element: Access **Standard: Coverage and Authorization**	1	–	2
Three elements reviewed for CAPs: • 438.210(b) (1) (2) (3) Authorization of services – Met • 438.210(c) Notice of adverse benefit determination – Repeat Finding* • 438.210(c) Notice of adverse benefit determination – Met			
Element: Timeliness **Standard: Grievance Systems**	–	–	4
Four elements reviewed for CAPs • 438.228 Grievance systems – Met • 438.402(c)(1) Filing requirements - Authority to file – Met • 438.408(a) Resolution and notification: Grievances and appeals - Basic rule – Met • 438.408(b) and (c) Resolution and notification: Grievances and appeals - specific timeframes and extension of timeframes – Met			

**Repeat finding is also scored as not met.*

Table A-11. Summary of CHPW's 2020 PIPs.

Performance Improvement Projects (PIPs)*			
Type	**Study Topic**	**Confidence**	**Score**
Element: Quality **Clinical:** Washington State Institute for Public Policy Adult (AHMC, FIMC, BHSO)	Promoting wellness and recovery with peer specialists	Enough time has not elapsed to assess meaningful change	Not Met
Element: Access, Quality **Clinical:** Washington State Institute for Public Policy Children (FIMC)	Improving child health outcomes through connecting mothers to the Nurse-Family Partnership	Low confidence in reported MCO PIP results	Partially Met
Element: Access, Quality, Timeliness **Clinical:** Collaborative Well-Child Visits (AHMC)	Collaborative MCO Well-Child Visit Rate	Confidence in reported MCO PIP Results	Met

Performance Improvement Projects (PIPs)*			
Type	**Study Topic**	**Confidence**	**Score**
Element: Access, Quality **Non-clinical:** (AHMC, FIMC, BHSO)	Depression screening and follow-up in preferred languages	Confidence in reported MCO PIP results	Partially Met

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

Summary of Previous Year (2019) MCO PIP CAP

The response submitted by the MCO to the 2019 CAP was reviewed and accepted with the following response by HCA:

- **CHPW**: Met. Corrective action is completed.

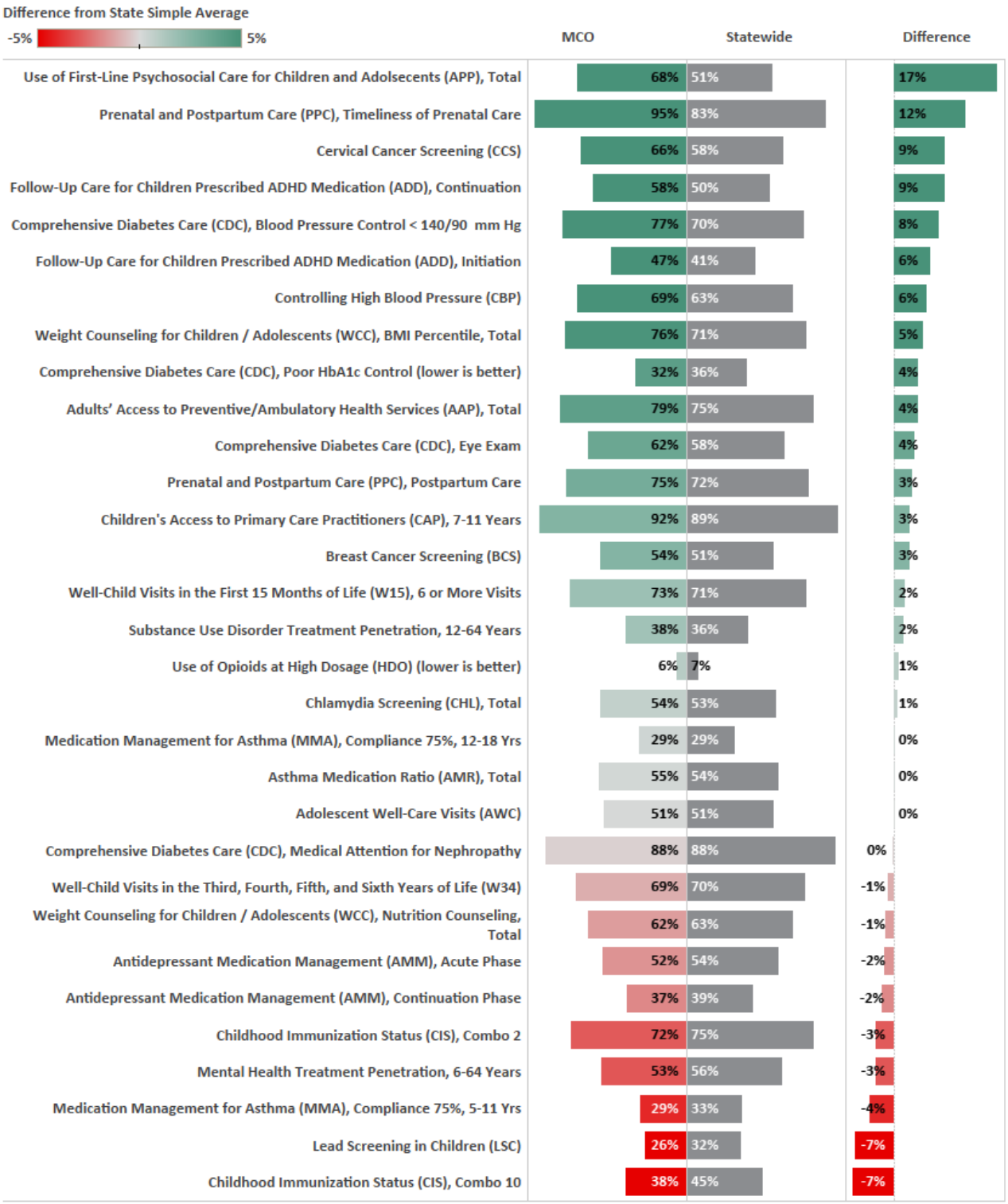
Table A-12. CHPW's Performance Measure Strengths and Weaknesses/Opportunities for Improvement.

Performance Measures	
Strengths	**Weaknesses/Opportunities for Improvement**
Access to Care Measures • Prenatal and Postpartum Care (PPC), Postpartum Care measure is above the state average.	**Access to Care Measures** • Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care measure is below the state average.
Preventive Care • Lead Screening in Children (LSC) measure is above the state average.	**Preventive Care** • Cervical Cancer Screening (CCS) measure is below the state average.

Chronic Care Management
• Two asthma medication measures above the state average:
  ○ Asthma Medication Ratio (AMR), Total
  ○ Medication Management for Asthma (MMA), 12-18 years
• Follow-Up Care for Children Prescribed ADHD Medication (ADD) is above the state average for both the Initiation and Continuation components.
	—

Molina Healthcare of Washington (MHW) Profile

Figure A-5. MHW Scorecard.



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

Table A-13. Summary of MHW's 2020 Compliance Review Results.

Compliance with Regulatory and Contractual Standards				
Standard	**MCO Score/Possible**	**%**	**BHSO Score/Possible**	**%**
Element: Quality **Enrollee Rights**	33/36	92%	30/33	91%
Weaknesses/Opportunities for Improvement: MHW-MCO and MHW-BHSO should focus improvement efforts on: • Enrollee notification of termination of providers • Process used to resolve instances when members are allegedly billed for covered services needs to include all required fields • Ensure all liability for payment issues are addressed and consistently include all required information				
Element: Access, Timeliness **Availability of Services**	16/21	76%	13/18	72%
Weaknesses/Opportunities for Improvement MHW-MCO and MHW-BHSO should focus improvement efforts on: • Process to include information related to providers accepting/not accepting new enrollees and how the issues are monitored and/or resolved • Ensure electronic/online provider directory includes information regarding accessibility • Documentation regarding how complaints/issues regarding availability of providers in enrollee's area of residence and health needs are addressed • Noncontracted provider processes are documented • Ensure policy on access and availability standards includes all requirements • Implement policy describing how the plans consider all required criteria when establishing, maintaining, monitoring and reporting the behavioral health provider network				
Element: Quality, Access **Coordination and Continuity of Care**	16/18	89%	16/18	89%
Weakness/Opportunities for Improvement MHW-MCO and MHW-BHSO should focus improvement efforts on: • Ensure care coordination policies include all required information				
Element: Quality **Practice Guidelines**	9/9	100%	9/9	100%
Strengths MHW-MCO and MHW-BHSO met all elements for the practice guidelines standard.				

Table A-14. Summary of 2019 Corrective Action Plans for MHW.

Review of 2019 MCO Corrective Action Plans	Not Met	Partially Met	Met
Element: Quality and Access **Standard: Care Coordination and Continuity of Care**	–	–	1
One element reviewed for CAPs • 438.208(c) (2) Assessment and (3) Treatment plans - Care Coordination for Individuals with Special Health Care Needs – Met			
Element: Access **Standard: Coverage and Authorization**	–	–	1
One element reviewed for CAPs • 438.210(b) (1) (2) (3) Authorization of services – Met			
Element: Quality **Standard: Program Integrity**	–	–	1
One element reviewed for CAPs • 438.608 (a)(1), (d)(2) Program integrity requirements – Met			

Table A-15. Summary of MHW's 2020 PIPs.

Performance Improvement Projects (PIPs)*			
Type	**Study Topic**	**Confidence**	**Score**
Element: Access, Quality, Timeliness **Clinical:** Washington State Institute for Public Policy Adult (AHMC, FIMC, BHSO)	WSIPP evidence-based collaborative primary care for depression	Confidence in reported MCO PIP results	Not Met
Element: *Quality* **Clinical:** Washington State Institute for Public Policy Children (FIMC, BHSO)	Enhancing Behavioral Parent Training for parents of children with ADHD	Low confidence in reported MCO PIP results	Not Met
Element: Access, Quality, Timeliness **Clinical:** Collaborative Well-Child Visits (AHMC)	Collaborative MCO Well-Child Visit Rate	Confidence in reported MCO PIP results	Met
Element: *Quality* **Non-clinical** (AHMC, FIMC)	Bridging the gap: Level of provider engagement and quality improvement	Low confidence in reported MCO PIP results	Partially Met

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

Summary of Previous Year (2019) MCO PIP CAP

The response submitted by the MCO to the 2019 CAP was reviewed and accepted with the following response by HCA:

- **MHW:** Not Met. Immediate correction of CAP required. The final part of this CAP is not met:
  - The BHSO population was not identified and addressed in clinical and non-clinical PIPs.
  - Individual PIP scores did not improve from last year.

Table A-16. MHW's Performance Measure Strengths and Weaknesses/Opportunities for Improvement.

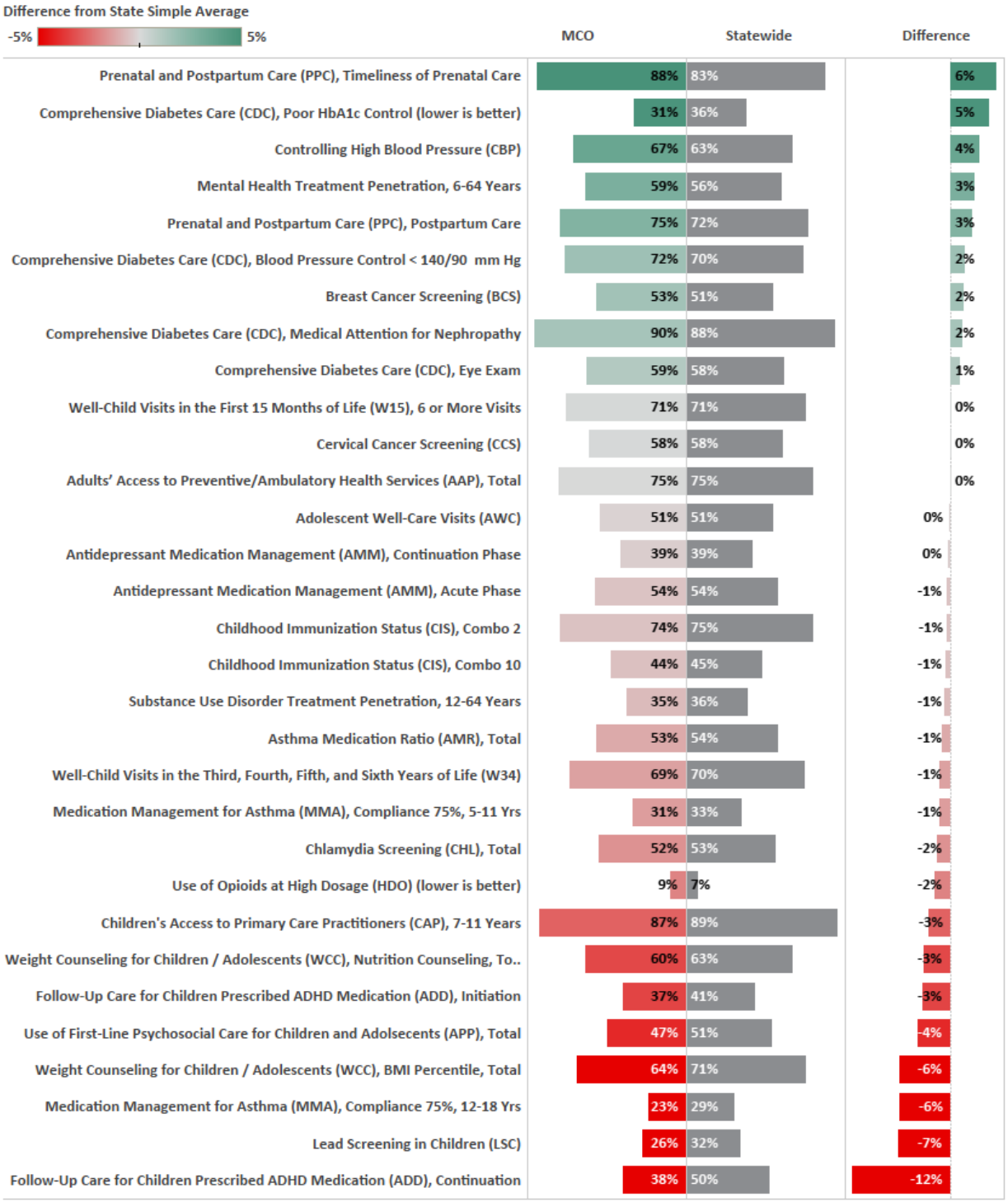
Performance Measures	
Strengths	**Weaknesses/Opportunities for Improvement**
Access to Care Measures • Prenatal and Postpartum Care (PPC) is above the state average for both the Timeliness of Prenatal Care and Postpartum Care measures.	**Preventive Care** • Lead Screening in Children (LSC) measure is below the state average. • Childhood Immunization Status (CIS), Combo 10 measure is below the state average.
Preventive Care • Cervical Cancer Screening (CCS) measure is above the state average.	—

Chronic Care Management
• All of the components of the Comprehensive Diabetes Care (CDC) measure are above the state average. Performance was particularly good on the following components:
  ○ Poor HbA1c Control
  ○ Blood Pressure Control < 140/90 mm Hg
• Controlling High Blood Pressure (CBP) measure is above the state average.
	—

Behavioral Health Medication Management • Use of First-Line Psychosocial Care for Children and Adolescents (APP), Total measure is 17% above the state average. • Follow-Up Care for Children Prescribed ADHD Medication (ADD) is above the state average for both the Initiation and Continuation components.	—

UnitedHealthcare Community Plan (UHC)

Figure A-6. UHC Scorecard.



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

Table A-17. Summary of UHC's 2020 Compliance Review Results.

Compliance with Regulatory and Contractual Standards				
Standard	**MCO Score/Possible**	**%**	**BHSO Score/Possible**	**%**
Element: Quality **Enrollee Rights**	34/36	94%	31/33	94%
Weaknesses/Opportunities for Improvement UHC-MCO and UHC-BHSO should focus their improvement efforts on: • When providers fail to demonstrate an understanding or compliance with enrollee rights, ensure corrective action process address all necessary steps, corrections, and retraining requirements • Provide information on provider termination report regarding the reason for termination				
Element: Access, Timeliness **Availability of Services**	17/21	81%	14/18	78%
Weaknesses/Opportunities for Improvement UHC-MCO and UHC-BHSO should focus their improvement efforts on: • Ensure policy addressing Provider Directory update reviews includes a process to confirm providers listed in the directory are practicing in Washington State or an allowed border state • Policy needs to include how the MCO/BHSO addresses issues identified in the network • Ensure network issues log includes all required elements • MCO/BHSO website needs to reflect the requirements regarding children's mental health treatment and services • The provider manual needs to include references related to billing the enrollee or balance billing • Policy on access and availability standards needs to include all requirements				
Element: Quality, Access **Coordination and Continuity of Care**	17/18	94%	18/18	100%
Strengths UHC-MCO and UHC-BHSO met all elements for the coordination and continuity of care standard.				
Element: Quality **Practice Guidelines**	9/9	100%	9/9	100%
Strengths UHC-MCO and UHC-BHSO met all elements for the practice guidelines standard.				

Table A-18. Summary of 2019 Corrective Action Plans for UHC.

Review of 2019 MCO Corrective Action Plans	Not Met	Partially Met	Met
Element: Access **Standard: Coverage and Authorization**	1	–	1
Two elements reviewed for CAPs • 438.210(b) (1) (2) (3) Authorization of services – Met • 438.210(c) Notice of adverse benefit determination – Repeat Finding*			
Element: Timeliness **Standard: Grievance systems**	–	–	1
One element reviewed for CAPs • 438.236(d) Application of [practice] guidelines – Met			
Element: Quality **Standard: QAPI**	–	–	1
One element reviewed for CAPs • 438.66(c)(3) - Provider Complaints and Appeals – Met			

**Repeat finding is also scored as not met.*

Table A-19. Summary of UHC's 2020 PIPs.

Performance Improvement Projects (PIPs)*			
Type	**Study Topic**	**Confidence**	**Score**
Element: Quality **Clinical:** Washington State Institute for Public Policy Adult (AHMC)	Increase anti-depressant treatment plan compliance for adult, female, TANF (Temporary Assistance for Needy Families) members diagnosed with depression	Confidence in reported MCO PIP results	Not Met
Element: Quality Clinical: Washington State Institute for Public Policy Adult (FIMC)	Increase anti-depressant treatment plan compliance for members diagnosed with depression	Confidence in reported MCO PIP results	Not Met
Element: Access, Quality **Clinical:** (BHSO)	Jail transition and Assertive Community Treatment	Reported MCO PIP results not credible	Not Met
Element: Quality, Timeliness **Clinical:** Washington State Institute for Public Policy Children (AHMC, FIMC)	Increasing The ADD (ADHD Medication Adherence) Initiation Phase HEDIS Measure Rate	Low confidence in reported MCO PIP results	Partially Met
Element: Access, Quality, Timeliness Non-clinical: (AHMC, FIMC)	Improving the rate of members receiving diabetic education services	Confidence in reported MCO PIP results	Partially Met

Performance Improvement Projects (PIPs)*			
Type	**Study Topic**	**Confidence**	**Score**
Element: Quality **Non-clinical:** (BHSO)	Coordination of care between behavioral health and medical providers	Reported MCO PIP results not credible	Not Met

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

Summary of Previous Year (2019) MCO PIP CAP

The response submitted by the MCO to the 2019 CAP was reviewed and accepted with the following response by HCA:

- **UHC:** Not Met. Immediate correction of CAP required. The final part of the CAP is not met, as the PIP scores this year were not improved from last year.
    - The AMM PIP (IMC, Adult WSIPP) that was a continuation from 2019, scored "partially met" last year and "not met" this year.
    - The non-clinical PIP on diabetic education services that was a continuation from 2019, scored "met" last year and "not met" this year.
    - Three other plan-specific PIPs were new topics this year. Of those, one is "partially met" and two are "not met."

Table A-20. UHC's Performance Measure Strengths and Weaknesses/Opportunities for Improvement.

Performance Measures	
Strengths	**Weaknesses/Opportunities for Improvement**
Access to Care Measures • Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care measure is above the state average.	**Behavioral Health Medication Management** • Follow-Up Care for Children Prescribed ADHD Medication (ADD) is below the state average for both the Initiation and Continuation components. The continuation component is especially low at 12% below the state average.
Preventive Care • Comprehensive Diabetes Care (CDC), Poor HbA1c Control is above the state average.	**Preventive Care** • Lead Screening in Children (LSC) measure is below the state average. • Weight Counseling for Children and Adolescent (WCC), BMI Percentile, Total measure is below the state average.
—	**Chronic Care Management** • Medication Management for Asthma (MMA) measure is 6% below the state average for the 12-18 years age group.

Appendix B: Compliance Regulatory and Contractual Requirements

Compliance Review and Manner of Reporting

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

Objectives

The purpose of the compliance review is to determine whether Medicaid managed care plans are in compliance with federal standards. The U.S. Department of Health & Human Services (HHS) developed standards for managed care plans, including 42 CFR §438 and 42 CFR §457.[23,24]

Technical Methods of Data Collection

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

Description of Data Obtained

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

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

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

Data Aggregation and Analysis

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

- Document Request

[23] Electronic Code of Federal Regulations. Title 42, part 438 – Managed Care. Available here: https://www.ecfr.gov/cgi-bin/text-idx?rgn=div5&node=42:4.0.1.1.8.

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

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

Regulations Subject to Compliance Review

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

- Availability of services §438.206
- Assurances of adequate capacity and services §438.207
    - TEAMonitor reviews this standard in conjunction with §438.206(b)(1)(i-v) & (c) Delivery network and §438.10 (h) Information for all enrollees – Provider directory
- Coordination and continuity of care §438.208
- Coverage and authorization of services §438.210
- Provider selection §438.214
- Confidentiality §438.224
    - TEAMonitor reviews this standard in conjunction within the review of §438.208(b)
- Grievance and appeal systems §438.228
- Subcontractual relationships and delegation §438.230
- Practice guidelines §438.236
- Health information systems §438.242
- Quality assessment and performance improvement program (QAPI) §438.330

Regulatory and Contractual Requirements

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

In addition, plans are reviewed on elements that received Partially Met or Not Met scores in previous reviews within the cycle.

438.56 - Disenrollment: Requirements and limitations

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

438.100 - Enrollee rights*

438.100(a) - General rule

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

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

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

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

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

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

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

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

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

438.100(d) Compliance with other federal and state laws

438.106 Liability for payment

438.206 - Availability of services*

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

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

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

438.206(b)(4) Services out of network

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

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

438.206(c)(2) Cultural considerations

438.207 - Assurances of adequate capacity and services

438.207(a) General rule

438.207(b) Nature of supporting documents

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

438.207(c) Timing of documentation

438.208 Coordination and continuity of care*

438.208 Continuity of Care - File review

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

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

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

438.240(b)(4) Care coordination oversight

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

438.210 - Coverage and authorization of services

438.210(b) Authorization of services

438.210(c) Notice of adverse action

438.210(d) Timeframe for decisions

438.210(e) Compensation for utilization management decisions,

438.114 Emergency and post-stabilization services

438.214 - Provider selection

438.214(a) General rules

438.214(b) Credentialing and recredentialing requirements

438.214(c) and 438.12 Nondiscrimination and provider discrimination prohibited

438.214(d) Excluded providers

438.214(e) State requirements

438.224 – Confidentiality

438.224 Confidentiality

438.228 - Grievance and appeal systems

438.228(a)(b) Grievance and appeal systems

438.400(b) Statutory basis and definitions

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

438.402(c)(2) Filing requirements - timing

438.402(c)(3) Filing requirements - procedures

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

438.404(b) Notice of action - content of notice

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

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

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

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

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

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

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

438.410 Expedited resolution of appeals

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

438.416 Recordkeeping and reporting requirements

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

438.424 Effectuation of reversed appeal resolutions

438.230 - Subcontractual relationships and delegation

438.230(a)(b) Subcontractual relationships and delegation

438.230(c)(2) Subcontractual relationships and delegation

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

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

438.236 - Practice guidelines*

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

438.236(c) Dissemination of [practice] guidelines

438.236(d) Application of [practice] guidelines

438.242 - Health information systems

438.242 Health information systems - General rule

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

438.242(b)(3) Basic elements

438.330 - Quality assessment and performance improvement program

438.330(a) General rules*

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

438.330(d) Performance improvement projects*

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

Appendix C: PIP Validation Procedures

PIP Validation Procedure

Objectives

As part of their overall compliance review of Apple Health MCOs, HCA (TEAMonitor) conducts a review of performance improvement projects (PIPs). The purpose of a PIP is to assess and improve the processes and outcomes of health care provided by an MCO.

Technical Methods of Data Collection

The TEAMonitor evaluations are based on Attachment A of *EQR Protocol 3: Validating Performance Improvement Projects, Version 2.0*[25] developed by the Centers for Medicare & Medicaid Services (CMS) to determine whether a PIP was designed, conducted and reported in a methodologically sound manner.

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

A. Assess the study methodology

B. Verify PIP study findings

C. Evaluate overall validity and reliability of study results

Part A: Assessing the Study Methodology

1. Review the selected study topic(s) for the appropriateness of the selected study topic(s) in addressing the overarching goal of a PIP to improve processes and outcomes of health care provided by the MCO.
2. Review the study question(s) for the appropriateness and adequacy of the study question(s) in identifying the focus and establishing the framework for data collection, analysis and interpretation.
3. Review the identified study population to determine whether the PIP population was clearly identified.
4. Review the selected study indicators to determine if appropriate measures are used.
5. Review the sampling methods for appropriateness and validity of the PIP's sampling method.
6. Review the data collection procedures to determine the validity of the procedures the MCO uses to collect the data that inform the PIP measurements.
7. Review the data analysis and interpretation of study results to determine the accuracy of the MCO's plan for analyzing and interpreting the PIP's results.
8. Assess the MCO's improvement strategies for the appropriateness of the strategy for achieving true improvements.
9. Access the likelihood that reported improvement is "Real" improvement.
10. Assess sustainability of the documented improvement.

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

Part B: Verifying Study Findings (optional)

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

Part C: Evaluate Overall Validity and Reliability of Study Results

Following the completion of Activity 1 and Activity 2, the EQRO will assess the validity and reliability of all findings to determine whether or not the State has confidence in the MCO's reported PIP findings.

TEAMonitor utilizes one of the following confidence indicators in reporting the results of the MCOs' PIPs:

- High confidence in reported results
- Confidence in reported results
- Low confidence in reported results
- Reported results not credible
- Enough time has not elapsed to assess meaningful change

Description of Data Obtained

TEAMonitor validates each PIP using data gathered and submitted by the MCO using Attachment A of *EQR Protocol 3: Validating Performance Improvement Projects, Version 2.0.*

Data Aggregation and Analysis

As the MCOs submit their PIP data directly within the protocol attachment, all elements necessary for the validation of the PIP is submitted and readily available for TEAMonitor to validate.

The TEAMonitor scoring method for evaluating PIPs is outlined below.

PIP Scoring

TEAMonitor scored the MCOs' PIPs as Met, Partially Met or Not Met according to how well they performed against a checklist of elements designed to measure success in meeting the standards specified by CMS. The elements associated with the respective scores follow.

To achieve a score of Met, the PIP must demonstrate all of the following 12 elements:

- A problem or need for Medicaid enrollees reflected in the topic of the PIP.
- The study question(s) stated in writing.
- Relevant quantitative or qualitative measurable indicators documented.
- Descriptions of the eligible population to whom the study questions and identified indicators apply
- A sampling method documented and determined prior to data collection

- The study design and data analysis plan proactively defined
- Specific interventions undertaken to address causes/barriers identified through data analysis and QI processes (e.g., barrier analysis, focus groups, etc.)
- Numerical results reported (e.g., numerator and denominator data)
- Interpretation and analysis of the reported results
- Consistent measurement methods used over time or, if changed, documentation of the rationale for the change
- Sustained improvement demonstrated through repeat measurements over time (baseline and at least two follow-up measurements required)
- Linkage or alignment between the following: data analysis documenting need for improvement, study questions, selected clinical or nonclinical measures or indicators, results

To achieve a score of Partially Met, the PIP must demonstrate all of the following seven elements. If the PIP fails to demonstrate any one of the elements, the PIP will receive a score of Not Met.

- A problem or need for Medicaid enrollees reflected in the topic of the PIP.
- The study question(s) stated in writing.
- Relevant quantitative or qualitative measurable indicators documented.
- A sampling method documented and determined prior to data collection
- The study design and data analysis plan proactively defined
- Numerical results reported (e.g., numerator and denominator data)
- Consistent measurement methods used over time or, if changed, documentation of the rationale for the change

Appendix D: Performance Measure Validation Methodology

Performance Measure Validation Methodology

This appendix contains additional information about the methodology used for the analysis presented in this report.

Technical Methods of Data Collection

HEDIS

Comagine Health assessed Apple Health MCO-level performance data for the 2020 reporting year (calendar year 2019). The measures include 56 Healthcare Effectiveness Data and Information Set (HEDIS®) performance measure rates collected in 2020, reflecting performance in calendar year 2019. It also includes behavioral health measures that were developed by the Washington State Health Care Authority. To be consistent with NCQA methodology, the 2019 calendar year (CY) is referred to as the 2020 reporting year (RY) in this report. The measures also include their indicators (for example, rates for specific age groups or specific populations).

Washington State Behavioral Health Measures

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

- Mental Health Service Penetration – Broad Definition (MH-B)
- Substance Use Disorder Treatment Penetration (SUD)

The MH-B metric is a state-developed measure of access to mental health services (among persons with an indication of need for mental health services). The SUD metric is a state-developed measure of access to SUD treatment services (among persons with an indication of need for SUD treatment services). HCA partners with the Department of Social and Health Services RDA to measure performance. Data is collected via the administrative method, using claims, encounters and enrollment data and assessed on a quarterly basis.

Administrative Versus Hybrid Data Collection

HEDIS measures draw from clinical data sources, utilizing either a fully "administrative" or a "hybrid" collection method, explained below:

- The administrative collection method relies solely on clinical information collected from electronic records generated through claims, registration systems or encounters, among others.
- The hybrid collection method supplements administrative data with a valid sample of carefully reviewed chart data.

Because hybrid measures are supplemented with sample-based data, scores for these measures will always be the same or better than scores based solely on the administrative data for these measures.[26]

Table D-1 outlines the difference between state rates for select measures comparing the administrative rate (before chart reviews) versus the hybrid rate (after chart reviews).

[26] *Tang et al. HEDIS measures vary in how completely the corresponding data are captured in course of clinical encounters and the degree to which administrative data correspond to the actual quality parameter they are designed to measure.*

Table D-1. Administrative versus Hybrid Rates for Select Measures, 2020 RY.

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

Description of Data Obtained

Supplemental Data

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

Rotated Measures

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

Table D-2 shows all the rotated measures and which MCO reported on them. MCO-specific charts in the report will include footnotes to indicate where rotated measures are reported.

Table D-2. Rotated Measures by MCOs.

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

Measure Name	AMG	CCW	CHPW	MHW	UHC
Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care	Y	—	—	—	—
Prenatal and Postpartum Care (PPC), Postpartum Care	Y	—	—	—	—
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC), All Components and Age Bands	Y	—	—	—	—
Well-Child Visits in the First 15 Months of Life (W15), 0, 1, 2, 3, 4, 5 and 6 or More Visits	Y	Y	—	—	—
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)	—	—	—	—	Y

Y = indicates yes; the MCO reported on that measure.
— Indicates the MCO did not report that measure.

Data Aggregation and Analysis

Calculations and Comparisons

Sufficient Denominator Size

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

Calculation of the Washington Apple Health Average

This report provides estimates of the average performance among the five Apple Health MCOs for the three most recent reporting years: 2018 RY, 2019 RY and 2020 RY. The majority of the analyses presented in this report use the state weighted average. The state weighted average for a given measure is calculated as the weighted average among the MCOs that reported the measure (usually five), with the MCOs' shares of the total eligible population used as the weighting factors.

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

Comparison to Benchmarks

This report provides national benchmarks for select HEDIS measures from the 2020 NCQA Quality Compass. These benchmarks represent the national average and selected percentile performance

among all NCQA-accredited Medicaid HMO plans and non-accredited Medicaid HMO plans that opted to publicly report their HEDIS rates. These plans represent states both with and without Medicaid expansion. The number of plans reporting on each measure varies, depending on each state's requirement (not all states require reporting; they also vary on the number of measures they require their plans to report).

The license agreement with NCQA for publishing HEDIS benchmarks in this report limits the number of individual indicators to 30, with no more than two benchmarks reported for each selected indicator. Therefore, a number of charts and tables do not include a direct comparison with national benchmarks but may instead include a narrative comparison with national benchmarks, for example, noting that a specific indicator or the state average is lower or higher than the national average.

Note there are no national benchmarks for the Washington State Behavioral Health measures. As an alternative approach, HCA leadership chose to consider the plan with the second highest performance in 2017 as the benchmark.

Interpreting Percentages versus Percentiles

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

The national benchmarks included in this report are often displayed as percentiles. The percentile shows how Plan A ranks among all other plans who have reported Breast Cancer Screening rates. For example, if we say the plan's Breast Cancer Screening rate is at the national 50th percentile, it means that approximately 50% of the plans in the nation reported Breast Cancer Screening rates that were equal to or below Plan A; approximately 50% of the plans in the nation had rates that were above. If Plan A is above the 90th percentile, that means that at least 90% of the plans reported rates below Plan A.

The national percentiles give a benchmark, or point of comparison, to assess how Plan A's performance compares to other plans. This is especially important for identifying high priority areas for quality improvement. For example, if Plan A performs below the 50th percentile, we can conclude there is a lot of room for improvement given the number of similar plans who perform better than Plan A. However, if Plan A performs above the 90th percentile, we can conclude that performance on that particular measure already exceeds the performance of most other plans and improving the actual rate for that measure may not be the highest priority.

Statistical Significance

Throughout this report, comparisons are frequently made between specific measurements (e.g., for an individual MCO) and a benchmark. Unless otherwise indicated, the terms "significant" or "significantly" are used when describing a statistically significant difference at the 95 percent confidence level. A Wilson Score Interval test was applied to calculate the 95 percent confidence intervals.

For individual MCO performance scores, a chi-square test was used to compare the MCO against the remaining MCOs as a group (i.e., the state average not including the MCO score being tested). The results of this test are included in Appendix B tables for all measures, when applicable. Occasionally a test may be significant even when the confidence interval crosses the state average line shown in the

bar charts, because the state averages on the charts reflect the weighted average of all MCOs, not the average excluding the MCO being tested.

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

Denominator Size Considerations and Confidence Intervals

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

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

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

For example, if a plan had a performance rate in the previous year of 286/432 (66.20%), the Wilson Score Interval would provide a 95% confidence interval of 61.62% (lower confidence interval value) to 70.50% (upper confidence interval value). The plan's current rate for the measure is then compared to the confidence interval to determine if there is a statistically significant change. If the plan is currently performing at a 72% rate, the new rate is above the upper confidence interval value and would represent a statistically significant improvement. However, if the plan is currently performing at a 63% rate, the new rate is within the confidence interval range and is statistically the same as the previous rate. If the current performance rate is 55%, the new rate is below the lower confidence interval value and would represent a statistically significant decrease in performance.

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

Interpreting Performance

Potential Sources of Variation in Performance

The adoption, accuracy and completeness of electronic health records (EHRs) have improved over recent years as new standards and systems have been introduced and enhanced. However, HEDIS performance measures are specifically defined; occasionally, patient records may not include the specific notes or values required for a visit or action to count as a numerator event. Therefore, it is

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

Additional Notes Regarding Interpretation

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

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

Limitations

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

The NCQA's decision was made to avoid placing a burden on clinics while they were dealing with the COVID-19 crisis. However, this means that Comagine Health did not have access to updated rates for certain measures from the plans.

- **State behavioral health measures**: There are no national benchmarks available for the Washington behavioral health measures.
- **Impact of Behavioral Health Integration**: For regions that have not been fully integrated, there will be data from the BHSOs that is not included in the behavioral health measure calculations.

Appendix E: TEAMonitor Review Schedule

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

In 2021, TEAMonitor will complete the current review three-year review cycle of the MCPs. In 2022, a new three-year cycle will begin.

Summary of Previous Findings Within the Current Review Cycle

In 2019, Year One (1) of the current review cycle, TEAMonitor reviewed the following standards:

- §438.228 - Grievance and Appeals Systems
- §438.214 - Provider Selection (Credentialing)
- §438.330 - Quality Assessment and Performance Improvement Program (QAPI)
    - TEAMonitor reviews §438.66 (c)(3) Monitoring Procedures - Claims payment monitoring in conjunction with the QAPI standard

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. If an MCP receives a corrective action plan or recommendations based on an element, that element will be re-reviewed the following year or until the finding is satisfied.

Scoring

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

Scoring Key:

- Score of 0 or 1 indicates 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) and the corresponding percentage. For example, in a section consisting of four elements in which the MCP scored a 3, or Met, in three categories and a 1, or Not Met, in one category, the total number of possible points would be 12, and the MCP's total points would be 10, yielding a score of 10 out of 12 with a corresponding 83%.

Table E-1 summarizes the previous scores of the current review cycle (2019-2021). Note Year 2 of the cycle is the first year of BHSO review and no scores are available for Year 1.

Table E-1: Summary of 2019 Scores (Year 1 of Current Review Cycle).

Compliance Area and CFR Citation	AMG		CCW		CHPW		MHW		UHC	
Element: Quality §438.228 - Grievance and Appeals Systems	45/54	83%	50/54	93%	49/54	91%	54/54	100%	54/54	100%
Element: Quality §438.214 - Provider Selection (Credentialing)	12/12	100%	12/12	100%	9/12	75%	12/12	100%	12/12	100%
Element: Quality §438.330 - Quality Assessment and Performance Improvement Program (QAPI)	13/15	87%	15/15	100%	15/15	100%	14/15	93%	14/15	93%

In addition, 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' 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 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 UM or coverage determinations and other functional areas is consistent with adopted practice guidelines.

Subcontractual Relationships and Delegation

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

Schedule For Review of Remaining Standards of the Review Cycle (Year 3)

The current review cycle will conclude with review of the following standards in 2021:

- §438.608: Program integrity requirements under the contract
- §447.46: Timely claims payment
- §438.210: Coverage and authorization of services
- §438.56: Disenrollment: Requirements and limitations
- §438.230: Subcontractual relationships and delegation

Appendix F: 2020 Enrollee Quality Report

Comagine Health produced the *2020 Enrollee Quality Report,* designed to provide Apple Health applicants and enrollees with simple, straightforward comparative health plan performance information that may assist them in selecting a plan that best meets their needs.

Data sources for this report include the Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measure sets. The rating method is in alignment with the star rating systems used by other states and reflects the data sources available for the Apple Health population in Washington. For more information on the methodology used to derive this report's star rating system, refer to Comagine Health's *2020 Enrollee Quality Report Methodology.*

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** ★☆☆

Table E-1. 2020 Washington Apple Health Plan Report Card.

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 2019. The information was reviewed for accuracy by independent auditors. Health plan performance scores were not adjusted for differences in their member populations or service regions.

Performance Area Definitions

Getting Care

- Members have access to a doctor
- Members report they get the care they need, when they need it

Keeping Kids Healthy

- Children in the plan get regular checkups
- Children get important immunizations
- Children get the appropriate level of care when they are sick

Keeping Women and Mothers Healthy

- Women get important health screenings, such as cervical cancer screenings
- New and expecting mothers get the care they need

Preventing and Managing Illness

- The plan helps its members keep long-lasting illness under control, such as asthma, high blood pressure or diabetes
- The plan helps prevent illnesses with screenings and appropriate care

Ensuring Appropriate Care

- Members receive 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